# BOARD QUALITY REVIEW COMMITTEE MEETING

**AGENDA**

Wednesday, July 27, 2022

4:00 pm Meeting

Participation will be virtual pursuant to
Board Resolution No. 01.10.22(03)-03
-Please see meeting log-in information on page 2-

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### CALL TO ORDER

4:00

1. **Establishment of Quorum**

2. **Public Comments**

3. **Action Item(s)**
   a. *Minutes: Board Quality Review Committee Meeting – June 16, 2022* **[ADD A-Pg 20]**
   b. *Approval of Contracted Services*
      - San Diego Urology Mobile Services **[ADD B-Pg 20]**
      - South Coast Perfusion **[ADD C-Pg 20]**
      - Specialty Care Intraoperative Monitoring Services **[ADD D-Pg 20]**
      - UHS Surgical Services, Inc. **[ADD E-Pg 20]**
      - Davita Dialysis **[ADD F-Pg 20]**

4. **Standing Item(s)**
   a. Medical Executive Committee (MEC) / Quality Management Committee (QMC) Update
   b. Supply Chain Equipment Acquisition/End of Life Process **[ADD G-Pg 41]**
   c. Centers of Excellence Annual Report **[ADD I-Pg 32]**
   d. Centers of Excellence Annual Report **[ADD J-Pg 33]**
   e. Rehabilitation Services **[ADD K-Pg 77]**
   f. Medical Staff: Utilization Review **[ADD L-Pg 85]**
   g. Medication Management (Pharmacy) **[ADD M-Pg 91]**

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i. Environment of Care & Emergency Management Annual Evaluation
   Dan Farrow, Sr. Dist. Director, Facilities
   Anis Trabelsi, Chief Security Officer

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<td>a. Pursuant to CA Gov’t Code §54962 &amp; CA Hlth &amp; Safety Code §32155; HEARINGS – Subject matter: rpt of quality assurance ctte.</td>
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<td>Linda Greer, RN – Chairperson, Board Member</td>
<td>Diane Hansen, CPA, President / Chief Executive Officer</td>
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<td>Terry Corrales, RN, Board Member</td>
<td>Sheila Brown, RN, MBA, FACHE, Chief Operations Officer</td>
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<td>Laura Barry, Board Member</td>
<td>Omar Khawaja, MD, Chief Medical Officer</td>
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<td>Kanchan Koirala, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido</td>
<td>Hugh King, Chief Financial Officer</td>
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<td>Sam Filiciotto, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway</td>
<td>Melvin Russell, RN, MSN, Chief Nursing Executive Palomar Medical Center</td>
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<td>Laurie Edwards Tate, MS - Board Member 1st Alternate</td>
<td>Kevin DeBruin, Esq., Chief Legal Officer</td>
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<td>David Lee, MD, Medical Quality Officer</td>
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<td>Tricia Kassab, EdD, RN, FACHE, Vice President Quality and Patient Safety</td>
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<td>Valerie Martinez, RN, BSN, MHA, CPHQ, CIC – Senior Director, Quality and Patient Safety/ Infection Prevention</td>
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NOTE: If you have a disability, please notify us by calling 44.281.2505, 72 hours prior to the event so that we may provide reasonable accommodations

*Asterisks indicate anticipated action. Action is not limited to those designated items.

1 3 minutes allowed per speaker with a cumulative total of 9 minutes per group. For further details & policy, see attachment.

PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE

https://meet.goto.com/559657853
Access Code: 559-657-853

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https://global.gotomeeting.com/install
### BOARD QUALITY REVIEW COMMITTEE MEETING
### ATTENDANCE ROSTER - CALENDAR YEAR 2022

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<td>SAM FILICIOTTO, MD, Chair, Medical Staff Quality Management Committee, PMC Poway</td>
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<td>SHEILA BROWN, RN, MBA, FACHE, Chief Operations Officer</td>
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<td>OMAR KHAWAJA, MD, Chief Medical Officer</td>
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<td>KEVIN DEBRUIN, Esq., Chief Legal Officer</td>
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<td>STEPHANIE BAKER, MBA, RN, CEN, Chief Administrative Officer</td>
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TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sheila Brown, Chief Operations Officer

Background: Upon retirement of Chief Operations Officer, recommend approval of Dr. Omar Khawaja, Chief Medical Officer, to the position of Administrative Liaison for the Board Quality Review Committee.

Budget Impact: N/A

Staff Recommendation: Recommendation to approve Chief Medical Officer replacing the Chief Operations Officer as Administrative Liaison to the Board Quality Review Committee.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information:

Required Time:
Board Quality Review Committee Minutes
Wednesday, July 27, 2022

TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: Minutes from the Thursday, June 16, 2022, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Thursday, June 16, 2022, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for San Diego Urology Mobile Services is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for South Coast Perfusion is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for Specialty Care Intraoperative Monitoring Services is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:
Motion: x
Individual Action:
Information:
Required Time:
TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for UHS Surgical Services, Inc. is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for Davita Dialysis is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sally Valle, Committee Secretary

Background: The PMC Poway Operating Room Quality Indicator report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: The Supply Chain Equipment Acquisition & End of Life Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:
Individual Action:
Information: X
Required Time:
TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: The Spine and Total Joint Centers of Excellence Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sally Valle, Committee Secretary

Background: The Bariatric Services Center of Excellence Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: The Rehabilitation Services report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee
MEETING DATE: Wednesday, July 27, 2022
FROM: Sally Valle, Committee Secretary

Background: The Medical Staff Utilization Review report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO:            Board Quality Review Committee

MEETING DATE:  Wednesday, July 27, 2022

FROM:          Sally Valle, Committee Secretary

Background:    The Medication Management (Pharmacy) report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 27, 2022

FROM: Sally Valle, Committee Secretary

Background: The Environment of Care & Emergency Management Plan Annual Evaluation is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
ADDENDUM A
**Board Quality Review Committee Meeting Minutes – Thursday, June 16, 2022**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Conclusion/Action</th>
<th>Follow Up / Responsible Party</th>
<th>Final?</th>
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**Notice of Meeting**

The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Thursday, June 2, 2022, consistent with legal requirements.

**Call to Order**

Pursuant to Board Resolution No. 01.10.22(03)-03 participation will be virtual and the meeting was called to order at 1:00 p.m. by Director Linda Greer, RN.

**Establishment of Quorum**

Quorum comprised of Board Directors: Director Linda Greer, Director Terry Corrales, RN; Director Laura Barry; and Physician Chair of the Medical Staff Quality Management Committees, Kanchan Koirala, M.D. Palomar Medical Center Escondido.

**Public Comment**

There were no public comments.

**Action Items:**

A. *Review / Approval: Open/Closed Session Meeting Minutes / Attendance Roster – March 23, 2022*

The BQRC meeting minutes from March 23, 2022, were presented for review and approval. Director Laura Barry, motioned for approval, second by Kanchan Koirala, MD.

**MOTION:** by Director Laura Barry, second by Kanchan Koirala, M.D., carried to approve the meeting minutes of March 23, 2022, as submitted. Roll call voting was utilized.

Directory Linda Greer, RN- Aye
Director Laura Barry – Aye
Kanchan Koirala, MD – Aye

All in favor. None opposed. The meeting minutes were approved as submitted.

B. *Review / Approval: Quality Assessment Performance Improvement Plan*
The committee reviewed Quality Assessment Performance Improvement Plan. No further discussion.

**MOTION:** by Director Laura Barry, second by Kanchan Koirala, M.D., to approve the Quality Assessment Performance Improvement Plan as presented.

Roll call voting was utilized.

Directory Linda Greer, RN- Aye
Director Laura Barry – Aye
Kanchan Koirala, MD – Aye
All in favor. None opposed.

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<th>C. * REVIEW / APPROVAL: CONTRACTED SERVICES</th>
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<td>Tricia Kassab, VP of Quality and Patient Safety, presented the Contracted Services report to the committee. Emerald provides our linen and scrubs service and Morrison provides our food and nutritional services. Both have met all of their performance metrics.</td>
<td><strong>MOTION:</strong> by Director Laura Barry, second by Kanchan Koirala, M.D., approved to accept contracted service reviews of Emerald Textiles and Morrison Management Specialists.</td>
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| Contracted Service Evaluations include:  
  - Emerald Textiles  
  - Morrison Management Specialists |  
| Sheila Brown & Debbie Hollick took a moment to introduce the new BQRC secretary, Sally Valle. |  

**STANDING ITEM(S)**

A. **MEDICAL EXECUTIVE COMMITTEE (MEC)/QUALITY MANAGEMENT COMMITTEE (QMC) UPDATE**
Dr. Kanchan Koirala provided the monthly report for the Medical Executive Committee (MEC) and Quality Management Committee (QMC) from PMC Escondido and PMC Poway.

Various quality updates and quality achievements throughout the district were highlighted:

- The hospital at home program policies & procedures were reviewed and approved. They included power plans and medication administration.
- In regards to safety and quality there were several policies reviewed from Pharmacy & Therapeutics and the Infection Control Committee. Policies included were the Look Alike – Sound Alike Drugs and the Medication Substitution policies.
- On-going audits were presented.
- Dr. Koirala explained how issues are reported, monitored and resolved in conjunction with hospital administration, by the Quality Medical Committee. Director Greer was glad to hear the function of the QMC, and reiterated how the function of the Board was that of oversight, and not to resolve operational issues.

NEW BUSINESS

A. SPINE & TOTAL JOINT CENTERS OF EXCELLENCE

Deferred until next meeting.

MOTION: N/A

B. INFECTION PREVENTION AND CONTROL (INCLUDES ANTIBIOTIC STEWARDSHIP)

Susan Trout, Infection Preventionist, Dr. Soni, and the Infectious Disease Pharmacist, Travis Lau presented the 2021 Infection Surveillance, Control and Prevention Program Assessment.

Highlights included:
- Increased hand hygiene compliance to 90%
- Surgical site infections, VRE blood stream, and C-diff had a notable downward trend over consecutive years.
- Some challenges that exist are preventing device associated infections. Much work is being done to reverse the upward trend.
- IRP Program received a gold status designation over the past two years by the California Department of Public Health. Palomar Health is only one of two hospital
systems, in San Diego County, to have received this designation.

- There has also been a lot of work done with the COVID19 therapeutics handling over the pandemic. Literature based guidelines were written for Palomar Health keeping in mind the very high drug costs.
- Challenges remain with keeping C-diff infection rates low. Historically had been in the top 90th percentile. Will continue to monitor antimicrobial use and scrutinize the use of high risk C-diff antibiotics.
- Director Greer noted how thankful and appreciative she was for this work which makes for a safer organization for both staff and patients.

### C. LABORATORY SERVICES BIANNUAL REPORT

Dr. Jerry Kolins presented the Laboratory Services Biannual Report, which is a culmination of work by the Laboratory team.

Highlights included:

- Met benchmark with critical care resulting
- Lab was recognized by the San Diego County California Department of Public Health at their 21st annual Champion Awards for the work done with COVID19 and the Laboratory Task Force, which generated a small publication.
- Continue to work with the Emergency Department turn-around-time. Prior to COVID19 times were meeting benchmark however currently struggling with Troponin times due to staffing shortages, and the availability of supplies (tubes).
- On behalf of the ICU team, Dr. Koirala thanked Dr. Kolins and team for quick turn-around-times in the ICU. He also made a recommendation to look the possibility of doing blood draws with pediatric tubes for patients in the ICU in an effort to reduce the incidence of iatrogenic anemia.
- Director Corrales noted what a great meeting this was as there was a lot of communication and team work to determine the root cause of issues.

### MOTION:

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### D. PULMONARY SERVICES BIANNUAL REPORT

Dr. Frank Bender, Medical Director for Pulmonary Services, presented the Biannual Pulmonary Services report to the committee.

Highlights included:

- Compliance of positive patient identification with scanning prior to this initiative was 30% with use of the scanner. With the initiative in place it is now at 90%. Focus on this compliance has also resulted in proper labeling of specimens collected.
- Compliance of positive patient identification with scanning prior to this initiative was 30% with use of the scanner. With the initiative in place it is now at 90%. Focus on this compliance has also resulted in proper labeling of specimens collected.
- Director Greer thanked Dr. Bender and team for all their hard work during the COVID19 pandemic.

### MOTION:

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Director Greer requested to invite the Supply Chain team to a future meeting to report on the process of acquiring new equipment and equipment end of life. (Tim Stevens & Heather Woodling)

### ADJOURNMENT TO CLOSED SESSION
| **PURSUANT TO CA GOV’T CODE §54962 & CA HLTH & SAFETY CODE §32155;** | **MOTION:** N/A |
| **HEARINGS – SUBJECT MATTER: REPORT OF QUALITY ASSURANCE COMMITTEE** | **Y** |

**ADJOURNMENT TO OPEN SESSION**
- There were no action items identified in the Closed Session of the meeting.

**PUBLIC COMMENTS**
There were no public comments.

**FINAL ADJOURNMENT** - The meeting adjourned at 2:00 p.m.
**MOTION:** N/A

**SIGNATURES:**

**COMMITTEE CHAIR**

Linda Greer, RN

**COMMITTEE ASSISTANT**

Sally Valle
ADDENDUM B
San Diego Urology Services – Mobile Lithotripsy Services

Review of Contract Service for FY22 (July 1, 2021 – June 30, 2022)

Name of Service: San Diego Urology Services – Mobile Lithotripsy Services
Date of Review: July 8, 2022
Name / Title of Reviewer: Bruce R. Grendell, MPH, BSN, RN
District Director, Perioperative Services
Palomar Health
Nature of Service (describe): The procedure performed by this mobile service is called Extracorporeal Shock Wave Lithotripsy (ESWL). This is a non-invasive treatment for kidney stones. The lithotriptor attempts to break up the stone with minimal collateral damage by using an externally applied, focused, high-intensity acoustic pulse.

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<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>METRIC</td>
<td>FY22 QTR 1</td>
<td>FY22 QTR 2</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
</tr>
<tr>
<td>ESWL equipment is clean and in good working order.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>ESWL Technician is professional, arrives on time and is competent in his / her duties.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No cancelled cases related to contracted service Key Performance Indicators (KPIs)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Contractor submits invoices for payment in a timely manner after service provided.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Comments:**
*In Q3 FY22, during Infection Control rounds in the OR at PMC Poway, dust was noted on the ESWL unit. This was corrected on the spot and notice sent to service provider. No additional incidents noted during contract evaluation period.*

**On June 30, 2022, the mobile lithotripter did not pass the biomed electrical safety test and the procedure was cancelled. Issue was resolved the next day and no further issues have been reported.*

Conclusion (check one)

√ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply):

☐ Monitoring and oversight of the contract service has been increased

☐ Training and consultation has been provided to the contract service

☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care

☐ Penalties or other remedies have been applied to the contract entity

☐ The contractual agreement has been terminated without disruption in the continuity of patient care

☐ Other:
  

________________________________________________________________________

27
ADDENDUM C
# South Coast Perfusion LLC

**Review of Contract Service for FY22 (July 1, 2021 – June 30, 2022)**

**Name of Service:** South Coast Perfusion, LLC  
**Date of Review:** July 8, 2022  
**Name / Title of Reviewer:** Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health

**Nature of Service (describe):** Services provided by South Coast Perfusion, LLC include Cardiopulmonary Bypass (CPB), Autotransfusion services, Ventricular Assist Device (VAD) set-up and monitoring, Extracorporeal Membrane Oxygenation (ECMO) / Cardiopulmonary Support (CPS), provision of Platelet Rich Plasma (PRP), Platelet Poor Plasma (PPP), Platelet Gel, Growth Factors, Intra-aortic Balloon Pump (IABP) set-up and monitoring services.

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td>✓</td>
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<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
## Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY22 QTR 1</th>
<th>FY22 QTR 2</th>
<th>FY22 QTR 3</th>
<th>FY22 QTR 4</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perfusionists in the group are current with BLS requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Perfusionists in the group are current with annual PPD requirements</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Perfusionists in the group are certified through the American Board of Cardiovascular Perfusion</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Annual proof of current professional liability insurance coverage</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

### Comments:

**Conclusion** (check one)

- **√** Contract service has met expectations for the review period
- **☐** Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply):
  - **☐** Monitoring and oversight of the contract service has been increased
  - **☐** Training and consultation has been provided to the contract service
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  - **☐** Penalties or other remedies have been applied to the contract entity
  - **☐** The contractual agreement has been terminated without disruption in the continuity of patient care
  - **☐** Other:
    
    ____________________________________________________________________

ADDENDUM D
Specialty Care IOM Services – Intraoperative Monitoring Services

Review of Contract Service for FY22 (July 1, 2021 – June 30, 2022)

Name of Service: Specialty Care IOM Services – Intraoperative Monitoring Services

Date of Review: July 11, 2022

Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health

Nature of Service (describe): Specialty Care Intraoperative Monitoring (IOM) Services provides the following intraoperative monitoring services:
- Somatosensory evoked potential (SSEP) monitoring
- Transcranial Motor Evoked Potential (TcMEP) monitoring
- Electromyography (EMG)
- Electroencephalography (EEG)
- Facial Nerve Monitoring
- Brainstem Auditory Evoked Potential monitoring.

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
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<td></td>
</tr>
</tbody>
</table>
## Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY22 QTR 1</th>
<th>FY22 QTR 2</th>
<th>FY22 QTR 3</th>
<th>FY22 QTR 4</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>IOM equipment is clean and in good working order.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>IOM Technician is professional, arrives on time and is competent in his / her duties.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No cancelled cases related to contracted service Key Performance Indicators (KPIs)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Contractor submits invoices for payment in a timely manner after service provided.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Personnel employed by contractor are current in all screening requirements per terms of the contract.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Comments:** No unusual occurrences documented during the contract service evaluation period.

**Conclusion (check one)**

- [x] Contract service has met expectations for the review period
- [ ] Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply):
  - [ ] Monitoring and oversight of the contract service has been increased
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  - [ ] Penalties or other remedies have been applied to the contract entity
  - [ ] The contractual agreement has been terminated without disruption in the continuity of patient care
  - [ ] Other:
ADDENDUM E
Review of Contract Service for FY22 (July 1, 2021 – June 30, 2022)

**Name of Service:** UHS Surgical Services, Inc.
**Date of Review:** July 11, 2022
**Name / Title of Reviewer:** Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health

**Nature of Service (describe):** UHS Surgical Services, Inc. provides services, equipment and supplies as stipulated by the contract. UHS also provides qualified, certified and or licensed personnel to provide technical support to the physicians. Equipment provided includes:

- Lasers for the treatment of Benign Prostatic Hypertrophy (BPH)
  - Greenlight XPS
  - Diode Ablation
  - Cyber TM
  - Morcellator
  - Holmium
  - Holmium Nd:YAG dual
  - KTP
  - KTP Aura
  - Revolix
  - CO2 Surgical
  - CO2 Omniguide
  - CO2 Clinicon
  - Argon Beam Coagulator
  - Cyberwand
  - Aloka Ultrasound
  - BK Ultrasound
  - ESWL
  - ESWL F2
  - Cryo Endocare for Prostate
  - Cryo Endocare for Renal
  - Cryo Endocare for IR
  - TMR Heart
  - SUSA
  - CO2 Cosmetic
  - GentleLase
  - KTP Aura Cosmetic
  - Medlight C6
  - Vbeam
<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td>✓</td>
<td></td>
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<tr>
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<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
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<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
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<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Metrics</th>
<th>Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>METRIC</td>
<td>FY22 QTR 1</td>
</tr>
<tr>
<td>UHS equipment is clean and in good working order.</td>
<td>Yes</td>
</tr>
<tr>
<td>UHS Technician is professional, arrives on time and is competent in his / her duties.</td>
<td>Yes</td>
</tr>
<tr>
<td>No cancelled cases related to contracted service Key Performance Indicators (KPIs)</td>
<td>Yes</td>
</tr>
<tr>
<td>Contractor submits invoices for payment in a timely manner after service provided.</td>
<td>Yes</td>
</tr>
<tr>
<td>Personnel employed by contractor are current in all screening requirements per terms of the contract.</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Comments: No unusual occurrences documented during the contract service evaluation period.

Conclusion (check one)

✓ Contract service has met expectations for the review period

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  ☐ Other:
ADDENDUM F
Name of Service: Dialysis

Date of Review: 7/8/2022

Name / Title of Reviewer: Victoria Veronese, Director of Critical Care

Nature of Service (describe): Dialysis including Hemodialysis, Peritoneal Dialysis, Plasmapheresis, CRRT

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Met Expectation</th>
<th>Did Not Meet Expectation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>CY 2021 3rd QTR</th>
<th>CY2021 4th QTR</th>
<th>CY 2022 1st QTR</th>
<th>CY 2022 2nd QTR</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis Machine Water Cultures/Endotoxins Escondido Campus</td>
<td>Pass</td>
<td>Pass</td>
<td>Pass</td>
<td>Pass</td>
<td>Pass</td>
</tr>
<tr>
<td>Dialysis Machine Water Cultures/Endotoxins Poway Campus</td>
<td>Pass</td>
<td>Pass</td>
<td>Pass</td>
<td>Pass</td>
<td>Pass</td>
</tr>
</tbody>
</table>

Comments

Conclusion (check one)

- [ ] Contract service has met expectations for the review period
- [ ] Contract service has not met expectations for the review period. The following action(s) has or will be taken: (check all that apply):
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  - [ ] Other:___________________________________________________________________
ADDENDUM G
# Quality Indicators

**PMC Poway Operating Room**

**CY 2021**

<table>
<thead>
<tr>
<th>Category</th>
<th>Metric</th>
<th>Definition</th>
<th>Performance</th>
<th>Action</th>
</tr>
</thead>
</table>
| Safety   | Retained foreign object(s)/Un-retrievable device fragments reported | Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained. | Zero | • Proactively examine equipment in SPD and with Scrub Techs prior to patient use.  
• Adherence to Association of Operating Room (AORN) guidelines related to the prevention of retained surgical items (RSI). Lucidoc policy # 11585 attached *  
• Concurrent count audits of each procedure. |
| Safety   | Unexpected returns to OR in 24 hours | Unexpected returns to OR within 24 hrs: any secondary procedure required for a complication resulting directly or indirectly from the index operation. Denominator is OR procedures CY 2021. | 12/3483 (inpatients and outpatients): 0.344% National rate 0.6%-9% (See link below) | • Judicious patient care monitoring per Palomar Health guidelines. Lucidoc policy # 35753 |
| Efficiency | First case on time starts (FCOTS) | In operating room on or before scheduled start time. | 71% (see graph below) Goal: 90% | • Improvements noted in CY Q2 2021.  
• Data reported to OR committee monthly.  
• Track and trend reason for delay.  
• Information shared at daily huddles for staff input. |
| Effective | Post op hemorrhage rate | Post op hemorrhage or hematoma cases involving a procedure to treat the hemorrhage or hematoma, following surgery per 1,000 surgical discharges for patients ages 18 years and older. | 1/772 (inpatients) 1.3/1000 admissions | • [https://icd10monitor.com/psi-9-can-a-postprocedural-hemorrhage-or-hematoma-be-unavoidable/](https://icd10monitor.com/psi-9-can-a-postprocedural-hemorrhage-or-hematoma-be-unavoidable/)  
• Judicious patient care monitoring per Palomar Health guidelines. Lucidoc policy # 35753 |
Excludes cases with a diagnosis of coagulation disorder; cases with a principal diagnosis of perioperative hemorrhage or hematoma; cases with a secondary diagnosis of perioperative hemorrhage or hematoma present on admission; cases where the only operating room procedure is for treatment of perioperative hemorrhage or hematoma; obstetric cases.

<table>
<thead>
<tr>
<th>Effective</th>
<th>Overall surgical site infection (SIR)</th>
<th># of actual infections/# of predicted infections as defined by NHSN.</th>
<th>National Rate based on type of procedure 2.5 per 1000 admissions (AHRQ, p 13)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.765 National threshold &lt; 1.0</td>
</tr>
</tbody>
</table>

- Vaginal betadine prep for GYN procedures approved within last 4 months
- Upcoming – re-explore glucose control and increased perioperative monitoring
- Transition away from using Betadine solution for skin preparation unless there is a documented allergy.
- Use an alcohol containing prep such as duraprep of chloraprep
- Nasal betadine pre-checked on orthopedic order sets – approved through IC and Ortho COE
- Proposing CHG bathing standard on fracture patients (low compliance) – approved in IC, pending second review in Ortho COE
- Minimize unnecessary OR traffic

### PI Projects

<table>
<thead>
<tr>
<th>Metric</th>
<th>Definition</th>
<th>Performance</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase safety for patients undergoing Surgery or Procedure at PH by preventing communication failures and adverse outcomes through use utilization of a pre-procedure safety checklist. Improve</td>
<td>78% compliance overall. We were doing better last year vs the first 6 months of this year.</td>
<td>ED and floor staff are asked to initiate the checklist prior to coming to preop</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Memo sent to nursing Leaders to remind staff</td>
</tr>
</tbody>
</table>
| Pre-op checklist | Organizational pre-procedure checklist compliance rates to goal of 90% for 6 months | • Working with Cerner to highlight the critical elements to be completed by ED and floor staff.  
• Monthly audits are performed |
| Pre-op phone calls for elective procedures | Ensure patients are called preoperatively (at least day before surgery) | Estimated performance 85% - 90%  
• Working with Clinical Informatics to develop a required documentation field. |
| Wound class accuracy | Ensure Wound Class is accurately documented for surgery type | 92%  
• IT request for Wound Classification hard stop for clean designation for the following surgeries, thus diluting our denominator; APPY, BILI, CHOL, COLO, REC, SB and VHYS.  
• Surgical services team education on wound class and verification at debrief |

Unexpected Returns to OR: [https://journals.lww.com/md-journal/Fulltext/2021/12100/Risk_factors_for_unplanned_return_to_the_operating.31.aspx](https://journals.lww.com/md-journal/Fulltext/2021/12100/Risk_factors_for_unplanned_return_to_the_operating.31.aspx)
ADDENDUM H
Palomar Health
Equipment Acquisition Process
Presented to Board Quality Review Committee

Presented by:
Tim Stevens, Director Diagnostic Imaging and Biomedical Engineering
Heather Woodling, Director Supply Chain Services

July 27th, 2022
Identification of Replacement or New Equipment

• Current equipment is identified as either
  – No longer supported due to age
  – Not meeting current standard of care requirements

OR

• Net new equipment need is
  – Identified to support a new or expanding service line
  – Requested by a physician or clinical expert
Expense Approval

- Equipment request is submitted
  - Approved and/or submitted by Senior Leader
- CFO approves and allocates funding for the equipment procurement
Preferred Vendors/Vendor Choice

- Vendors
  - Manufacturer or Distributor
  - Identified through incumbency, GPO (HealthTrust Purchasing Group), TracManager, or referral by Palomar Health leader(s)
  - For large purchases, vendor selected through an RFP or equipment trial process
  - Vendor equipment reviewed and approved through VIP (Value Analysis) team
Purchase vs. Lease Determination

• Factors considered
  – Expected equipment lifecycle length
  – Total cost of ownership
  – Required frequency of hardware and software updates/upgrades
  – Leasing expense structure
  – Consignment based placement
Service Agreement Management

- Equipment Category
  - General Biomed = Service conducted by in-house Biomed technicians
  - High Risk/Life Support
    - Obtain vendor training and then service equipment in-house, or
    - Contract service to manufacturer or 3rd party service organization
ADDENDUM I
Palomar Health Spine and Total Joint Centers of Excellence

Presented to the Board Quality Review Committee

Presented by:
James Bried, MD, Orthopedic Medical Director, PMC-P
Andrew Nguyen, MD, PhD, Spine Medical Director, PMC-E
Brian Cohen, MHA, Senior Director Service Lines

July 27, 2022
## Spine and Total Joint Centers of Excellence

<table>
<thead>
<tr>
<th><strong>Situation</strong></th>
<th>Palomar Medical Center Escondido and Poway’s COEs continue to be recognized for high quality care and patient outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>Palomar Health performed 3,598 orthopedic and spine procedures in 2021. Preparing patients for surgery remains a primary goal, especially as the teams have adapted to changing protocols throughout the pandemic. This includes ensuring patients are at their best health prior to surgery, and are educated about the care journey. Our Enhanced Recovery and Pain Control Protocols ensure early mobilization, better pain control and more rapid care transitions and discharges. Many patients are ready to go home same-day, and most patients experience a full return to function within the first year. While the COEs did not have access to rates of complications, return-to-ED, and readmissions in 2021, the COE teams remained focused on other quality measures, plus the patient’s experience, and operational efficiencies.</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Spine surgery volume increased 10% over pre-pandemic levels (457 to 503). This includes over 50 robotically-assisted spine fusions, and a shift to a higher proportion of multi-level fusions. The spine fusion SIR was better than threshold for 2021. Most importantly, patients that had a fusion at Palomar went from Severe Disability to Minimal Disability within the first year after surgery. Total Joint Replacement length of stay fell to below 1.5 days at both Palomar campuses, with 85%-92% going home before the 2nd midnight. The SIR was above threshold at PMC-Escondido Hip Replacement and at PMC-Poway for Knee Replacement in 2021. Most importantly, patients that had a total hip replacement at Palomar went from Moderate Disability to Limited to No Disability within 3-months of surgery. As a result, PMC-P is pursuing the Joint Commission’s Advanced Total Hip and Knee Replacement Accreditation (THKR).</td>
</tr>
<tr>
<td><strong>Recommendation</strong></td>
<td>Our Orthopedic Workgroups identified opportunities to improve compliance with several pre-op measures, including nasal betadine, CHG bathing and patient preparedness for surgery.</td>
</tr>
</tbody>
</table>
Ortho/Spine Awards

Palomar Medical Center Escondido is the ONLY hospital in San Diego County to, once again, achieve all 3 awards!
What are our True Differentiators?

• Specialized physicians and staff members
• High quality patient outcomes leading to faster recovery and less pain
• Coordinated care across Palomar Health services
• Patient readiness
• Staff education
Managing a Patient’s Risk

When Is Surgery Right for You?

Minimize health factors that increase risk for potential problems after surgery

<table>
<thead>
<tr>
<th>Health Factor</th>
<th>Ideal Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Mass Index (BMI)</td>
<td>20 – 35</td>
</tr>
<tr>
<td>Hemoglobin (red blood cell level/anemia)</td>
<td>Greater than 12.5</td>
</tr>
<tr>
<td>Hemoglobin A1c (blood sugar level)</td>
<td>Less than 8.0 (less than 7.5 preferred)</td>
</tr>
<tr>
<td>Albumin (blood protein level)</td>
<td>Greater than 3</td>
</tr>
<tr>
<td>Prealbumin (blood protein level)</td>
<td>Greater than 18</td>
</tr>
</tbody>
</table>

(Continued on next page.)
Engaging Patients in their Outcome

Online CarePath

To prepare for surgery, Palomar Health offers Online CarePath, a custom roadmap to get patients prepared and organized for surgery and recovery. Patients can interact with their care team about their health, from sleeping and eating, to pain control. Palomar Health specialists can reply with recommendations.

A Coordinated Journey
I’ve had many surgeries in the past but at no other time was I so prepared. In fact, I was over-prepared.

- Total Knee Patient

83% Of enrolled patients are actively using their CarePath

98% patients felt prepared for surgery

2,539 activated patients
Quality Metrics | Joint Replacement (2021)

<table>
<thead>
<tr>
<th>Average Length of Stay (days) (lower is better)</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC Escondido</td>
<td>1.6</td>
<td>1.4</td>
<td>1.9</td>
<td>1.5</td>
</tr>
<tr>
<td>PMC Poway</td>
<td>1.5</td>
<td>1.4</td>
<td>1.7</td>
<td>1.2</td>
</tr>
<tr>
<td>US Average</td>
<td>1.4</td>
<td>1.4</td>
<td>1.9</td>
<td>1.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Patients Discharged on the Day of Surgery, or the Next Day (higher is better)</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC Escondido</td>
<td>48%</td>
<td>65%</td>
<td>74%</td>
<td>85%</td>
</tr>
<tr>
<td>PMC Poway</td>
<td>74%</td>
<td>83%</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>2018</td>
<td>48%</td>
<td>65%</td>
<td>74%</td>
<td>85%</td>
</tr>
<tr>
<td>2019</td>
<td>74%</td>
<td>83%</td>
<td>90%</td>
<td>92%</td>
</tr>
</tbody>
</table>
Quality Metrics | Spine Surgery (2021)

Lumbar Fusion

- 2021: 130 84 51 5 26
- 2020: 108 90 38 4 26
- 2019: 120 100 34 3 18

+8% growth in Lumbar Fusions

- More 3+ Level Lumbar Fusions
  - from 12% to 17%

Cervical Fusion

- 2021: 35 31 39 26
- 2020: 28 27 29 2
- 2019: 33 38 31 16

+4% growth in Cervical Fusions

- More 3+ Level Cervical Fusions
  - from 28% to 35%

Case times down for most procedure types:
- 17 minutes for Lumbar Fusions
- 21 minutes for Cervical Fusion
Quality Metrics  |  Spine Surgery (2021)

PMC-E volume-weighted Z-Score, per Healthgrades (higher is better)
Telling Our Story
What’s Next?

• Focus on being below threshold for rates of complications, return-to-ED, readmissions, and infections
• Achieve full compliance with evidence-based guidelines around surgical management, and patient safety (e.g., infection prevention, rehab protocols)
• Leverage the Online CarePath to complement virtual education classes, as well as to communicate COVID-19 precautions and testing requirements
• Achieve The Joint Commission’s Advanced Total Hip and Knee Replacement Accreditation (THKR) at PMC Poway
Bariatric Surgical Services
Presented to Board Quality Review Committee

July 27, 2022

Presented by:
Karen J. Hanna, MD, Medical Director
Brian Cohen, MHA, Senior Director of Service Lines
# Bariatric Surgery | SBAR

<table>
<thead>
<tr>
<th>SITUATION</th>
<th>Palomar Medical Center Poway’s Bariatrics program continues to be recognized for high quality care and patient outcomes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>Palomar Medical Center Poway was accredited by Metabolic and Bariatric Surgery and Quality Improvement Program (MBSAQIP) since 2006. In addition, the facility was recognized as a <strong>Blue Distinction Center+</strong> for Bariatric Surgery by Anthem BlueCross and Blue Shield of California. The “+” indicates a comprehensive program with multiple components of weight management services for patients, all performed at a low cost to the patient and payer.</td>
</tr>
<tr>
<td>ASSESSMENT</td>
<td>Our 3-year MBSAQIP accreditation survey is expected in November 2022. The program has achieved high quality outcomes in Mortality Rate, Sleeve Gastrectomy outcomes, Gastric Bypass outcomes, and other Quality Control measures outlined nationally by MBSAQIP. The SSI rate for Sleeve Gastrectomy is above threshold. Volumes continue to rebound after previous Medical Director’s retirement, and COVID-related disruptions, but has exceeded the minimum requirements for MBSAQIP accreditation.</td>
</tr>
<tr>
<td>RECOMMENDATION</td>
<td>Palomar’s COE Committees has identified opportunities to improve compliance with several pre-op measures, including nasal betadine, CHG bathing and patient preparedness for surgery.</td>
</tr>
</tbody>
</table>
Bariatric Surgery | Recognitions

PMC Poway
2006* – present

* Initial Accreditation by ASMBS (2006)
* Last Re-Accreditation by MBSAQIP (2018)
* Next Accreditation Nov/Dec 2022 (Delayed due to COVID)
Bariatric Surgery | Volume

- **2017**: 287
  - Sleeve Gastrectomy: 13
  - Gastric Bypass: 261
  - Conversion/Revision: 6
  - Lap Band Removal: 0

- **2018**: 261
  - Sleeve Gastrectomy: 6
  - Gastric Bypass: 47
  - Conversion/Revision: 9
  - Lap Band Removal: 23

- **2019**: 6
  - Sleeve Gastrectomy: 6
  - Gastric Bypass: 9
  - Conversion/Revision: 23
  - Lap Band Removal: 40

- **2020**: 20
  - Sleeve Gastrectomy: 20
  - Gastric Bypass: 35
  - Conversion/Revision: 9
  - Lap Band Removal: 23

- **2021**: 40
  - Sleeve Gastrectomy: 40
  - Gastric Bypass: 35
  - Conversion/Revision: 9
  - Lap Band Removal: 23
### 30-day Mortality

<table>
<thead>
<tr>
<th>Date Range</th>
<th>Site</th>
<th>Number of Sites</th>
<th>Total Cases</th>
<th>Death Cases</th>
<th>Mortality Rate (%)</th>
<th>Mean Site Mortality Rate (%)</th>
<th>Standard Deviations From Mean Site Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/2019-12/31/2019</td>
<td>PMC-Poway</td>
<td>-</td>
<td>59</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(0.3985)</td>
</tr>
<tr>
<td></td>
<td>All Sites</td>
<td>863</td>
<td>206,085</td>
<td>240</td>
<td>0.1165</td>
<td>0.1286</td>
<td>-</td>
</tr>
<tr>
<td>1/1/2020-12/31/2020</td>
<td>PMC-Poway</td>
<td>-</td>
<td>35</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(0.2963)</td>
</tr>
<tr>
<td></td>
<td>All Sites</td>
<td>885</td>
<td>165,568</td>
<td>130</td>
<td>0.0771</td>
<td>0.0714</td>
<td>-</td>
</tr>
<tr>
<td>7/1/2020-6/30/2021</td>
<td>PMC-Poway</td>
<td>-</td>
<td>47</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(0.2969)</td>
</tr>
<tr>
<td></td>
<td>All Sites</td>
<td>892</td>
<td>204,416</td>
<td>154</td>
<td>0.0753</td>
<td>0.0830</td>
<td>-</td>
</tr>
</tbody>
</table>

ZERO mortality at PMC-P over 30-months
# Bariatric Surgery | Sleeve Gastrectomy

**MBSAQIP Annual Report 2021 (Q1-Q2)**

## Laparoscopic Sleeve Gastrectomy

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total Cases</th>
<th>Observed Events</th>
<th>Observed Rate**</th>
<th>Pred Obs Rate**</th>
<th>Expected Rate</th>
<th>Odds Ratio</th>
<th>95% C.I. Lower</th>
<th>95% C.I. Upper</th>
<th>Outlier</th>
<th>Decile</th>
<th>Adjusted Percentile</th>
<th>Adjusted Quartile</th>
<th>Assessment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>LSG Morbidity</td>
<td>31</td>
<td>2</td>
<td>6.45%</td>
<td>2.69%</td>
<td>1.54%</td>
<td>1.77</td>
<td>0.55</td>
<td>5.67</td>
<td>No</td>
<td>9</td>
<td>72</td>
<td>3</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG All Occurrences Morbidity</td>
<td>31</td>
<td>2</td>
<td>6.45%</td>
<td>3.56%</td>
<td>2.87%</td>
<td>1.25</td>
<td>0.52</td>
<td>2.99</td>
<td>No</td>
<td>8</td>
<td>62</td>
<td>3</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG Serious Event</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>1.32%</td>
<td>1.49%</td>
<td>0.89</td>
<td>0.33</td>
<td>2.41</td>
<td>No</td>
<td>4</td>
<td>43</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG Leak</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>0.14%</td>
<td>0.15%</td>
<td>0.98</td>
<td>0.32</td>
<td>3.07</td>
<td>No</td>
<td>7</td>
<td>49</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG Bleeding</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>0.53%</td>
<td>0.58%</td>
<td>0.92</td>
<td>0.23</td>
<td>3.65</td>
<td>No</td>
<td>5</td>
<td>46</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG SSI</td>
<td>31</td>
<td>2</td>
<td>6.45%</td>
<td>1.06%</td>
<td>0.28%</td>
<td>3.77</td>
<td>0.76</td>
<td>18.70</td>
<td>No</td>
<td>10</td>
<td>86</td>
<td>4</td>
<td>Needs Improvement</td>
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<tr>
<td>LSG All Cause Reoperation</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>0.47%</td>
<td>0.50%</td>
<td>0.94</td>
<td>0.29</td>
<td>3.12</td>
<td>No</td>
<td>5</td>
<td>47</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG Related Reoperation</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>0.30%</td>
<td>0.32%</td>
<td>0.96</td>
<td>0.26</td>
<td>3.52</td>
<td>No</td>
<td>6</td>
<td>48</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG All Cause Intervention</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>0.25%</td>
<td>0.27%</td>
<td>0.94</td>
<td>0.17</td>
<td>5.20</td>
<td>No</td>
<td>6</td>
<td>47</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG Related Intervention</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>0.19%</td>
<td>0.20%</td>
<td>0.95</td>
<td>0.16</td>
<td>5.52</td>
<td>No</td>
<td>7</td>
<td>47</td>
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<td>As Expected</td>
</tr>
<tr>
<td>LSG All Cause Readmission</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>1.58%</td>
<td>1.78%</td>
<td>0.89</td>
<td>0.35</td>
<td>2.22</td>
<td>No</td>
<td>4</td>
<td>42</td>
<td>2</td>
<td>As Expected</td>
</tr>
<tr>
<td>LSG Related Readmission</td>
<td>31</td>
<td>0</td>
<td>0.00%</td>
<td>1.26%</td>
<td>1.38%</td>
<td>0.92</td>
<td>0.37</td>
<td>2.24</td>
<td>No</td>
<td>4</td>
<td>44</td>
<td>2</td>
<td>As Expected</td>
</tr>
</tbody>
</table>
### Bariatric Surgery | Gastric Bypass

MBSAQIP Annual Report 2021(Q1-Q2)

#### Laparoscopic Roux-en-Y Gastric Bypass

<table>
<thead>
<tr>
<th></th>
<th>Total Cases</th>
<th>Observed Events</th>
<th>Rate</th>
<th>Pred Obs Rate**</th>
<th>Expected Rate</th>
<th>Odds Ratio</th>
<th>95% C.L. Lower</th>
<th>95% C.L. Upper</th>
<th>Outlier</th>
<th>Decile</th>
<th>Adjusted Percentile</th>
<th>Adjusted Quartile</th>
<th>Assessment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRYGB Morbidity</td>
<td>15</td>
<td>1</td>
<td>6.67%</td>
<td></td>
<td>4.85%</td>
<td>4.26%</td>
<td>1.15</td>
<td>0.35</td>
<td>3.80</td>
<td>No</td>
<td>7</td>
<td>55</td>
<td>3</td>
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<tr>
<td>LRYGB All Occurrences Morbidity</td>
<td>15</td>
<td>1</td>
<td>6.67%</td>
<td></td>
<td>7.24%</td>
<td>7.42%</td>
<td>0.97</td>
<td>0.37</td>
<td>2.56</td>
<td>No</td>
<td>5</td>
<td>48</td>
<td>2</td>
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<tr>
<td>LRYGB Serious Event</td>
<td>15</td>
<td>1</td>
<td>6.67%</td>
<td></td>
<td>4.52%</td>
<td>4.12%</td>
<td>1.10</td>
<td>0.41</td>
<td>2.96</td>
<td>No</td>
<td>7</td>
<td>55</td>
<td>3</td>
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<tr>
<td>LRYGB Leak</td>
<td>15</td>
<td>0</td>
<td>0.00%</td>
<td></td>
<td>0.24%</td>
<td>0.24%</td>
<td>0.97</td>
<td>0.17</td>
<td>5.44</td>
<td>No</td>
<td>6</td>
<td>49</td>
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<td>LRYGB Bleeding</td>
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<td></td>
<td>1.53%</td>
<td>1.66%</td>
<td>0.92</td>
<td>0.29</td>
<td>2.92</td>
<td>No</td>
<td>4</td>
<td>46</td>
<td>2</td>
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<tr>
<td>LRYGB SSI</td>
<td>15</td>
<td>0</td>
<td>0.00%</td>
<td></td>
<td>0.73%</td>
<td>0.79%</td>
<td>0.91</td>
<td>0.17</td>
<td>5.03</td>
<td>No</td>
<td>5</td>
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<td>1.42%</td>
<td>1.55%</td>
<td>0.92</td>
<td>0.27</td>
<td>3.07</td>
<td>No</td>
<td>4</td>
<td>45</td>
<td>2</td>
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<tr>
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<td>15</td>
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<td>0.00%</td>
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<td>1.04%</td>
<td>1.12%</td>
<td>0.93</td>
<td>0.26</td>
<td>3.30</td>
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<td>5</td>
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<tr>
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<td>1.05%</td>
<td>1.17%</td>
<td>0.90</td>
<td>0.19</td>
<td>4.15</td>
<td>No</td>
<td>4</td>
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<td>2</td>
</tr>
<tr>
<td>LRYGB Related Intervention</td>
<td>15</td>
<td>0</td>
<td>0.00%</td>
<td></td>
<td>0.85%</td>
<td>0.93%</td>
<td>0.92</td>
<td>0.19</td>
<td>4.32</td>
<td>No</td>
<td>5</td>
<td>46</td>
<td>2</td>
</tr>
<tr>
<td>LRYGB All Cause Readmission</td>
<td>15</td>
<td>1</td>
<td>6.67%</td>
<td></td>
<td>4.94%</td>
<td>4.62%</td>
<td>1.07</td>
<td>0.42</td>
<td>2.71</td>
<td>No</td>
<td>7</td>
<td>53</td>
<td>3</td>
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<tr>
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<td>6.67%</td>
<td></td>
<td>4.28%</td>
<td>3.87%</td>
<td>1.11</td>
<td>0.42</td>
<td>2.97</td>
<td>No</td>
<td>7</td>
<td>55</td>
<td>3</td>
</tr>
</tbody>
</table>
Report on Quality Improvement Project 2021
Improving Long Term Follow Up after Bariatric Surgery

Goal
– 100% of all bariatric surgery patients have visit with their surgeon at 6-month post-op, and 50% to have visit with their surgeon at 12-month post-op.

Methods
– Monthly meetings and constant communications rendered between the hospital Bariatric Team and the surgeons’ offices
– Phone calls and email reminders are sent to all postop patients to schedule their 6- and 12-month appointments

Outcomes
– Goals were all met for post-op patients follow up with their surgeons at 6-month (100%) and 1-year (62%).
– Phone calls and email reminders are sent to all postop patients as planned
– The communications between the staff of the Clinic and the Hospital are greatly improved
MBSAQIP Quality Improvement Project for 2022
Decreasing 30-Day ER visits after Bariatric Surgery

Goal
– The occurrence rate on all 30-day ER visits after bariatric surgery in 2021 was 12.7%
– The goal for 2022 is to decrease the 30-day ER visits by half to 6.3%

Methods
– Educate patients at discharge to call surgeon for any suspected complications prior to visiting ER
– Close follow up phone calls after discharge
– Refer to surgeons for concerns
– Send the call information to surgeon’s office for documentation
Bariatric Surgery | Surgical Appropriateness

• Surgical Appropriateness Criteria was updated and approved by the Palomar Metabolic & Bariatric Surgery (MBS) Committee in June 2021.
  – All patients must meet criteria before they are scheduled for surgery.

• A retrospective review was performed at MBS in October 2021. All sampled cases met all the criteria.
Goals for 2022

• Continue the growth in surgical volume through expansion of Palomar Weight Management Center
• Maintain center of excellence status with a focus on quality criteria
• Launch mobile health app to engage and support weight loss patients
ADDENDUM K
Rehabilitation Services Report to Board Quality Review Committee

Presented by:

Virginia Barragan, FACHE, DPT, MOMT
Vice President Continuum Care and Oncology Service Line

July 27, 2022
Rehabilitation Services

- Assessment of the work processes, equipment needs, staff education and ongoing monitoring needed for each quality metric

- Modifications in work processes, equipment use and staff education as needed to achieve national benchmark

- Training of staff on new work processes or competencies
- Implementation of work flow changes using new equipment as needed

- Ongoing review and audits to check compliance with new processes
## Data - Rehabilitation Services

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>PALOMAR HEALTH</th>
<th>NATIONAL BENCHMARK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care Inpatient Rehab Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Acute Care (PT/OT/ST)</td>
<td>5.8 patients triaged/day</td>
<td>&lt;2.6 patients triaged/day</td>
</tr>
<tr>
<td><strong>Outpatient Cardiac Rehab Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Care</td>
<td>21.3 days</td>
<td>&lt;31 days</td>
</tr>
<tr>
<td><strong>Outpatient Rehab Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to Care</td>
<td>6.3 days</td>
<td>&lt;5 days</td>
</tr>
<tr>
<td>Cancellation/No Show Rate</td>
<td>8.0 %</td>
<td>&lt;15 %</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>10.7 days</td>
<td>&lt;12 days</td>
</tr>
<tr>
<td><strong>The Villas Rehab Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Discharge to Home</td>
<td>81.6 %</td>
<td>=&gt;70%</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>14.5 days</td>
<td>&lt;12 days</td>
</tr>
</tbody>
</table>
## Inpatient | Outpatient Rehabilitation Services – Access to Care

| SITUATION | Access to care time for FY22 to date:  
Inpatient = 5.8 patients triaged/day (Benchmark <2.6 days) – NOTE: Q4 back to 1.81 triaged/day  
Cardiac Rehab = 21.3 days (Benchmark <31 days)  
Outpatient Rehab = 6.3 days (Benchmark < 5 days) |
| BACKGROUND | Historically Rehab Services have typically met/exceeded expectations for timeliness from referral to patient evaluation in Outpatient and daily triaging rates of patients in Inpatient/SNF.  
Access to Care benchmarks have been established at above industry standards for all Rehab settings. This data allows management the opportunity to quickly address trends negatively affecting the patient’s ability to receive timely care. |
| ASSESSMENT | Factors impacting access to care from 7/1/21-present as follows:  
1) Rise in staff call outs and LOAs as a result of the Pandemic throughout FY22 leading to increased wait time for care and triage rates across the rehab continuum.  
2) Increase in referrals for rehab services in the Acute/SNF settings creating larger need for staff  
3) Increased training time needed for Outpatient Rehab/Cardiac Rehab hiring to accommodate increased referral trends.  
4) Higher than normal annual staff turnover due to inflation (leaving state with short notices) and medical issues (Covid) |
| RECOMMENDATION | 1) Regular meetings/communication with HR to review open positions for recruitment.  
2) Development of Advanced Clinician role to enhance specialty therapist recruitment  
3) Continue expansion of hours offered for care in the outpatient setting  
4) Cross training of inpatient staff to provide district wide staffing flexibility  
5) Monthly review across rehab management on staffing and assistance of resources. |
# Villas at Poway Rehab Length of Stay (LOS)

| **SITUATION**                  | Length of Stay Benchmark = 12 days or less  
|                               | FY 22 ytd average LOS = 14.5 days          |
| **BACKGROUND**                | FY22 has seen fluctuations in length of stay as part of the pandemic due to:  
|                               | 1) Increased patient acuity requiring an increase length of stay  
|                               | 2) Changing safety requirements to provide out of room and Rehab gym care  
|                               | 3) Delays in transfers/placements (ARU, community based AL/Board and Care, etc.)  
|                               | 4) Delays in patient discharge due to COVID diagnosis                      |
| **ASSESSMENT**                | The pandemic has continued to impact level of patient acuity and LOS. The Villas has remained open during the pandemic surges throughout FY22 and has consistently modified processes as needed to ensure safety of residents and staff during spikes in infections. |
| **RECOMMENDATION**           | 1) Continue communication/teamwork adjustments to address high acuity patient needs.  
|                               | 2) Continue Comprehensive Care Conferences  
|                               | 3) Daily monitoring of hospital readmissions from SNF  
|                               | 4) Continued communication/meetings with case management to improve processes and ensure timely patient throughput.  
|                               | 5) Review SNF discharge planning with team & family participation for each patient  
|                               | 6) Quarter 4 added Home Health and Palliative to weekly IDT meetings   |
FY23 Action Plan - Rehabilitation Services

Palomar Medical Center Escondido & Poway – Acute Care

- Partner with HR to achieve & maintain full staffing across physical, occupational, and speech therapy to reduce triage rate.
- Continue to support multidisciplinary rounds across all units with close engagement with Hospital Case Management to streamline throughput.

Outpatient Cardiac Rehabilitation

- Focus on maintaining full classes with ongoing growth of services.
- Initiate and Integrate Pulmonary Rehabilitation during FY23.
- Continue education expansion for patients to further enhance quality of care.
- Successful move from SMACC to MOB#2 during FY23.
- Increased collaboration with hospital and cardiologists with closer proximity allowing for greater access to resources.
FY23 Action Plan - Rehabilitation Services

Outpatient Rehabilitation San Marcos & Poway
- Onboarding of staff (clinical/support) to decrease the time for access to care.
- Demonstrate growth in niche services for oncology, hand therapy, lymphedema, and pelvic floor for greater diversification.
- Successful clinic move during FY23 to MOB#2 creating opportunities for increased collaboration with the PMC Escondido hospital & Orthopedists
- Resumption of extensive community based education/marketing offerings.

Skilled Nursing Rehab
- Maintain full caseload as SNF admissions increase post-covid
- Onboard clinical staff to continue to ensure full rehabilitation services available daily.
- Reassess opportunities for specialty programs for subacute
FY23 Action Plan - Rehabilitation Services

District Wide

- Poway - Inpatient, Skilled Nursing, Home Health, and Outpatient services to partner with orthopedic program for Joint Commission Advanced Orthopedic Certification.
- Added Safe Patient Handling courses weekly in addition to weekends to ensure initial/annual training are provided to all clinical staff across the hospital.
- Ongoing training for Speech nurse swallow screening program
- Partnership with Employee Health for ergonomic injury prevention programs across our hospital system and partnerships.
- Collaborate with orthopedists to optimize recovery times for total joint patients.
- Continued to support IDT rounds to assist with timely throughput.
- Optimize staffing across the rehabilitation department and minimize time open positions are posted.
ADDENDUM L
Utilization Review Committee Bi-annual Report
Presented to
Board Quality Review Committee

Presented by:
Franklin Martin, MD

July 27, 2022
<table>
<thead>
<tr>
<th><strong>SITUATION</strong></th>
<th>Admissions are reviewed for status (IP vs. Outpatient/observation) and level of care (ICU, telemetry, Med-Surg)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND</strong></td>
<td>Utilization Review Committee required by CMS COP</td>
</tr>
<tr>
<td><strong>ASSESSMENT</strong></td>
<td>Payer specific requirements continue to evolve</td>
</tr>
<tr>
<td><strong>RECOMMENDATION</strong></td>
<td>Continue current processes</td>
</tr>
</tbody>
</table>
UR Committee Functions

• Required by CMS Conditions of Participation
• Review admissions of Medicare patients for medical necessity, Status (Inpatient, Outpatient/Observation)
• Code 44s, “Inpatient Only” procedures
• Oversee Case Management clinical screening for medical necessity of admissions (InterQual) for all payers
• Higher level of care transfer requests
• High dollar services medical necessity reviews
• Denials/peer to peer appeals health plans
Summary of Major Activities

• Secondary reviews of admissions: > 120 month
• Short Stay Reviews: 400 JAN-APR
  – Medicare inpatient admissions 2MNs or less
  – Initial review by denials nurse
  – Cases reviewed by chairman for meeting CMS inpatient criteria
  – Notice sent to admitting physician for input
  – “Fails” converted to outpatient after 14 days
  – Patient notified by mail
Example of Self Denial Cases

• 3/8/2022 Acute Encephalopathy, Cardiogenic Shock 03/08/2022 – 03/09/2022: 88 Year-old-female transported from local care facility when staff found patient unresponsive. After examination in ED, physician had discussion with family who confirmed they did not want aggressive interventions and were interested in palliative and comfort care. Morphine to be provided and patient status noted as very grave. Less than 24 hours LOS and documented plan of care was that of comfort care. Outpatient OTHER expectant care <2MN = observation
Example Self Denial Cases

• 4/11/2022 L Ankle Fusion w/Bonegraft 04/11/2022 – 04/12/2022: 72 Year-old-male patient admitted for planned Left Ankle Fusion w/Bone Graft. CPTs listed for procedure were 27870 and 28289 and are not listed on the CMS Inpatient only 2022 list. Patient arrived to hospital at 0509 AM on 04/11/2022, admitted to Inpatient Status at 0739 AM pre-surgery. Next day at 0828 AM a discharge home order was entered Outpatient 1 MN stay post-op, not Inpatient Only
ADDENDUM M
QUARTERLY MEDICATION ERROR REPORT

Presented to Board Quality Review Committee

Presented by:
Dondreia Gelios, PharmD, BCPS
District Director of Pharmacy

July 27, 2022
Pharmaceutical Purchase Optimization

**ACT**
- Increase Pharmacy Group Purchasing Organization (GPO) and 340B purchases and decrease Wholesale Acquisition Cost (WAC) spend for all qualifying medications

**PLAN**
- Establish baseline data. Evaluate all items purchased on WAC accounts
- Identify barriers to purchasing on GPO or 340B accounts

**STUDY**
- FY 2020, FY2021 baseline data
- FY 2022 QTR1 and QTR2 data

**DO**
- Change in GPO
- Drug Shortages
- IT Complications
- Tasks
- Monitor Accounts
- Audit Buyers Actions

**BARRIERS**
- Change in GPO
- Drug Shortages
- IT Complications
- Tasks
- Monitor Accounts
- Audit Buyers Actions
Pharmaceutical Purchase Optimization

Change in Hospital Pharmacies
Purchasing Accounts

Wholesale Acquisition Cost (WAC) Spend decreased 21%
340B Spend increased 21.8%
- WAC Spend decreased 28%
- 340B Spend increased 28%
Pharmaceutical Purchase Optimization

340B Savings Realized to Date

• FY22 is for the first two quarters only. Projected savings for Retail Pharmacy > $8 million and Hospital Pharmacies > $6 million.
IV to PO Therapeutic Interchange

• Purpose: To convert drug therapy from IV to oral or feeding tube route on medications with ~100% bio-availability when appropriate per hospital approved procedure.
• Benefits:
  – Easier and less time consuming for the nurse to administer.
  – Oral drug administration demonstrates decreased morbidity than IV.
  – Potential for discharging patient from the hospital sooner on appropriate medications.
  – Oral drug formulation is less expensive than IV
• Goal: Increase interchange rate districtwide over the next two years.
## IV to PO Therapeutic Interchange

### Pharmacist Interventions: 2022 Quarter 1 (baseline)

<table>
<thead>
<tr>
<th>Medication</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>125</td>
<td>68</td>
<td>32</td>
<td>225</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$3,550</td>
<td>$1,872</td>
<td>$900</td>
<td>$6,322</td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>28</td>
<td>19</td>
<td>22</td>
<td>69</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$2,050</td>
<td>$990</td>
<td>$638</td>
<td>$3,678</td>
</tr>
<tr>
<td>Metronidazole</td>
<td>0</td>
<td>4</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$0</td>
<td>$140</td>
<td>$430</td>
<td>$570</td>
</tr>
<tr>
<td>Doxycycline</td>
<td>5</td>
<td>3</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$50</td>
<td>$90</td>
<td>$80</td>
<td>$220</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$520</td>
<td>$190</td>
<td>$50</td>
<td>$760</td>
</tr>
<tr>
<td>Lacosamide</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$1,150</td>
<td>$130</td>
<td>$180</td>
<td>$1,460</td>
</tr>
<tr>
<td>Pantoprazole</td>
<td>28</td>
<td>19</td>
<td>22</td>
<td>69</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$2,050</td>
<td>$990</td>
<td>$638</td>
<td>$2,787</td>
</tr>
<tr>
<td>Levetiracetam</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$70</td>
<td>$432</td>
<td>$20</td>
<td>$522</td>
</tr>
<tr>
<td>Quinolones</td>
<td>13</td>
<td>13</td>
<td>16</td>
<td>42</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$760</td>
<td>$380</td>
<td>$420</td>
<td>$1,560</td>
</tr>
<tr>
<td>Thiamine</td>
<td>9</td>
<td>8</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Cost Saving</td>
<td>$260</td>
<td>$270</td>
<td>$1180</td>
<td>$1,710</td>
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<tr>
<td>Total Interventions</td>
<td>228</td>
<td>145</td>
<td>126</td>
<td>499</td>
</tr>
<tr>
<td>Total cost saving</td>
<td>$10,460</td>
<td>$5,484</td>
<td>$4,536</td>
<td>$20,480</td>
</tr>
</tbody>
</table>
ADDENDUM N
Management of the Environment of Care and Emergency Management Report

Presented to Board Quality Review Committee

Presented by:

Dan Farrow, Senior Director, Facilities and Plant Operations
Anis Trabelsi, Chief Security Officer

July 27, 2022
The Environment of Care (EOC) is comprised of six management plans: safety, security, hazardous materials, fire / life safety, medical equipment, and utilities. Each plan has performance improvement goals. The multidisciplinary EOC committee meets regularly and the owners of each management plan report on goals and exceptions and seek feedback and recommendations of each area of focus. The same process is completed with the Emergency Management program by the multidisciplinary Disaster Preparedness committee. Each plan uses the plan-do-study-act process.

During multidisciplinary EOC rounds, staff knowledge is tested by asking questions related to each management plan. The EOC team reviews the environment by inspecting life safety issues and staff knowledge. Plan owners also monitor high impact and regulatory driven events throughout the year. The goals stated below are some of the goals in the Management plan (refer to full annual report).

The 2021 program assessment demonstrates that all management plans were effective. The effectiveness was attributed to collaboration between leadership and frontline staff. Just in time training was is also found to be highly effective during EOC rounds.

### Safety Management Plan:
- Unsecured O2 tanks: Only 10 tanks were found in 2021 - Unmet
- Staff knowledge of RACE and PASS: 100% for 2021 - Met

### Hazardous Materials and Waste Management
- There were no spills requiring external assistance - Met
- Multiple phone replacements occurred in 2021, causing us to miss our goal of 90% for SDS stickers placement - Unmet

### Fire / Life Safety Management
- Hallway clutter management from Covid rooms and additional PPE used - Met
- Fire training in high risk areas, including the kitchen, Procedure platform, and laboratory – Met

### Medical Equipment Management
- Equipment that is unable to be located was within its goal of <5%. – Met
- 70% of high value medical equipment was tracked by either a manual or technology based process, a 4.5% increase compared to 2020. - Unmet
Environment of Care and Emergency Management

**ASSESSMENT, CONTINUED**

**Utilities Management**
- Elevator entrapments are monitored to ensure preventative maintenance orders are effective. - Unmet
- Monitoring # floods assists the facility teams in being proactive in predicting and making repairs ahead of water intrusion events. – Met

**Security Management Plan:**
- Code red drills scored 100% and there was no retesting necessary - Met
- 99% of staff were found properly displaying his / her name badge, goal is 100% - Unmet

**Emergency Management**
- Staff did very well in speaking to where departmental disaster supplies are located (flashlights, search and rescue bags, downtime forms, etc.). - Met
- Everbridge, our mass notification system is critical to communication redundancy. The staff knowledge goal of 90% was met.

**RECOMMENDATION**

Audit data will to be assessed at the EOC and Disaster Preparedness committees. For 2022 performance goals will include but not be limited to:

**Safety Management**
- Increase the just in time training and awareness with unsecured 02 tanks during rounds.

**Hazardous Materials and Waste Management**
- Partner with telecommunication team to have Safety Data Sheet (SDS) sticker install to be a part of phone replacement program.

**Medical Equipment Management**
- Collaborate with IT for a tracking system for high value medical equipment. Biomed will be aiming for 100% tracking on all of these device

**Utilities Management**
- District wide water quality program in 2022 to include 100% all clinical areas.
- Reduce # of entrapments by a new service agreement with contract company.

**Security Management**
- Increase just in time training and staff awareness with staff on how to wear a badge correctly.
Plan – Do – Study - Act

- If the goal is not achieved, communication is provided to department leadership
- Knowledge is tested during subsequent rounds

- Audit data is submitted to the EOC committee or the Disaster Preparedness committee on a regular basis for discussion and improvement planning

- Different departments are surveyed each month to audit staff knowledge on important aspects of each management plan

- Departments within a hospital campus: rounded upon biannually
- Departments within a satellite building: rounded upon annually
Performance Indicators:

Security Management:
- Code Red drills are completed with a passing grade and do not require a re-drill (100% goal)
- Code Grays to be properly called by staff to the call center emergency line (x111) vs. staff calling Security Services directly (100% goal)
- Code Greens to be properly called by staff to the call center emergency line (x111) vs. staff calling Security Services directly (100% goal)
- Staff are observed wearing their name badge according to Palomar Health procedure (Lucidoc #14753) (100% goal)
- Track and promote increased Code Grey response from departments other than Security (Goal is two extra staff per code)

Hazard Materials and Waste Management:
- Monitoring of hazardous material containers inspected / labeled incorrectly during monthly Environment of Care (EOC) rounds
- Monitoring of number of hazardous chemical incidents involving outside agency assistance for cleanup
- Monitoring of number of biohazard waste incidents involving outside agency assistance for cleanup
- Staff knowledge in obtaining SDS (Safety Data Sheet) information during monthly Environment of Care (EOC) rounds (90% goal)
- Inspected landline phones properly display an SDS sticker (90% goal)
- Staff knowledge in articulating appropriate steps to take in response to a spill (90% goal)

Life Safety / Fire Prevention Management:
- Monitoring of actual fires reported inside the facilities
- Monitoring of building and / or protection system monitoring – problems, significant incidents, unexpected repairs
- Number of high hazard departments trained
### Performance Indicators:

<table>
<thead>
<tr>
<th>Medical Equipment Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Preventative maintenance (PM) completion rate for high risk equipment, including life support equipment (100% goal)</td>
</tr>
<tr>
<td>- Preventative maintenance (PM) completion rate for non-life support equipment (95% goal)</td>
</tr>
<tr>
<td>- &lt;5% of unable to locate pieces of medical equipment</td>
</tr>
<tr>
<td>- ≥90% of equipment repairs completed within 30 days</td>
</tr>
<tr>
<td>- Tracking of high value mobile medical equipment (90% goal)</td>
</tr>
<tr>
<td>- Staff attending technical training classes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Utility Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Monitoring of facility utility failures (electricity, water, and natural &amp; medical gases)</td>
</tr>
<tr>
<td>- Monitoring of elevator failures</td>
</tr>
<tr>
<td>- Monitoring of flooding events</td>
</tr>
<tr>
<td>- Emergency generator testing compliance per regulatory standards (100% threshold)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Conduct / manage two disaster drills or actual events per year at each facility according to top Hazard Vulnerability Analysis (HVA) risks and evaluate event using The Joint Commission standards (90% threshold)</td>
</tr>
<tr>
<td>- Staff knowledge in articulating where his or her unit disaster supplies are located during monthly Environment of Care (EOC) rounds (90% threshold)</td>
</tr>
<tr>
<td>- Staff knowledge in articulating where his or her unit emergency and safety response guide is located during monthly Environment of Care (EOC) rounds (90% threshold)</td>
</tr>
<tr>
<td>- Staff knowledge in articulating what actions to take during an earthquake during monthly Environment of Care (EOC) rounds (90% threshold)</td>
</tr>
<tr>
<td>- Staff knowledge in articulating suitable actions to take following a Code Triage activation during monthly Environment of Care (EOC) rounds (90% threshold)</td>
</tr>
<tr>
<td>- Staff knowledge in articulating what action to take when an Everbridge notification is received (90% threshold)</td>
</tr>
<tr>
<td>- Staff is able to identify the location of their departments downtime forms/box and 7/24 computer, if applicable (90% threshold)</td>
</tr>
<tr>
<td>- Conduct / attend at least ten emergency management / safety training sessions for staff per quarter</td>
</tr>
</tbody>
</table>
Annual Evaluation of the Environment of Care
Management Plans and the Emergency Operations Plan

2021
EVALUATION - ENVIRONMENT OF CARE – OBJECTIVES

Introduction
Permeating every aspect of our medical centers and satellite buildings, the Environment of Care is an essential aspect of patient safety, from the first patient contact, through the assessment, treatment, discharge and continuing care. The Environment of Care overlaps with Infection Prevention and the management of Human Resources, as well as plays an integral part with Performance Improvement, Risk Management, and Patient Safety standards. The objectives of the various Environment of Care Management plans have been to provide a safe, functional, supportive and effective environment for patients, visitors, staff, volunteers and members of our physician community. This is critical to providing quality patient care.

Achieving our objectives is dependent upon performing the following central processes:

- Strategic and on-going master planning by organization leadership (Plan / Design)
- Educating staff about the role of the environment that supports patient care (Teach)
- Implementing various components of design (Implement)
- Measuring standards that we have set for ourselves (Respond)
- Gathering information about our outcomes (Monitoring / Measuring / Evaluating)
- Making decisions about our findings (Improving)

The Environment of Care Management plans address six elements, which include Safety, Security, Hazardous Materials and Waste, Fire Prevention, Medical Equipment and Utilities Management. Emergency Management addresses the Emergency Operations Plan (EOP). There is much diversity in the seven management plan elements, but each have parallels with planning, teaching, implementing, responding, monitoring, and improving. Through the work of our staff, the purpose with the Environment of Care is to ensure ongoing diminishment of risk (e.g., possible loss or injury) within our medical centers and satellite buildings. The Environment of Care Committee provides a leadership framework for the management of risks, promoting a teamwork approach, and ongoing attention to programs, plans, and related activities that point toward risk reduction. Whenever possible, the Environment of Care is integrated with the Occupational Safety and Health Administration (OSHA) objectives (e.g., regulatory requirements), as well as other agencies having jurisdiction, enforcing standards that encourage continued improvement in the workplace.

The Safety Management plan is designed to provide a physical environment wherein risks associated with physical harm and hazards will be minimized for the patient-care population, staff, volunteers, physicians, contracted workers and visitors. It is an accreditation/standards-based and regulatory driven plan. There are fundamental activities inherent in daily routines that support the ability to identify risk prior to any incident. These include formal proactive risk assessments such as accreditation, regulatory or insurer surveys, ongoing environmental surveillance, safety and infection prevention procedures that are based upon accreditation standards and regulations, and ongoing education.

Educating employees to the hazards that may pose risk, or contribute to an injury has been ongoing, as well as the efforts relating to accident investigation post injury. We continue to meet our objective relating to the minimization of risk within the built environment and continue to be poised to provide safety for our patients.

Through a medium of care and respect for everyone who comes to our facilities, the Security Management plan is designed to provide the highest quality safety and security. We strive to provide a challenging work environment for Security staff, as we work to create and support a peaceful environment so that people will feel at ease when they come to our medical centers. Overall, our Security Management program has catapulted into a higher level of awareness since the events of 9-11-01, and subsequent terrorist and security events worldwide, including the increasing Code Gray and Silver incidents at medical facilities. Our Security Management plan has provided a deterrent to criminal activity on our campuses, which has allowed us to meet our objective of promoting a peaceful environment. Security staff are visible in uniforms, and are service oriented to the public, as well as being trained in de-escalation techniques. Security has camera systems and ongoing monitoring that has allowed us to spot activity or trends that have assisted us in reducing security risks. The objectives of the Security Management Plan have been met, and we will continue to promote the reduction of risk throughout the year 2022, focusing on proactive activities, and ongoing education.
The objectives of the Hazardous Materials Management Plan are to ensure that information about the risks of hazardous chemicals / materials and wastes used in the facilities are known by affected employees, and to ensure that the information is given to employees in the form of SDS (Safety Data Sheets), education, and labeling. Another objective is to ensure that hazardous waste products do not endanger the health of the environment. Taken together, these objectives minimize the risk of exposures to hazardous chemicals within our facilities and community. Minimization of risk not only applies to our medical centers, but to the community at large (e.g., minimization of spills into the environment). Equally important, is our effort to reduce waste and to use non-hazardous products whenever feasible. Educating employees to the risks relating to hazardous material use, storage and disposal has been a program element designed to meet our objectives. Other activities within the medical centers have contributed to meeting our stated objective, and these include: assessing staff knowledge relative to the hazardous materials and waste management program, manifesting hazardous materials in accordance with regulations, the development of procedures, and the use of appropriate personal protective wear.

The objectives of the Fire Prevention Management plan are to provide a physical environment free from physical harm and hazards created by fire, the risk of fire, or the products of combustion for the patient care population, staff, volunteers, physicians and visitors. The risk of fire carries with it the most significant single threat to the environment of care as our patients are routinely incapable of self-preservation, and must rely on correct staff response and building fire protection features to assure their safety. Compliance with the Life Safety Code supports meeting our objectives, as well as practicing fire drills throughout the medical centers and satellite buildings and testing correct staff response during the drills. Proactively identifying life safety risks during routine surveillance (e.g., observing for doors that do not close and latch properly, wall and ceiling penetrations, illegal latching hardware, etc.) additionally supports meeting this objective. There are programs in place that increase the likelihood of our objectives being met, which include fire equipment testing and maintenance, annual certifications for fire detection and protection systems, and the ongoing monitoring of the Statement of Conditions which identifies any life safety vulnerabilities, and our plans and financial commitment to correct / enhance or minimize them.

The objective of the Medical Equipment Management Plan includes a joint effort of the clinical and non-clinical departments to minimize the risks inherent in the use of medical equipment that is used on our patients, and to ensure proper performance. In order to meet these objectives, multiple programs need to be in place, which include, but are not limited to: risk assessment of all incoming medical equipment, preventive and corrective maintenance programs, “out-of-service” program for equipment that needs repair, and general education of equipment and user / maintainer training programs. Quarterly monitoring of preventive maintenance completion rates for our medical equipment affords us the opportunity to promote quality performance, thereby minimizing the risks associated with medical equipment failures, which supports our patient safety efforts. These programs are in place throughout the medical centers, and have been effective in allowing us to meet the stated objectives.

The objectives of the Utility Management Plan include complying with regulatory-driven and accreditation standards to provide facilities that are safe, controlled, comfortable, and maintained in accordance with applicable regulation, requirement, and accepted engineering practice. Through a system of procedures, education, and ongoing quality monitoring and evaluation, the objectives are to provide the utility system users and operators with emergency response guidance in the event of a utility system failure, and to promote the reliability and performance of our utility systems. Risks, identified through the use of a computerized database program, factor adverse equipment experience into the quality assessment, risk management, and utility management functions. Our procedures, preventive maintenance program, education and quality monitoring all support the accomplishment of meeting our stated objectives, and also support our patient safety goals.

One primary objective of the Emergency Operations Plan is to mitigate harm to life and property due to unforeseen circumstances and risks identified in the Hazard Vulnerability Analysis. The Emergency Operations Plan comprehensively describes the organization’s approach to responding to emergencies within the organization or in its community that would suddenly and significantly affect the need for the organization’s services, or its ability to provide those services. The multidisciplinary District Disaster Preparedness Committee has been very active in the design and implementation of the Emergency Operations Plan, and it is expected to continue in this direction in 2021. The plan is intended to identify risks to the organization and addresses how the medical centers are prepared to respond as well as identify strategies in place to mitigate risks. These plan elements and other activities in the medical centers relating to emergency preparedness (e.g., education of staff, disaster exercise implementation / evaluation, and performance improvement demonstrate that the medical centers have been effective in meeting stated objectives.
EVALUATION OF THE SCOPE

Evaluation of the Scope of the Environment of Care Management plans: The scope of each management plan applies to all personnel in each facility and satellite building. Each facility and building is periodically surveyed, and every attempt is made to ensure risks are identified that may have an impact on the reduction of accidents or injury. Staff are required to work in a safe manner, and to report unsafe acts or observations, without any fear of reprisal. The following Environment of Care accomplishments throughout the year 2021 represent the emphasis on safe work behaviors and risk reduction, and validate leadership’s support of safety throughout the physical environments of our medical centers and satellite buildings, as well as support and dedicate attention to high standards of safe work behaviors for all staff. The multitude of accomplishments validate a breadth and depth of the scope of our Environment of Care management plans and the Emergency Operations Plan.

SAFETY MANAGEMENT

- Reporting standards further defined for the Environment of Care committee.
- Incorporated Honeywell N-95 masks into the PPE supply chain.
- Facility Manager Environment of Care reports reviewed quarterly by the Environment of Care Committee.
- Multi-disciplinary environmental surveillance: ongoing, with deficiencies identified and documented in Sentact and issues sent to Director for them to resolve and close out in Sentact.
- Review of workplace injuries and trends at the EOC / Safety Committee.
- Review of workplace violence data and trends at the EOC / Safety Committee.
- Cybersecurity preparedness discussed at the EOC / Safety Committee.

SECURITY MANAGEMENT

- Code Pink/Purple drills conducted and evaluated with effective outcomes.
- Wanding of bags/backpacks implemented at the lobby entrances to PMCE and PMCP to reduce the risk of prohibited items being brought on campus by visitors and patients.

HAZARDOUS MATERIAL MANAGEMENT

- No spills requiring outside agency assistance reported throughout 2021.
- Bi-Monthly meetings held with Stericycle and key departments (Lab, EVS, and Facilities) to ensure consistency in service and to address any issues as they arise.

MEDICAL EQUIPMENT MANAGEMENT

- Medical equipment failures and recalls monitored by biomedical leadership with appropriate actions taken.
- Preventive maintenance and corrective maintenance monitored for high risk (including life support equipment) and non-high risk medical equipment.
- Annual review of the districtwide Medical Equipment Management Plan completed by the EOC / Safety Committee.
- Annual evaluation of the Medical Equipment plan and program completed: Objectives, Scope, Performance Standards and Overall Effectiveness.
FIRE PREVENTION

- Fire drills conducted and evaluated by Security staff, one per shift per quarter, with additional drills completed per staffing requirements or construction areas and satellite buildings.
- Statement of Conditions (SOC) reviewed and kept updated by Facility Managers.
- Annual fire detection systems tested and certified.
- Annual fire extinguisher maintenance completed.
- Facility Environment of Care reports reviewed quarterly by the Environment of Care Committee.

UTILITIES MANAGEMENT

- Generator testing completed per regulatory standards.
- Preventive maintenance and corrective maintenance monitored for high risk (including life support equipment) and non-high risk utility equipment.
- Facility Environment of Care reports reviewed quarterly by the Environment of Care Committee.
- Utility failures reported to Environment of Care committee, each resolved with follow-up actions documented.
- Annual evaluation of the Utility Management plan and program completed: Objectives, Scope, Performance Standards and Overall Effectiveness.

EMERGENCY MANAGEMENT

- District disaster preparedness multidisciplinary committee meetings held with multiple activities accomplished.
- Hazard Vulnerability Analysis (HVA) reviewed / revised for 2021 with the top five hazards identified for each medical center.
- Everbridge notification drill completed to coincide with “The Great Shakeout” exercise. Over 800 physicians were included in the exercise notification.
- COVID-19 response coordination of key supplies, such as; PAPR’s, ventilators, respiratory PPE, disinfecting wipes, and pharmaceuticals such as Monoclonal Antibody Treatments.
- Ongoing membership with San Diego Healthcare Disaster Coalition (SDHDC) which strengthens whole-community relationships with other San Diego County hospitals, SD County Emergency Medical Services (EMS), SD County Office of Emergency Services (OES), Red Cross, SD County Public Health, and law enforcement agencies.
- Everbridge emergency notification system used exclusively during exercises and actual events.
- Disaster surge cart medical supplies inventoried by supply chain staff to ensure expiration dates are monitored and supplies are rotated into the supply stream.
- Continued collaboration with Kaiser Emergency Management and Rady’s Children’s colleagues to ensure communication is flawless during disaster events.
- Communications exercise completed in conjunction with “The Great Shakeout” at each site in October.
- Procedures written/updated and reviewed by Disaster Committee members in accordance with CMS disaster preparedness regulations.
EVALUATION: PERFORMANCE STANDARDS

OVERVIEW. The attached data sheets represent the evaluation of established performance standards, areas chosen on one or more of the following criteria:

1. The performance standard represents a measurable area of one of the EOC components.
2. The performance standard indicates a key reflection of the scope of the component.
3. The performance standard represents a high volume activity, or low volume but high risk consequences.
4. The performance standard requires improvement, or the existing process could be enhanced.

Safety Management Plan Performance Standards

The following performance activities were undertaken in 2021:

1. Monitoring of O2 bottles found unsecured during monthly Environment of Care (EOC) rounds
2. Staff knowledge on the meaning of R.A.C.E (Rescue, Alert, Contain, Evacuate/Extinguish) and P.A.S.S (Pull, Aim, Squeeze, Sweep) acronyms during monthly EOC rounds (90% threshold)

Security Management Plan Performance Standards

The following performance activities were undertaken in 2021:

1. Code Red drills are completed with a passing grade and do not require a re-drill (100% threshold)
2. Code Grays to be properly called by staff to the call center emergency line (x111) vs. staff calling Security Services directly (100% threshold)
3. Code Greens to be properly called by staff to the call center emergency line (x111) vs. staff calling Security Services directly (100% threshold)
4. Staff are observed wearing their name badge according to Palomar Health procedure (Lucidoc #14753) (100% threshold)
5. Track and promote increased Code Grey response from departments other than Security (2 extra staff per Code).

Hazardous Materials and Waste Management Plan Performance Standards

The following performance activities were undertaken in 2021:

1. Monitoring of hazardous material containers inspected / labeled incorrectly during monthly Environment of Care (EOC) rounds
2. Monitoring of number of hazardous chemical incidents involving outside agency assistance for cleanup
3. Monitoring of number of biohazard waste incidents involving outside agency assistance for cleanup
4. Staff knowledge in obtaining SDS (Safety Data Sheet) information during monthly Environment of Care (EOC) rounds (90% threshold)
5. Inspected landline phones properly display an SDS sticker (90% threshold)
6. Staff knowledge in articulating appropriate steps to take in response to a spill (90% threshold)

Fire Prevention Management Plan Performance Standards

The following performance activities were undertaken in 2021:

1. Monitoring of actual fires reported inside the facilities
2. Monitoring of building and / or protection system monitoring – problems, significant incidents, unexpected repairs
3. Number of high hazard departments trained.

Medical Equipment Management Plan Performance Standards

The following performance activities were undertaken in 2021:

1. Preventative maintenance (PM) completion rate for high risk equipment, including life support equipment (100% threshold)
2. Preventative maintenance (PM) completion rate for non-life support equipment (95% threshold)
3. <5% of unable to locate pieces of medical equipment
4. ≥90% of equipment repairs completed within 30 days
5. Tracking of high value mobile medical equipment (90% Threshold)
6. Staff attending technical training classes.
Utility Equipment Management Plan Performance Standards

The following performance activities were undertaken in 2021:
1. Monitoring of facility utility failures (electricity, water, and natural & medical gases).
2. Monitoring of elevator failures
3. Monitoring of flooding events
4. Emergency generator testing compliance per regulatory standards  (100% threshold)

Emergency Operations Plan Performance Standards

The following performance activities were undertaken in 2021:
1. Conduct / manage two disaster drills or actual events per year at each facility according to top Hazard Vulnerability Analysis (HVA) risks and evaluate event using The Joint Commission standards (90% threshold)
2. Staff knowledge in articulating where his or her unit disaster supplies are located during monthly Environment of Care (EOC) rounds (90% threshold)
3. Staff knowledge in articulating where his or her unit emergency and safety response guide is located during monthly Environment of Care (EOC) rounds (90% threshold)
4. Staff knowledge in articulating what actions to take during an earthquake during monthly Environment of Care (EOC) rounds (90% threshold)
5. Staff knowledge in articulating suitable actions to take following a Code Triage activation during monthly Environment of Care (EOC) rounds (90% threshold)
6. Staff knowledge in articulating what action to take when an Everbridge notification is received (90% threshold)
7. Staff is able to identify the location of their departments downtime forms/box and 7/24 computer, if applicable (90% threshold)
8. Conduct / attend at least ten emergency management / safety training sessions for staff per quarter
EVALUATION: PERFORMANCE STANDARDS

EOC Component: SAFETY MANAGEMENT
Performance Standard: The following performance activities were undertaken in 2021:
1. O2 bottles found unsecured during monthly EOC rounding
2. Staff knowledge of R.A.C.E (Rescue, Alarm, Contain, Evacuate / Extinguish), and P.A.S.S (Pull, Aim, Squeeze, Sweep) acronyms (90% threshold)

1. **O2 bottles found unsecured during monthly rounds:**

   ![Bar Chart showing monthly rounds with percentages for PMC E, PMC P, and Villa.]

   **Evaluation:**
   During monthly Environment of Care (EOC) multi-disciplinary rounds, facility operations staff monitored areas for unsecured O2 tanks. Not a single O2 tank was found unsecured at PMC Poway or The Villas at Poway during 2021. A total of 10 unsecured O2 tanks were found at PMC Escondido during 2021. These tanks were immediately secured and leadership was notified. Signage is posted at all O2 tank storage locations to help remind staff where to put empty and full tanks. Facilities will continue to monitor for unsecured O2 tanks in 2022.

2. **Staff knowledge of R.A.C.E and P.A.S.S acronyms (90% threshold):**

   ![Bar Chart showing quarterly knowledge percentages for PMC E, PMC P, and Villa.]

   **Evaluation:**
   During monthly EOC rounds, facility operations staff monitored staff knowledge regarding the R.A.C.E and P.A.S.S acronyms. Our threshold is 90% and was met at each facility in each quarter.

**Safety Management Plan for Improvement:**
- We will continue to monitor unsecured O2 tanks throughout the district during monthly EOC rounds to ensure O2 tanks continue to be stored and transported safely.
- We will continue to ensure that staff are able to define the meanings of RACE and PASS during monthly EOC rounding.
- Monitoring to continue on quarterly EOC reports.
EOC Component: SECURITY MANAGEMENT

Performance Standard: The following performance activities were undertaken in 2020:

1. At least one Code Red drill will be performed once per shift, per quarter, per medical facility (100% threshold)
2. Code Grays to be properly called by staff to call center emergency line (x111) vs. staff calling security services directly (100% threshold)
3. Code Greens to be properly called by staff to the call center emergency line (x111) vs. staff calling security services directly (100% threshold)
4. Staff are observed wearing their name badge according to Palomar Health procedure (Lucidoc #14753) (100% threshold)
5. Track and promote increased Code Grey response from departments other than Security (2 extra staff per Code).

1. At least one Code Red drill will be performed once per shift, per quarter, per medical facility (100% threshold):

   Evaluation:
   Code Red drills were consistently conducted at PMCE, PMCP, and The Villas at Poway in 2021. Security staff managed these drills and met the goal of 100%, meaning no departments needed to be re-drilled.

2. Code Grays to be properly called by staff to the call center emergency line (x111) vs. staff calling security services directly (100% threshold):

   Evaluation:
   In order to get appropriate response from the proper teams, staff was tested on how Code Grays are communicated to Security. The proper process is to call the call center emergency line for a more prompt response. The goal of 100% compliance for 2021 was met in every quarter with the exception of Q1 at PMC Escondido. This shows a significant increase over previous years. There were no Code Gray events for The Villas in 2021. Consistent reminders of the correct process during the morning safety huddles contributed to the improved numbers. Any failures to follow the procedure prompt department education immediately at the conclusion of the event and department leadership is advised of the deficiency.
3. **Code Greens to be properly called by staff to the call center emergency line (x111) vs. staff calling security services directly (100% threshold):**

![Graph](image)

**Evaluation:**
In order to get appropriate response from the proper teams, staff was tested on how Code Greens are communicated to Security. The proper process is to call the call center emergency line for a more prompt response. The goal of 100% for 2021 was not met in Q1 at PMCE and PMCP. No Code Greens occurred at The Villas at Poway in Q1 or Q2. Any failures to follow the procedure prompted department education immediately at the conclusion of the event and department leadership was advised of the deficiency.

4. **Staff are observed wearing their name badge according to Palomar Health procedure (Lucidoc #14753) (100% threshold):**

![Graph](image)

**Evaluation:**
50 Observations were conducted by Security per quarter, with the vast majority of staff being seen wearing their ID badge appropriately. All staff found to not be following the procedure were spoken with and corrected the behavior without issue.

5. **More participation from CPI trained staff during Code Grays:**

![Graph](image)

**Evaluation:**
Code Grays at PMC Escondido had greater than 3 Non-Security staff respond to assist, and is some cases greater than 4. PMC Poway had greater than 3 Non-Security staff respond. Both campuses far exceeded the goal of 2 or more responders per Code Gray and show increases of 1.45 at PMC Escondido and 0.41 at PMC Poway compared to 2020.
Security Management Plan for Improvement:

- We will continue to manage Code Red exercises with the main goal to teach staff how to respond to a Code Red event, and keep people and property safe.
- Code Gray and Code Green monitoring to continue. Staff in-services to continue if the 100% goal is not met.
- To continue improving facility access control Security will continue monitoring staff to ensure they are appropriately displaying their ID badges. This goal will be expanded in 2022 to include The Villas, where Security will be performing 25 spot checks per month, instead of 50.
- Tracking of prohibited items found during wanding at PMC Escondido and PMC Poway will be included in the Security Management plan for 2022.
EOC Component: HAZARDOUS MATERIALS AND WASTE MANAGEMENT

Performance Standard: The following performance activities were undertaken in 2021:

1. Monitoring of the number of hazardous material containers inspected / labeled incorrectly during monthly EOC rounds
2. Monitoring of the number of hazardous chemical incidents requiring outside agency cleanup
3. Monitoring of the number of bio hazardous waste incidents requiring outside agency cleanup
4. Staff knowledge on how to obtain Safety Data Sheet (SDS) information: 90% threshold
5. Landline phones properly displaying an SDS sticker
6. Staff knowledge in spill response

1. **Inappropriate labeling on hazardous material container monitoring:**

   ![Chart]

<table>
<thead>
<tr>
<th>1 Q 2021</th>
<th>2 Q 2021</th>
<th>3 Q 2021</th>
<th>4 Q 2021</th>
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   **Evaluation:**
   During monthly Environment of Care (EOC) multi-disciplinary rounds, facility operations staff monitored hazardous material containers for inappropriate labeling. All hazardous materials containers inspected were labelled properly.

2. **Number of hazardous chemical incidents:**

   ![Chart]

<table>
<thead>
<tr>
<th>1 Q 2021</th>
<th>2 Q 2021</th>
<th>3 Q 2021</th>
<th>4 Q 2021</th>
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   **Evaluation:**
   There were no hazardous chemical incidents requiring outside assistance for cleanup in 2021.

3. **Number of bio hazardous waste incidents:**

   ![Chart]

<table>
<thead>
<tr>
<th>1 Q 2021</th>
<th>2 Q 2021</th>
<th>3 Q 2021</th>
<th>4 Q 2021</th>
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</table>

   **Evaluation:**
   There were no bio-hazardous waste incidents requiring outside assistance for cleanup in 2021.
4. **Staff knowledge on how to obtain Safety Data Sheet (SDS) information (90% threshold):**

**Evaluation:**
During monthly EOC rounds, staff knowledge regarding how to locate Safety Data Sheet (SDS) information was surveyed. Our threshold was 90% and was not met in Q4 at PMCE and The Villas. In all instances where staff were not able to provide a suitable answer, Just in Time (JIT) training was provided and Sentact “fix-it” tickets were sent to department Leaders for their awareness.

5. **Landline phones properly displaying an SDS sticker (90% threshold):**

**Evaluation:**
During monthly EOC rounds, landline phones were inspected for a properly displayed SDS sticker. Having these stickers on every phone ensures that staff will always have quick access to 3E to be able to obtain SDS information on any spilled item. Almost every area inspected had phones with either no sticker displayed or had an old MSDS sticker. New stickers were made available via Security and sent “fix-it” tickets were sent to all department leaders for their awareness.

6. **Staff knowledge in spill response (90% threshold):**

**Evaluation:**
During monthly EOC rounds, staff were surveyed on what steps they should take when discovering a spill. Our threshold was 90% and not was met in Q4 at PMCE and Q1 at The Villas. Just in Time (JIT) training was provided and Sentact “fix-it” tickets were sent to department Leaders for their awareness.

**Plan for Improvement:**
- We will continue monitoring for correct staff response relating to various program elements in our hazardous materials plan, as high levels of compliance promote risk reduction relating to hazardous materials and waste usage.
EOC Component: FIRE PREVENTION MANAGEMENT
Performance Standard: The following performance activities were undertaken in 2021:
1. Monitoring of building and/or fire protection systems – failures
2. Number of high hazard departments trained.

1. Building fire protection system failures:

![Bar chart showing fire protection system failures by quarter and location]

Evaluation:
At PMC Escondido a total of 24 failures in the fire protection system were identified during routine monthly testing. 12 Instances involved fire alarm testing devices and 12 instances involved fire doors. All failures were immediately repaired.
There was a total of 2 unplanned fire system activations in 2021. Both occurred in August and were caused by fast rising steam in the LL kitchen.
The fire system went into bypass mode a total of 14 times in 2021.

At PMC Poway there were no failures in the fire protection system.
There was 1 unplanned fire system activation in 2021. This occurred in October and was caused by arcing in a shorted wall outlet in room 512. This led to minor smoke damage.
The fire system went into bypass mode a total of 4 times in 2021. All 4 instances were for scheduled duct detector replacement.

At The Villas at Poway a total of 5 failures in the fire protection system were identified during routine monthly testing. All instances involved fire doors and were repaired immediately.
There were no unplanned fire system activations in 2021 and the fire system did not go on bypass for any reason.

Siemens was involved in all events and there was no impact to services.

2. Number of high hazard departments trained:

![Bar chart showing number of high hazard departments trained by quarter]

Evaluation:
Of the pre-identified high risk departments, EVS, FANS, Facilities, Lab, and the OR/IR/Cath Lab, only FANS participated in fire safety training in 2021.

Plan for Improvement:
- We will continue to monitor the fire protection systems in all facilities.
- Further efforts will be made to provide Fire safety training for identified high risk departments in 2022.
**EOC Component:**  **MEDICAL EQUIPMENT MANAGEMENT**  
**Performance Standard:** The following performance activities were undertaken in 2021:

1. Preventative maintenance (PM) completion rate for high risk medical equipment (100% threshold)
2. Preventative maintenance (PM) completion rate for non-high risk medical equipment (95% threshold)
3. <5% of unable to locate pieces of medical equipment
4. ≥90% of equipment repairs completed within 30 days
5. ≥90% Tracking of high value mobile medical equipment
6. # Of staff attending technical training classes.

**1. Preventative maintenance completion rates on high risk medical equipment (100% threshold):**

![Graph](image1)

**Evaluation:**
Biomed failed to meet their 100% goal at PMC Escondido in 2Q2021 and 4Q2021, at PMC Poway in 1Q2021, 2Q2021, and 3Q2021, and again in 2Q2021 at The Villas at Poway. The other 3 quarters at The Villas had no high risk medical equipment scheduled for preventative maintenance. Despite not reaching the 100% goal, Biomed was still in regulatory compliance due to COVID-19 related waivers being in place to accommodate equipment in active use for COVID patients.

**2. Preventative maintenance completion rates on non-life support devices (95% threshold):**

![Graph](image2)

**Evaluation:**
Biomed consistently met their 95% threshold of preventative maintenance on non-life support equipment at PMC Escondido. PMC Poway met the threshold in 3 of the 4 quarters, barely missing it in 2Q2021 by 1%. The Villas at Poway missed the 95% threshold in the first 2 quarters, but were at 100% for the final 2.

**3. <5% of equipment that is unable to be located:**

![Graph](image3)

**Evaluation:**
The threshold was met and exceeded in all quarters across the district.
4. ≥90% of equipment repairs completed within 30 days:

Evaluation:
The threshold was not met in Q1 and Q3 in 2021. The surge of COVID patients in the winter and limited staffing was a significant factor in not reaching this goal in Q1. In Q3 the goal was barely missed (-0.3%) despite a County wide spike in COVID patients. Despite not reaching the 100% goal, Biomed was still in regulatory compliance due to COVID-19 related waivers being in place.

5. ≥90% Tracking of high value mobile medical equipment:

Evaluation:
In 2021, 70% of high value medical equipment was tracked by either a manual or technology based process, a 4.5% increase compared to 2020. In 2022 Biomed will be aiming for 100% tracking on all of these devices.

6. # Of staff attending technical training classes.

Evaluation:
All 7 Biomed Technicians attended technical training in 2021.

Plan for Improvement:
- We will continue monitoring PM completion rates as high completion rates for both high risk and non-high risk medical equipment promotes operational reliability of equipment that is used on our patients, and supports our patient safety goals.
- We will continue to monitor our other goals and watch for any apparent trends or gaps.
EOC Component: **UTILITY EQUIPMENT MANAGEMENT**

Performance Standard: The following performance activities were undertaken in 2021:

1. Monitoring of utility failures
2. Monitoring of elevator entrapments
3. Monitoring of flooding events
4. Monitoring of emergency generator testing compliance per regulatory standard

1. **Utility failure monitoring: Electricity, water, natural and medical gas failures**

   ![Utility Failure Monitoring Chart]

   **Evaluation:**
   Utility failure monitoring includes any significant electricity, water, natural and medical gas failures.

   - **PMCE 1Q2021** – 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.
   - **PMCE 2Q2021** – 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.
   - **PMCE 3Q2021** – 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.
   - **PMCE 4Q2021** – A small amount of bacteria was found in the water in a patient room. The system was flushed, retested, and determined to be clear for use.
   - **PMCE 3Q2021** – A second incident occurred where a small amount of bacteria was found in the water in a patient room. The system was flushed, retested, and determined to be clear for use.
   - **PMCE 4Q2021** – 8 Repairs were needed to medical gas alarms. Nothing was compromised and the repairs were completed without issue.
   - **PMCP 1Q2021** – 8 Failures were found with the tube system during monthly testing. All repairs were made without issue.
   - **PMCP 2Q2021** – 9 Failures were found with the tube system during monthly testing. All repairs were made without issue.
   - **PMCP 2Q2021** – Cooling towers 1 and 2 tested positive for aerobic bacteria (>10000 cfu/ml). EAI was notified, chemicals in use were adjusted, a shock treatment was performed, and the water was retested and determined to be safe.
   - **PMCP 3Q2021** – 12 Failures were found with the tube system during monthly testing. All repairs were made without issue.
   - **PMCP 3Q2021** – Cooling towers 1 and 2 tested positive for Legionella (CT1-90cfu/ml, CT2-110cfu/ml). EAI was notified, chemicals in use were adjusted, a shock treatment was performed, and the water was retested and determined to be safe and free from Legionella.
   - **PMCP 4Q2021** – 6 Failures were found with the tube system during monthly testing. All repairs were made without issue.
   - **The Villas 2Q2021** – A collapsed drain line in Station “D” required removal of a section of concrete to access and repair.
2. Elevator entrapment monitoring:

Evaluation:
Elevator entrapments were monitored throughout 2021, there were a total of 3 entrapments at PMC Escondido and none at PMC Poway or The Villas at Poway.

3. Flooding events:

Evaluation:
No flooding events occurred at any facility during 2021.

4. Emergency generator testing per regulatory standard: 100% threshold:

Evaluation:
Generator testing, which is considered high risk utility equipment, was completed monthly for all facilities. PMCE had a total of 3 failures in 2021. In Q2, Q3, and Q4, the emergency generator still worked, but the control screen stopped working. A replacement screen is on order, but shipping has been greatly delayed. Generator testing for PMC Poway and The Villas at Poway had 1 failure during Q4. Generator 2 failed to switch back to normal power. The vendor found a failed relay which prevented it from automatically switching back to normal power. This failure meant that the generator would need to be manually switched to normal power and shut down.

Plan for Improvement:
- We will continue monitoring, keeping our efforts on prevention, and utility equipment operational reliability which strengthens our patient safety focus.
The multidisciplinary District Disaster Committee met regularly with a standing agenda developed by the Emergency Manager to address the growth and continual changes of disaster preparedness and the preparedness needs throughout the district and community.

The National Incident Management System (NIMS) and Hospital Incident Command System (HICS) principles are incorporated into exercise planning and actual event response. Committee members also reviewed the Hazard Vulnerability Analysis (HVA) documents which were completed with risks prioritized for the medical centers and balanced against mitigation strategies in place. Input was solicited from our medical staff, and community partners (San Diego County Emergency Medical Services (EMS) / San Diego County Office of Emergency Services (OES) and the other SD County medical centers and fire departments) who provided recommendations for our HVA’s. We have several disaster equipment storage areas that are inventoried annually and Supply Chain maintains the medical supplies on each disaster supply cart in each of our ED’s. Also utilized is an exercise / actual event evaluation tool that establishes performance standards in accordance with The Joint Commission emergency management standards (the six critical areas of communications, resources and assets, staff roles and responsibilities, security, utilities, and patient support services).

In 2021, Palomar Health planned to participate in several county and statewide exercises:
Typically, all exercises in which the EOP is activated at each facility is evaluated to ensure our 90% objective threshold is met.

**PMC E:**
1. The Spring 2021 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2021 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management participated in “The Great Shakeout” earthquake exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested. Event score: 91% with follow up activities identified.
5. A Cybersecurity tabletop exercise was completed to assess individual department’s response to a cyber-attack.

**PMC P:**
1. The Spring 2021 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2021 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management participated in “The Great Shakeout” earthquake exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested. Event score: 91% with follow up activities identified.
5. A Cybersecurity tabletop exercise was completed to assess individual department’s response to a cyber-attack.

**The Villas at Poway:**
1. The Spring 2021 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2021 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management participated in “The Great Shakeout” earthquake exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested. Event score: 91% with follow up activities identified.
5. A Cybersecurity tabletop exercise was completed to assess individual department’s response to a cyber-attack.

**Satellite Buildings, including Home Health:**
1. The Spring 2021 Countywide disaster exercise was cancelled due to the County’s response efforts with COVID-19.
2. The November 2021 Statewide disaster exercise was cancelled due to the States response efforts with COVID-19.
3. The Summer no-notice evacuation exercise was cancelled due to the County’s response efforts with COVID-19.
4. Emergency Management participated in “The Great Shakeout” earthquake exercise for the Palomar Health district. Everbridge, satellite phones, radios, TRAIN, and WebEOC were all tested. Event score: 91% with follow up activities identified.
5. A Cybersecurity tabletop exercise was completed to assess individual department’s response to a cyber-attack.

**Plan for Improvement:**
- We will continue collaborating with outside agencies to ensure we approach disaster preparedness with a ‘whole community’ approach.
- For the disaster exercise and events, debriefings occurred with plans for improvement identified. The Disaster Preparedness Committee has the responsibility for implementing the improvement actions. We will continue with pre-planning for drills, identifying objectives that test stressing our procedures and systems.
EOC Component: **EMERGENCY MANAGEMENT**

Performance Standards: The following performance activities were undertaken in 2021:

1. Conduct / manage two disaster exercises or actual events per year at each facility according to top Hazard Vulnerability Analysis (HVA) risks and evaluate event using The Joint Commission standards (90% threshold)
2. Staff knowledge during EOC surveillance rounds in articulating where his or her unit’s disaster supplies are located (90% threshold)
3. Staff knowledge during EOC surveillance rounds in articulating where his / her unit Emergency and Safety Response guide is located (90% threshold)
4. Staff knowledge during EOC surveillance rounds in articulating the actions to take during an earthquake (90% threshold)
5. Staff knowledge during EOC surveillance rounds in articulating what his / her role would be during a Code Triage event (90% threshold)
6. Staff knowledge during EOC surveillance rounds in articulating what actions to take when an Everbridge notification is received (90% threshold)
7. Staff knowledge during EOC surveillance rounds in identifying the location of their departments downtime forms/box (90% threshold)
8. Conduct / attend at least ten emergency management / safety training sessions for staff per quarter.

1. **Evaluation of disaster exercises / actual events using The Joint Commission Emergency Management chapter standards:** 90% threshold

![Great Shakeout Evaluation](chart1.png)

**Evaluation:**
For The Great Shakeout exercise in 2021, the threshold of 90% was met consistently at each medical center and satellite building. Action items were identified post event as well as what items went well. These items were forwarded to the Disaster Preparedness Committee for review.

2. **Staff knowledge during EOC surveillance rounds in articulating where his or her unit’s disaster supplies are located:** 90% threshold

![Staff Knowledge Evaluation](chart2.png)

**Evaluation:**
During monthly EOC rounds, Emergency Management staff monitored staff knowledge regarding the locations of disaster equipment. Our threshold is 90% and was met at all location in every quarter. Just in time training was provided and follow up emails were sent to department leadership for each department deficiency encountered.
3. **Staff knowledge of the location of his / her Emergency and Safety Response Guide: 90% threshold**

![Graph showing staff knowledge of emergency response guide locations]

**Evaluation:**
During monthly EOC Rounds, Emergency Management staff monitored staff knowledge regarding the locations of departmental Emergency and Safety Response Guides. Our threshold is 90% and was met at all locations in every quarter. Just in time training was provided and follow up emails were sent to department leadership for each department deficiency encountered.

4. **Staff knowledge during EOC surveillance rounds in articulating actions to take during an earthquake: 90% threshold**

![Graph showing staff knowledge articulating earthquake actions]

**Evaluation:**
During monthly EOC rounds, Emergency Management staff monitored staff knowledge regarding actions to take during an earthquake. Our threshold is 90% and was met at all locations in every quarter. Just in time training was provided and follow up emails were sent to department leadership for each department deficiency encountered.

5. **Staff knowledge during EOC surveillance rounds in articulating what actions to take during a Code Triage event: 90% threshold**

![Graph showing staff knowledge articulating Code Triage actions]

**Evaluation:**
During monthly EOC rounds, Emergency Management staff monitored staff knowledge regarding actions to take during a Code Triage event. Our threshold is 90% and was met at all location in every quarter. Just in time training was provided and follow up emails were sent to department leadership for each department deficiency encountered.
6. Staff knowledge during EOC surveillance rounds in articulating what actions to take when an Everbridge notification is received: 90% threshold

Evaluation:
During monthly EOC Rounds, Emergency Management staff monitored staff knowledge regarding how to confirm the receipt of an Everbridge notification. Our threshold is 90% and was met at all locations in every quarter. Just in time training was provided and follow up emails were sent to department leadership for each department deficiency encountered.

7. Staff is able to identify the location of their departments downtime forms/box: 90% threshold

Evaluation:
During monthly EOC Rounds, Emergency Management staff monitored staff knowledge on the location of their downtime forms/box and 7/24 computer. The 90% threshold was not met in the Q1 at PMCE. Just in time training was provided and follow up emails were sent to department leadership.

8. Conduct/Attend at least ten emergency management/safety training sessions for staff per quarter.

Evaluation:
A total of 29 emergency management and safety trainings were conducted for staff across the district in 2021. COVID-19 response activities greatly impacted COVID-19 response activities in both 2020 and 2021, including patient surge, staffing shortages, and the inability to conduct in person training sessions greatly impacted the ability to provide emergency management and safety trainings in 2021, unfortunately leading us to miss our goal of 40 training sessions.
SAFETY. Based upon the objectives, scope and performance standards, outcomes were positive for the safety management program at Palomar Health facilities and helped identify opportunities for additional focus in 2022. Based on the high level of commitment to education, surveillance, and ongoing activities, the Management Plan for Safety is highly effective in promoting safety standards for the organization, and in guiding the direction of safety-related activities.

SECURITY. The Management Plan for Security and the Security program is effective across the district, in spite of some objectives not being met in 2021. Event monitoring will continue in an effort to help meet our goals in 2022. Code Pink (infant abduction) and Purple (child abduction) drills were completed on a routine basis with excellent staff response. For the year 2022, we will continue monitoring security trends to identify areas of risk to the medical centers and satellite buildings, and infant and child abduction security drills, focusing on continued education and effective drill outcomes.

HAZARDOUS MATERIALS. The Management Plan for Hazardous Materials and the overall Hazardous Materials program at Palomar Health facilities is effective, as there were no spills requiring an outside response team. Rounding questions continued to help identify gaps, specifically in staff education, which resulted in follow up education and communications to leadership. Hazardous waste was manifested in accordance with agencies having jurisdiction. This focus on ongoing education reflects Palomar Health’s commitment to the safety of our employees, especially as it relates to hazardous materials issues. We maintained our multidisciplinary staff spill response team and provided additional HAZWOPER classes to expand the team to up 20 staff members from various departments.

FIRE PREVENTION MANAGEMENT. Based upon the objectives, scope and performance standards, the Fire Prevention Management plan is effective. Fire drills were completed for the medical centers and satellite buildings, with performance standards monitored, and found to be in compliance throughout the year. Fire equipment inspection, maintenance and testing was completed, with ongoing monitoring of the Statement of Conditions in effect.

MEDICAL EQUIPMENT MANAGEMENT. Based upon the objectives, scope and performance standards, the Medical Equipment Management Plan and program are effective at the medical centers. Preventive maintenance was monitored quarterly, with established thresholds met in compliance with regulatory waivers. The separation of our inventory (i.e., high risk medical equipment from non-high risk medical equipment) places a higher focus on the safety of our patients, and keeps the Environment of Care closely integrated with Patient Safety standards. The Medical Equipment Plan and program are effective in promoting safe equipment usage for our patients. We will continue to monitor equipment user errors and equipment that is not located for >30 days and be prepared to observe and report out any trending that may occur.

UTILITY EQUIPMENT MANAGEMENT. All utilities failures or interruptions to services were resolved as quickly and safely as possible to minimize all impact to our ability to provide care to patients in a safe environment. The Utility Equipment Management plan is an effective way to manage the Utility Equipment program based on the successful completion of goals and performance standard monitoring.

EMERGENCY MANAGEMENT. Based upon the objectives, scope and performance standards, the Emergency Management and Operations Plan is effective. Between COVID-19 response activities and other smaller scale responses, all of which were rated as likely risks in our Hazard Vulnerability Analysis, many successes and areas of opportunity were identified. The Disaster Preparedness Committee provided an excellent forum to support response activities and promote preparedness among recognized areas for improvement. This continues to be a highly effective and energetic committee that will continue to meet and oversee the day-to-day emergency planning in 2022. The Hazard Vulnerability Analysis’s are reviewed annually and are found to be an effective tool in prioritizing critical events, and assessing the prioritization against the medical center’s preparedness. Staff were monitored for their knowledge relating to components in our Emergency Operations Plan, and their roles in a disaster, and education was provided when gaps were identified. Palomar Health as a district is actively involved with whole community-wide preparedness activities, which strengthens our ties with agencies having jurisdiction, creating a whole-community approach to Emergency Management.