# BOARD QUALITY REVIEW COMMITTEE MEETING

## AGENDA

Thursday, June 16, 2022

1:00 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-

**PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM AND WHEN NOT SPEAKING**

<table>
<thead>
<tr>
<th>Time</th>
<th>Form A Page</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00</td>
<td>1:00</td>
<td></td>
</tr>
</tbody>
</table>

### CALL TO ORDER

1. **Establishment of Quorum**
   
   Tricia Kassab, RN, EdD, VP Quality/Patient Safety

2. **Public Comments**
   
   30 - 1:35

### Action Item(s)

- **Minutes:** Board Quality Review Committee Meeting – March 23, 2022
  
  Tricia Kassab, RN, EdD, VP Quality/Patient Safety

  5 - 1:05

- **Approval of Annual Review of Quality Assessment Performance Improvement Plan**

  5 - 1:45

- **Approval of Contracted Services**

  Emerald Textile & Morrison Management Specialists

  Tricia Kassab, RN, EdD, VP Quality/Patient Safety

  5 - 1:50

### Standing Item(s)

- **Medical Executive Committee (MEC) / Quality Management Committee (QMC)**

  Kanchan Koirala, MD, Chair, Quality Management Committee, Palomar Medical Center Escondido

  Sam Filiciotto, MD, Chair, Quality Management Committee, Palomar Medical Center Poway

  10 - 2:00

### New Business

- **Spine & Total Joint Centers of Excellence**

  Orthopedic Services - Brian Cohen, Sr. Director, Jim Bried, MD

  Spine Services – Brian Cohen, Sr. Director, Andrew Nguyen, MD

  5 - 6 2:05

- **Infection Prevention and Control (includes Antibiotic Stewardship)**

  Susan Trout, RN, CIC, Infection Preventionist

  Sandeep Soni, MD, Medical Director Infection Control

  - Antibiotic Stewardship – John Engelbert, Infectious Dis Pharmacist

  - Travis Lau, Infectious Disease Pharmacist

  5 - 7 2:10

- **Laboratory Services Biannual Report**

  Gloria Austria, Director of Laboratory Services

  Jerry Kollins, MD, Medical Director Laboratories

  5 - 8 2:15

- **Pulmonary Services Biannual Report**

  Gloria Austria, District Director, Laboratory, Pulmonary, and EEG Services

  Frank Bender, MD Medical Director

  5 - 9 2:20

### Adjournment to Closed Session


   30 - 2:51

### Adjournment to Open Session

1 - 2:52

### Action Resulting From Executive Session

1 - 2:53

**FINAL ADJOURNMENT**

2 - 2:55
<table>
<thead>
<tr>
<th>VOTING MEMBERSHIP</th>
<th>NON-VOTING MEMBERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda Greer, RN – Chairperson, Board Member</td>
<td>Diane Hansen, CPA, President / Chief Executive Officer</td>
</tr>
<tr>
<td>Terry Corrales, RN, Board Member</td>
<td>Sheila Brown, RN, MBA, FACHE, Chief Operations Officer</td>
</tr>
<tr>
<td>Laura Barry, Board Member</td>
<td>Omar Khawaja, MD, Chief Medical Officer</td>
</tr>
<tr>
<td>Kanchan Koirala, MD - Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido</td>
<td>Hugh King, Chief Financial Officer</td>
</tr>
<tr>
<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 Escondido</td>
</tr>
<tr>
<td>Laurie Edwards Tate, MS - Board Member 1st Alternate</td>
<td>Kevin DeBruin, Esq., Chief Legal Officer</td>
</tr>
<tr>
<td></td>
<td>David Lee, MD, Medical Quality Officer</td>
</tr>
<tr>
<td></td>
<td>Tricia Kassab, EdD, RN, FACHE, Vice President Quality and Patient Safety</td>
</tr>
<tr>
<td></td>
<td>Valerie Martinez, RN, BSN, MHA, CPHQ, CIC – Senior Director, Quality and Patient Safety/ Infection Prevention</td>
</tr>
</tbody>
</table>

NOTE: If you have a disability, please notify us by calling 442.281.2505, 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

**PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM**

New to GoToMeeting? Download the app at:
https://meet.goto.com/install
# BOARD QUALITY REVIEW COMMITTEE MEETING

**ATTENDANCE ROSTER - CALENDAR YEAR 2022**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>LINDA GREER, RN, Chairperson, Board Member</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TERRY CORALES, RN, Board Member</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAURA BARRY, Board Member</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KANCHAN KOIRALA, MD, Chair, Medical Staff Quality Management Committee, PMC Escondido</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAM FILICIOTTO, MD, Chair, Medical Staff Quality Management Committee, PMC Poway</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laurie Edwards-Tate, MS- 1st Board Alternate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NON-VOTING MEMBERS</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DIANE HANSEN, CPA, President &amp; CEO</td>
<td>E</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SHEILA BROWN, RN, MBA, FACHE, Chief Operations Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OMAR KHAWAJA, MD, Chief Medical Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MICHAEL BOGERT, Chief Financial Officer</td>
<td>X</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MEL RUSSELL, RN, MSN, Chief Nursing Officer, PMC Escondido</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRICIA KASSAB, EdD., RN, FACHE, Vice President, Quality and Patient Safety</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Sr. Director, Quality and Patient Safety</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DAVID LEE, MD, Medical Quality Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KEVIN DEBRUIN, Esq., Chief Legal Officer</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEPHANIE BAKER, MBA, RN, CEN, Chief Administrative Officer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
TO: Board Quality Review Committee

MEETING DATE: Thursday, June 16, 2022

FROM: Sally Valle, Committee Secretary

Background: Minutes from the Wednesday, March 23, 2022, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, January 26, 2022, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Thursday, June 16, 2022

FROM: Sally Valle, Committee Secretary

Background: The Annual Review of the Quality Assessment Performance Improvement Plan 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: Thursday, June 16, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation reports are 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: Thursday, June 16, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation reports are 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: Thursday, June 16, 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: Thursday, June 16, 2022  
FROM: Sally Valle, Committee Secretary  

Background: The Infection Prevention and Control (Antibiotic Stewardship) Report is provided to the Board Quality Review Committee for information only.  

Budget Impact: N/A  

Staff Recommendation: For information only.  

Committee Questions:  

<table>
<thead>
<tr>
<th>COMMITTEE RECOMMENDATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motion:</td>
</tr>
<tr>
<td>Individual Action:</td>
</tr>
<tr>
<td>Information: X</td>
</tr>
<tr>
<td>Required Time:</td>
</tr>
</tbody>
</table>
TO: Board Quality Review Committee
MEETING DATE: Thursday, June 16, 2022
FROM: Sally Valle, Committee Secretary

Background: The Laboratory Services Biannual Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: Informational only.

Committee Questions:

COMMITTEE RECOMMENDATION:
Motion:
Individual Action:
Information: X
Required Time:
TO: Board Quality Review Committee

MEETING DATE: Thursday, June 16, 2022

FROM: Sally Valle, Committee Secretary

Background: The Pulmonary Services Biannual Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: Informational only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
ADDENDUM A
## Board Quality Review Committee Meeting Minutes – Wednesday, March 23, 2022

### Agenda Item

<table>
<thead>
<tr>
<th>Notice of Meeting</th>
<th>Conclusion/Action</th>
<th>Follow Up / Responsible Party</th>
<th>Final?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Notices of Meeting</strong></td>
<td>The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Monday, March 14, 2022, consistent with legal requirements.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Call to Order</strong></td>
<td>Pursuant to Board Resolution No. 01.10.22(03)-03 participation will be virtual and the meeting was called to order at 4:00 p.m. by Director Linda Greer, RN.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Establishment of Quorum</strong></td>
<td>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 and Sam Filiciotto, MD, Palomar Medical Center Poway</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Public Comment</strong></td>
<td>There were no public comments.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Action Items:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. <em>Review / Approval: Open/Closed Session Meeting Minutes / Attendance Roster – January 26, 2022</em></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The BQRC meeting minutes from January 26, 2022, were presented for review and approval. Kanchan Koirala, MD, motioned for approval, second by Laura Barry.

**MOTION:** by Kanchan Koirala, MD, second by Laura Barry, carried to approve the meeting minutes of January 26, 2022, as submitted. Roll call voting was utilized.

Directory Linda Greer, RN- Aye
Director Terry Corrales, RN – Aye
Director Laura Barry – Aye
Kanchan Koirala, MD – Aye
Sam Filiciotto, MD- Aye

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

Administration to follow up with Legal for input on Committee edits within the Bylaws | Y |
### B. *Review / Approval: Workplace Violence Plan #59592*

The committee reviewed Workplace Violence Plan #59592.

Director Greer commented on how this was well done in a timely manner. She noted we have increased Security vigilance at the hospital, who are identifying weapons and/or items not allowed in our facility.

**MOTION:** by Laura Barry, second by Terry Corrales to approve Workplace Violence Plan as presented.

Roll call voting was utilized.

- Directory Linda Greer, RN - Aye
- Director Terry Corrales, RN – Aye
- Director Laura Barry – Aye
- Kanchan Koirala, MD – Aye
- Sam Filiciotto, MD- Aye

All in favor. None opposed.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>

### C. *Review / Approval: Patient Complaints and Grievance – Home Health #11163*

The committee reviewed the red line edits and clean copy of the Patient Complaints and Grievance – Home Health #11163 procedure.

No further discussion.

**MOTION:** by Director Laura Barry, second by Terry Corrales to accept redline edits as written

Roll call voting was utilized.

- Directory Linda Greer, RN- Aye
- Director Terry Corrales, RN – Aye
- Director Laura Barry – Aye
- Kanchan Koirala, MD – Aye
- Sam Filiciotto, MD- Aye

All in favor. None opposed.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

### D. *Review / Approval: Patient Complaints / Grievance #35072*

The committee reviewed the red line edits and clean copy of the Patient Complaints / Grievance #35072 procedure.

No further discussion.

**MOTION:** by Director Laura Barry, second by Terry Corrales to accept redline edits as written

Roll call voting was utilized.

- Directory Linda Greer, RN- Aye
- Director Terry Corrales, RN – Aye
- Director Laura Barry – Aye
- Kanchan Koirala, MD – Aye
- Sam Filiciotto, MD- Aye

All in favor. None opposed.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Y</td>
<td></td>
</tr>
</tbody>
</table>
E. REVIEW / APPROVAL: CONTRACTED SERVICES

Valerie Martinez, Sr. Director of Quality and Patient Safety and Infection Control, presented the Contracted Services report to the committee.

Contracted Service Evaluations include:
- Corticare Monitoring
- Olympus Equipment

MOTION: by Director Laura Barry, second by Terry Corrales approved to accept contracted service reviews of Corticare Monitoring and Olympus Equipment

Roll call voting was utilized.

Directory Linda Greer, RN- Aye
Director Terry Corrales, RN – Aye
Director Laura Barry – Aye
Kanchan Koirala, MD – Aye
Sam Filiciotto, MD- Aye

All in favor. None opposed.

STANDING ITEM(S)

A. MEDICAL EXECUTIVE COMMITTEE (MEC)/QUALITY MANAGEMENT COMMITTEE (QMC) UPDATE

Dr. Sam Filiciotto, MD, 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:
- Organizational changes have been put in place to improve areas of opportunities identified at QMC. Dr. Khawaja will oversee and be more involved in Quality, and all perioperative services and surgery services are under Mel Russel, Chief Nurse Executive
- Highlights from the last meeting:
  - Radiology continues to do well with monitoring their readings as well as the contracted STAT Rad services
  - Trauma Services doing well. Identifies problems and address accordingly
  - Trauma services have a American College site review May 4th, 5th virtually
  - Mel Russell is addressing Nursing Sensitive indicators during the daily huddles, looking at moderate level indicators and those that are already doing well
  - Stroke program from 2008 continues to excel and is making improvement in transport times and the program is starting to branch out to provide more interventional opportunities
  - Working on 3 areas to provide follow up reports - Anesthesia Department is integrating their electronic medical record starting July 1, and will start to bring back follow up reports to QMC. Dr. Khawaja and his leaders will be working on improving their bi-annual reports to include patient safety and quality data.
  - Department of Surgery report will come to MEC and QMC
  - Sustainability and staffing continue to be significant areas for improvement and the committee continues to work on these issues. Director Greer requested to have a
follow up on the Surgery Department to monitor issues and/or improvements from a Quality standpoint. Dr. Filiciotto noted that from a medical staff peer review standpoint, incidents in the OR have improved. The current issues are more of an operational nature.

NEW BUSINESS

A. EMERGENCY DEPARTMENT SERVICES ANNUAL REPORT

Tom Siminski, District Director of Emergency Services and Dr. Bruce Friedberg, MC, ED Medical Directory PMC Poway presented the annual Emergency Department Services report.

- Highlighted accomplishments
  - Amazing Success with Verticare or POD D used to sort patients in the lobby based on acuity decreasing the time the patient has to wait from the door to seeing a provider, and decreasing length of stay. Seeing improvement in patient satisfaction scores.
  - New grad program in collaboration with the Emergency nurses Association to help with staffing started. Ability to utilize their evidence based best practices on how to develop and onboard new grads to be successful in the Emergency Department.
  - Much improvement made in collaboration with other departments, such as Registration, Imaging, Behavioral Health.
  - Have a new interim Manager, Tracy Page who has her DNP.
  - Have implemented a robust action plan to help decrease falls.

(See Addendum F for additional information)

MOTION: N/A

B. TRAUMA SERVICES ANNUAL REPORT

N/A

Y
Dr. John Steele, MD, Trauma Medical Director and Melinda Case, Trauma Services Manager presented the annual Trauma Services report to the committee.

- Working on preparations for the ACS re-verification survey. Four of the six trauma centers in the County have been surveyed to date.
- The Trauma Program reviews every trauma patient, monitors, collects data, and evaluates over 250 data points and audit filters mandated by the ACS-COT and the San Diego Trauma/EMS System. Annually, the Trauma Program reviews and strategizes to focus on the top 3-4 audits that currently demonstrate opportunities for improvement and meet the criterion for a Level II Trauma Center.
- Dr. Steele reported on top areas of the program which are currently challenging (staffing), and pointed out they are not unique to our facility. Director Greer noted how the Board need to discuss new, different strategies to address the staffing issues.

*(See Addendum G for additional information)*

<table>
<thead>
<tr>
<th>MOTION: N/A</th>
<th></th>
<th>Y</th>
</tr>
</thead>
</table>

**c. REGULATORY BIANNUAL REPORT**

Jami Piearson, Regulatory Director presented the Biannual Regulatory report to the committee.

- Documentation audit data from the last 6 months was shared. Emergency Department data is 100% automated and pulling for each patient encounter. Acute care audits are random sample size. Currently working with IT to fully automate audit data pulling directly from Cerner.
- Center for Improvement in Healthcare Quality (CIHQ) conducts the mock surveys from CMS standpoint vs. Joint Commission
- Mock Survey at PMC Poway conducted March 7-9, 2022. A few highlights:
  - Each surveyor was very complementary of the staff; transparent, engaging and very respectful
  - No practice issues. Opportunities identified in documentation, and in the environment- space is an issue
- Mock Survey scheduled for PMC Escondido for March 28-31, 2022
- Joint Commission survey is excepted this year for both facilities; PMC Poway expected in November and PMC Escondido is expected in December

*(See Addendum H for additional information)*

<table>
<thead>
<tr>
<th>MOTION: N/A</th>
<th>N/A</th>
<th>Y</th>
</tr>
</thead>
</table>

**d. STROKE PROGRAM ANNUAL REPORT**

Lourdes Januszewicz, Stroke Program Coordinator, and Remia Paduga, MD, Medical Director presented the annual Stroke Program report to the committee.

- Stroke Program continues to show improvement with the Joint Commission Metrics. Volumes of Stroke patients declined both 2020 and 2021 due to the COVID 19 Pandemic.
- Stroke Program Highlights:
  - PMC Poway was recertified as a Primary Advanced Stroke Center at the end of 2021. (Seventh recertification)
  - PMC Escondido has obtained initial certification as a Thrombectomy Capable Stroke Center
- Opportunities moving into 2022:
- Implementation of Viz AI software that will allow radiologists, neurologists, and ED providers, the ability to quickly hear and actively see large vessel occlusion for stroke code patients allowing them to make decisions quicker, improving patient outcomes.
- Transfer process from PMC Poway to PMC Escondido, looking to improve times with the partnership with Advantage Ambulance company.
- Dr. Khawaja thanked Dr. Paduga and Lourdes for their work and noted that Lourdes is not only our internal expert but is also seen as an external expert as she has been selected to lead the San Diego Stroke Consortium.

*(See Addendum I for additional information)*

### E. COVID UPDATE

Valerie Martinez, Sr. Director of Quality and Patient Safety, and Sandeep Soni, MD, Medical Director of Infection Control presented a COVID update to the committee.

- Infection Control Team has done a great job making Palomar Health a safe place to work. COVID task force, multidisciplinary team put together by Infectious Disease team and Antibiotic Stewardship team.
- Waiting on CDC to come out with guidance for the 2nd booster shot for healthcare workers.
- Director Greer commented on the amazing job done by the Administration, the Leaders, and the front line staff on keeping our patients and staff safe.

*(See Addendum J for additional information)*

### MOTION

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>VOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### ADJOURNMENT TO CLOSED SESSION

- Pursuant to Health and Safety Code Section 32155 - Events Log

### MOTION

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>VOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### 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 5:30 p.m.

### MOTION

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>VOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### SIGNATURES

Committee Chair: Linda Greer, RN
ADDENDUM B
Quality Assurance & Performance Improvement (QAPI)

2021 Annual Review and Program Assessment
# Table of Contents

Introduction ................................................................................................................... 4

QAPI Information Flow Structure .................................................................................... 6

Patient Falls .................................................................................................................. 10

District Wound, Ostomy and Continence Nurse (WOCN) Consultant Team................. 12

Organ and Tissue Donation Performance Metrics .......................................................... 15

Core Measures .............................................................................................................. 17
  Opportunities .................................................................................................................. 20
  Behavioral Health Hospital Based Inpatient Psychiatric Services (HBIPS) 2021 .......... 26

Trauma Services at PMC Escondido ............................................................................... 30

Centers of Excellence (COE) ........................................................................................... 35
  Cardiovascular (CV) Services ...................................................................................... 35
  Total Joint and Spine Services .................................................................................... 37
  Metabolic and Bariatric Surgery Services ..................................................................... 38

Centers for Medicare & Medicaid Services (CMS) Pay for Performance Reports .......... 40
  Value-Based Purchasing (VBP) Program ...................................................................... 40
  Hospital Readmissions Reduction Program (HRRP) ..................................................... 41
  Hospital-Acquired Condition (HAC) Reduction Program ............................................. 42
  Leapfrog Hospital Safety Grades .................................................................................. 43

Regulatory Update ........................................................................................................ 44

Failure Mode Effectiveness Analysis (FMEA) ................................................................. 45
Our Mission
To heal, comfort and promote health in the communities we serve.

Our Vision
Palomar Health will be the health system of choice for patients, physicians, and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services.

Our Values
Excellence  Teamwork  Service
Compassion  Trust  Integrity
Introduction

Quality Assurance & Performance Improvement (QAPI) is a data-driven, proactive approach to improving the quality of care of services across the health care continuum. The activities of QAPI are designed to engage members at all levels of the organization to identify opportunities for improvement, address gaps in systems and processes, develop and implement appropriate improvement or corrective plans, and continuously monitor the effectiveness of interventions.

Characteristics of our QAPI Program:

1. Leadership-driven through a culture of safety and transparency, which utilizes a Quality Dashboard as the monitoring tool.
2. Data-driven based on evidenced-based practices, using national benchmarks (when available) and comparative data.
3. Integrated and coordinated to engage all levels of leadership, physicians, and employee staff.
4. Proactive in design to promote continuous performance improvement and high-reliability, quality, and safe patient care and services.
5. Communication through a common language created by an ongoing process that prioritizes QAPI opportunities using consistent methods and statistical tools that are the tenets of Plan, Do, Study, Act (PDSA) and, when appropriate, FOCUS is an acronym whose steps help to simplify the process of identifying the area of a healthcare organization that requires improvement, bringing together a team capable of achieving that improvement, and selecting the best possible solution to implement the improvement. (F - find a process to improve, O - organize the effort to work on improvement, C - clarify current knowledge of the process, U - understand process variation and capability, S - select a strategy for continued improvement. A calendar of reporting is used to ensure ongoing systematic communication to all key stakeholders, ensure accountability, and maintain the ongoing improvement gains for all QAPI activities.
6. Educational programs designed to enhance statistically-based QAPI tools for every level of leadership, physicians, and staff.
7. Standardized processes for investigation of events and follow up on near-miss events, adverse events, and sentinel events when appropriate. These standardized processes address:
   a. What practice/process change is required to prevent recurrence?
   b. How the practice/process change will be accomplished?
   c. Who is responsible for the practice/process change?
   d. Timeline for completion
   e. Description of the monitoring process to prevent a recurrence

As part of the annual evaluation of our QAPI Program, specific priority Process Improvement (PI) activities are identified each calendar year.

The evaluation of our performance in the various PI activities involves obtaining data on our performance; comparing our performance against national benchmarks (when available) and against our own recent performance; identifying opportunities for improvement; developing and implementing corrective plans; and monitoring for effectiveness of interventions. The reach of the QAPI program is organization-wide.
Services impacted include (but are not limited to):

1. Contract Services
2. Management of the Care Environment
3. Management of the Medical Record
4. Infection Prevention and Antimicrobial Stewardship Program
5. Patient Rights, including Patient Grievances
6. Medication Management
7. Anesthesia Services
8. Dietary Services
9. Discharge Planning
10. Laboratory Services
11. Nuclear Medicine Services
12. Nursing Services
13. Operative and Invasive Services
14. Outpatient Services
15. Radiology Services
16. Rehabilitation Services
17. Respiratory Services
QAPI Information Flow Structure

- **Paliomar Health Board Quality Review Ctee (BQRC)**
  - Medical Staff Departments and Ctees
  - Medical Executive Ctee (MEC)
  - Quality Management Ctee (QMC)
    - Blood Utilization
    - Centers of Excellence
    - Critical Care
    - Imaging/Radiation Safety
    - Infection Prevention
    - Laboratory
    - Pharmacy & Therapeutics
    - Stroke Ctee
    - Tissue Review
    - Trauma Program
    - Utilization Review

- **Interdisciplinary Governance Council (IGC)**
  - Clinical Informatics Council (CIC)
  - Education and Organization Development Council (EOCD)
  - Regulatory Steering Ctee
  - Environment of Care (EOC)
  - Emergency Management
  - Disaster Preparedness

- **Patient Experience Council (PEC)**
  - Patient and Medication Safety Council (PMSC)
  - Staff Practice Council (SPC)
Performance Improvement Projects

The Vice President, Senior Director, and Clinical Nurse Specialists/Advance Practice Nurses in the Quality and Patient Safety Department support operational leaders and departments across the health system to improve the quality of care provided. Performance Improvement (PI) projects are identified through data and processes analysis, and the Interdisciplinary Governance Council’s direction. The Quality Department assists in identifying additional PI projects when facilitating system Root Cause Analyses (RCA) and supports leaders in the implementation of associated action plans designed to address performance improvement issues. Clinical Nurse Specialists/Advance Practice Nurses review Quality Review Reports (QRR) daily to address issues contemporaneously by disseminating information on daily huddle calls, supporting escalation of adverse events, and addressing the educational needs of staff. They also track and trend the QRRs to identify PI opportunities.

2021 Accomplishments

Through Root Cause Analyses (RCAs) this past year, the following opportunities were identified:

1. Allergy Documentation
   **Opportunity:** Worked with FANS/Operational Leads/Information Technology/Pharmacy to improve the accuracy of food and medication allergy documentation in Cerner.
   **Improvement Work:**
   - Eliminated free texting of allergies in Cerner.
   - Developed robust food allergy library.
   - Created process to address new allergies needing to be added to the library.
   **2022 Goals:**
   - Meet biannual to review new allergies needing to be added to the library.
   - Create a report/process to transition previously entered allergies to the new process utilizing the allergy library.
   - Address eliminating free texting diet orders and enhancing the diet order modifier library.

2. Respiratory Services
   **Opportunity:** Worked collaboratively with Department Director and ICU leadership to address:
   - Immediate access to wall O₂ flowmeter in emergent situations.
   - Standardize care of patients mechanically ventilated requiring large amounts of Positive end-expiratory pressure (PEEP) and temporarily clamping of endotracheal tube.
   **Improvement Work:**
   - Collaborated with oxygen flowmeter eliminator vendor/rep to design a prototype that configures to Palomar Health equipment and rooms at Escondido campus.
   - Reviewed literature and created a procedure to address process for clamping endotracheal tube.
   **2022 Goals:**
   - Conduct 3-month trial of oxygen flowmeter eliminator.
   - Conduct intermittent audits of compliance with established procedure.
3. **Critical Care Department**  
**Opportunity:** Worked with Operational Leads and Pharmacy to improve safe administration of high concentration fentanyl via the Alaris pump.

**Improvement Work:**
- New labeling created and applied by pharmacy to high concentration medication infusions alerting nursing staff to use high concentration Alaris Guardrail.
- Display of wording in high concentration fentanyl order in the chart changed to distinguish the different concentrations of fentanyl.
- Included education on verification of infusion pump settings with high-risk medications, Fentanyl, in Annual Competencies Evaluation (ACE) for nursing staff.
- Audits of all fentanyl infusions in the Escondido ICU with greater than 90% compliance achieved for 6 months. Data reported to Patient Medication Safety Council (PMSC).

**2022 Goals:**
- Conduct intermittent audits of compliance with established procedure.

4. **Cath Lab**  
**Opportunity:** Worked with Department Director to address the following:
- Inconsistent process for managing supplies used and unused throughout and at the end of the procedure.
- Inconsistent debrief process.
- Variability in staff education and training.
- Access to procedure equipment in proximity to areas/rooms where procedure is performed.

**Improvement Work:**
- Create IR- Cath universal protocol boards.
- Implement debrief process utilizing IR- Cath universal protocol boards.
- Create opening and count process of guidewires, sheaths, micro-introducers, dilators.
- Provide training for dedicated TAVR team to include.
- Procured procedure carts for the TAVR team to house procedure specific equipment.

**2022 Goals:**
- Audit count process utilizing IR-Cath universal protocol boards for 6 consecutive months with >90% compliance.
- Audit debrief-verbal communication of no Retained Foreign Object (RFO) for 6 consecutive months with >90% compliance.

5. **Sepsis Steering Committee**  
**Improvement Work:**
- Collaborated with ED, Hospitalist, and ICU physicians to share best practices.
- Sepsis Order Sets were updated.
• Enhanced the process for leveraging information technology (Cerner) to help meet SEP-1 core measure requirements.
  o Process has been enhanced such that whenever the QM Sepsis Initial Documentation Form is utilized, it will trigger Cerner to scan for the ordering of blood cultures. Blood cultures will automatically be ordered by the computer system if not already ordered.
  o Also, a single repeat lactate level will automatically be ordered by the computer system in response to any initial abnormal lactate level >2 mmol/L.

Outcomes:
• Achieved Sep-1 Compliance rates above California and National Benchmarks for most of 2021.

2022 Goals:
1. Compliance 10 percentage points higher than National average.
2. Conduct another Sepsis Grand Rounds educational session during the month of September (Sepsis awareness month).
Patient Falls

Department- Quality and Patient Safety

In 2021, the Quality Clinical Nurse Specialists (CNS) facilitated Palomar Health’s Fall Prevention Program aimed at reducing preventable falls and fall related injuries in the hospital. Due to the continued effects of the pandemic the Staff Practice Council (SPC), an interdisciplinary group of frontline staff who traditionally serves as the fall team, was unable to meet consistently during 2021. In an effort to maintain meaningful transference of information around fall prevention the Quality CNS initiated a monthly fall prevention newsletter and a fall prevention intranet page.

This newsletter highlights individual department/unit efforts for process improvement around falls, communicates meaningful information from the literature regarding how to maintain a culture of safety around falls, and recognizes organizational success in fall prevention. The newsletter is disseminated via email to department/unit leaders who then share with staff. The Intranet webpage http://www.palomarhealth.net/PPHContentPage.aspx?nd=2577 provides a centralized location for staff and providers to access district fall data, which communicates Palomar Health’s fall prevention performance improvement, showcasing improved, sustained, and declining rates of falls. As well, the intranet webpage serves as a repository of fall prevention education, which includes the fall newsletter.

Assessment of Our 2021 Performance in Falls Prevention

2021 Goal

- Palomar Health district to perform at or better than the national median.

Patient Falls per 1000 Patient Days

CY2021 Inpatient Units

<table>
<thead>
<tr>
<th>Month</th>
<th>Escondido</th>
<th>Poway</th>
<th>Nat’l Median</th>
<th>Nat’l Top Quartile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>1.00</td>
<td>1.15</td>
<td>1.30</td>
<td>1.70</td>
</tr>
<tr>
<td>Feb</td>
<td>1.10</td>
<td>1.20</td>
<td>1.40</td>
<td>1.80</td>
</tr>
<tr>
<td>Mar</td>
<td>1.20</td>
<td>1.35</td>
<td>1.50</td>
<td>1.90</td>
</tr>
<tr>
<td>Apr</td>
<td>1.30</td>
<td>1.45</td>
<td>1.60</td>
<td>2.00</td>
</tr>
<tr>
<td>May</td>
<td>1.40</td>
<td>1.60</td>
<td>1.70</td>
<td>2.10</td>
</tr>
<tr>
<td>Jun</td>
<td>1.50</td>
<td>1.75</td>
<td>1.80</td>
<td>2.20</td>
</tr>
<tr>
<td>Jul</td>
<td>1.60</td>
<td>1.90</td>
<td>1.90</td>
<td>2.30</td>
</tr>
<tr>
<td>Aug</td>
<td>1.70</td>
<td>2.05</td>
<td>2.00</td>
<td>2.40</td>
</tr>
<tr>
<td>Sep</td>
<td>1.80</td>
<td>2.20</td>
<td>2.10</td>
<td>2.50</td>
</tr>
<tr>
<td>Oct</td>
<td>1.90</td>
<td>2.40</td>
<td>2.20</td>
<td>2.60</td>
</tr>
<tr>
<td>Nov</td>
<td>2.00</td>
<td>2.55</td>
<td>2.30</td>
<td>2.70</td>
</tr>
<tr>
<td>Dec</td>
<td>2.10</td>
<td>2.70</td>
<td>2.40</td>
<td>2.80</td>
</tr>
</tbody>
</table>

Inpatient

- **PMC Escondido**: 1.20 falls per 1000 patient days, better than the national quartile, 1.82
- **PMC Poway**: 1.93 falls per 1000 patient days, better than the national median, 2.62
Emergency Department

- **PMC Escondido:** 0.68 falls per 1000 visits, above the national median, 0.63
- **PMC Poway:** 0.30 falls per 1000 visits, above the national median, 0.52

**2022 Goals – Inpatient and Emergency Departments:**

- Palomar Health district to perform at or better than the national top quartile
- 5% reduction in accidental and anticipated physiological falls across the district
District Wound, Ostomy and Continence Nurse (WOCN) Consultant Team

The Wound, Ostomy and Continence Nurse (WOCN) Consultant team supports the Palomar Health quality goals for preventing Hospital Acquired Pressure Injuries (HAPI). This support is accomplished through the WOCN’s actions of providing expert complex wound consultation, disseminating best practices for the prevention of HAPI, and supporting system-wide education.

1. **Accomplishments:**

   Assessment of our 2020 (Calendar Year) Performance for Pressure Injuries
   
   - PMC Escondido
     - Percentage of Patients with HAPI Stage >2 maintained at 0.00% for CY2020 to 0.00% for CY2021
   
   - PMC Poway
     - Percentage of Patients with HAPI Stage >2 maintained at 0.00% for CY2020 to 0.00% for CY2021

   During the pandemic resurgence, the WOCN team worked to mitigate the impact of COVID-19 on patients’ quality of life and outcomes in partnership with clinical interdisciplinary teams by enhancing education, developing accessible resources and implementing/measuring new interventions.

   In 2021 the WOCN team and Quality team identified an opportunity to revise the weekly HAPI meeting to a monthly HAPI meeting which allowed for a more complete review of the real-time trends and data in order to create action items to improve how we support our patients, nursing and Nursing Leadership.

2. **Improvement Work:** Implemented focused nursing leadership rounding with the WOCN team to identify barriers for HAPI prevention best practices and processes.

3. **2022 Goals:**

   - Work with system leaders and clinical educators to understand identified barriers for the bedside nurse to provide care to prevent HAPI.
   
   - Work with system leadership and clinical educators to remove identified barriers.
   
   - Continue to achieve Zero reportable HAPI while continuing to decrease non-reportable HAPI incidence.
Palomar Medical Center

Compared by: Non Magnet
Peer Group: Non-Magnet Facilities
Measure: Percent of Surveyed Patients with Hospital Acquired Pressure Injuries Stage 2 and Above

![Graph showing trends over time](image)

<table>
<thead>
<tr>
<th>Metrics</th>
<th>2020 Q1</th>
<th>2020 Q2</th>
<th>2020 Q3</th>
<th>2020 Q4</th>
<th>2021 Q1</th>
<th>2021 Q2</th>
<th>2021 Q3</th>
<th>2021 Q4</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-Unadjusted Measure</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Mean</td>
<td>1.32</td>
<td>1.77</td>
<td>1.60</td>
<td>1.81</td>
<td>2.03</td>
<td>1.46</td>
<td>1.91</td>
<td>2.23</td>
<td>1.77</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>2.00</td>
<td>2.55</td>
<td>2.40</td>
<td>2.92</td>
<td>2.78</td>
<td>2.22</td>
<td>2.63</td>
<td>3.60</td>
<td>2.64</td>
</tr>
<tr>
<td>10th Percentile</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>50th Percentile (Median)</td>
<td>0.57</td>
<td>0.79</td>
<td>0.81</td>
<td>0.96</td>
<td>1.00</td>
<td>0.65</td>
<td>1.06</td>
<td>1.37</td>
<td>0.90</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>2.04</td>
<td>2.67</td>
<td>2.49</td>
<td>2.67</td>
<td>3.13</td>
<td>2.22</td>
<td>2.78</td>
<td>3.25</td>
<td>2.66</td>
</tr>
<tr>
<td>90th Percentile</td>
<td>3.57</td>
<td>5.24</td>
<td>4.21</td>
<td>4.76</td>
<td>5.56</td>
<td>4.16</td>
<td>5.17</td>
<td>5.56</td>
<td>4.78</td>
</tr>
<tr>
<td># Hospitals</td>
<td>1,005</td>
<td>810</td>
<td>959</td>
<td>888</td>
<td>948</td>
<td>975</td>
<td>897</td>
<td>861</td>
<td>917.88</td>
</tr>
</tbody>
</table>
Pomerado Hospital

Compared by: Non Magnet
Peer Group: Non-Magnet Facilities
Measure: Percent of Surveyed Patients with Hospital Acquired Pressure Injuries Stage 2 and Above

![Graph showing hospital performance over time with metrics and data points labeled]

<table>
<thead>
<tr>
<th>Metrics</th>
<th>2020 Q1</th>
<th>2020 Q2</th>
<th>2020 Q3</th>
<th>2020 Q4</th>
<th>2021 Q1</th>
<th>2021 Q2</th>
<th>2021 Q3</th>
<th>2021 Q4</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital-Unadjusted Measure</td>
<td>0.00</td>
<td>1.56</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.20</td>
</tr>
<tr>
<td>Mean</td>
<td>1.32</td>
<td>1.77</td>
<td>1.60</td>
<td>1.81</td>
<td>2.03</td>
<td>1.46</td>
<td>1.91</td>
<td>2.23</td>
<td>1.77</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>2.00</td>
<td>2.55</td>
<td>2.40</td>
<td>2.92</td>
<td>2.78</td>
<td>2.22</td>
<td>2.63</td>
<td>3.60</td>
<td>2.64</td>
</tr>
<tr>
<td>10th Percentile</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>25th Percentile</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>50th Percentile (Median)</td>
<td>0.57</td>
<td>0.79</td>
<td>0.81</td>
<td>0.96</td>
<td>1.00</td>
<td>0.65</td>
<td>1.06</td>
<td>1.37</td>
<td>0.90</td>
</tr>
<tr>
<td>75th Percentile</td>
<td>2.04</td>
<td>2.67</td>
<td>2.49</td>
<td>2.67</td>
<td>3.13</td>
<td>2.22</td>
<td>2.78</td>
<td>3.25</td>
<td>2.66</td>
</tr>
<tr>
<td>90th Percentile</td>
<td>3.57</td>
<td>5.24</td>
<td>4.21</td>
<td>4.76</td>
<td>5.56</td>
<td>4.16</td>
<td>5.17</td>
<td>5.56</td>
<td>4.78</td>
</tr>
<tr>
<td># Hospitals</td>
<td>1,005</td>
<td>810</td>
<td>959</td>
<td>888</td>
<td>948</td>
<td>975</td>
<td>897</td>
<td>861</td>
<td>917.88</td>
</tr>
</tbody>
</table>
Organ and Tissue Donation Performance Metrics

Palomar Health collaborates with Lifesharing with the goal to facilitate healing and life enhancement through organ and tissue donation. Types of donations include eye, tissue, organ, whole body, and living donation.

Metrics tracked:
- Organ timely referral rate - patients referred within one hour of meeting a clinical trigger.
- Conversion rate - total organ donors / total organ potential

All ventilated patients with any of these triggers:
- Neurological injury/insult/suspected anoxia
- Return of Spontaneous Circulation (ROSC) or hypothermia protocol
- Discussion of de-escalation of care and/or extubation to comfort care
- Withdrawal of support
- Transition to comfort care or change of code status
- Cardiac death

Quality data

<table>
<thead>
<tr>
<th>Palomar Medical Center</th>
<th>Report Date: 1/1/2021 - 12/31/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ Outcome Measures</strong></td>
<td>Goals</td>
</tr>
<tr>
<td>Total Organ Referrals</td>
<td>N/A</td>
</tr>
<tr>
<td>Missed Referrals **</td>
<td>N/A</td>
</tr>
<tr>
<td>Organ Potential</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Organ Donors</td>
<td>N/A</td>
</tr>
<tr>
<td>Organs Transplanted - Lives Saved!</td>
<td>N/A</td>
</tr>
<tr>
<td>Conversion Rate</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| CMS Conversion Rate ** | 75% | 67% | N/A | N/A | N/A | 100% | 100% | 100% | 100% | N/A | 67% | 100% | 100% | 89% |

<table>
<thead>
<tr>
<th>Tissue Outcome Measures</th>
<th>Goals</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Tissue Donors</td>
<td>N/A</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>9</td>
<td>4</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>53</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Palomar Medical Center Poway</th>
<th>Report Date: 1/1/2021 - 12/31/2021</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ Outcome Measures</strong></td>
<td>Goals</td>
</tr>
<tr>
<td>Total Organ Referrals</td>
<td>N/A</td>
</tr>
<tr>
<td>Missed Referrals **</td>
<td>N/A</td>
</tr>
<tr>
<td>Organ Potential</td>
<td>N/A</td>
</tr>
<tr>
<td>Total Organ Donors</td>
<td>N/A</td>
</tr>
<tr>
<td>Organs Transplanted - Lives Saved!</td>
<td>N/A</td>
</tr>
<tr>
<td>Conversion Rate</td>
<td>N/A</td>
</tr>
</tbody>
</table>

| CMS Conversion Rate ** | 75% | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |

<table>
<thead>
<tr>
<th>Tissue Outcome Measures</th>
<th>Goals</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Tissue Donors</td>
<td>N/A</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

| Organ Timely Referral Rate ** | 100% | 60% | 61% | 50% | 78% | 69% | 33% | 51% | 63% | 76% | 52% | 42% | 67% | 57% |
No goal is set for a hospital’s conversion rate as hospitals are not required to achieve a certain number of donors each year. In July, there was one patient who was identified as potentially becoming a donor, but did not (due to family decline or medical criteria, etc.) and that is why the metric changed to 0% of potential donors converted to donors that month. The conversion rate metric is not reported to any quality or regulatory entities and is only used between Lifesharing and the hospital to yield a more comprehensive picture of all actual and potential donor activity in order to focus the hospital’s education efforts.

Wins/Opportunities

- In 2021, we celebrated **50 lives saved** from organ donors and thousands of others who are healed and can live enhanced lives thanks to the 60 tissue donors across Palomar Health. This is an amazing accomplishment with a massive ripple effect from donors and their families to recipients.
- Based on a retrospective review of hospital mortality reports, 20 missed clinical trigger patient referral calls were identified in 2021 between our two campuses. These were patients that met one or more of the clinical triggers and qualified to be referred to Lifesharing per CMS and TJC standards, as well as hospital policy, but were not referred.
- Majority of missed referrals are trending from patients in the EDs and Critical Care Units, where family/next of kin have elected to transition to comfort care and withdraw of support. These represent missed donation opportunities.
- All referrals should be called in as soon as staff are aware of any discussion or wishes to withdraw support or de-escalate care, so that the patient can be evaluated by Lifesharing prior to removal of ventilator support. Once ventilator support is removed, the patient is no longer a valid candidate for organ donation.
- Organ referral call timeliness rate ended with an average of 59% of all referral calls being made within the CMS timeframe of 1 hour in 2021. This is up from 40% timely in 2020, a huge improvement!

Improving Metrics

- Reeducate all staff to ensure referral calls are being made within the CMS, TJC and Palomar Health policy standard of 1 hour from the time of a patient meeting any clinical triggers.
- Continue quarterly Lifesharing meetings with stakeholders to increase awareness and continue to educate on clinical triggers. We have many new leaders within the organization, so including them in our educational sessions will be imperative to continued success.
- Continue to share successful case outcomes with stakeholders to close the loop.

2022 goals

- Increase organ referral call timeliness to an average of at least 75% by end of CY 2022.
- Increase conversion rate to an average of at least 75% by end of CY 2022.
Core Measures

Core measures are national standards of care and treatment processes for common conditions. These processes are demonstrated to reduce complications and lead to better patient outcomes. Core measure compliance reflects how often a hospital provides each recommended treatment for certain medical conditions. Core measures are a mandated reporting requirement for both CMS and The Joint Commission.

Core measures are designed to be meaningful to patients, consumers, and physicians. The alignment of these core measure sets should aid in:

- Promotion of measurement that is evidence-based and generates valuable information for quality improvement
- Consumer decision-making
- Value-based payment and purchasing
- Reduction in the variability in measure selection
- Decreased provider’s collection burden and cost
<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>SEP-1: Sepsis Early Management Bundle</td>
<td>Q1-2021</td>
<td>9</td>
<td>14</td>
<td>64%</td>
<td>57%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>10</td>
<td>17</td>
<td>59%</td>
<td>57%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>13</td>
<td>17</td>
<td>76%</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>19</td>
<td>25</td>
<td>76%</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td>Perinatal</td>
<td>PCM-01: Elective Delivery</td>
<td>Q1-2021</td>
<td>2</td>
<td>40</td>
<td>5%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>(Lower rate is better)</td>
<td>Q2-2021</td>
<td>0</td>
<td>40</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>2</td>
<td>42</td>
<td>5%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>2</td>
<td>74</td>
<td>3%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td>PCM-02a: Cesarean Section</td>
<td>Q1-2021</td>
<td>47</td>
<td>206</td>
<td>23%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(Lower rate is better)</td>
<td>Q2-2021</td>
<td>50</td>
<td>211</td>
<td>24%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>48</td>
<td>235</td>
<td>20%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>44</td>
<td>296</td>
<td>15%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PCB-05: Exclusive Breast Milk Feeding</td>
<td>Q1-2021</td>
<td>66</td>
<td>109</td>
<td>61%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(Higher rate is better)</td>
<td>Q2-2021</td>
<td>70</td>
<td>114</td>
<td>61%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>56</td>
<td>104</td>
<td>54%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>52</td>
<td>99</td>
<td>53%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PCB-06.0: Unexpected Complications in Term Newborns - Overall Rate</td>
<td>Q1-2021</td>
<td>5</td>
<td>529</td>
<td>0.5%</td>
<td>3.2%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(Lower rate is better)</td>
<td>Q2-2021</td>
<td>5</td>
<td>563</td>
<td>0.5%</td>
<td>3.1%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>6</td>
<td>609</td>
<td>1.0%</td>
<td>3.1%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>10</td>
<td>766</td>
<td>1.3%</td>
<td>3.1%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PCB-06.1: Unexpected Complications in Term Newborns - Severe Rate</td>
<td>Q1-2021</td>
<td>5</td>
<td>529</td>
<td>0.5%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(Lower rate is better)</td>
<td>Q2-2021</td>
<td>5</td>
<td>563</td>
<td>0.5%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>6</td>
<td>609</td>
<td>1.0%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>9</td>
<td>766</td>
<td>1.2%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>PCB-06.2: Unexpected Complications in Term Newborns - Moderate Rate</td>
<td>Q1-2021</td>
<td>0</td>
<td>529</td>
<td>0.0%</td>
<td>1.9%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>(Lower rate is better)</td>
<td>Q2-2021</td>
<td>0</td>
<td>563</td>
<td>0.0%</td>
<td>1.8%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>0</td>
<td>609</td>
<td>0.0%</td>
<td>1.8%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>1</td>
<td>766</td>
<td>0.1%</td>
<td>1.8%</td>
<td>N/A</td>
</tr>
<tr>
<td>Stroke</td>
<td>STK 1: Venous Thromboembolism (VTE) Prophylaxis</td>
<td>Q1-2021</td>
<td>87</td>
<td>100</td>
<td>87%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(Higher rate is better)</td>
<td>Q2-2021</td>
<td>104</td>
<td>116</td>
<td>90%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>84</td>
<td>93</td>
<td>90%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>77</td>
<td>79</td>
<td>97%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-2: Discharged on Antithrombotic Therapy</td>
<td>Q1-2021</td>
<td>87</td>
<td>87</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(Higher rate is better)</td>
<td>Q2-2021</td>
<td>91</td>
<td>91</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>70</td>
<td>70</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>56</td>
<td>56</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter</td>
<td>Q1-2021</td>
<td>23</td>
<td>24</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>(Higher rate is better)</td>
<td>Q2-2021</td>
<td>22</td>
<td>23</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>13</td>
<td>13</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
## PMC Escondido Core Measure Compliance & Benchmarks
### Reporting Period: Q1-2021 to Q4-2021

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
</table>
|             | **STK-4: Thrombolytic Therapy**  
*Higher rate is better*          | Q1-2021 | 10        | 10         | 100%          | 89%              | 100%    |
|             |                                                                              | Q2-2021 | 13        | 13         | 100%          | 89%              | 100%    |
|             |                                                                              | Q3-2021 | 5         | 5          | 100%          | 89%              | 100%    |
|             |                                                                              | Q4-2021 | 11        | 11         | 100%          | 89%              | 100%    |
|             | **STK-5: Antithrombotic Therapy By End of Hospital Day 2**  
*Higher rate is better*          | Q1-2021 | 72        | 75         | 96%          | 100%            | 100%    |
|             |                                                                              | Q2-2021 | 62        | 70         | 89%          | 100%            | 100%    |
|             |                                                                              | Q3-2021 | 58        | 59         | 98%          | 100%            | 100%    |
|             |                                                                              | Q4-2021 | 38        | 42         | 90%          | 100%            | 100%    |
| Stroke      | **STK-6: Discharged on Statin Medication**  
*Higher rate is better*          | Q1-2021 | 85        | 87         | 98%          | 100%            | 100%    |
|             |                                                                              | Q2-2021 | 89        | 90         | 99%          | 100%            | 100%    |
|             |                                                                              | Q3-2021 | 68        | 69         | 99%          | 100%            | 100%    |
|             |                                                                              | Q4-2021 | 53        | 55         | 96%          | 100%            | 100%    |
|             | **STK-8: Stroke Education**  
*Higher rate is better*          | Q1-2021 | 46        | 64         | 72%          | 100%            | 100%    |
|             |                                                                              | Q2-2021 | 54        | 67         | 81%          | 100%            | 100%    |
|             |                                                                              | Q3-2021 | 39        | 50         | 78%          | 100%            | 100%    |
|             |                                                                              | Q4-2021 | 31        | 32         | 97%          | 100%            | 100%    |
|             | **STK-10: Assessed for Rehabilitation**  
*Higher rate is better*          | Q1-2021 | 101       | 101        | 100%         | 100%            | 100%    |
|             |                                                                              | Q2-2021 | 118       | 119        | 99%          | 100%            | 100%    |
|             |                                                                              | Q3-2021 | 89        | 89         | 100%         | 100%            | 100%    |
|             |                                                                              | Q4-2021 | 73        | 73         | 100%         | 100%            | 100%    |
|             | **CSTK-01: National Institutes of Health Stroke Scale**  
*Higher rate is better*          | Q1-2021 | 90        | 105        | 86%          | N/A             | N/A     |
|             |                                                                              | Q2-2021 | 79        | 100        | 79%          | N/A             | N/A     |
|             |                                                                              | Q3-2021 | 69        | 81         | 85%          | N/A             | N/A     |
|             |                                                                              | Q4-2021 | 57        | 66         | 86%          | N/A             | N/A     |
| ED          | **OP-23: Head CT/MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT/MRI Scan Interpretation Within 45 Mins of ED Arrival**  
*Higher rate is better*          | Q1-2021 | 5         | 6          | 83%          | 72%             | 100%    |
|             |                                                                              | Q2-2021 | 5         | 7          | 71%          | 72%             | 100%    |
|             |                                                                              | Q3-2021 | 4         | 5          | 80%          | 72%             | 100%    |
|             |                                                                              | Q4-2021 | 5         | 7          | 71%          | 72%             | 100%    |
| Outpatient  | **OPWeb-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients**  
*Higher rate is better*          | Q1-2021 | 3         | 4          | 75%          | 91%             | 100%    |
|             |                                                                              | Q2-2021 | 4         | 4          | 100%         | 91%             | 100%    |
|             |                                                                              | Q3-2021 | 3         | 3          | 100%         | 90%             | 100%    |
|             |                                                                              | Q4-2021 | 3         | 3          | 100%         | 90%             | 100%    |
Opportunities

**Stroke**

A. STK3 Anticoagulation for Atrial Fibrillation:
   
   **Issue:** Provider not ordering anticoagulation and not providing reason for not ordering

   **Improvement Work:**

   1. Communicated to providers regarding each core measure miss and the expectation for documenting reason(s) if anticoagulation not prescribed

   2. Worked with IT to ensure that the order for Stroke Measures is present and pre-checked in all Stroke PowerPlans

   3. Worked with IT to ensure that the order for Stroke Measures is also available in all Non Stroke Admission PowerPlans (Provider would need to check the order to activate.)

   4. Order for Stroke Measures aids in alerting the provider on discharge to either prescribe or give reason for not prescribing.

   5. Monitoring Use of Stroke PowerPlans
B. STK5 Antithrombotic by Day 2:  
Issue: Nursing missed administration due to NPO status – did not use the rectal order or indicate if patient refused.  

Improvement Work:  
1. Communicated with Nurse Managers for follow up with the RNs.

C. STK6 Discharged on Statin:  
Issue: Provider did not order and did not give reason for not ordering.  

Improvement Work:  
1. Communicated to providers regarding each core measure miss and the expectation for documenting reason(s) if statin not prescribed.  
2. Worked with IT to ensure that the order for Stroke Measures is present and prechecked in all Stroke PowerPlans.  
3. Worked with IT to ensure that the order for Stroke Measures is also available in all Non Stroke Admission PowerPlans (Provider would need to check the order to activate.)  
4. Order for Stroke Measures aides in alerting the provider on discharge to prescribe or give reason.  
5. Monitoring Use of Stroke PowerPlans

D. STK8 Stroke Education:  
Issue: Nursing missed opportunity to provide 1 out of 5 education topic areas.  

Improvement Work:  
1. Communicated to nursing on 5 Stroke topics required  
2. Worked with IT to update the Discharge Instructions to include the Stroke Signs and Symptoms and Call 911 – this was an area that was missed in the past
### PMC Poway Core Measure Compliance & Benchmarks

**Reporting Period: Q1-2021 to Q4-2021**

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sepsis</td>
<td>SEP-1: Sepsis Early Management Bundle [Higher rate is better]</td>
<td>Q1-2021</td>
<td>8</td>
<td>9</td>
<td>89%</td>
<td>57%</td>
<td>62%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>11</td>
<td>12</td>
<td>92%</td>
<td>57%</td>
<td>82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>9</td>
<td>14</td>
<td>64%</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>7</td>
<td>13</td>
<td>54%</td>
<td>57%</td>
<td>80%</td>
</tr>
<tr>
<td>PCM-01: Elective Delivery [Lower rate is better]</td>
<td>Q1-2021</td>
<td>0</td>
<td>12</td>
<td>0%</td>
<td>3%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>0</td>
<td>11</td>
<td>0%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>1</td>
<td>25</td>
<td>4%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>0</td>
<td>17</td>
<td>0%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>PCM-02a: Cesarean Section [Lower rate is better]</td>
<td>Q1-2021</td>
<td>10</td>
<td>65</td>
<td>15%</td>
<td>25%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>16</td>
<td>56</td>
<td>23%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>20</td>
<td>66</td>
<td>30%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>17</td>
<td>76</td>
<td>22%</td>
<td>25%</td>
<td>N/A</td>
</tr>
<tr>
<td>Perinatal Care</td>
<td>PCB-05: Exclusive Breast Milk Feeding [Higher rate is better]</td>
<td>Q1-2021</td>
<td>27</td>
<td>40</td>
<td>68%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>30</td>
<td>39</td>
<td>77%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>28</td>
<td>34</td>
<td>82%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>30</td>
<td>40</td>
<td>75%</td>
<td>50%</td>
<td>N/A</td>
</tr>
<tr>
<td>PCB-06.0: Unexpected Complications in Term Newborns - Overall Rate [Lower rate is better]</td>
<td>Q1-2021</td>
<td>1</td>
<td>139</td>
<td>0.7%</td>
<td>3.2%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>2</td>
<td>174</td>
<td>1.1%</td>
<td>3.1%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>2</td>
<td>164</td>
<td>1.2%</td>
<td>3.1%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>1</td>
<td>192</td>
<td>0.5%</td>
<td>3.1%</td>
<td>N/A</td>
</tr>
<tr>
<td>PCB-06.1: Unexpected Complications in Term Newborns - Severe Rate [Lower rate is better]</td>
<td>Q1-2021</td>
<td>1</td>
<td>139</td>
<td>0.7%</td>
<td>1.3%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>0</td>
<td>174</td>
<td>0.0%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>0</td>
<td>164</td>
<td>0.0%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>1</td>
<td>192</td>
<td>0.5%</td>
<td>1.3%</td>
<td>N/A</td>
</tr>
<tr>
<td>PCB-06.2: Unexpected Complications in Term Newborns - Moderate Rate [Lower rate is better]</td>
<td>Q1-2021</td>
<td>0</td>
<td>139</td>
<td>0.6%</td>
<td>1.9%</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>2</td>
<td>174</td>
<td>1.1%</td>
<td>1.8%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>2</td>
<td>164</td>
<td>1.2%</td>
<td>1.8%</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>0</td>
<td>192</td>
<td>0.0%</td>
<td>1.8%</td>
<td>N/A</td>
</tr>
<tr>
<td>STK 1: Venous Thromboembolism (VTE) Prophylaxis [Higher rate is better]</td>
<td>Q1-2021</td>
<td>13</td>
<td>14</td>
<td>93%</td>
<td>96%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>96%</td>
<td>100%</td>
</tr>
<tr>
<td>Stroke</td>
<td>STK-2: Discharged on Antithrombotic Therapy [Higher rate is better]</td>
<td>Q1-2021</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter [Higher rate is better]</td>
<td>Q1-2021</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
## PMC Poway Core Measure Compliance & Benchmarks

**Reporting Period:** Q1-2021 to Q4-2021

<table>
<thead>
<tr>
<th>Measure Set</th>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td>STK-4: Thrombolytic Therapy [Higher rate is better]</td>
<td>Q1-2021</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>0</td>
<td>0</td>
<td>N/A</td>
<td>89%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-5: Antithrombotic Therapy By End of Hospital Day 2 [Higher rate is better]</td>
<td>Q1-2021</td>
<td>14</td>
<td>16</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-6: Discharged on Statin Medication [Higher rate is better]</td>
<td>Q1-2021</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>14</td>
<td>14</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-8: Stroke Education [Higher rate is better]</td>
<td>Q1-2021</td>
<td>9</td>
<td>9</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>6</td>
<td>7</td>
<td>88%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>STK-10: Assessed for Rehabilitation [Higher rate is better]</td>
<td>Q1-2021</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>15</td>
<td>15</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>8</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>CSTK-01: National Institutes of Health Stroke Scale [Higher rate is better]</td>
<td>Q1-2021</td>
<td>15</td>
<td>20</td>
<td>75%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>16</td>
<td>17</td>
<td>94%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>14</td>
<td>15</td>
<td>93%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ED</td>
<td>OP-23: Head CT/MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who received Head CT/MRI Scan Interpretation Within 45 Mins of ED Arrival [Higher rate is better]</td>
<td>Q1-2021</td>
<td>7</td>
<td>10</td>
<td>70%</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>13</td>
<td>15</td>
<td>87%</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>OPWeb-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients [Higher rate is better]</td>
<td>Q1-2021</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2-2021</td>
<td>3</td>
<td>4</td>
<td>75%</td>
<td>91%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3-2021</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4-2021</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>
Opportunities

**Stroke**

A. STK1 VTE Prophylaxis:
   Issue: VTE ordered in 2 cases but documentation was delayed – entered on Day 3

   **Improvement Work:**
   1. Communicated to Nurse Manager for review with RNs
   2. To Do: IT Ticket to explore option for placing a task/alert for Nursing by day 2 if documentation is missing on day 1.

B. STK6 Discharged on Statin:
   Issue: Provider did not order and no reason given for not ordering

   **Improvement Work:**
   1. Communicated to providers regarding each core measure miss and the expectation for documenting reason(s) if statin not prescribed
   2. Worked with IT to ensure that the order for Stroke Measures is present and prechecked in all Stroke PowerPlans
3. Worked with IT to ensure that the order for Stroke Measures is also available in all Non Stroke Admission PowerPlans (Provider would need to check the order to activate.)

4. Order for Stroke Measures aides in alerting the provider on discharge to prescribe or give reason.

5. Monitoring Use of Stroke PowerPlans

C. STK8 Stroke Education:
   Issue: Nursing provided education however not documented as written information provided.
   
   Improvement Work:
   1. Communicated to nursing to indicate that education information was also provided in written format
   2. Worked with IT to update the Discharge Instructions to include the Stroke Signs and Symptoms and Call 911 – this was an area that was missed in the past.
## PMC Poway - Gero Psych Core Measure Compliance & Benchmarks

**Reporting Period: Q1-2021 to Q4-2021**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
</table>
| **HBIPS-2: Hours of Physical Restraint Use**  
  [Rate Per 1000 Patient Hours]  
  [Lower rate is better] | Q1-2021 | 0         | 1043        | 0.000         | 0.34             | N/A     |
|              | Q2-2021 | 0         | 1339        | 0.000         | 0.34             | N/A     |
|              | Q3-2021 | 0.25      | 1373        | 0.008         | 0.26             | N/A     |
|              | Q4-2021 | 0.07      | 1233        | 0.002         | 0.26             | N/A     |
| **HBIPS-3: Hours of Seclusion**  
  [Rate Per 1000 Patient Hours]  
  [Lower rate is better] | Q1-2021 | 0         | 1043        | 0.000         | 0.27             | N/A     |
|              | Q2-2021 | 0         | 1339        | 0.000         | 0.27             | N/A     |
|              | Q3-2021 | 0         | 1373        | 0.000         | 0.25             | N/A     |
|              | Q4-2021 | 0         | 1233        | 0.000         | 0.25             | N/A     |
| **HBIPS-5a: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification**  
  [Higher rate is better] | Q1-2021 | 14        | 17          | 82%            | 65%              | 100%    |
|              | Q2-2021 | 9         | 13          | 69%            | 65%              | 100%    |
|              | Q3-2021 | 16        | 18          | 89%            | 65%              | 100%    |
|              | Q4-2021 | 6         | 10          | 60%            | 65%              | 100%    |
| **IPF-TR-1: Transition Record with Specified Elements Received by Discharged Patients**  
  [Higher rate is better] | Q1-2021 | 62        | 63          | 98%            | 68%              | 100%    |
|              | Q2-2021 | 93        | 94          | 99%            | 68%              | 100%    |
|              | Q3-2021 | 92        | 93          | 99%            | 69%              | 100%    |
|              | Q4-2021 | 88        | 93          | 95%            | 69%              | 100%    |
| **IPF-TR-2: Timely Transmission of Transition Record**  
  [Higher rate is better] | Q1-2021 | 61        | 63          | 97%            | 59%              | 99%     |
|              | Q2-2021 | 92        | 94          | 98%            | 56%              | 99%     |
|              | Q3-2021 | 92        | 93          | 99%            | 60%              | 98%     |
|              | Q4-2021 | 85        | 93          | 91%            | 60%              | 98%     |
| **MET-1: Screening For Metabolic Disorders**  
  [Higher rate is better] | Q1-2021 | 39        | 41          | 95%            | 77%              | 100%    |
|              | Q2-2021 | 66        | 66          | 100%           | 77%              | 100%    |
|              | Q3-2021 | 59        | 66          | 89%            | 78%              | 100%    |
|              | Q4-2021 | 51        | 58          | 88%            | 78%              | 100%    |
| **IMM-2: Influenza Immunization**  
  [Higher rate is better] | Q1-2021 | 63        | 64          | 98%            | 75%              | 100%    |
|              | Q2-2021 | 73        | 90          | 81%            | 79%              | 100%    |
| **SUB-2: Alcohol Use Brief Intervention Provided or Offered**  
  [Higher rate is better] | Q1-2021 | 15        | 15          | 100%           | 84%              | 100%    |
|              | Q2-2021 | 16        | 16          | 100%           | 84%              | 100%    |
|              | Q3-2021 | 10        | 10          | 100%           | 79%              | 100%    |
|              | Q4-2021 | 12        | 12          | 100%           | 79%              | 100%    |
| **SUB-2a: Alcohol Use Brief Intervention**  
  [Higher rate is better] | Q1-2021 | 15        | 15          | 100%           | 77%              | 100%    |
|              | Q2-2021 | 16        | 16          | 100%           | 77%              | 100%    |
|              | Q3-2021 | 10        | 10          | 100%           | 72%              | 100%    |
|              | Q4-2021 | 12        | 12          | 100%           | 72%              | 100%    |
# PMC Poway - Gero Psych
## Core Measure Compliance & Benchmarks
### Reporting Period: Q1-2021 to Q4-2021

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge</td>
<td>Q1-2021</td>
<td>11</td>
<td>12</td>
<td>92%</td>
<td>73%</td>
<td>100%</td>
</tr>
<tr>
<td>[Higher rate is better]</td>
<td>Q2-2021</td>
<td>12</td>
<td>13</td>
<td>92%</td>
<td>73%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>9</td>
<td>10</td>
<td>90%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>75%</td>
<td>100%</td>
</tr>
<tr>
<td>SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge</td>
<td>Q1-2021</td>
<td>10</td>
<td>12</td>
<td>83%</td>
<td>62%</td>
<td>99%</td>
</tr>
<tr>
<td>[Higher rate is better]</td>
<td>Q2-2021</td>
<td>11</td>
<td>13</td>
<td>85%</td>
<td>62%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>8</td>
<td>10</td>
<td>80%</td>
<td>63%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>8</td>
<td>12</td>
<td>67%</td>
<td>63%</td>
<td>99%</td>
</tr>
<tr>
<td>TOB-2: Tobacco Use Treatment Provided or Offered</td>
<td>Q1-2021</td>
<td>10</td>
<td>10</td>
<td>100%</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td>[Higher rate is better]</td>
<td>Q2-2021</td>
<td>7</td>
<td>8</td>
<td>88%</td>
<td>82%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>6</td>
<td>7</td>
<td>86%</td>
<td>81%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>11</td>
<td>11</td>
<td>100%</td>
<td>81%</td>
<td>100%</td>
</tr>
<tr>
<td>TOB-2a: Tobacco Use Treatment</td>
<td>Q1-2021</td>
<td>6</td>
<td>10</td>
<td>60%</td>
<td>47%</td>
<td>89%</td>
</tr>
<tr>
<td>[Higher rate is better]</td>
<td>Q2-2021</td>
<td>6</td>
<td>8</td>
<td>75%</td>
<td>47%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>4</td>
<td>6</td>
<td>67%</td>
<td>45%</td>
<td>89%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>9</td>
<td>11</td>
<td>82%</td>
<td>45%</td>
<td>89%</td>
</tr>
<tr>
<td>TOB-3: Tobacco Use Treatment Provided or Offered at Discharge</td>
<td>Q1-2021</td>
<td>6</td>
<td>9</td>
<td>67%</td>
<td>60%</td>
<td>99%</td>
</tr>
<tr>
<td>[Higher rate is better]</td>
<td>Q2-2021</td>
<td>7</td>
<td>7</td>
<td>100%</td>
<td>60%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>6</td>
<td>6</td>
<td>100%</td>
<td>61%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>5</td>
<td>10</td>
<td>50%</td>
<td>61%</td>
<td>99%</td>
</tr>
<tr>
<td>TOB-3a: Tobacco Use Treatment at Discharge</td>
<td>Q1-2021</td>
<td>2</td>
<td>9</td>
<td>22%</td>
<td>22%</td>
<td>81%</td>
</tr>
<tr>
<td>[Higher rate is better]</td>
<td>Q2-2021</td>
<td>1</td>
<td>7</td>
<td>14%</td>
<td>22%</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>2</td>
<td>6</td>
<td>33%</td>
<td>22%</td>
<td>83%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>2</td>
<td>10</td>
<td>20%</td>
<td>22%</td>
<td>83%</td>
</tr>
</tbody>
</table>

**Notes:**
CMS released 2020 comparative data in October 2021. Data prior to Q3 2021 is benchmarking against 2019 National Average and Top 10%. Data from Q3 2021 and onward is benchmarking against 2020 National Average and Top 10%.
### PMC Poway - BHU Adult
### Core Measure Compliance & Benchmarks
**Reporting Period: Q1-2021 to Q4-2021**

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Quarter</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Facility Rate</th>
<th>National Average</th>
<th>Top 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HBIPS-2: Hours of Physical Restraint Use [Rate Per 1000 Patient Hours] [Lower rate is better]</td>
<td>Q1-2021</td>
<td>10.22</td>
<td>1012</td>
<td>0.417</td>
<td>0.34</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>1.27</td>
<td>1023</td>
<td>0.052</td>
<td>0.34</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>19.03</td>
<td>1031</td>
<td>0.769</td>
<td>0.26</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>2.08</td>
<td>1077</td>
<td>0.080</td>
<td>0.26</td>
<td>N/A</td>
</tr>
<tr>
<td>HBIPS-3: Hours of Seclusion [Rate Per 1000 Patient Hours] [Lower rate is better]</td>
<td>Q1-2021</td>
<td>4.95</td>
<td>1022</td>
<td>0.202</td>
<td>0.27</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>1.75</td>
<td>1023</td>
<td>0.071</td>
<td>0.27</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>1.15</td>
<td>1031</td>
<td>0.046</td>
<td>0.25</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>0</td>
<td>1077</td>
<td>0.000</td>
<td>0.25</td>
<td>N/A</td>
</tr>
<tr>
<td>HBIPS-5a: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification [Higher rate is better]</td>
<td>Q1-2021</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>65%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>4</td>
<td>5</td>
<td>80%</td>
<td>65%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>2</td>
<td>3</td>
<td>67%</td>
<td>65%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>4</td>
<td>7</td>
<td>57%</td>
<td>65%</td>
<td>100%</td>
</tr>
<tr>
<td>IPF-TR-1: Transition Record with Specified Elements Received by Discharged Patients [Higher rate is better]</td>
<td>Q1-2021</td>
<td>143</td>
<td>149</td>
<td>96%</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>103</td>
<td>112</td>
<td>92%</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>96</td>
<td>98</td>
<td>98%</td>
<td>69%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>104</td>
<td>112</td>
<td>93%</td>
<td>69%</td>
<td>100%</td>
</tr>
<tr>
<td>IPF-TR-2: Timely Transmission of Transition Record [Higher rate is better]</td>
<td>Q1-2021</td>
<td>128</td>
<td>149</td>
<td>86%</td>
<td>59%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>102</td>
<td>112</td>
<td>91%</td>
<td>59%</td>
<td>99%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>95</td>
<td>98</td>
<td>97%</td>
<td>60%</td>
<td>98%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>102</td>
<td>112</td>
<td>91%</td>
<td>60%</td>
<td>98%</td>
</tr>
<tr>
<td>MET-1: Screening For Metabolic Disorders [Higher rate is better]</td>
<td>Q1-2021</td>
<td>58</td>
<td>73</td>
<td>79%</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>55</td>
<td>58</td>
<td>95%</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>61</td>
<td>65</td>
<td>94%</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>63</td>
<td>67</td>
<td>94%</td>
<td>78%</td>
<td>100%</td>
</tr>
<tr>
<td>IMM-2: Influenza Immunization [Higher rate is better]</td>
<td>Q1-2021</td>
<td>135</td>
<td>142</td>
<td>95%</td>
<td>79%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>89</td>
<td>105</td>
<td>85%</td>
<td>79%</td>
<td>100%</td>
</tr>
<tr>
<td>SUB-2: Alcohol Use Brief Intervention Provided or Offered [Higher rate is better]</td>
<td>Q1-2021</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>84%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>19</td>
<td>22</td>
<td>86%</td>
<td>84%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>79%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>17</td>
<td>18</td>
<td>94%</td>
<td>79%</td>
<td>100%</td>
</tr>
<tr>
<td>SUB-2a: Alcohol Use Brief Intervention [Higher rate is better]</td>
<td>Q1-2021</td>
<td>20</td>
<td>20</td>
<td>100%</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q2-2021</td>
<td>19</td>
<td>19</td>
<td>100%</td>
<td>77%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q3-2021</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>72%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Q4-2021</td>
<td>17</td>
<td>17</td>
<td>100%</td>
<td>72%</td>
<td>100%</td>
</tr>
</tbody>
</table>
The Behavioral Health Unit (BHU) and Geriatric Psych Unit (GPU) have historically performed well on these core measures. The specific measures are dynamic and constantly evolving in support of emerging clinical research and improvement of clinical outcomes. From Q1-4, The BHU outperformed the benchmark in 17 of 21 core measures and the BHU scored in the top 10% in Measures 3 and SUB2a in the 4th quarter. From Q1-4, The GPU outperformed the benchmark in 22 of 23 core measures and scored in the top 10% in Measures 3, SUB2, SUB2a and TOB2 in the 4th quarter.

Over the past several months, the Tobacco and Substance Use Disorder core measure performance has been inconsistent. These measures are complex and are difficult to achieve in part due to given FDA approved medication options for some diagnoses.

**Action Plan:** The Team has implemented a new process that hardwires discussion of core measures in the daily multidisciplinary treatment meetings to improve core measure performance. This relatively new process includes clarification of diagnosis, medication management, discharge referrals and dispositions and assignment of tasks to improve core measure performance.
Trauma Services at PMC Escondido

Introduction:
Trauma Quality Improvement Program (TQIP) is the benchmarking program/process sponsored through the American College of Surgeons Committee on Trauma (ACS COT). The program uses risk-adjusted benchmarking to provide our hospital and similar centers with accurate national comparisons. Currently, over 875 trauma centers enter data into the national databank. The program aims to provide the following:
- Measuring patient outcomes through risk-adjusted benchmarking
- Promoting best practices
- Adhering to performance improvement principles

Data is shared and reported at the Quality Management Committee, Trauma Operational Committee, and the Medical Executive Committee.

Quality data
Goal for 2021: Increase Compliance with the Trauma VTE Guideline; Chemoprophylaxis given to trauma patients within 72 hours of admission unless documented contradiction.

The rate of Pulmonary Embolism occurrences were better than the TQIP national benchmark. Palomar PE rates dropped to less than 1 percent per admitted trauma patient.

Goal for 2021: Increase alcohol-screening tool to over 80% compliance by documented use of screening tool from Social Services Department (screening tool is required as a Level II Trauma Center).
Cut down, Annoyed, Guilty, Eye-Opener (CAGE) Audits dipped below 80% in late 2020 into 1st quarter of 2021. A task force involving Trauma Services and Case Management developed a revised form to indicate a required CAGE assessment audit on all trauma patients with stated or known alcohol consumption.

**Opportunity:** Unplanned Visit to O.R. 2021 rate above the national benchmark of 1.3%. Palomar rate 2.0 %

**Goals 2022:**

1. Reduce Unplanned O.R. visits from 2% to 1.5% or below. An MRI protocol is in development to reduce the need for orthopedic patients returning to the O.R. to remove hardware prior to an MRI study.
2. Improve I/O ratio in shock population to below confidence line (green shaded area is best practice).
   a) Call for Massive Transfusion Protocol (MTP) while 2nd unit of whole blood is transfusing by TNTL.
   b) Massive Transfusion Protocol education provided in bi-annual skills day training scheduled for 2022 (February 2022 and September 2022).
   c) Audit MTP for variances; report out monthly to Trauma Operational Committee
# Stroke Program

Palomar Health Stroke Program offers a comprehensive and coordinated high quality of care services to our community in the North County area. Services include emergency care, emergency interventions, stroke workup for preventive care, and rehabilitation services for recovery. Palomar Health received certification of distinction by the Joint Commission. PMC Escondido Medical Center received initial certification as Thrombectomy Capable Stroke Center, and PMC Poway Medical Center received recertification as Advanced Primary Stroke Center. Certification improves the quality of patient care by reducing variation in clinical processes, providing a framework for program structure and management, providing an objective assessment of clinical excellence, and strengthening community confidence in the quality and safety of care, treatment, and services. In addition, San Diego County has designated Palomar Medical Center Escondido and Poway as receiving centers for EMS services to take patients with stroke symptoms for emergency treatment.

## Accomplishments

Ongoing tracking and reporting of the Stroke Metrics occurs through the AHA-ASA National Registry Get with the Guidelines (GWTG) for Stroke and through the regulatory agency, The Joint Commission.

**Highlights of the Stroke Program 2021:**

<table>
<thead>
<tr>
<th></th>
<th>PMC Escondido</th>
<th>PMC Poway</th>
</tr>
</thead>
</table>
| **Total Stroke Code (SC) Activations** | ED SC: 1101  
Inpatient SC: 47 | ED SC: 357  
Inpatient SC: 15 |
| **Final Diagnosis:** | TOTAL: 783  
- AIS: 396  
- HS: 206  
- TIA: 181 | TOTAL: 136  
- AIS: 68  
- HS: 22  
- TIA: 46 |
| **Total Plasminogen Activator (tPA) Alteplase Administrations:** | 59 tPA Administrations  
- Compliance ≤ 60 Minutes: 86% | 25 tPA Administrations  
- Compliance ≤ 60 minutes: 80% |
| **Neuro Endovascular Cases: Total 78** | Total Cases: 55  
- ED SC Cases: 48  
- Inpatient SC Cases: 7  
- 40 Thrombectomy candidates  
  - 15 received tPA | Total Cases: 23  
- ED SC Cases: 22  
- Inpatient SC Cases: 1  
- 18 Thrombectomy candidates  
  - 7 received tPA |
| **Overall Treatment Rates: 37%** | tPA Only: 19%  
tPA + MER: 7%  
Mechanical Endovascular Reperfusion (MER) Only: 11% | |

## Outcomes

Outcomes for Stroke are based on reduction in disability. Palomar Health has a very active Rehabilitation Service that provides stroke patients with speech, occupational therapy, and physical therapy as inpatients and outpatients. With stroke interventions and rehab services, the disposition for the stroke patient includes Home, Home with Home Health, Acute Rehab, and Skilled Nursing Rehab.
Goals for 2022

Palomar Health Stroke Program has selected the following goals for 2022:

1. San Diego County Stroke Consortium have provided the following goals for all Stroke Centers. Palomar Health Stroke Committee has adopted these goals for 2022-2024.

   **Goal 1**: Achieve door-to-needle times within 60 minutes of hospital arrival in 85% or more of acute ischemic stroke patients treated with tPA

   **Goal 2**: Achieve door-to-needle times within 45 minutes of hospital arrival in 75% or more of acute ischemic stroke patients treated with tPA

   **Goal 3**: Achieve door-to-needle times within 30 minutes of hospital arrival in 50% or more of acute ischemic stroke patients treated with tPA

   **Goal 4**: Achieve door-to-device times (arrival to first pass of thrombectomy device) in 50% or more of eligible acute ischemic stroke patients treated with endovascular therapy

       - Within 90 minutes for direct arrivals
       - Within 60 minutes for transfer patients

   **Goal 5**: Increase the number of ischemic stroke patients arriving to the ED in <4 hours from LKWT or symptom onset

2. Implementation of VIZ Artificial Intelligence (AI)

3. Provide Community Education on Stroke via Social Media and Virtual Platform for classes.
Centers of Excellence (COE)

Cardiovascular (CV) Services
Palomar Health (PH) CV Services is a comprehensive and coordinated offering of high-quality programs spanning the continuum of care. Services are emergent, maintenance and preventative care including interventional, medical, non-interventional, diagnostic, emergency, and surgical and rehabilitation services. PH CV Services have been nationally recognized by the American College of Cardiology (ACC), American Heart Association (AHA) and US News World Report for high quality specialty cardiac care.

Ongoing quality reporting, tracking and responsiveness occurs through several mechanisms. CV care metrics is reported to national and local registries including Chest Pain/Myocardial Infarction (MI), Cardiac Catheterization / Percutaneous Coronary Intervention (CATH PCI), Transcatheter Valve Therapy (TVT), EP Device Implant, Left Atrial Appendage Occlusion (LAAO), Society of Thoracic Surgeons (STS), California CABG (Coronary Artery Bypass Graft) Outcomes Reporting Program (CCORP), Perfusion Services and San Diego County ST-Elevation Myocardial Infarction (STEMI).

The CV Service line has an internal quality structure that includes a dyad relationship with nursing/administration and the three program medical directors. Bimonthly and/or quarterly review of quality data and patient experience results occurs at the CV COE, quarterly at Cardiology Committee and other quality meetings.

The CV COE is continuously pursuing new ways to improve, track and report quality. We are planning to add additional national quality registries/programs to include Left Atrial Appendage Closure

Accomplishments & Highlights:
STEMI (ST Elevated Myocardial Infarct) Door to Balloon (D2B) Time
- National recommendation is <90 minutes. In 2021, Palomar’s D2B is 61 minutes.
- 98.9% of STEMI/NSTEMI patients met all 8 acute MI quality measures recommended by ACC
- National Cardiovascular Data Registry (NCDR) Chest Pain MI (CPMI) registry Platinum Award

Open Heart Surgery – Coronary Artery Bypass Graft (CABG)
- Beta Blocker documentation has improved to 76% in 2021 from 68% in 2018
- Prolonged ventilation (greater than 24 hours) improved to 9% in 2021 from 18% in 2018
- Readmitted within 30 days 6.06% (Jan 2021- Jun 2021) (national STS average 9.24%)

Transcatheter Aortic Valve Replacement (TAVR)
- Achieved American College of Cardiology (ACC) TAVR 2 Star Quality rating in 2021
- Re-admitted within 30 days 6.5% (national TVT average 7.1%)
- Fluoro time during procedure average of 9.7 minutes (national TVT average 16.9 minutes)
- Patients with Acceptable Quality of Life Outcome at 30 days based on KCCQ summary score 93.7% (national TVT average 65.6%)

Percutaneous Coronary Intervention
- 450+ PCIs per year
- 4 advanced capability procedural suites

Advanced Capabilities
- Impella heart pump
- IABP (Intra-Aortic Balloon Pump)
- Leadless Pacemaker
- EP Suite with comprehensive services available
Goals for 2022

1. Start ECMO program to provide advanced treatment options for patients that have life-threatening lung or heart conditions.
2. Start Left Atrial Appendage closure program to reduce risk of stroke in this patient population (January 2022).
3. Improve Overall STS Quality Star Rating to 2 Stars and Medication domain to 3 Stars
   - Start CV Service Line Multidisciplinary Committee focused on quality outcomes.
   - Review quality metrics at this committee meeting and develop action plans to improve outcomes.
   - Continue to improve prolonged ventilation metric through RN/RT driven protocol with ICU/CT provider collaboration with goal of 7% or better.
4. Streamline ordering process for Outpatient Cardiac Rehab to increase outpatient referrals
5. Start MR echo alert process to help ensure timely medical, surgical, or endovascular intervention
6. Community Health
   - AHA Heart & Stroke Walk 2022 (if available)
   - Virtual Stroke Class for Community
   - Social Media Outreach and planned outreach to providers regarding Watchman program
   - Wellness classes specifically related to Diabetes and Medication management
Centers of Excellence (COE)

Total Joint and Spine Services
In FY21, Palomar Health performed 3,598 orthopedic and spine procedures. A majority of those surgeries are organized under the Total Joint and Spine Surgery Centers of Excellence (COE) framework. Each COE is designed around the patient’s needs, and includes:
- Highly specialized physicians and staff
- High quality patient outcomes
- Faster recovery and less pain

Our goal is to improve our patient’s quality of life, increase their mobility, and make their care experience as easy as possible. For patients who need surgery, most are leaving our facility sooner than they may have expected. That’s why our team has designed an Online CarePath that keeps them, and the rest of their care team connected and moving towards the same goals.

2021 Accomplishments
Across the Ortho/Spine Platform:
1. Enrolled 492 new patients in our Online CarePath for patient education, and Patient Reported Outcome Data Collections. 98% of participating patients reported feeling prepared for surgery.
2. Hosted our 8th Annual Ortho and Spine Symposium (virtually) with 75 nurses and therapists from around southern California.

Total Joint Replacement:
1. Only one TJR fall across the district since implementing CQI process in June 2019 (0.3 falls per 1,000 bed days)
2. Variable Cost of an elective TJR has decreased 3.5% year over year (better implant pricing and shorter LOS)
3. On average, patients who have an elective total joint at Palomar report almost a full return to function one year after surgery (measured using HOOS Jr - hip disability and osteoarthritis outcome score, and KOOS Jr. - knee injury and osteoarthritis outcome score).

Spine Surgery:
1. Performed 47 robotic-assisted spine fusions since implementing the program in July 2020
2. Spinal Fusion volume in 2021 outperformed 2019 (pre-pandemic) by 7%
3. On average, patients who have a spinal fusion at Palomar go from ‘Severe Disability’ to ‘Minimal Disability’ within the first year after surgery; that’s a 61% improvement (measured using the Oswestry Disability Index)

2022 Goals
1. Focus on bringing avoidable complications, readmissions, and infections to below threshold.
2. Achieve full compliance with evidence-based guidelines around surgical management, and patient safety (e.g., infection prevention, sterile processing, rehab protocols).
3. Leverage the Online CarePath to complement virtual education classes, as well as to communicate COVID-19 precautions and testing requirements.
4. Achieve The Joint Commission’s Advanced Total Hip and Knee Replacement Accreditation (THKR) at PMC Poway.
Centers of Excellence (COE)

Metabolic and Bariatric Surgery Services

The Palomar Health Bariatric Surgery Program has achieved a Comprehensive Center accreditation from Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). An MBSAQIP accreditation for Palomar Medical Center Poway formally acknowledges our commitment to providing and supporting quality improvement and patient safety efforts for metabolic and bariatric surgery patients.

A comprehensive bariatric program includes both surgical and medical weight management. The Weight Management Center at Poway opened on August 17, 2020.

2021 Accomplishments

1. Enrolled our first patient in Go Further, Palomar Health’s mobile Bariatric Surgery and Weight Management application.

2. Two risk-adjusted semi-annual reports are received each year from MBSAQIP. There was zero 30-day mortality, but a need for improvement on 30-day Superficial SSI in the past year. 2 out of 31 sleeve gastrectomy patients developed superficial wound infections. No trends were identified.
The 2021 Quality Improvement Initiative was “Improving Long Term Follow-Up after Bariatric Surgery”. The goals were:

1. 100% of all bariatric surgery patients who are required to have long term follow-up will have visits with their surgeons within the 6-month follow-up timeframe.  
   **Result:** 100% follow-up rate achieved by December 2021

2. 50% of patients will have visits with their surgeons within the one-year follow-up timeframe.  
   **Result:** 58% visit rate achieved by December 2021

3. Improving communications of documentation on follow-up contact attempts.  
   **Result:** Both the hospital and surgeons’ teams have reached a consensus on communications

**2022 Goals**

1. Continue to exceed minimum volume of 50 stapling cases per year to meet the MBSAQIP volume requirement (see chart) by conducting 2 bariatric surgery education seminars per month.

2. MBSAQIP Quality Improvement Project for 2022, “DVT/VTE and PPI Prophylaxis after Bariatric Surgery”. There is an opportunity of participating in the American Society Metabolic Bariatric Surgery / MBSAQIP Collaborative Research Project. A meeting on the participation of the research project was held in October 2021 and followed by email communications.
Centers for Medicare & Medicaid Services (CMS) Pay for Performance Reports

The Quality Division routinely reviews with hospital leaders and key stakeholders our performance in Medicare Quality Programs. These programs include:

- Hospital Value-Based Purchasing (VBP) Program
- Hospital Readmissions Reduction Program (HRRP), and
- Hospital-Acquired Condition (HAC) Reduction Program

**Value-Based Purchasing (VBP) Program**

For the 2021 VBP Program, the metrics used to measure our hospitals’ performance fell under 4 domains:

- **Person and Community Engagement** = scores on specific HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) dimensions
- **Clinical Outcomes** = 30-day Mortality rates for Acute Myocardial Infarction, Chronic Obstructive Pulmonary Disease, Heart Failure, and Pneumonia as well as complications for Total hip/total knee arthroplasties
- **Safety** = Rates of selected Healthcare-Associated Infections (HAI), including Catheter-Associated Urinary Tract infections, *Clostridium difficile* infections, Central Line-Associated Bloodstream Infections, Methicillin-resistant *Staphylococcus aureus* Bacteremia, and Surgical Site Infections involving Colon Surgery and Abdominal Hysterectomy
- **Efficiency and Cost Reduction** = Medicare Spending per Beneficiary (MSPB)

For the FY 2022 Program, due to the COVID-19 public health emergency, CMS suppressed several measures. As a result, there were not enough data to award Total Performance Scores to hospitals and, therefore, no hospital will be financially rewarded or penalized in the FY 2022 Hospital VBP Program.

Review of the VBP Program metrics reveal that hospitals that perform well in this program demonstrate low costs (low Medicare Spending Per Beneficiary) in the setting of high quality (as measured by low mortality rates and low hospital-acquired infection rates) and a great patient experience (as measured by specific HCAHPS measures).

The HCAHPS measures that impact the VBP score include:

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- Communication about Medicines
- Cleanliness and Quietness of Hospital Environment
- Discharge Information
- Overall Rating of Hospital
- Care Transitions
The Hospital Readmissions Reduction Program (HRRP) looks at 30-Day All-Cause Unplanned Risk-Standardized Readmission rates for patients who were initially admitted to the hospital for Heart Attack (AMI), Heart Failure (HF), Pneumonia (PN), Hip/Knee Surgery (THA/TKA), Chronic Obstructive Pulmonary Disease (COPD), or Coronary Artery Bypass Graft (CABG). The performance measurement period for the FY 2022 HRRP was July 1, 2017 - December 1, 2019. (Because of the COVID-19 public health emergency, CMS made the decision to exclude data reflecting services from January 1, 2020 - June 30, 2020. CMS also excluded COVID-19 patients from the RRP conditions.)

For 2022 HRRP the total number of dollars at risk for Palomar Health was around $2.27M (which represents 3% of our Estimated Inpatient Operating Payments Subject to Adjustment). Based on our hospitals’ performance, PMC-Escondido will receive a small penalty of approximately $22,800 ($12,700 for COPD and $10,100 for PN excess readmissions) and PMC-Poway will receive a minimal penalty of approximately $11,300 for COPD excess readmissions.

This is fantastic! Due to our strong performance in preventing hospital readmissions between July 2017 - December 2019, our penalty at Escondido will be a negligible 0.04% and our penalty at Poway will be a mere 0.06% of Inpatient Operating Payments (out of what could have been a maximum penalty of 3% at each facility!)

Things we can do to continue to keep our hospital readmission rates low:

- At discharge, provide detailed education to patients, including what they can expect during their recovery
- Take time to ensure patients’ medications are reconciled
- Order Case Resource Management or Care Transition for high-risk patients
- Consider utilizing the patient medication assistance program for high-cost medications
- For complicated patients, consider performing "warm handoffs" to the patients’ PCPs
- Order Home Health to assess medication safety and/or Home Health Social Worker in high-risk patients
- At the time of discharge, ensure that patients are appropriate for discharge (but don’t hang on to them too long or else we will face penalties in the Value Based Purchasing Program!)
**Hospital-Acquired Condition (HAC) Reduction Program**

Under the Hospital-Acquired Condition (HAC) Reduction Program, CMS reduces overall Medicare payments for hospitals that fall in the worst-performing quartile of all hospitals on measures of hospital-acquired conditions (infections and complications). These worst-performing hospitals are penalized with a 1% payment reduction.

Metrics used to determine performance in the HAC Reduction Program consist of:

**CMS Patient Safety Indicators 90 (CMS PSI 90):**

1. Pressure Ulcers
2. Iatrogenic Pneumothoraces
3. In-Hospital Falls with Hip Fracture
4. Perioperative Hemorrhage or Hematoma
5. Postoperative Acute Kidney Injury Requiring Dialysis
6. Postoperative Respiratory Failure
7. Perioperative Pulmonary Embolism or Deep Vein Thromboses
8. Postoperative Sepsis
9. Postoperative Wound Dehiscence
10. Unrecognized Abdominopelvic Accidental Puncture/Lacerations

**Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) hospital-associated infections (HAI) measure scores:**

1. Central Line-Associated Blood Stream Infection (CLABSI)
2. Catheter-Associated Urinary Tract Infection (CAUTI)
3. Postoperative surgical site infections (SSI) following abdominal hysterectomy and colon procedures
4. Methicillin Resistant *Staphylococcus aureus* (MRSA) Bacteremia
5. Hospital-associated *Clostridium difficile* infection (CDI)

For FY 2022, the performance period for CMS PSI calculations included patient discharges from July 1, 2018 through December 31, 2019, and the performance period for CDC NHSN HAI measures included discharges from January 1, 2019 through December 31, 2019.

For the 2022 program Palomar Health will not be assessed any penalties in the HAC Reduction Program. This is our health system’s fifth consecutive year of being penalty-free in this program!

We can continue to succeed in the Hospital-Acquired Condition (HAC) Reduction Program by remaining diligent with infection control best practices, including consistent hand hygiene, and by focusing on improving physician documentation and increasing coding accuracy.
Leapfrog Hospital Safety Grades

The Leapfrog Group is a national nonprofit organization driving a movement for giant "leaps" forward in the quality and safety of American health care. The Leapfrog Hospital Safety Grade is a grade that the Leapfrog Group assigns to each general hospital in the U.S., rating how safe they are for their patients. Each grade reflects a composite of over thirty measures of patient safety, including rates of preventable errors, injuries, and infections, and whether hospitals have systems in place to prevent them. Grades are updated twice annually, once in the spring and then again in the fall.

Leapfrog Hospital Safety Grades assigned in fall 2021:

**PMC Escondido Grade - B**
Areas for improvement included opportunities to decrease hospital-associated infections and complications, including Retained Foreign Objects, Patient Falls, Catheter-Associated Urinary Tract Infection, and Death rate of surgical inpatients with serious treatable conditions. Additional opportunities identified revolved around how quickly staff responded to patients after they pressed their call buttons.

**PMC Poway Grade - A**
Areas for improvement included opportunities to improve patient experience via more robust Communication about Medicines, Discharge Information, and Staff Responsiveness. Additional opportunities identified revolved around decreasing hospital-associated infections, including Central Line-Associated Bloodstream Infection and Clostridium difficile.

**Action Plan**
Continue to follow continually evolving performance scores and engage interdisciplinary teams to address areas identified as opportunities for improvement.
Regulatory Update

Key issues from CMS Validation Survey held November 7-9, 2021
1. Patient Rights/Grievance
2. Patient Advanced Directives
3. Conditions of Admission (CoA)
4. QAPI Minutes

Plan of Correction (POC) Accepted by CMS on April 13, 2022 Includes:
1. Monitoring CoA compliance for Inpatients, Outpatients and in the Emergency Department
2. Monitoring Advanced Directives adherence to policy
   a. RNs to ensure the loop is closed if the patient has an Advanced Directive to ensure it is scanned to the Electronic Health Record
3. Grievance letters, if able, are closed within 7 days
4. Quality minutes reflect actions taken to improve quality of care

Policies and Procedures
1. 2,033 documents approved
2. 90% of policies in compliance with 3-year time frame

Opportunities during Environmental Rounds:
Clutter, blocking fire doors, blocking gasses, egress blocked at times, O₂ signage (Poway) not posted in all required locations

Regulatory Steering Committee Highlights from 2021:
1. Analytic support on building audits
2. POCs accepted, many complaints from consumers had no deficiency
3. Improved compliance overall on the ED, Acute Care, Universal Protocol, and Behavioral Health audits
   a. Many maintained at 90% or above

Opportunities for Improvement in 2022:
1. Noted issues with the interdisciplinary plan of care being individualized
2. Transition of care/hand-off communication
3. Restraint assessment data inconsistent
4. PRN pain reassessment inconsistent
5. Non-Violent Restraint usage requires better tracking
6. HAPI issues noted with documentation of patient’s refusal to turn or self-turn
7. ED Discharge Disposition Documentation: Nursing to include mode of transportation, location of discharge (e.g. home or other), time, and date
Failure Mode Effectiveness Analysis (FMEA)

FMEA 2020: Handoff Communication, Unit to Unit

“A Failure Modes Effects Analysis (FMEA) is a systematic, proactive method for evaluating a process to identify where and how it might fail and to assess the relative impact of different failures in order to identify the parts of the process that are most in need of change” (IHI, 2021). The Joint Commission requires hospitals to select one high-risk process to conduct a proactive risk assessment every 18 months.

Thematic data, pulled from the 2020 Culture of Safety Survey results, Root Cause Analyses (RCAs) conducted over the past year, and Quality Review Report (QRR) submissions, identified hand-off communication as a high-risk process. Specifically, hand-off communication between units/departments was highlighted as a focus that had risk of failure.

The Quality Department conducted an initial FMEA meeting in April 2021. The team consisted of leaders from departments/units across the system and frontline staff. Over the course of 6 months the team met monthly to identify the top risk categories and devise an action plan to address the highest risk areas. The team outlined the care process and identified the top 3 areas of concern:

1. Combine sources of information to streamline hand-off communication
2. Standardize hand-off communication tools
3. Establish minimum criteria of information that must be provided during hand-off

New processes in hand-off that addressed the failure points above, include the following:

Revision of the Hand-off Procedure
- Procedure includes minimum criteria of information that must be provided during hand-off
- ISBAR communication template used at Palomar Health included in procedure

Trip Tik Revised
- Format changed to adopt Palomar Heath ISBAR communication template
  - New elements add to address code status, preferred languages, high risk observation, C-Spine Precautions, Transportation Mode

Preferred Languages
- Consolidate documentation fields (3 different fields) in Cerner to establish standardized documentation
- Establish standardized definition for preferred language based on JC

Revision of Hand-off Mpage
- Working with IT to finalize a build to include information needed during hand-off on Mpage.
ADDENDUM C
Palomar Health - Review of Contract Service

Name of Service: Emerald Textile – Linen Management Program / Scrub Management Program

Date of Review: 5/15/2022 Name / Title of Reviewer: Sven Clark, District Director, Environmental Services

Nature of Service (describe): Clean linen delivery/Provides for hospital scrubs, picks up and processes soiled linen.

<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 too.</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 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 to prevent and reduce medical errors.</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>1st QTR 2021</th>
<th>2nd QTR 2021</th>
<th>3rd QTR 2021</th>
<th>4th QTR 2021</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of pieces ordered versus percentage of pieces delivered.</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
<tr>
<td>Components of Plant Tour Checklist (e.g. Soiled Linen Processing; Clean Linen Processing and/or Sanitization; Pack Room, In-service Programs). If deficiencies are found, Emerald had 30 days to correct deficiencies.</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
<tr>
<td>Quarterly Scrub Inventory / Replenishment</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
</tbody>
</table>

Comments

The vendor is meeting the quality expectation of our agreement, and continues to provide

Recommendations for additional audits and process to monitor linen/scrub loss by unit.

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 have 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: ______________________________________________________
Palomar Health
Review of Contract Service

Name of Service: Morrison Management Specialists, Inc.
Date of Review: 05.15.2022
Name / Title of Reviewer: Russell Riehl, VP, Director Operational Support Services
Nature of Service (describe): Food and Nutrition Services

Evaluation

<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 Escondido

<table>
<thead>
<tr>
<th>METRIC</th>
<th>1st QTR 2021</th>
<th>2nd QTR 2021</th>
<th>3rd QTR 2021</th>
<th>4th QTR 2021</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>RD ADIME Documentation Compliance</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
<tr>
<td>RD Pressure Injury Documentation Compliance</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
<tr>
<td>Free Texted Food Allergens - Elimination</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
<tr>
<td>Tray Accuracy</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
<tr>
<td>Temperature of Food</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>NOT MET</td>
<td>MET</td>
</tr>
<tr>
<td>Labeling and Dating</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
<td>MET</td>
</tr>
</tbody>
</table>

Comments:

There was a decrease in food temperature due to transition of a new tray line installation in Poway.
Initial implementation and process re-design quickly eliminated the issue.

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:
☐ 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: ___________________________________________________________________________________
ADDENDUM D
Palomar Health’s Spine and Total Joint Centers of Excellence (COEs)
Presented to Board Quality Review Committee

James Bried, MD, Orthopedic Medical Director, PMC-P
Andrew Nguyen, MD, PhD, Spine Medical Director, PMC-E
Brian Cohen, MHA, Senior Director Service Lines
June 16, 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>
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

###理想数字

<table>
<thead>
<tr>
<th>医疗项目</th>
<th>理想数值</th>
</tr>
</thead>
<tbody>
<tr>
<td>体重指数 (BMI)</td>
<td>20 - 35</td>
</tr>
<tr>
<td>血红蛋白 (红细胞水平/贫血)</td>
<td>大于12.5</td>
</tr>
<tr>
<td>血糖 A1c (血糖水平)</td>
<td>小于8.0 (小于7.5为优选)</td>
</tr>
<tr>
<td>血清蛋白 (血蛋白水平)</td>
<td>大于3</td>
</tr>
<tr>
<td>前清蛋白 (血蛋白水平)</td>
<td>大于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
Ortho/Spine Solutions | Engaging Patients

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

2,539 activated patients

83% Of enrolled patients are actively using their CarePath

98% patients felt prepared for surgery
**Quality Metrics | Joint Replacement (2021)**

<table>
<thead>
<tr>
<th>Year</th>
<th>PMC Escondido</th>
<th>PMC Poway</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>1.6</td>
<td>1.5</td>
</tr>
<tr>
<td>2019</td>
<td>1.4</td>
<td>1.4</td>
</tr>
<tr>
<td>2020</td>
<td>1.9</td>
<td>1.7</td>
</tr>
<tr>
<td>2021</td>
<td>1.5</td>
<td>1.2</td>
</tr>
</tbody>
</table>

**Average Length of Stay (days)**
- Lower is better
- US Average

**% of Patients Discharged on the Day of Surgery, or the Next Day**
- Higher is better
Quality Metrics | Spine Surgery (2021)

**Lumbar Fusion**

- 2021: 130 84 51 5 26
- 2020: 108 90 38 4 26
- 2019: 120 100 34 318

**Cervical Fusion**

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

**+8% growth in Lumbar Fusions**

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

**+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

2015
BACK TO THE FUTURE
The 2nd Annual Orthopedic & Spine Symposium

2016
Bodies in Motion
The 3rd Annual Orthopedic & Spine Symposium
Hosted by Palomar Health

2017
14th Annual Orthopedic & Spine Symposium
A Mile to Remember

2018
Ready Set Go!

2019
6th Annual Orthopedic & Spine Symposium
Your Lucky Day
09/27/19

2020
7th Annual Orthopedic & Spine Symposium
Our Future Is Still Bright in 2020

2021
8th Annual Orthopedic & Spine Symposium
Charging Forward in 2021
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
# Table of Contents

Introduction ....................................................................................................................................................... 3

Annual Review and Program Assessment ..................................................................................................... 3

Infection Prevention Mission ......................................................................................................................... 3

Purpose .......................................................................................................................................................... 3

Authority Statement ...................................................................................................................................... 4

Department Structure .................................................................................................................................... 4

Hand Hygiene ..................................................................................................................................................... 5

2020 & 2021 Hand Hygiene Compliance by Facility ...................................................................................... 5

2021 Hand Hygiene Compliance by Discipline............................................................................................... 5

2021 Hand Hygiene Compliance by Unit ....................................................................................................... 6

Home Health Hand Hygiene Compliance ...................................................................................................... 7

Central Line-Associated Bloodstream Infection (CLABSI) ............................................................................. 8

CLABSI Standardized Infection Ratio (SIR) ..................................................................................................... 8

Catheter-Associated Urinary Tract Infections (CAUTI) .................................................................................... 12

CAUTI Standardized Infection Ratio................................................................................................................ 12

Ventilator-Associated Pneumonia (VAP) ......................................................................................................... 15

Infection Related Ventilator-Associated Complications Plus (IVAC Plus) SIR .............................................. 15

Multi-Drug Resistant Organism (MDRO) Lab-Identified Event .................................................................... 18

*Clostridioides difficile* Infection (CDI) Standardized Infection Ratio................................................................. 18

MRSA Bloodstream Infection (BSI) .................................................................................................................. 19

Surgical Site Infections (SSI) ............................................................................................................................. 21

Colon Surgery ............................................................................................................................................... 23

Abdominal Hysterectomy (HYST) .................................................................................................................. 23

Orthopedic Surgery ...................................................................................................................................... 24

Environment of Care (EOC) .............................................................................................................................. 25

EOC Rounds .................................................................................................................................................. 25
## Table of Contents

- Environmental Sanitation Measures .................................................................................................................. 26
- Environmental Testing ........................................................................................................................................... 27
- Construction ......................................................................................................................................................... 28
- Infection Control Education .................................................................................................................................. 29
- Reportable Diseases & Emerging Infections ........................................................................................................ 30
- Employee Health .................................................................................................................................................... 31
- Influenza Vaccination Compliance ...................................................................................................................... 31
- COVID-19 Vaccine Compliance through March 23, 2022 .................................................................................... 33
- Palomar Health Staff Exposures .......................................................................................................................... 34
- First Responder/Pre-Hospital Exposures .............................................................................................................. 34
- COVID-19 ............................................................................................................................................................. 35
- Summary of Projects ............................................................................................................................................ 36
- Antibiotic Stewardship ......................................................................................................................................... 36
- Product Review ..................................................................................................................................................... 37
- Procedure Review ................................................................................................................................................ 37
- References ............................................................................................................................................................. 38
Introduction

Annual Review and Program Assessment

The Infection Prevention and Control program is evaluated annually. This assessment compares outcomes from calendar year 2020 to 2021. The assessment includes all surveillance modalities, both process and outcome measures and what is performed by the various disciplines including the Infection Preventionists (IP). In addition to infection control measures, ongoing monitoring of processes involving high-level disinfection, Sterile Processing Department, medication preparation, food and nutrition services, construction, and satellite services are included. The IP staff use their role as department resources and consultants to provide their expertise, support, and evidence-based recommendations to ensure the program and the system wide surveillance plan is followed. The program assessment provides information to steer the Infection Prevention and Control Department’s focus for the upcoming year. Each measure is evaluated for effectiveness and is considered a driver for departmental and unit based action planning. Process and outcome measures are shared at the Board of Directors, physician, nursing, support services levels and used to sustain or improve patient care activities. Infection Control rounding activities help to identify opportunities for improvement. Liaisons for Infection Prevention provide an extension of the Infection Prevention and Control Department with collaboration and implementation of program activities in specialty areas.

Guidance from various regulatory and nationally recognized professional organizations including but not limited to are The Centers for Disease Control (CDC), The Joint Commission (TJC), California Department of Public Health (CDPH), Center for Medicare/Medicaid Services (CMS), and California Occupational Health and Safety Administration (Cal OSHA). These organizations provide direction in identifying indicators and implementation of the plan. The program is fluid and can change based on emerging infectious diseases or new risks associated with the provision of care. The Infection Prevention and Control Department keeps abreast of these through the media, participation in the San Diego County Emerging Infectious diseases community meetings, Association of Professionals in Infection Control (APIC), and scientific journals. This assessment provides the reader with information on the status of the Infection Prevention and Control Plan.

Infection Prevention Mission

Develop and maintain an Infection Prevention and Control program that reflects the Mission, Vision, and Values of Palomar Health. The program promotes patient safety by reducing the risk of acquiring and transmitting infections among patients, healthcare providers, volunteers, and visitors. The program is guided by Quality and Regulatory Standards developed by TJC, CDC, CMS, CDPH, Cal OSHA and other nationally recognized organizations.

Purpose

This document provides information to establish a framework and structure for Palomar Health’s organization-wide, facility specific approach in identifying and reducing the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of services, the management of infection prevention and control processes are assigned to qualified personnel by virtue of education, training, licensure, experience and/or certification.
Authority Statement

Palomar Health has designated the Infection Control Officers per CMS to the Senior Director of Quality, Patient Safety, Infection Prevention, and the Chair of the Infection Prevention and Control Committee.

The Infection Control Officers are qualified and maintain qualifications through education, training, experience and certification related to infection control.

The Infection Control Officers have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The Infection Control Committee, through its chairperson and/or Senior Director of the Infection Prevention and Control Program, are granted authority to institute any appropriate emergency control measures throughout the health system when there is a reasonable risk or danger to any patient, healthcare provider, volunteer, or visitor.

Department Structure

The Infection Prevention and Control Department is structured under the Operations Division. The Infection Prevention and Control Program reports directly to the Quality Management Committee.
Hand Hygiene

**Goal:** Increase facility *before patient contact* (orange) hand hygiene compliance by ≥10% or maintain above 85% compliance from 2020; measured by Palomar Health Infection Control standardized methods.

### 2020 & 2021 Hand Hygiene Compliance by Facility

#### Hand Hygiene by Facility and N

<table>
<thead>
<tr>
<th>Facility</th>
<th>BEFORE</th>
<th>AFTER</th>
<th>COMBINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escondido</td>
<td>82%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>Poway</td>
<td>87%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>Villas</td>
<td>81%</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>82%</td>
<td>92%</td>
<td>92%</td>
</tr>
</tbody>
</table>

### 2021 Hand Hygiene Compliance by Discipline

#### Hand Hygiene by Discipline and N

<table>
<thead>
<tr>
<th>Discipline</th>
<th>BEFORE</th>
<th>AFTER</th>
<th>COMBINED</th>
</tr>
</thead>
<tbody>
<tr>
<td>EVS</td>
<td>97%</td>
<td>86%</td>
<td>95%</td>
</tr>
<tr>
<td>FANS</td>
<td>89%</td>
<td>88%</td>
<td>92%</td>
</tr>
<tr>
<td>LAB</td>
<td>95%</td>
<td>91%</td>
<td>94%</td>
</tr>
<tr>
<td>MD</td>
<td>95%</td>
<td>86%</td>
<td>83%</td>
</tr>
<tr>
<td>NURSE</td>
<td>94%</td>
<td>80%</td>
<td>86%</td>
</tr>
<tr>
<td>OTHER</td>
<td>83%</td>
<td>76%</td>
<td>89%</td>
</tr>
<tr>
<td>PM</td>
<td>93%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>RAD</td>
<td>93%</td>
<td>67%</td>
<td>82%</td>
</tr>
<tr>
<td>REHAB</td>
<td>93%</td>
<td>82%</td>
<td>89%</td>
</tr>
<tr>
<td>RESP</td>
<td>96%</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>TRANS</td>
<td>85%</td>
<td>77%</td>
<td>81%</td>
</tr>
</tbody>
</table>

NURSE=RN, LVN, CNA, HCA; RAD=imaging; TRANS=transporters, lift team; REHAB=OT, PT, ST; FANS includes Registered Dietician; PM=pathmaker, student, and volunteers. "COMBINED" is the mean rate of before and after patient contact.
2021 Hand Hygiene Compliance by Unit

Summary Analysis: During 2021, Palomar Health System maintained focus on increasing hand hygiene before patient contact yet did not achieve the goal of 85%. The compliance was 87% (N=32,562) compared to 2020 82% compliance (N=22,646). At the facility level, PMC Escondido increased compliance by 6.10%. Overall measures essentially stayed the same at Poway and The Villas at Poway. It appears that staff is clear on rationale for decontaminating hands after patient contact, but fail to comprehend the full consequences of missing hand hygiene prior to patient contact.

Goal Met/Unmet:

PMC Escondido - Goal Unmet

PMC Poway – Goal Unmet

The Villas at Poway – Goal Met

Action Plan:

1. Infection Prevention to begin providing monthly case reviews to staff which may be associated with unclean hands and transmission of organisms.
2. Medical staff engagement - trained observers will continue to notate physician names on observation worksheets. This will be shared with Medical Director leaders for peer follow up
3. Provide quarterly facility and unit-level data (report cards).
4. Provide list of interventions and assistance with implementing to unit leaders.
5. Provide transparency to data collection methods and expectations.
6. Continue to provide hand hygiene education to employees upon hire, annually, and regularly with units or disciplines.
7. Incorporate hand hygiene return demonstration during Annual Competency Evaluation.
8. Work with employee health to accommodate non-alcohol formula for reported sensitivities.
9. Explore logistics and compatibility with Human Resources recognition program.
10. Improve product accessibility with pilot unit, infection control, unit leader, facilities, and EVS.
Home Health Hand Hygiene Compliance

**Goal:** Facility maintain above 90% compliance, measured through Sentact Survey

**Summary Analysis:** During 2021, Infection Control focused on COVID-19 training including hand hygiene, equipment cleaning, and donning doffing PPE. Infection Control Home Health audits were performed by an onsite observer with 123 surveys completed and a total of 92% compliance.

**Goal Met/Unmet:**

Met

**Action Plan:**

1. Continue observed hand hygiene compliance monitoring using Sentact Survey by designating an onsite observer during 2022.
Central Line-Associated Bloodstream Infection (CLABSI)

CLABSI Standardized Infection Ratio (SIR)

Goal: Facility does not exceed established threshold 1.0, analyzed by NHSN.

Summary Analysis:

1. Among 13 CLABSI events (10 at Escondido, 3 at Poway) there were 5 PICC lines in place with a mean dwell time of 9 days.
2. Escondido decreased CLABSI by 18% during 2021, compared with 2020 data, but is slightly above threshold.
3. Nine or 69% of patients had COVID-19 infection.
4. In five of thirteen cases, lines were inserted in the TICU, three in Poway ICU. All others were inserted in either 5W, 6W, ED, PMCED and 4NW.
5. Of thirteen patients with CLABSI, 3 had internal jugular and 3 had femoral lines in place, including two of the Poway patients. CDC recommendations include “Use a subclavian site, rather than a jugular or a femoral site, in adult patients to minimize infection risk for nontunneled CVC placement [50–52]. Category IB”.
6. CHG bathing is a nursing standard of care at Palomar Health for patients who have central venous catheters. However, data reveals that this is not implemented daily as recommended, with evidence of 63% compliance.
7. Poway had an uptick of CLABSI by 96% during 2021. Total CLABSI events were 3 for the facility, with all occurring in the ICU. Two cases were in COVID positive patients culturing \textit{C. albicans} and \textit{C. glabrata} both of these were internal jugular lines. One was associated with a PICC line.
8. Eight patients had dialysis catheters in place.
9. Eight lines were inserted by physicians and five by RN Vascular Access Team members.
10. Physician documentation of necessity of the central venous catheter is a California mandate with 68.14% compliance among these cases.
11. Dressing changes are not consistently changed per protocol, with 6 of 13 (46%) patients not meeting 7-day dressing change requirements.
12. Dwell time among this group of patients was 0-7 days (38%) and >7 days (62%) implicating insertion practices, site choice, and maintenance as causative risk factors.

Goal Met/Unmet:

PMC Escondido – Goal Unmet
PMC Poway – Goal Unmet

Action Plan:

1. Reinforce hand hygiene before patient contact.
2. Perform CLABSI bundle prevalence study and report results to stakeholders.
3. Explore implementation of an institutional standard for inserting at the subclavian site over femoral or internal jugular.
4. Reinforce CLIP form documentation of all elements for patients who have a central line.
5. Review emergently inserted femoral lines for change recommendations per nationally recognized standards.
6. Continue case reviews with unit leaders and evaluate process measure compliance.
7. Provide device utilization data and outcomes measures to unit Medical Directors, involving hospitalist and intensivists in device reduction strategies during Quality monthly meetings.

Figure 3
1. Increase daily CHG bathing compliance for patients with central venous catheters in place through audits and reporting to unit based leadership.
2. Review feasibility of a standardized process for central line dressing changes throughout system.
3. Use midlines when appropriate.
4. Expand decolonization to include nasal application in the intensive care units.
5. Documentation of Central Line Insertion Practices (CLIP) elements established within the EMR during 2021. Audit utilization of this new electronic form by physicians and provide data to committees as appropriate.
CLABSI Process Measures – Central Line Insertion Practices (CLIP)

Figure 1. System CLIP adherence, measuring full sterile barrier precautions, hand hygiene, and appropriate skin prep. In 2021 a new measure was added to the CLIP process including ultrasound guided insertion and sterile probe cover.

Summary:

CLIP compliance included hand hygiene and optimal barrier precautions prior to 2021. During 2021, ultrasound guidance with sterile process element recommendations were implemented. The new data shows 14% overall compliance with the new element which includes documentation when it was implemented mid-2021. The CLIP form was made part of the electronic medical record and includes the new ultrasound intervention.

Palomar Health Central Line Indication Documentation Percent Compliance 2021

Figure 2. Adherence to evaluation of necessity for central venous catheters is measured by physician response to a prompt in Cerner to evaluate the current need for a central venous catheter. Physician compliance with this process has increased indicating the necessity of the catheter has been assessed and confirmed necessity on a daily basis. However, physicians are not consistently adhering to documentation of insertion and subsequent indication requirements.
Device utilization as shown in a Standardized Utilization Ratio (SUR) is above threshold at PMC Escondido. During 2021, the Escondido campus increased utilization by 89%. PMC Poway campus has decreased utilization by 17%. The objective of the physician documenting the necessity of the central line is to remove unnecessary lines as soon as possible.
Catheter-Associated Urinary Tract Infections (CAUTI)

CAUTI Standardized Infection Ratio

Goal: Reduce facility CAUTI SIR from previous year, analyzed by NHSN.

Summary Analysis:

1. There is an increased number of cases, 29 (Escondido 25, Poway 4), compared to the previous year with 25, system-wide.
2. PMC Escondido evidenced a 17% increase compared with 2020, and PMC Poway evidenced an increase above the 1.0 SIR which equals 4 cases.
3. Dwell time of catheters is 0-7 days (34%) and >7 days (66%) indicating insertion and maintenance risks.
4. During 2020, most cases evidenced gut flora which is the same during 2021 with *E. coli* and *E. faecalis* as leading causative organisms.
5. Average utilization of pericare products was performed and demonstrated an increase in utilization by 153%, as compared to 2020 data.
6. All of the twenty-nine patients were tested for COVID-19 and 14 were positive.
7. Most cases occurred on 5W (28%) followed by 4SW (24%), 4NW (10%), 6WCCU (10%), Poway ICU (10%) 6W IMC (7%), MST4 (3%), 4E (3%), 6E (3%).
8. Of cases occurring in non-critical care units the indication for the catheter was “output monitoring, critically ill patient” occurred on 3 patient’s records. This indication is not appropriate in these locations.

Goal Met/Unmet:

PMC Escondido – Goal Unmet

PMC Poway – Goal Unmet

Action Plan:

1. Reinforce hand hygiene before patient contact and aseptic technique.
2. Perform CAUTI bundle prevalence study and report results to stakeholders.
3. Explore acquisition of the Infection Control Foley Catheter kit. This kit has specific insertion instructions which guide the inserter to sustain aseptic technique.
4. Promote the use for external catheter.
5. Hospitalist engagement in CAUTI reduction and bundle elements during monthly Quality meeting.
6. CAUTI bundle rounds with a focus on missed opportunities and notification to unit Leaders.
7. Collaborate with nursing to aggressively use Foley catheter removal protocol with assistance of the CNS group.
9. Daily Quality huddle to ensure accountability for necessary catheters.

**CAUTI Process Measures - CAUTI Bundle Monitoring**

**Figure 4.** CAUTI Bundle compliance is a measure of 6 maintenance intervention elements: tamper seal intact (ensures closed system), securement device, unobstructed urine flow, drainage tubing/bag off floor, drainage tubing/bag below bladder, indication for catheter documented if not discontinued.

**Indwelling Urinary Catheter Standardized Utilization Ratio (SUR)**

**Figure 5.** Indwelling urinary catheter use is measured by NHSN as the number of observed catheter days / the number of predicted catheter days.
The facility SUR is 1.174 at Poway with an 8% decrease in utilization and 1.131 at Escondido with an 11% increase in utilization. Both campuses are above threshold.
Ventilator-Associated Pneumonia (VAP)

Infection Related Ventilator-Associated Complications Plus (IVAC Plus) SIR

**Goal:** Facility ICUs to reduce IVAC Plus SIR from previous year.

**Summary Analysis:**

1. Reinforce hand hygiene before patient contact and aseptic technique.
2. The total cases of IVAC plus for PMC Escondido and PMC Poway is 29. 5W had (14), 4SW (9) and Poway (6).
3. IVAC Plus data includes IVAC (infection-related ventilator complication) and PVAP (probable ventilator associated pneumonia), and the SIR is the number of observed / number of predicted IVAC and PVAPs in intensive care units.
4. PMC Escondido decreased IVAC SIR by 5% PMC Poway decreased IVAC SIR by 5%.
5. Measures taken during 2021 to decrease ventilator-associated events included a collaborative approach by the ICU medical staff the Respiratory therapy team, nursing, and Infection Prevention participation for monitoring the ventilator bundle. (Figure 3).
6. All measures of VAP bundle have improved throughout the year at both campuses with the exception of Daily Spontaneous Breathing Trial Initiated. A workgroup formed to standardize process and documentation of daily awakening, sedation vacation, and readiness to extubate.
7. Twenty-eight of 29 patients/cases were tested for COVID-19 and 12 were positive.

**Goal Met/Unmet:**

PMC Escondido (5W & 4SW) – Goal met

PMC Poway (ICU) – Goal met

**Action Plan:**

1. Reinforce hand hygiene before patient contact and aseptic technique.
2. Collaboration with Intensivists, Respiratory and Unit leaders on each case for an in depth review. Report findings to various committees.
3. Interdisciplinary device rounds and planning strategy to prevent VAE with Respiratory
4. Continue to engage Intensivists in reducing Standardized Utilization Ratio (Figure 4), and assessing device necessity during multidisciplinary rounds.
5. Continue to report all IVAC Plus and Standardized Infection Ratio outcomes to various committees indicating areas of opportunity.
6. Workgroup to focus on a standardized process for documentation for daily awakening, sedation vacation, and assessing readiness to extubate.

VAP Process Measures – Ventilator Bundle Monitoring

![Ventilator Bundle Compliance, Escondido 4SW & 5W](chart)

**Figure 2.**

![Ventilator Bundle Compliance, Poway ICU](chart)

**Figure 3. Mechanical Ventilator Standardized Utilization Ratio (SUR)**
Figure 4. Mechanical ventilator use is measured by NHSN as the number of observed vent days / the number of predicted vent days.
**Multi-Drug Resistant Organism (MDRO) Lab-Identified Event**

*Clostridioides difficile* Infection (CDI) Standardized Infection Ratio

**Goal:** Reduce facility hospital-onset (HO) CDI SIR below benchmark of 1.0.

### Summary Analysis:

SIR data for both PMC Escondido and PMC Poway have remained under the 1.0 SIR. During 2021, PMC Escondido reduced CDI SIR by 5% compared to previous year, and PMC Poway decreased by 35%. Hospital Onset (HO) cases are reviewed with the leadership and Infection Preventionists.

**Goal Met/Unmet:**

- PMC Escondido – Goal Met
- PMC Poway – Goal Met

**Action Plan:**

1. Continue to notify unit leaders of HO-cases for full review.
2. Collaborative with antibiotic stewardship subcommittee on usage and report out to appropriate committees.
**MRSA Bloodstream Infection (BSI)**

**Goal:** (1) Reduce facility MRSA BSI SIR from previous year and (2) below threshold 1.0.

![MRSA BSI SIR by Facility](chart)

*SIRs cannot be calculated when the predicated value is < than 1.0

**Summary Analysis:**

1. MRSA bacteremia SIR is a surrogate marker for the risk of transmission.
2. PMC Escondido showed a 107% increase from previous year of Hospital Onset (HO) MRSA bacteremia, and is above threshold. This reflects 6 cases.
3. PMC Poway had one MRSA BSI event during 2021 for a SIR not calculated. The predicted number of infections equaling 0.822.
4. Patient review reveals risk factors that accompanied them to the facility. These included: 1) substance abuse 2) homelessness 3) discitis with MRSA.
5. In-hospital risks include: 1) intubation/pneumonia 2) peripheral IV phlebitis.

**Goal Met:**

PMC Escondido – Goal Unmet

PMC Poway – Goal Unmet

**Action Plan:**

1. Reinforce Standard Precautions with Hand Hygiene adherence before and after patient contact.
2. Unit based review of all HO cases with feedback from Pharmacy.
3. Round and follow up with unit isolation precaution compliance (Figure 5).
4. Continue with hand hygiene program (Hand Hygiene Table of Contents).
5. Review needs and protocol for universal decolonization in ICUs (nasal and full body).
6. Use Contact Precautions for patients with MRSA in nares who are admitted with or discovered to be infected.
7. Continue surveillance testing for MRSA colonization per Senate Bill 1058 of high risk patients on admission and inpatient dialysis at discharge. Compliance for MRSA testing of high risk group at discharge is at or above 90% at PMC Escondido and Poway (Figure 11).
**MDRO Process Measures – Isolation Precautions Compliance**

**Figure 5.** Processes that reduce the risk of transmission for MDRO’s include; Isolation initiation, patient education, use of the correct signs, ensuring gloves and gowns are available and wearing them when it is indicated.

**Figure 6.** The figure presented above demonstrates compliance with California mandate for testing a high risk population.

**Summary Analysis:** The data demonstrates a slight decrease in compliance comparing 2020 to 2021. It was noted that when an order is written to discharge the patient and the patient was not discharged, the task for this measure doesn’t populate for the nurse to implement.

**Action Plan:** Work with IT for a process for the task to populate again for the nurse to implement.
**Surgical Site Infections (SSI)**

**Goal:** (1) Reduce facility overall SSI SIR from previous year and (2) below SIR threshold of 1.0

**Summary Analysis:** Targeted surgical site infection surveillance is performed routinely, with 25 surgical procedures that are mandatory to report. The overall SSI SIR represents the 25 reported procedure events.

1. There were 32 SSI cases overall during 2021.
2. PMC Escondido overall SSI SIR increased 11% from previous year.
   The following procedures SSI SIR is above threshold: 1) Open Reduction Internal Fixation (ORIF) SIR 1.363 2) Gastric Surgery (GAST) SIR not calculated with 1 infection, 3) Hip Replacement surgery (HPRO) with a SIR of 1.411 4) Hysterectomy SIR not calculated with 1 infection, Small Bowel (SB) with SIR 1.204.
3. PMC Poway SIR increased SIR by 3% from previous year. The following procedures SSI SIR is above threshold: 1) ORIF SIR not calculated with 4 infections, Cholecystectomy (CHOL) SIR not calculated with 1 infection, Knee Replacement surgery (KPRO) SIR not calculated with 1 infection.
4. Skin Antisepsis CHG bathing for targeted patients in this population is compliant at 60%.
5. Nasal Decolonization for a targeted patient population with 11% compliance.
6. In two patients, Betadine skin preparation was used. It is recommended, and a facility standard that an alcohol based preparation be used. Perform intraoperative skin preparation with an alcohol-based antiseptic agent unless contraindicated. (Category IA–strong recommendation; high-quality evidence.)

7. Seventeen patients the surgeon used topical antibiotic ointments and this is not recommended. Do not apply antimicrobial agents (ie, ointments, solutions, or powders) to the surgical incision for the prevention of SSI. (Category IB–strong recommendation; low-quality evidence.)

8. A high BMI is known to be a risk factor 54% of the observed population.

9. 64% of patients in this population had surgery related to trauma.

10. 36% of patients in this group had Diabetes.

11. Antibiotic irrigation is being done 11% of the patients in this group. Randomized controlled trial evidence suggested uncertain trade-offs between the benefits and harms regarding intraoperative antimicrobial irrigation (e.g., intra-abdominal, deep, or subcutaneous tissues) for the prevention of SSI. (No recommendation/unresolved issue.)

**Action Plan:**

1. Improve compliance on decolonization with nasal betadine and CHG for orthopedic cases.
2. Explore expansion to patients undergoing Open Reduction Internal Fixation (ORIF) procedures.
4. Transition away from using Betadine solution for skin preparation unless there is a documented allergy.
5. Enhance pre-op interventions for Orthopedic surgery to include emergent ORIF surgery.
6. Reiterate with perioperative services, appropriate wound classification and documentation of infection when present at the time of surgery.
7. Continue to notify surgeons and OR leaders of SSI events.

**Goal Met:**

PMC Escondido – Goal Met

PMC Poway – Goal Met
Colon Surgery

Summary Analysis: With multiple interventions, PMC Escondido decreased COLO SSI SIR by 16% compared to previous year, from 8 to 2 SSI events. PMC Poway reduced SSI events from one to zero.

Abdominal Hysterectomy (HYST)

Summary Analysis: There was one HYST SSI event during 2021 occurring at PMCE the Escondido campus. A SIR was not calculated as the predicted number was 0.678. Goal not met.
Summary Analysis:

During 2021, SSI at PMC Escondido increased by 36% including 9 - Open Reduction Internal Fixation SSI, 1 - Knee Replacement SSI, 3 - fusion SSI and 3 - Hip Replacement SSI. At PMC Poway Orthopedic SSI increased by 87% including 4 - Open Reduction and Internal Fixation SSI and 1 - Knee Replacement SSI.

Compliance with CHG bathing is reported by patients as high. Poway has agreed to model that all elective orthopedic procedures receive a CHG waterless bath regardless of patient responses to home CHG bathing.
**Environment of Care (EOC)**

**EOC Rounds**

**Goal:** Maintain facility ≥90% compliance

<table>
<thead>
<tr>
<th></th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC Escondido</td>
<td>87.26%</td>
<td>98.30%</td>
</tr>
<tr>
<td>PMC Poway</td>
<td>94.97%</td>
<td>95.40%</td>
</tr>
<tr>
<td>Villas at Poway</td>
<td>87.25%</td>
<td>93.90%</td>
</tr>
</tbody>
</table>

**Summary Analysis:** Using the infection control EOC rounds within Sentact, compliance with standard and transmission-based precautions, facilities related infection risks, cleanliness, waste disposal, and appropriate storage and processing of patient care equipment and devices was measured. Also observed is the proper decontamination, handling, transport, and storage of sterilized devices. Trends included visibly dusty environment, cleaning of glucometers, left open disinfectant wipes, and clean supply storage bins, microwaves and refrigerator.

**Goal Met/Unmet:**

- PMC Escondido – Goal Met
- PMC Poway – Goal Met
- Villas at Poway – Goal Met

**Action Plan:**

1. EVS focus on dust in the environment.
2. Delineate responsibility of environmental cleaning by discipline.
3. EOC team rounding monthly in scheduled areas.
4. Report findings to Department Directors according to urgency of finding.
5. Infection Control to report trends and data to EOC and Infection Control committee.
6. Leadership to develop action plan to address repeated or high-risk findings.
Environmental Sanitation Measures

Florescent Marker Validation of Environmental Cleaning

**Goal:** Facility to maintain compliance ≥95%

**Summary Analysis:** This measure is implemented in accordance California Public Health Department Senate Bill requirement. During 2021, florescent marker tool was used and represented by the data above. The results are used in real time education and training.

**Goal Met/Unmet:**

PMC Escondido – Goal Met

PMC Poway – Goal Met

**Action Plan:**

1. Continue to monitor observations and use as a practice enhancement tool.
2. Routine reporting through Infection Control Committee by EVS Leadership.
3. Explore use of florescent markers in outpatient settings.
Environmental Testing

**Goal:** Periodic environmental testing with certification where applicable. Action planning and resolution expected when tests are out of range.

**Summary:** Environmental testing is performed in compliance with Infection Control Risk Assessment. Results outside normal parameters are reported directly to the Infection Prevention and Control Committee with a plan of correction.

**Action Plan:**

1. Continue environmental testing via 3rd party vendors for identification and control of environmental risks and hazards
2. If results exceed threshold, services may be interrupted while investigations and action plans are created and implemented.
Construction

**Goal:** System provides consultation, perform Infection Control Risk Assessment (ICRA) for construction and renovation projects, and provide education to facility and construction personnel

**Summary Analysis:** Palomar Health has an infection control procedure in place for assessing the risk of construction/renovation jobs to determine the appropriate barriers for mitigating dust dispersion. There were no outbreaks associated with construction. Of note, some patients at Palomar Health with COVID-19 pneumonia tended to be colonized, and some were treated for aspergillosis. This has been reported in the literature among patients with COVID-19 infection.

**Goal Met:**

Palomar Health – Goal Met

**Action Plan:**

1. Continue to monitor all construction activities and issue an Infection Control Risk Assessment prior to start of any project.
2. Continue to provide dust-mitigation education to facility, construction, and contracted personnel annually and before any hospital construction and renovation activity.
**Infection Control Education**

**Goal:** Provide Infection Prevention education to Palomar Health staff on areas of focus

**Summary Analysis:** During 2021, IP staff provided information to staff regarding COVID-19 precautions and changes in practice or workflow. These included; routine, just in time education, and scheduled in services (e.g. de-escalation protocol, visitation policy, PPE use, discontinuing isolation, testing, vaccine mandates, etc.). Monthly in person education is provided for Nursing Services and New Leader orientation. Routine educational programs were maintained.

<table>
<thead>
<tr>
<th>Month</th>
<th>Education Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>New Staff Orientation (NSO), Orthopedic SSI prevention</td>
</tr>
<tr>
<td>Feb</td>
<td>NSO</td>
</tr>
<tr>
<td>Mar</td>
<td>NSO, FANS annual, Orthopedic SSI prevention</td>
</tr>
<tr>
<td>Apr</td>
<td>NSO, EVS annual, CLABSI and Decolonization</td>
</tr>
<tr>
<td>May</td>
<td>UPC meetings: Decolonization, Orthopedic SSI prevention</td>
</tr>
<tr>
<td>June</td>
<td>NSO, Hand hygiene</td>
</tr>
<tr>
<td>July</td>
<td>NSO, Monkey pox and masking, Orthopedic SSI prevention, PMCP ED COVID-19, importance of strict mask adherence with staff, patients and visitors, importance of isolation signage, visitor masking on in patient units, PMCE ED masking and social distancing, ICU masking at all times and observing social distancing.</td>
</tr>
<tr>
<td>Aug</td>
<td>NSO, hand hygiene, IC documentation, contact time of wipes</td>
</tr>
<tr>
<td>Sept</td>
<td>NSO, Orthopedic SSI prevention, Poway COVID-19/PPE HH, IC documentation</td>
</tr>
<tr>
<td>Oct</td>
<td>NSO</td>
</tr>
<tr>
<td>Nov</td>
<td>NSO, Orthopedic SSI prevention</td>
</tr>
<tr>
<td>Dec</td>
<td>NSO, PMCE ED, registration, Patient access team, Social Services, scribes, Radiology, Lab - mask expectation, and eye protection when patients are unable to mask</td>
</tr>
</tbody>
</table>

**Interventions:** Infection Control provided education routinely, upon request and during real time opportunities. Construction and renovation is ongoing and in virtual format. *Candida auris* screening education was provided as just-in-time teaching.

**Goal:**

PMC Escondido - Goal Met

PMC Poway – Goal Met

**Action Plan:**

1. Update the ready reference site on intranet for Infection Control topics
2. Provide real time education when indicated during Infection Prevention unit/department rounds
3. Provide hand hygiene education addressing non-compliance.
Reportable Diseases & Emerging Infections

Maintain compliance with Title 17, California Code of Regulations, CDPH Confidential Morbidity Reporting (CMR) Requirements. When emerging infectious diseases are occurring in the community or community at large, infection control and hospital ensure staff and the facilities are prepared for the detection and management of these cases. Infection Control attends a virtual monthly meeting with County Epidemiology on current public health issues, and receives weekly and monthly reports on influenza and communicable diseases in San Diego County, respectively. During 2021, there was a significant number of COVID-19 patients reported (6,021). Reporting responsibility was taken by staff in Health Information temporarily, then returned to IP’s when staffing was impacted. Infection Control may use the information and data to identify unusual clusters in the patient population. Infection Preventionist’s routinely work with San Diego County Epidemiology staff, responding to requests and initiating reports.
## Employee Health

### Influenza Vaccination Compliance

**Goal:** System and facility above 90% compliance with immunization program by end of 2020-2021 influenza season.

<table>
<thead>
<tr>
<th>SYSTEM</th>
<th>Employees</th>
<th>Med Staff</th>
<th>Volunteer &amp; Students</th>
<th>Contractors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Personnel</strong></td>
<td>3541</td>
<td>410</td>
<td>506</td>
<td>312</td>
<td>4759</td>
</tr>
<tr>
<td><strong>Received Vaccination</strong></td>
<td>1705</td>
<td>154</td>
<td>204</td>
<td>163</td>
<td>2226</td>
</tr>
<tr>
<td><strong>Received Elsewhere</strong></td>
<td>284</td>
<td>28</td>
<td>126</td>
<td>59</td>
<td>497</td>
</tr>
<tr>
<td><strong>Medical Contraindication</strong></td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Declined</strong></td>
<td>605</td>
<td>2</td>
<td>67</td>
<td>33</td>
<td>707</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>947</td>
<td>226</td>
<td>108</td>
<td>57</td>
<td>1338</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>56%</td>
<td></td>
<td>57%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health</th>
<th>Employees</th>
<th>Med Staff</th>
<th>Volunteer &amp; Students</th>
<th>Contractors</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Personnel</strong></td>
<td>144</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>145</td>
</tr>
<tr>
<td><strong>Received Vaccination</strong></td>
<td>76</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>77</td>
</tr>
<tr>
<td><strong>Received Elsewhere</strong></td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td><strong>Medical Contraindication</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Declined</strong></td>
<td>24</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>24</td>
</tr>
<tr>
<td><strong>Unknown</strong></td>
<td>32</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td>61%</td>
<td></td>
<td>61%</td>
</tr>
</tbody>
</table>
**Summary Analysis:** Overall compliance for Palomar Health (excluding Home Health) is 57%. Escondido compliance was 55%, Poway at 58%, the Villas at Poway had a compliance rate of 79% and Home Health was at 61%. Staff awareness and participation in the program is encouraged. Mandated masking breaks the chain of transmission for those who may be unknowingly contagious. Factors influencing compliance with influenza vaccination include COVID-19 immunization, low circulating influenza and mandatory masking for all.

Palomar Health – Goal Unmet

PMC Escondido – Goal Unmet

PMC Poway – Goal Unmet

Villa Pomerado and Subacute - Goal unmet

Home Health – Goal Unmet

**Action Plan:**

1. Focus on Influenza vaccination education during Infection Control Week 2021
2. Include education on common reasons for influenza vaccination declination
COVID-19 Vaccine Compliance through March 23, 2022

**Analysis:** Palomar Health currently has 92% of employees are vaccinated for COVID. 39% of staff with booster vaccinations on file. We have 8% of staff with approved vaccine exemptions on file, and 1% of staff whom have been waived from this requirement due to exclusively working remotely and will never have contact with employees in person or be on-site for work purposes.

**Action Plan:** Palomar Health continues to offer vaccination clinics on-site at PMC Escondido with online registration and scheduling, but have had significant reduction in employee's signing up in the last two weeks. We continue to offer vaccination in our Escondido Employee Health clinic on Wednesday and Friday's. We are working with Human Resources to assist non-boosted employees to complete vaccination or exemption criteria prior to 3.1.2022.

<table>
<thead>
<tr>
<th>Boosted</th>
<th>Fully Vaccinated</th>
<th>Approved Exemption</th>
<th>Waived</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2899</td>
<td>520</td>
<td>367</td>
<td>244</td>
<td>4030</td>
</tr>
<tr>
<td>72%</td>
<td>13%</td>
<td>9%</td>
<td>6%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Employee COVID Vaccination Analysis

- **Boosted, 72%**
- **Fully Vaccinated, 13%**
- **Approved Exemption, 9%**
- **Waived, 6%**
Palomar Health Staff Exposures

**Goal:** Continue to assess and mitigate exposure risk

**Summary Analysis:** During 2021, there were 2081 exposures. The majority of which are unprotected exposures to COVID contacts prior to initiation of isolation precautions. Exposures are based on the use of PPE during contact and isolation precautions initiated. Measures were put into place to identify, isolate and inform. There were no TB conversions identified.

**Goal Met:**

Palomar Health – Goal Met

First Responder/Pre-Hospital Exposures

**Goal:** Comply with Ryan White Law and Senate Bill 432 exposure to blood borne pathogens and Cal OSHA Aerosol Transmissible Disease Regulations

**Analysis:** There were 650 pre-hospital exposures for the Palomar Health system, all associated with patients confirmed with COVID-19, and a significant increase from the previous year. All exposures were handled in accordance with established processes. Notification given to the appropriate Infection Control Medic contact for all potential exposures, County notification sent for confirmed exposures

**Goal Met:**

Palomar Health – Goal Met
COVID-19

During 2021, there were 6,021 COVID-19 cases reported with 249 deaths.

Summary of Infection Control Interventions

- “Identify, isolate, inform” at ED triage using electronic charting triggers for isolation orders.
- Separating patients with infectious signs and symptoms.
- Implemented order and charting-based triggers for isolation orders through system.
- Provided staff education and reinforcement for PPE use, limited reuse, and extended use.
- PPE supplies were routinely monitored by supply chain, and strategies to optimize and conserve were implemented throughout the pandemic.
- During rounding, Infection Preventionist’s replenished PPE and answered staff questions especially during the surges.
- Hand hygiene is routinely monitored through trained observation
- Exposure and transmission mitigation through universal [source control measure] masking of patients and staff, and staff eye protection recommendation, if patients cannot tolerate face covering while provided care.
- Visitation restrictions and vaccination/testing mandates implemented.
- Physical distancing, minimized in-person meetings and hospital gatherings, breakroom capacity assessments and notice.
- Maintained ‘airborne & contact’ isolation status and patient placement (in AIIR) for COVID-19, but used de-escalation protocol for downgrading to enhanced droplet precautions (private room with standard ACH) reviewing patient clinical presentation and anticipation of aerosol-generating procedures.
- Using guidance adapted from CDC, developed protocol to safely discontinue isolation precautions and updated.
- Exposure process honed to respond to patient and staff exposures from any sources in and out of facility including contact tracing, outbreak investigation and reporting.
- Executive memos to communicate policy or practice changes surrounding COVID-19
- Maintained communication with California Department of Public Health and County Epidemiology.
- Employee vaccination made available and process for booster requirements underway.
Summary of Projects

Antibiotic Stewardship

- Reviewed appropriate usage of anti-*pseudomonal* beta-lactam agents
- Developed PowerPlan for gonococcal infections in the emergency room
- Updated and revised policies and procedures
  - Monoclonal antibodies administration at Palomar Health
  - Clinical Pharmacy Services – procalcitonin and MRSA PCR
  - Desensitization and Graded Challenge
  - Intrathecal Antibiotics
  - Aminoglycoside Dosing Service
  - Restricted Antibiotics
  - Standardized Antibiotic Dosing
- Reviewed influenza vaccine and therapy
- Attended regular antimicrobial stewardship meetings at nursing home at Villas at Poway
- Presented comprehensive review of COVID-19 therapeutics and outcomes data
- Reviewed pharmacist and physician ordering of MRSA PCR to effectively de-escalate anti-MRSA antibiotics in pneumonias
- Developed workflow for inpatient COVID-19 vaccination
- Met regularly with new QIP (quality initiative pool) group and reported out on quality measures of antibiotic stewardship every meeting
  - C. difficile infection reduction
  - Surgical site infection reduction
- Developed screening workflow and criteria for inpatient pneumococcal vaccines
- Presented pharmacy residency projects related to antimicrobial stewardship
  - Daptomycin as first-line therapy for confirmed MRSA bacteremia
  - IV to PO step-down in *Enterobacterales* Bacteremia Secondary to Pyelonephritis
- Presented data on removing penicillin allergy alerts when cephalosporins are ordered
- Met regularly with new QIP (quality initiative pool) group and reported out on quality measures of antibiotic stewardship every meeting
  - C. difficile infection reduction
  - Surgical site infection reduction
- Developed screening workflow and criteria for inpatient pneumococcal vaccines
- Presented data on removing penicillin allergy alerts when cephalosporins are ordered
- Created guidance on alterative for anaerobic coverage during critical IV metronidazole shortage
- Updated ASP committee and COVID-19 taskforce on Omicron variant and impact on current and new therapeutics
- Updated Antibiogram for 2021 and sent best practice recommendations to all members of medical staff
- Tracked pharmacist antimicrobial stewardship interventions
Product Review

Members of the Infection Prevention and Control team participate in the Value Improvement Process at Palomar Health. Several interventions for improving infection outcomes and risk mitigation were approved by the VIP during 2021. The team also collaborates with departments for products that are reprocessed by validating that there is an infrastructure in place to properly clean and disinfect or sterilize items purchased.

Procedure Review

Infection Preventionist’s worked to review, update and maintain all Infection Control Procedures. Infection Control reviewed relevant procedures and collaborated with other departments who have procedures that relate to infection control.
References


15. https://jamanetwork.com/journals/jamasurgery/fullarticle/2623725
Antimicrobial Stewardship Report

Reported to Board Quality Review Committee

Sandeep Soni, MD, Chair
John Engelbert, PharmD, BCIDP, Co-Chair
Travis Lau, PharmD, ASP Pharmacist
Kevin Tran, PharmD, PGY2 ID Resident
June 16, 2022
Antimicrobial Committee Summary

• ASP Goals for 2021 and 2022
• Antibiotic Usage 2021
• Palomar Health COVID-19 Treatment Algorithm

ASP – Antimicrobial Stewardship Program; COVID – Coronavirus Disease
Palomar Health’s Infectious Diseases Team

- Mission Infectious Diseases
  - Sandeep Soni, MD
  - Roger Bitar, MD, MPH
  - Hayden Burke, MD
  - Catherine Konyn, NP
- Kaiser Infectious Diseases
  - Townson Tsai, MD
- Pharmacy
  - Kevin Tran (left)
  - John Engelbert (middle)
  - Travis Lau (right)
Gold Designation for ASP

Dear Antimicrobial Stewardship Leaders at Palomar Medical Center Escondido,

We have finally completed reviewing all applications for the California Department of Public Health (CDPH) Healthcare-Associated Infections (HAI) Antimicrobial Stewardship Honor Roll. We want to thank you for all your efforts in the work that you do into your program, for engaging staff and keeping everyone accountable for antimicrobial stewardship. We recognize this is not an easy task; it takes hard work and dedication.

We know how much time and effort you put into completing the application itself for the Honor Roll, so we want to thank you for your patience during the review process. The review entailed three phases. The first phase entailed reviewing each application for missing documentation and evaluating each program’s core elements. The second phase consisted of reviewing the outcomes portion of the application for those applying for Silver or Gold status, and the community engagement portion for those applying for Gold. For the review of the outcomes portion, we engaged external blinded reviewers along with CDPH internal reviewers. The external reviewers consisted of antimicrobial stewardship experts representing different facility types: community, academia, major teaching, and community with special populations. They reviewed each outcomes section similarly to how one would review a scientific abstract looking for effective interventions and programs. For the third phase of the review process, each applicant’s program was reviewed and rereviewed in its entirety, evaluating each program’s quality and impact beyond marking elements on a checklist.

We are excited to inform you that your program is now a member of the California Department of Public Health Antimicrobial Stewardship Honor Roll. You have been designated with GOLD status. The designation period is for two years and will expire November 30, 2022. Thank you for developing a strong program that can serve as a model for others and for engaging the community.

Attached in this email is your Official Designation image. You can copy and paste the image or use the HTML coding to embed into your website.

Sincerely,

Jane Kriengkauykijit, PharmD, DrPH, BCPS
Infectious Disease Pharmacist
Healthcare-Associated Infections Program
California Department of Public Health

Erin Epson, MD
Medical Director, Chief
Healthcare-Associated Infections Program
California Department of Public Health
## ASP Goals

<table>
<thead>
<tr>
<th>2021 (Completed)</th>
<th>2022 (To be completed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRIME Goals met for all four ID-related items</td>
<td>Review best practice for treatment of MDRO per IDSA guidelines</td>
</tr>
<tr>
<td>Reviewed recommended durations for common disease states posted on annual antibiogram</td>
<td>Develop institution specific guidelines for common infections and publish on intranet</td>
</tr>
<tr>
<td>Tracking COVID-19 therapeutics, co-infection, and influenza data</td>
<td>Staphylococcus aureus bacteremia care bundle/recommendations to guide medical staff</td>
</tr>
<tr>
<td>Review appropriate antimicrobial therapy on CRE</td>
<td>Review current antibiotic PowerPlans in Cerner</td>
</tr>
<tr>
<td>Review appropriate use of high-cost antimicrobials</td>
<td>Education and tracking of prescribing antibiotics for bacteriuria</td>
</tr>
<tr>
<td>Designation of Gold status for antimicrobial stewardship by California Department of Public Health</td>
<td>Utilizing MRSA nasal screen beyond just in pneumonia</td>
</tr>
<tr>
<td></td>
<td>Analysis of use of procalcitonin and improve utilization</td>
</tr>
<tr>
<td></td>
<td>Improve IV to PO change opportunities</td>
</tr>
</tbody>
</table>

PRIME – Public Hospital Redesign and Incentives in Medi-Cal; ID – Infectious Diseases; CRE – Carbapenem Resistant Enterobacterales; MDRO – multi-drug resistant organisms; IDSA – Infectious Diseases Society of America; IV – intravenous; PO - oral
Historical C. difficile Infection SIR

CDI – Clostridioides difficile infection; SIR – Standardized Infection Ratios
Antibiotic Usage via SAAR – Comparison With Other Hospitals

What is a SAAR?

- SAAR Definition
  - Standardized risk-adjusted metric of antibiotic use
  - Available to facilities reporting to the AU Option in NHSN
  - Compares observed to predicted days of antimicrobial use

\[
\text{Observed} \div \text{Predicted} = \frac{100 \text{ antimicrobial days observed}}{85 \text{ antimicrobial days predicted}} = 1.176
\]

SAAR – Standardized Antimicrobial Administration Ratio
## COVID-19 Treatment Algorithm

<table>
<thead>
<tr>
<th>Clinical Situation at Time of Initiation of Treatment</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| **SpO2 > 94% on room air**                          | - If reason for admission is not COVID-19 and meets criteria – Sotrovimab® 500 mg IVPB x1  
  o If in ED and stable for discharge  
  - Within 5 days of symptom onset, consider prescription for Paxlovid (nirmatrelvir-ritonavir) 300mg/100mg BID for five days. Must dose adjust for renal function. (see criteria below)  
  - **As of 1/4/22, MARC do not have Sotrovimab. Consider giving in ED** **Onset of symptoms are less than 10 days refer patient to county’s MARC for monoclonals at (619) 685-2500.**  
  - Consider prophylactic anticoagulation unless contraindicated  |
| **Requiring oxygen to maintain SpO2 > 94% and abnormal chest X ray, but not requiring HFNC (≥15L/min) or Non-Invasive Ventilation (NIV)** | - Recommend dexamethasone 6mg IV or PO q24h x 10 days*  
  - Recommend remdesivir. May be more beneficial if symptom onset within 10 days.  
  o 200mg IVPB now, followed by 100mg q24h IVPB x 4 days*  
  o If oxygenation status progresses to HFNC, NIV, or mechanical ventilation, may complete full course of remdesivir.  
  - Recommend prophylactic anticoagulation unless contraindicated*  |
| If require rapidly increasing oxygen supplementation (i.e. on high-flow device even if <15L/min) and/or elevated inflammation (i.e. CRP ≥ 7.5) | - May consider adding baricitinib 4mg PO q24h x14 days if patient meets further criteria**  
  - If unable to receive baricitinib, then tocilizumab if patient meets further criteria*  |
| **Requiring HFNC (≥ 15L/min) or NIV to maintain SpO2 > 94% but not requiring mechanical ventilation** | - Dexamethasone 6mg IV or PO q24h x 10 days*  
  - Baricitinib 4mg PO q24h x14 days if patient meets further criteria**  
  - If unable to receive baricitinib, then tocilizumab if patient meets further criteria*  
  - Recommend prophylactic anticoagulation unless contraindicated*  
  May consider full dose anticoagulation (enoxaparin 1mg/kg SQ q12h or continuous infusion heparin). Intensity of anticoagulation may be guided by thrombosis risk.  |
| **Patient requiring mechanical ventilation or has signs of multi-organ failure** | - Recommend dexamethasone 6mg IV q24h x 10 days*  
  - Baricitinib 4mg PO q24h x14 days if patient meets further criteria**  
  - If unable to receive baricitinib, then tocilizumab if patient meets further criteria*  
  - Recommend prophylactic anticoagulation unless contraindicated*  
  May consider full dose anticoagulation (enoxaparin 1mg/kg SQ q12h or continuous infusion heparin). Intensity of anticoagulation may be guided by thrombosis risk.  |

*If patient is clinically ready for discharge, do not need to keep patient in hospital to complete the full course of remdesivir, dexamethasone, or baricitinib.

*These medications require EUA fact sheet be given to patient prior to starting therapy
*Enoxaparin 40mg SQ q24h* or heparin 5,000 units SQ q8-12h
*See separate Baricitinib criteria
*See separate Tocilizumab criteria
*Enoxaparin requires renal dose adjustment
ADDENDUM F
Laboratory Biannual Presentation
Presented to Board Quality Review Committee

Jerry Kolins, M.D., Medical Director, Laboratory
Gloria Austria, Senior Director, Laboratory, Respiratory, EEG Services
June 16, 2022
<table>
<thead>
<tr>
<th><strong>SITUATION</strong></th>
<th>The ED STAT turn around time for Basic Metabolic Panel (BMP) and Troponin have not met target for the past few months at both Escondido and Poway</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BACKGROUND</strong></td>
<td>The performance measure is test completion within 60 minutes from the time the sample is ordered to test result verification 85% of the time. The outcome has been out of expected target for BMP and Troponin at both Escondido and Poway.</td>
</tr>
</tbody>
</table>
| **ASSESSMENT** | In review of the process, the following were the identified challenges:  
- Longer response time from order to draw as a result of phlebotomy staffing challenges  
- Longer response time from draw to receive at Escondido as a result of staffing challenges  
- Longer response time from receive to testing due to supply chain challenges that started in late February, substitute tubes are not compatible with the automation line resulting in manual processing of specimens thus delaying result turn around time  
- Longer completion time for troponin that started during conversion to high sensitivity troponin in September with manual work around to aliquot samples |
| **RECOMMENDATION** | - Work with Human Resources (HR) for active staff recruitment of benefited, per diem, and temporary positions to meet the need  
- Use Critical Staffing Incentive (CSI) pay during critical staff shortage  
- Review incentive pay options with HR to minimize call offs  
- Partnership with supply chain to pro-actively identify high risk inventory and mitigate risk  
- Work with Information Technology (IT) to resolve the high sensitivity troponin container requirement to use primary tube testing instead of aliquoting and relabeling  
- Partnership with Emergent Medical Associates (EMA) group on the process improvement opportunities |
PDCA: Order to Completion on STAT orders from Emergency Department

**Plan**
- Implementation of CSI pay for phlebotomists in January 2022
- Supply chain and lab review weekly specimen collection inventory started the week of April 11
- Communicate with key stakeholders any identified challenges that affect turn around time - ongoing
- Ongoing IT fix/troubleshooting on primary container solution for troponin and BMP – started October 2021

**Do**
- Work with HR on incentive plan options
- Continue to work with IT to correct sample container requirement for BMP and high sensitivity troponin
- Continue partnership with key stakeholders

**Study**
- Supply chain- ongoing challenges with constraints from many vendors or substitute vacutainers not compatible with the automated processing line
- Staffing challenges – ongoing issues with sick calls, staff turnover, fatigue, and lack of on-call volunteers

**Act**
- Implement a new critical staffing plan for key job positions
- Use primary tube for sampling/testing of BMP and high sensitivity troponin
- Work with key stakeholders like ED physicians, HR, supply chain

**Implementation of CSI pay for phlebotomists in January 2022**
Supply chain and lab review weekly specimen collection inventory started the week of April 11
- Communicate with key stakeholders any identified challenges that affect turn around time - ongoing
- Ongoing IT fix/troubleshooting on primary container solution for troponin and BMP – started October 2021
# Laboratory FY 22 Quality Indicators

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Frequency</th>
<th>Target</th>
<th>Units</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specimen Identification error</td>
<td>Monthly</td>
<td>93.390</td>
<td>%</td>
<td>93.994</td>
<td>93.998</td>
<td>93.991</td>
<td>93.993</td>
<td>93.993</td>
<td>93.990</td>
<td>93.991</td>
<td>93.990</td>
<td>93.990</td>
</tr>
<tr>
<td>Test order accuracy</td>
<td>Monthly</td>
<td>95</td>
<td>%</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>95</td>
<td>95</td>
</tr>
<tr>
<td>Escondido Hematology</td>
<td></td>
<td></td>
<td></td>
<td>35%</td>
<td>34%</td>
<td>94%</td>
<td>94%</td>
<td>93%</td>
<td>93%</td>
<td>90%</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>Escondido Chemistry</td>
<td></td>
<td></td>
<td></td>
<td>82%</td>
<td>81%</td>
<td>80%</td>
<td>82%</td>
<td>83%</td>
<td>81%</td>
<td>77%</td>
<td>80%</td>
<td>75%</td>
</tr>
<tr>
<td>Escondido Coagulation</td>
<td></td>
<td></td>
<td></td>
<td>88%</td>
<td>84%</td>
<td>86%</td>
<td>81%</td>
<td>85%</td>
<td>82%</td>
<td>81%</td>
<td>87%</td>
<td>82%</td>
</tr>
<tr>
<td>Escondido Troponin</td>
<td></td>
<td></td>
<td></td>
<td>83%</td>
<td>76%</td>
<td>76%</td>
<td>68%</td>
<td>74%</td>
<td>74%</td>
<td>73%</td>
<td>73%</td>
<td>67%</td>
</tr>
<tr>
<td>Poway Hematology</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
<td>94%</td>
<td>94%</td>
<td>94%</td>
<td>92%</td>
<td>91%</td>
<td>91%</td>
<td>92%</td>
<td>94%</td>
</tr>
<tr>
<td>Poway Chemistry</td>
<td></td>
<td></td>
<td></td>
<td>86%</td>
<td>86%</td>
<td>85%</td>
<td>85%</td>
<td>85%</td>
<td>82%</td>
<td>80%</td>
<td>83%</td>
<td>83%</td>
</tr>
<tr>
<td>Poway Coagulation</td>
<td></td>
<td></td>
<td></td>
<td>83%</td>
<td>86%</td>
<td>86%</td>
<td>84%</td>
<td>85%</td>
<td>81%</td>
<td>84%</td>
<td>82%</td>
<td>82%</td>
</tr>
<tr>
<td>Poway Troponin</td>
<td></td>
<td></td>
<td></td>
<td>86%</td>
<td>84%</td>
<td>82%</td>
<td>68%</td>
<td>77%</td>
<td>75%</td>
<td>77%</td>
<td>78%</td>
<td>78%</td>
</tr>
<tr>
<td><strong>Blood Culture Contamination</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escondido</td>
<td>Monthly</td>
<td>&lt;2.0</td>
<td>%</td>
<td>2.40%</td>
<td>2.70%</td>
<td>1.40%</td>
<td>1.9</td>
<td>1.90%</td>
<td>1.60%</td>
<td>2.00%</td>
<td>2.40%</td>
<td>1.80%</td>
</tr>
<tr>
<td>Poway</td>
<td>Monthly</td>
<td>&lt;2.0</td>
<td>%</td>
<td>1.20%</td>
<td>1.50%</td>
<td>2.20%</td>
<td>1.7</td>
<td>1.70%</td>
<td>2.00%</td>
<td>1.90%</td>
<td>1.10%</td>
<td>2.00%</td>
</tr>
<tr>
<td><strong>Hand Hygiene</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escondido</td>
<td>Quarterly</td>
<td>75</td>
<td>Qty %</td>
<td>91%</td>
<td>93%</td>
<td>787</td>
<td>77</td>
<td>69%</td>
<td>163</td>
<td>72%</td>
<td>69%</td>
<td>83%</td>
</tr>
<tr>
<td>Poway</td>
<td>Quarterly</td>
<td>75</td>
<td>Qty %</td>
<td>100%</td>
<td>100%</td>
<td>52</td>
<td>99%</td>
<td>99%</td>
<td>83%</td>
<td>72%</td>
<td>69%</td>
<td>83%</td>
</tr>
<tr>
<td><strong>Critical Value Reporting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escondido Hematology</td>
<td>Monthly</td>
<td>4/5</td>
<td>%</td>
<td>4/5</td>
<td>2/5</td>
<td>5/5</td>
<td>4/5</td>
<td>4/5</td>
<td>5/5</td>
<td>5/5</td>
<td>5/5</td>
<td>5/5</td>
</tr>
<tr>
<td>Escondido Chemistry</td>
<td>Monthly</td>
<td>100%</td>
<td>%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Poway Hematology</td>
<td>Monthly</td>
<td>100%</td>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Poway Chemistry</td>
<td>Monthly</td>
<td>100%</td>
<td>%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Microbiology</td>
<td>Monthly</td>
<td>99.9%</td>
<td>%</td>
<td>99.90%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
</tr>
</tbody>
</table>
## FY 22 Process Improvement Focus Data

<table>
<thead>
<tr>
<th>Metrics</th>
<th>Frequency</th>
<th>Target</th>
<th>Units</th>
<th>Monthly Data</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>July</td>
</tr>
<tr>
<td><strong>ED Order to Draw Response Time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escondido</td>
<td>Monthly</td>
<td>17</td>
<td>minutes</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>PM</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Night</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>Poway</td>
<td>Monthly</td>
<td>15</td>
<td>minutes</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>PM</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>Night</td>
<td></td>
<td></td>
<td>19</td>
</tr>
<tr>
<td><strong>ED Draw to Receive Response Time</strong></td>
<td></td>
<td>8</td>
<td>minutes</td>
<td>10</td>
</tr>
<tr>
<td>Escondido</td>
<td>Monthly</td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>PM</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Night</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Poway</td>
<td>Monthly</td>
<td>7</td>
<td>minutes</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>AM</td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>PM</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Night</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><strong>ED STAT Perform to Completion</strong></td>
<td></td>
<td>30</td>
<td>minutes</td>
<td>5</td>
</tr>
<tr>
<td>Escondido Hematology</td>
<td>Monthly</td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Escondido Chemistry</td>
<td></td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Escondido Troponin</td>
<td></td>
<td></td>
<td></td>
<td>26</td>
</tr>
<tr>
<td>Poway Hematology</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Poway Chemistry</td>
<td></td>
<td></td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Poway Troponin</td>
<td></td>
<td></td>
<td></td>
<td>24</td>
</tr>
</tbody>
</table>
Project Improvement Team

• Jerry Kolins, MD, Medical Director, Laboratory
• Laboratory leadership team:
  – Gloria Austria (Senior Director)
  – Tim Barlow, Mariel Teng, Joane Barriteau (Managers)
  – Sandy Lajeunesse, Mary Ann Snoke, Evelyn Chua, Rebecca Anderson (Supervisors)
• Emergency Physician team led by Drs. Cohen, Puckett, Brady, Friedberg, and Bromley
• Supply Chain team
• Information Technology (IT) team
• Human Resources (HR) recruitment team
Action Plan with Timeline

• Standing meeting with EMA group to identify challenges, pain points, and opportunities — on going
• Active inventory review of lab specimen collection supplies with supply chain — on going
• Open communication with HR recruitment team — on going
• Ongoing IT fix/troubleshooting on primary container solution for high sensitivity troponin — Target 4/27/2022
• Review incentive pay options to minimize call offs — pending review with HR
• Modify Lab Quality Indicator measures to adapt the new dashboard report — July 2022
FY 22 Accomplishments and Process Improvement Opportunities

Accomplishments

• 2022 Live Well San Diego 21st Annual Public Health Champion Award recipient for the work on the COVID-19 Laboratory Testing Task Force
• Successful implementation of new testing assays for women’s health performed at Palomar Health to detect chlamydia/gonorrhea, bacterial vaginosis, candida species associated with vulvovaginal candidiasis
• Critical Value reporting compliance met target

Process Improvement Focus

• Turn around time on STATs ordered at the Emergency Department
ADDENDUM G
Pulmonary Services Biannual Report
Presented to Board Quality Review Committee

Gloria Austria, District Sr Director Respiratory Care, EEG, LAB
Frank Bender MD Medical Director
Kerwin Pipersburgh, District Sr Manager Respiratory Care, EEG
Krysti Johnson, District Operations Manager Respiratory Care, EEG
Chris Perez, District Supervisor Respiratory Care, EEG
June 16, 2022
The number of ventilator days at Palomar Health is above the national average of 3.5 days. This is not the Standard Utilization ratio (SUR) which is the benchmark used by the National Healthcare Safety Network (NHSN).

Currently ventilator days at Palomar Health is 5.2 including trauma. At Escondido it is 5.36 and Poway it is 5.05.

* Exclusion: patients on the vent for greater than 21 days

In review of the process the following challenges were identified:
- Lack of standardized procedure for nursing and a protocol for respiratory care for the Spontaneous Awakening Trial (SAT) and Spontaneous Breathing Trial (SBT) resulting in non-compliance
- Gaps in communication between nursing and respiratory
- Gaps in educating nursing and respiratory staff
- Inconsistent start times for initiating the SAT

Work with Information Technology (IT) to develop a Power Plan with standardized protocol
Respiratory Care Practitioner (RCP) will collaborate with the patient care team daily during rounds to discuss Ventilator SAT and SBT bundle compliance and consistent start times
Physician and key stakeholders education on the new protocol
Perform audits on SAT and SBT monthly compliance
Ventilator Days Reduction

- Respiratory continues to work collaboratively with our physician and nursing partners to reduce patient ventilator days across the district
- RCP staff education on scripting around SAT and SBT bundle during daily rounds

- Implement new SAT/SBT standardized protocol
- Audits with real time feedback is given to practitioners.
- Collaborate with key stakeholders, IT, physicians, clinical educators

- Continuing monthly monitoring of ventilator days
- Continue to work with IT on standardized protocol
- Continuing enforcing SAT, SBT via education and accountability

- Education in this initiative was given to: RCP's, Nursing in CCU (Esc, Poway), IMC (Esc, Poway), Unit Practice Council (UPC), Review of vent days data monthly
- Perform monthly audit of SAT and SBT compliance to monitor progress
Project Improvement Team

• Dr. Frank Bender, Medical Director Respiratory Care
• Gloria Austria, Senior Director of Respiratory Care
• Kerwin Pipersbrugh, Senior Manager of Respiratory Care
• Krysti Johnson, Operations Manager of Respiratory Care
• Chris Perez, Supervisor District Respiratory Care
• Information Technology (IT)
• Clinical Educators
• Physician Partners
Action Steps and Timeline

• Monitor for compliance to SAT and SBT (on-going)
• IT implementation of standardized protocol and procedure for SAT and SBT in Clarity (in-progress)
  • Nursing standardized procedure under development (in-progress)
  • Nursing leadership to update nursing procedure to add new standardized protocol
  • Nurse education
• Update respiratory procedure to add a new protocol (completed)
  • Respiratory education of new protocol (on-going)
• Physician education to follow once IT implementation is completed
FY 22 Accomplishments and Process Improvement Focus

Accomplishments
• Positive patient identification scanning compliance
• Decreased equipment rentals (ventilator, High flow, BiPAP)

Process Improvement Focus
• Decrease Ventilator days across the district
  – This is a discrete measurement of the vent days specific to Palomar Health and not the, Standard Utilization Ratio (SUR)
  – The Standardized Utilization Ratio (SUR) is the primary summary measure used by the National Healthcare Safety Network (NHSN) to compare device utilization at the national, state, or facility level by tracking central line, urinary catheter, and ventilator use