# BOARD QUALITY REVIEW COMMITTEE MEETING

**AGENDA**

Wednesday, September 28, 2022

4:00 pm Meeting

Participation will be virtual pursuant to

Board Resolution No. 01.10.22(03)-03

-Please see meeting log-in information on page 2-

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

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## CALL TO ORDER

1. Establishment of Quorum

   - 5 - 4:05

2. Public Comments

   - 30 - 4:35

3. Action Item(s)

   
   - 5 - 4:40

   b. *Approval of Contracted Services*

     - San Diego Blood Bank [ADD B-Pp 23]
     - Becton Dickinson and Company [ADD C-Pp 26]
     - Boston Scientific Labsystem Pro Recording Equipment [ADD D-Pp 28]
     - Boston Scientific Micropace Essential Care [ADD E-Pp 31]
     - Gold Coast Surgical, Inc. [ADD F-Pp 34]

   - Tricia Kassab, Vice President Quality and Patient Safety

   - 5 - 4:45

## Standing Item(s)

4. **Medical Executive Committee (MEC) / Quality Management Committee (QMC) Update**

   - Kanchan Koirala, MD, Chair, Quality Management Committee, Palomar Medical Center Escondido
   - Sam Filiciotto, MD, Chair, Quality Management Committee, Palomar Medical Center Poway

   - 10 - 4:55

## New Business

5. **Center of Excellence — Cardiovascular Services** [ADD G-Pp 37]

   - Thomas McGuire, RN, BSN, MBA, Cardiovascular Services Director
   - Mikhail Malek, MD, Cardiovascular Services Medical Director

   - 5 - 5:00

   b. **Medical Staff – Anesthesia Services** [ADD H-Pp 40]

   - Richard Engel, MD
   - Graham Davis, DO

   - 5 - 5:05

   c. **Operative & Invasive Procedure Services** [ADD I-Pp 47]

   - Bruce Grendell, MPH, BSN, RN, Perioperative Services Sr. Director
   - Richard Engel, MD

   - 5 - 5:10

   d. **Management of the Medical Record** [ADD J-Pp 50]

   - Kim Jackson, Health Information Management Director

   - 5 - 5:15

   e. **Throughput and Discharge Planning** [ADD K-Pp 58]

   - Joseph Parker, RN, MSN, CNL, Transitions Officer
   - Stephanie Baker, MBA, RN, CEN, Chief Operations Officer

   - 5 - 5:20

   f. **Service Excellence (HCAHPS)** [ADD L-Pp 69]

   - Stephanie Baker, MBA, RN, CEN, Chief Operations Officer

   - 5 - 5:25

## Adjournment to Closed Session

6. **Adjournment to Closed Session**

   - 1 - 5:26


   - 10 - 5:36

## Adjournment to Open Session

7. **Adjournment to Open Session**

   - 1 - 5:37

## Action Resulting From Executive Session

8. **Action Resulting From Executive Session**

   - 1 - 5:38

**FINAL ADJOURNMENT**

2 - 5:40
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<tr>
<th>VOTING MEMBERSHIP</th>
<th>NON-VOTING MEMBERSHIP</th>
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<tbody>
<tr>
<td>Linda Greer, RN– Chairperson, Board Member</td>
<td>Diane Hansen, CPA, President / Chief Executive Officer</td>
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<tr>
<td>Terry Corrales, RN, Board Member</td>
<td>Stephanie Baker, MBA, RN, CEN Chief Operations Officer</td>
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<tr>
<td>Laura Barry, Board Member</td>
<td>Omar Khawaja, MD, Chief Medical Officer</td>
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<tr>
<td>Kanchan Koirala, MD - Chair of Medical Staff Quality Management Committee</td>
<td>Hugh King, Chief Financial Officer</td>
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<td>for Palomar Medical Center Escondido</td>
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<td>Sam Filiciotto, MD - Chair of Medical Staff Quality Management Committee</td>
<td>Melvin Russell, RN, MSN, Chief Nursing Executive</td>
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<tr>
<td>for Palomar Medical Center Poway</td>
<td>Palomar Medical Center</td>
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<tr>
<td>Laurie Edwards Tate, MS - Board Member 1st Alternate</td>
<td>Kevin DeBruin, Esq., Chief Legal Officer</td>
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# BOARD QUALITY REVIEW COMMITTEE MEETING
## ATTENDANCE ROSTER - CALENDAR YEAR 2022

## VOTING MEMBERS

<table>
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<tr>
<th>Name</th>
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<tr>
<td>TERRY CORALES, RN, Board Member</td>
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<td>LAURA BARRY, Board Member</td>
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<tr>
<td>KANCHAN KOIRALA, MD, Chair, Medical Staff Quality Management Committee, PMC Escondido</td>
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<tr>
<td>SAM FILICIOTTO, MD, Chair, Medical Staff Quality Management Committee, PMC Poway</td>
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<td>Laurie Edwards-Tate, MS- 1st Board Alternate</td>
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## NON-VOTING MEMBERS

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<td>DIANE HANSEN, CPA, President &amp; CEO</td>
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<td>SHEILA BROWN, RN, MBA, FACHE, Chief Operations Officer</td>
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<td>OMAR KHAWAJA, MD, Chief Medical Officer</td>
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<td>MICHAEL BOGERT, Chief Financial Officer</td>
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<td>MEL RUSSELL, RN, MSN, Chief Nursing Executive, PMC</td>
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<td>HUGH KING, Chief Financial Officer</td>
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<tr>
<td>TRICIA KASSAB, EdD., RN, FACHE, Vice President, Quality and Patient Safety</td>
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<td>VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Sr. Director, Quality and Patient Safety</td>
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<td>DAVID LEE, MD, Medical Quality Officer</td>
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<td>KEVIN DEBRUIN, Esq., Chief Legal Officer</td>
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<td>STEPHANIE BAKER, MBA, RN, CEN, Chief Operations Officer</td>
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Board Quality Review Committee Minutes
Wednesday, September 28, 2022

TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

Background: Minutes from the Wednesday, July 27, 2022, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, July 27, 2022, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO:                Board Quality Review Committee

MEETING DATE:     Wednesday, September 28, 2022

FROM:             Sally Valle, Committee Secretary

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

Budget Impact:   N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

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

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

<table>
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<th>COMMITTEE RECOMMENDATION:</th>
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<td>Motion: X</td>
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<td>Individual Action:</td>
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<td>Information:</td>
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<td>Required Time:</td>
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</table>
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for the Boston Scientific Labsystem Pro Recording Equipment is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

Background: The Contracted Services Evaluation report for the Boston Scientific Micropace Essential Care is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

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

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

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

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

Background: The Medical Staff – Anesthesia Services Bi-Annual Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

Background: The Operative & Invasive Procedure Services Annual Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee

MEETING DATE: Wednesday, September 28, 2022

FROM: Sally Valle, Committee Secretary

Background: The Management of the Medical Record Annual Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:
TO: Board Quality Review Committee  
MEETING DATE: Wednesday, September 28, 2022  
FROM: Sally Valle, Committee Secretary  

Background: The Patient Throughput/Discharge Planning (CRM) report is provided to the Board Quality Review Committee for information only.  

Budget Impact: N/A  

Staff Recommendation: For information only.  

Committee Questions:  

COMMITTEE RECOMMENDATION:  

Motion:  
Individual Action:  
Information: X  
Required Time:  

TO: Board Quality Review Committee
MEETING DATE: Wednesday, September 28, 2022
FROM: Sally Valle, Committee Secretary

Background: The Service Excellence (HCAHPS) Annual 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:
ADDENDUM A
**BOAARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, JULY 27, 2022**

<table>
<thead>
<tr>
<th>AGENDA ITEM</th>
<th>CONCLUSION/ACTION</th>
<th>FOLLOW UP / RESPONSIBLE PARTY</th>
<th>FINAL?</th>
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**NOTICE OF MEETING**

The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Friday, July 22, 2022, consistent with legal requirements.

**CALL TO ORDER**

Pursuant to Board Resolution No. 01.10.22(03)-03 participation will be virtual and the meeting was called to order at 4:00 p.m. by Director Linda Greer, RN.

**ESTABLISHMENT OF QUORUM**

Quorum comprised of Board Directors: Director Linda Greer, Director Terry Corrales, RN; Director Laura Barry; and Physician Chair, Sam Filiciotto, MD, Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway

**PUBLIC COMMENT**

There were no public comments.

**ACTION ITEMS:**

A. **REVIEW / APPROVAL: OPEN/CLOSED SESSION MEETING MINUTES / ATTENDANCE ROSTER – JUNE 16, 2022**

The BQRC meeting minutes from June 16, 2022, were presented for review and approval. Director Laura Barry, motioned for approval, second by Director Terry Corrales.

**MOTION:** by Director Laura Berry, second by Director Terry Corrales, carried to approve the meeting minutes of June 16, 2022, as submitted. Roll call voting was utilized.

Director Laura Barry – Aye
Director Corrales - Aye
Director Greer - Aye

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

Y

B. **REVIEW / APPROVAL: APPROVAL OF CONTRACTED SERVICES**
-San Diego Urology Mobile Services
-South Coast Perfusion
-Specialty Care Intraoperative Monitoring Services
-UHS Surgical Services, Inc.
-Davita Dialysis

The contracts were presented for annual review. All have met indicators and expectations for the quality indicators in their contracts.

**MOTION:** by Director Corrales, second by Director Barry, to approve the contracted service reviews for San Diego Urology Mobile Services, South Coast Perfusion, Specialty Care Intraoperative Monitoring Services, UHS Surgical Services, Inc., and Davita Dialysis.

Roll call voting was utilized.

Director Greer, RN - Aye
Director Corrales, RN - Aye
Director Laura Barry – Aye
Sam Filiciotto, MD – Aye
Kanchan Koirala, M.D. – Aye

All in favor. None opposed.

### STANDING ITEM(S)

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

Dr. Sam Filiciotto provided a brief update from the most recent QMC meeting:
- Reviewed and approved the organizational Capacity Management Plan which outlines the phased approach to overcrowding and each department’s responses.
- Our last bariatric program accreditation was in 2018. We are coming up for re-accreditation in November. The bariatric program provided their report which demonstrated great quality outcomes.
- Working with Dr. Ginther and providers on CPOE alerts to ensure Leapfrog compliance.
- Radiology and Nuclear Medicine are working with the ED on turn-around-times. There has been significant improvements. Those departments will continue to monitor radiation exposure for staff and providers.
- The new Director of Rehabilitation, Tyler Powell, was introduced.
- Reviewed the status of the Joint Commission, CDPH, and CMS deficiencies and most are moving into the green areas. Actions are having positive results.

**MOTION:** N/A

### NEW BUSINESS

#### A. COMMITTEE MEMBERSHIP
Sheila Brown explained that with her impending retirement her position will be removed from the Board Quality Review Committee effective this meeting. Dr. Omar Khawaja, Chief Medical Officer, will assume the liaison position in this Committee, starting in September.

This change will have to be recorded in the Bylaws.

Dr. Omar Khawaja also noted that this change will also require documentation with the Board of Pharmacy – he will have oversight of the Pharmacy. Donna Gelios indicated that the DEA will also require this change in their documentation records.

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b. **PMC Poway Operating Room Quality Indicators**

Dr. Filiciotto, thanked the committee for the opportunity to present this report. He also thanked Diane Hansen, and the entire team that contributed, and collaborated to produce this report.

Dr. Filiciotto reviewed the PMC Poway Operating Room Quality Indicators for CY2021, with the committee. He explained the initiatives, metrics, performance and actions of each metric.

Highlights of the report:
- Unexpected return to the operating room. Well below the national rate.
- First Case On Time Starts (FCOTS) – In 2021 the overall rate was 71%, and recent data for June 2022, the FCOTS averaged 80%.
- Post-operative hemorrhage rate was 1.3 per 1000 admissions. Excellent result well below the national rate.
- Surgical Site Infection Rate was 0.765 which is below the national threshold.
- Performance Improvement Projects:
  - The use of a pre-procedure check list
  - Pre-operative phone calls
  - Documentation of wound classes
- There has been a significant improvement in completing the Poway leadership team in the operating room. Dr. Filiciotto thanked the Human Resources team for their work in finding and hiring leaders during this unusual extraordinary time.
  - Leadership staff is being hired.
  - A new Supervisor was hired and scheduled to start in August.
  - The full time Educator position remains undecided at this time.

Dr. Filiciotto, again, thanked the committee for allowing him to present and indicated he would be happy to provide any other data metrics the Board was interested in hearing about.

Director Greer thanked Dr. Filiciotto for his report. She noted that this was the type of high level report the Board appreciates.

Director Barry noted that she appreciated that fact that in areas demonstrating needing improvement, there was a plan in place to move toward meeting the national average.

The Committee requested to have this report on the agenda on a bi-annual basis.

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c. **Supply Chain Equipment Acquisition/End of Life Process**
Heather Woodling and Tim Stevens presented the Equipment Acquisition Process to the Committee.

- Heather outlined the identification process of replacement or new equipment
  - The expense approval
  - Vendor(s) choice & vetting
  - Consideration of purchase vs. lease
- Tim outlined the process of receiving, management, and maintenance of the equipment

See addendum H for further details

D. CENTERS OF EXCELLENCE ANNUAL REPORT – ORTHOPEDIC & SPINE SERVICES

Brian Cohen, Dr. Bried, and Dr. Nguyen presented the Orthopedic & Spine Services report.

Highlights were:
- Our joint replacement program is in the 100 best from Healthgrades, in the country for 7 years in a row. Orthopedics is 6 years in a row, and spine program for 3 years in a row.
- We are the only hospital in the county that has achieved the 100 best designation for all three service lines.
- US News says we are high performing for hips and knees, the “Blues” say we are a center of distinction, and Aetna says we are an institute of quality.
- We achieved this status due to our world class surgeons, our commitment to continuing education events, coordination of care, continuum of care teams, maintaining patient readiness for surgery, post-operative care, and our meeting infrastructure, amongst others.
- Areas of increased focus are our surgical site infection ratio, which is above threshold at Escondido for hip replacement and Poway for knee replacement. For spine fusions our surgical site infection ratio is better than threshold.
- Queries to hip patients demonstrated their return to limited to no disability mobility within three months post-surgery.
- Spine fusion patients go from a severe level of disability before surgery to a minimal level one year post surgery.
- PMC P will be applying for the Joint Commission advanced accreditation for hips and knees. Plan to expand the accreditation to the Escondido campus as well.
- Dr. Bried noted that the new Outpatient Surgery Center will be more conducive to achieve same day surgeries.
- Dr. Nguyen noted that the success of the programs is due to the cohesiveness of the program team, Brian’s leadership, and having Dr. Bried as a role model.

Director Corrales inquired as to what was thought that was contributing to the high infection rate. Brian explained that the hip infection rate was above threshold at Escondido, and below threshold at Poway – reversed for knees. He believes there has not been one common reason contributing to infections however their focus is on adherence to the pre-operative measures, 100% of the time to decrease the infection ratio.

See addendum I for further details

E. CENTERS OF EXCELLENCE ANNUAL REPORT – BARIATRIC SERVICES (METABOLIC & BARIATRIC SURGERY ACCREDITATION & QUALITY IMPROVEMENT PROGRAM)

Brian Cohen and Dr. Karen Hanna presented the Bariatric Services Program report.

Highlights were:
Due for Metabolic & Bariatric Surgery re-accreditation in November/December 2022.
Issues faced since transitioning from Dr. Callery to Dr. Hanna was volume. Due to insurance contracting and the pandemic. Have been able to make minimum volume to maintain accreditation. Program continues to grow.
Mortality rate at zero for the last 6 – 8 years
Wound infection rate for sleeve gastrectomy had 2 wound infections out of 31 cases. Due to low volume our percentage rate was higher than the benchmark. Reviewed infection prevention protocols, adjusted them, and continue to monitor. A recent report semiannual report had zero wound infections.
For gastric bypass, had expected rates of complications.
Annual QI project for 2021, was to improve on long term follow up. Adjusted follow up process by increasing patient phone calls, were able to reach 100% follow up at six months and 62% at one year. QI project for 2022, is to reduce post-operative ER visits. New initiatives in place to reduce visits.
Goal is to increase volume and expand program. PMC Poway now has a medical weight management program in addition to the surgical weight loss program.
Currently there is one physician managing the medical weight loss program and soon will have a PA who will be onboarding.

Director Corrales thought that perhaps the use of nurse practitioners would assist with program growth.
Sheila Brown noted that perhaps discussions regarding challenges & resources, with Stephanie Baker and Brian Cohen could possibly assist with developing strategies assisting with program growth.

F. REHABILITATION SERVICES

Virginia presented the Rehabilitation Services Report to the Committee.

Highlights were:
- Outpatient Cardiac Rehabilitation team minimized the amount of time to get into the program for patients requiring immediate support. Down to 21 days from physician referral to admission to the program – the national benchmark is 31 days or less.
- In 2021, the Outpatient Rehabilitation staff maintained a cancellation/no show rate of 8% - the national average is 15%.
- Access to care measures were affected by the pandemic due to both staff and patient's getting ill with COVID. On the average, on the inpatient side there are < 2 patient's triaged per day, this increased up to 5 – 6 during 2021.
- On the Outpatient side, the average time to get into the program is typically just under one week. During COVID it went up to slightly over one week.
- Hiring and retention issues were encountered for the first time in more than a decade. Worked with Human Resources to re-adjust wages, and working on a loan forgiveness program.

G. MEDICAL STAFF – UTILIZATION REVIEW

Dr. Frank Martin presented a brief update of the Utilization Review Committee. He explained that the committee is a medical staff committee mandated by our Medicare Conditions of Participation. The committee reviews all Medicare admissions for appropriateness of admission and services provided.
Dr. Martin also provided the committee's main functions, and a summary of the committee's major activities.

Currently working on increased communications with the hospitalists to ensure appropriateness of admissions and services provided.

See addendum L for further details

H. **MEDICATION MANAGEMENT REPORT (PHARMACY)**

Donna Gelios presented the Medication Management Report.

Highlights were:
- Currently have 2 quality initiatives:
  - Medication purchasing optimization
    - Over the past two years the Pharmacy has worked to optimize how medications are being purchased which translates to an average savings of 14 million dollars.
    - A HRSA (Health Resources and Services Administration) audit was conducted last February. Passed with only one finding – had to do with outside state pharmacy that was not listed on the exclusion file. Passing this audit allows us to utilize the 340b program for another three years.
  - Clinical initiative on therapeutic medication interchange
    - This looks at changing IV medication formulation to the oral form when the oral form is approximately 100% bio available.
    - Want to do this as it increases nursing satisfaction and decreases the patient’s length of stay in the hospital.
    - Less expensive in most cases, to give the oral form.
    - Studies show a decrease in morbidity.
    - Already have policies in place to change the form when patient’s meet criteria
    - Pharmacy tracking over the next two years to determine savings and, number of interchanges made.

I. **ENVIRONMENT OF CARE & EMERGENCY MANAGEMENT ANNUAL EVALUATION**

Dan Farrow and Anis Trabelsi presented the Environment of Care and Emergency Management Annual Evaluation.

Dan explained the Environment of Care is comprised of six different management plans. Each one has metrics tracked annually for continuous improvement. Scope encompasses all PH facilities/campuses.

Dan and Anis reported that overall the plans performance was acceptable. Education was provided in the areas below threshold.
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<td>➢ PURSUANT TO CA GOV’T CODE §54962 &amp; CA HLTH &amp; SAFETY CODE §32155; HEARINGS – SUBJECT MATTER: REPORT OF QUALITY ASSURANCE COMMITTEE</td>
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<thead>
<tr>
<th><strong>SIGNATURES:</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMITTEE CHAIR</td>
<td>Linda Greer, RN</td>
</tr>
<tr>
<td>COMMITTEE ASSISTANT</td>
<td>Sally Valle</td>
</tr>
</tbody>
</table>
ADDENDUM B
Name of Service:  San Diego Blood Bank
Date of Review:  8/30/2022
Name / Title of Reviewer:  Tim Barlow, PH Laboratory Operations and Transfusion Services Manager
Nature of Service (describe):  Blood Product Supplier and Immunohematology Reference Laboratory

<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</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>provision of its care, treatment, and service.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>that the organization itself must adhere to.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>comparable had the organization provided such care, treatment, and service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>itself.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>program, responds to concerns regarding care, treatment, and service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rendered, and undertakes corrective actions necessary to address issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>identified.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe,</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>effective, efficient, and timely manner emphasizing the need to – as</td>
<td></td>
<td></td>
</tr>
<tr>
<td>applicable to the scope and nature of the contract service – improve</td>
<td></td>
<td></td>
</tr>
<tr>
<td>health outcomes and the prevent and reduce medical errors.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics Escondido

<table>
<thead>
<tr>
<th>METRIC</th>
<th>2nd QTR 2020</th>
<th>3rd QTR 2020</th>
<th>4th QTR 2021</th>
<th>1st QTR 2021</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Product Inventory Fill Rate</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>100%</td>
<td>= 99%</td>
</tr>
<tr>
<td>Metric &gt; 98% per Quarter</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics Escondido

<table>
<thead>
<tr>
<th>METRIC</th>
<th>2nd QTR 2020</th>
<th>3rd QTR 2020</th>
<th>4th QTR 2021</th>
<th>1st QTR 2021</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Blood availability</td>
<td>99%</td>
<td>97%</td>
<td>99%</td>
<td>100%</td>
<td>= 99%</td>
</tr>
<tr>
<td>Metric &gt;95%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics Escondido

<table>
<thead>
<tr>
<th>METRIC</th>
<th>3rd QTR 2020</th>
<th>4th QTR 2021</th>
<th>1st QTR 2020</th>
<th>2nd QTR 2020</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunohematology Reference Laboratory TAT</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>= 100%</td>
</tr>
<tr>
<td>Metric &lt; 24 hours 100% of the time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Performance Metrics Escondido

<table>
<thead>
<tr>
<th>METRIC</th>
<th>2nd QTR 2020</th>
<th>3rd QTR 2020</th>
<th>4th QTR 2021</th>
<th>1st QTR 2021</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with HIPPA Standards</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>= 100%</td>
</tr>
<tr>
<td>of PH Patient information. Metric</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>= 100% Compliance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments

With consideration of the ongoing pandemic and decrease in Donor Blood Volume and Donor recruitment challenges, SDBB has maintained
our inventory of blood products throughout the year with no cancellations of procedures or ED / Trauma bypass. Whole Blood O neg collections due to lack of donor availability and supply chain issues with collection bags have impacted Whole Blood O neg inventory at times.

Overall SDBB service has been acceptable and often noteworthy this past year.

---

**Conclusion** (check one)

- X **Contract service has met expectations for the review period**

☐ Contract service has **not met** expectations for the review period. The following action(s) has or will be taken:
  (check all that apply:
  ☐ Monitoring and oversight of the contract service has been increased
  ☐ 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 C
Name of Service: Becton Dickinson and Company

Date of Review: August 30, 2022

Name / Title of Reviewer: Gloria Austria/Jessica D’Angelo

Nature of Service (describe): Micro lab equipment and reagent supplier

---

**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>Met</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>Met</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>Met</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>Met</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>Met</td>
<td></td>
</tr>
</tbody>
</table>

---

**Performance Metrics**

<table>
<thead>
<tr>
<th>METRIC</th>
<th>1st QTR 2022</th>
<th>2nd QTR 2022</th>
<th>3rd QTR 2022</th>
<th>4th QTR 2022</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equipment reliability</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Target: =&gt; 90% up and operational</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fill rate of reagent/consumables order</td>
<td>100%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>95%</td>
</tr>
<tr>
<td>Target: =&gt; 90% order fulfillment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Timely service request</td>
<td>N/A</td>
<td>100%</td>
<td>100%</td>
<td>N/A</td>
<td>100%</td>
</tr>
<tr>
<td>Target: Response time &lt;= 48 hours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments**

Reagent fill rate are at 100%, challenges with supply chain on other consumables the last 3 quarters

N/A = no service request during that time period

---

**Conclusion (check one)**

- X Contract service has met expectations for the review period

☐ Contract service has **not met** expectations for the review period. The following action(s) has or will be taken:
  (check all that apply):
  ☐ Monitoring and oversight of the contract service has been increased
  ☐ 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
**Name of Service:** Boston Scientific Labsystem Pro Recording Equipment Service Agreement  

**Date of Review:** 8/30/2022  

**Name / Title of Reviewer:** Tom McGuire/ Director of Interventional Services  

**Nature of Service (describe):**  
- Unlimited Service Repair  
- 100% Coverage on replacement parts for spend predictability  
- 24x7x365 phone support to provide first line of help for reduced downtime  
- Annual preventative maintenance visit to ensure optimum working condition of equipment  
- Loaner unit for downtime  
- Service contract covers LSPRO CPU and clear channel amplifier system  

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

**Performance Metrics**

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY 22 QTR 1</th>
<th>FY 22 QTR 2</th>
<th>FY 22 QTR 3</th>
<th>FY 22 QTR 4</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cancelled cases related to contracted service Key Performance Indicators (KPIs)</td>
<td>YES</td>
<td>YES</td>
<td>NO*</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Boston Sci service technicians are professional, arrive on time and is competent in his / her duties.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Personnel employed by contractor are current in all screening requirements per terms of the contract.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

**Comments**
• “In FY 22 Qtr 3. EP cases were canceled due to equipment covered under this contract being down. Contract was upgraded in August 2022 to include new hardware and software upgrades. New service agreement has additional entitlements and upgraded hardware to prevent future issues.

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
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☐ 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 E
**Boston Scientific**

**Review of Contract Service**

**Name of Service:** Boston Scientific Micropace Essential Care Service Agreement

**Date of Review:** 8/30/2022

**Name / Title of Reviewer:** Tom McGuire/ Director of Interventional Services

**Nature of Service (describe):**
- Unlimited Service Repair
- 100% Coverage on replacement parts for spend predictability
- 24x7x365 phone support to provide first line of help for reduced downtime
- Annual preventative maintenance visit to ensure optimum working condition of equipment
- 48 hour response time
- Service contract covers Micropace Stimulator used in the EP lab

**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>√</td>
<td></td>
</tr>
<tr>
<td>2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>4. Actively participates in the organization’s quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.</td>
<td>√</td>
<td></td>
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</tbody>
</table>

**Performance Metrics**

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY 22 QTR 1</th>
<th>FY 22 QTR 2</th>
<th>FY 22 QTR 3</th>
<th>FY 22 QTR 4</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No cancelled cases related to contracted service Key Performance Indicators (KPIs)</td>
<td>YES</td>
<td>YES</td>
<td>Yes</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Boston Sci service technicians are professional, arrive on time and is competent in his / her duties.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Personnel employed by contractor are current in all screening requirements per terms of the contract.</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>
Comments
- The micropace stimulator was replaced once under the service agreement in FY 22. The replacement and downtime did not result in having to cancel any cases. Service contract allowed for timely replacement of equipment.

Conclusion (check one)
√ Contract service has met expectations for the review period
☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
   (check all that apply):
   ☐ Monitoring and oversight of the contract service has been increased
   ☐ Training and consultation has been provided to the contract service
   ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
   ☐ Penalties or other remedies have been applied to the contract entity
   ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
   ☐ Other: ________________________________________________________________________________
ADDENDUM F
Name of Service: Gold Coast Surgical, Inc.

Date of Review: August 31, 2022

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

Nature of Service (describe): Thulium Laser rental services used in the treatment of urological procedures (e.g. removal of kidney stones)

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

Performance Metrics

<table>
<thead>
<tr>
<th>METRIC</th>
<th>FY22 Q2</th>
<th>FY22 Q3</th>
<th>FY22 Q4</th>
<th>FY23 Q1</th>
<th>Cumulative Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gold Coast Surgical equipment is clean and in good working order</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Gold Coast Technician is professional, arrives on time and is competent in his / her duties.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No cancelled cases related to contracted service</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Key Performance Indicators (KPIs)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Contractor submits invoices for payment in a timely manner after service provided.</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Comments: No unusual occurrences documented during the contract service evaluation period. Limited number of Thulium laser rentals requested by urology surgeons. This contract was negotiated as a bridge solution until Palomar Health’s regular contracted laser rental company was able to procure a Thulium laser and made available for use. This contract will be permitted to expire on December 2, 2022 and will not be renewed.

Conclusion (check one)

√ Contract service has met expectations for the review period

☐ Contract service has not met expectations for the review period. The following action(s) has or will be taken:
(check all that apply):
☐ Monitoring and oversight of the contract service has been increased
☐ Training and consultation has been provided to the contract service
☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
☐ Penalties or other remedies have been applied to the contract entity
☐ The contractual agreement has been terminated without disruption in the continuity of patient care
☐ Other: ________________________________________________________________________________
ADDENDUM G
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, 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 have added additional national quality registries/programs to include Left Atrial Appendage Closure and Extracorporeal Life Support Organization (ELSO) with start of ECMO program.

Accomplishments & Highlights:

STEMI (ST Elevated Myocardial Infarct) Door to Balloon (D2B) Time
- ACC 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%)
Fluoroscopic 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
- Cardiomems coming in 2022

Provider and Staff Educational Conferences
- Bi-Weekly Cath Conference
- Monthly Echo Conference

Recognitions & Awards 2021

Goals for 2022
- Start ECMO program to provide advanced treatment options for patients that have life-threatening lung or heart conditions
- Start Left Atrial Appendage closure program to reduce risk of stroke in this patient population (Jan 2022)
- Improve Overall STS Quality Star Rating to 2 Stars and Medication domain to 3 Stars
  - CV COE is a 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
- Streamline ordering process for Outpatient Cardiac Rehab to increase outpatient referrals
- Start MR echo alert process to help ensure timely medical, surgical, or endovascular intervention
- Pulmonary Artery Pressure Monitor Implant (Cardiomems) to start in 2022. Allows remote monitoring of PA pressures aiding physicians in preventing worsening heart failure and preventing CHF admissions
- Move towards Stroke Target Phase 3 Goals in 2022 with implementation of AI rapid detection of LVO and process improvement initiatives
  - Door to Puncture Target Phase 3 Goal: < 60 minutes
  - Door to Device Activation Target Phase 3 Goal: D2DA < 90 min 50% of the time
ADDENDUM H
Future of Anesthesia Quality Reporting and Performance Improvement Projects

Electronic Anesthesia Record

Project beginning this month. Will take 8-12 months to implement

An Electronic Anesthesia Record will greatly improve our ability to gather accurate and actionable data that will allow us to develop future performance and process improvement plans.

Anesthesia Dashboard (in development; this is an example)

Things we will be able to track, evaluate, and make evidence-based improvements on include items in the dashboard below. We might also choose to track: antibiotic timing, OB-specific measures, lung-protection ventilation, sustainability (low gas flows), temperature management, transfer of care, etc.

*This example is from MPOG (Multicenter Perioperative Outcomes Group)*
Quality Assurance: Multispecialty Peer Review Committee *

4/1/2022 – 6/30/2022

<table>
<thead>
<tr>
<th></th>
<th># MSPRC Cases</th>
<th>Track/Trend Yes</th>
<th>Track/Trend No</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMC Escondido</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Improvement Opportunity</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>None needed</td>
</tr>
<tr>
<td>Minor Improvement Opportunity</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>Anesthesia representative reviewed the cases with the physicians</td>
</tr>
<tr>
<td>PMC Poway (not scored)</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>None needed</td>
</tr>
</tbody>
</table>

* Info pulled by Isabel Cheong, Sr. Clinical Data Analyst

Assessment: Acceptable (very low) number of cases deemed “minor improvement” or for 4/1/22 through 6/30/22.
Quality Assurance: Oversight of Sedation and Analgesia by Non-anesthesiologists (Jul 2021 through Jun 2022)

CMS §482.52: The head of anesthesia services has the authority and responsibility for directing the administration of all anesthesia services, including anesthesia and analgesia, throughout the hospital (including all departments in all campuses and off-site locations where anesthesia services are provided)

Adverse Drug Event: Opioid use requiring reversal with Narcan

PMC Escondido: 1-4 events per month; no outliers; no action required.

PMC Poway: 0-2 events per month; no outliers; no action required

ED Discharge of Patients with Schedule II Opioid Medication

Total Schedule II opioid discharge prescriptions written at PMCE and PMCP is trending down (from approximately 10% down to 7-8%). Palomar Health is still below the national benchmark of 17.4%. Most prescribed opioids at discharge at both facilities are Norco 5mg, Norco 10mg, and Percocet 5mg. No action required.

Inpatient IV Opioid Use per Acute Patient Days (excluding pre/post and surgical areas)

0.3-0.5 doses of IV opioid per acute patient days for both hospitals. No trends identified. No action required.

Patient Controlled Analgesia (PCA) Usage/1000 Adjusted Patient Days

Overall stable at or less than 1.5%, except for a one-month spike to 2% at Poway (Aug 2021) and Escondido (Mar 2022). Hydromorphone PCA is the most utilized PCA for both facilities. No action required

Fentanyl Black Box Warning

2-30 orders per month; 100% compliance

Extended-Release Oral Opioid

1-6 orders per month; 100% compliance with dosage for non-opioid naïve patients
Assessment:
Improvement year-on-year (Jan-Jun 2021 96%-99%).
Missing/incomplete Anesthesia Consent forms are more common in OB

Plan:
1. Education for OB nurses regarding appropriate/complete documentation
2. Examine each chart to be sure it’s not exempt from consent (trauma, emergencies)

Assessment:
Year-on-year improvement at both locations.
(2021 Esc Jan-Jun 85-90%; 2021 Poway Jan-Jun 91-97%)
Dip in June at Escondido corresponds to hiring of new anesthesiologists

Plan:
1. EMR for anesthesia record
2. Improved education of new anesthesiologists
Performance Improvement: Patient Experience

PMC Escondido Outpatient Surveys

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr 2022</th>
<th>May 2022</th>
<th>Jun 2022</th>
</tr>
</thead>
<tbody>
<tr>
<td># Surveys</td>
<td>146</td>
<td>146</td>
<td>135</td>
</tr>
<tr>
<td>Top Box Percentage (Percentile ranking)</td>
<td>76.0 (3)</td>
<td>80.1 (9)</td>
<td>86.7 (37)</td>
</tr>
<tr>
<td>Facility Would Recommend</td>
<td>74.1 (6)</td>
<td>79.1 (16)</td>
<td>73.2 (6)</td>
</tr>
<tr>
<td>Anesthesia Explained</td>
<td>68.7 (13)</td>
<td>75.2 (28)</td>
<td>73.2 (23)</td>
</tr>
</tbody>
</table>

**Situation and Background**

In April 2022 two anesthesia-specific questions were added to Outpatient Survey sent by NRC

**Assessment**

1. Despite Top Box percentage >70%, our scores are below the NRC average for Outpatient services
2. Anesthesia “gateway” question is a bit vague regarding who provided the sedation/anesthesia (“Anesthesia is something that would make you feel sleepy or go to sleep during your procedure. Were you given anesthesia?”)

**Action Plan**

1. Change “gateway” question to something like “Did an anesthesiologist provide care for you during your visit?” – done; implemented 7/25/22
2. Provide in-services to anesthesiologists regarding evidence-based techniques to use when conducting a pre-anesthesia evaluation.
3. Patient hand-outs in pre-op explaining types of anesthesia and what to expect before/during/after anesthesia.
Performance Improvement: Total Joint Center of Excellence

THKR-OP-1: Regional Anesthesia

Results: Rolling 4-month data through June 2022. Benchmark 81%. PMC-E compliance 76.9%; PMC-P compliance 87.2%. There is some question re: validity of data.


THKR-OP-2: Postoperative Ambulation on Day of Surgery

Goal: 90%

PMC-P rolling average through June 2022 is 88.5%. PMC-P June 2022 = 35 of 37 = 95%

Plan: Success is mostly attributed to scheduling factors. To facilitate the goal of early ambulation, anesthesiologists will continue to use appropriate “low dose” spinals, and low concentration of local anesthetic in adductor canal block (for postop pain management).
ADDENDUM I
Perioperative Services Dashboard - PMCP

**Patient Satisfaction**

- Surgical Site Infection
- SIR (standardized infection ratio) > 1.0 indicates that more infections were observed than predicted, accounting for differences in the types of patients followed; conversely, an SIR < 1.0 indicates that fewer infections were observed than predicted.

**Surgical Site Infections**

- Facility would recommend Anesthesia courtesy/respect
- Anesthesia explained
- Care providers explain things
- Care providers listened
- Confident in care team
- Doctors Explain Understandably
- Explain when allowed to leave
- Family involved in visit
- Got help as soon as wanted
- Informed of delays
- Procedure began on time
- Rate facility
- Received consistent info
- Staff explained
- Trust providers w/ care

**OR Volume**

**Surgical Site Infections**

- Facility would recommend Anesthesia courtesy/respect
- Anesthesia explained
- Care providers explain things
- Care providers listened
- Confident in care team
- Doctors Explain Understandably
- Explain when allowed to leave
- Family involved in visit
- Got help as soon as wanted
- Informed of delays
- Procedure began on time
- Rate facility
- Received consistent info
- Staff explained
- Trust providers w/ care

**OR Volume**

- OR Case Volume by Day of Week - PMCP

**OR Case Volume**

- OR Case Volume by Day of Week - PMCP

**Finance**

- Monthly SIR is not available as NHSN calculates quarterly SIR only. SIR values only calculated if number of expected (or predicted) infections >= 1 for all cases included in SSI's — those reviewed are:
  - Colon
  - Gallbladders
  - Hysterectomies
  - Small Bowel
  - Spinal Fusions
  - C-Sections

**SPD**

- Facility would recommend Anesthesia courtesy/respect
- Anesthesia explained
- Care providers explain things
- Care providers listened
- Confident in care team
- Doctors Explain Understandably
- Explain when allowed to leave
- Family involved in visit
- Got help as soon as wanted
- Informed of delays
- Procedure began on time
- Rate facility
- Received consistent info
- Staff explained
- Trust providers w/ care
ADDENDUM J
Management of the Medical Record
Presented to
Board Quality Review Committee
## Situation
PMC Escondido and PMC Poway Bi-Annual Review

## Background
Medical Records continually monitors production and quality of primary Medical Records functions.

## Assessment
Overall, the Medical Records department is meeting or exceeding goals for production and quality. There are two areas of focus for this review period which are below the expected outcome:

1. Document imaging (scanning) turn around time, for non-critical documents. Although Medical Records made headway on this issue in recent months, turn around times are falling behind again. Factors primarily include staffing/turnover. To provide sustained improvement to this area, we have engaged Cerner to implement “Advance Capture” and “Cerner Mobile E-Sig Forms Suite” which will use AI, electronic signature, and Natural Language Processing to speed the document recognition process, and eliminate additional paper forms, thereby requiring less manual paper processing. Anticipated implementation is 1st quarter calendar 2023.

2. Immediate post-op notes are tracked for timely completion by Medical Records and results are reported monthly to Chiefs of Staff and O.R. The compliance goal is 100%, and current results fall short.

## Recommendation
1. Medical Records will monitor non-critical document scanning turn around times before and after implementation of “Advance Capture” and report any further issues.

2. Immediate post-op notes are only required for medical staff members that do not complete their operative reports immediately after surgery. Medical Records will provide detailed trending information to the Medical Staff Leadership for follow up.
Cerner Provision Document Imaging (CPDI)
Turn-Around Time

CRITICAL DOCUMENTATION (GOAL = 24 HOURS)

ALL OTHER DOCUMENTS (GOAL = 72 HOURS)
Post-Op Notes for Dictated OP Report
Goal = 100 %

<table>
<thead>
<tr>
<th></th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
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<tbody>
<tr>
<td>PMC Esc</td>
<td>90.9</td>
<td>91.3</td>
<td>92.4</td>
<td>95.8</td>
<td>92.8</td>
<td>88.6</td>
</tr>
<tr>
<td>Cath Lab</td>
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<td>97.2</td>
<td>100</td>
<td>97.5</td>
<td>98.9</td>
<td>96.6</td>
</tr>
<tr>
<td>PMC Poway</td>
<td>100</td>
<td>94.5</td>
<td>97</td>
<td>97.2</td>
<td>96.8</td>
<td>98.2</td>
</tr>
</tbody>
</table>
Other Documentation Review

PM C ESCONDIDO

- TRANSCRIBED REPORTS % TAT MET TARGET = 90%
- DYN DOC % TARGET = 100%
- CRITICAL COPY/PASTE CRITERIA MET TARGET = 90%
- PERCENTAGE OF REPORTS DONE IN DYN DOC TARGET = 80%

Other Documentation Review

PM C POWAY

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- DYN DOC FREE * % TARGET = 100%
- CRITICAL COPY/PASTE CRITERIA MET TARGET = 90%
- PERCENTAGE OF REPORTS DONE IN DYN DOC TARGET = 80%

* Most common deficiency is failure to edit Dragon dictation and/or typos and misspelled words *
** Failure to indicate attribution of where copied from**
Action Plan with Timeline

1. Cerner Advance Capture and Mobile E-Sign Suite implementation
   Planned for Quarter 1 Calendar 2023

2. Provide detailed trending data to Medical Staff regarding failure to complete immediate post-op notes (for operative/procedure reports not completed immediately after surgery).
   Beginning September 2022
ADDENDUM K
Throughput and Discharge Planning
Presented to Board Quality Review Committee

Joseph Parker, Transitions Officer

9.28.2022
## Discharge Planning & Patient Throughput

<table>
<thead>
<tr>
<th><strong>Situation</strong></th>
<th>Reduce the YTD (July 21 – Jan 22) LOS from overall 4.75 days to budgeted 3.93 days Manage anticipated COVID and other complicated discharges. FYTD LOS: PMC Escondido 4.62 / Budgeted 3.71 PMC Poway 5.10 / Budgeted 4.76</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>Throughput and DC planning are strategic initiatives for FY2022</td>
</tr>
</tbody>
</table>
| **Assessment** | **Discharge Planning Challenges:**  
- SNFs/ALFs remain reluctant on taking COVID+ referrals  
- Health Plans authorization processes causing Discharge delays  
- Several patients with limited to no funding (uninsured / Restricted Medical)  
- Few SNFs with Custodial Beds  
- Homelessness/Drug and Alcohol Abuse  
- Legal challenges (Conservatorship etc.)  
**Patient Throughput:**  
- Emergency Department volumes continue to increase at both campuses  
- COVID+ inpatient volume has remained low throughout the district  
- Discharge lounge utilization remains high at both campuses  
- New PMC Escondido discharge lounge construction estimated completion 7/5/22  
- ALOS continues to decrease over the last 4 months  
- Capacity Management Plan draft completed and is being routed through committees for approval |
| **Recommendation** |  
- Multi-disciplinary rounds active on all inpatient nursing units as of 4/27/2022  
- Revamped CRM Staffing model with increased staffing 7 days/week.  
- Pro-active approach on DC planning for improved patient throughput and timely discharge.  
- Replicate PMC Poway discharge lounge staffing model at PMC Escondido to “pull” patients to the discharge lounge. Discharge Lounge Social Worker hired. Construction lounge estimated completion 7/5/22.  
- Meetings scheduled with stakeholders to operationalize the new Capacity Management plan once approved  
- CRM Strategic Planning meeting group launched 3/14/2022, meeting monthly.  
- Launched ED Rounds pilot at Escondido 6/22/22. |
Average Length of Stay – Acute by Days
Palomar Medical Center - Escondido

Average Length of Stay - Acute by Days
PMC Escondido

Days

July 4.04 4.19
August 4.16 3.7
September 4.08 3.88
October 4.18 3.74
November 4.33 4.5
December 4.09 4.96
January 3.99 5.88
February 3.96 5.15
March 4.04 5.03
April 4.14 5.17

FY20 FY21 FY22 Budget (3.72)
Average Length of Stay – Acute by Days
Palomar Medical Center - Poway

Average Length of Stay - Acute by Days
PMC Poway

FY20 FY21 FY22 Budget (4.76)

July 3.87 4.43 5.87 6.21
August 3.9 4.28 5.39 4.5
September 4.08 4.5 4.14 4.47
October 4.47 4.37 5.13 4.67
November 4.67 4.98 4.31 4.42
December 4.99 4.9 4.25 4.5
January 5.17 5.25 5.09 5.17
February 5.23 5.08 5.08 5.08
March 5.08 4.55 4.55 4.55
April 4.55 4.14 4.14 4.14
Average Length of Stay – Observation by Hours
Palomar Medical Center - Escondido

Observation by Hours
PMC Escondido

<table>
<thead>
<tr>
<th>Hours</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>
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<td>20</td>
<td>24</td>
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<td>27</td>
<td>23</td>
<td>30</td>
<td>30</td>
<td>22</td>
<td>19</td>
</tr>
<tr>
<td>Budget (22)</td>
<td>24</td>
<td>24</td>
<td>24</td>
<td>23</td>
<td>23</td>
<td>23</td>
<td>33</td>
<td>30</td>
<td>19</td>
<td>19</td>
</tr>
</tbody>
</table>

July August September October November December January February March April
Average Length of Stay – Observation by Hours

Palomar Medical Center - Poway

Observation by Hours

PMC Poway

FY20  FY21  FY22  Budget (22)

July: 20  22  27  32
August: 21  21  22  28
September: 20  21  22  27
October: 19  22  22  26
November: 22  23  27  27
December: 23  21  23  29
January: 22  24  22  22
February: 19  20  36  36
March: 19  19  34  36
April: 19  22  36  36
Emergency Department Volume Trends
Palomar Medical Center - Escondido

Emergency Department Patient Volume
PMC Escondido

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>FYTD 21</td>
<td>79,114</td>
</tr>
<tr>
<td>FYTD 22</td>
<td>80,258</td>
</tr>
<tr>
<td>Volume Difference</td>
<td>+ 1,144</td>
</tr>
</tbody>
</table>

COVID-19 Stay at Home Order (Mar. 19, 2020)
EMA Start - Aug 2021
PMC Escondido

Fiscal Year Volume
FYTD 21 | 79,114
FYTD 22 | 80,258
Volume Difference | + 1,144
Emergency Department Volume Trends

Palomar Medical Center - Poway

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Volume</th>
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<tbody>
<tr>
<td>FYTD 21</td>
<td>24,280</td>
</tr>
<tr>
<td>FYTD 22</td>
<td>28,972</td>
</tr>
<tr>
<td>Volume Difference</td>
<td>+ 4,692</td>
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</table>

COVID-19 Stay at Home Order (Mar. 19, 2020)  
EMA Start - Aug 2021  
PMC Poway
Discharge Lounge Utilization: – PMCE

![Discharge Lounge Utilization Chart](chart.png)
Discharge Lounge Utilization: – PMCP

Discharge Lounge staffed 6 days in December 2021 and staffed 0 days in Jan 2022 due to short staffing, increased census and acuity of patients.
ADDENDUM L
HCAHPS and ED Customer Service Data
Presented to
Board Quality Review Committee

Stephanie Baker, MBA, RN, CEN
Chief Administrative Officer
| SITUATION   | Customer Service HCAHPS Data: Timeframe July 2021 – June 2022  
Customer Service ED Data: Timeframe July 2021 – June 2022 |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>BACKGROUND</td>
<td>The HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care.</td>
</tr>
</tbody>
</table>
| ASSESSMENT | **PMC Escondido HCAHPS** – 2/10 metrics equal to or above CMS benchmark, or within 1 point of CMS benchmark for FY22 Q4 (Would Recommend Hospital, Discharge Information).  
**PMC Poway HCAHPS** – 0/10 metrics equal to or above CMS benchmark, or within 1 point of CMS benchmark for FY22 Q4.  
**PMCE Emergency Department** – 3/12 metrics equal to or above National Research Corporation (NRC) benchmark, or within 1 point of NRC benchmark for FY22 Q4 (Doctors Listened Carefully, Doctors Explained Understandably, Imaging Exceeded Expectations).  
**PMCP Emergency Department** – 8/12 metrics equal to or above National Research Corporation (NRC) benchmark, or within 1 point of NRC benchmark for FY22 Q4 (Doctors Courtesy & Respect, Doctors Listened Carefully, Doctors Explained Understandably, Nurses Listened Carefully, Nurses Explained Understandably, New Medicines Explained, Was Told What To Do If Not Better, Imaging Exceeded Expectations). |
| RECOMMENDATION | ➢ Refreshed Patient Experience Council (PEC) membership in May 2022 to include all IP, OP and ED Directors, Senior Leadership Team (SLT) and Executive Leader Team (EMT) across the District  
➢ 15+ IP, OP and ED “boot” camp sessions held over last six weeks with Directors, Managers and Supervisors to review data, priority matrix recommendations, and to develop a 90 day action plan for hardwiring foundational leader and staff behaviors- I.e. Leader Rounding on Staff, Leader Rounding on Patients, Performance Boards, Huddles, AIDET/Key Words, Bedside Shift Report, and Hourly Rounding  
➢ Hired a new Director of Patient Experience- start date 9/12/22 |
HCAHPS

*Results current as of 8/22/2022
Would Recommend Hospital

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Top Box Percentage</th>
<th>n (E)</th>
<th>n (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY22 Q1</td>
<td>74.6</td>
<td>668</td>
<td>169</td>
</tr>
<tr>
<td>FY22 Q2</td>
<td>73.1</td>
<td>603</td>
<td>150</td>
</tr>
<tr>
<td>FY22 Q3</td>
<td>71.9</td>
<td>601</td>
<td>133</td>
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<tr>
<td>FY22 Q4</td>
<td>72.1</td>
<td>556</td>
<td>160</td>
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</table>

- PMC Escondido HCAHPS
- PMC Poway HCAHPS
- CMS HCAHPS Average
Communication with Nurses

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY22 Q1</td>
<td>77.3</td>
<td>76.9</td>
<td>80.0</td>
</tr>
<tr>
<td>FY22 Q2</td>
<td>77.9</td>
<td>77.6</td>
<td>80.0</td>
</tr>
<tr>
<td>FY22 Q3</td>
<td>76.1</td>
<td>74.6</td>
<td>80.0</td>
</tr>
<tr>
<td>FY22 Q4</td>
<td>77.5</td>
<td>71.6</td>
<td></td>
</tr>
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</table>

n=673 (E) n=611 (E) n=608 (E) n=570 (E) n=170 (P) n=152 (P) n=134 (P) n=161 (P)
Communication with Doctors

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Top Box Percentage</th>
<th>FY22 Q1</th>
<th>FY22 Q2</th>
<th>FY22 Q3</th>
<th>FY22 Q4</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>n=667 (E)</td>
<td>n=607 (E)</td>
<td>n=605 (E)</td>
<td>n=568 (E)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>n=169 (P)</td>
<td>n=151 (P)</td>
<td>n=135 (P)</td>
<td>n=161 (P)</td>
</tr>
</tbody>
</table>

- PMC Escondido HCAHPS
- PMC Poway HCAHPS
- CMS HCAHPS Average
Room Kept Clean During Stay

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Top Box Percentage</th>
</tr>
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<tbody>
<tr>
<td>FY22 Q1</td>
<td>65.5</td>
</tr>
<tr>
<td></td>
<td>(E) n=666</td>
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<tr>
<td></td>
<td>(P) n=165</td>
</tr>
<tr>
<td>FY22 Q2</td>
<td>60.9</td>
</tr>
<tr>
<td></td>
<td>(E) n=601</td>
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<tr>
<td></td>
<td>(P) n=146</td>
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<tr>
<td>FY22 Q3</td>
<td>63.0</td>
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<td></td>
<td>(E) n=600</td>
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<td>(P) n=135</td>
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<tr>
<td>FY22 Q4</td>
<td>66.4</td>
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<tr>
<td></td>
<td>(E) n=562</td>
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<tr>
<td></td>
<td>(P) n=159</td>
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</table>

- **PMC Escondido HCAHPS**
- **PMC Poway HCAHPS**
- **CMS HCAHPS Average**
Quiet Around Room at Night

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
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</thead>
<tbody>
<tr>
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<td>56.2</td>
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<tr>
<td>FY22 Q2</td>
<td>51.5</td>
<td>44.6</td>
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</tr>
<tr>
<td>FY22 Q3</td>
<td>50.8</td>
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<tr>
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<td>50.9</td>
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Communication about Medicines

<table>
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<tr>
<th>Quarter</th>
<th>PMC Escondido HCAHPS</th>
<th>PMC Poway HCAHPS</th>
<th>CMS HCAHPS Average</th>
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<td>n=338 (E)</td>
<td>n=93 (P)</td>
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Source: Palomar Health
Care Transitions

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<th>CMS HCAHPS Average</th>
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Emergency Department

*Results current as of 08/22/2022
Rate Facility 0-10

Top Box Percentage

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<tr>
<th>Quarter</th>
<th>PMC Escondido ED</th>
<th>PMC Poway ED</th>
<th>NRC Average</th>
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<tbody>
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<tr>
<td>FY22 Q4</td>
<td>52.2</td>
<td>56.1</td>
<td>59.6</td>
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FY22 Q1: n=2633 (E) n=884 (P)  
FY22 Q2: n=2440 (E) n=812 (P)  
FY22 Q3: n=2500 (E) n=813 (P)  
FY22 Q4: n=2737 (E) n=896 (P)
Doctors Listened Carefully

<table>
<thead>
<tr>
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<th>NRC Average</th>
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Doctors Explained Understandably

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<td>FY22 Q4</td>
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n=3050 (E)  n=2819 (E)  n=2977 (E)  n=3246 (E)
n=1025 (P)  n=926 (P)    n=957 (P)    n=1042 (P)
Nurses Courtesy & Respect

<table>
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<th>NRC Average</th>
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<td>n=3462 (E)</td>
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Nurses Explained Understandably

<table>
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<td>n=3140 (E)</td>
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<td>n=3351 (E)</td>
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<td>n=1069 (P)</td>
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Quarter:
- PMC Escondido ED
- PMC Poway ED
- NRC Average
Was Told What To Do If Not Better

<table>
<thead>
<tr>
<th>Quarter</th>
<th>PMC Escondido ED</th>
<th>PMC Poway ED</th>
<th>NRC Average</th>
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<tbody>
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<td>FY22 Q1</td>
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<td>FY22 Q4</td>
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n=3019 (E) n=1015 (P) n=2795 (E) n=916 (P) n=2937 (E) n=937 (P) n=3200 (E) n=1031 (P)
Imaging Exceeded Expectations

- **FY22 Q1**: n=2021 (E), n=666 (P)
- **FY22 Q2**: n=1804 (E), n=572 (P)
- **FY22 Q3**: n=1908 (E), n=595 (P)
- **FY22 Q4**: n=2015 (E), n=662 (P)

- **PMC Escondido ED**
- **PMC Poway ED**
- **NRC Average**

Top Box Percentage:
- FY22 Q1: 45.6%
- FY22 Q2: 53.6%
- FY22 Q3: 57.0%
- FY22 Q4: 59.2%

Top Box Percentage (P):
- FY22 Q1: 42.9%
- FY22 Q2: 47.6%
- FY22 Q3: 49.0%
- FY22 Q4: 48.7%
Were You Seen In A Timely Manner

<table>
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<tr>
<th>Quarter</th>
<th>PMC Escondido ED</th>
<th>PMC Poway ED</th>
<th>NRC Average</th>
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<td>25.4</td>
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<tr>
<td>FY22 Q4</td>
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<td>36.2</td>
<td>25.1</td>
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</table>

n=3317 (E) n=984 (P) n=3045 (E) n=1034 (P) n=3249 (E) n=1122 (P)