PALOMAR HEALTH

POSTED
WEDNESDAY
MAY 17, 2023

BOARD QUALITY REVIEW COMMITTEE MEETING
AGENDA

Wednesday, May 24, 2023
4:00pm Meeting

PLEASE SEE PAGE 3 FOR MEETING LOCATION

	PLEASE TURN OFF CELL PHONES OR SET THEM TO SILENT MODE UPON ENTERING THE MEETING ROOM	Time	Form A Page	Target
CALL TO ORDER				**4:00**
1.	Establishment of Quorum	5	-	4:05
2.	**Public Comments**[1]	30	-	4:35
3.	**Action Item(s)**			
	a. ***Minutes: Board Quality Review Committee Meeting – March 22, 2022** (ADD A – Pp 16-19)	5	6	4:40
	b. *Approval of Contracted Services *Valerie Martinez, Sr. Director, Quality, Patient Safety & Inf Prevention* -BDCare Fusion IV Prep Workflow (ADD B – Pp 20) -Corticare EEG Monitoring (ADD C – Pp 21) -Olympus Equipment (Bronchoscopes) Service Agreement (ADD D – Pp 22)	5	7 8 9	4:45
	c. *Approval of Annual Review of Quality Assessment Performance Improvement (QAPI) & Pt. Safety Plan (ADD E – Pp 23-56) *Valerie Martinez, Sr. Director, Quality, Patient Safety & Inf Prevention* *Omar Khawaja, MD, Chief Medical Officer*	5	10	4:50
.	**Standing Item(s)**			
	a. Medical Executive Committee (MEC)/Quality Management Committee (QMC) Update *Andrew Nguyen, MD, PhD, Chair, Quality Management Committee, Palomar Medical Center Escondido* *Mark Goldsworthy, MD, Chair, Quality Management Committee, Palomar Medical Center Poway*	10	-	5:00
5.	**New Business**			
	a. **Spine Surgery and Total Joint Centers of Excellence Annual Report** (ADD F – Pp 57 - 70) *Brian Cohen, Sr. Director* *Andrew Nguyen, MD, PhD, Medical Director (Spine Surgery)* *James Bried, MD, Medical Director (Total Joint Surgery)*	5	11	5:05
	b. Laboratory Annual Report (including Blood Use & Pathology Reports) (ADD G – Pp 71 - 85) *Gloria Austria, Laboratory District Director* *Jerry Kolins, MD, Medical Director Laboratory*	5	12	5:10
	c. Respiratory Services Annual Report (ADD H – Pp 86 - 94) *Gloria Austria, Laboratory Services District Director* *Frank Bender, MD, Medical Director*	5	13	5:15
	d. **Quality Assurance & Performance Improvement (QAPI) 2022 Annual Rev & Prog Assessment to the Board of Directors** (ADD I – Pp 95 - 142) *Valerie Martinez, Sr. Director, Quality, Patient Safety & Inf Prevention* *Omar Khawaja, MD, Chief Medical Officer*	5	14	5:20
	e. Infection Prevention & Control Program 2022 Annual Review & Assessment (includes Antibiotic Stewardship) (ADD J – Pp 143 - 206) *Valerie Martinez, Sr. Director, Quality, Patient Safety & Inf Prevention* *Sandeep Soni, MD, Medical Director Infection Control* *Travis Lau, PharmD, Infectious Disease Specialist (Antibiotic Stewardship)*	5	15	5:25
6.	**Adjournment to Closed Session**	1	-	5:26

	a. Pursuant to CA Gov't Code §54962 & CA Hlth & Safety Code §32155; HEARINGS – Subject matter: rpt of quality assurance ctte.	10	-	5:36
7.	**Adjournment to Open Session**	1	-	5:37
8.	**Action Resulting from Executive Session**	1	-	5:38
FINAL ADJOURNMENT		2	-	5:40

VOTING MEMBERSHIP	***NON-VOTING MEMBERSHIP***
Linda Greer, RN – Chairperson, Board Member	**Diane Hansen, CPA**, President/Chief Executive Officer
Terry Corrales, RN, Board Member	**Omar Khawaja, MD**, Chief Medical Officer
Laura Barry, Board Member	**Hugh King**, Chief Financial Officer
Andrew Nguyen, MD, PhD – Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido	**Melvin Russell, RN, MSN**, Chief Nursing Executive Palomar Medical Center
Mark Goldsworthy, MD – Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway	**Kevin DeBruin, Esq**., Chief Legal Officer
Laurie Edwards Tate, MS – Board Member 1st Alternate	**David Lee, MD**, Medical Quality Officer
	Valerie Martinez, RN, BSN, MHA, CPHQ, CIC, Senior Director Quality and Patient Safety, Infection Prevention

NOTE: If you have a disability, please notify us by calling 44.281.2505, 72 hours prior to the event so that we may provide reasonable accommodations

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

[1] *3 minutes allowed per speaker with a cumulative total of 9 minutes per group. For further details & policy, see page 4.*

PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE

https://meet.goto.com/754797621
Access Code: 754-797-621

PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM

New to GoToMeeting? Download the app at:
https://global.gotomeeting.com/install

Public Comments and Attendance at Public Board Meetings

Board Quality Review Committee Location Options

- The Linda Greer Conference Room, 2125 Citracado Parkway, Suite 300, Escondido, CA 92029
  - Committee members who are elected members of the Board of Directors will attend at this location, unless otherwise noticed below.
  - Elected members of the Board of Directors who are not members of the Committee and wish only to observe, non-Board member attendees, and members of the public may also attend at this location.
- https://meet.goto.com/754797621 or Dial in using your phone at 866-899-4679; Access Code: 754797621#[1]
  - Elected members of the Board of Directors who are not members of the Committee and wish only to observe, non-Board member attendees and members of the public may attend the meeting virtually utilizing the above link.

[1] *New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/754797621*

PALOMAR HEALTH
Reimagining Healthcare

Board Quality Review Committee Meeting

Meeting will begin at 4:00 p.m.

Request for Public Comments

If you would like to make a public comment, please submit a request by doing the following:

- **Enter your name and "Public Comment" in the chat function once the meeting opens**

Those who submit a request will be called on during the Public Comments section and given 3 minutes to speak

Public Comments Process

Pursuant to the Brown Act, the Board of Directors and Board Committees can only take action on items listed on the posted agenda. To ensure comments from the public can be made, there is a 30-minute public comments period at the beginning of the meeting. Each speaker who has requested to make a comment is granted three (3) minutes to speak. The public comment period is an opportunity to address the Board of Directors or a specific Board Committee on agenda items or items of general interest within the subject matter jurisdiction of Palomar Health.

PALOMAR HEALTH

BOARD QUALITY REVIEW COMMITTEE MEETING
ATTENDANCE ROSTER -
CALENDAR YEAR 2023

[P = PRESENT V = VIRTUAL E = EXCUSED A = ABSENT G = GUEST]

VOTING MEMBERS	**2.22.2023**	**3.22.2023**	**5.24.2023**				
LINDA GREER, RN, Chairperson, Board Member	P	P					
TERRY CORALES, RN, Board Member	P	P					
LAURA BARRY, Board Member	E	P					
ANDREW NGUYEN, MD, PhD, Chair, Medical Staff Quality Management Committee, PMC Escondido	A	P					
MARK GOLDSWORTHY, MD, Chair, Medical Staff Quality Management Committee, PMC Poway	P	E					
Laurie Edwards-Tate, MS- 1ST *Board Alternate*		P					
STAFF ATTENDEES/NON-VOTING MEMBERS							
DIANE HANSEN, CPA, President & CEO	P						
OMAR KHAWAJA, MD, Chief Medical Officer	P	P					
MEL RUSSELL, RN, MSN, Chief Nursing Executive, PMC	P	P					
HUGH KING, Chief Financial Officer							
TRICIA KASSAB, EdD., RN, FACHE, Vice President, Quality and Patient Safety	P	E					
VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Sr. Director, Quality and Patient Safety	P	P					
DAVID LEE, MD, Medical Quality Officer	P	P					
KEVIN DEBRUIN, Esq., Chief Legal Officer	V						
SALLY VALLE – Committee Assistant	P	E					
INVITED GUESTS	**SEE TEXT OF MINUTES FOR NAMES OF INVITED GUESTS**						

Board Quality Review Committee Minutes
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Sally Valle, Committee Assistant

Background: Minutes from the Wednesday, March 22, 2023, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, March 22, 2023, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Contracted Services – BD Carefusion IV Prep Workflow Program
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Valerie Martinez, Sr. Dir Quality and Patient Safety
Omar Khawaja, MD, Chief Medical Officer

Background: The Contracted Services Evaluation report for BD Carefusion IV Prep Workflow Program 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:

Board Quality Review Committee
Contracted Services – CortiCare, Inc.
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Valerie Martinez, Sr. Dir Quality and Patient Safety
Omar Khawaja, MD, Chief Medical Officer

Background: The Contracted Services Evaluation report for CortiCare, 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:

Board Quality Review Committee
Contracted Services – Olympus
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Valerie Martinez, Sr. Dir Quality and Patient Safety
Omar Khawaja, MD, Chief Medical Officer

Background: The Contracted Services Evaluation report for Olympus 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:

Board Quality Review Committee
Annual Review of Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Valerie Martinez, Sr. Dir Quality and Patient Safety
Omar Khawaja, MD, Chief Medical Officer

Background: The Annual Review of the Quality Assessment Performance Improvement (QAPI) & Patient Safety 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:

Board Quality Review Committee
Annual Report – Spine Surgery & Total Joint Centers of Excellence
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Brian Cohen, Sr. Director
Andrew Nguyen, MD, PhD, Med Dir (Spine Surgery)
James Bried, MD, Medical Director (Total Joint)

Background: The annual report for the Spine Surgery & Total Joint Centers of Excellence 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:

Board Quality Review Committee
Annual Report – Laboratory Services
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Gloria Austria, District Director
Jerry Kolins, Medical Director

Background: The annual report for the Laboratory Services 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:

Board Quality Review Committee
Annual Report – Respiratory Services
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Gloria Austria, District Director
Frank Bender, Medical Director

Background: The annual report for Respiratory Services 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:

Board Quality Review Committee
Quality Assurance & Performance Improvement (QAPI) 2022
Annual Review & Program Assessment
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Valerie Martinez, Sr. Director, Quality & Patient Safety
Omar Khawaja, MD, Chief Medical Officer

Background: The Quality Assurance & Performance Improvement (QAPI) 2022 Annual Review & Program Assessment 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:

Board Quality Review Committee
Infection Surveillance, Control & Prevention Program 2022
Annual Review & Assessment (*incl* Antibiotic Stewardship)
Wednesday, May 24, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 24, 2023

FROM: Valerie Martinez, Sr. Director, Quality & Patient Safety
Sandeep Soni, MD, Medical Director
Travis Lau, Infectious Disease Specialist

Background: The Infection Surveillance, Control & Prevention Program 2022 Annual Review & Assessment (including Antibiotic Stewardship) 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:

PALOMAR HEALTH

ADDENDUM A

BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, MARCH 22, 2023			
AGENDA ITEM	***CONCLUSION/ACTION***	***FOLLOW UP / RESPONSIBLE PARTY***	***FINAL?***
NOTICE OF MEETING			
The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health (PH) website on Thursday, March 16, 2023, consistent with legal requirements.			
CALL TO ORDER			
The meeting, which was held in the Linda Greer Board Room at 2125 Citricado Parkway, Suite 300, Escondido, CA 92029, and virtually, 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, RN, Director Terry Corrales, RN, Director Laura Berry; and PMC Poway Chief of Staff, Sam Filiciotto, MD for Physician Chair Mark Goldsworthy, MD, Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway, Physician Chair, Andrew Nguyen, MD, Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido			
PUBLIC COMMENT			
• There were no public comments. • Board Quality Review Committee Alternate Laurie Edwards-Tate was present.			
ACTION ITEMS:			
A. *** REVIEW / APPROVAL: OPEN/CLOSED SESSION MEETING MINUTES / ATTENDANCE ROSTER – FEBRUARY 22, 2023**			
The BQRC meeting minutes from February 22, 2023, were presented for review and approval. Director Laura Berry, 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 February 22, 2023, as submitted. Roll call voting was utilized. Director Corrales - Aye Andrew Nguyen, MD - Aye Director Greer – Aye Director Barry - Aye	N/A	Y

	All in favor. None opposed. The meeting minutes were approved as submitted.		
B. *** REVIEW / APPROVAL: APPROVAL OF CONTRACTED SERVICES ANNUAL EVALUATIONS**			
The Premier Laser Services, Stericycle and Valley Pathology Medical Group, Inc., service contracts were reviewed and approved. Valerie explained that all three service contracts met their requirements for the year.	**MOTION:** by Director Laura Berry, second by Director Terry Corrales, to approve the service contracts for Premier Laser Services, Stericycle, and Valley Pathology Medical Group, Inc. Roll call voting was utilized. Director Greer, RN - Aye Director Corrales, RN- Aye Director Berry - Aye Andrew Nguyen, MD - Aye All in favor. None opposed.	N/A	Y
STANDING ITEMS:			
A. **MEDICAL EXECUTIVE COMMITTEE (MEC)/QUALITY MANAGEMENT COMMITTEE (QMC) UPDATE**			
Dr. Nguyen provided a brief update on the quality measures being worked on at the hospital. Highlights were: • Posey bed compliance continues to be sustained for a 4th year in a row. • The acquisition of radio frequency enabled technology was recommended at the last meeting to support the Obstetrical Unit. • Work continues on improving HCAHPS scores overall, especially in the Emergency Departments, where our patient volumes continue to be one of the highest in our County. Dr. Nguyen went on to note that we have the highest volume of patients being transported via ambulance, in the County. • Various Information Technology project requests were recently approved at our last Interdisciplinary Governance Council. • In the Emergency Department Bi-annual report, over the last two months, there was a high number of boarding hours. We anticipate that the opening of two new floors will alleviate this issue. • The Trauma Department received their ACS accreditation as anticipated in 2022. Their next accreditation year will be in 2025 • Our Stroke Program is due for their first re-certification of a Thrombectomy Capable Stroke Center at the Escondido campus.	**MOTION:** N/A		Y

• Discharge summary compliance doing well since October, 2022. • Medication reconciliation moving in the right direction. Have recently hired additional Pharmacy Medication Technicians. Director Barry inquired as to whether the new Kaiser facility will have emergency services. Dr. Khawaja responded that they would however they will not have services like STEMI (ST Elevation Myocardial Infarction), stroke or Trauma services. He went on to note that Palomar Health has about 20-30 patients in our facility every day, and we anticipate those beds opening up to assist with our non-Kaiser patient volume. Director Corrales noted that we would still be a trauma center which was re-affirmed by Dr. Steele who noted that the trauma service involves a lot of moving parts, and is thankful for the hard work of the team that includes, Melinda Case, Zach, Honda and the Trauma Team Nurse Leads (TNTLs). He also noted that currently, there is a review of the catchment area being done at the County level. This review is required to be done every 10 years. He is interested to see what the results are however does not expect any changes.			
NEW BUSINESS:			
A. **EMERGENCY DEPARTMENT SERVICES ANNUAL REPORT**			
The report was reviewed prior to the meeting. There were no questions posed at the meeting.	**MOTION:** N/A		Y
B. **TRAUMA PROGRAM ANNUAL REPORT**			
Director Barry requested further information on the "Cut Down, Annoyed, Guilty and Eye Opener (CAGE)" audit. Dr. Khawaja explained that this a screening that falls under the Trauma Program, to assess whether patients are at risk for alcohol abuse. We track to identify those patients who are at risk and intervention can be provided during their hospital stay. Melinda Case, added that this a requirement of the Trauma Program, to assess whether illicit drug use or alcohol played a part in the patient's injury. If so, education would be provided to the patient.	**MOTION:** N/A	N/A	Y
C. **STROKE PROGRAM ANNUAL REPORT**			
The report was reviewed prior to the meeting. There were no questions posed at the meeting.	**MOTION:** N/A	N/A	Y
D. **REGULATORY ANNUAL UPDATE**			
The report was reviewed prior to the meeting. There were no questions posed at the meeting.	**MOTION:** N/A	N/A	Y

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

➢ There were no action items identified in the Closed Session of the meeting.	
PUBLIC COMMENTS	
There were no public comments.	
FINAL ADJOURNMENT - The meeting adjourned at 5:30 p.m.	**MOTION:** N/A

SIGNATURES:

COMMITTEE CHAIR

_____
Linda Greer, RN

COMMITTEE ASSISTANT

_____
Sally Valle

Palomar Health - Review of Contract Service

Name of Service: _BD Carefusion - IV Prep Workflow program_____ ADDENDUM B

Date of Review: 4/20/2023 **Name / Title of Reviewer:** _Dondreia Gelios, District Director of Pharmacy

Nature of Service (describe): __Annual Evaluation_____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Met	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Met	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	Met	
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.		Current program did not meet expectation. We are negotiating new contract with additional software
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.		Current program did not meet expectation. We are negotiating new contract with additional software

Performance Metrics

METRIC	__1___ QTR	___2__ QTR	__3__ QTR	__4__ QTR	Cumulative Total
Responsiveness to workflow issues with beta-site program	100%	100%	100%	100%	100%
Identified issues resolved in timely manner	0%	0%	0%	0%	0%

Comments
Palomar Health is a beta site for the BD IV Prep Workflow program. Multiple medications cannot be compounded with the current program. Working with BD to improve software. BD has agreed to adjust current contract to include MedKeeper and discount organization by approximately $50,000/year due to the issues identified.

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: _____

ADDENDUM C

Corticare Inc.
Review of Contract Service

Name of Service: CortiCare Monitoring Service

Date of Review: 4/20/23 **Name / Title of Reviewer:** Ashley Rowe/7W Nurse Manager

Nature of Service (describe): __Continuous Monitoring of EMU patients for seizure activity replacement____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	x	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	x	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	x	
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.	x	
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.	x	

Performance Metrics

METRIC	__1___ QTR	___2__ QTR	__3__ QTR	_4___ QTR	Cumulative Total
Continuous Remote monitoring of EMU	100%	100%	100%	100%	100%
Timely notification for any seizure event lasting more than 5 minutes	100%	100%	100%	100%	100%

Comments

Without contracted service we would have to increase the FTE for the EEG department to meet continuous monitoring of the EMU patients.

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

Olympus Inc.
Review of Contract Service

Name of Service: Olympus Equipment Service

Date of Review: ___4/2023 **Name / Title of Reviewer:** Kerwin Pipersburgh, Sr. Mg Pulmonary EEG

Nature of Service (describe): _____Bronchoscope/EBUS scope repair with loaner replacement_____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	x	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	x	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	x	
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.	x	
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.	x	

Performance Metrics

METRIC	__1___ QTR	___2__ QTR	__3__ QTR	_4___ QTR	Cumulative Total
% timely repair - > 90% goal	100%	100%	100%	100%	100%
% response within 4 hour service call window – > 90% goal	100%	100%	100%	100%	100%

Comments
Ransom ware attack in end of 3rd quarter caused significant delays in scope repair. EBUS scope components were returned without repair and were sent in back in 10/2021 for repair. The team is working with the vendor on a back-up plan to mitigate any risk of ransom ware that could delay service response. Other than 3rd quarter response time the other 3 quarters met the metric 100%. There was no impact to patient care.

Conclusion (check one)

X Contract service has met expectations for the review period. See above for 3rd quarter < than goal.

☐ 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 E

PALOMAR HEALTH

DocID: 11234
Revision: 19
Status: Official

Source: Administrative Plans

Applies to Facilities: All Palomar Health Facilities

Applies to Departments: All Departments

Plan : Quality Assessment Performance Improvement (QAPI) and Patient Safety Plan

Differences between version ~~19~~ and 20 .

I. **PURPOSE** :

A. To outline the framework for a leadership driven, systematic, interdisciplinary approach to continuous improvement using our performance improvement model known as Plan, Do, Study, Act (PDSA). Our efforts will focus on all care and service outcomes for our patient populations and meet the mission, vision, and standards of excellence for Palomar Health as follows:

1. Mission: The mission of Palomar Health is to heal, comfort, and promote health in the communities we serve.
2. 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.
3. Values: Excellence, Teamwork, Service, Compassion, Trust and Integrity.
4. Palomar Health's Patient Safety Officer/s are the Senior Director of Quality/Patient Safety and the Medical Quality Officer.

II. **DEFINITIONS:**

A. Quality Assessment Performance Improvement (QAPI) Plan

1. QAPI is the merger of two complementary approaches to quality, namely Quality Assessment (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways:
   a. QA is a process of meeting quality standards and assuring that care reaches an exceptional level. Hospitals and health systems typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is the data collection and analysis through which the degree of conformity to predetermined standards and criteria are exemplified. If the quality, through this process is found to be unsatisfactory, attempts are made to discover the reason for this. On the basis of this, remedial actions are instituted and the quality reevaluated after a suitable time period.
   b. PI is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches in order to fix underlying causes of persistent/systemic problems. PI in hospitals and health systems across the care continuum aims to improve processes involved in health care delivery and quality of life. ~~PI can make good~~ .
   c. QAPI is a data-driven, proactive approach to improving the quality ~~even better~~ of care and services across the care continuum. The activities of QAPI engage members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions .
2. ~~QAPI is a data~~ A Performance Improvement Project (PIP) typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.
3. Performance Improvement Activities (PIA), are typically smaller in scope than a PIP and focused at the unit level.

4. A Patient Safety Event is an event, or condition (not related to the natural course of the patient's illness or underlying condition) that could have resulted or did result in harm to the patient. Patient Safety events the reach a patient and result in death, permanent harm, or severe temporary harm, are also known as adverse events, sentinel events or never events.
5. A Good Catch/Near Miss is a patient safety event that does not reach the patient as a result of a built - ~~driven~~ in detection barrier , ~~proactive approach to improving the quality of care and services across the care continuum~~ mitigation or chance . ~~The activities of QAPI engage members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions~~
6. An unsafe condition is neither a patient safety event nor a Good Catch/Near Miss but is a circumstance that make the occurrence of such an event more likely .

III. **Authority and Responsibility**

A. Governing Body
The Governing Body authorizes the establishment of this performance improvement program. This Governing Body is responsible for assuring:
1. An ongoing program for quality improvement is defined, implemented, and maintained.
2. An ongoing program for patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
3. An organization-wide quality assessment and performance improvement efforts address priorities for improved quality of care, and patient safety and that all improvement actions are evaluated.
4. Clear expectations for safety are established.
5. Adequate resources are allocated for measuring, assessing, improving, and sustaining the health system's performance and patient safety.
6. A determination of the number of distinct improvement projects ~~is~~ are conducted annually.

B. Medical Executive Committee / Quality Management Committee
The Governing Body delegates the development, implementation, and evaluation of this program to the Medical Executive Committee (MEC). The MECs are responsible for monitoring and improving the quality of care, safety and service provided by its medical staff. The MEC has formed a Quality Management Committee to carry out this responsibility.

C. Administration & Management
The Governing Body also delegates the development, implementation, and evaluation of this program to the organization's Administrative team. Administration is responsible for improving the quality of care, safety, and service provided by organization staff. The Administrative team has developed structures and processes to carry out this responsibility.

D. Further Delegation of Authority and Responsibility ~~The~~ ; the MEC and/or Administration & Management may further delegate aspects of this program as necessary.

IV. **Core Components**

A. The following are the core components of the framework:
1. Recognizing that defects are primarily from processes and systems, not people. Performance improvement will focus on systems, processes and outcomes.
2. Leadership driven by a commitment to a culture of safety and transparency that uses a ~~Quality Dashboard as the~~ monitoring tool.
3. Data driven based on evidenced based practices using national benchmarks (when available) and comparative data.
4. Integrated and coordinated processes to engage all levels of leadership, physicians, employee staff, and community members as appropriate .

5. Proactive by design in order to sustain continuous performance improvement, promote high reliability, quality, safe patient care and services.
6. Communication through a common language created by an ongoing process to prioritize Quality Assessment/Performance Improvement opportunities using consistent methods and statistical tools that are the tenets of PDSA and when appropriate Lean- i.e., 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 - u ~~nderstand~~ understand process variation and capability, S - select a strategy for continued improvement.
7. A calendar of reporting to ensure ongoing systematic communication to all key constituents, ensure accountability and maintain the ongoing improvement gains for all continuous quality assessment/performance improvement activities.
8. Educational programs and meetings to enhance statistically-based quality assessment/performance improvement tools for every level of leadership, physicians, and staff.
9. Standardized processes for investigation of events and followup on ~~near miss adverse~~ Good Catches/Near Misses , ~~adverse events and sentinel events~~ Patient Safety Events, Sentinel Events and unsafe conditions . These standardized processes address:
    a. An investigation into the cause of the adverse event may be undertaken pursuant to the Medical Center's Review Process .
    b. The investigation would be conducted for the purpose of the evaluation and improvement of the quality of care.
    c. What practice/process change is required to prevent recurrence.
    d. How the practice/process change will be accomplished.
    e. Who is responsible for the practice/process change.
    f. Timeline for completion.
    g. Description of the monitoring ~~process~~ and sustainment of processes to prevent a recurrence. ~~Novel Virus Covid-19 Pandemic Mitigation Plan (Refer to COVID-19 Exposure Control Plan) CMS is waiving 482.21(a)-(d) and (f), and 485.641(a), (b), and (d), which provide details on the scope of the program, the incorporation, and setting priorities for the program's performance improvement activities, and integrated QAPI. Any improvements to the plan must focus on the Public Health Emergency. While this waiver decreases the burden associated with the development of a hospital or QAPI program, the requirement that hospitals maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program will remain. Upon declaration of end of pandemic, QAPI will return to normal processes. Waivers will be tracked and monitored accordingly throughout Pandemic.~~

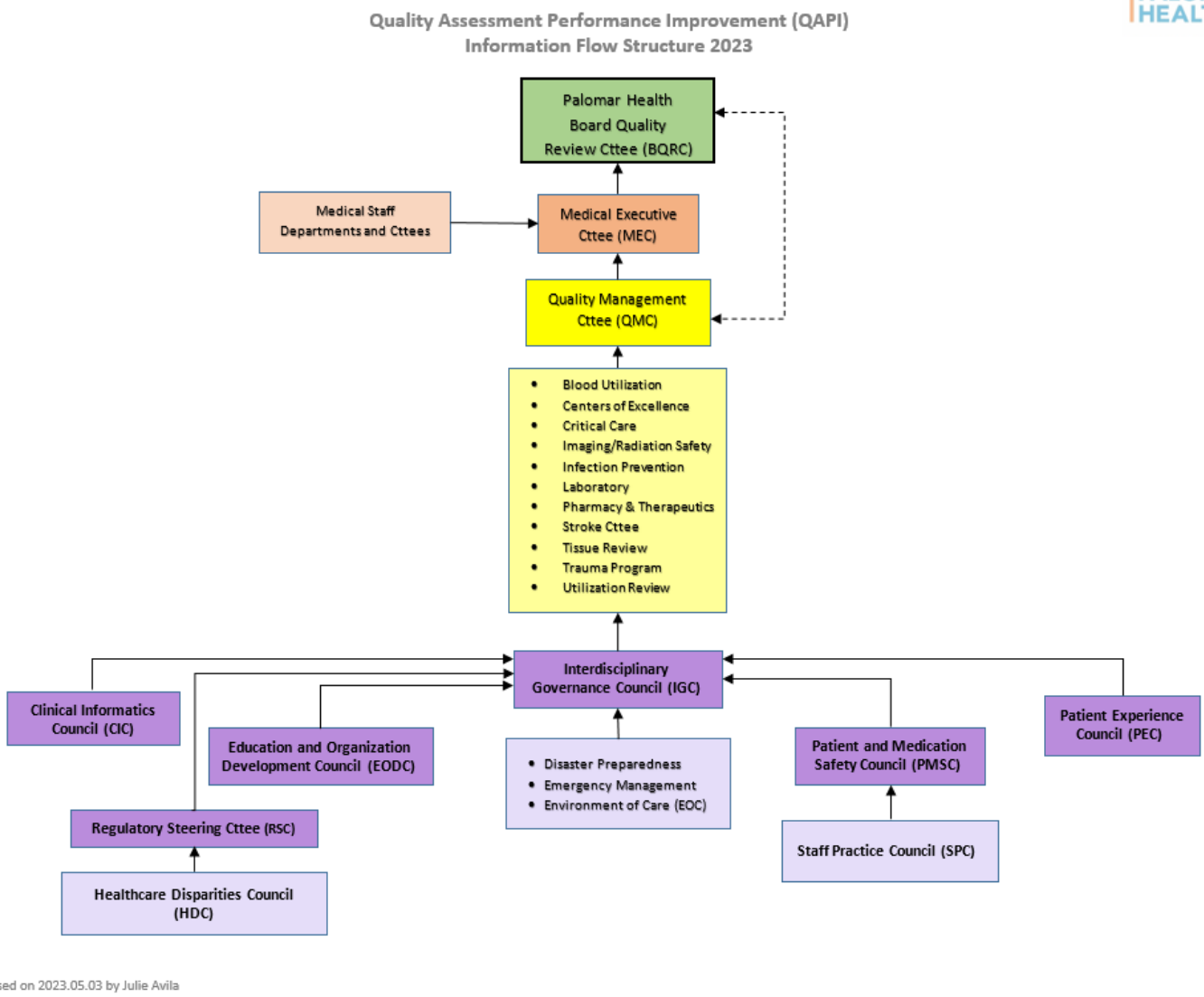
V. **Goals**

A. As part of the annual evaluation of the Quality Assessment Performance Improvement (QAPI) activities and goals are identified for each calendar year to ensure continuous improvement. The following actions should be taken in forming specific goals:

1. Enhance key processes to ensure that "Evidence Based Practices" are considered in all opportunities for improvement of care and services.
2. Integrate the Quality Assessment/Performance Improvement Plan into a culture of safety that recognizes the key behaviors and attitudes that result in a safe environment for patients, families, employees, and physicians.
3. Create a support structure for data collection and analysis through collaboration with Information Technology, Strategy, and Finance when appropriate .
4. Review and revise as necessary the peer review methodology to ensure a quality driven process that provides a consistent, objective, data-driven evaluation of physician and nurse performance via their respective peer review programs.
5. Identify core components for Quality Assessment/Performance Improvement methods and tools for the organization.

B. The organization has an effective program that assesses the quality and safety of its services including Local, State, and Federal regulations to identify opportunity for improvement, and works to address those opportunities. Services include but not limited to:
   1. Management of the Care Environment - to include but not limited to, risk assessments and environmental surveillance as it pertains to patient safety. Refer to Safety Management Plan # 11495.
   2. Management of the Medical Record
   3. Infection Prevention and Control and Antibiotic Stewardship
   4. Patient Rights
   5. Medication Management
   6. Anesthesia Services
   7. Dietary Services
   8. Discharge Planning
   9. Laboratory Services
   10. Nuclear Medicine Services
   11. Nursing Services
   12. Operative and Invasive Services
   13. Outpatient Services
   14. Radiology Services
   15. Rehabilitation Services
   16. Respiratory Services
   17. Contracted Service:
      1. All contracted services including one for shared services, ~~including one for shared services and joint ventures,~~ patient care services, and all other services, provided under contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital. The hospital will assess the services furnished directly by hospital staff and those services provided under contract, identify quality ~~and~~ , assigned performance ~~problems~~ metric for compliance and identify corrective or improvement activities for those metrics or elements that are less than the established thresholds.
      2. The Medical Staff , ~~implement appropriate corrective or improvement activities~~ pursuant to Bylaws , ~~and~~ Section 16.11-16.1.4 shall review all contracted serviced provided by the members of the Medical Staff. The outcome of these reviews will be presented to the Medical Executive Committee's (MEC) on an annual basis, and an attestation signed on behalf of the MEC attesting that the metrics and quality of services have met the established thresholds will be sent to the Board of Director Chair to ensure ~~the monitoring and sustainability of those corrective or improvement activities~~ compliance with the quality of the Medical Staff contracts . .
   18. Patient Grievances - The hospital's Governing Body has delegated the grievance process to the Quality/Patient Safety Department. The Quality/Safety department receives, reviews, and collaborates with appropriate unit/department leader and/or physician, in addition to, but not limited to; Regulatory, Finance, and Risk Management for review and investigation. Upon completion of the investigation, a letter will be sent to the complainant informing them of the outcome. Outcome data will be presented to various stakeholder meetings including up to the Governing Body. ~~Acute Hospital Care at Home Program (AHCaH) - The program has a set of designated metrics that include patient census within the program, unanticipated mortalities, and the critical event escalation rates per volume. These metrics are reported to CMS as required and reported annually to the Quality Management Committee.~~

VI. Reporting Structure, Responsibilities, and Constituents of the QAPI Plan



A. Board Quality Review Committee (BQRC):

1. Duties:

a. Pursuant to the BQRC bylaws. The Board Quality Review Committee shall ~~also~~ review the prioritized proposed performance improvement projects and patient safety activities and shall report to the governing body.

2. Composition:

a. Voting Membership: The committee shall consist of five voting members, including three members of the Governing Body and the Chairs of the Quality Management Committees (QMC) of Palomar Medical Center Escondido and Palomar Medical Center Poway. Nonvoting Members include: The President and Chief Executive Officer; the Chief ~~Administrative Officer, the Chief~~ Medical Officer; Medical Quality Officer; the Chief Legal Officer; the Chief Nurse Executive, Vice President of Quality/Patient Safety, Senior Director of Quality/Patient Safety.

B. Medical Staff Executive Committees (MEC):

1. Duties:

a. The Medical Executive Committee (MEC) is the primary governance committee for the independent medical staff. The MEC, with input from the medical staff, makes key

leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. They are also responsible for adopting and implementing medical staff policies and procedures and creating medical staff appointment and reappointment criteria.

b. The ~~MECs review and approve~~ MEC reviews and approves all recommendations submitted by the Quality Management Committee and initiate any special studies or recommendations as deemed appropriate to maintain an effective program.

2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the Medical Staff Bylaws.

C. The Quality Management Committee (QMC) of the Medical Staff:
1. Purpose:
   a. The Quality Management Committees of the Medical Staff will regularly review specified performance metrics recognized as measurements of quality and safety, including but not limited to: blood usage, medication us age, pharmacy and therapeutics, nutrition, medical record timeliness, special care review, utilization review, nursing sensitive indicators (e.g., falls, hospital acquired pressure injuries, and medical restraint use), infection control, patient safety, and other items identified by this committee and in the body of this plan. Appropriate summaries and recommendations first referred to the appropriate clinical departments and subcommittees are then forwarded to the respective Medical Staff Executive Committee for review and approval.
   b. The QMC reviews and prioritizes proposed performance improvement projects as recommended by the Interdisciplinary Governance Council (IGC).
   c. The QMC provides oversight for the Quality Assessment Performance Improvement (QAPI) activities of medical staff, nursing, and clinical departments and committees.
2. Composition:
   a. The Committee has Physician Chairs (preferably the Chief of Staff-elects at each licensed acute care facility). Committee members will include the department chairs-elect of the medical staff or their designee, along with representatives from Medical Staff, Administration, Nursing, Department Directors, and staff responsible for overseeing quality assessment and performance improvement activities.
3. Voting Membership: Physicians and Executive Leadership Team (VPs, CNE, Executives) present at time of voting.

D. Interdisciplinary Governance Council (IGC):
1. Purpose: The Interdisciplinary Governance Council is responsible for providing oversight and approval for all councils in the IGC infrastructure. The Governance Council will work closely with the Regulatory Steering Committee and QMC. The intention is to improve communication, efficiency, and effectiveness in regard to decision making and to provide a mechanism and structure for a communication and approval process that will expedite process improvement changes as well as implementation.
2. Governance: The IGC is the oversight council for Learning and Organizational Development Council (LODC), Clinical Informatics Council (CIC), ~~the~~ Patient and Medication Safety Council (PMSC) ~~and~~ , Patient Experience Council, the Regulatory Steering Committee, Environment of Care Committee and Disaster Preparedness Committee. The Staff Practice Council (SPC) ~~will report through the~~ reports up to PMSC.

E. Clinical Informatics Council (CIC):
1. Purpose: The Clinical Informatics Council is an interdisciplinary group whose purpose is to serve as the oversight body for all clinical Informatics projects. The council discusses and oversees clinical informatics requests, and change orders to determine priority and provide feedback and

support to the end users. This council is the team that advises on priorities and recommendations regarding electronic health record (EHR) support for safe patient care.

2. Governance: This council will make recommendations for final approval to the Interdisciplinary Governance Council based on the authority level granted. Recommendations regarding project prioritization, strategy, or capital expense will then be referred to the IT Steering Committee.

F. Learning and Organizational Development Council (LODC) :

1. Purpose: The purpose of the Learning and Organizational Development Council (LODC) is to develop, implement, evaluate, and provide oversight over integrated education and leadership development plan that meets regulatory requirements, as well as to facilitate implementation of strategic initiatives that support a culture of excellence.
2. Governance: The LODC will make recommendations regarding education plans and practices to the IGC for approval.

G. Regulatory Steering Committee :

1. Purpose: The purpose of the Regulatory Steering Committee is to provide guidance and oversight for the implementation and monitoring of CMS Conditions of Participation (COP), Title 22 and the Joint Commission (TJC) accreditation standards for maintaining Medicare Reimbursement and Quality Accreditation approved status as an organization. The oversight and guidance also applies to all applicable local, state, and federal regulatory regulations across the system.
2. Governance: The committee will provide a report to the IGC on a regular basis and any recommendations to IGC for approval.

H. Patient and Medication Safety Council (PMSC) :

1. Purpose: The purpose of the Patient and Medication Safety Council ~~is to promote~~ includes but not limited to the following: Promote a culture of safety through oversight and implementation of the Quality Assessment and Performance Improvement (QAPI) Plan. The council will ensure the development of documents, policies, procedures, and practices that reflect evidence-based practice (EBP) and meet the standards of professional organizations, state and federal professional practice acts, scopes of practice, as well as regulatory standards. ~~Responsibility will include oversight for~~ Incorporate Medication Safety reports and Medication Error Reduction Plan (MERP) updates. S Support medication safety and recommendations for process improvement projects that will facilitate an interdisciplinary approach to the Plan, Do, Study, Act (PDSA) model for daily work processes. Review Sentinel Event Alerts (SEA), Institute for Safe Medication Practices (ISMP), and National Patient Safety Goals (NPSG) and discuss follow up, as appropriate. Recommend Failure Mode Effects Analysis (FMEA) for approval and review and monitor performance improvement activities that have been performed.
2. Governance: The Patient and Medication Safety Council will make recommendations for final approval of policies to be sent to specialty committees (e.g. Infection Prevention, QMC) and will refer policies/procedures to IGC for approval for posting. This council will also make recommendations regarding various committee and project proposals to the IGC for approval .

I. Patient Experience Council (PEC):

1. Purpose: The purpose of the Patient Experience Council is to provide oversight and guidance on achieving and sustaining patient-centered care. The council will oversee the development, implementation and monitoring for all best practices, performance metrics, policies and procedures that enhance and/or promote the ideal patient and family experience while always advocating for the communities we serve, aligning with our mission, vision, and values.
2. Governance: The Patient Experience Council will make recommendations regarding performance improvement plans and best practices to the Interdisciplinary Governance Council for approval.

J. Staff Practice ~~Council:~~ Council (SPC):

1. Purpose: The purpose of the Staff Practice Council is to facilitate staff input and feedback from an interdisciplinary perspective into decisions effecting patient care and professional practice. The council also seeks to enhance sharing and reporting of unit/dept. specific work plans related to the Plan for Patient Care Services, the organizational strategic plan related to clinical practice, patient and employee satisfaction, and quality and patient safety. The work, conversations, and recommendations from the council should be based on the Relationship Based Care model. The SPC serves as an Interdisciplinary fall team for the system. Teams reporting into SPC include: Nursing Peer Review; Safe Patient Handling and Patient Classification.
2. Composition: The Staff practice Council (SPC) will be made up of representatives of the Unit/Department Based Practice Council Chairs, a sponsor from the Patient and Medication Safety Council (PMSC), and staff representatives from teams that have been meeting to make decisions with staff input (e.g. Nursing Peer Review, Patient Classification, and Safe Patient Handling).
3. Governance: This council will report to the PMSC. The PMSC will provide guidance and mentoring for professional practice. Sponsors will provide updates from (PMSC) and also the Interdisciplinary Governance Council (IGC).

K. Medical Staff Committees: Pursuant to the Medical Staff Bylaws, Medical Staff departments and committees are responsible for the quality of care, service and safety of patient care delivered by the members of their respective departments. Medical Staff Departments and Committees shall demonstrate quality assurance and performance improvement by:
1. Participating in departmental and quality assessment/performance improvement activities.
2. Utilizing results and recommendations from interdisciplinary performance improvement efforts to improve services.
3. Utilizing information from the Medical Staff Peer Review Committee (MSPRC) and Quality Department that includes data addressing each of the six physician core competencies for credentialing, privileging and the reappointment process.
4. Reviewing and analyzing summary reports of trended data reported out by department and/or by physician for processes dependent primarily on the activities of one or more individuals with clinical privileges.
5. Sharing responsibility for planning, designing, measuring, assessing, and improving the overall safe care of patients.

L. Medical Staff Peer Review Committee (MSPRC):
1. Duties:
   a. Review cases referred by physicians and staff or by screening criteria with the goal of improving physician performance at the individual and aggregate levels, improving patient outcomes, and supporting a culture of compassion and respect.
   b. Promote efficient use of physician and quality staff resources.
   c. Provide accurate and timely performance data as available for physician feedback and Ongoing Professional Practice Evaluation (OPPE).
   d. Recognize physician excellence in addition to identifying system improvement opportunities.
2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the respective Medical Staff Peer Review Charter for each facility.

M. Critical Care Committee (CCC)
1. Duties: The District wide Critical Care Committee is responsible for:
   a. Identifying indicators for monitoring the important aspects of critical care.
   b. Evaluating results of data collected for these indicators.
   c. Making recommendations for actions to improve care or correct identified problems.

2. Composition: Co-chairs, both of whom will be Medical Directors of ICU, along with broad representation from appropriate areas of the Medical Staff, Administration, Nursing and other disciplines as appropriate.

N. Imaging Services - District Radiation Safety Committee (RSC) :

1. Duties:
   a. The RSC will regularly review metrics recognized as measurements of quality and safety and safety in radiation safety and protection. Metrics reviewed include, but are not limited to, dosimetry badge readings, medical physicist reports, and fluoroscopy quality assurance.
2. Composition:
   a. The Committee Chair is the Radiation Safety Officer (RSO). Committee members will include representatives from Imaging Services, Surgical Services, Interventional Radiology, Cath Lab, ~~Environmental Services,~~ Radiation Oncology, Administration, nursing representation and a medical physicist.

O. Infection Prevention and Control Committee (IPCC): The District wide Palomar Health Infection Prevention and Control Committee is responsible for carrying out the following:

1. Duties:
   a. Novel Virus Covid-19 Pandemic Mitigation Plan (refer to the Infection Control COVID-19 Exposure Control Plan).
   b. Develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health. The program includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and other nationally recognized organizations as appropriate.
   c. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff, contracted service workers, and volunteers.
   d. The IPCC ~~will report~~ reports directly to the Quality Management Committee.
   e. To provide structure for an organization-wide , facility specific approach to identify and reduce the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of services, the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, licensure , experience or certification.
      i. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science.
      ii. Implementation of changes mandated by regulatory, accrediting, and licensing agencies.
      iii. Education efforts directed at interventions to reduce infection risk.
      iv. Consultation on risk assessment, prevention, and control strategies (includes activities related to occupational health, construction, and emergency management.
      v. Development and review of procedures and evaluation of products.
      vi. Review and analysis of surveillance data.
   f. The hospital has designated one or more individual(s) as its Infection Control Officer(s). The Infection Control Officer(s) is/are qualified and maintain(s) qualifications through education, training, experience or certification related. The Infection Control Officer(s) 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 IPCC through its chairperson and Senior Director of of Quality and Infection Prevention and Control Program are the Infection Control Officers. The Infection Control Officers are granted the authority to institute any appropriate emergency measures throughout the health system when there is reasonable risk or danger to any patient, personnel, or visitors as it relates to Infection Prevention and Control.

2. Composition:

    a. The Committee is composed of a physician chair who is an infectious disease specialist, and representatives but not limited to: Infection Prevention, Nursing, Administration, and personnel responsible for overseeing facility infection control activities, (e.g., Home Health, ~~Villa Pomerado~~ The Villas at Poway , Peri-operative Services, Facilities, Environmental Services, Food and Nutrition, Pharmacy and Corporate/Employee Health, Lab, Respiratory Services, and Wound Care).

P. Pharmacy and Therapeutics Committee (P&T):

1. Duties:

    a. Develop and implement written policies and procedures for the establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of medications.

    b. Develop and maintain a formulary of drugs throughout the hospitals.

    c. Monitor the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition, and clinical dietary consultations.

    d. Review Adverse Drug Reaction Event Program.

    e. Review Medication Error Reduction Plan at least annually.

    f. Make recommendations to improve care or to correct identified problems to the Quality Management Committee based on analysis and evaluation of data collected through indicators.

    g. Refer to the Chair of either Palomar Medical Center Escondido (PMCE) or Palomar Medical Center Poway (PMCP) ~~-~~ any matter within the scope of the Medical Staffs' responsibilities for performance improvement as appropriate.

    h. The P&T committee will report to the Quality Management Committee.

2. Composition:

    a. The minimum committee quorum shall consist of the Physician Chair, the Director of Pharmaceutical Services or representative, the Chief ~~Nursing Officers from PMCE and PMCP~~ Nurse Executive or representatives, a System Administrator or representative. Representatives from Medical Staff, Nursing, Laboratory, Nutritional Services and Allied Health care Staff may also participate on the committee.

Q. Subcommittees:

1. Nutrition and Therapeutics Committee (N&TC): The purpose of the N&TC is to provide appropriate nutrition care to patients using evidenced based information, bridging the gap between research and practice.

a. Duties: The duties of the Nutrition and Therapeutics Committee include, but are not limited to:
   i. Assisting the pharmaceutical service in maintaining the enteral and parenteral Hospital Formulary.
   ii. Monitoring the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition and clinical dietary consultations.

b. Composition:
   i. The N&TC is comprised of a multidisciplinary team of health professionals including Nutritional Services, Medical Staff, Pharmacy and Nursing.

2. Antibiotic Stewardship Subcommittee:

a. Duties: In view of the dramatic increase in antibiotic resistance, the Antibiotic Stewardship Subcommittee's responsibilities include, but are not limited to:
   i. Reviewing new antimicrobial agents.
   ii. Reviewing antibiotic usage and expenditures, including restricted antibiotics.
   iii. Developing empiric treatment guidelines, protocols, and Power Plans to minimize the development of resistance organisms.

b. Composition:
   i. The Antibiotic Stewardship Subcommittee is comprised of one or more Infectious Disease Physicians, Physicians representing various medical specialties, Antibiotic Stewardship Pharmacist, a Microbiology Representative from the Laboratory and an Infection Preventionist.

R. Non-Medical Staff QAPI Committees and Functions

1. Center of Excellence - Metabolic and Bariatric Surgery (Palomar Medical Center Poway)

1. Duties:
   1. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and values.
   2. To achieve and maintain the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Accredited Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care .

2. Composition:
   a. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).

2. Centers of Excellence - Cardiovascular and Total Joint Replacement (PMCE and PMCP) and Spine Surgery (PMC ~~Escondido and PMC Poway) and Spine Surgery (PMC~~ Escondido)

1. Duties:
   i. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.
   ii. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.

2. Composition:
    i. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).
3. Stroke Committee:
    a. Duties:
        i. Provide oversight, coordination and direction to the individuals caring for the stroke patients.
        ii. Evaluate appropriateness and adequacy of the program through a review of clinical practice guidelines, power plans, and procedures.
        iii. Coordinate education programs for staff and the community we serve.
        iv. Monitor, analyze, and evaluate stroke measures; identify opportunities for improvement; share recommendations and outcomes.
        v. Participate in the Palomar Health Quality Assessment and Performance Improvement program.
        vi. Maintain Joint Commission ~~Advanced~~ Stroke Program certification standards.
        vii. Stroke Committee will report through the Quality Management Committee.
    b. Composition:
        i. The committee is chaired by the Stroke Medical Director and facilitated by the Stroke Coordinator.
        ii. The committee is comprised of a multidisciplinary team of health professionals including Administrative Leaders; Medical Staff: Neurology, Neurosurgery, Neuro-Interventionist, Emergency, Critical Care, Anesthesiology, and Hospitalist; Stroke Program Coordinator; Pharmacy; Nursing; Radiology; Laboratory; Rehabilitation Services; Case Resource Management; Patient Access and Quality.
4. Laboratory Services: Quality
    a. Duties: Laboratory Services: Lab Quality includes, but are not limited to:
        i. Review and approve monthly Lab Quality indicators and ~~blood bank~~ Blood Bank audits .
        ii. Collects data by reviewing QA variance reports and summarizing by month and year on the Laboratory QA and QM Database, Laboratory Leadership Committees make recommendation to improve laboratory services and quality to Laboratory Executive Management and the Laboratory Medical Director based on analysis and evaluation of data collected through indicators and performance metrics. Changing regulatory requirements will also prompt policy and procedure review.
        iii. Identify opportunities for process improvement from staff feedback, variance reports, QRR reports, and quality indicator results.
        iv. Evaluate results of monthly ED turnaround time report.
        v. Review ~~for completion of follow up action and plan of corrections.~~ ~~Review~~ actions and decisions with Medical Laboratory Director.
    b. Composition:
        i. The District Laboratory Director ~~and~~ chairs the Laboratory ~~Managers chair and~~ Quality Committee and is co- ~~chair the monthly meeting~~ chaired by the District Laboratory Managers . Members include the ~~medical laboratory director~~ Medical Laboratory Director , ~~laboratory managers~~ Clinical Laboratory Scientist Supervisors , shift

supervisors and section ~~supervisors, shift supervisors, and Chairs of the Lab Professional Practice~~ leads .

5. Environment of Care (EOC) Committee:
   a. Duties: Specific responsibilities include, but are not limited to the following:
      i. Development and review of procedures
      ii. Develop and monitor the Environment of Care management plans, Hazardous Materials and Waste program, and the Illness and Injury Prevention program.
      iii. Environmental Surveillance, Safety Education and Product Recall Monitoring.
      iv. Monitor the results of regulatory inspections and refer to Regulatory Steering Committee.
      v. Analyze and aggregate data. Recommendations are developed and approved as applicable.
      vi. This committee will report up through the Interdisciplinary Governance Committee.
   b. Composition:
      i. The Committee is composed of the Chair and Co-Chair, Facilities, Risk Management, Security, Employee Health, Biomedical Engineering, EVS, Infection Control as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.
6. Disaster Preparedness Committee (DPC):
   a. Duties: The District wide Disaster Preparedness Committee is responsible for ensuring:
      i. Develop and review of procedures.
      ii. Develop and monitor the Emergency Management Program.
      iii. Disaster planning and disaster related activities are managed and implemented.
      iv. Ensure meetings are scheduled and information, progress notes, and followup activities from this committee are reported to the Environment of Care Committee.
      v. This committee will report up through the Interdisciplinary Governance Committee.
   b. Composition:
      i. The Committee is composed of the Chair and Co-chair, Facilities, Risk Management, Security, Infection Control, Emergency Department as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.
7. Continuum Care Operations Division :
   a. Purpose: Under the direction of the Vice President, the Continuum Care Directors, the Continuum Care Operations Division promotes improvement of patient safety and outcomes by providing an organization-wide approach for continually assessing and improving the quality of health services that we provide to our patients, employees, and community outside our acute care facilities. Under the oversight of the Vice President, Continuum Care, the Continuum Directors are responsible for the performance improvement and patient safety program at the departmental level within their respective specialties. The ongoing monitoring and analysis of Quality indicators are based on the following :
      i. Identification of patient needs and expectations and evaluation of how these needs and expectations are met
      ii. Identification of staff education and training needs and ongoing measurements to demonstrate sustained i ~~mprovement~~ improvement
      iii. Use of evidence-based data from internal and external sources to improve the quality of c are

iv. Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing, home health and ambulatory s ervices
v. Analysis of data to establish priorities and identify opportunities for future i ~~mprovement~~ improvement

b. Entities under the umbrella of the Continuum Care Operations Improvement Function include:
i. ~~Villa Pomerado~~ The Villas at Poway Quality Committee
ii. Home Health Quality Committee
iii. Rehabilitation Services
iv. Ambulatory Specialty Outpatient Services

c. The performance improvement measures that reflect a direct contribution of Continuum Care achieving quality and safe patient care outcomes may include:
i. Physician and Employee Engagement
ii. Patient Experience
iii. Risk
iv. Regulatory or accreditation requirements
v. Patient and community outcomes
vi. CMS Quality Indicators for Skilled Nursing and Home Health

METHODS:

A. Understanding that performance improvement and patient safety permeate every level of the organization. The Palomar Health Leadership Team empowers and assigns individuals to lead these by providing time and resources to achieve optimal outcomes.

B. Whenever possible, sound statistical methods and the techniques of continuous quality improvement will be utilized. In most projects, a Plan-Do-Study-Act Cycle (PDSA) methodology model will be used.

C. Prioritization: When selecting Quality Assessment Performance Improvement (QAPI) projects, Palomar Health leaders recognize the importance of using criteria to do ongoing prioritization of Quality Assessment Performance Improvement projects. A focus is on high risk, high volume, problem prone areas and the effects on outcomes, patient safety and quality of care. Therefore, proposed projects will be coordinated to avoid duplication of ~~projects~~ efforts .

D. Designing Processes: When creating or modifying programs and/or processes, consideration is taken to ensure the design:
1. Is consistent with the mission, vision, values, goals, objectives and plans;
2. Meets the needs of individuals served, staff and others;

3. Is clinically sound and current (for instance, use of best practice guidelines, successful practices, information from relevant literature, and clinical standards);
4. Incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesign processes, functions, or services;
5. Utilizes tools and methods to proactively identify risk points and eliminate them prior to implementing changes;
6. Includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement; and
7. Incorporates the results of Quality Assessment Performance Improvement activities.
8. Data Collection: Data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. Collected data is used to:
    a. Compare performance about processes and outcomes through the use of reference databases.
    b. Compare performance data about processes with information from up-to-date sources.
    c. Make comparisons of performance of processes and outcomes over time.
    d. Data is collected on important processes and outcomes and includes, but is not limited to, key processes related to:
        i. Leadership ~~priorities~~ Priorities
        ii. Reducing Disparity in Health Care
        iii. Code Blue and Rapid Response
        iv. Patient Safety
        v. Environment of ~~care~~ Care
        vi. Patient ~~Satisfaction~~ Experience
        vii. Pain Management
        viii. Medication Management
        ix. Blood and ~~blood products~~ Blood Products
        x. Restraint and Seclusion
        xi. Operative and ~~other invasive procedures~~ Other Invasive Procedures
        xii. Organ Procurement
        xiii. Resuscitation
        xiv. Risk Management
        xv. Infection Control Healthcare Associated Infections and Antimicrobial Stewardship
        xvi. Imaging Services
        xvii. Laboratory Services
        xviii. Patient Grievances
        xix. Contracted Services - Evaluations
    e. Benchmarks: Whenever available, benchmarks from local, state and national databases and medical literature will be obtained and used. Available bench marking systems include but are not limited to:
        i. The Joint Commission (TJC)
        ii. Centers for Medicare & Medicaid Services (CMS) through CMS.Gov
        iii. Society of Thoracic Surgeons Cardiac Surgery Database
        iv. Center for Disease Control and Prevention (CDC) Database
        v. National Database for Nursing Quality Indicators (NDNQI)
        vi. Department of Health Care ~~Acess~~ Access and Information (HCAI)

E. Palomar Health is a member of the California Hospital Patient Safety Organization (CHPSO) and Health Services Advisory Group (HSAG).
F. Best Practice Core Measures: Proactively engaged with bench marking systems performance through their involvement with The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) in order to continuously seek out opportunities to improve our performance based on best practices, such as those promulgated by the National Quality Forum.
G. Data Assessment: The data is organized for reporting purposes in a manner that allows for analysis of the results. Data is systematically aggregated and analyzed on an ongoing basis:
    1. Aggregated data is analyzed to make judgments about:
        a. Whether design specifications for processes were met
        b. The level of performance and stability of important existing processes
        c. Opportunities for improvement
        d. Actions to improve the performance of processes
        e. Whether changes in processes resulted in improvement
    2. Appropriate statistical techniques are used to analyze and display data. These techniques include, run charts, control charts, Pareto charts, and other statistical tools as appropriate.
H. Failure Mode and Effects Analysis (FMEA): involves the prospective evaluation of processes identified by the organization as being vulnerable to risk and the redesign of such processes to build safety in (e.g., through creating redundancies) before an adverse event occurs.
I. Root Cause Analysis (RCA): When a serious, unexpected adverse outcome or near-miss occurs, the RCA process may be used to determine the most basic or immediate factor(s) or causes of why the event occurred. The RCA process is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again. RCAs are retrospective, focus on system issues rather than blame, and are not appropriate in cases of negligence or willful harm. An action plan is then identified and monitored.
J. Improving and Sustaining Performance: Changes to improve performance are identified, planned, ~~and~~ tested , and audited using the PDSA Cycle Model. Effective changes are incorporated into standard operating procedure.
K. Training and Education: Training and Education in performance improvement/patient safety and reporting events is provided throughout the organization.
L. Communication:
    1. Communication of Performance Improvement/Patient Safety activities throughout the Medical ~~Staffs~~ Staff and Hospital ~~Staffs~~ Staff occurs through a variety of means including:
        a. Through the QAPI Committee structure, e.g., the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and Medical Staff Committees.
        b. Through newsletters, memos, education programs, and educational offerings .
    2. QAPI reports are communicated to the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and other clinical committees according to the calendar of reporting.
M. Confidentiality:
    1. Data generated by the QAPI Program are considered to be products of the Quality Management Committee of the applicable health facility and are protected from discoverability under Section 1157 of the California Evidence Code. Practitioners and Palomar Health personnel have a duty to preserve this confidentiality.
    2. The performance improvement activities must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient's medical information. Compliance is also maintained with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

N. Conflict of Interest:
   1. A Practitioner may not participate in the review of any case in which he has been or anticipates being professionally involved. Practitioners having either a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization review activities pertaining thereto.
O. Annual Reappraisal: This QAPI plan is reviewed annually to evaluate the overall effectiveness considering such factors as results achieved, operational problems encountered, and deficiencies noted. The Plan with any amendments will be forwarded to the Board of Directors Quality Review Committee for final approval.

Document Owner:	Martinez, Valerie A
Approvals	
- Committees:	(04/20/2022) Quality Management (QMC) (joint), (04/25/2022) Medical Executive Committee, Escondido, (04/26/2022) Medical Executive Committee, Poway
Revision Date:	[05/02/2022 Rev. 19]
Standards: (WHICH REFERENCE THIS DOCUMENT)	**College of American Pathologists:** • Laboratory General - GEN.13806 • Laboratory General - GEN.13806 • Laboratory General - GEN.13806
Attachments: (REFERENCED BY THIS DOCUMENT)	Quality Assurance Plan in Surgical Pathology Patient Safety Event Response, Investigation and Follow-Up patientsafetyreport@jointcommission.org Patient Complaint/Grievance Process CMS.Gov COVID-19 Exposure Control Plan

PALOMAR HEALTH

DocID: 11234
Revision: 20
Status: Pending Committee Approval

Source: Administrative Plans

Applies to Facilities: All Palomar Health Facilities

Applies to Departments: All Departments

Plan : Quality Assessment Performance Improvement (QAPI) and Patient Safety Plan

I. **PURPOSE**:

A. To outline the framework for a leadership driven, systematic, interdisciplinary approach to continuous improvement using our performance improvement model known as Plan, Do, Study, Act (PDSA). Our efforts will focus on all care and service outcomes for our patient populations and meet the mission, vision, and standards of excellence for Palomar Health as follows:

1. Mission: The mission of Palomar Health is to heal, comfort, and promote health in the communities we serve.
2. 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.
3. Values: Excellence, Teamwork, Service, Compassion, Trust and Integrity.
4. Palomar Health's Patient Safety Officer/s are the Senior Director of Quality/Patient Safety and the Medical Quality Officer.

II. **DEFINITIONS:**

A. Quality Assessment Performance Improvement (QAPI) Plan

1. QAPI is the merger of two complementary approaches to quality, namely Quality Assessment (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways:
   a. QA is a process of meeting quality standards and assuring that care reaches an exceptional level. Hospitals and health systems typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is the data collection and analysis through which the degree of conformity to predetermined standards and criteria are exemplified. If the quality, through this process is found to be unsatisfactory, attempts are made to discover the reason for this. On the basis of this, remedial actions are instituted and the quality reevaluated after a suitable time period.
   b. PI is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches in order to fix underlying causes of persistent/systemic problems. PI in hospitals and health systems across the care continuum aims to improve processes involved in health care delivery and quality of life.
   c. QAPI is a data-driven, proactive approach to improving the quality of care and services across the care continuum. The activities of QAPI engage members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.
2. A Performance Improvement Project (PIP) typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.
3. Performance Improvement Activities (PIA), are typically smaller in scope than a PIP and focused at the unit level.

4. A Patient Safety Event is an event, or condition (not related to the natural course of the patient's illness or underlying condition) that could have resulted or did result in harm to the patient. Patient Safety events the reach a patient and result in death, permanent harm, or severe temporary harm, are also known as adverse events, sentinel events or never events.
5. A Good Catch/Near Miss is a patient safety event that does not reach the patient as a result of a built-in detection barrier, mitigation or chance.
6. An unsafe condition is neither a patient safety event nor a Good Catch/Near Miss but is a circumstance that make the occurrence of such an event more likely.

III. Authority and Responsibility

A. Governing Body

The Governing Body authorizes the establishment of this performance improvement program. This Governing Body is responsible for assuring:

1. An ongoing program for quality improvement is defined, implemented, and maintained.
2. An ongoing program for patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
3. An organization-wide quality assessment and performance improvement efforts address priorities for improved quality of care, and patient safety and that all improvement actions are evaluated.
4. Clear expectations for safety are established.
5. Adequate resources are allocated for measuring, assessing, improving, and sustaining the health system's performance and patient safety.
6. A determination of the number of distinct improvement projects are conducted annually.

B. Medical Executive Committee / Quality Management Committee

The Governing Body delegates the development, implementation, and evaluation of this program to the Medical Executive Committee (MEC). The MECs are responsible for monitoring and improving the quality of care, safety and service provided by its medical staff. The MEC has formed a Quality Management Committee to carry out this responsibility.

C. Administration & Management

The Governing Body also delegates the development, implementation, and evaluation of this program to the organization’s Administrative team. Administration is responsible for improving the quality of care, safety, and service provided by organization staff. The Administrative team has developed structures and processes to carry out this responsibility.

D. Further Delegation of Authority and Responsibility; the MEC and/or Administration & Management may further delegate aspects of this program as necessary.

IV. Core Components

A. The following are the core components of the framework:

1. Recognizing that defects are primarily from processes and systems, not people. Performance improvement will focus on systems, processes and outcomes.
2. Leadership driven by a commitment to a culture of safety and transparency that uses a monitoring tool.
3. Data driven based on evidenced based practices using national benchmarks (when available) and comparative data.
4. Integrated and coordinated processes to engage all levels of leadership, physicians, employee staff, and community members as appropriate.
5. Proactive by design in order to sustain continuous performance improvement, promote high reliability, quality, safe patient care and services.
6. Communication through a common language created by an ongoing process to prioritize Quality Assessment/Performance Improvement opportunities using consistent methods and

statistical tools that are the tenets of PDSA and when appropriate Lean- i.e., 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 - uunderstand process variation and capability, S - select a strategy for continued improvement.

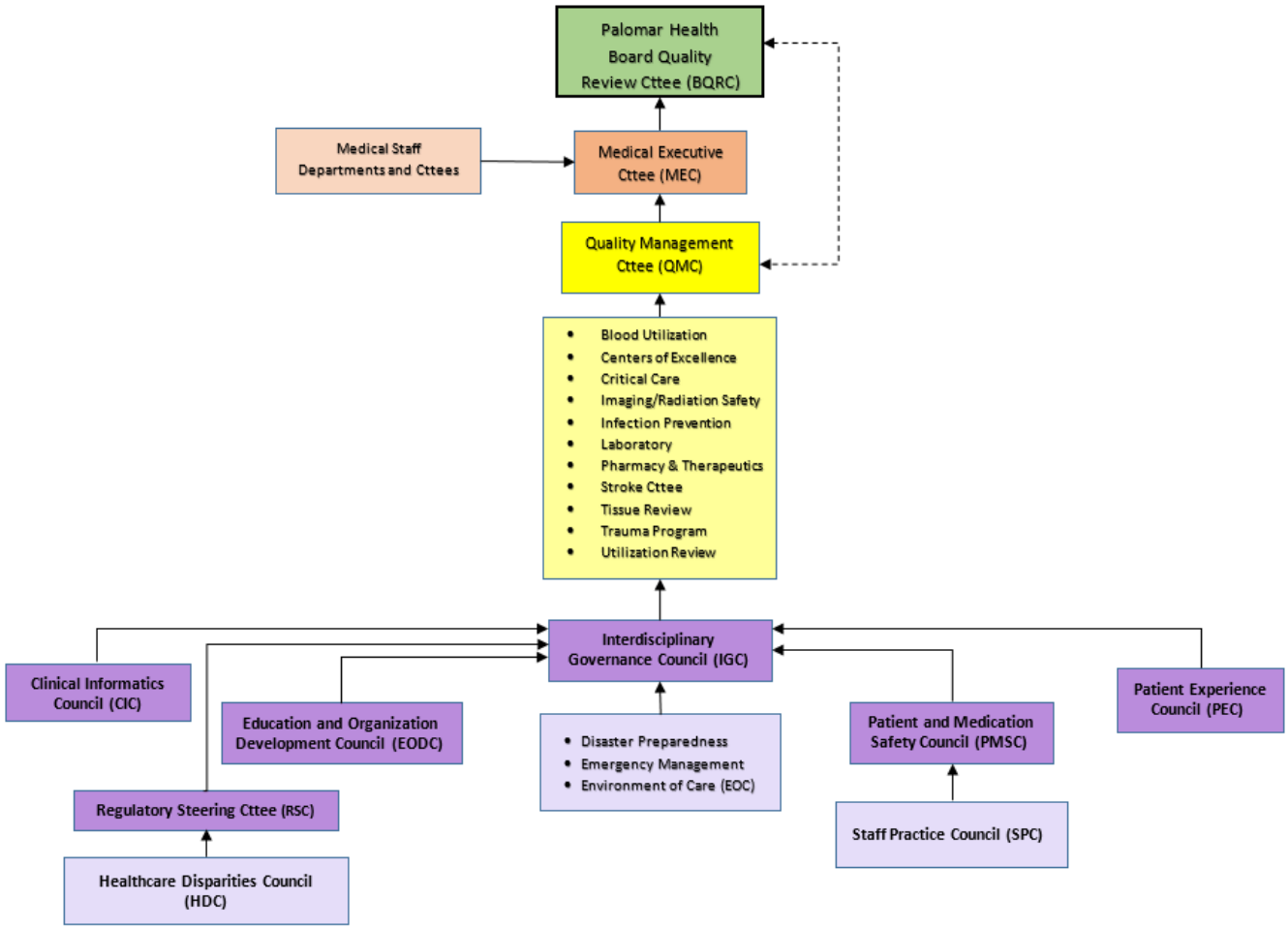
7. A calendar of reporting to ensure ongoing systematic communication to all key constituents, ensure accountability and maintain the ongoing improvement gains for all continuous quality assessment/performance improvement activities.
8. Educational programs and meetings to enhance statistically-based quality assessment/performance improvement tools for every level of leadership, physicians, and staff.
9. Standardized processes for investigation of events and followup on Good Catches/Near Misses, Patient Safety Events, Sentinel Events and unsafe conditions. These standardized processes address:
    a. An investigation into the cause of the adverse event may be undertaken pursuant to the Medical Center’s Review Process.
    b. The investigation would be conducted for the purpose of the evaluation and improvement of the quality of care.
    c. What practice/process change is required to prevent recurrence.
    d. How the practice/process change will be accomplished.
    e. Who is responsible for the practice/process change.
    f. Timeline for completion.
    g. Description of the monitoring and sustainment of processes to prevent a recurrence.

V. **Goals**

A. As part of the annual evaluation of the Quality Assessment Performance Improvement (QAPI) activities and goals are identified for each calendar year to ensure continuous improvement. The following actions should be taken in forming specific goals:
    1. Enhance key processes to ensure that "Evidence Based Practices" are considered in all opportunities for improvement of care and services.
    2. Integrate the Quality Assessment/Performance Improvement Plan into a culture of safety that recognizes the key behaviors and attitudes that result in a safe environment for patients, families, employees, and physicians.
    3. Create a support structure for data collection and analysis through collaboration with Information Technology, Strategy, and Finance when appropriate.
    4. Review and revise as necessary the peer review methodology to ensure a quality driven process that provides a consistent, objective, data-driven evaluation of physician and nurse performance via their respective peer review programs.
    5. Identify core components for Quality Assessment/Performance Improvement methods and tools for the organization.
B. The organization has an effective program that assesses the quality and safety of its services including Local, State, and Federal regulations to identify opportunity for improvement, and works to address those opportunities. Services include but not limited to:
    1. Management of the Care Environment - to include but not limited to, risk assessments and environmental surveillance as it pertains to patient safety. Refer to Safety Management Plan # 11495.
    2. Management of the Medical Record

3. Infection Prevention and Control and Antibiotic Stewardship
4. Patient Rights
5. Medication Management
6. Anesthesia Services
7. Dietary Services
8. Discharge Planning
9. Laboratory Services
10. Nuclear Medicine Services
11. Nursing Services
12. Operative and Invasive Services
13. Outpatient Services
14. Radiology Services
15. Rehabilitation Services
16. Respiratory Services
17. Contracted Service:
    1. All contracted services including one for shared services, patient care services, and all other services, provided under contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital. The hospital will assess the services furnished directly by hospital staff and those services provided under contract, identify quality, assigned performance metric for compliance and identify corrective or improvement activities for those metrics or elements that are less than the established thresholds.
    2. The Medical Staff, pursuant to Bylaws, Section 16.11-16.1.4 shall review all contracted serviced provided by the members of the Medical Staff. The outcome of these reviews will be presented to the Medical Executive Committee's (MEC) on an annual basis, and an attestation signed on behalf of the MEC attesting that the metrics and quality of services have met the established thresholds will be sent to the Board of Director Chair to ensure compliance with the quality of the Medical Staff contracts.
18. Patient Grievances - The hospital’s Governing Body has delegated the grievance process to the Quality/Patient Safety Department. The Quality/Safety department receives, reviews, and collaborates with appropriate unit/department leader and/or physician, in addition to, but not limited to; Regulatory, Finance, and Risk Management for review and investigation. Upon completion of the investigation, a letter will be sent to the complainant informing them of the outcome. Outcome data will be presented to various stakeholder meetings including up to the Governing Body.

VI. Reporting Structure, Responsibilities, and Constituents of the QAPI Plan



A. Board Quality Review Committee (BQRC):

1. Duties:
   a. Pursuant to the BQRC bylaws. The Board Quality Review Committee shall review the prioritized proposed performance improvement projects and patient safety activities and shall report to the governing body.
2. Composition:
   a. Voting Membership: The committee shall consist of five voting members, including three members of the Governing Body and the Chairs of the Quality Management Committees (QMC) of Palomar Medical Center Escondido and Palomar Medical Center Poway. Nonvoting Members include: The President and Chief Executive Officer; the Chief Medical Officer; Medical Quality Officer; the Chief Legal Officer; the Chief Nurse Executive, Vice President of Quality/Patient Safety, Senior Director of Quality/Patient Safety.

B. Medical Staff Executive Committees (MEC):

1. Duties:
   a. The Medical Executive Committee (MEC) is the primary governance committee for the independent medical staff. The MEC, with input from the medical staff, makes key leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. They are also responsible

for adopting and implementing medical staff policies and procedures and creating medical staff appointment and reappointment criteria.

b. The MEC reviews and approves all recommendations submitted by the Quality Management Committee and initiate any special studies or recommendations as deemed appropriate to maintain an effective program.

2. Composition:

a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the Medical Staff Bylaws.

C. The Quality Management Committee (QMC) of the Medical Staff:

1. Purpose:

a. The Quality Management Committees of the Medical Staff will regularly review specified performance metrics recognized as measurements of quality and safety, including but not limited to: blood usage, medication usage, pharmacy and therapeutics, nutrition, medical record timeliness, special care review, utilization review, nursing sensitive indicators (e.g., falls, hospital acquired pressure injuries, and medical restraint use), infection control, patient safety, and other items identified by this committee and in the body of this plan. Appropriate summaries and recommendations first referred to the appropriate clinical departments and subcommittees are then forwarded to the respective Medical Staff Executive Committee for review and approval.

b. The QMC reviews and prioritizes proposed performance improvement projects as recommended by the Interdisciplinary Governance Council (IGC).

c. The QMC provides oversight for the Quality Assessment Performance Improvement (QAPI) activities of medical staff, nursing, and clinical departments and committees.

2. Composition:

a. The Committee has Physician Chairs (preferably the Chief of Staff-elects at each licensed acute care facility). Committee members will include the department chairs-elect of the medical staff or their designee, along with representatives from Medical Staff, Administration, Nursing, Department Directors, and staff responsible for overseeing quality assessment and performance improvement activities.

3. Voting Membership: Physicians and Executive Leadership Team (VPs, CNE, Executives) present at time of voting.

D. Interdisciplinary Governance Council (IGC):

1. Purpose: The Interdisciplinary Governance Council is responsible for providing oversight and approval for all councils in the IGC infrastructure. The Governance Council will work closely with the Regulatory Steering Committee and QMC. The intention is to improve communication, efficiency, and effectiveness in regard to decision making and to provide a mechanism and structure for a communication and approval process that will expedite process improvement changes as well as implementation.

2. Governance: The IGC is the oversight council for Learning and Organizational Development Council (LODC), Clinical Informatics Council (CIC), Patient and Medication Safety Council (PMSC), Patient Experience Council, the Regulatory Steering Committee, Environment of Care Committee and Disaster Preparedness Committee. The Staff Practice Council (SPC) reports up to PMSC.

E. Clinical Informatics Council (CIC):

1. Purpose: The Clinical Informatics Council is an interdisciplinary group whose purpose is to serve as the oversight body for all clinical Informatics projects. The council discusses and oversees clinical informatics requests, and change orders to determine priority and provide feedback and support to the end users. This council is the team that advises on priorities and recommendations regarding electronic health record (EHR) support for safe patient care.

2. Governance: This council will make recommendations for final approval to the Interdisciplinary Governance Council based on the authority level granted. Recommendations regarding project prioritization, strategy, or capital expense will then be referred to the IT Steering Committee.

F. Learning and Organizational Development Council (LODC):
1. Purpose: The purpose of the Learning and Organizational Development Council (LODC) is to develop, implement, evaluate, and provide oversight over integrated education and leadership development plan that meets regulatory requirements, as well as to facilitate implementation of strategic initiatives that support a culture of excellence.
2. Governance: The LODC will make recommendations regarding education plans and practices to the IGC for approval.

G. Regulatory Steering Committee:
1. Purpose: The purpose of the Regulatory Steering Committee is to provide guidance and oversight for the implementation and monitoring of CMS Conditions of Participation (COP), Title 22 and the Joint Commission (TJC) accreditation standards for maintaining Medicare Reimbursement and Quality Accreditation approved status as an organization. The oversight and guidance also applies to all applicable local, state, and federal regulatory regulations across the system.
2. Governance: The committee will provide a report to the IGC on a regular basis and any recommendations to IGC for approval.

H. Patient and Medication Safety Council (PMSC):
1. Purpose: The purpose of the Patient and Medication Safety Council includes but not limited to the following: Promote a culture of safety through oversight and implementation of the Quality Assessment and Performance Improvement (QAPI) Plan. The council will ensure the development of documents, policies, procedures, and practices that reflect evidence-based practice (EBP) and meet the standards of professional organizations, state and federal professional practice acts, scopes of practice, as well as regulatory standards. Incorporate Medication Safety reports and Medication Error Reduction Plan (MERP) updates. sSupport medication safety and recommendations for process improvement projects that will facilitate an interdisciplinary approach to the Plan, Do, Study, Act (PDSA) model for daily work processes. Review Sentinel Event Alerts (SEA), Institute for Safe Medication Practices (ISMP), and National Patient Safety Goals (NPSG) and discuss follow up, as appropriate. Recommend Failure Mode Effects Analysis (FMEA) for approval and review and monitor performance improvement activities that have been performed.
2. Governance: The Patient and Medication Safety Council will make recommendations for final approval of policies to be sent to specialty committees (e.g. Infection Prevention, QMC) and will refer policies/procedures to IGC for approval for posting. This council will also make recommendations regarding various committee and project proposals to the IGC for approval.

I. Patient Experience Council (PEC):
1. Purpose: The purpose of the Patient Experience Council is to provide oversight and guidance on achieving and sustaining patient-centered care. The council will oversee the development, implementation and monitoring for all best practices, performance metrics, policies and procedures that enhance and/or promote the ideal patient and family experience while always advocating for the communities we serve, aligning with our mission, vision, and values.
2. Governance: The Patient Experience Council will make recommendations regarding performance improvement plans and best practices to the Interdisciplinary Governance Council for approval.

J. Staff Practice Council (SPC):
1. Purpose: The purpose of the Staff Practice Council is to facilitate staff input and feedback from an interdisciplinary perspective into decisions effecting patient care and professional practice.

The council also seeks to enhance sharing and reporting of unit/dept. specific work plans related to the Plan for Patient Care Services, the organizational strategic plan related to clinical practice, patient and employee satisfaction, and quality and patient safety. The work, conversations, and recommendations from the council should be based on the Relationship Based Care model. The SPC serves as an Interdisciplinary fall team for the system. Teams reporting into SPC include: Nursing Peer Review; Safe Patient Handling and Patient Classification.

2. Composition: The Staff practice Council (SPC) will be made up of representatives of the Unit/Department Based Practice Council Chairs, a sponsor from the Patient and Medication Safety Council (PMSC), and staff representatives from teams that have been meeting to make decisions with staff input (e.g. Nursing Peer Review, Patient Classification, and Safe Patient Handling).
3. Governance: This council will report to the PMSC. The PMSC will provide guidance and mentoring for professional practice. Sponsors will provide updates from (PMSC) and also the Interdisciplinary Governance Council (IGC).

K. Medical Staff Committees: Pursuant to the Medical Staff Bylaws, Medical Staff departments and committees are responsible for the quality of care, service and safety of patient care delivered by the members of their respective departments. Medical Staff Departments and Committees shall demonstrate quality assurance and performance improvement by:

1. Participating in departmental and quality assessment/performance improvement activities.
2. Utilizing results and recommendations from interdisciplinary performance improvement efforts to improve services.
3. Utilizing information from the Medical Staff Peer Review Committee (MSPRC) and Quality Department that includes data addressing each of the six physician core competencies for credentialing, privileging and the reappointment process.
4. Reviewing and analyzing summary reports of trended data reported out by department and/or by physician for processes dependent primarily on the activities of one or more individuals with clinical privileges.
5. Sharing responsibility for planning, designing, measuring, assessing, and improving the overall safe care of patients.

L. Medical Staff Peer Review Committee (MSPRC):

1. Duties:
   a. Review cases referred by physicians and staff or by screening criteria with the goal of improving physician performance at the individual and aggregate levels, improving patient outcomes, and supporting a culture of compassion and respect.
   b. Promote efficient use of physician and quality staff resources.
   c. Provide accurate and timely performance data as available for physician feedback and Ongoing Professional Practice Evaluation (OPPE).
   d. Recognize physician excellence in addition to identifying system improvement opportunities.
2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the respective Medical Staff Peer Review Charter for each facility.

M. Critical Care Committee (CCC)

1. Duties: The District wide Critical Care Committee is responsible for:
   a. Identifying indicators for monitoring the important aspects of critical care.
   b. Evaluating results of data collected for these indicators.
   c. Making recommendations for actions to improve care or correct identified problems.
2. Composition: Co-chairs, both of whom will be Medical Directors of ICU, along with broad representation from appropriate areas of the Medical Staff, Administration, Nursing and other

disciplines as appropriate.

N. Imaging Services - District Radiation Safety Committee (RSC):
   1. Duties:
      a. The RSC will regularly review metrics recognized as measurements of quality and safety and safety in radiation safety and protection. Metrics reviewed include, but are not limited to, dosimetry badge readings, medical physicist reports, and fluoroscopy quality assurance.
   2. Composition:
      a. The Committee Chair is the Radiation Safety Officer (RSO). Committee members will include representatives from Imaging Services, Surgical Services, Interventional Radiology, Cath Lab, Radiation Oncology, Administration, nursing representation and a medical physicist.

O. Infection Prevention and Control Committee (IPCC): The District wide Palomar Health Infection Prevention and Control Committee is responsible for carrying out the following:
   1. Duties:
      a. Novel Virus Covid-19 Pandemic Mitigation Plan (refer to the Infection Control COVID-19 Exposure Control Plan).
      b. Develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health. The program includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and other nationally recognized organizations as appropriate.
      c. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff, contracted service workers, and volunteers.
      d. The IPCC reports directly to the Quality Management Committee.
      e. To provide structure for an organization-wide, facility specific approach to identify and reduce the risk of endemic and epidemic healthcare-associated infections (HAI). To ensure optimal provision of services, the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, licensure, experience or certification.
         i. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science.
         ii. Implementation of changes mandated by regulatory, accrediting, and licensing agencies.
         iii. Education efforts directed at interventions to reduce infection risk.
         iv. Consultation on risk assessment, prevention, and control strategies (includes activities related to occupational health, construction, and emergency management.
         v. Development and review of procedures and evaluation of products.
         vi. Review and analysis of surveillance data.
      f. The hospital has designated one or more individual(s) as its Infection Control Officer(s). The Infection Control Officer(s) is/are qualified and maintain(s) qualifications through education, training, experience or certification related. The Infection Control Officer(s) 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 IPCC through its chairperson and Senior

Director of of Quality and Infection Prevention and Control Program are the Infection Control Officers. The Infection Control Officers are granted the authority to institute any appropriate emergency measures throughout the health system when there is reasonable risk or danger to any patient, personnel, or visitors as it relates to Infection Prevention and Control.

2. Composition:

   a. The Committee is composed of a physician chair who is an infectious disease specialist, and representatives but not limited to: Infection Prevention, Nursing, Administration, and personnel responsible for overseeing facility infection control activities, (e.g., Home Health, The Villas at Poway, Peri-operative Services, Facilities, Environmental Services, Food and Nutrition, Pharmacy and Corporate/Employee Health, Lab, Respiratory Services, and Wound Care).

P. Pharmacy and Therapeutics Committee (P&T):

1. Duties:

   a. Develop and implement written policies and procedures for the establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of medications.

   b. Develop and maintain a formulary of drugs throughout the hospitals.

   c. Monitor the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition, and clinical dietary consultations.

   d. Review Adverse Drug Reaction Event Program.

   e. Review Medication Error Reduction Plan at least annually.

   f. Make recommendations to improve care or to correct identified problems to the Quality Management Committee based on analysis and evaluation of data collected through indicators.

   g. Refer to the Chair of either Palomar Medical Center Escondido (PMCE) or Palomar Medical Center Poway (PMCP) any matter within the scope of the Medical Staffs' responsibilities for performance improvement as appropriate.

   h. The P&T committee will report to the Quality Management Committee.

2. Composition:

   a. The minimum committee quorum shall consist of the Physician Chair, the Director of Pharmaceutical Services or representative, the Chief Nurse Executive or representatives, a System Administrator or representative. Representatives from Medical Staff, Nursing, Laboratory, Nutritional Services and Allied Health care Staff may also participate on the committee.

Q. Subcommittees:

1. Nutrition and Therapeutics Committee (N&TC): The purpose of the N&TC is to provide appropriate nutrition care to patients using evidenced based information, bridging the gap between research and practice.

   a. Duties: The duties of the Nutrition and Therapeutics Committee include, but are not limited to:

i. Assisting the pharmaceutical service in maintaining the enteral and parenteral Hospital Formulary.

ii. Monitoring the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition and clinical dietary consultations.

b. Composition:

i. The N&TC is comprised of a multidisciplinary team of health professionals including Nutritional Services, Medical Staff, Pharmacy and Nursing.

2. Antibiotic Stewardship Subcommittee:

a. Duties: In view of the dramatic increase in antibiotic resistance, the Antibiotic Stewardship Subcommittee's responsibilities include, but are not limited to:

i. Reviewing new antimicrobial agents.

ii. Reviewing antibiotic usage and expenditures, including restricted antibiotics.

iii. Developing empiric treatment guidelines, protocols, and Power Plans to minimize the development of resistance organisms.

b. Composition:

i. The Antibiotic Stewardship Subcommittee is comprised of one or more Infectious Disease Physicians, Physicians representing various medical specialties, Antibiotic Stewardship Pharmacist, a Microbiology Representative from the Laboratory and an Infection Preventionist.

R. Non-Medical Staff QAPI Committees and Functions

1. Center of Excellence - Metabolic and Bariatric Surgery (Palomar Medical Center Poway)

1. Duties:

1. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and values.
2. To achieve and maintain the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Accredited Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.

2. Composition:

a. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).

2. Centers of Excellence - Cardiovascular and Total Joint Replacement (PMCE and PMCP) and Spine Surgery (PMC Escondido)

1. Duties:

i. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.

ii. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.

2. Composition:

i. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other medical directors).

3. Stroke Committee:
   a. Duties:
      i. Provide oversight, coordination and direction to the individuals caring for the stroke patients.
      ii. Evaluate appropriateness and adequacy of the program through a review of clinical practice guidelines, power plans, and procedures.
      iii. Coordinate education programs for staff and the community we serve.
      iv. Monitor, analyze, and evaluate stroke measures; identify opportunities for improvement; share recommendations and outcomes.
      v. Participate in the Palomar Health Quality Assessment and Performance Improvement program.
      vi. Maintain Joint Commission Stroke Program certification standards.
      vii. Stroke Committee will report through the Quality Management Committee.
   b. Composition:
      i. The committee is chaired by the Stroke Medical Director and facilitated by the Stroke Coordinator.
      ii. The committee is comprised of a multidisciplinary team of health professionals including Administrative Leaders; Medical Staff: Neurology, Neurosurgery, Neuro-Interventionist, Emergency, Critical Care, Anesthesiology, and Hospitalist; Stroke Program Coordinator; Pharmacy; Nursing; Radiology; Laboratory; Rehabilitation Services; Case Resource Management; Patient Access and Quality.
4. Laboratory Services: Quality
   a. Duties: Laboratory Services: Lab Quality includes, but are not limited to:
      i. Review and approve monthly Lab Quality indicators and Blood Bank audits.
      ii. Collects data by reviewing QA variance reports and summarizing by month and year on the Laboratory QA and QM Database, Laboratory Leadership Committees make recommendation to improve laboratory services and quality to Laboratory Executive Management and the Laboratory Medical Director based on analysis and evaluation of data collected through indicators and performance metrics. Changing regulatory requirements will also prompt policy and procedure review.
      iii. Identify opportunities for process improvement from staff feedback, variance reports, QRR reports, and quality indicator results.
      iv. Evaluate results of monthly ED turnaround time report.
      v. Review actions and decisions with Medical Laboratory Director.
   b. Composition:
      i. The District Laboratory Director chairs the Laboratory Quality Committee and is co-chaired by the District Laboratory Managers. Members include the Medical Laboratory Director, Clinical Laboratory Scientist Supervisors, shift supervisors and section leads.
5. Environment of Care (EOC) Committee:
   a. Duties: Specific responsibilities include, but are not limited to the following:
      i. Development and review of procedures

ii. Develop and monitor the Environment of Care management plans, Hazardous Materials and Waste program, and the Illness and Injury Prevention program.
iii. Environmental Surveillance, Safety Education and Product Recall Monitoring.
iv. Monitor the results of regulatory inspections and refer to Regulatory Steering Committee.
v. Analyze and aggregate data. Recommendations are developed and approved as applicable.
vi. This committee will report up through the Interdisciplinary Governance Committee.

b. Composition:
i. The Committee is composed of the Chair and Co-Chair, Facilities, Risk Management, Security, Employee Health, Biomedical Engineering, EVS, Infection Control as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

6. Disaster Preparedness Committee (DPC):
a. Duties: The District wide Disaster Preparedness Committee is responsible for ensuring:
i. Develop and review of procedures.
ii. Develop and monitor the Emergency Management Program.
iii. Disaster planning and disaster related activities are managed and implemented.
iv. Ensure meetings are scheduled and information, progress notes, and followup activities from this committee are reported to the Environment of Care Committee.
v. This committee will report up through the Interdisciplinary Governance Committee.

b. Composition:
i. The Committee is composed of the Chair and Co-chair, Facilities, Risk Management, Security, Infection Control, Emergency Department as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

7. Continuum Care Operations Division:
a. Purpose: Under the direction of the Vice President, the Continuum Care Directors, the Continuum Care Operations Division promotes improvement of patient safety and outcomes by providing an organization-wide approach for continually assessing and improving the quality of health services that we provide to our patients, employees, and community outside our acute care facilities. Under the oversight of the Vice President, Continuum Care, the Continuum Directors are responsible for the performance improvement and patient safety program at the departmental level within their respective specialties. The ongoing monitoring and analysis of Quality indicators are based on the following:
i. Identification of patient needs and expectations and evaluation of how these needs and expectations are met
ii. Identification of staff education and training needs and ongoing measurements to demonstrate sustained iimprovement
iii. Use of evidence-based data from internal and external sources to improve the quality of care
iv. Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing, home health and ambulatory services
v. Analysis of data to establish priorities and identify opportunities for future iimprovement

b. Entities under the umbrella of the Continuum Care Operations Improvement Function include:

i. The Villas at Poway Quality Committee
ii. Home Health Quality Committee
iii. Rehabilitation Services
iv. Ambulatory Specialty Outpatient Services

c. The performance improvement measures that reflect a direct contribution of Continuum Care achieving quality and safe patient care outcomes may include:
i. Physician and Employee Engagement
ii. Patient Experience
iii. Risk
iv. Regulatory or accreditation requirements
v. Patient and community outcomes
vi. CMS Quality Indicators for Skilled Nursing and Home Health

METHODS:

A. Understanding that performance improvement and patient safety permeate every level of the organization. The Palomar Health Leadership Team empowers and assigns individuals to lead these by providing time and resources to achieve optimal outcomes.

B. Whenever possible, sound statistical methods and the techniques of continuous quality improvement will be utilized. In most projects, a Plan-Do-Study-Act Cycle (PDSA) methodology model will be used.

C. Prioritization: When selecting Quality Assessment Performance Improvement (QAPI) projects, Palomar Health leaders recognize the importance of using criteria to do ongoing prioritization of Quality Assessment Performance Improvement projects. A focus is on high risk, high volume, problem prone areas and the effects on outcomes, patient safety and quality of care. Therefore, proposed projects will be coordinated to avoid duplication of efforts.

D. Designing Processes: When creating or modifying programs and/or processes, consideration is taken to ensure the design:
1. Is consistent with the mission, vision, values, goals, objectives and plans;
2. Meets the needs of individuals served, staff and others;
3. Is clinically sound and current (for instance, use of best practice guidelines, successful practices, information from relevant literature, and clinical standards);
4. Incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesign processes, functions, or services;
5. Utilizes tools and methods to proactively identify risk points and eliminate them prior to implementing changes;

6. Includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement; and
7. Incorporates the results of Quality Assessment Performance Improvement activities.
8. Data Collection: Data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. Collected data is used to:
    a. Compare performance about processes and outcomes through the use of reference databases.
    b. Compare performance data about processes with information from up-to-date sources.
    c. Make comparisons of performance of processes and outcomes over time.
    d. Data is collected on important processes and outcomes and includes, but is not limited to, key processes related to:
        i. Leadership Priorities
        ii. Reducing Disparity in Health Care
        iii. Code Blue and Rapid Response
        iv. Patient Safety
        v. Environment of Care
        vi. Patient Experience
        vii. Pain Management
        viii. Medication Management
        ix. Blood and Blood Products
        x. Restraint and Seclusion
        xi. Operative and Other Invasive Procedures
        xii. Organ Procurement
        xiii. Resuscitation
        xiv. Risk Management
        xv. Infection Control Healthcare Associated Infections and Antimicrobial Stewardship
        xvi. Imaging Services
        xvii. Laboratory Services
        xviii. Patient Grievances
        xix. Contracted Services Evaluations
    e. Benchmarks: Whenever available, benchmarks from local, state and national databases and medical literature will be obtained and used. Available bench marking systems include but are not limited to:
        i. The Joint Commission (TJC)
        ii. Centers for Medicare & Medicaid Services (CMS) through CMS.Gov
        iii. Society of Thoracic Surgeons Cardiac Surgery Database
        iv. Center for Disease Control and Prevention (CDC) Database
        v. National Database for Nursing Quality Indicators (NDNQI)
        vi. Department of Health Care Access and Information (HCAI)

E. Palomar Health is a member of the California Hospital Patient Safety Organization (CHPSO) and Health Services Advisory Group (HSAG).
F. Best Practice Core Measures: Proactively engaged with bench marking systems performance through their involvement with The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) in order to continuously seek out opportunities to improve our performance based on best practices, such as those promulgated by the National Quality Forum.

G. Data Assessment: The data is organized for reporting purposes in a manner that allows for analysis of the results. Data is systematically aggregated and analyzed on an ongoing basis:
   1. Aggregated data is analyzed to make judgments about:
      a. Whether design specifications for processes were met
      b. The level of performance and stability of important existing processes
      c. Opportunities for improvement
      d. Actions to improve the performance of processes
      e. Whether changes in processes resulted in improvement
   2. Appropriate statistical techniques are used to analyze and display data. These techniques include, run charts, control charts, Pareto charts, and other statistical tools as appropriate.

H. Failure Mode and Effects Analysis (FMEA): involves the prospective evaluation of processes identified by the organization as being vulnerable to risk and the redesign of such processes to build safety in (e.g., through creating redundancies) before an adverse event occurs.

I. Root Cause Analysis (RCA): When a serious, unexpected adverse outcome or near-miss occurs, the RCA process may be used to determine the most basic or immediate factor(s) or causes of why the event occurred. The RCA process is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again. RCAs are retrospective, focus on system issues rather than blame, and are not appropriate in cases of negligence or willful harm. An action plan is then identified and monitored.

J. Improving and Sustaining Performance: Changes to improve performance are identified, planned, tested, and audited using the PDSA Cycle Model. Effective changes are incorporated into standard operating procedure.

K. Training and Education: Training and Education in performance improvement/patient safety and reporting events is provided throughout the organization.

L. Communication:
   1. Communication of Performance Improvement/Patient Safety activities throughout the Medical Staff and Hospital Staff occurs through a variety of means including:
      a. Through the QAPI Committee structure, e.g., the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and Medical Staff Committees.
      b. Through newsletters, memos, education programs, and educational offerings.
   2. QAPI reports are communicated to the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and other clinical committees according to the calendar of reporting.

M. Confidentiality:
   1. Data generated by the QAPI Program are considered to be products of the Quality Management Committee of the applicable health facility and are protected from discoverability under Section 1157 of the California Evidence Code. Practitioners and Palomar Health personnel have a duty to preserve this confidentiality.
   2. The performance improvement activities must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient's medical information. Compliance is also maintained with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

N. Conflict of Interest:
   1. A Practitioner may not participate in the review of any case in which he has been or anticipates being professionally involved. Practitioners having either a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization review activities pertaining thereto.

o. Annual Reappraisal: This QAPI plan is reviewed annually to evaluate the overall effectiveness considering such factors as results achieved, operational problems encountered, and deficiencies noted. The Plan with any amendments will be forwarded to the Board of Directors Quality Review Committee for final approval.

Document Owner:	Martinez, Valerie A
Approvals	
- Committees:	(Not yet approved) Quality Management (QMC) (joint), (Not yet approved) Medical Executive Committee, Escondido, (Not yet approved) Medical Executive Committee, Poway
Revision Date:	
Standards: (WHICH REFERENCE THIS DOCUMENT)	**College of American Pathologists:** • Laboratory General - GEN.13806 • Laboratory General - GEN.13806 • Laboratory General - GEN.13806
Attachments: (REFERENCED BY THIS DOCUMENT)	Quality Assurance Plan in Surgical Pathology Patient Safety Event Response, Investigation and Follow-Up patientsafetyreport@jointcommission.org Patient Complaint/Grievance Process CMS.Gov COVID-19 Exposure Control Plan

PALOMAR HEALTH

ADDENDUM F

Palomar Health
Total Joint and Spine Surgery
Centers of Excellence (COEs)

Presented to Board Quality Review Committee (BQRC) on
May 24, 2023

Brian Cohen, MHA, Senior Director Service Lines

Total Joint and Spine Surgery Centers of Excellence

SITUATION	Palomar Medical Center Escondido and Poway's COEs continue to be recognized for high quality care and patient outcomes.
BACKGROUND	Palomar Health performed over 1,500 Total Joint and Spine procedures in 2022. Preparing patients for elective surgery remains a primary goal, especially as the teams have adapted to changing protocols brought about by 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. Both COEs meet regularly to review quality metrics, including SSIs, Return-to-ED, readmissions, plus metrics concerning patient preparedness, and operational efficiencies.
ASSESSMENT	PMC-Poway earned the Joint Commission's Advanced Total Hip and Knee Replacement Accreditation (THKR). Total Joint Replacement patients at both campuses are meeting there therapy goals quicker than ever, and 85%-96% are being discharged home before the 2nd midnight. The SIR for HPRO and KPRO at both campuses is above threshold for 2022, and opportunities for improvement persist. 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. Spine surgery volume has grown slightly even compared to pre-pandemic levels (482 to 457). This includes over 100 robotically-assisted spine fusions, and an increase in non-instrumented spine surgery. The spine fusion SIR was above threshold in 2022, , and opportunities for improvement persist. Most importantly, patients that had a fusion at Palomar went from Severe Disability to Minimal Disability within the first year after surgery.
RECOMMENDATION	Our Total Joint and Spine Workgroups identified opportunities to improve by ensuring each patient has the chance to ambulate quickly after surgery, and we improve compliance with several pre-op measures, including nasal decolonization, and CHG bathing.

CONGRATS

to PMC-Poway for Earning
The Joint Commission's
Gold Seal of Approval®

Total Hip and Knee Replacement

PALOMAR HEALTH
Reimagining Healthcare

PalomarHealth.org

EXCELLENCE
Doesn't Go Unnoticed

AMERICA'S 100 Best JOINT REPLACEMENT™ 2016-2023 healthgrades.

AMERICA'S 100 Best SPINE SURGERY™ 2020-2023 healthgrades.

AMERICA'S 100 Best ORTHOPEDIC SURGERY™ 2017-2023 healthgrades.

We are proud to be recognized as the only hospital in San Diego County to win all three America's 100 Best Awards for Joint Replacement, Spine Surgery & Orthopedic Surgery by Healthgrades, four years in a row!

PALOMAR HEALTH
Reimagining Orthopedic & Spine Care

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

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

3,145

activated patients through 2022

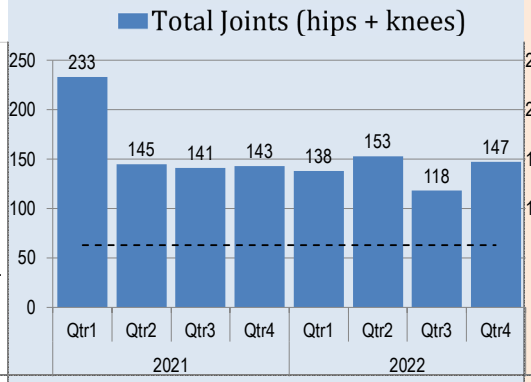
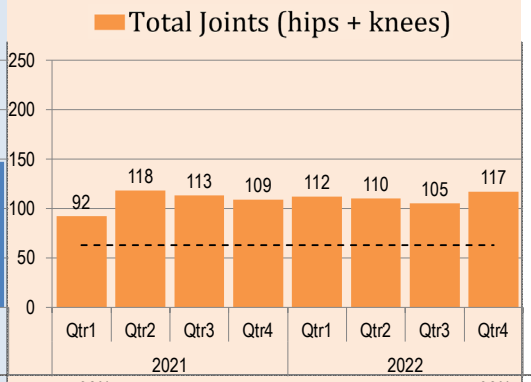
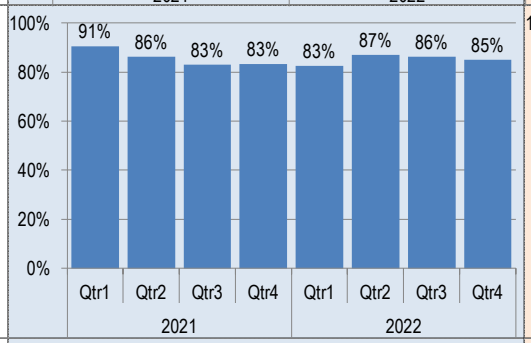
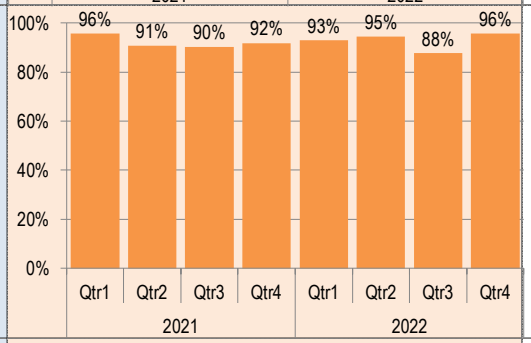
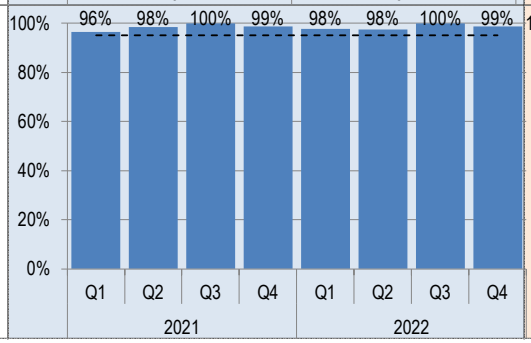
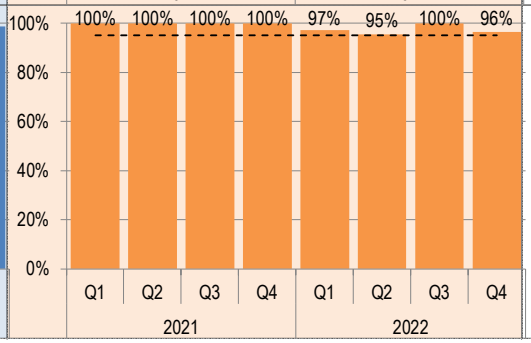
83%

Of enrolled patients **are actively using their CarePath**

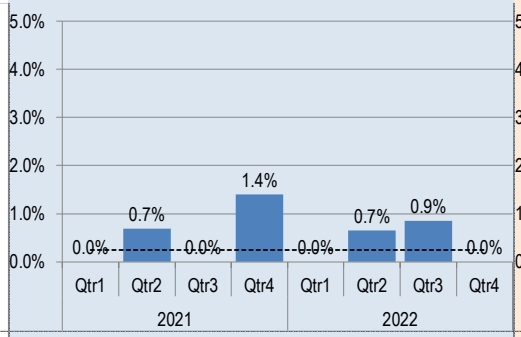
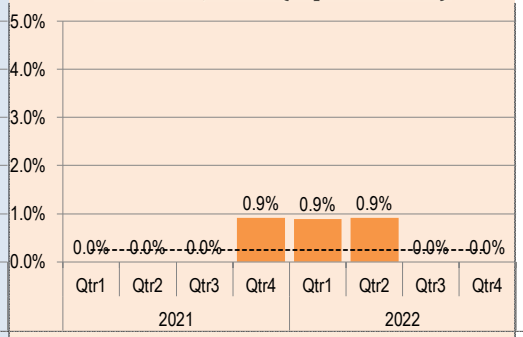
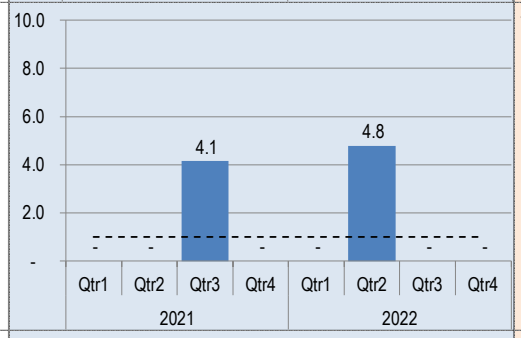
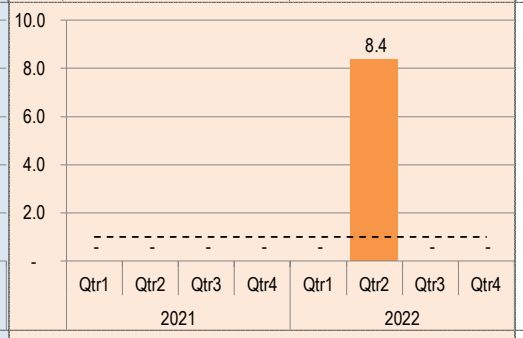
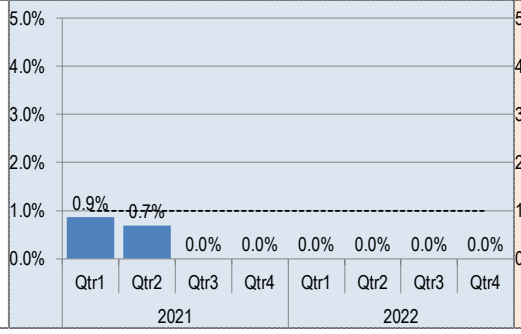
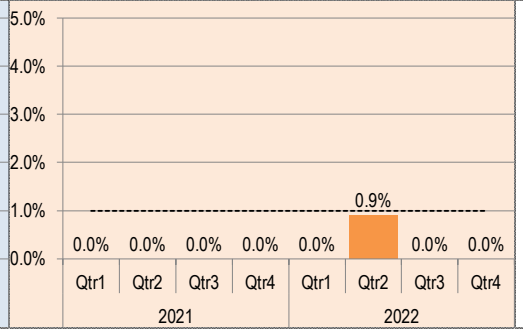
35-94

Age range of **engaged** patients

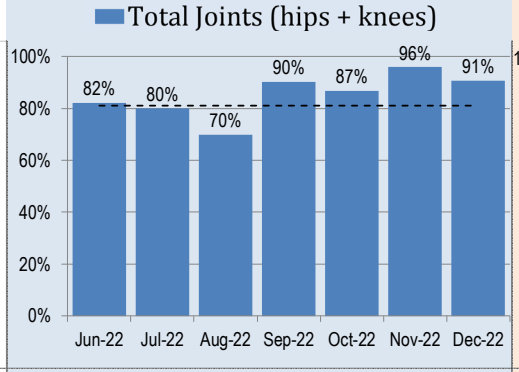
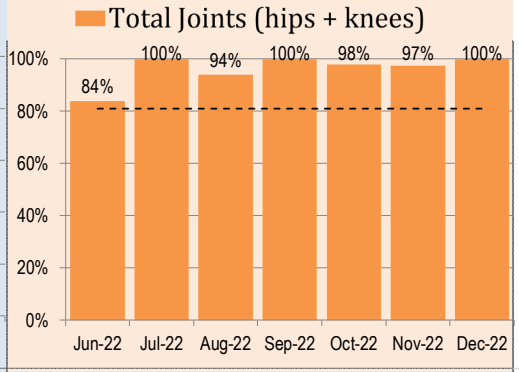
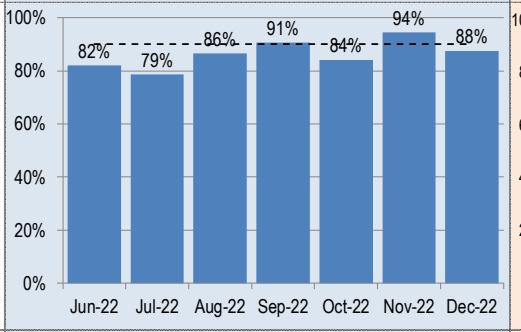
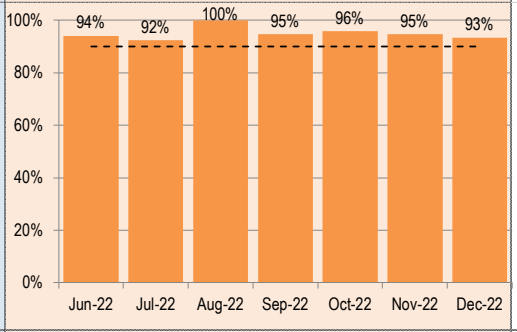
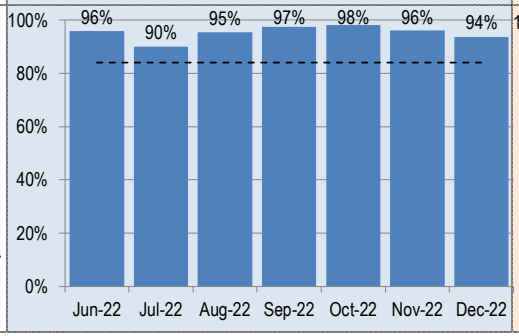
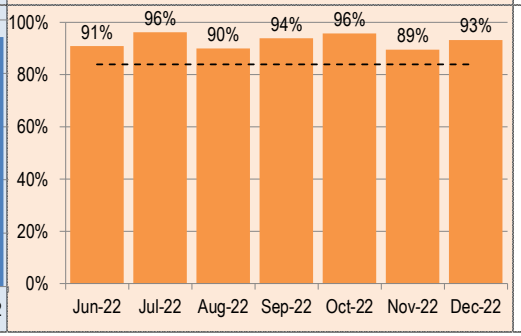
Quality Metrics | Joint Replacement (2021-2022)

	PMC Escondido	PMC Poway	Why is this important?
Volume of Surgical Procedures (higher is better) _ _ _ _ _ _ _ Goal (63+ per qtr)			**High volume is associated with high quality.** Hospitals that perform more than 250 total joint replacements in a year (or 63 per quarter) are associated with lower risk of patient harm, lower risk of readmission, and higher likelihood of being discharged home.
% of Patients Discharged on the Day of Surgery, or the Next Day (higher is better)			**Patients are meeting their therapy goals faster.** Our lower length of stay means our patients met their therapy goals and are ready to go home faster. This reduces their chances of a complication, like infection.
% of Patients That Felt Prepared for Surgery (higher is better) _ _ _ _ _ _ _ Goal (>95%)			**Feeling prepared for surgery can help ease a person's anxiety.** That's why our team has designed an Online CarePath that keeps the patient and their care team connected and moving towards the same goals.

Quality Metrics | Joint Replacement (2021-2022)

	PMC Escondido	PMC Poway	Why is this important?
Surgical Site Infection Rate (lower is better) Goal (<0.3%)			**Patient safety is our top priority.** Achieving superior clinical outcomes after surgery requires you start on the road to recovery without any setbacks.
Fall Rate per 1,000 Bed Days (lower is better) Goal (<1.0 per 1,000 bed days)			**Finding balance and strength.** Rapid rehabilitation and smart patient care practices ensure our patients feel strong and stable.
30-Day All-Cause Readmission Rate (lower is better) Goal (<1%)			**The road to recovery should be a free of setbacks.** Every member of our team plays a role in reducing the likelihood of a patient needing to return to the hospital. To achieve these low rates, we focused on patient safety after discharge and improved handoffs from the hospital to the home caregivers.

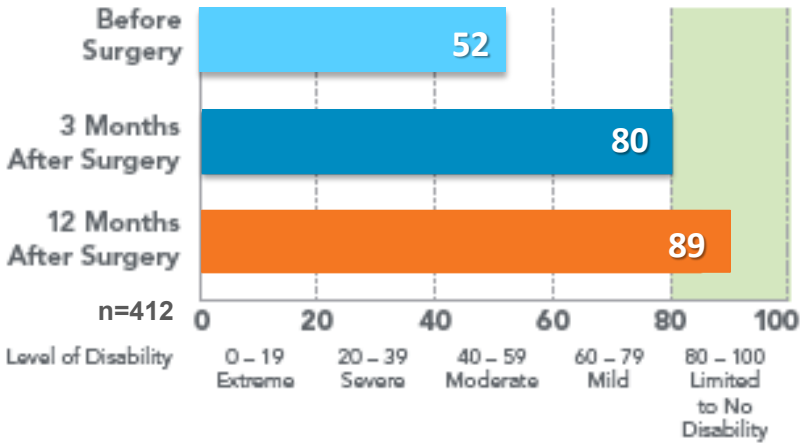
Quality Metrics | AHKR Joint Commission (2022)

	PMC Escondido	PMC Poway	Why is this important?
% Patients w/ Regional Anesthesia (higher is better) Goal (>81%)			**Regional anesthesia, including spinal anesthesia, has many positive benefits.** Spinal anesthesia has been associated with improved outcomes and lower complication rates, if used when indicated (spinal anesthesia should not be performed in patients with known contraindications).
% of Patients who Ambulated on Day of Surgery (higher is better) Goal (>90%)			**Patients are ready to ambulate with therapy.** Getting out of bed and moving on the day of surgery means our patients had good pain control, and minimal negative effects of anesthesia.
% of Patients Discharged to Home (higher is better) Goal (>85%)			**There is no place like home (to recover).** The Palomar Home Health team can provide wellness programs, home visits, and nurse check-ins. Plus our online surveys and follow-up visits are all designed to keep you on track in the comfort of home.

Quality Metrics | Patient Improvement in Function and Pain

Patient Reported Improvement in Function and Pain

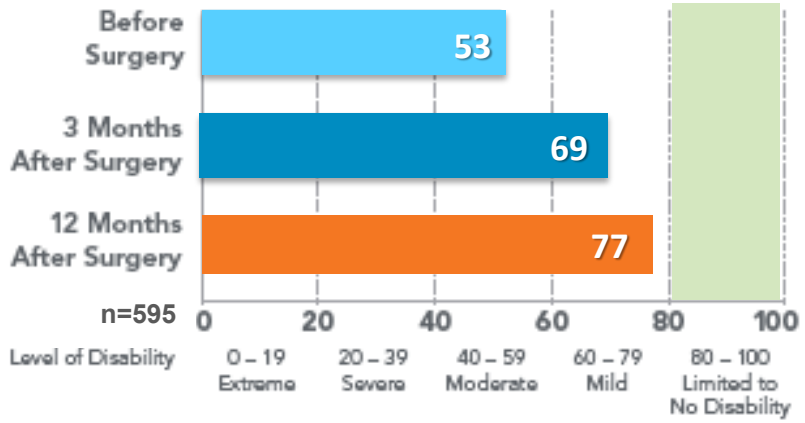
Hip Replacement



Why is this Important?
Palomar Health wants to know how much surgery has improved our patient's daily lives. That's why we ask our patients to report on their function and pain before surgery, and **again** after surgery. We use a standardized survey called the HOOS Jr, which is scored on a scale of 0 – 100.
0 is the lowest score, and 100 means full function.

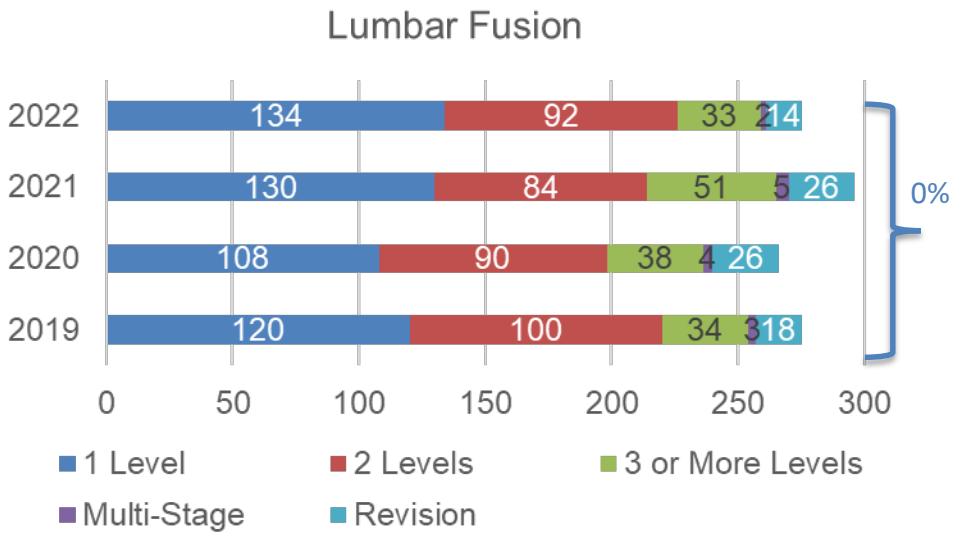
Patients report almost a full return to function one year after surgery!

Knee Replacement

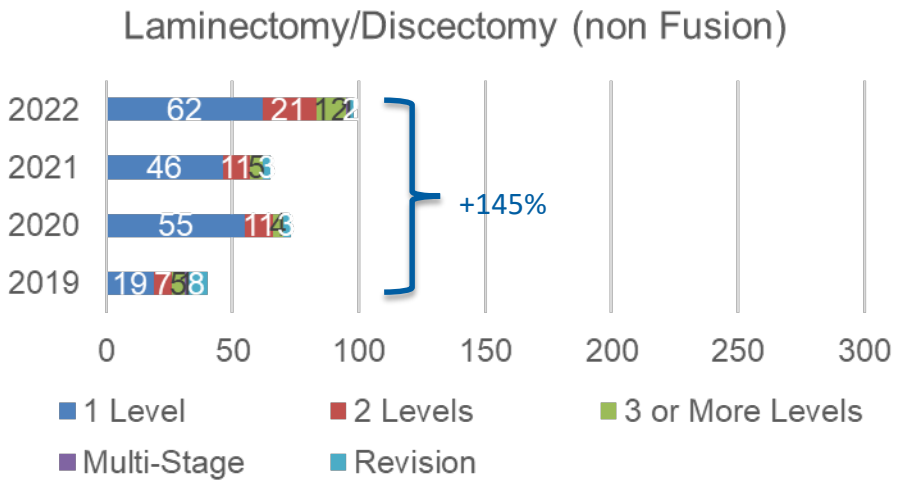


Why is this Important? Palomar Health wants to know how much surgery has improved our patients' daily lives. That's why we ask our patients to report on their function and pain before surgery, and **again** after surgery. We use a standardized survey called the KOOS Jr, which is scored on a scale of 0 – 100. 0 is the lowest score, and 100 means full function.

Quality Metrics | Spine Surgery (2022)



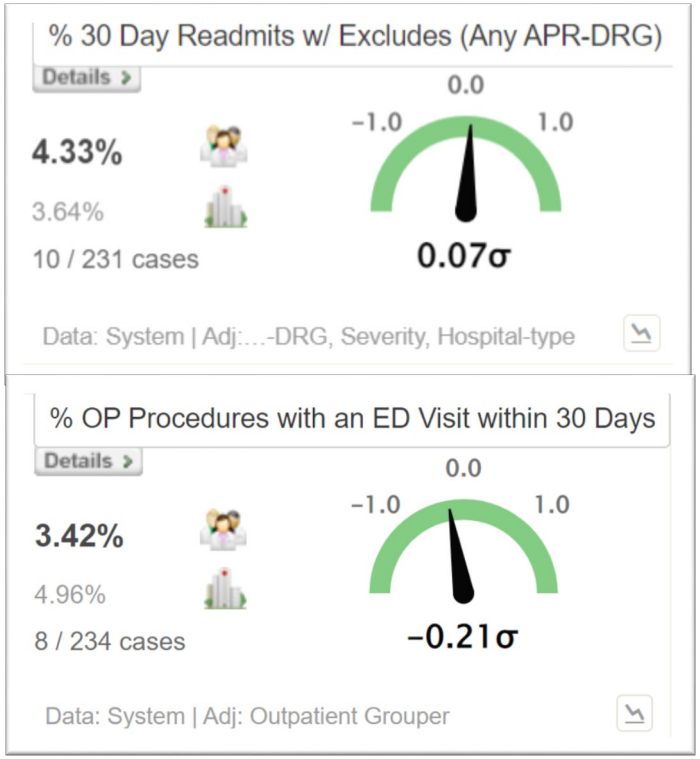
Lumbar Fusion returned to 2019 volume
12% growth in 1 level fusions
11% reduction in costs



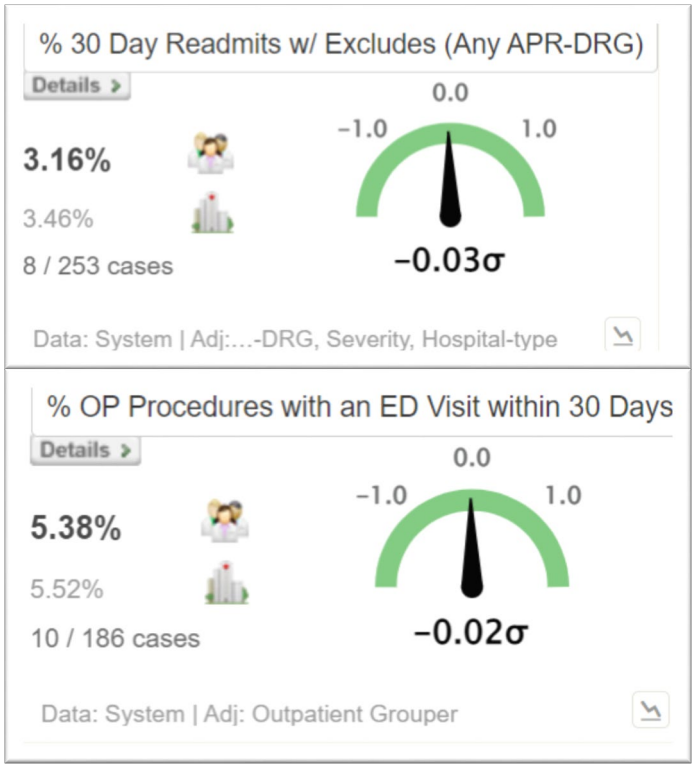
Growth in all types of Lami/Discectomy
23% reduction in costs

Quality Metrics | Readmissions and Return to Hospital

2021



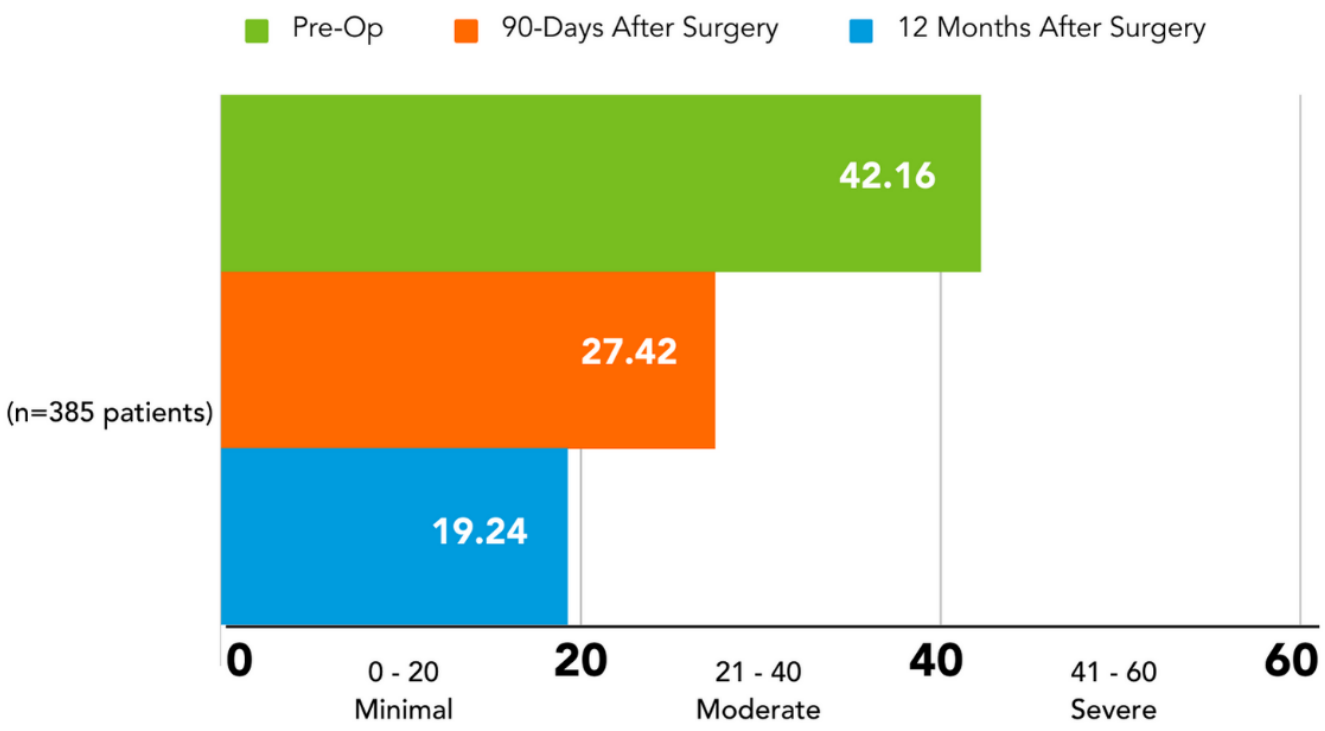
2022



Readmission Reasons (2022)

Cardiac Issue, 3, 23%
Wound Drainage, 3, 23%
UTI, 2, 15%
Syncope, 1, 7%
Retroperitoneal Fluid, 1, 7%
Infection, 1, 7%
Pneumonia, 1, 7%
Fall, 1, 7%

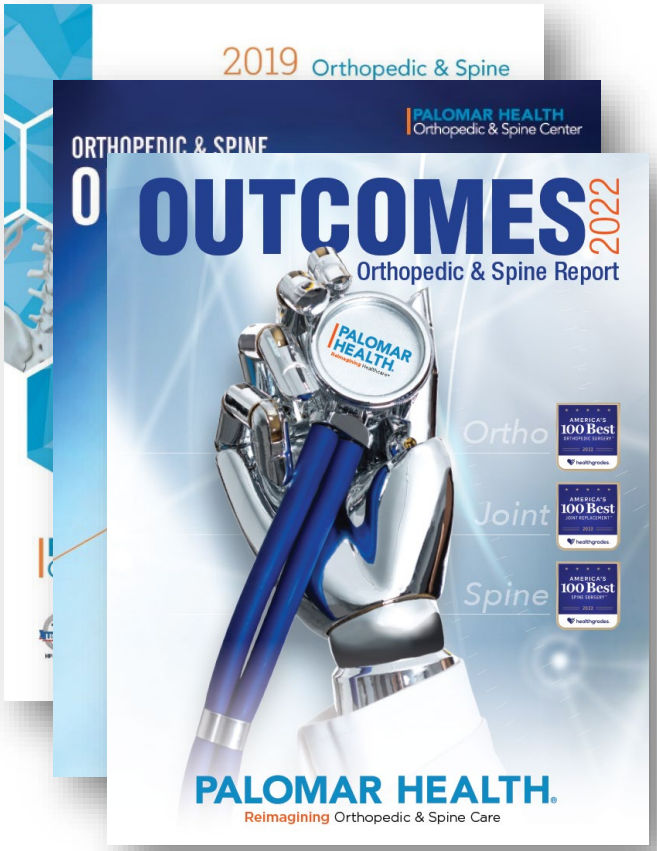
Quality Metrics | Patient's Reduction in Disability



Why is this important?

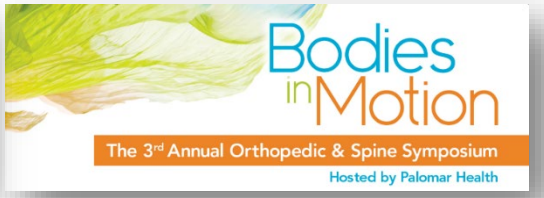
Palomar Health wants to know how much surgery has improved our patients' daily lives. Patients report on their function & pain before and after surgery. We use a standardized survey called Oswestry Disability Index (lower score the better).

Telling Our Story



2015

2016



2017

2018

2019

2020

2021

2022

2023

Goals for 2023

- Focus on keeping surgical site infections to below threshold
- Host the 10th Annual Orthopedic and Spine Symposium
- Publish our 3rd Orthopedic and Spine Outcomes Report
- Ensure total joint patients are ambulating on POD0
- Ensure total joint surgeons are documenting Share Decision Making principles when discussing surgical options with the patient.
- Ensure patient's education needs are being met at discharge, by including the medicine reconciliation form that includes last dose and next dose.

PALOMAR HEALTH

ATTACHMENT G

Laboratory Annual Presentation

(including Blood Use & Pathology Reports)

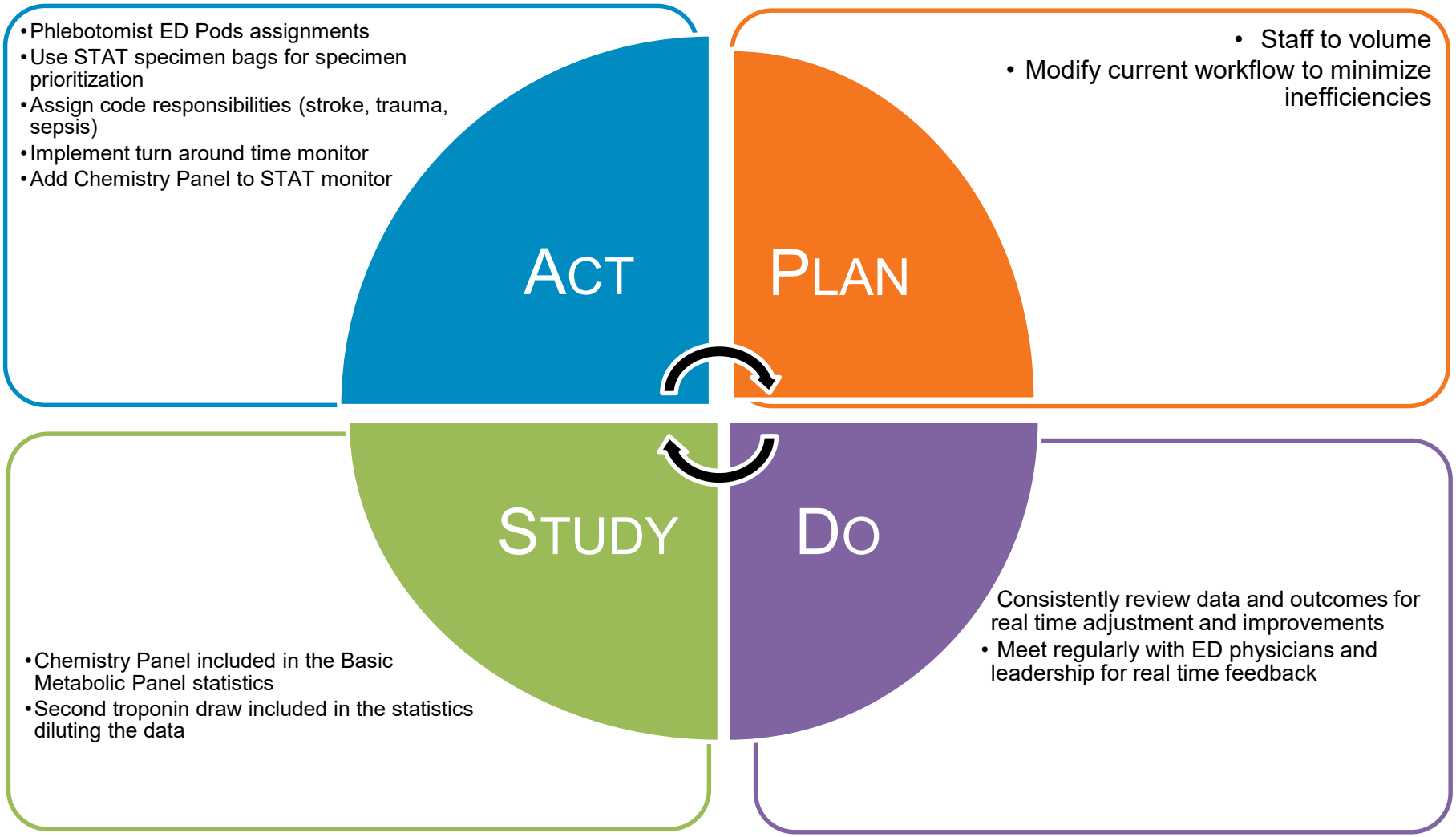
Presented to
Board Quality Review Committee

Jerry Kolins, M.D., Medical Director, Laboratory
Gloria Austria, Senior Director, Laboratory, Respiratory, EEG Services
May 24, 2023

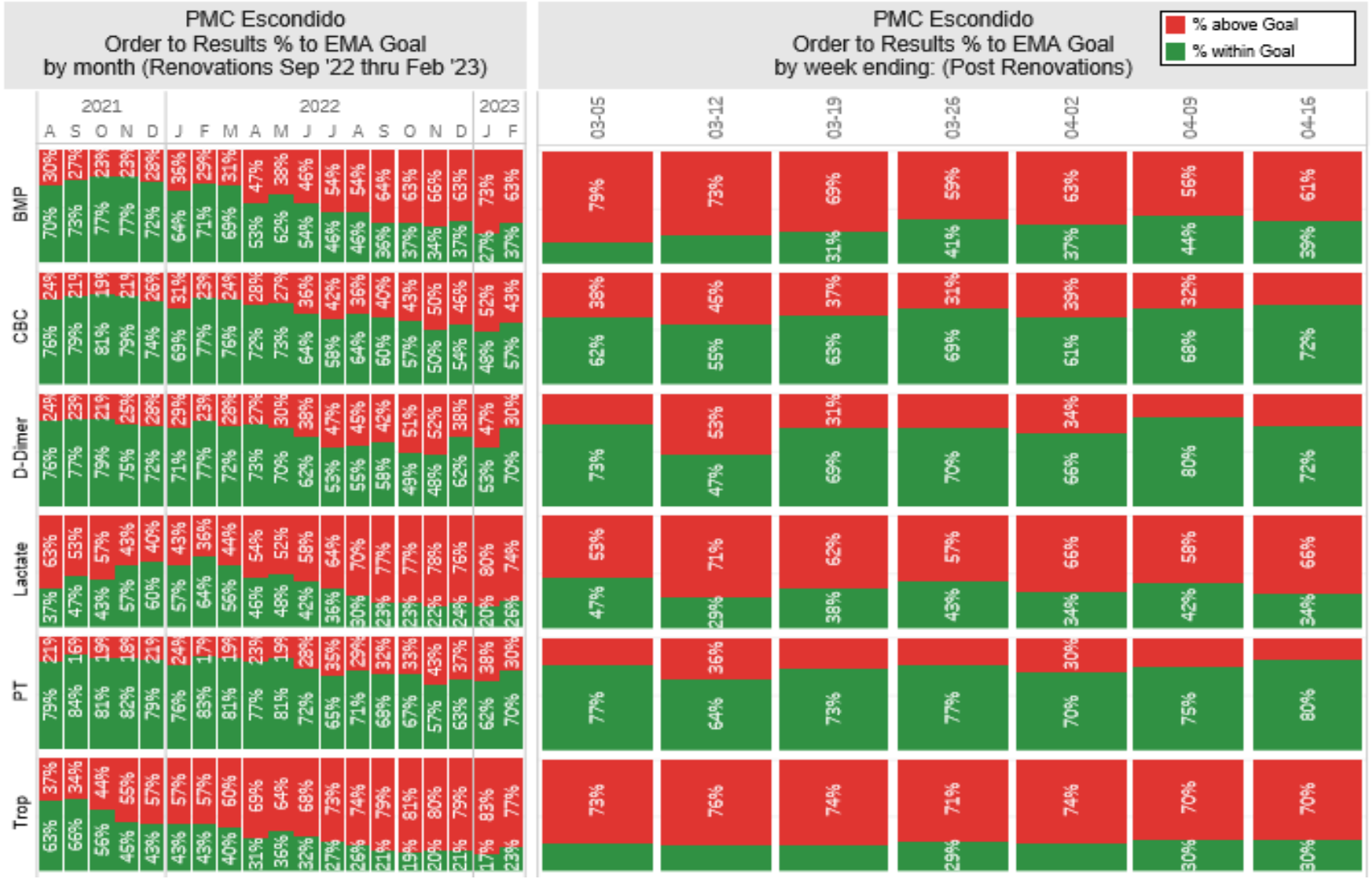
Delay in Order to Completion on Stat orders from Emergency Department (ED)

SITUATION	The ED STAT turn around time for Complete Blood Count (CBC), Basic Metabolic Panel , (BMP), Chem Panel, Troponin, and Lactic Acid continue to be a challenge at Palomar Medical Center Escondido (PMCE) Laboratory
BACKGROUND	The performance measure is test completion within 45 minutes for CBC, 60 minutes for BMP, Chem, Lactic Acid, and Troponin from the time the sample is ordered to test result verification.
ASSESSMENT	In review of the process, the following were the identified challenges: 1. **Pre-analytical phase** - Access to patient with other diagnostic procedures - Shift in peak hours and staffing needs - Staffing challenges - STAT receiving prioritization 2. **Analytical/Testing** - New Chemistry automation line implementation with pre-implementation construction that started July 2022 (manual processing), Chemistry instrument went live Feb 28, 2023 - New equipment reliability - New equipment, workflow, software, middleware learning curve 3. **Post analytical** - Data published on the DART report did not match the laboratory data, 2nd troponin draw and Chemistry Panel included in the Basic Metabolic Panel reporting
RECOMMENDATION	- Staff to volume - Review and modify workflow to prioritize processing, monitoring, and tracking of STAT specimens - Review data for accuracy and appropriate action plan - Staff re-training and upskilling - Establish vendor support for training - Engage vendor on timely service commitment and pro-active approach to address instrument failures

PDCA: Order to Completion on STAT orders from Emergency Department



FY 23 Process Improvement Focus Data



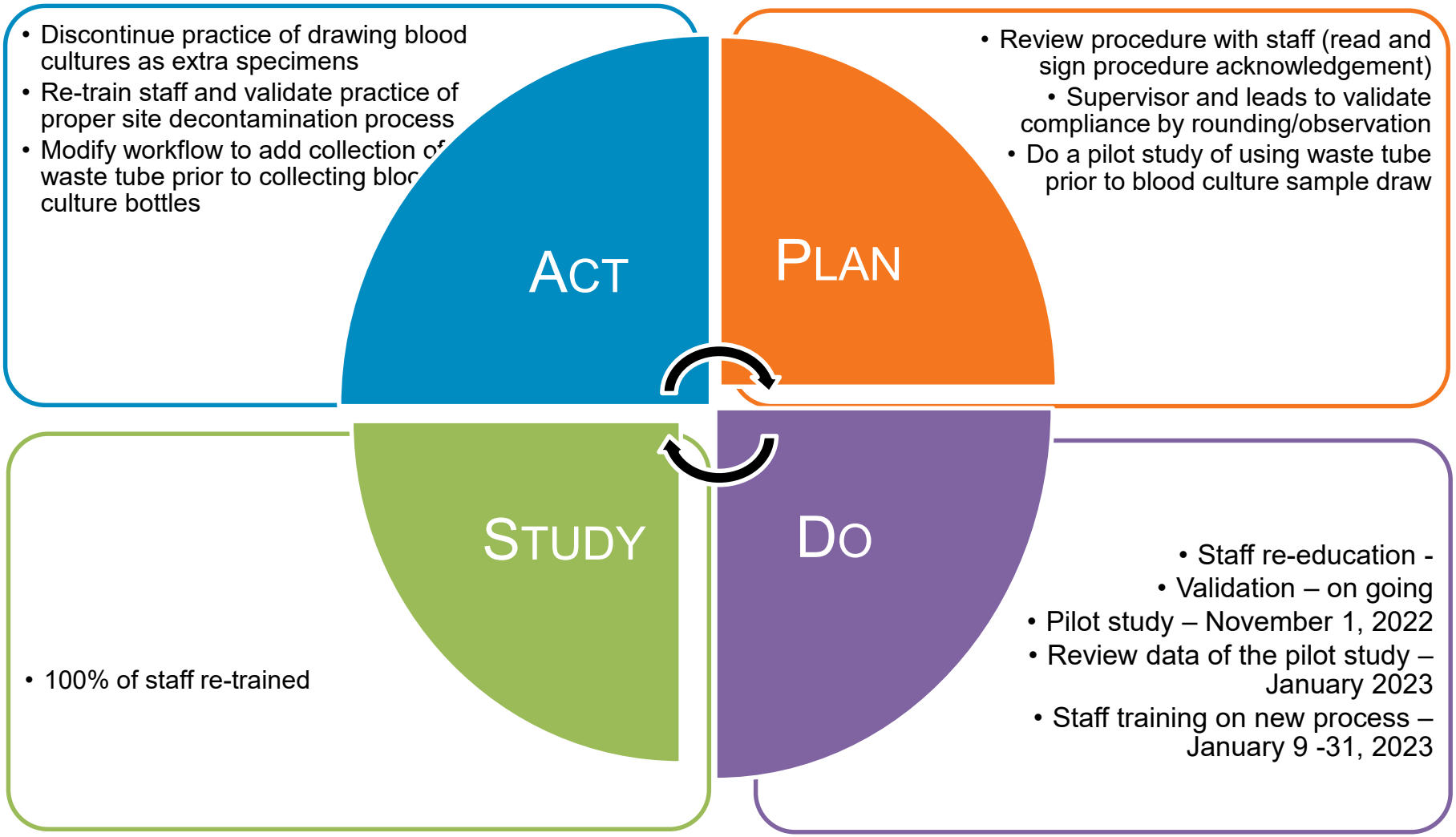
Action Plan with Timeline

- Aggressive recruitment and onboarding (hiring incentive, critical staffing incentive) – December 2022/January2023
- Implementation of new STAT specimen bag system for prioritization – February 6, 2023
- Shift hours and staff to volume – March 12, 2023
- Modify ED unit assignments (dedicated phlebotomist)– March 12, 2023
- Temporary staff to manage manual process – On going
- Shift hours on the analytic side to support the volume – Training in progress
- Code assignment/responsibility – Feb 14, 2023
- Set up a work station for Chemistry STAT pending management – March 13, 2023
- TAT monitor tracker implemented for BMP, Troponin, Lactate, and added Chem Panel – March 15, 2023
- Retrained Chemistry instrument operators – March 6 to March 31, 2023
- Upskill Chemistry operators - ongoing
- Engaged vendor for full service support – 4/18/2023
- Full Chemistry Line Go live – Target TBD, pending CDPH licensing

Blood Culture Contamination Rate

SITUATION	The blood culture contamination rate is >2 % but <3% since July 2022.
BACKGROUND	The outcome measure is a contamination rate target of < 2.0 % at Palomar Health. The national benchmark is <3% with < 1% as the recommended stretch goal.
ASSESSMENT	In review of the process, the following were the identified challenges: - Inconsistent decontamination process - Practice of drawing blood culture samples as extra specimens, not using the recommended decontamination process - Not enough wasted blood to minimize skin contaminants - Staff turnover and backfilled with new grad/licensed personnel - Strict adherence to procedure for correct volume and order of draw
RECOMMENDATION	- Discontinue practice of drawing blood cultures as extra specimens - Re-train staff and validate practice of proper site decontamination process, order of draw, and correct volume - Modify workflow to add collection of a waste tube prior to collecting blood culture bottles

PDCA: Blood Culture Contamination Rate



Data

Pre-analytical Performance Indicators													
				FY 23									
Metrics	**Frequency**	**Target**	**Units**	**Monthly Data**									
				July	August	September	October	November	December	January	February	March	
Blood Culture Contamination													
Escondido	Monthly	<2.0	%	2.70%	2.30%	2.50%	2.2	2.10%	2.30%	2.10%	2.70%		
Poway				1.50%	2.10%	1.80%	1.2	1.10%	1.60%	1.20%	1.80%		

Action Plan with Timeline

- Staff re-education on proper site decontamination- completed
- Validate staff compliance on correct decontamination process – ongoing
- Pilot the use of waste tube prior to collection – November 1, 2022
- Review data on pilot data to measure success – January 1, 2023
- Implementation of the new waste tube process prior to blood culture collection – February 1, 2023

FY 23 Accomplishments

- Fentanyl assay added as part of the Urine Drug Screen in January to be compliant with Tyler's Law
- Courtesy call on ED patients with first Lactic Acid >2 and <4
- Went live with new Chemistry equipment on February 28, 2023
- Critical value reporting compliance meets target
- Positive Patient identification compliance meets target

PMC Escondido and PMC Poway Blood Use Committee Report
Interpretation and Summary

Jerry Kolins, MD, Medical Director
April 19, 2023

The Blood Use Committee meets quarterly and reports to the Quality Management Committee semi-annually.

The Blood Use Committee evaluates appropriateness of blood transfusion as well as efficient and effective use of laboratory testing in the transfusion service. The Committee concluded review of the 2022 calendar year at its meeting on February 6, 2023. Based on chart review triggered by pre-transfusion testing, the medical staff continues to follow performance guidelines as outlined in the minutes of these meetings.

As regards efficient laboratory testing we use the crossmatch:transfusion ratio to assess effective use of the clinical laboratory. This ratio continues to be less than 2 indicating excellent performance as shown in the spreadsheets from each acute care facility. This success is largely due to medical staff decisions as regards type and screen ordering practice as well as reflexive testing when antibody screens are positive. Blood product wastage is also tracked, trended and, when indicated, individual physicians or departments are notified of any deviations from expectation.

All suspected transfusion reactions are evaluated by the Department of Pathology and a written report is issued based on the clinical findings and the serologic test results. Our most frequent confirmed transfusion reactions are the febrile non-hemolytic reactions and allergic (hives) reactions. Delayed hemolytic reactions are detected about once every 2-3 years and are due to undetectable alloantibody prior to transfusion followed by an anamnestic response to transfusion. This is a non-preventable occurrence. There has not been a transfusion related death at either institution.

The Blood Use Committee at the direction of the Medical Executive Committee uses a transfusion review trigger of hemoglobin greater than 8g/dl. A random sampling of transfusions with pre-transfusion hemoglobin > 8 g/dL are reviewed by the Blood Use Committee and documentation of review and assessment is kept in the Medical Staff Office.

Review of individual chart review for 2022 indicates strong medical staff awareness of a transfusion trigger of less than 8 g/dL in that most transfusions occur with pre-transfusion hemoglobin values less than 8 g/dL. Due to acute blood loss in trauma and intraoperative hemorrhagic cases, exceptions to the established transfusion review trigger exist and are documented in review of such cases.

PALOMAR HEALTH
Reimagining Healthcare

Palomar Medical Center Escondido
Transfusion Medicine Review 2022

Blood Usage: Blood Bank Director	Target(s)	Best Practice	CY Total 2017	CY Total 2018	CY Total 2019	CY Total 2020	CY Total 2021	1st QTR 2022	2nd QTR 2022	3rd QTR 2022	4th QTR 2022	CY Total 2022
1a Total red blood cell transfusions	100%		5877	6371	6810	5614	6367	1608	1276	1442	1518	5844
1b. Transfusions Meeting Criteria (%) (# meet criteria/ # reviewed)	100%		234/240= 97.5%	237/240= 98.75%	235/240= 97.9%	238/240 = 99%	238/240= 99.2%	60/60= 100%	59/60= 98.3%	60/60= 100%	60/60= 100%	239/240= 99.58%
2. Crossmatched to transfusion (C:T) ratio (hospital wide)	< or= 2.0	< or= 1.5	9365/5877= 1.59	9467/6371= 1.49	9322/6810= 1.37	8481/5614= 1.51	9197/6367= 1.44	2318/1608= 1.44	1833/1276= 1.44	2053/1442= 1.42	2205/1518= 1.45	8409/5844= 1.44
3. % wasted RBC units (% outdate/# RBC received	< or= 0.5%	< or= 0.1%	29/6000= 0.48%	56/6408= 0.84%	24/6692= 0.36%	31/5683 = 0.55%	40/6340= 0.63%	6/1624= 0.37%	7/1342= 0.52%	7/1465= 0.48%	4/1528= 0.26%	24/5959= 0.40%
4. % expired / RBC received	< or= 0.5%	< or= 0.1%	49/6000= 0.82%	28/6408= 0.44%	16/6692= 0.24%	22/5683 = 0.39%	10/6340= 0.16%	0/1624= 0%	2/1342= 0.15%	1/1465= 0.07%	0/1528= 0%	3/5959= 0.05%
5. Reported Reaction Rate= # reported Transfusion Reactions / total # transfusions (hospital-wide)												
a. Hemolytic	< 1%		0	0	0	0	0	0	0	0	0	0
b. Febrile Non-Hemolytic	< 5%		17/5877= 0.3%	8	14	9	5	5	1	2	1	9
c. Allergic			11/5877= 0.2%	9	7	5	3	0	4	1	0	5
d. Transfusion Related Acute Lung Injury (TRALI)	< 1%		0	0	0	0	0	0	0	0	0	0
e. Fluid overload (TACO)			0	0	2	1	2	0	0	0	0	0
f. Bacterial Contamination			0	0	0	0	0	0	0	0	0	0
g. Transfusion Rx not confirmed			0	3	14	2	5	0	0	2	3	5

PALOMAR HEALTH
Reimagining Healthcare

Palomar Medical Center Poway
Transfusion Medicine Review 2022

Blood Usage: Blood Bank Director	Target(s)	Best Practice	CY Total 2017	CY Total 2018	CY Total 2019	CY Total 2020	CY Total 2021	1st QTR 2022	2nd QTR 2022	3rd QTR 2022	4th QTR 2022	CY Total 2022
1a. Total red blood cell transfusions	100%		1123	1186	1365	1482	1425	252	304	252	300	1108
1b. Transfusions Meeting Criteria (%) (# meet criteria/ # reviewed)	100%		120/120= 100%	101/101= 100%	119/120= 99.2%	119/120= 99%	108/110= 98.2%	30/30= 100%	30/30= 100%	30/30= 100%	30/30= 100%	120/120= 100%
2. Crossmatched to transfusion (C:T) ratio (hospital wide)	< or= 2.0	< or= 1.5	1591/1123= 1.42	1746/1186= 1.47	1799/1365= 1.32	474/370 = 1.28	1745/1425= 1.30	408/252= 1.62	400/304= 1.32	330/252= 1.31	410/300= 1.37	1548/1108= 1.40
3. % wasted RBC units (% outdate/# RBC received	< or= 0.5%	< or= 0.1%	4/1205= 0.33%	2/1261= 0.16%	8/1432= 0.56%	4/1512 = 0.26%	6/1435= 0.42%	1/227= 0.44%	1/328= 0.30%	0/261 = 0%	0/312= 0%	2/1128= .18%
4. % expired / RBC received	< or= 0.5%	< or= 0.1%	0/1205= 0%	3/1261= 0.24%	1/1432= 0.07%	2/1512 = 0.13%	2/1435= 0.14%	0/227= 0%	0/328= 0%	0/261= 0%	0/312= 0%	0/1128= 0%
5. Reported Reaction Rate= #reported Transfusion Reactions / total # transfusions (hospital-wide)												
a. Hemolytic	< 1%		0	0	0	0	0	0	0	0	0	0
b. Febrile Non-Hemolytic	< 5%		3/1123= 0.3%	3	2	4	7	0	2	0	0	2
c. Allergic			1/1123= 0.1%	1	2	1	2	0	1	0	0	1
d. Transfusion Related Acute Lung Injury (TRALI)	< 1%		0	0	0	0	0	0	0	0	0	0
e. Fluid overload (TACO)			0	0	0	0	1	0	0	0	0	0
f. Bacterial Contamination			0	0	0	0	0	0	0	0	0	0
g. Transfusion Rx not confirmed			0	0	2	2	4	0	0	0	1	1

Pathology QA Summary PMC/Escondido 2022

	Benchmarks	1Q	2Q	3Q	4Q	2022	2021	2020	2019	2018
# surgical	N/A	1846	1951	1990	1996	**7783 (+1.8%)**	**7643 (+1.8%)**	**7520**	**10505**	**10829**
# QA +IDC review	>10%	20%	21%	19 %	20 %	20%	20.5%	18%	11%	12%
# Discordant <u>Total</u> : -Outside review - consultations	0-2	0/28 0/21 0/7	0/28 0/11 0/17	0/32 0/14 0/18	2/39 2/25 0/14	2/127 2/71 0/56	2/150 2/97 0/53	2/119 1/65 1/54	2/231 0/120 2/111	4/225 2/164 2/61
TAT time (% of < 48 h)	>90%	90.3%	92%	90 %	90%	91%	92%	93%	91.6%	92.5%
# FS cases	N/A	67	42	79	78	266	288	347	351	413
# discordant FS/perm: <u>Total:</u> Due to misinterpretation Due to sampling	5% or less	6% (4) 0 6% (4)	4%(2) 0 4% (2)	5% (4) 0 5%(4)	3%(3) 0 3% (3)	4.5% (13) 0 4.5% (13)	1.3% 0.3% 1%	2% 0 2%	2.3% 0.3% 2%	3.6% 0.2% 3.4%
TAT FS: Average (min) % called in < 20 min	<20 min >90%	14min 100%	15 min 100%	13 min 100%	14 min 97%	14 min 99%	12.75 min 97%	12 min 99.75%	13 min 99%	13 min 98%

Pathology QA Summary PMC/Poway 2022

	Benchmarks	1Q	2Q	3Q	4Q	2022	2021	2020	2019	2018
# surgical	N/A	661	682	696	761	**2800 (+0.6%)**	**2785 (+15%)**	**2365**	**2978**	**3236**
# QA review	>10%	26.5%	22%	28 %	25%	25%	23%	24%	16.75%	14%
# Discordant Total : -Outside review - consultations	0-2	0/14 0/8 0/6	0/13 0/9 0/2	0/10 0/8 0/2	0/16 0/14 0/2	0/53 0/39 0/12	0/57 0/42 0/15	1/63 1/58 0/5	0/57	0/50
TAT time (% of < 48 h)	>90%	89.9%	93%	91.7%	90.4%	91.3%	92%	93%	91.6%	94%
# FS cases	N/A	45	56	54	55	210	201	141	180	182
# discordant FS/perm: Total: Due to misinterpretation Due to sampling	5% or less	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	2.9% 0 2.9%	0.7% 0 0.7%	2% 0 2%	1% 0 1%
TAT FS: Average (min) % called in < 20 min	<20 min >90%	14 min 97%	14.5 min 100%	15 min 97 %	12 min 98%	14 min 98%	12.5 min 98.5%	13 min 99.5%	13 min 97%	13 min 98%

PALOMAR HEALTH

ADDENDUM H

Respiratory Annual Presentation
Presented to
Board Quality Review Committee

Gloria Austria, District Sr. Director Respiratory Care, EEG, LAB
Frank Bender MD Medical Director
Kerwin Pipersburgh, District Sir Manager Respiratory Care, EEG
Krysti Johnson, District Manager Respiratory Care, EEG
Chris Perez, District Supervisor Respiratory Care, EEG
Margaret Strimple, District Supervisor Respiratory Care, EEG
May, 2023

Access to care Pulmonary Function Test (PFT)

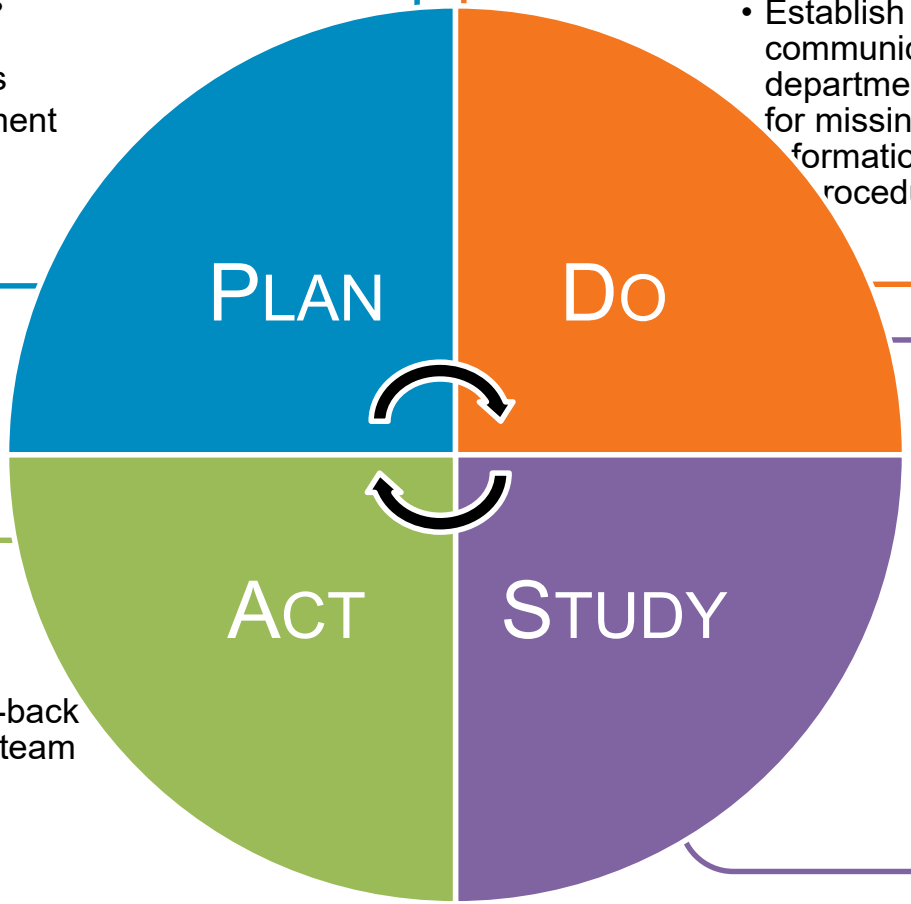
SITUATION	Historically patients who tried to schedule a PFT at Palomar Health encountered a very inefficient process which included many pain points causing delay in access to care
BACKGROUND	Palomar Health patients in need of a PFT had to schedule their testing using a system that many times created a delay in testing
ASSESSMENT	Challenges Identified • No dedicated appointment phone line • No structured appointment process including dedicated scheduler • Lack of communication between department and physician's office on patients with missing or incorrect information • Patients not calling back after 3 attempts to schedule an appointment • Patients opted to use another facility because of insurance
RECOMMENDATION	• Set up a performance metrics for accountability with a target of access to care within 5 days from patient call back to appointment is scheduled for the procedure • Have a consistent daily schedule to manage appointments • Assign a dedicated phone line with voicemail set up for patients to leave call back number • Establish a process to communicate with the referring provider if unable to contact patient

Access to Care PFT: (Pulmonary Function Test)

TAT: (Turnaround Time)

- Performance measure from the time the patient called back to time the appointment was scheduled
- Set target at within 5 days
- Structure for the appointment process

- Dedicate scheduler to PFT
- Set up a dedicated phone line
- Establish an effective communication between the department and ordering provider for missing and incorrect formation or if the patient refused rocedure



- Audits with real time feed-back is provided to Pulmonary team

- Education in this initiative will be provided to team
- Review of adherence to establish guidelines by health care team

Access to Care: PFT (Pulmonary Function Testing)

- PFT: TAT (Turnaround Time) = time from scheduling to completed testing
- No baseline data, identified as a process improvement opportunity from patient complaints and physician feedback

				FY 24									
Metrics	Frequency	Target	Units	Monthly Data									
				July	August	September	October	November	December	January	February	March	April
Acess to Care-PFT	<5 days	90%	%	n/a	n/a	**n/a**	**n/a**	**n/a**	**81**	**88**	**100**	**100**	

VAP (Ventilator Associated Pneumonia) Bundle

SITUATION	• Elements of the VAP bundle are currently charted in several locations in the patients Electronic Medical Record (eMR) • Completion of the VAP bundle is a pivotal part of reducing VAE (Ventilator Associate Events) • Validation of perfumed elements of the VAP bundle is essential to reducing VAE rates
BACKGROUND	• Elements of the VAP bundle are a shared responsibility by the critical care team with charting done by each discipline • Currently the VAP Bundle audits are completed manually by the Respiratory Care leadership team because of decentralized charting by the patient care team
ASSESSMENT	Respiratory Care leadership currently completes the VAP Bundle audits manually and charting for the components that make up the bundle is not reflected in a centralized location in the eMR Challenges Identified: • Staff education to charting elements of the VAP bundle directly in one location in the patient's eMR • Information Technology (IT) continuing support as we move forward with final implementation of Cerner build
RECOMMENDATION	• Continue best practice of completing 30 audits per month of VAP bundle • Finalize VAP bundle IT build in Cerner • Final implementation/education of patient care team to completed VAP bundle charting in a central location in the eMR

VAP (Ventilator Associated Pneumonia) Bundle

- Continue best practice with 30 audits of VAP bundle
- Centralize VAP Bundle Charting in Cerner

- IT build in Cerner
- Education of patient care team of centralized VAP bundle documentation

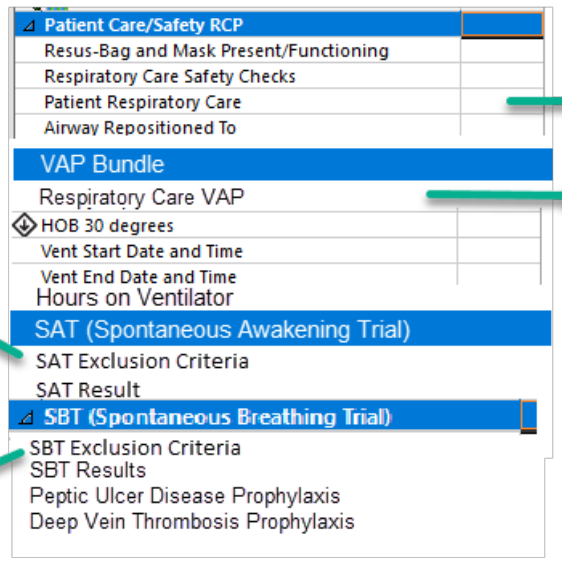
- Audits with real time feed-back is given to health care team

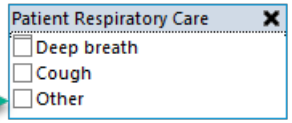
- Education in this initiative will be provided to team
- Review of adherence by health care team

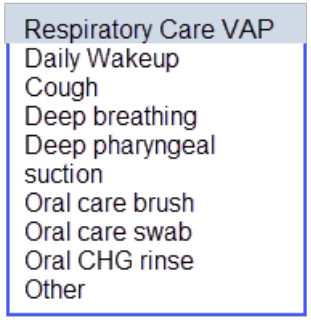
VAP BUNDLE CERNER Charting

Active seizures
Alcohol withdrawal
Agitation (SAS 3-4)
Paralytics
Myocardial ischemia
Abnormal intracranial pressure
None *(If None selected, open SAT Complete DTA)*

- SAT Result (single select)
  - Pass, complete SBT
  - Fail, restart sedatives at half dose
  - Other







Agitation (SAS 3-4)
SpO2 less than 88%
FiO2 greater than 50%
PEEP greater than 7.5 cm H20
Myocardial ischemia
Vasopressor use
No inspiratory efforts
None *(If None selected, open SAT Complete DTA)*

- SBT Result (single select)
  - Pass, consider extubation
  - Fail, full vent support
  - Other

FY 23 Accomplishments and Process Improvement Focus

Accomplishments

- VAP rounding charting in the eMR is nearing IT build out
- 95% of patients requesting PFT are scheduled within 5 days
- NICU was opened successfully with new Servo-N vent training for Respiratory Care Professional (RCP)

Process Improvement Focus

- IT build for ARDS NET
- ARDS (Adult Respiratory Distress Syndrome) NET protocol is nearing committee approval and
- Decrease Ventilator Associated Events (VAE)
  - Decreasing Infection-related Ventilator Associated Complication (IVAC) rate across the district post COVID

Thank you

ADDENDUM I

PALOMAR HEALTH

Quality Assurance & Performance Improvement (QAPI)

2022

Annual Review and Program Assessment

Table of Contents

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 healthcare 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, which 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 continuous improvement). A calendar of reporting is used to ensure ongoing systematic communication with all key stakeholders, ensure accountability, and maintain the ongoing improvement gains for all QAPI activities.
6. Educational programs are designed to enhance statistically-based QAPI tools for every level of leadership, physicians, and staff.
7. Standardized processes for investigating and following up on near-miss, adverse, and sentinel events when appropriate. These standardized processes address the following:
    a. What practice/process change is required to prevent recurrence?
    b. How will the practice/process change 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

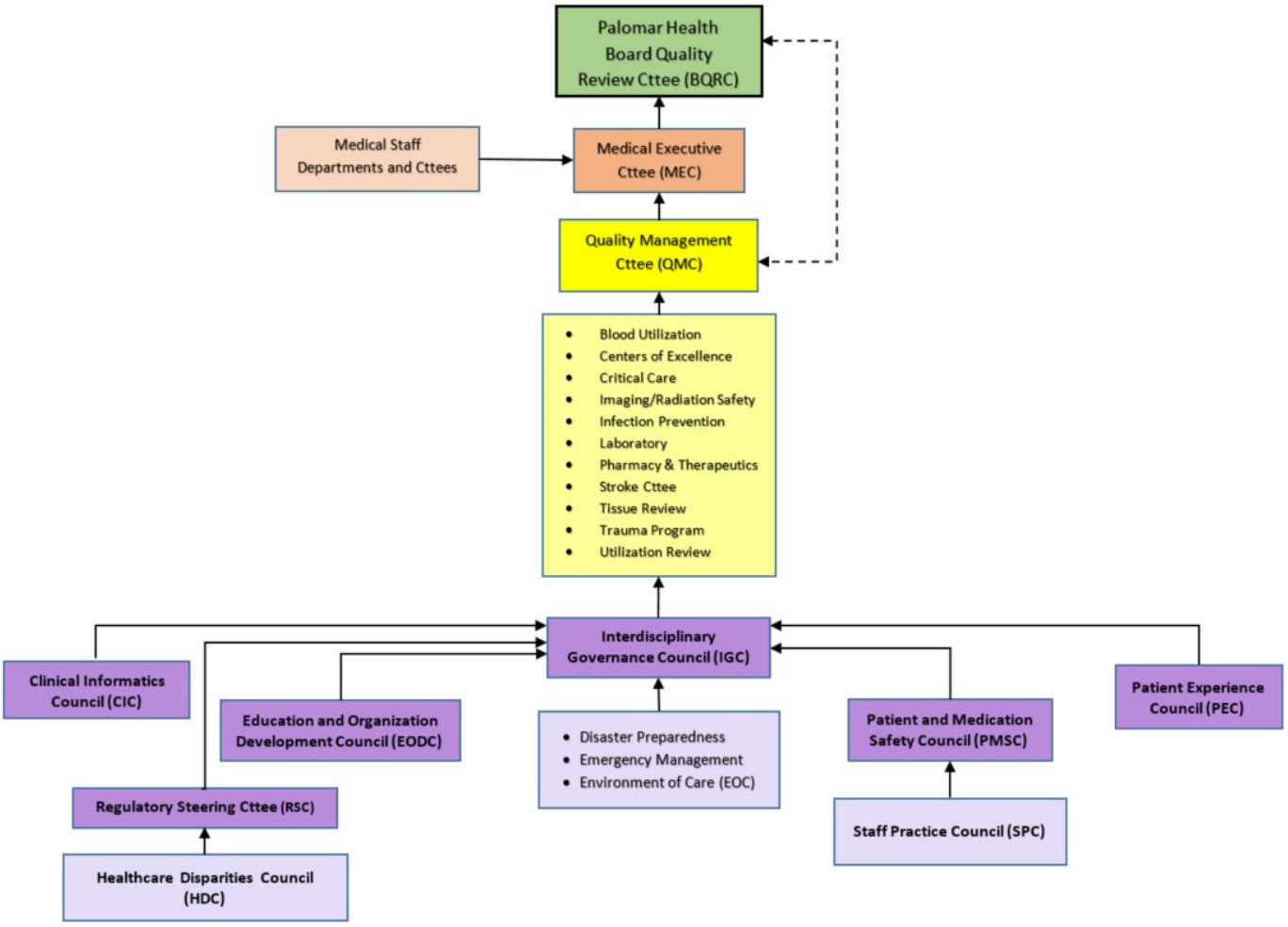
As part of the annual evaluation of our QAPI Program, specific priority Process and Performance Improvement (PI) activities are identified each calendar year.

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 our recent performance; identifying opportunities for improvement; developing and implementing corrective plans; and monitoring the effectiveness of interventions. The reach of the QAPI program is organization-wide.

Services for review 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



Performance Improvement Projects

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, process analysis, and the Interdisciplinary Governance Council's direction. The Quality Department assists in identifying additional PI projects when facilitating Root Cause Analyses (RCA) and supports leaders in implementing associated action plans to address performance improvement issues. The Quality and Patient Safety Department reviews Quality Review Reports (QRR) daily to address issues contemporaneously by disseminating information on daily huddle calls, supporting the escalation of adverse events, and addressing the educational needs of staff. They also track and trend the QRRs to identify PI opportunities.

2022 Accomplishments

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

1. **Interventional Radiology**
   Opportunity: Worked collaboratively with Department Director to address the following:
   - Enhance process of conducting pre-procedure briefings per universal protocol procedure.
   - Reinforce process of performing Time Outs and marking laterality.
   - Reinforce documentation standards for informed consent.

   Improvement Work:
   - Implementation of IR universal protocol boards.
   - Site markings are performed with the involvement of the patient/responsible party and provider in the pre-op area.
   - RN is actively involved in visualizing the actual site being marked.
   - Verifying that the procedure written on the consent matches the procedure identified on the informed consent.

   2023 Goals:
   - Conduct intermittent audits of compliance with universal protocol boards, time out procedure, and consent documentation.

2. **Surgical Services**
   Opportunity: Worked collaboratively with Department Director to address the following:
   - Reinforce standards of the universal protocol for surgery.
   - Competency and training of Myosure.
   - Procedure for standards of care related to specimen labeling.

   Improvement Work:
   - Created provider documentation to be used to attest that they conducted a debrief.
   - Create a nursing attestation in the operative note stating that debrief occurred.
   - iXpand module created to train RNs and Surgical techs on Myosure.
   - Revise Lucidoc #15109, Standards and Care of Specimens, to include process on how to collect specimen when not handed off from sterile field.

2023 Goals:

- Audit debrief process for 6 consecutive months looking for ≥90% compliance, then 4-month audit check.
- Audit specimen identification process by provider for 6 consecutive months looking for 100% compliance, then 4-month audit check.
- Audit specimen labeling process identification process for 6 consecutive months looking for 100% compliance, then 4-month audit check.

3. **Nuclear Medicine**

Opportunity: Worked with Department Leaders to address the following:

- Improve the process for procedure site verification.

Improvement Work:

- Create and institute use of a body diagram form for site verification.
- Revise Lucidoc #13724, Radioactive Material-Injection, to include detail regarding Role/responsibility of Radiologist, site verification process, and Time Out.

2023 Goals:

- Audit documentation and process of site verification for 6 consecutive months with 100% compliance, them 4-month audit check.
- Conduct intermittent audits of compliance with established policy and procedure.

4. **Sepsis Steering Committee**

Improvement Work:

- Collaborated with ED, Hospitalist, and ICU physicians to share best practices.
- Reviewed and updated Sepsis Order Sets.
- Enhanced the process for leveraging information technology (Cerner) to help meet SEP-1 core measure requirements.
  - Process has been enhanced that whenever the QM Sepsis Initial Documentation Form is utilized, it will trigger Cerner to scan for ordering blood cultures. Blood cultures will automatically be ordered by the computer system if not already ordered.
  - The computer system will automatically order a single repeat lactate level in response to any initial abnormal lactate level >2 mmol/L.
- Sepsis chart abstraction validation team continued to meet regularly, identify individuals or departments responsible for each Sepsis core measure fallout, and provide feedback directly to the individuals or department leaders.

Outcomes:

- Achieved Sep-1 Compliance rates at or above National Benchmarks in three of four quarters in 2022.

2023 Goals:

- Compliance rates at or above national average rates in all quarters of 2023.
- Conduct another Sepsis Grand Rounds educational session during the month of September (Sepsis awareness month).

Patient Falls

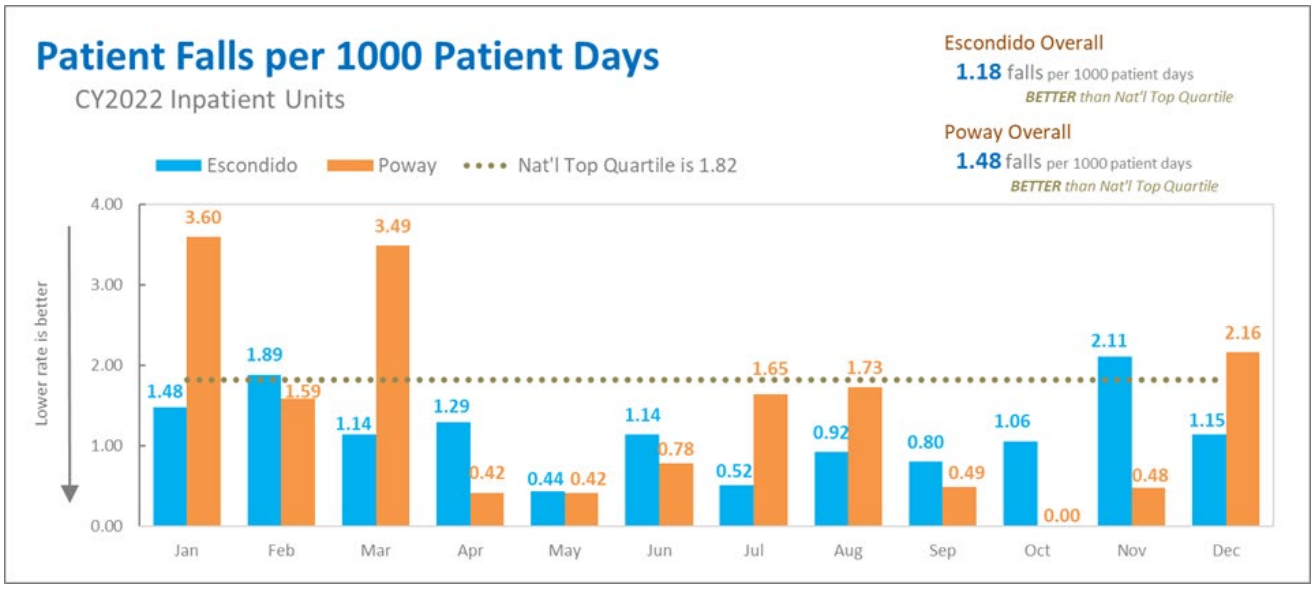
Department - Quality and Patient Safety

In 2022, the Quality Clinical Nurse Specialist (CNS) facilitated Palomar Health's Fall Prevention Program to reduce preventable falls and fall-related injuries in the hospital. Fall data is reviewed and validated monthly with an operational lead. Data and trends are disseminated to leaders across the district; Staff Practice Council (SPC), an interdisciplinary group of frontline staff; and other committees as outlined in the committee and council reporting structure.

Accomplishments

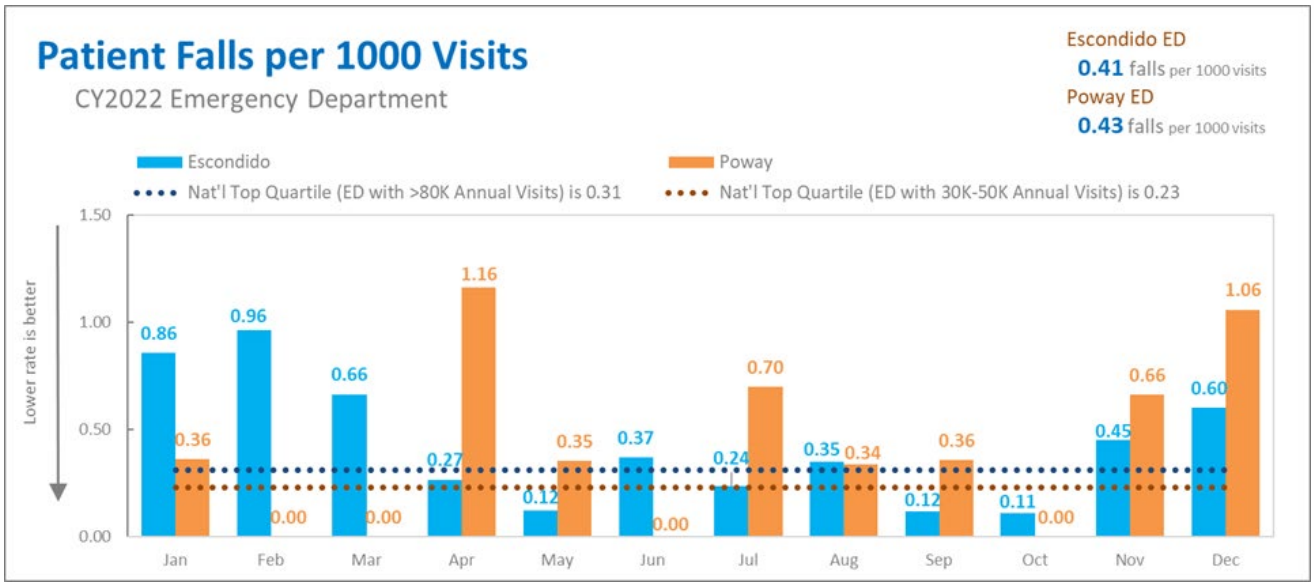
- Overall, Palomar Health inpatient units performed better than the top national quartile for 2022
- New interactive fall graphs were designed and disseminated to leaders to optimize fall analysis

Data 2022



Inpatient

- **PMC Escondido**: 1.18 falls per 1000 patient days, better than the national top quartile, 1.82
- **PMC Poway**: 1.48 falls per 1000 patient days, better than the national top quartile, 1.82



Emergency Department

- **PMC Escondido:** 0.41 falls per 1000 visits, above the national top quartile, 0.31
- **PMC Poway**: 0.43 falls per 1000 visits, above the national to quartile, 0.23

Goals for 2023:

- Palomar Health district to perform at or better than the top national quartile.
- 5 percentage point reduction in accidental and anticipated physiological falls across the district.
- Collaborate with administrate and clinical leaders to identify, evaluate, and implement a fall risk and assessment tool by end of the calendar year.

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 2022 (Calendar Year) Performance for Pressure Injuries

   - PMC Escondido
     - Percentage of Patients with HAPI Stage >2 maintained at 0.00% for CY2022
   - PMC Poway
     - Percentage of Patients with HAPI Stage >2 maintained at 0.00% for CY2022

   During 2022, the WOCN team leveraged the monthly HAPI call to work with system leaders and clinical educators to understand and remove identified barriers for the bedside nurse to provide care to prevent HAPI. With that, we continue to achieve zero reportable avoidable HAPIs in the health system.

   The WOCN team pulled together a system-wide flash mob to promote HAPI prevention awareness throughout the health system and community.

2. **Improvement Work:**

   Developed information cards and resources for the nursing staff and published them on the intranet. Topics included Wound Vac/Vashe® and moisture associated skin damage prevention.

3. **2023 Goals:**
   - Continue achieving zero reportable HAPI while decreasing non-reportable HAPI incidence.
   - Collaborate with system leaders to develop and launch an Ostomy patient journey process to:
     - Decrease the ostomy patient 30-day readmission rate.
     - Improve the Ostomy patient experience.
     - Improve the staff experience through process definition.

PRESS GANEY®

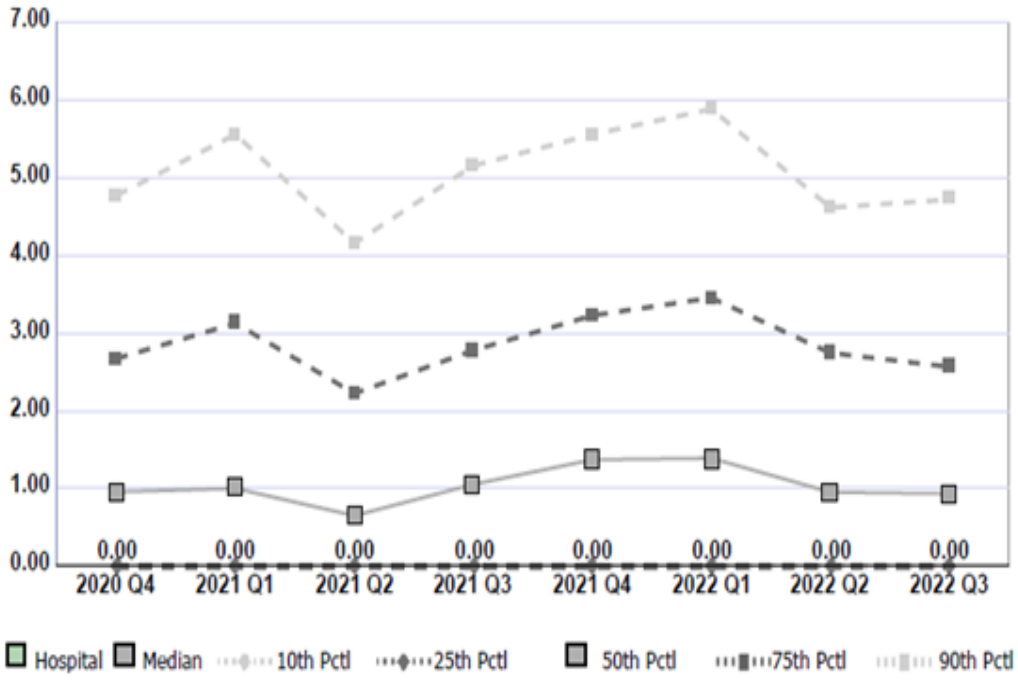
NDNQI™

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



Metrics	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	Average
Hospital-Unadjusted Measure	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Mean	1.77	2.02	1.45	1.90	2.23	2.33	1.79	1.81	1.91
Standard Deviation	2.44	2.78	2.20	2.64	3.61	3.63	2.59	3.90	2.98
10th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
25th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
50th Percentile (Median)	0.96	1.00	0.65	1.05	1.37	1.39	0.95	0.93	1.04
75th Percentile	2.67	3.13	2.22	2.78	3.23	3.45	2.74	2.56	2.85
90th Percentile	4.77	5.56	4.16	5.15	5.56	5.88	4.62	4.72	5.05
# Hospitals	890	949	978	901	886	976	1,051	1,036	958.38

PRESS GANEY®

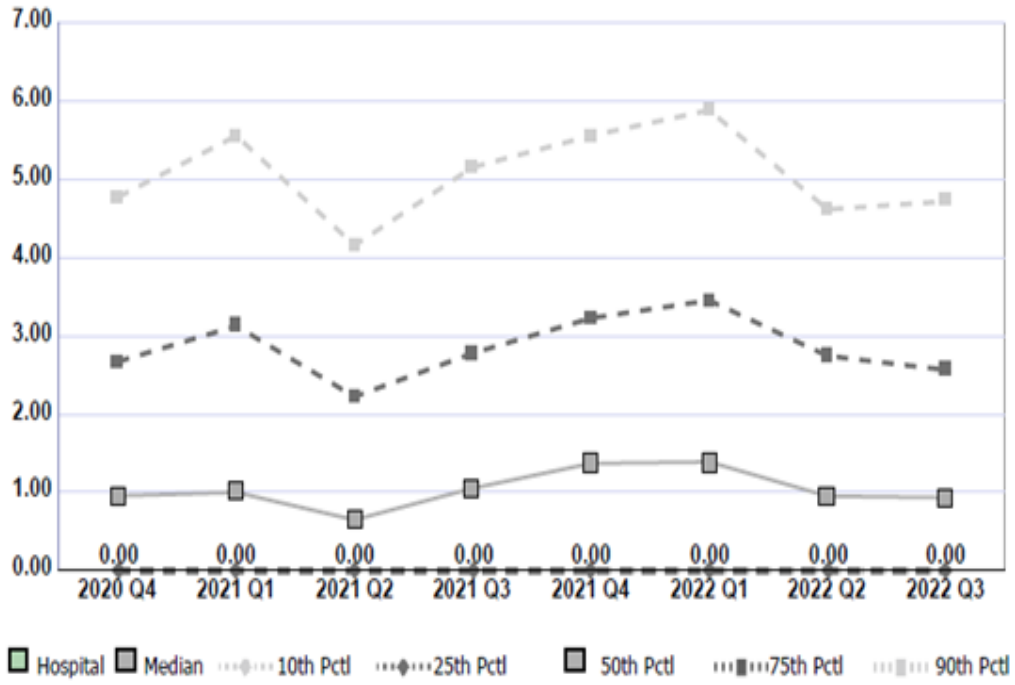
NDNQI™

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



Metrics	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	Average
Hospital-Unadjusted Measure	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
Mean	1.77	2.02	1.45	1.90	2.23	2.33	1.79	1.81	**1.91**
Standard Deviation	2.44	2.78	2.20	2.64	3.61	3.63	2.59	3.90	**2.98**
10th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
25th Percentile	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
50th Percentile (Median)	0.96	1.00	0.65	1.05	1.37	1.39	0.95	0.93	**1.04**
75th Percentile	2.67	3.13	2.22	2.78	3.23	3.45	2.74	2.56	**2.85**
90th Percentile	4.77	5.56	4.16	5.15	5.56	5.88	4.62	4.72	**5.05**
# Hospitals	890	949	978	901	886	976	1,051	1,036	**958.38**

Organ and Tissue Donation Performance Metrics

Palomar Health partners with Life Sharing to facilitate healing and life enhancement through organ and tissue donation.

Types of donation: 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 extubation to comfort care
- Withdrawal of support
- Transition to comfort care or change of code status
- Cardiac death

Quality data

Palomar Medical Center **Report Date: 1/1/2022 - 12/31/2022**

Organ Outcome Measures	Goals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Organ Referrals	**N/A**	26	18	19	21	13	17	23	19	15	24	22	32	**249**
Missed Referrals **	**N/A**	5	1	3	2	1	2	4	2	0	3	3	0	**26**
Organ Potential	**N/A**	1	1	3	2	1	1	2	0	1	2	1	1	**16**
Total Organ Donors	**N/A**	1	1	1	2	1	1	2	0	1	1	1	1	**13**
Organs Transplanted - Lives Saved!	**N/A**	6	0	6	5	4	0	8	0	6	1	2	6	**44**
Conversion Rate	**N/A**	100%	100%	33%	100%	100%	100%	100%	N/A	100%	50%	100%	100%	**81%**
Total Organ Donors / Organ Potential		1/1	1/1	1/3	2/2	1/1	1/1	2/2	0/0	1/1	1/2	1/1	1/1	13/16
DCD Conversion Rate	**N/A**	N/A	100%	N/A	0%	N/A	100%	N/A	N/A	N/A	100%	100%	N/A	**80%**
DCD Donors / DCD Potential		0/0	1/1	0/0	0/1	0/0	1/1	0/0	0/0	0/0	1/1	1/1	0/0	4/5
Effective Request Process	**100%**	60%	200%	100%	80%	100%	50%	133%	100%	100%	75%	100%	50%	**87%**
# Approached by Trained Requestor / Total Approaches		3/5	2/1	3/3	4/5	1/1	1/2	4/3	1/1	2/2	3/4	1/1	1/2	26/30
Organ Referral Rate **	**100%**	84%	95%	86%	91%	93%	89%	85%	90%	100%	89%	88%	100%	**91%**
# Refs. / # Refs. + Missed Refs.		26/31	18/19	19/22	21/23	13/14	17/19	23/27	19/21	15/15	24/27	22/25	32/32	249/275
Organ Timely Referral Rate **	**100%**	35%	42%	32%	30%	43%	32%	15%	29%	47%	48%	20%	41%	**34%**
Referred w/in 1 hour of meeting clinical criteria / # Refs. + Missed Refs		11/31	8/19	7/22	7/23	6/14	6/19	4/27	6/21	7/15	13/27	5/25	13/32	93/275
CMS Conversion Rate **	**75%**	100%	100%	33%	100%	100%	100%	100%	N/A	100%	50%	100%	100%	**81%**
Total Donors / Eligible Deaths + Missed Eligibles + Non-Eligible Donors		1/1	1/1	1/3	2/2	1/1	1/1	2/2	0/0	1/1	1/2	1/1	1/1	13/16
Tissue Outcome Measures	**Goals**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total Tissue Donors	**N/A**	1	5	2	2	5	3	8	2	3	5	2	5	**43**
Routine Referral of ALL Deaths	**Goals**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total Hospital Deaths	**N/A**	111	87	93	72	58	76	77	52	57	69	71	0	**823**
Total NOT Referred	**N/A**	4	2	4	1	1	0	4	0	0	0	0	0	**16**
Compliance Rate	**N/A**	96%	98%	96%	99%	98%	100%	95%	100%	100%	100%	100%	N/A	**98%**

*** Pending Medical Record Review. Due to quality assurance procedures, slight variations in data may occur over time.*

Palomar Medical Center Poway **Report Date: 1/1/2022 - 12/31/2022**

Organ Outcome Measures	Goals	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Total Organ Referrals	**N/A**	3	4	2	1	2	3	3	4	5	3	3	1	**34**
Missed Referrals **	**N/A**	1	1	0	0	0	0	2	0	2	0	0	0	**6**
Organ Potential	**N/A**	0	0	0	0	0	1	0	0	3	0	0	0	**4**
Total Organ Donors	**N/A**	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Organs Transplanted - Lives Saved!	**N/A**	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Conversion Rate	**N/A**	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	0%	N/A	N/A	N/A	**0%**
Total Organ Donors / Organ Potential		0/0	0/0	0/0	0/0	0/0	0/1	0/0	0/0	0/3	0/0	0/0	0/0	0/4
DCD Conversion Rate	**N/A**	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	0%	N/A	N/A	N/A	**0%**
DCD Donors / DCD Potential		0/0	0/0	0/0	0/0	0/0	0/1	0/0	0/0	0/2	0/0	0/0	0/0	0/3
Effective Request Process	**100%**	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	**100%**
# Approached by Trained Requestor / Total Approaches		0/0	0/0	0/0	0/0	0/0	1/1	0/0	0/0	0/0	0/0	0/0	0/0	1/1
Organ Referral Rate **	**100%**	75%	80%	100%	100%	100%	100%	60%	100%	71%	100%	100%	100%	**85%**
# Refs. / # Refs. + Missed Refs.		3/4	4/5	2/2	1/1	2/2	3/3	3/5	4/4	5/7	3/3	3/3	1/1	34/40
Organ Timely Referral Rate **	**100%**	50%	40%	50%	100%	50%	33%	60%	75%	43%	0%	67%	0%	**48%**
Referred w/in 1 hour of meeting clinical criteria / # Refs. + Missed Refs		2/4	2/5	1/2	1/1	1/2	1/3	3/5	3/4	3/7	0/3	2/3	0/1	19/40
CMS Conversion Rate **	**75%**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0%	N/A	N/A	N/A	**0%**
Total Donors / Eligible Deaths + Missed Eligibles + Non-Eligible Donors		0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/0	0/1	0/0	0/0	0/0	0/1
Tissue Outcome Measures	**Goals**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total Tissue Donors	**N/A**	0	1	0	3	0	0	1	0	0	1	1	0	**7**
Routine Referral of ALL Deaths	**Goals**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**YTD**
Total Hospital Deaths	**N/A**	31	27	24	15	18	19	21	16	17	21	31	0	**240**
Total NOT Referred	**N/A**	0	0	0	0	0	0	1	0	0	0	0	0	**1**
Compliance Rate	**N/A**	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%	100%	N/A	**100%**

*** Pending Medical Record Review. Due to quality assurance procedures, slight variations in data may occur over time.*

Accomplishments

In 2022, Palomar Health celebrated **44 lives saved** from organ donors and thousands of others who are healed and can live enhanced lives thanks to the *50 tissue donors* across Palomar Health. This is an amazing accomplishment with a massive ripple effect from donors and their families to recipients!

Successful case outcomes regularly shared with stakeholders via email to close the loop on wins for each campus.

April 2022 - Life Sharing Seminar (Navigating DCD Donation) and celebrations for National Donate Life Month.

Life Sharing coordinators came to PH and provided education, badge reels, water bottles, pens, etc., to bring awareness to clinical triggers and the donation process.

Improving Metrics

There is no goal set for a hospital's conversion rate, as hospitals are not required to achieve a certain number of donors each year. The conversion rate metric is not sent to any quality or regulatory entities and is only used between Life Sharing and the hospital to see a complete picture of all actual and potential donor activity to focus our education efforts.

CY 2022 Goals:

1. Increase organ referral call timeliness to an average of at least 75% by end of CY 2022.
    - CY 2022 Timeliness
        - PMCE 34%
        - PMCP 48%

- Various referral calls were not made within the 1-hr CMS timeframe of meeting a clinical trigger.

2. Increase CMS conversion rate to an average of at least 75% by end of CY 2022.
   - CY 2022 CMS Conversion Rate
     - PMCE 81% (13/16) – Goal Met
     - PCMP 0% (0/1) – one missed eligible donor

2023 goals

1) Increase organ referral call timeliness to an average of at least 75% by end of CY 2023.
2) Decrease missed referrals by 50% by end of CY 2023.

Will continue to host quarterly Life Sharing meetings with all stakeholders to increase awareness and continue to educate on clinical triggers. With many new leaders/staff onboarding within the organization, including them in our educational sessions will be imperative to improved metrics.

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 specific 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 the following:

- 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

PMC Escondido Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg. | Worse than Nat'l Avg. | Reach Top 10% or Best Performance | N/A = Not Available

Measure Set	Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
Sepsis	SEP-1: Sepsis Early Management Bundle *(Higher is better)*	Q4-2021	19	25	76%	57%	80%
		Q1-2022	14	25	56%	57%	79%
		Q2-2022	15	26	58%	57%	79%
		Q3-2022	17	29	59%	58%	78%
Perinatal Care	PCM-01: Elective Delivery *(Lower is better)*	Q4-2021	2	74	3%	3%	0%
		Q1-2022	0	58	0%	2%	0%
		Q2-2022	0	49	0%	2%	0%
		Q3-2022	1	66	2%	2%	0%
	PCM-02a: Cesarean Section *(Lower is better)*	Q4-2021	44	296	15%	25%	N/A
		Q1-2022	61	265	23%	26%	N/A
		Q2-2022	45	251	18%	26%	N/A
		Q3-2022	66	328	20%	26%	N/A
	PCB-05: Exclusive Breast Milk Feeding *(Higher is better)*	Q4-2021	52	99	53%	50%	N/A
		Q1-2022	48	110	44%	50%	N/A
		Q2-2022	67	108	62%	50%	N/A
		Q3-2022	61	104	59%	50%	N/A
	PCB-06.0: Unexpected Complications in Term Newborns - Overall Rate *(Lower is better)*	Q4-2021	10	766	1.3%	3.1%	N/A
		Q1-2022	9	686	1.3%	3.1%	N/A
		Q2-2022	8	661	1.2%	3.1%	N/A
		Q3-2022	13	851	1.5%	3.1%	N/A
	PCB-06.1: Unexpected Complications in Term Newborns - Severe Rate *(Lower is better)*	Q4-2021	9	766	1.2%	1.3%	N/A
		Q1-2022	8	686	1.2%	1.3%	N/A
		Q2-2022	8	661	1.2%	1.3%	N/A
		Q3-2022	13	851	1.5%	1.3%	N/A
	PCB-06.2: Unexpected Complications in Term Newborns - Moderate Rate *(Lower is better)*	Q4-2021	1	766	0.1%	1.8%	N/A
		Q1-2022	1	686	0.1%	1.8%	N/A
		Q2-2022	0	661	0.0%	1.8%	N/A
		Q3-2022	0	851	0.0%	1.8%	N/A
Stroke	STK 1: Venous Thromboembolism (VTE) Prophylaxis *(Higher is better)*	Q4-2021	77	79	97%	96%	100%
		Q1-2022	57	62	92%	96%	100%
		Q2-2022	81	88	92%	96%	100%
		Q3-2022	102	109	94%	96%	100%
	STK-2: Discharged on Antithrombotic Therapy *(Higher is better)*	Q4-2021	56	56	100%	100%	100%
		Q1-2022	52	52	100%	100%	100%
		Q2-2022	66	66	100%	100%	100%
		Q3-2022	81	83	98%	100%	100%
	STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter *(Higher is better)*	Q4-2021	16	17	94%	100%	100%
		Q1-2022	11	11	100%	100%	100%
		Q2-2022	21	21	100%	100%	100%
		Q3-2022	11	11	100%	100%	100%

PMC Escondido Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg.
Worse than Nat'l Avg.
Reach Top 10% or Best Performance
N/A = Not Available

Measure Set	Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
Stroke	STK-4: Thrombolytic Therapy *[Higher is better]*	Q4-2021	11	11	100%	89%	100%
		Q1-2022	10	10	100%	89%	100%
		Q2-2022	11	11	100%	89%	100%
		Q3-2022	11	11	100%	89%	100%
	STK-5: Antithrombotic Therapy By End of Hospital Day 2 *[Higher is better]*	Q4-2021	38	42	90%	100%	100%
		Q1-2022	35	36	97%	100%	100%
		Q2-2022	47	49	96%	100%	100%
		Q3-2022	62	64	97%	100%	100%
	STK-6: Discharged on Statin Medication *[Higher is better]*	Q4-2021	53	55	96%	100%	100%
		Q1-2022	51	52	98%	100%	100%
		Q2-2022	63	64	98%	100%	100%
		Q3-2022	79	81	98%	100%	100%
	STK-8: Stroke Education *[Higher is better]*	Q4-2021	31	32	97%	100%	100%
		Q1-2022	26	33	79%	100%	100%
		Q2-2022	42	49	86%	100%	100%
		Q3-2022	48	54	89%	100%	100%
	STK-10: Assessed for Rehabilitation *[Higher is better]*	Q4-2021	73	73	100%	100%	100%
		Q1-2022	64	64	100%	100%	100%
		Q2-2022	85	86	99%	100%	100%
		Q3-2022	102	102	100%	100%	100%
	CSTK-01: National Institutes of Health Stroke Scale *[Higher is better]*	Q4-2021	57	66	86%	N/A	N/A
		Q1-2022	47	58	81%	N/A	N/A
		Q2-2022	71	77	92%	N/A	N/A
		Q3-2022	93	99	94%	N/A	N/A
	CSTK-02: Modified Rankin Score (mRS at 90 Days) *[Higher is better]*	Q4-2021	8	8	100%	N/A	N/A
		Q1-2022	16	16	100%	N/A	N/A
		Q2-2022	22	22	100%	N/A	N/A
		Q3-2022	22	22	100%	N/A	N/A
	CSTK-05: Hemorrhagic Transformation - Overall Rate *[Lower is better]*	Q4-2021	1	25	4%	N/A	N/A
		Q1-2022	1	20	5%	N/A	N/A
		Q2-2022	0	29	0%	N/A	N/A
		Q3-2022	0	32	0%	N/A	N/A
	CSTK-08: Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade *[Higher is better]*	Q4-2021	13	17	76%	N/A	N/A
		Q1-2022	13	15	87%	N/A	N/A
		Q2-2022	19	23	83%	N/A	N/A
		Q3-2022	26	30	87%	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 is better]*	Q4-2021	5	7	71%	72%	100%
		Q1-2022	5	7	71%	70%	100%
		Q2-2022	4	4	100%	70%	100%
		Q3-2022	3	8	38%	69%	100%

PMC Escondido Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg.
Worse than Nat'l Avg.
Reach Top 10% or Best Performance
N/A = Not Available

Measure Set	Measure Name	Quarter	Facility Performance (in mins)	# of Patients	National Average	Top 10%
ED	OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure *[Lower is better]*	Q4-2021	293	88	183	N/A
		Q1-2022	211	85	186	N/A
		Q2-2022	219	82	186	N/A
		Q3-2022	215	82	190	N/A
	OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients *[Lower is better]*	Q4-2021	543	4	325	N/A
		Q1-2022	1311	1	332	N/A
		Q2-2022	448	8	332	N/A
		Q3-2022	447	8	333	N/A
	OP-18d: Median Time from ED Arrival to ED Departure for Discharged ED Patients - Transfer Patients *[Lower is better]*	Q4-2021	446	1	348	N/A
		Q1-2022	531	2	348	N/A
		Q2-2022	505	4	348	N/A
		Q3-2022	386	3	348	N/A
Cardiac Care	OP-3b: Median Time to Transfer to Another Facility for Acute Coronary Intervention - Reporting Measure *[Lower is better]*	Q4-2021	N/A	0	61	37
		Q1-2022	N/A	0	62	39
		Q2-2022	N/A	0	62	39
		Q3-2022	N/A	0	63	41
Stroke	STK-OP-1a: Median Time to Transfer of Stroke Patient - Overall Rate *[Lower is better]*	Q4-2021	288	3	N/A	N/A
		Q1-2022	479	2	N/A	N/A
		Q2-2022	401	2	N/A	N/A
		Q3-2022	371	5	N/A	N/A
	CSTK-09: Median Time from Arrival to Skin Puncture - Overall Rate *[Lower is better]*	Q4-2021	77	14	N/A	N/A
		Q1-2022	27	11	N/A	N/A
		Q2-2022	119	18	N/A	N/A
		Q3-2022	73	24	N/A	N/A

Notes:

CMS released national averages for OP-18b, OP-18c and OP-3b (posted on Hospital Compare starting in January 2020) include Veterans Health Administration (VHA) hospital data and Department of Defense (DoD) hospital data. Thus, they may look different than the previous national averages.

PMC Escondido Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg.
Worse than Nat'l Avg.
Reach Top 10% or Best Performance
N/A = Not Available

Measure Set	Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
Outpatient	OPWeb-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients *[Higher is better]*	Q4-2021	3	3	100%	90%	100%
		Q1-2022	3	4	75%	90%	100%
		Q2-2022	7	7	100%	90%	100%
		Q3-2022	6	6	100%	91%	100%

Opportunities

ED Discharge Times

A. The Emergency Department Physician and Nursing Leadership have and continue to review and improve discharge times through Lean Workshop groups. Q3 -2022 there is a decrease in discharge time.

Stroke

A. STK3 - Anticoagulation for Atrial Fibrillation:
Issue: Providers not ordering anticoagulation and not providing a reason for not ordering

Improvement Work:

1. Communicated to providers regarding each core measure missed and the expectation for documenting reason(s) if anticoagulation is 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 the reason for not prescribing.
5. Monitoring Use of Stroke PowerPlans

B. STK5 - Antithrombotic by Day 2:
Issue: Nursing missing administration due to NPO status – did not use the rectal order or indicate if the patient refused.

Improvement Work:

1. Communicated with Nurse Managers for follow-up with the RNs.

C. STK6 – Patients discharged on Statin:
Issue: Providers not ordering and not giving a reason for not ordering.

Improvement Work:

1. Communicated to providers regarding each core measure missed and the expectation for documenting reason(s) if a statin is 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 aids in alerting the provider on discharge to prescribe or give a reason.
5. Monitoring Use of Stroke PowerPlans

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

Improvement Work:

1. Communicated to nursing on the 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: Q4-2021 to Q3-2022

Better than Nat'l Avg
Worse than Nat'l Avg
Reach Top 10% or Best Performance
N/A = Not Available

Measure Set	Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
Sepsis	SEP-1: Sepsis Early Management Bundle *[Higher is better]*	Q4-2021	7	13	54%	57%	80%
		Q1-2022	5	12	42%	57%	79%
		Q2-2022	9	14	64%	57%	79%
		Q3-2022	9	12	75%	58%	78%
Perinatal Care	PCM-01: Elective Delivery *[Lower is better]*	Q4-2021	0	17	0%	3%	0%
		Q1-2022	1	13	8%	2%	0%
		Q2-2022	0	11	0%	2%	0%
		Q3-2022	0	20	0%	2%	0%
	PCM-02a: Cesarean Section *[Lower is better]*	Q4-2021	17	76	22%	25%	N/A
		Q1-2022	13	75	17%	26%	N/A
		Q2-2022	13	59	22%	26%	N/A
		Q3-2022	14	75	19%	26%	N/A
	PCB-05: Exclusive Breast Milk Feeding *[Higher is better]*	Q4-2021	30	40	75%	50%	N/A
		Q1-2022	28	35	80%	50%	N/A
		Q2-2022	25	32	78%	50%	N/A
		Q3-2022	28	34	82%	50%	N/A
	PCB-06.0: Unexpected Complications in Term Newborns - Overall Rate *[Lower is better]*	Q4-2021	1	192	0.5%	3.1%	N/A
		Q1-2022	2	181	1.1%	3.1%	N/A
		Q2-2022	0	157	0.0%	3.1%	N/A
		Q3-2022	3	168	1.8%	3.1%	N/A
	PCB-06.1: Unexpected Complications in Term Newborns - Severe Rate *[Lower is better]*	Q4-2021	1	192	0.5%	1.3%	N/A
		Q1-2022	0	181	0.0%	1.3%	N/A
		Q2-2022	0	157	0.0%	1.3%	N/A
		Q3-2022	2	168	1.2%	1.3%	N/A
	PCB-06.2: Unexpected Complications in Term Newborns - Moderate Rate *[Lower is better]*	Q4-2021	0	192	0.0%	1.8%	N/A
		Q1-2022	2	181	1.1%	1.8%	N/A
		Q2-2022	0	157	0.0%	1.8%	N/A
		Q3-2022	1	168	0.6%	1.8%	N/A
Stroke	STK 1: Venous Thromboembolism (VTE) Prophylaxis *[Higher is better]*	Q4-2021	8	10	80%	96%	100%
		Q1-2022	20	22	91%	96%	100%
		Q2-2022	14	14	100%	96%	100%
		Q3-2022	14	14	100%	96%	100%
	STK-2: Discharged on Antithrombotic Therapy *[Higher is better]*	Q4-2021	8	8	100%	100%	100%
		Q1-2022	24	24	100%	100%	100%
		Q2-2022	16	17	94%	100%	100%
		Q3-2022	10	10	100%	100%	100%
	STK-3: Anticoagulation Therapy for Atrial Fibrillation/Flutter *[Higher is better]*	Q4-2021	1	1	100%	100%	100%
		Q1-2022	5	5	100%	100%	100%
		Q2-2022	4	4	100%	100%	100%
		Q3-2022	2	2	100%	100%	100%

PMC Poway Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg
Worse than Nat'l Avg
Reach Top 10% or Best Performance
N/A = Not Available

Measure Set	Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
Stroke	STK-4: Thrombolytic Therapy *[Higher is better]*	Q4-2021	0	0	N/A	89%	100%
		Q1-2022	0	0	N/A	89%	100%
		Q2-2022	0	0	N/A	89%	100%
		Q3-2022	0	0	N/A	89%	100%
	STK-5: Antithrombotic Therapy By End of Hospital Day 2 *[Higher is better]*	Q4-2021	9	9	100%	100%	100%
		Q1-2022	25	25	100%	100%	100%
		Q2-2022	18	18	100%	100%	100%
		Q3-2022	14	14	100%	100%	100%
	STK-6: Discharged on Statin Medication *[Higher is better]*	Q4-2021	7	8	88%	100%	100%
		Q1-2022	21	22	95%	100%	100%
		Q2-2022	17	17	100%	100%	100%
		Q3-2022	10	10	100%	100%	100%
	STK-8: Stroke Education *[Higher is better]*	Q4-2021	3	4	75%	100%	100%
		Q1-2022	12	15	80%	100%	100%
		Q2-2022	6	6	100%	100%	100%
		Q3-2022	3	3	100%	100%	100%
	STK-10: Assessed for Rehabilitation *[Higher is better]*	Q4-2021	8	8	100%	100%	100%
		Q1-2022	24	24	100%	100%	100%
		Q2-2022	17	17	100%	100%	100%
		Q3-2022	10	10	100%	100%	100%
	CSTK-01: National Institutes of Health Stroke Scale *[Higher is better]*	Q4-2021	8	10	80%	N/A	N/A
		Q1-2022	24	27	89%	N/A	N/A
		Q2-2022	19	20	95%	N/A	N/A
		Q3-2022	11	14	79%	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 is better]*	Q4-2021	8	10	80%	72%	100%
		Q1-2022	6	7	86%	70%	100%
		Q2-2022	6	7	86%	70%	100%
		Q3-2022	7	9	78%	69%	100%
Outpatient	OPWeb-29: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients *[Higher is better]*	Q4-2021	11	11	100%	90%	100%
		Q1-2022	9	9	100%	90%	100%
		Q2-2022	2	2	100%	90%	100%
		Q3-2022	11	11	100%	91%	100%

PMC Poway Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg
Worse than Nat'l Avg
Reach Top 10% or Best Performance
N/A = Not Available

Measure Set	Measure Name	Quarter	Facility Performance (in mins)	# of Patients	National Average	Top 10%
ED	OP-18b: Median Time from ED Arrival to ED Departure for Discharged ED Patients - Reporting Measure *[Lower is better]*	Q4-2021	219	81	169	N/A
		Q1-2022	160	78	173	N/A
		Q2-2022	194	93	173	N/A
		Q3-2022	210	85	171	N/A
	OP-18c: Median Time from ED Arrival to ED Departure for Discharged ED Patients - Psychiatric/Mental Health Patients *[Lower is better]*	Q4-2021	255	10	267	N/A
		Q1-2022	572	9	278	N/A
		Q2-2022	N/A	0	278	N/A
		Q3-2022	370	5	271	N/A
	OP-18d: Median Time from ED Arrival to ED Departure for Discharged ED Patients - Transfer Patients *[Lower is better]*	Q4-2021	370	6	348	N/A
		Q1-2022	499	4	348	N/A
		Q2-2022	494	3	348	N/A
		Q3-2022	370	5	348	N/A
Cardiac Care	OP-3b: Median Time to Transfer to Another Facility for Acute Coronary Intervention - Reporting Measure *[Lower is better]*	Q4-2021	N/A	0	61	37
		Q1-2022	N/A	0	62	39
		Q2-2022	N/A	0	62	39
		Q3-2022	N/A	0	63	41
Stroke	STK-OP-1a: Median Time to Transfer of Stroke Patient - Overall Rate *[Lower is better]*	Q4-2021	375	12	N/A	N/A
		Q1-2022	230	18	N/A	N/A
		Q2-2022	207	14	N/A	N/A
		Q3-2022	160	18	N/A	N/A

Notes:
CMS released national averages for ED-2b, OP-18b, OP-18c and OP-3b (posted on Hospital Compare starting in January 2020) include Veterans Health Administration (VHA) hospital data and Department of Defense (DoD) hospital data. Thus, they may look different than the previous national averages.

Opportunities

ED Discharge times

A. The Emergency Department Physician and Nursing Leadership have and continue to review and improve discharge times through Lean Workshop groups.

Stroke

A. STK1 - VTE Prophylaxis; STK8 - Education:
Issue: VTE fallouts noted with documentation > 2 days, and documentation of education lacking

Improvement Work:

1. Reminders/Emails to Nursing Staff about documentation misses leading to fallouts:
    a. VTE documentation required by hospital day 2
    b. Stroke Education documentation of printed materials or handbook to meet compliance that education was provided by discharge.
2. Deep Dive Review with each fallout to identify areas for improvement

3. Brainstorming Session with Nursing Leaders to address the constant fallouts
    a. Focus was documentation enhancements to help both the bedside RN as well as the Nurse Leader for prospective versus retroactive reviews. Ideas collected and Change request for Cerner Updates initiated.
    b. Change request for Stroke Updates in Cerner to improve compliance by Nursing:
        i. Request to add Handbook in the Teaching Methods in the Stroke Band – approved and completed QTR4 2022
        ii. Request to update Stroke PowerPlans and add daily to the Stroke Education order so that the RN receives a daily task which would serve as a reminder for nursing to document.
            1. During the deep dive review with IT, we discovered that once the RN completed the stroke education order it would no longer generate a task to the following RNs to complete education as well.
            2. Request approved and all Stroke Admission PowerPlans were updated and went live in QTR4 2022.
        iii. Request to have Quality Measures Workflow added to the Nurse View. This would promote a quick check for Nursing that Stroke Core Measures are in place – an example is the VTE measure and the view would show when ordered and when documented. Approved and completed QTR4 2022.
        iv. Request to have Quality Safety Dashboard updated and available for the Charge RNs and Managers to view Stroke and VTE measures. Approved and completed QTR4 2022.
    c. ISBAR Communication with Cerner enhancements with project completion.

B. STK2 - Discharge on Antithrombin, STK5 - Antithrombin by Day 2, STK6 - Discharged on Statin:
Issue: Provider lack of order for antithrombin and statin, and no reason given for not ordering

Improvement Work:

1. Communicated to providers regarding each core measure missed 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 aids in alerting the provider on discharge to prescribe or give reason.
5. Monitoring Use of Stroke PowerPlans

Palomar Medical Center Poway Behavioral Health Unit (BHU)

The BHU is a 12-bed adult acute psychiatric unit on the 3rd floor at Palomar Medical Center Poway. It is the only LPS-designated acute inpatient psychiatric unit in North County, San Diego. The average daily census (ADC) is 12 patients with an average length of stay (ALOS) of 8 days. It provides care for patients with acute psychotic and mood disorders and largely serves MediCal recipients. It accepts both voluntary and involuntary patients, with the majority of patients being involuntary. The BHU participates in the Hospital Based Inpatient Psychiatric Services (HBIPS) core measures to improve hospital-based inpatient psychiatric services' quality, safety, and performance by collaborating with hospitals, physicians, and consumers.

Accomplishments

Our (HBIPS) performance significantly improved from CY2021 to CY2022. In the 2021/2022 time period, we outperformed the prior 2020/2021 time period in 9 of the psychiatric core measures. We outperformed the National Average in 13 of the 14 psychiatric core measures and were in the top 10% nationally in one measure for the 2021/2022 period. BHU has increased the overall quality of care over the last year. More patients than ever are being prescribed medication for nicotine use disorder. Patients also receive improved access to medication and treatment in the community for alcohol and other substance use disorders.

Outcomes

PMC Poway - BHU Adult

Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Avg.
Worse than Nat'l Avg.
Reach Top 10% or Best Performance
N/A = Not Available

Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
HBIPS-2: Hours of Physical Restraint Use [Rate Per 1000 Patient Hours] *[Lower is better]*	Q4-2021	2.08	1077	0.080	0.26	N/A
	Q1-2022	2.8	964	0.121	0.26	N/A
	Q2-2022	0.52	992	0.022	0.26	N/A
	Q3-2022	2.90	1049	0.115	0.26	N/A
HBIPS-3: Hours of Seclusion [Rate Per 1000 Patient Hours] *[Lower is better]*	Q4-2021	0	1077	0.000	0.25	N/A
	Q1-2022	5.38	964	0.233	0.25	N/A
	Q2-2022	6.93	992	0.291	0.25	N/A
	Q3-2022	1.68	1049	0.067	0.25	N/A
HBIPS-5a: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification *[Higher is better]*	Q4-2021	4	7	57%	65%	100%
	Q1-2022	7	9	78%	65%	100%
	Q2-2022	5	8	63%	65%	100%
	Q3-2022	4	8	50%	65%	100%
IPF-TR-1 : Transition Record with Specified Elements Received by Discharged Patients *[Higher is better]*	Q4-2021	104	112	93%	69%	100%
	Q1-2022	96	106	91%	69%	100%
	Q2-2022	103	107	96%	69%	100%
	Q3-2022	108	117	92%	69%	100%
SMD-1: Screening For Metabolic Disorders *[Higher is better]*	Q4-2021	63	67	94%	78%	100%
	Q1-2022	55	58	95%	78%	100%
	Q2-2022	54	61	89%	78%	100%
	Q3-2022	62	68	91%	78%	100%
IMM-2: Influenza Immunization *[Higher is better]*	Q4-2021	89	105	85%	79%	100%
	Q1-2022	91	98	93%	79%	100%
SUB-2: Alcohol Use Brief Intervention Provided or Offered *[Higher is better]*	Q4-2021	17	18	94%	79%	100%
	Q1-2022	13	14	93%	79%	100%
	Q2-2022	13	15	87%	79%	100%
	Q3-2022	22	24	92%	79%	100%
SUB-2a: Alcohol Use Brief Intervention *[Higher is better]*	Q4-2021	17	17	100%	72%	100%
	Q1-2022	13	13	100%	72%	100%
	Q2-2022	13	13	100%	72%	100%
	Q3-2022	22	22	100%	72%	100%
SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge *[Higher is better]*	Q4-2021	25	37	68%	75%	100%
	Q1-2022	41	45	91%	75%	100%
	Q2-2022	30	32	94%	75%	100%
	Q3-2022	37	38	97%	75%	100%
SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge *[Higher is better]*	Q4-2021	22	37	59%	63%	99%
	Q1-2022	40	45	89%	63%	99%
	Q2-2022	30	32	94%	63%	99%
	Q3-2022	37	38	97%	63%	99%

PMC Poway - BHU Adult
Core Measure Compliance & Benchmarks

Reporting Period: Q4-2021 to Q3-2022

Better than Nat'l Ave
Worse than Nat'l Ave
Reach Top 10% or Best Performance
N/A = Not Available

Measure Name	Quarter	Numerator	Denominator	Facility Rate	National Average	Top 10%
TOB-2: Tobacco Use Treatment Provided or Offered *[Higher is better]*	Q4-2021	45	46	98%	81%	100%
	Q1-2022	46	48	96%	81%	100%
	Q2-2022	33	37	89%	81%	100%
	Q3-2022	48	54	89%	81%	100%
TOB-2a: Tobacco Use Treatment *[Higher is better]*	Q4-2021	36	45	80%	45%	89%
	Q1-2022	44	46	96%	45%	89%
	Q2-2022	33	35	94%	45%	89%
	Q3-2022	44	50	88%	45%	89%
TOB-3: Tobacco Use Treatment Provided or Offered at Discharge *[Higher is better]*	Q4-2021	30	34	88%	61%	99%
	Q1-2022	32	36	89%	61%	99%
	Q2-2022	26	29	90%	61%	99%
	Q3-2022	41	43	95%	61%	99%
TOB-3a: Tobacco Use Treatment at Discharge *[Higher is better]*	Q4-2021	19	34	56%	22%	83%
	Q1-2022	29	36	81%	22%	83%
	Q2-2022	25	29	86%	22%	83%
	Q3-2022	37	43	86%	22%	83%

Notes:
CMS released 2020 comparative data in October 2021. Data from 3Q 2021 and onward is benchmarking against 2020 National Average and Top 10%.

Goals for 2023

The HBIPS team, which includes BHU Providers, Nursing, Social Workers, and Case Managers, meets monthly and supports small workgroups to improve documentation templates and processes to improve performance. Providers and staff will continue to work on aligning the assessment of nicotine, alcohol, and other substance use disorders to match the assessments. Decreased incongruity in assessments will help to continue to decrease the failure rate for these measures. Clinical leadership will develop and implement order sets consistent with the standard of care for the use of clozapine and the evaluation and treatment of metabolic syndrome in patients on antipsychotic medications.

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. The Fall 2022 TQIP Benchmark Report is based on admissions from 2021 and the first quarter of 2022, including a total of 437,068 admissions that meet TQIP inclusion/exclusion criteria.

Measuring patient outcomes through risk-adjusted benchmarking

Promoting best practices

Adhering to performance improvement principles

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

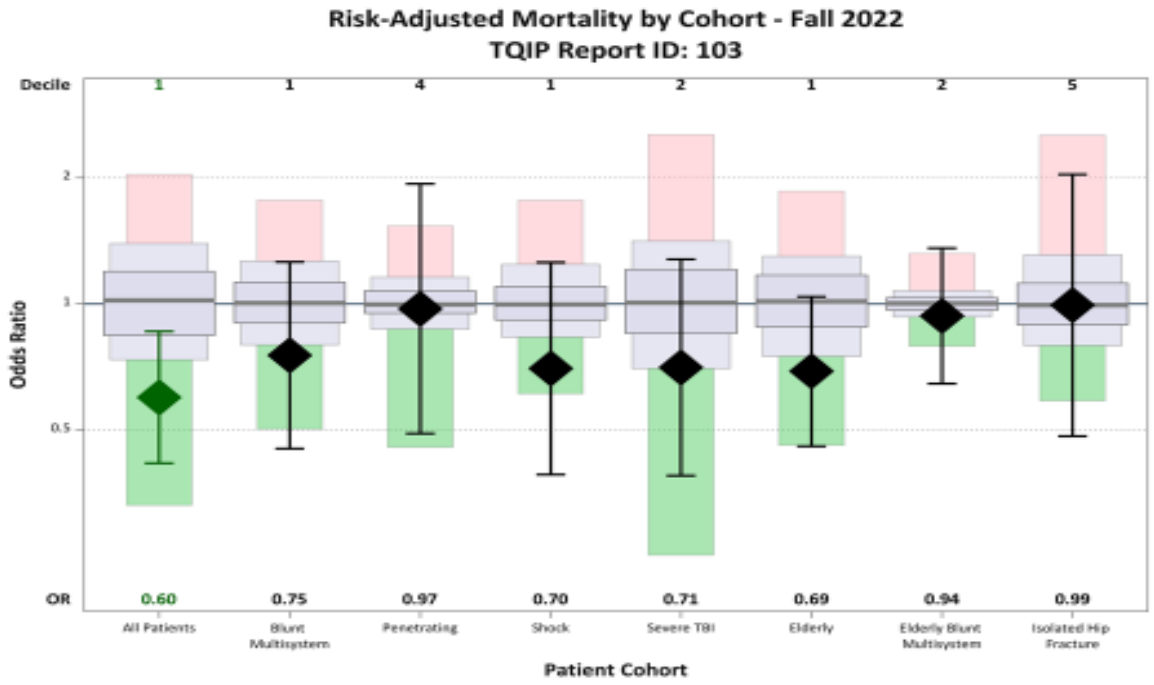
Quality and Outcome

Hospital Event: Venous Thrombus Embolism

Goal for 2022: Increase Compliance with the Trauma VTE Guideline; Chemoprophylaxis given to trauma patients within 72 hours of admission unless documented contraindication.

Process Improvement: Compliance with Trauma VTE Guideline improved based on the data for Trauma Guideline Compliance

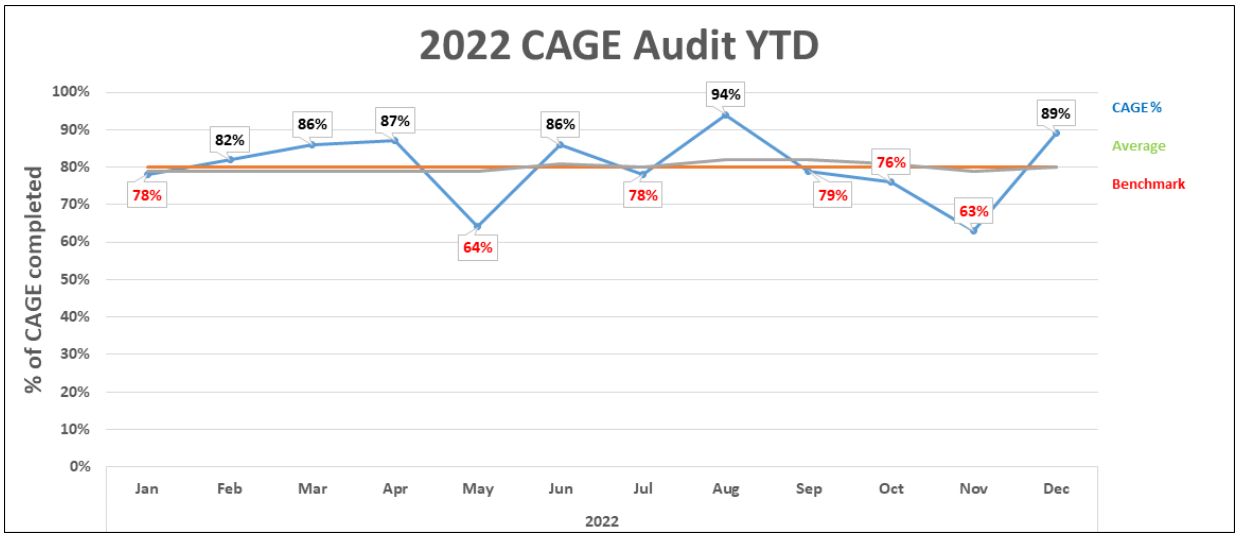
Outcome: The rate of pulmonary embolism did NOT decrease but remained within benchmark parameters. We attributed this to the increase in injury severity in this population, which rose from an average of 9 to 10.3, a significant increase for our trauma patient population.



Substance Abuse Screening: Alcohol

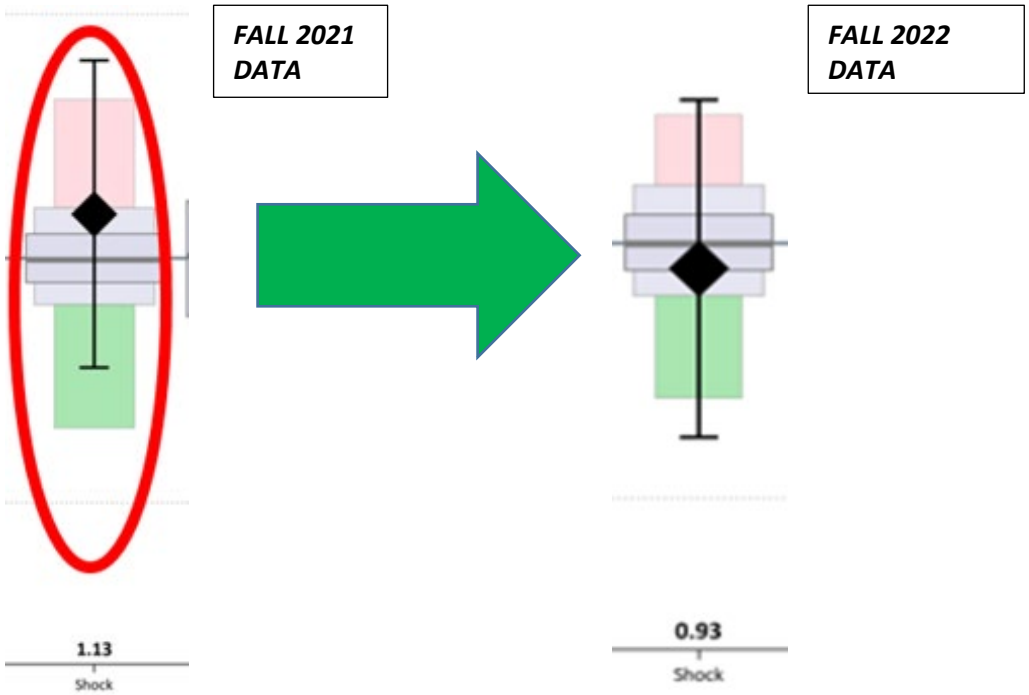
Goal for 2021: Increase alcohol-screening tool to over 80% compliance by documented use of screening tool from Social Services Department. (The screening tool is required as a Level II Trauma Center).

Goal for 2022: We achieved our goal of over 80% for screening from 80% to 89% in 2022



Massive Transfusion Protocol (MTP) Process

Goals for 2022: Improve I/O ratio in shock population to below confidence line (green shaded area is best practice).



In 2021 we improved the I/O ratio from 1.13 to 0.93!

Hospital Event: Unplanned OR Visits

Unplanned Visit to OR 2021 rate above the national benchmark of 1.3%. Palomar rate 2.0 %

The Fall 2022 TQIP Benchmark report national rate is 1.6%. Palomar rate is 1.9%. This metric is no longer reported in the TQIP reports; Palomar has re-adjusted goals and opportunities to reflect this change.

Data and Goals for 2023:

Hospital Event: Delays to OR for Surgical Intervention

Goal: Reduce time to craniotomy from Trauma Resuscitation to OR under 2 hours per best practice.

From 2022 Fall TQIP Report:

Table 29: Craniotomy for Severe TBI Patients

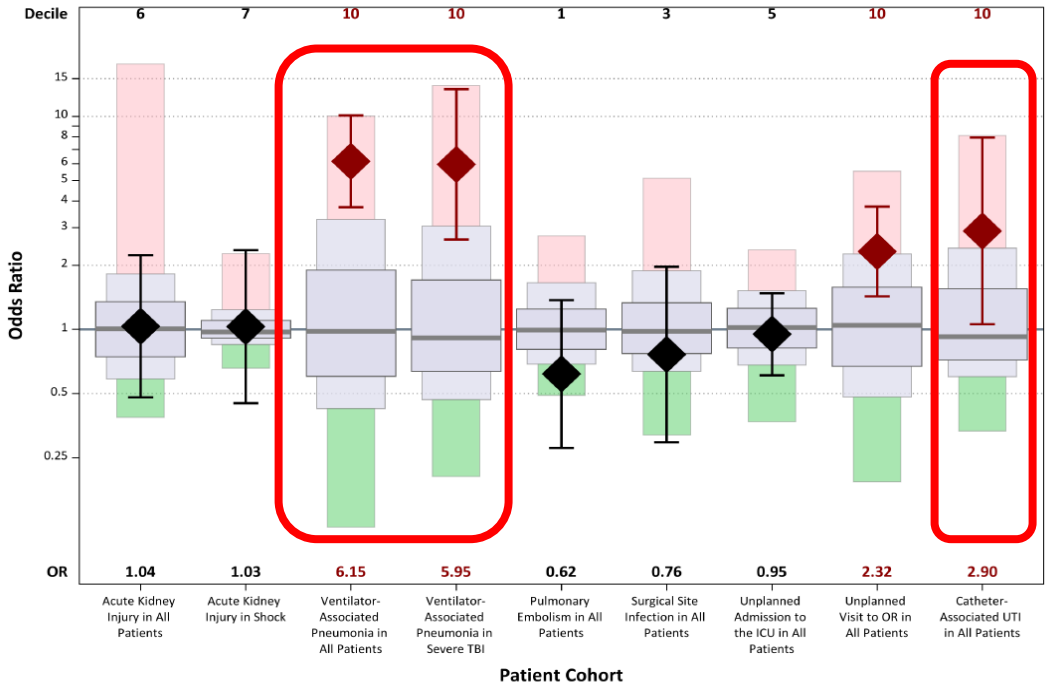
	Severe TBI	Craniotomy	Time to Craniotomy (hours)	Unknown Time to Craniotomy
Group	N	N (%)	Median (IQR)	N (%)
All Hospitals	27,855	5,343 (19.2)	2.38 (1.65-5.08)	39 (0.7)
Your Hospital	40	6 (15.0)	5.45 (1.53-13.43)	0 (0.0)

Hospital Event: Nursing Sensitive Indicators

Goal: Decrease VAP and CAUTI rates to under the 90th percentile for Spring 2023.

From 2022 FALL TQIP REPORT:

Figure 5: Risk-Adjusted Specific Hospital Events by Hospital Event/Cohort



Stroke Program

Palomar Health Stroke Program offers a comprehensive and coordinated high-quality 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 from 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. The benefit of 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 strengthens 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

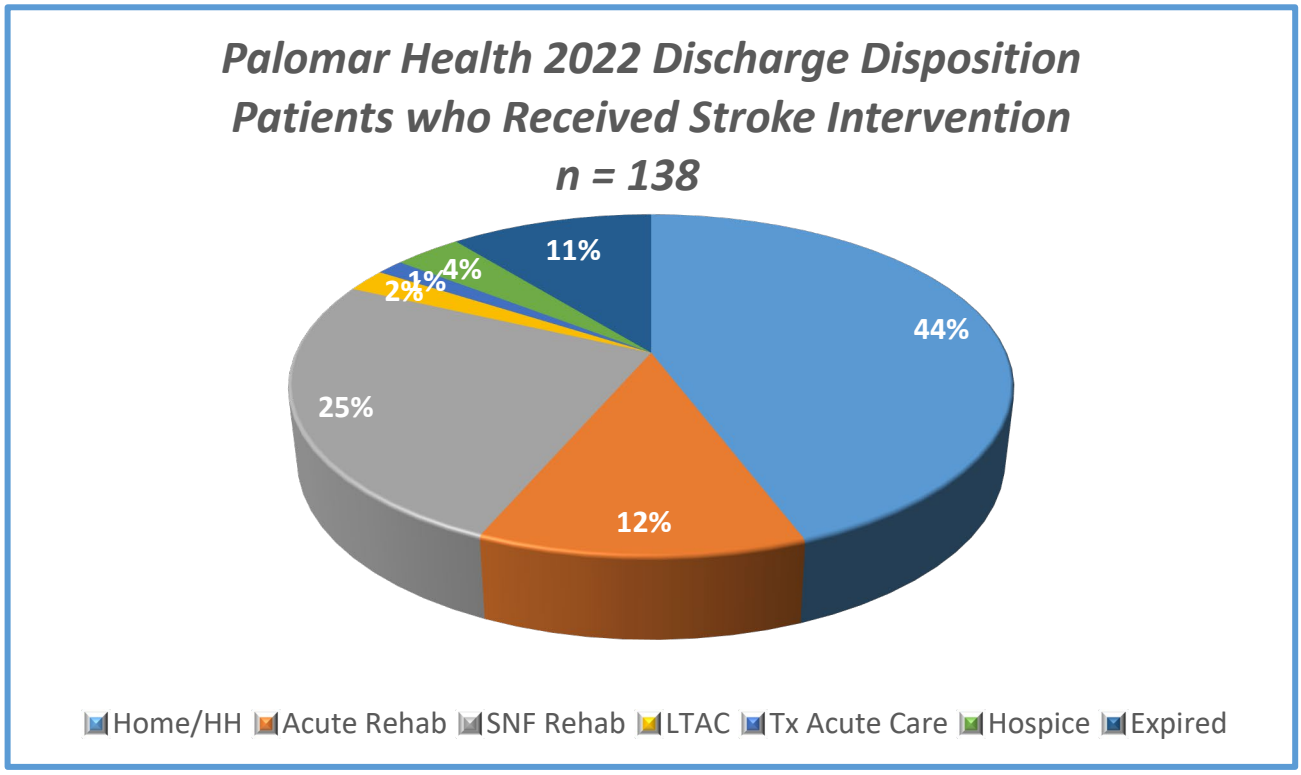
Ongoing tracking and reporting of the Stroke Metrics occurs through the AHA-ASA National Registry Get with the Guidelines (GWTGs) for Stroke and through the regulatory agency, The Joint Commission.

Highlights of the Stroke Program 2022:

	PMC Escondido	**PMC Poway**
Total Stroke Code (SC) Activations: 2022 Total ED SC: 1075 Total Inpatient Stroke Code (IPSC): 68	ED SC: 773 – 137 canceled Inpatient SC: 48	ED SC: 302 – 45 canceled Inpatient SC: 20
Final Diagnosis: • Acute Ischemic Stroke (AIS) • Hemorrhagic Stroke (HS) • TIA	TOTAL: 737 • AIS: 358 • HS: 206 • TIAs: 173	TOTAL: 149 • AIS: 75 • HS: 16 • TIAs: 58
Alteplase (tPA) Administrations: Total 89	65 tPA Administrations • ED: 65 • ≤ 60 Minutes: 100%	24 tPA Administrations • ED: 23 IPSC: 1 • ≤ 60 minutes: 75%
Neuro Endovascular Cases: Total 100 Candidates • 84 Thrombectomies • 16 Angio/Cancel/Venous	Total Cases: 75 • 62 Thrombectomy candidates • ED: 66 IPSC: 9	Total Cases: 25 • 22 Thrombectomy candidates • ED: 24 IPSC: 1
Treatment Rates: AIS Total 433 Overall Thrombolytic & Thrombectomy Treatment Rates: 38.5%	Thrombolytic Treatment rate: 65/358 = 18% MER Treatment Rate: 62/358 = 17%	Thrombolytic Treatment rate: 24/75 = 32% MER Treatment Rate: 22/75 = 29%

Outcomes

Outcomes for Stroke are based on a 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.



Stoke Program Successes for 2022

1. VIZ AI Project: Successful Go-Live June 2022
2. Achieved Target Phase 3 Thrombolytic Goals as follows:
   - PMCE: 60 min > 85% of the time; we achieved 100%!!!
   - PMCE: 45 min > 75% of the time; we achieved 79%!!!
3. Achieved Door In-Door Out for Intervention Cases as follows:
   - PMCP: < 120 minutes; we achieved 82 minutes!!!
4. Achieved door to 1st Device for Transfer Cases:
   - PMCP: < 60 min 50% of the time; we achieved 78%!!!
5. Active Participation with SD County Stroke Consortium
   - Co-Chair with UCSD Neurology Chair
   - Honorary 1st Pitch at SD Padre Game for Stroke Awareness
6. IT Documentation Improvements for Nursing and Stroke Education

Stroke Program Recognitions for 2022

Healthgrades: 2022 Excellence Award – Stroke Care
Healthgrades: 2022 Five-Star Recipient – Treatment of Stroke
US News & World Report: 2021-2022 High Performing Hospitals Stroke

Goals for 2023

Palomar Health Stroke Program has selected the following goals for 2023:

1. Evidenced-Based Swallow Screen Implementation
2. Achieve door-to-needle times within **45 minutes** of hospital arrival in **75%** or more of acute ischemic stroke patients treated with thrombolytics
3. 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**
4. VIZ AI – all provider participation: ED, Neurology, Radiology, and IR Interventionalists
5. Continue active participation with SD County Stroke Consortium
6. Community Education
7. Successful recertification with the Joint Commission

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 occur through several mechanisms. CV care metrics are 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 at other quality meetings.

The CV COE continuously pursues new ways to improve, track and report quality.

Accomplishments & Highlights:

STEMI (ST Elevation Myocardial Infarct) Door to Balloon (D2B) Time

- National recommendation is <90 minutes. In 2022, Palomar's D2B was 56 minutes
- Overall AMI Performance: 97.9% of eligible opportunities met for 14 AMI measures (as defined by ACC). Includes FMC-device time (STEMI only)
- STEMI Performance: 99.5% of care opportunities met for 12 AMI measures (as defined by ACC). Includes FMC-device time (STEMI only)
- NSTEMI Performance: 96.9% of care opportunities met for 9 AMI measures (as defined by ACC)
- Cardiac Rehab: 93.1% of eligible patients, up from 88.8% same time last year
- National Cardiovascular Data Registry (NCDR) Chest Pain MI (CPMI) registry Platinum Award

Open Heart Surgery – Coronary Artery Bypass Graft (CABG)

- Started CV Surgery Excellence committee
- Beta Blocker documentation improved to 94.1%* in 2022 from 75.0% in 2020
- Readmitted within 30 days 6.66% in 2022, National STS average 8.92%

Structural Heart

- TAVR program celebrated its 300th implant milestone
- Started Watchman Program with over 50 successful implants in the 1st year

Stroke

- Implemented AI rapid software detection system for LVO and PE
- Improving door-to-puncture and activation times for stroke patients with LVO

Service Line Growth

- Performed 527 PCIs in 2022 (up from 431 in 2021)
- Approval to upgrade 4 advanced capability procedural suites and build 5th suite

- Hired additional Interventional Cardiologist
- Hired Director of Cardiovascular Service Line to direct overall growth and development across the district

Advanced Capabilities

- Impella heart pump
- IABP (Intra-Aortic Balloon Pump)
- Leadless Pacemaker
- EP Suite with comprehensive services available
- Structural heart program

Recognitions & Awards 2021

2021-2022 High Performing Hospitals Stroke
U.S. News & World Report
Palomar Medical Center Escondido

Goals for 2023

1. Renovate the Cardiac catheterization lab to modernize technology, equipment, and environment and allow the hospital to treat patients more effectively. Build out of additional Structural Heart/EP Cath lab room to continue the growth of the service line and services available to the community.
2. Develop an ECMO program to provide advanced treatment options for patients with life-threatening lung or heart conditions.
3. Implement GetWell digital patient engagement platform for the CV service line to improve patient outcomes and experience
4. Implement CardioMEMS HF System to help treat Heart Failure patients by wirelessly measuring and monitoring their pulmonary artery pressure and heart rate.
5. Streamline ordering process for Outpatient Cardiac Rehab to increase outpatient referrals
6. Host the 1st Annual CV Symposium for employees and the community
7. Community Health
   - Participate in the 2023 AHA Heart & Stroke Walk
   - Increase community outreach through CV screenings and education

- Host virtual Stroke Class for the community
- Social Media Outreach and planned outreach to providers regarding the Watchman program
- Wellness classes specifically related to Diabetes and Medication management

Centers of Excellence (COE)

Total Joint and Spine Services

In 2022, Palomar Health performed 3,330 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 the following:

- 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.

2022 Accomplishments

Across the Ortho/Spine Platform:

- PMC-Escondido was the only hospital in San Diego County to achieve 100 Best Hospitals for Orthopedic Surgery, Joint Replacement Surgery, and Spine Surgery for the third year in a row!
- Enrolled 1,050 new patients in our Online CarePath mobile app for patient education and Patient Reported Outcome Data Collection.
- 98% of patients reported feeling prepared the day prior to their elective surgery.
- Hosted our 9th Annual Ortho and Spine Symposium, in person, for the first time since 2019.

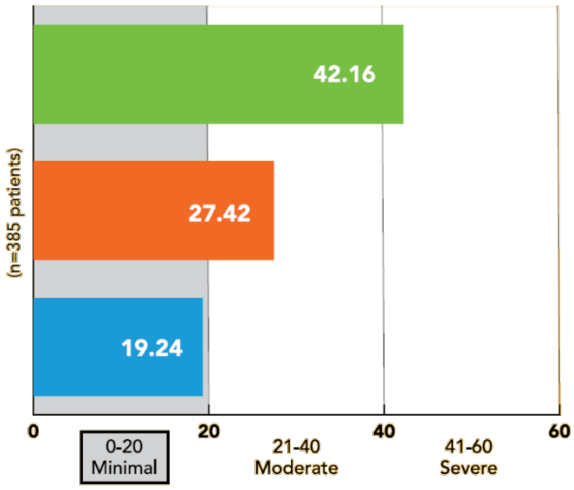
Total Joint Replacement:

- PMC-Poway earned the Joint Commission's Gold Seal of Approval® for Advanced Total Hip and Total Knee Replacement
- Educational content for patients preparing for Joint Replacement Surgery is now available in Spanish and English.
- Started a pilot program in PMC-Poway at discharge where patients get a detailed list of medications to take at home, including details about the last dose given, and next expected dose.
- On average, patients with an elective total joint at Palomar report almost a full return to function one year after surgery (measured using HOOS JR. and KOOS JR.)

Spine Surgery:

- Performed our 100th robotic-assisted spine fusion since implementing the program in July 2020, saving an average of 17 surgical minutes per fusion
- Palomar Health Ranks as One of the Top 5 Hospitals in the State of California and Among the Top 5% in the Nation for Spine Surgery! This includes a readmission rate of 2.9% and a full standard deviation below the national rate of 3.8%.
- On average, patients who have a spinal fusion at Palomar go from 'Severe Disability' to 'Minimal Disability' within the first year after surgery based on Oswestry Disability Index responses from 385 patients.

Palomar Patient's Reduction in Disability After Spine Fusion



Score	Disability Level
0 - 20	Minimal Disability
21 - 40	Moderate Disability
41 - 60	Severe Disability

Pre-Op
90 Days After Surgery
12 Months After Surgery

LOWER IS BETTER

Why is this Important?
Palomar Health wants to know how much surgery has improved our patient's daily lives. Patients report on their function & pain before and after surgery. We use a standardized survey called Oswestry Disability Index.

2023 Goals

- Focus on bringing surgical site infections below the threshold.
- Host over 100 nurses and therapists at the 10th Annual Orthopedic and Spine Symposium
- Publish our 3rd Annual Orthopedic and Spine Outcomes Report
- Ensure total joint surgeons use Share Decision Making principles when discussing surgical options with patients.
- Ensure the patients' education needs are met at discharge by including the medication reconciliation form that includes the last and next doses.

Centers of Excellence (COE)

Metabolic and Bariatric Surgery Services

The Palomar Health Bariatric Surgery Program went through the triennial reaccreditation survey in January as a Comprehensive Center 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

- Digitized our patient engagement process by implementing the Go Further mobile app for Medical Weight Management.
- Educational content for patients preparing for Bariatric Surgery is now available in Spanish and English.
- Two risk-adjusted semi-annual reports are received each year from MBSAQIP. There was still zero 30-day mortality and no “Outliers” or “Needs Improvement” outcomes in the past year.

MBSAQIP 01/01/2021 - 12/31/2021 Semiannual Report: Site Summary

Palomar Medical Center Poway Site: 09704

Laparoscopic Sleeve Gastrectomy

	Total Cases	Observed Events	Observed Rate	Pred Obs Rate**	Expected Rate	Odds Ratio	95% C.I. Lower	95% C.I. Upper	Outlier	Decile	Adjusted Percentile	Adjusted Quartile	Assessment*
LSG Morbidity	41	1	2.44%	1.59%	1.36%	1.17	0.37	3.77	No	7	55	3	As Expected
LSG All Occurrences Morbidity	41	1	2.44%	2.60%	2.64%	0.99	0.43	2.26	No	5	48	2	As Expected
LSG Serious Event	41	0	0.00%	1.09%	1.23%	0.88	0.33	2.37	No	4	42	2	As Expected
LSG Leak	41	0	0.00%	0.12%	0.12%	0.96	0.18	5.08	No	7	48	2	As Expected
LSG Bleeding	41	0	0.00%	0.43%	0.47%	0.92	0.26	3.31	No	5	46	2	As Expected
LSG SSI	41	1	2.44%	0.53%	0.31%	1.72	0.37	7.95	No	9	67	3	As Expected
LSG All Cause Reoperation	41	0	0.00%	0.43%	0.47%	0.92	0.26	3.29	No	5	46	2	As Expected
LSG Related Reoperation	41	0	0.00%	0.31%	0.32%	0.95	0.28	3.24	No	6	48	2	As Expected
LSG All Cause Intervention	41	0	0.00%	0.26%	0.28%	0.93	0.20	4.35	No	6	47	2	As Expected
LSG Related Intervention	41	0	0.00%	0.18%	0.19%	0.95	0.20	4.62	No	6	47	2	As Expected
LSG All Cause Readmission	41	0	0.00%	1.46%	1.69%	0.86	0.35	2.14	No	3	41	2	As Expected
LSG Related Readmission	41	0	0.00%	1.22%	1.36%	0.89	0.37	2.16	No	4	43	2	As Expected

Laparoscopic Roux-en-Y Gastric Bypass

	Total Cases	Observed Events	Observed Rate	Pred Obs Rate**	Expected Rate	Odds Ratio	95% C.I. Lower	95% C.I. Upper	Outlier	Decile	Adjusted Percentile	Adjusted Quartile	Assessment*
LRYGB Morbidity	20	2	10.00%	5.72%	3.93%	1.49	0.50	4.44	No	9	66	3	As Expected
LRYGB All Occurrences Morbidity	20	2	10.00%	8.47%	7.93%	1.08	0.47	2.43	No	7	54	3	As Expected
LRYGB Serious Event	20	1	5.00%	4.00%	3.81%	1.05	0.43	2.59	No	7	52	3	As Expected
LRYGB Leak	20	0	0.00%	0.35%	0.37%	0.96	0.22	4.24	No	6	49	2	As Expected
LRYGB Bleeding	20	0	0.00%	1.39%	1.54%	0.90	0.28	2.90	No	3	45	2	As Expected
LRYGB SSI	20	1	5.00%	1.54%	0.86%	1.80	0.36	9.13	No	9	67	3	As Expected
LRYGB All Cause Reoperation	20	0	0.00%	1.58%	1.77%	0.89	0.29	2.72	No	3	44	2	As Expected
LRYGB Related Reoperation	20	0	0.00%	1.23%	1.34%	0.92	0.30	2.80	No	4	45	2	As Expected
LRYGB All Cause Intervention	20	0	0.00%	0.92%	1.04%	0.88	0.19	4.04	No	4	45	2	As Expected
LRYGB Related Intervention	20	0	0.00%	0.66%	0.73%	0.90	0.17	4.79	No	5	46	2	As Expected
LRYGB All Cause Readmission	20	1	5.00%	5.28%	5.34%	0.99	0.45	2.15	No	6	49	2	As Expected
LRYGB Related Readmission	20	1	5.00%	4.40%	4.29%	1.03	0.44	2.41	No	6	51	3	As Expected

30-day Mortality for Site 09704 and Total 30-day Mortality for All Sites: 1/1/2021 - 12/31/2021

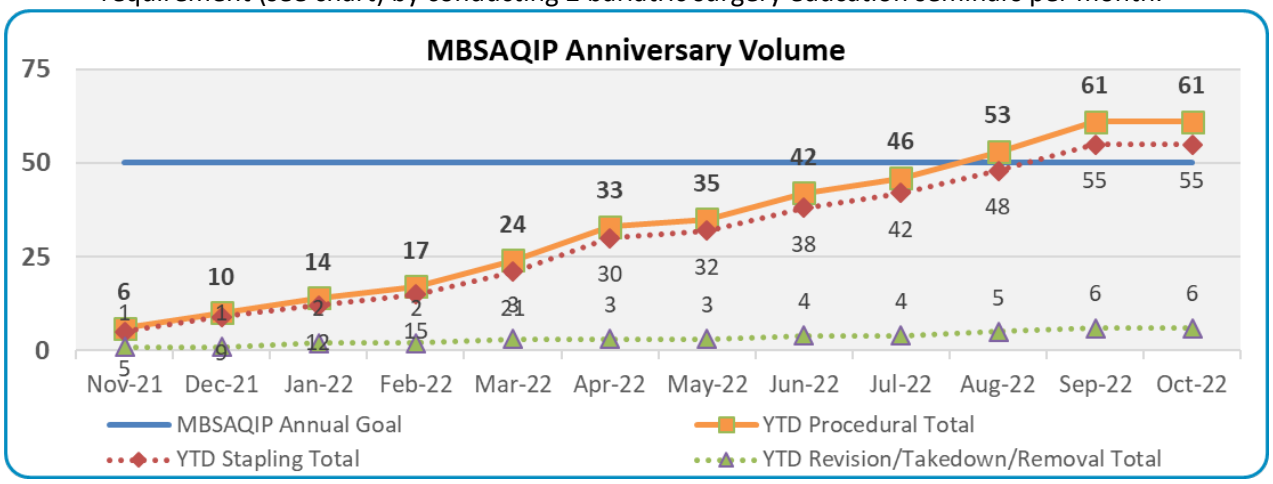
Site	Number of Sites	Total Cases	Death Cases	Mortality Rate(%)	Mean Site Mortality Rate(%)	Standard Deviations From Mean Site Rate
09704	-	61	0	0	-	-0.259
All Sites	902	211254	164	0.0776	0.0965	-

The 2022 Quality Improvement Initiative was "Decreasing 30-Day Bariatric Related ED Visits after Bariatric Surgery".

1. Data Review: 8 ED visits out of 64 cases in 2021 (12.5%). 4 of those visits are bariatric related (6.25%).
2. The project aims to reduce the 30-day bariatric-related ED visits to half (3%).
3. Pre-op and hospital patient education and post-op phone calls to increase patient awareness of early abnormal symptoms/possible complications, report to their surgeons for early management, and avoid unnecessary ED visits.
4. Bariatric-related ED visits have been unexpectedly high (15%) from April to August.
5. A pocket-size card and a magnet with "Tips for Surgery" and "Things to Keep in Mind" are created and provided to patients during their hospitalization as a reminder.
6. The bariatric-related ED visit was down to 10% at the end of November.
7. The data collection period was extended until June 2023.

2023 Goals

1. Pass the tri-annual MBSAQIP accreditation to maintain Comprehensive Center status by the American College of Surgeons
2. MBSAQIP Quality Improvement Project for 2023, "The Use of Carbohydrate Drink Pre-Operatively" or "DVT/VTE and PPI prophylaxis after bariatric surgery."
3. Implement GetWell digital patient engagement platform for Bariatric Surgery to improve patient outcomes and experience
4. Continue to exceed a 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.



Centers for Medicare & Medicaid Services (CMS) Pay for Performance Reports

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

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

Hospital Value-Based Purchasing (VBP) Program

For the VBP Program, the metrics used to measure hospital performance fall 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 2023 Program, CMS suppressed several measures due to the COVID-19 public health emergency. As a result, there were not enough data to award Total Performance Scores to hospitals. Therefore, no hospital will be financially rewarded or penalized in the FY 2023 Hospital VBP Program.

Review of the VBP Program metrics reveals 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
- Care Transitions
- Overall Rating of Hospital

Hospital Readmissions Reduction Program (HRRP)

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 2023 HRRP was July 1, 2018 - December 1, 2019, *and* July 1, 2020 – June 30, 2021. (Because of the COVID-19 public health emergency, CMS excluded data reflecting services from January 1, 2020 - June 30, 2020. CMS also excluded Pneumonia (PN) patients from the RRP conditions.)

For 2023 HRRP, the total number of dollars at risk for Palomar Health was around $1.85M, representing 3% of our Estimated Revenue Subject to Adjustment. Based on our hospitals' performance, PMC-Escondido will receive a penalty of approximately $164,600 ($53,000 for AMI, $84,100 for THA/TKA, $8,900 for COPD, and $18,700 for CABG excess readmissions) and PMC-Poway will receive a penalty of approximately $38,000 ($6,700 for HF and $31,300 for THA/TKA excess readmissions).

Potential strategies to reduce hospital readmissions include:

1. **Appropriately determine** each patient's **readiness for discharge**.
2. Perform **medication reconciliation** and **teach patients** about the **importance of medication adherence**.
3. **Coach patients on discharge instructions** and **self-management**. Improve patient education procedures and create checklists to ensure that patients understand post-care instructions and changes in medication and can also recognize red flags. Confirm patient comprehension and provide translation services for non-English speakers.
4. **Involve family members** throughout the discharge process.
5. **Schedule follow-up appointments** on behalf of patients; help to **arrange transportation to appointments**.
6. **Determine** the **optimal post-discharge care setting** for each patient.
7. Provide **care coordination** and **care setting transition planning**. Utilize transitional care nurses and other care coordination professionals to smooth the transition to outpatient care. Coordinate closely to reduce common communication gaps between inpatient and outpatient providers.
8. Implement a **Discharge Follow-up Program** (video visit or phone call).

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)

In response to the COVID-19 public health emergency, CMS decided not to calculate measure scores or Total HAC Scores for any hospital for the FY 2023 program year. As a result, no hospital was ranked in the worst-performing quartile or subject to the 1-percent payment reduction.

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 healthcare. The Leapfrog Hospital Safety Grade is a grade that the Leapfrog Group assigns to each general hospital in the US, 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 again in the fall.

Leapfrog Hospital Safety Grades assigned in fall 2022:

PMC Escondido Grade - B

The greatest areas for improvement included opportunities to improve our Hand Hygiene program, enhance CPOE (Computerized Physician Order Entry) safety functionalities and alerts, decrease rates of Patient Falls and Trauma, decrease rates of Catheter-Associated Urinary Tract Infection (CAUTI) and decrease rates of Deaths of surgical inpatients with serious treatable conditions.

PMC Poway Grade - B

The greatest areas for improvement included opportunities to decrease rates of Central Line-Associated Bloodstream Infection (CLABSI), improve our Hand Hygiene program, enhance CPOE (Computerized Physician Order Entry) safety functionalities and alerts, decrease rates of Catheter-Associated Urinary Tract Infection (CAUTI), and improve patient experience via more robust Staff Responsiveness.

Action Plan

To improve CPOE safety functionalities and alerts:

- For Fall 2022, Medication Safety Alert Categories that were added included:
  - Drug Route
  - Drug Patient Age
  - Drug Laboratory
  - Drug Diagnosis
- For Spring 2023, plan also to add:
  - Dose Range Checking
  - Reducing Excessive Alerts

To improve safety-related HCAHPS scores:

- Begin tracking reasons our patients are using call lights (bathroom, pain, positioning, IV alarm, or other) to obtain baseline data and see results as we move forward
- Refresh and recommit to high-quality Hourly Rounding
- Support/accountability from executive leadership
- Commitment from 6E leadership and staff to consistently conduct high-quality Hourly Rounding as well as call light tracking
- Validation of high-quality Hourly Rounding via direct observation and leader rounding on patients

Failure Mode Effectiveness Analysis (FMEA)

FMEA 2020: Hand-off 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 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 a risk of failure.

The Quality Department conducted an initial FMEA meeting in April 2021. The team comprised 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 included the following:

- Revision of the hand-off procedure
- Trip Tik revised
- Preferred languages standardized in documentation
- Revision of hand-of mPage

Continued Process Improvement

- Trip Tik audits for 2022 identify a practice gap in documentation
- February 2023 feedback received from Staff Practice Council on revisions needed to improved documentation compliance

Goals for 2023

- Revise and implement Trip Tik form end of QTR 2 CY 2023
- Increase compliance of Trip Tik documentation by at least 50% by the end of CY 2023.

Culture of Safety Survey

"Safety Culture" is the sum of what an organization is and does in the pursuit of safety. We periodically administer Culture of Safety Surveys to:

- Raise staff awareness about the importance of patient safety
- Diagnose and assess the current status of our health system's patient safety culture
- Identify strengths and opportunities for improvement in our patient safety culture
- Evaluate the cultural impact of patient safety initiatives and interventions

Accomplishments

In 2022 we switched to a new vendor (GLINT) to administer the Culture of Safety Survey. While this change in vendor has resulted in the inability to compare apples-to-apples our most recent survey results with the results of prior years' surveys (which were administered by a different vendor), the current vendor provides unprecedented capability to analyze survey results by finer cohorts – e.g., by Department, by Job Title, by unit, etc.

Results of the 2022 Culture of Safety Survey

The overall response rate (survey participation) was 2,221 out of 4,771 surveyed = 47%. 47% is the highest level of participation our health system has achieved thus far on any culture of safety survey, and we will continue to strive for even greater participation in subsequent surveys.

2,017 free text comments were submitted, which provided useful, actionable feedback that is difficult to ascertain via simple checkbox responses. This also represents the greatest number of free text comments we've ever received in a culture of safety survey.

Top Strengths Organization-wide

- Modeling – "Leadership's actions show that patient safety is a top priority."
- Change Willingness – "Actions taken based on safety event reporting have led to positive changes here."
- Communication – "There is good communication between leaders and employees here about patient safety."

Top Opportunities Organization-wide

- Root Cause – "At this organization, we seek to solve problems permanently rather than just come up with a 'quick fix.'"
- Training – "The patient safety-related training I receive is effective."
- Teamwork – "We support each other in caring for patients safely here."

Goals for 2023

Continue to cultivate a healthy Culture of Patient Safety by:

- Creating an environment where people feel free to speak up about errors without fear of punishment
- Using the feedback received from the survey to identify and address system vulnerabilities that could potentially predispose to errors
- Applying a fair and consistent approach to the evaluation of staff actions associated with patient safety incidents (a.k.a. Just Culture)
- Supporting the reporting of Good Catches
- Promoting an organization-wide willingness to examine system weaknesses and applying our findings to improve the safety of the patient care we deliver

PALOMAR HEALTH

ADDENDUM J

INFECTION PREVENTION & CONTROL CALENDAR YEAR 2022 ANNUAL REVIEW AND PROGRAM ASSESSMENT

Table of Contents

Introduction

Annual Review and Program Assessment

The Infection Prevention and Control program is evaluated annually. This assessment compares outcomes from calendar year 2021 to 2022. 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

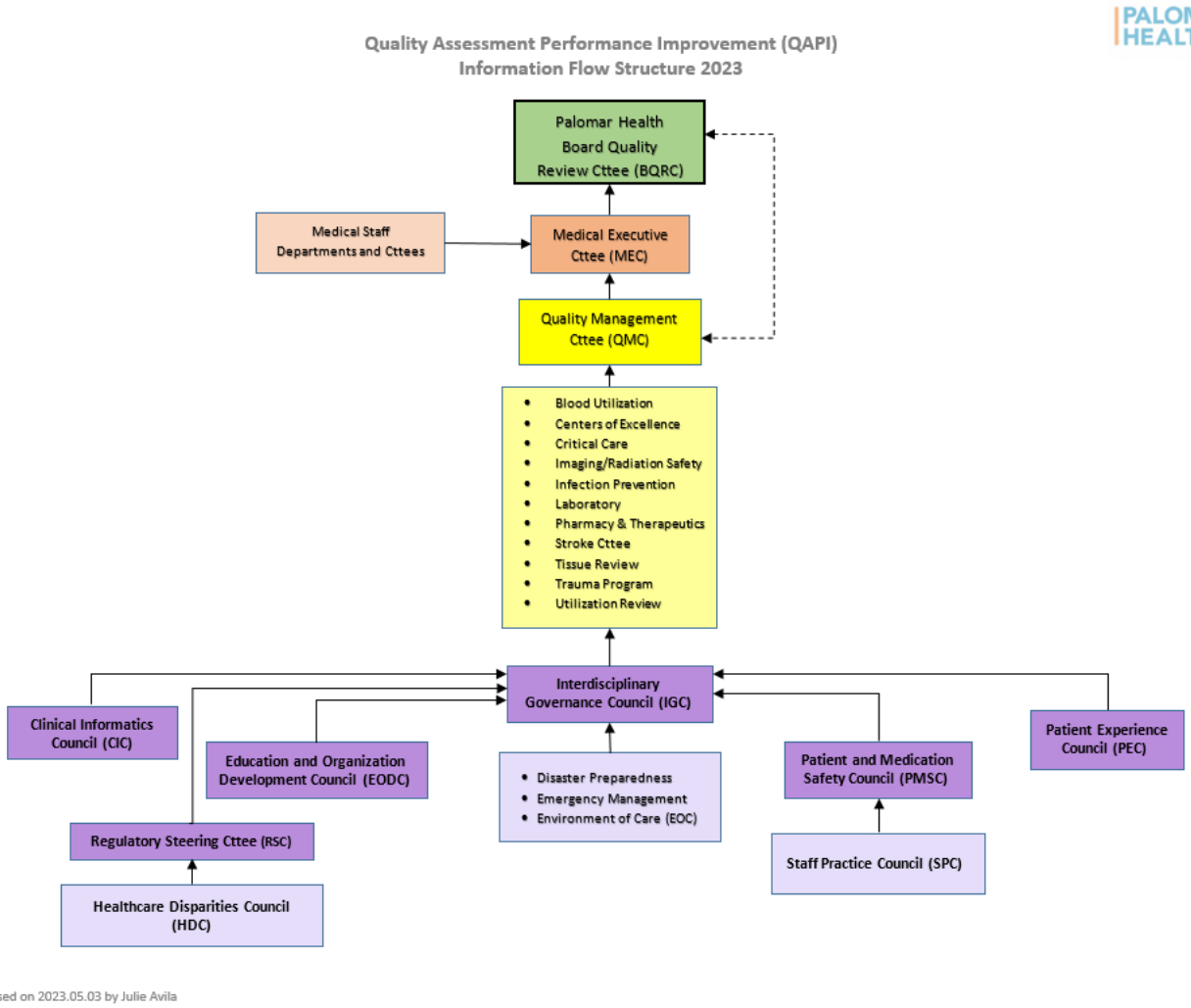
Palomar Health has designated the Infection Control Officers per CMS to the Senior Director of Quality, Patient Safety, Infection Prevention, and the Chair of the Infection Prevention and Control Committee.

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

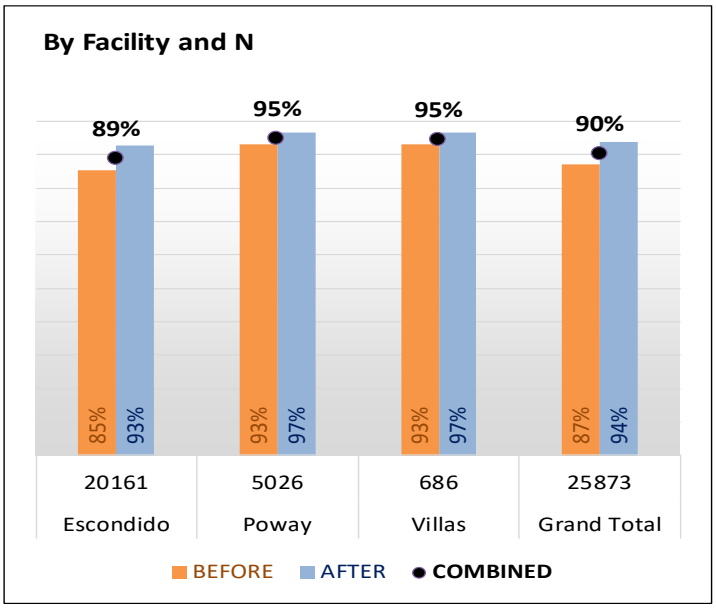
The Infection Prevention and Control Department is structured under the Operations Division. The Infection Prevention and Control Program reports directly to the Quality Management Committee.

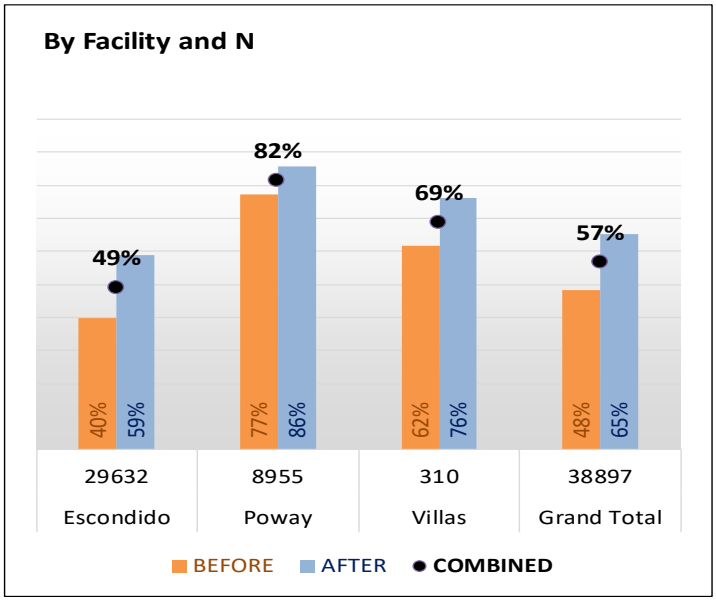


Hand Hygiene

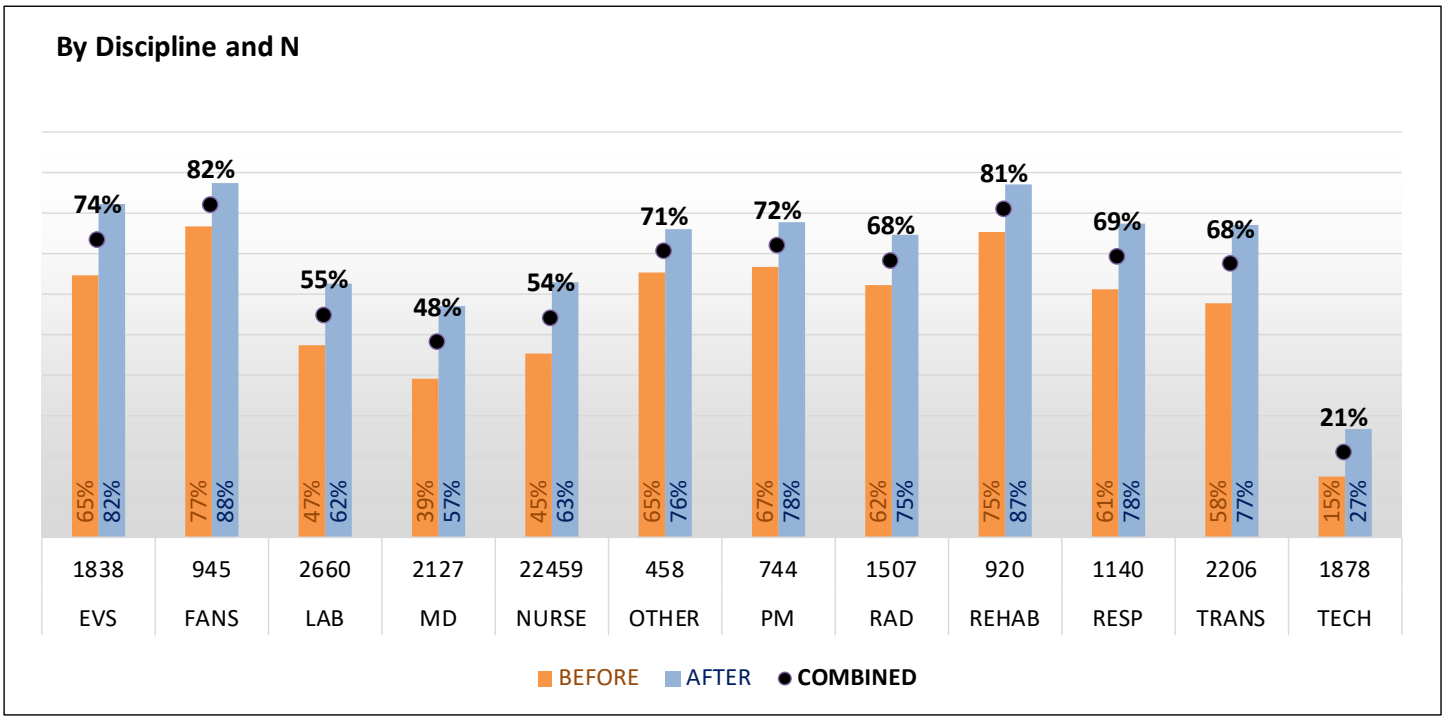
Goal: Increase facility *before patient contact* (orange) hand hygiene compliance by ≥10% or maintain above 85% compliance from 2021; measured by Palomar Health Infection Control standardized methods.

2021 & 2022 Hand Hygiene Compliance by Facility





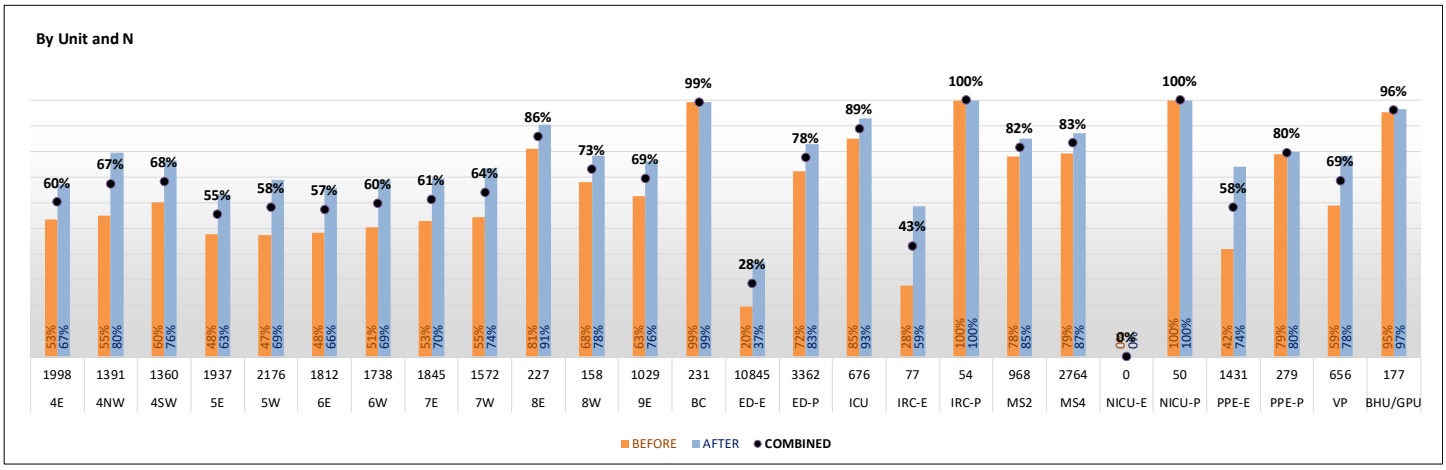
2022 Hand Hygiene Compliance by Discipline



NURSE = RN, LVN, CNA, PSC, RN Case Management; RAD = Radiology/Imaging; MD = MD, OD, PA, Nurse Practitioner (NP); FANS = Food service, registered dieticians (RD); RESP = Respiratory care practitioners (RCP); TRANS = Transport/lift team; EVS =

Environmental Service; REHAB = PT, OT, Speech therapists; LAB = Phlebotomists; PM = CCE, Pathmakers, Volunteers, Students; TECH = ED techs, Cardiology techs, Medical tech/asst.; OTHER = Security, Social worker, Chaplain, etc.

2022 Hand Hygiene Compliance by Unit



Summary Analysis: During 2022, each facility maintained focus on increasing hand hygiene *before patient contact* yet did not achieve the goal of increasing compliance by at least 10% nor maintaining compliance at 85%. The *before patient* compliance rate for each facility decreased by the end of 2022, Escondido by -45%, Poway by -14%, and Villas by -27% when compared to 2021. The most common note documented by observers this year is the use of gloves in lieu of hand hygiene. At the unit level, some units reported the lack of alcohol dispensers in their corridors.

Goal Met/Unmet:

PMC Escondido - Goal Unmet

PMC Poway – Goal Unmet

The Villas at Poway – Goal Unmet

Action Plan:

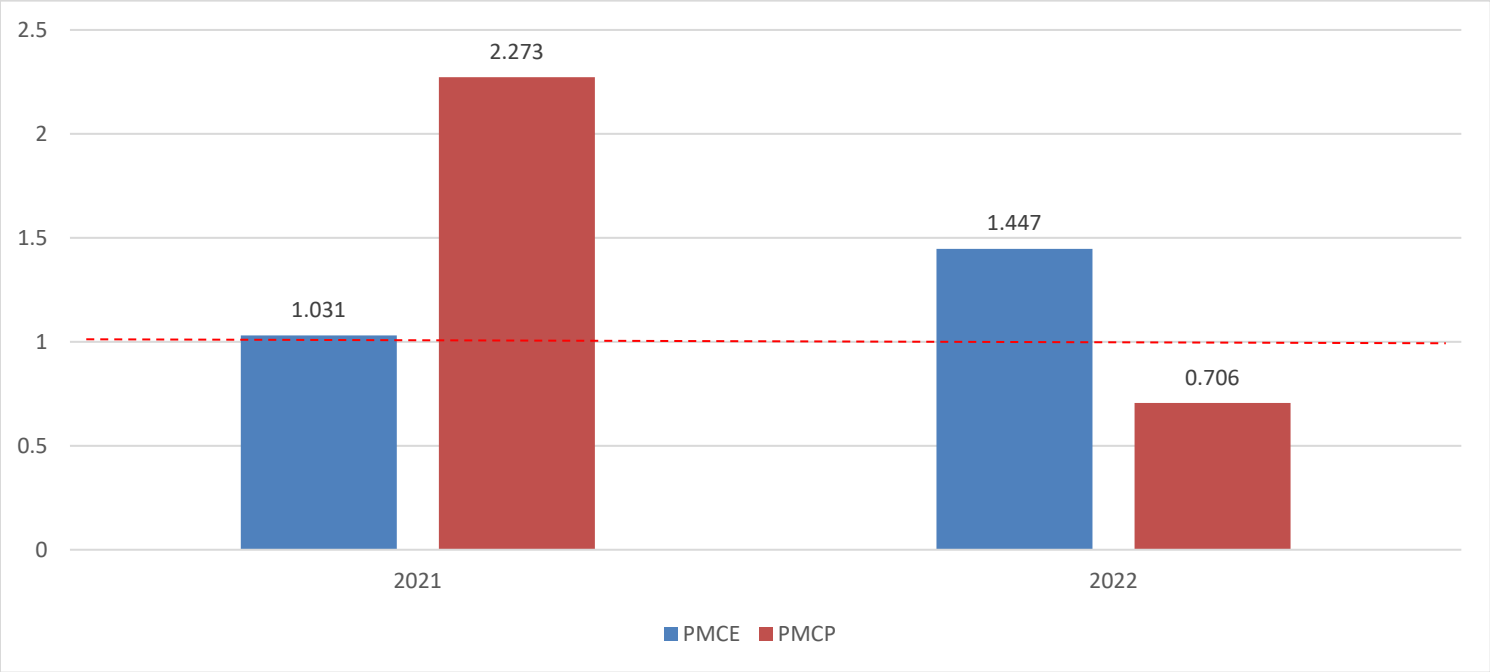
1. Infection Prevention to begin providing unit-level data monthly
2. Medical staff engagement - trained observers will notate physician names on observation worksheets. This will be shared with Medical Director leaders for peer follow up
3. Staff Leader engagement – select leaders to report out their unit-based interventions to improve their hand hygiene at the Infection Control & Prevention Committee
4. *Tech* discipline added to 2023 collection worksheet
5. If *Nurse* is observed, trained observer will notate if CNA
6. Provide quarterly facility and unit-level data (report cards).
7. Provide list of interventions and assistance with implementing to unit leaders, as well as data collection methods and expectations.
8. Provide hand hygiene education to employees upon hire, annually, and regularly with units or disciplines.
9. Three-month retraining among observers implemented

10. Explore logistics and compatibility with Human Resources recognition program by end of June.
11. Improve product accessibility with pilot unit, infection control, unit leader, facilities, and EVS.
12. Add alcohol dispensers where appropriate.

Central Line-Associated Bloodstream Infection (CLABSI)

CLABSI Standardized Infection Ratio (SIR)

Goal: Facility does not exceed established threshold 1.0, analyzed by NHSN with a 10% reduction



Summary Analysis:

1. Among 16 CLABSI events (15 at Escondido, 1 at Poway) there were 8 PICC lines and 8 CVC's in place.
2. Escondido increased CLABSI by 40% during 2022, compared with 2021 data, and is above threshold.
3. Three, or 18% of patients had COVID-19 infection.
4. In 8 of 16 cases, lines were inserted in 5W CCU, three in Interventional Radiology, 1 in ED 2 were present on admission and one in Poway ICU.
5. Of sixteen patients with CLABSI, 5 had internal jugular and 1 had femoral lines in place. 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. Data reveals that this is not implemented for all patients with central venous catheters daily as recommended, with evidence of 56% compliance.
7. Location of attribution was primarily Escondido 5CCU with 9 cases attributable to this unit.
8. Poway reduced CLABSI by 69% during 2022 with one total CLABSI event for the facility occurring on MST4.
9. Seven lines were inserted by physicians and 7 by RN Vascular Access Team members.

10. 92% were documented to be indicated by Physicians. Documentation of necessity of the central venous catheter is a California mandate.
11. Dressing changes are not consistently changed per protocol, with 6 of 16 (46%) patients not meeting 7-day dressing change requirements.
12. Dwell time among this group of patients was 0-7 days (37%) implicating insertion practices and >7 days (63%) implicating, site choice, and maintenance as causative risk factors.

Goal Met/Unmet:

PMC Escondido – Goal Unmet

PMC Poway – Goal Met

Action Plan:

1. Improve hand hygiene before patient contact.
2. Increase compliance with documentation for central line indication for necessity through collaboration with physician groups to 90% compliance.
3. Peripherally drawn blood specimens when possible, to reduce access.
4. Use double lumen midlines when appropriate.
5. Improve MD Central Line Indication documentation and timely removal of unnecessary lines.
6. Adhere to a Central Line Dressing Change day starting in ICU's and moving to all unit locations.
7. Reinforce CLIP form documentation of all elements for patients who have a central line.
8. Perform reviews with unit leaders and evaluate process measure compliance.
9. Provide device utilization data and outcomes measures to unit Medical Directors, involving hospitalist and intensivists in device reduction strategies (**Figure 3**)
10. Remove femoral line within 24 hours – Intensivists
11. Improve daily CHG bathing for all patients with central venous catheters by 10% during 2023 through unit based leadership. Explore alternate CHG agents for implementation.

CLABSI Prevention Measures – Central Line Insertion Practices (CLIP)

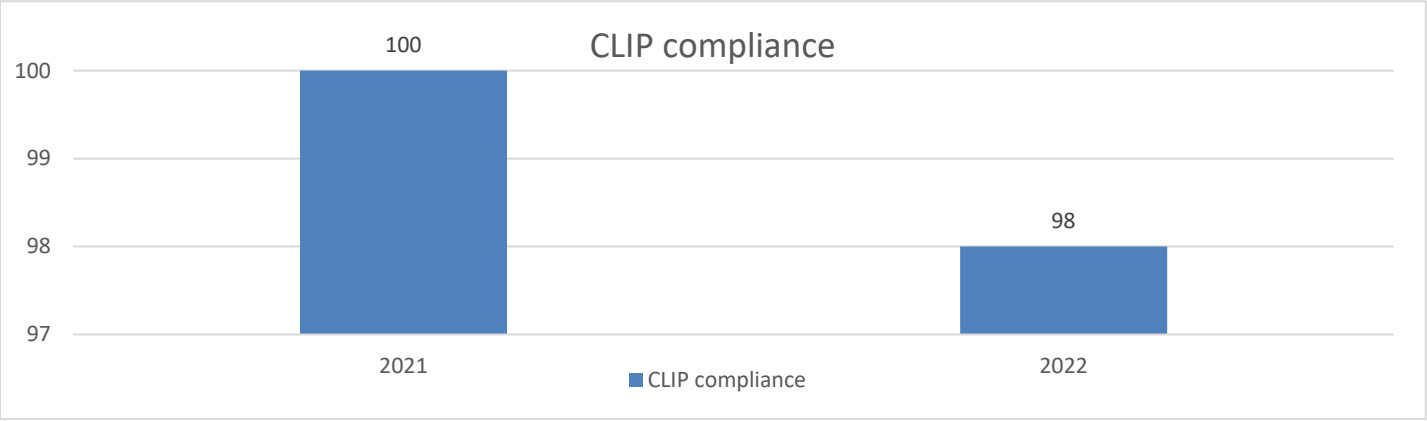


Figure 1 System CLIP adherence, measuring full sterile barrier precautions, hand hygiene, and appropriate skin

prep. In 2021, a new measure was added to the CLIP process including ultrasound guided insertion and sterile probe cover. Compliance decreased by 2% during 2022, however, remains above goal.

Palomar Health Central Line Indication Documentation Percent Compliance 2022

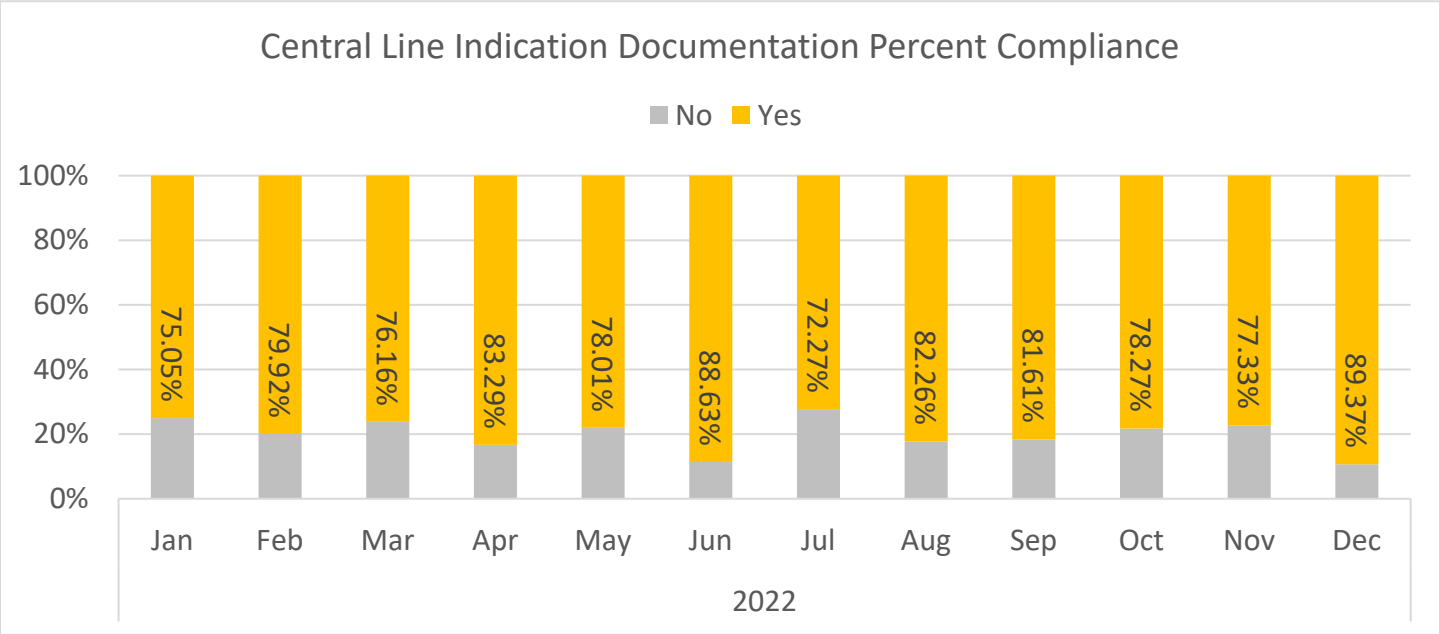


Figure 2 *Adherence to evaluation of necessity for central venous catheters is measured by physician response to a prompt in Cerner to evaluate the current need for a central venous catheter. Physician compliance with this process has increased indicating the necessity of the catheter has been assessed and confirmed necessity on a daily basis. However, physicians are not consistently adhering to documentation of insertion and subsequent indication requirements.*

Central Venous Catheter Standardized Utilization Ratio (SUR)

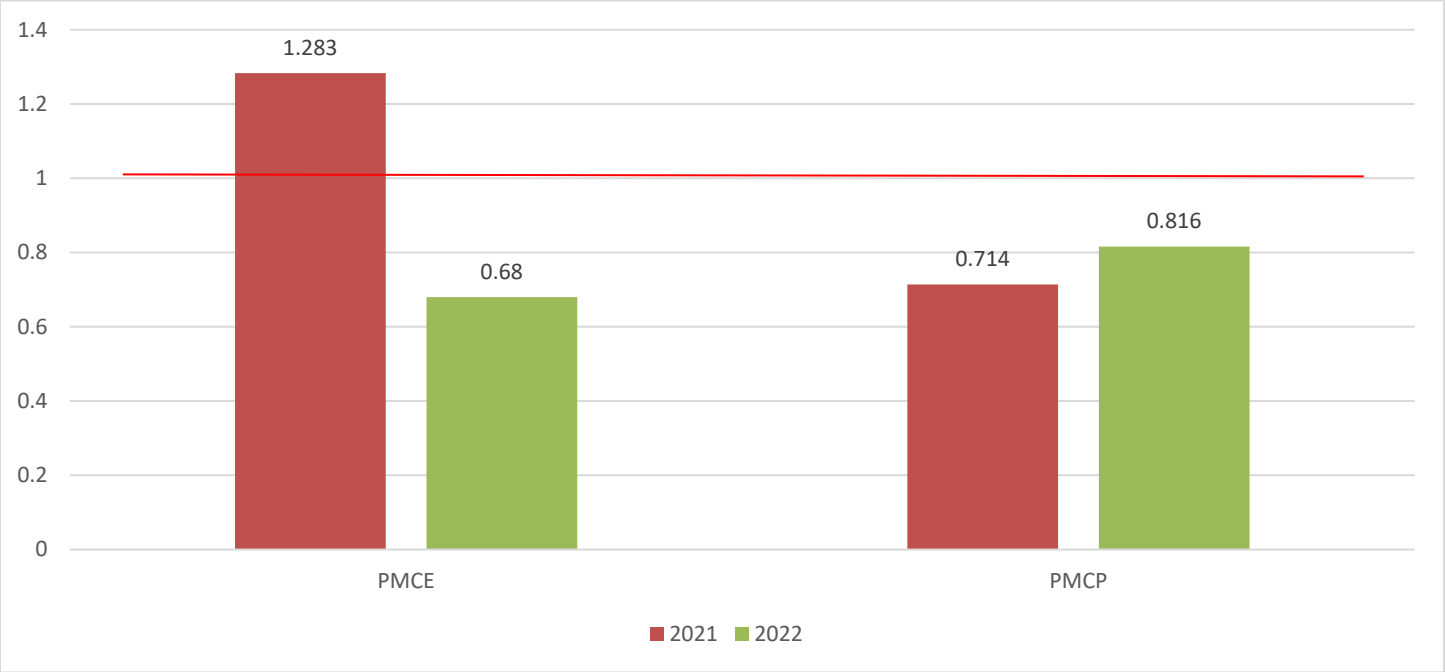


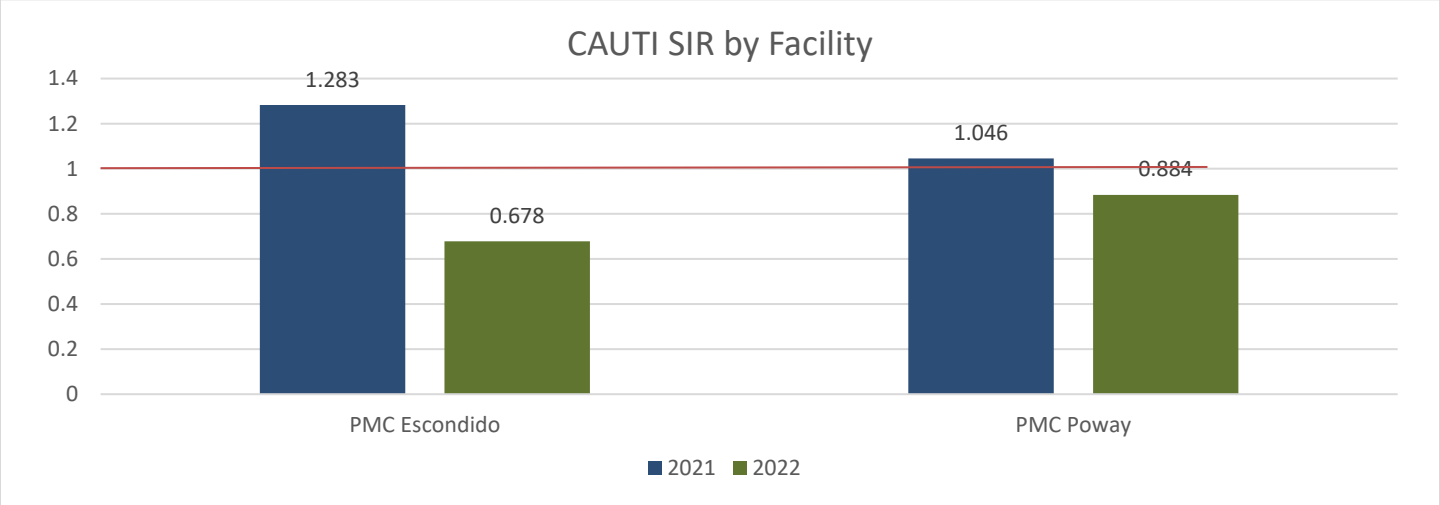
Figure 3. *Central line use is measured by NHSN as the number of observed catheter days / the number of predicted catheter days.*

Device utilization as shown in a Standardized Utilization Ratio (SUR) is below threshold at PMC Escondido and PMC Poway. During 2022, the Escondido campus and decreased utilization by 47%. PMC Poway campus has increased utilization by 14% but remains below threshold. 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 by 10%, analyzed by NHSN.



Summary Analysis:

1. There is a decreased number of cases during 2022, 17 (Escondido 14, Poway 3), compared to the previous year with 29, system-wide. This is attributable to defining and identifying dependent loops, and increasing awareness of the Nurse Driven Protocol. Nursing and transportation services are demonstrating diligence in identifying and correcting dependent loops.
2. PMC Escondido evidenced a 47% decrease compared with 2021, and PMC Poway evidenced an 15% decrease.
3. Dwell time of catheters is 0-7 days is similar to 2021 at (35.29%) and >7 days (64.71%) indicating opportunities for improvement in insertion and maintenance processes.
4. During 2022, it is noted that Pseudomonas as the leading causative organism at 29% of all organisms identified. This is followed by *E. coli* then *S. aureus* which is different from 2021 where the top three organisms were gastrointestinal flora and indicating contamination.
5. Average utilization of pericare products was performed and demonstrated a decrease in utilization by 17%, as compared to 2021 data.
6. All of the 17 were tested for COVID-19 and 7 were positive.
7. Most cases occurred on 5W (24%) followed by 6WCCU (12%), 5E (12%), ICU Poway, 4SW TICU, 4NW, (12%) 6E, MS4 and 4E at (5%)
8. Of cases occurring in non-critical care units the indication for the catheter was “output monitoring, critically ill patient” occurred on 4 patient’s records. This indication is not appropriate for these locations.

Goal Met/Unmet:

PMC Escondido – Goal Met

PMC Poway – Goal Met

Action Plan:

1. Improve hand hygiene before patient contact and aseptic technique during insertion.
2. Utilization of the Nurse Driven Protocol for catheter removal.
3. Promote the use for external catheters when appropriate.
4. Multidisciplinary rounds assess need for catheter.
5. Insert less catheters in ED allow ICU to decide on insertion.
6. CAUTI bundle rounds with a focus on missed opportunities and notification to unit Leaders.
7. Unit based representatives report in Daily Quality huddle to ensure accountability for identifying unnecessary catheters.

CAUTI Process Measures - CAUTI Bundle Monitoring

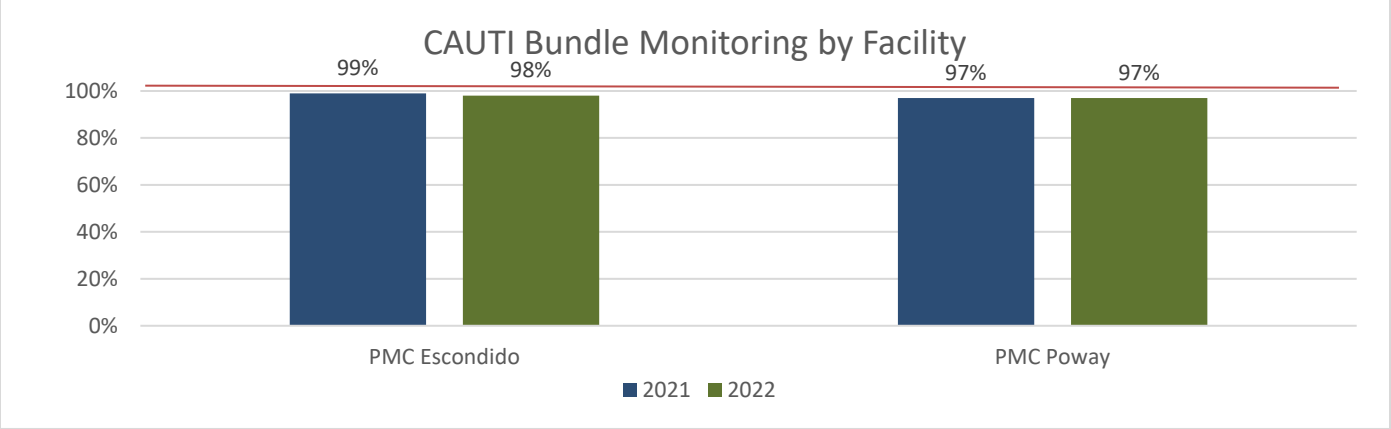


Figure 4. *CAUTI Bundle compliance is a measure of 6 maintenance intervention elements: tamper seal intact (ensures closed system), securement device, unobstructed urine flow, drainage tubing/bag off floor, drainage tubing/bag below bladder, indication for catheter documented if not discontinued. Goal is 90% compliance.*

Indwelling Urinary Catheter Standardized Utilization Ratio (SUR)

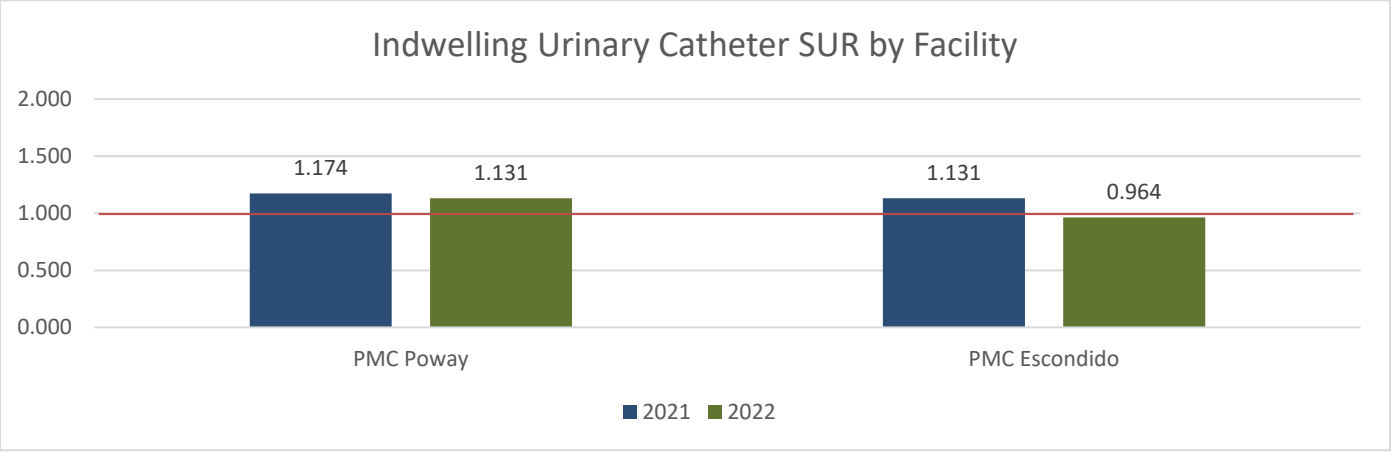


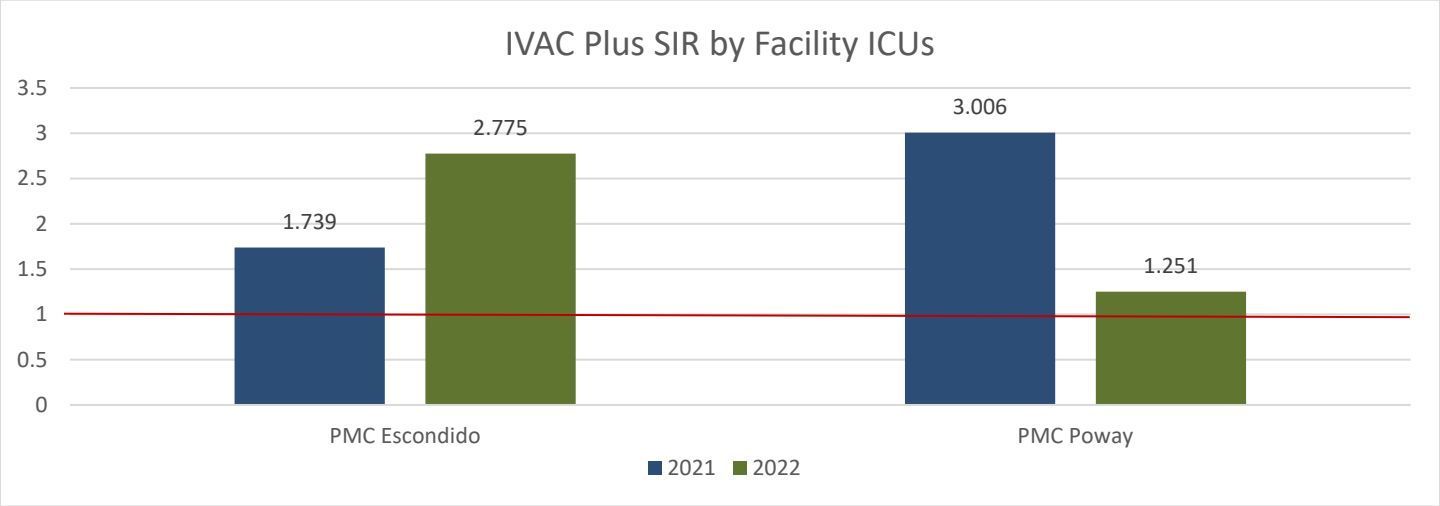
Figure 5. *Indwelling urinary catheter use is measured by NHSN as the number of observed catheter days / the number of predicted catheter days.*

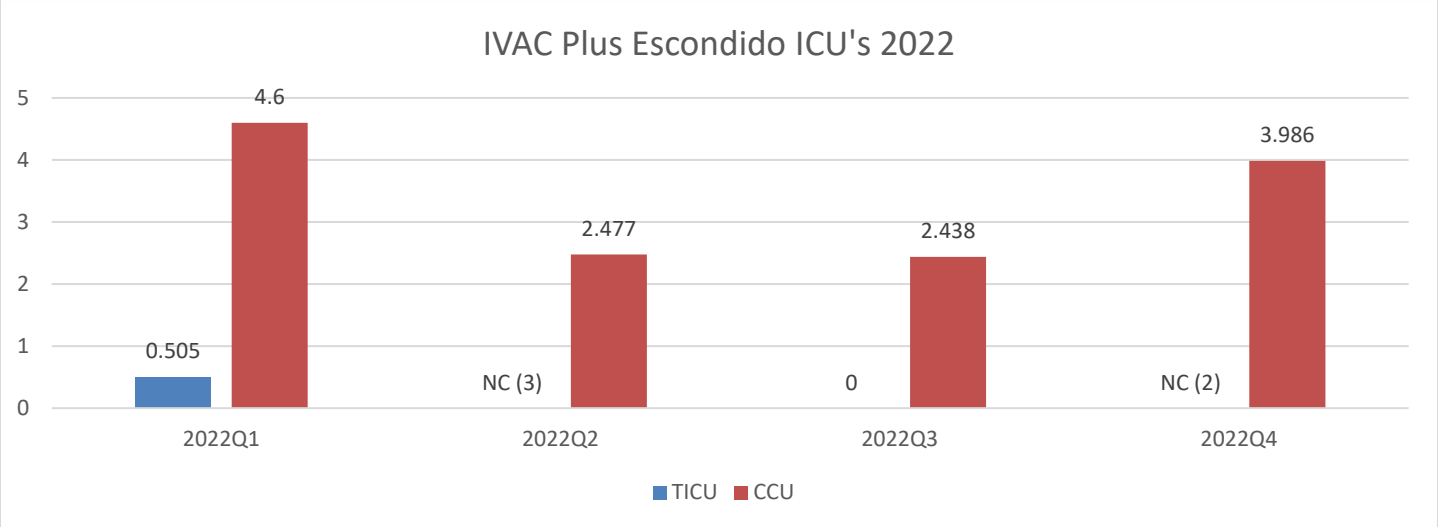
The facility SUR is 1.131 at Poway with an 3% decrease in utilization and 0.964 at Escondido with an 15% decrease in utilization. Poway campus remains above threshold. Goal is below 1.0 SUR.

Ventilator-Associated Pneumonia (VAP)

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

Goal: Facility ICUs to reduce IVAC Plus SIR below 1.0 from previous year.





Summary Analysis:

1. The total cases of IVAC plus for PMC Escondido and PMC Poway is 32 which is increased from 29 cases in 2021. 5W had (24), 4SW (6) and Poway (2). Increases occurred on 5W, while Poway ICU and 4SW reduced cases from 2021.
2. 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.
3. PMC Escondido increased IVAC SIR by 73% PMC Poway decreased IVAC SIR by 58%.
4. Measures taken during 2022 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 7**).

5. 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.
6. All cases were tested for COVID-19 and 10 were positive.

Goal Met/Unmet:

PMC Escondido (5W & 4SW) – Goal Unmet

PMC Poway (ICU) – Goal met

Action Plan:

1. Reinforce hand hygiene before patient contact and aseptic technique.
2. Audit oral care compliance by unit based clinical staff.
3. Collaboration with Intensivists, Respiratory and Unit leaders to review cases. Report findings to various committees.
4. Subglottic endotracheal tube investigation underway through the Value Improvement Process.
5. Interdisciplinary device rounds and planning strategy to prevent VAE with Respiratory
6. Engage Intensivists (**Figure 8**), and assessing device necessity.
7. Report all IVAC Plus and Standardized Infection Ratio outcomes to various committees indicating areas of opportunity.
8. Workgroup to focus on a standardized process for documentation for daily awakening, sedation vacation, and assessing readiness to extubate.
9. Apply manual count for both campuses.

VAP Process Measures – Ventilator Bundle Monitoring - Goal 95%

Figure 2

Facility	Bundle Element	Q1 Compliance	Q2 Compliance	Q3 Compliance	Q4 Compliance	2022 Grand Total Compliance
Grand Total		99.83%	99.72%	99.53%	98.98%	99.59%
Escondido	Daily awakening trial initiated	99.19%	98.66%	100.00%	98.68%	99.19%
	Daily spontaneous breathing trial initiated	100.00%	100.00%	100.00%	100.00%	100.00%
	Deep vein thrombosis prophylaxis initiated	100.00%	100.00%	99.52%	100.00%	99.87%
	Head of bed is 30 to 45°	100.00%	99.52%	98.51%	96.55%	98.91%
	Oral care with CHG completed	99.52%	100.00%	99.52%	99.16%	99.60%
	PUD prophylaxis is initiated	100.00%	100.00%	100.00%	100.00%	100.00%
Poway	Daily awakening trial initiated	100.00%	100.00%	-	-	100.00%
	Daily spontaneous breathing trial initiated	100.00%	100.00%	-	-	100.00%
	Deep vein thrombosis prophylaxis initiated	100.00%	100.00%	-	-	100.00%
	Head of bed is 30 to 45°	100.00%	100.00%	-	-	100.00%
	Oral care with CHG completed	100.00%	100.00%	-	-	100.00%
	PUD prophylaxis is initiated	100.00%	100.00%	-	-	100.00%

Figure 3. *Mechanical Ventilator Standardized Utilization Ratio (SUR)*

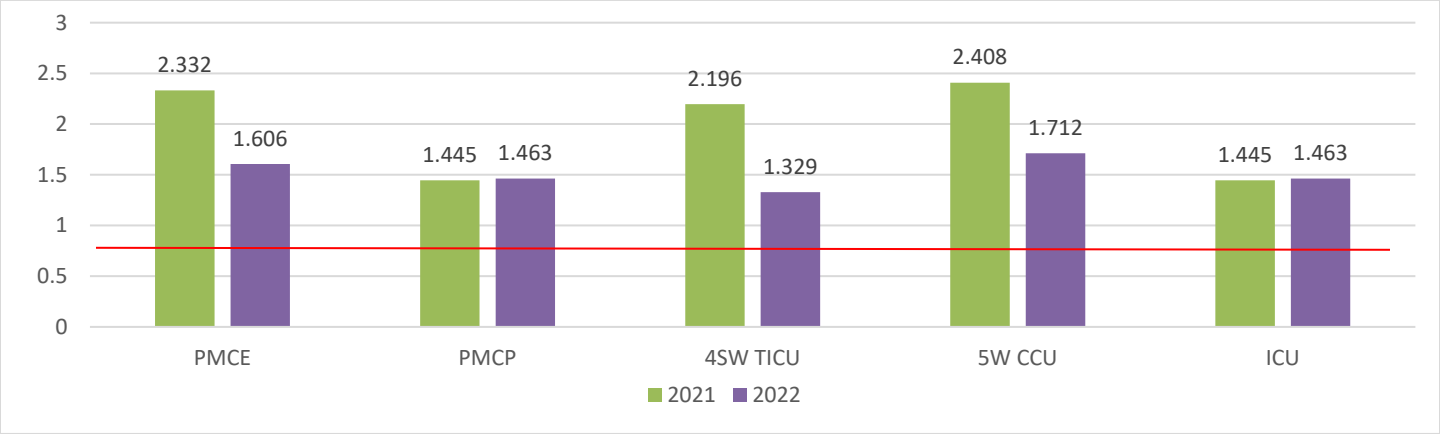


Figure 4. *Mechanical ventilator use is measured by NHSN as the number of observed vent days / the number of predicted vent days.*

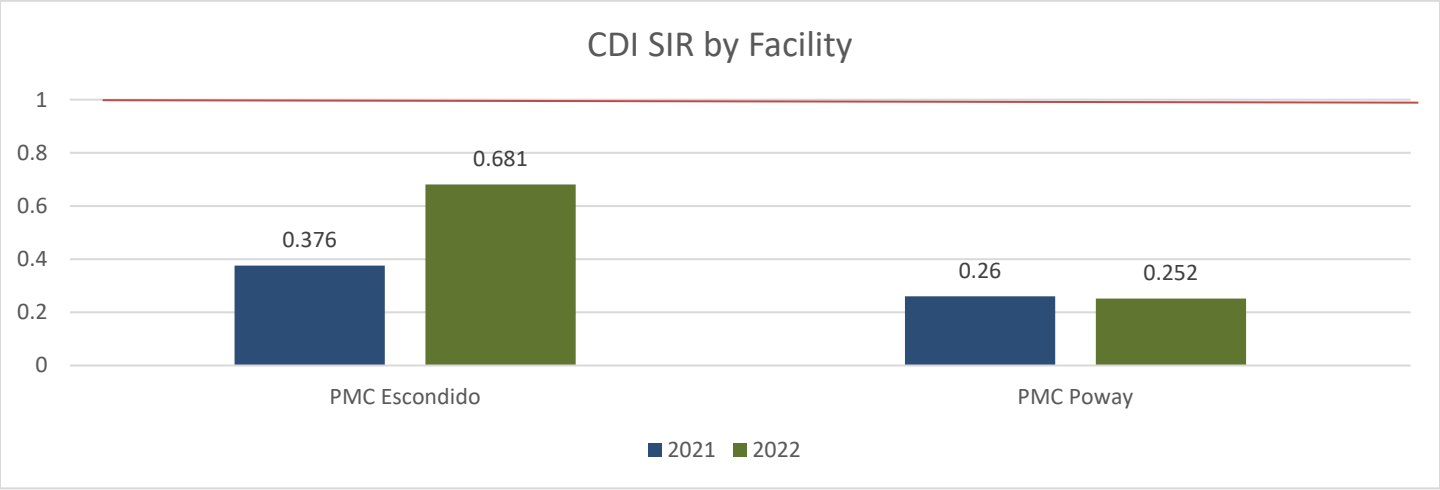
Summary Analysis:

1. Ventilator utilization has decreased at PMCE by 31%. Both campuses remain above threshold of 1.0 SUR Poway utilization increased utilization during 2022 by 1%.

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 remained under the 1.0 SIR with a total of 29 cases system wide compared with 17 during 2021. During 2022, PMC Escondido increased CDI SIR by 81% compared to previous year, and PMC Poway increased by 3%. Hospital Onset (HO) cases are reviewed with the unit based leadership, Infectious Disease Pharmacists and Infection Preventionists. A trend was identified that the

existing testing algorithm is not being used consistently for identifying and meeting criteria of three liquid stools and non-use of laxatives within 48 hours of testing.

Goal Met/Unmet:

PMC Escondido –Met

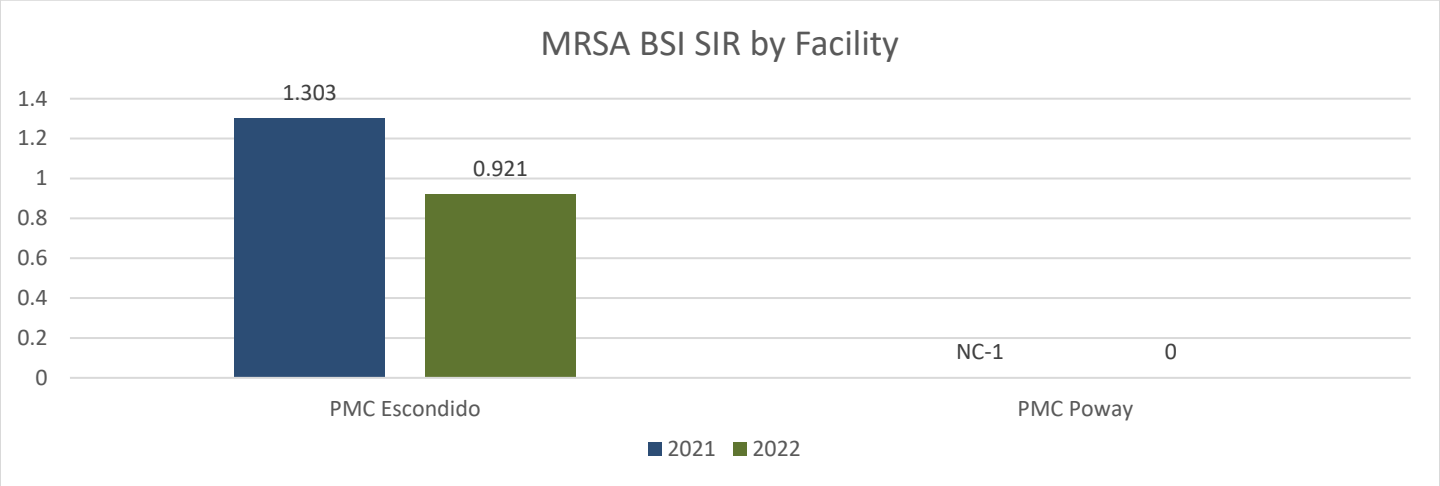
PMC Poway – Met

Action Plan:

1. Notify unit leaders of HO-cases for full review.
2. Collaborative with antibiotic stewardship subcommittee on usage and report out to appropriate committees.
3. Review of CDI algorithm when testing is ordered.
4. Observation of CDI (contact plus) room cleaning.
5. *C. difficile* reduction team during 2023.

MRSA Bloodstream Infection (BSI)

Goal: (1) Reduce facility MRSA BSI SIR by 10% and below threshold 1.0.



*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 29% decrease from previous year of Hospital Onset (HO) MRSA bacteremia, and is below threshold. This reflects 4 cases compared with 6 during 2021.
3. PMC Poway had zero MRSA BSI events during 2022.

Goal Met:

PMC Escondido – Goal met

PMC Poway – Goal met

Action Plan:

1. Ongoing reinforcement of Standard Precautions with Hand Hygiene adherence before and after patient contact
2. Unit based review of all HO cases
3. Round and follow up with unit isolation precaution compliance (**Figure 9**)
4. Explore new CHG agent for ease of use in ICU.
5. Use Contact Precautions for patients with MRSA in nares who are admitted with, or discovered to have infection.
6. Follow 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

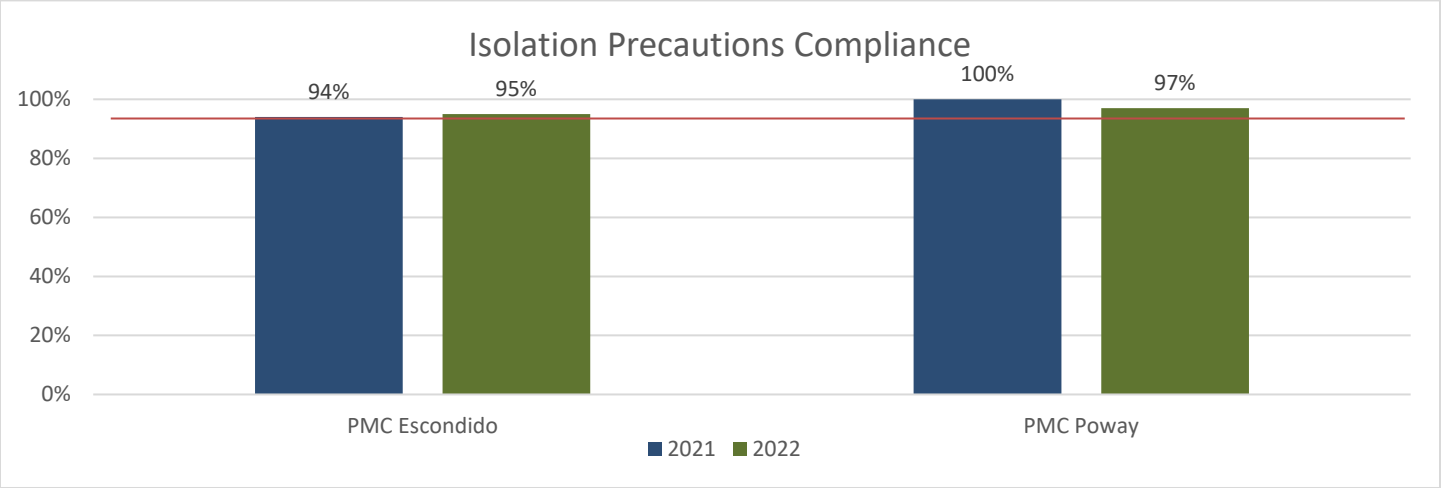


Figure 5. *Processes that reduce the risk of transmission for MDRO's include; Isolation initiation, patient education, use of the correct signs, ensuring gloves and gowns are available and wearing them when it is indicated.*

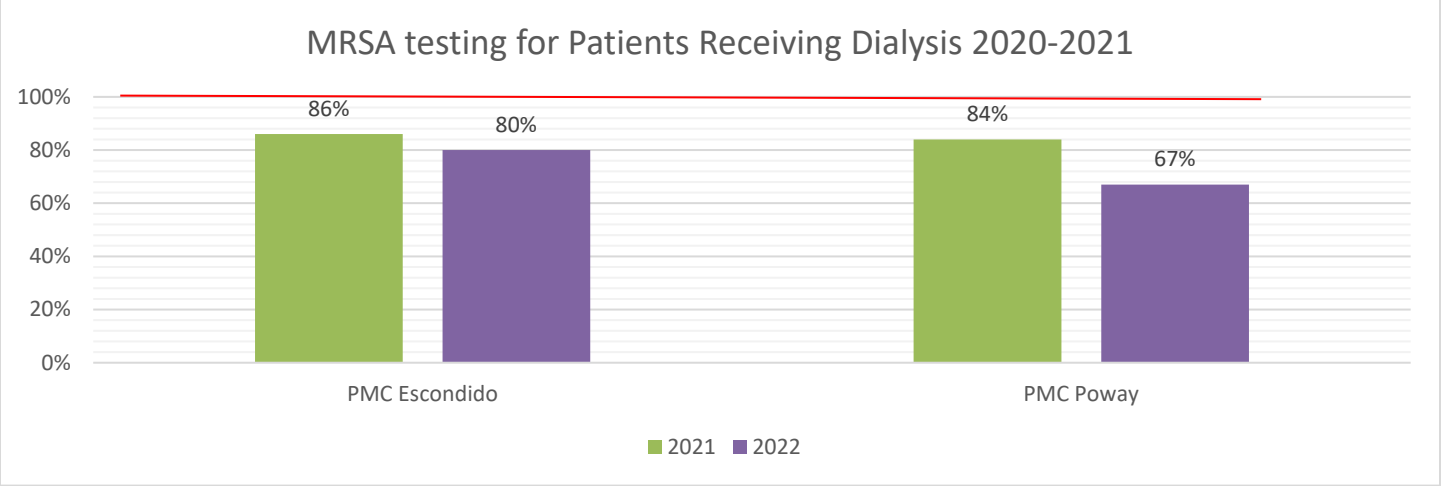


Figure 6. *The figure presented above demonstrates compliance with California mandate for testing a high risk population.*

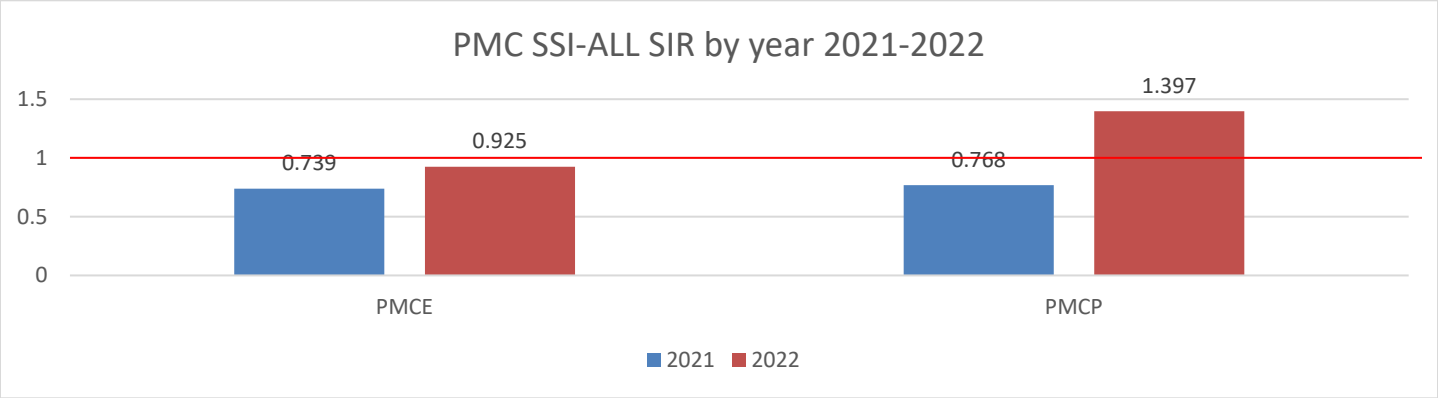
Summary Analysis: Both PMCE and PMCP showed a decreases in 2022. A daily patient list has been established and is distributed to the unit based leadership for awareness. The Infection Control committee did not come to agreement on the another high risk group to test during 2022.

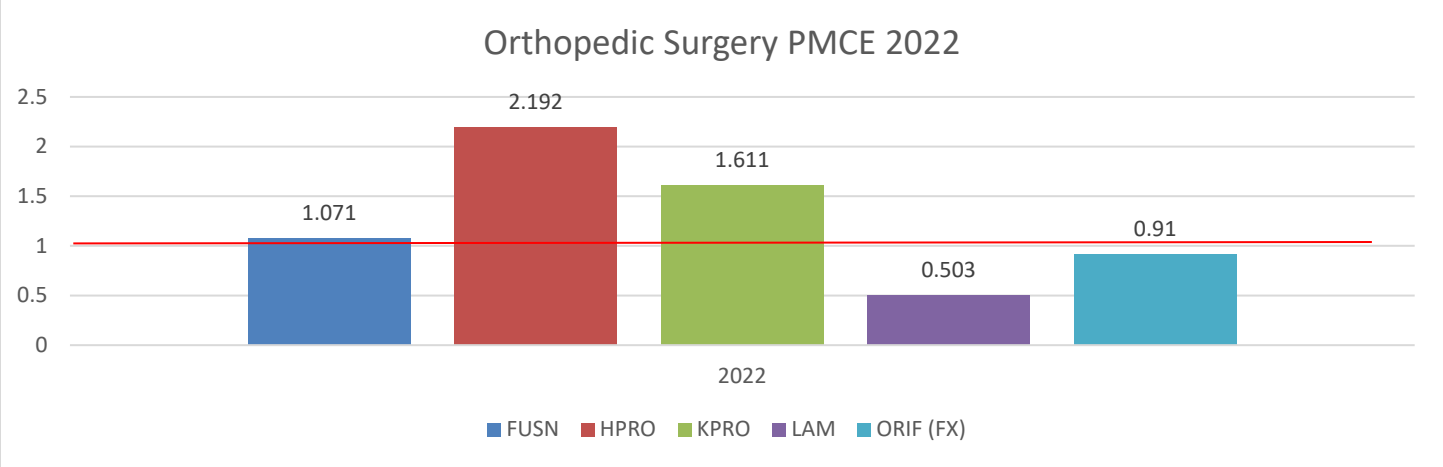
Action Plan:

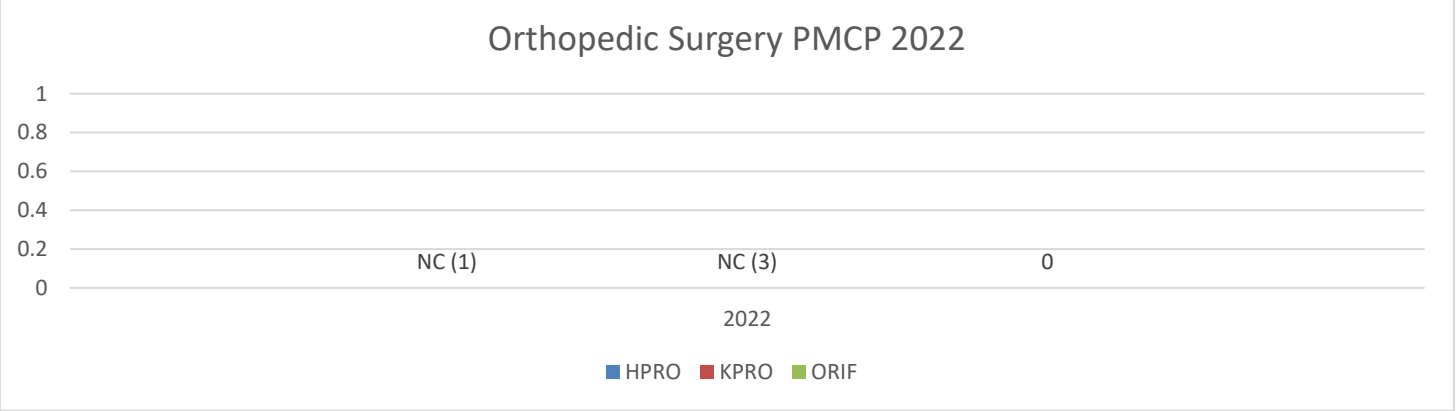
1. Increase compliance with testing by 10% during 2023

Surgical Site Infections (SSI)

Goal: (1) Reduce facility overall SSI SIR by 10% from previous year and below SIR threshold of 1.0







Summary Analysis: Not calculated (NC) because the predicted number of infections in this population are less than 1. Targeted SSI 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 79 SSI cases system wide during 2022.
2. PMC Escondido overall SSI SIR increased 25% from previous year.
3. PMC Poway overall SSI SIR increased by 82% from previous year.
4. Skin Antisepsis CHG bathing for targeted patients in this population is compliant at 63%.
5. Nasal Decolonization for a targeted patient population with increased compliance from 11% to 18% compliance.
6. It was noted during 2022 that there are high traffic counts during orthopedic surgery. This was verified by Infection Preventionists and reported to the appropriate committees.
7. It was noted during surveillance that patients undergoing certain procedures have been misclassified as clean. NHSN does not allow the clean classification for the following surgeries; appendectomy, biliary system, cholecystectomy, colon rectal, small bowel and vaginal hysterectomy. Infection Preventionists are bringing these cases to the platform for review when appropriate. A new Information Technology fix is in place to avoid inadvertent misclassification.

Action Plan:

1. Operationalize decolonization with nasal betadine and CHG for orthopedic cases.
2. Review Colon bundle to ensure consistent implementation.
3. Infection Preventionists assess turn around and terminal cleaning. Issues discovered during these observations are shared with EVS and the Surgical Platform leaders.
4. Pursue post op oxygenation recommendations - 2017 Centers for Disease Control and Prevention Guideline for the Prevention of Surgical Site Infection.
5. Transition away from using Betadine solution for skin preparation unless there is a documented allergy.
6. Notify surgeons and OR leaders of SSI events.
7. Standardize surgical preparation agent to alcohol based such as Chloraprep and Duraprep

Orthopedic Surgery

Goal Met:

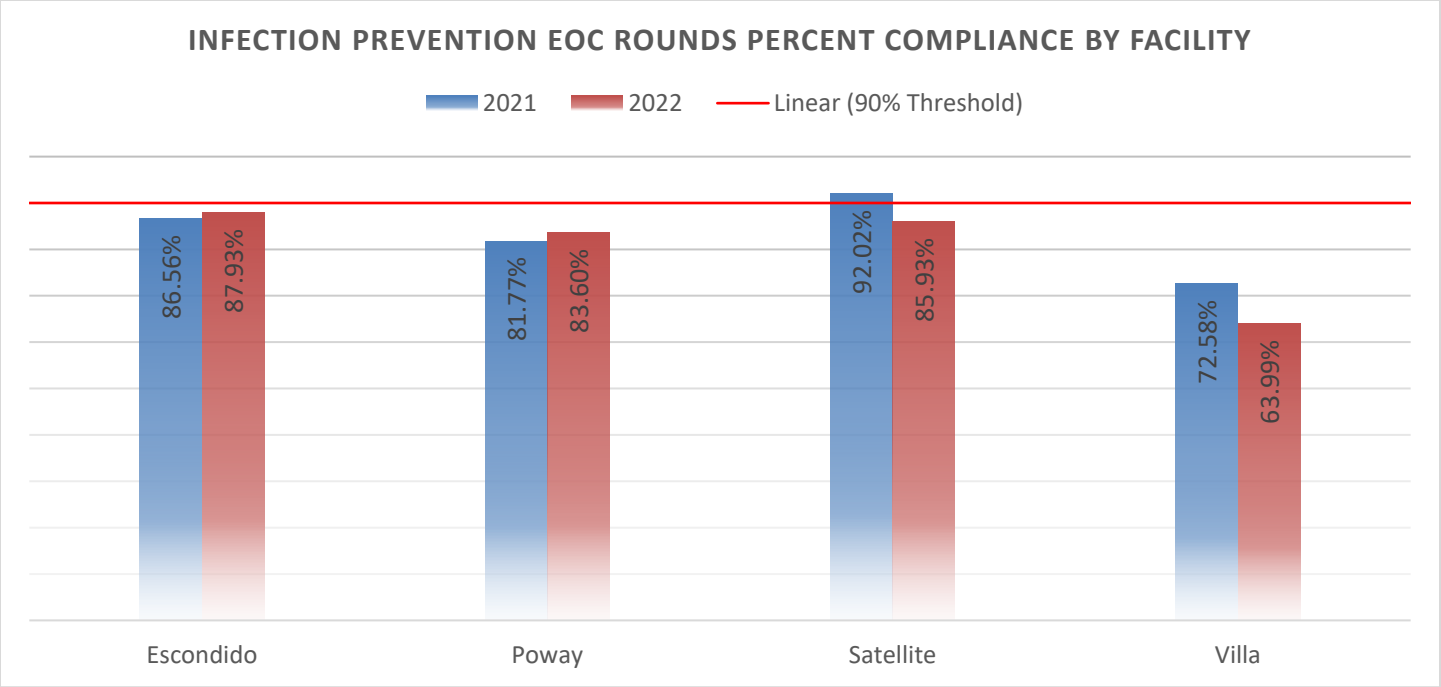
PMC Escondido – Goal Not Met

PMC Poway – Goal Not Met

Environment of Care (EOC)

EOC Rounds

Goal: Maintain facility ≥90% compliance



Summary Analysis: Using the Infection Control EOC rounds survey 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 reprocessed devices. There are 87 questions in a survey. Trends of noncompliance in 2022 differed between site locations. Some of the trends include; high dusting, tape residue on equipment, corrugated boxes in high risk areas, cleanliness of patient care equipment.

Goal Met/Unmet: 90% compliance

PMC Escondido – Goal Unmet

PMC Poway – Goal Unmet

Satellite – Goal Unmet

Villas at Poway – Goal Unmet

Action Plan:

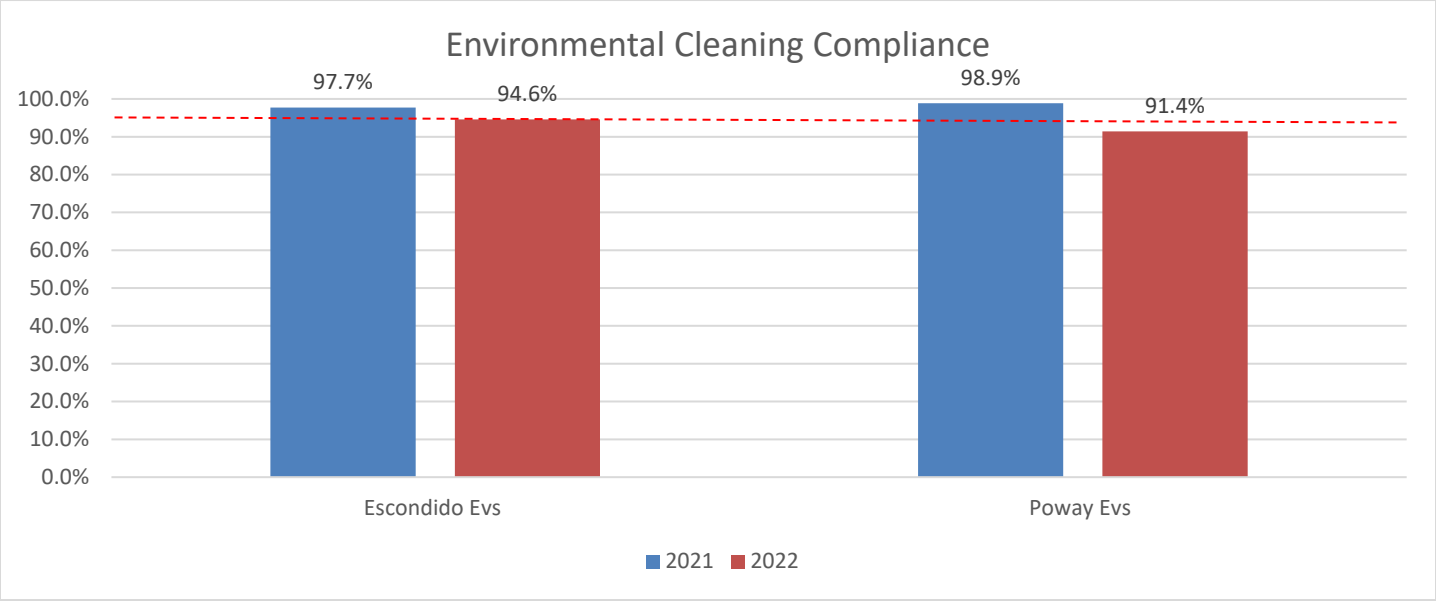
1. Send monthly IC EOC Rounds summary to all department leaders (implemented October 2022).
2. Correct Sentact Deficiency Routing and provide training (ISBAR sent to all leaders January 2023).
3. EVS focus on dust in the environment.
4. Delineate responsibility of environmental cleaning by discipline.
5. Multidisciplinary EOC team rounding monthly in scheduled areas.
6. Report findings to Department Directors according to urgency of finding.
7. Infection Control to report trends and data to EOC and Infection Control committee.

8. 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. The goal is 95%. During 2022, 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 Not Met

PMC Poway – Goal Not Met

Action Plan:

1. Continue to monitor observations and retrain in real time.
2. Ensure both campuses are completing number of room's required.
3. Working recruitment to back fill vacant positions to staff adequately.
4. Routine reporting through Infection Control Committee by EVS Leadership.

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

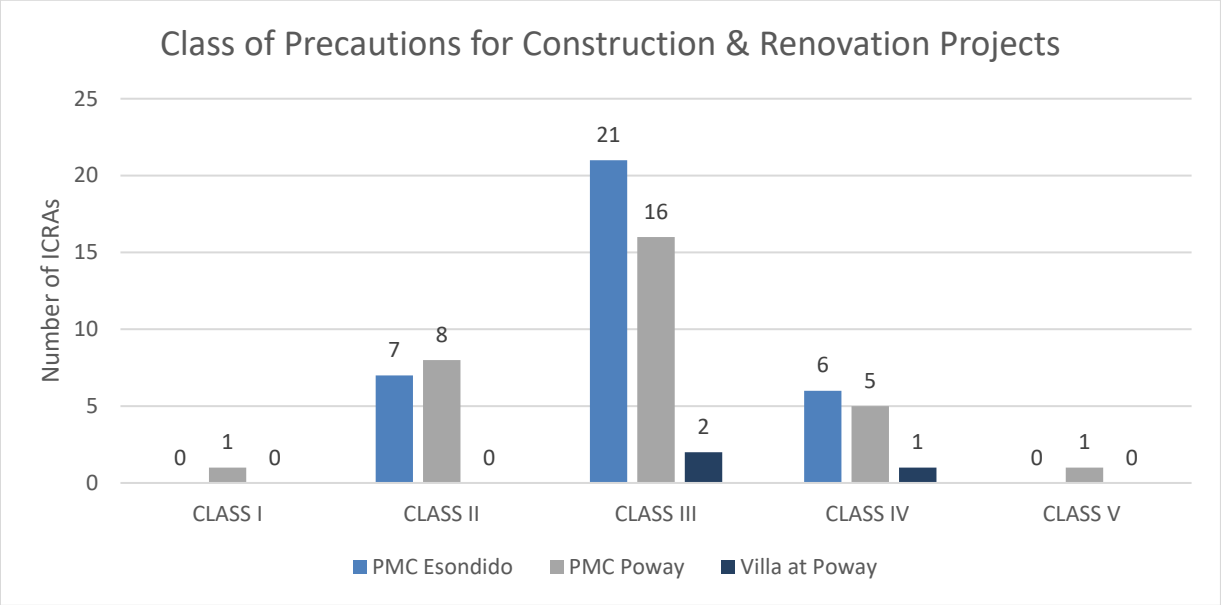
plan of correction. The Water Management Plan outlines testing of water sources on inpatient and outpatient locations. Please see that document for further information on this testing.

Action Plan:

1. Perform environmental testing via 3rd party vendors for identification and control of environmental risks and hazards as indicated.
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 Operations, Information Technology (I.T) and Construction personnel.



Summary Analysis: Palomar Health has an Infection Control and Prevention procedure in place for assessing the risk on construction/renovation projects to determine the appropriate barriers needed in order to mitigate the dispersion of dust. In addition, there were no outbreaks associated with construction or renovation projects.

Goal Met: Goal Met: Goal Met

Action Plan:

1. Monitor all construction and renovation projects and issue an ICRA.
2. Provide dust mitigation education to Facility Operations, Information Technology and Construction personnel annually and prior to hospital construction and renovation activity.
3. Collaborate with Facility Operations, Information Technology and Environmental Services (EVS) through virtual meetings.

Infection Control Education

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

Summary Analysis: Among routine New Staff Orientation held monthly the following educational opportunities were offered in real time and otherwise scheduled inservices including:

1. Food and Nutrition Services annual
2. EVS annual
3. Catheter Associated Urinary Tract Infection prevention measures including dependent loops
4. *C. difficile* collection
5. Mask and eye protection as protection from COVID-19
6. Chlorhexidine bathing
7. Respiratory Panel and isolation precautions for such
8. RSV (ED)
9. MRSA colonization vs. infection and isolation precautions
10. Pre-treatment and transport of reusable devices
11. Hand Hygiene
12. Monkey pox (Mpox)
13. Ebola assessment and triage
14. Infection Present at the time of surgery
15. Would classification

Interventions: Infection Control provided education routinely, upon request and during real time opportunities. Construction and renovation is ongoing and in virtual format.

Goal:

PMC Escondido - Goal Met

PMC Poway – Goal Met

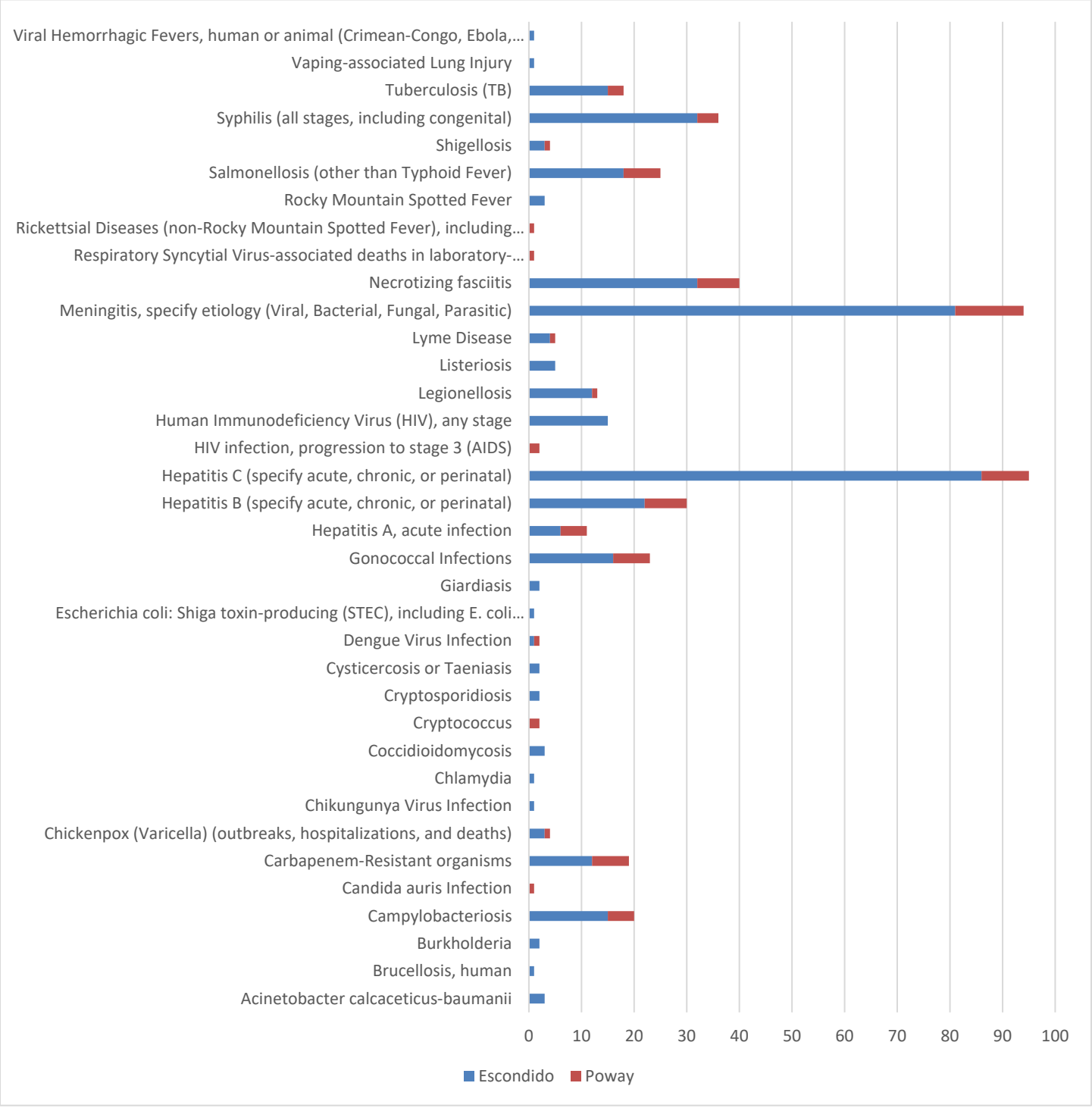
Action Plan:

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 Communicable Disease

Summary Analysis: 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 2022, Infection Prevention assumes the role of daily reporting of COVID-19 and hospital capacity data to NHSN. Infection Prevention continues to report COVID-19 hospitalization data to CDPH and healthcare personnel vaccination (HCP) data to NHSN. Infection

Prevention routinely works with San Diego County Epidemiology, responding to requests, initiating reports, and outbreak investigations.



Employee Health

Influenza Vaccination Compliance

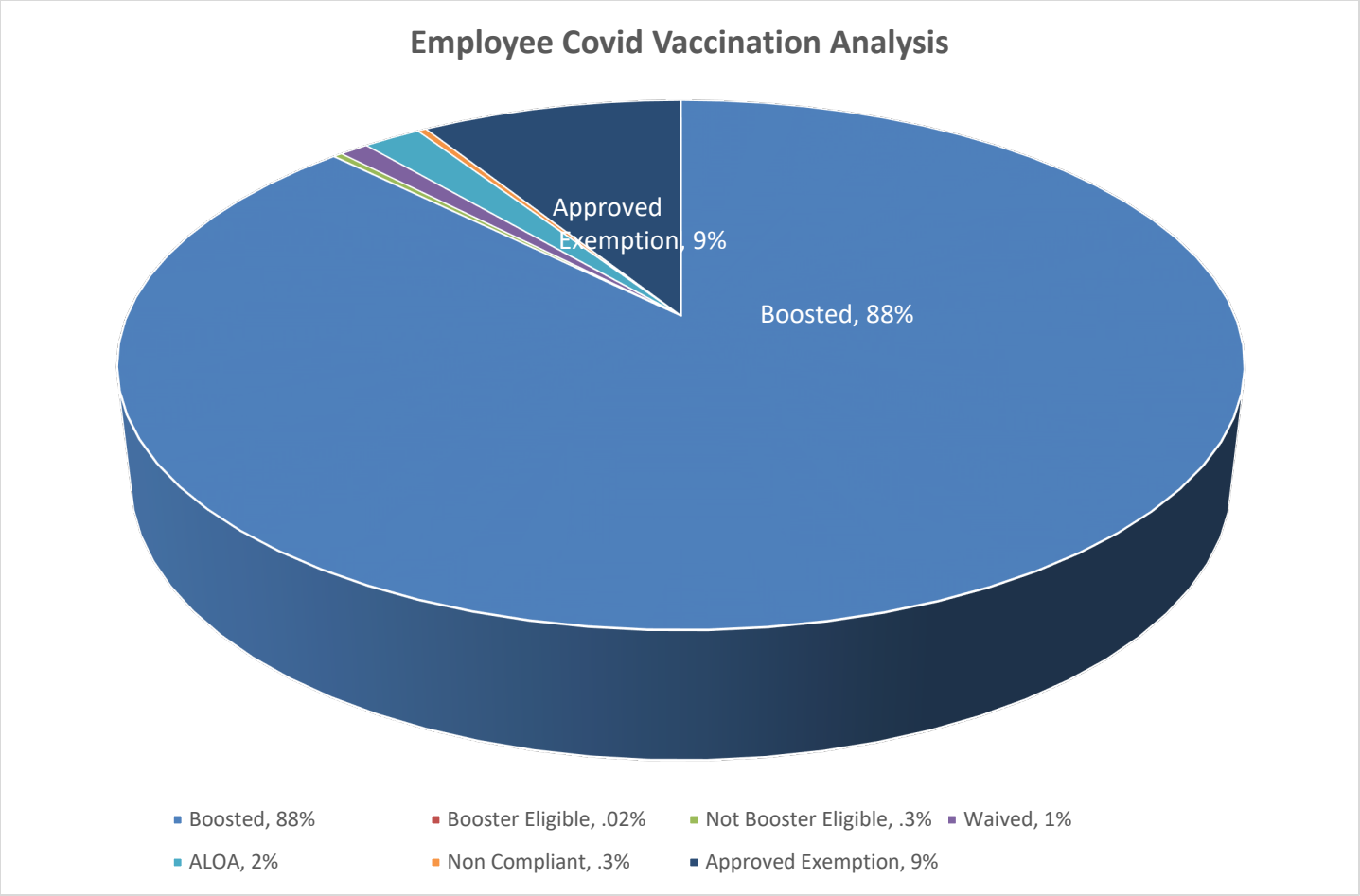
SYSTEM	Employees	Med Staff	Volunteer	Students	Contractors	Totals
Total Personnel	4127	838	222	229	1650	7066
Received Vaccination	1414	392	62	218	1296	3382
Received Elsewhere	255	32	23		72	382
Medical Contraindication	0	4	0	0	0	4
Declined	1170	22	40	11	19	1262
Unknown	1288	388	97	0	263	2036
Compliance	**69%**	**54%**	**56%**	100%	**83%**	**72%**

COVID-19 Vaccine Compliance through 2022

Analysis: Palomar Health currently has 88% of employees vaccinated and boosted for COVID. We have 9% 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.

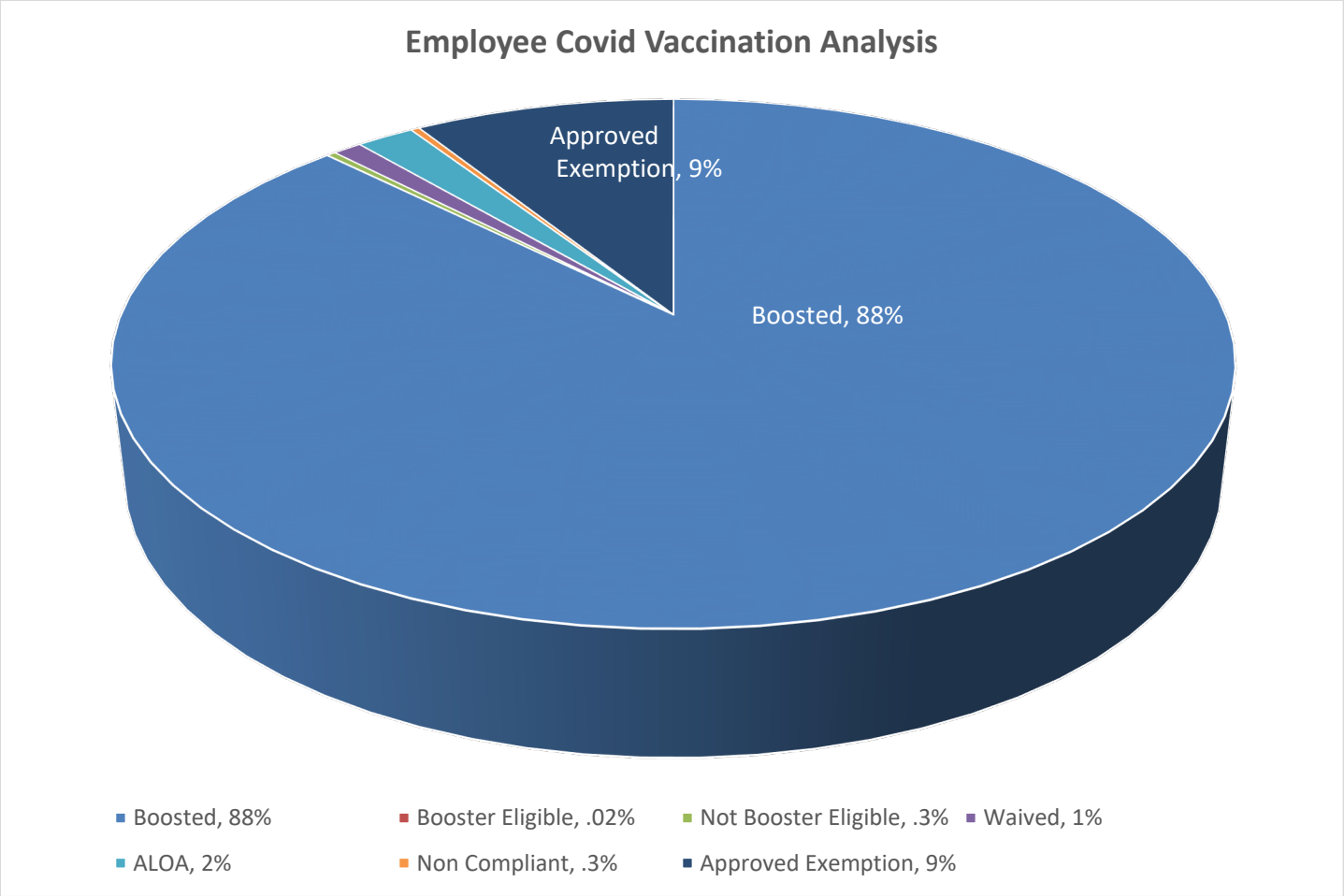
Action Plan: Palomar Health continues to offer vaccination clinics on-site at PMC Escondido with online registration and scheduling. We continue to offer vaccination in our Escondido Employee Health clinic. Employee Health is working with Human Resources to assist new employees, Administrative Leave of Absence, and booster eligible employees to complete vaccination or exemption criteria.

Boosted	Booster Eligible	Not Booster Eligible	Waived	ALOA	Non-Compliant	Approved Exemption	Total
3305	1	11	41	67	11	325	3761
88%	.02%	.3%	1%	2%	.3%	9%	100%



Provider COVID-19 Vaccination Compliance 2022

Boosted	Booster Eligible	Not Booster Eligible	Waived	ALOA	Non-Compliant	Approved Exemption	Total
3305	1	11	41	67	11	325	3761
88%	.02%	.3%	1%	2%	.3%	9%	100%

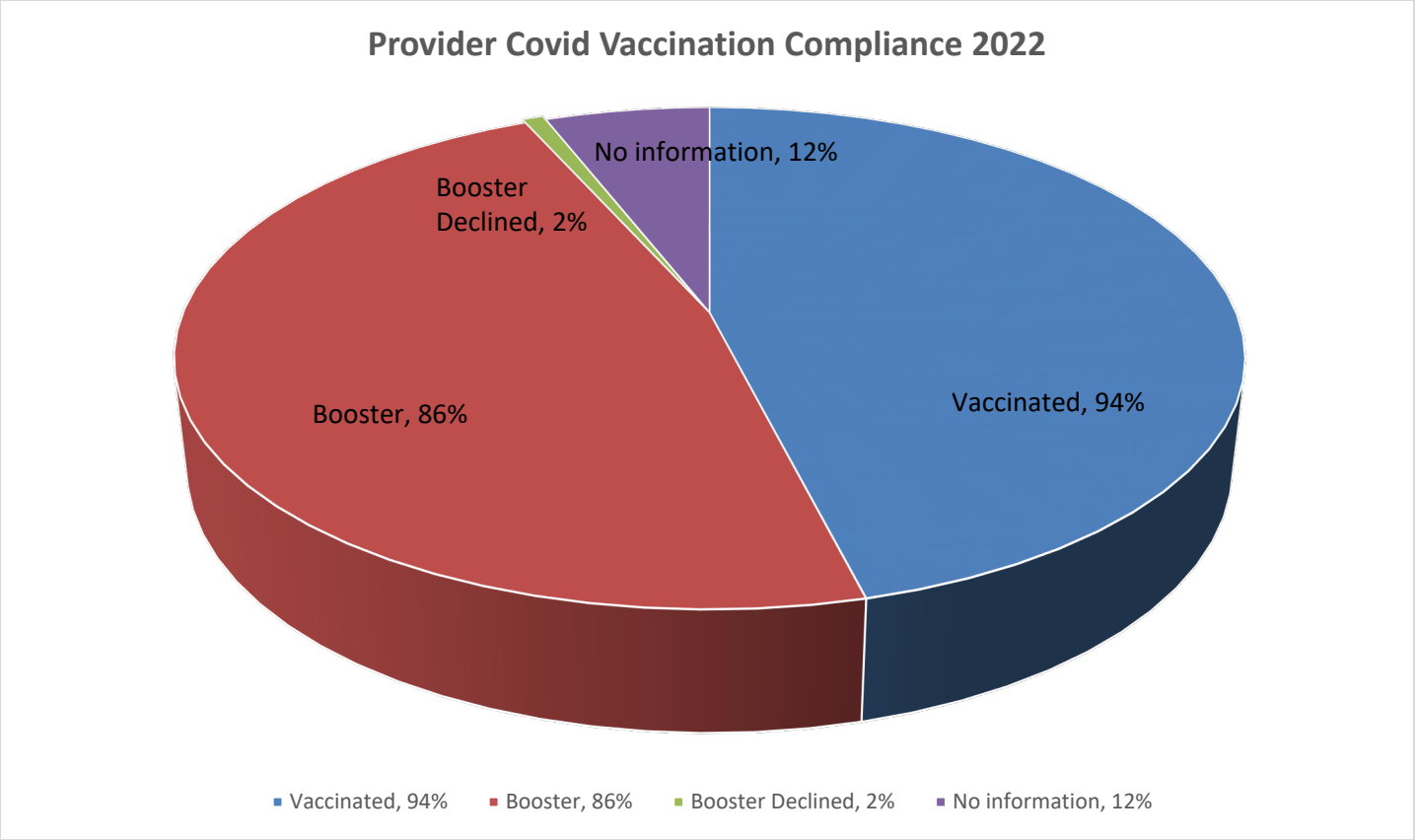


Analysis: Palomar Health currently has 88% of employees vaccinated and boosted for COVID. We have 9% of staff with approved vaccine exemptions on file, and 1% of staff whom have been waived from this requirement due to exclusively working remotely and will never have contact with employees in person 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. We continue to offer vaccination in our Escondido Employee Health clinic. Employee Health is working with Human Resources to assist new employees, ALOA, and booster eligible employees to complete vaccination or exemption criteria.

Provider COVID-19 Vaccination Compliance 2022

Vaccinated	Booster	Booster declined	No information	Total
902	825	15	116	956
94%	86%	2%	12%	100%



Analysis: Palomar Health currently has 94% of providers vaccinated with 1 dose of J&J or 2 doses of Pfizer/ Moderna. Of the 94% with vaccinations on file, 86% are vaccinated and boosted for COVID. We have 2% of staff with vaccine declination on file, and 12% of providers with no information on file regarding their vaccination status.

Action Plan: Medical Staff office will continue to collect vaccination data. Palomar Health continues to offer vaccination clinics on-site at PMC Escondido with online registration and scheduling. We continue to offer vaccination to Providers and Employees in our Escondido Employee Health clinic.

Palomar Health Staff Exposures 2022

Goal: Continue to assess and mitigate exposure risk

Year to Date Total	TB	Scabies	Pertussis	Varicella	Mpox	Lice	Brucella	Covid-19	Total
Total number of exposures	7	0	0	0	10	1	1	1394	1413
Number of employees identified as potentially exposed	146	0	0	0	15	0	4	72	237
Number of confirmed & tested	5	0	0	0	0	0	4	0	9
Number of employee conversions	1*	0	0	0	0	0	0	2	3
Number confirmed & non-compliant with follow up	0	0	0	0	0	0	0	0	0

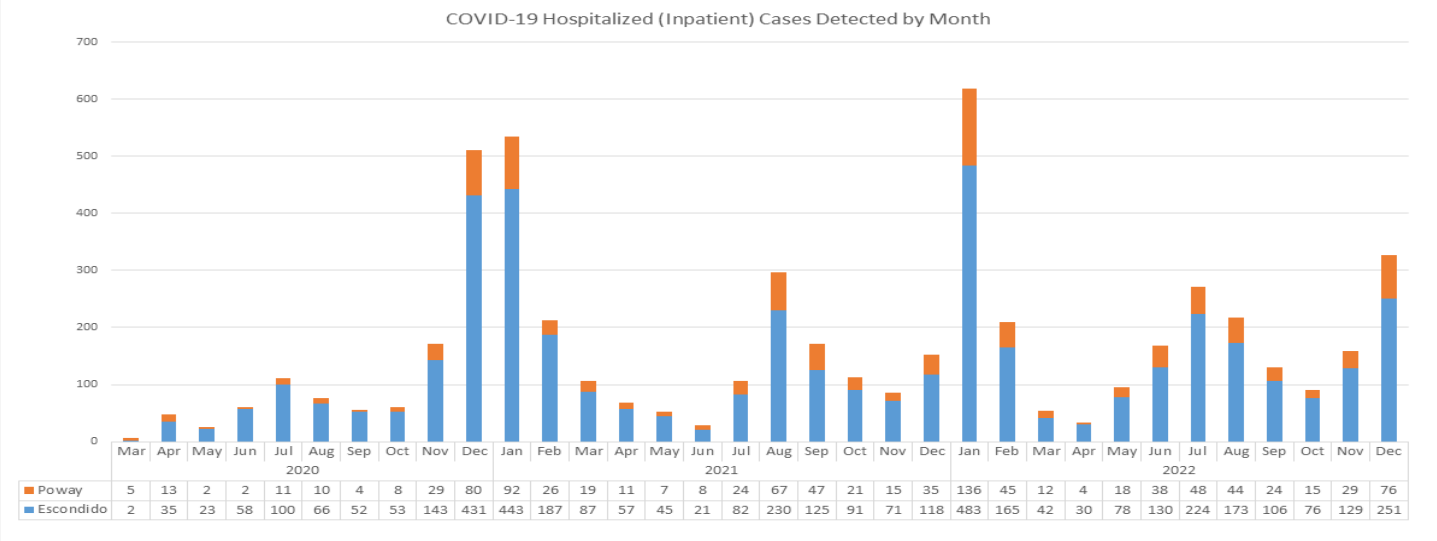
*Tested through agency, QFT indeterminate, CXR ordered through agency, employee did not follow up with Employee Health, several phone messages left
Two Covid-19 WC claims, both denied

Summary Analysis: During 2022, there were 1413 exposures, less than 2021 exposures at 2081. The majority of potential exposures 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 confirmed TB conversions, no Mpox or Brucella employee infections identified.

Goal Met: Goal Met

COVID-19

During 2022, there were 1887 COVID-19 hospitalizations at the Escondido campus and 372 at the Poway campus. This is an increase from 2021 at 1557 and 372 respectively. Infection Preventionists reported 136 COVID-19 deaths for the Escondido campus (up from 109 during 2021) and 35 deaths at the Poway campus (down from 39 during 2021).



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
	2020										2021												2022											
Poway	5	13	2	2	11	10	4	8	29	80	92	26	19	11	7	8	24	67	47	21	15	35	136	45	12	4	18	38	48	44	24	15	29	76
Escondido	2	35	23	58	100	66	52	53	143	431	443	187	87	57	45	21	82	230	125	91	71	118	483	165	42	30	78	130	224	173	106	76	129	251

Summary of Infection Control Interventions

- Daily COVID-19 statistics incorporated into NHSN.
- "Identify, isolate, inform" at ED triage using electronic charting triggers for isolation orders.
- Separating patients with infectious signs and symptoms.
- PPE supplies routinely monitored by supply chain, and strategies to optimize and conserve 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

- Physical distancing, minimized in-person meetings and hospital gatherings, breakroom capacity assessments and notice.
- Executive memos to communicate policy or practice changes surrounding COVID-19
- Attended California Public Health Department COVID-19 Update Conference Calls
- Maintain communication with California Department of Public Health and County Epidemiology.

Summary of Projects

Antibiotic Stewardship

- Reviewed appropriate usage of anti-*pseudomonal* beta-lactam agents
- Developed Power Plan 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 (VIP) at Palomar Health. Several interventions for improving infection outcomes and risk mitigation were approved by the VIP during 2022. 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.

IP Project Collaborations with VIP Committees in 2022:

- SureStep Foley Conversion
- Stryker Chemistry Conversion
- Patient Bathing (replace basin method)
- Ongoing review of disposable ECG cables
- Foley Life Cycle Assessment
- Vascular Access Management Assessment
- Ebola PPE Cart Restock

Equipment Management

A careful review of equipment was performed prioritizing water containing units.

- Cardioquip –SPD
- MPS2 –SPD
- Hotlines – all cleaned during the month of July 2022. Annual Biomed
- Hydratherm – PT Technician responsibility
- Artic Sun – Biomed every 6 months maintenance and cleaning

NICU transition Escondido and Poway

The Infection Control Program will expand to surveillance for CLABSI in Escondido NICU. Poway NICU scheduled for closure June 2023.

Procedure Review

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

References:

https://www.ahrq.gov/hai/pfp/haccost2017-results.html

Antimicrobial Stewardship Summary

Presented to Board Quality Committee

May 24, 2023

Sandeep Soni, MD, Chair

John Engelbert, PharmD, BCIDP, Co-Chair

Travis Lau, PharmD, BCIDP, ASP Pharmacist

Sharon Luong, PharmD, PGY-2 ID Resident

Attendance

- ASP Goals for 2022 and 2023
- Pharmacy ASP Interventions Data Q3 2022 – Q1 2023
- Antibiotic Usage Q3 2022 – Q1 2023
- Vancomycin De-Escalation Cost Analysis
- ED Culture Callback Pharmacist Interventions Cost Analysis

ASP – Antimicrobial Stewardship Program

Palomar Health's ID Team

- Mission Infectious Diseases
  - Sandeep Soni, MD
  - Roger Bitar, MD, MPH
  - Hayden Burke, MD
  - Taliha Yasin, MD
- Kaiser Infectious Diseases
  - Townson Tsai, MD
- Pharmacy
  - Travis Lau (left)
  - Sharon Luong (middle)
  - John Engelbert (right)

The Challenge of Antimicrobial Use in the Era of increasing Antimicrobial Resistance and Cost

- Balance between providing the most effective therapy for individual patients and the overuse of antimicrobials causing ADE and resistance
- Two most effective tools
  - Best practice in empiric use of antibiotics and rapid diagnostics to ensure rapid effective therapy
  - Effective methods to safely de-escalate antibiotics and limit unnecessary antimicrobial exposure and cost

ADE – Adverse Drug Event

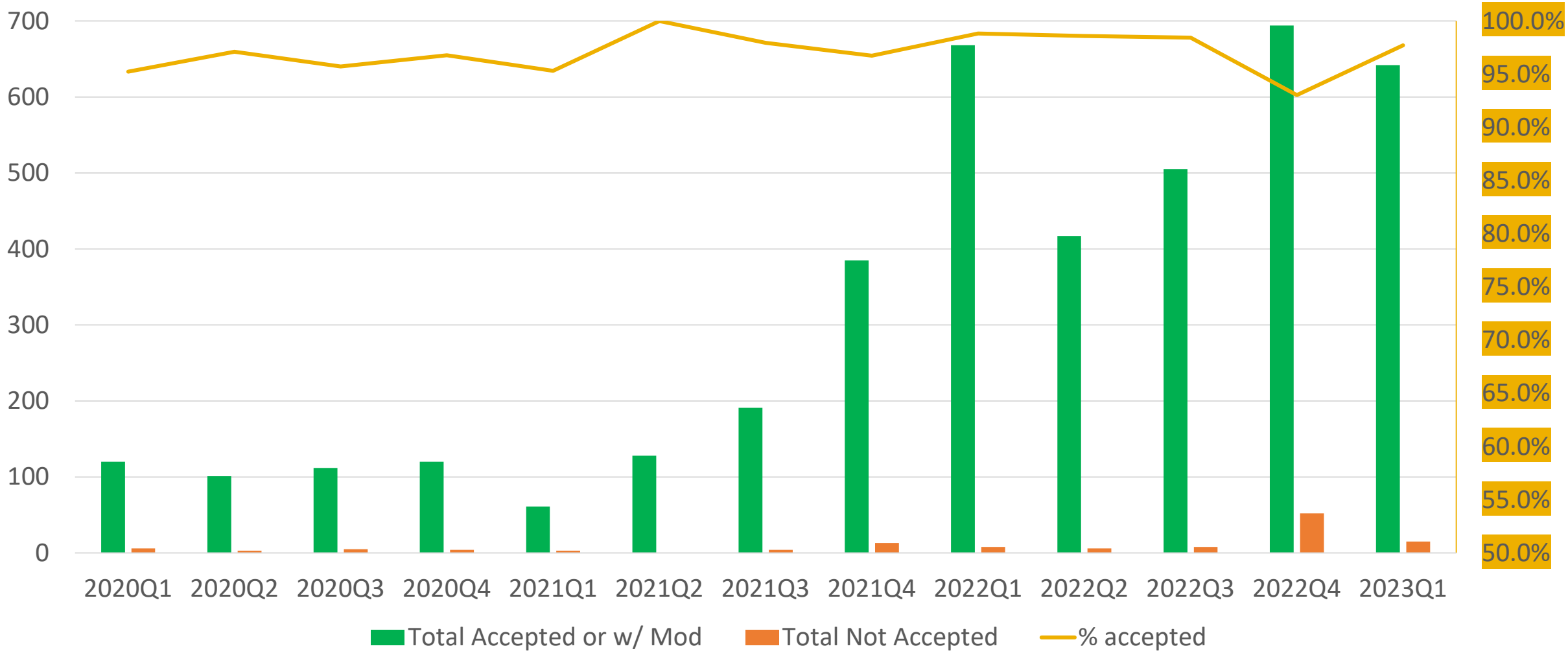
ASP Goals

2022 (Completed)	2023 (To Be Completed)
Review best practice for treatment of MDRO (IDSA) - Completed May 2022	Recertify CDPH Gold designation 2023 to 2026
Develop institution specific guidelines for common infections and publish on intranet	Submit NHSN Antibiotics Resistance Module data and review and determine best practice
Review of 2021 IDSA Guidelines on Treatment of CDI	Complete and implement best practice for Staph bacteremia (i.e. Daptomycin vs. Vancomycin)
IV/PO Change Opportunity Analysis	Individual prescriber feedback on adherence to carbapenems usage. (CRE considered high priority threat by CDC)
Optimize implementation of oral vancomycin prophylaxis to reduce CDI	Achieve PGY-2 ID Pharmacy Residency re-accreditation
Full compliance with new JCAHO standards for 2023	Analysis of use of procalcitonin and improve utilization
IT updates on antimicrobial PowerPlans to reflect Palomar specific Guidelines	MRSA nasal screen usage beyond MRSA pneumonia
Analysis of Adherence to Palomar Health CAP Treatment Guidelines	Achieve 2023 QIP Goals for CDI and SSI

CAP – Community acquired pneumonia; CDC - Centers for Disease Control and Prevention; CDI - *Clostridioides Difficile* Infection; CDPH - California Department of Public Health; CRE – Carbapenem Resistant Enterobacterales; ID – Infectious Diseases; IDSA – Infectious Diseases Society of America; IV – Intravenous; JCAHO – Joint Commission on Accreditation of Healthcare Organizations; NHSN - National Healthcare Safety Network; PO – Oral; MDRO – Multi-drug resistant organisms; MRSA – Methicillin Resistant *Staphylococcus aureus*; QIP – Quality Incentive Pool; SSI – Surgical Site Infection

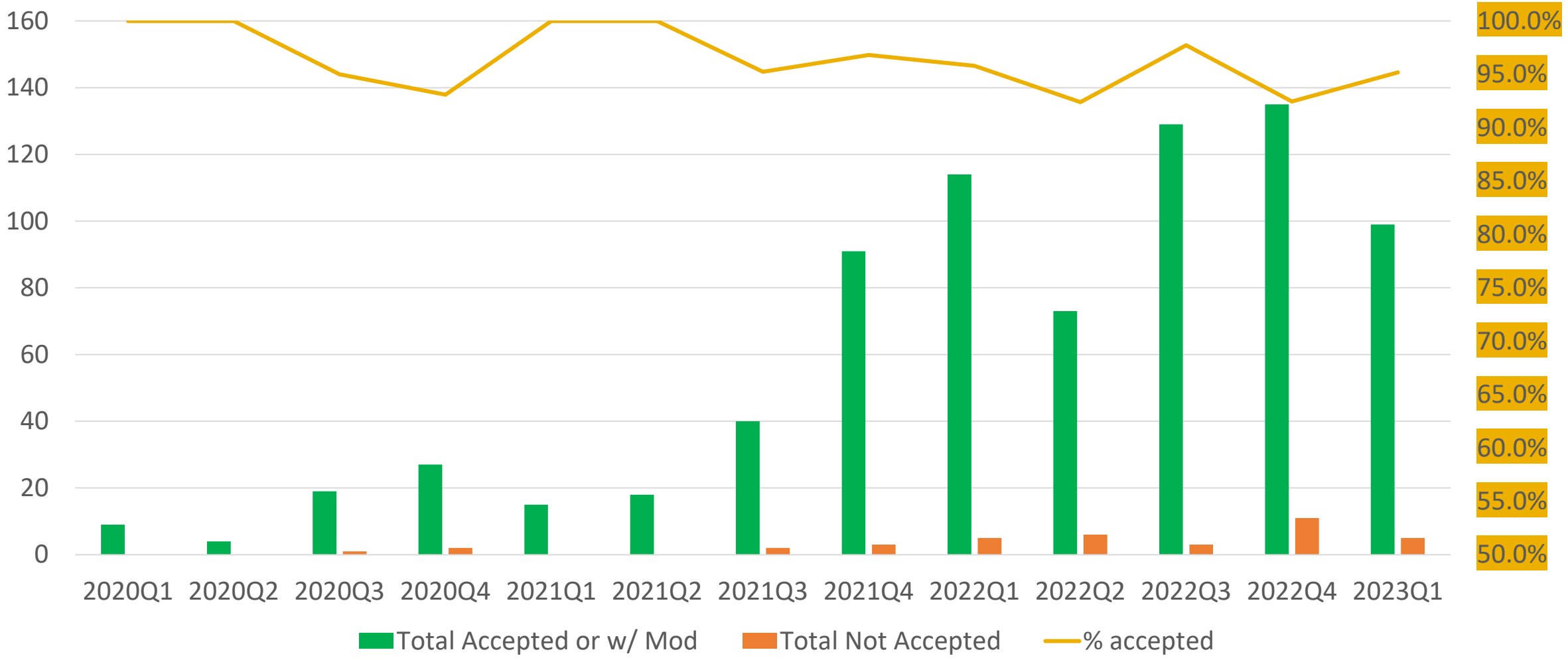
ASP Interventions Data Q1 2020 to Q1 2023

PMCE Pharmacy ASP Interventions



PALOMAR HEALTH

PMCP Pharmacy ASP Interventions



ED Culture Callback Interventions Cost Savings Q1 2023

ED – Emergency Department

ED Culture Callback Interventions Q1 2023

- ED pharmacist reviews ED Results Callback list for any positive culture for discharged patients seen in the ED
  - Assess current antimicrobial therapy and informs ED Provider if therapy intervention is needed
  - If ED Provider agrees with plan, the ED pharmacist contacts the patient and sends new prescription to patient's preferred pharmacy
- Reviewed ED Results Callback Report from 1/1/2023 to 3/31/23
  - N = 450 interventions documented and accepted by ED provider

ED Pharmacist Outpatient Culture Review - Cost Savings

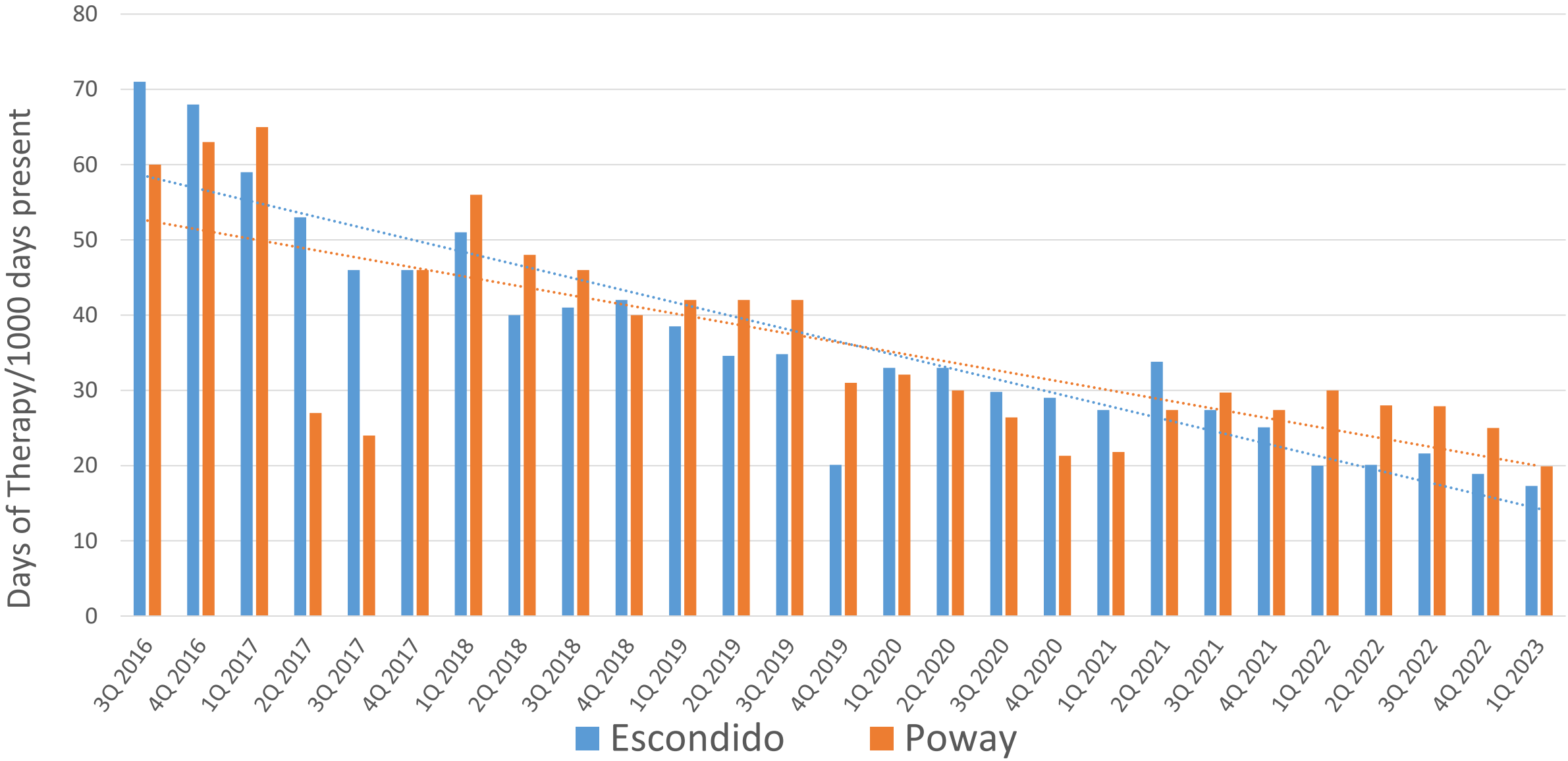
- Literature estimated ~$325-646.48 per ED outpatient culture review intervention in cost savings
- Quarterly savings:
  - 450 interventions x $325 = $146,250
    - Excludes “Review Only – Appropriate Cultures”
    - All 450 interventions required provider to review and resulted in therapy change

Estimated annual savings: at least ~$585,000

1. Dietrich SK, Bushong BT, Schneider-Smith EA, Mixon MA. Emergency medicine pharmacist interventions reducing exposure to costs (EMPIRE-C). *Am J Emerg Med*. 2022;54:178-183. doi:10.1016/j.ajem.2022.01.054
2. Hammond DA, Gurnani PK, Flannery AH, et al. Scoping Review of Interventions Associated with Cost Avoidance Able to Be Performed in the Intensive Care Unit and Emergency Department. *Pharmacotherapy*. 2019;39(3):215-231. doi:10.1002/phar.2224
3. Lee AJ, Boro MS, Knapp KK, Meier JL, Korman NE. Clinical and economic outcomes of pharmacist recommendations in a Veterans Affairs medical center. *Am J Health Syst Pharm*. 2002;59(21):2070-2077. doi:10.1093/ajhp/59.21.2070

Antibiotic Usage Report
Q3 2022 - Q1 2023

Facility-Wide Fluoroquinolone Use



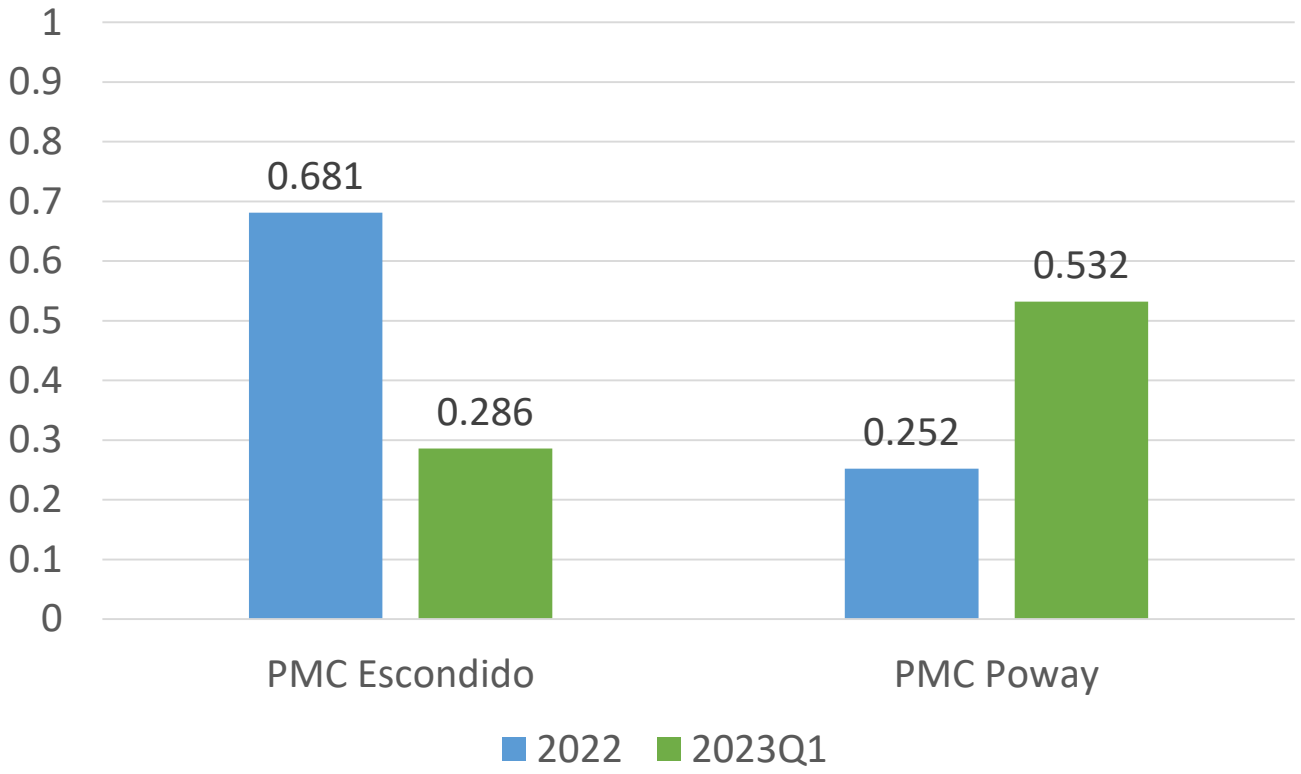
Antibiotic Usage via SAAR - NHSN Comparison with like Hospitals

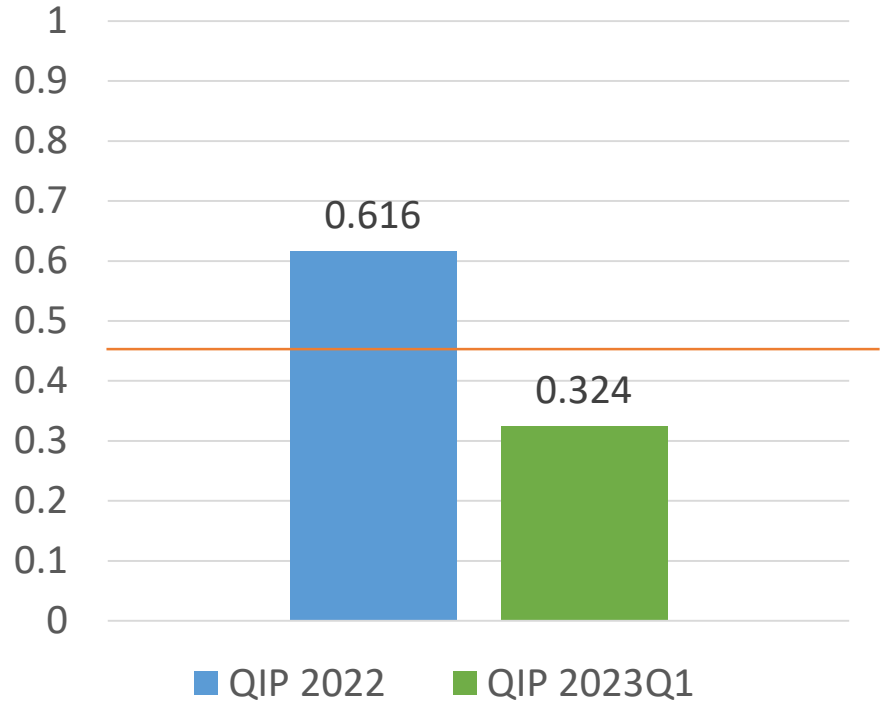
What is a SAAR?

- 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

$$\frac{Observed}{Predicted} = \frac{\text{100 antimicrobial days observed}}{\text{85 antimicrobial days predicted}} = 1.176$$

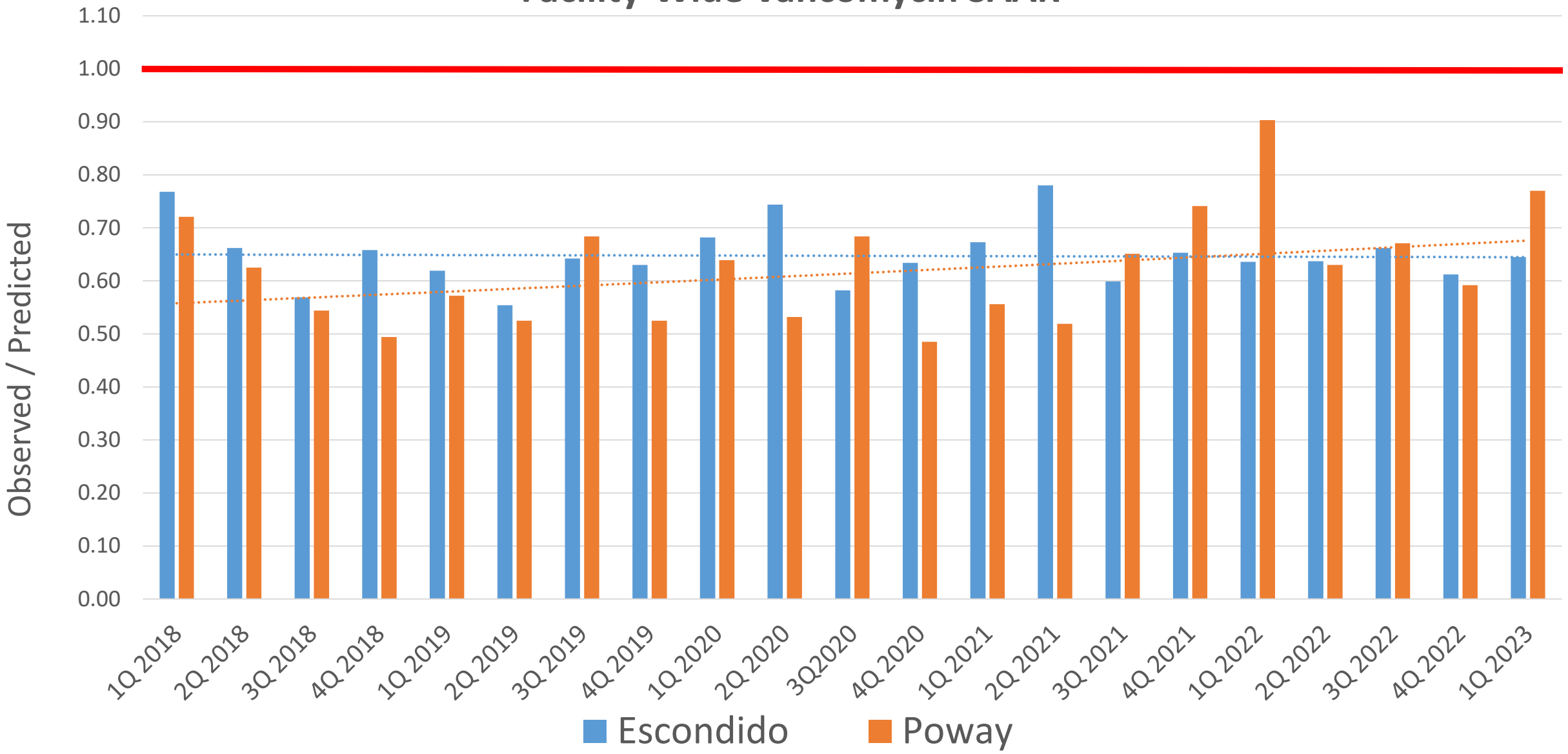
QIP *C. difficile* Infection





Threshold 0.45

Facility-Wide Vancomycin SAAR



Vancomycin De-Escalation Cost Savings Q1 2023

Documented Number of De-escalations

- Q1 2023: 201 De-escalations from Vancomycin
  - 181 at Escondido; 20 at Poway

Results - Costs

Drug / Intervention	Item Cost	Total Cost
Vancomycin 1g	$8.89	2g/day x 7 days = $124.46
Vancomycin TDM Laboratory Costs	$40 Phlebotomy $69 Measurement	2 levels per week = $218
Pharmacist TDM time	$70 per hour	16 minutes x 7 days = $130.67
Total Cost of Vancomycin		**1 week cost = $473.13**

- Most Vancomycin are de-escalated by day 4 when cultures result or a MRSA nares PCR returns. This results in a minimum reduction of 3 days of vancomycin treatment if assuming a standard minimum 7d day treatment for common infections (SSTI and PNA)

MRSA – Methicillin Resistant Staphylococcus aureus; PCR – Polymerase Chain Reaction; SSTI – Skin and soft tissue infection

Calculated Cost Savings - Drug/Lab/Personnel

- Daily cost of Vancomycin (Including labs/supplies/drug cost) is ~$48.92. Not including Pharmacist monitoring time.
- Literature has estimated ~$40-108 per patient in cost savings by appropriately de-escalating vancomycin[1, 2]
- Quarterly Savings:
  - 201 de-escalations x $48.92/d x 4 days saved = ~$39,331.68

Annual Savings (lab/drug/supplies): At least $157,326.72

1. Meng L, et al. Discontinuation Patterns and Cost Avoidance of a Pharmacist-Driven Methicillin-Resistant Staphylococcus aureus Nasal Polymerase Chain Reaction Testing Protocol for De-escalation of Empiric Vancomycin for Suspected Pneumonia. Open Forum Infect Dis. 2021;8(4):ofab099
2. Smith MN, et al. Clinical utility of methicillin-resistant Staphylococcus aureus nasal polymerase chain reaction assay in critically ill patients with nosocomial pneumonia. J Crit Care. 2017;38:168-171.

Calculated Cost Savings – Drug/Lab/Personnel + Avoiding nephrotoxicity

COST AND LENGTH OF STAY ASSOCIATED WITH VANCOMYCIN-INDUCED NEPHROTOXICITY

Stevens V[1], Yoo M[1], Brown J[2]

of stay, respectively. Cost estimates are reported in 2009 USD. **RESULTS:** Forty-nine (12%) of patients had NT. The unadjusted median variable costs for patients with NT were higher than for patients without NT ($47,511 vs. $22,355, p<.0001). On multi-

- Estimated cost savings per episode is ~$25,000
- Incidence rate of nephrotoxicity from Vanco is as low as 5%, and as high as 43% in literature[1]
- Possible cost savings if going off 2% incidence rate based on Palomar's historical nephrotoxicity rates with vancomycin
  - 201 de-escalations x 2% x $25,000 x4 quarters = $402,000 per year

Grand total cost savings as much as $559,326.72 per year

1. van Hal SJ, Paterson DL, Lodise TP. Systematic review and meta-analysis of vancomycin-induced nephrotoxicity associated with dosing schedules that maintain troughs between 15 and 20 milligrams per liter. *Antimicrob Agents Chemother*. 2013;57(2):734-744.

Tuberculosis (TB) Risk Assessment 2023

Assessment of Year 2022

Incidence of TB

San Diego County Rate

- 2018: 6.8 cases per 100,000 persons
- 2019: 7.9 cases per 100,000 persons
- 2020: 5.7 cases per 100,000 persons
- 2021: 6.1 cases per 100,000 persons
- 2022: 6.3 cases per 100,000 persons

California Rate

- 2021 = 4.4 cases per 100,000 persons
- 2022 = 4.7 cases per 100,000 persons

National Rate

- 2021 = 2.4 cases per 100,000 persons
- 2022 = 2.5 cases per 100,000 persons. 8,300 TB cases were reported in the United States

High Risk Procedures Identified in the Palomar Health TB Exposure Control Plan

- Operative procedures such as tracheotomy, thoracotomy, or lung biopsy.
- Respiratory care procedures such tracheostomy or endotracheal tube care.
- Diagnostic procedures such as bronchoscopy and pulmonary function testing.
- Resuscitative procedures performed by emergency personnel.
- Autopsy or pathology procedures performed on a body or on specimens suspected to be or infected with TB.
- High Risk Departments include but are not limited to:
    - Respiratory Therapy
    - Bronchoscopy
    - Emergency Department
    - Radiology
    - Nursing
    - Bacteriologists testing AFB smears

Facility Risk Classification

A. The table below outlines the prioritized risks identified as the result of the assessment and provides a brief description of those risks. A risk level is assigned (low, medium, or high) based on the care setting, (outlines in summary form), interventions that have been or will be taken by the organization to address the risks, and how the organization will evaluate the effectiveness of the interventions.

B. **Inpatient Setting(s): Medium Risk**
   a. PMC Escondido encountered six (6) patients confirmed with TB *and* where exposure was identified
   b. PMC Poway encountered one (1) patient confirmed with TB *and* where exposure was identified
   c. No evidence of person-to-person transmission of M. tuberculosis in the healthcare setting
   d. TST/BAMT test conversion rate is not greater than in areas or groups without occupational exposure to TB patients or than previous rates in the same area or group
   e. There are no clusters of TB test conversions

C. **Ambulatory Setting(s): Low Risk**
   a. No evidence of person-to-person transmission of M. tuberculosis in the healthcare setting
   b. There may be a low incidence of immunocompromised patients in the healthcare setting
   c. Not a TB clinic(s)
   d. TST/BAMT test conversion rate is not greater than in areas or groups without occupational exposure to TB patients or than previous rates in the same area or group
   e. There are no clusters of TB test conversions
   f. There are less than 3 (for <200 beds) and less than 6 (for >200 beds) patients with active TB hospitalized per year.

D. **Outpatient Setting(s): Low Risk**
   a. There may be a high incidence of immunocompromised patients in the radiation oncology setting
   b. No evidence of person-to-person transmission of M. tuberculosis in the healthcare setting
   c. Not a TB clinic(s)
   d. TST/BAMT test conversion rate is not greater than in areas or groups without occupational exposure to TB patients or than previous rates in the same area or group
   e. There are no clusters of TB test conversions
   f. There are less than 3 (for <200 beds) and less than 6 (for >200 beds) patients with active TB hospitalized per year.

Prioritized Risk Description	Care Setting / Risk Level (See legend)			Summary of Risk Mitigation Strategies	How Effectiveness of Strategies is evaluated
	I	A	O		
Exposure to patient with active pulmonary tuberculosis	M	L	L	-Automated isolation orders for nurse documentation of patient symptoms (fever, cough, etc.) -Automated isolation orders based on lab orders made by physician (i.e. TB Powerplan, AFB, PCR) -ED education - masking of patients in ED with respiratory symptoms -Isolation discontinuation oversight by IPs and ID MD. -Standardized rule out process for inpatient cases -Additional health department PCR testing requirements for discharges/transfers to congregate setting -Initial and annual ATD exposure prevention education -Introduction of alternative respirator options for staff, e.g powered air purifying respirators and reusable respirators (AKA elastomeric respirator) -ATD and TB Exposure Control Plan reviewed, evaluated, and updated annually and when necessary	Annual reduction/no significant change of exposures

Legend*

I = Inpatient services such as medical surgical, critical care, maternal / child, surgery, behavioral health, and other care units

A = Ambulatory care services such as outpatient surgery, procedural and diagnostic services, and the Emergency Department

O = Outpatient services such as primary and specialty care clinics, wellness centers, infusion centers, rehabilitation clinics, and other services

* For each setting, the risk assessment also takes into account - as applicable - support services such as facilities, environmental services, materials management, sterile supply and processing, dietary, clinical laboratory, and all other departments and services of the organization.

Allocation – Enter the Level of Assessed Risk for Each Care Setting:

L = Low risk

M = Medium Risk

H = High Risk or Potential ongoing transmission

Risk Classification for HCW Testing Needs and Screening Frequency

Risk Classification	Need for Testing	Frequency of Testing
Low risk	Should be used for settings in which persons with TB disease are **not** expected to be encountered.	Exposure to *M. tuberculosis* in these settings is unlikely, and further testing is **not** needed unless exposure has occurred.
Medium risk	Should be used for facilities in which the risk assessment has determined that HCWs will possibly be exposed to persons with TB disease.	~~Repeat testing should be done annually.~~ -Not routinely recommended for any risk setting. Changes to this recommendation below.
Potential ongoing transmission	Should be temporarily assigned to any setting where there is evidence of person-to-person transmission of *M. tuberculosis* in the past year.	Testing should be repeated every 8 to 10 weeks until there is **no** evidence of ongoing transmission.

Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and CDC, 2019

A systematic review found a low percentage of HCP have a positive TB test at baseline and upon serial testing. Updated recommendations for screening and testing HCP include an individual baseline (preplacement) risk assessment, symptom evaluation and testing of persons without prior TB or latent TB infection (LTBI), no routine serial testing in the absence of exposure or ongoing transmission, treatment for HCP diagnosed with LTBI, annual symptom screening for persons with untreated LTBI, and annual TB education of all HCP.

Comparison of 2005 and 2019 recommendations for tuberculosis (TB) screening and testing of U.S. health care personnel (HCP)		
Category	**2005 Recommendation**	**2019 Recommendation**
Baseline (preplacement) screening and testing	TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI.	TB screening of all HCP, including a symptom evaluation and test (IGRA or TST) for those without documented prior TB disease or LTBI **(unchanged)**; individual TB risk assessment **(new)**.
Postexposure screening and testing	Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8–10 weeks after the last exposure.	Symptom evaluation for all HCP when an exposure is recognized. For HCP with a baseline negative TB test and no prior TB disease or LTBI, perform a test (IGRA or TST) when the exposure is identified. If that test is negative, do another test 8–10 weeks after the last exposure **(unchanged)**.
Serial screening and testing for HCP without LTBI	According to health care facility and setting risk assessment. Not recommended for HCP working in low-risk health care settings. Recommended for HCP working in medium-risk health care settings and settings with potential ongoing transmission.	Not routinely recommended **(new)**; can consider for selected HCP groups **(unchanged)**; recommend annual TB education for all HCP **(unchanged)**, including information about TB exposure risks for all HCP **(new emphasis)**.
Evaluation and treatment of positive test results	Referral to determine whether LTBI treatment is indicated.	Treatment is encouraged for all HCP with untreated LTBI, unless medically contraindicated **(new)**.

IP Workflow for TB Rule Out & Exposure Follow Up

① When to report case to TB Control (County Epi)

Presents with TB symptoms, epi risk factors, abnormal chest ray, **and/or** provider is ruling out

OR

Positive AFB in respiratory specimen (begin exposure follow-up)

OR

Patient is with cavitary lung **and/or** other TB symptom/risks **and** anticipated discharge to congregate setting

- Ask TB Control if further workup can be done as outpatient.
- Gather above information
- Hand off to CM for DC Planning
- Note: HIV and QFT may be requested by TB control

② How to report case to TB Control (County Epi)

- See "Epi Reporting with New Reporting App" video to pull records as PDFs
- In email to TB Control, include (CC) the unit Charge RN, the assigned CM (if listed in the record), and ID MD or attending contact information. This is typically located at the bottom of their clinical notes.
- Records not included in the New Reporting App that you may need to send separately
    - QFT Gold results
    - CT imaging
    - Reference Lab reports
    - Case management notes
    - Medications
    - Current unit and room number
- For in-house patients, please send any updated information ASAP

③ Review case for potential exposure follow-up (submit to EH)

Positive AFB or MTB PCR in respiratory specimen, complete Infection Control Exposure Reporting form as "PENDING". Will be "PENDING" until cultures are finalized, or diagnosis.

Infection Control Exposure Reporting v7 (2020.03)_BLANK

④ Discontinue Airborne Precautions After…

≥3 or more negative AFB stains for appropriate respiratory specimens, induced as necessary or gastric lavage (in lieu of failed induction), collected at least 8-hours apart, with one at least one collected in the morning

AND

None or improving clinically (cough, fever, night sweats, chills) and radiographically (cxr, ct chest) from abx therapy **AND/OR** cause of clinical symptoms/diagnostics identified, or diagnosis to otherwise documented (lung cancer pathology, identified bacterial/viral pneumonia, etc.)

AND

≥1 or more negative MTB PCR on above respiratory specimens

OR

An alternative diagnosis is determined and provider cancels dispatched rule out orders (ends rule out process).

OR

Unless otherwise specified by TB Control for high-risk patients (symptomatic, epi risks) that may be placed on RIPE therapy. If so, maintain precautions until discharged.

2022 TB Susceptibility

Susceptibility Results for *Mycobacterium tuberculosis* complex*				
	PMC Escondido		PMC Poway	
	# Sensitive	# Resistant	# Sensitive	# Resistant
Ethambutol 5.0 ug/ml	6	0	1	0
INH 0.1 µg/ml	6	0	1	0
Pyrazinamide 100 ug/ml	6	0	1	0
Rifampin 1.0 ug/ml	6	0	1	0

* All results are from inpatients and outpatients

Employee Conversion Rate

2022					
	+	-	Total		
New Hire	26	597	623	4.17%	New Hire Positivity Rate
Annual Screening	9	2494	2503	0.36%	Annual Conversion Rate
Exposure(s)**	0	58	58	0.00%	Exposure Conversion Rate
TOTALS	35	3149	3184	1.10%	Total Positivity Rate

** 7 Exposures

Annual Comparison Reporting					
	2018	2019	2020	2021	2022
New Hire Positivity Rate	5.6%	7.5%	3.5%	5.2%	4.2%
Annual Conversion Rate	1.8%	1.1%	0.7%	0.7%	0.4%
Exposure Conversion Rate	0.0%	0.0%	0.0%	0.0%	0.0%
Total Positivity Rate	3.1%	3.3%	1.0%	1.4%	1.1%

Annual Conversion Rates by Dept					
Department	-	+	Total	%	Exp +
Patient Sitter	29	1	30	3.3%	0
EVS	80	2	82	2.4%	0
CSU	34	0	34	0.0%	0
BMU	25	1	26	3.8%	0
Med/ Surg	65	1	66	1.5%	0
Transport	54	1	55	1.8%	0

Summary:

During 2022, HCW Tuberculosis testing at Palomar Health Employee Health Services followed intermediate risk recommendations for annual TB testing.

- Conversion rates associated with known exposure are 0% and annual conversation rate is 0.4%.
- There were 1 TB patient encountered at PMC Poway.
- There were 6 TB patients encountered at PMC Escondido.
- Susceptibility: There were 0 resistant to INH.

Recommendations:

A. Palomar Health hospitals should remain with the TB risk status of 'Medium Risk Facility' based on the increasing TB rate in San Diego, the health system's large service reach in North County, the increase in total annual conversion, and the CDC's risk categorization schema.
B. Interdisciplinary team will perform case reviews of all TB exposures and share that data with department leadership and appropriate committees.
C. Identify through annual employee health screening survey, employee positions that require and do not require fit testing for N95 respirator or PAPR training
D. Validate alternative forms of respiratory protection anticipating surge capacity and stress on supply chain
E. Favor N95 fit pass over PAPR use among direct-patient care staff
    a. Encourage removal of facial hair in light of PAPR hood shortage
F. Support process algorithm for determining if isolation precautions should be discontinued with nursing and ID medical staff.
G. Infection Control and Nursing collaboration on discontinuing isolation precautions.