Posted
Thursday
July 20, 2023

PALOMAR HEALTH

BOARD QUALITY REVIEW COMMITTEE MEETING
AGENDA

Wednesday, July 26, 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 – May 24, 2023 (ADD A – Pp 16 - 19)	5	7	4:40
	b. Approval of Annual Review of Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan (ADD B – Redline Pp 20-44, Clean Pp 45 - 60) *Valerie Martinez, Senior Director, Quality, Patient Safety & Infection Prevention* *Omar Khawaja, MD, Chief Medical Officer*	5	8	4:45
	c. Approval of Contracted Services *Valerie Martinez, Senior Director, Quality, Patient Safety & Infection Prevention* I. Emerald Textiles (ADD C – Pp 61) II. Morrison (ADD D – Pp 62) III. DaVita Dialysis (ADD E – Pp 63)	5	9 10 11	4:50
4.	**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. Environment of Care & Emergency Management Program Annual Report (ADD F – Pp 64 - 81) *Russell Riehl, Vice President, Operations Support Services*	5	12	5:05
	b. Medication Management (Pharmacy) (ADD G – Pp 82 - 94) *Donna Gelios, Director, Pharmacy Services* *Omar Khawaja, MD, Chief Medical Officer*	5	13	5:10
	c. Patient Throughput/Discharge Planning (Clinical Resource Management) (ADD H – Pp 95 - 107) *Ryan Fearn-Gomez, Director, Clinical Operations Improvement* *Debora Bitzer, Interim Director, Clinical Resource Management*	5	14	5:15
	d. Rehabilitation Services (ADD I – Pp 108 - 114) *Tyler Powell, Director, Rehabilitation Services* *Virginia Barragan, FACHE, DPT, MOMT, Vice President, Continuum Care*	5	15	5:20
6.	**Adjournment to Closed Session**	1	-	5:21
	Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee	10	-	5:31
7.	**Adjournment to Open Session**	1	-	5:32
8.	**Action Resulting from Executive Session**	1	-	5:33
FINAL ADJOURNMENT		2	-	5:35

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
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 5.*

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Board Quality Review Committee Location Options

The Linda Greer Conference Room

2125 Citracado Parkway, Suite 300, Escondido, CA 92029

- Elected members of the Board of Directors will attend at this location, unless otherwise noticed below – Members of the public may also attend at this location.
- PLEASE TURN OFF CELL PHONES OR SET THEM TO SILENT MODE UPON ENTERING THE MEETING ROOM.

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- Non-Board member attendees and members of the public may attend the meeting virtually utilizing the above link.
- New to Teams? Get the app now and be ready when your first meeting starts @ https://www.microsoft.com/en-us/microsoft-teams/download-app

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.

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Policy : Public Comments and Attendance at Public Board Meetings

I. PURPOSE:

A. It is the intention of the Palomar Health Board of Directors to hear public comment about any topic that is under its jurisdiction. This policy is intended to provide guidelines in the interest of conducting orderly, open public meetings while ensuring that the public is afforded ample opportunity to attend and to address the board at any meetings of the whole board or board committees.

II. DEFINITIONS:

A. None defined.

III. TEXT / STANDARDS OF PRACTICE:

A. There will be one time period allotted for public comment at the start of the public meeting. Should the chair determine that further public comment is required during a public meeting, the chair can call for such additonal public comment immediately prior to the adjournment of the public meeting. Members of the public who wish to address the Board are asked to complete a Request for Public Comment form and submit to the Board Assistant prior to or during the meeting. The information requested shall be limited to name, address, phone number and subject, however, the requesting public member shall submit the requested information voluntarily. It will not be a condition of speaking.

B. Should Board action be requested, it is encouraged that the public requestor include the request on the *Request for Public Comment* as well. Any member of the public who is speaking is encouraged to submit written copies of the presentation.

C. The subject matter of any speaker must be germane to Palomar Health's jurisdiction.

D. Based solely on the number of speaking requests, the Board will set the time allowed for each speaker prior to the public sections of the meeting, but usually will not exceed 3 minutes per speaker, with a cumulative total of thirty minutes.

E. Questions or comments will be entertained during the "Public Comments" section on the agenda. All public comments will be limited to the designated times, including at all board meetings, committee meetings and board workshops.

F. All voting and non-voting members of a Board committee will be seated at the table. Name placards will be created as placeholders for those seats for Board members, committee members, staff, and scribes. Any other attendees, staff or public, are welcome to sit at seats that do not have name placards, as well as on any other chairs in the room. For Palomar Health Board meetings, members of the public will sit in a seating area designated for the public.

G. In the event of a disturbance that is sufficient to impede the proceedings, all persons may be excluded with the exception of newspaper personnel who were not involved in the disturbance in question.

H. The public shall be afforded those rights listed below (Government Code Section 54953 and 54954).

1. To receive appropriate notice of meetings;
2. To attend with no pre-conditions to attendance;
3. To testify within reasonable limits prior to ordering consideration of the subject in question;
4. To know the result of any ballots cast;
5. To broadcast or record proceedings (conditional on lack of disruption to meeting);
6. To review recordings of meetings within thirty days of recording; minutes to be Board approved before release,
7. To publicly criticize Palomar Health or the Board; and
8. To review without delay agendas of all public meetings and any other writings distributed at the meeting.

I. This policy will be reviewed and updated as required or at least every three years.

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**	**7.26.2023**			
LINDA GREER, RN, Chairperson, Board Member	P	P	P				
TERRY CORALES, RN, Board Member	P	P	P				
LAURA BARRY, Board Member	E	P	P				
ANDREW NGUYEN, MD, PhD, Chair, Medical Staff Quality Management Committee, PMC Escondido	A	P	P				
MARK GOLDSWORTHY, MD, Chair, Medical Staff Quality Management Committee, PMC Poway	P	E	P				
LAURIE EDWARDS-TATE, MS- 1ST *Board Alternate*		G	G				
STAFF ATTENDEES/NON-VOTING MEMBERS							
DIANE HANSEN, CPA, President & CEO	P						
OMAR KHAWAJA, MD, Chief Medical Officer	P	P	P				
MEL RUSSELL, RN, MSN, Chief Nursing Executive	P	P	P				
HUGH KING, Chief Financial Officer							
VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety	P	P	P				
DAVID LEE, MD, Medical Quality Officer	P	P	P				
KEVIN DEBRUIN, Esq., Chief Legal Officer	V						
SALLY VALLE – Committee Assistant	P	E	P				
INVITED GUESTS	**SEE TEXT OF MINUTES FOR NAMES OF INVITED GUESTS**						

Board Quality Review Committee Minutes
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Sally Valle, Committee Assistant

Background: Minutes from the Wednesday, May 24, 2023, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, May 24, 2023, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Contracted Services – Quality Assessment Performance Improvement (QAPI) and Patient Safety Plan
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Valerie Martinez, Senior Director, Quality and Patient Safety

Background: The Quality Assessment Performance Improvement (QAPI) and 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
Contracted Services – Emerald Textile
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Valerie Martinez, Senior Director, Quality and Patient Safety

Background: The Contracted Services Evaluation report for Emerald Textile 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 – Morrison
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Valerie Martinez, Senior Director, Quality and Patient Safety

Background: The Contracted Services Evaluation report for Morrison 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 – DaVita Dialysis
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Valerie Martinez, Senior Director, Quality and Patient Safety

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

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Annual Report – Environment of Care and Emergency Management
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Russell Riehl, Vice President,
Operations Support Services

Background: The annual report for the Environment of Care and Emergency Management 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 – Medication Management (Pharmacy) Report
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Donna Gelios, Pharmacy Director
Omar Khawaja, MD, Chief Medical Officer

Background: The annual report for the Medication Management (Pharmacy) 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 – Patient Throughput/Discharge Planning
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Ryan Fearn-Gomez, District Director, Clinical Operations
Deb Bitzer, Interim Director, Clinical Resource Management

Background: The annual report for Patient Throughput/Discharge Planning 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 – Rehabilitation Services Annual Report
Wednesday, July 26, 2023

TO: Board Quality Review Committee

MEETING DATE: Wednesday, July 26, 2023

FROM: Tyler Powell, Director, Rehabilitation Services
Virginia Barragan, Vice President, Continuum Care

Background: The annual report for Rehabilitation 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:

PALOMAR HEALTH

ADDENDUM A

BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, MAY 24, 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 Wednesday, May 17, 2023, consistent with legal requirements.			
CALL TO ORDER			
The meeting, which was held in the Linda Greer Board Room at 2125 Citracado 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 Barry; and 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 – MARCH 22, 2023**			
The BQRC meeting minutes from March 22, 2023, were presented for review and approval. Director Laura Barry, motioned for approval, second by Director Terry Corrales.	**MOTION:** by Director Laura Barry, second by Director Terry Corrales, carried to approve the meeting minutes of March 22, 2023, as submitted. Roll call voting was utilized. Director Corrales - Aye Andrew Nguyen, MD - Aye Director Greer – Aye Director Barry – Aye Mark Goldsworthy, MD - 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 BDCare Fusion IV Prep Workflow, Corticare EEG Monitoring, and Olympus Equipment, service contracts were reviewed and approved.	**MOTION:** by Director Laura Barry, second by Director Terry Corrales, to approve the service contracts for BDCare Fusion IV Prep Workflow, Corticare EEG Monitoring, and Olympus Equipment. Roll call voting was utilized. Director Greer, RN - Aye Director Corrales, RN- Aye Director Barry - Aye Andrew Nguyen, MD – Aye Mark Goldsworthy, MD - Aye All in favor. None opposed.	N/A	Y
C. ***REVIEW/APPROVAL: ANNUAL REVIEW OF QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) & PATIENT SAFETY PLAN**			
The Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan was reviewed. QAPI to return to the next meeting for review, and consideration for approval.	**MOTION:** N/A.	Dr. Khawaja, CMO	Y
STANDING ITEMS:			
A. **MEDICAL EXECUTIVE COMMITTEE (MEC)/QUALITY MANAGEMENT COMMITTEE (QMC) UPDATE**			
Dr. Nguyen provided the Medical Executive Committee/Quality Management Committee update on the following topics: • Radiology Services • Retained Foreign Bodies: • CMS Plans of Correction: • Prior Joint Commission Plans of Correction The report was accepted as provided.	**MOTION:** N/A		Y
NEW BUSINESS:			
A. **SPINE SURGERY AND TOTAL JOINT CENTERS OF EXCELLENCE ANNUAL REPORT**			
The Total Joint & Spine Surgery Centers of Excellence Annual Report was presented by Brian	**MOTION:** N/A		Y

Cohen, Sr. Director of Service Lines. The report was accepted as provided.			
B. **LABORATORY ANNUAL REPORT (INCLUDING BLOOD USE & PATHOLOGY REPORTS)**			
The Laboratory Annual Report was presented by Dr. Kolins. The report was accepted as provided.	**MOTION:** N/A	N/A	Y
C. **RESPIRATORY SERVICES ANNUAL REPORT**			
The Respiratory Services annual report was presented by Dr. Frank Bender. The report was accepted as provided.	**MOTION:** N/A	N/A	Y
D. **QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI) 2022 ANNUAL REVIEW & PROGRAM ASSESSMENT TO THE BOARD OF DIRECTORS**			
The Quality Assurance & Performance Improvement (QAPI) 2022 Annual Review & Program Assessment was presented by Valerie Martinez. The report was accepted as provided.	**MOTION:** N/A	Dr. Omar Khawaja	Y
E. **INFECTION PREVENTION & CONTROL PROGRAM 2022 ANNUAL REVIEW & ASSESSMENT (INCLUDES ANTIBIOTIC STEWARDSHIP)**			
The Infection Prevention & Control Program 2022 Annual Review & Assessment (including Antibiotic Stewardship) was presented by Valerie Martinez. The report was accepted as provided.	**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 6:02 p.m.	**MOTION:** N/A	

SIGNATURES:

COMMITTEE CHAIR

_____
Linda Greer, RN

COMMITTEE ASSISTANT

Sally Valle

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 ~~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 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 - 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 follow-up 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:

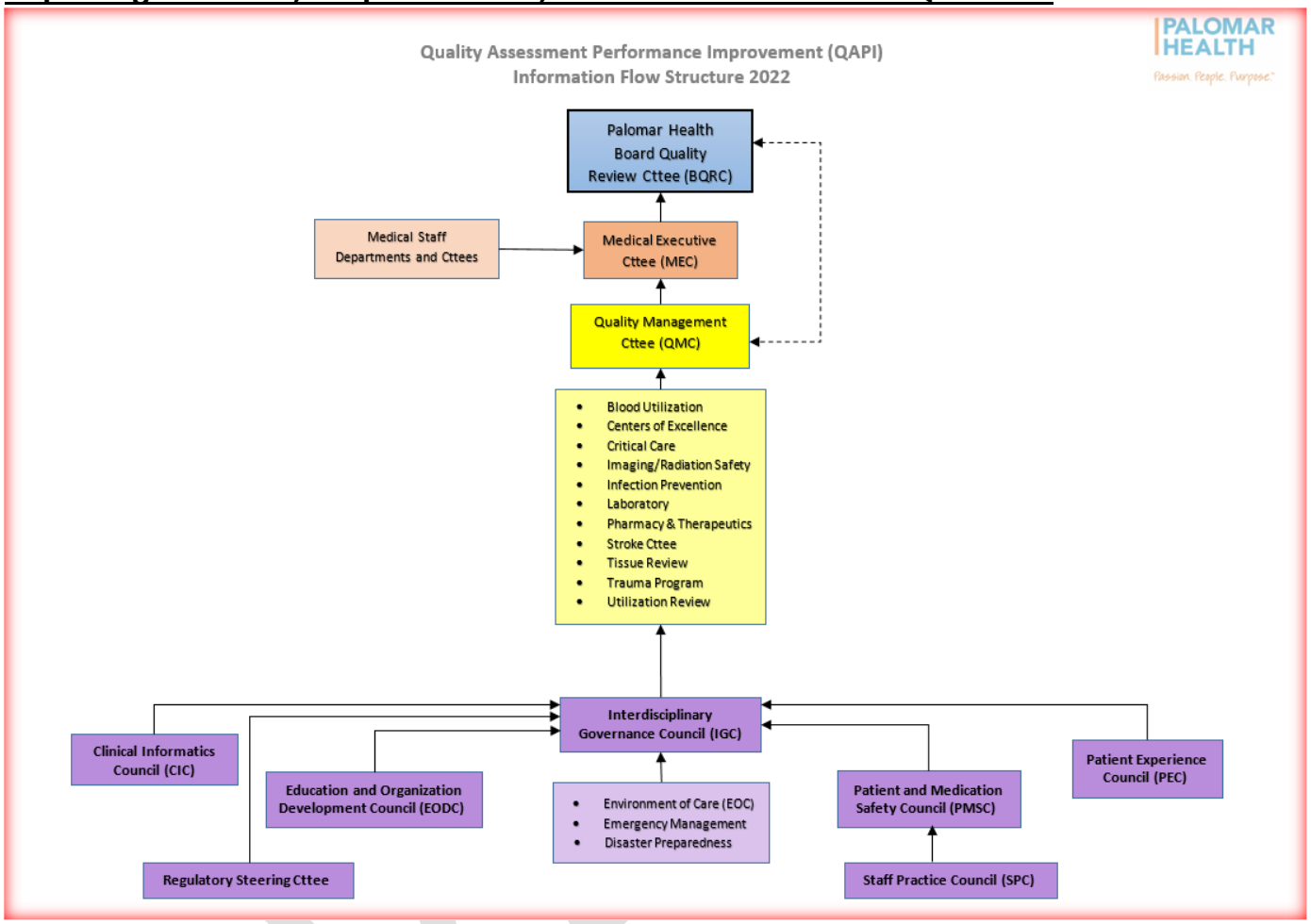
1. Enhance key processes to ensure that "Evidence Based Practices" are considered in all opportunities for improvement of care and services.
2. Integrate the Quality Assessment/Performance Improvement Plan into a culture of safety that recognizes the key behaviors and attitudes that result in a safe 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.

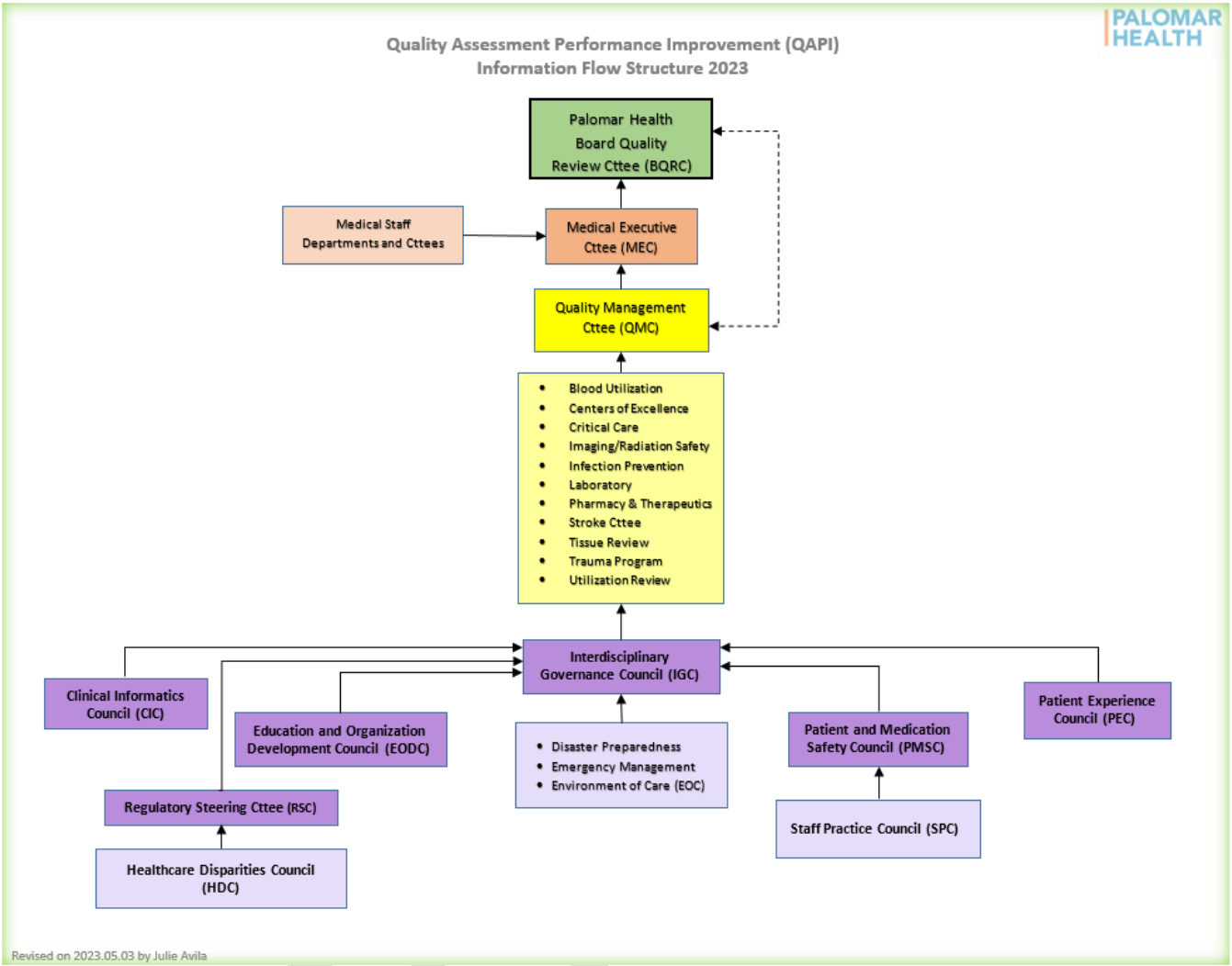
B. The organization has an effective program that assesses the quality and safety of its services including Local, State, and Federal regulations to identify opportunity for improvement, and works to address those opportunities. Services include but not limited to:

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 Services:
    1. All contracted services including patient care services, and all other services, provided under a clinical 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 metrics for compliance and identify corrective or improvement activities for those metrics or elements that are less than the established thresholds. ~~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 thesereviews 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/Patient 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 investigate. 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):

0. Duties:

. 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.

1. Composition:

. Voting Membership: The committee shall consist of five voting members, including three members of the Governing Body and the Chairs of the Quality Management Committee (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, and the Senior Director of Quality/Patient Safety.

B. Medical Staff Executive Committees (MEC):

0. 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.

1. 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:

0. Purpose:

    a. The Quality Management Committee 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.

1. 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.

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

D. Interdisciplinary Governance Council (IGC):

0. 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.

1. 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, 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):

0. 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.

1. 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):

0. 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.

1. Governance: The LODC will make recommendations regarding education plans and practices to the IGC for approval.

G. Regulatory Steering Committee:

0. 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.

1. 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):

0. 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. Incorporates Medication Safety reports and Medication Error Reduction Plan (MERP) updates. Supports 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. Reviews 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.

1. 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):

0. 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.

1. 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):

0. 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.

1. 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).
2. 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:

0. Participating in departmental and quality assessment/performance improvement activities.
1. Utilizing results and recommendations from interdisciplinary performance improvement efforts to improve services.
2. 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.
3. 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.
4. Sharing responsibility for planning, designing, measuring, assessing, and improving the overall safe care of patients.

L. Medical Staff Peer Review Committee (MSPRC):

0. 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.

1. 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)
0. 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.
1. 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):
0. 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.
1. 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. 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.

    b. 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.

c. The IPCC reports directly to the Quality Management Committee.

d. 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.

e. 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 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 representative, 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

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

a. Duties:

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

b. 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).

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

   a. 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.

   b. 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).

2. 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.

3. 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 ~~and~~ 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.

4. 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.

5. 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 follow-up 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.

6. 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:
      . Identification of patient needs and expectations and evaluation of how these needs and expectations are met
      i. Identification of staff education and training needs and ongoing measurements to demonstrate sustained improvement
      ii. Use of evidence-based data from internal and external sources to improve the quality of care
      iii. Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing~~, home health~~ and ambulatory services
      iv. Analysis of data to establish priorities and identify opportunities for future improvement
   b. Entities under the umbrella of the Continuum Care Operations Improvement Function include:
      i. The Villas at Poway Quality Committee
      ii. Rehabilitation Services
      iii. 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.

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. Risk Management
        xiv. Infection Control Healthcare Associated Infections and Antimicrobial Stewardship
        xv. Imaging Services
        xvi. Laboratory Services
        xvii. Patient Grievances
        xviii. 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.

CLEAN

PALOMAR HEALTH

DocID: 11234
Revision: 21
Status: In preparation

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 - understand process variation and capability, S - select a strategy for continued improvement.

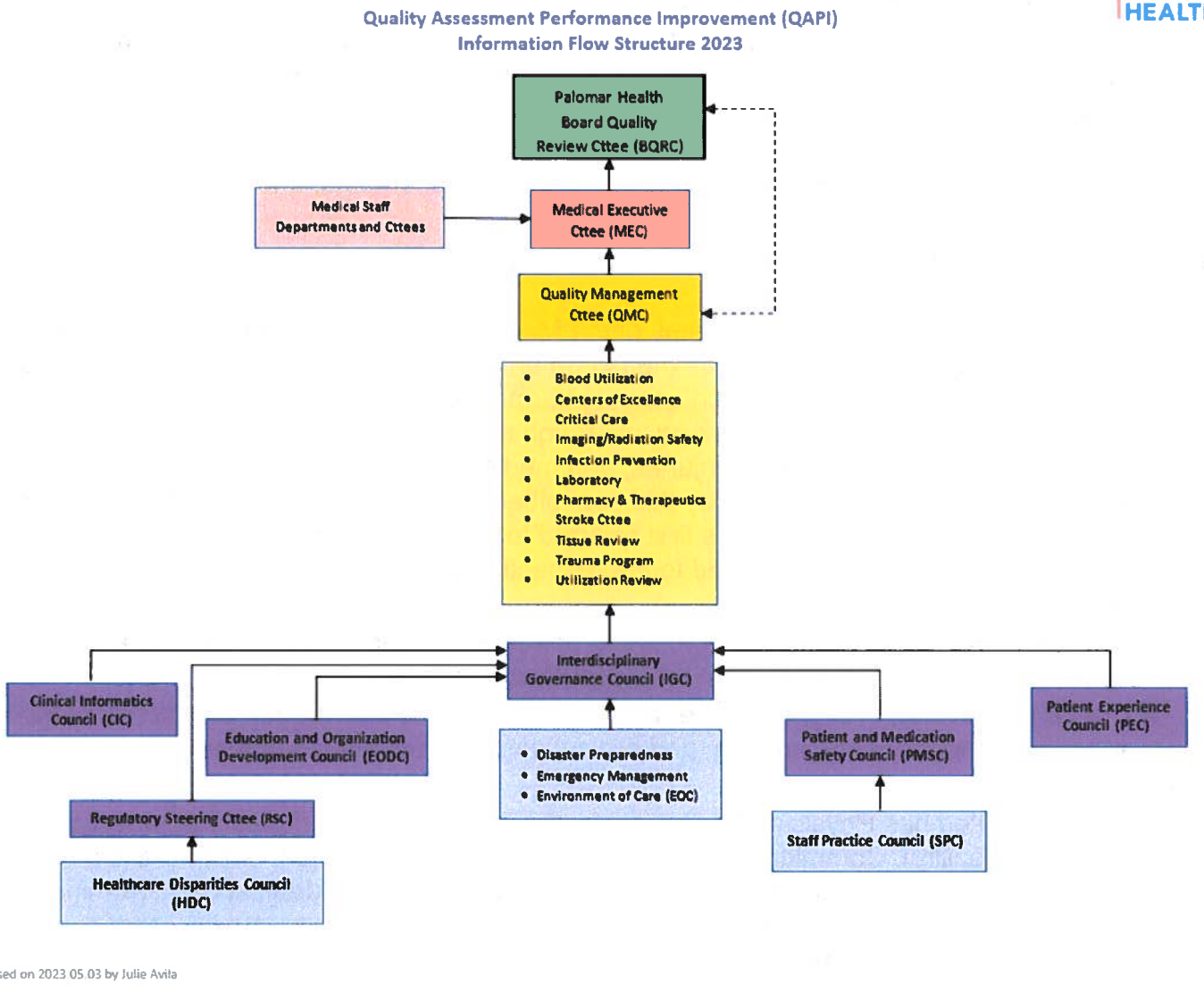
7. A calendar of reporting to ensure ongoing systematic communication to all key constituents, ensure accountability and maintain the ongoing improvement gains for all continuous quality assessment/performance improvement activities.
8. Educational programs and meetings to enhance statistically-based quality assessment/performance improvement tools for every level of leadership, physicians, and staff.
9. Standardized processes for investigation of events and follow-up 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 Services:
    1. All contracted services including patient care services, and all other services, provided under a clinical 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.
18. Patient Grievances - The hospital's Governing Body has delegated the grievance process to the Quality/Patient Safety Department. The Quality/Patient 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 Committee (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, 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. Incorporates Medication Safety reports and Medication Error Reduction Plan (MERP) updates. Supports 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. 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.

b. 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.

c. The IPCC reports directly to the Quality Management Committee.

d. 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.

e. 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., 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 representative, 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)

a. Duties:

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

b. 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).

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

a. 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.

b. 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 follow-up 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, 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. Rehabilitation Services

iii. 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

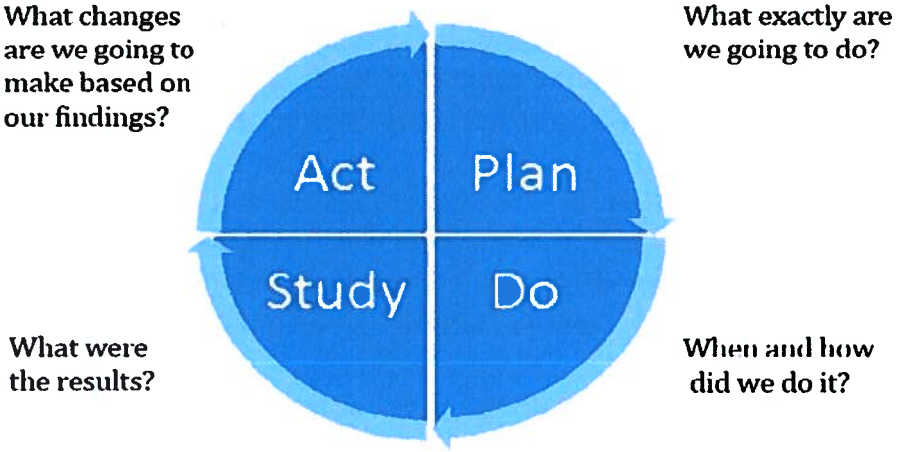
iii. Risk

iv. Regulatory or accreditation requirements
v. Patient and community outcomes
vi. CMS Quality Indicators for Skilled Nursing

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:

Revision Date:

Standards:
(WHICH REFERENCE THIS DOCUMENT)

College of American Pathologists:

- Laboratory General - GEN.13806
- Laboratory General - GEN.13806
- Laboratory General - GEN.13806

ADDENDUM C

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

Date of Review: 6/14/2023 **Name / Title of Reviewer:** David Contreras, District Director, Environmental Services

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

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 too.	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 service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and to prevent and reduce medical errors.		X

Performance Metrics

METRIC (75% Threshold)	1st QTR 2022	2nd QTR 2022	3rd QTR 2022	4th QTR 2022	Cumulative Total
Percentage of pieces ordered versus percentage of pieces delivered.	MET 98%	MET 95%	MET 85%	MET 80%	MET 89.5%
Components of Plant Tour Checklist (e.g. Soiled Linen Processing; Clean Linen Processing and /or Sanitization; Pack Room, In-service Programs). If deficiencies are found, Emerald had 30 days to correct deficiencies.	MET 100%	MET 100%	MET 88%	NOT MET 60%	MET 87%
Quarterly Scrub Inventory / Replenishment	MET 90%	MET 87%	MET 75%	NOT MET 70%	MET 80.5%

Comments

The vendor struggled to meet quality and quantity expectations in the 4th quarter. We are monitoring daily delivery's for both quality and correct quantities and communicating corrections with the vendor.

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):

- X Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation have been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: _____

PALOMAR HEALTH

ADDENDUM D

Palomar Health
Review of Contract Service

Name of Service: Morrison Management Specialists, Inc.

Date of Review: 06.2023 **Name / Title of Reviewer:** Russell Riehl, VP. Director Operational Support Services

Nature of Service (describe): Food and Nutrition Services

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

METRIC	1st QTR 2022	2nd QTR 2022	3rd QTR 2022	4th QTR 2022	Cumulative Total
Regulatory Compliance (Health Dept., CDPH, JC) (**Goal: 95%**)	100% MET	100% MET	100% MET	100% MET	100% MET
RD Pressure Injury Documentation Compliance (**Goal: 95%**)	97% MET	96% MET	95% MET	97% MET	96% MET
Tray Accuracy (**Goal: 95%**)	100% MET	94% **Not Met**	98% MET	96% MET	97% MET
Test Tray - Temperature of Food (**Goal 95%**)	93% Not Met	95% MET	96% MET	97% MET	96% MET
Labeling and Dating (**Goal 95%**)	90% **Not Met**	95% MET	98% MET	99% MET	96% MET

Comments:

We had 1 metric in Q1, and 1 metric in Q2 that were under our goal threshold, however the vendor implemented Workflow changes to improve the outcomes. All items achieved their goals when assessed across the year.

Conclusion (check one)

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

ADDENDUM E

DaVita Dialysis
Review of Contract Service

Name of Service: DaVita Dialysis

Date of Review: 6/30/23 **Name / Title of Reviewer:** **Victoria Veronese, Director of Critical Care**

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

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	CY 2022 3rd QTR	CY2022 4th QTR	CY 2023 1st QTR	CY 2023 2nd QTR	Cumulative Total
Dialysis Machine Water Cultures/Endotoxins Escondido Campus	100% Pass	100% Pass	100% Pass	100% Pass	100% Pass
Dialysis Machine Water Cultures/Endotoxins Poway Campus	100% Pass	100% Pass	100% Pass	100% Pass	100% Pass

Comments

Conclusion (check one)

■ Contract service has met expectations for the review period

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

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation has been provided to the contract service
- ☐ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: _____

PALOMAR HEALTH

ADDENDUM F

Environment of Care & Emergency Management Annual Report

(Jan. 2022 – Dec. 2022)

Russell Riehl, Vice President Support Services

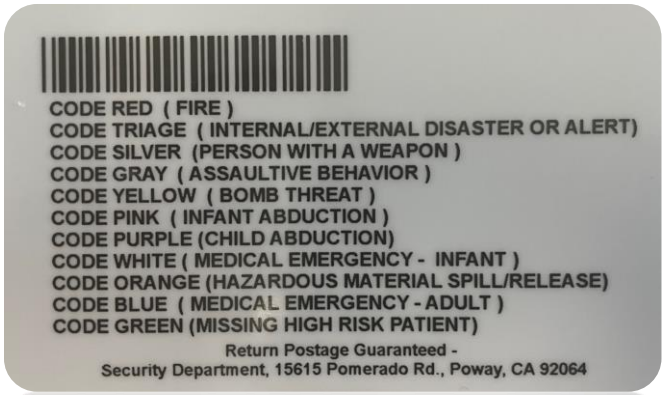
July, 2023

Emergency Codes

The Hospital Association of Southern California's (HASC) Safety & Security Committee standardized the identification of emergency situations.

- RED - Fire
- BLUE - Adult Medical Emergency
- WHITE - Neonatal/Pediatric Medical Emergency
- PINK - Infant Abduction
- PURPLE - Child Abduction
- YELLOW - Bomb Threat
- GRAY - Combative Person/Assaultive Behavior or Intruder
- SILVER - Person with a Weapon/Hostage Situation
- ORANGE - Hazardous Material Spill/Release
- GREEN - Patient Elopement/Missing High-Risk Patient
- TRIAGE - Disaster/Unplanned Event

Back of Employee ID Badge



Annual Evaluation of the Environment of Care

(Safety, Security, Hazardous Materials, Fire Prevention, Medical Equipment, and Utilities)

Situation: Environment of Care covers healthcare safety, from first patient contact through their care path with Palomar Health. Environment of Care Management plans ensure a safe, functional, and effective environment for patients, visitors, all healthcare workers. The District Environment of Care Committee reviews and develops performance goals for each management plan annually.

Background: Each management plan has diversity, but also have parallels in process (planning, teaching, implementing, responding, monitoring, and improving). Through the work of our staff, the purpose with the Environment of Care is to diminish risk within our medical centers and satellite buildings.

Assessment: Throughout 2022, performance metrics were completed and measured, during environment of care (EOC) rounding sessions with staff, during exercises / drills, and multiple training sessions. Based upon the objectives and performance standards, outcomes were positive for each management plan and each plan is deemed to be effective.

Recommendation: We have identified a number of metrics which have been exceeding goals for multiple years. The EOC Committee will be reviewing and discussing goal/metric updates with each plan owner, as well as continued action plan updates for areas which did not achieve their goals.

Achievements

- Staff knowledge of RACE & PASS
- Monthly Code Red Drills
- Staff Displaying ID Badge Correctly
- Flooding Events

Opportunities/Risks

- Fire Prevention Training for High Hazard Departments
- Medical Equipment Management Tracking Across Platforms

Safety Management Plan

1. Unsecured O2 bottles found during monthly EOC rounds

	2022
PMC Escondido	11
PMC Poway	0
The Villas at Poway	0

Evaluation:

- 11 unsecured tanks at Escondido in 2022.
  - Tanks were secured and leadership was notified
- Signage was posted at all tank storage locations to remind staff where to place empty and full tanks
- No unsecured tanks at Poway or The Villas in 2022

2. Staff knowledge of R.A.C.E and P.A.S.S during monthly EOC rounds

	2022
PMC Escondido	100%
PMC Poway	100%
The Villas at Poway	100%

Evaluation:

- We exceeded the 90% goal.

Security Management Plan

1. Monitoring of fire protection systems, and activation response

	2022	
	Total Drills	Pass Rate
PMC Escondido	42	100%
PMC Poway	21	100%
The Villas at Poway	12	100%

Evaluation

- Code Red drills consistently conducted at all facilities
- Security staff manages the drills and there was NO department deficiencies triggering a re-drill

2. Every Code Gray activation was assessed to ensure the correct process was followed

	2022	
	Code Grays	Compliance
PMC Escondido	639	100%
PMC Poway	309	100%
The Villas at Poway	0	N/A

Evaluation

- 100% compliance using Call Center at Ext. 111
- 100% compliance was met every quarter at PMC Escon dido and PMC Poway
- Ongoing reminders of the process during daily safety huddles contributed to improvement

Security Management Plan (cont.)

3. **Every Code Green activation was assessed to ensure the correct process was followed**

	2022	
	Code Greens	Compliance
PMC Escondido	32	100%
PMC Poway	12	100%
The Villas at Poway	0	N/A

Evaluation:

- 100% compliance using Call Center at Ext. 111

4. **Staff were monitored to ensure they were properly displaying their ID badges**

	Spot Checks	Compliance
PMC Escondido	600	99.5%
PMC Poway	600	100%
The Villas at Poway	300	100%

Evaluation:

- Minimum observations conducted per quarter, and majority of staff were wearing ID badge appropriately
- All staff found to not be following the procedure were spoken with and corrected the behavior without issue.

5. **Code Gray incidents tracked for # of NON-Security CPI trained staff response**

	Code Gray	Non-Security Responders
PMC Escondido	639	3.59
PMC Poway	309	2.86

Evaluation:

- Exceeded goal of two Non-Security responders to Code Gray
- Saw a decrease at both campuses from 2021, but still exceeded goal.

Hazardous Materials & Waste Management Plan

1. **Hazardous material containers labelled incorrectly.**

	2022
PMC Escondido	0
PMC Poway	0
The Villas at Poway	0

Evaluation

- All hazardous materials containers inspected were labelled properly

2. **Hazardous chemical and biohazard waste incidents requiring outside assistance to clean up**

	2022
PMC Escondido	80%
PMC Poway	91.67%
The Villas at Poway	95.24%

Evaluation

- NO hazardous chemical or bio-hazard waste incidents requiring outside cleanup support

3. **Landline phones were monitored for properly displayed Safety Data Sheet (SDS) stickers**

	2022
PMC Escondido	80%
PMC Poway	91.7%
The Villas at Poway	95.2%

Evaluation

- All 3 locations had significant improvement over the past 3 years.
- Stickers are available by Security and communication was sent to department leaders for awareness.

Hazardous Materials & Waste Management Plan (cont.)

4. **Staff knowledge on obtaining Safety Data Sheet (SDS) information was tested on EOC Rounds**

	2022
PMC Escondido	97%
PMC Poway	88.9%
The Villas at Poway	100%

Evaluation

- 90% goal NOT met at PMC Poway (77% in Q3)
- Just in time training with employee and deficiency communication sent to leadership for each incidence identified

5. **Staff knowledge on managing a spill was tested during monthly EOC rounds**

	2022
PMC Escondido	98.5%
PMC Poway	100%
The Villas at Poway	100%

Evaluation

- 90% goal MET at all 3 locations
- Just in time training with employee and deficiency communication sent to leadership for each incidence identified

Fire Prevention Management

1. **Staff knowledge on obtaining Safety Data Sheet (SDS) information was tested on EOC Rounds**

	2022
PMC Escondido	29
PMC Poway	8
The Villas at Poway	8

Evaluation

- Failures were related to fire alarm testing devices or fire doors
- Failures were repaired immediately and no impact to services

2. **Staff knowledge on managing a spill was tested during monthly EOC rounds**

	2022
Departs Trained	0

Evaluation

- Pre-identified High Hazard departments include EVS, FANS, Facilities, Lab, and the OR/IR/Cath Lab
- No high hazard departments participated in fire safety training.

Medical Equipment Management

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

	2022	2021
PMC Escondido	85.2%	91.1%
PMC Poway	98.1%	87.2%
The Villas at Poway	100%	0%

Evaluation

- Did NOT meet goal due to not able to locate devices during Q2 (75% at Escondido)
- Biomed was in regulatory compliance due to COVID-19 waivers for equipment in use for COVID patients
- Primary devices of concern: Servo vents, rapid fluid diffusers, Olympus ultrasonic scanners, and defibrillators

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

	2022
PMC Escondido	97.8%
PMC Poway	98.3%
The Villas at Poway	95.5%

Evaluation

- The goal of 95% was met at all locations.

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

	2022
PMC Escondido	4.1%
PMC Poway	2.5%
The Villas at Poway	5.4%

Evaluation

- The goal was MET at both PMC Escondido and PMC Poway
- The goal was NOT met at Villas by 0.4% (9.1 & 10 in 1st & 2nd Qtr.)
- All items which could not be located were considered “non-high risk”

Medical Equipment Management (cont.)

4. ≥90% of equipment repairs completed within 30 days

	2022
PMC Escondido	N/A
PMC Poway	N/A
The Villas at Poway	N/A

Evaluation:

- Biomed reports reflect equipment repaired within 90 days.
- The data metric is for 30 days of opened repair ticket.
- Data for equipment repairs within 30 days can not be pulled ret roactively, and software vendor has updated their protocol.

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

	2022
Tracked Equipment	70%

Evaluation:

- 70% of high value medical equipment tracked, equaled 2021
- RFID tracking system has been on hold for IT integration

6. # Of staff attending technical training classes

	2022	2021
Staff Training	1	7

Evaluation:

- Biomed recorded 1 tech training course in 2022.
- Training was intestinally minimized due to staffing challenges at both campuses.

Utility Equipment Management

1. Utility repair monitoring: Electricity, water, natural and medical gas component repairs

	2022
PMC Escondido	34
PMC Poway	28
The Villas at Poway	0

Evaluation:

- Primary utility repairs included:
  - 33 Medical gas system alarms (Escondido & Poway)
    (these were single component repairs)
    (There were zero system failures)
  - 25 Tube system repairs (Poway)
- All repairs were completed without issue and none impacted se rvices.

2. Elevator entrapment monitoring

	2022
PMC Escondido	4
PMC Poway	0
The Villas at Poway	0

Evaluation:

- A total of 4 elevator entrapments occurred during 2022, a comparable number to previous years.

Utility Equipment Management (cont.)

3. Water Intrusion Events

	2022
PMC Escondido	13
PMC Poway	8
The Villas at Poway	5
Satellite Facilities	11

Evaluation

- A we expand into additional satellite facilities, we are seeing an increase in intrusions in our leased buildings.
- The events in our hospital campuses are consistent with prior years.

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

	2022
PMC Escondido	96.67%
PMC Poway	100%
The Villas at Poway	100%

Evaluation

- PMC Escondido had a 2 failures in 2022.
  - Both instances involved the ATS transfer taking greater than 10 seconds to switch to E-power (11.5 seconds).
  - Vendor repairs were made in both instances to ensure compliance.

Annual Evaluation of the Emergency Management Program (EMP)

SITUATION: Emergency Management Program (EMP) is designed using an all-hazards approach to ensure disasters, unusual events, and other emergencies have minimal impact on the ongoing operations of our services. The Disaster Preparedness Committee reviewed and developed performance goals for the EMP in early 2022 and the goals are applicable to healthcare workers, medical staff and volunteers.

BACKGROUND: The objective of the Emergency Management Plan is to mitigate harm to life and property due to unforeseen circumstances and risks identified by Hazard Vulnerability Analysis' conducted annually. The Plan comprehensively describes our approach to responding to emergencies that would suddenly and significantly affect the organization's services, or ability to provide those services. The plan is intended to identify risks and addresses how the facilities are prepared to respond as well as identify strategies in place to mitigate risks.

ASSESSMENT: Throughout 2022, performance metrics were completed and measured, during environment of care (EOC) rounding sessions with staff, during disaster exercises, and multiple training sessions. These plan elements and other activities in the facilities relating to emergency preparedness demonstrate that the facilities have been effective in meeting stated objectives in the EOP. However, we also noticed a decrease in staff knowledge on few items.

RECOMMENDATION: Experience through 2022 and before has shown drill participation and staff rounding are the best opportunities to train leaders, and test staff knowledge. We will be focusing on the return on in person disaster drills and table top exercises, as well as focus on staff knowledge during rounding.

Annual Risks/Issues

- Decrease in staff knowledge on Departmental Safety Guide locations
- Decrease in staff knowledge on Code Triage Response
- Decrease in staff knowledge on Network Downtime forms and 7/24 computers

Emergency Management / Emergency Operations Plan (EOP)

1. **Disaster exercises/events evaluated by Joint Commission Emergency Management standard**

	2022
PMC Escondido	91%
PMC Poway	91%
The Villas at Poway	91%

Evaluation

- Goal met at all locations in every quarter.
- Action items were identified were forwarded to the District Disa ster Preparedness Committee for review.

2. **Staff knowledge of department disaster supplies was surveyed**

PMC Escondido	96.67%
PMC Poway	100%
The Villas at Poway	100%

Evaluation:

- Goal met at all locations in every quarter.
- Just in time training with employee and deficiency communication to leadership provided for each incidence

3. **Staff knowledge of the Emergency and Safety Response Guide in their department**

PMC Escondido	98.7%
PMC Poway	97.1%
The Villas at Poway	95.2%

Evaluation:

- Goal met at all locations in every quarter.
- Just in time training was provided and follow up communication to department leadership for deficiencies.

Emergency Management / Emergency Operations Plan (EOP)

4. Staff knowledge on earthquake response (Drop, Cover, Hold)

	2022
PMC Escondido	98.7%
PMC Poway	100%
The Villas at Poway	100%

Evaluation

- 90% goal was MET at all location in every quarter.
- Just in time training was provided and follow up emails were sent to department leadership

5. Staff knowledge when a Code Triage is activated

	2022
PMC Escondido	95.4%
PMC Poway	94.3%
The Villas at Poway	100%

Evaluation

- 90% goal was MET at all location in every quarter

6. Staff knowledge on actions to take when receiving an Everbridge notification

	2022
PMC Escondido	100%
PMC Poway	100%
The Villas at Poway	100%

Evaluation

- 90% goal was MET at all location in every quarter
- Just in time training was provided and follow up emails were sent to department leadership

Emergency Management / Emergency Operations Plan (EOP)

7. Staff knowledge of their departmental downtime forms and 7/24 computer was surveyed during monthly rounds.

	2022	2021
PMC Escondido	95.2%	97.1%
PMC Poway	93.3%	98.1%
The Villas at Poway	86.7%	100%

Evaluation:

- The 90% threshold was not met at The Villas at Poway.
- Just in time training was provided and follow up emails w ere sent to department leadership.

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

	2022
Training Sessions	32

Evaluation:

- 10% increase in Emergency Management and Safety trainings conducted for Palomar healthcare personnel in 2022.

Questions?

PALOMAR HEALTH

ADDENDUM G

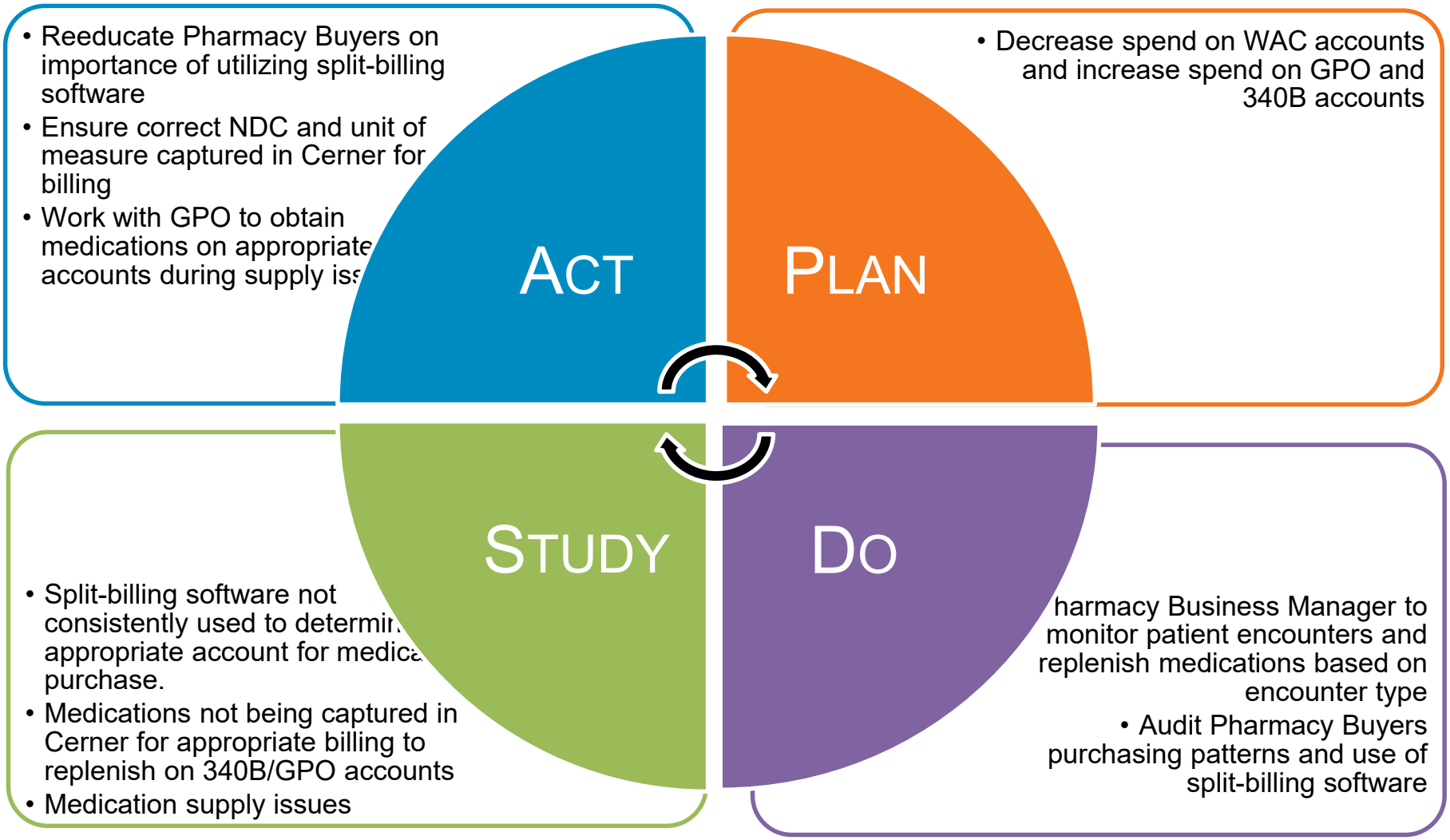
Pharmaceutical Services Quality Assessment Performance Improvement

(Purchasing Optimization, Intravenous to Oral Interchange, Medication Intake Coordinator Medication History)

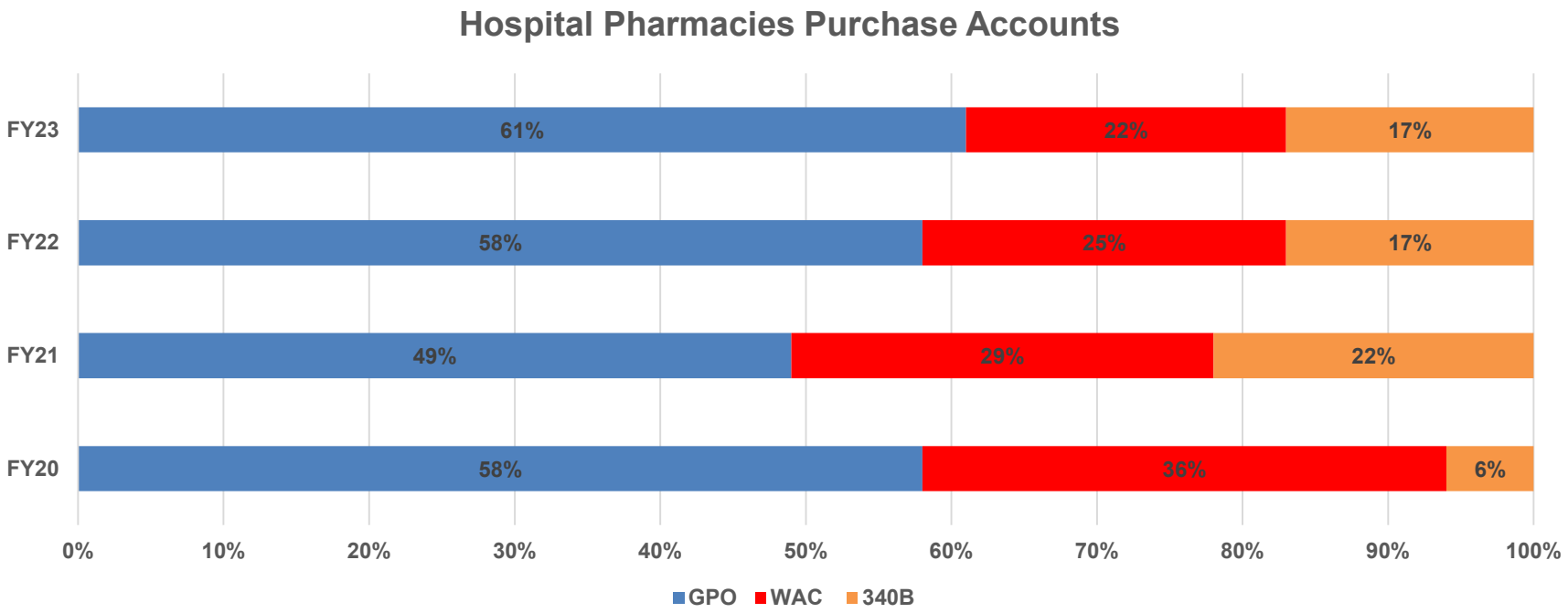
Presented to Board Quality Review Committee

by
Dondreia Gelios, PharmD, BCPS
District Director of Pharmacy
July, 2023

Account Purchase Optimization

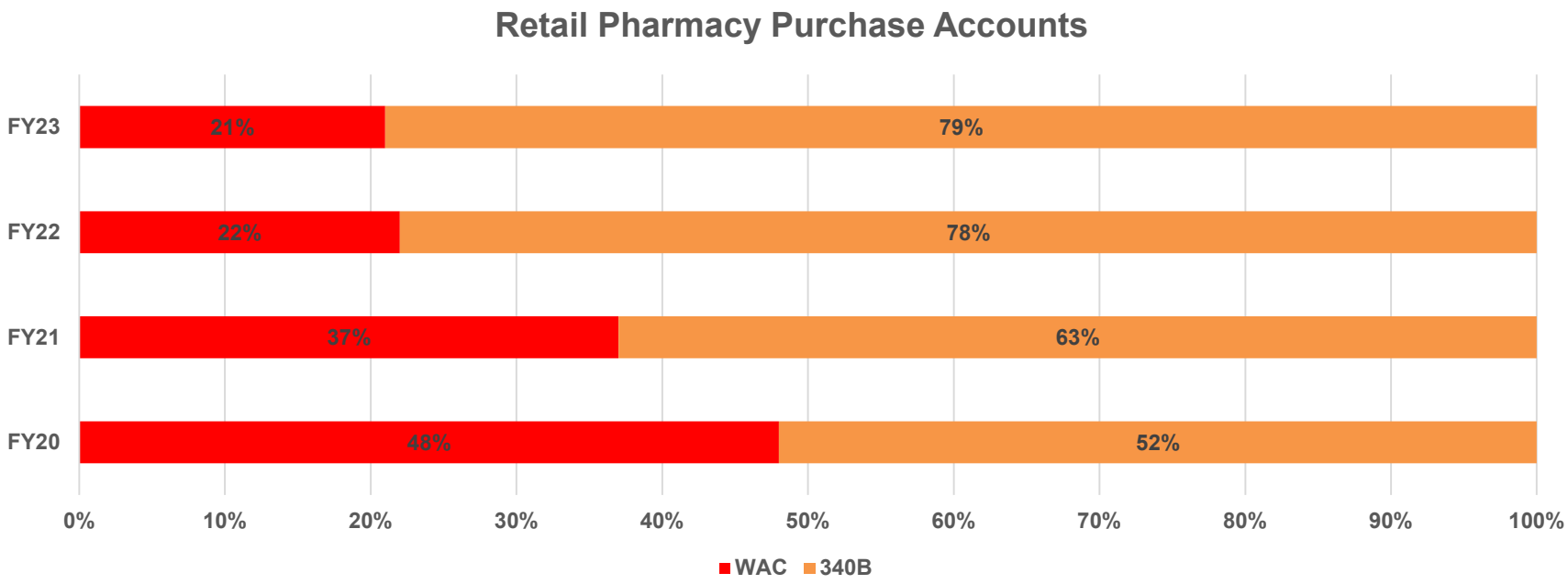


Purchasing Optimization



- GPO change FY22
  - Required increased WAC spend
- Medication shortages d/t COVID-19 pandemic
  - Non-preferred products

Purchasing Optimization



Purchasing Optimization

TABLE 1: 340B NET FINANCIAL IMPACT					
340B Benefits *Add the following three metrics together for total 340B benefit.* **TOTAL**		MINUS –	**340B Maintenance Costs** **TOTAL**	EQUALS =	**340B Net Financial Impact**
Hospital	$ 6,322,791.76				
Retail Pharmacy	$ 7,743,336.35	–	$ 177,014.03	=	$ 13,889,114.08
Contract pharmacy	$ -				

NOTES

- Hospital savings calculation = GPO pricing - 340B pricing
- Retail savings calculation = WAC pricing - 340B pricing
- PMC does not participate in contract pharmacy revenue program
- 340B maintenance costs include third party administration, 1/3 of Business Operations Manager total compensation, and educational opportunities

Pharmaceutical Purchase Optimization

- FY23 able to maintain strong purchasing despite
  - Medication shortages
  - Change in GPO
  - Transportation/shutdown issues
- Moving Forward
  - Evaluate medication formulary
  - Monitor accounts and audit buyers

IV to PO Interchange

SITUATION	Medication interchange from IV to PO route appears low compared to other organizations in the region.
BACKGROUND	• Purpose: To convert drug therapy from IV to oral or feeding tube route on medications with ~100% bioavailability when appropriate per hospital approved procedure. • Benefits: - Easier and less time consuming for the nurse to administer - Oral drug administration demonstrates decreased morbidity than IV - Potential for discharging patient from the hospital sooner on appropriate medications - Oral drug formulation is less expensive than IV
ASSESSMENT	• Organization not utilizing the IV to PO interchange procedure consistently • Many opportunities missed by pharmacy due to: - Vigilance software not alerting on potential interchanges - Pharmacists not prioritizing opportunities - Physician/nursing requesting IV route when not necessary
RECOMMENDATION	• Reeducate the pharmacists on importance of route interchange • Monitor for compliance • Provide feedback to the team on successes and opportunities • Track interventions and savings to demonstrate importance

IV to PO Interchange

Medication	CY22 QTR1	CY22 QTR2	CY22 QTR3	CY22 QTR4	CY23 QTR1
Azithromycin	225	166	194	216	271
Cost Saving	$33,300	$24,568	$28,712	$31,968	$40,108
Pantoprazole	69	130	123	78	39
Cost Saving	$10,212	$19,240	$18,204	$11,544	$5,772
Famotidine	0	116	409	301	247
Cost Saving	$0	$17,168	$60,532	$44,548	$36,556
Metronidazole	22	90	113	123	77
Cost Saving	$3,256	$13,320	$16,724	$18,204	$11,396
Doxycycline	9	14	16	32	27
Cost Saving	$1,332	$2,072	$2,368	$4,736	$3,996
Fluconazole	15	4	9	7	3
Cost Saving	$2,220	$592	$1,332	$1,036	$444
Lacosamide	16	3	7	8	3
Cost Saving	$2,368	$444	$1,036	$1,184	$444
Levetiracetam	7	68	55	47	32
Cost Saving	$1,036	$10,064	$8,140	$6,956	$4,736
Quinolones	42	34	59	47	19
Cost Saving	$6,216	$4,996	$8,732	$6,956	$2,812
Thiamine	25	41	65	34	29
Cost Saving	$3,700	$6,068	$9,620	$5,032	$4,292
Linezolid	0	2	2	0	0
Cost Saving	$0	$296	$296	$0	$0
Total Interventions	430	591	1,052	893	747
Total Cost Savings	$63,640	$87,468	$155,696	$132,164	$110,556

IV to PO Therapeutic Interchange

- Success
  - Averaging 250 IV to PO interventions monthly
    - Doubling from baseline
    - $37,000 in cost savings*
  - 98% physician acceptance rate
- Moving Forward
  - Add additional medications to the interchange procedure pending medical approval
  - Proactive interventions

*Cost savings based on $148 cost avoidance per intervention: Cost Savings Associated With Pharmacy Student Interventions During APPEs, doi: 10.5688/ajpe78471

Medication Reconciliation

SITUATION	Obtaining accurate medication histories on patients admitted to the hospital is time intensive increasing the burden on both the nurse and physician.
BACKGROUND	Prior to the COVID-19 pandemic, the pharmacy department employed seven full time Medication Intake Coordinators (MIC) to obtain medication histories on patients being admitted to the hospital facilities. During the pandemic this program was downsized to two and one-half MICs requiring nursing and physicians to obtain the information.
ASSESSMENT	• MICs decrease the burden on the nurse and physician when obtaining the medication history • MICs have shown to obtain accurate medication history documentation • See spreadsheet next two slides
RECOMMENDATION	• Continue to monitor completion of medication histories districtwide • Potentially increase the coverage to two shifts daily at Escondido

Medication Intake Coordinator (MIC) Medication History

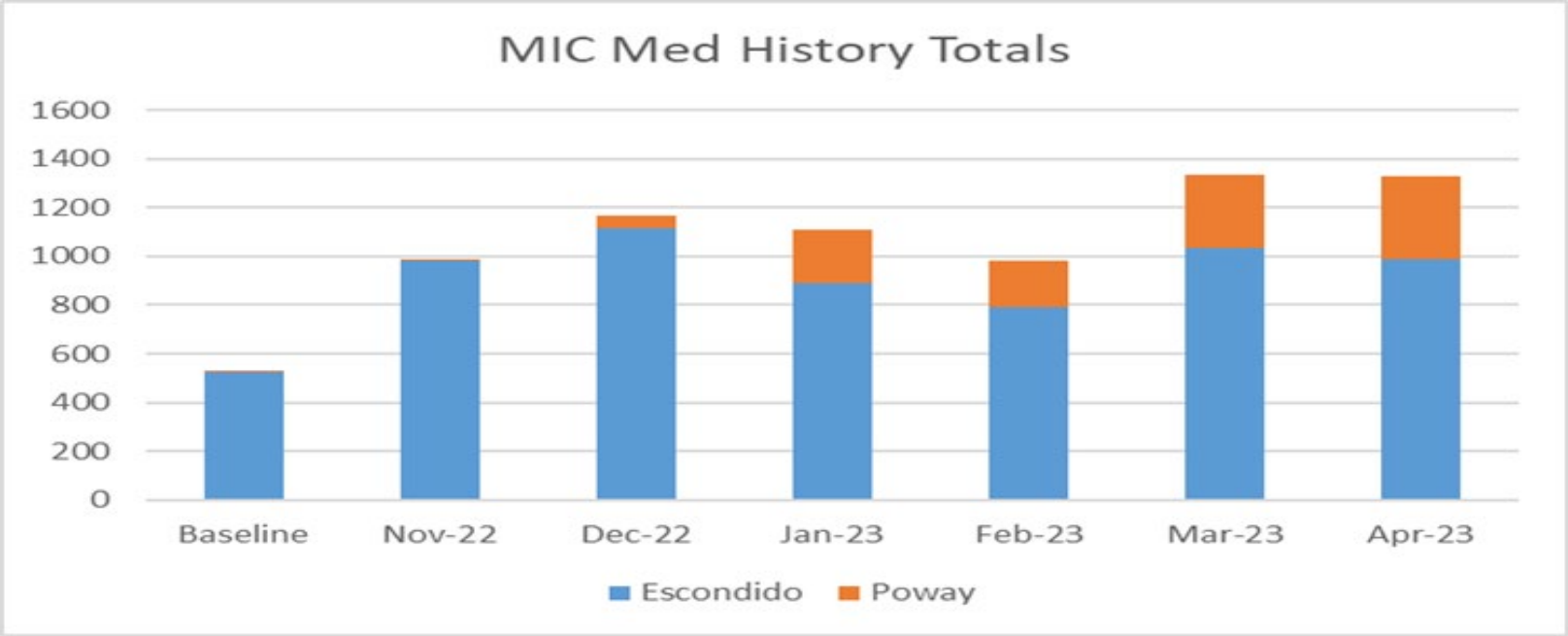
PMCE Electronic Medication Reconciliation	Jun-22		Nov-22		Dec-22		Jan-23		Feb-23		Mar-23		Apr-23	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Inpatient Encounters	2,167		2,415		2,425		2,406		2,218		2,350		2,114	
Medication History Complete	**1,741**	**80.3%**	**2,167**	**89.7%**	**2,226**	**91.8%**	**2,130**	**88.5%**	**1,967**	**88.7%**	**2,126**	**90.5%**	**1,890**	**89.4%**
Completed by MIC	*485*	*27.9%*	*905*	*41.8%*	*1,056*	*47.4%*	*809*	*38.0%*	*737*	*37.5%*	*923*	*43.4%*	*877*	*46.4%*
Completed by non-MIC	*1,256*	*72.1%*	*1,262*	*58.2%*	*1,170*	*52.6%*	*1,321*	*62.0%*	*1,230*	*62.5%*	*1,203*	*56.6%*	*1,013*	*53.6%*
Admission Medication Reconciliation Completed	**1,223**	**56.4%**	**1,428**	**59.1%**	**1,369**	**56.5%**	**1,252**	**52.0%**	**1,313**	**59.2%**	**1,381**	**58.8%**	**1,202**	**56.9%**
Admission Med Rec Completed within 24 Hours	**736**	**34.0%**	**782**	**32.4%**	**757**	**31.2%**	**774**	**32.2%**	**769**	**34.7%**	**790**	**33.6%**	**724**	**34.2%**
Discharge Medication Reconciliation Completed	**1,964**	**90.6%**	**2,250**	**93.2%**	**2,239**	**92.3%**	**2,255**	**93.7%**	**2,074**	**93.5%**	**2,210**	**94.0%**	**1,966**	**93.0%**
All Patients	10,058		10,914		10,354		10,378		9,659		10,745		10,105	
Medication History Complete	**2,280**	**22.7%**	**2,746**	**25.2%**	**2,760**	**26.7%**	**2,746**	**26.5%**	**2,501**	**25.9%**	**2,759**	**25.7%**	**2,479**	**24.5%**
Completed by MIC	*527*	*23.1%*	*984*	*35.8%*	*1,112*	*40.3%*	*891*	*32.4%*	*790*	*31.6%*	*1,035*	*37.5%*	*987*	*39.8%*
Completed by non-MIC	*1,753*	*76.9%*	*1,762*	*64.2%*	*1,648*	*59.7%*	*1,855*	*67.6%*	*1,711*	*68.4%*	*1,724*	*62.5%*	*1,492*	*60.2%*

PMCP Electronic Medication Reconciliation	Nov-22		Nov-22		Dec-22		Jan-23		Feb-23		Mar-23		Apr-23	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Inpatient Encounters	537		603		604		563		535		557		555	
Medication History Complete	**396**	**73.7%**	**464**	**76.9%**	**493**	**81.6%**	**498**	**88.5%**	**463**	**86.5%**	**514**	**92.3%**	**524**	**94.4%**
Completed by MIC	*0*	*0.0%*	*5*	*1.1%*	*51*	*10.3%*	*178*	*35.7%*	*168*	*36.3%*	*241*	*46.9%*	*273*	*52.1%*
Completed by non-MIC	*396*	*100.0%*	*459*	*98.9%*	*442*	*89.7%*	*320*	*54.3%*	*295*	*63.7%*	*273*	*53.1%*	*251*	*47.9%*
Admission Medication Reconciliation Completed	**288**	**53.6%**	**368**	**61.0%**	**355**	**58.8%**	**376**	**66.8%**	**343**	**64.1%**	**420**	**75.4%**	**410**	**73.9%**
Admission Med Rec Completed within 24 Hours	**212**	**39.5%**	**281**	**46.6%**	**273**	**45.2%**	**290**	**51.5%**	**268**	**50.1%**	**304**	**54.6%**	**317**	**57.1%**
Discharge Medication Reconciliation Completed	**442**	**82.3%**	**530**	**87.9%**	**532**	**88.1%**	**507**	**90.1%**	**470**	**87.9%**	**489**	**87.9%**	**503**	**90.6%**
All Patients	3655		3954		3792		3657		3493		3799		3637	
Medication History Complete	**819**	**22.4%**	**903**	**22.8%**	**929**	**24.5%**	**914**	**25.0%**	**884**	**25.3%**	**997**	**26.2%**	**877**	**24.1%**
Completed by MIC	*1*	*0.1%*	*5*	*0.6%*	*52*	*5.6%*	*219*	*24.0%*	*189*	*21.4%*	*302*	*30.3%*	*343*	*39.1%*
Completed by non-MIC	*818*	*99.9%*	*898*	*99.4%*	*877*	*94.4%*	*695*	*76.0%*	*695*	*78.6%*	*695*	*69.7%*	*534*	*60.9%*

PMCE RN in Women's Health complete ~ 500 medication histories/month

PMCP RN in Women's Health complete ~ 100 medication histories/month

MIC Medication History



Medication History Overview

- Districtwide number of medication histories obtained by MICs increased over baseline by 2.5x
  - June 2022 – 528
  - April 2023 – 1,330
- Inpatient Medication History Totals
  - PMC Escondido increased by 9.1%
  - PMC Poway increased by 20.7%

PALOMAR HEALTH

ADDENDUM H

Discharge Planning and Patient Throughput

Presented to
Board Quality Review Committee

Ryan Fearn-Gomez, District Director, Clinical Operations
Debora Bitzer, Interim Director, Clinical Resource Management
July, 2023

Discharge Planning & Patient Throughput

SITUATION	YTD (July 22 – May 23) overall LOS 4.44 days to budgeted 4.46 days Manage anticipated COVID and other complicated discharges. FYTD LOS: **PMC Escondido** 4.45 / Budgeted 4.34 **PMC Poway** 4.39 / Budgeted 4.88
BACKGROUND	Throughput and DC planning are strategic initiatives for FY2023
ASSESSMENT	**Discharge Planning Challenges:** • Health Plans authorization processes causing Discharge delays • Several patients with limited to no funding (uninsured / Restricted Medical) • Few SNFs with Custodial Beds • Homelessness/ Drug and Alcohol Abuse • Lack of social support and financial resources • Legal challenges (Conservatorship etc.) • PMC Escondido discharge lounge utilization has increased/remained consistent the last five months at both campuses **Patient Throughput:** • Emergency Department volumes continue to increase at both campuses • COVID+ inpatient volume has remained low throughout the district • New Capacity Management Plan rollout and utilization of Code Alpha and Code Delta alerts has allowed for greater collaboration throughout the district to improve patient flow and throughput. • 2 Floor Overflow Unit (201 – 208) is being used for Med/Surg inpatients during high volume periods • Continue coordination with Women's Services to utilize Tele beds on 9E when available • Poway MST3 opened 18 additional Telemetry beds February 2023
RECOMMENDATION	**Discharge Planning** • Discharge lounges up and running at both campuses. • Working on contract for SNF leased beds for difficult to place patients. • Leverage messaging network to preferred SNF partners regarding bed capacity situation. **Patient Throughput** • Engaged with transfer center workgroup to refine and maximize intra-facility transfers between PMCE & PMCP • Inpatient leaders will identify patients that are appropriate for the discharge lounge each morning and also review pending admissions targeted to their units, entering comments into TeleTracking to ensure appropriate placement • ED/Clinical Operations team to review potential inpatient hold discharges with Dr. Fadhil at MDR meeting • Physician notification during/post Code Delta initiation – (Dr. Khal and Dr. Harrison) • Pro-active approach to Capacity Management. Communication and collaboration between the ED, Clinical Ops, Inpatient Units, Case Management, and ancillary departments will be proactive and focused on early patient movement and discharges

Emergency Department Volume

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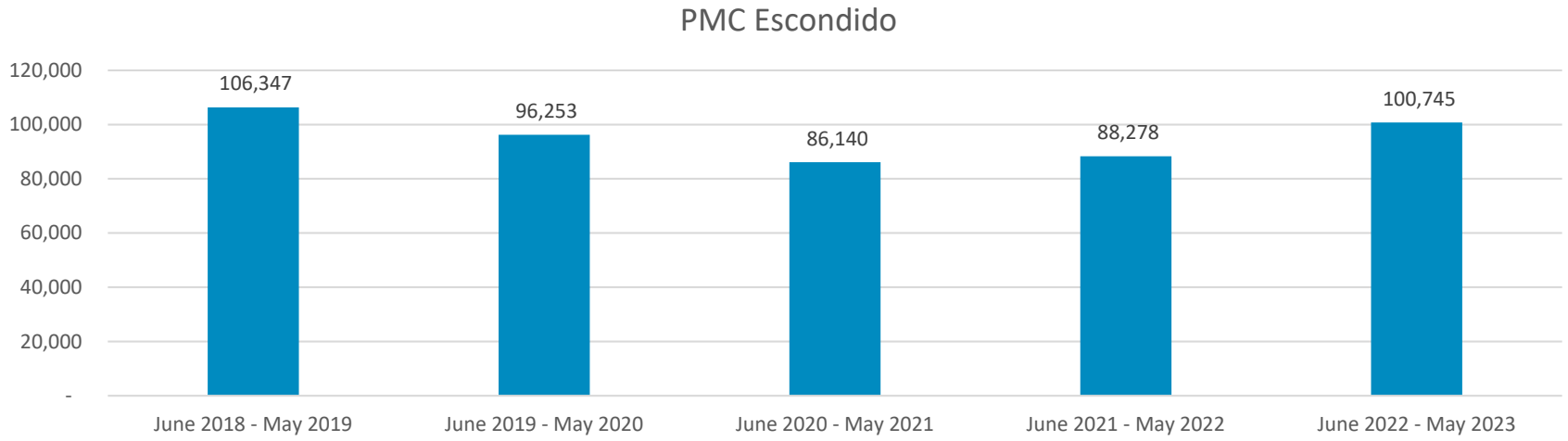

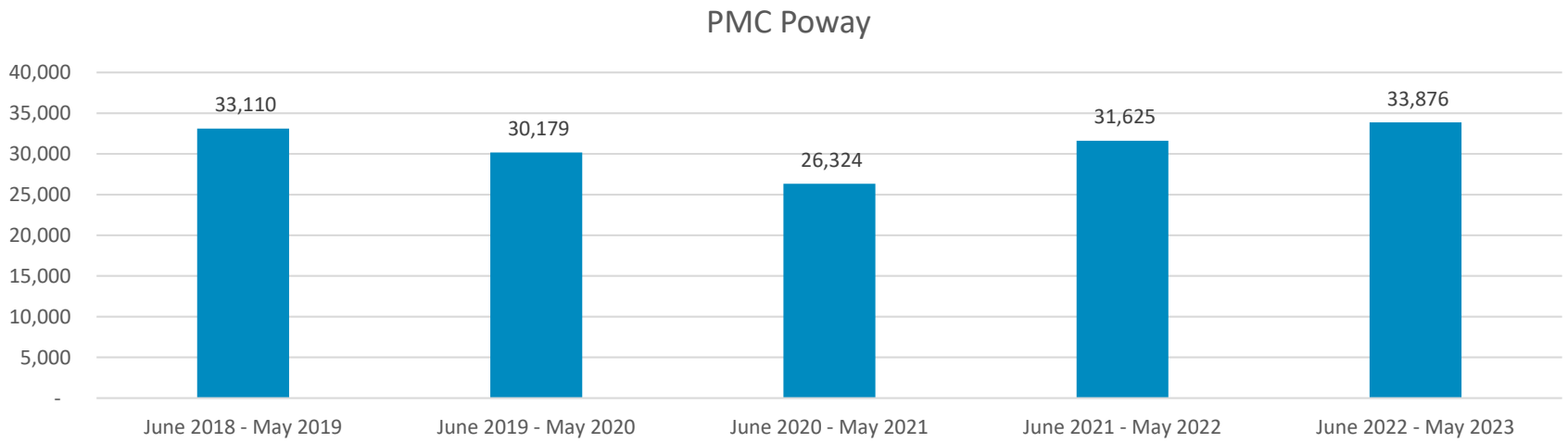

* March 19, 2020 Gov. Gavin Newsom declared a stay-at-home order for all of California

Intra-Facility Transfers

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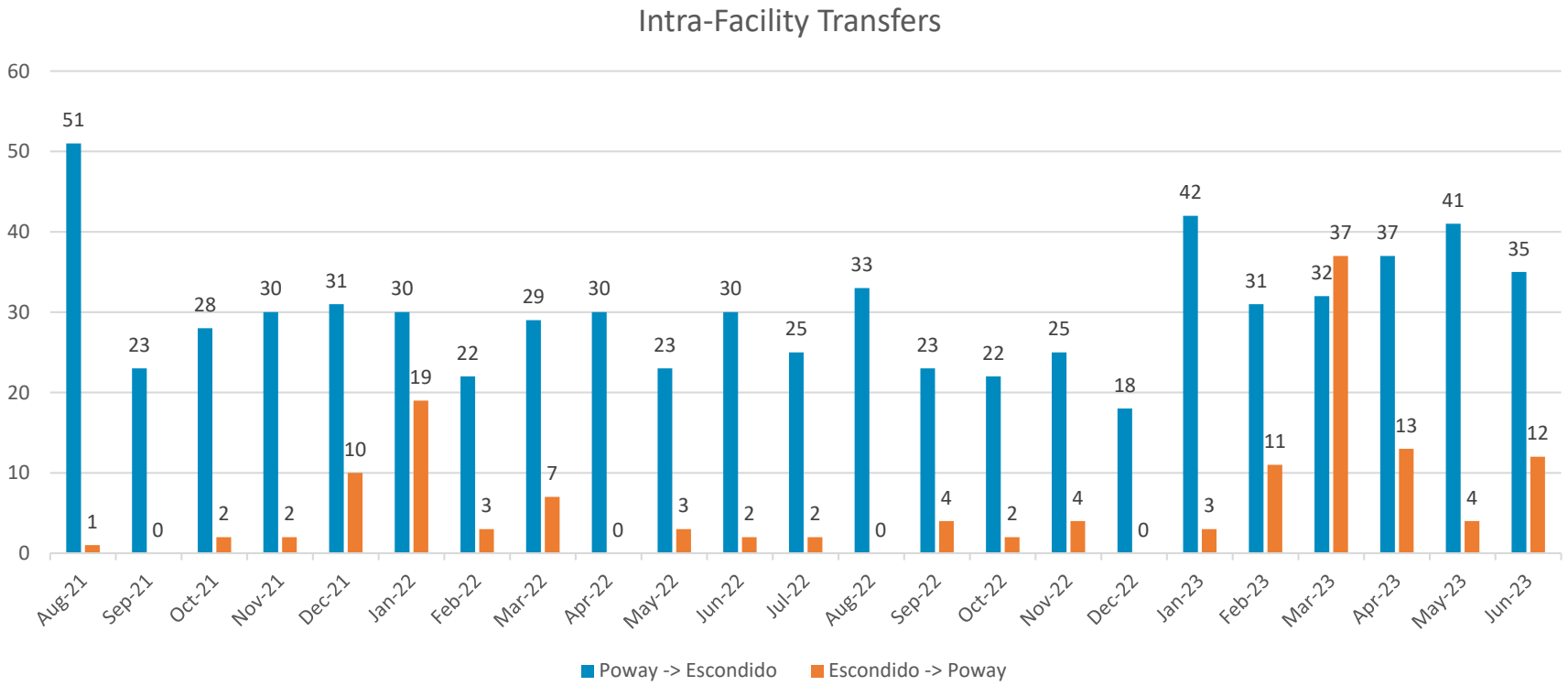

June 2023 = June 1, 2023 – June 26, 2023

- Transfer Center Process workgroup to include: Clinical Ops, Case Management, ED Nursing and Physician leadership, Hospitalists to maximize Intra-Facility Transfers
- Patient Placement updates the FirstNet ED Dashboard with available beds at each campus

Capacity Management Plan

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- Capacity Management Plan (*Lucidoc: 68712*)
  - Multi-layered solution to maintain throughput during high census times and address overcrowding at Palomar Health

- NEDOCS (National Emergency Department Overcrowding Scale)

- Elevated Capacity Alert Levels:
  - Alpha
  - Delta
  - Code Triage (Internal/External Disaster, Mass Casualty, CBRNE, etc.)

- **Go Live: August 15, 2022**

- iXpand Module – Capacity Management Plan and Discharge Lounge

- Added 50+ hospitalists to Everbridge notification – 1/11/2023

- Added PMC Poway specific criteria for Code Alpha and Code Delta – approved by MEC March 2023

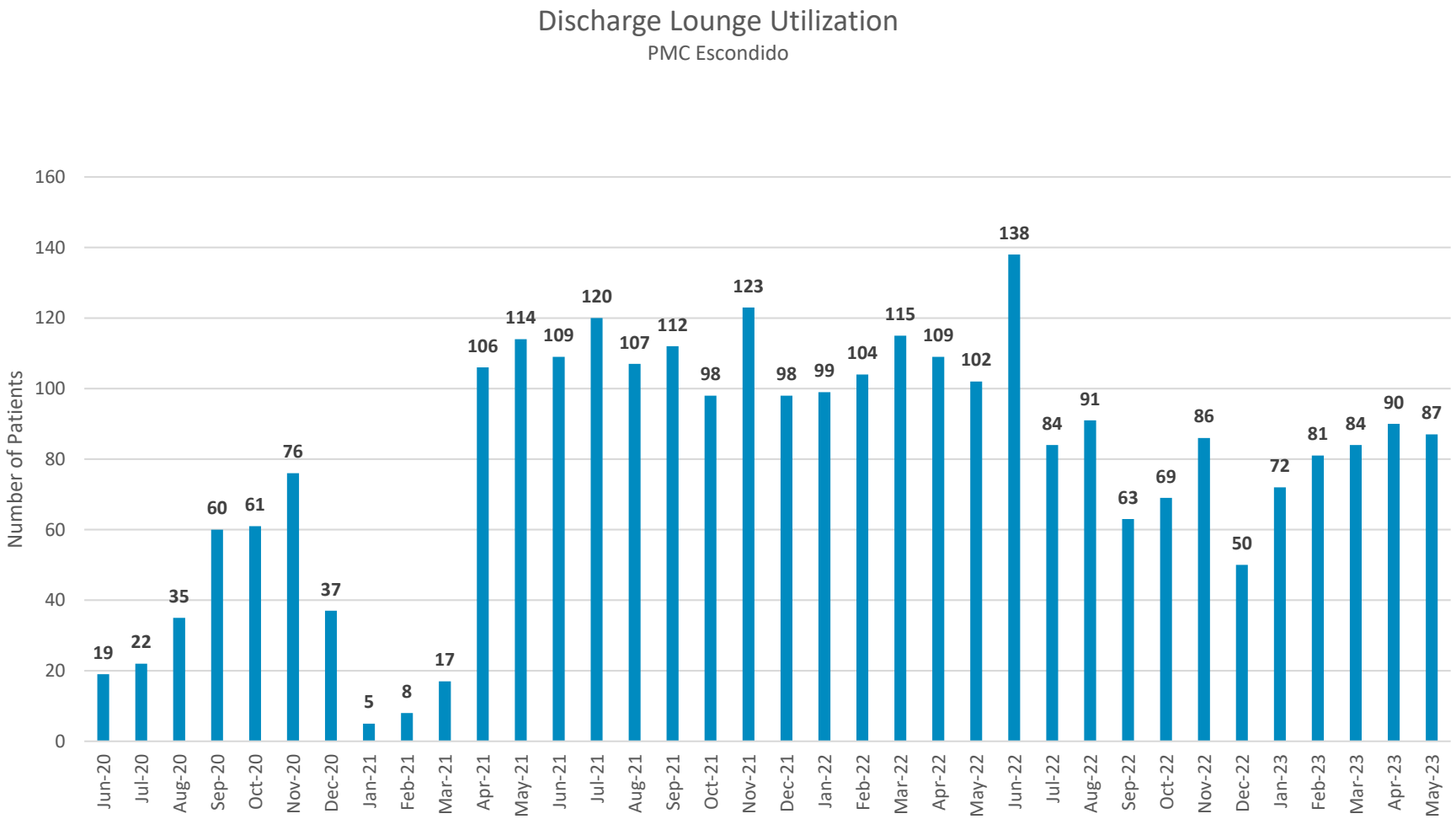
Discharge Lounge

Discharge Lounge was implemented at both Escondido and Poway campuses as a potential mechanism to mitigate Emergency Department boarding and crowding. The goal is to provide a space for patients that are medically ready for discharge but waiting for transportation. By facilitating earlier discharge and opening beds on inpatient floors, the lounge aims to improve patient flow and decompress the ED. Patient eligibility for the lounge is based on the following criteria:

- Discharge order to home or other facility
- All conditions met for discharge
- Planned transportation has been arranged
- No form of isolation
- No high acuity patient care needs

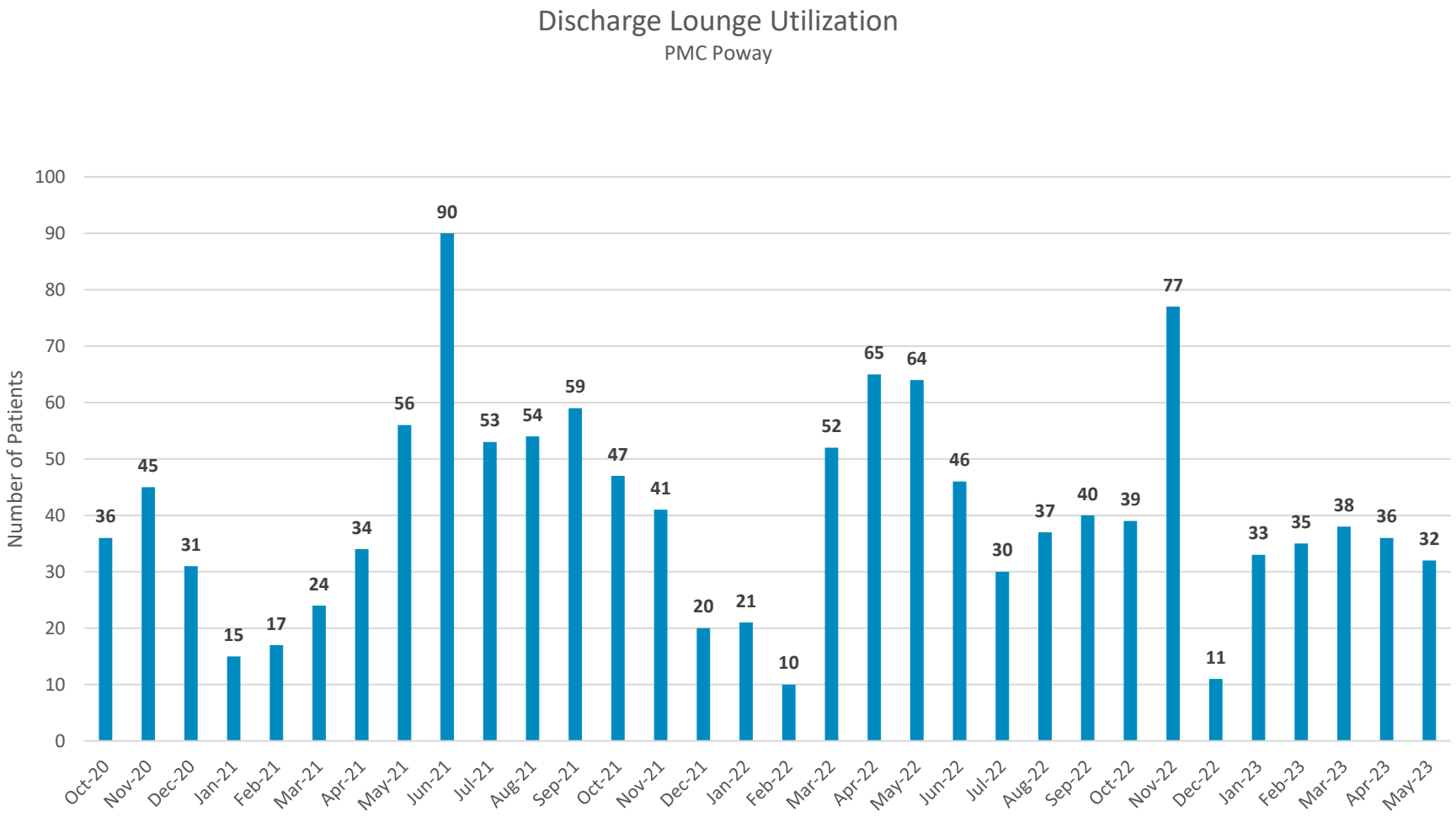
Discharge Lounge Utilization

PMC Escondido



Discharge Lounge Utilization

PMC Poway



Avoidable Days

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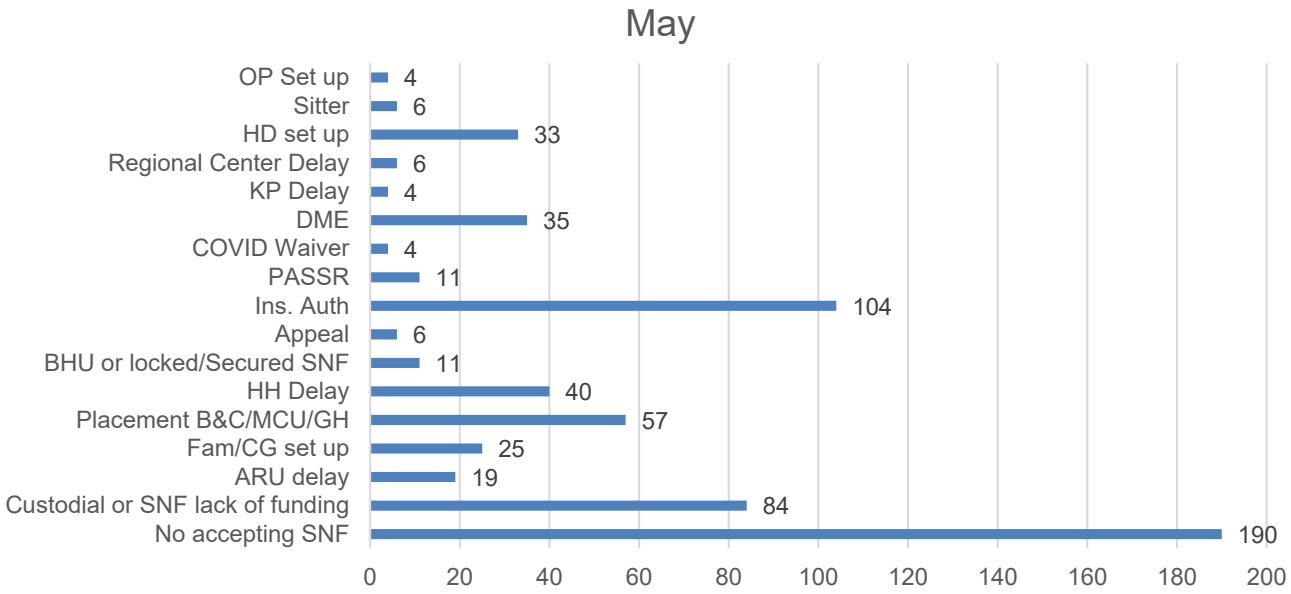
Avoidable Days are any delay in the patient's progression of care and/or discharge that have led to resource consumption without medical necessity. These occur when patients who are medically ready for discharge are kept longer than necessary in the hospital. These days are categorized by reason and attribution some of which are related to the loss of the COVID waiver.



Average Length of Stay

Average Length of Stay (ALOS) refers to the number of days patients spend in hospital. It is an indicator of efficiency in health service delivery. Shorter stays will reduce the cost per discharge shifting care from inpatient to less expensive settings. Longer stays can be a sign of poor coordination of care resulting on some cases waiting unnecessarily in the hospital until other arrangements can be made.

According to AHA, the ALOS has increased 19% in 2022 compared to 2019. This is due to patients being sicker and requiring more complex and intensive care as compared to pre-pandemic levels.

The benchmark ALOS for hospitalization is 5 ½ days

Average Length of Stay

Things impacting ALOS include continued medical care such as physical therapy, surgical interventions, and oncology treatments. Non-medical reasons can be attributed to staffing, delays in securing equipment (DME) or waiting for a lower level of care bed or community hemodialysis chair to be available.

Other challenges are related to the increased length of time in working with insurance companies to obtain authorization.

Average Length of Stay

ALOS Trend - Excluding OB

By Facility

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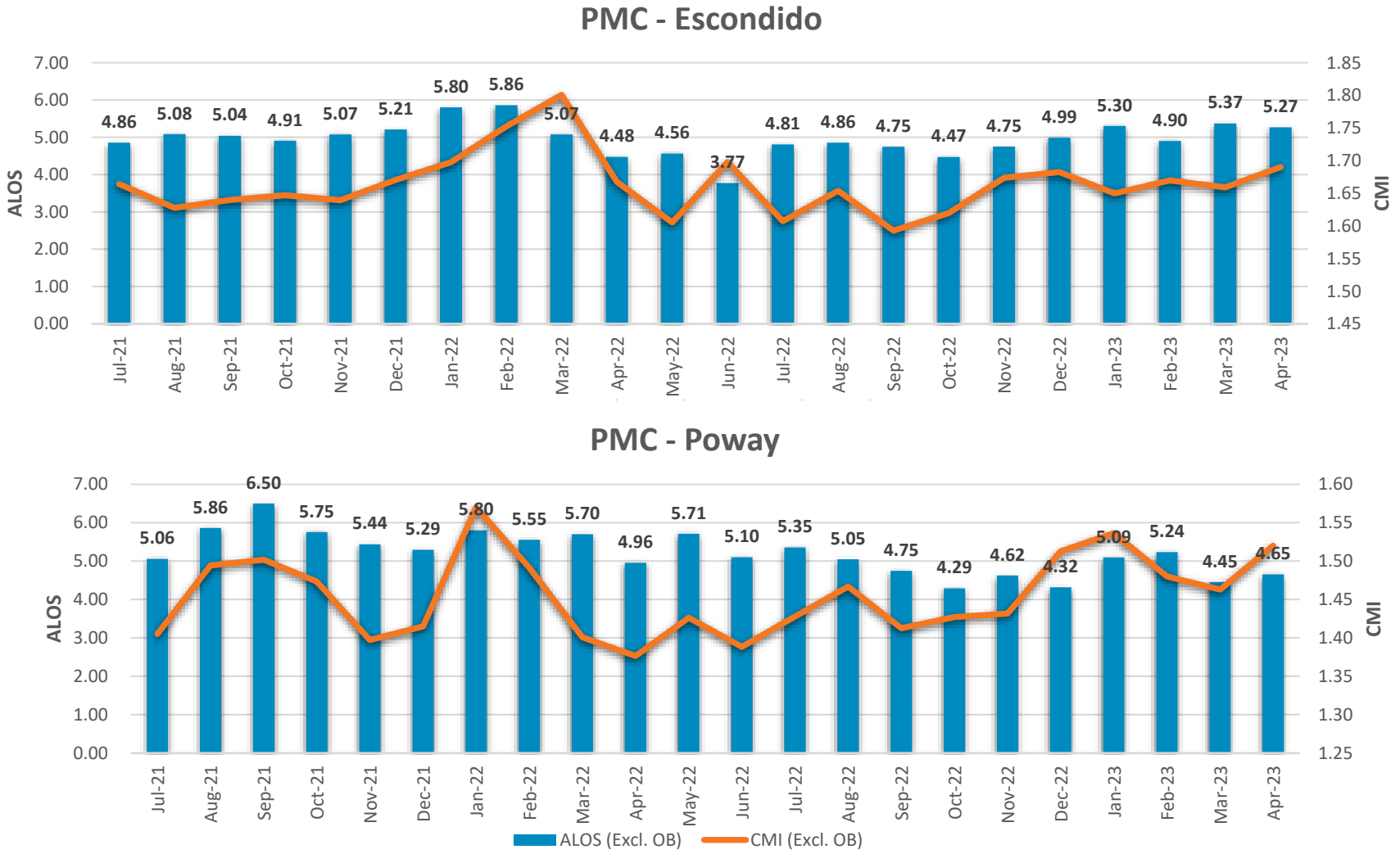
Note: Data represents all Palomar Health Inpatient encounters

	FY22												FYTD23									
Location	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**	**May-22**	**Jun-22**	**Jul-22**	**Aug-22**	**Sep-22**	**Oct-22**	**Nov-22**	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**Apr-23**
PMC - Escondido																						
Patient Days	6,478	6,694	6,282	6,035	5,983	6,399	7,381	6,564	6,374	5,451	5,481	5,558	5,966	6,114	5,805	5,694	6,310	7,111	7,233	6,159	7,021	6,550
Avg Daily Census	**209**	**216**	**209**	**195**	**199**	**206**	**238**	**234**	**206**	**182**	**177**	**185**	**192**	**197**	**194**	**184**	**210**	**229**	**233**	**220**	**226**	**218**
Discharges	1,334	1,317	1,246	1,230	1,179	1,228	1,272	1,120	1,256	1,218	1,201	1,473	1,241	1,259	1,223	1,273	1,329	1,426	1,364	1,257	1,307	1,244
ALOS (Excl. OB)	**4.86**	**5.08**	**5.04**	**4.91**	**5.07**	**5.21**	**5.80**	**5.86**	**5.07**	**4.48**	**4.56**	**3.77**	**4.81**	**4.86**	**4.75**	**4.47**	**4.75**	**4.99**	**5.30**	**4.90**	**5.37**	**5.27**
CMI (Excl. OB)	1.66	1.63	1.64	1.65	1.64	1.67	1.70	1.75	1.80	1.67	1.61	1.70	1.61	1.65	1.59	1.62	1.67	1.68	1.65	1.67	1.66	1.69
PMC - Poway																						
Patient Days	2,109	2,408	2,326	2,181	2,207	2,223	2,332	2,105	2,074	2,037	1,902	2,131	2,045	1,948	1,685	1,557	1,651	1,817	1,900	1,691	1,749	1,778
Avg Daily Census	**68**	**78**	**78**	**70**	**74**	**72**	**75**	**75**	**67**	**68**	**61**	**71**	**66**	**63**	**56**	**50**	**55**	**59**	**61**	**60**	**56**	**59**
Discharges	417	411	358	379	406	420	402	379	364	411	333	418	382	386	355	363	357	421	373	323	393	382
ALOS (Excl. OB)	**5.06**	**5.86**	**6.50**	**5.75**	**5.44**	**5.29**	**5.80**	**5.55**	**5.70**	**4.96**	**5.71**	**5.10**	**5.35**	**5.05**	**4.75**	**4.29**	**4.62**	**4.32**	**5.09**	**5.24**	**4.45**	**4.65**
CMI (Excl. OB)	1.41	1.49	1.50	1.47	1.40	1.41	1.57	1.49	1.40	1.38	1.43	1.39	1.43	1.47	1.41	1.43	1.43	1.51	1.54	1.48	1.46	1.52
District Total																						
Patient Days	8,587	9,102	8,608	8,216	8,190	8,622	9,713	8,669	8,448	7,488	7,383	7,689	8,011	8,062	7,490	7,251	7,961	8,928	9,133	7,850	8,770	8,328
Avg Daily Census	**277**	**294**	**287**	**265**	**273**	**278**	**313**	**310**	**273**	**250**	**238**	**256**	**258**	**260**	**250**	**234**	**265**	**288**	**295**	**280**	**283**	**278**
Discharges	1,751	1,728	1,604	1,609	1,585	1,648	1,674	1,499	1,620	1,629	1,534	1,891	1,623	1,645	1,578	1,636	1,686	1,847	1,737	1,580	1,700	1,626
ALOS (Excl. OB)	**4.90**	**5.27**	**5.37**	**5.11**	**5.17**	**5.23**	**5.80**	**5.78**	**5.21**	**4.60**	**4.81**	**4.07**	**4.94**	**4.90**	**4.75**	**4.43**	**4.72**	**4.83**	**5.26**	**4.97**	**5.16**	**5.12**
CMI (Excl. OB)	1.61	1.60	1.61	1.61	1.58	1.61	1.67	1.69	1.71	1.60	1.57	1.63	1.57	1.61	1.56	1.58	1.62	1.65	1.63	1.63	1.62	1.66

Average Length of Stay

Palomar Health



PALOMAR HEALTH

ADDENDUM 1

Rehabilitation Services

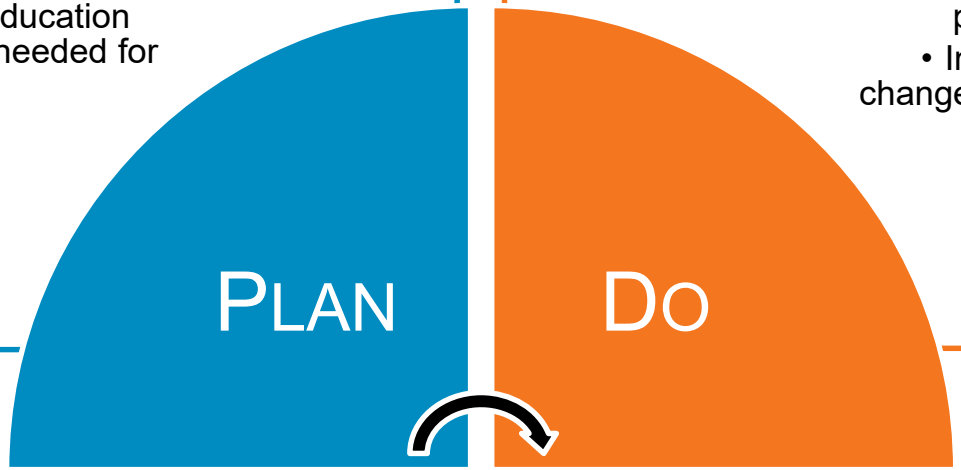
Board Quality Review Committee

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

Tyler Powell, DPT, MBA, CEAS
Director of Rehabilitation Services

July 26, 2023

Rehabilitation Services



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

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

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

- Ongoing review and audits to check compliance with new processes

Data - Rehabilitation Services

	INDICATORS	PALOMAR HEALTH	BENCHMARK
Acute Care Inpatient Rehab Services	Access to Acute Care (PT/OT/ST)	10.2 patients triaged/day	<2.6 patients triaged/day
Outpatient Rehab Services	Access to Care	8.6 days	<5 days
	Cancellation/No Show Rate	8.6 %	<15 %
	Average Length of Stay	10.37 days	<12 days
The Villas Rehab Services	% Discharge to Home	77.1 %	=>70%
	Average Length of Stay	FY 23 14.9 days (Updated benchmark to previous year total)	Palomar FY22 15.73 days

Inpatient/Outpatient Rehabilitation Services – Access to Care

SITUATION	Outpatient Rehab = 8.6 days (Benchmark < 5 days) Inpatient = 10.2 patients triaged/day (Benchmark <2.6 days)
BACKGROUND	The established Access to Care benchmark in our outpatient setting is utilized to ensure our patients are being seen in a timely manner after receipt of a referral for care. The triage rate in inpatient is utilized to assist in showing our full hospital coverage for PT/OT/ST. This data allows management the opportunity to address trends negatively affecting access to care for both inpatient and outpatient rehabilitation.
ASSESSMENT	Factors impacting access to care are as follows: 1. New admin staff in outpatient rehabilitation inputting data which did not include appointment reschedules to sooner date impacting data. 2. Increased inpatient/outpatient referrals outweighing staff availability and creating temporary impact to wait time/triage rate., 3. Outpatient referral sources with less staff leading to delays in response 4. Implementation of unit rounds and safe patient handling program require additional inpatient rehabilitation staffing.
RECOMMENDATION	1) Regular meetings/communication with HR to review open positions 2) Ensure accurate data entry to decrease outliers. 3) Cross training of staff to take advantage of new location. 4) Communication and process optimization with frequent referral sources to expedite any delays.

FY24 Action Plan - Rehabilitation Services

Palomar Medical Center Escondido & Poway – Acute Care

- Continued support multidisciplinary rounds across all units with close engagement with nursing/MDs/Case Management to streamline throughput
- Initiate early mobility with appropriate patients to assist in recovery
- Further support the hospital safe patient handling needs to increase safety of patients and decrease employee injuries.
- Ensure consistent staffing to minimize triage rate to provide high quality of care and to increase throughput.

Skilled Nursing Rehab

- Onboard clinical staff to continue to ensure full rehabilitation services available daily.
- Assess opportunities for specialty programs for subacute
- Partner with outpatient CHT for increase quality of splinting.

FY24 Action Plan - Rehabilitation Services

Outpatient Rehabilitation Escondido & Poway

- Further collaborate and grow with the full continuum of care as outpatient rehabilitation services are now both strategically located in a shared building with high referring physicians and across the way from PHRI and Cancer Institute.
- Increase growth in niche services for neurologic, oncology, hand therapy, lymphedema, and pelvic floor for greater diversification.
- Resumption of extensive community based education/marketing offerings partnering with other service lines.
- Further integrate IT for ease of referrals across the continuum.

FY24 Action Plan - Rehabilitation Services

District Wide

- Hire and support staff to obtain advanced certification completion to provide internal growth, increase quality of care, and further advance our niche services.
- Reassess and further optimize Safe Patient Handling courses to ensure initial/annual training are provided to all clinical staff across the hospital.
- Partnership with Employee Health for ergonomic injury prevention programs across our hospital system and Palomar Health Medical Group.
- Partner with InnoVision in marketing efforts for new outpatient service location.
- Optimize process flow through Cerner updates to streamline services and increase timeliness in workflow.
- Support MDR rounds to assist with timely throughput.
- Optimize staffing across the rehabilitation department and minimize time open positions are posted.
- Further program growth with orthopedic partnership within Inpatient, Skilled Nursing, and Outpatient services in Poway for Joint Commission Advanced Orthopedic Certification.