Posted
FRIDAY
MARCH 22, 2024

PALOMAR HEALTH

BOARD QUALITY REVIEW COMMITTEE MEETING
AGENDA

Wednesday, March 27, 2024
3:30pm 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 Start
CALL TO ORDER				**3:30**
1.	**Establishment of Quorum**	5	-	3:30
2.	**Public Comments**[1]	30	-	3:35
3.	**Action Item(s)**			
	a. *Minutes: Board Quality Review Committee Meeting – January 24, 2024 (ADD A – Pp 13)	5	7	4:05
	b. *Approval of Contracted Services *Valerie Martinez, Sr. Director, Quality, Patient Safety & Infection Prevention* a) Premier Laser Services (ADD B – Pp 17)	5	8	4:10
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	-	4:15
5.	**New Business**			
	a. Emergency Medicine Annual Update (ADD C – Pp 19) *Tracy Page, DNP, RN, PHN, Emergency Dept Director* *Nicholle Bromley, MD, Medical Director*	5	9	4:25
	b. Trauma Program Annual Update (ADD D – Pp 34) *Melinda Case, MSN, TCRN, Trauma Program Director* *John T. Steele, MD, Medical Director*	5	10	4:30
	c. Respiratory Services Annual Update (ADD E – Pp 50) *Valerie Martinez, BSN, MHA, Sr. Dir, Quality/Patient Safety/Respiratory Services* *Frank Bender, MD, Medical Director*	5	11	4:35
	d. Stroke Program Annual Update (ADD F – Pp 60) *Lourdes Januszewicz, MSN, APRN, Stroke Program Coordinator* *Remia Paduga, MD, Medical Director*	5	12	4:40
6.	**Adjournment to Closed Session**	1	-	4:45
	Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee	10	-	4:55
7.	**Adjournment to Open Session**	1	-	5:05
8.	**Action Resulting from Executive Session**	1	-	5:06
FINAL ADJOURNMENT		2	-	5:07

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	**Melissa Wallace**, **MPH,** Interim 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.*

PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE

Join on your computer, mobile app or room device

Click here to join the meeting
Meeting ID: 273 911 668 238
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PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM

Board Quality Review Committee Location Options

- Elected members of the Board of Directors will be attending the meeting virtually from the locations below. Members of the public may also attend at the location below :

The Linda Greer Conference Room

2125 Citracado Parkway, Suite 300, Escondido, CA 92029

- PLEASE TURN OFF CELL PHONES OR SET THEM TO SILENT MODE UPON ENTERING THE MEETING ROOM.

Click here to join the meeting

Meeting ID: 273 911 668 238
Passcode: SB8QEw

Download Teams | Join on the web

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+1 929-352-2216,,67809109# United States, New York City

Phone Conference ID: 678 091 09#

Find a local number | Reset PIN

Learn More | Meeting options

- 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 3:30p.m.

Request for Public Comments

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

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

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

Public Comments Process

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

PALOMAR HEALTH
Reimagining Healthcare®

DocID:	21790
Revision:	9
Status:	Official

Source:	Applies to Facilities:	Applies to Departments:
Administrative Board of Directors	All Palomar Health Facilities	Board of Directors

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 additional 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.

(REFERENCED BY Public Comment Form

PALOMAR HEALTH

BOARD QUALITY REVIEW COMMITTEE MEETING
ATTENDANCE ROSTER -
CALENDAR YEAR 2024

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

VOTING MEMBERS	**1/24/2024**	**3/27/2024**					
LINDA GREER, RN, Chairperson, Board Member	P						
TERRY CORALES, RN, Board Member	P						
LAURA BARRY, Board Member	P						
ANDREW NGUYEN, MD, PhD, Chair, Medical Staff Quality Management Committee, PMC Escondido	P						
MARK GOLDSWORTHY, MD, Chair, Medical Staff Quality Management Committee, PMC Poway	P						
LAURIE EDWARDS-TATE, MS- 1ST *Board Alternate*							
STAFF ATTENDEES/NON-VOTING MEMBERS							
DIANE HANSEN, CPA, President & CEO							
OMAR KHAWAJA, MD, Chief Medical Officer	P						
MEL RUSSELL, RN, MSN, Chief Nursing Executive	P						
VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety	P						
DAVID LEE, MD, Medical Quality Officer	P						
KEVIN DEBRUIN, Esq., Chief Legal Officer	P						
SALLY VALLE – Committee Assistant	P						
INVITED GUESTS	**SEE TEXT OF MINUTES FOR NAMES OF INVITED GUESTS**						

Board Quality Review Committee Minutes
Wednesday, March 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, March 27, 2024

FROM: Sally Valle, Committee Assistant

Background: Minutes from the Wednesday, January 24, 2024, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, January 24, 2024, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Contracted Services – Premier Laser Services
Wednesday, March 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, March 27, 2024

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

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

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Annual Report – Emergency Medicine
Wednesday, March 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, March 27, 2024

FROM: Tracy Page, DNP, RN, PHN, District ED Director
Nicholle Bromley, MD, Medical Director

Background: The annual report for Emergency Medicine 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 – Trauma Services
Wednesday, March 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, March 27, 2024

FROM: Melinda Case, RN, MSN, TCRN
John Steele, MD, Medical Director

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

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:

Board Quality Review Committee
Annual Report – Respiratory Services
Wednesday, March 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, March 27, 2024

FROM: Valerie Martinez, Sr. Director, Respiratory Care, EEG, Lab
Frank Bender, MD, Medical Director

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

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:

Board Quality Review Committee
Annual Report – Stroke Program
Wednesday, March 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, March 27, 2024

FROM: Lourdes Januszewicz, MSN, APRN, ACNS-BC, SCRN
Remia Paduga, MD, Medical Director

Background: The annual report for the Stroke Program 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, JANUARY 24, 2024			
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 website on Friday, January 19, 2024, 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: Greer, Corrales, Barry, Goldsworthy, MD, Nguyen, MD			
PUBLIC COMMENT			
• There were no public comments.			
ACTION ITEMS:			
a. Minutes: Board Quality Review Committee Meeting – October 25, 2023	**MOTION:** by Director Barry, second by Director Corrales, carried to approve the meeting minutes of October 25, 2023, as submitted. Roll call voting was utilized. Director Barry – aye Director Greer – aye Director Corrales - aye All in favor. None opposed. Motion approved		
Discussion:			

b. Approval of Annual Review of Board Quality Review Committee (BQRC) Charter ○ Motion to add "Medical Quality Officer" to section II, C.	**MOTION:** by Director Barry, second by Director Corrales, carried to approve item B Board Quality Review Committee Charter, with said edits. Roll call voting was utilized. Director Barry – aye Director Greer – aye Director Corrales - aye All in favor. None opposed. Motion approved		
Discussion:			
c. Approval of Annual Review of Board Quality Review Committee (BQRC) Reporting Calendar. ○ Motion to change Board Quality Review Committee (BQRC) meeting time to 3:30p.	**MOTION:** by Director Corrales, second by Director Barry, carried to approve item C Board Quality Review Committee Reporting Calendar as presented, and changing the meeting time to 3:30p. Roll call voting was utilized. Director Barry – aye Director Corrales – aye Director Greer - aye All in favor. None opposed. Motion approved		
Discussion:			

d. Adopt Board Quality Review Committee Meeting Resolution for Calendar Year 2024	**MOTION:** by Director Barry, second by Director Corrales, carried to approve item D Board Quality Review Committee Resolution for Calendar Year 2024 as presented. Roll call voting was utilized. Director Barry – aye Director Corrales – aye Director Greer - aye All in favor. None opposed. Motion approved		
Discussion:			
e. Approval of Contracted Services I. PraxAir II. Vital Care III. Pharmerica IV. Agiliti Health Asset Management of Infusion Pumps	**MOTION:** by Director Corrales, second by Director Barry, carried to approve item E, I-IV Contracted Services as presented. Roll call voting was utilized. Director Corrales - aye Director Barry – aye Director Greer - aye Mark Goldsworthy, MD – aye Andrew Nguyen, MD - aye All in favor. None opposed. Motion approved		
Discussion:			
STANDING ITEMS:			
a. Medical Executive Committee (MEC)/Quality Management Committee (QMC) Update			
• Andrew Nguyen, MD, shared an update of the Medical Executive Committee & the Quality Management Committee, Palomar Medical Center, Poway and Palomar Medical Center, Escondido.			
NEW BUSINESS:			
a. Continuum of Care (Radiation Oncology, SNF, Women's Center, Wound Care) Annual Report			
• Tyler Powell, Director of Rehabilitation Services, presented the Continuum of Care Annual Report.			
b. Rehabilitation Services Annual Report			

- Tyler Powell, Rehabilitation Services presented the Rehabilitation Services Annual Report.

ADJOURNMENT TO CLOSED SESSION

Pursuant to California Government Code § 54962 and California Health and Safety Code § 32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee

ADJOURNMENT TO OPEN SESSION

ACTION RESULTING FROM CLOSED SESSION

- There were no action items identified in the Closed Session of the meeting.

FINAL ADJOURNMENT - The meeting adjourned at 5:00 p.m.

SIGNATURES:

COMMITTEE CHAIR

Linda Greer, RN

COMMITTEE ASSISTANT

Sally Valle

ADDENDUM B

Premier Laser Services, Inc.
Review of Contract Service

Name of Service: Premier Laser Services, Inc.

Date of Review: February 5, 2024

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

Nature of Service (describe): Surgical laser rental services used in the treatment of kidney stones and urological conditions to treat the prostate, Types of lasers and associated peripherals that can be rented include the Holmium laser. Thulium laser, Aloka Ultrasound, Shockpulse, Cyberwand, and KTP laser.

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.	√	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	√	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	√	
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.	√	
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.	√	

Performance Metrics Met and Not Met

METRIC	CY23 Q1	CY23 Q2	CY23 Q3	CY23 Q4	Cumulative Total
Equipment is clean and in good working order	100%	100%	100%	100%	100%
Laser Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%

No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%

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

Conclusion (check one)

√ Met 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

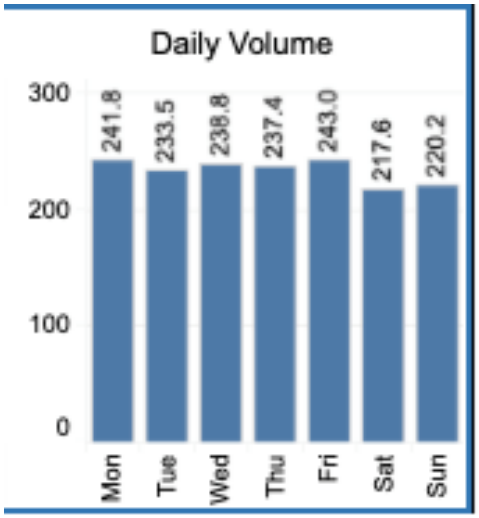
ADDENDUM C

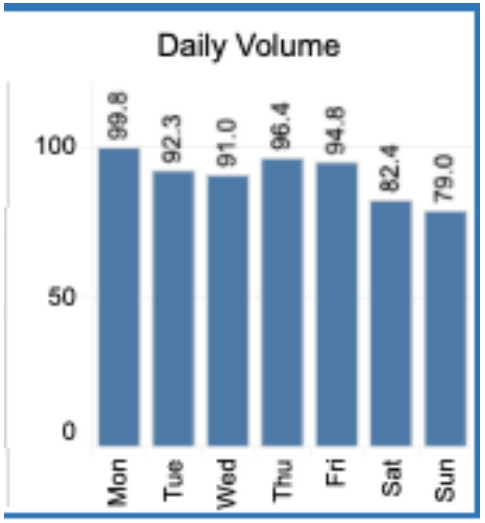
Emergency Department:
Annual Report
to
Board Quality Review Committee

Tracy Page DNP, RN, PHN District ED Director
Nicholle Bromley, MD, Medical Director
March 27, 2024

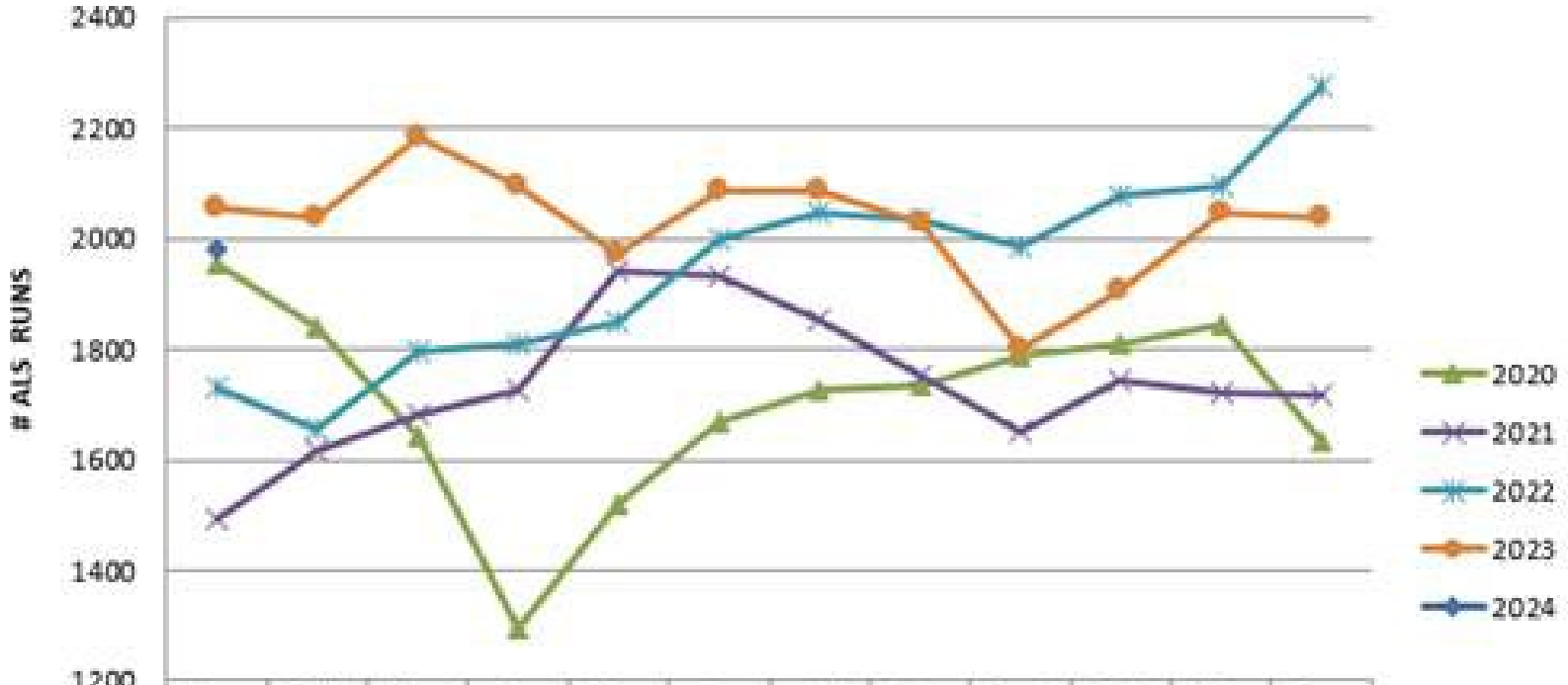
Emergency Department (ED) Volume for 2023

- Escondido – 94,523 patients
  - 259 patients/day
  - Down from 95,980 in 2022
- Poway – 33,207 patients
  - 91 patients/day
  - Up from 32,892 in 2022

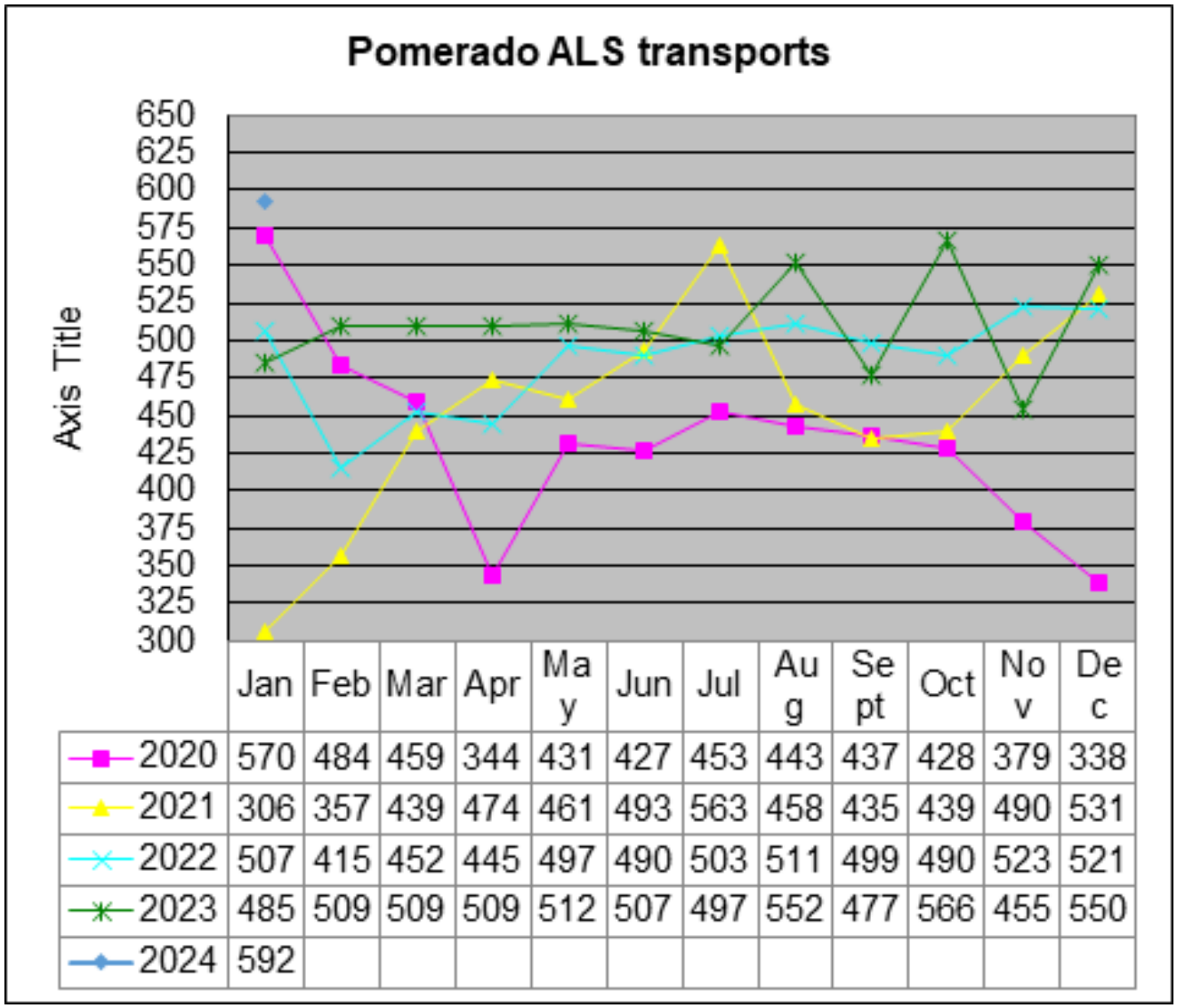




ALS Transports PMC

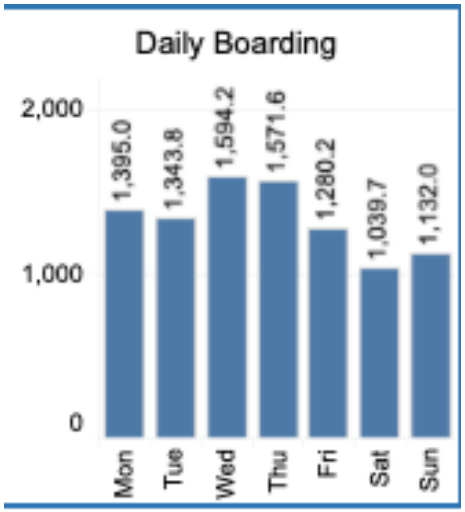


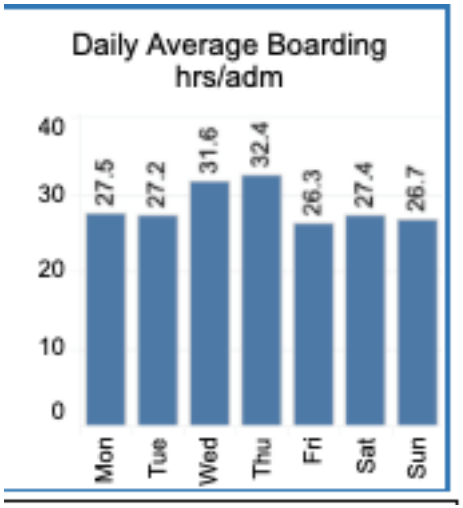
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2020	1954	1841	1644	1296	1517	1667	1726	1733	1785	1809	1842	1634
2021	1494	1617	1683	1726	1942	1930	1853	1751	1652	1744	1722	1718
2022	1728	1654	1797	1811	1847	1998	2047	2033	1984	2078	2093	2273
2023	2055	2037	2181	2093	1972	2084	2085	2031	1800	1904	2047	2037
2024	1979											



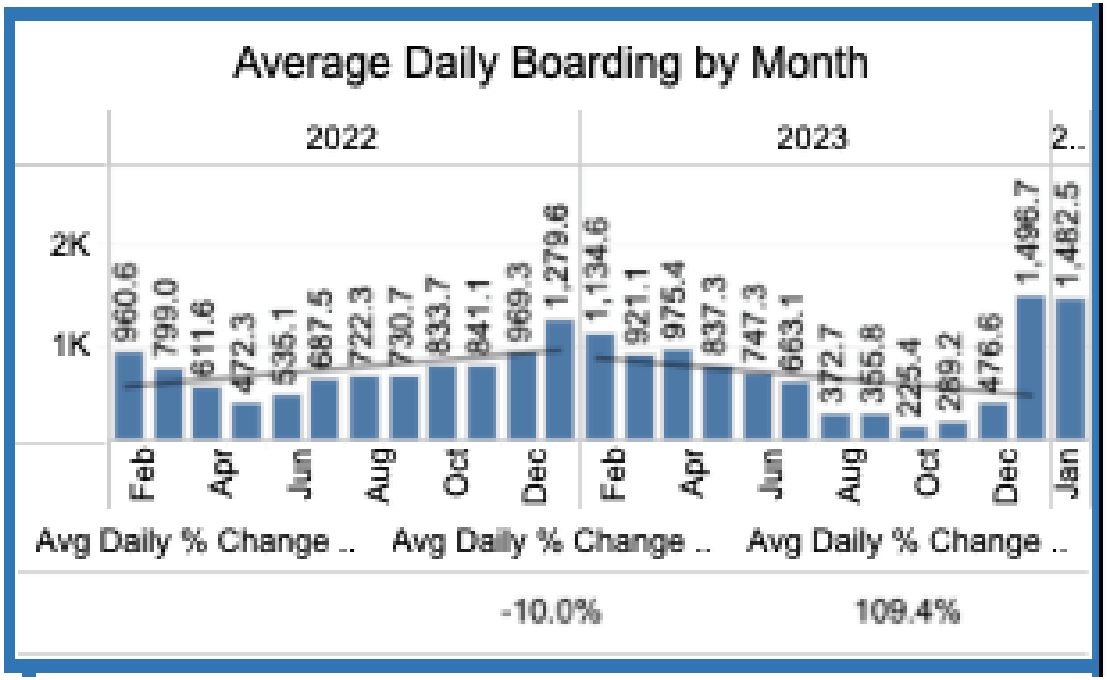
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
2020	570	484	459	344	431	427	453	443	437	428	379	338
2021	306	357	439	474	461	493	563	458	435	439	490	531
2022	507	415	452	445	497	490	503	511	499	490	523	521
2023	485	509	509	509	512	507	497	552	477	566	455	550
2024	592											

Length of Stay for Admissions - Escondido



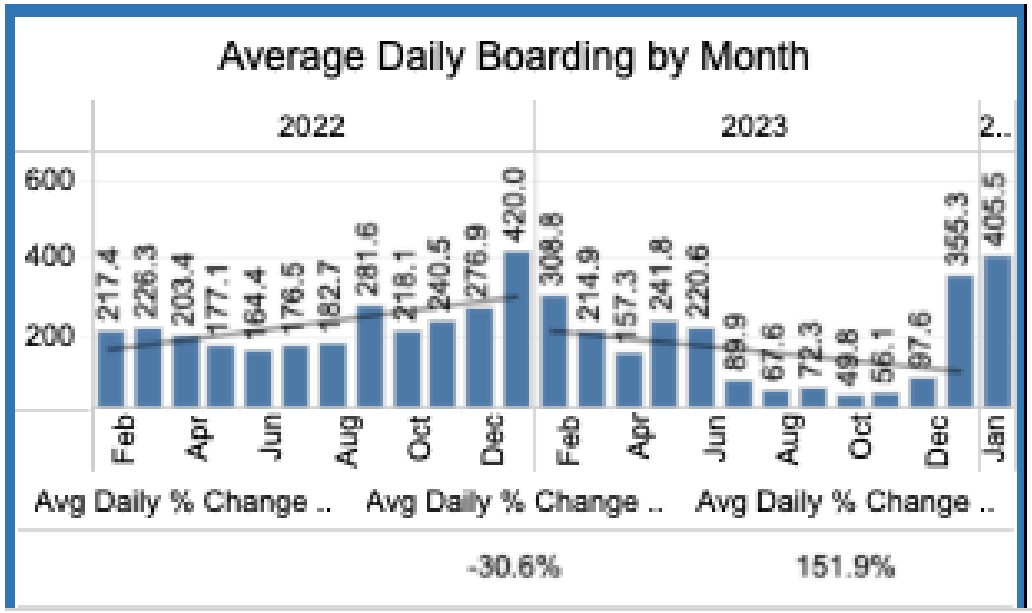


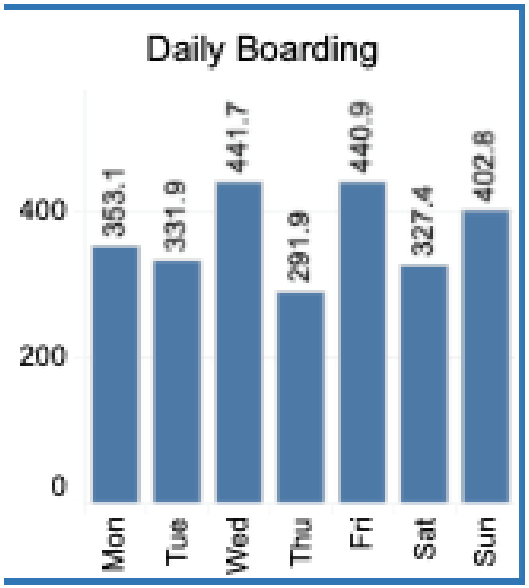
- 231 median door-to-decision to admit
- Median Admit LOS 1343 minutes (down from 1363)
- Total boarding hours 43,745 (down from 46,397)
- Average 30 hours/admit



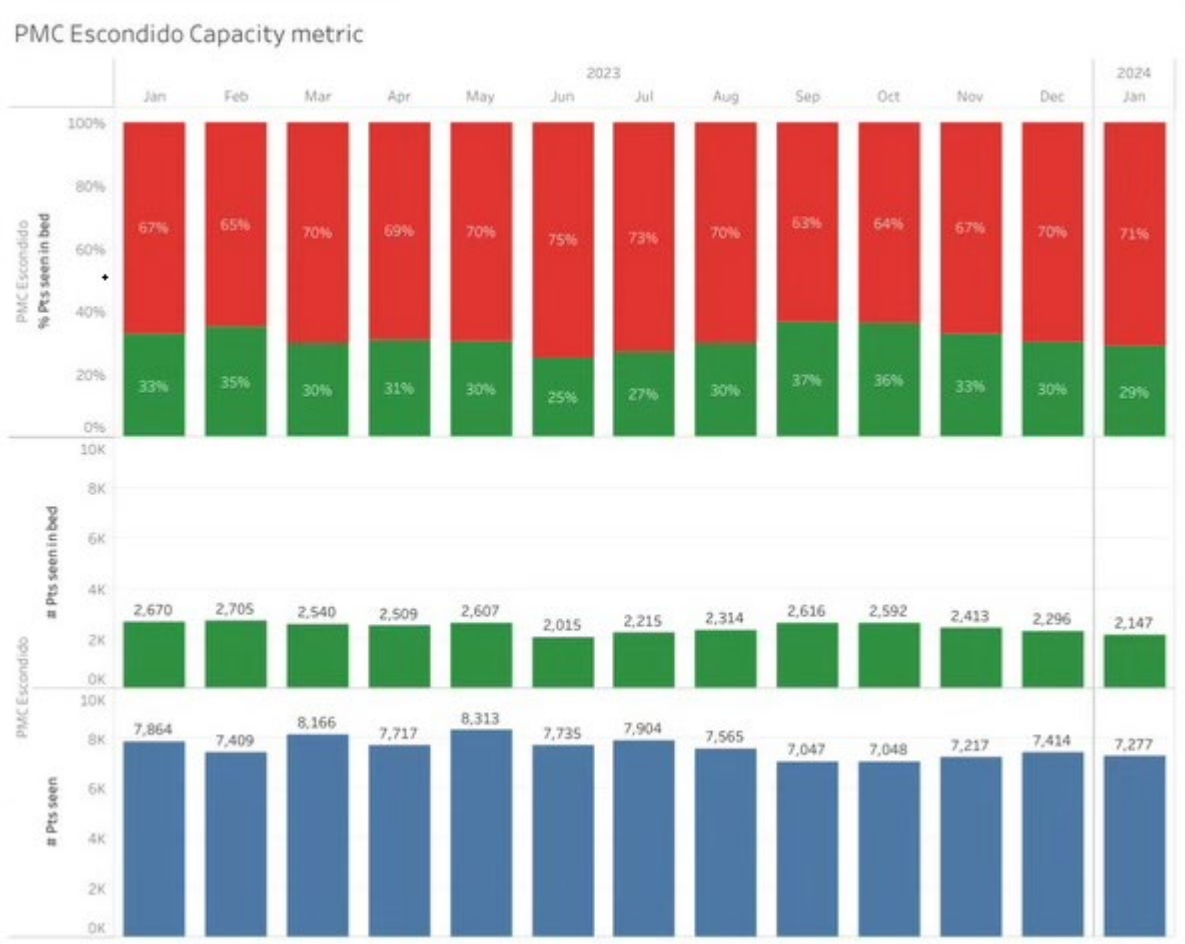
Length of Stay for Admissions - Poway

- Door to Decision: 222 minutes
- Median Admit LOS: 684 minutes
- Total Boarding hours: 11,734 (up from 11,013)
- Average 25 hours/admit



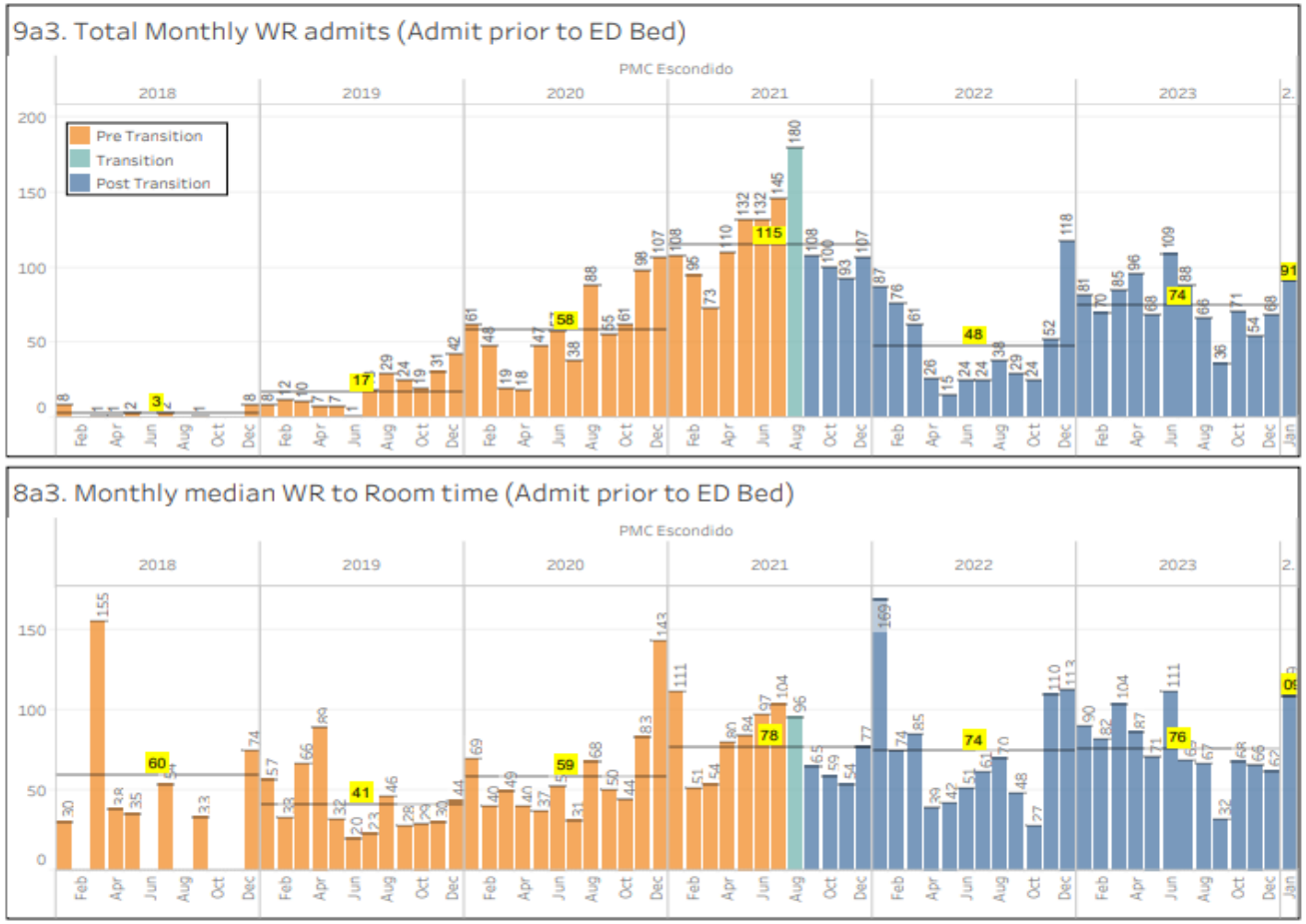


Use of Alternate Care Spaces



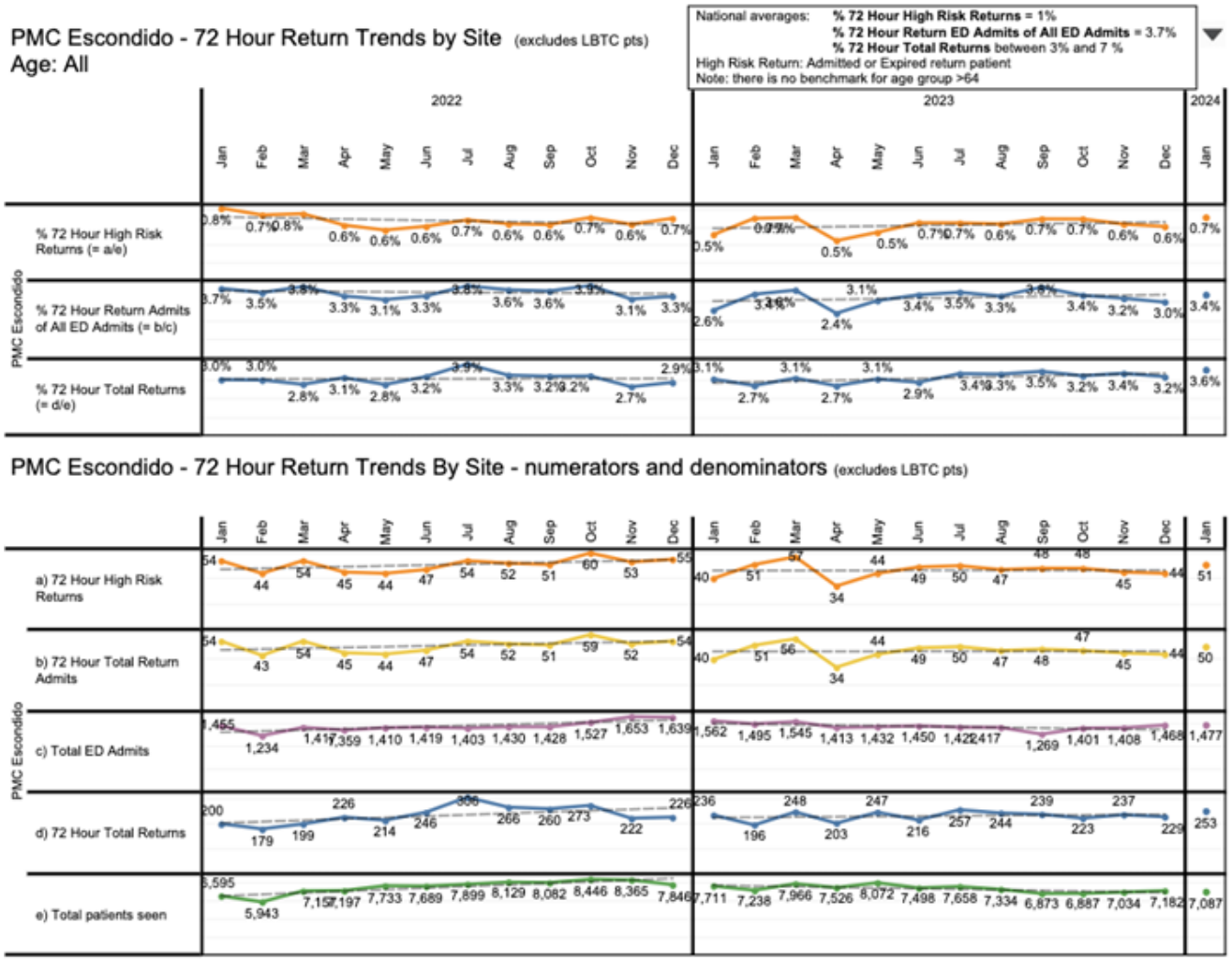
In spite of decreased volume, only 30% of patients are seen in beds due to boarding patients in the ED

WR and Offload Admits



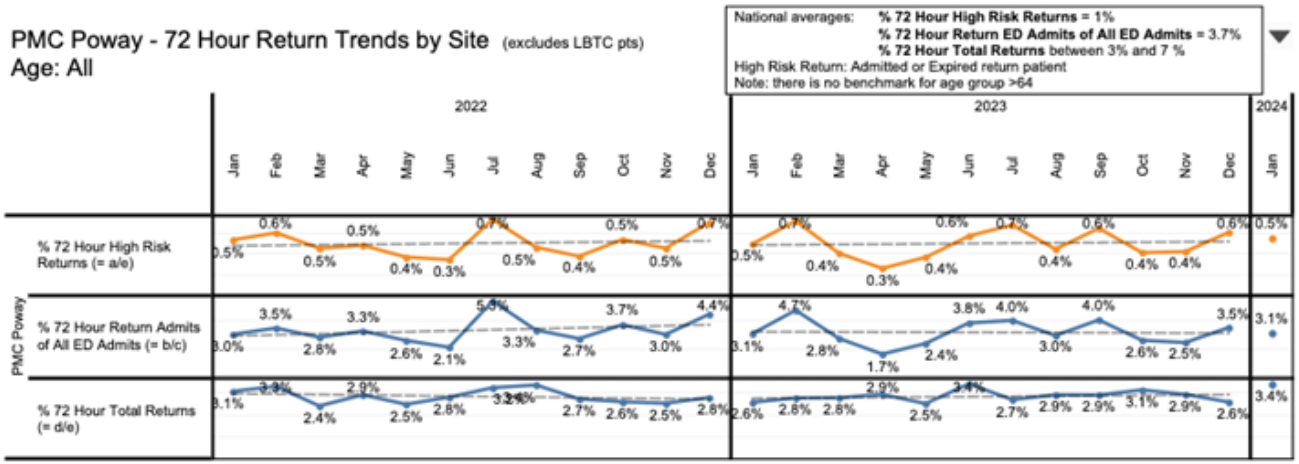
If the ED has exhausted all resources and cannot open additional care spaces to accommodate WR and Offload admits, clinical ops team will be contacted for hold nurses or to expedite discharges/admissions

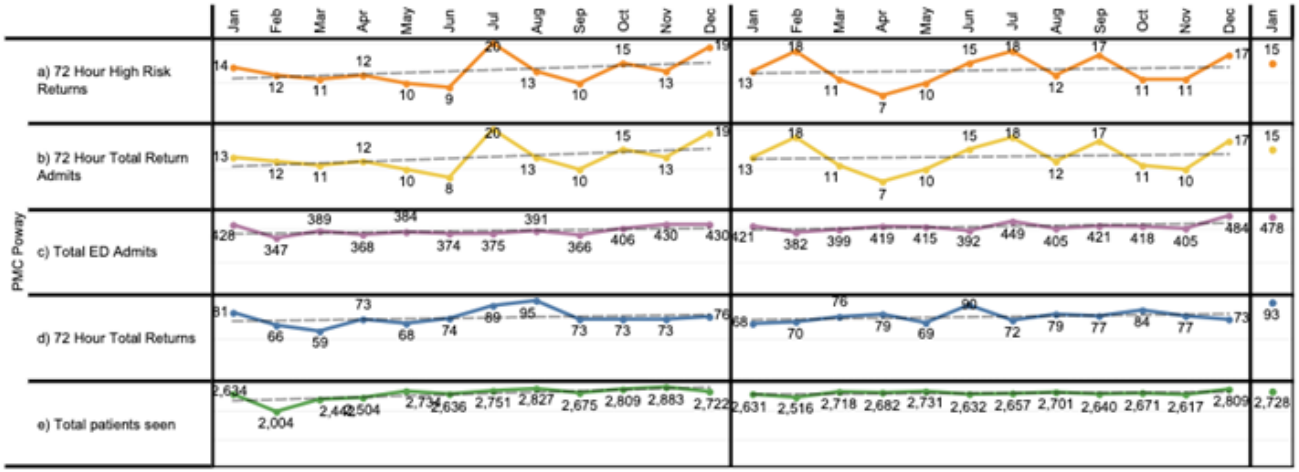
72-Hour Return Trends - Escondido



% 72 Hour High Risk Returns
National Average = 1%
PMCE – 0.5 -0.7%

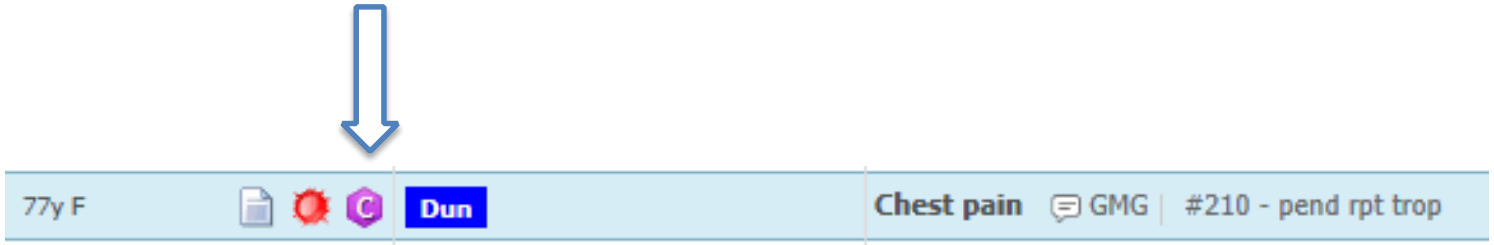
72-Hour Return Trends - Poway

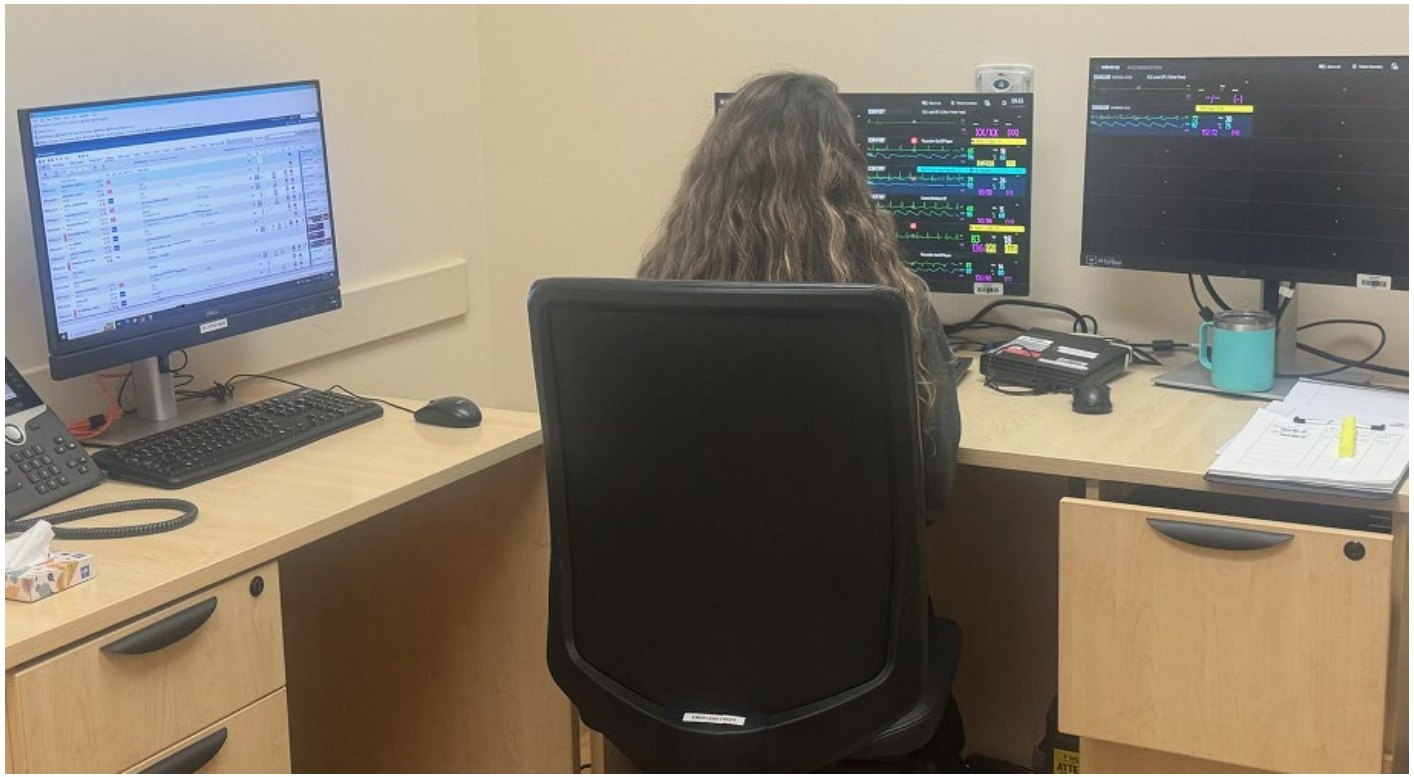




% 72 Hour High Risk Returns
National Average = 1%
PMCP – 0.3 -0.6%

Follow up from Code Blue Event





Stakeholders Meeting

- Stakeholders continue to meet to work on throughput challenges as they present
  - Code Delta
  - Open Short Stay
  - Advantage Ambulance prioritizing txs
  - Transfers between campuses
  - SOS in real-time to ask for help with decompression

Front Care Process at Poway

Current Focus

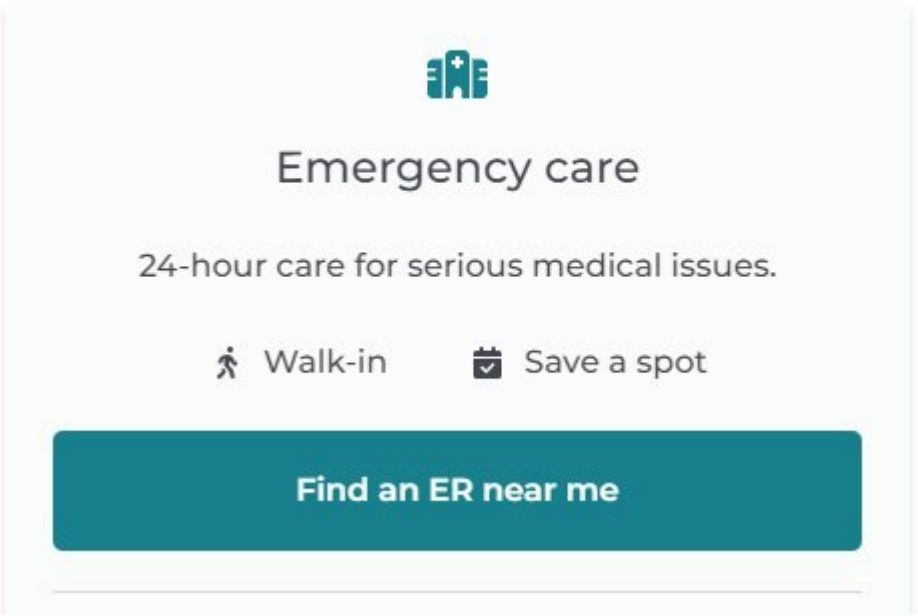
- Pulling Rooms until Full
- Standard flow process
- Creating standard work so everyone understands expectations
- Escalation process for times of surge

Back-to-the-Basics - Escondido

- Reinforcement of our current processes
- Starting in March daily report door-to-EKG times
- Front Care Process – use of passport card and movement of patients between EKG, XR, Lab
- Verti-Care – pulling until full
- Stroke Process – with CT pit stop
- Code Sepsis Process

Appointment System

- Vertical Patients
- Control Flow
- Make people feel prioritized
- Increase Pod D volume
- Market to NEW patients



PALOMAR HEALTH

ADDENDUM D

Trauma Services Annual Report

Presented to
Board Quality Review Committee

Melinda Case, RN, MSN, TCRN,
Trauma Program Director
John Steele, MD, Medical Director

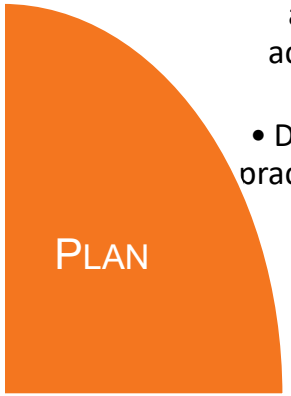
March 27, 2024

PMCE Trauma Services

SITUATION	Palomar Trauma Service is a Level II American College of Surgeons-Committee on Trauma verified Trauma Center; and is currently due for re-verification in May of 2025. Trauma Services is currently preparing for the 2025 American College of Surgeons-Committee on Trauma (ACS-COT) based on the newest standards, the 2022 Resources for Optimal Care of the Injured Patient.
BACKGROUND	PMCE is a verified Level II Trauma Center through the American College of Surgeons-Committee on Trauma (ACS-COT). San Diego County designates the trauma center annually based on criteria from both Title 22 and the ACS-COT Resources for the Care of the Injured Patient. The PMCE Trauma Program is subject to an annual review as reflected in the San Diego Emergency Medical Services (EMS) County Trauma agreement. The application for the May 2025 site survey was submitted in August 2023.
ASSESSMENT	PMCE Trauma Service continues to assess, monitor, and evaluate for any potential ACS Criteria Deficiencies. The Trauma Program monitors, collects data, and evaluates over 250 data points and audit filters mandated by the ACS-COT and the San Diego Trauma/EMS System. Annually, the Trauma Program reviews and strategizes to focus on the top 3-4 audits that currently demonstrate opportunities for improvement and meet the criterion for a Level II Trauma Center.
RECOMMENDATION	Trauma continues to monitor audits that were considered opportunities in previous ACS Site Reviews, which includes monitoring new filters and criterion listed in the new Resources for Optimal Care of the Injured Patient by the Committee on Trauma-American College of Surgeons, released in March, 2022. The focus of our PI Program over the next 3 years will include weaknesses and recommendations found in our verification report.

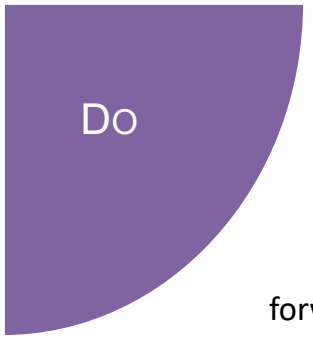
PMCE Trauma Services

- Trauma is monitoring over 20 various audit filters based on the ACS-COT 2022 standards (Chap. 7; PIPS Plan). Highlights for the fall 2023 QMC report include:
- Delays in Radiology Imaging Reporting
- VAP
- Significant complications & adverse events



- All audit filters are monitored currently and retrospectively for fallouts with action plans implemented to address particulars
- Discussed in Peer Review ; individual practitioners and units/departments as needed

- Radiology: Time Delays between patient scan and final result
- Delays to appropriate VTE prophylaxis
- Partnered with Infection Prevention to review all Ventilator-Associated Complications and appropriate culture collection
- Prospective review of complications/adverse events; daily multi-discipline rounds/daily chart review



- All cases requiring review are presented at monthly Trauma Committee Peer Review; cases requiring specialty input are forwarded to the appropriate medical peer review committee and the overall Hospital Quality Committee

Revised 2024 Dashboard

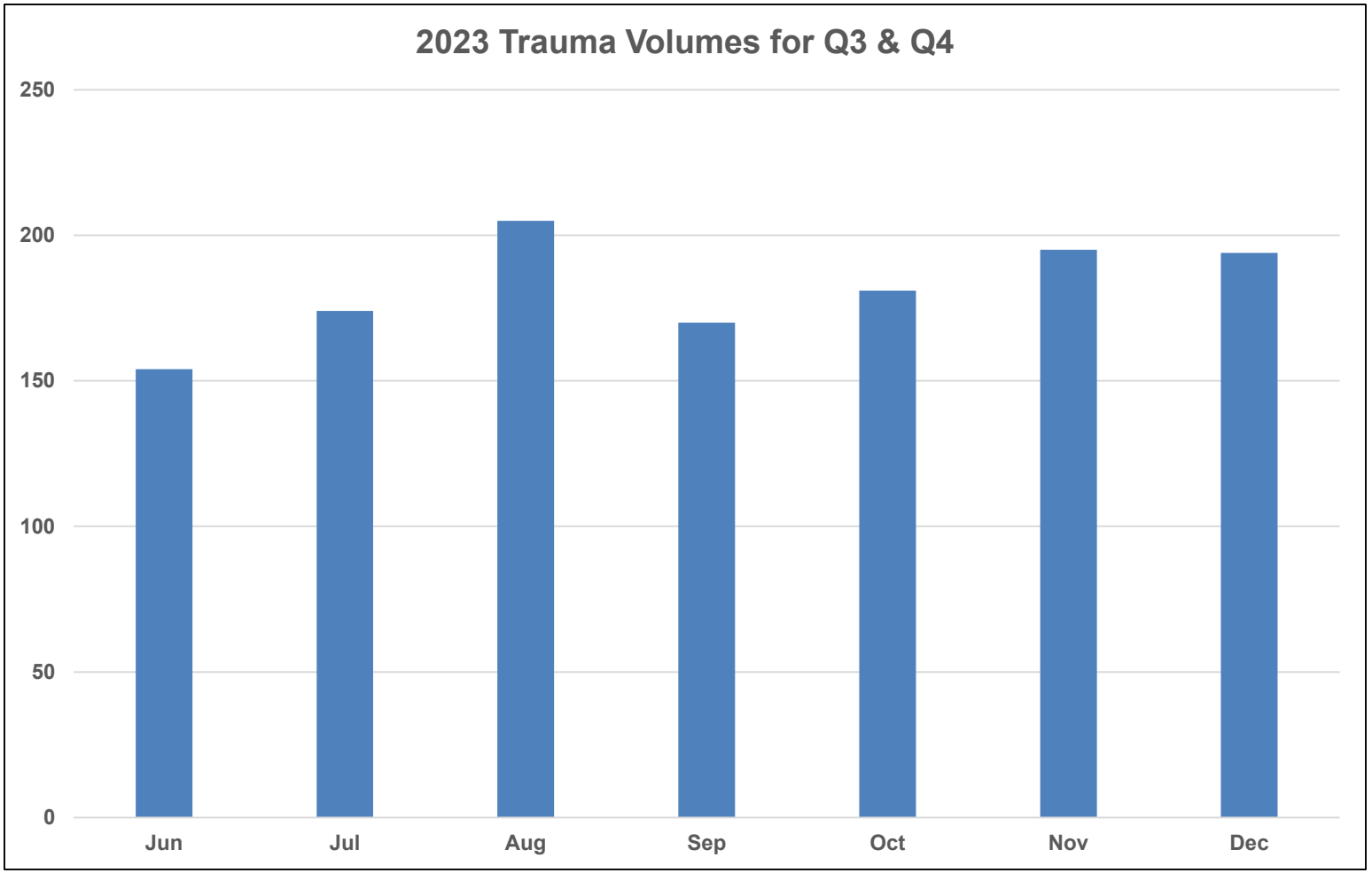
2023 Rolling Trauma Dashboard

Trauma Volume & Utilization	Months and Totals													
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Totals	Trend
Monthly Volume	192	166	173	179	166	159	180	210	169	185	196	195	2170	
Full Activations	44	39	24	30	37	34	39	44	37	41	43	49	461	
Partial Activations	81	71	93	82	81	84	69	100	84	81	85	78	989	
Consults	27	26	18	26	18	17	40	26	21	24	35	30	308	
Resources	27	26	17	25	20	14	34	26	22	30	25	38	304	
Average ISS	8	10	7	7	7	8	8	7	7	9	8		86	
Deaths	8	3	7	3	10	6	7	5	2	4	6	8	69	
Transfers to Hospice	0	2	1	0	1	0	2	0	0	1	2		9	
ED Discharges	47	40	63	64	51	55	48	43	51	51	54	65	632	
ED Discharges by %	24%	24%	36%	36%	31%	35%	27%	20%	30%	28%	28%	33%	29%	
Transfers In	5	6	7	3	4	5	5	10	11	11	15	5	87	
Transfers Out	2	1	2	3	2	5	7	11	9	4	9		55	
ICU Admissions	28	28	19	33	25	30	24	27	15	25	34		288	
IMC Admissions	42	31	25	31	47	38	48	40	39	45	46		432	
Floor Admissions	43	33	37	51	43	36	37	44	29	41	33		427	
Resus to OR	28	23	28	19	22	15	28	29	17	19	28		256	
Resus to IR/Cath	4	1	0	0	1	1	2	2	1	2	1		15	
Pediatric Admissions	1	2	1	1	1	3	2	3	0	2	0		16	
Direct Admits	0	0	0	0	0	0	0	1	0	0	0		1	
Total Admissions	146	118	110	135	139	123	141	146	101	134	142		1435	
Average ED LOS in HRs	3.8	4.3	4.4	4.8	5.1	5.4	5.6	5.3	4.8	5.2	4.5		4.8	
Average ICU LOS in HRs	4.1	5.7	5.6	6.1	6	5.2	5	4.9	5.3	6.7	5.1		5.4	
Average Hospital LOS in Days	3.8	5.6	4.1	3.7	4.7	4.1	3.8	5.3	5	5.2	5		4.6	
Pre-Hospital Opportunities														
Missing EMS Documentation	32	27	33	25	26	25	31	28	32	35	34		328	
Prehospital Delays	3	4	3	3	14	42	28	23	22	24	34		200	
Trauma Team Activation Opportunities														
Delayed Trauma Team Activation	0	0	0	0	0	0	0	0	1	4	2		7	
Missed Trauma Team Activation	0	1	1	0	0	0	0	0	1	1	1		5	
Under Triage	8.8%	11.2%	13.5%	5.5%	7.4%	13.9%	16.2%	8.9%	9.4%	8.3%	15.8%		10.8%	
Over Triage	62.0%	58.9%	82.6%	80.0%	70.2%	67.6%	76.9%	82.2%	80.0%	63.4%	66.7%		71.9%	
Delay in Trauma Surgeon Arrival Times	0	0	0	0	0	0	0	0	0	2	0		2	
Delay in Call Panel Consulting Physicians or Surgeons	--	--	--	--	--	--	1	0	0	0	0		1	
Resuscitation Opportunities														
Delays to Radiology	--	--	--	--	--	--	--	1	0	1	0		2	
Delays to Interventional Radiology	--	--	--	--	--	--	--	0	1	0	0		1	
Delays to Crani	--	--	--	--	--	--	0	0	0	4	2		6	
Delays to Ex Lap	--	--	--	--	--	--	2	2	1	2	0		7	
MTP Activations	4	1	4	2	2	5	3	2	1	2	3		29	
Antibiotics Given > 1 HR for Open Fractures	3	2	2	3	4	1	2	5	3	1	3		29	
Non-Trauma Service Admissions	52	46	49	46	33	30	37	45	24	38	34		434	
Inpatient Opportunities														
Transfers to Higher Level of Care	--	--	--	--	--	--	1	0	0	2	1		4	
Substance Use/Abuse Screening	84%	78%	44%	81%	87%	80%	77%	39%	48%	49%	42%	37%	62%	
Brief Intervention and Referral for Treatment	--	--	--	--	--	--	--	66%	80%	100%	100%	33%	76%	
COVID-19	2	1	1	0	0	0	0	0	1	0	1		6	
Unexpected readmission	1	1	0	0	0	0	1	1	0	0	4		8	
Hospital Events														
Acute Kidney Injury	1	0	1	0	1	1	0	1	0	1	0		6	
Acute Resp. Distress Syndrome	2	2	0	0	0	1	1	1	0	2	1		10	
Alcohol Withdrawal Syndrome	1	2	2	1	2	3	0	1	1	2	2		17	
Cardiac Arrest with CPR	0	0	0	0	0	0	2	1	0	1	1		5	
Catheter-Associated Urinary Tract Infection	0	1	1	1	0	0	0	2	1	1	0		7	
Central Line-Associated Blood Stream Infection	0	0	0	0	0	0	0	0	0	0	0		0	
Deep Surgical Site Infection	1	1	0	0	0	0	0	0	0	0	0		2	
Deep Vein Thrombosis	0	0	1	2	0	2	1	4	4	1	0		15	
Delirium	0	0	0	1	1	1	0	2	1	1	1		8	
Myocardial Infarction	0	0	0	0	1	0	0	0	0	0	0		1	
Organ Space Surgical Site Infection	0	0	0	2	0	0	0	0	0	0	0		2	
Osteomyelitis	1	0	0	1	0	0	0	0	0	0	1		3	
Hospital Acquired Pressure Injuries	0	0	0	0	0	1	0	0	0	0	0		1	
Pulmonary Embolism	0	1	0	0	0	0	1	0	1	0	0		3	
Severe Sepsis	0	0	0	0	0	3	0	1	0	0	0		4	
Stroke/CVA	0	0	0	0	0	1	0	1	0	1	0		3	
Superficial Incisional Surgical Site Infections	0	1	0	0	0	0	0	0	0	0	1		2	
Unplanned Admission to ICU	2	2	3	0	3	1	3	2	0	5	2		23	
Unplanned Intubation	3	2	0	0	3	2	2	2	1	3	2		20	
Unplanned Visit to Operating Room	2	1	0	0	4	0	3	5	4	2	5		26	
Ventilator-Associated Pneumonia	1	2	0	0	1	1	1	4	1	4	2		17	

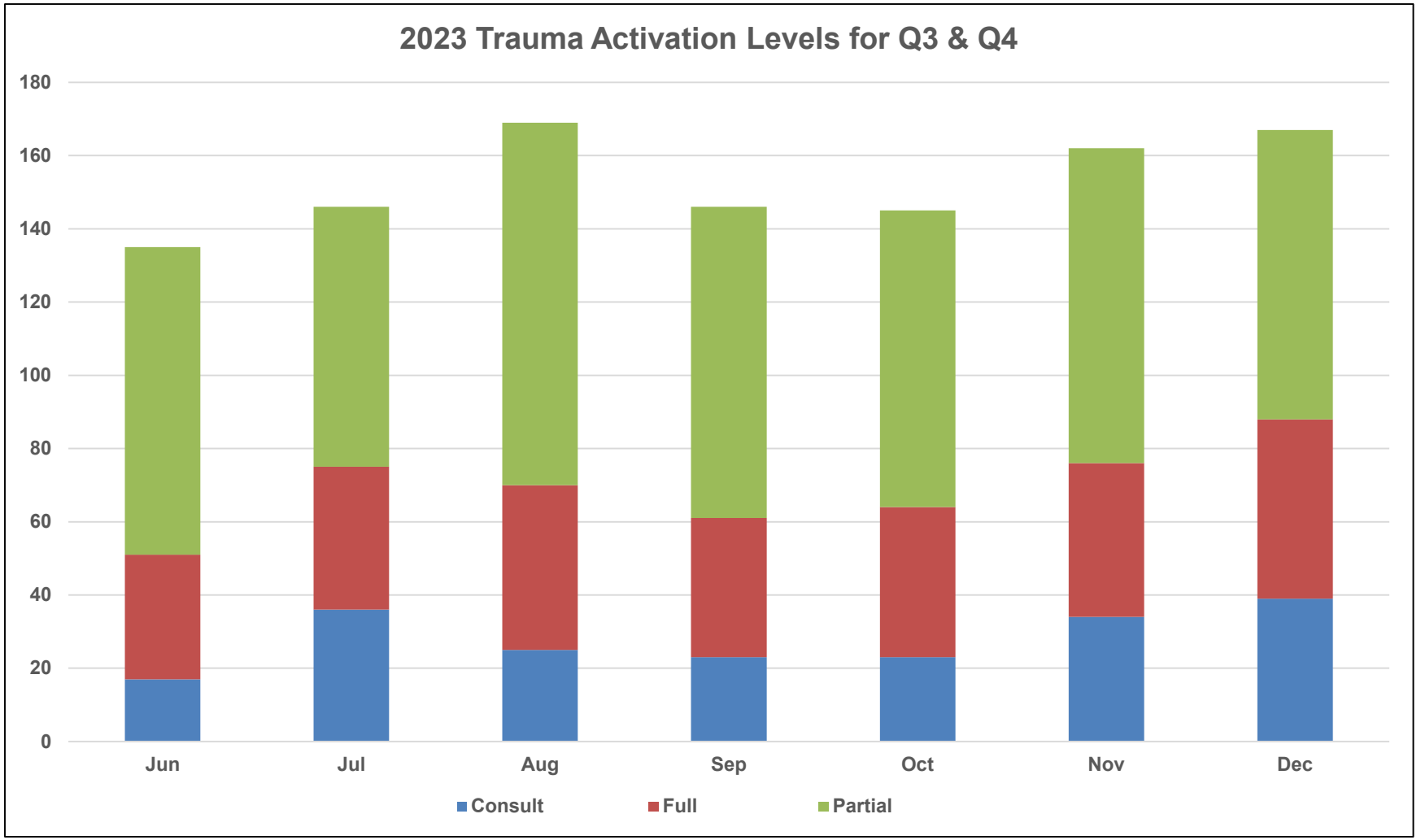
ACS Standards for Dashboard

- Surgeon arrival time for the highest level of activation
- Delay in response for urgent assessment by the neurosurgery and orthopaedic specialists
- Delayed recognition of or missed injuries
- Compliance with prehospital triage criteria, as dictated by regional protocols
- Delays or adverse events associated with prehospital trauma care
- Compliance of trauma team activation, as dictated by program protocols
- Accuracy of trauma team activation protocols
- Delays in care due to the unavailability of emergency department physician (Level III)
- Unanticipated return to the OR
- Unanticipated transfer to the ICU or intermediate care
- Transfers out of the facility for appropriateness and safety
- All nonsurgical admissions (refer to Standard 7.8)
- Radiology interpretation errors or discrepancies between the preliminary and final reports
- Delays in access to time-sensitive diagnostic or therapeutic interventions
- Compliance with policies related to timely access to the OR for urgent surgical intervention
- Delays in response to the ICU for patients with critical needs
- Lack of availability of essential equipment for resuscitation or monitoring
- MTP activations
- Significant complications and adverse events
- Transfers to hospice
- All deaths: inpatient, died in emergency department (DIED), DOA
- Inadequate or delayed blood product availability
- Patient referral and organ procurement rates
- Screening of patients for psychological sequelae (LI/LII/PTCI/PTCII))
- Delays in providing rehab services
- Screening and intervention for alcohol misuse
- Pediatric admissions to nonpediatric trauma centers
- Neurotrauma care at Level III trauma centers
- Trauma and neurotrauma diversion
- Benchmarking reports

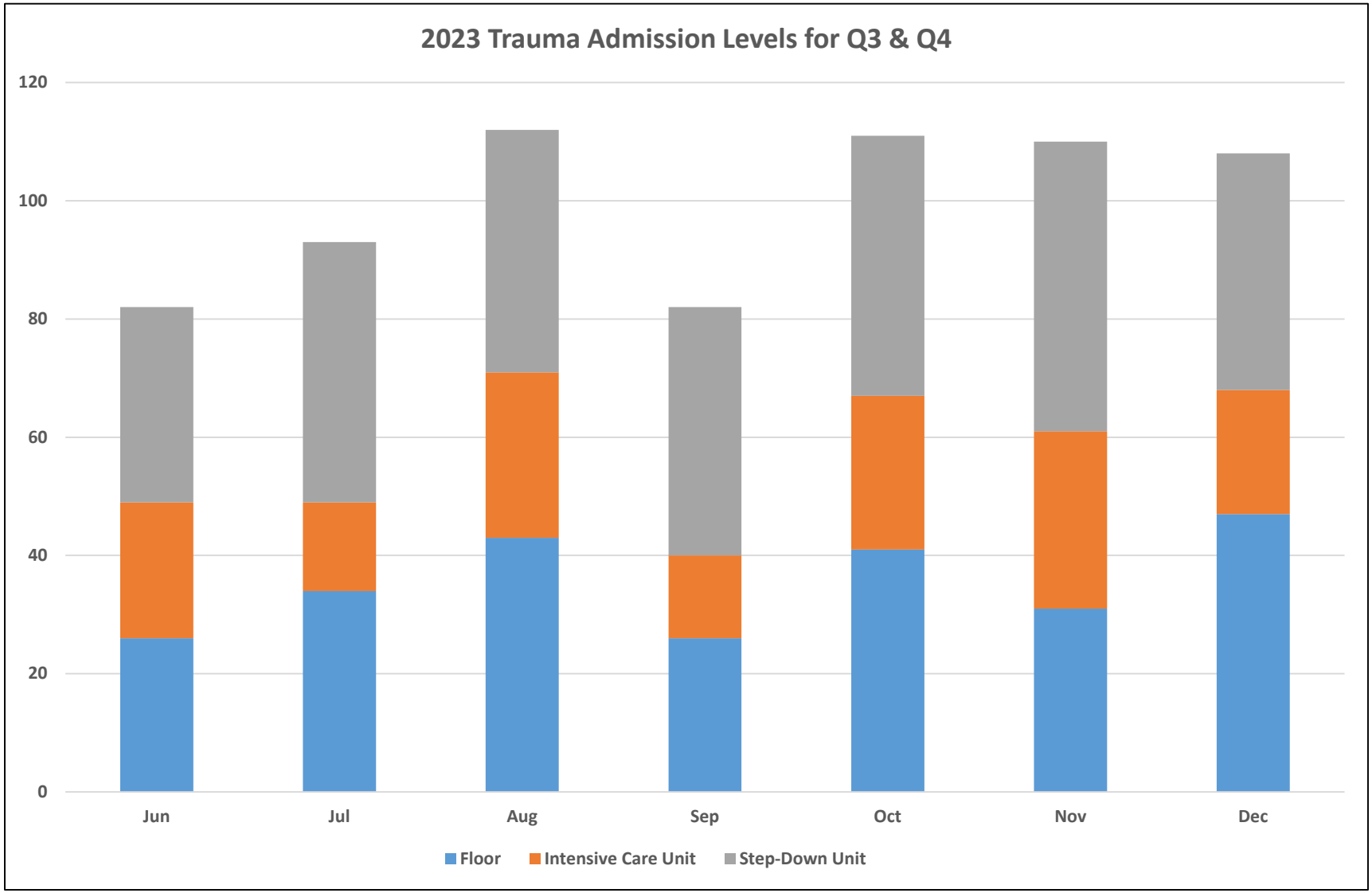
Trauma Volumes



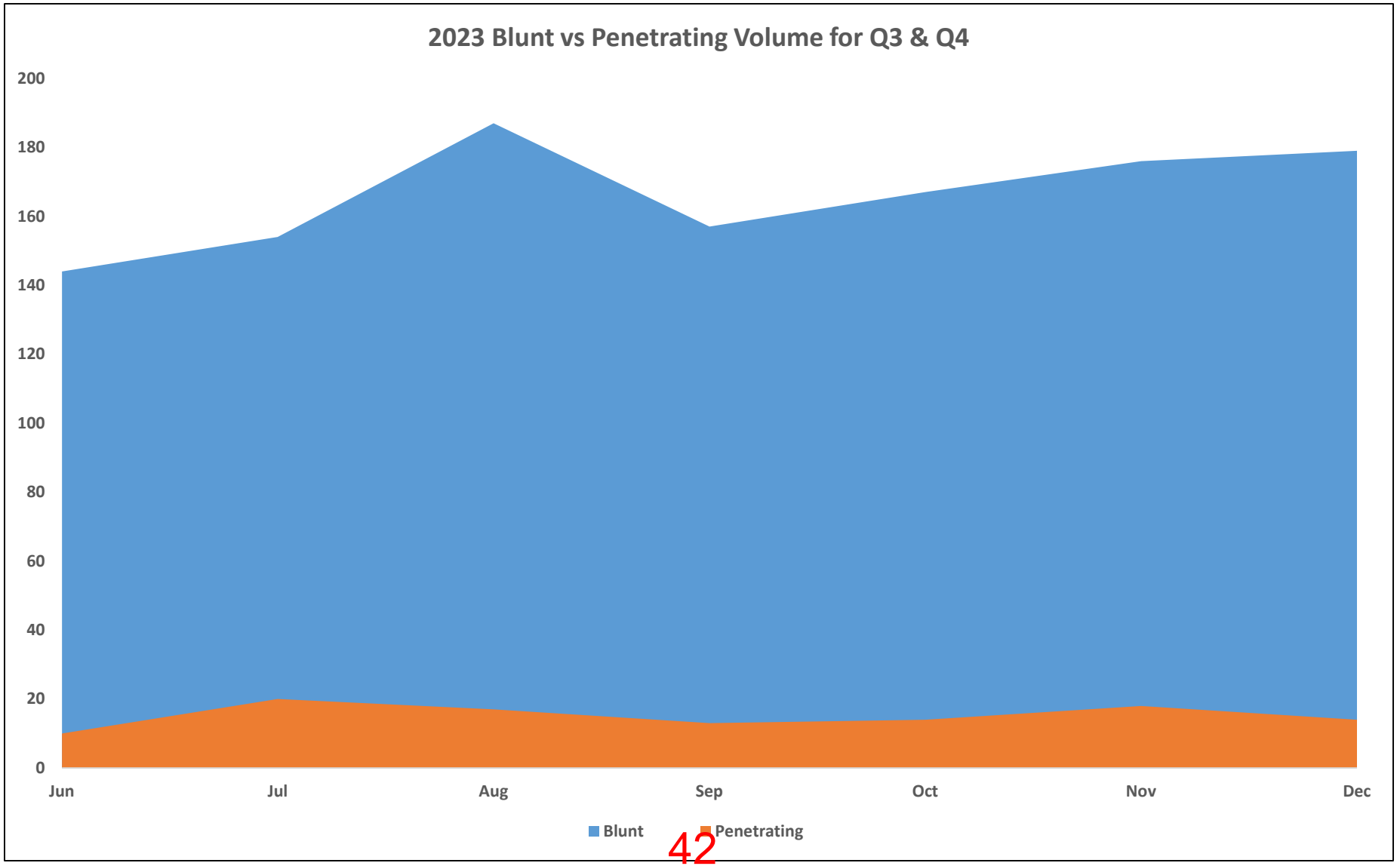
Trauma Activation Levels



Admission Rates



Blunt vs Penetrating Trauma Statistics



PLAN-Radiology Imaging Reporting Delays

- There has been a change in coverage for PMCE Radiologists.
- This change has resulted in a delay in time from scan to documentation of final interpretation.
- ACS VRC Standard 5.26: As a Level 2 Trauma Center PMC Escondido is required to provide timely reports for CT Scanning.
- “In all trauma centers, documentation of the final interpretation of CT scans must occur no later than 12 hours after completion of the scan.”
- In a review of data from May 2023:
  - Patients: 99
  - Scans fell out of the 12 hour compliance window: 317
- Recommendation: *Provide education to the various radiology CT Scans for Trauma Patients prioritized for final reports within the radiology department when possible*

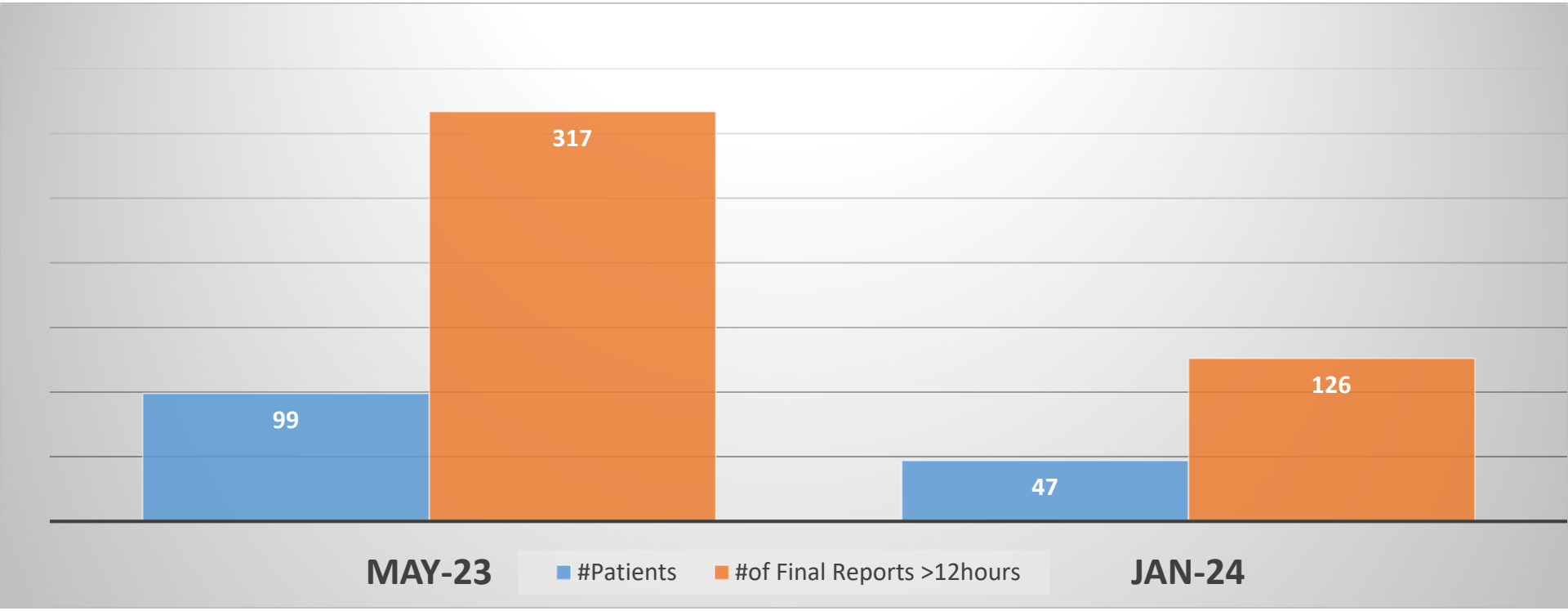
DO-Radiology Imaging Reporting Delays

- Since this change, education has been performed
  - Trauma Surgeons
  - Trauma Service Staff
  - Radiologist
  - Radiology Staff Members
- Creation of a radiologist leader on call role to prioritize CT scans on off hours or when needed.
- Example:

Friday 2/23	Radiologist	Phone #	Send to	Group
7a-5p	NCRA	1-877-734-7237	McKesson	NCRA
5p-10p	Dr. Dunn/Dr. Green	818-203-7466/ 619-822-6418	McKesson	GREEN
10p-1a	STAT RAD	(858) 546-3800	StatRad	StatRad
1a-7a	STAT RAD	(858) 546-3800	StatRad	StatRad
Lead on call	Ivana Byrd	760-270-5677		
Saturday 2/24	Radiologist	Phone #	Send to	Group
7a-11a	Dr. Anderson/Dr. Cutts	720-891-8322/ 858-444-6366	McKesson	GREEN
11a-1p	Dr. Anderson/Dr.Cutts/Dr. Green	720-891-8322/ 858-444-6366/ 619-822-6418	McKesson	GREEN
1p-5p	Dr. Cutts/Dr. Green	858-444-6366/ 619-822-6418	McKesson	GREEN
5p-10p	Dr. Cutts/Dr. Dunn	858-444-6366/ 818-203-7466	McKesson	GREEN
10p-1a	STAT RAD	858-546-3800	StatRad	StatRad
1a-7a	STAT RAD	858-546-3800	StatRad	StatRad
Lead on call	Ivana Byrd	760-270-5677		

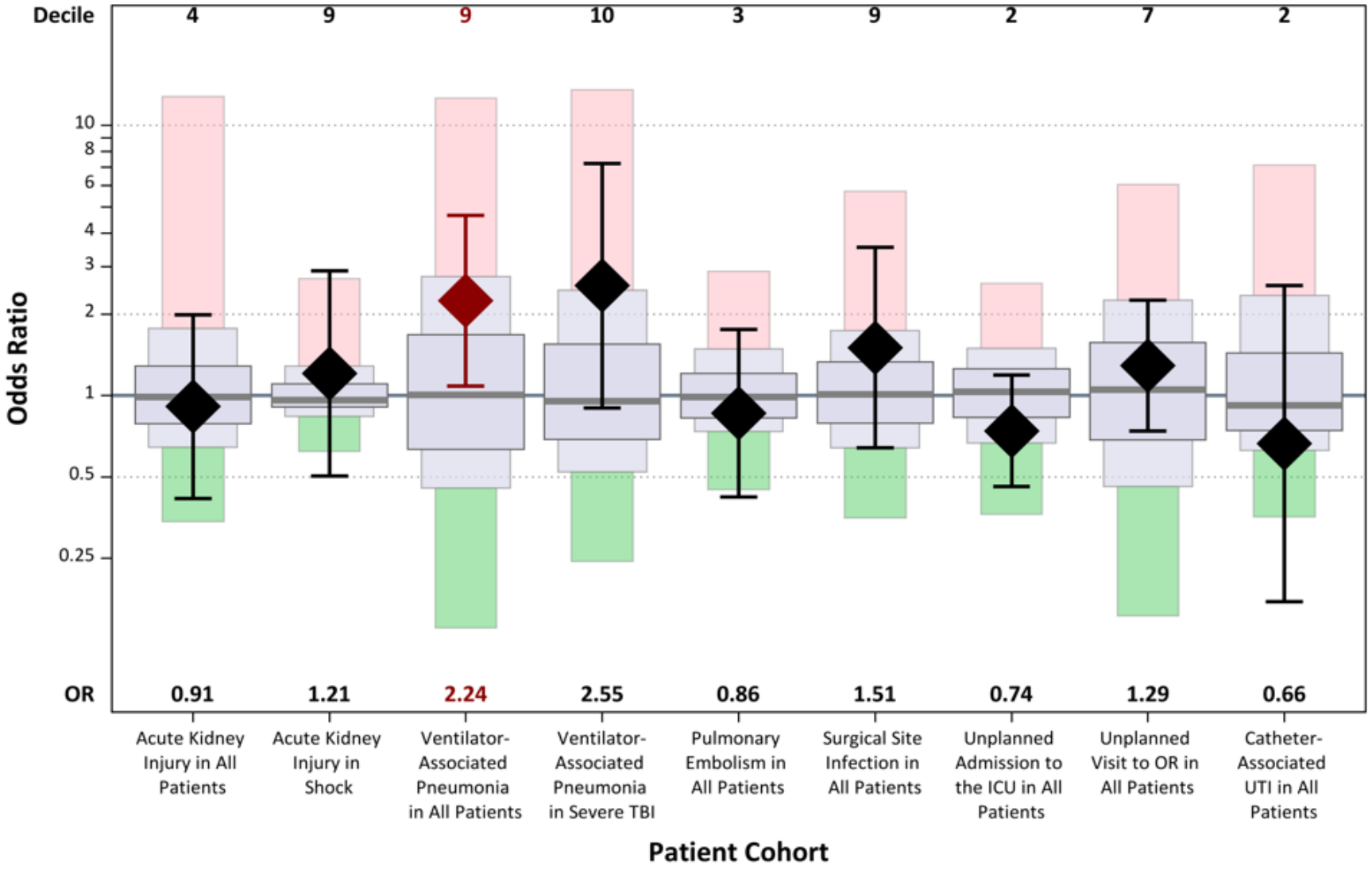
STUDY-Radiology Imaging Reporting Delays

- After education and radiology leadership escalation process the most recent data for January 2024:
  - Patients: 47
  - Scans fell out of the 12 hour compliance window: 126



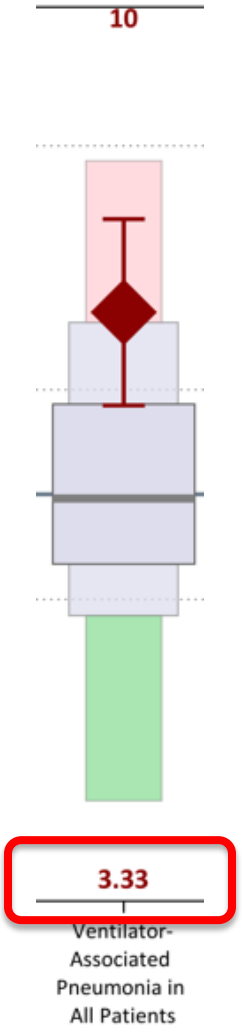
Risk-Adjusted Specific Hospital Events by Cohort - Fall 2023

TQIP Report ID: 103

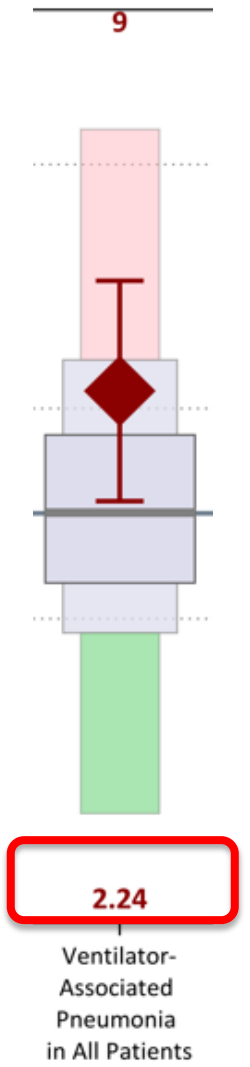


Ventilator-Associated Pneumonia Rates

Spring 2023



Fall 2023



Significant Complications and Adverse Events

- All complications and adverse events are reviewed under the Performance Improvement Plan levels of review.
- Events are escalated through the hospital chain of command process based on the impact to patient care, safety, and global consequences.
- Each case is subject to the appropriate level of impact per the trauma taxonomy and care; (care appropriate, care with opportunity, care unacceptable).
- Education for staff and physicians provided within a timely interval and evaluated for effectiveness.

Action Plan with Timeline

1. All cases with outliers without an identified rationale are reviewed at the monthly Trauma Peer Review Committee and discussed with both the multi-disciplined trauma team members and individual practitioner. Cases requiring further review are sent to the overall Medical Peer Review Committee for determination of care or next level review.
2. Geriatric Guideline implemented; both Benchmark and Graybill Geriatricians participate in the daily call schedule for trauma patient population.
3. Benchmarks for time to transfer for pediatric patients developed.
4. O.R. delays due to staffing are minimal; no bypass due to O.R. staffing/capacity since December 2023.

PALOMAR HEALTH

ADDENDUM E

Respiratory Services Presented to Board Quality Review Committee

Valerie Martinez, District Sr. Director Respiratory Care, EEG, LAB
Frank Bender MD Medical Director
Kerwin Pipersburgh, District Sir Manager Respiratory Care, EEG
Krysti Johnson, District Manager Respiratory Care, EEG

March 2024

Ion Robotic-assisted Bronchoscopy-Early Lung Cancer Detection

SITUATION	Historically patients who needed to be staged for lung cancer under went a biopsy of lung tissue at later stages in the disease process
BACKGROUND	Palomar Health patients suspected of having lung cancer underwent a bronchoscopy with an EBUS that staged and identified cancer at a later point of development.
ASSESSMENT	Challenges Identified • Early detection of lung cancer in the peripheral airways • Leverage Palomar resources and support to on-boarding of a Ion robotic-assisted bronchoscopy team
RECOMMENDATION	• Continue one year trial of Ion robotic-assisted bronchoscopy platform • Establish measurable outcome for patient undergoing Ion procedure

Ion by Intuitive: Uses robotic-assisted bronchoscopy for minimally invasive peripheral lung biopsy of all 18 segments of the lung

aEPO-Aerosolized Epoprostenol Sodium (Flolan)

SITUATION	• ARDS (Adult Respiratory Distress Syndrome) patients many times require complex therapeutic inhaled medication as an adjunct to complex ventilator support.
BACKGROUND	• Patients with ARDS (PaO2/FiO2 < 300) with worsening hypoxemia and clinical deterioration despite the use of ventilator strategies recommended by the ARDS network many time require therapeutic inhaled medication as an adjunct to ventilator support.
ASSESSMENT	Aerosolized epoprostenol should be considered when the ventilator strategies provide inadequate support despite an FiO2 implementation of 80% or more and a PEEP of 12 or more Goal to Go Live – July 2024 Challenges Identified: • Implementation of needed equipment to administer inhaled medication • Pharmacy support • Information Technology (IT) continuing support
RECOMMENDATION	• Implement best practice for administration of Epopprostenol • Educate patient care team on implementation of aEPO-Aerosolized epoprosteno • Monitor for patient outcomes

aEPO-Aerosolized Epoprostenol Sodium (Flolan)

- Implement best practice for aEPO-Aerosolized epoprostenol
- Collaborate in patient care team for desired patient outcomes

- Pharmacy support
- IT build in Cerner
- Education of patient care team on aEPO-Aerosolized epoprostenol implementation

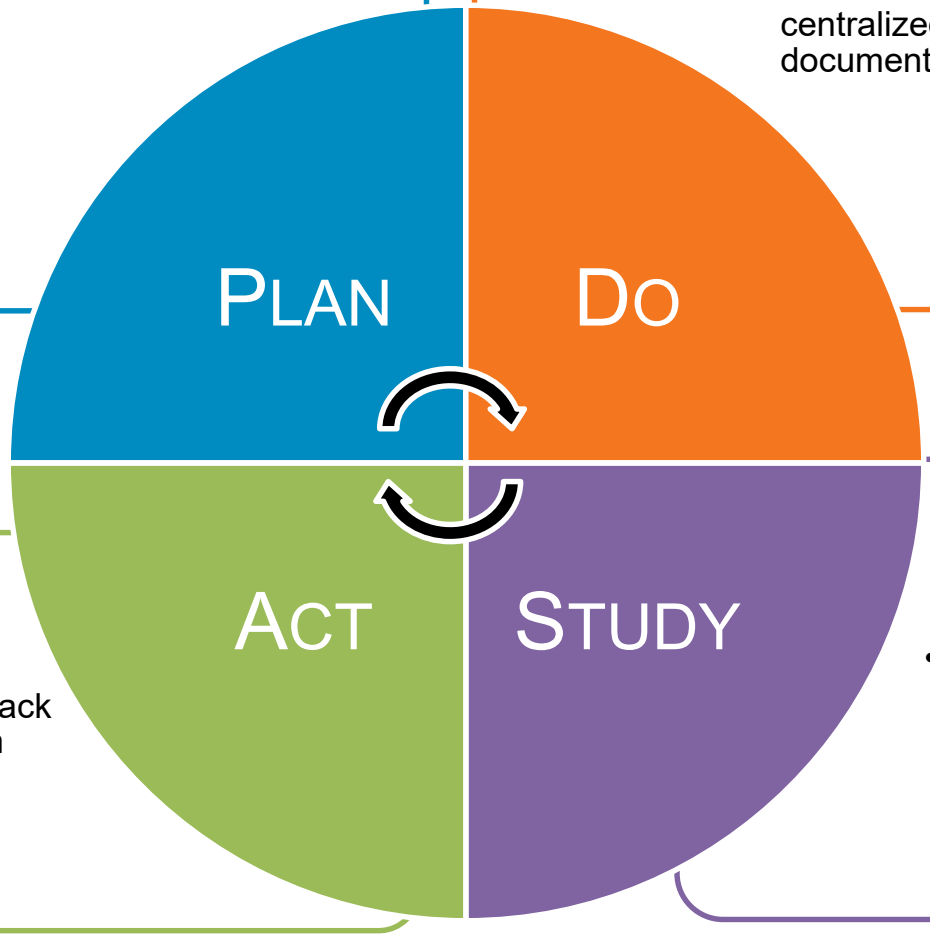
- Audits with patient outcome

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

VAP (Ventilator Associated Pneumonia) Bundle

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

VAP (Ventilator Associated Pneumonia) Bundle



- Centralize VAP Bundle Charting in Cerner

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

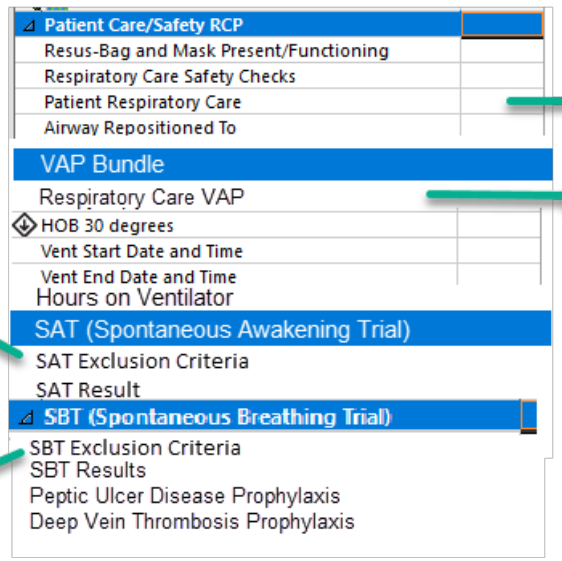
- Audits with real time feed-back is given to health care team

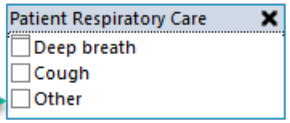
- Review of adherence of documentation by health care team

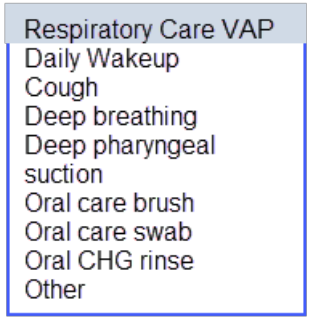
VAP BUNDLE CERNER Charting

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

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







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

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

FY 24 Accomplishments and Goals/Process Improvement Focus

Accomplishments

- Implementation of ARDS NET protocol
- Implementation of centralized VAP rounds charting in the eMR:
- Implementation of RCP taking charge of oral care for ventilated patients:

Goals/Process Improvement for 2024

- Bronchodilator Protocol Implementation system wide
- Implementation of aEPO-Aerosolized Epoprostenol Sodium (Flolan)
- Decrease Ventilator Associated Events (VAE)

Thank you

The Joint Commission Disease Specific Stroke Program Annual Report

ADDENDUM F

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RN, BSN, MHA, CIC, CPHQ, NEA-BC

Remia Paduga, MD, Stroke Program Medical Director

March 27, 2024

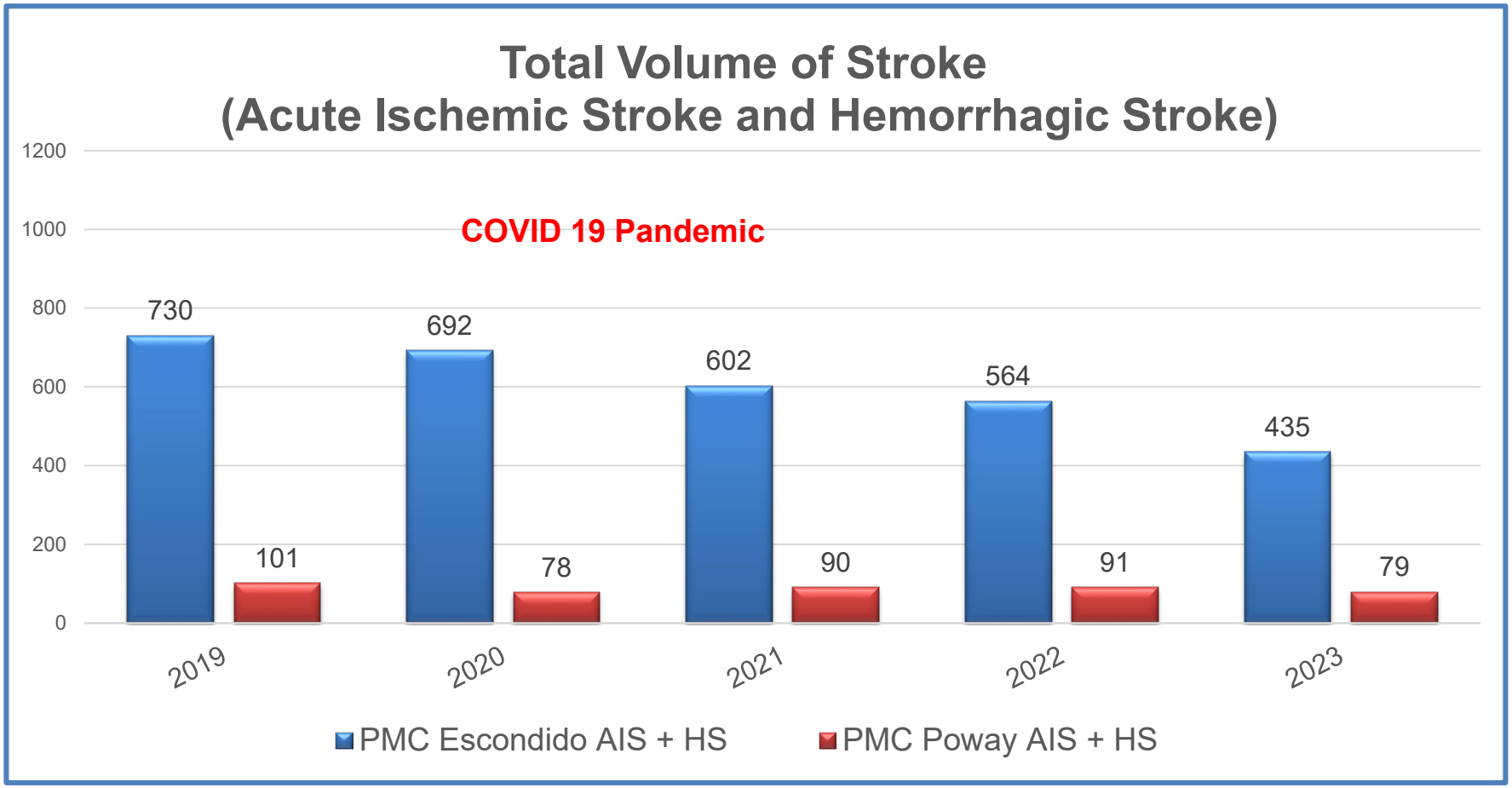
Presented to Board Quality Review Committee

PALOMAR HEALTH
Reimagining Healthcare

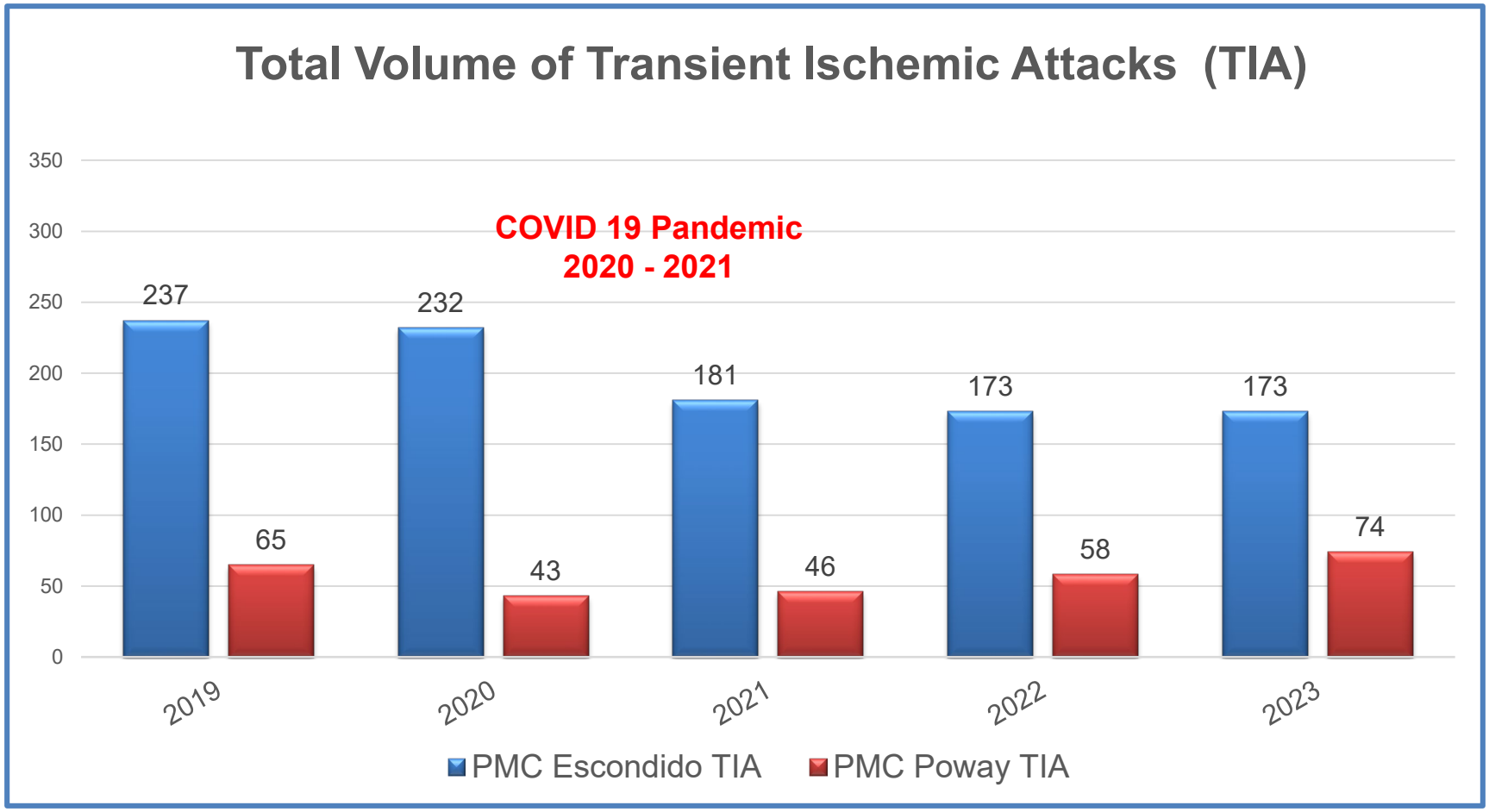
District Stroke Program

SITUATION	Palomar Health Stroke Program Annual Review
BACKGROUND	Annual Report provides an overview of the success and opportunities for the Stroke Program at Palomar Health. Continuous monitoring of the Stroke Metrics provides opportunities for process improvement.
ASSESSMENT	We have successfully recertified as a Thrombectomy-Capable Stroke Center @ Escondido and Advanced Primary Stroke Center @ Poway in 2023. During 2023, we implemented several process improvements to enhance the Stroke Program. We continue to closely monitor the "Door to" metrics and the STK and CSTK Core Measure metrics to evaluate the compliance of best practices. We continue to actively participate in the San Diego County Stroke Advisory Committee to share best practices across the stroke centers in the community.
RECOMMENDATION	Goals for 2024: 1. Stroke Program time metric goals in alignment with the San Diego Stroke Consortium Goals for 2022-2024 for Door to Needle for Thrombolytic candidates and Door to First Device Activation for the Endovascular candidates. These time metrics are from the AHA/ASA and Brain Coalition Target Stroke Phase III goals. 2. Process improvement for EMS arrivals to improve the Endovascular Door to Puncture and Door to First Device time metrics for Escondido cases. 3. Process improvement for the Inpatient Stroke Code process for faster activation. 4. Adoption of an Evidenced –based Caregiver Readiness Assessment tool for stroke patients going home.

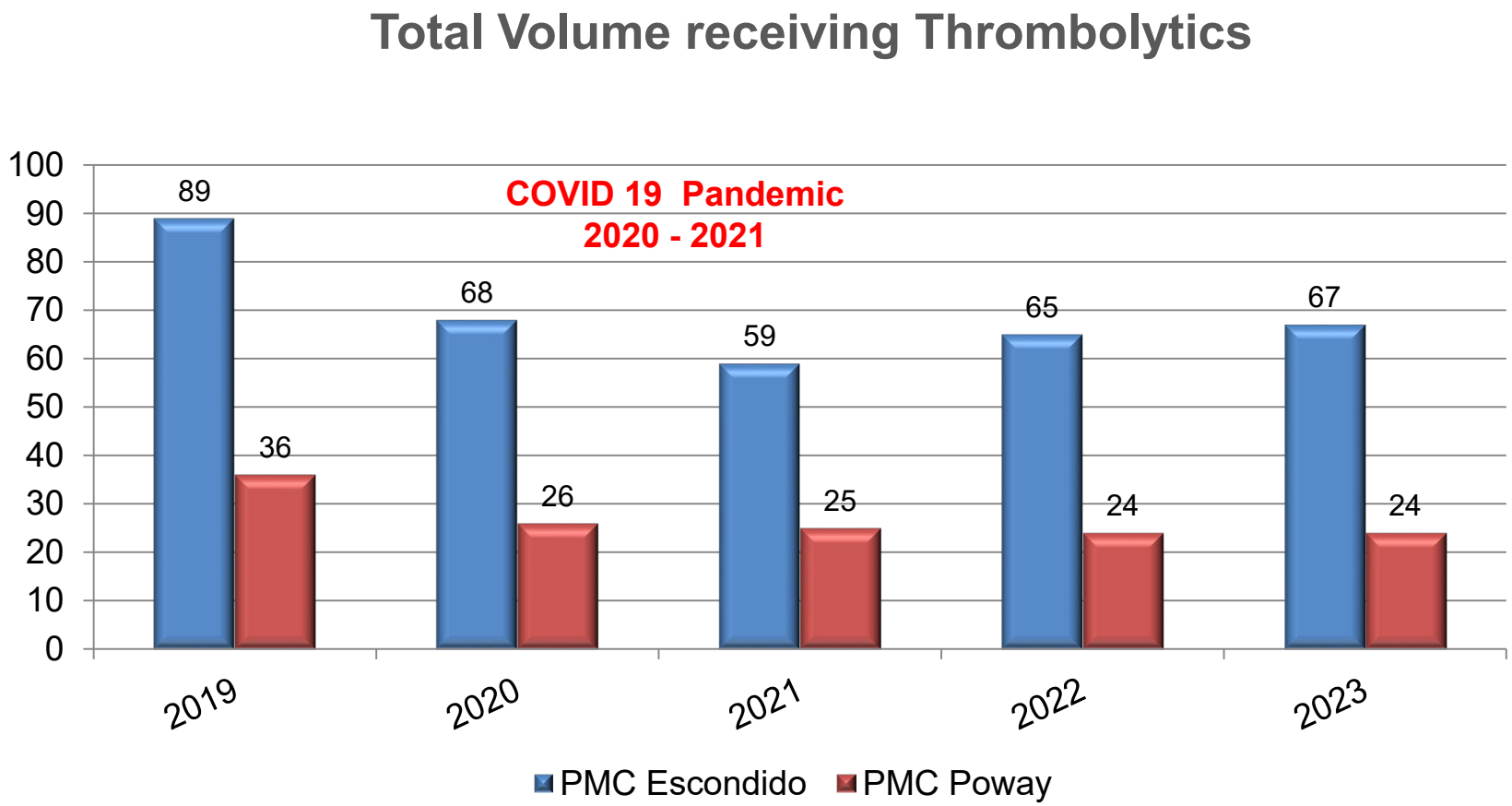
Program Overview: Patient Volumes



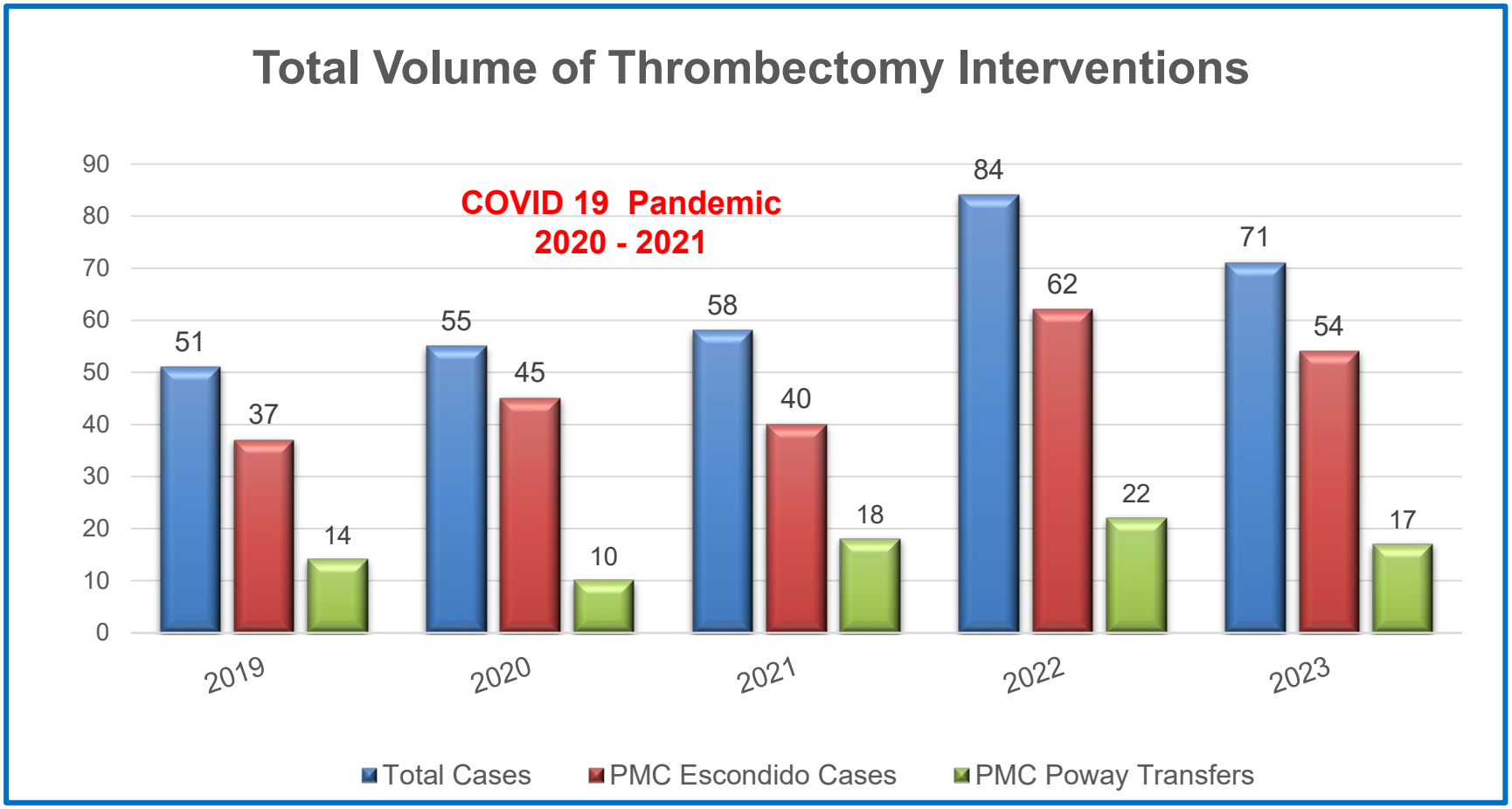
Program Overview: Patient Volumes



Program Overview: Thrombolytic Volume



Program Overview: Neuro Thrombectomy



Program Overview: Summary

2023 Summary	PMC Escondido	PMC Poway
Total Stroke Code Activations: 2023 • Total ED SC: 1322 • Total IPSC: 82 • Total SC Canc: 99	ED SC: 984 – 77 cancelled Inpatient SC: 66	ED SC: 338 – 22 cancelled Inpatient SC: 16
Final Diagnosis: 2023 • Acute Ischemic (AIS) • Hemorrhagic Stroke (HS) • TIA	TOTAL: 707 • AIS: 213 • HS: 222 • TIAs: 173	TOTAL: 153 • AIS: 61 • HS: 18 • TIAs: 74
Thrombolytic Administrations: 2023 Total: 91 Administrations	67 Thrombolytic Administrations • ED: 64 IPSC: 3	24 Thrombolytic Administrations • ED: 24 IPSC: 0
Neuro Endovascular Cases: 2023 Total: 86 Candidates • 71 Thrombectomies • 15 Angio/Cancel/Venous	Total Cases: 63 • 54 Thrombectomy ○ ED: 47 IPSC: 7 • 9 Angio/Cancel/Venous	Total Cases: 23 • 17 Thrombectomy ○ ED: 17 IPSC: 0 • 6 Angio/Cancel/Venous
Treatment Rate for Thrombolytic Combined 2023: 26% Rate of sICH Post Thrombolytic Combined: 1% Treatment Rate for Thrombectomy 2023: 20% Rate of sICH Post Thrombectomy 2023: 5.6%		

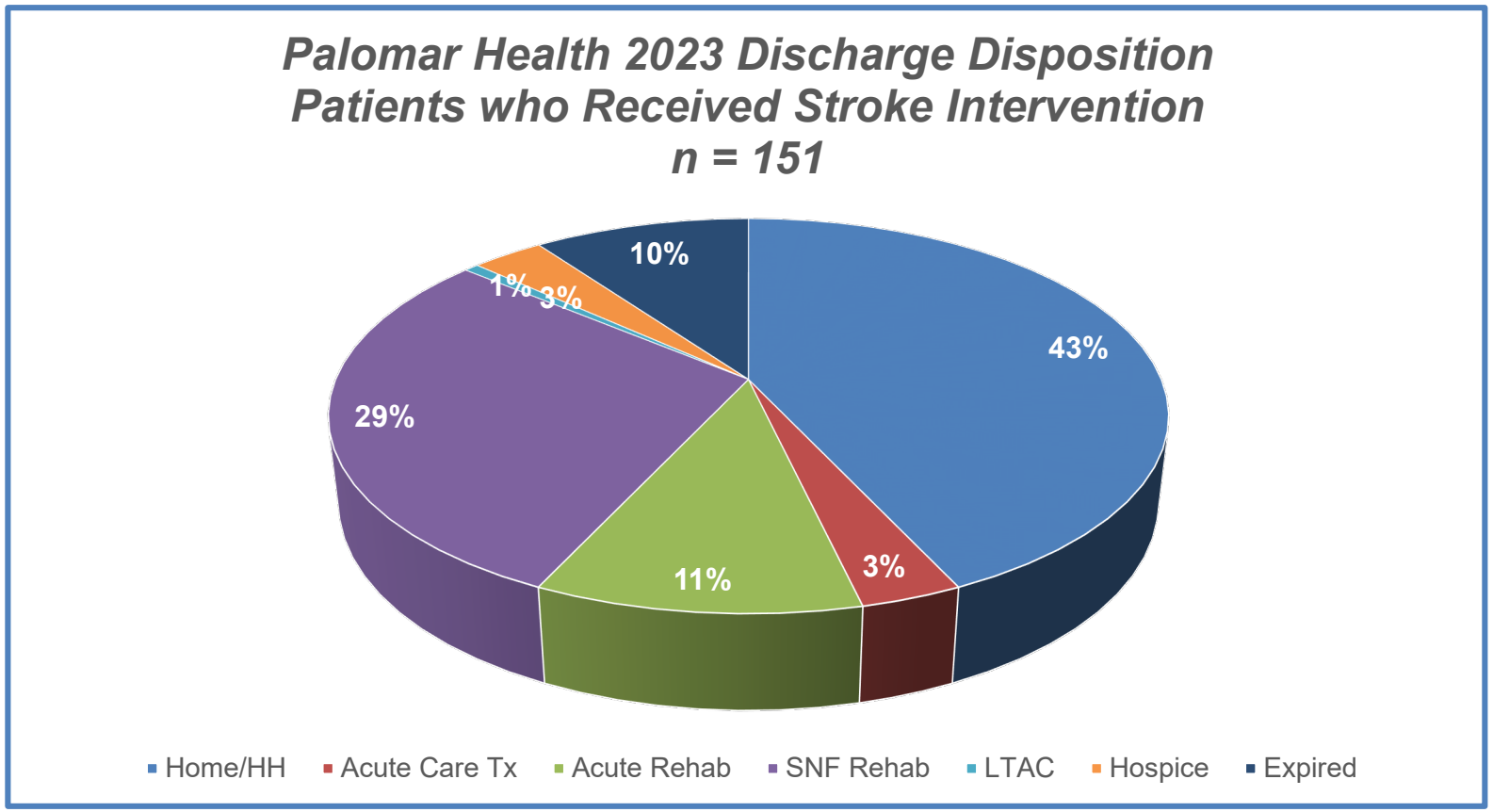
Program Overview: Summary Metrics

Door to Metrics 2022 & 2023 MEDIAN Minutes	PMC Escondido	PMC Poway	Benchmark
Door to Provider	2022: 6 2023: 7	2022: 5 2023: 4	≤ 10
Door to CT Start	2022: 13 2023: 14	2022: 13 2023: 11	≤ 15
Door to CT Results	2022: 31 2023: 37	2022: 30 2023: 33	≤ 35
Door to POCT Glucose	2022: 8 2023: 10	2022: 4 2023: 4	≤ 10
Door to Needle – Thrombolytic Administration	2022: 39 2023: 41	2022: 53 2023: 42	2022: ≤ 60 2023: ≤ 45
Door to Needle - % Met	2022: 100% ≤ 60 min 2022: 79% ≤ 45 min 2022: 17% ≤ 30 min 2023: 87% ≤ 60 min 2023: 71% ≤ 45 min 2023: 29% ≤ 30 min	2022: 67% ≤ 60 min 2022: 22% ≤ 45 min 2022: 0% ≤ 30 min 2023: 91% ≤ 60 min 2023: 64% ≤ 45 min 2023: 18% ≤ 30 min	Joint Commission (JC): • % ≤ 60 min > 50% Target Phase 3 (TP3): • % ≤ 60 min > 85% • % ≤ 45 min > 75% • % ≤ 30 min > 50%

Program Overview: Summary Metrics

Door to Metrics 2022 & 2023 MEDIAN Minutes	PMC Escondido	PMC Poway	Benchmark
Door In – Door Out (DIDO) Transfers	NA	2022 Transfer DIDO: 82 2023 Transfer DIDO: 81	JC: ≤ 120 min PH Goal: ≤ 90 min TP3: ≤ 75 min
Door to Groin Puncture	2022 Direct Cases: 89.5 2023 Direct Cases: 75.0	2022 Transfer Cases: 16.5 2023 Transfer Cases: 18.0	TP3 Direct: ≤ 75 min TP3 Transfer: ≤ 30 min
Door to First Device Pass	2022 Direct Cases: 115.0 2023 Direct Cases: 96.5	2022 Transfer Cases: 44.0 2023 Transfer Cases: 39.5	TP3 Direct: ≤ 90 min TP3 Transfer: ≤ 60 min
Door to First Device Pass – % Met	2022 Direct Cases: 19% 2023 Direct Cases: 40%	2022 Transfer Cases: 78% 2023 Transfer Cases: 94%	TP3 Direct: • % ≤ 90 min > 50% TP3 Transfer: • % ≤ 60 min > 50%

Program Overview:
2023 Discharge Disposition



Program Overview:
2023 Performance Improvement Summary

- Continued success with the use of VIZ-AI for Stroke Codes
- Successful Implementation of the Evidenced-Based YALE Swallow Screen
- Successful switch in thrombolytic medication from Alteplase to Tenecteplase
- Pre-Hospital Stroke Code Activation for EMS arrivals at PMCE
- Pre-Hospital Stroke Code PIT STOP location is direct to CT Scan location
- Successful administration of thrombolytic in the CT Scan location @ Escondido
- Adoption of the FASTED Stroke Severity Scale by San Diego County EMS with early notification of severity score to the Stroke Team as part of the Prehospital Stroke Code activation.
- Stroke patients who are IR Thrombectomy candidates transfer directly to IR Suite versus to an ED Patient Room during normal business hours
- Continue active participation with SD County Stroke Consortium: continue to serve as the Chair of the SD County Stroke Advisory Committee.
- Successful Community Stroke Awareness Event at the San Diego Padres
- Successful IT Improvements/Updates in EHR for Stroke Documentation

Program Overview:
2024 Performance Improvement Initiatives

- Adopt all Target Stroke Phase 3 “Door to” metrics
- Continue to improve “Door to” metrics for thrombectomy cases @ Escondido
- Implement an Evidenced-based tool for “Caregiver Readiness Assessment” for Stroke patients going home.
- Develop an education program for staff regarding stroke and stroke program outcomes.
- Implement an improved process for Inpatient Stroke Code activations.