Posted
FRIDAY
MAY 17, 2024

PALOMAR HEALTH

BOARD QUALITY REVIEW COMMITTEE MEETING
AGENDA

Wednesday, May 22, 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 – March 27, 2024 (ADD A – Pp 16)	5	7	4:05
	b. *Approval of Contracted Services *Valerie Martinez, Sr. Director, Quality, Patient Safety & Infection Control* a) Corticare (ADD B – Pp 19) b) BD Fusion (ADD C – Pp 20)	5	8 9	4:10
	c. *Approval of Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan (ADD D – Pp 21) *Valerie Martinez, Sr. Director, Quality, Patient Safety & Infection Control* *Omar Khawaja, MD, Chief Medical Officer*	5	10	4:15
	d. *Approval of Infection Prevention & Control CY2023 Annual Review and Program Assessment (ADD E – Pp 29) *Valerie Martinez, Sr. Director, Quality, Patient Safety & Infection Control* *Sandeep Soni, MD, Medical Director, Infection Control*	5	11	4:20
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	-	4:25
5.	**New Business**			
	a. Radiology & Nuclear Medicine Medical Staff & Department Report (ADD F – Pp 71) *Sims Kendall, Sr. District. Director, Diagnostic Imaging Services* *Ryan Fearn-Gomez, VP Operations* *Charles McGraw, MD, Chair Dept of Radiology, PMCE* *Arian Nasiri, MD, Chair, Dept of Radiology, PMCP*	5	12	4:35
	b. Laboratory Services (includes Blood Usage, Tissue Review) (ADD G – Pp 86) *Gloria Austria, Director of Laboratories* *Jerry Kolins, MD, Medical Director, Laboratories* *Bradley Harward, MD, (Tissue Review)*	5	13	4:40
	c. Centers of Excellence –Spine & Total Joint Surgery Annual Report (ADD H – Pp 101) *Najeebe Geagea, MSN, RN, CNS, Service Line Clinical Coordinator* *James Bried, MD, Medical Director* *Andrew Nguyen, MD, Medical Director*	5	14	4:45
	d. Antimicrobial Stewardship Annual Report (ADD I – Pp 117) *Travis Lau, PharmD, Infectious Disease Specialist (Antibiotic Stewardship)* *Sandeep Soni, MD, Medical Director, Infection Control*	5	15	4:50
6.	**Adjournment to Closed Session**	1	-	4:55
	Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: *Report of Quality Assurance Committee*	10	-	4:56

7.	**Adjournment to Open Session**	1	-	5:06
8.	**Action Resulting from Executive Session**	1	-	5:07
FINAL ADJOURNMENT		2	-	5:08

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	**Andrew Tokar,** Chief Financial Officer
Andrew Nguyen, MD, PhD – Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido	**Melvin Russell, RN, MSN**, Chief Nurse Executive/Chief Operating Officer
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 442.281.2505, 72 hours prior to the event so that we may provide reasonable accommodations

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

[1] *3 minutes allowed per speaker with a cumulative total of 9 minutes per group. For further details & policy, see page 5.*

PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE

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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.

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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 3:30 p.m.

Request for Public Comments

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

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

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

Public Comments Process

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

PALOMAR HEALTH
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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**	**5/22/2024**				
LINDA GREER, RN, Chairperson, Board Member	P	P					
TERRY CORALES, RN, Board Member	P	P					
LAURA BARRY, Board Member	P	P					
ANDREW NGUYEN, MD, PhD, Chair, Medical Staff Quality Management Committee, PMC Escondido	P	P					
MARK GOLDSWORTHY, MD, Chair, Medical Staff Quality Management Committee, PMC Poway	P	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	P					
MEL RUSSELL, RN, MSN, Chief Nursing Executive	P	P					
VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety	P	P					
DAVID LEE, MD, Medical Quality Officer	P	P					
KEVIN DEBRUIN, Esq., Chief Legal Officer	P						
SALLY VALLE – Committee Assistant	P	P					
INVITED GUESTS	**SEE TEXT OF MINUTES FOR NAMES OF INVITED GUESTS**						

Board Quality Review Committee Minutes
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

FROM: Sally Valle, Committee Assistant

Background: Minutes from the Wednesday, March 27, 2024, Board Quality Review Committee meeting are respectfully submitted for approval.

Budget Impact: N/A

Staff Recommendation: Recommend to approve the Wednesday, March 27, 2024, Board Quality Review Committee minutes

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Contracted Services – Corticare
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

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

Background: The Contracted Services Evaluation report for Corticare 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 – BD Fusion
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

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

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

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Annual Review of Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

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

Background: The Annual Review of the Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan is provided to the Board Quality Review Committee for review & approval.

Budget Impact: N/A

Staff Recommendation: To approve.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion: X

Individual Action:

Information:

Required Time:

Board Quality Review Committee
Annual Review of Infection Prevention & Control CY2023
Annual Review & Program Assessment
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

FROM: Valerie Martinez, Sr. Dir Quality and Patient Safety
Sandeep Soni, MD, Medical Director

Background: The Annual Review of the Infection Prevention & Control CY2023 Annual Review & Program Assessment 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 – Department of Radiology & Nuclear Medicine
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

FROM: Ryan Fearn-Gomez, VP Operations
Charles McGraw, MD, Chair, Department of Radiology, PMC Escondido

Background: The annual report for the Department of Radiology & Nuclear 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 – Laboratory Services (includes tissue & blood usage)
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

FROM: Gloria Austria, District Director
Jerry Kolins, Medical Director
Bradley Harward, MD

Background: The annual report for the Laboratory Services (includes tissue & blood usage) 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 – Spine Surgery & Total Joint Centers of Excellence
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

FROM: Najeebe Geagea, MSN, RN, CNS, Service Line Clinical Coordinator
Andrew Nguyen, MD, PhD, Med Dir (Spine Surgery)
James Bried, MD, Medical Director (Total Joint)

Background: The annual report for the Spine Surgery & Total Joint Centers of Excellence is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:

Board Quality Review Committee
Antimicrobial Stewardship Annual Report
Wednesday, May 22, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, May 22, 2024

FROM: Travis Lau, Infectious Disease Specialist
Sandeep Soni, MD, Medical Director

Background: The Antimicrobial Stewardship Annual Report is provided to the Board Quality Review Committee for information only.

Budget Impact: N/A

Staff Recommendation: For information only.

Committee Questions:

COMMITTEE RECOMMENDATION:

Motion:

Individual Action:

Information: X

Required Time:

PALOMAR HEALTH

ADDENDUM A

BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, MARCH 27, 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, March 22, 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 3:30 p.m. by Director Linda Greer, RN.			
ESTABLISHMENT OF QUORUM			
Quorum comprised of Board Directors: Greer, Corrales, Barry, Goldsworthy, MD, Nguyen, MD (*joined during Emergency Medicine Report)*			
PUBLIC COMMENT			
• There were no public comments.			
ACTION ITEMS:			
a. Minutes: Board Quality Review Committee Meeting – January 24, 2024	**MOTION:** by Director Barry, second by Dr. Goldsworthy, carried to approve the meeting minutes of January 24, 2024, as submitted. Roll call voting was utilized. Director Barry – aye Director Greer – aye Director Corrales – aye Dr. Mark Goldsworthy - aye All in favor. None opposed. Motion approved		

Discussion:			
b. Approval of Contracted Services I. Premier Laser Services	**MOTION:** by Director Corrales, second by Director Barry, carried to approve item B, I Contracted Services as presented. Roll call voting was utilized. Director Corrales - aye Director Barry – aye Director Greer - aye Mark Goldsworthy, MD – aye All in favor. None opposed. Motion approved		
Discussion:			
STANDING ITEMS:			
a. Medical Executive Committee (MEC)/Quality Management Committee (QMC) Update			
• Mark Goldsworthy, 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. Emergency Medicine Annual Report			
• Tracy Page, Emergency Department Director and Nicholle Bromley, MD, Emergency Department Medical Director, presented the Emergency Medicine Annual Report.			
b. Trauma Program Annual Report			
• Melinda Case, Trauma Program Director and John Steele, MD, Trauma Program Medical Director, presented the Trauma Program Annual Report.			
c. Respiratory Services Annual Report			
• Kerwin Pipersburgh, Respiratory Services Manager and Frank Bender, MD, Respiratory Services Medical Director, presented the Respiratory Services Annual Report.			
d. Stroke Program Annual Report			
• Lourdes Januszewicz, Stroke Program Coordinator and Remia Paduga, MD, Stroke Program Medical Director, presented the Respiratory 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 4:45 p.m.
SIGNATURES: **COMMITTEE CHAIR** _____ Linda Greer, RN **COMMITTEE ASSISTANT** _____ Sally Valle

ADDENDUM B

Corticare Inc.
Review of Contract Service

Name of Service: CortiCare Monitoring Service

Date of Review: 4/20/24 **Name / Title of Reviewer:** Ashley Rowe/7W Nurse Manager

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

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

Performance Metrics

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

Comments

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

Conclusion (check one)

X Contract service has met expectations for the review period

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

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

ADDENDUM C

Name of Service: BD Carefusion - IV Prep Workflow program

Date of Review: 5/1/2024 **Name / Title of Reviewer:** Dondreia Gelios, District Director of Pharmacy

Nature of Service (describe): Annual Evaluation

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Met	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Met	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	Met	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.		Current program did not meet expectation. We are negotiating new contract with additional software
5. Assures that care, treatment, and service is provided in a safe, effective, efficient, and timely manner emphasizing the need to – as applicable to the scope and nature of the contract service – improve health outcomes and the prevent and reduce medical errors.		Current program did not meet expectation. We are negotiating new contract with additional software

Performance Metrics

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

Comments
BD has determined their IV Prep Workflow program did not meet customer's expectations and is removing this program from the market by end of year 2025. Palomar Health will be moving to a different program in July 2024 to handle IV room regulatory compliance.

Conclusion (check one)

☐ Contract service has met expectations for the review period

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

- ☐ Monitoring and oversight of the contract service has been increased
- ☐ Training and consultation have been provided to the contract service
- ■ The terms of the contractual agreement have been renegotiated with the contract entity without disruption in the continuity of patient care
- ☐ Penalties or other remedies have been applied to the contract entity
- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ■ Other: New contract with MedKeeper to be implemented in July 2024

ADDENDUM D

PALOMAR HEALTH

DocID: 11234
Revision: 23
Status: Official

Source: Administrative Plans

Applies to Facilities: All Palomar Health Facilities

Applies to Departments: All Departments

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

I. **SUMMARY/INTENT:**

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 that 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 followup on Good Catches/Near Misses, Patient Safety Events, Sentinel Events and unsafe conditions. These standardized processes address:
   a. An investigation into the cause of the adverse event may be undertaken pursuant to the Medical Center's Review Process.
   b. The investigation would be conducted for the purpose of the evaluation and improvement of the quality of care.
   c. What practice/process change is required to prevent recurrence.
   d. How the practice/process change will be accomplished.
   e. Who is responsible for the practice/process change.
   f. Timeline for completion.
   g. Description of the monitoring and sustainment of processes to prevent a recurrence.

V. **GOALS**

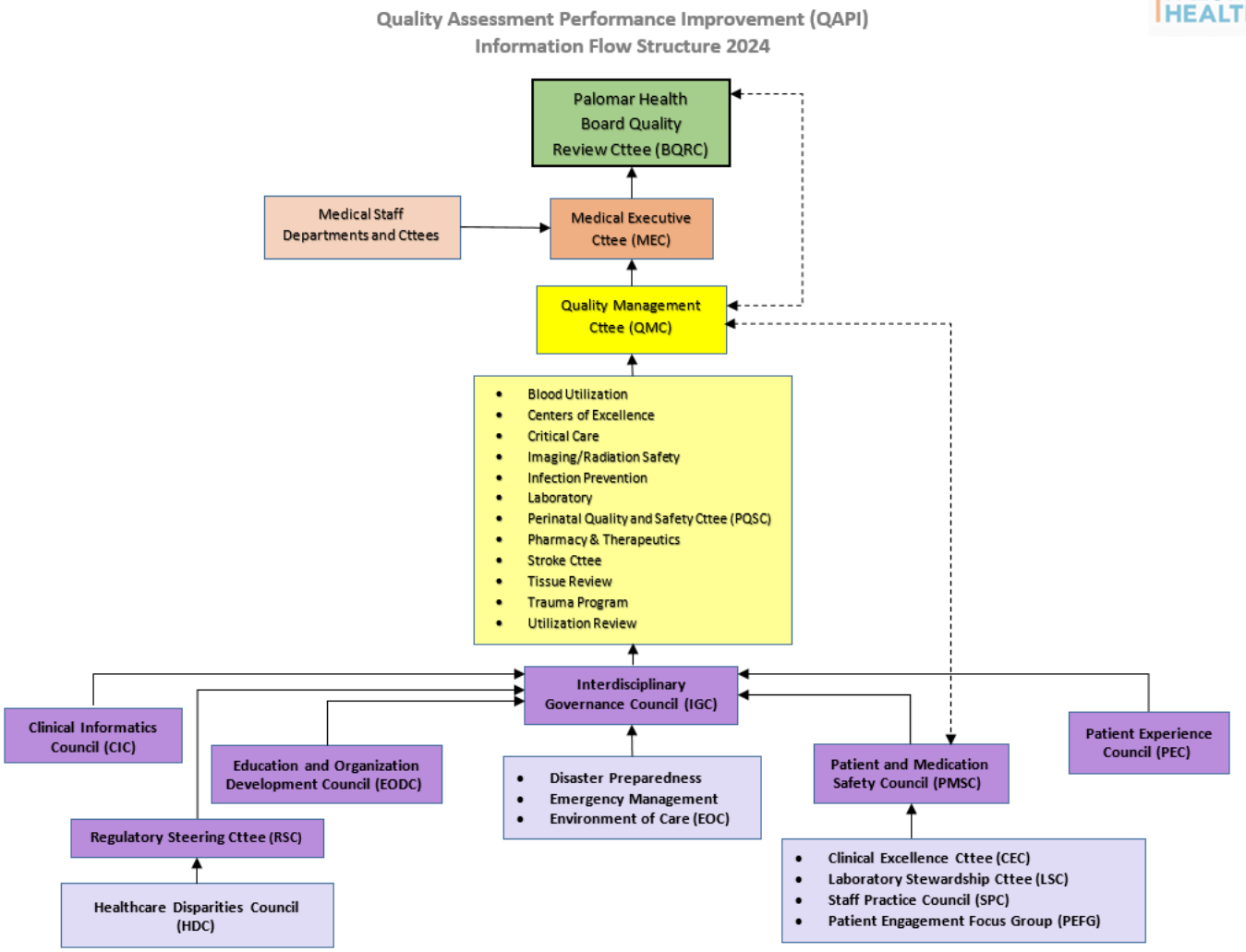
A. As part of the annual evaluation of the Quality Assessment Performance Improvement (QAPI) activities and goals are identified for each calendar year to ensure continuous improvement. The following actions should be taken in forming specific goals:

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

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

1. Management of the Care Environment - to include but not limited to, risk assessments and environmental surveillance as it pertains to patient safety. Refer to Safety Management Plan # 11495.
2. Management of the Medical Record
3. Infection Prevention and Control and Antibiotic Stewardship
4. Patient Rights
5. Medication Management
6. Anesthesia Services
7. Dietary Services
8. Discharge Planning
9. Laboratory Services
10. Nuclear Medicine Services
11. Nursing Services
12. Operative and Invasive Services
13. Outpatient Services
14. Radiology Services
15. Rehabilitation Services
16. Respiratory Services
17. Contracted Services:
    a. 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 requests. 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: The CIC will make recommendations for final approval to the Interdisciplinary Governance Council based on the authority level granted. Recommendations regarding request 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 (RSC):**
   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 RSC 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: PMSC will make recommendations and project proposals from councils/committees that report to PMSC to the IGC for updates and approval. PMSC has a dotted line directly to QMC to report out any information solely for quality improvement purposes in accordance with California Evidence Code 1157.

I. **Clinical Excellence Committee (CEC):**
   1. Purpose: To share nursing clinical practice encompassing but not limited to the following: to provide high quality and safe patient care through the implementation of evidenced based practice, standardization of clinical practice, and effective communication that includes frontline staff.
   2. Governance: The CEC has the authority to make decisions and approve new processes and clinical practice changes that directly affect nursing practice. Any practice change that affects disciplines outside of nursing, requires approval from the appropriate department/s and IGC.

J. **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 PEC will make recommendations regarding performance improvement plans and best practices to the IGC for approval.

K. **Staff Practice Council (SPC)**:
   1. Purpose: The purpose of the Staff Practice Council (SPC) 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 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 IGC.

L. **Patient Engagement Focus Group (PEFG):**
   1. Purpose: The purpose of the Patient Engagement Focus Group (PEFG) is to provide patient and family feedback, and provide recommendations on patient and family centered care.
   2. Composition: The PEFG will be made up of former patients/patient family, and Palomar Health staff liaison(s).
   3. Governance: This group will report to the PMSC and provide guidance. Sponsors will provide updates or requests for IGC approval via PMSC.

M. **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.

N. **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.

O. **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.

P. **Subcommittee of Critical Care - Code Blue Committee**:
   1. Duties:
      1. Review and monitor Code Blue, Code White and Rapid Response events, ensure evidence and standardized policies & procedures, and processes while addressing new opportunities for improvement.
      2. Monitor and review data and perform case reviews to identify opportunities for improvement and/or education.
      3. Review and provide input of changes in Code Blue equipment and/or supplies, ensuring quality assurance, and developing and monitoring regional education programs and quality plans.
   2. Composition: Co-Chairs are ED, ICU Providers and ICU Leader, along with broad representation from appropriate areas of Medical Staff, Nursing, Respiratory Therapy, Rapid Response, Leadership and other disciplines as appropriate.

Q. **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.

R. **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 actions or 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).

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

A. Duties:
    1. Develop and implement written policies and procedures for the establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of medications.
    2. Develop and maintain a formulary of drugs throughout the hospitals.
    3. Monitor the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition, and clinical dietary consultations.
    4. Review Adverse Drug Reaction Event Program.
    5. Review Medication Error Reduction Plan at least annually.
    6. 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.
    7. 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.
    8. The P&T committee will report to the Quality Management Committee.

B. 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.

T. Subcommittees of P&T:

A. **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.
    1. Duties: The duties of the Nutrition and Therapeutics Committee include, but are not limited to:
        a. Assisting the pharmaceutical service in maintaining the enteral and parenteral Hospital Formulary.
        b. Monitoring the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition and clinical dietary consultations.
    2. Composition: The N&TC is comprised of a multidisciplinary team of health professionals including Nutritional Services, Medical Staff, Pharmacy and Nursing.

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

C. **Controlled Substance Diversion Prevention Committee (CSDPC):**
    1. Duties: The committee is responsible for oversight of diversion prevention, detection and investigation, including to:
        a. Foster a multidisciplinary approach to proactive diversion prevention, detection, and investigation.
        b. Manage all projects and procedures related to diversion prevention for both the hospital staff and Medical Staff.
        c. Ensure adequate resourcing of drug diversion prevention efforts.
        d. Prioritization and management of projects related to diversion prevention.
        e. Review all suspected diversion formal investigations to identify appropriate follow up and learning or performance improvement opportunities.
        f. Develop educational strategies to ensure that hospital staff and medical staff are aware of the risks of abuse, the prevalence of diversion, and their role in following hospital procedures related to drug diversion.
        g. Monitor the effectiveness of the diversion prevention program by defining and monitoring key metrics for the program.
        h. Establish and manage the strategic priorities of the diversion prevention program.
        i. Lead efforts to ensure appropriate controlled substance medication use including prescribing, dispensing, administering, education and monitoring in an effort to minimize the risk to our patients, employees, and the community we serve.
    2. Composition: Includes but not limited to; Pharmacy, Nursing, Medical Staff, Quality, and Regulatory. Ad hoc members may include but not limited to; Risk Management, Security, Information Technology, Human Resources, Information Security, Infection Control, and Corporate Compliance.
    3. Meetings: The CSDPC will meet at least six times a year.

VII. NON-MEDICAL STAFF QAPI COMMITTEES AND FUNCTIONS

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

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

B. **Centers of Excellence - Cardiovascular and Total Joint Replacement (PMCE and PMCP) and Spine Surgery (PMCE)**
1. Duties:
    a. To achieve success through partnerships committed to delivering the ideal care experience with the highest levels of quality and value.
    b. To achieve and maintain Center of Excellence status by providing comprehensive, coordinated and integrated services across the continuum of care.
2. Composition:
    a. Co-Chaired by the Service Line Director and Medical Director(s), Clinical Resource Management, Nursing Unit Leaders / Clinical Nurse Specialists, Operating Room (OR) and Post Anesthesia Care Unit (PACU) Leaders, Physical Therapy / Rehabilitation, Pharmacy, Quality/Infection Control, Home Health, Executive Leaders, Surgeons and Anesthesiologists, Supply Chain, Physician's private practice administrators and invited guests (other Medical Directors).

C. **Perinatal Quality and Safety Committee (PQSC)**
1. Duties:
    a. Review cases of severe maternal and neonatal morbidity for process and quality improvement opportunities. These case reviews do not take the place of medical staff peer review. Cases will also be sent to Medical Staff Peer Review and Nurse Peer Review committees when appropriate.
    b. Review Joint Commission Perinatal Core Measures and Perinatal Quality Incentive Program (QIP) measures and make recommendations for process and quality improvement opportunities.
    c. Seek out additional opportunities for department improvements; determine steps necessary to make improvements and metrics to measure success.
    d. Lead with a team-based, collaborative approach that supports Just Culture.
    e. Provide interdisciplinary case presentations for both medical and nursing staff on a regular basis.
    f. This committee will report directly to QMC.
2. Composition: Physician leaders, Nursing leaders, front line staff and ad-hoc members as necessary.

D. **Stroke Committee:**
1. Duties:
    a. Provide oversight, coordination and direction to the individuals caring for the stroke patients.
    b. Evaluate appropriateness and adequacy of the program through a review of clinical practice guidelines, power plans, and procedures.
    c. Coordinate education programs for staff and the community we serve.
    d. Monitor, analyze, and evaluate stroke measures; identify opportunities for improvement; share recommendations and outcomes.
    e. Participate in the Palomar Health Quality Assessment and Performance Improvement program.
    f. Maintain Joint Commission Stroke Program certification standards.
    g. Stroke Committee will report through the Quality Management Committee.
2. Composition:
    a. The committee is chaired by the Stroke Medical Director and facilitated by the Stroke Coordinator.
    b. 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.

E. **Laboratory Services: Quality**
1. Duties: Laboratory Services: Lab Quality includes, but are not limited to:
    a. Review and approve monthly Lab Quality indicators and Blood Bank audits.
    b. 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.
    c. Identify opportunities for process improvement from staff feedback, variance reports, QRR reports, and quality indicator results.
    d. Evaluate results of monthly ED turnaround time report.
    e. Review actions and decisions with Medical Laboratory Director.
2. Composition:
    a. 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.

F. **Laboratory Stewardship Committee:**
1. Duties:
    a. Review testing utilization and frequency.
    b. Monitor data to review appropriateness of the test ordered, test interpretation, and test result accessibility.
    c. Identify opportunities to improve processes, education, test menu, workflow, turnaround times.
    d. Make recommendations on evidence-based testing algorithms.
2. Composition:
    a. All departments within the laboratory, IT and any ad-hoc departments as needed to include but not limited to; Quality, Nursing, Pharmacy, Regulatory, Finance, Providers and Compliance.

G. **Environment of Care (EOC) Committee**:
1. Duties: Specific responsibilities include, but are not limited to the following:
    a. Development and review of procedures
    b. Develop and monitor the Environment of Care management plans, Hazardous Materials and Waste program, and the Illness and Injury Prevention program.
    c. Environmental Surveillance, Safety Education and Product Recall Monitoring.
    d. Monitor the results of regulatory inspections and refer to Regulatory Steering Committee.
    e. Analyze and aggregate data. Recommendations are developed and approved as applicable.
    f. This committee will report up through the Interdisciplinary Governance Committee.
2. Composition:
    a. 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.

H. **Disaster Preparedness Committee (DPC):**
1. Duties: The District Wide Disaster Preparedness Committee is responsible for ensuring:
    a. Develop and review of procedures.
    b. Develop and monitor the Emergency Management Program.
    c. Disaster planning and disaster related activities are managed and implemented.
    d. Ensure meetings are scheduled and information, progress notes, and follow-up activities from this committee are reported to the Environment of Care Committee.
    e. This committee will report up through the Interdisciplinary Governance Committee.
2. Composition:
    a. 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.

I. **Continuum Care Operations Division:**
1. Purpose: Under the direction of the Vice President, the Directors within the Continuum Care promote 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, the 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:
    a. Identification of patient needs and expectations and evaluation of how these needs and expectations are met

b. Identification of staff education and training needs and ongoing measurements to demonstrate sustained improvement
c. Use of evidence-based data from internal and external sources to improve the quality of care
d. Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing, and ambulatory services
e. Analysis of data to establish priorities and identify opportunities for future improvement

2. Entities under the umbrella of the Continuum Care Operations Improvement Function include:
   a. The Villas at Poway Quality Committee
   b. Rehabilitation Services
   c. Ambulatory Specialty Outpatient Services
3. The performance improvement measures that reflect a direct contribution of Continuum Care achieving quality and safe patient care outcomes may include:
   a. Physician and Employee Engagement
   b. Patient Experience
   c. Risk
   d. Regulatory or accreditation requirements
   e. Patient and community outcomes
   f. CMS Quality Indicators for Skilled Nursing

VIII. 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:	(03/13/2024) Quality Management (QMC) (joint), (03/25/2024) Medical Executive Committee, Escondido, (03/26/2024) Medical Executive Committee, Poway
Revision Date:	[04/02/2024 Rev. 23]
Standards: (WHICH REFERENCE THIS DOCUMENT)	**College of American Pathologists:** • Laboratory General - GEN.13806 • Laboratory General - GEN.13806 • Laboratory General - GEN.13806 • Laboratory General - GEN.13806
Attachments: (REFERENCED BY THIS DOCUMENT)	Quality Assurance Plan in Surgical Pathology Patient Safety Event Response, Investigation and Follow-Up patientsafetyreport@jointcommission.org Patient Complaint/Grievance Process CMS.Gov Reducing Disparity in Health Care Safety Management Plan

Paper copies of this document may not be current and should not be relied on for official purposes. The current version is in Lucidoc at https://www.lucidoc.com/cgi/doc-gw.pl?ref=pphealth:11234$23.

ADDENDUM E

PALOMAR HEALTH

INFECTION PREVENTION & CONTROL CALENDAR YEAR 2023 ANNUAL REVIEW AND PROGRAM ASSESSMENT

PALOMAR HEALTH

Table of Contents

PALOMAR HEALTH

Introduction

Annual Review and Program Assessment

The Infection Prevention and Control program is evaluated annually. This assessment compares outcomes from calendar year 2022 to 2023. The assessment includes all surveillance modalities, both process and outcome measures and what is performed by the various disciplines including the Infection Preventionists (IP). Infection control measures include hand hygiene adherence monitoring, the ongoing monitoring of high-level disinfection processes, Sterile Processing Department, medication preparation, food and nutrition services, construction, and outpatient services are included. The IP staff use their role as department resources and consultants to provide their expertise, support, and evidence-based recommendations to ensure the program and the system wide surveillance plan is followed. The program assessment provides information to steer the Infection Prevention and Control Department's focus for the upcoming year. Each measure is evaluated for effectiveness and is considered a driver for departmental and unit based action planning. Process and outcome measures are shared at the Board of Directors, physician, nursing, support services levels and used to improve patient care activities. Infection Control rounding activities help to identify opportunities for improvement.

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

Infection Prevention Mission

Develop and maintain an Infection Prevention and Control program that reflects the Mission, Vision, and Values of Palomar Health. The program promotes patient safety by reducing the risk of acquiring or transmitting infections among patients, healthcare providers, volunteers, and visitors.

Purpose

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

Authority Statement

Palomar Health has designated the Infection Control Officers to the Senior Director of Quality, Patient Safety, Infection Prevention, and the Medical Director of Infection Control and Antibiotic Stewardship.

The Infection Control Officers have clinical authority over the infection prevention and control program for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The Infection Control Officers are qualified through education, training, experience, and certification in infection prevention and control. The officers are appointed by the governing body to be responsible for the infection prevention and control program. This appointment is based on recommendations of the medical staff and nursing leadership. When the Infection Control Officers do not have expertise in a particular area they consult with someone who has such expertise in order to make knowledgeable decisions.

The Infection Control Officers are responsible for:

- Developing and implementing hospital-wide infection surveillance, prevention, and control policies and procedures that adhere to nationally recognized guidelines
- Documenting infection prevention and control program surveillance, prevention, and control activities
- Communicating and collaborating with the quality assessment and performance improvement program on infection prevention and control issues
- Training and educating staff, including medical staff on the practical applications of infection prevention and control guidelines, policies and procedures, preventing and controlling healthcare associated infections
- Auditing of adherence to infection prevention and control policies and procedures by hospital staff including medical staff, communicating and collaborating with the antibiotic stewardship program

The Infection Control Committee, through its chairperson and/or Senior Director of the Infection Prevention and Control Program, are granted authority to institute any appropriate emergency control measures throughout the health system when there is a reasonable risk or danger to any patient, healthcare provider, volunteer, or visitor.

Access to Information

Patient information used in infection surveillance is accessed through the Cerner electronic medical record. Cerner also has an Infection Prevention Worklist program which assists in identifying patients who have communicable reportable diseases, recent discharges, and multi-drug resistant organisms. Cerner analytics reports allow for follow up of isolation, and monthly lab review. The ECHOview system allows for daily review of microbiological reports.

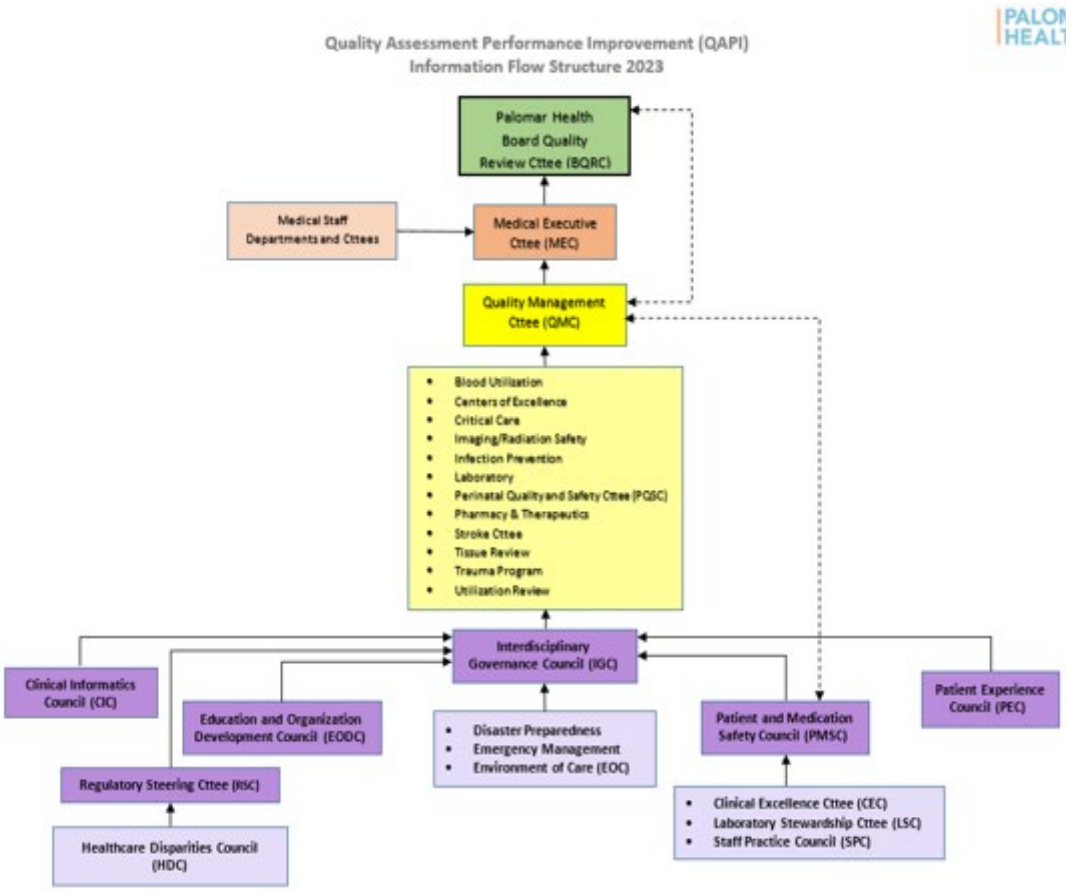
Equipment and Resources

Access to information and laboratory resources support the infection prevention and control program. Equipment and supplies are available to support the infection prevention and control program.

PALOMAR HEALTH

Department Structure

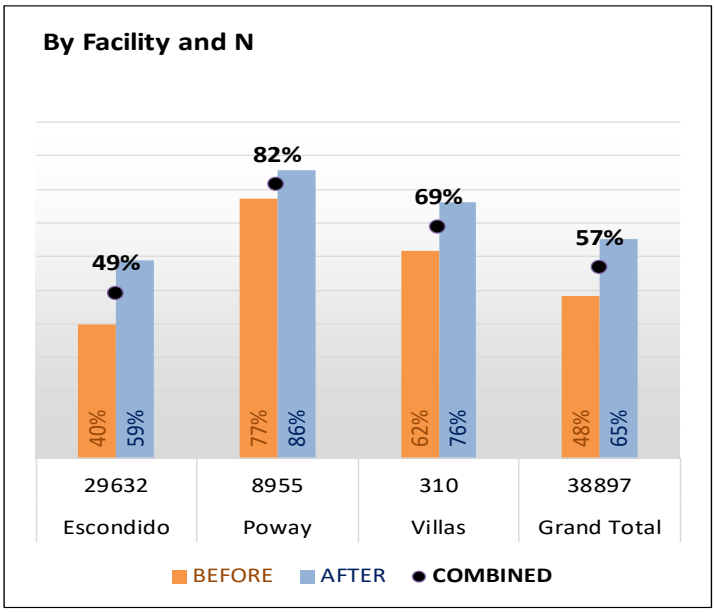
The Infection Prevention and Control Department is structured under the Chief Medical Officer and Quality Department. The Infection Prevention and Control Program reports directly to the Quality Management Committee.

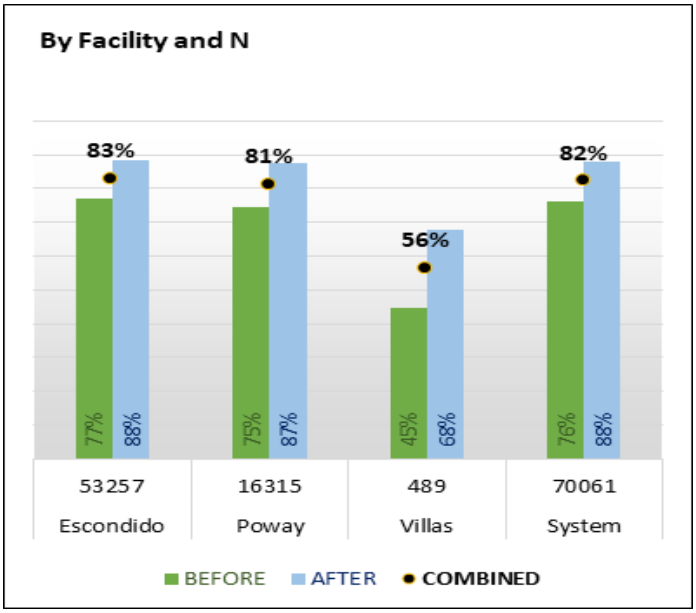


Hand Hygiene

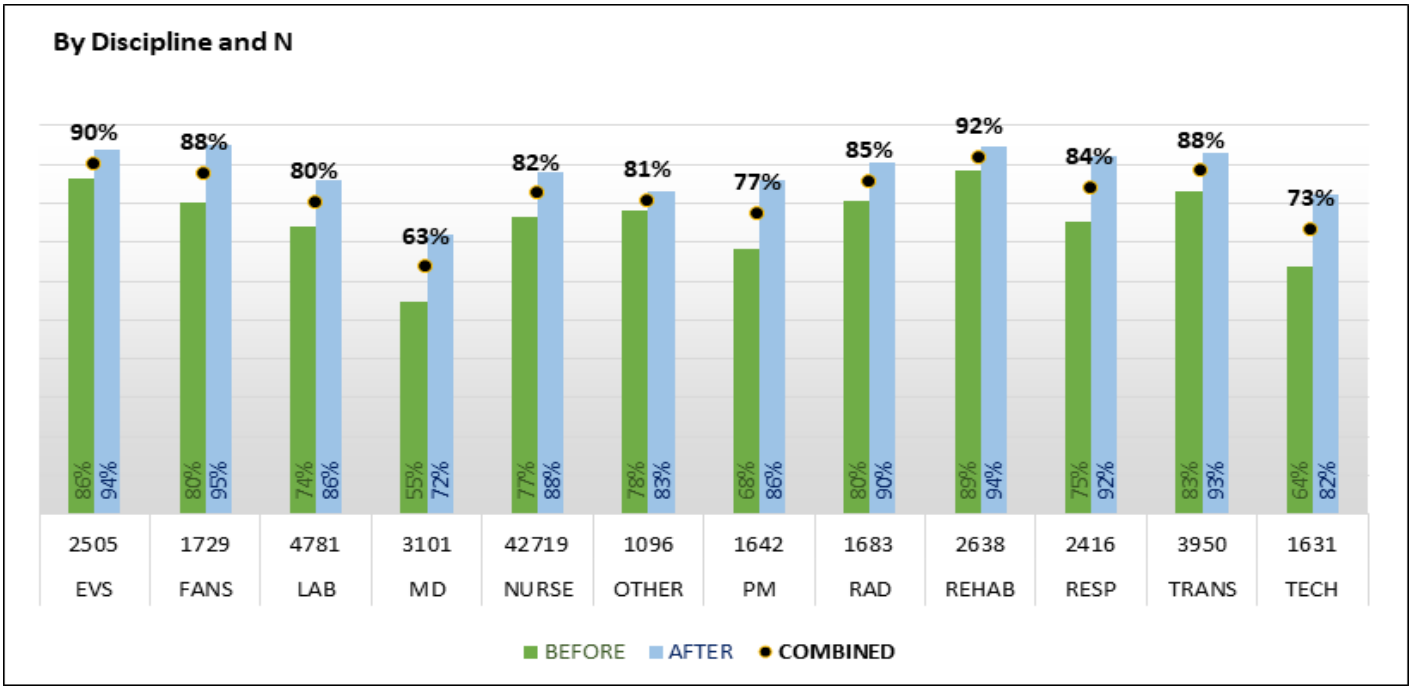
Goal: Increase facility *before patient contact* hand hygiene compliance by ≥10% or maintain above 85% compliance from 2022; measured by Palomar Health Infection Control standardized methods.

2022 & 2023 Hand Hygiene Compliance by Facility





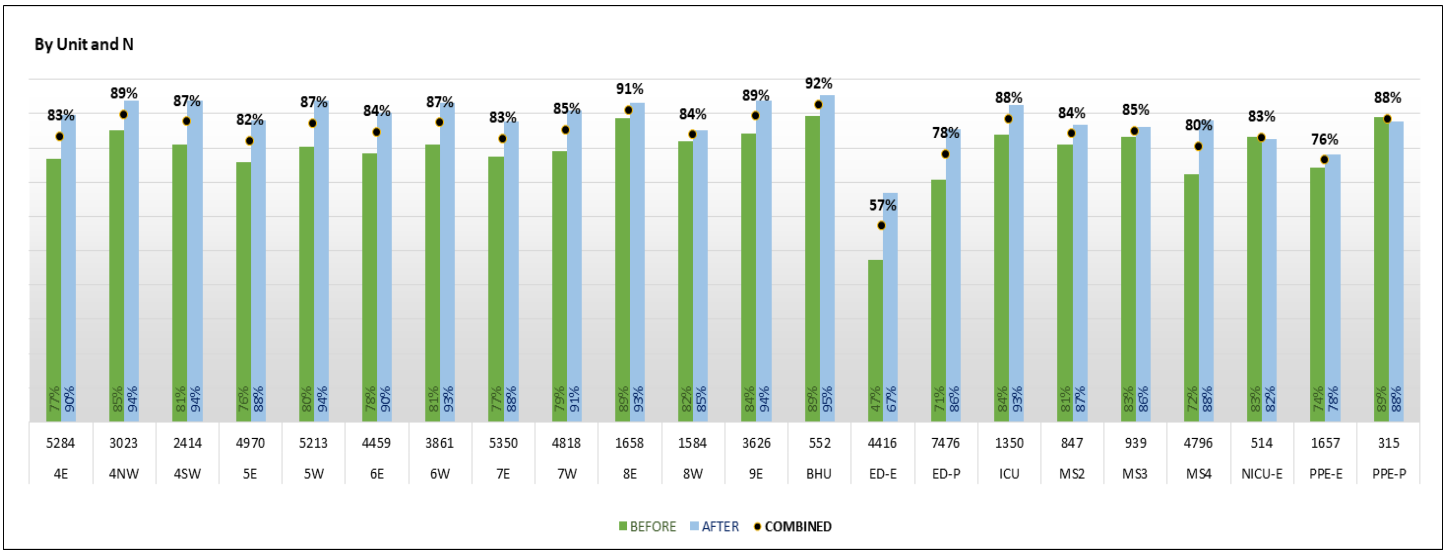
2023 Hand Hygiene Compliance by Discipline



NURSE = RN, CNA; RAD = Radiology/Imaging; MD = MD, OD, PA, NP; FANS = Food service, RD; RESP = Respiratory care practitioners; TRANS = Transport/lift team; EVS = Environmental Service; REHAB = PT, OT, ST; LAB = Phlebotomists; PM = CCE, Pathmakers, Volunteers, Students; TECH = ED techs, Cardiology techs, Medical tech/asst.; OTHER = Security, Social worker, Chaplain, etc.

PALOMAR HEALTH

2023 Hand Hygiene Compliance by Unit



Summary Analysis: During 2023, hand hygiene compliance system-wide improved before patient contact by 63% and 44% for both before and after contact meeting the goal of ≥10% increase. This is primarily because PMC Poway overall compliance is 81% is below goal of 85% from 2022 data. PMC Escondido realized a 69% increase overall during 2023. None of the participating facilities demonstrated >85 % compliance during 2023. Palomar Health provides education upon hire, and annually thereafter. This education is dynamic and includes return demonstration. Physician onboarding process was improved to include this education.

Goal Met/Unmet:

PMC Escondido - Goal Met

PMC Poway – Goal Unmet

Action Plan:

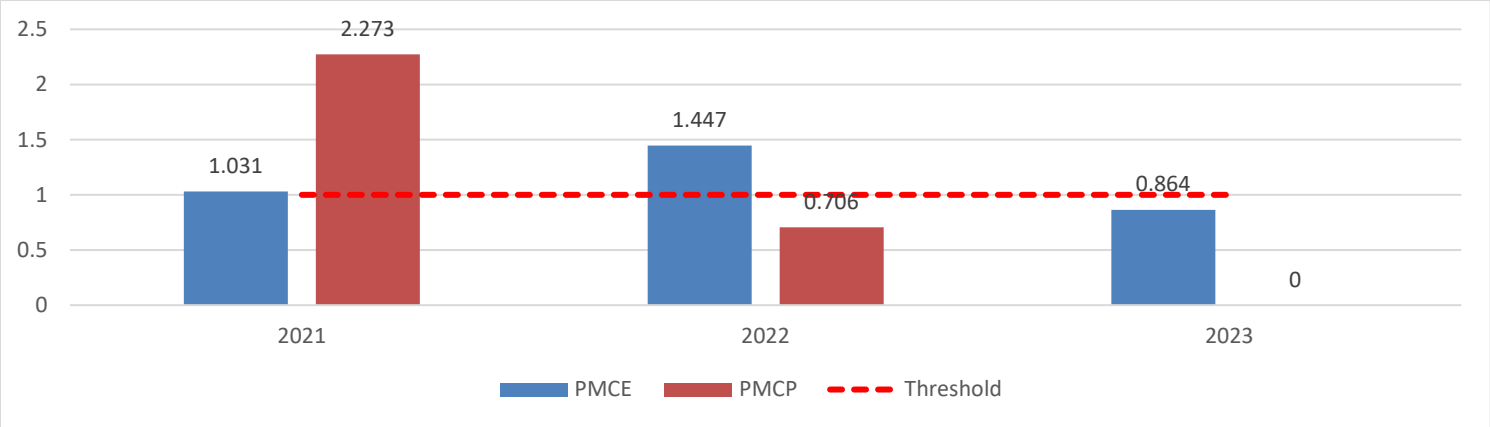
1. Provide hand hygiene education to employees upon hire, annually, and regularly with units or disciplines as appropriate.
2. Add to secret shoppers, department based leaders trained and assigned to hand hygiene data collection.
3. Provide Leaders department level data monthly.
4. Medical staff engagement – during onboarding physicians participate in hand hygiene competency.
5. Staff Leader engagement – leaders in areas of low compliance report their unit-based interventions to improve their hand hygiene at the Infection Control & Prevention Committee.
6. Add alcohol-based hand sanitizer dispensers where appropriate.

PALOMAR HEALTH

Central Line-Associated Bloodstream Infection (CLABSI)

CLABSI Standardized Infection Ratio (SIR)

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



Summary Analysis:

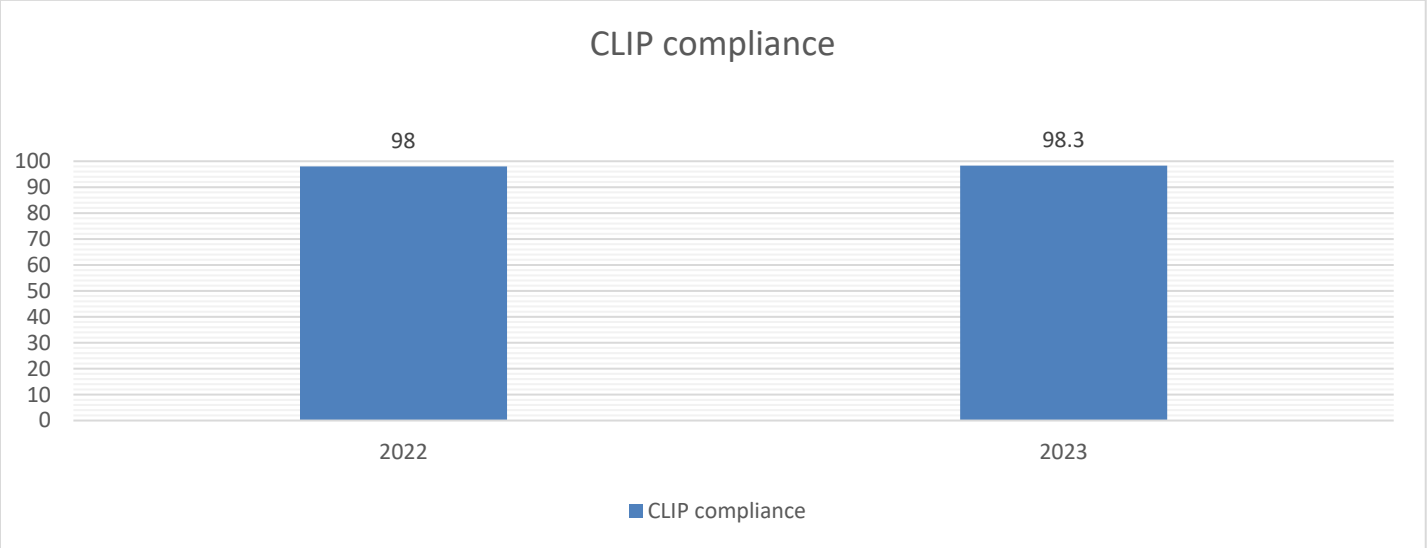
1. Among 10 CLABSI events (compared with 16 during 2022) (10 at Escondido, zero at Poway). Central line types included; six CVC's, two tunneled catheters and two umbilical catheters. None were attributed to PICC lines. Escondido decreased CLABSI by 40% during 2023, compared with 2022 data, and is below threshold. Poway had zero CLABSI during 2023 with a 100% reduction. 4SW had zero CLABSI during 2023. 5W reduced CLABSI SIR from 2.663 during 2022 to 0.970 and below threshold in 2023. 6E, 4NW, 9E and NICU exceeded SIR threshold. NICU Education on Prevention of HAI's performed in August 2023.
2. CLABSI risk reviews initiated by Infection Prevention to provide education on CLABSI bundle elements.
3. A team of ICU stakeholders met monthly, identified trends and implemented prevention measures.
4. Physician documentation of central line necessity is monitored, reported to the physician on record and at the IPCC.
5. Chlorhexidine (CHG) bathing education in 2023 emphasized for patients with central lines.
6. A new CHG agent was trialed and implemented.
7. Daily Quality Huddle reporting of the number of patients with central lines and appropriateness.
8. Daily Quality Huddle reporting of last CLABSI episode for all units.
9. Risk review of all CLABSI events by unit based leadership.
10. Removal within 48 hours of femoral lines in ICU.
11. Midlines used when appropriate.
12. Late in 2023, an assessment of blood culture contamination rates was performed and processes were identified which may contribute to over identification of bloodstream infection and overuse of antibiotics. A formal group was established by Infection Prevention to improve blood culture contamination rates and reduce unnecessary antibiotic utilization.

CLABSI Goal Met/Unmet:

PMC Escondido – Goal Met

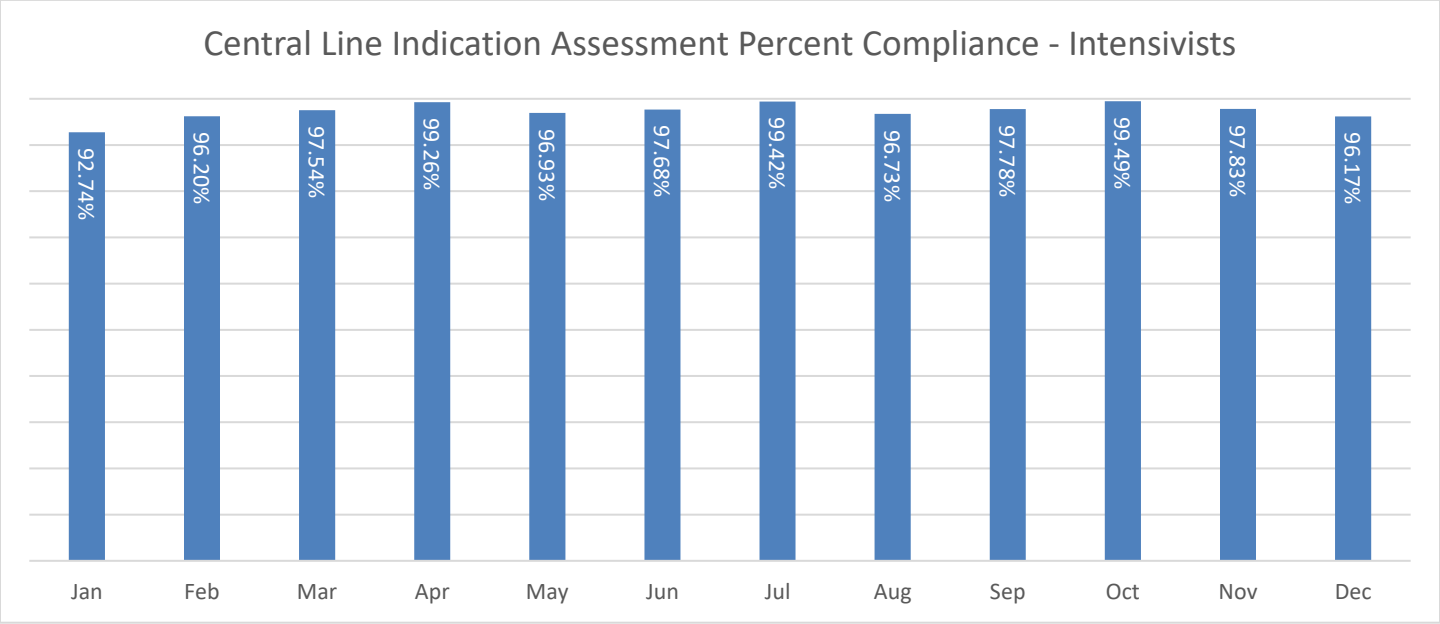
PMC Poway – Goal Met

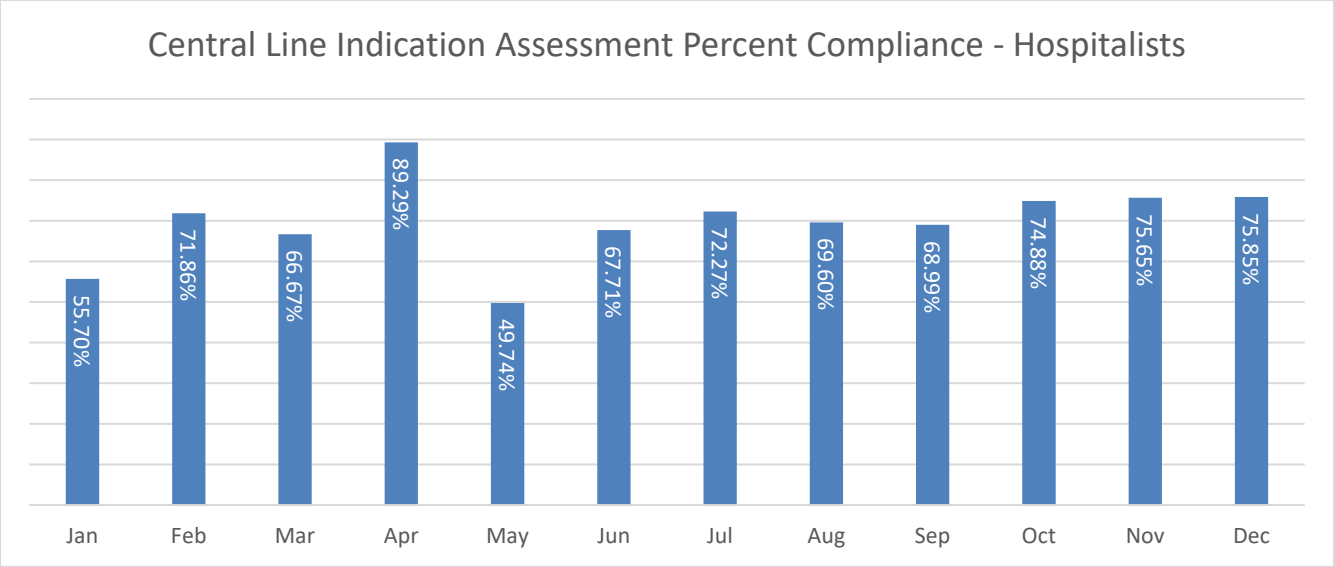
CLABSI Prevention Measures – Central Line Insertion Practices (CLIP)



System CLIP adherence, measuring full sterile barrier precautions, hand hygiene, and appropriate skin prep. In 2021, a new measure was added to the CLIP process including ultrasound guided insertion and sterile probe cover. Compliance improved by 3% during 2023, and remains above goal. Palomar Health Central Line Indication Documentation Percent Compliance 2023

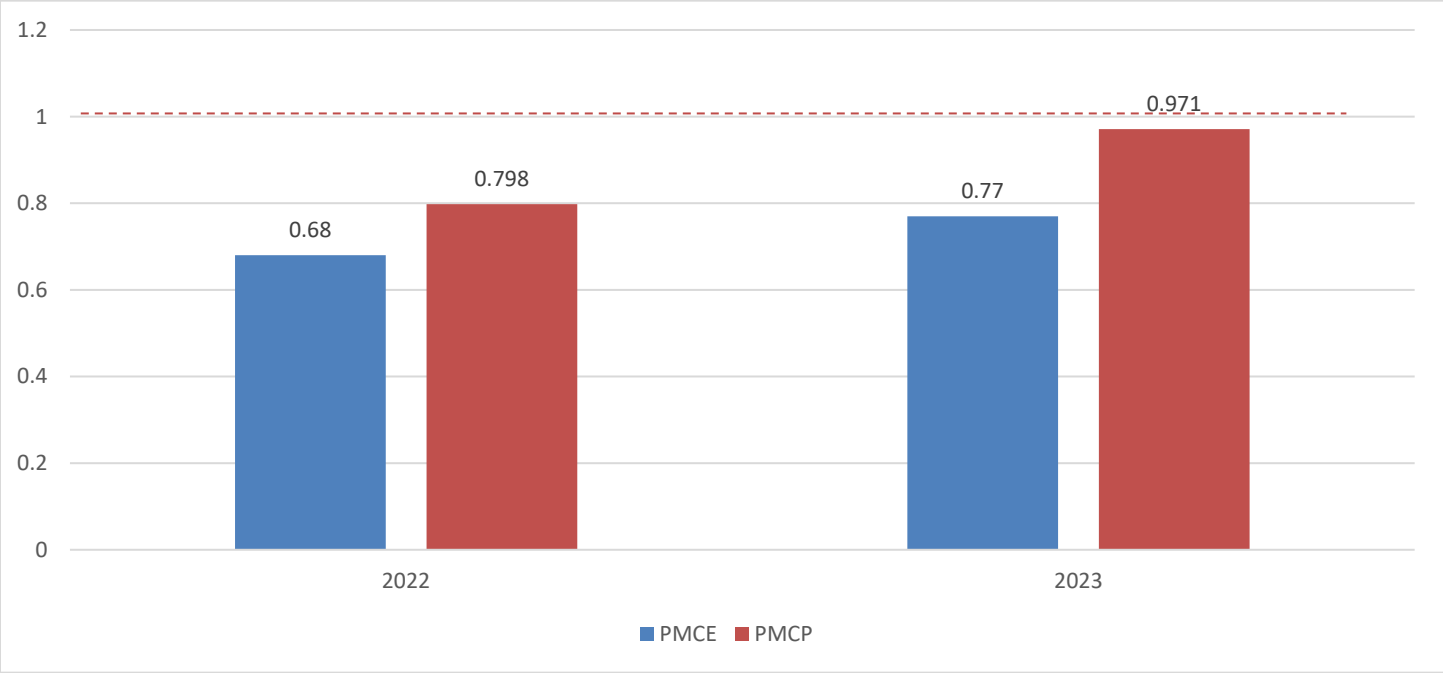
Goal: Facility exceeds 90% compliance with 10% improvement among Hospitalist Group





Daily evaluation of the patient with a central venous catheter is measured by physician response to a prompt in the electronic medical record. Physician compliance with this process has improved indicating the necessity of the catheter has been assessed and confirmed on a daily basis. However, physicians are not consistently adhering to indication requirements.

Central Venous Catheter Standardized Utilization Ratio (SUR)



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

Device utilization as shown in a Standardized Utilization Ratio (SUR). During 2023, PMC Escondido increased utilization by 13%. PMC Poway has increased utilization by 21% but both remain below threshold. The

objective of physician documentation of the necessity of the central line is to remove unnecessary lines as soon as possible.

CLABSI Prevention Goal Met/Unmet:

PMC Escondido – Goal Met

PMC Poway – Goal Met

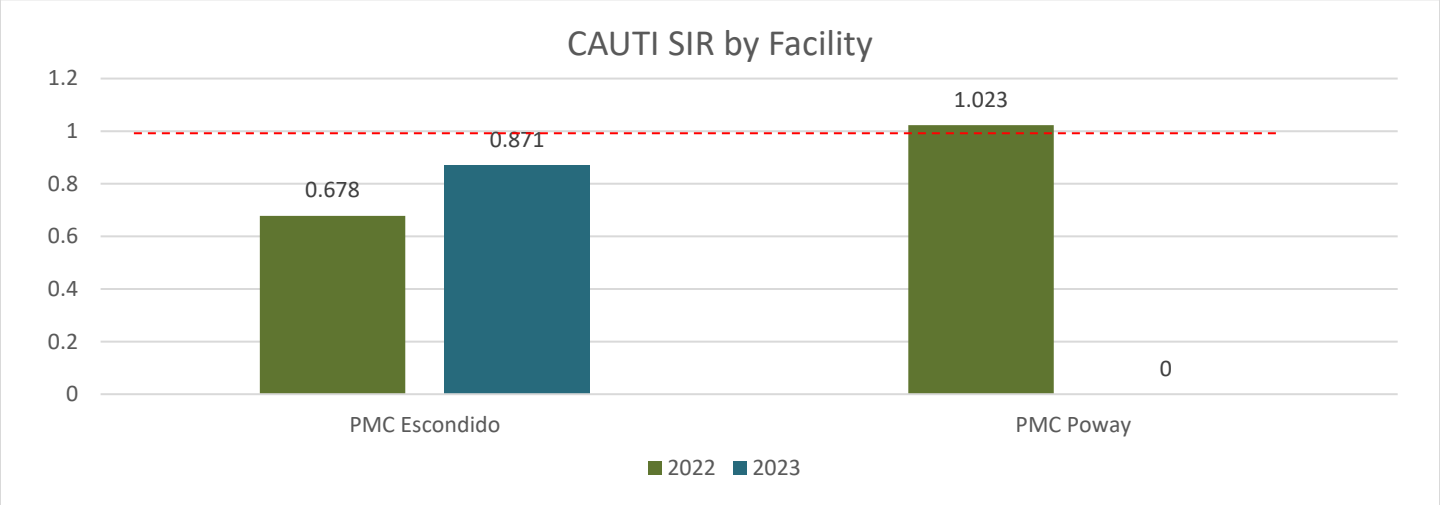
Action Plan:

1. Target zero.
2. Continue to improve hand hygiene compliance.
3. Continue to monitor central lines and CLABSI cases in Quality Huddle.
4. Improve compliance to 90% for documentation of central line indication and necessity through collaboration with Hospitalist group.
5. Timely removal of all unnecessary central venous catheters by medical staff.
6. Quality improvement process for blood culture collection and contamination reporting.
7. Reinforce CLABSI prevention measures with focus on 6E, 4NW, 9E and NICU
8. Continue to use double lumen midlines when appropriate.
9. Perform reviews with unit staff and evaluate process measure compliance.
10. Provide device utilization data and outcomes measures to unit Medical Directors, involving hospitalist and intensivists in device reduction strategies.

Catheter-Associated Urinary Tract Infections (CAUTI)

CAUTI Standardized Infection Ratio

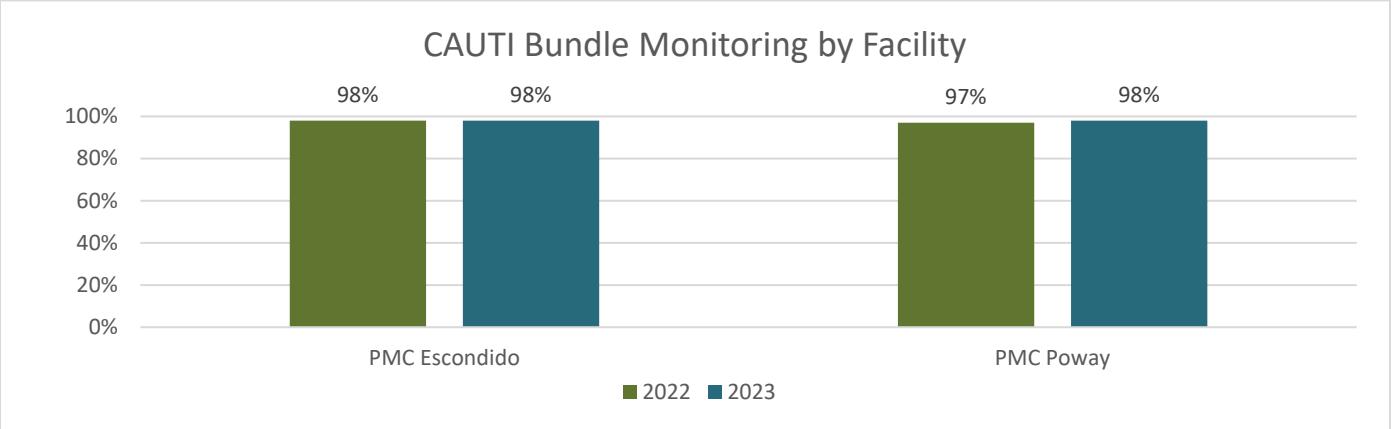
Goal: Reduce facility CAUTI SIR from previous year by 10%, analyzed by NHSN.



Summary Analysis:

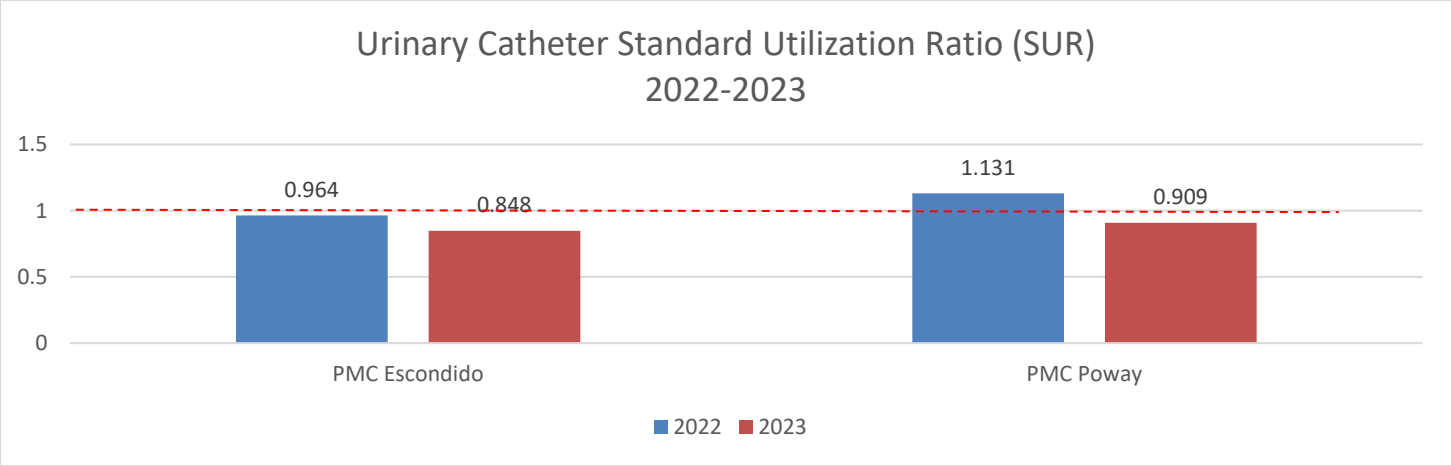
1. Palomar Health realized a decrease in the number of cases during 2023, (Escondido 16, Poway 0), compared to the previous year with 17, system-wide. Efforts to eliminate urine contamination was a focus of the Infection Prevention team beginning in August of 2023. Trials of new products and thorough review of processes for collecting and transporting urine samples were undertaken. Infection Preventionists review the CAUTI bundle at the bedside and increasing awareness of the Nurse Driven Foley Catheter Removal Protocol.
2. PMC Escondido realized a 28% increase compared with 2022, and PMC Poway evidenced a 100% decrease with zero CAUTI during 2023.
3. 4SW TICU had the most CAUTI events with 3, followed by 4NW, 5WCCU, 6E, 6W and 7E with two each and 4E, 5E and 9E with one event each.
4. Fifty percent of the CAUTI events were in patients who had catheters in place greater than 7 days and the other fifty percent were in place less than 7 days. Indicating insertion and maintenance practices as causative factors.
5. During 2023, it is noted that *E. coli* was the leading causative organism at 38% of all organisms identified. This is followed by *P. aeruginosa 25% M. morganii 13%, K. pneumoniae 6%, E. cloacae 12%, and E. faecium 6%.*

CAUTI Process Measures - CAUTI Bundle Monitoring



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

Indwelling Urinary Catheter Standardized Utilization Ratio (SUR)



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

The facility SUR is 0.909 at Poway with a 20% decrease in utilization and 0.848 at Escondido with a 12% decrease in utilization. Both campuses are below threshold. Goal is below 1.0 SUR.

CAUTI Reduction Goal Met/Unmet:

PMC Escondido – Goal Unmet

PMC Poway – Goal Met

Action Plan:

1. Improve hand hygiene compliance,

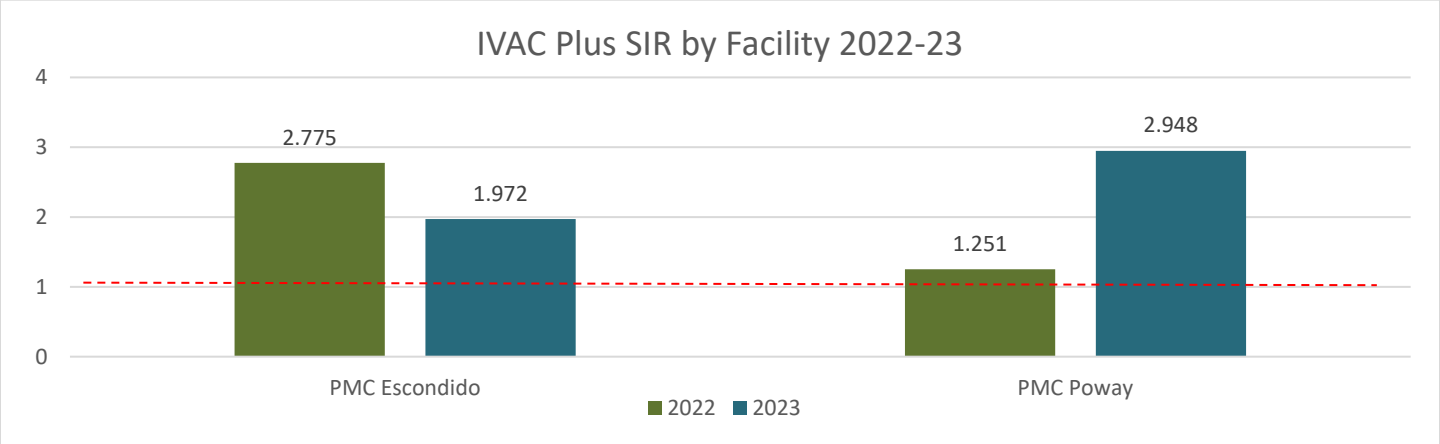
2. Continue to monitor Catheters for necessity and report to Quality Huddle daily.
3. Review Diagnostic stewardship recommendations.
4. Bard SureStep education focusing on the usual inserters (e.g. ED, OR and ICU)
5. Continue product assessment for urinary specimen collection in ED
6. Continue to promote the use for external catheters when appropriate.
7. Multidisciplinary rounds to assess need for catheter.
8. When feasible, insert less catheters in ED and allow ICU to decide on insertion.
9. CAUTI bundle rounds with a focus on missed opportunities and notification to unit Leaders.

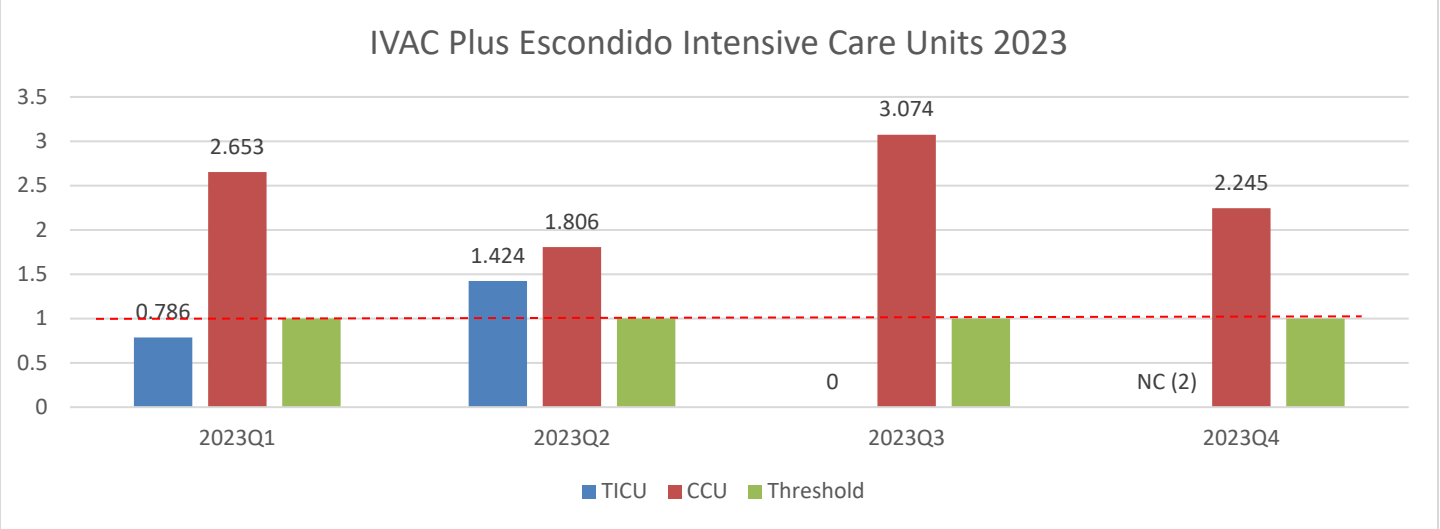
PALOMAR HEALTH

Infection-related Ventilator-Associated Complication Plus (IVAC+PVAP)

IVAC Plus Standardized Infection Ratio

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





Summary Analysis:

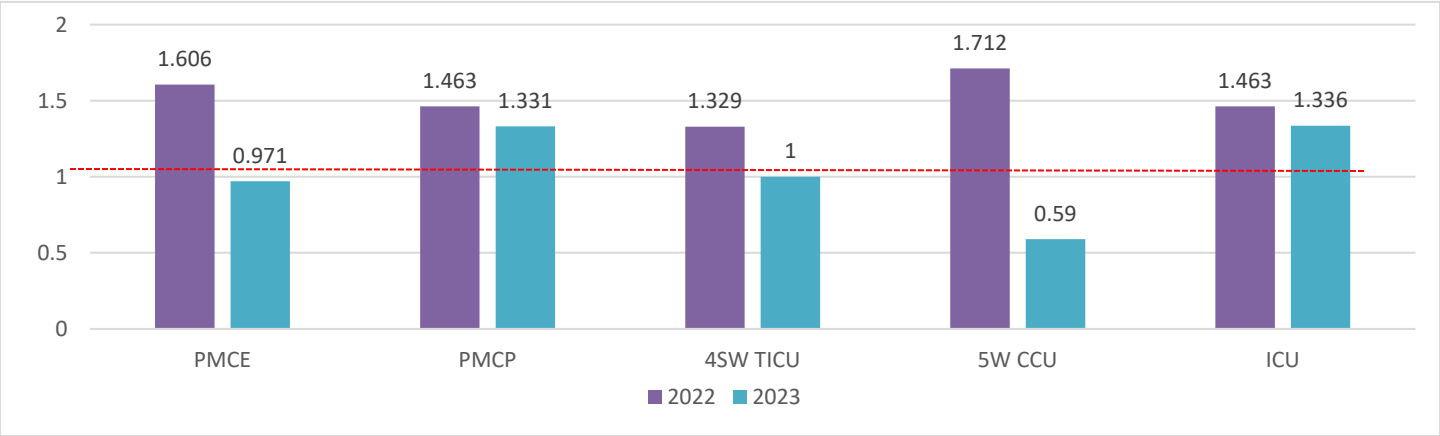
1. The total IVAC plus cases for PMC Escondido and PMC Poway is 22 which decreased from 32 cases in 2022 for a SIR of 1.972 which demonstrates a 29% reduction during 2023. 5W had (12) cases which is a 50% decrease from the number of cases during 2022 4SW had (5) compared with 6 cases during 2022 demonstrating a 17% decrease. Poway ICU had (5) with a SIR of 2.948, an increase of 135% during 2023 as compared with 2022.
2. IVAC Plus data includes IVAC (infection-related ventilator complication) and PVAP (probable ventilator associated pneumonia), and the SIR is the number of observed / number of predicted IVAC and PVAPs in intensive care units.
3. Measures taken during 2023 to decrease ventilator-associated events included a collaborative approach by the ICU medical staff, the Respiratory therapy team, nursing, educators, and Infection Prevention for monitoring the ventilator bundle.

4. Ventilator days were validated to ensure accurate denominator.
5. VAP Process Measures – Palomar Health Ventilator Bundle Monitoring - Goal 95%

IVAC Plus Process Measures – VAP Bundle

Compliance by Question	
Oral care with CHG completed	100.00%
Deep vein thrombosis prophylaxis initiated	99.78%
Head of bed is 30 to 45°	99.78%
PUD prophylaxis is initiated	99.78%
Daily spontaneous breathing trial initiated	88.30%
Daily awakening trial initiated	87.40%

Mechanical Ventilator Standardized Utilization Ratio (SUR)



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

Summary Analysis:

PMC ESCONDIDO ventilator utilization has decreased by 40%. PMC POWAY SIR remains above threshold at 1.331 with a reduction of 9% during 2023 compared with 2022 SUR data.

VAE Prevention Goal Met/Unmet:

PMC Escondido (5W & 4SW) – Goal Unmet

PMC Poway (ICU) – Goal Unmet

Action Plan:

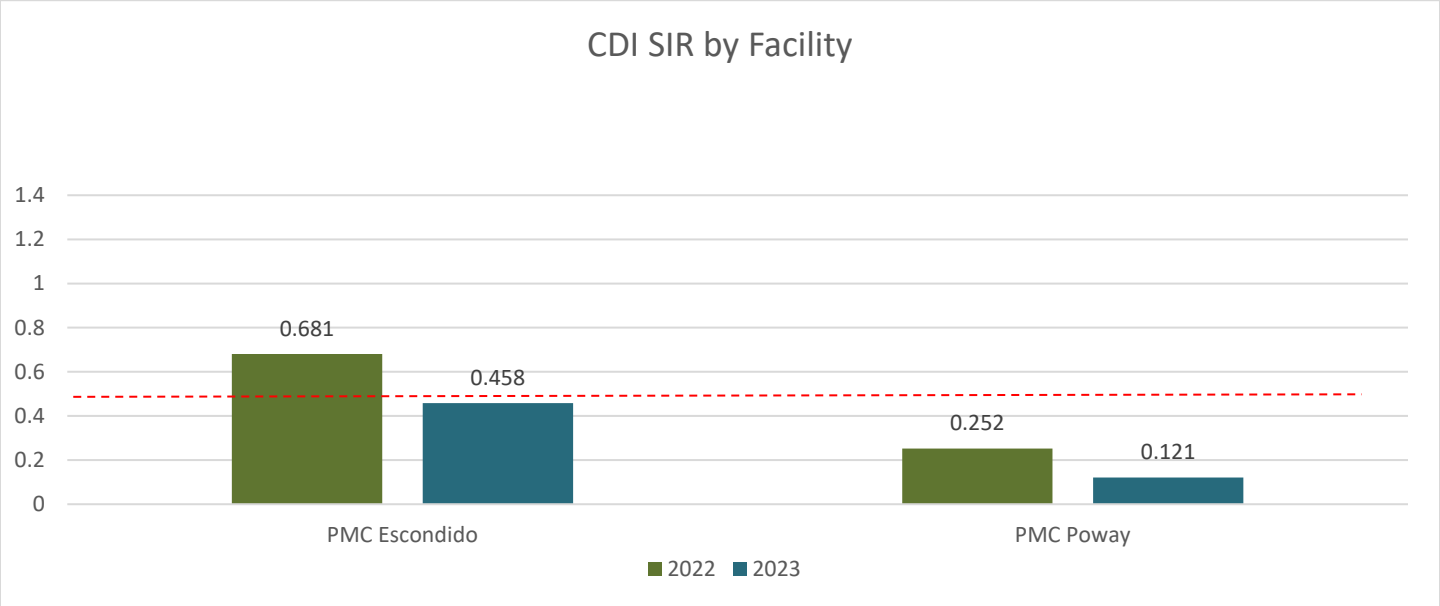
1. Improve combined hand hygiene by 10% among RCP's.
2. RCP oral care administration beginning February 2, 2024.
3. Ongoing collaboration with Intensivists, Respiratory and Unit leaders to review cases. Report findings to Critical Care and IPCC committees.
4. Interdisciplinary device rounds and planning strategy to prevent VAE with Respiratory Care.
5. Report all IVAC Plus and Standardized Infection Ratio outcomes to various committees indicating areas of opportunity.

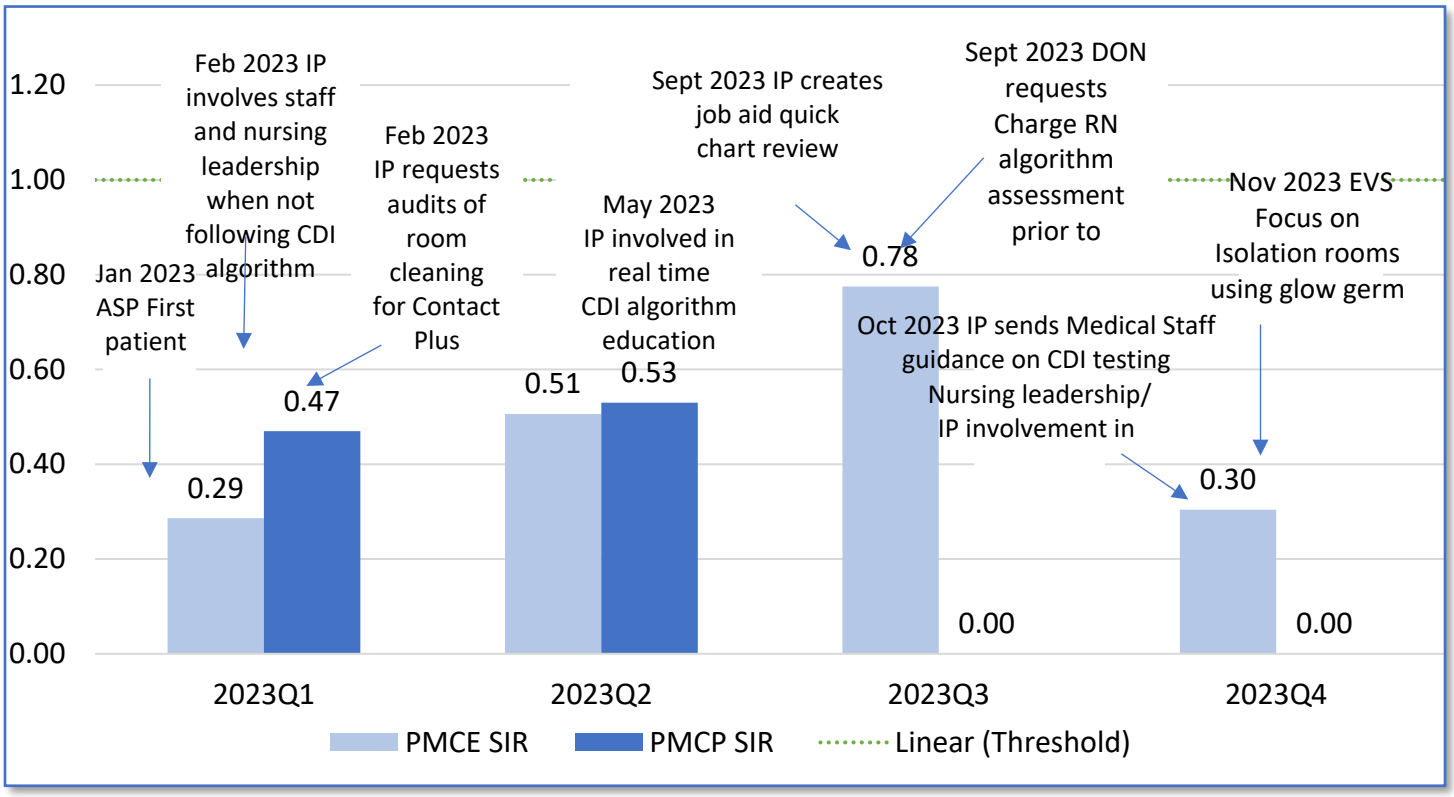
PALOMAR HEALTH

Multi-Drug Resistant Organism (MDRO)

Clostridioides difficile Infection (CDI) Standardized Infection Ratio

Goal: Reduce facility hospital-onset (HO) CDI SIR by 10% and below benchmark of 1.0.





Summary Analysis:

SIR data for combined PMC Escondido and PMC Poway achieved below threshold SIR at 0.399, a total of 19 cases compared to 29 cases system wide during 2022. In 2023, PMC Escondido decreased the CDI SIR by 33% and PMC Poway decreased by 51%. Stringent evaluation of appropriate specimens collected for *C. difficile* testing was placed in multiple workflows. Hospital Onset (HO) cases are reviewed with the unit based leadership, Infectious Disease Pharmacists and Infection Preventionists. CDI (contact plus precautions) room cleaning measures were reviewed and education of EVS staff was put into place to ensure the appropriate cleaning methods for these rooms. Quality improvement and infection prevention efforts to reduce HO-CDI included strict adherence to standard and contact precautions, using a sporicidal disinfectant for surface and equipment cleaning, hand hygiene, and appropriate donning and doffing of personal protective equipment. Hand hygiene data steers attention to specific clinical locations or disciplines and focuses on performing upon entry to the patient room and when exiting. Palomar Health continued to use the CDI testing algorithm to guide appropriate testing. Newly added in 2023, to address diagnostic stewardship, was a second review performed by the charge nurse to ensure the algorithm was followed before sending the specimen for testing. The goal is to avoid inappropriate use of antibiotics for asymptomatic and colonized patients. Cases and SIR data are reviewed at the Infection Prevention and Control Committee, the antimicrobial stewardship committee, other medical staff committee's and among smaller healthcare associated infection work groups in order to create awareness for the importance of adhering to the algorithm. A parallel review of cases is performed by nursing leadership at the time an HO-CDI case is identified. This collaboration with infection prevention provides additional information that is used to identify opportunities for improvement, risk factors, and provide education when needed. In 2022, Vancomycin prophylaxis was made available for high-risk patients. Antibiotic usage is tracked quarterly, benchmarked via NHSN and presented to the medical staff in the context of CDI prevention.

Goal Met/Unmet:

PMC Escondido –Met

PMC Poway – Met

Action Plan:

1. Infection Prevention and Control Committee to review CDI algorithm and update to current evidence-based practices
2. Infection Prevention review of HO cases for diagnostic stewardship purposes.
3. Notify unit leaders of HO-cases for full review.
4. Prepare for surveillance of the treatment of CDI.
5. Nursing review of CDI algorithm when specimen is collected. Infection Prevention availability to review when nursing leader is unavailable.

Candida auris

Summary:

A *C. auris* case was detected at a long-term care facility with recent admission at PMC Escondido. County Public Health Department provided cleaning recommendations to patient's location history (5W and 7W rooms), and to implement a point prevalence survey (PPS) of current patients (in 5W and 7W) within given parameters.

At the direction of San Diego County Public Health, perform *C. auris* testing on 40 patients within given parameters for a point prevalence survey. County Public Health provided testing materials lab support, and educational support, as needed. This is the only patient with HO *C. auris* documented. One other case was community onset and was at the PMC Poway. The county public health department coordinated the following measures and testing parameters:

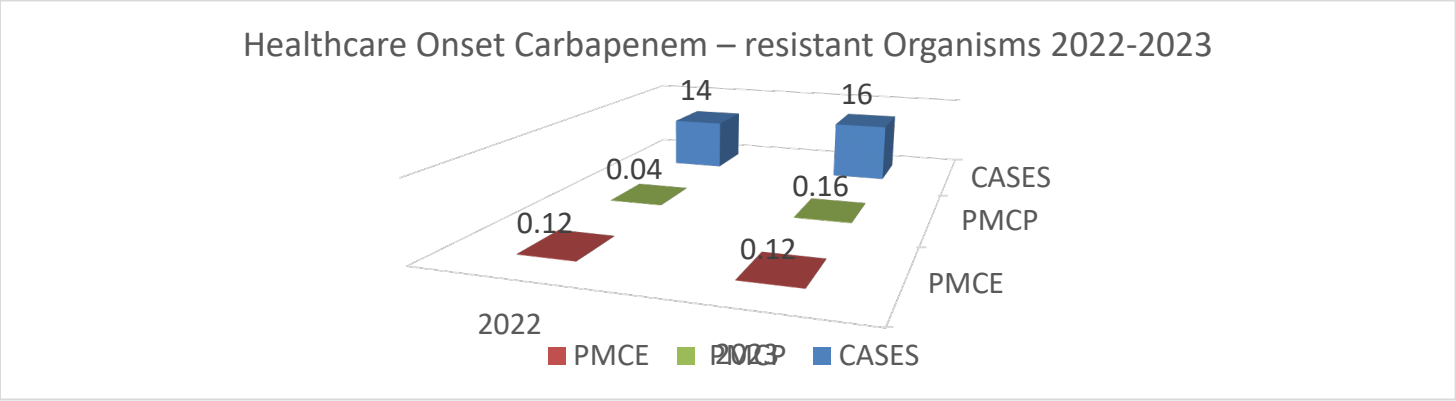
- 40 Patients had *C. auris* lab ordered and promptly collected by nursing.
- Tested patients were empirically isolated in Contact Plus precautions pending result.
- Turn-around time was approximately 1 week.
- Anticipated SNF/LTCFs discharges (determined by Case Management) were concurrently tested with in-house lab for 3-day turnaround time.
- For SNF/LTCFs discharges among tested patients, to avoid delays, Case Management/RN communicated purpose of testing and ensured SNF/LTCFs had resources to accept patient in contact isolation pending result.
- County supported with delayed SNF discharges.

Action Plan: To comply with updated CDPH Health Advisory to screen high risk patients for *C. auris*, Infection Prevention did the following:

- Submit expedited informatics updates on screening and surveillance of *C. auris.*
- Ensure Contact Plus isolation is placed upon return of patients with any *C. auris* history.
- Add screening updates per CDPH advisory.
- Add *C. auris* testing rule upon return of patients with CRE/O

Carbapenem-resistant Organisms (CRO)

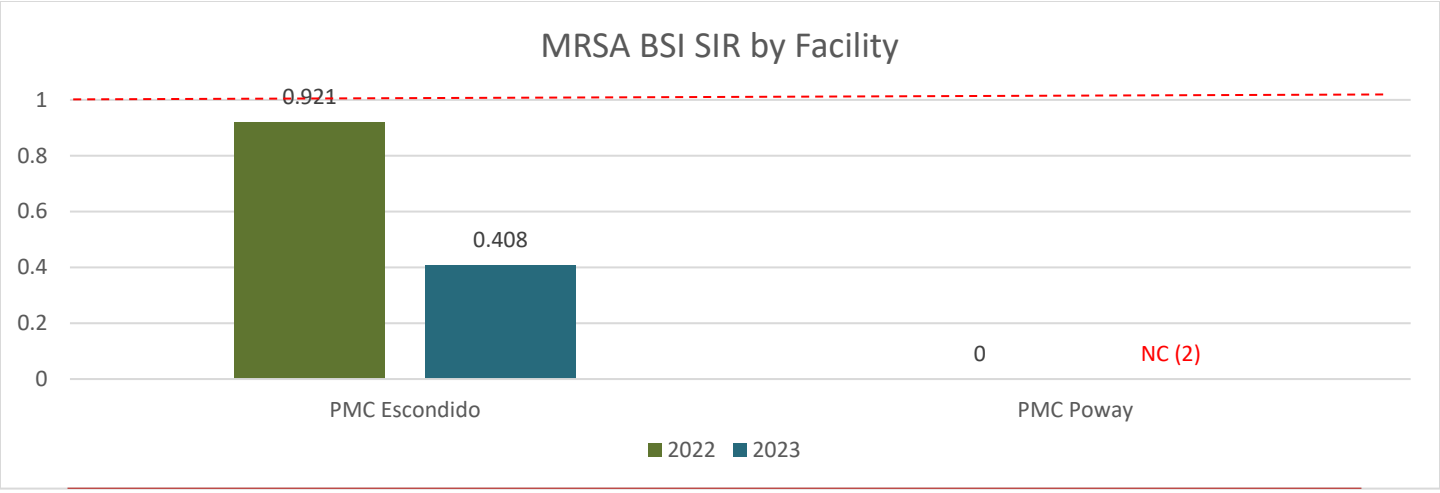
Goal: Decrease HO CRO cases by 10% during 2024.



Summary: Healthcare onset is defined as day four or later in the admission which NHSN definition requires for MDRO LabID cases. All specimen sources are considered. A SIR cannot be calculated because predicted numbers are not available. There was no change in the rate of HO CRO cases at PMC ESCONDIDO comparing 2022 to 2023. There was a 300% increase in HO CRO rates at PMC POWAY. This represents 4 cases during 2023 compared with one during 2022. Infection Preventionists identified that EVS cleaning in CRO rooms was performed as routine cleaning and left privacy curtains in the room. There were no trends in location and since the rooms are private at PMC ESCONDIDO and PMC POWAY there were no close contacts. Education and monitoring of these rooms for cleaning efficacy was implemented. Early identification and precautions are used for high risk patients.

MRSA Bloodstream Infection (BSI)

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

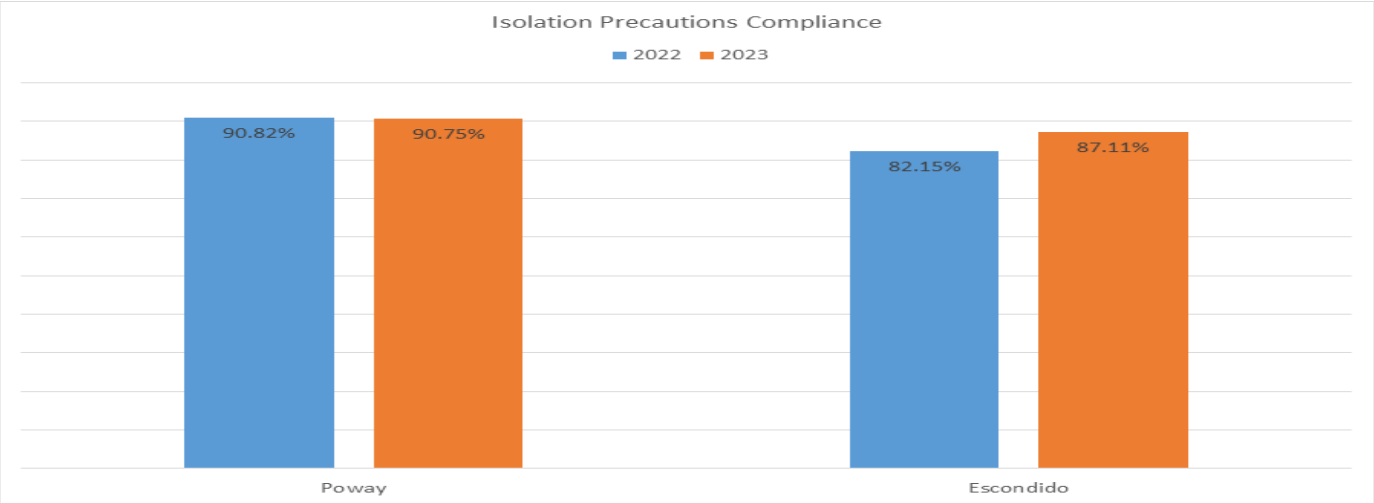


*SIRs cannot be calculated when the predicated value is < than 1.0

Summary Analysis:

1. MRSA bacteremia SIR is a surrogate marker that may indicate the risk of transmission in the healthcare setting.
2. PMC Escondido showed a 56% decrease from previous year of Hospital Onset (HO) MRSA bacteremia, and is below threshold. This reflects 2 cases compared with 4 during 2022.
3. PMC Poway had two MRSA BSI events during 2023 which is above number predicted by NHSN and above threshold.

MDRO Process Measures – Isolation Precautions Compliance



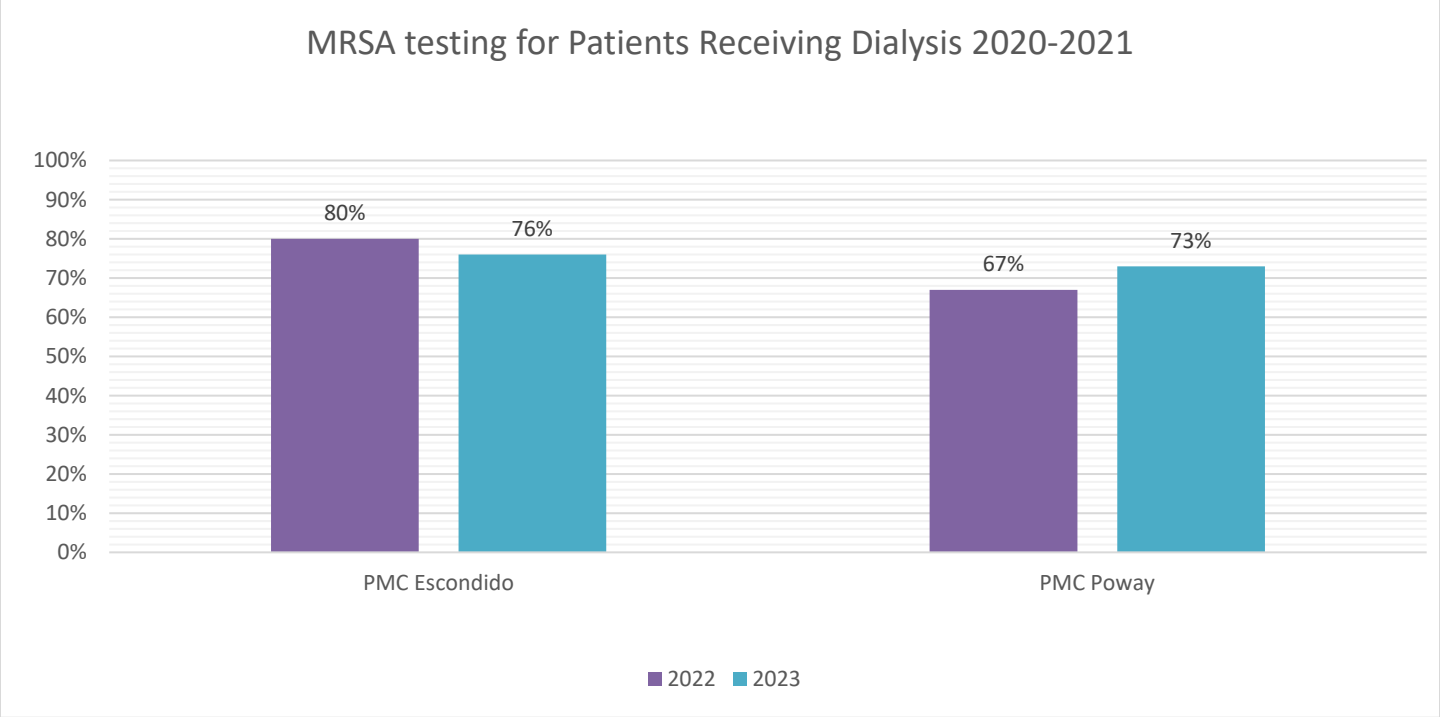
Summary:

Processes which reduce the risk of transmission for MDRO's include; transmission based precautions, patient education, use of the correct precaution signs, ensuring gloves and gowns are available and wearing PPE when it is indicated.

Isolation Rounding revealed 90.75% compliance at PMC POWAY. Although PMC ESCONDIDO increased in the elements there was a rate of 87.11% which is below compliance heavily weighted on patient education documentation.

Action Plan:

Redistribute and reiterate the standards for providing education for patients in precautions with an MDRO through unit based Practice council and nursing leadership meetings.



Summary:

The data presented above demonstrates compliance with California mandate for *testing among* a high risk population. Dialysis *patients are the high* risk group that the Infection Control & Prevention Committee identified for testing upon admission and at discharge. Poway has increased compliance with MRSA testing during 2023 by 9% just missing goal. Though required, this dynamic surveillance is labor intensive.

Action Plan:

1. Increase compliance with testing by 10% during 2023.
2. Explore automation of surveillance for MRSA testing in the Dialysis population.
3. Consider including in the daily Quality and Patient Safety huddle reports.

MDRO Elimination Goal Met:

CDI Met PMC POWAY and PMC ESCONDIDO
C. auris Unmet PMC Escondido **Met PMC Poway**
Carbapenem Resistant Organisms Unmet at PMC POWAY and PMC ESCONDIDO
MRSA BSI Met PMC ESCONDIDO Unmet at PMC POWAY

Action Plan:

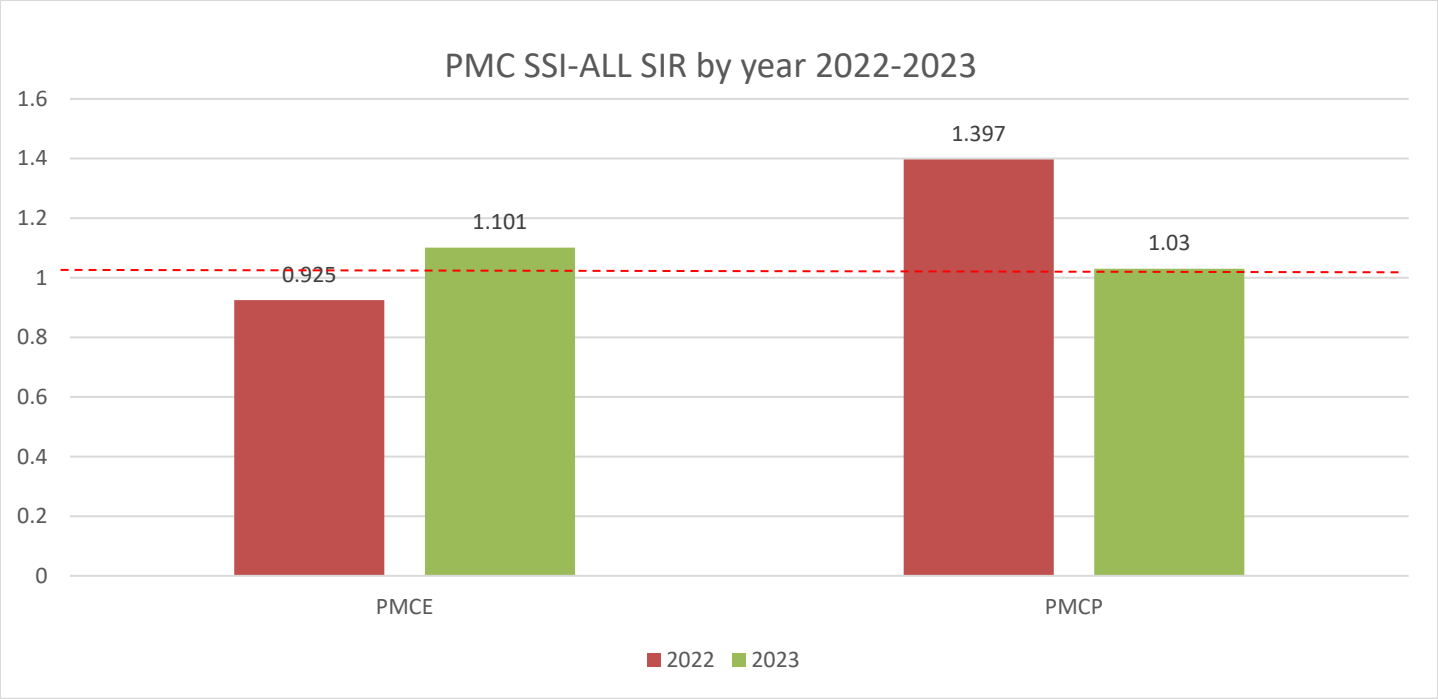
1. Hand Hygiene adherence before and after patient contact
2. Ongoing reinforcement of Standard and Transmission Based Precautions
3. Unit based review of all HO cases
4. Contact Precautions for patients with MRSA in nares and are identified as having any infection
5. Follow surveillance testing for MRSA colonization per Senate Bill 1058 of high risk patients on admission and inpatient dialysis at discharge. Compliance for MRSA testing of high risk group at discharge is at or above 90% at PMC Escondido and Poway
6. Continue to use Contact Precautions for infants colonized with MRSA and in NICU.
7. Glow germ data utilization by isolation room type.

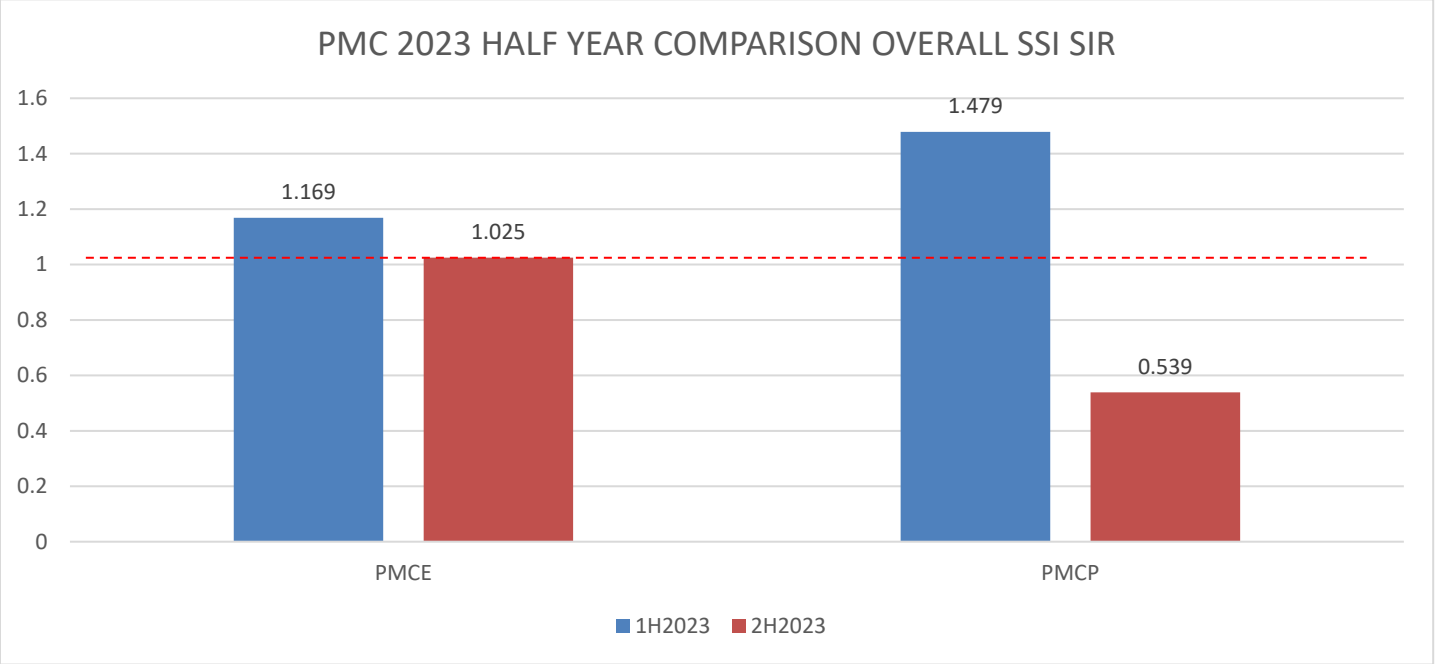
PALOMAR HEALTH

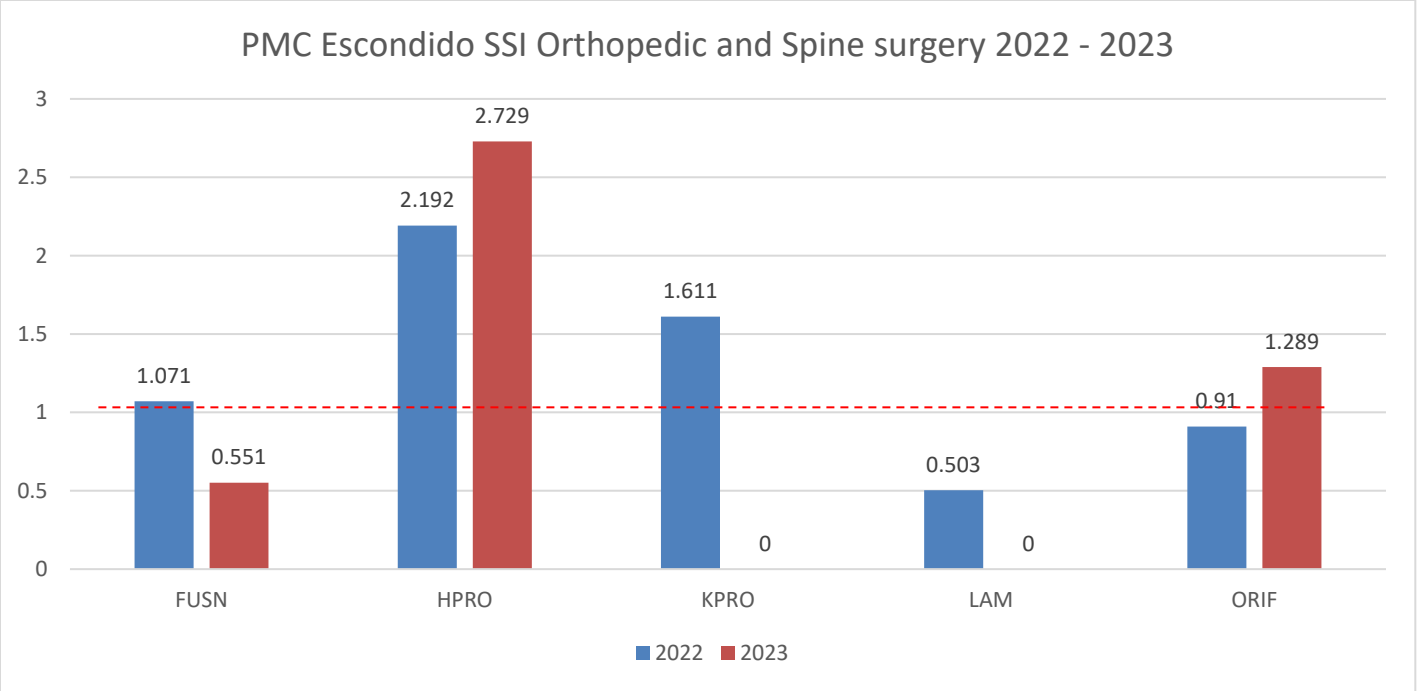
Surgical Site Infections (SSI)

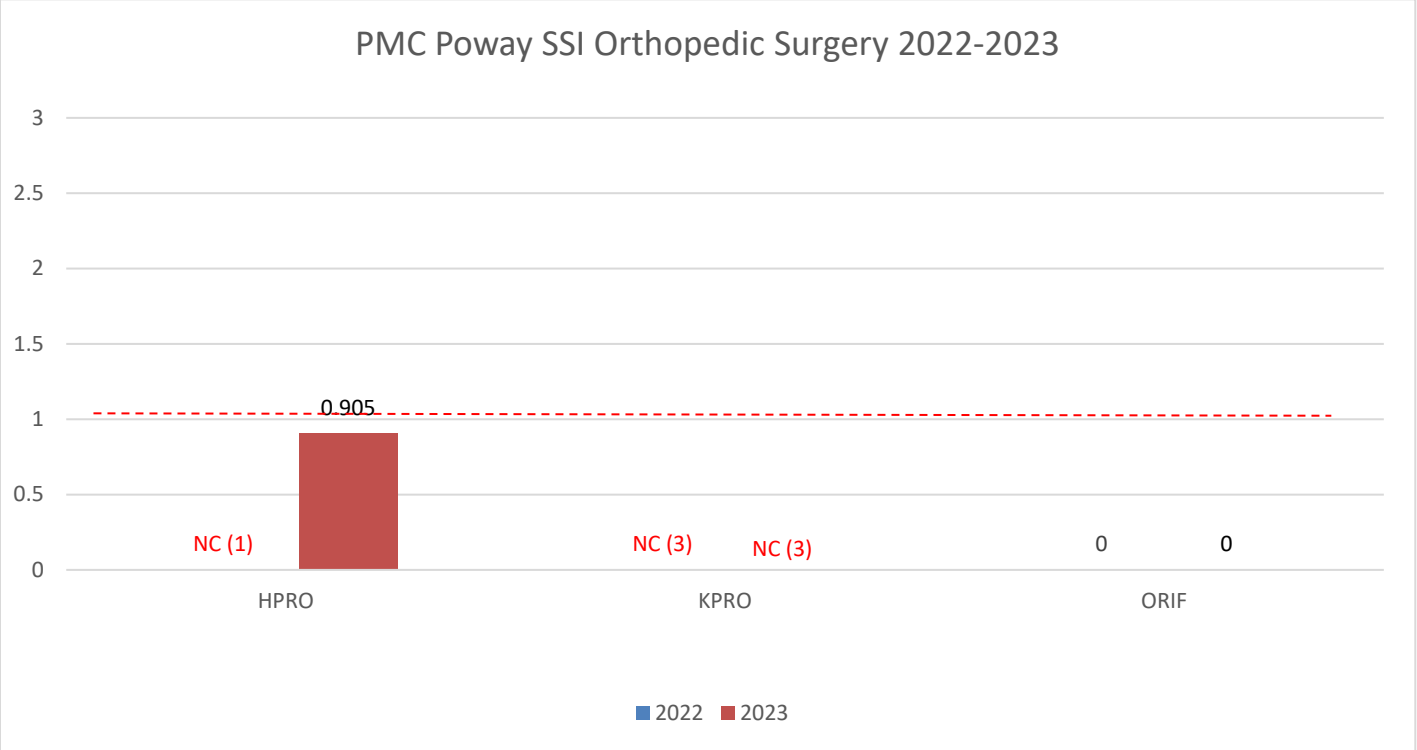
Goal: (1) Reduce facility overall SSI SIR by 10% from previous year and below SIR threshold of 1.0

SSI Standardized Infection Ratio



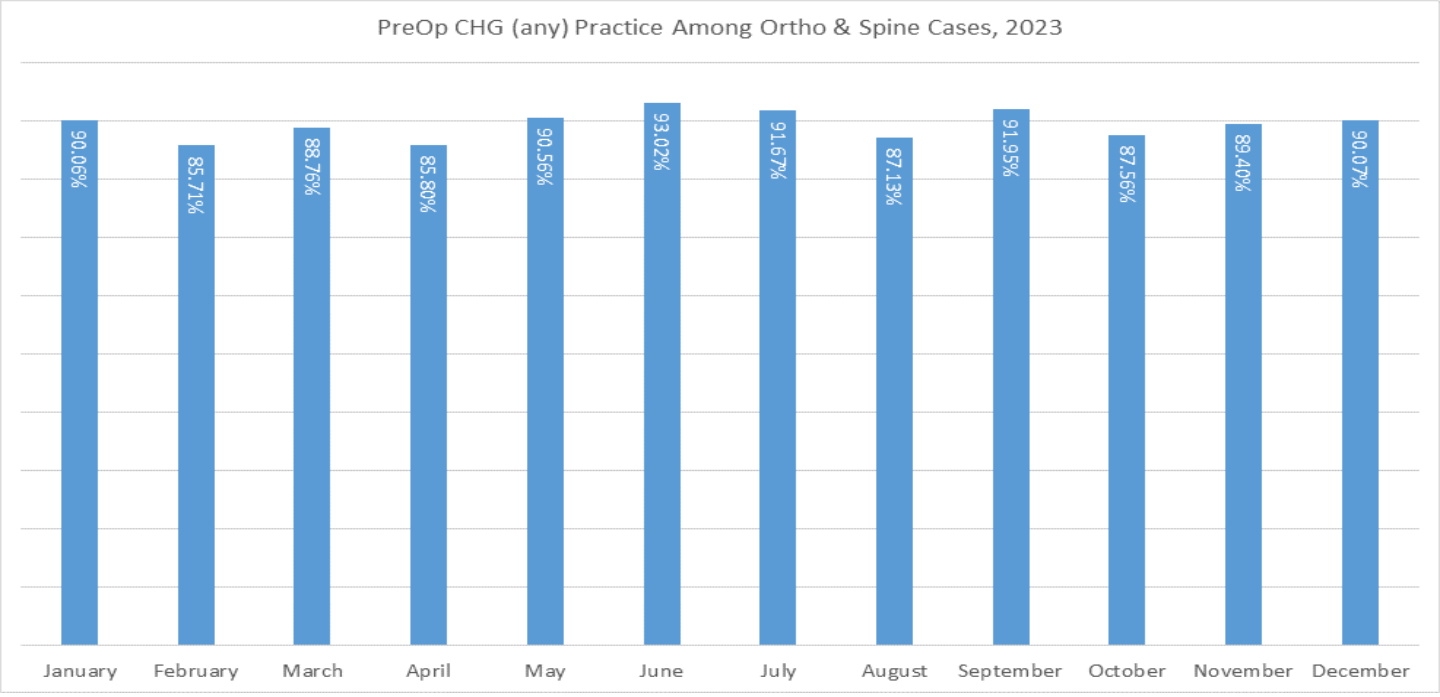


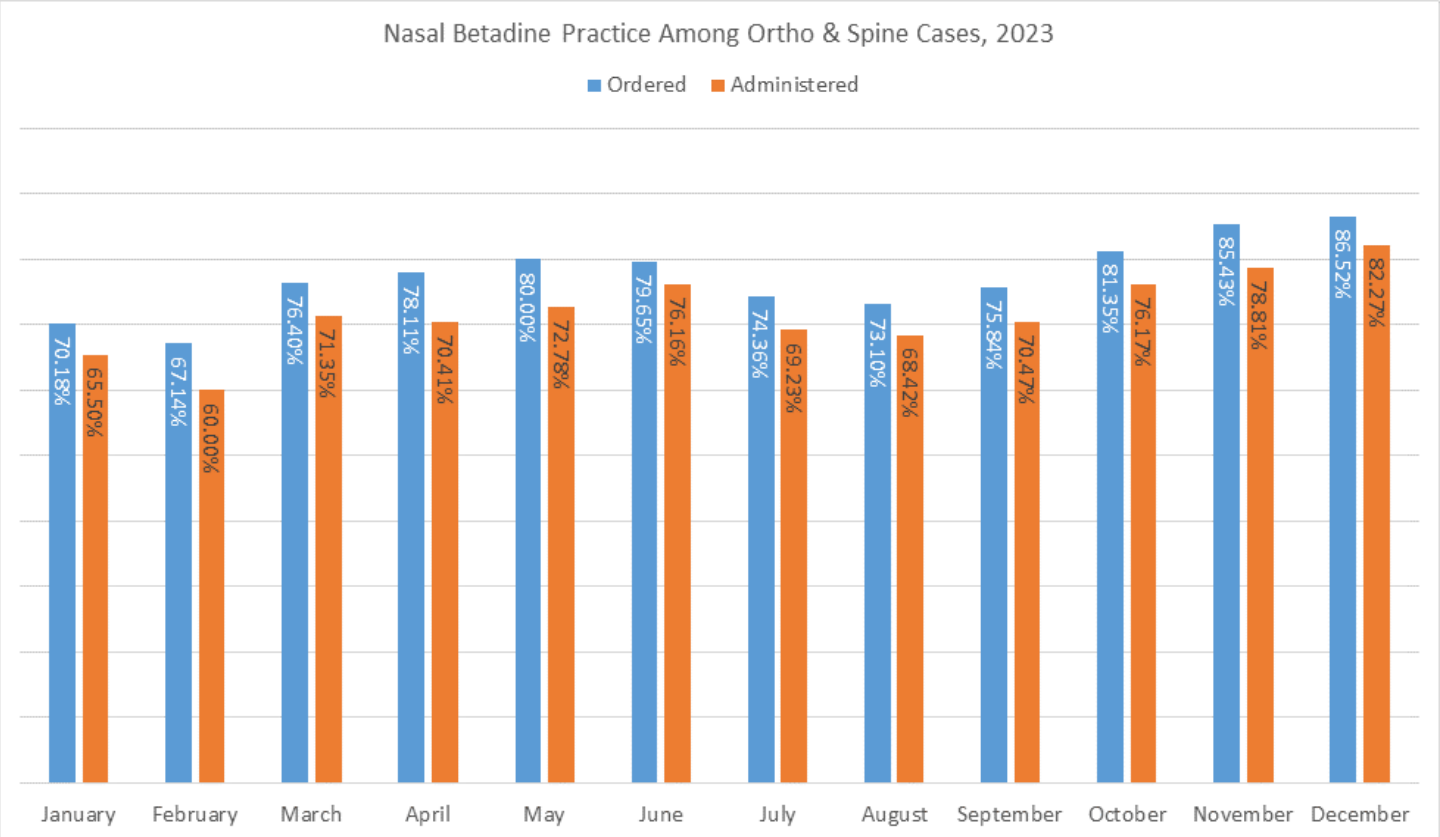

PMC Escondido SSI Orthopedic and Spine surgery 2022 - 2023
3
2.5
2
1.5
1
0.5
0
1.071
0.551
2.192
2.729
1.611
0
0.503
0
0.91
1.289
FUSN
HPRO
KPRO
LAM
ORIF
2022
2023


PMC Poway SSI Orthopedic Surgery 2022-2023
3
2.5
2
1.5
1
0.5
0
0.905
NC (1)
NC (3)
NC (3)
0
0
HPRO
KPRO
ORIF
2022
2023

PALOMAR HEALTH

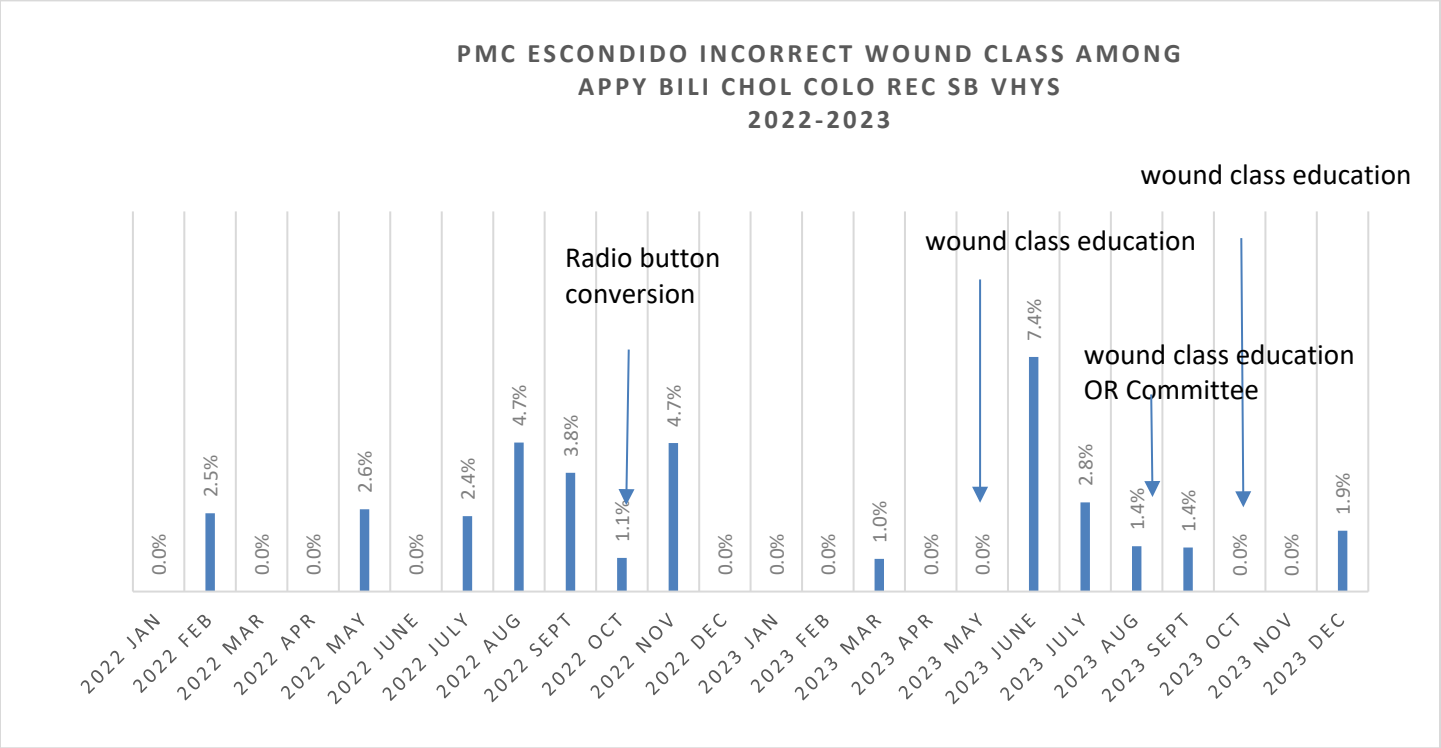
SSI Process Measures – Preoperative Decolonization

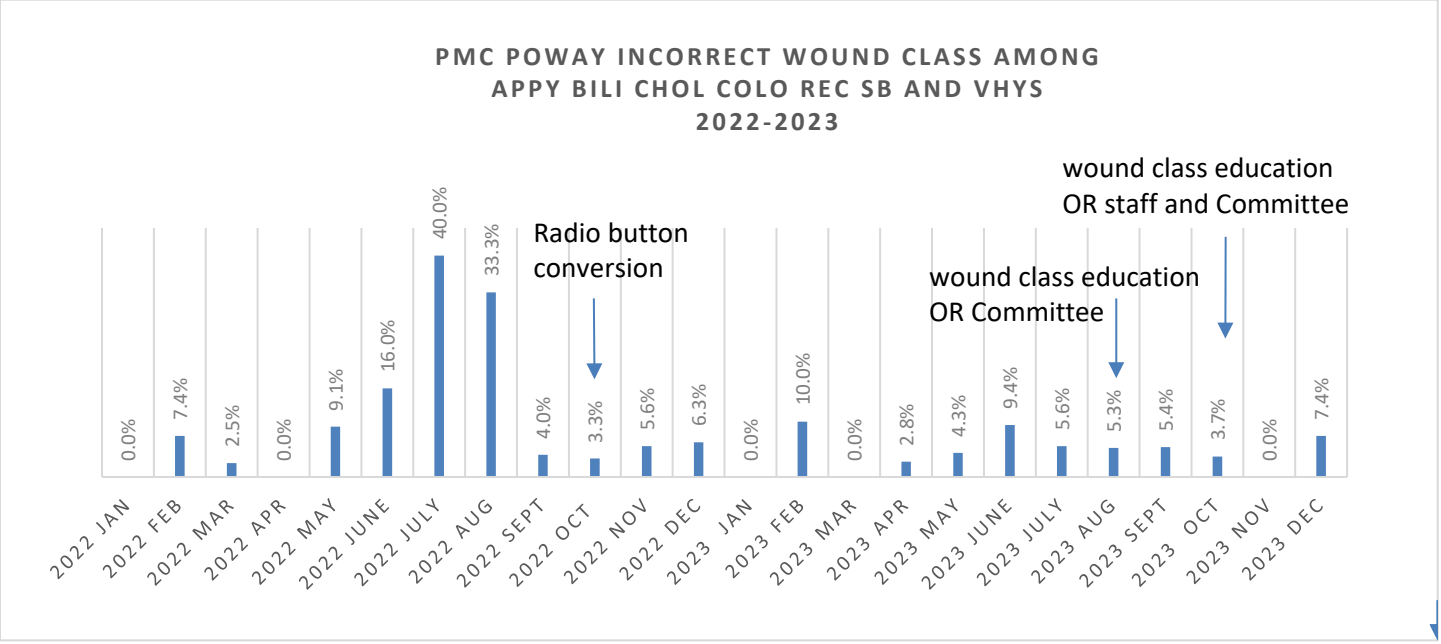




PALOMAR HEALTH

SSI Process Measures – Wound Class Documentation





Summary Analysis:

PMC POWAY and PMC ESCONDIDO are above threshold of 1.0. during 2023. PMC ESCONDIDO had 52 SSI during 2023 and a SIR of 1.025 with an increase of 19%. PMC POWAY had 12 SSI during 2023 and a SIR of 1.03 and a decrease of 26%. However both facilities are above SIR threshold of 1.0. When a SIR is not calculated (NC) the predicted number of infections in this population are less than 1. Targeted SSI

surveillance is performed routinely, with 25 surgical procedures that are mandatory to report. The overall SSI SIR represents the 25 reported procedure events. The CDC NHSN application does not offer Wound Class Clean (C) a choice for the following procedure surgical procedures: APPY, BILI, CHOL, COLO, REC, SB and VHYS. Procedures in these categories that are assigned a Clean (C) wound class do not meet the definition of an NHSN operative procedure and should not be included in denominator reporting for NHSN SSI surveillance. Since this NHSN rule does not allow upload of these cases, IP and Surgical Services have determined to measure compliance with wound classification in these surgical procedure groups as a marker of overall wound class accuracy. During 2023, PMC ESCONDIDO reduced the number of wound class errors in these surgical procedures by 27% (1.8% vs. 1.3%) Alternately, PMC POWAY reduced errors in this category by 57% (10.6% vs. 4. 5%).There were 64 SSI cases system wide during 2023 which is a reduction of cases overall. In light of higher SIR's noted at the end of 2022, Infection Prevention implemented the following interventions during 2023:

1. Reviewed and updated Colon Bundle
2. AORN wound classification education for surgical services staff and surgical committees
3. Orthopedic committee approval for nasal betadine and CHG bathing decolonization and Vancomycin prophylaxis for patients with history of MRSA
4. Initiated increased O2 during the immediate post-operative period with Anesthesia group
5. Powerplans updated to precheck nasal betadine
6. Developed reports to determine compliance with nasal betadine and CHG bathing
7. Prophylaxis order sets updated to latest standards

In addition to the actions above the IP staff monitored the following activities:

a. OR Terminal cleaning
b. SPD AAMI ANSI standards rounding
c. EOC rounds in SPD and OR

In addition to the above listed interventions;

a. Infectious Disease Pharmacist performed a surgical site infection case review
b. Surgical observations were performed by Infection Preventionists
c. Traffic control discussed and monitored during case observations
d. Point of use decontamination monitoring at PMC ESCONDIDO
e. Transitioned away from betadine only in OR for prep and irrigation
f. Proposed Surgiphor irrigation for orthopedics

Action Plan:

1. Point of use decontamination audits at Poway location – Sterile Processing Department
2. Continue surgical case observations include Anesthesia observation
3. Collaborate with Anesthesia Combined Committee glucose control below 200 for all patients undergoing surgical procedures.
4. Quality improvement project for OR room access and exiting
5. Wound classification data sharing

SSI Reduction Goal Met:

PMC Escondido – Goal Unmet

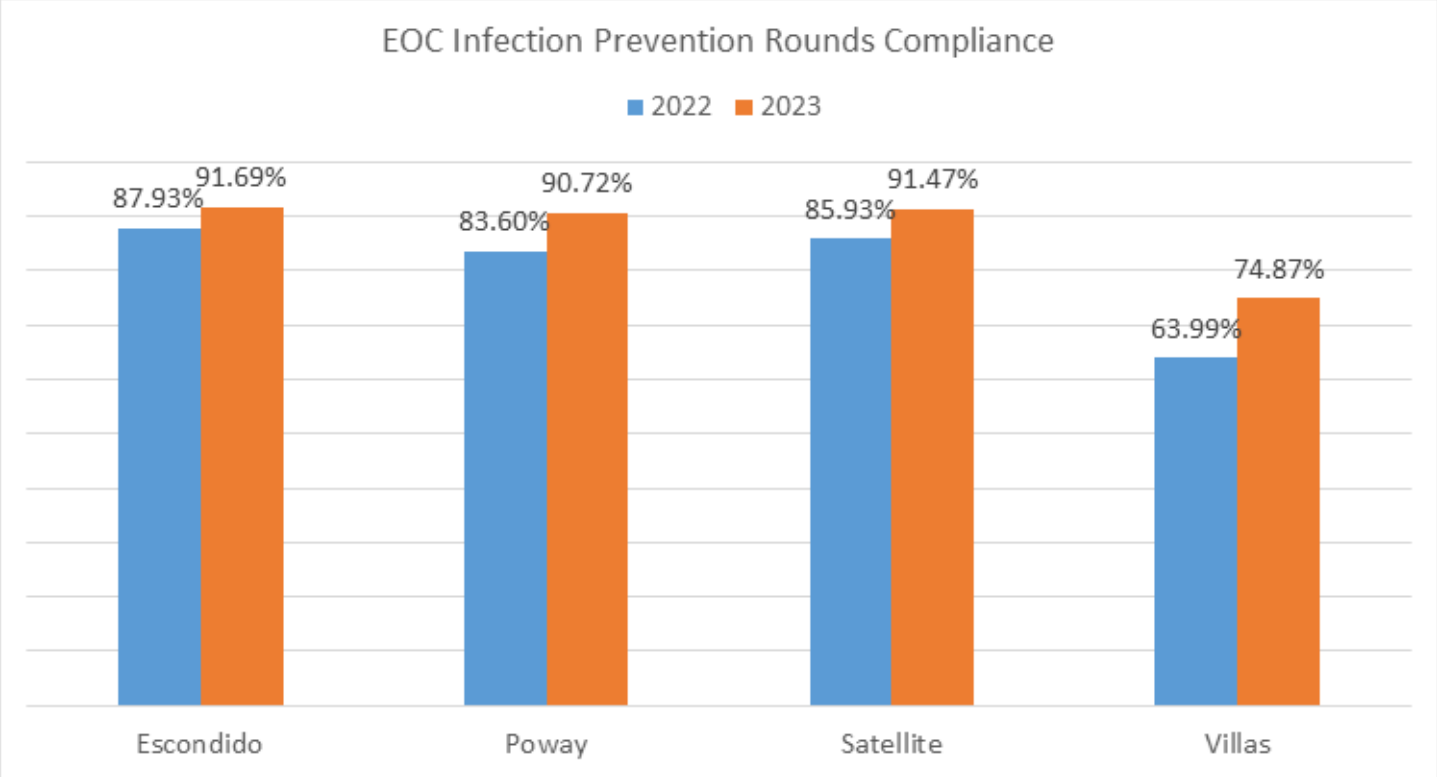
PMC Poway – Goal Unmet

PALOMAR HEALTH

Environment of Care (EOC)

EOC Rounds

Goal: Maintain facility ≥90% compliance



Summary Analysis: Using the Infection Control EOC rounds survey within Sentact; compliance with standard and transmission-based precautions, facilities related infection risks, cleanliness, waste disposal, and appropriate storage and processing of patient care equipment and devices was measured. Also observed is the proper decontamination, handling, transport, and storage of reprocessed devices. There are 87 questions in a survey. Trends of noncompliance in 2023 differed between site locations including; patient's food covered and labeled, dated and thrown away after 3 days, environment free of dust, including high dust, environment and equipment are free of tape, no town mattresses, gurneys, chairs, patient care equipment found, patient care equipment is visibly clean.

EOC Infection Prevention Goal Met/Unmet: 90% compliance

PMC Escondido – Goal Met

PMC Poway – Goal Met

Satellite – Goal Met

Villas at Poway – Goal Unmet

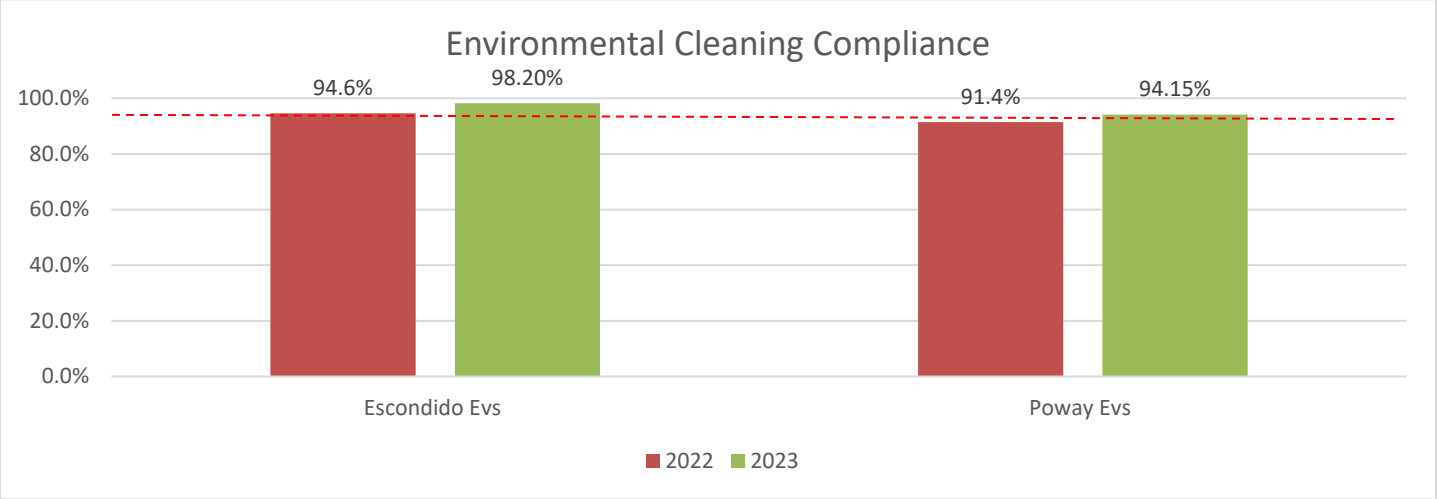
Action Plan:

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

Environmental Sanitation Measures

Florescent Marker Validation of Environmental Cleaning

Goal: Facility to maintain compliance ≥95%.



Summary Analysis: This measure is implemented in accordance California Public Health Department Senate Bill requirement. The goal is 95%. During 2023, a florescent marker tool was used and is represented by the data above. The results are used in real time education and training. Escondido was able to increase score, achieving the goal of 95%. Poway came in right under 95% but increased by 3%.

Goal Met/Unmet:

PMC Escondido – Goal Met

PMC Poway – Goal Not Met

Action Plan:

1. Continuous efforts from the management team on improving the department with unit based observations, real time training and regular education.
2. Ensure both campuses are completing number of room's required.
3. Filter out isolation room cleaning observations.
4. Working recruitment to back fill vacant positions to staff adequately.
5. Routine reporting through Infection Control Committee by EVS Leadership.

Environmental Testing

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

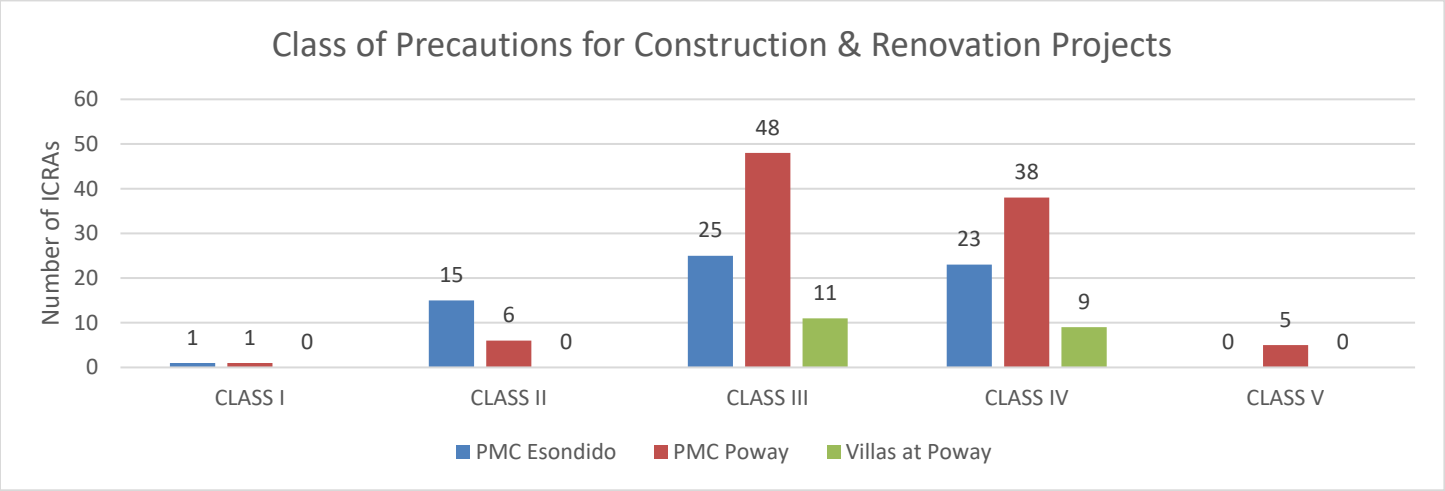
Summary: Environmental testing is performed in compliance with Infection Control Risk Assessment. Results outside normal parameters are reported directly to the Infection Prevention and Control Committee with a plan of correction. The Water Management Plan outlines testing of water sources on inpatient and outpatient locations. Please see that document for further information on this testing. Dialysis testing has been no growth during 2023.

Action Plan:

1. Perform environmental testing via 3rd party vendors for identification and control of environmental risks and hazards as indicated.
2. Follow recommendations of 3rd party vendor for remediation and follow up testing.
3. If results exceed threshold, services may be interrupted while investigations and action plans are created and implemented.

Construction

Goal: System provides consultation, perform Infection Control Risk Assessment ICRA) for construction and renovation projects, and provide education to Facility Operations, Information Technology (I.T) and Construction personnel.



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

Goal Met/Unmet:

PMC Escondido – Goal Met

PMC Poway – Goal Met

Villas at Poway – Goal Met

Action Plan:

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

Infection Control Education

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

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

1. Mask and eye protection as transmission based precaution to prevent COVID-19 exposure
2. Chlorhexidine bathing
3. Automated isolation precautions orders based on lab orders
4. MRSA colonization vs. infection and isolation precautions
5. Pre-treatment and transport of reusable devices
6. Hand Hygiene
7. Trophon 2 implementation
8. Ion device cleaning and disinfection
9. Infection Present at the time of surgery Would classification
10. Food and Nutrition education is now provided by the department.
11. Annual EVS education for both campuses, and added physical demonstration of hand hygiene.
12. Hand hygiene return demonstration for staff that have contact with patients (Including providers, EVS staff, new clinical staff hires) and Providers during onboarding.
13. CAUTI and CLABSI Risk Reduction Rounds with unit educators, CNS and primary nurses. Just in time education is provided when needed and unit leaders received a summary of findings with recommendations. CNAs were included in the education.
14. Regular review of C diff testing orders/collection and provided unit feedback when a test appeared not properly collected. Rounded with staff responsible for collecting and documenting stools and reviewing C diff algorithm.
15. Attended unit huddles and provided infection prevention education on different topics.
16. Rounded with staff regularly and reviewed different topics: C diff algorithm, CHG bath, Pericare with Foley and other topics that reduce risk for infections.
17. Provided infection control education with visitors which included hand hygiene and how to use PPE.
18. EVS cleaning observations with leadership and just in time recommendations when needed including contact plus precautions.

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

Goal:

PMC Escondido - Goal Met

PMC Poway – Goal Met

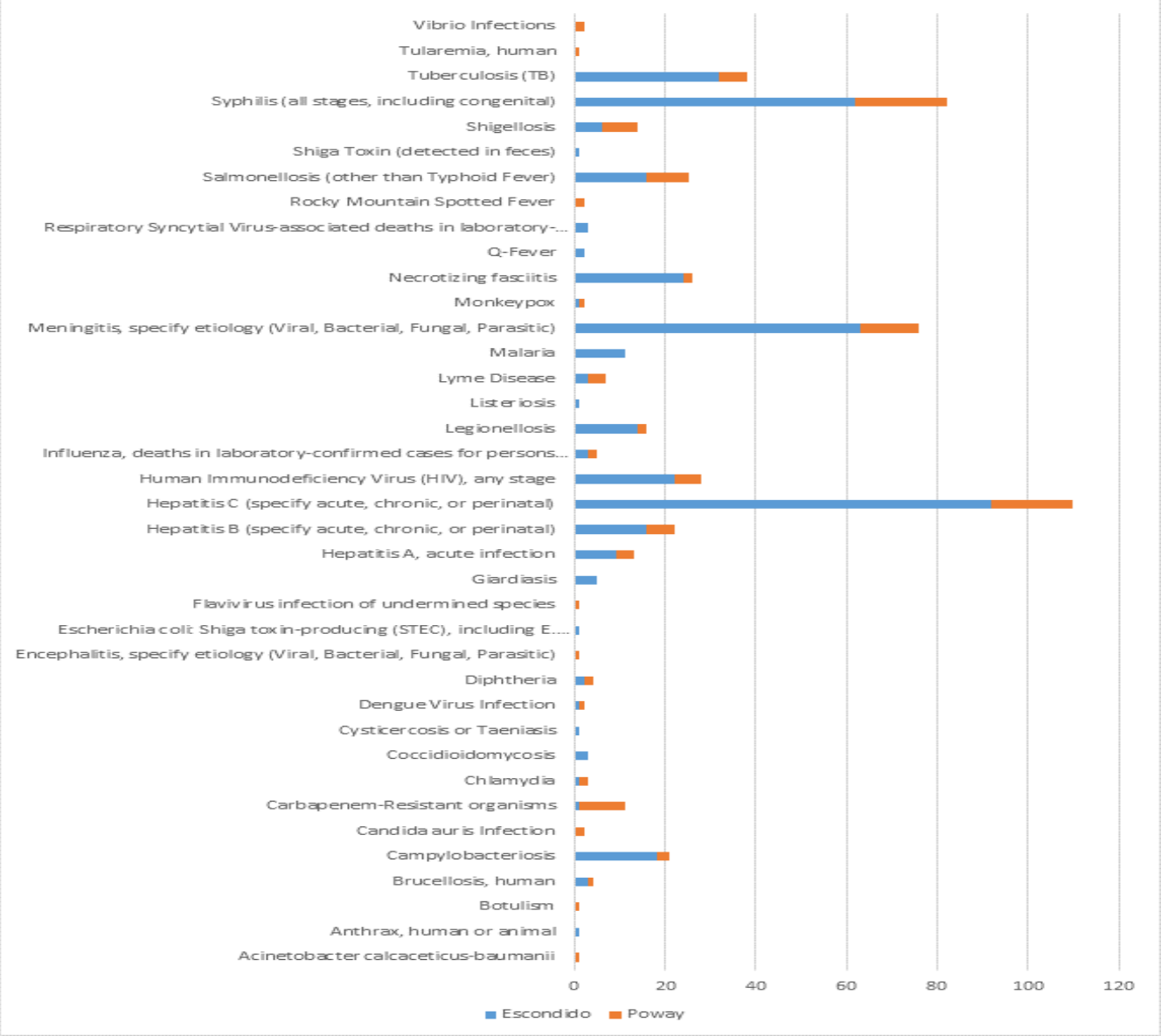
Action Plan:

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

PALOMAR HEALTH

Reportable Communicable Diseases

Summary Analysis: Maintain compliance with Title 17, California Code of Regulations, CDPH Confidential Morbidity Reporting (CMR) Requirements. When emerging infectious diseases are occurring in the community or community at large, infection control and hospital ensure staff and the facilities are prepared for the detection and management of these cases. Infection Control attends a virtual monthly meeting with County Epidemiology on current public health issues, and receives weekly and monthly reports on influenza and communicable diseases in San Diego County, respectively. During 2022, Infection Prevention assumes the role of daily, weekly in 2023, reporting of COVID-19 and hospital capacity data to NHSN. Infection Prevention continues to report COVID-19 hospitalization data to CDPH and healthcare personnel vaccination (HCP) data to NHSN. Infection Prevention routinely works with San Diego County Epidemiology, responding to requests, initiating reports, and outbreak investigations.



COVID-19

During 2023, the COVID pandemic was declared over. Control measures remain in place and exposure follow up is ongoing when indicated.

Summary of Projects

Antimicrobial Stewardship/Infectious Diseases Projects

- 2020-2023 California Department of Public Health Healthcare-Associated Infections Antimicrobial Stewardship Program Honor Roll – Gold Status
- Underwent The Joint Commission survey with no findings at either Palomar Escondido or Poway
- Underwent CDPH survey at Escondido with no findings. Poway is pending.
- Reaccredited Palomar's PGY-2 Infectious Diseases Pharmacy Residency for additional 4 years
- Responses to CDC Health Alerts
    - MPOX – Carry tecovirimat and processes paperwork to send to CDC
    - Malaria – 6/26/23: Carry Coartem and Malrone. Develop method of obtaining IV artesunate from CDC
- Beyfortus – 10/26/23: Implementation of Beyfortus in neonates during critical shortage and develop criteria for highest risk neonates.
- Antimicrobial committee
    - Meets at least once a quarter (on average every 2 months)
- Quarterly review of all surgical site infection and Clostridioides difficile infection (CDI) cases
- Quarterly review of facility-wide antimicrobial usage and resistance data
- Quarterly review of protected/restricted antimicrobial usage
- Quarterly review of pharmacist initiated antimicrobial stewardship interventions
- Annual review of influenza vaccine efficacy and cost analysis
- Information Technology (IT) projects
    - Update intra-abdominal antibiotic PowerPlan
    - Creating order sets for extended infusion Zosyn and cefepime
    - Update sepsis and meningitis PowerPlans
    - Remdesivir PowerPlan Revision
    - Anti-Pseudomonal Beta-Lactam pop-up alerts
    - Antibiotics on Antepartum Admit PowerPlan
    - Updated pneumococcal inpatient screener
    - Updated treatment of intrapartum and postpartum infections PowerPlan
- Microbiology Collaboration
    - Review and publication of annual antibiogram and letter to prescribers
    - Review of all blood polymerase chain reaction (PCR) discordant results
    - Updated reporting for beta hemolytic streptococcus and viridans group streptococcus
    - Removal of routine susceptibility testing for Staphylococcus saprophyticus
    - Reviewed new CLSI M100 2023 updates and implemented in susceptibility reporting

  - Update reporting of CARBA-R results
  - Annual review of resistance rates of multi-drug resistant organisms
  - Review need for Biofire PCR Pneumonia (lower respiratory tract) and Joint Panel
  - Susceptibility Testing on Stool Isolates
  - Reporting of Nutritionally Variant Streptococci and Gemella
  - Susceptibility Testing on Corynebacterium Species
  - Reporting Zosyn and Cefepime Susceptible Dose Dependent Reporting on Enterobacterales

- Medication Usage Evaluations (MUE)
  - Prescriber compliance with institutional guidelines for treatment of community acquired pneumonia
  - Appropriateness of cefepime usage empirically and for targeted therapy
  - Annual analysis of cost savings from Emergency Department (ED) Callback Program driven by ED pharmacist
  - Quarterly analysis of cost savings from de-escalation of vancomycin by pharmacy
  - Blood culture timing review. Time from alert of positive blood culture to administration of appropriate antimicrobials.
  - Annual Carbapenem Resistant Organisms (CRO) Case Review
  - Ertapenem Usage analysis based on indication, duration, empiric, and targeted therapy
- ASP Updates to medical, nursing, and pharmacy staff
  - COVID-19
    - Phasing out of monoclonal antibodies
    - Transition from Bivalent vaccines to the updated 2023-24 COVID-19 vaccines
    - Building inpatient screener with IT to capture eligible patients for COVID-19 vaccines
    - Updating COVID-19 treatment algorithm and provide education the ED, hospitalists, and intensivists
  - Revised ASP nursing orientation and iXpand
  - Education to ED medical staff on best practices in antimicrobial therapy
  - Presentation to department of surgery on best practice for pre-operative antibiotics
  - Presentation to department of anesthesia on importance of administering azithromycin for emergent C-sections and modified availability in OR Pyxis
- Policy and Procedure Updates
  - Preoperative and Pre-Procedure Antibiotic Dosing and Timing
  - Antimicrobial Allergy Management for Inpatients
  - Drug Dosing by Indication, Weight, and Renal function
    - Added ECMO dosing
  - Influenza, Pneumococcal, and COVID-19 Vaccine, Screening, and Administration
  - Aminoglycoside Protocol
  - Restricted Antimicrobials Procedure
  - Antimicrobial Sub-Committee

  - Antibiotic Stewardship Program
  - Standardized Adult Antibiotic Doses
  - Bioterrorism Employee Prophylaxis Antibiotic Cache Deployment
  - Creatine Kinase (CK) Monitoring During Daptomycin Therapy
- Manage Shortages and offer alternatives
  - Oseltamivir for 2022-23 influenza season
  - Neomycin oral tablets for use in antimicrobial bowel decontamination prior to colon surgery
  - Amoxicillin suspension
  - Amphotericin B deoxycholate
  - Clindamycin IV
  - Ciprofloxacin IV
  - Bicillin L-A
  - Beyfortus
  - Erythromycin ointment
- Formulary Review
  - RSV vaccines – Arexvy and Abryvso
  - Sulbactam/Durlobactam (Xacduro)
  - Nirsevimab (Beyfortus)
- Guidelines
  - Updated Beta-lactam Allergy Guidance Document
  - Developed institutional guidelines for common infectious disease states
    - Intra-abdominal infections + CDI
    - Urinary tract infections (UTI)
    - Skin soft tissue infections (SSTI)
    - Pneumonia
- Antimicrobial Stewardship Resident Projects
  - Evaluating the Negative Predictive Value of MRSA Nares PCR Screen in Skin and Soft Tissue Infections Above the Waist
  - Impact of Additional Comments on Microbiology Reporting for Organisms at Moderate to High Risk of AmpC De-Repression to Improve Appropriate Culture and Susceptibility Directed Therapy
  - Using MRSA Nares Screen to De-escalate Vancomycin Therapy in Patients with Skin and Soft Tissue Infections
  - Assessing the Impact of Oral Vancomycin for Secondary Prevention of Clostridioides difficile infection

Product Review

Members of the Infection Prevention and Control team participate in the Value Improvement Process (VIP) at Palomar Health. Several interventions for improving infection outcomes and risk mitigation were approved by

the VIP during 2023. The team also collaborates with departments for products that are reprocessed by validating that there is an infrastructure in place to properly clean and disinfect or sterilize items purchased.

ECMO Implementation

Infection Prevention was involved in the planning and implementation of this service modality. Through an FDA alert of improper storage of disposables used in ECMO equipment, a risk assessment was performed to mitigate infection or complications through supply and patient monitoring.

ION procedure implementation

Palomar Health initiated a new early diagnostics ION procedure. This procedure involves the use of multiple devices requiring high level disinfection. The implementation process was overseen by Infection Preventionists.

Trophon2 installation

New high level disinfection devices (Trophon2) were acquired for specific used to reprocess endocavity probes used for vaginal ultrasound. This device utilizes the same mechanism of disinfection as Trophon EPR with smart features. The transition included maintaining manual documentation logs. This remains the current method for documentation as there are still electronic record malfunctions.

BD urine collection pilot in ED

A 4-month pilot in the emergency departments using the BD Urine Collection System to reduce contamination rates. The emergency departments have the largest volume of patient urine specimen collections and the highest culture contamination rates compared to other departments in the hospital. The urine contamination rate in the emergency departments collectively decreased 14.1 percent since process implementation. However, the difference between the means of urine culture contamination rate before (13 months) and during (4 months) the use of the BD Urine Collection System is not statistically significant (p=0.146). The urine collection system will be maintained in the ED and be part of the department's annual clinical skills. Instead of extending the system to the inpatient units, it was opted by VIP Acute Committee to enforce traditional and appropriate urine specimen collection practices as part of their annual clinical skills.

Hand hygiene conversion walk through

Hand washing products were approved for conversion. Product was reviewed by infection prevention as an appropriate replacement. A walkthrough of all Palomar Health locations with Facilities, EVS, Supply Chain, and some unit representatives was performed with the goal to map dispenser locations for installation and improve accessibility. It will be a standard for there to be an alcohol-based hand sanitizer (ABHS) dispenser inside and outside every patient room.

CHG Bathing Conversion

A series of unit-trials for a new CHG foam soap was evaluated with our routine bathing method (Easicleanse cloths). The CHG wipe and/or CHG soap products were stocked for each unit according to historic usage, indications, and trial evaluations. The CHG wipes are specifically indicated for preoperative patients, and were

retained for units with that higher need, otherwise either CHG bathing method is appropriate. The objective was to increase CHG bathing to reduce CLABSI and SSI, and move away from off-label use of wipes.

Equipment Management

During 2023, the workload involved in identifying new and inventoried equipment while ensuring manufacturer's instructions for use are available and implemented. This project was significant enough to warrant a recommendation for a multidisciplinary approach to inventory and instructions for use. Infection Control will continue to lead this project and partner with SPD and other relevant departments across the system during 2024. The team will report findings to the Infection Prevention and Control Committee.

Procedure Review

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

PALOMAR HEALTH

ADDENDUM F

Annual Dept of Radiology Report

Imaging Errors and Report Discrepancies

Presented to Board Quality Review Committee

May 22, 2024

Dr. Charles McGraw

Chair, Department of Radiology, PMC-Escondido

Biannual Department of Radiology Report to Quality Management Committee

SITUATION	Report on the number of discrepant FINAL reports for North County Radiology (NCR, formerly SDI) and SHPS/Synthesis as well as 1099 Cohort ('Green and Co.') and accuracy of StatRad preliminary interpretations
BACKGROUND	• This quality assurance measure is to evaluate reported errors by NCR, SHPS and Green and Co., respectively, as well as ensure accuracy of interpretation of preliminary reads by StatRad. • For every preliminary StatRad interpretation, there is a final ('over-read') by a NCR radiologist. If there is discrepancy, the ordering physician is typically notified and this discrepancy is recorded. It is then reviewed and scored (as listed below). • Conversely, NCR, SHPS and Green and Co. are reported discrepancies mostly reported by NCR radiologists, or notified by various other physicians, including members of members of MSPRC. Similar feedback to radiologist and ordering physician also occurs. • This data is typically collected every 6 months. This is collated and reviewed by Dr. Brian Goelitz, NCR director of QA. There is no benchmark for this, but rather trends. • Additionally, Dr. Goelitz reviewed 15-20 random cases per each of 7 current diagnostic radiologists to evaluate for discrepancies.
ASSESSMENT	• There is overall a low rate of reported errors across NCR, SHPS, Green and Co. and StatRad • No discrepancies on the randomly reviewed cases for NCR radiologists reflects a very low error rate ('needle in a haystack').
RECOMMENDATION	• Continue to monitor and trend, provide feedback to radiologist. • Will report out again during next QMC Biannual Department of Radiology report.

PMC Radiology Coverage

Previous (Pre-April 2023)

- SDI – 6 am to 2 am, 7 days a week
- StatRad – 2-6 am, 7 days a week

1st Iteration (Post-April 2023)

- SDI – 7 am to 5 pm, M-F
- Synthesis –
  - 5-10pm, M-F
  - 8 am to 10 pm, weekend
- StatRad – 10 – 7/8 am, 7 days a week

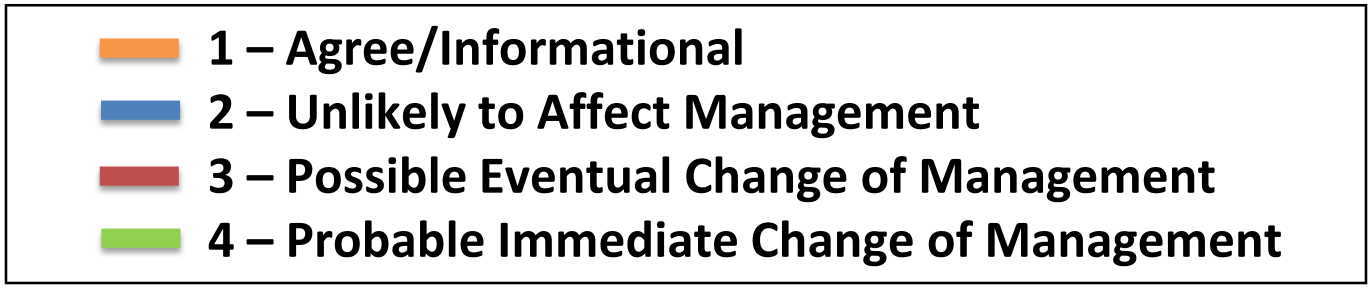
Next Iteration (last 4-6 mo)

- NCR – 7 am to 5 pm, M-F
- SHPS/Green –
  - 5-10pm or 1 am, M-F
  - 8 am to 10 pm or 1am, wkd
- StatRad – 10p or 1 am – 7/8 am, 7 days a week

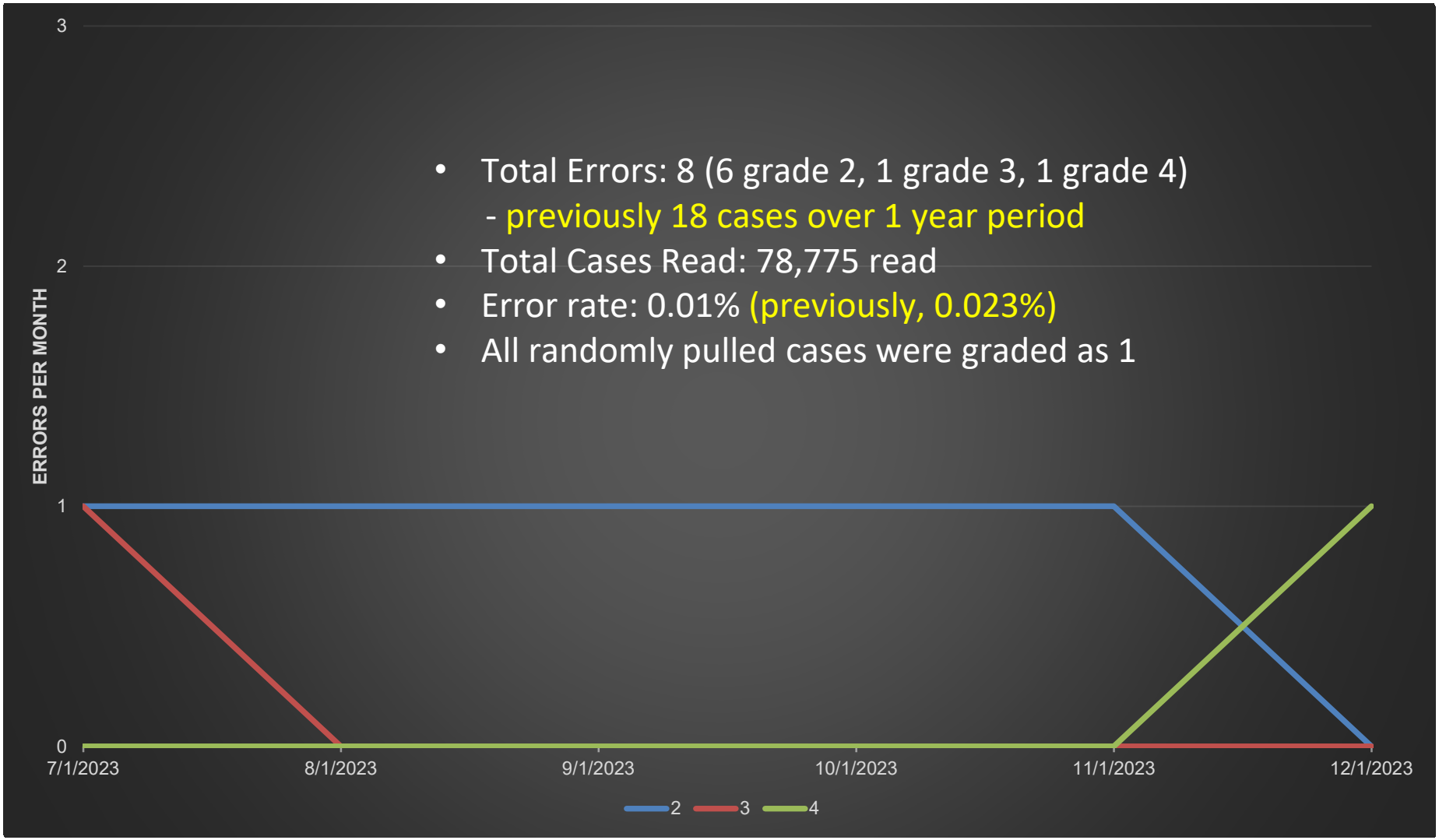
Process of Quality Assurance (QA)

- Studies flagged by NCR radiologist or requested to be submitted by other physician
  - Submitted by emailing Dr. Brian Goelitz or Sylvia Ramirez (NCR)
- Dr. Goelitz reviewed 34 studies submitted for PMC from 7/1/2023 to 12/31/2023
- He also reviewed an additional 80-90 randomly pulled cases (10-20 per diagnostic radiologists (x7) – 4 of current DRs not reviewed as they started after 7/2023).
- Studies scored as follows:

Scoring Errors/Discrepancies



North County Radiology (NCR)



- Total Errors: 8 (6 grade 2, 1 grade 3, 1 grade 4)
  - previously 18 cases over 1 year period
- Total Cases Read: 78,775 read
- Error rate: 0.01% (previously, 0.023%)
- All randomly pulled cases were graded as 1

Takeaways

- Overall, low rate of report errors, likely falsely low for NCR, SHPS and Green
  - Minority of cases reviewed independently
  - Low reporting rate by radiologist, usually only NCR
- All the randomly reviewed NCR cases (15-20 cases per rad) had no discrepancies → reflects low error rate
- Anecdotally, SHPS has more errors, which is somewhat borne out by data.
- Stat Rad will naturally have higher error rate, since every case is over-read and finalized.

PALOMAR HEALTH

BQRC – FY2024 to present

Palomar Health Imaging Services – Radiology and Nuclear Medicine
Annual Report to Board Quality Review Committee

Annual Report | FY2024

Sims Kendall, MHA-SI | District Senior Director, Imaging Services
Ryan Fearn-Gomez | Vice President of Operations and Support Services
Charles McGraw, MD | Chair, Department of Radiology, PMCE
Arian Nasiri, MD | Chair, Department of Radiology, PMCP

Radiology and Nuclear Medicine Annual Report – FY2024

SITUATION	Radiology and Nuclear Medicine measures, evaluates and reports on specific performance metrics to ensure compliance with Palomar Health policies and regulatory requirements.
BACKGROUND	The exceptions noted by Radiology and Nuclear Medicine for FY2024 include partially achieved PI goals, 0 ALARA badge breaches, and delayed read times due to shortages in Radiologist reading coverage.
ASSESSMENT	Process improvement actions were implemented to reduce turn-around-times (TAT) for Emergency Department(ED) ordered imaging studies in FY2023 and beyond. The specific actions were developed through bi-weekly intra-departmental leadership meetings between ED and Imaging. We improved our times significantly, but did not achieve the goals for each modality. The radiation dose badge program identified no physician badges which breached the ALARA level 2 range during this reporting period. The MRI modality did not have any MRI Burns, or Ferrous events from the beginning of FY2024 to present.
RECOMMENDATION	Radiation and Nuclear Medicine will: 1. Continuation of bi-weekly process improvement meetings with ED Leadership including providers to reach goal achievement in the targeted period. 2. Provide ongoing communication and data to physicians and staff on the radiation dose badge program requirements and results.

Radiation Safety and Imaging Performance Indicators

- **Process Improvement**: Turn-Around-Times for ED imaging studies
- **MD Dosimetry Badge:** Occupational dose and ALARA* breaches
- **Staff Dosimetry Badge:** Occupational dose and ALARA* breaches
- **Physicist report:** Required annual testing of all Imaging equipment
- **MRI:**
  - Burns
  - Ferrous events
- **Nuclear Medicine:** Linearity testing

*ALARA – As Low a Reasonably Achievable

Process Improvement: Turn-Around-Time for ED Imaging Studies

Goal: Complete 75% of ED ordered imaging studies within the benchmark timeframe

- CT | 60 min
- Ultrasound | 60 min
- Diagnostic Imaging | 30 min

Target Date: Ongoing

Action Plan:

- Onboard and train additional CT, Ultrasound, and Radiologic Techs, along with additional Tech Assistants to support ED services 24/7 per the FY24 operational plan and beyond. This ongoing.
- Dedicated DI and Ultrasound Techs in POD D (Verticare)
- Purchased additional US and Portable DI equipment to support efficient work function in ED
- Bi-weekly leadership collaboration with ED to identify and implement process improvement opportunities and collaborate to implement solutions.

Imaging Process Improvement Accomplishments

- **Process Improvement**: ED Imaging Median Turn-Around-Times (TAT)
  - CT order to complete (Goal 60min)
    ESC: 69 to 58 min (↓16.0%) | **POW**: 64 to 69 min (↑ 7.8%)
  - US order to complete (Goal 60min)
    ESC: 79 to 73 min (↓ 7.6%) | **POW**: 46 to 43 min (↓ 6.5%)
  - XR order to complete (Goal 30min)
    ESC: 36 to 33 min (↓ 8.3%) | **POW**: 21 to 23 min (↑ 9.5%)
  - MRI efficiency:
    ESC: ↑ 2.0 patients per day on 1st shift; cases starting :31 minutes earlier

Radiology Enhancements

- Bedside High Level Disinfectant for Ultrasound, Poway and Escondido implemented in Q2.
- ESCO – New ED Radiology suite installed in December 2023 and in use. Installation of 2nd ED Radiology Suite is currently underway.
- Optimization of MRI staff scheduling to increase efficiency and throughput; collaboration with Clinical Operations to utilize focused transport when necessary.
- Developed Advanced Imaging Technologist Aide position. These aides have been integrated into the CT Care Team to help expedite patient visits.

Physician and Staff Dosimetry Badges (FY2024)

- Physician Dosimetry Badges
  - No badges breached ALARA Level 2 range

- Staff dosimetry Badges
  - No badges breached ALARA Level 1 or 2 ranges

* Radiation Protection and Safety Plan, Lucidoc #56232

Annual Testing & Physicist Inspections FY24

Annual Physicist Testing

- 100% compliance with timeliness of inspection.
  - Annual Physicist Inspections are required on all:
    - Ultrasound machines and transducers
    - Magnetic Resonance Imaging Scanners
    - Diagnostic Imaging systems
  - All mobile (trailer) units also have current Physicist inspections

Dose Calibrator Linearity Test

- Score is pass or fail
- This test is performed quarterly by the Physicist
- FY24 to Present Dose Calibrator Linearity Testing (performed quarterly)
  - PMC Escondido: **PASS**
  - PMC Poway: **PASS**

MRI Burns and Ferrous Events:

- **Confirmed MRI Burns**:
  - Escondido: **0**
  - Poway: 0
- **Ferrous events**:
  - Escondido
    - With injury: **0**
    - Without injury: **0**
  - Poway
    - With injury: **0**
    - Without injury: **0**

PALOMAR HEALTH

ADDENDUM G

Laboratory Annual Presentation

(including Tissue Reports & Blood Use)

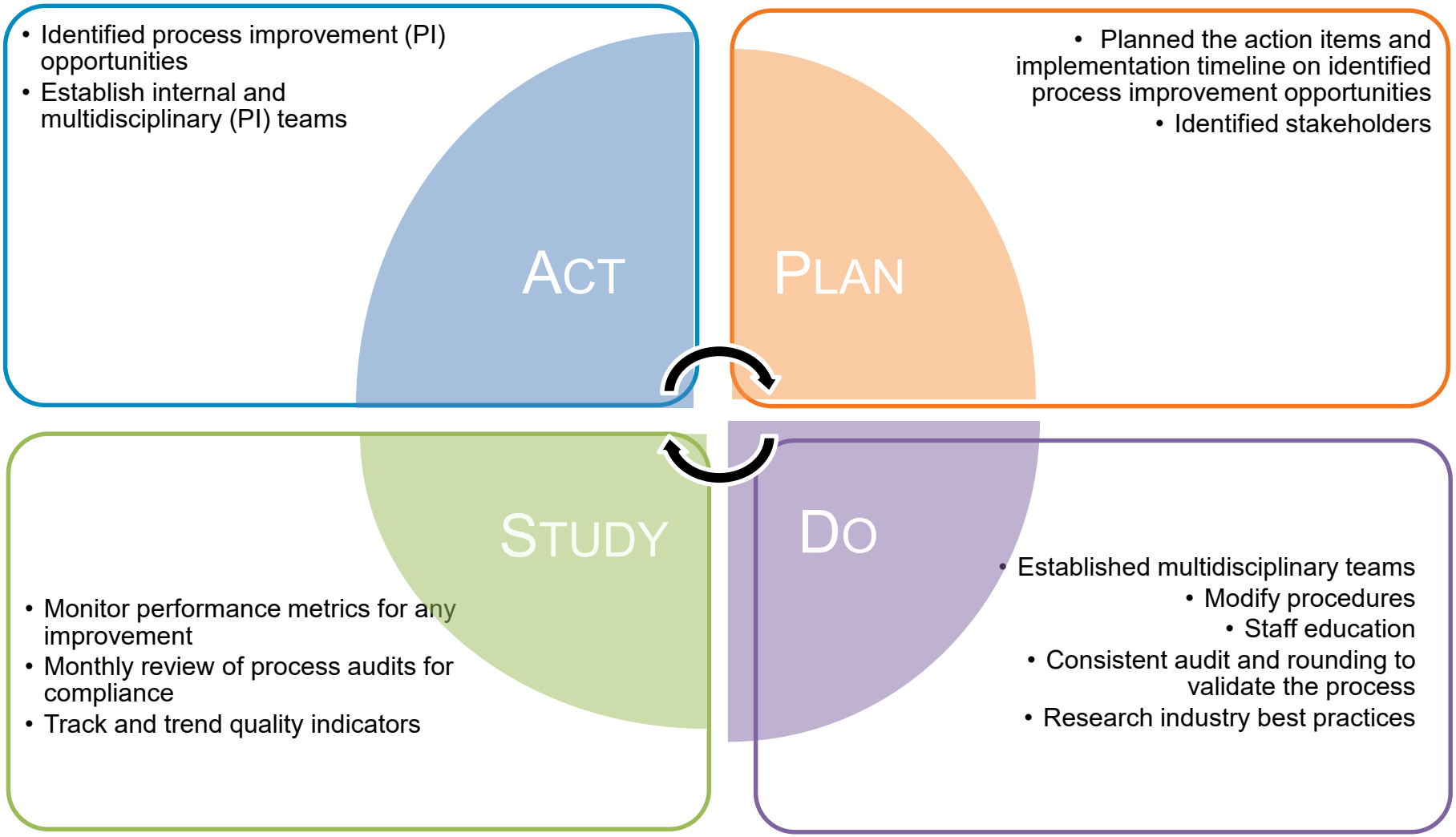
Presented to Board Quality Review Committee

Jerry Kolins, M.D., Medical Director, Laboratory
Gloria Austria, Senior Director, Laboratory Services
May 22, 2024

Laboratory Annual Report

SITUATION	The Laboratory Quality Committee meets monthly to review lab quality indicators performance metrics for trends and opportunities to improve
BACKGROUND	The Laboratory Quality Committee identifies different quality indicators for all three phases of laboratory operations to monitor annually according to regulatory requirements, identified high risk process, and multidisciplinary quality initiatives. The committee, with the approval of the medical director, sets the target base on national benchmark.
ASSESSMENT	Fiscal Year (FY) 24 performance • Out of the thirteen performance metrics, nine met the target, two are being monitored for opportunities, and two were identified as process improvement projects • Critical value reporting, test order accuracy, proper specimen identification, consistently met performance targets • Hand Hygiene compliance and Newborn Screening Specimen (NBS) Transit turn around time performance are being closely monitored • Stat turn around time in the Emergency Department and Blood Culture Contamination Rate were identified as process improvement projects for FY 24 Laboratory Stewardship • The lab committee assessed the need to establish a formal structure to review test utilization, test order frequency and trend, test order management • Laboratory stewardship committee was approved and reports to Patient Medication and Safety Council • Opportunity to in-source testing for faster turn around time, improve quality of care, and financial savings
RECOMMENDATION	- Continue to focus on blood culture contamination rate for FY 25 and report back on progress at the next biannual report to QMC - Continue to track and trend the NBS transit turn around time (TAT) for any opportunities to improve - Continue to review test utilization and ordering pattern for any improvement opportunities, assays to start testing in-house

PDCA: Laboratory Quality Committee



FY 24 Laboratory Quality Dashboard						
	FY24 Q1	FY 24 Q2	FY 24 Q3			Target
			Jan-24	Feb-24	Mar-24	
Specimen Identification Error	99.99%	99.99%	99.99%	99.99%	99.99%	99.99%
Specimen Integrity	99.99%	99.99%	99.99%	99.99%	99.99%	99.97%
Test order accuracy	99%	99%	99%	99%	99%	99%
Critical Value Reporting	100%	100%	100%	100%	100%	100%
Pre-op Abnormal Value Call	100%	100%	99%	100%	100%	100%
Lost specimen	0%	0%	0%	0%	0%	0%
PPID scanning compliance	91%	81%	81%	87%	87%	90%
Hand Hygiene						
Escondido	81%	85%	90%	95%	na	75%
Poway	68%	69%	91%	86%	na	
NBS Specimen Transit TAT	79%	82%	76%	81%	85%	85%
Blood Culture Contamination Escondido	3%	3%	3%	2.9%	2.7%	<2.0 %
ED Stat TAT						
Order to Draw	20	19	19	17	20	17 minutes
Draw to Receive	10	9	9	9	8	8 minutes
Receive to Completion						
Chemistry	33	30	30	30	30	30 minutes
Lactate	26	22	23	27	26	
Troponin	33	29	29	29	27	

Blood Culture Contamination Rate

SITUATION	The blood culture contamination rate is not meeting the target set by the laboratory at <2.0.
BACKGROUND	The outcome measure is a contamination rate target of < 2.0 % at Palomar Health. The national benchmark is <3% with < 1% as the recommended stretch goal.
ASSESSMENT	In review of the process, the following were the identified challenges: - Inconsistent decontamination process - Practice of drawing blood culture samples as extra specimens, not using the recommended decontamination process - Not enough wasted blood to minimize skin contaminants - Staff turnover and backfilled with new grad/licensed personnel - Strict adherence to procedure for correct volume and order of draw - Non lab (RN) specimen collection not trained on proper decontamination process
RECOMMENDATION	- Discontinue practice of drawing blood cultures as extra specimens - Re-train staff and validate practice of proper site decontamination process, order of draw, and correct volume - Modify workflow to add collection of a waste tube prior to collecting blood culture bottles - Discourage nursing from collecting blood culture samples from intravenous (IV) start

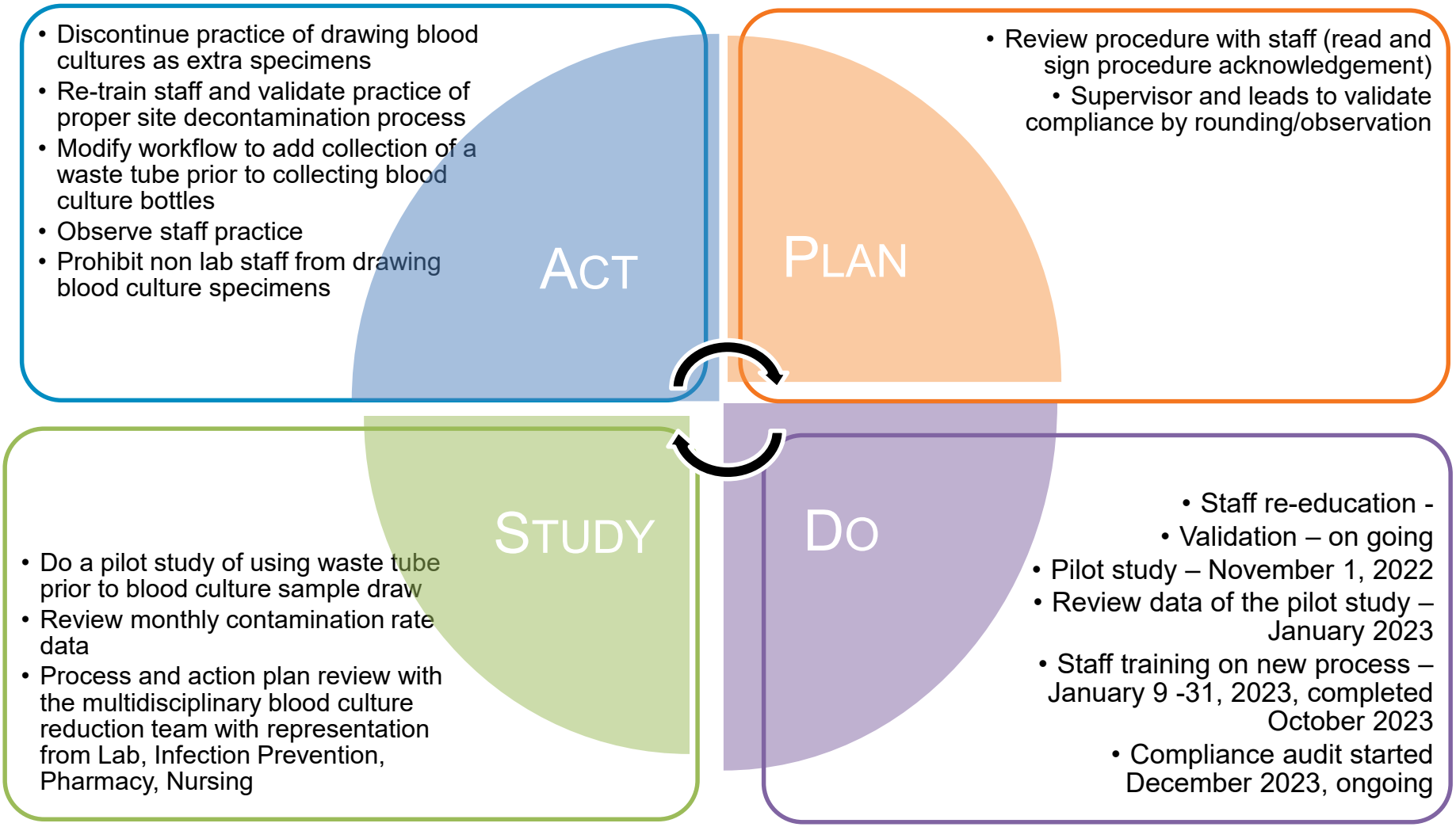
Data

Escondido Blood Culture Contamination Rate

FY	Goal	July	August	September	October	November	December	January	February	March	April	May	June
2019	<2.5 %	2.1	2.2	2.1	2.1	1.9	1.9	1.4	1.5	2	1.4	1.5	1.5
2020	<2.5 %	1.8	2.5	2	2.2	1.6	1.6	1.7	1.5	1.5	2.5	2.3	1.3
2021	<2 %	1.3	2.2	1.7	1.8	2.3	1.8	2	1.9	1.9	1.7	1.69	2.5
2022	<2 %	2.4	2.7	1.4	1.9	1.9	1.6	2	2.4	1.8	1.6	1.5	2.1
2023	<2 %	2.7	2.3	2.5	2.2	2.1	2.3	2.1	2.7	2.1	2.1	2.3	2.5
2024	<2 %	2.5	3.1	3.4	2.9	3.0	3.1	3.0	2.9	2.7			

Metrics	Frequency	Target	Units	FY 24 Monthly Data											
				July	August	September	October	November	December	January	February	March	April	May	June
Escondido Lab	Monthly	<2.0	%	2.50%	3.10%	3.40%	2.90%	3.00%	3.10%	3.00%	2.90%	2.70%			
Escondido Non-lab											10.00%	5.10%			
Units															
ED											47	43			
5W											3	1			
5E											2	2			
4SW											3	2			
9E											2				
SSU											1				
6W											1				
7W												2			
4NW												1			
4E												1			

PDCA: Blood Culture Contamination Rate



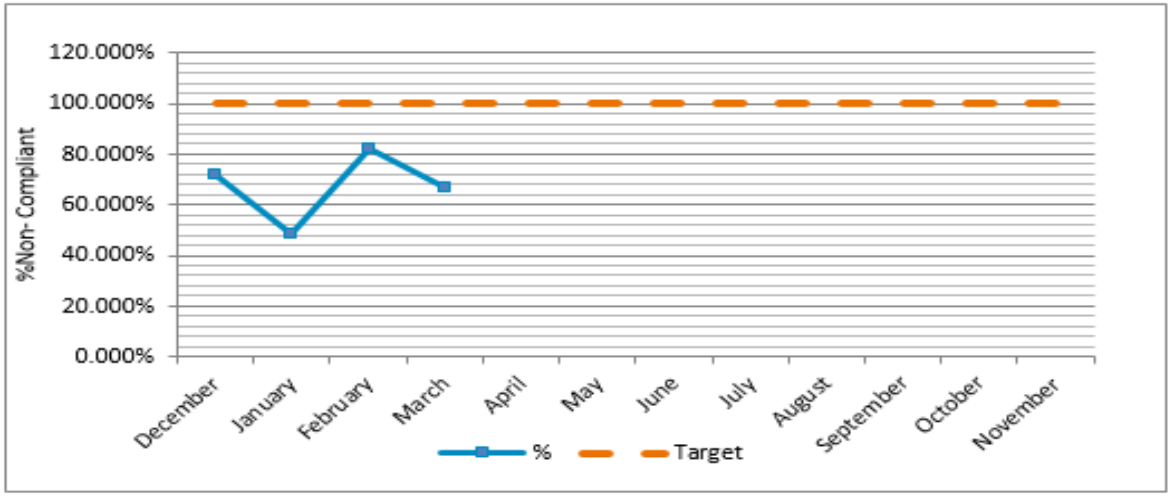
Compliance Audit

PMC Escondido Laboratory

Plan		Do - Measurement
Indicator	Numerator (Successes)	Total Number of Observed Proper Decontamination/Collection Process
BC Proper Decontamination Process Compliance	Denominator (Total)	Total Number of Observe Blood Culture Collection

Start Date: 12/4/2023 Target: 100.000% Responsible Leader: Mariel Teng

	Summary		
	Num	Den	%
December	31	43	72.093%
January	17	35	48.571%
February	18	22	81.818%
March	4	6	66.667%
April			#N/A
May			#N/A
June			#N/A
July			#N/A
August			#N/A
September			#N/A
October			#N/A
November			#N/A



Analysis	Actions Taken
Current blood culture rate is at 2.4% calculated from January - November 2023. 2/2024- January dropped in compliance compared to December with the change in the audit process from supervisor performing the audit to "lab secret shopper". 4/1/2024 -March total audit reprot is low due to limited resources available to perform the observation/audit.	Staff re-education on proper site decontamination, use waste tube before collection, staff re-education of the acceptable blood culture volume, perform audit on proper collection/decontamination process.

Action Plan with Timeline

- Staff re-education on proper site decontamination- completed
- Validate staff compliance on correct decontamination process – ongoing
- Pilot the use of waste tube prior to collection – November 1, 2022
- Review data on pilot data to measure success – January 1, 2023
- Re-education on correct blood culture volume (minimum of 10 ml) – October 2023
- Implementation of the new waste tube process prior to blood culture collection – November 17, 2023
- Stop practice of drawing extra pediatric blood culture bottles – December 2023
- Audit waste tube use compliance – Initiated December 2023 and on going
- Multidisciplinary **(Lab, Infection Prevention, Pharmacy, Nursing)** Blood Culture Reduction Team – Initiated November 2023
- Use “lab secret shopper” to perform the audit – January 15, 2024

Laboratory Stewardship

Assay	Purpose	Go - Live
Enteric Bacterial and Enteric Parasite Polymerase Chain Reaction (PCR)	• Direct qualitative detection and differentiation of enteric bacteria pathogen and enteric parasitic pathogen on stool • Faster turn around time versus traditional stool culture	9/5/2023
Streptococcus pneumoniae Antigen	• Detection of Strep pneumonia antigen in the urine of patients with pneumonia • Faster turn around time • Tangible cost savings approximately 50% of current spend to send- out	2/27/2024
Legionella urine Antigen	• Detection of Legionella pneumophilia serogroup 1 antigen in urine for presumptive diagnosis of Legionaire's disease • Faster turn around time	2/27/2024
Anti-Xa	• Quantitative determination of unfractionated and low molecular weight heparin • Intended to support the ECMO service line • Faster turn around time	March 2024
Herpes Simplex Virus 1 and 2 IgG antibody	• Determine primary or secondary infection within 24 hours of life • Primary infection – NICU admission, complete workup including lumbar puncture with automatic anti-viral treatment (Acyclovir) for 10 days • In-house testing result within 24 hours versus 3 – 5 days (send-out)	March 2024

Laboratory Stewardship

Process	Purpose	Go - Live
ED Sepsis Protocol	• Support ED's workflow to screen possible septic patients not presenting visible signs and symptoms with implementation of ABL 90 point of care device (venous lactic acid, venous electrolytes, venous glucose, and venous blood gas)	12/2023
STAT turn around time	• Completion of STAT within 60 minutes from order to release of results	On going
Antibiotic Stewardship	• Auto-verification of blood culture no growth	9/2023
Diabetes Management	• Treat patients appropriately and safely in timely manner when glucose results are high.	3/2024

Pathology QA Summary PMC/Escondido, 2023

	Benchmarks	1Q	2Q	3Q	4Q	2023	2022	2021	2020
# surgical	N/A	1803	1692	1597	1527	**6619 (-15%)**	**7783 (+1.8%)**	**7643 (+1.8%)**	**7520**
# QA +IDC review	>10%	29%	20%	20%	18.5%	22%	20%	20.5%	18%
# Discordant **Total** : -Outside review -consultations	0-2	0/35 0/27 0/8	0/24 0/15 0/9	0/29 0/24 0/5	0/21 0/12 0/9	0/109 0/78 0/31	2/127 2/71 0/56	2/150 2/97 0/53	2/119 1/65 1/54
TAT time (% of < 48 h)	>90%	90%	90.5%	89.4%	91%	90.2%	91%	92%	93%
# FS cases	N/A	73	83	77	42	275	266	288	347
# discordant FS/perm: Total: Due to misinterpretation Due to sampling	 5% or less	1.4% (1) 0 1.4% (1)	0 0 0	2%(2) 0 2%(2)	0 0 0	<1% 0 <1%	4.5% (13) 0 4.5% (13)	1.3% 0.3% 1%	2% 0 2%
TAT FS: Average (min) % called in < 20 min	<20 min >90%	13.5 min 97%	14 min 99%	13 min 98%	16 min 100%	14 min 98.5%	14 min 99%	12.75 min 97%	12 min 99.75%

Pathology QA Summary PMC/Poway, 2023

	Benchmarks	1Q	2Q	3Q	4Q	2023	2022	2021	2020
# surgical	N/A	707	688	670	684	**2749 (-2%)**	**2800 (+0.6%)**	**2785 (+15%)**	**2365**
# QA review	>10%	24%	25%	25%	24%	24.5%	25%	23%	24%
# Discordant **Total** : -Outside review -consultations	0-2	0/18 0/14 0/4	0/16 0/14 0/2	0/16 0/15 0/1	0/16 0/12 9/4	0/66 0/55 0/11	0/53 0/39 0/12	0/57 0/42 0/15	1/63 1/58 0/5
TAT time (% of < 48 h)	>90%	91%	91%	91.5%	93%	92%	91.3%	92%	93%
# FS cases	N/A	47	58	52	35	192	210	201	141
# discordant FS/perm: Total: Due to misinterpretation Due to sampling	5% or less	4% (2) 0 4% (2)	0 0 0	7.7% (4) 1.9% (1) 5.8% (3)	6% (2) 0 6% (2)	4% (8) 0.4% (1) 3.6% (7)	0 0 0	2.9% 0 2.9%	0.7% 0 0.7%
TAT FS: Average (min) % called in < 20 min	<20 min >90%	12 min 100%	11 min 98%	14 min 94%	16 min 94%	13 min 97%	14 min 98%	12.5 min 98.5%	13 min 99.5%

PALOMAR HEALTH
Reimagining Healthcare

Palomar Medical Center Escondido
Transfusion Medicine Review 2024

Blood Usage: Blood Bank Director	Target	CY Total 2019	CY Total 2020	CY Total 2021	CY Total 2022	CY Total 2023	1st QTR 2024	2nd QTR 2024	3rd QTR 2024	4th QTR 2024	Year to Date
1a Total red blood cell transfusions		6810	5614	6367	5844	4488	1293				
1b. Transfusions Meeting Criteria (%) (# meet criteria/ # reviewed)	100%	235/240= 97.9%	238/240 = 99%	238/240= 99.2%	239/240= 99.58%	238/240= 99.2%					
2. Crossmatched to transfusion (C:T) ratio (hospital wide)	< or= 2.0	9322/6810= 1.37	8481/5614= 1.51	9197/6367= 1.44	8409/5844= 1.44	6889/4488 1.53	2053/1293= 1.58				
3. % wasted RBC units (% outdate/# RBC received	< or= 0.5%	24/6692= 0.36%	31/5683 = 0.55%	40/6340= 0.63%	24/5959= 0.40%	29/4603= 0.63%	7/1188= 0.58%				
4. % expired / RBC received	< or= 0.5%	16/6692= 0.24%	22/5683 = 0.39%	10/6340= 0.16%	3/5959= 0.05%	2/4603= 0.04%	4/1188= 0.34%				
5. Reported Reaction Rate= # reported Transfusion Reactions / total # transfusions (hospital-wide) a. Hemolytic		0	0	0	0	0	0				
b. Febrile Non-Hemolytic		14	9	5	9	15	2				
c. Allergic		7	5	3	5	4	1				
d. Transfusion Related Acute Lung Injury (TRALI)		0	0	0	0	0	0				
e. Fluid overload (TACO)		2	1	2	0	0	0				
f. Bacterial Contamination		0	0	0	0	0	0				
g. Transfusion Rx not confirmed		14	2	5	5	3	2				

PALOMAR HEALTH
Reimagining Healthcare

Palomar Medical Center Poway
Transfusion Medicine Review 2024

Blood Usage: Blood Bank Director	Target	CY Total 2019	CY Total 2020	CY Total 2021	CY Total 2022	CY Total 2023	1st QTR 2024	2nd QTR 2024	3rd QTR 2024	4th QTR 2024	Year to Date
1a. Total red blood cell transfusions		1365	1482	1425	1108	849	251				
1b. Transfusions Meeting Criteria (%) (# meet criteria/ # reviewed)	100%	119/120= 99.2%	119/120= 99%	108/110= 98.2%	120/120= 100%	119/120= 99.2%					
2. Crossmatched to transfusion (C:T) ratio (hospital wide)	< or= 2.0	1799/1365= 1.32	474/370 = 1.28	1745/1425= 1.30	1548/1108= 1.40	1097/849= 1.29	360/314= 1.15				
3. % wasted RBC units (% outdate/# RBC received	< or= 0.5%	8/1432= 0.56%	4/1512 = 0.26%	6/1435= 0.42%	2/1128= .18%	1/891= 0.001%	0/293= 0%				
4. % expired / RBC received	< or= 0.5%	1/1432= 0.07%	2/1512 = 0.13%	2/1435= 0.14%	0/1128= 0%	0/891= 0%	0/293= 0%				
5. Reported Reaction Rate= #reported Transfusion Reactions / total # transfusions (hospital-wide)											
a. Hemolytic		0	0	0	0	0	0				
b. Febrile Non-Hemolytic		2	4	7	2	0	0				
c. Allergic		2	1	2	1	1	0				
d. Transfusion Related Acute Lung Injury (TRALI)		0	0	0	0	0	0				
e. Fluid overload (TACO)		0	0	1	0	0	0				
f. Bacterial Contamination		0	0	0	0	0	0				
g. Transfusion Rx not confirmed		2	2	4	1	0	0				

PALOMAR HEALTH

ADDENDUM H

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

Presented to
Board Quality Review Committee (BQRC) on
May 22 2024

Najeebe Geagea, MSN, RN, CNS, Service Line Clinical Coordinator
James Bried, MD, Orthopedic Medical Director, PMC-P
Andrew Nguyen, MD, PhD, Spine Medical Director

Spine and Total Joint Centers of Excellence

SITUATION	Palomar Medical Center Escondido and Poway's Total Joint Replacement and Spine Surgery COEs continue to be recognized for high quality care and patient outcomes.
BACKGROUND	Palomar Health performed over 2,000 Joint Replacement and Spine procedures in 2023, a 6% growth over 2022 volumes. Preparing patients for elective surgery remains a primary goal. This includes ensuring patients are at their best health prior to surgery, and are educated about the care journey. Our Enhanced Recovery and Pain Control Protocols ensure early mobilization, better pain control and more rapid care transitions and discharges. Many patients are ready to go home same-day, and most patients experience a full return to function within the first year. Both COEs meet regularly to review quality metrics, including SSIs, Return-to-ED, readmissions, plus metrics concerning patient preparedness, and operational efficiencies.
ASSESSMENT	Spine surgery volume grew 4% since 2022, and 18% compared to pre-pandemic levels (570 to 482). We've performed 200+ robotically-assisted spine fusions, and are able to perform increasingly complex cases. The observed spine fusion and laminectomy SIR has been better than expected for 2021, 2022, and 2023. Most importantly, patients that had a fusion at Palomar went from Severe Disability to Minimal Disability within the first year after surgery. Total Joint Replacement patients are meeting there therapy goals quicker than ever, and 85%-96% are being discharged home before the 2nd midnight. The SIR for HPRO was worse than expected in Escondido and better than expected in Poway. The SIR for KPRO was better than expected in Escondido and worse than expected in Poway. Most importantly, patients that had a total hip replacement at Palomar went from Moderate Disability to Limited to No Disability within 3-months of surgery. PMC-Poway passed its mid-cycle survey for the Joint Commission's Advanced Total Hip and Knee Replacement Accreditation (THKR).
RECOMMENDATION	Our Orthopedic and Spine Workgroups identified opportunities to improve by ensuring each patient has the chance to ambulate quickly after surgery, and we improve compliance with several pre-op measures, including nasal betadine, and CHG bathing.

CONGRATS

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

Total Hip and Knee Replacement

PALOMAR HEALTH
Reimagining Healthcare

PalomarHealth.org

EXCELLENCE

Doesn't Go Unnoticed

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

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

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

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

PALOMAR HEALTH
Reimagining Orthopedic & Spine Care

What are our True Differentiators?

- Specialized physicians and staff members
- High quality patient outcomes leading to faster recovery and less pain
- Coordinated care across Palomar Health services
- Patient readiness
- Staff education

Ortho/Spine | Engaging Patients

I've had many surgeries in the past but **at no other time was I so prepared**. In fact, I was **over-prepared.**

- Total Knee Patient

4,338

activated patients through 2023

81%

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

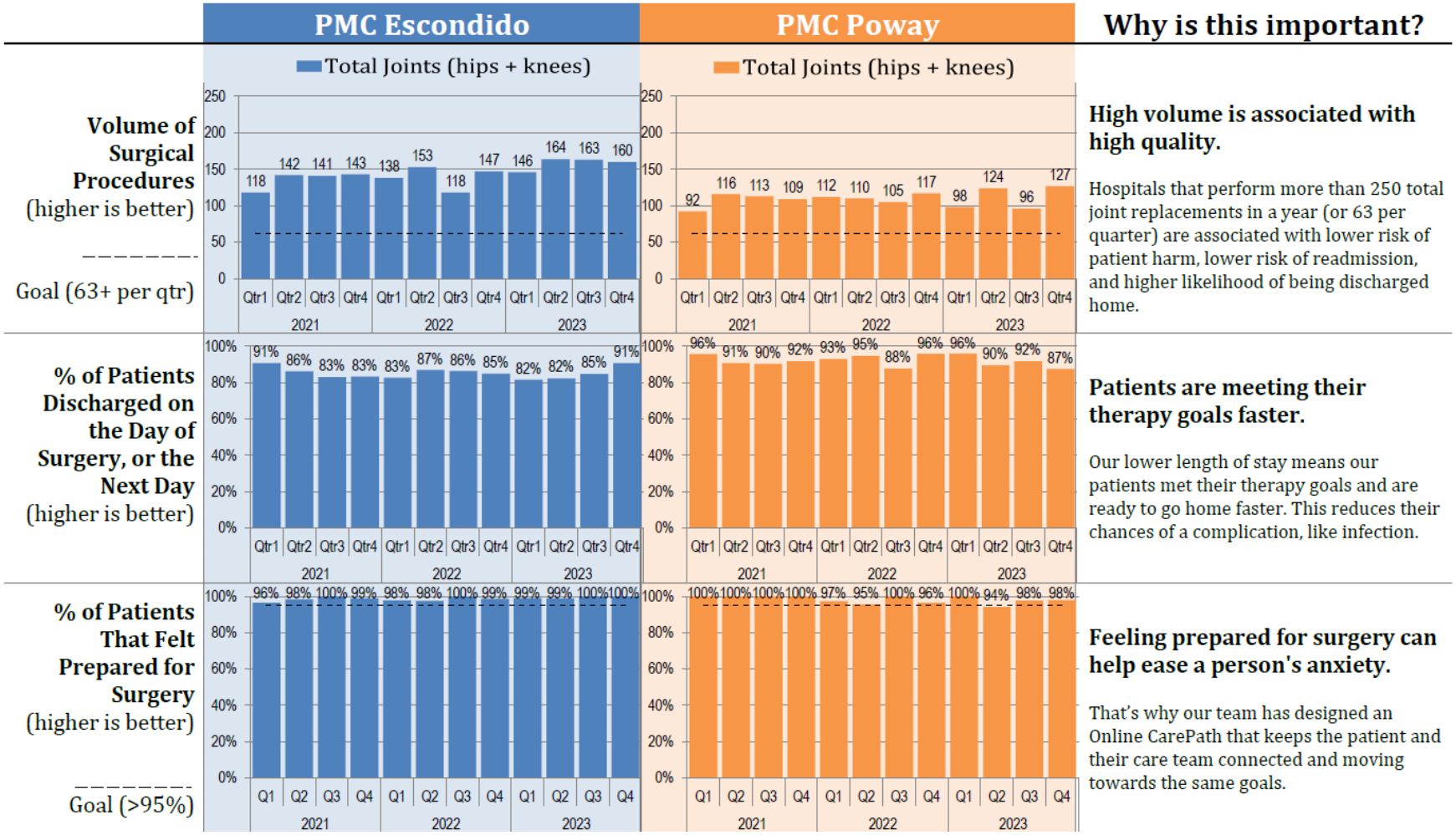
78%

engagement rate for patients **older than 75 years**

Quality Metrics | Joint Replacement (2021-2023)

PALOMAR HEALTH

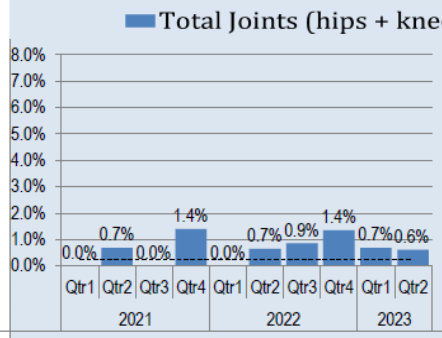
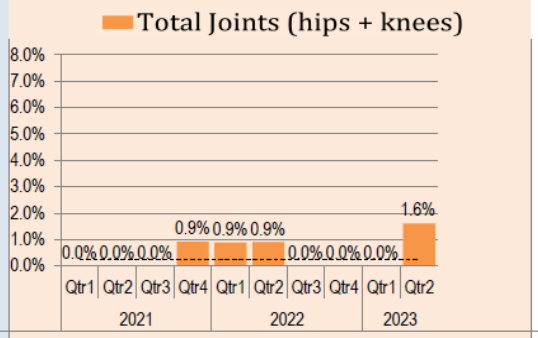
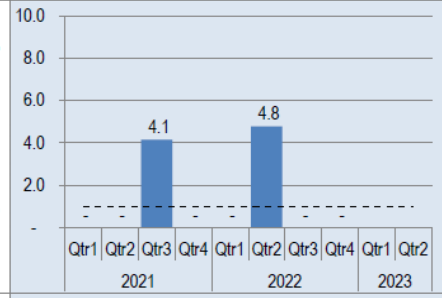
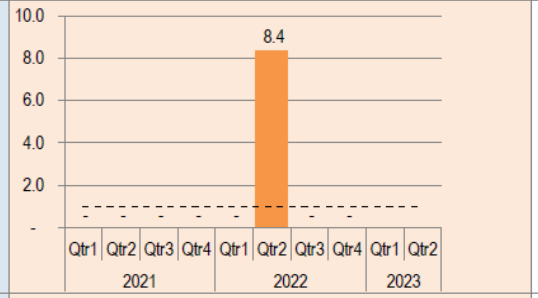
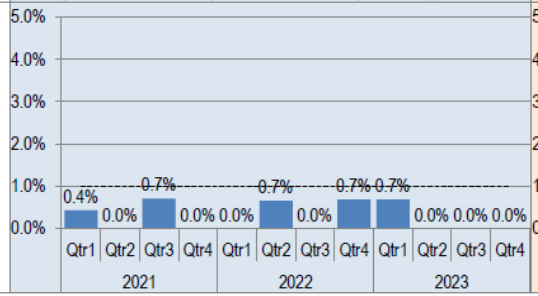
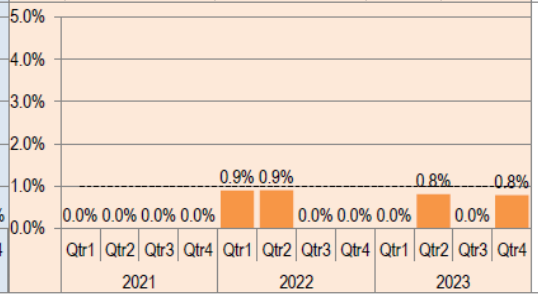
Total Hip and Knee Replacement - page 1 of 3
(excludes revisions, hemi, and partial replacements)



Quality Metrics | Joint Replacement (2021-2023)

PALOMAR HEALTH

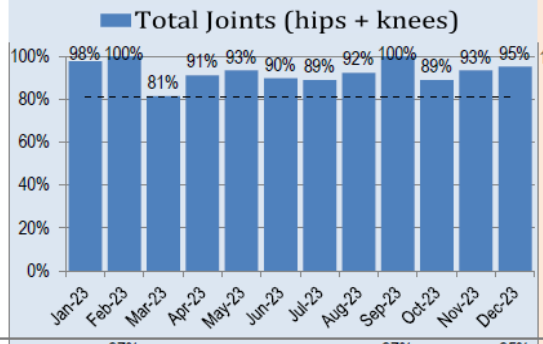
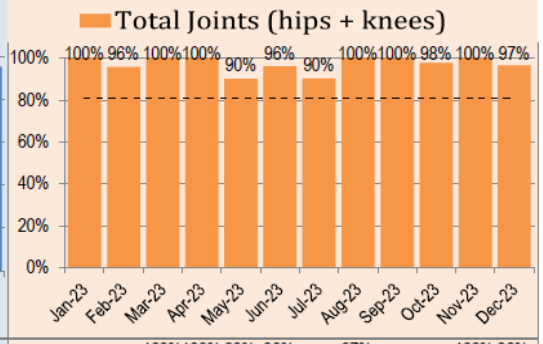
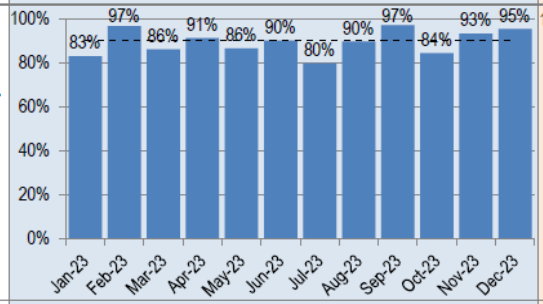
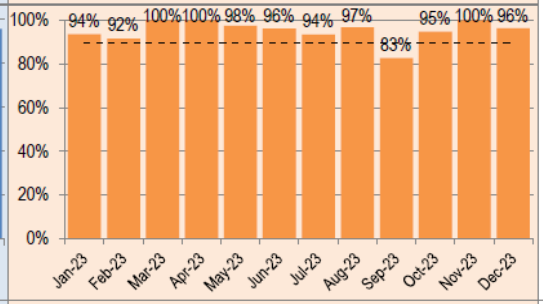
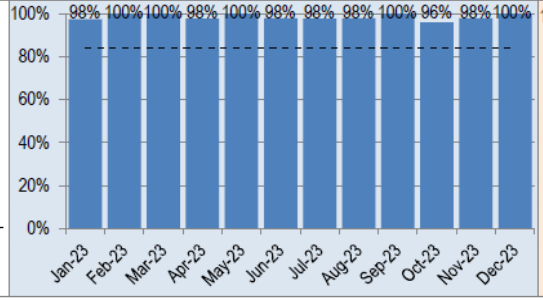
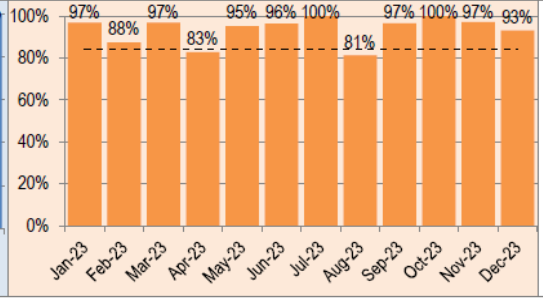
Total Hip and Knee Replacement - page 2 of 3
(excludes revisions, hemi, and partial replacements)

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

Quality Metrics | Joint Replacement (2023)

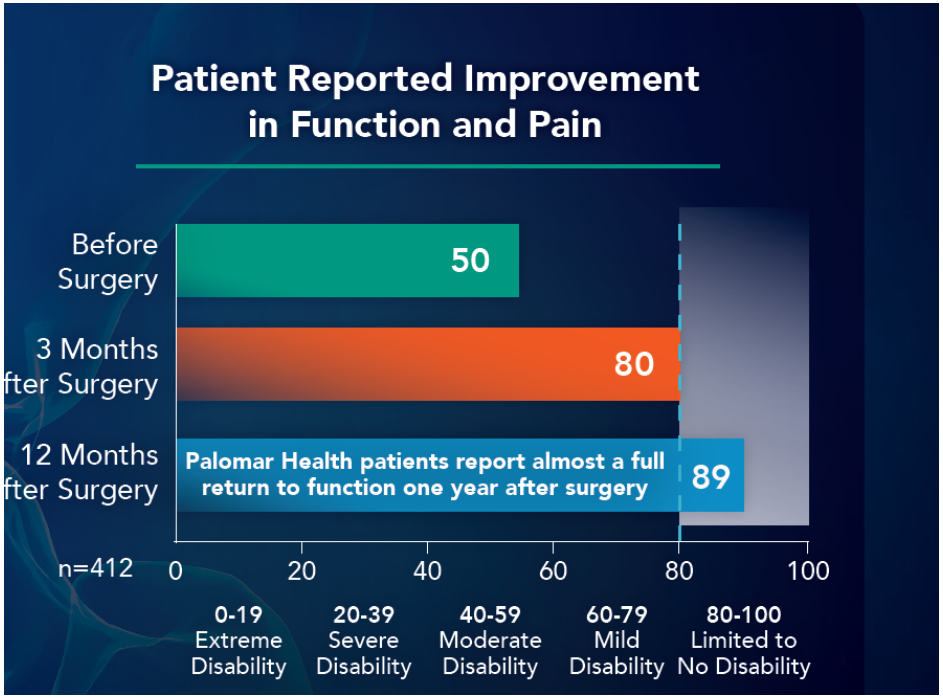
PALOMAR HEALTH

Total Hip and Knee Replacement - page 3 of 3
(excludes revisions, hemi, and partial replacements)

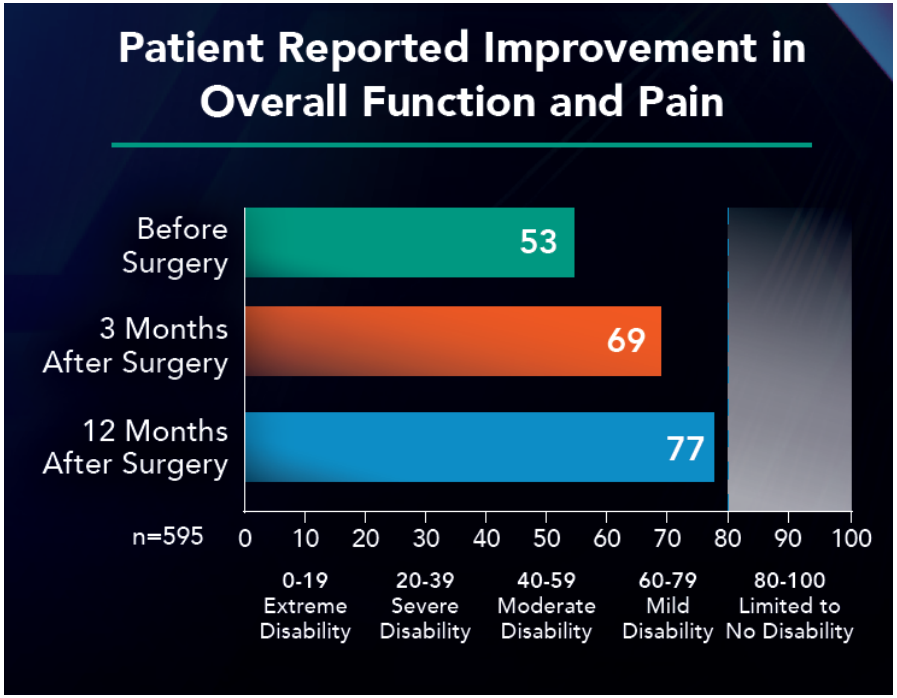
	PMC Escondido	PMC Poway	Why is this important?
% Patients w/ Regional Anesthesia (higher is better) Goal (>81%)			**Regional anesthesia, including spinal anesthesia, has many positive benefits.** Spinal anesthesia has been associated with improved outcomes and lower complication rates, if used when indicated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

Quality Metrics | Joint Replacement

Hip Replacement



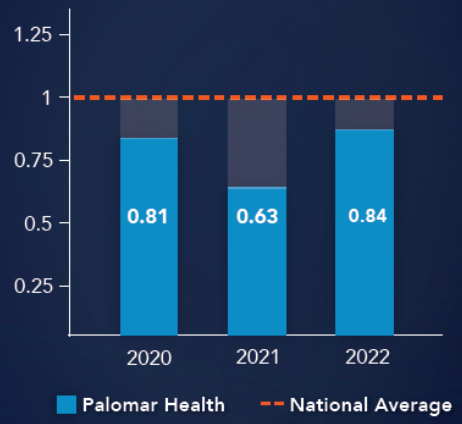
Knee Replacement



Quality Metrics | Spine Surgery

Complication Rate

In the area of complications of care during spine surgery, such as infection, blood clots or nerve injury, Palomar Health consistently outperforms the national average. **In 2022, Palomar Health's complication rate was 16% lower than the expected complication rate!**

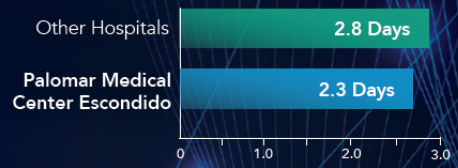


Lower is Better!

Why Is This Important?

Achieving superior outcomes in back and neck surgery requires you to staart on the road to recovery without any setbacks.

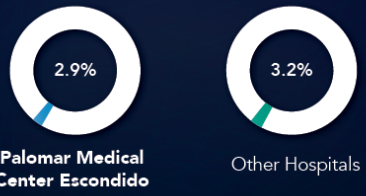
Average Length of Stay



Why Is This Important?

Patients are meeting their therapy goals faster. Our lower length of stay means our patients met their therapy goals and are ready to go home faster. This reduces their chances of a complication, like infection.

Percent of Readmission Within 30 Days

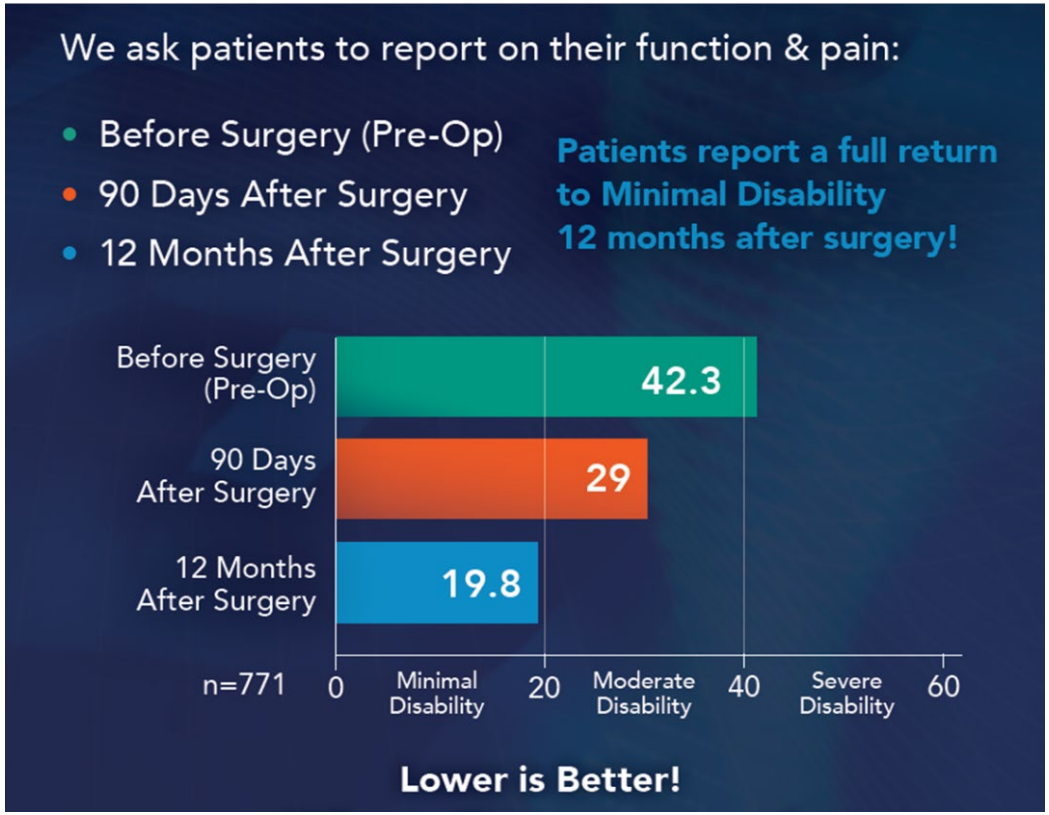


Why Is This Important?

The road to recovery should be free of setbacks. Every member of our team plays a role in reducing the likelihood of a patient needing to return to the hospital. To achieve these low rates, we focused on patient safety after discharge and improved handoffs from the hospital to the home caregivers.

Quality Metrics | Spine Surgery

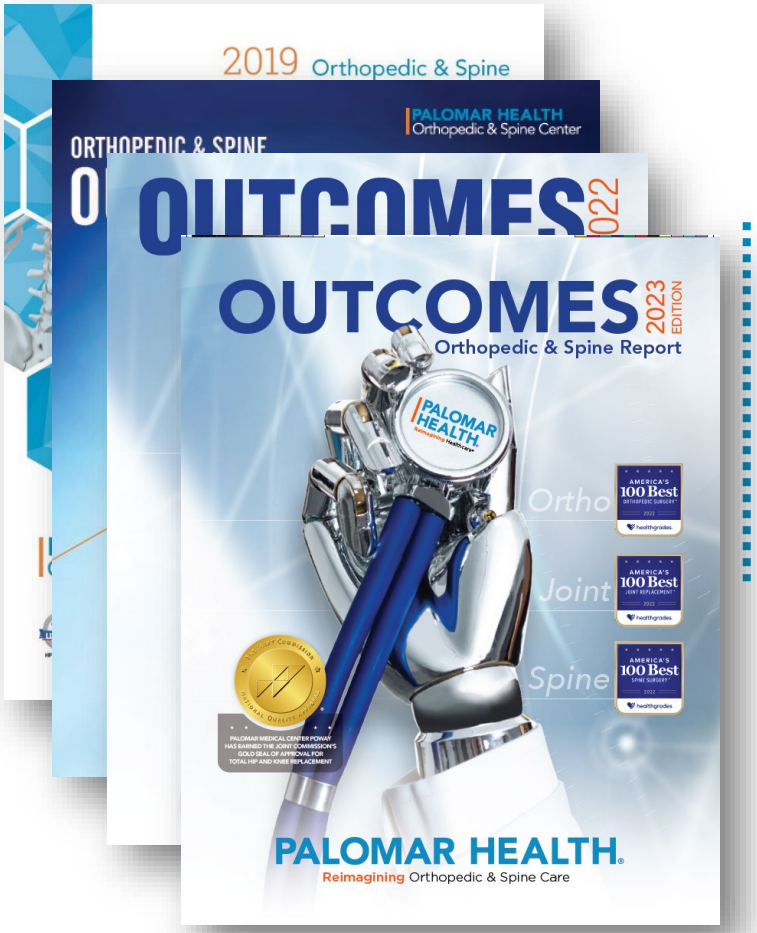
Reduction in Disability After Lumbar Spine Fusion



Why is this important?

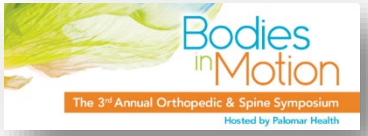
Palomar Health wants to know how much surgery has improved our patients' daily lives. Patients report on their function & pain before and after surgery. We use a standardized survey called Oswestry Disability Index (lower score the better).

Telling Our Story

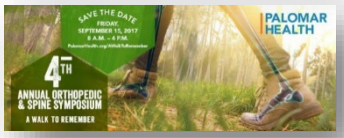


2015

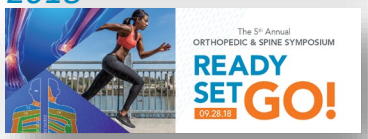
2016



2017



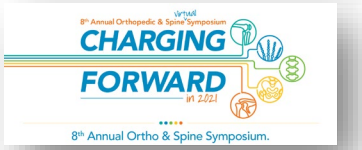
2018



2019

2020

2021



2022

2023

2023 Accomplishments | Total Joint and Spine Surgery

- PMC-Escondido was one of only two hospitals in California to be America's 100 Best for ortho-pedic and spine surgery, 5 years in a row.
- Enrolled 1,161 new patients in our Online CarePath
- mobile app for patient education, and Patient
- Reported Outcome Data Collections.
- 99% of patients reported feeling prepared the day prior to their elective surgery.
- Hosted our 10th Annual Ortho and Spine Symposium, with over 100 clinical participants and 15 corporate sponsors.
- Implemented various new protocols for the prevention of surgical site infections, including standardized order sets, universal nasal decolonization, and updated antibiotic guidelines.

2023 Accomplishments | Total Joint Replacement

- PMC-Poway successfully completed their mid-cycle review for the Joint Commission's Gold Seal of Approval® for Advanced Total Hip and Total Knee Replacement.
- 91% of total hip and knee patients were up and ambulating on POD0, exceeding the 90% benchmark set by the American Academy of Orthopedic Surgeons.
- 97% of total hip and knee patients were discharged home (and not SNF or ARU), exceeding the 84% benchmark set by the American Academy of Orthopedic Surgeons.
- 94% of patients achieved a meaningful improvement (calculated using Minimal Clinical Important Difference, or MCID) after their total hip replacement (measured using HOOS Jr).

2023 Accomplishments | Spine Surgery

- Palomar's 2.9% 30-day all-cause readmission rate is 10% lower than the comparison group of over 1,100 hospitals.
- Palomar Medical Center is the only hospital in San Diego County to earn America's 100-Best award for Spine Surgery, meaning our patients are 2.5 times less likely to experience a complication than other hospitals.
- Palomar Medical Center ranks as one of the Top 5 hospitals in the state of California and among the Top 2% in the nation for spine surgery.
- On average, patients who have a spinal fusion at Palomar go from 'Severe Disability' to 'Minimal Disability' within the first year after surgery based on Oswestry Disability Index responses from 771 patients.

Goals for 2024 | Total Joint and Spine Surgery

- Focus on keeping surgical site infections to below threshold
- Ensure total joint surgeons are using and documenting Share Decision Making principles when discussing surgical options with the patient.
- Ensure patient's education needs are being met at discharge, by including the medicine reconciliation form that includes last dose and next dose.

Antimicrobial Stewardship Summary

ADDENDUM I

Presented to Board Quality Review Committee

May 22, 2024

John Engelbert, PharmD, BCIDP, Co-Chair

Travis Lau, PharmD, BCIDP, ASP Pharmacist

Erin Tsou, PharmD, PGY-2 ID Resident

Sandeep Soni, MD, Chair

Antimicrobial Stewardship Program (ASP) - Annual Report

SITUATION	Antimicrobial Stewardship Program (ASP) is essential to ensure antimicrobials are judiciously prescribed so patients receive the most effective antibiotic for the shortest time to improve morbidity and mortality. ASP is required by Joint Commission and the California Department of Public Health (CDPH).
BACKGROUND	Antimicrobial resistance is designated as a major threat by the Centers for Disease Control & Prevention (CDC). Loss of effective antimicrobials will drastically impact medical care and cost. CDC recognizes that one of the biggest threats in the hospital is overuse of carbapenems leading to carbapenem resistant organisms. Another big threat is development of hospital acquired Clostridioides Difficile Infection (CDI). ASP has been documented to be an effective strategy in minimizing the development of resistance ensuring best care for patients with infectious diseases. All hospitals are required to have an infectious diseases physician and pharmacist to lead ASP. ASP is required to report to the highest level of the organization.
ASSESSMENT	Antimicrobial use, resistance rates, and key quality improvement processes are submitted for review. In summary, antimicrobial usage remains lower than expected rate based off the standardized administration ratio (SIR). However, there is a trend of increased usage over the last 2 quarters at Poway. Comparative hospital CDI rates, carbapenem usage in appropriate indications, and summary pharmacy antimicrobial interventions are presented.
RECOMMENDATION	The ASP team has been successful in helping reaching the CDI goal. Carbapenem (ertapenem) usage is in high compliance. ASP interventions remain high and appropriate relative to the previous year. The ASP team will continue focus on these goals for 2024.

ASP – Antimicrobial Stewardship Program; CDPH - California Department of Public Health; JCAHO - Joint Commission on Accreditation of Healthcare Organizations; QIP – Quality Incentive Pool; CDC – Centers of Disease Control and Prevention

Antimicrobial Resistant Threats

What is driving the rise in multidrug-resistant superbugs?

The more antibiotics are used, the less effective they become. Unnecessary and inappropriate use accelerates that process.

1 in 3

antibiotic prescriptions written in doctors' offices, emergency rooms, and hospital-based clinics are **unnecessary**—this equals about **47 million prescriptions each year.**

52%

only about half of patients treated with antibiotics for common infections received the recommended antibiotic based on established prescribing guidelines.

The COVID-19 pandemic has intensified the superbug threat.

Early in the pandemic, antibiotics were often given to patients even though these drugs do not effectively treat viral illnesses.

↑ The U.S. saw a **15%** increase in infections and deaths from drug-resistant bacteria in the first year of the COVID-19 pandemic.

Antibiotic-resistant bacteria pose an urgent and growing public health threat.

Common bacteria, such as those that cause urinary tract infections and sexually transmitted infections, are becoming **increasingly difficult to treat.**

Without effective antibiotics, even **simple infections could become deadly,** making medical procedures like surgery, chemotherapy, and dialysis too dangerous.

2.8 million

antibiotic-resistant infections occur in the U.S. each year.

More than 35,000 die as a result.

Globally, some 1.27 million people died from antibiotic-resistant infections in 2019.

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

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

ADE – Adverse Drug Event

Antimicrobial Stewardship at Palomar

- Mandated by CDPH and JCAHO in all hospitals since 2018. Meeting new standards established in 2023 are now a condition of Medicare participation.
- Effectively and efficiently treating infectious diseases along with control of cost of antimicrobial are a major part of overall provision of care.
- ASP is involved in improvement in key infectious diseases indicators (clostridium difficile rates and surgical site infections) to retrieve full Medi-Cal funds via the QIP program. Meeting these indicators are worth over $1,000,000.

ASP – Antimicrobial Stewardship Program; CDPH - California Department of Public Health; JCAHO - Joint Commission on Accreditation of Healthcare Organizations; QIP – Quality Incentive Pool

Palomar Health's ID Team

- Mission Infectious Diseases
  - Sandeep Soni, MD
  - Roger Bitar, MD, MPH
  - Hayden Burke, MD
  - Taliha Yasin, MD
- Pharmacy
  - Travis Lau (left)
  - Erin Tsou (middle)
  - John Engelbert (right)

Antimicrobial Stewardship at Palomar Health

- Renewed Antimicrobial Stewardship Honor Roll with CDPH for 2023-2026
- Palomar Poway was designated at **Gold**
- Palomar Escondido was designated **Silver**. Pending application to upgrade to Gold status submitted in 2/2024. To result in next months.
  - Gold status requires community outreach so does not reflect qualify of our inpatient antimicrobial stewardship

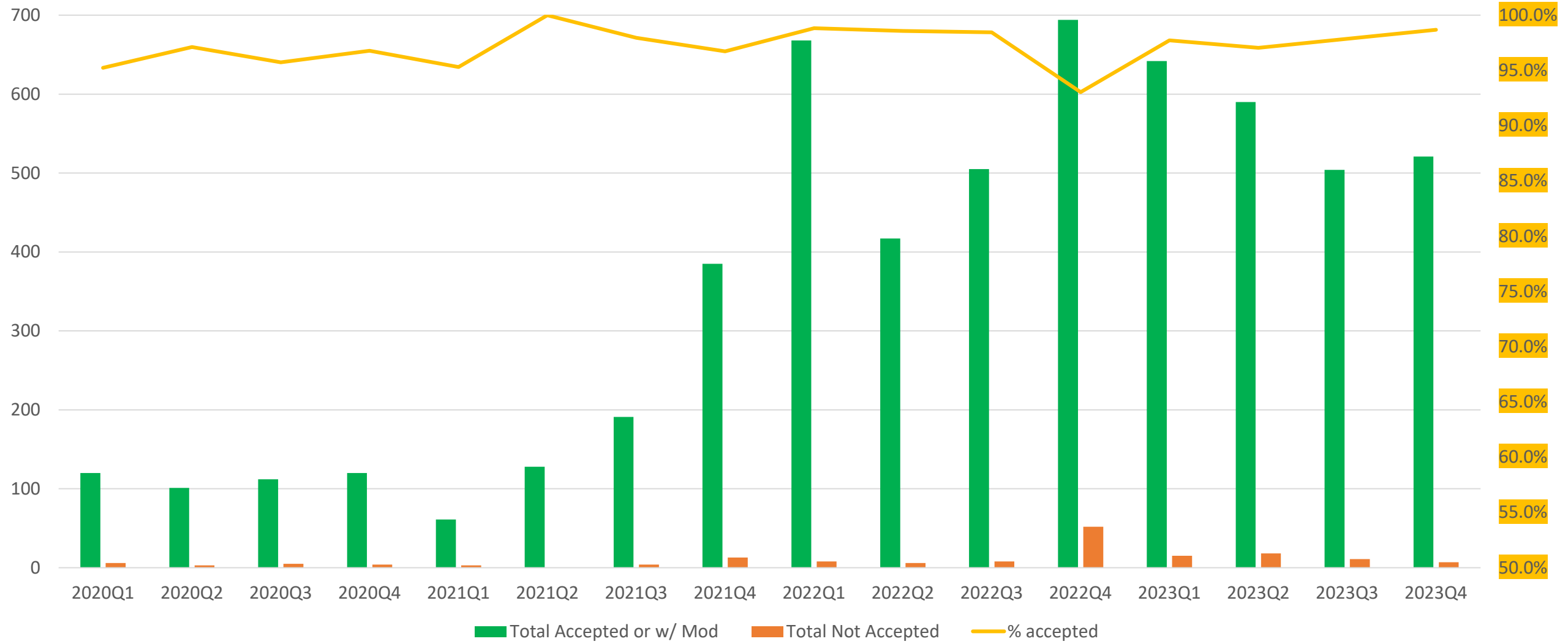
ASP Accomplishments and Goals

2023- 2024 (Completed)	2025 (To Be Completed)
Achieved PGY-2 Infectious Disease Reaccreditation (designated now through 2027 (8/2023)	Staphylococcus aureus Bacteremia Treatment Bundle
Rectify CDPH Gold designation for 2023-2026. Gold at Poway Campus. Silver at Escondido Campus.	Submit NHSN Antibiotics Resistance Module data and review and determine best practice
Submit NHSN Antibiotic Resistance Module date (completed 6/23)	Revisit all antimicrobial PowerPlans with IT
Full compliance with JCAHO standards (passed both JCAHO and DHS survey)	Individual prescriber feedback on adherence to carbapenems usage. (CRE considered high priority threat by CDC)
Optimize implementation of oral vancomycin prophylaxis (1/2023)	Analysis of use of procalcitonin and improve utilization
Meet QIP standard CDI (1/2024)	MRSA nasal screen usage beyond MRSA pneumonia
MRSA nasal screening beyond Pneumonia (underway)	Achieve QIP Goals for CDI and SSI for 2024
Review of Carbapenem prescribing (2/2024)	Partnering with CDPH in improving prescribing in treatment of UTIs in nursing homes (Villas at Poway)
Implement Daptomycin as preferred agent staph bacteremia (completed 2023)	Evaluate additional disease state antimicrobial prescribing (i.e. pyelonephritis/CDI)
Competency based module on hire for physicians (6/2023)	Ensure best practice and implementation for preoperative antibiotic prophylaxis

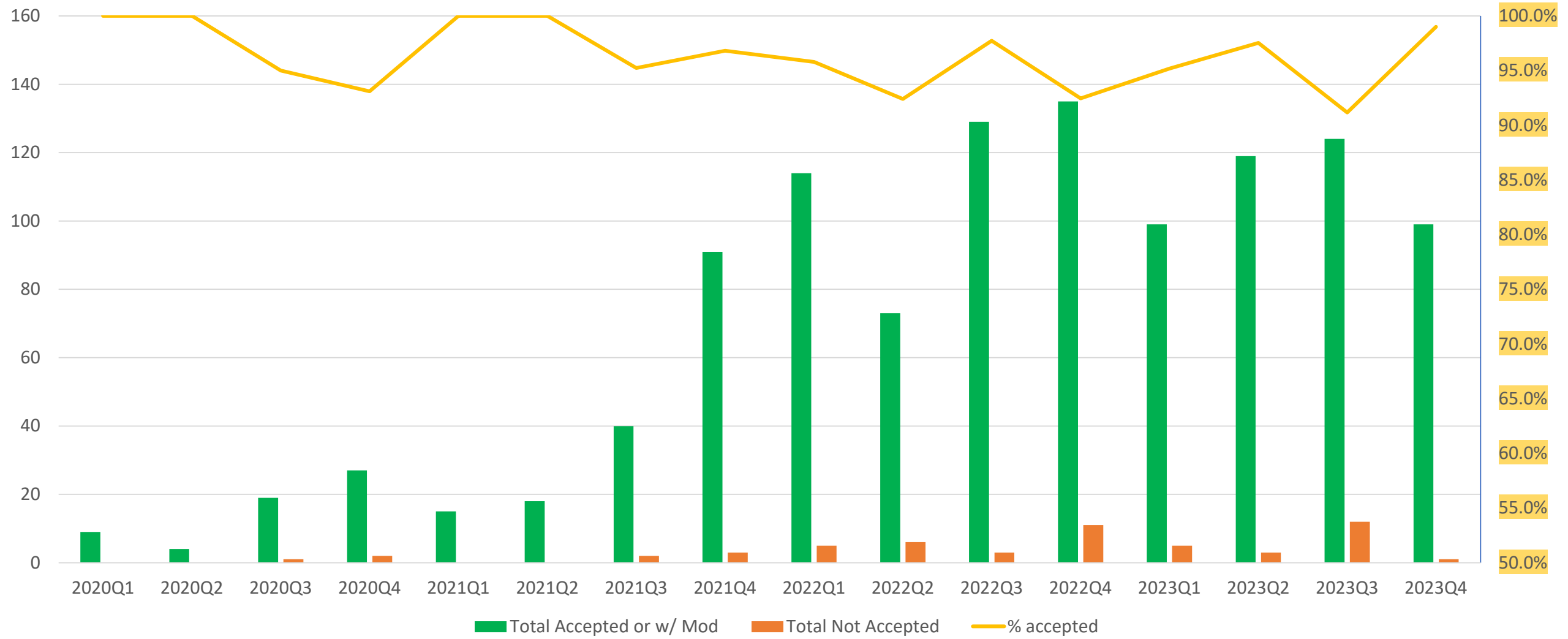
CDC - Centers for Disease Control and Prevention; CDI - *Clostridioides Difficile* Infection; CDPH - California Department of Public Health; CRE – Carbapenem Resistant Enterobacterales; ID – Infectious Diseases; UTI – Urinary Tract Infection; JCAHO – Joint Commission on Accreditation of Healthcare Organizations; NHSN - National Healthcare Safety Network; PO – Oral; MDRO – Multi-drug resistant organisms; MRSA – Methicillin Resistant *Staphylococcus aureus*; SSI – Surgical Site Infection

ASP Interventions Data 2020 Q1 to 2023 Q4

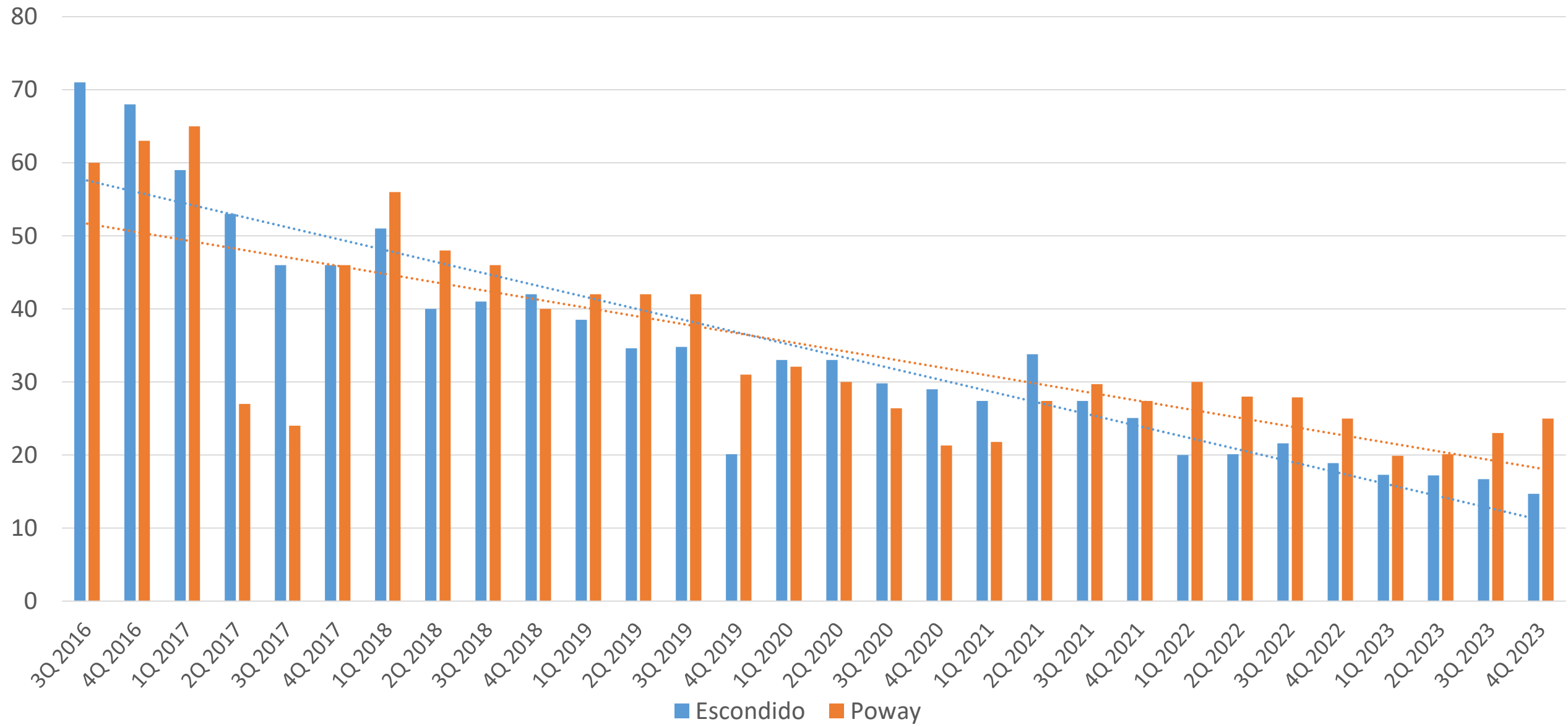
Escondido Pharmacy ASP Interventions



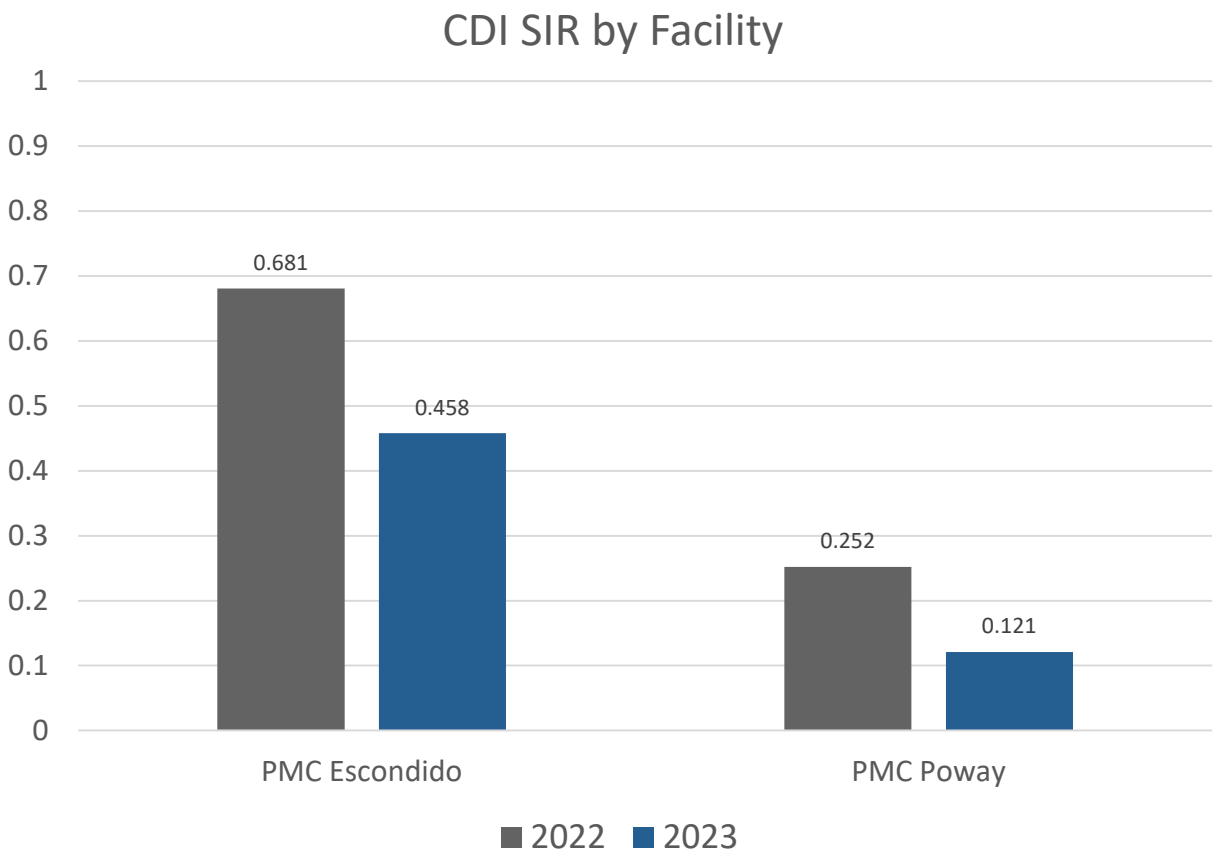
Poway Pharmacy ASP Interventions

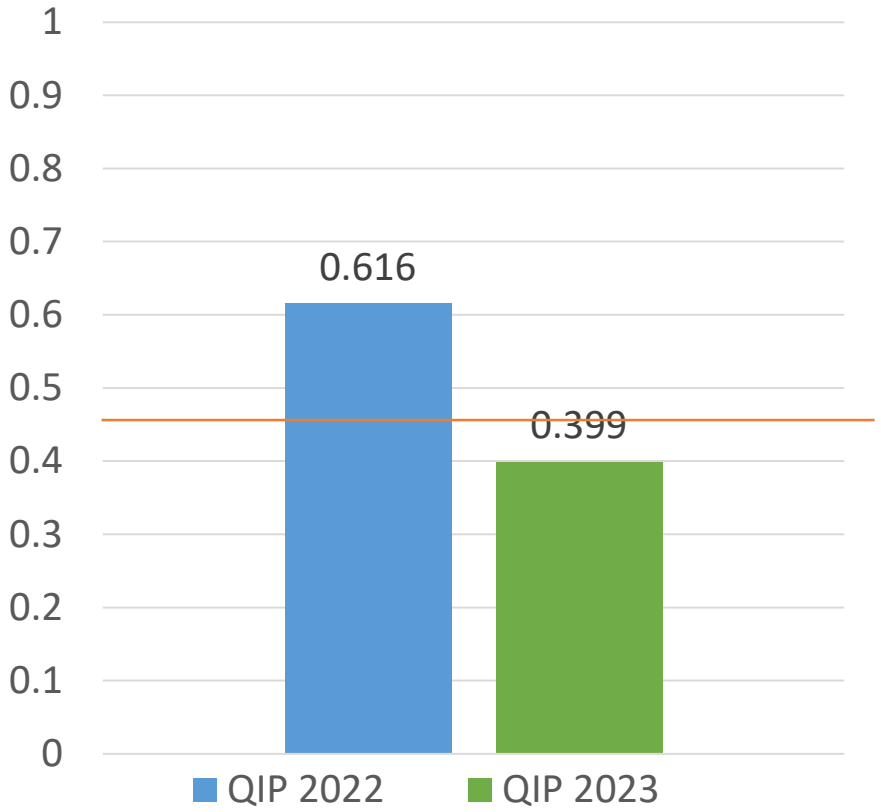


Facility-Wide Fluoroquinolone Use



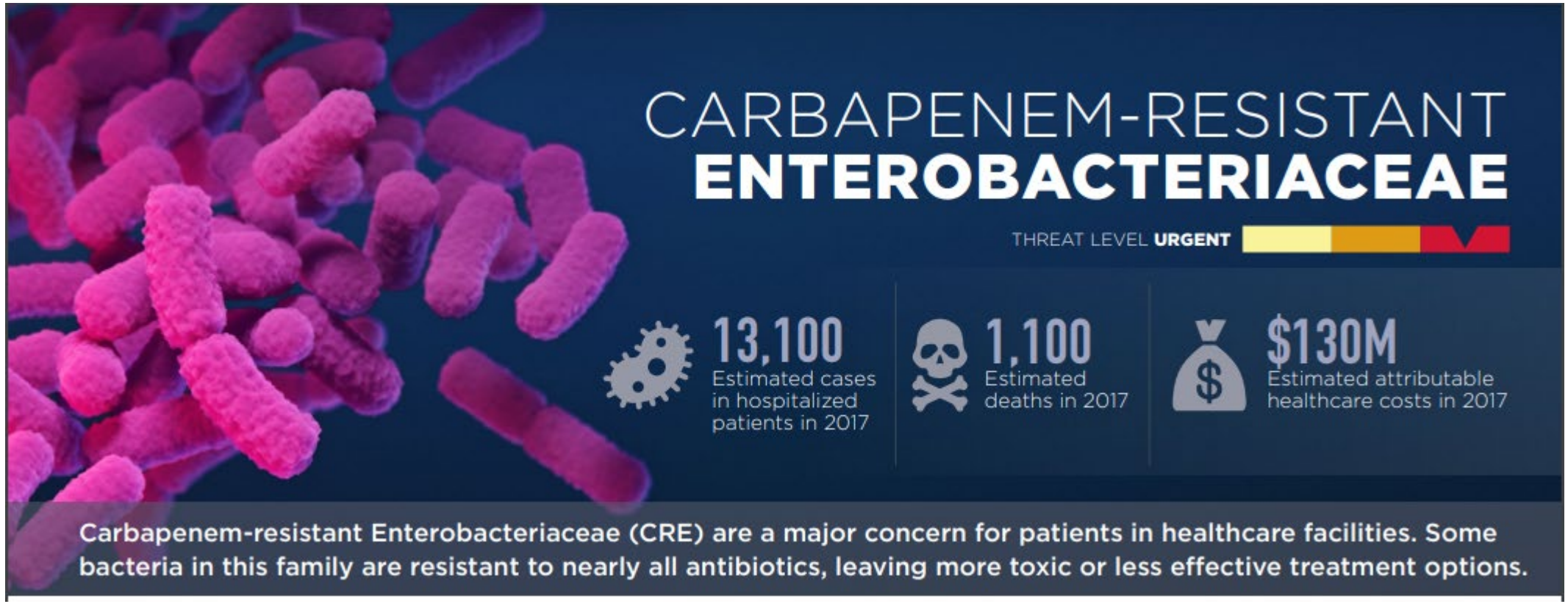
QIP *C. difficile* Infection



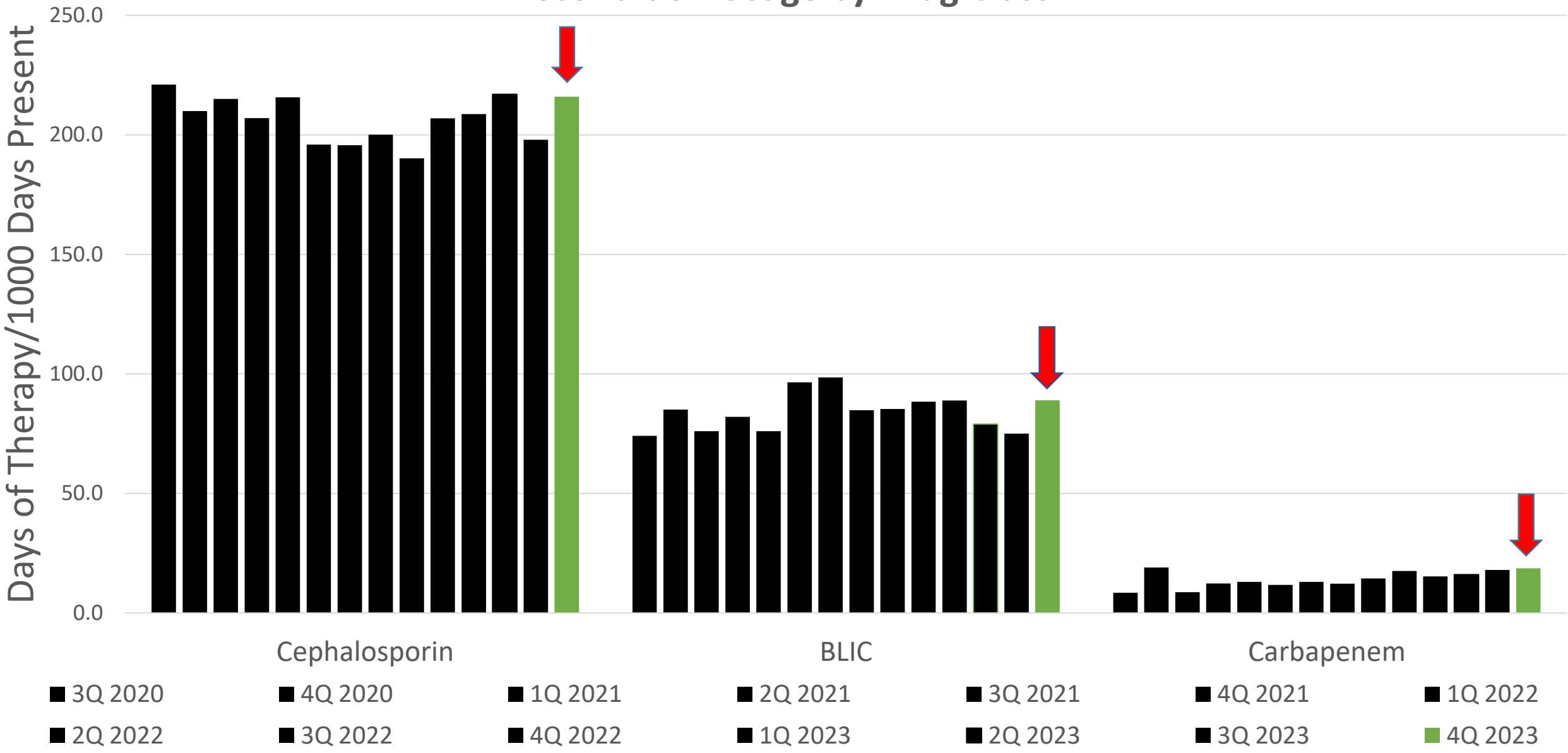


2023 Threshold = 0.45

Ertapenem Usage Review 2023 Q3



Escondido - Usage by Drug Class



Indications for Ertapenem

- Alternative to Type 2 Carbapenems (meropenem and imipenem) for the treatment of infections caused by ESBL in non-critically ill patients.
- Patients who have had cultures at any time documenting an ESBL or MDRO may be empirically prescribed a carbapenem.
- Patients who have a history of residency or travel to an endemic for ESBLs.
- Number of ertapenem orders that were appropriate: 38/40 (95%)