Posted
Friday,
October 17, 2025

PALOMAR HEALTH
Reimagining Healthcare

QUALITY REVIEW COMMITTEE
MEETING AGENDA

Wednesday, October 22, 2025
3:00pm

Please see page 3 for meeting location

	The Board may take action on any of the items listed below, including items specifically labeled "Informational Only"	Time	Form A Page	Target
Call To Order				**3:00**
1.	**Establishment of Quorum**	1		3:01
2.	**Public Comments**[1]	30		3:31
3.	**Action Item(s)** *(ADD A)*	15		3:46
	a. Board Quality Review Committee Meeting Minutes – July 23, 2025 *(Pp 7-9)*			
	b. Approval of Contracted Services i. Access Telecare *(Pp 10)* ii. Advantage Ambulance *(Pp 11)* iii. Alheiser Comer *(Pp 12)* iv. Alians Neuromonitoring, Inc. *(Pp 13-14)* v. Alliance For Wellness *(Pp 15)* vi. Becton Dickinson and Co *(Pp 16-17)* vii. Boston Sci Micropace Essential Care *(Pp 18-19)* viii. Boston Sci Labsystem Pro Recording Equip *(Pp 20-21)* ix. California Transplant Services *(Pp 22)* x. Davita Dialysis *(Pp 23)* xi. Equiti Health (FKA Voyce) *(Pp 24)* xii. Morrison *(Pp 25)* xiii. Richard Bravo Intraoperative Monitoring Services *(Pp 26-27)* xiv. South Coast Perfusion *(Pp 28-29)* xv. Specialty Care IOM *(Pp 30-31)* xvi. UHS Surgical Services Inc. *(Pp 32-34)* xvii. Valley Pathology *(Pp 35)*			
4.	**Annual Reports – *Informational Only*** *(ADD B)*	15		4:01
	a. Stroke Program *(Pp 37-80)* b. Behavioral Health Services *(Pp 81)* c. Continuum Care *(Pp 82-86)* d. Dietary Services [Food and Nutrition Services (FANS)] *(Pp 87-103)* e. Hand Hygiene *(Pp 104-105)* f. Management of the Medical Record *(Pp 106-110)* g. MedStaff: Anesthesia Services *(Pp 111-123)* h. Nursing Services *(Pp 124-142)* i. Patient Discharge Planning (Clinical Resource Management) & Patient Throughput *(Pp 143-152)* j. PeriOperative Services *(Pp 153-168)* k. Service Excellence *(Pp 169-180)* l. Safe Practices for Better Healthcare *(Pp 181-192)* m. Annual BQRC Assessment *(Pp 193)*			
5.	**Adjournment to Closed Session**	1		4:02
	Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee	10		4:12
6.	**Adjournment to Open Session**	1		4:13
7.	**Action Resulting from Closed Session**	1		4:14
Final Adjournment		1		4:15

Note: If you need special assistance to participate in the meeting,
please call 760.740.6375, 72 hours prior to the meeting so that we may provide reasonable accommodations.

[1] 3 minutes allowed per speaker. For further details, see Request for Public Comment Process and Policy on page 3 of the agenda.

Voting Membership	*Non-Voting Membership*
Linda Greer, RN, Chair	**Diane Hansen, CPA**, President/Chief Executive Officer
Terry Corrales, RN	**Omar Khawaja, MD**, Chief Medical Officer
Abbi Jahaaski, MSN, BSN, RN	**Andrew Tokar,** Chief Financial Officer
Andrew Nguyen, MD, PhD – Chief of Staff-Elect Palomar Medical Center Escondido	**Melvin Russell, RN, MSN**, Chief Nurse Executive/Chief Operating Officer
Paul Ritchie, MD – Chief of Staff-Elect Palomar Medical Center Poway	**Kevin DeBruin, Esq**., Chief Legal Officer
	Valerie Martinez, RN, BSN, MHA, **CPHQ, CIC**, Senior Director Quality and Patient Safety, Infection Prevention
Laurie Edwards Tate, MS –1st Alternate	

Note: If you need special assistance to participate in the meeting,
please call 760.740.6375, 72 hours prior to the meeting so that we may provide reasonable accommodations.

[1] 3 minutes allowed per speaker. For further details, see Request for Public Comment Process and Policy on page 3 of the agenda.

Board Quality Review Committee Location Options

Linda Greer Board Room

2125 Citracado Parkway, Suite 300, Escondido, CA 92029

- Elected Members of the Palomar Health Board of Directors will attend at this location, unless otherwise noticed below
- Other non-Board member attendees, and members of the public may also attend at this location

https://www.microsoft.com/en-us/microsoft-teams/join-a-meeting?rtc=1

Meeting ID: 288 627 823 177
Passcode: De2hx353
or
Dial in using your phone at 929.352.2216; Access Code: 871 963 771#[1]

- Non-Board member attendees, and members of the public may also attend the meeting virtually utilizing the above link

[1] *New to Microsoft Teams? Get the app now and be ready when your first meeting starts:* Download Teams

PALOMAR HEALTH
Reimagining Healthcare®

DocID:	21790
Revision:	9
Status:	Official

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

Policy: Public Comments and Attendance at Public Board Meetings

I. PURPOSE:

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

II. DEFINITIONS:

A. None defined.

III. TEXT / STANDARDS OF PRACTICE:

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

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

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

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

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

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

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

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

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

(REFERENCED BY Public Comment Form

BOARD QUALITY REVIEW COMMITTEE

Meeting will begin at 3:00 p.m.

Request for Public Comments

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

- ***In Person: Submit a Public Comment Form, or verbally submit a request, to the Board Clerk***
- ***Virtual: Enter your name and "Public Comment" in the chat function***

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 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 on agenda items or items of general interest within the subject matter jurisdiction of Palomar Health.

ADDENDUM A

PALOMAR HEALTH
Reimagining Healthcare

Board Quality Review Committee Minutes – Wednesday, July 23, 2025			
AGENDA ITEM	***CONCLUSION/ACTION***	***FOLLOW UP/RESPONSIBLE PARTY***	***FINAL?***
DISCUSSION			
NOTICE OF MEETING			
Notice of Meeting was posted at the Palomar Health Administrative Office at 2125 Citracado Parkway, Suite 300, Escondido, CA 92029, as well as on the Palomar Health website, on Friday, July 18, 2025, which is consistent with legal requirements.			
CALL TO ORDER			
The meeting, which was held in the Palomar Health Administrative Office at 2125 Citracado Parkway, Suite 300, Escondido, CA. 92029, and virtually, was called to order at 3:05 p.m. by Committee Chair Linda Greer.			
1. ESTABLISHMENT OF QUORUM			
• Quorum comprised of: Directors Greer, Corrales, Jahaaski*, and Ritchie, MD • Excused Absences: Nguyen, MD • Attended: Director Jahaaski * Director Jahaaski joined the meeting at 3:06pm during the Minutes section of the agenda. Motion by Ritchie MD, to allow Director Jahaaski to attend virtually based on emergency circumstances. No second. Motion failed. Directors Greer noted Director Jahaaski may attend and observe. Meeting proceeded.			
2. PUBLIC COMMENTS			
• None			

3. ACTION ITEMS			
a. Minutes: Board Quality Review Committee Meeting – May 28, 2025	**MOTION** by Director Corrales, 2nd by Ritchie, MD to approve the May 28, 2025, Board Quality Review Committee meeting minutes as written. Roll call voting utilized. Director Corrales – aye Director Greer – aye Director Jahaaski - absent Nguyen, MD – absent Ritchie, MD - aye Three in favor. None opposed. None absent. None abstain Motion approved		
Discussion: • No discussion			
4. Annual Reports – Informational Only			
a. Center of Excellence (Spine & Total Joint) b. Outpatient Services (Infusion Services & Radiation Oncology) c. Management of the Environment of Care (EOC) and Emergency Management d. Laboratory Services e. MedStaff : Utilization Review f. Medication Management (Pharmaceutical Services)	**Informational Only**		

Discussion:

- All questions by Committee Members were satisfied.

5. Adjournment to Closed Session

Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee

6. Adjournment to Open Session

7. Action Resulting from Closed Session

FINAL ADJOURNMENT

Meeting adjourned by Committee Chair Linda Greer at 3:54p.m.

Signatures:

Committee Chair _____ Linda Greer, RN

Committee Assistant _____ Gen Dieu

Palomar Health
Review of Contract Service

Name of Service: Access Telecare

Date of Review: 10/16/2025 **Name / Title of Reviewer:** Lourdes Januszewicz – Dist Stroke Coordinator

Nature of Service (describe): Stroke Telemedicine

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

Performance Metrics

METRIC	Jul-Sep 2024 QTR	Oct-Dec 2024 QTR	Jan-Mar 2025 QTR	April-Jun 2025 QTR	Cumulative Total
Provides remote monitoring 24 hr day/7days a week/ 365 days a year	Met	Met	Met	Met	Met
Establish and limit planned downtime	Met	Met	Met	Met	Met
Provider workstations and equipment functional with 24/7 representative support services	Met	Met	Met	Met	Met
Vendor timely resolution of any issues or problems	Met	Met	Met	Met	Met

Comments- This is service is for equipment, software and connectivity. They do not provide Physician coverage. Telecare has met the requirements needed for the TeleStroke program. Issues related to equipment handled timely. Current carts used for TeleStroke exchanged due to end of life for current equipment. The new carts should provide improved performance overall. Continue to work on improving the user experience for the TeleStroke consult.

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: _____

Palomar Health
Review of Contract Service

Name of Service: Advantage Ambulance

Date of Review: 8/26/2025 **Name / Title of Reviewer:** Ryan Gomez, Vice President of Operations

Nature of Service (describe): Ambulance Transports of Patients

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
Turnaround time from request to pick-up	96%	97%	97%	96%	97%
Transfer documentation required sent with patient	100%	100%	100%	100%	100%
Appropriate type of ambulance and competency of transport team available when requested.	100%	100%	100%	100%	100%

Comments:

Advantage Ambulance has been a reliable partner, ensuring our patients receive safe and timely transportation with professionalism and care. Their crews are professional, courteous, and always responsive to our needs, making them a trusted extension of the Palomar Health team.

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: _____

Palomar Health
Review of Contract Service

Name of Service: Alhiser Comer

Date of Review: 10/10/2025 **Name / Title of Reviewer:** Donnie Miller. District Manager – Clinical Operations

Nature of Service (describe): Removal and overflow storage of deceased bodies

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

Performance Metrics

METRIC	Q1 2025 QTR	Q2 2025 QTR	Q3 2025 QTR	Q4 2025 QTR	Cumulative Total
Timely response Target: =/< 160 minutes 90% of the time	100%	100%	100%	100%	100%
Storage capacity Target: 0 capacity issues	100%	100%	100%	100%	100%

Comments
No issue with the vendor's service. Current agreement remains active through 2026.

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: _____

Alians Neuromonitoring, Inc.

Review of Contract Service for FY25 (July 1, 2024 – June 30, 2025)

Name of Service: Alians Neuromonitoring, Inc.

Date of Review: October 14, 2025
Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health

Nature of Service (describe): Alians Neuromonitoring, Inc. provides the following intraoperative monitoring services:

- Somatosensory evoked potential (SSEP) monitoring
- Transcranial Motor Evoked Potential (TcMEP) monitoring
- Electromyography (EMG)
- Electroencephalography (EEG)
- Facial Nerve Monitoring
- Brainstem Auditory Evoked Potential monitoring.

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

Performance Metrics

METRIC	FY25 QTR 1	FY25 QTR 2	FY25 QTR 3	FY25 QTR 4	Cumulative Total
IOM equipment is clean and in good working order.	100%	100%	100%	100%	100%
IOM Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%
Contract employee is current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

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

Conclusion (check one)

√ Contract service has met expectations for the review period

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

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

Palomar Health
Review of Contract Service

Name of Service: _Alliance For Wellness_

Date of Review: ___October 16th 2025_____
Name / Title of Reviewer: ___Don Myers Director District Behavioral Health Services _____

Nature of Service (describe): _____Psychiatry Consult Service

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

Performance Metrics

METRIC	_FY25 Q2	FY 25Q3	FY 25 Q4	FY26 Q1	Cumulative Total
Providers complete psych consults within 24 hours of order being placed in accordance with Med Staff Bylaws	100%	100%	100%	100%	100%
Provider will be available to complete telepsych consult within 15 minutes when bedside device connection has been established	100%	100%	100%	100%	100%
All providers maintain California licensure and compliance with Med Staff Bylaws	100%	100%	100%	100%	100%

Comments No adverse outcomes during this reporting period.

Conclusion (check one)

√ Contract service has met expectations for the review period

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

Palomar Health
Review of Contract Service

Name of Service: Becton Dickinson (BD)

Date of Review: 10/9/2025 **Name / Title of Reviewer:** Jessica D'Angelo and Tim Barlow

Nature of Service (describe): Microbiology Testing Instruments and Reagents

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 are 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 prevent and reduce medical errors.	X	

Performance Metrics

METRIC	QTR 1 2025	QTR 2 2025	QTR 3 2025	QTR 4 2025	Cumulative Total
Response Time: Time from call logged to engineer onsite/remote response	≤24 hours	≤24 hours	≤24 hours	≤24 hours	≤24 hours response time
Calibration/Verification Accuracy: Number of post-PM QC failures	0 failures	0 failures	0 failures	0 failures	0 failures
% of Orders Backordered	0% orders backordered due to vendor	0% orders backordered due to vendor	0% orders backordered due to vendor	0% orders backordered due to vendor	0% orders backordered due to vendor

Comments

The BD service and reagent contract encompasses multiple core instruments that support the microbiology laboratory's diagnostic operations. The current contracts include the following systems:

- BD Phoenix M50 – for automated organism identification and antimicrobial susceptibility testing (AST).
- BD BACTEC FX series – for continuous monitoring and detection of microbial growth in blood and body fluid cultures.
- BD MAX System – for molecular diagnostic testing, including multiplex PCR assays.
- BD MGIT – for mycobacterial culture.
- BD AP – for automated inoculum standardization.

Together, these platforms provide critical diagnostic support across bacteriology, molecular, and mycobacteriology sections of the lab. The BD service contract includes preventive maintenance (PM), corrective service visits, software updates, and remote technical support, along with reagent and consumable supply agreements that directly affect workflow continuity.

Conclusion (check one)

Yes Contract service has met expectations for the review period

☐ Contract service has <u>not met</u> 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: _____

Boston Scientific
Review of Contract Service

Name of Service: ___Boston Scientific Micropace Essential Care Service Agreement ___

Date of Review: _____10/10/2025 **Name / Title of Reviewer:** _Tom McGuire/ Director of Interventional Services_

Nature of Service (describe):

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

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

Performance Metrics

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

Comments

Conclusion (check one)

√ Contract service has met expectations for the review period

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

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

Boston Scientific
Review of Contract Service

Name of Service: ___Boston Scientific Labsystem Pro Recording Equipment Service Agreement ___

Date of Review: _____10/10/2025 **Name / Title of Reviewer:** _Tom McGuire/ Director of Interventional Services_

Nature of Service (describe):

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

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

Performance Metrics

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

Comments

Conclusion (check one)

√ Contract service has met expectations for the review period

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

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

California Transplant Services, Inc.
Review of Contract Service

Name of Service: California Transplant Services, Inc.

Date of Review: October 9, 2025

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

Nature of Service (describe): California Transplant Services, Inc. provides human autologous tissue storage services for Palomar Health. (e.g. cranial bone flaps)

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

Performance Metrics

METRIC	FY25 Q2	FY 25Q3	FY 25 Q4	FY26 Q1	Cumulative Total
Maintains current American Association of Tissue Banks (AATB) Accreditation Certificate	100%	100%	100%	100%	100%
Maintains current Food & Drug Administration (FDA) Tissue Bank Registration	100%	100%	100%	100%	100%
Maintains current State of California Tissue Bank License	100%	100%	100%	100%	100%
Maintains current certificate of Liability Insurance as stipulated in the terms of the contract	100%	100%	100%	100%	100%

Comments: No adverse outcomes reported during this contract evaluation period.

Conclusion (check one)

√ Contract service has met expectations for the review period.

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

DaVita Dialysis
Review of Contract Service

Name of Service: __DaVita Dialysis_____

Date of Review: _10/9/25_____ **Name / Title of Reviewer:** ___Tom McGuire, Director of Critical Care

Nature of Service (describe): _Dialysis Including Hemodialysis, Peritoneal Dialysis, Plasmapheresis, CRRT____

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service are 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 prevent and reduce medical errors.	X	

Performance Metrics

METRIC	CY 2025 1st QTR	CY 2025 2ND QTR	CY 2025 3rd QTR (through Aug 25)	CY 2025 4TH QTR	Cumulative Total
Dialysis Machine Water Cultures/Endotoxins Escondido Campus	100% complete	100% complete	100% complete	n/a	
Dialysis Machine Water Cultures/Endotoxins Poway Campus	100% complete	100% complete	100% complete	n/a	

Comments
Action is taken for out of range results by Davita and those requests are available by request as needed. I verified by asking for 2 months in 2025 that had results requiring further action.

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: _____

Palomar Health
Review of Contract Service

Name of Service: Equiti Health (FKA Voyce)

Date of Review: 10/15/2025 **Name / Title of Reviewer:** Valerie Martinez Sr. Dir of Quality/Patient Safety

Nature of Service (describe): Audio and Video patient language interpretation

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

Performance Metrics

METRIC	_____ QTR	_____ QTR	____ QTR	____ QTR	Cumulative Total
Average wait time in seconds Goal: (30 seconds)	73 sec Not met	22 sec Met	20 sec Met	NA	38 seconds Over due to Q1
Fulfillment rate of call Goal :(95%)	93% Not met	96% Met	99% Met	NA	96%
Timeliness of service tickets addressed 1-3 days	Met	Met	Met	NA	Met

Comments
From Q1 to Q3 there has been significant improvement. Due to lack of interpreters being available in a timely manner, they made some manual changes to the way the interpreters were scheduled, by moving more interpreters to the schedule during times of higher demand. Increased training and hiring new interpreters.
They made some technical changes tied to IP addresses on the back end of their platform that have allowed more calls to flow through the network and land with interpreters.

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: _____

Palomar Health
Review of Contract Service

Name of Service: Morrison Management Specialists, Inc.

Date of Review: 10.2025 **Name / Title of Reviewer:** Ryan Fearn-Gomez, Vice President. Operations

Nature of Service (describe): Food and Nutrition Services

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

Performance Metrics Escondido

METRIC	1st QTR 2025	2nd QTR 2025	3rd QTR 2025	4th QTR 2025	Cumulative Total
Regulatory Compliance (Health Dept., CDPH, JC) (Goal: 95%)	100% MET	100% MET	100% MET	100% MET	100% MET
San Diego County Health Dept inspections: at least twice a year (Goal: 90%)					
a. PMC Escondido	99% Met	N/A	99% Met	98% Met	99%
b. PMC Poway	98% Met	93% Met	N/A	N/A	96%
Patient Experience Food and Nutrition Rollup Top Box					
a. PMC Escondido Goal: (65.5)	62.4	63.8	60.6	63.3	63 Not met
b. PMC Poway Goal: (62.2)	67.2.	64.4	68.7	66.4	67 Met

Comments: Poway Operations Manager has been moved to Escondido to put similar processes in place to address Patient Experience due to the success at Poway. While she was at Poway, strong processes put in place that will sustain the Patient Experience, with oversight from the Dist Director.
Morrison Healthcare continues to be a reliable and collaborative partner, consistently delivering high-quality Food and Nutrition Services that enhance the patient experience at Palomar Health. Their team demonstrates excellence in service, safety, and responsiveness, aligning well with our mission and operational goals.

Conclusion (check one)

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

Richard Bravo Intraoperative Monitoring Services

Review of Contract Service for FY25 (July 1, 2024 – June 30, 2025)

Name of Service: Richard Bravo Intraoperative Monitoring Services
Date of Review: October 9, 2025
Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health

Nature of Service (describe): Richard Bravo Intraoperative Monitoring (IOM) Services provides the following intraoperative monitoring services:

- Somatosensory evoked potential (SSEP) monitoring
- Transcranial Motor Evoked Potential (TcMEP) monitoring
- Electromyography (EMG)
- Electroencephalography (EEG)
- Facial Nerve Monitoring
- Brainstem Auditory Evoked Potential monitoring.

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

Performance Metrics

METRIC	FY25 QTR 1	FY25 QTR 2	FY25 QTR 3	FY25 QTR 4	Cumulative Total
IOM equipment is clean and in good working order.	100%	100%	100%	100%	100%
IOM Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%
Contract employee is current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

Comments: No unusual occurrences documented during the contract service evaluation period. Positive feedback from the surgeons who utilize this service.

Conclusion (check one)

√ Contract service has met expectations for the review period

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

South Coast Perfusion LLC

Review of Contract Service for FY25 (July 1, 2024 – June 30, 2025)

Name of Service: South Coast Perfusion, LLC
Date of Review: August 26, 2025
Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health
Nature of Service (describe): Services provided by South Coast Perfusion, LLC include Cardiopulmonary Bypass (CPB), Autotransfusion services, Ventricular Assist Device (VAD) set-up and monitoring, Extracorporeal Membrane Oxygenation (ECMO) / Cardiopulmonary Support (CPS), provision of Platelet Rich Plasma (PRP), Platelet Poor Plasma (PPP), Platelet Gel, Growth Factors, Intra-aortic Balloon Pump (IABP) set-up and monitoring services.

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	√	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere.	√	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	√	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	√	
5. Assures that care, treatment, and service provided is safe, timely, effective, efficient, equitable and patient focused.	√	

Performance Metrics

METRIC	FY25 QTR 1	FY25 QTR 2	FY25 QTR 3	FY25 QTR 4	Cumulative Total
Perfusionists in the group are current with BLS requirements	100%	100%	100%	100%	100%
Perfusionists in the group are current with annual PPD requirements	100%	100%	100%	100%	100%
Perfusionists in the group are certified through the American Board of Cardiovascular Perfusion	100%	100%	100%	100%	100%
Annual proof of current professional liability insurance coverage	100%	100%	100%	100%	100%

Comments: Contract amendments and new rate terms were finalized during this fiscal year.

Conclusion (check one)

√ **Contract service has met expectations for the review period**

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

_____

Specialty Care IOM Services – Intraoperative Monitoring Services

Review of Contract Service for FY25 (July 1, 2024 – June 30, 2025)

Name of Service: Specialty Care IOM Services – Intraoperative Monitoring Services

Date of Review: August 26, 2025

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

Nature of Service: Specialty Care Intraoperative Monitoring (IOM) Services provides the following intraoperative monitoring services:

- Somatosensory evoked potential (SSEP) monitoring
- Transcranial Motor Evoked Potential (TcMEP) monitoring
- Electromyography (EMG)
- Electroencephalography (EEG)
- Facial Nerve Monitoring
- Brainstem Auditory Evoked Potential monitoring.

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	√	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere.	√	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	√	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	√	
5. Assures that care, treatment, and service is provided is safe, timely, effective, efficient, equitable and patient focused.	√	

Performance Metrics

METRIC	FY25 QTR 1	FY25 QTR 2	FY25 QTR 3	FY25 QTR 4	Cumulative Total
IOM equipment is clean and in good working order.	100%	100%	100%	100%	100%
IOM Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%
Personnel employed by contractor are current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

Comments: No deficiencies documented during the contracted service evaluation period. Quality Assurance reports submitted for review in a timely manner.

Conclusion (check one)

√ **Contract service has met expectations for the review period**

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

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

UHS Surgical Services, Inc.

Review of Contract Service for FY25 (July 1, 2024 – June 30, 2025)

Name of Service: UHS Surgical Services, Inc.
Date of Review: August 26, 2025
Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN Director, District Perioperative Services, Palomar Health
Nature of Service: UHS Surgical Services, Inc. provides services, equipment and supplies as stipulated by the contract. UHS also provides qualified, certified and or licensed personnel to provide technical support to the physicians.

Equipment provided includes:

- Lasers for the treatment of Benign Prostatic Hypertrophy (BPH)
    - Greenlight XPS
    - Diode Ablation
    - Cyber TM
    - Morcellator
    - Holmium
    - Holmium Nd:YAG dual
    - KTP
    - KTP Aura
    - Revolix
    - CO2 Surgical
    - CO2 Omniguide
    - CO2 Clinicon
    - Argon Beam Coagulator
    - Cyberwand
    - Aloka Ultrasound
    - BK Ultrasound
    - ESWL
    - ESWL F2
    - Cryo Endocare for Prostate
    - Cryo Endocare for Renal
    - Cryo Endocare for IR
    - TMR Heart
    - SUSA
    - CO2 Cosmetic
    - GentleLase
    - KTP Aura Cosmetic
    - Medlight C6
    - Vbeam

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	√	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere.	√	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	√	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	√	
5. Assures that care, treatment, and service provided is safe, timely, effective, efficient, equitable and patient focused.	√	

Performance Metrics

METRIC	FY25 QTR 1	FY25 QTR 2	FY25 QTR 3	FY25 QTR 4	Cumulative Total
UHS equipment is clean and in good working order.	100%	100%	100%	100%	100%
UHS Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%
Personnel employed by contractor are current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

Comments: Contractor consistently met expectations as specified in the contract.

Conclusion (check one)

√ **Contract service has met expectations for the review period**

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

Palomar Health
Review of Contract Service

Name of Service: Valley Pathology Medical Associates, Inc. – Pathology Svcs – Professional & Administrative Agreement

Date of Review: 10.2025 **Name / Title of Reviewer:** Ryan Fearn-Gomez, Vice President of Operations

Nature of Service (describe): Pathology Services

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 are 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 prevent and reduce medical errors.	X	

Performance Metrics

METRIC	1st QTR	2nd QTR	3rd QTR	4th QTR	Cumulative Total
Passed CAP Survey and in compliance	100%	100%	100%	100%	100%
VPMA Tumor Board Participation and Presentations	100%	100%	100%	100%	100%
VPMA Medical Director is compliant with all required Transfusion Utilization Review, Quality Assurance Presentations and Laboratory Safety Rounding activities.	100%	100%	100%	100%	100%

Comments
The contract with Valley Pathology Medical Associates continues to demonstrate their commitment to providing exceptional service and meeting our operational needs with consistent quality.

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

ADDENDUM B

The Joint Commission Disease Specific Stroke Program Bi-Annual Report

Lourdes Januszewicz MSN APRN ACNS-BC SCRN CCRN
Remia Paduga, MD, Stroke Program Medical Director
Valerie Martinez, Sr. Director Quality & Patient Safety
RN, BSN, MHA, CIC, CPHQ, NEA-BC

October 8, 2025

Presented to Quality Management Cttee (QMC)

PALOMAR HEALTH
Reimagining Healthcare

District Stroke Program

SITUATION	Palomar Health Stroke Program Bi-Annual Review
BACKGROUND	The Bi-Annual Report provides an overview of the success and opportunities for the Stroke Program at Palomar Health. Continuous monitoring of the Stroke Metrics provides opportunities for process improvement.
ASSESSMENT	1. Successful Joint Commission Recertification for the PMCE Thrombectomy-Capable Stroke Center with 3 findings. Using the Safer Matrix findings categorized as follows: #1 Low/Limited – NIHSS documented outside of the allowed time x 1; #2 Moderate/Limited – Missing Brief OP Note for Post Craniotomy x 1; #3 Moderate/Widespread – Missing Neurology in the Core for admitting privileges for Family Practice and Internal Medicine. Plan of Corrections in progress. 2. Successful "Door to" times for Metrics monitored. Successful adoption of Target Stroke Phase 3 Metrics. 3. PMC Poway awarded the Gold Plus Performance Achievement Award from the American Heart Association and American Stroke Association's "Get with the Guidelines" program for 2025. This includes recognition for Target: Stroke Honor Roll Elite for rapid response and treatment times for stroke care and the Target: Type 2 Diabetes Honor Roll. 4. Increase in Stroke Code activations for Hemorrhagic Strokes.
RECOMMENDATION	Monitoring of 2025 Goals & New Initiatives for 2025-2026: 1. Continue to improve/monitor TNKase administration to </= 45 minutes 75% of the time. 2. Continue to improve/monitor "Door to" times for thrombectomy direct cases to achieve </= 90 minutes for Door to Device. 3. Continue preparations for PMC Poway Joint Commission Primary Stroke Center Recertification – window opens October 14th, 2025 through 1/12/2026. 4. New initiatives to improve Door to Transfer times from PMC Poway. 5. New initiative to call Code Bleed with Hemorrhagic Strokes to help expedite care. 6. Continue with new initiative with County EMS for Witness information.

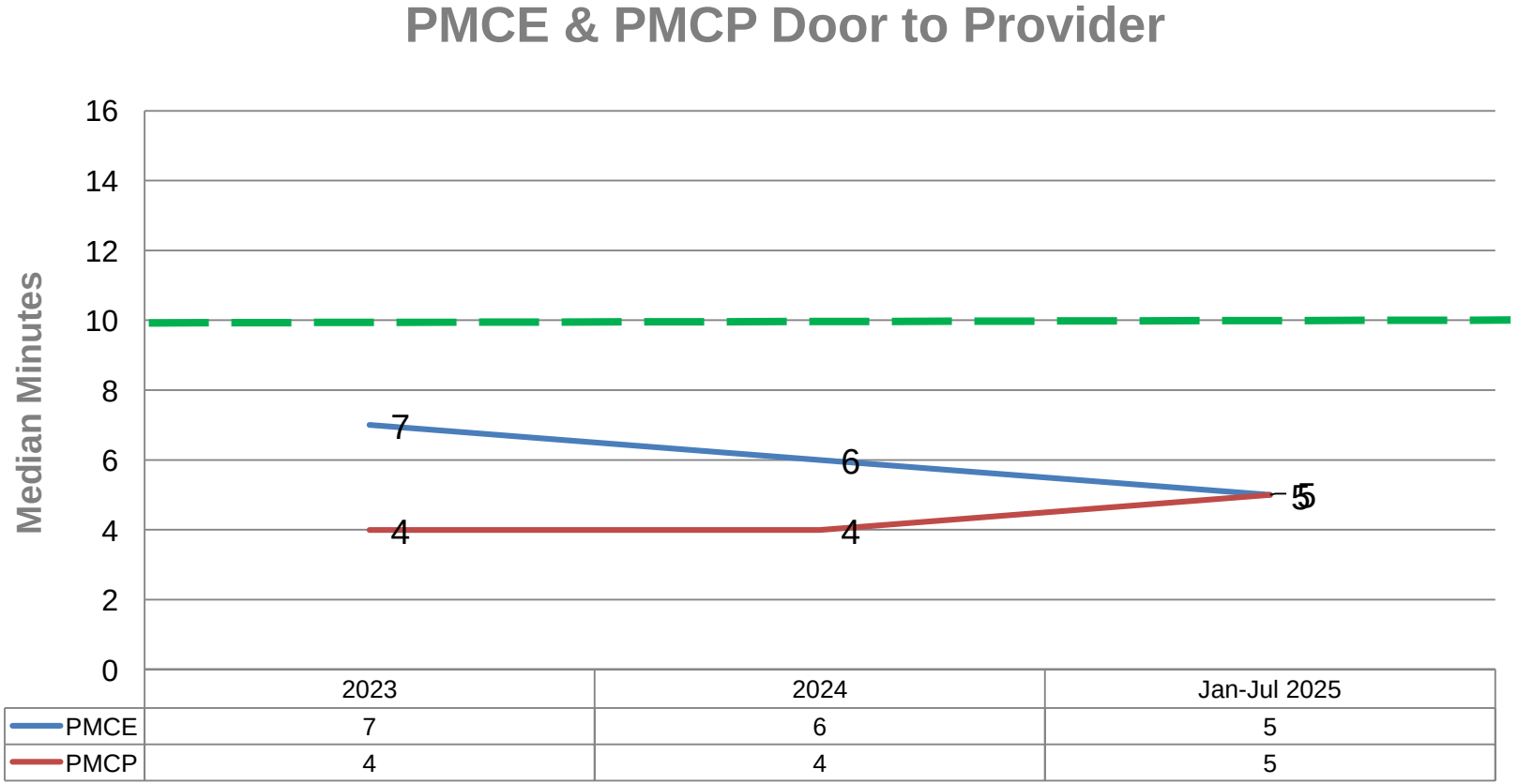
PALOMAR HEALTH

TARGET INDICATORS FOR THROMBOLYTIC ADMINISTRATION

METRIC	Target Stroke Phase III for Thrombolytic < 60 min	Target Stroke Phase III for Thrombolytic < 45 min	Target Stroke Phase III for Thrombolytic < 30 min
Door to Provider	< 10 min	< 5 min	< 2.5 min
Door to Stroke Code activation	< 15 min	< 10 min	< 5 min
Door to POCT Glucose	< 15 min	< 10 min	< 5 min
Door to NIHSS Begin	< 15 min	< 10 min	< 5 min
Door to CT Begin	< 25 min	< 20 min	< 15 min
Door to CT Results	< 45 min	< 35 min	< 25 min
Door to Needle	< 60 min	NA	NA
Door to Needle Compliance %	85% of the time	NA	NA
Door to Needle Secondary goals	NA	< 45 min	< 30 min
Door to Needle Secondary goals Compliance %	NA	75% of the time	50% of the time

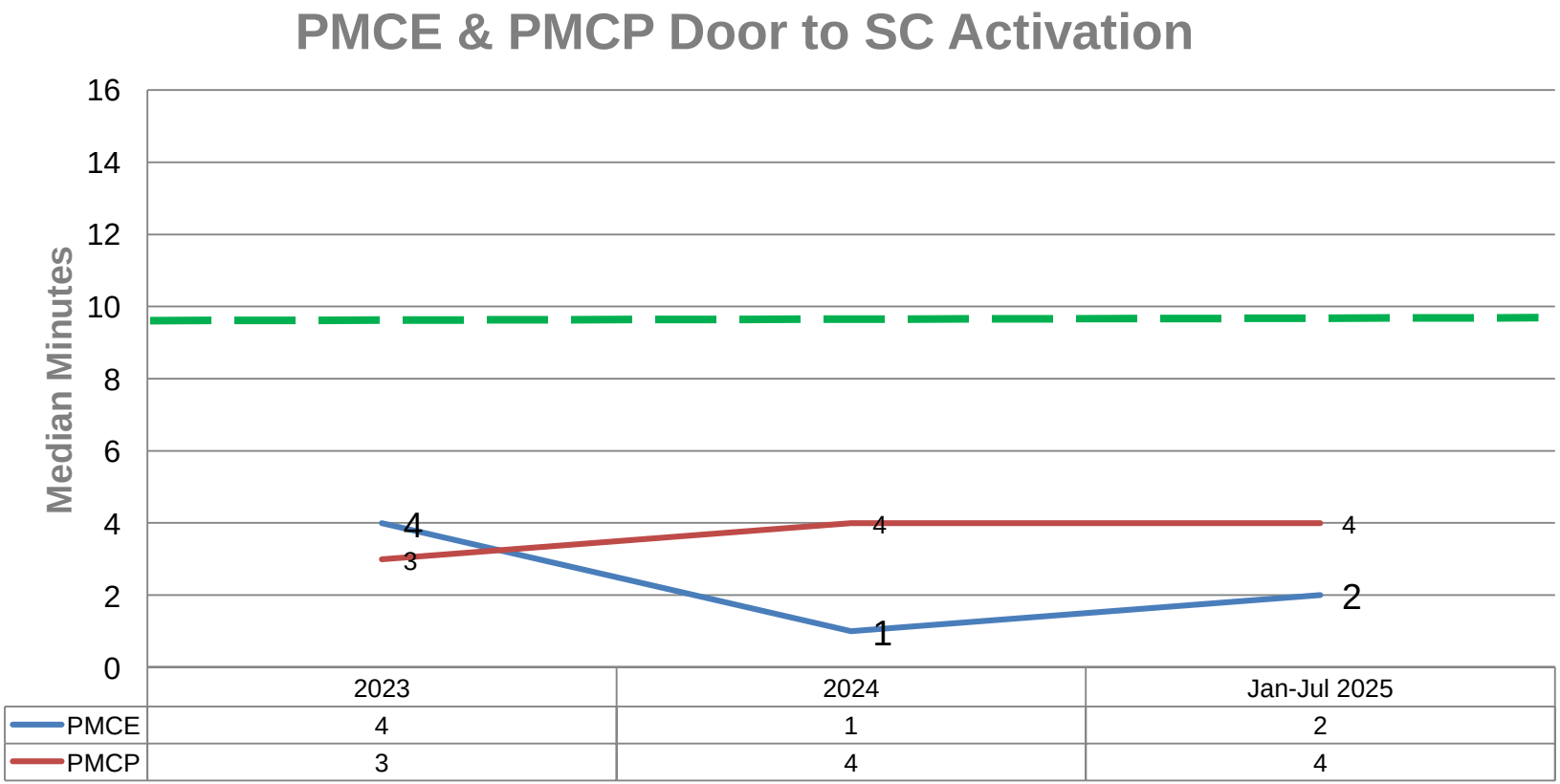
PMC Escondido & PMC Poway

Door to Provider ≤ 10 Minutes



PMC Escondido & PMC Poway

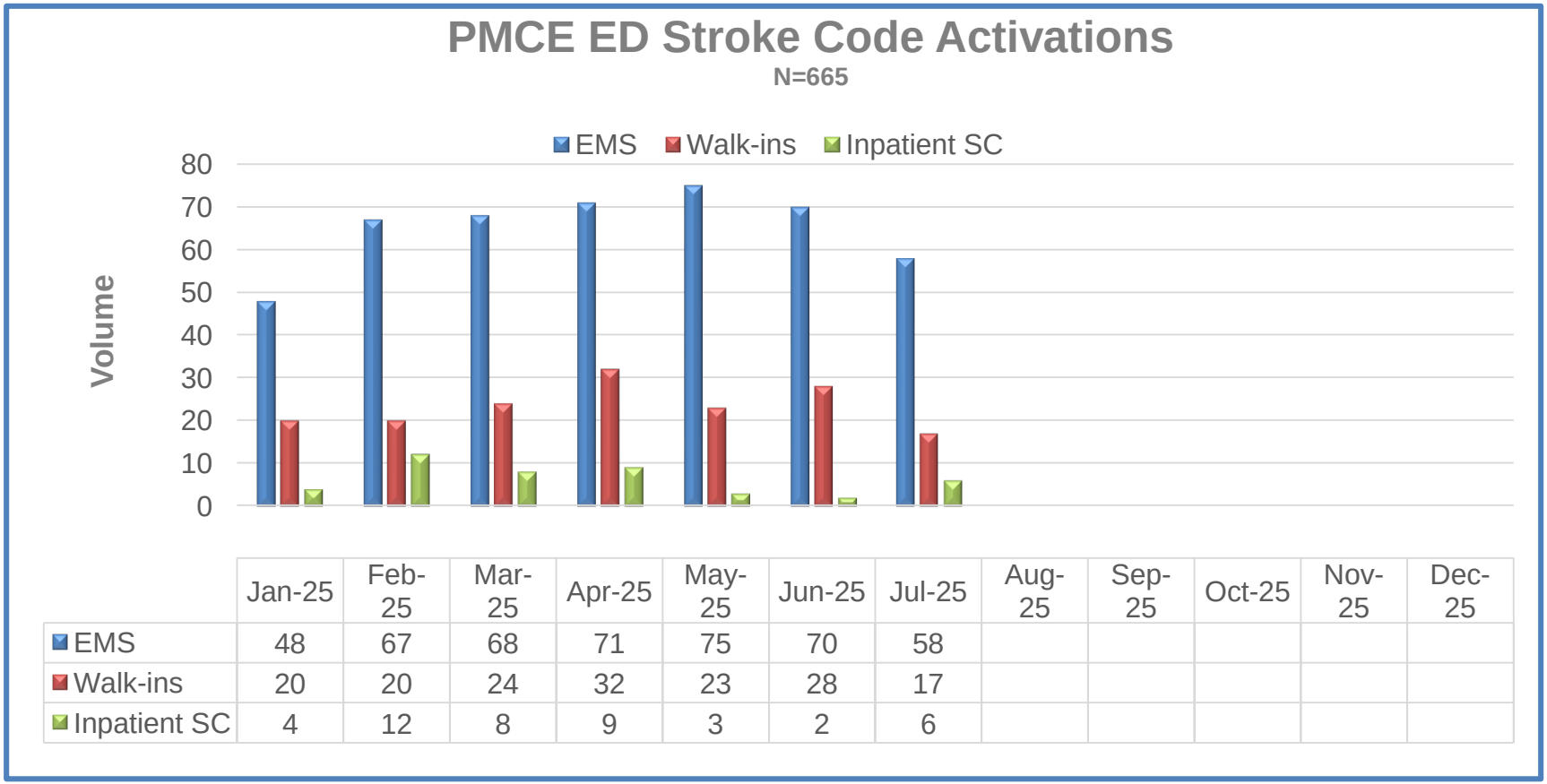
Door to Stroke Code Activation ≤ 10 Minutes



	2023	2024	Jan-Jul 2025
PMCE	4	1	2
PMCP	3	4	4

Palomar Medical Center Escondido

Stroke Code Activation Volumes



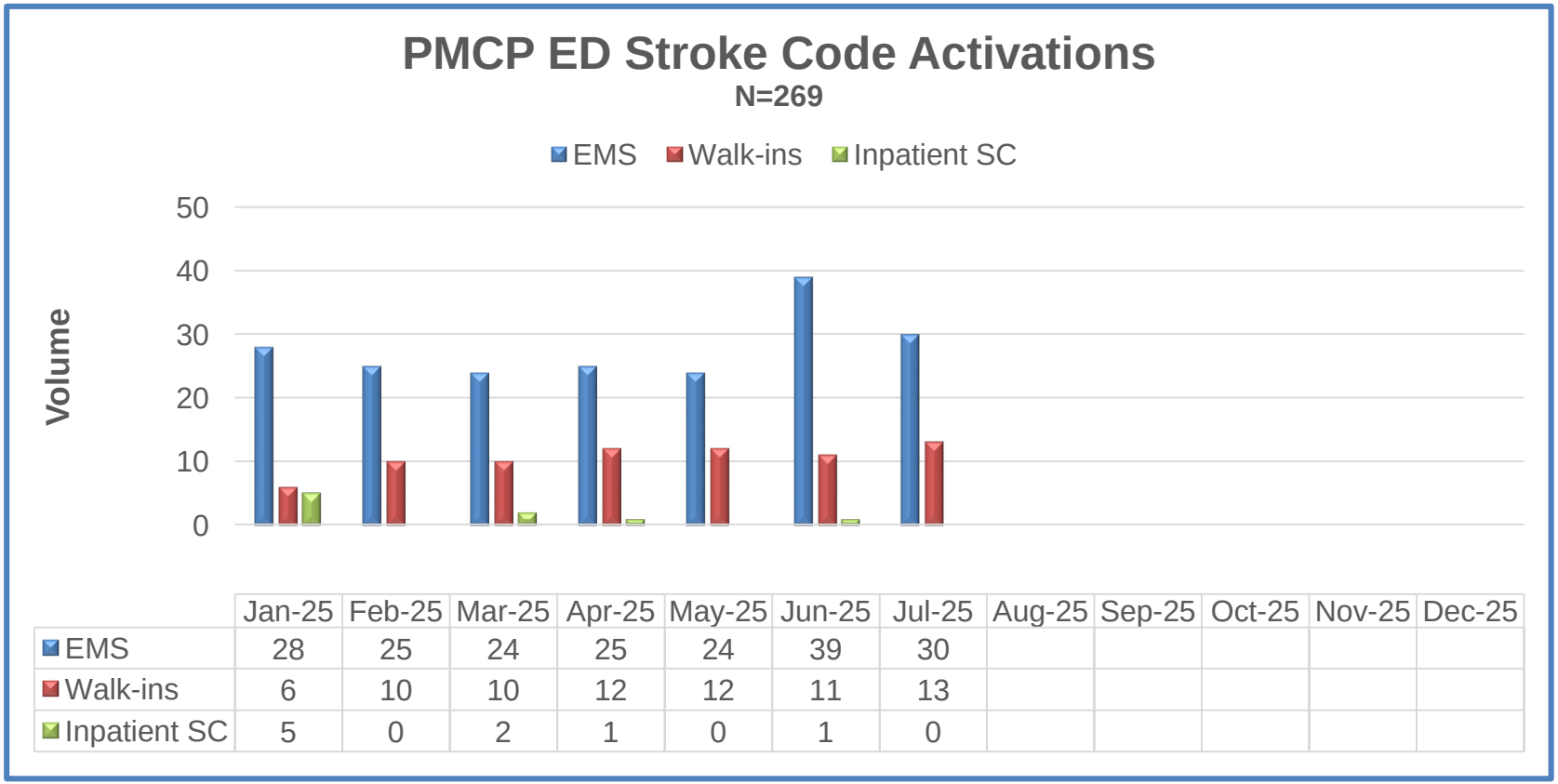
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
EMS	48	67	68	71	75	70	58					
Walk-ins	20	20	24	32	23	28	17					
Inpatient SC	4	12	8	9	3	2	6					

YTD % Arrival via EMS = 74%

YTD % Arrival Walk-ins = 26%

Palomar Medical Center Poway

Stroke Code Activation Volumes



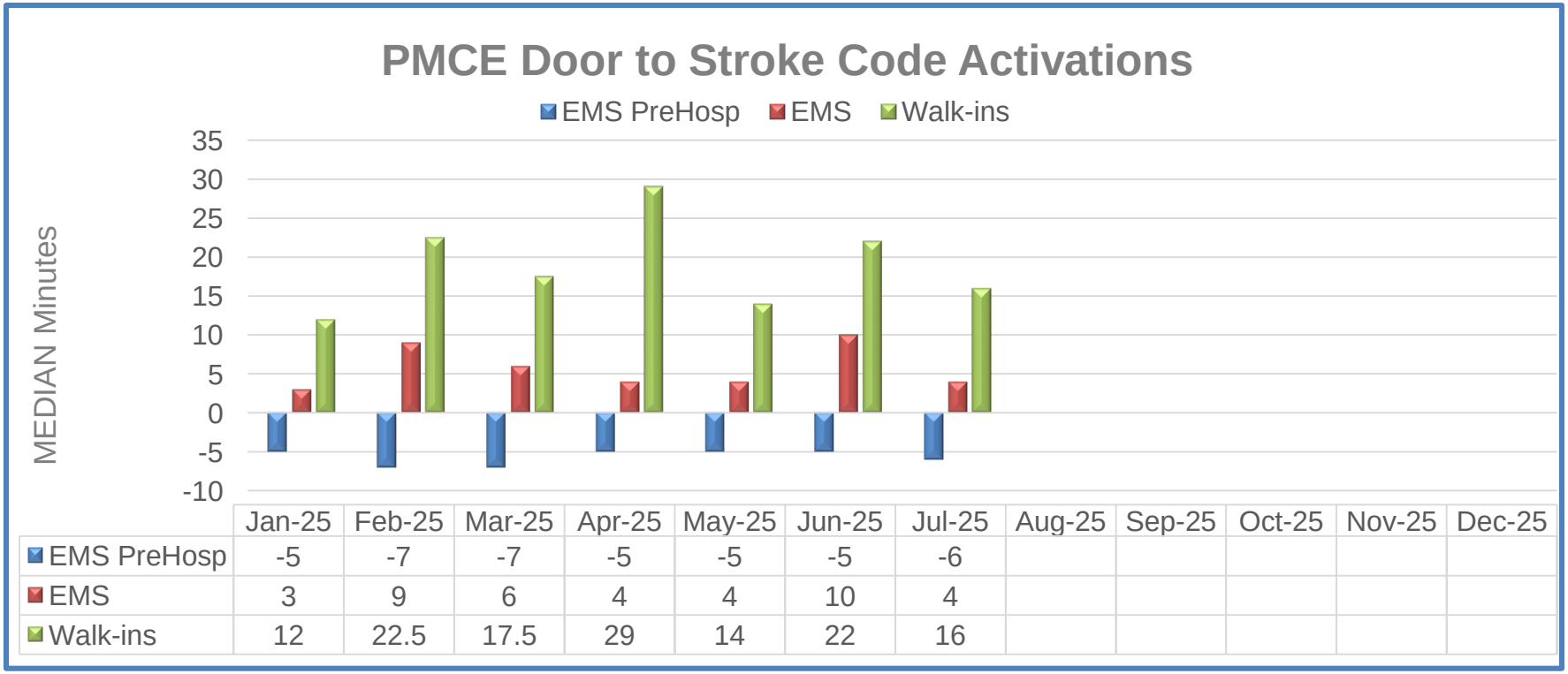
	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
EMS	28	25	24	25	24	39	30					
Walk-ins	6	10	10	12	12	11	13					
Inpatient SC	5	0	2	1	0	1	0					

YTD % Arrival via EMS = 72%

YTD % Arrival Walk-ins = 28%

Palomar Medical Center Escondido

Door to Stroke Code – Median Min

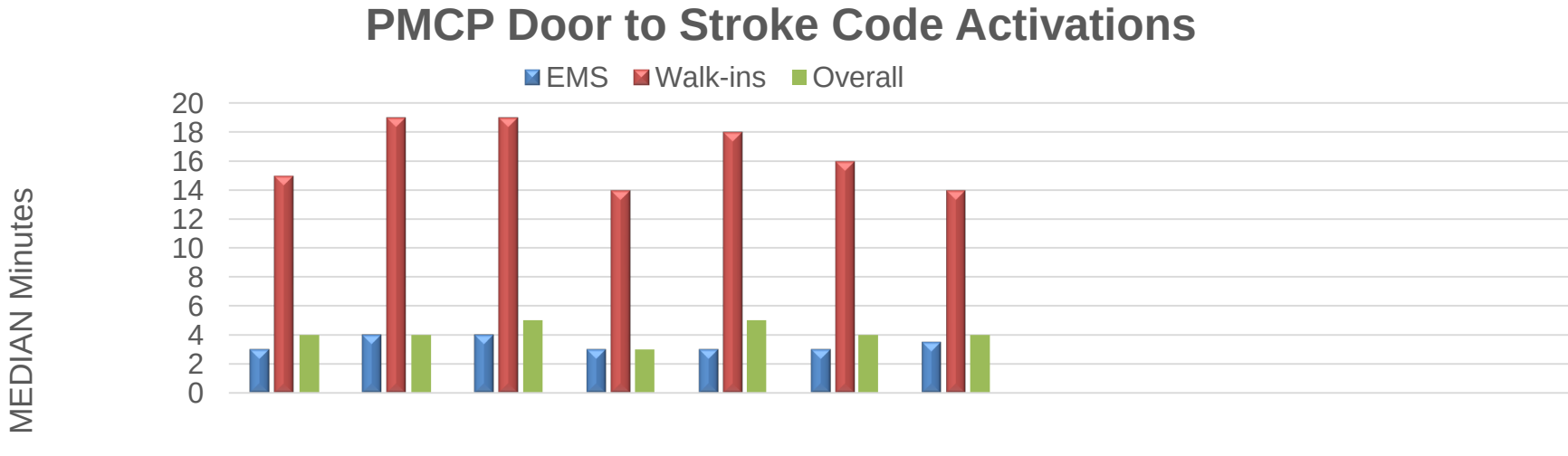


	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
EMS PreHosp	-5	-7	-7	-5	-5	-5	-6					
EMS	3	9	6	4	4	10	4					
Walk-ins	12	22.5	17.5	29	14	22	16					

YTD EMS Prehospital Arrivals to Stroke Activation: -5 Median Minutes
YTD EMS Arrivals to Stroke Activation: 4 Median Minutes
YTD Walk-in Arrivals to Stroke Activation: 17.5 Median Minutes
YTD Overall Arrivals to Stroke Activation: 2 Median Minutes
2025 Metric Goal ≤ 10 minutes

Palomar Medical Center Poway

Door to Stroke Code – Median Min

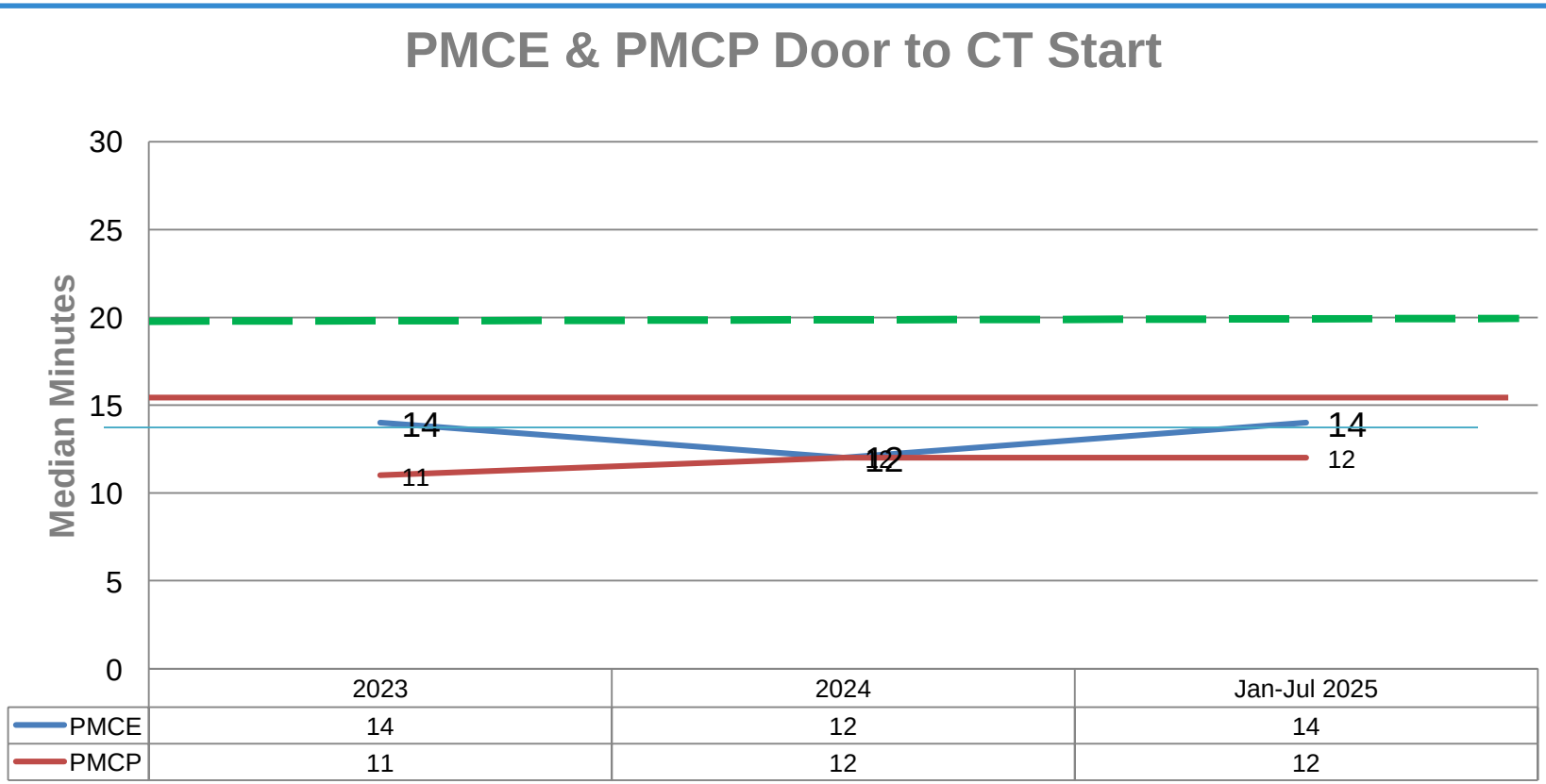


	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
EMS	3	4	4	3	3	3	3.5					
Walk-ins	15	19	19	14	18	16	14					
Overall	4	4	5	3	5	4	4					

YTD EMS Arrival to Stroke Code Activation: 3 Median Minutes
YTD Walk-ins to Stroke Code Activation: 16 Median Minutes
YTD Overall to Stroke Code Activation: 4 Median Minutes
2025 Metric Goal ≤ 10 minutes

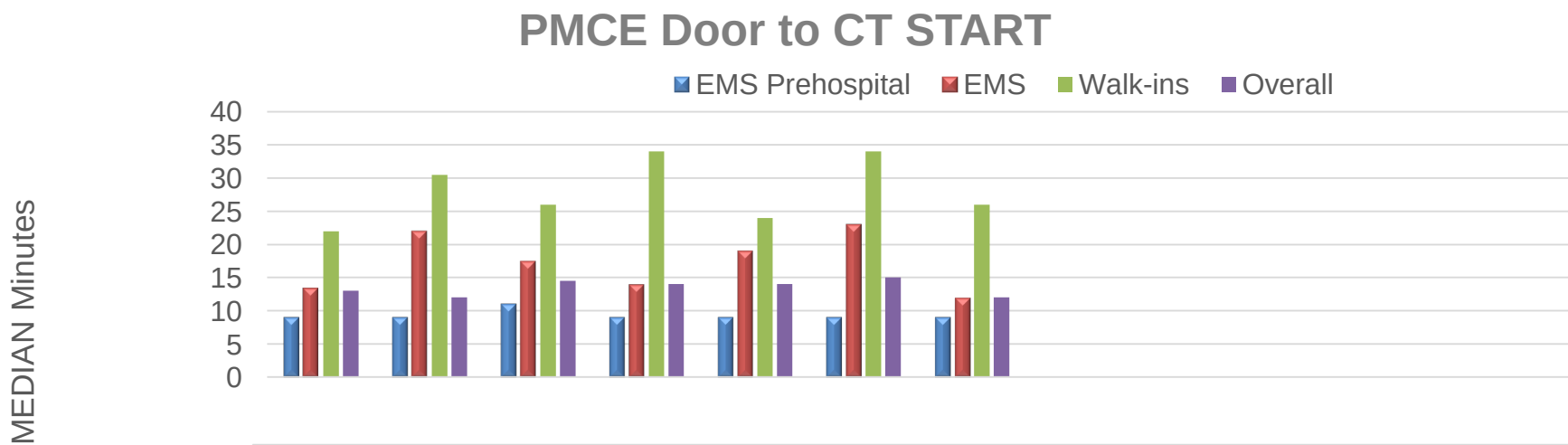
PMC Escondido & PMC Poway

Door to CT Start ≤ 20 Minutes



Palomar Medical Center Escondido

Door to CT START– Median Min



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
EMS Prehospital	9	9	11	9	9	9	9					
EMS	13.5	22	17.5	14	19	23	12					
Walk-ins	22	30.5	26	34	24	34	26					
Overall	13	12	14.5	14	14	15	12					

YTD EMS Prehospital Arrivals to CT Start: 9 Median Minutes

YTD EMS Arrivals to CT Start: 17.5 Median Minutes

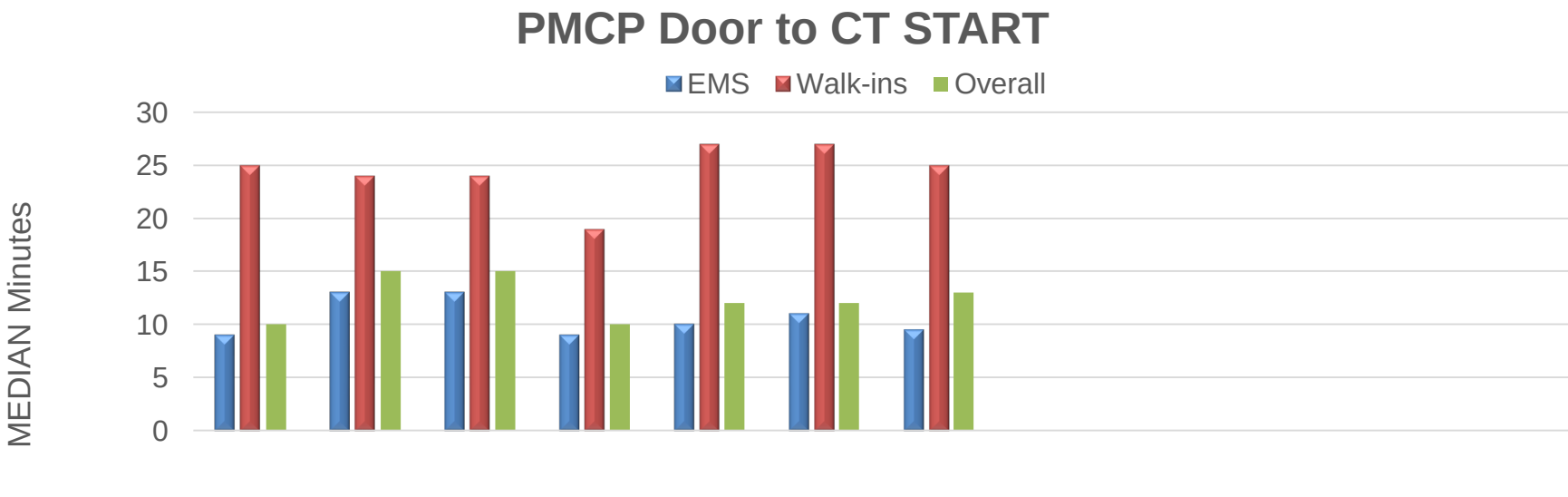
YTD Walk-in Arrivals to CT Start: 26 Median Minutes

Overall Arrivals to CT Start: 14 Median Minutes

2025 Target Measure Goal: < 20 minutes **PH Metric Goal ≤ 15 minutes**

Palomar Medical Center Poway

Door to CT START– Median Min



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
EMS	9	13	13	9	10	11	9.5					
Walk-ins	25	24	24	19	27	27	25					
Overall	10	15	15	10	12	12	13					

YTD EMS Arrival to CT START: 10 Median Minutes

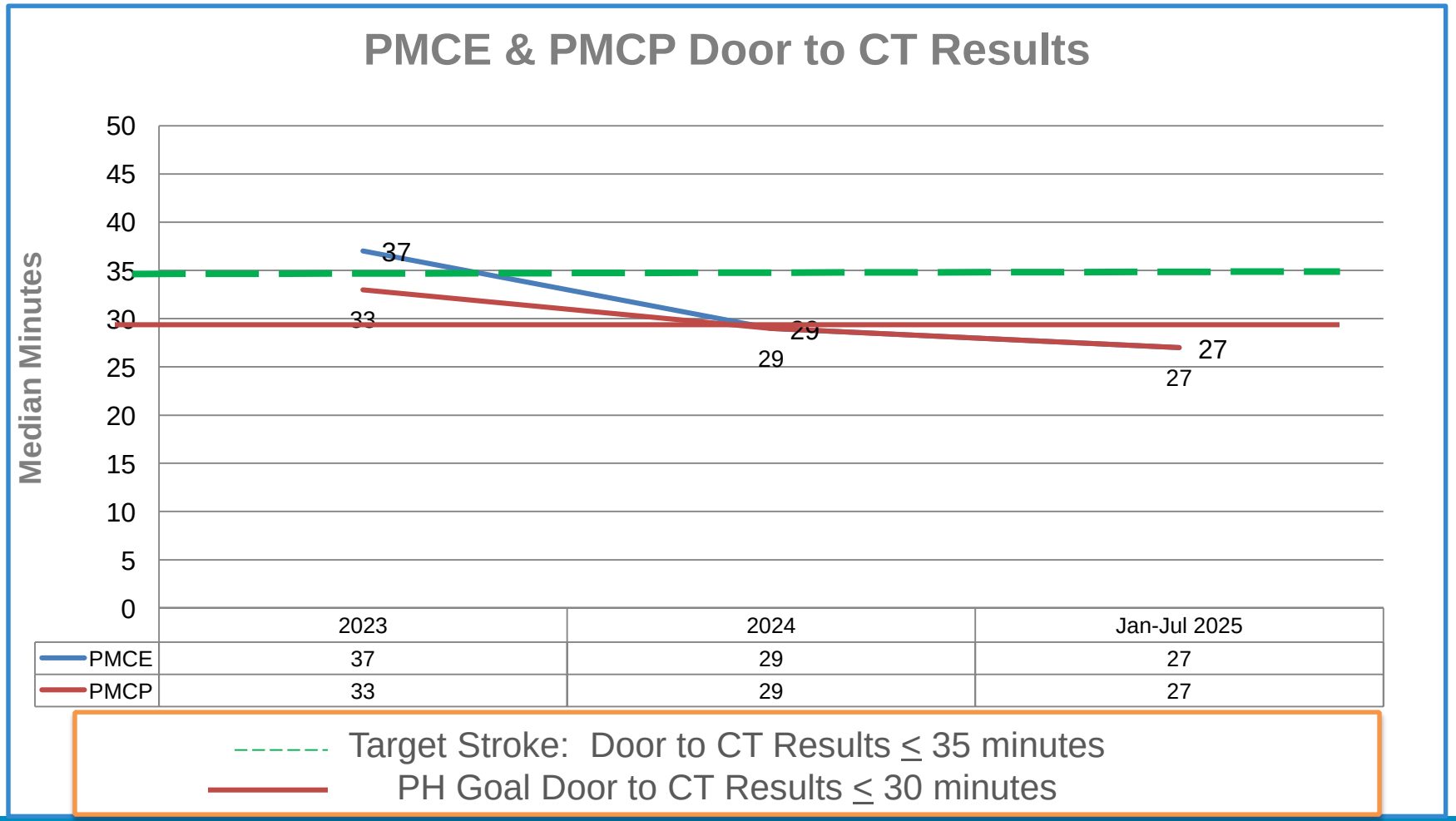
YTD Walk-ins to CT Start: 25 Median Minutes

YTD Overall to CT Start: 12 Median Minutes

2025 Target Measure Goal: < 20 minutes PH Metric Goal ≤ 15 minutes

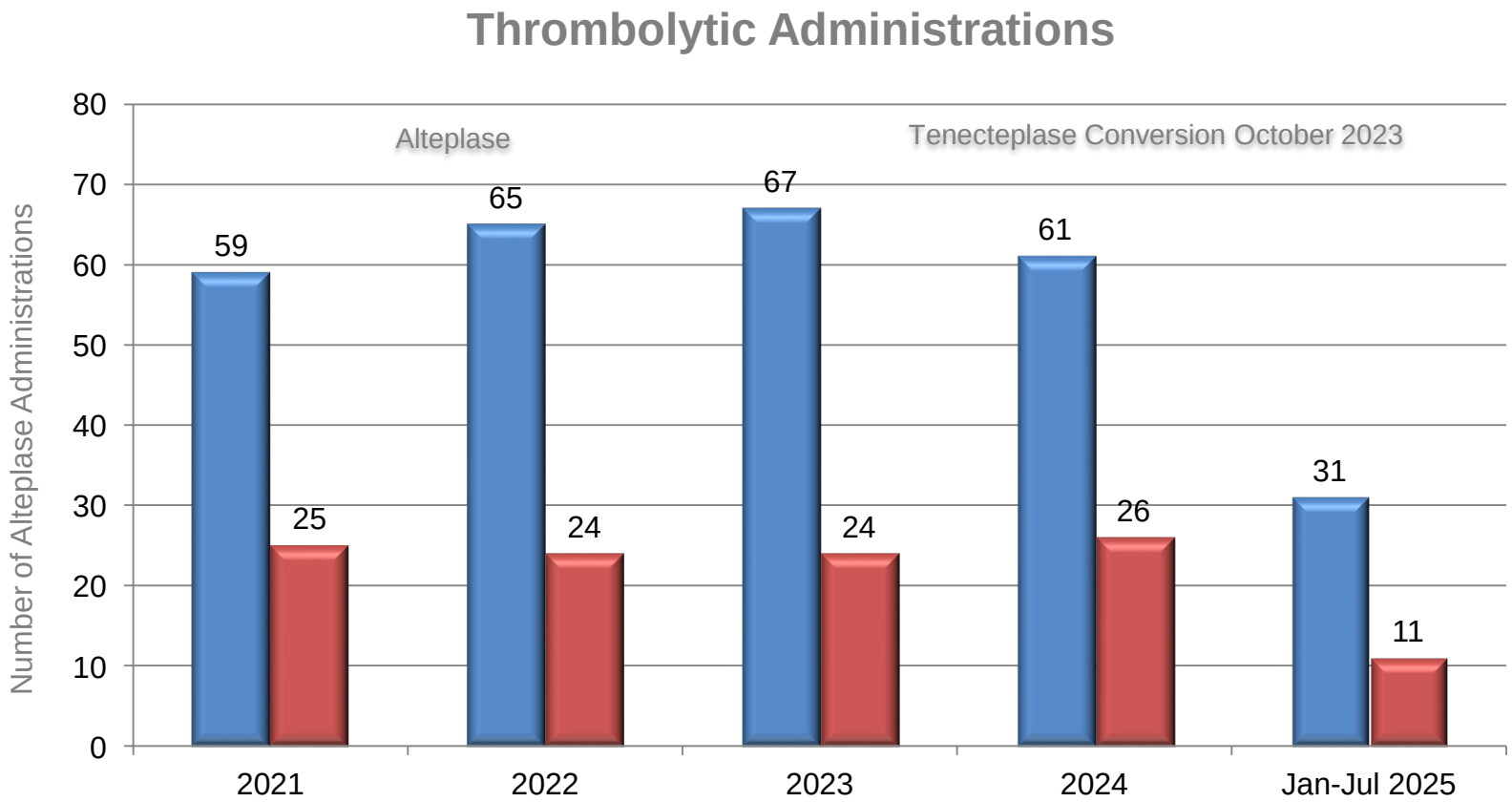
PMC Escondido & PMC Poway

Door to CT Results ≤ 35 Minutes



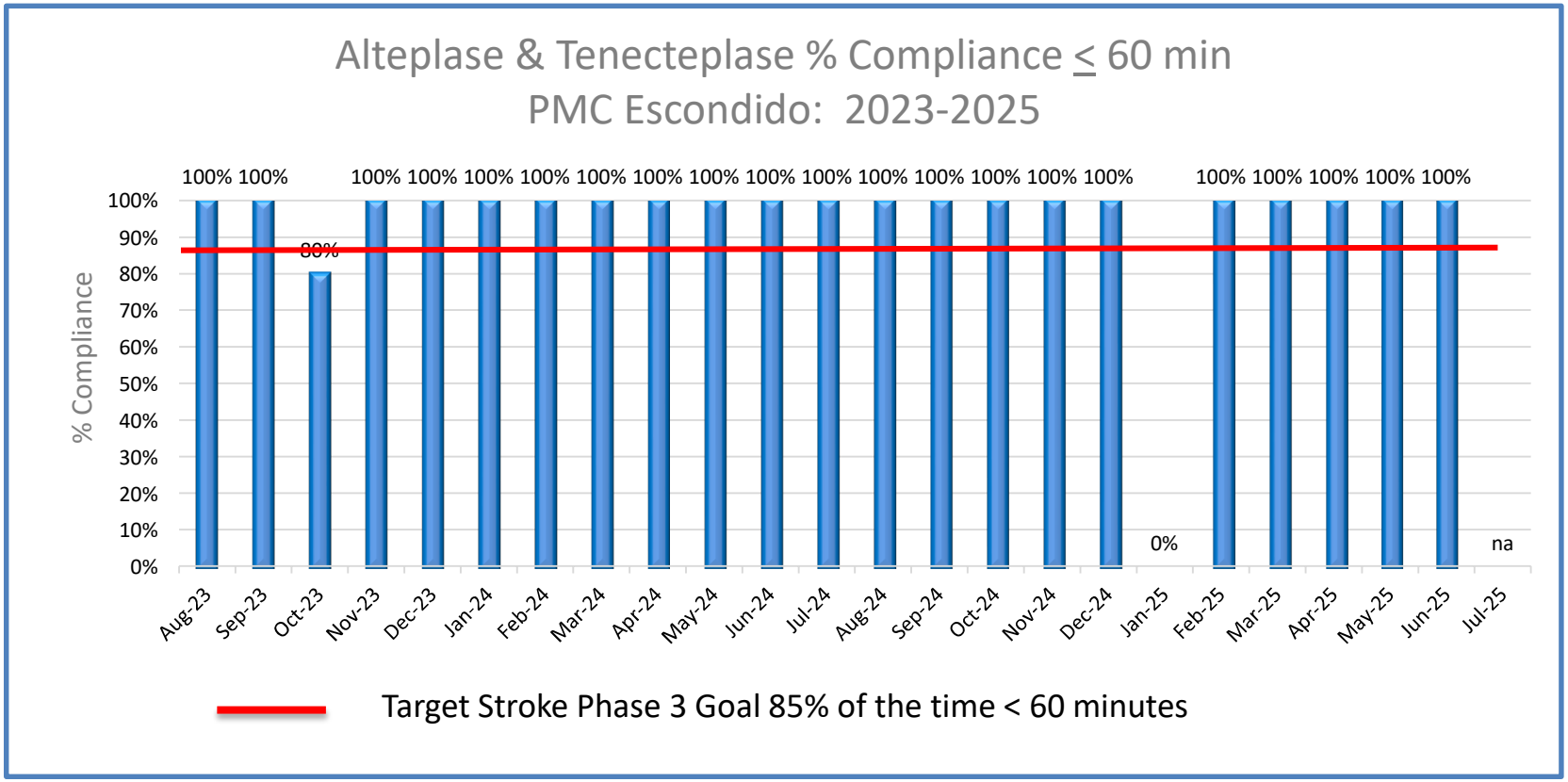
PMC Escondido & PMC Poway

Thrombolytic Utilization Volumes



Palomar Medical Center Escondido

Thrombolytic DTN ≤ 60 minutes

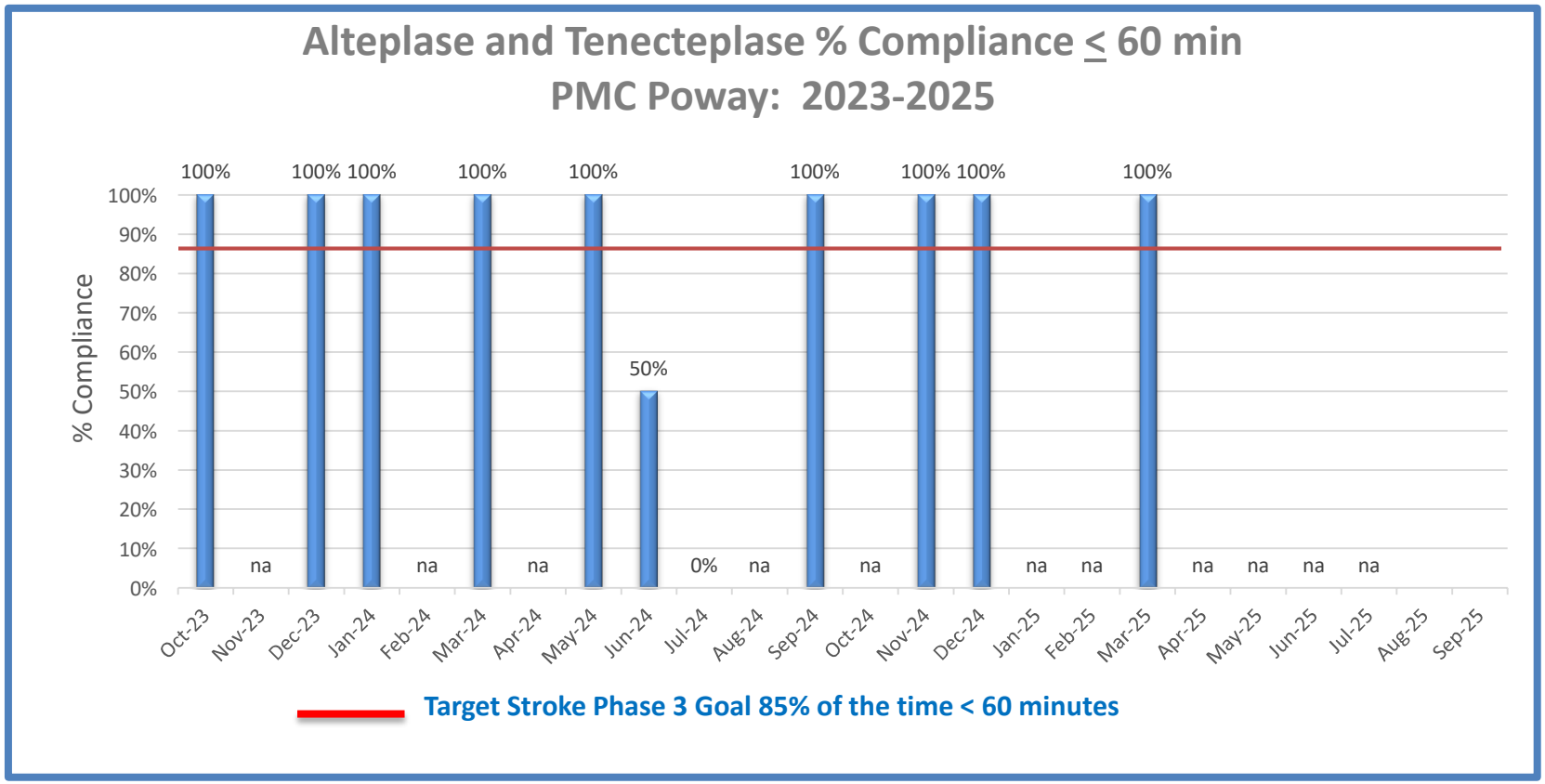


PMC Escondido Aug 2023– Jul 2025: 69/71 = 97% Compliance ≤ 60 minutes

NOTE: na = no cases met criteria for inclusion

Palomar Medical Center Poway

Thrombolytic DTN ≤ 60 minutes

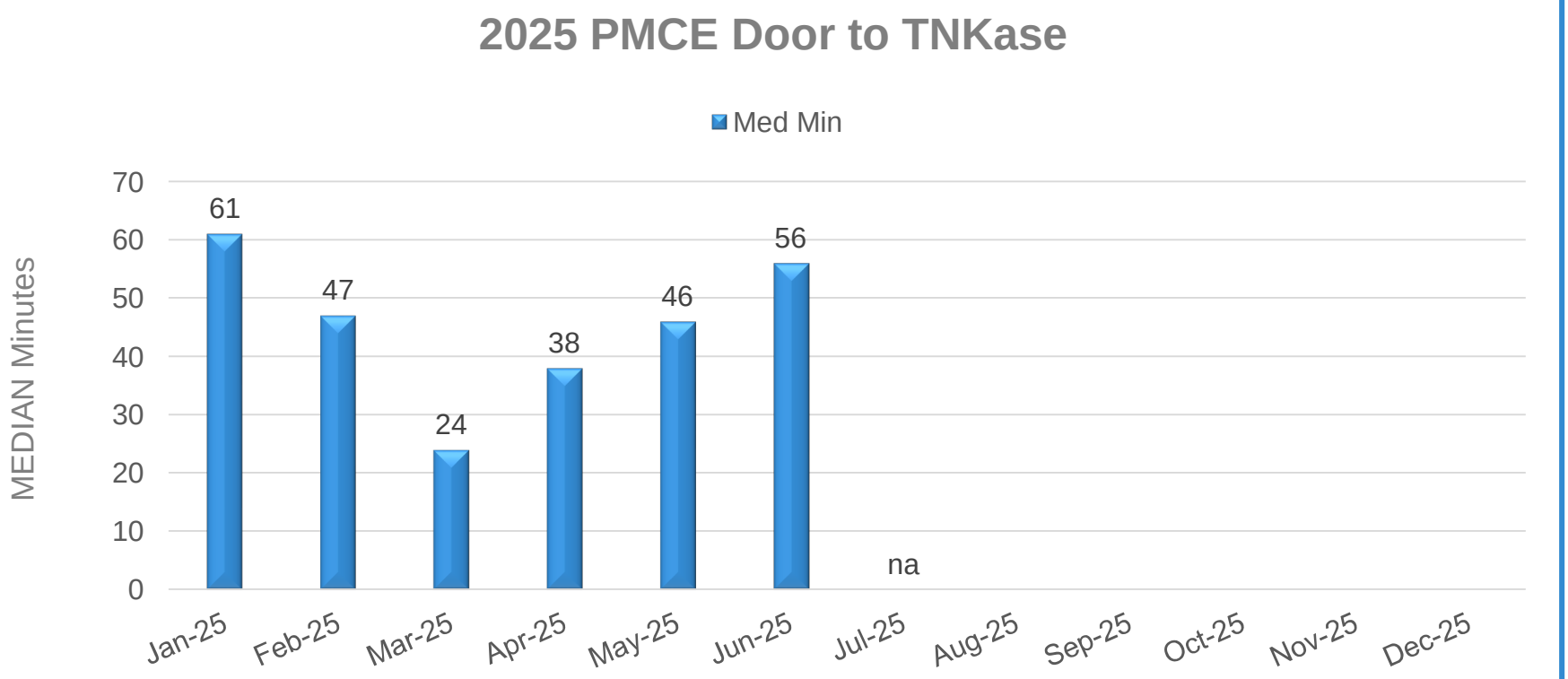


PMC Poway Oct 2023– Jul 2025: 18/20 cases = 90% Compliance ≤ 60 minutes

NOTE: na = no cases met criteria for inclusion

Palomar Medical Center Escondido

Door to TNKase – Median Min



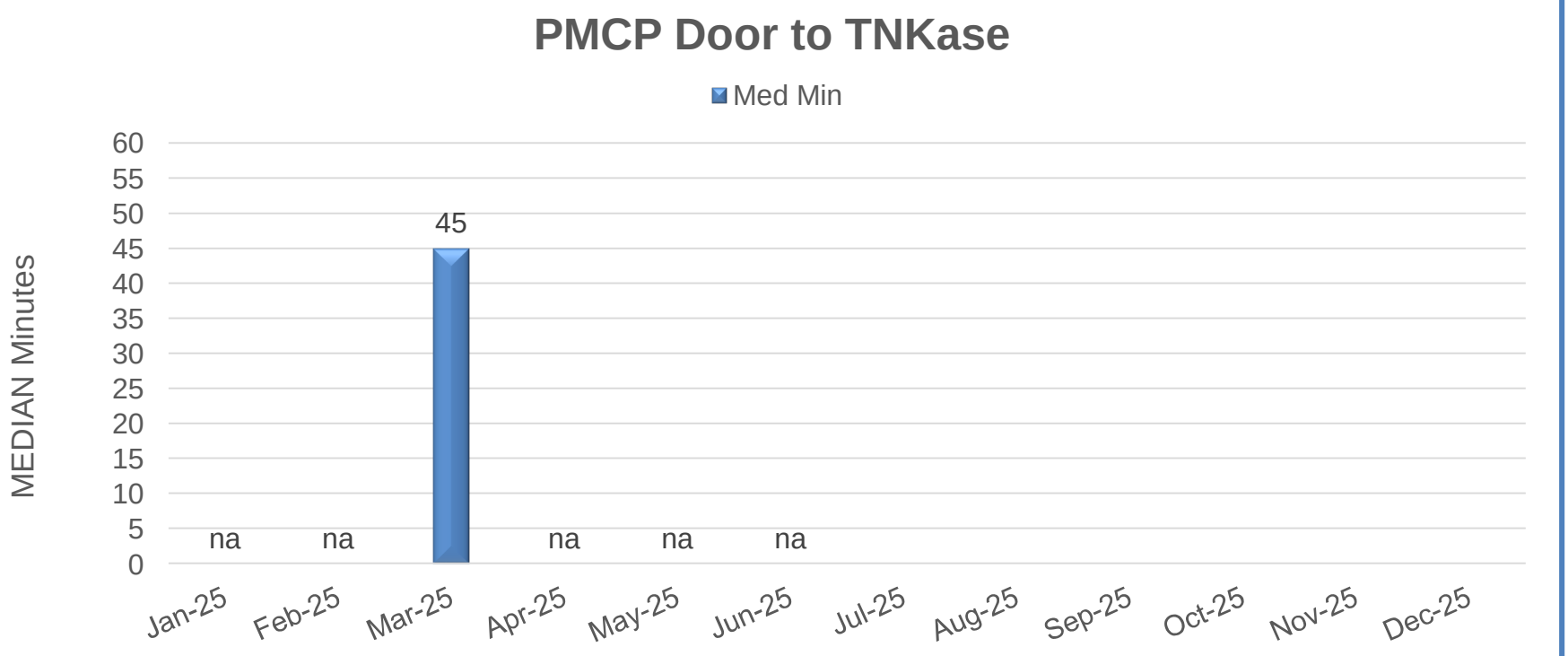
YTD Median Minutes: **46.5** minutes – cases that met criteria

2025 Metric Goal ≤ 45 minutes

YTD Median Minutes: 52 minutes – All Thrombolytic cases (including cases DQ)

Palomar Medical Center Poway

Door to TNKase – Median Min



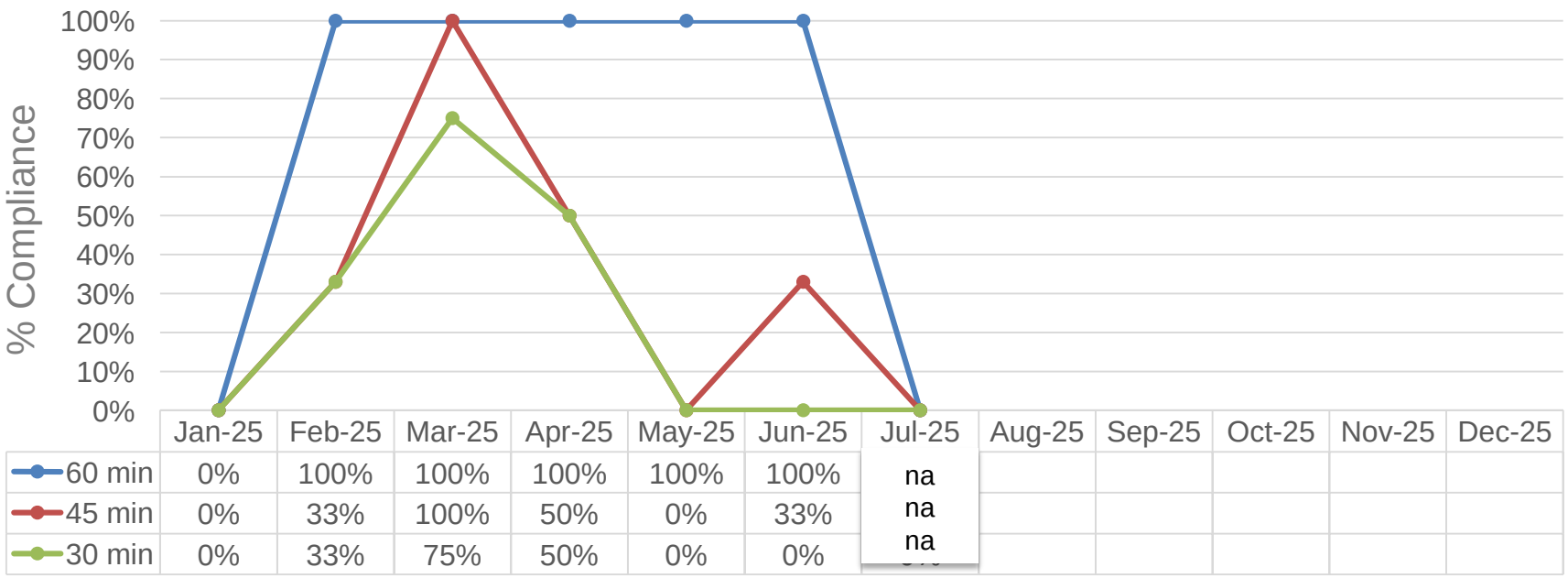
YTD Median Minutes: 45 minutes – cases that met criteria

2025 Metric Goal ≤ 45 minutes

YTD Median Minutes: 66 minutes – All Thrombolytic cases (includes cases DQ)

Palomar Medical Center Escondido

Door to TNKase Phase 3 Metric Initiatives



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
60 min	0%	100%	100%	100%	100%	100%	na					
45 min	0%	33%	100%	50%	0%	33%	na					
30 min	0%	33%	75%	50%	0%	0%	na					

PMC Escondido Door to Drug YTD Phase 3 Metric Success

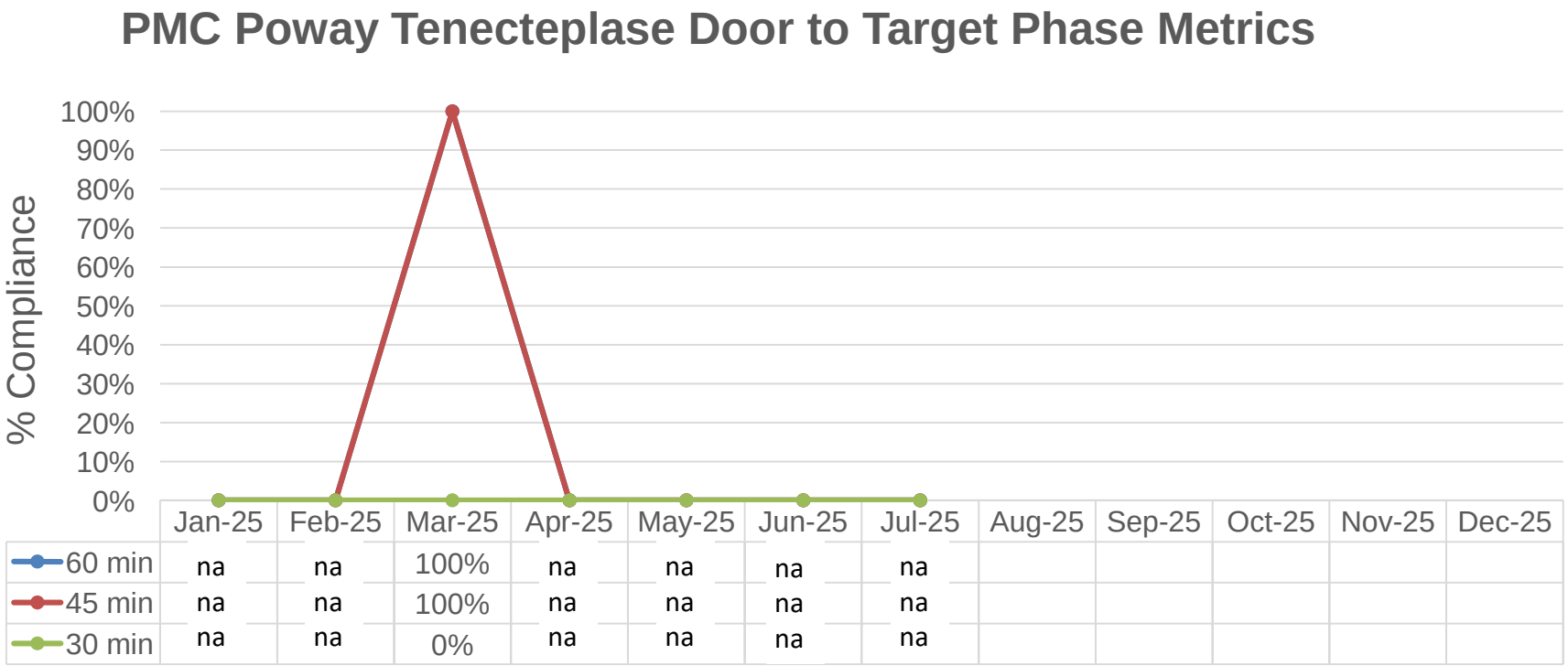
YTD 60 min = 93% - Goal: 85%

YTD 45 min = 47% - Goal: 75%

YTD 30 min = 33% - Goal: 50%

Palomar Medical Center Poway

Door to TNKase Phase 3 Metric Initiatives



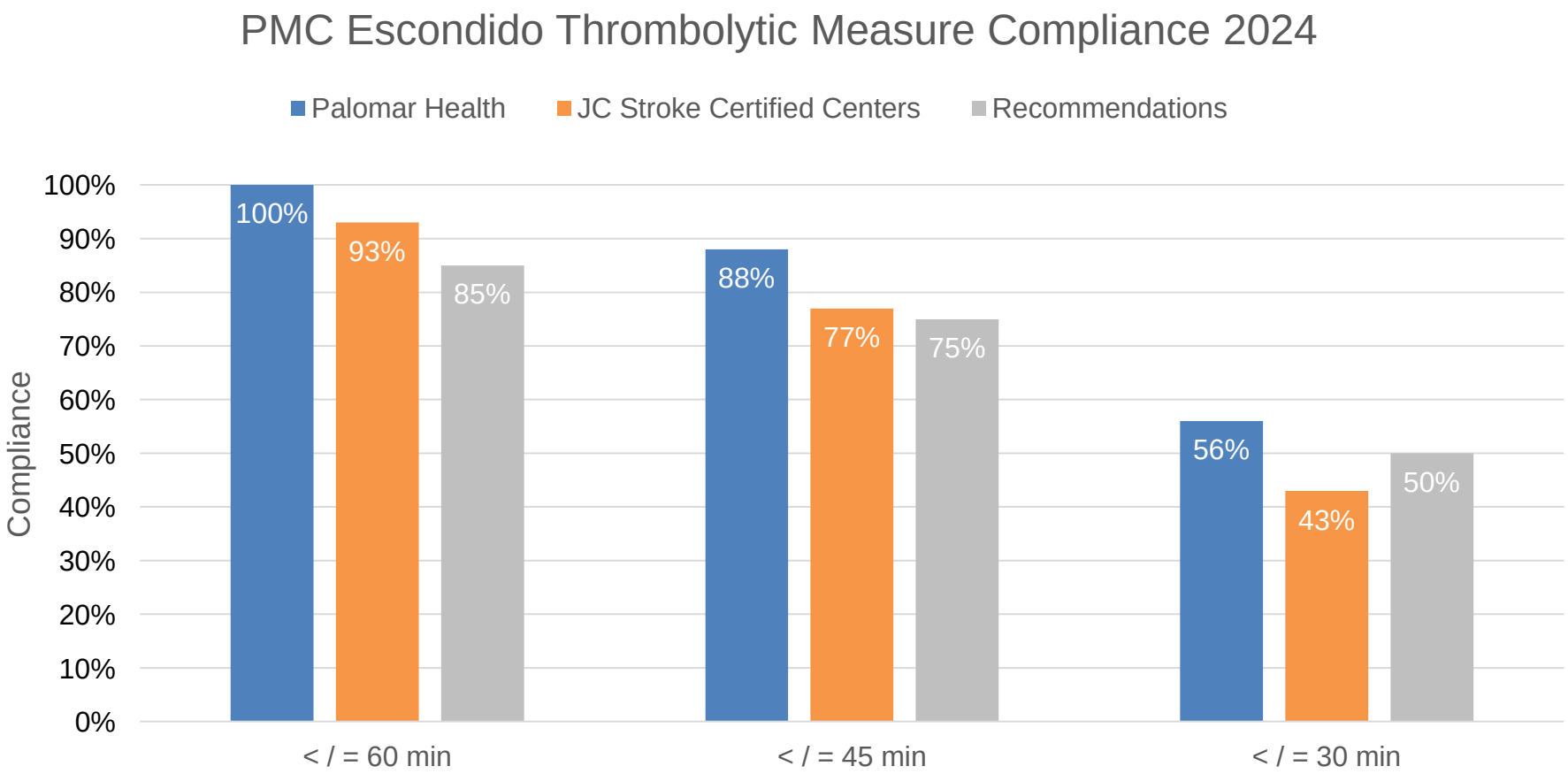
PMC Escondido Door to Drug YTD Phase 3 Metric Success

YTD 60 min = 100% - Goal: 85%

YTD 45 min = 100% - Goal: 75%

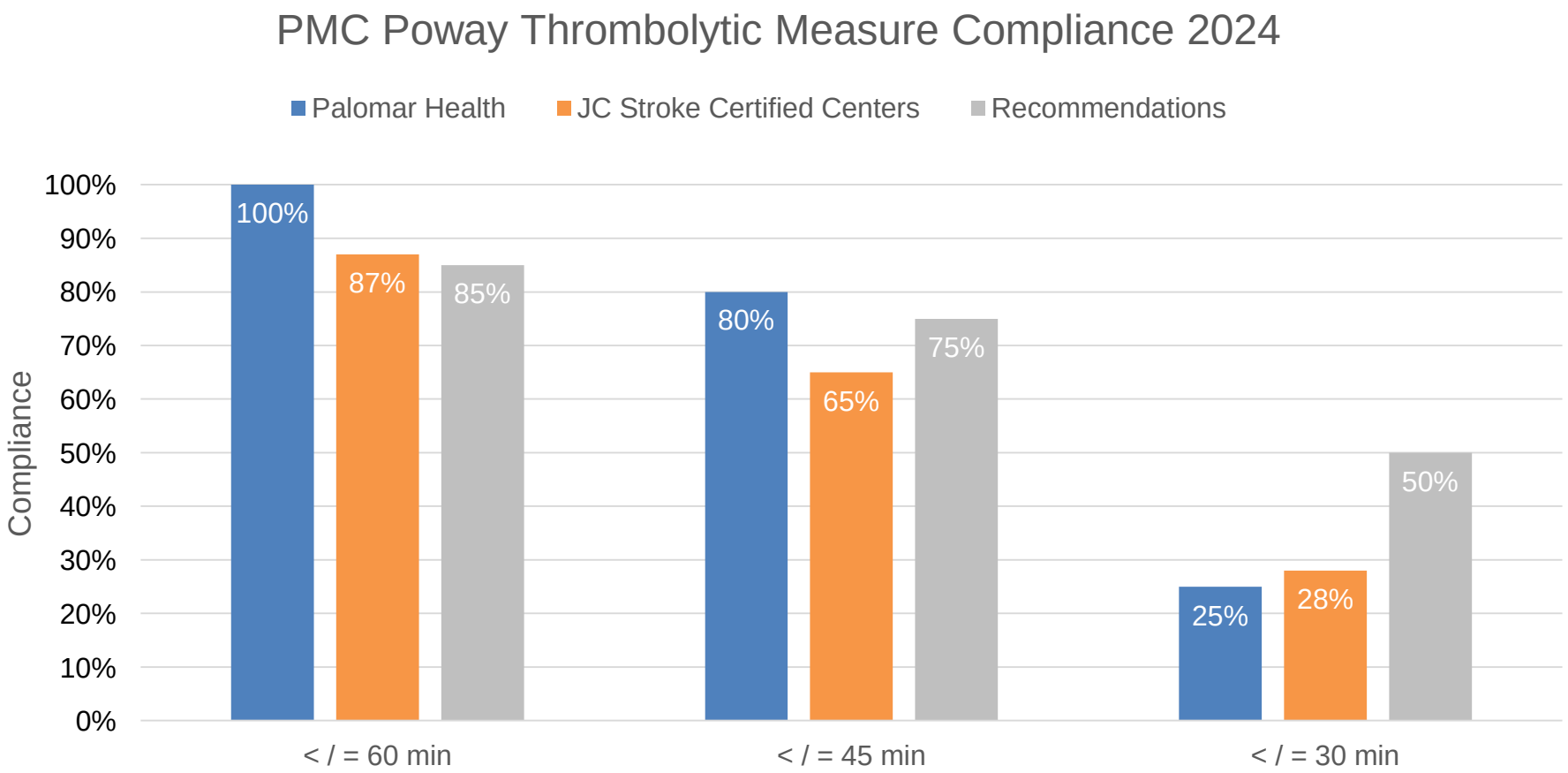
YTD 30 min = 0% - Goal: 50%

THROMBOLYTIC MEASURE COMPLIANCE



Recommendation Source:
a. Door to Drug: AHA Target Stroke Phase 3 Measures

THROMBOLYTIC MEASURE COMPLIANCE



Recommendation Source:
a. Door to Drug: AHA Target Stroke Phase 3 Measures

Palomar Medical Center Escondido

Target Indicators for Thrombectomy

METRIC	Target Stroke Phase III - Direct Cases	Target Stroke Phase III - Transfer Cases
Door to Provider	≤ 5 min	≤ 5 min
Door to Stroke Code activation	≤ 10 min	≤ 10 min
Door to CT Begin	≤ 20 min	≤ 20 min
Door to CT Reported Results	≤ 35 min	≤ 35 min
Door to IR Brain Alert	≤ 40 min	≤ 40 min
Door to Needle (if applicable)	≤ 45 min	≤ 45 min
Door to IR Suite	≤ 60 min	NA
Door IN – Door Out (DIDO)	NA	≤ 75 min
Door to Puncture (Groin Stick	≤ 75 min	≤ 30 min
Door to First Device	≤ 90 min	≤ 60 min
Door to First Device Compliance	50% of the time	50% of the time
Door to Vessel Open with TICI 2b or >	≤ 150 min	≤ 150 min
TICI Score	2b/3 ≥ 80%	2b/3 ≥ 80%

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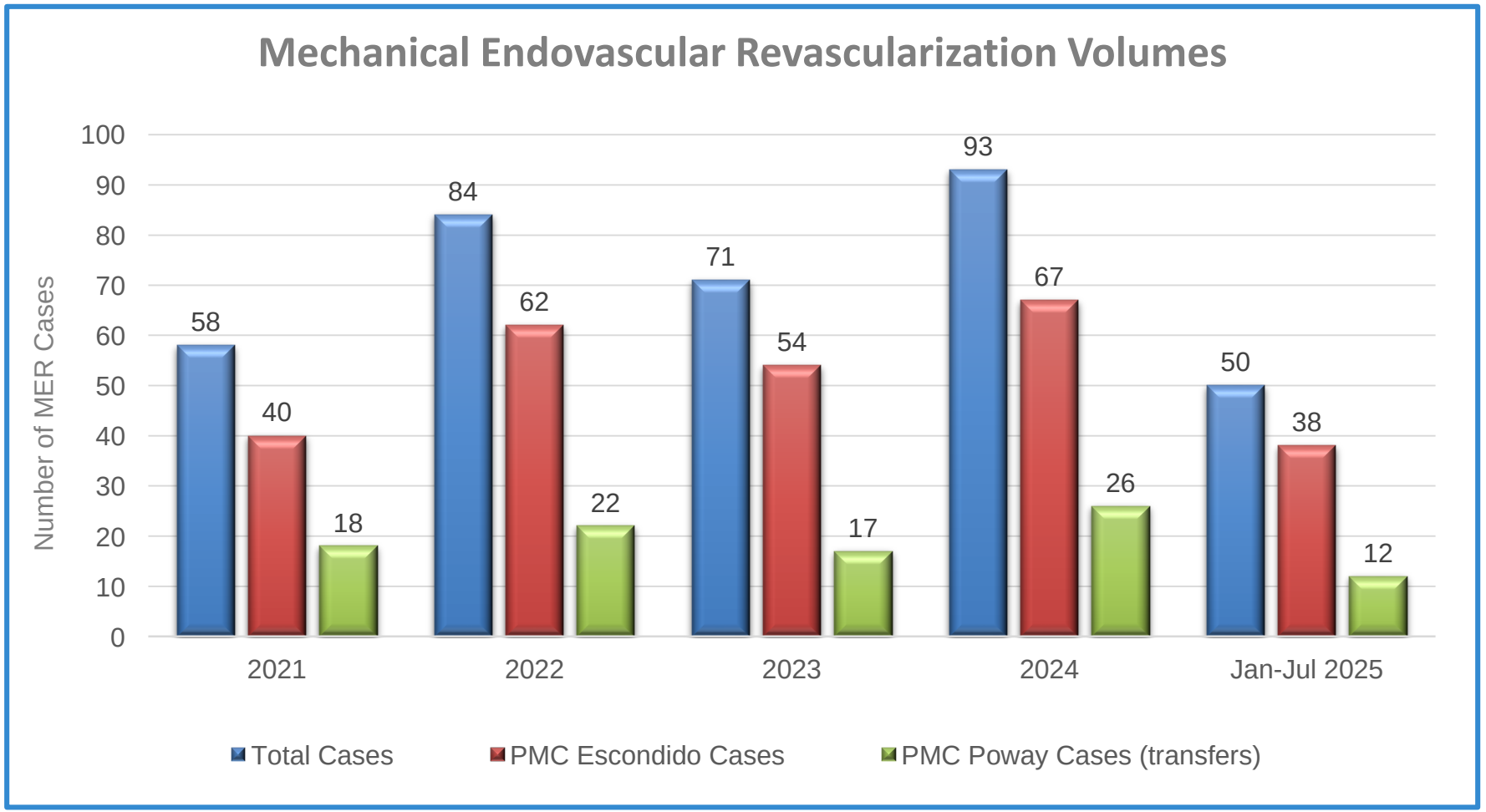
Mechanical Endovascular Revascularization



Palomar Medical Center Escondido

MER Provider Counts

2 Year Cycle: July 2023 – July 2025	
Provider	Total
MD #1	32
MD #2	43
MD #3**	4
MD #4	36
MD #5	41
MD #6	55
MD #7	36
MD #8	40

- Providers on TSC Application at time of Submission – not including MD#3**

Palomar Medical Center Escondido

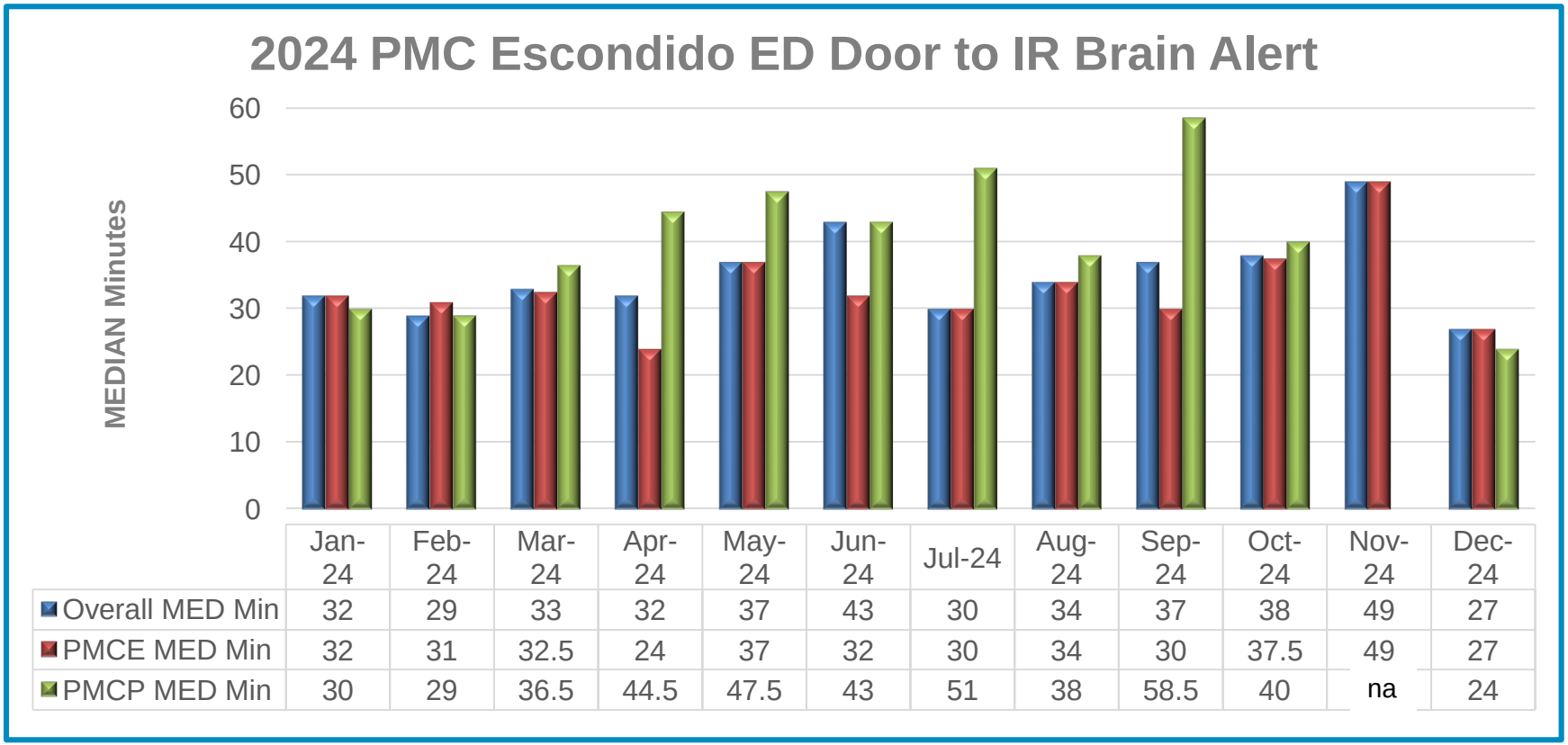
Treatment Rates & sICH Rate; All Cause Death </=72 Hours

Treatment Rate & sICH Rate	2023	2024	Jan – Jul 2025
All Thrombolytic	27% sICH = 0%	23% sICH = 0%	21% sICH = 2.4%
All Thrombectomy	21.3% sICH = 0%	25% sICH = 5.4%	25% sICH = 2.0%
All Cause Death 72 Hours**	**2023**	**2024**	**Jan – Jul 2025**
All Thrombectomy	0%	3.2%	6.0%

**MSPRC Review

Palomar Medical Center Escondido

2024 ED Door to IR Brain Alert Activations



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Overall MED Min	32	29	33	32	37	43	30	34	37	38	49	27
PMCE MED Min	32	31	32.5	24	37	32	30	34	30	37.5	49	27
PMCP MED Min	30	29	36.5	44.5	47.5	43	51	38	58.5	40	na	24

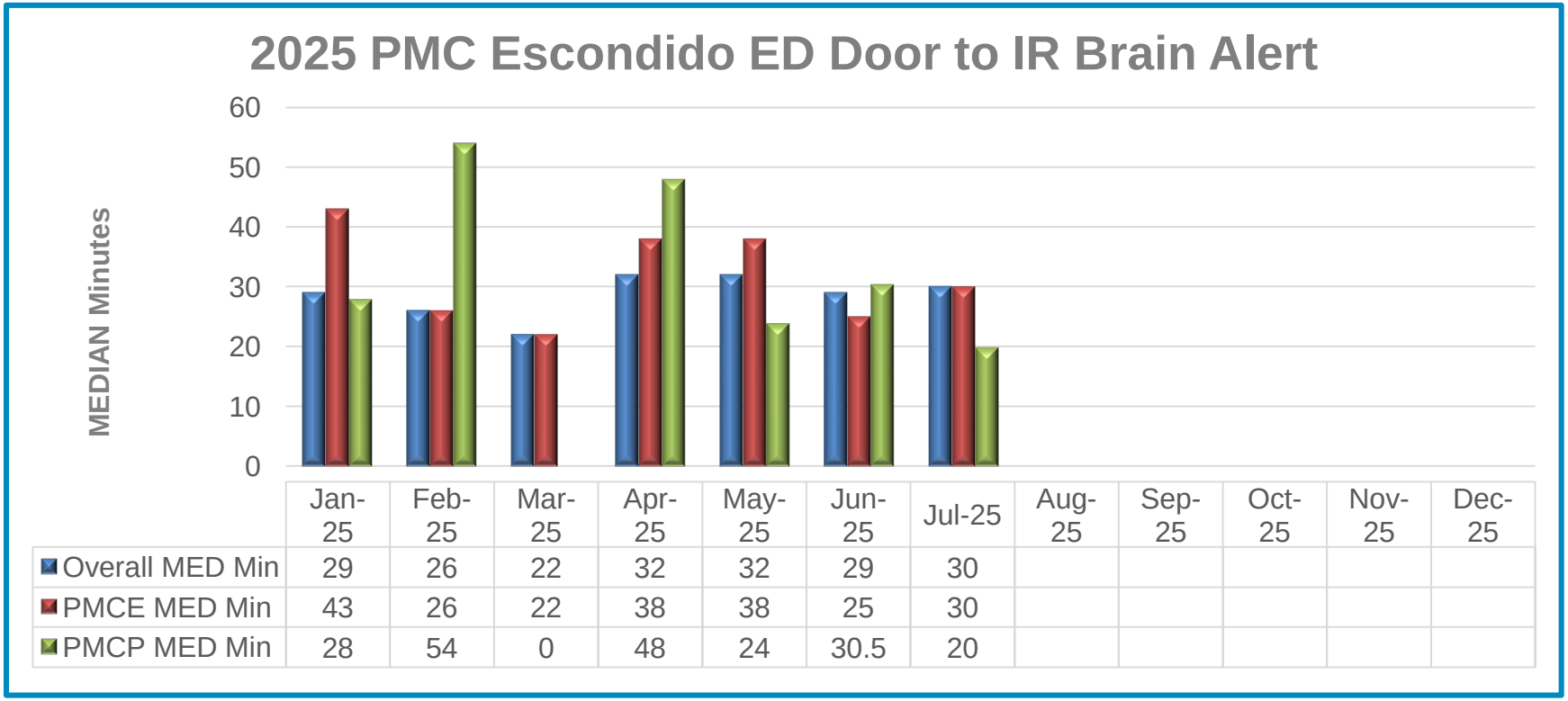
2024 Overall ED Door to IR Brain Alert Median Min: 34

Target Stroke Phase 3 IR Brain Alert Goal: ≤ 40 minutes

Compliance of Goal: 60/97 = 62% ED cases; 6/7 = 86% IPSC Brain Alerts (MED Min: 36)

Palomar Medical Center Escondido

2025 ED Door to IR Brain Alert Activations



	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25
Overall MED Min	29	26	22	32	32	29	30					
PMCE MED Min	43	26	22	38	38	25	30					
PMCP MED Min	28	54	0	48	24	30.5	20					

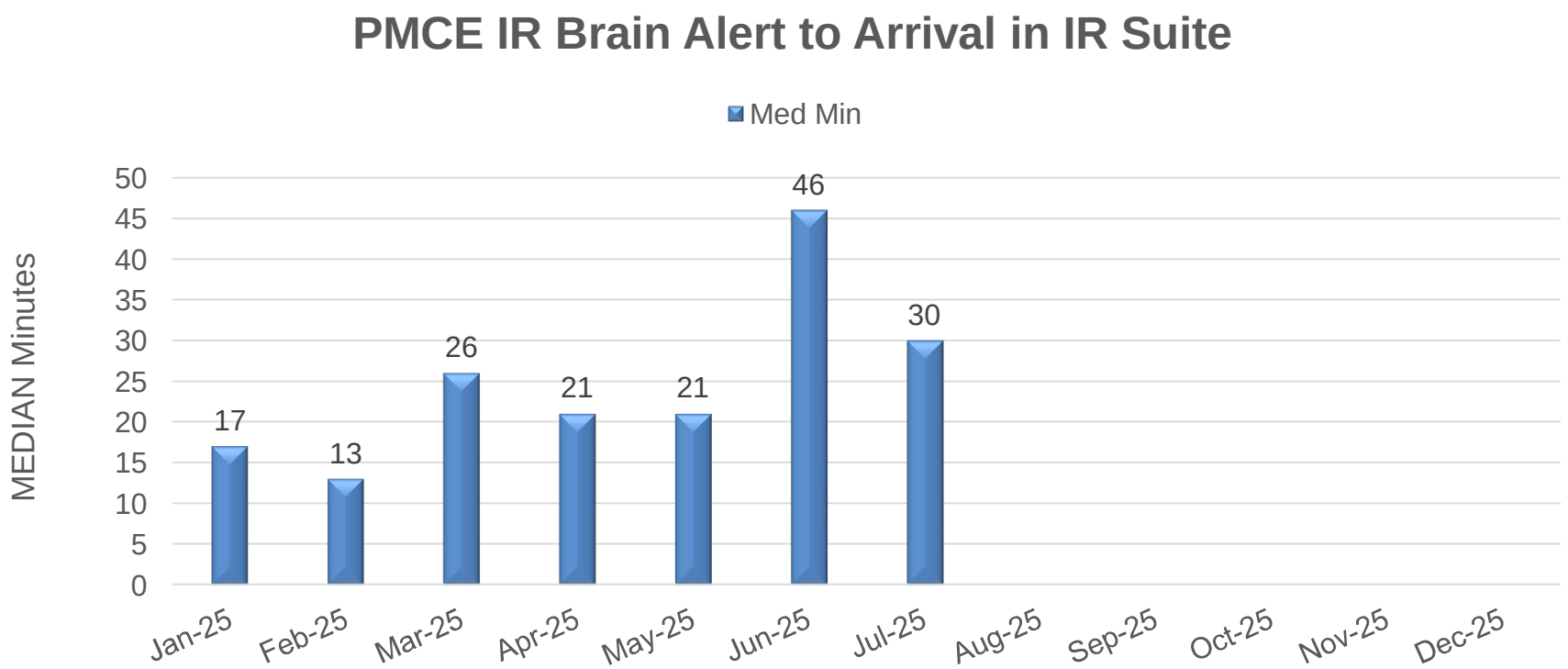
2025 Overall ED Door to IR Brain Alert Median Min: 29

Target Stroke Phase 3 IR Brain Alert Goal: ≤ 40 minutes

Compliance of Goal: ED Cases: 32/44 = 73% IPSC: 5/9 = 55.5%

Palomar Medical Center Escondido

IR Brain Alert to Arrival in IR Suite – Med Min

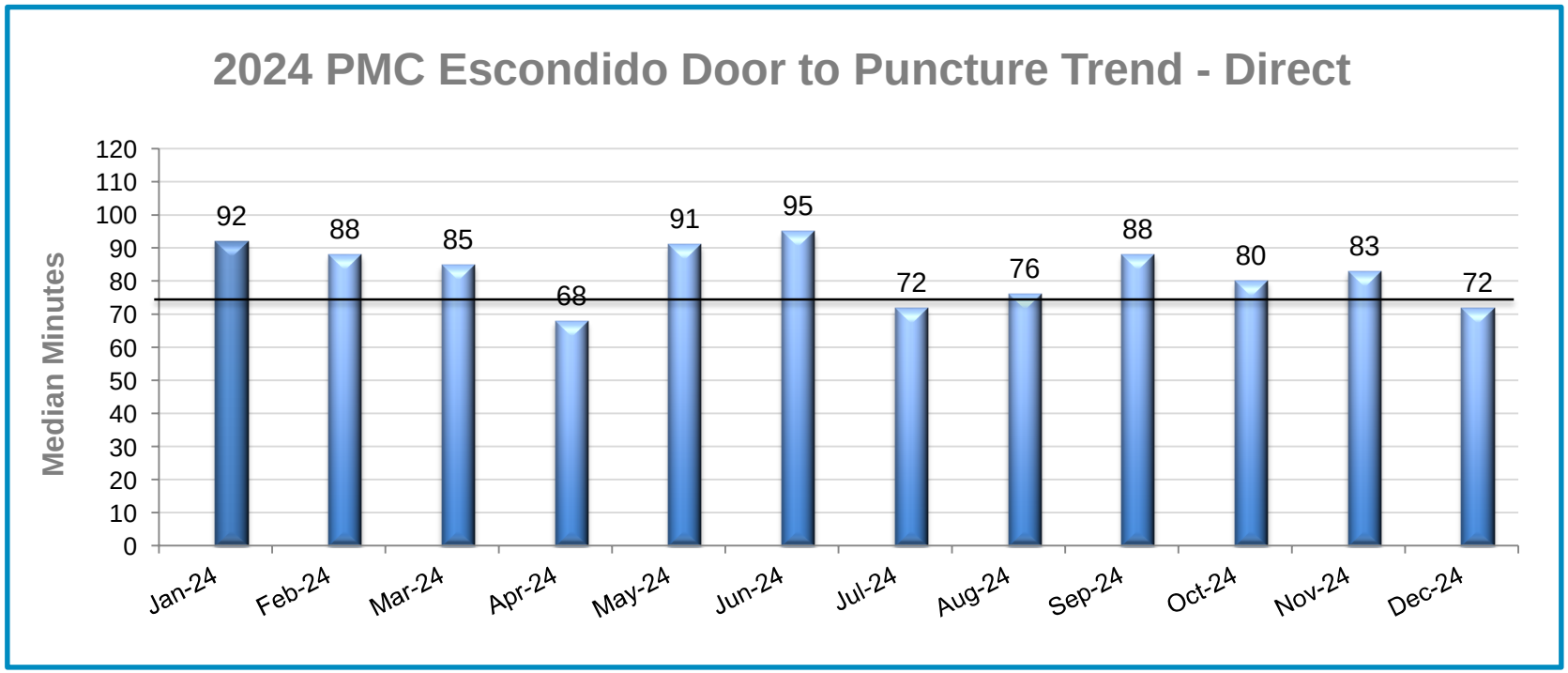


YTD Median Minutes: **21** minutes

2025 Metric Goal ≤ 20 minutes

Palomar Medical Center Escondido

2024 Door to Puncture(D2P) - Direct



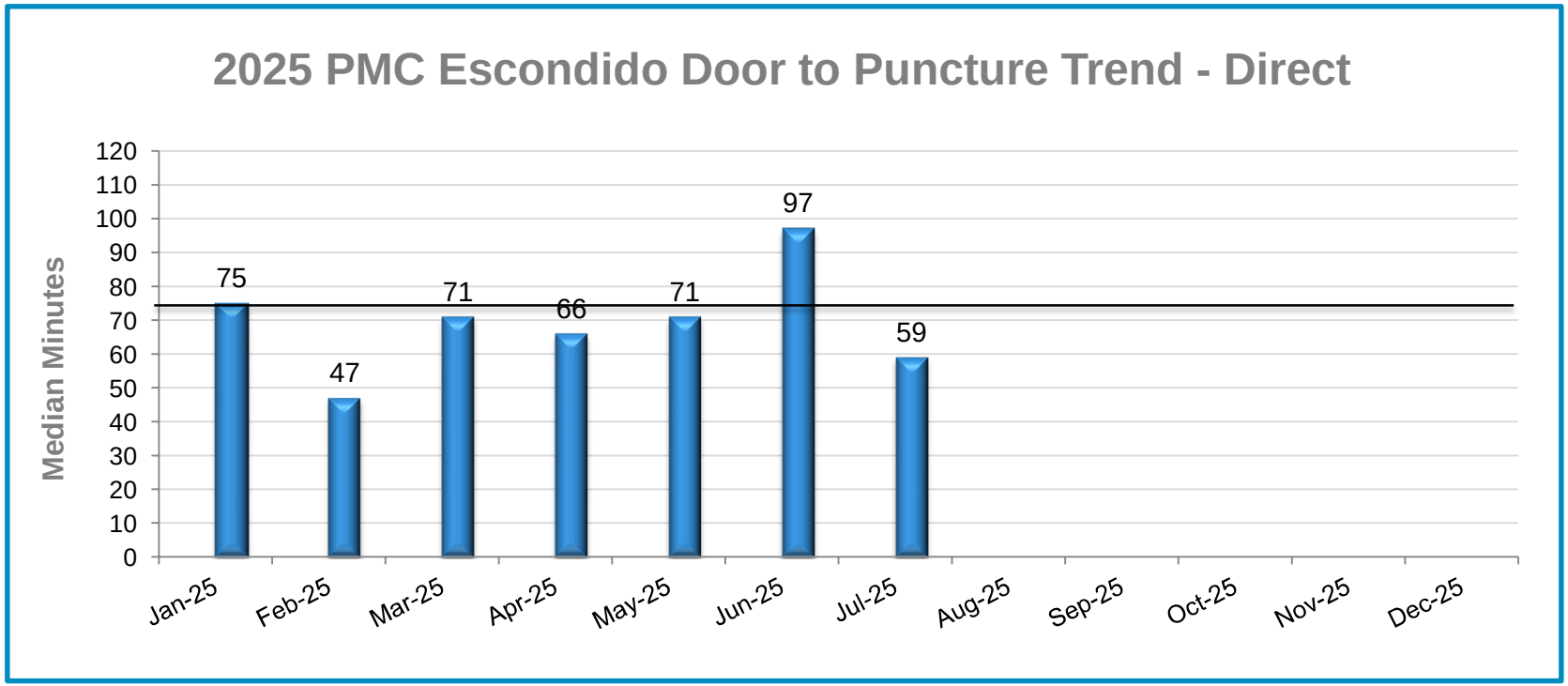
2024 PH Escondido Direct D2P Median Min: 84

Target Phase 3 Goal ≤ 75 minutes 50% of the time: ED 28/61 = 46%

IPSC 2/6 = 33% IPSC Med Min:

Palomar Medical Center Escondido

2025 Door to Puncture(D2P) - Direct



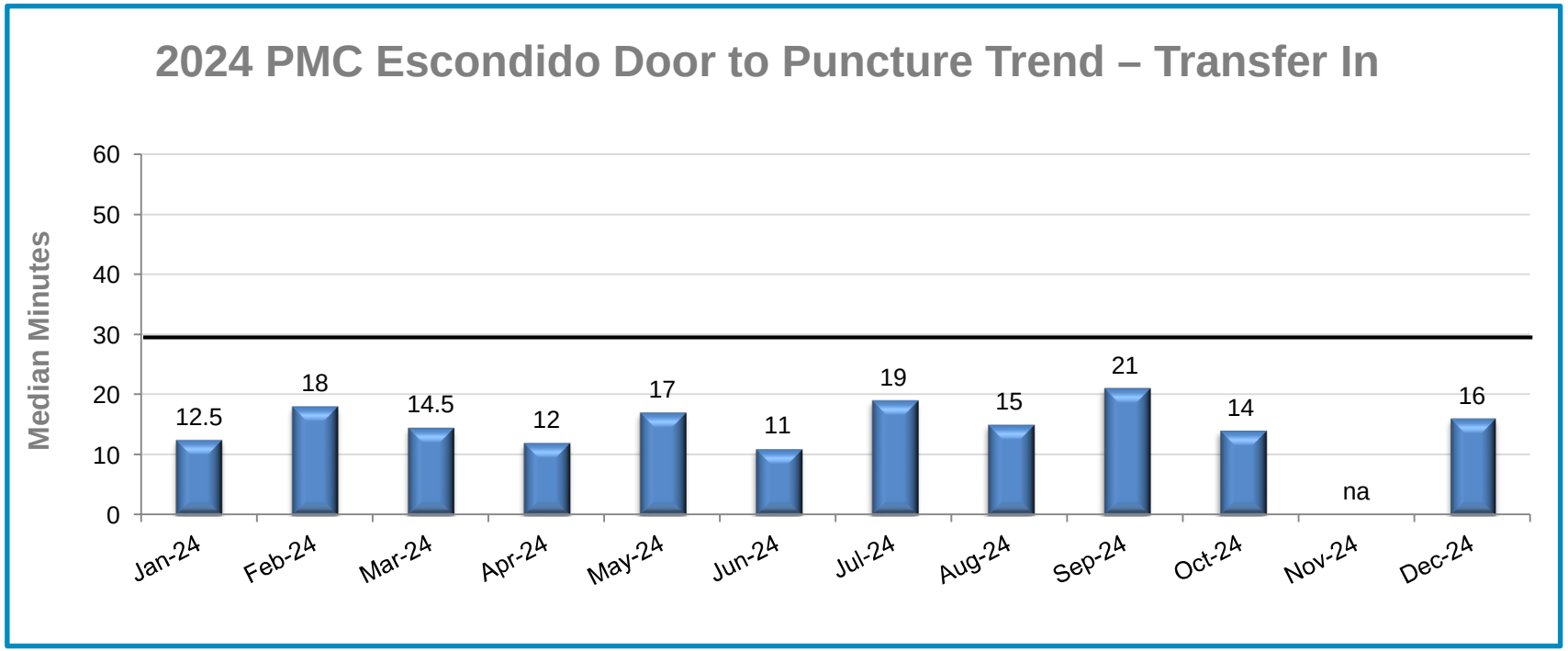
2025 PH Escondido Direct D2P Median Min: 71

Target Phase 3 Goal ≤ 75 minutes 50% of the time: ED 16/22 = **73%**

IPSC 3/6 = 50% IPSC Med Min: **81.5 min**

Palomar Medical Center Escondido

2024 Door to Puncture(D2P) – Transfer In

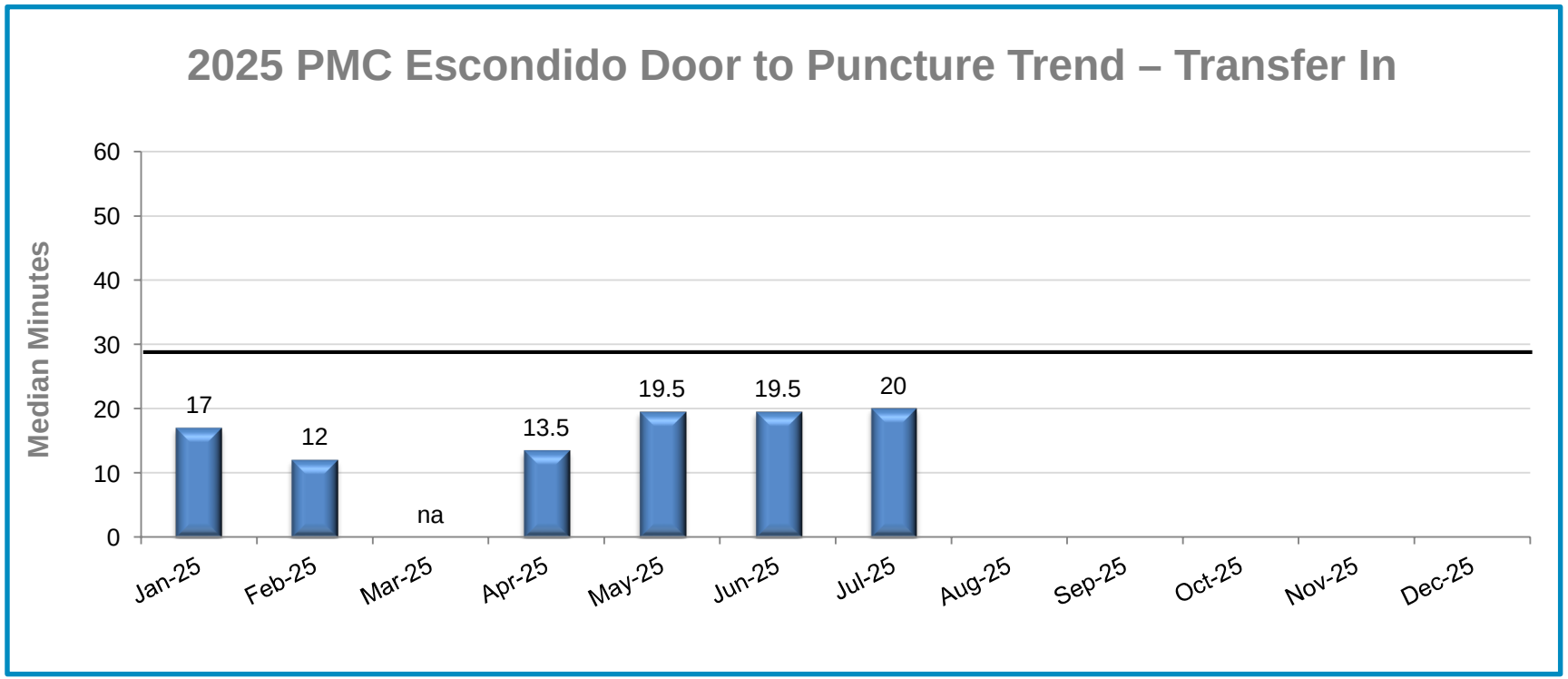


2024 PH Escondido Transfer D2P Median Min: 15

Target Phase 3 Goal ≤ 30 minutes 50% of the time: 26/26 Cases = 100%

Palomar Medical Center Escondido

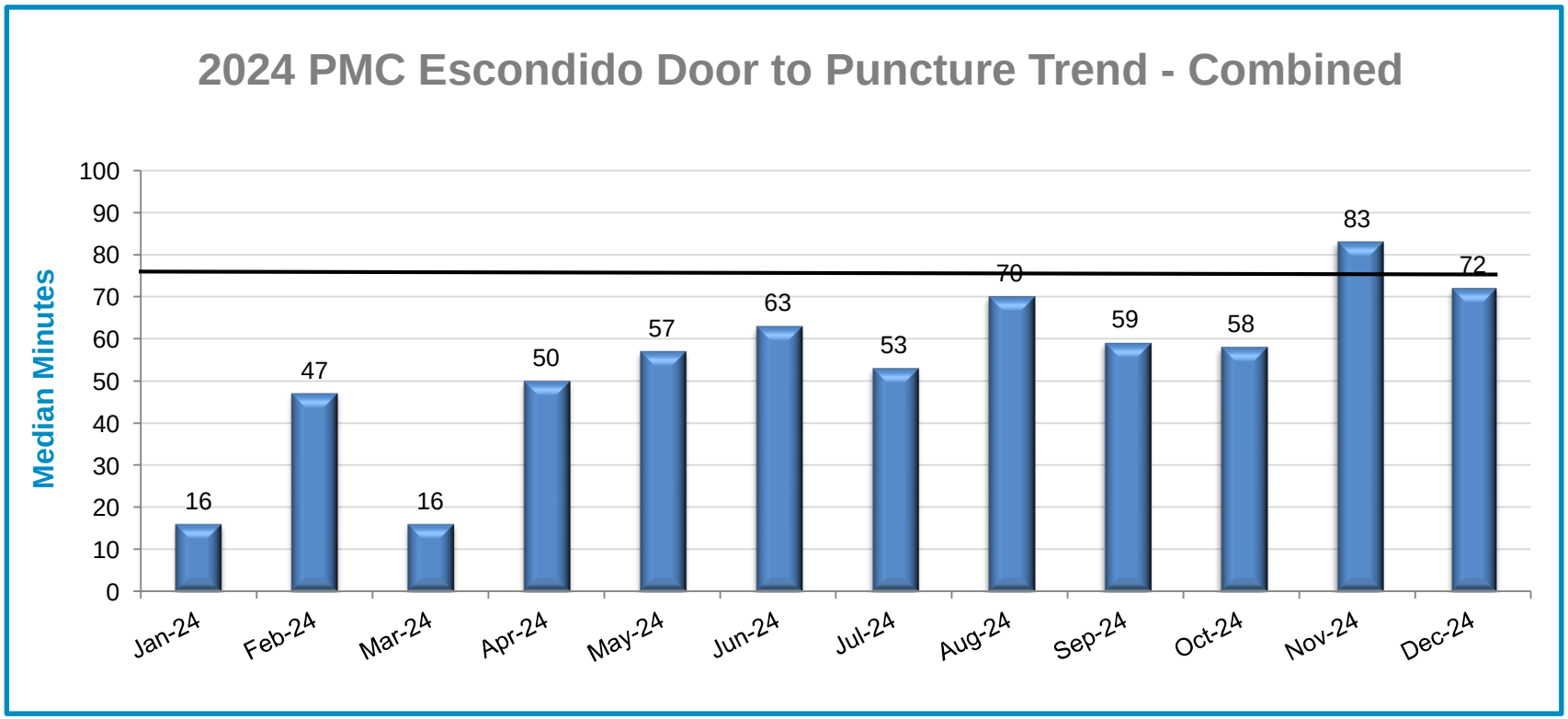
2025 Door to Puncture(D2P) – Transfer In



2025 PH Escondido Transfer D2P Median Min: 18.25

2025 Target Phase 3 Goal ≤ 30 minutes 50% of the time: 11/11 Cases = 100%

Palomar Medical Center Escondido:
2024 Door to Puncture(D2P) Combined

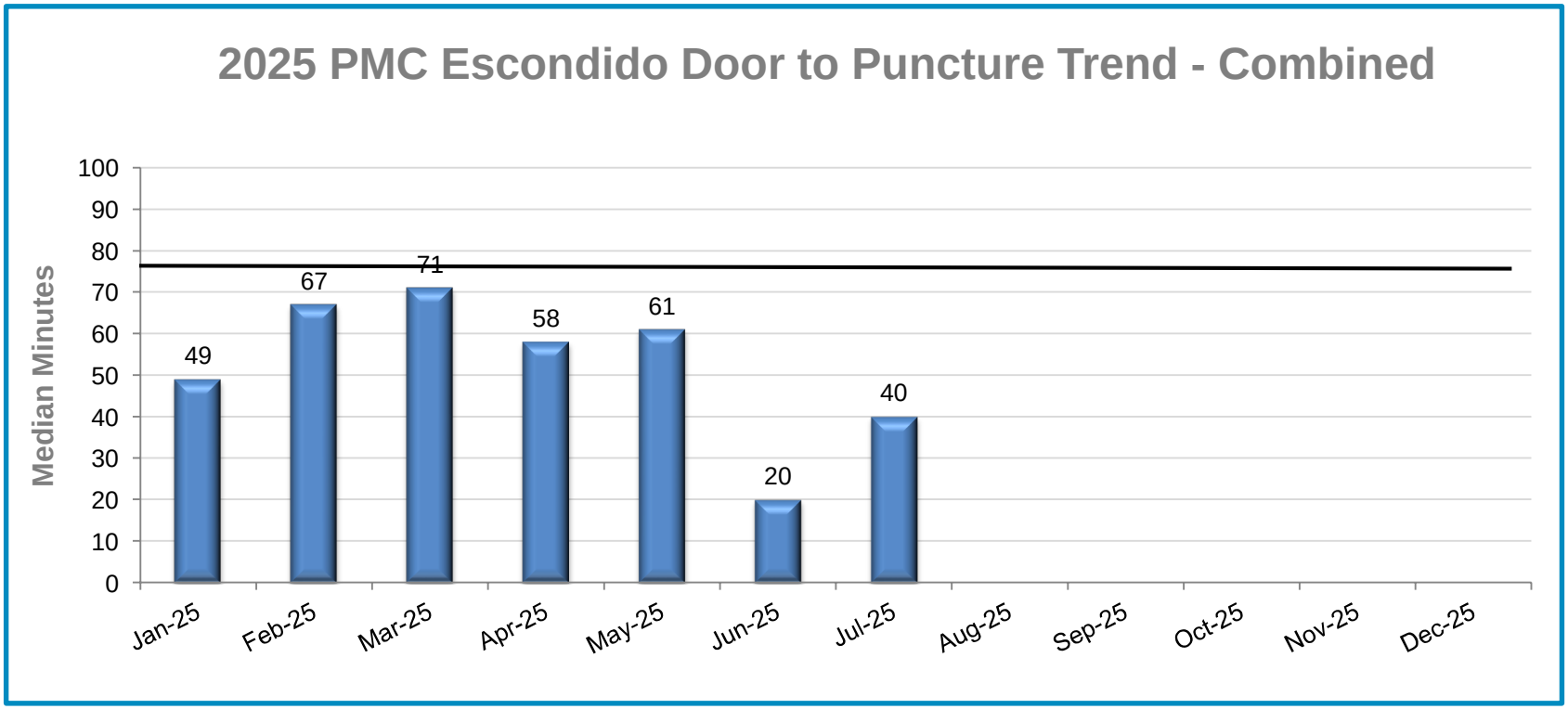


2024 Palomar Health Combined D2P Median Min: 58

Target Phase 3 Cases ≤ 75 min 50% of the time: 54/87 = 62 %

IPSC: 2/6 = 33% Median Min:

Palomar Medical Center Escondido:
2025 Door to Puncture(D2P) Combined



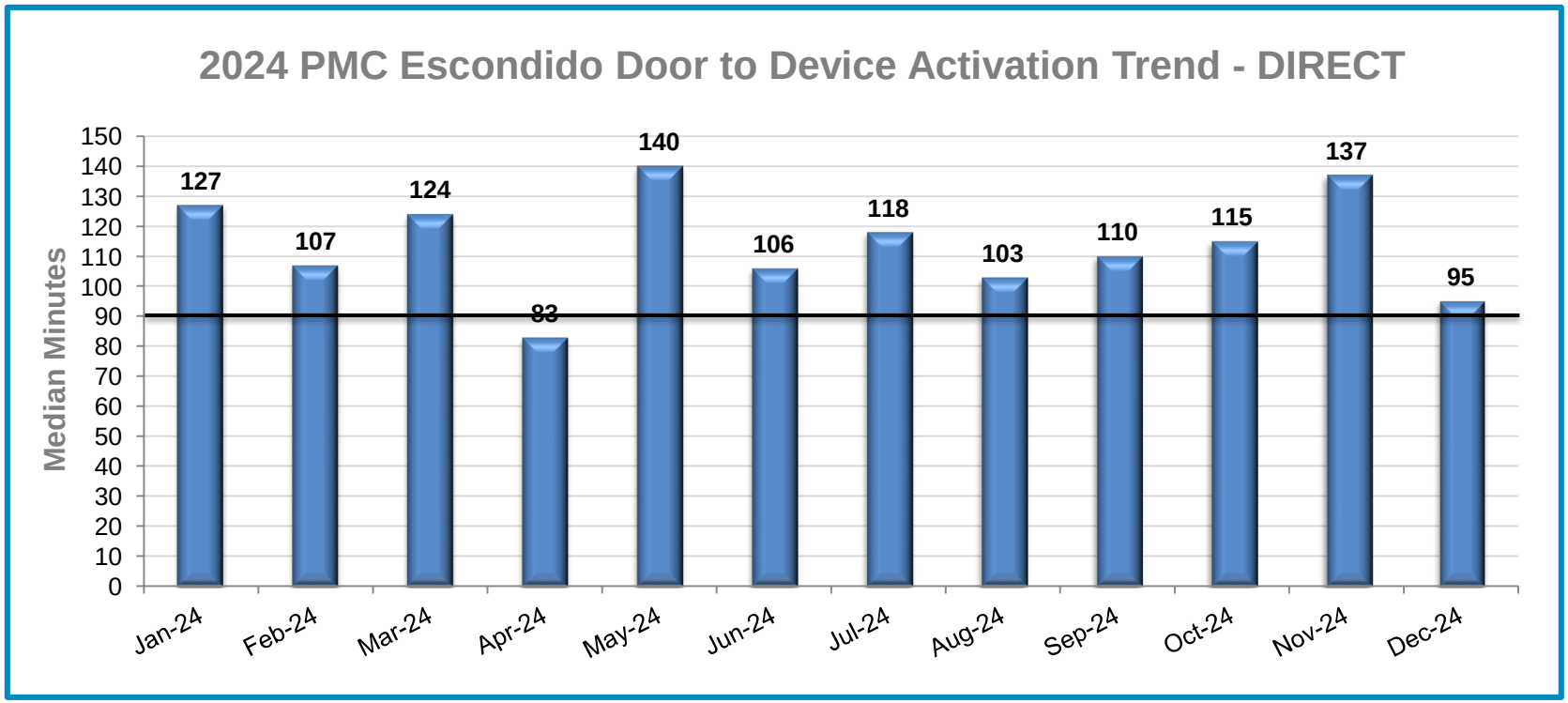
2025 Palomar Health Combined D2P Median Min: 58

Target Phase 3 Cases ≤ 75 min 50% of the time: ED Cases 25/31 = 81%

IPSC: 3/6 = 60% Median Min: 81.5

Palomar Medical Center Escondido

2024 Door to First Device Activation (D2DA)



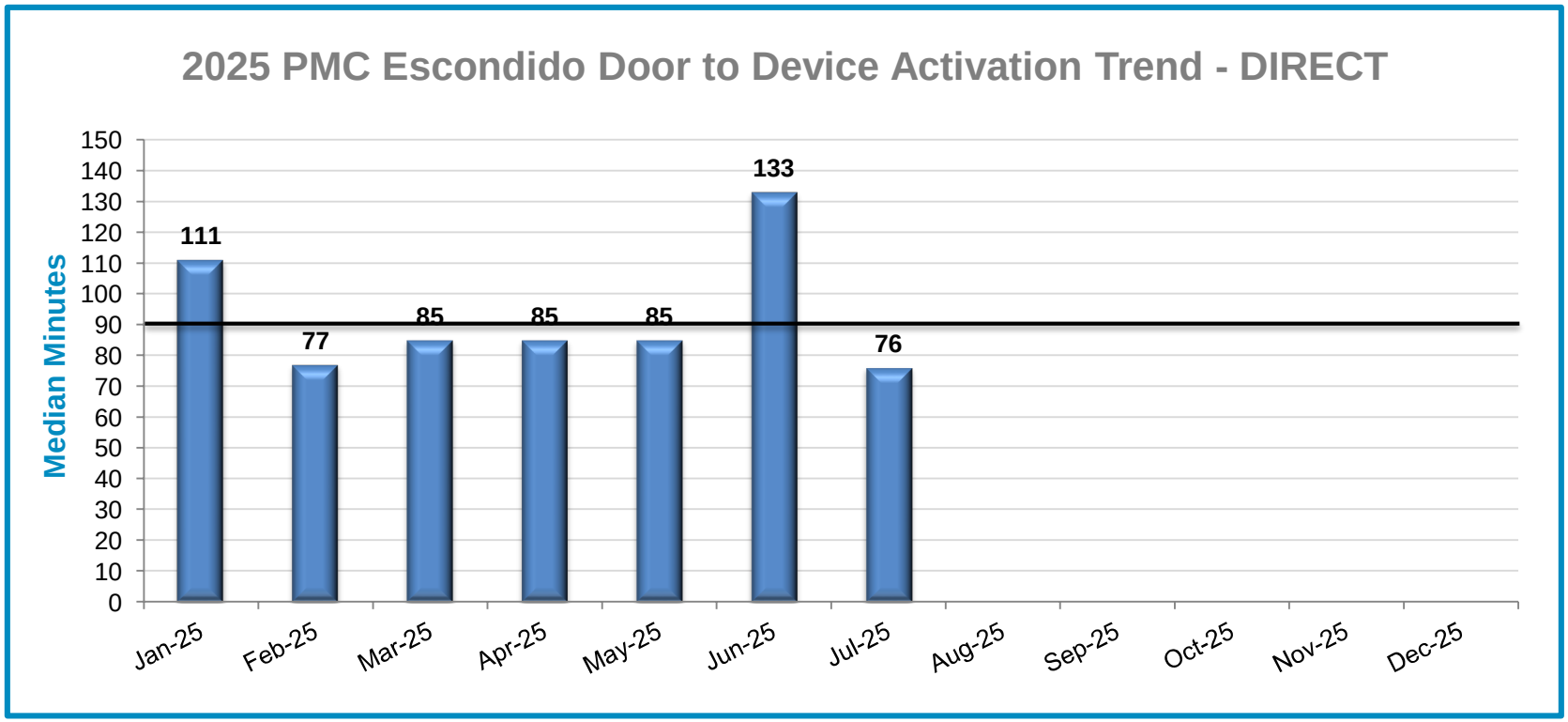
2024 PH Escondido Direct D2DA Median Minutes: 112.5

Target Phase 3 Goal D2DA ≤ 90 min 50% of the time: 20/87 = 23%

IPSC D2DA: 2/6 = 33% Med Minutes:

Palomar Medical Center Escondido

2025 Door to First Device Activation (D2DA)



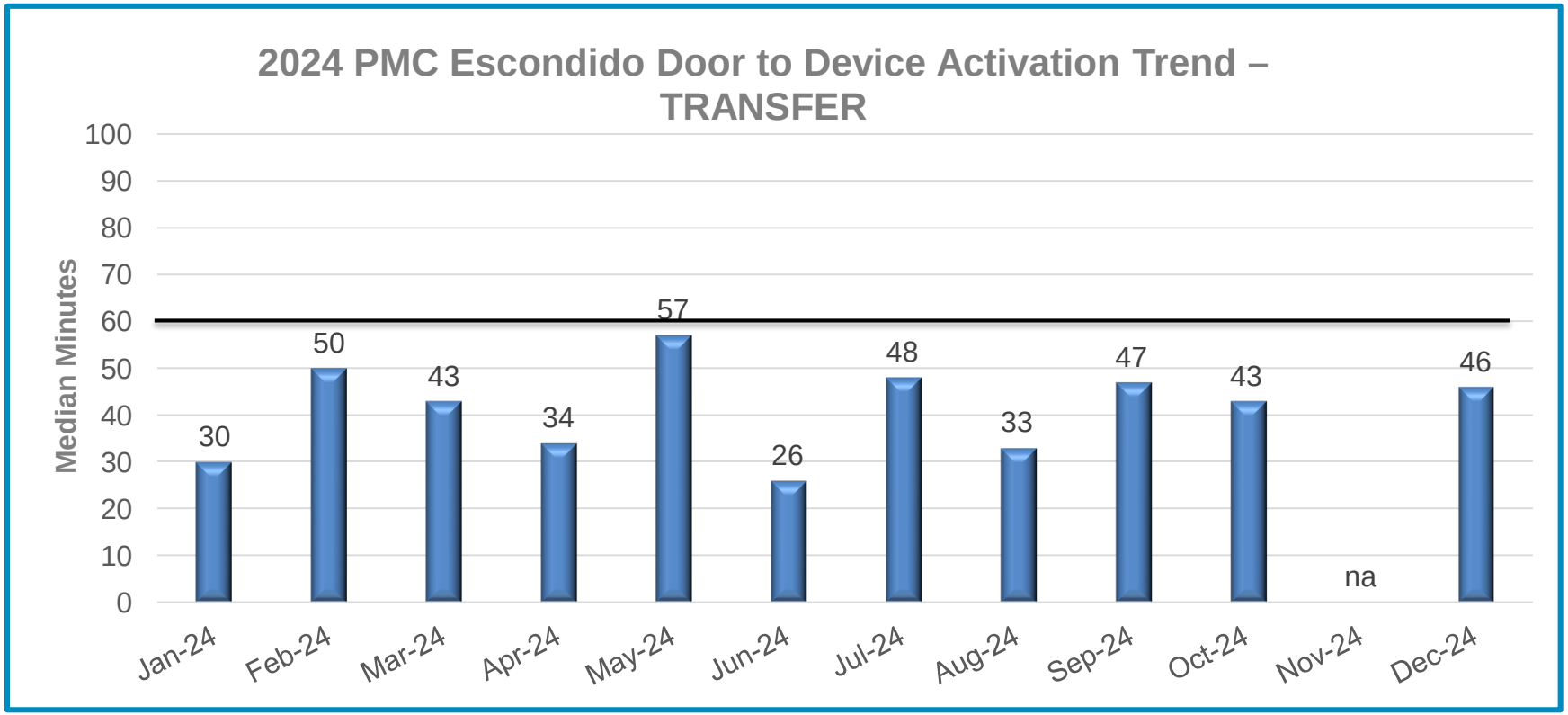
2025 PH Escondido Direct D2DA Median Minutes: 85

Target Phase 3 Goal D2DA ≤ 90 min 50% of the time: ED Cases 13/19 = 68%

IPSC D2DA: 1/4 = 25% Med Minutes: 111.5

Palomar Medical Center Escondido

2024 Door to First Device Activation (D2DA)

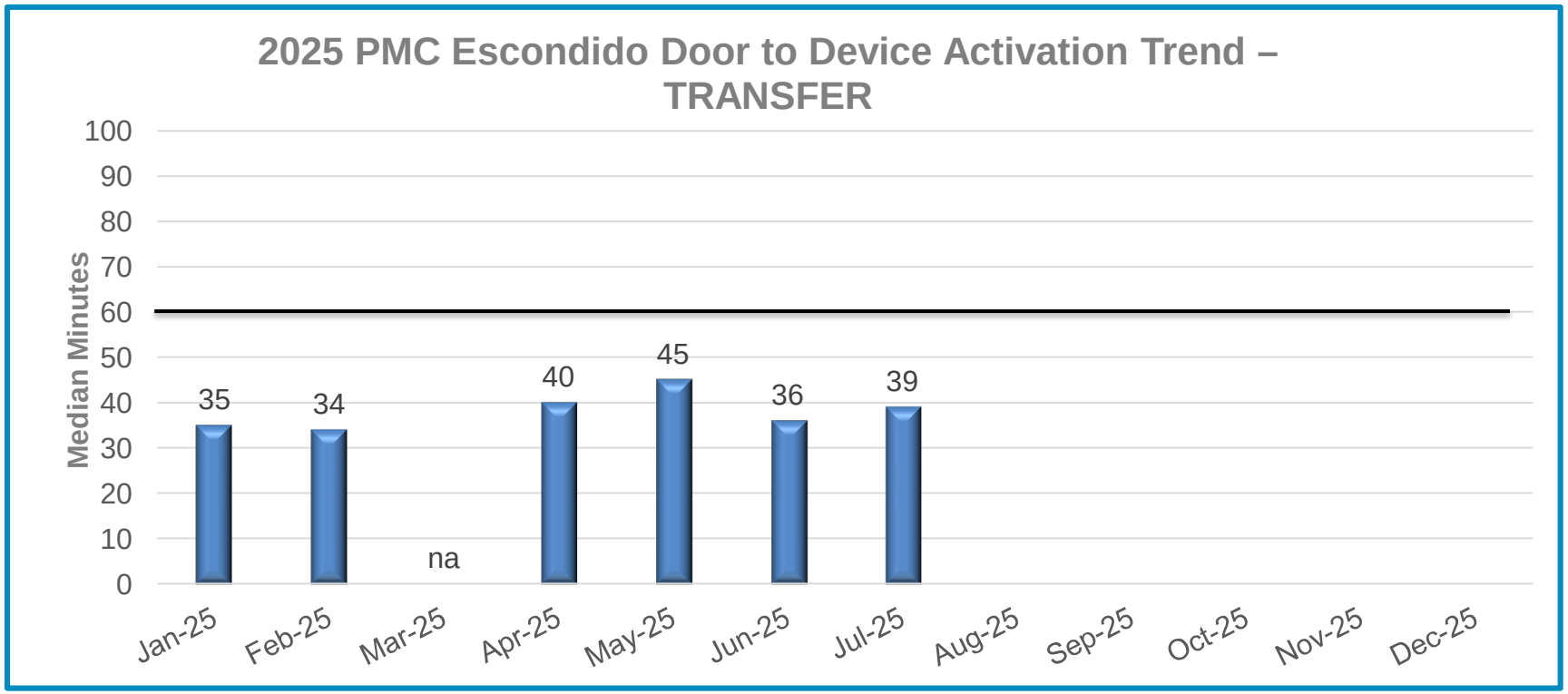


2024 PH Escondido Transfer D2DA Median Minutes: 43

Target Phase 3 Goal D2DA ≤ 60 min 50% of the time: 24/26 = 92%

Palomar Medical Center Escondido

2025 Door to First Device Activation (D2DA)

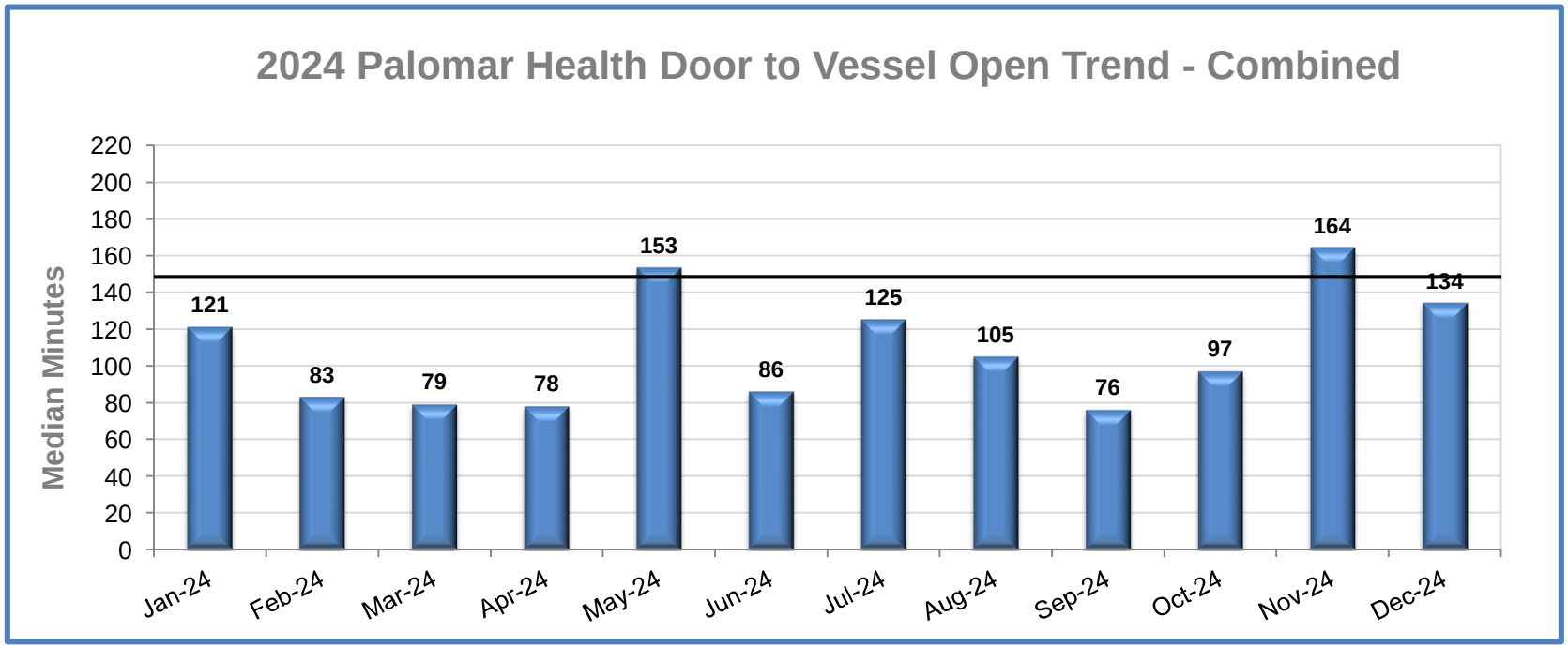


2025 PH Escondido Transfer D2DA Median Minutes: 37.5

Target Phase 3 Goal D2DA ≤ 60 min 50% of the time: 11/11 = 100%

Palomar Medical Center Escondido

2024 Door to Vessel Open (D2VO) - Combined



2024 Palomar Health D2VO (TICI 2b/3) Median Minutes: 108

SVIN* Procedural Metrics Door to Vessel Open (TICI 2b/3) = ≤ 150 min 50% of the time

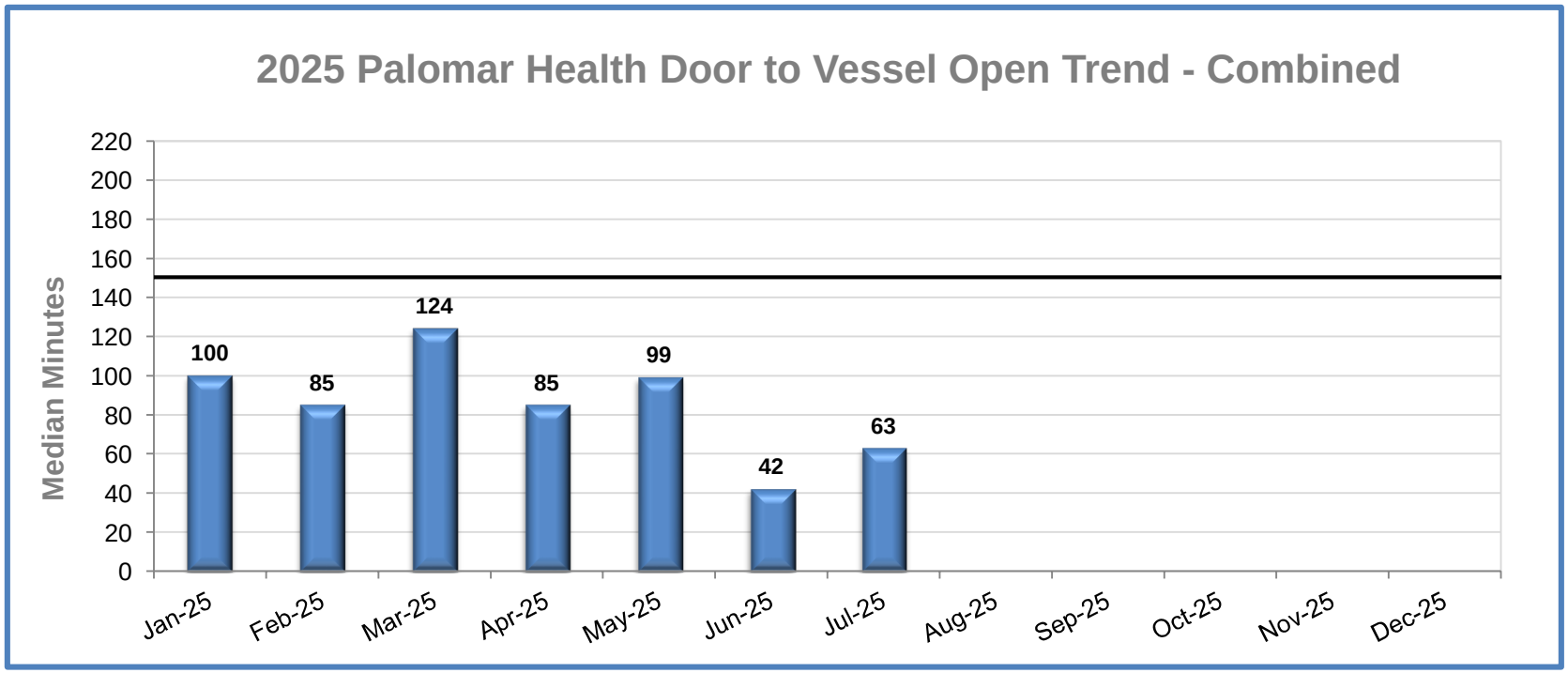
CSTK 11 for CSC Stroke Centers: 62/77 = 80.5%

IPSC: 2/6 = 33% Median Minutes:

*SVIN: Society of Vascular & Interventional Neurology

Palomar Medical Center Escondido

2025 Door to Vessel Open (D2VO) - Combined



2025 Palomar Health D2VO (TICI 2b/3) Median Minutes: 85

SVIN* Procedural Metrics Door to Vessel Open (TICI 2b/3) = ≤ 150 min 50% of the time

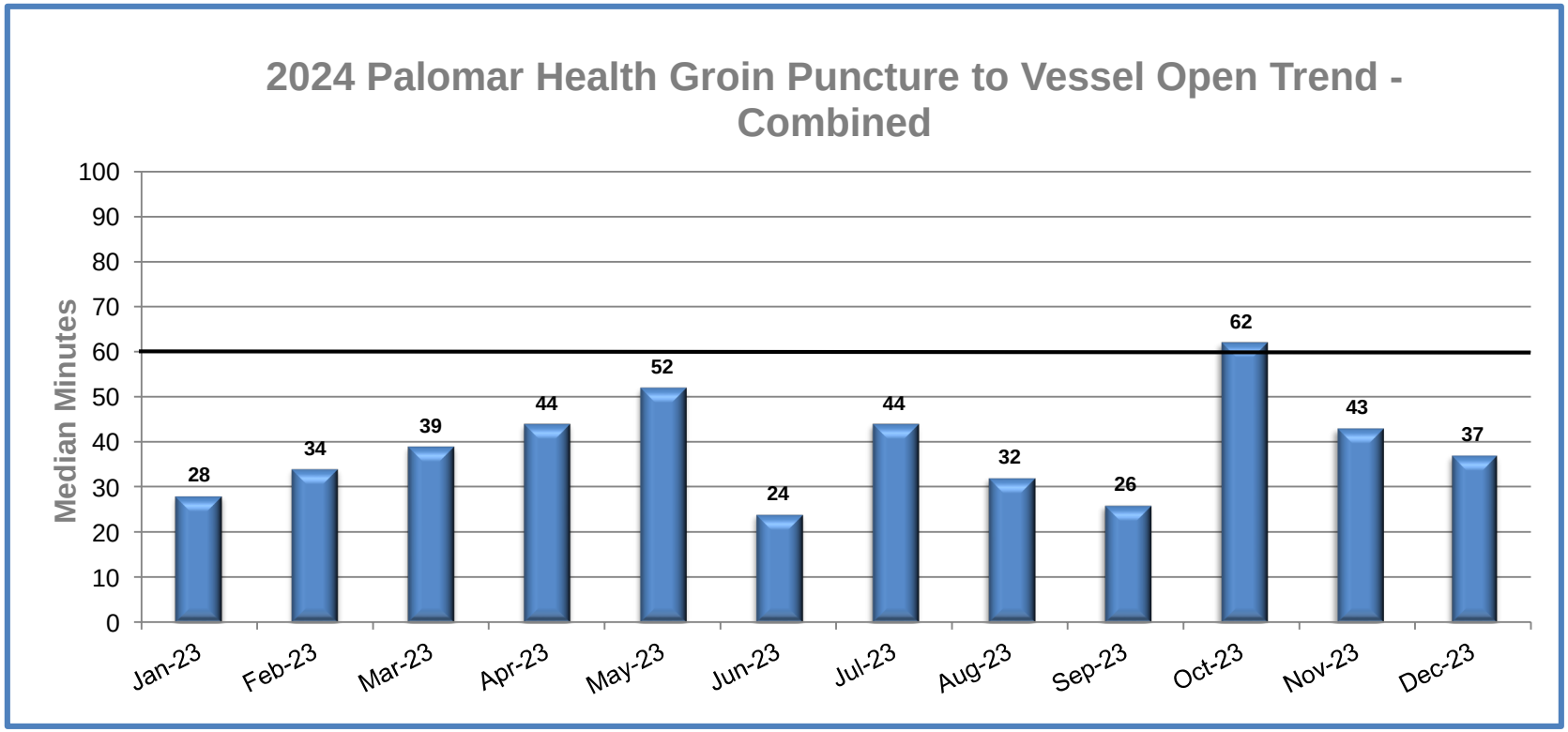
CSTK 11 for CSC Stroke Centers: 27/30 = **90%**

IPSC: 2/4 = **50%** Median Minutes: **147**

*SVIN: Society of Vascular & Interventional Neurology

Palomar Medical Center Escondido

2024 Groin Puncture to Vessel Open (GP2VO) - Combined



2024 Palomar Health GP2VO (TICI 2b/3) Median Minutes: 38

SVIN* Procedural Metrics Groin Puncture to Vessel Open (TICI 2b/3) = ≤ 60 min 50% of the time

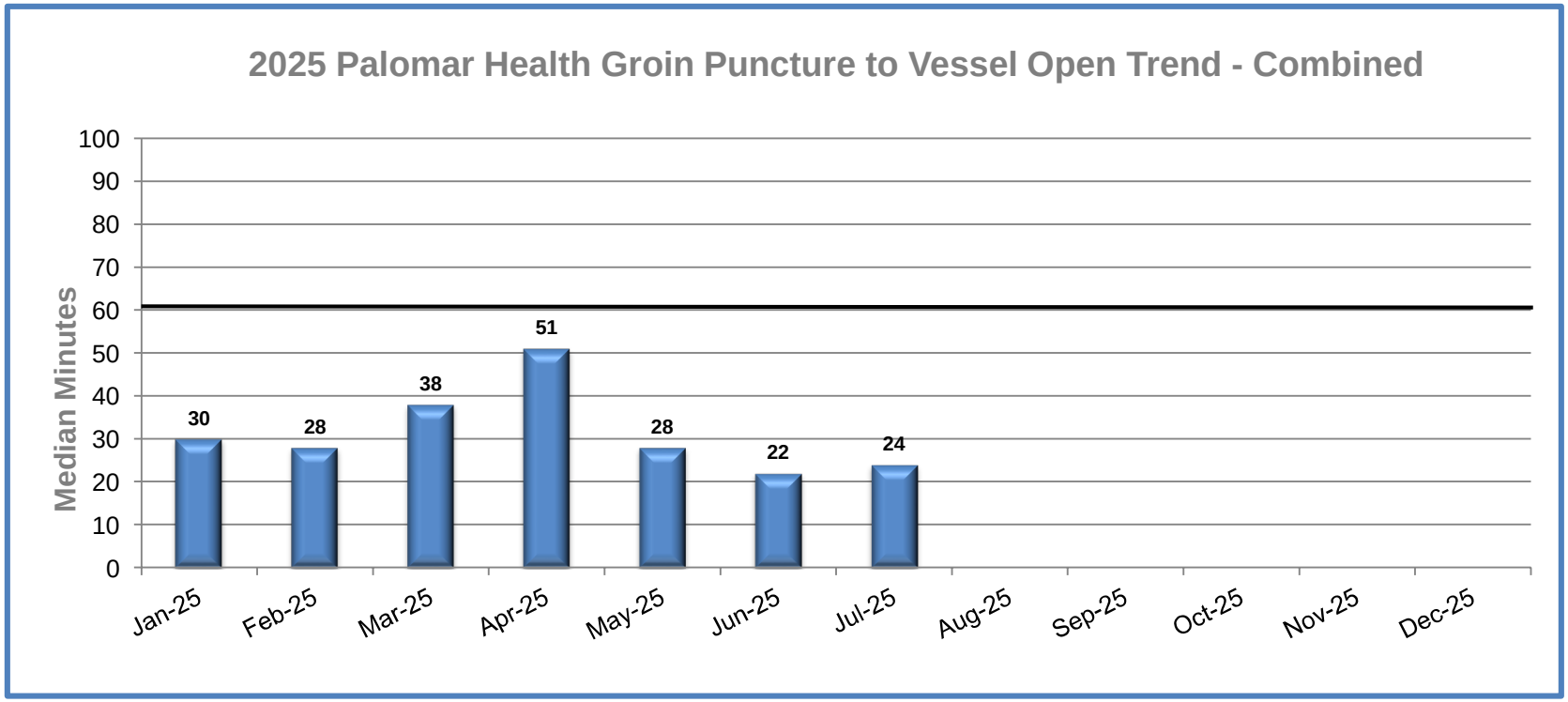
CSTK 12 for CSC Stroke Centers: 61/77 = 79%

IPSC: 4/6 = 67% Median Minute:

*SVIN: Society of Vascular & Interventional Neurology

Palomar Medical Center Escondido

2025 Groin Puncture to Vessel Open (GP2VO) - Combined



2025 Palomar Health GP2VO (TICI 2b/3) Median Minutes: 28

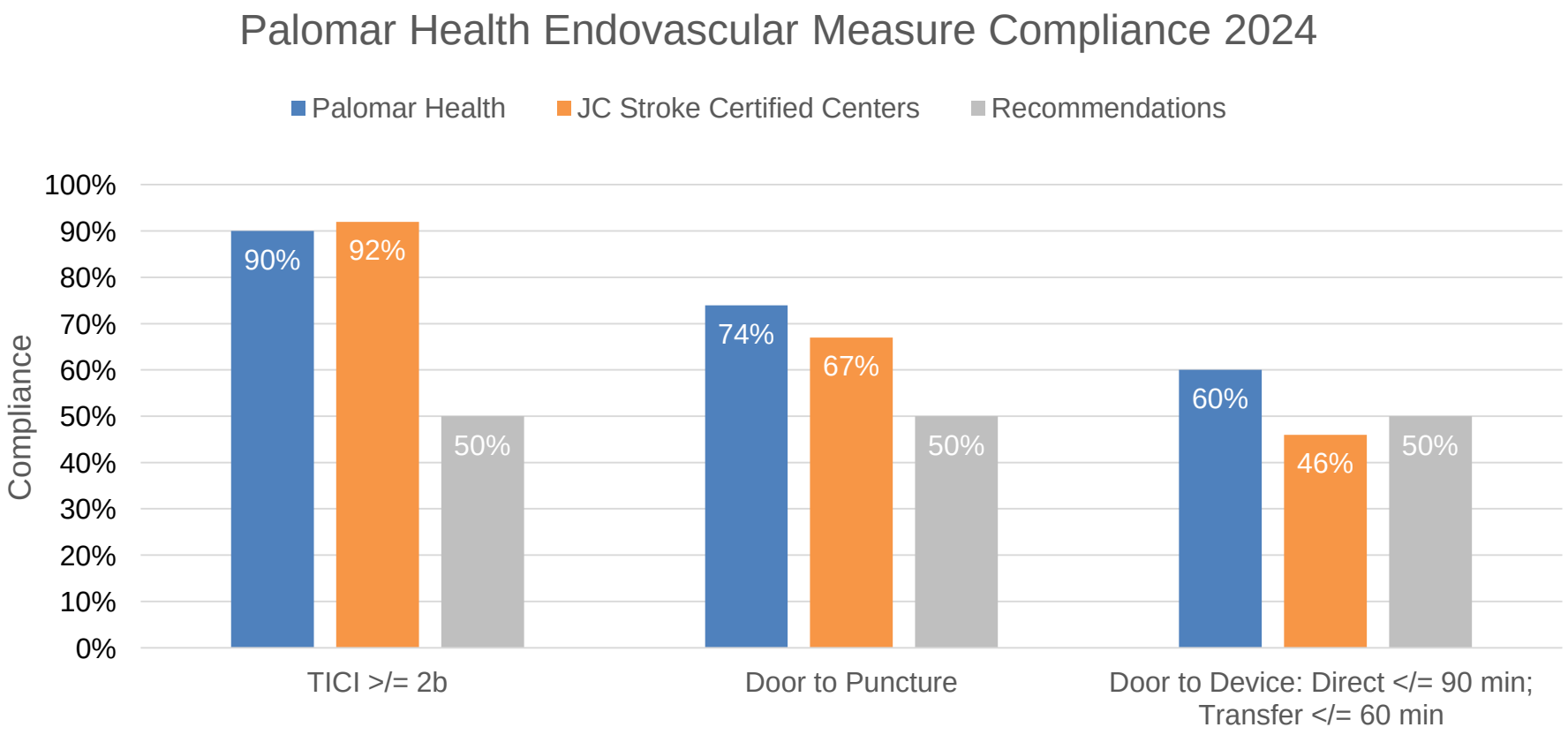
SVIN* Procedural Metrics Groin Puncture to Vessel Open (TICI 2b/3) = ≤ 60 min 50% of the time -

CSTK 12 for CSC Stroke Centers: 29/30 = **97%**

IPSC: 2/4 = **50%** Median Minute: 65.5

*SVIN: Society of Vascular & Interventional Neurology

ENDOVASCULAR MEASURE COMPLIANCE



Recommendation Source:
a. TICI: Society of Vascular and Interventional Neurology
b. Door to Puncture: Joint Commission
c. Door to Device: AHA Target Measures

Quality Management Committee ISBARR Executive Summary

PALOMAR HEALTH

Topic/Project: Behavioral Health Annual Report, October 2025

Submitted By: Don Myers, District Director Behavioral Health

Introduction	Palomar Health and Joint Venture Partner, Lifepoint, hosted a ceremonial groundbreaking of the 120 bed Palomar Health Behavioral Health Institute situated on the south end of the Palomar Health Medical Center Escondido Campus on September 12, 2024. This State-of-the-Art Behavioral Health Facility is a 2 story, 84,700 square foot facility that will offer adolescent, adult and geriatric inpatient and outpatient behavioral health programming. It will also provide Help for Heroes program for active duty and retired military personnel, veterans, first responders and healthcare workers for the first time ever on the West Coast. Palomar Health has completed construction site testing and preparation and is working to secure funding to begin construction to be completed in 2027.
Situation	Palomar Health opted out of the Voluntary LPS Designation in July 2024 as part of a reallocation of resources to support the development of the Palomar Health Behavioral Health Institute. Palomar Health continues to operate Emergency Psychiatric Consultation Services at both Palomar Medical Center Escondido and Poway, as well as, 16 chair LPS Designated Crisis Stabilization Unit at Palomar Health Medical Center Escondido campus. It is anticipated that San Diego County Behavioral Health will open a 16 bed Psychiatric Health Facility (inpatient psychiatric unit) on Tri-City Medical Center campus late November 2025.
Background	Palomar Health has a long tradition and commitment to providing access behavioral health services in North County. Palomar Health's strategic plan to develop comprehensive behavioral health services to support the North County behavioral health supports the need for construction of a facility specially designed to deliver high quality, cost effective behavioral health care to the communities we serve.
Assessment	There is sufficient behavioral health demand and need in North County to support the operation and mission of the Palomar Health Behavioral Health Institute. Lifepoint is a well-respected nationally recognized behavioral health provider and proven successful partner with Palomar Health.
Recommendation	Palomar Health will continue to support the Behavioral Health Emergency Services Consult Service and Crisis Stabilization Unit while we work to open the Palomar Health Behavioral Health Institute as part of our mission to heal, comfort and promote health in the communicates we serve.

THE VILLAS AT POWAY

Alicia Lockett, LNHA, MBA
Administrator | August 13, 2025

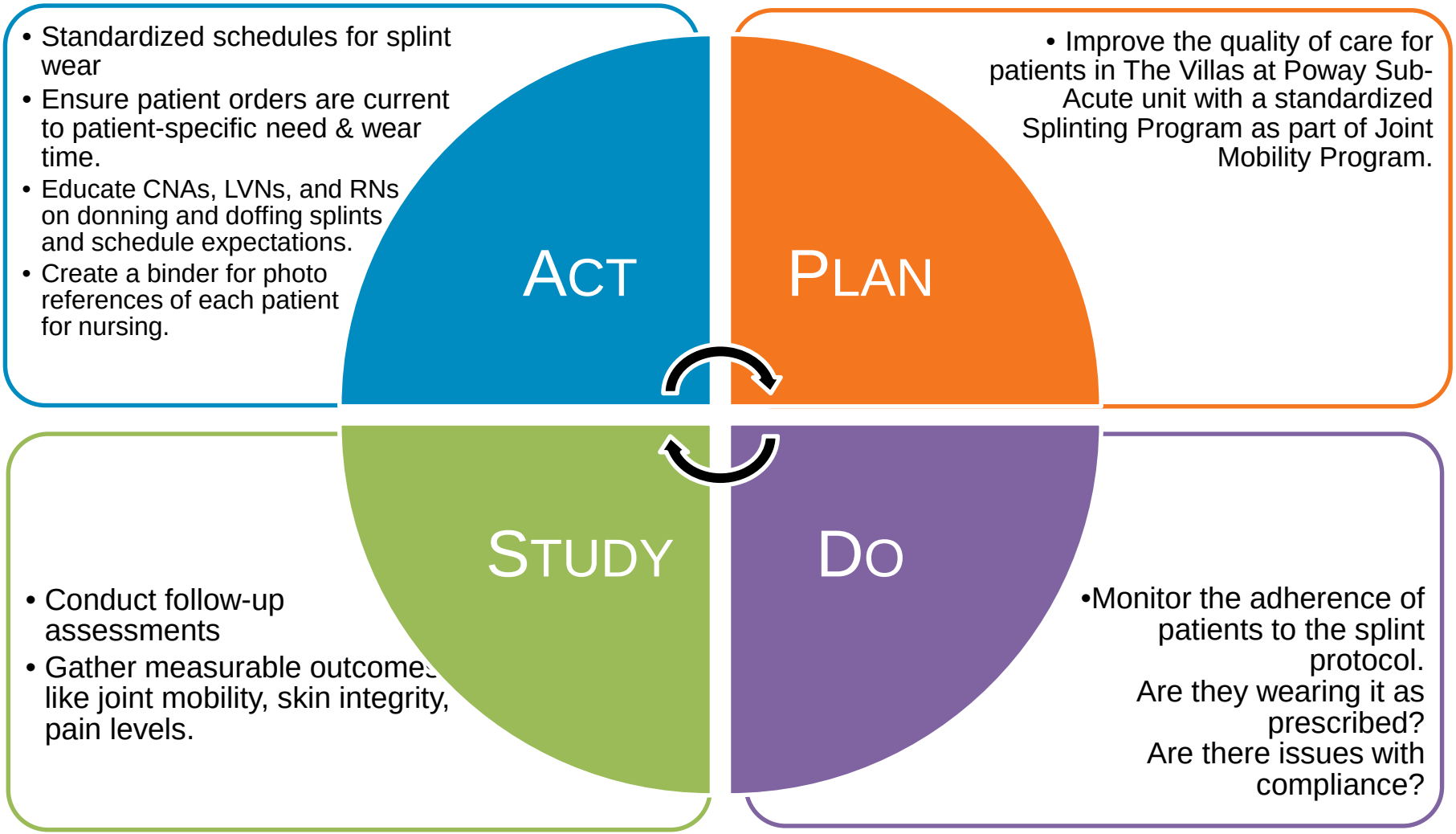
Presented to Quality Management Cttee (QMC)

PALOMAR HEALTH
Reimagining Healthcare

The Villas at Poway

SITUATION	The Villas at Poway quality metrics are designated by state and federal government regulatory bodies. These metrics directly influence publically reported star ratings.
BACKGROUND	The Villas at Poway make up key components of Palomar Health's post acute continuum, supporting patient throughput from acute care.
ASSESSMENT	The post acute arena provides the patient and their family with a variety of care levels after their discharge from the hospital. Their quality metrics reflect their role in that transition. Post acute levels of care nationally have established metrics to transition into value based purchasing.
RECOMMENDATION	Palomar Health's Skilled Nursing facility is continually evolving their practices to meet and exceed national benchmarks while supporting patient care transitions within our communities.

Sub-Acute Splinting QIP



Data Slide – The Villas at Poway

- CMS Quality Measures

	Palomar Health	National Benchmark
Hospital Readmission	**13%**	**23.5%**
Antipsychotic Medication Use	**8%**	**14.6%**
Star Rating	**4**	**>/=3 star**
Falls with Major Injury	**1.1%**	**3.3%**

FY26 Quality Action Plan –The Villas at Poway

- Monthly meetings addressing quality metrics emphasizing
  1. Antipsychotic medication utilization
  2. Return to the Community/Readmission Rate
  3. Fall Prevention
  4. Infection Prevention
- Ongoing adherence with COVID-19 data submission
- Aligned day to day operations as dictated by The Centers for Medicare/Medicaid Services (CMS), Title 22, All Facilities Letter (AFL), and local state regulations to remain survey ready.

PALOMAR HEALTH

FANS & Clinical Nutrition QAPI

Presented to QMC

Nicole Hite, MS, RDN- Director of FANS
Carrie Johnsen, MPH, RDN- Clinical Nutrition Manager
October 2025

FANS Test Trays

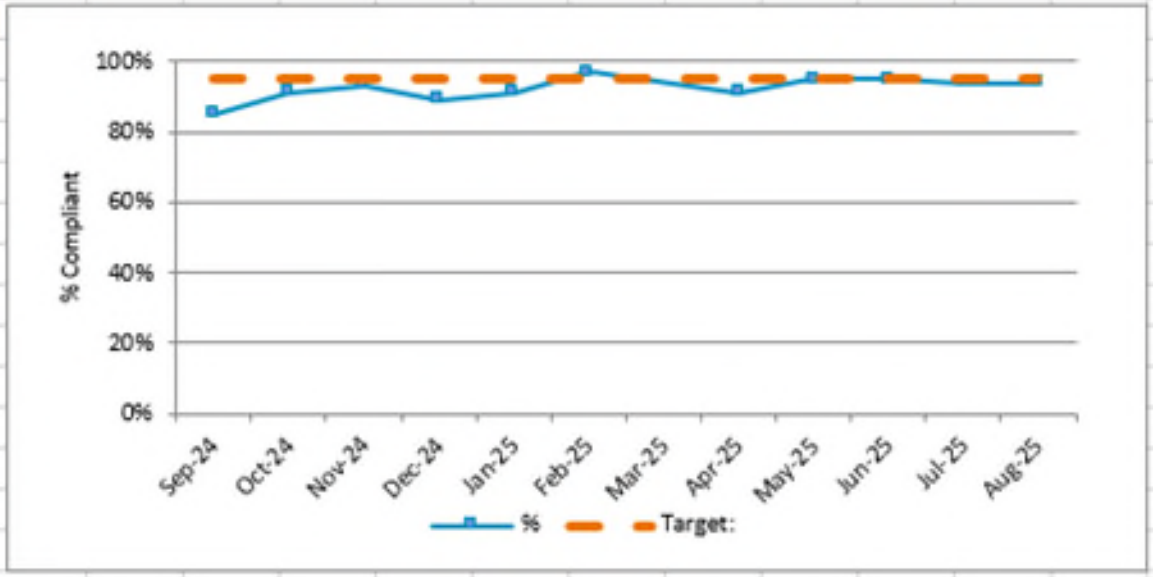
SITUATION	Random test tray audits are utilized to monitor the temperature, freshness, and accuracy for the patient food items, portion size, and flavor.
BACKGROUND	Test trays previously completed indicated a drill down was needed on accuracy and temperatures. Temperatures are monitored for food safety and palatability. Tray accuracy, portion size, and flavor are monitored for diet specific needs.
ASSESSMENT	PMCE overall score for accuracy over the last 12 months is 96%, meeting the target, and temperature is 92%, a 1% improvement from the previous six months. A new patient menu debuted in July 2025 which caused production and tray building time to slow, thus decreasing tray temperatures. PMCP overall score for accuracy over the last 12 months is 95%, meeting the target, and temperature is 94%, a 1% decrease over the previous 6 months. The decline in temperature scores is largely attributed to the new patient menu, as scores decreased significantly in July and August. Cold items on patient trays is the area with the most opportunity for improvement.
RECOMMENDATION	The target for tray accuracy can be discontinued. The new focus will be on the transition from National Dysphagia Diets to IDDSI Diet textures and accuracy of food preparation. Continue to monitor tray temperatures until consistency can be maintained for next 6 months. Supervisors have been retrained on proper meal timing and are expected to maintain tray timing delivery standards. Monitor staff's appropriate usage of cool check bins when delivering cold items on patient trays.

Test Tray Temperatures- Escondido

PMC Escondido

Plan				Do - Measurement	
Indicator				Numerator (Successes)	percentage of test trays at proper temperature & appearance
Patient trays maintain temperature, and are appropriate in appearance.				Denominator (Total)	100
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Nathanial Kozma

	Summary		
	Num	Den	%
September-24	85	100	85%
October-24	91	100	91%
November-24	93	100	93%
December-24	89	100	89%
January-25	91	100	91%
February-25	97	100	97%
March-25	92	100	92%
April-25	91	100	91%
May-25	95	100	95%
June-25	95	100	95%
July-25	94	100	94%
August-25	94	100	94%

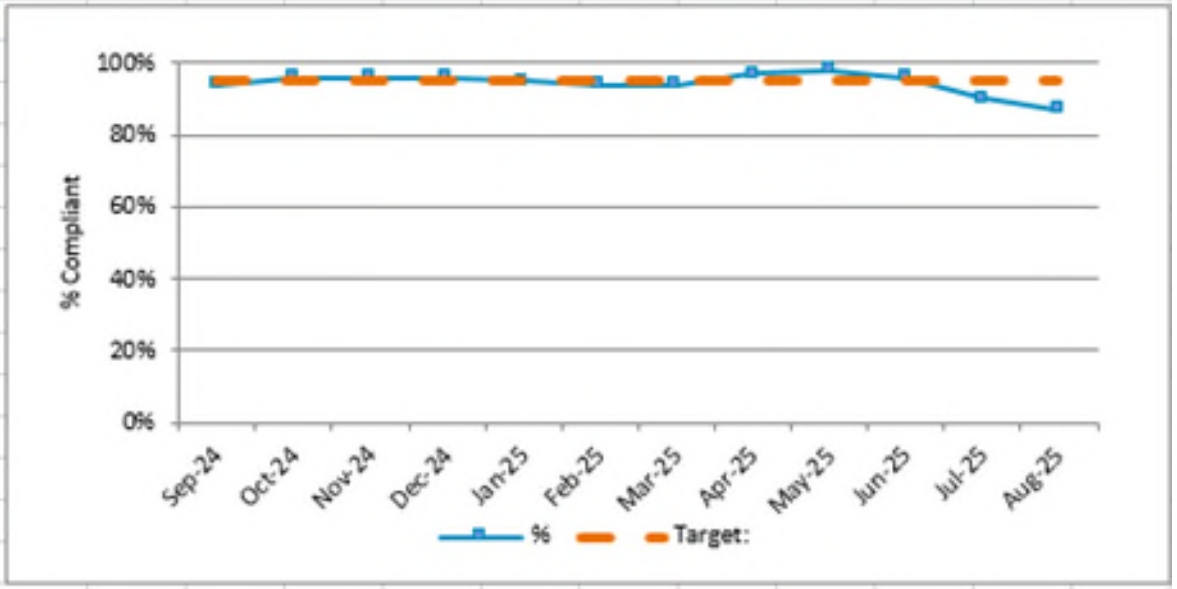


Test Tray Temperatures- Poway

PMC Poway

Plan				Do - Measurement	
Indicator				Numerator (Successes)	percentage of test trays at proper temperature & appearance
Patient trays maintain temperature, and are appropriate in appearance.				Denominator (Total)	100
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Megan Melendrez

	Summary		
	Num	Den	%
September-24	94	100	94%
October-24	96	100	96%
November-24	96	100	96%
December-24	96	100	96%
January-25	95	100	95%
February-25	94	100	94%
March-25	94	100	94%
April-25	97	100	97%
May-25	98	100	98%
June-25	96	100	96%
July-25	90	100	90%
August-25	87	100	87%

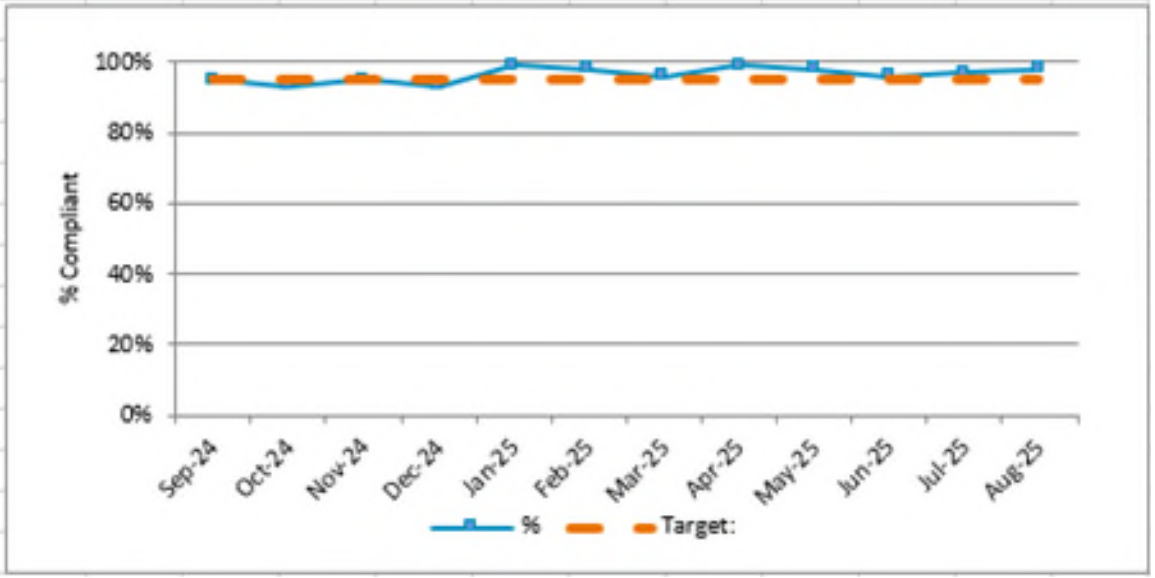


Tray Accuracy- Escondido

PMC Escondido

Plan				Do - Measurement	
Indicator				Numerator (Successes)	percentage of accurate test trays
Patient trays accuratley reflect diet order, allergies and preferences/requests.				Denominator (Total)	100
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Nathanial Kozma

	Summary		
	Num	Den	%
September-24	95	100	95%
October-24	93	100	93%
November-24	95	100	95%
December-24	93	100	93%
January-25	99	100	99%
February-25	98	100	98%
March-25	96	100	96%
April-25	99	100	99%
May-25	98	100	98%
June-25	96	100	96%
July-25	97	100	97%
August-25	98	100	98%

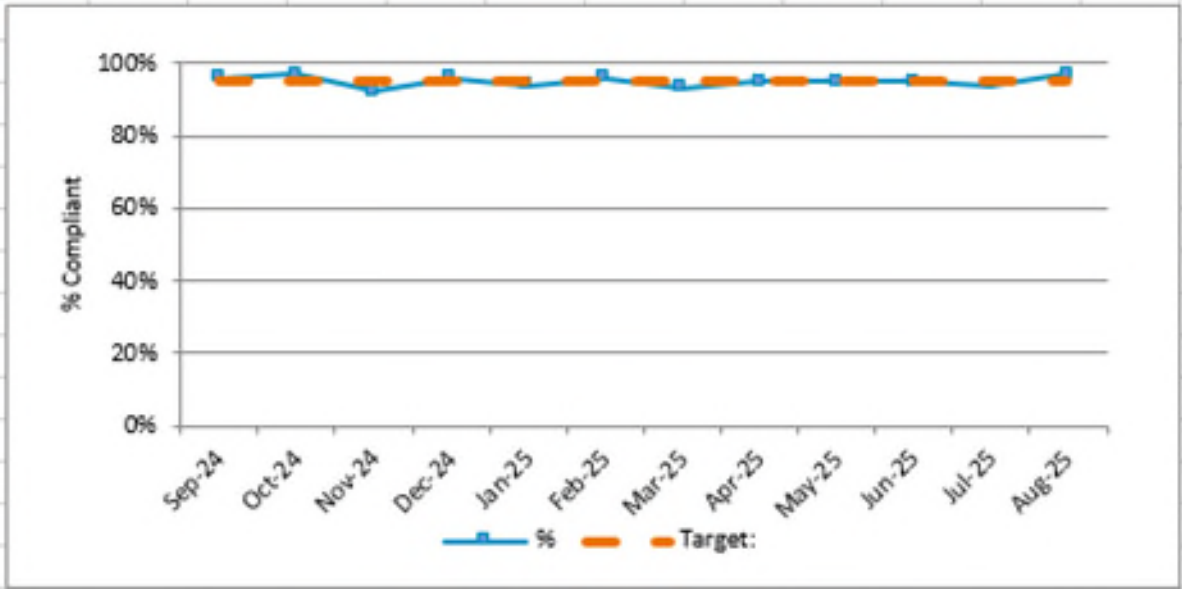


Tray Accuracy- Poway

PMC Poway

Plan				Do - Measurement	
Indicator				Numerator (Successes)	percentage of accurate test trays
Patient trays accuratley reflect diet order, allergies and preferences/requests.				Denominator (Total)	100
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Megan Melendrez

	Summary		
	Num	Den	%
September-24	96	100	96%
October-24	97	100	97%
November-24	92	100	92%
December-24	96	100	96%
January-25	94	100	94%
February-25	96	100	96%
March-25	93	100	93%
April-25	95	100	95%
May-25	95	100	95%
June-25	95	100	95%
July-25	94	100	94%
August-25	97	100	97%



FANS Labeling and Dating

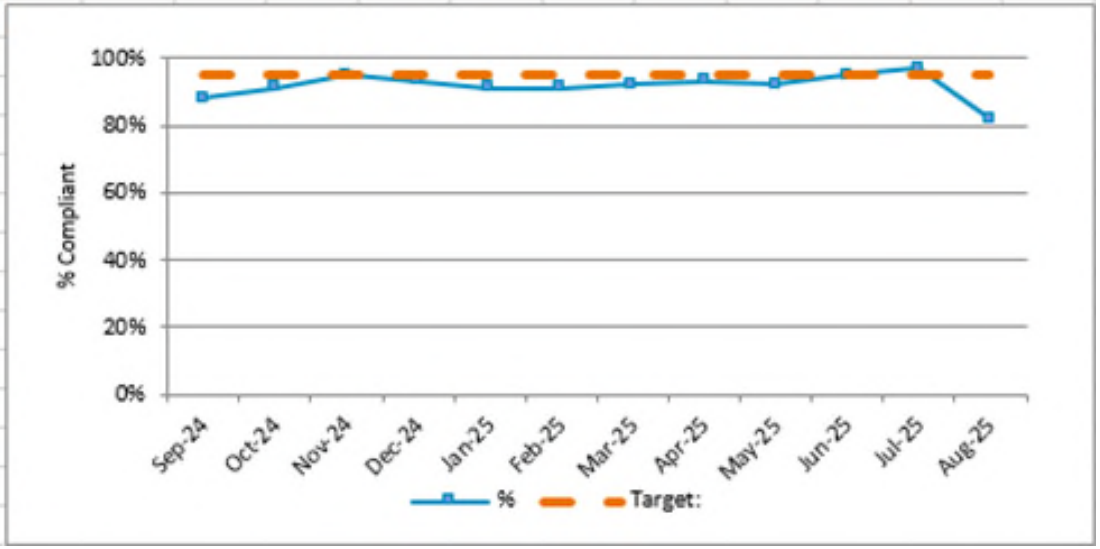
SITUATION	FANS is currently monitoring label and dating of food items in all storage areas of the kitchen.
BACKGROUND	FANS leadership is conducting labeling and dating audits to drill down on survey findings. Labeling and dating is monitored to ensure food and patient safety.
ASSESSMENT	PMCE overall score for labeling and dating is at 91%, a 1% decrease over the prior 6 months. Scores were trending up from May to July 2025, with a significant decline seen in August 2025.Transition in leadership occurred in mid-August, leading to a temporary decrease in data collection and sample size. PMCP overall score for labeling and dating is 98%, meeting the 95% goal for the previous 12 months.
RECOMMENDATION	New monitoring forms are being developed for PMCE to ensure all areas of the department are thoroughly monitored. New rounding schedules for leadership have also been implemented to ensure data is being captured daily. Continue to monitor labeling and dating accuracy with new data collection tools until consistency can be maintained for next 6 months.

Labeling and Dating- Escondido

PMC Escondido

Plan				Do - Measurement	
Indicator				Numerator (Successes)	percentage of accurate walkthroughs
Labeling and Dating - staff can consistently demonstrate and complete accurate label and dating procedures.				Denominator (Total)	100
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Nathanial Kozma

	Summary		
	Num	Den	%
September-24	88	100	88%
October-24	91	100	91%
November-24	95	100	95%
December-24	93	100	93%
January-25	91	100	91%
February-25	91	100	91%
March-25	92	100	92%
April-25	93	100	93%
May-25	92	100	92%
June-25	95	100	95%
July-25	97	100	97%
August-25	82	100	82%

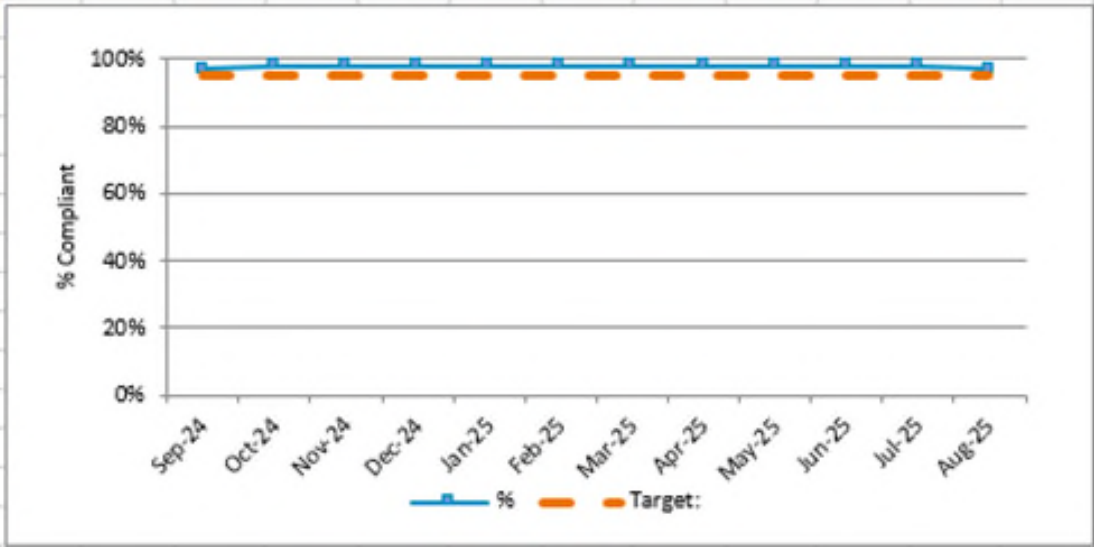


Labeling and Dating- Poway

PMC Poway

Plan				Do - Measurement	
Indicator				Numerator (Successes)	percentage of accurate walkthroughs
Labeling and Dating - staff can consistently demonstrate and complete accurate label and dating procedures.				Denominator (Total)	100
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Megan Melendrez

	Summary		
	Num	Den	%
September-24	97	100	97%
October-24	98	100	98%
November-24	98	100	98%
December-24	98	100	98%
January-25	98	100	98%
February-25	98	100	98%
March-25	98	100	98%
April-25	98	100	98%
May-25	98	100	98%
June-25	98	100	98%
July-25	98	100	98%
August-25	97	100	97%



Food Service - Action Plan

- **Tray Accuracy:** Compliance has consistently been above target of 95%, monitoring can be discontinued. **Requesting to replace this measure with "IDDSI Diet Food Preparation Standards" to begin in January 2026. Need approval.**

- **Tray Temperatures:** Continue to monitor tray temperatures until consistency can be maintained for next 6 months. Supervisors have been retrained on proper meal timing and are expected to maintain tray timing delivery standards. Monitor staff's appropriate usage of cool check bins when delivering cold items on patient trays.

- **Label and Dating:** Continue to monitor labeling and dating accuracy with new data collection tools until consistency can be maintained for next 6 months.New monitoring forms are being developed for PMCE to ensure all areas of the department are thoroughly monitored. New rounding schedules for leadership have also been implemented to ensure data is being captured.

FANS Clinical Nutrition- Pressure Injury

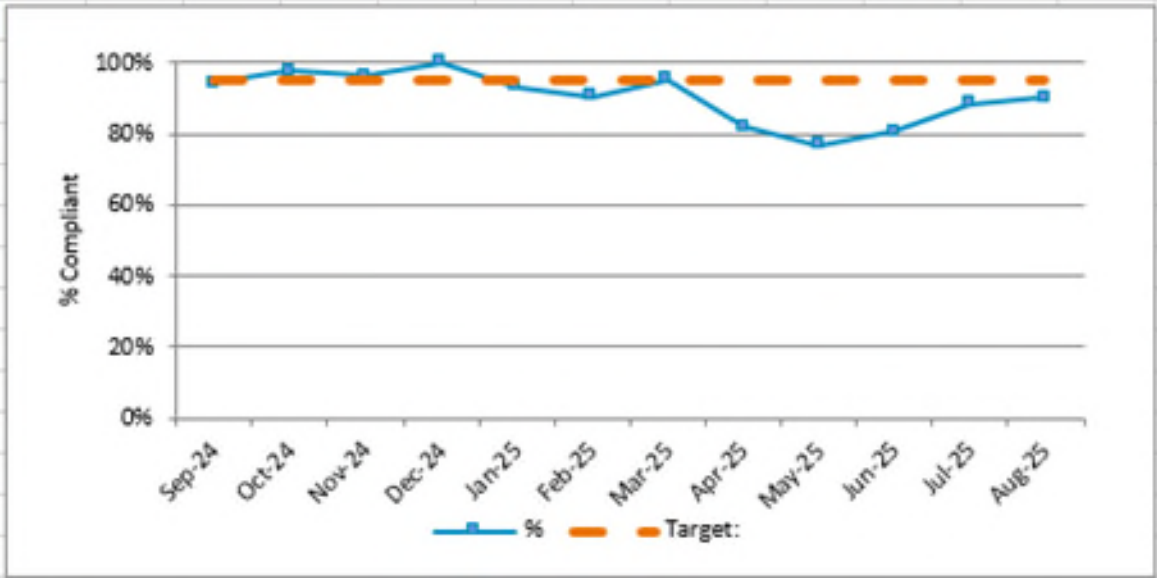
SITUATION	We monitor Registered Dietitian (RD) documentation and RD Pressure Injury documentation compliance for our Clinical Nutrition indicators.
BACKGROUND	Accurate nutrition assessment and intervention by the Registered Dietitian (RD) is critical to successfully optimize patients nutritional needs. We consistently conduct chart audits/peer reviews for each dietitian to ensure appropriate documentation. Pressure Injury documentation and notification has historically been inconsistent, and needed some process improvement.
ASSESSMENT	The processes for notification of Pressure Injury have been working well and RD documentation of Pressure Injury are trending towards goal measures. PMCE has averaged 90% compliance for the last 12 months. A decline in compliance occurred in March 2025, with steady increases being seen fro April 2025-August 2025. Large transitions in Dietitian staffing lead to an increase of new Dietitians who were in training during this period. PMCP has achieved 93% compliance, remaining consistent from prior 6 months. Small samples sizes and difficulties in staffing affect achievement of goal at PMC Poway.
RECOMMENDATION	Maintain current goal achievement for pressure injury documentation until we can show sustained improvement at PMCP for 6 months. Clinical Nutrition Specialist to continue education on Pressure Injuries for all new Dietitians. Larger wound care QAPI project being developed to encompass current data being collected.

PI Documentation - Escondido

PMC Escondido

Plan				Do - Measurement	
Indicator				Numerator (Successes)	Charts with Appropriate PI Intervention by RD
Pressure Injury Documentation				Denominator (Total)	Charts Audited
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Carrie Johnsen

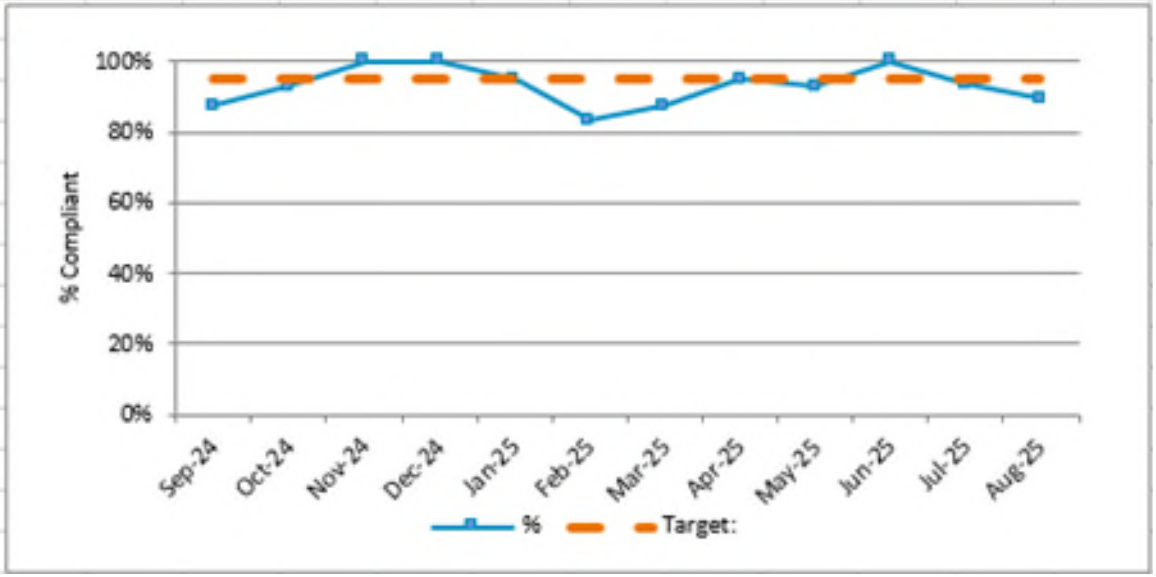
	Summary		
	Num	Den	%
September-24	16	17	94%
October-24	40	41	98%
November-24	26	27	96%
December-24	33	33	100%
January-25	41	44	93%
February-25	38	42	90%
March-25	39	41	95%
April-25	27	33	82%
May-25	30	39	77%
June-25	33	41	80%
July-25	23	26	88%
August-25	37	41	90%



PI Documentation - Poway

PMC Poway					
Plan				**Do - Measurement**	
Indicator				Numerator (Successes)	Charts with Appropriate PI Intervention by RD
Pressure Injury Documentation				Denominator (Total)	Charts Audited
Start Date:	1/1/2022	Target:	95%	Responsible Leader:	Carrie Johnsen

	Summary		
	Num	Den	%
September-24	14	16	88%
October-24	13	14	93%
November-24	20	20	100%
December-24	17	17	100%
January-25	18	19	95%
February-25	20	24	83%
March-25	14	16	88%
April-25	18	19	95%
May-25	13	14	93%
June-25	11	11	100%
July-25	14	15	93%
August-25	17	19	89%



Clinical Nutrition- Malnutrition

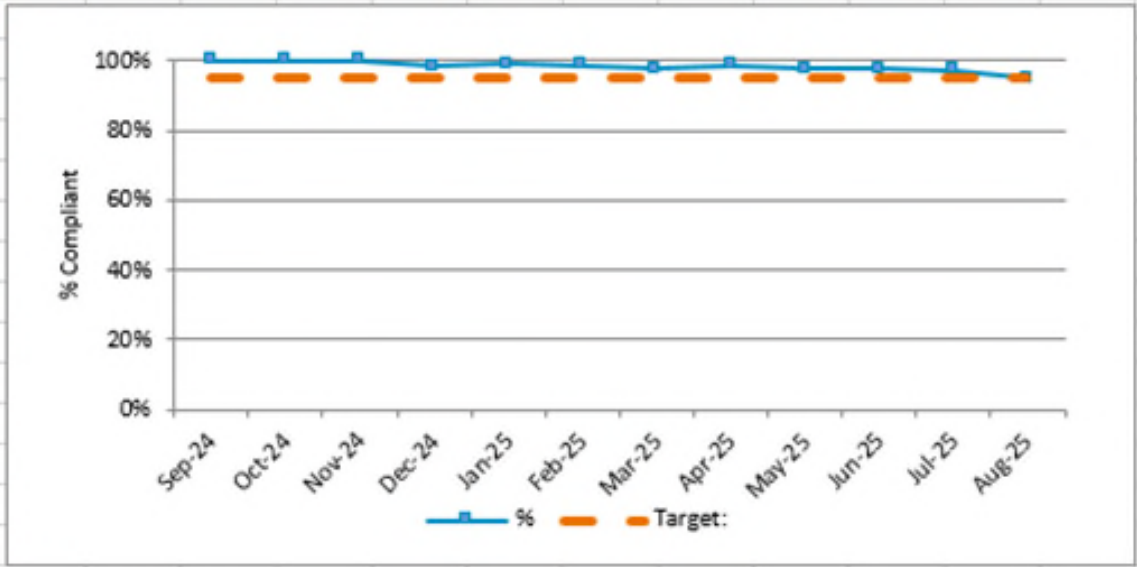
SITUATION	Patients that are malnourished can increase the cost, Length of Stay, overall outcomes, and increased risk for readmission. The clinical Dietitians had not been following a standardized process to identify malnutrition which includes: conducting Nutrition Focused Physical Examinations (NFPE) using appropriate techniques, using appropriate Problem, Etiology and Signs/symptoms (PES) statements in documentation and providing appropriate interventions.
BACKGROUND	Evidence has shown that identifying patients with malnutrition in a timely manner and providing appropriate interventions will drastically reduce costs, LOS, overall outcomes and risk of re-admissions.
ASSESSMENT	A malnutrition process was identified and implemented for the clinical nutrition department starting January 2023 to include a comprehensive training on NFPEs, malnutrition and a guideline for providing interventions. PMCE averaged 98% compliance over the last 12 months, achieving the 95% compliance target. PMCP averaged 95% compliance for the last 12 months, also achieving the 95% compliance target.
RECOMMENDATION	RDs have met target for RD documentation and monitoring can be discontinued. The new focus will be on the Physician Documentation of Malnutrition after Dietitian Malnutrition Assessment.

Malnutrition Documentation- Escondido

PMC Escondido

Plan				Do - Measurement	
Indicator				Numerator (Successes)	Charts with Appropriate Malnutrition Documentaiton by RD
Malnutrition Documentation				Denominator (Total)	Charts Audited
Start Date:	1/1/2023	Target:	95%	Responsible Leader:	Carrie Johnsen

	Summary		
	Num	Den	%
September-24	88	88	100%
October-24	81	81	100%
November-24	104	104	100%
December-24	122	124	98%
January-25	95	96	99%
February-25	75	76	99%
March-25	84	86	98%
April-25	75	76	99%
May-25	84	86	98%
June-25	116	119	97%
July-25	107	110	97%
August-25	111	117	95%



Malnutrition Documentation- Poway

PMC Poway

Plan				Do - Measurement	
Indicator				Numerator (Successes)	Charts with Appropriate Malnutrition Documentaiton by RD
Malnutrition Documentation				Denominator (Total)	Charts Audited
Start Date:	1/1/2023	Target:	95%	Responsible Leader:	Carrie Johnsen

	Summary		
	Num	Den	%
September-24	20	20	100%
October-24	8	9	89%
November-24	13	13	100%
December-24	13	13	100%
January-25	26	26	100%
February-25	22	24	92%
March-25	14	15	93%
April-25	14	16	88%
May-25	18	18	100%
June-25	18	18	100%
July-25	11	14	79%
August-25	14	14	100%

Clinical Nutrition - Action Plan

- PI Documentation: Maintain current goal achievement for pressure injury documentation until we can show sustained improvement at PMCP for 6 months. Clinical Nutrition Specialist to create a training template for all new Dietitians. Larger wound care QAPI project being developed to encompass current data being collected.

- Malnutrition: Compliance has consistently been above target of 95%, monitoring can be discontinued. **Requesting to replace this measure with "Physician Documentation of Malnutrition after Dietitian Malnutrition Assessment." to begin in January 2026. Need approval.**

Quality Management Committee ISBARR Executive Summary

PALOMAR HEALTH

Topic/Project: Hand Hygiene Quarter Report

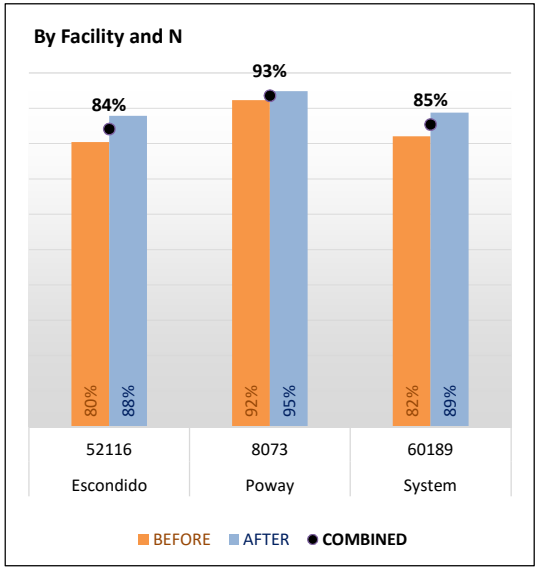
Submitted By: Valerie Martinez RN, BSN, MHA, CIC, CPHQ, CPPS

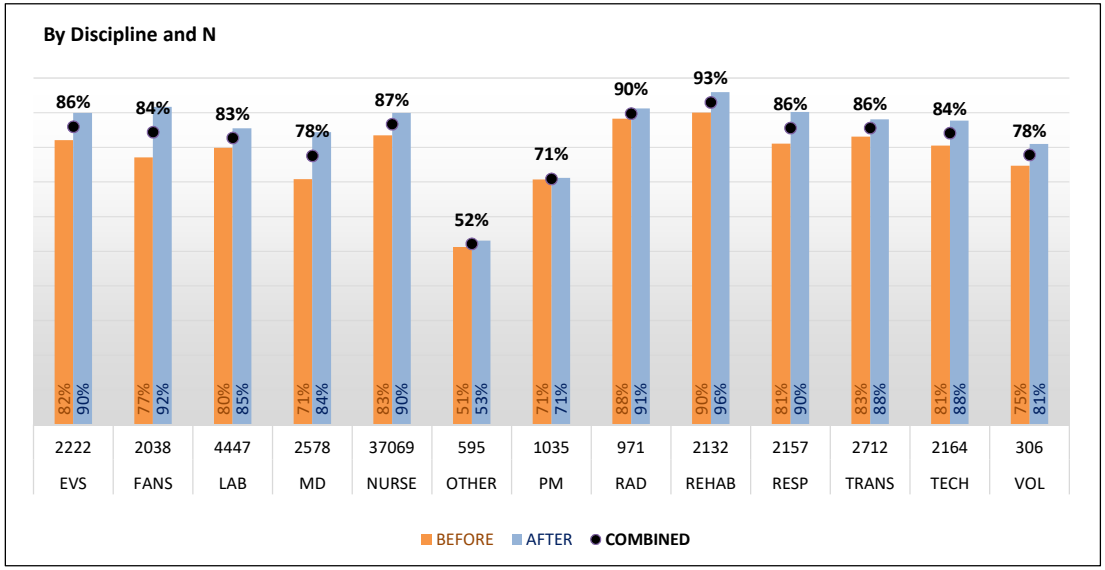
Introduction	Hand hygiene is the most effective way to prevent the spread of infection.
Situation	In alignment with The Joint Commission National Patient Safety Goal and standards, our mission in reducing risks for hospital-associated infections, and efforts to improve compliance at the unit level, a **2025 system goal is to improve the mean compliance of hand hygiene to 88% by the end of the year**.
Background	The Joint Commission's National Patient Safety Goal (NPSG) 07.01.01 is to reduce the risk of health care-associated infections (HAIs) by improving hand hygiene. This goal applies to organizations that provide physical care and requires compliance with the hand hygiene guidelines of either the Centers for Disease Control and Prevention (CDC) or the World Health Organization (WHO). Hand hygiene compliance is measured through direct observation and supported by a robust training program of modified duty personnel.
Assessment	The August year-to-date Palomar Health Hand Hygiene Compliance rate by facility, discipline, shift, and unit attached. **Since the 2024 System compliance rate (84%), there has been a 1% increase in hand hygiene**. In the last 3 months, the following units and disciplines were identified to have lower rates and tasked to work on unit-based interventions to improve, evaluate, and present to IPCC. • Escondido ED Nursing & Techs • 4E Nurses • 6E Nurses • 7W Nurses • MST4 Nurses • 9E Nurses • Escondido Pathmakers
Recommendation	Continue to focus on improving low-performing units and disciplines, with large samples, through unit-based interventions and support from infection prevention and the organization.

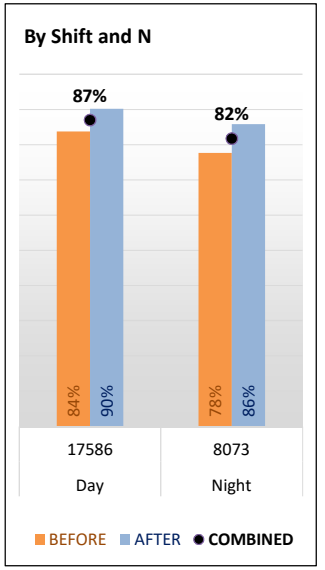
Hand Hygiene Compliance Rate | January to August 2025

PALOMAR HEALTH

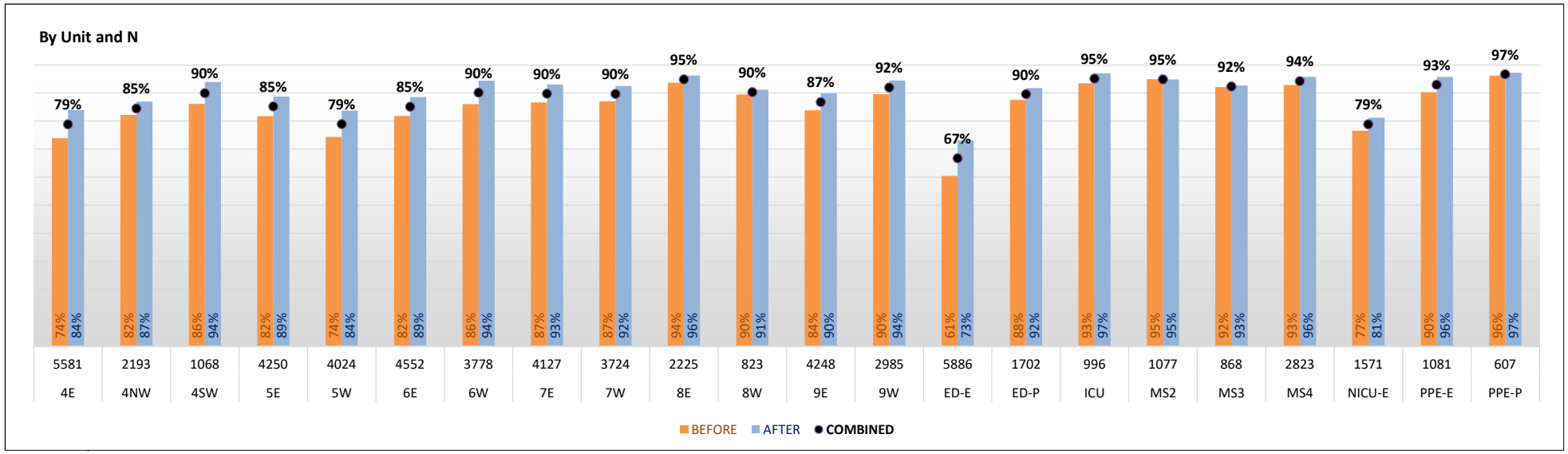
Total Observations (BEFORE and AFTER patient contact): 60,189







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



Portioning or discarding "excess" sanitizer dispensed from wall units is a noncompliant performance of hand hygiene
If you have any questions or would like to request unit-based data, please contact Infection Control at 881-5431
Previous quarter data and data collection methods can be found on the Palomar Health Intranet on the Infection Control page

PALOMAR HEALTH

Management of Medical Record Dept.

Semi-Annual Report to Quality Management Cttee

Carla Hacker
August 26, 2025

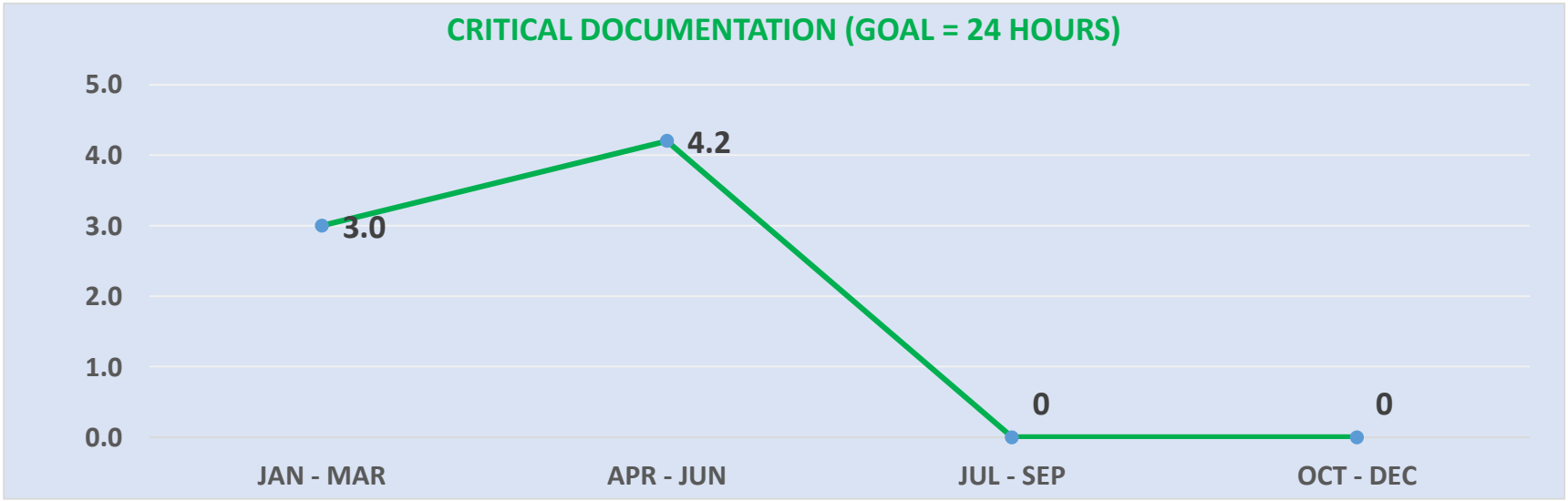
Palomar Health Medical Records

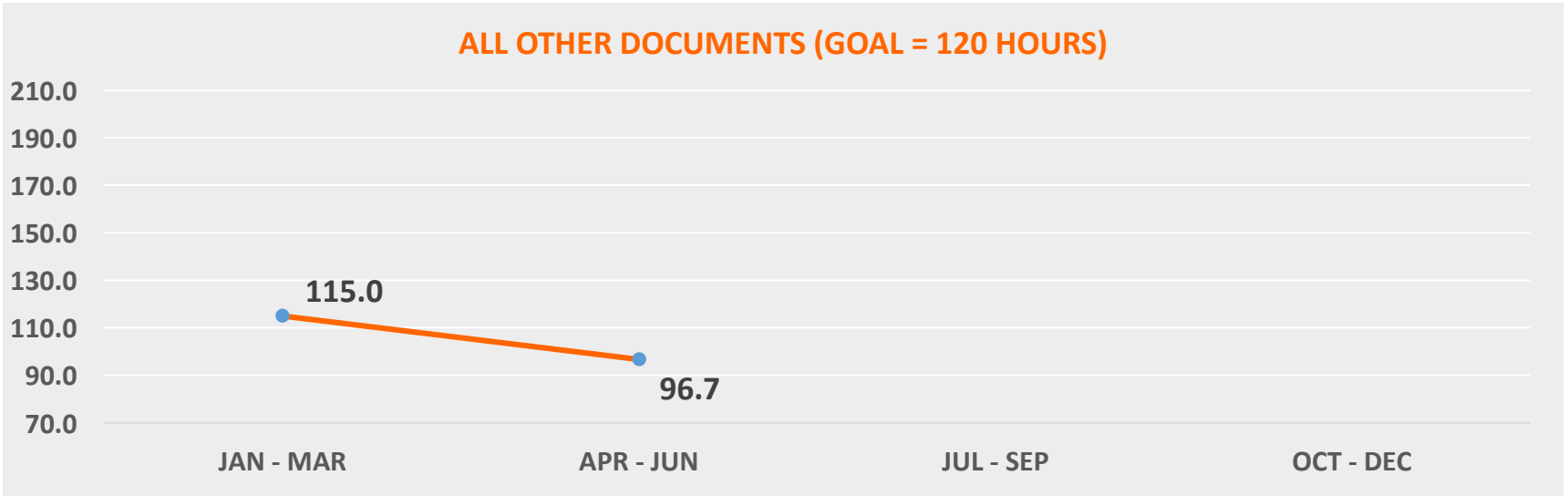
SITUATION	**PMC Escondido and PMC Poway Bi-Annual Review**
BACKGROUND	**Medical Records: Current Productivity and Operational Status**
ASSESSMENT	The Medical Records Department is currently experiencing fluctuations in productivity turnaround times however, it is important to note that performance in the first two quarters was below benchmark. The implementation of Cerner's Adv. Capt. Document recognition along with comprehensive cross training of staff has provided critical support in sustaining operations. In addition, the recent rollout of Cerner's Clinical e-Signature is expected to significantly reduce paper documentation which will lessen administrative workload and support progress toward achieving our productivity benchmarks.
RECOMMENDATION	1. Strengthen workforce capacity through ongoing training and system optimization in Advanced Capture to stabilize productivity. 2. Drive adoption of the Clinical eSignature project to decrease paper records, streamline processes, and reduce workload, positioning the department to meet performance benchmarks.

MEDICAL RECORDS QMC 2025 DATA REPORTING

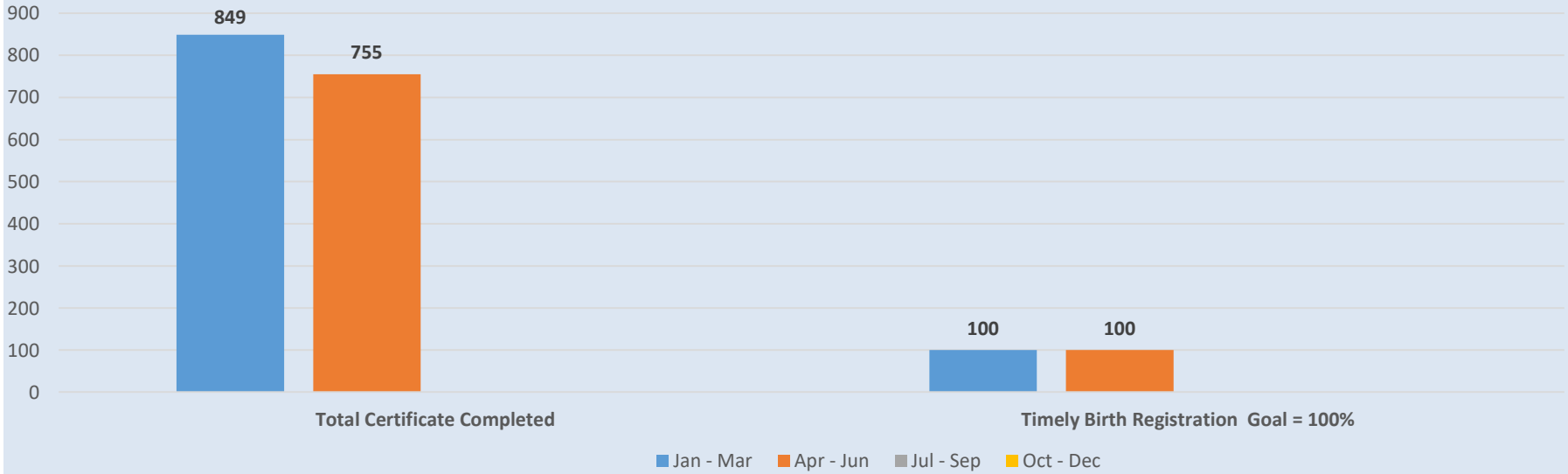
INDICATORS	BENCHMARK	LOCATION	CY 2025 1st Qtr.	CY 2025 2nd Qtr.	CY 2025 3rd Qtr.	CY 2025 4th Qtr.
CPDI SCANNING						
Critical Documentation TAT	24 Hrs.	PMC Escondido	3	4.2	--	--
		PMC Poway	3	4.2	--	--
Non-Critical Docs TAT	120 Hrs.	PMC Escondido	115 hrs.	75.6 hrs.	--	--
		PMC Poway	96.7 hrs.	76.8 hrs.	--	--
REPORT OF DELINQUENT RECORDS						
Delinquency Rate	≤ 50 %	PMC Escondido			--	--
		PMC Poway			--	--
BIRTH CERTIFICATES						
Timely Birth Registration	100 % Within 21 Days	PMC Escondido	100 %	100 %	--	--
OTHER DOCUMENTATION REVIEW						
Transcribed Reports TAT Turn Around Time (TAT)	90 %	PMC Escondido & PMC Poway	99%	97%	--	--
Percentage of Reports Done in DynDoc vs. Dictation	80 %	PMC Escondido PMC Poway	96%	96%	--	--
OTHER QUALITY REVIEW						
AQuity Outside Transcription Accuracy	97 %	PMC Escondido	98%	99%	--	--
AQuity Outside Transcription Accuracy	97%	PMC Poway	99%	99%		
Release of Information					--	--
Patient Access Requests Continuity of Care Requests	≤ 5 Days ≤ 2 Days	PMC Escondido & PMC Poway	2.59	2.05	--	--
Patient Access Requests Continuity of Care Requests	≤ 5 Days ≤ 2 Days	PMC Escondido & PMC Poway	2.69	1.67	--	--

Cerner Provision Document Imaging (CPDI)
Turn-Around Time

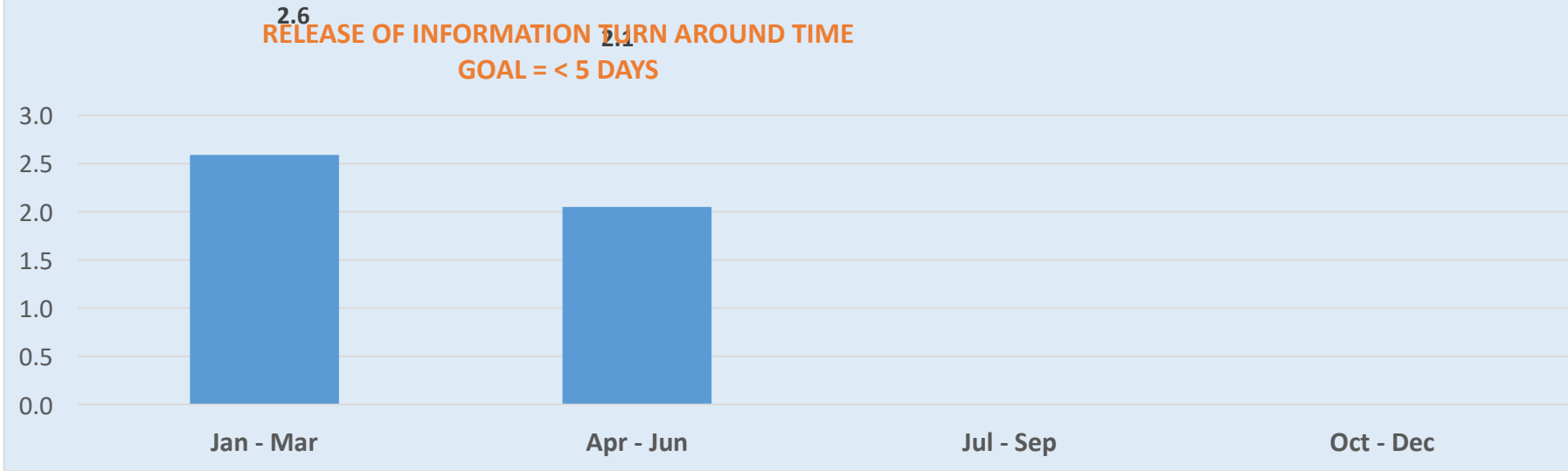




PMC ESCONDIDO
BIRTH CERTIFICATE COMPLETION & TIMELY REGISTRATION



PATIENT ACCESS



Quality Reporting: Anesthesia Consultants of California Medical Group (ACCMG)

Presented to Quality Management Cttee (QMC)

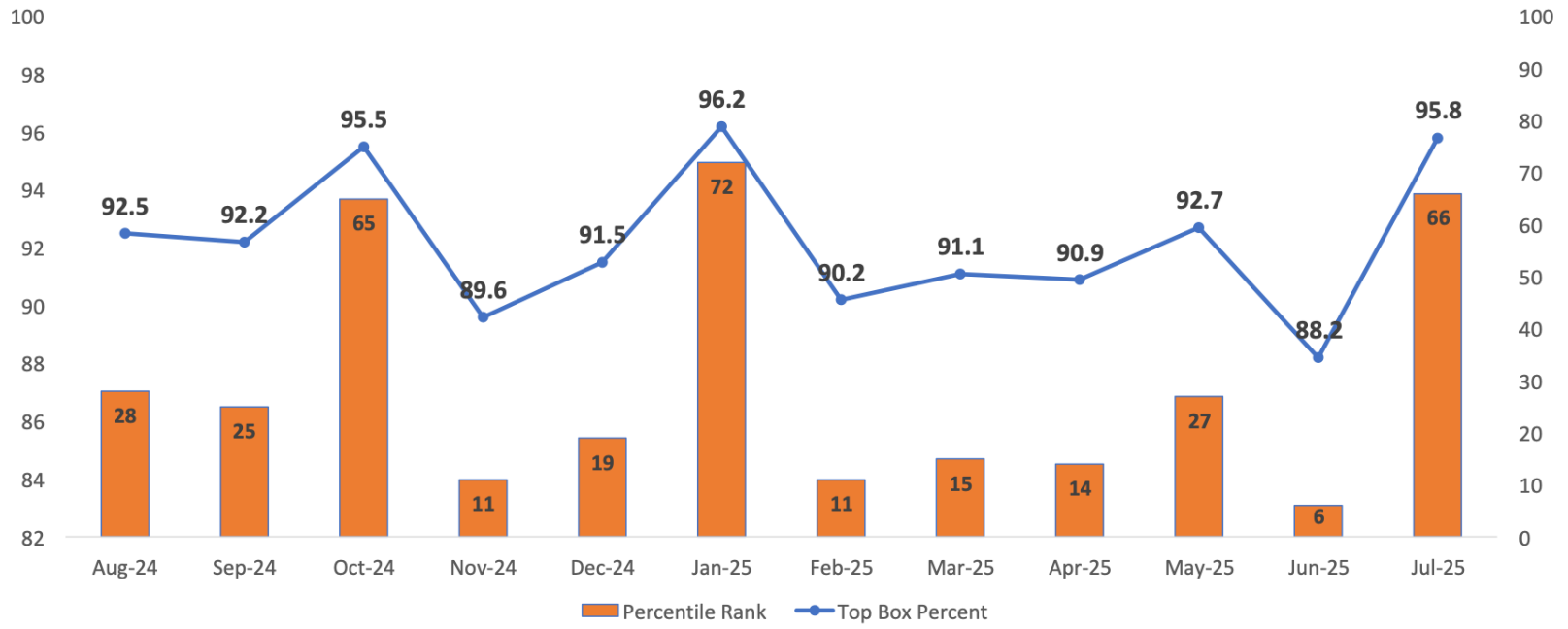
Graham W. Davis, DO
Chairman, Department of Anesthesiology
Palomar Medical Center Escondido

PALOMAR HEALTH
Reimagining Healthcare

NRC Patient Satisfaction Survey (Outpatients)

Escondido

Process of Anesthesia Explained

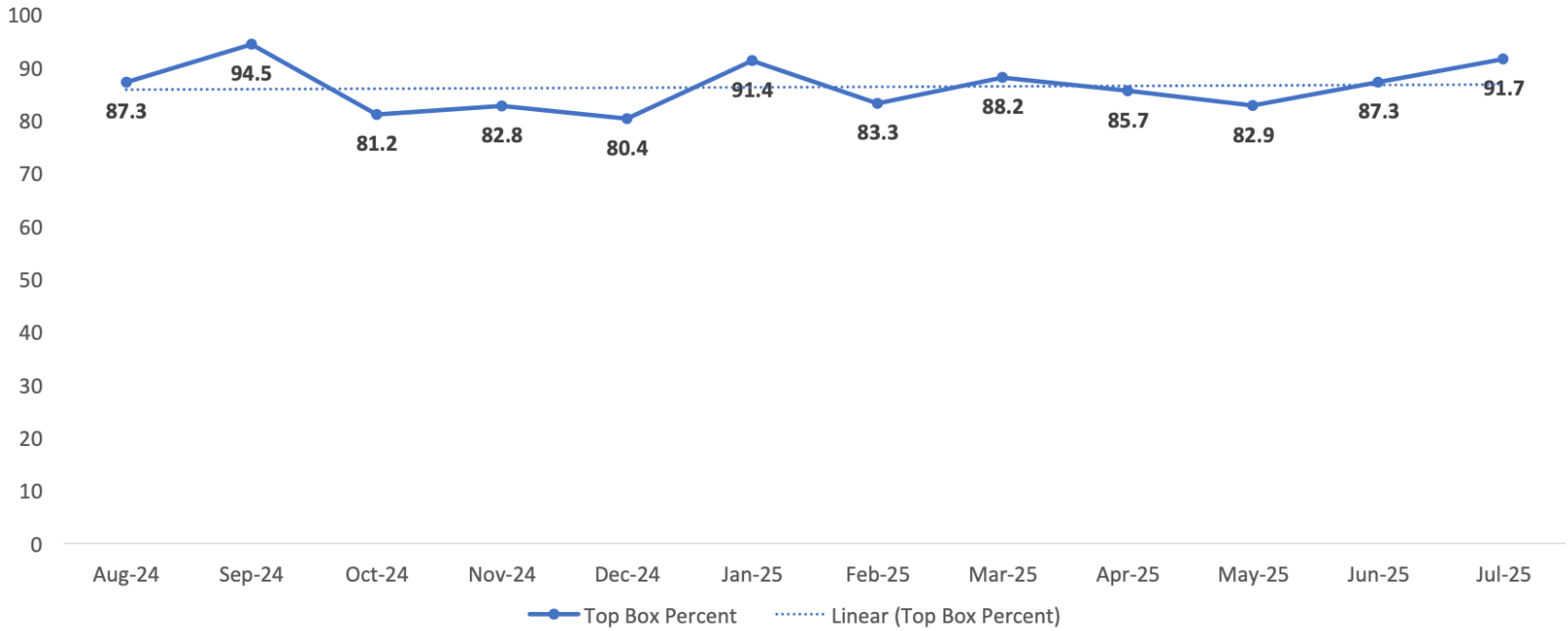


Please note July data is preliminary and will be considered final in mid-September

NRC Patient Satisfaction Survey (Outpatients)

Escondido (n sizes 40-70/month for Escondido)

Anesthesiologist Courtesy and Respect

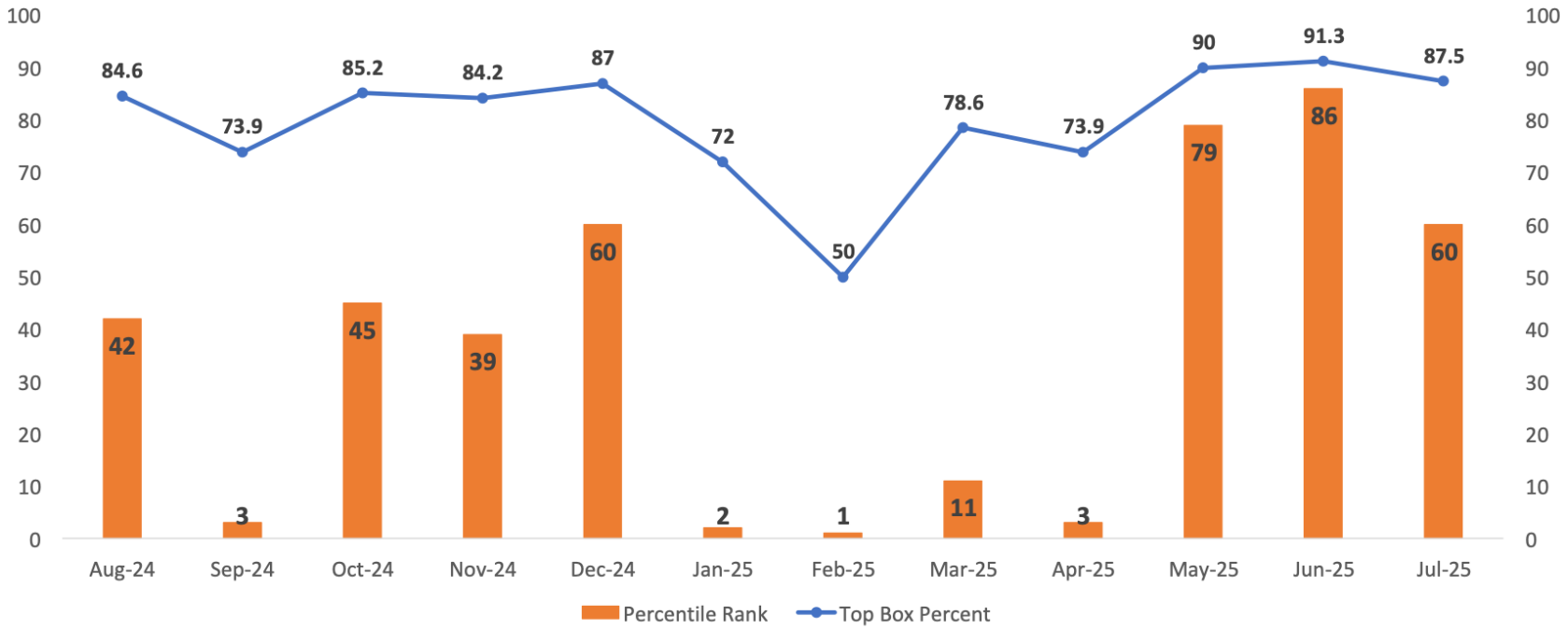


Please note July data is preliminary and will be considered final in mid-September

NRC Patient Satisfaction Survey (Outpatients)

Poway

Anesthesia Side Effects Explained

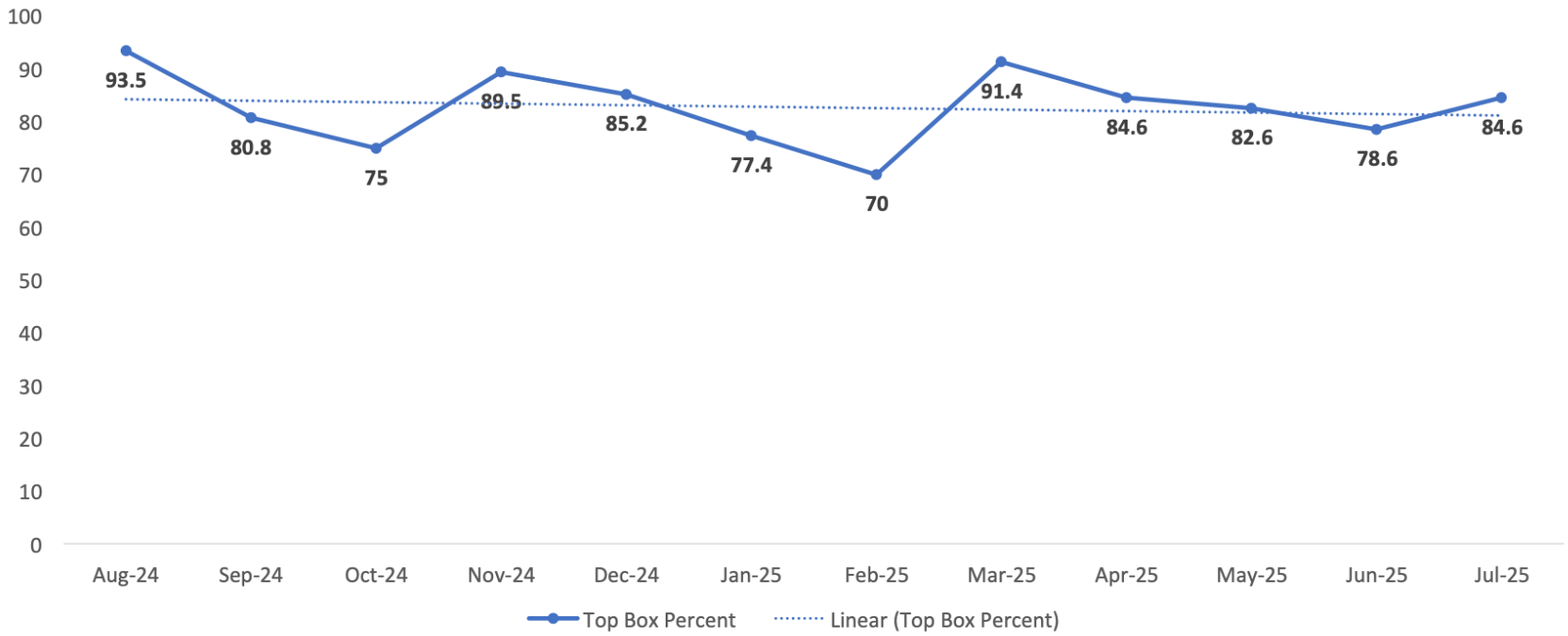


Please note July data is preliminary and will be considered final in mid-September

NRC Patient Satisfaction Survey (Outpatients)

Poway (n sizes 20-35/month for Poway)

Anesthesiologist Courtesy and Respect



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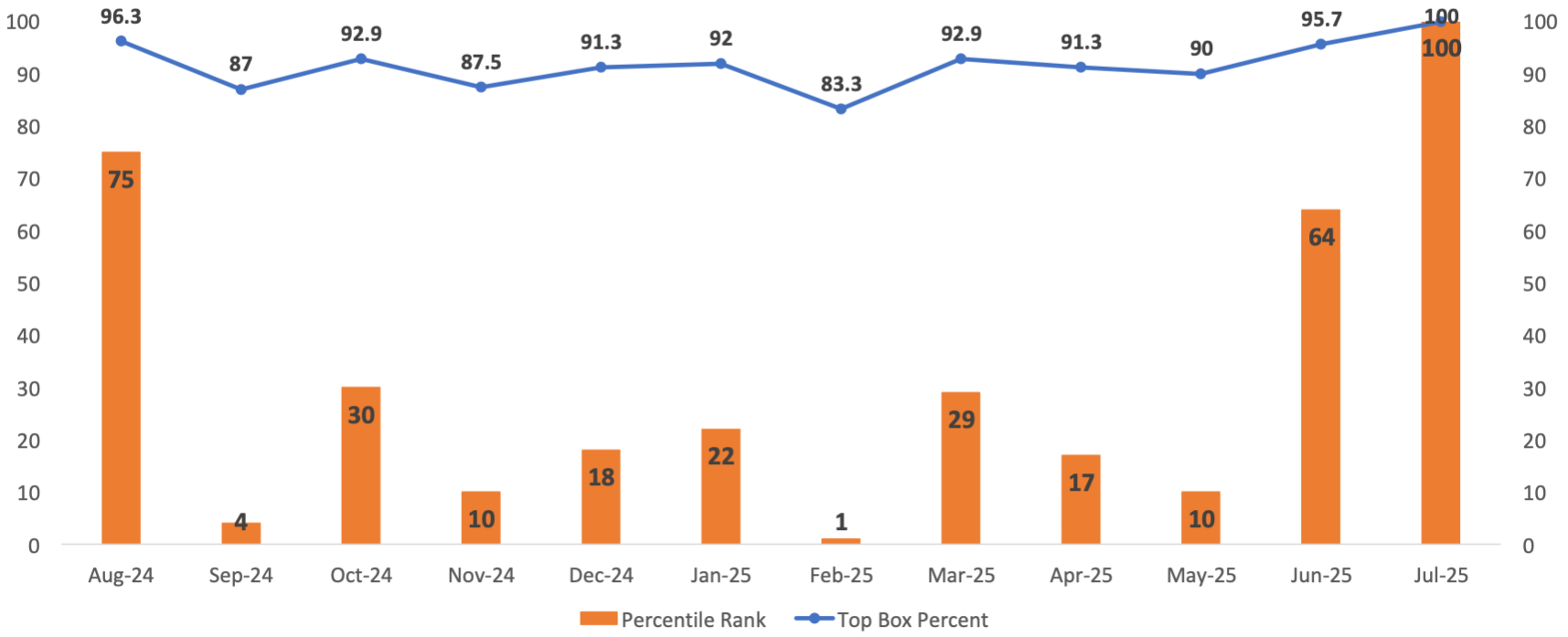
NRC Patient Satisfaction Survey (Outpatients)

Poway

Process of Anesthesia Explained



Please note July data is preliminary and will be considered final in mid-September

First Case On-time Start (FCOT) - Escondido

Delay Reason Analysis | PMCW Preop Record
Institution: PMCE
Date Range: 9/1/2024 - 8/31/2025

Delay Description Preop Record	Monday	Tuesday	Wednesday	Thursday	Friday	Grand Total	% of Grand Total
Surgeon Late	14	4	13	17	9	**57**	**40%**
Staff Late	3	5	6	11	4	**29**	**20%**
Surgical/Informed Cons	7	1	5	5	6	**24**	**17%**
Anesthesiologist Late	2	1	4	6	5	**18**	**13%**
Room Not Ready	1	3	3	3	4	**14**	**10%**
Surgeon Marking pt	3	2	4	1	4	**14**	
MD Orders Not Comple	2	2	2	3	1	**10**	
Patient Difficult IV Start	3	1	--	--	4	**8**	
H&P/24 HR Note Waitir	1	2	3	1	1	**8**	
Surgeon Interview	2	1	2	1	2	**8**	
Patient Request MD Cor	1	--	1	1	2	**5**	
Pharmacy Delay	2	1	--	1	--	**4**	
Peripheral Nerve Block	--	2	1	1	--	**4**	
Transport Delay	2	--	2	--	--	**4**	
Interpreter Services Del	1	1	--	1	--	**3**	
Lab Results Unavailable	--	2	--	1	--	**3**	
Patient Awaiting Family	1	--	1	--	--	**2**	
Inpatient Unit Delay	--	1	--	--	1	**2**	
Patient Late Arrival to H	--	1	--	--	--	**1**	
Case Order Switched	--	--	--	--	1	**1**	
X-Ray Results Unavailab	--	--	1	--	--	**1**	
Abnormal Lab Values	--	1	--	--	--	**1**	
Sterilization Delay or Eq	--	--	--	1	--	**1**	
Equip/Company Rep Nc	--	1	--	--	--	**1**	
Grand Total	**45**	**32**	**48**	**54**	**44**	**223**	

First Case On-time Start (FCOT) - Poway

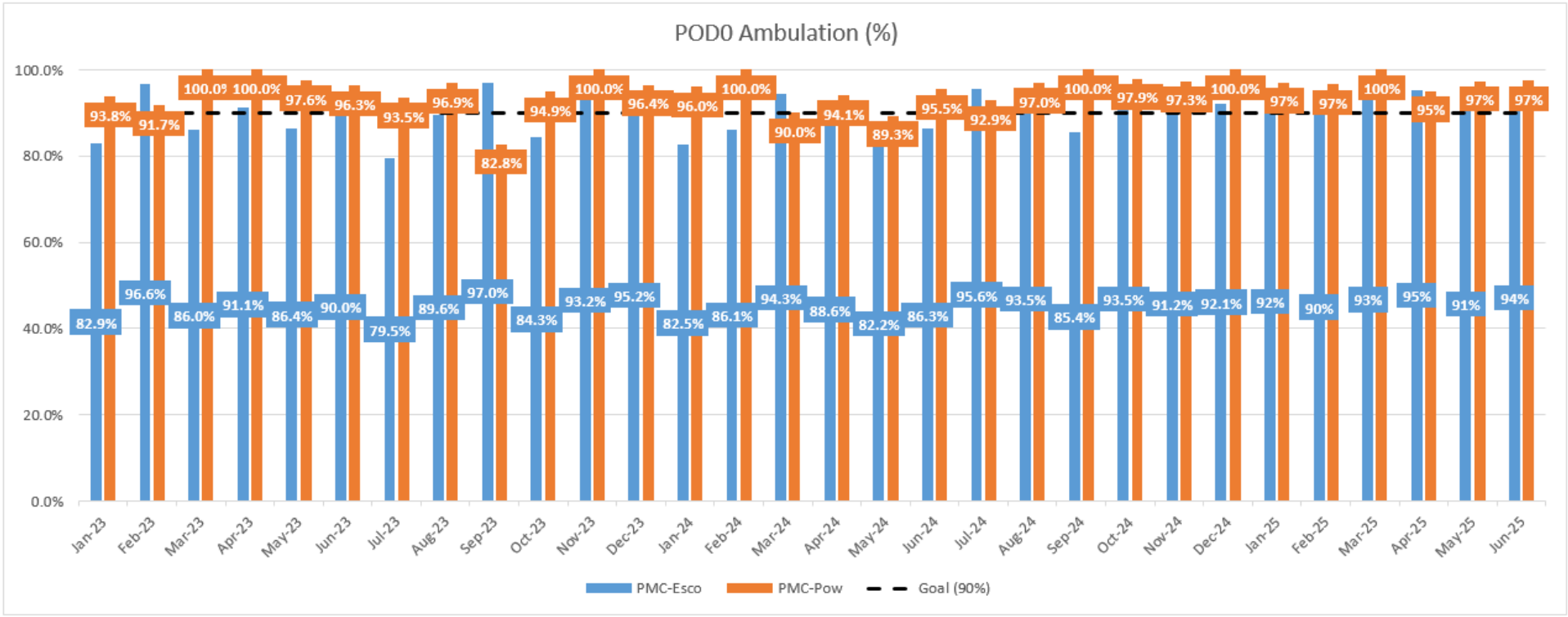
Delay Reason Analysis | POM Preop Record

Institution: PMCP

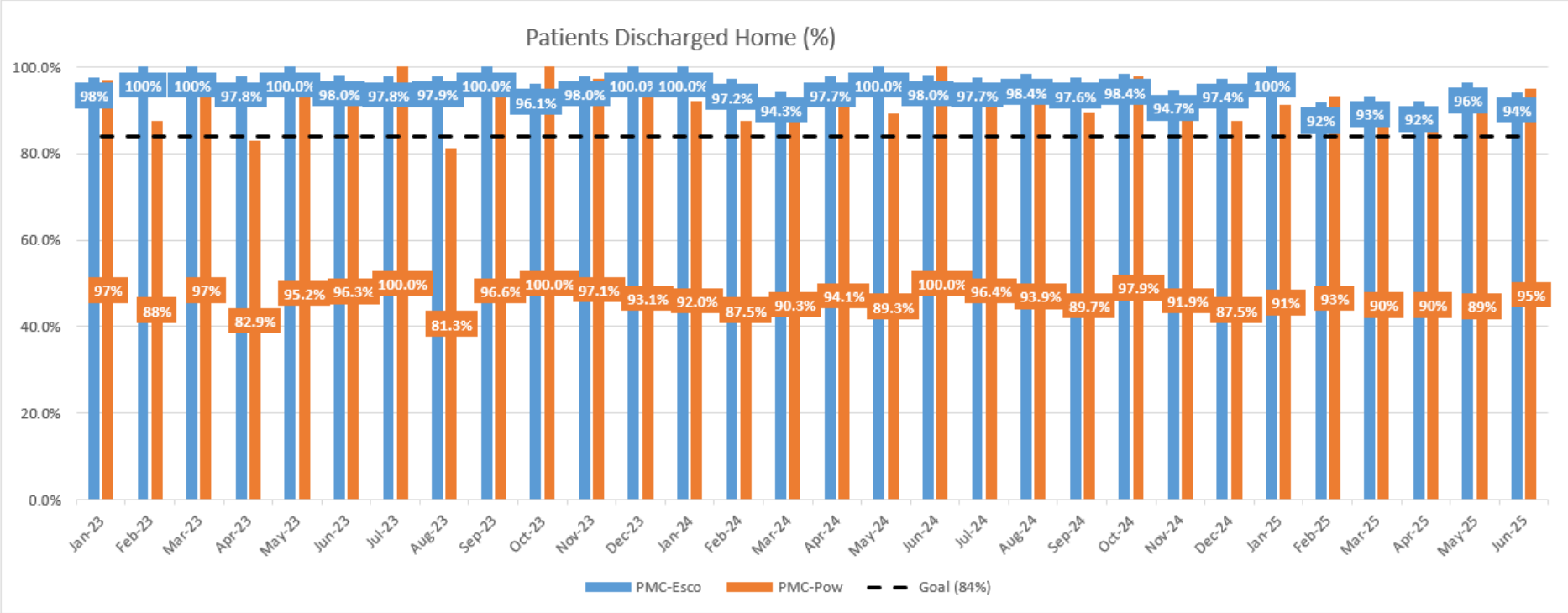
Date Range: 9/1/2024 - 8/31/2025

Delay Description Preop Record	Monday	Tuesday	Wednesday	Thursday	Grand Total
Surgeon Late	5	10	9	9	**33**
Surgical/Informed	1	--	3	3	**7**
Room Not Ready	4	1	--	2	**7**
Equip/Company Re	--	--	--	2	**2**
Anesthesiologist La	--	--	1	1	**2**
Interpreter Service	--	--	--	1	**1**
Patient Difficult IV	--	1	--	--	**1**
Sterilization Delay	1	--	--	--	**1**
Peripheral Nerve B	--	--	1	--	**1**
Grand Total	**11**	**12**	**14**	**18**	**55**

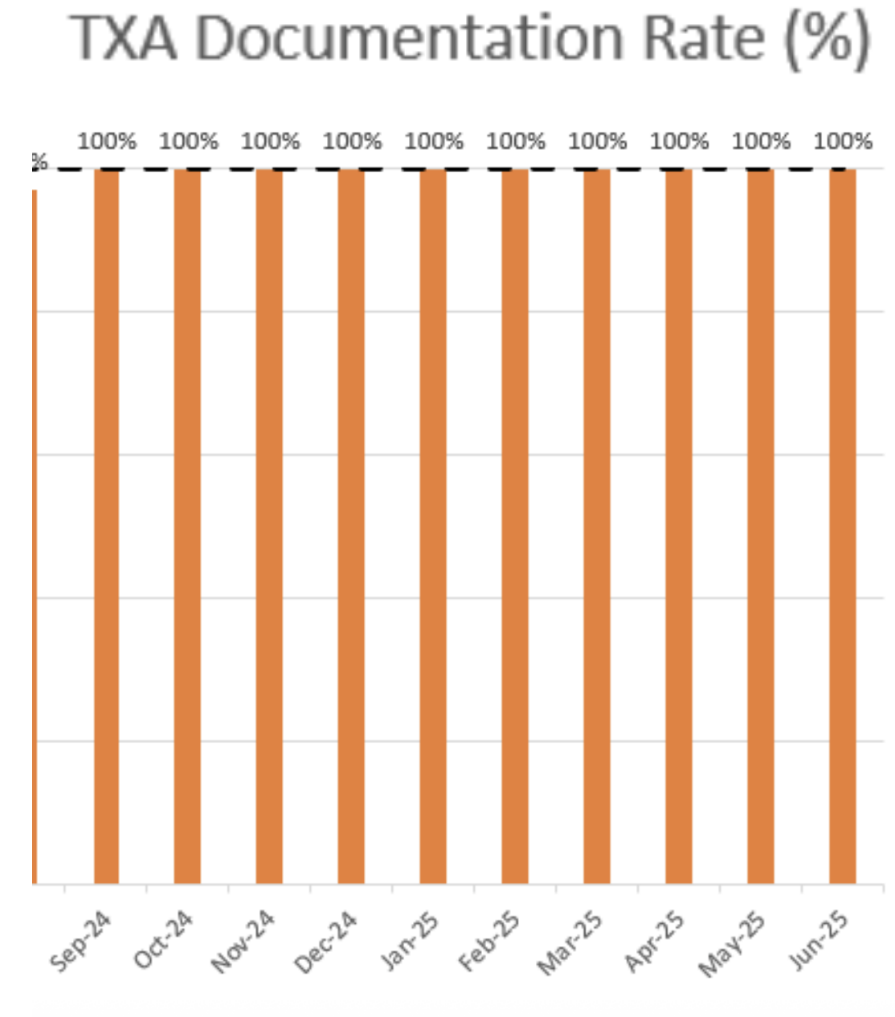
Total Joint COE Metrics



Total Joint COE Metrics

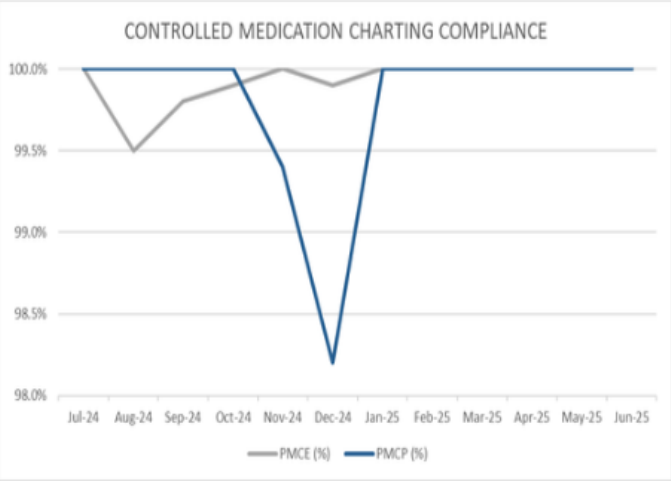


Total Joint COE Metrics



Controlled Substance Compliance

Anesthesia – Controlled Medication Documentation



Month	PMCE (n)	PMCE (%)	PMCP (n)	PMCP (%)
Jul-24	887	100.0%	351	100.0%
Aug-24	849	99.5%	367	100.0%
Sep-24	893	99.8%	322	100.0%
Oct-24	882	99.9%	323	100.0%
Nov-24	830	100.0%	313	99.4%
Dec-24	810	99.9%	329	98.2%
Jan-25	919	100.0%	327	100.0%
Feb-25	973	100.0%	334	100.0%
Mar-25	950	100.0%	279	100.0%
Apr-25	865	100.0%	326	100.0%
May-25	982	100.0%	269	100.0%
Jun-25	1,037	100.0%	310	100.0%

Medication Charge/ Capturing Pitfalls

Total OR vs Endo Cases PMC June - August 2025

	OR Cases*	Endo Cases	Total
PMC Escondido	3114	351	**3465**
PMC Poway	777	46	**823**
Total:	**3891**	**397**	**4288**

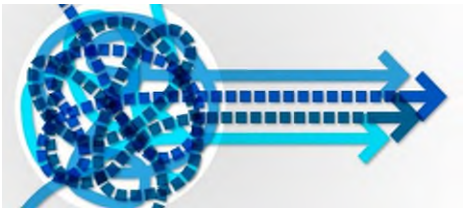
* OR cases include OB & IR

PALOMAR HEALTH

Nursing Annual Report

Presented to
Quality Management Committee

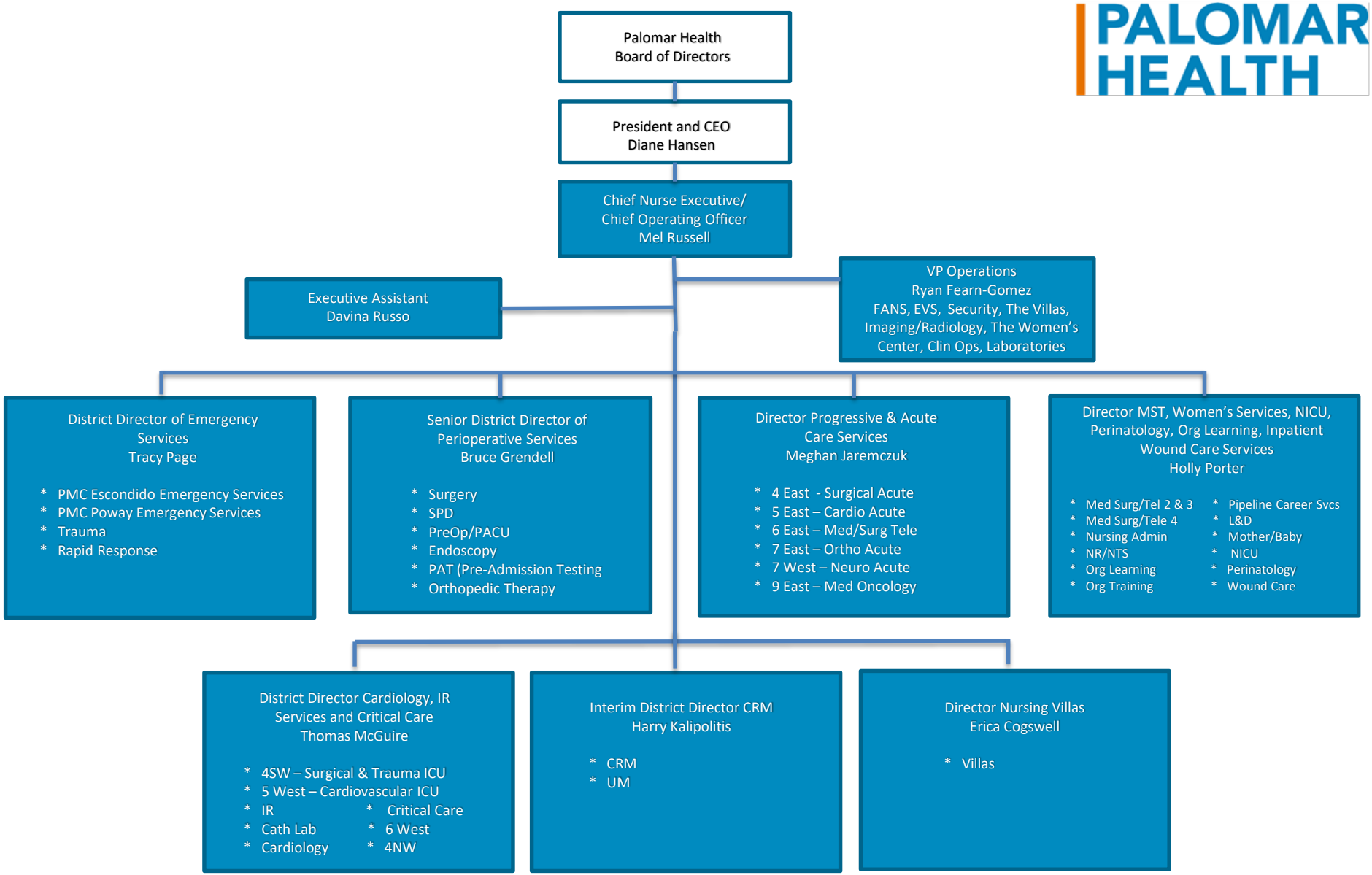
Mel Russell, RN, MSN
Chief Nurse Executive/Chief Operating Officer
September 10, 2025



Systemness

Systemness is the state, quality, or condition of a complex system, that is, of a set of interconnected elements that behave as, or appear to be, a whole, exhibiting behavior distinct from the behavior of the parts.

- Streamlined regulatory compliance
- Efficient policies & procedures
- Improved quality data management
- Cost savings


Palomar Health
Board of Directors
President and CEO
Diane Hansen
Chief Nurse Executive/
Chief Operating Officer
Mel Russell
Executive Assistant
Davina Russo
VP Operations
Ryan Fearn-Gomez
FANS, EVS, Security, The Villas, Imaging/Radiology, The Women's Center, Clin Ops, Laboratories
District Director of Emergency Services
Tracy Page
* PMC Escondido Emergency Services
* PMC Poway Emergency Services
* Trauma
* Rapid Response
Senior District Director of Perioperative Services
Bruce Grendell
* Surgery
* SPD
* PreOp/PACU
* Endoscopy
* PAT (Pre-Admission Testing
* Orthopedic Therapy
Director Progressive & Acute Care Services
Meghan Jaremczuk
* 4 East - Surgical Acute
* 5 East – Cardio Acute
* 6 East – Med/Surg Tele
* 7 East – Ortho Acute
* 7 West – Neuro Acute
* 9 East – Med Oncology
Director MST, Women's Services, NICU, Perinatology, Org Learning, Inpatient Wound Care Services
Holly Porter
* Med Surg/Tel 2 & 3
* Med Surg/Tele 4
* Nursing Admin
* NR/NTS
* Org Learning
* Org Training
* Pipeline Career Svcs
* L&D
* Mother/Baby
* NICU
* Perinatology
* Wound Care
District Director Cardiology, IR Services and Critical Care
Thomas McGuire
* 4SW – Surgical & Trauma ICU
* 5 West – Cardiovascular ICU
* IR
* Cath Lab
* Cardiology
* Critical Care
* 6 West
* 4NW
Interim District Director CRM
Harry Kalipolitis
* CRM
* UM
Director Nursing Villas
Erica Cogswell
* Villas

Service Area

Palomar Health is the largest public healthcare district in the state of California, serving communities in an 850-square-mile area.

Custom Territories

- PSA – North
- PSA – South
- SSA – Coastal
- SSA – Fallbrook/Bonsall
- SSA – Inland South
- SSA – North County
- SSA – Riverside

PSA = Primary Service Area SSA = Secondary Service Area

Competitor Market: Tri-City Medical Center, Kaiser Permanente, UCSD, Scripps, and Sharp.

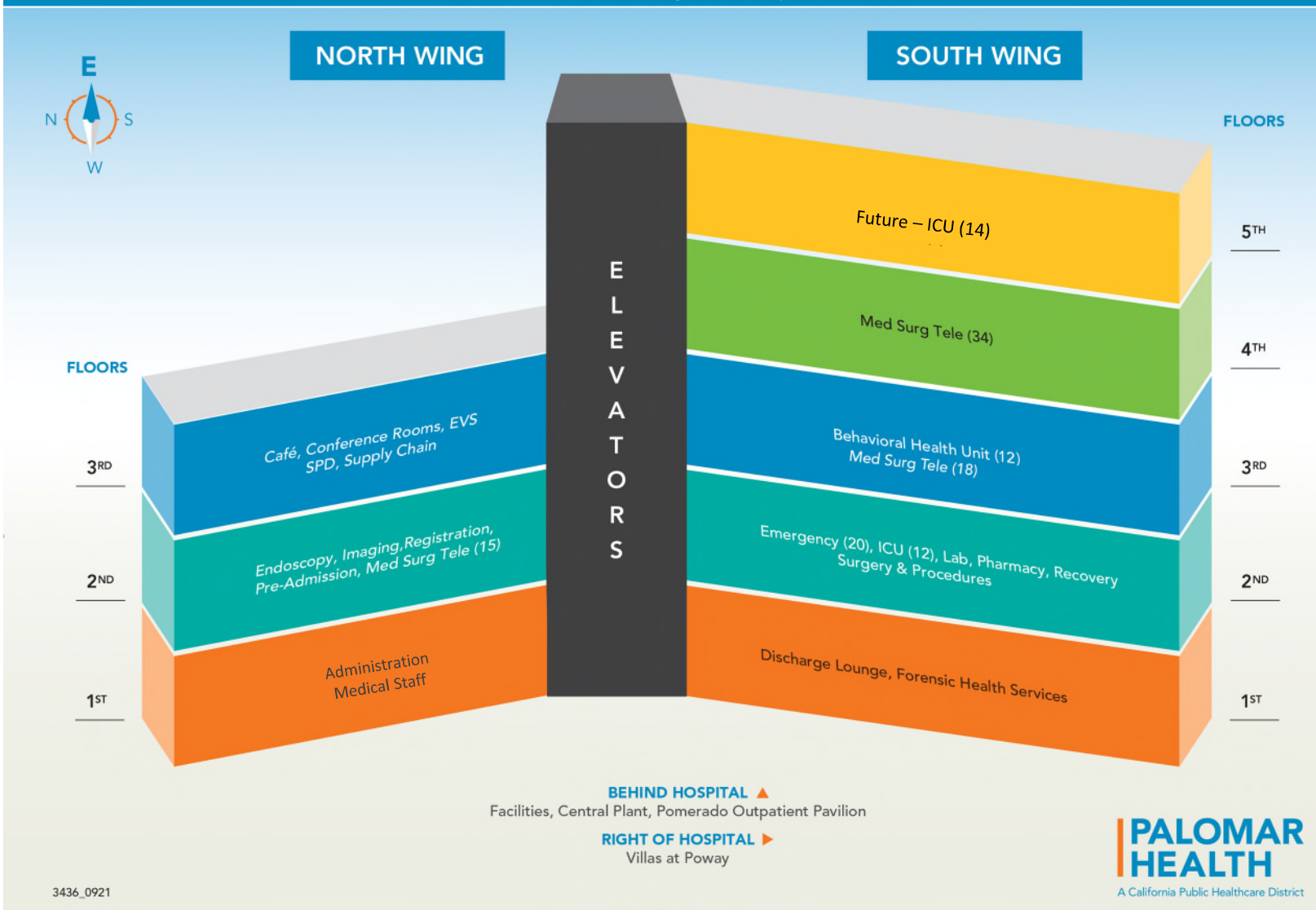
PALOMAR HEALTH
Reimagining Healthcare• 4

Palomar Medical Center Escondido

2185 Citracado Parkway, Escondido, CA 92029 | 442.281.5000

Palomar Medical Center Poway

15615 Pomerado Road, Poway, CA 92064 | 858.613.4000



Palomar Health Nursing Operations

Palomar Health Nursing Operations Includes 36 Departments & 2500+ Staff Members

PMC Escondido	
Emergency Department	4E: Surgical Acute Care
Trauma	5W: Cardiovascular ICU
Surgery & Procedures	5E: Cardiovascular Acute
Interventional Radiology	6W: Pulmonary Progressive Care
Cardiac Cath Lab	6E: MS-Tele
Cardiology Services	7W: Neuro Acute
Sterile Processing Department	7E: Ortho Acute
Endoscopy	8W: Labor & Delivery
PreOp/PACU	8E: Postpartum/NICU
4SW: Surgical & Trauma ICU	9E: Medical Oncology
4NW: Surgical Progressive	

PMC Poway
Emergency Department
Critical Care
Surgery & Procedures
Interventional Radiology
Cardiology Services
Sterile Processing Department
Endoscopy
PreOp/PACU
Med Surg Tele (2nd/3rd /4th)

District
Clinical Operations
Staffing Office
Float Pool
Patient Transport/Lift Services
Pre Admission Testing
Clinical Resource Management

Palomar Health Distinguished & Key Service Lines

- Orthopedics Center of Excellence
- Stroke Accreditation
- Emergency & Trauma
- Center of Distinction, Obstetrics

The following slides show the delivery of exceptional care through collaboration and ongoing performance improvement.

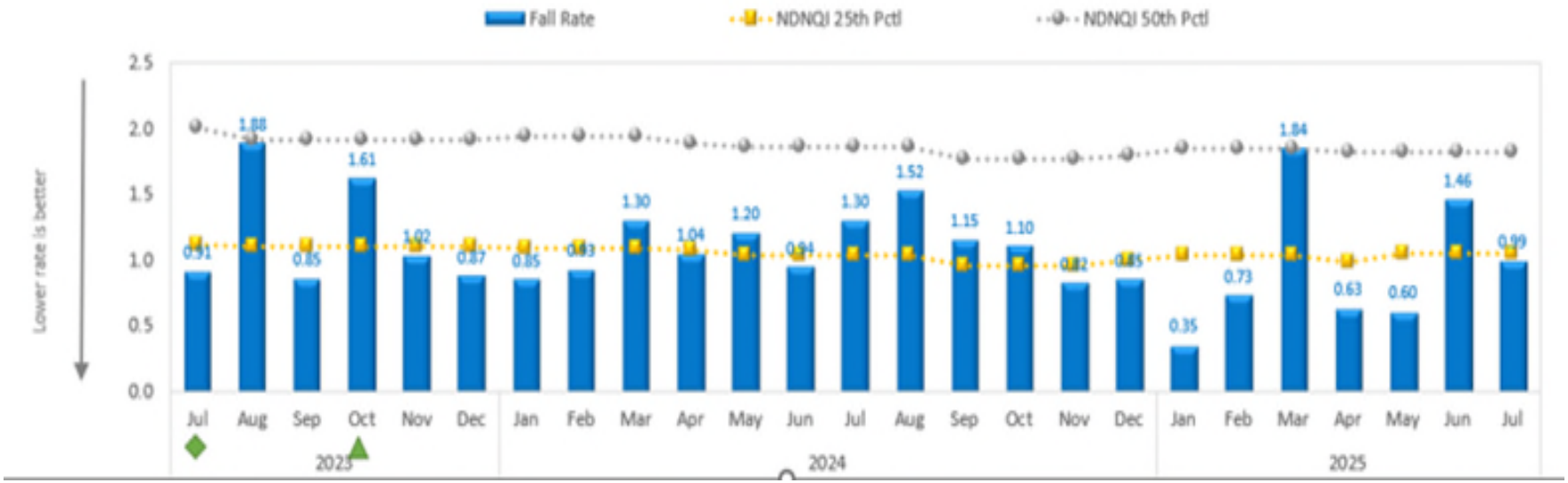
Palomar Health Zero Patient Harm

FY2025 Results [July 2024 - June 2025]		PMC Escondido	PMC Poway	Benchmark
CAUTI	SIR	1.176	0.000	0.54
CLABSI	SIR	0.214	Pred < 1	0.65
CDI	SIR	0.336	0.519	0.40
MRSA	SIR	0.449	Pred < 1	0.72
SSI - COLO	SIR	1.790	0.000	0.83
SSI - HYST	SIR	Pred < 1	0.000	1.00
Injury Fall	Rate	0.41	0.05	0.23
Pressure Injury	Percent	0.12	1.33	0.64

Notes:

1. *Injury Fall data include inpatient units only. Behavioral Health Unit is excluded.*
2. *Injury Fall benchmark is the non-Magnet 75th percentile from the National Database of Nursing Quality Indicators(NDNQI)*
3. *Pressure Injury benchmark is the non-Magnet 50th percentile from NDNQI*
4. *CAUTI, CLABSI, CDI, MRSA, SSI-COLO benchmarks are LeapFrog moving, national means*
5. *SSI-HYST benchmark is the Standard NHSN SIR*

Palomar Health Total Patient Falls



- Post Fall Huddle Call
- Hendrich Fall Tool (Jan 2026)

Months Since Last HAI from December 2021 to July 2025

Unit of Attribution	End Date	Months since CAUTI	End Date	Months since CLABSI
4E	07/31/25	2	07/31/25	43
4NW	07/31/25	14	07/31/25	20
4SW	07/31/25	26	07/31/25	2
5E	07/31/25	24	07/31/25	30
5W	07/31/25	0	07/31/25	0
6E	07/31/25	19	07/31/25	25
6W	07/31/25	11	07/31/25	37
7E	07/31/25	29	07/31/25	43
7W	07/31/25	43	07/31/25	43
8E	07/31/25	43	07/31/25	43
8W	07/31/25	43	07/31/25	43
9E	07/31/25	15	07/31/25	23
9W	07/31/25	6	07/31/25	6
NICU	07/31/25	IC does not track CAUTI in this population	07/31/25	15
ICU - Poway	07/31/25	41	07/31/25	7
MS2	07/31/25	43	07/31/25	43
MS3	07/31/25	30	07/31/25	30
MS4	07/31/25	18	07/31/25	17

December 1, 2021 is earliest reference point, unless otherwise limited to unit open dates below
MS3 opened January 1, 2023
SSU opened December 1, 2022
NICU (Escondido) opened [surveillance] December 1, 2022
9W (Escondido) opened January 31, 2025
Months is a measure of 30 days and not calendar months

- **3 years without an HAI:**

Unit of Attribution	Years since CAUTI
7W	3
8E	3
8W	3
ICU	3
MS2	3

Unit of Attribution	Years since CLABSI
4E	3
6W	3
7E	3
7W	3
MS2	3

- **Honorable mentions:**
- 6W and 6E in CLABSI. They are among the units with the highest central line volume and no infections in the last 2 years.
- 6W in CAUTI. The unit with the second highest foley volume (almost as much as 5W) and no infections in last nearly a year.

Ambulance Traffic - Escondido

2nd highest volume in the county – 2072 runs

Total Offloads
1,707

Percent Offloads Under 30 Minutes
91.1%

90th Percentile Offload Time in Minutes
29.1

Median Offload Time in Minutes
13.0

TOC Compliance
100.0%

Percent Offloads Under 20 Minutes
77.0%

San Diego County
Transfer of Care - via FirstWatch Emergency Department Data
Use filters below to select data by Emergency Department, Month, and Year

Emergency Department

SD COUNTY	Alvarado
Kaiser San Diego	Kaiser San Marcos
Kaiser Zion	Naval Med Center
Palomar	Palomar-Poway
Paradise Valley	Rady Childrens
Scripps Chula Vista	Scripps Encinitas
Scripps La Jolla	Scripps Mercy
Sharp Chula Vista	Sharp Coronado
Sharp Grossmont	Sharp Memorial
Temecula Valley	Tri-City
UCSD	UCSD East

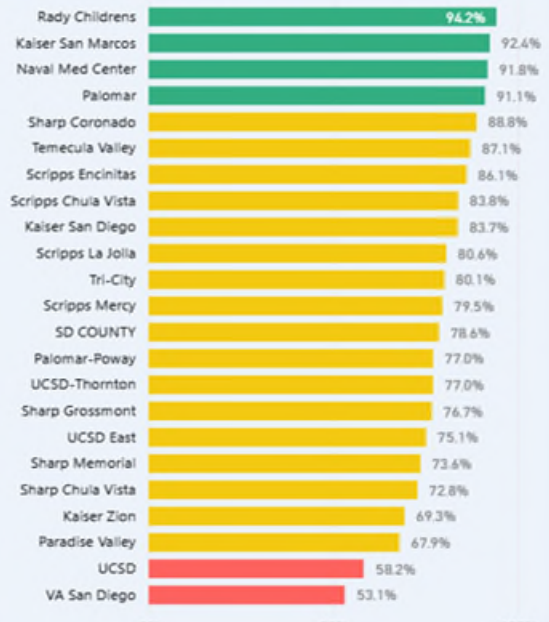
Month

January	February	March
April	May	June
July	August	September
October	November	December

Year
2018 2019 2020 2021 2022 2023 2024 2025

Emergency Department Rank - Percent Under 30 Minutes
4.0

Percent Under 30 Minutes



- Rady Childrens = 462 ambulances
- Kaiser San Marcos – 331 ambulances
- Naval Medical Center – 171 ambulances

Ambulance Traffic - Poway

561 total runs

Total Offloads
521

Percent Offloads Under 30 Minutes
77.0%

90th Percentile Offload Time in Minutes
43.8

Median Offload Time in Minutes
17.6

TOC Compliance
100.0%

Percent Offloads Under 20 Minutes
56.6%

San Diego County

Transfer of Care - via FirstWatch
Emergency Department Data
Use filters below to select data by Emergency Department, Month, and Year

Emergency Department

SD COUNTY	Alvarado
Kaiser San Diego	Kaiser San Marcos
Kaiser Zion	Naval Med Center
Palomar	Palomar-Poway
Paradise Valley	Rady Childrens
Scripps Chula Vista	Scripps Encinitas
Scripps La Jolla	Scripps Mercy
Sharp Chula Vista	Sharp Coronado
Sharp Grossmont	Sharp Memorial
Temecula Valley	Tri-City
UCSD	UCSD East

Month

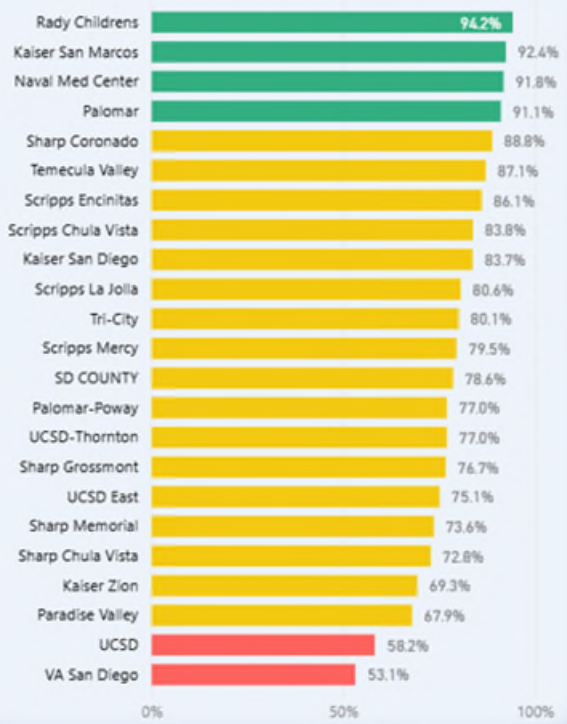
January	February	March
April	May	June
July	August	September
October	November	December

Year

2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025

Emergency Department Rank - Percent Under 30 Minutes
13.0

Percent Under 30 Minutes



Topic/Project: Nursing Sensitive Indicators 09.10.2025

Submitted By: Melvin Russell, MSN, Chief Nurse Executive/Chief Operating Officer

Situation	PMC Poway and PMC Escondido Nursing Sensitive Indicators FY2025.
Background	All cases are escalated real-time by the end of the shift. Cases are discussed/reviewed with CNE and unit leadership.
Assessment	

PMC Poway

Inpatient Falls with Injury

Measure / Unit	Performance for Jun 2025		Performance for Jul 2024 - Jun 2025		Benchmark
Falls with Injury	# of Injury Falls	Rate per 1000 Patient Days	# of Injury Falls	Rate per 1000 Patient Days	Previous Quarter Top Quartile
ICU	0	0.00	0	0.00	0.00
Med-Surg-Tele & IMC	0	0.00	1	0.06	0.00

ED Falls with Injury

FALLS	Performance for Jun 2025		Performance for Jul 2024 - Jun 2025		Benchmark
	Numerator	Rate	Numerator	Rate	
Falls per 1000 Visits	1	0.35	18	0.52	0.27
Falls with Injury per 1000 Visits	1	0.35	3	0.09	0.00

HAPI:

Measure / Unit	Performance for CY25 Q2		Performance for CY24 Q3 - CY25 Q2		Benchmark
Hospital Acquired Pressure Injuries (HAPI) - Stage II or Above	# of Pts with HAPI II+	% Pt with HAPI II+	# of Pts with HAPI II+	% Pt with HAPI II+	Previous Quarter 50th Percentile
ICU	0	0.00%	2	5.41%	0.00%
Med-Surg-Tele & IMC	0	0.00%	1	0.53%	0.00%

Physical Restraints

Measure / Unit	Performance for CY25 Q2		Performance for CY24 Q3 - CY25 Q2		Benchmark
Physical Restraints (Limb and/or Vest)	# of Pts with Restraints	% Pt with Restraints	# of Pts with Restraints	% Pt with Restraints	Previous Quarter 50th Percentile
ICU	1	16.67%	4	10.81%	11.11%
Med-Surg-Tele & IMC	1	3.03%	1	0.53%	0.00%

PMC Escondido

Inpatient Falls with Injury

Measure / Unit	Performance for Jun 2025		Performance for Jul 2024 - Jun 2025		Benchmark
Falls with Injury	# of Injury Falls	Rate per 1000 Patient Days	# of Injury Falls	Rate per 1000 Patient Days	Previous Quarter Top Quartile
4E Surgical Acute	3	3.18	7	0.60	0.00
4NW Surgical Acute	0	0.00	2	0.48	0.00
4SW Critical Care	0	0.00	0	0.00	0.00
5E Cardiovascular Acute	0	0.00	6	0.51	0.00
5W Critical Care	0	0.00	1	0.14	0.00
6E Med Surg Tele	1	1.19	4	0.40	0.00
6W Medical Acute	0	0.00	1	0.12	0.00
7E Ortho Acute	1	1.17	8	0.79	0.00
7W Neuro Acute	0	0.00	5	0.60	0.00
8E&W Postpartum	0	0.00	1	0.09	0.00
9E Med Oncology	0	0.00	2	0.24	0.00
9W Tele	0	0.00	2	0.60	0.00

ED Falls with Injury

FALLS	Performance for Jun 2025		Performance for Jul 2024 - Jun 2025		Benchmark
	Numerator	Rate	Numerator	Rate	
Falls per 1000 Visits	1	0.15	30	0.34	0.41
Falls with Injury per 1000 Visits	0	0.00	11	0.13	0.07

OB Baby Drops

Measure / Unit	Performance for Jun 2025		Performance for Jul 2024 - Jun 2025		Benchmark
Baby Drops	# of Baby Drops	Rate per 1000 Newborn Days	# of Baby Drops	Rate per 1000 Newborn Days	Previous Quarter Top Quartile
8E&W Postpartum (Mother/Baby)	0	0.00	1	0.18	0.00

HAPI:

Measure / Unit	Performance for CY25 Q2		Performance for CY24 Q3 - CY25 Q2		Benchmark
Hospital Acquired Pressure Injuries (HAPI) - Stage II or Above	# of Pts with HAPI II+	% Pt with HAPI II+	# of Pts with HAPI II+	% Pt with HAPI II+	Previous Quarter 50th Percentile
4E Surgical Acute	0	0.00%	0	0.00%	0.00%
4NW Surgical Acute	0	0.00%	0	0.00%	0.00%
4SW Critical Care	0	0.00%	0	0.00%	0.00%
5E Cardiovascular Acute	0	0.00%	0	0.00%	0.00%
5W Critical Care	0	0.00%	0	0.00%	0.00%
6E Med Surg Tele	0	0.00%	0	0.00%	0.00%
6W Medical Acute	0	0.00%	0	0.00%	0.00%
7E Ortho Acute	0	0.00%	0	0.00%	0.00%
7W Neuro Acute	0	0.00%	0	0.00%	0.00%
9E Med Oncology	0	0.00%	0	0.00%	0.00%
9W Tele	1	5.26%	1	2.50%	0.00%

Physical Restraints

Measure / Unit	Performance for CY25 Q2		Performance for CY24 Q3 - CY25 Q2		Benchmark
Physical Restraints (Limb and/or Vest)	# of Pts with Restraints	% Pt with Restraints	# of Pts with Restraints	% Pt with Restraints	Previous Quarter 50th Percentile
4E Surgical Acute	0	0.00%	1	0.96%	0.00%
4NW Surgical Acute	1	9.09%	1	2.56%	0.00%
4SW Critical Care	0	0.00%	3	13.64%	11.11%
5E Cardiovascular Acute	0	0.00%	0	0.00%	0.00%
5W Critical Care	4	28.57%	15	26.79%	11.11%
6E Med Surg Tele	0	0.00%	0	0.00%	0.00%
6W Medical Acute	0	0.00%	1	1.25%	0.00%
7E Ortho Acute	0	0.00%	1	1.05%	0.00%
7W Neuro Acute	0	0.00%	0	0.00%	0.00%
9E Med Oncology	0	0.00%	0	0.00%	0.00%
9W Tele	0	0.00%	0	0.00%	0.00%

Recommendation

1. Department leaders performing focused rounds to capture high-risk patients.
2. Nursing Leaders perform and in depth review of each HAPI and Fall and collaborate with Wound Care and Quality CNS for discussion and/or recommendation.
3. Weekly CNE Friday call with Nursing Directors & Managers to review unusual occurrences.
4. Daily report out of restraint use during unit huddle. Q4 hour reassessment of restraint need.

Patient Discharge Planning and Throughput

Harry Kallipolitis, Interim District Director, Clinical Resource Management

Donald Miller, District Manager, Clinical Operations

August 2025

Presented to Quality Management Cttee (QMC)

PALOMAR HEALTH
Reimagining Healthcare

Discharge Planning & Patient Throughput

SITUATION	FYTD 25 overall LOS including OB 4.30 days to budgeted 4.56 days Manage anticipated COVID, RSV, and other complicated discharges and manage Observation stays. FYTD LOS: **PMC Escondido** 4.42/ Budgeted 4.61 **PMC Poway** 3.81 / Budgeted 4.40
BACKGROUND	Throughput and discharge planning are strategic initiatives for FY2025
ASSESSMENT	**Discharge Planning Challenges:** • Health Plans authorization processes causing Discharge delays • Health Plans contracted providers not accepting their patients causing Discharge Delays • Several patients with limited or no funding (Uninsured / Restricted Medical) • Custodial Beds in SNFs are full • Homelessness with lack of available recoup beds • History of or active Drug and/or Alcohol Abuse • Lack of social support and financial resources • Legal challenges (Conservatorship, etc.) • Limited resources for Behavioral Health related patients & Dementia patients • Social Determinants of Health discoveries. (Pt with no electricity, Could no longer afford rent) **Patient Throughput:** • Emergency Department volume has slightly increased at PMC Poway and slightly decreased at PMC Escondido. • (PMCP = avg. 94 daily visits -> 97 visits/day, PMCE = avg. 247 daily visits -> 239) • Emergency Department admission rates have increased from previous year. (PMCE = 19.53% -> 21%, PMCP = 15.6% -> 16%) • 9W (24 Telemetry beds) opened January 30. Consistently running at or near capacity. Optimizing bed utilization and reduction in ED boarding times. • Long Length of Stay (LLOS) rounds w/ RN Management & CRM team to decrease pts hospital stay. • Daily MDR rounds which include unit Manager, Attending MD, Rehab Dept., and CRM team. • Daily 0630 Poway Throughput Meeting – Interdepartmental collaboration to increase workflow. • Monthly Throughput/Capacity Management Workgroup Committee. Multidisciplinary approach (includes EVS, Lab, Pharmacy, CRM, Patient Experience, Imaging, PT/OT, Emergency Services, Inpatient Managers) • CMS Age Friendly Measure Equity Committee - Reduce department delirium by minimizing ED stay, targeting transfer of pts >65 within 8 hours of arrival and/or within 3 hours of decision to admit.
RECOMMENDATION	**Discharge Planning** • Conversion to Triad Model of Care Management. • Contracted leased beds for difficult to place patients • Complex Case Management Team partnering with providers to reduce LOS and high dollar patients (Mar ‘25-Jun ‘25 – 496 pts/$253,378,942 charges) • Filled vacant RN/SW positions and utilizing travel RN, to supplement staffing, as needed. • Dedicated Observation UR RN focusing on these types of patients. (Escondido 8.5%, Poway 9%) National avg: 12% • Observation specific CRM rounds (twice daily) with physician advisor for decreased LOS. **Patient Throughput** • New Tableau Reports – Daily Discharge, Midnight Census, Age Friendly Metrics –Improve situational awareness and supported efforts to optimize throughput. • DC60 program – Go Live: July 1, 2024 -> 6.9% - Identify “home no need” inpatient d/c and discharge them in less than 1 hour. June 2025 -> 32.2% - Increases overall throughput and increases early discharges. • Engaged with Providers to maximize intra-facility transfers between PMCE & PMCP – Updating bed control tracking board to show available beds at Poway campus. Improve patient throughput districtwide. • Utilization of Code Alpha and Code Delta alerts has allowed for greater collaboration for decreased throughput • Pro-active approach to Capacity Management. Communication and collaboration between the ED, Clinical Ops, Inpatient Units, Case Management, and ancillary departments focusing on early patient movement / discharges. • Assigning designated transport aides to decrease imaging TAT and ED boarding times during high volumes.

Average Length of Stay

ALOS Trend - Including OB

Budget vs Actual

PALOMAR HEALTH

Note: Data represents all Palomar Health Inpatient encounters

	FYTD25											
Location	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
PMC - Escondido												
Budget ALOS	4.56	4.63	4.58	4.54	4.60	4.64	4.65	4.65	4.63	4.66	4.55	4.58
Actual ALOS	4.27	4.44	4.46	4.29	4.34	4.49	4.83	4.79	4.39	4.20	4.16	4.32
Variance	**0.29**	**0.19**	**0.12**	**(0.25)**	**(0.26)**	**(0.16)**	**0.18**	**0.14**	**(0.24)**	**(0.47)**	**(0.39)**	**(0.26)**
PMC - Poway												
Budget ALOS	4.42	4.43	4.43	4.43	4.39	4.36	4.37	4.37	4.42	4.43	4.41	4.38
Actual ALOS	3.72	3.97	4.03	4.04	4.09	3.48	4.41	4.21	3.72	3.07	3.46	3.52
Variance	**0.70**	**0.46**	**0.40**	**(0.39)**	**(0.29)**	**(0.87)**	**0.04**	**(0.16)**	**(0.71)**	**(1.36)**	**(0.95)**	**(0.86)**
District Total												
Budget ALOS	4.53	4.58	4.55	4.51	4.56	4.58	4.59	4.58	4.59	4.61	4.52	4.54
Actual ALOS	4.17	4.35	4.38	4.24	4.29	4.27	4.75	4.67	4.27	3.99	4.03	4.16
Variance	**0.36**	**0.23**	**0.16**	**(0.27)**	**(0.26)**	**(0.31)**	**0.15**	**0.09**	**(0.32)**	**(0.62)**	**(0.49)**	**(0.37)**

Average Length of Stay

ALOS Trend - Excluding OB

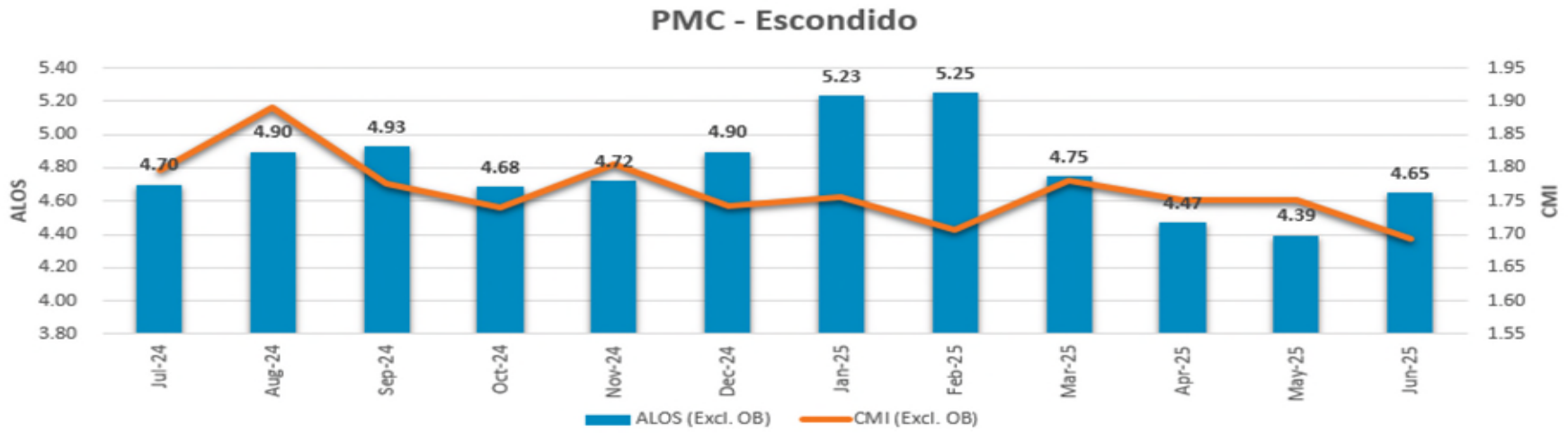
By Facility

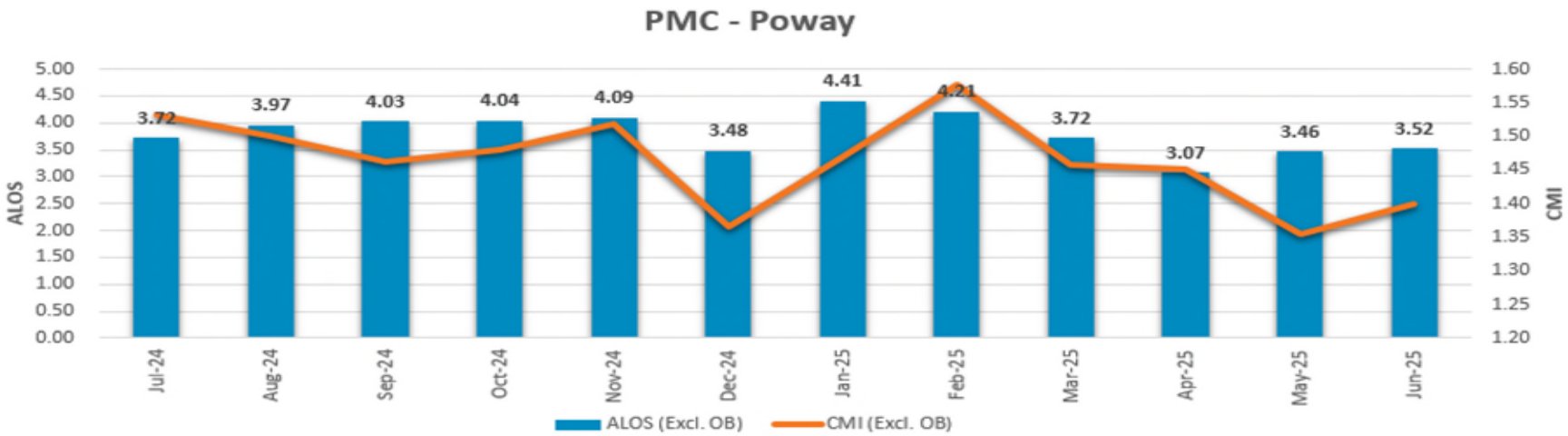
Note: Data represents all Palomar Health Inpatient encounters

	FYTD25											
Location	**Jul-24**	**Aug-24**	**Sep-24**	**Oct-24**	**Nov-24**	**Dec-24**	**Jan-25**	**Feb-25**	**Mar-25**	**Apr-25**	**May-25**	**Jun-25**
Patient Days	6,428	6,812	6,903	6,159	6,405	7,198	7,890	7,516	7,673	7,055	7,600	7,313
Avg Daily Census	**207**	**220**	**230**	**199**	**214**	**232**	**255**	**268**	**248**	**235**	**245**	**244**
Discharges	1,368	1,391	1,401	1,315	1,357	1,470	1,508	1,432	1,616	1,579	1,730	1,573
ALOS (Excl. OB)	**4.70**	**4.90**	**4.93**	**4.68**	**4.72**	**4.90**	**5.23**	**5.25**	**4.75**	**4.47**	**4.39**	**4.65**
CMI (Excl. OB)	1.80	1.89	1.78	1.74	1.80	1.74	1.76	1.71	1.78	1.75	1.75	1.69
PMC - Poway												
Patient Days	1,424	1,602	1,559	1,603	1,572	1,655	2,109	1,887	1,609	1,261	1,575	1,579
Avg Daily Census	**46**	**52**	**52**	**52**	**52**	**53**	**68**	**67**	**52**	**42**	**51**	**53**
Discharges	383	404	387	397	384	475	478	448	433	411	455	449
ALOS (Excl. OB)	**3.72**	**3.97**	**4.03**	**4.04**	**4.09**	**3.48**	**4.41**	**4.21**	**3.72**	**3.07**	**3.46**	**3.52**
CMI (Excl. OB)	1.53	1.50	1.46	1.48	1.52	1.36	1.47	1.58	1.46	1.45	1.35	1.40
District Total												
Patient Days	7,852	8,414	8,462	7,762	7,977	8,853	9,999	9,403	9,282	8,316	9,175	8,892
Avg Daily Census	**253**	**271**	**282**	**250**	**266**	**286**	**323**	**336**	**299**	**277**	**296**	**296**
Discharges	1,751	1,795	1,788	1,712	1,741	1,945	1,986	1,880	2,049	1,990	2,185	2,022
ALOS (Excl. OB)	**4.48**	**4.69**	**4.73**	**4.53**	**4.58**	**4.55**	**5.03**	**5.00**	**4.53**	**4.18**	**4.20**	**4.40**
CMI (Excl. OB)	1.74	1.81	1.71	1.69	1.75	1.66	1.69	1.68	1.72	1.69	1.67	1.63

Average Length of Stay

Palomar Health

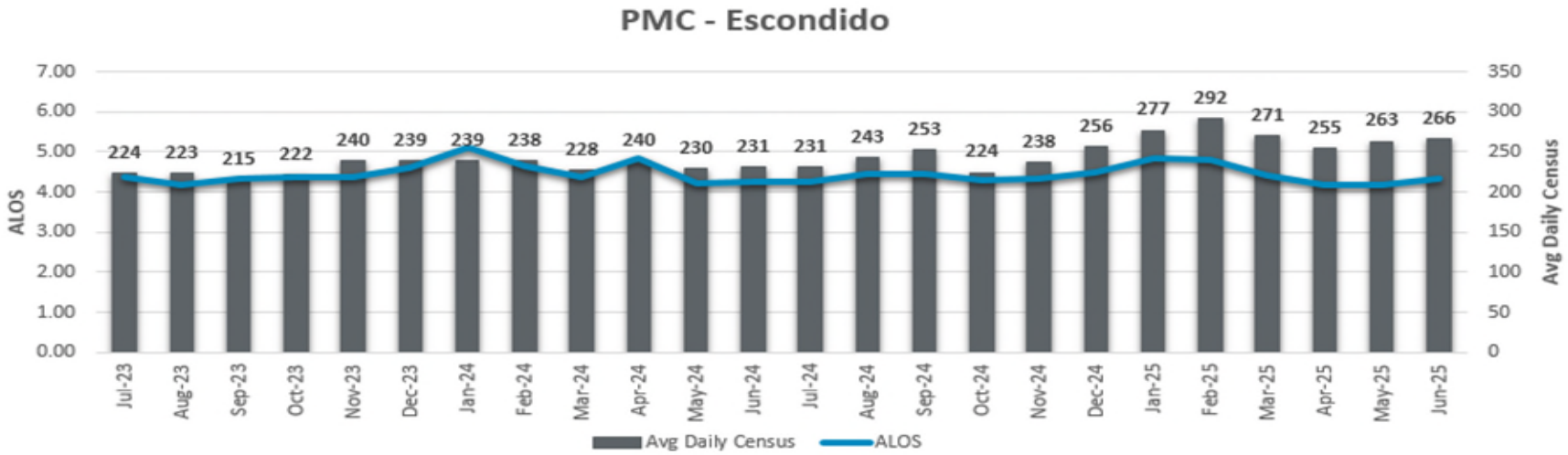


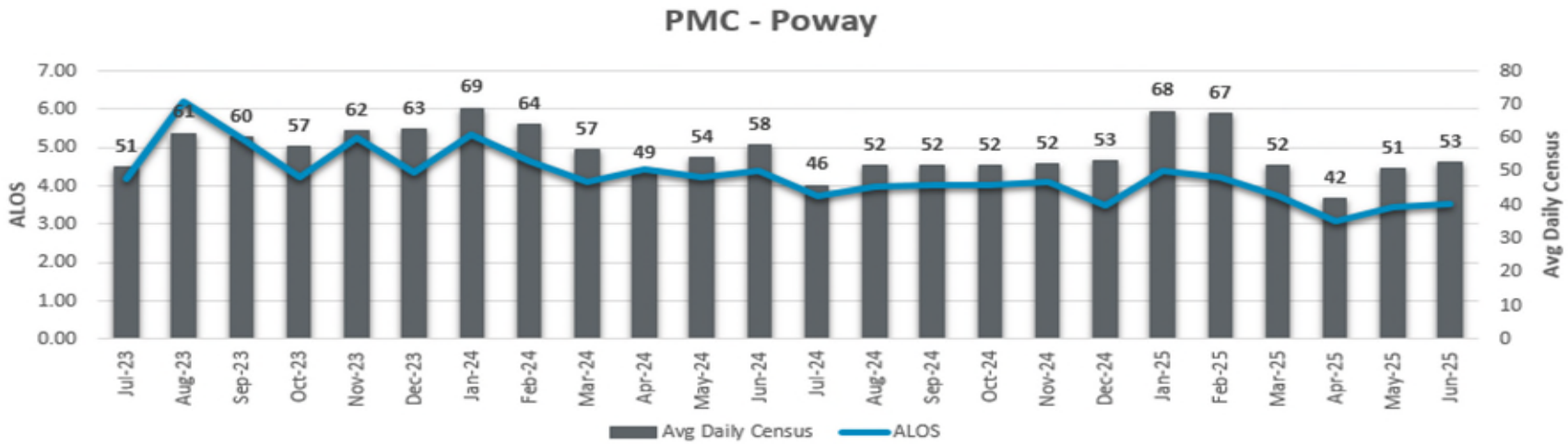


Average Length of Stay Trend

	Excluding OB					Including OB				
	FYTD22 June	FYTD23 June	FYTD24 June	FYTD25 June	Trend Line *FY24 to FYTD25*	FYTD22 June	FYTD23 June	FYTD24 June	FYTD25 June	Trend Line *FY24 to FYTD25*
PMC - Escondido										
Patient Days	74,680	76,769	75,450	84,952		82,077	86,317	84,345	93,268	
Discharges	15,074	15,400	15,290	17,740		18,316	19,303	18,887	21,133	
Avg Daily Census	205	210	206	233		225	236	230	256	
ALOS	4.95	4.99	4.93	4.79		4.48	4.47	4.47	4.41	
CMI	1.68	1.65	1.84	1.76		1.67	1.65	1.66	1.62	
PMC - Poway										
Patient Days	26,035	21,331	21,553	19,435		27,708	22,730	21,553	19,435	
Discharges	4,698	4,486	4,611	5,104		5,468	5,150	4,611	5,104	
Avg Daily Census	71	58	59	53		76	62	59	53	
ALOS	5.54	4.76	4.67	3.81		5.07	4.41	4.67	3.81	
CMI	1.45	1.48	1.50	1.46		1.44	1.48	1.50	1.46	
District Total										
Patient Days	100,715	98,100	97,003	104,387		109,785	109,047	105,898	112,703	
Discharges	19,772	19,886	19,901	22,844		23,784	24,453	23,498	26,237	
Avg Daily Census	276	269	265	286		301	299	289	309	
ALOS	5.09	4.93	4.87	4.57		4.62	4.46	4.51	4.30	
CMI	1.62	1.62	1.77	1.70		1.62	1.61	1.63	1.59	

ALOS & Avg. Daily Census





CMS Age Friendly Data

Escondido

	2025						
	Jan	Feb	Mar	Apr	May	Jun	Total
Census	2,345	2,006	2,129	1,999	2,157	2,059	12,695
Total Admissions	888	793	844	858	887	872	5,142
% Overall LOS < 8 hrs (CMS)	63%	62%	71%	74%	70%	70%	68%
Median Overall LOS (hours)	6.1	6.2	5.8	5.6	5.8	5.8	5.9
Avg. Overall LOS (hours)	11.1	10.5	8.1	7.3	8.2	8.1	8.9
% Boarding < 3 hrs (CMS goal)	11%	12%	30%	36%	33%	29%	25%
Median Boarding (hours)	15.9	10.5	4.6	4.0	4.2	4.8	5.8
Avg. Boarding (hours)	16.6	14.5	8.7	6.7	8.1	8.1	10.4
Median Discharge LOS (hours)	4.7	4.6	4.6	4.4	4.6	4.4	4.5
Avg. Discharge LOS (hours)	5.2	5.1	5.1	4.8	5.2	5.0	5.1

Poway

	2025						
	Jan	Feb	Mar	Apr	May	Jun	Total
Census	996	815	873	921	947	948	5,500
Total Admissions	353	267	256	252	292	287	1,707
% Overall LOS < 8 hrs (CMS)	75%	82%	89%	89%	88%	85%	85%
Median Overall LOS (hours)	5.2	4.9	4.8	4.6	4.8	4.9	4.9
Avg. Overall LOS (hours)	6.9	6.2	5.5	5.4	5.5	5.8	5.9
% Boarding < 3 hrs (CMS goal)	38%	52%	63%	75%	65%	59%	58%
Median Boarding (hours)	3.9	2.9	2.3	2.0	2.3	2.5	2.6
Avg. Boarding (hours)	7.2	5.4	4.3	3.9	3.8	4.8	5.0
Median Discharge LOS (hours)	4.1	4.2	4.0	4.0	4.0	4.3	4.1
Avg. Discharge LOS (hours)	4.7	4.5	4.3	4.5	4.4	4.5	4.5

CMS Age Friendly Data – Level of Care

Age Friendly | PMC-Escondido

ED Overview and Age Friendly Admission LOC

PALOMAR HEALTH

Overview of ED

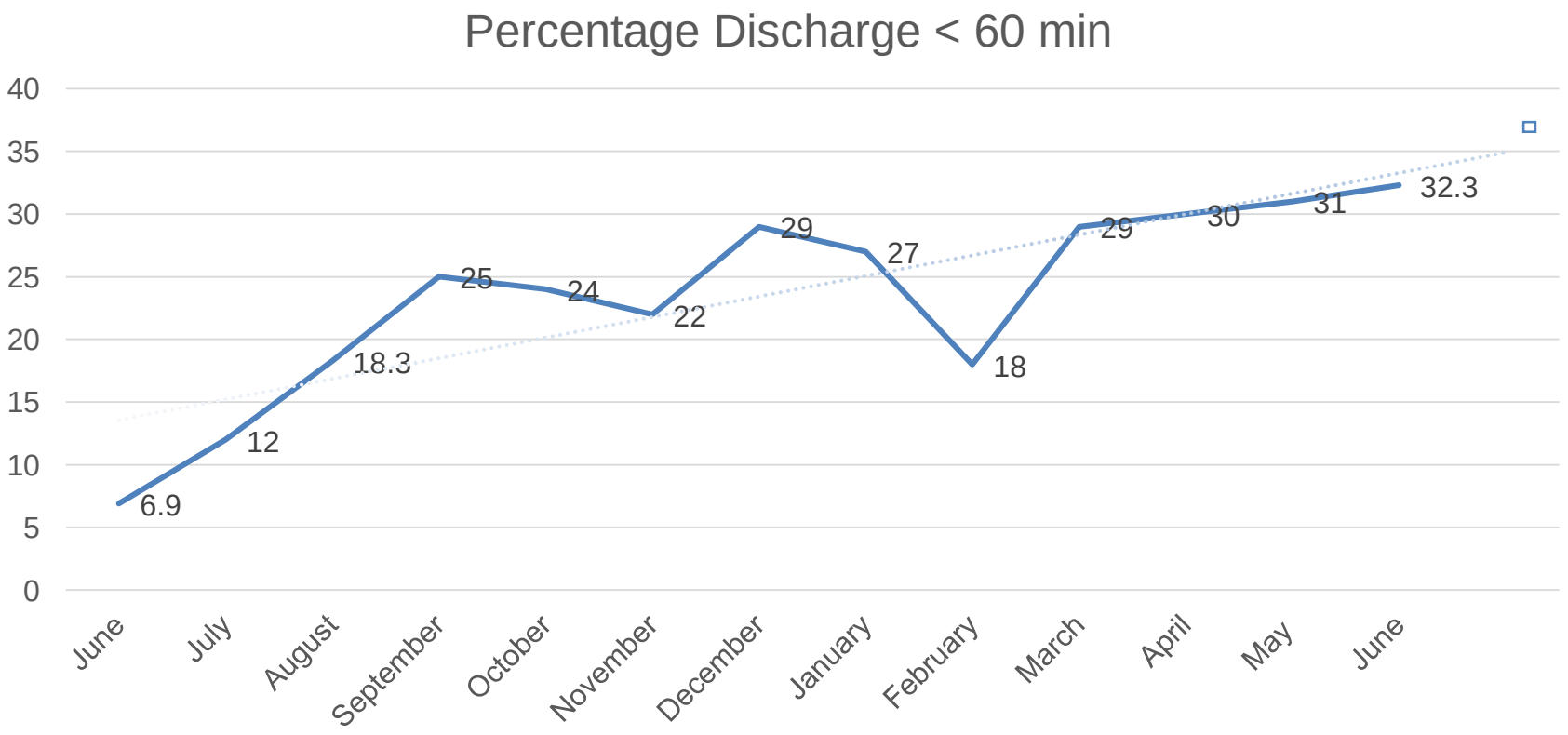
	Age Friendly Grouping	07/20	07/21	07/22	07/23	07/24	07/25	07/26	07/27	07/28	07/29
Census	< 65	157	170	173	141	169	187	134	158	144	163
	>= 65	67	71	65	71	72	73	65	61	60	72
	Total	224	241	238	212	241	260	199	219	204	235
Admissions	< 65	24	23	22	22	25	18	19	19	19	14
	>= 65	30	26	22	37	27	26	29	27	26	28
	Total	54	49	44	59	52	44	48	46	45	42

Admissions by Level of Care >=65*

Level of Care	07/20	07/21	07/22	07/23	07/24	07/25	07/26	07/27	07/28	07/29
NO PSO AT TIME OF REPORT RUN	0	0	0	0	0	0	0	0	0	5
INTENSIVE CARE/CRITICAL CARE	3	4	1	4	2	2	0	1	1	3
INTERMEDIATE CARE	4	1	0	4	1	5	5	2	6	4
MED/SURG	7	7	8	9	5	4	6	4	5	5
NICU (3) INTERMEDIATE CARE	0	0	0	0	0	0	0	0	0	1
TELEMETRY	13	13	11	17	15	14	18	18	13	10
TRAUMA CCU	1	0	1	2	0	0	0	2	1	0
TRAUMA IMC	1	1	1	1	4	1	0	1	0	0
TRAUMA MED-SURG	1	0	0	0	0	0	0	0	0	0
TOTAL	30	26	22	37	27	26	29	27	26	28

Escondido | DC 60 Monthly Trends

Baseline Measurement Period: June 1, 2024, through June 30, 2025



Perioperative Services

Bruce Grendell MPH, BSN, RN
Sr. Director, District Perioperative Services
August 13th, 2025

Presented to Quality Management Cttee (QMC)

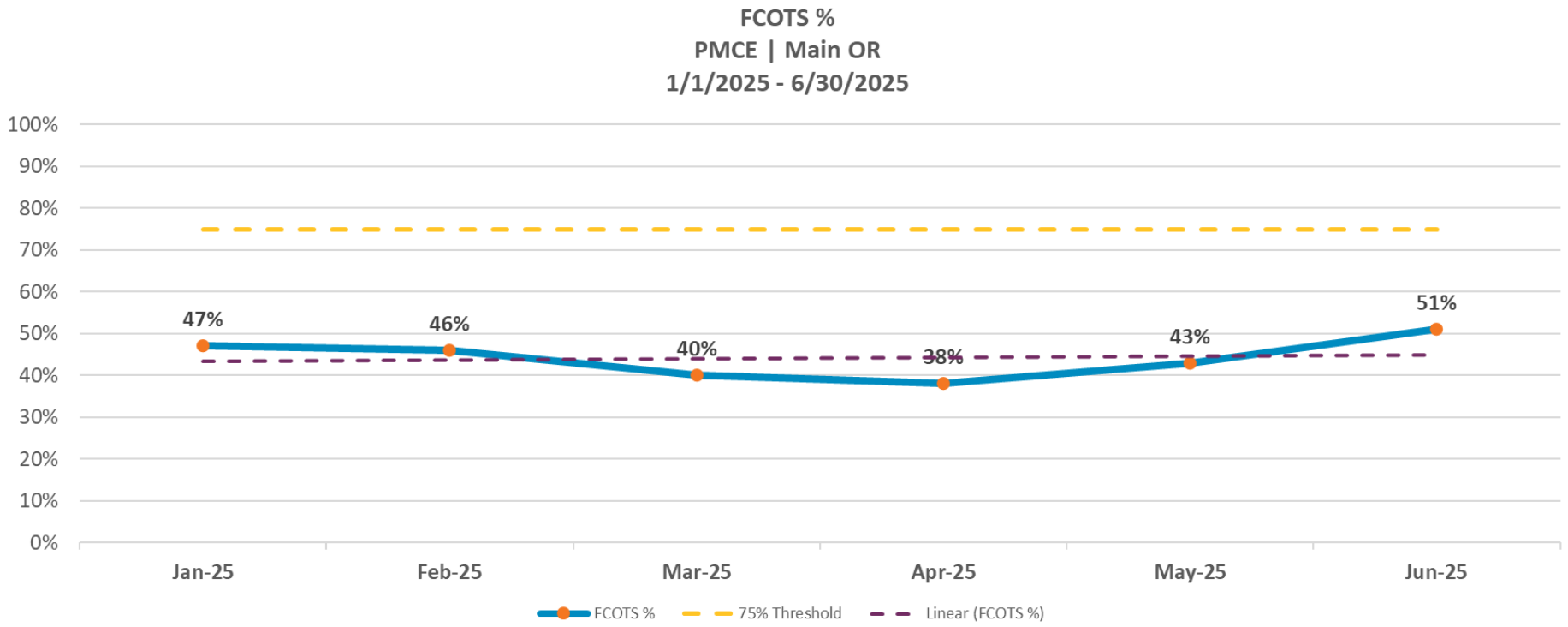
PALOMAR HEALTH
Reimagining Healthcare

Perioperative Services KPIs

SITUATION	The Palomar Health Executive Leadership Team has recommended that Operating Room Leadership track and trend six Key Performance Indicators (KPIs) on a monthly basis in order to improve operational efficiency. • First Case on Time Starts (FCOTS) • Turn Around Time (TAT) • Block Time Utilization (BUR) • Block Release Time • Operating Room Capacity • Scheduled Case Duration Accuracy
BACKGROUND	KPI metrics selected for review are standard benchmarks in the community
ASSESSMENT	KPI metrics will be reported monthly at each OR Committee.
RECOMMENDATION	The KPI metrics related to OR efficiency will be tracked, trended, and action plans developed for continuous process improvement.

FCOTS | PMCE

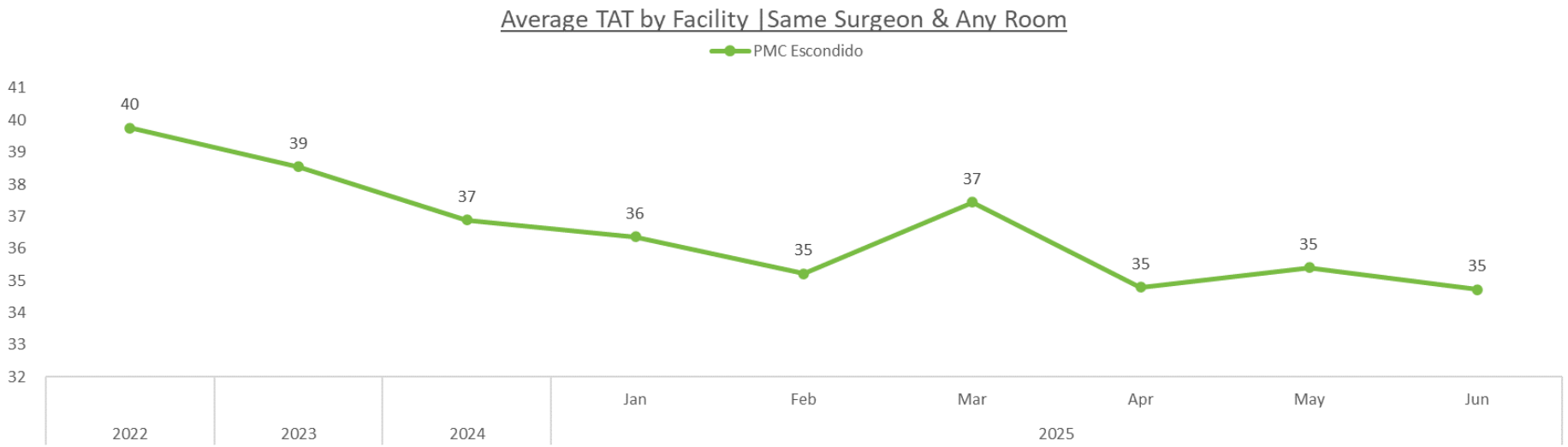
April 2025 – June 2025 Average Room Utilization = 44%



o First Case on Time Start = Patient in the OR by the scheduled start time of the procedure. | Target Threshold = **75% (Higher is better)**

TAT | PMCE

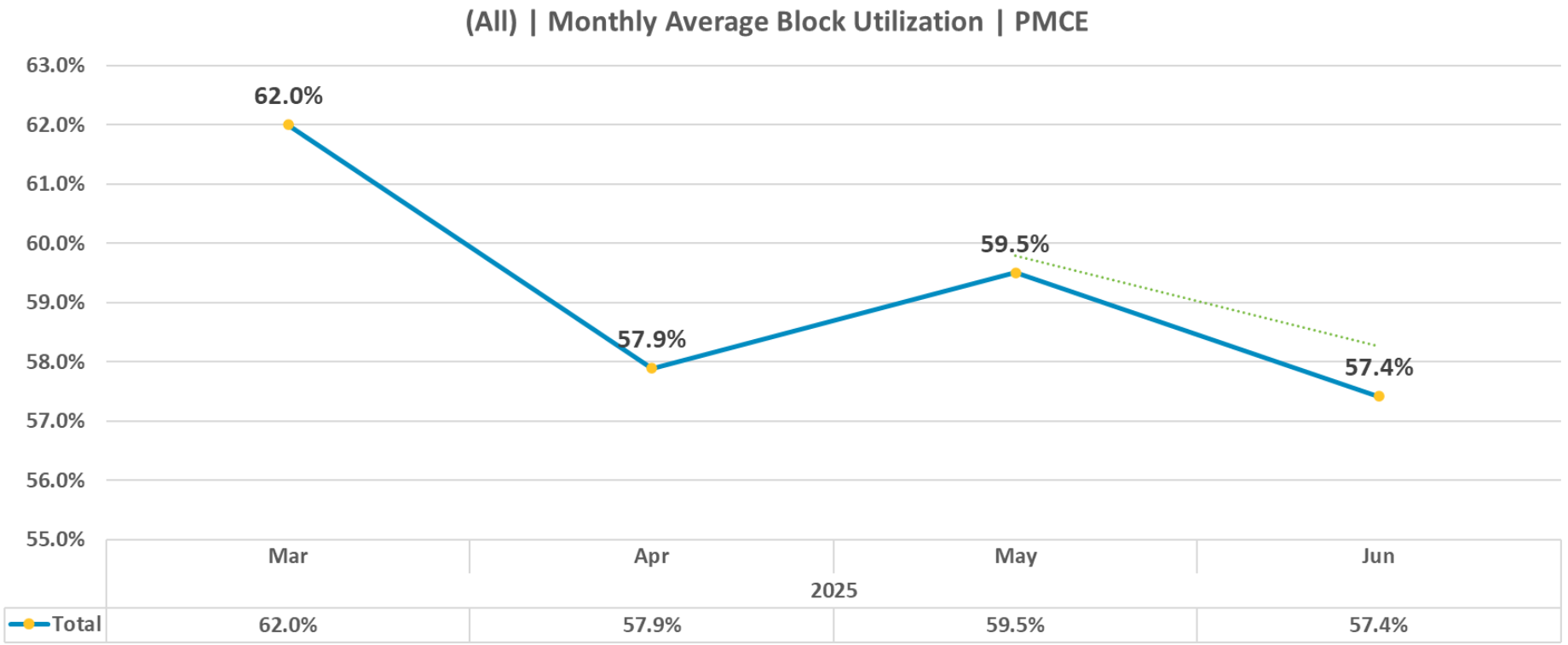
3 Month Average PMCE (Apr 25 – Jun 25) = 35



o Turn Around Time = (Patient Wheels Out of the Prior Case – Patient Wheels In of the Next Case) **(Lower is better)**

BUR | PMCE

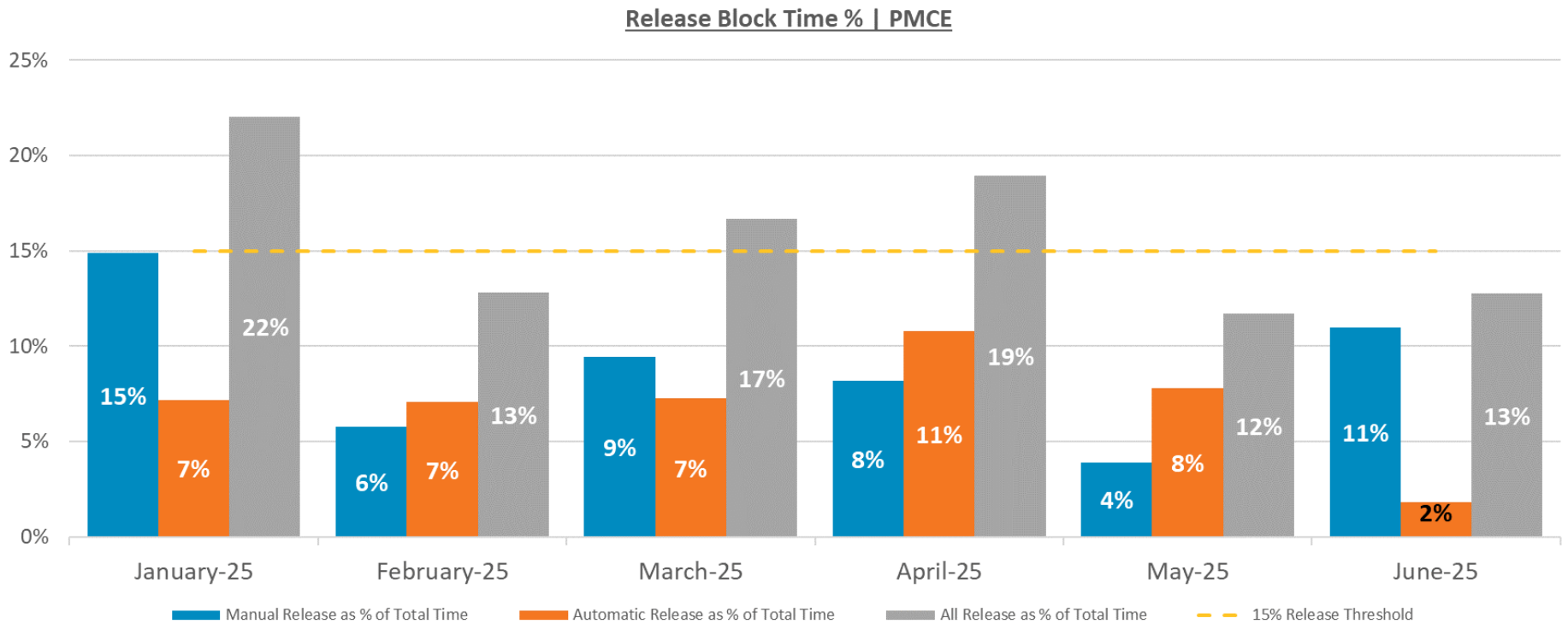
April 2025 – June 2025 Average Block Utilization = 58.3%



o Average includes only those Surgeon and Surgeon Group Blocks | BUR Goal = **75% (Higher is better)**

Release Time % | PMCE

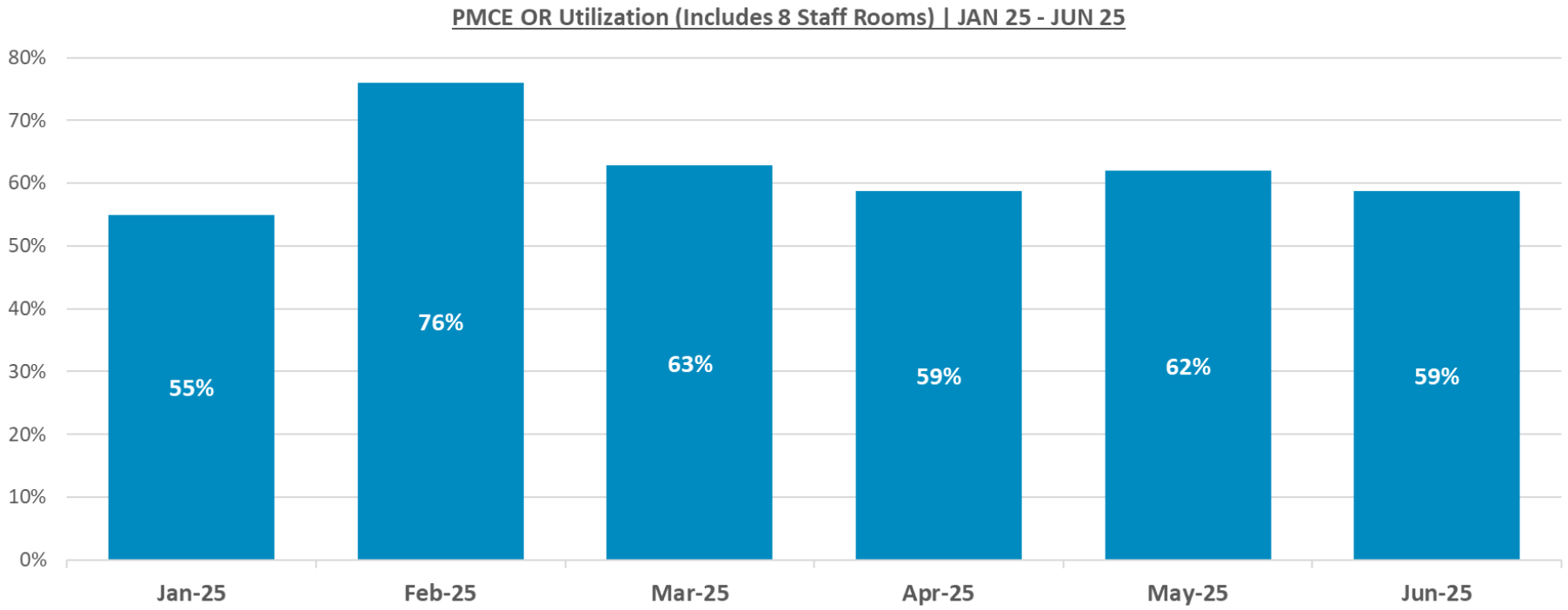
April 2025 – June 2025: Manual Release = 8% |Automatic Release = 7% | All Release = 15%



o Starting July 1st, 2025: Blocks must be manually released **14** Calendar Days prior to the start of the block if they will not be used. | Blocks automatically release **7** Calendar Days prior to the start of the block | Threshold of all Releases = **15% (Lower percentage is better)**

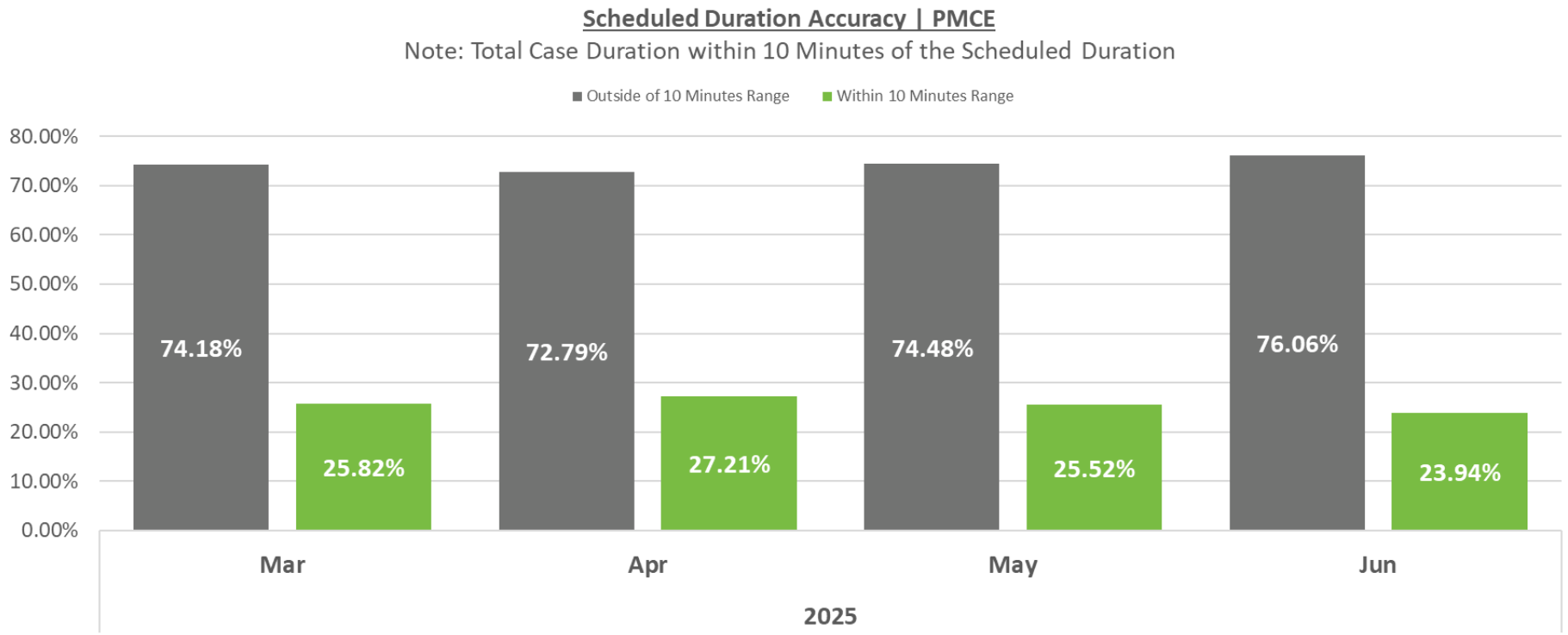
OR Capacity | PMCE

April 2025 – June 2025 Average Room Utilization = 61.15%



o **Room Utilization** = Total Time Patient In Room (Wheels Out – Wheels In) ÷ Total Allocated Time During Normal Hours of Operation M – F Includes block time and FCFS Open Community Time | Goal: **75% (Higher is better)**

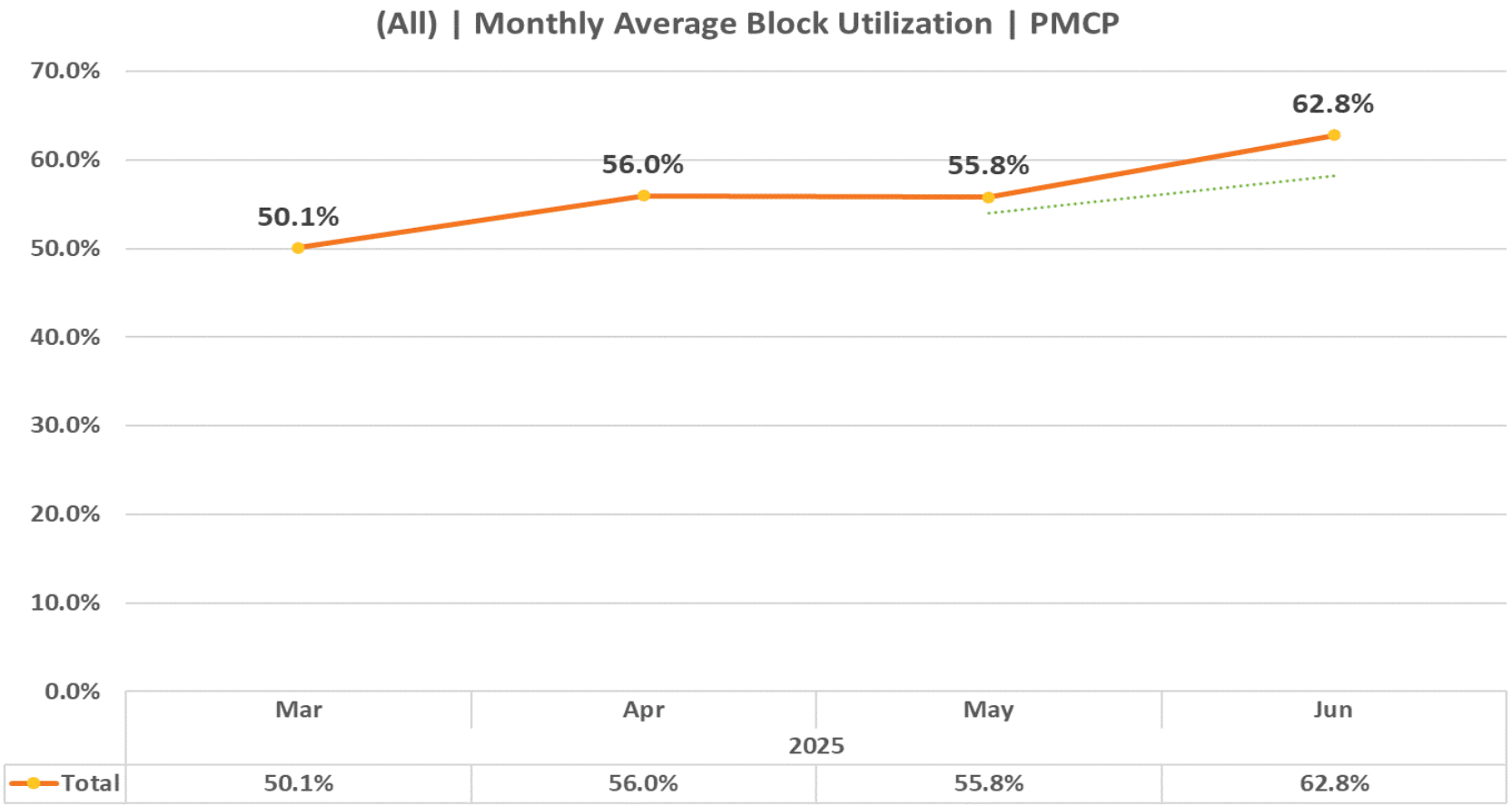
Scheduled Case Duration Accuracy | PMCE



o Scheduled Case Duration Accuracy goal is One Standard Deviation of a normal distribution

BUR | PMCP

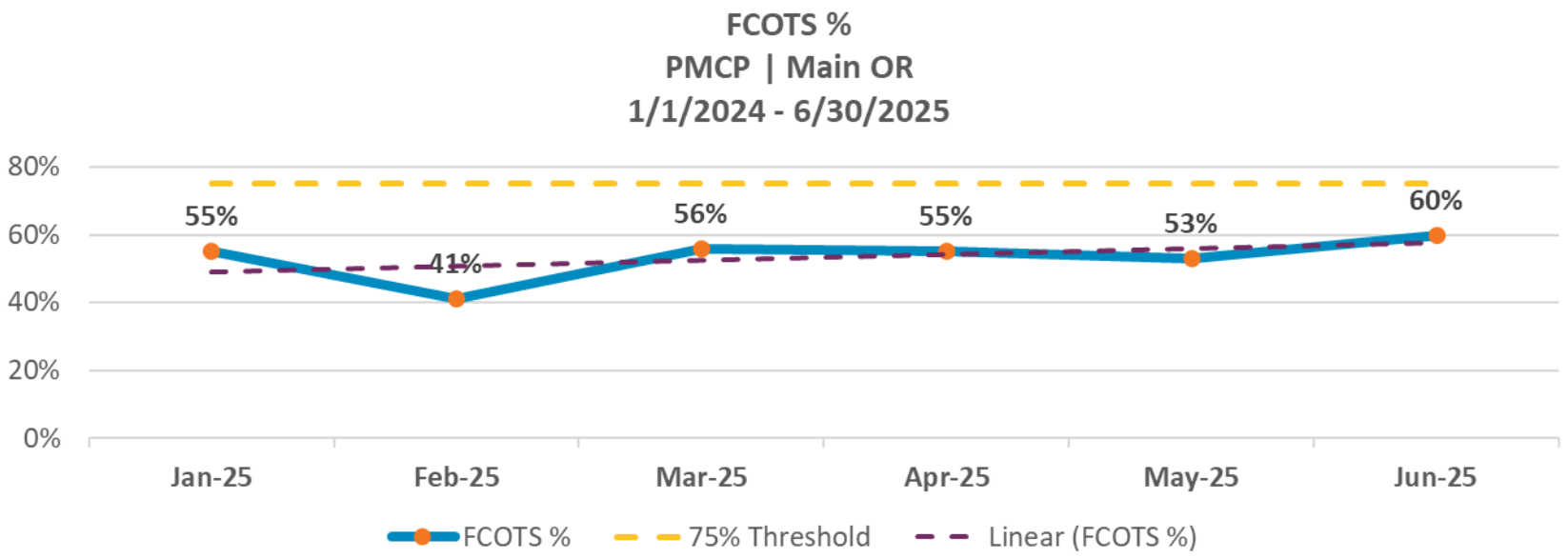
April 2025 – June 2025 Average Block Utilization = 58.0%



o Average includes only those Surgeon and Surgeon Group Blocks | BUR Goal = **75% (Higher is better)**

FCOTS | PMCP

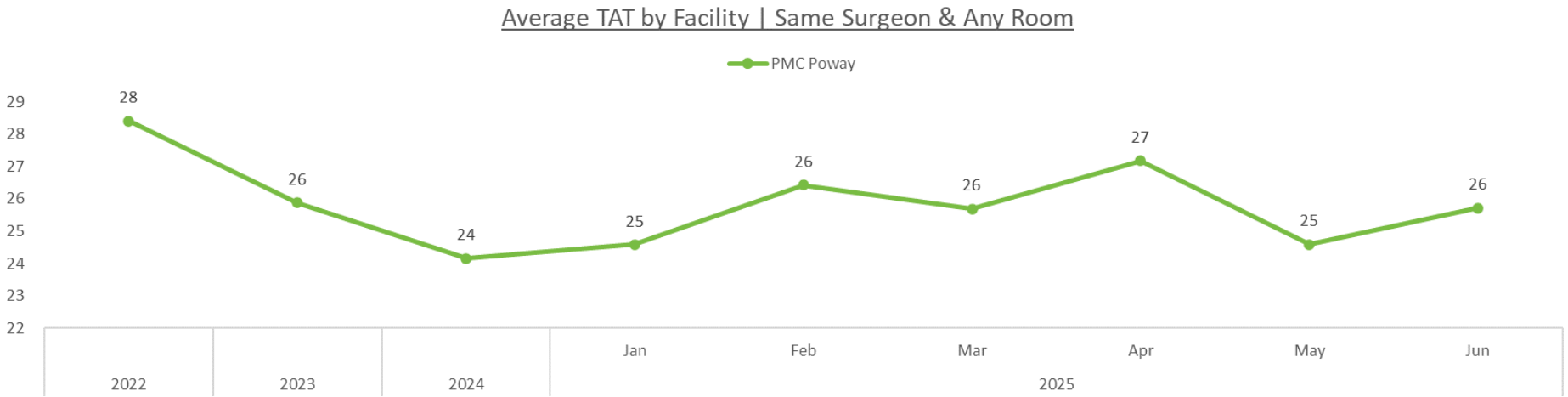
April 2025 – June 2025 Average Room Utilization = 56%



o First Case on Time Start = Patient in the OR by the scheduled start time of the procedure. | Target Threshold = **75% (Higher is better)**

TAT | PMCP

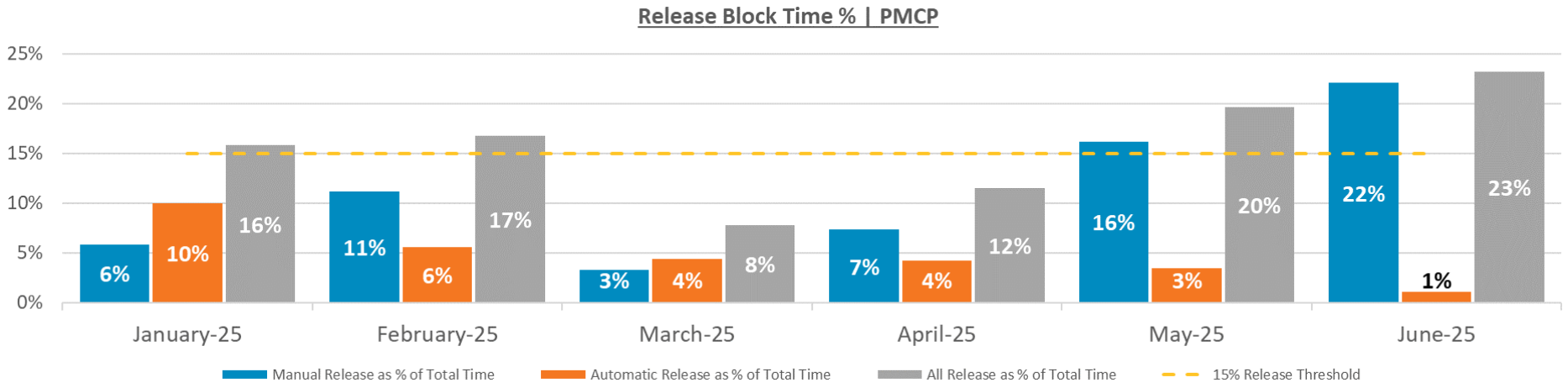
April 2025 – June 2025 Average TAT = 26



o Turn Around Time = (Patient Wheels Out of the Prior Case – Patient Wheels In of the Next Case) **(Lower is better)**

Release Time % | PMCP

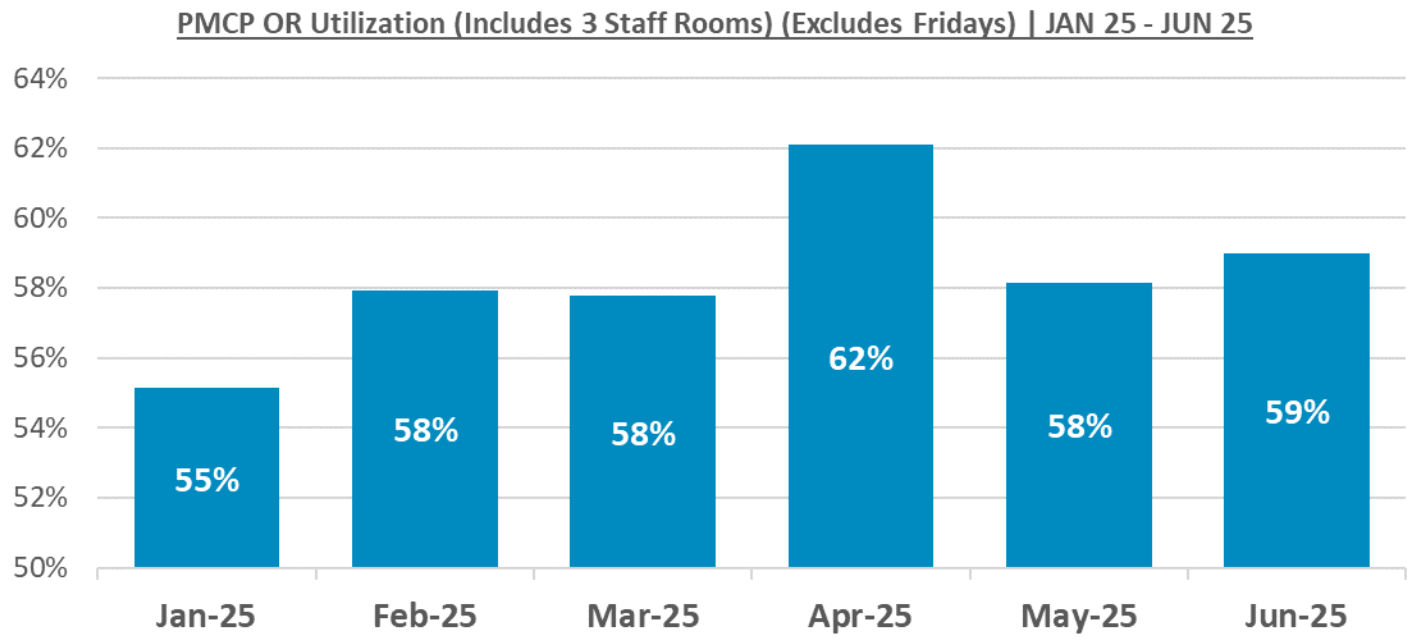
April 2025 – June 2025: Manual Release = 15% |Automatic Release = 3% | All Release = 18%



o Starting July 1st, 2025: Blocks must be manually released **14** Calendar Days prior to the start of the block | Blocks automatically release **7** Calendar Days prior to the start of the block | Threshold of all Releases = **15% (Lower percentage is better)**

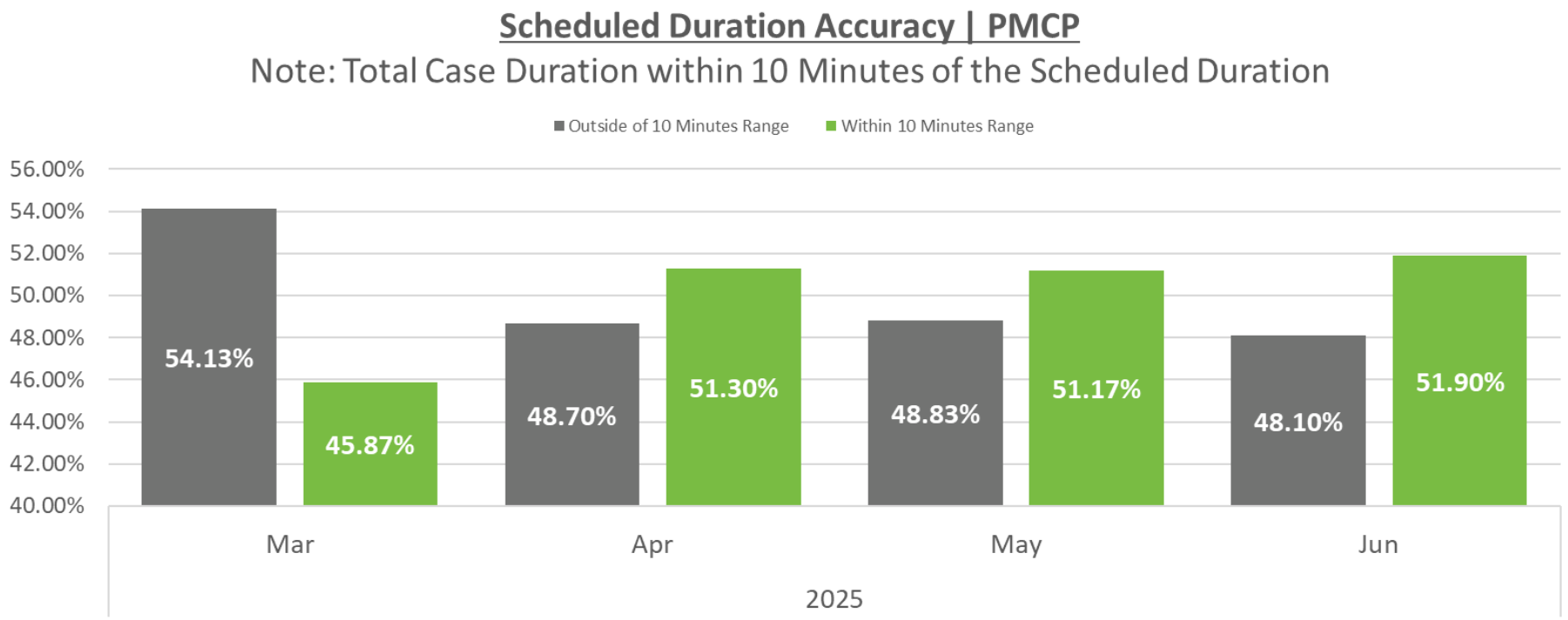
OR Capacity | PMCP

April 2025 – June 2025 Average Room Utilization = 59.83%



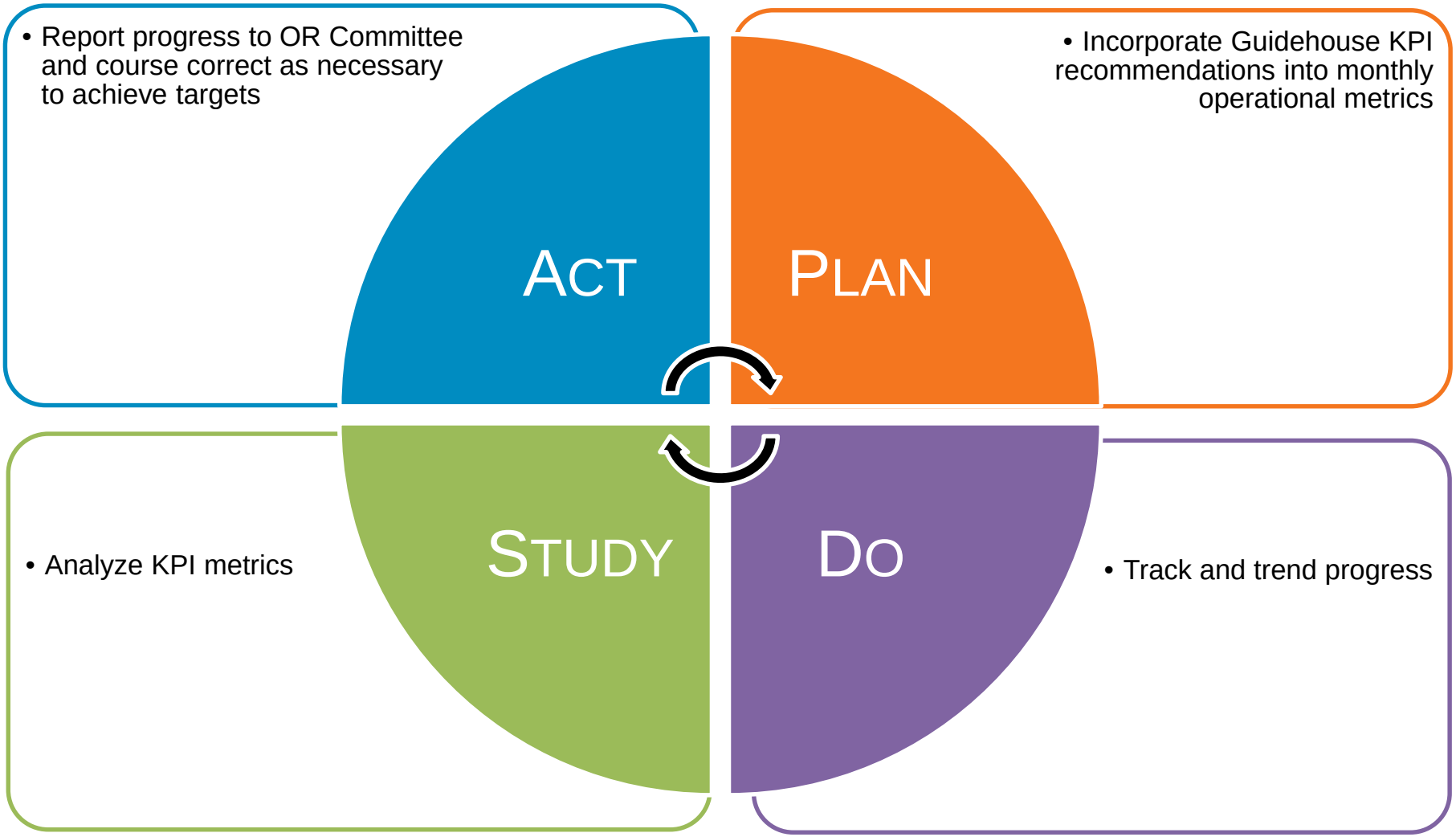
o **Room Utilization** = Total Time Patient In Room (Wheels Out – Wheels In) ÷ Total Allocated Time During Normal Hours of Operation M – F Includes block time and FCFS Open Community Time | Goal: **75% (Higher is better)**

Scheduled Case Duration Accuracy | PMCP



o Scheduled Case Duration Accuracy goal is One Standard Deviation of a normal distribution

PDSA – Continuous Process Improvement



Action Plan with Timeline

By the conclusion of FY26 (June 30, 2026) we will meet or exceed the following OR Key Performance Indicators.

- FCOTS ≥ 75%
- TAT ≤ 30 minutes
- Block Time Utilization ≥ 75%
- Block Release Time ≤ 15%
- OR Operational Capacity ≥ 75%
- Scheduled Case Duration Accuracy ≥ 68% within + / - 10 minutes. (e.g. one standard deviation in a normal curve distribution)

HCAHPS and ED Patient Experience Data

Presented to QMC
September 10th, 2025

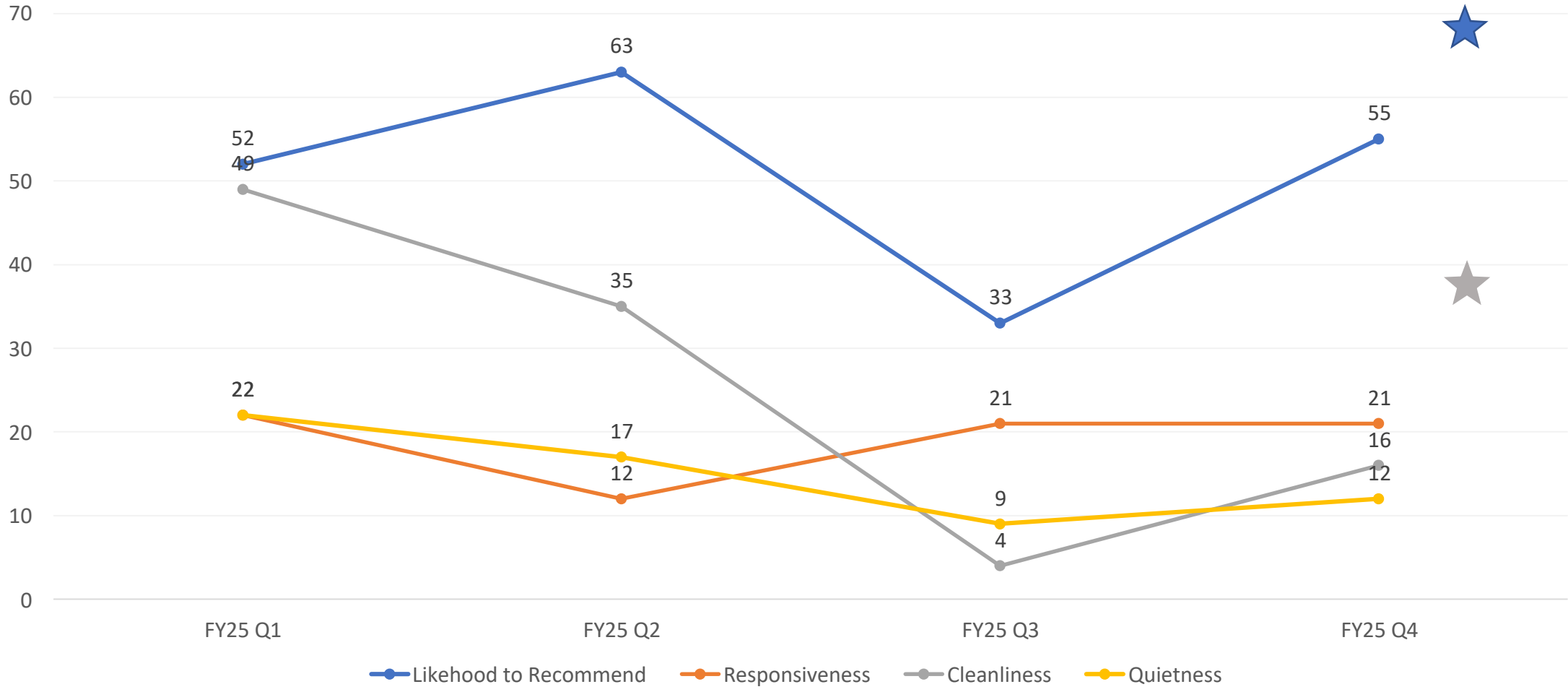
Suz Fisher, MHA, RN
District Director, Patient Experience

Situation	HCAHPS Data: Timeframe July 2024-June 2025 (FY25) ED Data: Timeframe July 2024-June 2025 (FY25)
Background	The **HCAHPS** (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. The survey was updated by CMS most recently on January 1st, 2025. In July of 2025, the executive team approved patient experience (PX) goals for leaders across the district for FY26, based on results from patients seen between April of 2024 and March of 2025, the national average rate of change for each area, and PX domains that overlap among CMS Star Ratings, Leapfrog, and Value-Based Purchasing (VBP), as well as aligning with our internal priority matrices. Results as compared to goal are tracked and updated transparently on a quarterly cadence and can be found on the Leadership drive.
Assessment	**PMC Escondido HCAHPS** – 3/9 metrics equal to or above CMS benchmark for FY25 Q4 (likelihood to recommend, overall rating, and discharge information); likelihood to recommend and discharge information have been equal to or above benchmark for the last 12 consecutive quarters. **PMC Poway HCAHPS** – 1/9 metrics equal to or above CMS benchmark for FY25 Q4 (communication about medications). **PMC-E Emergency Department** – 0/13 metrics equal to or above National Research Corporation (NRC) benchmark for FY25 Q4. **PMC-P Emergency Department** – 3/13 metrics equal to or above National Research Corporation (NRC) benchmark for FY25 Q4 (doctors explained understandably, doctors listened carefully, and imaging exceeded expectations); doctors explaining has been equal to or above benchmark for the last 12 consecutive quarters, and our internal goal was also met for imaging exceeding expectations for the second consecutive quarter.
Recommendation	• PX goals were further individualized in various areas for FY26 based on overlapping domains and priority matrices in order to ensure alignment and impact to value-based purchasing, Leapfrog, and CMS Star Ratings. • PX goals and results continue to be shared in a standardized manner at leadership meetings, every other week at safety huddle, at Diane's directors-and-above meeting, and at Town Halls. • Leaders meet monthly with leaders who report to them to discuss results as compared to goal and plans to close the gap/sustain; some areas are also incorporating this into team meetings, which is a best practice. • PEC continues to meet on a monthly cadence; leaders report out and discuss results compared to goal quarterly on a rotating basis for alignment, accountability, and best practice sharing – this has been very well received.

HCAHPS

Results current as of 8/25/25

Escondido Results, by Percentile



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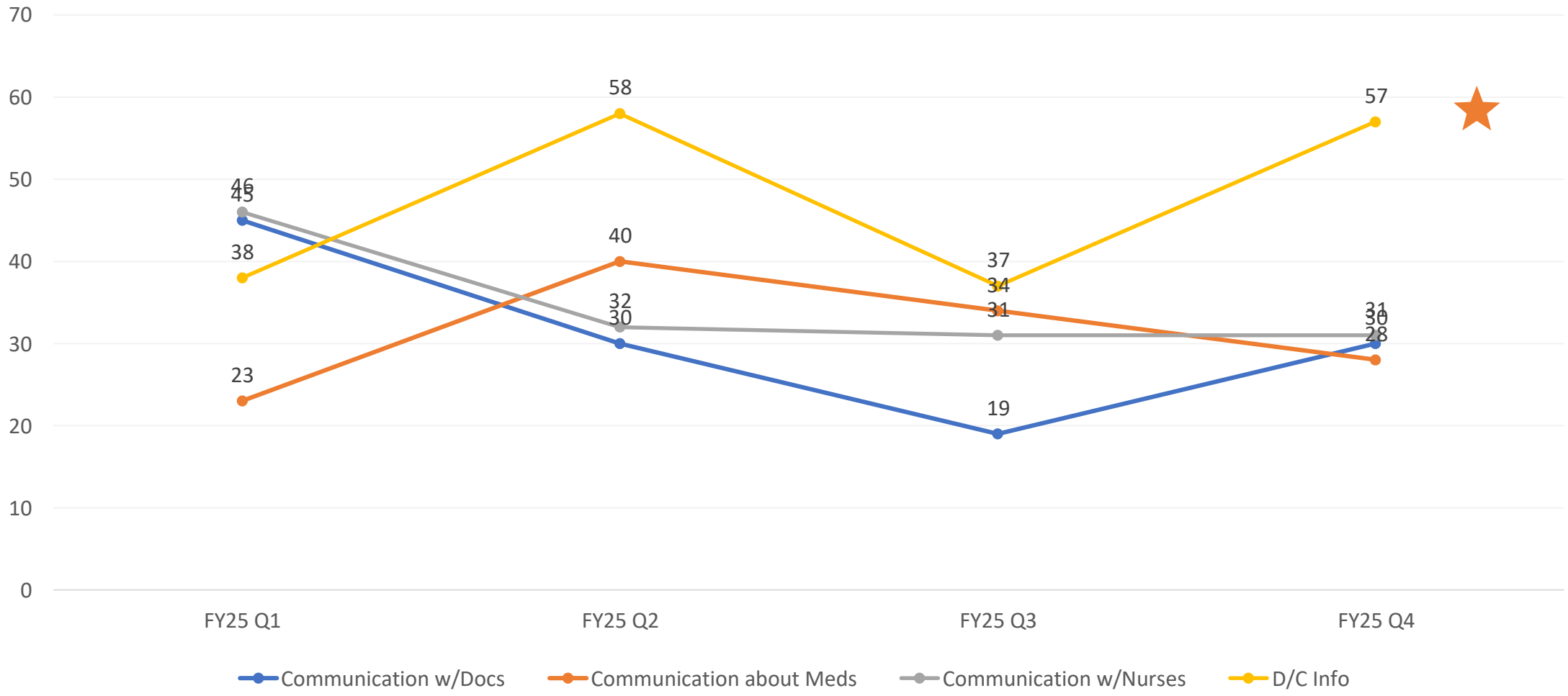
★ indicates approximate FY25 goals for the campus overall. Responsiveness and quietness have unit-level goals.

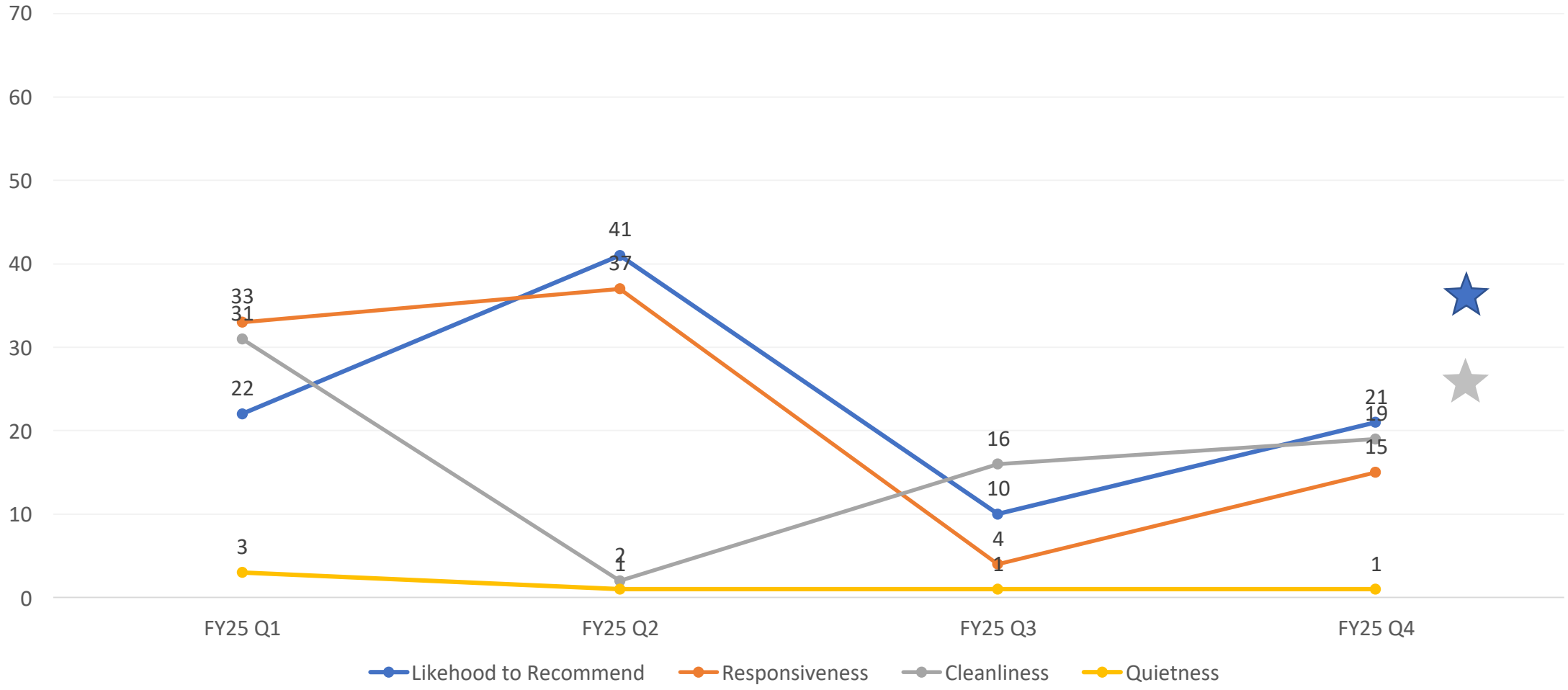
Escondido Results, by Percentile



PALOMAR HEALTH
Reimagining Healthcare

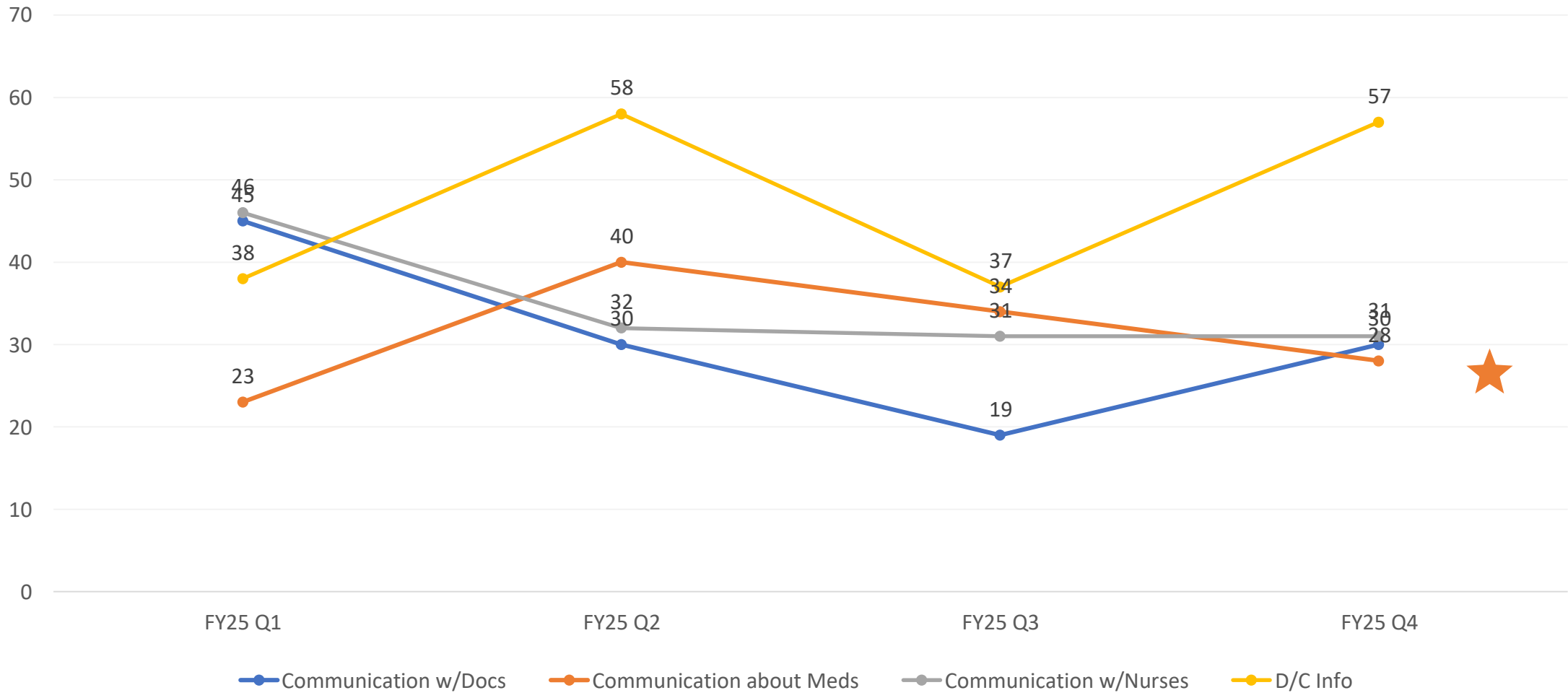
★ indicates approximate FY25 goal for the campus overall. Communication with nurses has unit-level goals; communication with doctors and D/C info did not have formal goals in FY25.

Poway Results, by Percentile



★ indicates approximate FY25 goals for the campus overall. Responsiveness and quietness have unit-level goals.

Poway Results, by Percentile



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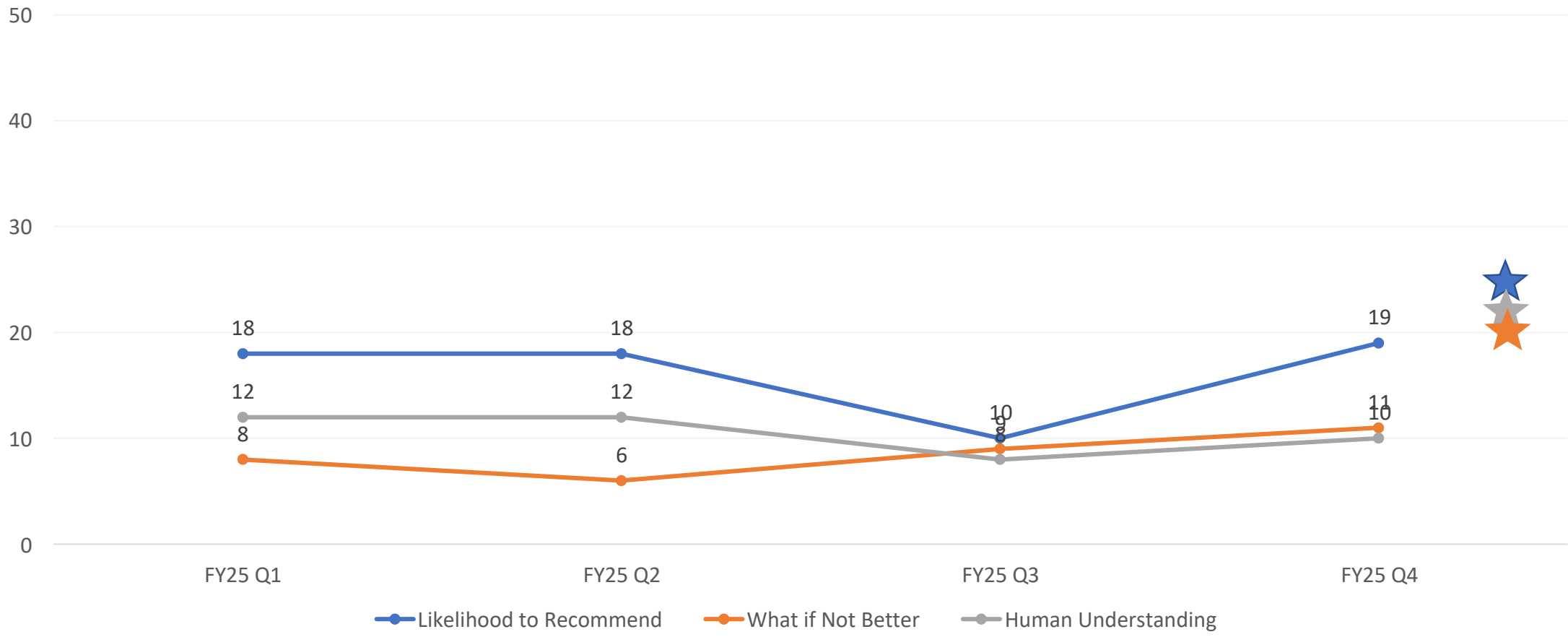
★ indicates approximate FY25 goal for the campus overall. Communication with nurses has unit-level goals; communication with doctors and D/C info did not have formal goals in FY25.

Emergency Department

Results current as of 8/25/25

Escondido ED Results, by Percentile



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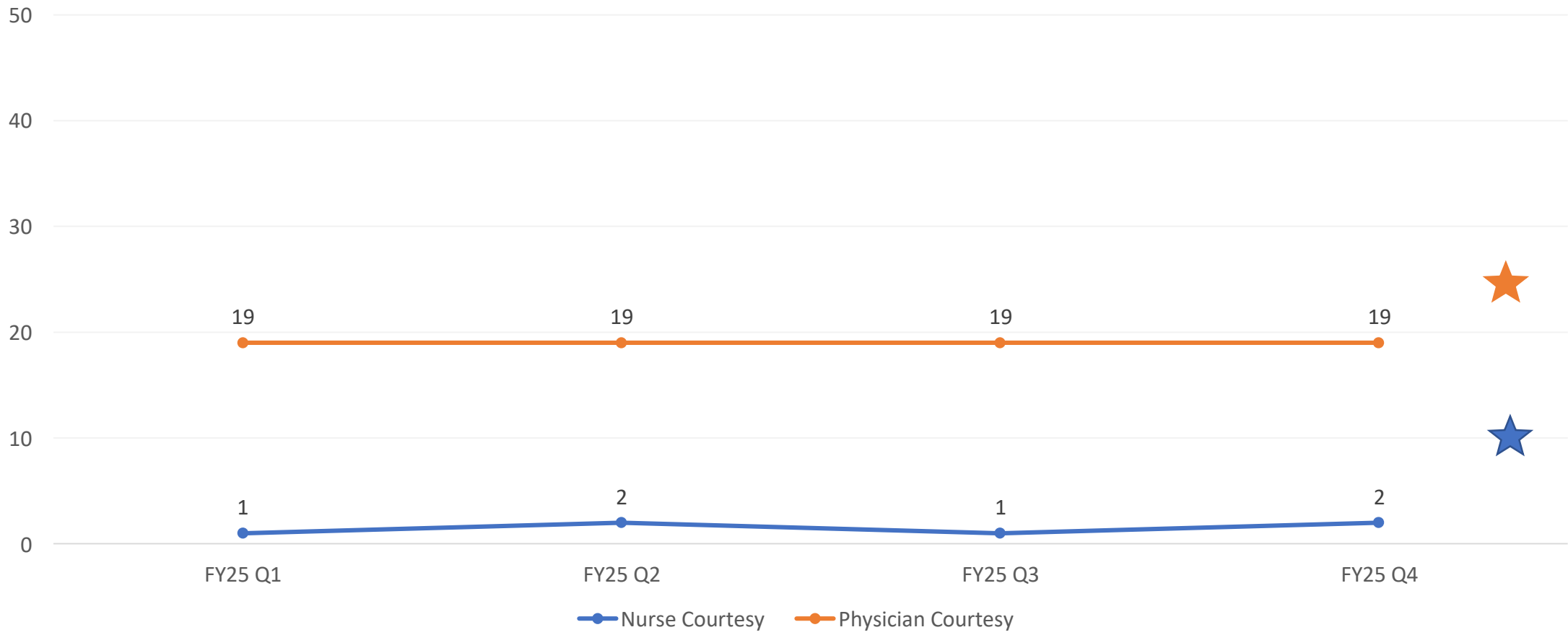
★ indicates approximate FY25 goal

Escondido ED Results, by Percentile



PALOMAR HEALTH
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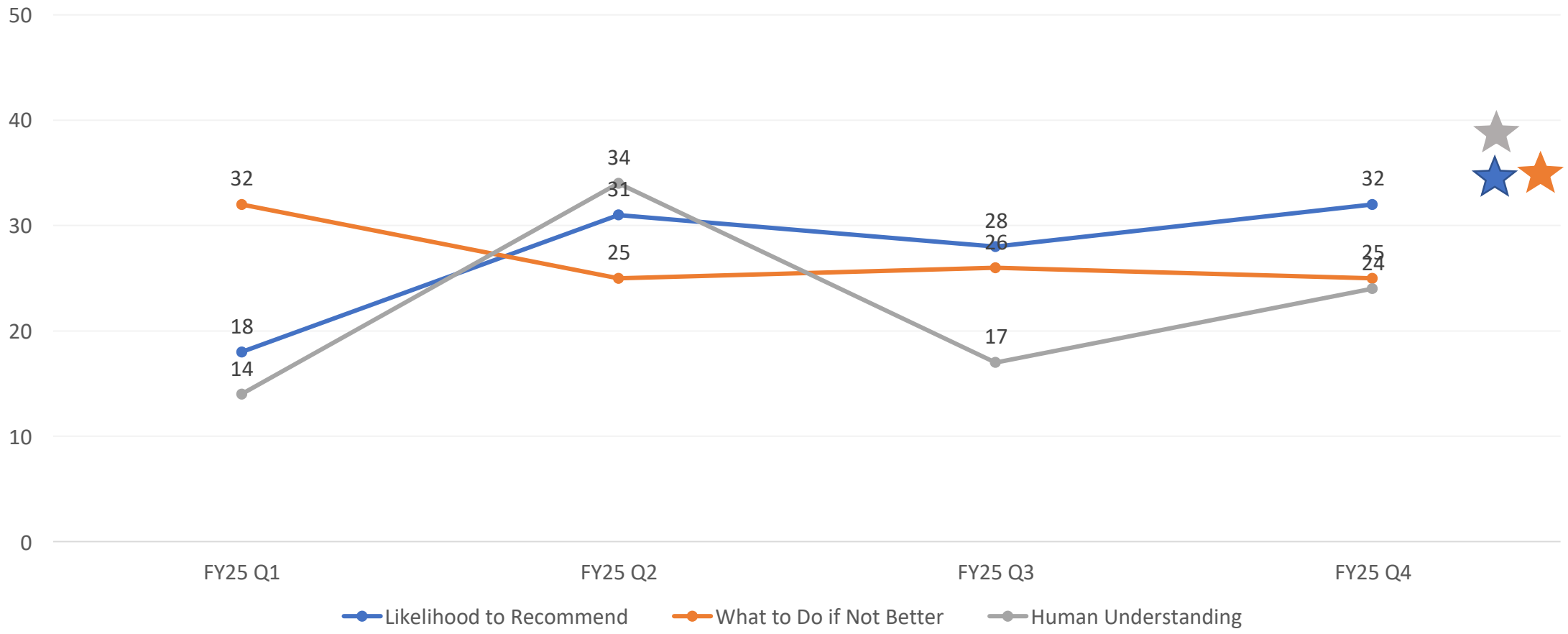
★ indicates approximate FY25 goal

Poway ED Results, by Percentile



PALOMAR HEALTH
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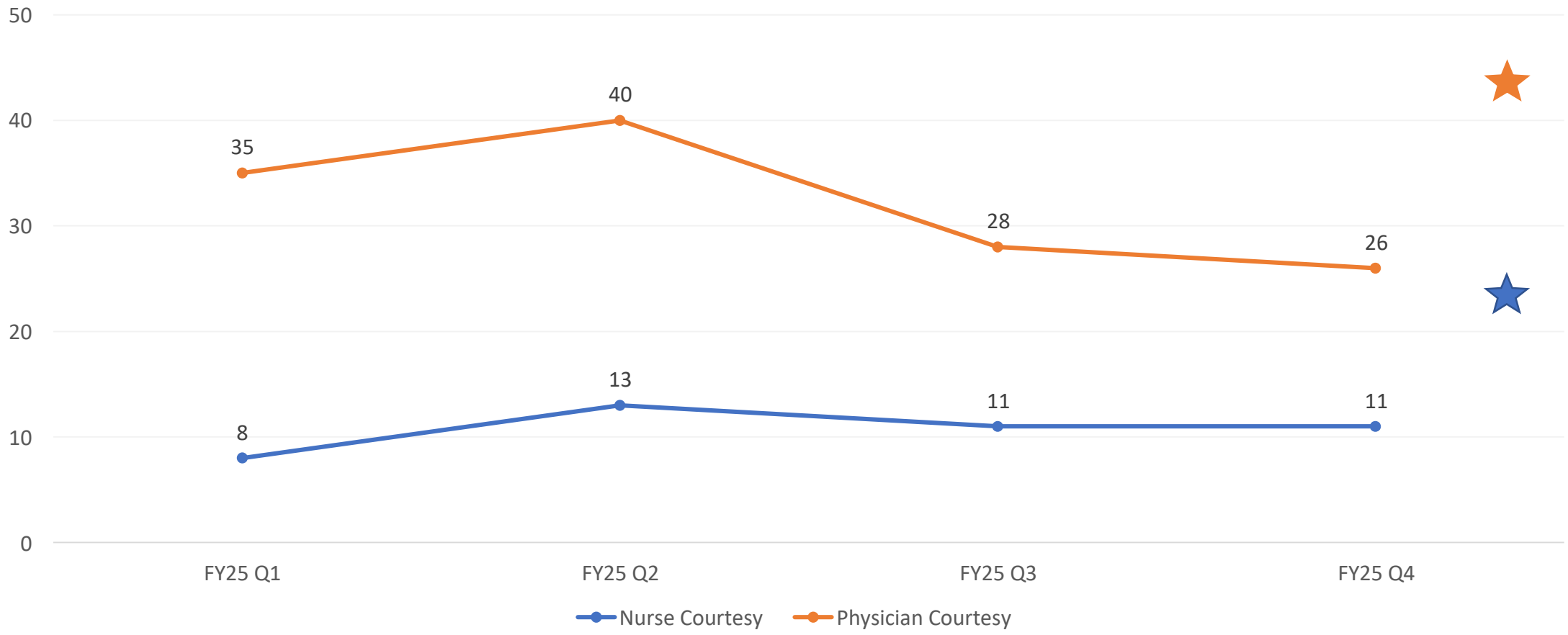
★ indicates approximate FY25 goal

Poway ED Results, by Percentile



★ indicates approximate FY25 goal

Safe Practices for Better Healthcare

Valerie Martinez RN, BSN, MHA, CIC, CPHQ, CPPS

Senior Director of Quality & Patient Safety

BQRC October 22, 2025

National Quality Forum (NQF)

- The National Quality Forum (NQF) is a not-for-profit organization that works to improve healthcare outcomes, safety, equity, and affordability.
- NQF published a document, titled *Safe Practices for Better Healthcare*, which endorses 34 distinct practices that promote patient safety and reduce patient harm.

1. Identification and Mitigation of Risks and Hazards

- **Objective:** Ensure that patient safety risks and hazards are continually identified and communicated to all levels of the organization, that mitigation activities are aggressively undertaken to minimize harm to patients, and that patient safety information is communicated to the appropriate external organizations.

1. Identification and Mitigation of Risks and Hazards

Activities we have been undertaking to meet this objective:

- Patient and Medication Safety Committee (PMSC)meetings
  - CNE/COO and CMO are members of PMSC
  - Unit/Dept performance/process improvement activities presented
- Monthly Good Catch newsletters distributed to all levels of the organization
- Diane's Team Member Update videos
- Engage the Patient Engagement Focus Group (PEFG)
  - a former patient who is on PEFG sits on PMSC meeting
- Communication to involved stakeholders regarding Leapfrog Hospital Safety Grade and measures

2. Safety Culture Measurement, Feedback, and Intervention

- **Objective:** Ensure that organizations are measuring their patient safety culture, providing feedback to all levels of the organization, and, most importantly, undertaking interventions that generate improvements that reduce patient harm.

2. Safety Culture Measurement, Feedback, and Intervention

Activities we have been undertaking to meet this objective:

- The last Patient Safety Culture Survey was administered in July 2024.
- The next Patient Safety Culture Survey is scheduled for July 2026.
- Results from the 2024 survey were shared across the organization including senior administrative leadership and the Board.
- Follow-up meetings were held with units to discuss the unit's unique results and concerns, as captured on the survey.
- Performance improvement interventions were implemented based on the results.

2. Safety Culture Measurement, Feedback, and Intervention

Example of Performance Improvement interventions resulting from 2024 Safety Culture Survey:

"The feedback I got was: " I feel safe when I come to work"

Bulletin board
Communication
Rounds

Emergency Services

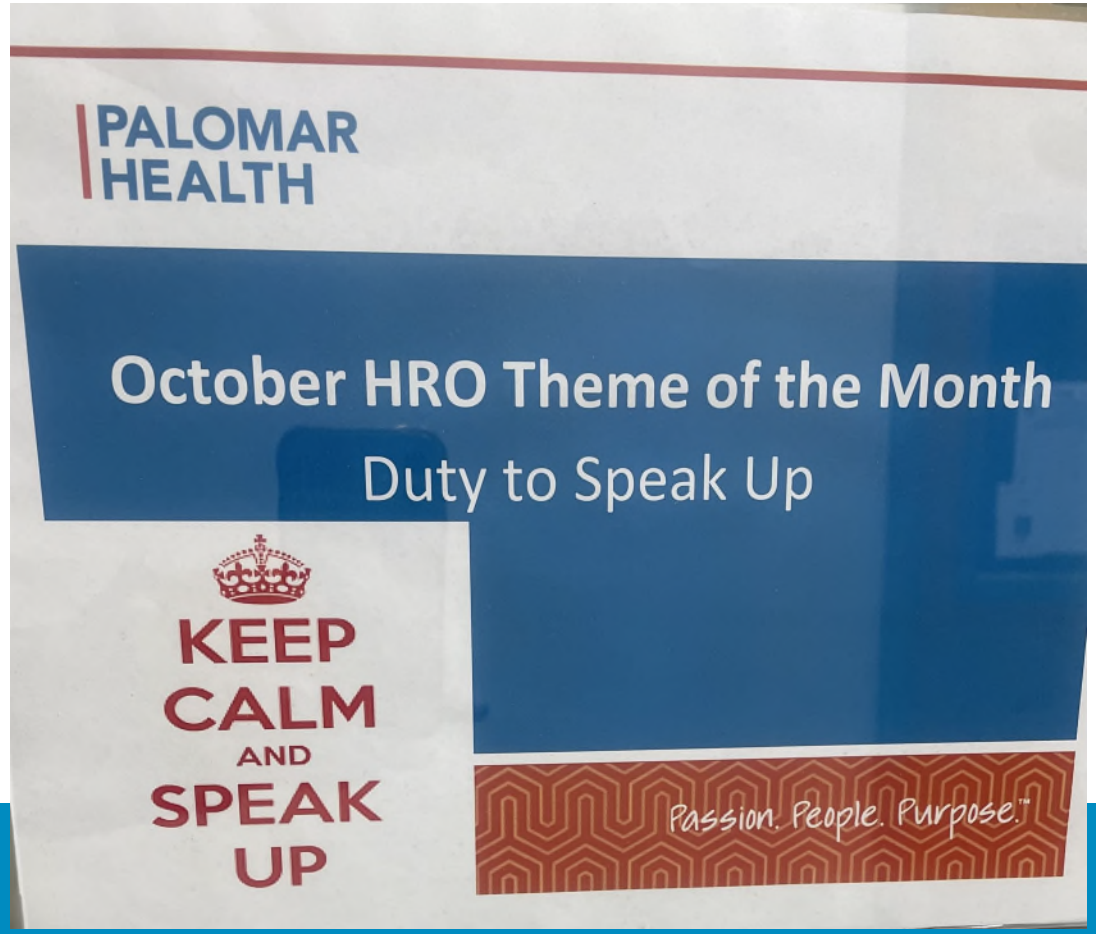
2. Safety Culture Measurement, Feedback, and Intervention

Example of Performance Improvement interventions resulting from 2024 Safety Culture Survey:

"Ensuring patient safety is the way we do things around here"

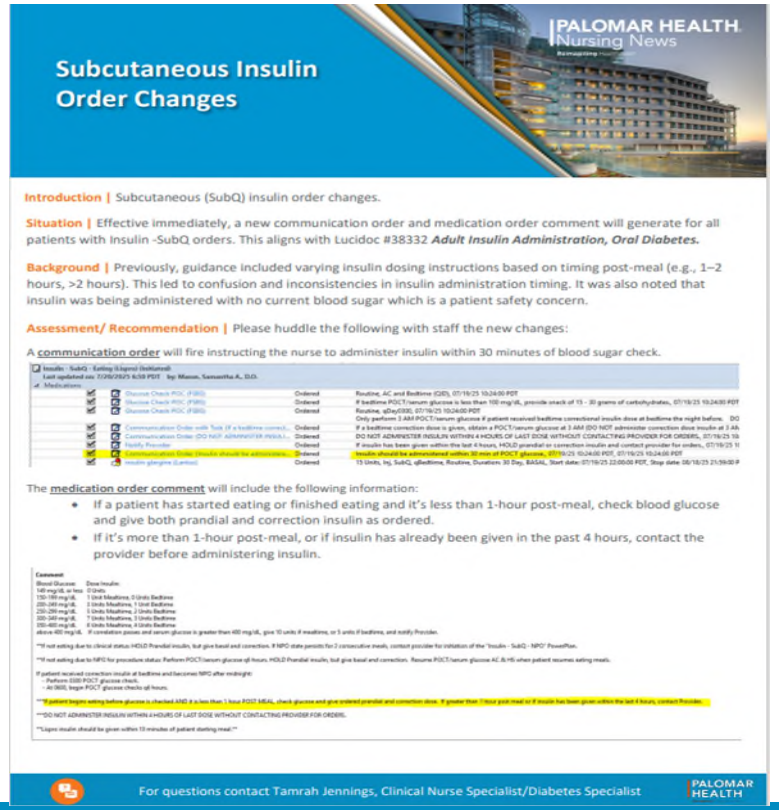
Department newsletter
High Reliability theme of the month
Education and training sessions

Surgical Services



2. Safety Culture Measurement, Feedback, and Intervention

- Implemented Nursing News – communication and updates on patient safety



PALOMAR HEALTH Nursing News

Subcutaneous Insulin Order Changes

Introduction | Subcutaneous (SubQ) insulin order changes.

Situation | Effective immediately, a new communication order and medication order comment will generate for all patients with Insulin -SubQ orders. This aligns with Lucidoc #38332 ***Adult Insulin Administration, Oral Diabetes.***

Background | Previously, guidance included varying insulin dosing instructions based on timing post-meal (e.g., 1–2 hours, >2 hours). This led to confusion and inconsistencies in insulin administration timing. It was also noted that insulin was being administered with no current blood sugar which is a patient safety concern.

Assessment/ Recommendation | Please huddle the following with staff the new changes:

A **communication order** will fire instructing the nurse to administer insulin within 30 minutes of blood sugar check.

The **medication order comment** will include the following information:

- If a patient has started eating or finished eating and it's less than 1-hour post-meal, check blood glucose and give both prandial and correction insulin as ordered.
- If it's more than 1-hour post-meal, or if insulin has already been given in the past 4 hours, contact the provider before administering insulin.

For questions contact Tamrah Jennings, Clinical Nurse Specialist/Diabetes Specialist

PALOMAR HEALTH Nursing News

IV Line Reconciliation

Introduction | This is a patient safety reminder regarding IV line reconciliation and tracing during infusions and handoffs. This aligns with Lucidoc #24372: *Procedure: Patient Hand-off Communication.*

Situation | As part of our commitment to maintaining high standards in medication safety, we are reinforcing best practices for IV line tracing and reconciliation. Ensuring accuracy in IV line management helps prevent errors and supports safe, effective patient care.

Background | To reduce errors, our policy requires nurses to trace all IV lines and verify infusion details at key moments — including when starting, reconnecting, or changing infusions, and during nurse handoffs. Pump programming must match the MAR and medication label.

Assessment | Inconsistent line tracing and reconciliation practices increase the risk of incorrect medication delivery, pump setting errors, or tubing misconnections, potentially leading to adverse events.

Recommendation |

- **Trace IV lines** by hand from the solution container → pump and channel → connection port → patient.
- **Verify** that the infusion dose, rate, and route are correct in the smart pump and match the MAR and label.
- **Reconcile all IV lines** to ensure each line goes to the correct access site.
- **During handoffs**, both nurses should trace and confirm all IV lines and pump settings together.
- **At shift changes**, the oncoming nurse must review infusions and trace tubing to prevent rate or line swaps.

3. Governance Board and Senior Management Briefings/Meetings

- **Objective:** Patient safety risks, hazards, and progress toward performance improvement objectives are being addressed at board meetings.

3. Governance Board and Senior Management Briefings/Meetings

Activities we have been undertaking to meet this objective:

- Patient Safety Events communicated to the Board of Directors
- Review/discussion of Patient Safety Events at BQRC meetings (during closed sessions)
- Discussion of mitigation strategies to prevent recurrence of such events

Questions

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Annual BQRC Assessment