Posted
Friday,
May 22, 2026

PALOMAR HEALTH
Reimagining Healthcare

QUALITY REVIEW COMMITTEE
MEETING AGENDA

Wednesday, May 27, 2026
3:00pm

Please see page 2 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 – January 28, 2025 *(Pp 6-8)*			
	b. Approval of Contracted Services i. ARUP *(Pp 9)* ii. Corticare Monitoring *(Pp 10)* iii. Image First Linen *(Pp 11)* iv. Premier Laser Services *(Pp 12-13)* v. San Diego Blood Bank *(Pp 14)* vi. San Diego Urology Mobile Services *(Pp 15-16)*			
4.	**Annual Reports – *Informational Only*** *(ADD B)*	15		4:01
	a. Quality and Patient Safety Improvement Projects Focus 2026 *(Pp 18)* b. MedStaff Dept: Emergency Medicine Biannual Report *(Pp 19-21)* c. MedStaff Dept: Trauma Program Biannual Report *(Pp 22-27)* d. Rehabilitation and Wound Care Services *(Pp 28-33)* e. Respiratory Services *(Pp 34-40)* f. Infection Prevention and Control *(Pp 41-114)* g. Laboratory Services *(Pp 115-117)* h. Radiology & Nuclear Medicine Med Staff Report *(Pp 118-125)* i. Outpatient Services – Infusion and Radiation Oncology *(Pp 126-133)* j. Stroke Program *(Pp 134-147)*			
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

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
James Puckett, MD– 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: De2hx3s3
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

- 4002 Vista Way, Oceanside, CA 92056

- An elected member of the Board of Directors will be attending the meeting virtually from these locations

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

PALOMAR HEALTH

DocID: 21790
Revision: 10
Status: Official

Source:

Applies to Facilities:
All Palomar Health Facilities

Applies to Departments:
Board of Directors

Policy : Public Comments and Attendance at Public Board Meetings

I. SUMMARY/INTENT:

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. POLICY: COMPLIANCE - KEY ELEMENTS:

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

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

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

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

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

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

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

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

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

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

Board Quality Review Committee Meeting

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, January 28, 2026			
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, January 23, 2026, 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 3:01 p.m. by Committee Chair Linda Greer.			
1. ESTABLISHMENT OF QUORUM			
• Quorum comprised of: Directors Greer, Corrales, Jahaaski* and Puckett, MD* and Ritchie, MD *Director Jahaaski arrived in person at 3:02pm, after the quorum was established. *Puckett, MD arrived in person at 3:05 pm during the Approval of Contracted Services section of the meeting, after motion was made.			
2. PUBLIC COMMENTS			
• None			

3. ACTION ITEMS			
a. Minutes: Board Quality Review Committee Meeting – October 22, 2025	MOTION by Director Corrales, 2nd by Director Jahaaski to approve the October 22, 2025, Board Quality Review Committee meeting minutes as written. Roll call voting utilized. Director Corrales – aye Director Greer – aye Director Jahaaski - aye Puckett, MD - absent Ritchie, MD - aye Four in favor. None opposed. One absent. None abstain Motion approved		
Discussion: • No discussion			
b. Approval of Contracted Services i. Vital Care ii. PharMerica iii. Linde Portable Medical Gas iv. Agili	**MOTION** by Director Corrales, 2nd by Director Jahaaski to approve agenda item 3,b,i-iv. Roll call voting utilized. Director Corrales – aye Director Greer – aye Director Jahaaski - aye Puckett, MD -absent Ritchie, MD - aye Four in favor. None opposed. One absent. None abstain Motion approved		
Discussion: • All questions by Committee Members were satisfied.			

4. Annual Reports – Informational Only			
a. Annual Review of BQRC Charter and Reporting Calendar	**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 3:22 p.m.

Signatures:

Committee Chair _____ Linda Greer, RN

Committee Assistant _____ Gen Dieu

Palomar Health
Review of Contract Service

Name of Service: ARUP Reference Laboratory

Date of Review: 2/26/2026 **Name / Title of Reviewer:** Tim Barlow, Laboratory Director-Palomar Health

Nature of Service (describe): Primary Reference Laboratory Service for Palomar Health

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
Amended Report Rate <0.5% - 100% of the Time	100%	100%	100%	100%	MET
Customer Service Response <24 hours- 100% of the Time. Including Account Rep . Barry Beck.	100%	100%	100%	100%	MET
Result Interface Connectivity to PH >98% of the time available.	100%	100%	100%	100%	MET

Comments
Excellent Organization, Laboratory Service and Customer Support.

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: CortiCare

Date of Review: 5-19-26 **Name / Title of Reviewer:** Meghan Jaremczuk

Nature of Service (describe): EEG 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 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 2025	2__ QTR 2025	3__ QTR 2025	4___ QTR 2025	Cumulative Total
Missed event notification	0%	0%	0%	0%	0%

Comments

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: ImageFirst – Linen Management Program / Scrub Management Program

Date of Review: 5/20/2025 **Name / Title of Reviewer:** Ryan Fearn-Gomez, Vice President of Operations

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

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere 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	1st QTR FY 2026	2nd QTR FY 2026	3rd QTR FY 2026	4th QTR FY 2026	Cumulative Total
Percentage of pieces ordered versus percentage of pieces delivered.	MET – 95%	MET – 95%	MET – 95%	MET -100%	96.25%
Components of Plant Tour Checklist (e.g. Soiled Linen Processing; Clean Linen Processing and /or Sanitization; Pack Room, In-service Programs). If deficiencies are found, Emerald had 30 days to correct deficiencies.	Not MET – 85%	Not MET – 87%	MET – 95%	MET -95%	90.5%
Quarterly Scrub Inventory / Replenishment	MET – 98%	MET – 95%	MET - 95%	MET – 100%	97%

Comments:
We are approaching the end of our second year with ImageFirst as our linen and scrub provider. Throughout this partnership, they have continued to be a dependable and collaborative partner. While we did experience some quality concerns during the year, those issues were addressed and resolved through strong collaboration between ImageFirst, EVS leadership, and the Infection Control team. Their team has remained responsive, solution-oriented, and engaged in supporting our operational needs. Overall, the service has remained strong, and the partnership continues to add value to our organization.

Conclusion (check one)

X - Contract service has met overall 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: _____

Premier Laser Services, Inc.
Review of Contract Service

Name of Service: Premier Laser Services, Inc.

Date of Review: May 14, 2026

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

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

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

Performance Metrics Met and Not Met

METRIC	CY25 Q1	CY25 Q2	CY25 Q3	CY25 Q4	Cumulative Total
Equipment is clean and in good working order	100%	100%	100%	100%	100%
Laser Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%

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

Comments: No unusual occurrences documented or communicated by the provider utilizing this contracted purchased service during the contract service evaluation period.

Conclusion (check one)

√ Met 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 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: ___San Diego Blood Bank……..

Date of Review: __2/26/2026 **Name / Title of Reviewer:** Tim Barlow, PH Lab Operations Manager

Nature of Service (describe): Provider of Blood Products for Transfusion and ImunoHema Reference Lab 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.	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
Response to emails and inquiries < 24 hours 99% of the time—M-F	100%	100%	100%	100%	MET
Blood Product Inventory Minimum Fill Rate >98%	100%	99%	99%	100%	MET
Automated Online Inventory Management System Available >98% for real time monitoring and replenishment.	99%	100%	100%	99%	MET

Comments

Excellent, local and regional blood product supplier. Customer Service is excellent and Leadership engaged and available.

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: _____

San Diego Urology Services – Mobile Lithotripsy Services

Review of Contract Service for CY2025 (January 1, 2025 to December 31, 2025)

Name of Service: San Diego Urology Services – Mobile Lithotripsy Services
Date of Review: March 5, 2026
Name / Title of Reviewer: Bruce R. Grendell, MPH, BSN, RN
District Director, Perioperative Services
Palomar Health
Nature of Service (describe): The procedure performed by this mobile service is called Extracoporeal Shock Wave Lithotripsy (ESWL). This is a non-invasive treatment for kidney stones. The lithotriptor attempts to break up the stone with minimal collateral damage by using an externally applied, focused, high-intensity acoustic pulse.

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 is safe, timely, effective, efficient, equitable and patient focused.	√	

Performance Metrics

METRIC	CY2025 QTR 1	CY2025 QTR 2	CY2025 QTR 3	CY2025 QTR 4	Cumulative Total
ESWL equipment is clean and in good working order.	100%	100%	100%	100%	100%
ESWL Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%

Comments:

Conclusion (check one)

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

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

ADDENDUM B

Quality and Patient Safety Improvement Projects Focus for 2026

1. **HCAHPS –** Prioritize domains and questions that impacts PH from a financial or reputational standpoint (ie: VBP, Leapfrog).

2. **Patient Falls** – Focus on preventable falls. A preventable fall definition is classified falls that are not "anticipated physiological" (those associated with known risks) as potential indicators of opportunities to enhance care.

3. **Healthcare Acquired Infections –** Focus on all HAI outcomes and process measures. In addition, there will focus on hand hygiene compliance.

4. **Readmissions –** Focus on specific conditions within the CMS Readmission Reduction Program (RRP). This work will be integrated in the HCAI readmission workgroup.

Emergency Department Report

Presented to Board Quality Review Committee

Nicholle Bromley, MD

Tracy Page DNP, RN, PHN, LNC, ED & Trauma Director

May 27, 2026

PALOMAR HEALTH
Reimagining Healthcare

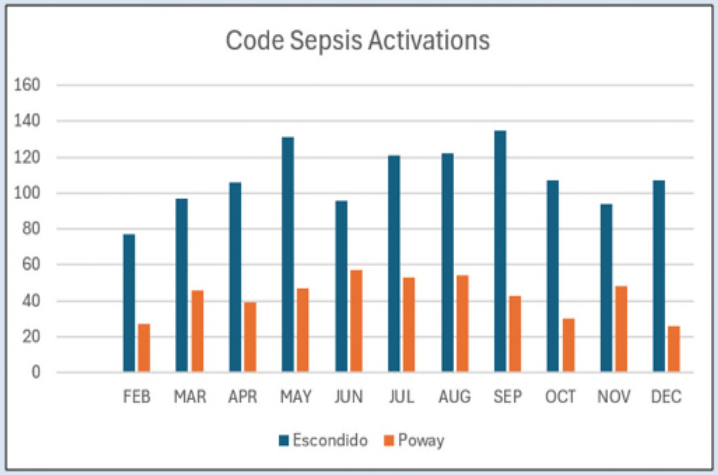
SBAR: Code Sepsis Process in the Emergency Department

SITUATION	Prior to implementation of the Code Sepsis process, our Emergency Department's SEP-1 compliance rate was 44%, well below state and national benchmarks. Following the pandemic, many ED nurses struggled with core concepts of SIRS, sepsis, severe sepsis, and septic shock, as clinical focus had shifted heavily toward COVID care and elements of the sepsis bundle were often contraindicated.
BACKGROUND	To address this gap, we launched a multidisciplinary Code Sepsis process designed to remove patients from the chaos of routine ED workflow and ensure rapid identification, evaluation, and timely bundle-driven treatment. The team included the ED physician, ED RN, laboratory, and the Rapid Response Team, which played a critical role in education, implementation of a sepsis checklist, and serving as a real-time resource until bundle principles became ingrained in practice.
ASSESSMENT	Since rollout, Escondido ED has activated Code Sepsis 1,193 times and is now exceeding state and national SEP-1 benchmarks. Poway ED has had 470 activations, is performing above the top 10% nationally, and achieved 100% SEP-1 compliance during three separate months in 2025.
RECOMMENDATION	This structured, team-based approach has resulted in sustained improvement, stronger clinical confidence, and high-reliability sepsis care delivery.

CODE SEPSIS

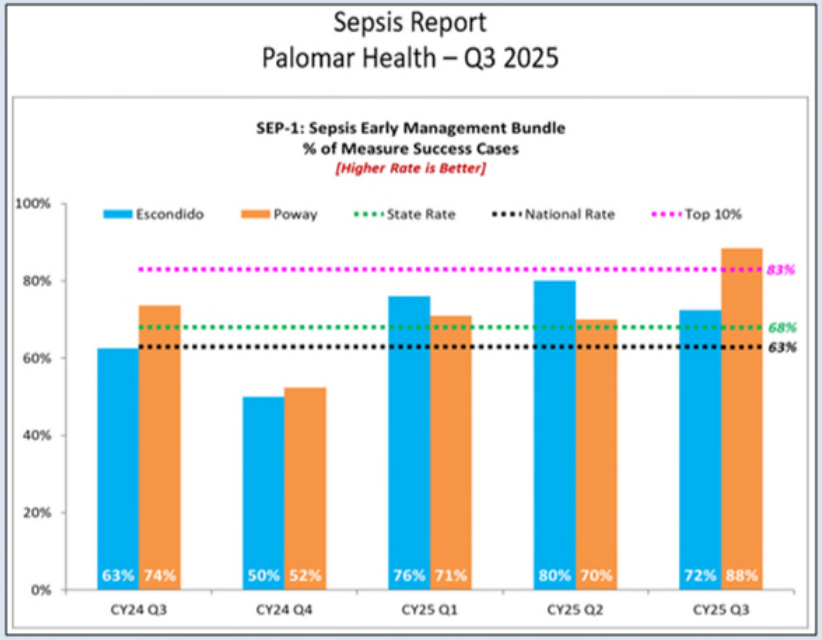
- Goal = improved patient care, decreased morbidity & mortality, and improved sep-1 compliance
- MDR approach with phlebotomy, rapid response nurses, lab, ED, RN, ED MD
- Code sepsis checklist + overhead page in hospital
- Daily ED report for audits
- Direct feedback & education

Code Sepsis Activations 2025



Escondido: 1193
Poway: 470

SEP-1: Sepsis Early Management Bundle



Trauma Services Report

Presented to Board Quality Review Committee

Dr. John Steele MD, Trauma Medical Director

Zachary Heinemann MSN, RN, CCRN, TCRN, Trauma Program Manager

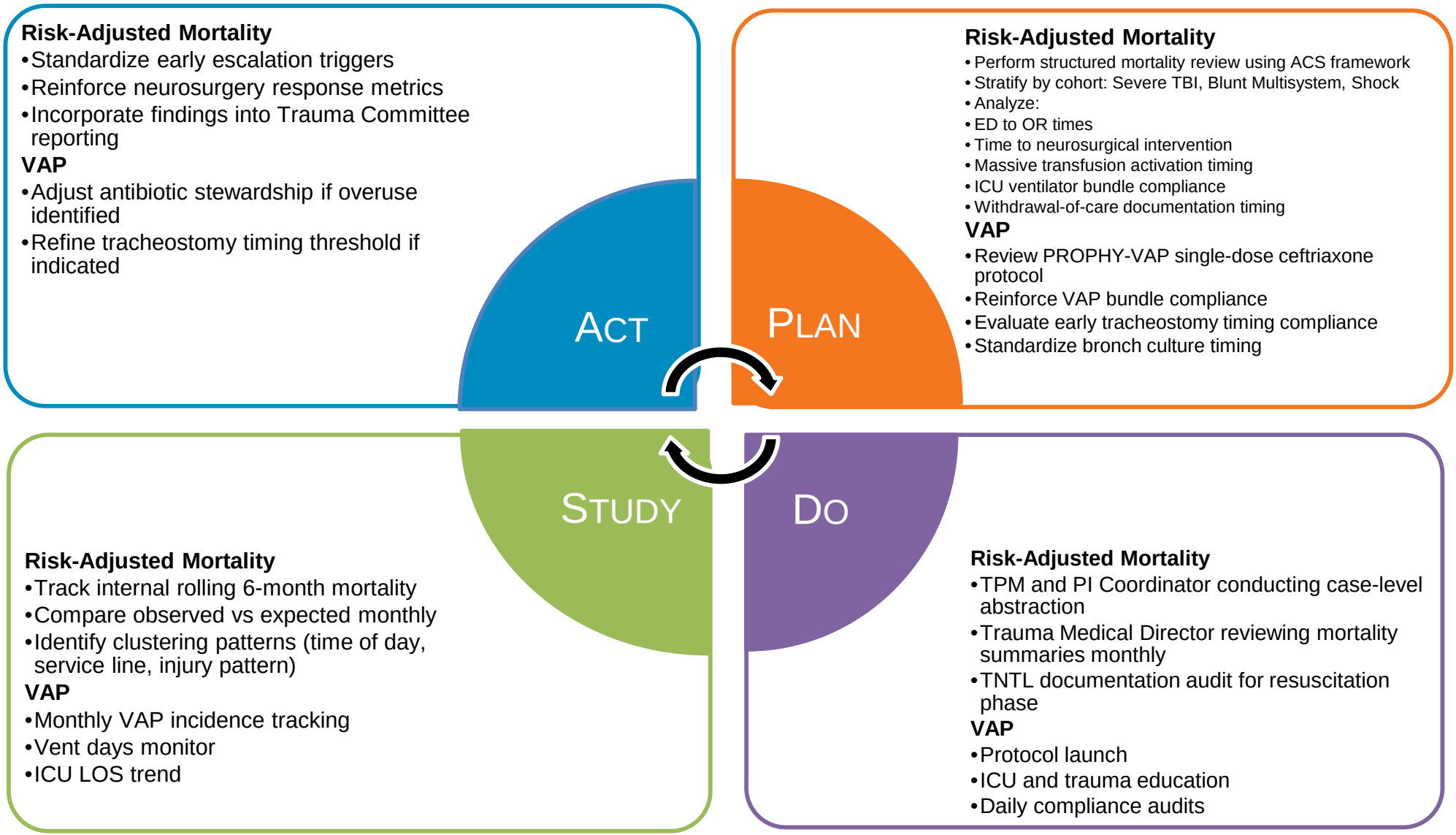
Tracy Page DNP, RN, PHN, LNC, ED & Trauma Director

May 27, 2026

PALOMAR HEALTH
Reimagining Healthcare

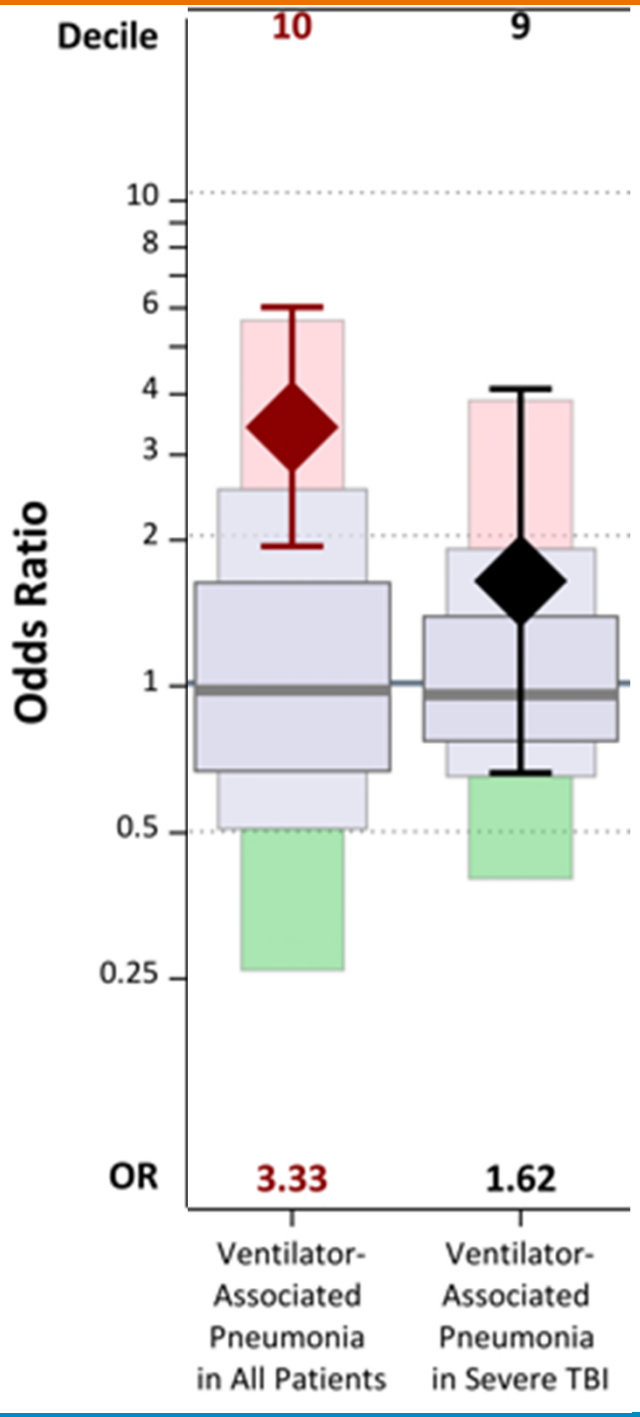
PMCE Trauma Services

SITUATION	**Risk-Adjusted Mortality (All Patients)**: • Fall 2025 TQIP shows an increase in risk-adjusted mortality compared to Spring 2025. **VAP:** • 2025 TQIP identified Ventilator-Associated Pneumonia (VAP) as a high outlier in trauma patients.
BACKGROUND	**Risk-Adjusted Mortality (All Patients)**: • Spring 2025 All Patient Mortality OR: 1.04 • Fall 2025 All Patient Mortality OR: 1.19 • Mortality remains statistically "Average" and is not a high outlier. • Fall 2025 modeling includes IHF patients differently than prior reports **VAP:** • Trauma patients requiring mechanical ventilation are high risk. • Severe TBI subgroup particularly affected. Prior bundle compliance in place
ASSESSMENT	**Risk-Adjusted Mortality (All Patients)**: • Upward shift in OR from 1.04 → 1.19 • No current outlier status • Severe TBI OR increased from 1.01 → 1.13 • Blunt Multisystem OR increased from 0.93 → 1.07 • This suggests case-mix complexity and possible reliability variation. **VAP**: • VAP Odds Ratio: 4.75 (High Outlier) • VAP in Severe TBI: OR 2.79 • Major Hospital Events OR 1.66 driven largely by VAP
RECOMMENDATION	**Risk-Adjusted Mortality (All Patients)**: • Maintain mortality as active PI focus • Drill into Severe TBI and Blunt Multisystem cohorts • Evaluate care timeliness, withdrawal-of-care patterns, and documentation integrity • Monitor next two TQIP cycles for trend confirmation **VAP:** Targeted VAP reduction initiative with protocol standardization, early tracheostomy optimization, and antibiotic stewardship.


Risk-Adjusted Mortality
•Standardize early escalation triggers
•Reinforce neurosurgery response metrics
•Incorporate findings into Trauma Committee reporting
VAP
•Adjust antibiotic stewardship if overuse identified
•Refine tracheostomy timing threshold if indicated
ACT
PLAN
Risk-Adjusted Mortality
• Perform structured mortality review using ACS framework
• Stratify by cohort: Severe TBI, Blunt Multisystem, Shock
• Analyze:
• ED to OR times
• Time to neurosurgical intervention
• Massive transfusion activation timing
• ICU ventilator bundle compliance
• Withdrawal-of-care documentation timing
VAP
•Review PROPHY-VAP single-dose ceftriaxone protocol
•Reinforce VAP bundle compliance
•Evaluate early tracheostomy timing compliance
•Standardize bronch culture timing
STUDY
DO
Risk-Adjusted Mortality
•Track internal rolling 6-month mortality
•Compare observed vs expected monthly
•Identify clustering patterns (time of day, service line, injury pattern)
VAP
•Monthly VAP incidence tracking
•Vent days monitor
•ICU LOS trend
Risk-Adjusted Mortality
•TPM and PI Coordinator conducting case-level abstraction
•Trauma Medical Director reviewing mortality summaries monthly
•TNTL documentation audit for resuscitation phase
VAP
•Protocol launch
•ICU and trauma education
•Daily compliance audits

Data Slide

- VAP



Data Slide

- Risk-Adjusted Mortality
  - Severe TBI OR: 1.13
  - Blunt Multisystem OR: 1.07
  - Shock OR: 0.94

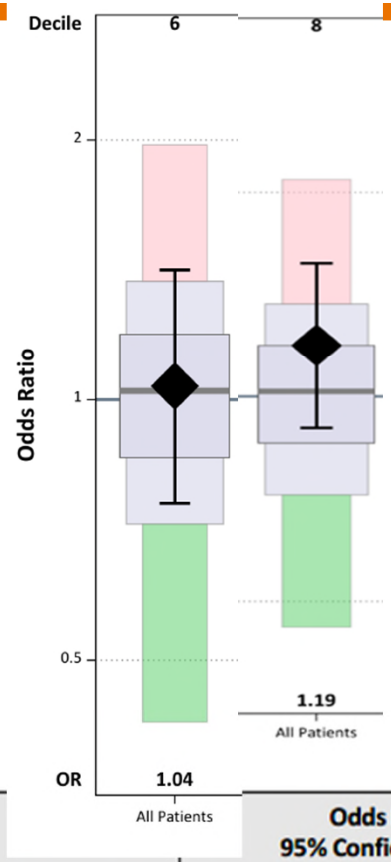


Table 2: Risk-Adjusted Mortality by Cohort

	Patients	Mortality				Odds Ratio and 95% Confidence Interval				
Cohort	N	Observed Events	Observed (%)	Expected (%)	TQIP Average (%)	Odds Ratio	Lower	Upper	Outlier	Decile
All Patients	848	76	9.0	8.0	6.8	1.19	0.90	1.57	Average	8
Blunt Multisystem	120	17	14.2	13.1	14.2	1.07	0.69	1.64	Average	7
Penetrating	22	2	9.1	13.5	10.1	0.88	0.44	1.79	Average	2
Shock	35	7	20.0	22.8	24.9	0.94	0.56	1.56	Average	3
Severe TBI	46	28	60.9	57.3	46.4	1.13	0.67	1.91	Average	8
Elderly	422	47	11.1	9.8	7.9	1.18	0.85	1.63	Average	8
Elderly Blunt Multisystem	32	7	21.9	13.8	19.8	1.16	0.72	1.87	Average	10
LIFT	80	10	12.5	7.2	6.0	1.32	0.81	2.15	Average	10
IHF	70	3	4.3	3.4	3.3	1.08	0.56	2.06	Average	7

Action Plan with Timeline

- **VAP**

Action	Owner	Timeline	Metric
Enforce ceftriaxone protocol	Trauma	Q3	% eligible patients treated
Early trach review	Trauma	Ongoing	% trach <7 days
Vent day reduction initiative	Trauma	Ongoing	Vent days per patient
Monthly QI audit	TMD/TPM	Ongoing	VAP rate trend

- **Risk-Adjusted Mortality**

Q1	Q2	Q3	Q4
Complete detailed mortality review of last 12 months	Implement targeted process adjustments if indicated	Reassess internal mortality trend	Monthly mortality dashboard
Present structured findings to Trauma PIPS	Reinforce escalation algorithms for Severe TBI	Compare with next TQIP cycle	Peer review classification per ACS standards
Identify any Opportunities for Improvement (OFIs)	Audit compliance with neurosurgical response standards	Report back to QMC on trajectory	Loop closure tracking for identified OFIs

Rehabilitation Services & Outpatient Wound Care

Presented to Board Quality Review Committee

Tyler Powell, DPT, MBA, CEAS
Director of Rehabilitation Services, Wound Care and Hyperbaric Center, Patient Access

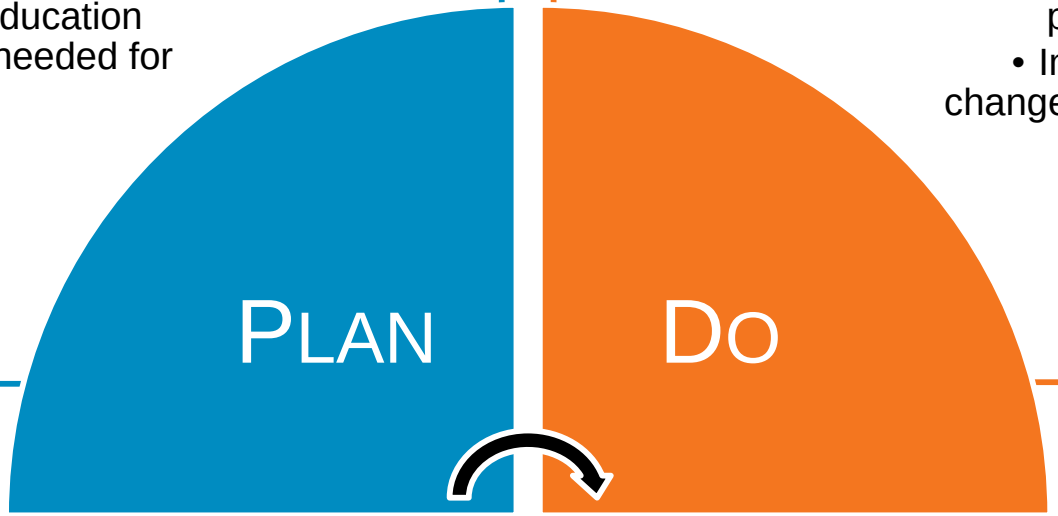
May 27, 2026

PALOMAR HEALTH
Reimagining Healthcare

Inpatient/Outpatient Rehabilitation Services – Access to Care

SITUATION	Outpatient Rehab = 11 days (Benchmark < 5 days) Inpatient = 9.1 patients triaged/day (Benchmark <7.1 days)
BACKGROUND	The established Access to Care benchmark is measured to ensure timely and full access to our services: Outpatient Rehab- Utilized to ensure our patients are being seen in a timely manner after receipt of a referral for care. Inpatient Rehab- Utilized to assist in showing our full hospital coverage for PT/OT/ST. This data allows management the opportunity to address trends negatively affecting access to care for both inpatient and outpatient rehabilitation.
ASSESSMENT	Factors impacting access to care are as follows: 1. Outpatient Rehabilitation Services continues to grow with its increased niche service offerings. This can result in increased wait times as compared to the general referral. There was also a temporary staffing shortage due to a few staff on LOA during this timeframe. 2. Inpatient referrals outweighing staff availability and creating impact to triage rate. When there is an increased hospital volume leads to increased need for therapy services.
RECOMMENDATION	1) Prioritize filling open clinical and assistant positions to meet patient volume demands effectively. 2) Increase internal training for niche services offerings. 3) Regular meetings/communication with HR to review open positions 4) Cross training of staff between inpatient and outpatient to support needed care and timeliness. 5) Communication and process optimization with frequent referral sources to expedite any delays.

Rehabilitation Services



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

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

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

- Ongoing review and audits to check compliance with new processes

Data- Outpatient Rehabilitation Services

Location	Indicators	Palomar Health	Benchmark
Outpatient Wound Care	Days to Heal	54	</= 66
Outpatient Cardiac Rehab Services	Peak METs	Initial 2.4 DC 4.5 2.1 increase	Initial 3.3 DC 4.7 1.4 increase
Outpatient Rehab Services	Access to Care	11	<5 days
Outpatient Rehab Services	Cancellation/No Show Rate	10.96%	<15 %
Outpatient Rehab Services	Average Length of Stay	9.5	<12 days

Data- Inpatient/SNF Rehabilitation Services

Location	Indicators	Palomar Health	Benchmark
Acute Care Inpatient Rehab Services	Access to Acute Care (PT/OT/ST)	9.1	<7.1 patients triaged/day
Acute Care Inpatient Rehab Services	Total Joint Post Op Day Zero ambulation and evaluation	95%/99%	>90%
The Villas Rehab Services	% Return to Community	96%	>70%

Action Plan - Rehabilitation Services

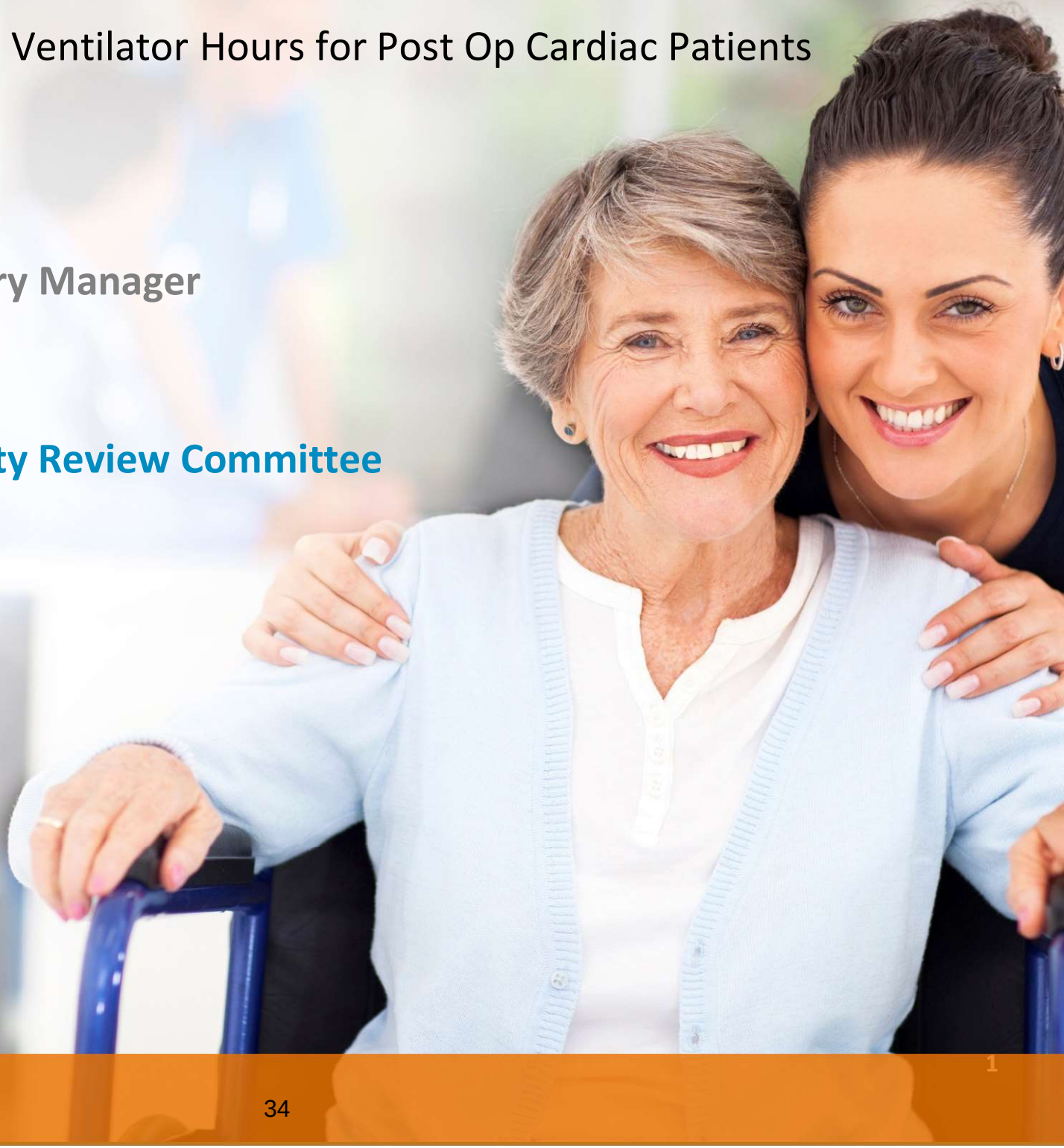
- **Improve access times and scheduling processes**
  - Preschedule post ops for evaluation and treatments at time of receipt of referral
  - Collaborate with referral offices to reduce access delays and streamline insurance authorization processes
  - Further educate providers on inpatient referral appropriateness
  - Improve patient phone responsiveness
- **Advance Clinical Specialties**
  - Offer continuing education in strategic niche specialties
  - Promote staff development through advanced certifications
  - Expand niche service support to elevate quality of care
- **Program Excellence**
  - Deepen engagement with Nursing, Physicians, and Case Management to improve patient throughput
  - Expand partnerships across key service areas: Orthopedic, Vascular, Cardiovascular, Pulmonary, Oncology, and Stroke
  - Support growth across Inpatient, Skilled Nursing, and Outpatient settings

Respiratory Care: Reducing Ventilator Hours for Post Op Cardiac Patients

Respiratory Services

Krysti Johnson, Respiratory Manager

Presented to Board Quality Review Committee
May 27, 20206

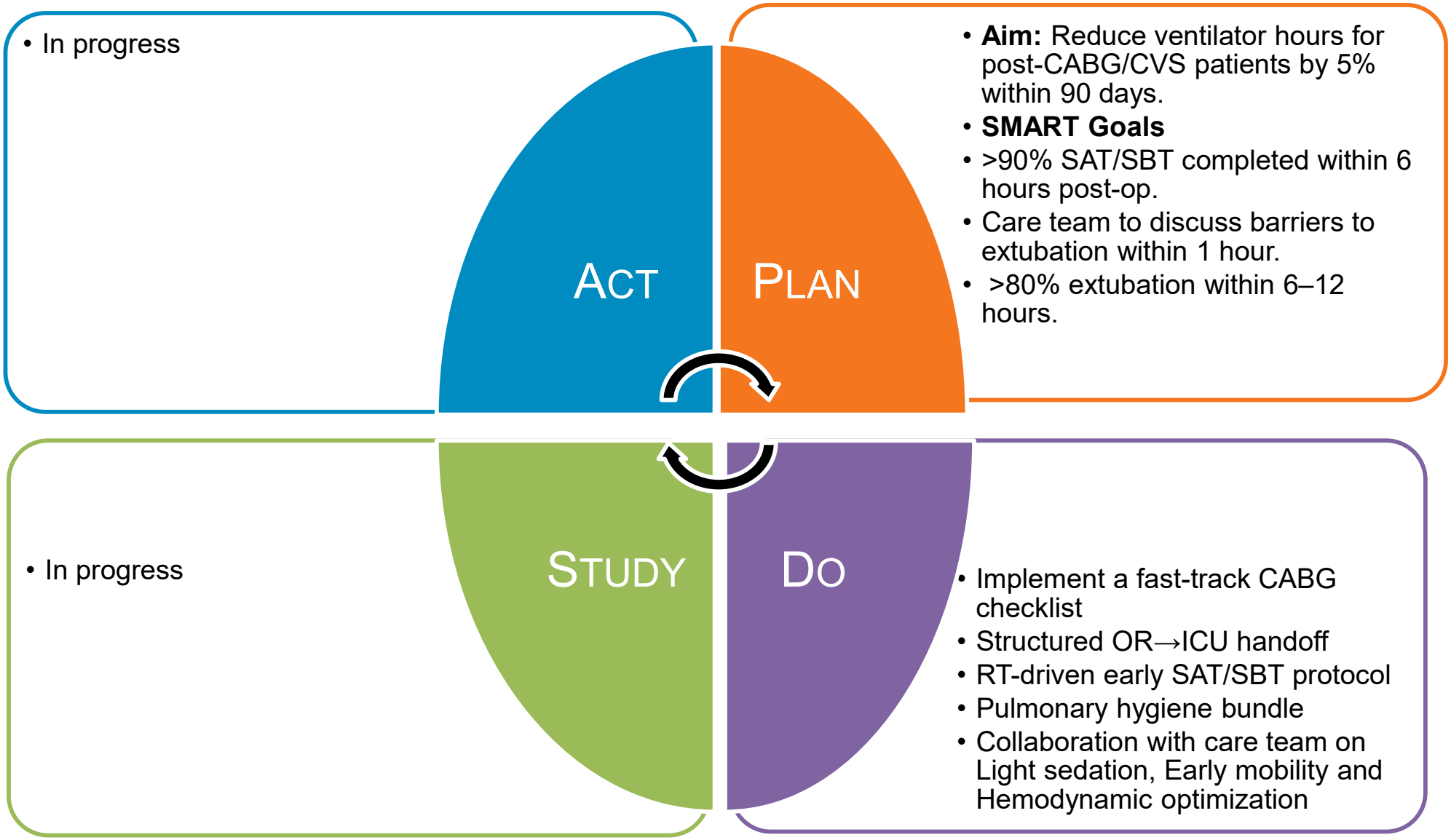


PALOMAR HEALTH
Reimagining Healthcare

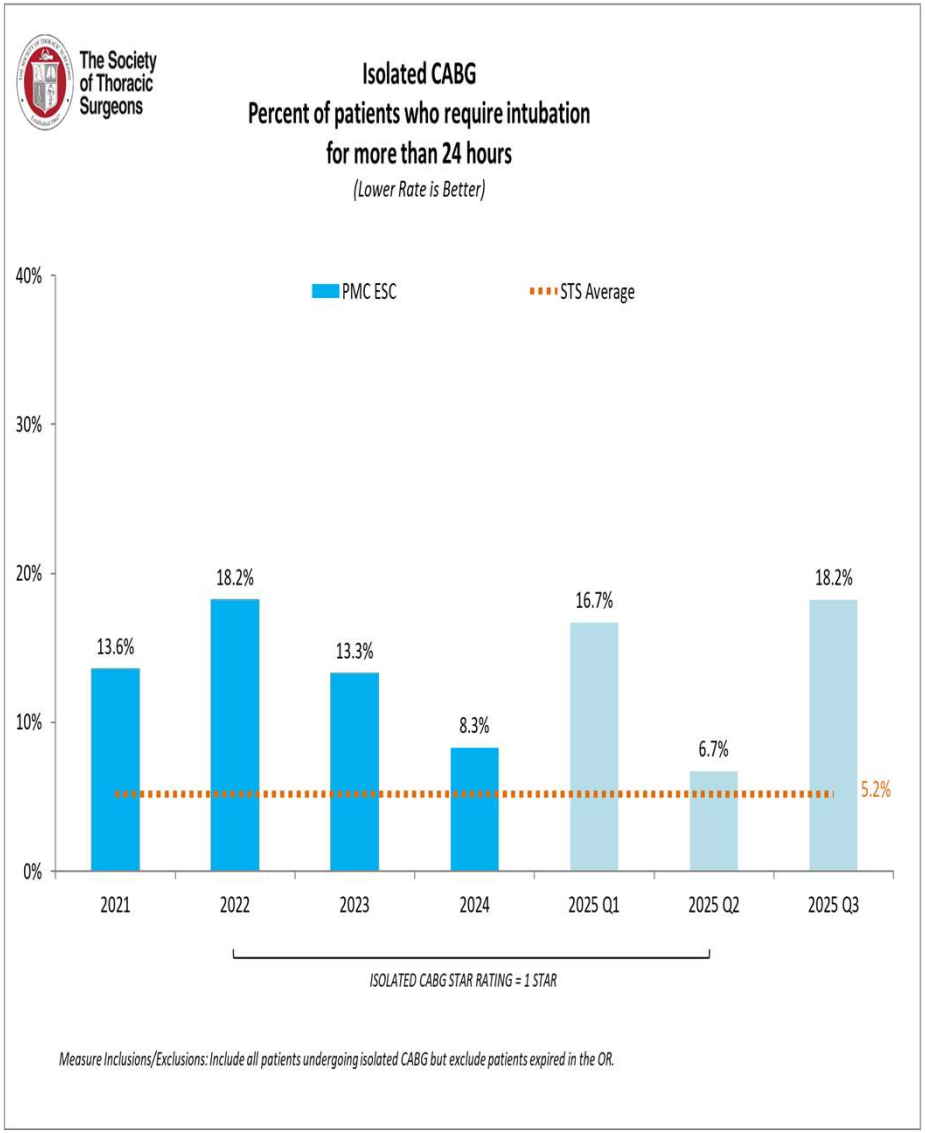
Reducing Ventilator Hours for Post Op Cardiac Patients

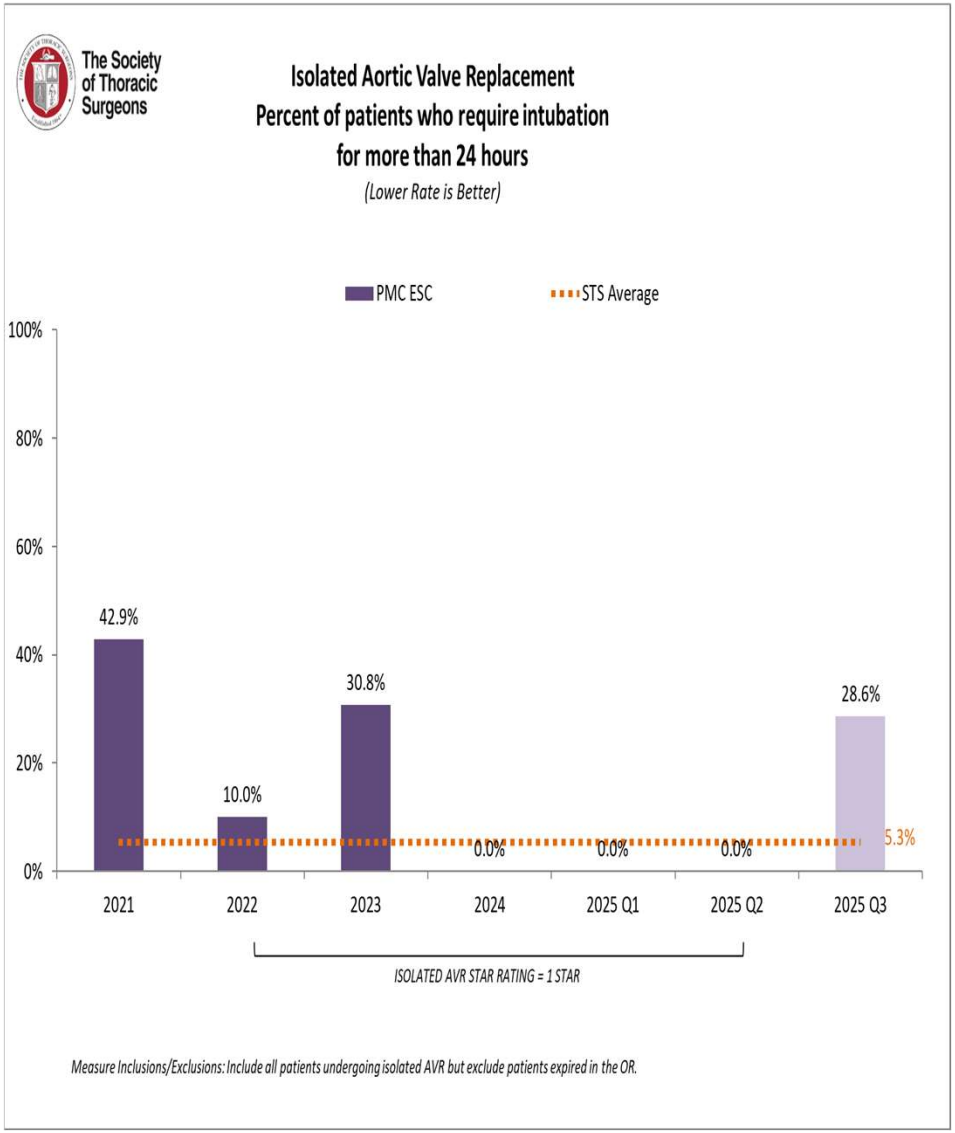
SITUATION	Post-operative cardiac surgery patients at times remain intubated longer than 24 hours. This increases the risk of VAP, delirium, hemodynamic fluctuations, and prolonged ICU LOS. We are implementing a structured early-extubation pathway to reduce ventilator hours and standardize care.
BACKGROUND	Fast-track extubation within 6–12 hours is the national standard for uncomplicated cardiac surgery patients. delays are most commonly related to: • Late or inconsistent SAT/SBT • Pulmonary atelectasis/fluid shifts • Team communication • Excess sedation • Hemodynamic instability Reducing ventilator hours improves outcomes and decreases ICU resource utilization.
ASSESSMENT	To meet internal and national benchmarks and improve our CBAG Star rating the number of pt. receiving mechanical ventilation greater than 24 hours intensive care unit needs to be decreased. Current opportunities to timely extubation include: • Ensure sedation is being titrated • Initiate SBTs early (target within 4–6 hours post-op) • Decrease variability for extubation readiness • Ensure structured handoff from OR→ICU
RECOMMENDATION	Respiratory Interventions • Implement structured OR→ICU Handoff • Early SBT • Pulmonary Hygiene Bundle • Escalation: If patient is not extubated within target window, RT partners with MD within 1 hour.

PDSA: Reducing Ventilator Hours for Post Op Cardiac Patients



Data Slide


The Society of Thoracic Surgeons
Isolated CABG
Percent of patients who require intubation
for more than 24 hours
(Lower Rate is Better)
PMC ESC
STS Average
40%
30%
20%
10%
0%
13.6%
18.2%
13.3%
8.3%
16.7%
6.7%
18.2%
5.2%
2021
2022
2023
2024
2025 Q1
2025 Q2
2025 Q3
ISOLATED CABG STAR RATING = 1 STAR
Measure Inclusions/Exclusions: Include all patients undergoing isolated CABG but exclude patients expired in the OR.


The Society of Thoracic Surgeons
Isolated Aortic Valve Replacement
Percent of patients who require intubation
for more than 24 hours
(Lower Rate is Better)
PMC ESC
STS Average
100%
80%
60%
40%
20%
0%
42.9%
10.0%
30.8%
0.0%
0.0%
0.0%
28.6%
5.3%
2021
2022
2023
2024
2025 Q1
2025 Q2
2025 Q3
ISOLATED AVR STAR RATING = 1 STAR
Measure Inclusions/Exclusions: Include all patients undergoing isolated AVR but exclude patients expired in the OR.

Action Plan with Timeline

Education: Respiratory Interventions (on-going)

- Implement Standardized OR→ICU Handoff
- Early SBT
- Pulmonary Hygiene Bundle
- Escalation: If patient is not extubated within target window, RT documents and escalates barriers to MD within 1 hour.

Pilot Implementation: - Apply to all CABG patients for 4 weeks. (3/15/2026)

- Begin SBT at 4 -6 hours when appropriate.
- RT to discuss extubation readiness Q4 hours with RN and MD.

Data Collection: (3/15/2026)

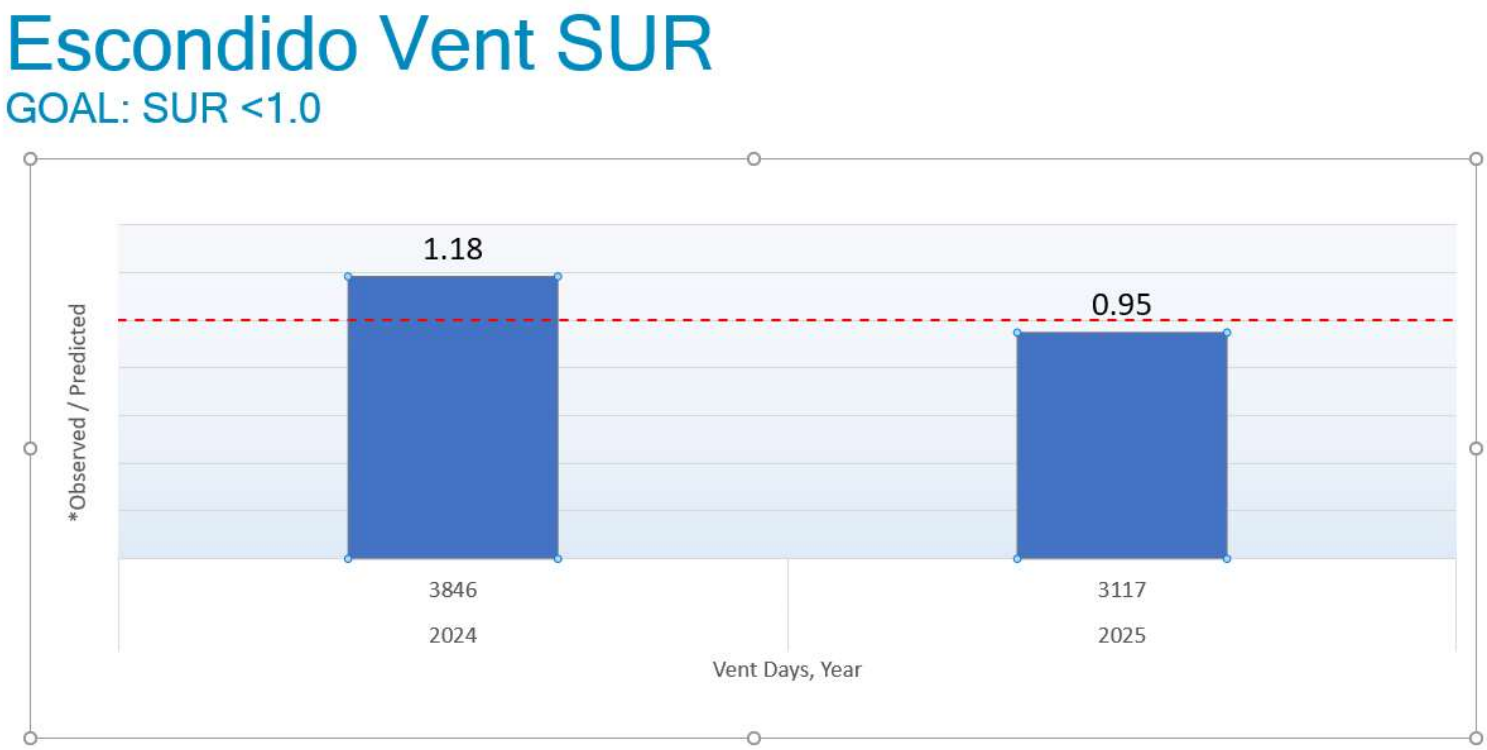
- Ventilator hours
- SAT/SBT timing
- Extubation timing
- Barriers to extubation
- VAP bundle adherence
- Reintubation rate

What are we working on?

Reducing Ventilator Days (on-going)

- Continue to focus on the use of non-invasive ventilation and High Flow Therapy to prevent intubation and immediately upon Extubation to prevent reintubation. Education will be provided on 9/26/2025.
- Continue daily SBT and discuss SBT results at rounds

Goal: Ventilator Standardized Utilization Ratio (SUR) < 1.0



What are we working on?

Pediatric Education & Competency Focus Escondido completed 12/2025 and Poway beginning March 2026

We identified 5 priority areas to improve pediatric care in the ED:

- Airway Supplies: Standardize and label location of pediatric airway supplies.
- High-Flow Therapy: Setup guides by age/weight. Intubation Assist: Simulation practice
- Mechanical Ventilation: Reference charts for initial settings.
- Annual skills validation.
  - Pediatric simulation & quick-reference cards.

Goal: Improve RCP confidence, supply access, and patient safety in pediatric emergencies.

Respiratory Staffing and upskilling

- Our department continues to strengthen coverage across all specialty areas.
- Five newly trained NICU respiratory care practitioners have successfully completed their specialty onboarding and are now supporting the NICU team. (completed)
- In addition, one dedicated Bronch RCP (on-going) and one PFT RCP (completed) have completed their training pathways.
- Overall, ten new RCPs have been fully onboarded, enhancing our ability to maintain safe staffing, support high-acuity areas, and ensure consistent respiratory care across both campuses. (completed)

PALOMAR HEALTH

ANNUAL REVIEW AND ASSESSMENT OF THE 2025 INFECTION PREVENTION & CONTROL PROGRAM

Table of Contents

Introduction

Overview

The Infection Prevention and Control Program and Plan is evaluated annually. This assessment compares outcome and process measures from calendar year 2024 to 2025, and integrates a comprehensive interdisciplinary risk assessment to prioritize and set goals to minimize the possibility if transmitting infections. The Program assessment includes all surveillance modalities performed by Infection Preventionist (IP). Infection control measures include hand hygiene adherence monitoring, the monitoring of high-level disinfection and sterilization processes, medication preparation, food and nutrition services, construction and renovation, dialysis, and outpatient services. The role of the IP is a department resource and consultant, providing their subject matter-expertise, support, and evidence-based recommendations to ensure the Program and the organization-wide surveillance plan and goals are aligned and met. The Program assessment provides information to steer the Infection Prevention and Control Department's focus for the upcoming year. Each measure is evaluated for effectiveness and is considered a driver for departmental and unit-based action plans and goals. Information is shared at the Board of Directors, provider, nursing, and support service levels and used to improve patient care. Infection Prevention & Control rounding activities help to identify opportunities for improvement.

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

Infection Prevention Mission

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

Purpose

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

Authority Statement

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

The Infection Control Officers have clinical authority over the infection prevention and control program for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The Infection Control Officers are qualified through education, training, experience, and certification in infection prevention, control and epidemiology. The officers are appointed by the governing body to be responsible for the infection prevention and control program. This appointment is based on recommendations of the medical staff and nursing leadership. When the Infection Control Officers do not have

expertise in a particular area, they consult with someone who has such expertise in order to make knowledgeable decisions.

The Infection Control Officers are responsible for:

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

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

Access to Information

Patient information used in surveillance is accessed through the Cerner electronic medical record. Cerner also has an Infection Prevention Worklist program, which assists in identifying patients who have communicable reportable diseases, recent discharges, multi-drug-resistant organisms, and hospital-associated infections. Cerner analytics reports allow for follow up of patients in isolation precautions, review or abnormal and positive labs, identification of outbreaks, device-associated infections, surgical site infections, and analyze other metrics that aid in infection prevention or epidemiologic investigation.

Equipment and Resources

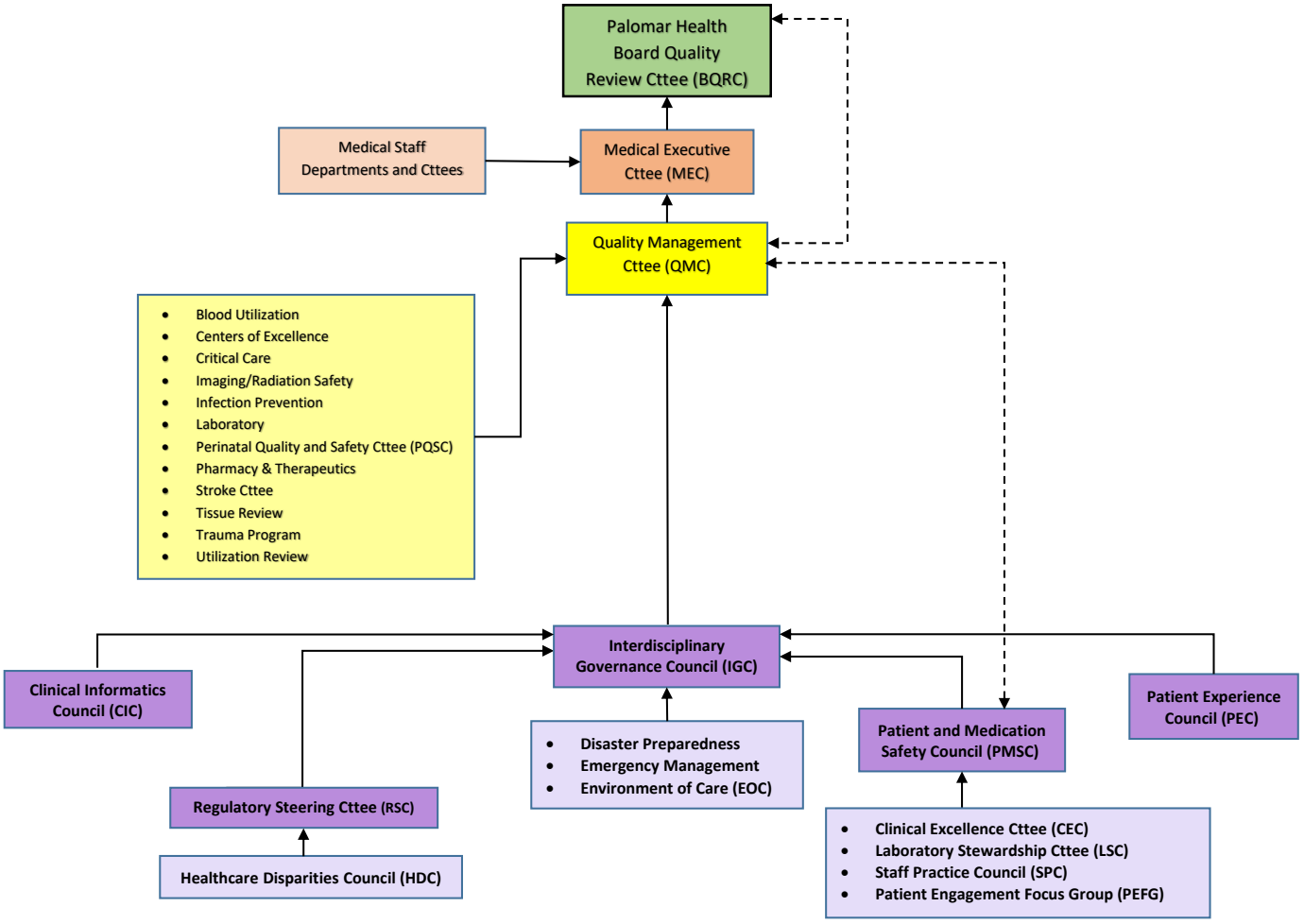
Access to information, laboratory resources, and equipment and supplies are available to support the infection prevention and control program.

Procedure Review

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

Department Structure

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



Key Definitions

Standardized infection ratio (SIR): a statistical measure used to compare the actual number of healthcare-associated infections (HAIs) observed at a healthcare facility to the predicted number of infections expected based on national baseline data, essentially adjusting for patient risk factors to allow for fair comparisons between different facilities. An SIR greater than 1 indicates more infections than predicted, while an SIR less than 1 indicates fewer infections than predicted.

Standardized utilization ratio (SUR): a metric that compares the actual number of device days to the predicted number of device days. It is used to track device use over time at the facility, state, local, or national level. Having a SUR above 1.0 means the facility or unit utilizes a higher proportion of ventilators than what is predicted for the facility or unit.

IVAC+: is the aggregate SIR calculation of both infection-related ventilator associated condition (IVAC) and possible ventilator associated pneumonia (PVAP).

Complex AR SIR Model: a specific model used to calculate an SIR for surgical site infections (SSIs), where "AR" stands for "Admission/Readmission," meaning the model takes into account the risk factors associated with both the initial admission and any subsequent readmissions when determining the predicted infection rate for a patient.

Population SIR (pSIR): a relatively newer metric designed to fix a "blind spot" in traditional hospital reporting. The result is a prioritization chart or focus map.

The Problem: If a hospital unit works very hard to remove unnecessary catheters, they are left with only the "sickest" patients who absolutely must have one. Because these patients are high-risk, the infection rate (SIR) might actually go up even though the hospital is doing a better job. The Solution: The pSIR "marries" the infection ratio with the Standardized Utilization Ratio (SUR). It measures the total harm to the population, rewarding hospitals for both preventing infections and reducing device use. The pSIR is the product of your infection performance and your device usage or SIR x SUR.

Quadrant	Stats	Priority Level	Strategy
High SIR / High SUR	High Infections & High Usage	Urgent / High	Focus on both "bedside" hygiene and protocols to remove devices faster.
High SIR / Low SUR	High Infections & Low Usage	Medium	These units have few devices but high infection rates; focus on maintenance/insertion technique.
Low SIR / High SUR	Low Infections & High Usage	Medium	"Clean but over-using." Focus on stewardship—are all these devices necessary?
Low SIR / Low SUR	Low Infections & Low Usage	Low (Sustain)	These are your high-performing units. Use them as "best practice" examples.

Hand Hygiene

Situation

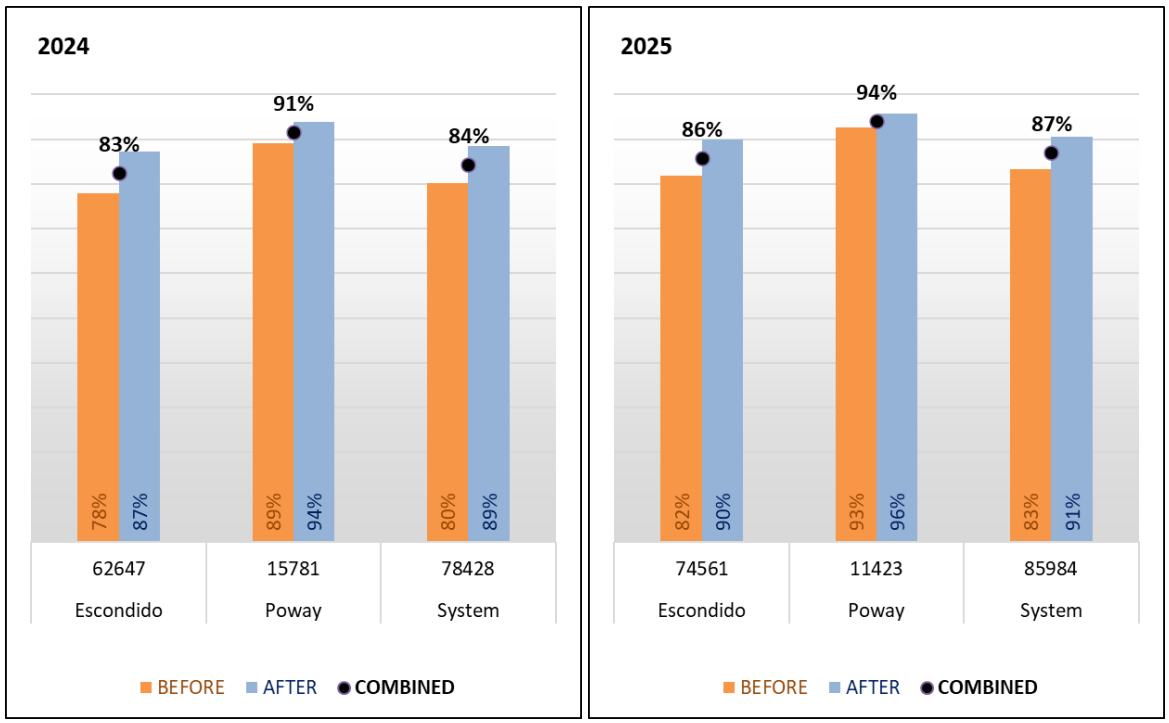
Hand hygiene is crucial in healthcare settings as it significantly reduces the risk of infections by preventing the spread of harmful pathogens. This protects both patients and healthcare providers, and it helps combat antimicrobial resistance by decreasing the need for antibiotics. Studies have shown that proper hand hygiene can prevent up to 50% of healthcare-associated infections, highlighting its importance in maintaining a safe healthcare environment.

Background

Increase the System mean hand hygiene compliance to 88% compliance by end of 2025; measured by a standardized method via direct observation.

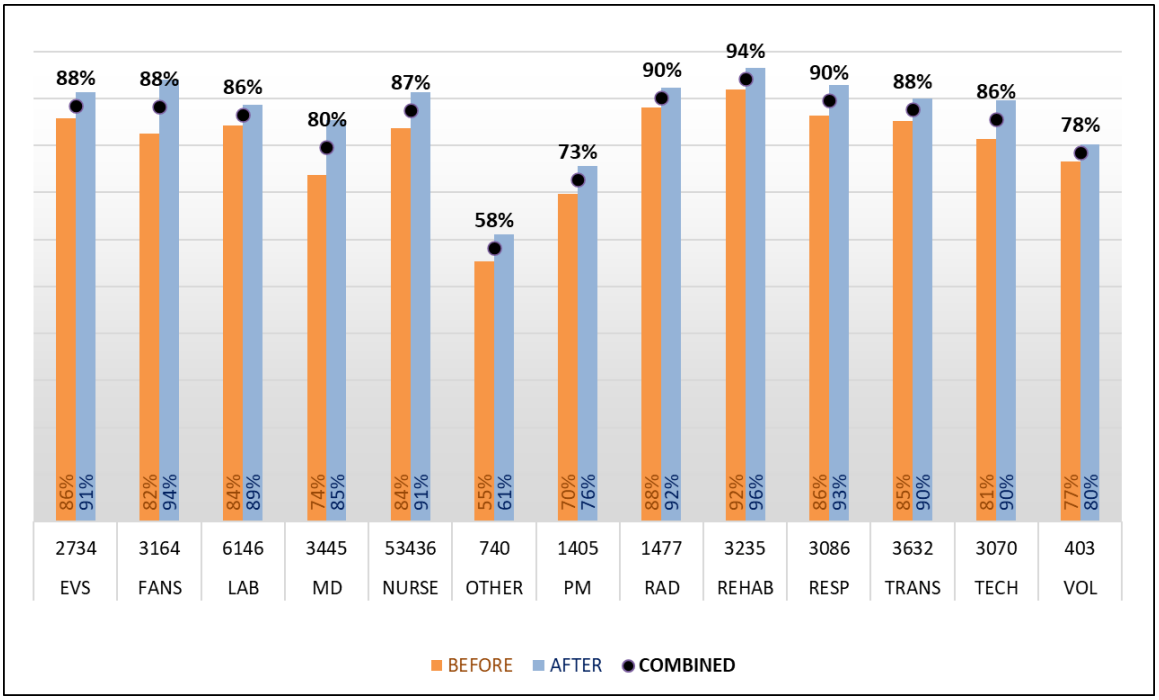
Assessment

Hand Hygiene by System



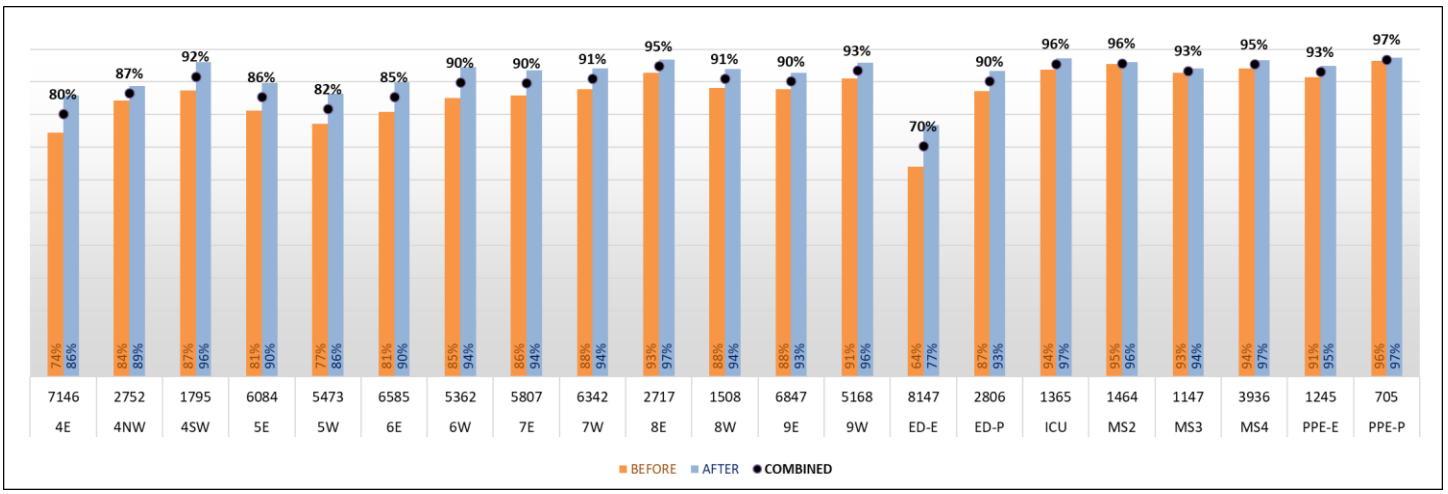
System mean hand hygiene compliance increased 3.6% from previous year.

Hand Hygiene Compliance by Discipline



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

Hand Hygiene Compliance by Unit



Intervention Summary

1. Provide hand hygiene education to employees and medical staff upon hire (physical demonstration), annually, and regularly with units or disciplines as appropriate.
2. Every month, share data, engage department/discipline leaders with low compliance, collaborate to identify specific problems and possible solutions, and request the implementation of a comprehensive action plan with goals and presented at the Infection Control & Prevention Committee.

Central Line-Associated Bloodstream Infection (CLABSI)

Situation

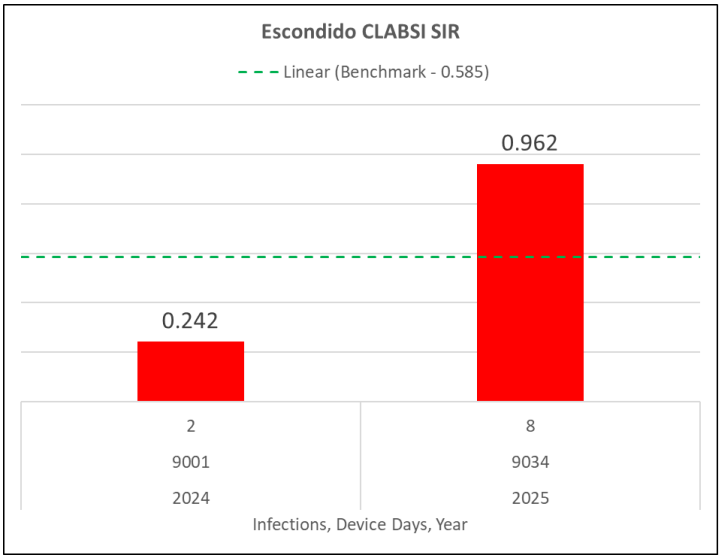
CLABSIs remain a critical focus of infection prevention programs due to their significant clinical and financial impact. Nationally, CLABSIs are associated with a mortality rate ranging from 12% to 25%, contributing to approximately 30,000 preventable infections annually. CLABSI SIR is a key component of the Hospital-Acquired Condition (HAC) Reduction Program. Hospitals falling into the worst-performing quartile (the top 25% of SIR scores) face a 1% reduction in all Medicare fee-for-service payments. The Leapfrog Group heavily weights CLABSI SIR within its "Infections" domain. Poor performance in this category can significantly lower a facility's letter grade, directly influencing public perception and patient choice in the competitive San Diego healthcare market.

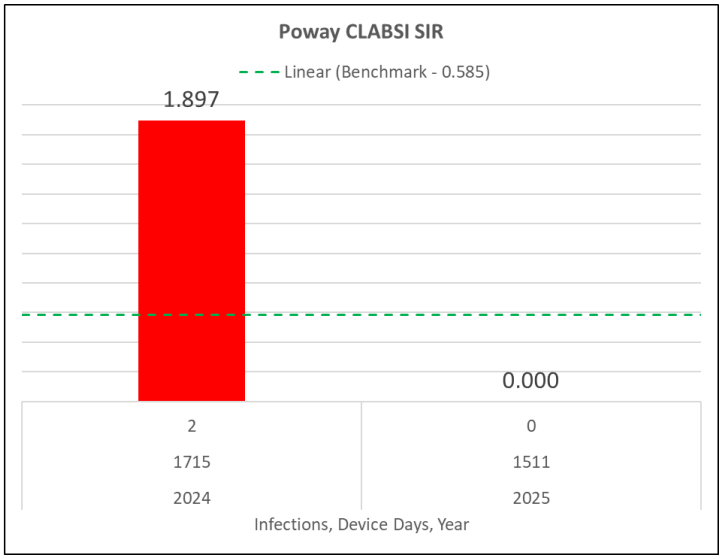
Background

Each facility goal to have a CLABSI SIR that does not exceed the national average SIR, a moving benchmark, of 0.593 for the calendar year.

Assessment

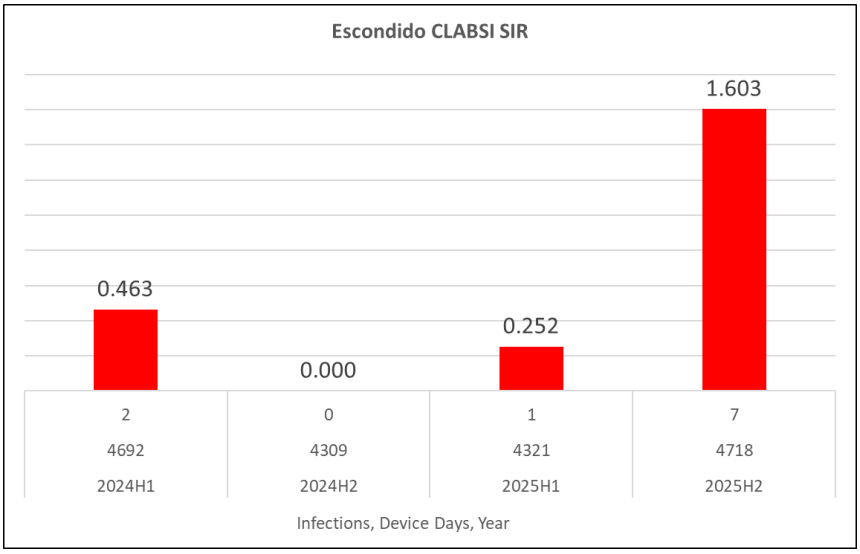
CLABSI Standardized Infection Ration (SIR)





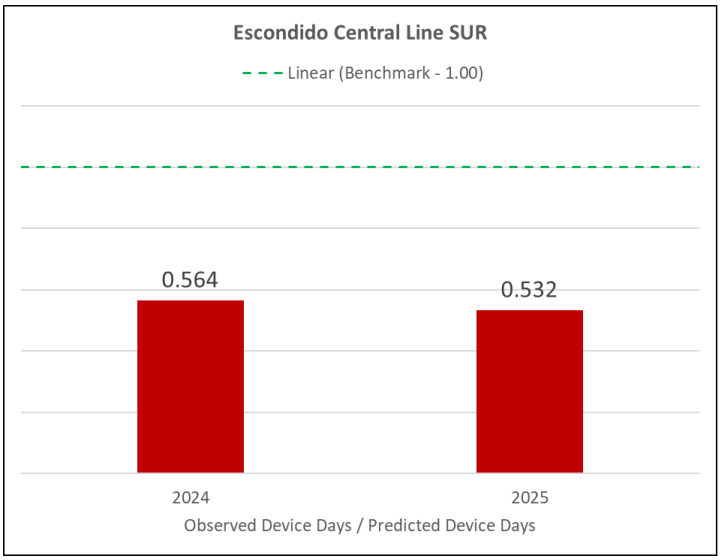
Escondido CLABSI SIR (0.962) is above SIR benchmark. Among the 8 CLABSI events, 5 were outside of critical care and all with concurrent vascular access (PIV or another CVC, including femoral lines). Twenty-nine percent of these central lines were not consistently assessed (daily) by a provider for necessity. These assessments are more consistent among Intensivists than the Hospitalists in non-ICUs, where most of the events were identified. A temporal staffing issue among the vascular access team (VAT) was identified that may have contributing to 71% of the events associated with PICCs near the end of the year. The VAT is responsible for inserting and managing, including dressing changes, all PICC lines. A lack of hand off communication to primary care nursing can impact consistent practice interventions. Additionally, among the events, only 14% of patients consistently received (daily) a chlorhexidine gluconate (CHG) bath. In a 2025 audit of morning patients with central lines, excluding ports and lines present on admission, only 67% received a CHG bath in the previous 24 hours (2 shifts).

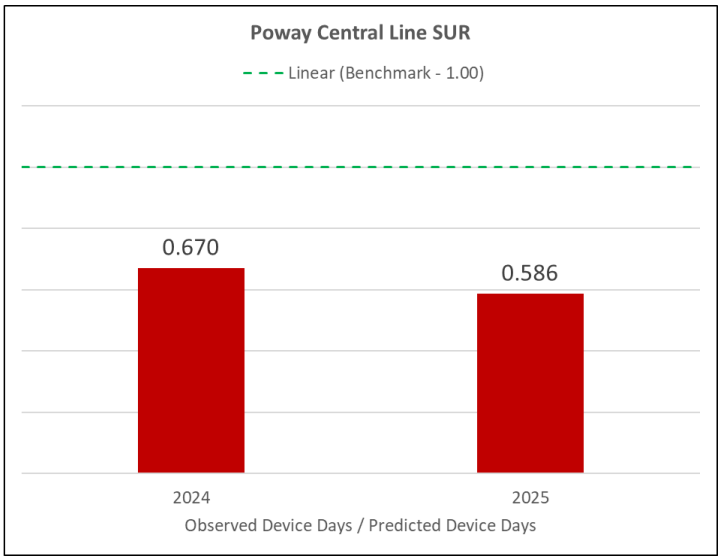
Seven of the 8 CLABSI at Escondido occurred within the last half of the year, highlighting the immediate need to implement an effective intervention early in 2026.



Poway CLABSI SIR (0.000) is below SIR benchmark and decreased from previous year.

CLABSI Standardized Utilization Ratio (SUR)





The SUR for both Escondido and Poway are below SUR Benchmark and reduced from previous year.

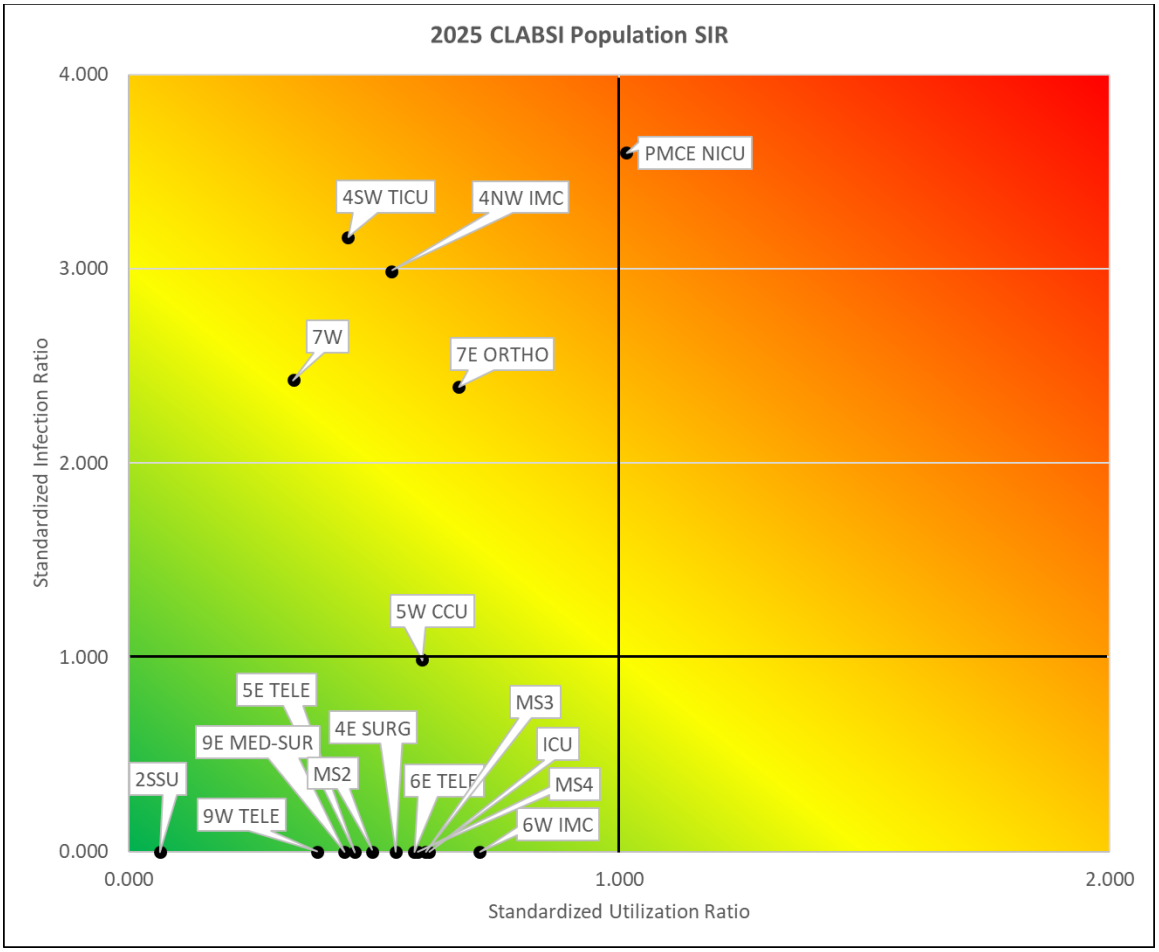
Intervention Summary

1. A critical care workgroup meets monthly to review infections trends and propose solutions that can be implemented by critical care team. This group includes a clinical nurse specialist and clinical education, nursing leadership, respiratory care, intensivists, infection prevention.
2. Provider documentation of assessing central line necessity daily is monitored monthly, and part of an intensivist medical group performance measure. Intensivist compliance with this metric is 94% (N=2,332 eligible central line days); however, Hospitalist compliance is 64% (N=3,086). This data is reported to the medical directors monthly.
3. A transparent CHG-impregnated dressing was trialed and implemented in 2024 and carried onto 2025. The dressing replaced the need for both a CHG-impregnated patch and a transparent dressing, improving the workflow for assessing the site for infection and dressing changes.

4. Root cause analyses are performed for all CLABSI events by unit-based leadership. An electronic form to streamline this review was developed to guide this analysis among leadership. It will pilot in 2026.
5. A workgroup created in 2023 to reduce blood culture contamination (BCC) rate is still active with an organization-wide goal of 2.0%. They have trialed a blood diversion product among CPTs in the ED with a <1.0% BCC. The BCC rate outside this trial is 2.4%.
    - While the goal was not met outside the product trial, the organization will need to determine the cost-benefits of a purchasing the product for system-use.
6. CLABSI bundle compliance is monitored by unit-based leadership through ServiceNow, with an annual facility goal of at least 90% among all CLABSI prevention practices, each a sample unit: Antiseptic protector caps are utilized for all line, connectors, CHG-containing bath provided within last 2 nursing shifts, CHG-impregnated dressing is used CVC dressing clean, dry, and intact (with no additional tape used), CVC dressing is labeled with date and initials, CVC dressing is not past due (i.e. at least Q7 and PRN), CVC has been assessed for necessity, CVC insertion date documented, no visible blood in extension legs or injection caps, and nursing staff can verbalize appropriate CHG bathing. Escondido bundle compliance is 92% (N=52,886). Poway bundle compliance is 96% (N=11,960).
    - Escondido goal was met.
    - Poway goal was met.

Goal Assessment & Action Plan

Escondido did not meet facility goal. Poway met facility goal. After review of the national hospital average and our 2025 Population SIR (pSIR) focus map, our 2026 CLABSI goal is that each facility does not exceed the moving national average SIR for CLABSI, focusing attention to 4SW and units outside of critical care, like 7W, and 4NW. NICU oversight has been relicensed to Rady Children's Hospital, but our Program will continue to support the unit with infection prevention practices and environmental safety.



- Improve Hospitalist central line indication assessment compliance with the goal of improving 10% from previous year. Work with medical director and hospitalist group to improve this documentation.
- Maintain CLABSI bundle compliance facility goal of at least 90%.
- Continue to improve hand hygiene compliance.
- Assess barriers to CHG bathing patients with central lines and improve the practice standard.
- While the organization already uses an antimicrobial catheter (CHG+sulfa), there is an ongoing conversion initiative to a silver-based antimicrobial catheter. Both agents on catheters are supported by data to reduce risk of infection; however, the CHG-sulfa agents have more labelled contraindications and risk of adverse events from potential allergies.

Catheter-Associated Urinary Tract Infections (CAUTI)

Situation

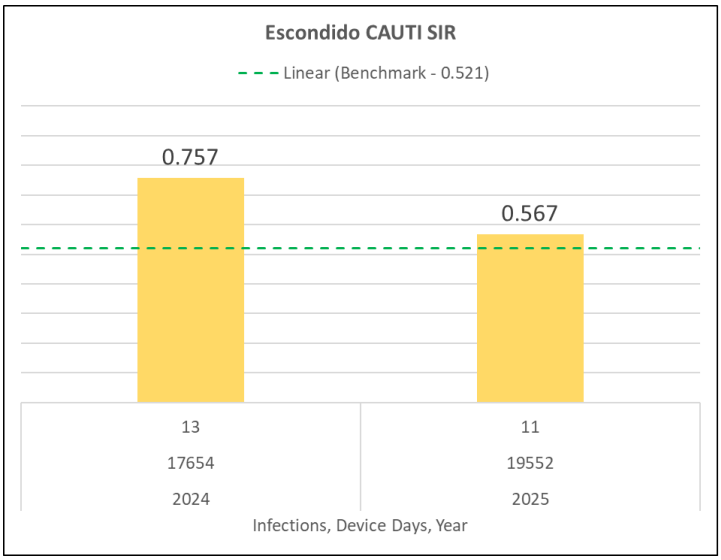
Catheter-Associated Urinary Tract Infections (CAUTIs) are among the most prevalent healthcare-associated infections (HAIs), driven primarily by the prolonged and often unnecessary use of indwelling urinary catheters. Annually, CAUTIs account for over 560,000 infections in the U.S., with an estimated 13,000 attributable deaths. While the individual mortality rate for CAUTI is approximately 2.3%, the high volume of infections creates a massive cumulative burden on the healthcare system. CAUTI performance is a core metric in the Hospital-Acquired Condition (HAC) program and assigned a significant weight by Leapfrog.

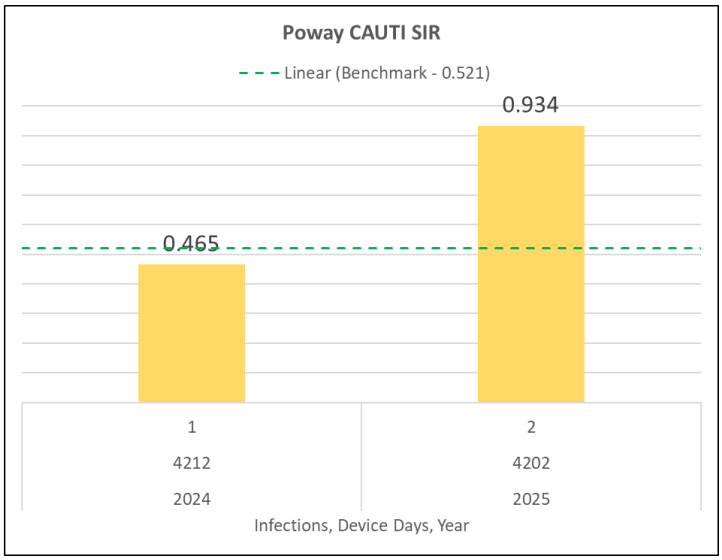
Background

Each facility goal to have a CAUTI SIR that does not exceed the national average SIR, a moving benchmark, of 0.521 for the calendar year.

Assessment

CAUTI Standardized Infection Ration (SIR)



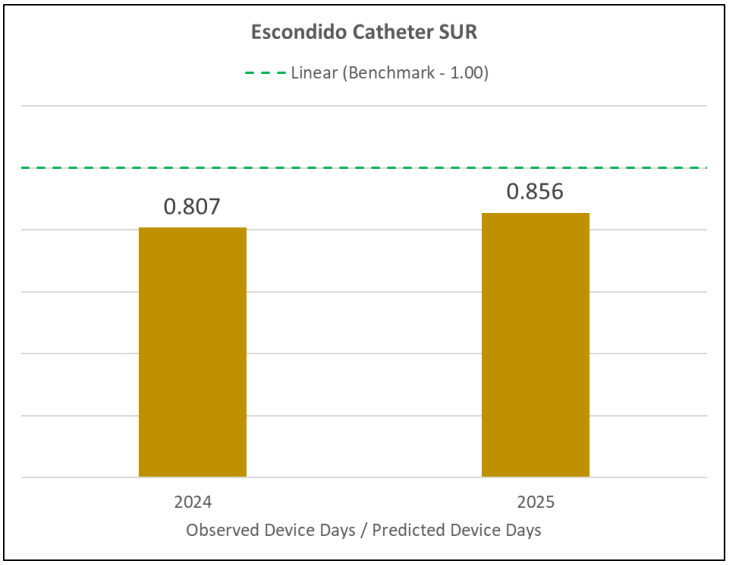


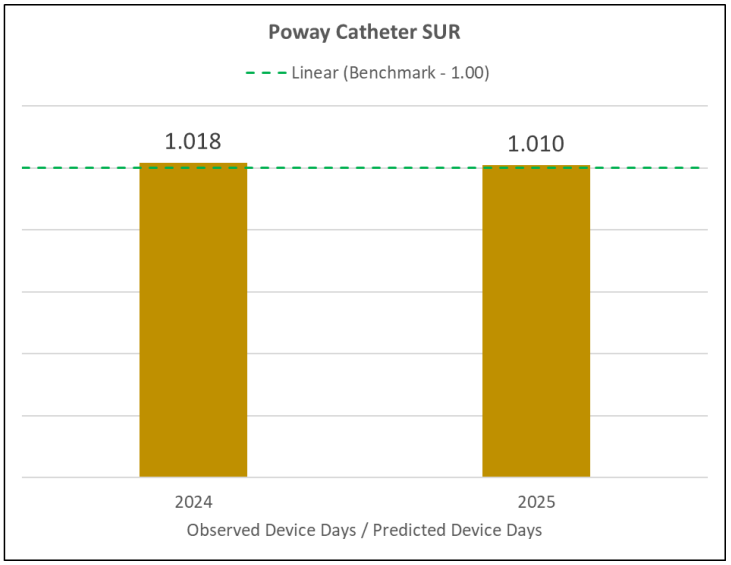
Escondido CAUTI SIR (0.567) is above SIR Benchmark but reduced 25% from previous year.

Poway CAUTI SIR (0.934) is above SIR Benchmark and increased 114% from previous year; however, only represents 2 CAUTI events. The predicted number of CAUTI for Poway is low relative to size, volume, and other risk-adjusted factors.

There were 12 CAUTI events across the district (1 at Poway). Sixty-seven percent of event catheters were indicated for acute urinary retention; however, had a 15-day average dwell time, suggesting a lack of removal attempts. Five events were from critical care, 2 from step-down, and 5 from a medical/surgical/telemetry unit. 92% of events were with a fecal/GI pathogen, half of these event patients had at least one episode of stool incontinence. Only half of event patients received consistent (daily) peri and catheter care.

CAUTI SUR





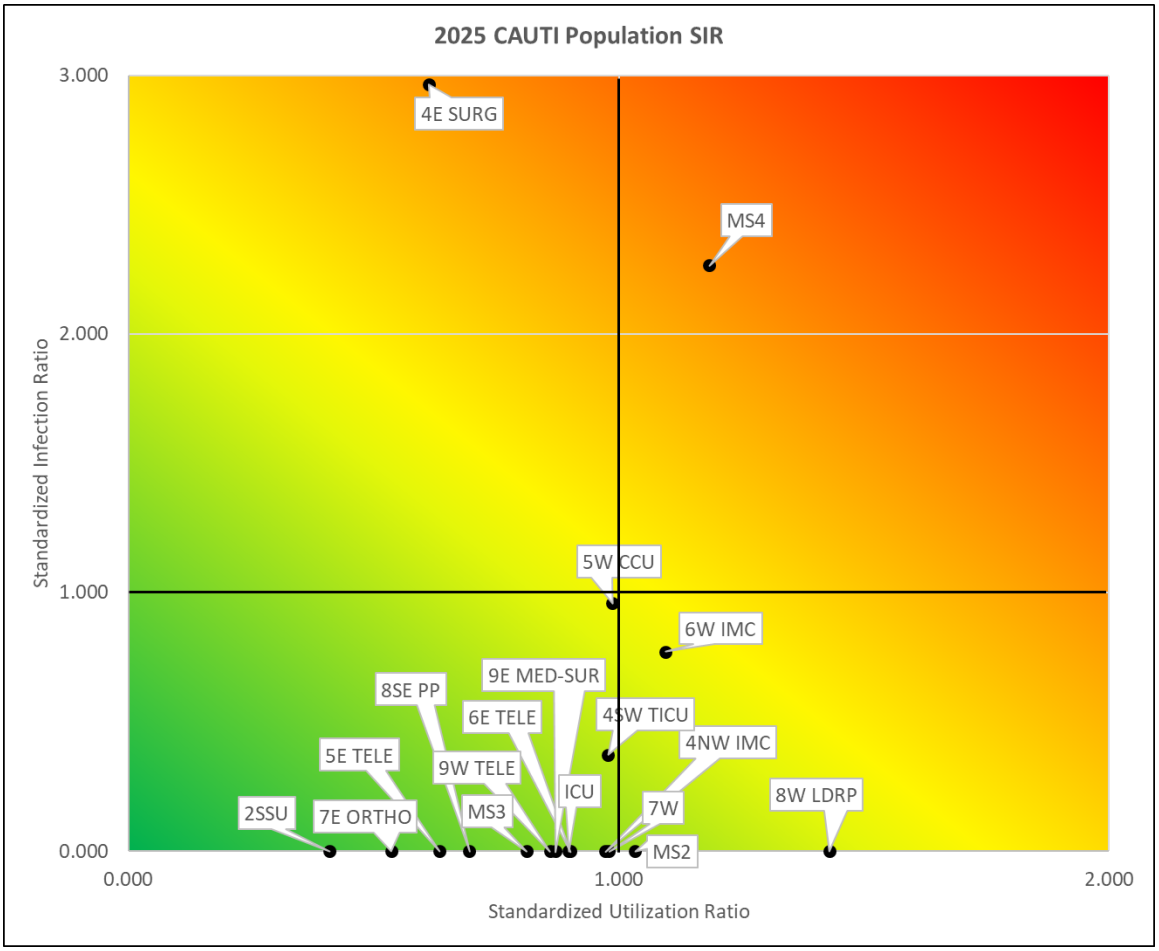
Escondido Catheter SUR is below SUR benchmark. Poway Catheter SUR is slightly above SUR benchmark.

Intervention Summary

1. Nurse-driven removal protocol are Cerner rules that automatically place an order to discontinue indwelling catheters based on nursing assessment and documentation.
2. A critical care workgroup meets monthly to review infections trends and propose solutions that can be implemented by critical care team. This group includes a clinical nurse specialist and clinical education, nursing leadership, respiratory care, intensivists, infection prevention.
3. UA culture reflex change. After robust analyses of patient risks, benefits, and cost avoidance, and much discussion at the workgroup and medical staff committee levels, our laboratory urine diagnostics and antimicrobial therapy practices will be optimized through a small change in urinalysis (UA) orders. Laboratory urinalysis orders will no longer reflex to urine cultures if “WBC >5” by default. The culture reflex benchmark will now default to “WBC >10” in all UA orders and those within order sets. Providers will still have the ability to place orders for a urine culture without a UA or within the UA order. Change went live February 2025. The lab and estimated treatment savings were significant.
4. Root cause analyses are performed for all CLABSI events by unit-based leadership. An electronic form to streamline this review was developed to guide this analysis among leadership. It will pilot in 2026.
5. CAUTI bundle compliance is monitored by unit-based leadership through ServiceNow, with an annual facility goal of at least 90% among all CAUTI prevention practices, each a sample unit – Appropriate urine specimen collection, Assessed for device necessity, Pericare provided, Properly secured, TES intact, Tubing and reservoir below bladder, Urine flow unobstructed. Escondido bundle compliance is 98% (N=219,000). Poway bundle compliance is 99% (N=20,672). Despite the high bundle compliance for each facility, among the top three missed measures was proper securement, the provision of pericare, and the system remained closed (TES not intact).
    - Escondido goal was met.
    - Poway goal was met.

Goal Assessment & Action Plan

Escondido did not meet facility goal. Poway did not meet facility goal. After review of the national hospital average and our 2025 Population SIR (pSIR) focus map, our 2026 CAUTI goal is that each facility does not exceed the moving national average SIR for CAUTI, focusing attention (PDSA) to MS4, 4E, and 5W.



- Improve hand hygiene compliance.
- Maintain CAUTI bundle compliance facility goal of at least 90%. Work with unit-based leadership to validate this data at least annually.
- Implement PDSA of developing nurse-driven catheter removal protocol and algorithm for acute urinary retention.
- Urinary Catheter Insertion Orders with Indications. An ED provider change request to compel the ordering providers to select a clinical indication for urinary catheter insertion orders to execute the order.
- Assess barriers to consistent peri and foley practice standards.

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

Situation

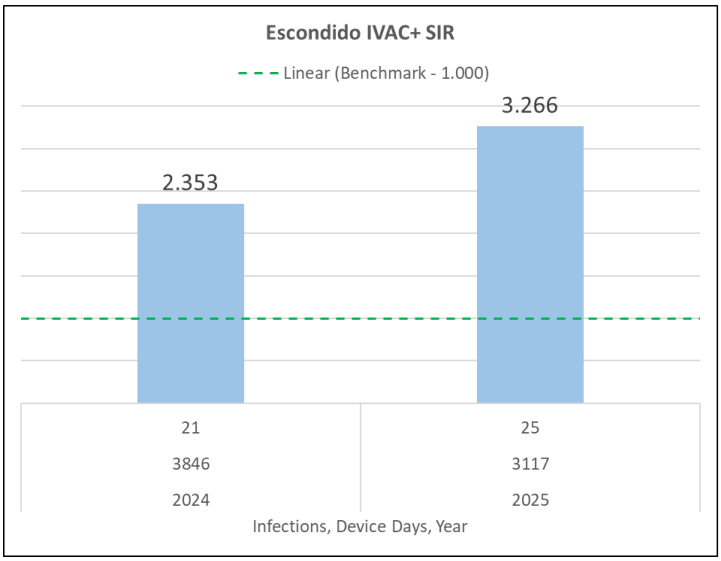
Ventilator-associated pneumonia (VAP) is a serious lung infection that develops in patients who have been on mechanical ventilation for at least 48 hours, posing a significant concern in healthcare settings, particularly ICUs. VAP carries a significant impact, increasing mortality rates (ranging from 10% to 40%), prolonging hospital stays and increasing healthcare costs, and raising the risk of complications like sepsis and acute respiratory distress syndrome (ARDS). The rise of antibiotic-resistant organisms in VAP further complicates treatment and infection control efforts.

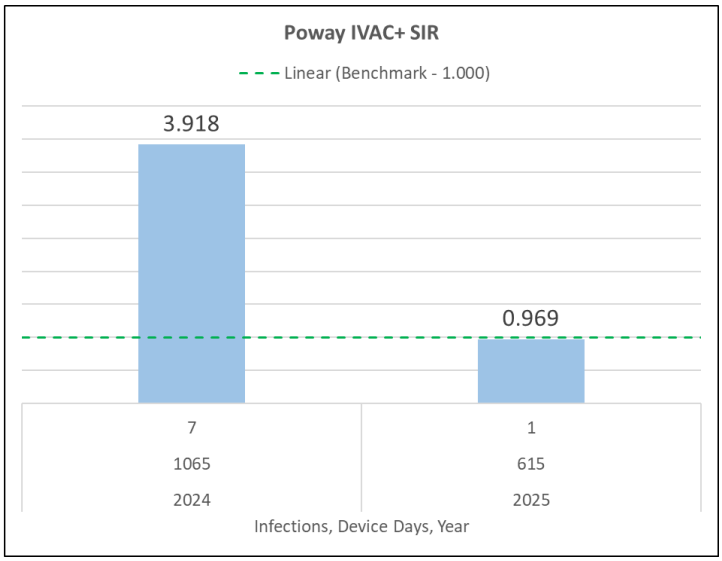
Background

Each facility goal to have an IVAC+ SIR that does not exceed the SIR Benchmark of 1.000 for the calendar year.

Assessment

IVAC+ Standardized Infection Ration (SIR)

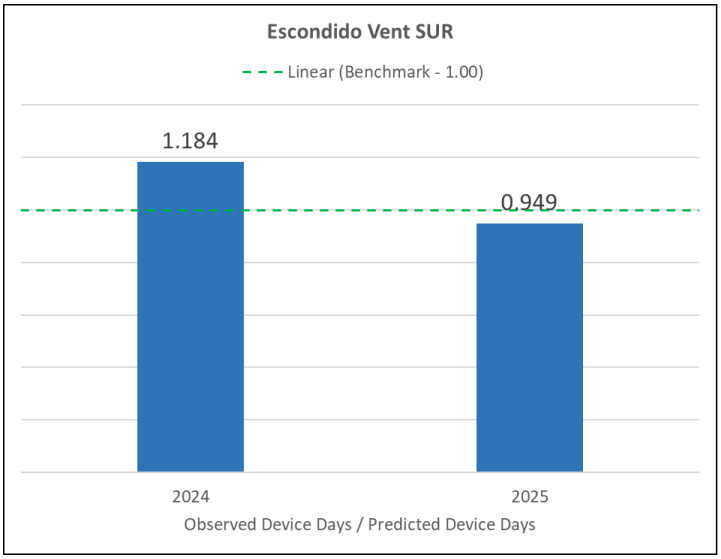


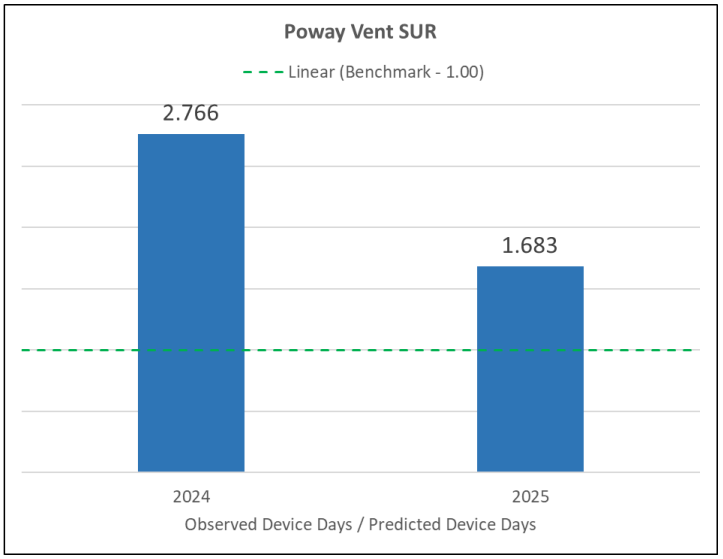


Escondido IVAC+ SIR (3.266), representing both 4SW and 5W, is above SIR Benchmark and increased 39% from previous year.

Poway IVAC+ SIR (0.969), representing ICU, is slightly below SIR Benchmark and decreased 74% from previous year.

IVAC+ SUR





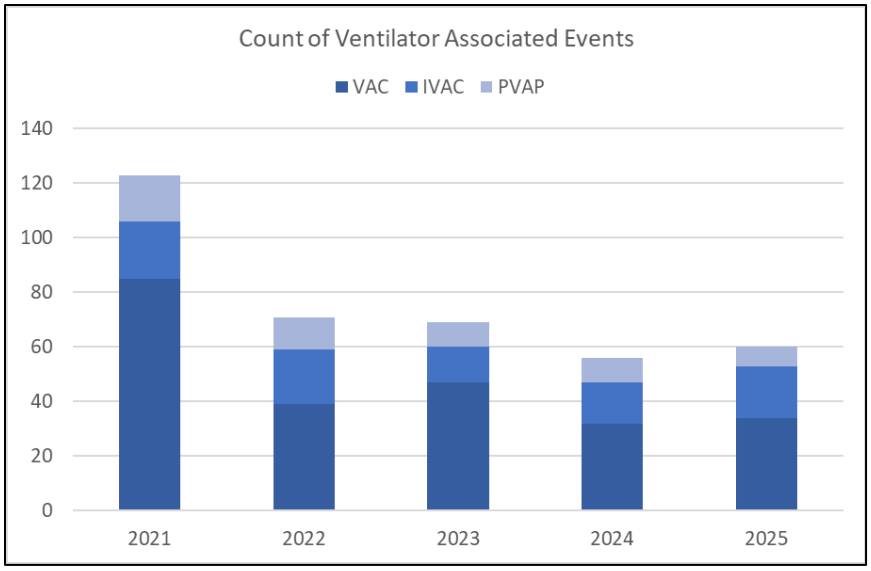
Escondido ventilator SUR is below SUR benchmark and reduced utilization by 15% from previous year. Poway ventilator SUR (representing only ICU) is above SUR benchmark but reduced 39% from previous year.

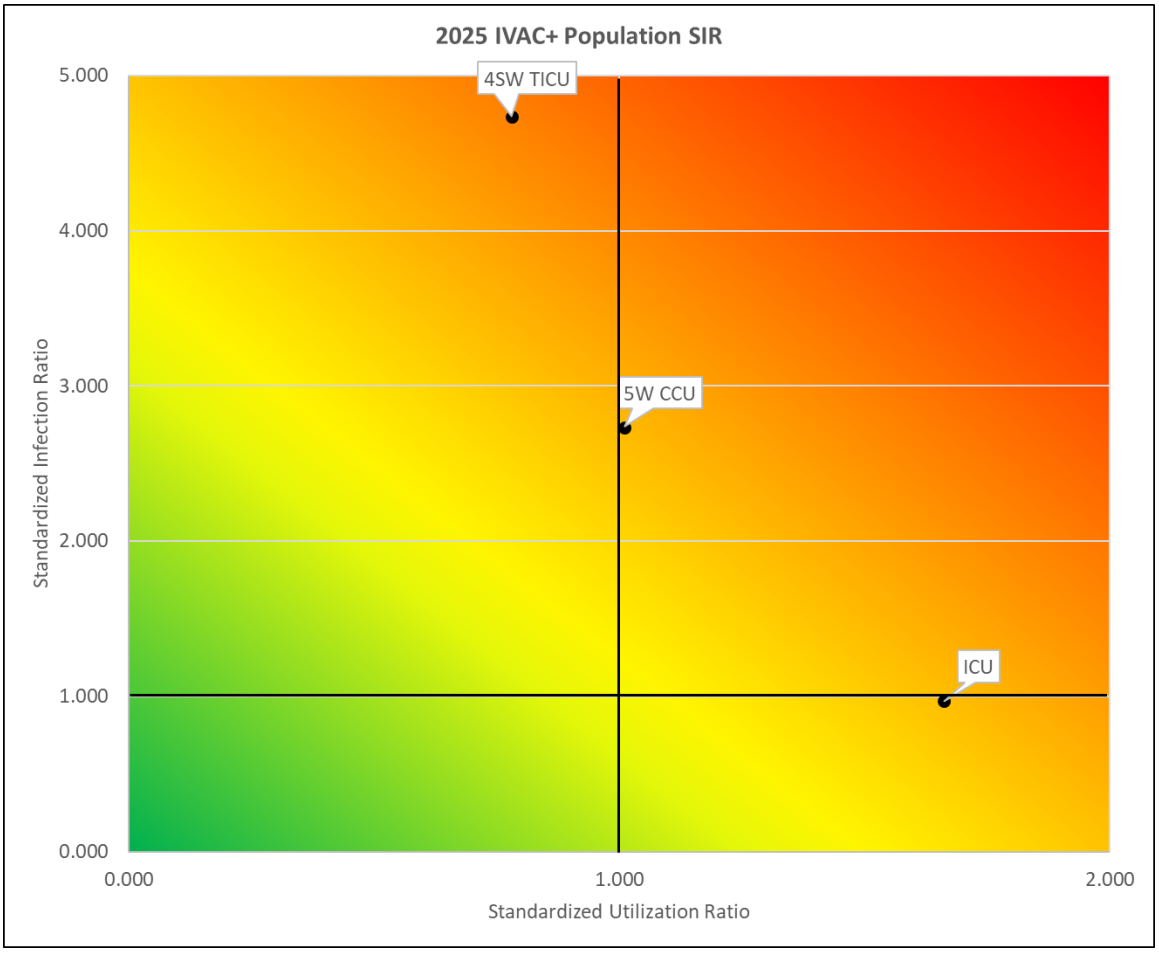
Intervention Summary

1. A critical care workgroup meets monthly to review infections trends and propose solutions that can be implemented by critical care team. This group includes a clinical nurse specialist and clinical education, nursing leadership, respiratory care, intensivists, infection prevention.
2. Root cause analyses are performed for all IVAC+ events by unit-based leadership.
3. RCP staff took over the responsibility of routine oral care for ventilated patients to standardize practice and the quality of this care, so RCP staff set a goal to improve their organization-wide hand hygiene compliance by 5% compared to previous year. RCP staff did not meet goal, but their hand hygiene improved 1% from the previous year.
4. Start PEEP at 8 to minimize scenarios of “worsening oxygenation” from default 5
5. VAP bundle compliance is monitored by RCP and IP leadership through ServiceNow, with an annual facility goal of at least 90% among all VAP prevention practices, each a sample unit. Escondido bundle compliance is 94% (N=578). Poway bundle compliance is 92% (N=88).
    - Escondido goal was met. Poway goal was met.

Goal Assessment & Action Plan

Escondido did not meet facility critical care unit goal. Poway did not meet facility critical care unit goal. Despite this increase, there is evident improvement (downward trend) over a span of multiple years since 2021. Not only the totally number of ventilator-associated events, but the number of severe outcomes (complications and pneumonia) have reduced since 2021. The facility critical care units will retain the goal of not exceeding an SIR benchmark of 1.00, and a 10% reduction from previous year.





- Improve hand hygiene compliance.
- Considering their compliance of 89% and the rate of improvement, improve mean hand hygiene by 5% among RCPs compared to previous year.
- Monitor initiative of setting PEEP at 8 at start of mechanical ventilation.
- Maintain VAP bundle compliance facility goal of at least 90%.

Clostridioides difficile Infection (CDI)

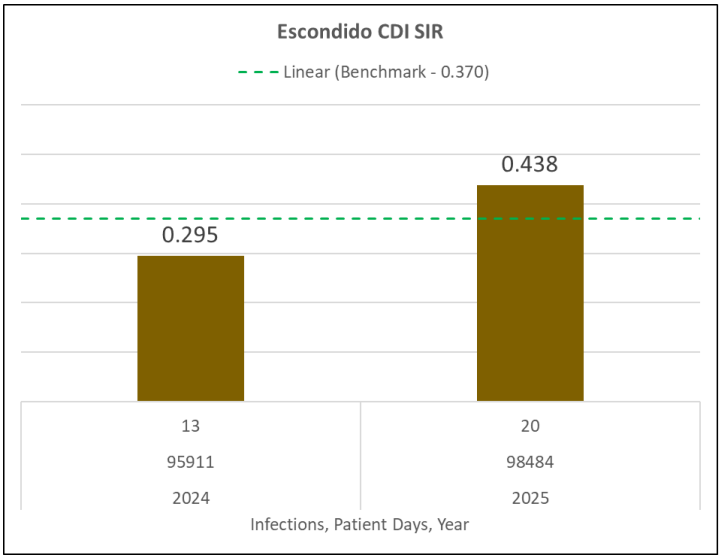
Situation

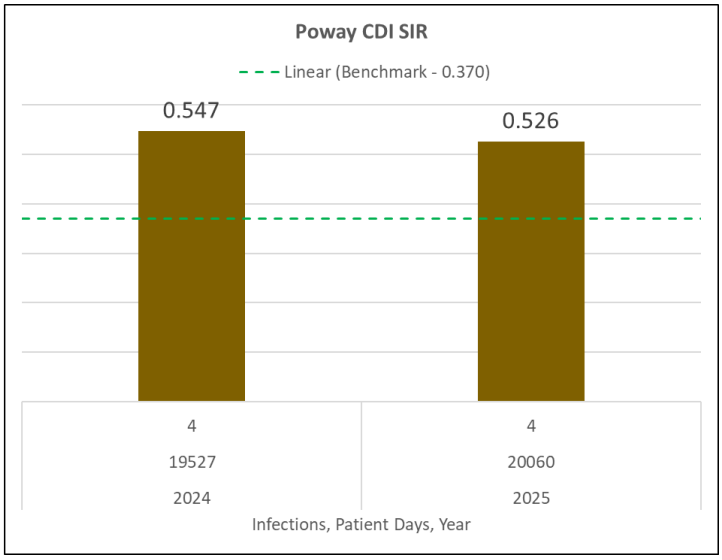
CDI is a significant healthcare-associated infection (HAI) characterized by severe diarrhea and colitis, often triggered by antibiotic use that disrupts normal intestinal flora. CDI is associated with high morbidity and a mortality rate of approximately 9% to 15% within 30 days of diagnosis. Nationally, there are roughly 13,000 to 15,000 annual deaths attributed directly to CDI. CDI is part of "Domain 2" in the Hospital-Acquired Condition (HAC) Reduction Program and a heavily weighted component of the Leapfrog "Infections" score. CDI performance is also tied to a specific Quality Incentive Pool (QIP). This program measures the aggregate SIR across the Escondido and Poway campuses. To receive the full financial incentive from this pool, the system's combined performance must meet or exceed a pre-established benchmark

Background

Each facility goal to have a CDI SIR that does not exceed the national average SIR, a moving benchmark, of 0.369 for the calendar year.

Assessment





Escondido CDI SIR (0.438) is above SIR Benchmark and increased 48% from previous year. Facility is performing slightly worse than the national average.

Poway CDI SIR (0.526) is above SIR Benchmark but decreased 4% from previous year. Facility is performing worse than the national average.

Among the 24 CDI hospital-onset cases, 71% of stool specimens were collected appropriately by nursing without concurrent laxative-use within 48 hours of collection. This appropriate collection rate has improved tremendously throughout the last several years. The same proportion of cases had at least one risk factor for CDI prior to testing. There were no seasonal trends when it comes to CDI associated with higher antibiotic use during the respiratory season. At Escondido, there the same number of cases between the first and last half of the year.

Intervention Summary

1. There is a Cerner rule that help identify community-onset CDI early in a patient's admission - A CDI lab order is placed if there is nursing documentation of 3 or more liquid/watery stools within 48 hours of the patient's admission.
2. A stool collection algorithm for CDI testing continues to be shared with nurses and is available as a reference text for the lab order and GI assessment.
3. EVS room cleaning validation is performed routinely with a focus on patient in Contact and Contact Plus precautions.
4. Antimicrobial stewardship (see full project list below); oral vancomycin prophylaxis.
5. Stool specimen validation is a nursing-led collaborative practice of unit leadership reviewing collection practices with their team per stool collection algorithm.
6. Testing Cerner alerts – alerts ordering providers to assess patient before testing unnecessarily (laxatives, previous positive)
7. Root cause analyses are performed for all CDI events by unit-based leadership.

Goal Assessment & Action Plan

Escondido did not meet facility goal. Poway did not meet facility goal. After review of hospital averages at a national level, our 2026 SIR goal is that each facility does not exceed an SIR benchmark of the national average.

- Distribute provider letter for appropriate CDI testing at least annually or as needed.
- Follow stool collection algorithm, give 48h rest for laxatives before collecting
- Encourage more provider-to-provider coaching towards improving diagnostic stewardship.

Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bloodstream Infection (BSI)

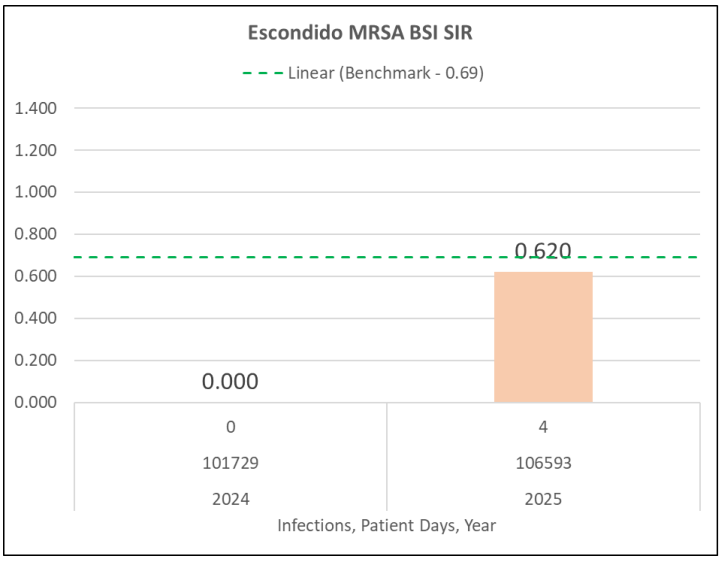
Situation

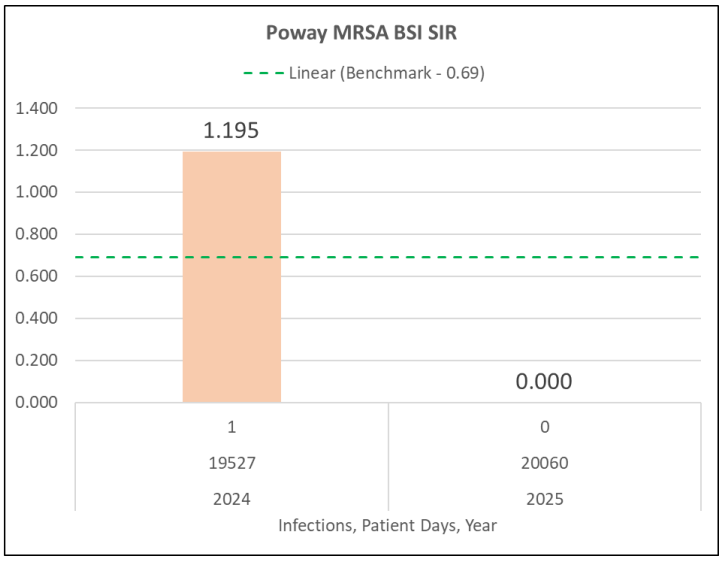
MRSA BSIs carry a high mortality burden, with 30-day mortality rates estimated between 20% and 30%. While national rates showed a decade of decline prior to 2020, recent data indicates a significant post-pandemic "rebound," with the average MRSA SIR increasing by as much as 37% since 2021. MRSA BSI is a core metric in CMS HAC Reduction Program and a performance indicator for the Leapfrog Safety Grade.

Background

Reduce facility MRSA BSI SIR by 10% and below benchmark 0.620. This outcome measure is analyzed as an SIR.

Assessment

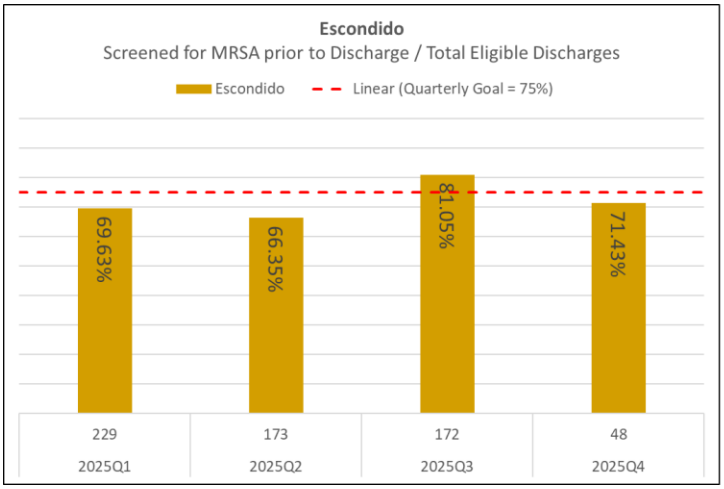


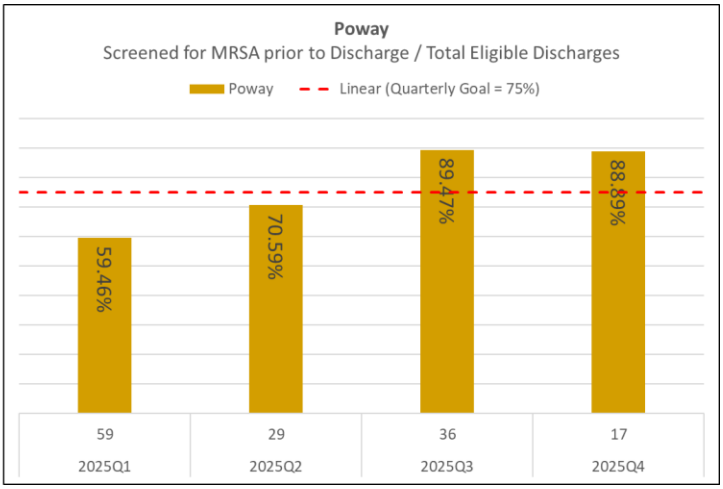


Escondido MRSA BSI SIR increased from previous year but below SIR benchmark of 0.620.

Poway MRSA BSI cases decreased to zero from previous year, and was below SIR benchmark.

High-Risk Dialysis MRSA Discharge Screening





The data presented above demonstrates compliance with California mandate for testing among a high-risk population. Dialysis patients are the high-risk group that the Infection Control & Prevention Committee identified for testing upon admission and at discharge.

Intervention Summary

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

1. Hand Hygiene adherence before and after patient contact (see Hand Hygiene)
2. Transmission-based precautions practices are assessed for compliance routinely with ongoing reinforcement of Standard and Transmission Based Precautions.
3. Follow surveillance testing for MRSA colonization per Senate Bill 1058 of high-risk patients on admission and inpatient dialysis at discharge. Facility compliance goal for screening dialysis patients prior to discharge is at or above 75%.
    a. Escondido did not meet goal.
    b. Poway met goal.
4. Continue to use Contact Precautions for infants colonized with MRSA and in NICU.
5. Patients colonized with MRSA and active infection, staff order contact isolations precautions
6. Environmental cleaning validation is performed routinely for patient rooms in Contact and Contact Plus precautions.

Goal Assessment & Action Plan

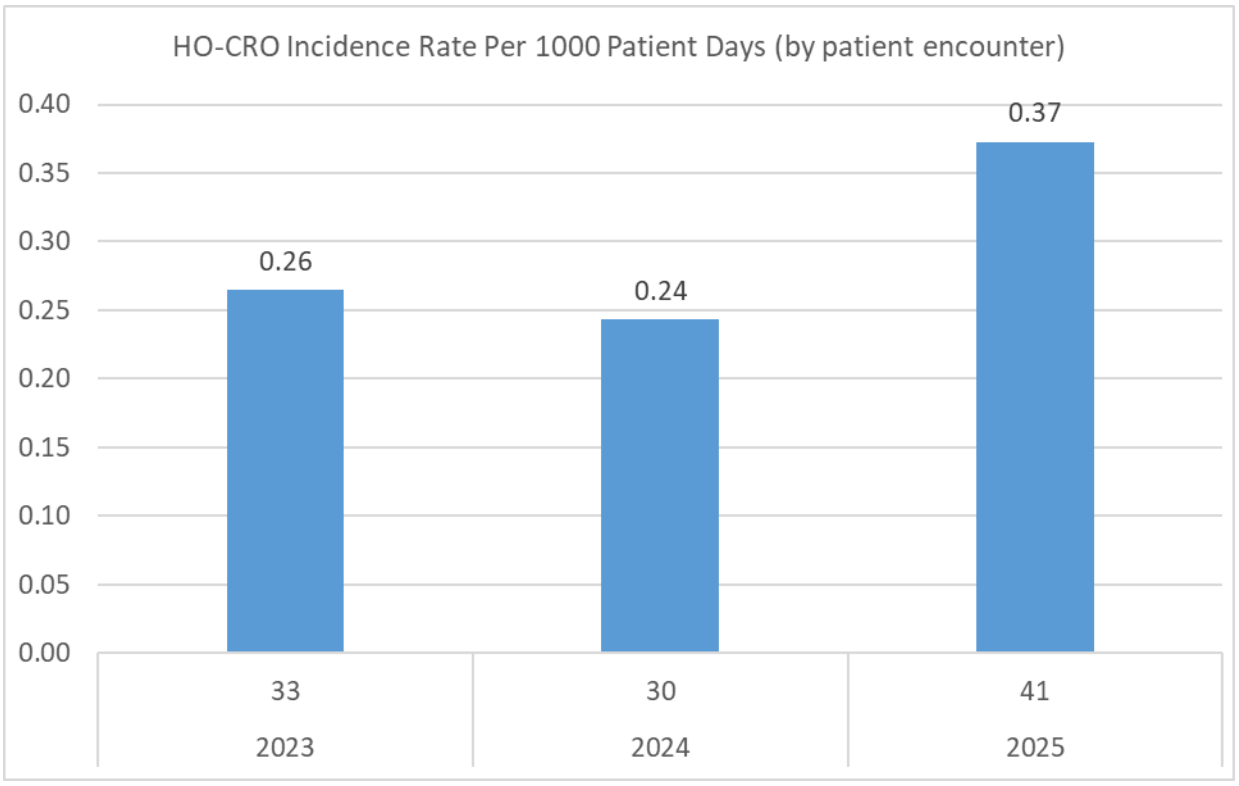
Escondido met facility goal. Poway did not meet facility goal. Maintain facility goal of a MRSA BSI SIR below benchmark the moving national average.

- Improve facility dialysis discharge MRSA screening by 10% from previous year.
- Review toolkits for hospital-onset bacteremia and fungemia prevention.

Other Multidrug-Resistant Organisms of Concern

Carbapenem-Resistant Organisms (CRO)

CRO infections are associated with exceptionally high mortality rates, often cited between 30% and 50% for systemic infections. A 2022 CDC special report estimated approximately 13,000 CRE infections and 1,100 deaths annually in the U.S., though recent data shows a 460% surge in specific resistant strains (like NDM-producing CRE) since 2019, suggesting the current death toll is likely higher.



Healthcare onset is defined as day four or later in the admission, which NHSN definition requires for MDRO LabID cases. All specimen sources are considered. An SIR cannot be calculated because predicted numbers are not available. Hospital-onset incidence increased 54% from previous year. There are no benchmarks available.

Infection Preventionists identified that EVS cleaning in CRO rooms was performed as routine cleaning and left privacy curtains in the room. There were no trends in location and since the rooms are private at PMC Escondido and Poway, there were no close contacts. Education and monitoring of these rooms for cleaning efficacy was implemented. Early identification and precautions are used for high-risk patients. Patient with any organism with carbapenem resistance, regardless of mechanism, are placed in Contact Precautions to mitigate transmission. The system has automatic processes to identify and isolate patients with histories of a CRO.

Candida auris

Candida auris is an emerging and multidrug-resistant yeast, and a contact-transmissible pathogen via hands or environment. Per the local public health jurisdiction, Palomar Health screens admitted patient at risk for *C. auris*. If identified, they will be tested via bilateral swab of axillae and groin. Patients identified within or outside our facility are placed in transmission-based precautions, and investigated for possible hospital transmission or epidemiological linkage to another patient case. A risk group was modified in this screening to focus testing for residents from subacute care facilities versus all skilled nursing facilities. The system has automatic processes to identify and isolate patients with histories of a Candida auris.

At the direction of County Public Health Department, a point prevalence survey (PPS) may be performed on a patient census to assess for prevalence in this population. Infection prevention measures are concurrently assessed among affected units. Testing was performed February 10th on 23 patients from both 5W and 6W, and received a positive result for one patient. IP team performed an investigation and assessment of infection prevention practices on unit, with possible evidence of epi-linkage (same room, shared 2 staff), despite case's individual risks. SDPH was followed up with this information. Hand hygiene on unit will be closely monitored. Testing performed on 2/26 on 16 patients from 5W, all resulting negative for C. auris.

A PPS was performed in the ICU at Poway on February 27th. The IP team performed an investigation and assessment of infection prevention practices on unit, with no evidence of epi-linkage (same room, shared 2 staff). SDPH was followed up with this information. Hand hygiene on unit will be closely monitored.

A PPS was performed on 9W on September 29th on 9 patients where possible a case was admitted. The case was reported by SDPH after days of admission.

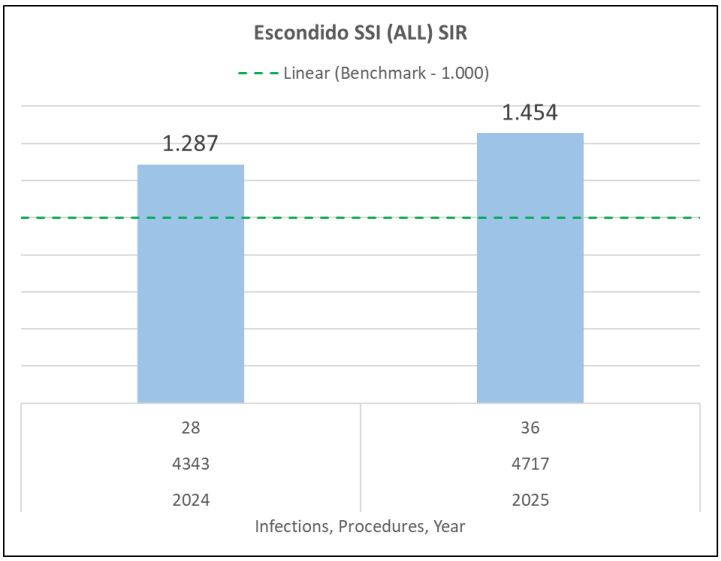
Surgical Site Infections (SSI)

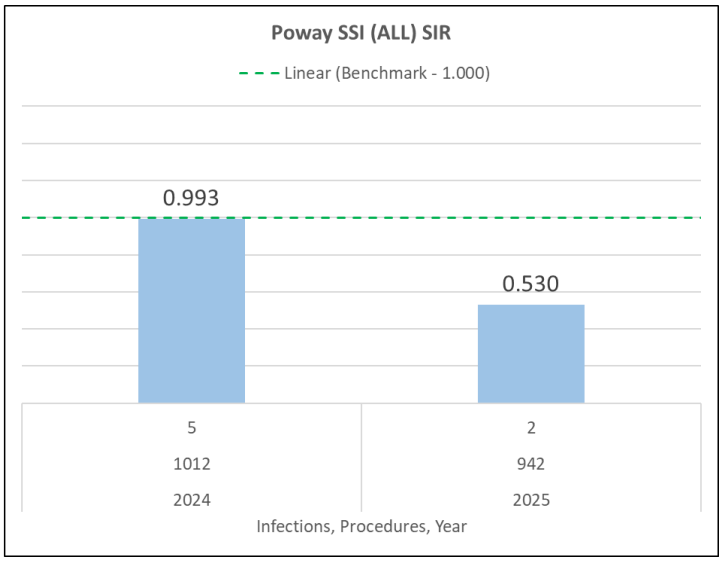
Background

Reduce facility overall SSI SIR by 10% from previous year and below SIR benchmark of 1.0. This outcome measure is analyzed as a SIR using the Complex A/R SIR Model.

Assessment

Overall SSI SIR

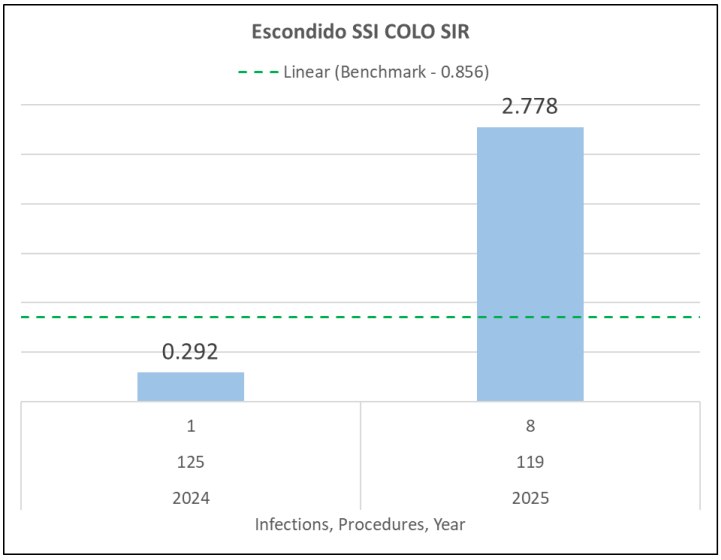


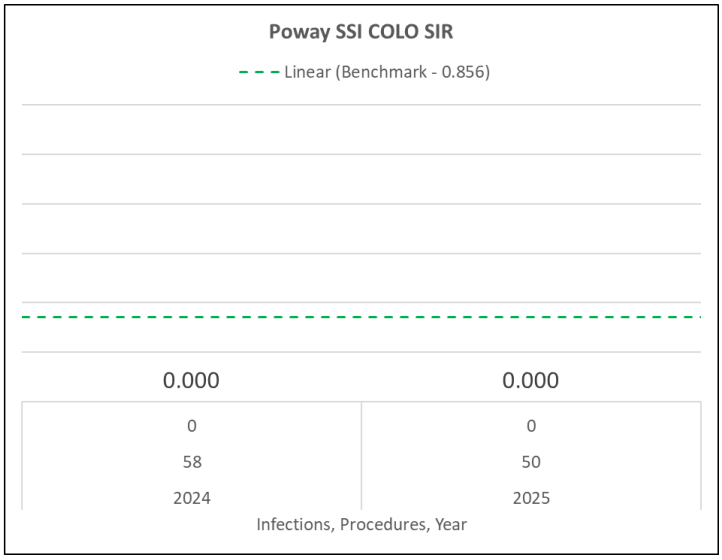


Escondido Overall SSI SIR (1.454) is above SIR Benchmark and increased 13% from previous year. Trends are identified by procedure type.

Poway Overall SSI SIR (0.530) is below SIR Benchmark and decreased 47% from previous year. Trends are identified by procedure type.

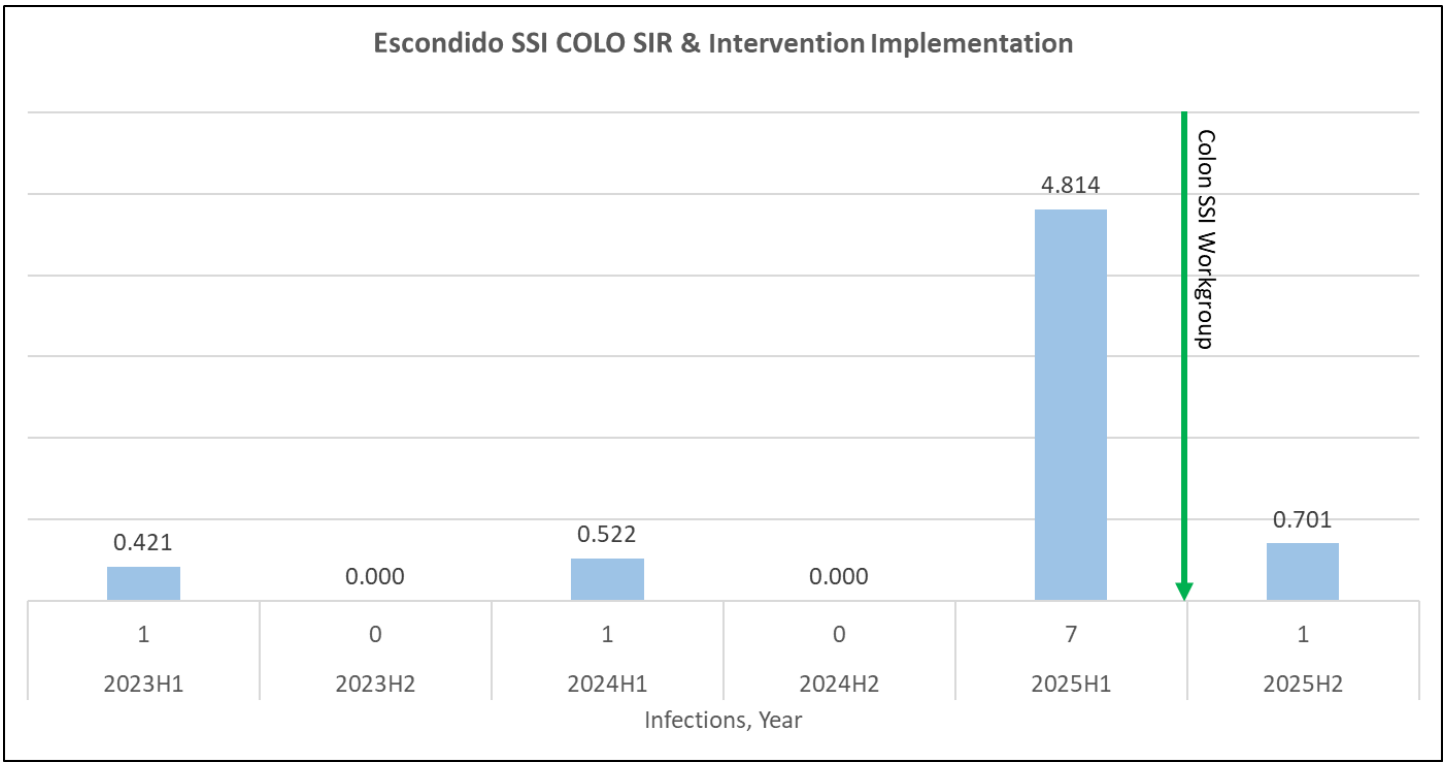
Colon (COLO) SSI SIR



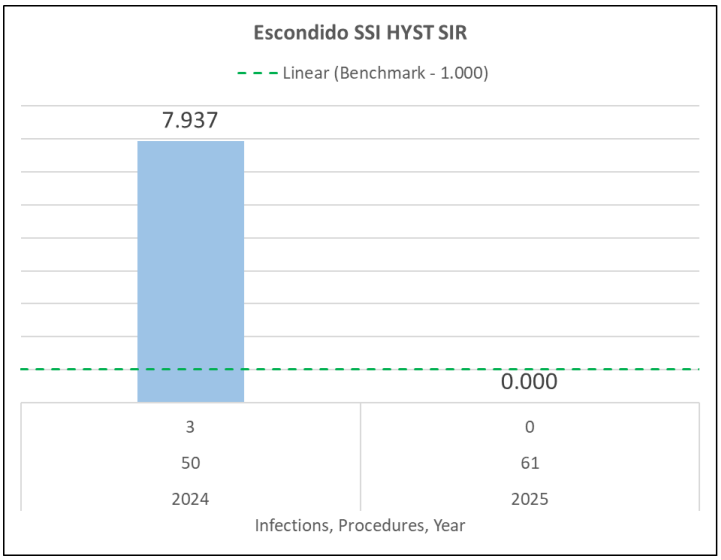


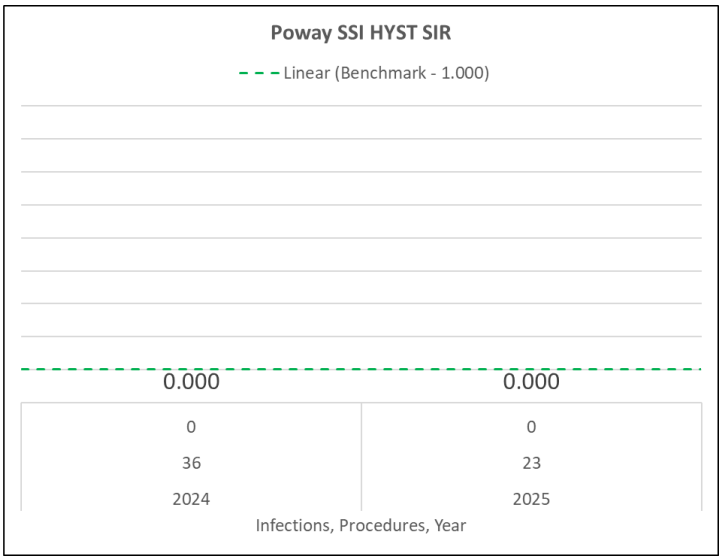
Escondido COLO SSI SIR (2.778) is above SIR Benchmark and increased significantly from previous year. Seven colon infections occurred in the 1st half of the year in June. Very acute preoperative diagnoses, 3-4 ASA patients. A workgroup met in July and August with surgeon champions, preop, surgery, PACU, clinical education, pharmacy, and IPs to review cases, benchmarks, the Colon bundle, literature, and select interventions to implement. We implemented internal PATOS documentation audits, ensuring surgeons document exclusion criteria when appropriate, and reconcile exclusion documentation using CDC NHSN protocols and guidance among cases and future cases. A documentation job aid was developed and provided to general surgeons. Re-implemented audit of the Colon Bundle (form approved through Hospital Forms)

Poway COLO SSI SIR (0.000) is below SIR Benchmark.



Abdominal Hysterectomy (HYST) SSI SIR

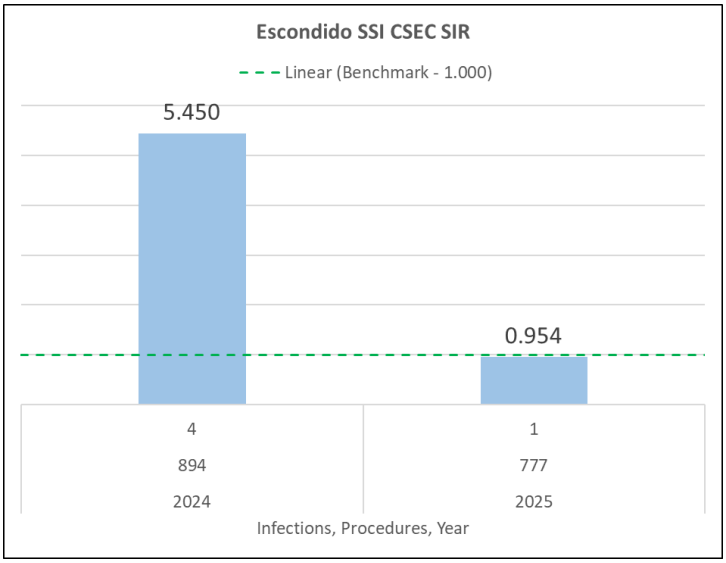




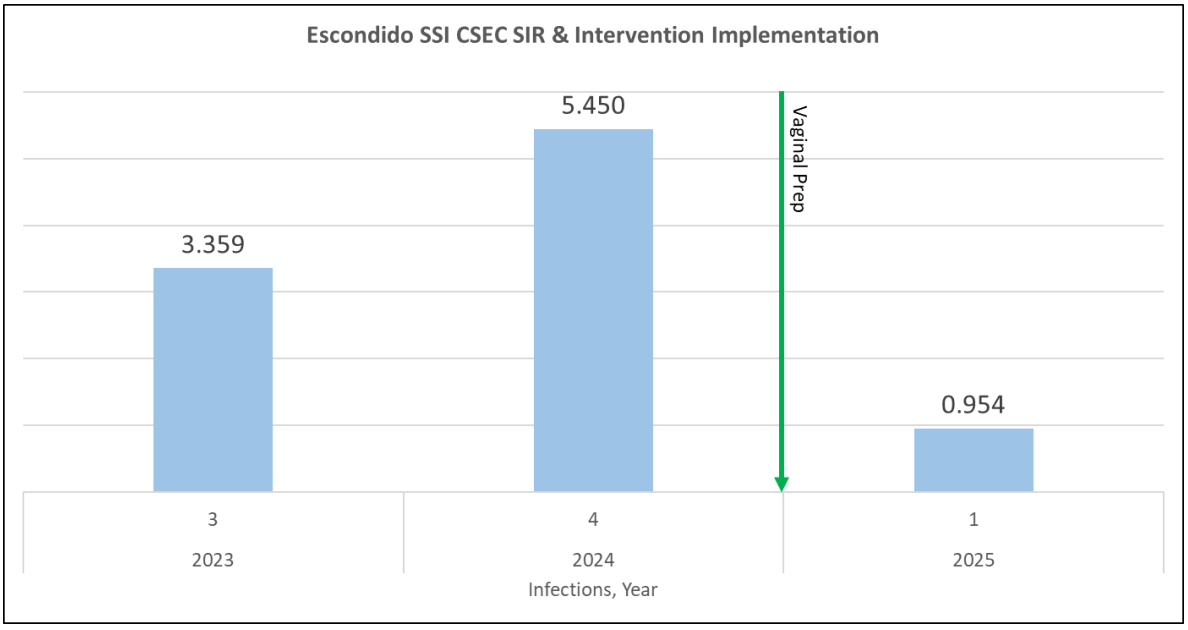
Escondido HYST SSI SIR is zero and below SIR Benchmark.

Poway HYST SSI SIR is zero and below SIR Benchmark.

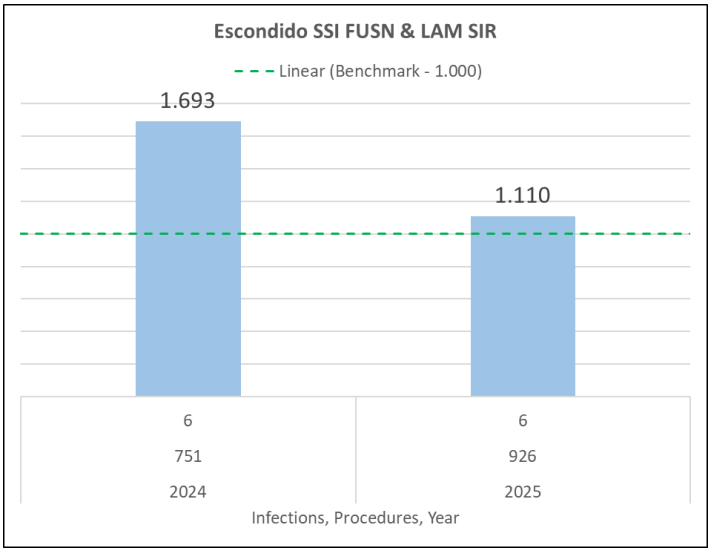
Cesarean Section (CSEC) SSI SIR



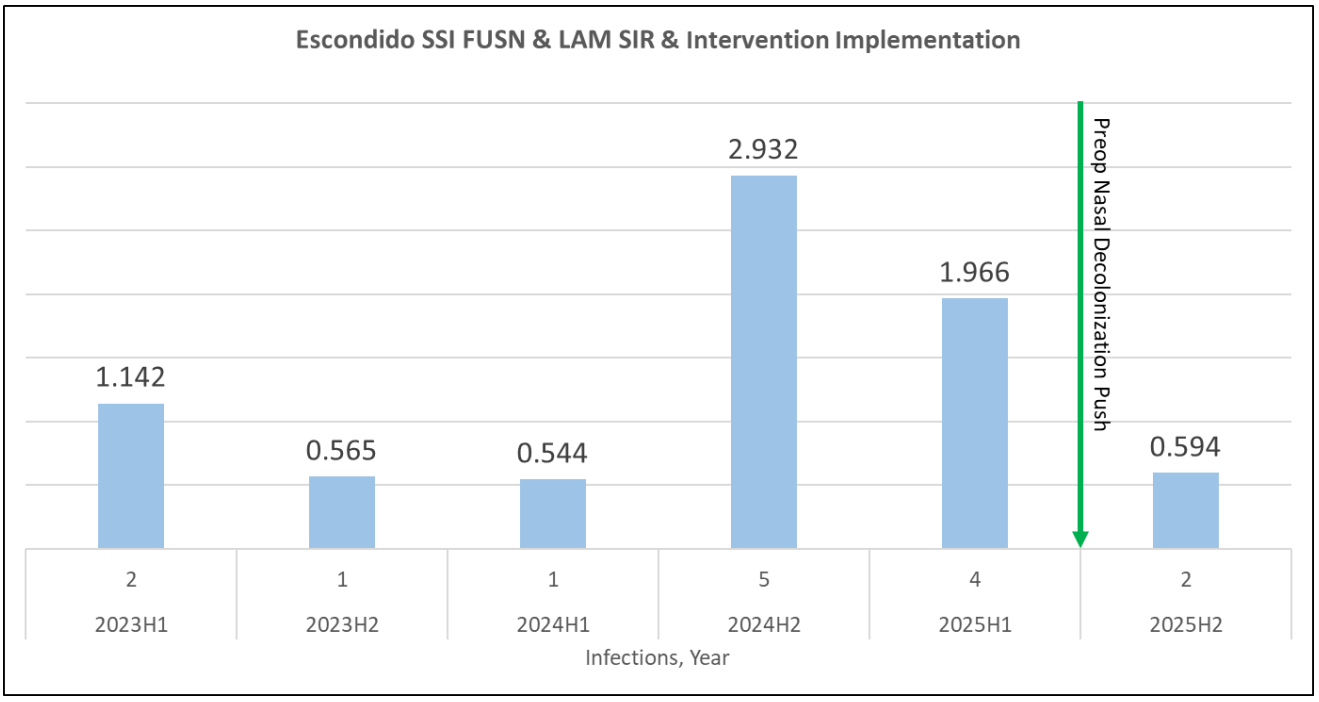
Escondido CSEC SSI SIR (0.954) is below SIR Benchmark and significantly decreased from the previous year. There are no trends identified in these four cases. Facility is performing worse than other general acute care hospitals in San Diego County.

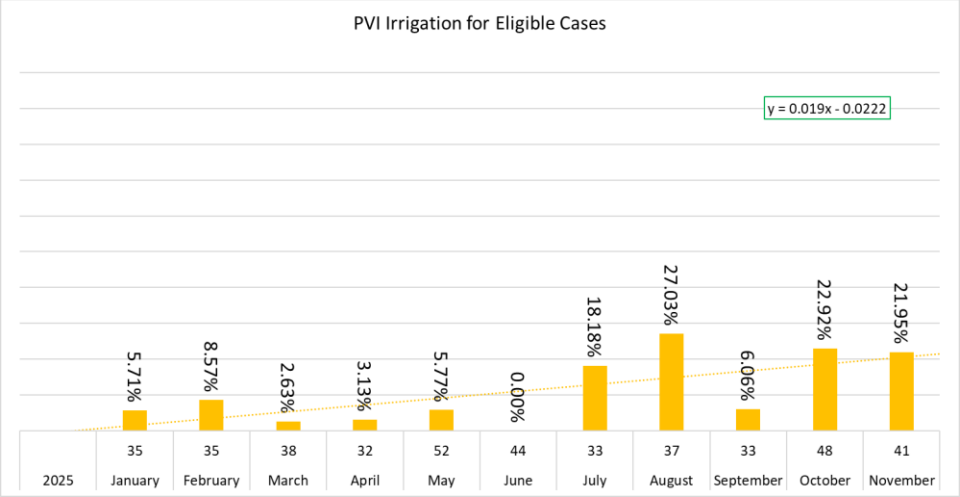


Spinal Fusion (FUSN) and Laminectomy (LAM) SSI SIR

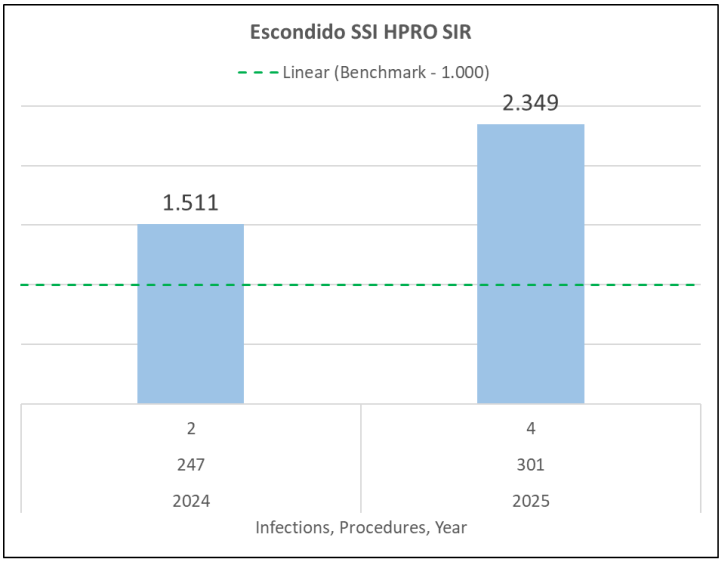


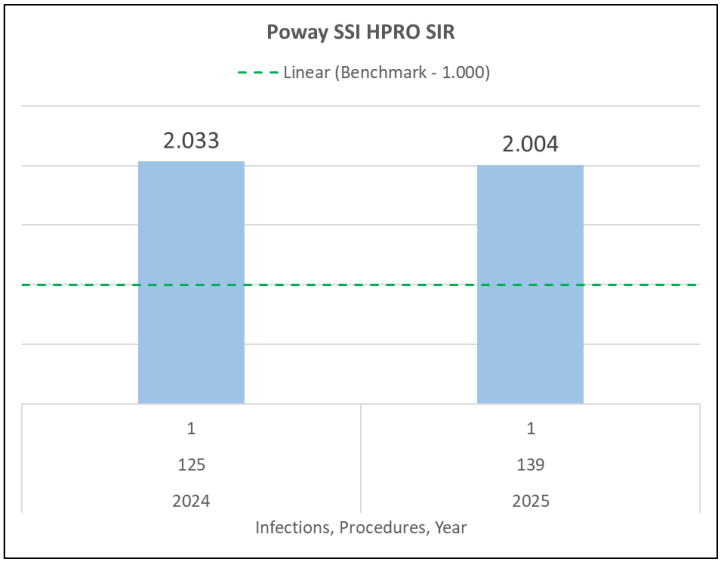
Escondido FUSN & LAM SSI SIR (1.110) is slightly above SIR Benchmark but decreased 34% from previous year. Escondido has had elevated post op infections among spinal procedures in 2024 and continue into 2025. A multidisciplinary workgroup including 2 neurosurgeon champions met, reviewed the cases, the rates in the community and among peers, literature to reduce infections, and came to support the 100% implementation of preoperative nasal PVI. Compliance with neurosurgeons ordering nasal betadine have improved from an average of 63% in the pre-intervention period to 92%. Continuing to elicit peer-to-peer engagement of neurosurgeons to pre-check nasal betadine in their preop order sets, and review practice compliance and new cases with neurosurgery, Preop, PACU, and Spine COE. The use of a povidone iodine intrawound irrigate (Surgiphor) was also recommended but has had a soft launch on adoption. Supply chain was still prepared for an anticipated increase in Surgiphor usage and the neurosurgeons were provided the recommendation via the Spine COE.





Hip Prosthesis (HPRO) SSI SIR

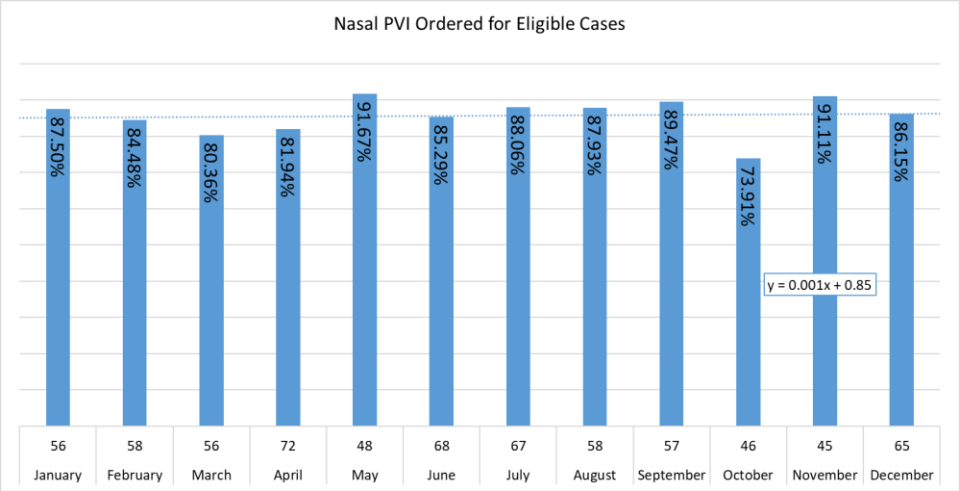


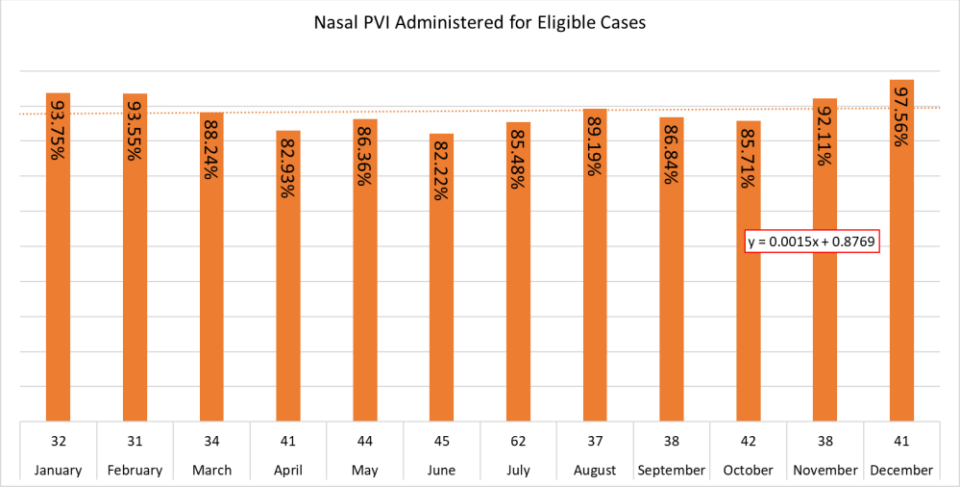


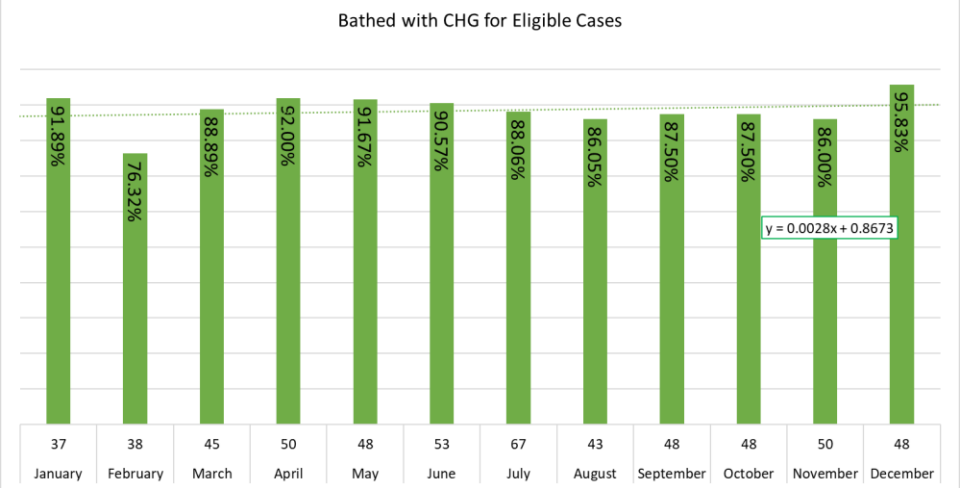
Escondido HPRO SSI SIR (2.349) is above SIR Benchmark and increased from previous year. There are no trends identified in these 4 cases; however, all preop measures continue to be monitored and each case is reviewed by a multidisciplinary group among the Center of Excellence.

Poway HPRO SSI SIR (2.004) is above SIR Benchmark but slightly decreased from previous year. This SIR only represents 1 HPRO SSI event. The predicted number of SSI for Poway is low relative to size, volume, and other risk-adjusted factors. There are no trends identified in this 1 case; however, all preop measures continue to be monitored and each case is reviewed by a multidisciplinary group among the Center of Excellence.

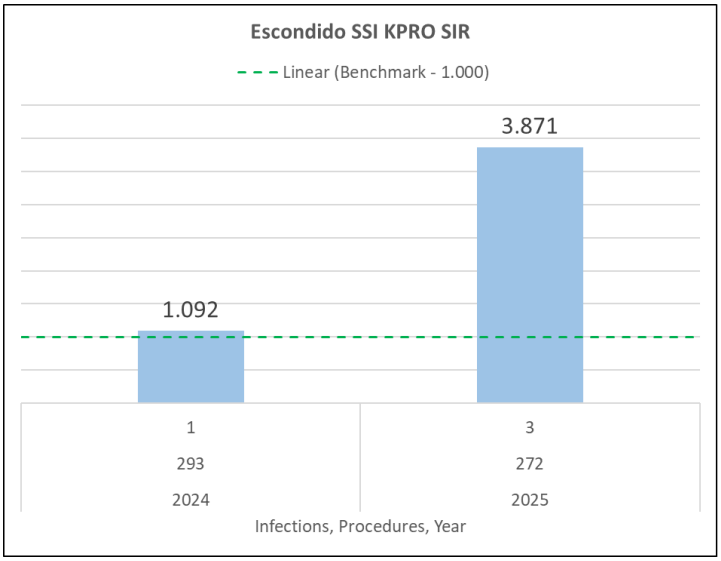
The only trend observed is temporal, where 4 of the 5 cases across the district occurred at the end of the year. Intervention implementation should begin early in 2026.

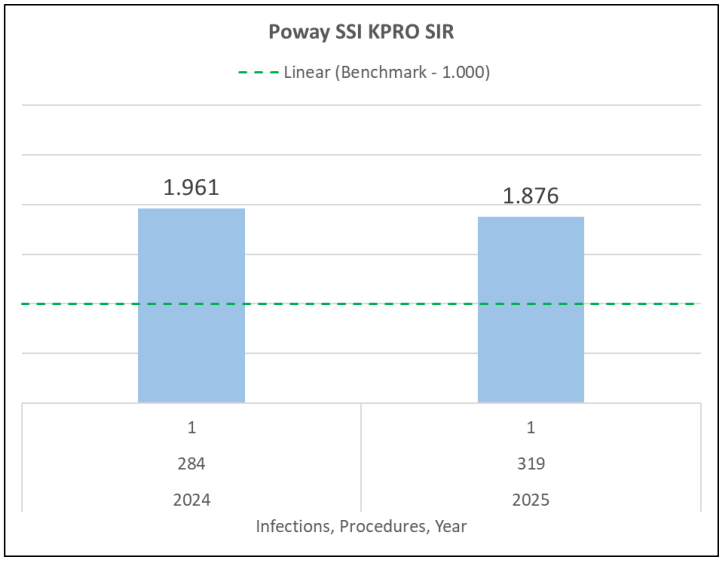

Nasal PVI Ordered for Eligible Cases
87.50%
84.48%
80.36%
81.94%
91.67%
85.29%
88.06%
87.93%
89.47%
73.91%
91.11%
86.15%
y = 0.001x + 0.85
56 January
58 February
56 March
72 April
48 May
68 June
67 July
58 August
57 September
46 October
45 November
65 December


Nasal PVI Administered for Eligible Cases
93.75%
93.55%
88.24%
82.93%
86.36%
82.22%
85.48%
89.19%
86.84%
85.71%
92.11%
97.56%
y = 0.0015x + 0.8769
32 January
31 February
34 March
41 April
44 May
45 June
62 July
37 August
38 September
42 October
38 November
41 December


Bathed with CHG for Eligible Cases
91.89%
76.32%
88.89%
92.00%
91.67%
90.57%
88.06%
86.05%
87.50%
87.50%
86.00%
95.83%
y = 0.0028x + 0.8673
37 January
38 February
45 March
50 April
48 May
53 June
67 July
43 August
48 September
48 October
50 November
48 December

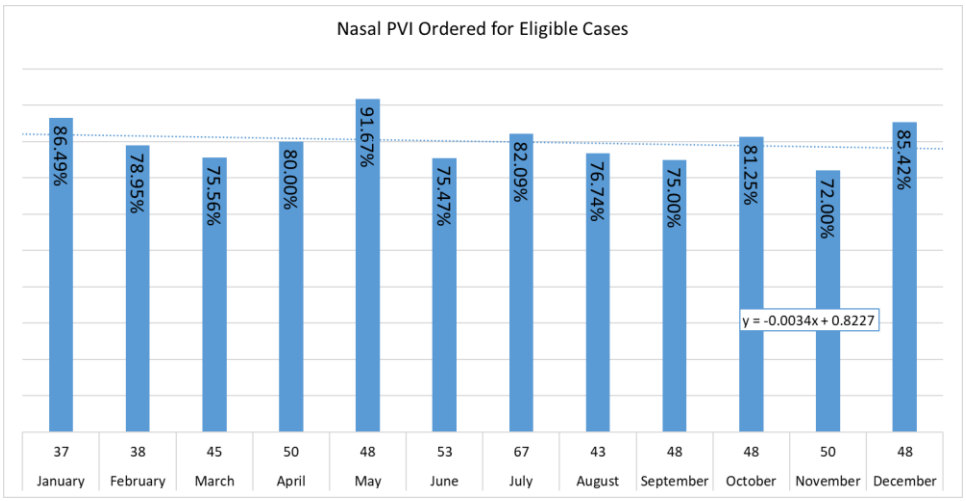
Knee Prosthesis (KPRO) SSI SIR

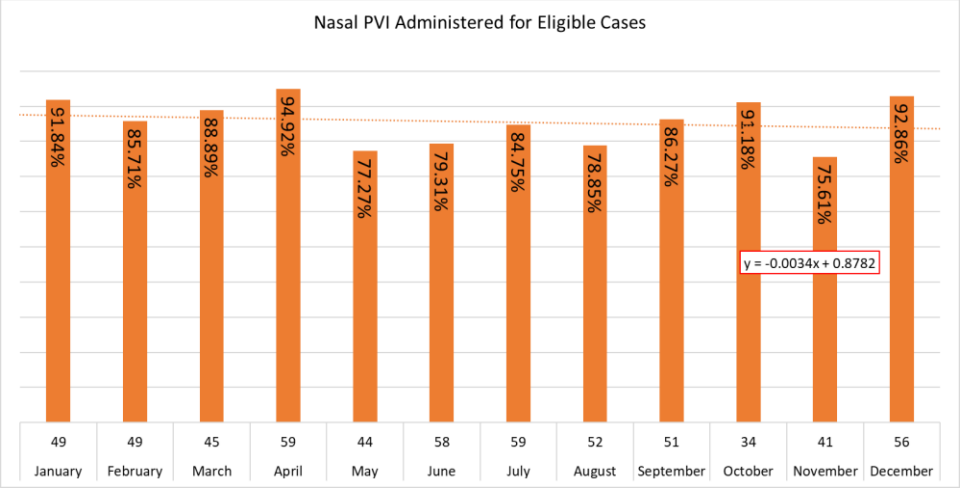


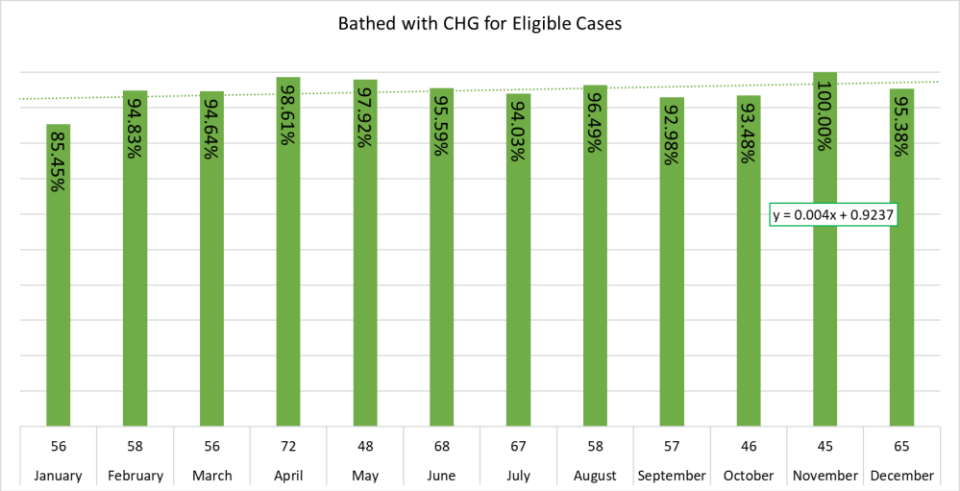


Escondido KPRO SSI SIR (3.871) is above SIR Benchmark and increased from previous year. There are no trends identified in these 3 cases; however, all preop measures continue to be monitored and each case is reviewed by a multidisciplinary group among the Center of Excellence.

Poway KPRO SSI SIR (1.876) is above SIR Benchmark but slightly decreased from previous year. This SIR only represents 1 KPRO SSI event. There are no trends identified in this 1 case; however, all preop measures continue to be monitored and each case is reviewed by a multidisciplinary group among the Center of Excellence.




Nasal PVI Administered for Eligible Cases
91.84%
85.71%
88.89%
94.92%
77.27%
79.31%
84.75%
78.85%
86.27%
91.18%
75.61%
92.86%
y = -0.0034x + 0.8782
49 January
49 February
45 March
59 April
44 May
58 June
59 July
52 August
51 September
34 October
41 November
56 December

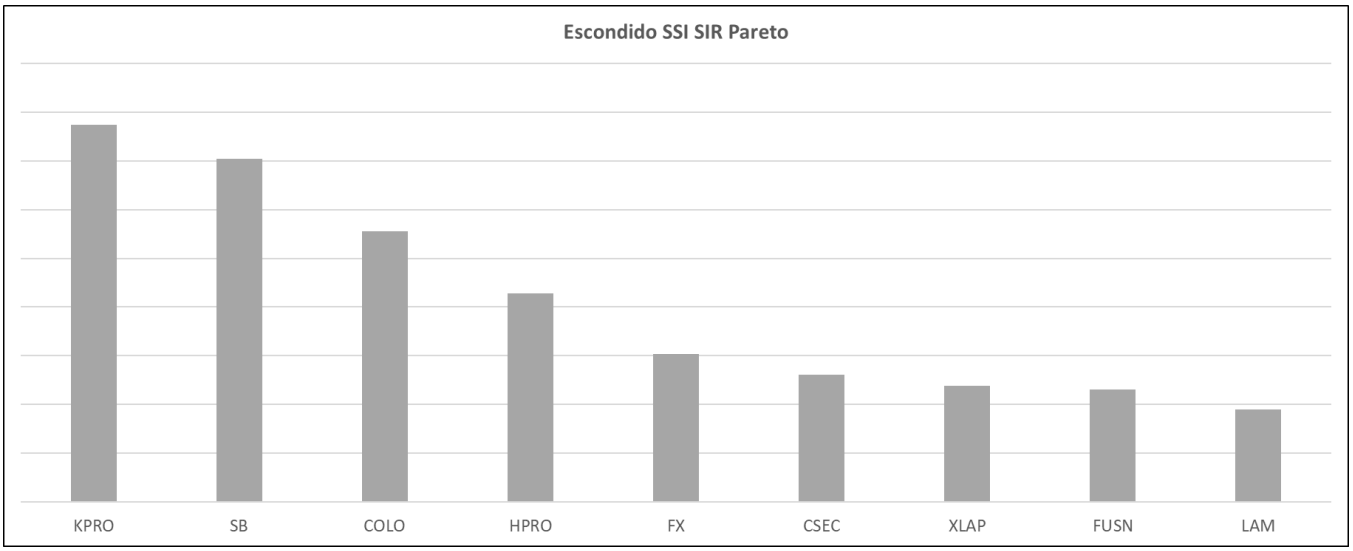

Bathed with CHG for Eligible Cases
85.45%
94.83%
94.64%
98.61%
97.92%
95.59%
94.03%
96.49%
92.98%
93.48%
100.00%
95.38%
y = 0.004x + 0.9237
56 January
58 February
56 March
72 April
48 May
68 June
67 July
58 August
57 September
46 October
45 November
65 December

Intervention Summary

1. Provision of AORN wound classification and PATOS education for surgical services staff and surgical committees. Engaged medical director champions to identify and implement peer-to-peer responses to misses. Wound classification documentation errors are monitored and reported to surgical services.
2. Identifying and implementing surgeon champion for improving provider documentation.
3. RCAs are performed for each SSI for process measure compliance and practice or infection trends.
4. Orthopedic and Spine clinical workgroups review infections, trends, and process measures monthly. Preoperative decolonization (nasal betadine and CHG bathing) are reviewed process measures. Preoperative CHG bathing among this population improved 2% from previous year. Preoperative nasal betadine improved 4% from previous year. This order was standardized to be pre-checked in orthopedic and spine order sets. Issues identified with order or administration of nasal betadine is reviewed and reported back to this workgroup and preop nursing for education.
5. Preoperative nasal betadine is a practice standard for cardiac procedures and improved 27% from previous year.
6. A colon bundle procedure is implemented as a guideline for colorectal surgeries.
7. Vaginal cleansing intervention continued for elective cesarean surgeries. Intervention was re-evaluated and clinical education to surgery staff was implemented. This performance measure will be closely monitored.
8. Antibiotic prophylaxis for surgery and procedures updated to latest standards. Vancomycin prophylaxis for patients with history of MRSA is a practice standard among orthopedic and spine procedures. Ensure non-elective caesarian sections receive azithromycin. Antibiotic choice, dosing and timing is monitored routinely among surgical site infections.
9. Daily between case and terminal cleaning of operating rooms by EVS. EVS leaders perform cleaning validation routinely.
10. Sterile processing of surgical instruments closely follow standards of The Association for the Advancement of Medical Instrumentation (AAMI). These standards are routinely monitored.
11. Environment of care rounds are routinely performed in SPD and surgery.
12. “PATOS Synoptic”

Goal Assessment & Action Plan

Escondido did not meet facility goal (overall SSI). Poway met facility goal (overall SSI). Maintain facility goal of reducing the overall SSI SIR by 10% from previous year and below SIR benchmark of 1.0. Prioritize the lower performing procedures or higher SIRs in 2026.



- Continue surgical case observations include Anesthesia observation. Develop checklist to standardize audit.

- Improve practice compliance with colon bundle elements like preoperative nasal betadine, CHG bathing, and antibiotic prophylaxis.
- There may be an opportunity to improve preoperative nasal betadine for cardiac procedures. Although compliance improved from previous year, the rate is only 60% (N=82). Explore standardizing order sets.
- Collaborate with the Department of Anesthesia Committee glucose control below 200 for all patients undergoing surgical procedures.
- Quality improvement project for OR room access and exiting.
- Continue wound classification data sharing and education as needed.
- Include race-ethnicity and location (zip code) to surveillance to analyze possible sources of health inequity.
- Develop and implement a PATOS synoptic template for operative report documentation. This will streamline SSI surveillance and identifying exclusion criteria.

Employee Health

Influenza Vaccination Rates

Organization influenza vaccination documentation rate >75% by end of 2025-2026 influenza season. The overall Hospital Quality Star Rating by CMS summarizes a variety of measures across 5 areas of quality into a single star rating and includes the percentage of healthcare workers given influenza vaccination. To effectively move the needle of the Quality Star Rating, each facility vaccination goal should meet or exceed XX percent at the end of the measurement period (respiratory season).

Palomar Health District	Employees	Providers	Volunteers / Students/ Pathmaker
1. Number of HCP who worked at this healthcare facility for at least 1 day between October 1 and March 31	3561	891	P=342 S=446 V=444
2. Number of HCP who received a Flu vax at this healthcare facility since Flu vax became available this season	1753	147	P=96 S=368 V=238
3. Number of HCP who provided documentation of Flu vax outside this healthcare facility	316	470	P=130 V=119
4. Number of HCP who have a medical contraindication to Flu vax	14	12	P=1 V=0
5. Number of HCP who declined to receive Flu vax	493	91	P=27 S=78 V=48
6. Number of HCP with unknown vax status	985	171	P=88, S=0 V=158
Percent vaccinated	58.10%	69.25%	P=66.08% S=82.51% V=53.60%
Total percent vaccinated or declined	72.34%	80.81%	P=74.27% S=100% V=64.41%

	Palomar Health	PMC-E (26)	Poway (30)
Facility Code		**26**	**30**
Completed	1753	1170	298
Elsewhere	316	196	61
Refused	493	315	93
Medical	14	10	2
Unknown	985	634	186
Total	**3561**	**2325**	**640**
Percent vax	**58.10%**	**58.75%**	**56.09%**
% vax or declined	**72.34%**	**72.73%**	**70.93%**

The organization's influenza vaccination documentation (vaccinated or declined) rate is 65%. There were 1402 employees with an unknown influenza vaccine status at the time of this report. TJC standard establishing IC Standard for influenza vaccination for staff. California SB 739: annually offer on-site influenza vaccination to all staff. If employee declines vaccination, document "why" to provide insights for improvement efforts.

Organization did not meet goal. Improve vaccine documentation by 10% compared to previous season. Additionally, improve percent vaccination of the organization to 90%.

- Increased roving vaccination sites
- Increased night vaccination sites
- Continue to engage clinical leaders to assist with vaccinations (Villas, night supervisors)

- Employee Health Walk-in vaccinations encouraged
- Dedicated RN to administer Flu vaccinations Monday through Thursday
- Improve denominator by reducing the number of healthcare personnel with an unknown vaccination status.

Needle stick Injuries

Total needle stick injuries Palomar Health is 34

- Escondido Campus 30
- Poway Campus 4

Develop actionable data for needle sticks. Perform standard post exposure investigations and implement corrective actions. Continue notification by Employee Health and Safety when needle substitutes occur for employee education. Employee interview, what happened, why, how to prevent injury going forward. Assignment of education module Needle stick Prevention.

ATD Exposures

YEAR TO DATE TOTALS	TB	Meningitis	Scabies	Pertussis	Measles	Varicella	Lice	Brucella	Mpox	Mumpa	Covid-19	TOTAL
Total number of exposures:	9			1		3				1	876	890
Number of exposures pending completion:	0			0		0				0	0	0
Number of exposures completed:	53			3		41				4	41	142
Number of employees tested:	1			0		0				0	0	1
Number of employee conversions:	0			0		0				0	0	0
Conversion rate: # conversions/total tested	0%	0%	0%	0%	0%	0%				0%	0%	0%
Number of employees non-compliant with follow up:	0			0		0	0			1	0	0

Comments

Non Exposures

- TB: No conversions, one employee non-compliant with f/u
- Pertussis: All employees potentially exposed seen in EH, antibiotic script given. One exposed MD- will self-evaluate and prescribe antibiotic
- Mumps: One employee identified as susceptible, non-compliant with f/u
- Varicella: All employees potentially exposed had immunity either by titer or documented vaccination x2
- COVID-19: No WC claims

COVID-19 exposures among ED staff remain high. COVID-19 exposures are primarily related to documentation of masking the patient with influenza like illness while under emergency care. In January 2025, Emergency Department leadership was tasked with reducing these exposures. See TB Exposure Plan and Risk Assessment for additional information.

Environment of Care (EOC)

Multidisciplinary EOC Rounding

Maintain facility ≥ 90% compliance.

Using the Infection Control EOC rounds survey in ServiceNow, compliance with standard and transmission-based precautions, facilities related infection risks, cleanliness, waste disposal, appropriate storage and processing of patient care equipment and devices was measured, and proper decontamination, handling, transport, and storage of reprocessed devices can be measured. There are 63 questions in a survey. Trends of noncompliance in 2024 differed between site locations. Deficiencies are immediately reported to the appropriate leader if not resolved on site.

Escondido compliance rate is 89.33%, with the most deficient survey questions below:

1. Walls in need of repair
2. Environment with heavy dust
3. Environment and equipment are not free of tape.
4. Single use items are not disposed of after use.
5. Patient care furniture in need of repair

Poway compliance rate is 86.99%, with the most deficient survey questions below:

1. Environment with heavy dust
2. Walls in need of repair
3. Environment and equipment are not free of tape.
4. Sink fixtures are free from mineral buildup and visibly clean
5. Supplies are not within recommended expiration date.

Escondido did not meet facility goal. Poway did not meet facility goal. Maintain facility goal of ≥ 90% compliance.

- EVS focus on dust in the environment.
- Multidisciplinary EOC team rounding monthly in scheduled areas.
- Report findings to Department Directors according to urgency of finding.
- Submit tickets through ServiceNow for service/repair requests.
- Infection Control to report trends and data to EOC and Infection Control committee.
- Leadership to develop action plan to address repeated or high-risk findings.

Environmental Cleaning Measures

EVS management validates environmental cleaning using a florescent marker validation tool and reports out at the Infection Prevention and Control Committee. This measure is implemented in accordance California Public Health Department Senate Bill requirement. The goal is 95%. The results are used in real time education and training.

Patient rooms, care areas, and public spaces are cleaned routinely and are scheduled according to time or frequency of use. The EVS Cleaning procedure outlines this cleaning in detail.

Environmental Testing

Environmental testing is performed in compliance with Infection Control Risk Assessment. Results outside normal parameters are reported directly to the Infection Prevention and Control Committee with a plan of correction. The Water Management Plan outlines testing of water sources on inpatient and outpatient locations. Environmental testing is performed by third-party consultant for identification and control of environmental risks and hazards as indicated. The organization follows recommendations of third-party consultant for remediation and follow up testing. If results exceed

benchmark, services may be interrupted while investigations and action plans are created and implemented. Dialysis machines are tested monthly testing for bacterial growth, and there has been no growth reported in 2025.

See Escondido and Poway Water Management Plans.

Construction

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

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

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

Environmental Cleaning

EVS management through either direct observations or Florescent Marker Validation routinely monitors environmental cleaning. Cleaning of special rooms or area is audited routinely following the EVS Cleaning Procedure. These rooms include but not limited to, Isolation Rooms, Operating Rooms, Pharmacy IV Compounding, food preparation areas, and the NICU.

Disinfection & Sterilization

Review of Cleaning and Disinfection Agents

The Infection Prevention and Control Committee reviews and approves all major disinfectants used within the system, and that they are used safely and according to their manufacturer's instructions, and compatible with materials and equipment used. Committee to continue to review with users to optimize disinfectants based on updated or new equipment MIFUs. IPC and EHS to review manufacturer's IFU and SDS of all disinfection chemistries prior to purchase approval, i.e. follow VIP product review process.

Cleaner/Disinfectant	User
GERMICIDE LAB CONTROL III GAL	Laboratory Services
SPONGE CLING ENDOZIME	Speech, Endo, Cardiology, SPD
BLEACH 8.25% CLOROX PRO 121OZ	Laboratory Services, Facilities
WIPE DISINFECT ALCOHOL PURPLE	All Patient Care and Ancillary Users
WIPE DISINFECT BLEACH LT.BLUE	All Patient Care and Ancillary Users
CLEANER DISINFECT DISPATCH	Interventional Radiology
SOL DISINFECT OPA 1 GL	SPD
STERILANT STERIS 1E 40 CONCTRT	Respiratory Therapy
DISINFECTANT OER-PRO ACECIDE-C	Endo
DETERGENT ENDOQUICK OER-PRO	Endo
WIPE PHARMA DRY STRL 9X9"	Pharmacy
WIPE PHARMA WET STR 9X9"	Pharmacy
DISINFECTANT CLEANER OXYCIDE	EVS
ALCOHOL 70% ISOPRP 16OZ SPRAY	Pharmacy
DISINFECTANT SONEX-HL TROPHON	Perinatology, Ultrasound, SPD
DISINFECTANT PERIDOX RTU 1 GL	Pharmacy, EVS
KIT COMPLIANCE ENDO KIT	Endo
DISINFECTANT PERIDOX RTU 32 OZ	Pharmacy, EVS
WIPE GERMICIDAL AF3 GRY	Ultrasound Technology Users
CLEANER DISINFECT 10%BLEACH 32	SART/Child Abuse Program
WIPE OXIVIR 1	Cardiology
DETERGENT ENZYMATIC PURE	Endo
WIPE DISINFECTANT PLUS	Wound Care (HBC)
DISINFECTANT VIREX 2.5L	EVS
DETERGENT ENZYMATIC E62	SPD
DETERGENT PRESPRAY BLU62	Wound Care, Surgery, IR, SPD
WIPE CLEANING TROPHON	Perinatology, Ultrasound, SPD
DETERGENT ENZOL 1 GL ENZYMATIC	SPD

Review of Patient Care Equipment and Reusable Medical Equipment

The Infection Prevention and Control Committee reviews all new patient care equipment and reusable medical equipment (RME) as a standing agenda item. The organization has three Value Improvement Process committees to vet the safety of new or changed patient care equipment and assess the current capacity of cleaning according to the manufacturer's instructions for use (IFU).

Equipment cleaning and disinfection is outlined in a procedure for reducing the risk of transmission of infectious diseases using medical equipment and by way of the environment. A Device Equipment Location and Accountability grid is reviewed annually and as needed as a comprehensive list of reusable medical equipment, its Spaulding classification, location/owner, the person(s) responsible for cleaning, how often it should be cleaned, and the approved cleaner/disinfectant.

Daily Schedule Time-out (DST): Surgery, supply chain, and SPD daily review of OR schedule to assess procedure staffing, vendor instrument, and vendor RME needs.

Dialysis machines must be cleaned routinely following manufacturer's instructions. Dialysis machine equipment cleaning is audited routinely for appropriate disinfection between patient uses.

Infection Prevention Team and Supply Chain review FDA alerts, such as recalls and outbreaks due to product or medical device routinely.

Sterilization Rounds

In the context of a Sterile Processing Department (SPD), sterilization is the process of completely destroying or eliminating all forms of microbial life, including bacteria, viruses, and spores, from medical devices and instruments to ensure patient safety and prevent infections. The sterile processing department is robust with engineered redundancies to mitigate infection risk through inappropriately sterilized medical equipment and instruments. SPD is routinely audited using an AAMI rounding tool. Results and deficient findings are reported directly with SPD management.

Immediate-Use Steam Sterilization Rate

Immediate-Use Steam Sterilization (IUSS) is a sterilization process in healthcare used for instruments needed immediately, often called "flash sterilization." It involves short sterilization cycles for unwrapped items transferred quickly to the sterile field. It should be reserved for urgent clinical situations only and strictly adheres to manufacturer instructions

The IUSS rate is a, key performance indicator in healthcare tracking the percentage of surgical instruments sterilized quickly for immediate use rather than via standard, wrapped, and stored methods. It measures how often "flash" sterilization is used, which should only be for urgent, unanticipated needs

IUSS Rate remains < 1% at both facilities.

High-level Disinfection Rounds

High-level disinfection (HLD) is a process that eliminates most microorganisms from medical devices and instruments. It is required semi-critical items that come into contact with non-intact skin or mucous membranes, heat-sensitive items that cannot be sterilized, critical ultrasound probes that cannot be sterilized, gastrointestinal endoscopes. All HLD processes and process owners are audited routinely and include but not limited to speech therapy, cardiology, perinatology, endoscopy, respiratory services, and ultrasound. Results and deficient findings are reported directly with department management.

The HLD Process can be grouped in five crucial steps. Departments that participate in HLD processes are routinely monitored for quality assurance, competency, process changes, new equipment, and/or supply shortages.

Patient Use	Point of Use Treatment	Manual Cleaning	High Level Disinfection	Drying & Storage

Departments that perform HLD across Palomar Health:

- Sterile Processing Department
- Endoscopy

- Respiratory Services
- Ultrasound
- Outpatient Perinatology

Complete HLD Process Table

					Patient Use	Point of Use Treatment		Manual Cleaning						High Level Disinfection							Drying & Storage			
Device Users	**Device Manufacturer & Type**	**Model**	**Reprocessing Users** (Competency and training maintained annually)	**Site Device Used**	**Covers, Sheaths, Transmission Gel**	**Current Point of Use Pretreatment** (performed by device user)	**Transport** (performed by device user)	**Decontamination Location**	**Current Enzymatic Cleaner**	**Enzymatic Expiration Date**	**Enzymatic Dilution Ratio to Water**	**Water Solution Temp. Range**	**Enzymatic Soak Time**	**High-Level Disinfection/ Sterilization Process**	**AR Detergent**	**AR Detergent Expiration Date**	**Disinfectant, Chemistry**	**Disinfectant Expiration Date**	**Disinfectant Test Strips**	**Disinfectant Test Strips Expiration Date**	**Drying**	**Storage** (performed by device user)	**Storage Location**	**Storage Time & Tracking System**
Outpatient Perinatology	GE Endocavity Probe	Voluson	Outpatient Perinatology	MOB1	Probe Cover, EcoVue Transmission Gel	trophon® Companion Wipes	Leak-proof, puncture-resistant, biohazard container, moist towel, absorbent pad	N/A	trophon® Companion Wipes	N/A	N/A	N/A	4 minute contact time	Trophon 2	None	N/A	Sonex-HL (cartridge), H2O2	Manufacturer's expiration date	Trophon Chemical Indicator	Manufacturer's expiration date	Trophon Companion Drying Wipes	Ventilated cabinet, cleaned routinely	MOB1 2nd floor Perinatology Clean Utility	14 Days, whiteboard
Outpatient Women's Center	Siemens Endocavity Probe, GE Endocavity Probe	Sequioa 9EC4, Voluson	Outpatient Women's Center	POP	Probe Cover, EcoVue Transmission Gel	trophon® Companion Wipes	Leak-proof, puncture-resistant, biohazard container, moist towel, absorbent pad	N/A	trophon® Companion Wipes	N/A	N/A	N/A	4 minute contact time	Trophon 2	None	N/A	Sonex-HL (cartridge), H2O2	Manufacturer's expiration date	Trophon Chemical Indicator	Manufacturer's expiration date	Trophon Companion Drying Wipes	Ventilated cabinet, cleaned routinely	POP 1st fl Perinatology Clean Utility	14 Days, whiteboard
Birth Center	Mindray Endocavity Probe	TE7 V113WS	SPD	PMCE	Probe Cover, EcoVue Transmission Gel	Endozime sponge	Leak-proof, puncture-resistant, biohazard container, moist towel, absorbent pad	N/A	trophon® Companion Wipes	N/A	N/A	N/A	4 minute contact time	Trophon 2	None	N/A	Sonex-HL (cartridge), H2O2	Manufacturer's expiration date	Trophon Chemical Indicator	Manufacturer's expiration date	Trophon Companion Drying Wipes	Ventilated cabinet, cleaned routinely	PMCE 8W Birth Center Clean Utility	14 Days; logbook and device labels/tags
Respiratory	Olympus Bronchoscopes, Olympus Bronchovideoscopes	BF TYPE, EVIS-EXERA, EBUS, ION	Respiratory	PMCE	N/A	Endozime sponge	CIVCO probe transport tray	PMCE 2nd floor Endoscopy	Pure	Manufacturer's expiration date	1/2 oz : 1 gallon	90-140°F	1 to 5 minutes	Steris 1E	None	N/A	S40® Sterilant Concentrate, H2O2	Manufacturer's expiration date	Verify® Chemical Indicator	6 months after opening	Lint-free cloth, 10-12 minute air purge of channels	HEPA-ventilated cabinet, cleaned routinely	PMCE 1st fl Respiratory Clean Workroom	14 Days, tags
Ultrasound	Philips Endocavity Probe	iU22	Ultrasound	PMCP	Probe Cover, EcoVue Transmission Gel	trophon® Companion Wipes	N/A	N/A	trophon® Companion Wipes	N/A	N/A	N/A	4 minute contact time	Trophon 2	None	N/A	Sonex-HL (cartridge), H2O2	Manufacturer's expiration date	Trophon Chemical Indicator	Manufacturer's expiration date	Trophon Companion Drying Wipes	Ventilated cabinet, cleaned routinely	PMCP 1st fl ED Room	14 Days, whiteboard
Ultrasound	Siemens Endocavity Probe	Sequioa 9EC4, iOEV3	Ultrasound	PMCE, PMCP	Probe Cover, EcoVue Transmission Gel	trophon® Companion Wipes	N/A	N/A	trophon® Companion Wipes	N/A	N/A	N/A	4 minute contact time	Trophon 2	None	N/A	Sonex-HL (cartridge), H2O2	Manufacturer's expiration date	Trophon Chemical Indicator	Manufacturer's expiration date	Trophon Companion Drying Wipes	Ventilated cabinet, cleaned routinely	PMCE 1st floor Ultrasound Clean Utility, PMCE 1st floor ED Pod D Room, PMCP 1st floor ED Room	14 Days, whiteboard
Cardiology	Philips TEE Probes	S8-2T, S7-3T, S7-2T, 3D-OMNI	SPD	PMCE, PMCP	EcoVue Transmission Gel	Endozime sponge	CIVCO probe transport tray, moist towel	PMCE LL SPD, PMCP 3rd floor SPD	Stryker E62 Enzymatic Detergent	Manufacturer's expiration date	1/2 oz : 1 gallon	52-140°F	2 to 6 minutes	Astra-TEE	None	N/A	Metricide OPA Plus, OPA	75 days after opening; [Reuse] up to 14 days after opening	Metricide OPA Plus Test Strips	90 days after opening	Lint-free cloth	Ventilated cabinet, cleaned routinely	PMCE 1st fl Cardiology Clean Workroom, PMCP 2nd fl Cardiology	14 Days, whiteboard
Speech Therapy	Pentax Video Nasopharyngo-Laryngoscope	Escondido: 24NA97A, 24NA90A, 25NB46A H140767, H142460, H142470 Poway: 23NA15A	SPD	PMCE, PMCP	N/A	Endozime sponge	CIVCO probe transport tray, moist towel	PMCE LL SPD; PMCP 3rd floor SPD	Stryker E62 Enzymatic Detergent	Manufacturer's expiration date	1/2 oz : 1 gallon	52-140°F	2 to 6 minutes	Manual OPA	None	N/A	Metricide OPA Plus, OPA	75 days after opening; [Reuse] up to 14 days after opening	Metricide OPA Plus Test Strips	90 days after opening	Lint-free cloth	Ventilated cabinet, cleaned routinely	PMCE 9th fl Rehab Clean Workroom Villas 1st fl Rehab Clean Workroom	14 Days, whiteboard
Endoscopy	Olympus Duodenoscope, Olympus Colonovideoscope, Olympus Gastrointestinal Videoscope	TJF TYPE, GIF TYPE, PCF TYPE CF TYPE	Endoscopy	PMCE, PMCP	N/A	Endozime sponge, Endokit	Disposable Leak-proof, pucture-resistant, biohazard container (SAFESTART), tranport cart	PMCP 2nd floor Endoscopy; PMCE 2nd floor Endoscopy	Pure	Manufacturer's expiration date	1/2 oz : 1 gallon	90-140°F	2 to 3 minutes	Olympus AR	EndoQuick	Replace revery 30 to 33 cycles (after 30 days)	Acecide-C, H2O2, paracetic acid	[Reuse] up to 5 days after opening (every M, Th)	Acecide-C Comply Test Strips	30 days after opening	Lint-free cloth, 10-12 minute air purge of channels	HEPA-ventilated cabinet, cleaned routinely	PMCE 2nd fl Endo Workroom PMCP 2nd fl Endo Workroom	14 Days, whiteboard
Respiratory	Olympus Bronchoscopes, Olympus Bronchovideoscopes	BF TYPE, EVIS-EXERA, EBUS, ION	Respiratory	PMCE, PMCP	N/A	Endozime sponge	CIVCO probe transport tray	PMCP 2nd floor Endoscopy; PMCE 2nd floor Endoscopy	Pure	Manufacturer's expiration date	1/2 oz : 1 gallon	90-140°F	1 to 5 minutes	Olympus AR	EndoQuick	Replace revery 30 to 33 cycles (after 30 days)	Acecide-C, H2O2, paracetic acid	[Reuse] up to 5 days after opening (every M, Th)	Acecide-C Comply Test Strips	30 days after opening	Lint-free cloth, 10-12 minute air purge of channels	HEPA-ventilated cabinet, cleaned routinely	PMCE 1st fl Respiratory Clean Workroom PMCP 2nd fl Respiratory Clean Workroom	14 Days, tags

AR = automatic reprocessor

Infection Prevention Education

The Infection Preventionist (IP) is expected to lead a multifaceted educational program that transitions seamlessly from formal, monthly New Staff Orientation and annual skills validation to high-impact, "just-in-time" clinical coaching. This role encompasses the oversight of foundational safety protocols—such as hand hygiene return demonstrations for all providers and staff, PPE usage for COVID-19, and automated isolation systems—while simultaneously managing highly technical training regarding Trophon 2 implementation, significant manufacturer instruction changes, and the aseptic transport of reusable medical equipment.

By conducting collaborative risk-reduction rounds for CAUTI and CLABSI, reviewing *C. difficile* algorithms and specimen collection at the bedside, and participating in unit huddles, the IP ensures that evidence-based practices like chlorhexidine bathing and proper wound classification are integrated into daily workflows. Furthermore, the IP extends the IPC umbrella through annual EVS training, departmental oversight of food and nutrition safety, and direct education for visitors, ultimately serving as a visible, expert resource who validates competency through physical demonstrations and real-time feedback.

To streamline these extensive requirements and ensure consistent tracking across campuses, the program is leveraging iXpand to centralize mandatory education and compliance documentation, like bloodborne pathogen and ATD exposures mitigation and triage protocols to identify, isolate, and inform of any high-consequence infectious diseases (HCID). Content is created collaboratively with associated departments and organizational learning.

Just-in-time education is a common style of education provided by the IP, and topics can vary across the entire breadth of infection prevention and occur any time. Topics from 2025 include but not limited to,

- Botulism
- Candida auris
- C. difficile, collecting specimen
- Interfacility transfer form
- Central line disinfection caps
- Diphtheria
- Emerging special pathogen
- CAHAN Health Advisories
- Environmental room cleaning
- Hemorrhagic viral fevers
- Surgical site infections
- Measles
- MRSA
- Pertussis
- Universal precautions for lab
- Sharp injury prevention
- Rubella
- Tuberculosis and exposure follow up
- Completing the infection control risk assessment
- Physician education on wound class and infection present at the time of surgery

Reportable Communicable Diseases

The organization has a critical role in complying with Title 17 of the California Code of Regulations, particularly concerning Confidential Morbidity Reporting (CMR) requirements from the California Department of Public Health (CDPH).

Here is a summary of the organization's responsibilities:

- Reporting of Reportable Diseases: Hospitals, through their healthcare providers, are obligated to report specific diseases and conditions listed in Title 17 to the local health officer. This includes a wide range of communicable diseases, and the urgency of reporting varies depending on the disease.
- Adherence to Reporting Timeframes: Title 17 specifies different reporting timeframes. Some diseases require immediate telephone reporting, while others must be reported within one working day or seven calendar days. Hospitals must establish procedures to ensure these deadlines are met.
- Accurate and Complete Reporting: Reports must include accurate and complete patient information, such as demographics, diagnosis, and relevant clinical findings. The Confidential Morbidity Report (CMR) form is a key tool for this process.
- Establishing Internal Procedures: Hospital administrators are responsible for creating and implementing internal procedures to ensure that all healthcare providers within the facility comply with reporting requirements. This may involve training, clear communication channels, and designated reporting personnel.
- Confidentiality: Hospitals must maintain the confidentiality of patient information reported under CMR requirements.
- Staying Updated: Hospitals must stay up to date on changes to title 17, and changes to what diseases are reportable, and how they are to be reported.

When emerging infectious diseases are occurring in the community or community at large, infection control and hospital ensure staff and the facilities are prepared for the detection and management of these cases. Infection Control attends a virtual monthly meeting with County Epidemiology on current public health issues, and receives weekly and monthly reports on influenza and communicable diseases in San Diego County, respectively. Infection Prevention continues to report COVID-19 hospitalization data to and healthcare personnel vaccination (HCP) data to NHSN. Infection Prevention routinely works with San Diego County Epidemiology, responding to requests, initiating reports, and outbreak investigations.

Antimicrobial Stewardship/Infectious Diseases Projects

- 2024-2027 California Department of Public Health Healthcare-Associated Infections Antimicrobial Stewardship Program Honor Roll – Gold Status
- Responses to CDC Health Alerts
    - Extension of Long-Acting Benzathine Penicillin G (Bicillin L-A) Shortage
    - Accelerated Subtyping of Influenza A in Hospitalized Patients
    - Influenza Update: Vaccinate, Test, and Administer Influenza Antivirals
    - Evaluation of Adverse Events Following Receipt of Injectable Ceftriaxone
    - Mycoplasma pneumoniae Infections Among Children and Adolescents in California
- Antimicrobial Committee
    - Meets at least once a quarter (on average every 2 months)
- Quarterly Review of All Surgical Site Infection and *Clostridioides difficile* Infection (CDI) Cases
- Quarterly Review of Facility-Wide Antimicrobial Usage and Resistance Data
- Quarterly Review of Protected/Restricted Antimicrobial Usage
- Quarterly Review of Pharmacist Initiated Antimicrobial Stewardship Interventions
- Annual Review of Influenza Vaccine Efficacy and Cost Analysis
- Joint Commission Response to Pre-Op Antibiotic Administrations
- Information Technology (IT) projects
    - Update Gonorrhea Antibiotics PowerPlan – Ceftriaxone Order Sentences
    - Develop Default IV Set for Ganciclovir IV Order
    - Removal of Anti-Pseudomonal Beta Lactam Pop-Up Alert
    - Update Clindamycin Order Sentences in Power Chart
    - Updating Dose Range Alerts for Minocycline
    - Update Power Chart Order Sentences for Minocycline
    - Changing Default Diluents on Antimicrobials During National Fluid Shortage
    - Removal of Restricted Antimicrobial Alert for Linezolid
    - Removal of Vancomycin 1750mg IV dose
    - Add MRSA PCR to Rxorders Vancomycin PowerPlan
    - Remove Anti-Pseudomonal Beta Lactam Popup Alert
    - Update antibiotics on Cardiac Catheterization Pre-Procedure PowerPlan
    - Update 4 PowerPlans Cellulitis, Febrile Neutropenia, Pan Culture, and Pneumonia
    - Carbapenem and Valproate Interaction Alert
    - Update Nursing Pneumococcal Vaccination
    - Update Antepartum Admit PowerPlan – Change IV Erythromycin to IV/PO Azithromycin
    - Update Ambisome PowerPlan Lab Orders
    - Create Suspected HIV Diagnosis PowerPlan and Opportunistic Infection Prophylaxis and Treatment PowerPlan
- Microbiology Collaboration
    - CP-CRO Organism Carbapenem Susceptibility Reporting
    - Review Avycaz and Zerbaxa Resistant MDRO *Providencia stuartii* Isolate
    - *Staphylococcus aureus* Daptomycin Nonsusceptibility Reporting
    - Update Cascading Rules for Carbapenem Susceptibilities
    - Publish 2025 Antibiogram and Antibiogram Letter
    - Annual Review of Resistance Rates of Multi-Drug-Resistant Organisms
    - *Clostridioides difficile* PCR Testing Update
    - Discuss Workflow for Updating Blood Culture Updates on Discharged Patients
    - Reporting of Indeterminate Results for *Clostridioides difficile* Screen
    - Update Susceptible Dose Dependent Reporting for *Enterococcus faecium*

    - Update Antimicrobial Breakpoints
        - Daptomycin: Non-faecium *Enterococcus*
        - Ampicillin/sulbactam and minocycline: *Acinetobacter* spp.
        - Removal of Breakpoints: *Burkholderia cepacia* complex
        - Oxacillin: Coagulase Negative *Staphylococcus* spp.
- Medication Usage Evaluations (MUE)
    - 2025 *C. difficile* Treatment Adherence MUE
    - Analysis of Cost Savings from Therapeutic Interchange of Vancomycin to Linezolid or Daptomycin by Pharmacy
- ASP Updates to Medical, Nursing, and Pharmacy Staff
    - Orthopedics Symposium – When Metal Meets Microbes: Infection Challenges in Prosthetic Joints
    - Removal of OpenBiome Fecal Microbiota Transplant Procedure
    - Review New Joint Commission Standard for Antimicrobial Stewardship Programs
    - Education to Medical Staff on Best Practices in Antimicrobial Therapy
    - Update Antimicrobial Stewardship Program Prescriber Onboarding Module
    - Update Antimicrobial Stewardship Program Nursing Onboarding Module
    - Oral Vancomycin Prophylaxis Criteria Expansion
- Policy and Procedure Updates
    - Aminoglycoside Dosing Service
    - Antimicrobial Stewardship Program
    - Restricted Antimicrobial Procedure
    - Standard Adult Antibiotic Doses
    - Antimicrobial Sub-Committee
    - Bioterrorism Employee Prophylaxis Antibiotic Cache Deployment
    - CK Monitoring During Daptomycin Therapy
    - Drug Dosing by Indication – Weight – Renal Function
    - Influenza, Pneumococcal and COVID-19 Vaccine, Screening, and Administration
    - Preoperative and Pre-Procedure Antibiotic Dosing and Timing
    - Vancomycin Dosing Guidelines
- Manage Shortages and offer alternatives
    - Bicillin L-A
    - IV Amphotericin B Liposomal (AmBisome)
    - IV Azithromycin
    - IV Caspofungin
    - IV Erythromycin
    - IV Isavuconazole
    - IV Levofloxacin
    - PO Isavuconazole
    - PO Primaquine
- Formulary Review
    - Aztreonam-avibactam (Emblaveo)
    - Micafungin (Mycamine)
- Antimicrobial Stewardship Resident Projects
    - Evaluation of Vancomycin to Linezolid Substitution for Pneumonia and SSTI
    - Evaluating the Impact of an Antibiotic Time-Out Alert on Antimicrobial Use

Antimicrobial Stewardship Summary

Presented to Board Quality Review Committee
May 27, 2026

Sandeep Soni, MD, Chair

Travis Lau, PharmD, BCIDP, Co-Chair

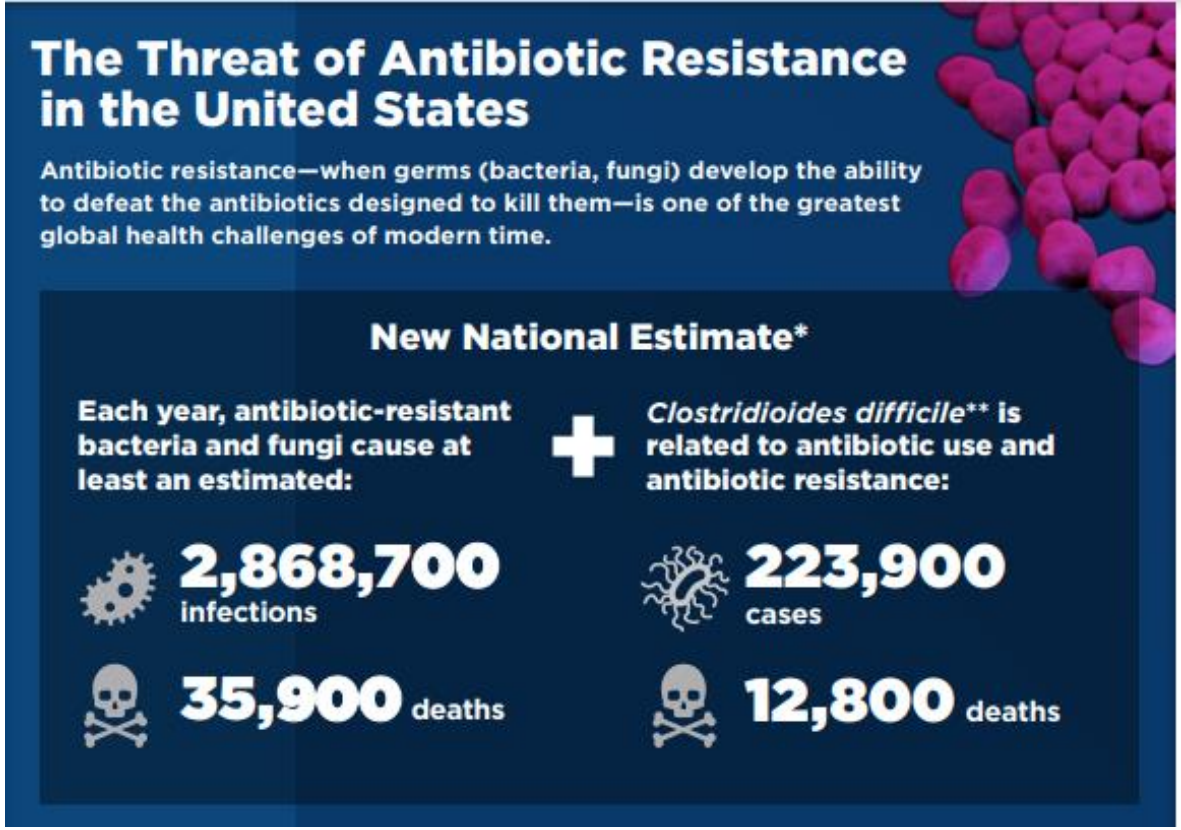
Rachel Lee, PharmD, ID Pharmacist

Antimicrobial Stewardship Program (ASP) – Biannual Report

SITUATION	ASP is essential to ensure antimicrobials are judiciously prescribed so patients receive the most effective antibiotic for the shortest time to improve morbidity and mortality. ASP is required by the joint commission and CDPH.
BACKGROUND	Antimicrobial resistance is designated as a major threat by the CDC. Loss of effective antimicrobials will drastically impact medical care and cost. CDC recognizes that one of the biggest threats in the hospital is overuse of carbapenems leading to carbapenem resistant organisms. Another big threat is development of hospital acquired CDI. ASP has been documented to be an effective strategy in minimizing the development of resistance ensuring best care for patients with infectious diseases. All hospitals are required to have an infectious diseases physician and pharmacist to lead ASP. ASP is required to report to the highest level of the organization.
ASSESSMENT	Antimicrobial use, resistance rates, and key quality improvement processes are submitted for review. In summary, antimicrobial usage remains stable based off the standardized antibiotic administration ratio (SAAR). Comparative hospital CDI rates and summary pharmacy antimicrobial interventions are presented.
RECOMMENDATION	The ASP team is monitoring and reviewing appropriate usage of anti-MRSA antibiotics and overall antimicrobial durations. ASP team is continuing to implement OVP and optimize antimicrobial usage to help maintain the CDI goal. ASP interventions remain high and appropriate relative to the previous year. These interventions are estimated to result in significant hospital cost savings. The ASP team will continue to focus on these goals for 2027.

ASP – Antimicrobial Stewardship Program; CDI – *Clostridioides difficile* infection; CDPH - California Department of Public Health; OVP – Oral Vancomycin Prophylaxis
QIP – Quality Incentive Pool; CDC – Centers of Disease Control and Prevention

The Threat of Antibiotic Resistance



What is driving the rise in multidrug-resistant superbugs?

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

1 in 3

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

52%

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

PALOMAR HEALTH
Reimagining Healthcare

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

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

Antimicrobial Stewardship at Palomar

- Mandated by CDPH and TJC in all hospitals since 2018. Meeting new standards established in 2023 are now a condition of Medicare participation.
- Effectively and efficiently treating infectious diseases along with control of cost of antimicrobial are a major part of overall provision of care.
- ASP is involved in improvement in key infectious diseases indicators (clostridium difficile rates and surgical site infections) to retrieve full Medi-Cal funds via the QIP program. Meeting these indicators are worth over $1,600,000.

ASP – Antimicrobial Stewardship Program; CDPH - California Department of Public Health; TJC – The Joint Commission; QIP – Quality Incentive Pool

Palomar Health's ID Team

Physicians

- Sandeep Soni, MD
- Roger Bitar, MD, MPH
- Sarah Ettinger, MD
- Taliha Yasin, MD
- Jeannette Aldous, MD
- Hayden Burke, MD

Pharmacy

- Travis Lau, PharmD, BCIDP, ID Pharmacist
- Rachel Lee, PharmD, ID Pharmacist

CDPH ASP Gold Honor Roll Status

- Palomar Health received Gold Status on CDPH's ASP Honor Roll
- Combined designation for both Escondido and Poway
- Designation from 2024-2027

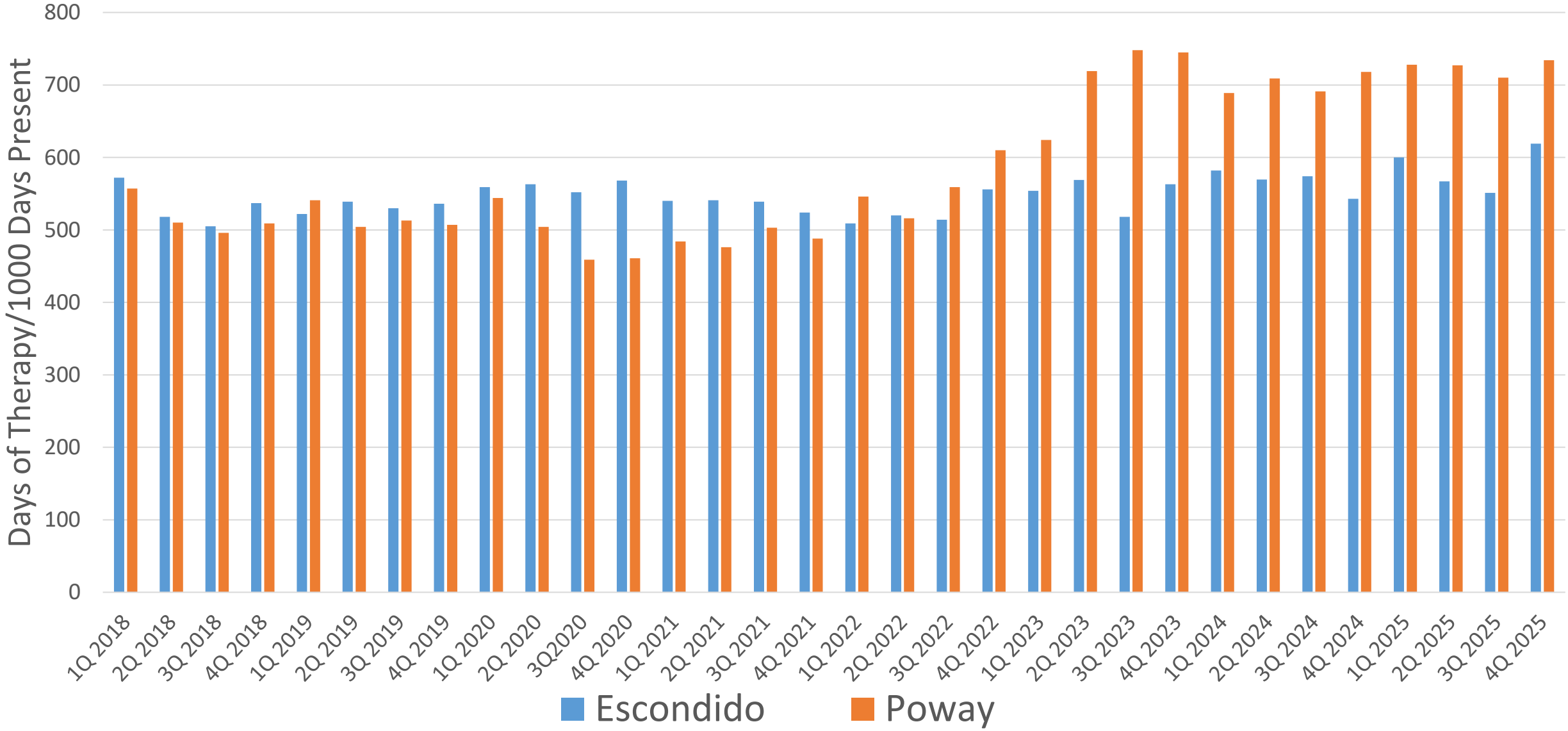
ASP Accomplishments and Goals

2025 (Completed)	2026 (To Be Completed)
CDPH ASP Honor Roll Gold at Poway and Escondido Campus through 2027 (2024)	*Staphylococcus aureus* Bacteremia Treatment Bundle
Submitted Monthly NHSN Antibiotic Usage and Resistance Module (2026)	Submit NHSN Antibiotics Resistance Module data and review and determine best practice
Optimized implementation of oral vancomycin prophylaxis (1/2026)	Assess Effectiveness and Cost Analysis of Oral Vancomycin Prophylaxis Criteria Expansion
Reviewed and Responded to CDC Health Alerts on Infectious Diseases (1/2026)	Continue Management of Antimicrobial Shortages
Updated Inpatient Pneumococcal Vaccine Screener in Cerner (3/2026)	Achieve QIP Goals for CDI and SSI for 2026
Analyzed Cost Savings from Optimizing Daptomycin and Linezolid over Vancomycin (2025)	Partnering with CDPH in improving prescribing in treatment of UTIs in nursing homes with emphasis at Villas at Poway (ongoing)
Created Order Sets to Aid Diagnosis of HIV and Treatment of Opportunistic Infections such as Tuberculosis	Assess Opportunities for Urine Testing Diagnostic and Antimicrobial Stewardship in the Emergency Department
Presented at Annual Palomar Health Orthopedics Symposium on Infection Challenges in Prosthetic Joints	Provide Cost Savings Analysis for ASP interventions and Projects (ongoing)
Updated ASP Program Prescriber and Nursing Onboarding Module to Maintain TJC Compliance	Review of Appropriate Carbapenem Usage and other Restricted Antimicrobials (ongoing)

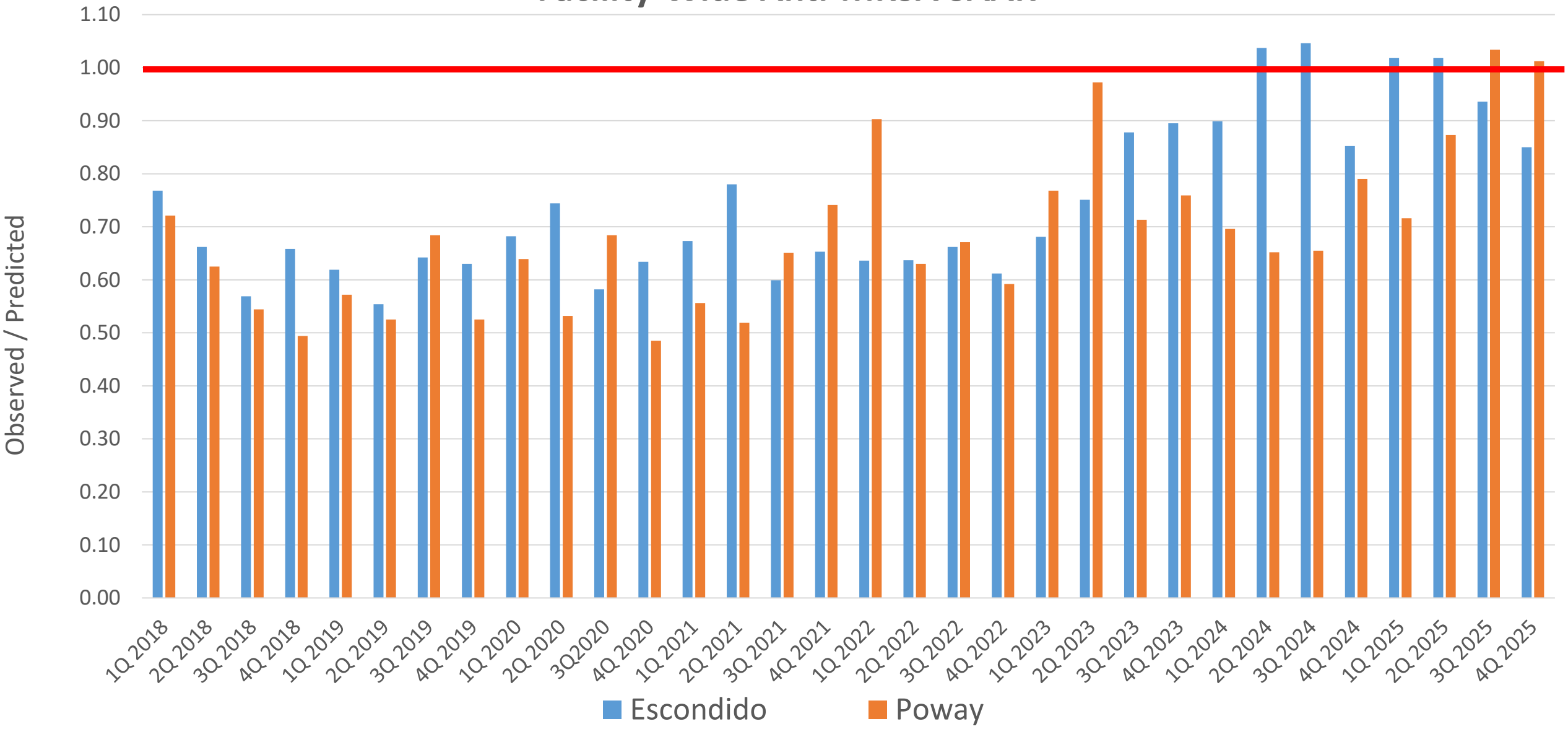
CDC - Centers for Disease Control and Prevention; CDI - *Clostridioides Difficile* Infection; CDPH - California Department of Public Health; PO – Oral; ID – Infectious Diseases; UTI – Urinary Tract Infection; NHSN - National Healthcare Safety Network; MRSA – Methicillin Resistant *Staphylococcus aureus*; SSI – Surgical Site Infection; SSTI – Skin Soft Tissue Infection; ASP – Antimicrobial Stewardship Program

Agent Specific Antimicrobial Analysis

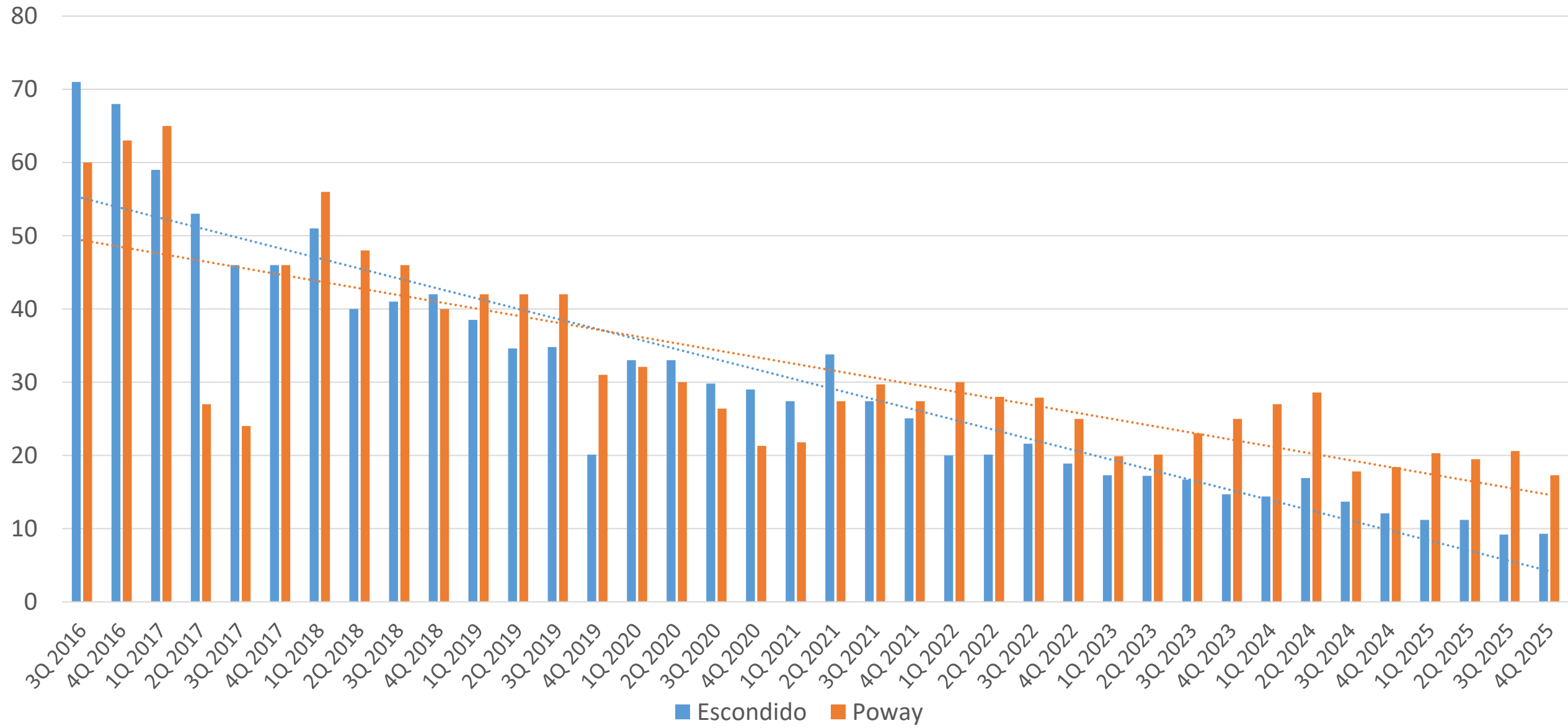
Facility-Wide Antibiotic Use



Facility-Wide Anti-MRSA SAAR



Facility-Wide Fluoroquinolone Use

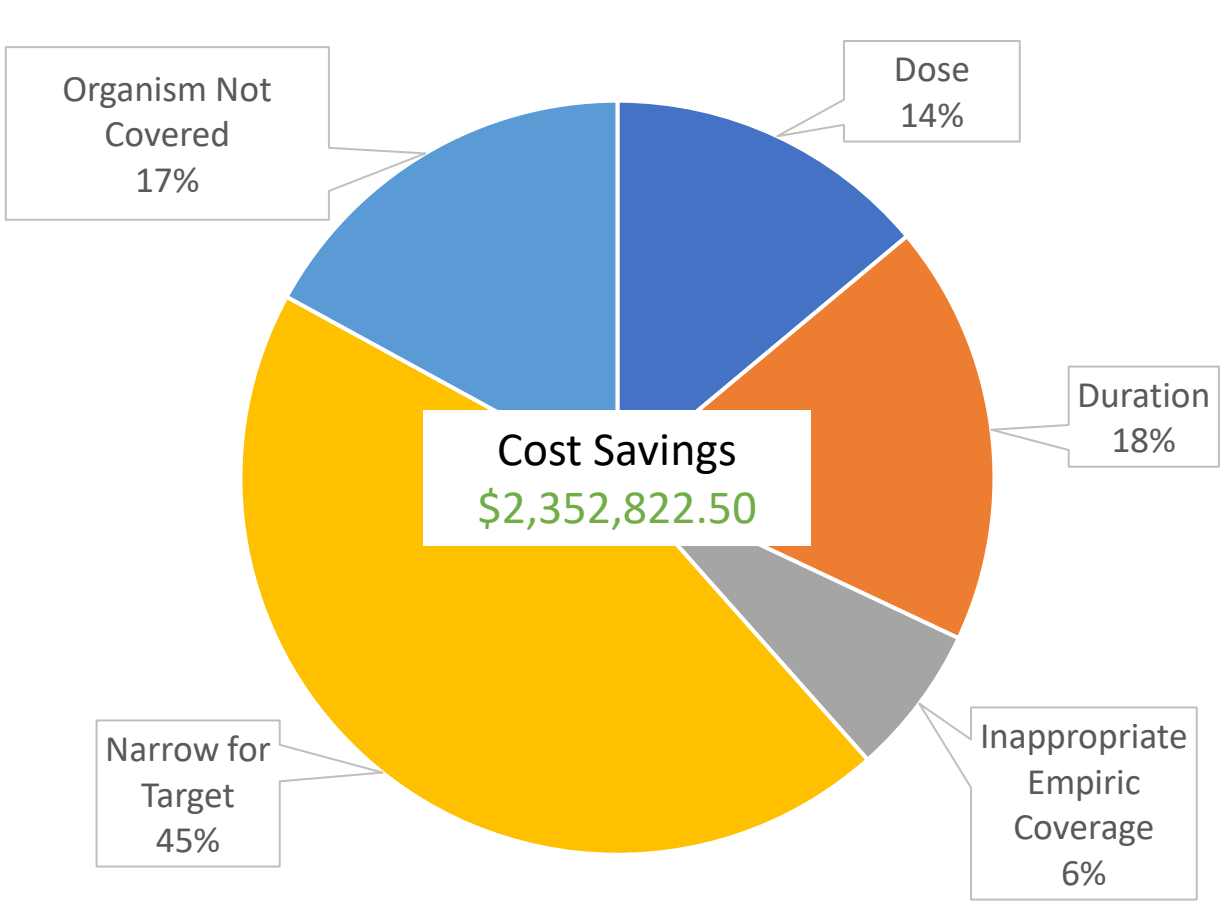


2025
ASP Interventions Data and Cost Savings Analysis

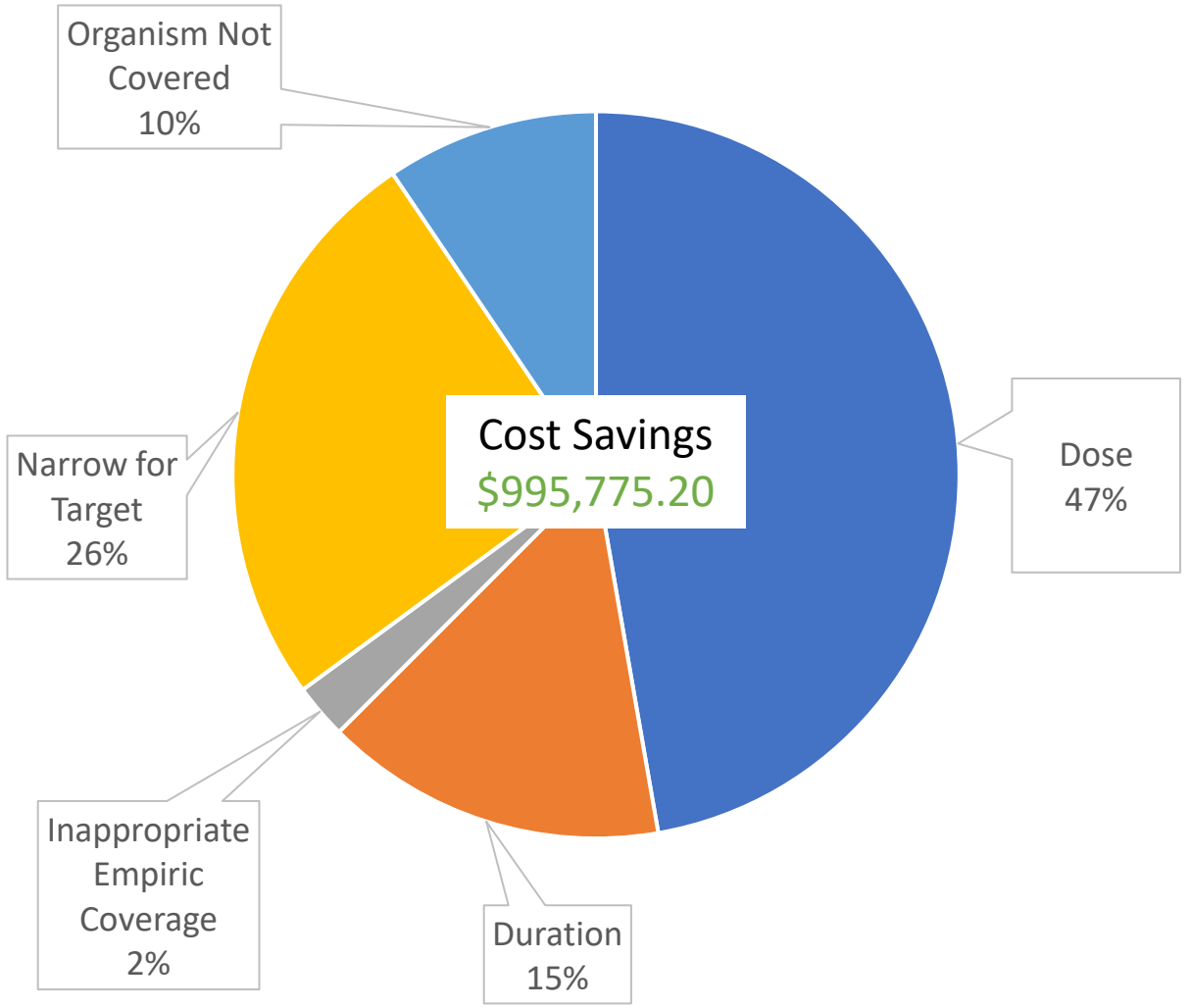
Travis Lau, PharmD, BCIDP, ID Pharmacist

Rachel Lee, PharmD, ID Pharmacist

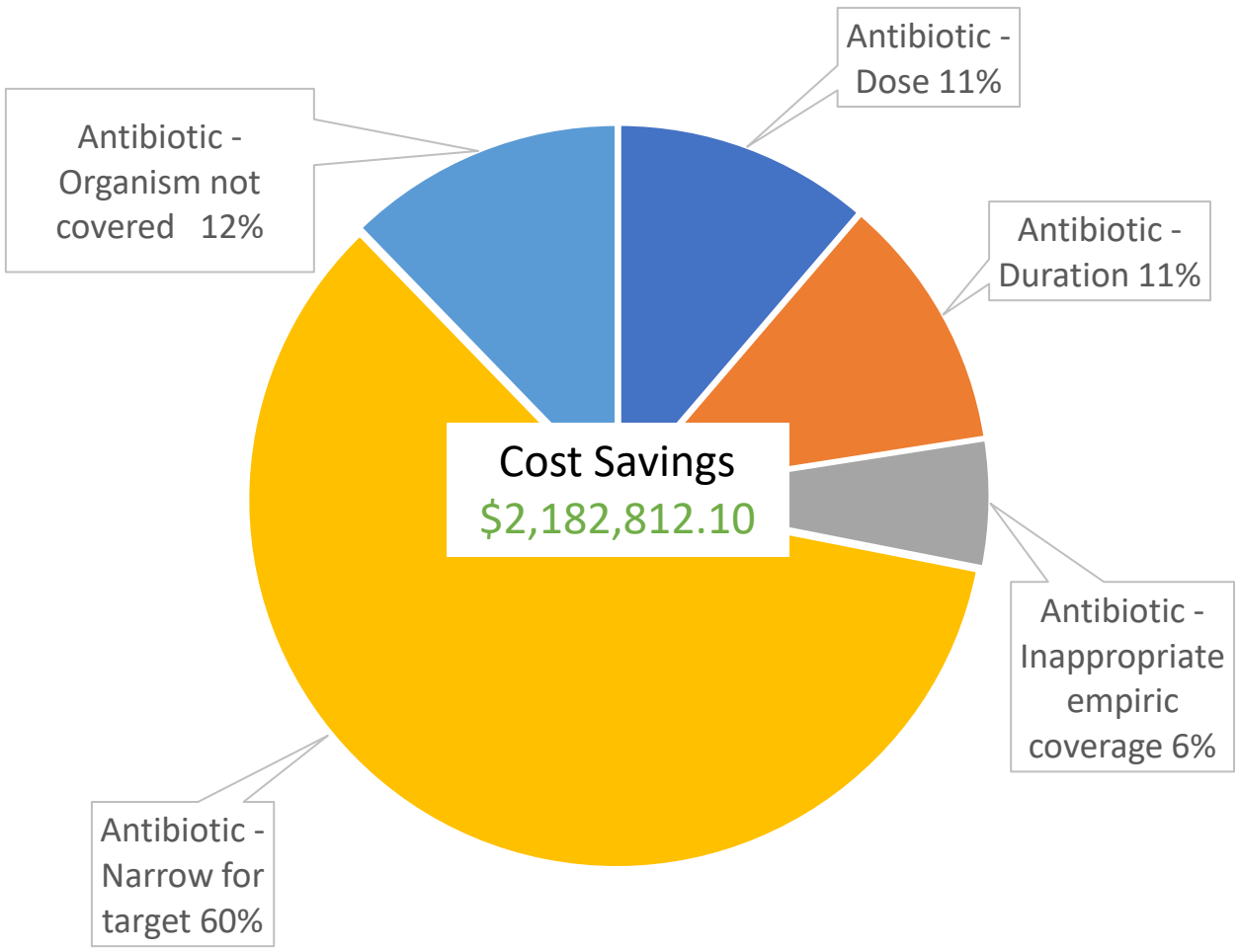
2025 Q1 Escondido n=775



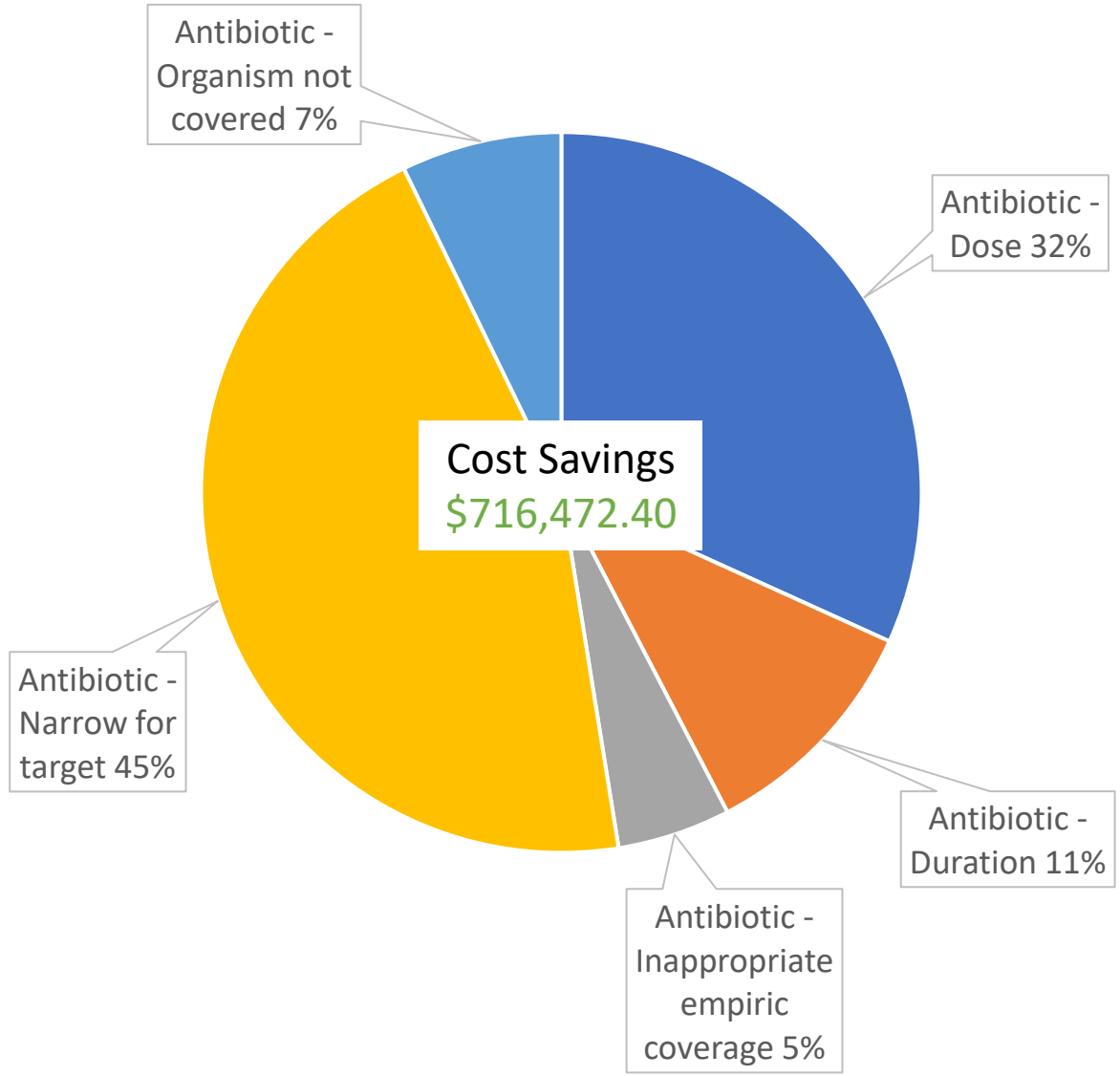
2025 Q1 Poway n=328



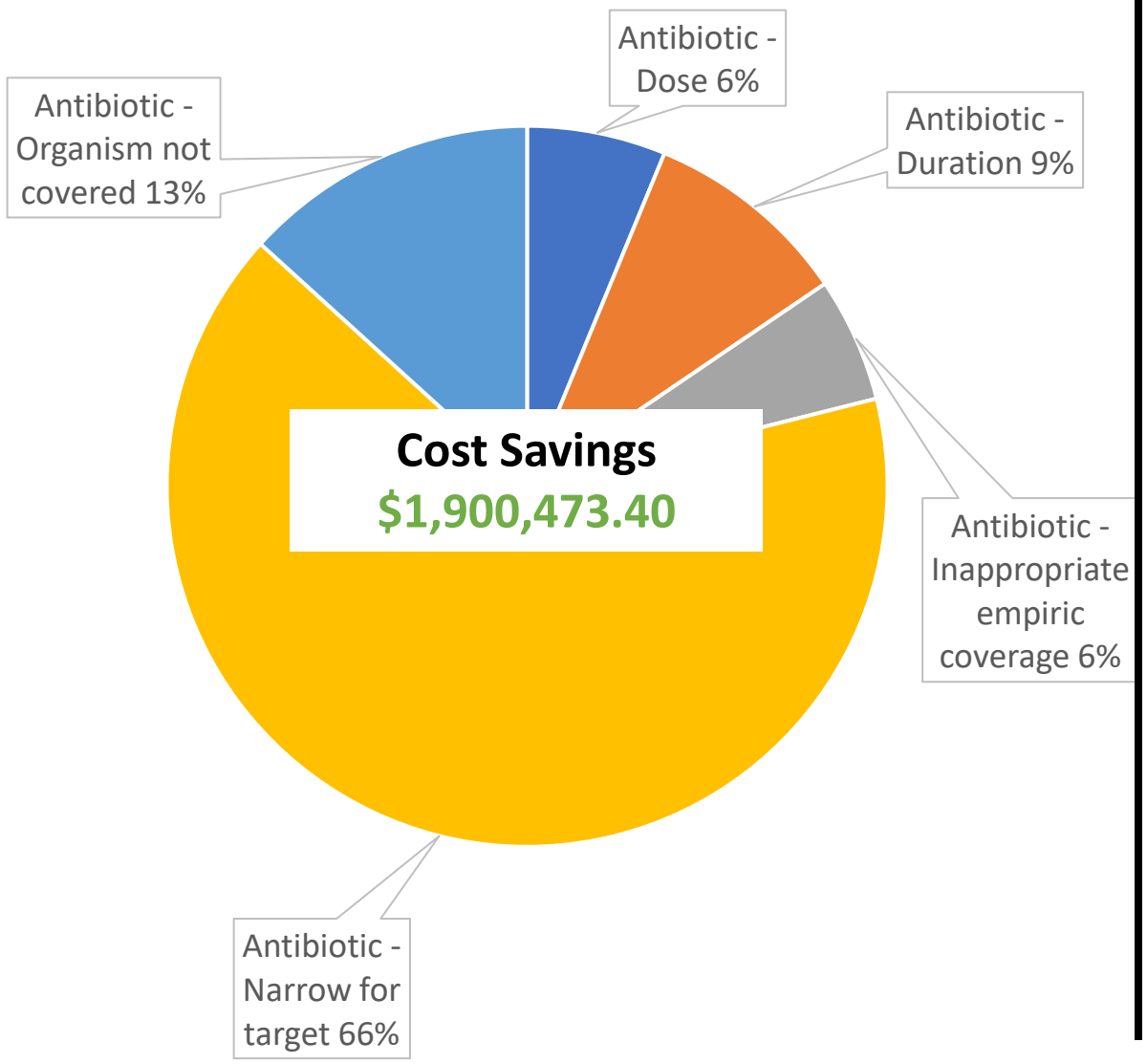
2025 Q2 Escondido n=719



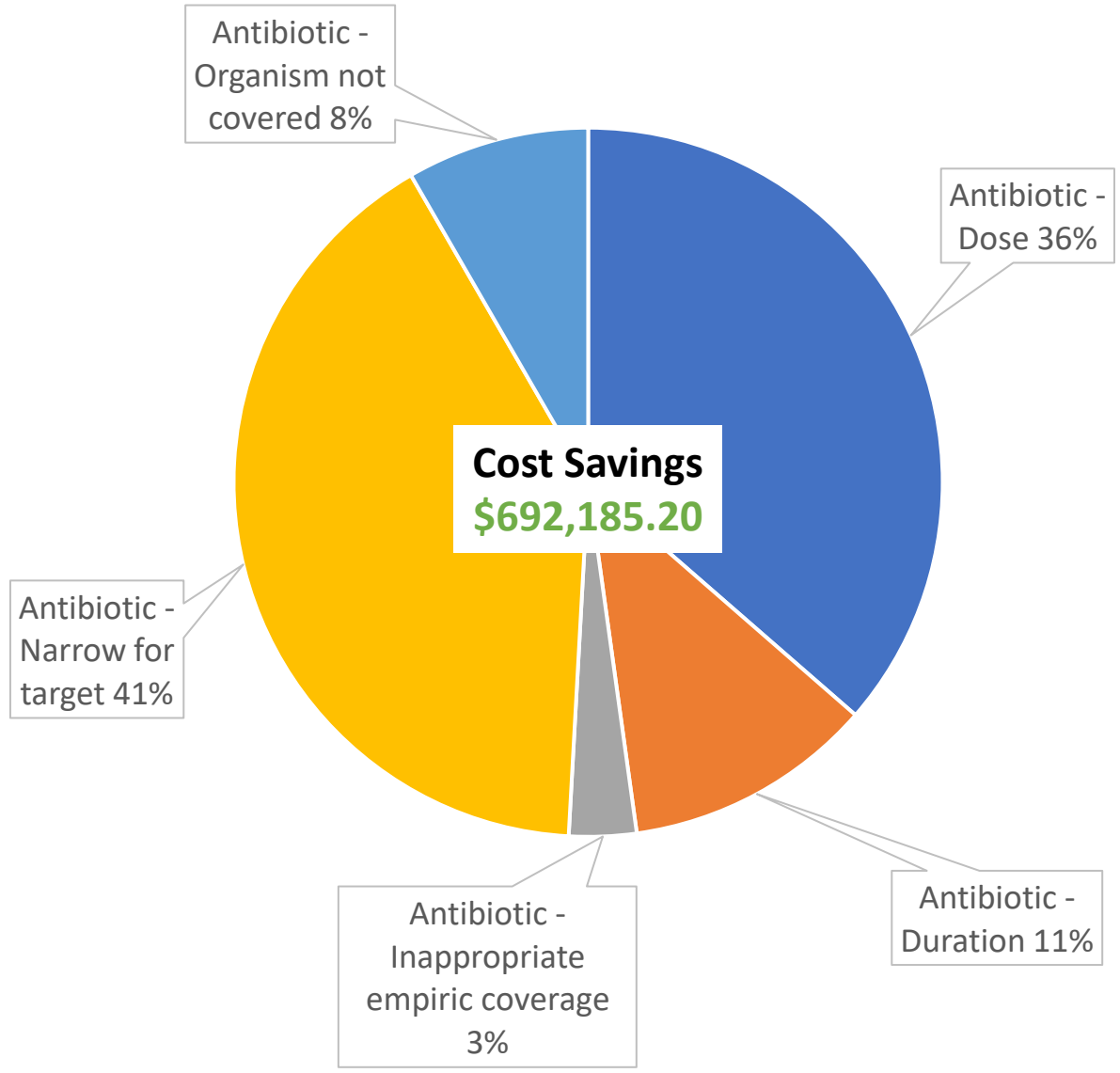
2025 Q2 Poway n=236



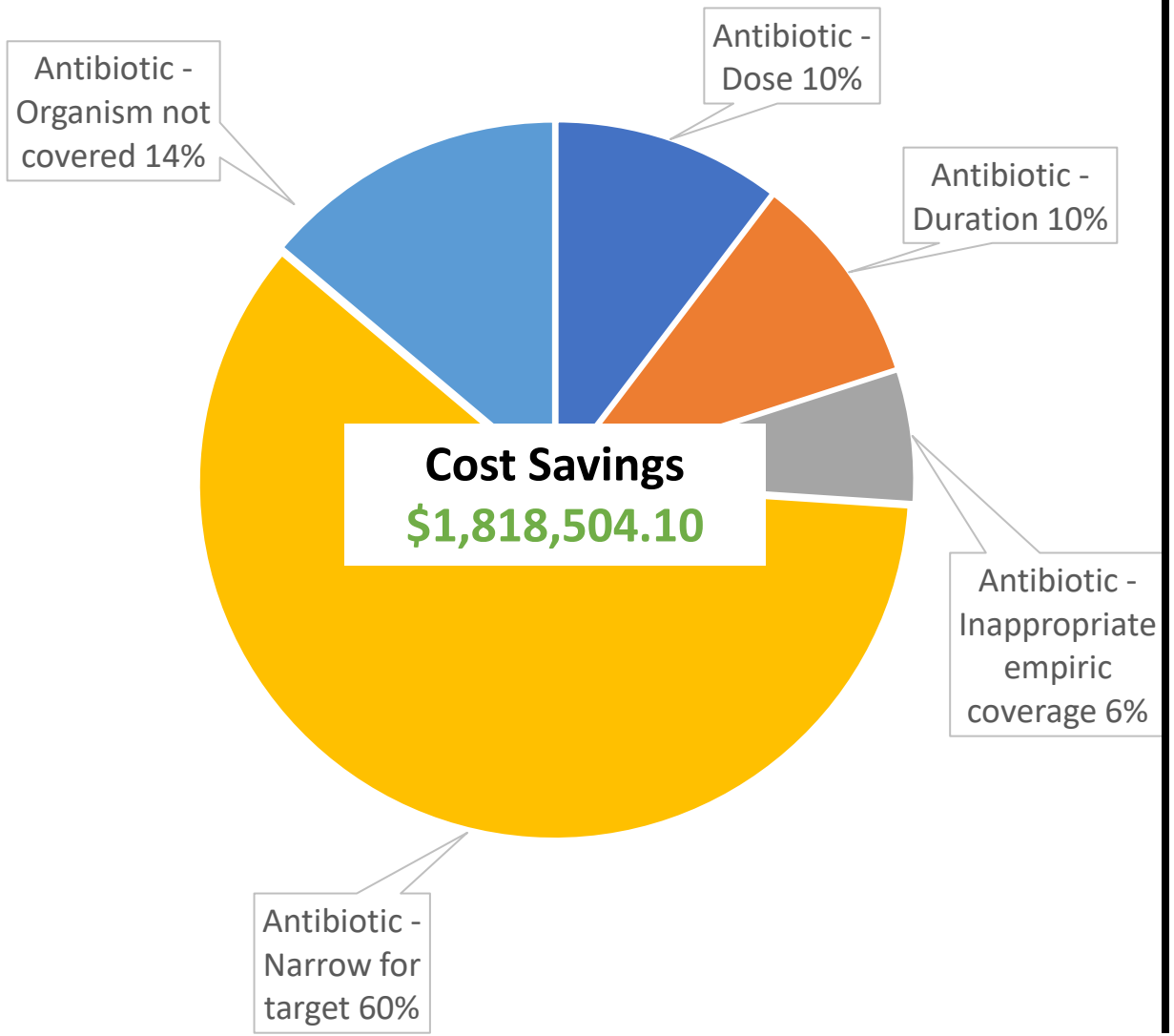
2025 Q3 Escondido n=626



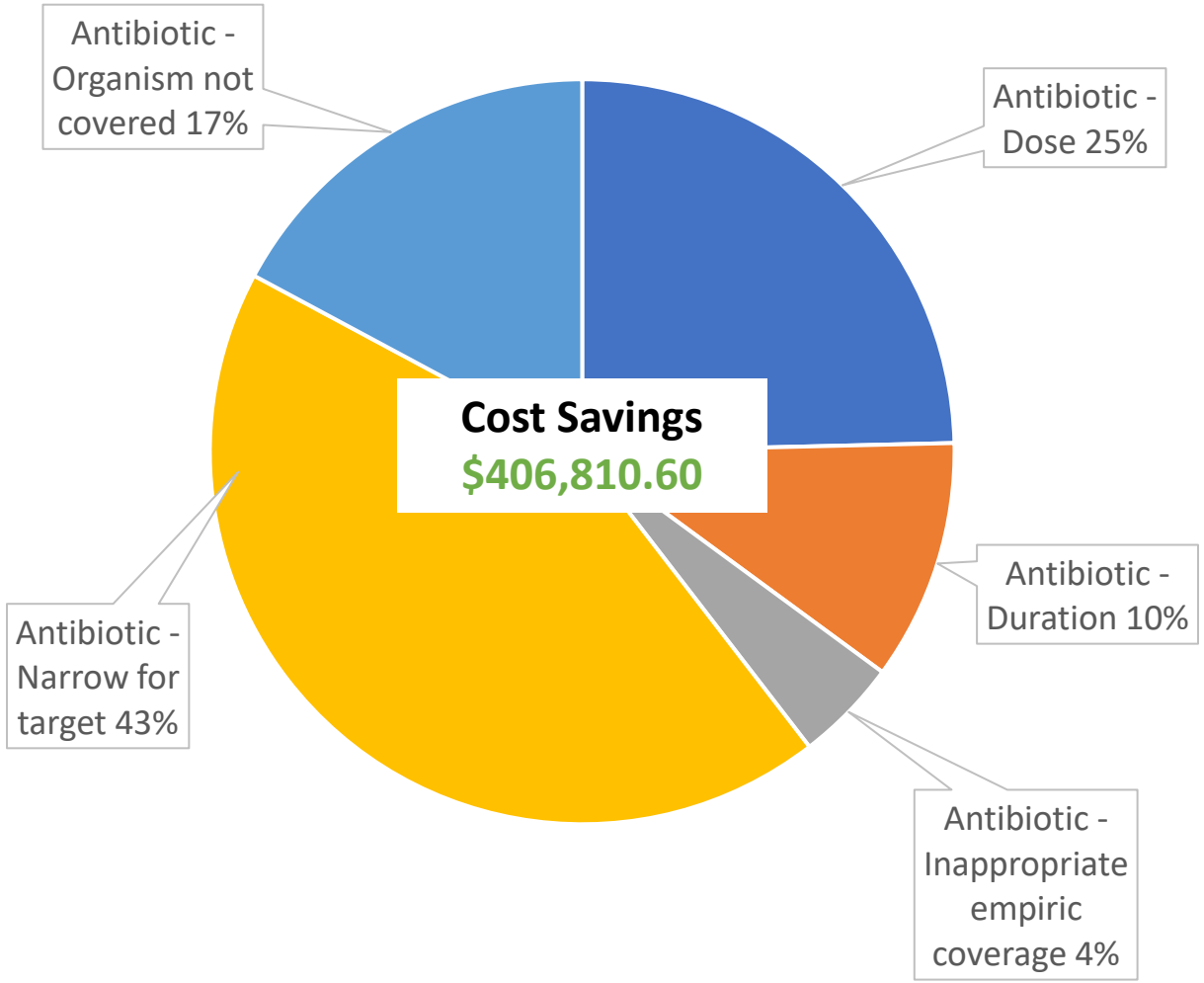
2025 Q3 Poway n=228



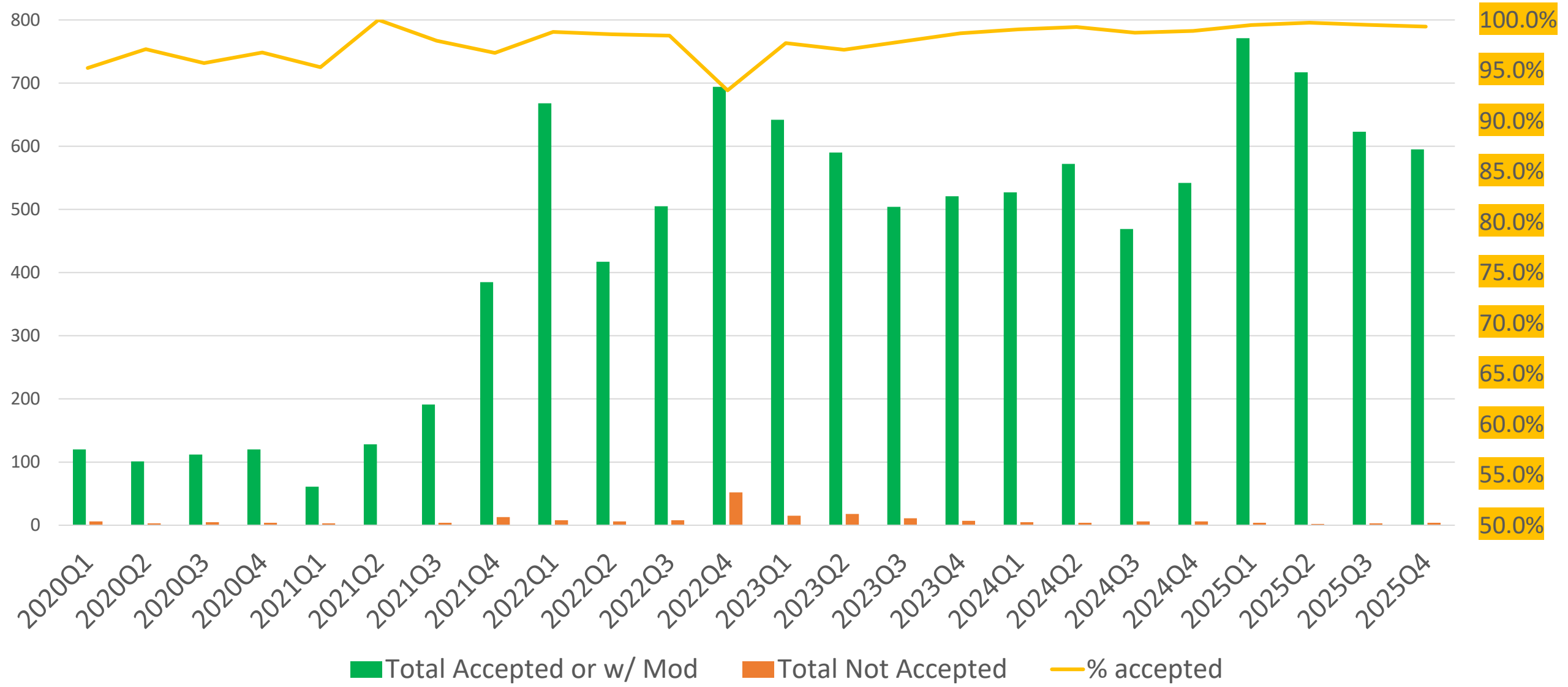
2025 Q4 Escondido n=599



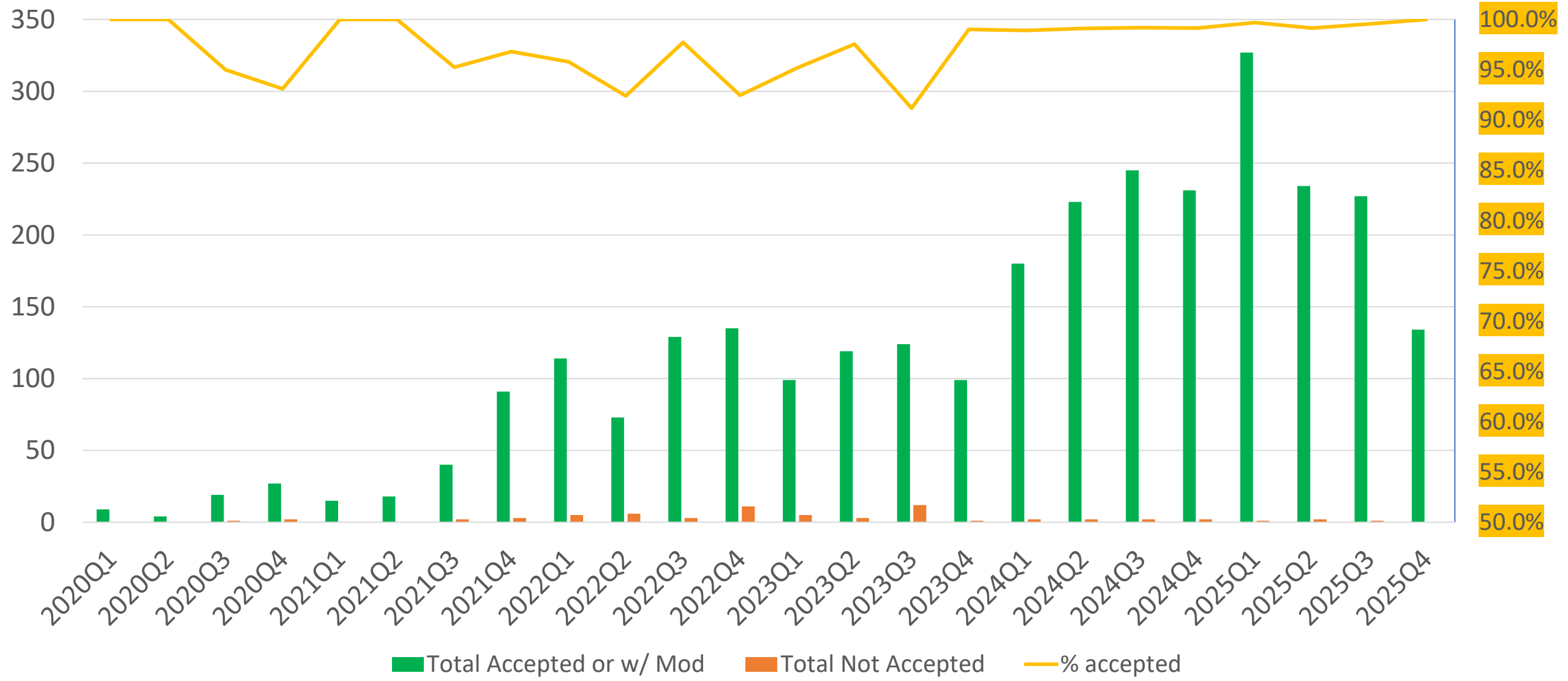
2025 Q4 Poway n=134



ASP Interventions - Escondido



ASP Interventions - Poway



ASP Cost Savings Analysis

Davey P, et al (2019)

- Literature search resulted in 221 studies (58 RCTs) in North America and Europe looking at efficacy of ASP interventions to improve antibiotic prescribing in hospital inpatients
- Found ASP interventions reduced length of stay by average **1.12 days** (95% CI 0.7-1.54 days)

Davey P, et al. Interventions to improve antibiotic prescribing practices for hospital inpatients. Cochrane Database Syst Rev. 2017;2(2):CD003543. Published 2017 Feb 9.

ASP Cost Savings Analysis

Average hospital bed day cost in 2022 in US is $4,337 according to data obtained by the Kaiser Family Foundation from the American Hospital Association

Cost savings calculation

- 0.7 day reduced length of stay per intervention x 3,645 interventions x $4,337 per bed day cost

Estimated **$11,065,855.50** cost savings for 2025

2025 Daptomycin and Linezolid Cost Savings Analysis

Background

- Linezolid is FDA-approved and non-inferior to vancomycin for pneumonia and SSTI indications.
- Daptomycin is FDA-approved and non-inferior to vancomycin for SSTI and *Staphylococcus aureus* bacteremia indications.
- Use of linezolid or daptomycin is supported by the 2011 IDSA Practice Guideline for MRSA infections.
- Medications require no therapeutic drug monitoring, are not associated with nephrotoxicity, and require less nursing/phlebotomist/nursing time.
- When clinically appropriate, ID pharmacists contacted physicians to switch vancomycin to daptomycin or linezolid.

IDSA – Infectious Diseases Society of America; MRSA – Methicillin Resistant *Staphylococcus aureus;* SSTI: Skin soft tissue infection

Antibiotic Cost – Drug/lab/personnel

Drug / Intervention	Item Cost	Total Cost
Vancomycin 1 g	$10.57	2 g/day x 7 days = $147.98
Vancomycin TDM Laboratory Costs	$40 Phlebotomy $69 Measurement	2 levels per week = $218
Pharmacist TDM time	$70 per hour	16 minutes x 7 days = $130.67
Total Cost of Vancomycin		1 week cost = $496.65
		1 day cost = $70.95
Linezolid		
IV	$14	**1 day cost = $14**
PO	$4	**1 day cost = $4**
Daptomycin 500 mg	$12.64	**1 day cost = $12.64**

TDM = Therapeutic drug monitoring

Estimated Cost Savings 2025

Estimated cost savings if all linezolid and daptomycin in 2025 would have remained on vancomycin

- Linezolid
  - IV = 957 x ($70.95-$14) = **$54,501.15**
    = Days of therapy of linezolid IV x (cost of 1 day of vancomycin – cost of 1 day of linezolid IV)
  - PO = 1609 days of therapy x ($70.95-$4) = **$107,722.55**
    = Days of therapy of linezolid PO x (cost of 1 day of vancomycin – cost of 1 day of linezolid PO)
- Daptomycin
  = 3902 x ($70.95-$12.64) = **$227,525.62**
  = days of therapy of daptomycin x (cost of 1 day of vancomycin – cost of 1 day of daptomycin 500mg)

Total Cost Savings = $389,749.32

PALOMAR HEALTH

Laboratory Biannual Presentation

Presented to Board Quality Review Committee

Jerry Kolins, M.D., Medical Director, Laboratory
Tim Barlow, CLS (ASCP) MT, Laboratory Director
May 2026

Laboratory Biannual Report

SITUATION	The Laboratory Quality Committee meets monthly to review lab quality indicators, performance metrics for trends and opportunities to improve laboratory services.
BACKGROUND	The Laboratory Quality Committee identifies different quality indicators for all three phases of laboratory operations to monitor annually according to regulatory requirements, identify high risk processes, and multidisciplinary quality initiatives. The committee, with the approval of the medical director, sets the target base on national benchmarks or needed process improvement activities for patient care and safety.
ASSESSMENT	Fiscal Year (FY) 26 performance trends and improvement opportunities: • Critical value reporting, test order accuracy, proper specimen identification, specimen integrity, consistently met performance targets • Improve STAT turn around time (TAT) for Lab results in the Emergency Department at PMC Escondido. ESC Phlebotomy Team has had a 40% Turnover rate in the last 6 months. Continued short staffing and expertise challenges at PMC ESC. PMC Poway Lab consistently is meeting ED STAT lab result TAT goals. • Blood Culture Contamination Rate is a process improvement project that started in FY 25 and carried over to FY 26. New goal of < 2% contamination rate has not yet been met. Trial of a Blood Culture collection system (expensive) that sidelines skin contaminants was trialed with inconsistent results. • Lab stewardship and engagement with Medical Staff examples: ProBNP interpretative table added to results in Clarity for ED. Syphilis reflex testing and interfaced results to Clarity from reference lab to improved result TAT for Rady NICU. Bring in house testing for enteric pathogens (stool panel) and vaginosis panels via PCR Done-2/26 • On going Antimicrobial Stewardship: New breakpoint validation for Daptomycin and Oxacillin
RECOMMENDATION	- PMC ESC phlebotomy staffing recruitment and retention focus to decrease PMC ESC ED Lab specimen collection time as this was identified as a leading cause of increased TAT of ED STAT Lab results. - Phlebotomy Leadership priority to focus on decreasing blood culture contamination rate with employee in-servicing on proper use of discard tube, individual metrics for contamination rate, average of total volume of draws (minimize short sampling) and compliance for (2) bottle collection (Aer/ANA) for FY 26.

Summary of Tissue Review 2025

1) Our overall surgical volume at Escondido increased very slightly (+1%) while it decreased at Poway (-8%) when compared to 2024.

2) The number of frozen sections has decreased at both Escondido (-20%) and Poway (-54%) as compared to 2024.

All of our quality metrics are within the expected ranges:

1) The percentage of cases undergoing quality review remains well above 10%
2) There have been no discordant diagnoses for cases which were reviewed at outside institutions
3) 90% or more of all surgical cases are signed out in less than 48 hours
4) There were no frozen sections with a discrepancy secondary to pathologist misinterpretation
5) We continue to meet the goal of greater than 90% of frozen sections being completed in 20 minutes or less

PALOMAR HEALTH

QMC – FY2026 to present

Palomar Health Imaging Services – Radiology and Nuclear Medicine Biannual Report

Annual Report | FY2026

Charles McGraw, MD | Chair, Department of Radiology, PMCE
Arian Nasiri, MD | Chair, Department of Radiology, PMCP
Ryan Fearn-Gomez | Vice President of Operations
Sims Kendall, MHA-SI | District Senior Director, Imaging Services
Tony Sanchez, ARRT, CRT (R)(F) | Manager

Radiology and Nuclear Medicine Annual Report – FY2026

SITUATION	Radiology and Nuclear Medicine evaluates and reports on specific performance metrics to ensure compliance with Palomar Health policies and regulatory requirements.
BACKGROUND	The exceptions noted by Radiology and Nuclear Medicine for FY2026 include partially achieved PI goals to include decreased turnaround times (TAT) on ED studies, lower percentage of incomplete MRI screening forms. Throughput delays plaguing MRI at Escondido. Radiation exposure to staff and physicians is closely monitored monthly.
ASSESSMENT	Process improvement actions were implemented to reduce turn-around-times (TAT) for Emergency Department ordered imaging studies in FY2023 and beyond. The specific actions were developed through bi-weekly (now monthly) intra-departmental leadership meetings between ED and Imaging. MRI throughput has increased due to, in part, collaboration between Imaging and Clinical Operations personnel. New electronic screening process for MRI was implemented, work in progress. The radiation dose badge program identified no physician or staff badges which breached the ALARA level 2 range during this reporting period.
RECOMMENDATION	1. **Radiology**: Continuation of monthly process improvement meetings with ED Leadership, including providers, to reach goal achievement in the targeted period. 2. **MRI**: Continued use of electronic MRI screening forms with the goal being to increase compliance and patient throughput. Continued monitoring of unexpected ferrous events and burns. 3. **Radiation Safety**: Provide ongoing communication and data to physicians and staff on the radiation dose badge program requirements and results to maintain regulatory compliance. Continued physicist monitoring of Imaging equipment to ensure we are compliant will all Federal, State, and Regulatory guidelines.

Radiation Safety and Imaging Performance Indicators

- **Process Improvement**: Turn-Around-Times for ED imaging studies
- **MD Dosimetry Badge:** Occupational dose and ALARA* breaches
- **Staff Dosimetry Badge:** Occupational dose and ALARA* breaches
- **Physicist report:** Required annual testing of all Imaging equipment
- **MRI:**
  - Burns
  - Ferrous events
  - Throughput
  - Compliance with electronic screening process

**ALARA – As Low a Reasonably Achievable*

Imaging Process Improvement Accomplishments (FY2026)

- **Process Improvement**: ED Imaging Median Turn-Around-Times (TAT)
  - CT order to complete (Goal 60 min)
    ESC: 63 to 66 min (↑ 4.8%) | **POW**: 66 to 68 min (↑ 3.0%)
    US order to complete (Goal 60 min)
    ESC: 71 to 72 min (↑ 1.4%) | **POW**: 50 to 50 min (NC)
  - XR order to complete (Goal 30 min)
    ESC: 32 to 32 min (NC) | **POW**: 20 to 22 min (↑ 10.0%)
  - MRI efficiency:
    ESC: We continue to see increased efficiency in throughput year over year.
    ESC: We have work to do with screening form compliance, but we see improvements every month.

Radiology Enhancements

- Consistent reading of studies 24/7, 365.
- MRI: Transition to 12-hour shifts has yielded higher efficiency and throughput despite using less staff. Continued collaboration with Clinical Services for targeted help during peak times has been beneficial.

Radiation Safety (FY2026)

Physician and Staff Dosimetry Badges

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

*** Radiation Protection and Safety Plan, Lucidoc #56232**

Annual Testing, Physicist Inspections, and Regulatory (FY2026)

Annual Physicist Testing

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

Licensing

- All Imaging licensure is in compliance.

MRI Safety (FY2026)

- MRI Safety Committee (MRSC)
  - Drafted charter for the formation of MRSC
- Transitioned from paper MRI Screener to Electronic
  - March 1st went live with rollout of MRI Screener Patient Care Order and first week has proven notably successful

MRI Burns and Ferrous Events:

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

Infusion Services

Todd Renner, Director, Cancer Services | FY26 Q3

Presented to Board Quality Review Committee (BQRC)
May 2026

PALOMAR HEALTH
Reimagining Healthcare

Infusion Referrals to Scheduled Appointments

SITUATION	Almost all of the infusion centers referrals are initiated by a HCP in the ambulatory setting vs inpatient discharge. Depending on the diagnosis and disease process, patients may experience acute complications and discomfort until OP treatment is initiated.
BACKGROUND	The infusion center sees patients from a range of specialties including rheumatology, GI, Neurology, Dermatology, and pulmonology. (Note: Cancer volume was excluded from this reporting). Biologics make up the largest drug classification order in the infusion center.
ASSESSMENT	Timely access to treatment improves patient physiological wellbeing and patients can achieve quicker remission of their disease status.
RECOMMENDATION	The infusion service team aims to initiate treatment within 14 days of receiving a referral from the HCP.

of Days from Referral to Scheduled Treatment

Timeframe	Goal	JAN	FEB	MARCH	Average
Referral to Scheduled Treatment	**10 days (business)**	**10**	**8**	**8.5**	**8.83 days**

Note: Data inclusive of referrals that are incomplete

Action Plan

- Continue close alignment with scheduling staff
- Fully staffed RN infusion team (productivity 93%)

Radiation Oncology Services

Todd Renner, Director, Cancer Services | FY26 Q3

Presented to Board Quality Review Committee (BQRC)
May 2026

PALOMAR HEALTH
Reimagining Healthcare

Radiation Oncology Tracking Times

SITUATION	Cancer patients have expectations regarding timeliness of care upon hearing they have a cancer diagnosis. Radiation treatment can be used in an adjuvant setting or neoadjuvant setting therefore timeliness of treatment start is imperative to receiving the next treatment modality.
BACKGROUND	The radiation oncology department has been in service to north country region for 15 years. As a mature program arm of the cancer institute's 3 main departments, it plays a critical referral source for growth and sustainability of the Health systems strategic objectives.
ASSESSMENT	Timely access to treatment improves patient physiological wellbeing and patients can achieve quicker remission of their disease status.
RECOMMENDATION	The radiation oncology team aims for the following goals: Referral to Consult - 10 business days Consult to Sims – Not tracked due to payer "influences" CT Sim to First Treatment – 10 days

Data

Timeframe	Goal	January	February	March	Average
Referral to Consult	10 days	10.2	9.8	12.6	10.9

Timeframe	Goal	January	February	March	Average
CT Sim to 1st Treatment	10 days	8	9	9	8.6 days

Action Plan with Timeline

- Improvements in CT Sim (planning period)
- Working with MDs to increase consult capacity
- Locum coverage started in April to cover vacations

The Joint Commission Disease Specific Stroke Program Annual Report

Vanessa Zimmerlee BSN SCRN – Stroke Coordinator
Remia Paduga, MD, Stroke Program Medical Director
Valerie Martinez, Sr. Director Quality & Patient Safety
RN, BSN, MHA, CIC, CPHQ

Presented to Board Quality Review Committee
May 2026

PALOMAR HEALTH
Reimagining Healthcare

District Stroke Program

SITUATION	Palomar Health Stroke Program Annual Review
BACKGROUND	Annual Report provides an overview of the success and opportunities for the Stroke Program at Palomar Health. Continuous monitoring of the Stroke Metrics provides opportunities for process improvement.
ASSESSMENT	• Follow Target Stroke Phase III initiatives for Metric Reporting. • Successful Joint Commission Recertification for both PMC Escondido as a Thrombectomy-Capable Stroke Center and PMC Poway as an Advanced Primary Stroke Center. • Stroke Survey findings @ PMC Escondido: 3 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 submitted to JC and accepted. Monitoring and reporting have in progress for 2026. • Stroke Survey findings @ PMC Poway: 3 findings categorized as follows: #1 Low/Limited – Documentation missing for DME arranged after discharge; 1; #2 Moderate/Pattern – Co-Witness documentation for Tenecteplase prior to administration; #3 Moderate/Pattern – Documentation of VS per orders and treatments per orders. Plan of Corrections submitted to JC and accepted. Monitoring and reporting have in progress for 2026. • Actively participate in the San Diego County Stroke Advisory Committee to share best practices and work on County initiatives to improve stroke care from pre-hospital to hospital acute phase: projects include Witness Information on arrival by EMS and introduce CTA Turnaround for Results time. • PMC Poway has been awarded the Gold Plus Performance Achievement Award from the American Heart Association and American Stroke Association's "Get with the Guidelines" program. 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.

District Stroke Program

SITUATION	Palomar Health Stroke Program Annual Review - continued
RECOMMENDATION	Initiatives for 2026: 1. Continue to improve/monitor TNKase administration to </= 45 minutes 75% of the time. 2. Sustain improvements made with the “Door to” times for thrombectomy direct cases to achieve </= 90 minutes for Door to Device. 3. Collaborate with ED for new initiatives to improve Door to Transfer times from PMC Poway for thrombectomy candidates, hemorrhagic strokes and post thrombolytic strokes. 4. Continue to work with County EMS and Stroke Consortium to reach outcomes for initiatives in progress: a) Promote goal to obtain Witness Information for EMS arrivals and document in field created in ED Nursing Triage form. This helps to improve time to decision making for interventions. b) Participate with County and Stroke Consortium initiative to establish a best practice for San Diego Stroke Centers for CTA Results Turnaround Times.

Program Overview: 2025 Summary

2025 Summary	PMC Escondido	PMC Poway
Total Stroke Code Activations: Jan-Dec 2025 • Total ED SC: 1485 • Total SC Canc: 114 • Total IPSC: 99	Total: ED: 1070 - Canc: 93 IPSC: 82	Total: ED: 415 - Canc: 21 IPSC: 17
Final Diagnosis: 2025 • Acute Ischemic (AIS) • Hemorrhagic Stroke (HS) • TIA	Total: 613 ▪ AIS: 304 ▪ HS: 189 ▪ TIAs: 120	Total: 138 ▪ AIS: 67 ▪ HS: 16 ▪ TIAs: 55
Thrombolytic Administrations: Jan-Dec 2025 • Total Administrations: 64 • Total ED: 63 • Total IPSC: 1	Total: 46 Thrombolytic Administrations ▪ ED: 45 IPSC: 1	Total: 18 Thrombolytic Administrations ▪ ED: 18 IPSC: 0
Neuro Endovascular Cases: Jan-Dec 2025 • Total Candidates: 103 • Total Thrombectomies: 83 • Total Angio/Cancel/ Venous: 16/4/0	Total Cases: 80 ▪ 65 Thrombectomy o ED: 57 IPSC: 8 ▪ Angio/Cancel/Venous: 11/4/0	Total Cases: 23 ▪ 18 Thrombectomy o ED: 18 IPSC: 0 ▪ Angio/Cancel/Venous: 5/0/0

Treatment Rate & sICH Rate	2025
Thrombolytic	**17%** **sICH = 5% (3 cases)**
Thrombectomy	**22%** **sICH = 5% (4 cases)**

Quality Metrics Adopted: Target Stroke Phase III "Door to" Measures for Thrombolytic

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

Quality Metrics: Target Stroke Phase III

"Door to" Measures 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%

PMC Escondido Stroke Program Highlights

STROKE: PMC Escondido	CY2025	CY2024	CY2023	Benchmark 2025
Thrombolytic Volumes	TNK - 46	TNK - 61	tPA - 67	
Goal for Thrombolytic Administration Metric	45 min	60 min to 45 min	60 min	
Median Time from Door to Provider for Acute Ischemic Stroke Patients (in Minutes)	5	6	7	10
Median Time from Door to Initiation of CT Scan for Acute Ischemic Stroke Patients (in Minutes)	13	12	14	15
Median Time from Door to CT Scan Results for Acute Ischemic Stroke Patients (in Minutes)	26	29	37	30
Median Time from Door to POCT Glucose for Acute Ischemic Stroke Patients (in Minutes)	6	6	10	10
Median Time from Door to NIHSS for Acute Ischemic Stroke Patients (in Minutes)	7	10	13	10
Median Time from Door to IV thrombolytic Given for Acute Ischemic Stroke Patients (in Minutes)	39	37	41	60
% of Acute Ischemic Stroke Patients who Received IV thrombolytic within 60 Minutes of ED Arrival	95%	100%	87%	85%
% of Acute Ischemic Stroke Patients who Received IV thrombolytic within 45 Minutes of ED Arrival	59%	68%	71%	75%
% of Acute Ischemic Stroke Patients who Received IV thrombolytic within 30 Minutes of ED Arrival	41%	38%	29%	50%

PMC Escondido Stroke Program Highlights

STROKE: PMC Escondido	CY2025	CY2024	CY2023	Benchmark 2025
Endovascular Total Candidates - Direct	80	72	63	
Endovascular Thrombectomies - Direct	65	67	54	
Median Time from Door to CTA Start for Acute Ischemic Stroke Patients (in Minutes)	14	13	16	20
Median Time from Door to CTA Results for Acute Ischemic Stroke Patients (in Minutes)	39	43	50	40
Median Time from Door to IR Brain Alert for Thrombectomy Candidates (in Minutes)	31	34	40	40
Median Time from Door to Groin Stick for All Thrombectomy Candidates (in Minutes)	69	84	75	75
Median Time from Door to 1st Device Pass for All Thrombectomy Candidates (in Minutes)	85	112.5	97	90
% of Thrombectomy Candidates who achieved Door to 1st Device Pass < 90 Minutes	65%	23%	40%	50%
Median Time from Door to Vessel Open for all Thrombectomy Candidates with TICI 2B or greater (in Minutes)	85	108	100	150
ALL TICI Scores >/= 2b	93%	89%	93%	80%

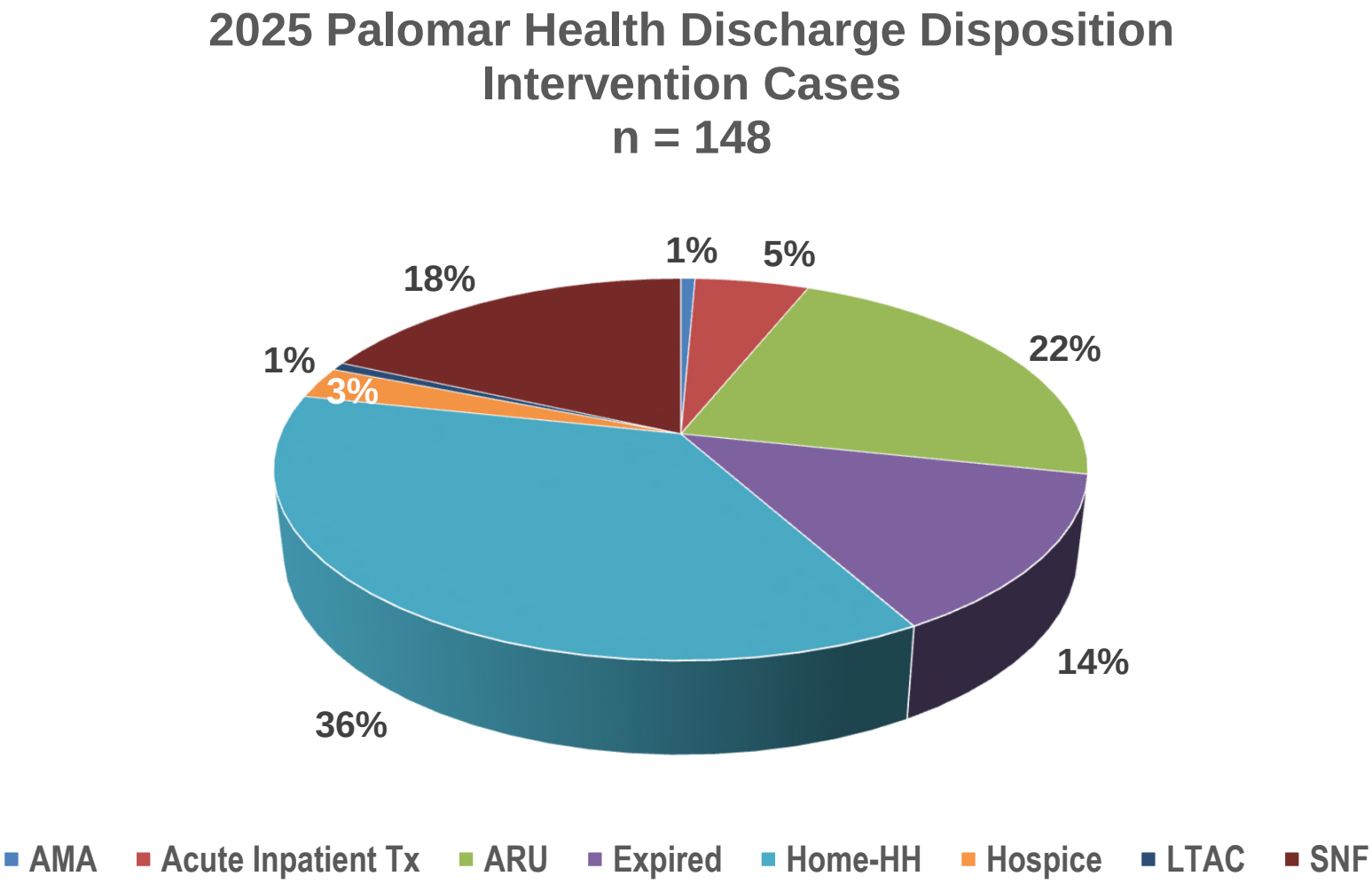
PMC Poway Stroke Program Highlights

STROKE: PMC Poway	CY 2025	CY2024	CY2023	Benchmark 2025
Thrombolytic Volumes	**TNK - 18**	**TNK - 26**	**tPA - 24**	
Goal for Thrombolytic Administration Metric	**45 min**	**60 min to 45 min**	**60 min**	
Median Time from Door to Provider for Acute Ischemic Stroke Patients (in Minutes)	**5**	**4**	**3**	**10**
Median Time from Door to Initiation of CT Scan for Acute Ischemic Stroke Patients (in Minutes)	**12**	**12**	**11**	**15**
Median Time from Door to CT Scan Results for Acute Ischemic Stroke Patients (in Minutes)	**26**	**29**	**33**	**30**
Median Time from Door to POCT Glucose for Acute Ischemic Stroke Patients (in Minutes)	**5**	**4**	**4**	**10**
Median Time from Door to NIHSS for Acute Ischemic Stroke Patients (in Minutes)	**8**	**7**	**8**	**10**
Median Time from Door to IV thrombolytic Given for Acute Ischemic Stroke Patients (in Minutes)	**40**	**37**	**42**	**60**
% of Acute Ischemic Stroke Patients who Received IV thrombolytic within 60 Minutes of ED Arrival	100%	**85%**	**91%**	**85%**
% of Acute Ischemic Stroke Patients who Received IV thrombolytic within 45 Minutes of ED Arrival	80%	62%	64%	**75%**
% of Acute Ischemic Stroke Patients who Received IV thrombolytic within 30 Minutes of ED Arrival	**20%**	15%	18%	**50%**

PMC Poway Stroke Program Highlights

STROKE: PMC Poway	CY 2025	CY2024	CY2023	Bench mark 2025
Endovascular Total Candidates - Transfers	23	32	23	
Endovascular Thrombectomies - Transfers	18	26	17	
Median Time from Door to CTA Start for Acute Ischemic Stroke Patients (in Minutes)	14	14	13	20
Median Time from Door to CTA Results for Acute Ischemic Stroke Patients (in Minutes)	45	42	51	40
Median Time for Door In – Door Out for AIS Patients with for Neuro IR Interventions (in Minutes)	67	84	81	90 - ↓ 75
Median Time from Door to IR Brain Alert for Thrombectomy Candidates (in Minutes)	31	34	45	40
Median Time from Door to Groin Stick for All Thrombectomy Candidates (in Minutes)	15	15	18	30
Median Time from Door to 1st Device Pass for All Thrombectomy Candidates (in Minutes)	36	43	40	60
% of Thrombectomy Candidates who achieved Door to 1st Device Pass < 60 Minutes	100%	92%	94%	50%

Program Overview:
2025 Discharge Disposition



Program Overview:

2025 Performance Improvement Summary

- Follow Target Stroke Phase III initiatives for Metric Reporting.
- Increase use of VIZ AI with all Radiology Provider Groups for Stroke Codes.
- Adoption of Reasons for DQ Thrombectomy cases from AHA GWTGs
- Improvement in Door to Groin Puncture Metric and Door to 1st Device activations Metric
- Successful Joint Commission Recertification for both PMC Escondido as a Thrombectomy-Capable Stroke Center and PMC Poway as an Advanced Primary Stroke Center.
  - Stroke Survey findings @ PMC Escondido: 3 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 submitted to JC and accepted. Monitoring and reporting have in progress for 2026

Program Overview:

2025 Performance Improvement Summary

  - Stroke Survey findings @ PMC Poway: 3 findings categorized as follows:
    - #1 Low/Limited – Documentation missing for DME arranged after discharge; 1;
    - #2 Moderate/Pattern – Co-Witness documentation for Tenecteplase prior to administration;
    - #3 Moderate/Pattern – Documentation of VS per orders and treatments per orders.
  - Plan of Corrections submitted to JC and accepted. Monitoring and reporting have in progress for 2026.
- Actively participate in the San Diego County Stroke Advisory Committee:
  - Serve as Past Chair in 2025
  - Participate in County initiatives to improve stroke care:
    - Witness Information on arrival by EMS leads to informed decision-making
    - Improved CTA Turnaround Results time for earlier intervention
- PMC Poway has been awarded the Gold Plus Performance Achievement Award from the American Heart Association and American Stroke Association's "Get with the Guidelines" program. 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.
- Successful Community Stroke Awareness Event at the San Diego Padres September 2025
- Successful IT Improvements/Updates in EHR for Stroke Documentation

Program Overview:
2026 Performance Improvement Initiatives

- Continued focus on metrics for Tenecteplase candidates to achieve primary and secondary goals for “Door to” administration times.
  - Primary Goal: Door to Drug < 60 min 85% of the time
  - Secondary Goal: Door to Drug < 45 min 75% of the time
- Continued focus on metrics for Thrombectomy candidates to improve the “Door to 1st Device” for direct cases.
  - Goal: </= 90 minutes in 50% of cases
  - Review of fallouts for continued improvements
  - Review of cases to ensure they meet criteria for inclusion in the data.
- Continue to focus on “Door In – Door Out” metrics at Poway for the Thrombectomy candidates and Hemorrhagic strokes patients needing higher level of care.
  - Implementation of Air CCT transfers versus CCT Ground due to traffic delays
- Continue to focus Trauma-Stroke Dual Activations to improve early treatments if stroke cases.