Posted
FRIDAY
OCTOBER 20, 2023

PALOMAR HEALTH

# BOARD QUALITY REVIEW COMMITTEE MEETING
# AGENDA

Wednesday, October 25, 2023
4:00pm Meeting

## PLEASE SEE PAGE 3 FOR MEETING LOCATION

| | PLEASE TURN OFF CELL PHONES OR SET THEM TO SILENT MODE UPON ENTERING THE MEETING ROOM | Time | Form A Page | Target |
|---|---|---|---|---|
| **CALL TO ORDER** | | | | **4:00** |
| **1.** | **Establishment of Quorum** | 5 | - | 4:05 |
| **2.** | **Public Comments**[1] | 30 | - | 4:35 |
| **3.** | **Action Item(s)** | | | |
| | **a. Minutes: Board Quality Review Committee Meeting – September 27, 2023** (ADD A – Pp 20-22) | 5 | 7 | 4:40 |
| | **b. Approval of Contracted Services**<br>*Valerie Martinez, Sr. Director, Quality, Patient Safety & Infection Prevention*<br>I. Advantage Ambulance (ADD B – Pp 23)<br>II. Alhiser Comer (ADD C – Pp 24)<br>III. ARUP (ADD D – Pp 25)<br>IV. California Transplant Services (ADD E – Pp 27)<br>V. R. Bravo Intra Operative Monitoring Services (ADD F – Pp 28) | 10 | 8<br>9<br>10<br>11<br>12 | 4:50 |
| | **c. Approval of Quality Assessment Performance Improvement (QAPI) and Patient Safety Plan** (ADD G – Pp 30-38)<br>*Valerie Martinez, Sr. Director, Quality, Patient Safety & Infection Prevention* | 10 | 13 | 5:00 |
| **4.** | **Standing Item(s)** | | | |
| | **a. Medical Executive Committee (MEC)/Quality Management Committee (QMC) Update**<br>*Andrew Nguyen, MD, PhD, Chair, Quality Management Committee, Palomar Medical Center Escondido*<br>*Mark Goldsworthy, MD, Chair, Quality Management Committee, Palomar Medical Center Poway* | 10 | - | 5:10 |
| **5.** | **New Business** | | | |
| | **a. Radiology & Nuclear Medicine Med Staff Report** (ADD H – Pp 39-49)<br>*Charles McGraw, MD, Medical Director* | 5 | 14 | 5:15 |
| | **b. Behavioral Health Services Annual Review** (ADD I – Pp 50-53)<br>*Don Myers, Behavioral Health Services Director*<br>*H. Scott Kane, MD, Department Chair* | 5 | 15 | 5:20 |
| | **c. Perioperative Services (includes Endo) Annual Report** (ADD J – Pp 54-77)<br>*Bruce Grendell, Sr. Director, Perioperative Services*<br>*Richard Engel, MD, Medical Director, Perioperative Services* | 5 | 16 | 5:25 |
| | **d. Dietary Services (Food & Nutrition Services)** (ADD K – Pp 78-94)<br>*Russell Riehl, VP Operational Support Services* | 5 | 17 | 5:30 |
| | **e. Nursing Services Annual Report** (ADD L – Pp 95-142)<br>*Melvin Russell, Chief Nurse Executive* | 5 | 18 | 5:35 |
| | **f. Infection Prevention and Control Update** (ADD M – Pp 143-145)<br>*Valerie Martinez, Sr. Director Quality, Patient Safety & Infection Prevention* | 5 | 19 | 5:40 |
| | **g. Annual Board Quality Review Committee (BQRC) Assessment**<br>*Valerie Martinez, Sr. Director Quality, Patient Safety & Infection Prevention*<br>*Omar Khawaja, MD, Chief Medical Officer* | 5 | - | 5:45 |
| **6.** | **Adjournment to Closed Session** | 1 | - | 5:46 |
| | *Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee* | 10 | - | 5:56 |
| **7.** | **Adjournment to Open Session** | 1 | - | 5:57 |

| | | | | |
|---|---|---|---|---|
| **8.** | **Action Resulting from Executive Session** | 1 | - | 5:58 |
| **FINAL ADJOURNMENT** | | 2 | - | 6:00 |

| *VOTING MEMBERSHIP* | *NON-VOTING MEMBERSHIP* |
|---|---|
| **Linda Greer, RN** – Chairperson, Board Member | **Diane Hansen, CPA**, President/Chief Executive Officer |
| **Terry Corrales, RN**, Board Member | **Omar Khawaja, MD**, Chief Medical Officer |
| **Laura Barry**, Board Member | **Hugh King**, Chief Financial Officer |
| **Andrew Nguyen, MD, PhD** – Chair of Medical Staff Quality Management Committee for Palomar Medical Center Escondido | **Melvin Russell, RN, MSN**, Chief Nursing Executive |
| **Mark Goldsworthy, MD** – Chair of Medical Staff Quality Management Committee for Palomar Medical Center Poway | **Kevin DeBruin, Esq.**, Chief Legal Officer |
| **Laurie Edwards Tate, MS** – Board Member 1st Alternate | **David Lee, MD**, Medical Quality Officer |
| | **Valerie Martinez, RN, BSN, MHA**, CPHQ, CIC, Senior Director Quality and Patient Safety, Infection Prevention |

NOTE: If you have a disability, please notify us by calling 44.281.2505, 72 hours prior to the event so that we may provide reasonable accommodations

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

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

***PLEASE JOIN THE MEETING FROM YOUR COMPUTER, TABLET OR SMARTPHONE***

**Join on your computer, mobile app or room device**

Click here to join the meeting

Meeting ID: 217 601 050 746

Passcode: AGgdxe

Download Teams | Join on the web

**Or call in (audio only)**

+1 929-352-2216,,125530414# United States, New York City

Phone Conference ID: 125 530 414#

***PLEASE MUTE YOUR MICROPHONE UPON ENTERING THE VIRTUAL MEETING ROOM***

# Board Quality Review Committee Location Options

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

The Linda Greer Conference Room

2125 Citracado Parkway, Suite 300, Escondido, CA 92029

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

Click here to join the meeting

Meeting ID: 217 601 050 746

Passcode: AGgdxe

or

call in (audio only)

929-352-2216,,125530414# Phone Conference ID: 125 530 414#

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

# Board Quality Review Committee Meeting

**Meeting will begin at 4:00 p.m.**

## Request for Public Comments

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

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

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

**Public Comments Process**

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

PALOMAR HEALTH
Reimagining Healthcare

# Policy : Public Comments and Attendance at Public Board Meetings

## I. PURPOSE:

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

## II. DEFINITIONS:

A. None defined.

## III. TEXT / STANDARDS OF PRACTICE:

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

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

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

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

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

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

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

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

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

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

PALOMAR HEALTH

**BOARD QUALITY REVIEW COMMITTEE MEETING**
**ATTENDANCE ROSTER -**
**CALENDAR YEAR 2023**

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

| **VOTING MEMBERS** | **2.22.2023** | **3.22.2023** | **5.24.2023** | **7.26.2023** | **9.27.2023** | | |
|---|---|---|---|---|---|---|---|
| LINDA GREER, RN, Chairperson, Board Member | P | P | P | P | P | | |
| TERRY CORALES, RN, Board Member | P | P | P | P | P | | |
| LAURA BARRY, Board Member | E | P | P | P | P | | |
| ANDREW NGUYEN, MD, PhD, Chair, Medical Staff Quality Management Committee, PMC Escondido | A | P | P | P | | | |
| MARK GOLDSWORTHY, MD, Chair, Medical Staff Quality Management Committee, PMC Poway | P | E | P | P | P | | |
| LAURIE EDWARDS-TATE, MS- 1ST *Board Alternate* | | G | G | | | | |
| **STAFF ATTENDEES/NON-VOTING MEMBERS** | | | | | | | |
| DIANE HANSEN, CPA, President & CEO | P | | | E | | | |
| OMAR KHAWAJA, MD, Chief Medical Officer | P | P | P | P | P | | |
| MEL RUSSELL, RN, MSN, Chief Nursing Executive | P | P | P | P | P | | |
| HUGH KING, Chief Financial Officer | | | | | | | |
| VALERIE MARTINEZ, RN, BSN, MHA, CPHQ, CIC, Senior Director, Quality and Patient Safety | P | P | P | P | P | | |
| DAVID LEE, MD, Medical Quality Officer | P | P | P | P | P | | |
| KEVIN DEBRUIN, Esq., Chief Legal Officer | V | | | V | P | | |
| SALLY VALLE – Committee Assistant | P | E | P | E | P | | |
| **INVITED GUESTS** | **SEE TEXT OF MINUTES FOR NAMES OF INVITED GUESTS** | | | | | | |

**Board Quality Review Committee Minutes**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Sally Valle, Committee Assistant

**Background:** Minutes from the Wednesday, September 27, 2023, Board Quality Review Committee meeting are respectfully submitted for approval.

**Budget Impact:** N/A

**Staff Recommendation:** Recommend to approve the Wednesday, September 27, 2023, Board Quality Review Committee minutes

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Contracted Services – Advantage Ambulance**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

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

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

**Budget Impact:** N/A

**Staff Recommendation:** To approve.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Contracted Services – Alhiser Comer**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

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

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

**Budget Impact:** N/A

**Staff Recommendation:** To approve.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Contracted Services – Associated Regional & University Pathologists (ARUP) Lab**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

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

**Background:** The Contracted Services Evaluation report for Associated Regional & University Pathologists **(**ARUP) Lab is provided to the Board Quality Review Committee for review & approval.

**Budget Impact:** N/A

**Staff Recommendation:** To approve.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Contracted Services – California Transplant Services**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

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

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

**Budget Impact:** N/A

**Staff Recommendation:** To approve.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Contracted Services – R. Bravo IntraOperative Monitoring Services**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

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

**Background:** The Contracted Services Evaluation report for R. Bravo IntraOperative Monitoring Services is provided to the Board Quality Review Committee for review & approval.

**Budget Impact:** N/A

**Staff Recommendation:** To approve.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Annual Evaluation - Quality Assessment Performance Improvement (QAPI) and Patient Safety Plan**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

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

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

**Budget Impact:** N/A

**Staff Recommendation:** To approve.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**: X

**Individual Action**:

**Information:**

**Required Time:**

**Board Quality Review Committee**
**Annual Report – Department of Radiology & Nuclear Medicine**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Charles McGraw, MD, Chair, Department of Radiology, PMC Escondido

**Background:** The annual report for the Department of Radiology & Nuclear Medicine is provided to the Board Quality Review Committee for information only.

**Budget Impact:** N/A

**Staff Recommendation:** For information only.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**:

**Individual Action**:

**Information: X**

**Required Time:**

**Board Quality Review Committee**
**Annual Report – Behavioral Health Services**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Don Myers, Behavioral Health Services Director
H. Scott Kane, MD, Department Chair

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

**Budget Impact:** N/A

**Staff Recommendation:** For information only.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**:

**Individual Action**:

**Information: X**

**Required Time:**

**Board Quality Review Committee**
**Annual Report – Perioperative Services (including Endoscopy) Services**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Bruce Grendell, Sr. Director, Perioperative Services
Richard Engel, MD, Medical Director

**Background:** The annual report for Perioperative Services (including Endoscopy) is provided to the Board Quality Review Committee for information only.

**Budget Impact:** N/A

**Staff Recommendation:** For information only.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**:

**Individual Action**:

**Information: X**

**Required Time:**

**Board Quality Review Committee**
**Annual Report – Food and Nutritional Services**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Russ Riehl, Vice President Operations

**Background:** The annual report for Food and Nutritional Services is provided to the Board Quality Review Committee for information only.

**Budget Impact:** N/A

**Staff Recommendation:** For information only.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**:

**Individual Action**:

**Information: X**

**Required Time:**

**Board Quality Review Committee**
**Annual Report – Nursing Services**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Melvin Russell, Chief Nurse Executive

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

**Budget Impact:** N/A

**Staff Recommendation:** For information only.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**:

**Individual Action**:

**Information: X**

**Required Time:**

**Board Quality Review Committee**
**Update – Infection Prevention & Control Hand Hygiene Program**
**Wednesday, October 25, 2023**

**TO:** Board Quality Review Committee

**MEETING DATE:** Wednesday, October 25, 2023

**FROM:** Valerie Martinez, Senior Director, Quality & Patient Safety, Infection Prevention, Stroke

**Background:** The update for the Infection Prevention & Control Hand Hygiene Program is provided to the Board Quality Review Committee for information only.

**Budget Impact:** N/A

**Staff Recommendation:** For information only.

**Committee Questions:**

**COMMITTEE RECOMMENDATION:**

**Motion**:

**Individual Action**:

**Information: X**

**Required Time:**

PALOMAR HEALTH

# ADDENDUM A

| BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, SEPTEMBER 27, 2023 | | | |
|---|---|---|---|
| **AGENDA ITEM** | **CONCLUSION/ACTION** | **FOLLOW UP / RESPONSIBLE PARTY** | **FINAL?** |
| **NOTICE OF MEETING** | | | |
| The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Friday, September 22, 2023, consistent with legal requirements. | | | |
| **CALL TO ORDER** | | | |
| The meeting, which was held in the Linda Greer Board Room at 2125 Citracado Parkway, Suite 300, Escondido, CA 92029, and virtually, was called to order at 4:00 p.m. by Director Linda Greer, RN. | | | |
| **ESTABLISHMENT OF QUORUM** | | | |
| Quorum comprised of Board Directors: Greer, Corrales, Barry, Goldsworthy, MD | | | |
| **PUBLIC COMMENT** | | | |
| • There were no public comments. | | | |
| **ACTION ITEMS:** | | | |
| a. Minutes: Board Quality Review Committee Meeting – July 26, 2023 | **MOTION:** by Director Corrales, second by Barry, carried to approve the meeting minutes of July 26, 2023, as submitted.<br><br>Roll call voting was utilized.<br><br>Director Barry – aye<br>Director Corrales – aye<br>Director Greer - aye<br>Mark Goldsworthy, MD - aye<br>All in favor. None opposed. Motion approved | | |
| **Discussion:** | | | |

| | | | |
|---|---|---|---|
| b. Approval of Contracted Services<br>I. San Diego Urology<br>II. South Coast Perfusion<br>III. Specialty Care Intra Operative Monitoring<br>IV. UHS Surgical Services<br>V. San Diego Blood Bank<br>VI. Becton Dickinson and Company<br>VII. Boston Scientific Labsystem Pro Recording Equipment<br>VIII. Boston Scientific Micropace Evercare | **MOTION:** by Director Corrales, second by Director Barry carried to approve item B, I-VIII Contracted Services as presented.<br><br>Roll call voting was utilized.<br><br>Director Barry – aye<br>Director Corrales – aye<br>Director Greer - aye<br>Mark Goldsworthy, MD - aye<br>All in favor. None opposed. Motion approved | | |

**Discussion:**

**STANDING ITEMS:**

a. Medical Executive Committee (MEC)/Quality Management Committee (QMC) Update

- Mark Goldsworthy, MD, shared an update of the Quality Management Committee, Palomar Medical Center, Poway and Palomar Medical Center, Escondido.

**NEW BUSINESS:**

a. Center of Excellence – Cardiovascular Services Annual Report

- Thomas McGuire, District Director of Interventional Radiology and Cardiology presented the Cardiovascular Services Center of Excellence annual report.

b. Bariatric Surgical Services Annual Report

- Karen Hanna, MD Medical Director and Brian Cohen, Sr. Director of Service Lines presented the Bariatric Surgical Services annual report.
  - Director Barry requested clarification regarding mortality rate data. Dr. Hanna provided a more detailed explanation to Director Barry.
  - Chair Greer inquired whether it was difficult to obtain health insurance approval for these types of surgeries. Dr. Hanna provided a brief explanation and answered her question.

c. Management of the Medical Record

- Kim Jackson, Director of Health Information Services presented the Management of the Medical Record annual report.

d. Medical Staff: Utilization Review Annual Report

- Frank Martin, MD, Physician Advisor, presented the Utilization Review Committee annual report.

e. Medical Staff Anesthesia Services Annual Report

- Graham Davis, DO, Chairman, Department of Anesthesia, presented the Anesthesia Services annual report.
  - Dr. Davis expressed his gratitude to the Administration and the Board for their support in accomplishing the implementation of the new Anesthesia Electronic Medical Record (EMR).

- Brian Cohen, Sr. Director of Service Lines, commended the Department of Anesthesia for their collaboration with the Total Joint Program.

f. Service Excellence (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

- Omar Khawaja, MD, Chief Medical Officer, Mel Russell, Chief Nurse Executive, and Suz Fisher, Patient Experience District Director, presented the Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) and Emergency Department Patient Experience annual report for both campuses.
  - Chair Greer and Director Corrales requested clarification on some of the measurements and goals. A detailed explanation was provided.
  - Director Corrales suggested to see additional information in regards to metrics and action plans in the future.

**ADJOURNMENT TO CLOSED SESSION**

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

**ADJOURNMENT TO OPEN SESSION**

**ACTION RESULTING FROM CLOSED SESSION**

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

**FINAL ADJOURNMENT -** The meeting adjourned at 5:27 p.m.

**SIGNATURES:**

**COMMITTEE CHAIR**

Linda Greer, RN

**COMMITTEE ASSISTANT**

Sally Valle

# ADDENDUM B

***Advantage Ambulance***
**Review of Contract Service**

**Name of Service:** Ambulance Services
**Date of Review:** 10/4/2023
**Name / Title of Reviewer:** Ryan Gomez, District Director, Clinical Operations
**Nature of Service (describe):** Ambulance Transports of Patients

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

**Performance Metrics**

| METRIC | CY 2021 3rd QTR | CY2021 4th QTR | CY 2022 1st QTR | CY 2022 2nd QTR | Cumulative Total |
|---|---|---|---|---|---|
| Turnaround time from request to pick-up | 98% | 99% | 100% | 99% | 99% |
| Transfer documentation required sent with patient | 100% | 100% | 100% | 100% | 100% |
| Appropriate type of ambulance and competency of transport team available when requested. | 100% | 100% | 100% | 100% | 100% |

**Comments**
**Advantage Ambulance continues to be a great partner and is very responsive to Palomar Health's requests.**

**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 C

***Palomar Health***
**Review of Contract Service**

**Name of Service:** Alhiser Comer

**Date of Review:** 9/29/2023 **Name / Title of Reviewer:** Gloria Austria

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

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

**Performance Metrics**

| METRIC | Q1 2023__ QTR | _Q2 2023_ QTR | Q3 2023____ QTR | Q4 2023____ QTR | Cumulative Total |
|---|---|---|---|---|---|
| Timely response<br>Target: =/< 160 minutes 90% of the time | 100% | 100% | 100% | 100% | 100% |
| Storage capacity<br>Target: 0 capacity issues | 100% | 100% | 100% | 100% | 100% |

**Comments**
No issue with the vendor's service.

**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

# ADDENDUM D

***Palomar Health***
**Review of Contract Service**

**Name of Service:** Associated Regional and University Pathologists (ARUP) Lab
**Date of Review:** 10/03/2023 **Name / Title of Reviewer:** Sandra LaJeunesse
**Nature of Service (describe):** Clinical and Esoteric Testing Reference Laboratory

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

**Performance Metrics PHLS**

| METRIC | 1st QTR 2023 | 2nd QTR 2023 | 3rd QTR 2023 | 4th QTR 2023 | Cumulative Total |
|---|---|---|---|---|---|
| QA report based on Critical Value, Amended Results and Cancellation Notification Metric = 100% | 100% | 100% | 100% | 100% | = 100% |

**Performance Metrics PHLS**

| METRIC | 1st QTR 2023 | 2nd QTR 2023 | 3rd QTR 2023 | 4th QTR 2023 | Cumulative Total |
|---|---|---|---|---|---|
| Result Delivery Turn Around Time<br>Metric >95% within 72 hours from sample receipt. | 93.4% | 93.9% | 96.1% | 97.1% | = 95.1% |

**Performance Metrics PHLS**

| METRIC | 1st QTR 2023 | 2nd QTR 2023 | 3rd QTR 2023 | 4th QTR 2023 | Cumulative Total |
|---|---|---|---|---|---|
| Customer Service Responsiveness<br>Metric Response call < 2 hours @ 100% of the time | 100% | 100% | 100% | 100% | = 100% |

**Performance Metrics PHLS**

| METRIC | 1st QTR 2023 | 2nd QTR 2023 | 3rd QTR 2023 | 4th QTR 2023 | Cumulative Total |
|---|---|---|---|---|---|
| Variance Report due to Wrong Order, Non-testable request, Sample integrity and Improper specimen handling<br>Metric = 95% Compliance based on total test/sample submitted per quarter | 99% | 98% | 99% | 99% | = 99% |

PALOMAR HEALTH

**Comments**

Q1 and Q2 result delivery turn-around time (TAT) did not meet the target of 95% because of staffing challenges. However, Q3 and Q4 showed improvement with meeting the target with more stable staffing. Overall, ARUP met the goal for FY23 TAT metric.

**Conclusion** (check one)

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

# ADDENDUM E

***California Transplant Services, Inc.***
**Review of Contract Service**

**Name of Service:** California Transplant Services, Inc.

**Date of Review:** September 28, 2023

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

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

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

**Performance Metrics**

| METRIC | FY23 Q2 | FY 23 Q3 | FY 23 Q4 | FY24 Q1 | Cumulative Total |
|---|---|---|---|---|---|
| Maintains current American Association of Tissue Banks (AATB) Accreditation Certificate | 100% | 100% | 100% | 100% | 100% |
| Maintains current Food & Drug Administration (FDA) Tissue Bank Registration | 100% | 100% | 100% | 100% | 100% |
| Maintains current State of California Tissue Bank License | 100% | 100% | 100% | 100% | 100% |
| Maintains current certificate of Liability Insurance as stipulated in the terms of the contract | 100% | 100% | 100% | 100% | 100% |

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

**Conclusion** (check one)

√ Contract service has met expectations for the review period.

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

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

# ADDENDUM F

***Richard Bravo Intraoperative Monitoring Services***

**Review of Contract Service for FY23 (July 1, 2022 – June 30, 2023)**

**Name of Service:** Richard Bravo Intraoperative Monitoring Services
**Date of Review:** September 28, 2023
**Name / Title of Reviewer:** Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health

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

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

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

**Performance Metrics**

| METRIC | FY23 QTR 1 | FY23 QTR 2 | FY23 QTR 3 | FY23 QTR 4 | Cumulative Total |
|---|---|---|---|---|---|
| IOM equipment is clean and in good working order. | 100% | 100% | 100% | 100% | 100% |
| IOM Technician is professional, arrives on time and is competent in his / her duties. | 100% | 100% | 100% | 100% | 100% |
| No cancelled cases related to contracted service Key Performance Indicators (KPIs) | 100% | 100% | 100% | 100% | 100% |
| Contractor submits invoices for payment in a timely manner after service provided. | 100% | 100% | 100% | 100% | 100% |
| Contract employee is current in all screening requirements per terms of the contract. | 100% | 100% | 100% | 100% | 100% |

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

**Conclusion** (check one)

√ Contract service has met expectations for the review period

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

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

PALOMAR HEALTH

# ADDENDUM G

DocID: 11234
Revision: 22
Status: Pending Committee Approval

Source: Administrative Plans

Applies to Facilities: All Palomar Health Facilities

Applies to Departments: All Departments

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

I. **SUMMARY/INTENT:**

A. To outline the framework for a leadership driven, systematic, interdisciplinary approach to continuous improvement using our performance improvement model known as Plan, Do, Study, Act (PDSA). Our efforts will focus on all care and service outcomes for our patient populations and meet the mission, vision, and standards of excellence for Palomar Health as follows:

1. Mission: The mission of Palomar Health is to heal, comfort, and promote health in the communities we serve.
2. Vision: Palomar Health will be the health system of choice for patients, physicians, and employees, recognized nationally for the highest quality of clinical care and access to comprehensive services.
3. Values: Excellence, Teamwork, Service, Compassion, Trust and Integrity.
4. Palomar Health's Patient Safety Officer/s are the Senior Director of Quality/Patient Safety and the Medical Quality Officer.

II. **DEFINITIONS:**

A. Quality Assessment Performance Improvement (QAPI) Plan

1. QAPI is the merger of two complementary approaches to quality, namely Quality Assessment (QA) and Performance Improvement (PI). Both involve seeking and using information, but they differ in key ways:
   a. QA is a process of meeting quality standards and assuring that care reaches an exceptional level. Hospitals and health systems typically set QA thresholds to comply with regulations. They may also create standards that go beyond regulations. QA is the data collection and analysis through which the degree of conformity to predetermined standards and criteria are exemplified. If the quality, through this process is found to be unsatisfactory, attempts are made to discover the reason for this. On the basis of this, remedial actions are instituted and the quality reevaluated after a suitable time period.
   b. PI is a proactive and continuous study of processes with the intent to prevent or decrease the likelihood of problems by identifying areas of opportunity and testing new approaches in order to fix underlying causes of persistent/systemic problems. PI in hospitals and health systems across the care continuum aims to improve processes involved in health care delivery and quality of life.
   c. QAPI is a data-driven, proactive approach to improving the quality of care and services across the care continuum. The activities of QAPI engage members at all levels of the organization to: identify opportunities for improvement; address gaps in systems or processes; develop and implement an improvement or corrective plan; and continuously monitor effectiveness of interventions.
2. A Performance Improvement Project (PIP) typically is a concentrated effort on a particular problem in one area of the facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements.
3. Performance Improvement Activities (PIA), are typically smaller in scope than a PIP and focused at the unit level.
4. A Patient Safety Event is an event, or condition (not related to the natural course of the patient's illness or underlying condition) that could have resulted or did result in harm to the patient. Patient Safety events that reach a patient and result in death, permanent harm, or severe temporary harm, are also known as adverse events, sentinel events or never events.
5. A Good Catch/Near Miss is a patient safety event that does not reach the patient as a result of a built-in detection barrier, mitigation or chance.
6. An unsafe condition is neither a patient safety event nor a Good Catch/Near Miss but is a circumstance that make the occurrence of such an event more likely.

III. **AUTHORITY AND RESPONSIBILITY**

A. Governing Body
The Governing Body authorizes the establishment of this performance improvement program. This Governing Body is responsible for assuring:

1. An ongoing program for quality improvement is defined, implemented, and maintained.
2. An ongoing program for patient safety, including the reduction of medical errors, is defined, implemented, and maintained.
3. An organization-wide quality assessment and performance improvement efforts address priorities for improved quality of care, and patient safety and that all improvement actions are evaluated.
4. Clear expectations for safety are established.
5. Adequate resources are allocated for measuring, assessing, improving, and sustaining the health system's performance and patient safety.
6. A determination of the number of distinct improvement projects are conducted annually.

B. Medical Executive Committee / Quality Management Committee
The Governing Body delegates the development, implementation, and evaluation of this program to the Medical Executive Committee (MEC). The MECs are responsible for monitoring and improving the quality of care, safety and service provided by its medical staff. The MEC has formed a Quality Management Committee to carry out this responsibility.

C. Administration & Management
The Governing Body also delegates the development, implementation, and evaluation of this program to the organization's Administrative team. Administration is responsible for improving the quality of care, safety, and service provided by organization staff. The Administrative team has developed structures and processes to carry out this responsibility.

D. Further Delegation of Authority and Responsibility; the MEC and/or Administration & Management may further delegate aspects of this program as necessary.

IV. **CORE COMPONENTS**

A. The following are the core components of the framework:

1. Recognizing that defects are primarily from processes and systems, not people. Performance improvement will focus on systems, processes and outcomes.
2. Leadership driven by a commitment to a culture of safety and transparency that uses a  monitoring tool.
3. Data driven based on evidenced based practices using national benchmarks (when available) and comparative data.
4. Integrated and coordinated processes to engage all levels of leadership, physicians, employee staff, and community members as appropriate.
5. Proactive by design in order to sustain continuous performance improvement, promote high reliability, quality, safe patient care and services.
6. Communication through a common language created by an ongoing process to prioritize Quality Assessment/Performance Improvement opportunities using consistent methods and statistical tools that are the tenets of PDSA and when appropriate Lean- i.e., FOCUS is an acronym whose steps help to simplify the process of identifying the area of a healthcare organization that requires improvement, bringing together a team capable of achieving that improvement, and selecting the best possible solution to implement the improvement. (F - find a process to improve, O - organize the effort to work on improvement, C - clarify current knowledge of the process, U - understand process variation and capability, S - select a strategy for continued improvement.

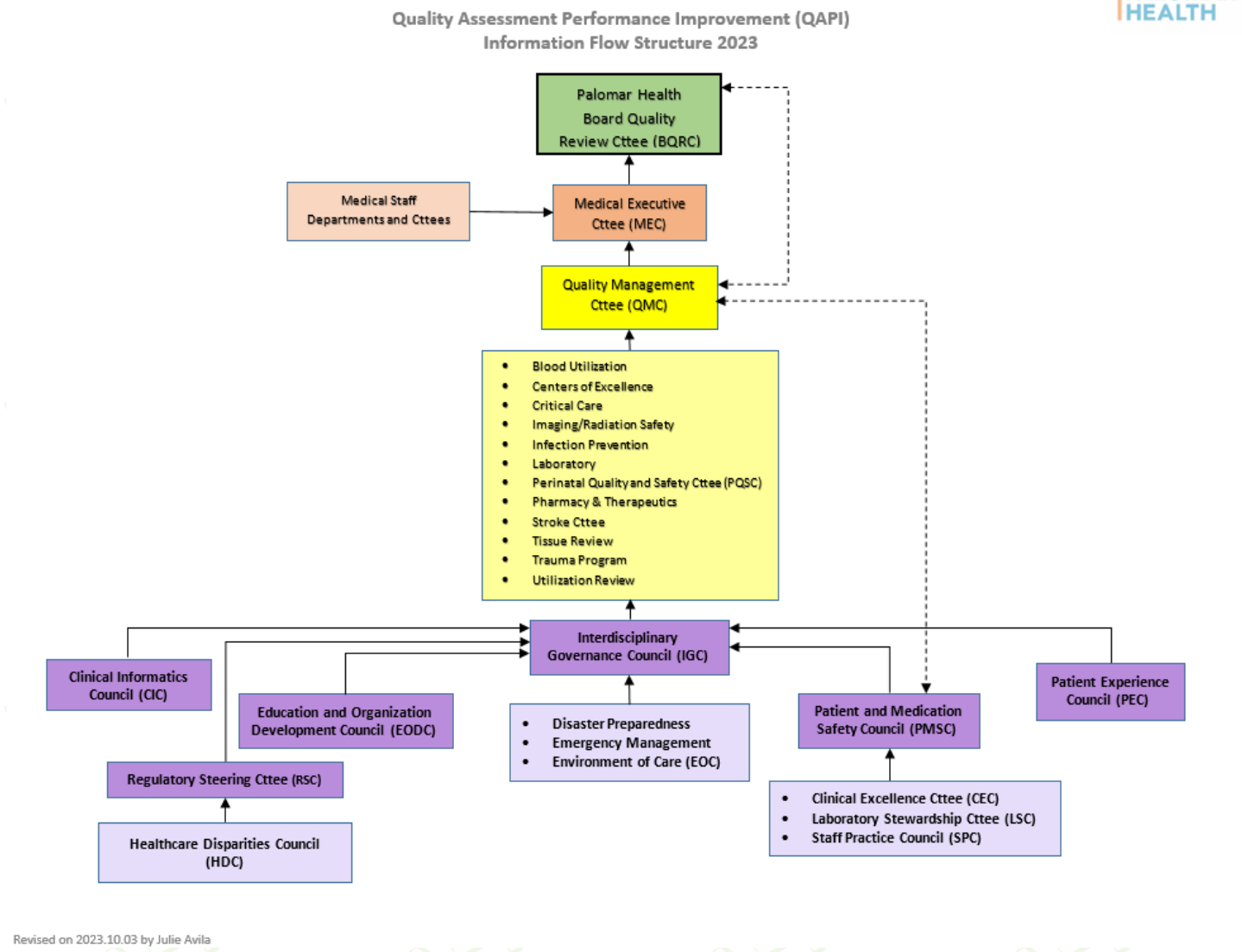
7. A calendar of reporting to ensure ongoing systematic communication to all key constituents, ensure accountability and maintain the ongoing improvement gains for all continuous quality assessment/performance improvement activities.
8. Educational programs and meetings to enhance statistically-based quality assessment/performance improvement tools for every level of leadership, physicians, and staff.
9. Standardized processes for investigation of events and followup on Good Catches/Near Misses, Patient Safety Events, Sentinel Events and unsafe conditions. These standardized processes address:
    a. An investigation into the cause of the adverse event may be undertaken pursuant to the Medical Center's Review Process.
    b. The investigation would be conducted for the purpose of the evaluation and improvement of the quality of care.
    c. What practice/process change is required to prevent recurrence.
    d. How the practice/process change will be accomplished.
    e. Who is responsible for the practice/process change.
    f. Timeline for completion.
    g. Description of the monitoring and sustainment of processes to prevent a recurrence.

V. **GOALS**

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

B. The organization has an effective program that assesses the quality and safety of its services including Local, State, and Federal regulations to identify opportunity for improvement, and works to address those opportunities. Services include but not limited to:
1. Management of the Care Environment - to include but not limited to, risk assessments and environmental surveillance as it pertains to patient safety. Refer to Safety Management Plan # 11495.
2. Management of the Medical Record
3. Infection Prevention and Control and Antibiotic Stewardship
4. Patient Rights
5. Medication Management
6. Anesthesia Services
7. Dietary Services
8. Discharge Planning
9. Laboratory Services
10. Nuclear Medicine Services
11. Nursing Services
12. Operative and Invasive Services
13. Outpatient Services
14. Radiology Services
15. Rehabilitation Services
16. Respiratory Services
17. Contracted Services:
    a. All contracted services including patient care services, and all other services, provided under a clinical contract are subject to the same hospital-wide quality assessment and performance improvement (QAPI) evaluation as other services provided directly by the hospital. The hospital will assess the services furnished directly by hospital staff and those services provided under contract, identify quality, assigned performance metric for compliance and identify corrective or improvement activities for those metrics or elements that are less than the established thresholds.
18. Patient Grievances - The hospital's Governing Body has delegated the grievance process to the Quality/Patient Safety Department. The Quality/Patient Safety department receives, reviews, and collaborates with appropriate unit/department leader and/or physician, in addition to, but not limited to; Regulatory, Finance, and Risk Management for review and investigation. Upon completion of the investigation, a letter will be sent to the complainant informing them of the outcome. Outcome data will be presented to various stakeholder meetings including up to the Governing Body.

VI. **REPORTING STRUCTURE, RESPONSIBILITIES, AND CONSTITUENTS OF THE QAPI PLAN**




A. **Board Quality Review Committee (BQRC)**:
1. Duties:
   a. Pursuant to the BQRC bylaws. The Board Quality Review Committee shall review the prioritized proposed performance improvement projects and patient safety activities and shall report to the governing body.
2. Composition:
   a. Voting Membership: The committee shall consist of five voting members, including three members of the Governing Body and the Chairs of the Quality Management Committee (QMC) of Palomar Medical Center Escondido and Palomar Medical Center Poway. Nonvoting Members include: The President and Chief Executive Officer; the Chief Medical Officer; Medical Quality Officer; the Chief Legal Officer; the Chief Nurse Executive, Senior Director of Quality/Patient Safety.

B. **Medical Staff Executive Committees (MEC):**
1. Duties:
   a. The Medical Executive Committee (MEC) is the primary governance committee for the independent medical staff. The MEC, with input from the medical staff, makes key leadership decisions related to medical staff policies, procedures, and rules, with an emphasis on quality control and quality improvement initiatives. They are also responsible for adopting and implementing medical staff policies and procedures and creating medical staff appointment and reappointment criteria.
   b. The MEC reviews and approves all recommendations submitted by the Quality Management Committee and initiate any special studies or recommendations as deemed appropriate to maintain an effective program.
2. Composition:
   a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the Medical Staff Bylaws.

C. **The Quality Management Committee (QMC) of the Medical Staff**:
1. Purpose:
   a. The Quality Management Committees of the Medical Staff will regularly review specified performance metrics recognized as measurements of quality and safety, including but not limited to: blood usage, medication usage, pharmacy and therapeutics, nutrition, medical record timeliness, special care review, utilization review, nursing sensitive indicators (e.g., falls, hospital acquired pressure injuries, and medical restraint use), infection control, patient safety, and other items identified by this committee and in the body of this plan. Appropriate summaries and recommendations first referred to the appropriate clinical departments and subcommittees are then forwarded to the respective Medical Staff Executive Committee for review and approval.
   b. The QMC reviews and prioritizes proposed performance improvement projects as recommended by the Interdisciplinary Governance Council (IGC).
   c. The QMC provides oversight for the Quality Assessment Performance Improvement (QAPI) activities of medical staff, nursing, and clinical departments and committees.
2. Composition:
   a. The Committee has Physician Chairs (preferably the Chief of Staff-elects at each licensed acute care facility). Committee members will include the department chairs-elect of the medical staff or their designee, along with representatives from Medical Staff, Administration, Nursing, Department Directors, and staff responsible for overseeing quality assessment and performance improvement activities.

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

D. **Interdisciplinary Governance Council (IGC)**:
   1. Purpose: The Interdisciplinary Governance Council is responsible for providing oversight and approval for all councils in the IGC infrastructure. The Governance Council will work closely with the Regulatory Steering Committee and QMC. The intention is to improve communication, efficiency, and effectiveness in regard to decision making and to provide a mechanism and structure for a communication and approval process that will expedite process improvement changes as well as implementation.
   2. Governance: The IGC is the oversight council for Learning and Organizational Development Council (LODC), Clinical Informatics Council (CIC), Patient and Medication Safety Council (PMSC), Patient Experience Council, the Regulatory Steering Committee, Environment of Care Committee and Disaster Preparedness Committee. The Staff Practice Council (SPC) reports up to PMSC.

E. **Clinical Informatics Council (CIC):**
   1. Purpose: The Clinical Informatics Council is an interdisciplinary group whose purpose is to serve as the oversight body for all clinical Informatics projects. The council discusses and oversees clinical informatics requests, and change orders to determine priority and provide feedback and support to the end users. This council is the team that advises on priorities and recommendations regarding electronic health record (EHR) support for safe patient care.
   2. Governance: The CIC will make recommendations for final approval to the Interdisciplinary Governance Council based on the authority level granted. Recommendations regarding project prioritization, strategy, or capital expense will then be referred to the IT Steering Committee.

F. **Learning and Organizational Development Council (LODC):**
   1. Purpose: The purpose of the Learning and Organizational Development Council (LODC) is to develop, implement, evaluate, and provide oversight over integrated education and leadership development plan that meets regulatory requirements, as well as to facilitate implementation of strategic initiatives that support a culture of excellence.
   2. Governance: The LODC will make recommendations regarding education plans and practices to the IGC for approval.

G. **Regulatory Steering Committee (RSC):**
   1. Purpose: The purpose of the Regulatory Steering Committee is to provide guidance and oversight for the implementation and monitoring of CMS Conditions of Participation (CoP), Title 22 and the Joint Commission (TJC) accreditation standards for maintaining Medicare Reimbursement and Quality Accreditation approved status as an organization. The oversight and guidance also applies to all applicable local, state, and federal regulatory regulations across the system.
   2. Governance: The RSC will provide a report to the IGC on a regular basis and any recommendations to IGC for approval.

H. **Patient and Medication Safety Council (PMSC)**:
   1. Purpose: The purpose of the Patient and Medication Safety Council includes but not limited to the following: Promote a culture of safety through oversight and implementation of the Quality Assessment and Performance Improvement (QAPI) Plan. The council will ensure the development of documents, policies, procedures, and practices that reflect evidence-based practice (EBP) and meet the standards of professional organizations, state and federal professional practice acts, scopes of practice, as well as regulatory standards. Incorporates Medication Safety reports and Medication Error Reduction Plan (MERP) updates. Supports medication safety and recommendations for process improvement projects that will facilitate an interdisciplinary approach to the Plan, Do, Study, Act (PDSA) model for daily work processes. Review Sentinel Event Alerts (SEA), Institute for Safe Medication Practices (ISMP), and National Patient Safety Goals (NPSG) and discuss follow up, as appropriate. Recommend Failure Mode Effects Analysis (FMEA) for approval and review and monitor performance improvement activities that have been performed.
   2. Governance: PMSC will make recommendations and project proposals from councils/committees that report to PMSC to the IGC for updates and approval. PMSC has a dotted line directly to QMC to report out any information solely for quality improvement purposes in accordance with California Evidence Code 1157.

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

J. **Patient Experience Council (PEC)**:
   1. Purpose: The purpose of the Patient Experience Council is to provide oversight and guidance on achieving and sustaining patient centered care. The council will oversee the development, implementation and monitoring for all best practices, performance metrics, policies and procedures that enhance and/or promote the ideal patient and family experience while always advocating for the communities we serve, aligning with our mission, vision, and values.
   2. Governance: The PEC will make recommendations regarding performance improvement plans and best practices to the IGC for approval.

K. **Staff Practice Council (SPC)**:
   1. Purpose: The purpose of the Staff Practice Council (SPC) is to facilitate staff input and feedback from an interdisciplinary perspective into decisions effecting patient care and professional practice. The council also seeks to enhance sharing and reporting of unit/dept. specific work plans related to the Plan for Patient Care Services, the organizational strategic plan related to clinical practice, patient and employee satisfaction, and quality and patient safety. The work, conversations, and recommendations from the council should be based on the Relationship Based Care model. The SPC serves as an Interdisciplinary fall team for the system. Teams reporting into SPC include: Nursing Peer Review; Safe Patient Handling and Patient Classification.
   2. Composition: The SPC will be made up of representatives of the Unit/Department Based Practice Council Chairs, a sponsor from the Patient and Medication Safety Council (PMSC), and staff representatives from teams that have been meeting to make decisions with staff input (e.g. Nursing Peer Review, Patient Classification, and Safe Patient Handling).
   3. Governance: This council will report to the PMSC. The PMSC will provide guidance and mentoring for professional practice. Sponsors will provide updates from (PMSC) and also the IGC.

L. **Medical Staff Committees:** Pursuant to the Medical Staff Bylaws, Medical Staff departments and committees are responsible for the quality of care, service and safety of patient care delivered by the members of their respective departments. Medical Staff Departments and Committees shall demonstrate quality assurance and performance improvement by:
   1. Participating in departmental and quality assessment/performance improvement activities.
   2. Utilizing results and recommendations from interdisciplinary performance improvement efforts to improve services.
   3. Utilizing information from the Medical Staff Peer Review Committee (MSPRC) and Quality Department that includes data addressing each of the six physician core competencies for credentialing, privileging and the reappointment process.
   4. Reviewing and analyzing summary reports of trended data reported out by department and/or by physician for processes dependent primarily on the activities of one or more individuals with clinical privileges.
   5. Sharing responsibility for planning, designing, measuring, assessing, and improving the overall safe care of patients.

M. **Medical Staff Peer Review Committee (MSPRC):**
   1. Duties:
      a. Review cases referred by physicians and staff or by screening criteria with the goal of improving physician performance at the individual and aggregate levels, improving patient outcomes, and supporting a culture of compassion and respect.
      b. Promote efficient use of physician and quality staff resources.
      c. Provide accurate and timely performance data as available for physician feedback and Ongoing Professional Practice Evaluation (OPPE).
      d. Recognize physician excellence in addition to identifying system improvement opportunities.
   2. Composition:
      a. The specific composition, responsibilities, meeting requirements, and reporting requirements are as specified in the respective Medical Staff Peer Review Charter for each facility.

N. **Critical Care Committee (CCC)**:
   1. Duties: The District Wide Critical Care Committee is responsible for:
      a. Identifying indicators for monitoring the important aspects of critical care.

b. Evaluating results of data collected for these indicators.
c. Making recommendations for actions to improve care or correct identified problems.

2. Composition: Co-chairs, both of whom will be Medical Directors of ICU, along with broad representation from appropriate areas of the Medical Staff, Administration, Nursing and other disciplines as appropriate.

O. **Subcommittee of Critical Care - Code Blue Committee**:

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

P. **Imaging Services - District Radiation Safety Committee (RSC)**:

1. Duties:
   a. The RSC will regularly review metrics recognized as measurements of quality and safety and safety in radiation safety and protection. Metrics reviewed include, but are not limited to, dosimetry badge readings, medical physicist reports, and fluoroscopy quality assurance.
2. Composition:
   a. The Committee Chair is the Radiation Safety Officer (RSO). Committee members will include representatives from Imaging Services, Surgical Services, Interventional Radiology, Cath Lab, Radiation Oncology, Administration, nursing representation and a medical physicist.

Q. **Infection Prevention and Control Committee (IPCC):** The District wide Palomar Health Infection Prevention and Control Committee is responsible for carrying out the following:

1. Duties:
   a. Develop and maintain an Infection Prevention and Control program that reflects the Mission and Vision of Palomar Health. The program includes Quality and Regulatory Standards developed by The Joint Commission (TJC), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), California Department of Public Health (CDPH), and other nationally recognized organizations as appropriate.
   b. To ensure implementation of prevention measures, and monitoring outcomes with the ultimate goal of preventing and controlling infection transmission among patients, employees, medical staff, contracted service workers, and volunteers.
   c. The IPCC reports directly to the Quality Management Committee.
   d. To provide structure for an organization-wide, facility specific approach to identify and reduce the risk of endemic and epidemic healthcare associated infections (HAI). To ensure optimal provision of services, the management of the infection prevention and control process is assigned to qualified personnel by virtue of education, training, licensure, experience or certification.
      i. Application of epidemiological principles, including activities directed at improving patient outcomes using implementation science.
      ii. Implementation of changes mandated by regulatory, accrediting, and licensing agencies.
      iii. Education efforts directed at interventions to reduce infection risk.
      iv. Consultation on risk assessment, prevention, and control strategies (includes activities related to occupational health, construction, and emergency management.
      v. Development and review of procedures and evaluation of products.
      vi. Review and analysis of surveillance data.
   e. The hospital has designated one or more individual(s) as its Infection Control Officer(s). The Infection Control Officer(s) is/are qualified and maintain(s) qualifications through education, training, experience or certification related. The Infection Control Officer(s) have the authority and responsibility for ensuring the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the Infection Prevention and Control Program. The IPCC through its chairperson and Senior Director of of Quality and Infection Prevention and Control Program are the Infection Control Officers. The Infection Control Officers are granted the authority to institute any appropriate emergency measures throughout the health system when there is reasonable risk or danger to any patient, personnel, or visitors as it relates to Infection Prevention and Control.
2. Composition:
   a. The Committee is composed of a physician chair who is an infectious disease specialist, and representatives but not limited to: Infection Prevention, Nursing, Administration, and personnel responsible for overseeing facility infection control activities, (e.g., The Villas at Poway, Peri-operative Services, Facilities, Environmental Services, Food and Nutrition, Pharmacy and Corporate/Employee Health, Lab, Respiratory Services, and Wound Care).

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

A. Duties:
   1. Develop and implement written policies and procedures for the establishment of safe and effective systems of procurement, storage, distribution, dispensing and use of medications.
   2. Develop and maintain a formulary of drugs throughout the hospitals.
   3. Monitor the quality and appropriateness of nutritional support services to patients, including enteral and parenteral nutrition, and clinical dietary consultations.
   4. Review Adverse Drug Reaction Event Program.
   5. Review Medication Error Reduction Plan at least annually.
   6. Make recommendations to improve care or to correct identified problems to the Quality Management Committee based on analysis and evaluation of data collected through indicators.
   7. Refer to the Chair of either Palomar Medical Center Escondido (PMCE) or Palomar Medical Center Poway (PMCP) any matter within the scope of the Medical Staffs' responsibilities for performance improvement as appropriate.
   8. The P&T committee will report to the Quality Management Committee.
B. Composition:
   a. The minimum committee quorum shall consist of the Physician Chair, the Director of Pharmaceutical Services or representative, the Chief Nurse Executive or representative, a System Administrator or representative. Representatives from Medical Staff, Nursing, Laboratory, Nutritional Services and Allied Health Care Staff may also participate on the committee.

S. Subcommittees of P&T:

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

B. **Antibiotic Stewardship Subcommittee:**
   1. Duties: In view of the dramatic increase in antibiotic resistance, the Antibiotic Stewardship Subcommittee's responsibilities include, but are not limited to:
      a. Reviewing new antimicrobial agents.
      b. Reviewing antibiotic usage and expenditures, including restricted antibiotics.

c. Developing empiric treatment guidelines, protocols, and Power Plans to minimize the development of resistance organisms.

2. Composition: The Antibiotic Stewardship Subcommittee is comprised of one or more Infectious Disease Physicians, Physicians representing various medical specialties, Antibiotic Stewardship Pharmacist, a Microbiology Representative from the Laboratory and an Infection Preventionist.

C. **Controlled Substance Diversion Prevention Committee (CSDPC):**

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

**VII. NON-MEDICAL STAFF QAPI COMMITTEES AND FUNCTIONS**

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

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

B. **Centers of Excellence - Cardiovascular and Total Joint Replacement (PMCE and PMCP) and Spine Surgery (PMCE)**

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

C. **Perinatal Quality and Safety Committee (PQSC)**

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

D. **Stroke Committee:**

1. Duties:
   a. Provide oversight, coordination and direction to the individuals caring for the stroke patients.
   b. Evaluate appropriateness and adequacy of the program through a review of clinical practice guidelines, power plans, and procedures.
   c. Coordinate education programs for staff and the community we serve.
   d. Monitor, analyze, and evaluate stroke measures; identify opportunities for improvement; share recommendations and outcomes.
   e. Participate in the Palomar Health Quality Assessment and Performance Improvement program.
   f. Maintain Joint Commission Stroke Program certification standards.
   g. Stroke Committee will report through the Quality Management Committee.
2. Composition:
   a. The committee is chaired by the Stroke Medical Director and facilitated by the Stroke Coordinator.
   b. The committee is comprised of a multidisciplinary team of health professionals including Administrative Leaders; Medical Staff: Neurology, Neurosurgery, Neuro-Interventionist, Emergency, Critical Care, Anesthesiology, and Hospitalist, Stroke Program Coordinator, Pharmacy, Nursing; Radiology, Laboratory, Rehabilitation Services, Case Resource Management, Patient Access and Quality.

E. **Laboratory Services: Quality**

1. Duties: Laboratory Services: Lab Quality includes, but are not limited to:
   a. Review and approve monthly Lab Quality indicators and Blood Bank audits.
   b. Collects data by reviewing QA variance reports and summarizing by month and year on the Laboratory QA and QM Database, Laboratory Leadership Committees make recommendation to improve laboratory services and quality to Laboratory Executive Management and the Laboratory Medical Director based on analysis and evaluation of data collected through indicators and performance metrics. Changing regulatory requirements will also prompt policy and procedure review.
   c. Identify opportunities for process improvement from staff feedback, variance reports, QRR reports, and quality indicator results.
   d. Evaluate results of monthly ED turnaround time report.
   e. Review actions and decisions with Medical Laboratory Director.
2. Composition:
   a. The District Laboratory Director chairs the Laboratory Quality Committee and is co-chaired by the District Laboratory Managers. Members include the Medical Laboratory Director, Clinical Laboratory Scientist Supervisors, shift supervisors and section leads.

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

G. **Environment of Care (EOC) Committee**:
   1. Duties: Specific responsibilities include, but are not limited to the following:
      a. Development and review of procedures
      b. Develop and monitor the Environment of Care management plans, Hazardous Materials and Waste program, and the Illness and Injury Prevention program.
      c. Environmental Surveillance, Safety Education and Product Recall Monitoring.
      d. Monitor the results of regulatory inspections and refer to Regulatory Steering Committee.
      e. Analyze and aggregate data. Recommendations are developed and approved as applicable.
      f. This committee will report up through the Interdisciplinary Governance Committee.
   2. Composition:
      a. The Committee is composed of the Chair and Co-Chair, Facilities, Risk Management, Security, Employee Health, Biomedical Engineering, EVS, Infection Control as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

H. **Disaster Preparedness Committee (DPC):**
   1. Duties: The District Wide Disaster Preparedness Committee is responsible for ensuring:
      a. Develop and review of procedures.
      b. Develop and monitor the Emergency Management Program.
      c. Disaster planning and disaster related activities are managed and implemented.
      d. Ensure meetings are scheduled and information, progress notes, and follow-up activities from this committee are reported to the Environment of Care Committee.
      e. This committee will report up through the Interdisciplinary Governance Committee.
   2. Composition:
      a. The Committee is composed of the Chair and Co-chair, Facilities, Risk Management, Security, Infection Control, Emergency Department as well as representatives from the multidisciplinary team of healthcare professionals and ancillary departments. These professionals include but are not limited to Administration and Nursing.

I. **Continuum Care Operations Division:**
   1. Purpose: Under the direction of the Vice President, the Continuum Care Directors, the Continuum Care Operations Division promotes improvement of patient safety and outcomes by providing an organization-wide approach for continually assessing and improving the quality of health services that we provide to our patients, employees, and community outside our acute care facilities. Under the oversight of the Vice President, Continuum Care, the Continuum Directors are responsible for the performance improvement and patient safety program at the departmental level within their respective specialties. The ongoing monitoring and analysis of Quality indicators are based on the following:
      a. Identification of patient needs and expectations and evaluation of how these needs and expectations are met
      b. Identification of staff education and training needs and ongoing measurements to demonstrate sustained iimprovement
      c. Use of evidence-based data from internal and external sources to improve the quality of care
      d. Integration and coordination of quality initiatives across the care continuum including: acute care, skilled nursing, and ambulatory services
      e. Analysis of data to establish priorities and identify opportunities for future improvement
   2. Entities under the umbrella of the Continuum Care Operations Improvement Function include:
      a. The Villas at Poway Quality Committee
      b. Rehabilitation Services
      c. Ambulatory Specialty Outpatient Services
   3. The performance improvement measures that reflect a direct contribution of Continuum Care achieving quality and safe patient care outcomes may include:
      a. Physician and Employee Engagement
      b. Patient Experience
      c. Risk
      d. Regulatory or accreditation requirements
      e. Patient and community outcomes
      f. CMS Quality Indicators for Skilled Nursing

**VIII. METHODS:**

A. Understanding that performance improvement and patient safety permeate every level of the organization. The Palomar Health Leadership Team empowers and assigns individuals to lead these by providing time and resources to achieve optimal outcomes.
B. Whenever possible, sound statistical methods and the techniques of continuous quality improvement will be utilized. In most projects, a Plan-Do-Study-Act Cycle (PDSA) methodology model will be used.


C. Prioritization: When selecting Quality Assessment Performance Improvement (QAPI) projects, Palomar Health leaders recognize the importance of using criteria to do ongoing prioritization of Quality Assessment Performance Improvement projects. A focus is on high risk, high volume, problem prone areas and the effects on outcomes, patient safety and quality of care. Therefore, proposed projects will be coordinated to avoid duplication of efforts.

D. Designing Processes: When creating or modifying programs and/or processes, consideration is taken to ensure the design:

1. Is consistent with the mission, vision, values, goals, objectives and plans;
2. Meets the needs of individuals served, staff and others;
3. Is clinically sound and current (for instance, use of best practice guidelines, successful practices, information from relevant literature, and clinical standards);
4. Incorporates available information from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel events in order to minimize risks to patients affected by the new or redesign processes, functions, or services;
5. Utilizes tools and methods to proactively identify risk points and eliminate them prior to implementing changes;
6. Includes analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement; and
7. Incorporates the results of Quality Assessment Performance Improvement activities.
8. Data Collection: Data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement. Collected data is used to:
    a. Compare performance about processes and outcomes through the use of reference databases.
    b. Compare performance data about processes with information from up-to-date sources.
    c. Make comparisons of performance of processes and outcomes over time.
    d. Data is collected on important processes and outcomes and includes, but is not limited to, key processes related to:
        i. Leadership Priorities
        ii. Reducing Disparity in Health Care
        iii. Code Blue and Rapid Response
        iv. Patient Safety
        v. Environment of Care
        vi. Patient Experience
        vii. Pain Management
        viii. Medication Management
        ix. Blood and Blood Products
        x. Restraint and Seclusion
        xi. Operative and Other Invasive Procedures
        xii. Organ Procurement
        xiii. Resuscitation
        xiv. Risk Management
        xv. Infection Control Healthcare Associated Infections and Antimicrobial Stewardship
        xvi. Imaging Services
        xvii. Laboratory Services
        xviii. Patient Grievances
        xix. Contracted Services Evaluations
    e. Benchmarks: Whenever available, benchmarks from local, state and national databases and medical literature will be obtained and used. Available bench marking systems include but are not limited to:
        i. The Joint Commission (TJC)
        ii. Centers for Medicare & Medicaid Services (CMS) through CMS.Gov
        iii. Society of Thoracic Surgeons Cardiac Surgery Database
        iv. Center for Disease Control and Prevention (CDC) Database
        v. National Database for Nursing Quality Indicators (NDNQI)
        vi. Department of Health Care Access and Information (HCAI)

E. Palomar Health is a member of the California Hospital Patient Safety Organization (CHPSO) and Health Services Advisory Group (HSAG).

F. Best Practice Core Measures: Proactively engaged with bench marking systems performance through their involvement with The Joint Commission (TJC) and Centers for Medicare & Medicaid Services (CMS) in order to continuously seek out opportunities to improve our performance based on best practices, such as those promulgated by the National Quality Forum.

G. Data Assessment: The data is organized for reporting purposes in a manner that allows for analysis of the results. Data is systematically aggregated and analyzed on an ongoing basis:

1. Aggregated data is analyzed to make judgments about:
    a. Whether design specifications for processes were met
    b. The level of performance and stability of important existing processes
    c. Opportunities for improvement
    d. Actions to improve the performance of processes
    e. Whether changes in processes resulted in improvement
2. Appropriate statistical techniques are used to analyze and display data. These techniques include, run charts, control charts, Pareto charts, and other statistical tools as appropriate.

H. Failure Mode and Effects Analysis (FMEA): involves the prospective evaluation of processes identified by the organization as being vulnerable to risk and the redesign of such processes to build safety in (e.g., through creating redundancies) before an adverse event occurs.

I. Root Cause Analysis (RCA): When a serious, unexpected adverse outcome or near-miss occurs, the RCA process may be used to determine the most basic or immediate factor(s) or causes of why the event occurred. The RCA process is a systematic approach to understanding the causes of an adverse event and identifying system flaws that can be corrected to prevent the error from happening again. RCAs are retrospective, focus on system issues rather than blame, and are not appropriate in cases of negligence or willful harm. An action plan is then identified and monitored.

J. Improving and Sustaining Performance: Changes to improve performance are identified, planned, tested, and audited using the PDSA Cycle Model. Effective changes are incorporated into standard operating procedure.

K. Training and Education: Training and Education in performance improvement/patient safety and reporting events is provided throughout the organization.

L. Communication:

1. Communication of Performance Improvement/Patient Safety activities throughout the Medical Staff and Hospital Staff occurs through a variety of means including:
    a. Through the QAPI Committee structure, e.g., the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and Medical Staff Committees.
    b. Through newsletters, memos, education programs, and educational offerings.
2. QAPI reports are communicated to the Board Quality Review Committee, Quality Management Committee, Interdisciplinary Governance Council, Patient and Medication Safety Council, and other clinical committees according to the calendar of reporting.

M. Confidentiality:

1. Data generated by the QAPI Program are considered to be products of the Quality Management Committee of the applicable health facility and are protected from discoverability under Section 1157 of the California Evidence Code. Practitioners and Palomar Health personnel have a duty to preserve this confidentiality.
2. The performance improvement activities must abide by the Confidentiality of Medical Information Act in maintaining the confidentiality of the patient's medical information. Compliance is also maintained with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations.

N. Conflict of Interest:

1. A Practitioner may not participate in the review of any case in which he has been or anticipates being professionally involved. Practitioners having either a direct or indirect financial interest in the case(s) being reviewed may not participate in the utilization review activities pertaining thereto.

O. Annual Reappraisal: This QAPI plan is reviewed annually to evaluate the overall effectiveness considering such factors as results achieved, operational problems encountered, and deficiencies noted. The Plan with any amendments will be forwarded to the Board of Directors Quality Review Committee for final approval.

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|---|---|
| **Document Owner:** | Martinez, Valerie A |
| **Approvals** | |
| **- Committees:** | ( 10/11/2023 ) Quality Management (QMC) (joint), ( Not yet approved ) Medical Executive Committee, Escondido, ( Not yet approved ) Medical Executive Committee, Poway |
| **Revision Date:** | |
| **Standards:**<br>(WHICH REFERENCE THIS DOCUMENT) | **College of American Pathologists:**<br>• Laboratory General - GEN.13806<br>• Laboratory General - GEN.13806<br>• Laboratory General - GEN.13806 |
| **Attachments:**<br>(REFERENCED BY THIS DOCUMENT) | Quality Assurance Plan in Surgical Pathology<br>Patient Safety Event Response, Investigation and Follow-Up<br>patientsafetyreport@jointcommission.org<br>Patient Complaint/Grievance Process<br>CMS.Gov<br>COVID-19 Exposure Control Plan<br>Reducing Disparity in Health Care<br>Safety Management Plan |

PALOMAR HEALTH

**ADDENDUM H**

# Annual Dept of Radiology Report
*Quality Assurance*

## Presented to Board Quality Review Cttee

**Dr. Charles McGraw**
*Chair, Department of Radiology, PMC-Escondido*

# Department of Radiology Report to Board Quality Review Committee

| | |
|---|---|
| **SITUATION** | Report on the number of discrepant FINAL reports for San Diego Imaging (SDI) and Synthesis and accuracy of Statrad preliminary interpretations |
| **BACKGROUND** | • This quality assurance measure is to evaluate reported errors by SDI and Synthesis, respectively as well as ensure accuracy of interpretation of preliminary reads by Statrad.<br>• For every preliminary Statrad interpretation, there is a final ('over-read') by an SDI radiologist. If there is discrepancy, the ordering physician is typically notified and this discrepancy is recorded. It is then reviewed and scored (as listed below).<br>• Conversely, SDI and Synthesis are reported discrepancies mostly reported by SDI radiologists, notified by various other physicians, including members of Medical Staff Peer Review Committee (MSPRC). Similar feedback to radiologist and ordering physician also occurs.<br>• This data is typically collected every 6 months. This is collated and reviewed by Dr. Brian Goelitz, new director of Quality Assurance (QA). There is no benchmark for this, but rather trends. |
| **ASSESSMENT** | • There is overall a low rate of reported errors across SDI, Synthesis and Statrad. |
| **RECOMMENDATION** | • Continue to monitor and trend, provide feedback to radiologist.<br>• Potentially move toward Peer Learning, as previously planned.<br>• Will report out again during next Quality Medical Committee (QMC) Biannual Department of Radiology report. |

# PMC Radiology Coverage

## Previous (Pre-April 2023)

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

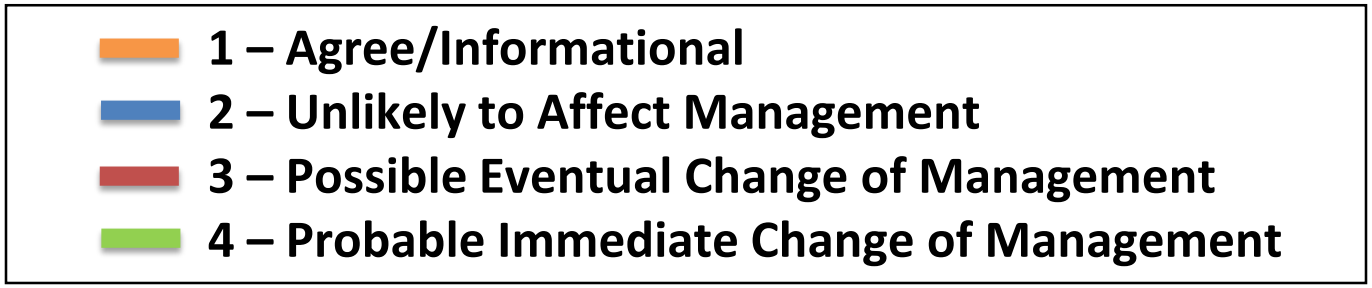
## Current (Post-April 2023)

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

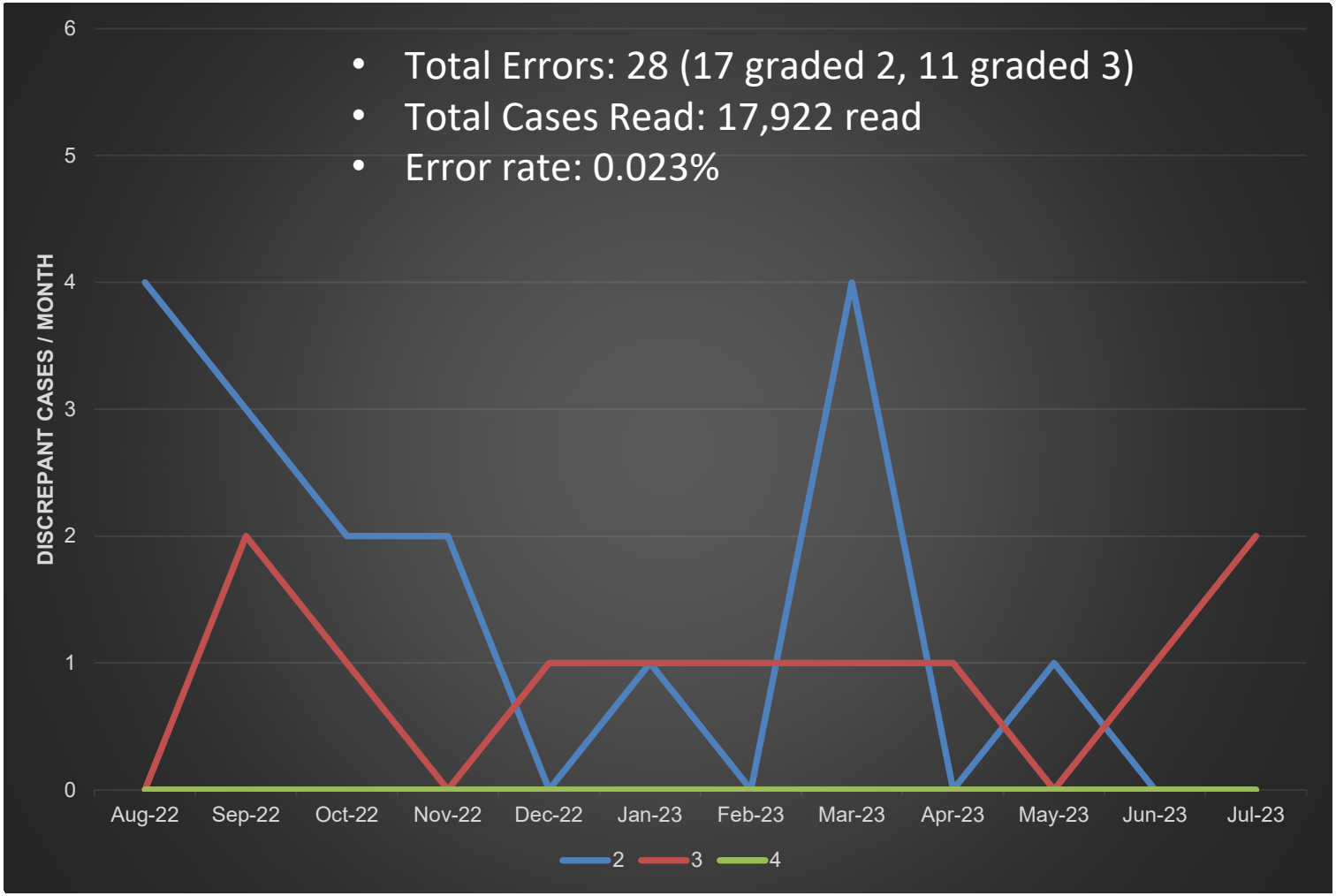
# Process of Quality Assurance

- Plan of transitioning to Peer Learning – delayed; departure of Dr. Pinnell, prior QA Director
- Studies flagged by SDI radiologist or requested to be submitted by other physician
  - Submitted by emailing to QA@sandiegoimaging.com or via eRadReview app
- Dr. Goelitz reviewed 168 studies submitted from 8/2022 to 7/2023
- Studies scored as follows:

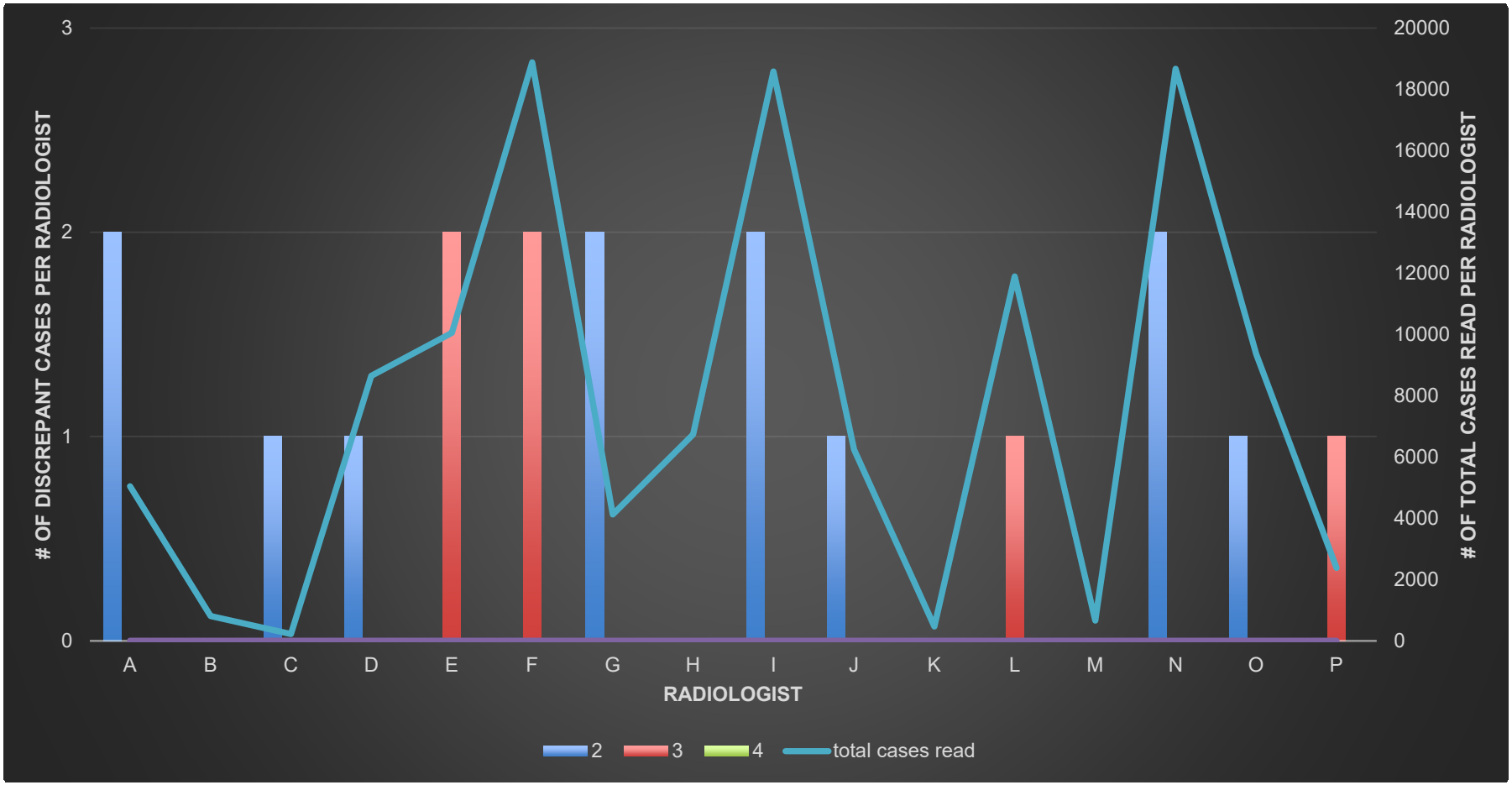
# Scoring Errors/Discrepancies



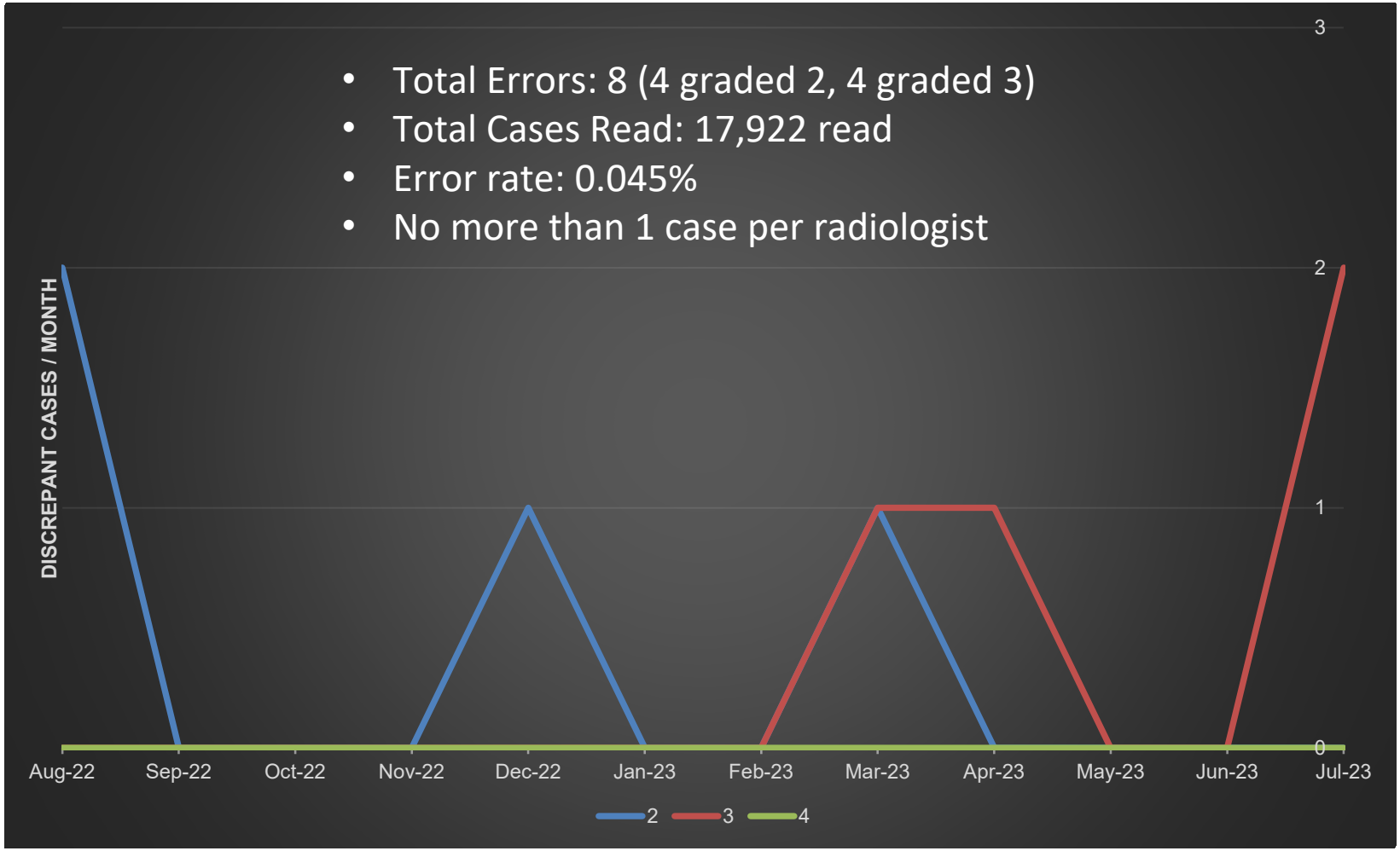
# SDI QA Errors by month



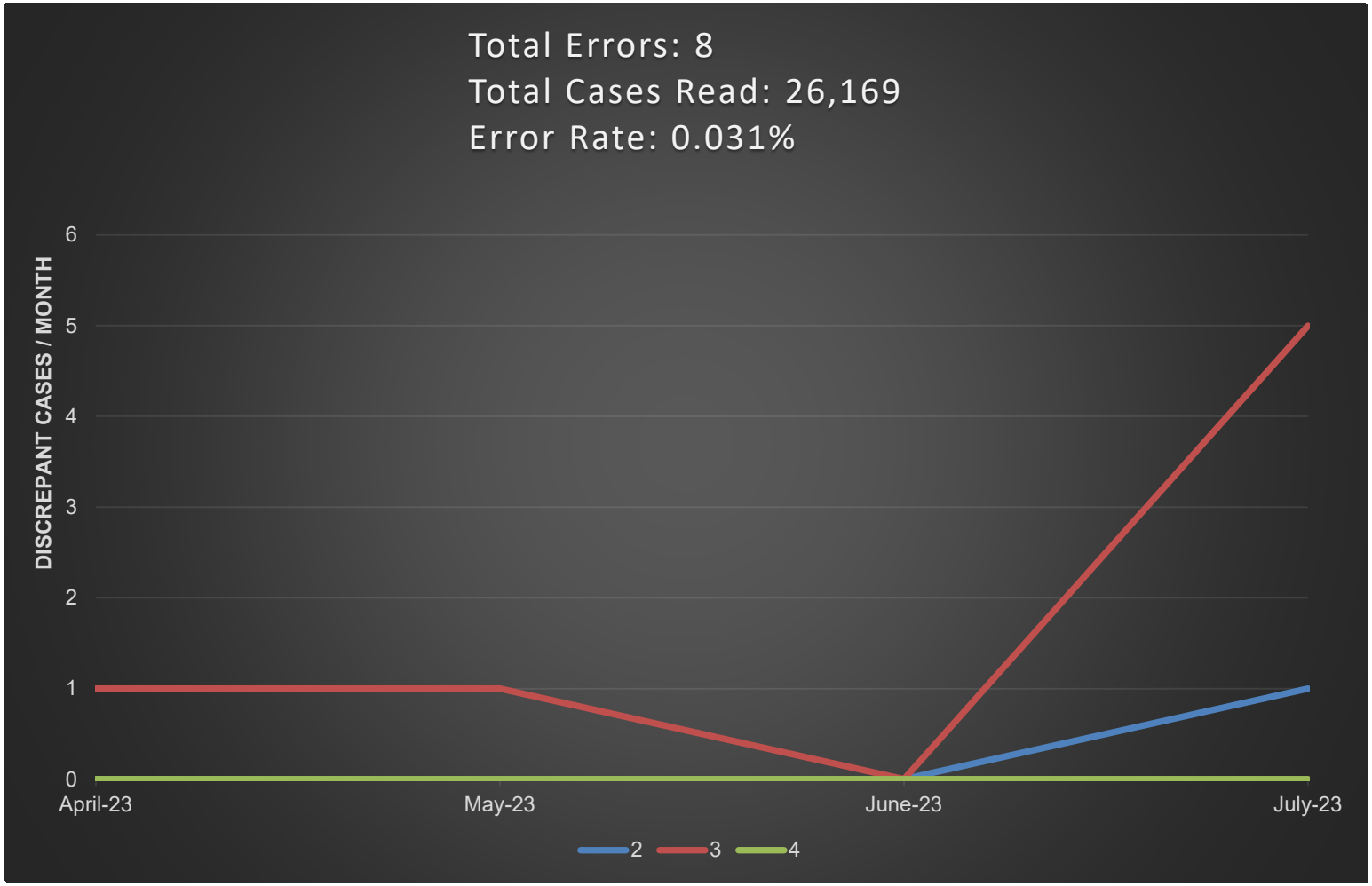
# SDI Discrepancies Compared to Total Cases Read (8/22-7/23)



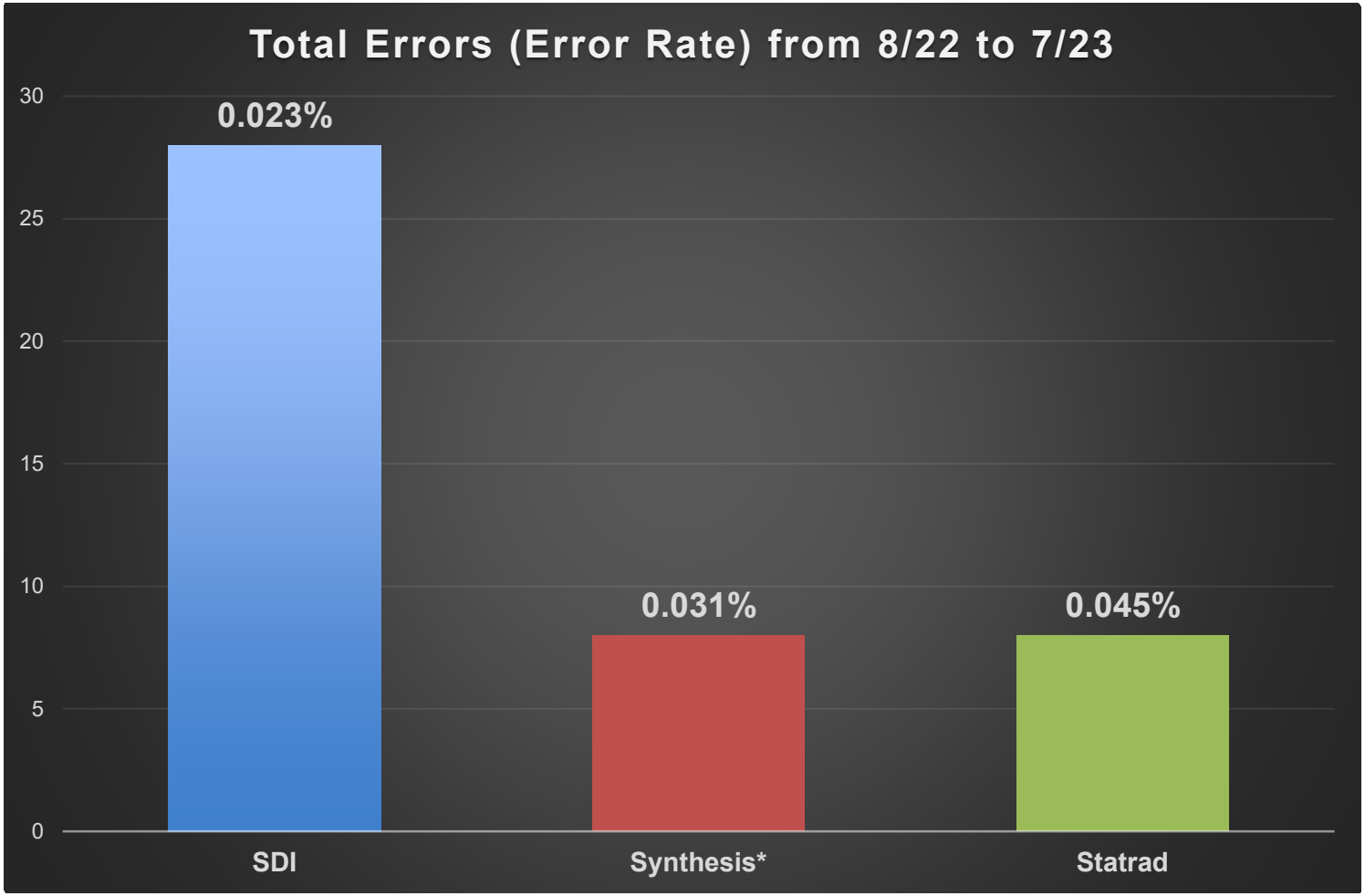
# StatRad QA Errors per month



# Synthesis Discrepancies per Month



# Errors per Group



# Challenges

- Siloed reporting of errors
  - Various committees discuss errors or perceived errors that are not submitted
  - Errors submitted directly to Statrad and Synthesis, not included
- Radiologist too busy to report discrepancy
- Radiologist doesn't want to engage in punitive process

PALOMAR HEALTH

**ADDENDUM I**

# Behavioral Health Annual Quality Report

Presented to
**Board Quality Review Committee**

**H. Scott Kane, MD- Behavioral Health Medical Director**
**Don Myers- Behavioral Health District Operations Director**
**October 2023**

Passion. People. Purpose.™

# Behavioral Health Annual Quality Report

| | |
|---|---|
| **SITUATION** | The Behavioral Health Unit (BHU) Medical Directors, Providers, Nursing, Clinical Staff and Case Management Team meet monthly to review abstractions, clinical documentation and Hospital Based Inpatient Psychiatric Services (HBIBS) Core Measure performance. The Team educates and implements changes accordingly to support core measure performance improvement. |
| **BACKGROUND** | The BHU has historically performed well on these core measures. The specific measures are dynamic and constantly evolving in support of emerging clinical research and improvement of clinical outcomes.<br>From Quarter2, 2022 through Q12, 2023, The BHU met/outperformed the benchmark in all but core measures except Hours of Physical Restraint Use in Q1-2023 and Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification Q3- 2022. The BHU scored in the top 10% in 13 core measures from Q3-2022 thru Q2-2023. |
| **ASSESSMENT** | CMS final changes are to remove these 2 measures beginning FY2025:<br>1. Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification (HBIPS-5)<br>2. Tobacco Use Brief Intervention Provided or Offered at Discharge (TOB-2/2a)<br>CMS is adopting 4 new measures in FY2025:<br>1. Facility Commitment to Health Equity<br>2. Screening for Social Drivers of Health<br>3. Screen Positive Tare for Social Drivers of Health<br>4. Psychiatric Inpatient Experience (PIX) Survey |
| **RECOMMENDATION** | The team will continue to integrate review of core measures in the daily multidisciplinary treatment meetings to sustain core measure performance. This process includes clarification of diagnosis, medication management, discharge referrals and dispositions and assignment of tasks to improve core measure performance. The team will now focus on process to support performance of the 4 newly adopted measures. |

# Data Slide

## PMC Poway - BHU Adult
## Core Measure Compliance & Benchmarks

**Reporting Period: Q3-2022 to Q2-2023**

Better than Nat'l Avg
Worse than Nat'l Avg
Reach Top 10% or Best Performance

N/A = Not Available

| Measure Name | Quarter | Numerator | Denominator | Facility Rate | National Average | Top 10% |
|---|---|---|---|---|---|---|
| HBIPS-2: Hours of Physical Restraint Use [Rate Per 1000 Patient Hours] *[Lower is better]* | Q3-2022 | 2.90 | 1049 | 0.115 | 0.26 | N/A |
| | Q4-2022 | 2.55 | 956 | 0.111 | 0.26 | N/A |
| | Q1-2023 | 17.68 | 995 | 0.740 | 0.38 | N/A |
| | Q2-2023 | 4.45 | 972 | 0.191 | 0.38 | N/A |
| HBIPS-3: Hours of Seclusion [Rate Per 1000 Patient Hours] *[Lower is better]* | Q3-2022 | 1.68 | 1049 | 0.067 | 0.25 | N/A |
| | Q4-2022 | 3.32 | 956 | 0.145 | 0.25 | N/A |
| | Q1-2023 | 2.37 | 995 | 0.099 | 0.36 | N/A |
| | Q2-2023 | 4.05 | 972 | 0.174 | 0.36 | N/A |
| HBIPS-5a: Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification *[Higher is better]* | Q3-2022 | 4 | 8 | 50% | 65% | 100% |
| | Q4-2022 | 8 | 8 | 100% | 65% | 100% |
| | Q1-2023 | 10 | 11 | 91% | 62% | 100% |
| | Q2-2023 | 9 | 9 | 100% | 62% | 100% |
| IPF-TR-1 : Transition Record with Specified Elements Received by Discharged Patients *[Higher is better]* | Q3-2022 | 108 | 117 | 92% | 69% | 100% |
| | Q4-2022 | 120 | 130 | 92% | 69% | 100% |
| | Q1-2023 | 100 | 101 | 99% | 67% | 100% |
| | Q2-2023 | 117 | 122 | 96% | 67% | 100% |
| SMD-1: Screening For Metabolic Disorders *[Higher is better]* | Q3-2022 | 62 | 68 | 91% | 78% | 100% |
| | Q4-2022 | 54 | 61 | 89% | 78% | 100% |
| | Q1-2023 | 57 | 62 | 92% | 77% | 100% |
| | Q2-2023 | 61 | 63 | 97% | 77% | 100% |
| IMM-2: Influenza Immunization *[Higher is better]* | Q4-2022 | 113 | 126 | 90% | 77% | 99% |
| | Q1-2023 | 88 | 96 | 92% | 77% | 99% |
| SUB-2: Alcohol Use Brief Intervention Provided or Offered *[Higher is better]* | Q3-2022 | 22 | 24 | 92% | 79% | 100% |
| | Q4-2022 | 20 | 20 | 100% | 79% | 100% |
| | Q1-2023 | 14 | 18 | 78% | 65% | 100% |
| | Q2-2023 | 19 | 19 | 100% | 65% | 100% |

# Data Slide

| Measure Name | Quarter | Numerator | Denominator | Facility Rate | National Average | Top 10% |
|---|---|---|---|---|---|---|
| SUB-2a: Alcohol Use Brief Intervention *[Higher is better]* | Q3-2022 | 22 | 22 | 100% | 72% | 100% |
| | Q4-2022 | 20 | 20 | 100% | 72% | 100% |
| | Q1-2023 | 14 | 15 | 93% | 76% | 100% |
| | Q2-2023 | 19 | 19 | 100% | 76% | 100% |
| SUB-3: Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge *[Higher is better]* | Q3-2022 | 37 | 38 | 97% | 75% | 100% |
| | Q4-2022 | 39 | 43 | 91% | 75% | 100% |
| | Q1-2023 | 28 | 31 | 90% | 75% | 100% |
| | Q2-2023 | 36 | 38 | 95% | 75% | 100% |
| SUB-3a: Alcohol and Other Drug Use Disorder Treatment at Discharge *[Higher is better]* | Q3-2022 | 37 | 38 | 97% | 63% | 99% |
| | Q4-2022 | 37 | 43 | 86% | 63% | 99% |
| | Q1-2023 | 26 | 31 | 84% | 62% | 100% |
| | Q2-2023 | 36 | 38 | 95% | 62% | 100% |
| TOB-2: Tobacco Use Treatment Provided or Offered *[Higher is better]* | Q3-2022 | 48 | 54 | 89% | 81% | 100% |
| | Q4-2022 | 47 | 53 | 89% | 81% | 100% |
| | Q1-2023 | 36 | 42 | 86% | 72% | 99% |
| | Q2-2023 | 53 | 57 | 93% | 72% | 99% |
| TOB-2a: Tobacco Use Treatment *[Higher is better]* | Q3-2022 | 44 | 50 | 88% | 45% | 89% |
| | Q4-2022 | 46 | 47 | 98% | 45% | 89% |
| | Q1-2023 | 36 | 37 | 97% | 42% | 88% |
| | Q2-2023 | 53 | 53 | 100% | 42% | 88% |
| TOB-3: Tobacco Use Treatment Provided or Offered at Discharge *[Higher is better]* | Q3-2022 | 41 | 43 | 95% | 61% | 99% |
| | Q4-2022 | 27 | 33 | 82% | 61% | 99% |
| | Q1-2023 | 23 | 25 | 92% | 57% | 99% |
| | Q2-2023 | 43 | 44 | 98% | 57% | 99% |
| TOB-3a: Tobacco Use Treatment at Discharge *[Higher is better]* | Q3-2022 | 37 | 43 | 86% | 22% | 83% |
| | Q4-2022 | 26 | 33 | 79% | 22% | 83% |
| | Q1-2023 | 23 | 25 | 92% | 18% | 81% |
| | Q2-2023 | 43 | 44 | 98% | 18% | 81% |

PALOMAR HEALTH

**ADDENDUM J**

# Perioperative Services Annual Report

(Operating Room, Endoscopy, Pre-Assessment Testing (PAT), Pre-Op, Post Anesthesia Care Unit (PACU), Sterile Processing Department (SPD)

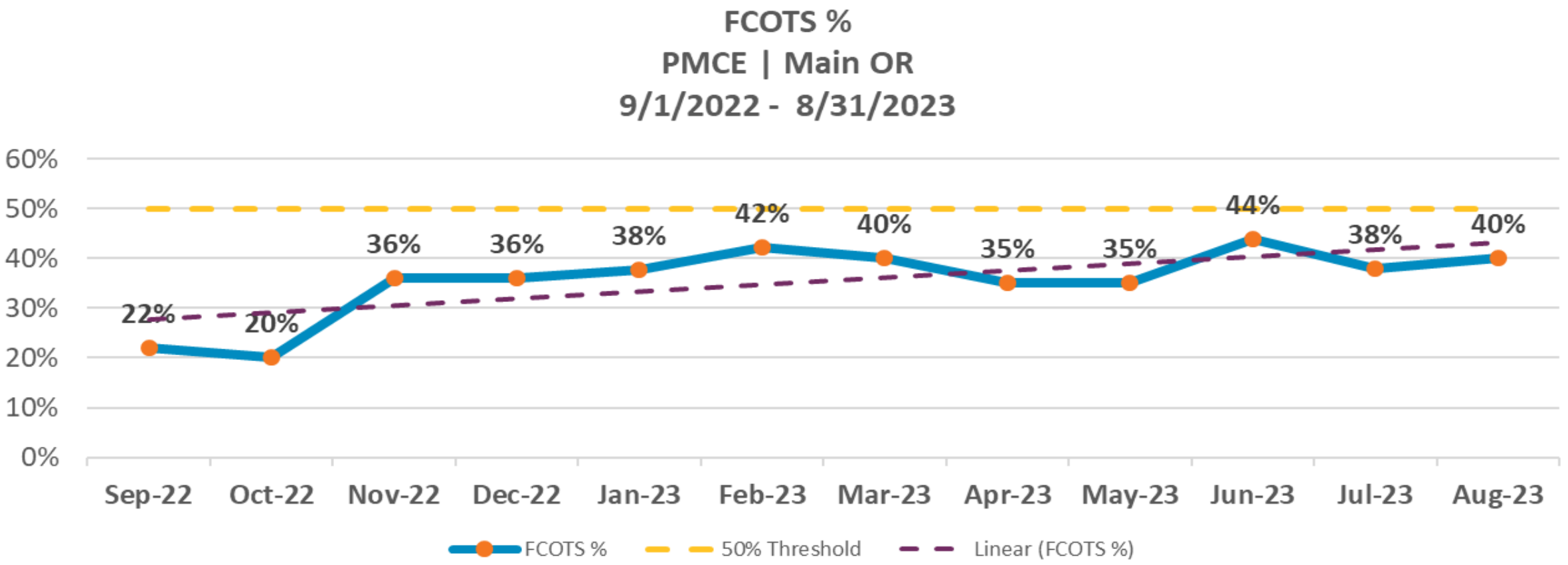
## Presented to Board Quality Review Cttee

**Bruce Grendell, MPH, BSN, RN, Senior Director**
**Richard Engel, MD, Medical Director**
**Ariel Palanca, MD OR Cttee Chair, PMCP**
**Gregory Campbell, MD, OR Cttee Chair, PMCE**

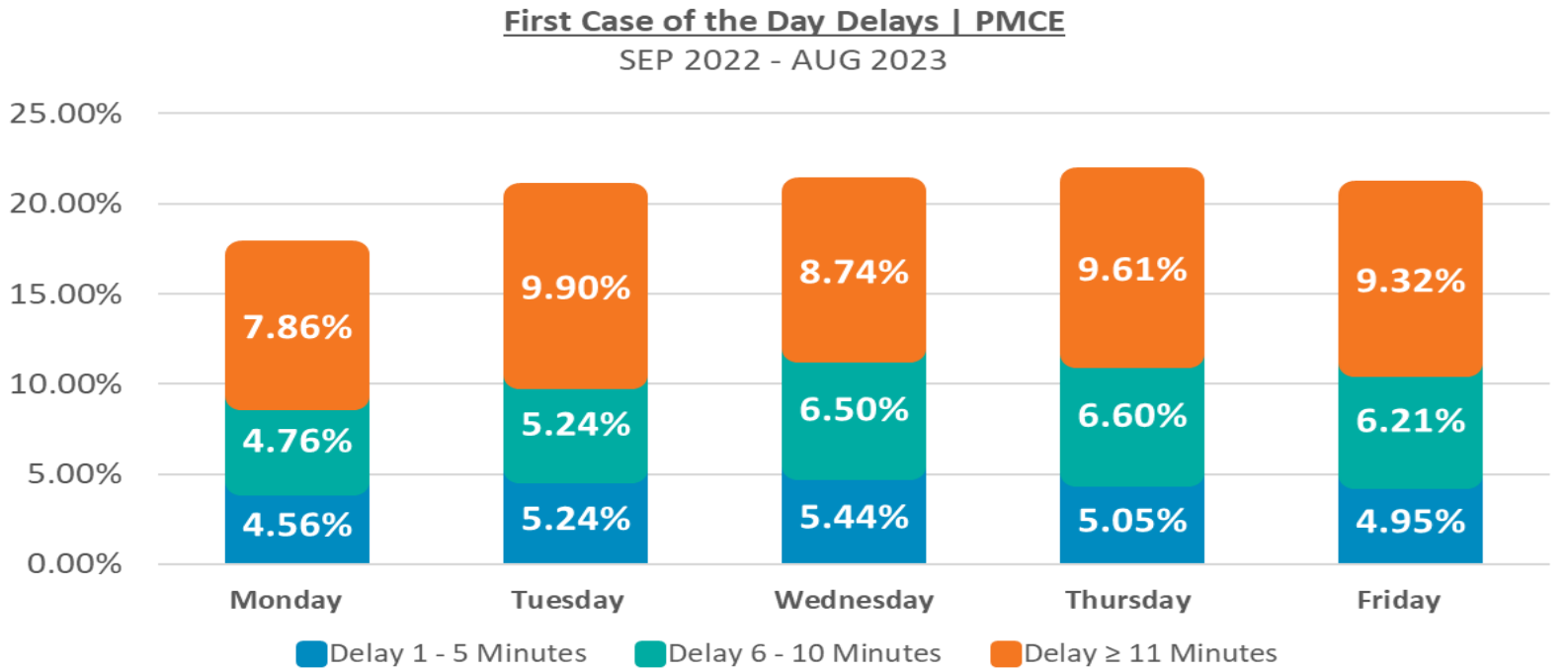
# FY 24 Quality Goals

| | |
|---|---|
| Situation | Focus on top five quality metrics |
| Background | Monthly review at Operating Room (OR) Committee |
| Assessment | • First Case On Time Starts (FCOTS) trends<br>• Block Time Utilization and allocation<br>• Patient Experience scores<br>• Surgical Site Infections / Standardized Infection Ratios (SIR)<br>• Immediate Use Steam Sterilization (IUSS) rates |
| Recommendation | • Continued focus on improving communication between PreOp nursing personnel, physicians and OR nursing personnel to ensure PreOp orders are completed, patients are ready for their procedure, warm patient handoff completed and patients enter the Operating Room on time.<br>• Monthly monitoring of block time utilization. Reallocation as required.<br>• Monthly review of patient experience scores and patient comments<br>• Monthly review of targeted surveillance for SSIs.<br>• Monthly review of IUSS rates. |

# First Case on Time (FCOTS) | PMCE



# First Case of the Day Delays | PMCE

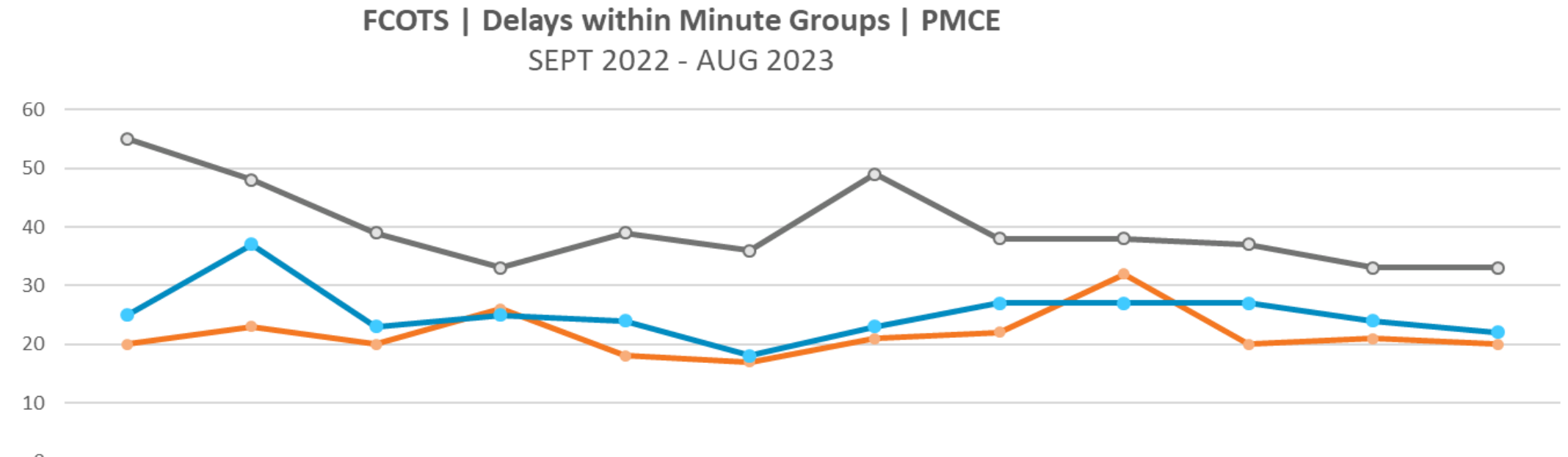



| SEPT 2022 - AUG 2023 | Monday | Tuesday | Wednesday | Thursday | Friday | Grand Total | % Total |
|---|---|---|---|---|---|---|---|
| **Delay 1 - 5 Minutes** | 47 | 54 | 56 | 52 | 51 | 260 | **25%** |
| **Delay 6 - 10 Minutes** | 49 | 54 | 67 | 68 | 64 | 302 | **29%** |
| **Delay ≥ 11 Minutes** | 85 | 103 | 91 | 101 | 98 | 478 | **46%** |
| **Grand Total** | **181** | **211** | **214** | **221** | **213** | **1040** | |
| **% Total Delay Each Day** | **17%** | **20%** | **21%** | **21%** | **20%** | | |

# FCOTS – Top 3 Delay Reasons Minute Group | PMCE

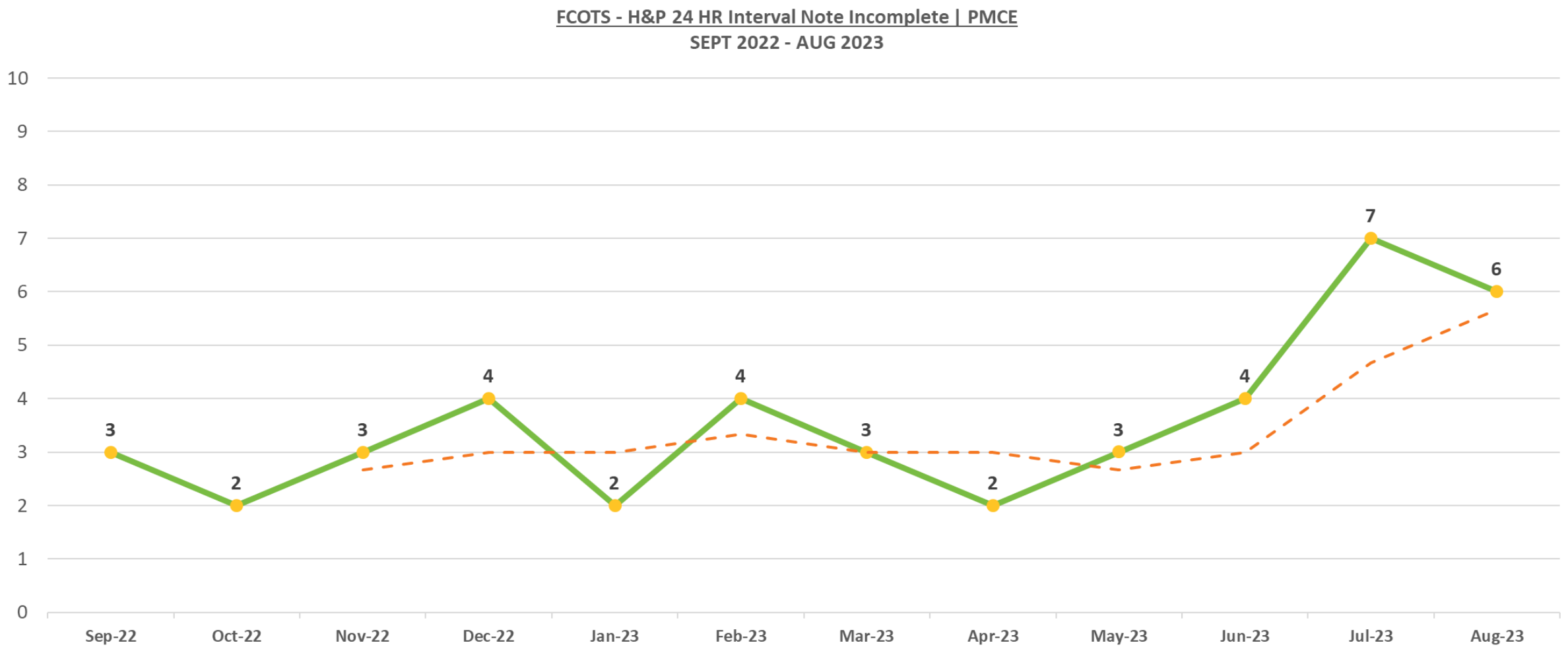
| PMCE | | | | | | |
|---|---|---|---|---|---|---|
| SEPT 2022 – AUG 2023 | Monday | Tuesday | Wednesday | Thursday | Friday | Grand Total |
| **Delay 1 - 5 Minutes** | | | | | | |
| Room Not Ready | 2 | 4 | 3 | 3 | 3 | 15 |
| Surgical/Informed Consent Incomplete | 3 | -- | 5 | 2 | 4 | 14 |
| H&P 24 HR Interval Note Incomplete | 2 | 2 | 3 | 2 | 4 | 13 |
| **Delay 6 - 10 Minutes** | | | | | | |
| Surgeon Late | 9 | 3 | 5 | 5 | 6 | 28 |
| Surgical/Informed Consent Incomplete | 3 | 4 | 3 | 8 | 8 | 26 |
| Room Not Ready | 2 | 6 | 4 | 6 | 3 | 21 |
| **Delay ≥ 11 Minutes** | | | | | | |
| Surgeon Late | 9 | 16 | 15 | 15 | 18 | 73 |
| Surgical/Informed Consent Incomplete | 11 | 14 | 13 | 15 | 11 | 64 |
| Room Not Ready | 1 | 9 | 4 | 3 | 3 | 20 |

# FCOTS Delays within Minute Groups | PMCE

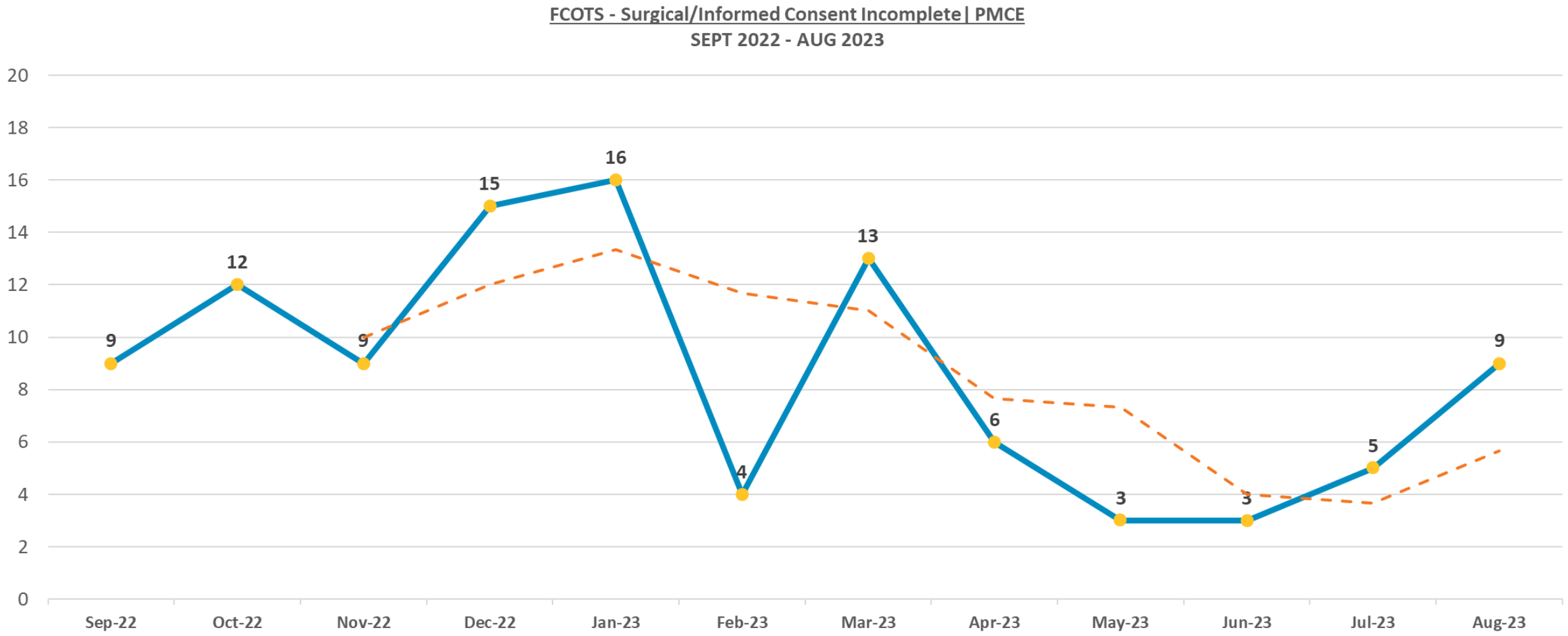



| | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2022 | | | | 2023 | | | | | | | |
| Delay 1 - 5 Minutes | 20 | 23 | 20 | 26 | 18 | 17 | 21 | 22 | 32 | 20 | 21 | 20 |
| Delay 6 - 10 Minutes | 25 | 37 | 23 | 25 | 24 | 18 | 23 | 27 | 27 | 27 | 24 | 22 |
| Delay ≥ 11 Minutes | 55 | 48 | 39 | 33 | 39 | 36 | 49 | 38 | 38 | 37 | 33 | 33 |

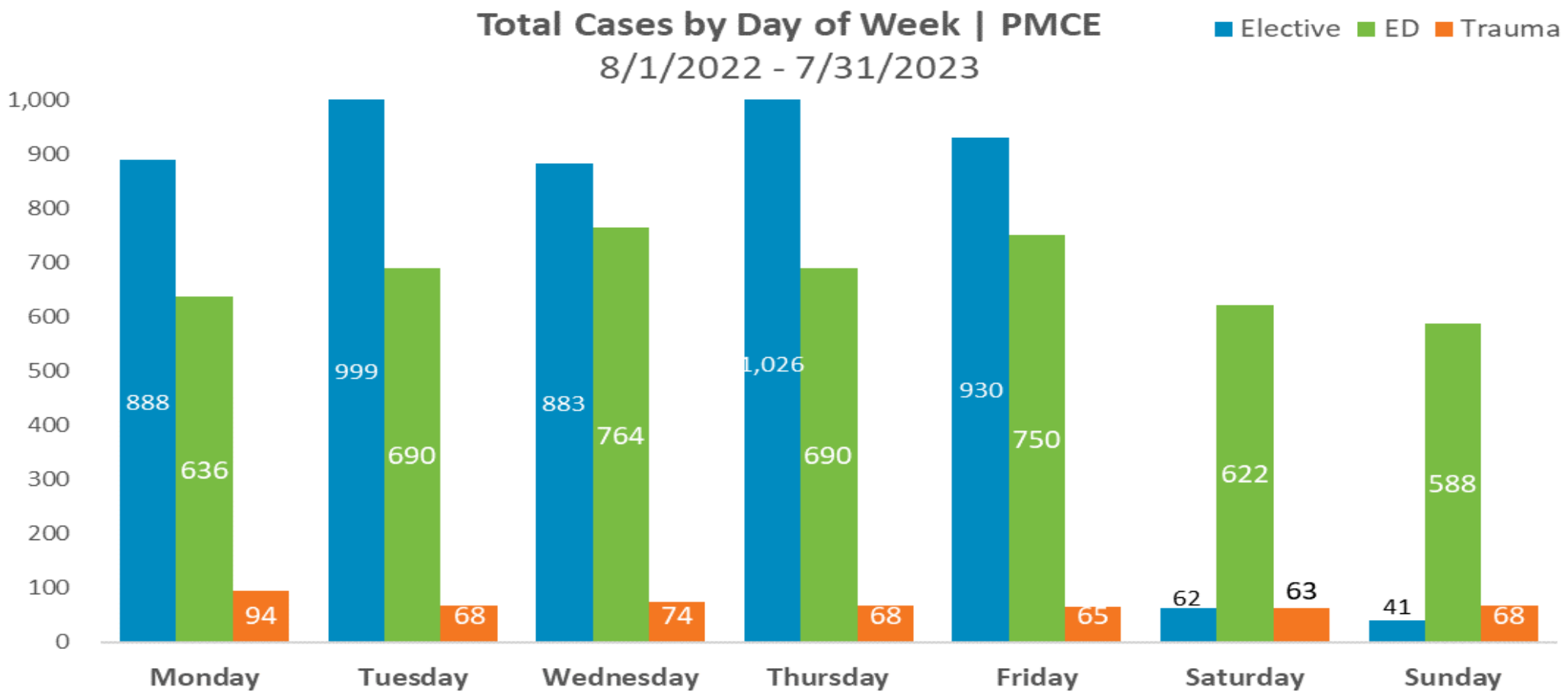
# FCOTS Delay Reason Trend | PMCE



# FCOTS Delay Reason Trend | PMCE

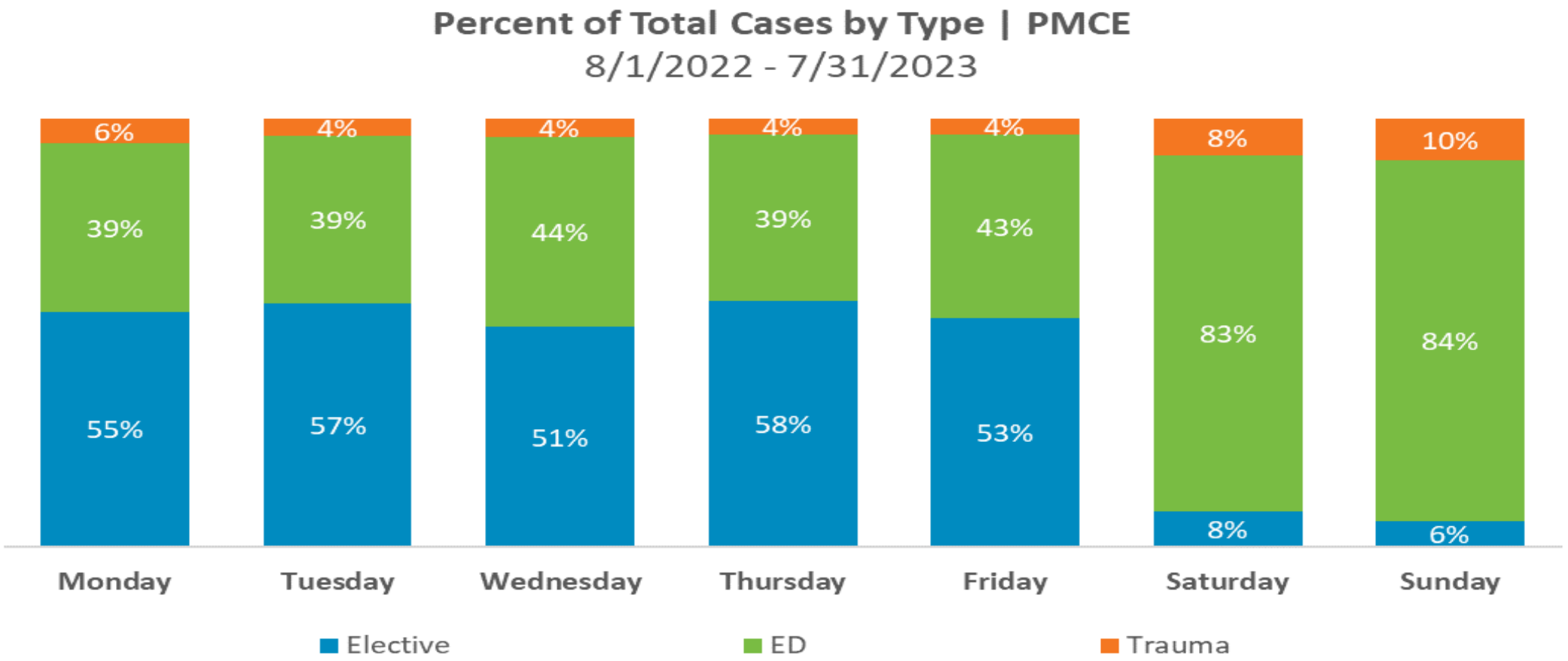


# OR Case Volume by Day of Week | PMCE



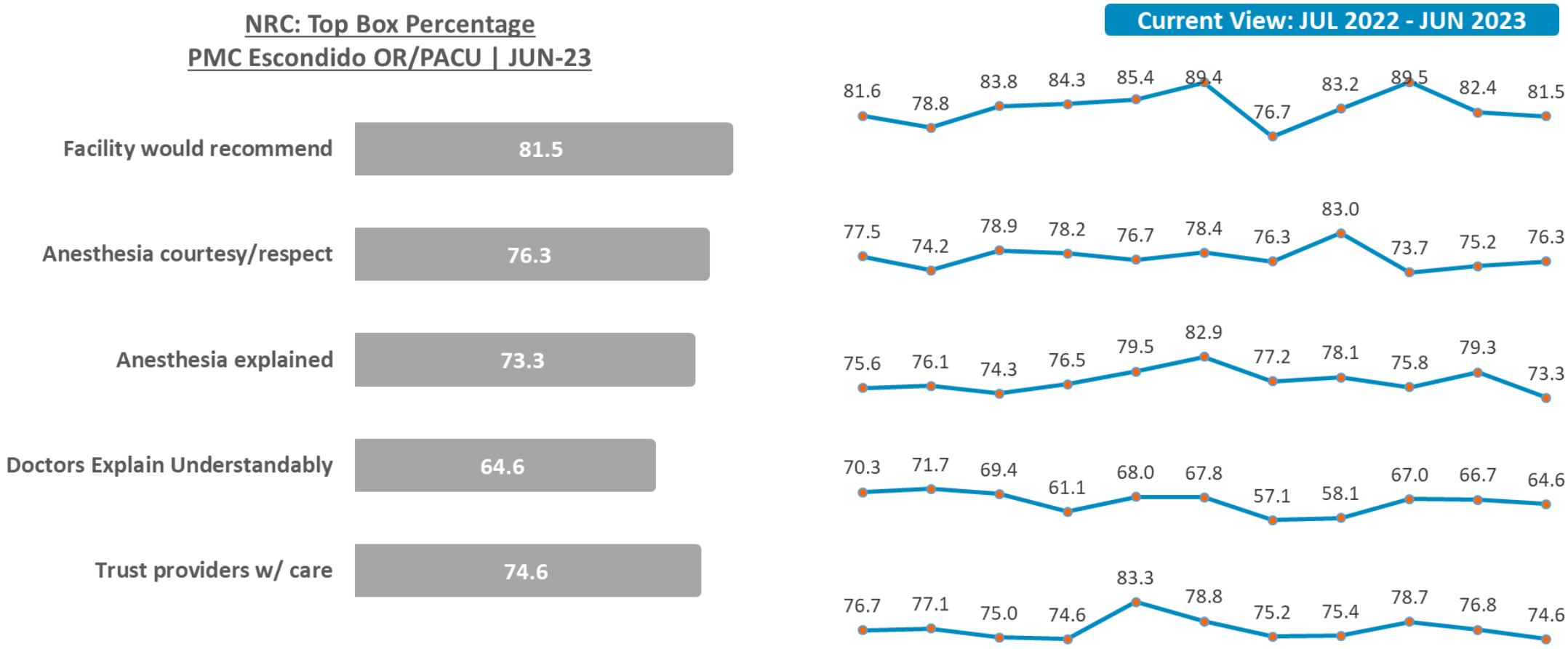

**Note:** Elective cases indicated on Saturday and Sunday are from inpatient floor.

# Percent of Total Cases by Type | PMCE




**Note:** Elective cases indicated on Saturday and Sunday are from inpatient floor.

# NRC: Patient Experience (OR/PACU) | PMCE




**Note:** Green indicates that the Top Box Score for this month is at or above the NRC Average

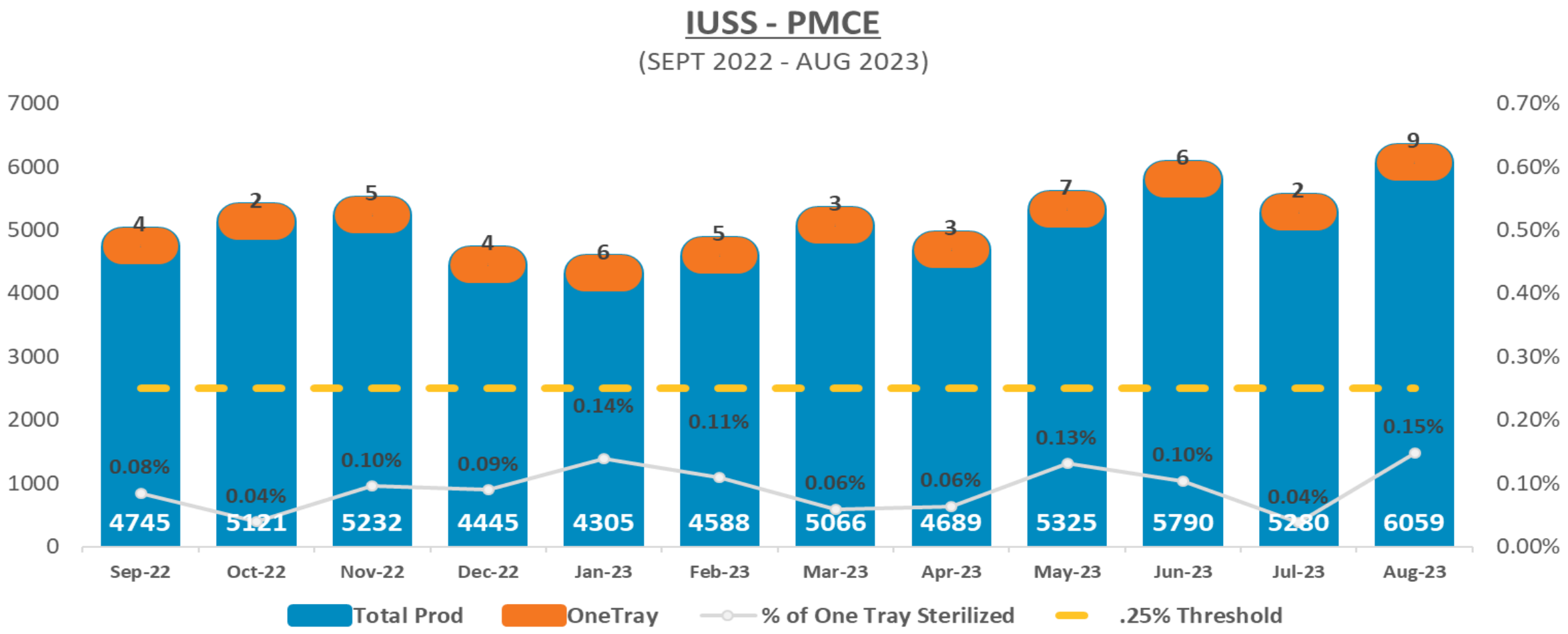
# Surgical Site Infection (SSI) | PMCE

| Colon | |
|---|---|
| SIR for CY2023 Q1 | Benchmark for SIR |
| 1.57 | 1.00 |
| # of Infections CY23 YTD \| 5 | |

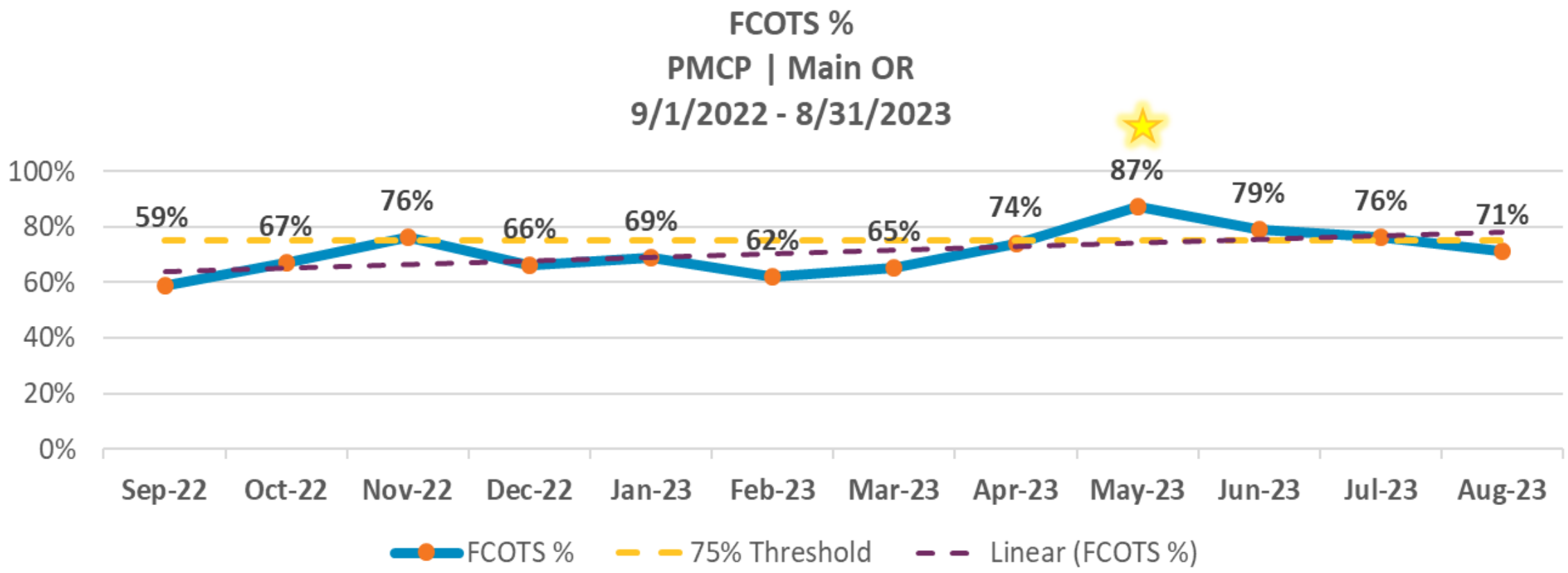
| Abdominal Hysterectomy | |
|---|---|
| SIR for CY2023 Q1 | Benchmark for SIR |
| Pred < 1 | 1.00 |
| # of Infections CY23 YTD \| 1 | |

| All SSI | |
|---|---|
| SIR for CY2023 Q1 | Benchmark for SIR |
| 0.97 | 1.00 |
| # of Infections CY23 YTD \| 18 | |

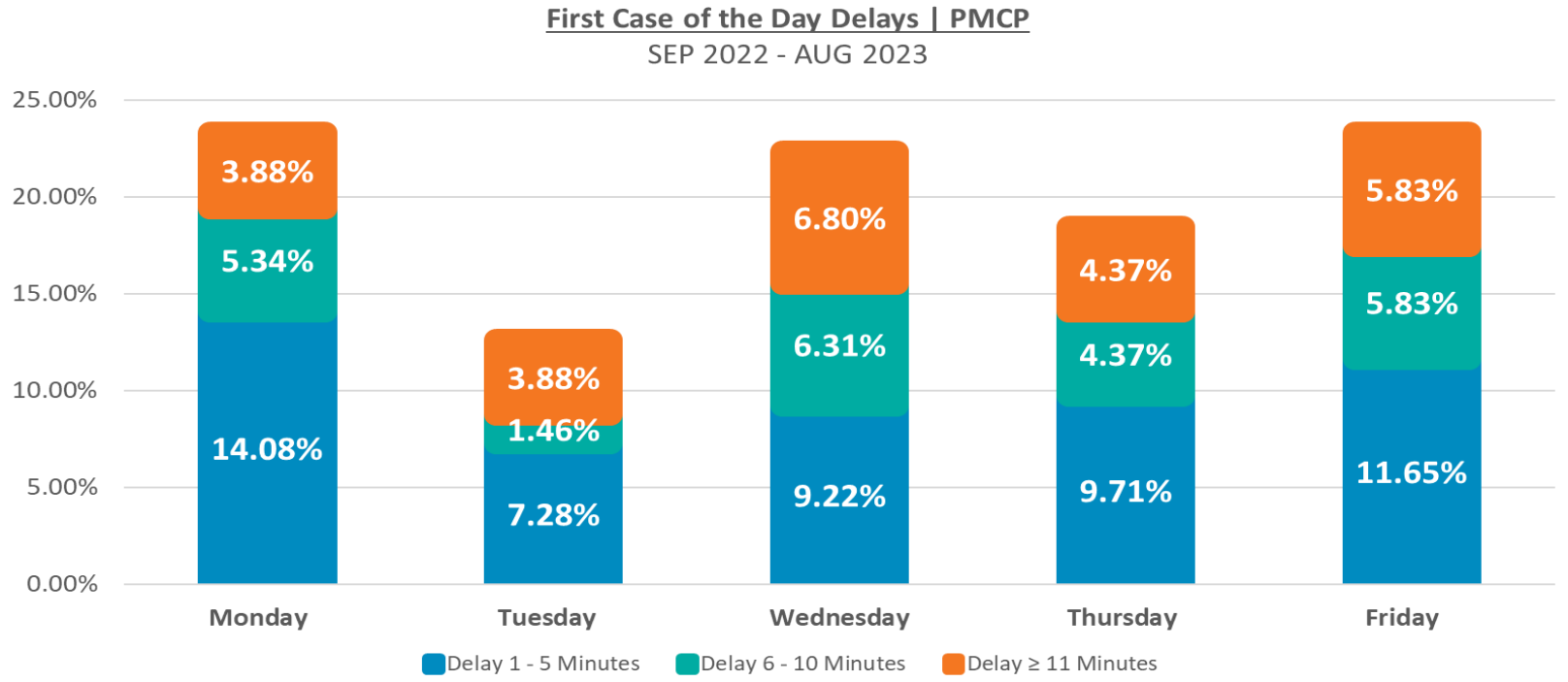
# Immediate Use Cases (IUSS) | PMCE



# First Case on Time | PMCP



# First Case of the Day Delays | PMCP

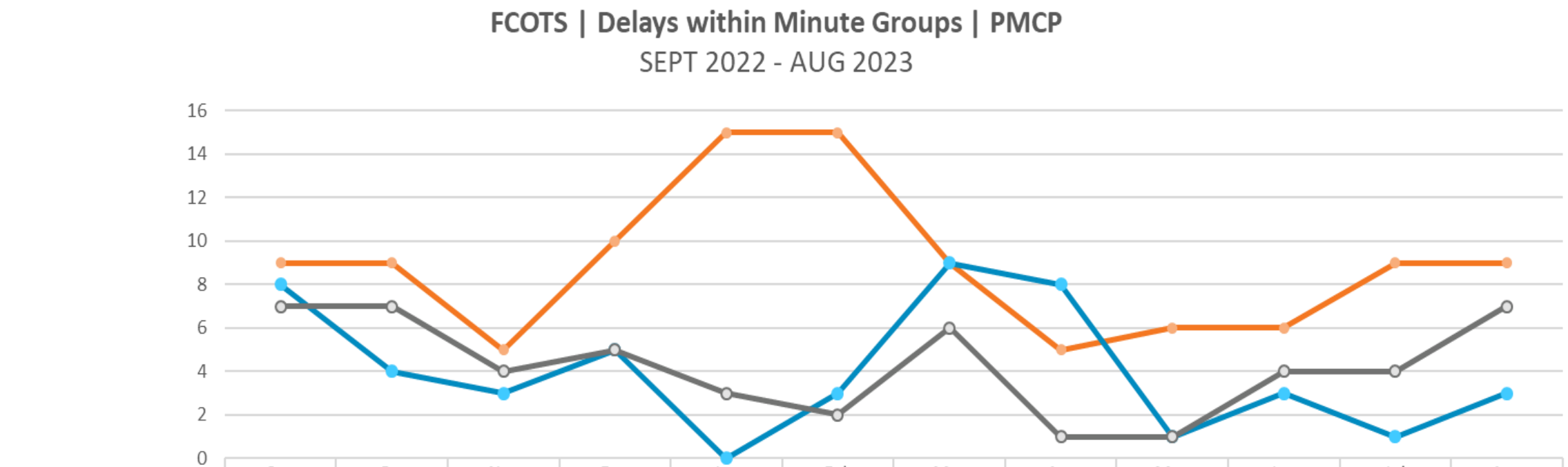



| SEPT 2022 - AUG 2023 | Monday | Tuesday | Wednesday | Thursday | Friday | Grand Total | % Total |
|---|---|---|---|---|---|---|---|
| **Delay 1 - 5 Minutes** | 29 | 15 | 19 | 20 | 24 | 107 | **52%** |
| **Delay 6 - 10 Minutes** | 11 | 3 | 13 | 9 | 12 | 48 | **23%** |
| **Delay ≥ 11 Minutes** | 8 | 8 | 14 | 9 | 12 | 51 | **25%** |
| **Grand Total** | 48 | 26 | 46 | 38 | 48 | 206 | |
| **% of Total Each Day** | **23%** | **13%** | **22%** | **18%** | **23%** | | |

# FCOTS – Top 3 Delay Reasons Minute Group | PMCP

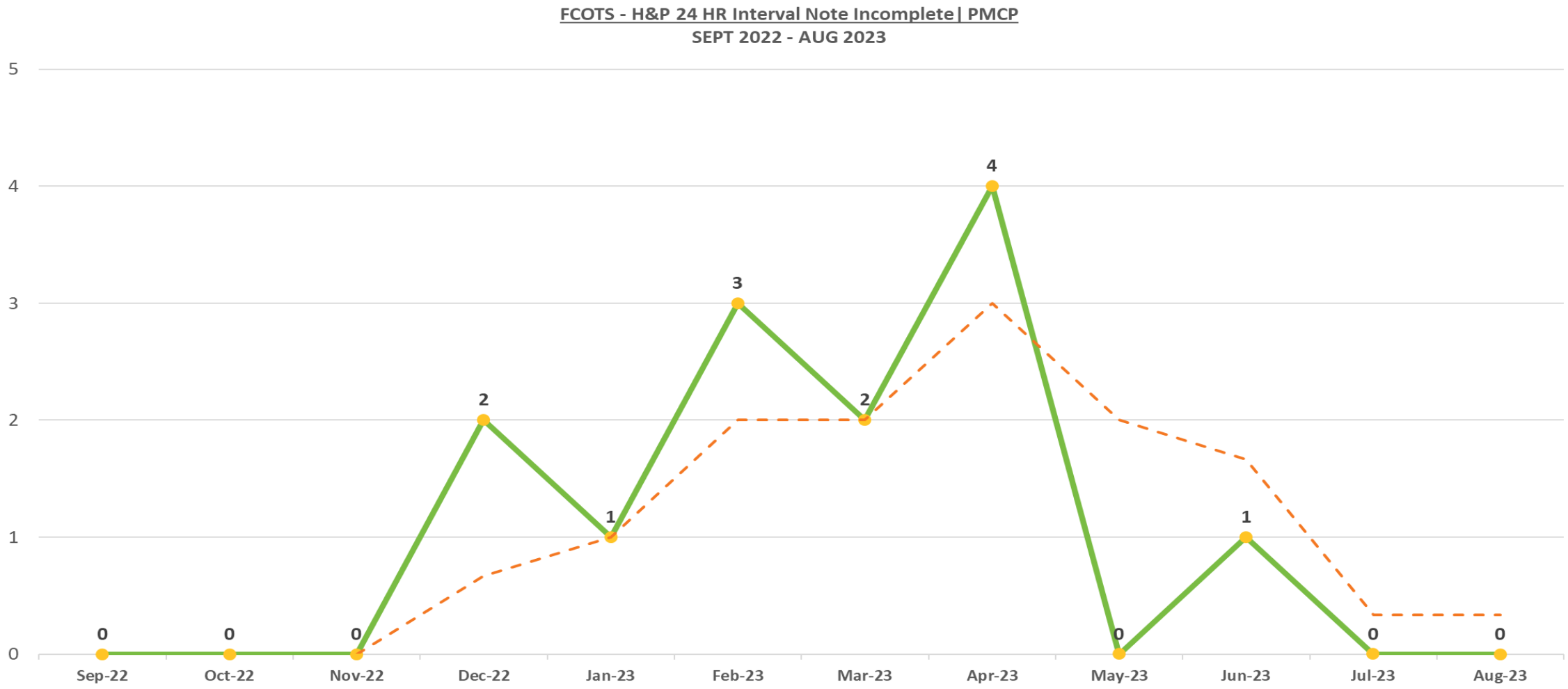
| PMCP | | | | | | |
|---|---|---|---|---|---|---|
| SEPT 2022 – AUG 2023 | Monday | Tuesday | Wednesday | Thursday | Friday | Grand Total |
| **Delay 1 - 5 Minutes** | | | | | | |
| Surgeon Late | 1 | -- | 1 | 6 | 1 | 9 |
| Surgeon Marking pt/Surgeon Interview | 2 | 1 | 2 | 1 | 2 | 8 |
| H&P 24 HR Interval Note Incomplete | 2 | -- | 1 | 1 | 1 | 5 |
| **Delay 6 - 10 Minutes** | | | | | | |
| H&P 24 HR Interval Note Incomplete | 2 | -- | 3 | 1 | 2 | 8 |
| Surgeon Late | 3 | -- | 2 | -- | 2 | 7 |
| Surgeon Marking pt/Surgeon Interview | -- | 2 | -- | 2 | -- | 4 |
| **Delay ≥ 11 Minutes** | | | | | | |
| Surgeon Late | -- | 3 | 4 | 2 | 2 | 11 |
| Surgical/Informed Consent Incomplete | -- | 2 | -- | 1 | 2 | 5 |
| Room Not Ready | -- | -- | 2 | 2 | -- | 4 |

# FCOTS Delays within Minute Groups | PMCP

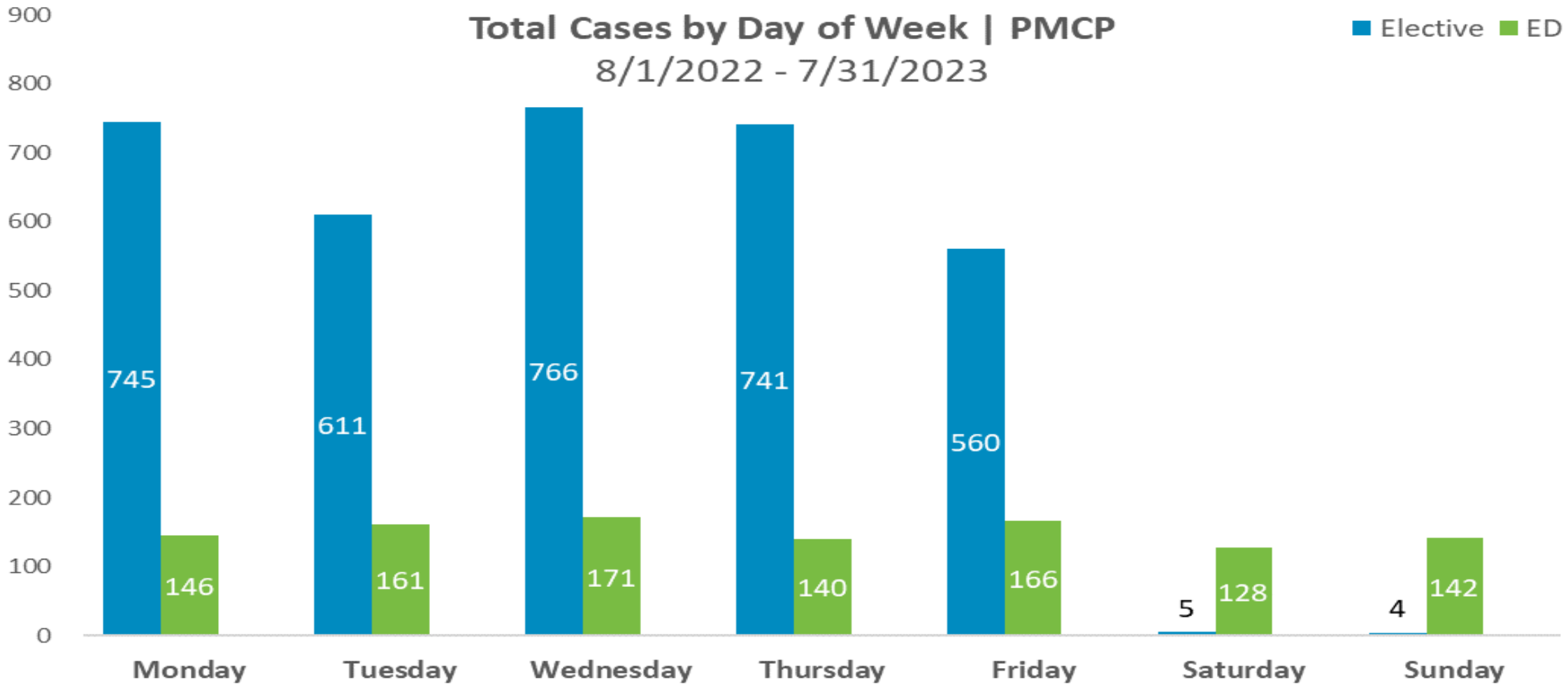



| | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2022 | | | | 2023 | | | | | | | |
| Delay 1 - 5 Minutes | 9 | 9 | 5 | 10 | 15 | 15 | 9 | 5 | 6 | 6 | 9 | 9 |
| Delay 6 - 10 Minutes | 8 | 4 | 3 | 5 | 0 | 3 | 9 | 8 | 1 | 3 | 1 | 3 |
| Delay ≥ 11 Minutes | 7 | 7 | 4 | 5 | 3 | 2 | 6 | 1 | 1 | 4 | 4 | 7 |

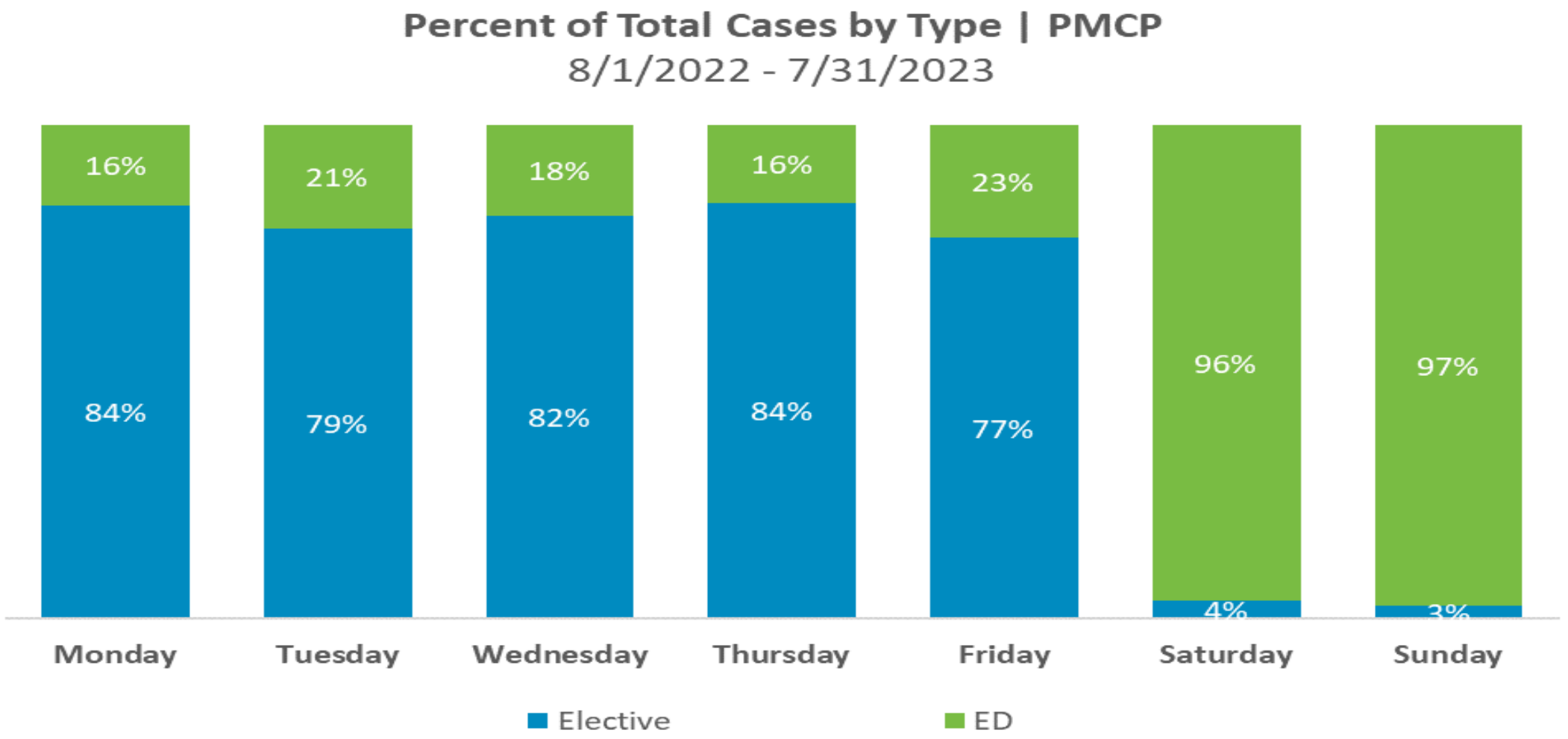
# FCOTS Delay Reason Trend | PMCP



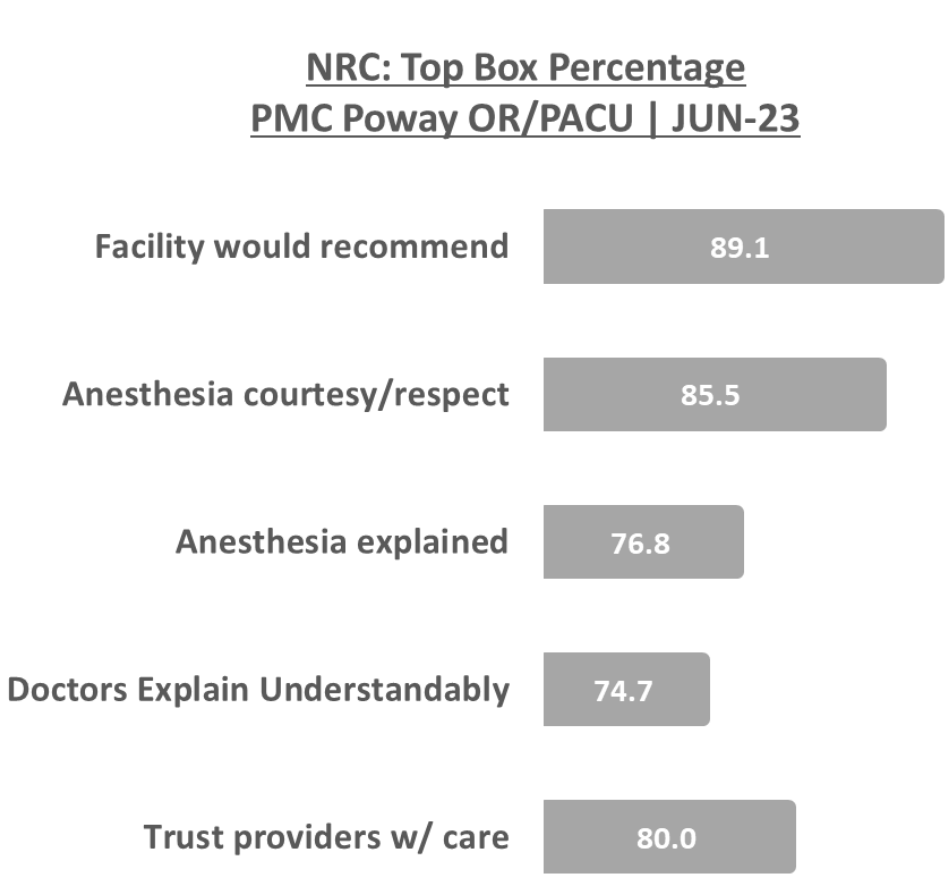
# OR Case Volume by Day of Week | PMCP

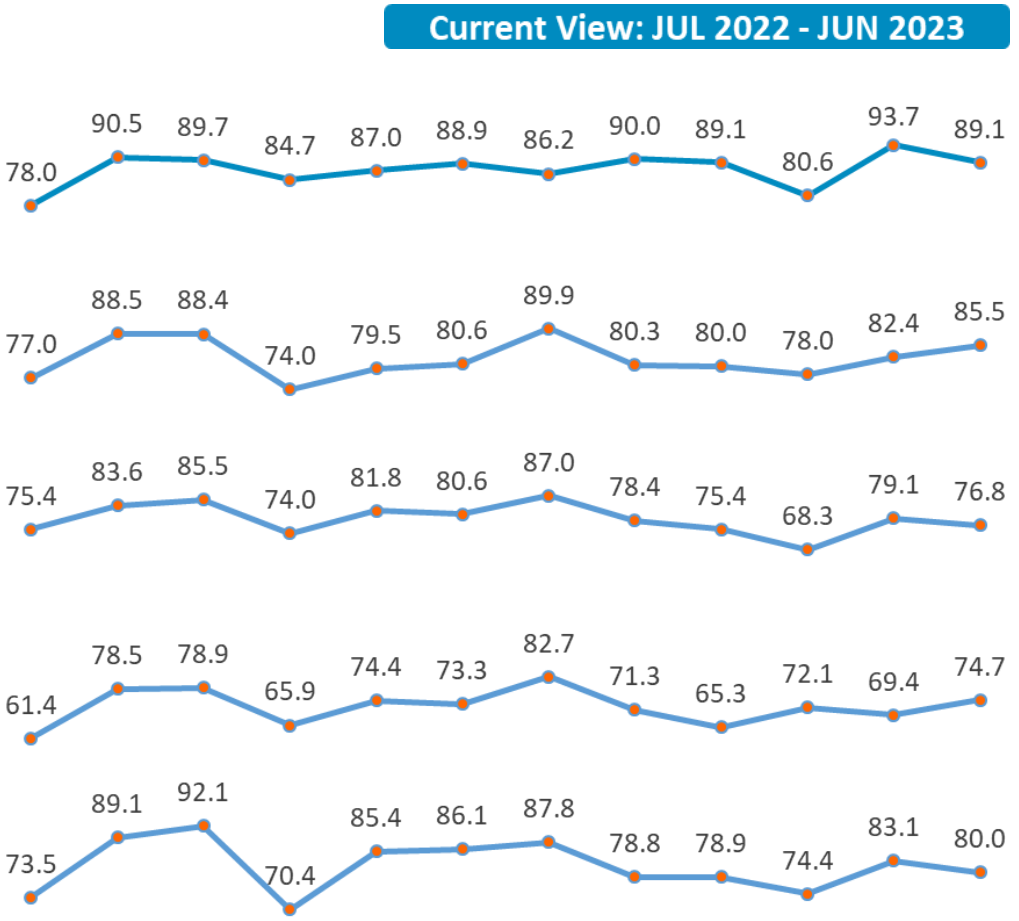


# Percent of Total Cases by Type | PMCP



# NRC: Patient Experience (OR/PACU) | PMCP




Note: **Green** indicates that the Top Box Score for this month is at or above the NRC Average

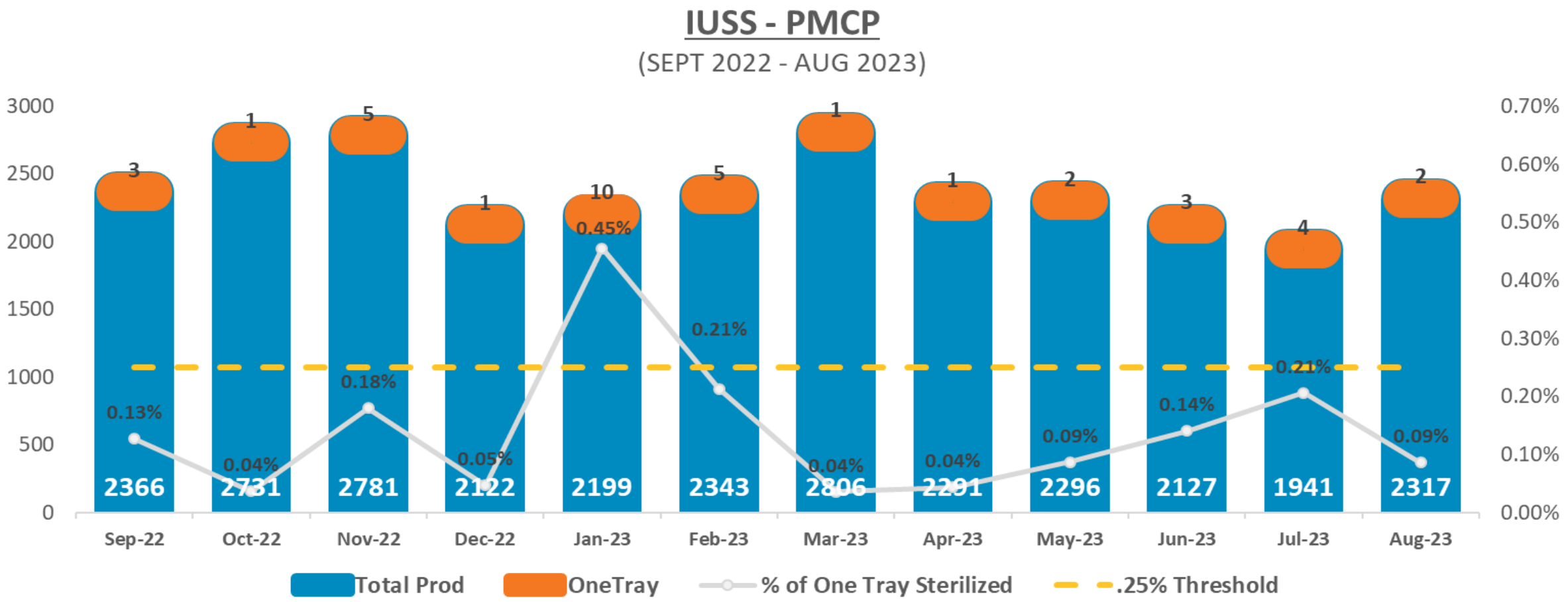
# Surgical Site Infection (SSI) | PMCP

| Colon | |
|---|---|
| SIR for CY2023 Q1 | Benchmark for SIR |
| Pred < 1 | 1.00 |
| # of Infections CY23 YTD \| 1 | |

| Abdominal Hysterectomy | |
|---|---|
| SIR for CY2023 Q1 | Benchmark for SIR |
| 0.00 | 1.00 |
| # of Infections CY23 YTD \| 0 | |

| All SSI | |
|---|---|
| SIR for CY2023 Q1 | Benchmark for SIR |
| 2.00 | 1.00 |
| # of Infections CY23 YTD \| 6 | |

# Immediate Use Cases (IUSS) | PMCP



# Action Plan with Timeline

| Initiative | Date |
|---|---|
| Improve and sustain FCOTS at PMCE to 50th percentile<br><br>Improve and sustain FCOTS at PMCP to 75th percentile | 6/30/2024<br><br>6/30/2024 |
| Improve and maintain block time utilization > 75% at PMCE and 60% at PMCP | 6/30/2024 |
| Improve targeted NRC Patient Experience scores to at or above NRC average (“in the green”) | 6/30/2024 |
| Improve and sustain targeted SSI rates to below SIR of 1.0 | 6/30/2024 |
| Maintain IUSS rates at or below 0.25% rate. Review and adjust goal on an annual basis. | 6/30/2024 |

PALOMAR HEALTH

**ADDENDUM K**

# Food and Nutritional Services (FANS) & Clinical Nutrition Quality Assurance Performance Improvement (QAPI) Plan

Presented to

**Board Quality Review Committee**

**Russ Riehl, VP Operations | Nicole Hite, MS, RDN- Director of FANS**
**Carrie Johnsen, MPH, RDN- Clinical Nutrition Manager**

**October 2023**

# FANS Test Trays

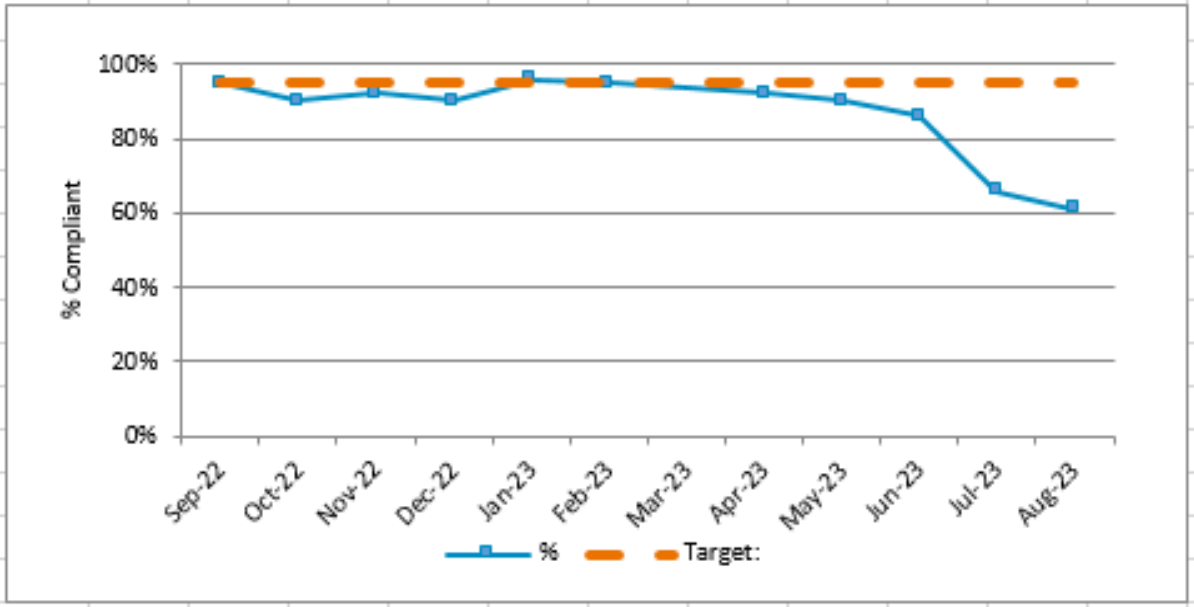
| | |
|---|---|
| **SITUATION** | Random test tray audits are utilized to monitor the temperature, freshness, and accuracy for the patient food items, portion size, and flavor. |
| **BACKGROUND** | Test trays previously completed indicated a drill down was needed on accuracy and temperatures. Temperatures are monitored for food safety and palatability. Tray accuracy, portion size, and flavor are monitored for diet specific needs. |
| **ASSESSMENT** | PMCE overall score for accuracy is 95% and temperature is 83% with a steady trend upwards for accuracy over the previous six months. Temperatures have declined due to broken heating equipment and electrical wiring.<br><br>PMCP overall score for accuracy is 94% and temperature is 80%. |
| **RECOMMENDATION** | Test trays at both sites have been increased, to include Registered Dietitians completing trays. New Executive Chef beginning in October 2023 to work with cooks on prep and holding techniques to maintain temperatures.<br><br>PMCE: Maintain current goal achievement for tray accuracy until we can show sustained improvement. New heating equipment has been ordered and is onsite with new wiring to trayline scheduled to be completed early October 2023. Cook workflows being adjusted, along with new competencies, as of October 1, 2023 to adjust plating standards to maintain temperature.<br><br>PMCP: New trayline procedure implemented in June 2023, causing temperatures to dip in June as adjustments were made. Improved trayline delivery schedule implemented in July 2023 shows improved temperatures. |

# Test Tray Temperatures- Escondido

PMC Escondido

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 95 | 100 | 95% |
| October-22 | 90 | 100 | 90% |
| November-22 | 92 | 100 | 92% |
| December-22 | 90 | 100 | 90% |
| January-23 | 96 | 100 | 96% |
| February-23 | 95 | 100 | 95% |
| March-23 | 98 | 100 | 98% |
| April-23 | 92 | 100 | 92% |
| May-23 | 90 | 100 | 90% |
| June-23 | 86 | 100 | 86% |
| July-23 | 66 | 100 | 66% |
| August-23 | 61 | 100 | 61% |

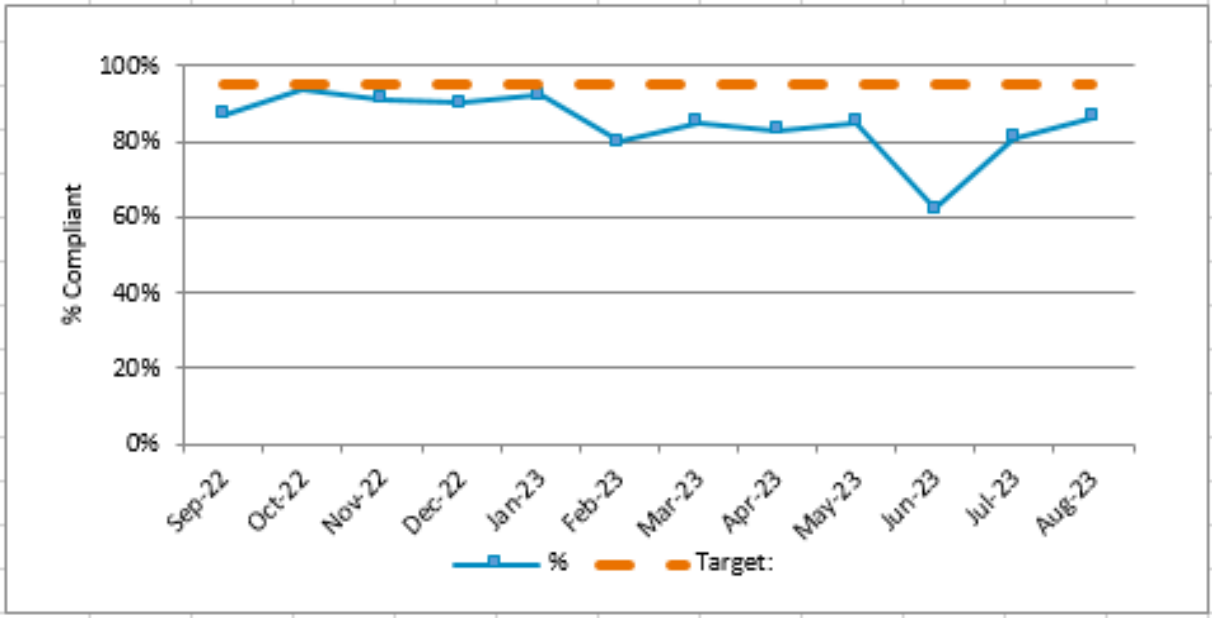


# Test Tray Temperatures- Poway

PMC Poway

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 87 | 100 | 87% |
| October-22 | 94 | 100 | 94% |
| November-22 | 91 | 100 | 91% |
| December-22 | 90 | 100 | 90% |
| January-23 | 92 | 100 | 92% |
| February-23 | 80 | 100 | 80% |
| March-23 | 85 | 100 | 85% |
| April-23 | 83 | 100 | 83% |
| May-23 | 85 | 100 | 85% |
| June-23 | 62 | 100 | 62% |
| July-23 | 81 | 100 | 81% |
| August-23 | 86.4 | 100 | 86% |

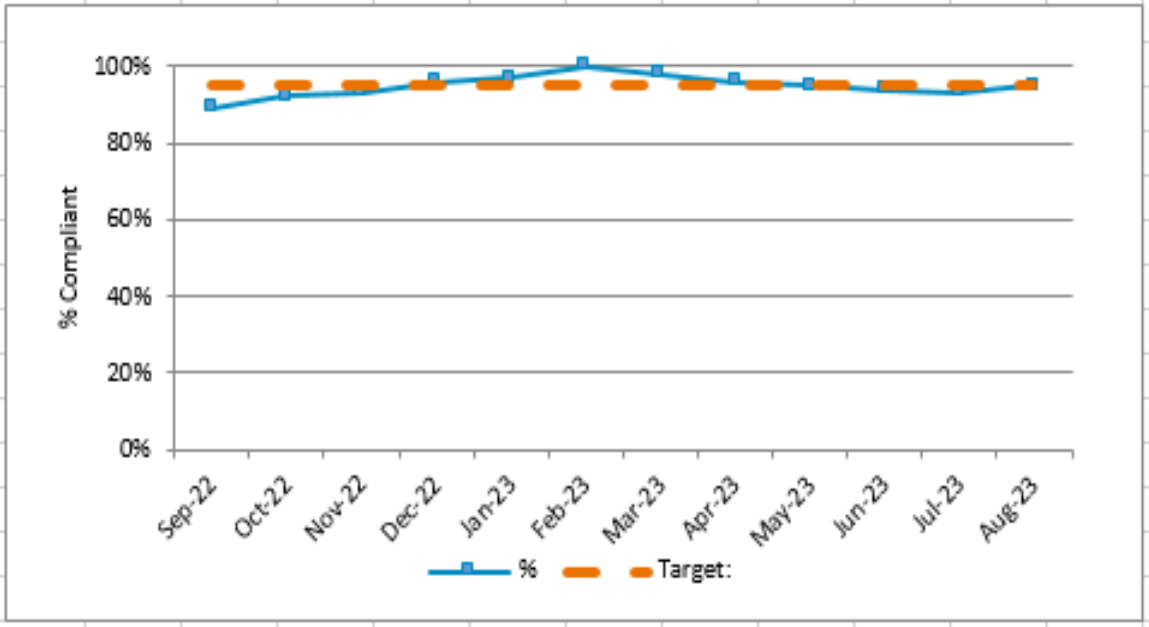


# Tray Accuracy- Escondido

PMC Escondido

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 89 | 100 | 89% |
| October-22 | 92 | 100 | 92% |
| November-22 | 93 | 100 | 93% |
| December-22 | 96 | 100 | 96% |
| January-23 | 97 | 100 | 97% |
| February-23 | 100 | 100 | 100% |
| March-23 | 98 | 100 | 98% |
| April-23 | 96 | 100 | 96% |
| May-23 | 95 | 100 | 95% |
| June-23 | 94 | 100 | 94% |
| July-23 | 93 | 100 | 93% |
| August-23 | 95 | 100 | 95% |

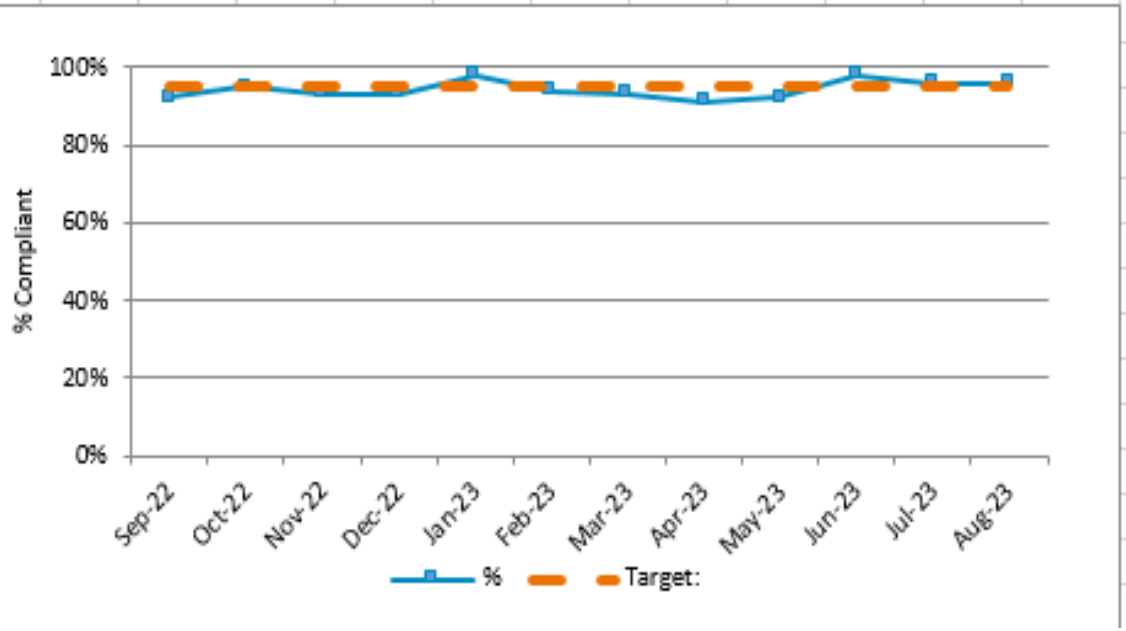


# Tray Accuracy- Poway

PMC Poway

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 92 | 100 | 92% |
| October-22 | 95 | 100 | 95% |
| November-22 | 93 | 100 | 93% |
| December-22 | 93 | 100 | 93% |
| January-23 | 98 | 100 | 98% |
| February-23 | 94 | 100 | 94% |
| March-23 | 93 | 100 | 93% |
| April-23 | 91 | 100 | 91% |
| May-23 | 92 | 100 | 92% |
| June-23 | 98 | 100 | 98% |
| July-23 | 96 | 100 | 96% |
| August-23 | 96 | 100 | 96% |



# Food and Nutritional Services (FANS)

# Labeling and Dating

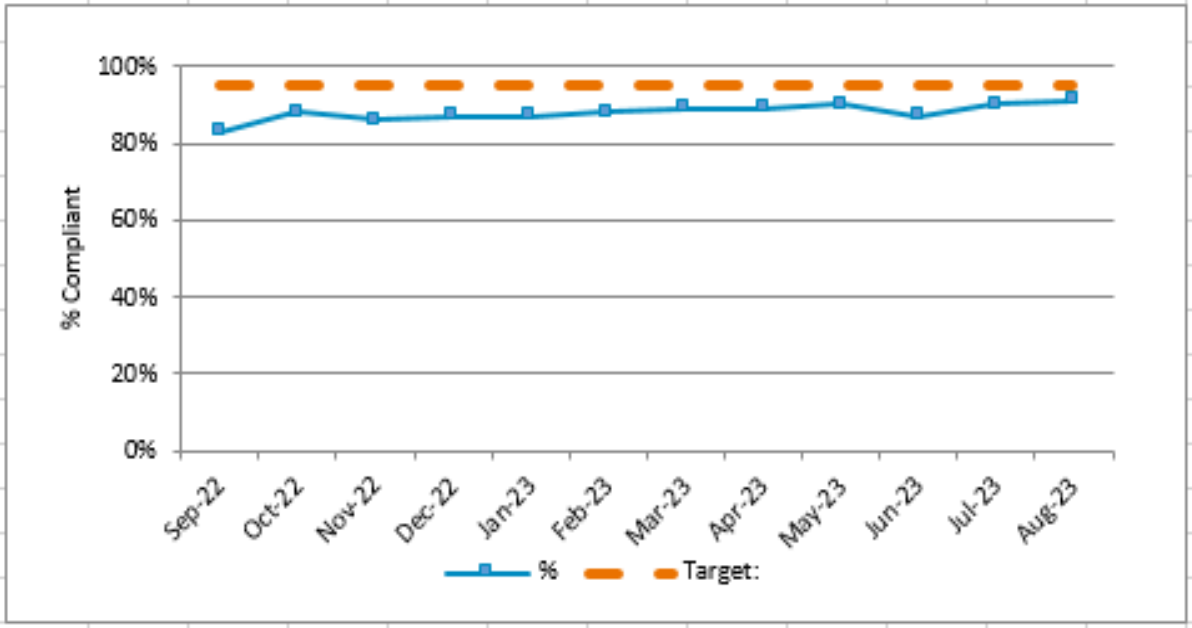
| | |
|---|---|
| **SITUATION** | Currently monitoring label and dating in all storage areas of the kitchen. |
| **BACKGROUND** | FANS leadership is conducting labeling and dating audits to drill down on survey findings. Labeling and dating is monitored to ensure food and patient safety. |
| **ASSESSMENT** | PMCE overall score for labeling and dating is 89%, with an overall consistent upward trend for the past 6 months. PMCP overall score for labeling and dating is 85%.<br><br>Increase in supervisors completing audit has allowed for an increase in rounding. |
| **RECOMMENDATION** | Maintain current goal achievement for label and dating until we can show sustained improvement. With a full supervisor staff at both sites, add additional supervisor and manager rounding at each site. Increase staff education on proper labeling and dating of items. Complete Just-In-Time training with staff when deficiencies are found. |

# Labeling and Dating- Escondido

PMC Escondido

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 83 | 100 | 83% |
| October-22 | 88 | 100 | 88% |
| November-22 | 86 | 100 | 86% |
| December-22 | 87 | 100 | 87% |
| January-23 | 87 | 100 | 87% |
| February-23 | 88 | 100 | 88% |
| March-23 | 89 | 100 | 89% |
| April-23 | 89 | 100 | 89% |
| May-23 | 90 | 100 | 90% |
| June-23 | 87 | 100 | 87% |
| July-23 | 90 | 100 | 90% |
| August-23 | 91 | 100 | 91% |

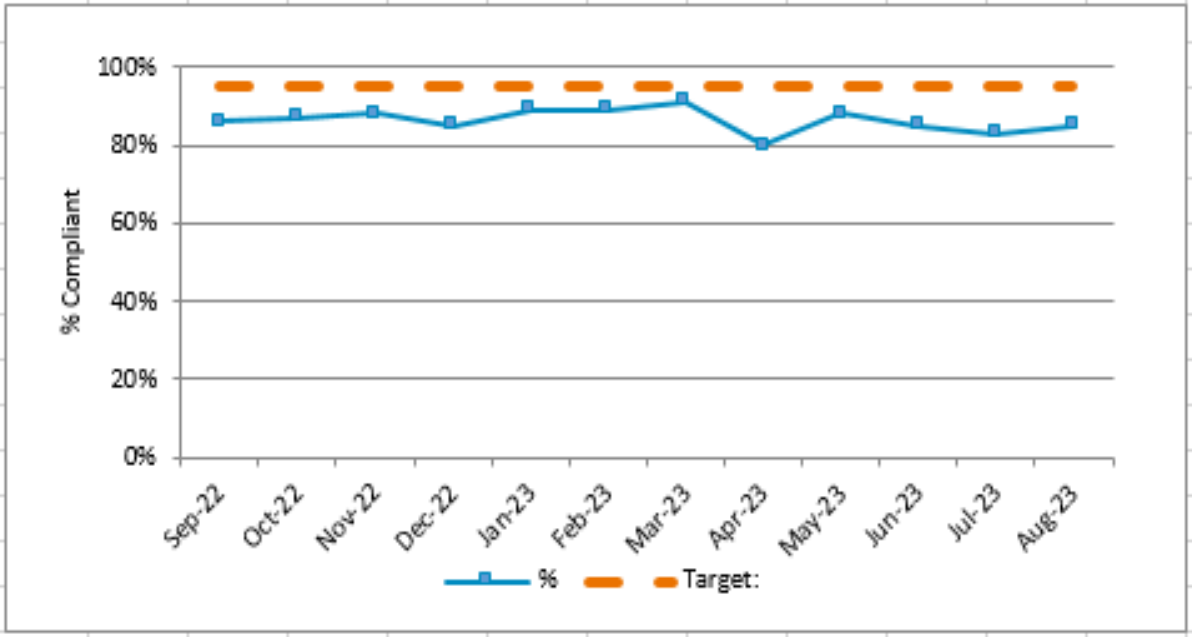


# Labeling and Dating- Poway

PMC Poway

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 86 | 100 | 86% |
| October-22 | 87 | 100 | 87% |
| November-22 | 88 | 100 | 88% |
| December-22 | 85 | 100 | 85% |
| January-23 | 89 | 100 | 89% |
| February-23 | 89 | 100 | 89% |
| March-23 | 91 | 100 | 91% |
| April-23 | 80 | 100 | 80% |
| May-23 | 88 | 100 | 88% |
| June-23 | 85 | 100 | 85% |
| July-23 | 83 | 100 | 83% |
| August-23 | 85 | 100 | 85% |



# Food Service - Action Plan

- **Test Trays:** Test trays at both sites have been increased, to include Registered Dietitians completing trays. New heating equipment has been ordered and is onsite with new wiring to trayline scheduled to be completed early October 2023. Cook workflows being adjusted, along with new competencies, as of October 1, 2023 to adjust plating standards to maintain temperature. New Executive Chef beginning in October 2023 to work with cooks on prep and holding techniques to maintain temperatures.

- **Label and Dating:** Increase staff education on proper labeling and dating of items. Complete Just-In-Time training with staff when deficiencies are found. Increase daily rounding by supervisors to monitor all storage spaces.

# FANS Clinical Nutrition- Pressure Injury

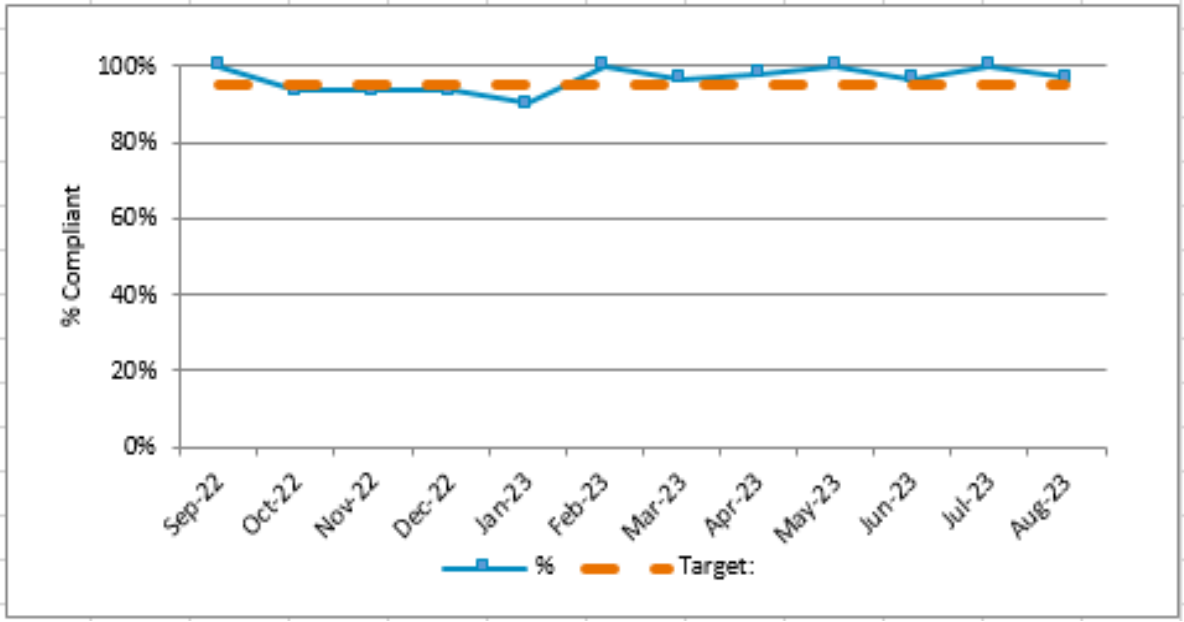
| | |
|---|---|
| **SITUATION** | We monitor Registered Dietitian (RD) documentation and RD Pressure Injury documentation compliance for our Clinical Nutrition indicators. |
| **BACKGROUND** | Accurate nutrition assessment and intervention by the Registered Dietitian (RD) is critical to successfully optimize patients nutritional needs. We consistently conduct chart audits/peer reviews for each dietitian to ensure appropriate documentation.<br><br>Pressure Injury documentation and notification has historically been inconsistent, and needed some process improvement. |
| **ASSESSMENT** | The processes for notification of Pressure Injury have been working well and RD documentation of Pressure Injury are trending towards goal measures. PMCE has achieved and sustained a goal of above 95%. PMCP has achieved 94% compliance with a steady trend towards goal for the previous 3 months. |
| **RECOMMENDATION** | Maintain current goal achievement for pressure injury documentation until we can show sustained improvement at PMCP. Clinical Nutrition Specialist to provide additional education to Dietitians when necessitated. |

# PI Documentation - Escondido

PMC Escondido

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 30 | 30 | 100% |
| October-22 | 28 | 30 | 93% |
| November-22 | 28 | 30 | 93% |
| December-22 | 28 | 30 | 93% |
| January-23 | 27 | 30 | 90% |
| February-23 | 30 | 30 | 100% |
| March-23 | 29 | 30 | 97% |
| April-23 | 47 | 48 | 98% |
| May-23 | 49 | 49 | 100% |
| June-23 | 54 | 56 | 96% |
| July-23 | 57 | 57 | 100% |
| August-23 | 32 | 33 | 97% |

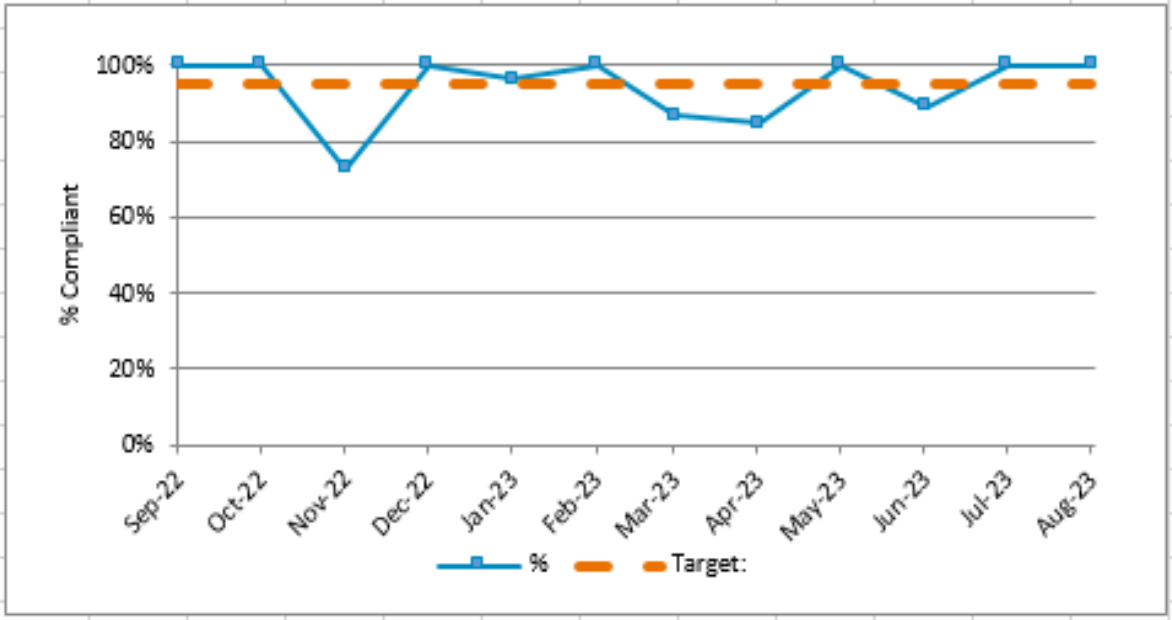


# PI Documentation - Poway

PMC Poway

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| September-22 | 18 | 18 | 100% |
| October-22 | 12 | 12 | 100% |
| November-22 | 8 | 11 | 73% |
| December-22 | 20 | 20 | 100% |
| January-23 | 25 | 26 | 96% |
| February-23 | 19 | 19 | 100% |
| March-23 | 13 | 15 | 87% |
| April-23 | 11 | 13 | 85% |
| May-23 | 20 | 20 | 100% |
| June-23 | 16 | 18 | 89% |
| July-23 | 18 | 18 | 100% |
| August-23 | 20 | 20 | 100% |



# Clinical Nutrition- Malnutrition

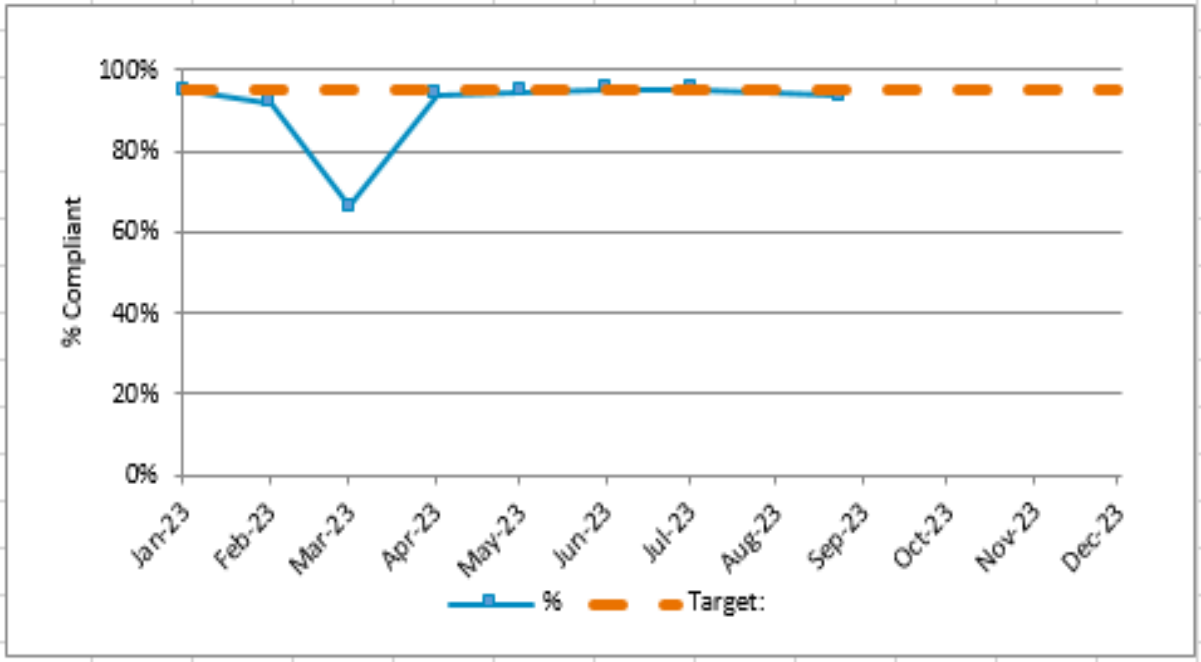
| | |
|---|---|
| **SITUATION** | Patients that are malnourished can increase the cost, Length of Stay, overall outcomes, and increased risk for readmission. The clinical Dietitians had not been following a standardized process to identify malnutrition which includes: conducting Nutrition Focused Physical Examinations (NFPE) using appropriate techniques, using appropriate Problem, Etiology and Signs/symptoms (PES) statements in documentation and providing appropriate interventions. |
| **BACKGROUND** | Evidence has shown that identifying patients with malnutrition in a timely manner and providing appropriate interventions will drastically reduce costs, LOS, overall outcomes and risk of re-admissions. |
| **ASSESSMENT** | A malnutrition process was identified and implemented for the clinical nutrition department starting January 2023 to include a comprehensive training on NFPEs, malnutrition and a guideline for providing interventions.<br><br>PMCE averaged 89% compliance over the last 6 months, however have showed steady improvement towards goal since April 2023. PMCP averaged 78% compliance, showing steady increases towards goal since July 2023. These numbers have been affected by the onboarding of new Dietitians who need additional education on malnutrition interventions and documentation. |
| **RECOMMENDATION** | Educate new Dietitians on proper malnutrition interventions and documentation. Provide education on malnutrition during monthly RD meetings. |

# Malnutrition- Escondido

PMC Escondido

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| January-23 | 108 | 114 | 95% |
| February-23 | 78 | 85 | 92% |
| March-23 | 67 | 101 | 66% |
| April-23 | 92 | 98 | 94% |
| May-23 | 71 | 75 | 95% |
| June-23 | 81 | 85 | 95% |
| July-23 | 79 | 83 | 95% |
| August-23 | 70 | 75 | 93% |
| September-23 | | | #N/A |
| October-23 | | | #N/A |
| November-23 | | | #N/A |
| December-23 | | | #N/A |

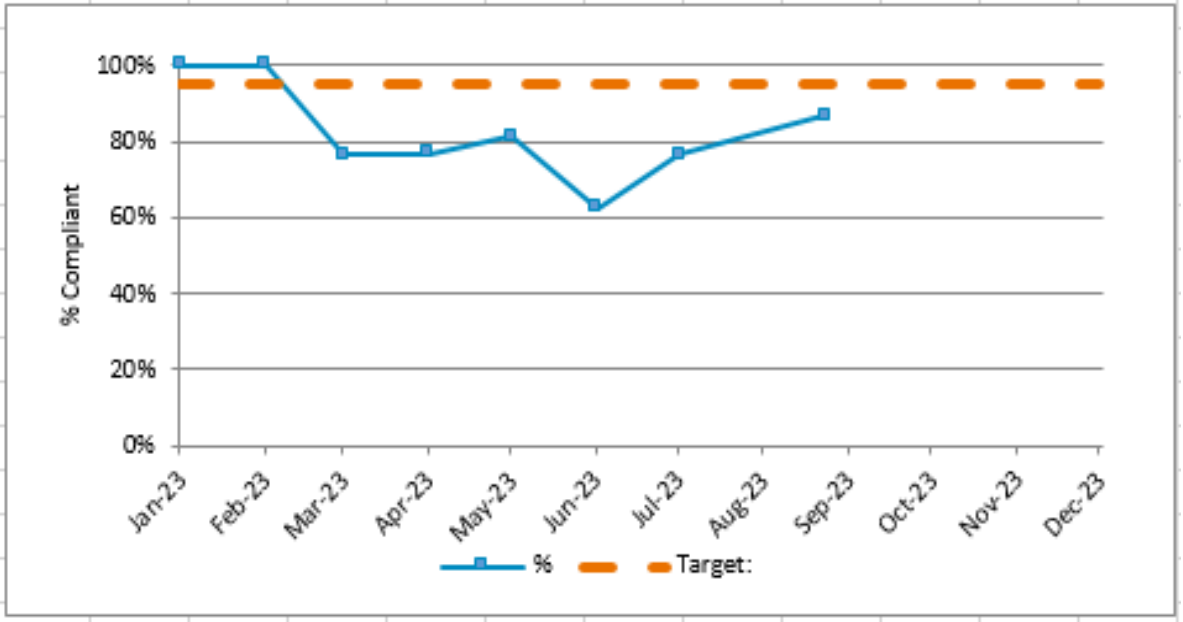


# Malnutrition- Poway

PMC Poway

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

| | Summary | | |
|---|---|---|---|
| | Num | Den | % |
| January-23 | 15 | 15 | 100% |
| February-23 | 14 | 14 | 100% |
| March-23 | 13 | 17 | 76% |
| April-23 | 10 | 13 | 77% |
| May-23 | 13 | 16 | 81% |
| June-23 | 5 | 8 | 63% |
| July-23 | 13 | 17 | 76% |
| August-23 | 13 | 15 | 87% |
| September-23 | | | #N/A |
| October-23 | | | #N/A |
| November-23 | | | #N/A |
| December-23 | | | #N/A |



# Clinical Nutrition - Action Plan

- Malnutrition: Maintain monitoring of proper malnutrition documentation until steady trend to goal can be achieved. Clinical Nutrition Specialist to provide additional education to Dietitians when necessitated. Provide education on malnutrition during monthly RD meetings.

- PI Documentation: Due to significance of pressure injuries, Clinical Nutrition will monitor Pressure Injury documentation with standardized data collection between both facilities.

PALOMAR HEALTH

**ADDENDUM L**

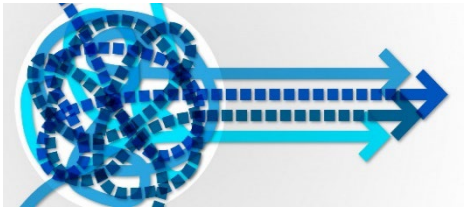
# Nursing Annual Report

## Presented to
## Board Quality Review Committee

**Mel Russell, RN, MSN**
**Chief Nurse Executive**
**October 26, 2023**

# Nursing Annual Report

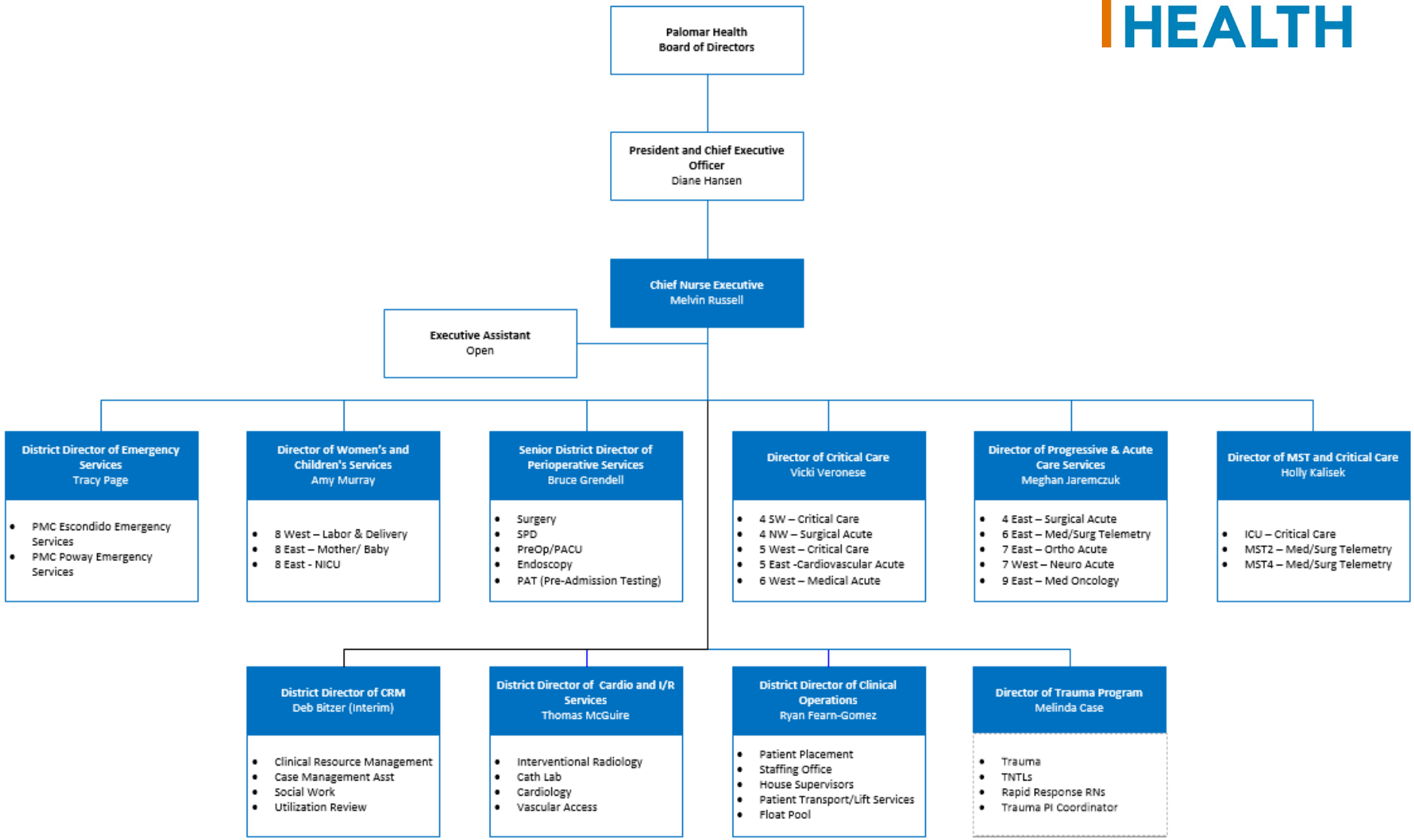
| | |
|---|---|
| **SITUATION** | • Annual presentation to QMC and BQRC |
| **BACKGROUND** | • On an annual basis, the nursing services provide an update on varies awards, metrics, programs, and strategies for improvement. |
| **ASSESSMENT** | • **Awards recognition:** These achievements include a variety of categories including the Emergency department Lantern Award.<br>• **Quality:** Patient Zero Harm: Out of 8 Healthcare acquired conditions - PMCE (6 out of 8) PMCP (6 out of 8) are below the benchmark.<br>• Of note: PMCP had zero Hospital Acquired Conditions during July 2022 – June 2023, which includes CAUTI, CLABSI, and pressure injuries.<br>• **Throughput - Operations:** We consistently maintain high utilization of the discharge lounge at both PMCE and PMCP. Organization wide Capacity Management Plan.<br>• **Birth Center:** HCAHPS – PMCE Birth Center show consistent high scores through August 2023. The overall Cesarean birth rate is below national benchmark.<br>• **Emergency Services:** Process improvement in the Offload area, improved patient communication by implementing Lobby Navigator and Care Plan Passport.<br>• **Inpatient Services:** Creation of Extracorporeal Membrane Oxygenation (ECMO) Program with tentative launch date October 30th |
| **RECOMMENDATION** | • Continue to monitor all extensive performance improvement (PI) work in the Emergency Room, adjusting based on data and feedback.<br>• Monitor Zero Harm: We Aim to drive all eight metrics below zero.<br>• Continue to maximize the utilization of the discharge lounge to support our efforts to improve patient flow.<br>• Continue to monitor data and consistent PI work for the Birth Center and adjust strategies if needed.<br>• ECMO: Upon implementation of ECMO, monitor all metrics and report out to the committees as appropriate. |



# Systemness

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

- Transitioning to a single license
  - Streamlined regulatory compliance
  - Simplified patient transfers
  - Financial efficiency
  - Efficient policies & procedures
  - Improved quality data management
  - Cost savings


Palomar Health
Board of Directors
President and Chief Executive Officer
Diane Hansen
Chief Nurse Executive
Melvin Russell
Executive Assistant
Open
District Director of Emergency Services
Tracy Page
PMC Escondido Emergency Services
PMC Poway Emergency Services
Director of Women's and Children's Services
Amy Murray
8 West – Labor & Delivery
8 East – Mother/ Baby
8 East - NICU
Senior District Director of Perioperative Services
Bruce Grendell
Surgery
SPD
PreOp/PACU
Endoscopy
PAT (Pre-Admission Testing)
Director of Critical Care
Vicki Veronese
4 SW – Critical Care
4 NW – Surgical Acute
5 West – Critical Care
5 East -Cardiovascular Acute
6 West – Medical Acute
Director of Progressive & Acute Care Services
Meghan Jaremczuk
4 East – Surgical Acute
6 East – Med/Surg Telemetry
7 East – Ortho Acute
7 West – Neuro Acute
9 East – Med Oncology
Director of MST and Critical Care
Holly Kalisek
ICU – Critical Care
MST2 – Med/Surg Telemetry
MST4 – Med/Surg Telemetry
District Director of CRM
Deb Bitzer (Interim)
Clinical Resource Management
Case Management Asst
Social Work
Utilization Review
District Director of Cardio and I/R Services
Thomas McGuire
Interventional Radiology
Cath Lab
Cardiology
Vascular Access
District Director of Clinical Operations
Ryan Fearn-Gomez
Patient Placement
Staffing Office
House Supervisors
Patient Transport/Lift Services
Float Pool
Director of Trauma Program
Melinda Case
Trauma
TNTLs
Rapid Response RNs
Trauma PI Coordinator

# Palomar Health Nursing Operations

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

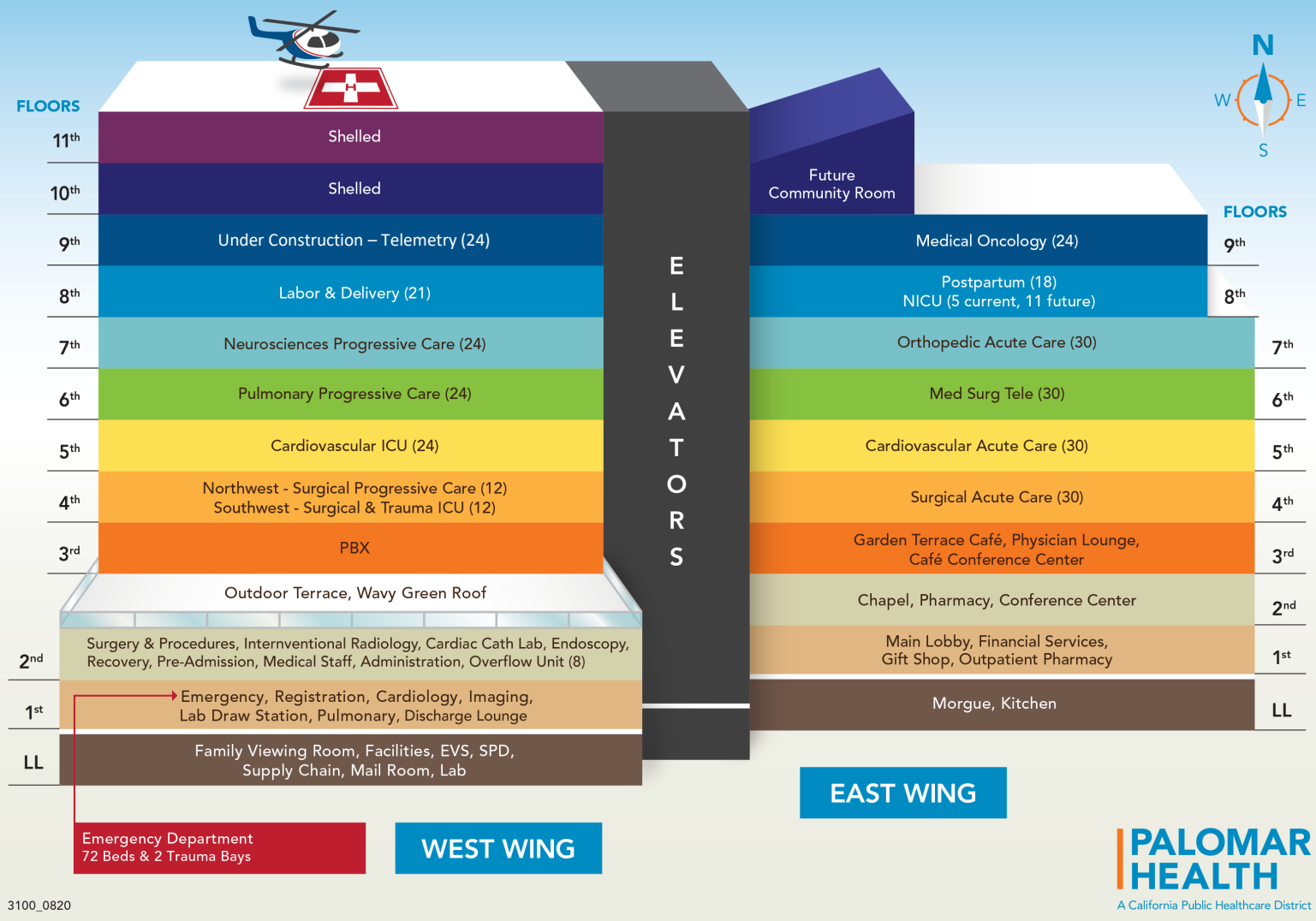
| PMC Escondido | |
|---|---|
| Emergency Department | 4E: Surgical Acute Care |
| Trauma | 5W: Cardiovascular ICU |
| Surgery & Procedures | 5E: Cardiovascular Acute |
| Interventional Radiology | 6W: Pulmonary Progressive Care |
| Cardiac Cath Lab | 6E: MS-Tele |
| Cardiology Services | 7W: Neuro Acute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

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

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

# Palomar Medical Center Escondido

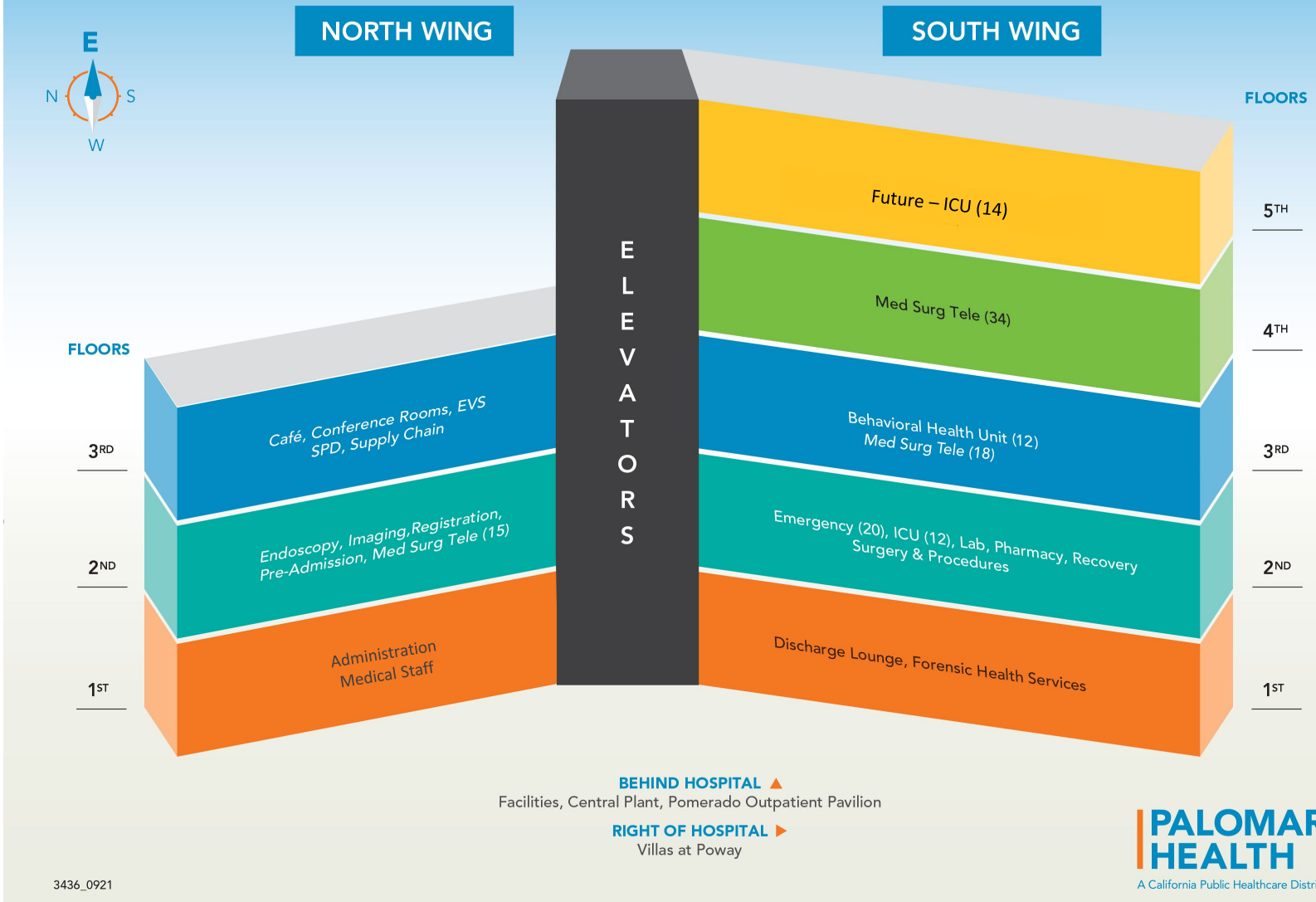
2185 Citracado Parkway, Escondido, CA 92029 | 442.281.5000




PALOMAR HEALTH
A California Public Healthcare District

# Palomar Medical Center Poway

15615 Pomerado Road, Poway, CA 92064 | 858.613.4000



# Palomar Health Distinguished & Key Service Lines

- Orthopedics Center of Excellence
- Bariatric Surgery Center of Excellence
- Stroke Accreditation
- Behavioral Health Services
- Emergency & Trauma
- Center of Distinction, Obstetrics

# Best Hospital Awards



# Quality Awards & Recognition





healthgrades.

**PMC Escondido – 2023:** Patient Safety Excellence Award and Named Among the Top 10% in the Nation for Patient Safety

# Quality Awards & Recognition







**PMC Poway**

**Joint Commission Advanced Total Hip and Total Knee**

# Quality Awards and Recognition

- Escondido:


- Poway:

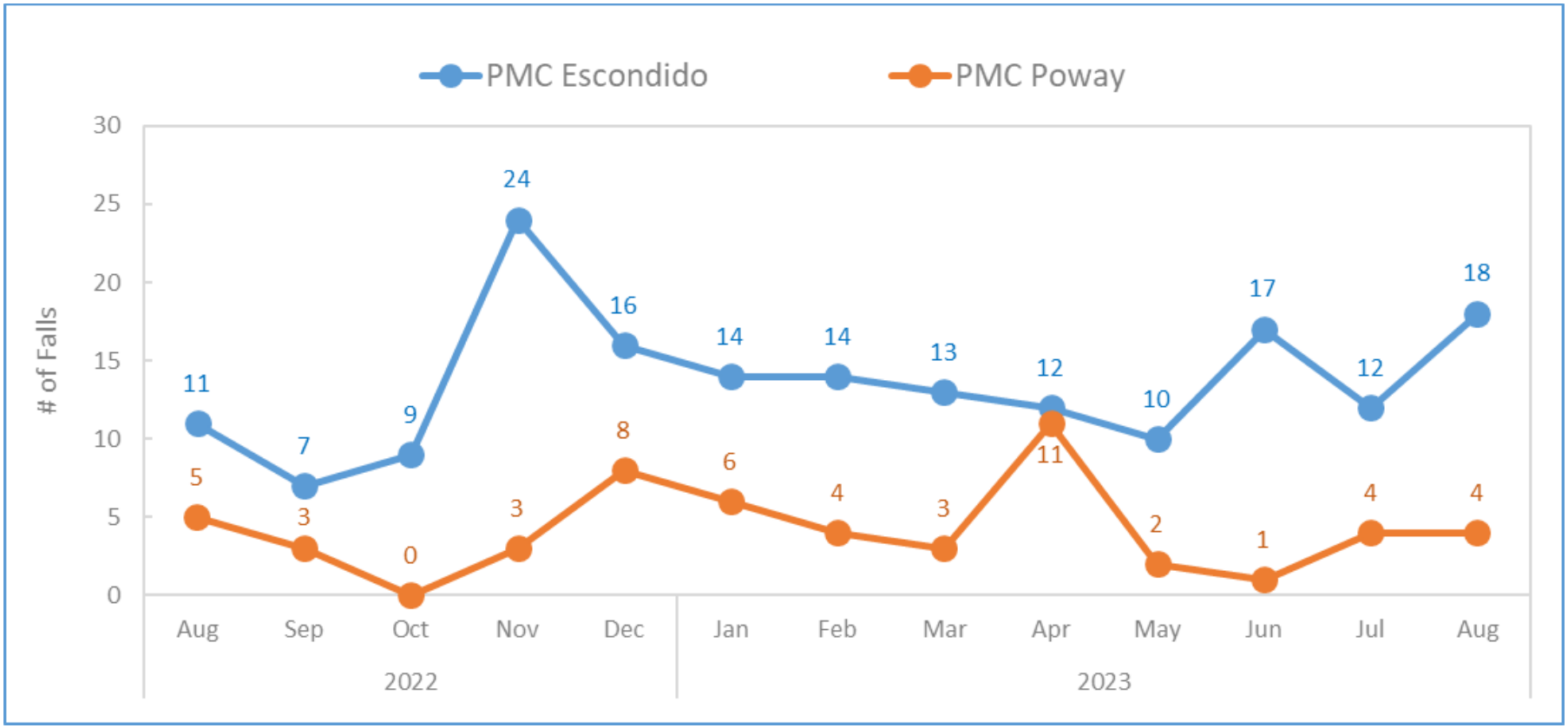
# Palomar Health Zero Patient Harm

| FY2023 Results [July 2022 - June 2023] | | PMC Escondido | PMC Poway | Benchmark |
|---|---|---|---|---|
| CAUTI | SIR | 0.861 | 0.000 | 1.0 |
| CLABSI | SIR | 1.084 | 0.000 | 1.0 |
| CDI | SIR | 0.514 | 0.249 | 1.0 |
| MRSA | SIR | 0.593 | Pred < 1 | 1.0 |
| SSI - COLO | SIR | 0.542 | 0.672 | 1.0 |
| SSI - HYST | SIR | Pred < 1 | Pred < 1 | 1.0 |
| Injury Fall | Rate | 0.29 | 0.19 | 0.26 |
| Pressure Injury | Percent | 0.41 | 0.00 | 1.07 |

*Notes:*

1. *Injury Fall data include inpatient units only. Behavioral Health Unit is excluded.*
2. *Injury Fall benchmark is the non-Magnet 75th percentile from the National Database of Nursing Quality Indicators(NDNQI)*
3. *Pressure Injury benchmark is the non-Magnet 50th percentile from NDNQI*

# Palomar Health Total Patient Falls



PALOMAR HEALTH

# Telephone and Verbal Order (TO/VO) Update

Passion. People. Purpose.™

# The Problem (2021) – Refused Orders

- 530k Total Orders entered per month
- 30k Telephone and Verbal orders
- Refused Orders approx 600/month
  - Patient Safety
  - Regulatory

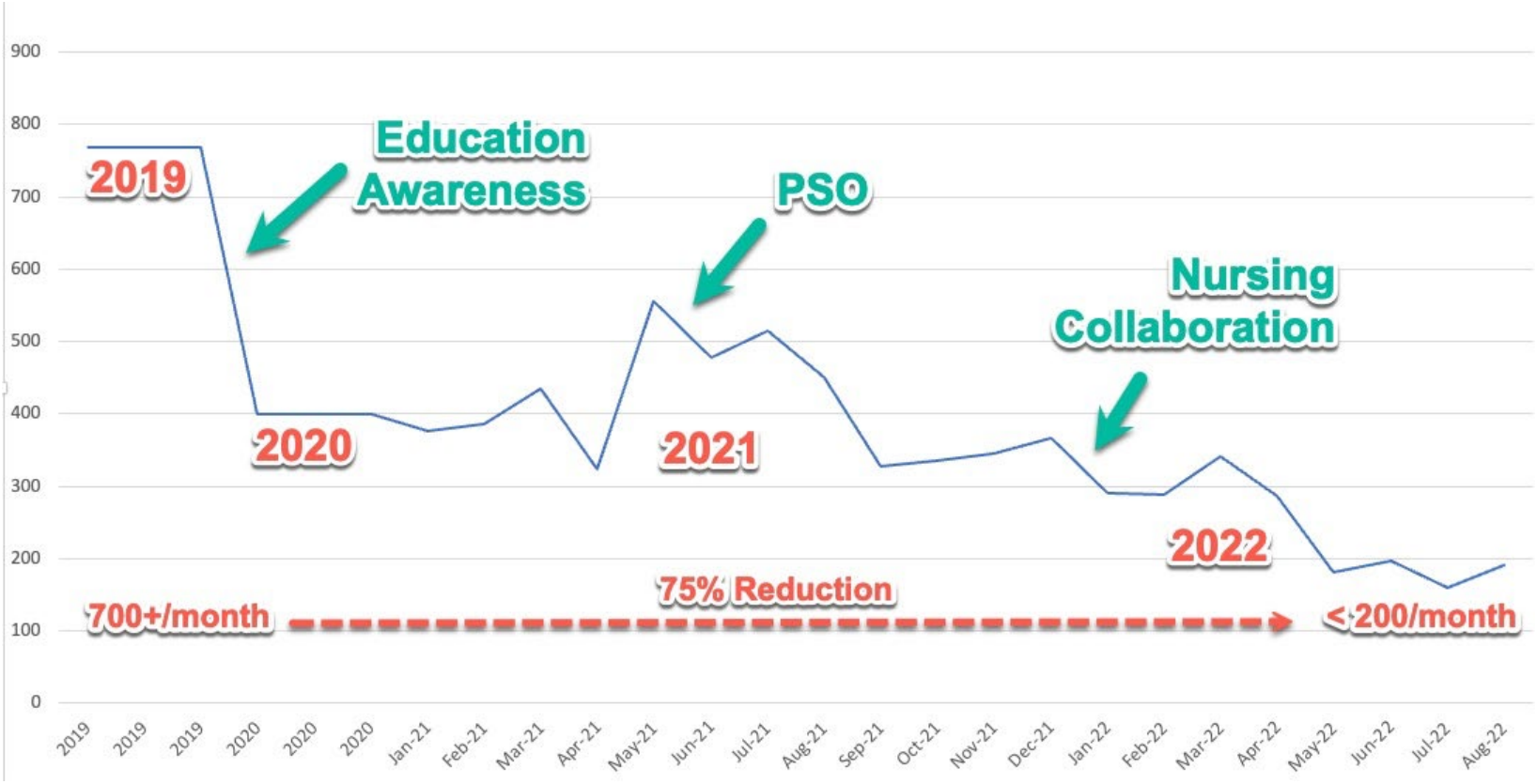
- Collaborative work process resulted in: →

# 2021 to 2023 Update

| Year | CPOE | TO/VO | <48h | >48h | Refused |
|---|---|---|---|---|---|
| Aug 2021 | 86.3% | 25k | 22.1k | 2.9k | 600 |
| Aug 2023 | 87.1% | 23.5k | 19.9k | 3.4k | 158 |

# Refused Orders - Results

- Results have maintained consistently through **August 2023**



PALOMAR HEALTH

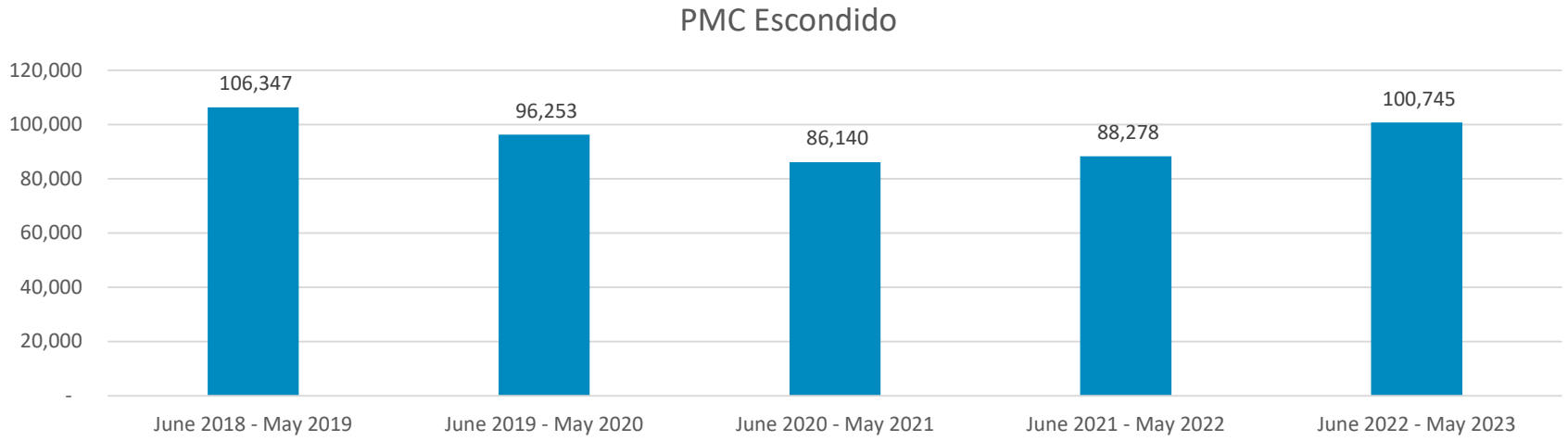
# Discharge Planning and Patient Throughput

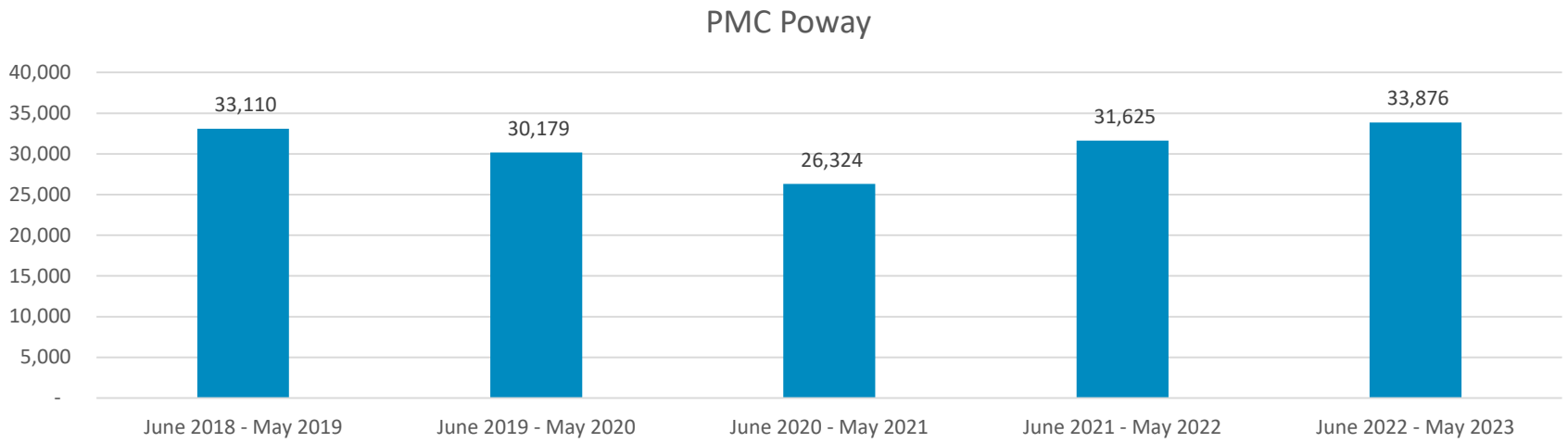
# Discharge Planning & Patient Throughput

| | |
|---|---|
| **SITUATION** | YTD ( July 22 – June 23) overall LOS 4.9 days to budgeted 5.0 days<br>FYTD LOS: **PMC Escondido** 5.0 / Budgeted 4.8 **PMC Poway** 4.8 / Budgeted 5.5 |
| **BACKGROUND** | Throughput and DC planning are strategic initiatives for FY2023 |
| **ASSESSMENT** | **Discharge Planning Challenges:**<br>• Health Plans authorization processes causing Discharge delays<br>• Several patients with limited to no funding ( uninsured / Restricted Medical )<br>• Few SNFs with Custodial Beds<br>• Homelessness/ Drug and Alcohol Abuse<br>• Lack of social support and financial resources<br>• Legal challenges (Conservatorship etc.)<br>• PMC Escondido discharge lounge utilization has increased/remained consistent the last five months at both campuses<br>**Patient Throughput:**<br>• COVID+ inpatient volume has remained low throughout the district<br>• New Capacity Management Plan rollout and utilization of Code Alpha and Code Delta alerts has allowed for greater collaboration throughout the district to improve patient flow and throughput.<br>• 2 Floor Overflow Unit (201 – 208) is being used for Med/Surg inpatients during high volume periods<br>• Continue coordination with Women's Services to utilize Tele beds on 9E when available<br>• Poway MST3 opened 18 additional Telemetry beds February 2023 |
| **RECOMMENDATION** | **Discharge Planning**<br>• Discharge lounges up and running at both campuses.<br>• Working on contract for SNF leased beds for difficult to place patients.<br>• Leverage messaging network to preferred SNF partners regarding bed capacity situation.<br>**Patient Throughput**<br>• Engaged with transfer center workgroup to refine and maximize intra-facility transfers between PMCE & PMCP<br>• Inpatient leaders will identify patients that are appropriate for the discharge lounge each morning and also review pending admissions targeted to their units, entering comments into TeleTracking to ensure appropriate placement<br>• ED/Clinical Operations team to review potential inpatient hold discharges with Dr. Fadhil at MDR meeting<br>• Physician notification during/post Code Delta initiation – (Dr. Khal and Dr. Harrison)<br>• Pro-active approach to Capacity Management. Communication and collaboration between the ED, Clinical Ops, Inpatient Units, Case Management, and ancillary departments will be proactive and focused on early patient movement and discharges |

# Emergency Department Volume

## Palomar Health




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

# Capacity Management Plan

## Palomar Health

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

- NEDOCS (National Emergency Department Overcrowding Scale)

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

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

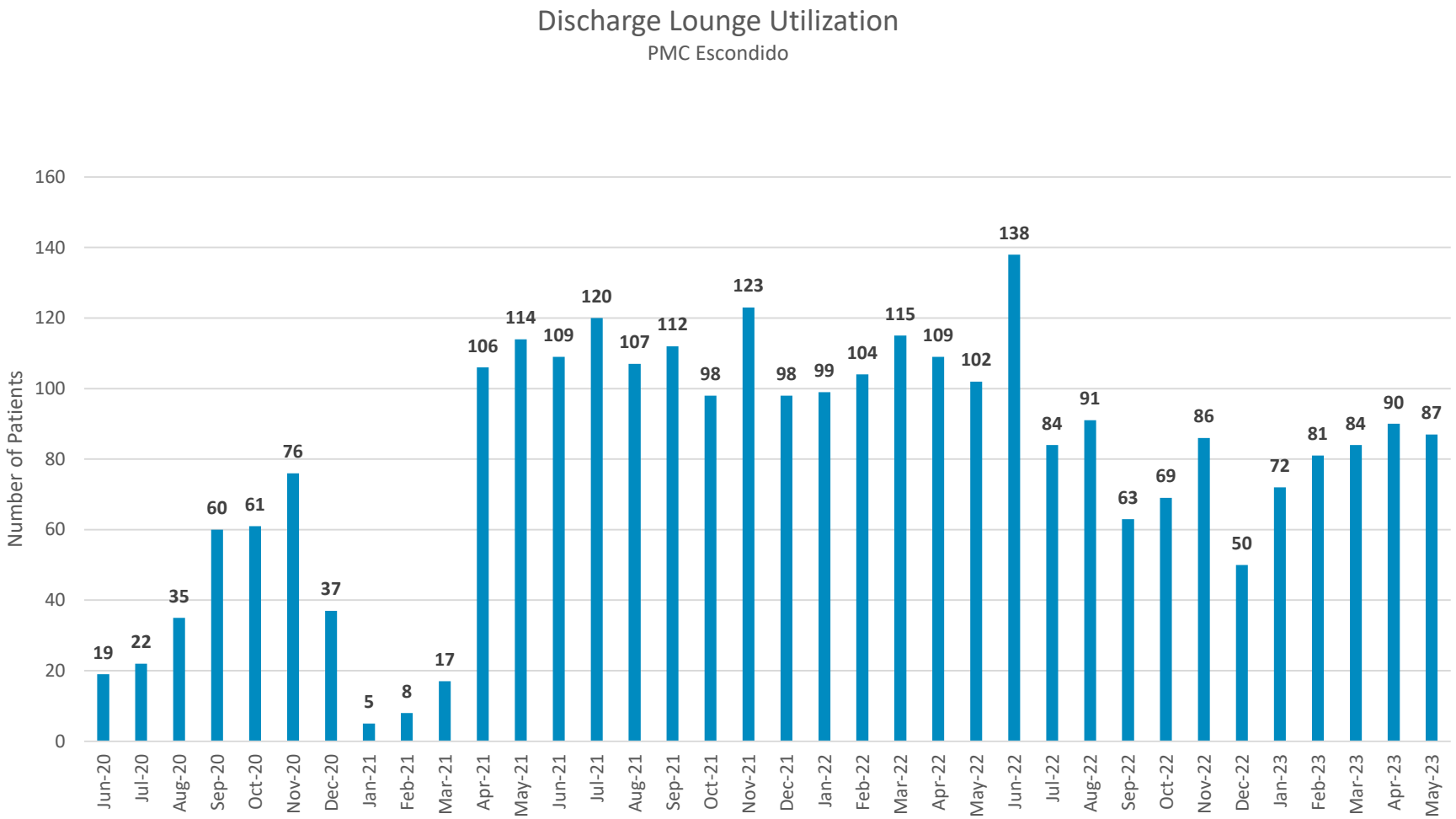
- iXpand Module – Capacity Management Plan and Discharge Lounge

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

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

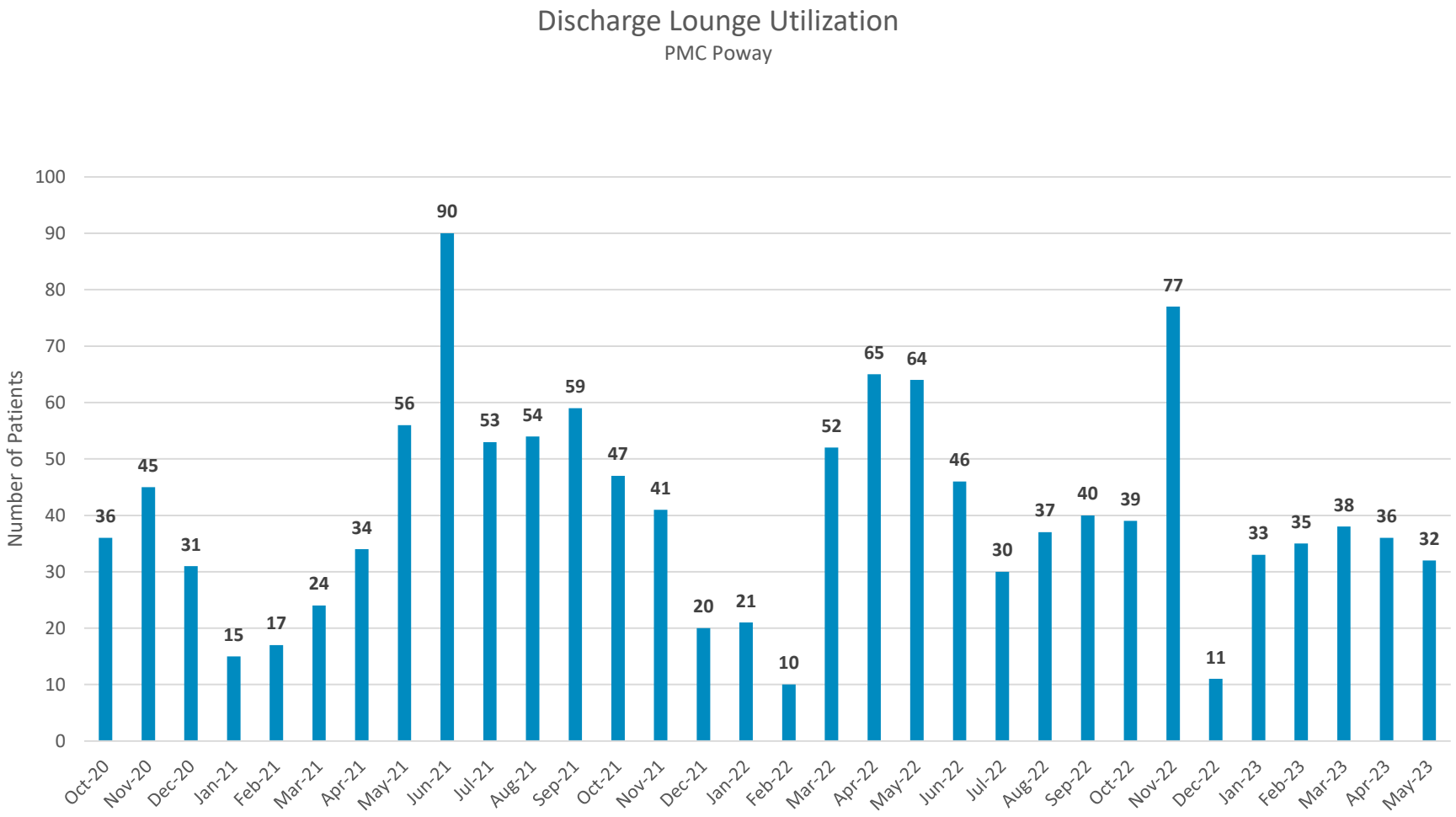
# Discharge Lounge Utilization

## PMC Escondido



# Discharge Lounge Utilization

## PMC Poway

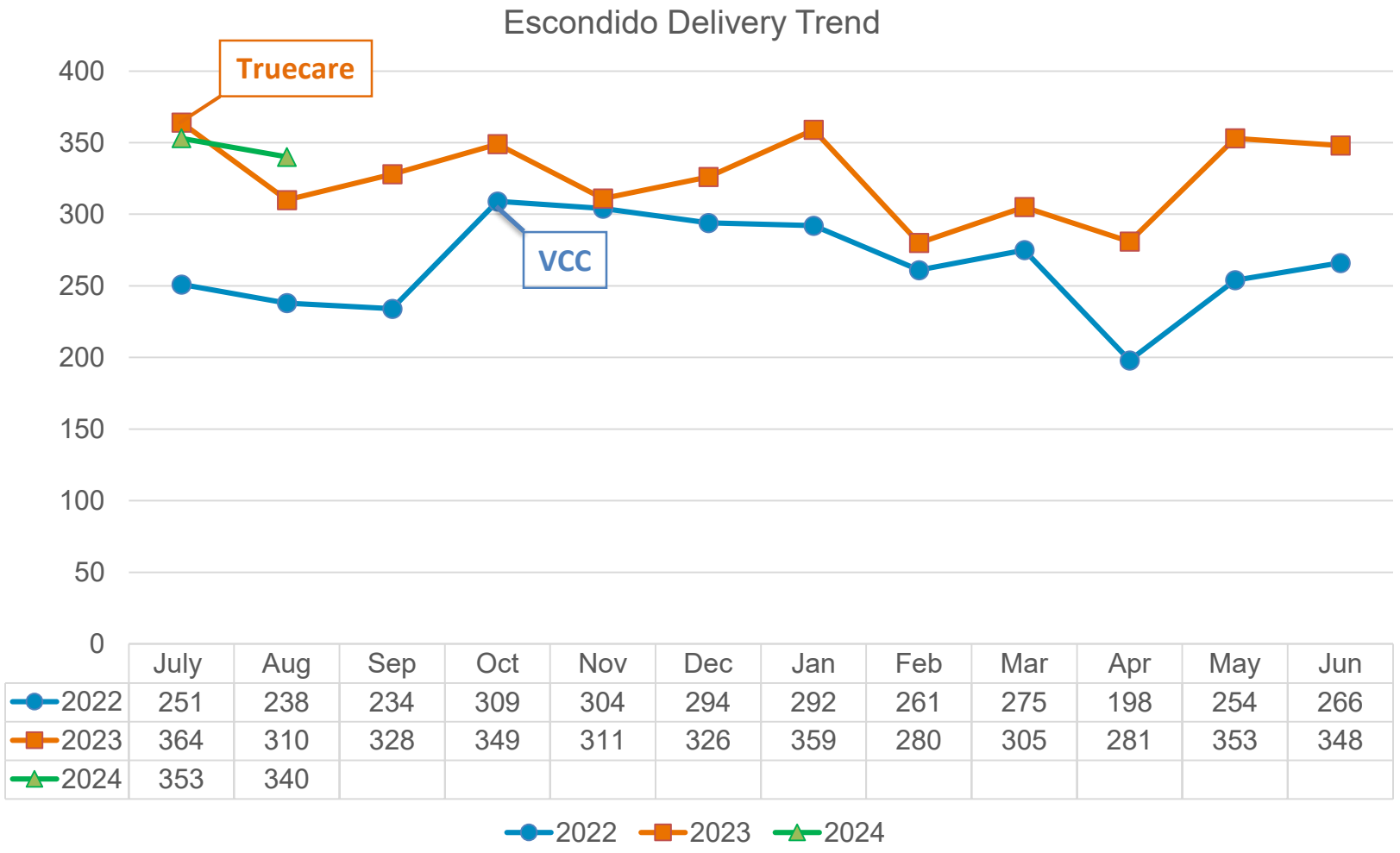


PALOMAR HEALTH

# PMC Escondido Birth Center & NICU

Passion. People. Purpose.™

# Delivery Volume



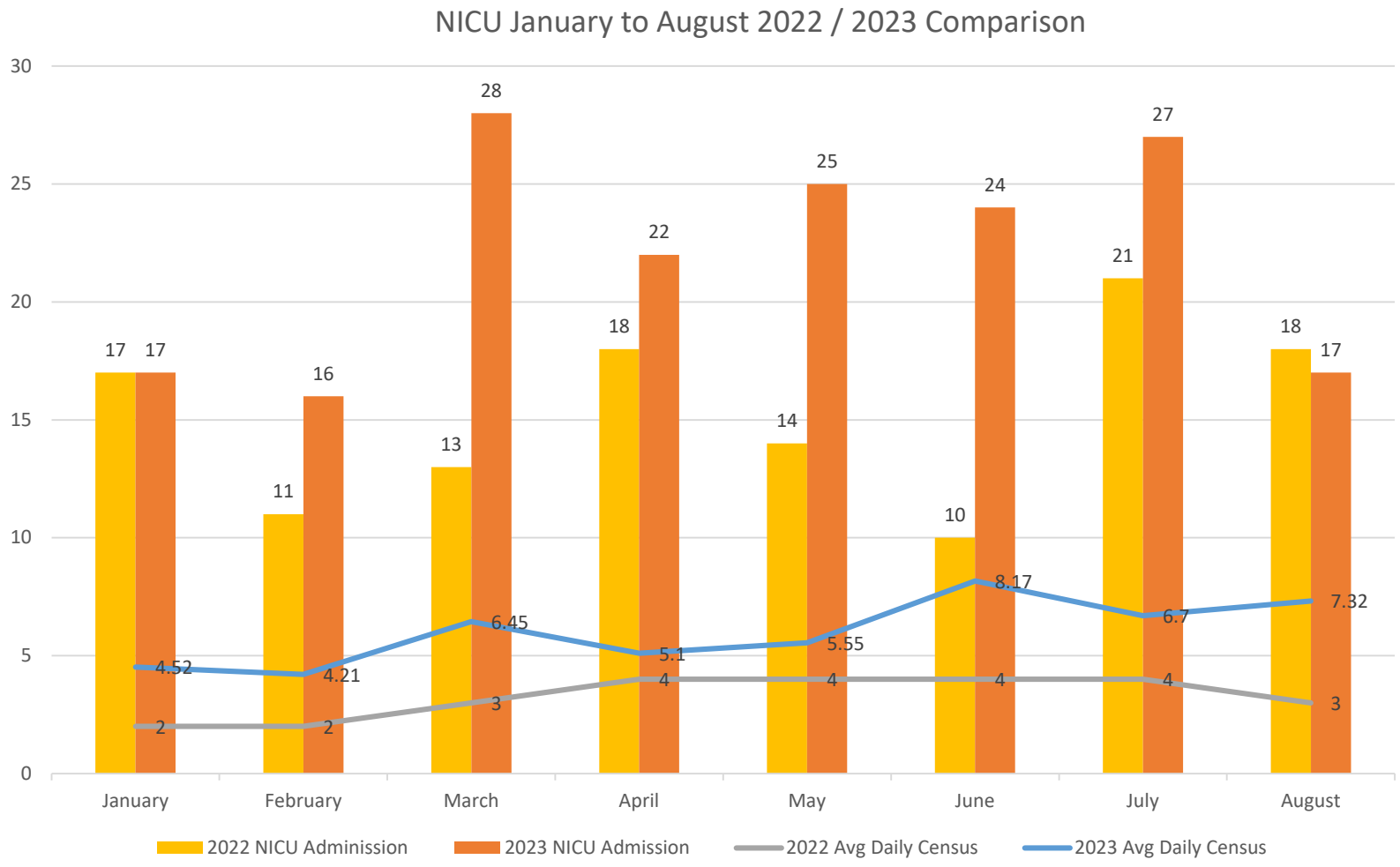

| | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2022 | 251 | 238 | 234 | 309 | 304 | 294 | 292 | 261 | 275 | 198 | 254 | 266 |
| 2023 | 364 | 310 | 328 | 349 | 311 | 326 | 359 | 280 | 305 | 281 | 353 | 348 |
| 2024 | 353 | 340 | | | | | | | | | | |

# Delivery Volume

- Poway closure- June 2, 2023
  - Dr. Fan, +10-15 deliveries per month
  - Dr. Cobb, +30-40 deliveries per month
- Kaiser San Marcos opened- August 9, 2023
  - -80 deliveries per month
- Tri-City Closure- September 30, 2023
  - Volume going to Scripps Encinitas (~20/month)
  - With exception of +5 Optum patients/month

Net change for PMC Escondido Birth Center-
10-35 deliveries/month decrease

# Palomar NICU



# Poway Closure

- Honored the work of Poway Birth Center during the closure
- Held an open house after the closure for past and present staff to celebrate many years of excellent patient care
- Welcomed Poway Birth Center staff to Escondido
  - 21 joined the PMC Escondido Birth Center staff
  - Additional staff took positions within Palomar and with Rady for Palomar's NICU
  - Welcomed staff swag bags, tours, FAQs and more

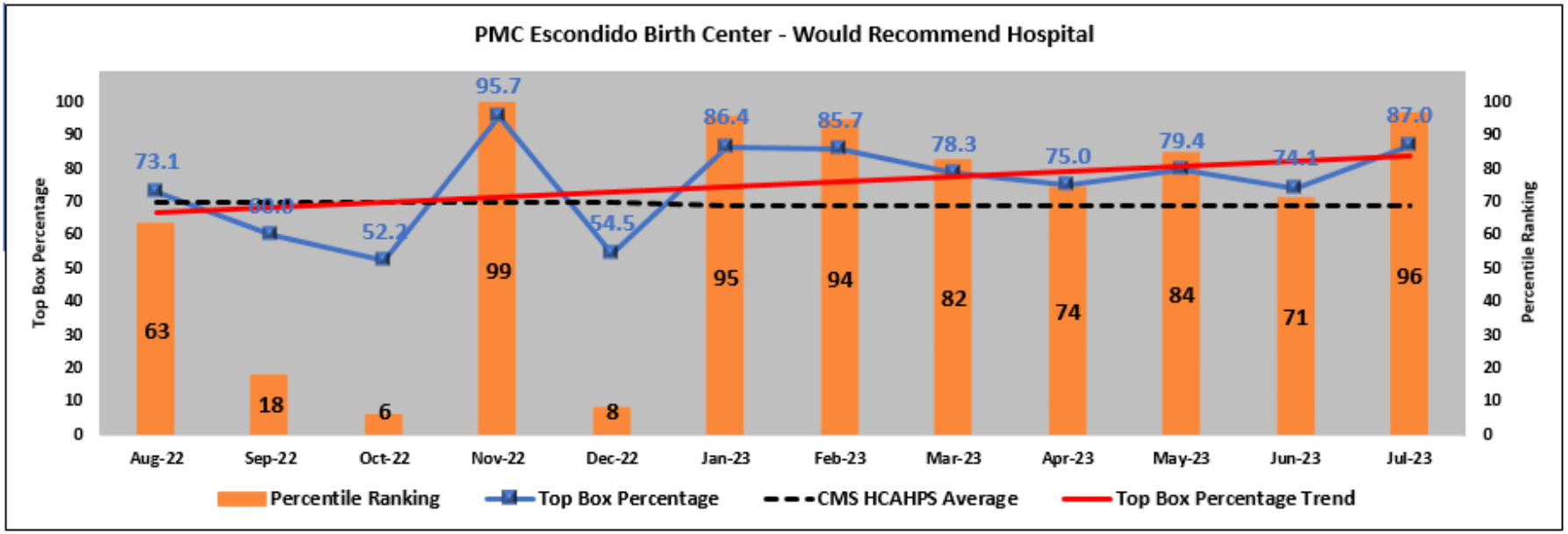
# We Deliver Excellence… in Quality

| Award | 2023 |
|---|---|
| Cal Hospital Compare | ✓ |
| BlueDistinction Specialty Care | ✓ |
| HIGH PERFORMING HOSPITALS U.S.News & WORLD REPORT | **Due out in December** |
| AMERICA'S BEST MATERNITY HOSPITALS 2023 Newsweek statista | ✓ |

# We Deliver Excellence… in Quality

| | August | Q2 2023 | Goal |
|---|---|---|---|
| Overall Cesarean | 20.9% | 25% | ≤ 27.9% |
| Low Risk Cesarean (NTSV) | 18.2% | 21.1% | ≤ 23.6% |
| Timely Treatment of Severe HTN | 100% | 95% | 100% |
| Exclusive Breastfeeding | 58.0% | 52.9% | ≤ 53.2% |

# We Deliver Excellence… in Patient Experience




Interventions leading to consistently high scores:

- Improved leader rounding with real-time feedback to staff
- Standardized patient discharge education process spread over hospital stay
- Increased lactation consultant hours

PALOMAR HEALTH

# Best Practices, Verti-care, Offload Line, Lantern Award: *Palomar Emergency Department*

Passion. People. Purpose.™

# Offload Process


- Standard Work
- Quality Care
- Communication
- Safety
- Patient Experience
- Collaboration with EMS

- Standard Work based on roles (TL, RN, ED Tech, Provider, Charge Nurse)
- Care spaces divided by zones
- RN/ED Tech sign up for patients in their zone and complete orders to the best of their ability
- New Offload Treatment Room

# Collaboration with EMS

- Presented at the County EMS Meeting in March to discuss a county escalation plan once our hospital surge plan has been enacted and medics are in offload delay
- Working on creating of a Ambulance Patient Offload Time (APOT) Committee (Palomar, Tri-City, Scripps Encinitas, North County EMS)
- Building collaboration through EMS Days
  - Community BBQ
- Collaborating with EMS on learning activities
  - Field Care Audits, CEUs
- Charge RN/Offload TL to provide frequent updates when medics are holding the wall
  - #1 complaint is being ignored

# Improvements made by Offload Work Group

## Improving Safety

- Tele Monitoring
- Whistling O2 tanks
- ABL90
- More power outlets
- VPO trial


# Improving Communication

- Gurney labeling
- Communication signs
- Offload TL
- Place Holder


## Improving Quality

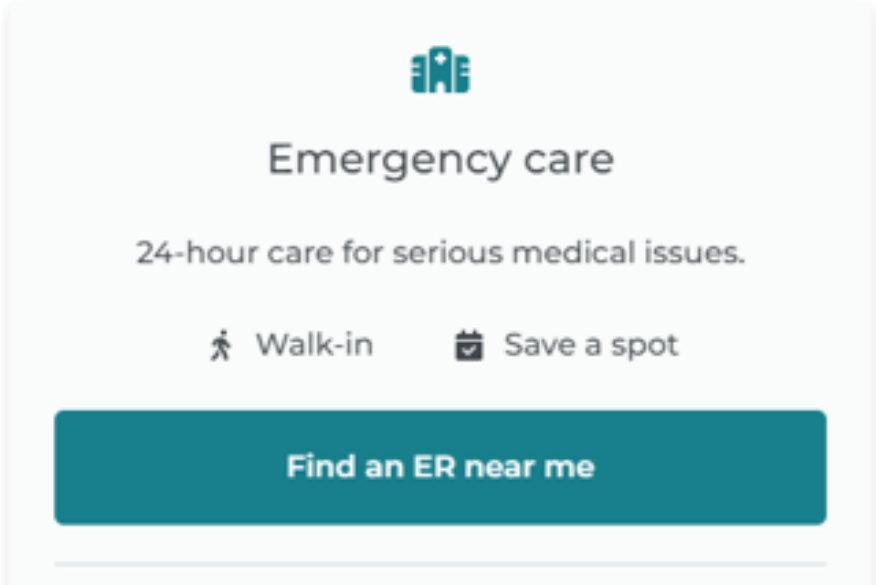
- Aspen Collars

## Improving Patient Satisfaction

- Support Person
- Window tinting

# Appointments

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



# D Hall Extension

- Increased daily census
- Improved door-to-provider times

# Lobby Navigator



Staffed Mon-Fri
11am-9pm

- Customer Service
- Keeping patients/family informed
- Medicating
- Pulling Care Spaces Full
- Addressing Issues in the Waiting Room
- Escorting family back to the offload line

# Care Plan Passport

## MY TEST & MY STATUS

| | Average Time | Ordered | Completed/Care Team Member |
|---|---|---|---|
| EKG | 10–30 Minutes | | |
| Blood Test | 60–90 Minutes | | |
| Urine Test | 60 Minutes After You Provide Sample | | |
| Imaging | X-Ray 60–90 Minutes | | |
| | CT Scan 60–150 Minutes | | |
| | Ultrasound 60–90 Minutes | | |
| Registration | 10–20 Minutes | | |

I Need an IV ☐

Please remove all jewelry and continuous glucose monitors **BEFORE** having imaging studies.

Please do not eat or drink until you are told it is safe to do so.

DESTINATION:

Pod D ☐

Main ED ☐

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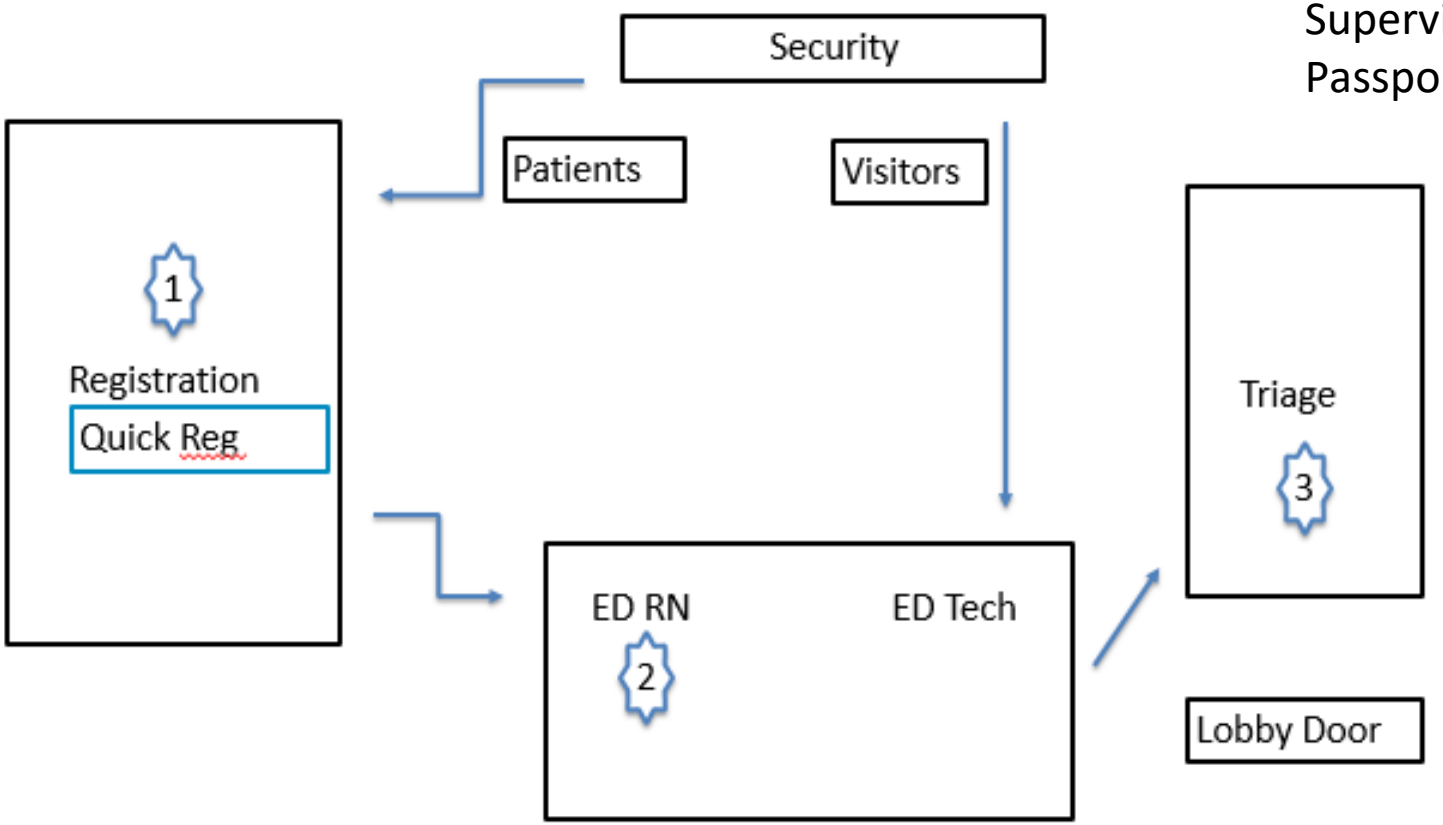
Reimagining Healthcare™

# Nurse Courtesy/Respect

Daily Rounding
Supervisor Classes
Passport Card



# Positive Comments

- I want to say thanks to all the ICU staff, Emergency staff and the 4th & 6th floor nurses & doctors who saw me.  I love everything about Palomar Hospital
- Carol Z. is a really good nurse. She went to school in Philadelphia. Very compassionate and caring. Best nurse I ever had!

# What is the Lantern Award

The ENA Lantern Award was created to recognize emergency departments demonstrating exceptional and innovative leadership, practice, education, advocacy and research performance

# ENA Conference



# Poster Presentations

## The Use of a Hospital-Wide Surge Plan to Decrease Emergency Department Overcrowding

Saturday, September 23, 2023

1:30 PM – 2:00 PM PST

**Tracy Page, DNP, RN, PHN**

District Director of Emergency Services
Palomar Medical Center
Santee, California, United States

## Out-of-Network Transfer/Admission Notification Process Improves Door-to-Registration Time, Patient Repatriation, Through-put and Lost Revenue

Saturday, September 23, 2023

1:00 PM – 1:30 PM PST

**Tracy Page, DNP, RN, PHN**

District Director of Emergency Services
Palomar Medical Center
Santee, California, United States

## Ambulance Offload Process Improves Offload Times

Saturday, September 23, 2023

11:30 AM – 12:00 PM PST

**Tracy Page, DNP, RN, PHN**

District Director of Emergency Services
Palomar Medical Center
Santee, California, United States

PALOMAR HEALTH

# PMC Poway
# Inpatient Services Department

# ECMO- Extracorporeal Membrane Oxygenation Program Update

- Two modes of ECMO
  - VA-Heart and lung support
  - VV-Lung support
- If potential patient for ECMO call 881-ECMO and team will be activated by ICU Charge RN. ECMO Team will review and make decision whether or not to proceed.
- ICU RN ECMO Specialist and Perfusionist will be activated for insertion in OR then transport to ICU.
- With 2 machines we can do 1 patient at a time. For patients that will be long-term on ECMO or potential transplant/other specialty care not done at PH, we will work with our partner hospitals in the county to transfer for ongoing ECMO care.
- Long term vendor back order with the HLS disposable sets for the Cardiohelp (ECMO machine) continue to pose challenges for ECMO centers and has delayed our start.

| Item | Status |
|---|---|
| The two Cardiohelp ECMO machines shipped to Germany for maintenance | Completed |
| Cerner Powerplan and Documentation Build | 90% complete, final meeting to review contents |
| ECMO Cart Build | 90% complete, waiting for two items |
| Finalize staffing with South Coast Perfusions for ECMO Specialist Coverage | Waiting for confirmation from South Coast Perfusion |
| RN ECMO Training including orientation to the OR | Completed 2 cohorts |
| ELSO Hospital Membership | Completed |
| Intensivist Training/Credentialing | Completed |
| ECMO Wet Labs for ongoing education | Started Aug 2023 with bi-monthly schedule |
| ECMO Program Manager | Brian Viele Interim<br>Veblen Hope Zerrudo, Start Date 10/9. Will orient with Brian. |
| Cardiohelp HLS disposables | 2 sets arrived from overseas, 2 more on backorder. |
| Tentative launch date* | October 30th |

***If cannot get 3rd HLS set by this date, will have transfer out process when 1st set used***

PALOMAR HEALTH

**ADDENDUM M**

# Update Infection Prevention & Control Hand Hygiene Program

*January 2023 – August 2023*

Presented to
Board Quality Review Cttee
October 25, 2023

**Valerie Martinez, RN, BSN, MHA, CIC, CPHQ, CPPS**
Senior Director of Quality/Patient Safety/Infection Prevention
Quality and Patient Safety Department

# Board Quality Review Committee ISBARR Executive Summary

PALOMAR HEALTH

Topic: System wide Hand Hygiene Compliance

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

Date: 10.25.2023

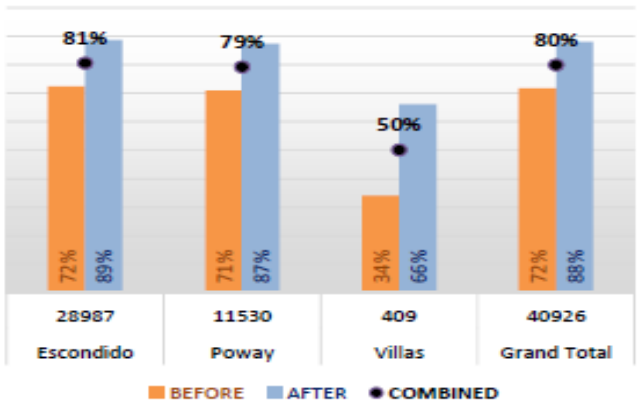
| | |
|---|---|
| *Introduction* | Hand Hygiene: The number one way to prevent infections, a Joint Commission National Patient Safety Goal (NPSG.07.01.01), and a Leapfrog Hospital Survey Patient Safety Practice measure. |
| *Situation* | Set goals for improvement based on guidelines from the Centers do Disease Control and Prevention. Meet patient safety practice measures expressed by Leapfrog. |
| *Background* | The 2022 annual average hand hygiene compliance for all Palomar Health staff included in our direct observation surveillance is 57%. Compliance before and after patient contact was 49% and 65%, respectively. |
| *Assessment* | The 2023 year-to-date overall average hand hygiene compliance is 80%. Palomar Health compliance with hand hygiene has improved 40% from last year.<br>The 2023 compliance before and after patient contact is 72% and 88%, respectively. Palomar Health compliance with hand hygiene before and after patient contact has improved 47% and 35% respectively in comparison to 2022.<br>[graph attached] |
| *Recommendation* | Continue system and unit-based interventions and monitoring:<br>• Monthly system compliance report sent to out to unit Leaders to share with teams.<br>• Infection Prevention and Control Committee (IPCC) monitoring. Units with low compliance create an action plan for discussion and feedback at IPCC.<br>• Unit-based action planning among low-performing units<br>  ○ Monthly unit compliance report & progress tracking<br>  ○ Some actions plans included:<br>  ▪ Staff surveys (e.g. barriers to hand hygiene, perception of indications, etc.)<br>  ▪ Increasing number of dispensers in unit<br>  ▪ Providing personal sanitizer dispensers<br>  ▪ Staff huddle topic<br>• Training & education<br>  ○ Onboarding hand hygiene training with return-demonstration tools<br>  ○ Annual online training module |

# Hand Hygiene Compliance Rate | January to August 2023

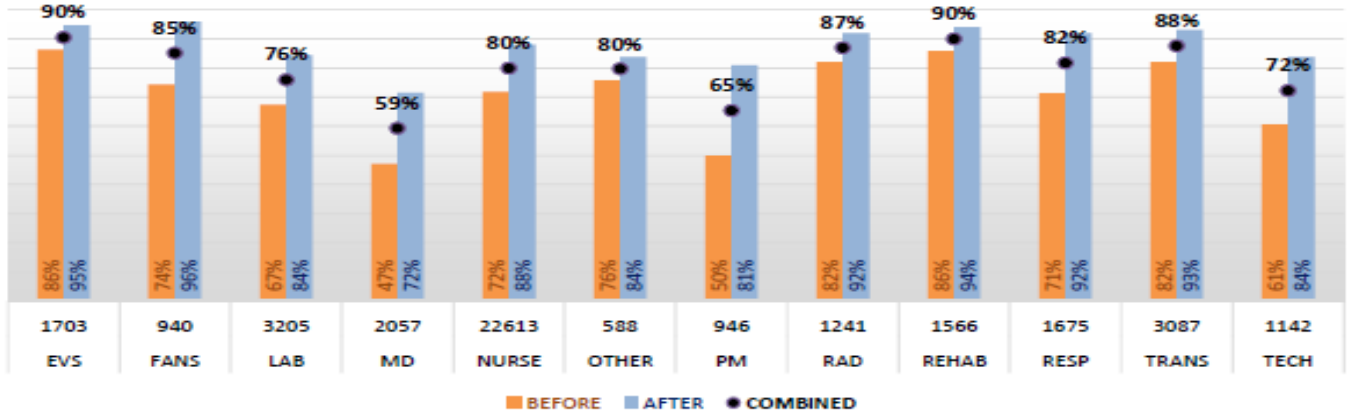
Total Observations (BEFORE and AFTER patient contact): 40926

PALOMAR HEALTH

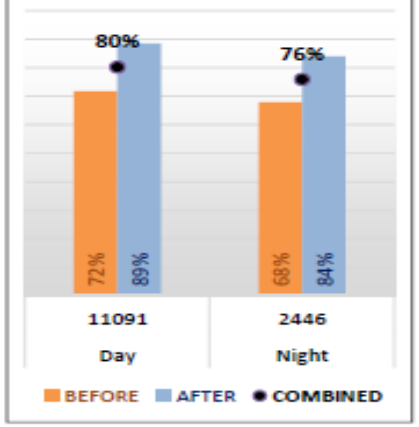
## By Facility and N




## By Discipline and N

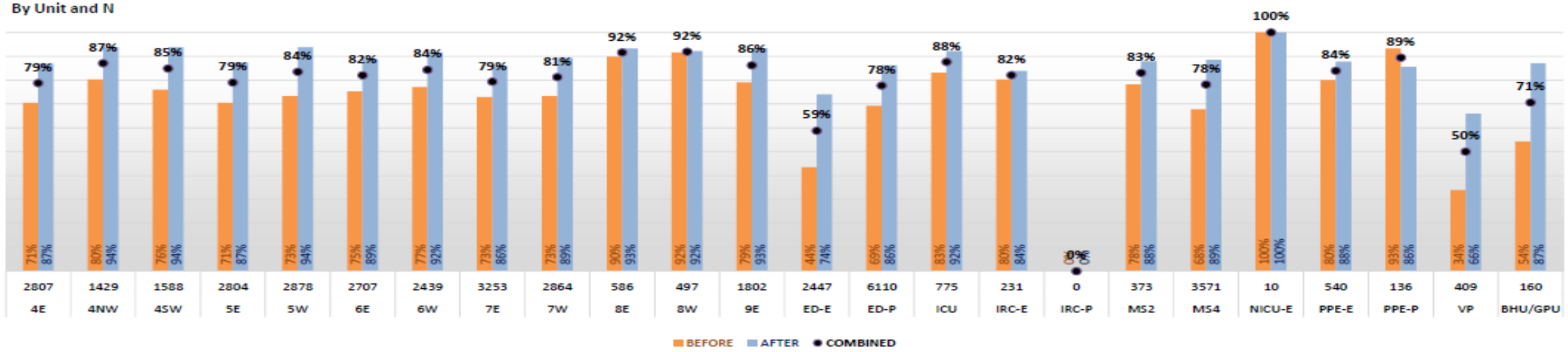



## By Shift and N




NURSE = RN, LVN, CNA, PSC, RN Case Management; RAD = Radiology/Imaging; MD = MD, OD, PA, Nurse Practitioner (NP); FANS = Food service, registered dieticians (RD); RESP = Respiratory care practitioners (RCP); TRANS = Transport/lift team; EVS = Environmental Service; REHAB = PT, OT, Speech therapists; LAB = Phlebotomists; PM = CCE, Pathmakers, Volunteers, Students; TECH = ED techs, Cardiology techs, Medical tech/asst.; OTHER = Security, Social worker, Chaplain, etc.

## By Unit and N




**REMINDERS:**

Portioning or discarding "excess" sanitizer dispensed from wall units is a noncompliant performance of hand hygiene

If you have any questions, please contact Infection Control at 760-521-5243

Previous quarter data and data collection methods can be found on the Palomar Health Intranet on the Infection Control page