Posted
Friday,
November 22, 2024

BOARD QUALITY REVIEW COMMITTEE MEETING AGENDA

Wednesday, November 27, 2024
3:00pm Meeting

PLEASE SEE PAGE 3 FOR MEETING LOCATION

	The Board may take action on any of the items listed below, including items specifically labeled "Informational Only"	Time	Form A Page	Target
CALL TO ORDER				**3:00**
1.	**Establishment of Quorum**	1		3:31
2.	**Public Comments**[1]	30		4:01
3.	**Action Item(s)** *(ADD A)*	5		4:05
	a. Minutes: Board Quality Review Committee Meeting – May 22, 2024 *(Pp 5-8)*	5		4:10
	b. Approval of Contracted Services i. Advantage Ambulance Service *(Pp 9)* ii. Alhiser-Comer Mortuary *(Pp 10)* iii. Becton Dickinson and Company *(Pp 11)* iv. Boston Scientific LabSystem Pro Recording Equipment Evercare *(Pp 12-13)* v. Boston Scientific Micropace Evercare *(Pp 14-15)* vi. California Transplant Services, Inc. *(Pp 16-17)* vii. DaVita Dialysis *(Pp 18-19)* viii. Linde Gas and Equipment Inc. *(Pp 20-21)* ix. Morrison Management Specialists, Inc. *(Pp 22)* x. Richard Bravo Intraoperative Monitoring Services *(Pp 23-24)* xi. South Coast Perfusion, LLC *(Pp 25-26)* xii. Specialty Care IOM Services – Intraoperative Monitoring Services *(Pp 27-28)* xiii. UHS Surgical Services, Inc. *(Pp 29-31)* xiv. Valley Pathology Medical Associates, Inc. *(Pp 32)*	5	2	4:15
4.	**Annual Reports – *Informational Only*** *(ADD B)*	5	3	4:20
	a. Center of Excellence; Cardiovascular and Cardiothoracic Services Annual Report *(Pp 34-44)* b. Dietary (Food and Nutrition Services) Annual Report *(Pp 45-61)* c. Environment of Care and Emergency Management Biannual Report *(Pp 62-73)* d. Hand Hygiene - ISBAR *(Pp 74-75)* e. Management of the Medical Record Biannual Report *(Pp 76-79)* f. Medication Management Biannual Report *(Pp 80-88)* g. Utilization Review Biannual Report *(Pp 89-98)* h. Anesthesia Biannual Report *(Pp 99-108)* i. Nursing Annual Report *(Pp 109-122)* j. Patient Discharge Planning and Throughput Biannual Report *(Pp 123-129)* k. Perioperative Services Biannual Report *(Pp 130-139)* l. Service Excellence (HCAHPS) Biannual Report *(Pp 140-151)*			
5.	**Adjournment to Closed Session**	1		4:21

	Pursuant to CA Gov't Code §54962 & CA Health & Safety Code §32155; HEARINGS – Subject Matter: Report of Quality Assurance Committee	10		4:31
6.	**Adjournment to Open Session**	1		4:32
7.	**Action Resulting from Closed Session**	1		4:33
FINAL ADJOURNMENT		1		4:34

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

NOTE: If you have a disability, please notify us by calling 760.740.6375, 72 hours prior to the event so that we may provide reasonable accommodations

[1] *3 minutes allowed per speaker. For further details, see Request for Public Comment Process and Policy on page 4 of agenda.*

Board Quality Review Committee
Location Options

Palomar Medical Center Escondido
First Floor Conference Room
2125 Citracado Parkway, Suite 300, Escondido, CA 92029

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

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

Meeting ID: 273 911 668 238
Passcode: SB8QEw
or
Dial in using your phone at 929.352.2216; Access Code: 678 091 09#[1]

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

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

		DocID:	21790
		Revision:	9
		Status:	Official
Source: Administrative Board of Directors	**Applies to Facilities:** All Palomar Health Facilities	**Applies to Departments:** Board of Directors	

Policy: Public Comments and Attendance at Public Board Meetings

I. PURPOSE:

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

II. DEFINITIONS:

A. None defined.

III. TEXT / STANDARDS OF PRACTICE:

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

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

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

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

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

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

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

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

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

(REFERENCED BY Public Comment Form

BOARD QUALITY REVIEW COMMITTEE

Meeting will begin at 3:00 p.m.

Request for Public Comments

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

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

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

Public Comments Process

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

Board Quality Review Committee
Contracted Services
Wednesday, November 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, November 27, 2024

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

Background: The Contracted Services Evaluation Reports, agenda item 3, b, i-xiv, are presented to the Board Quality Review Committee for review & approval

Budget Impact: N/A

Staff Recommendation: Approval

Committee Questions:

COMMITTEE RECOMMENDATION:
Motion: Individual
Action:
Information:
Required Time:

Board Quality Review Committee
Annual and Biannual Reports
Wednesday, November 27, 2024

TO: Board Quality Review Committee

MEETING DATE: Wednesday, November 27, 2024

FROM: Omar Khawaja, MD, Chief Medical Officer
Valerie Martinez, Senior Director,
Quality and Patient Safety

Background: The annual and biannual reports, agenda item 4 a-l, are 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:

Required Time:

ADDENDUM A

<table>
<tr><td colspan="4">BOARD QUALITY REVIEW COMMITTEE MEETING MINUTES – WEDNESDAY, MAY 22, 2024</td></tr>
<tr><td>AGENDA ITEM</td><td>CONCLUSION/ACTION</td><td>FOLLOW UP / RESPONSIBLE PARTY</td><td>FINAL?</td></tr>
<tr><td colspan="4">NOTICE OF MEETING</td></tr>
<tr><td colspan="4">The Notice of Meeting was posted at Palomar Health Administrative Office; also posted with full agenda packet on the Palomar Health website on Friday, May 17, 2024, consistent with legal requirements.</td></tr>
<tr><td colspan="4">CALL TO ORDER</td></tr>
<tr><td colspan="4">The meeting, which was held in the Linda Greer Board Room at 2125 Citracado Parkway, Suite 300, Escondido, CA 92029, and virtually, was called to order at 3:30 p.m. by Director Linda Greer, RN.</td></tr>
<tr><td colspan="4">ESTABLISHMENT OF QUORUM</td></tr>
<tr><td colspan="4">Quorum comprised of Board Directors: Greer, Corrales, Barry, MD, Nguyen, MD, Goldsworthy, MD (joined during the New Business section of the agenda)</td></tr>
<tr><td colspan="4">PUBLIC COMMENT</td></tr>
<tr><td colspan="4">• There were no public comments.</td></tr>
<tr><td colspan="4">ACTION ITEMS:</td></tr>
<tr><td>a. Minutes: Board Quality Review Committee Meeting – March 27, 2024</td><td>MOTION: by Director Barry, second by Director Corrales, carried to approve the meeting minutes of March 27, 2024, as submitted.

Roll call voting was utilized.

Director Barry – aye
Director Greer – aye
Director Corrales – aye
Andrew Nguyen, MD - aye

All in favor. None opposed. Motion approved</td><td></td><td></td></tr>
</table>

DRAFT

Discussion:			
b. Approval of Contracted Services I. Corticare II. BD Fusion	**MOTION:** by Director Corrales, second by Director Barry, carried to approve item B, I & II Contracted Services as presented. Roll call voting was utilized. Director Corrales - aye Director Barry – aye Director Greer - aye Andrew Nguyen, MD – aye All in favor. None opposed. Motion approved		
Discussion:			
c. Approval of Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan	**MOTION:** by Director Barry, second by Director Corrales, carried to approve item C Quality Assessment Performance Improvement (QAPI) & Patient Safety Plan. Roll call voting was utilized. Director Corrales - aye Director Barry – aye Director Greer - aye Andrew Nguyen, MD – aye All in favor. None opposed. Motion approved		
Discussion:			
d. Approval of Infection Prevention & Control CY2023 Annual Review and Program Assessment	**MOTION:** by Director Corrales, second by Director Barry, carried to approve item D Infection Prevention & Control CY2023 Annual Review and Program Assessment. Roll call voting was utilized. Director Corrales - aye Director Barry – aye Director Greer - aye Andrew Nguyen, MD – aye		

DRAFT

	All in favor. None opposed. Motion approved		

Discussion:

STANDING ITEMS:

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

- Andrew Nguyen, MD, shared an update of the Medical Executive Committee & the Quality Management Committee, Palomar Medical Center, Poway and Palomar Medical Center, Escondido.

NEW BUSINESS:

a. Radiology & Nuclear Medicine Medical Staff & Department Annual Report

- Dr. Charles McGraw, Chair of Department of Radiology, PMC E and Sims Kendall, Sr. District Director of Imaging, presented the Radiology & Nuclear Medicine Medical Staff & Department Annual Report.

b. Laboratory Services Annual Report (*includes Blood Usage, Tissue Review*)

- Dr. Jerry Kolins, Laboratory Medical Director, presented the Laboratory Services Annual Report.

c. Centers for Excellence – Spine & Total Joint Surgery Annual Report

- Dr. Andrew Nguyen, Spine Surgery Program Medical Director, presented the Centers of Excellence – Spine Annual Report. The Total Joint Report was provided in the meeting packet.

d. Antimicrobial Stewardship Annual Report

- Travis Lau, PharmD, Infectious Disease Specialist and Dr. Sandeep Soni, Medical Director, Infection Control, presented the Antimicrobial Stewardship Annual Report.

ADJOURNMENT TO CLOSED SESSION

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

ADJOURNMENT TO OPEN SESSION

ACTION RESULTING FROM CLOSED SESSION

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

FINAL ADJOURNMENT - The meeting adjourned at 4:45 p.m.

SIGNATURES: **COMMITTEE CHAIR**

____
Linda Greer, RN

DRAFT

COMMITTEE ASSISTANT	______________________ Sally Valle

DRAFT

Advantage Ambulance
Review of Contract Service

Name of Service: Advantage Ambulance Services
Date of Review: 11/21/2024
Name / Title of Reviewer: Ryan Gomez, Vice President of Operations
Nature of Service (describe): Ambulance Transport 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	1st QTR	2nd QTR	3rd QTR	4th QTR	Cumulative Total
Turnaround time from request to pick-up	95%	98%	97%	96%	97%
Transfer documentation required sent with patient	100%	100%	100%	100%	100%
Appropriate type of ambulance and competency of transport team available when requested.	100%	100%	100%	100%	100%

Comments

Advantage Ambulance 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: ______

Palomar Health
Review of Contract Service

Name of Service: Alhiser-Comer Mortuary

Date of Review: 11/2024

Name / Title of Reviewer: Ryan Gomez, Vice President of Operations

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

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

Performance Metrics

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

Comments
No issue with the vendor's service.

Conclusion (check one)

X Contract service has met expectations for the review period

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

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

Palomar Health
Review of Contract Service

Name of Service: Becton Dickinson and Company

Date of Review: 11/2024

Name / Title of Reviewer: Tim Barlow/Ryan Gomez

Nature of Service (describe): Micro lab equipment and reagent supplier

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

Performance Metrics

METRIC	1st_QTR	2nd QTR	3rd QTR	4th QTR	Cumulative Total
Equipment reliability **Target: =/> 90 % up and operational**	100%	100%	100%	100%	100%
Fill rate of reagent/consumables order **Target: =/> 90% order fulfillment**	~95%	~95%	~95%	~95%	95%
Timely service request **Target: Response time </= 48 hours**	<24 hours	<24 hours	<24 hours	<24 hours	<24 hours

Comments
Beckton Dickinson (BD) is very responsive on any type of service or information request.

Conclusion (check one)

X Contract service has met expectations for the review period

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

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

Boston Scientific
Review of Contract Service

Name of Service: Boston Scientific Labsystem Pro Recording Equipment EverCare Service Agreement

Date of Review: 11/21/2024

Name / Title of Reviewer: Tom McGuire/ Director of Interventional Services

Nature of Service (describe):

- Unlimited Service Repair
- One CPU and Amplifier upgrade including all software upgrades
- 100% Coverage on replacement parts for spend predictability
- 24x7x365 phone support to provide first line of help for reduced downtime
- Annual preventative maintenance visit to ensure optimum working condition of equipment
- Loaner unit for downtime
- 48 hour in-person response time
- Priority designation meaning our service prioritized ahead of others without agreement
- One system relocation
- 3 days of clinical training each year of agreement
- Service contract covers LSPRO CPU and clear channel amplifier system

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

Performance Metrics

METRIC	CY 24 QTR 1	CY 24 QTR 2	CY 24 QTR 3	CY 24 QTR 4 (through Nov 21st)	Cumulative Total
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Boston Sci service technicians are professional, arrive on time and is competent in his / her duties.	100%	100%	100%	100%	100%
Personnel employed by	100%	100%	100%	100%	100%

contractor are current in all screening requirements per terms of the contract.					

Comments

Conclusion (check one)

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

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

Boston Scientific
Review of Contract Service

Name of Service: Boston Scientific Micropace Evercare Care Service Agreement

Date of Review: 11/21/24

Name / Title of Reviewer: Tom McGuire/ Director of Interventional Services

Nature of Service (describe):

- Unlimited Service Repair
- Upgrade to Maestro 4000 system
- 100% Coverage on replacement parts for spend predictability
- 24x7x365 phone support to provide first line of help for reduced downtime
- Annual preventative maintenance visit to ensure optimum working condition of equipment
- 48 hour response time
- Service contract covers Micropace Stimulator used in the EP lab

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

Performance Metrics

METRIC	CY 24 QTR 1	CY 24 QTR 2	CY 24 QTR 3	CY 24 QTR 4 (though Nov 21st)	Cumulative Total
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Boston Sci service technicians are professional, arrive on time and is competent in his / her duties.	100%	100%	100%	100%	100%
Personnel employed by contractor are current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

Comments

Conclusion (check one)

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

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

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

California Transplant Services, Inc.
Review of Contract Service

Name of Service: California Transplant Services, Inc.

Date of Review: November 21, 2024

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	FY24 Q2	FY 24 Q3	FY 24 Q4	FY25 Q1	Cumulative Total
Maintains current American Association of Tissue Banks (AATB) Accreditation Certificate	100%	100%	100%	100%	100%
Maintains current Food & Drug Administration (FDA) Tissue Bank Registration	100%	100%	100%	100%	100%
Maintains current State of California Tissue Bank License	100%	100%	100%	100%	100%
Maintains current certificate of Liability Insurance as stipulated in the terms of the contract	100%	100%	100%	100%	100%

Comments: No adverse outcomes reported during this contract evaluation period. CTS was very helpful in providing a list of 33 cranial bone flaps in storage. Annual chart audit revealed cost avoidance opportunity by removing 10 cranial bone flaps that no longer needed to be kept in ultra-low temperature storage.

Conclusion (check one)

√ Contract service has met expectations for the review period.

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

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

☐ The contractual agreement has been terminated without disruption in the continuity of patient care
☐ Other: ____

DaVita Dialysis
Review of Contract Service

Name of Service: DaVita Dialysis

Date of Review: 11/21/24 **Name / Title of Reviewer:** Tom McGuire, Director of Critical Care

Nature of Service (describe): Dialysis including Hemodialysis, Peritoneal Dialysis, Plasmapheresis, CRRT

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	X	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	X	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	X	
4. Actively participates in the organization's quality improvement program, responds to concerns regarding care, treatment, and service rendered, and undertakes corrective actions necessary to address issues identified.	X	
5. Assures that care, treatment, and service 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 2024 1st QTR	CY2024 2nd QTR	CY 2024 3rd QTR	CY 2024 4th QTR (through Nov 21st)	Cumulative Total
Dialysis Machine Water Cultures/Endotoxins Escondido Campus	100% Pass	100% Pass	100% Pass	100% Pass	100% Pass
Dialysis Machine Water Cultures/Endotoxins Poway Campus	100% Pass	100% Pass	100% Pass	100% Pass	100% Pass

Comments

Conclusion (check one)

■ Contract service has met expectations for the review period

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

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

- ☐ The contractual agreement has been terminated without disruption in the continuity of patient care
- ☐ Other: ____

Palomar Health
Review of Contract Service

Name of Service: Linde Gas and Equipment Inc.

Date of Review: 11/21/2024 **Name / Title of Reviewer:** Krysti Johnson RCP Mgr.

Nature of Service (describe): Portable medical gas delivery

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

METRIC	1nd QTR	2rd QTR	3th QTR	4st QTR	Cumulative Total

Performance Metrics Escondido

METRIC	1nd QTR	2rd QTR	3th QTR	4st QTR	Cumulative Total
Responsiveness to emergency request for additional O2	100%	100%	100%	100%	100%

Performance Metrics Escondido

METRIC	1rd QTR	2th QTR	3st QTR	4nd QTR	Cumulative Total
Anticipates increase demand for O2	100%	100%	100%	100%	100%

Performance Metrics Escondido

METRIC	1nd QTR	2rd QTR	3th QTR	4st QTR	Cumulative Total
Cleanliness in service units	100%	100%	100%	100%	100%

Comments

Linde continues be valuable partner in providing Palomar Health with a consistent source/supply of portable O2 cylinders.

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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: ___

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Palomar Health
Review of Contract Service

Name of Service: Morrison Management Specialists, Inc.

Date of Review: 11/2024 **Name / Title of Reviewer:** Ryan Gomez, Vice President of Operations

Nature of Service (describe): Food and Nutrition Services

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

Performance Metrics Escondido

METRIC	1st QTR	2nd QTR	3rd QTR	4th QTR	Cumulative Total
Regulatory Compliance (Health Dept., CDPH, JC) (**Goal: 95%**)	100% MET	100% MET	100% MET	100% MET	100% MET
RD Pressure Injury Documentation Compliance (**Goal: 95%**)	98% MET	87% MET Not Met	97% MET	95% MET	95% MET
RD Malnutrition Documentation **(Goal: 95%)**	93% Not Met	95% MET	98% MET	98% MET	96% MET
Tray Accuracy (**Goal: 95%**)	95% MET	95% MET	96% MET	97% MET	96% MET
Test Tray - Temperature of Food (**Goal 95%**)	75% Not Met	85% Not Met	89% Not Met	91% Not Met	87% Not Met
Labeling and Dating (**Goal 95%**)	89% Not Met	92% Not Met	94% Not Met	95% MET	93% MET Not Met

Comments:

Temperatures of food suffered due to equipment issues/downtime. There were no untoward effects related to temperature. All metrics improving and progressing towards or met goal by end of year.

.

Conclusion (check one)

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

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Richard Bravo Intraoperative Monitoring Services

Review of Contract Service for FY23 (July 1, 2023 – June 30, 2024)

Name of Service: Richard Bravo Intraoperative Monitoring Services
Date of Review: November 21, 2024
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	FY24 QTR 1	FY24 QTR 2	FY24 QTR 3	FY24 QTR 4	Cumulative Total
IOM equipment is clean and in good working order.	100%	100%	100%	100%	100%
IOM Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%
Contract employee is current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

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

Conclusion (check one)

√ Contract service has met expectations for the review period

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

South Coast Perfusion LLC

Review of Contract Service for FY22 (July 1, 2023 – June 30, 2024)

Name of Service: South Coast Perfusion, LLC
Date of Review: November 21, 2024
Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health
Nature of Service (describe): Services provided by South Coast Perfusion, LLC include Cardiopulmonary Bypass (CPB), Autotransfusion services, Ventricular Assist Device (VAD) set-up and monitoring, Extracorporeal Membrane Oxygenation (ECMO) / Cardiopulmonary Support (CPS), provision of Platelet Rich Plasma (PRP), Platelet Poor Plasma (PPP), Platelet Gel, Growth Factors, Intra-aortic Balloon Pump (IABP) set-up and monitoring services.

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

Performance Metrics

METRIC	FY23 QTR 1	FY23 QTR 2	FY23 QTR 3	FY23 QTR 4	Cumulative Total
Perfusionists in the group are current with BLS requirements	100%	100%	100%	100%	100%
Perfusionists in the group are current with annual PPD requirements	100%	100%	100%	100%	100%
Perfusionists in the group are certified through the American Board of Cardiovascular Perfusion	100%	100%	100%	100%	100%
Annual proof of current professional liability insurance coverage	100%	100%	100%	100%	100%

Comments:

Conclusion (check one)

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

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

Specialty Care IOM Services – Intraoperative Monitoring Services

Review of Contract Service for FY23 (July 1, 2023 – June 30, 2024)

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

Date of Review: November 21, 2024

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

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

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

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

Performance Metrics

METRIC	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%
Personnel employed by contractor are 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:

UHS Surgical Services, Inc.

Review of Contract Service for FY22 (July 1, 2023 – June 30, 2024)

Name of Service: UHS Surgical Services, Inc.
Date of Review: November 21, 2024
Name / Title of Reviewer: Bruce R Grendell MPH, BSN, RN District Director, Perioperative Services, Palomar Health
Nature of Service (describe): UHS Surgical Services, Inc. provides services, equipment and supplies as stipulated by the contract. UHS also provides qualified, certified and or licensed personnel to provide technical support to the physicians.

Equipment provided includes:

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

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

Performance Metrics

METRIC	FY24 QTR 1	FY24 QTR 2	FY24 QTR 3	FY24 QTR 4	Cumulative Total
UHS equipment is clean and in good working order.	100%	100%	100%	100%	100%
UHS Technician is professional, arrives on time and is competent in his / her duties.	100%	100%	100%	100%	100%
No cancelled cases related to contracted service Key Performance Indicators (KPIs)	100%	100%	100%	100%	100%
Contractor submits invoices for payment in a timely manner after service provided.	100%	100%	100%	100%	100%
Personnel employed by contractor are current in all screening requirements per terms of the contract.	100%	100%	100%	100%	100%

<u>Comments:</u> All contractors who have involvement in a surgical procedure are expected to arrive on time so biomed can complete their electrical safety checks. There was one incident where the truck broke down on the freeway and the procedure had to be rescheduled. This was deemed beyond the contractor's control. A future mitigation strategy agreed to by the contractor included the staging of a second back-up truck in the Southern Riverside area.

Conclusion (check one)

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

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

Review of Contract Service

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

Date of Review: 11/20/2024 **Name / Title of Reviewer:** Omar Khawaja, MD, MBA, Chief Medical Officer

Nature of Service (describe): Pathology Services

Evaluation	Met Expectation	Did Not Meet Expectation
1. Abides by applicable law, regulation, and organization policy in the provision of its care, treatment, and service.	Y	
2. Abides by applicable standards of accrediting or certifying agencies that the organization itself must adhere to.	Y	
3. Provides a level of care, treatment, and service that would be comparable had the organization provided such care, treatment, and service itself.	Y	
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.	Y	
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.	Y	

Performance Metrics

METRIC	1st QTR	2nd QTR	3rd QTR	4th QTR	Cumulative Total
Passed CAP survey	Y	Y	Y	Y	Y

Comments

Conclusion (check one)

☒ Contract service has met expectations for the review period

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

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

ADDENDUM B

CV COE 2024 Annual Report
Tom McGuire, Director Interventional Svcs | Nov 2024
Presented to Board Quality Review Cttee (BQRC)
PALOMAR HEALTH
Reimagining Healthcare
1

CV COE 2024 Annual Report

SITUATION	Palomar Health (PH) CV Services is a comprehensive and coordinated offering of high quality programs spanning the continuum of care.
BACKGROUND	Services are emergent, maintenance and preventative care including interventional, medical, non-interventional, diagnostic, emergency, surgical and rehabilitation services. Ongoing quality reporting, tracking and responsiveness occurs through several mechanisms. CV care metrics are reported to national and local registries. The CV COE is continuously pursuing new ways to improve, track and report quality.
ASSESSMENT	• STEMI-ACC National Recommendation is <FMC2B is 90 minutes. Current compliance for 2024 is 71% with goal of 75%. Median D2B time for 2024 is 56 minutes. • Chest Pain-MI Platinum award received for 8th consecutive year and successfully recertified for TAVR through NCDR. New metric of EKG read time documentation added this year with current compliance of 63%. • STS CABG- One star in Medication and Morbidity domains and overall one star rating. Improvements being sustained in both categories with higher rate of fall outs occurring in 2021- 2022. Star rating is a rolling 3 year period. • Cath lab room upgrades started in 2024 and will continue in 2025 to improve technology and capacity for advanced procedure capabilities (EP, Neuro and Vascular) • ECMO program started at end of 2023 with 8 patients cannulated thus far. Developed ECMO team alert for faster mobilization and streamlined communication.
RECOMMENDATION	• Start direct to Cath Lab STEMI program with updated PIT stop process to improve FMCD2 compliance • Trial EKG stamp system to remind physicians to time/date and sign all EKGs performed in the ER. Upgrade outdated GE EKG carts district wide to improve compliance and accountability for D2EKG times. • Continue with CVS Excellence committee meetings to evaluate STS metrics and follow-up timely when there are data fallouts. • Continue to develop ECMO program and evaluate opportunity to apply for SD ECRP Designation in 2025

Data Slide

D2D REPORT

Plan	Do - Measurement:		
Indicator	**Numerator**	D2B < or =90 min.	**Target**
D2D < or = 90 min.	**Denominator**	# D2D patients	98%

2024			
	Num	**Den**	**%**
Jan	6	7	86%
Feb	9	11	82%
Mar	9	10	90%
Apr	7	7	100%
May	18	18	100%
Jun	11	11	100%
Jul	10	10	100%
Aug	10	11	91%
Sep	5	6	83%
Oct	3	3	100%
Nov			
Dec			
YTD	88	94	94%

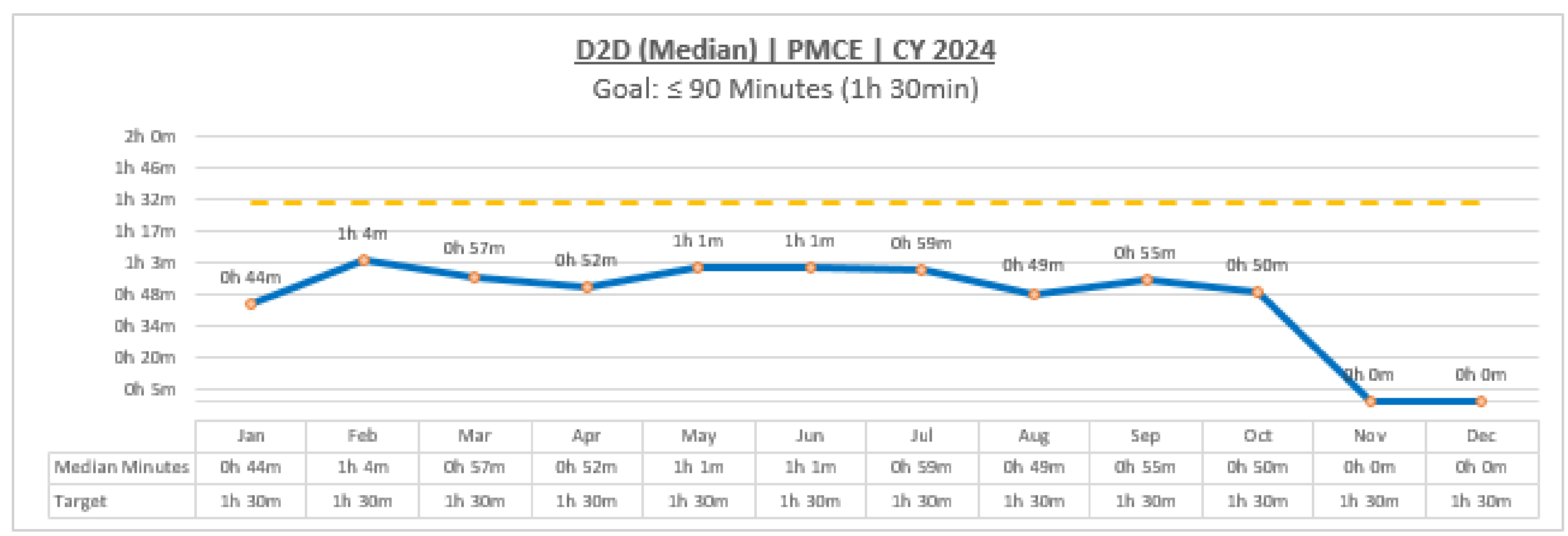
2024

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

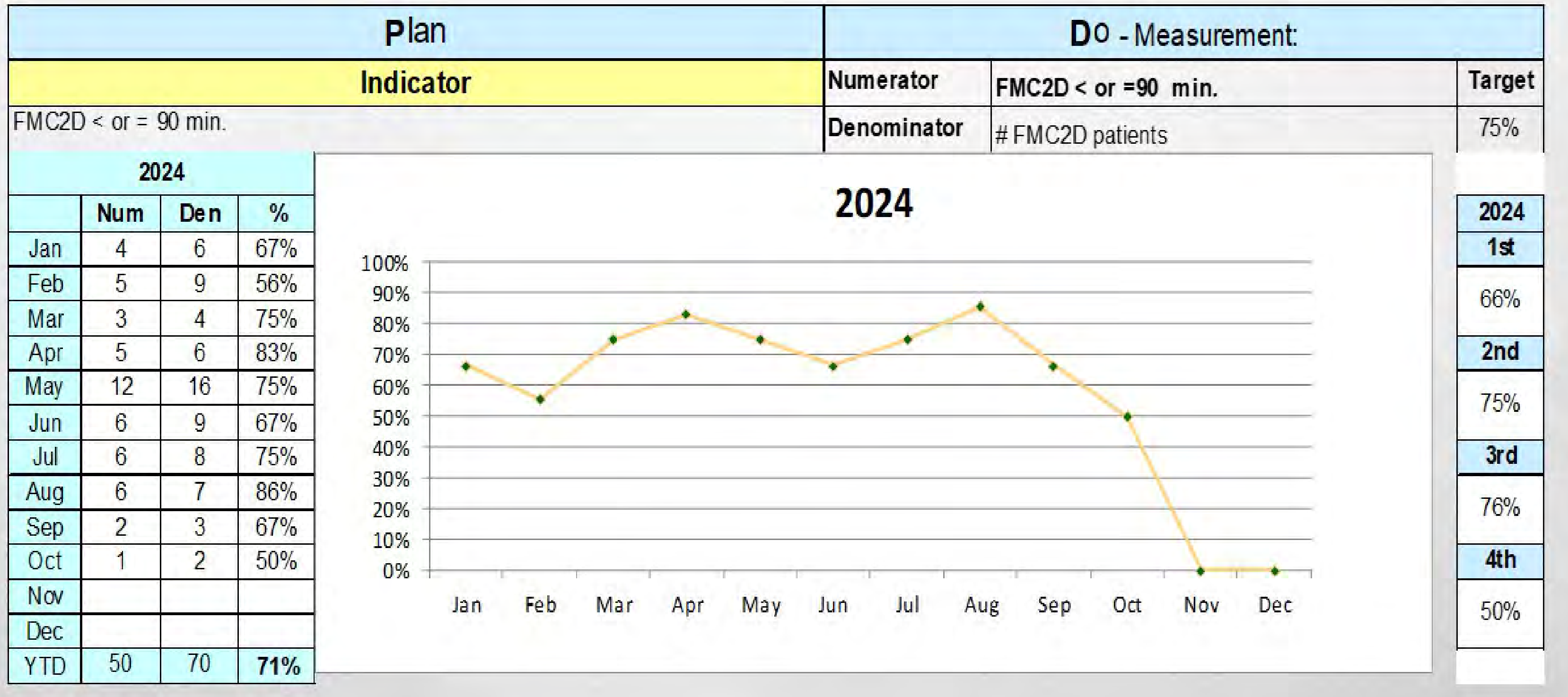
2024
1st
86%
2nd
100%
3rd
91%
4th
100%

Data Slide



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Median Minutes	0h 44m	1h 4m	0h 57m	0h 52m	1h 1m	1h 1m	0h 59m	0h 49m	0h 55m	0h 50m	0h 0m	0h 0m
Target	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m	1h 30m

Data Slide



FMC2D REPORT

Plan	Do - Measurement:		
Indicator	Numerator	FMC2D < or =90 min.	Target
FMC2D < or = 90 min.	Denominator	# FMC2D patients	75%

2024			
	Num	Den	%
Jan	4	6	67%
Feb	5	9	56%
Mar	3	4	75%
Apr	5	6	83%
May	12	16	75%
Jun	6	9	67%
Jul	6	8	75%
Aug	6	7	86%
Sep	2	3	67%
Oct	1	2	50%
Nov			
Dec			
YTD	50	70	**71%**

2024
1st
66%
2nd
75%
3rd
76%
4th
50%

Data Slide

NCDR — Chest Pain - MI Registry™

AMERICAN COLLEGE of CARDIOLOGY

Overview | Metric Summary | Metric Detail | DQR Summary | Switch Registry | Log out

BENCHMARKS FROM: 2024Q1 | ENDING TIMEFRAME: 2024Q2* | SUBMITTED AS OF: 8/23/2024 2:17:02 PM | AGGREGATED AS OF: 9/29/2024 8:26:00 AM

Key Metrics		My R4Q	50th US Pctl	% Qtr Variance
7172	Overall AMI performance composite	97.9% (2650/2708)	96.4%	-2.2%
8134	Overall defect free care (NQF Endorsed)	86.3% (328/380)	79.4%	-15.4%
7915	STEMI performance composite	98.5% (1163/1181)	97.8%	-1.1%
8402	NSTEMI performance composite	97.4% (1487/1527)	96.1%	-3.2%
8311	Acute AMI performance composite	97.8% (653/668)	97.4%	-2.7%
7702	Discharge AMI performance composite	97.9% (1992/2035)	96.4%	-2.0%

Patient Type and Mode of Arrival

Patient Type

396

2

163

231

NSTEMI

STEMI (pre-admit)

STEMI (in-hosp)

Mode of Arrival

115

96

EMS Self/Family Transferred in

Outcome Metrics		Observed	Outcome	50th US Pctl
8461	In-hospital risk standardized mortality (All AMI patients)			4.88
7727	In-hospital risk standardized bleeding rate			3.56
12007	In-hospital Risk Standardized Length of Stay >= 3days			15.14
11896	In-hospital Risk Standardized Discharge to Post Acute Care			2.67

Time-Based Metrics		My R4Q	50th US Pctl	% Qtr Var
11392	Median time (min) from symptoms to device	156	153	-31%
11460	Median time (min) arrival to device	60	57	-7%
11575	Median time (min) from cath lab arrival to device	29	24	-3%

Data Slide

NCDR AMERICAN COLLEGE of CARDIOLOGY

CathPCI Registry®

Jennifer De La Barrera
961287 - Palomar Medical Center

Overview | Metric Summary | Metric Detail | Follow-up | Follow-up Detail | DQR Summary | Switch Registry | Log out

BENCHMARKS FROM:	ENDING TIMEFRAME:	SUBMITTED AS OF:	AGGREGATED AS OF:
2024Q1	2024Q1	(Blank)	7/2/2024 11:59:59 PM

Key Metrics

		My R4Q		50th US Pctl	% Qtr Variance
4449	PCI for STEMI w/in 90 min	95.92% (94/98)	↑	94.12%	-4.17%
4603	Composite: Major AE all pts	5.13% (27/526)	↓	2.39%	14.59%
4855	Composite: PCI guideline discharge meds	99.0% (490/495)	↑	98.4%	-1.6%
5002	PCI radiation dose documented	99.8% (539/540)	↑	98.9%	-0.7%
5000	Composite: Major AE select pts	2.1% (10/482)	↓	1.6%	-11.1%
5003	Cardiac rehabilitation referral	88.6% (437/493)	↓	92.2%	0.9%

Volume Summary

Number of Patients

526

526

Pts with PCI (with or without dx coronary a... Pts with dx coronary angi...

Number of Procedures

540

PCI procedures (with or without dx coronary an... Dx coronary angio procedures...

Outcome Metrics

		Observed	Outcome		50th US Pctl
4934	Risk standardized bleeding (all pts)	15	2.13	↓	1.93
13046	Risk standardized mortality (all pts)	21	1.81	↑	1.97
13047	Risk standardized mortality (pts w/out STEMI)	8	0.99	↑	1.08
15678	Risk standardized AKI (all pts)	38	7.89	↓	7.47

Time-Based Metrics

		My R4Q	50th US Pctl	% Qtr Var
4448	Median time to PCI for STEMI pts	61	63	4%
4451	Median transfer time door to door for STEMI pts	71	78	5%
4452	Median time to PCI for transfer STEMI pts	106	109	23%
4340	Median LOS post STEMI PCI	2.15	2.21	-2.35%
5004	Median time to PCI for in-hosp STEMI	44.0	69.7	417.6%

Data Slide

No changes on Star Ratings comparing to last reporting period ending Dec 2022

STS CABG Composite Quality Rating
Participant: 14836
STS Period Ending Dec 2023

Domain	Rating	Participant			STS				
		Score	95% CI	Change	Score	Min - Max	10th	50th	90th
Overall	★	94.98% ↑	(93.20-96.42)	Increase from 94.58%	96.87% ↑	(87.84-99.17)	95.35%	97.08%	98.18%
Absence of Mortality	★★	97.10% ↑	(95.12-98.45)	Increase from 96.92%	97.49% ↑	(90.59-99.38)	96.12%	97.69%	98.63%
Absence of Morbidity	★	84.37% ↑	(79.51-88.57)	Increase from 83.92%	90.39% ↑	(66.54-96.81)	86.37%	90.83%	93.89%
Use of IMA	★★	98.87% ↓	(97.22-99.75)	Decrease from 99.57%	99.55% ↑	(87.09-99.99)	99.01%	99.77%	99.95%
Medications	★	89.33% ↑	(84.54-93.29)	Increase from 79.04%	95.06% ↑	(31.93-99.97)	88.37%	97.65%	99.63%

★ Worse than Expected. Participant's performance is significantly worse than expected for their specific case-mix.

★★ As Expected. Participant's performance is not statistically different than expected for their specific case-mix.

★★★ Better than Expected. Participant's performance is significantly better than expected for their specific case-mix.

Data Slide

The Society of Thoracic Surgeons

Isolated CABG
Percent of patients who received beta blockers within 24 hours preceding surgery
(Higher Rate is Better)

PMC ESC
STS Average

100%
80%
60%
40%
20%
0%

98.0%
95.5%
100.0%
100.0%
100.0%
96.7%

2021
2022
2023
2024 Q1
2024 Q2

ISOLATED CABG STAR RATING = 1 STAR

Measure Inclusions/Exclusions: Include all patients undergoing isolated CABG but exclude "Contraindicated" or "Emergent" or "Emgergent/Salvage".

Data Slide

The Society of Thoracic Surgeons

Isolated CABG
Percent of patients who require intubation for more than 24 hours
(Lower Rate is Better)

PMC ESC
STS Average

40%
30%
20%
10%
0%

13.6%
18.2%
13.3%
0.0%
6.7%
5.6%

2021
2022
2023
2024 Q1
2024 Q2

ISOLATED CABG STAR RATING = 1 STAR

Measure Inclusions/Exclusions: Include all patients undergoing isolated CABG but exclude patients expired in the OR.

Action Plan with Timeline

- Started direct to Cath Lab STEMI program October 1st 2024 with updated PIT stop process to improve FMCD2 compliance
- Nov 2024-Trial EKG stamp system in ER
- Ongoing-Continue with CVS Excellence committee meetings to evaluate STS metrics and follow-up timely when there are data fallouts

FANS & Clinical Nutrition QAPI

Presented to Board Quality Review Committee

Nicole Hite, MS, RDN- Director of FANS
Carrie Johnsen, MPH, RDN- Clinical Nutrition Manager
November 2024

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 86% with a steady trend upwards for tray temperatures over the previous six months. Temperatures had slight declines in June 2024 when disposable tray ware was used due to a broken dish machine. Equipment was repaired in late July 2024, with tray temperatures showing improvement shortly after. PMCP overall score for accuracy is 96% and temperature is 90%, a 6% increase over the previous 12 months. New dishware, smaller tray delivery carts, and improved education on production tallies contributed to increase in tray accuracy and temperatures. New patient dishware was implemented in March 2024 at both campuses, improving temperatures of main entrees and hot sides. Challenges remain with keeping cold foods and beverages at temperature.
RECOMMENDATION	Maintain current goal achievement for tray accuracy to show consistency can be maintained for next 6 months. Continue phase in of new dishware and holding equipment to maintain improvement in temperatures of hot foods. Monitor staff's appropriate usage of cool check bins when delivering cold items on patient trays.

Test Tray Temperatures- Escondido

PMC Escondido

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

	Summary		
	Num	Den	%
September-23	63	100	63%
October-23	75	100	75%
November-23	86	100	86%
December-23	83	100	83%
January-24	90	100	90%
February-24	89	100	89%
March-24	89	100	89%
April-24	89	100	89%
May-24	90	100	90%
June-24	87	100	87%
July-24	90	100	90%
August-24	91	100	91%

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-23	89	100	89%
October-23	84	100	84%
November-23	89	100	89%
December-23	89	100	89%
January-24	93	100	93%
February-24	87	100	87%
March-24	83	100	83%
April-24	94	100	94%
May-24	95	100	95%
June-24	86	100	86%
July-24	94	100	94%
August-24	95	100	95%

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-23	92	100	92%
October-23	95	100	95%
November-23	93	100	93%
December-23	96	100	96%
January-24	95	100	95%
February-24	95	100	95%
March-24	96	100	96%
April-24	99	100	99%
May-24	95	100	95%
June-24	97	100	97%
July-24	95	100	95%
August-24	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-23	96	100	96%
October-23	92	100	92%
November-23	97	100	97%
December-23	98	100	98%
January-24	97	100	97%
February-24	97	100	97%
March-24	95	100	95%
April-24	97	100	97%
May-24	96	100	96%
June-24	97	100	97%
July-24	96	100	96%
August-24	95	100	95%

FANS Labeling and Dating

SITUATION	FANS is currently monitoring label and dating of food items in all storage areas of the kitchen.
BACKGROUND	FANS leadership is conducting labeling and dating audits to drill down on survey findings. Labeling and dating is monitored to ensure food and patient safety.
ASSESSMENT	PMCE overall score for labeling and dating remains at 90 for the past 12 months. PMCP overall score for labeling and dating is 96%, meeting the 95% goal for the previous 9 months.
RECOMMENDATION	Maintain current goal achievement for label and dating until we can show sustained improvement. Increase staff education on using the correct labels for open items. Complete Just-In-Time training with staff when deficiencies are found. Have PMC Poway leadership meet with PMC Escondido leadership to share best practices for increasing labeling and dating compliance.

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-23	88	100	88%
October-23	87	100	87%
November-23	90	100	90%
December-23	91	100	91%
January-24	91	100	91%
February-24	92	100	92%
March-24	90	100	90%
April-24	89	100	89%
May-24	89	100	89%
June-24	89	100	89%
July-24	87	100	87%
August-24	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-23	92	100	92%
October-23	94	100	94%
November-23	94	100	94%
December-23	95	100	95%
January-24	96	100	96%
February-24	95	100	95%
March-24	96	100	96%
April-24	97	100	97%
May-24	96	100	96%
June-24	97	100	97%
July-24	96	100	96%
August-24	97	100	97%

Food Service - Action Plan

- **Test Trays:** Maintain current goal achievement for tray accuracy to show consistency can be maintained for next 6 months. Continue phase in of new dishware and holding equipment to maintain improvement in temperatures of hot foods. Monitor staff's appropriate usage of cool check bins when delivering cold items on patient trays.

- **Label and Dating:** Maintain current goal achievement for label and dating until we can show sustained improvement. Increase staff education on using the correct labels for open items. Complete Just-In-Time training with staff when deficiencies are found. Have PMC Poway leadership meet with PMC Escondido leadership to share best practices for increasing labeling and dating compliance.

FANS Clinical Nutrition- Pressure Injury

SITUATION	We monitor Registered Dietitian (RD) documentation and RD Pressure Injury documentation compliance for our Clinical Nutrition indicators.
BACKGROUND	Accurate nutrition assessment and intervention by the Registered Dietitian (RD) is critical to successfully optimize patients nutritional needs. We consistently conduct chart audits/peer reviews for each dietitian to ensure appropriate documentation. Pressure Injury documentation and notification has historically been inconsistent, and needed some process improvement.
ASSESSMENT	The processes for notification of Pressure Injury have been working well and RD documentation of Pressure Injury are trending towards goal measures. PMCE has averaged 95% compliance for the last 12 months. PMCP has achieved 91% compliance with a steady trend towards goal for the previous 4 months. Small samples sizes affect achievement of goal at PMC Poway.
RECOMMENDATION	Maintain current goal achievement for pressure injury documentation until we can show sustained improvement at PMCP for 6 months. Clinical Nutrition Specialist to provide additional education to Dietitians when necessitated. Larger wound care QAPI project being developed to encompass current data being collected.

PI Documentation - Escondido

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

	Summary		
	Num	Den	%
September-23	27	28	96%
October-23	34	44	77%
November-23	34	35	97%
December-23	25	26	96%
January-24	40	41	98%
February-24	39	40	98%
March-24	49	49	100%
April-24	45	46	98%
May-24	35	36	97%
June-24	36	36	100%
July-24	42	45	93%
August-24	29	31	94%

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-23	21	22	95%
October-23	13	19	68%
November-23	18	21	86%
December-23	18	19	95%
January-24	23	23	100%
February-24	12	13	92%
March-24	16	18	89%
April-24	13	14	93%
May-24	12	14	86%
June-24	15	17	88%
July-24	8	8	100%
August-24	14	14	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. PMCE averaged 97% compliance over the last 11 months, however have showed steady improvement towards goal since April 2023. PMCP averaged 93% compliance for the same duration. Improved malnutrition interventions and documentation was seen at PMCP until June 2024, intersecting with training of new Dietitians. Dietitians to attended NFPE workshops to improve their knowledge in performing exams and proper interventions and documentation.
RECOMMENDATION	Educate and emphasize importance for new Dietitians on proper malnutrition interventions and documentation. Ensure new Dietitians are trained on NFPE practices within 60 days of hire. Provide education on malnutrition during monthly RD meetings.

Malnutrition Documentation- Escondido

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

	Summary		
	Num	Den	%
September-23	79	82	96%
October-23	80	84	95%
November-23	74	76	97%
December-23	70	73	96%
January-24	99	100	99%
February-24	114	116	98%
March-24	95	99	96%
April-24	107	109	98%
May-24	100	103	97%
June-24	94	94	100%
July-24	85	86	99%
August-24			#N/A

Malnutrition Documentation- Poway

PMC Poway

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

	Summary		
	Num	Den	%
September-23	9	10	90%
October-23	15	17	88%
November-23	14	16	88%
December-23	19	21	90%
January-24	19	19	100%
February-24	20	21	95%
March-24	10	11	91%
April-24	8	8	100%
May-24	9	9	100%
June-24	11	12	92%
July-24	16	17	94%
August-24			#N/A

Clinical Nutrition - Action Plan

- Malnutrition: Educate and emphasize importance for new Dietitians on proper malnutrition interventions and documentation. Ensure new Dietitians are trained on NFPE practices within 60 days of hire. Provide education on malnutrition during monthly RD meetings.

- PI Documentation: Maintain current goal achievement for pressure injury documentation until we can show sustained improvement at PMCP for 6 months. Clinical Nutrition Specialist to provide additional education to Dietitians when necessitated. Larger wound care QAPI project being developed to encompass current data being collected.

Environment of Care & Emergency Management

Annual Report (July 2023 – December 2023)

Board Quality Review Committee

November, 2024
Brian Willey, Director Emergency Management & Safety
Brent Ansell, Manager Emergency Management & Safety

Environment of Care (July - December 2023)

SITUATION	The Environment of Care (EOC) is comprised of six management plans: safety, security, hazardous materials, fire/life safety, medical equipment, and utilities. Each plan has performance improvement goals.
BACKGROUND	During monthly multidisciplinary EOC rounds, staff knowledge is tested by asking questions related to each management plan. The EOC team reviews the environment by inspecting life safety issues and staff knowledge. Plan owners also monitor high impact and regulatory driven events throughout the year.
ASSESSMENT	<u>Safety Management Plan:</u> • O2 bottles continue to be found unsecured (0): MET (Goal: 0)* • Staff knowledge of RACE and PASS (100%): MET (Goal: 100%) <u>Security Management Plan:</u> • Code red drills scored (100%): MET (Goal: 100%) • Staff properly displaying their name badge at (100%): MET (Goal: 100%) <u>Hazardous Materials and Waste Management</u> • There were no spills requiring external assistance (0): MET (Goal: 0) • Phones found displaying SDS stickers (73.5%): NOT MET (Goal: 90%) • Metric being removed as SDS changed to online <u>Fire / Life Safety Management</u> • Hallway clutter management (18): NOT MET (Goal: 0)

Environment of Care (July - December 2023)

ASSESSMENT (CONT.)

Medical Equipment Management

- Equipment that is unable to be located was within its goal (4.6%): MET (Goal <5%)
- High risk medical equipment preventative maintenance completed timely (71.5%): MET (Goal 100%)

Utilities Management

- Elevator entrapments monitored to ensure preventative maintenance is effective (0): MET (Goal 0)
- # of water intrusions for being proactive in preventing events(0): MET (Goal 0)

Emergency Management

- Staff knowledge to where departmental disaster supplies are located (90%): MET (Goal 90%)
- Staff knowledge in actions to take upon activation of a Code Triage (90%): MET (Goal 90%)

RECOMMENDATION

Safety Management

- Safety, dept. leadership, educators to increase real time training and awareness related to unsecured 02 tanks.

Hazardous Materials and Waste Management

- Enhance education on the improved online Safety Data Sheet (SDS) retrieval process

Medical Equipment Management

- Documenting devices in use for extended periods of time, which cannot be accessed for PM’s.
- Increase BioMed training on equipment repair typically outsourced

Utilities Management

- Water safety plan developed and implemented to help ensure water system remain safe. Regulation due 2030

Plan - Do - Study - Act

- If the **goal is not achieved, communication is provided to department leadership**
- Continued improvement is tested during subsequent rounds

- Different departments are **surveyed each month** to audit staff knowledge on important aspects of each management plan

ACT

PLAN

STUDY

DO

- Audit **data is submitted to the EOC Committee or the Disaster Preparedness committee** on a regular basis for discussion and improvement planning

- Departments within a hospital campus: **rounded upon biannually**
- Departments within a satellite building: **rounded upon annually**

2023 Performance Indicators

Safety Management:

- O2 bottles found unsecured
- Staff knowledge of RACE and PASS (90% goal)

Security Management:

- Code **Red** drills are completed with a passing grade and do not require a re-drill (100% goal)
- Code **Grays** properly called by staff to the call center emergency line (x111) vs. Security directly (100% goal)
- Code **Greens** properly called by staff to the call center emergency line (x111) vs. Security directly (100% goal)
- Staff observed wearing name badge according to Palomar Health procedure (Lucidoc #14753) (100% goal)
- Promote and track increased Code Grey response from departments other than Security (2+ more staff Goal)

Medical Equipment Management:

- Preventative maintenance (PM) completion rate for high-risk life support equipment (100% goal)
- Preventative maintenance (PM) completion rate for non-life support equipment (95% goal)
- <5% of unable to locate pieces of medical equipment
- ≥90% of equipment repairs completed within 30 days
- Tracking of high value mobile medical equipment (90% goal)
- Staff attending technical training classes
- Increase training on equipment repair which would typically be outsourced

2023 Performance Indicators (cont.)

Hazard Materials and Waste Management:

- Monitoring of hazardous material containers inspected / labeled incorrectly
- Monitoring of number of hazardous chemical incidents involving outside agency assistance for cleanup
- Monitoring of number of biohazard waste incidents involving outside agency assistance for cleanup
- Staff can articulate how to obtain SDS (Safety Data Sheet) information (90% goal)
- Inspected landline phones properly display an SDS sticker (90% goal)
- Staff knowledge in articulating appropriate steps to take in response to a spill (90% goal)

Life Safety / Fire Prevention Management:

- Monitoring of actual fires reported inside the facilities
- Monitoring of building and / or protection system monitoring – problems, significant incidents, unexpected repairs
- Number of high hazard departments trained

2023 Performance Indicators (cont.)

Utility Management:

- Monitoring of flooding events, Utility failures, and elevator failures
- Emergency generator testing compliance per regulatory standards (100% threshold)

Emergency Management:

- Conduct TWO disaster drills or events annually per our HVA in accordance to Joint Commission standards.
- Staff can articulate where his or her unit disaster supplies are located (90% threshold)
- Staff can articulate where his or her unit emergency and safety response guide is located (90% threshold)
- Staff can articulate what actions to take during an earthquake (90% threshold)
- Staff can articulate suitable actions to take following a Code Triage activation (90% threshold)
- Staff can articulate what action to take when an Everbridge notification is received. (90% threshold)
- Staff can articulate where departments downtime forms/box and 7/24 computer. (90% threshold)
- Conduct at least ten emergency management / safety training sessions for staff per quarter

Emergency Management

Situation	Emergency Management is responsible for ensuring staff's knowledge of the actions to take in a disaster or emergency situation.
Background	Emergency Management has historically achieved greater than 90% staff accuracy to departmental knowledge audits. Audits typically occur during regular business hours, but occasional audits are performed during the early mornings, late evenings, and weekends.
Assessment	Emergency Management staff perform scheduled departmental audits to test staff knowledge. The knowledge audits consist of 6 questions. Palomar Health staff were able to answer all 6 questions with greater than 90% accuracy.
Recommendation	All departments with knowledge gaps are sent a Sentact fix-it ticket and provided specific information and resources to communicate with and educate staff. Departments will be re-audited to assess for knowledge improvement.

Emergency Management

Act
- If **90% goal is not achieved, communication is sent to department leadership** with instructions to review with staff during huddles/staff meetings
- Knowledge is re-tested on subsequent rounds

Plan
- Different departments are **surveyed** each month to audit staff knowledge of critical disaster preparedness actions
- Six Emergency Management questions are asked
- Goal is 90% accuracy

Study
- Audit **data is presented to the Disaster Preparedness Committee** for discussion and improvement planning

Do
- Departments within a hospital campus: **Rounded upon bi-annually**
- Departments within a satellite building: **Rounded upon annually**

Monthly Rounding

Goal: > 90% staff accuracy to Emergency Management questions

100%	Describe what disaster supplies are available in your unit.
100%	Describe where your department's Emergency and Safety Response Guide is located.
100%	Describe what actions to take during an earthquake.
98.9%	Describe at least two actions employees perform during a Code Triage.
98.6%	Describe what actions to take when an Everbridge notification is received.
96.7%	Describe the location of your Downtime forms/box and 7/24 computer.

Action Plan | Timeline

- Audit questions have been revised for 2024 to focus on new areas of emergency preparedness.
- Departments not achieving the 90% accuracy threshold are sent a Sentact fix-it ticket and provided specific information and training resources within one week of their audit
- Just in time training provided for any staff knowledge deficiencies
- Auditing is performed every 6 months for hospital based departments

Active Projects

- Safety Data Sheets (SDS)
  - Replaced 3E with OneSource to greatly improve the time it takes to obtain the SDS on chemicals
- Community Ham Radio Class/Certifications
  - Partnered with ARES to provide a Ham radio certification class for 30 community partners
- Ham Radio system install (PMCE)
  - Ham radio equipment has been purchased and is pending installation by Facilities
- Quarterly Everbridge tests for 2024
  - Frequent testing of the emergency notification system will occur in 2024
- Supplement Palomar Health's ventilator supply
  - Pending an MOU with County, our Respiratory Dept. will house, use, and maintain additional Serv-O vents for the County of San Diego
- Relocate Hospital Command Center
  - The Hospital Command Center at Escondido will be relocated to the new 1st Floor Conference room 2
  - The Hospital Command Center at Poway will be relocated to the new Admin Conference room
- Evacuation device decentralization (PMCE)
  - MedSleds mounted on floors 2, 4, 5, 6, 7, 8, and 9 to enable fast deployment in the event of an evacuation

Topic/Project: Hand Hygiene Compliance September 2024

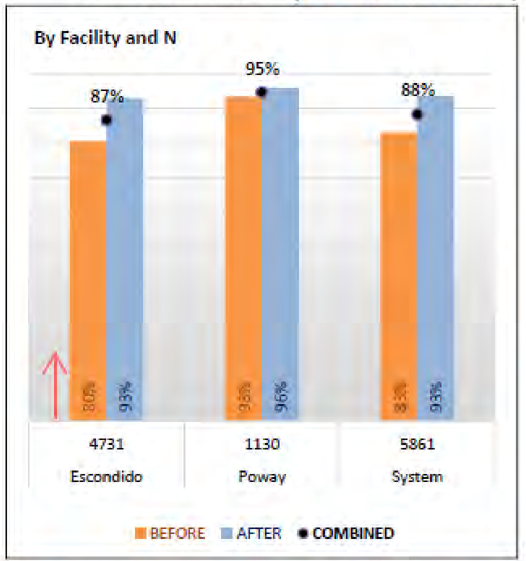
Submitted By: Jarrod Becasen

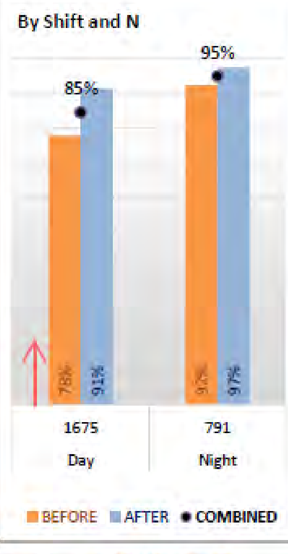
Facility: District   Area(s): Patient Care Units

Introduction	Hand hygiene is considered the most effective way to reduce the risk of infection.
Situation	Palomar Health's goal is to have a district mean compliance of 95% for 2024. Our 2023 district mean compliance was 82%.
Background	Hand hygiene compliance measures are collected by direct observations among trained modified personnel, and recently, trained nurse designees from select units.
Assessment	Many disciplines and units improved since August (arrow indicates at least a 10% increase from previous month). Transport & Lift team (TRANS) and EVS were asked to provide and implement an improvement plan for their respective disciplines, and report out at the November IPCC. Our year-to-date district compliance is 85%.
Recommendation	Continue to collect and provide compliance data to IPCC members monthly. Identify low-performing disciplines/units and task their leaders to develop and implement an improvement plan.

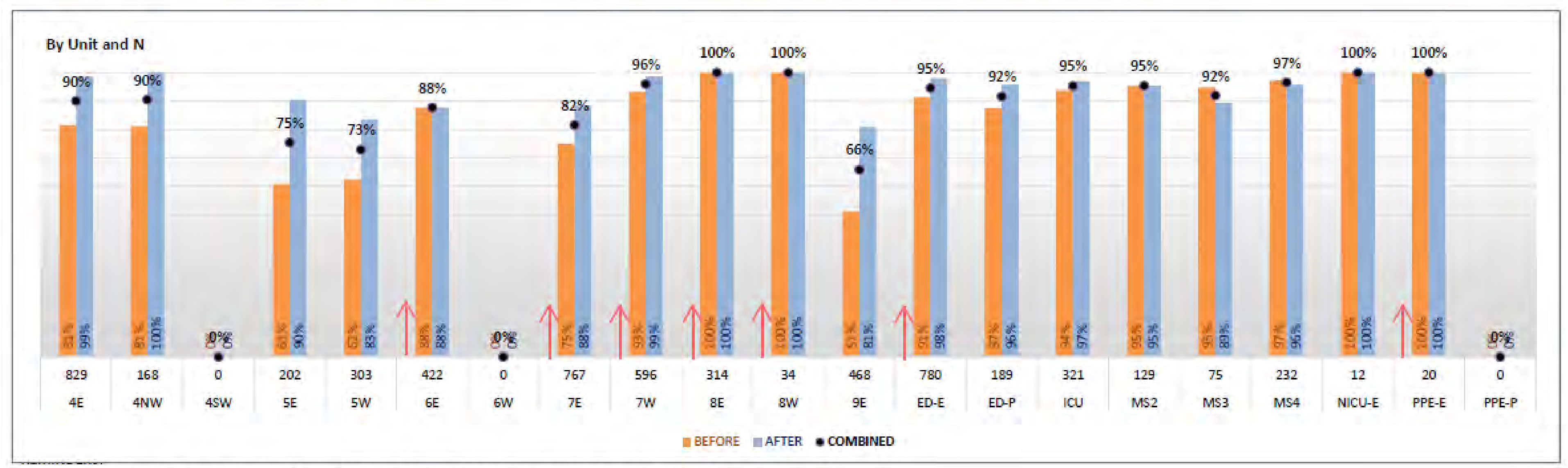
Hand Hygiene Compliance Rate | September 2024

Total Observations (BEFORE and AFTER patient contact): 5,861





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



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

If you have any questions or would like to request unit-based data, please contact Infection Control at 881-5431

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

Management of the Medical Record

Annual Report to Board Quality Review Committee

Kim Jackson, District Director, Medical Records and Privacy Officer
November, 2024

MEDICAL RECORDS
QMC 2024 DATA REPORTING

INDICATORS	BENCHMARK	LOCATION	CY 2024 1st QUARTER	CY 2024 2nd QUARTER
CPDI SCANNING				
Critical Documentation TAT	24 Hours	PMC Escondido	2.7	3.1
		PMC Poway	2.7	3.1
Non-Critical Docs TAT	120 Hours	PMC Escondido	63.5	102.6
		PMC Poway	62.3	107.0
REPORT OF DELINQUENT RECORDS				
Delinquency Rate	≤ 50 %	PMC Escondido	0.41 %	0.23 %
		PMC Poway	0.13 %	0.06 %
CANCER REGISTRY				
Abstracting Quality Rate	97 %	PMC Escondido	99 %	100 %
		PMC Poway	100 %	99%
BIRTH CERTIFICATES				
Timely Birth Registration	100 % Within 21 Days	PMC Escondido	100 %	100 %
OTHER DOCUMENTATION REVIEW				
Transcribed Reports % TAT	90 %	PMC Escondido & PMC Poway	96 %	98 %
Percentage of Reports Done in DynDoc	80 %	PMC Escondido & PMC Poway	94 %	93 %
OTHER QUALITY REVIEW				
AQuity Outside Transcription Accuracy	97 %	PMC Escondido & PMC Poway	98 %	98 %
RELEASE OF INFORMATION				
Patient Access	≤ 5 Days	PMC Escondido & PMC Poway	1.9	1.6
Continuity of Care	≤ 2 Days	PMC Escondido & PMC Poway	2.1	1.9

SITUATION	PMC Escondido and PMC Poway Bi-Annual Review
BACKGROUND	Medical Records continually monitors production and quality of primary Medical Records functions.

ASSESSMENT

Overall, the Medical Records department is meeting goals for production and quality. Our release of information (ROI) office processed 21,684 requests in the first 6 months of this year. The established on-line records request portal on Palomarhealth.org where patients can request records at their convenience, provides very good turn around times. We continue to offer on site service at the Escondido campus and are working with Palomar's Brand and Design Coordinator to improve access and resources for requestors at the Poway Campus Lobby area.

Type of Request	January	February	March	April	May	June	**6 months Total Request**
All ROI Request	3691	3315	3242	3279	3504	3316	20,347
Billing Records	211	210	186	172	202	356	1,337
Monthly Total Combined	3902	3525	3428	3451	3706	3672	**21,684**

1. Mindray Print → PDF project rolled out in late July. This is having a positive impact on scanning turnaround times

2. Medical Staff Monitoring:

If the operative or procedural report is not placed in the medical record immediately following the procedure, then the progress note must be immediately entered after the procedure to provide pertinent information to the next provider of care.

The goal for timely completion is 90% or greater.

PMC Esco. Compliance Rate: Jan-Jun = 81%

PMC Esco. Cath Lab Compliance Rate: Jan-Jun = 97%

PMC-Poway Compliance Rate: Jan-Jun = 91%

2024	PMC Escondido	PMC Poway	Cath Lab
January	77.8%	97.5%	98.8%
February	81.5%	100.0%	98.8%
March	84.4%	80.6%	96.1%
April	81.4%	93.7%	96.9%
May	78.1%	82.0%	98.1%
June	83.7%	90.6%	95.3%

Dynamic Documentation Usage-as opposed to Dictation (average for all providers) = 93%

1. Medical Records continues to advocate for transition from paper to electronic documentation. Current project request supports electronic signature on forms that presently require an ink signature. Awaiting approval and prioritization.

2. Medical Records will continue to audit and report compliance rates for immediate post-op notes to Med Staff. Suggests action plan from Medical Staff for the Escondido results.

Pharmaceutical Services QAPI

- IV to PO Interchange
- Barcode Scanning
- MIC Medication History

Presented to Board Quality Review Committee

Dondreia Gelios, PharmD, BCPS District Director of Pharmacy – November, 2024

IV to PO Interchange

Medication	Jan	Feb	Mar	QTR1 2023	Apr	May	Jun	QTR2 2023	Jul	Aug	Sep	QTR3 2023	Oct	Nov	Dec	QTR4 2023	Total 2023	Jan	Feb	Mar	QTR1 2024
Azithromycin	96	85	90	**271**	79	71	78	**228**	57	31	51	**139**	45	52	73	**170**	**808**	70	45	83	**198**
Cost Saving	$14,208	$12,580	$13,320	**$40,108**	$11,692	$10,508	$11,544	**$33,744**	$8,436	$4,588	$7,548	**$20,572**	$6,660	$7,696	$10,804	**$25,160**	**$119,584**	$10,360	$6,660	$12,284	**$29,304**
Pantoprazole	11	13	15	**39**	19	25	84	**128**	83	66	54	**203**	68	58	93	**219**	**589**	91	94	90	**275**
Cost Saving	$1,628	$1,924	$2,220	**$5,772**	$2,812	$3,700	$12,432	**$18,944**	$12,284	$9,768	$7,992	**$30,044**	$10,064	$8,584	$13,764	**$32,412**	**$87,172**	$13,468	$13,912	$13,320	**$40,700**
Famotidine	84	85	78	**$247**	75	75	211	**361**	208	211	228	**647**	205	262	223	**690**	**1,945**	218	237	274	**729**
Cost Saving	$12,432	$12,580	$11,544	**36,556**	$11,100	$11,100	$31,228	**$53,428**	$30,784	$31,228	$33,744	**$95,756**	$30,340	$38,776	$33,004	**$102,120**	**$287,860**	$32,264	$35,076	$40,552	**$107,892**
Metronidazole	24	28	25	**77**	30	32	73	**135**	80	70	67	**217**	64	70	87	**221**	**650**	62	73	65	**200**
Cost Saving	$3,552	$4,144	$3,700	**$11,396**	$4,440	$4,736	$10,804	**$19,980**	$11,840	$10,360	$9,916	**$32,116**	$9,472	$10,360	$12,876	**$32,708**	**$96,200**	$9,176	$10,804	$9,620	**$29,600**
Doxycycline	7	9	11	**$27**	9	13	10	**32**	15	8	10	**33**	10	18	10	**38**	**130**	28	18	15	**61**
Cost Saving	$1,036	$1,332	$1,628	**3,996**	$1,332	$1,924	$1,480	**$4,736**	$2,220	$1,184	$1,480	**$4,884**	$1,480	$2,664	$1,480	**$5,624**	**$19,240**	$4,144	$2,664	$2,220	**$9,028**
Fluconazole			3	**3**	4	2	5	**11**	4	1	2	**7**	3	2	1	**6**	**27**	2	5	1	**8**
Cost Saving	$0	$0	$444	**$444**	$592	$296	$740	**$1,628**	$592	$148	$296	**$1,036**	$444	$296	$148	**$888**	**$3,996**	$296	$740	$148	**$1,184**
Lacosamide	2	1		**$3**	2	0	5	**7**	4	2	1	**7**	0	1	2	**3**	**20**	1	6	2	**9**
Cost Saving	$296	$148	$0	**444**	$296	$0	$740	**$1,036**	$592	$296	$148	**$1,036**	$0	$148	$296	**$444**	**$2,960**	$148	$888	$296	**$1,332**
Levetiracetam	13	15	4	**32**	8	5	20	**33**	23	33	22	**78**	21	29	31	**81**	**224**	36	30	18	**84**
Cost Saving	$1,924	$2,220	$592	**$4,736**	$1,184	$740	$2,960	**$4,884**	$3,404	$4,884	$3,256	**$11,544**	$3,108	$4,292	$4,588	**$11,988**	**$33,152**	$5,328	$4,440	$2,664	**$12,432**
Quinolones	5	9	5	**$19**	11	9	13	**33**	28	19	10	**57**	18	15	26	**59**	**168**	21	19	16	**56**
Cost Saving	$740	$1,332	$740	**2,812**	$1,628	$1,332	$1,924	**$4,884**	$4,144	$2,812	$1,480	**$8,436**	$2,664	$2,220	$3,848	**$8,732**	**$24,864**	$3,108	$2,812	$2,368	**$8,288**
Thiamine	6	17	6	**29**	17	14	18	**49**	32	33	27	**92**	34	29	27	**90**	**260**	20	14	33	**67**
Cost Saving	$888	$2,516	$888	**$4,292**	$2,516	$2,072	$2,664	**$7,252**	$4,736	$4,884	$3,996	**$13,616**	$5,032	$4,292	$3,996	**$13,320**	**$38,480**	$2,960	$2,072	$4,884	**$9,916**
Linezolid	0	0	0	**0**	1		4	**5**	1	1	1	**3**	1	2	2	**5**	**13**	1	0	0	**1**
Cost Saving	$0	$0	$0	**$0**	$148	$0	$592	**$740**	$148	$148	$148	**$444**	$148	$296	$296	**$740**	**$1,924**	$148	$0	$0	**$148**
Levothyroxine	0	0	0	**0**	1	2	1	**4**	0	0	0	**0**	1	0	0	**0**	**4**	13	13	10	**36**
Cost Saving	$0	$0	$0	**$0**	$148	$296	$148	**$592**	$0	$0	$0	**$0**	$148	$0	$0	**$148**	**$740**	$1,924	$1,924	$1,480	**$5,328**
Acetaminophen	0	0	0	**0**			10	**10**	20	16	17	**53**	12	24	17	**53**	**116**	26	32	20	**78**
Cost Saving	$0	$0	$0	**$0**	$0	$0	$1,480	**$1,480**	$2,960	$2,368	$2,516	**$7,844**	$1,776	$3,552	$2,516	**$7,844**	**$17,168**	$3,848	$4,736	$2,960	**$11,544**
Folic acid	0	0	0	**0**	0	0	2	**2**	0	1	0	**1**	0	0	0	**0**	**3**	0	0	1	**1**
Cost Saving	$0	$0	$0	**$0**	$0	$0	$296	**$296**	$0	$148	$0	**$148**	$0	$0	$0	**$0**	**$444**	$0	$0	$148	**$148**
Total Interventions	248	262	237	**747**	256	248	534	**1,038**	555	492	490	**1,537**	482	562	592	**1,635**	**4,957**	589	586	628	**1,803**
Total Cost Savings	$36,704	$38,776	$35,076	**$110,556**	$37,888	$36,704	$79,032	**$153,624**	$82,140	$72,816	$72,520	**$227,476**	$71,336	$83,176	$87,616	**$241,980**	**$733,636**	$87,172	$86,728	$92,944	**$266,844**

QTR1 2023: Average 8 interventions/day ($1,184/day)
QTR2 2023: Average 11 interventions/day ($1,628/day)
QTR3 2023: Average 17 interventions/day ($2,516/day)
QTR4 2023: Average 18 interventions/day ($2,664/day)
CY 2023: Average 14 interventions/day ($2,072/day)

QTR1 2024: Average 20 interventions/day ($2,960/day)

IV to PO Therapeutic Interchange

- Success
  - CY23 average interventions ***monthly***
    - 3 times greater than baseline
    - Cost savings* $61,000
  - QTR1 2024
    - 2.4 times greater than QTR1 2023
  - 98% physician acceptance rate
  - Projected CY24 savings $1.1 million
- Moving Forward
  - Add additional medications to the interchange procedure pending medical approval
  - Proactive interventions during daily pharmacist rounding

*Cost savings based on $148 cost avoidance per intervention: Cost Savings Associated With Pharmacy Student Interventions During APPEs, doi: 10.5688/ajpe78471

Barcode Scanning – All Areas

Barcode Scanning - All Units

99.0%
98.5%
98.0%
97.5%
97.0%
96.5%
96.0%
95.5%
95.0%
94.5%
94.0%
93.5%
93.0%

Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

PMCE Med
PMCE Pt
PMCP Med
PMCP Pt
Linear (PMCE Med)
Linear (PMCE Pt)
Linear (PMCP Med)
Linear (PMCP Pt)

Barcode Scanning – Inpatient Settings

Barcode Scanning - Inpatient Units

99.0%
98.5%
98.0%
97.5%
97.0%
96.5%
96.0%
95.5%
95.0%
94.5%
94.0%

Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24

PMCE Med · PMCE Pt · PMCP Med · PMCP Pt
Linear (PMCE Med) · Linear (PMCE Pt) · Linear (PMCP Med) · Linear (PMCP Pt)

Barcode Scanning

- Bedside barcode scanning implemented in 2011
- Goal: Scan rate >95% for both medications and patients
- Improvement actions
  - Review medications with low scan rates for problems
    - KCL oral suspension
    - Methadone 0.1mg
    - Azithromycin 500mg
    - NS liter bags
  - Change frequency of barcode scanning report from monthly to weekly to identify issue timely
- Results
  - Inpatient units medication scan rate
    - PMCE 1.5% increase to 96.5%
    - PMCP 0.5% increase to 96.2%
  - All units
    - PMCE 2.8% increase to 96.4%
    - PMCP 1.3% increase to 95.8%

MIC Electronic Medication History

PMCE Electronic Medication Reconciliation (Med Rec)	Apr-23		May-23		Jun-23		Jul-23		Aug-23		Sep-23		Oct-23		Nov-23		Dec-23		Jan-24		Feb-24		Mar-24	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Inpatient Encounters	2,114		1,952		1,954		1,939		1,965		1,737		1,947		1,956		1,889		1,914		1,788		1,872	
Medication History Complete	**1,890**	**89.4%**	**1,748**	**89.5%**	1,734	**88.7%**	**1,756**	**90.1%**	**1,784**	**90.8%**	**1,562**	**89.9%**	**1,711**	**87.9%**	**1,775**	**90.7%**	**1,698**	**89.9%**	**1,768**	**92.4%**	**1,611**	**90.1%**	**1,705**	**91.1%**
Completed by MIC	*877*	*46.4%*	*726*	*41.5%*	**658**	*37.9%*	*700*	*39.9%*	*756*	*42.4%*	*661*	*42.3%*	*722*	*42.2%*	*755*	*42.5%*	*686*	*40.4%*	*799*	*45.2%*	*723*	*44.9%*	*794*	*46.6%*
Completed by non-MIC	*1,013*	*53.6%*	*1,022*	*58.5%*	*1,296*	*62.1%*	*1,056*	*60.1%*	*1,028*	*57.6%*	*901*	*57.7%*	*989*	*57.8%*	*1,020*	*57.5%*	*1,012*	*59.6%*	*969*	*54.8%*	*888*	*55.1%*	*911*	*53.4%*
Admission Med Rec Completed	1,202	56.9%	945	48.4%	982	50.3%	933	48.1%	982	50.0%	851	49.0%	1,041	53.5%	1,074	54.9%	1,064	56.3%	1,144	59.8%	958	53.6%	1,055	56.4%
Discharge Med Rec Completed	**1,966**	**93.0%**	**1,821**	**93.3%**	**1,831**	**93.7%**	**1,827**	**94.2%**	**1,861**	**94.7%**	**1,640**	**94.4%**	**1,829**	**93.9%**	**1,838**	**94.0%**	**1,780**	**94.2%**	**1,805**	**94.3%**	**1,684**	**94.2%**	**1,756**	**93.8%**
All Patients	10,105		13,386		12,781		14,132		14,472		13,194		13,629		10,558		10,369		12,145		11,240		12,659	
Medication History Complete	**2,479**	**24.5%**	**2,915**	**21.8%**	**2,874**	**22.5%**	**2,844**	**20.1%**	**2,864**	**19.8%**	**2,560**	**19.4%**	**2,725**	**20.0%**	**2,811**	**26.6%**	**2,755**	**26.3%**	**2,332**	**19.2%**	**2,568**	**22.9%**	**2,845**	**22.5%**
Completed by MIC	*987*	*39.8%*	*1,054*	*36.2%*	*950*	*33.1%*	*981*	*34.5%*	*1,032*	*36.0%*	*899*	*35.1%*	*990*	*36.3%*	*1,002*	*35.6%*	*949*	*34.4%*	*981*	*42.1%*	*974*	*37.9%*	*1,105*	*38.8%*
Completed by non-MIC	*1,492*	*60.2%*	*1,861*	*63.8%*	*1,924*	*66.9%*	*1,863*	*65.5%*	*1,832*	*64.0%*	*1,661*	*64.9%*	*1,735*	*63.7%*	*1,809*	*64.4%*	*1,806*	*65.6%*	*1,351*	*57.9%*	*1,594*	*62.1%*	*1,740*	*61.2%*

PMCP Electronic Medication Reconciliation (Med Rec)	Apr-23		May-23		Jun-23		Jul-23		Aug-23		Sep-23		Oct-23		Nov-23		Dec-23		Jan-23		Feb-23		Mar-23	
	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%	Total	%
Inpatient Encounters	555		444		310		358		308		320		342		331		385		397		349		381	
Medication History Complete	**524**	**94.4%**	**406**	**91.4%**	**295**	**95.2%**	**337**	**94.1%**	**294**	**95.5%**	**311**	**97.2%**	**327**	**95.6%**	**325**	**98.2%**	**369**	**95.8%**	**385**	**97.0%**	**335**	**96.0%**	**368**	**96.6%**
Completed by MIC	*273*	*52.1%*	*236*	*58.1%*	*199*	*67.5%*	*229*	*68.0%*	*205*	*69.7%*	*208*	*66.9%*	*225*	*68.8%*	*241*	*74.2%*	*252*	*68.3%*	*287*	*74.5%*	*230*	*68.7%*	*264*	*71.7%*
Completed by non-MIC	*251*	*47.9%*	*170*	*41.9%*	*96*	*32.5%*	*108*	*32.0%*	*89*	*30.3%*	*103*	*33.1%*	*102*	*31.2%*	*84*	*25.8%*	*117*	*31.7%*	*98*	*25.5%*	*105*	*31.3%*	*104*	*28.3%*
Admission Med Rec Completed	410	73.9%	282	63.5%	244	78.7%	301	84.1%	263	85.4%	281	87.8%	288	84.2%	295	89.1%	322	83.6%	321	80.9%	300	86.0%	322	84.5%
Discharge Med Rec Completed	**503**	**90.6%**	**381**	**85.8%**	**276**	**89.0%**	**332**	**92.7%**	**292**	**94.8%**	**301**	**94.1%**	**315**	**92.1%**	**307**	**92.7%**	**352**	**91.4%**	**376**	**94.7%**	**327**	**93.7%**	**356**	**93.4%**
All Patients	3637		6178		6006		4344		4401		4109		4238		3320		4337		4131		3687		3861	
Medication History Complete	**877**	**24.1%**	**888**	**14.4%**	**783**	**13.0%**	**810**	**18.6%**	**789**	**17.9%**	**743**	**18.1%**	**822**	**19.4%**	**783**	**23.6%**	**814**	**18.8%**	**867**	**21.0%**	**798**	**21.6%**	**851**	**22.0%**
Completed by MIC	*343*	*39.1%*	*357*	*40.2%*	*337*	*43.0%*	*355*	*43.8%*	*340*	*43.1%*	*307*	*41.3%*	*367*	*44.6%*	*383*	*48.9%*	*351*	*43.1%*	*445*	*51.3%*	*350*	*43.9%*	*392*	*46.1%*
Completed by non-MIC	*534*	*60.9%*	*531*	*59.8%*	*446*	*57.0%*	*455*	*56.2%*	*449*	*56.9%*	*436*	*58.7%*	*455*	*53.4%*	*400*	*51.1%*	*463*	*56.9%*	*422*	*48.7%*	*448*	*56.1%*	*459*	*53.9%*

MIC: Medication Intake Coordinator

MIC Electronic Medication History

Medication History Totals

1600
1400
1200
1000
800
600
400
200
0

Baseline, Nov-22, Dec-22, Jan-23, Feb-23, Mar-23, Apr-23, May-23, Jun-23, Jul-23, Aug-23, Sep-23, Oct-23, Nov-23, Dec-23, Jan-24, Feb-24, Mar-24

■ PMCE ■ PMCP

Electronic Medication History Overview

- Districtwide number of medication histories obtained by MICs increased over baseline by 2.8x
  - June 2022 – 528 (18/day)
  - CY2023 – averaging 1,285 monthly (42/day)
  - QTR1 CY24 – Averaging 1,416 monthly (47/day)
- Inpatient Medication History Completed by MICs
  - PMC Escondido increased from 27.9% (baseline) to 45.6% (QTR1 CY24 average)
  - PMC Poway increased by from 0.1% (baseline) to 69.3% (QTR1 CY24 average)

Utilization Review Summary
Nas Jalil, MD UR Chair | 11/27/24
Presented to Board Quality Review Committee (BQRC)
PALOMAR
HEALTH
Reimagining Healthcare

Utilization Review Biannual Report

Situation	Utilization Review Department Chair
Background	○ Promotion of UR best practices: quality driven, compliant, efficient, budget friendly, and effective process improvement plans thereby ensuring patient advocacy and in turn, impacting ROI ○ Performing data analytics, identifying areas of opportunity, review of high dollar accounts, mitigation of high dollar losses ○ Ongoing education on UR based best practices to the medical staff and UM Team ○ Participation in the denial management space
Assessment	✓ CERNER Implementation Project ✓ Revamped Compliant CODE 44 Process with Key Players ✓ Hospitalist Enhancements/Provider Documentation Education ✓ Short Stay Reviews ✓ Utilization Management Team Optimization ✓ CMI: Case Mix Index
Recommendation	➢ CERNER Phase I launched on April 11th, 2024 with a plan for Phase II launch post CERNER freeze in June 2024 ➢ Bimodal communication with centralized UM on Call uploaded in *lightening bolt* for real time queries (Ext 3330) ➢ CODE 44 process in play, enforcing compliance and a collaborative triad team approach between the attending, UR RN and the UR Physician Committee Member ➢ Ongoing provider education and support. Documentation tip sheet created and disseminated with instruction on proper usage ➢ Short stays: 60% Inpatient conversion rate → substantial increase in ROI for funds that would otherwise have not been captured ➢ UR RN staffing model: focused chart reviews by case type vs prior floor based model → highest quality charge capture. Education on proper guidelines by payer ➢ Robust documentation, CDI queries, complex surgical focus → increase in CMI

Cerner EMR Integration Concepts Phase I – Launched on April 11th 2024!

GOAL: Provider virtual assistance efficient workflow capturing highest ROI, and ensuring quality and compliant processes

- **Hard Stops**

  - CODE 44: ensure all steps completed to avoid failure
  - DISCHARGE ORDER: avoidance of PSO adjustments

- **Soft Stops:**
  - MEDICARE A&B INPATIENT DC < 2MN: robust documentation to support the medical record
  - ALL PAYERS WITH ATTEMPT TO DOWNGRADE STATUS TO A LOWER LEVEL OF CARE: mitigate erroneous loss → ⬆ **ROI**

ROBUST CODE 44 WORKFLOW PROTOCOL

- ❑ **CONDITION CODE 44 DEFINITION:** Traditional Medicare A&B patient < 2 MN with change in status order (downgrade) from IP → OBS or Outpatient in a Bed *but only if performed* PRIOR TO DC

- ❑ IF any of the proper steps are not performed PRIOR TO DC, it is a FAILED CODE 44 (*major revenue implications)
- ❑ Appointment and training of UR Physician Committee Members to assist in the review process and maintain compliance
- ❑ **Workable solutions deployed to avoid failure:**
  - ➢ UM communication to attending protocol
  - ➢ Timely PSO order change by the attending w/escalation as necessary
  - ➢ Timely distribution of the MOON letter
  - ➢ Squash the “FAILED” CODE 44 process

  - ❖ **GOALS ACHIEVED:**
    - ▪ Eradication of high volume adjustment orders (470 in 2023 → 0 unnecessary status order adjustments today)
    - ▪ Compliant process

PROVIDER/HOSPITALIST ENHANCEMENTS

- ✓ Timely PSO order changes → increased ROI
- ✓ Documentation tip sheet → clinical accuracy supporting the patient and optimization of CMI
- ✓ Template enhancements boosting CDI, weighted DRGs
- ✓ Compliant CODE 44 process with key players identified for UR committee review participation
- ✓ Ongoing education/support

Provider Template Enhancements & Documentation Tips

Dr. Jalil, UR Chair

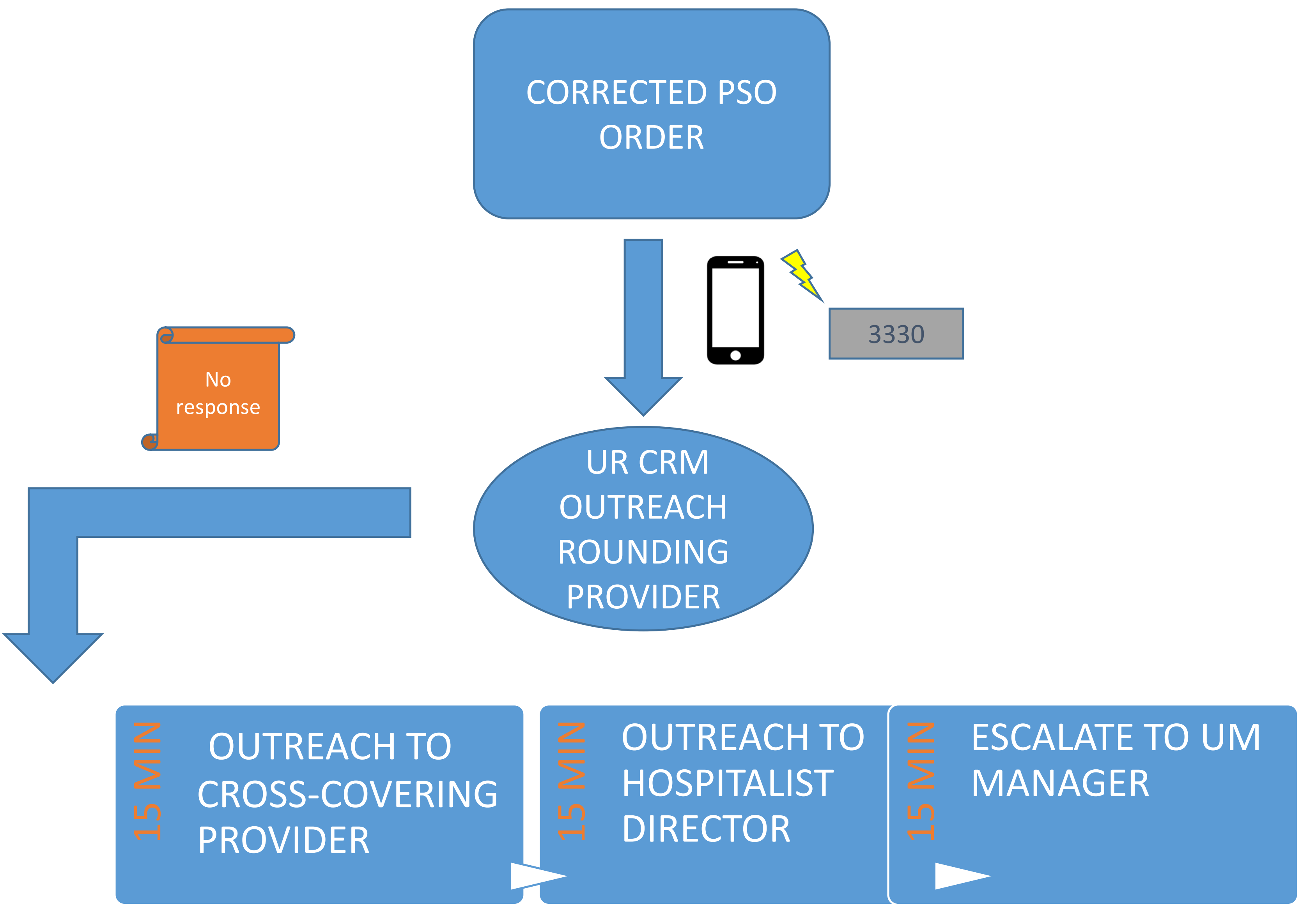
GOAL: Consistency in capturing the complete picture including the *why.*
Remember: If it isn't in ink, it didn't happen!

- IF you anticipate a patient will cross 2 midnights of medically necessary hospital level services, document the following phrase in the H&P
  - *"I anticipate that the patient's stay with cross 2 midnights of medically necessary hospital level services."*
- Document clearly in the H&P comorbidities and risk of adverse events, for ex,
  - *"Inpatient level of care is supported given the patient's underlying high risk and complex comorbidities including x,y,z…as well as their high risk for the following adverse events: ….."*
- Document in Discharge Summary an *unexpected* Rapid Clinical Recovery RCR for Medicare A&B short stays (Inpatient status < 2 midnights) <u>when applicable</u>
  - *"The patient had an unexpected rapid clinical recovery and therefore, Inpatient level of care is supported."*
- Medicare A&B CODE 44 note: Inpatient to Observation/Outpatient in a Bed
  - *"This case was discussed with the UR Physician Committee Member. The patient does not meet Inpatient status and will be changed to Observation status as the current level of care is Observation appropriate."*

UTILIZATION MANAGEMENT OPTIMIZATION

- ✓ **"UM on Call"** schedule created to promote seamless communication posted in *Lightning Bolt* for centralized access
- ✓ PSO Order change protocol = eradicating unnecessary adjustment orders
- ✓ Focused UR RN staffer who owns the CODE 44 process & OBS cases with management oversight to ensure quality, efficiency, and compliance

- ❑ Ongoing education of UM staff on criteria & processes
- ❑ Compliant workflows


CORRECTED PSO ORDER
3330
No response
UR CRM OUTREACH ROUNDING PROVIDER
15 MIN
OUTREACH TO CROSS-COVERING PROVIDER
15 MIN
OUTREACH TO HOSPITALIST DIRECTOR
15 MIN
ESCALATE TO UM MANAGER

Documentation Specificity

Coding Accuracy

Weighted DRGs

PC Assisted Coding

CMI

CERNER PSO IMPLEMENTATION PROJECT

BIMODAL COMMUNICATION

HIGH YIELD PROVIDER DOCUMETATION TEMPLATES

QUALITY, COMPLIANCE, EFFICIENCY, ACCURACY

ROI & CMI

PROACTIVE CASE SPECIFIC CM STAFFING

REVAMPED CODE 44 PROCESS

HIGH QUALITY SHORT STAY REVIEWS

COMPLEX SURGICAL SERVICES

Department of Anesthesia
Graham W. Davis, DO
Department Chair
Palomar Medical Center Escondido
Presented to Board Quality Review Committee (BQRC)
PALOMAR
HEALTH
Reimagining Healthcare
1

Total Joint Center of Excellence Metrics

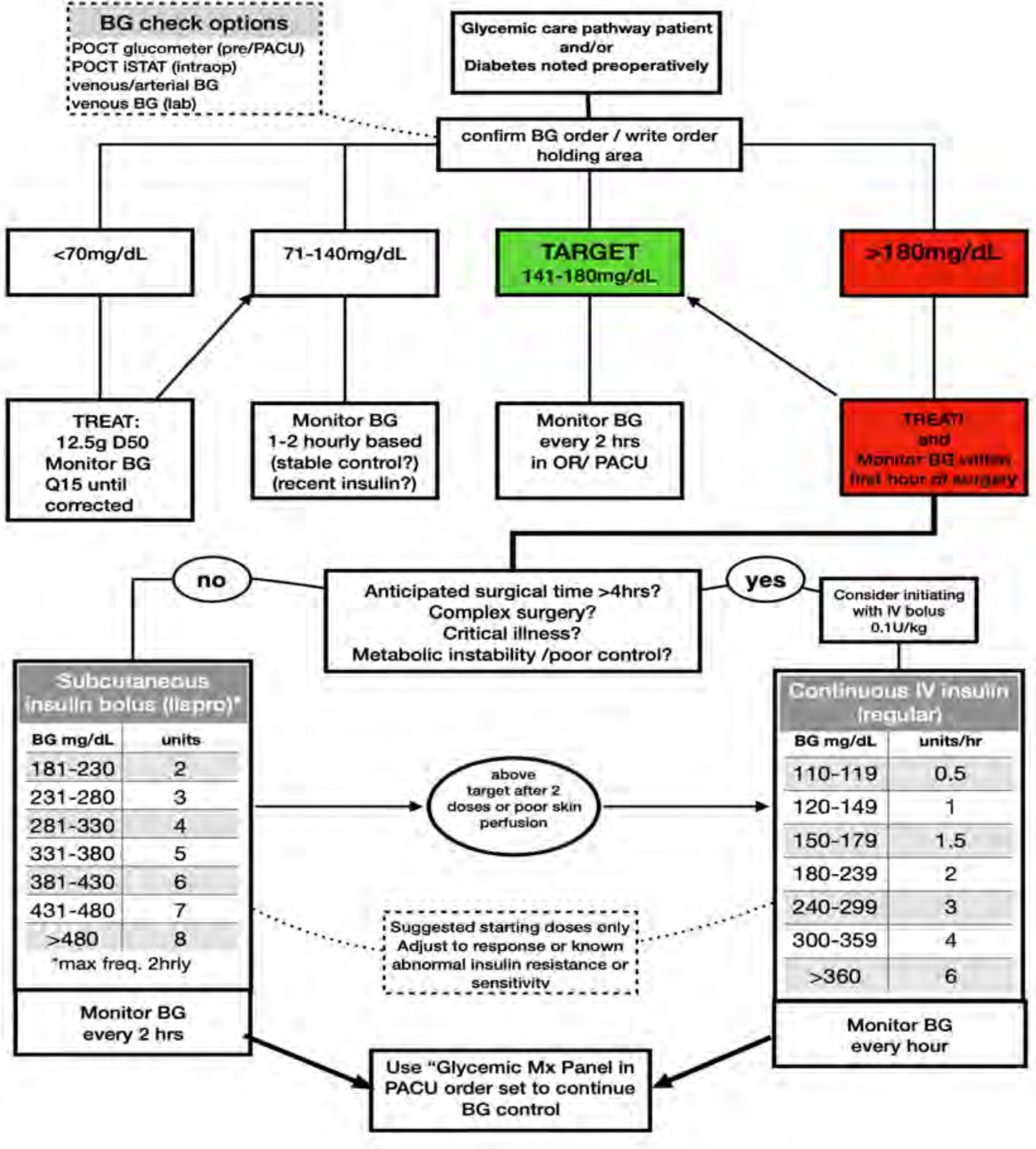
Anesthesia Type - Spinal (%)

Month	PMC-E	PMC-P
Jun-22	82.1%	83.9%
Jul-22	80.0%	100.0%
Aug-22	69.8%	94.0%
Sep-22	90.3%	100.0%
Oct-22	90.6%	97.9%
Nov-22	96.2%	97.4%
Dec-22	90.6%	100.0%
Jan-23	97.6%	100.0%
Feb-23	100.0%	95.8%
Mar-23	81.4%	100.0%
Apr-23	91.1%	100.0%
May-23	93.3%	90.2%
Jun-23	89.8%	96.2%
Jul-23	88.9%	90.3%
Aug-23	92.3%	100.0%
Sep-23	100.0%	100.0%
Oct-23	88.9%	97.9%
Nov-23	93.3%	100.0%
Dec-23	95.2%	96.6%
Jan-24	90.0%	92.0%
Feb-24	94.4%	100.0%
Mar-24	100.0%	100.0%
Apr-24	93.2%	97.1%
May-24	91.1%	92.9%
Jun-24	96.1%	95.5%

Axis: 0.0%, 20.0%, 40.0%, 60.0%, 80.0%, 100.0%

Legend: PMC-E, PMC-P, Goal (81%)

Intraoperative Glucose Management Plan



Approved by MEC in May 2024

2024 Performance Improvement Project

Situation	Patient satisfaction surveys are distributed to all outpatients undergoing surgical procedures. Despite various alterations in questions asked to specifically focus on the Anesthesia Department, as well as implementing various degrees of staffing education to boost scores, overall our scores are inconsistent on a monthly basis and often fall below the National Average.
Background	National Research Corporation (NRC) is a patient experience company which Palomar Health has been utilizing over the past several years to track and improve all aspects of patient care including quality, safety, and patient experience. Three anesthesia specific questions are provided; ***1. Did the anesthesiologist treat you with courtesy and respect?*** ***2. Were the anesthesia side effects explained?*** ***3. Was the anesthesia process explained understandably?***
Assessment	Improvements in scores have been achieved over the past one to two year span, however results are inconsistent. Looking at both campuses, Escondido and Poway, Palomar Health at Poway has historically proved to produce superior scores despite the same conglomerate of anesthesiologists providing care at both campuses. The reason for this discrepancy is unclear. A couple potential explanations for the variation among scores include difference in patient population and PMC-E being typically much busier with patients, differences in nursing staff at each respective facility, and other miscellaneous factors such as a multitude of staff entering and exiting the room while patient interviews are being conducted.
Recommendation	Anesthesiologists are often in a unique position when preparing to care for patients. By nature, the anesthesiologist will meet the patient for the very first time merely moments before their surgical procedure - a procedure the patient may have been preparing for weeks or even months prior. The patients often have a long-standing relationship with their surgeon and have had plenty of time to ask questions and fully understand their proposed surgical procedure. The anesthesiologist often provides an abundance of complex information in a short-time period. The patient is mentally ascertaining if they can trust this person as well as attempt to comprehend all that is being said to them. Our recommendation to attempt to improve patient satisfaction scores would be produce a pre-operative informational video that would give the basics of anesthesia and what to expect on their day of surgery. This preoperative video can be watched in the comfort of their home as many times as needed, and can additionally be viewed at the time of their pre-op arrival. Our hope is that this video may allow patients to formulate questions to ask the anesthesiologist and further comprehend all information provided day of surgery enhancing their overall experience.

NRC Patient Satisfaction Survey - Escondido

PMC Escondido Overall - NRC Question: Anesthesiologist courtesy/respect

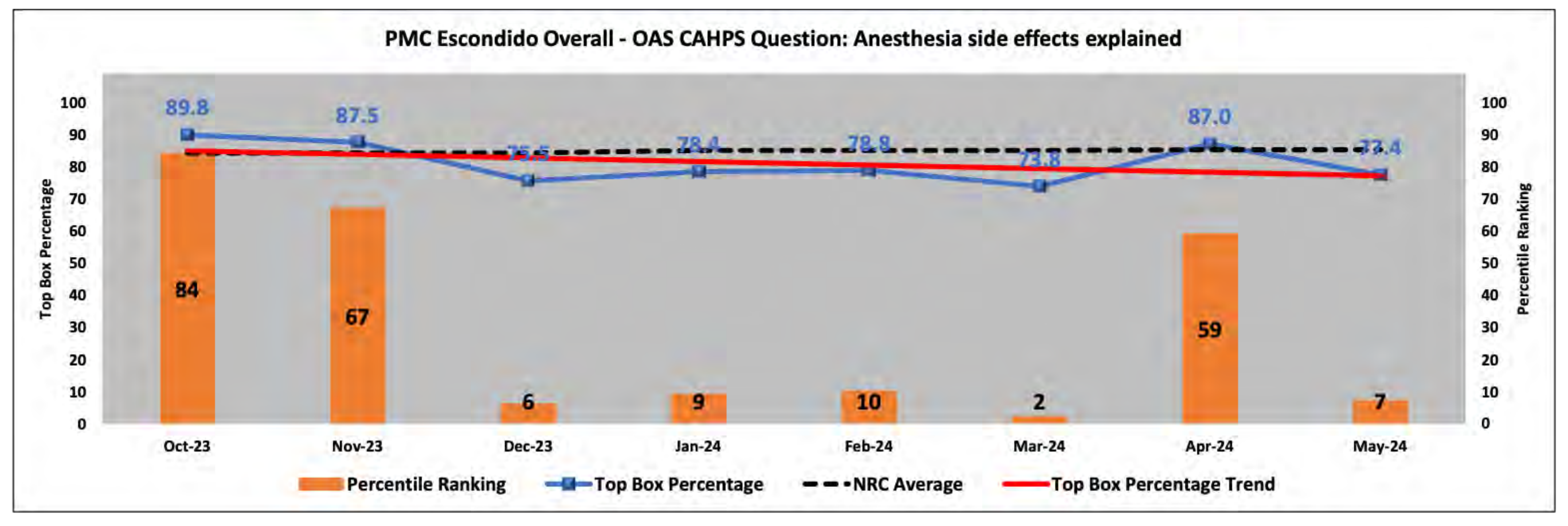
Date	Number of Surveys	Top Box Percentage	NRC Average	Percentile Ranking
Oct-23	67	92.5	92.3	
Nov-23	60	86.7	92.3	
Dec-23	59	93.2	92.3	
Jan-24	59	88.1	92.5	
Feb-24	77	88.3	92.5	
Mar-24	60	85.0	92.5	
Apr-24	57	93.0	92.3	
May-24	67	95.5	92.3	

Green - score is at or above the NRC Average
Yellow - score is below the NRC Average

PMC Escondido Overall - OAS CAHPS Question: Anesthesia side effects explained

Date	Number of Surveys	Top Box Percentage	NRC Average	Percentile Ranking
Oct-23	59	89.8	84.2	84
Nov-23	56	87.5	84.2	67
Dec-23	53	75.5	84.2	6
Jan-24	51	78.4	85.0	9
Feb-24	66	78.8	85.0	10
Mar-24	61	73.8	85.0	2
Apr-24	54	87.0	85.2	59
May-24	62	77.4	85.2	7

Green - score is at or above the NRC Average
Yellow - score is below the NRC Average



PMC Escondido Overall - OAS CAHPS Question: Process of anesthesia explained understandably

Date	Number of Surveys	Top Box Percentage	NRC Average	Percentile Ranking
Oct-23	58	89.7	93.3	12
Nov-23	58	93.1	93.3	38
Dec-23	53	86.8	93.3	2
Jan-24	51	94.1	93.8	46
Feb-24	67	91.0	93.8	19
Mar-24	61	88.5	93.8	8
Apr-24	54	96.3	94.0	72
May-24	62	93.5	94.0	37

PMC Escondido Overall - OAS CAHPS Question: Process of anesthesia explained understandably

Top Box Percentage: Oct-23 89.7, Nov-23 93.1, Dec-23 86.8, Jan-24 94.1, Feb-24 91.0, Mar-24 88.5, Apr-24 96.3, May-24 93.5

Percentile Ranking: Oct-23 12, Nov-23 38, Dec-23 2, Jan-24 46, Feb-24 19, Mar-24 8, Apr-24 72, May-24 37

Percentile Ranking | Top Box Percentage | NRC Average | Top Box Percentage Trend

NRC Patient Satisfaction Survey - POWAY

PMC Poway Overall - NRC Question: Anesthesiologist courtesy/respect

Date	Number of Surveys	Top Box Percentage	NRC Average	Percentile Ranking
Oct-23	29	89.7	92.3	
Nov-23	36	91.7	92.3	
Dec-23	32	84.4	92.3	
Jan-24	33	90.9	92.5	
Feb-24	59	89.8	92.5	
Mar-24	51	96.1	92.5	
Apr-24	58	84.5	92.3	
May-24	38	97.4	92.3	

PMC Poway Overall - NRC Question: Anesthesiologist courtesy/respect

Top Box Percentage (left axis, 0–100); Percentile Ranking (right axis, 0–100)

Data labels: Oct-23 89.7; Nov-23 91.7; Dec-23 84.4; Jan-24 90.9; Feb-24 89.8; Mar-24 96.1; Apr-24 84.5; May-24 97.4

Legend: Percentile Ranking; Top Box Percentage; NRC Average; Top Box Percentage Trend

PMC Poway Overall - OAS CAHPS Question: Anesthesia side effects explained

Date	Number of Surveys	Top Box Percentage	NRC Average	Percentile Ranking
Oct-23	27	77.8	84.2	11
Nov-23	35	77.1	84.2	9
Dec-23	28	92.9	84.2	95
Jan-24	31	87.1	85.0	60
Feb-24	55	81.8	85.0	24
Mar-24	48	72.9	85.0	2
Apr-24	51	90.2	85.2	82
May-24	36	86.1	85.2	52

PMC Poway Overall - OAS CAHPS Question: Anesthesia side effects explained

Top Box Percentage
Percentile Ranking
100
90
80
70
60
50
40
30
20
10
0
92.9
87.1
81.8
72.9
90.2
86.1
77.8
77.1
11
9
95
60
24
2
82
52
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Percentile Ranking
Top Box Percentage
NRC Average
Top Box Percentage Trend

PMC Poway Overall - OAS CAHPS Question: Process of anesthesia explained understandably

Date	Number of Surveys	Top Box Percentage	NRC Average	Percentile Ranking
Oct-23	28	85.7	93.3	1
Nov-23	35	85.7	93.3	1
Dec-23	29	96.6	93.3	83
Jan-24	30	90.0	93.8	13
Feb-24	55	94.5	93.8	52
Mar-24	48	89.6	93.8	11
Apr-24	51	98.0	94.0	91
May-24	36	100.0	94.0	100

PMC Poway Overall - OAS CAHPS Question: Process of anesthesia explained understandably

Top Box Percentage / Percentile Ranking

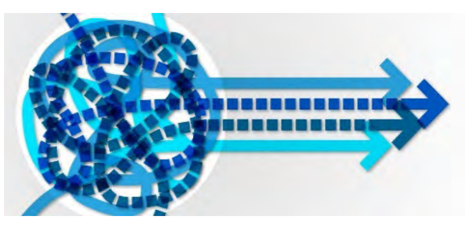
Oct-23: 85.7, 1
Nov-23: 85.7, 1
Dec-23: 96.6, 83
Jan-24: 90.0, 13
Feb-24: 94.5, 52
Mar-24: 89.6, 11
Apr-24: 98.0, 91
May-24: 100.0, 100

Percentile Ranking — Top Box Percentage — NRC Average — Top Box Percentage Trend

Nursing Annual Report

Presented to
Board Quality Review Committee

Mel Russell, RN, MSN
Chief Nurse Executive/Chief Operating Officer
November 27, 2024



Systemness

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

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

PALOMAR HEALTH

Palomar Health
Board of Directors

President and CEO
Diane Hansen

Chief Nurse Executive/
Chief Operating Officer
Mel Russell

Executive Assistant
Davina Russo

District Director of Emergency Services
Tracy Page

- PMC Escondido Emergency Services
- PMC Poway Emergency Services

Senior District Director of Perioperative Services
Bruce Grendell

* Surgery
* SPD
* PreOp/PACU
* Endoscopy
* PAT (Pre-Admission Testing
* Orthopedic Therapy

Director Progressive & Acute Care Services
Meghan Jaremczuk

* 4 East - Surgical Acute
* 5 East – Cardio Acute
* 6 East – Med/Surg Tele
* 7 East – Ortho Acute
* 7 West – Neuro Acute
* 9 East – Med Oncology

Director Critical Care and MST
Holly Porter

* Med Surg/Tel 2 & 3
* Med Surg/Tele 4
* Nursing Admin
* NR/NTS
* Org Learning
* Org Training
* Wound Care
* Pipeline Career Services
* Critical Care
* L&D
* Mother/Baby
* NICU
* Perinatology

District Director Cardiology, KR Services and Critical Care
Thomas McGuire

* 4SW – Surgical & Trauma ICU
* 5 West – Cardiovascular ICU
* IR
* Cath Lab
* Cardiology
* 6 West
* 4NW

Director Trauma Program
Melinda Case

* Trauma
* TNTLs
* Rapid Response RNs
* Trauma PI Coordinator

District Director CRM
Lisa Roush

* CRM
* UM

Director Nursing Villas
Erica Cogswell

* Villas

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

N W E S

WEST WING

FLOORS	
11th	Shelled
10th	Shelled
9th	Under Construction – Telemetry (24)
8th	Labor & Delivery (21)
7th	Neurosciences Progressive Care (24)
6th	Pulmonary Progressive Care (24)
5th	Cardiovascular ICU (24)
4th	Northwest - Surgical Progressive Care (12) Southwest - Surgical & Trauma ICU (12)
3rd	PBX
	Outdoor Terrace, Wavy Green Roof
2nd	Surgery & Procedures, Internventional Radiology, Cardiac Cath Lab, Endoscopy, Recovery, Pre-Admission, Medical Staff, Administration, Overflow Unit (8)
1st	Emergency, Registration, Cardiology, Imaging, Lab Draw Station, Pulmonary, Discharge Lounge
LL	Family Viewing Room, Facilities, EVS, SPD, Supply Chain, Mail Room, Lab

Emergency Department
72 Beds & 2 Trauma Bays

ELEVATORS

EAST WING

FLOORS	
	Future Community Room
9th	Medical Oncology (24)
8th	Postpartum (18) NICU (5 current, 11 future)
7th	Orthopedic Acute Care (30)
6th	Med Surg Tele (30)
5th	Cardiovascular Acute Care (30)
4th	Surgical Acute Care (30)
3rd	Garden Terrace Café, Physician Lounge, Café Conference Center
2nd	Chapel, Pharmacy, Conference Center
1st	Main Lobby, Financial Services, Gift Shop, Outpatient Pharmacy
LL	Morgue, Kitchen

3100_0820

PALOMAR HEALTH
A California Public Healthcare District

Palomar Medical Center Poway

15615 Pomerado Road, Poway, CA 92064 | 858.613.4000

Floor	North Wing	South Wing
5th		Future – ICU (14)
4th		Med Surg Tele (34)
3rd	Café, Conference Rooms, EVS SPD, Supply Chain	Behavioral Health Unit (12) Med Surg Tele (18)
2nd	Endoscopy, Imaging, Registration, Pre-Admission, Med Surg Tele (15)	Emergency (20), ICU (12), Lab, Pharmacy, Recovery Surgery & Procedures
1st	Administration Medical Staff	Discharge Lounge, Forensic Health Services

ELEVATORS

N E S W

BEHIND HOSPITAL ▲
Facilities, Central Plant, Pomerado Outpatient Pavilion

RIGHT OF HOSPITAL ▶
Villas at Poway

3436_0921

PALOMAR HEALTH
A California Public Healthcare District

Palomar Health Distinguished & Key Service Lines

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

Best Hospital Awards

Year after year, Palomar Health has been recognized by Newsweek as a World's Best Hospital due to our Commitment to providing extraordinary patient experience.

Quality Awards & Recognition

Quality Awards & Recognition

Service Area

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

Custom Territories

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

PSA = Primary Service Area SSA = Secondary Service Area

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

Palomar Health Zero Patient Harm

FY2024 Results [July 2023 - June 2024]		PMC Escondido	PMC Poway	Benchmark
CAUTI	SIR	0.603	0.386	1.0
CLABSI	SIR	1.097	0.774	1.0
CDI	SIR	0.430	0.383	1.0
MRSA	SIR	0.183	Pred < 1	1.0
SSI - COLO	SIR	0.259	1.091	1.0
SSI - HYST	SIR	Pred < 1	0.000	1.0
Injury Fall	Rate	0.25	0.44	0.25
Pressure Injury	Percent	0.00	0.00	0.88

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

	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
PMC Escondido	18	8	18	14	11	14	15	16	12	17	13	15	15
PMC Poway	4	3	7	2	6	5	8	9	5	5	4	5	2

# of Falls (y-axis: 0, 5, 10, 15, 20, 25, 30)

Months Since Last HAI from December 2021 to August 2024

Unit of Attribution	Date of Last CAUTI	Months since CAUTI	Date of Last CLABSI	Months since CLABSI
2SSU	12/01/22	20	12/01/22	20
4E	08/28/23	12	12/01/21	32
4NW	05/22/24	3	11/18/23	9
4SW	05/01/23	15	11/26/22	21
5E	07/10/23	13	01/26/23	19
5W	07/26/24	1	02/16/24	6
6E	12/06/23	8	06/27/23	14
6W	08/13/24	0	06/29/22	26
7E	02/01/23	18	12/01/21	32
7W	12/01/21	32	12/01/21	32
8E	12/01/21	32	12/01/21	32
8W	12/01/21	32	12/01/21	32
9E	04/15/24	4	08/03/23	12
NICU	N/A	IC does not track CAUTI in this population	04/12/24	4
ICU	02/16/22	30	12/01/21	32
MS2	12/01/21	32	12/01/21	32
MS3	01/01/23	19	01/01/23	19
MS4	01/12/24	7	02/13/24	6

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

Donald Miller, Manager, Clinical Operations

November 2024

Presented to Board Quality Review Committee (BQRC)

Discharge Planning & Patient Throughput

Situation	FYTD 24 overall LOS including OB 4.22 days to budgeted 4.38 days (through May 2024) Manage anticipated COVID, RSV, and other complicated discharges and manage Observation stays. FYTD LOS: **PMC Escondido** 4.22/ Budgeted 4.37 **PMC Poway** 4.23 / Budgeted 4.41
Background	Throughput and DC planning are strategic initiatives for FY2024
Assessment	**Discharge Planning Challenges:** • Health Plans authorization processes causing Discharge delays • Health Plans contracted providers not accepting their patients causing Discharge Delays • Several patients with limited or no funding (Uninsured / Restricted Medical) • Custodial Beds in SNFs are full • Homelessness with lack of available recoup beds • History of or active Drug and/or Alcohol Abuse • Lack of social support and financial resources • Legal challenges (Conservatorship, etc.) • Limited resources for Behavioral Health related patients & Dementia patients **Patient Throughput:** • Emergency Department utilization have slightly increased at PMC Poway and have decreased at PMC Escondido • Emergency Department admission rates have increased from previous year. (PMCE = 18.36% -> 19.53%, PMCP = 14.9% -> 15.6%) • 2 Floor Overflow Unit (201 – 208) is being used for Med/Surg inpatients during high volume periods – CDPH Waiver through July '25 • 9W (24 Telemetry beds) construction is estimated to be completed in end August 2024. Licensing estimated Nov 2024 • Long Length of Stay (LLOS) rounds w/ RN Management & CRM team to decrease pts hospital stay
Recommendation	**Discharge Planning** • Contracted leased beds for difficult to place patients • Complex Case Management Team partnering with providers to reduce LOS and high dollar patients • Traveler RN Case Managers assisting at both facilities focused on discharges and patient statusing • Observation Case Management team focusing on only Observation patients to decrease LOS • Observation specific CRM rounds (twice daily) for decreased throughput (was average 39 hours for Observation patients – goal 20-22 hours) with team and UM Medical Director: Go Live: August 2024. **Patient Throughput** • Collaborate with nursing and Dr. Al Shawwaf to implement new communication order for downgrading patients from tele to med/surg • Engaged with Providers to maximize intra-facility transfers between PMCE & PMCP • Utilization of Code Alpha and Code Delta alerts has allowed for greater collaboration for decreased throughput • Pro-active approach to Capacity Management. Communication and collaboration between the ED, Clinical Ops, Inpatient Units, Case Management, and ancillary departments focusing on early patient movement / discharges • Assign designated transport aides to decrease imaging TAT and ED boarding times during high volumes • DC60 program – Go Live: July 1, 2024 – Identify "home no need" inpatient d/c and discharge them in less than 1 hour. Goal of 25% by Oct 2024 and stretch of 35% of unfacilitated discharges

Average Length of Stay Trend

ALOS Trend - Including OB

Budget vs Actual

Note: Data represents all Palomar Health Inpatient encounters

	FYTD24										
Location	**Jul-23**	**Aug-23**	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**	**Feb-24**	**Mar-24**	**Apr-24**	**May-24**
PMC - Escondido											
Budget ALOS	4.27	4.27	4.28	4.31	4.36	4.39	4.44	4.40	4.37	4.37	4.37
Actual ALOS	4.38	4.20	4.35	4.37	4.39	4.59	5.10	4.63	4.38	4.85	4.22
Variance	**0.12**	**(0.08)**	**0.07**	**0.06**	**0.03**	**0.20**	**0.66**	**0.23**	**0.01**	**0.49**	**(0.15)**
PMC - Poway											
Budget ALOS	4.42	4.43	4.43	4.43	4.39	4.36	4.37	4.37	4.42	4.43	4.41
Actual ALOS	4.20	6.21	5.25	4.25	5.25	4.36	5.33	4.63	4.11	4.42	4.23
Variance	**(0.21)**	**1.78**	**0.82**	**(0.18)**	**0.86**	**(0.00)**	**0.96**	**0.26**	**(0.31)**	**(0.01)**	**(0.19)**
District Total											
Budget ALOS	4.30	4.30	4.31	4.34	4.36	4.38	4.42	4.40	4.38	4.38	4.38
Actual ALOS	4.35	4.51	4.52	4.34	4.54	4.54	5.15	4.63	4.33	4.77	4.22
Variance	**0.05**	**0.21**	**0.20**	**0.01**	**0.18**	**0.16**	**0.73**	**0.23**	**(0.06)**	**0.39**	**(0.16)**

Average Length of Stay

ALOS Trend - Including OB

By Facility

Note: Data represents all Palomar Health Inpatient encounters

FY23												FYTD24											
Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
6,836	6,853	6,597	6,574	7,105	7,906	8,008	6,847	7,809	7,252	7,087	7,443	6,933	6,900	6,435	6,868	7,190	7,411	7,403	6,908	7,062	7,189	7,127	
221	221	220	212	237	255	258	245	252	242	229	248	224	223	215	222	240	239	239	238	228	240	230	
1,605	1,569	1,551	1,622	1,640	1,752	1,709	1,538	1,614	1,525	1,581	1,597	1,582	1,644	1,481	1,572	1,639	1,614	1,452	1,491	1,612	1,481	1,689	
4.26	4.37	4.25	4.05	4.33	4.51	4.69	4.45	4.84	4.76	4.48	4.66	4.38	4.20	4.35	4.37	4.39	4.59	5.10	4.63	4.38	4.85	4.22	
1.58	1.64	1.59	1.61	1.64	1.66	1.62	1.64	1.63	1.67	1.61	1.60	1.65	1.59	1.64	1.60	1.60	1.68	1.71	1.73	1.73	1.63	1.67	
2,169	2,094	1,808	1,685	1,805	1,975	2,027	1,837	1,856	1,870	1,853	1,751	1,592	1,905	1,806	1,779	1,868	1,947	2,138	1,860	1,757	1,481	1,678	
70	68	60	54	60	64	65	66	60	62	60	58	51	61	60	57	62	63	69	64	57	49	54	
438	460	411	429	432	493	433	385	439	432	428	370	379	307	344	419	356	447	401	402	427	335	397	
4.95	4.55	4.40	3.93	4.18	4.01	4.68	4.77	4.23	4.33	4.33	4.73	4.20	6.21	5.25	4.25	5.25	4.36	5.33	4.63	4.11	4.42	4.23	
1.44	1.48	1.42	1.43	1.41	1.51	1.52	1.47	1.46	1.48	1.45	1.66	1.45	1.63	1.53	1.50	1.53	1.53	1.51	1.57	1.39	1.44	1.46	
9,005	8,947	8,405	8,259	8,910	9,881	10,035	8,684	9,665	9,122	8,940	9,194	8,525	8,805	8,241	8,647	9,058	9,358	9,541	8,768	8,819	8,670	8,805	
290	289	280	266	297	319	324	310	312	304	288	306	275	284	275	279	302	302	308	302	284	289	284	
2,043	2,029	1,962	2,051	2,072	2,245	2,142	1,923	2,053	1,957	2,009	1,967	1,961	1,951	1,825	1,991	1,995	2,061	1,853	1,893	2,039	1,816	2,086	
4.41	4.41	4.28	4.03	4.30	4.40	4.68	4.52	4.71	4.66	4.45	4.67	4.35	4.51	4.52	4.34	4.54	4.54	5.15	4.63	4.33	4.77	4.22	
1.55	1.61	1.55	1.57	1.60	1.63	1.60	1.61	1.60	1.63	1.58	1.61	1.62	1.60	1.62	1.58	1.59	1.65	1.67	1.70	1.66	1.60	1.63	

Average Length of Stay

Palomar Health

ALOS Trend - Including OB

By Facility

Note: Data represents all Palomar Health Inpatient encounters

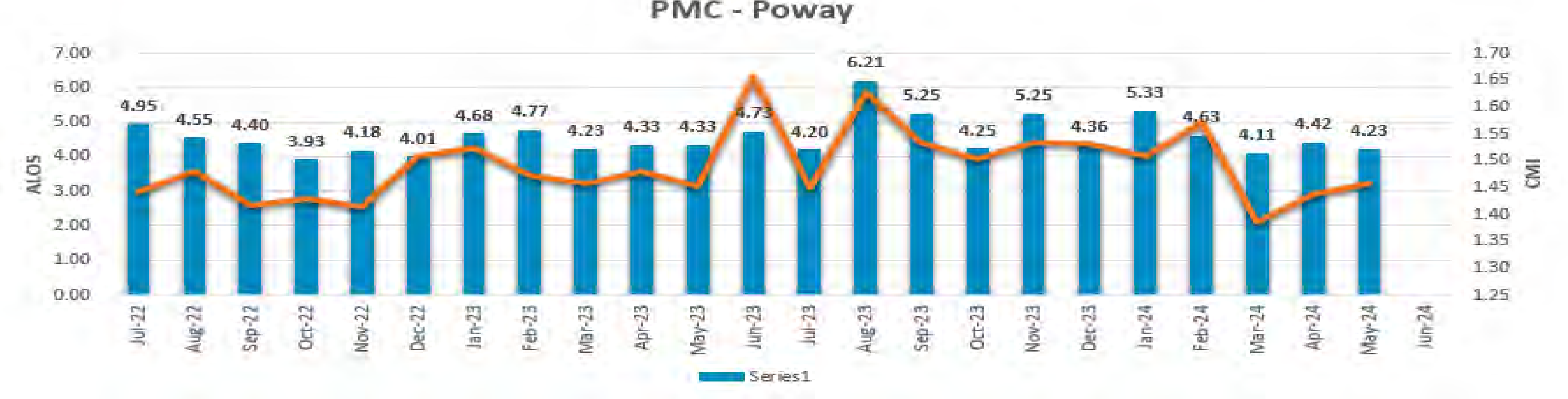
ALOS & CMI

PMC - Escondido

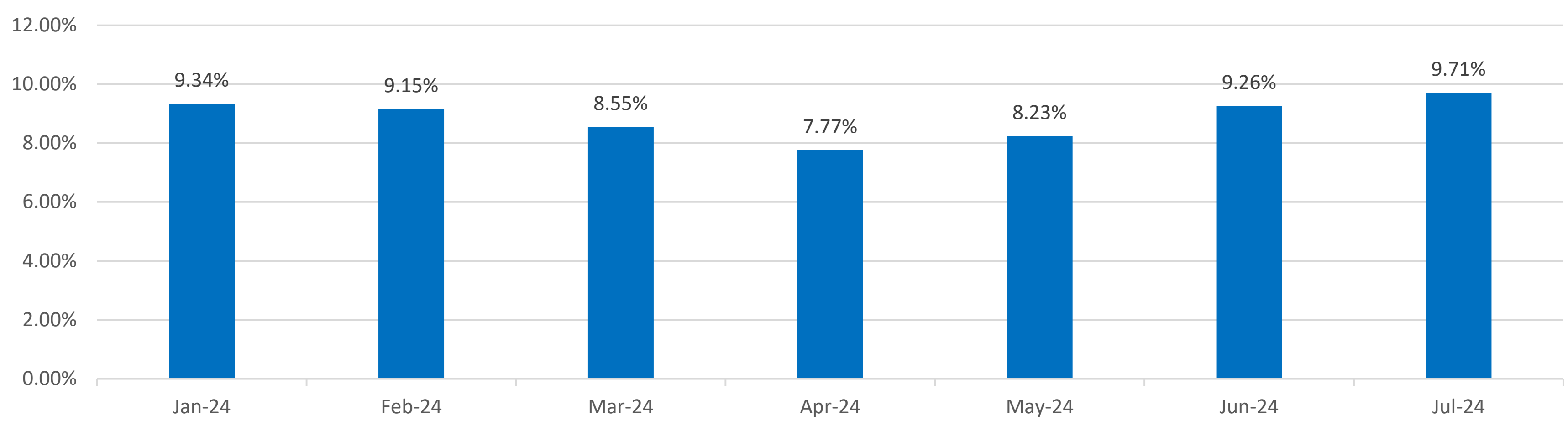
ALOS: 7.00, 6.00, 5.00, 4.00, 3.00, 2.00, 1.00, 0.00
CMI: 2.00, 1.90, 1.80, 1.70, 1.60, 1.50, 1.40

Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
4.26	4.37	4.25	4.05	4.33	4.51	4.69	4.45	4.84	4.76	4.48	4.66	4.38	4.20	4.35	4.37	4.39	4.59	5.10	4.63	4.38	4.85	4.22	

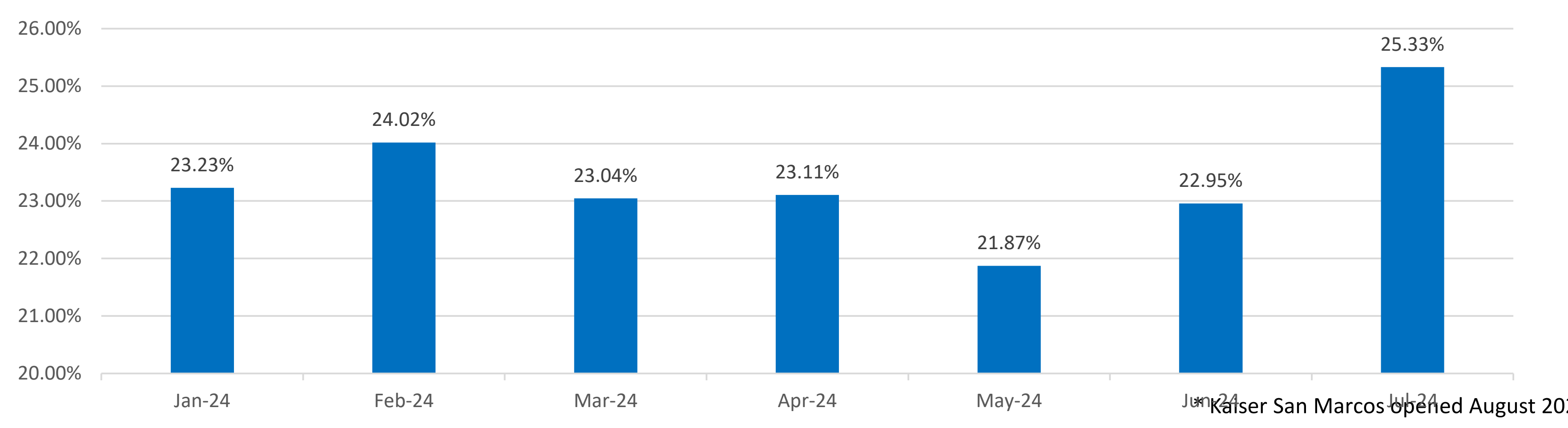
Series1



Emergency Department Volume



Discharges before 13:00



* Kaiser San Marcos opened August 2023

Discharges Home w/ “no needs” (percentage)

	June	July
< 1 hr	6.80%	12%
< 2 hrs	18.80%	21.40%
< 3 hrs	22%	21.40%
< 4 hrs	17%	13%
< 5 hrs	12%	10%
Over 5hrs	22.60%	21.60%

Y-axis: 0.00%, 5.00%, 10.00%, 15.00%, 20.00%, 25.00%

* July 1 – July 15, 2024

Legend: June, July

PeriOperative Services

[Pre-Admission Testing, Operating Room, Post-Anesthesia

Care Unit, Endoscopy Services, Sterile Processing Services]

Board Quality Review Committee, November 2024

Dr. Richard Engel, MD, Medical Director

Dr. Julian Anthony, MD, OR Committee Chair at PMCP

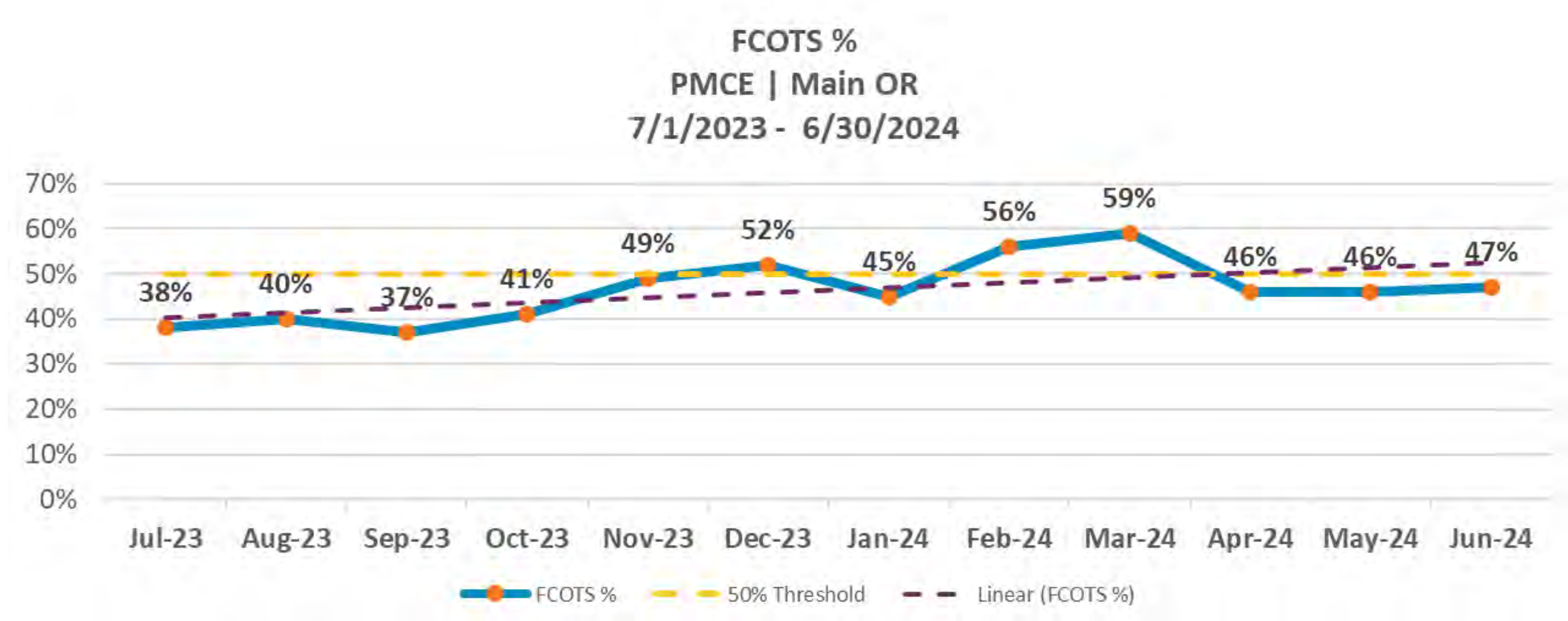
Dr. Gregory Campbell, MD, OR Committee Chair at PMCE

Bruce Grendell, MPH, BSN, RN, Sr. Director, Perioperative Services

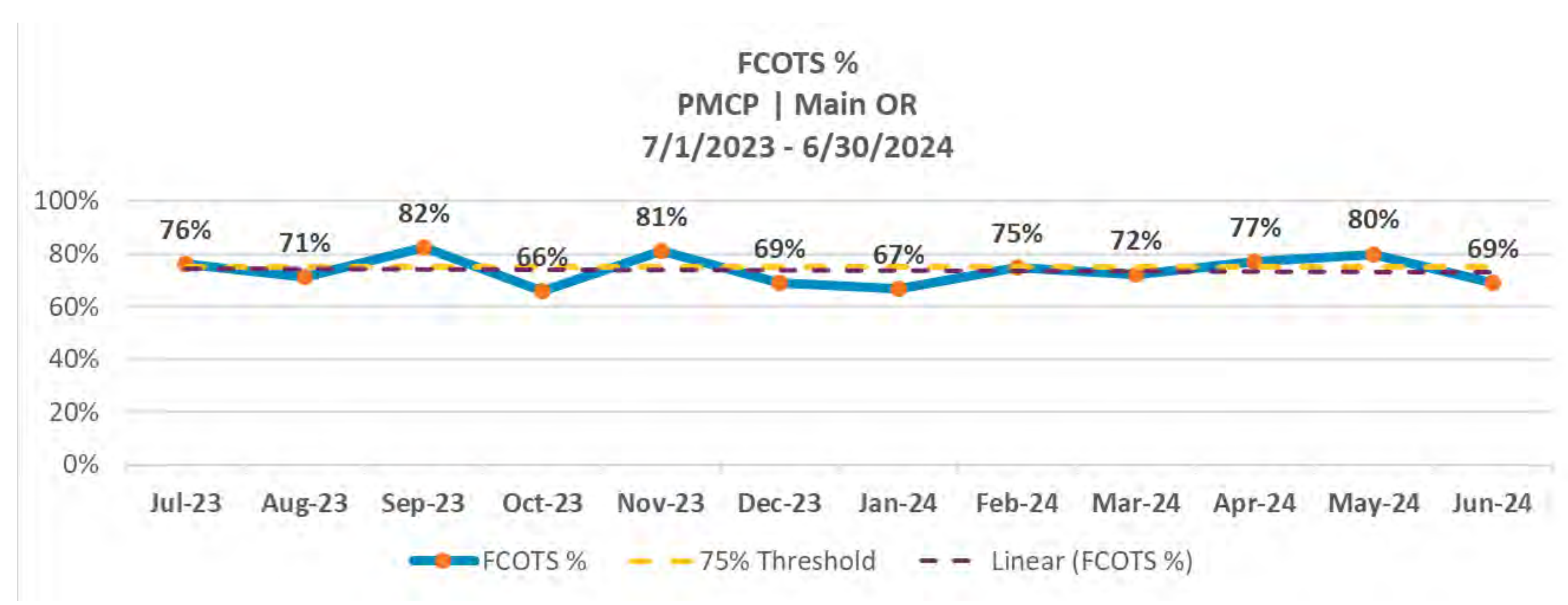
FY 24 Quality Goals

SITUATION	Focus on top five quality and efficiency metrics
BACKGROUND	Monthly review at OR Committee
ASSESSMENT	• First Case On Time Starts (FCOTS) trends • Block Time Utilization and Allocation • Patient Experience Scores • Surgical Site Infections / Standardized Infection Ratios (SIR) • Immediate Use Steam Sterilization (IUSS) rates
RECOMMENDATION	• Continued focus on improving communication between preoperative nursing personnel, physicians and OR nursing personnel to ensure preoperative orders are completed, patients are ready for their procedure, warm patient handoff completed and patients enter the OR on time. • Monthly monitoring of block time utilization. Reallocation as required. • Monthly review of patient experience scores and patient comments. • Monthly review of targeted surveillance for SSIs and wound class documentation. • Monthly review of IUSS rates in Sterile Processing Services.

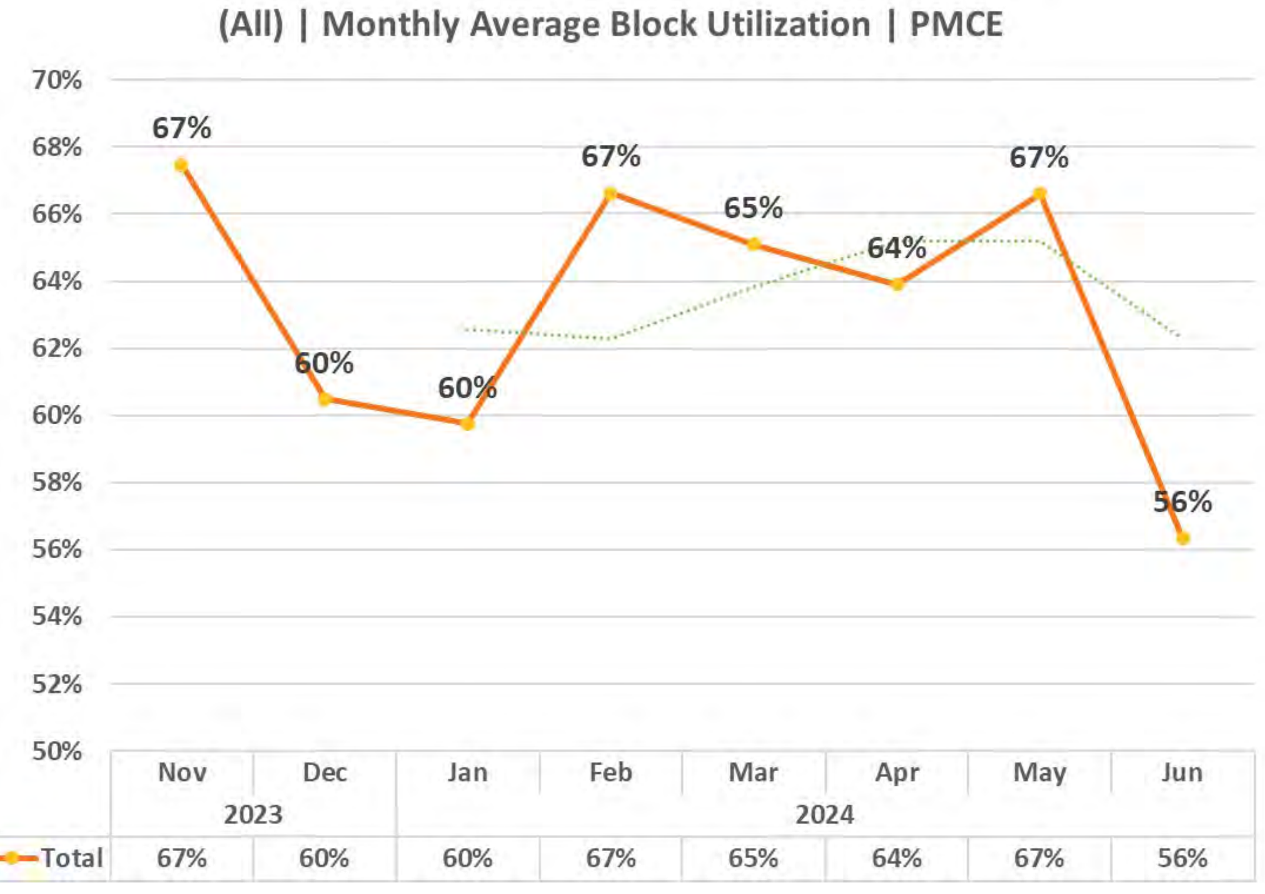
First Case on Time | PMCE



First Case on Time | PMCP



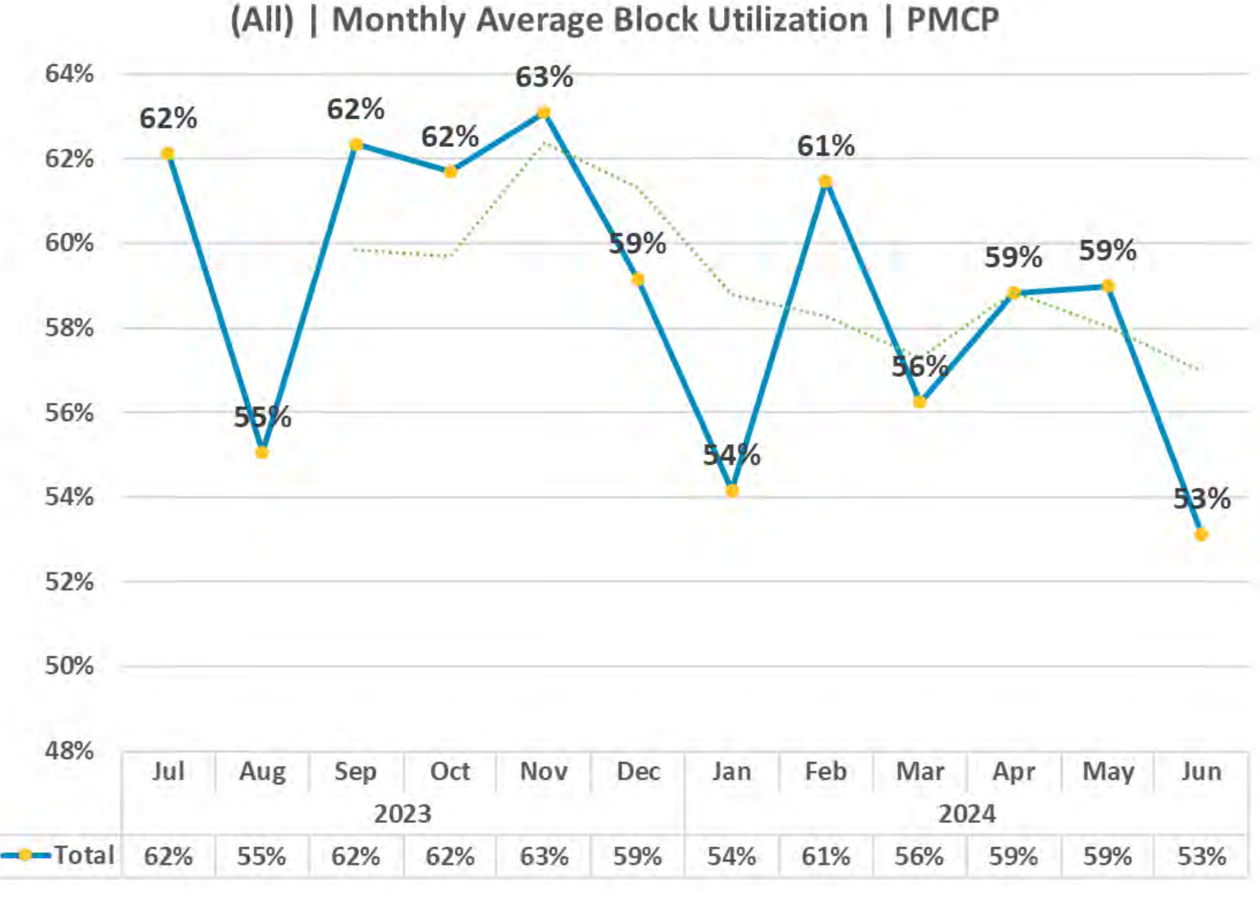
Block Utilization Summary | PMCE



Timeline of Events

- New BUR tracking methodology adopted at PMCE in November 2023
- Reduction in overall utilization in June 2024 are characterized by:
  1) Lag effect from PHMG IT issue experienced in May 2024.
  2) Implementation of logic to exclude FCOTS credit if case delayed > 1 minute due to “surgeon late”.

Block Utilization Summary | PMCP



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	2023						2024					
Total	62%	55%	62%	62%	63%	59%	54%	61%	56%	59%	59%	53%

Timeline of Events

○ Reduction in overall utilization in June 2024 are characterized by:

1) Lag effect from PHMG IT issue experienced in May 2024.

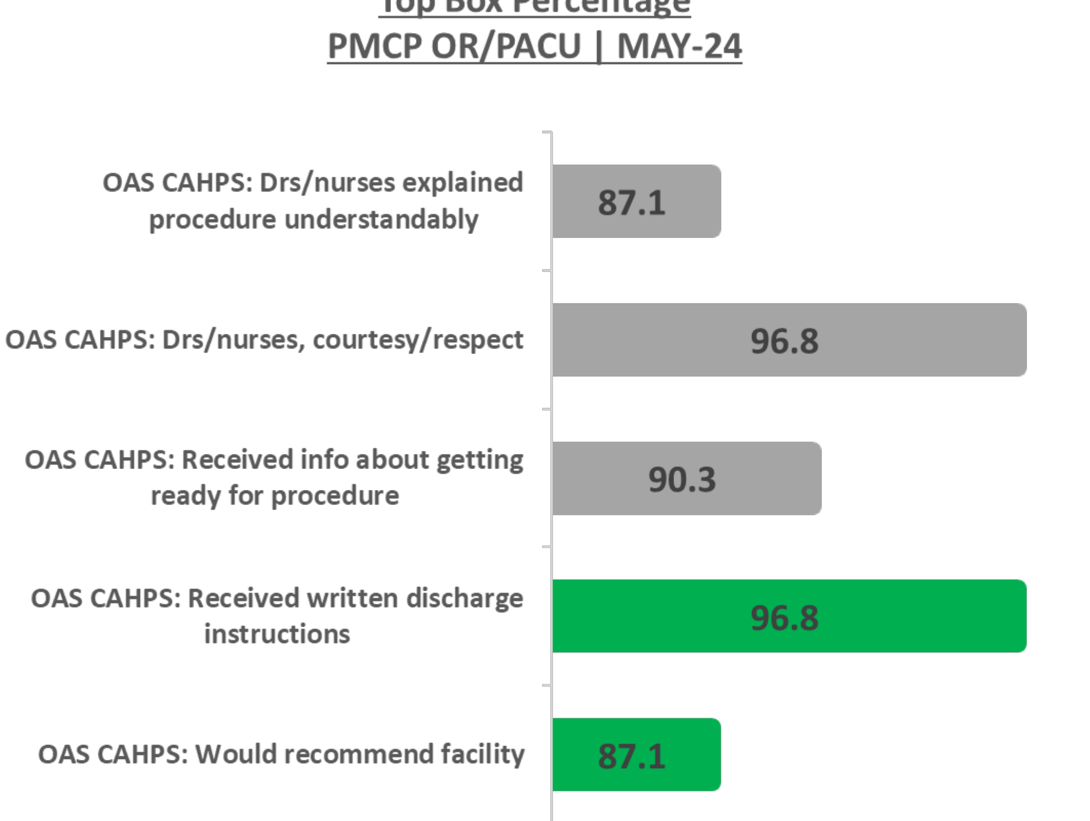
OAS CAHPS: Patient Experience (OR/PACU) | PMCE

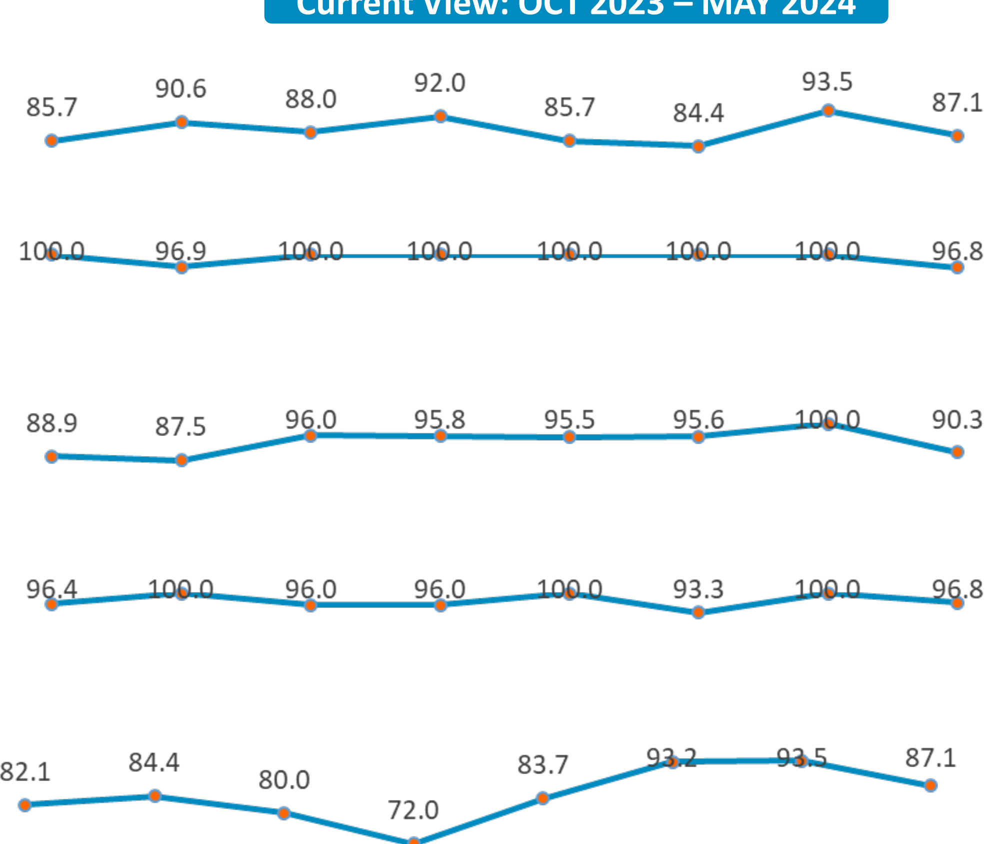
Measure	MAY-24 Top Box	Trend (OCT 2023 – MAY 2024)							
OAS CAHPS: Drs/nurses explained procedure understandably	94.1	94.1	92.0	89.5	92.0	94.9	92.5	95.5	94.1
OAS CAHPS: Drs/nurses, courtesy/respect	98.0	100.0	98.0	97.4	92.0	98.3	100.0	97.7	98.0
OAS CAHPS: Received info about getting ready for procedure	94.0	96.0	96.0	94.9	92.0	86.4	92.2	95.5	94.0
OAS CAHPS: Received written discharge instructions	96.0	100.0	100.0	92.3	100.0	93.2	98.0	97.6	96.0
OAS CAHPS: Would recommend facility	86.0	84.3	90.0	84.6	85.7	79.7	82.7	77.3	86.0

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

OAS CAHPS: Outpatient and Ambulatory Surgery CAHPS

OAS CAHPS: Patient Experience (OR/PACU) | PMCP





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

OAS CAHPS: Outpatient and Ambulatory Surgery CAHPS

Immediate Use Cases (IUSS) | PMCE

IUSS - PMCE

(JUL 2023 - JUN 2024)

Month	Total Prod	OneTray	% of One Tray Sterilized
Jul-23	5280	2	0.04%
Aug-23	6059	9	0.15%
Sep-23	5390	0	0.00%
Oct-23	5510	3	0.05%
Nov-23	5525	1	0.02%
Dec-23	5040	1	0.02%
Jan-24	5583	2	0.04%
Feb-24	5058	1	0.02%
Mar-24	5613	4	0.07%
Apr-24	5593	0	0.00%
May-24	5626	4	0.07%
Jun-24	5457	5	0.09%

Left axis: 0 – 7000; right axis: 0.00% – 0.70%

Legend: Total Prod · OneTray · % of One Tray Sterilized · .20% Threshold

Note: Starting January 2024, the IUSS threshold will be changed from .25% to .20% at PMCE

Immediate Use Cases (IUSS) | PMCP

IUSS - PMCP

(JUL 2023 - JUN 2024)

Month	Total Prod	OneTray	% of One Tray Sterilized
Jul-23	1941	4	0.21%
Aug-23	2317	2	0.09%
Sep-23	1994	5	0.25%
Oct-23	1810	3	0.17%
Nov-23	2144	2	0.09%
Dec-23	1580	4	0.25%
Jan-24	1549	4	0.26%
Feb-24	1316	4	0.30%
Mar-24	1389	3	0.22%
Apr-24	1573	4	0.25%
May-24	1424	3	0.21%
Jun-24	1313	1	0.08%

Left axis: 0, 500, 1000, 1500, 2000, 2500, 3000. Right axis: 0.00%, 0.10%, 0.20%, 0.30%, 0.40%, 0.50%, 0.60%, 0.70%.

Legend: Total Prod; OneTray; % of One Tray Sterilized; .20% Threshold

Note: Starting January 2024, the IUSS threshold will be changed from .25% to .20% at PMCP

HCAHPS and ED Patient Experience Data

Presented to
Board Quality Review Committee
November 27th, 2024

Suz Fisher, RN
District Director, Patient Experience

Situation	HCAHPS Data: Timeframe July 2023-June 2024 (FY24) ED Data: Timeframe July 2023-June 2024 (FY24)
Background	The **HCAHPS** (Hospital Consumer Assessment of Healthcare Providers and Systems) Survey, also known as the CAHPS® Hospital Survey or Hospital CAHPS®, is a standardized survey instrument and data collection methodology that has been in use since 2006 to measure patients' perspectives of hospital care. In July of 2024, the executive team approved patient experience (PX) goals for leaders across the district for FY25, based on results from patients seen between April of 2023 and March of 2024, the national average rate of change for each area, and PX domains that overlap among CMS Star Ratings, Leapfrog, and Value-Based Purchasing (VBP). Results as compared to goal are tracked and updated quarterly.
Assessment	**PMC Escondido HCAHPS** – 3/9 metrics equal to or above CMS benchmark for FY24 Q4 (likelihood to recommend, overall rating, and discharge information); likelihood to recommend has been equal to or above benchmark for the last 12 consecutive quarters and discharge information has been equal to or above benchmark for the last 10 consecutive quarters. **PMC Poway HCAHPS** – 0/9 metrics equal to or above CMS benchmark for FY24 Q4, although our internal PX communication with nurses goal was met for the quarter. **PMC-E Emergency Department** – 0/13 metrics equal to or above National Research Corporation (NRC) benchmark for FY24 Q4, although our internal PX likelihood to recommend goal was met for the quarter. **PMC-P Emergency Department** – 3/13 metrics equal to or above National Research Corporation (NRC) benchmark for FY24 Q4 (doctors explained understandably, doctors listened carefully, and imaging exceeded expectations); all three metrics have been equal to or above benchmark for the last 12 consecutive quarters.
Recommendation	• PX goals were expanded for FY25 – more leaders are carrying goals, there is increased horizontal cascading, and goals have been further personalized for each area based on overlapping domains and priority matrices. • PX goals and results continue to be shared in a standardized manner at leadership meetings and every other week at safety huddle; we are working to expand this even further and share goals and results at nearly every meeting. • Leaders meet monthly with leaders who report to them to discuss results as compared to goal and plans to close the gap/sustain. • Changes have been made to PEC – we will meet monthly beginning in October, membership has been aligned to directors and above with PX goals, and leaders will report out and discuss results compared to goal at PEC quarterly on a rotating basis.

HCAHPS

Results current as of 8/27/24

Escondido Results, by Percentile

90
80
70
60
50
40
30
20
10
0

64
60
52
59
72
55
34
31
36
34
29
21
20
21
19
15
24
17

FY24 Q1
FY24 Q2
FY24 Q3
FY24 Q4

Likehood to Recommend
Communication w/Nurses
Responsiveness
Cleanliness
Quietness

★ indicates approximate FY25 goal for the campus overall. Communication w/nurses, responsiveness, and quietness have unit-level goals.

Escondido Results, by Percentile

90
80
70
60
50
40
30
20
10
0

FY24 Q1 — 80, 73, 61, 60, 50
FY24 Q2 — 60, 52, 45, 22, 14
FY24 Q3 — 86, 50, 49, 47, 34
FY24 Q4 — 64, 54, 53, 50, 39

Communication About Meds | Care Transitions | Communication w/Docs | D/C Info | Overall 0-10

★ indicates approximate FY25 goal for the campus overall. Communication w/docs, D/C info, and Overall 0-10 do not have formal goals this year.

Poway Results, by Percentile

90
80
70
60
50
40
30
20
10
0

FY24 Q1: 26, 22, 19, 15, 1
FY24 Q2: 48, 37, 21, 8, 1
FY24 Q3: 15, 3, 1
FY24 Q4: 28, 23, 16, 5, 1

Likehood to Recommend | Communication w/Nurses | Responsiveness | Cleanliness | Quietness

★ indicates approximate FY25 goal for the campus overall. Communication w/nurses, responsiveness, and quietness have unit-level goals.

Poway Results, by Percentile

	FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4
Communication About Meds	35	11	1	3
Care Transitions	59	22	6	42
Communication w/Docs	36	18	2	12
D/C Info	20	52	24	24
Overall 0-10	16	24	7	25

★ indicates approximate FY25 goal for the campus overall. Communication w/docs, D/C info, and Overall 0-10 do not have formal goals this year.

Emergency Department

Results current as of 8/27/24

Escondido ED Results, by Percentile

50
45
40
35
30
25
20
15
10
5
0

	FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4
Likelihood to Recommend	20	15	18	15
What to do if Not Better	9	12	8	9
Human Understanding	13	8	12	7

Likelihood to Recommend   What to do if Not Better   Human Understanding

★ indicates approximate FY25 goal

Escondido ED Results, by Percentile

	FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4
Nurse Courtesy	1	2	2	2
Physician Courtesy	10	18	18	18

★ indicates approximate FY25 goal

Poway ED Results, by Percentile

50
45
40
35
30
25
20
15
10
5
0

35
23
21
19
24
26
25
20
19
17

FY24 Q1
FY24 Q2
FY24 Q3
FY24 Q4

Likelihood to Recommend
What to do if Not Better
Human Understanding

★ indicates approximate FY25 goal

Poway ED Results, by Percentile

	FY24 Q1	FY24 Q2	FY24 Q3	FY24 Q4
Nurse Courtesy	7	13	11	8
Physician Courtesy	28	40	37	31

★ indicates approximate FY25 goal