November 13, 2025

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **QUALITY AND EFFICIENT PRACTICES COMMITTEE - COMMITTEE OF THE WHOLE** of **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, NOVEMBER 17, 2025, AT 8:30 A.M., HEART CENTER TELECONFERENCE ROOM, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA**.

(V*isit* https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2025/ *for Public Access Information*).

Allen Radner, MD
President/Chief Executive Officer

[1] Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Committee Voting Members: **Catherine Carson**, Chair, **Rolando Cabrera, MD**, Vice-Chair, **Clement Miller,** Chief Operating Officer, **Carla Spencer, RN**, Chief Nursing Officer; **Richard Gerber, MD**, Medical Staff Member.
Advisory Non-Voting Members: Administrative Executive Team.

QUALITY AND EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH[1]

MONDAY, NOVEMBER 17, 2025, 8:30 A.M.
HEART CENTER TELECONFERENCE ROOM

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California

(Visit SalinasValleyHealth.com/virtualboardmeeting for Public Access Information)

AGENDA

1. Call to Order / Roll Call

2. Public Comment

   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

3. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of October 13, 2025. (CARSON)

   - Motion/Second
   - Public Comment
   - Action by Committee/Roll Call Vote

4. Patient Care Services Update (SPENCER)
   - Perioperative Services Unit Based Practice Council

5. Perioperative Services / ERAS Program updates (INMAN)

6. Women's and Children's Services Report (SPENCER)

7. Age Friendly Program Update (KUKLA/INMAN & SPENCER)

8. Closed Session

9. Reconvene Open Session/Report on Closed Session

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

10. Adjournment

The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, December 15, 2025 at 8:30 a.m.**

This Committee meeting may be attended by Board Members who do not sit on this Committee. In the event that a quorum of the entire Board is present, this Committee shall act as a Committee of the Whole. In either case, any item acted upon by the Committee or the Committee of the Whole will require consideration and action by the full Board of Directors as a prerequisite to its legal enactment.

The Salinas Valley Health (SVH) Committee packet is available at the Board Meeting, electronically at https://www.salinasvalleyhealth.com/~/about-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2025/, and in the SVH Human Resources Department located at 611 Abbott Street, Suite 201, Salinas, California, 93901. All items appearing on the agenda are subject to action by the SVH Board.

Requests for a disability related modification or accommodation, including auxiliary aids or Spanish translation services, in order to attend or participate in-person at a meeting, need to be made to the Board Clerk during regular business hours at 831-759-3050 at least forty-eight (48) hours prior to the posted time for the meeting in order to enable the District to make reasonable accommodations.

QUALITY & EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH

AGENDA FOR CLOSED SESSION

Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance with Section 54954.5 of the Government Code.

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)
Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, hospital internal audit report, or report of quality assurance committee): _____

1. Report of the Medical Staff Quality and Safety Committee
   Accreditation and Regulatory Report (INMAN)
2. Quality and Safety Board Dashboard Review (KUKLA)
3. Consent Agenda:
   Sepsis
   Organ/Tissue Procurement
   Respiratory Care
   Transporters and Interpreters
   Cardiovascular Service Line
   Case Management/Utilization Management
   Taylor Farms Family Health and Wellness Center

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES OCTOBER 13, 2025

Committee Member Attendance:

Voting Members Present: **Catherine Carson**, Chair, **Rolando Cabrera, M.D.,** Vice Chair, **Clement Miller**, COO, **Carla Spencer,** CNO; and **Richard Gerber, M.D.**;

Voting Members Absent: None;

Advisory Non-Voting Members Present:
In Person: Allen Radner, M.D., President/CEO, Timothy Albert, M.D., CCO, Iftikhar Hussain, CFO, Alysha Hyland, CAO, Cheryl Pirozzoli, Family/Patient Council Advisor;

Via WebEx: Michelle Childs, CHRO, and Gary Ray, CLO;

Other Board Members Present, Constituting Committee of the Whole:
Via teleconference: Victor Rey, Jr.

Victor Rey left at 9:11 a.m.
Dr. Cabrera left at 9:46 a.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:31 a.m. in the Downing Resource Center CEO Conference Room 117.

2. PUBLIC COMMENT

None.

3. APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF SEPTEMBER 15, 2025.

Approve the minutes of the September 15, 2025 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

PUBLIC COMMENT:
None

MOTION:

Upon motion by Committee Member Spencer, second by Vice-Chair Cabrera, the minutes of the September 15, 2025 Quality and Efficient Practices Committee Meeting are approved as presented.

ROLL CALL VOTE:
Ayes: Carson, Dr. Cabrera, Miller, Dr. Gerber and Spencer;
Nays: None;
Abstentions: None;
Absent: None.

Motion Carried

[1]Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

4. PATIENT CARE SERVICES UPDATE: PEDIATRIC UNIT PRACTICE COUNCIL

Carla Spencer, CNO, introduced Pamela Yates, RN, Chair, and Lisa Sandberg, BSN, CPN, Co-Chair, who reported on the Council's purpose, 2025 goals, initiatives and data. Initiatives include gifting digital thermometers, and asthma education. Future initiatives will include nutrition and movement for obesity prevention and screening for postpartum depression. A full report was included in the packet.

COMMITTEE DISCUSSION: Epic will assist with data collection. Thermometer availability: the unit doesn't perform a social determinants of health assessment on pediatric patients but social workers identify needs to add to the patient/family support. Recommendations: (1) Involve school nurses in the Asthma Action Plan to assist with education; asthma camp information is provided if age appropriate. (2) Involve Tiffany DiTullio in the nutrition/movement initiative. (3) Consider vaccine education as a future initiative.

5. REPORT OF THE MEDICAL STAFF QUALITY AND SAFETY COMMITTEE

- Aniko Kukla, Director of Quality & Patient Safety, reported on the CMS Star Rating and Patient Experience Action Plan. Patient safety will be a current focus. A full report was included in the packet.

  COMMITTEE DISCUSSION: The alarm fatigue project is a multidisciplinary house-wide project.

- Carla Spencer, CNO, and Cynthia Vargas, BS, CPXP, Patient Experience Manager, reported on Service Excellence (Patient Experience) and Complaints and Grievances. A full report was included in the packet.

  COMMITTEE DISCUSSION: There is a physician-involved team focusing on Communication with doctors. Most of our patients are in the category of 75-79 years of age. Focusing on this group's complaints/lost items is an Age-Friendly initiative. Safety huddle discusses lost items daily.

- Brenda Inman, Vice President Quality and Risk Management, reported on the new multidisciplinary Patient Safety Structural Events Committee (PSEC) purpose, review process, membership and is aimed at system-level improvements through action plans and will be monitored for sustainability.

  COMMITTEE DISCUSSION: PSEC will be a multidisciplinary team focusing on system-level improvements and will be a formalized process to discuss, review and ensure actions are put into place and will be protected as patient safety work products. Physician issues will continue to be evaluated on MSEC. There will be some overlap. Dr. Singh, Vice President of Medical Affairs will be a PSEC member.

6. CLOSED SESSION

Chair Carson announced that the items to be discussed in Closed Session are *Hearings/Reports* as listed on the closed session agenda. The meeting recessed into Closed Session under the Closed Session protocol at 9:35 a.m.

7. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:54 a.m. Chair Carson reported that in Closed Session, the *Hearings/Reports* were accepted as follows:

1. Quality and Safety Board Dashboard proposed changes
2. Quality and Safety Board Dashboard Review
3. Medical Staff Quality & Safety Committee Consent Agenda
    - Pharmacy and Therapeutics

8. ADJOURNMENT

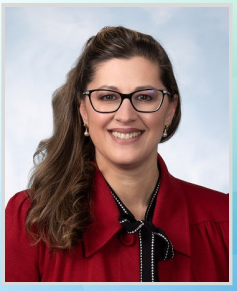
There being no other business, the meeting adjourned at 9:55 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, November 17, 2025** at 8:30 a.m.

_____

Catherine Carson, Chair
Quality and Efficient Practices Committee

Patient Care Services Update

Salinas Valley HEALTH



Presented by:
Carla Spencer, MSN, RN, NEA-BC
Chief Nursing Officer

Featuring: Perioperative Clinical Practice Council

November 17, 2025

PERIOPERATIVE CLINICAL PRACTICE COUNCIL

Council Membership:

- Chair: Deborah Ralph, *BSN, RN*
- Co-Chair: Abby Acosta, *MSN, RN, CPAN, CAPA*
- Associate Co-Chair: Avrie Calabro, *RN*

Advisor: Leslie Hawthorne, BSN, RN, CNOR

Members:

- Amanda Maguire Martin, *MSN,RN, CNOR*
- Jeanette Bedenbaugh, *BSN, RN, CNOR*
- Alex Beadles, *RN, CPAN*
- Diana Griggs, *MSN, RN, CNE*

PROCESS:

To **identify process improvement opportunities** and implement standards of care and evidence-based practice specific to the department's clinical areas

To **identify and resolve clinical and systems issues** that impacts care coordination, a healthy work environment, the delivery of patient-family centered care, patient safety, clinical outcomes and staff engagement

Topics:

- **Enculturating a Warm Protocol** *to Prevent Inadvertent Hypothermia in Perioperative Patients*
- **Updating Family for All Phases of Care**

Enculturating a Warming Protocol *to Prevent Inadvertent Hypothermic Perioperative Patients*

BACKGROUND:

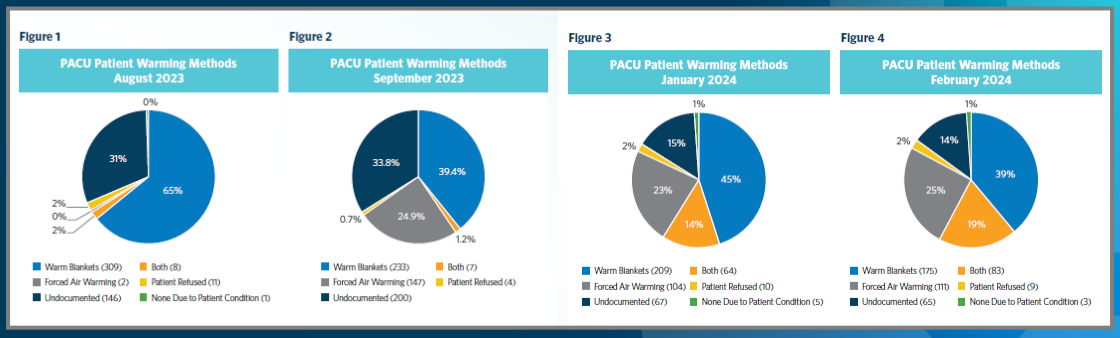
- Perioperative hypothermia remains a clinical concern, increasing morbidity and mortality; corrective measures, such as using warm blankets should be implemented when temperature falls below 36°

INTERVENTION:

- Evidence-Based Practice [EBP] Cohort
- Implemented warming protocol included these elements:
  - Warm patient for 30 minutes before surgery
  - Start active warming if surgery lasts 60 minutes or more and continue in the Post-Anesthesia Care Unit [PACU]

Enculturating a Warming Protocol *Cont.*

OUTCOME DATA:



Updating Family for All Phases of Care

BACKGROUND:

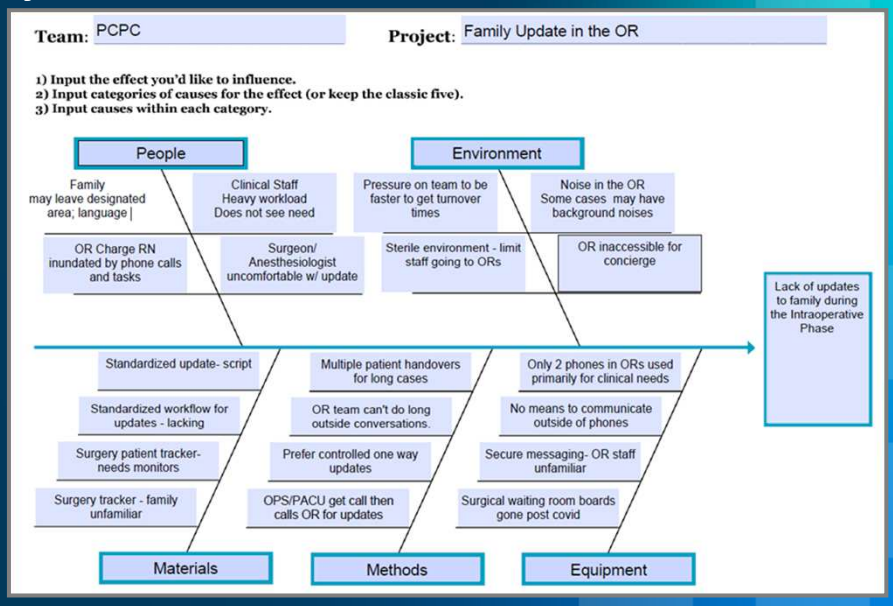
- Updating families during surgery helps reduce anxiety and improve patient satisfaction. We identified the need to keep families informed through phone or in-person updates during the patient's care

INTERVENTION:

- Intraoperative phase of care update options were implemented based on stakeholder needs
  - Message templates were developed in TigerConnect© allowing Operating Room [OR] RNs to send brief surgery milestones messages to the concierge, who then updates the family
  - Big Screen monitors in the waiting room now display Surgery Patient Trackers, providing real-time updates on patients' location in the department

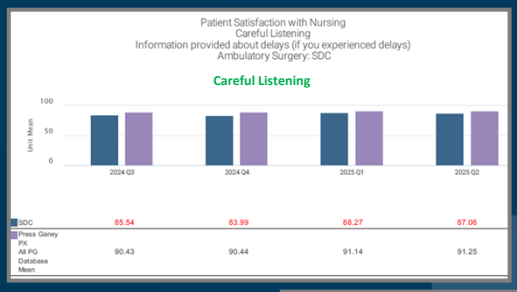
Updating Family for All Phases of Care, *Cont.*:

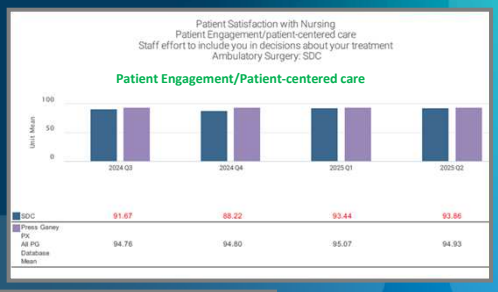
OUTCOME DATA: *CAUSE and EFFECT DIAGRAM*



Updating Family for All Phases of Care, *Cont.*:

OUTCOME DATA: *Patient Satisfaction with Nursing*





Initiatives *In-Progress:*

- **Enhancing House-Wide Awareness on Pre-Op Readiness**

  BACKGROUND:
  The Perioperative Clinical Practice Council [PCPC] receives annual referrals to improve understanding of pre-operative readiness. Ensuring nursing staff are fully aware of patient's pre-operative status, from physical and psychological preparation to administrative and logistical checks, prevent delays, reduce errors, and improve the patient experience

- **Improving the Care of the Neurodiverse Perioperative Patient**

  BACKGROUND:
  Staff are building skills in caring for neurodiverse patients to enhance the patient and family experience

Salinas Valley HEALTH

Questions?

Salinas Valley HEALTH

Quality and Safety Committee

November 6th , 2025

Dr. Richard Gerber – Chair Quality and Safety Committee
Kukla, RN, DNP, CPHQ
Director Quality and Patient Safety/Patient Safety Officer

Salinas Valley HEALTH

Safety Leadership Story

Today in **human reliability we bring you the story of the** panda Meng Er. He was separated from his mother very young and learned how to be a panda from humans at the Beijing Zoo. His humans grimaced when breaking the bamboo for feeding. Bamboo is strong and difficult for a human to break by hand. Meng Er is strong. Bamboo is easy to break. Yet Meng Er makes the face every time he breaks bamboo. **That is how he learned the task. That is just how we do things around here. Make the face.**
That is the **power of habit** in human reliability. **Teach safe habits** where you work, live, learn, and play. Safe habits protect you even when you're not thinking to protect yourself ... or others.
And, as all teachers know, **habits are caught - not taught**. Don't worry that your "students" don't listen to you. Worry that they are always watching you.

PERIOPERATIVE SERVICES
Quality Improvement Reports

Report to QIC

Salinas Valley HEALTH

Aisha D. Huebner
Director, Perioperative Services

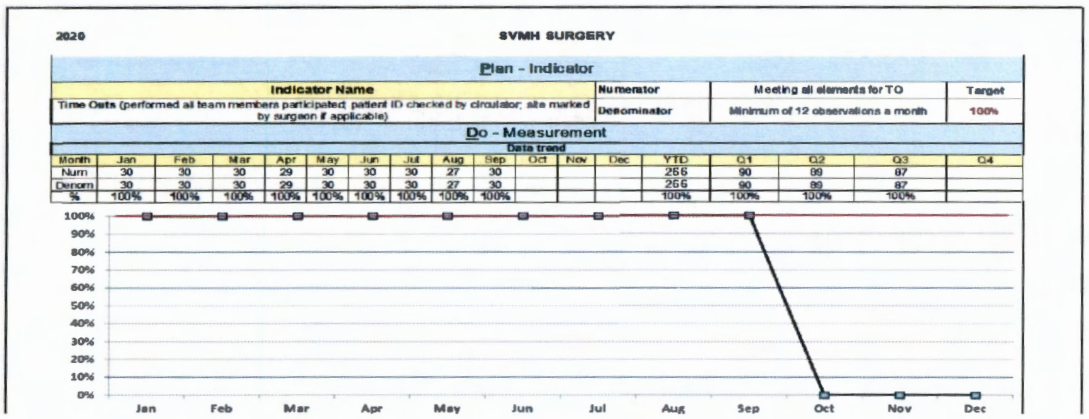
Date: October 15, 2025

Quality and Safety Goals 2025
Perioperative Services

Salinas Valley HEALTH

- Site Marking
- Time Outs
- Sharps Injury

Quality Control Data: Site Markings YTD (Jan- Sept. 2025)– 100%



2020 SVMH SURGERY

Plan - Indicator

Indicator Name	Numerator	Meeting all elements for TO	Target
Time Outs (performed all team members participated; patient ID checked by circulator; site marked by surgeon if applicable)	Denominator	Minimum of 12 observations a month	100%

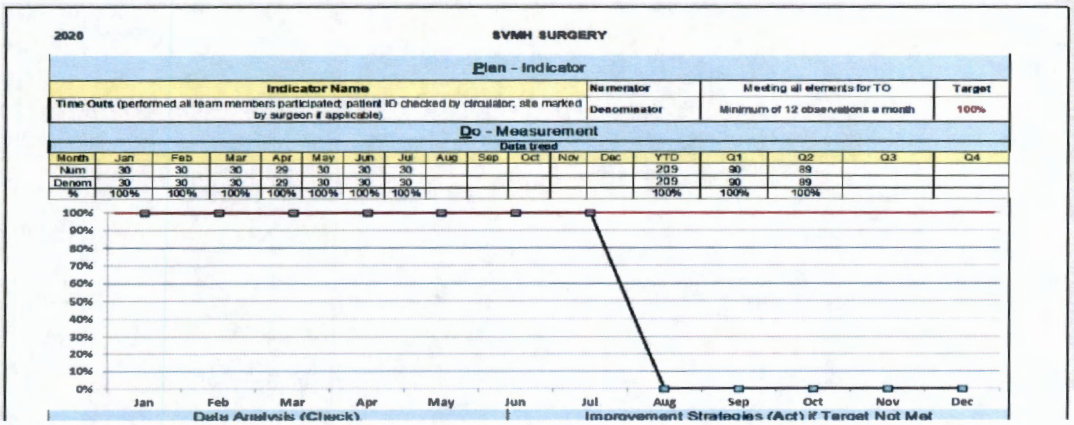
Do - Measurement

Data trend

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Q1	Q2	Q3	Q4
Num	30	30	30	29	30	30	30	27	30				266	90	89	87	
Denom	30	30	30	29	30	30	30	27	30				266	90	89	87	
%	100%	100%	100%	100%	100%	100%	100%	100%	100%				100%	100%	100%	100%	

Site Markings are 100% in the observations completed.

Quality Control Data: Time Outs YTD (Jan-July 2025) – 100%



2020 SVMH SURGERY

Plan - Indicator

Indicator Name	Numerator	Meeting all elements for TO	Target
Time Outs (performed all team members participated; patient ID checked by circulator; site marked by surgeon if applicable)	Denominator	Minimum of 12 observations a month	100%

Do - Measurement

Data trend

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Q1	Q2	Q3	Q4
Num	30	30	30	29	30	30	30						209	90	89		
Denom	30	30	30	29	30	30	30						209	90	89		
%	100%	100%	100%	100%	100%	100%	100%						100%	100%	100%		

Time out observation measure: 100%

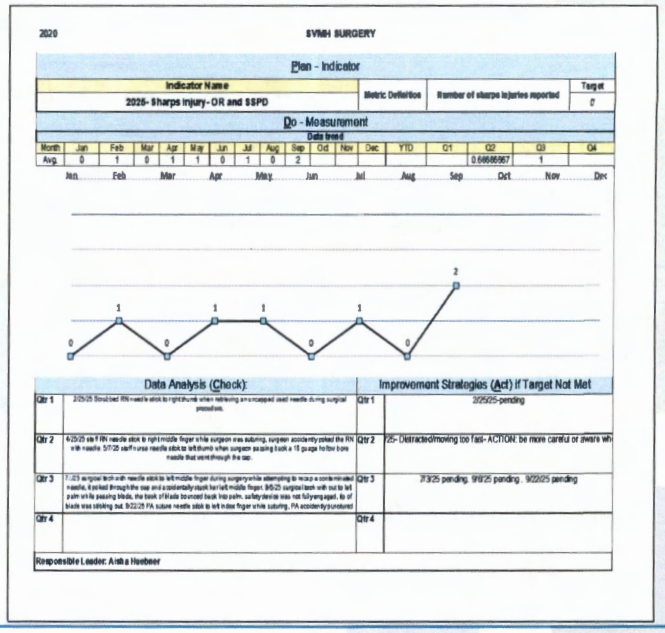
Quality Control Data: Sharps Injury

Quality Control Data: Sharps Injuries Q1, Q2, Q3

- February – 1
- April – 1
- May – 1
- July – 1
- September – 2

Improvement Strategies:

- Individual communication
- Group communication
- Focused education on safe sharps handling



2020 SVMH SURGERY

Plan - Indicator

Indicator Name	Metric Definition	Target
2025- Sharps injury- OR and SSPD	Number of sharps injuries reported	0

Do - Measurement

Data trend

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	Q1	Q2	Q3	Q4
Avg	0	1	0	1	1	0	1	0	2						0.6666667	1	

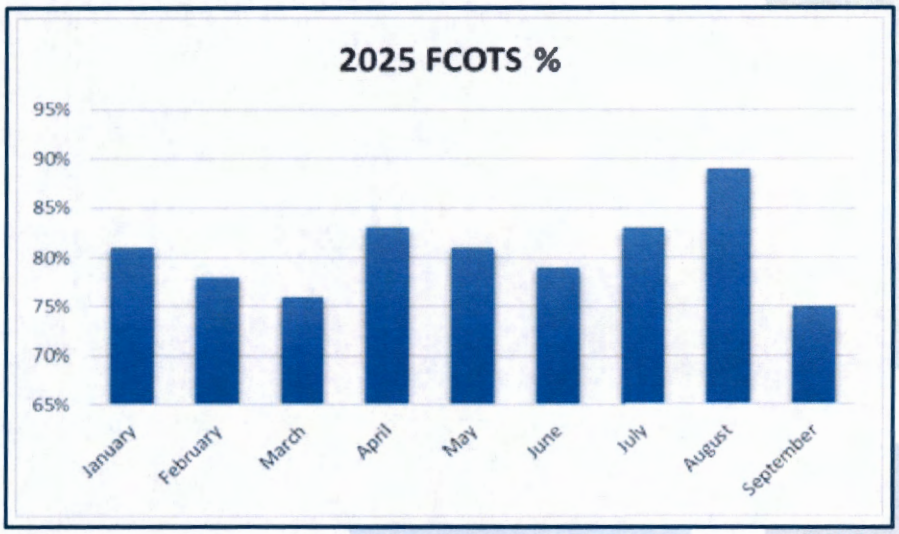
	Data Analysis (Check):		Improvement Strategies (Act) If Target Not Met
Qtr 1	2/25/25 Sterilized RN needle stick to right thumb when retrieving an uncapped used needle during surgical procedure.	Qtr 1	3/25/25-pending
Qtr 2	4/25/25 staff RN needle stick to right middle finger while surgeon was suturing, surgeon accidently poked the RN with needle. 5/7/25 staff nurse needle stick to left thumb when surgeon passing back a 18 gauge histor bone needle that went through the cap.	Qtr 2	7/25- Distracted/moving too fast- ACTION: be more careful or aware wh
Qtr 3	7/23 surgical tech with needle stick to left middle finger during surgery while attempting to recap a contaminated needle, it poked through the cap and accidentally stuck her left middle finger. 9/5/25 surgical tech with cut to left palm while passing blade, the back of blade bounced back into palm, safety device was not fully engaged, tip of blade was sticking out. 9/22/25 PA suture needle stick to left index finger while suturing, PA accidently punctured	Qtr 3	7/3/25 pending. 9/8/25 pending . 9/22/25 pending
Qtr 4		Qtr 4	

Responsible Leader: Aisha Huebner

Perioperative Services Metrics

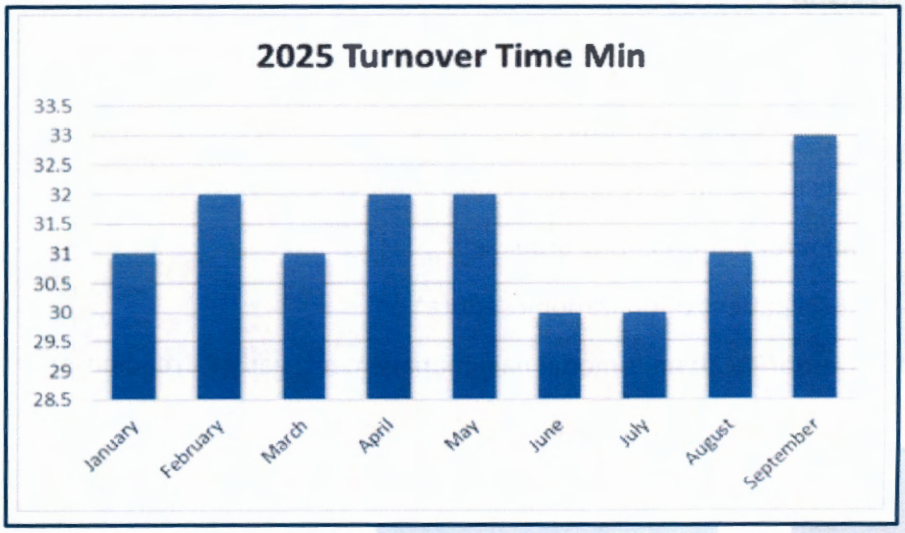
First Case On-Time Starts

- First Case Start for scheduled case is 0730
- All first cases are required to be in the room 5 minutes prior to the scheduled start time (0725)



Turnover Time

- Turnover Time refers to the interval between when one surgical case ends and the next begins
- Average benchmark across U.S. hospitals: 25-40 minutes



Nursing Practice and Unit Based Council Quality Initiatives

ERAS Implementation – Total Joint Replacements

Go-Live: Dec 1, 2025

Implementation Process

- ERAS Steering Committee formed
- Collect baseline data (LOS, readmissions, opioid use)
- Standardize protocols & order sets
- Pre-op patient optimization & education
- Intra-op/PACU: multimodal pain management, early PT readiness
- Define discharge criteria & follow-up process
- Continuous review & pathway updates

Next: Expand to other service lines (Q2 2026)

What is ERAS?

Enhanced Recovery After Surgery (ERAS) is an evidence-based, multidisciplinary model of perioperative care designed to improve patient outcomes, safety, and efficiency across the surgical journey. It integrates best practices from surgery, anesthesia, nursing, pharmacy, rehabilitation, nutrition, and case management into a standardized pathway that minimizes the physical and emotional stress of surgery.

Core Principles

- **Standardization** of perioperative practices
- **Patient optimization** before surgery (nutrition, comorbidities, education)
- **Multimodal pain management** to reduce opioids
- **Early mobilization** and functional recovery
- **Continuous measurement** for quality improvement

Why it Matters

- Shorter hospital stays
- Lower complication and readmission rates
- Improved patient satisfaction and outcomes
- Supports efficiency and value-based care

Program Overview

- **ERAS:** Total Joint Replacement (TJR)
- **Multidisciplinary approach:** Orthopedics, Anesthesia, Nursing, PT/OT, Pharmacy, Nutrition, Case Management, Admin
- **Program Goals:**
  - Reduce LOS, readmissions, complications
  - Standardize protocols and order sets
  - Improve patient experience and functional outcomes
  - *Go-Live* December 1, 2025

Key Pre-Implementation Steps

- **Team Formation and Governance:** ERAS Steering Committee
- **Baseline Data Collection:** LOS, readmissions, opioid use, complications, patient reported outcome measures (PROMs)
- **Pre-Op Optimization:**
  - Smoking cessation 6 weeks pre/post
  - BMI <40, A1C <8 (with PCP/LAMP support)
  - Health coaching and patient contracts

Patient Education: ERAS class and education (focus: hydration, mobility, discharge readiness)

Intraoperative & PACU Protocols

- **Intra-Op:** Normothermia, mindful fluids, multimodal analgesia (Tylenol, Toradol, Decadron, TXA, RECK infiltration)
- **PACU Priorities:** Pain control, nausea prevention, hemodynamic stability, early PT readiness
- **Standardization:** Epic ERAS order sets for anesthesia, analgesia, antibiotics, and fluids

Discharge & Recovery

- **Discharge Criteria:** Pain controlled, nausea resolved, safe ambulation/ADLs (stairs included)
- **Barriers Addressed:** Nausea, hypotension, pain, transport planning
- **Patient Follow-up:**
  - 24-48 hour post-discharge call
  - Clinic follow-up within 2 weeks
  - PROMs collection for QI

Continuous Improvement

- **Monthly ERAS Review:** LOS, readmissions, complications, patient satisfaction, PROMs
- **Annual Pathway Updates:** Evidence-based revisions
- **Education:** Ongoing staff huddles, in-services, Epic tip sheet prior to go-live
- **Strategic Impact:** Standardized care, improved efficiency, patient-centered outcomes
- **Implementation of subsequent service lines** is scheduled for Q2 2026

Questions?

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Completed Projects/Initiatives

- **Patient Warming Protocol Implementation**
  - Standardized perioperative warming protocol established
  - Pre- and intra-op active warming now standard of care
  - Improved patient safety; protocol expanded beyond periop areas

- **Enhanced intraoperative communication with real-time family updates**
  - Evaluated and implemented intraoperative communication improvements
  - OR RNs use TigerConnect templates to send milestone updates via concierge
  - Waiting room monitors display real-time surgery patient trackers for families

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In-Progress Projects/Initiatives

- **Pre-op Readiness**
- Identified gaps in pre-op readiness awareness among inpatient/ED staff
- Implemented multi-faceted intervention: education, tools, mentorship, audits
- Goals and measures for tracking:
  - 20% decrease in same-day cancellations
  - Checklist compliance
  - Improved patient satisfaction reflected in Press Ganey Survey results

- **Bee Mindful: Supporting the Neurodiverse Patient Experience**
- Challenge: Staff lack confidence in managing neurodiverse patients, impacting patient and family experience
- Plan: Implement "Bee Mindful" protocols for all neurodiverse patients
- Measures: staff surveys, patient experience scores, and real-time feedback

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Endoscopy

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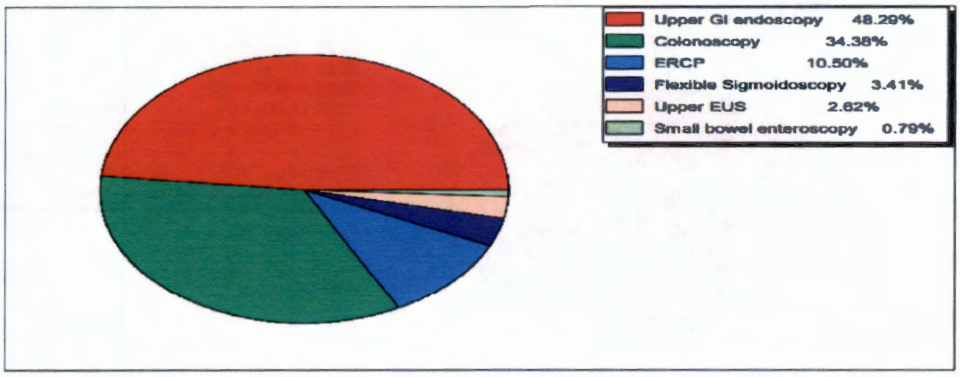
Quarterly Data: January 1 – March 31

Gastroenterology

Summary by Procedure — From 1/1/2025 to 3/31/2025

Notes included: All

Procedure	Number	Percent
Upper GI endoscopy	184	48.29%
Colonoscopy	131	34.38%
ERCP	40	10.50%
Flexible Sigmoidoscopy	13	3.41%
Upper EUS	10	2.62%
Small bowel enteroscopy	3	0.79%
Total	381	100.00%



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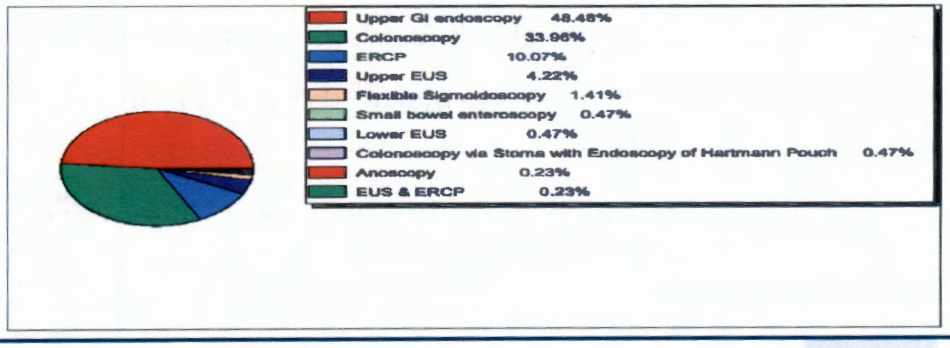
Quarterly Data: April 1 – June 30

Gastroenterology

Summary by Procedure — From 4/1/2025 to 6/30/2025

Notes included: All

Procedure	Number	Percent
Upper GI endoscopy	207	48.48%
Colonoscopy	145	33.96%
ERCP	43	10.07%
Upper EUS	18	4.22%
Flexible Sigmoidoscopy	6	1.41%
Small bowel enteroscopy	2	0.47%
Lower EUS	2	0.47%
Colonoscopy via Stoma with Endoscopy of Hartmann Pouch	2	0.47%
Anoscopy	1	0.23%
EUS & ERCP	1	0.23%
Total	427	100.00%



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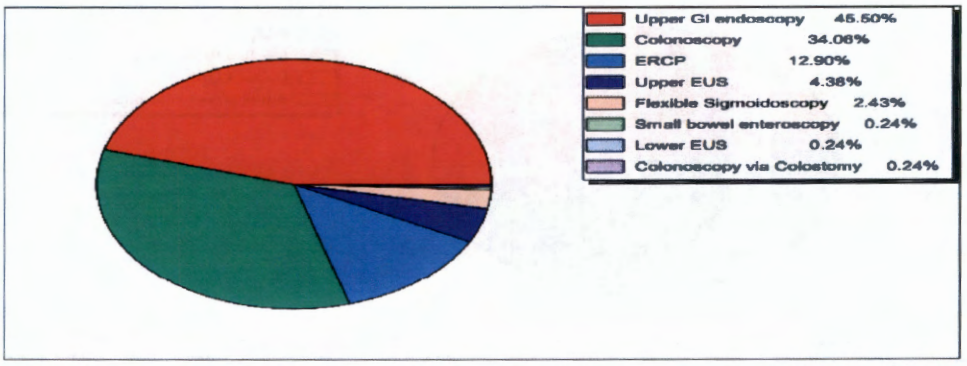
Quarterly Data: July 1 – August 31

Gastroenterology

Summary by Procedure — From 7/1/2026 to 9/30/2026

Notes included: All

Procedure	Number	Percent
Upper GI endoscopy	187	45.50%
Colonoscopy	140	34.06%
ERCP	53	12.90%
Upper EUS	18	4.38%
Flexible Sigmoidoscopy	10	2.43%
Small bowel enteroscopy	1	0.24%
Lower EUS	1	0.24%
Colonoscopy via Colostomy	1	0.24%
Total	411	100.00%



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Endoscopy Quality Initiatives

- All scopes are sent out for preventative maintenance after 100 uses.
  - Electronic and manual tracking within the department to ensure timeliness of scope maintenance.
- Implemented new process for scope cleaning efficacy.
  - The ChannelCheck, 3-in-1 Residual Soil Test for Internal Channels.
  - Used to detect any internal channel exposed to protein, hemoglobin, and/or carbohydrate during clinical use.
  - Testing is conducted after cleaning and prior to disinfection/sterilization.

Sterile Processing

Sterilization Summary Report

Month	Sets Sterilized	Peel Packs Sterilized
January	2,644	2,984
February	2,404	2,579
March	2,615	3,613
April	2,948	3,489
May	2,616	3,004
June	2,577	2,980
July	2,647	3,066
August	2,945	3,242
September	2,813	2,995
Total	24,209	28,952

Immediate Use Steam Sterilization (IUSS)

IUSS Activity

Month	IUSS Events	Description / Reason	BI Result
January	0	—	—
February	0	—	—
March	0	—	—
April	0	—	—
May	0	—	—
June	0	—	—
July	1	07/03/25 – Donor loaner instruments arrived late to SPD for processing	Passed
August	0	—	—
September	0	—	—

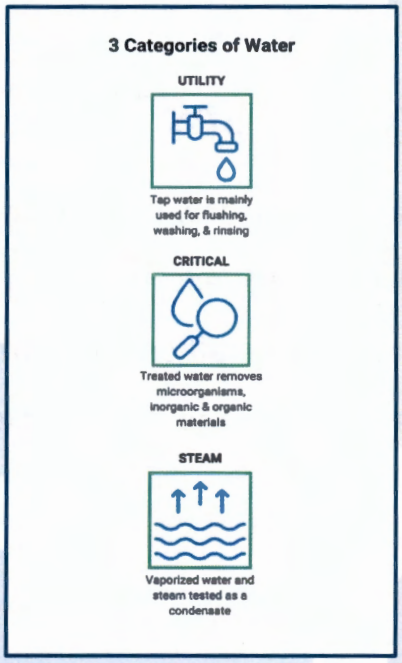
Total IUSS Events: 1
BI Pass Rate: 100%

The national target for IUSS use of below 5% is a best practice recommendation based on AAMI guidelines, not a federally mandated standard.

Sterile Processing Department
Quality Improvement Project
Water System Upgrade

Why this Matters

- Reliable instrument cleaning is essential for patient safety.
- Current system is outdated and does not meet updated national standards.
- Risk: Potential contamination, equipment damage, and compliance issues.



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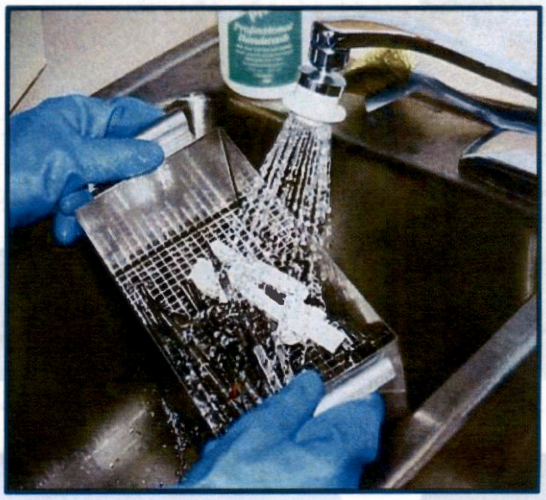
Project Goal

- Upgrade water system to **meet current standards**.
- Ensure **consistent, high-quality instrument reprocessing**.
- Support **patient safety and regulatory compliance**.



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Improvement Plan

- **Replace**: Install new Reverse Osmosis water system.
- **Validate**: Test to ensure system meets quality standards.
- **Educate**: Train staff on monitoring and maintenance.
- **Sustain**: Ongoing routine checks and reporting.

Expected Benefits

- **Improved Patient Safety** – safer, cleaner instruments.
- **Regulatory Compliance** – meet updated standards.
- **Operational Efficiency** – fewer re-cleans, less downtime.
- **Cost Savings** – protect instruments, extend equipment life.
- The project ensures **SPD water quality meets AAMI standards**, strengthening **patient safety, compliance**, and **operational reliability.**

Perinatal
Quality Improvement Reports
Women and Children's Services

Report to QEPC

Salinas Valley HEALTH

Julie Vasher DNP, RNC-OB, CNS, NE-BC
Director

Date: November 2025

Labor & Delivery QAPI 2025

Salinas Valley HEALTH

QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT PLAN – 2025
Labor and Delivery

MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA COLLECTION METHOD	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
UNC (Unexpected NB Comp)	Outcome	non defined	Effective	Single case review	100%	Concurrent chart review			
Timely Treatment of Severe HTN	Process	100%	Timely	Single case review	100%	Retro chart review	Monthly		Monthly
Magnet Metrics									
Performance Improvement									
NTSV	Outcome	<23.6%	Effective	Single case review	100%	Retro chart review	Monthly		Monthly

L & D Nurse Sensitive Indicators

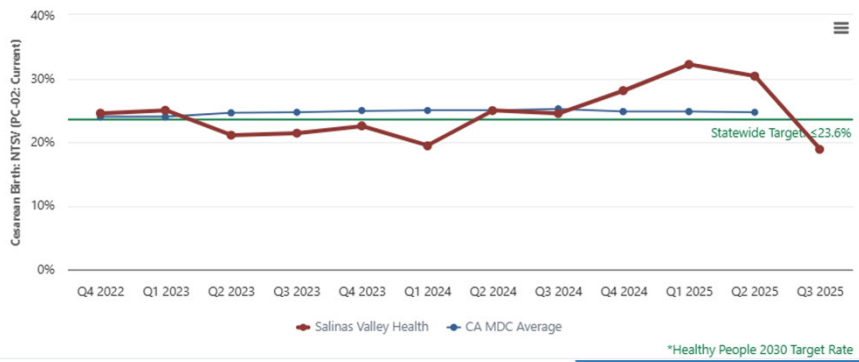
Fall Rates

Falls Data		Q1 2023			Q2 2023			Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Magnet Score *
		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
Total Patient Falls per 1000 Patient Days	Quarterly Fall Rate		0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00		8 /8
	Benchmark		n/a			n/a			n/a			n/a			n/a			n/a			n/a			n/a		
	Monthly Fall Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	L&D Patient Days	83	101	123	112	112	126	112	120	102	98	143	94	106	94	101	75	87	101	114	166	155	113	120	0	
Injury Falls per 1000 Patient Days	Quarterly Fall w/ Injury Rate		0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00		8 /8
	Benchmark		n/a			n/a			n/a			n/a			n/a			n/a			n/a			n/a		
	Monthly Fall w/ Injury Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls w/ Injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Baby Drops per 1000 Newborn Days	Quarterly Baby Drop Rate		0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00		8 /8
	Benchmark		n/a			n/a			n/a			n/a			n/a			n/a			n/a			n/a		
	Monthly Baby Drop Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# of Baby Drops Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Data Analysis: All Nurse Sensitive quality assurance measures are meeting goals: with 0 falls and 0 baby drops during the last 2 years.

SECTION TITLE

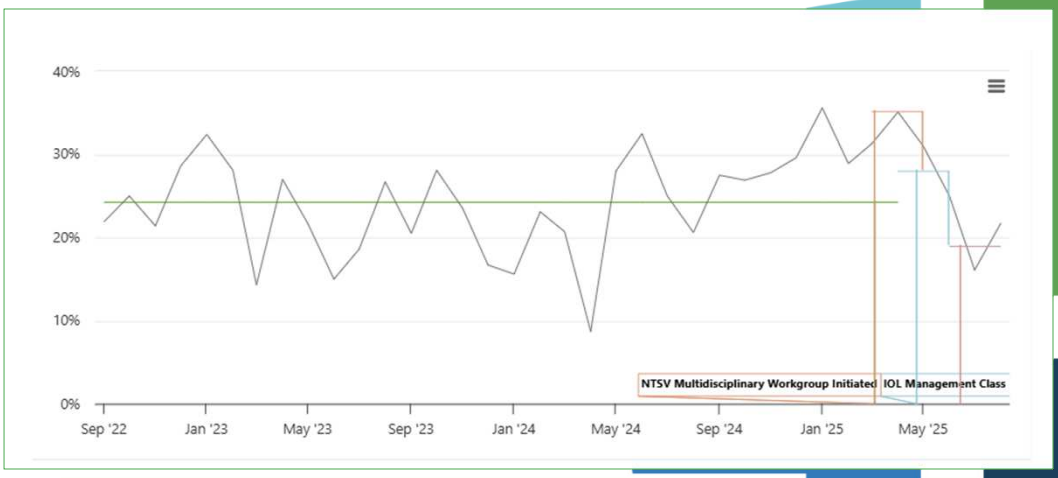
NTSV C- section rates Q4 2022- Q3 2025



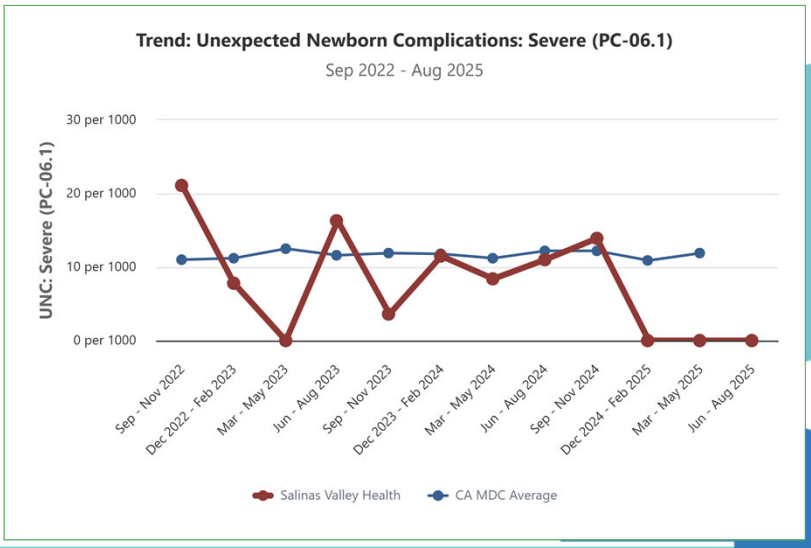
*Healthy People 2030 Target Rate

Data Analysis: Q3 outcomes are meeting targets.

NTSV CS – Intervention chart



Unexpected Newborn Complications - severe



Data Analysis: no unexpected severe newborn complications were observed this year.

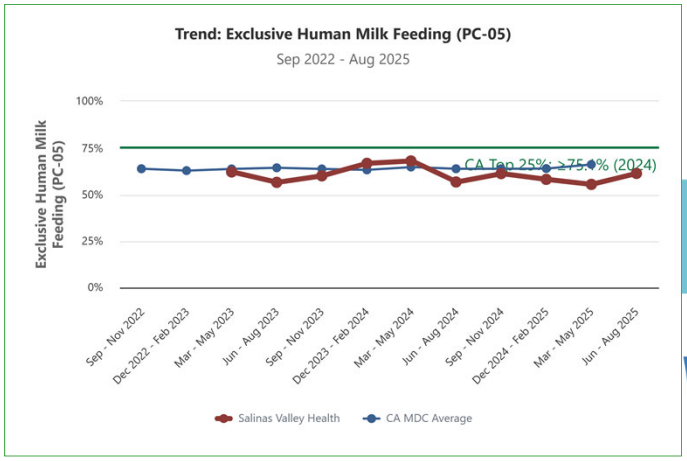
Mother Baby QAPI 2025

Salinas Valley HEALTH

QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT PLAN – 2025
Mother Baby

MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA COLLECTION METHOD	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
Bilirubin Screening	Process	100%	Effective	Single case review	30%	Retro chart review	Monthly	CDPH	Annually
Magnet Metrics									
Falls	Process	0%	Effective	Single case review	100%	Concurrent chart review	Monthly	NDNQI	Annually
Performance Improvement									
Exclusive Human Milk Feeding		75%	Effective	Single case review	30%	Retro chart review	Monthly	CMQCC	Quarterly

Exclusive Human Milk feeding



- Growing our lactation team – more IBCLCs to provide more comprehensive outpatient services
- Revamping breastfeeding prenatal education
- Lactation welcome rounds during labor admission for appropriate patients
- Lactation coverage on off hours to support during night hour meltdowns

Mother-Baby Nurse Sensitive Indicators

Fall Rates

Falls Data		Q1 2023			Q2 2023			Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Magnet Score *
		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	
Total Patient Falls per 1000 Patient Days	Quarterly Fall Rate		0.81			0.00			0.00			0.79			0.00			0.91			0.00			0.85		4 /8
	Benchmark		0.36			0.35			0.36			0.33			0.45			0.45			0.40					
	Monthly Fall Rate	0.00	2.45	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.50	0.00	0.00	0.00	0.00	2.58	0.00	0.00	0.00	0.00	0.00	0.00	2.66	
	# falls	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	0	0	1	
	Newborn Patient Days	195	193	207	206	208	234	181	202	194	200	221	195	154	163	151	148	174	201	174	198	209	163	201	157	
	Maternal Patient Days	222	215	207	207	202	240	214	216	212	216	235	205	173	177	184	156	214	210	201	233	239	206	226	219	
Injury Falls per 1000 Patient Days	Quarterly Fall w/ Injury Rate		0.00			0.00			0.00			0.00			0.00			0.91			0.00			0.00		7 /8
	Benchmark		0.05			0.07			0.04			0.06			0.07			0.07			0.08					
	Monthly Fall w/ Injury Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.58	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls w/ Injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	
Baby Drops per 1000 Newborn Days	Quarterly Baby Drop Rate		0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00		7 /8
	Benchmark		0.15			0.15			0.19			0.24			0.13			0.31			0.18					
	Monthly Baby Drop Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# of Baby Drops Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Data Analysis: Nurse sensitive quality indicators for falls with injury and baby drops are meeting benchmarks. CY 2024 there were 2 falls with 1 fall resulting in a minor injury.
Improvement Plans: continue with the targeted assessment of post delivery fall risk in moms and teaching patient not to get up without help.

NICU QAPI 2025

Salinas Valley HEALTH

QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT PLAN – 2024

NICU

MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA COLLECTION METHOD	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
Antepartum Steroid Administration	Process	90%	Effective	Rate based (N/D)	100%	Registry data	Monthly		Monthly
Antibiotic Stewardship	Outcome	<11.6%	Safe - Effective	Rate based (N/D)	100%	Concurrent chart review	Monthly		Monthly
Magnet Measures									
CLABSI	Outcome	0	Effective	Rate based (N/D)	100%	Concurrent chart review	Monthly	Multiple	Monthly
Newborn Falls	Outcome	0	Effective	Single case review	100%	Concurrent chart review	Daily	Multiple	Monthly
Performance Improvement Measures									
CCHD Screen	Process	100%	Timely	Rate based (N/D)	100%	Registry data	Monthly	CDPH	Monthly

SECTION TITLE

NICU Nurse Sensitive Indicators

Fall Rates

Falls Data		Q1 2023			Q2 2023			Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Magnet Score *
		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
Total Patient Falls per 1000 Patient Days	Quarterly Fall Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			8 /8
	Benchmark	0.00			0.02			0.04			0.01			0.00			0.01			0.00						
	Monthly Fall Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Patient Days	69	95	114	179	50	60	122	100	164	148	119	140	79	48	65	72	102	44	76	129	132	120	60	78	
Injury Falls per 1000 Patient Days	Quarterly Fall w/ Injury Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			8 /8
	Benchmark	0.00			0.00			0.00			0.00			0.00			0.00			0.00						
	Monthly Fall w/ Injury Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls w/ Injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Baby Drops per 1000 Newborn Days	Baby Drop Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			8 /8
	Benchmark	0.00			0.00			0.01			0.01			0.00			0.00			0.00						
	# of Baby Drops	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Hospital Acquired Infection Rates

HAI Data		Q1 2023			Q2 2023			Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Magnet Score *
		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
Central Line Associated Blood Stream Infection per 1000 Central Line Days	Quarterly CLABSI Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			8 /8
	Benchmark	0.56			0.30			0.76			0.41			0.27			1.67			0.00						
	CLABSI Monthly Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# of CLABSI for unit	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Total Central Line Days	20	9	19	18	12	12	15	22	8	13	19	2	4	1	3	1	0	0	41	12	19	0	11	14	

Pressure Injury & Restraint Use Rates

HAPI and Resraints Data		Q1 2023			Q2 2023			Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Magnet Score *
		Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
Hospital Acquired Pressure Injury Stage 2 and above	% of HAPI Prevalence	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			8 /8
	Benchmark HAPI 2+	0.00			0.03			0.00			0.31			0.44			0.00			0.02						
	# pts with Stage 2+ HAPI on Prevalence day (not mucosal)		0			0			0			0			0			0			0			0		
	# of Patients Surveyed		1			0			3			3			3			2			5			1		
	# of pts with of mucosal PI		0			0			0			0			0			0			0			0		
Hospital Acquired Pressure Injury- Device Related	% of patients HAPI Device Related	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			8 /8
	Benchmark	0.00			0.13			0.10			0.13			0.34			0.00			0.06						
	# of pts w/ Device HAPI		0			0			0			0			0			0			0			0		
	# of Patients Surveyed		1			0			3			3			3			2			5			1		

SECTION TITLE

Data Analysis: All Nurse Sensitive Indicators are meeting benchmarks with 0 harm.

Perinatal Unit Practice Council

- Improved communication during handover from LD to MB
- Mother Baby Discharge Process
- NICU SCENTS program


Barriers/Challenges & Next Steps
Reaching out to Perioperative UPC to collaborate on project below
Working to disseminate feedback to providers regarding NTSV CS
Coming up –
Exclusive human milk feeding scores – new innovations with new team
OPS communication with MB – GYN patients

SVH: Age-Friendly Health System

Comprehensive Improvement Program
with EPIC EHR Integration

SVH Age-Friendly Task Force

Salinas Valley HEALTH

The Why?

The John A. Hartford Foundation and the **Institute for Healthcare Improvement (IHI),** in partnership with the **American Hospital Association (AHA)** and the **Catholic Health Association of the United States (CHA)**, set a bold vision to build a social movement so that **all care with older adults is age-friendly care.** This means all older adults receive care that:

- ❑ Follows an essential set of **evidence-based practices in a framework known as the 4M**
- ❑ **Cause no harm**
- ❑ **Aligns with What Matters to the older adult** and their **family** caregivers

Shifts from: "What is the Matter?" to "What **Matters** to **You**?"

For example:

"What **are your hopes** for your visit today (or hospitalization)?"

"What **concerns** you most when you think about your health right now?"

"What **outcome** do you most want?

Vs. What is your goal for the visit?

SECTION TITLE

IHI: The 4Ms Framework

What Matters: Align care with older adult's preferences and goals

Medication: Avoid high-risk medications

Mentation: Prevent, identify, and manage delirium

Mobility: Ensure safe movement to maintain function

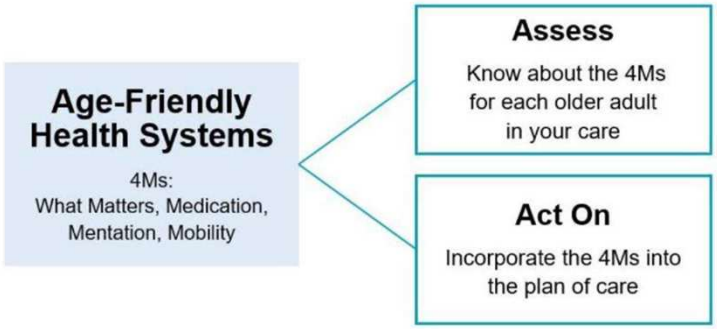
TABLE 1 4Ms Framework of an Age-Friendly Health System

4Ms	Focus
What Matters	Advance care planning Goal-concordant care
Medication	Underprescribing Deprescribing High-risk medications
Mentation	Dementia Depression Delirium Posttraumatic stress disorder Substance use
Mobility	Safe mobility Falls risk reduction Maximizing function

Abbreviation: 4Ms, what matters, medication, mentation, mobility.

What does the Age-Friendly Designation mean?

Developed by IHI to recognize Hospitals and ambulatory settings that comply with a set of best Practices.



SECTION TITLE

Age Friendly Designation from IHI- not mandated by CMS

Recommended steps

1. **Understand your current state.**
   - Know the older adults in your health system.
   - Know the 4Ms in your system.
   - Select a care setting
   - Set up a team.
2. **Describe care consistent with the 4Ms.**
   - Set an aim.
3. **Design or adapt your workflow.**
4. **Provide Care.**
5. **Study your performance.**
6. **Improve and sustain care.**

Application Completed in 2 stages:

1. Self assessment & basic structural data collection and analysis (geriatric population)- COMPLETED

2. Data collection post implementation Of the 4 M's process measures for 3 months. Submission to IHI. –IN PROGRESS

CMS Age Friendly Structural Measure

- Assesses hospital commitment to improving care for patients ≥65…in the hospital, OR, & ED
- A pay for reporting program - no outcome measures currently exist
- Provide hospitals flexibility - without being overly prescriptive

CMS Age Friendly Structural Measure

Five attestation domains

Table IX.C.1

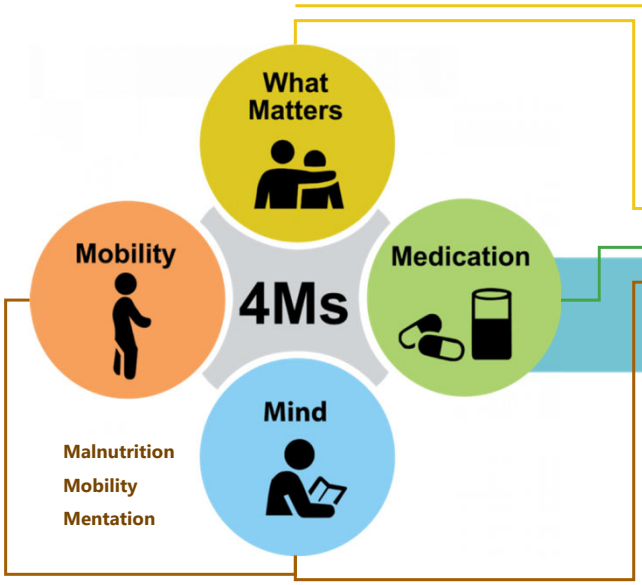
Domain 1: Eliciting Patient Healthcare Goals This domain focuses on obtaining patient's health related goals and treatment preferences which will inform shared decision making and goal concordant care.	**(A)** Established protocols are in place to ensure patient goals related to healthcare (health goals, treatment goals, living wills, identification of healthcare proxies, advance care planning) are obtained/reviewed and documented in the medical record. These goals are updated before major procedures and upon significant changes in clinical status.
Domain 2: Responsible Medication Management This domain aims to optimize medication management through monitoring of the pharmacological record for drugs that may be considered inappropriate in older adults due to increased risk of harm.	**(A)** Medications are reviewed for the purpose of identifying potentially inappropriate medications (PIMs) for older adults as defined by standard evidence-based guidelines, criteria, or protocols. Review should be undertaken upon admission, before major procedures, and/or upon significant changes in clinical status. Once identified, PIMS should be considered for discontinuation, and/or dose adjustment as indicated.
Domain 3: Frailty Screening and Intervention This domain aims to screen patients for geriatric issues related to frailty including cognitive impairment/delirium, physical function/mobility, and malnutrition for the purpose of early detection and intervention where appropriate.	**(A)** Patients are screened for risks regarding mentation, mobility, and malnutrition using validated instruments ideally upon admission, before major procedures, and/or upon significant changes in clinical status. **(B)** Positive screens result in management plans including but not limited to minimizing delirium risks, encouraging early mobility, and implementing nutrition plans where appropriate. These plans should be included in discharge instructions and communicated to post-discharge facilities. **(C)** Data are collected on the rate of falls, decubitus ulcers, and 30-day readmission for patients >65. These data are stratified by demographic and/or social factors. **(D)** Protocols exist to reduce the risk of emergency department delirium by reducing length of emergency department stay with a goal of transferring a targeted percentage of older patients out of the emergency department within 8 hours of arrival and/or within 3 hours of the decision to admit.
Domain 4: Social Vulnerability This domain seeks to ensure that hospitals recognize the importance of social vulnerability screening of older adults and have systems in place to ensure that social issues are identified and addressed as part of the care plan.	**(A)** Older adults are screened for geriatric-specific social vulnerability including social isolation, economic insecurity, limited access to healthcare, caregiver stress, and elder abuse to identify those who may benefit from care plan modification. The assessments are performed on admission and again prior to discharge. **(B)** Positive screens for social vulnerability (including those that identify patients at risk of mistreatment) are addressed through intervention strategies. These strategies should include appropriate referrals and resources for patients upon discharge.
Domain 5: Age-Friendly Care Leadership This domain seeks to ensure consistent quality of care for older adults through the identification of an age friendly champion and/or interprofessional committee tasked with ensuring compliance with all components of this measure.	**(A)** Our hospital designates a point person and/or interprofessional committee to specifically ensure age friendly care issues are prioritized, including those within this measure. This individual or committee oversees such things as quality related to older patients, identifies opportunities to provide education to staff, and updates hospital leadership on needs related to providing age friendly care. **(B)** Our hospital compiles quality data related to the Age Friendly Hospital measure. These data are stratified by demographic and/or social factors and should be used to drive improvement cycles.

Ten attestation statements

SECTION TITLE

Medicare Hospital Inpatient Quality Reporting (IQR) Program
Published: Federal Register 08/28/2024 https://federalregister.gov/d/2024-17021

CMS Age Friendly Measure Attestation due May, 2026 for work completed by the end of 2025



CMS Measure Domains

- Domain 1. Eliciting Patient Healthcare Goals.
- Domain 2: Responsable Médication Management
- Domain 3: Frailty Screening & Intervention
- Domain 4: Social Vulnerability
- Domain 5: Age-Friendly Care Leadership

SVH Implementation Phase

Phase 1: Building the System
Phase 2: Staff Awareness & Engagement
Phase 3: Data Collection & Submission

Phase 1. Building the System

4Ms System building Q4 2023 - Nov 2025

Project Kickoff and Team Setup:

Falls committee rebranded as ***Mobility*** *Committee* and BMAT as a mobility tool implemented 2024-2025

Implementation of **Meds that ring the Bell** (BEERS criteria) to address the **Medication part of the model**

Mentation (Delirium Task Force): implemented Delirium screening, order sets, and interventions completed in2024

Age Friendly Task Force created – Q3 2025

1. Patient Engagement Tools Integration- white board- COMPLETED
2. Integration of Screening Tools In Meditech and Epic (Cognitive, Mobility, Medication) - COMPLETED
3. Epic EHR Customization for 4Ms – FIELDS ARE BUILT, DATA CAPTURE IS IN PROGRESS
4. **CMS requirement:** Social vulnerability screening – added to Meditech and is part of Epic- COMPLETED

Phase 2. Staff Awareness & Engagement

1. The program will commence on December 1-30, 2025, to give way to EPIC Go Live
    1. **Staff Training on Age-Friendly Care Protocols**
    2. **Map out Age Friendly Documentation data** elements for a dashboard- IN PROGRESS
        - **Care Plans Documentations**
        - **Medication Review**
        - **Frailty Screening and Interventions**
        - **Mobility Documentation**
        - **Mentation Documentation**
        - **Social Vulnerability Screen**
    3. **Continue Implementation of What Matters to you 4th M**

Phase 3: Data Collection & Submission

1. Collection and submission start in January to May 2026
    1. Launch of Age-Friendly Care Leadership Dashboard
    2. Testing and Data Monitoring (Epic Reports)
    3. Full Program Rollout across All Units
    4. Continuous Feedback Loop and Patient-Centered Care Refinement

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT