February 5, 2026

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, FEBRUARY 9, 2026, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, 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, FEBRUARY 9, 2026, 8:30 A.M.
DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117

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 January 12, 2026. (CARSON)

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

4. Patient Care Services Update (SPENCER)
   - Oncology Unit Practice Council Report

5. Report on Quality and Safety (INMAN)
   - CMS Quality Incentive Programs (SYED)
   - Infection Prevention Updates (DEEN)
   - Age-Friendly Updates (GROOTERS)

6. Closed Session

7. Reconvene Open Session/Report on Closed Session

8. Adjournment

   The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, March 16, 2026 at 8:30 a.m.**

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

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/2026/, 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 831-759-3208 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. Quality and Safety Board Dashboard Review (INMAN)

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 JANUARY 12, 2026

Committee Member Attendance:

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

Voting Members Absent: **Rolando Cabrera, M.D.**, Vice Chair

Advisory Non-Voting Members Present:
In Person: Alysha Hyland, CAO, Clement Miller, COO, and Cheryl Pirozzoli, Family/Patient Council Advisor;
Via teleconference: Michelle Childs, CHRO

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

1. CALL TO ORDER/ROLL CALL
A quorum was present and Chair Carson called the meeting to order at 8:32 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 DECEMEBR 15, 2025.

Approve the minutes of the December 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 Miller, second by Committee Member Spencer, the minutes of the December 15, 2025 Quality and Efficient Practices Committee Meeting are approved as presented.

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

Motion Carried

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

4. PATIENT CARE SERVICES UPDATE: QUALITY COUNCIL

Carla Spencer, CNO, introduced Laurie Freed, BSN, RN, CCRN-CSC, Staff Nurse, who reported on the Quality Council's purpose, 2026 goals, initiatives and data. Initiatives in progress include Improving HAPI rates, Improving Patient Experience and Recuding Falls with Injury. A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: Chair Carson asked what the group is doing to prepare for the upcoming MAGNET visit. Ms. Freed explained they're encouraging team members to speak up and keep communication clear.

5. QUALITY AND SAFETY OVERVIEW

Brenda Inman, MSN, VP of Quality and Risk Management, reported on the Quality and Safety Committee. Ms. Inman gave an overview of the Quality and Safety Committee, it's purpose, Regulatory and Accrediting Bodies and various programs. Additionally, the Restructuring of the Quality Department was reviewed, including restructured meetings, improved data analytics and a relaunch of We Care System. A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: None.

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 9:00am.

7. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:07 a.m. Chair Carson reported that in Closed Session, the *Hearings/Reports* were accepted as follows:

1. Report of the Medical Staff Quality and Safety Committee
    - Accreditation and Regulatory Report (INMAN)
2. Quality and Safety Board Dashboard Review (INMAN)
3. Consent Agenda:
    - Quality Incentive Program

8. ADJOURNMENT

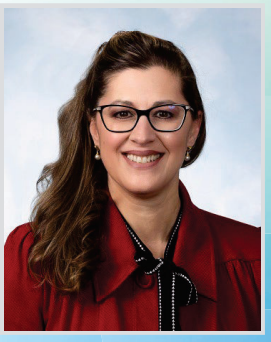
There being no other business, the meeting adjourned at 9:08 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, February 9, 2026** at 8:30 a.m.

_____

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: Oncology Unit Practice Council

February 9, 2026

ONCOLOGY UNIT PRACTICE COUNCIL

MEMBERS:

- Maritess Condalor, *BSN, RN [Chair]*
- Nelly Hillen, *BSN, SNIII, OCN, [Co-chair]*
- Chantary Pich, *BSN, RN, MSRN [Associate Co-Chair]*
- Glaiza Farnal, *BSN, RN [Advisor]*
- Meghan Ackerman, *BSN, SNIII, OCN [Quality Representative]*
- Ashley Folck, *BSN, SNIII, OCN [Member]*
- Mary Ann Artuz, *BSN, RN, OCN [Oncology Informatics]*
- Daisy Carrillo, *BSN, RN [Oncology Nurse Navigator]*
- Thelma Baker, *MSN, RN, OCN, NEA-BC [Outpatient Infusion Director]*
- Jessica Valero, *BSN, RN, OCN [Cancer Resource Center Manager]*
- Anthony Duenas, *MS [Outpatient Infusion & Wound Care Manager]*
- Matthew Valdez *BSN,RN [Clinical Outpatient Infusion Manager]*

*"The **PURPOSE** of the unit practice council [UPC] is to identify and implement standards of care and evidence-based practice specific to clinical area, and identify and resolve clinical and systems issues impacting or affecting care coordination, a healthy work environment, the delivery of patient-family centered care, patient safety and clinical outcomes."*

Topics:

- Standardized Taxane Titration Rates
- Creation of Chemo Precautions Cheat Sheet

Standardized Taxane Titration

BACKGROUND:
Taxane drugs have a high risk of infusion reactions during the first two doses. The lack of a standardized titration protocol led to inconsistent nursing practices, creating potential safety risks for patients and staff

INTERVENTION:
Members researched and read different Evidence-Based Practice [EBP] articles for safe administration and titration for taxane. The UPC created a standard titration rates for taxane drugs and educated every nurses in outpatient infusion

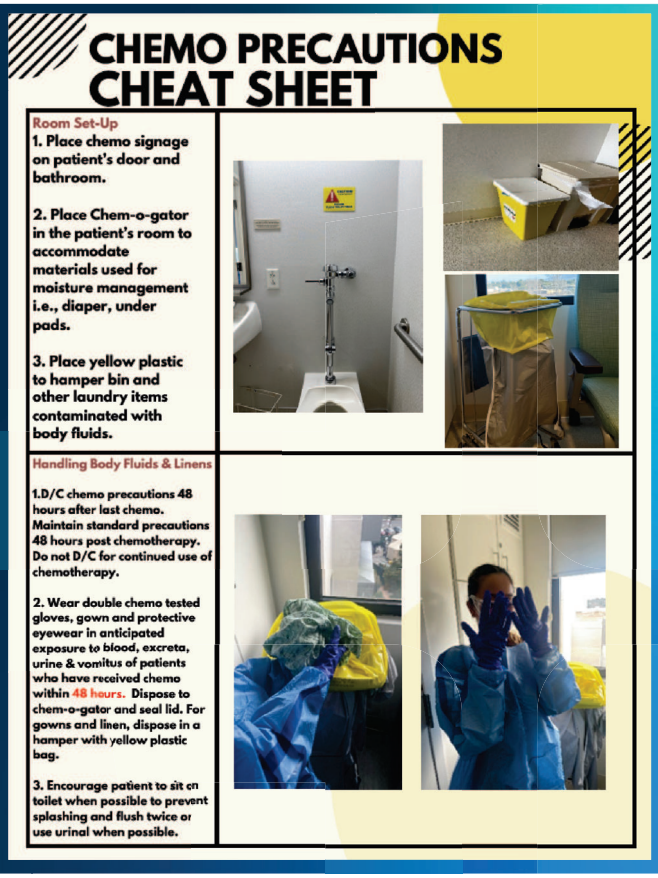
OUTCOME/DATA:
Pre and post-surveys were conducted among nurses. Nurses reported increased comfort administering taxane drugs using standardized titration rates. Patients tolerated the treatment better and were able to continue treatment

Creation of Chemo Precautions Cheat Sheet

BACKGROUND:
Oncology patients may be located throughout the hospital after chemotherapy or while receiving oral chemotherapy. Other units were not consistently aware of the chemotherapy precautions required to protect patients and staff

INTERVENTION:
The UPC developed a chemotherapy precautions cheat sheet for all units

OUTCOME/DATA:
Other units are now familiar with and aware of the precautions required when caring for patients after chemotherapy or during treatment (See attached chemotherapy precautions cheat sheet.)



What's Ahead:

- **OCN Certification:** *Increase certification rate by 1% for both inpatient and outpatient areas*
  - *Inpatient Baseline: 32%*
  - *Outpatient Baseline: 44.44%*
  - *Cancer Resource Center: 60%*
- **Moment of Silence:** *Initiate to honor patients who have passed away in the hospital*
- **Monthly Journal Club:** *Continue to review evidence-based practices*

Thank You For
Your Time Today

ANY QUESTIONS?

Quality Data Reporting to CMS?

By
Athar Syed MBBS, MSHS
February 05, 2026

Today's Agenda

- Discuss 3 Pay-For-Reporting Programs

1. Hospital Inpatient Quality Reporting Program (IQR)
2. Hospital Outpatient Quality Reporting Program (OQR)
3. Medicare Promoting Interoperability Program (PIP)

Reimbursement Model: Pay for Reporting
Risk: Hospital Revenue Loss / Reputation

Hospital **Inpatient** Quality Reporting Program (IQR)

Inpatient Quality Reporting Program

Calendar Years & Fiscal Years

Centers for Medicare and Medicaid Services (CMS) uses quality data reported by hospitals from a previous calendar year to make payment decisions for a future year.

Calendar Year (CY) = Past Year
(Sometimes called a reporting year)

Fiscal Year (FY) = Future Year
(Sometimes called a payment year)

Every **Calendar Year** is permanently connected to a specific **Fiscal Year** (e.g. CY 2026 reporting is permanently connected to FY 2028 payment).

Reporting Year
Measurement Period
(Performance Year)
Calendar Year 2026
(Jan 01, 2026 - Dec 31, 2026)

Quarterly/Annually Data Reporting

Jan 01, 2026 – May 15, 2027

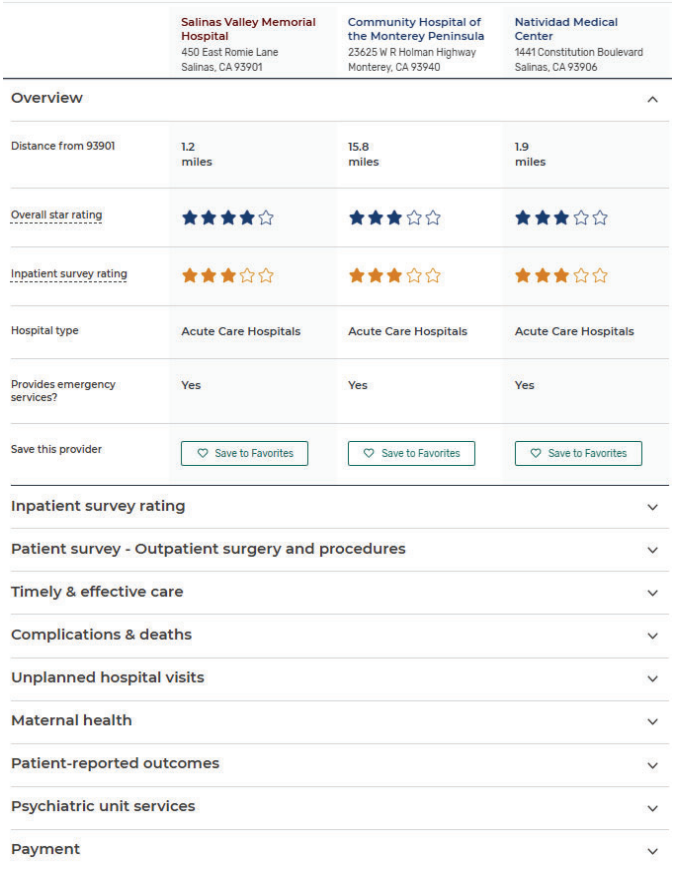
Payment Year
(Claims Payment)

Fiscal Year 2028
(Oct 01, 2027 - Sept 30, 2028)

Reimbursement Model: Pay for Reporting

Risk: Hospital Revenue Loss / Hospital Reputation

- This program was established in 2003.
- Under the inpatient prospective payment system (IPPS);
  1. CMS provides a financial incentive to hospitals who **Report data** on the quality of their services they provide to public.
  2. CMS **Publicly displays** that data to consumers to help them make informed healthcare decisions.
- Hospitals in the Hospital IQR Program must meet quarterly and annual quality measures submission deadlines and other requirements.
- Hospitals that do not participate, or that participate but do not comply with program requirements, receive a 25% reduction of the applicable percentage increase in their annual Market Basket update for the applicable fiscal year



	Salinas Valley Memorial Hospital 450 East Romie Lane Salinas, CA 93901	Community Hospital of the Monterey Peninsula 23625 W R Holman Highway Monterey, CA 93940	Natividad Medical Center 1441 Constitution Boulevard Salinas, CA 93906
Overview			
Distance from 93901	1.2 miles	15.8 miles	1.9 miles
Overall star rating	★★★★☆	★★★☆☆	★★★☆☆
Inpatient survey rating	★★★☆☆	★★★☆☆	★★★☆☆
Hospital type	Acute Care Hospitals	Acute Care Hospitals	Acute Care Hospitals
Provides emergency services?	Yes	Yes	Yes
Save this provider	♡ Save to Favorites	♡ Save to Favorites	♡ Save to Favorites

Inpatient survey rating

Patient survey - Outpatient surgery and procedures

Timely & effective care

Complications & deaths

Unplanned hospital visits

Maternal health

Patient-reported outcomes

Psychiatric unit services

Payment

CY 2026 Hospital IQR Program Requirements	
Chart-Abstracted Measures	▪ Severe Sepsis and Septic Shock Management Bundle (Composite Measure) ▪ Influenza Vaccination Coverage among HCP
Claims-Based Measures	▪ MORT-30-STK ▪ COMP-HIP-KNEE ▪ ISCMR- Thirty-day Risk-Standardized Inpatient Surgical Complications Mortality Rate ▪ AMI Excess Days ▪ HF Excess Days ▪ PN Excess Days ▪ MSPB (Medicare Spending Per Beneficiary)
Hybrid Measures	▪ HWR-Hybrid Hospital Wide Readmission ▪ HWM-Hybrid Hospital Wide Mortality

CY 2026 Hospital IQR Program Requirements	
Web-based Structural Measures	• Maternal Morbidity • Patient Safety • Age Friendly Hospital
Patient Reported Outcome Performance Measures (PRO-PM)	• THA/TKA Patient-reported Outcome-based Performance
Healthcare-Associated Infections (HAIs)	• Influenza Vaccination • CLABSI • CAUTI • SSI • MRSA • C-Diff
Hospital Experience Survey	Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)

	Electronic Clinical Quality Measures (eCQMs)	2025	2026	2027	2028
PC-02	Cesarean Birth	Mandatory	Mandatory	Mandatory	Mandatory
PC-07	Severe Obstetric Complications	Mandatory	Mandatory	Mandatory	Mandatory
CMS506	Safe Use of Opioids – Concurrent Prescribing	Mandatory	Mandatory	Mandatory	Mandatory
HH-Hypo	Hospital Harm—Severe Hypoglycemia Measure	Available	Mandatory	Mandatory	Mandatory
HH-Hyper	Hospital Harm—Severe Hyperglycemia Measure	Available	Mandatory	Mandatory	Mandatory
HH-ORAE	Hospital Harm—Opioid Related Adverse Events	Available	Available	Mandatory	Mandatory
HH-PI	Hospital Harm—Pressure Injury	Available	Available	Available	Mandatory
HH-AKI	Hospital Harm—Acute Kidney Injury	Available	Available	Available	Mandatory
HH-RF	Hospital Harm—Postoperative Respiratory Failure	Available	Available	Available	Available
HH-FI	Hospital Harm—Falls with Injury	Available	Available	Available	Available
STK-02	Discharged on Antithrombotic Therapy	Available	Available	Available	Available
STK-03	Anticoagulation Therapy for Atrial Fibrillation/Flutter	Available	Available	Available	Available
STH-05	Antithrombotic Therapy by the End of Hospital Day Two	Available	Available	Available	Available
VTE-1	Venous Thromboembolism Prophylaxis	Available	Available	Available	Available
VTE-2	Intensive Care Unit Venous Thromboembolism Prophylaxis	Available	Available	Available	Available
MCS	Malnutrition Care Score	Available	Available	Available	Available
IP-ExRad	Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults	Available	Available	Available	Available

Financial Impact of CY 2025 (FY 2027 IQR Program)

- **If hospital fails to complete any quarterly or annual requirements, it faces the penalty of 25% of annual Market Basket Update.**

- **Estimated IPPS Payments = $81,183,500**
- **Market Basket Update ⇧ 3.4% Increase = $2,741,500**
- **If requirements not met ⇩ 25% reduction = -$693,000**

Reimbursement Model: Pay for Reporting
Risk: Hospital Revenue Loss / Reputation

Hospital **Outpatient** Quality Reporting Program (OQR)

Hospital Outpatient Quality Reporting Program (OQR)

- ❑ Modeled after the Hospital Inpatient Quality Reporting Program, the Hospital OQR Program became effective for payments beginning in calendar year 2009
- ❑ Under this program, hospitals report data using standardized measures of care to receive the full update to their OPPS payment rate.
- ❑ Participating hospitals agree that they will allow CMS to **publicly report** data for the quality measures
- ❑ Hospitals that meet data reporting requirements during a given calendar year (CY) receive their full OPPS payment update for the upcoming calendar year.
- ❑ Those hospitals that do not participate or fail to meet these requirements receive a 2% reduction of their annual payment update.
- ❑ Program uses those measures that assess processes of care, imaging efficiency patterns, care transitions, ED throughput efficiency, the use of health information technology, care coordination, patient safety, and volume.

CY 2026 Hospital OQR Program Requirements	
Chart-Abstracted Web-based Measures	**OP-18:** Median Time from ED Arrival to ED Departure for Discharged ED Patients **OP-22:** Left Without Being Seen **OP-23:** Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients Who Received Head CT for MRI Scan Interpretation Within 45 Minutes of Arrival **OP-29:** Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients
Electronic Measures (eCQMs)	**OP-40:** ST Elevation Myocardial Infarction **OP:** Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults
Claims-Based Measures	**OP-10:** Abdomen CT—Use of Contrast Material **OP-39:** Breast Cancer Screening Recall Rate **OP-32:** Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy **OP-35:** Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy **OP-36:** Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery
Patient-Reported Outcome-based Performance Measures (PRO-PM)	**OP-42:** Hospital-level Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA PRO-PM) **OP-46:** Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery (Information Transfer PRO-PM)
Patient Survey	**OP-37 a-e:** Outpatient and Ambulatory Surgery Consumer Assessment of Healthcare Providers and Systems (OAS CAHPS)

Financial Impact of CY 2025 OQR Program

- **If hospital fails to complete any quarterly or annual requirements, it faces the penalty of 2% of annual Market Basket Update.**

- **Estimated OPPS Payments: $55,232,200**
- **Market Basket Update: ⇧ 2% addition = $862,900**
- **If requirements not met = ⇩ 2% reduction of MBU: $862,900**

Reimbursement Model: Pay for Reporting

Risk: Hospital Revenue Loss / Reputation

Medicare Promoting Interoperability Program

(Meaningful Use Initiative/EHR Incentive Program)

Medicare Promoting Interoperability Program

- The Medicare and Medicaid EHR Incentive Programs were followed by establishment of Medicare Promoting Interoperability Program (PIP) for eligible hospitals and the Merit-based Incentive Payment System (MIPS) for eligible Clinicians in 2011, with the goal of incentivizing eligible hospitals, and MIPS eligible clinicians who adopt and meaningfully use Certified electronic health record technology (CEHRT).

- This quality program drives quality improvement, safety, and efficiency of healthcare by promoting and prioritizing interoperability and the exchange of health care data through the use of CEHRT.

- Eligible hospitals are required to submit measure data focused on the objectives of electronic prescribing, health information exchange, provider to patient exchange, public health and clinical data exchange, and protecting patient health information, as well as electronic clinical quality measure (eCQM) data; answer attestations; and earn a minimum total score of 70 out of 100, based on CMS' data collection and submission timelines for the current reporting period.

Promoting Interoperability Program

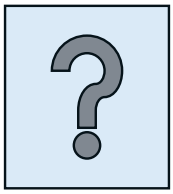
OBJECTIVES	MEASURES			POSSIBLE POINTS
Electronic Prescribing	e-Prescribing [10 points]	Query of PDMP [10 points]		20
Health Information Exchanges	**OPTION 1** *(Report on Both)*: Support Electronic Referral Loops by Sending Health Information [15 points] + Support Electronic Referral Loops and Reconciling Health Information [15 points]	**OPTION 2**: Health Information Exchange Bi-Directional Exchange [30 points]	**OPTION 3**: Enabling Exchange under TEFCA [30 points]	30
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information [25 points]			25
Public Health and Clinical Data Exchange	**Report on the following** [25 points]: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Electronic Laboratory Reporting • Antimicrobial Use Surveillance Reporting • Antimicrobial Resistance Surveillance Reporting	**BONUS** **Report only one** [5 bonus points]: 1. Public Health Registry Reporting 2. Clinical Data Registry Reporting		25 [+5 bonus points]
			TOTAL POSSIBLE POINTS	105

Reminder: *When calculating the performance rates and measure and objective scores, scores will be rounded to the nearest whole number. A score of 0 in the numerator or an objective will result in a program failure.*

Financial Impact of CY 2025 PI Program

- **If hospital fails to complete any quarterly or annual requirements, it faces the penalty of 75% of annual Market Basket Update.**

- **Estimated IPPS Payments: $81,183,500**
- **Market Basket Update: ↑ 3.4% addition = $2,741,500**
- **If requirements not met = ↓ 75% reduction of MBU: -$1,947,900**



Questions/Comments

Infection Prevention

February 05, 2026

Melissa Deen, MPH, BSN, RN
Manager of Infection Prevention

Salinas Valley HEALTH

Infection Prevention (IP)

CURRENT STATE:

- Achieved a 50% reduction in hospital-acquired infection costs since 2019 through targeted surveillance, evidence-based protocols, and continuous staff education.
- Infection rates for CLABSI, CAUTI, SSI, and CDI remain below national benchmarks, and compliance with federal and state reporting requirements remains ongoing.
  - Feedback with clinical leaders, Magnet Quality Committee and Unit UPCs when events occur
- Robust partnerships with public health agencies and continuous surveillance ensure rapid response to emerging threats.
- Sustained hand hygiene compliance above 80% and active integration of infection prevention across all departments.

IP Data Reporting Structure for Hospital-Acquired Infections(HAI)

CMS HAI Core Measures

NHSN HAI Measures:

CAUTI (Catheter-Associated Urinary Tract Infections)

- CLABSI (Central Line-Associated Bloodstream Infections)
- SSI (Surgical Site Infections) COLO/HYST
- LAB ID:
  - MRSA/VRE Bacteremia
  - CDI (Clostridioides difficile Infection)
- AUR (Antimicrobial Use and Resistance)
- COVID-19 HCW vaccination
- HRD (Hospital Respiratory Data)

CMS Reporting (via NHSN/CDC):

- Quarter 1 (January – March): August 15th
- Quarter 2 (April – June): November 15th
- Quarter 3 (July – September): February 15th
- Quarter 4 (October – December): May 15th
- Quarter 4 & Quarter 1 (October 1 – March 31) Healthcare Personnel Influenza Vaccination Summary data: May 15th

Leap Frog

- Hand Hygiene Practices (previous year and stays for 1 year)
  - *The Leap Frog metric is based on a facility survey completed annually*
- Outcome Measures (NHSN CMS reports):
  - CAUTI
  - CLABSI
  - SSI Colon
  - MRSA Bacteremia
  - CDI

NHSN Data download:

January 31, 2026: HAI reporting period 01/2025 to 12/2025

October 31, 2026: 07/2025 to 06/2026

CDPH

NHSN HAI Measures:

CAUTI (Catheter-Associated Urinary Tract Infections)

CLABSI (Central Line-Associated Bloodstream Infections)

SSI (Surgical Site Infections) ALL Procedures

LAB ID:

MRSA/VRE Bacteremia

CDI (Clostridioides difficile Infection)

AUR (Antimicrobial Use and Resistance)

COVID-19 HCW vaccination

HRD (Hospital Respiratory Data)

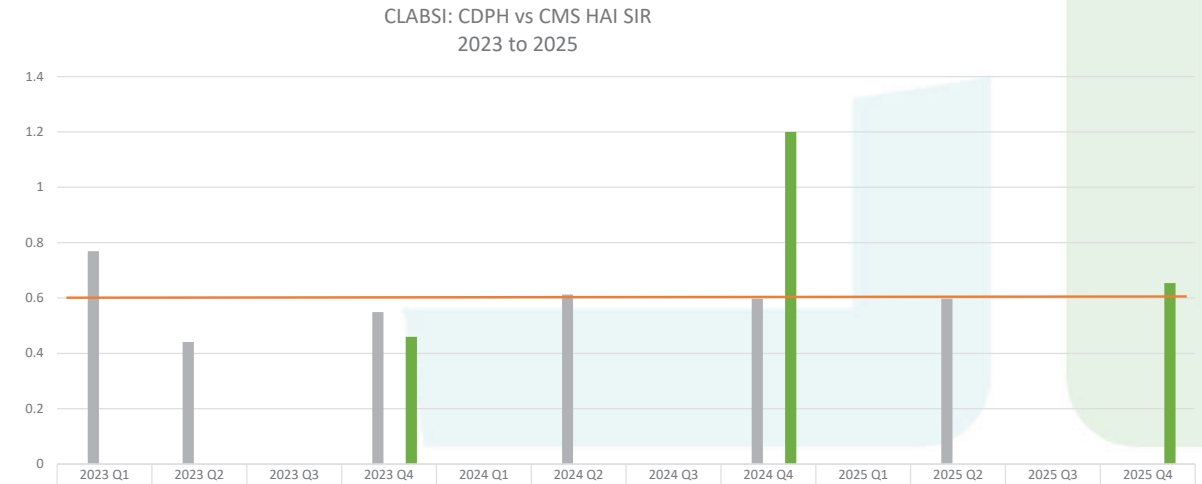
California State Reporting via NHSN:

- All data must be completed by 30 days from the previous month.
- Example January, completed by Feb 28th
- Calendar year closes, Jan 30th, SSI closes March 30th

NDNQI/Magnet Data pulled from NHSN Data

SIR data converted to Rates

Infection Prevention – HAI Data example



	2023 Q1	2023 Q2	2023 Q3	2023 Q4	2024 Q1	2024 Q2	2024 Q3	2024 Q4	2025 Q1	2025 Q2	2025 Q3	2025 Q4
CDPH (ALL) HAI's	1	0	1	0	1	0	0	1	1	0	0	0
CDPH Predicted	1.3	0.968	0.892	0.93	0.836	0.796	0.855	0.82	0.84	0.834	0.729	0.864
CDPH SIR	0.77	0.44	0.00	0.55	0.00	0.61	0.00	0.60	0.00	0.60	0.00	0.00
CMS HAI's	0	0	1	0	1	0	0	1	1	0	0	0
CMS Predicted	0.675	0.514	0.446	0.538	0.424	0.43	0.424	0.387	0.392	0.395	0.328	0.414
CMS SIR	0.00	0.00	0.00	0.46	0.00	0.00	0.00	1.20	0.00	0	0	0.654
HHS 2024-2028 SIR Benchmark	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60

Infection Prevention Structure & Reporting Overview

Infection Prevention, Next Steps

Salinas Valley Health's infection prevention program delivers comprehensive, evidence-based strategies to protect patients, staff, and the community.

- By combining rigorous protocols, interdisciplinary collaboration, ongoing education, and continuous improvement, the program achieves measurable reductions in infection risks and ensures the highest standards of healthcare safety.

NEXT STEPS:

- Enhanced surveillance and transparency of findings with SVHMC departments and leaders.
  - With real-time feedback on infection prevention best practices.
- Expand staff training and education
- Continue reducing device-associated infections and improving environmental monitoring.
- Conduct ongoing risk assessment (s) and update goals to address new and emerging threats.

Infection Prevention Committee

Infection Prevention Committee:
Structure & Reporting Overview

Committee Structure – At a Glance

- Led by Infection Prevention Medical Officer (Chair) and Infection Prevention Leadership (Co-Chair)
- Core members include Infection Prevention, Nursing, Microbiology, Pharmacy, Environmental Services, Employee Health, Nutrition Services, Facilities, IT, and Quality/Safety
- Facility-specific leaders and liaisons support tailored oversight across hospital and outpatient settings

Reporting Framework – Essentials

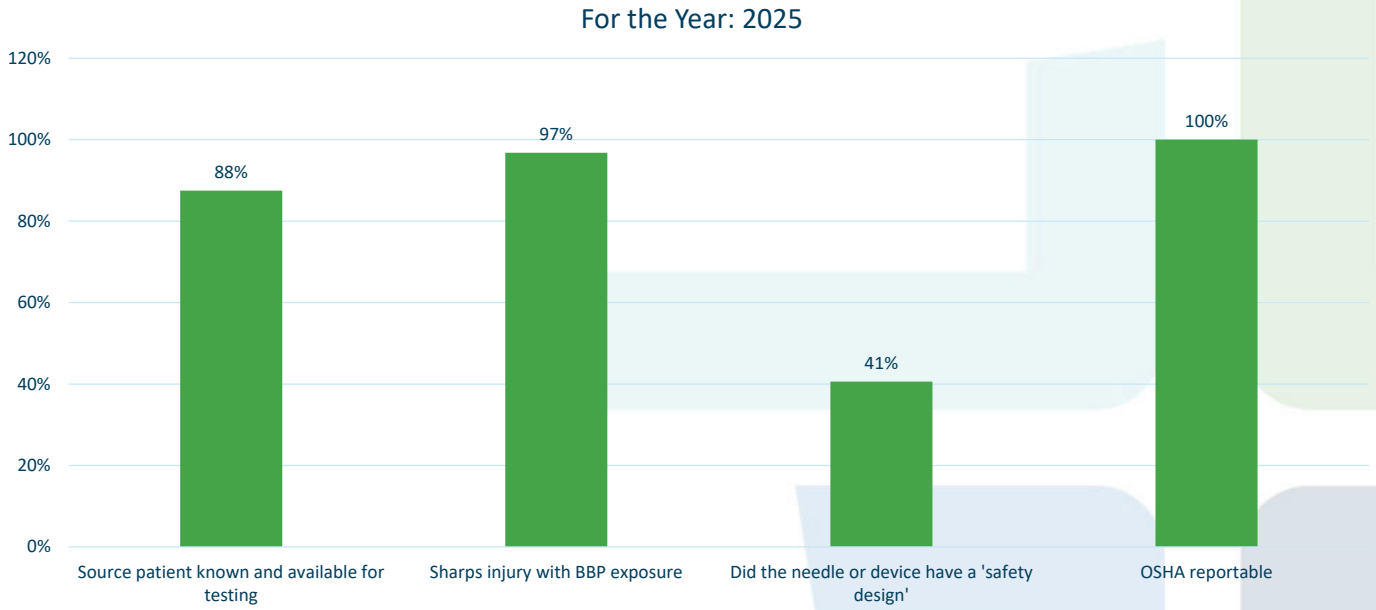
- Regular committee meetings, with additional ad-hoc sessions for urgent issues
- Annual reviews: membership, charter, risk assessments, infection control plans, and key policies
- Quarterly departmental reports: surveillance data, infection trends, compliance audits, and quality projects from all hospital units and outpatient sites
- Reports submitted internally to leadership:
  - Quality & Safety, MEC, and then the Hospital Board

Key Points

- A multidisciplinary team structure ensures comprehensive infection prevention
- Scheduled reporting supports transparency, regulatory compliance, and continuous improvement
- Ongoing communication and rapid response to incidents are central to program success

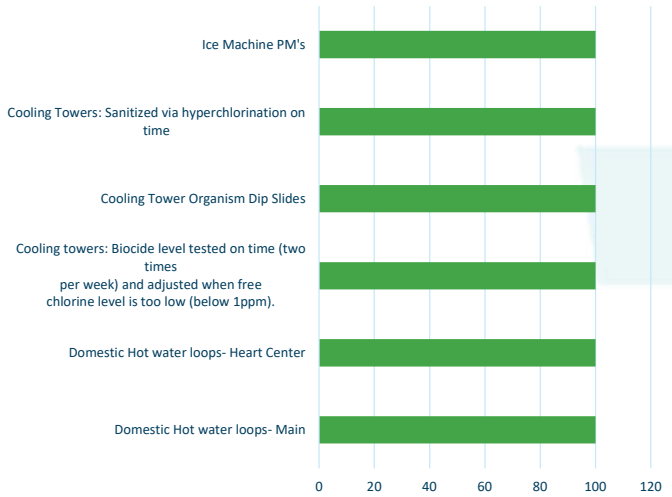
Examples of Department Data Reported in the Infection Prevention Committee

Employee Health: Sharps Injury Summary

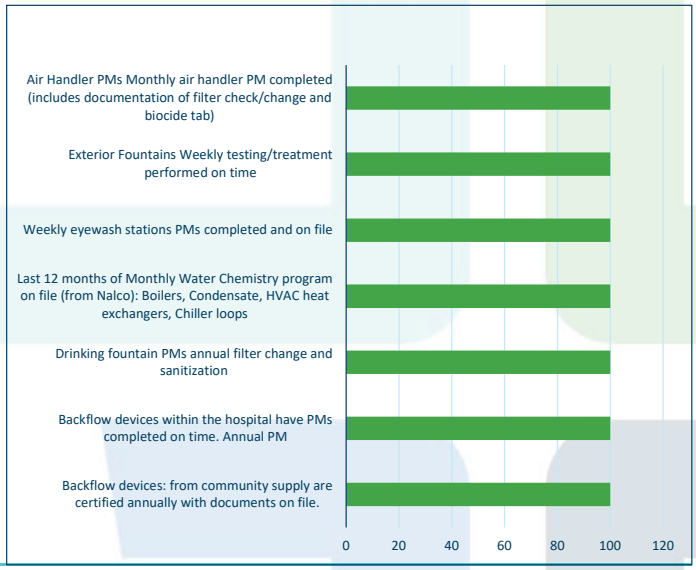


Engineering: Water Management

Potable Water Systems and Water Utility Systems



Annual Spot-Check of low-risk level items- main hospital building

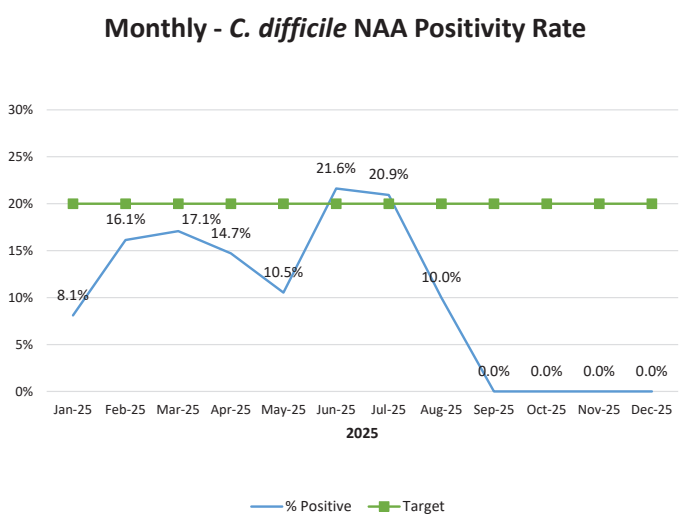


Pharmacy USP 797

- **Air monitoring:**
  - This is normally done by our certifiers, but on occasion, I can also perform our air sampling. If we had CERTS report results outside of the acceptable limits, we would have our staff do a full terminal clean prior to resampling. The pharmacy owns a TrioBas air sampler that is calibrated and recertified annually.
- **Personnel competency:**
  - Our staff receive annual didactic competencies and biannual or annual practical competencies. Compounding staff perform biannual practical competencies, non-compounding staff receive annual practical competencies. These practical competencies consist of post-garbing, gloved fingertip sampling, compounding media fill, and post-compounding fingertip sampling.
- **Daily/Monthly Cleaning**:
  - **Daily cleaning**: Our compounding hoods are cleaned at least 3 times per day (once per shift). We begin by cleaning with a disinfectant (TB1-3300) with a 1-minute contact time, followed by Sterile 70 % Isopropyl alcohol.
    - PM tech: Cleans sinks, counters, and floors with TB1-3300
  - Our daily cleaning is logged into a system called Med Storage (Veriform)
- **Monthly cleaning**:
  - Our monthly cleaning consists of cleaning the entire room. We clean with a sporicidal (Peridox) with a 3-minute contact time, followed by Sterile 70 % Isopropyl alcohol
  - We clean all items inside the clean room as well as the hoods, walls, floors, refrigerators, and pass-through chambers.
  - Our monthly cleaning is logged on paper.
- **Environmental controls:**
  - These are maintained by the Engineering and pharmacy monitors, and reports anything out of range to Engineering for correction. We have a dedicated computer that is next to our lead pharmacists to monitor Centrak and place work orders with engineering when needed.

Microbiology

Positivity for Clostridioides difficile NAA Assays



Data Conclusion/Analysis & Actions

- **May 2025**: 4 of 38 tests were positive, giving a 10.5% positive rate
  - **Target met. The positive rate is below the maximum threshold and does not indicate a concern about false-positive results. Continue to monitor**.
- **June, 2025**: 8 of 37 tests were positive, giving a 21.6% positive rate.
  - Target not met. The positive rate is slightly above the maximum threshold.
  - Note that the Solana HDA method changed to GeneXpert PCR with reflex to toxin antigen on 7/1/25. Continue to monitor.
- **July, 2025:** 9 of 43 tests were positive, giving a 20.9% positive rate.
  - Target not met. Given this was a slight elevation within the historical range, all surfaces were decontaminated with 10% bleach, followed by 70% ethanol. Negative QC performed 8/1/25 & 8/2/25 passed.
  - **An elevated positive rate may be related to specimens submitted for testing, such as inappropriate testing requests. Continue to monitor**.
- **August, 2025 Target Met**

Age-Friendly Health System

Quality Management Department

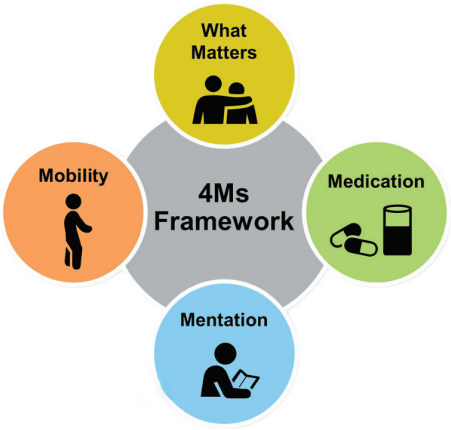
Project Plan

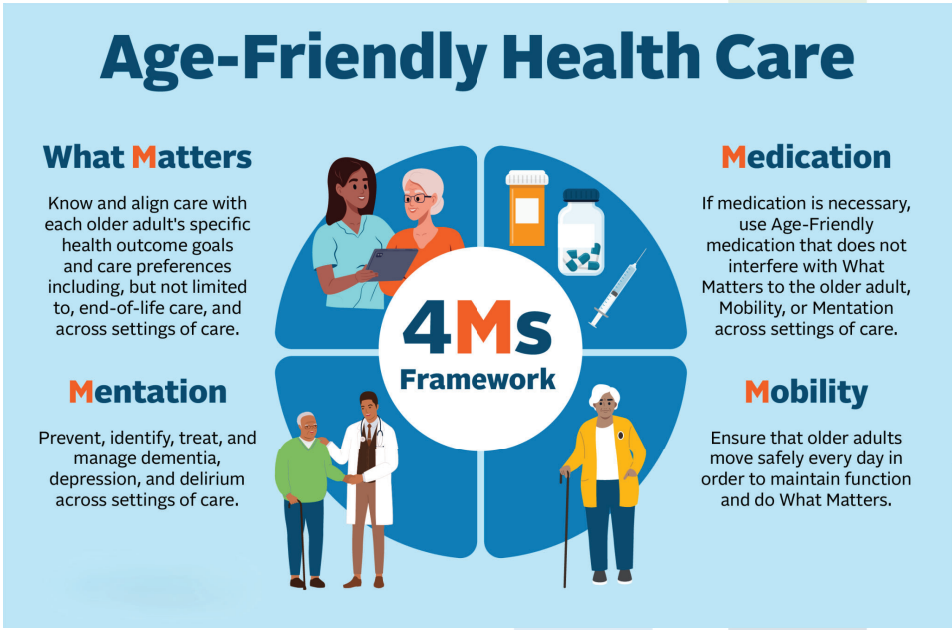
- Age Friendly Task Force
  - Met 1/27/2026 to solidify education plan
- Education
  - Education to hospitalists by Dr. Singh and Brenda Inman on 2/12/26
  - Followed by ED physician group
  - Nursing Education
  - Annual mandatory competency for all staff
- Documentation in Epic
  - Focus on creating “What Matter’s to You” assessment documentation in Epic
- Whiteboards
  - Working with clinical staff on updating whiteboards with patient’s statement of what matter’s most to them
- Dashboard Development
  - Developing dashboard to capture IHI data for certification
- Next Steps
  - Evaluation of data
  - Identification of opportunities
  - Submission of data to IHI

This means all older adults aged 65 and above receive care that:

- Follows an essential set of evidence-based practices in a framework known as the 4Ms (**What Matters, Medication, Mentation, Mobility**).
- Causes No Harm
- Aligns with What Matters to them and their family & caregivers.

IHI 4Ms Framework





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

Focus – Advance Care Planning and Goal Concordant Care

- Ask the older adult What Matters most, including each person's **health outcome goals and care preferences.**
- Adapt the What Matters process based on language, culture, or other patient factors to ensure that it aligns with the needs of all patients.
- May include End-of-Life care, but not limited to Advanced Care Planning.
- **Documentation** should be done in one or more of the following ways: Whiteboard, EPIC EHR, and on paper, so the older adult can share with family members and caregivers.

What we are already doing

- Documentation of Patient Specific Goals in EPIC
  - Patient stated reason for admission
  - Patient stated goal for admission
- Whiteboards with "Today's Plan"
  - Care plan goals for the day

Medication Reconciliation upon admission & transfers

FOCUS- Reducing, deprescribing high-risk medications

Review of High-risk & Potentially Inappropriate Medication (PIMs) Use
- Benzodiazepines
- Opioids
- Highly anticholinergic medications (e.g., diphenhydramine)
- All prescription and over-the-counter sedatives and sleep medications
- Muscle relaxants
- Tricyclic antidepressants
- Antipsychotics
- Mood stabilizers

What we are already doing

- Home medication review beginning in ED by pharmacy technician and then by RN on inpatient
- Pharmacy reviews discharge medications and home medications for errors and opportunities for deprescribing or modifications
- Pharmacy provides discharge follow-up phone calls, especially for high-risk medication education

Screen for delirium at least every 12 hours and upon change in function or behavior

FOCUS- Dementia, Depression, and Delirium

- **Post-traumatic stress disorder, Substance abuse**

- Ensure sufficient oral hydration.
- Orient to time, place, and situation (validation and orienting cues if they have dementia).
- Ensure that older adults have their personal adaptive equipment.
- Avoid high-risk medication that may cause delirium.
- Prevent sleep interruptions; use nonpharmacological interventions to support sleep.
- Treat delirium with hydration, safe mobility, and good sleep practice, following best practice guidelines, including avoiding medications.
- Provide screening and follow-up for patients exhibiting signs or symptoms of dementia or cognitive impairment.

What we are currently doing

- Delirium committee
- In-patient delirium screening
- Activity Blankets and VR goggles for patients with dementia
- Belonging list on whiteboard to indicate personal adaptive equipment, hourly rounding to ensure within reach
- Night Shift Unit Practice Council
  - Quiet Menu
  - Decibel monitors at nursing station
- Depression screening in EPIC
- Early discharge home or admission from ED

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Screen for mobility limitations, document the results, and act on them.

FOCUS- Safe Mobility, Fall risk reduction, Maximizing function

- Mobilize three times a day or as directed by the clinical team.
- Facilitate the patient getting out of bed or leaving the room for meals, therapy, or activities.
- Initiate physical therapy intervention, if appropriate.
- Avoid restraints (physical or chemical).
- Remove catheters and other tethering devices, if appropriate.
- Assess for medications that may limit mobility
- Understand any variations in assessing and acting on Mobility through stratification by race and ethnicity.
- Ensure that older adults have their personal adaptive equipment and hearing, and vision devices.

What we are already doing

- Mobility Protocol - Nursing Standardized Procedure
- Nurse-Driven Urinary Catheter Removal Protocol – Nursing Standardized Procedure
- Belonging list on whiteboard to indicate personal adaptive equipment, hourly rounding to ensure close proximity
- Vent Mobilization for Critically Ill Patients in the ICU
  - Reduces delirium as well
- Bedside Mobility Assessment Tool (BMAT) for PT referral
- ADL screening
- Mobility Committee

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Opportunities for Improvement Moving Forward

- **What Matter's To You**?
  - Effective use of whiteboards to include what matter's to the patient
  - Add to EPIC documentation that reflects the patient's statement of what matter's to them
  - Bring conversation into end-of-life care
  - Involve family and caregivers
- **Medication**
  - Compliance with medication reconciliation
  - Deprescribing and reduction of high-risk medications
- **Mentation**
  - Staff education around hydration and re-orientation
  - Reinforcement of assessment and reassessment
- **Mobility**
  - Increase staff comfort levels with use of mobility screening tools and early mobilization of patients, through reinforcement of staff education
  - Awareness around BMAT documentation and making part of nursing assessment

Thank you!

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT