



June 11, 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, JUNE 15, 2026, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

(For Public Access Information Visit <https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/board-committee-meetings-virtual-link/>.)

A handwritten signature in black ink, appearing to read "Allen Radner".

Allen Radner, MD
President/Chief Executive Officer

¹Salinas 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 and **Richard Gerber, MD**, Medical Staff Member

Advisory Non-Voting Members: Cheryl Pirozzoli, Community Member

**QUALITY AND EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH¹**

**MONDAY, JUNE 15, 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 May 18, 2026. (CARSON)
 - Motion/Second
 - Public Comment
 - Action by Committee/Roll Call Vote
4. Patient Care Services Update (SPENCER)
 - Report from Perioperative Clinical Practice Council (RALPH)
5. Quality & Safety Updates (WILDE)
 - Sepsis (THOMPSON)
 - Enhanced Recovery After Surgery (ERAS) Updates (GOTTFRIED)
 - Readmissions (SYED)
 - Transitional Care (ORTA)
6. Closed Session
7. Reconvene Open Session/Report on Closed Session

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

8. Adjournment

The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **July 13, 2026** 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/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 (SYED)

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH¹
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES MAY 18, 2026

Committee Member Attendance:

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

Voting Members Absent: **Richard Gerber, M.D.**, Medical Staff Member

Advisory Non-Voting Members Present:

In Person: Allen Radner, MD, CEO, Tim Albert, MD, CCO, Alysha Hyland, CAO, Rakesh Singh, MD, VPMA
Via teleconference: Michelle Childs, CHRO

Other Board Members Present, Constituting Committee of the Whole:

Via teleconference: Joel Hernandez and Victor Rey

1. CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:30a.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 APRIL 13, 2026

Approve the minutes of the April 13, 2026 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

PUBLIC COMMENT: None.

COMMITTEE MEMBER DISCUSSION: None.

MOTION:

Upon motion by Committee Vice Chair Cabrera, second by Committee Member Spencer, the minutes of the April 13, 2026 Quality and Efficient Practices Committee Meeting are approved as presented.

ROLL CALL VOTE:

Ayes: Chair Carson, Vice Chair Dr. Cabrera, Miller, Spencer;

Nays: None;

Abstentions: None;

Absent: Dr. Gerber;

Motion Carried.

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

4. PATIENT CARE SERVICES UPDATE: REPORT FROM THE CLINICAL INQUIRY COUNCIL

Carla Spencer, CNO, introduced members of her team to present an update on the Clinical Inquiry Council. Kristen Green-Meadows, BSN, RN, CCRN-CSC, Staff Nurse III, ICU/CCU, 2026 Nurse of the Year, gave an overview of the council's members and purpose. Three topics were presented: Poster Expo 2025, Nursing Grand Rounds 2025, Evidence-Based Practice Cohort 2026. Council's goals include increasing Quality Improvement competence and EBP competence by end of CY 2026.

COMMITTEE MEMBER DISCUSSION: Vice Chair Cabrera complimented the council's incredible work. One suggestion he offered is instituting more marketing of this program, especially to the medical staff. It's important for more people to be aware of this work, and could encourage more participation.

5. QUALITY AND SAFETY:

Brenda Inman, MSN, VP of Quality and Risk Management, introduced members of her team to report on the following items:

- **Age-Friendly Health System Update:** Amy Grooters, Patient Safety Manager, overviewed the Age-Friendly Health System. She detailed the project plan which included age friendly task force, education, documentation in Epic, and Whiteboards. She also provided an update on when the Age-Friendly taskforce is meeting (once in January and again in May), and that the CMS attestation is currently due. EPIC updates and data elements/creation were also discussed.
- **Leapfrog Survey Update:** Stacy Wilde, Director of Quality and Safety, gave an update on the Leapfrog Annual Hospital Survey. The purpose, data sources, assessment cycle, public display, and url were all explained. Highlights include the 9 Survey domains and a comparison of where we stand currently versus the previous years.
- **Vizient Clinical Data Base (CBD) Implementation:** Brenda Inman, MSN, VP of Quality and Risk Management introduced Vizient Implementation Team: Chris Shore & Maeve Lotten, both present via Webex. Ms. Inman presented the Vizient Roles & Responsibilities versus Client Roles & Responsibilities. An overview of the clinical data base was given, highlighting how many hospitals utilize, reporting modules/capabilities, Vizient quality and accountability, and national rankings. Lastly, she discussed the implementation overview which included the data file priority for the clinical data base and the Salinas Valley Health implementation plan.

Full reports were included in the packet.

COMMITTEE MEMBER DISCUSSION: (Age Friendly Task Force): Chair Carson had concerns about due date for Attestation and the frequency of Task Force meetings. She'd also like to see an inventory of EPIC data populated and program dashboard. Vice Chair Cabrera had clarifying questions about the purpose of Task Force and the meeting frequency. Ms. Inman assured the group that the task force is on track to meet its goals.

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 8:58 a.m.

7. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:31 a.m. Chair Carson reported that in Closed Session, the *Hearings/Reports* were accepted as follows:

1. Hearings/Reports: Quality and Safety Board Dashboard Review (INMAN)
 - Quality Improvement Reports: Critical Care Cluster
 - Leapfrog Hospital Grade, Spring 2026

8. ADJOURNMENT

There being no other business, the meeting adjourned at 9:35 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **June 15, 2026** at 8:30 a.m.

Catherine Carson, Chair
Quality and Efficient Practices Committee

PATIENT CARE SERVICES UPDATE



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

Featuring: Perioperative Clinical Practice Council
Monday, June 15, 2026

PERIOPERATIVE CLINICAL PRACTICE COUNCIL

COUNCIL MEMBERS:

- Chair: Deborah Ralph, *BSN, RN*
- Co-Chair: Avrie Calabro, *RN, CAPA*
- Assoc. Co-Chair: Amanda Maguire Martin, *MSN, RN, CNOR*
Advisor: Leslie Hawthorne, BSN, RN, CNOR
- Abigail Kathleen M. Acosta, *MSN, RN, CPAN, CAPA*
 - Jeanette Bedenbaugh, *BSN, RN, CNOR*
 - Alex Beadles, *RN, CPAN*
 - Grant Stephens, *BSN, RN, PCCN*
 - Diana Griggs, *MSN, RN, CNE (Educator)*

COUNCIL PURPOSE:

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:

- Updating Family for All Phases of Care
- Care of Neuro Diverse Patient
- Enhancing Safety for the Care of the Patient on Chemotherapeutics

UPDATING FAMILY FOR ALL PHASES OF CARE:

BACKGROUND:

- Enhancing communication elevates our patient experience scores
- Enriching communication alleviates the stress felt by the patient's loved ones
- The main goal was to facilitate collaboration between nurses and family members

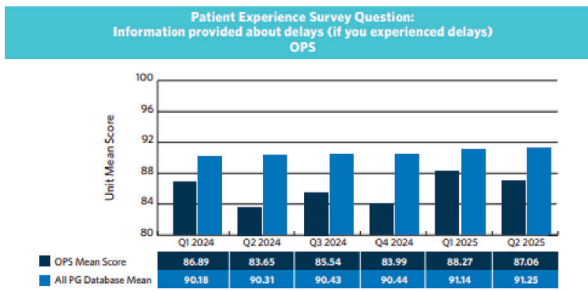


INTERVENTION:

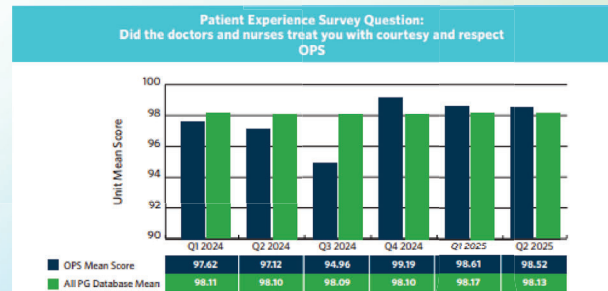
- Re-emphasized the value of pre-op rounding and family updates post procedure
- Standardized secure messaging process intraoperatively
- Revived surgery status boards in waiting rooms
- Sharing knowledge:
 - Poster presentation at 2026 American Society of PeriAnesthesia Nurses (ASPAN) National Conference
 - 2026 SVH Hospital Week Poster Expo: Best in Class, Quality Improvement Category

UPDATING FAMILY FOR ALL PHASES OF CARE *Cont.:*

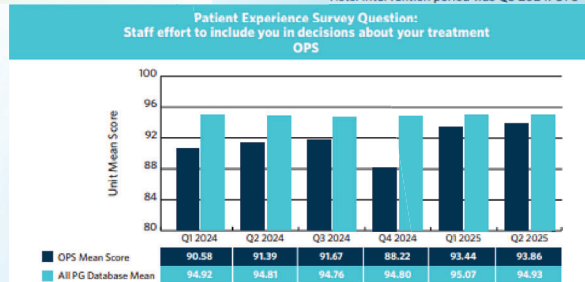
OUTCOME DATA: Patient experience scores for OPS improved on all three questions from the pre-implementation baseline



Note. Intervention period was Q3 2024. OPS = Outpatient Surgery; PG = Press Ganey



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Note. Intervention period was Q3 2024. OPS = Outpatient Surgery; PG = Press Ganey

UPDATING FAMILY FOR ALL PHASES OF CARE *Cont.:*

Perioperative Procedure Status Card

Tarjeta de estado del procedimiento perioperatorio

Patient Tracking ID# / ID de Seguimiento del Paciente:

Check-in/Registración	
Pre-Procedure/Pre-Procimiento	
Surgery/Cirugía	
Surgery Complete/Cirugía Completada	
Post-anesthesia	
Recovery/Recuperación	

Speak with a volunteer for additional information. Hable con un voluntario para obtener información adicional.

Salinas Valley HEALTH 2000493/12-2025

Status Board - Full Screen OR: Waiting Room Board (6:00) (Tue 5/12/2026)	
81011 Surgery in progress	45593174
45637999	126390 Preparing for surgery
81914 All done!	126456 All done!
86410 All done!	Close
88574 Preparing for surgery	45786166
96380 Preparing for surgery	129733 Waking up
96662 Waking up	131094 Preparing for surgery
45878928	132094 Getting registered
98140 All done!	132739 Can
100918 Preparing to go home	132960 Getting registered
113396 Waking up	133077 Getting registered
115091 All done!	133114 Surgery in progress
115486 All done!	133188 Surgery in progress
116613 All done!	133236 Getting registered
45740548	

Implementing Family Updates in All Phases of Perioperative Care: Enhancing Family-Centered Care

Abigail Kathleen M. Acosta, MSN, RN, CPAN, CAPA; Jeannette Biedenbaugh, BSN, RN; Deborah Ralph, BSN, RN; and Arriv Calabro, RN, CAPA

Background

Family centered care recognizes the family's role in a patient's health and well-being, and its benefits are well-documented in healthcare settings (Gardner et al., 2022; Vignaroli et al., 2024). Because patients are not typically with their family members in the perioperative setting, ongoing communication between the healthcare team and family members is important. A lack of updates to the family can increase their anxiety, decrease satisfaction, and pose a barrier for family centered care (Chen et al., 2022). Patients with families have reported being disappointed and anxious, particularly during the intraoperative phase if they had no direct contact with the surgical team (Chen et al., 2022). Poor communication can lead to increased family stress and decreased patient and family satisfaction (Chen et al., 2022).

At Salinas Valley Health Medical Center, Q1 and Q2 2024 patient experience survey results indicated dissatisfaction in three questions pertaining to information about surgery, waiting positions with courtesy and respect, and efforts to include patients in decisions. The Perioperative Department and the medical center provided family updates during the preoperative, pre-anesthesia, and post-anesthesia phases of care. Patient family members were made aware of the patient's status through a phone call or in-person conversation from the perioperative medical and/or nursing staff. However, no communication was provided during the intraoperative phase, which poses a significant gap. Survey results may be attributed to a perceived lack of communication during the intraoperative period (Chen et al., 2022). Because families did not receive updates during the intraoperative phase, other units, like the Post Anesthesia Care Unit (PACU) and Outpatient Surgery (OPS), located adjacent to the family waiting area, took responsibility for updates. Specifically, during the post-anesthesia phase, the PACU staff provided updates to the family. During the intraoperative phase, the OPS staff provided updates to the family. The Perioperative Department and the medical center provided family updates during the intraoperative phase to ensure that communication occurred through all perioperative phases to address this problem and align practice with professional standards (American Society of Perioperative Nurses, 2023; Association of Perioperative Registered Nurses, n.d.).

Purpose Statement

The purpose of this quality improvement initiative was to implement family updates during intraoperative care.

Methods

Multiple discussions in the Perioperative Clinical Practice Council (PCPC) related to a referral from 2023 data to the identification of various barriers to updating family in the intraoperative phase of care. The PCPC conducted a fishbone diagram in May 2023 to explore and categorize the barriers (see Figure 1).

Using multiple Plan-Do-Study-Act (PDSA) cycles, a process familiar to most team members, progress for family updates during the intraoperative phase was considered from Q2 2023 to Q4 2024. The PCPC explored available applications for updates, the functionality of the existing electronic health record, and using phone calls to family. Project stakeholders, which included clinical staff, nurse leaders, and clinicians, found that three general processes were not fully compatible with the necessary components. After multiple PDSA cycles, the PCPC used a team approach for family updates during the intraoperative phase (see Appendix 1) and established updates through the medical center's existing messaging application to communicate with caregivers who would relay the information to the waiting family members, and 2) creating a surgery tracker in the waiting rooms.

The secure messaging application allows surgical nurses to notify caregivers with updates regarding surgery and time spent on the family. All surgical nurses utilized the application, resulting in updates being sent to the waiting family members. The application was approved by the Information Management and Security Department. We piloted the use of the messaging application by providing family updates to assigned family members at the surgical admission desk, "stand-in" in the OR, "surgery is complete", "surgery is completed". Caregivers received the message and relayed it to the family. These updates were supplemented with a comment from the consulting nurse to provide a personal update via phone call if the surgery extended beyond the estimated time. After the PCPC revised the process for implementation, no process was used in July 2024.

The second approach was revising the use of a surgery tracker in the waiting rooms. The PCPC facilitated using the family waiting room members' use of the waiting room with the surgery tracker. A previous version of the tracker was retired, updated, and approved by stakeholders. The tracker was initially intended to be a single page process to immediately provide family updates via the secure messaging process via being developed in 2024. By August 2024, families in both the main and surgical waiting rooms were able to see a real-time view of the family and location in the department.

The PCPC evaluated the impact of the new intraoperative updates by monitoring patient experience scores on three patient experience questions: 1) information provided about surgery, 2) efforts to include you in decisions about your care, and 3) waiting room staff. Data were collected during implementation for two quarters, and implementation of the new process compared with baseline data from Q1 and Q2 2024. The rationale for evaluating data during the intervention was that changes were implemented by the middle of the affected quarter, and we expected to see some improvement in scores as a result.

Figure 1: Fishbone Diagram on Lack of Family Updates Intraoperatively

Figure 2: Patient Experience Survey Question: Information provided about surgery (7 pre implemented dates) Q1-Q4

Figure 3: Patient Experience Survey Question: Efforts to include you in decisions about your treatment Q1-Q4

Figure 4: Patient Experience Survey Question: Staff effort to include you in decisions about your treatment Q1-Q4

Table: Patient Experience Survey Question: Information provided about surgery (7 pre implemented dates) Q1-Q4

QTR	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Q1 2024	85.2	85.2	85.2	85.2
Q2 2024	85.2	85.2	85.2	85.2
Q3 2024	85.2	85.2	85.2	85.2
Q4 2024	85.2	85.2	85.2	85.2

Table: Patient Experience Survey Question: Efforts to include you in decisions about your treatment Q1-Q4

QTR	Q1 2024	Q2 2024	Q3 2024	Q4 2024
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Table: Patient Experience Survey Question: Staff effort to include you in decisions about your treatment Q1-Q4

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Q2 2024	85.2	85.2	85.2	85.2
Q3 2024	85.2	85.2	85.2	85.2
Q4 2024	85.2	85.2	85.2	85.2

CARE FOR THE NEURO DIVERSE PATIENTS:

BACKGROUND:

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

INTERVENTION:

- The Peri-Op Council adapted a screening tool allowing documentation of a neurobehavioral assessment
- A flag is triggered in the record which is visualized by the multidisciplinary team
- We also implemented physical chart flags so all staff are aware of patients needs
- We created a Bee Box that patients can pick a neurodiverse trinket of their choice
- By screening these patients we are able to decrease patient and family anxieties
- Our staff provides a safer environment for our patients



NEUROBEHAVIORAL ASSESSMENT

Neurobehavioral Assessment

Time taken: 5/12/2026 18:20 Responsible Show Row Info Show L

Macro Manager

Neurobehavioral Assessment

Neurobehavioral Assessment

Hx of neurobehavioral disorders or behavioral concerns?

Able to respond to questions/follow simple direction

Preferred communication method
 Electronic Devices Pictures Social Stories First/Then Communication Board Sign language Verbal Communication

Expression of needs
 Electronic Device Pointing or gesturing toward need Leading to need Sign Language Pictures Verbal Communication Other (in comment)

Expression of pain
 Aggressive behavior Crying Isolating behavior Pointing Screaming Self harm Verbal Communication Other (in comment)

Time comprehension
 Analog clock Digital clock Timer Counting aloud Schedule board Other (in comment)

Physical Exam coping methods
 Distraction Allow to touch/feel equipment Show equipment just before use Verbal instruction step by step through ... Simulate/Demo on family member or staff Other (in comment)

Please perform this stressful exam last
 Abdominal Lung sounds Vital signs Ears, Noss, Throat Neurological Other (in comment)

Potential Triggers
 Bright Lights Loud Sounds Smells Textures Being touched Other (in co...

Helpful interventions
 Dim lighting Music Toys, games, cards Electronic devices Noise canceling ... Weighted Blanket Other (in comment)

Additional information to facilitate care

ENHANCING SAFETY FOR THE CARE OF THE PATIENT OF CHEMOTHERAPEUTICS:

BACKGROUND:

- Perioperative patients can be on chemotherapeutic agents or are given these during the case. Prior to this initiative, our staff was not properly protected

INTERVENTION:

- Our council created a chemo cart for our surgical cases for patients on chemotherapy medications
 - The cart contains all the necessary equipment and supplies to keep staff safe
 - The blue compact cart follows the patient throughout their peri-op stay to help ensure safety measures are followed
- We also review the chemo precautions during annual competency validation with our Peri-Op Peers

CHEMO PRECAUTIONS CHEAT SHEET

Inpatient RNs to order the following from Central Supply:

- Inpatient Chemo Safety Kit**
This kit includes Chemo precaution signage, chemo tested gloves & gowns
- Infection Control Glasses**
- 8 Gallon Chem-o-gator**
- Sharps Container Chem-o-gator**
- Yellow Plastic Bag**
- Yellow stickers to be attached to all lab specimens (can get from pharmacy).**
- For Oncology RNs only:** Spill Kit, Reaction kit, Positive Pressure Cap, Male/Female adaptors during chemo infusion, & portacath needles if needed.

Order
<input type="checkbox"/> CONTAINER SHARPS CHEMO 8 GL [DIST]
<input type="checkbox"/> Stat (1)
<input type="checkbox"/> Routine (1)
<input type="checkbox"/> KIT CHEMO SPILL [DIST]
<input type="checkbox"/> Stat (1)
<input type="checkbox"/> Routine (1)
<input type="checkbox"/> KIT INPATIENT CHEMO SAFETY [DIST]
<input type="checkbox"/> Stat (1)
<input type="checkbox"/> Routine (1)
<input type="checkbox"/> GLASSES INFECTION CONTROL [DIST]
<input type="checkbox"/> Stat (1)
<input type="checkbox"/> Routine (1)
<input type="checkbox"/> CONTAINER SHARPS CHEM-O-GATOR [DIST]
<input type="checkbox"/> Stat (1)
<input type="checkbox"/> Routine (1)
<input type="checkbox"/> CONTAINER YELLOW WASTE 18 GAL [DIST]
<input type="checkbox"/> Stat (1)
<input type="checkbox"/> Urgent (1)
<input type="checkbox"/> Routine (1)

Initiatives - In-Progress:

ENHANCING HOUSE-WIDE AWARENESS ON PRE-OP READINESS

BACKGROUND:

The Perioperative Clinical Practice Council [PCPC] receives and addresses annual referrals to improve understanding of pre-operative readiness. This helps to ensure nursing staff are fully aware of our patient's pre-operative status, physical and psychological preparation as well as administrative and logistical checks while preventing delays, reducing errors and improving the patient experience

MANAGEMENT OF PRE-OP ANXIETY

BACKGROUND:

- Pre-operative anxiety is being assessed before surgery; interventions to support patients experiencing anxiety will be explored



DEPARTMENT/SERVICE Quality Improvement Reports

Sepsis Initiative

Report to QIC

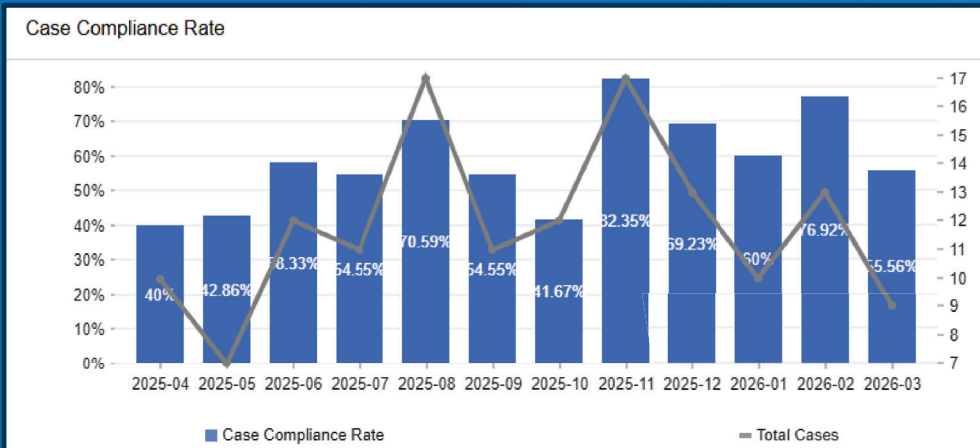


David Thompson
Director, Emergency

Date: 5/2026

"CONFIDENTIAL PATIENT SAFETY WORK PRODUCT. This document is privileged and protected under the Federal Patient Safety and Quality Improvement Act. Do not disclose unless authorized by the Medical Executive Committee."

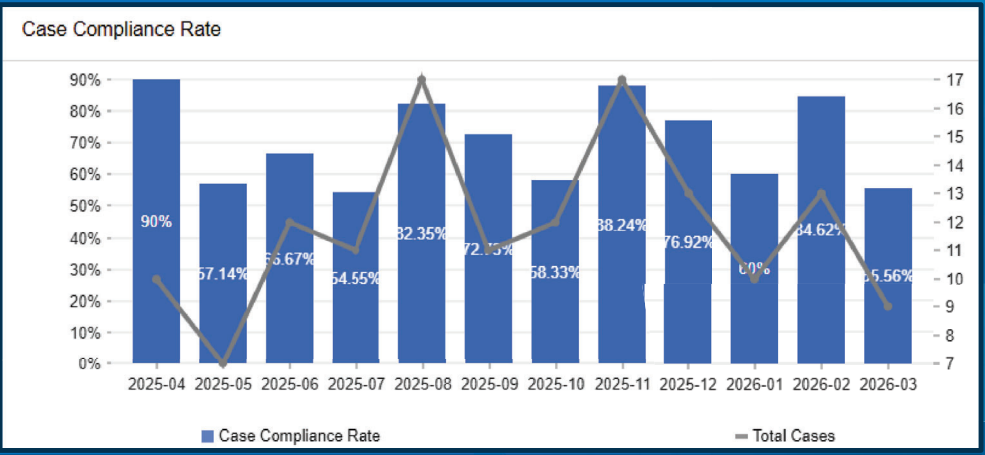
Data: 3 Hour Bundle Compliance



Case Type	Total Cases	Cases Passed	Cases Not Passed	Case Compliance Rate
Septic Shock (CMS)	57	48	9	84.21%
Severe Sepsis (CMS)	85	39	46	45.88%
Σ	142	87	55	61.27%



Data: Crystalloid Fluid Administration



Facility Name	Case Type	Total Cases	Total Elements	Total Elements Passing	Total Elements Exception	Total N/A	Element Compliance Rate
Salinas	Septic Shock (CMS)	57	57	48	9	0	84.21%
	Severe Sepsis (CMS)	85	85	55	30	0	64.71%
Sub-Summary		Σ 142	Σ 142	Σ 103	Σ 39	Σ 0	() 72.54%
		Σ 142	Σ 142	Σ 103	Σ 39	Σ 0	() 72.54%



Data: 6 Hour Bundle Compliance



Case Type	Total Cases	Cases Passed	Cases Not Passed	Case Compliance Rate
Septic Shock (CMS)	57	42	15	73.68%
Severe Sepsis (CMS)	85	39	46	45.88%
Σ	Σ 142	Σ 81	Σ 61	() 57.04%



Measure Compliance April 2025 to March 2026

Qapps

- Initial Lactate – 92.25
- Blood Culture – 98.59
- Antibiotic Administration – 97.89
- Volume Status and Tissue Perfusion Assessment – 96.48
- Vasopressor Administration – 99.3
- Repeat Lactate – 100% - contradicted in EPIC shows low compliance for Dec – Mar ranging from 25 to 50 %

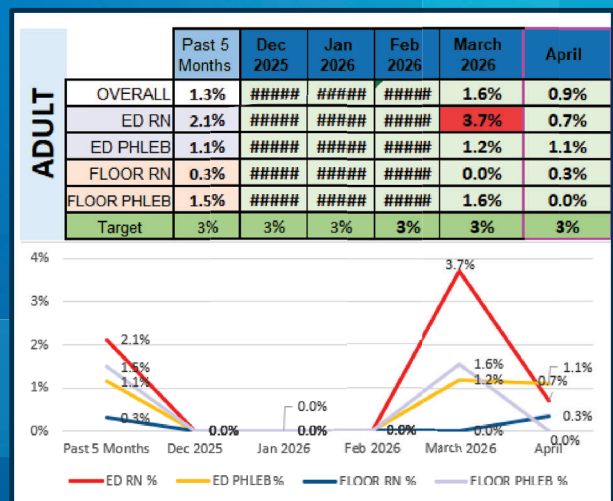


Blood Cultures – Adult

Salinas Valley HEALTH 2026 April Blood Culture Statistics

1. Adult Contamination: Overall April **0.95%**

a. Each "set" represents a single draw and is counted once.
 b. Note: Unofficial goal is <=1.0% to align with publications indicating that is a possible future CMS target.
 c. "Adult" age range is 18+ years of age.
 d. Transition to Epic includes changes to data collection; cultures are no longer assessed as "sets" but individual aerobic and anaerobic bottles.
 e. Phlebotomy team utilized Steripath Micro diversion devices; ED Nursing team utilizes VI Bypass Syringe.



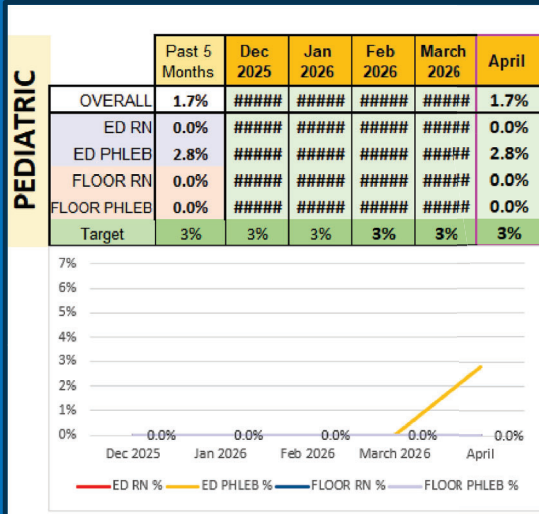
Blood Cultures – Pediatric



2026 April Blood Culture Statistics

2. Pediatric Contamination: Overall April **1.69%**

a. "Pediatric" age range is <=17 years of age.



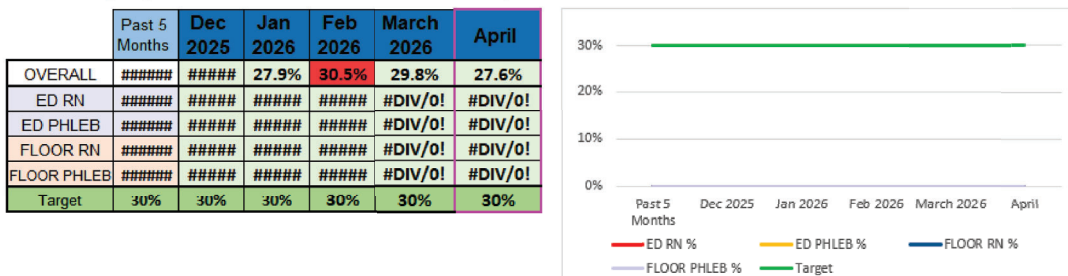
Blood Cultures – Underfilled Bottles



2026 April Blood Culture Statistics

3. Underfilled Bottles: Overall April **27.6%**

- a. Derived from automated optical measuring by blood culture analyzer with target of >=8% blood.
- b. Target of <=30% implemented 11/2024 and retroactive data reviewed.
- c. Floor draws by RNs are almost always line draws, so a low underfill rate is expected.
- d. Historically only aerobic bottles were monitored; transition to Epic now includes anaerobic bottles.



Next Steps

- EPIC Sepsis documentation validation
- Physician documentation
- Continued follow-up with fallouts



Qapp Fallouts Review

Exception Reporting

Salinas Change Facility

[go back](#)
[Initiate Exception](#)

Search

Case Type: Sepsis (CMS) - Dx equals no Sepsis (CMS) - No Initial Hypertension Sepsis (CMS) - Transfers In Sepsis Shock (CMS) Severe Sepsis (CMS)

Date Type: Select an Option From: 01/01/2026 To: 05/01/2026

Case Status: Pending Initial Client Review Pending QC Review Pending Client Review Pending Completion

Facility	Case Type	MRN	Visit	Discharge Date	
Salinas	Severe Sepsis (CMS)	3227194	30266506	04/08/26	● ○ ○ ○ ○
Salinas	Severe Sepsis (CMS)	3231976	30264702	04/05/26	● ○ ○ ○ ○

Crystalloid Fluid Administration:

Element Passing: Exception N/A

Unit: Select an Option

Choose Unit: Select an Option

Select Providers

Name: Role: Select an Option

[+ add provider](#)

Facility:

Agree with the Assessment? Yes No

Exception Comments

Ashley Hollins Fri, 6/5/26 11:17 am

1)Inf: Infection present/suspected yes ED timeline 1418
 2)SIRS: RR24 1354 EMS
 2)SIRS: T101.3 1354 EMS
 3)OD: LA 2.7 1515

SSP: 04/05 1515

ABX: Rocephin 1652
 BC: 04/05 1432

ILA: 1446 2.7
 RLA: 1638 04/05

IH: Yes MAP 62 1800
 MAP 55 1900

CF: Pt wt 70.8(kg)30=2124(191.2), pt rec:
 1L NS 1434-1534
 500mL NS 1928-2028
 Zosyn 100mL in NS 1902-1932

Fallout: Less than target volume of fluids ordered/initiated in timeframe

No documentation located for lesser volume H&P note states cautious IV fluids but no volume ordered

Case Type: Severe Sepsis



EPIC Sepsis Dashboard

- Sepsis Prevalence
- Patients by Sepsis Type
- In-Hospital Mortality Rate
- Sepsis Patients Deceased v. Deceased
- 30-Day Readmission Rate
- Length of Stay
- Median Time from ED Triage Start to First Antibiotic Admin (Adult)
- 3 hours Sepsis Bundle Compliance
- 6 Hour Sepsis Bundle Compliance
- Order Set Usage
- * The data in the dashboard needs verified,



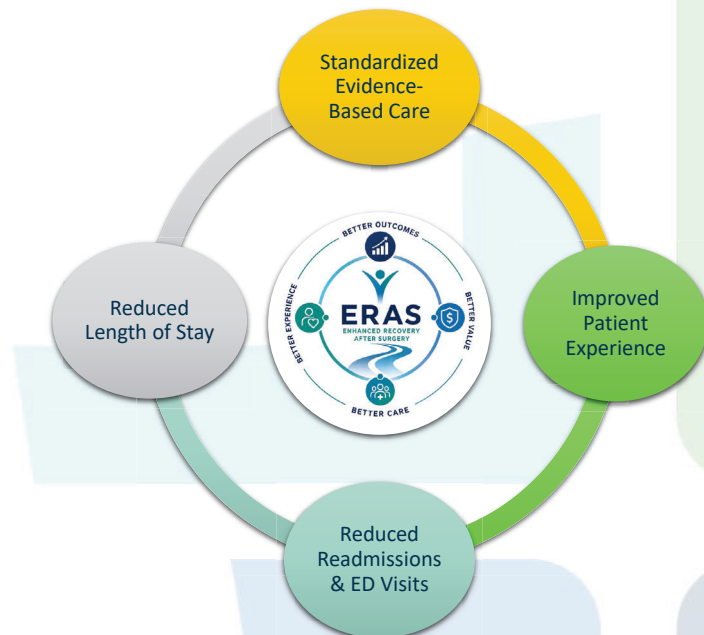
ERAS Implementation Update: Total Joint Replacement Program

Lilia Meraz-Gottfried, MSN, RN, CMNL
Director Clinical Development

June 15, 2026

Why ERAS?

Enhanced Recovery After Surgery (ERAS) is an evidence-based, multidisciplinary approach designed to achieve early recovery, improve patient outcomes, and decrease variation in care.



<https://pmc.ncbi.nlm.nih.gov/articles/PMC10566339/>

Enhanced Recovery After Surgery

- ERAS pathway successfully implemented in November 2025.
- Existing best practices standardized and made measurable.
- Early indicators demonstrate strong compliance with pathway elements while additional metrics become available through Epic reporting.

ERAS is the next step in the evolution of an already high-performing program.



What did we enhance with ERAS?

- Implemented interventions impacting 3 phases of care:



What are we measuring?

- ERAS Metrics Dashboard

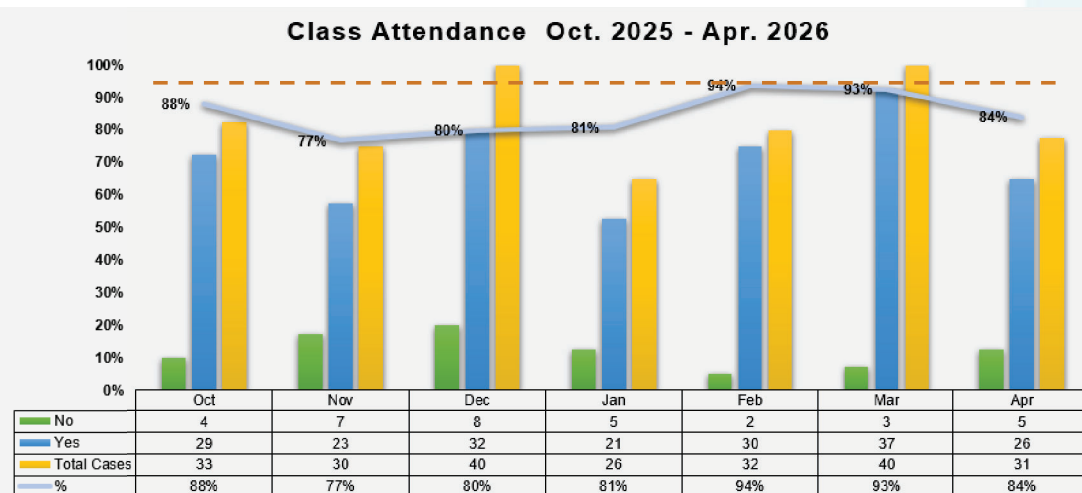
■ Complete
■ In Progress

Pre-Op
Intra-Op
Post-Op

Status	Metric	Definition	Target
■	ERAS Enrollment Rate	% of eligible surgical patients enrolled in ERAS pathway	≥ 90%
■	Education Completion	% of enrolled patients completing ERAS education	≥ 95%
■	Optimization Compliance	% of patients meeting pre-op optimization bundle	Pending Physician Feedback
■	A1C Compliance	% of diabetic patients with documented A1C within protocol timeframe	≥ 95%
■	Normothermia	% of cases maintaining temp ≥ 36°C at end of case	Pending Anesthesia Feedback
■	Multimodal Analgesia	% of cases using ≥2 non-opioid modalities	Pending Anesthesia Feedback
■	PONV Rate	% of patients with documented PONV in PACU or PODO	≤ 20%
■	Fluid Therapy Compliance	% adherence to ERAS fluid protocol	≥ 80%
■	Early Oral Intake Compliance	% patients tolerating oral intake within protocol timeframe	≥ 85%
■	Pain Score	Average PACU discharge pain score	Benchmark under review
■	Oral Opioid Compliance (PACU)	% receiving oral opioid prior to discharge when indicated	≥ 80%
■	Length of Stay	Median LOS for ERAS pathway patients	Procedure-specific benchmark
■	30-Day Readmission Rate	% readmitted within 30 days of index surgery	≤ Benchmark
■	30-Day ED Visit Rate	% presenting to ED within 30 days	≤ Benchmark

Education Class Completion

- All patients highly encouraged to attend education class, 2-3 classes/week offered.
- Navigator calls patients 1 week prior to surgery to ensure they have basic understanding of educational content.

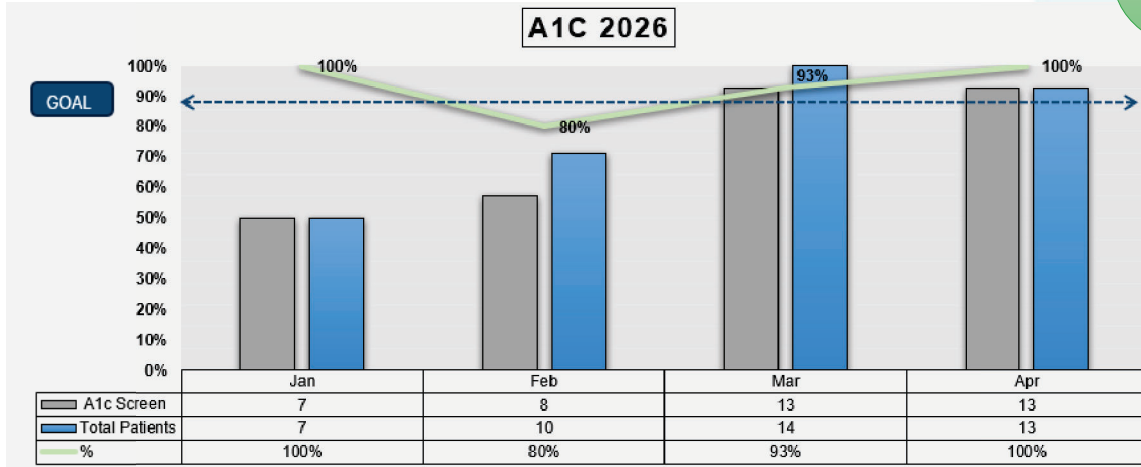


Target
95%

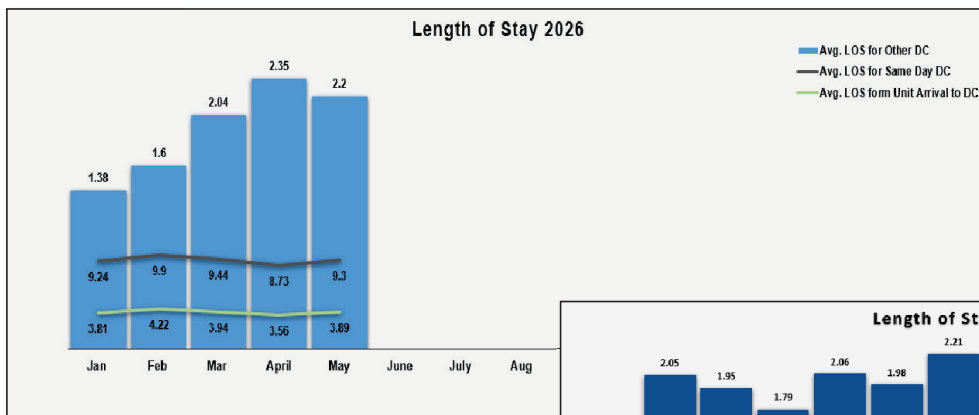
A1C Compliance

- Diabetic/Pre-Diabetic patients with A1C drawn 90 days prior to surgery.

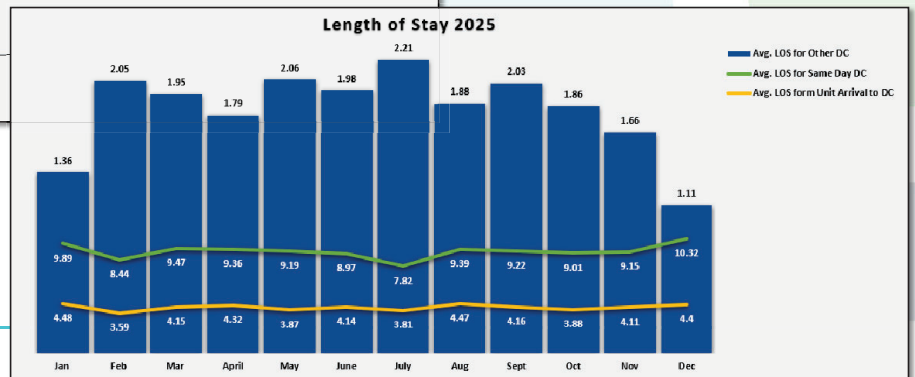
**Target
90%**



Length of Stay

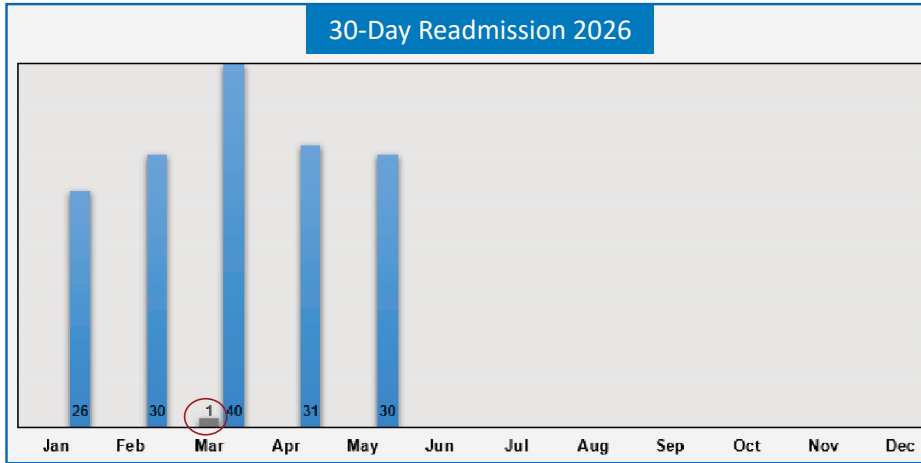


**Target
<4 Hrs.**



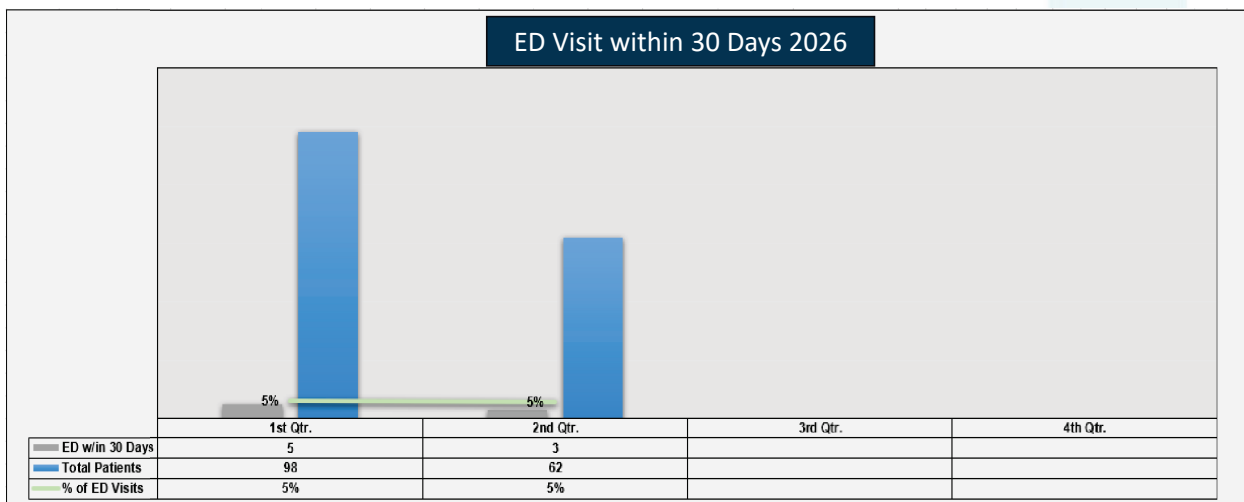
30-Day Readmission Rate

- 67 y/o – female returned to ED with periprosthetic hip fracture.
- QTR1 – 2026 = 1%



30-Day ED Visit Rate

	Jan	Feb	Mar	Apr	May
Volume	1	1	3	2	1
Reason for Visit	R/O clot	Facial swelling	Periprosthetic fx Vomiting; diarrhea	R knee effusion Blisters to incision	Hip pain, no DVT
			Hiccups, n/v		



Next Steps

- Continue to monitor data
- Finalize metric reports and work with Epic team to develop dashboard
- Present data at Joint Replacement Program quarterly meetings
- Share 30-Day ED Visits and 30-Day Readmission data with orthopedic surgeons monthly for trend identification and process improvement opportunities.
- ERAS expansion roadmap
 - Cardiac Surgery followed by General Surgery

CMS Pay For Performance Model **Hospital Readmission Reduction Program**



Athar Syed
(Quality Data Integrity Specialist)

June 15, 2026

Hospital Readmission Reduction Program

- Readmission Reduction Program is another Medicare Pay-For-Performance program that supports the CMS goal of improving health care for Americans by linking payment to the quality of hospital care.
- Under the HRRP, CMS penalizes hospitals with higher-than-expected rates of readmissions, following treatment for specific conditions and procedures, that significantly affect the lives of many Medicare patients, thus encouraging hospitals to provide high-quality care to reduce avoidable returns to the hospital.
- Measures are established in advance through the annual IPPS rule.

Current Diagnosis and Procedures

Readmissions Reduction Program	Hospital IQR and OQR Programs
1. AMI	Stroke
2. CHF	Hybrid Readmissions
3. Pneumonia	OP-32-Colonoscopy Measure
4. COPD	OP-35-Chemotherapy Measure
5. CABG	OP-36-Outpatient Surgery Measure
6. THA/TKA	

Patient Cohorts	
1. Age	Aged 65 or older.
2. Principal diagnosis	discharge diagnosis of AMI, HF, Pneumonia, or COPD
3. Principal Procedure	Isolated CABG or THA/TKA
4. Payer Enrollment Conditions	Enrolled in Medicare FFS and/or Medicare Advantage for the 12 months prior to the date of admission; and enrolled in FFS or MA during the index admission.
5. Hospitalization	Discharged alive from non-federal, short-term acute care hospitals
6. Discharge Status	Not transferred out to another acute care facility

Index Admissions Exclusions

Admissions to inpatient rehabilitation facilities long-term care hospitals and hospice facilities are not considered readmissions in the RRP

Without at least 30 days post-discharge enrollment in FFS Medicare.

Discharged against medical advice (AMA).

For the AMI cohort, patients admitted and discharged on the same day are not included as index admissions.

Planned Readmissions

(Transplant surgery, Maintenance Chemotherapy/Radiotherapy/ Immunotherapy, Rehabilitation)

Extra Specifications

Readmissions within 30 days of discharge from an index admission are not considered index admissions.

Readmissions for transferred patients are attributed to the hospital that ultimately discharges the patient to a non-acute care setting

Readmissions to the same hospital, on the same day of discharge, for the same diagnosis as the index admission, are considered one single continuous admission.

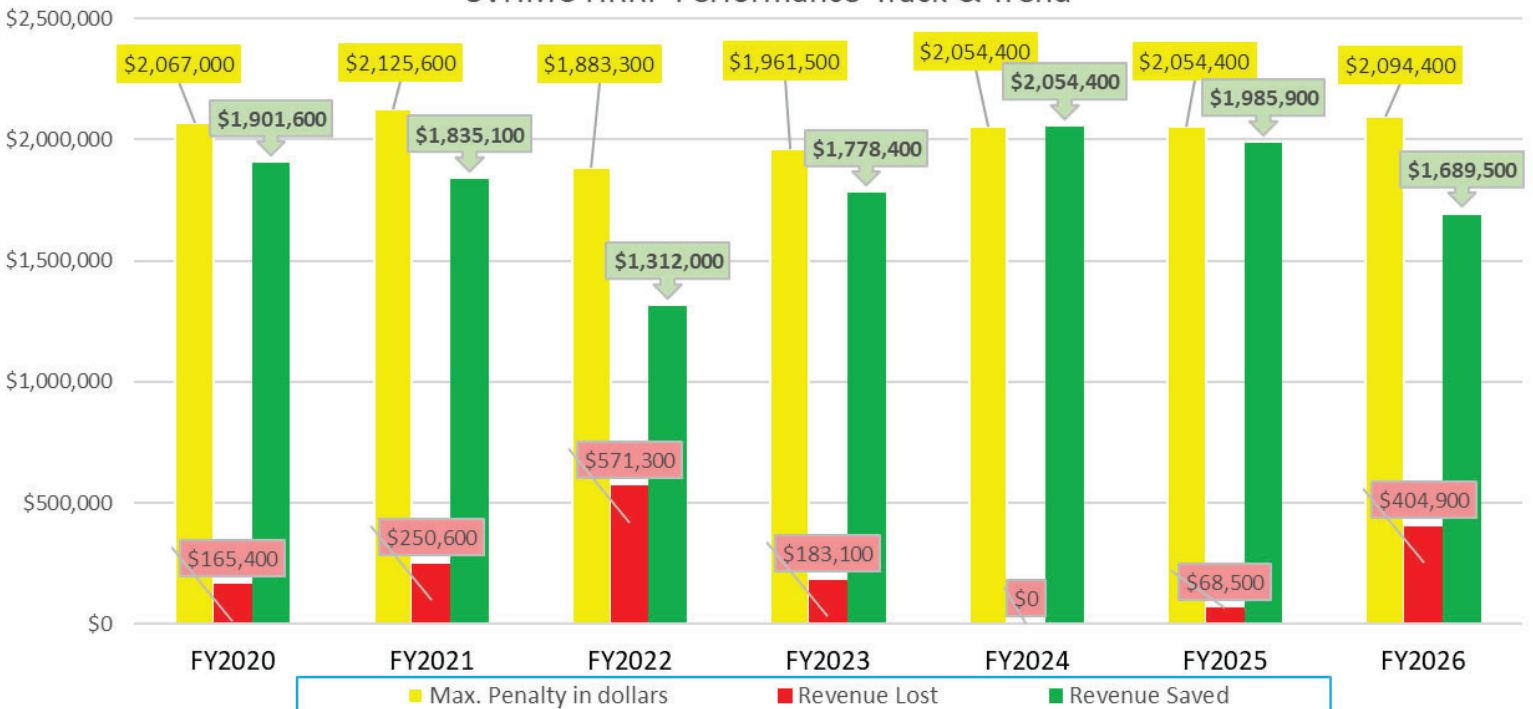
Readmissions to the same hospital, on the same day of discharge, for the different diagnosis as the index admission, are considered readmissions in the measures.

If a patient has more than one unplanned admission within 30 days of discharge from the index admission, only the first is counted as a readmission.

Variables	Condition Specific Revenue	Performance
▪ AMI Excess Revenue	\$7,069,200	\$126,800
▪ HF Excess Revenue	\$10,260,000	\$155,700
▪ PN Excess Revenue	\$7,677,500	\$122,400
▪ COPD Excess Revenue	\$2,226,100	\$0
▪ THA/TKA Excess Revenue	\$206,300	\$0
▪ CABG Excess Revenue	\$6,703,200	\$0
▪ Total Condition-specific Excess Revenue	\$34,142,300	\$404,900

Variables	Performance	Dollar Amount
Payment Adjustment factor (Actual)	0.9942	-
Neutrality Modifier	0.9627	-
Max Readmissions Penalty	3%	\$2,094,400
ERR Penalty % Applied to Inpatient	-0.58%	-\$404,900
Payment Loss Prevented	2.42%	\$1,835,100

SVHMC HRRP Performance Track & Trend



Transitional Care Department

Michelle Orta, MSN, RN, PHN, CCM
Director, Continuum of Care

TRANSITIONAL CARE PROGRAM OVERVIEW

Coordinated Support. Better Outcomes. Stronger Communities.



Transitional Care provides targeted clinical and social support to high-risk patients before and after discharge to improve outcomes and reduce preventable utilization.

PATIENTS SUPPORTED BY TRANSITIONAL CARE

DISEASE-SPECIFIC POPULATIONS	HEALTH PLAN	CLINIC SPECIFIC POPULATIONS	ADDITIONAL HIGH-RISK POPULATIONS
<p>ALL PAYERS</p> <ul style="list-style-type: none"> Heart Failure Chronic Obstructive Pulmonary Disease (COPD) Coronary Artery Bypass Graft (CABG) Acute Myocardial Infarction (AMI) Diabetes (A1C >10%) <p>MEDICARE</p> <ul style="list-style-type: none"> Pneumonia 	<ul style="list-style-type: none"> Aspire Medicare Advantage Coastal TPA Employee Health Plan 	<p>ALL PAYERS</p> <ul style="list-style-type: none"> Taylor Farms PrimeCare High-Risk Patients (LACE) 	<p>ALL PAYERS</p> <ul style="list-style-type: none"> Elevated LACE Score Patients with Social Needs or Barriers to Care

COMPREHENSIVE TRANSITIONAL CARE SUPPORT



DURING HOSPITALIZATION

- Conduct patient assessment and engagement
- Identify clinical and social barriers to recovery
- Collaborate with care teams on discharge planning
- Facilitate follow-up appointments with primary and specialty providers
- Coordinate referrals and community resources



POST-DISCHARGE SUPPORT

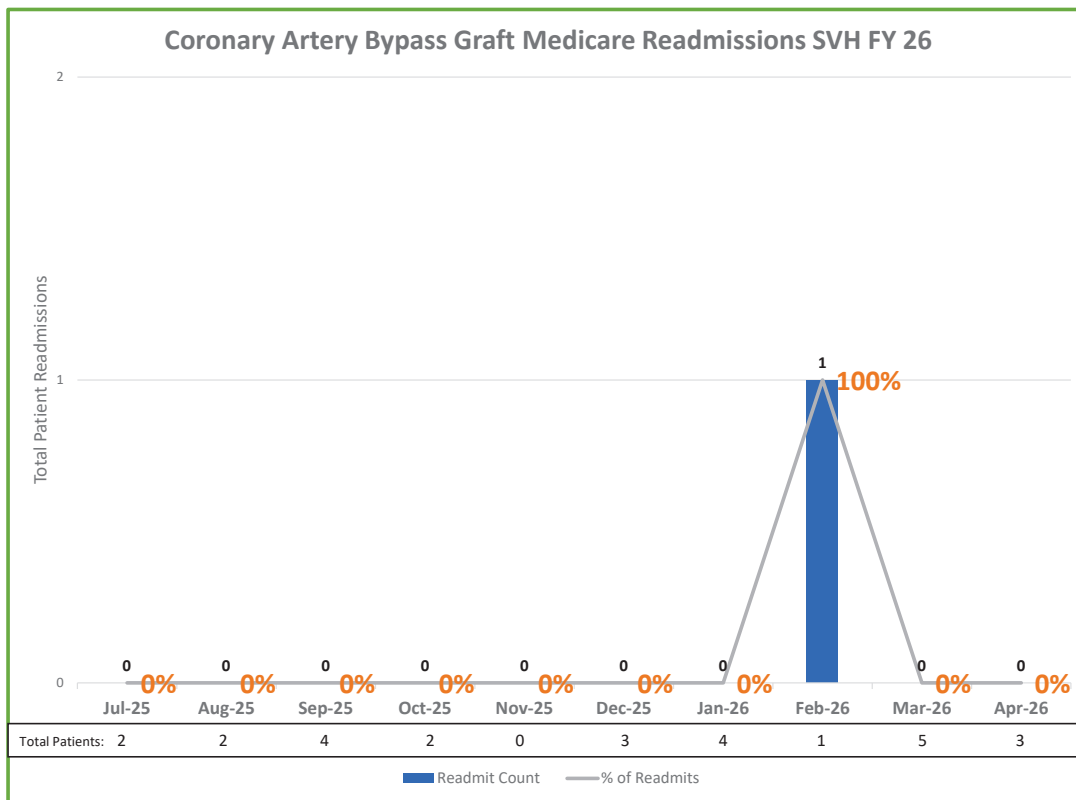
- Contact patient within 24-48 hours of discharge
- Address barriers to medication access
- Confirm medication reconciliation and pickup
- Reinforce discharge instructions and self-management education
- Verify referral completion and follow-up appointments
- Coordinate care with skilled nursing facilities and community partners
- Provide ongoing support for up to 30 days following discharge

PROGRAM OBJECTIVES

- Reduce avoidable readmissions
- Improve patient outcomes and experience
- Support successful transitions from hospital to home
- Address social determinants impacting recovery
- Strengthen coordination across the continuum of care



Our goal is a safe transition, healthier patients, and stronger communities.



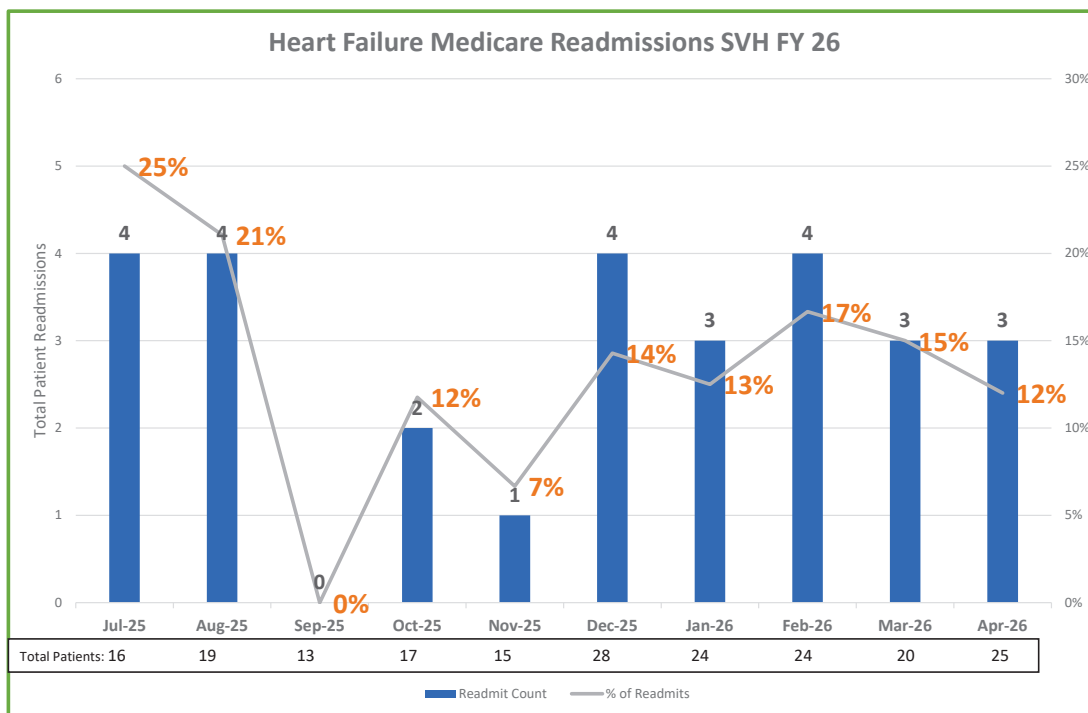
Currently averaging 10% Readmission Rate for FY26

CMS Performance Period 7/2021 - 5/2024:
 National Observed Readmission Rate 10.5%
 SVHMC Expected Rate 11.7 %
 SVHMC Readmission Rate 10.5%

CABG

Interventions:

- Bedside Interviews to support discharge
 - 64% of all patients interviewed in person before discharge
 - Provided a Blood Pressure Cuff and Weight Scale if unable to afford one
- Participate in daily interdisciplinary rounding with Cardiothoracic PA-C Team
- Increased communication with Case Management
- Utilizing Guideline Directed Medication Therapy (GDMT)
- Weekly CABG schedule review
- Close coordination with Acute rehabs for DC notification
- All follow up appts are scheduled by PAs prior to discharge
- **Next Steps:**
 - Leverage Epic for Video visits
 - Stay the course, stay vigilant



Currently averaging 13% Readmission Rate for FY26

CMS Performance Period 7/2021 - 5/2024:
 National Observed Readmission Rate 19.6%
 SVHMC Expected Rate 19.0%
 SVHMC Readmission Rate 20.2%

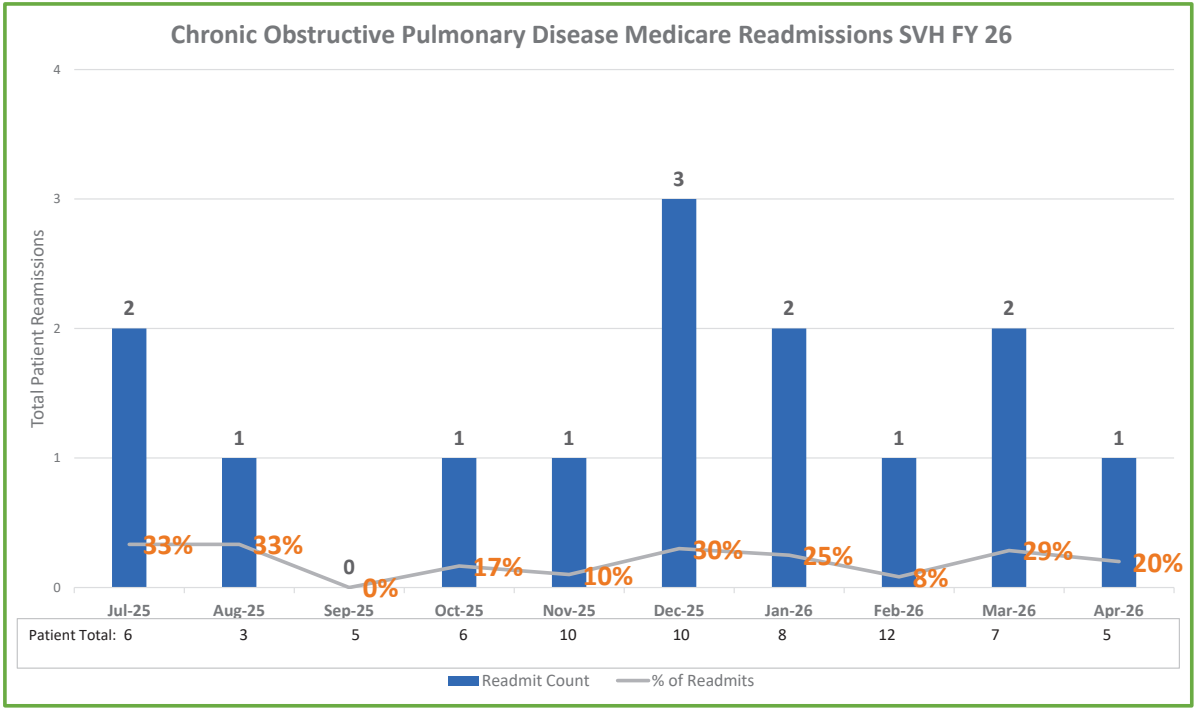
Heart Failure

Interventions:

- Bedside Interviews to support discharge
 - 74% of all patients interviewed in person before discharge
- 54% of all patients are seen by Cardio within 7 days of discharge
- 75% are seen by PCP or cardio within 7 days of discharge
- Implemented CHF follow-up at 3 weeks post-discharge (in addition to 1 week appt)
- Meet with CHF committee every other month
- Collaborate with coding team regarding discharge diagnosis coding accuracy for data collection
- Education with the Skilled Nursing Facilities and Home Health Agencies

Next Steps:

- Increase bedside interview to 80%
- Increase 7-day cardio appointments (improving CHF order set in Epic)
- Recurring SNF education (CHF symptoms, CardioMEMS, Furoscix) to address staff turnover
- Add CHF to Healing at Home



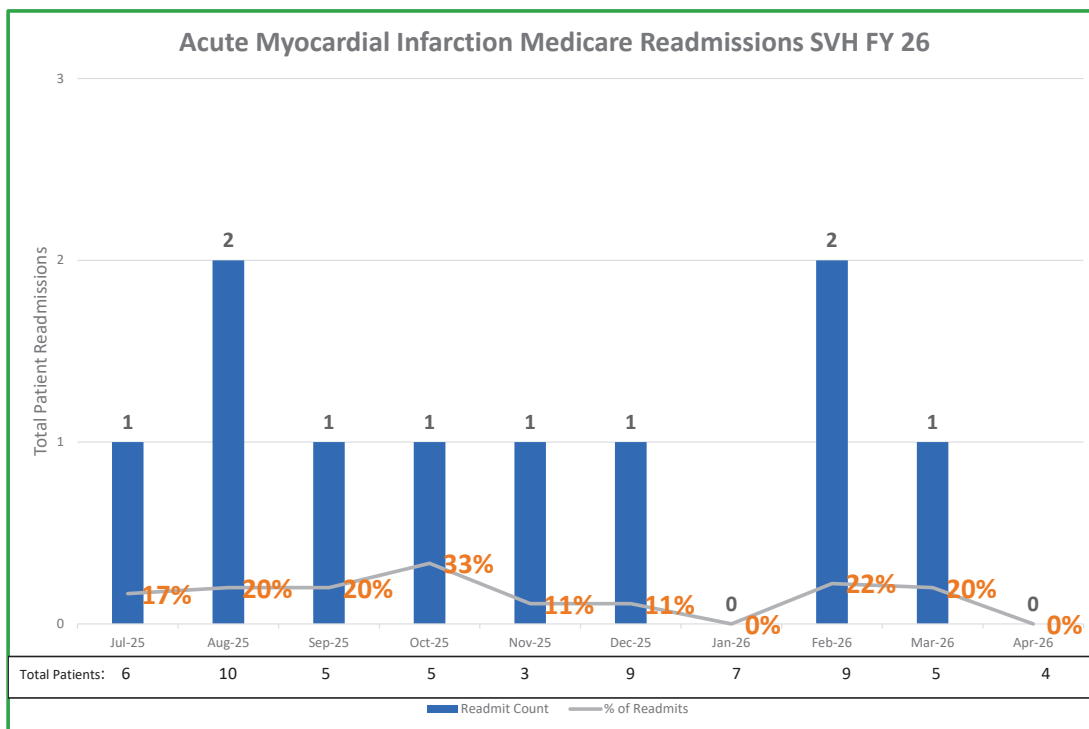
Currently
Averaging 20%
Readmission Rate
for FY26

CMS Performance Period for 7/2021 - 5/2024:
National Observed Readmission Rate 18.3%
SVHMC Expected rate 17.6%
SVHMC Readmission Rate 16.5%

COPD

Interventions:

- Bedside Interviews to support discharge
 - 72% of all patients interviewed in person before discharge
- Coordination with RT Supervisor daily COPD patient list for education
- Proactively collaborate with the Clinical Documentation and Coding Teams
- Communication to Pulmonary Clinic MAs when a new medication is started upon discharge and needs continued support
- 67% of all patients are seen in person in pulm clinic within 7 days of discharge
- **Next Steps:**
 - Increase bedside interview to 82%
 - TOC Pharmacy and RN to start daily huddles
 - Add COPD to Healing at Home



Currently averaging
15% Readmission Rate
for FY26

CMS Performance Period
7/2021 - 5/2024:
National Observed Readmission Rate 13.3%

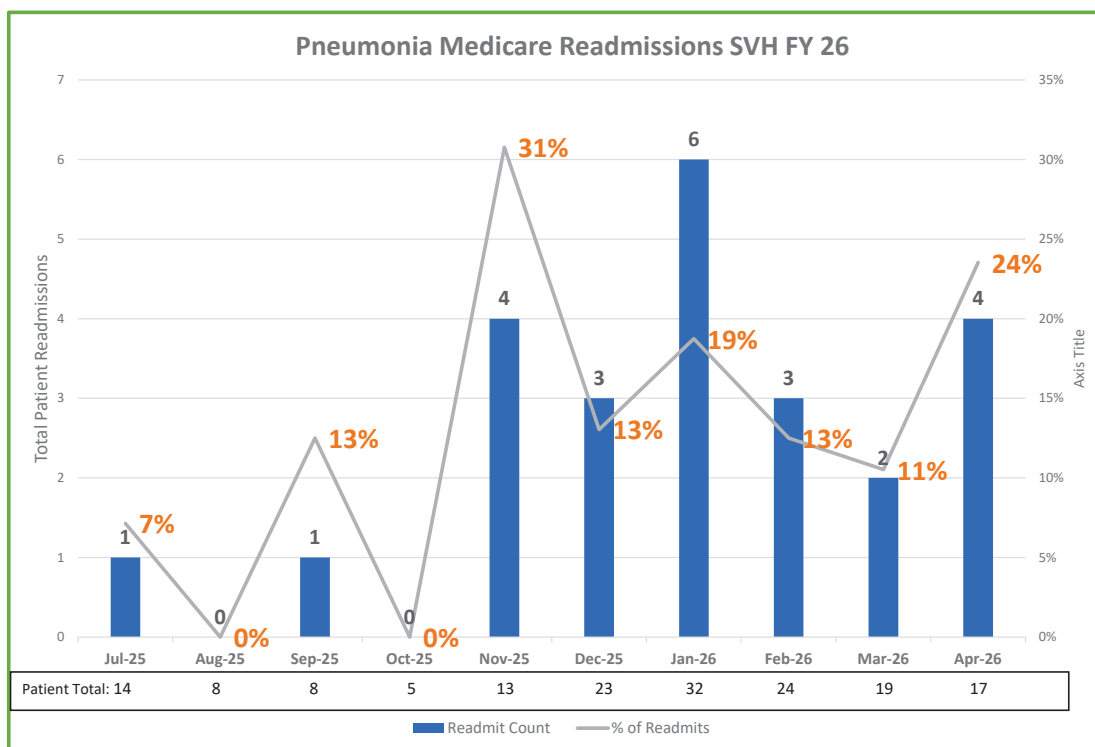
SVHMC Expected Readmission Rate 13.4%

SVHMC Readmission Rate 14.2%

AMI

Interventions:

- Bedside Interviews to support discharge
 - 58% of all patients interviewed in person before discharge
- Given an AMI education booklet, additional support from Chest Pain Navigator
- Utilize GDMT
- If referred to Cardiac Rehab, TCM will confirm and coordinate
- Goal: Replace fear driven ED visits with reassurance and triage. Do they have the knowledge to understand the difference between MI vs. fear/stress.
- **Next Steps:**
 - Increase bedside interview to 65%
 - Review scheduled procedures with surgeon



Currently averaging 13% Readmission Rate for FY26

CMS Performance Period 7/2021 - 5/2024:
 National Observed Readmission Rate 16.0%
 SVHMC Expected rate 15.3%
 SVHMC Readmission Rate 16.3%

Pneumonia

Interventions:

- Bedside Interviews to support discharge
 - 52% of all patients are interviewed in person before discharge
 - Provide Incentive Spirometers reinforce deep breathing exercises
 - Effective secretion clearance techniques and recognition of sputum changes
- Coordinate with RT if they have a comorbidity of COPD for additional education
- Provided a Zones Chart for understanding when to escalate care
- Meetings with Dr. Singh, Clinical Documentation and Coding teams for case review
- **Next Steps:**
 - Increase bedside interviews to 60%
 - Add COPD to Healing at Home

Next Steps

- Continue Monthly readmission case reviews to find patterns
- Educate and support clinic population health team
- Expand Healing at Home program (COPD, HF)
- Expand patient education prior to discharge
- Enhance After Visit Summary information
- Collaborate with Case Management to address SDOH
- Improve SNF collaboration
- Improve TOC Epic Dashboard

CLOSED SESSION

*(Report on Items to be
Discussed in Closed Session)*

*RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION*

(Meeting Chair)

ADJOURNMENT