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/.)

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 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 HEALTH[1]

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

[1]Salinas 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 HEALTH[1]
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.

[1]Salinas 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 Survery 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

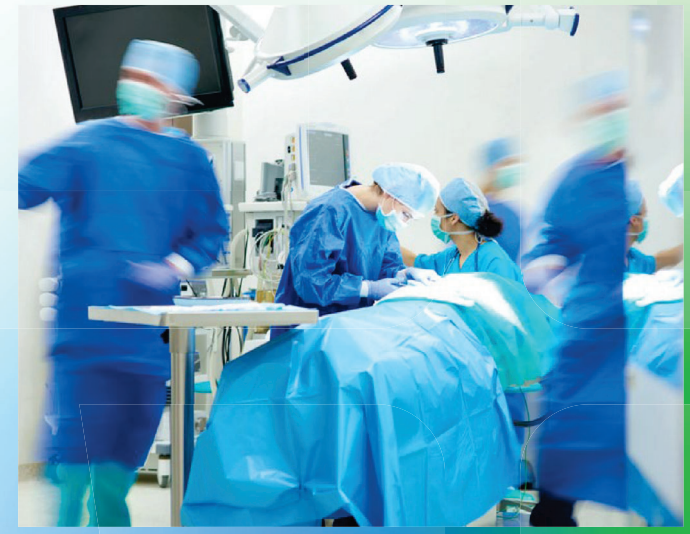
Advisor: Leslie Hawthorne, BSN, RN, CNOR

- 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

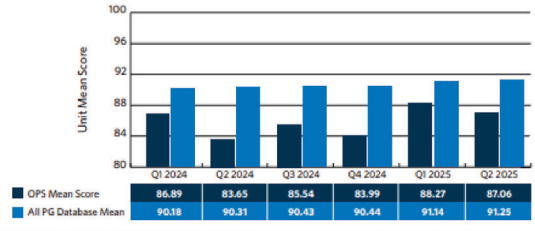
INTERVENTION:

- 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

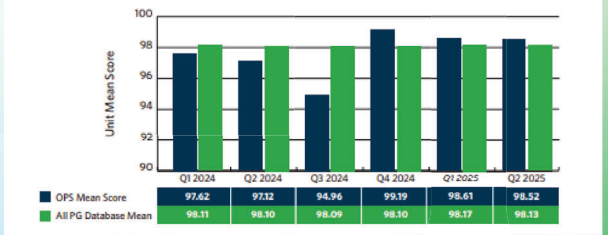
Patient Experience Survey Question:
Information provided about delays (if you experienced delays)
OPS



	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
OPS Mean Score	86.89	83.65	85.54	83.99	88.27	87.06
All PG Database Mean	90.18	90.31	90.43	90.44	91.14	91.25

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

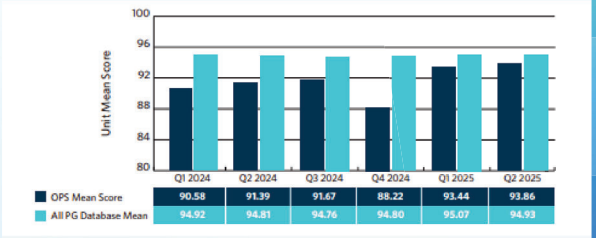
Patient Experience Survey Question:
Did the doctors and nurses treat you with courtesy and respect
OPS



	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
OPS Mean Score	97.62	97.12	94.96	99.19	98.61	98.52
All PG Database Mean	98.11	98.10	98.09	98.10	98.17	98.13

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

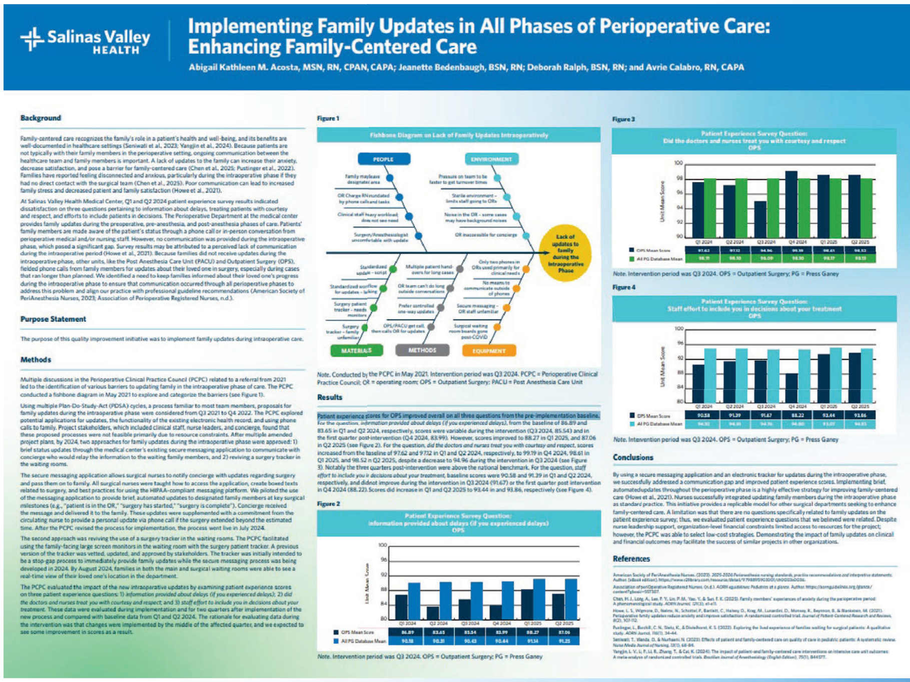
Patient Experience Survey Question:
Staff effort to include you in decisions about your treatment
OPS

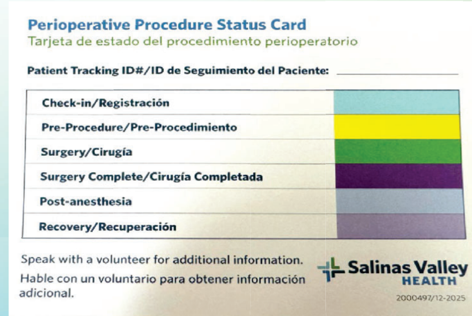


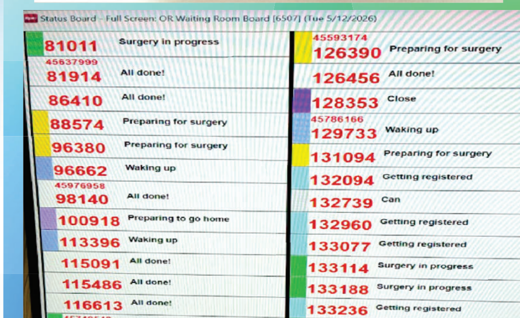
	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025
OPS Mean Score	90.58	91.39	91.67	88.22	93.44	93.86
All PG Database Mean	94.92	94.81	94.76	94.80	95.07	94.93

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

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







CARE FOR THE NEURO DIVERSE PATIENTS:

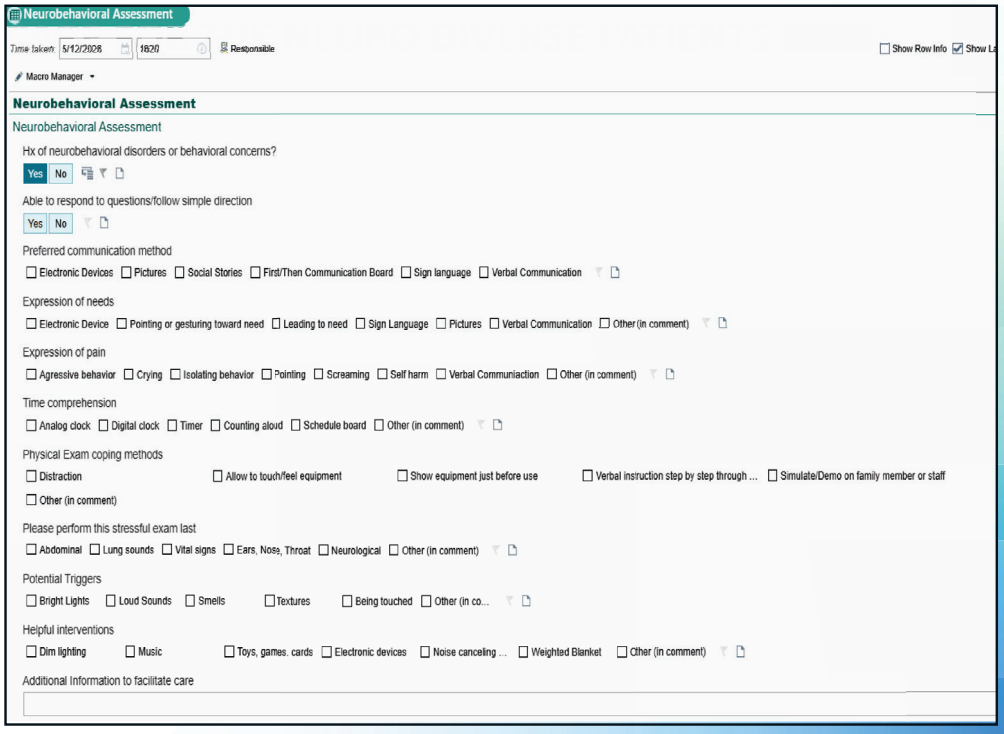
BACKGROUND:

- 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



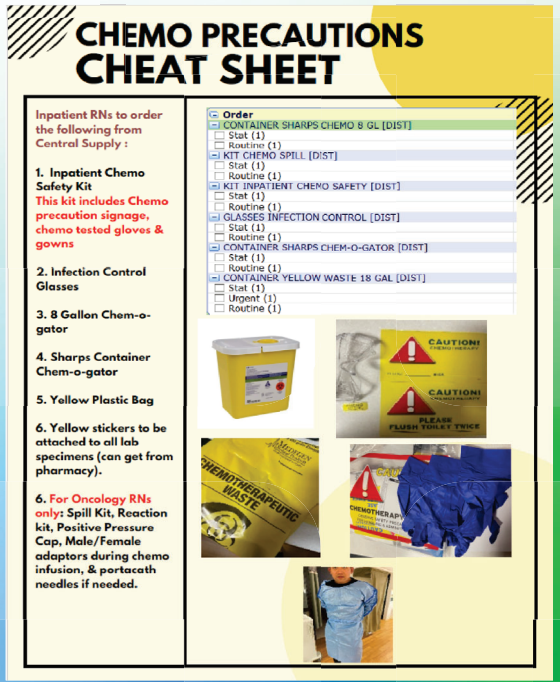
ENHANCING SAFETY FOR THE CARE OF THE PATIENT OF CHEMOTHERAPEUTICS:

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



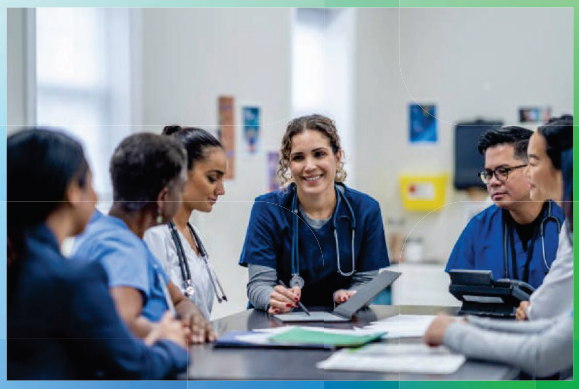
Initiatives - *In-Progress*:

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

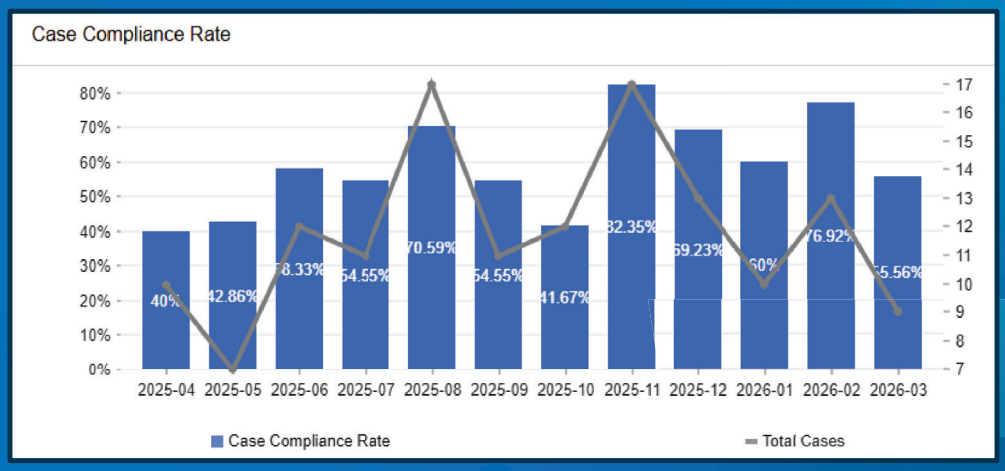
Report to QIC

Salinas Valley HEALTH

David Thompson
Director, Emergency

Date: 5/2026

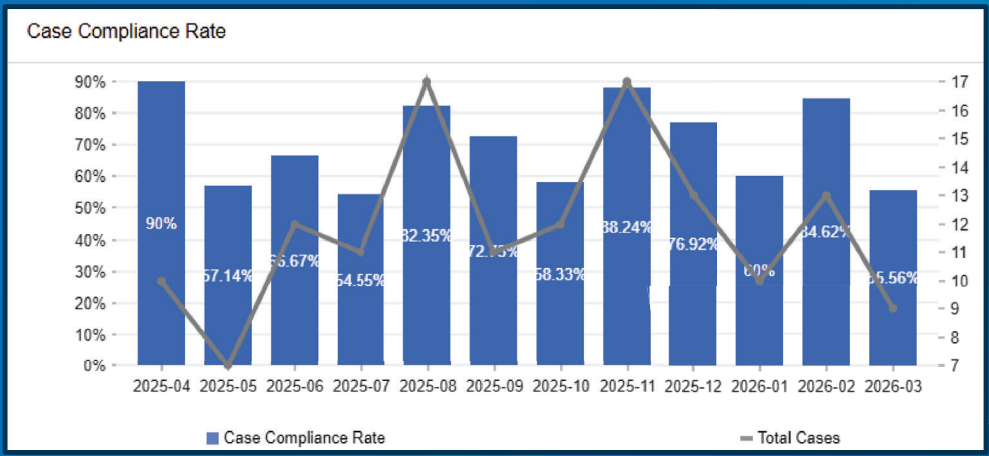
Data: 3 Hour Bundle Compliance



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	Σ 87	Σ 55	{} 61.27%

Salinas Valley HEALTH

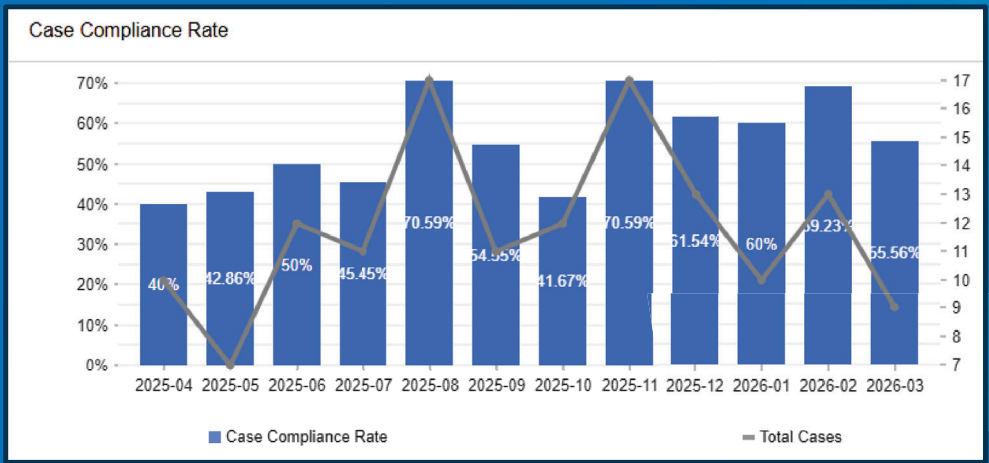
Data: Crystalloid Fluid Administration



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%

Salinas Valley HEALTH

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 142	Σ 81	Σ 61	{} 57.04%

Salinas Valley HEALTH

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 %**

Salinas Valley HEALTH

Blood Cultures – Adult

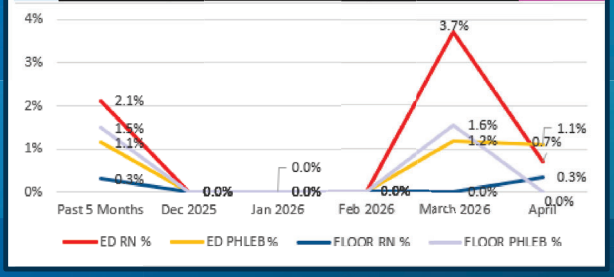
Salinas Valley HEALTH

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.

ADULT	Past 5 Months	Dec 2025	Jan 2026	Feb 2026	March 2026	April
OVERALL	1.3%	#####	#####	#####	1.6%	0.9%
ED RN	2.1%	#####	#####	#####	3.7%	0.7%
ED PHLEB	1.1%	#####	#####	#####	1.2%	1.1%
FLOOR RN	0.3%	#####	#####	#####	0.0%	0.3%
FLOOR PHLEB	1.5%	#####	#####	#####	1.6%	0.0%
Target	3%	3%	3%	3%	3%	3%



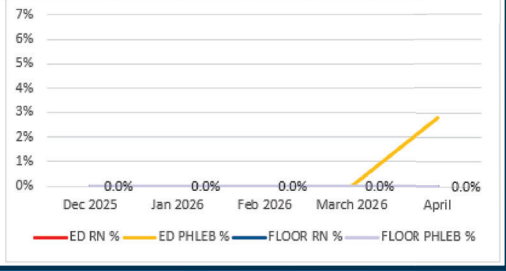
Salinas Valley HEALTH

Blood Cultures – Pediatric

Salinas Valley HEALTH 2026 April Blood Culture Statistics

2. **Pediatric Contamination:** **Overall** **April** **1.69%**
   a. "Pediatric" age range is <=17 years of age.

PEDIATRIC	Past 5 Months	Dec 2025	Jan 2026	Feb 2026	March 2026	April
OVERALL	1.7%	#####	#####	#####	#####	1.7%
ED RN	0.0%	#####	#####	#####	#####	0.0%
ED PHLEB	2.8%	#####	#####	#####	#####	2.8%
FLOOR RN	0.0%	#####	#####	#####	#####	0.0%
FLOOR PHLEB	0.0%	#####	#####	#####	#####	0.0%
Target	3%	3%	3%	3%	3%	3%



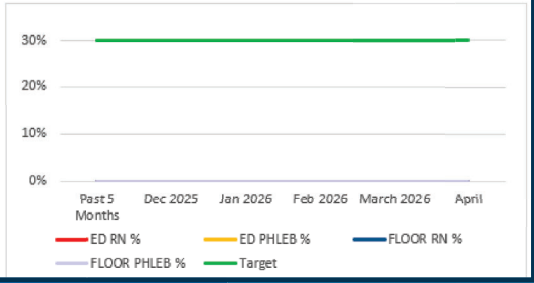
Salinas Valley HEALTH

Blood Cultures – Underfilled Bottles

Salinas Valley HEALTH 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.

	Past 5 Months	Dec 2025	Jan 2026	Feb 2026	March 2026	April
OVERALL	#####	#####	27.9%	30.5%	29.8%	27.6%
ED RN	#####	#####	#####	#####	#DIV/0!	#DIV/0!
ED PHLEB	#####	#####	#####	#####	#DIV/0!	#DIV/0!
FLOOR RN	#####	#####	#####	#####	#DIV/0!	#DIV/0!
FLOOR PHLEB	#####	#####	#####	#####	#DIV/0!	#DIV/0!
Target	30%	30%	30%	30%	30%	30%



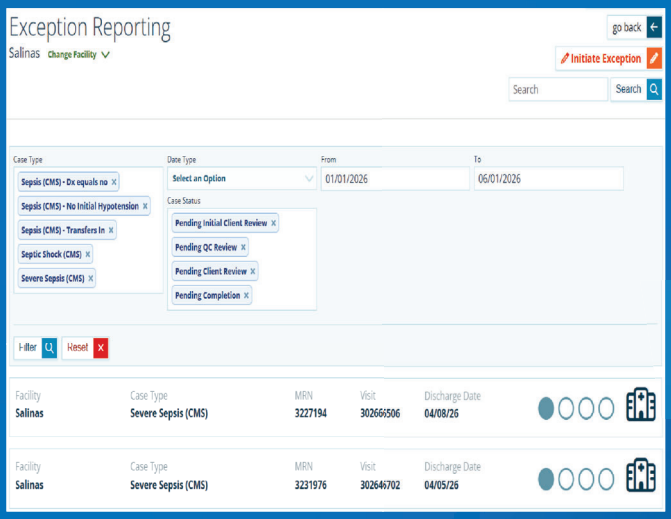
Salinas Valley HEALTH

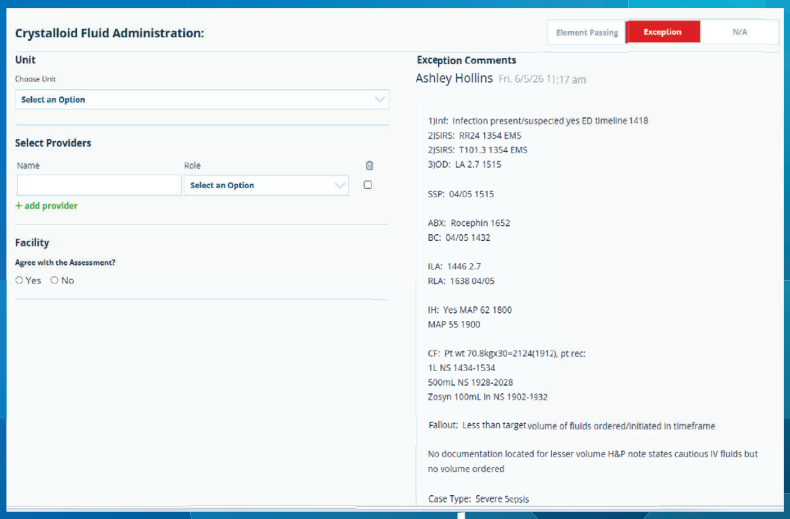
Next Steps

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

Salinas Valley HEALTH

Qapp Fallouts Review





Salinas Valley HEALTH

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,

Salinas Valley HEALTH

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.


SICOT-J OPEN ACCESS

EDITORIAL • SICOT J. 2023 Oct 11;9:E1. doi: 10.1051/sicotj/2023030

Enhanced recovery after surgery (ERAS) protocols for total joint replacement surgery

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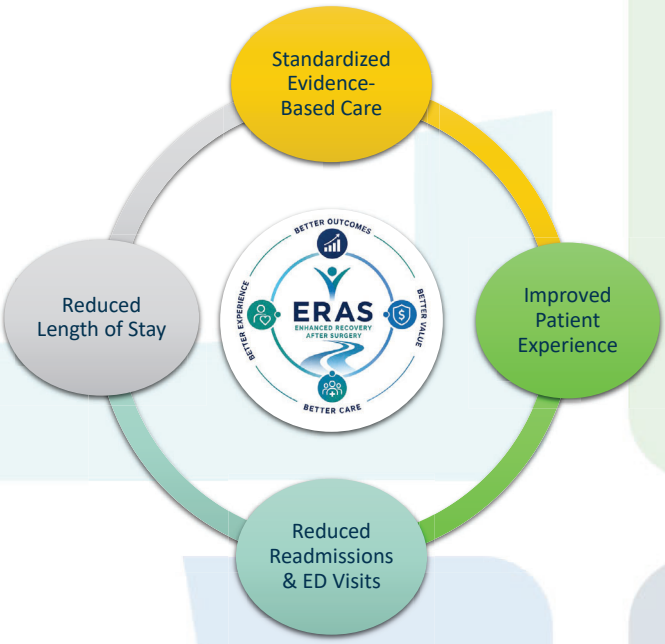
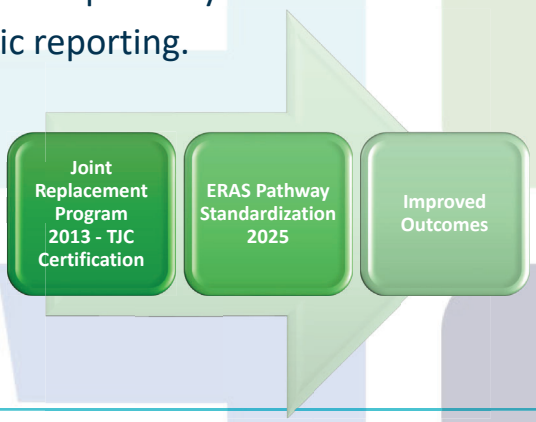


https://pmc.ncbi.nlm.nih.gov/articles/PMC10566339/

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:

Pre-Op	Intra-Op	Post-Op
❑ Optimization ❑ Smoking cessation protocol ❑ BMI & A1C criteria ❑ Normothermia ❑ Hydration	❑ Multi-modal analgesia ❑ Fluid management ❑ Pharmacy developed antibiotic protocol guides	❑ Oral pain meds in PACU ❑ PACU—routine bolus for hips unless HF, prn LR bolus for BP<110 ❑ Floor—continue maintenance IV, LR 500cc bolus for BP <110

What are we measuring?

- ERAS Metrics Dashboard

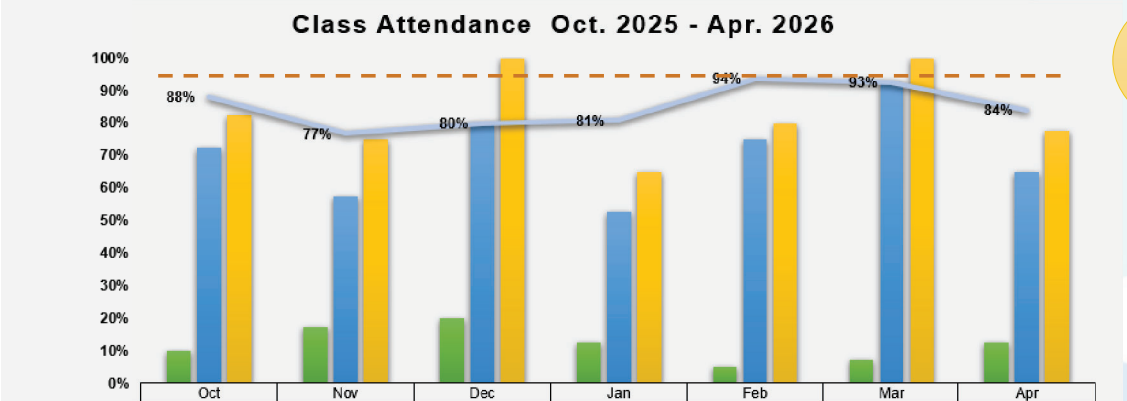
Complete
In Progress

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

Pre-Op
Intra-Op
Post-Op

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.



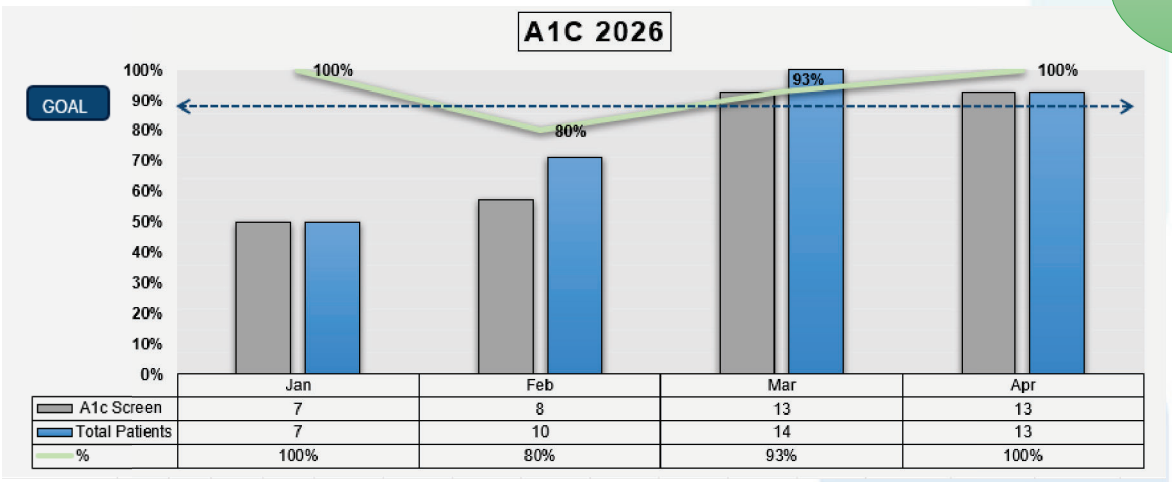
	Oct	Nov	Dec	Jan	Feb	Mar	Apr
No	4	7	8	5	2	3	5
Yes	29	23	32	21	30	37	26
Total Cases	33	30	40	26	32	40	31
%	88%	77%	80%	81%	94%	93%	84%

Target 95%

A1C Compliance

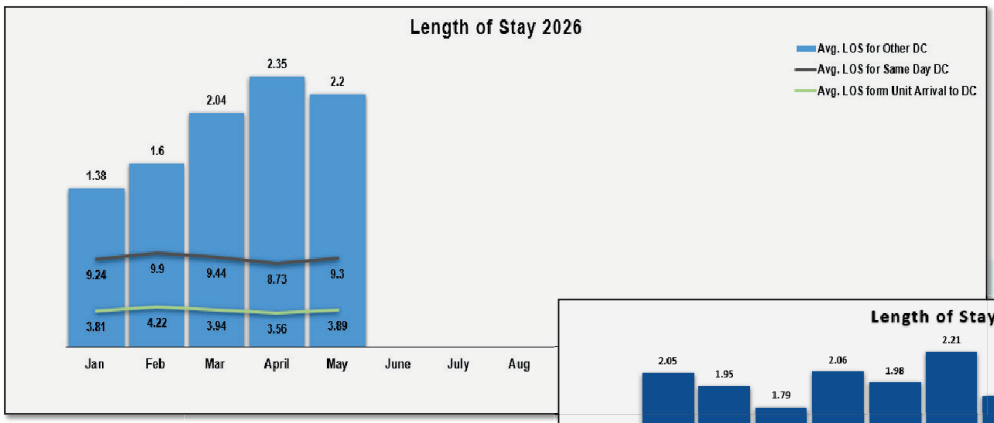
- Diabetic/Pre-Diabetic patients with A1C drawn 90 days prior to surgery.

Target 90%



	Jan	Feb	Mar	Apr
A1c Screen	7	8	13	13
Total Patients	7	10	14	13
%	100%	80%	93%	100%

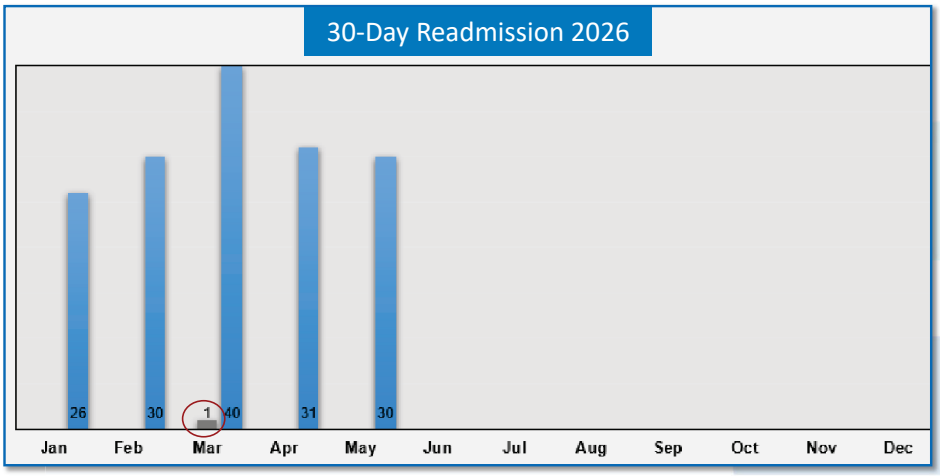
Length of Stay



Target <4 Hrs.

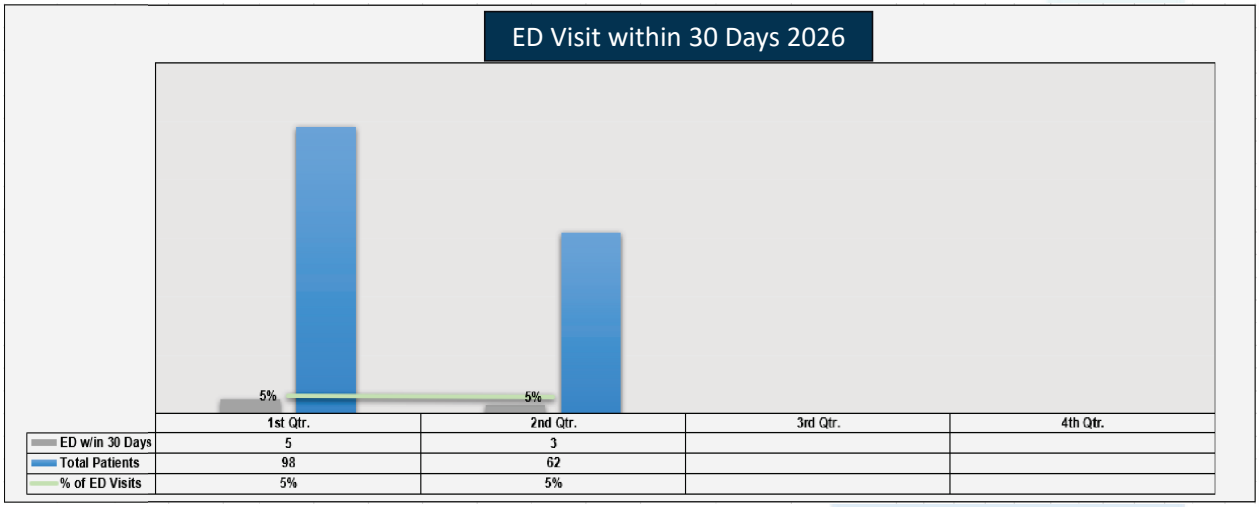
30-Day Readmission Rate

- 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	R knee effusion	Hip pain, no DVT
			Vomiting; diarrhea	Blisters to incision	
			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	

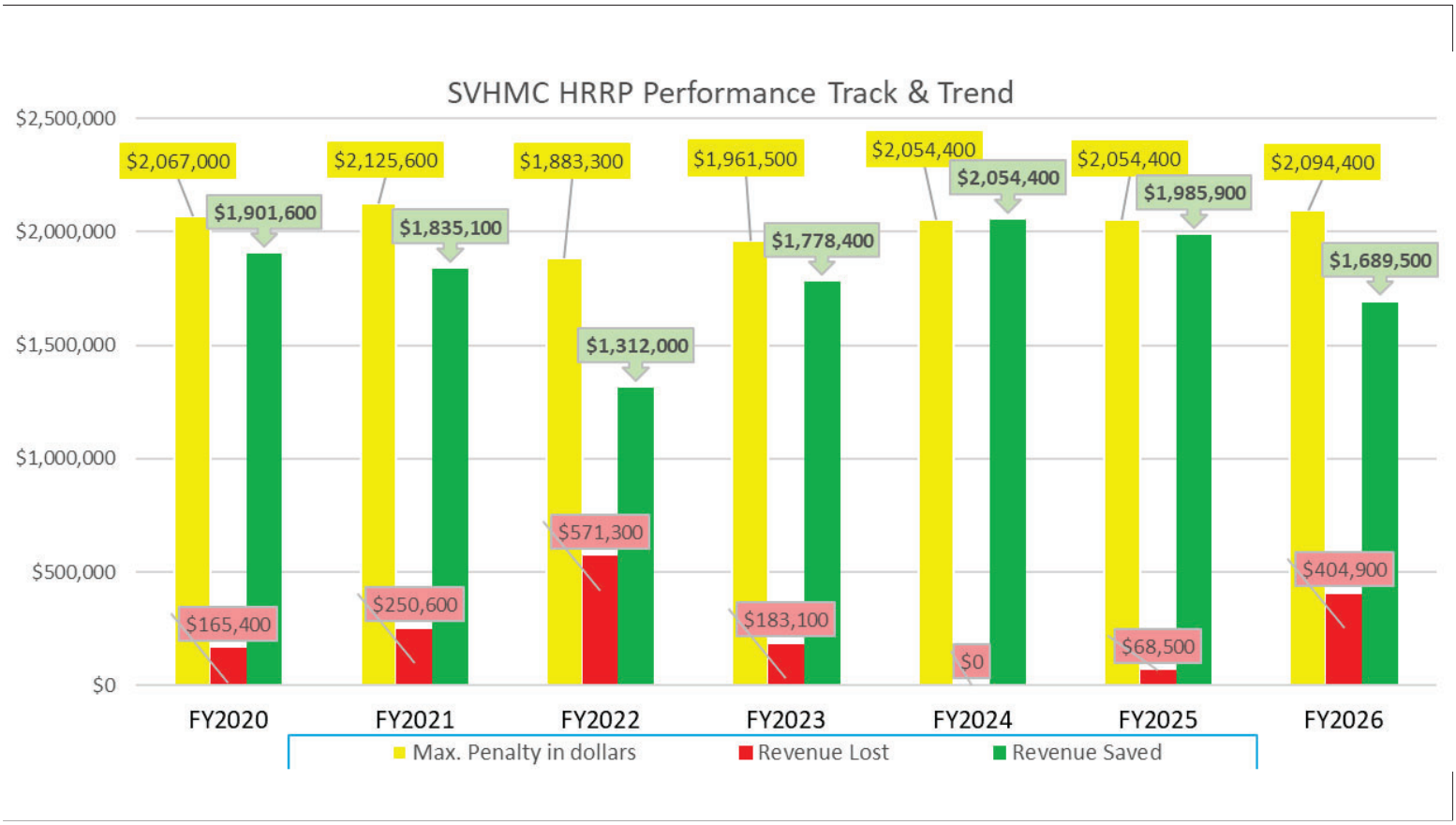
Patient Cohorts	
1. Age	Aged 65 or older.
2. Principal diagnosis	discharge diagnosis of AMI, HF, Pneumonia, or COPD
3. Principal Procedure	Isolated CABG or THA/TKA
4. Payer Enrollment Conditions	Enrolled in Medicare FFS and/or Medicare Advantage for the 12 months prior to the date of admission; and enrolled 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.

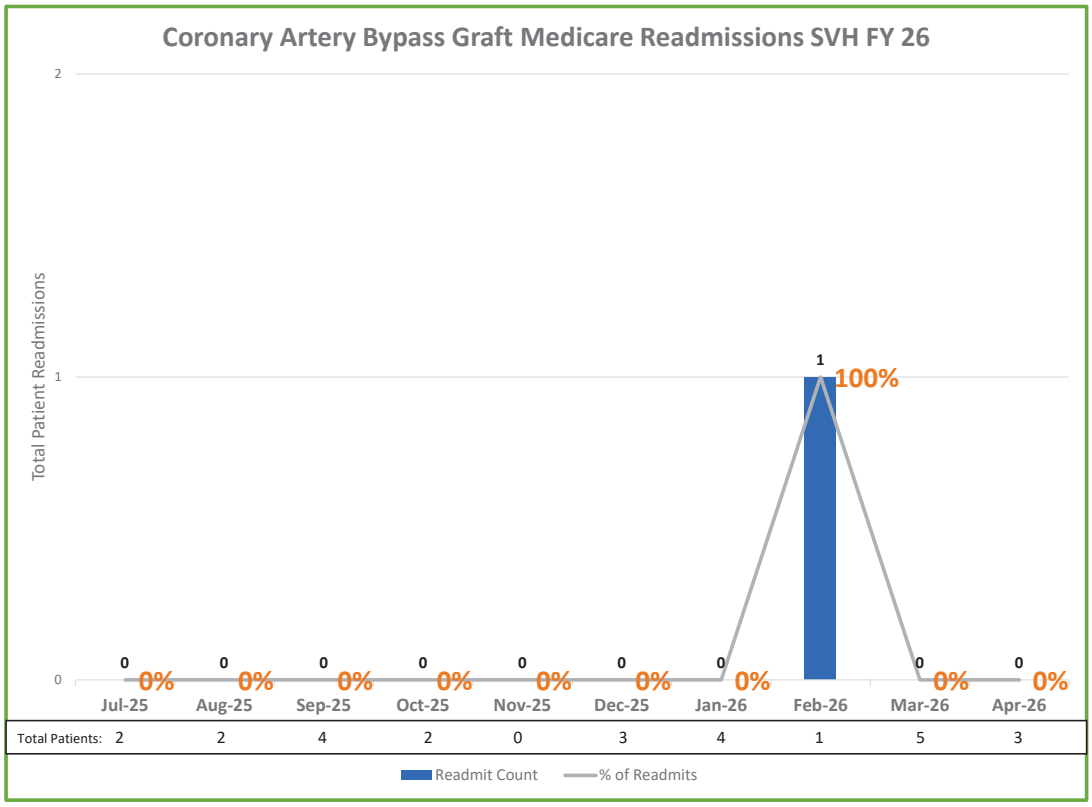
Variables	Condition Specific Revenue	Performance
▪ AMI Excess Revenue	$7,069,200	$126,800
▪ HF Excess Revenue	$10,260,000	$155,700
▪ PN Excess Revenue	$7,677,500	$122,400
▪ COPD Excess Revenue	$2,226,100	$0
▪ THA/TKA Excess Revenue	$206,300	$0
▪ CABG Excess Revenue	$6,703,200	$0
▪ Total Condition-specific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



Transitional Care Department

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



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 %

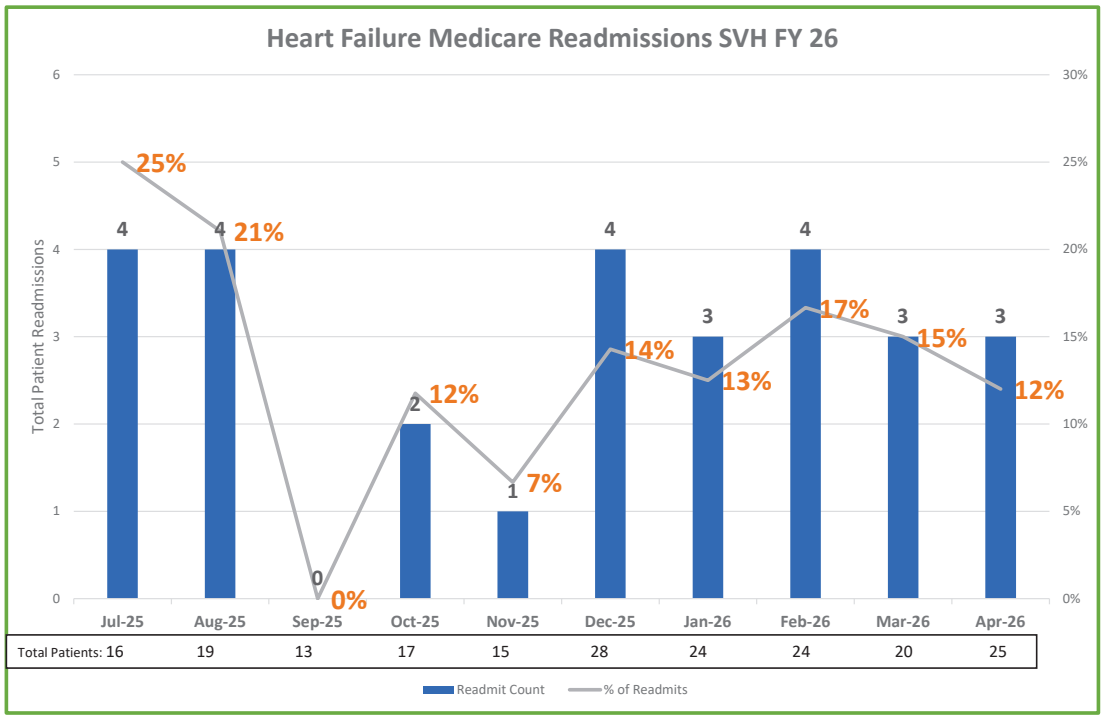
SVHMC Readmission Rate 10.5%

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%

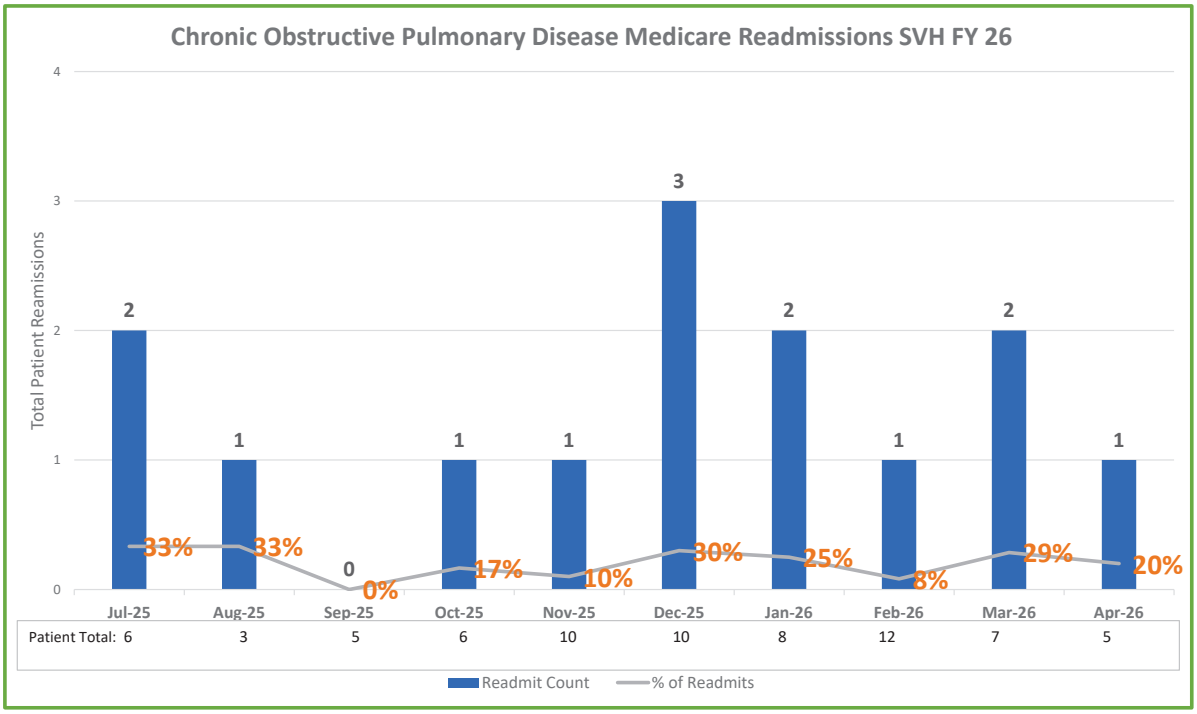
SVHMC Readmission Rate 20.2%

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%

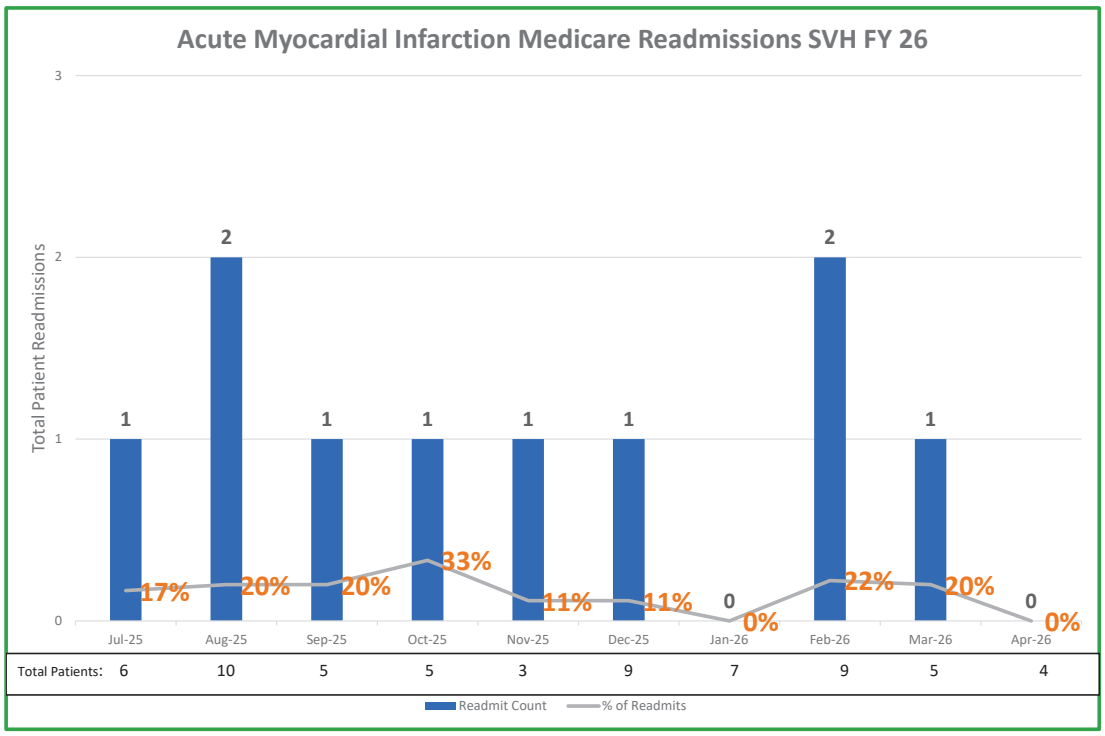
SVHMC Expected rate 17.6%

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%

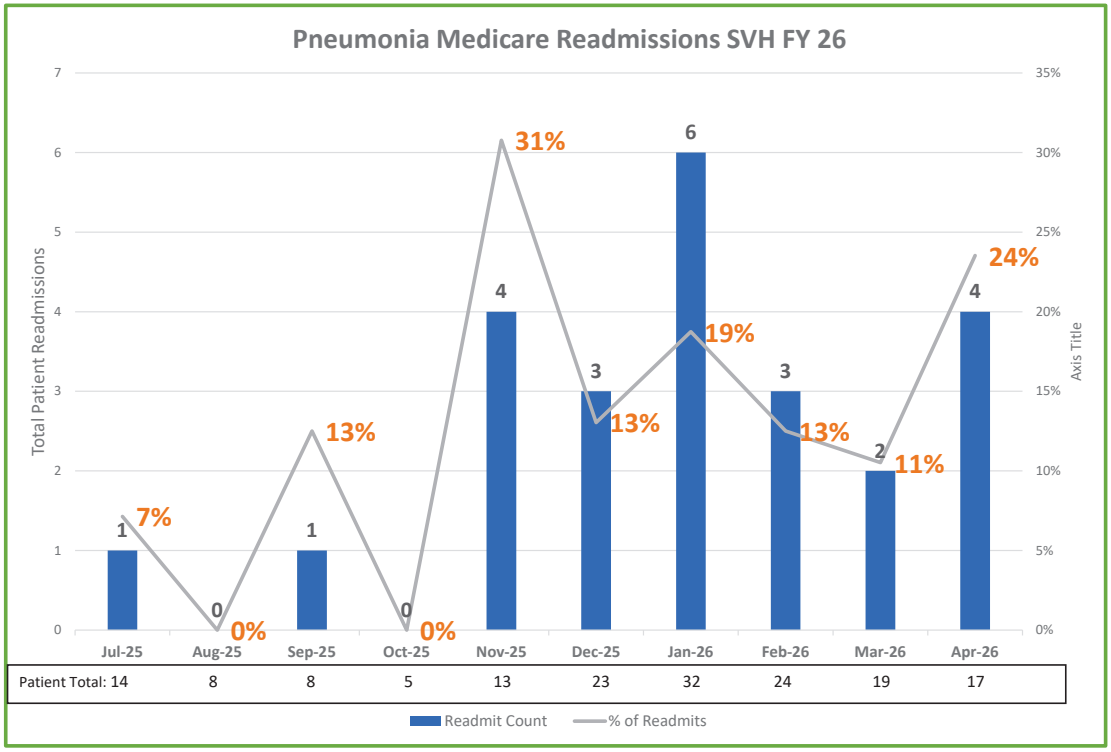
SVHMC Expected Readmission Rate 13.4%

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