August 13, 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, AUGUST 17, 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, AUGUST 17, 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 July 13, 2026. (CARSON)

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

4. Patient Care Services Update (SPENCER)
   - Report from Collaborative Care Practice Council (YATES)

5. Performance Improvement Reports
   - Pharmacy Update (delos SANTOS)
   - Total Joint Replacement Program (GOTTFRIED)
   - Bariatric Program (ZESATI)

6. Age Friendly Program Update (GROOTERS)

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

7. Consider Recommendation for Board Approval of the Quality Assessment and Performance Improvement Plan (QAPI) (SPENCER)

    - Staff Report
    - Committee Questions to Staff
    - Public Comment
    - Committee Discussion/Deliberation
    - Motion/Second
    - Action by Committee/Roll Call Vote

8. Closed Session

9. Reconvene Open Session/Report on Closed Session

10. Adjournment

    The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **September 14, 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 JULY 13, 2026

Committee Member Attendance:

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

Voting Members Absent: None

Advisory Non-Voting Members Present:
In Person: Allen Radner, M.D., President/CEO, Tim Albert, M.D., CCO, Alysha Hyland, CAO, Rakesh Singh, M.D., VPMSA, Iftikhar Hussain, CFO, Gary Ray, CLO, Cheryl Pirozzoli, Family/ Patient Advisor
Via Teleconference: Michelle Childs, CHRO, Orlando Rodriguez, MD, CMO

Other Board Members Present, Constituting Committee of the Whole:
Via Teleconference: Victor Rey

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 THE AMENDED MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF JUNE 15, 2026

Approve the amended minutes of the June 15, 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 Member Spencer, second by Vice Chair Cabrera, the minutes of the June 15, 2026 Quality and Efficient Practices Committee Meeting are approved as presented.

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

Motion Carried.

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

4. PATIENT CARE SERVICES UPDATE: REPORT FROM THE CRITICAL CARE UNIT PRACTICE COUNCIL

Carla Spencer, CNO, introduced a member of her team to present an update on the Perioperative Clinical Practice Council. David Martin, BSN, RN, PCCN, gave an overview of the council's purpose. Three topics were presented CNA Handover Tool, Increase Certification Rate, and What's Ahead (which highlighted their top three goals).

COMMITTEE MEMBER DISCUSSION: Dr. Albert commended the use of objective goals with defined measures and asked what is required to obtain PCCN certification.

5. QUALITY AND SAFETY:

- **Contract Performance Evaluations**: Timothy Albert, M.D., Chief Clinical Officier, provided an overview of the purpose, required standard, annual evaluation process, and board oversight. He noted that annual performance evaluations have been completed for 102 active contracts and those are reflected in the board minutes. He highlighted that one contract with Vesta Solutions has been continuously monitored since 2023 for turnaround time performance and service quality concerns. A request for proposal (RFP) process is planned for mid-July 2026 to evaluate long-term teleradiology partners following stabilization of the Epic implementation.
- **Complaints and Grievances**: Cynthia Vargas, BS CPXP, Patient Experience Manager, provided an overview of the WeCare Data, Lost Belongings, and Interventions. She presented charts providing historical data trends across various categories. In the intervention section of her presentation, she highlighted the Volunteer Ambassador Program and reviewed data related to volunteer rounding with patients aged 65 and older.
- **Emergency Department**: David Thompson, BSN, RN, Director of Emergency Services, presented the Emergency Department Report and provided an overview of Quality & Safety Goals. He reviewed performance data, including left without being seen (LWBS) rates, median outpatient length of stay, median admit order-to-departure times, and door-to-EKG times. He also presented blood culture contamination rate data and highlighted opportunities for improvement.
- **Risk Management Plan**: Don Rodriguez, MSN, RN, NPD-BC, Interim Risk Manager, gave an overview of Risk Management, including the purpose of the Risk Management Plan, associated regulations, review and approval process, key focus areas, and opportunity domains. Dr. Albert noted that Don Rodriguez has been instrumental in the Hospital's Root Cause Analysis (RCA) program and that his clinical knowledge is highly valuable.
    - Vice Chair Cabrera made a motion to bring the Risk Management Plan to the board for approval and Dr. Gerber seconded.

Full reports were included in the packet.

COMMITTEE MEMBER DISCUSSION: Vice Chair Cabrera, M.D., discussed concerns related to the Contracts Performance Evaluation presentation, noting issues with receiving scans from the receptionist and how that places undue pressure on staff to provide information that is not readily available.

Regarding the WeCare Data presentation, Dr. Radner recommended revising the graph to reflect a more specific data range. During discussion of the Complaints and Grievances presentation, Committee Member Carla Spencer noted that the Volunteer Program was specifically designed to support patients aged 65 and older.

During discussion of the Emergency Department presentation, Dr. Radner acknowledged the department's success in discharging patients while noting that high discharge volumes may create additional operational pressures for other departments.

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 9:28 a.m.

7. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:34 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 (SYED)

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, **August 17, 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: Collaborative Care Council

Monday, August 17, 2026

COLLABORATIVE CARE COUNCIL

COUNCIL LEADERSHIP:

- Chair: Pamela Yates, *RN, CPN*
- Co-Chair: Laurel Black, *MSN, RN, CCRN*
- Assoc. Co-Chair: Laurie Edelman, *BSN, RN, CCRN-CSC*

Advisor: Carla Spencer, MSN, RN, NEA-BA

COUNCIL MEMBERSHIP:

- Kirsten Wisner, PhD, RNC-OB,CNS, F-EFM, NE-BC, Magnet Program Director
- Rebecca Rodriguez, MSN,RN, CEN, CPHQ, Clinical Excellence Specialist
- Anna Paz Santos, BSN,RN, ONC (Practice Council)
- Norma Coyazo, MSN, RN, RNC-OB, C-EFM, (Practice Council)
- Megan Ackerman, BSN, RN (Quality Council)
- Kristen Green Meadows, BSN,RN, CCRN, CSC (Clinical Inquiry Council)
- Suzette Eliopoulos, RN (Clinical Inquiry Council)
- Mikhail Brown, MS, BSN, PCCN (Professional Development Council)

COUNCIL PURPOSE:

"The Collaborative Care Council has executive oversight for the professional governance structure at Salinas Valley Health. Its purpose is to promote professional nursing practice and excellent patient outcomes through the coordination, integration, and monitoring of the professional governance councils."

AREAS OF RESPONSIBILITY:

- Provide direction in setting council priorities
- Ensure action plans are in place for underperforming measures
- Review, update and revise the Professional Governance bylaws
- Maintain and revise the council structure
- Train, support, and recognize clinical nurse leaders
- Generate an annual report of Professional Governance work
- Drive strategic alignment with organizational goals and the nursing strategic plan

TOPICS:

- COUNCIL DAY
- PROFESSIONAL GOVERNANCE EDUCATION SESSIONS
- **WHAT'S AHEAD**

COUNCIL DAY PROJECT:

BACKGROUND:

Having designated and protected time for council work, regular attendance, clear guidelines for decision-making, and ample training for council members ensures that nurses can engage in decision-making, evaluate and implement practice changes, revise policies, and lead improvement initiatives

- Clinical nurses expressed challenges participating in multiple council meetings due to scheduling conflicts and clinical responsibilities. Nurses reported that competing schedules and multiple meeting days, including attendance on scheduled days off, affected work-life balance

  - ❑ **PROTECTS BEDSIDE CARE CAPACITY**: Consolidating meetings into a single, predictable day eliminates the constant friction between clinical scheduling and governance duties, ensuring optimal nurse staffing at the bedside

  - ❑ **MITIGATES FIDUCIARY AND TURNOVER RISKS**: Eliminating fragmented meeting dates stops incremental overtime spending and prevents the staff burnout that directly drives expensive nursing turnover

  - ❑ **ACCELERATES CLINICAL QUALITY OUTPUT**: A single, synchronized Council Day removes communication silos, drastically reducing the turnaround time required to pass, implement, and reassess council projects

COUNCIL DAY PROJECT *Cont.*:

INTERVENTION:

To determine the feasibility, Project leads conducted a review of all council member schedules to identify potential meeting days that minimized unit-level disruption. Following identification of the optimal day, feedback was sought from all councils to assess anticipated benefits and challenges of the proposed structure. Extensive collaboration between Critical Care Council, CNO, and leadership to coordinate logistics and secure meeting spaces on one single day each month

OUTCOME/DATA:

A designated monthly council day, during which all councils meet and nurses attend consecutive meetings, has been used to improve attendance, support protected meeting time, and coordinate shared governance activities

The Survey: A 12-question survey was given to all professional governance members (29 nurses responded)
A follow-up survey planned one year after implementation

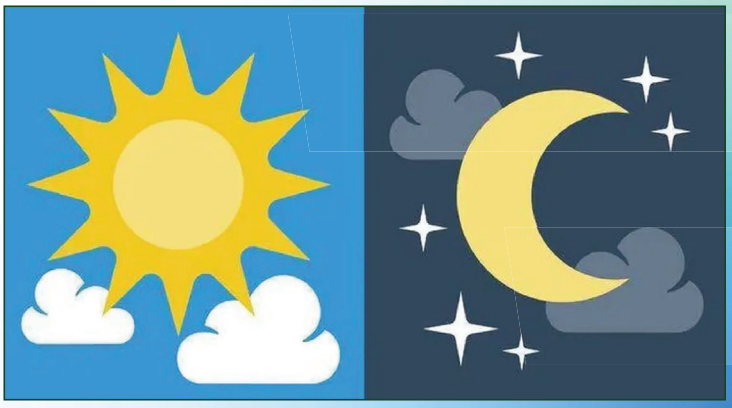
Findings suggest that Council Day improved collaboration, communication, meeting efficiency, and reduced meeting fatigue:

- 78.6% of respondents rated their overall Council Day experience as favorable (excellent or good)
- 69.0% of respondents agreed or strongly agreed that Council Dy promoted collaboration among councils
- 64.3% of respondents agreed or strongly agreed that Council Day improved meeting efficiency and coordination
- 70.6% of respondents agreed or strongly agreed that Council Day reduced feelings of burnout and meeting fatigue

COUNCIL DAY PROJECT *Cont.*:

Night & Day:

- There were significant differences between day and night shift nurses in overall experience with council day, support for participation in professional governance activities, communication between councils, and protection of time off and work-life balance. No significant differences were found in engagement, council collaboration, meeting efficiency, or burnout and meeting fatigue



PROFESSIONAL GOVERNANCE EDUCATION SESSIONS:

BACKGROUND:

- Forum was needed to provide essential education to PG Members and nurse leaders

INTERVENTION:

- A dedicated education hour was added mid-day each Council Day, scheduled monthly
- Session Topics YTD:
  - ❑ Strategies for Nurse Engagement
  - ❑ Project Planning
  - ❑ Data Collection
  - ❑ Goal Setting
  - ❑ Quality and the WeCare reporting System
  - ❑ Project Tracker and Excel "Helpful Hints"
  - ❑ Clinical Practice Guidelines

OUTCOME:

- *We have an average of 67 members attend the monthly sessions since inception July 2025*

WHAT'S AHEAD:

Raising the Bar for Council's Annual Goal

BACKGROUND:

- Past Council goals were lacking structure and often didn't define measurable outcomes

INTERVENTION:

- CCC leadership met with each council individually to help develop measurable (SMART) annual goals

OUTCOME/DATA:

- *We met with 100% of PG Councils, and all 14 councils finalized SMART goals*
- *Each council will now be tracking measurable outcomes each year*
- *CCC will track safety culture scores, council leader vacancy rates, and QI and EBP competency scores*

WHAT'S AHEAD:

Annual Summary – CCC Yearly Project

BACKGROUND:

- The document is a compilation of council work from 2025
- It highlights each council's accomplishments and projects

INTERVENTION:

- The annual summary will be posted on STARnet (Professional Governance page)
- We have copies to share with you all today…

OUTCOME/DATA:

- *Each council tracks their own measures for each of their projects described in the annual summary*

Questions?

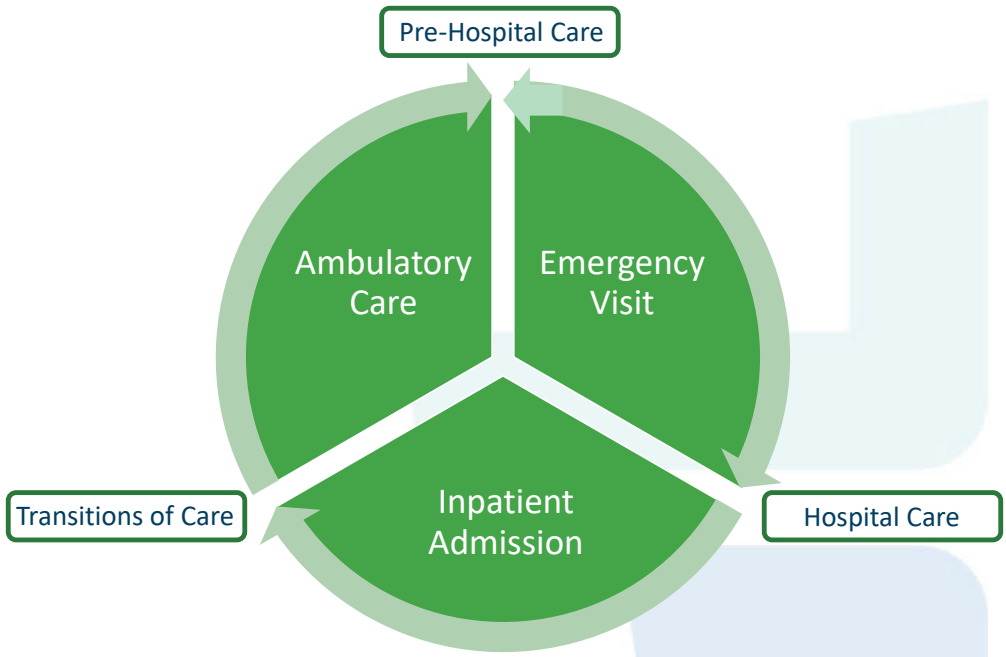
Pharmacy Department: Updates and Highlights

Genevieve delos Santos, Director of Pharmacy

Quality & Efficient Practices Committee

August 17, 2026

Patient Care Continuum at SVH



Patient Care Continuum at SVH

2019: Outpatient Infusion Center Pharmacy

Aug 2022: Retail Pharmacy

Dec 2025: Retail Pharmacy, 24-hours

Dec 2025: Pharmacotherapy Clinic

March 2026: Expand PTC Services

March 2026: Specialty Pharmacy

2020: Medication Reconciliation Pharmacy Techs

Oct 2024: ED Pharmacists

Aug 2025: Healing at Home (M2B)

Dec 2025: Meds to Beds (ED)

2020: TOC Pharmacist

April 2023: Meds to Beds (Inpatient)

June 2026: Silver designation – CDPH Antimicrobial Stewardship Honor Roll

***2026:** Pharmacy Practice Council

***2026:** VFC Program

- Leapfrog Safety Grade
- CMS Star Rating
- Inpatient – Recommend the Hospital
- Emergency Room – Likelihood of recommending
- Ambulatory – Recommend the Hospital
- Outpatient – Likelihood of recommending

- Operationalize Vaccinations for Children (VFC) via the Mobile Clinic
- Develop an aligned outreach program in coordination with community schools and establish school engagement

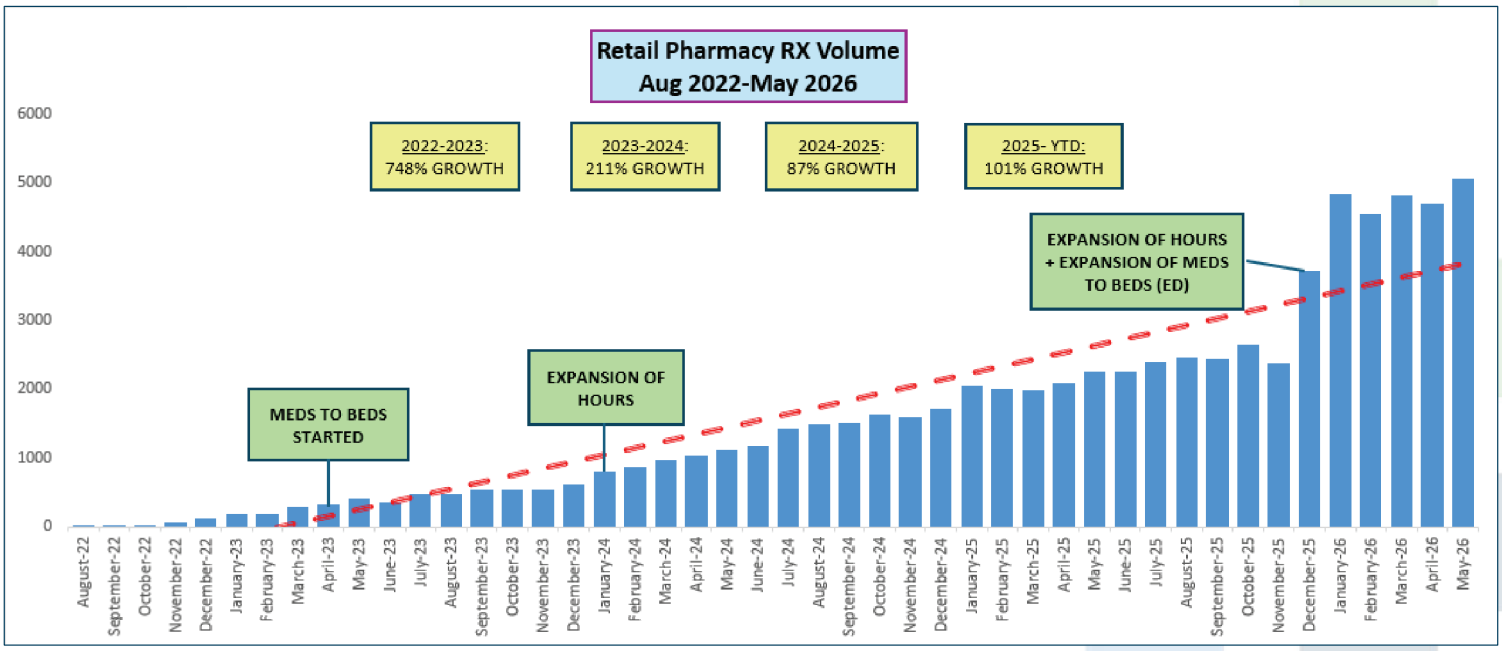
- Implementation of Pharmacotherapy Clinic
- Clinic expansion of service lines/ locations
- Salinas Valley Health Ventures

- Culture of safety, with a focus on prevention and reporting

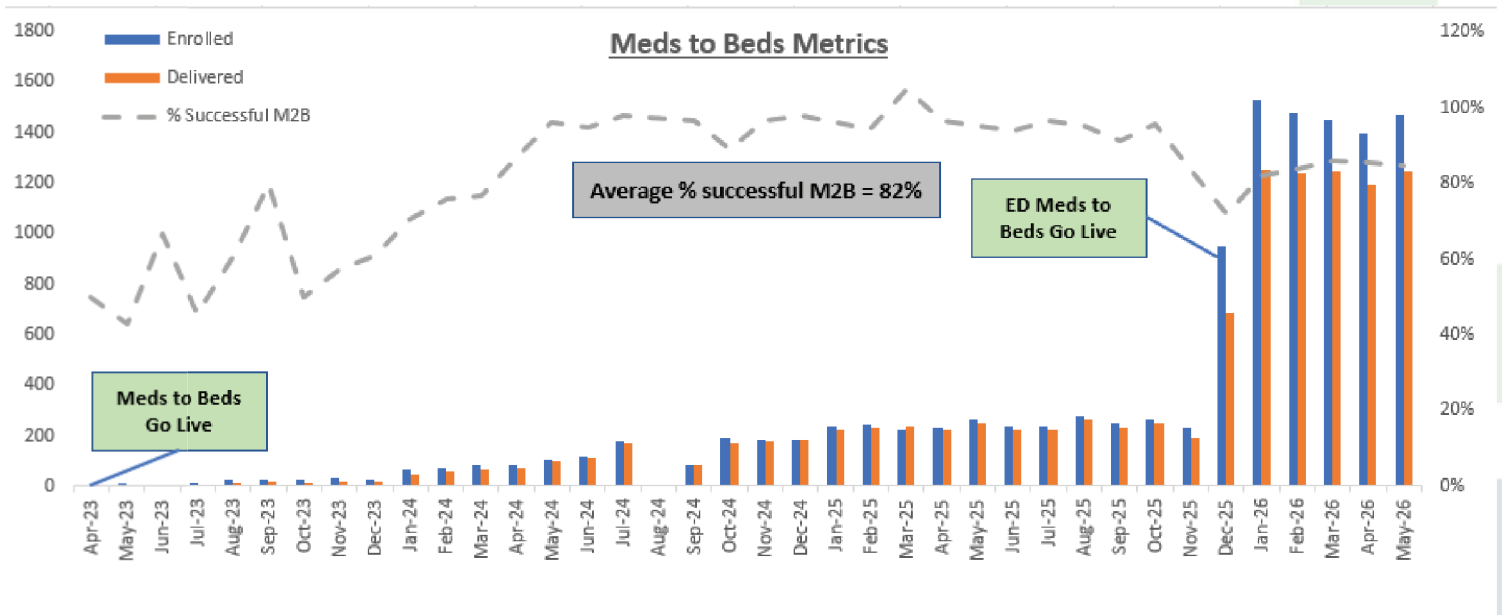
- Epic Implementation
- SVH Retail Pharmacy expansion of hours
- Increase Meds-to-Beds

- Achieve defined operating margin %

Goal: Expand SVH Retail Pharmacy Hours



Goal: Increase Meds to Beds



Goal: Implementation of Pharmacotherapy Clinic

Salinas Valley HEALTH

ABOUT US | EVENTS | FOUNDATION | FIND A PROVIDER | LOCATIONS | PATIENTS & VISITORS | SERVICES

SERVICES > PHARMACOTHERAPY SERVICES

PHARMACOTHERAPY SERVICES

Pharmacotherapy services are led by clinical ambulatory care pharmacy specialists (pharmacists) and focus on providing medication therapy management to achieve clinical goals of care (A1c, LDL, decreased admissions, etc.), patient medication education, and assistance with medication access.

Patients will continue to receive medical and disease management from their physician. A clinical pharmacy specialist may be added to the patient's care team to provide optimal medication support.

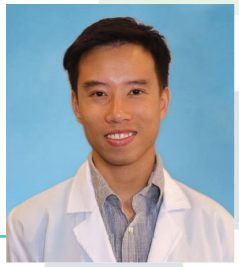
At Salinas Valley Health, we are committed to providing our patients with an experience of connected care and improved health outcomes.

We are excited to announce the launch of the Pharmacotherapy Services designed to support safe and effective medication management for our patients.

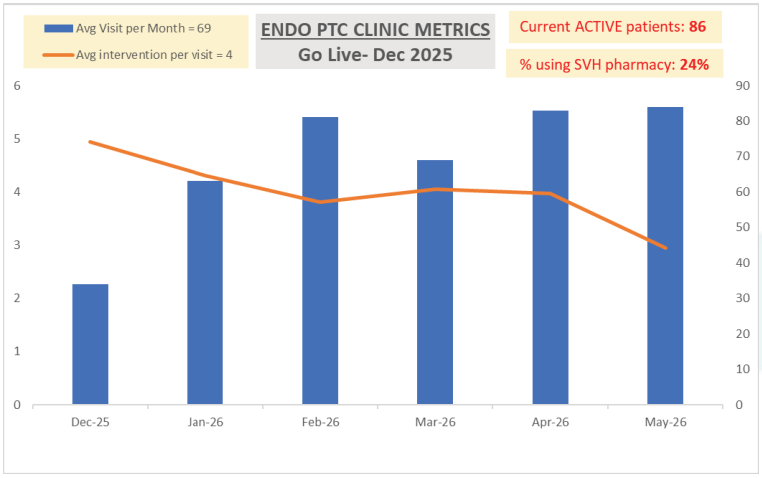
- Initial collaboration: Salinas Valley Health Diabetes and Endocrine Center, and the Lifestyle and Metabolic Program (LAMP).

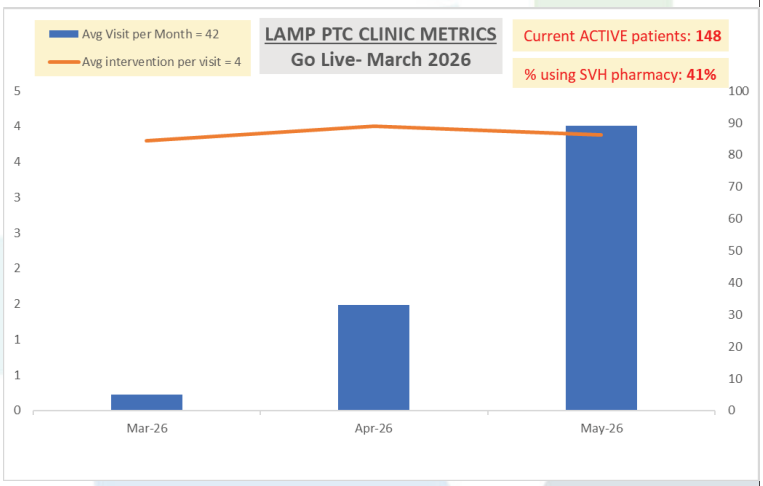
PHARMACOTHERAPY SERVICES

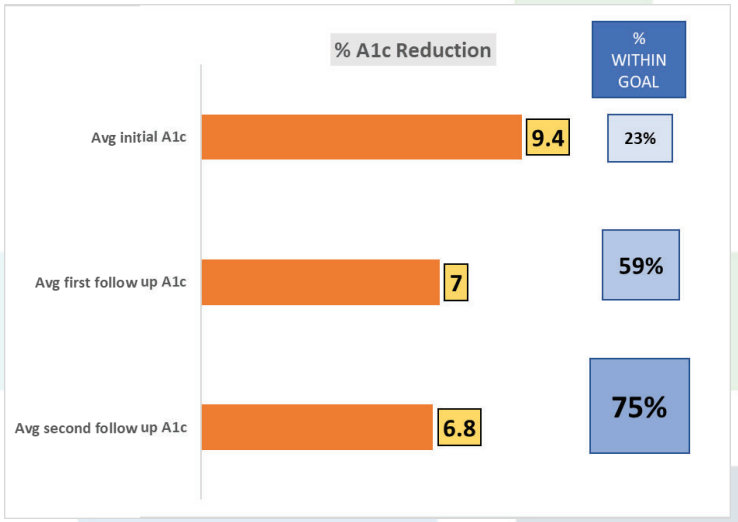
MEET YOUR CLINICAL PHARMACY SPECIALIST



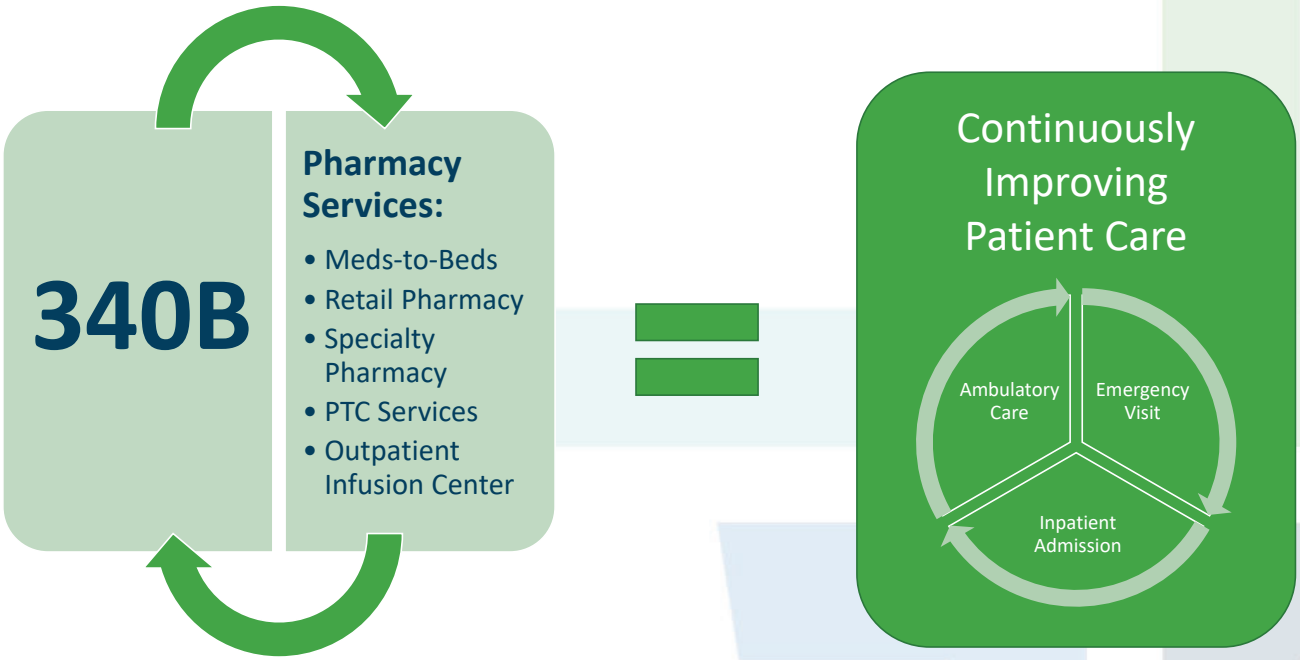
Pharmacotherapy Clinic Metrics







340B and the Patient Care Continuum at SVH



Total Joint Replacement Program

2026 Performance Improvement Plan

Lilia Meraz-Gottfried, MSN, RN, CMNL
Director Clinical Development
Disease Specific Care

August 17, 2026

Total Joint Replacement Program

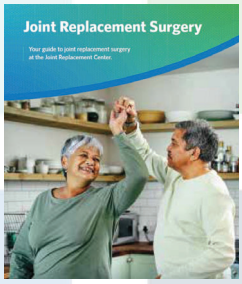
Joint Commission certified since **2013**

Program Purpose

- The purpose of the Disease-Specific Care **Hip and Knee Joint Replacement Program** is to provide the following:
  - Standardized evidence-based care
  - Improve patient outcomes and safety
  - Reduce complications and promote early mobilization
  - Promote multidisciplinary collaboration
- The structured program ensures patients receive coordinated, evidenced-based treatment throughout their joint replacement journey.

Multidisciplinary Team

- Orthopedic Surgeons
- Orthopedic Nurse Navigator
- Perioperative Nurses
- ONS Nurses
- Rehab Services
- Anesthesia
- Pharmacy



Performance Measures

- The Joint Commission requires tracking and reporting of 4 performance measures.
- The performance target is set at 90% for each goal.
- New performance improvement goals are suggested at each 2 year survey cycle.

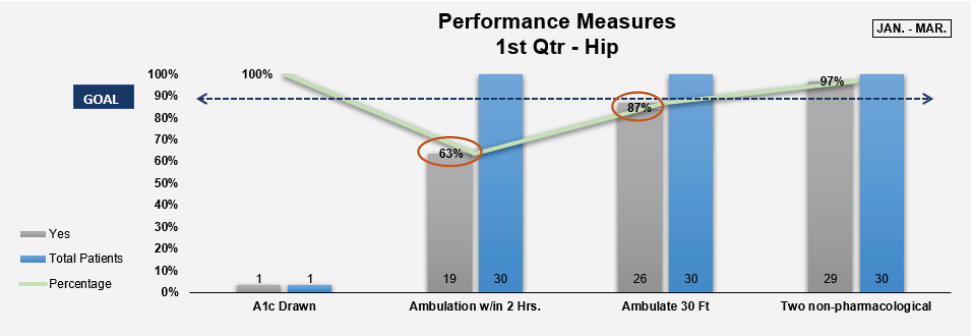
Ambulate 30 ft on day of surgery

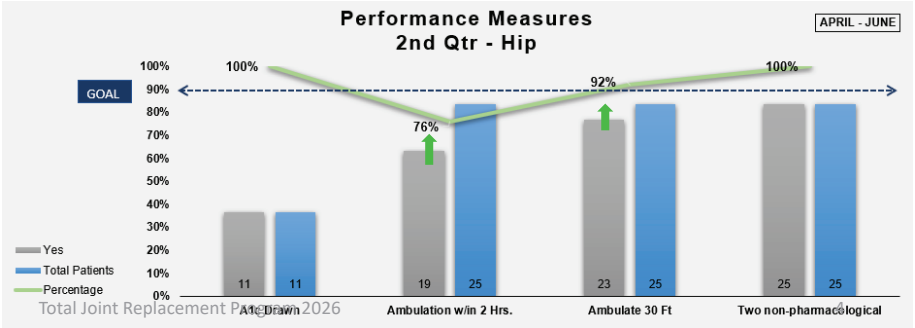
Ambulate within 2 hours of arrival to ONS

Hemoglobin A1C within 90 days of surgery for all pre-diabetic and diabetic patients

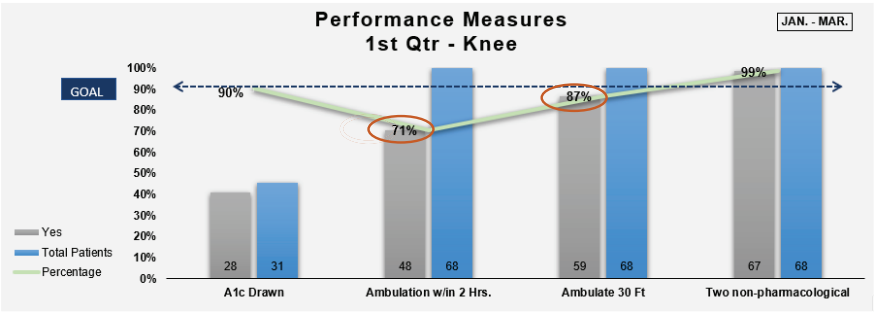
Non-pharmacological pain management (NPPM); patient states 2 measures

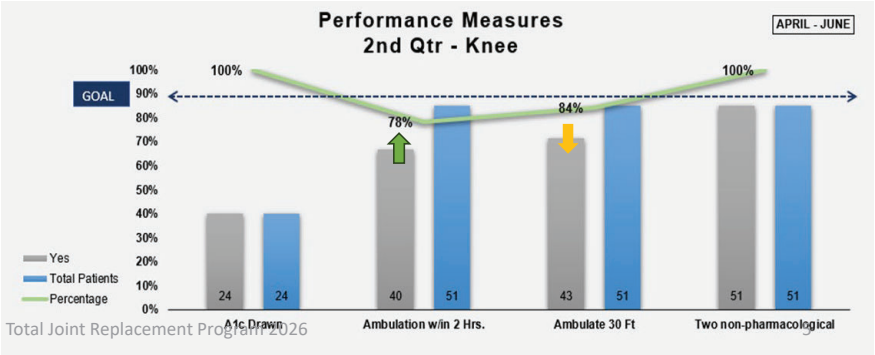
2026 Performance Measures - Hip





2026 Performance Measures - Knee





Measure Performance Review

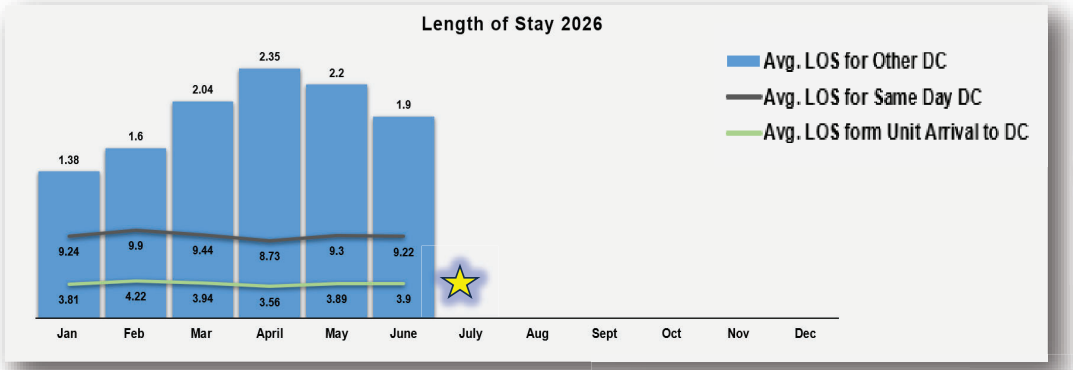
Data Analysis

- Consistently good performance with A1C and Non-Pharmacological Pain Control measures for both surgery types.
- Did not meet goal in QTR1 for Ambulation measures for both hips and knees
- Improvement in QTR2; met goal for Ambulation in 30 ft for hips
- While not all of the ambulation performance metrics met goal, the LOS for Arrival to Unit to D/C Home met goal 4/5 months!

Improvement Efforts

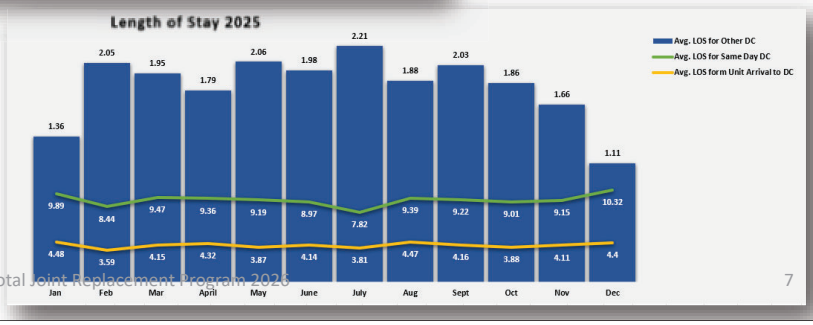
- Nurse Navigator reviews fallouts weekly and sends findings to team.
- Performance Measure graph displaying data for past 2 weeks shared weekly with staff.
- Monitoring of ERAS pathway compliance, with focused review of perioperative fluid management and timely administration of oral analgesia.
- Ongoing audits of documentation compliance.

Length of Stay



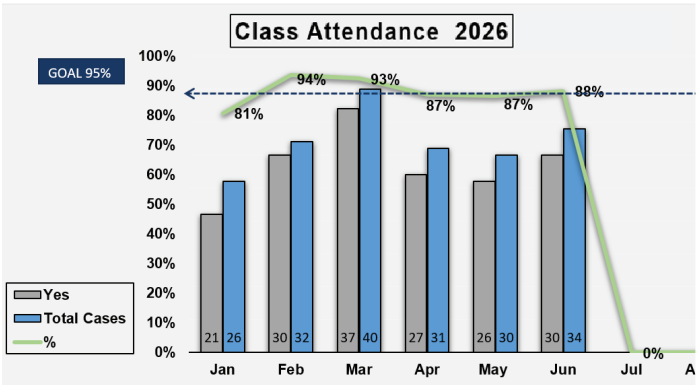
Unit Arrival to DC Home GOAL: <4 hrs.

Surgical Volume = 358



Education Class Completion

- All patients highly encouraged to attend education class held at Orthopedic Clinic.
- 2-3 classes offered per week, typically one in English and one in Spanish depending on class size.



New Initiatives - ERAS

- ERAS Pathway implementation in November 2025.
  - Implemented interventions in all phases of care: Pre-op/Intra-Op/Post-Op
  - Enhanced standardization of care delivery
  - Developing quality metrics dashboard to track and trend outcomes.
- Patient Reported Outcome Measures (PROMS)
  - Working on leveraging Epic reports for data upload to AJRR Registry
- Epic – unified platform across inpatient and ambulatory settings has made ALL the Difference!

Barriers/Next Steps

Barriers

- Documentation compliance
- Education class completion, health literacy challenges

Next Steps

- Continue reviewing fallouts weekly
- Explore different venues for class participation
- Launch monthly performance reporting and outcomes review with orthopedic surgeons (quarterly prior).
- Maintain continuous survey readiness in preparation for Joint Commission recertification (2027).
- Implement innovative knee brace to support postoperative range-of-motion protection and optimize recovery (includes cold therapy insert).

Bariatric Program
2026 Performance Improvement Plan

Veronica Zesati, BSN, RN
Bariatric Coordinator
Disease Specific Care

August 17, 2026

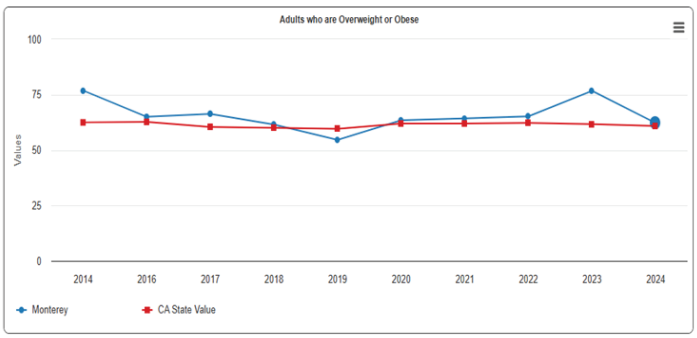
Bariatric Surgery Program

When it started and why?

- Launched in 2022 to complement the Lifestyle and Metabolic Clinic by providing comprehensive spectrum of weight management services.
- Bariatric surgery offers an effective treatment option for severe obesity or obesity-related comorbidities.
- Modeled after Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSQIP) standards.

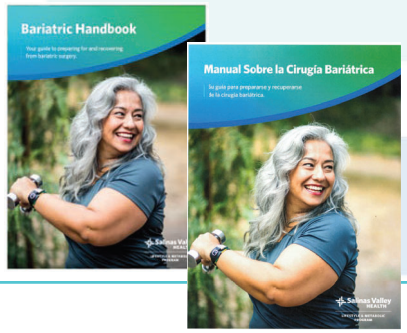
Why it matters?

- Obesity is major health issue in our community – 62% are over weight.
- Obesity drives other chronic diseases.



Bariatric Program Care Pathway

- Bariatric surgery criteria
  - ➢ BMI 30-35 with at least one obesity-related condition
  - ➢ BMI >35
  - ➢ Maximum weight of 350 pounds
- The program operates within a structured, evidence-based care pathway designed to ensure
  - ➢ patient safety
  - ➢ multi-disciplinary evaluation
  - ➢ sustainable long-term outcomes



- Referral and Intake
- Psychiatric Evaluation
- Nutritional Evaluation
- GI Evaluation/Endoscopy
- Surgical Evaluation
- Post-Op Follow-Up

Multidisciplinary Team

We have developed a comprehensive, multidisciplinary bariatric program designed to support sustained weight loss and improve long-term health outcomes.


Meet Our Care Team

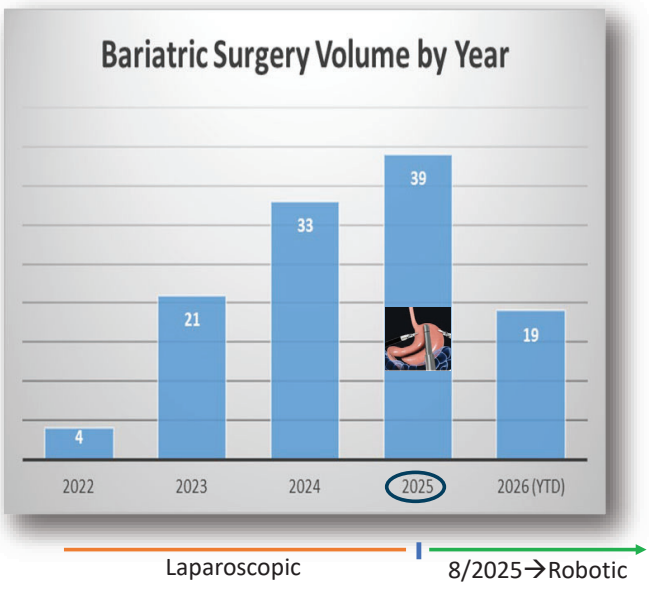
At Salinas Valley Health's Lifestyle and Metabolic Surgery Program (LAMP), you can be confident that we have highly skilled experts and resources to achieve the best outcome possible for you. Our staff will guide you through the bariatric surgery process, explaining the information you need to know and providing support.

Tarun Bajaj, MD — Medical Director, General Surgeon
Joanna Oppenheim, MD — Director, Lifestyle and Metabolic Program, Obesity Specialist
Robert Fernandez, MD — Lifestyle and Metabolic Program, Obesity Specialist
Veronica Zesati, RN, BSN, HACP — Bariatric Program Coordinator

Bariatric Surgery Medication Optimization Initiative

- **Goal:** Improve perioperative safety and weight-loss outcomes through collaborative medication review and management.
- **Process:**
  1. Obesity Medicine Specialist conducts comprehensive preoperative medication assessment.
  2. Recommendations are documented regarding:
     1. Diabetes medications
     2. Antihypertensives
     3. GLP-1 receptor agonists
     4. Other medications affected by bariatric surgery
  3. Bariatric surgeon reviews recommendations pre-operatively and incorporates into post-operative orders and discharge instructions.
  4. Nurse Navigator reviews plan preoperatively, postoperatively and reinforces with patient on discharge and during initial post-operative call (24-48 hrs).

Vertical Sleeve Gastrectomy (VSG) Volume



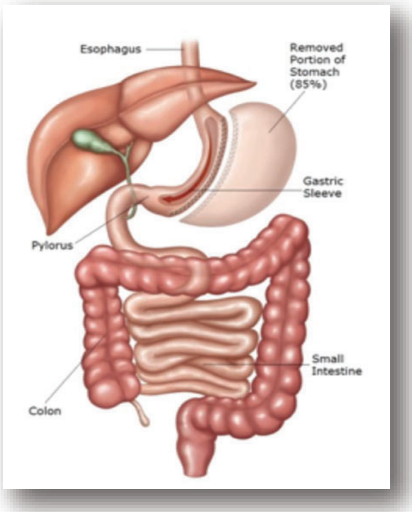
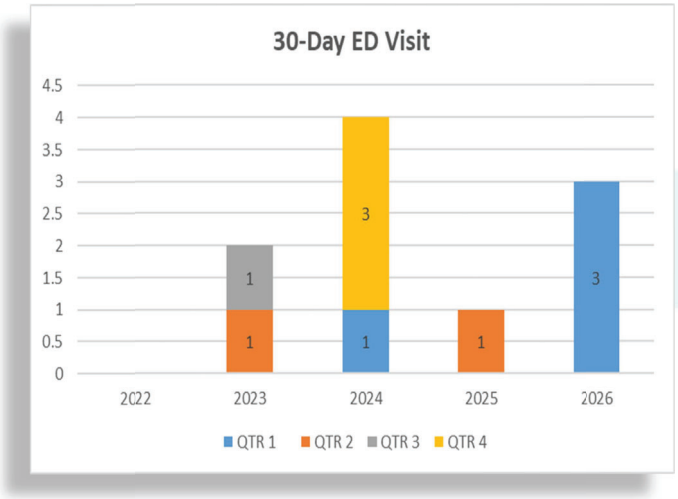
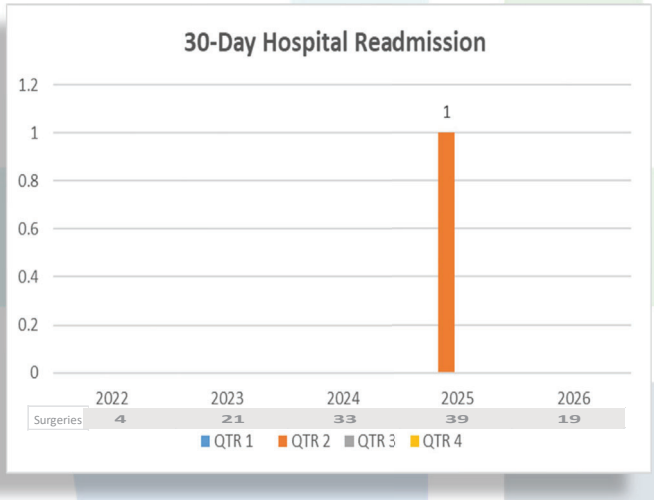


Image credit: weightlosssurgery.ca

Quality Metrics





Weight Loss Outcomes

- According to the American Society for Metabolic and Bariatric Surgery (ASMBS):
  - Bariatric surgery sleeve gastrectomy procedure demonstrated total weight loss of 29.5% one year after surgery.
- **How do we compare?**

Average Weight Loss One Year After Surgery			
2022	2023	2024	2025
20%	22%	23%	24%

https://asmbs.org/news_releases/bariatric-surgery-more-effective-and-durable-than-new-obesity-drugs-and-lifestyle-intervention/

Clinical Impact and Outcomes

- Significant clinical improvements are frequently observed within the first 1–3 months following surgery.
- **Type 2 Diabetes:** Many patients with non–insulin-dependent diabetes are able to discontinue oral antihyperglycemic medications shortly after vertical sleeve gastrectomy (VSG). Patients requiring insulin often experience substantial reductions in dosing requirements, with some achieving remission of Type 2 diabetes.
- **Hypertension:** Improvements in blood pressure control commonly result in medication reduction or discontinuation, often within the early postoperative period.
- **Metabolic Dysfunction–Associated Steatotic Liver Disease (MASLD):** Liver health frequently improves following surgery, as demonstrated by favorable trends in laboratory markers.
- **Mental Health and Quality of Life:** Many patients report improvements in mood, self-esteem, anxiety, depression symptoms, and overall quality of life as weight loss progresses.

Barriers and Challenges in the Bariatric Pathway

- **Care Coordination Complexity**
  - Bariatric surgery candidates often require multiple specialty evaluations and clearances (e.g., cardiology, sleep medicine, behavioral health, nutrition, and gastroenterology.
  - Coordination of appointments across multiple providers can prolong time to surgery and contribute to throughput.
- **Health Literacy and Patient Education**
  - The bariatric pathway requires patients to understand complex information related to nutrition, lifestyle modification, medication management, and postoperative expectations.
  - Variability in health literacy may impact patient engagement, readiness for surgery, and adherence to long-term follow-up requirements.

Next Steps

- Continue to monitor medication optimization initiative.
- Improved tracking of clinical outcomes.
- Enhancement of culturally responsive educational content to support long term weight loss goals.
- We are evaluating future participation in the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) as a potential opportunity to align with nationally recognized standards for bariatric surgery care.

Age-Friendly Health System

Age Friendly Health System - Update

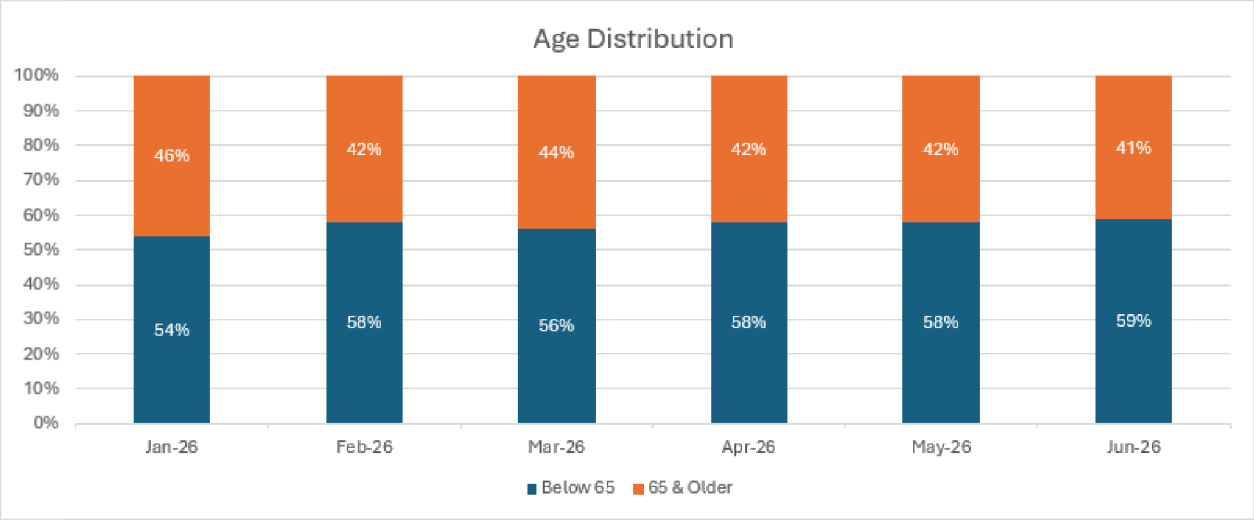
Patients aged 65years and older at SVH

Age Friendly Task Force

Dashboard Development

Hospital-wide Age Friendly campaign

Patients Aged 65 years and Older since January 2026



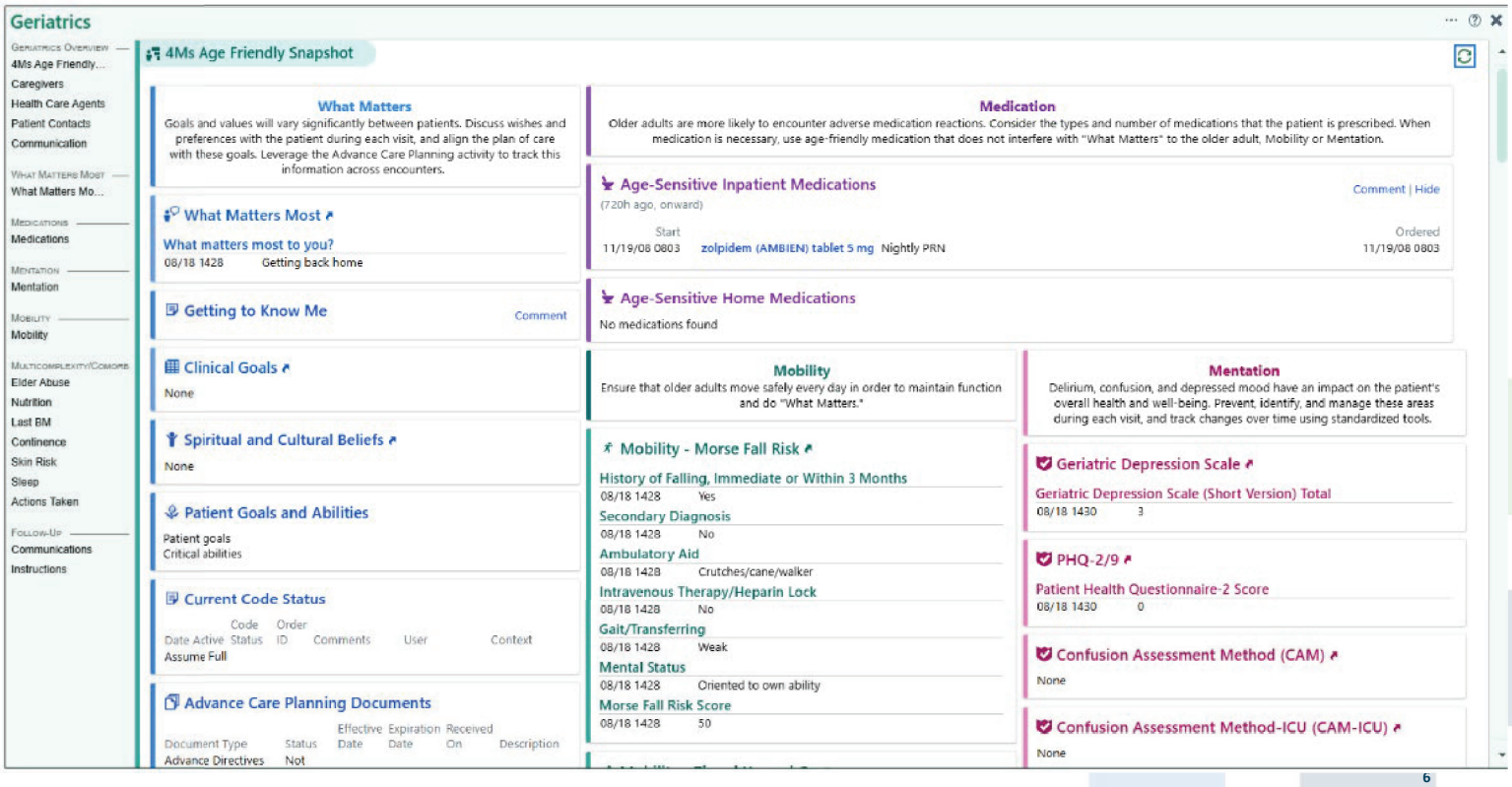
Age Friendly Task Force

- Regularly meeting every two weeks
- Last meeting August 4 , 2026
  - Next meeting August 18
- Engaging and thoughtful participation
- Discussed dashboard builds and hospital-wide campaign

Dashboard Development

- Epic project manager
- Epic Specialist and team meeting for dashboard build occurs weekly
- “Turbocharger” Age Friendly report
- Goal is to have the build completed by September
- Data abstraction for 10% sample to obtain base line

5



6

Hospital-wide Campaign

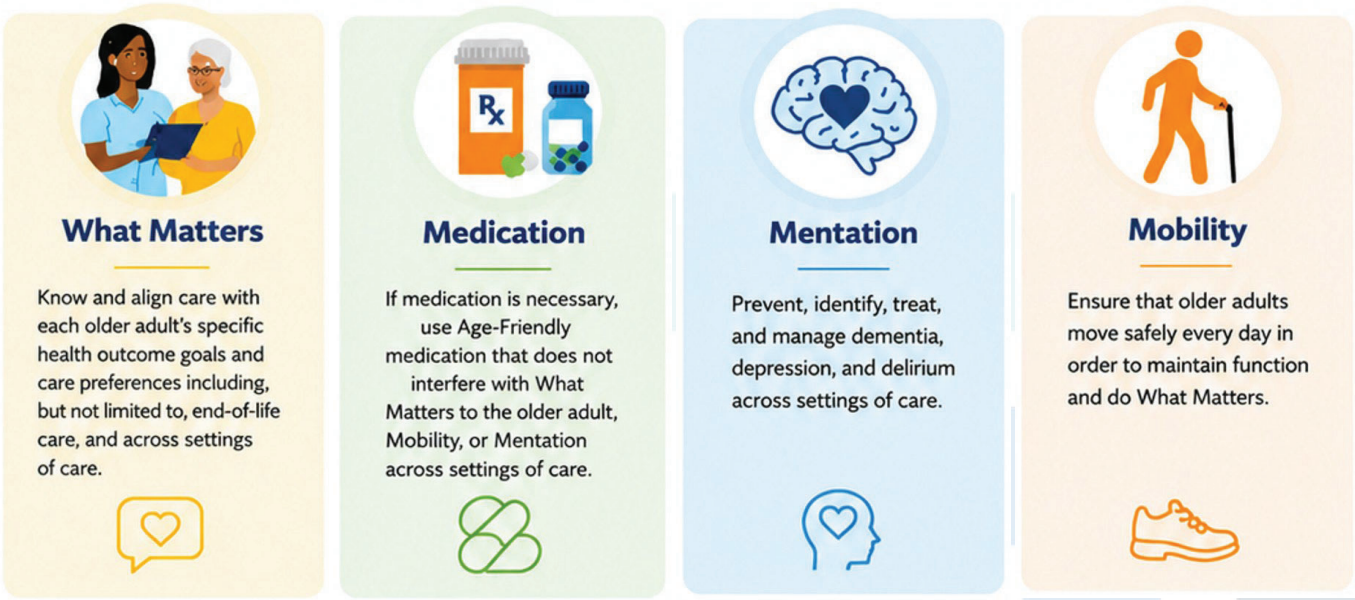
- Task Force implementation of a hospital –wide campaign to bring further awareness and socialization to embed it in our culture
- Patient and staff education
  - Providing awareness for our patients
- Systematic
  - Roll out in phases
  - Utilize Team TV
  - Huddle
  - Rounds
  - Information sessions for leaders and staff

AFHS Campaign Timelines: June- Dec 31, 2026

Status	Focus	Key Activities	Deliverables	Responbile Party	Start Date	End Date	Days
Started	AFHS Awareness Campaign	Launch Age-Friendly Health System Campaign		AFHS Taskforce	01-Jun-26	01-Jan-27	215
Started		AFHS Project Planning	AFHS Project Charter		02-Jun-26	31-Jul-26	60
Started		AFHS Project Charter Executive Review & Approval	Signed/ Approved AFHS Project Charter		03-Aug-26	07-Aug-26	5
Started		AFHS Gathering of Baseline Data		EPIC Specialist/ Digital Nsg Practice	03-Aug-26	01-Jan-27	152
Started		AFHS Communication from Executives	AFHS Email Communications & Starnet	AFHS Sponsors	10-Aug-26	14-Aug-26	5
		4M What Matters: Staff Awareness	AFHS What Matters TEAM TV	AFHS Taskforce c/o Lisa	10-Aug-26	28-Aug-26	19
			AFHS Posters/Brochures	AFHS Taskforce	11-Aug-26	28-Aug-26	18
			AFHS Taskforce Unit Visit (Area: TBD)	AFHS Taskforce	11-Aug-26	11-Aug-26	1
			AFHS Additional Unit Rounds	John & Amy	18-Aug-26	18-Aug-26	1
		4M Medication: Staff Awareness	AFHS Medication TEAM TV	AFHS Taskforce c/o Lisa	31-Aug-26	25-Sep-26	26
			AFHS Posters/Brochures	AFHS Taskforce	31-Aug-26	25-Sep-26	26
			AFHS Taskforce Unit Visit (Area: TBD)	AFHS Taskforce	01-Sep-26	01-Sep-26	1
			AFHS Additional Unit Rounds	John & Amy	14-Sep-26	14-Sep-26	1
		4M Mentation: Staff Awareness	AFHS Mentation TEAM TV	AFHS Taskforce c/o Lisa	03-Aug-26	28-Aug-26	26
			AFHS Posters/Brochures	AFHS Taskforce	03-Aug-26	28-Aug-26	26
			AFHS Taskforce Unit Visit (Area: TBD)	AFHS Taskforce	04-Aug-26	04-Aug-26	1
			AFHS Additional Unit Rounds	John & Amy	18-Aug-26	18-Aug-26	1
		4M Mobility: Staff Awareness	AFHS Mobility TEAM TV	AFHS Taskforce c/o Lisa	02-Nov-26	27-Nov-26	26
			AFHS Posters/Brochures	AFHS Taskforce	02-Nov-26	27-Nov-26	26
			AFHS Taskforce Unit Visit (Area: TBD)	AFHS Taskforce	03-Nov-26	03-Nov-26	1
			AFHS Additional Unit Rounds	John & Amy	17-Nov-26	17-Nov-26	1
		All 4Ms Patient Awareness (What Matters, Medication, Mentation, Mobility)	AFHS 4Ms TEAM TV	AFHS Taskforce c/o Lisa	30-Nov-26	01-Jan-27	33
			AFHS Posters/Brochures	AFHS Taskforce	03-Aug-26	28-Aug-26	26
			AFHS Taskforce Unit Visit (Area: TBD)	AFHS Taskforce	08-Dec-26	08-Dec-26	1
			AFHS Additional Unit Rounds	John & Amy	15-Dec-26	15-Dec-26	1

SECTION TITLE

IHI 4Ms for people 65 years and older



Provider & Staff To Do List

Action	Documentation Frequency
1. Most current daily goals documented on the **Whiteboard**.	**Minimum Frequency:** • Once per stay • Upon a significant change of condition. **Source: IHI 4Ms Worksheet.**
2. Patient's health, treatment goals & preferences **aligned to Care Plan.**	
3. **Living Wills, Advance Care Plan, End-of-Life & Palliative Care** are obtained, reviewed & documented.	
4. **Health Proxies/ Surrogate Decisionmaker & Caregiver preferences** are identified.	

CMS/ IHI Activity Update

CMS

- 2026- 2027
  - AFH Measures were submitted: **May 18, 2026**, to the Hospital Inpatient Quality Reporting (IQR) website.
  - Score 4 out of 5: **Domain 2: Responsible Meds. Management.** Inconsistent Potentially Inappropriate Meds (PIMs) review and interventions.
- **Note: CMS does not expect all hospitals to achieve a score of five out of five**. Hospitals that are unable to attest positively to all domains can still meet the measure reporting requirements. ***They may receive a score lower than five, but would not be subject to a payment reduction so long as they attest to each domain (positively or negatively).*** *Source: Hospital Inpatient Quality Reporting (IQR) Program: Final Rule.*

IHI

- Achieved **Level 1 Participant level December 2025**
  - Goal is to achieve Level 2 Goal to reach Institute for Healthcare Improvement (IHI) "Committed to Care Excellence" recognition by end of year
  - Requires collection of 3months of data

Thank you!

Status Draft PolicyStat ID 20680621

Origination 1/1/2022
Approved N/A
Expires N/A

Owner Brenda Inman: Vice President Quality and Risk Management
Area Plans and Program

Quality Assessment and Performance Improvement Plan

I. SCOPE/PURPOSE

A. The Purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Plan at Salinas Valley Health Medical Center (SVHMC) is to ensure that the Governing Body, Medical Staff, and professional services personnel consistently strive to deliver safe, effective, and optimal patient care in an environment that minimizes risk. The QAPI Plan serves as the framework for developing, implementing, and sustaining an effective, organization-wide, data-driven quality assessment and performance improvement program. This program uses a planned, systematic, and interdisciplinary approach to improving the care, treatment, and services provided across the organization.

B. This organization-wide plan applies to the clinical services identified in the grid below, including services provided directly by the organization and those delivered through contractual agreements and other arrangements.

Category	Services Provided
Main Hospital Campus	**Inpatient Acute Care:** General, Perinatal, NICU Level III, Pediatric, CCU, ICU, Telemetry; **Procedural:** Perioperative Services (Inpatient & Ambulatory Care), Cardiac Catheterization, Cardiovascular Services, Rehab Services, Emergency Services; **Diagnostic and Support:** Diagnostic Imaging/Nuclear Medicine Services (Inpatient & Outpatient), including Ultrasound, MRI, and Cardiovascular Imaging, Laboratory Services (Inpatient & Outpatient), Pathology including Blood Bank, Pharmacy (Inpatient & Outpatient), Respiratory Care Services
Mobile Modalities - Main Hospital Campus	Lithotripsy; PET/Nuclear Medicine; Interventional Radiology; MRI; Temporary Outpatient Modular Units
Outpatient/Specialty Clinics	Outpatient services across Monterey, Salinas, and Gonzales, including Primary Care; Infusion; Imaging; Wound Care; Breast Health; Cardiac Services; Sleep Services, Rehab Services, Sleep Medicine

C. The QAPI Program is designed to foster an environment where patient care and services are continuously improved, professional performance and employee competence are strengthened, and operational systems function efficiently. Through an integrated, interdisciplinary process, patient care and the processes that influence patient outcomes are routinely measured, assessed, and improved to achieve optimal results.

D. The Board of Directors, Medical Staff, organizational leaders and all personnel share accountability for the quality of care and services provided at the organization. They are collectively responsible for supporting a culture of safety, transparency, and continuous improvement. The QAPI Program is designed to align with and support the organizational mission, vision and values.

E. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley Health Medical Center is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationship, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of the care. These decision-making committees include committees in Administrative Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and nursing practice initiatives are incorporated into the overall organizational performance improvement.

II. OBJECTIVES/GOALS

A. **Objectives**

1. The organizational QAPI program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and on patient safety practices conducted throughout the organization. The program encompasses elements of the mission, vision, values and organizational strategic objectives and consists of performance improvement, patient safety and quality control activities. Indicators are objective based on current knowledge and experience, and are structured to produce statistically valid, data driven measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time when appropriate.
2. The QAPI Plan includes data collection, data aggregation and analysis of patterns or trends, identifying and managing adverse events, improving performance, patient safety and reducing risk of adverse/sentinel events, and conducting proactive risk reduction activities, including processes that involve the Medical Staff as well as clinical and support services. The QAPI program is implemented in conjunction with the organizational PATIENT SAFETY PROGRAM PLAN **and the** RISK MANAGEMENT PLAN

B. **Goals**

1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, and performance monitoring and environmental monitoring.

2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for FY 2027:
    - Annual Quality and Safety Pillar Strategic Initiatives
    - Patient Perception of Care, Services and Treatment
    - Patient Flow Initiatives
    - Magnet Recognition/Nurse Sensitive Indicators
    - Early Recovery After Surgery
    - Age Friendly Initiative

III. DEFINITIONS

A. CMS	Centers for Medicare and Medicaid Services
B. MEC	Medical Executive Committee
C. PI	Process Improvement
D. QAPI	Quality Assessment and Performance Improvement
E. QSC	Quality and Safety Committee of the Medical Staff

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. **Measuring Performance**

a. Data Collection

The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities ensuring that performance improvement activities reflect the complexity of the organization and the services provided. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and implement changes that lead to sustainability. The program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. The following are categories of data collected and analyzed. The identified areas of data listed below are not intended to be an all-inclusive. The Board of Directors and Leadership may identify additional data elements at any time based on the organization's priorities, emerging risks, identified areas of opportunity or regulatory requirements.

- Clinical Quality Measures: Evidence-based metrics such as sepsis bundle compliance, stroke care, NTSV C-section rate, readmissions, and mortality indicators.
- CMS electronic Clinical Quality Measures (eCQM's)
- Patient Safety Events: Falls, pressure injuries, adverse events, near misses, other safety indicators and root-cause analysis outcomes.

- Patient Flow and Throughput: Emergency department throughput, operating room utilization, discharge efficiency, and length of stay.
- Patient Experience: HCAHPS results, complaints, grievances, and service recovery outcomes.
- Staff Competency and Performance: Credentialing, privileging, peer review, and training compliance.
- Resource Utilization: As identified by Executive Leadership and the Board of Directors.
- Population Health Measures: Preventive care rates, chronic disease management, and community health indicators, health care disparity and Age Friendly Initiative.
- Regulatory and Accreditation Compliance: audit findings, tracer results, and corrective action implementation.
- Processes and data as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program, Medication Management Plan.
- Required data for regulatory bodies and clinical registries such as the Joint Commission, CMS, OSHA and the FDA, AHA and ACC.
- Data submitted to or received from Medicare quality reporting and quality performance programs, including but not limited to hospital readmissions and hospital-acquired conditions.

2. **Assessing Performance**

a. **Data Compilation and Analysis**

Data aggregation and analysis are conducted to transform raw data into meaningful information that supports organizational decision-making. Data are systematically collected, aggregated, and analyzed to monitor the effectiveness and safety of services, evaluate the quality of care provided, and assess performance levels, patterns, and trends across the organization. These activities support the performance improvement initiatives and ensure that opportunities are identified in a timely and reliable manner.

Consistent with the organization's Professional Governance model, data are transparently shared with leaders, interprofessional teams, and Professional Governance councils. Clinical nurses and other frontline team members participate in the review, interpretation, and application of performance data to identify opportunities for improvement, develop evidence-based interventions, and evaluate the effectiveness of actions taken.

i. Data aggregation is performed at a frequency appropriate to the activity, process, or measure being monitored.

ii. Statistical tools and techniques are used, when appropriate, to display, analyze and interpret data.

iii. Data are analyzed and compared internally over time and externally with other sources of information when available.

iv. Comparative benchmarking data are used to assess variation in performance, identify best practices, establish performance

targets, and determine whether performance falls outside expected levels.

v. Performance data are reviewed through the organization's Professional Governance structure, leadership committees, and interprofessional teams, as appropriate, to support shared decision-making, promote accountability for professional practice, and guide evidence-based performance improvement initiatives.

vi. An intensive analysis is conducted when data identify undesirable patterns or trends, or when significant patient safety events occur that warrant further evaluation. The analysis identifies contributing factors, system opportunities, and corrective actions, with ongoing monitoring to evaluate the effectiveness of implemented improvements.

vii. Results of data analysis, benchmarking, and intensive analyses are used to identify, prioritize, implement, and sustain performance improvement initiatives. Outcomes are communicated through the appropriate leadership, quality, and Professional Governance structures to promote organizational learning, transparency, and continuous improvement.

3. **Improving Performance**

   a. Data is collected, analyzed and integrated into performance improvement initiatives. Performance improvement initiatives may be organization-wide in scope or targeted to specific areas, departments and services, or focused on select populations. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.

      - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
      - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
      - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
      - Changes that will reduce the risk of sentinel events are identified and implemented.

4. **Identifying and Managing Adverse or Unexpected Occurrences**

   a. Processes for identifying and managing sentinel events are defined in the organization wide ADVERSE EVENTS - REPORTABLE.

5. **Proactive Risk Reduction Program**

   a. SVHMC is dedicated to preventing harm to patients, visitors and staff. This is supported and encouraged through internal reporting in order to identify potential system or process failures. The organization is committed to utilizing proactive risk assessments to identify potential hazards, analyze their likely hood and impact and develop strategies to prevent and mitigate harm before incidents occur. At a minimum of every 18 months the hospital selects one high-risk process and conducts a proactive risk assessment.

6. **Priority Patient Population**

a. The priority patient populations are based on high-risk, high volume, high risk/low volume and/or problem prone areas with consideration of the incidence, prevalence and severity of problems in those areas which may affect patient outcomes, safety and quality of care.

7. **Analysis of Staffing**

a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment,

credentialing, supervision of staff, orientation, training and education may also be analyzed.

b. When analysis reveals a problem with the adequacy of staffing, the QSC is informed of the results of the analysis and actions taken to resolve the identified problem(s).

B. **Plan Management**

1. **Performance/Process Improvement Model**

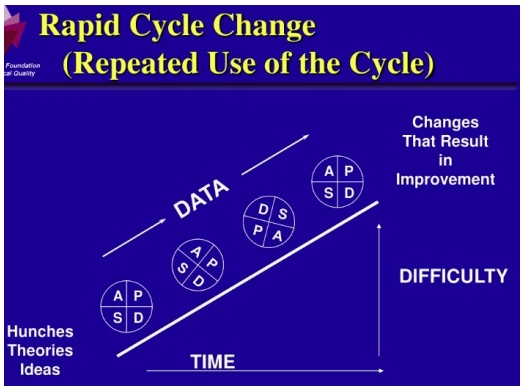
a. SVHMC utilizes a wide range of systematic and structured problem-solving approaches to plan, design, measure, assess and improve organizational performance/processes. Methodologies include Lean for Healthcare, F O C U S – P D C A and Rapid Cycle Improvement.

- F O C U S – P D C A.
  F – Find a process to improve.
  O –Organize a team that understands the process.
  C –Clarify how the current process works.
  U –Understand the causes of process variation, the "root cause".
  S – Select changes that will improve the process.

  P – Plan how the changes will be implemented.
  D – Do/implement the plan.
  S – Study the results of the improvement plan by collecting post-implementation data.
  A – Act on the findings of post-implementation data by standardizing the process or testing another change.

- Systems Redesign
  Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.

- Rapid Cycle Improvement/Kaizen
  When appropriate, the *rapid cycle improvement* process may be utilized. The advantages of the rapid cycle improvement process include:
    - Using a small sample to test a proposed change idea quickly.
    - Testing ideas side by side with existing processes.
    - Testing many ideas quickly. Build upon the success of the previous test.
    - Providing opportunities for failures without impacting performance.
    - Minimizing resistance to successful change.



C. **Plan Responsibility**

1. Performance / Process Improvement Structure

a. The Quality Oversight Structure defines the organization framework through which quality, patient safety, and performance improvement activities are coordinated, monitored, evaluated, and decentralized The structure ensures that all service lines and disciplines are active members in the QAPI in addition to ensuring accountability at all levels within the organization. Each department and service line supports the SVHMC's commitment to continuously improve the quality of patient care to the patient's we serve and to an environment which encourages performance improvement within all levels of the organization. Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care or service provided meets the customer's needs. This is articulated in each department and service line's Scope of Service.

b. The annual reporting calendar is developed and maintained by the Quality Department. Key components include but are not limited to; required reporting, committee reviews, performance dashboards and regulatory submissions. The calendar is reviewed on a regular basis and updated to meet the changing needs of the organization, regulatory requirements or when performance initiatives shift or evolve.

c. **Governing Board**

i. The Board of Directors holds ultimate responsibility for the organization's performance-improvement program and ensures that all activities reflect the complexity of the hospital's structure, services, and patient populations. This responsibility encompasses

all patient-care- services-inpatient, outpatient, and ambulatory-licensed under the organization, including those delivered through contracts or other arrangements.

ii. Performance-improvement efforts emphasize indicators that support improved health outcomes and the prevention and reduction of medical errors.

iii. The Board assigns the Quality and Efficiency Practices Board Committee to evaluate and enhance the quality and efficiency of patient care. While the Board retains ultimate oversight, it delegates operational authority for performance-improvement activities to the Medical Staff and Hospital Leadership.

iv. In exercising its supervising responsibility, the Board:

1. Reviews and approves the QAPI, Risk Management and Patient Safety Program Plans.
2. Reviews periodic reports on findings, actions, and results of program activities, including input from the populations served via results of patient experience data.
3. Reviews reports on the following: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; results of analyses related to adequacy of staffing; all actions taken to improve safety, both proactively and in response to actual occurrences.
4. Assesses the QAPI, Risk Management and Patient Safety Programs' effectiveness and efficiency and required modification, as necessary.
5. Provides resources and support for performance improvement, change management, patient safety and risk management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

d. **Medical Executive Committee (MEC)**

i. MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI program.

ii. MEC is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients. This responsibility extends across all patient-care settings- including inpatient, outpatient, and ambulatory services-licensed under the organization, as well as services delivered through contracts or other arrangements.

iii. The Medical Staff participates in developing measures to evaluate care systematically. Their participation may be in individual departments, medical staff committees, or on interdepartmental or interdisciplinary process/performance improvement teams.

iv. The Medical Staff departments review and evaluate the results of ongoing measures that include the medical staff review functions as well as risk management, patient safety, infection control, case management, and organizational planning.

v. The Medical Staff has established the Medical Staff Excellence Committee to ensure that the hospital, through the activities of its medical staff, assess the Ongoing Professional Practice Evaluation of individuals granted clinical privileges and uses the results of such assessments to improve care, and when necessary, conduct Focused Professional Practice Evaluations. The goals of the Medical Excellence Committee are to:

- Improve the quality of care provided by individual practitioners
- Monitor the ongoing performance of practitioners who have privileges
- Identify opportunities for performance improvement
- Monitor significant trends by analyzing aggregate data
- Assure that the process for peer review is clearly defined, fair, defensible, timely and useful
- Evaluation the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.

e. **Organizational Executives and Vice-Presidents**

i. Set expectations for performance/process improvement.

ii. Lead the development of performance/process improvement initiatives.

iii. Participate in processes to improve hospital performance as indicated.

iv. Ensure participation from key stakeholders in all performance/ process improvement activities.

v. Monitor contracted services by establishing expectations for the performance of the contracted services.

vi. Ensure that new or modified processes or services incorporate the following:

- Needs and/or expectations of patients, staff and all identified key stakeholders.
- Results of performance improvement activities, when applicable.
- Information about potential risk to patients, when applicable.
- Every new service must have a proactive risk assessment completed before opening.
- Current knowledge and/or best practice
- Information about sentinel events, if applicable

- Testing and analysis to determine whether the proposed design or redesign will have a positive impact

vii. Ensure that an integrated patient safety program is implemented throughout the organization.

viii. Establish and maintain operational linkages between risk management activities related to patient care and safety, and performance improvement activities.

ix. Review results from key financial indicators in order to ensure overall financial stability.

x. Ensure compliance with state and federal laws, and the Joint Commission regulations/standards.

f. **Support Service Departments/Department Directors**

i. The department leaders are accountable to the organizational executives, QSC and the Board of Directors for the quality of care/ services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services provided. The Department Directors:

a. Promote the development of standards of care and measures to assess the quality of care/services rendered in their departments.

b. Monitor the processes in their areas, which affect patient safety, care, outcomes and the patient's perception of care received.

c. Promote the integration of their department's performance improvement activities with those of other support services and the Medical Staff through participation in performance improvement teams.

d. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure. (see Appendix A).

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to determine what measures will be evaluated at least annually and updated/revised ongoing as compliance is sustained.

2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities based on assessment and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.

3. **Confidentiality**

a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance

with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.

b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Organizational Executives, and/or the Governing Body.

c. HIPAA regulations will be followed.

E. **Orientation and Education**

1. Orientation, education and/or training is provided on an as needed basis.

V. REFERENCES

A. Joint Commission

B. Title 22 (CDPH)

C. CMS Conditions of Participation

Attachments

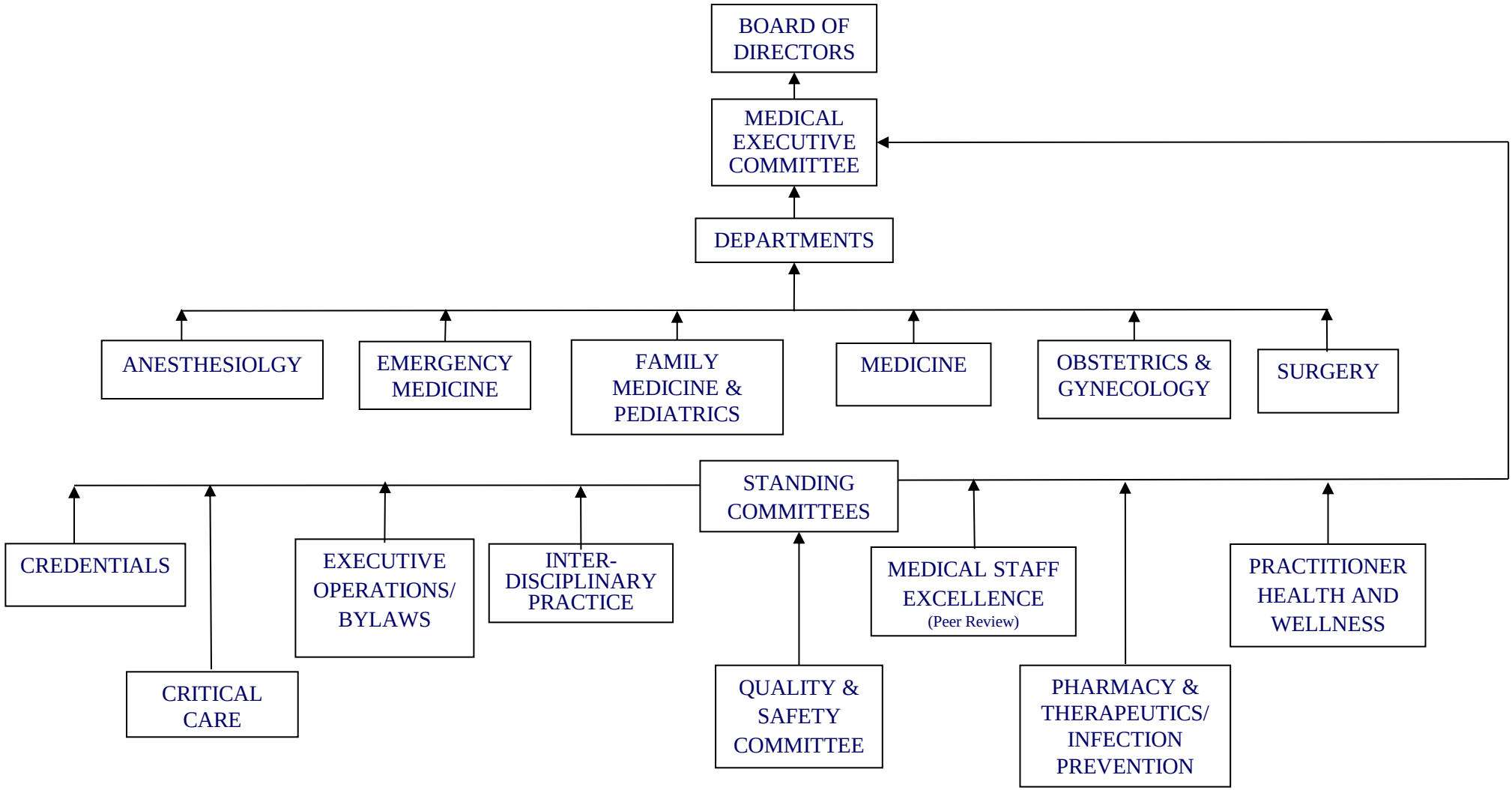
Medical Staff Organizational Chart 03-28-26.pdf

Approval Signatures

Step	Description	Approver	Date

Standards

No standards are associated with this document



Family Medicine/Pediatrics Dept: Pediatric Cardiology, Neonatology, Pediatric Allergy
Medicine Dept: Cardiology, Critical Care, Dermatology, Palliative Medicine, Rheumatology, Nephrology, Sleep Medicine, Internal Medicine, Radiation Oncology, Physical Med & Rehab, Psychiatry, Pain Medicine, Infectious Diseases, Hem/Onc, GI, Endocrinology, Neurology
Surgery Dept: Ortho, Pathology, Podiatry, Vascular, Ophthalmology, Gen Surg, ENT, Colorectal, Surg Onc, Radiology, Urology, Plastics, OMFS, Neurosurgery, Dentistry

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT