September 10, 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, SEPTEMBER 14, 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, SEPTEMBER 14, 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 August 17, 2026. (CARSON)

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

4. Patient Care Services Update (SPENCER)
   - Report from Professional Development Council (BROWN)

5. Accreditation & Regulatory Update (SPARKS)

6. Performance Improvement Reports
   - Perinatal Units (VASHER)
   - Case Management (SCOTT)
   - Environmental Health and Safety Program (WARDWELL)

7. Closed Session

8. Reconvene Open Session/Report on Closed Session

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

9. Adjournment

   The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **October 12, 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 AUGUST 17, 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: Tim Albert, M.D., CCO, Cheryl Pirozzoli, Family/ Patient Advisor
Via Teleconference: Michelle Childs, CHRO, Gary Ray, CLO

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

Rolando Cabrera, M.D. left at 9:40 a.m.

1. CALL TO ORDER/ROLL CALL

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

Approve the amended minutes of the July 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 Vice Chair Cabrera, and second by Committee Member Miller the amended minutes of the July 13, 2026 Quality and Efficient Practices Committee Meeting are approved.

ROLL CALL VOTE:
Ayes: Chair Carson, Vice Chair Dr. 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. Pamela Yates, RN, PCCN, gave an overview of the council's purpose. The three topics presented were Council Day, Professional Governance Education Sessions, and What's Ahead.

A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: Chair Carson asked if the Council Day is making a noticeable difference. Vice Chair Cabrera, M.D., clarified that they meet once a month. He also noted that people who responded to the Council Day survey reached a 100% participation rate. Committee member Carla Spencer noted that the nursing leadership joins the Council Day meetings. Vice Chair Dr. Cabrera suggested giving the nurses credit for attending the sessions.

5. PERFORMANCE IMPROVEMENT REPORTS:

- **Pharmacy Updates**: Genevive delos Santos, Director of Pharmacy, provided an overview of the patient Care Continuum at SVH. She then highlighted the goals to expand SVH Retail Pharmacy Hours, Increase Meds to Beds, and Implementation of Pharmacotherapy Clinic. Lastly, she discussed the 340B and the Patient Care Continuum at SVH.
- **Total Joint Replacement Program**: Lilia Meraz-Gottfried, MSN, RN, CMNL, Director of Clinical Development, Disease Specific Care, provided an overview of the purpose and team of the Total Joint Replacement Program. She presented all the different performance measures which also highlighted the Data Analysis and Improvement efforts. Lastly, she discussed new initiatives and next steps.
- **Bariatric Program**: Veronica Zesati, BSN, RN, Bariatric Coordinator, Disease Specific Care, presented when and why the Bariatric Surgery Program was started. She gave an overview of pathway of care and the team behind the care. She then went on to explain the Bariatric Surgery Medication Optimizatoin and Initiative. She gave an overview of the Quality Metrics and Weight Loss outcomes. Lastly she discussed the barriers and challenges and what the next steps are for the program.

Full reports were included in the packet.

COMMITTEE MEMBER DISCUSSION: In regards to the Pharmacy Updates presentation, Chair Carson, commented that we should look into how the meds to beds program affects our admission numbers to the ED. Regarding the Total Joint Replacement presentation, Chair Carson asked how the hospital is preparing for the anticipated increase in patients who will be required to receive care on an outpatient basis rather than as inpatients.

6. AGE FIENDLY PROGRAM UPDATE

Amy Grooters, MSN, RN, NE-BC, CEN, Patient Safety Manager, gave an overview of Age Friendly Program. She reviewed the Patients aged 65 years and older at SVH, Age Friendly Task Force, Dashboard Development, and Hospital-wide Age Friendly Campaign.

COMMITTEE MEMBER DISCUSSION: None.

7. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF THE QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPI)

Committee Member, Carla Spencer presented our Quality Assessment and Performance Improvement Plan (QAPI).

A full report was included in the packet.

PUBLIC COMMENT: None.

COMMITTEE MEMBER DISCUSSION: None.

MOTION:
Upon motion by Committee Member Miller and second by Committee Member Spencer the Quality Assessment and Performance Improvement Plan (QAPI) is approved as presented.

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

Motion Carried.

8. 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 9:41 a.m.

9. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:48 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)

10. ADJOURNMENT

There being no other business, the meeting adjourned at 9:48 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **September 14, 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: Professional Development Council
Monday, September 14, 2026

PROFESSIONAL DEVELOPMENT COUNCIL

COUNCIL LEADERSHIP:

- Chair: Mikhail Brown, *MS, BSN, RNIII, PCCN*
- Co-Chair: Samantha Lopez, *BSN, RN*
- Assoc. Co-Chair: Rachel Wiley, *BSN, RNIII, PCCN, CMSRN*

Advisor: Stephanie Frizzell, MSN, RN, NPD-BC

COUNCIL MEMBERSHIP:

- Gabriela Morales, *BSN, RNIII, PCCN*
- Najiba Caplan, *BSN, RNIII, RN-BC*
- Ludy Lim, *MSN, RNIII, RNC-LRN*
- Sandra Tapia, *BSN, RN, PCCN*

FY2027 Smart Goals:

- Increase the org-level **BSN-OR-HIGHER RATE** by 0.5% from 74.11% (FY2026) to ≥ 74.61% by end of FY2027
- Increase the org-level **RN BOARD CERTIFICATION RATE** by 1% from 40.23% (FY2026) to ≥ 41.23% by end of FY2027
- Maintain the org-level **RN TURNOVER RATE** below 10% from 7.94% (FY2026) by end of FY2027

Initiatives:

- RN BSN or Higher Degree
- RN Professional Certification
  - Certification Preparation Classes / Nurse Builders
  - Certified Nurses Day
- Clinical Ladder - Staff Nurse III
- RN Turnover
- Professional Development & Education Fair
- Daisy Program Revitalization
- Strategic Retention & Engagement from Exit Interviews

RN BSN or Higher Degree

Magnet® Goal 80%

Nursing Professional Development Committee FY Goal: 73.22%

RN Bachelor Degree of Higher %

Magnet Hospitals

201-300 Beds

Average 60%

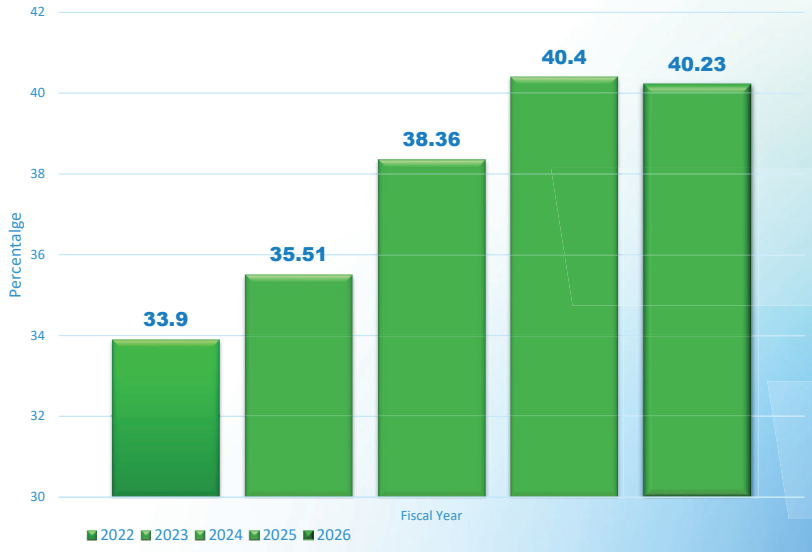
(Updated December 2025)

Source:

Characteristics of Magnet Organizations | ANCC | ANA (nursingworld.org)

RN Professional Board Certification Data

Magnet® Goal ≥51%
Nursing Professional Development Committee FY Goal: 41.41%



RN Professional Board Certifications

Magnet Hospitals

201-300 Beds

Average 28%

(Updated December 2025)

Source:

Characteristics of Magnet Organizations | ANCC | ANA (nursingworld.org)

Board Certification Preparation Classes

Salinas Valley Health continues to support Registered Nurses seeking certification in their specialty by proving in-person and virtual review classes:

Continued course offerings:

- Medical Surgical Specialty (CMSRN, MEDSURG-BC)
- Progressive Care Specialty (PCCN)
- Critical Care Specialty (CCRN)
- Emergency Nurse Specialty (CEN)

"Second chance" program:

- Oncology Specialty
- Progressive Care & Critical Care Specialty
- Medical Surgical Specialty (CMSRN) – Coming Soon

Nurse builders:

- Board certification review e-course platform
  - 25 employees enrolled
    - 8 Passed Board Certification
  - 25 more seats available for 2026-2027

Professional Development & Education Fair
Nurse Recognition Activities

Ongoing Recognition Activities:

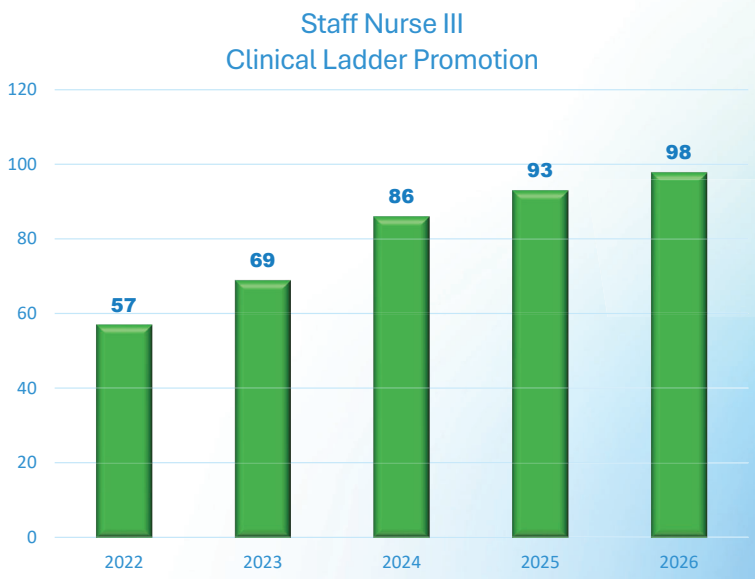
- Daisy Program revitalization complete with a noticeable increase in nominations
- Certified Nurses Day Celebration
- Ongoing Preceptor recognition

2026 Professional Development & Education Fair / Board Certified Nurse

Salinas Valley HEALTH — Magnet Recognition with Distinction, American Nurses Credentialing Center

Salinas Valley HEALTH — Magnet Recognition with Distinction, American Nurses Credentialing Center

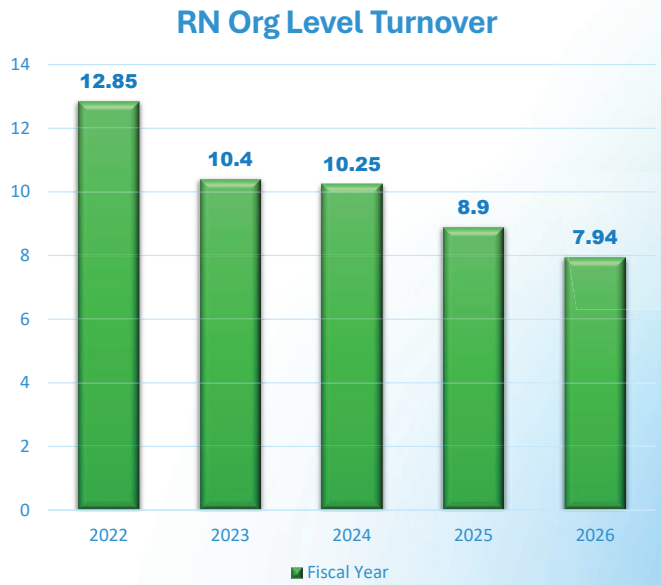
RN Recognition and Retention
Clinical Ladder Promotions – Staff Nurse III Data



- The Staff Nurse III functions as an exemplary care provider, demonstrates leadership, and a level of involvement beyond what is required for staff nurse II.
- An application based; points earned promotion established on enhanced knowledge, leadership, teaching and nursing practice skills
- Requires annual renewal and leadership support
- YOY Growth:
  - **5.4% increase** — FY25–FY26
  - **8.1% increase** — FY24–FY25
  - **24.6% increase** — FY23–FY24
  - **21.0% increase** — FY22–FY23
  - **9.0% increase** — FY21–FY22

Nurse Turnover

Magnet® Goal <10%
Nursing Professional Development Committee FY Goal: Maintain <10%



Magnet Hospitals

201-300 Beds

Average Turnover 9.6%

(Updated December 2025)

National Average 16.4%

(Updated April 2025)

Source:

Characteristics of Magnet Organizations | ANCC | ANA (nursingworld.org)

https://www.beckershospitalreview.com/finance/the-cost-of-nurse-turnover-in-24-numbers-2025/

Nurse Turnover

- EOY FY 26 Overall Organizational RN Turnover: 7.94%

Magnet® Goal <10%	
Nursing Professional Development Committee FY Goal	**Maintain <10%**
RN Turnover per clinical department	Assessing unit specific turnover with action plan
Experienced RN Transferring Specialty	0% Q4 FY26
New Hire experienced Nurse Turnover at 1 year service	1.51% Q4 FY26

Strategic Retention & Engagement

Professional Development Council partnered with Human Resources to develop nurse-specific questions for ***Press Ganey Exit Interview Survey***

COUNCIL GOAL: Capture unique challenges, experiences, and insights of nursing staff exiting the organization

❖ **STAY INTERVIEWS-NURSE LEADER ROUNDING:**

- **Data Review:** Reviewed exit interview data to identify opportunities
- **Evidence Review:** Conducted a literature review of best practices for retention
- **Stay Interview Framework:** Developed stay interview questions
- **Stakeholder Engagement:** Gathered input from the Clinical Managers Committee and presented at Nurse Leader Council

NEXT STEPS: Referral to Practice Council to gather input from nurses

Strategic Retention & Engagement, *Cont.*

COUNCIL GOAL: Capture unique challenges, experiences, and insights of nursing staff exiting the organization

❖ **STANDARDIZING NURSE RECOGNITION:**

- **Data Review:** Reviewed exit interview data to identify opportunities
- **Evidence Review:** Conducted a literature review of best practices for recognition
- **Evaluate Current Recognition Practices:** Survey sent out to leaders to evaluate current recognition practices across clinical areas
  - **Daisy & STAR awards**
  - **Employee of the Quarter**
  - **Gratitude Tree**

NEXT STEPS: Formulate standardized recognition recommendations across all clinical areas, partner with HR and present to Nurse Leader Council


Salinas Valley HEALTH
Magnet Recognition with Distinction American Nurses Credentialing Center
THANK YOU

Accreditation/Regulatory Update

Kimothy Sparks, JD, RN

Interim Director of Accreditation & Regulatory Compliance

Salinas Valley HEALTH

Salinas Valley HEALTH

2026 Mock Survey

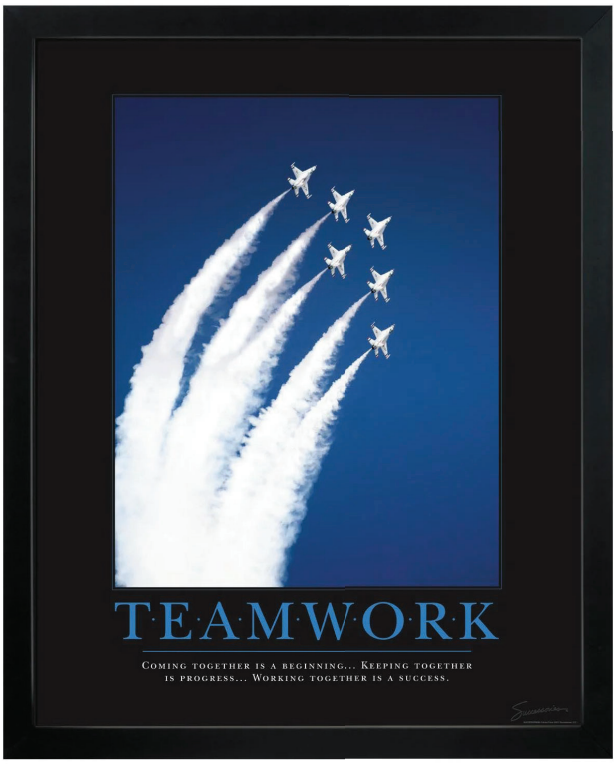
2027 Triennial TJC Survey

2026 Mock Survey – October 5-8

2027 Triennial TJC Survey – Late Winter 2026/Early Spring 2027

Preparations

- Initiate the Accreditation Readiness Committee (ARC)
- Survey Pocket Card
- Logistics Planning
- Weekly Safety Rounds
- Tracer Activity
- Chapter Focused Meetings



Salinas Valley HEALTH

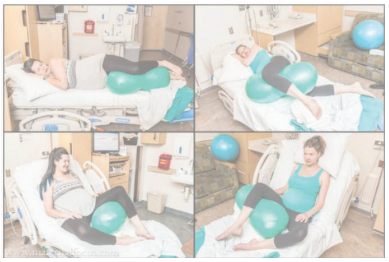
Perinatal Performance Improvement

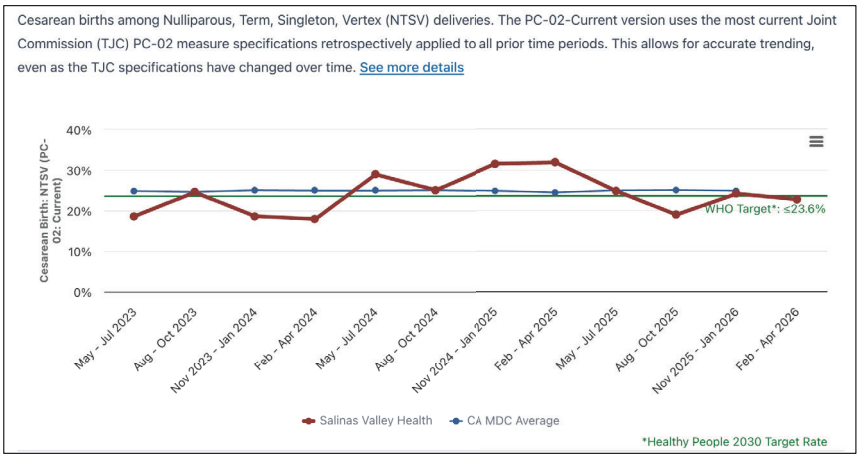
September 2026

NICU
Enhancing Developmental Care

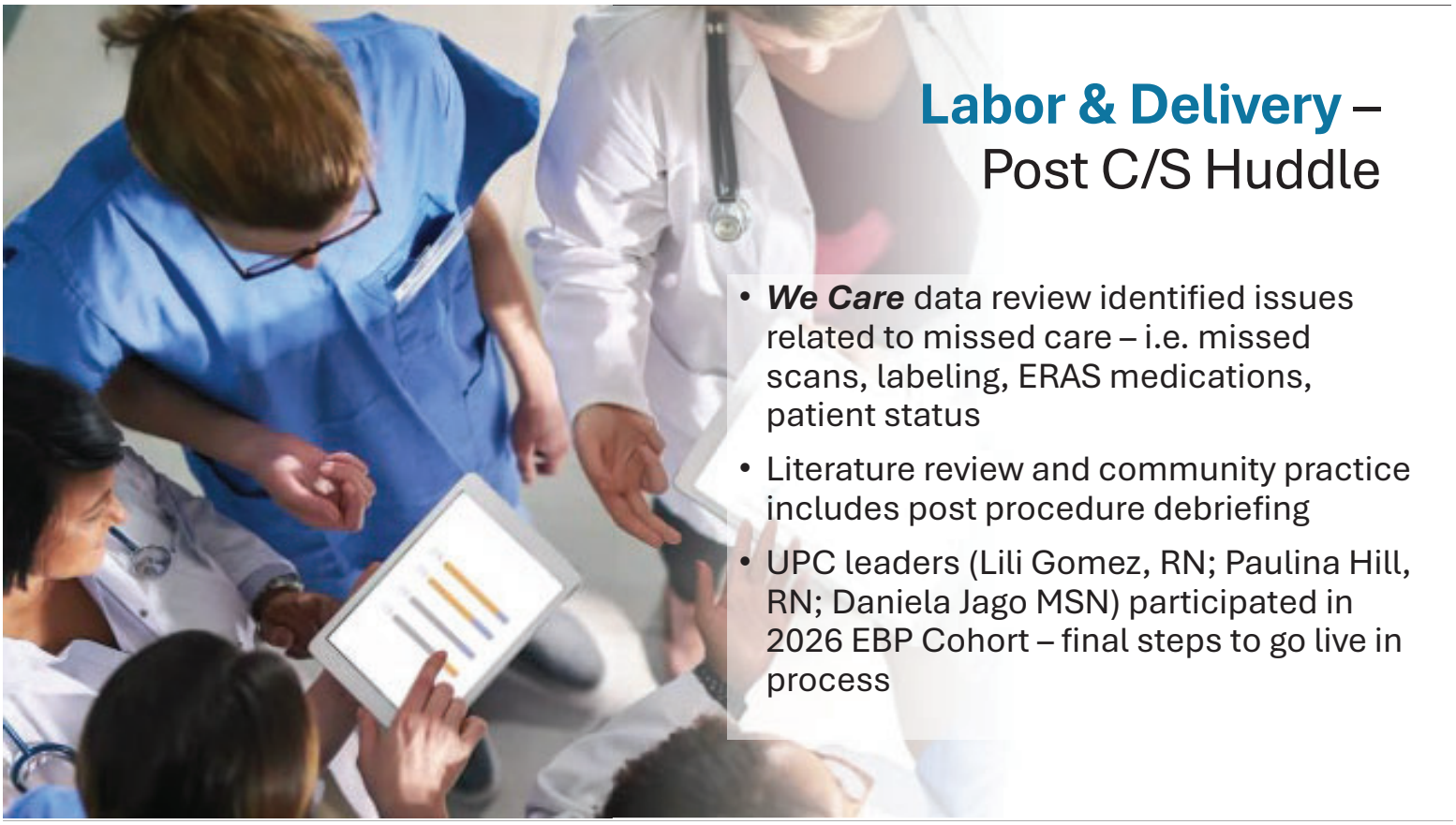
- **Sense program**
  - Smell is an infant's emotional compass
  - Is active before sight and language start to develop
  - The familiar scent helps promote attachment and ease stress ad anxiety for both baby and parents
- **Measurement**
  - Likert scale for parents on discharge specific to use of scented heart
  - Shared with staff regularly with other data points

Labor & Delivery - NTSV



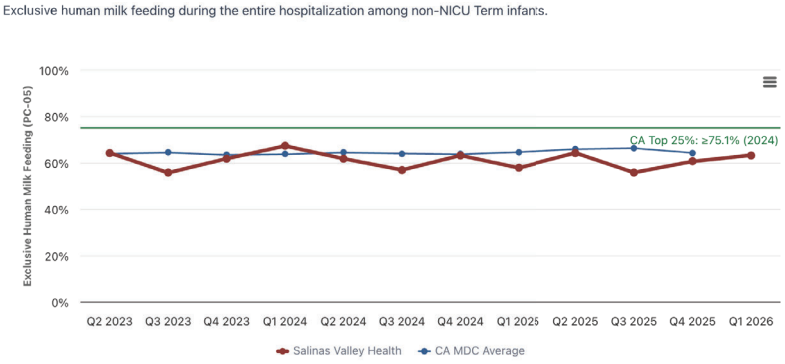


- NTSV Workgroup
  - Key stakeholders
  - Meet weekly
- Staff Education
  - SWELLs
  - Pitocin management
  - Cervical ripening
  - Spinning Babies
- Labor Dystocia checklist
- Recognitions
- Weekly data sharing



Labor & Delivery – Post C/S Huddle

- ***We Care*** data review identified issues related to missed care – i.e. missed scans, labeling, ERAS medications, patient status
- Literature review and community practice includes post procedure debriefing
- UPC leaders (Lili Gomez, RN; Paulina Hill, RN; Daniela Jago MSN) participated in 2026 EBP Cohort – final steps to go live in process

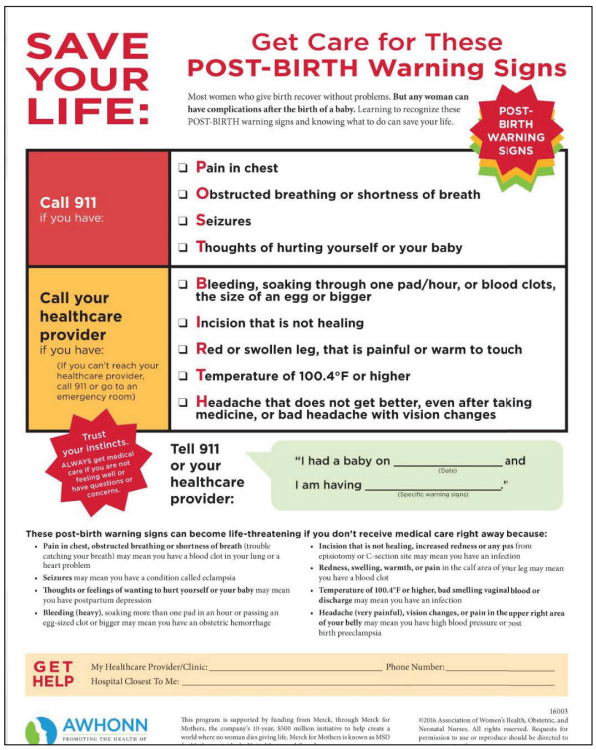


Mother Baby – Human donor milk

- Human donor milk
  - Offering exclusive breastfeeding mothers the use of donor milk for supplementation versus formula
  - Go live post Baby Friendly redesignation site visit

Mother-Baby Post Birth Warning Bracelets

- Post Birth Warning Signs
  - Take home messaging
- Collaboration with local EMS
- SVHMC Emergency department

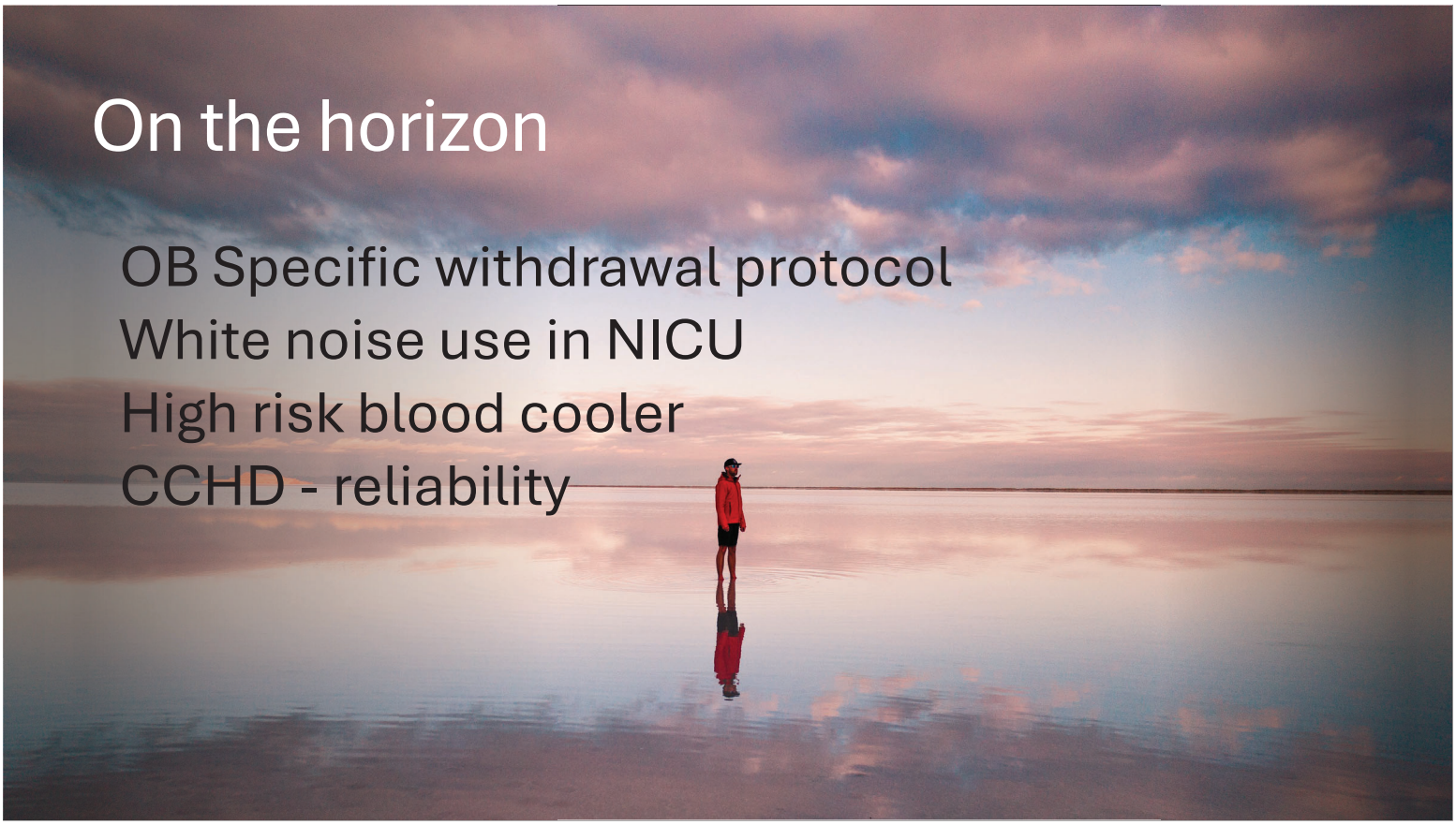


Lactation

- Baby Friendly Redesignation
- Exclusive breastfeeding rates
  - Site visit August 12, 13

Baby-Friendly USA

- Breastfeeding taskforce
- Expansion of outpatient lactation services
- Growth of # of IBCLC RNs
- Expanded support on nocs
- Provider inclusion/Taylor Farms participation



DEPARTMENT/SERVICE
Quality Improvement Reports

Case Management Department

Troy Scott *Director Case Management*
Vanity Horton Manager Case Management

Date: 9/14/2026

Notification of Admission

Notification of Admission (NOA) is the communication sent to the patient's health plan/payer notifying them that the patient has been admitted to the hospital and one of the earliest steps in the Revenue Cycle.

Patient admitted → Payer notified → Authorization/notification obtained → Concurrent review → Continued-stay authorization → Discharge notification

Notification completed by:

1. Phone Calls
2. Web Portal
3. Fax

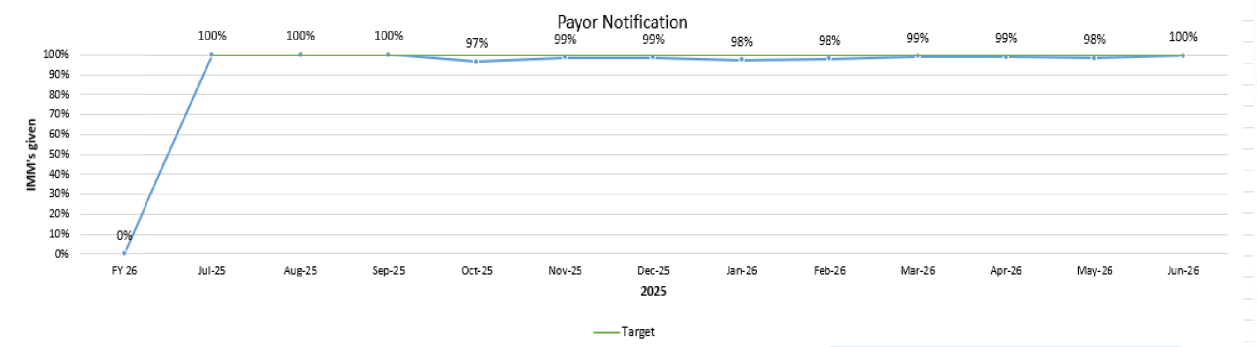
Data Analysis and Continuous Improvement Plans
NOA

Quality Assurance Measure	**Payor Notification**		
Target	**100%** Chart Area	Threshold	
Metric Definition	**Notification completed to insurance payor of admission within 24 hours.**		
Numerator	Number of admissions of patients with any insurance requiring admission notifications and the payor received notification within 24 hours of admission.	Denominator	Number of admissions of patients with any insurance requiring notification.
Inclusion	All patients with private insurance	Exclusion	None
Metric Rationale	**Private Insurance Contractual Requirement**		
Data Source	**Data Repository**		
Benchmark	**None**		

	FY 26	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	FY25 YTD	Q1 2026	Q2 2026	Q3 FY26	Q4 FY26
N		30	30	30	29	68	215	238	198	226	207	224	236	**1731**	90	312	662	667
D		30	30	30	30	69	218	244	202	228	209	228	237	**1755**	90	317	674	674
%		100%	100%	100%	97%	99%	99%	98%	98%	99%	99%	98%	100%	**99%**	100%	98%	98%	99%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data Analysis and Continuous Improvement Plans
NOA

	FY 26	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	FY25 YTD	Q1 2026	Q2 2026	Q3 FY26	Q4 FY26
N		30	30	30	29	68	215	238	198	226	207	224	236	**1731**	90	312	662	667
D		30	30	30	30	69	218	244	202	228	209	228	237	**1755**	90	317	674	674
%		100%	100%	100%	97%	99%	99%	98%	98%	99%	99%	98%	100%	**99%**	100%	98%	98%	99%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



Notification of Admission NOA

Barriers/Challenges

List what challenges you are experiencing and what you need support with:

Delayed Notification: Changes in payor are often not communicated in real time, leading to delays in updating systems and notifying the new payor.

Retroactive Coverage Confusion: Determining retroactive coverage dates can be complex and result in gaps in authorization or denial of services.

Authorization Mismatch: Services rendered under the initial payor may not meet the new payor's criteria, risking claim denials.

System Limitations: Hospital EMRs and financial systems may not automatically trigger alerts or re-authorization workflows when a payor changes.

Increased Administrative Burden: Staff must manually research, re-initiate notification, and obtain new authorizations, increasing workload and potential for error.

Communication Breakdown: Lack of coordination between registration, case management, billing, and utilization review departments can exacerbate delays and compliance issues.

Solution: EPIC Implementation and Automation

Medicare Outpatient Observation Notice
MOON

The Medicare MOON (Medicare Outpatient Observation Notice) is a notice hospitals must give to certain Medicare patients who are receiving outpatient observation services rather than being formally admitted as an inpatient.

- **That the patient is an outpatient status, even if they are staying in a hospital bed overnight.**
- **Why the patient is receiving observation services.**
- **That observation services are outpatient services and do not count as an inpatient admission.**
- **How the patient's Medicare coverage and cost-sharing may differ from an inpatient stay.**
- **That observation time does not count toward the 3-day inpatient hospital stay requirement for Medicare Part A SNF coverage.**
- **The patient's appeal rights and how to obtain additional information.**

Data Analysis and Continuous Improvement Plans

Audit Criteria

- **Patient Eligibility**
- **Observation Start Time**
- **Timeliness**
- **Reason for Observation**
- **Signature of patient or Family**
- **Interpreter utilization**
- **Electronic Consent**

Barriers/Challenges

List what challenges you are experiencing and what you need support with:

Observation Order entered late.

Observation over the Weekend.

Unexpected Discharge.

Payor change.

Solution: EPIC Work Queue

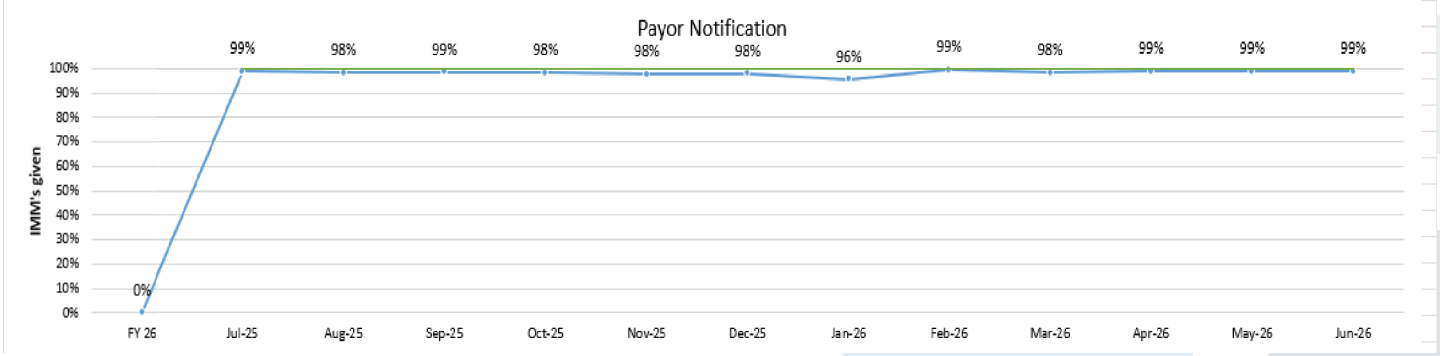
Data Analysis and Continuous Improvement Plans
MOON

Quality Assurance Measure	**Medicare Outpatient Observation Notice**		
Target	**100%**	Threshold	
Metric Definition	**Notification completed to patient within 36 hours of admission or within 4 hours prior to discharge**		
Numerator	Number of Medicare admissions of patients with final admission status "observation" that receive MOON Notification prior to discharge.	Denominator	Number of Medicare admissions with observation as the final admission status.
Inclusion	All medicare patients.	Exclusion	Medicare patient in Inpatient status.
Metric Rationale	**Condition of Participation requirement**		
Data Source	**EPIC**		
Benchmark	**None**		

	FY 26	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	FY25 YTD	Q1 2026	Q2 2026	Q3 FY26	Q4 FY26
N		30	30	29	29	43	84	76	62	71	64	69	72	659	89	156	209	205
D		30	30	30	30	43	84	76	62	71	64	69	72	661	90	157	209	205
%		100%	100%	97%	97%	100%	100%	100%	100%	100%	100%	100%	100%	**100%**	99%	99%	100%	100%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data Analysis and Continuous Improvement Plans
MOON

	FY 26	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	FY25 YTD	Q1 2026	Q2 2026	Q3 FY26	Q4 FY26
N		212	188	207	226	184	233	192	176	180	188	192	168	**2346**	607	643	548	548
D		214	191	210	230	188	238	201	177	183	190	194	170	**2386**	615	656	561	554
%		99%	98%	99%	98%	98%	98%	96%	99%	98%	99%	99%	99%	**98%**	99%	98%	98%	99%
Target		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%



EPIC Impact on NOA and MOON Completion

- Automated workflows in EPIC reduce manual tracking and administrative work associated with NOAs and MOONs.
- Standardized documentation improves accuracy and consistency of payer notifications and Medicare notices.
- EPIC workqueues and tasking help identify outstanding NOAs and MOONs, reducing the risk of missed notifications.
- Electronic MOON delivery and e-signature streamline patient notification and eliminate unnecessary paper processes.
- Real-time visibility allows Case Management leadership to monitor completion and address exceptions more quickly.
- Integrated patient and insurance information reduces duplicate data entry and transcription errors.
- Improved auditability provides a clear electronic record of notification, delivery, and completion.
- Reduced rework allows Case Managers to spend less time manually tracking compliance and more time on patient care coordination and discharge planning.
- **Overall impact**: EPIC is improving accuracy, compliance, visibility, and efficiency while reducing the administrative workload for Case Management

MOON

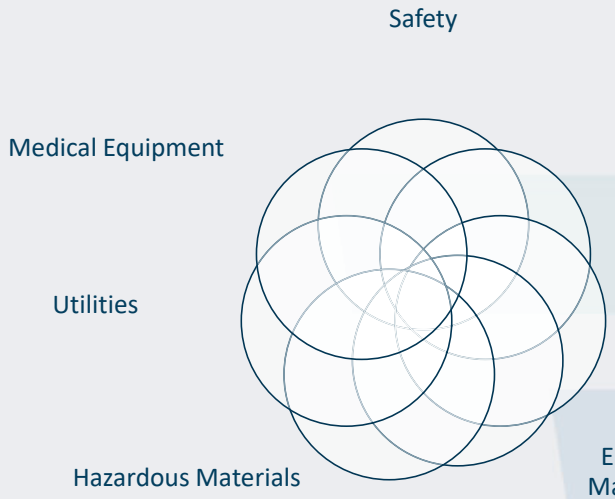
Quality and Efficient Practices Committee

Environmental Health and Safety Program

September 14, 2026

Salinas Valley HEALTH

Environmental Health and Safety



Regulatory, Standards, and Accreditation

Regulatory

State of California

CDPH – California Department of Public Health

Cal/OSHA – Occupational Safety and Health

HCAI – Department of Health Care Access and Information

DTSC – Department of Toxic Substances Control

Federal

CMS – Centers for Medicare and Medicaid Services

Accreditation

Joint Commission

Physical Environment Chapter

Emergency Management Chapter

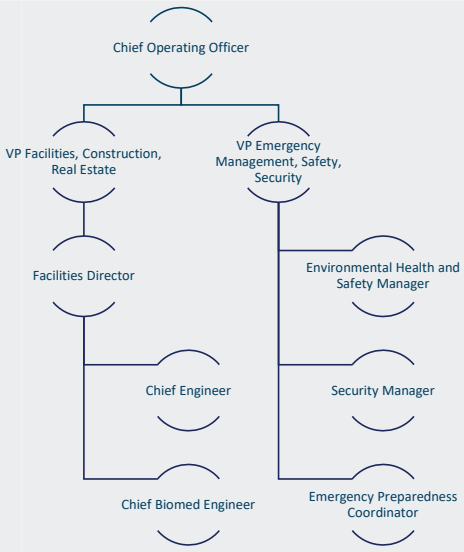
National Performance Goals

National Standards

NFPA – National Fire Protection Association

ANSI – American National Standards Institute

Program Hierarchy & Governance



Final

District Board

SME Review

Quality and Efficient Practices Committee

Staff

Physical Environment Committee

Workplace Safety Committee

Emergency Management Committee

Environmental Health and Safety

Mission → Culture of Safety ← Mindset

Safety Risk Management Cycle

Environmental Health and Safety

Mission → Culture of Safety ← Mindset

Program Performance Review

- ❑ Each program is reviewed annually
- ❑ Program objectives and performance measures are established
- ❑ Reporting occurs quarterly at the committee level
- ❑ Program Objectives and Performance Measures focus on areas improvement has been identified

Safety - 2025

The Safety Management Plan describes the programs used to manage a safety program to reduce the risk of injury for patients, staff and visitors for Salinas Valley Health Medical Center.

2025 Objective

1. Conduct Situational Awareness training for all staff to provide them with the tools they need to be more aware of their work surroundings for unsafe conditions that may impact the environment of care.

Performance Measures

1. During environmental tours and routine safety rounding ask employees to articulate the steps they would take should they observe a potentially unsafe condition. The goal for this performance measure is achieving a **95%** correct response rate. Assessment yielded a **92%** correct response rate, falling short of goal (95%).

Safety - 2026

2026 Objectives

1. Develop and implement enhanced Physical Environmental Assessment process that includes a more comprehensive feedback loop to ensure findings are addressed in real-time, and consistent data is available to ensure limited recurrence of issues.

2. Revitalize and deploy the Departmental Safety Champion program, focusing on peer-to-peer activities that emulate core elements of a strong culture of safety such as actions like speaking up to empower each other, holding accountability through shared responsibility, improved focus by celebrating and sharing good catches, educating to build stronger teams, embracing humility and fostering open dialog to enhance transparency, and driving a philosophy that everyone contributes to our safety culture.

3. Continue to reinforce an organizational culture of safety through enhanced situational awareness training and consistent safety rounds for all departments, with the goal of providing them with the tools needed to be more aware of their work surroundings for unsafe conditions that may impact the safety of our staff, our patients, and the public.

Performance Measures

1. Complete a physical environment assessment twice annually for each department.
2. Close the mitigation planning phase of Physical Environment Assessment findings within a 10-business day target window.
3. Onboard 4 departments into the Safety Champion Program.
4. Perform quarterly safety rounding for all departments to reenforce safety practices and assess employee's competency to articulate the steps necessary should they observe a potentially unsafe condition.

Fire Safety - 2025

The Fire Safety Management Plan describes the methods for preventing the potential for a fire at the Salinas Valley Health Medical Center (SVHMC) and it's licensed off site locations.

2025 Objectives

1. During environmental rounds and routine safety rounds ask staff to articulate the Salinas Valley Health policy for staff bringing their personally owned electrical devices into the hospital.

2. During environmental rounds and routine safety rounds, educate staff on the provisions of the Salinas Valley Health Decoration Policy.

Performance Measures

1. During environmental rounds and routine safety rounds ask staff to articulate the Salinas Valley Health policy for staff bringing their personally owned electrical devices into the hospital. Goal for compliance for this performance measure was set at **90%**. Exceeded goal with a **94%** compliance rate.

2. During environmental rounds and routine safety rounds, educate staff on the provisions of the Salinas Valley Health Decoration Policy. Objective achieved, however, additional training will be required to ensure compliance.

Fire Safety - 2026

2026 Objective

Re-educate staff on the provisions of Salinas Valley Health's Decoration Policy.

Performance Measures

1. During environmental rounds and routine safety rounds, educate staff on the provisions of the Salinas Valley Health Decoration Policy.

2. Increase staff participation during unannounced fire drills.

Security - 2025

The Security Management Plan describes the methods of providing physical security measures for people, equipment and other material through risk assessment and management of Salinas Valley Health Medical Center (SVHMC) and it's licensed off site locations.

2025 Objectives

1. Install a walkthrough metal detector in the main lobby to screen all patients and visitors entering the facility.

2. Achieve a 30% return rate of lost and found belongings to their rightful owners.

Performance Measures

1. The Evolv Weapon Detection System was purchased, however, installation was delayed due to regulatory-driven built environment.

2. A total of 1136 lost and found items were collected, of which 306 (27%) were returned successfully.

Security - 2026

2026 Objective

1. Install a walkthrough metal detector in the main lobby to screen all patients and visitors entering the facility.

2. Provide Active Assailant training to include 6 classroom sessions and 6 practical field exercises.

Performance Measures

1. Reduce the number of Code Grays by 10% by providing staff Techniques of Effective Aggression Management (TEAM) training.

Emergency Management - 2025

The Emergency Management Plan educates employees, medical staff and other individuals providing services at Salinas Valley Health Medical Center and its licensed off-site facilities, how to provide safe, effective and timely response in the event of an internal, external, natural, technological, or man-made disaster that could harm or disrupt the environment of care.

2025 Objectives

1. Increase the number of staff registered with the medical center's mass notification system, Everbridge, from 63% to 100% to enhance the hospital's communication plan during a disaster.

2. Train 29 hospital incident command staff on their roles and responsibilities during incident activations.

Performance Measures

1. The number of staff registered with Everbridge increased by 252 employees in 2025 to 74% overall.

2. Hospital Incident Command System (HICS) training sessions were held on two separate dates covering 29 staff in total.

Emergency Management - 2026

2026 Objective

1. Expand the scale and capabilities of the Hospital Emergency Response Team (HERT).

2. Revise the Emergency Management Communications Plan to include a comprehensive strategy for mass notification.

3. Redevelop and deploy a Hospital Incident Command System (HICS) training program to capture staff at all levels of the organization.

Performance Measures

1. Increase HERT participation by 42% and diversify the roster to decompress clinical and support staff.

2. Deliver draft Communications Plan for EM committee review, and facilitate pilot integration of Fire/Security alarm, Cisco phone, and environmental control systems to the Everbridge mass notification platform.

3. Roll out revised e-learning, in-person classroom, and executive table-top training modules for HICS.

Hazardous Materials & Waste - 2025

The Hazardous Material and Waste (HAZMAT) Management Plan describes the methods for handling and storing hazardous materials and waste through thorough risk assessment and physical plant management at Salinas Valley Health Medical Center (SVHMC) and it's licensed off site locations.

2025 Objectives

1. Review and successfully renegotiate contract renewal with current hazardous waste hauler (Stericycle).

Performance Measures

1. Waste hauler contract renewal executed March 14, 2025.

2. During routine safety rounding and environmental tours assessing for unlabeled containers of product, a compliance rate of 95% was achieved, exceeding the goal of 90%.

Hazardous Materials & Waste - 2026

2026 Objective

1. Expand scope of the current hazardous materials electronic communications platform to provide departments with improved access to specific, detailed health and safety information about the products utilized in their respective work areas.

2. Leveraging technology, improve management of the hazardous materials and waste manifest process through implementation of a comprehensive.

3. Continue to conduct safety rounding and regular hazardous materials spill procedure training.

Performance Measures

1. Complete a comprehensive review of both existing, as well as potential technological solutions for cataloging and tracking Safety Data Sheets (SDS), and achieve full implementation of a enhanced management system.

2. Complete discovery phase and initial approval for an electronic hazardous material manifest system.

3. Conduct quarterly hazardous material storage assessment rounds for all relevant departments, and ensure staff are competent and equipped to manage spills.

Utilities - 2025

The Utility Management Plan provides a process for the proper design, installation, and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment for Salinas Valley Health Medical Center (SVHMC) and it's licensed off-site locations.

2025 Objectives

1. Purchase and install a new heater/boiler for the medical center to replace the current unit that has reached the end of its service life.

2. Conduct quarterly utilities training for Facilities staff, helping to improve knowledge, awareness, and overall safety.

Performance Measures

1. Heater/boiler replacement installation was postponed. Temporary unit was deployed as an interim measure.

2. Quarterly utilities training was completed.

Utilities - 2026

2026 Objective

1. Install permanent heater/boiler replacement for the medical center to replace the current unit that has reached the end of its service life.

Performance Measures

1. Replace 48 existing outdoor campus lighting with more efficient fixtures.

Medical Equipment - 2025

The Medical Equipment Management Program is designed to assure proper selection of the appropriate medical equipment to support a safe patient care and treatment environment for Salinas Valley Health Medical Center (SVHMC) and it's licensed off-site locations.

2025 Objectives

1. Manage the maintenance of all Centrak hardware used for Centani Asset/ Temperature applications and Hill Rom Nurse Call systems.

Performance Measures

1. 95% completion rate of corrective maintenance work orders. Threshold was 92%

Medical Equipment - 2026

2026 Objective

1. Complete the house-wide Philips patient monitoring software upgrade from PIC iX to PIC iX-4, ensuring all affected monitoring hardware is updated.

Performance Measures

1. Post-Preventative Maintenance Failure rate: Goal: < 1% of PMs result in device failure within (30) days following the completion of a PM.

Quality and Efficient Practices Committee

Environmental Health and Safety Program

September 14, 2026

Salinas Valley HEALTH

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT