November 5, 2026

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **QUALITY AND EFFICIENT PRACTICES COMMITTEE - COMMITTEE OF THE WHOLE** of **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, NOVEMBER 9, 2026, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA**.

(*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, NOVEMBER 9, 2026, 8:30 A.M.
DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California

(Visit SalinasValleyHealth.com/virtualboardmeeting for Public Access Information)

AGENDA

1. Call to Order / Roll Call

2. Public Comment

   This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.

3. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of October 12, 2026. (CARSON)

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

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

5. Performance Improvement Reports
   - Cardiology/Sleep Medicine (GIOVANETTI)

6. Closed Session

7. Reconvene Open Session/Report on Closed Session

8. Adjournment

   The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **December 14, 2026** at 8:30 a.m.

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

This Committee meeting may be attended by Board Members who do not sit on this Committee. In the event that a quorum of the entire Board is present, this Committee shall act as a Committee of the Whole. In either case, any item acted upon by the Committee or the Committee of the Whole will require consideration and action by the full Board of Directors as a prerequisite to its legal enactment.

The Salinas Valley Health (SVH) Committee packet is available at the Board Meeting, electronically at https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2026/, and in the SVH Human Resources Department located at 611 Abbott Street, Suite 201, Salinas, California, 93901. All items appearing on the agenda are subject to action by the SVH Board.

Requests for a disability related modification or accommodation, including auxiliary aids or Spanish translation services, in order to attend or participate in-person at a meeting, need to be made to the Board Clerk during regular business hours at 831-759-3208 at least forty-eight (48) hours prior to the posted time for the meeting in order to enable the District to make reasonable accommodations.

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

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)
2. Mock Survey Quality & Safety Results (SPARKS)

ADJOURN TO OPEN SESSION

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

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 OCTOBER 12, 2026

Committee Member Attendance:

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

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

Advisory Non-Voting Members Present:
In Person: Tim Albert, M.D., CCO, Cheryl Pirozzoli, Family/ Patient Advisor, Allen Radner, MD, President/ CEO, Alysha Hyland, CAO, Rakesh Singh, VPMA

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

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 SEPTEMBER 14, 2026

Approve the minutes of the September 14, 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, and second by Committee Member Miller the minutes of the September 14, 2026 Quality and Efficient Practices Committee Meeting are approved as presented.

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

Motion Carried.

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

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

Carla Spencer, CNO, introduced a member of her team to present an update on the Night Shift Practice Council Members. Hannah Dickerson, BSN, RN, CMSRN, gave an overview of the council's purpose, FY26 Council Goals and Accomplishments, and FY 27 Council Goals. She highlighted that they have two goals this year: Restfulness of Hospital Environment and Safety Culture: Prevention and Reporting. Ray Morales presented the different areas of their FY 26 Council Goals and Accomplishments. Lastly, Hannah reviewed the FY27 projects.

COMMITTEE MEMBER DISCUSSION: None.

5. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF PATIENT SAFETY PLAN

Amy Grooters, RN NE-BC Patient Safety Manager, presented the purpose of the patient safety program. She overviewed the scope of work, patient safety structural measures, national performance goals, and the health and safety code.

A full report was included in the packet.

PUBLIC COMMENT: None.

COMMITTEE MEMBER DISCUSSION: Committee Member Dr. Gerber was unaware that the Patient Safety Plan was finalized.

MOTION:
Upon motion by Committee Member Spencer and second by Committee Member Miller the Patient Safety Plan is approved as presented.

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

Motion Carried.

6. PERFORMANCE IMPROVEMENT REPORTS:

- **Nutrition Services**: Jennifer Nader, MPH, RD, Director of Nutrition Services, gave an overview of the Nutrition Services Department structure. She then went on to explain how they assess the RD Competency and Malnutrition Diagnosis. Then she overviewed the malnutrition initiative purpose, process, and why it matters. She then reviewed the top six things the Nutrition Services team is doing and reviewed data for the Test Tray program. Lastly, she discussed the next steps.
- **Laboratory Services**: Timothy Johnson, MLS (ASCP), Laboratory Quality Assurance and Quality Improvement Supervisor, gave an overview of Quality and Safety Goals 2027. He then went on to review the Data for: Blood Bank Metrics, ER Turn Around Times, Microbiology

Turn Around Times, Microbiology Blood Culture Contamination Rates. Lastly, he overviewed the Barriers/Challenges and next steps.

Full reports were included in the packet.

COMMITTEE MEMBER DISCUSSION: In regards to Laboratory Services presentation, Chair Carson asked if molecular assay is a new feature. She also asked what the rationale was for reducing draws from two to one.

7. 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 9:13 a.m.

8. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:20 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)

9. ADJOURNMENT

There being no other business, the meeting adjourned at 9:21 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for Monday, **November 9, 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: Perinatal Unit Practice Council
Monday, November 9, 2026

Perinatal Unit Practice Council (PUPC)

COUNCIL MEMBERS

Chair: Liliana Gomez, BSN, RNC-OB

Co-Chair: Maria Melendrez, BSN

Assoc. Co-Chair: Paulina Hill, BSN, RNC-MNN, CLC

Advisor: Dani Jago, MSN, RNC-OB, CNML

Angelica Gomez, BSN, RN, PHN, RNC-MNN

Leticia Jara, BSN, RNC-MNN

Weronica Paden, BSN, RNC-MNN

Jamie Crompton, BSN

Anna Rider, BSN

COUNCIL PURPOSE

- ❑ **To identify and implement standards of care, and evidence-based practice specific to the Perinatal care area**
- ❑ **To identify and resolve clinical and systems issues impacting of affecting care coordination, a healthy work environment, the delivery of patient-family centered care, patient safety, and clinical outcomes**

Initiatives:



COMPLETED:
POST BIRTH Alert Bracelets

COMPLETED:
SENSE Program:
Cloth Hearts

In-Progress #1:
MFTI: Triage Relaunch Plan

Post Birth Alert Bracelet:

BACKGROUND:

- Most postpartum women recover without complications after giving birth, but complications can occur up to one year after delivery
- Learning to recognize **POST-BIRTH Warning Signs** and knowing what to do can save lives
- AWHONN[1] has developed a bracelet with a QR code linking to critical **POST-BIRTH Warning Signs** information

INTERVENTION:

- Paulina Hill, *Mother-Baby RN*, established a working group within the Perinatal Unit Practice Council (PUPC) with direct support from:
  - Julie Vasher, *Director, Women & Children's Services*
  - David Thompson, *Director, Emergency Room*
  - Kimberly Hernandez, *Monterey County EMS Services Analyst*
  - Bedside Mother-Baby RNs across shifts who provided feedback
- Education and instructions for distributing the bracelet were provided to perinatal staff
- All postpartum mothers who deliver at SVH will receive a bright orange bracelet with a QR code and instructions on how to access **POST BIRTH Warning Signs** information
- **Go Live date:** 07/24/2026.

[1]Association of Women's Health, Obstetric and Neonatal Nurses

Post Birth Alert Bracelet, *Cont.*:

OUTCOME:

- The bracelet promotes safety across care settings by helping healthcare providers recognize a patient's recent birth history and remain alert to potential postpartum complications
- The bracelet also serves as a daily visual reminder for postpartum mothers to monitor their bodies for **POST BIRTH Warning Signs**
- The initiative promotes awareness and early recognition of **POST-BIRTH Warning Signs** to support timely medical evaluation and intervention



Photo provided by Paulina Hill (MB RN), 2026

SENSE Program: Cloth Hearts

BACKGROUND:

- The fetus's sense of smell begins developing very early in pregnancy, with olfactory receptors forming by eight weeks and the sense of smell becoming functional around 24 weeks gestation
- The purpose of implementing the **Scent Cloth Hearts** is to provide appropriate sensory stimulation to optimize infant development. **Scent Cloth Hearts** combined with maternal scent and breast milk, assist in olfactory exposures for the infant and can also aid in parental/infant bonding

INTERVENTION:

- Parents place a soft cotton heart against their skin, inside their shirt or bra, for at least three hours to transfer their natural scent to the cloth
- The scented heart is placed inside the baby's incubator or isolette to promote calmness, provide comfort and reassurance during parental separation
- **Go Live date:** 05/2026.

SENSE Program: Cloth Hearts, *Cont.*:

OUTCOME:

- Helps mothers and babies recognize each other's scent
- Helps provide mothers with their babies' scent and babies with their mothers' scent
- Familiar scent exposure reduces infant stress, improves feeding cues, and promotes healthy neurodevelopment
- It can also support maternal milk production



Photograph provided by Julie Vasher, 2026

OBED Volume:



- OBED volume increases highlight the need to redesign workflow to room patients by acuity versus "first come first served"
- Utilize AWHONN MFTI (Maternal Fetal Triage Index) to drive prioritization for treatment room assignment or waiting room assignment

MFTI: OB Emergency Department Triage Workflow

BACKGROUND:

- Maternal Fetal Triage Index (MFTI) moves away from a traditional "first-come, first-served" approach, ensuring that patients with high-risk or emergency conditions are seen immediately
- The MFTI scale consists of five levels, ranging from Priority 1 (highest acuity, requiring immediate intervention) to Priority 5 (lowest acuity, such as a scheduled procedure in the absence of active complaints)

INTERVENTION:

- A team of Labor & Delivery RNs (Aubree Collins, Norma Coyazo, and Lily Gomez) was developed with support from Dani Jago, L&D Clinical Manager, and Alyssa Alexander, Perinatal Services Clinical Educator

PLAN/UPDATE:

- Provide L&D nurses with instructions and a framework for appropriate triage of patients presenting to the OBED[1]
- Education and review of the MFTI framework will take place during the Q4 Perinatal Skills Day in October 2026

[1]Obstetric Emergency Department

Happening Now:

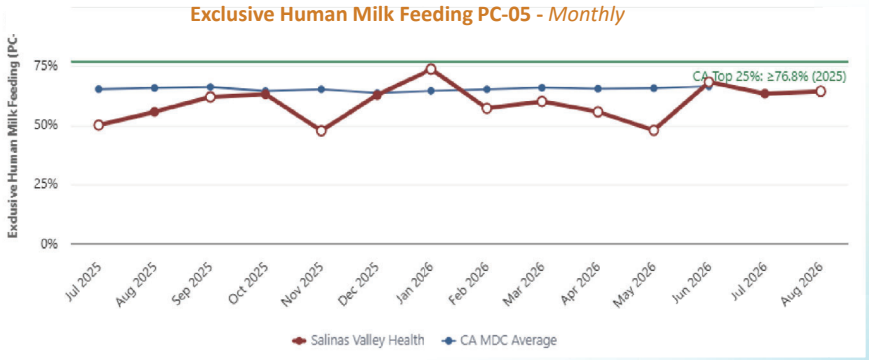
2026 Initiatives:

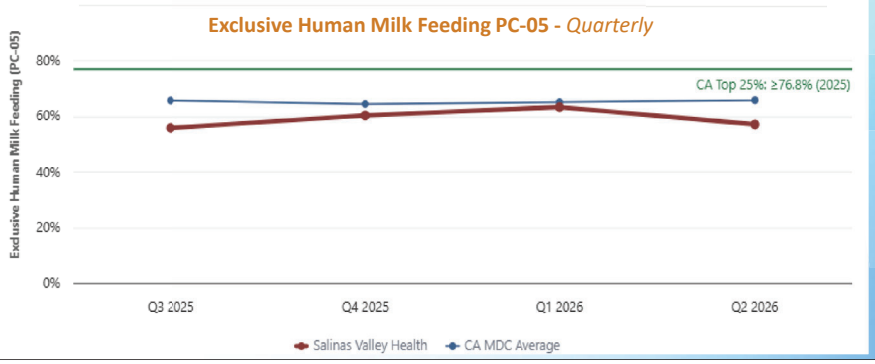
- ❑ Standardized perinatal Blood Glucose (BG)/Insulin process for gestational diabetes, antepartum
- ❑ End of case debrief following Cesarean Sections (C/S)
- ❑ Standardize timelines for scheduled C/S
- ❑ NICUs parental discharge readiness; whiteboards
- ❑ Obstetric withdrawal protocol – Clinical Opiate Withdrawal Scale (COWS)

2026 Council Goals:

- ❑ Goal #1: INCREASE the Perinatal Cluster (L&D, MB, and NICU) **Safety Culture Index:** Prevention and Reporting Score from 4.02 in 2025 to ≥ 4.13 in 2026
- ❑ Goal #2: INCREASE the Perinatal Cluster (L&D, MB, and NICU) **Certification Rate** from 45% in February 2026 (baseline) to ≥ 52% by February 2027
- ❑ Goal #3: *(See next slide for data)*

PUPC Subcommittee: Lactation Taskforce





- **Goal #3:** INCREASE the **Exclusive Breastfeeding Rate** Across the Perinatal Cluster (L&D, MB, and NICU) by 1 Percentage Point, from the 2025 baseline mean rate of 59.6% to a target rate of 60.6% in 2026
  - Final steps of implementation of offering human donor milk to those who select exclusive breastfeeding on admission

Thank you, questions?

DEPARTMENT/SERVICE
Quality Improvement Reports

Cardiovascular Service line

Report to Quality and Efficient Practices Committee (QEPC)

Salinas Valley HEALTH

Megan Giovanetti
Director Cardiovascular Services and Sleep

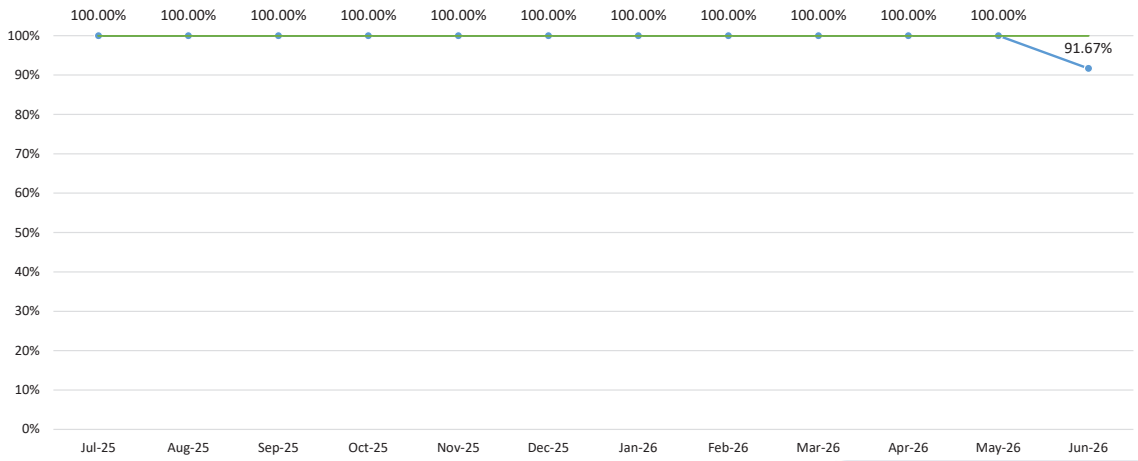
Date: November 9, 2026

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

Quality / Safety Goals - Cardiology

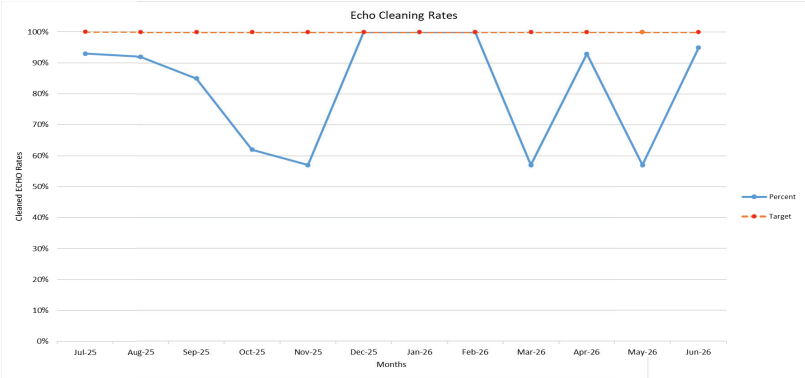
MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA SOURCE	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
STAT ECHO read within 60 min	Process	100%	Patient	Rate based (N/D)	Variable	Retro chart review	Quarterly	CV Service line meeting, Staff Meeting	Quarterly
Performance Improvement Measures									
100% Equipment Cleaning Sign-Off Complete	Process	100%	Safety	Rate Based	Variable	Retro chart review	As needed	Staff meetings, email	Monthly
Door to EKG	Outcome	90.00%	Patient Centered	Rate based (N/D)	Variable	Retro chart review	As needed	Staff meetings, email	Monthly

Data/ Data Analysis and Continuous Improvement Plans



STAT ECHOs read within 60 minutes remained consistently above target, with 100% compliance.

Data/ Data Analysis and Continuous Improvement Plans - Echo Equipment Cleaning Compliance Trend



Echo Cleaning Logs (2027 Fiscal year)

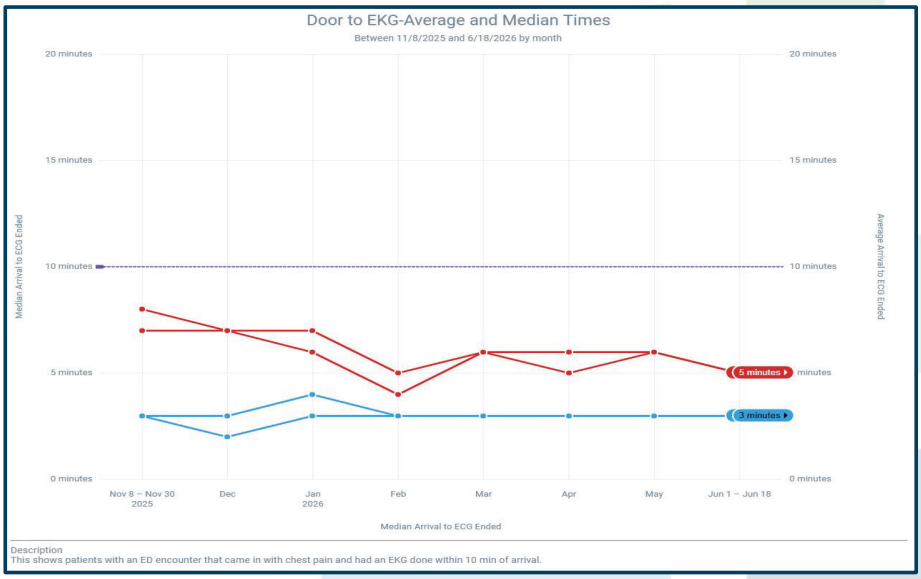
7	2026	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27		Qtr 1	Qtr 2	Qtr 3	Qtr 4
N		300	304	304														
D		304	304	304														
%		98.70%	100.00%	100.00%										99.57%	99.57%			
Goal		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%					

- Strong early compliance (Jul–Sep: **92–93%**)
- Decline noted in Oct–Nov (**57–62%**)
- Peak performance achieved Dec–Feb (**100% compliance**)
- Variability continued Mar–Jun (**57–95%**), highlighting opportunity for consistency

Data/ Data Analysis and Continuous Improvement Plans - Echo Equipment Cleaning Trend

	2025	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 FY25	Q2 FY2	Q3 FY26	Q4 FY26
N		54	42	51	13	12	20	60	57	40	28	40	21	424	147	45	157	75
D		58	46	60	20	21	20	60	57	70	30	70	22	495	164	61	187	83
%		93.0%	92.0%	85.0%	62.0%	57.0%	100.0%	100.0%	100.0%	57.0%	93.0%	57.0%	95.0%	85.7%	73.8%	73.8%	84.0%	90.4%
NTE 2%		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Data/ Data Analysis and Continuous Improvement Plans- Door to EKG Average and Median Times



- Target Met
- Time Range: November 2025 – June 2026
- Blue: Walk In, Red: Ambulance

Barriers/Challenges

- Echo STAT ordering policy compliance
- Inconsistent completion of cleaning sign-off

Next Steps

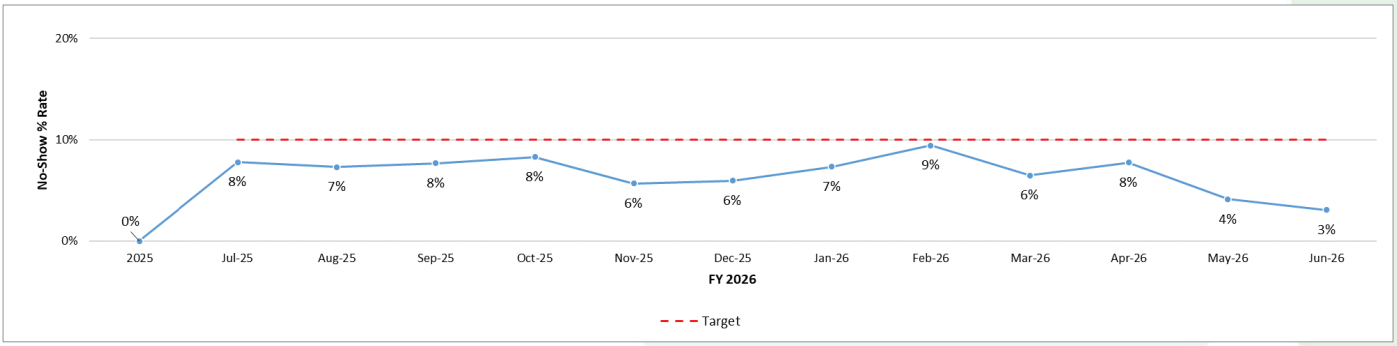
- Education and real-time feedback provided
- Reinforcing cleaning and documentation standards
- Reviewing expectations during huddles/meetings
- Providing real-time feedback and coaching
- Daily review of cleaning logs by lead tech

Quality / Safety Goals- Cardiac Wellness

MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA SOURCE	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
No shows	Outcome	<10%	Effective	Rate Based	100%	Data repository	Monthly	Staff meeting, QIC	Monthly
Performance Improvement Measures									
Blood pressure management	Outcome	80%	Effective	Rate based (N/D)	100%	Retro chart review	Monthly	Staff meeting, QIC	Monthly

No-show rates meets the <10% target.

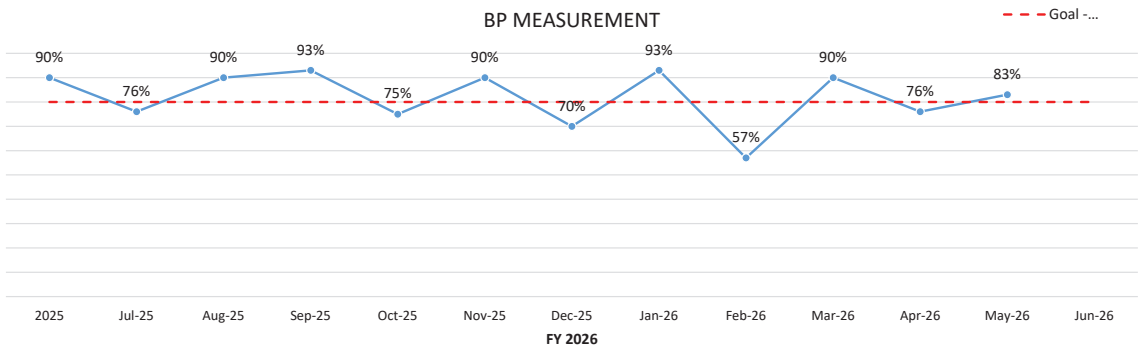
Data/Data Analysis No-Show Rates



	2026	Jul-26	Aug-26	Sep-26
N		20	22	30
D		402	406	425
%		5%	5%	7%
Target		10%	10%	10%

- Target: No-Show Rates < 10%
- Goal Met

Data/Data Analysis BP Measurement



	2026	Jul-26	Aug-25	Sep-25
N	18	21	15	10
D	20	26	16	11
%	90%	76%	90%	93%
Goal - 80%	80%	80%	80%	80%

- Met or exceeded 80% goal in **7 of 12 months**
- Performance ranged from **57%–93%**
- Highest score: **93%**

Barriers/Challenges

- Medication compliance challenges
- Unhealthy eating habits
- Limited exercise participation

Next Steps

- Medication reminders and pharmacy support
- Wellness Center education
- Promote exercise and healthy lifestyle changes

Quality / Safety Goals – Cardiovascular Diagnostics

Reporting Period: 7/2024 – 6/2025

Locations: **230 San Jose Street, Suite B (SJ)**
Lower Ragsdale, Suite 103 (RR)

- **Informed About Delays**
- **Sensitivity to Patient Needs**

Data Analysis and Continuous Improvement Plans

Informed About Delays:

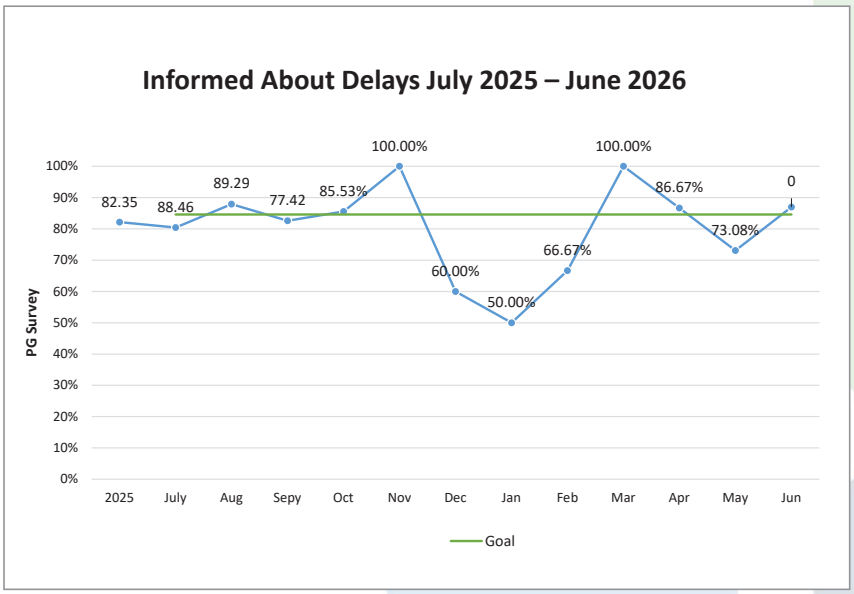
Baseline: 82.14%

Goal: Increase PG Score 3%

Target: 84.6%

- low 50% Jan. 2026
- high 100%

Nov. 2025 & Mar 2026



Barriers/Challenges

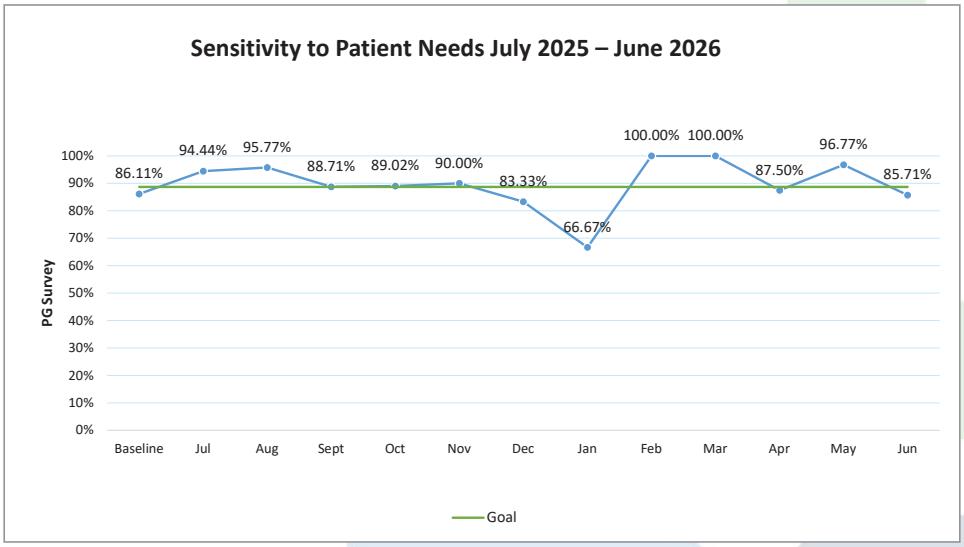
- Awareness
  - Space & Time
  - Logistics
- Communication
  - Front/Back/Front

Next Steps

- Refresh
  - SJ 95% complete
  - RR evaluating
- Communication
  - Awareness
  - Huddle more, Huddle often
  - Accountability

Sensitivity to Patient Needs

- Baseline: 86.11%
- Goal: Increase PG Score 3%
- Target: 88.69%
  - low 66.67% Jan 2026
  - high 100% Feb & Mar 2026

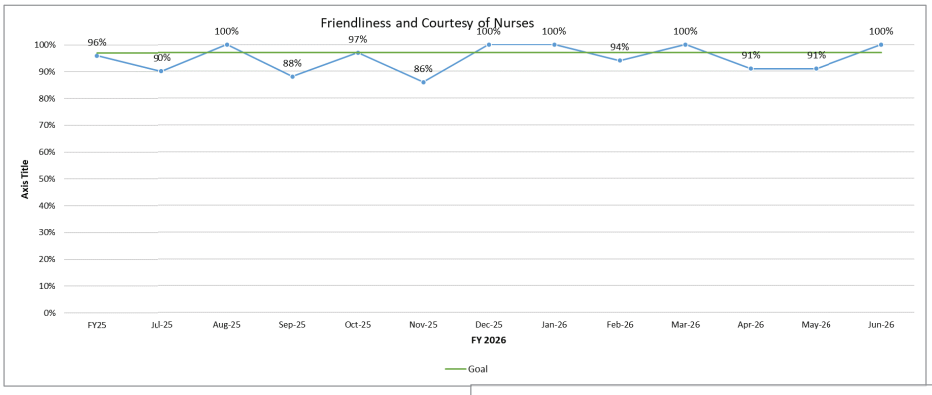


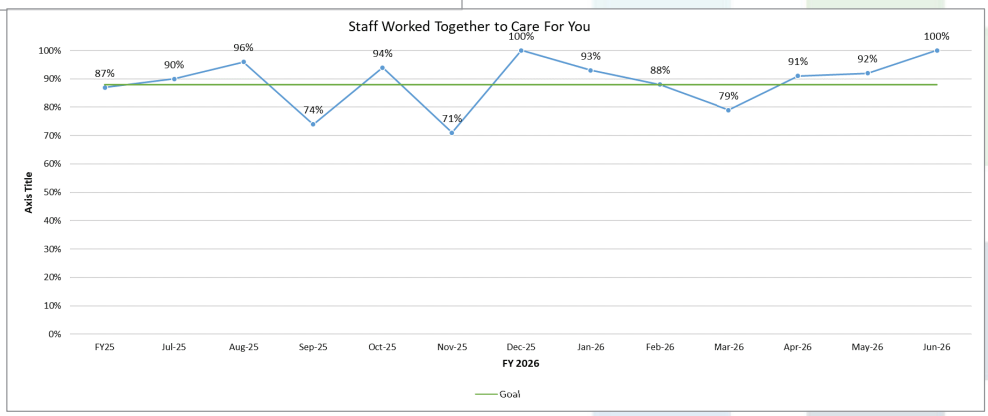
Salinas Valley HEALTH

QUALITY ASSESSMENT / PERFORMANCE IMPROVEMENT PLAN – 2027
CARDIOVASCULAR DIAGNOSTICS

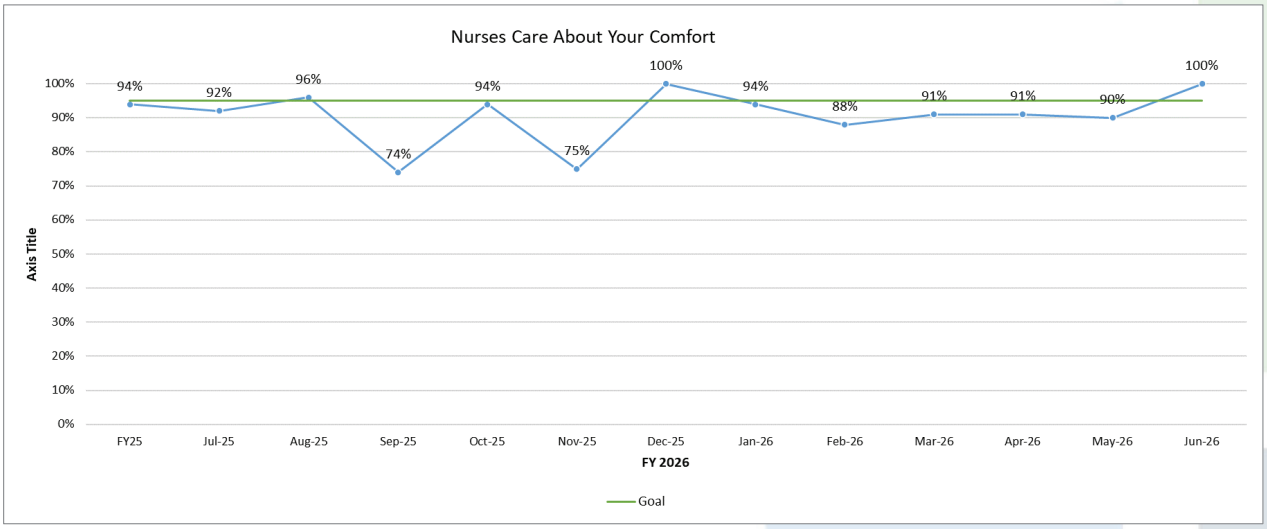
MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA COLLECTION METHOD	DATA COLLECTION FREQUENCY
Quality Assurance Measures							
Waiting Time In Registration	Process	86.50%	Timely	Rate based (N/D)	Rate based (N/D)	Registry data	Daily
Performance Improvement Measures							
Informed About Delays	Process	86%	Timely	Rate based (N/D)		Registry data	Daily

MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA SOURCE	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
Avoximeter QCs	Process	100%	Safe	Rate based (N/D)	52	Observation	Monthly	Staff Meetings	Monthly
Performance Improvement Measures									
Friendliness/Courtesy of Nurses	Outcome	97%	Patient-Centered	Rate based (N/D)		Interview	Monthly	Staff Meetings/ Magnet	Monthly
Staff work together to take care of you	Outcome	88%	Patient-Centered	Rate based (N/D)		Interview	Monthly	Staff Meetings/ Magnet	Monthly
Nurses care about your comfort	Outcome	95%	Patient-Centered	Rate based (N/D)		Interview	Monthly	Staff Meetings/ Magnet	Monthly
Patient Readiness	Outcome	85%	Timely	Rate based (N/D)		Retro chart review	Monthly	Staff Meeting	Monthly
Discharge Phonecalls	Outcome	80%	Patient-Centered	Rate based (N/D)		Retro chart review	Monthly	Staff Meeting	Monthly

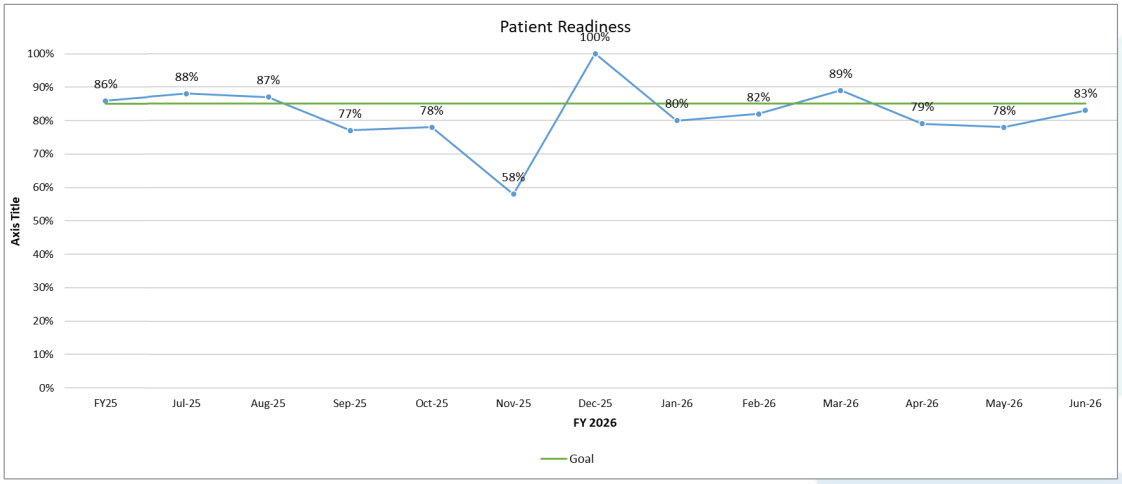




Nurses Care About Your Comfort

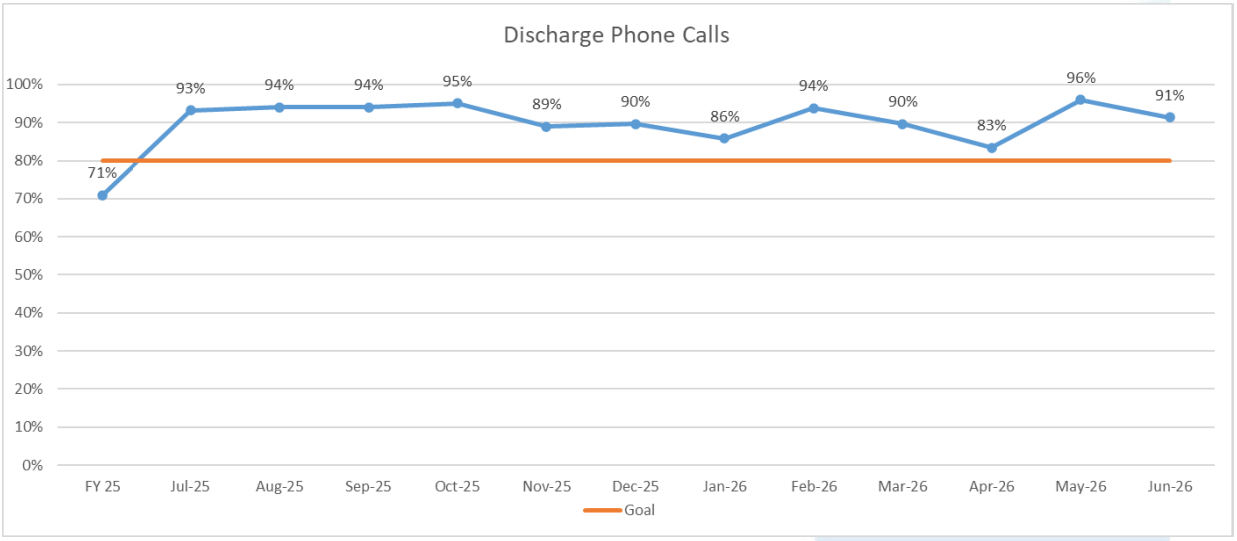


Patient Readiness



	FY26	Jul-26	Aug-26	Sep-26
N	84	92	95	84
D	100	100	100	100
%	84%	92%	95%	84%
Goal	85%	85%	85%	85%

Discharge Phone Calls



New Goals for FY 2027

Our Focus for Ambulatory (Cath Lab and Cath Lab Holding) will be in the Communication Domain.

We are in the process of gathering data and have a draft tentative plan.

Salinas Valley HEALTH

DEPARTMENT/UNIT: FY2027 PATIENT EXPERIENCE WORKPLAN

Last Updated: 10/23/2026

OUTCOME MEASURE:	FY27 TARGET	FY27 CURRENT
"Communication" Domain Top Box Score	TBD	

ORGANIZATION IMPACT MEASURE(S):
Staff worked together to care for you

PROCESS MEASURE(S):	TARGET	COMPLIANCE
Procedure information easy to understand	93%	

ACTION/INTERVENTION	RESPONSIBLE PERSON	START DATE	END DATE	OUTCOME/BARRIERS/NOTES	STATUS
Purposable rounding to follow up on procedure, how it went and verify they understand the procedure and what they went through.	Jennifer Thieneman, Sherri Arias, Leslie Trapin	11/2/2026	6/30/2026	Patients are very forgetful post sedation	In Progress
Remind Nursing team to remind patients of Procedure information before, after, at DC and when placing the post call.	Jennifer Thieneman, Sherri Arias, Leslie Trapin and Cath Lab Holding Staff	11/2/2026	6/30/2026	Patients are very forgetful post sedation	In Progress

BENCHMARKS FROM: 2024Q4 | ENDING TIMEFRAME: 2024Q4 | SUBMITTED AS OF: 3/6/2025 8:50:46 PM | AGGREGATED AS OF: 3/6/2025 11:59:59 PM

Key Metrics	My R4Q		50-74th Pctl	% Qtr Variance
7172 Overall AMI performance composite	97.5% (1432/1468)	↑	96.5%	-1.8%
8134 Overall defect free care (NQF Endorsed)	85.2% (179/210)	↑	80.1%	-15.9%
7915 STEMI performance composite	97.0% (487/502)	↓	97.7%	-0.8%
8402 NSTEMI performance composite	97.8% (945/966)	↑	96.2%	-2.6%
8311 Acute AMI performance composite	96.5% (354/367)	↓	97.2%	-2.6%
7702 Discharge AMI performance composite	97.9% (1077/1100)	↑	96.6%	-1.5%

Patient Type and Mode of Arrival

Number of Patients	R4Q	R4Q%
8993 Pts with STEMI (pre-admit)	72	33.03%
8994 Pts with STEMI (in-hospital)	0	0.00%
8987 Pts with NSTEMI	146	66.97%
8991 Pts with unstable angina	0	0.00%
8992 Pts with low risk chest pain	0	0.00%
Total	**218**	**100.00%**

Mode of Arrival	R4Q	R4Q%
11878 Pts arrived by self/family	84	38.53%
11879 Pts arrived by EMS	79	36.24%
11880 Pts transferred in from outsi...	55	25.23%
Total	**218**	**100.00%**

Outcome Metrics	Observed	Outcome		50-74th Pctl
8461 In-hospital risk standardized mortality (All AMI patients)	15	6.29	↓	5.04
7727 In-hospital risk standardized bleeding rate	5	2.32	↑	4.13
12007 In-hospital Risk Standardized Length of Stay >= 3days	81	16.58	↓	15.22
11896 In-hospital Risk Standardized Discharge to Post Acute Care	27	4.00	↓	2.45

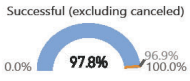
Time-Based Metrics	My R4Q	50-74th Pctl	% Qtr Var
11392 Median time (min) from symptoms to device	161	156	37%
11460 Median time (min) arrival to device	64	57	-23%
11575 Median time (min) from cath lab arrival to device	28	23	12%

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BENCHMARKS FROM: 2024Q4 | ENDING TIMEFRAME: 2024Q4 | SUBMITTED AS OF: 3/3/2025 11:15:55 AM | AGGREGATED AS OF: 3/6/2025 11:59:59 PM

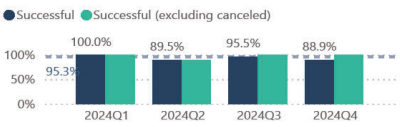
Key Metrics

Successful Procedures R4Q



US Hospitals: 96.2%

Successful Procedures by Quarter



Complications R4Q

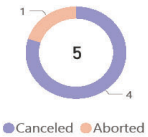
Pts with a major complication

0.0%

US Hospitals: 1.2%

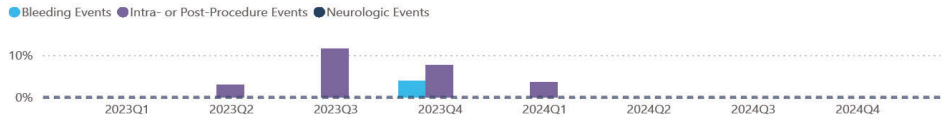
Volume Summary

96 Total Procedures



Outcome Metrics

Total Events by Quarter



Key Outcome Metrics R4Q

Pts with a disabling or life threatening bleeding event	Pts with stroke (ischemic or hemorrhagic), or systemic thromboembolism, or mortality	Pts with an ischemic stroke or systemic thromboembolism
0.0%	0.0%	0.0%
US Hospitals: 0.2%	US Hospitals: 0.1%	US Hospitals: 0.2%

Process Metrics

My R4Q

Procedures where the pt meets FDA indications



US Hospitals: 98.6%

Risk and Compliance Scores R4Q

Average CHA2DS2-VASc Score

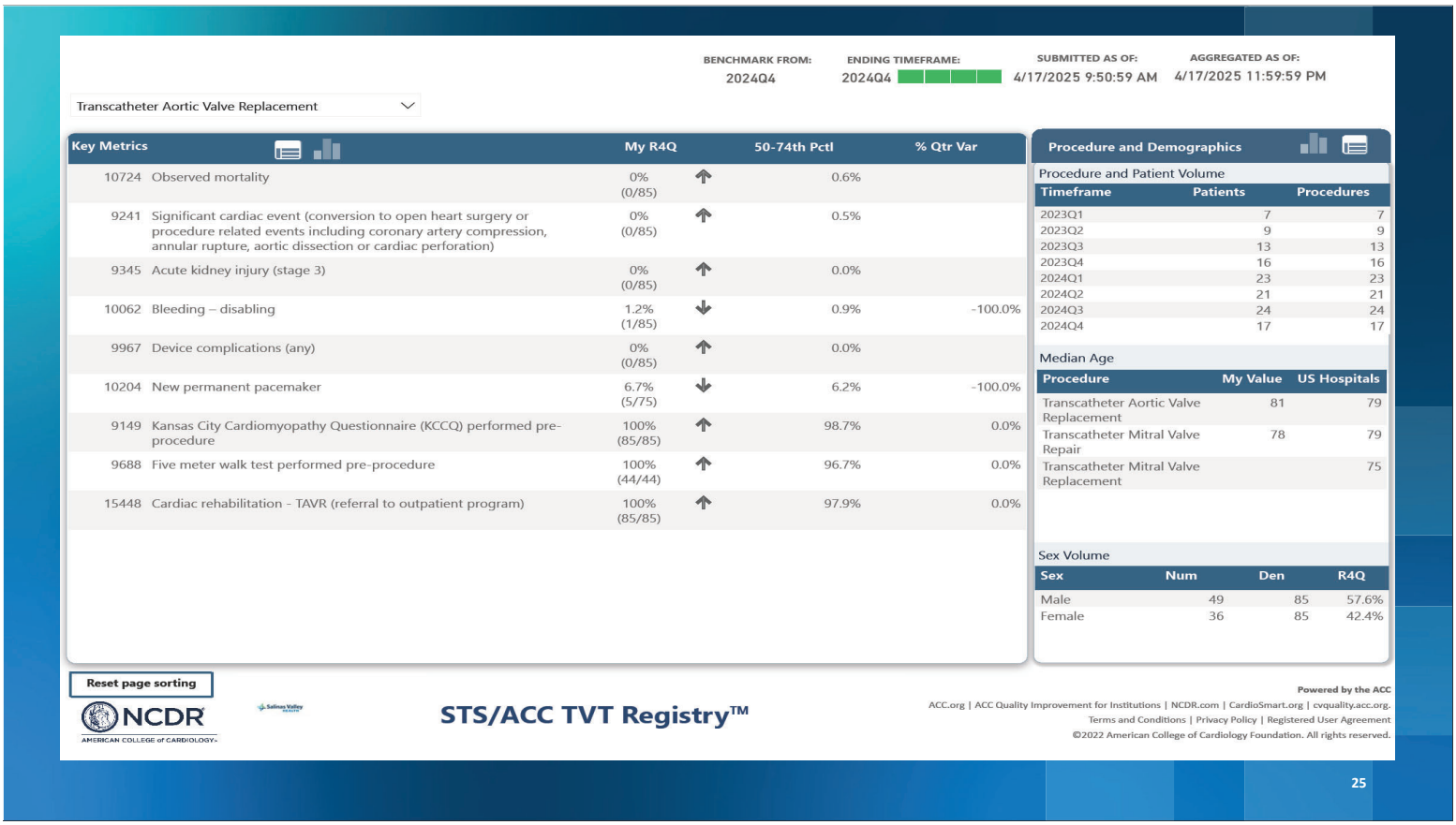
4.83

Average HAS-BLED Score

2.29

Benchmark: 50-74th Pctl — Selected Registry Benchmark

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Barriers/Challenges

- Time
- Language
- Sedation
- Increase in procedures
- Space

Next Step

- Plan to try to leverage new data capabilities out of epic to continue working on our current goals and set new goals

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Nursing Practice and Unit Based Council Quality Initiatives-Cath Lab

Unit/Clinic	Metrics	Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Q1 2025			Q2 2025			Magnet Score *
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	
Fall Rates per 1000 Patient Visits																										
Cath Lab	Quarterly Fall Rate	2.04			0.00			0.00			0.00			0.00			0.00			0.00			0.00			7 /8
	Falls Benchmark	0.36			0.28			0.16			0.21			0.20			0.19			0.27						
	Total Patient Fall Rate	6.02	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
	# falls with Injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8 /8
	Quarterly Injury Falls Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			
	Injury Benchmark	0.15			0.13			0.04			0.07			0.07			0.07			0.04						
	Visits	166	183	142	195	192	191	190	195	214	206	223	199	180	193	190	205	189	198	182	201	198	218	234	222	

Note: Any patient fall in Cath Lab or Cath Holding Area is inputted as a fall for the unit of "Cath Lab" (above dashboard)

KEY
- Exceeds Benchmark
- Does not exceed benchmark
- Caution--Close to moving into the red
- No data or Not reported or Unit Closed
- National benchmark/comparison value

Unit/Clinic	Metrics	Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Q1 2025			Q2 2025			Magnet Score *
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	
Door to PCI (percutaneous coronary intervention)																										
Cath Lab	Quarterly D2B (Avg)	55			63			58			63			57			45			57			70			8 /8
	Door-to-balloon Benchmark	< 90 minutes			< 90 minutes			< 90 minutes			< 90 minutes			< 90 minutes			< 90 minutes			< 90 minutes			< 90 minutes			
	Door to PCI (AVG)	63	57	46	56	56	78	71	55	48	60	54	75	72	59	41	47	29	59	51	64	56	72	71	66	

Unit/Clinic	Metrics	Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Q1 2025			Q2 2025			Magnet Score *
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	
Surgical/Procedural Errors & Burns																										
Cath Lab	Quarterly Pt. Burns/ 1000 Pt. Visits	0			0			0			0			0			0			0			0			8 /8
	Benchmark	0.02			0.00			0.00			0.14			0.00			0.00			0.00						
	Quarterly Errors/ 1000 Pt. Visits	0			0			0			0			0			0			0			0			8 /8
	Benchmark	0.02			0.02			0.01			0.01			0.03			0.02			0.01						
	Quarterly RFO/ 1000 Pt. visits	n/a			n/a			n/a			0			0			0			0			0			4 /4
	Benchmark										0.00			0.00			0.00			0.00						

Nursing Practice and Unit Based Council Quality Initiatives-Cardiology

Data Display for Sept 2025 – Feb 2026 **Unit: Cardiology/CDOCs** **Peer Feedback Focus: Huddle every day at 0745**

Unit/Clinic	Metrics	Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Q1 2025			Q2 2025			Magnet Score *
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	
Fall Rates per 1000 Patient Visits																										
CDOC	Quarterly Fall Rate	0.00			0.00			0.00			0.00			0.00			0.68			0.00			0.72			6 /8
	Benchmark	0.14			0.06			0.14			0.18			0.14			0.07			0.10						
	Total Patient Fall Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.80	0.00	0.00	0.00	0.00	0.00	0.00	2.22	0.00	
	# falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	
	# falls with Injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	
	Quarterly Injury Falls Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.72			7 /8
	Injury Benchmark	0.03			0.03			0.03			0.05			0.06			0.03			0.03						
	Visits	469	549	464	517	453	428	518	449	526	511	513	462	455	530	458	556	450	457	510	467	510	511	450	437	

Note: Any patient fall in cardiology, CDOC-SJ, or CDOC-RR would be inputted as a fall for the unit of "CDOC" (above dashboard)

KEY
- Exceeds Benchmark
- Does not exceed benchmark
- Caution--Close to moving into the red
- No data or Not reported or Unit Closed
- National benchmark/comparison value

Key Driver Patient Experience Questions (Cardiology Focus Summary Report):


Dashboard Name: My Focus Items Summary | System Name: Salinas Valley Health - System | System ID: 764 | Facility Name: Salinas Valley Health | Facility ID: 766 | Service Line: Outpatient Services | Breakout Type:Unit | Breakout Name: CARDIO | Metric: Top Box Score | Date Type: Received Date | Time Frame: Last Month | Peer Group:All Facility DB | eSurvey Adjustment: Not Applied | Current Benchmarking Period:05/01/2025 - 07/31/2025 | Fiscal Start Month:07 | Download Date & Time:Sep 1, 2025 3:34 pm EDT

FILTER BY All sections selected

● High Point ● Low Point

Top Box Score

Survey Items	Survey Type	n	Current (Aug 2025)	Previous (Jul 2025)	Goal	Change	Percentile Rank	Score Trendline
YOUR CARE: Friendliness of staff	PG	40	92.50%	90.32%	—	2.18%	81	
PERSONAL ISSUES: Our sensitivity to your needs	PG	37	91.89%	80.00%	—	11.89%	96	
OVERALL ASSESSMENT: Staff worked together care for you	PG	37	83.78%	86.21%	—	-2.42%	23	
OVERALL ASSESSMENT: Likelihood of recommending	PG	40	82.50%	86.67%	—	-4.17%	19	

Mar 2025 Apr 2025 May 2025 Jun 2025 Jul 2025 Aug 2025

† Custom Question ^ Focus Question

At or Above Goal <5 Points Below Goal >5 Points Below Goal No Goal

~Hand Hygiene Dashboard available on STARnet on the Infection Prevention Page to view hand hygiene audit data.

Nursing Practice and Unit Based Council Quality Initiatives-Cardiology

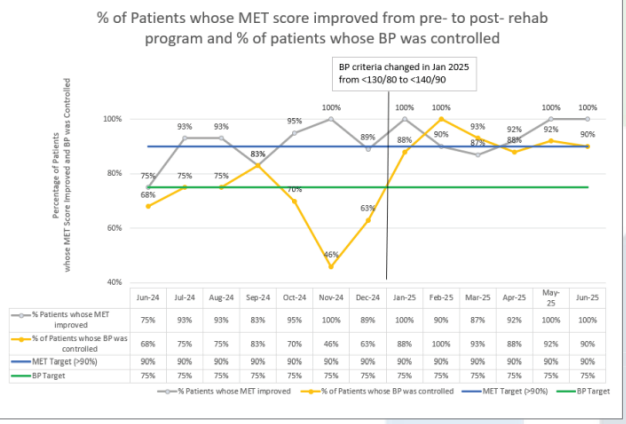
Data Display for Sept 2025 – Feb 2026 **Unit: Cardiac Rehab/Wellness** **Peer Feedback Focus**

Continue to use the word "ORANGE" if we hear an unfavorable tone or conversation with patients or each other & use a visual prop to reinforce prn.

Unit/Clinic	Metrics	Q3 2023			Q4 2023			Q1 2024			Q2 2024			Q3 2024			Q4 2024			Q1 2025			Q2 2025			Magnet Score *
		July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	
Fall Rates per 1000 Patient Visits																										
Cardiac Wellness	Quarterly Fall Rate	0.00			0.00			0.00			0.00			0.00			0.71			0.00			0.00			7 /8
	Benchmark	0.14			0.06			0.14			0.18			0.14			0.07			0.10						
	Total Patient Fall Rate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.56	0.00	0.00	0.00	0.00	0.00	0.00	
	# falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	
	# falls with Injury	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	8 /8
	Quarterly Injury Falls Rate	0.00			0.00			0.00			0.00			0.00			0.00			0.00			0.00			
	Injury Benchmark	0.03			0.03			0.03			0.06			0.06			0.03			0.03						
	Visits	396	434	344	387	359	347	465	433	493	544	507	420	505	520	465	554	472	391	398	400	501	586	457	491	

KEY
Exceeds Benchmark
Does not exceed benchmark
Caution--Close to moving into the red
No data or Not reported or Unit Closed
National benchmark/comparison value

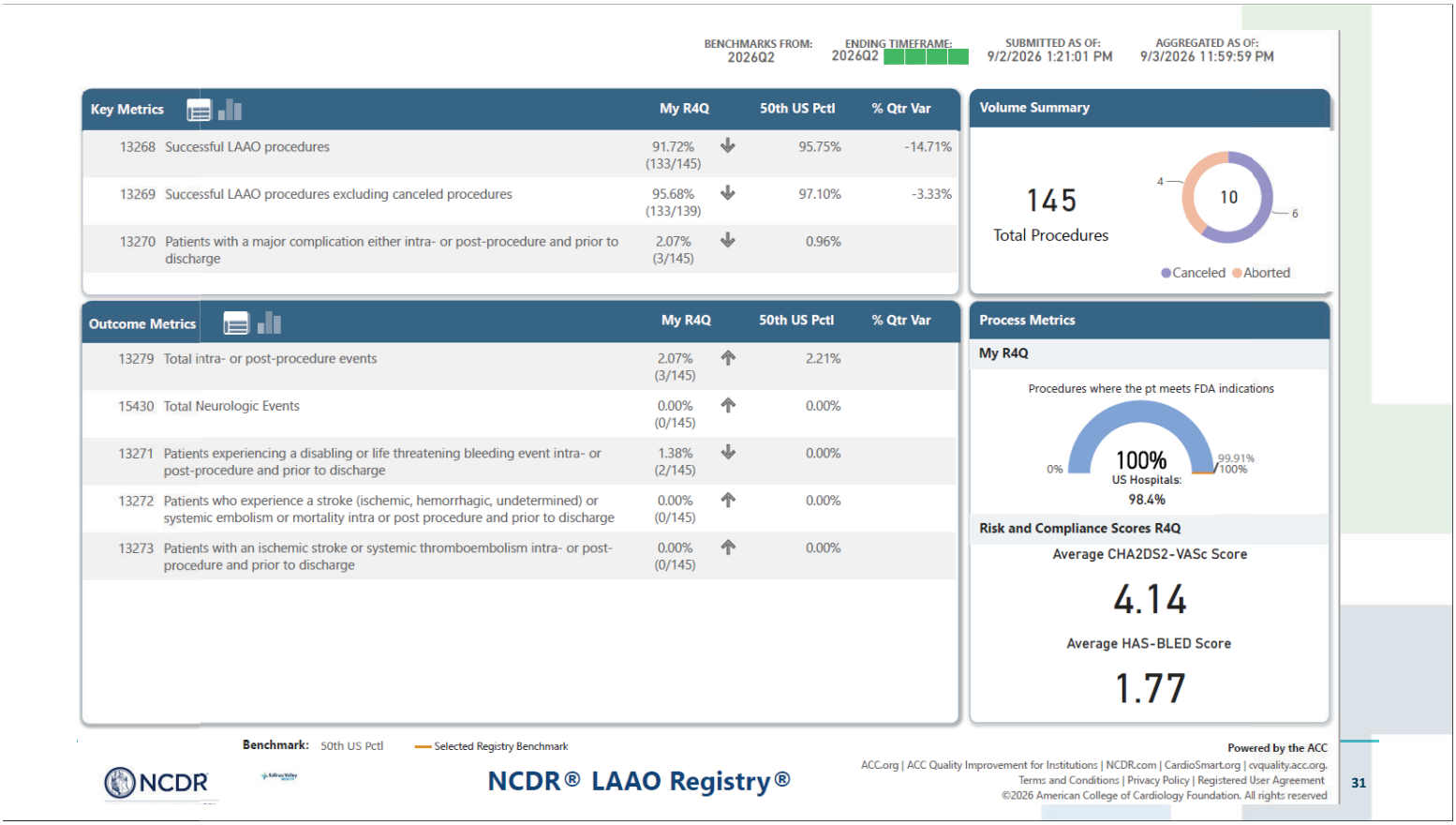
The graph demonstrates the monthly rate of patients whose MET score improved (pre-cardiac rehab program vs. post cardiac rehab program) AND the percentage of patients whose BP was controlled w/in the normal range for their age-group

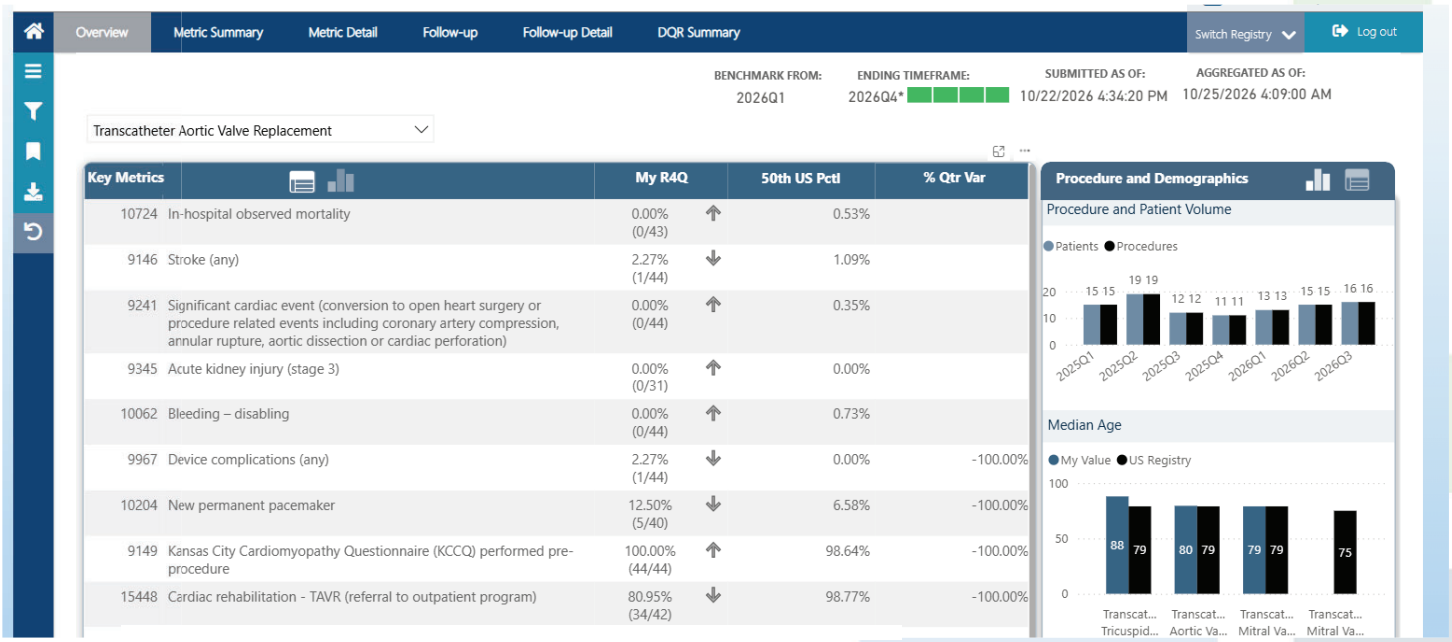


	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25
% Patients whose MET improved	75%	93%	93%	83%	95%	100%	89%	100%	90%	87%	92%	100%	100%
% of Patients whose BP was controlled	68%	75%	75%	83%	70%	46%	63%	88%	100%	93%	88%	92%	90%
MET Target (>90%)	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
BP Target	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%

% Patients whose MET improved — % of Patients whose BP was controlled — MET Target (>90%) — BP Target

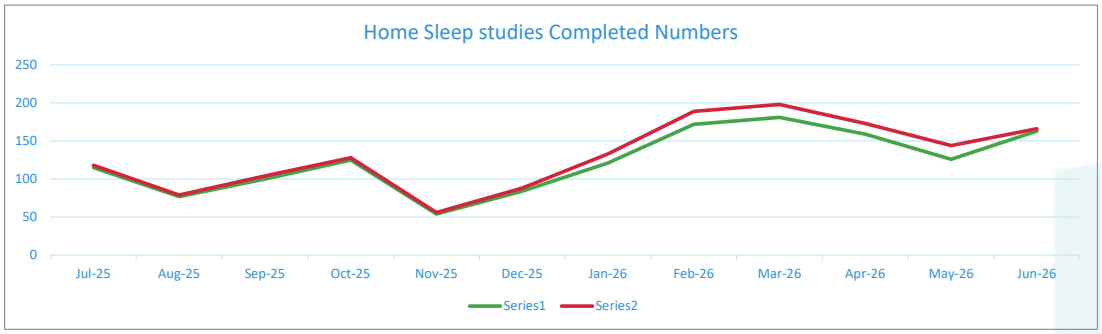
MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA SOURCE	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
Avoximeter QCs	Process	100%	Safe	Rate based (N/D)	52	Observation	Monthly	Staff Meetings	Monthly
Performance Improvement Measures									
Friendliness/Courtesy of Nurses	Outcome	97%	Patient-Centered	Rate based (N/D)		Interview	Monthly	Staff Meetings/ Magnet	Monthly
Staff work together to take care of you	Outcome	88%	Patient-Centered	Rate based (N/D)		Interview	Monthly	Staff Meetings/ Magnet	Monthly
Nurses care about your comfort	Outcome	95%	Patient-Centered	Rate based (N/D)		Interview	Monthly	Staff Meetings/ Magnet	Monthly
Patient Readiness	Outcome	85%	Timely	Rate based (N/D)		Retro chart review	Monthly	Staff Meeting	Monthly
Discharge Phonecalls	Outcome	80%	Patient-Centered	Rate based (N/D)		Retro chart review	Monthly	Staff Meeting	Monthly

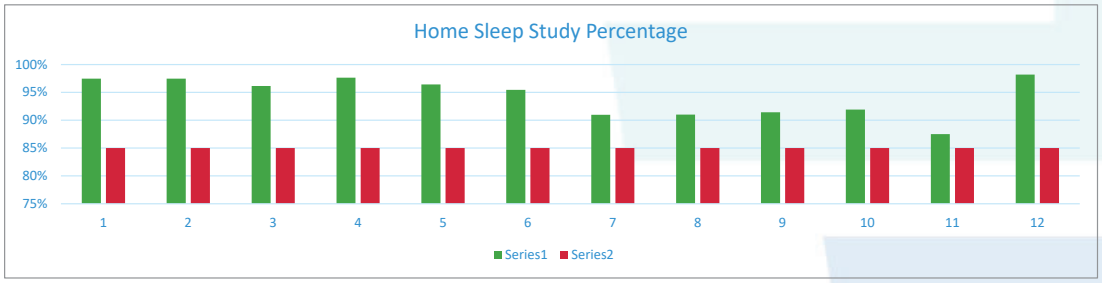

BENCHMARKS FROM: 2026Q2
ENDING TIMEFRAME: 2026Q2
SUBMITTED AS OF: 9/2/2026 1:21:01 PM
AGGREGATED AS OF: 9/3/2026 11:59:59 PM
Key Metrics
My R4Q
50th US Pctl
% Qtr Var
13268 Successful LAAO procedures 91.72% (133/145) 95.75% -14.71%
13269 Successful LAAO procedures excluding canceled procedures 95.68% (133/139) 97.10% -3.33%
13270 Patients with a major complication either intra- or post-procedure and prior to discharge 2.07% (3/145) 0.96%
Volume Summary
145
Total Procedures
4
10
6
Canceled
Aborted
Outcome Metrics
My R4Q
50th US Pctl
% Qtr Var
13279 Total intra- or post-procedure events 2.07% (3/145) 2.21%
15430 Total Neurologic Events 0.00% (0/145) 0.00%
13271 Patients experiencing a disabling or life threatening bleeding event intra- or post-procedure and prior to discharge 1.38% (2/145) 0.00%
13272 Patients who experience a stroke (ischemic, hemorrhagic, undetermined) or systemic embolism or mortality intra or post procedure and prior to discharge 0.00% (0/145) 0.00%
13273 Patients with an ischemic stroke or systemic thromboembolism intra- or post-procedure and prior to discharge 0.00% (0/145) 0.00%
Process Metrics
My R4Q
Procedures where the pt meets FDA indications
0%
100%
US Hospitals:
98.4%
99.91%
100%
Risk and Compliance Scores R4Q
Average CHA2DS2-VASc Score
4.14
Average HAS-BLED Score
1.77
Benchmark: 50th US Pctl
Selected Registry Benchmark
NCDR
NCDR® LAAO Registry®
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Overview
Metric Summary
Metric Detail
Follow-up
Follow-up Detail
DQR Summary
Switch Registry
Log out
BENCHMARK FROM: 2026Q1
ENDING TIMEFRAME: 2026Q4*
SUBMITTED AS OF: 10/22/2026 4:34:20 PM
AGGREGATED AS OF: 10/25/2026 4:09:00 AM
Transcatheter Aortic Valve Replacement
Key Metrics
My R4Q
50th US Pctl
% Qtr Var
10724 In-hospital observed mortality 0.00% (0/43) 0.53%
9146 Stroke (any) 2.27% (1/44) 1.09%
9241 Significant cardiac event (conversion to open heart surgery or procedure related events including coronary artery compression, annular rupture, aortic dissection or cardiac perforation) 0.00% (0/44) 0.35%
9345 Acute kidney injury (stage 3) 0.00% (0/31) 0.00%
10062 Bleeding – disabling 0.00% (0/44) 0.73%
9967 Device complications (any) 2.27% (1/44) 0.00% -100.00%
10204 New permanent pacemaker 12.50% (5/40) 6.58% -100.00%
9149 Kansas City Cardiomyopathy Questionnaire (KCCQ) performed pre-procedure 100.00% (44/44) 98.64% -100.00%
15448 Cardiac rehabilitation - TAVR (referral to outpatient program) 80.95% (34/42) 98.77% -100.00%
Procedure and Demographics
Procedure and Patient Volume
Patients
Procedures
2025Q1 2025Q2 2025Q3 2025Q4 2026Q1 2026Q2 2026Q3
Median Age
My Value
US Registry
Transcat... Tricuspid...
Transcat... Aortic Va...
Transcat... Mitral Va...
Transcat... Mitral Va...
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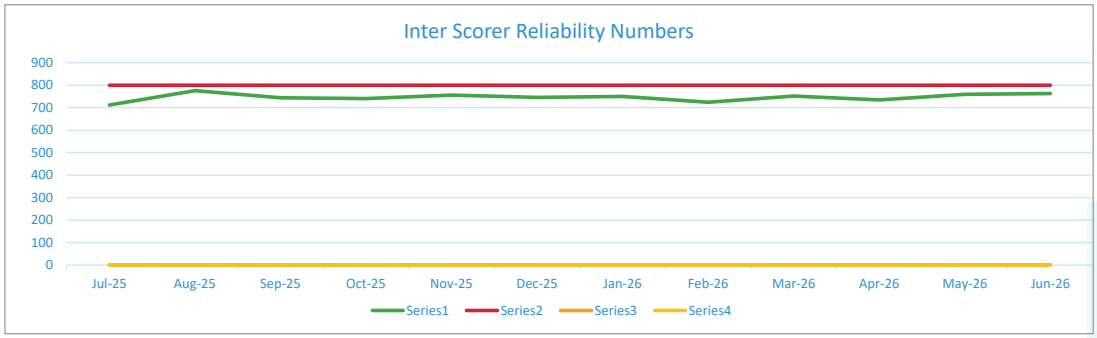
Quality / Safety Goals Sleep Center

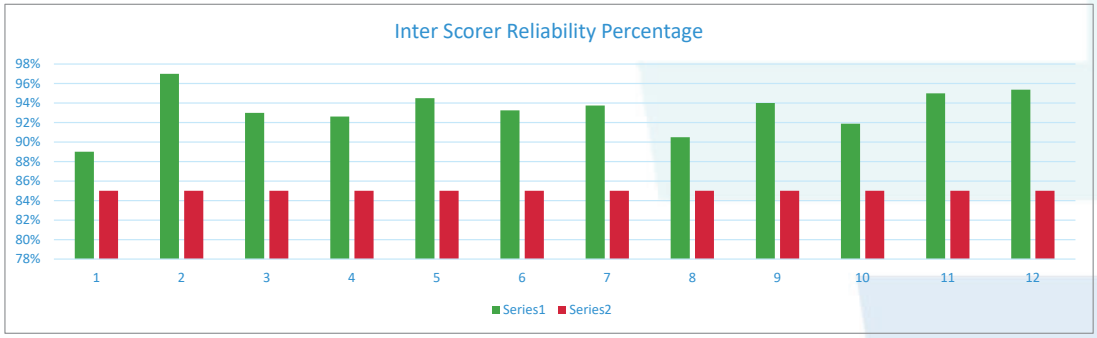
MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA SOURCE	DATA COLLECTION FREQUENCY	REPORTING STRUCTURE	REPORTING FREQUENCY
Quality Assurance Measures									
Home Sleep Study Efficiency	Process	85%	Efficient	Single case review	single case review	Retro chart review	Monthly	Home Sleep report	Quarterly
Inter Scorer Reliability Testing # of epochs in agreement between two scoring techs	Process	85%	Efficient	Single case review	compare 200 scored epochs	Retro chart review	quarterly	AASM ISR portal	quarterly





	2026	Jul-26	Aug-26	Sep-26
N	1477	127	165	158
D	1576	134	180	178
%	94%	95%	92%	89%
Target	85%	85%	85%	85%





	2026	Jul-26	Aug-26	Sep-26
N	8959	766	755	740
D	9600	800	800	800
%	93%	96%	94%	93%
Target	85%	85%	85%	85%

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Barriers/Challenges

- Patient education for direct HST referrals
- Staffing (Scorers)
- Education for scorers
- Applications-Natus

Next Steps

- Scoring to Dictation
- Close collaboration w/sleep clinic
- Rounding with referring clinics for support
- Schedule Educational Scoring meetings
- Continuous review of Natus & HL7

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Quality Assessment / Safety Goals– 2027 Sleep Center

MEASURE	MEASURE TYPE	TARGET	QUALITY DOMAIN	METHOD OF PERFORMANCE ASSESSMENT	SAMPLE SIZE	DATA SOURCE	DATA COLLECTION FREQUENCY	REPORTING FREQUENCY
Quality Assurance Measures								
Home Sleep Study Efficiency	Process	85%	Efficient	Single case review	single case review	Retro chart review	Monthly	Quarterly
Inter Scorer Reliability Testing # of epochs in agreement between two scoring techs	Process	85%	Efficient	Single case review	compare 200 scored epochs	Retro chart review	Monthly	Quarterly
Performance Improvement Measures								
Likelihood of recommending	Process	85%	Efficient	Single case review	single case review	Press Ganey	Monthly	Quarterly
Registration Process Overall	Process	88%	Efficient	Single case review	single case review	Press Ganey	Monthly	Quarterly

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT