January 8, 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, JANUARY 12, 2026, AT 8:30 A.M., DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA**.

(V*isit* https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2025/ *for Public Access Information*).

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; **Richard Gerber, MD**, Medical Staff Member.

Advisory Non-Voting Members: Administrative Executive Team.

QUALITY AND EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH[1]

MONDAY, JANUARY 12, 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 December 15, 2025. (CARSON)

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

4. Patient Care Services Update (SPENCER)
   - Report from the Quality Council

5. Quality and Safety Overview (INMAN)

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, February 9, 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.

QUALITY & EFFICIENT PRACTICES COMMITTEE
COMMITTEE OF THE WHOLE
SALINAS VALLEY HEALTH

AGENDA FOR CLOSED SESSION

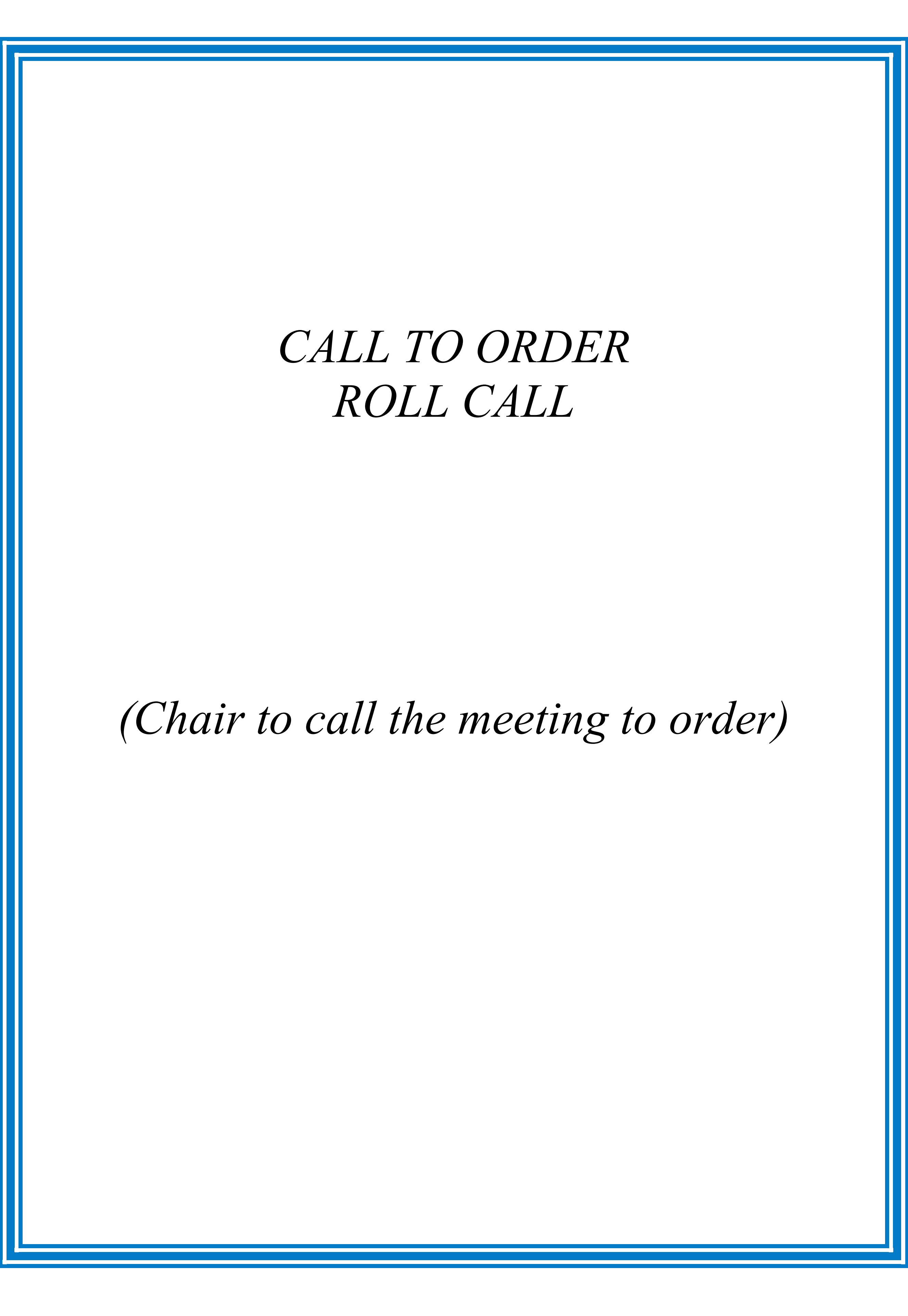
Pursuant to California Government Code Section 54954.2 and 54954.5, the board agenda may describe closed session agenda items as provided below. No legislative body or elected official shall be in violation of Section 54954.2 or 54956 if the closed session items are described in substantial compliance 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): ______________________

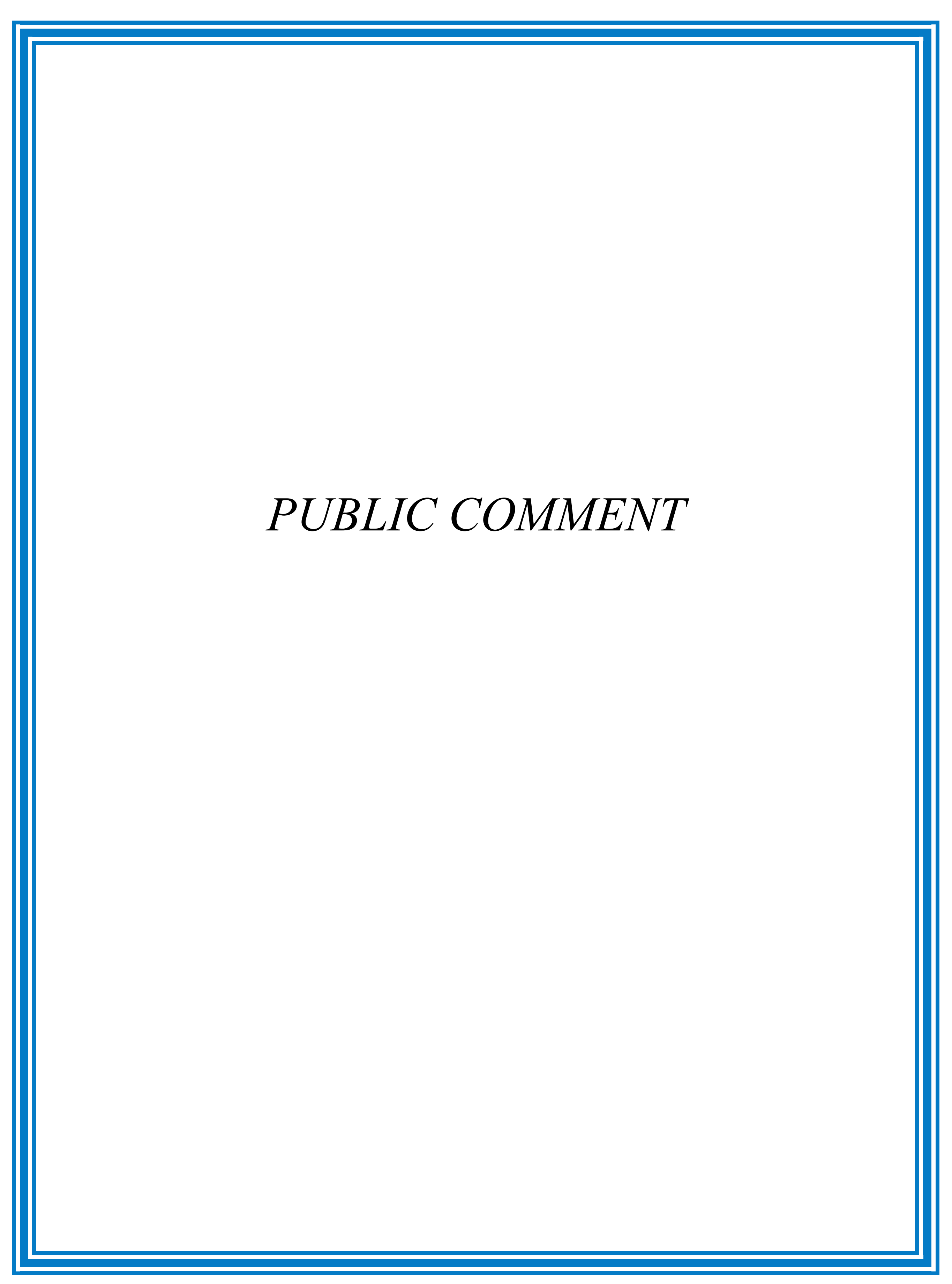
1. Report of the Medical Staff Quality and Safety Committee
    - Accreditation and Regulatory Report (INMAN)
2. Quality and Safety Board Dashboard Review (INMAN)
3. Consent Agenda
    - Quality Incentive Program

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 DECEMBER 15, 2025

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

Voting Members Absent: None

Advisory Non-Voting Members Present:
In Person: Allen Radner, M.D., President/CEO, Timothy Albert, M.D., CCO, Alysha Hyland, CAO, Iftikhar Hussain, CFO, Clement Miller, COO, and Cheryl Pirozzoli, Family/Patient Council Advisor;
Via teleconference: Michelle Childs, CHRO

Other Board Members Present, Constituting Committee of the Whole:
Via teleconference: 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 MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF NOVEMBER 17, 2025.

Approve the minutes of the November 17, 2025 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

PUBLIC COMMENT: None

MOTION:
Upon motion by Committee Vice Chair Cabrera, second by Committee Member Gerber, the minutes of the November 17, 2025 Quality and Efficient Practices Committee Meeting are approved as presented.

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

Motion Carried

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

4. PATIENT CARE SERVICES UPDATE: NIGHT SHIFT PRACTICE COUNCIL

Carla Spencer, CNO, introduced Claudia Getz, BS, RN and Michael Brown, MS, BSN, RN, PCCN, who reported on the Council's purpose, 2025 goals, initiatives and data. Initiatives including the Standardized Quiet Champion Role. Initiatives in progress include the Night Shift Staff Wellness Guide and upcoming in 2026 introducing a Streamlined Nurse-Physician Communication at Night. A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: Chair Carson asked if the team is using SBAR, Mr. Brown confirmed yes, SBAR is being used. Chair Carson also emphasized the need to partner with lab & phlebotomy, as well as including age-friendly considerations. Dr. Radner commented that unfortunately noise during night shift is a hurdle we face that other local hospitals do not, despite the high quality care provided here. Ms. Inman commented that she was impressed with the presentation, and has never seen a Night Shift Council – great idea. Board Member Cabrera asked about the percentage of nurses who take double shifts, and how that can affect noise, Ms. Spencer confirmed there are concessions in place.

5. EPIC CLINICAL ACUTE APPLICATIONS REPORT

Randy Richards, Epic Acute Clinical Applications Manager had an unexpected illness, instead Anna Linn, reported on Quality Improvement Through Technology Implementation and the purpose of the Epic implementation. With the advanced reports available via Epic, leaders have more opportunites to review/utilize trend data, identify action areas and promote utilization and training. A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: Chair Carson is looking forward to seeing the positive improvements and outcomes.

6. 2026 REGULATORY QUALITY AND SAFETY CHANGES

Brenda Inman, Vice President Quality and Risk Management, reported on the purpose of the Regulatory and Accrediting Bodies, 2025 Year in Review and an Oversight Landscape Overiew of 2026. Also reviewed were Key Programs, Concepts and Updates (including CMS, Joint Commission & CDPH. A full report was included in the packet.

COMMITTEE DISCUSSION: None.

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 9:17 a.m.

8. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened for Open Session at 9:27 a.m. Chair Carson reported that in Closed Session, the *Hearings/Reports* were accepted as follows:

1. Report of the Medical Staff Quality and Safety Committee
   - Accreditation and Regulatory Report (INMAN)
2. Consent Agenda:
   - Update: Recruitment of Director of Quality and Safety (ALBERT/INMAN)

9. ADJOURNMENT

There being no other business, the meeting adjourned at 9:28 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, January 12, 2026** at 8:30 a.m.

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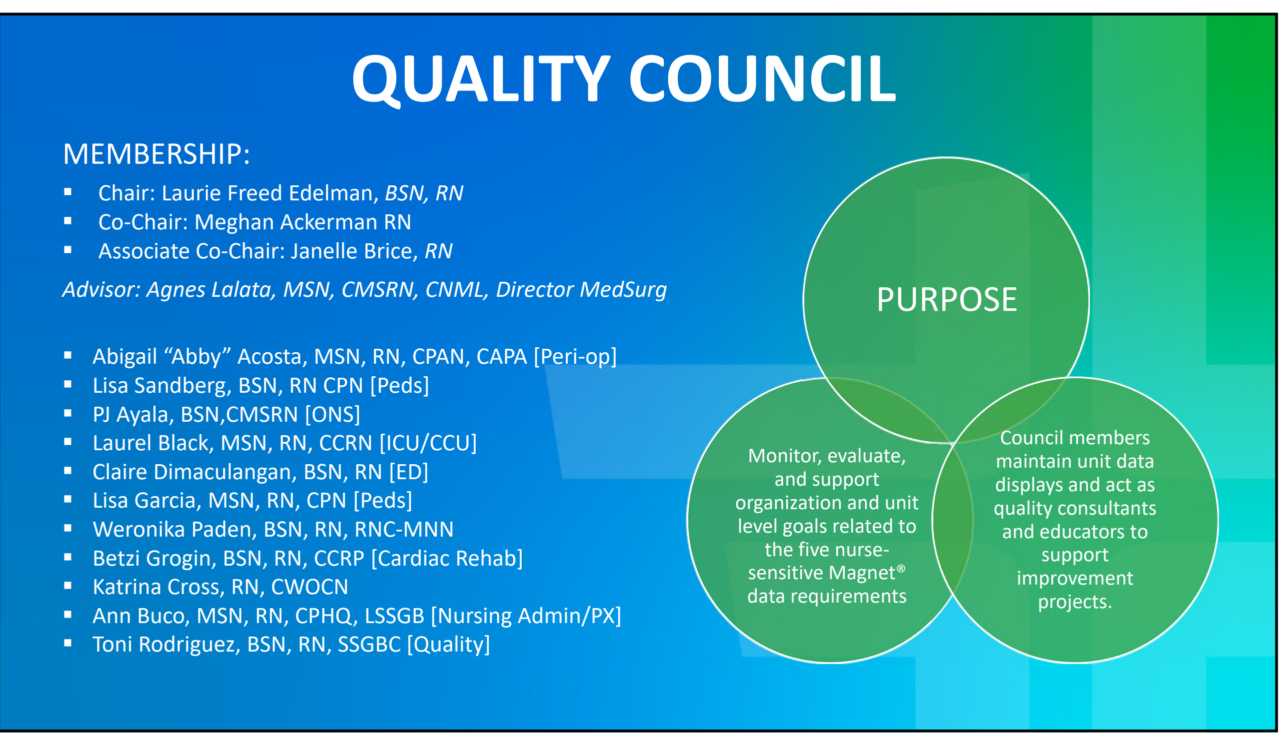
Catherine Carson, Chair
Quality and Efficient Practices Committee

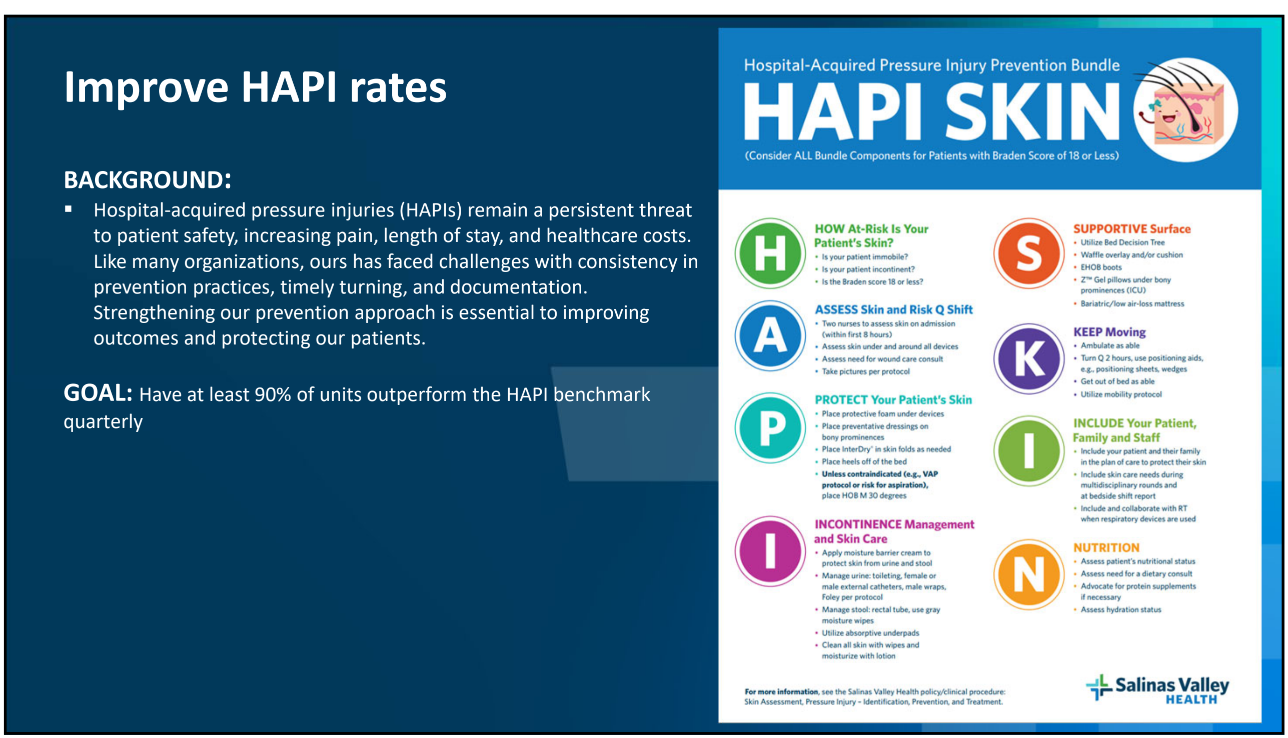
Patient Care Services Update
Salinas Valley
HEALTH
PRIDE
CARE DELIVERY MODEL · REWARD/RECOGNITION · PROFESSIONAL RELATIONSHIPS · PROFESSIONAL GOVERNANCE
TEACH
EMPOWER
PROTECT
HEAL
Presented by:
Carla Spencer, MSN, RN, NEA-BC
Chief Nursing Officer
Featuring: Quality Council
January 12, 2026


QUALITY COUNCIL
MEMBERSHIP:
Chair: Laurie Freed Edelman, BSN, RN
Co-Chair: Meghan Ackerman RN
Associate Co-Chair: Janelle Brice, RN
Advisor: Agnes Lalata, MSN, CMSRN, CNML, Director MedSurg
Abigail “Abby” Acosta, MSN, RN, CPAN, CAPA [Peri-op]
Lisa Sandberg, BSN, RN CPN [Peds]
PJ Ayala, BSN,CMSRN [ONS]
Laurel Black, MSN, RN, CCRN [ICU/CCU]
Claire Dimaculangan, BSN, RN [ED]
Lisa Garcia, MSN, RN, CPN [Peds]
Weronika Paden, BSN, RN, RNC-MNN
Betzi Grogin, BSN, RN, CCRP [Cardiac Rehab]
Katrina Cross, RN, CWOCN
Ann Buco, MSN, RN, CPHQ, LSSGB [Nursing Admin/PX]
Toni Rodriguez, BSN, RN, SSGBC [Quality]
PURPOSE
Monitor, evaluate, and support organization and unit level goals related to the five nurse-sensitive Magnet® data requirements
Council members maintain unit data displays and act as quality consultants and educators to support improvement projects.

Initiatives:

- **Improve [1]HAPI rates:** Have at least 90% of units outperform the HAPI benchmark quarterly
- **Improve Patient Experience:** Have at least 4 [2]PX domains where 100% of units are meeting magnet criteria quarterly
- **Reduce Falls with Injury:** Consistently maintain the org-level goal of injury fall rate of 0.5.

[1] Hospital-Acquired Pressure Injury
2 Patient Experience



Outcome: 2025 HAPI Rates

INTERVENTION:

- Establishing an action plan with the units practice council so they may implement interventions appropriate for their units to decrease HAPIs
- Establishing a “HAPI Squad” to assess for HAPIs once a week with in the critical care cluster.
- Continuing with HAPI Prevalence Day for the entire facility
- Collaboration with respiratory therapist (RT) in use of foams whenever airway apparatuses are in use.
- Continue to enculturate HAPI Bundle

HAPI 2+

Unit	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Score
1 Main	0.00	0.00	0.00	10.00	0.00	0.00	0.00	0.00	7 /8
ICU	25.00	0.00	20.00	25.00	0.00	50.00	12.50	0.00	3 /8
HC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
5T Tele	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
OBS/OCU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
4T Tele	10.00	0.00	0.00	0.00	0.00	10.00	0.00	0.00	6 /8
MS1/3M	0.00	4.17	8.33	0.00	13.04	4.17	0.00	0.00	4 /8
ONS/4M	0.00	0.00	0.00	0.00	0.00	0.00	4.35	0.00	7 /8
ONC	0.00	10.00	0.00	0.00	0.00	0.00	0.00	n/d	6 /8
NICU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
Peds	0.00	0.00	0.00	n/d	0.00	0.00	0.00	0.00	7 /8
% of units meeting or exceeding the benchmark in ≥ 5/8 quarters:									81.82%

HAPI Medical Device

Unit	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Score
1 Main	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
ICU	0.00	0.00	0.00	25.00	0.00	25.00	0.00	0.00	6 /8
HC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
5T Tele	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
OBS/OCU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
4T Tele	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
MS1/3M	0.00	0.00	8.33	0.00	8.70	0.00	0.00	0.00	6 /8
ONS/4M	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
ONC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	n/d	7 /8
NICU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
Peds	0.00	0.00	0.00	n/d	0.00	0.00	0.00	0.00	7 /8
% of units meeting or exceeding the benchmark in ≥ 5/8 quarters:									100.00%

Improve Patient Experience

BACKGROUND:

- Patient experience directly reflects the quality of care we provide. Strengthening communication, responsiveness, and consistency across the care journey is essential to improving satisfaction and building trust with our patients and families.

GOAL:

- Have at least 4 PX domains where 100% of units are meeting magnet criteria quarterly

INTERVENTION:

- Monitoring & collecting PX data and sharing it with UPCs to disperse to units.

- Patient Experience data needing improvement is included on our Data Displays with interventions to help improve this data. Data Displays are displayed on each unit and dispersed by UPC members.

Outcome: 2025 Patient Experience

Magnet/Nurse-Sensitive Patient Experience Data from Q4 2023-Q3 2025 (8 Quarters) - Received Date

Inpatient Units

Unit: / Domains:	ICU	1 Main (TELESD)	Heart Center	OCU	5 Tower (5T-TELE)	3 Main (MEDSURG1)	Oncology (3T)	4 Main (ONS)	4 Tower (4T - TELE)	Peds (PD)	Peds-Adult (PEDS)	NICU	Perinatal	Total Units Meeting
Patient Engagement/Patient Centered Care (13)	2 of 2	2 of 3	5 of 5	3 of 3	5 of 5	1 of 1	2 of 4	2 of 2	3 of 4	3 of 3	4 of 4	0 of 4	5 of 5	12 of 13
Care Coordination (13)	1 of 1	n/a	3 of 3	1 of 1	3 of 3	n/a	2 of 3	1 of 1	2 of 3	1 of 1	n/a	2 of 2	3 of 3	10 of 10
Safety (12)	4 of 4	4 of 5	5 of 5	3 of 3	5 of 5	1 of 2	3 of 5	1 of 2	5 of 5	2 of 3	4 of 4		5 of 5	12 of 12
Service Recovery (11)	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	0 of 1	0 of 1	0 of 1	1 of 1		1 of 1		1 of 1	8 of 11
Courtesy & Respect (13)	2 of 2	3 of 4	4 of 4	4 of 4	4 of 4	0 of 4	0 of 4	1 of 4	5 of 6	1 of 1	4 of 4	1 of 4	4 of 4	11 of 13
Responsiveness (13)	1 of 1	4 of 4	4 of 4	4 of 4	4 of 4	0 of 2	2 of 4	3 of 4	3 of 4	1 of 1	4 of 4	1 of 2	4 of 4	12 of 13
Patient Education (13)	3 of 6	4 of 7	7 of 7	6 of 7	7 of 7	1 of 4	6 of 7	3 of 6	3 of 7	3 of 3	6 of 7	3 of 3	7 of 7	13 of 13
Pain (13)	1 of 1	0 of 1	1 of 1	1 of 1	1 of 1	0 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	11 of 13
Careful Listening (13)	2 of 2	3 of 3	3 of 3	2 of 3	3 of 3	0 of 2	0 of 2	0 of 2	3 of 3	3 of 3	3 of 3	0 of 3	3 of 3	9 of 13

Outpatient/Ambulatory Units

Unit: / Domains:	Cardiac Wellness (CARWCTR)	ED	Cath Lab	Endo	DI-- SP Proc Rad	OPS (SDC)	Wound Center	CDOC-RR	CDOC-SJ	CADI-CVDIAGCR	Cardiology	Lactation	Infusion	Total Units Meeting
	OP	ED	AS	AS	AS	AS	OP	OP	OP	OP	OP	OP	OP	
Patient Engagement/Patient Centered Care (13)	1 of 1	2 of 2	0 of 1	1 of 1	0 of 1	0 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	9 of 13
Care Coordination (12)	1 of 1	1 of 1	0 of 3	0 of 3	0 of 3	0 of 3	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	9 of 13
Safety (13)	4 of 4	3 of 3	1 of 5	3 of 5	3 of 5	2 of 5	4 of 4	4 of 4	4 of 4	4 of 4	4 of 4	4 of 4	4 of 4	13 of 13
Service Recovery (13)	1 of 1	2 of 2	0 of 1	0 of 1	0 of 1	1 of 1	0 of 1	1 of 1	1 of 1	0 of 1	0 of 1	1 of 1	1 of 1	7 of 13
Courtesy & Respect (13)	2 of 4	3 of 3	1 of 2	1 of 2	1 of 2	0 of 2	4 of 4	4 of 4	4 of 4	3 of 4	3 of 4	4 of 4	4 of 4	12 of 13
Responsiveness (13)	1 of 3	5 of 5	1 of 4	1 of 4	0 of 4	2 of 4	1 of 3	3 of 3	3 of 3	2 of 3	2 of 3	3 of 3	3 of 3	12 of 13
Patient Education (13)	1 of 1	1 of 1	1 of 12	4 of 12	4 of 12	6 of 12	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	13 of 13
Pain (13)	1 of 1	1 of 1	0 of 3	2 of 3	2 of 3	3 of 3	0 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	1 of 1	11 of 13
Careful Listening (13)	2 of 4	5 of 5	0 of 2	0 of 2	0 of 2	1 of 2	2 of 4	4 of 4	4 of 4	2 of 4	3 of 4	4 of 4	4 of 4	10 of 13

Green = Meeting Magnet Criteria

Red = Not Meeting Magnet Criteria

Note: '3 of 4', for example, means that unit is exceeding the Magnet criteria in 3 out of 4 questions in that domain

~~~Choose questions from the domains that your unit has '0' questions that are exceeding Magnet criteria (indicated with pink background and red text)

Units Meeting Magnet Criteria in ALL Domains — These units should consider using Org-Level PX data to determine Areas of Opportunity to focus improvements efforts on

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Outcome: 2025 Patient Falls

Interventions:

- Action plans are escalated to the Unit Practice Council, engaging frontline clinicians in collaborative problem-solving to generate unit-specific, evidence-based strategies for fall reduction.
- The data are incorporated into unit performance dashboards to promote staff awareness, transparency, and engagement in fall-reduction initiatives.

Total Patient Falls per 1000 Patient Days/ Patient Visits

Unit	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Score
1 Main	0.00	1.06	0.00	2.41	1.17	1.11	0.00	0.00	7 /8
ICU	1.70	0.00	0.00	3.33	0.00	0.00	0.00	0.00	6 /8
HC	0.00	0.00	0.00	0.91	0.00	2.89	0.93	0.97	7 /8
5T Tele	0.00	2.86	1.01	0.00	1.15	1.02	0.00	2.11	6 /8
OBS/OCU	0.00	0.00	1.51	2.71	0.89	0.89	2.33	0.00	6 /8
4T Tele	0.00	2.16	1.35	1.15	0.00	1.13	1.20	1.32	8 /8
MS1/3M	0.53	1.59	1.64	1.08	2.04	0.53	0.00	1.66	7 /8
ONS/4M	4.05	0.00	0.59	0.00	1.74	0.59	1.69	1.81	7 /8
ONC	1.01	3.15	0.00	0.00	1.04	0.00	0.00	1.23	7 /8
NICU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
Peds	0.00	2.05	0.00	2.30	0.00	4.31	0.00	2.05	4 /8
MB	0.79	0.00	0.91	0.00	0.85	0.00	0.00	0.00	5 /8
% of units meeting or exceeding the benchmark in ≥ 5/8 quarters:									91.67%

Injury Falls per 1000 Patient Days/Patient Visits

Unit	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Score
1 Main	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
ICU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
HC	0.00	0.00	0.00	0.00	0.00	0.96	0.00	0.00	7 /8
5T Tele	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
OBS/OCU	0.00	0.00	0.76	0.00	0.89	0.00	0.78	0.00	5 /8
4T Tele	0.00	0.00	0.00	1.15	0.00	0.00	0.00	0.00	7 /8
MS1/3M	0.53	1.59	1.64	0.54	0.51	0.53	0.00	0.00	6 /8
ONS/4M	1.73	0.00	0.00	0.00	0.58	0.00	0.56	0.60	6 /8
ONC	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.23	7 /8
NICU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	8 /8
Peds	0.00	0.00	0.00	2.30	0.00	2.16	0.00	2.05	5 /8
MB	0.00	0.00	0.91	0.00	0.00	0.00	0.00	0.00	7 /8
% of units meeting or exceeding the benchmark in ≥ 5/8 quarters:									100.00%

Quality and Safety Overview

Quality and Safety Committee

Richard Gerber, MD, Vice Chief of Staff
Brenda Inman, MSN, VP, Quality and Risk Management

January 8, 2026

What is Quality Healthcare?

Joint Commission:

Joint Commission plays a vital role in maintaining and enhancing quality standards in healthcare facilities across the United States. As an independent, non-profit organization, the Joint Commission sets the bar for excellence in patient care and safety.

Centers for Medicare & Medicaid Services (CMS):

CMS implements quality initiatives to assure quality health care for Medicare Beneficiaries through accountability and public disclosure. CMS uses quality measures in its various quality initiatives that include quality improvement, pay for reporting, and public reporting.

Regulatory and Accrediting Bodies:

	CMS *Centers for Medicare & Medicaid Services*	**JC** *Joint Commission*	**CDPH** *California Department of Public Health*
Purpose	**Federal agency** administering Medicare, Medicaid , and related programs	Independent, nonprofit **accrediting organization** that evaluates healthcare organization performance	**State regulatory authority** overseeing healthcare facilities in California
Focus	Ensure hospitals meet minimum standards for **quality, safety and patient rights**	Support safety via **clinical workflows**, **physical environment**, **medication management**, and **leadership accountability**	**Enforce state licensing requirements**, investigates complaints/reportable events, and ensure state health and safety code compliance
Implications for Acute Care Hospitals	Nation-wide safety/quality initiatives, reimbursement, and surveys to evaluate compliance	Accreditation is voluntary but demonstrates high reliability and can grant "deemed status" with CMS	Routine, unannounced surveys and validation of CMS survey findings
Standards	▪ Federal Conditions of Participation (CoPs) ▪ State Operations Manual (SOM)	▪ Joint Commission Hospital Accreditation Program (HAP) Standards ▪ CMS Deemed Status Requirements	▪ California Health & Safety Code ▪ Title 22, California Code of Regulations (CCR) ▪ All Facilities Letters (AFLs) ▪ CMS CoPs (when conducting federal validation surveys)

SECTION TITLE

How Does Medical Staff Interact With Quality?

Salinas Valley Memorial Healthcare System Bylaws:

- Article I. Purpose, Authority, Obligations
- 1.5 Obligations
- The business of SVMHS is conducted by the Board with due attention to relevant community interests and concerns. Obligations of the Board include, but are not limited to:
- 1.5.1 Ultimate accountability for the safety and quality of care, treatment, and services provided by SVMHS
- 1.5.6 Delegate certain specific responsibilities, subject to Board authority, to the Hospital Medical Staff

Salinas Valley Memorial Healthcare System Bylaws (Cont'd):

- Article VII. Medical Staff
- 7.1 Appointments and Duties. The Board shall:
- 7.1.6 Provide adequate support personnel to assist the Medical Staff with organizational functions, including…collection and analysis of clinical data (quality assurance...)
- 7.1.7 Review, revise and update as appropriate the Performance Improvement Plan for Medical Staff and Hospital activities

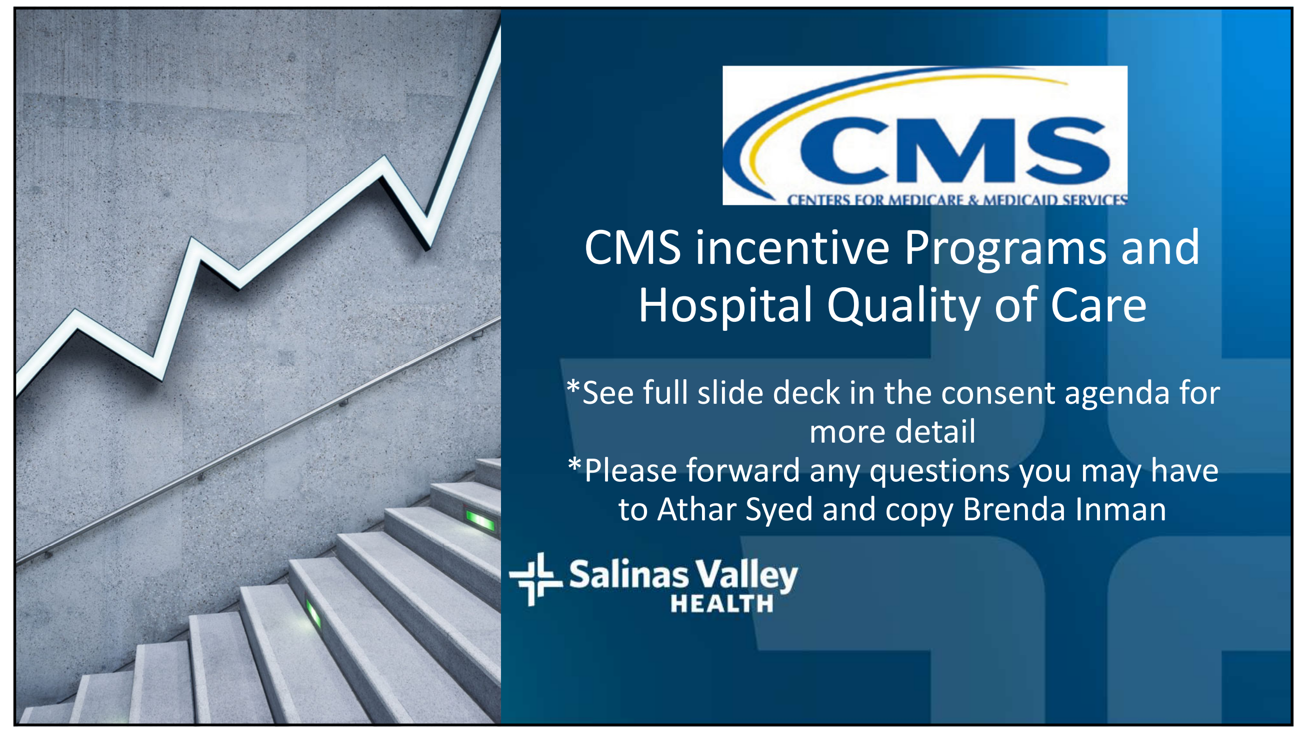
Bylaws of the Medical Staff of Salinas Valley Health Medical Center:

- Preamble
- These Bylaws are adopted in recognition of the mutual accountability, interdependence, and responsibility of the Medical Staff and the Board of Directors of Salinas Valley Health Medical Center in protecting the quality of medical care provided in the Hospital…
- Article I
- 1.2 Purpose and Responsibilities
- The Medical Staff's purpose and responsibilities are:
- 1.2.1 To assure that all patients admitted or treated in any of the Hospital services receives care at a uniform level of quality and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances;

Bylaws of the Medical Staff of Salinas Valley Health Medical Center (Cont'd):

- Article X Committees of the Medical Staff
- 10.1 Designation
- The purpose of Medical Staff committees shall be to monitor and improve quality of patient care services and perform other functions relative to the needs of the facility, the regulation of the state and federal government and the standards of The Joint Commission.
- 10.10 Quality and Safety Committee
- 10.10.2 Duties
- Performance Improvement Structure
- The Quality and Safety Committee (QSC) is an interdisciplinary medical staff committee that oversees all aspects of performance improvement and patient safety throughout the hospital.

How Do We Currently Measure Quality at Salinas Valley and Against Our Peers?



Financial Implications of Quality Based Incentive Programs

	Program/Initiative	% of Payment at risk
CMS	1. Hospital Inpatient Quality Reporting Program (HIQRP) 2. Hospital Outpatient Quality Reporting Program (HOQRP)	1/4th applicable Annual Payment Update (Market Basket Update) 2% reduction of annual payment update.
CMS	Hospital Value Based Purchasing Program (HVBPP)	2% of base Operating DRG payments
CMS	Hospital Readmission Reduction Program (HRRP)	3% of base Operating DRG payments
CMS	Hospital-Acquired Condition Reduction Program (HACRP)	1% of base Operating DRG payments
CMS	DRA HAC Program or HAC POA Program (DRA=Deficit Reduction Act /POA= Present on Admission)	No Payment for the treatment of 14 complications, if occurred in the hospital (NPOA)
CMS	National Coverage Determinations (NCD) for New Procedures and new treatments, like TAVR, Watchman etc.	No payment for non-compliance with mandatory quality data reporting.
Managed Care	Excellence Center/Blue Distinction Center designations by Blue Cross/Blue Shield, TriWest (VA) and United Healthcare	Quality of care related Incentive contracts with chances of higher reimbursements

Public Reporting/Hospital Image

Organization	Public Display
CMS	Care Compare publicly release data on HIQRP, HVBPP, HRRP, HACRP and Hospital Star Ratings
TJC	Quality Check: ORYX data on core measures
Leapfrog Group	Hospital Safety Grade scoring methodology uses CMS publicly released data.
US News & World Report	Hospital Ranking uses CMS publicly released data
Healthgrades	Hospital Ranking uses CMS publicly released data
Healthcare Bluebook (Quantros)	Hospital Ranking uses CMS publicly released data
American College of Cardiology (ACC)	Public Reporting of Heart Attack, ICD implant. Soon launching TAVR
American Heart Association (AHA)	Public Reporting of Heart Attack, Heart Failure, Stroke and Resuscitation
Society of Thoracic Surgery	Public Reporting of Cardiac Surgery Star Ratings
HCAI (formerly) OSHPD	Public Reporting of hospital complications and mortalities by diagnosis, cardiac surgeons and hospitals ranking, TKA/THA care data.

FFY 2028 Hospital IQR Program Requirements	FFY 2028 Hospital OQR Program Requirements
Chart-Abstracted Measures • Sepsis-1 Bundle • Influenza Vaccination	**Chart-Abstracted Measures** OP-18 ED Measure OP-22 ED Measure OP-23 CT or MRI Interpretation within 45 minutes of arrival for Stroke OP-29 Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients *see attached slide deck for full definitions
Electronic Measures • Mandatory Measures: PC-02-Cesarean Birth • PC-07-Severe Obstetric Complications • OPI-1-Safe use of Opioid - Concurrent prescribing • 3 additional optional measures	**Electronic Measures** OP-40: ST Elevation Myocardial Infarction OP: Excessive Radiation Dose or Inadequate Image Quality for Diagnostic CT in Adults
Claims-Based Measures • COMP-HIP-KNEE • ISCMR-Death Rate Among Surgical Inpatients with Complications • MORT-30-STK • AMI Excess Days • HF Excess Days • PN Excess Days • MSPB	**Claims-Based Measures** OP-10: Abdomen CT—Use of Contrast Material OP-39: Breast Cancer Screening Recall Rate OP-32: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy OP-35: Admissions and ED Visits for Patients Receiving Outpatient Chemotherapy OP-36: Risk-Standardized Hospital Visits Within 7 Days After Hospital Outpatient Surgery
Hybrid Measures • HWR-Hybrid Hospital Wide Readmission • HWM-Hybrid Hospital Wide Mortality	**Patient Reported Outcome Performance Measures** OP-42: Hospital-level Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA PRO-PM) OP-46: Patient Understanding of Key Information Related to Recovery After a Facility-Based Outpatient Procedure or Surgery (Information

Leapfrog Programs

	LEAPFROG HOSPITAL SURVEY	LEAPFROG HOSPITAL SAFETY GRADE
Purpose	Measure implementation of evidence-based safety practices (process focused)	Simple consumer tool to compare safety between facilities (outcome focused)
Data sources	▪ Facility self-reported responses ▪ NHSN	▪ Sub-set of hospital survey responses ▪ Selected CMS metrics
Assessment cycle	Annually since 2001	Biannually (spring and fall) since 2012
Public display	Related measures summarized in a 4-bar scale from "limited achievement" to "achieved the standard"	Facility performance summarized as a single letter grade A B C D F
URL	https://ratings.leapfroggroup.org/	https://www.hospitalsafetygrade.org/

CMS Star Rating

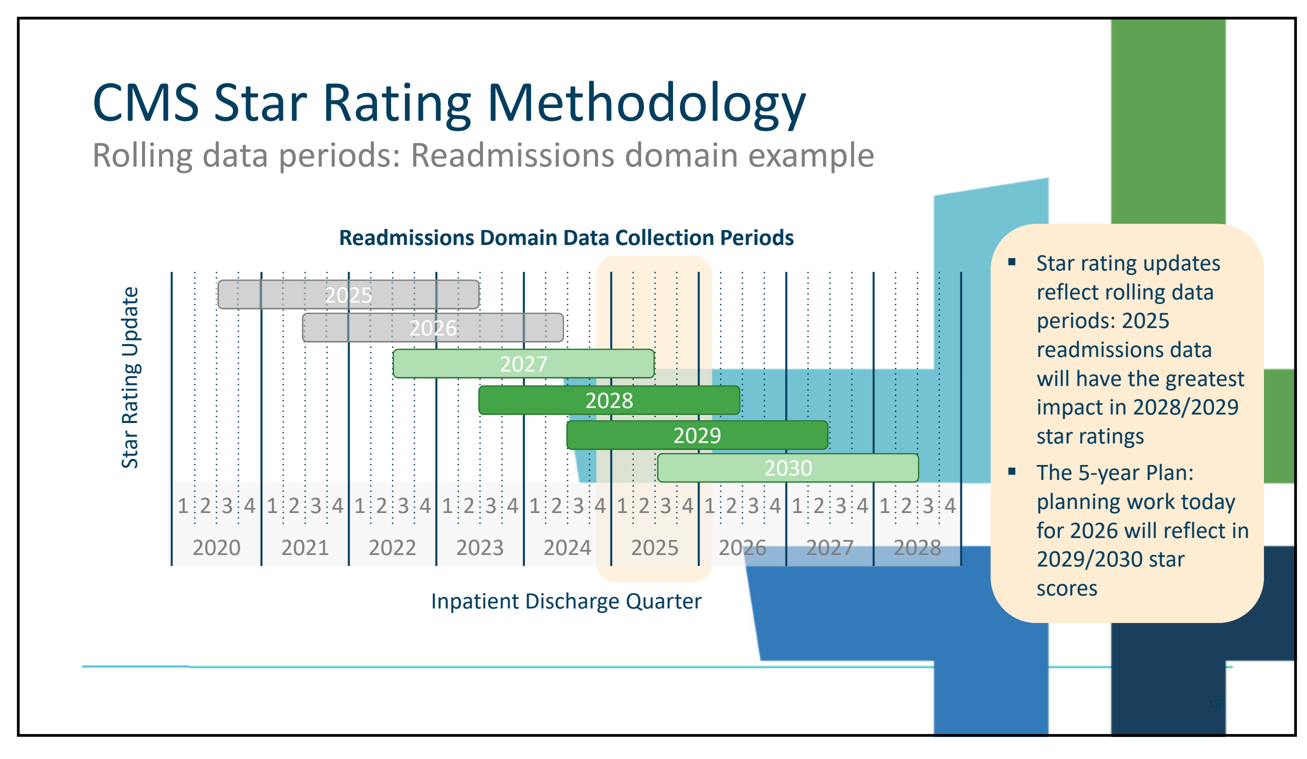
Current measure framework

Measure Group	Measures	Individual Measures (relative weight)	2025 Reporting Period*	Total Weight
Mortality	AMI, CABG, COPD, HF, PNE, Stroke, and PSI 04	7 (3.1%)	2020-2023	22%
Safety	HAIs, SSIs, PSI 90, Knee and hip complications	8 (2.8%)	2023	22%
Readmission	Excess days (AMI, HF, PNE), All-cause readmissions (CABG, COPD, Joint, overall) Unplanned ED and IP utilization (Chemo, colonoscopy, outpatient surgery)	11 (2.0%)	2020-2023	22%
Pt Experience	HCAHPS	8 (2.8%)	2023	22%
Timely & Effective Care	Vaccinations, ED throughput, Clinical care pathways	12 (1.0%)	2022-2023	12%
Totals: 5 measure groups		**46 measures**		

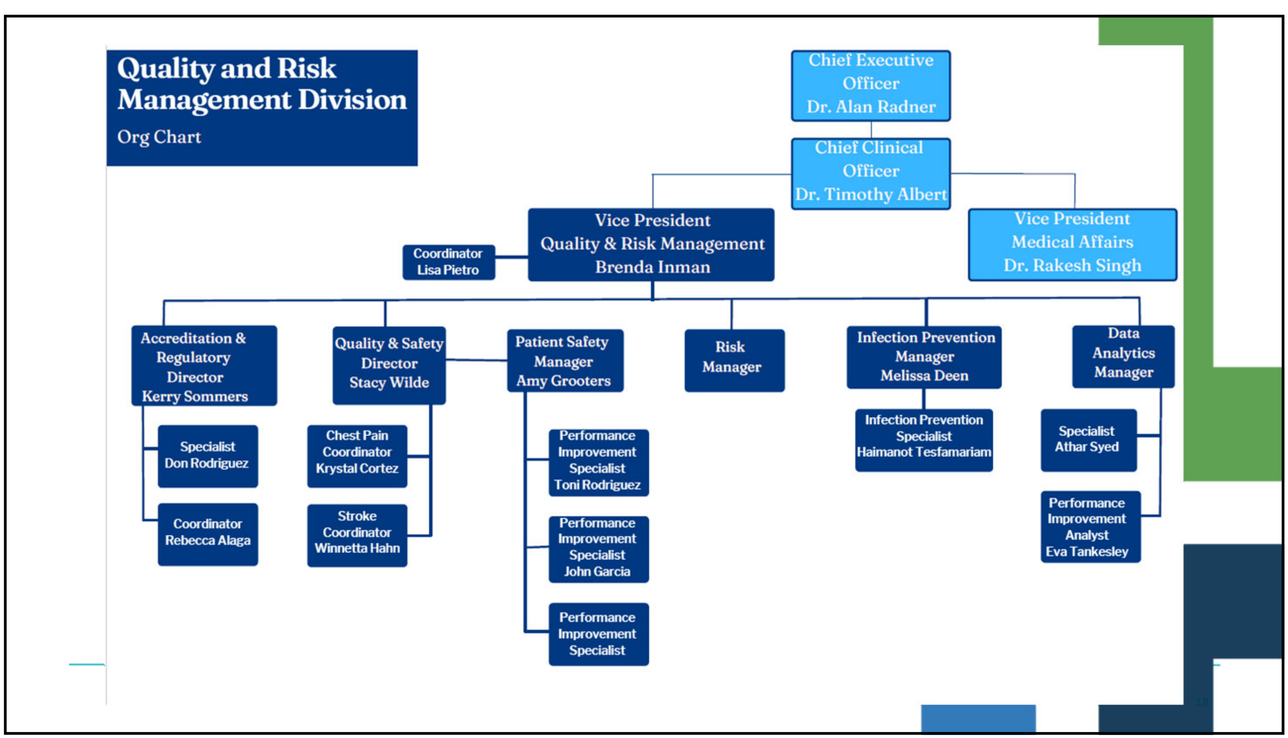
Methodology

* Some variability in reporting period by measure within most domains
Source: https://qualitynet.cms.gov/inpatient/public-reporting/overall-ratings/resources

15



Salinas Valley
HEALTH
Where is the Quality and Safety Department Headed at Salinas Valley Health?


Quality and Risk Management Division
Org Chart
Chief Executive Officer Dr. Alan Radner
Chief Clinical Officer Dr. Timothy Albert
Vice President Quality & Risk Management Brenda Inman
Coordinator Lisa Pietro
Vice President Medical Affairs Dr. Rakesh Singh
Accreditation & Regulatory Director Kerry Sommers
Specialist Don Rodriguez
Coordinator Rebecca Alaga
Quality & Safety Director Stacy Wilde
Chest Pain Coordinator Krystal Cortez
Stroke Coordinator Winnetta Hahn
Patient Safety Manager Amy Grooters
Performance Improvement Specialist Toni Rodriguez
Performance Improvement Specialist John Garcia
Performance Improvement Specialist
Risk Manager
Infection Prevention Manager Melissa Deen
Infection Prevention Specialist Haimanot Tesfamariam
Data Analytics Manager
Specialist Athar Syed
Performance Improvement Analyst Eva Tankesley

Restructuring Quality Collaboration

- The hiring of the Vice President of Quality and Risk Management brought 6 departments under one leader: Quality, Safety, Risk Management, Infection Prevention, Data Analytics, and Accreditation and Regulatory
- The work of most of these departments is being restructured. The new structure will be service-line based, allowing for Quality staff to provide better support for service lines, nursing units, and the hospital overall

Improved Data Analytics to Drive Quality and Performance Improvement

- A new Data Analytics Manager role is currently under recruitment. This manager will lead a team of data analysts and report to the Vice President of Quality and Risk Management
- In FY 2026, we will sign a contract and join the Vizient Large Community Hospital peer cohort
  - Vizient benchmarks our data against our peer cohort on a quarterly and annual basis and in a much shorter timeline that CMS benchmarks
  - We will be able to use benchmarked Vizient data to drive performance improvement in as close to real time as currently possible
- The data analytics team with work with service lines, nursing units, and Quality staff to provide data in a meaningful way that can used to drive change, such as dashboards, goal setting, PI project outcomes, etc.

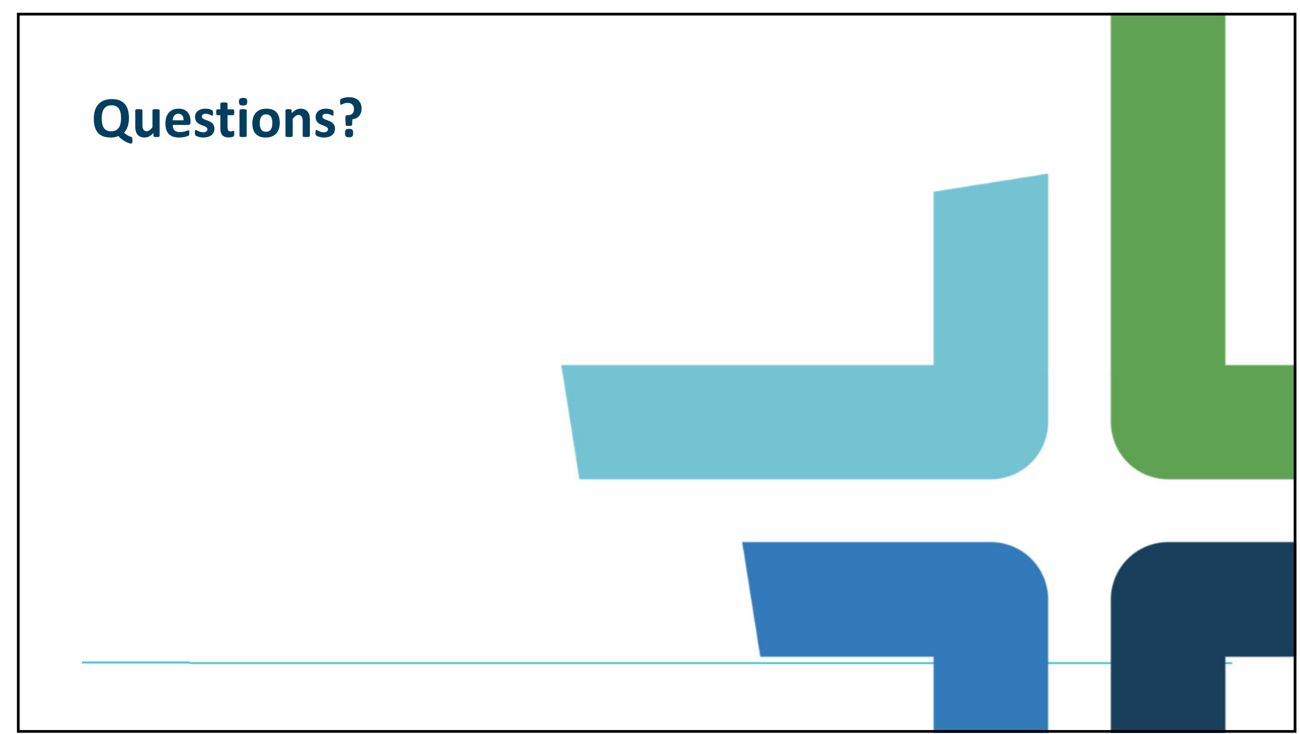
Restructuring Quality Meetings
We will be implementing a new meeting which will be held every Thursday, 9-9:30. This meeting will take the place of QIC moving forward
Each week, a different department or service will present to Hospital and Quality leadership. Quality will work with all groups to help them prepare slide decks
Presentations will include QAPI data, trends, successes, opportunities, performance improvement project updates, etc.
These presentations may be further reviewed at Quality and Safety Committee, Medical Executive Committee, or the Quality and Efficient Practices Committee.
High-Quality Healthcare
Patient-Centered
Safe
Effective
Timely
Efficient
Equitable

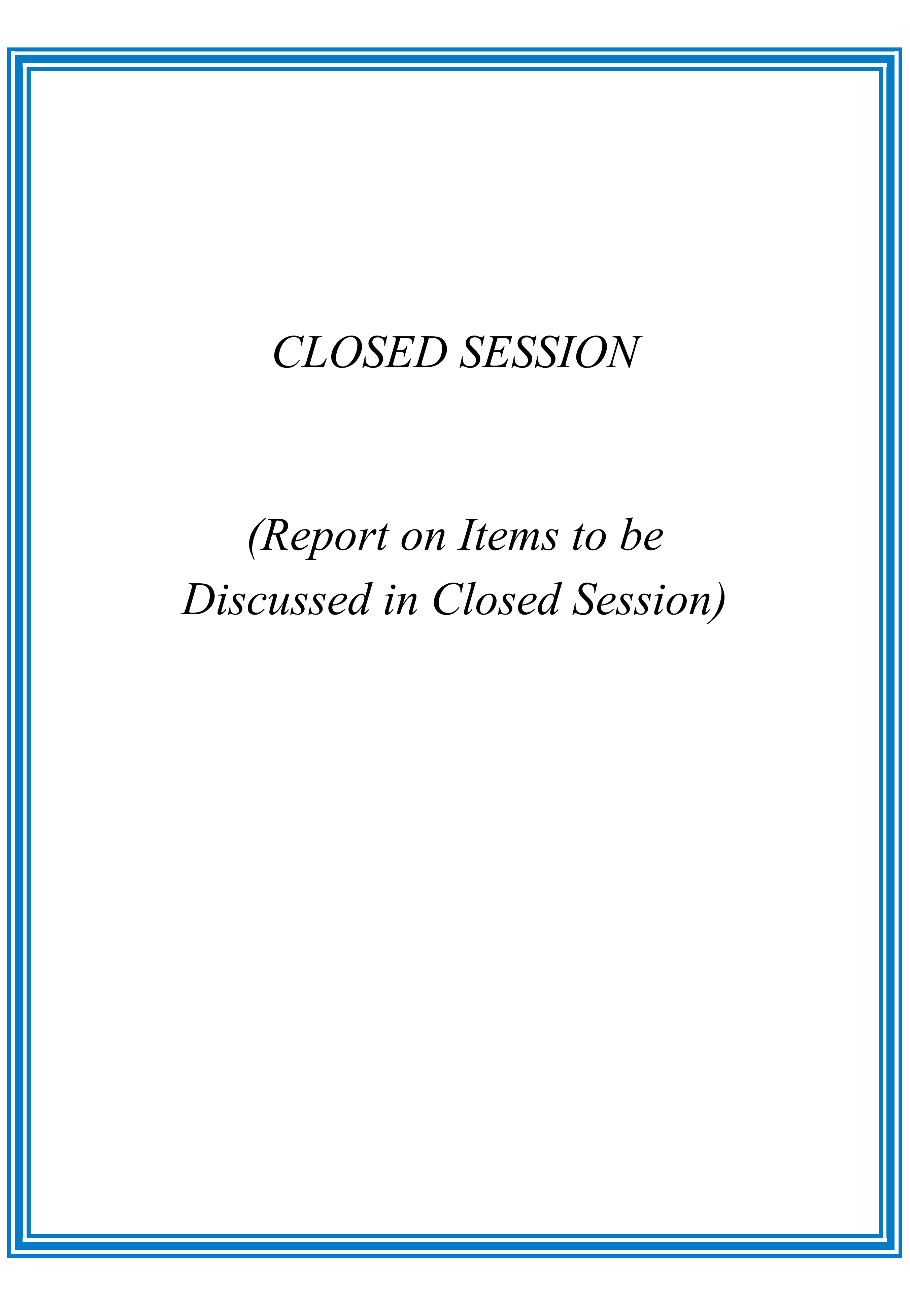
Relaunch of We Care System (RL Datix)
In February, we will relaunch the We Care (RL Datix) event reporting system
A link to RL Datix to report events is already built into Epic
We will be implementing a provider hotline for event reporting. We will have a dedicated voice mail line where providers may call and leave details about safety events. Quality staff will input the We Care on your behalf, follow the event to closure, and email you when the event is closed so you are aware of improvements that were put into place
We will be launching a Good Catch program to recognize near-miss events
SAFETY FIRST.

Patient Safety Events Committee (PSEC)

- This is a new, confidential, multidisciplinary committee comprised of hospital leadership that will be formed to review sentinel events. This committee will be focused on system-level improvements to prevent recurrence of similar events
- PSEC will be made aware of events through incident reports filed in RL Datix or notification directly to committee members
- After events are discussed, action plans will be developed and implemented
- Quality staff will follow action plans through to completion and ensure sustainability of improvements after events are closed

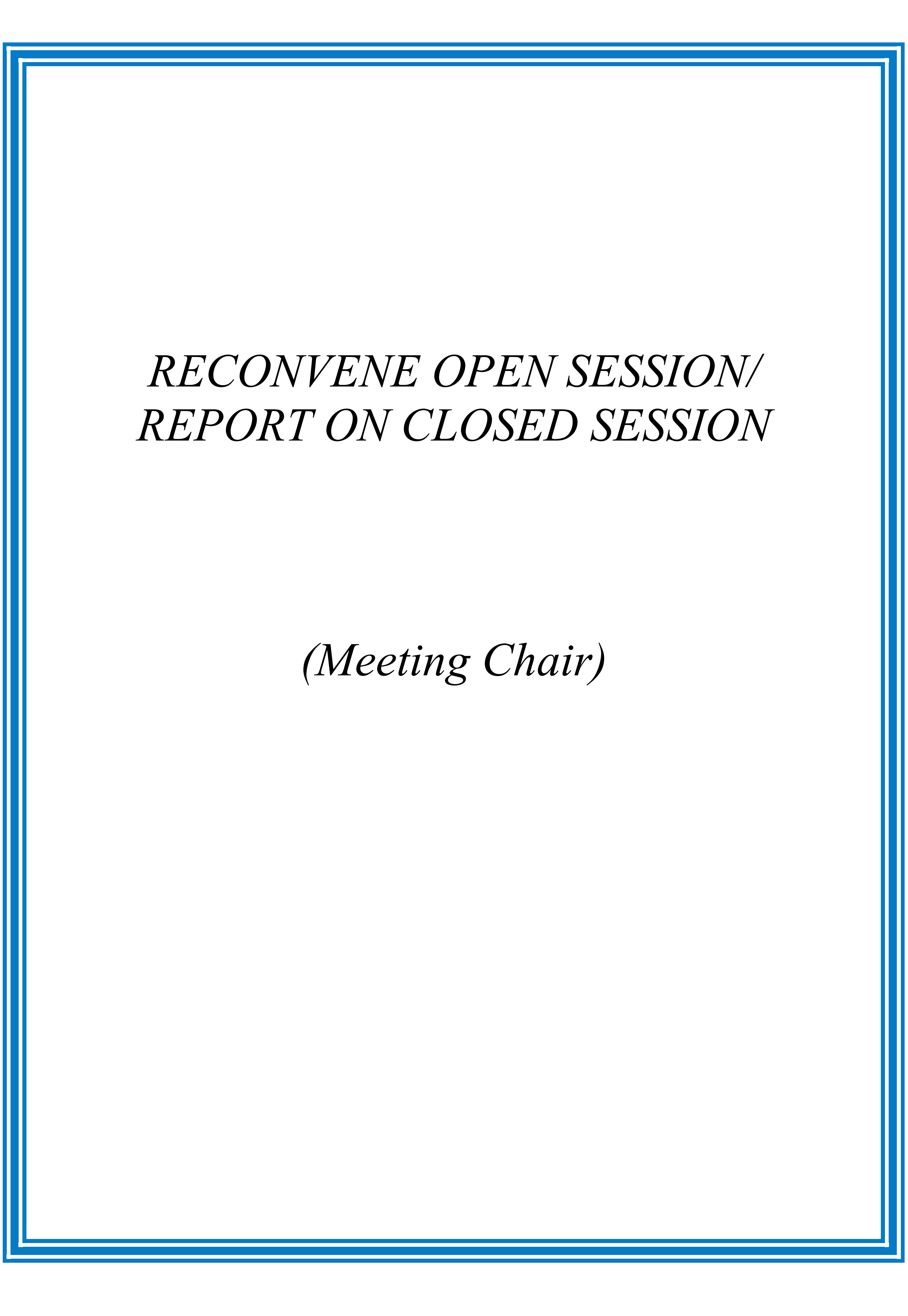
Questions?





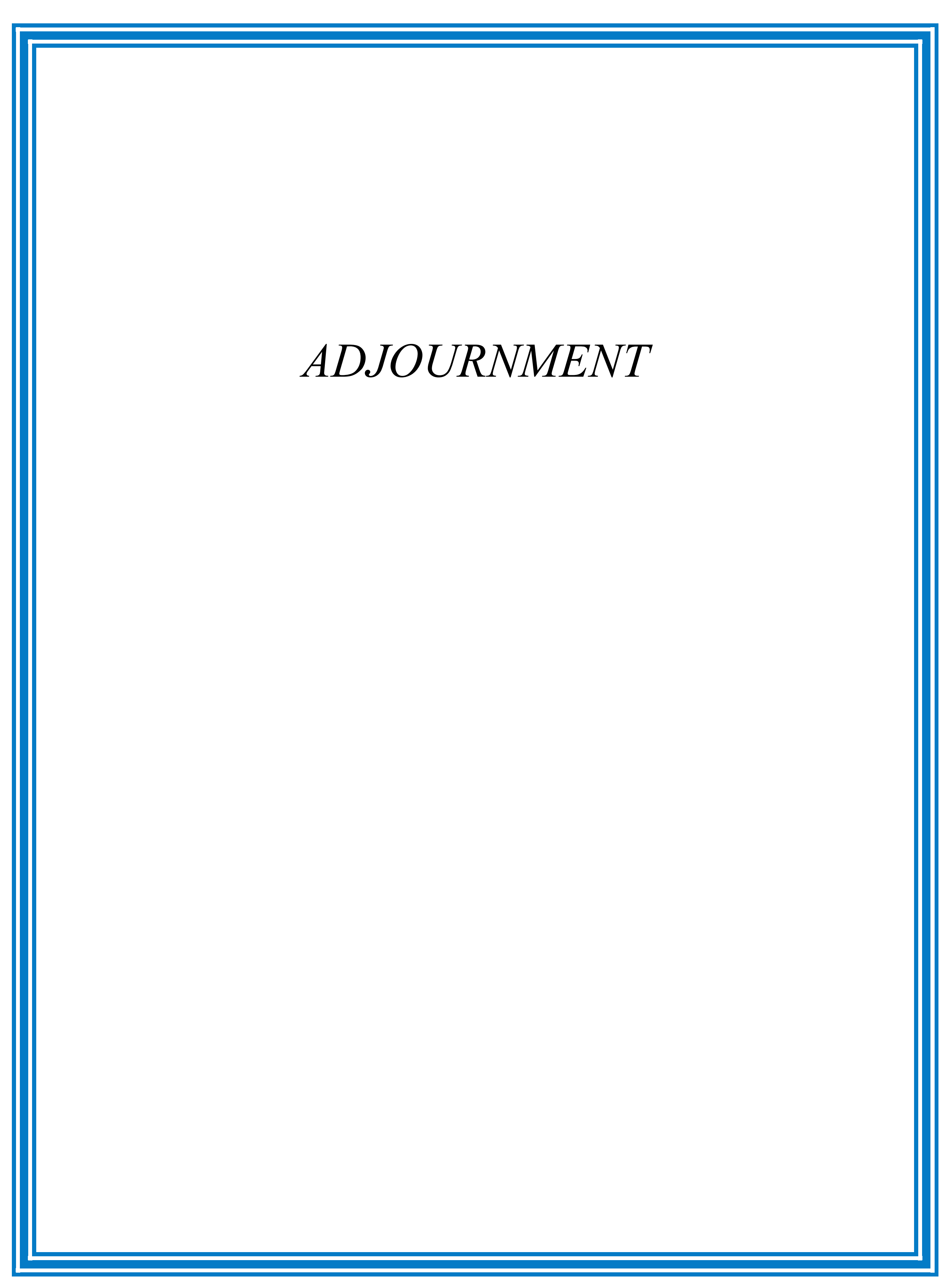
CLOSED SESSION

(Report on Items to be Discussed in Closed Session)



RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)



ADJOURNMENT