May 18, 2023

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 the **SALINAS VALLEY HEALTH**[1] will be held **MONDAY, MAY 22, 2023, AT 8:30 A.M., CEO CONFERENCE ROOM, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeetinglink** *for Access Information*).

Pete Delgado
President/Chief Executive Officer

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

Committee Members: Catherine Carson, Chair; Rolando Cabrera, MD, Vice Chair; Pete Delgado, President/CEO; Allen Radner, MD, Chief Medical Officer; Clement Miller, Chief Operating Officer; Lisa Paulo, Chief Nursing Officer; Rakesh Singh, MD, Medical Staff Member; Michele Averill, Community Member

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

MONDAY, MAY 22, 2023 8:30 A.M.
DOWNING RESOURCE CENTER, CEO CONFERENCE ROOM 117

Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California
or via Teleconference
(Visit SalinasValleyHealth.com/virtualboardmeeting for Access Information)

AGENDA

1. Call to Order / Roll Call
2. Approve the Minutes of the Quality and Efficient Practices Committee Meeting of April 17, 2023. (DELGADO)
   - Motion/Second
   - Action by Committee/Roll Call Vote
3. Patient Care Services Update (PAULO)
   - Collaborative Care Committee Annual Update
4. Laboratory Services Update (MILLER)
5. Quality Assessment and Performance Improvement Plan (QAPI) (KUKLA)
6. New CMS measures: Health Equity/Social Determinants of Health (KUKLA)
7. Public Input

   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.
8. Closed Session
9. Reconvene Open Session/Report on Closed Session
10. CMS Star and Leapfrog Report (KUKLA)
11. Adjournment

    The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, June 19, 2023 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 Committee packet is available at the Committee Meeting, at www.SalinasValleyHealth.com, and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Committee.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-759-3050. Notification received 48 hours before the meeting will 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. Invited Reports of the May 4, 2023 Medical Staff Quality and Safety Committee
    a. Women's Services Report (Vasher)
    b. Resuscitation Committee Report (Spencer)
    c. Critical Care Services Report (Spencer)

2. Quality and Safety Board Dashboard Report

3. Summary Report of the Quality and Safety Reports

4. Receive & Accept Quality and Safety Reports
    a. Quality and Safety Committee
        i. Transitions of Care
        ii. Critical Care Services
        iii. MedSurg Cluster/Peds/In-patient Wound Care Program
        iv. HIM (Health Information Management)
        v. Nursing Admin/Transporters/Interpreter Services
        vi. Nursing Education
        vii. Taylor Farms
        viii. Community/Volunteer Services
        ix. Food Services
        x. Respiratory Care
        xi. Rehab Services (PT, OT, Speech)
        xii. Sleep Medicine
    b. Miscellaneous
        i. CMS Data Report July 2023
        ii. CMS Star Report July 2023
        iii. Accreditation and Regulatory Report

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

SALINAS VALLEY HEALTH[1]
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES APRIL 17, 2023

Committee Members Present: Catherine Carson, Chair, Michele Averill *(Via Teleconference)*, Rolando Cabrera, MD, Vice-Chair, Pete Delgado, Clement Miller, Lisa Paulo, Allen Radner, MD, and Rakesh Singh, MD;

Committee Members Absent: None

Other Board Members Present Constituting Committee Of The Whole**:**
Juan Cabrera and Victor Rey, Jr. *(both via teleconference)*

Juan Cabrera, joined the meeting at 8:37 a.m.
Committee Member Rakesh Singh, MD, joined the meeting at 8:45 a.m.
Committee Member Averill left at 8:59 a.m.
Committee Member Singh left at 9:55 a.m.

CALL TO ORDER/ROLL CALL

A quorum was present and Chair Carson called the meeting to order at 8:35 a.m. Heart Center Teleconference room.

APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF MARCH 20, 2023

Approve the minutes of the Quality and Efficient Practices Committee for the March 20, 2023 meeting, as presented. The information was included in the Committee packet.

No public input received:

MOTION:

Upon motion by Committee Member Paulo, second by Vice Chair Cabrera, the Quality and Efficient Practices Committee minutes of March 20, 2023 were approved.

Ayes: Committee members: Dr. Cabrera, Delgado, Miller, Paulo, Radner, Carson; Noes: None; Abstentions: Averill; Absent: Dr. Singh. Motion carried.

PATIENT CARE SERVICES UPDATE

Lisa Paulo, MSN/MPA, RN, CNO, provided a report on Salinas Valley Health patient experience. Ms. Paulo discussed examples of patient specific and employee specific efforts to improve patient experience and staff engagement.

Ms. Paulo introduced Norma Coyazo, MSN, RN, Research & Evidence-Based Practice (REBP) Council Chair and Kristen Green Meadows, BSN, ICU, who provided a report on the Council. A full report was provided in the packet.

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

CONTRACT EVALUATIONS SUMMARY

Chair Carson stated that the contract evaluation is a CMS Condition of Participation. Salinas Valley Health has an excellent contract evaluation process in place.

A comprehensive evaluation and review of direct and indirect contracts is completed every three years. 27 out of 27 Salinas Valley Health direct contracts have met required criteria and 322 out of 322 indirect contracts have met required criteria and have been renewed or extended. There were 2 direct and 4 indirect contracts that had opportunities for improvement and action plans and monitoring are in effect.

72 out of 72 Chief Medical Officer (CMO) direct contracts have met required criteria and 76 out of 76 indirect contracts have met required criteria and have been renewed or extended.

A full report was included in the packet.

HEALTHGRADES PATIENT SAFETY EXCELLENCE AWARD

Salinas Valley Health Medical Center has received the Healthgrades Patient Safety Excellence Award for 2023 which is based on CMS 2019-2021 data and excludes patients with COVID diagnosis. Salinas Valley Health Medical Center had better than expected Patient Safety Indicator rates for:

- Occurrence of pressure injuries
- Post-procedural and surgical bleeding rates
- Occurrence of pulmonary embolism and leg DVTs.

Discussion: CMS excludes COVID patients because most have a high rate of comorbidities. For example, 40-50 COVID patients have DVTs.

PUBLIC INPUT

No public comment received.

CLOSED SESSION

Chair Carson announced that the item to be discussed in Closed Session is *Hearings/Reports – Report of the Medical Staff Quality and Safety Committee* and *Trade Secrets Strategic Planning, Proposed New Programs and Services*. The meeting recessed into Closed Session under the Closed Session protocol at 9:11 a.m.

RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened Open Session at 9:53 a.m., Chair Carson reported that in Closed Session, the Committee discussed *Hearings/Reports – Report of the Medical Staff Quality and Safety Committee* and *Trade Secrets, Strategic Planning, Proposed New Programs and Services*. The following actions were taken:

The Committee received and accepted the following reports:

- Reports of the Medical Staff Quality and Safety Committee
    - Risk Management/Patient Safety Report
    - Accreditation and Regulatory Report

- Disease Specific Care Program
    - Chest Pain Program
    - Total Joint Program
- Review Quality and Safety Dashboard Development Results and Current Data
- Pharmacy and Therapeutics/Infection Prevention & Antibiotics Stewardship Committee
- Contract evaluation packet

RISK MANAGEMENT PLAN 2023

Proposed changes to the Risk Management Plan were presented for review and discussion. A redlined copy was provided in the packet.

MOTION:

Upon motion by Committee Member Dr. Radner, second by Committee Member Paulo, the Risk Management Plan 2023 was approved.

Ayes: Committee members: Dr. Cabrera, Delgado, Miller, Paulo, Radner, Singh, Carson; Noes: None; Abstentions: None; Absent: Averill. Motion Carried.

PATIENT SAFETY PLAN 2023

Proposed changes to the Patient Safety Plan were presented for review and discussion. A redlined copy was provided in the packet.

MOTION:

Upon motion by Committee Member Delgado, second by Committee Member Radner, the Patient Safety Plan 2023 was approved.

Ayes: Committee members: Dr. Cabrera, Delgado, Miller, Paulo, Radner, Singh, Carson; Noes: None; Abstentions: None; Absent: Averill. Motion Carried.

ADJOURNMENT

There being no other business, the meeting adjourned at 9:56 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Monday, May 22, 2023 at 8:30 a.m.**

_____

Catherine Carson, Chair
Quality and Efficient Practices Committee

/KmH

Board Paper: Quality & Efficient Practices Committee

Agenda: Patient Care Services Update
Executive Sponsor: Lisa Paulo, MSN/MPA, RN
Date: May 22, 2023

Pillar/Goal Alignment:

☐ Service ☐ People ☒ Quality ☐ Finance ☐ Growth ☐ Community

QUALITY:

Collaborative Care Committee

- Aubree Collins, BSN, RN, RNC-OB, C-EFM [Chair]
- Pamela Yates, RN [Co-Chair]
- Anna Mercado BSN, RN, ONC [Practice Council]
- Heather Barigian, BSN, RN, PCCN [Practice Council]
- Francie Espino, BSN, RN, CCRN [Quality Council]
- Laurie Freed, BSN, RN, CCRN-CSC [Quality Council]
- Stephanie Fierro, BSN, RN, CCRN [Professional Development Council]
- Krystal Cortez, BSN, RN, PCCN [Professional Development Council]
- Norma Coyazo, MSN, RN, RNC-OB, C-EFM, [Research and EBP Council]
- Celina Medina, MSN, RN, [Research and EBP Council]

- Carla Spencer, MSN, RN, NEA-BC, Director of Critical Care Services [Advisor]
- Kirsten Wisner, PhD, RNC-OB,CNS, C-EFM, NE-BC, Magnet Program Director
- Bhargavi (Bee) Simhadri, MSN, RN, NE-BC, CCRN-K, Director Clinical Operations [Nurse Leadership Council]
- Rebecca Rodriguez, MSN, RN, CEN, CPHQ, Clinical Excellence Specialist

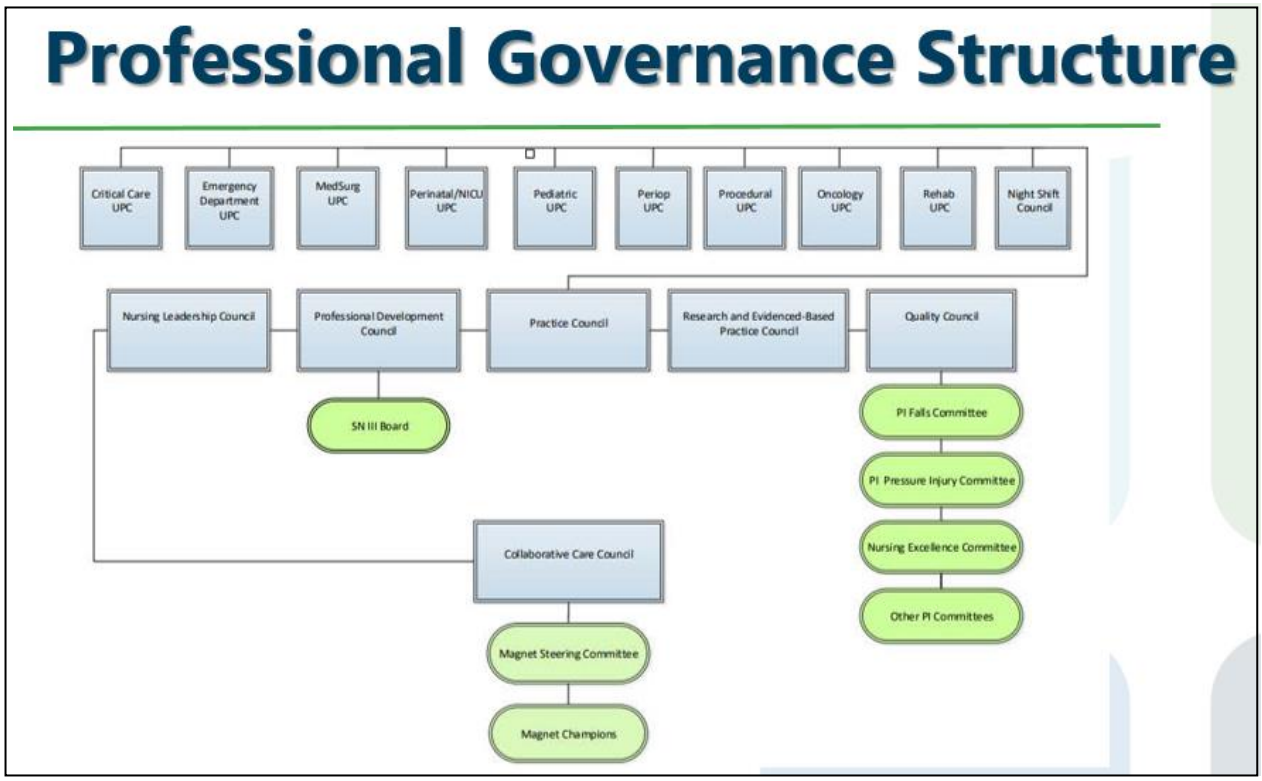
MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

Purpose

Salinas Valley HEALTH

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

QUALITY:



Tim Porter O'Grady Workgroup

1. **Who is Tim**? World renowned expert in Professional Governance.
2. **What did he recommend for us?**
   a. Clearly define your professional roles and accountabilities.
   b. Increase nursing professionalism and ownership of practice.
   c. Focus Leadership on providing the resources needed for patient care.
3. **How are we doing it?**
   a. We formed a workgroup that meets monthly.
   b. Wrote accountabilities statements for Clinical Nurses, Nurse Leaders and the CNO.
4. **Implementation**
   a. Administered the Verran Professional Governance Scale (VPGS) to survey 151 Salinas Valley Heath nurses. The VPGS assesses behaviors associated with Professional Governance.
   b. Education regarding the accountability statements and role clarification has begun.
   c. Full revision of the bylaws to reflect changes in perspective and language.

QUALITY:

Leadership Training

Professional Governance Leadership Training

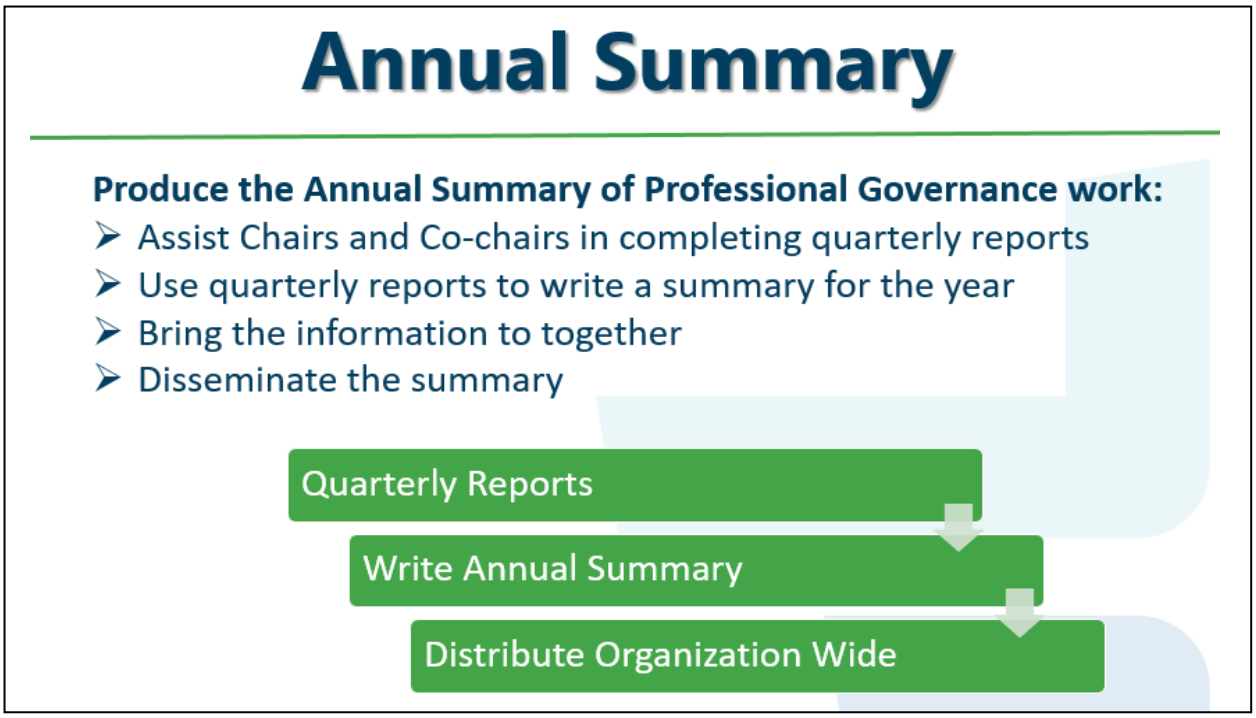
- Lunch and Learn Workshop 2/23/23
- New Chair Co-chair Training 9/15/22
- **Curriculum:**
  - The Professional Practice Model
  - Leading a meeting
  - The Referral System
  - Council Management
  - Coordination between Nurses and Nursing Leadership

Bylaws

Bylaw Revisions:

- Maintain bylaws
- Approve exceptions to the bylaws
- A major bylaw revision is in progress as we work with Tim Porter O'Grady

QUALITY:


Annual Summary
Produce the Annual Summary of Professional Governance work:
Assist Chairs and Co-chairs in completing quarterly reports
Use quarterly reports to write a summary for the year
Bring the information to together
Disseminate the summary
Quarterly Reports
Write Annual Summary
Distribute Organization Wide

LABORATORY SERVICES UPDATE

(MILLER)

Salinas Valley Health: Pathology Laboratory

Quality Improvements and LEAN Systems

Salinas Valley HEALTH

Welcome to Salinas Valley Health, Pathology Laboratory

Regulatory Oversight

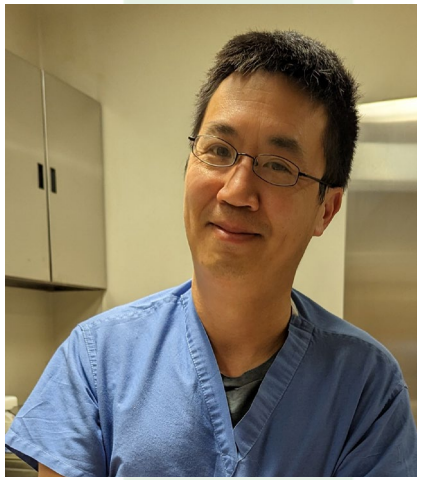
-Inspected every 2 years by the College of American Pathology

-Participation in Hospital-wide JCAHO surveys every 3 years

-Compliance with all CLIA and CDPH regulations

-Over 400 Standard Operating Procedures and Policies

Yvonne Sandza, Laboratory Director



Johnny Hu, M.D. Medical Director

College of American Pathology

Joint Commission on Accreditation of Healthcare Organizations

Clinical Laboratory Improvement Amendments

California Dept of Public Health

Food and Drug Administration

Center for Medicare & Medicaid Services

American Association of Blood Banks

Office of Statewide Health Planning and Development

LEAN / Six Sigma

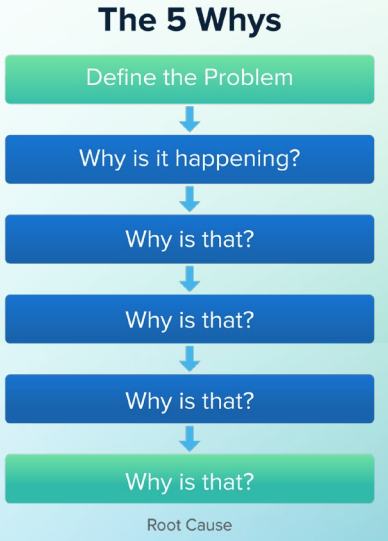
-Toyota Method

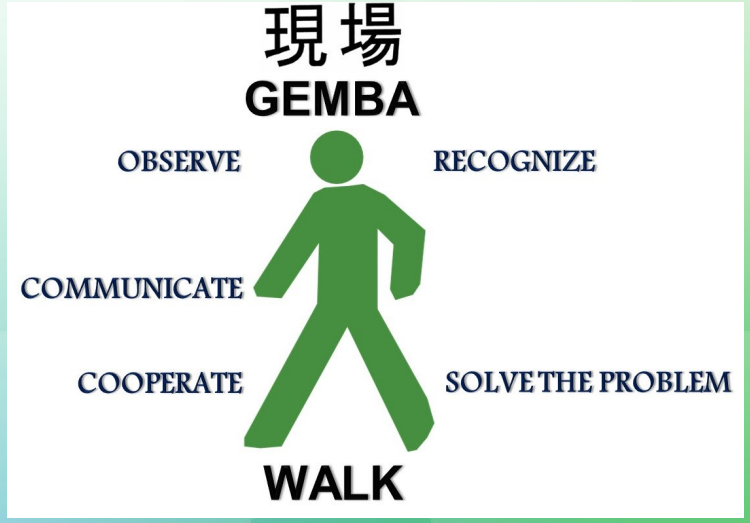
-Utilized Kanban Boards for organization and workflow

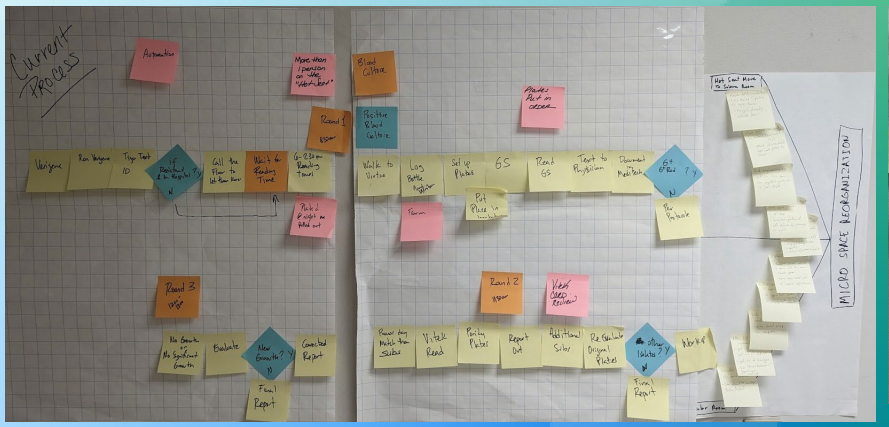
-Gemba Walks and “5 why’s” for root cause analysis

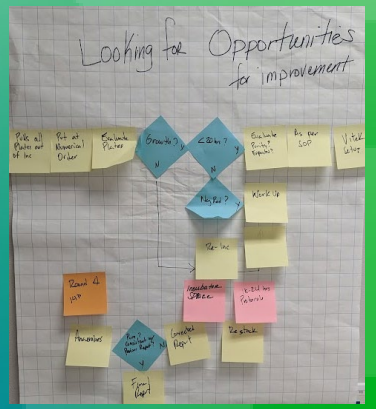
-Creates streamlined workflows, organizes use of space, and improves systematic efficiency to allow for scale

-Frees scientists and techs to focus on quality of work and the best patient care!









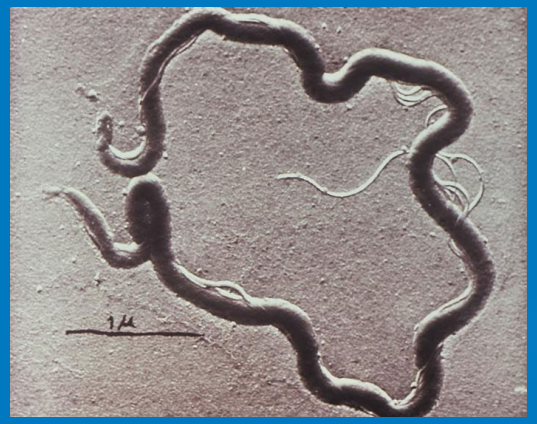
Hematology, Coagulation, Urinalysis

Daily RPR (Syphilis) Testing

-Will allow for quicker discharge of newborns

-Faster time to treatment

-More efficient Pre-natal Screenings



Anti-Xa Testing

-Collaborated with pharmacy to replace PTT testing for Patients on Heparin Therapy

-Achieve therapeutic range more quickly and consistently for Cardiac patients

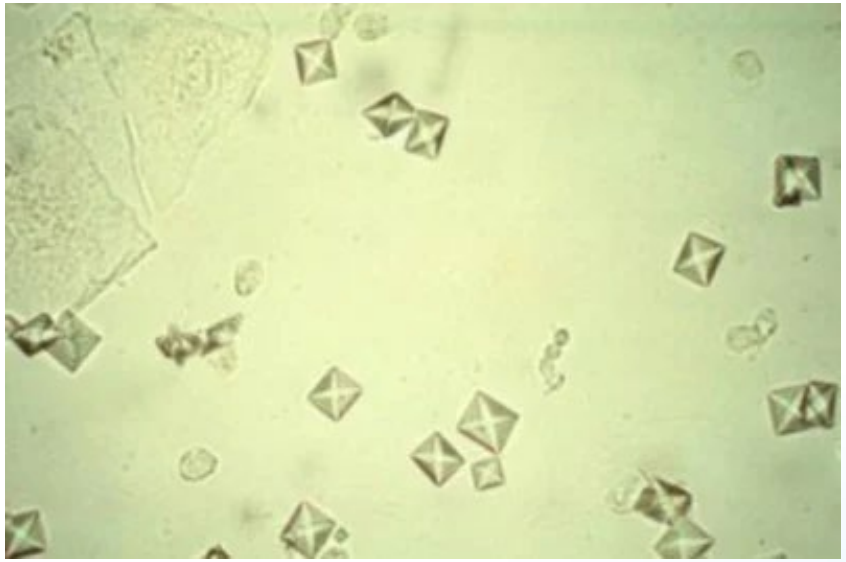
Autoverification

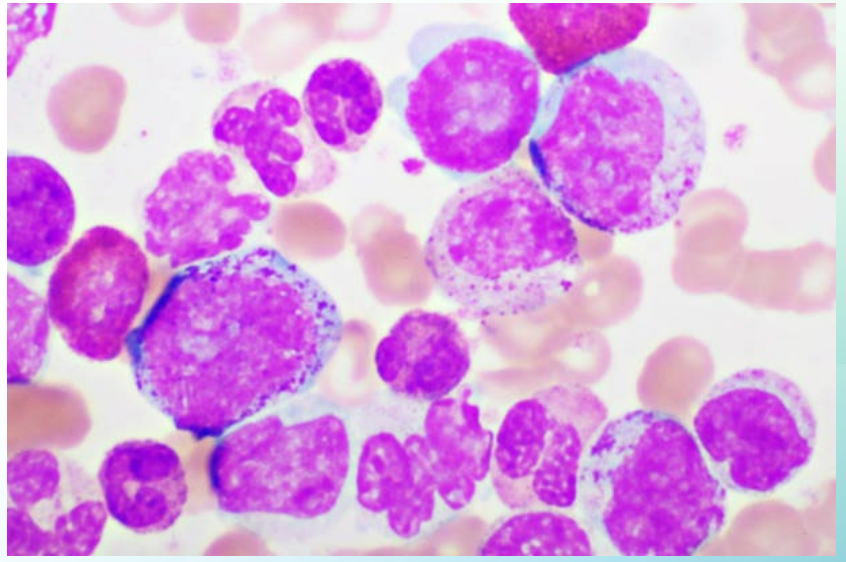
-Algorithm-driven automation

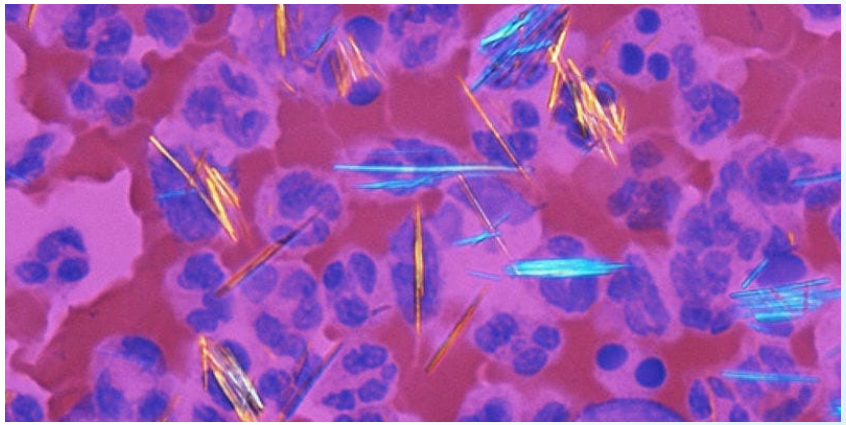
-Improved turn-around-times and throughput

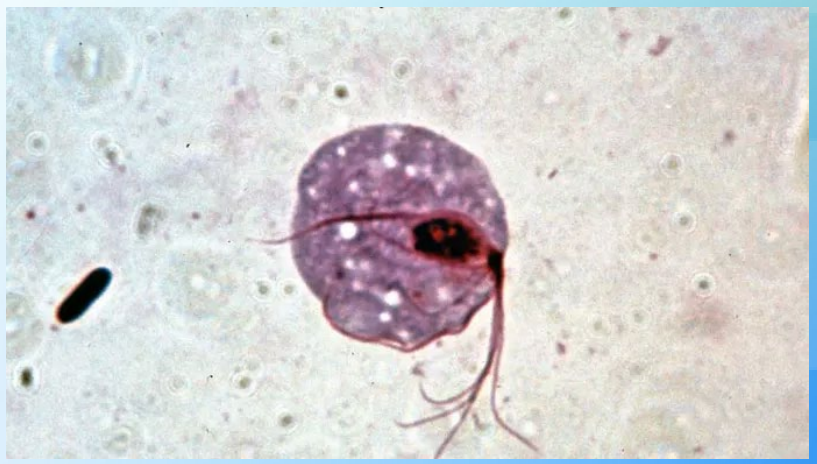
-More efficient and diverse use of Scientists

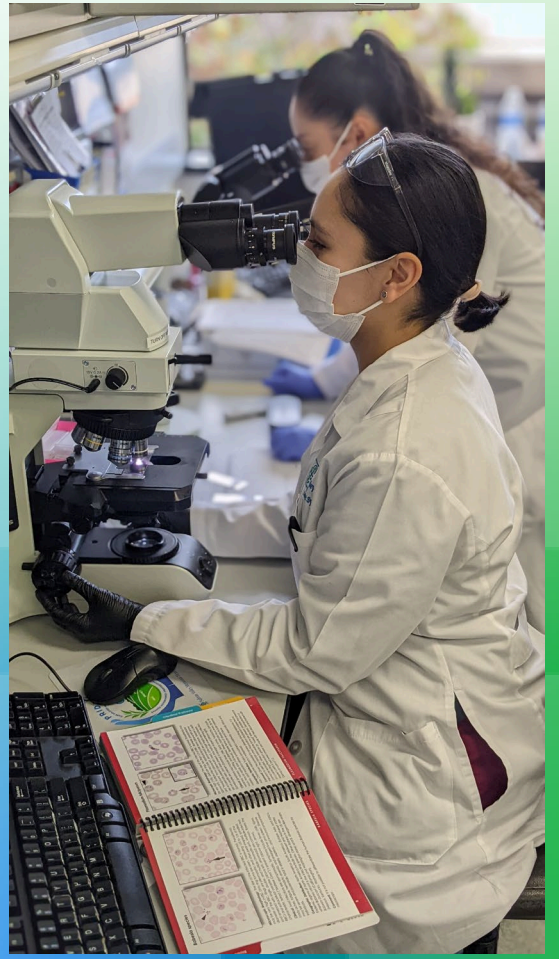
Hematology, Coagulation, Urinalysis: Microscopy



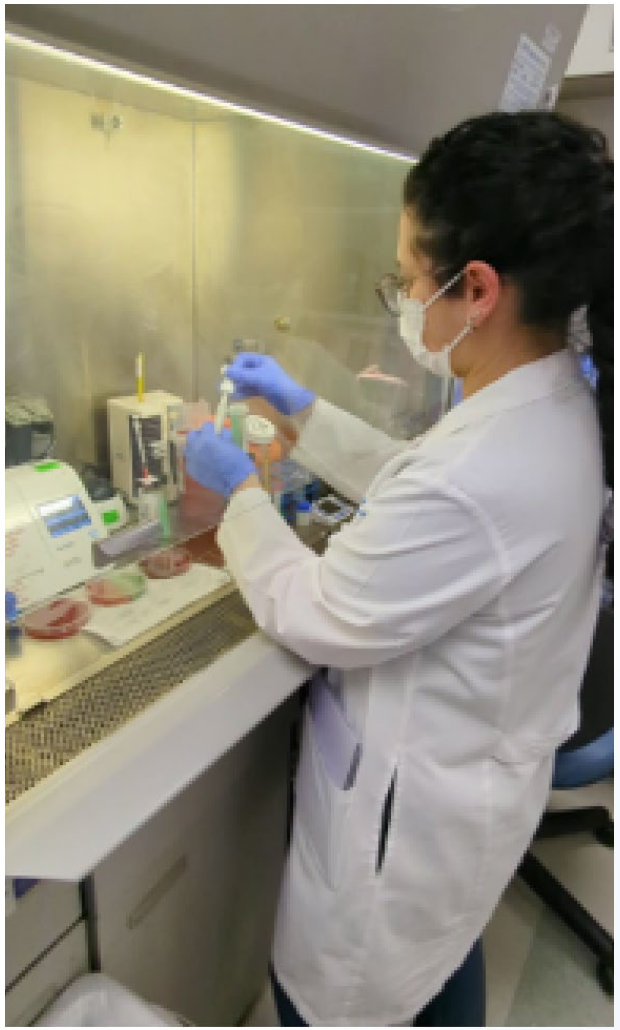








Microbiology/Molecular



Kathryn Marie, CLS Student

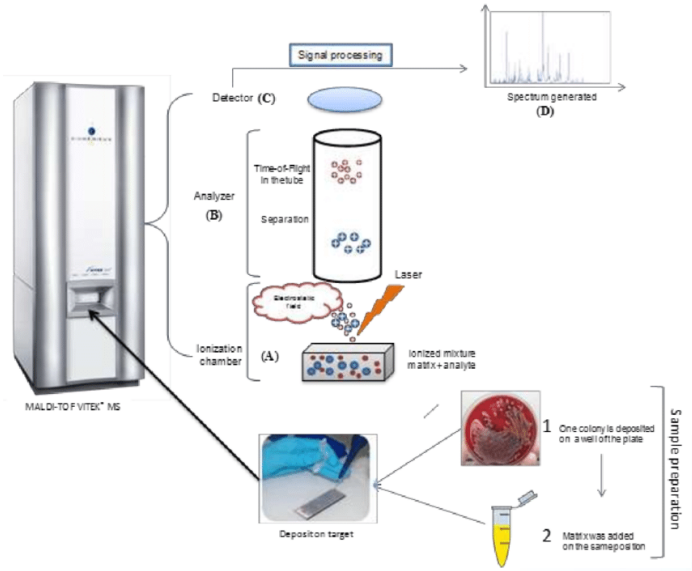
Microbiology

a. Specimen plating and setup for growth and recovery of pathogens

b. Identify organisms and test for appropriate antimicrobial agents for treatment

Michael Tran, CLS Microbiologist

Microbiology/Molecular



Maldi-TOF Analyzer

Cepheid Gene X-pert (Future)

Microbiology: Future Technologies

a. Working towards adoption of **molecular technology**

b. Altering **utilization of existing lab space** and personnel to accommodate Micro **workflow process changes**

Blood Transfusion Services

-Unit typing added to Echo Lumena for fully automated blood typing, Antibody Screening and Identification

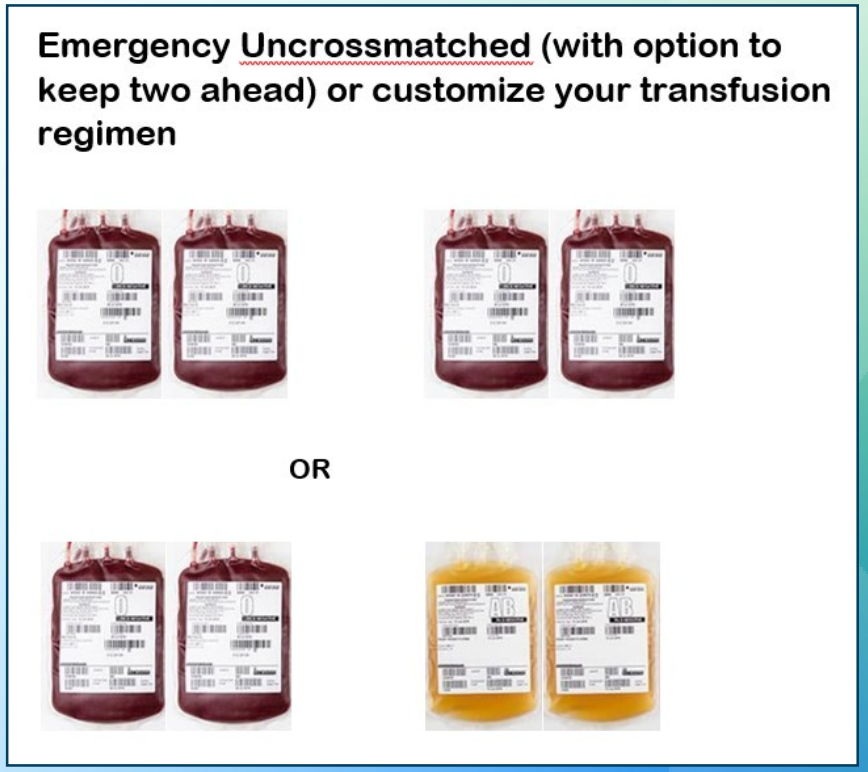
-Applied LEAN tools to standardize Massive Transfusion Protocol

Blood type via tube method was established in 1940!

Marial Dizon, Blood Bank Lead

New Echo Lumena Automated Analyzer for Blood Types, Antibody Screens, Donor Unit typing, and Antibody Identification.

Volume Replacement (MTP) or Rapid Release (Emergency Uncrossmatched)???

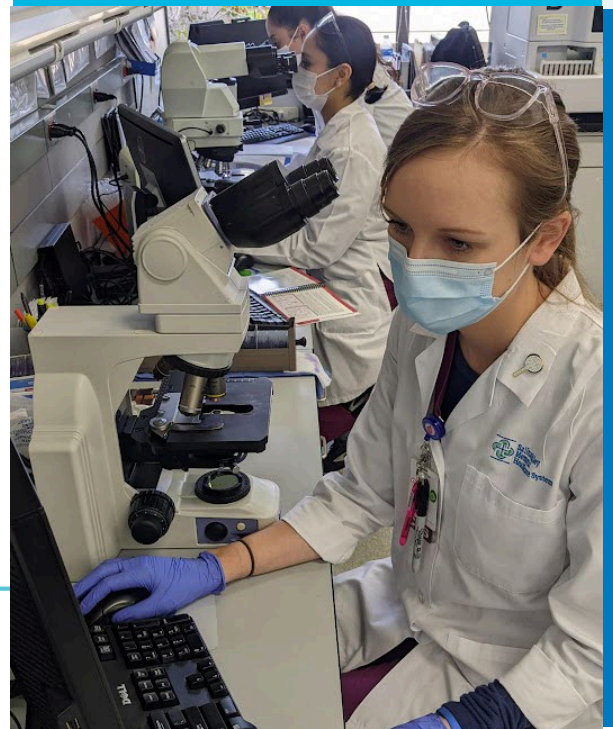


Point of Care Testing

I. Time sensitive Laboratory testing
II. Performed by RN's
III. Has oversight from Clinical Laboratory Scientist

WebMRE for RN POC Result Entry

I-STAT handheld Analyzers for ED

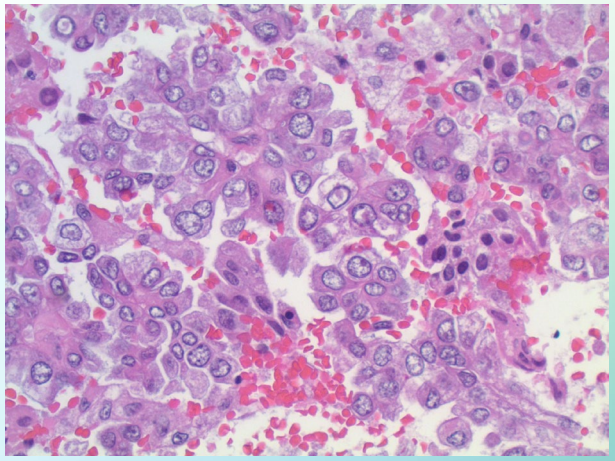


COVID Antigen and Amnisure-ROM Testing

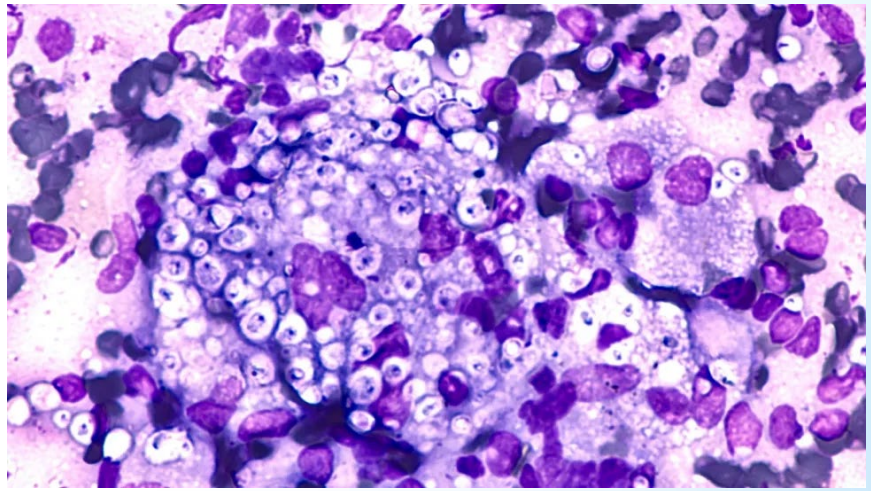
Histology and Anatomical Pathology

I. Pathologists work to identify diseased tissue or cells
II. Histotechnologists help to process specimens for examination of many different pathologies
III. Staining can provide contrast and help to identify diseased vs. healthy tissue and cells

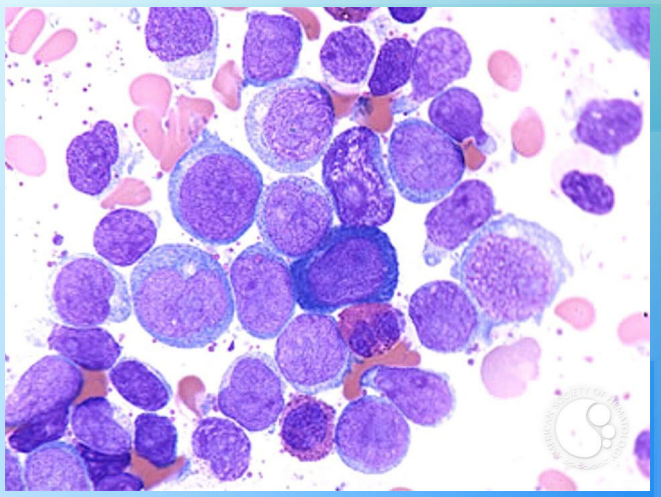
Adenocarcinoma

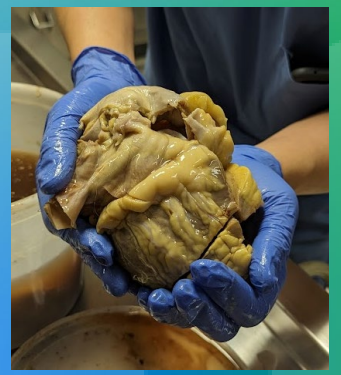


Disseminated Histoplasma Capsulatum



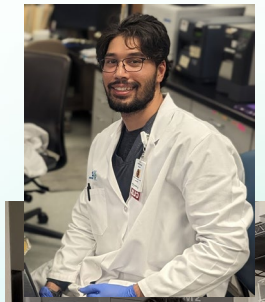
Blast Crisis - Leukemia





Clinical Laboratory Team

Salinas Valley HEALTH



It’s a privilege to serve our community.

Status **Pending** PolicyStat ID **13549799**

Last Approved	N/A
Last Revised	05/2023
Next Review	1 year after approval
Owner	Aniko Kukla: Director Quality & Patient Safety
Area	Plans and Program

Quality Assessment and Performance Improvement Plan

I. SCOPE

A. The purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Program Plan at Salinas Valley ~~Memorial Hospital~~Health Medical Center (~~SVMH~~SVHMC), under the Salinas Valley ~~Memorial Healthcare System (SVMHS)~~Health is to ensure that the Governing Body, medical staff and professional ~~service~~services staff demonstrate a consistent endeavor to deliver safe, effective, optimal patient care and services in an environment of minimal risk. Furthermore, the QAPI Plan is used as a mechanism to develop, implement, and maintain an effective, ongoing, organization-wide, data-driven quality assessment and performance improvement program through a planned, systematic, and interdisciplinary approach to improving the care, treatment and services provided. This is an organization-wide plan. It applies to all inpatient, outpatient departments and ambulatory outpatient services, licensed under ~~SVMH~~SVHMC including those services furnished under contract or arrangement.

B. The QAPI Program is designed to promote an environment where patient care and services are continually improved, where professional performance and employee competence are maximized, and in which operational systems are efficient. Through an interdisciplinary and integrated process, patient care and the processes that affect patient care are measured and assessed to provide optimal outcomes. The Board of Directors, Medical Staff, organizational leaders and all personnel assume appropriate accountability for the quality of care and services provided at ~~SVMH~~SVHMC. The QAPI Program is designed to align with and support the organizational MISSION, VISION, AND GOALS STATEMENT.

C. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley ~~Memorial Hospital~~Health Medical Center is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationships, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of care. These decision making committees include committees in Administrative

Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and nursing practice initiatives are incorporated into the overall organizational performance improvement.

II. OBJECTIVES/GOALS

A. **Objectives**

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

B. **Goals**

1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental monitoring.
2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for ~~2020~~2023:
    - Annual Quality and Safety Pillar Strategic Initiatives
    - Patient Perception of Care, Services and Treatment
    - Patient Flow Initiatives
    - Regulatory Reporting Requirements, including Value Based Purchasing
    - Adherence to National Patient Safety Goals
    - Maintenance of Disease Specific Care Certification Designations ~~Pain Management and Opioid reduction~~
    - Pain Management and Opioid Reduction Strategies
    - Safety and Reliability Improvement Initiatives
    - Magnet Recognition/Nurse Sensitive Indicators
    - Health Equity

III. DEFINITIONS

A. CMS	Centers for Medicare and Medicaid Services
B. MEC	Medical Executive Committee
C. PIT	Process Improvement ~~team~~Team
D. QAPI	Quality Assessment and Performance Improvement
E. QSC	Quality and Safety Committee

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. **Measuring Performance**

a. Data Collection

The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities for data collection as well as the frequency for collection. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement, or sustain improvement. The Program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. Data are collected and analyzed for the following ~~but~~ (not a comprehensive list):

- Performance improvement priorities identified by leaders
- Operative or other procedures that place patients at risk of disability or death
- All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses
- Adverse patient events
- Adverse events related to using moderate or deep sedation or anesthesia
- Blood management
- The results of resuscitation / Effectiveness of its response to change or deterioration in a patient's condition
- Medication errors
- Adverse drug reactions
- Patient perception of the safety and the quality of care, treatment or services
- Processes that improve patient outcomes such as fall reduction activities including assessment, interventions and education
- National Patient Safety Goals
- Processes as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program

- Organ Procurement Organization processes
- Staff opinions and needs, staff perceptions of risk to individuals, staff suggestions for improving patient safety, and willingness to report adverse events
- Core measure data and other required Centers for Medicare and Medicaid Services (CMS) measures
- Patient flow processes
- Contracted services
- Emergency Management
- Other areas as outlined in the Quality Oversight structure

Measurement of the above areas may be organization-wide in scope, targeted to specific areas, departments and services, or focused on selected populations. A reporting calendar has been defined for department and operational reporting. This is a dynamic document and may change throughout the year based on priorities and/or ~~compliance to metrics~~metric outcome trends.

Relevant information developed from the following activities is integrated into performance improvement initiatives as required:

- Patient safety
- Clinical outcomes
- Key financial/utilization indicators including length of stay
- Risk management
- Quality control
- Infection control surveillance and reporting
- Research when applicable
- Autopsies
- Other relevant data as required or identified

2. **Assessing Performance**

    a. **Data Compilation and Analysis**
    Data aggregation and analysis transforms data into information. Data are systematically aggregated and analyzed in order to monitor the effectiveness and safety of services and quality of care, and assess performance levels, patterns, or trends.

        i. Data aggregation is performed at the frequency appropriate to the activity or process.

        ii. Statistical tools and techniques are used to display and analyze data whenever possible.

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

iv. When available, comparative data are used to determine if there is excessive variability or unacceptable levels of performance.

v. Results of data analysis are used to identify improvement opportunities.

3. **Improving Performance**
    a. Information from data analysis is used to make changes that improve performance and safety. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.
        - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
        - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
        - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
        - Changes that will reduce the risk of sentinel events are identified and implemented.

4. **Identifying and Managing Adverse or Unexpected Occurrences**
    a. Processes for identifying and managing sentinel events are defined in the organization wide ADVERSE EVENTS - REPORTABLE.

5. **Proactive Risk Reduction Program**
    a. Salinas Valley Memorial Hospital has dedicated a consistent effort to reduce potential harm to patients and prevent unanticipated adverse events by remaining proactive in approaches to performance improvement. Periodically, a systematic proactive evaluation method is completed on a process to evaluate and identify how it might fail and determine the relative impact a failure might have. This process assists to identify the key parts in a process that require change.

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

7. **Analysis of Staffing**
    a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment, credentialing, supervision of staff, orientation, training and education may also be analyzed.

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

B. **Plan Management**

1. **Performance/Process Improvement Model**

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

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

  P – Plan how the changes will be implemented.
  D – Do/implement the plan.
  C – Check the results of the improvement plan by collecting post-implementation data.
  A – Act on the findings of post-implementation data by standardizing the process or testing another change.
- Systems Redesign
  Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.
- Rapid Cycle Improvement / Kaizen
  When appropriate, the *rapid cycle improvement* process may be utilized. The advantages of the rapid cycle improvement process include:
  - Using a small sample to test a proposed change idea quickly.
  - Testing ideas side by side with existing processes.
  - Testing many ideas quickly.
  - Providing opportunities for failures without impacting performance.
  - Minimizing resistance to successful change.

2. **Performance/Process Improvement Teams**

a. A performance/process improvement team is defined as a group of knowledgeable people, who are close to the process, that cooperate to achieve a common goal. Teams are composed of individuals with expertise in the process(es) that require(s) improvement.

3. **Performance/Process Improvement Team Request**

a. A request for approval for a formal performance/process improvement team

(PIT) may be presented to the Quality Interdisciplinary or Safety and Reliability Committee for consideration of a performance improvement team. PITs will be considered when interdisciplinary and/or interdepartmental processes require improvement that cannot be accomplished by an individual or by the individual department(s) or discipline(s). In order to prioritize and coordinate organizational improvement processes and resources, interdisciplinary / interdepartmental teams may be approved by the Quality and Safety Committee. NOTE: Individual departments may charter teams for the purpose of improving processes specific to their departments.

C. **Plan Responsibility**

1. Performance / Process Improvement Structure

    a. The Quality Oversite Structure outlines the quality and performance improvement structure and processes. A calendar for reporting is defined annually and changes made ongoing as the needs of the organization changes. The Quality Management Department, in collaboration with facility leaders, staff and medical staff, facilitates the implementation of the QAPI Program.

    b. **Governing Board**

        i. Responsibility for performance improvement rests with every employee of Salinas Valley Memorial Hospital. Overall responsibility rests with the Board of Directors. The Board of Directors requires review and evaluation of patient care activities to measure and improve the quality and efficiency of patient care and services in the organization. While maintaining overall responsibility, the Board delegates operational authority to the Medical Staff and Hospital Leadership. The MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI Program.

        ii. In exercising its supervising responsibility, the Board:

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

management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

c. **Medical Executive Committee**

i. The Medical Executive Committee (MEC) is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients.

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

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

d. **Organizational Leaders**

i. Set expectations for performance/process improvement.

ii. Develop plans for performance/process improvement.

iii. Manage processes to improve hospital performance.

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

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

vi. Participate in performance/process improvement activities when appropriate.

vii. Ensure participation from appropriate individuals in organization wide performance/process improvement activities.

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

- Needs and/or expectations of patients, staff and others.
- Results of performance improvement activities, when available.
- Information about potential risk to patients, when available.
- Current knowledge, when available and relevant.
- Information about sentinel events, when available and relevant.
- Testing and analysis to determine whether the proposed design or redesign is an improvement.
- Collaboration with staff and appropriate stakeholders to design services.

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

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

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

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

i. The Department leaders are accountable to the Organizational Leaders, QSC and the Board of Directors for the quality of care/ services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services they provide. The Department Directors:

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

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

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

v. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to determine what measures will be evaluated at least every 2 year. These measures are updated / revised ongoing as compliance is sustained.
2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities on the basis of assessment; and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.
3. **Confidentiality**

a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.

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

Leaders, and/or the Governing Body.

c. HIPAA regulations will be followed.

E. **Orientation and Education**

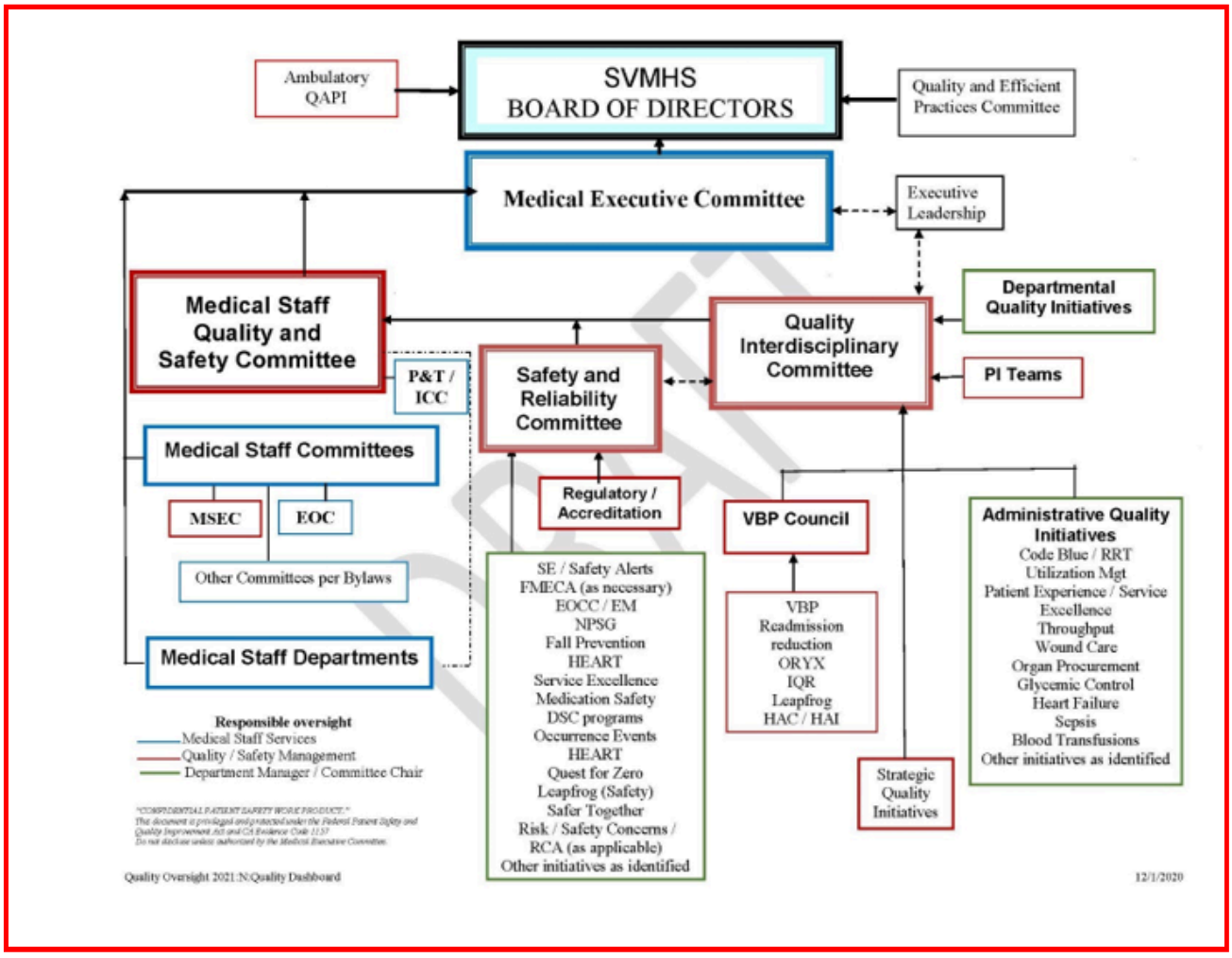
1. Orientation, education and/or training is provided on an as needed basis.

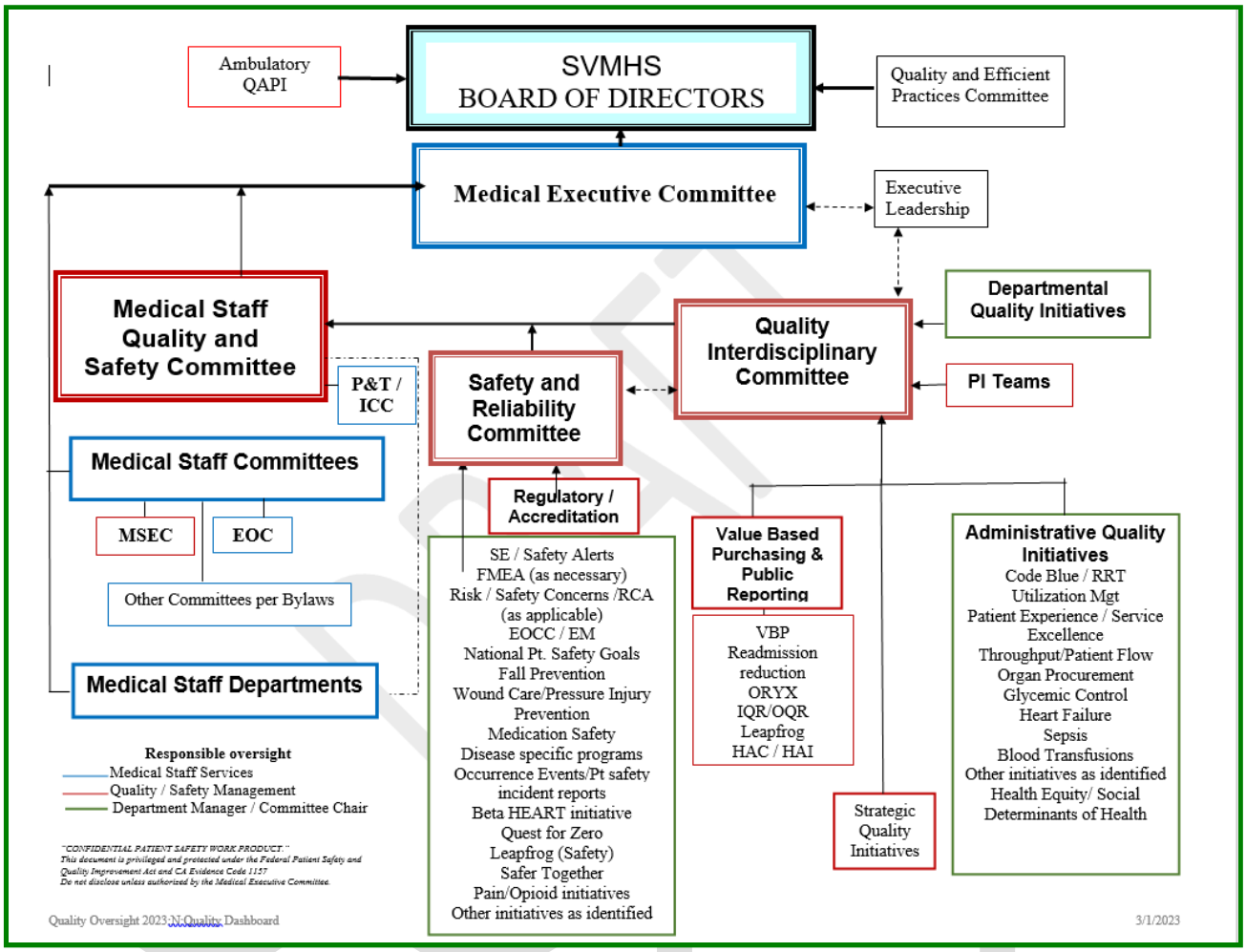
V. REFERENCES

A. The Joint Commission

B. Title 22 (CDPH)

C. CMS





Attachments

Image 1

Approval Signatures

Step Description	Approver	Date
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Owner	Aniko Kukla: Director Quality & Patient Safety	05/2023

Standards

No standards are associated with this document

History

Edited by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/25/2023, 6:19PM EDT

> Applied approval flow

Comment by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:48PM EDT

> The quality plan has been updated with the hospital new name and health equity was added as a focus

Comment by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:48PM EDT

> the quality structure has been updated too to reflect the current quality and safety structures

Draft saved by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:51PM EDT

Edited by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:52PM EDT

> Updated quality structure, changed hospital name and added health equity as a strategy

Last Approved by Kukla, Aniko: Director Quality & Patient Safety on 5/2/2023, 9:52PM EDT

Health Equity and Social Determinants of Health

MAy 2023

Salinas Valley HEALTH

What is Health Equity?

"Health equity is the attainment of the highest level of health for all people."

Healthy People 2030

There is a national agenda to advance health equity. **Why?** Health inequities can contribute to health disparities and impact quality outcomes of those affected. As the nation's largest health insurer, CMS is setting the stage for a strong infrastructure through the development of the CMS Framework for Health Equity in an effort to advance health equity and reduce health disparities.

TJC and CDPH also created action plans to address health equity policy and measurement needs.

Health-related social needs (HRSN) - TJC

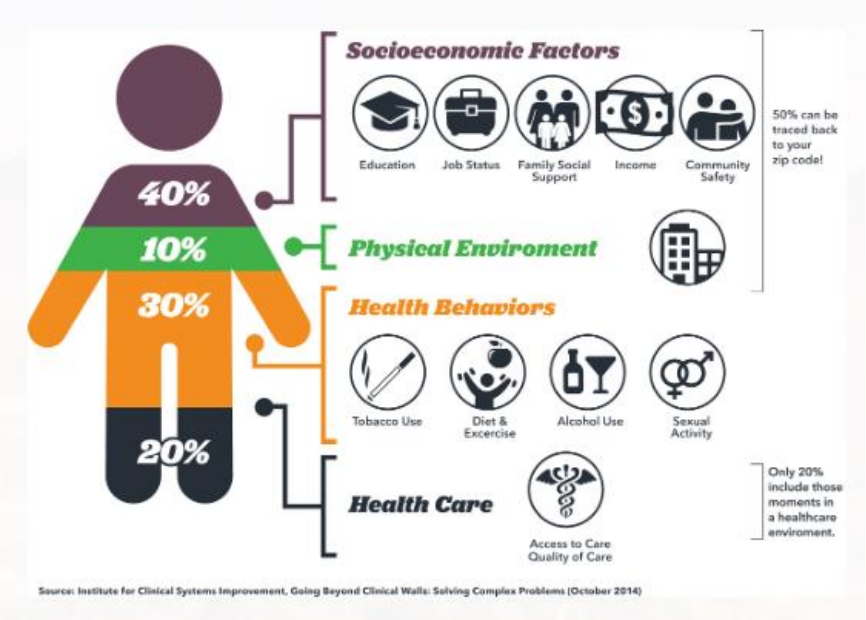
- Social drivers conveys that there are variables that can be controlled and changed if we're willing to work on them and that, ultimately, there is room for improvement. Together, we can *drive* healthcare and the vision of health equity forward.

www.cms.gov/files/document/cms-framework-health-equity.pdf

Social Determinants of Health: Examples

The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Income and social protection
- Early childhood development
- Access to affordable health services of decent quality.



World Health Organization. 2023. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

CMS Framework for Health Equity 2022–2032

In this framework, ***Priority (1)*** involves the collection, reporting and analysis of data.

Understanding demographic data and social determinants of health (SDOH) of the population we serve, allows CMS to drive change through new programs and policies aimed at addressing barriers to health equity.

www.cms.gov/files/document/cms-framework-health-equity.pdf

TJC, CMS and CDPH Health Equity Requirements

Effective **July 1, 2023,** Standard LD.04.03.08, which addresses health care disparities as a quality and safety priority, will become a **National Patient Safety Goal16: Improve health care equity**

- Identify an individual to lead activities to improve health care equity
- Assess the patient's health-related social needs
- Analyze quality and safety data to identify disparities
- Develop an action plan to improve health care equity
- Take action when the organization does not meet the goals in its action plan
- Inform key stakeholders about progress to improve health care equity

CMS Requirement	What It Is	2023	2024
HCHE: Hospital Commitment to Health Equity Measure	NEW Structural Measure	Mandatory	Mandatory
SDOH-01: Screening for Social Drivers of Health Measure	NEW Structural Measure	Voluntary	Mandatory
SDOH-02: Screen Positive Rate for Social Drivers of Health Measure	NEW Structural Measure	Voluntary	Mandatory

Health Equity Action Plan focus for 2023

1. Screening for Health Related Social Needs:

- Food insecurity
- Housing instability
- Transportation needs
- Utility difficulties
- Interpersonal safety

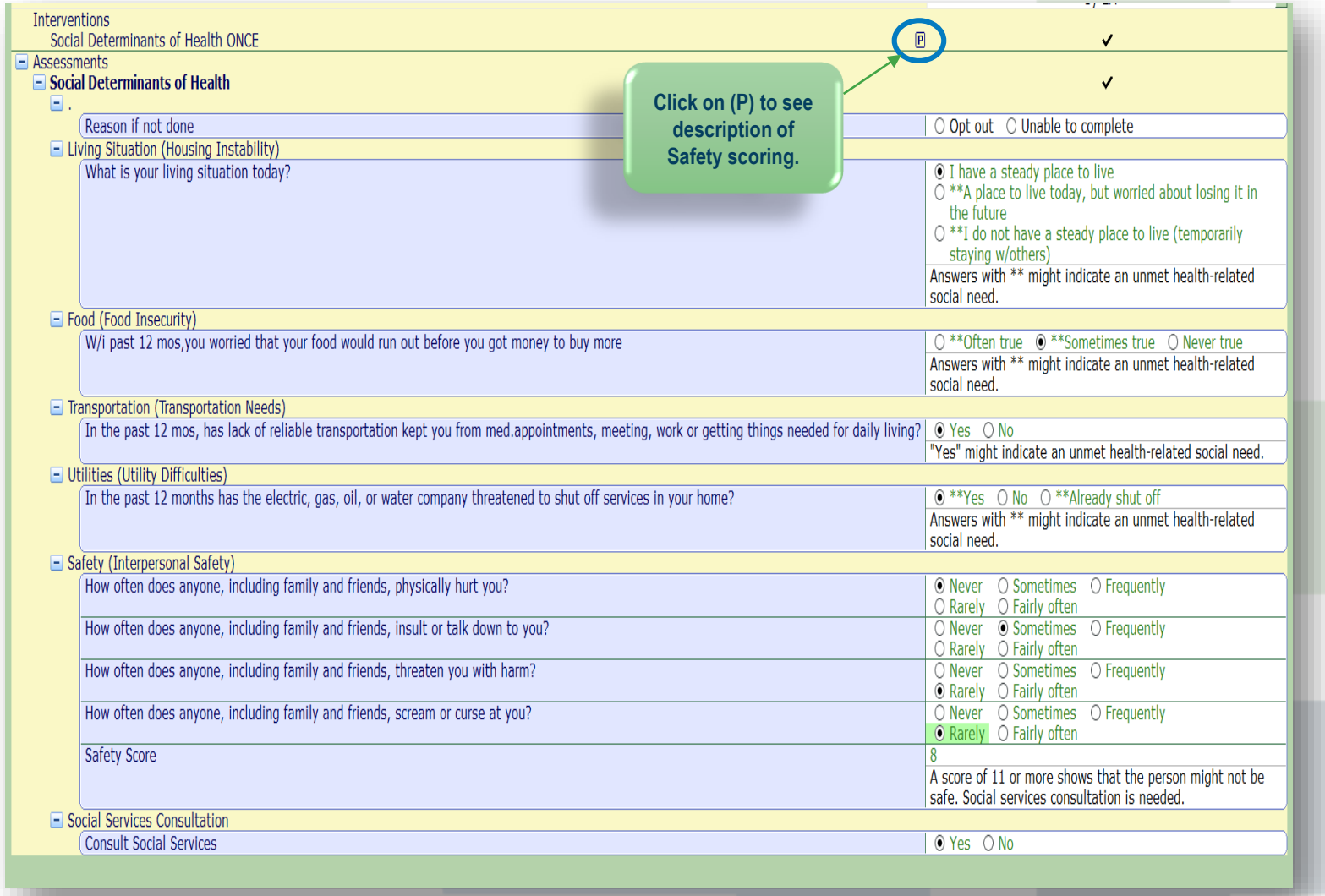
2. Health Equity Strategy

Develop, prioritize, and begin executing a health equity strategy.

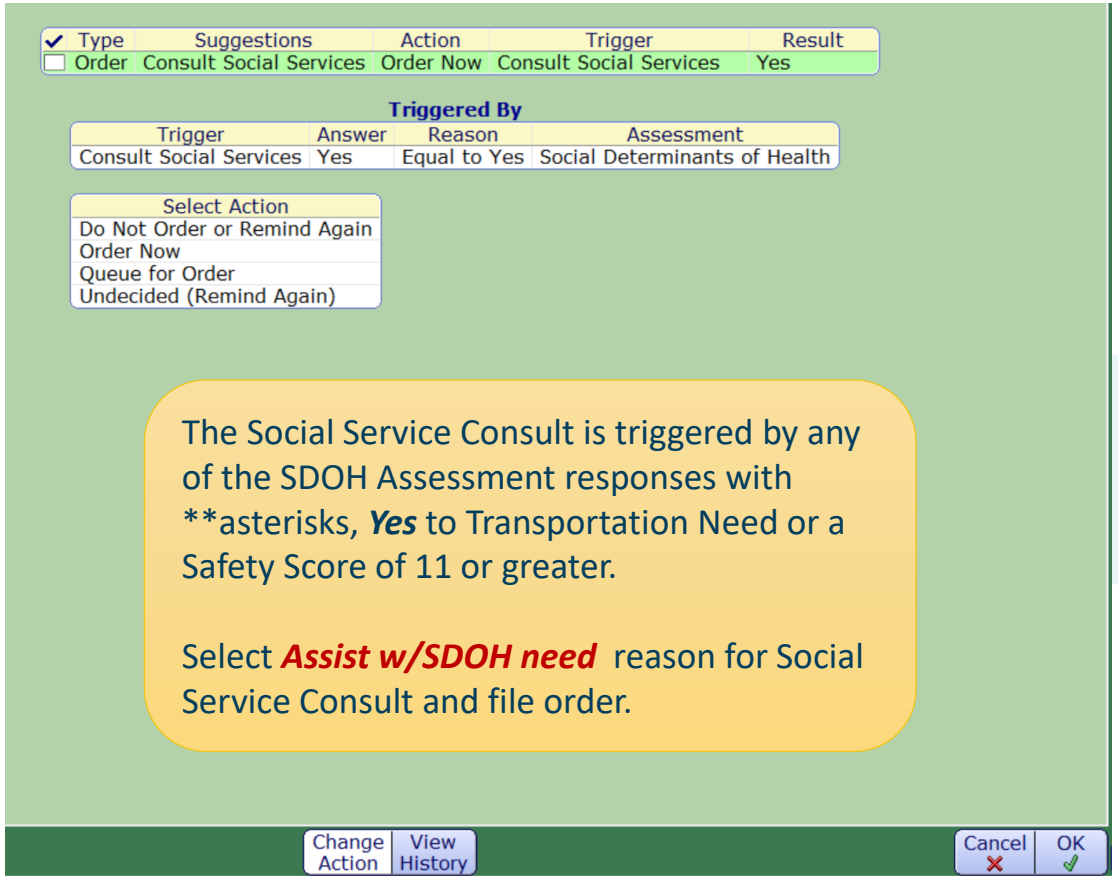
SDOH Documentation on Admission- Plans

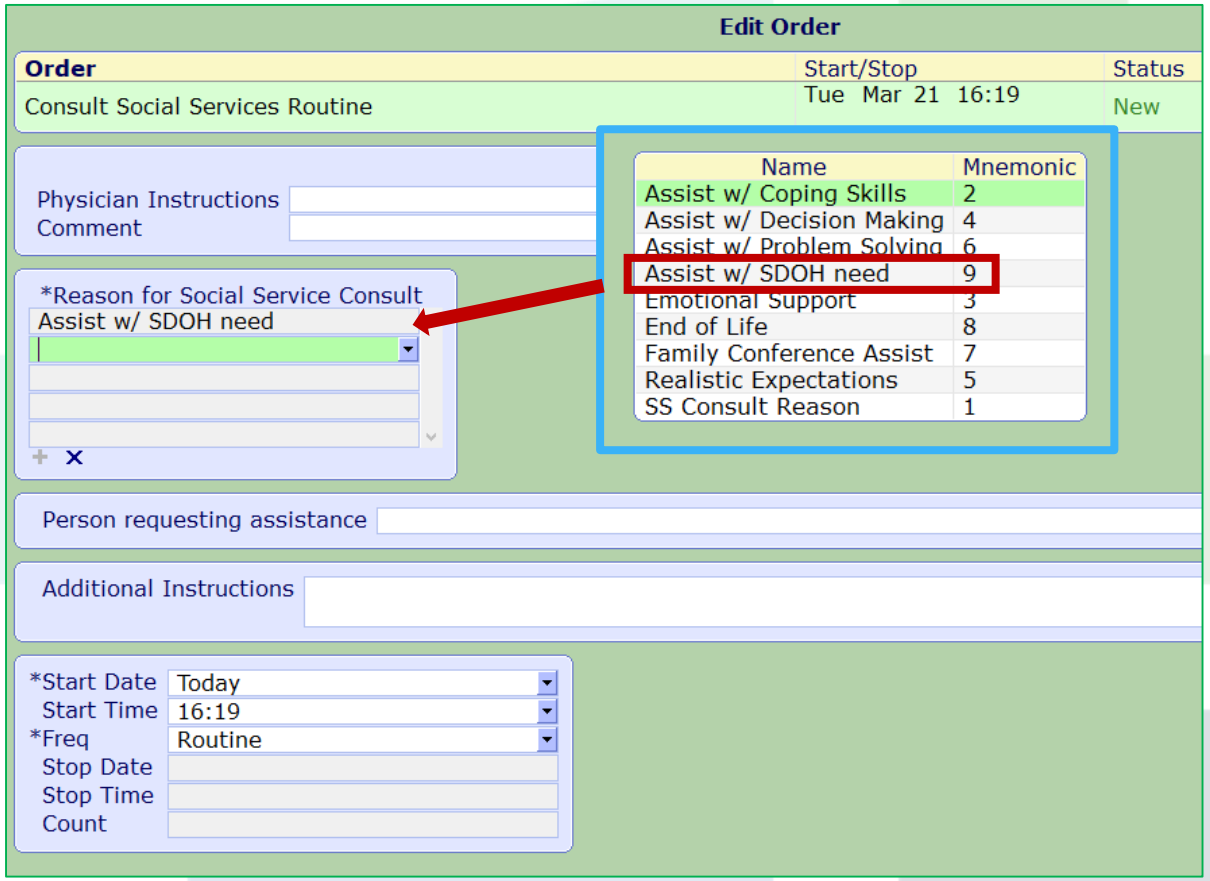
1. Documentation Specifics

- Documentation required for Inpatient >18 years of age
- Included in Admission Interventions
- 5 Sections
  - Housing Instability
  - Food Insecurity
  - Transportation Needs
  - Utility Difficulties
  - Interpersonal Safety
- Responses with double asterisks **, ***Yes*** to Transportation Needs or a Safety Score of 11 will trigger a Social Service Consult.



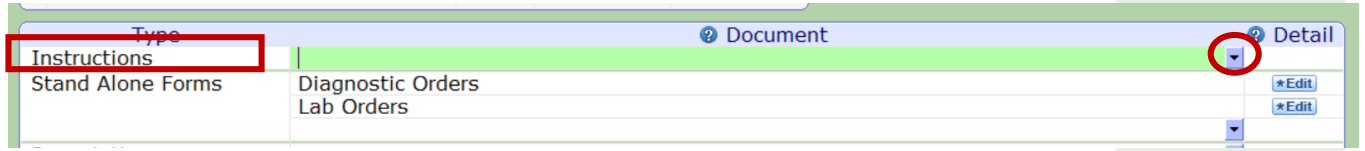
Trigger a Social Service Consult

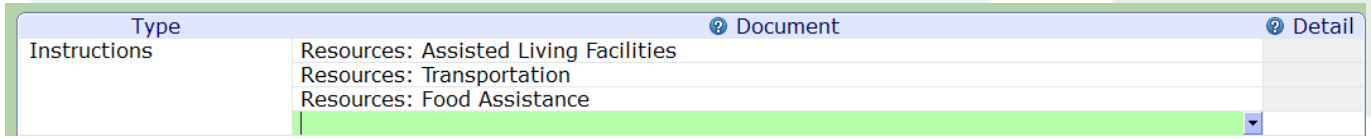


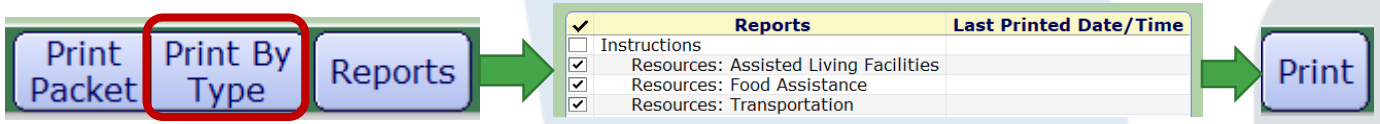


Patient Resources Lists created

- There are resource handouts you can access to provide the patient when other disciplines have not had the opportunity to consult prior to discharge.
- Patient resources can be found under the **Instruction** section of the Discharge button
- Enter ***Resources*** in the search field
- Any number of appropriate resources can be selected
- Will print with the discharge documents
- If document needs to be provided earlier, can print using the following steps:

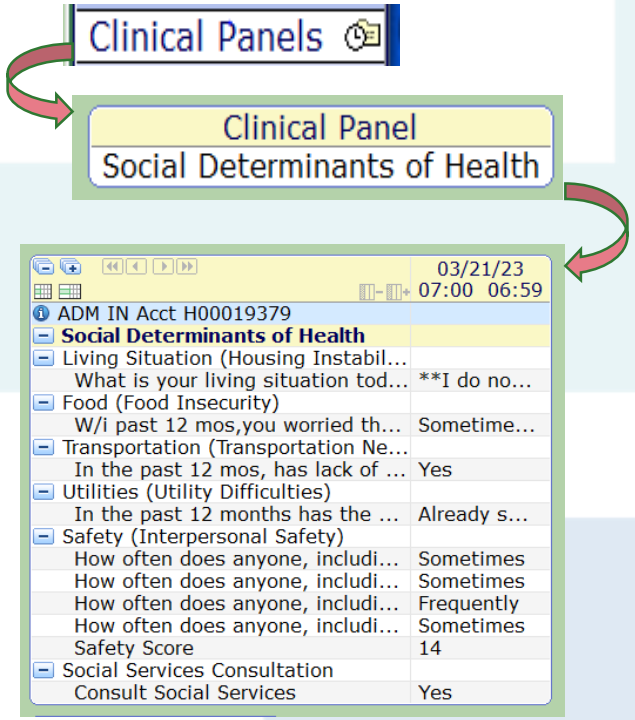




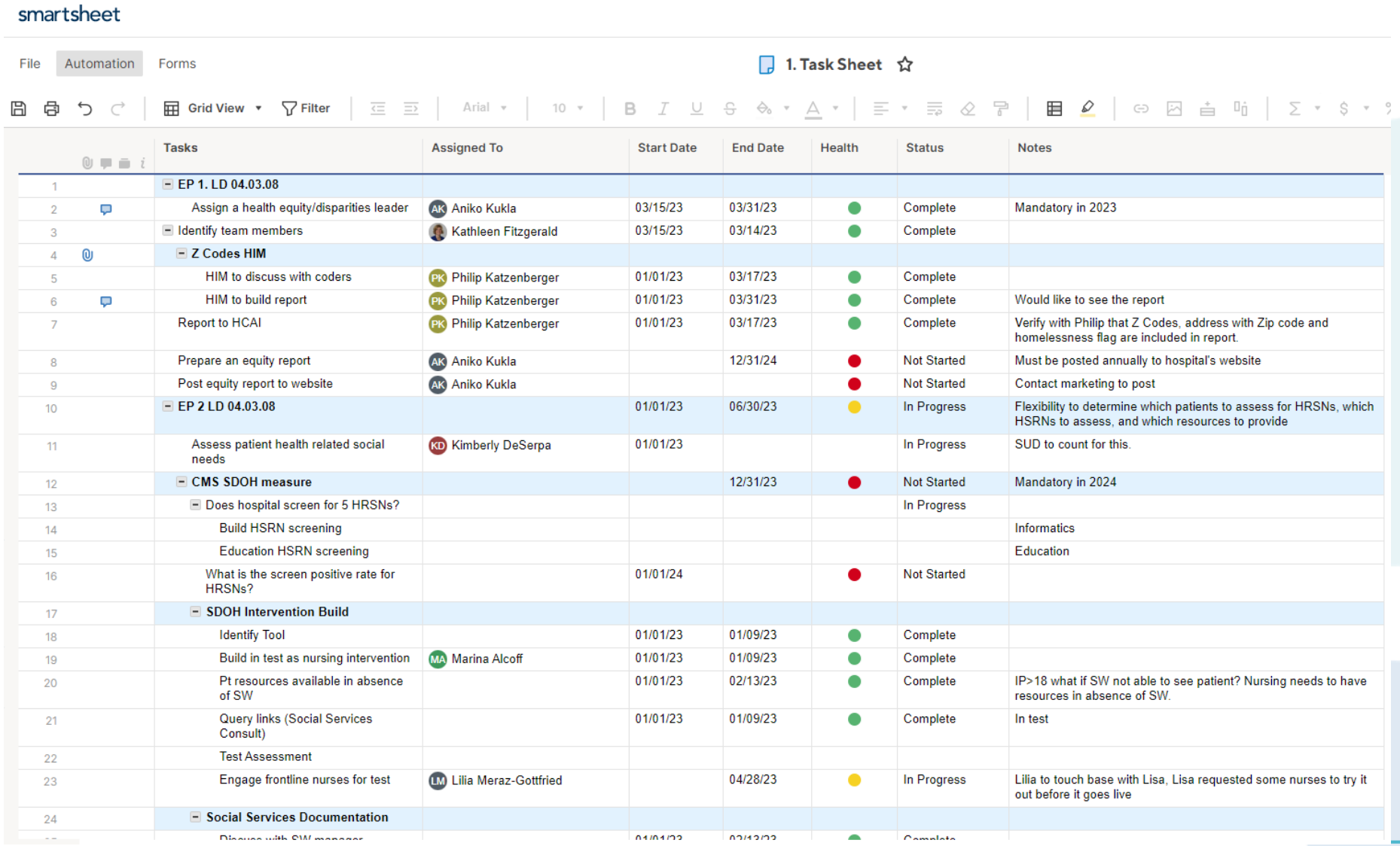


Interdisciplinary Collaboration – We All Have a Role in Health Equity

- Collaboration is critical in effort to identify and communicate patient needs across continuum.
- Nursing SDOH intake to be shared across disciplines
- Documentation from various disciplines related SDOH to be viewed through **Social Determinants of Health Clinical Panel.**
- Plans for: SDOH Assessment responses will display in the Hospitalist Note template under SDOH tab
- Coders will add appropriate Z-Codes in medical record to account for presence of SDOH



Health Equity Action Plan



	Tasks	Assigned To	Start Date	End Date	Health	Status	Notes
1	**EP 1. LD 04.03.08**						
2	Assign a health equity/disparities leader	Aniko Kukla	03/15/23	03/31/23		Complete	Mandatory in 2023
3	Identify team members	Kathleen Fitzgerald	03/15/23	03/14/23		Complete	
4	**Z Codes HIM**						
5	HIM to discuss with coders	Philip Katzenberger	01/01/23	03/17/23		Complete	
6	HIM to build report	Philip Katzenberger	01/01/23	03/31/23		Complete	Would like to see the report
7	Report to HCAI	Philip Katzenberger	01/01/23	03/17/23		Complete	Verify with Philip that Z Codes, address with Zip code and homelessness flag are included in report.
8	Prepare an equity report	Aniko Kukla		12/31/24		Not Started	Must be posted annually to hospital's website
9	Post equity report to website	Aniko Kukla				Not Started	Contact marketing to post
10	**EP 2 LD 04.03.08**		01/01/23	06/30/23		In Progress	Flexibility to determine which patients to assess for HRSNs, which HSRNs to assess, and which resources to provide
11	Assess patient health related social needs	Kimberly DeSerpa	01/01/23			In Progress	SUD to count for this.
12	**CMS SDOH measure**			12/31/23		Not Started	Mandatory in 2024
13	Does hospital screen for 5 HRSNs?					In Progress	
14	Build HSRN screening						Informatics
15	Education HSRN screening						Education
16	What is the screen positive rate for HRSNs?		01/01/24			Not Started	
17	**SDOH Intervention Build**						
18	Identify Tool		01/01/23	01/09/23		Complete	
19	Build in test as nursing intervention	Marina Alcoff	01/01/23	01/09/23		Complete	
20	Pt resources available in absence of SW		01/01/23	02/13/23		Complete	IP>18 what if SW not able to see patient? Nursing needs to have resources in absence of SW.
21	Query links (Social Services Consult)		01/01/23	01/09/23		Complete	In test
22	Test Assessment						
23	Engage frontline nurses for test	Lilia Meraz-Gottfried		04/28/23		In Progress	Lilia to touch base with Lisa, Lisa requested some nurses to try it out before it goes live
24	**Social Services Documentation**						

PUBLIC INPUT

CLOSED SESSION

(Report on Item to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

Quality and Efficient Practices Committee Meeting
Quality and Safety Committee report
Open session
CMS Hospital Star and Leapfrog Grade

May 22nd , 2023

Salinas Valley HEALTH

CMS Hospital Star Ratings- July 2023 release

Hospital Compare Preview Report

Exported 05/01/2023
July 2023 | Page 1

SALINAS VALLEY MEMORIAL HOSPITAL
450 EAST ROMIE LANE
SALINAS, CA, 93901

CCN-050334
(831) 757-4333

Facility Type:	Short-term
Ownership Type:	Voluntary non-profit - Other
Emergency Service:	Yes

Star Rating Preview

4 Stars

Summary Score: 0.24

	Standardized Group Score	Weight	Scored Measures	# Measures Better	# Measures Same	# Measures Worse
Safety of Care	0.73	22%	7	1	6	0
Mortality	-0.2	22%	7	0	7	0
Readmission	-0.38	22%	11	1	10	0
Patient Experience	0.68	22%	8	N/A	N/A	N/A
Timely and Effective Care	0.5	12%	10	N/A	N/A	N/A

Report highlights: CMS Patient Safety Indicators

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate (95% int. limits)	National Ratio	National Compare
PSI-3 Q3 (2019) - Q2 (2021) Pressure Ulcer Rate	3,983	0.67 (0, 1.53)	0.62	SAME
PSI-4 Q3 (2019) - Q2 (2021) Death among surgical inpatients with serious treatable complications Rate	59	143.37 (101.15, 185.59)	143.04	SAME
PSI-6 Q3 (2019) - Q2 (2021) Iatrogenic pneumothorax, adult Rate	4,819	0.15 (0, 0.29)	0.19	SAME
PSI-8 Q3 (2019) - Q2 (2021) In-Hospital Fall With Hip Fracture Rate	5,170	0.05 (0, 0.18)	0.07	SAME
PSI-9 Q3 (2019) - Q2 (2021)	999	2.06 (0.74, 3.39)	2.39	SAME

CMS Patient Safety Indicators

	Eligible Discharges	Facility Rate (95% int. limits)	National Ratio	National Compare
PSI-10 Q3 (2019) - Q2 (2021) Postoperative Acute Kidney Injury Requiring Dialysis Rate	330	0.63 (0, 1.63)	0.92	SAME
PSI-11 Q3 (2019) - Q2 (2021) Postoperative Respiratory Failure Rate	327	4.35 (0, 9.88)	6.47	SAME
PSI-12 Q3 (2019) - Q2 (2021) Perioperative Pulmonary Embolism (PE) or Deep Vein Thrombosis (DVT) Rate	1,079	2.50 (0.42, 4.59)	3.41	SAME
PSI-13 Q3 (2019) - Q2 (2021) Postoperative Sepsis Rate	338	4.38 (1.53, 7.24)	4.09	SAME
PSI-14 Q3 (2019) - Q2 (2021) Postoperative Wound Dehiscence Rate	417	0.70 (0, 1.62)	0.82	SAME
PSI-15 Q3 (2019) - Q2 (2021) Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate	1,080	0.78 (0, 1.94)	1.04	SAME

PSI-90 Q3 (2019) - Q2 (2021) Patient Safety and Adverse Events Composite	Not Applicable	0.83 (0.52, 1.15)	1.00	SAME

CMS 30 Day Mortality Rates

Complications & Deaths

30 Day Death Rates

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate	National Compare
MORT-30-AMI Q3 (2019) - Q2 (2022) Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	154	13.1% (10.2%, 16.8%)	12.6%	SAME
MORT-30-HF Q3 (2019) - Q2 (2022) Heart Failure (HF) 30-Day Mortality Rate	462	9.5% (7.5%, 11.9%)	11.8%	SAME
MORT-30-PN Q3 (2019) - Q2 (2022) Pneumonia 30-Day Mortality Rate	292	15.8% (12.8%, 19.1%)	18.2%	SAME
MORT-30-STK Q3 (2019) - Q2 (2022) Acute Ischemic Stroke (STK) 30-Day Mortality Rate	242	15.2% (11.5%, 19.7%)	13.9%	SAME
MORT-30-COPD Q3 (2019) - Q2 (2022) Chronic Obstructive Pulmonary Disease (COPD) 30-Day Mortality Rate	108	8.3% (5.6%, 12.2%)	9.2%	SAME
MORT-30-CABG Q3 (2019) - Q2 (2022) 30-Day All-Cause Mortality Following Coronary Artery	88	2.7% (1.4%, 5.4%)	2.9%	SAME

CMS Readmissions Rates

Unplanned Hospital Visits

Condition Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate	National Compare
READM-30-AMI Q3 (2019) - Q2 (2022) Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	160	13.5% (10.9%, 16.6%)	14%	SAME
READM-30-HF Q3 (2019) - Q2 (2022) Heart Failure (HF) 30-day Readmission Rate	522	18.4% (15.9%, 21.1%)	20.2%	SAME
READM-30-PN Q3 (2019) - Q2 (2022) Pneumonia (PN) 30-day Readmission Rate	292	16.9% (14.2%, 19.8%)	16.9%	SAME
READM-30-COPD Q3 (2019) - Q2 (2022) Chronic Obstructive Pulmonary Disease (COPD) 30-day Readmission Rate	127	18.7% (15.2%, 22.8%)	19.3%	SAME

This data being displayed on this page is being updated. You may see changes to the t

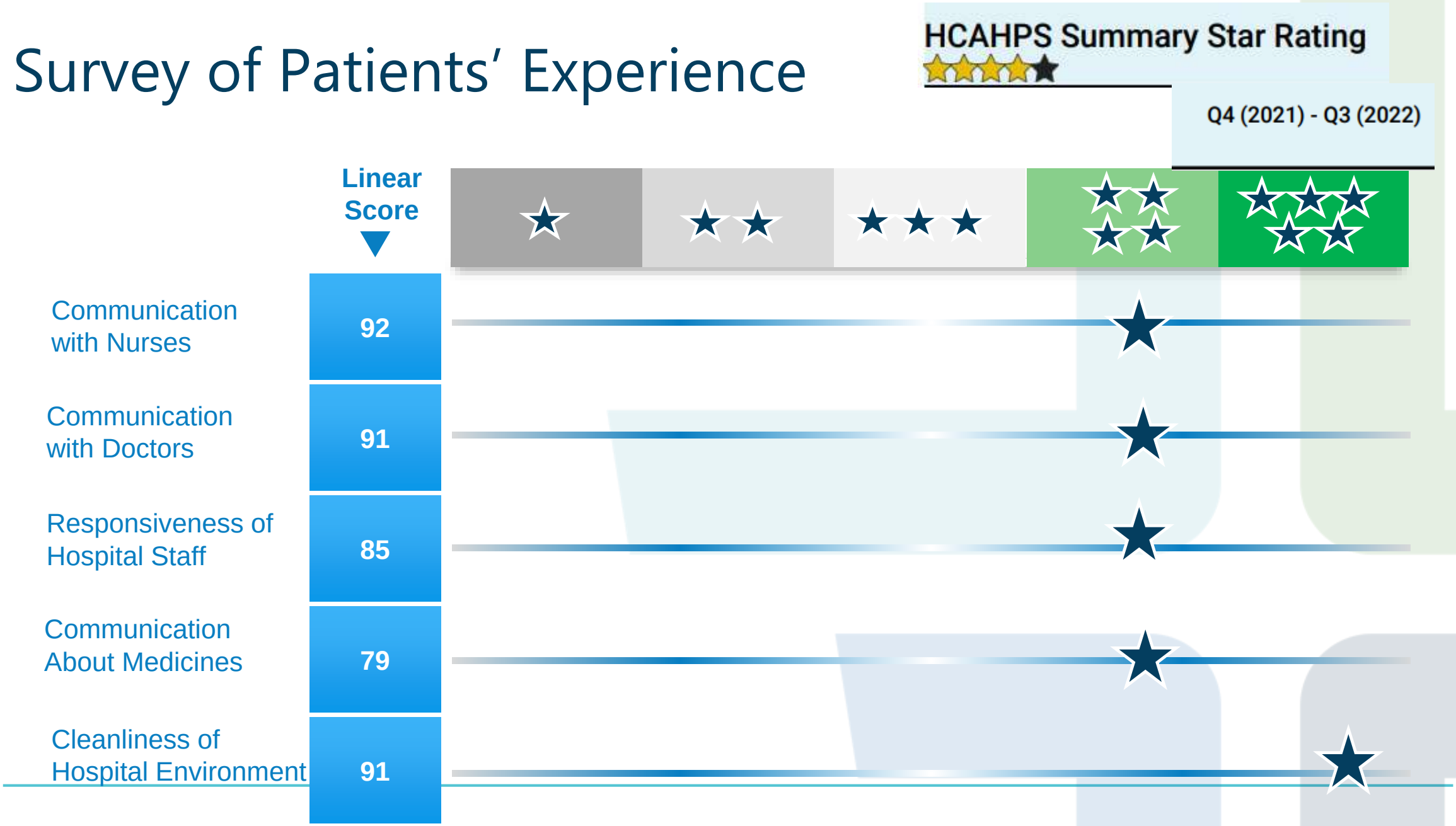
Procedure Specific Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate	National Compare
READM-30-CABG Q3 (2019) - Q2 (2022) Hospital-Level 30-day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	86	10.8% (7.9%, 14.3%)	11%	SAME
READM-30-HIP-KNEE Q3 (2019) - Q2 (2022) 30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	N/A(1)	N/A(1) (N/A(1), N/A(1))	4.3%	TOO FEW(1)

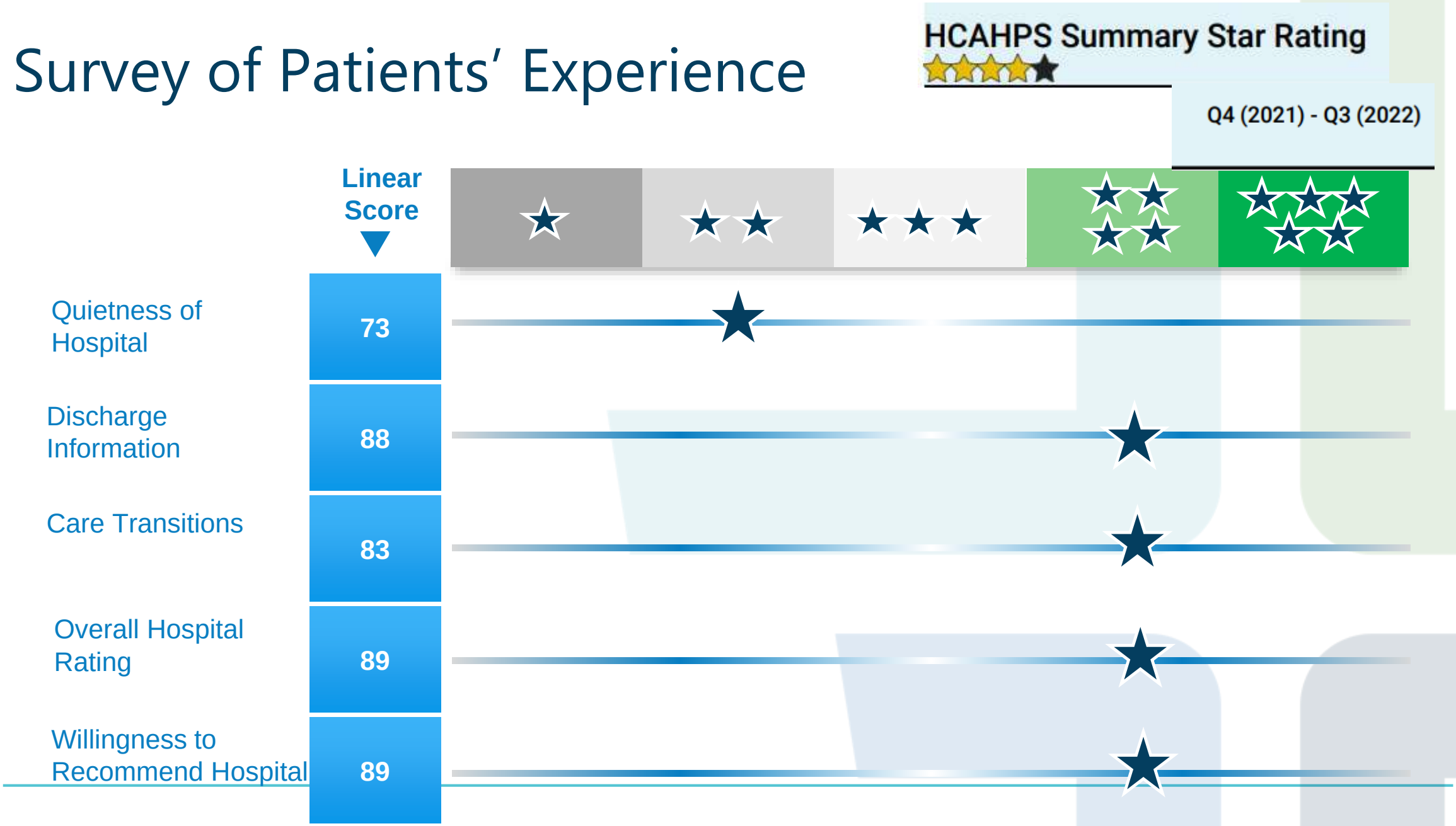
Hospital Wide Readmission

	Eligible Discharges	Facility Rate (95% int. limits)	National Rate	National Compare
READM-30-HOSPWIDE Q3 (2021) - Q2 (2022)	2,775	14% (13.1%, 14.9%)	14.6%	SAME

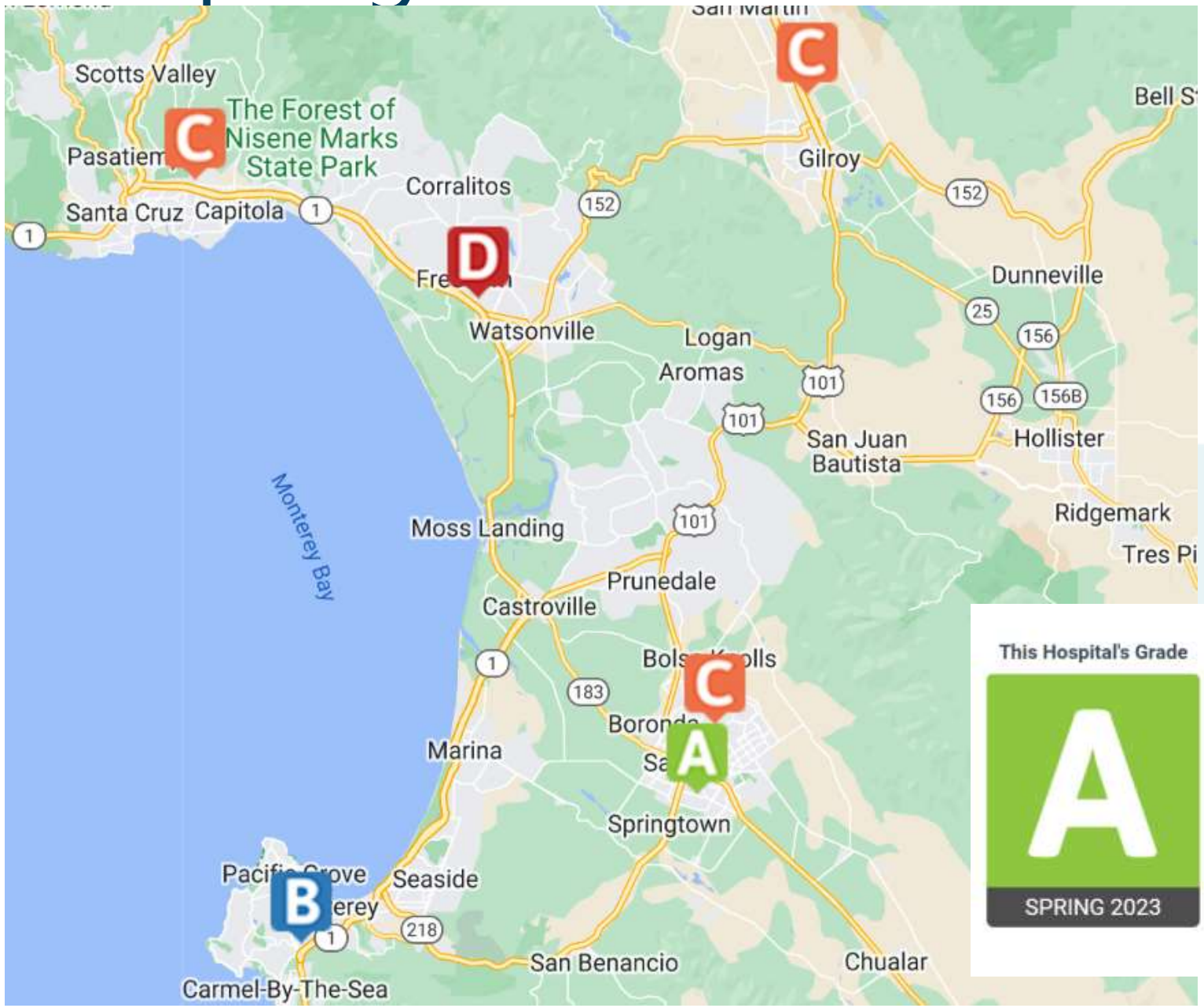
Survey of Patients' Experience



Survey of Patients' Experience



Leapfrog Scores Released on May 3rd, 2023



This map shows the Leapfrog Patient Safety Scores for Hospitals within 50 mile radius. Congratulations for maintaining the high level of patients safety.

This Hospital's Grade

A

SPRING 2023

Salinas Valley Health Medical Center

450 E. Romie Lane
Salinas, CA 93901-4098
Map and Directions

View this hospital's Leapfrog Hospital Survey Results

ADJOURNMENT