September 19, 2024

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 **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, SEPTEMBER 26, 2024, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, 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/board-committee-meetings-virtual-link/ *for Public Access Information*).



Allen Radner, MD
President/Chief Executive Officer

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

REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY HEALTH[1]

THURSDAY, SEPTEMBER 26, 2024, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C

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

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

	AGENDA	*Presented By*
1.	**CALL TO ORDER / ROLL CALL**	*Victor Rey, Jr.*
2.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Victor Rey, Jr.*
3.	**RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *(Estimated time 4:30 pm)*	*Victor Rey, Jr.*
4.	**AWARDS & RECOGNITION**	*Allen Radner, M.D.*
5.	**INTERPRETING SERVICES**	*Carla Spencer*
6.	**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.	*Victor Rey, Jr.*
7.	**BOARD MEMBER COMMENTS AND REFERRALS**	*Board Members*
8.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)* A. Minutes of the Regular Meeting of the Board of Directors August 22, 2024 B. Minutes of the Special Meeting of the Board of Directors September 5, 2024 C. Financial Report D. Statistical Report E. Policies Requiring Approval 1. CVIS Downtime Process 2. Dress Code: Protective Attire 3. Financial Assistance Program/Full & Discount Partial Charity Care - Taylor Farms Family Health & Wellness Center 4. Interpreter/Translator Communication 5. Management of Hypersensitivity & Anaphylaxis when Administering Chemotherapy and Immunotherapy 6. Obstetrical Hemorrhage 7. Pediatrics: Admission Criteria 8. Rho (D) Immune Globulin Administration 9. Scheduling: Cardiac Cath Lab	*Victor Rey, Jr.*

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

10. Tuition Assistance

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

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE *Catherine Carson*

Minutes of the September 16, 2024 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE *Juan Cabrera*

Minutes of the September 16, 2024 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider Recommendation for Board Approval approval of:
   (i) The Findings Supporting Recruitment of Divya Kishore, M.D.:
      - That the recruitment of a mammography and diagnostic imaging radiologist to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
      - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

   (ii) The Contract Terms of the Recruitment Agreement for Dr. Kishore; and

   (iii) The Contract Terms of the Mammography and Diagnostic Imaging Professional Services Agreement for Dr. Kishore.

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

2. Consider Recommendation for Board Approval approval of the Contract Terms of the Pediatrics Professional Services Agreement for Maryam Jalali, M.D.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

3. Consider Recommendation for Board Approval approval of:
   (i) The Findings Supporting Recruitment of Benjamin Berthet, D.O.:
      - That the recruitment of Internal Medicine and Pediatrics to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
      - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
   (ii) The Contract Terms of the Recruitment Agreement for Dr. Berthet; and
   (iii) The Contract Terms of the Internal Medicine and Pediatrics Professional Services Agreement for Dr. Berthet.

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

C. **FINANCE COMMITTEE** *Joel Hernandez Laguna*

Minutes of the September 23, 2024 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider Recommendation for Board approval to award FTG Builders the contract for construction of the Monterey Bay G.I. Consultants Medical Group office space expansion at 212 San Jose Street 2nd Floor.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
2. Consider Recommendation for Board approval of the Terms for a Lease Agreement with Monterey Bay G.I. Consultants Medical Group for 212 San Jose Street, 2nd Floor
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
3. Consider Recommendation for Board Approval of Terms for a Lease and Services Agreement Between SVH and Johnny Blanchard, M.D., Inc.
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

4. Consider Recommendation for Board approval of the terms presented for a Virtual Health Services Agreement with KeyCare Inc.

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

D. **CORPORATE COMPLIANCE AND AUDIT COMMITTEE** *Juan Cabrera*

Minutes of the September 18, 2024 Community Advocacy Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

10. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF THE FY 2025 ORGANIZATIONAL GOALS *Augustine Lopez*

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

11. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF SEPTEMBER 12, 2024, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: *Rakesh Singh, M.D.*

A. Reports

1. Credentials Committee Report (Including the following)
   - Ophthalmology -Clinical Privileges Delineation
   - General Surgery-Clinical Privileges Delineation
2. Interdisciplinary Practice Committee Report (Including the following)
   - Pneumococcal and Influenza Vaccine Screening and Administration Nursing Standardized Procedure
   - Chest Pain/Cardiovascular Nursing Standardized Procedure

B. Policies/Procedures/Plans:

1. Blood Borne Pathogen Exposure Control Plan
2. Infection Prevention Pandemic Plan Emerging Infectious Diseases
3. Laboratory Quality Management Plan
4. MRSA Active Surveillance Screening
5. Quality Assessment and Improvement Plan
6. Retained Surgical Items

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

12. EXTENDED CLOSED SESSION *(if necessary)* *Victor Rey, Jr.*

13. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION *Victor Rey, Jr.*

14. ADJOURNMENT *Victor Rey, Jr.*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, October 24, 2024, at 4:00 p.m.**

The Board packet is available at the Board Meeting and at https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2024/, and in the Human Resources Department of the District located at 611 Abbott Street, Suite 201, Salinas, California, 93901. 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.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS
SEPTEMBER 26, 2024
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, or report of quality assurance committee):

1. Medical Executive Committee
    - Report of the Medical Staff Executive Committee (With Comments)

2. Report of the Medical Staff Quality and Safety Committee to Quality and Efficient Practices
    - Rehab Services Report
    - Utilization Management Report
    - Quality and Safety Committee Consent Agenda
        - Cath Lab/Cardiology/ Cardiac Wellness
        - Med Surg Cluster, Wound Care Program
        - Perioperative Services
        - Food/Nutrition Svc
        - Respiratory Care
        - Environmental Services
        - Pathology Slide 1Q & 2Q 2024
        - Pharmacy & Therapeutics

CONFERENCE WITH REAL PROPERTY NEGOTIATORS
(Government Code §54956.8)

Property: (Specify street address, or if no street address, the parcel number or other unique reference, of the real property under negotiation): _____
Agency negotiator: (Specify names of negotiators attending the closed session): _____
Negotiating parties: (Specify name of party (not agent): _____

Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both): _____

CONFERENCE WITH LABOR NEGOTIATOR
(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session): Allen Radner, M.D.

Employee organization: (Specify name of organization representing employee or employees in question): California Nurses Association, or

Unrepresented employee: (Specify position title of unrepresented employee who is the subject of the negotiations):_____

REPORT INVOLVING TRADE SECRET
(Government Code §37606 & Health and Safety Code § 32106)

Discussion will concern: (Specify whether discussion will concern proposed new service, program, or facility): Trade Secret, Strategic Planning, Proposed New Programs and Services

Estimated date of public disclosure: (Specify month and year): Unknown

CONFERENCE WITH LEGAL COUNSEL-EXISTING LITIGATION
(Government Code §54956.9(d)(1))

Name of case: (Specify by reference to claimant's name, names of parties, case or claim numbers):
Araujo et al vs. Salinas Valley Memorial Healthcare System

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT

(VICTOR REY, JR.)

Awards & Recognition

Board of Directors Meeting

September 26, 2024

DAISY Award Honoree | August







Kimberly Jacobs, BSN, RN

Staff Nurse II

Heart Center



Introduction & Free Services

September 26, 2024



Celina Medina

Family Nurse Practitioner

Salinas Valley HEALTH

FREE Services through the Mobile Clinic

- ✓ Medical care – **over 17,000 patient visits**
- ✓ Food distribution (Food Bank for Monterey County)
- ✓ Blood pressure machines (Foundation)
- ✓ Glucose monitoring kits (Foundation)
- ✓ Gift cards (Foundation)
- ✓ Wellness & STD lab work (Foundation Laboratory)
- ✓ SHINGRIX (GSK, Patient Assistance Program)

Continuous Glucose Monitoring System

Jardiance®

Cologuard®

Salinas Valley HEALTH

Salinas Valley Health received the 2024 Healthgrades Patient Safety Award



Patient Safety Excellence Award™ (2024, 2023)

Top in the nation for providing excellence in patient safety by preventing infections, medical errors, and other preventable complications

The Patient Safety Award recognizes top 10% of the hospitals for patient safety outcomes
Clinical Quality Threshold – To be eligible, a hospital must have been rated by Healthgrades and be in the top 80% of hospitals for clinical quality, as measured by volume weighted z-scores across conditions and procedures evaluated using Medicare data.

The hospitals can not have events relating to foreign objects left in body during a surgery or procedure

Two ratings were better than expected:

- **In-Hospital Fall Associated Fracture Rate**
- **Respiratory Failure Following Surgery**

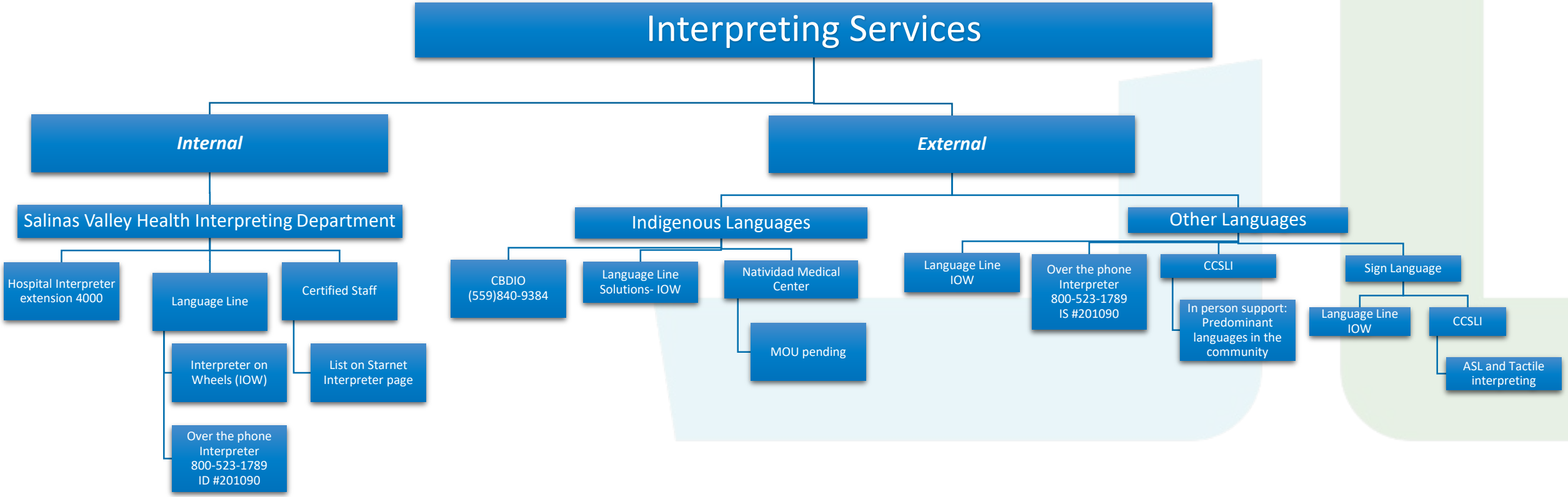
Awards & Recognition

Board of Directors Meeting

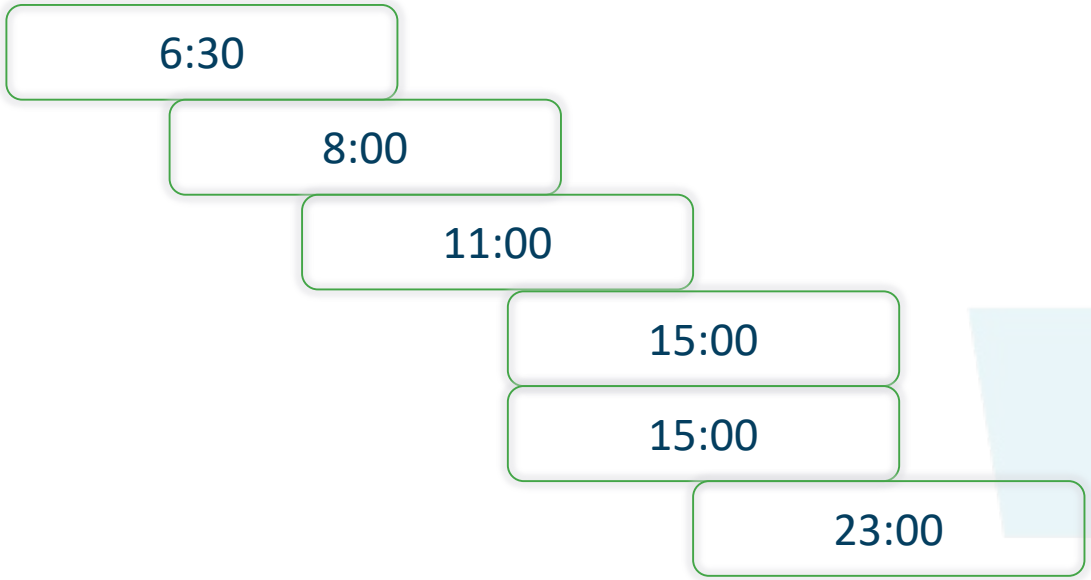
August 22, 2024

Interpreting Services

Salinas Valley HEALTH


Interpreting Services
Internal
External
Salinas Valley Health Interpreting Department
Hospital Interpreter extension 4000
Language Line
Certified Staff
Interpreter on Wheels (IOW)
List on Starnet Interpreter page
Over the phone Interpreter 800-523-1789 ID #201090
Indigenous Languages
CBDIO (559)840-9384
Language Line Solutions- IOW
Natividad Medical Center
MOU pending
Other Languages
Language Line IOW
Over the phone Interpreter 800-523-1789 IS #201090
CCSLI
In person support: Predominant languages in the community
Sign Language
Language Line IOW
CCSLI
ASL and Tactile interpreting

Interpreting team



How to Contact an In-House Spanish Interpreter

There are two ways to connect with an in-house Spanish interpreter:

1. Call **extension 4000** and remain on the line until you reach voicemail—your call will then be routed to an available interpreter.

2. Alternatively, you can use Tiger Connect. Simply search for “Interpreter Request” under the "Teams" section to get assistance.

Indigenous languages

Available Languages and variants:

- Mixteco Bajo/Alto
- Triqui Bajo/Alto
- Zapoteco Alto

CENTRO BINACIONAL PARA EL DESARROLLO INDÍGENA OAXAQUEÑO
BINATIONAL CENTER FOR THE DEVELOPMENT OF OAXACAN INDIGENOUS COMMUNITIES

Indigenous languages- *coming soon*

Collaborating with NMC to create an MOU that will allow us to utilize their services via phone. This should help mitigate the issue in the short term while we gather data with the hopes of expanding out in-person interpreting services.

Available Languages and variants:

- Mixteco Bajo/Alto
- Triqui Bajo/Alto
- Zapoteco Alto

PUBLIC COMMENT

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
AUGUST 22, 2024

Board Members Present: President Victor Rey, Jr., Vice-President Joel Hernandez Laguna, Juan Cabrera, Rolando Cabrera, M.D., and Catherine Carson;

Absent: None.

Also Present:
Allen Radner, M.D., President/Chief Executive Officer
Rakesh Singh, M.D., Chief of Staff
Matthew Ottone, Esq., District Legal Counsel (arrived 6:33 p.m.)
Kathie Haines, Executive Support

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 4:06 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

President Rey announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Conference with Labor Negotiator-California Nurses Association, (3) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (4) Conference with Legal Counsel Existing Litigation*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:07 p.m. The Board completed its business of the Closed Session at 4:41 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:44 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Conference with Labor Negotiator-California Nurses Association, and (3) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services.* The Board received and accepted the reports listed on the Closed Session agenda.

President Rey announced there is a need for an extended closed session. The items to be discussed in Extended Closed Session will be *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Conference with Legal Counsel Existing Litigation*.

4. AWARDS AND RECOGNITION

Dr. Radner announced it was his pleasure to open the Awards and Recognition portion of the Board of Directors. The following was presented:

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

- **STAR Award: Ana Mendez-Zamora:** Carla Spencer, CNO, Thelma Baker, Director Outpatient Oncology & Wound Services, and Anthony Duenas, Manager Outpatient Infusion & Wound Operations, introduced Ana Mendez-Zamora, Clerk Wound Care/OP Wound Care. Ana has been with SVH in the Wound Center since 2007. She consistently goes above and beyond, utilizes resources, is solution oriented, is committed to her patients and team members, prioritizes patients and is a certified interpreter for SVH. Ana creates a better patient experience. Ana made the comment that when she worked directly with Dr. Radner, he said to "always do right thing." She thanked Dr. Radner "for everything you taught me."
- **DAISY Award: David Martin, RN:** Carla Spencer, CNO, introduced David Martin, RN, Staff Nurse II, Telemetry/4-T, who has been with SVH since 2022. She stated he is an amazing nurse and that he is a relatively new nurse, however, this is his 3rd nomination for the Daisy Award. Patient's family member nominated him for this award stating that her father received wonderful, highly extraordinary compassionate care from David Martin. He provided comforting words and positive energy. Her father was treated with the greatest, always gentle care. David was loving and took care to a new level. "He's a super star," and he is being nominated with the "deepest gratitude." David commented that nurses don't go into the profession for awards, but to help people. He gave a shout out to his education at Hartnell College and his favorite instructor, Denise Diamond, who "made me what I am." Additionally he thanked the nurses on the floor and his preceptor, Marcia Mathew. He said, "It is humbling to work alongside these nurses." **Board Comments:** Director Hernandez Laguna thanked David for the heart that he has for this work.
- **Blue Zones Project Receives Certification.** Tiffany DiTullio, CAO Community Wellness, reported the Salinas BZP has become certified. Certification includes implementing food access, food policy, worksites certification, and improving the health and wellbeing of the community. There will be a community celebration on Sunday, September 8, 2024, from 11:00 a.m. to 2:00 p.m. in Central Park, 420 Central Avenue, Salinas.
- **Centers for Medicare & Medicaid Services (CMS) Five-Star Quality Rating:** Aniko Kukla, Director Patient Safety, reported the Centers for Medicare & Medicaid Services created the 5-star rating system as a way to compare hospital quality and performance nationwide. Salinas Valley Health joined the top 10% of hospitals by scoring the highest – 5 stars. SVH is one of 308 hospitals in the nation. We strive to have the best possible care including safety, efficiency and patient experience. She gave thanks to everybody who worked on it, that this is everybody's honor. **Board Comments:** Director Hernandez Laguna asked how many hospitals in our area have a 5-star rating. The closest are Palo Alto VA, Stanford, and San Luis Obispo. SVH is the only hospital in our area. Director Hernandez Laguna thanked Aniko for the great work she does and he would like to find a way to market this. Director Carson stated there are 42 measures that have been worked on with teams of nurses and physicians to achieve the quality. She attended a conference recently and a colleague stated that "SVH is a unicorn," because we have such a high payor mix for Medi-Cal/Medicare, but SVH still provides high quality care regardless of the ability to pay.

5. PUBLIC COMMENT:

Keena Kasunich, RN/ED spoke about staffing, retention, and recruitment and that it relates to caring for our patients. She stated that 15-minute and meal breaks and protection against workplace violence are identified as essential priorities and should be taken seriously.

Janet O'Clair, RN/PACU stated she is a part of the bargaining team. She is concerned that Senior Management hired a large outside law firm to represent SVH. The essentials are basic rights and protections for patients, nurses and the community.

Hugo, RN/4Tower stated the only way to ensure safe staffing is through rights and protections of a union contract and that priorities should be staffing, safety, rest breaks, technology, and protection against workplace violence. These priorities are for the greater good of patients.

Jean Marll read a statement from Jackie Banuelos stating she likes being a nurse in her own community and advocates safe staffing, retention, recruitment and rights of nurses.

RN/HC spoke about the value of patients, nurse respect and that a critical term of bargaining is meal and rest breaks governed by SB1334. A Charge Nurse is essential to oversee patient flow, support and assist floor nurses, communication, and to be leaders in emergent situations and that a dedicated break nurse is needed on every unit.

6. BOARD MEMBER COMMENTS AND REFERRALS

Vice President Joel Hernandez Laguna: Director Hernandez Laguna congratulated the team for the CMS 5-stars award. He encouraged other Board members to attend the Seaside Siembra Latinos Fund Celebration on 9/26 and the Ensen Community Park Celebration at Corral de Tierra Country Club on 9/12. He recently heard a good podcast by a physician on Primecare. He requested administration provide future education on the topic of language access for our patients.

Director Juan Cabrera: None.

Director Rolando Cabrera, MD: None.

Director Catherine Carson: None.

President Victor Rey, Jr.: President Rey congratulated the Blue Zone Project team for certification of Salinas and eventual certification county-wide; he knows this has been a heavy lift. He encouraged all Board members to attend the BZP celebration on September 8th.

7. CONSENT AGENDA – GENERAL BUSINESS

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors July 25, 2024
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval
    1. Infection Prevention Program Plan
    2. Patient Safety Program Plan

PUBLIC COMMENT:
None.

BOARD MEMBER DISCUSSION:

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Hernandez Laguna, the Board of Directors approved the Consent Agenda, Items (A) through (D), as listed above.

ROLL CALL VOTE:

Ayes: Directors Rey, J. Cabrera, Dr. Cabrera, Carson, and Hernandez Laguna;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The minutes were provided for Board review. Director Carson and Aniko Kukla, Director Patient Safety, reviewed Star Reports Center for Medicare and Medicaid Services as follows: Star ratings of surrounding hospitals including the Bay Area, the major categories (mortality, safety, readmission, patient experience and timely/effective care). Comparison data to hospitals from Bay Area 5-star hospitals was reviewed for percentage of patients who received appropriate care for severe sepsis and/or septic shock, patients who left the ED before being seen, ED volume, Average (median) time patient spent in the ED before leaving the visit, serious complications, deaths among patients with serious treatable complications after surgery, central line-associated bloodstream infections (CLABSI) in ICUs and select wards, Clostridium difficile (C.diff.) intestinal infections, hospital return days for heart attack patients, rate of readmission for heart failure patients, and hospital return days for heart failure patients. Dr. Singh thanked management to think outside the box to best accommodate our ED patients.

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

A report was received from Director Catherine Carson regarding the Personnel, Pension and Investment Committee. The following recommendation was made.

1. Consider Recommendation for Board Approval to remove the Transamerica Guaranteed Investment Account and transfer assets to the Vanguard Federal Money Market fund for SVMHS's 403 (b) Plan and 457 Plan, pending final fee negotiations and legal review.

PUBLIC COMMENT:

None.

BOARD MEMBER DISCUSSION: How long has SVH been with Transamerica and why the move? SVH has been with Transamerica for 5-7 years. This request is to move the fund to a better performer. Vanguard yield is 5.29% and Transamerica is 3.25%. Additionally, Vanguard only requires a 30-day notice to move money.

MOTION:

Upon motion by Director Cabrera, and second by Director Carson, the Board of Directors approves removal of the Transamerica Guaranteed Investment Account and transfer of assets to the Vanguard Federal Money Market fund for SVMHS's 403 (b) Plan and 457 Plan.

ROLL CALL VOTE:

Ayes: Directors Rey, J. Cabrera, Dr. Cabrera, Carson, and Hernandez Laguna;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

C. FINANCE COMMITTEE

A report was received from Director Joel Hernandez Laguna regarding the Finance Committee. The minutes were provided for Board review. The following recommendations were made:

1. Consider Recommendation to the Board of Directors to Award a Construction Contract to McLaughlin Painting & Waterproofing for the Medical Center Campus Exterior Repainting Project.

MOTION:

Upon motion by Director Cabrera, and seconded by Director Rey, the Board of Directors awards McLaughlin Painting & Waterproofing the contract for SVH Medical Center Campus Exterior Building Repainting at 450 E. Romie Lane in the amount of $669,580.

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

ROLL CALL VOTE:

Ayes: Directors Rey, J. Cabrera, Dr. Cabrera, Carson, and Hernandez Laguna;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

2. Consider Recommendation for Board of Directors Approval of Project Budget for the Salinas Valley Health X-Ray Rooms 1 and 2 Replacement Project, and Award of Contract to Philips for the X-Ray Equipment System and Service Agreement.

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Cabrera, the Board of Directors approves (i) the total estimated project cost for the Salinas Valley Health X-Ray Rooms 1 and 2 Equipment Replacement projects in the budgeted amount of $1,528,181 and $1,471,820 respectively, and (ii) award equipment supply to Philips in the amount of $562,616 and (iii) approve service agreement with Philips Healthcare in the amount of $745,004.

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

ROLL CALL VOTE:

Ayes: Directors Rey, J. Cabrera, Dr. Cabrera, Carson, and Hernandez Laguna;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

3. Consider Recommendation for Board Approval of Capital funding for the replacement of the medical center based cardiac Nuclear Medicine Camera (D-SPECT) and Five (5) year service agreement and equipment purchase with Spectrum Dynamics Medical.

MOTION:

Upon motion by Director Dr. Cabrera, and seconded by Director Carson, the Board of Directors approves (i) capital funding in the amount of $852,418 for the replacement of the medical-center based D-SPECT Nuclear Medicine camera to include associated project/construction costs and award as sole source, (ii) equipment purchase in the amount of $435,773 from Spectrum Dynamics Medical and (iii) the five (5) year service agreement in the amount of $195,505 with Spectrum Dynamics Medical.

PUBLIC COMMENT:
None.

BOARD DISCUSSION:
None.

ROLL CALL VOTE:

Ayes: Directors Rey, J. Cabrera, Dr. Cabrera, Carson, and Hernandez Laguna;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

D. COMMUNITY ADVOCACY COMMITTEE

A report was received from Director Dr. Cabrera regarding the Community Advocacy Committee. Dr. Cabrera offered kudos to the Mobile Clinic and complimented Dr. Orlando Rodriguez, CMO, and Lynette Fitzgerald, Director Community Benefit. Celina Medina, FNP, has been hired full time for the Mobile Clinic. There was also a Blue Zones Project update with discussion of future planning. The minutes were provided for Board review.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON AUGUST 8, 2024, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Rakesh Singh, MD, Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of August 8, 2024, and Policies/Procedures/Plans revisions. A full report was provided in the Board packet. Dr. Singh stated that Rebecca Adams, MD, has withdrawn her request to resign.

Recommend Board Approval of the Following:

A. Reports

1. Credentials Committee Report excluding the resignation request by Dr. Rebecca Adams.
2. Interdisciplinary Practice Committee Report (Including the following)
   - Amniotic Fluid Rupture Membrane Nursing Standardized Procedure
   - OB Medical Screen Examination Nursing Standardized Procedure

B. Policies/Procedures/Plans:
   1. Influenza (Respiratory Virus) Pandemic Plan
   2. Sedation Guidelines
   3. Bioterrorism Readiness Plan

C. Bylaws Amendments (Approved by a vote of the General Medical Staff)

PUBLIC COMMENT:
None.

BOARD DISCUSSION: Dr. Singh stated Dr. Adams withdrew her request for resignation.

MOTION:
Upon motion by Director Dr. Cabrera, second by Director J. Cabrera, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report, and approves the Policies, Procedures, Plans, and Bylaws as follows:

A. Reports

   1. Credentials Committee Report excluding the resignation request by Dr. Rebecca Adams.
   2. Interdisciplinary Practice Committee Report (Including the following)
      - Amniotic Fluid Rupture Membrane Nursing Standardized Procedure
      - OB Medical Screen Examination Nursing Standardized Procedure

B. Policies/Procedures/Plans:
   1. Influenza (Respiratory Virus) Pandemic Plan
   2. Sedation Guidelines
   3. Bioterrorism Readiness Plan

C. Bylaws Amendments (Approved by a vote of the General Medical Staff)

ROLL CALL VOTE:

Ayes: Directors Rey, J. Cabrera, Dr. Cabrera, Carson, and Hernandez Laguna;
Noes: None;
Abstentions: None;
Absent: None.

Motion Carried

10. EXTENDED CLOSED SESSION

President Rey announced items to be discussed in Extended Closed Session are *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Conference with Legal Counsel Anticipated Litigation*. The meeting recessed into Closed Session under the Closed Session Protocol at 6:05 p.m. The Board completed its business of the Closed Session at 7:18 p.m.

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 7:19 p.m. President Rey reported that in Extended Closed Session, the Board discussed *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Conference with Legal Counsel Existing Litigation*.

No action was taken.

12. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, September 26, 2024, at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:20 p.m.

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Rolando Cabrera, MD
Secretary, Board of Directors

DRAFT SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
SEPTEMBER 5, 2024

Board Members Present: **Victor Rey, Jr.,** President, **Joel Hernandez Laguna**, Vice President, **Rolando Cabrera, M.D.**, and **Catherine Carson.**

Absent: **Juan Cabrera**.

Also Present:
Matt Ottone, Esq., District Legal Counsel
Allen Radner, M.D., President/CEO
Kathie Haines, Executive Support

1. READING OF THE NOTICE OF SPECIAL MEETING

President Rey read the following: A Special Meeting of the Board of Directors of Salinas Valley Health will be held Thursday, September 5, 2024, at 5:00 p.m., Downing Resource Center, Conference Rooms A, B, C, Salinas Valley Health Medical Center, 450 E. Romie Lane, Salinas, California to discuss in closed session strategic planning, new programs and services.

2. CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 5:02 p.m.

3. PUBLIC COMMENT

None.

4. CLOSED SESSION

President Victor Rey, Jr. announced the items to be discussed in Closed Session as listed on the posted Agenda (1) *Report Involving Trade Secret-Strategic Planning, New Programs*. The meeting recessed into Closed Session under the Closed Session Protocol at 5:04 p.m. The Board completed its business of the Closed Session at 6:07 p.m.

5. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:08 p.m. President Victor Rey, Jr. reported that in Closed Session, the Board discussed (1) *Report Involving Trade Secret–Strategic Planning, New Programs and Services*.

No action was taken.

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

6. BOARD MEMBER COMMENTS

None

7. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, September 26, 2024 at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:09 p.m.

_____
Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
August 31, 2024

	Month of August,		Two months ended August 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 57,480,398	$ 46,220,446	$ 107,929,588	$ 95,511,162
Other operating revenue	1,679,857	1,186,536	2,867,038	2,228,398
Total operating revenue	59,160,255	47,406,982	110,796,626	97,739,560
Total operating expenses	51,849,264	47,591,796	98,756,849	94,607,592
Total non-operating income	213,871	(450,187)	1,436,394	(1,236,790)
Operating and non-operating income	$ 7,524,861	$ (635,002)	$ 13,476,171	$ 1,895,178

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
August 31, 2024

	Current year	Prior year
ASSETS:		
Current assets	$ 401,671,060	$ 445,929,153
Assets whose use is limited or restricted by board	170,331,642	159,053,150
Capital assets	251,618,697	248,850,702
Other assets	303,656,028	181,486,298
Deferred pension outflows	85,734,219	116,911,125
	$ 1,213,011,646	$ 1,152,230,429
LIABILITIES AND EQUITY:		
Current liabilities	92,945,850	86,638,346
Long term liabilities	20,628,598	22,722,645
Lease deferred inflows	1,884,477	2,856,606
Pension liability	90,863,576	118,792,064
Net assets	1,006,689,145	921,220,768
	$ 1,213,011,646	$ 1,152,230,429

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
August 31, 2024

	Month of August,		Two months ended August 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,609	1,791	3,410	3,653
Medi-Cal	1,114	921	2,082	1,947
Commercial insurance	554	561	1,085	1,252
Other patient	114	93	199	204
Total patient days	3,391	3,366	6,776	7,056
Gross revenue:				
Medicare	$ 126,686,438	$ 113,231,345	$ 252,272,980	$ 224,212,310
Medi-Cal	81,285,090	67,435,695	160,390,659	128,243,403
Commercial insurance	58,213,383	51,931,778	112,844,953	102,001,344
Other patient	12,173,269	9,874,241	21,661,552	18,992,826
Gross revenue	278,358,180	242,473,059	547,170,144	473,449,883
Deductions from revenue:				
Administrative adjustment	466,956	201,462	827,426	546,325
Charity care	610,804	1,275,270	1,382,709	1,926,685
Contractual adjustments:				
Medicare outpatient	43,796,737	37,772,969	84,743,471	71,927,614
Medicare inpatient	45,761,067	47,527,738	96,391,594	95,809,741
Medi-Cal traditional outpatient	1,255,808	2,743,779	2,779,006	5,109,016
Medi-Cal traditional inpatient	9,163,821	4,037,810	13,717,056	9,784,360
Medi-Cal managed care outpatient	37,779,140	31,410,007	77,531,932	57,624,795
Medi-Cal managed care inpatient	23,771,032	23,530,377	50,558,630	43,275,873
Commercial insurance outpatient	26,459,727	22,382,793	52,123,229	41,947,359
Commercial insurance inpatient	23,880,190	19,770,883	45,612,564	38,951,207
Uncollectible accounts expense	5,407,546	4,415,706	10,499,375	8,487,471
Other payors	2,524,953	1,183,819	3,073,564	2,548,275
Deductions from revenue	220,877,781	196,252,614	439,240,556	377,938,721
Net patient revenue	$ 57,480,399	$ 46,220,446	$ 107,929,588	$ 95,511,162
Gross billed charges by patient type:				
Inpatient	$ 131,021,849	$ 118,058,944	$ 260,491,312	$ 237,520,920
Outpatient	115,608,221	92,426,725	222,594,969	174,338,706
Emergency room	31,728,110	31,987,390	64,083,863	61,590,256
Total	$ 278,358,180	$ 242,473,059	$ 547,170,144	$ 473,449,883

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
August 31, 2024

	Month of August,		Two months ended August 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 57,480,398	$ 46,220,446	$ 107,929,588	$ 95,511,162
Other operating revenue	1,679,857	1,186,536	2,867,038	2,228,398
Total operating revenue	59,160,255	47,406,982	110,796,626	97,739,560
Operating expenses:				
Salaries and wages	18,019,653	16,259,581	34,691,701	32,435,126
Compensated absences	3,472,109	2,897,556	7,049,128	5,945,662
Employee benefits	8,719,522	9,178,334	16,430,105	17,865,559
Supplies, food, and linen	9,214,174	7,311,261	16,986,386	13,918,750
Purchased department functions	4,148,562	3,861,763	7,414,924	7,824,372
Medical fees	2,177,224	2,918,877	4,392,031	5,045,162
Other fees	1,677,496	1,499,051	3,009,090	4,387,647
Depreciation	2,481,166	1,805,101	4,956,977	3,611,600
All other expense	1,939,358	1,860,272	3,826,507	3,573,714
Total operating expenses	51,849,264	47,591,796	98,756,849	94,607,592
Income from operations	7,310,991	(184,814)	12,039,777	3,131,968
Non-operating income:				
Donations	267,721	1,153,867	273,121	1,132,687
Property taxes	476,714	333,333	953,429	666,667
Investment income	3,745,460	1,996,078	9,595,914	4,540,738
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,276,024)	(3,933,465)	(9,386,070)	(7,576,882)
Total non-operating income	213,871	(450,187)	1,436,394	(1,236,790)
Operating and non-operating income	7,524,861	(635,002)	13,476,171	1,895,178
Net assets to begin	999,164,284	921,855,770	993,212,974	919,325,590
Net assets to end	$ 1,006,689,145	$ 921,220,768	$ 1,006,689,145	$ 921,220,768
Net income excluding non-recurring items	$ 7,524,861	$ (635,002)	$ 13,476,171	$ 1,895,178
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 7,524,861	$ (635,002)	$ 13,476,171	$ 1,895,178

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
August 31, 2024

	Month of August,		Two months ended August 31,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (198,137)	$ (182,625)	$ (411,660)	$ (359,989)
Neurological Clinic	(46,016)	(56,266)	(106,971)	(135,431)
Palliative Care Clinic	(110,223)	(62,133)	(243,307)	(146,654)
Surgery Clinic	(199,631)	(173,977)	(462,151)	(400,367)
Infectious Disease Clinic	(30,030)	(26,966)	(61,184)	(61,449)
Endocrinology Clinic	(195,760)	(209,293)	(447,345)	(418,560)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(545,808)	(470,433)	(1,065,644)	(996,965)
OB/GYN Clinic	(388,366)	(379,119)	(760,585)	(698,916)
PrimeCare Medical Group	(832,903)	(763,843)	(1,739,498)	(1,497,877)
Oncology Clinic	(341,428)	(324,643)	(823,982)	(618,421)
Cardiac Surgery	(241,479)	(267,302)	(557,730)	(490,177)
Sleep Center	(65,743)	(35,147)	(157,241)	(72,356)
Rheumatology	(73,834)	(67,371)	(165,735)	(130,945)
Precision Ortho MDs	(434,814)	(395,399)	(825,768)	(801,762)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(70,962)	(38,538)	(168,079)	(101,870)
Vaccine Clinic	0	0	0	0
Dermatology	(47,670)	(48,127)	(95,910)	(49,769)
Hospitalists	0	0	0	0
Behavioral Health	(37,802)	(36,959)	(92,033)	(73,801)
Pediatric Diabetes	(48,601)	(40,007)	(112,383)	(91,614)
Neurosurgery	(95,834)	(29,828)	(224,144)	(60,354)
Multi-Specialty-RR	3,159	3,783	11,079	11,416
Radiology	(293,088)	(450,756)	(823,783)	(426,963)
Salinas Family Practice	(125,051)	(148,785)	(244,526)	(265,764)
Urology	(155,816)	(91,677)	(368,100)	(238,252)
Total SVHC	(4,575,837)	(4,295,411)	(9,946,680)	(8,126,840)
Doctors on Duty	166,462	152,462	187,337	186,331
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	188,142	115,107	339,682	225,757
Coastal	(132,121)	64,488	(98,740)	87,381
Apex	0	0	0	0
21st Century Oncology	0	17,428	0	1,017
Monterey Bay Endoscopy Center	77,330	12,461	132,329	49,472
Total	$ (4,276,024)	$ (3,933,465)	$ (9,386,070)	$ (7,576,882)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
August 31, 2024

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 264,234,048	$ 342,311,300
Patient accounts receivable, net of estimated uncollectibles of $45,440,988	114,926,129	80,708,653
Supplies inventory at cost	7,999,941	7,922,313
Current portion of lease receivable	1,510,630	1,921,803
Other current assets	13,000,312	13,065,084
Total current assets	401,671,060	445,929,153
Assets whose use is limited or restricted by board	170,331,642	159,053,150
Capital assets:		
Land and construction in process	46,476,448	65,148,659
Other capital assets, net of depreciation	205,142,249	183,702,043
Total capital assets	251,618,697	248,850,702
Other assets:		
Right of use assets, net of amortization	7,223,649	5,681,859
Long term lease receivable	404,025	1,115,546
Subscription assets, net of amortization	9,309,002	10,754,599
Investment in Securities	261,142,160	139,513,295
Investment in SVMC	1,964,249	7,905,874
Investment in Coastal	1,778,631	1,769,022
Investment in other affiliates	21,824,275	16,854,830
Net pension asset	10,037	(2,108,727)
Total other assets	303,656,028	181,486,298
Deferred pension outflows	85,734,219	116,911,125
	$ 1,213,011,646	$ 1,152,230,429
L I A B I L I T I E S A N D N E T A S S E T S		
Current liabilities:		
Accounts payable and accrued expenses	$ 61,880,795	$ 57,318,155
Due to third party payers	3,877,321	5,398,361
Current portion of self-insurance liability	20,777,733	17,396,477
Current subscription liability	3,816,833	4,630,742
Current portion of lease liability	2,593,168	1,894,611
Total current liabilities	92,945,850	86,638,346
Long term portion of workers comp liability	12,752,056	13,027,333
Long term portion of lease liability	4,708,365	3,980,405
Long term subscription liability	3,168,177	5,714,907
Total liabilities	113,574,448	109,360,991
Lease deferred inflows	1,884,477	2,856,606
Pension liability	90,863,576	118,792,064
Net assets:		
Invested in capital assets, net of related debt	251,618,697	248,850,702
Unrestricted	755,070,448	672,370,066
Total net assets	1,006,689,145	921,220,768
	$ 1,213,011,646	$ 1,152,230,429

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
August 31, 2024

	Month of August,				Two months ended August 31,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 278,358,180	$ 257,912,588	20,445,592	7.93%	$ 547,170,144	$ 515,825,175	31,344,969	6.08%
Dedutions from revenue	220,877,781	206,241,415	14,636,366	7.10%	439,240,556	412,901,382	26,339,174	6.38%
Net patient revenue	57,480,399	51,671,173	5,809,226	11.24%	107,929,588	102,923,793	5,005,795	4.86%
Other operating revenue	1,679,857	1,452,669	227,188	15.64%	2,867,038	2,905,338	(38,300)	-1.32%
Total operating revenue	**59,160,256**	**53,123,842**	**6,036,414**	**11.36%**	**110,796,626**	**105,829,131**	**4,967,495**	**4.69%**
Operating expenses:								
Salaries and wages	18,019,653	17,543,906	475,747	2.71%	34,691,701	34,539,664	152,037	0.44%
Compensated absences	3,472,109	3,285,555	186,554	5.68%	7,049,128	6,891,261	157,867	2.29%
Employee benefits	8,719,522	8,257,292	462,230	5.60%	16,430,105	16,309,296	120,809	0.74%
Supplies, food, and linen	9,214,174	7,302,276	1,911,898	26.18%	16,986,386	14,604,552	2,381,834	16.31%
Purchased department functions	4,148,562	3,825,284	323,278	8.45%	7,414,924	7,650,567	(235,643)	-3.08%
Medical fees	2,177,224	2,485,637	(308,413)	-12.41%	4,392,031	4,971,274	(579,243)	-11.65%
Other fees	1,677,496	1,756,428	(78,932)	-4.49%	3,009,090	3,512,857	(503,767)	-14.34%
Depreciation	2,481,166	2,345,865	135,301	5.77%	4,956,977	4,704,924	252,053	5.36%
All other expense	1,939,358	2,006,796	(67,438)	-3.36%	3,826,507	4,015,129	(188,622)	-4.70%
Total operating expenses	**51,849,264**	**48,809,038**	**3,040,226**	**6.23%**	**98,756,849**	**97,199,523**	**1,557,326**	**1.60%**
Income from operations	**7,310,992**	**4,314,804**	**2,996,188**	**69.44%**	**12,039,777**	**8,629,607**	**3,410,170**	**39.52%**
Non-operating income:								
Donations	267,721	208,333	59,388	28.51%	273,121	416,667	(143,546)	-34.45%
Property taxes	476,714	476,714	(0)	0.00%	953,429	953,429	0	0.00%
Investment income	3,745,460	1,891,173	1,854,286	98.05%	9,595,914	3,782,346	5,813,568	153.70%
Income from subsidiaries	(4,276,024)	(5,123,222)	847,198	-16.54%	(9,386,070)	(10,246,444)	860,374	-8.40%
Total non-operating income	**213,871**	**(2,547,001)**	**2,760,872**	**-108.40%**	**1,436,394**	**(5,094,003)**	**6,530,396**	**-128.20%**
Operating and non-operating income	**$ 7,524,863**	**$ 1,767,802**	**5,757,060**	**325.66%**	**$ 13,476,171**	**$ 3,535,605**	**9,940,566**	**281.16%**

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of August and two months to date

	Month of August		Two months to date		
	2023	2024	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	40	31	71	69	(2)
Other Admissions	89	76	171	160	(11)
Total Admissions	129	107	242	229	(13)
Medi-Cal Patient Days	56	120	107	184	77
Other Patient Days	146	54	276	186	(90)
Total Patient Days of Care	202	174	383	370	(13)
Average Daily Census	6.5	5.6	6.2	6.0	(0.2)
Medi-Cal Average Days	1.6	3.9	1.6	2.9	1.3
Other Average Days	1.5	0.7	1.7	1.2	(0.4)
Total Average Days Stay	1.6	1.6	1.7	1.7	0.1
ADULTS & PEDIATRICS					
Medicare Admissions	376	391	763	752	(11)
Medi-Cal Admissions	309	280	505	585	80
Other Admissions	358	303	571	621	50
Total Admissions	1,043	974	1,839	1,958	119
Medicare Patient Days	1,538	1,496	3,168	2,833	(335)
Medi-Cal Patient Days	960	981	2,018	2,153	135
Other Patient Days	858	714	1,790	1,570	(220)
Total Patient Days of Care	3,356	3,191	6,976	6,556	(420)
Average Daily Census	108.3	102.9	112.5	105.7	(6.8)
Medicare Average Length of Stay	4.0	3.8	4.2	3.7	(0.4)
Medi-Cal AverageLength of Stay	3.2	3.2	3.4	3.3	(0.1)
Other Average Length of Stay	2.3	1.9	2.4	2.0	(0.4)
Total Average Length of Stay	3.2	2.9	3.4	3.0	(0.3)
Deaths	26	37	51	54	3
Total Patient Days	3,558	3,365	7,359	6,926	(433)
Medi-Cal Administrative Days	2	0	5	0	(5)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	2	0	5	0	(5)
Percent Non-Acute	0.06%	0.00%	0.07%	0.00%	-0.07%

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of August and two months to date

	Month of August		Two months to date		
	2023	2024	2023-24	2024-25	Variance
PATIENT DAYS BY LOCATION					
Level I	216	271	439	541	102
Heart Center	338	313	667	649	(18)
Monitored Beds	598	570	1,223	1,145	(78)
Single Room Maternity/Obstetrics	329	303	642	690	48
Med/Surg - Cardiovascular	765	820	1,656	1,634	(22)
Med/Surg - Oncology	264	271	557	537	(20)
Med/Surg - Rehab	439	469	906	951	45
Pediatrics	150	98	245	202	(43)
Nursery	202	174	383	370	(13)
Neonatal Intensive Care	100	76	222	207	(15)
PERCENTAGE OF OCCUPANCY					
Level I	53.60%	67.25%	54.47%	67.12%	
Heart Center	72.69%	67.31%	71.72%	69.78%	
Monitored Beds	71.45%	68.10%	73.06%	68.40%	
Single Room Maternity/Obstetrics	28.68%	26.42%	27.99%	30.08%	
Med/Surg - Cardiovascular	54.84%	58.78%	59.35%	58.57%	
Med/Surg - Oncology	65.51%	67.25%	69.11%	66.63%	
Med/Surg - Rehab	54.47%	58.19%	56.20%	59.00%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	26.88%	17.56%	21.95%	18.10%	
Nursery	39.49%	34.02%	18.72%	18.08%	
Neonatal Intensive Care	29.33%	22.29%	32.55%	30.35%	

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of August and two months to date

	Month of August		Two months to date		
	2023	2024	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	125	123	236	231	(5)
C-Section deliveries	45	31	77	68	(9)
Percent of C-section deliveries	36.00%	25.20%	32.63%	29.44%	-3.19%
OPERATING ROOM					
In-Patient Operating Minutes	17,669	20,885	33,916	40,430	6,514
Out-Patient Operating Minutes	28,638	29,584	57,267	62,149	4,882
Total	46,307	50,469	91,183	102,579	11,396
Open Heart Surgeries	12	12	21	24	3
In-Patient Cases	128	134	246	262	16
Out-Patient Cases	299	301	572	611	39
EMERGENCY ROOM					
Immediate Life Saving	38	31	75	63	(12)
High Risk	744	838	1,443	1,748	305
More Than One Resource	3,005	2,736	5,772	5,407	(365)
One Resource	1,924	1,672	3,558	3,358	(200)
No Resources	110	62	225	135	(90)
Total	5,821	5,339	11,073	10,711	(362)

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of August and two months to date

	Month of August		Two months to date		
	2023	2024	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	13,697	13,389	27,788	26,261	-1,527
Out-patient requisitions	10,996	11,095	21,150	21,571	421
Emergency room requisitions	1,140	963	1,753	1,790	37
Interdepartmental requisitions	6,220	6,641	12,563	13,138	575
Total requisitions	32,053	32,088	63,254	62,760	-494
LABORATORY					
In-patient procedures	35,536	35,268	71,532	71,179	-353
Out-patient procedures	11,764	45,294	22,459	89,473	67,014
Emergency room procedures	14,285	12,689	26,447	25,041	-1,406
Total patient procedures	61,585	93,251	120,438	185,693	65,255
BLOOD BANK					
Units processed	365	234	665	465	-200
ELECTROCARDIOLOGY					
In-patient procedures	1,019	1,173	2,096	2,279	183
Out-patient procedures	426	435	822	782	-40
Emergency room procedures	1,249	1,300	2,459	2,549	90
Total procedures	2,694	2,908	5,377	5,610	233
CATH LAB					
In-patient procedures	125	145	240	270	30
Out-patient procedures	103	130	193	249	56
Emergency room procedures	0	0	0	0	0
Total procedures	228	275	433	519	86
ECHO-CARDIOLOGY					
In-patient studies	353	396	683	844	161
Out-patient studies	245	362	493	719	226
Emergency room studies	0	1	0	3	3
Total studies	598	759	1,176	1,566	390
NEURODIAGNOSTIC					
In-patient procedures	138	140	256	264	8
Out-patient procedures	22	27	42	41	-1
Emergency room procedures	0	0	0	0	0
Total procedures	160	167	298	305	7

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of August and two months to date

	Month of August		Two months to date		
	2023	2024	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	0	0
Out-patient procedures	245	268	434	538	104
Emergency room procedures	0	0	0	0	0
Total procedures	245	268	434	538	104
RADIOLOGY					
In-patient procedures	1,214	1,292	2,468	2,657	189
Out-patient procedures	451	419	858	863	5
Emergency room procedures	1,568	1,625	2,989	3,176	187
Total patient procedures	3,233	3,336	6,315	6,696	381
MAGNETIC RESONANCE IMAGING					
In-patient procedures	153	180	305	388	83
Out-patient procedures	145	124	278	235	-43
Emergency room procedures	11	6	20	12	-8
Total procedures	309	310	603	635	32
MAMMOGRAPHY CENTER					
In-patient procedures	4,360	3,085	8,003	6,333	-1,670
Out-patient procedures	4,331	3,077	7,939	6,313	-1,626
Emergency room procedures	0	0	0	1	1
Total procedures	8,691	6,162	15,942	12,647	-3,295
NUCLEAR MEDICINE					
In-patient procedures	18	19	39	45	6
Out-patient procedures	112	140	222	256	34
Emergency room procedures	0	0	0	0	0
Total procedures	130	159	261	301	40
PHARMACY					
In-patient prescriptions	80,197	80,108	161,993	162,863	870
Out-patient prescriptions	16,710	16,741	32,059	32,729	670
Emergency room prescriptions	9,502	9,824	18,273	19,141	868
Total prescriptions	106,409	106,673	212,325	214,733	2,408
RESPIRATORY THERAPY					
In-patient treatments	15,381	14,284	27,910	29,531	1,621
Out-patient treatments	1,606	1,109	2,785	1,760	-1,025
Emergency room treatments	366	369	688	729	41
Total patient treatments	17,353	15,762	31,383	32,020	637
PHYSICAL THERAPY					
In-patient treatments	2,330	2,485	4,776	4,683	-93
Out-patient treatments	234	259	497	528	31
Emergency room treatments	0	0	0	0	0
Total treatments	2,564	2,744	5,273	5,211	-62

SALINAS VALLEY HEALTH MEDICAL CENTER
PATIENT STATISTICAL REPORT
For the month of August and two months to date

	Month of August		Two months to date		
	2023	2024	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,539	1,475	2,957	3,072	115
Out-patient procedures	216	188	475	421	-54
Emergency room procedures	0	0	0	0	0
Total procedures	1,755	1,663	3,432	3,493	61
SPEECH THERAPY					
In-patient treatments	406	535	887	1,010	123
Out-patient treatments	49	40	73	63	-10
Emergency room treatments	0	0	0	0	0
Total treatments	455	575	960	1,073	113
CARDIAC REHABILITATION					
In-patient treatments	0	1	2	2	0
Out-patient treatments	585	654	1,084	1,326	242
Emergency room treatments	0	0	0	0	0
Total treatments	585	655	1,086	1,328	242
CRITICAL DECISION UNIT					
Observation hours	239	188	611	494	-117
ENDOSCOPY					
In-patient procedures	77	96	137	168	31
Out-patient procedures	49	65	95	109	14
Emergency room procedures	0	0	0	0	0
Total procedures	126	161	232	277	45
C.T. SCAN					
In-patient procedures	680	755	1,402	1,543	141
Out-patient procedures	491	519	962	935	-27
Emergency room procedures	813	812	1,566	1,565	-1
Total procedures	1,984	2,086	3,930	4,043	113
DIETARY					
Routine patient diets	21,027	14,890	42,325	29,832	-12,493
Meals to personnel	28,688	32,665	56,633	68,141	11,508
Total diets and meals	49,715	47,555	98,958	97,973	-985
LAUNDRY AND LINEN					
Total pounds laundered	95,358	96,048	193,409	189,713	-3,696

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: September 17, 2024

Re: Policies Requiring Approval

As required under Title 22, CMS, and The Joint Commission (TJC), please find below a list of regulatory required policies with summary of changes that require your approval.

	Policy Title	Summary of Changes	Responsible VP
1.	CVIS Downtime Process	Update the General Information section with regards to the date & time of the CVIS security patches and updates.	Carla Spencer, CNO
2.	Dress Code: Protective Attire	Updated AORN reference. Added Clean lab coats or cover gowns to IV -F.	Clement Miller, COO
3.	Financial Assistance Program/Full & Discount Partial Charity Care - Taylor Farms Family Health & Wellness Center	Edited to add income definition and eligibility reevaluation timeline.	Augustine Lopez, CFO
4.	Interpreter/Translator Communication	Typos corrected. Additions of indigenous peoples.	Carla Spencer, CNO
5.	Management of Hypersensitivity & Anaphylaxis when Administering Chemotherapy and Immunotherapy	Policy Updated and revised to align with practice recommendations.	Carla Spencer, CNO
6.	Obstetrical Hemorrhage	Added hemorrhage risk assessment on admission to postpartum unit, updated low/medium/high risk factors, updated references.	Carla Spencer, CNO
7.	Pediatrics: Admission Criteria	Added #6 to section B under V. Procedure Added #6 to section C under V. Procedure	Carla Spencer, CNO
8.	Publication Policy for Work, Projects and Research	Modified to include public-facing research information approval requirements.	Timothy Albert, MD
9.	Rho (D) Immune Globulin Administration	Updated references and minor updates to verbiage used to describe instances for administration of Rhogam to align with verbiage in references.	Carla Spencer, CNO
10.	Scheduling: Cardiac Cath Lab	Change to block utilization percentage	Carla Spencer, CNO
11.	Tuition Assistance	Update policy to show annual max for 2024, 2025.	Michelle Barnhart Childs, CHRO

Status Pending PolicyStat ID 16279582

Last Approved N/A

Next Review 3 years after approval

Owner Steven Nguyen: PACS/IT System Administrator

Area Cardiology Departments

CVIS Downtime Process

COPY

I. POLICY STATEMENT

A. NA

II. PURPOSE

A. The purpose of this policy is to provide guidance to users of the Cardiovascular Information System during downtime.

III. DEFINITIONS

A. CVIS- Cardiovascular Information System that encompasses Cardiac catheterizations and echocardiograms

IV. GENERAL INFORMATION

A. Occasionally there will be scheduled downtime to perform maintenance, usually between 2am and 4am or specific approved dates & times by the department managers or director, on the Change Healthcare Servers. Scheduled downtimes include security patches, driver updates, application updates, modular enhancements, updates and patches and system power cycles. The CVIS is made up of six servers- Application, Database, Merge, Fax, Web and Internet information server (IIS). Some of the servers are running concurrently on the same physical or virtual server or independently. Operating System (O/S) updates and security patches are also required on these machines to protect from outside harm and to fix known bugs.

V. PROCEDURE

A. During downtime, all users of the Change Healthcare CVIS (Cardiovascular Information System) will follow the procedure as outlined below.

B. Prior to scheduled downtime, staff in cardiac sonography and the cardiac cath lab will query all

modalities to populate the modality worklist with current orders.

C. Any new orders that come in during downtime will be manually entered into the respective modality by department staff.

D. Tests requiring immediate review by a physician may be viewed on the modality (i.e. echo cart, x-ray equipment)

E. Physicians may report on procedures during downtime by dictation or may wait until downtime has been lifted to complete reporting within the CVIS.

F. Once downtime has been lifted, all exams performed during downtime will be transferred/ downloaded to the CVIS and attached to corresponding orders for proper export of reports to the Electronic Health Record.

G. Department staff will check all exams for proper import and any mistakes in demographics that may have occurred during manual entry. The PACS Administrator can be contacted at ext. 3817 to address any issues.

H. Documentation:

1. "Emergency Mode User Guide" is located in the shared drive "N:\CARDIOPULMONARY SERVICES\ChangeHealthcare\Admin Guide

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

COPY

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Steven Nguyen: PACS/IT System Administrator	07/2024

Standards

No standards are associated with this document

COPY

Status **Pending** PolicyStat ID **14673590**

Last Approved	N/A	Owner	Aisha Huebner: Director Perioperative Services
Next Review	3 years after approval	Area	Patient Care

Dress Code: Protective Attire

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I. POLICY STATEMENT

A. The Operating / Procedural Room is considered to be a "controlled environment"; therefore, all persons entering the semi/restricted areas will be required to wear surgical scrub clothing as provided by the hospital. Fresh scrub attire will be donned daily.

II. PURPOSE

A. To acquaint all persons entering a "Semi" or "Restricted" area (i.e. Operating Suite / Procedural room) with the appropriate department dress code and to identity the required additional protective attire.

III. DEFINITIONS

A. AORN: Association of Operating Room Nurses.

B. AAMI: Association for the Advancement of Medical Instrumentation.

C. Campus: Main site on which the building of an organization or institution is located.

D. Gross contamination: The presence of increased blood / body fluids or surgical irrigation in a volume that presents a risk to staff performing a surgical procedure. Examples include but are not limited total hip / shoulder replacement, ACL / PCL Repair.

IV. GENERAL INFORMATION

A. Surgical Scrubs are provided by the hospital and are required to be removed and placed in the appropriate laundry area prior to exiting the building at the end of shift. Staff from other departments should not be allowed access to the surgical scrubs.

B. All head and facial hair, including side burns, beards and neckline, must be covered completely with a clean lint-free hat or surgical hood while in the restricted area. Staff may wear personal head coverings but restricted location disposable head covering may be used to protect

personal head covering from splash contamination of blood or bodily fluids. A surgeon's preference for head covering will be followed by surgical staff.

C. Shoe covers are not required to be worn in any area unless there is an anticipation of gross contamination. Shoe covers worn as PPE are removed immediately after the procedure and discarded.

D. Footwear should meet the safety requirements for the procedural area. Staff shall clean soiled shoes regularly or replace them as necessary.

E. Street clothes are permitted attire for physicians and visitors to the PACU.

F. Clean lab coats or cover gowns may be worn if exiting the main building for hospital workflow.

G. Fingernails should be kept clean, smooth, and manicured at all times. False fingernails in patient care areas are not allowed.

    1. This statement is in accordance with the Center for Disease Control (CDC) guidelines and approved by the Infection Control Committee (ICC), "No artificial nails/enhancements/tips may be worn by any employee with direct patient care responsibilities."

H. Individuals who provide direct patient care or have patient contact shall not wear fragrances, as the chemicals in these products could cause severe physical reactions to our patients.

I. No food and no drinks in the OR / Procedural area hallway or in restricted areas of the Operating / Procedural Room.

J. Refer to the Dress Code policy for other dress code requirements.

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V. PROCEDURE

A. All personnel must wear a departmental approved facemask at all times while in a restricted area/operating room where a sterile field exists.

    1. Nose and mouth must be covered.
    2. Mask must be completely secured to prevent gaps at the sides.
    3. A clean mask must be worn for each operative procedure.
    4. Masks are either "on" or "off", they are not to be left hanging loose around the neck partially tied, or saved for use at a later time.

B. All personnel must wear protective eye wear.

    1. Goggles and face shields are individually distributed and it is the responsibility of each person to don prior to the start of a surgical procedure.
    2. Personnel and medical staff that wear prescription glasses are encouraged to wear face shields to protect their glasses and improve the protection during unexpected splatter events.
    3. Special prescription, protective eye wear can be obtained to meet an individual with unique needs.
    4. Personnel are to wear face shield or goggles while decontaminating and cleaning instruments, equipment and/or supplies to prevent unexpected exposure for spills or

splatters.

C. Jewelry
    1. Medical personnel and surgical personnel will remove or cover dangle jewelry when performing procedures in the presence of a sterile field.
    2. Rings, necklaces and watches are allowed to be worn while circulating surgical procedures as long as they do not prohibit the proper use of protective gloves.

D. The circulator will wear examination gloves during surgical procedures when handling contaminated products or items from the sterile field.
    1. Both sterile and non-sterile examination gloves are stored in each OR.
    2. Gloves will be worn when counting contaminated sponges, handling specimens, instrumentation or any potentially contaminated item.
    3. All personnel cleaning or decontaminating instruments and equipment will wear gloves and face protection attire
    4. The circulator is required wear gloves during surgical skin antisepsis, sterile gloves are needed when applicator is not long enough to prevent contamination. Circulator may cover their arms during performance of preoperative skin antisepsis when requested by surgeon, extra precaution must be used to prevent contamination from loose fitting sleeves.

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VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Association of Operating Room Nurses, 2024 Edition
B. Association for the Advancement of Medical Instrumentation ST79
C. Center for Disease Control Guidelines

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	09/2024

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Carla Knight: Director Perioperative Services	07/2024

Standards

No standards are associated with this document

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Status **Pending** PolicyStat ID **16086685**

Last Approved	N/A	Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Next Review	3 years after approval	Area	Administration

Financial Assistance Program/Full & Discount Partial Charity Care - Taylor Farms Family Health & Wellness Center

COPY

I. POLICY STATEMENT

A. This policy pertains to financial assistance provided by Taylor Farms Family Health and Wlness Center (TFFH&WC). The Financial Assistance Policy is applicable only to services provided by TFFH&WC and specifically excludes medical care provided by physicians who may be members of the Salinas Valley Health Medical Center (SVHMC) Medical Staff. All requests for financial assistance from patients, patient families, physicians or clinic staff shall be addressed in accordance with this policy.

II. PURPOSE

A. SVHMC serves all persons in Salinas and the larger surrounding community area. As a California Healthcare District, SVHMC is committed to providing high quality, cost effective services to our patients. Providing patients with opportunities for financial assistance coverage for healthcare services is an important element in fulfilling the SVHMC mission. As an outpatient department of the hospital, Taylor Farms Family Health & Wellness Center will comply with this policy. This policy defines the TFFH&WC Financial Assistance Program; its criteria, systems, and methods.

III. DEFINITIONS

A. **Full Charity Care**

1. Any necessary outpatient clinic service provided to a patient who has an income below 120% of the current federal poverty level and is unable to pay for care and who has established qualification in accordance with requirements contained in the TFFH&WC Financial Assistance Policy.

B. **Discount Partial Charity Care**

1. Any necessary outpatient service provided to a patient at TFFH&WC who is uninsured or underinsured and 1) desires assistance with paying their bill; 2) has an income between 121% and 200% of the current federal poverty level; and 3) who has established qualification in accordance with requirements contained in the TFFH&WC Financial Assistance Policy.

C. **A Patient's Family**

1. For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and
2. For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent of caretaker relative.

IV. GENERAL INFORMATION

A. California acute care hospitals must comply with Health & Safety Code requirements for written policies providing discounts and charity care to financially qualified patients. This policy is intended to meet such legal obligations and provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the TFFH&WC Financial Assistance Program.

B. The Billing Clerk has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at TFFH&WC. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of SVHMC and TFFH&WC.

C. TFFH&WC strives to meet the health care needs of all patients who seek outpatient services. TFFH&WC is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their bill.

D. Depending upon individual patient eligibility, financial assistance may be granted for full charity care or discount partial charity care. Financial assistance may be denied when the patient or other responsible family representative does not meet the TFFH&WC Financial Assistance Policy requirements.

E. **Full Charity Care and Discount Partial Charity Care Reporting**

1. SVHMC will report actual Charity Care provided in accordance with regulatory requirements of the Office of Statewide Health Planning and Development (OSHPD) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, the clinic will maintain written documentation regarding its Charity Care criteria, and for individual patients, the clinic will maintain written documentation regarding all Charity Care determinations. As required by OSHPD, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.
2. SVHMC will provide OSHPD with a copy of this Financial Assistance Policy which includes the full charity care and discount partial charity care policies within a single document.

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a. The Financial Assistance Policy also contains:
    i. All eligibility and patient qualification procedures;
    ii. The unified application for full charity care and discount partial charity care; and
    iii. The review process for both full charity care and discount partial charity care. These documents shall be supplied to OSHPD every two years or whenever a significant change is made.

3. Eligibility is defined for any patient whose family income is less than 200% of the current federal poverty level, if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account. Income consists of gross wages, demonstrated via tax return or W2. Eligibility is reevaluated on an annual basis.
4. The TFFH&WC Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the clinic and such information will be used to qualify the patient or family representative for maximum coverage under the TFFH&WC Financial Assistance Program.
5. Eligible patients may qualify for the TFFH&WC Financial Assistance Program by following application instructions and making every reasonable effort to provide the clinic with documentation and health benefits coverage information such that the clinic may make a determination of the patient's qualification for coverage under the program. Eligibility alone is not an entitlement to coverage under the TFFH&WC Financial Assistance Program. TFFH&WC must complete a process of applicant evaluation and determine coverage before full charity care or discount partial charity care may be granted
6. The TFFH&WC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. To facilitate receipt of accurate and timely patient financial information, TFFH&WC will use a financial assistance application. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. In addition, uninsured patients will be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.
7. The financial assistance application should be completed as soon as there is an indication the patient may be in need of financial assistance. The application form may be completed, in advance of a patient visit, or after services are completed.

F. Completion of a financial assistance application provides:

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1. Information necessary for the clinic to determine if the patient has income sufficient to pay for services;
2. Documentation useful in determining qualification for financial assistance; and
3. An audit trail documenting the clinic's commitment to providing financial assistance.

G. However, a completed financial assistance application is not required if TFFH&WC determines it has sufficient patient financial information from which to make a financial assistance qualification decision.

V. PROCEDURE

A. **Qualification: Full Charity Care and Discount Partial Charity Care**

1. Qualification for full or discount partial financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
2. The patient and/or patient family representative who requests assistance in meeting their financial obligation to the clinic shall make every reasonable effort to provide information necessary for the clinic to make a financial assistance qualification determination. The clinic will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the clinic retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance.
4. Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Practice Manager at TFFH&WC. This process shall be clearly identified on the application instructions.
5. TFFH&WC will provide personnel who have been trained to review financial assistance applications for completeness and accuracy. Application reviews will be completed as quickly as possible considering the patient's need for a timely response.
6. A financial assistance determination will be made only by approved clinic personnel. Any charity care adjustments over $1,000 must be approved by a SVHMC or Cypress Manager.
7. Factors considered when determining whether an individual is qualified for financial assistance pursuant to this policy may include:
    a. Gross family income based upon tax returns or recent pay stubs

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b. Family size

8. Qualification criteria are used in making each individual case determination for coverage under the TFFH&WC Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this policy.
9. Financial Assistance Program qualification may be granted for full charity care (100% free services) or discount partial charity care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.
10. Once determined, Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, the clinic, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by the clinic. Other pre-existing patient account balances outstanding at the time of qualification determination by the clinic may be included as eligible for write-off at the sole discretion of management.
11. Patient obligations for Medi-Cal share of cost payments will not be waived under any circumstance.
12. Patients at or below 200% of the FPL will not pay more than Medicare would typically pay TFFH&WC for a similar episode of service. This shall apply to all services provided by TFFH&WC.

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B. **Full and Discount Partial Charity Care Income Qualification Levels**

1. If the patient's gross family income is 120% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off.
2. If the patient's gross family income is between 121% and 200% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply:

3. **Patient's care is not covered by a payer.** If the services are not covered by any third party payer so that the patient ordinarily would be responsible for the full- billed charges, the patient's payment obligation will be determined based on patient's income compared to current year Health and Human Services Agency

   Federal Poverty Guidelines discounted based on the following schedule:

Current Year Federal Poverty Level	Clinic Fee Schedule Discount
120% or Below	100%
121% to 150%	75%

151% to 200%	50%
201% or Above	No Discount

4. **Patient's care is covered by a payer.** If the services are covered by a third party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment), the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that would be due under the guidelines listed above for patients whose care is not covered by insurance. If the amount paid by insurance exceeds what would be due under the above sliding fee discount schedule, the patient will have no further payment obligation.

C. **Payment Plans**

1. When a determination of discount partial charity has been made by the clinic, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.
2. The clinic will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to pay. As a general guideline, payment plans will be structured to last no longer than 12 months. The clinic shall negotiate in good faith with the patient; however where an agreement cannot be reached regarding a payment plan the payment plan bill will require that monthly payments do not exceed 10% of a patient's family income for one month excluding deductions for "essential living expenses" "Essential living expenses are defined as expenses for any of the following: rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child and spousal support, transportation and automobile expenses (including insurance, fuel, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses. No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.

D. **Special Circumstances**

1. Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by TFFH&WC.
2. If the patient is determined to be homeless he/she will be deemed eligible for the Financial Assistance Program.

E. **Other Eligible Circumstances**

1. TFFH&WC deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be indigent. Therefore such patients are eligible under the Financial Assistance Policy when

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payment is not made by the governmental program.

2. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:
    a. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients; or
    b. The patient otherwise qualifies for financial assistance under this policy and then only to the extent of the write-off provided for under this policy.
3. Any account returned to the clinic from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.
4. All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by clinic billing personnel prior to any re-classification within the clinic accounting system and records.

F. **Dispute Resolution**

1. In the event that a dispute arises regarding qualification, the patient may file a written appeal for reconsideration with the clinic. The written appeal should contain a complete explanation of the patient's dispute and rationale for reconsideration. Any or all additional relevant documentation to support the patient's claim should be attached to the written appeal.
2. Any or all appeals will be reviewed by the clinic manager or director of patient financial services. The manager or director shall consider all written statements of dispute and any attached documentation. After completing a review of the patient's claims, the manager or director shall provide the patient with a written explanation of findings and determination.
3. In the event that the patient believes a dispute remains after consideration of the appeal by the director of patient financial services, the patient may request in writing, a review by the hospital's CFO. The CFO shall review the patient's written appeal and documentation, as well as the findings of the director of patient financial services. The CFO shall make a determination and provide a written explanation of findings to the patient. All determinations by the CFO shall be final. There are no further appeals.

G. **Public Notice**

1. TFFH&WC shall post notices informing the public of the Financial Assistance Program. Such notices shall be posted in the clinic Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance.
2. These notices shall be posted in English and Spanish and any other primary languages that are representative of 5% or greater of patients in the hospital's

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service area.

3. A copy of this Financial Assistance Policy will be made available to the public on a reasonable basis.

H. **Confidentiality**

1. It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. Confidentiality of requests, information and funding will be maintained for all that seek or receive financial assistance. The orientation of staff and selection of personnel who will implement this policy should be guided by these values.

I. **Good Faith Requirements**

1. TFFH&WC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or purposely inaccurate information has been provided by the patient or family representative. In addition, TFFH&WC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the TFFH&WC Financial Assistance Program.

J. **DOCUMENTATION**

1. TFFH&WC Financial Assistance Application
2. Charity Care Worksheet
3. Federal Poverty Guidelines
4. Charity care criteria for individual patients and determinations documentation is kept at TFFH&WC.

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VI. EDUCATION/TRAINING

A. Education is provided during general or department-specific orientation and periodically as practice or policy changes.

VII. REFERENCES

A. AB 774 (Chan, Chapter 755, Statutes of 2006)

B. Federal Poverty Guidelines

Attachments

A: Financial Assistance Application

B: Charity Care Eligibility Worksheet

C: 2019 Federal Poverty Guidelines

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024
Policy Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration	07/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16155614**

Last Approved	N/A	Owner	William Tienken: Manager Patient Care Services
Next Review	3 years after approval	Area	Administration

Interpreter/Translator Communication

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I. POLICY STATEMENT

A. SVHMC shall provide interpreter services to patients.

B. SVHMC shall annually transmit a copy of this policy to the California Department of Public Health.

II. PURPOSE

A. To ensure the implementation of measures supporting effective communication with individuals whose primary language is not English. This policy outlines arrangements for both telephone-based and face-to-face interpreting, as well as the translation of written materials.

B. SVHMC is committed to providing easily accessible, reliable, and relevant information to enable individuals to fully participate in their healthcare decisions and support them in making informed choices, including information about the quality of clinical services.

C. The objectives of this policy are to:

1. Ensure all individuals needing interpreting support receive it.
2. Ensure staff can identify the need for interpreting support and determine the most appropriate form of support for each consultation or activity.
3. Describe the practices and processes for providing interpretation and translation services.

III. DEFINITIONS

A. Interpreter: A person fluent in English and the necessary second language, capable of accurately speaking, reading, and interpreting the second language, or a person proficient in sign language. Interpreters must be able to translate body part names and competently describe symptoms and injuries in both languages. Medical or professional staff may serve as interpreters.

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B. **Qualified Interpreter:** An individual who has passed a standardized test assessing competency in interpretation skills specific to the healthcare setting, administered by an interpreter service company contracted with SVHMC.

C. "**Language or communication barriers" means**

1. Spoken language barriers experienced by individuals who are limited-English-speaking or non-English-speaking, comprising at least 5 percent of the population served by the hospital or the actual patient population. The state department determines the 5 percent population standard based on objective data.
2. Sign language barriers experienced by deaf individuals whose primary language is sign language.

D. Interpreting can be provided face to face, video conferencing or by telephone.

1. It should be noted that interpreting differs from advocacy and should not substitute for advocacy, which involves speaking up for or acting on behalf of the service user.

E. Translation Services

1. The provision of translated material does not replace an interpreter, but can be used to supplement or reinforce information being given via an interpreter. It should be noted that as for all people, some people whose first language is not spoken English, may not be able to read information in their first language.
2. SVHMC has access to a translation services as outlined in Attachment A. If an occasion arises where these are not suitable then all translation must be done through a qualified translator, for which the Trust has a contract.

F. Equality AND Diversity

1. SVH ensures that service provision reflects individual needs and does not discriminate against individuals or groups on any grounds.

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IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center (SVHMC) is committed to providing support and information in languages other than English, ensuring everyone can communicate with healthcare staff and access health services.

B. Interpretive services are available 24 hours a day, 7 days a week, and offered in over two hundred forty (240) different languages.

C. Professional spoken language interpreters enhance clinical care, improve outcomes, increase service utilization, enhance patient satisfaction, and reduce communication errors.

D. In cases of patient complaints or grievances, SVHMC follows the process outlined in the COMPLAINT AND GRIEVANCES: PATIENT. (See attachment Notice of Nondiscrimination.)

E. In compliance with state and federal regulations, the SVHMC posts signs that advise patients and their families of the availability of interpreters upon requests. These signs are posted throughout the facility and posted on the SVHMC Website.

F. This policy is relevant to: patient, family and/caregivers and other service users whose first language is not spoken English. If the patient is a child or person without mental capacity, it

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relates to those with responsibility for the patient.

V. PROCEDURE

A. Off-site locations follow their standard registration process to identify patients requiring interpreter services. Healthcare staff are responsible for identifying the need for an interpreter and documenting it in the patient's records outlined in this section.

B. Healthcare staff identifying the need for an Interpreter.

1. The ability to communicate with healthcare staff is fundamental to clinical care, and the referring practitioner should have highlighted the need for language support. This need should also be emphasized throughout the patient's care. It is important to recognize that while some individuals may be able to communicate about basic issues, they may lack the ability to comprehend medical information, especially when feeling vulnerable or stressed in the hospital. Additionally, some individuals, particularly older adults or those with dementia, may lose their ability to communicate effectively in a second language, such as English.
2. At the time of registration, the preferred language will be documented in the medical record by the registration staff.
3. If the need for language support has not been identified at the time of referral, or if the patient is admitted as an emergency, the person delivering the care is responsible for identifying the need for an interpreter. This should be recorded in the patient's records, and that person is responsible for ensuring that language services are provided.

C. Documenting the Need

1. The registered nurse completing the Admission History will also document the preferred language, indicating the exact language and dialect spoken.
2. The preferred language is available to all care providers in the Electronic Medical Record (EMR).
3. The preferred language is recorded on the EMR on the appropriate caregiver status boards. Upon identification of the preferred language, the status board is automatically populated.

D. Identifying the Type of Interpreting Service Needed

1. It is essential to provide the necessary type of interpreting service for the patient, or if the patient is a child or lacks mental capacity, for those responsible for the patient.
    a. Patients have the right to a qualified interpreter when actively making decisions about their care or relinquishing their rights.
    Examples of when to use a qualified interpreter include:
        i. A legal decision where a patient may waive a right such as a discussion of their advanced directive wishes and a DNR/ allowing natural death or during the consent process.
        ii. During care where a decision is made by the patient for course of care or treatment, such as whether to move forward with a

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surgery or opt for chemotherapy.

b. Use of Caregivers, Family & Friends
    i. It is the responsibility of health professionals to offer patients with limited English proficiency the use of trained professional interpreters. Using the patient's friends or family members as interpreters is generally not considered good practice. Whenever possible, it is best practice to work with trained, qualified interpreters instead of family members.
    ii. Staff must be aware that interpretation by people such as family and friends may be inaccurate and impartial due to factors such as lack of language skills, emotional involvement, and conflicting interests, and may also breach patient confidentiality.
    iii. For these reasons, relatives, caregivers, and friends should not typically be asked to interpret. Similarly, when a child cannot understand or speak English, parents should not be asked to interpret for the child; an external interpreter must be used. Children and young people should never be asked to interpret for anyone, including parents or siblings.

c. Where concerns arise about safeguarding issues (for both adults and children) or capacity issues, as outlined in the Mental Health Act and Mental Health Incapacity Acts, an approved qualified interpreter should always be used, even for basic communication.

d. Summary of Interpreter Use

Type of Communication	Examples	Type of Provision Available
Basic Needs	Personal demographic details, discussions/help on toileting and feeding.	Language cards can be used. If family members interpret for basic issues it is important to bear issues of accuracy and confidentiality in mind. If there are any concerns about **safeguarding issues** an qualified interpreter must be used even for basic communication
Intermediate and Advanced Needs	Assessment, investigations, treatment, explaining diagnosis, referral to other services	Approved qualified interpreter, via telephone or face to face. The professional's clinical

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	and discharge issues and for anything complicated.	judgment should be used to decide whether telephone or face to face interpreting is used.
Discussions about Safeguarding Children and Adults. Safety Issue	When there are concerns about safeguarding children adults. Issues related to Mental Capacity and Domestic Violence	Approved qualified interpreter, direct face to face interpretation **even for basic communication.**
SITUATIONS REQUIRING A CERTIFIED INTERPRETER	i. When obtaining consent for an investigation or treatment, an interpreter must be used to ensure that the patient or person with parental responsibility understands the full procedure planned. Details of the interpreter or service used must be documented on the consent form. ii. A legal decision where a patient may waive a right such as a discussion of their advanced directive wishes and a DNR/allowing natural death or during the consent	Approved qualified interpreter. Direct face to face interpretation, Language Line, Video Conferencing.

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	process.	

E. Approved Qualified Interpreting Services

1. All patients whose first language is other than spoken English and who need interpreting support beyond the most basic level should be offered access to an approved qualified interpreter.
2. Sign language users should be offered access to an independent approved interpreter. More information is given
    a. Spoken Language Interpreters: (Face to Face and Telephone) A list of qualified interpreters can be obtained from the Nursing Administration.
        i. SVHMC employs qualified interpreters for face to face interpretation. The professional's clinical judgment should be used to decide whether telephone/ video conferencing or face to face interpreting is used.
        ii. The qualified interpreter should have a discussion with patients about what is most useful for them may also be helpful.
        iii. Video conferencing and telephone interpreting can be set up in minutes and can be used for the duration of a clinical interaction or to support care until a face to face interpreter is available, if required.
3. Factors to consider when working with a Language Interpreter
    a. Consider the most appropriate method of translation. Will video or telephone translation provide you with what you require for the duration of the intervention or is it required until face to face interpretation is provided if required? Could you use it for some aspects of meeting patients' needs and have face to face translation at other times?
    b. Before the interpreting session starts, it is important for the clinician to spend some time with the interpreter to brief them, giving any appropriate background information and explaining any technical terms (for example medical or legal terms) that may arise. After the interpreter session, it is advisable to discuss how the interview went and discuss any issues for example cultural difference.
    c. If an interpreter does not arrive, follow the attached algorithm for interpreter options.
4. Health and safety for interpreters
    a. Interpreters are required to work in line with the health and safety requirements of their contract and with their code of conduct. You should consider whether any health and safety precautions that you take when undertaking your duties should also be applied to the interpreter. For example:
        i. If you wear a mask when you are examining a patient, you

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should also provide the same protection for the interpreter who is standing next to you.

ii. Make sure the interpreter knows where the antibacterial gel is located

iii. Interpreters should not be asked to help with any clinical tasks or to touch any bodily fluids.

b. Transport for patients

i. Interpreters are not responsible for providing transport to take patients to or from home. If a patient requests this service, the interpreter will convey this message to you.

5. Factors for the clinician to consider when using a Telephone or Video Language Interpreter

a. Identify the language and dialect you need, it may take a few minutes to connect to the appropriate Interpreter.

b. Telephone: Consider the most appropriate telephone equipment, dual handset, speaker phone, direct phone, consider confidentiality and need for participation of family/caregivers.

i. Advise the interpreter what phone set up you have, e.g. single handset, speaker phone, two handsets.

c. Video: Uses a Video iPad and can also provide sign language interpreters.

i. As an additional resource, the Video can be used to translate instructions:

ii. Video Interpreter will write out the instructions in the preferred language so the RN can copy the words onto the discharge instructions

d. Brief the Interpreter

i. Give any appropriate background information and explaining any technical terms (for example medical or legal terms) that may arise.

ii. Ask them to introduce you and themselves

iii. Follow this with your lead question, e.g. how may I help you?

e. Proceed with the conversation

i. The interpreter will relay the information between you and the patient.

f. End the by saying

i. "I have all the information I need, is there anything else you would like to ask me?

F. Hearing impaired/deaf patients:

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1. If it is determined that interpretation is needed for effective communications with hearing-impaired patients at the present time or at a future date, the following procedure will be followed:
    a. An American Sign Language interpreter can be contacted via contracted video remote interpreter. Interpreter on wheels (IOW) are available on all units and can be downloaded to your device.
    b. Pocket talkers are also available for patients to borrow. These personal amplification devices can help improve communication by amplifying sound directly into the patient's ears. Pocket talkers are located on each unit and can be checked out as needed. Staff should ensure the device is properly sanitized before and after each use.

G. Monitoring compliance:
    1. The interpreter/translator program is evaluated on an annual basis or as needed to determine its effectiveness. Program revisions, process improvements are made as necessary to meet the needs of the patient population served.
    2. If as a professional user you have any feedback or suggestions for improvement about the Interpreting Service these should be directed to the department director.
    3. If patients wish to complain about the Interpreting Service please direct them to the department director.
    4. As appropriate SVHMC reviews all forms, waivers, documents and informational materials available upon admission to determine which to translate into a language other than English

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VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Affordable Care Act Section 1557
B. The Joint Commission - Patient Rights
C. California Health and Safety Code Section 1259
D. Assembly Bill 389
E. CHA Consent Manual, Chapter 1 Patients' Rights and the Basic Principles of Consent
F. 45 C.F.R. Section 84.52 (d)

Attachments

Interpreting Services flow process.docx

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Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	William Tienken: Manager Patient Care Services	07/2024

Standards

No standards are associated with this document

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Status **Pending** PolicyStat ID **15974947**

Last Approved: N/A
Next Review: 3 years after approval

Owner: Thelma Baker: Director Outpatient Oncology & Wound Services
Area: Patient Care

Management of Hypersensitivity & Anaphylaxis when Administering Chemotherapy and Immunotherapy

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I. POLICY STATEMENT:

A. N/A

II. PURPOSE

A. To guide staff in management of hypersensitivity or anaphylaxis during chemotherapy or immunotherapy administration.

III. DEFINITIONS

A. Sensitized: To make hypersensitive or reactive to an antigen, especially by a second or repeated exposure.

IV. GENERAL INFORMATION

A. RNs may provide interventions to treat/manage hypersensitivity and anaphylactic reactions when administering antineoplastic and immune-modifying medications.

B. Drugs with potential for allergic response should be administered under constant supervision with adequate personnel to ensure optimal patient management in the event of allergic/ anaphylactic reaction.

C. An allergy history should be documented on the patient's record before administration of the initial dose.

D. All drugs should be administered in accordance with the approved mode and route of administration established by the manufacturer's labeling, the National Cancer Institute, and/or individual institutional policy and procedures.

E. Investigational drugs should be administered only in the presence of qualified personnel with provider supervision.

F. Emergency drugs and equipment should be readily available for immediate interventions. See Attachment A for list of emergency drugs.

G. Provider orders for management of potential hypersensitivity anaphylactic reactions are obtained before drug administration.

V. PROCEDURE

A. Preparation

1. Obtain and record baseline vital signs, height and weight, and patient assessment findings.
2. Perform a thorough pretreatment assessment to verify recovery from past treatment, consent to treatment and the need to reinforce key education about the treatment. A chart review includes but is not limited to diagnosis, regimen/ treatment plan, previous doses administered (eg premedications), dose modifications/delays, tolerance and reactions to past treatments, current cycle/day, cycle length, IV access, history of any category of acute infusion-related reaction, allergy history (e.g. food, medication, environment), and criteria to treat (including laboratory tests).
3. Administer pre-medications as ordered.
4. Ensure provider orders are in place for hypersensitivity protocol.
5. With each infusion instruct patients to report symptoms of hypersensitivity and infusion reaction immediately.

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B. Patient Education

1. Inform the patient of the possibility of a hypersensitivity reaction.
2. Educate the patient about the signs of a hypersensitivity reaction and to report signs such as:
    a. Rashes, or Hives (Urticaria).
    b. Localized or generalized itching.
    c. Shortness of breath with or without wheezing.
    d. Uneasiness or agitation.
    e. Periorbital or facial edema.
    f. Lightheadedness or dizziness.
    g. Tightness in the chest.
    h. Abdominal cramping, nausea, or vomiting. Vomiting is less common.
    i. Chills.
    j. Symptoms of hypotension.

C. Clinical Management

1. Stop drug infusion immediately and disconnect the allergen, noting the reaction start time.
2. Maintain an IV line with normal saline infusing.
3. Call for help. Notify the provider.
4. Maintain the patient upright if short of breath or vomiting. Place the patient in a supine position, if able, and elevate the legs if hypotensive (SBP < 60mmHg).
5. Monitor vital signs (i.e. temperature, pulse, respirations, blood pressure and oxygen saturation) as clinically appropriate until resolution (60-90 minutes post reaction).
6. Maintain airway, assessing the patient for increasing respiratory tract edema, shortness of breath, and dyspnea.
7. Administer Oxygen if needed.
8. Observe for and evaluate symptoms
    a. For grade 1-2 reactions, administer an H1 and H2 blocker.
        i. Treat symptoms with additional supportive care medications as indicated..
        ii. Continue ongoing assessment for signs and symptoms of acute infusion related reaction or advancement to anaphylaxis.
        iii. If symptoms are not resolving or worsening, prepare to administer epinephrine and activate the emergency team or local emergency services.
    b. For grade 3 reactions administer emergency medications based on symptoms, starting with epinephrine, and activate the emergency team or local emergency services.
        i. Do not restart the causative agent with grade 3 reactions. Observe the patient until stabilized.
    c. Monitor the patient until symptoms of anaphylaxis have fully resolved.
        i. Refer to provider for further instructions on restarting the infusion
        ii. Patients with severe anaphylaxis and those who require more than one dose of epinephrine are at increased risk for a biphasic reaction; therefore, emergency department monitoring or hospital admission should be considered. \

D. Documentation
1. Document all treatments, the grade of reaction and the patient's response to interventions in the medical record using the 'Hypersensitivity Reaction Note' template.
2. File an ooccurrence report.

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VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Castells, M. C., Matulonis, U.A. ,Horton, T.M. (2018, November). Infusion Reactions to Systemic Chemotherapy. Retrieved from: https://www.uptodate.com/contents/infusion-reactions-to-systemic-chemotherapy

B. Olsen, M., LeFebvre, K., Walker, S. & Prechtel Dunphy, E. (2023). Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice (2nd ed.). Pittsburg: Oncology Nursing Society.

Attachments

A: Oncology: Hypersensitivity Protocol

B: Algorithm for the Management of a Hypersensitivity Reaction

C: Chemotherapy Drugs Associated with Hypersensitivity Reactions

D: Immunotherapy Drugs Associated with Hypersensitivity Reactions

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Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	09/2024
Cancer Committee	Carol Renn: Comprehensive Cancer Center Program Coordinator	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024

Policy Owner	Thelma Baker: Director Outpatient Oncology & Wound Services	07/2024

Standards

No standards are associated with this document

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Status **Pending** PolicyStat ID **16076107**

Last Approved	N/A	Owner	Daniela Jago: Clinical Manager
Next Review	3 years after approval	Area	Women's and Children's Services

Obstetrical Hemorrhage

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I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in the medical and nursing management of the patient experiencing, or at increased risk of Obstetric Hemorrhage.

III. DEFINITIONS

A. Quantitative blood loss (QBL): measurement of blood loss using formal methods such as graduated containers, visual comparisons and weight of blood soaked materials (1gm = 1ml).

B. Cumulative blood loss (CBL): total quantitative blood loss at any point in time.

C. California Maternal Quality Care Collaborative (CMQCC).

IV. GENERAL INFORMATION

A. All patients should be evaluated using the hemorrhage risk assessment found in the electronic health record. Hemorrhage risk should be evaluated on admission, during each shift while in active labor, and upon admission to the postpartum unit. If, at any time during their birth admission, the patient has continued bleeding or abnormal blood loss, their status should be reflected as Stage 1, Stage 2, or Stage 3 and steps should be taken as recommended.

V. PROCEDURE

A. Patients admitted to Labor and Delivery should be evaluated for their hemorrhage risk status at the following occasions:

1. On admission

2. Throughout the peripartum period (at least every 8 hours) for any changes in condition. (see below)
3. Upon admission to the postpartum unit. (see below)
4. Admission and Labor Risk Factors:

Low Risk	Medium Risk	High Risk (consider obtaining T&C)
No previous uterine incision	Prior cesarean birth(s) or uterine surgery	Placenta previa, low lying placenta
Singleton pregnancy	Multiple gestation	Suspected/known placenta accreta spectrum
≤ 4 previous vaginal births	>4 previous vaginal births	Abruption or active bleeding (> than show)
No known bleeding disorder	Chorioamnionitis	Known coagulopathy
No history of postpartum hemorrhage	History of previous postpartum hemorrhage	History of > 1 postpartum hemorrhage
	Large uterine fibroids	HELLP Syndrome
	Platelets 50,000 - 100,000	Platelets <50,000
	Hematocrit <30% (HgB <10)	Hematocrit <24% (Hgb <8)
	Polyhydramnios	Fetal demise
	Gestational age <37 weeks or >41 weeks	2 or more medium risk factors
	Preeclampsia	
	Prolonged labor/ induction (>24 hrs)	

5. Additional Birth and Ongoing Postpartum Risk Factors

Low Risk (Routine Care)	Medium Risk	High Risk
	Increased Surveillance Postpartum Care Team Assess Response Readiness	
	Cesarean during this admission - *especially if urgent emergent/ 2nd stage*	Active bleeding soaking >1 pad per hour or passing a ≥6 cm clot
	Operative vaginal birth	Retained placenta
	Genital tract trauma including	Non-lower transverse uterine

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	3rd and 4th degree lacerations	incision for cesarean
	Quantitative cumulative blood loss 500-1000 mL with a vaginal birth	Quantitative cumulative blood loss ≥1000 mL or treated for hemorrhage
		Received general anesthesia
		Uterine rupture

B. Labor, Delivery and Recovery

1. Nurses should evaluate blood loss through labor (of more than normal show), delivery and immediate postpartum period utilizing the recognized quantification blood loss tools. These amounts should be documented in mLs in the patient's labor and vaginal recovery record. The frequency of entry is dependent on patient condition. The cumulative amount at time of transfer is considered the patient's cumulative blood loss (comprised of the cumulative QBL) based on:
    a. Direct measurement in standardized drapes/containers.
    b. Weight (converted from 1 gm = 1 mL)
2. Cesarean Birth
    a. Blood loss should be determined through direct measurement in suction canister minus amniotic fluid. In addition, the entire sponge/lap counter with used laps should be weighed at the conclusion of the case.
    b. QBL should be documented following each peri-pad or chux change in the PACU and for the first hour postpartum.
3. Measurement and documentation of QBL should continue beyond the immediate recovery period for vaginal or cesarean births where there is a clinical concern about blood loss.
4. See CMQCC Obstetric Hemorrhage Care Guidelines as Appendix A
5. Stabilization
    a. Patient should remain in L&D unit post Stage 2 hemorrhage and transferred to postpartum when condition is stable.
    b. Consider transfer to higher level of care for Stage 3 hemorrhages, dependent on patient condition.
    c. Level of hemorrhage should be communicated at each transfer of care (i.e. Stage 1, 2 or 3).

C. Documentation:

1. Communications with physician(s).
2. All interventions and patient response.
3. Document quantitative blood loss electronically.

D. Ongoing Training Process

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1. The department CNS/designee will provide education and training per orientation and maintenance of routine competency procedures.
2. Education on OB hemorrhage will be completed every two years
3. OB Hemorrhage simulations will be conducted annually.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Lagrew, D., McNulty, J., Sakowski, C., Cape, V., McCormick, E., & Morton, CH. (2022). *Improving Health Care Response to Obstetric Hemorrhage, Version 3.0. (California Maternal Quality Care Collaborative Toolkit)*. California Maternal Quality Care Collaborative. Available https://www.cmqcc.org/resources-tool-kits/toolkits/ob-hemorrhage-toolkit

B. The Joint Commission, Provision of Care Standard 06.01.01

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Attachments

Appendix A Obstetric Hemorrhage Care Guidelines Checklist Format.pdf

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	09/2024
Dept of OB/GYN	Katherine DeSalvo: Director Medical Staff Services	08/2024
Director of WCS	Julie Vasher: Director Women's & Children's Services	08/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Daniela Jago: Clinical Manager	07/2024

Standards

No standards are associated with this document

COPY

Status **Pending** PolicyStat ID **14097288**

Last Approved	N/A	Owner	Agnes Lalata: Director Medical/ Surgical Services
Next Review	3 years after approval	Area	Women's and Children's Services

Pediatrics: Admission Criteria

COPY

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide safe and appropriate care in the diagnosis and treatment of childhood and adult diseases. The pediatric department provides acute care management for pediatric patients (less than 14 years of age) and ambulatory adult medical surgical patients.

B. To establish guidelines for admission to Pediatrics Department.

III. DEFINITIONS

A. Pediatric patients: ages one (1) day through 13 years of age

B. Adult patients: 14 years through geriatric.

C. CCS –California Children's Services

D. Bariatric – body mass index of 40 or greater

IV. GENERAL INFORMATION

A. It is the responsibility of the director or designee in collaboration when necessary with the Department Chair of Pediatrics/designee to oversee placements on the pediatric unit.

V. PROCEDURE

A. Criteria for admission to Beds 335-343 (CCS designated pediatric rooms 335 - 337):

1. Pediatric patients requiring general care

a. Pediatric age patients, infectious or non-infectious

b. Newborns transferred from the well baby nursery requiring continued general care after the newborn's mother has been discharged from the MB Unit.

2. Adult patients, infectious or non infectious.
3. Adult patients requiring oxygen saturation monitoring without cardiac monitoring.
4. Pediatric patients who present with or develop suicidal ideation or intent while on the pediatric unit will be evaluated on a case by case basis by pediatric nursing staff under the direction of the director of the pediatric unit/designee and or the Administrative supervisor to ensure patient safety. Refer to CARE OF THE SUICIDAL PATIENT
    a. If the pediatric patient is to remain on the pediatric unit, it is recommended the patient will be placed in room 343. A patient safety attendant is required.

B. Patients that are **INAPPROPRIATE** for admission to the pediatric medical surgical unit include:
    1. Adult patients admitted due to injury/illness related to a known act of violence.
    2. Forensic patients.
    3. Patients that require continuous med-neb treatments greater than four (4) hours within a 24 hour period.
    4. Patient requiring insulin drip.
    5. Adult patients with or who develop suicidal ideation.
    6. Patient requiring cardiac monitoring or rhythm recognition.

C. It is recommended that the following patients not be admitted for general care to the pediatric unit:
    1. Adults going through acute withdrawal from ethanol or other mood altering substances.
    2. Adult patients that are confused related to illness or ongoing medical conditions.
    3. Adults requiring extensive assistance with mobility and activities of daily living due to chronic illnesses.
    4. Adults with a BMI of 40 or greater.
    5. Adults requiring any specialty beds due to the limited space available in the patient rooms.
    6. Adults requiring with multiple wounds requiring complex dressing changes

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California Children's Services Manual of Procedure. Chapter 3.3.2 Standards for Pediatric

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Community Hospitals. – Pediatric Community Hospital (CCS- 1999).

B. Department of Health Services (DHS) Licensing and Certification Division under California Code of Regulations, Title 22, Division 5, Chapter 1.

C. The Joint Commission (TJC) National Patient Safety Goals Hospital Program. Goal 15. (TJC-2010) of Patient Safety Goals 2013.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Agnes Lalata: Director Medical/Surgical Services	07/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16379997**

Last Approved	N/A	Owner	Terri Nielsen: Manager Clinical Research
Next Review	3 years after approval	Area	Clinical Research

Publication Policy for Work, Projects and Research

COPY

I. POLICY STATEMENT

A. Salinas Valley Health is committed to advancing healthcare through research, education, and the dissemination of knowledge. To ensure the integrity and quality of our published work, all publications authored by our employees, affiliates, or collaborators must adhere to this policy.

II. PURPOSE

A. The purpose of this policy is to ensure that any dissemination of knowledge, including publishing in journal articles, books, conferences, posters, presentations, and on websites regarding work, projects, or research conducted at Salinas Valley Health, adheres to all applicable state and federal laws, privacy standards, TJC and HIPAA regulations.

III. DEFINITIONS

A. ICMJE - International Committee of Medical Journal Editors

IV. GENERAL INFORMATION

This policy applies to all forms of publication, including journal articles, conference presentations, poster, books, and digital content. Compliance with these guidelines ensures that our publications reflect the highest standards of excellence and contribute positively to the field of healthcare.

All public-facing materials referencing Clinical Research conducted, sponsored, or supported by Salinas Valley Health and its affiliates, including the Foundation and the Clinics, undergo formal approval from the Research Oversight Committee (ROC) prior to publication or external dissemination (outside Salinas Valley Health). This policy applies to any content relating to Clinical Trials, Cancer Research, Stroke Research, or any specific research project, study, or clinical trial associated with Salinas Valley Health.

All advertisements, brochures, social media posts, videos, fliers, mailers, posters, signage, articles, press releases, and any other form of public communication regarding research activities must receive written

approval from the ROC before being published or distributed. In addition, this approval process extends to the re-purposing, editing, or excerpting of previously published information. To obtain permission, please submit a copy of the publication and its purpose and intended audience to ROC@SalinasValleyHealth.com.

All publications authored by our employees, affiliates, or collaborators must adhere to the following guidelines:

A. **Ethical Standards:** All research and scholarly publications must comply with ethical standards, including those set by relevant regulatory bodies, Institutional Review Boards (IRB), and professional organizations. This includes ensuring patient confidentiality, obtaining informed consent, and avoiding conflicts of interest.

B. **Authorship**: Authorship credit should reflect the contribution of each individual involved in the research or scholarly work. All authors must meet the criteria for authorship as defined by recognized guidelines, such as those from the International Committee of Medical Journal Editors (ICMJE).

C. **Review and Approval**: Prior to submission for publication, all manuscripts must be reviewed and approved by the appropriate departmental leadership or research oversight committee. This review ensures that the content is accurate, ethical, and aligns with the strategic goals of the healthcare system.

D. **Transparency and Disclosure**: Authors must disclose any financial relationships or conflicts of interest that could influence the interpretation of their research. Transparency is essential to maintaining trust in our published work.

E. **Affiliation Acknowledgment**: All publications must acknowledge the author's affiliation with Salinas Valley Health and, where applicable, the funding sources that supported the research.

F. **Data Access and Sharing:** Authors are encouraged to share data and materials related to their publications in accordance with open access policies and data-sharing agreements, while respecting patient privacy and proprietary information.

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V. PROCEDURE

A. Pre-publication Review Process

1. Prior to submitting any work, project, or research findings for publication or presentation, the author(s) must submit the content for review to the Salinas Valley Health Research Oversight Committee (ROC), which will facilitate the review.
2. Authors intending to publish must submit their materials to the ROC via email: ROC@SalinasValleyHealth.com

B. Publication Review includes consultation with the appropriate internal departments to complete the following:

1. Privacy Officer Review
2. Research regulatory opinion / IRB review
3. Quality Management Review for CMS and TJC compliance
4. Legal review for conflict of interest, intellectual property rights, publication rights in

any relevant institutional agreements

5. Marketing and Communications Review

C. The ROC publication review will consist of members from the legal, privacy, compliance, clinical research, and clinical departments. The review process will assess the content for compliance with legal and ethical standards, accuracy of information, and adherence to institutional policies.

D. Documentation: The ROC generate a written response to the prospective author, and retain a copy on file available upon request to the ROC.

VI. EDUCATION/TRAINING

A. Education and/or training is available upon request to the Clinical Research Department.

VII. REFERENCES

A. **International Committee of Medical Journal Editors (ICMJE)**. (2023). Recommendations for the Conduct, Reporting, Editing, and Publication of Scholarly Work in Medical Journals. Available at: ICMJE

- This comprehensive guide covers ethical standards for publishing in medical journals, including authorship criteria, conflicts of interest, and data sharing policies.

B. **National Institutes of Health (NIH)**. (2021). *NIH Public Access Policy*. Available at: NIH

- This policy mandates that all publications arising from NIH-funded research be made publicly accessible, providing guidelines on how to comply with open access requirements.

C. **The Joint Commission (TJC)**. (2021). *Standards for Research and Publication*. Available at: The Joint Commission

- Although specific details require access, TJC's standards emphasize ethical practices in healthcare research, particularly around patient safety and data use.

D. **Centers for Medicare & Medicaid Services (CMS)**. (2022). *Research, Data, and Publications Guidelines*. Available at: CMS

- CMS outlines specific requirements for the use of data in research and subsequent publications, ensuring that patient data is handled responsibly and in compliance with federal regulations.

E. **American Medical Association (AMA)**. (2022). *Code of Medical Ethics: Professional Self-Regulation, Publication and Research*. Available at: AMA

- The AMA provides ethical guidance on the publication of research findings, including issues related to authorship, conflicts of interest, and the dissemination of knowledge.

F. **American Nurses Association (ANA)**. (2020). *Ethical Guidelines for Publication in Nursing Journals*. Available at: ANA

- This document provides guidance on ethical standards for publishing in nursing

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journals, addressing issues like authorship, peer review, and the responsible reporting of research findings.

G. **Society for Healthcare Strategy & Market Development (SHSMD)**. (2022). *Healthcare Marketing and Communications Ethics and Publication Guidelines*. Available at: SHSMD

- This guideline outlines ethical standards and best practices for healthcare marketing and communications, including the publication of content, ensuring accuracy, transparency, and adherence to regulatory requirements.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Research Committees	Terri Nielsen: Manager Clinical Research	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2024
Policy Owner	Terri Nielsen: Manager Clinical Research	09/2024
ROC Coordinator	Cynthia Johnson: Contract Medical Librarian	09/2024

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16076325

Last Approved	N/A	Owner	Daniela Jago: Clinical Manager
Next Review	3 years after approval	Area	Women's and Children's Services

Rho (D) Immune Globulin Administration

COPY

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide nursing staff in the management of the patient requiring Rho (D) Immune Globulin.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Patients who are identified as candidates will be administered Rho (D) immune globulin within 72 hours of delivery.

B. In addition, Rh (D) negative patients who have not been previously sensitized should be administered Rho (D) immune globulin in the following instances:

1. Abdominal trauma
2. Antepartum hemorrhage
3. Ectopic pregnancy
4. External cephalic version
5. Intrauterine fetal death
6. Hydatidiform mole
7. Invasive procedures such as amniocentesis, chorionic villus sampling, fetal blood sampling
8. Molar pregnancy

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9. Threatened miscarriage or miscarriage
10. Therapeutic termination of pregnancy

C. If delivery occurs within three weeks of standard antenatal administration, repeat dosing may be withheld in the absence of excessive maternal/fetal hemorrhage.

V. PROCEDURE

A. Cord blood will be collected by the RN and evaluated by the laboratory on infants of Rh (D) negative mothers for type and direct Coombs as directed in the newborn order set.

B. If the infant is determined to be Rh (D) positive or Du positive (weak D) a test to detect the presence of fetal blood in the maternal circulation will be completed on the mother's post-delivery specimen.

C. If Rho (D) immune globulin is indicated, the patient will be educated and given care notes regarding indications and potential side effects.

D. The blood bank will notify the unit when Rho (D) immune globulin is available for pick-up.

E. When obtaining the Rho (D) immune globulin from the blood bank, the standard Blood Blank Transfusion Request form will be printed for patient identification.

F. The RN will confirm and sign the transfusion request form. Form is then brought to blood bank. Verification will be done by the blood bank and Perinatal unit personnel before the issuance of Rhogam by comparing the patient's name, medical record number, patient's blood type, Rhogam lot number and expiration date.

G. **Prior to administration**, verify with other licensed personnel, (the patient's name, medical record number, patient's blood type, Rhogam lot number and expiration date) the lot number on the immune globulin document with the printed lot number on the syringe

H. Complete the Rho (D) immune globulin form and place in the patient's chart under labs.

I. If the patient refuses the administration of Rho (D) immune globulin, the physician should be notified and the refusal to permit Rho (D) immune globulin document completed and placed in the patient's chart.

J. Documentation:

1. Complete the Rho (D) immune globulin form and place in the patient's chart under labs.
2. If the patient has refused administration of Rho (D) immune globulin:
    a. Complete the refusal to permit Rho (D) immune globulin document and place in chart; patient may have copy upon request

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American College of Obstetricians and Gynecologists. (2017). *Prevention of Rh D*

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alloimmunization. (Practice Bulletin No. 181).

B. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (2017). *Guidelines for perinatal care*. (8th ed.). Washington D.C.: AAP & ACOG.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	09/2024
Dept of OB/GYN	Katherine DeSalvo: Director Medical Staff Services	08/2024
Director of WCS	Julie Vasher: Director Women's & Children's Services	07/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2024
Policy Owner	Daniela Jago: Clinical Manager	07/2024

Standards

No standards are associated with this document

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Status **Pending** PolicyStat ID **16276069**

Last Approved	N/A
Next Review	3 years after approval
Owner	Megan Giovanetti: Manager Cath Lab
Area	Cardiology Departments

Scheduling: Cardiac Cath Lab

COPY

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To define the scheduling protocols which will provide optimal patient care while taking into account efficient operation of the Cardiac Cath Lab, the wellbeing of the Cardiac Cath Lab personnel, and whenever possible, the individual needs and preferences of the participating physicians.

III. DEFINITIONS

A. N/A

IV. PROCEDURE

A. General Information

- **Required Patient Data**

1. To schedule a procedure in the Cardiac Cath Lab, the physician operator or his representative will call the Cath Lab Office or request an appointment through the Sharepoint e-portal. All requests will include the following:
    a. Patient's name
    b. Social Security number
    c. Diagnosis
    d. Date of birth
    e. Insurance carrier and Authorization number if available at the

time of request

i. Authorization MUST be received before the date of procedure

f. Date and type of admission

g. Home phone number

h. The anticipated procedure to be performed

i. Any Vendors, Anesthesia or special equipment needed for the procedure

B. Scheduling

- Scheduling of procedures requiring Cardiac Cath Lab resources will be coordinated with the Cath lab Office during normal business hours. The Cath Lab is open 0730 to 1600, Monday – Friday, excluding official National Holidays.

1. Requests to perform procedures outside of these hours will be referred initially to the Senior Administrative Director/Cardiovascular Services and/or the Cath Lab Manager or Chair of the Department of Cardiology or Cath Lab Medical Director. The decision to perform studies outside the confines of the regular working day will be made with consideration toward staffing availability, clinical status of the patient and availability of alternative schedule possibilities. Provisions of laboratory time for the performance of urgent and emergency procedures are detailed below.
2. The elective schedule for the next business day will be finalized at 1300, Monday – Friday. All cases scheduled after 1300 for the current or next business day must be urgent or emergent, and scheduled with Cardiac Cath Lab clerical staff during working hours or the Senior Administrative Director (or designee when the Cath Lab is not staffed)

- Clinical Privileges to Schedule Cases

1. Only those cardiologists/physicians who have clinical privileges to perform procedures may schedule cases in the Cath Lab
    a. The physician may delegate to their office staff to schedule, cancel or amend surgical procedures.
    b. The physician is responsible for ensuring accuracy, as well as monitoring quality assurance with respect to these designees.
2. Privileges for the Cath Lab are obtained by following the procedures as stated in the Medical Staff Bylaws.
3. If there are any questions about a physician's privileges, the Medical Staff Services must be notified for clarification.

C. Case Duration

- Physician and procedure specific case duration will be estimated at the time of scheduling. Case duration is based on the Olympic mean (historical case time of last ten cases performed less the longest and shortest case time) as databased within

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the hemodynamic information system or historical case length by procedure type.

1. Case duration is based on case time (patient in room time – patient out of room plus the current practice turnover time by procedure.
2. When a physician's request for a case duration differs from the estimate provided by the hemodynamic information system:
    a. The Scheduler will document the clinical indications for the request. The request will be reviewed by the Senior Administrative Director and or Cath Lab Manager.

D. On-Time Start Performance

- Procedures are expected to start on time.
    1. The first case of the day will be at 0800 (stick time) unless other arrangements have been made and approved by the management team of the Cardiac Cath Lab. Requests to begin earlier or later than this time will be considered on an individual basis.
    2. Within reason, in cases of delayed start times of 0900 or later, accommodations will be made for physicians with earlier availability to add a case with a stick time of 0730 or 0800.
- The posted start time is defined as physician scrubbed in and time out has been performed
- The physician is to arrive in Cath Lab 10 minutes prior to the scheduled start time.
- Delays in the schedule will occur in spite of prior planning and effective facilitation of the schedule.
    1. Examples of acceptable delays include:
        a. Emergencies
        b. Patient has taken liquids or nourishment while NPO
        c. Last minute cancellations
        d. No show ambulatory patient
    2. Examples of inappropriate or unacceptable delays include:
        a. Tardiness on the part of the physician, anesthesia or Cath Lab staff
        b. Unavailable or malfunctioning equipment
        c. Lack of planning or preparations by the medical or Cath Lab staff
- First case on-time start performance will be monitored monthly and late starts will be categorized by delay reason by the Cath Lab Director or Cath Lab Manager.

E. Modified Block Scheduling

- In an effort to maximize Cath Lab efficiency through consecutive utilization of personnel and equipment, the elective case scheduling methodology is a modified

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block scheduling system.

1. Available resource hours for elective cases are defined as 0730 – 1600 Monday – Friday.
2. Staffing resources will be matched to demand.
3. Available weekday resource hours of Cath Lab time will be reserved for a physician, service or a group practice of physicians in blocks of time.
    a. Within a defined cut off period, this is time into which only the given physician, service or group practice of physicians may schedule.
    b. Block time cannot be exchanged or traded with another physician, group practice or service.

F. Block Time Allocation

- The Medical Director of Cardiology , Cath Lab Medical Director and the Senior Administrative Director of Cardiopulmonary Services has the sole authority to collaboratively allocate block time.
- Physicians are expected to petition for block time.

1. The petition must be submitted in writing to the Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services. The request is to be for no less than 4 hours of block time per week.
2. Block time requests will be evaluated based on whether there is block available on the day requested, evidence of the historical case volume of the requesting physician, the impact allocation of the block will have on inpatient and outpatient bed utilization and overall Cath lab utilization.
    a. An attempt will be made by the Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services to allocate blocks in such a manner that the schedule will be smoothed throughout the week.
3. The Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services will formally document a response to the petitioning physician request within 30 days of the physician's request.
4. A temporary block may be approved for 60 days, subject to utilization review.
5. Blocks are based on a two-week cycle.
    a. Thus, a block may be allocated to a physician, group practice or specialty every other week rather than every week.
6. Blocks will be granted as half day blocks.
    a. On designated late start days, early unused block time will be used for add-on cases and/or urgent and emergent cases.
    b. Physicians must first demonstrate that they can adequately

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utilize one half-day block prior to being granted a second half day block during the week. Preference for adjusting blocks will be given to those physicians who already occupy and have demonstrated they can utilize half-day blocks.

7. Total procedure time scheduled in block time will generally not exceed allocated block time. Exceptions will be made with the approval of the Senior Administrative Director.

G. Block Time Release

- Block time is held until three (3) business day prior to the scheduled day at 1:00pm and then released for general use if not utilized by the block physician.

Day of week Block	Monday	Tuesday	Wednesday	Thursday	Friday
Release Day 1:00 pm	Wednesday	Thursday	Friday	Monday	Tuesday

- Block time is released to first-come first served scheduling as follows:
    1. Eligibility to schedule elective cases in released block time extended to:
        a. Any physician who has not been allocated a block, Any physician who does not have block time on the scheduled day, or any physician who has completely filled his or her own block time on the scheduled day.
        b. Accommodation of urgent and emergent cases
    2. Physicians who elect to add cases after the release of block time are not guaranteed to follow themselves.
    3. In the event a case cancels after the release time and was scheduled during the allotted block time, the physician can substitute a case of equal or less duration for the canceled case if said case does not cause a resource conflict.
    4. Only case minutes performed within allocated block time will be considered in calculation of block utilization.
        a. Total allocated block time will include released block time when calculating block utilization.
    5. Physicians are responsible for notifying the Cath Lab of cancellation of block time for upcoming vacations and continuing medical education conferences.
        a. Notice is to be given in writing to the Cath Lab Director.
        b. Canceled block time will not be considered in the calculation of the physician's block time utilization when a signed and dated notice of cancellation of block time is received by the Heart Program Office greater than14 days prior to the block time.
        c. Failure to give notice of canceled block time will result in re-evaluation of block time eligibility.

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H. Block Utilization Monitoring

1. The Medical Director of Cardiology and the Senior Administrative Director of Cardiopulmonary Services have responsibility and authority for block utilization monitoring and adjustment.
    a. Decisions to adjust block time will be based on block time utilization over a rolling three-month period.
    b. Blocks will be adjusted in full block increments (i.e., half-day blocks).
2. Daily and overall block time will be monitored monthly and reported quarterly at the Cardiovascular Service line Meeting.
    a. The Cath Lab Manager or Senior Administrative Director of Cardiopulmonary Services will collect and analyze the utilization data.
    b. Greater than 75% utilization averaged over a rolling 3-month period is required to maintain block time.
    c. Block utilization is measured by the following definition: Elective procedure minutes performed in an allocated block plus the current practice turnover minutes/Allocated block minutes (including released minutes).
    d. Less than 50% utilization in any given month may result in the immediate loss of block time or a reduction in block time relative to current usage.
    e. Elective procedure minutes that occur outside the block will be tracked monthly and considered when a physician petitions for additional block time.
    f. Evening, Weekend and Holiday minutes that occur outside block time will be tracked monthly to identify trends.

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I. Bumping Protocol

- The physician who is to perform an emergency procedure contacts the Cath Lab Clerical staff when the emergency occurs during weekday resource hours.
- The physician who is to perform an emergency procedure contacts the Administrative Supervisor when the emergency occurs outside weekday resource hours.
- If it is identified that the procedure cannot be delayed and staff coverage is available within a timeframe that will not jeopardize patient safety, then the case will be placed in an empty and available Cath Lab.
- If it is identified that the procedure cannot be delayed and the existing Cath Lab schedule does not allow for it to be immediately scheduled in an empty and available Lab, a scheduled procedure in a blocked or open room will be bumped. Employing the following order:
    1. If the physician has block time at the time of the bump, he will bump himself.
    2. If the physician does not have block time, the first available room will be bumped.

3. When a physician bumps a case on his block day and the bump causes the delay of a scheduled case beyond the allocated block time, the scheduled case will be sequenced as an add-on case.

- The Senior Administrative Director, Charge RN or Cath Lab Manager will review the scheduled procedures to determine which room and procedure will be bumped.
- Direct physician-to-physician communication is mandatory for a case to be bumped
    1. The bumping physician has the authority to bump a case based on his clinical knowledge of the patient's condition.
    2. Disputes over appropriateness of the bump will be directed to the Medical Director of Cardiology for resolution.

J. Publishing the Next Day's Schedule

- The schedule will be reviewed by the management team of the Cardiac Cath Lab on the last working day prior to the anticipated procedures and the order of cases will be established. The schedule will then be posted and distributed to the hospital departments and physicians involved through the Meditech Community-Wide Scheduling Module.

K. Scheduling of Urgent Cases

- An urgent case will be defined as one in which clinical criteria indicate a need for performance of angiography or PTCA within the current hospitalization.
    1. Not elective status.
    2. Not emergency status.
    3. Procedure required without delay during same hospitalization in order to minimize chance of further clinical deterioration.
    4. Worsening, sudden chest pain, CHF, acute myocardial infarction (AMI), high risk coronary anatomy, IABP, unstable angina (USA) on intravenous (IV) nitroglycerin (NTG) or rest angina (in a stabilized patient) are examples of some such cases.

- Patients called into Admitting as urgent transfers from another facility will be given priority over scheduled/elective outpatients.
- All patients admitted or transferred from another facility to the hospital with a designation of "urgent" or "emergent" are expected to have a procedure completed within 24 hours of admission.
- These cases will ordinarily be performed at the end of the current working day. However, if the physician wishes to perform the test earlier in the day, that may be arranged with the consent of all physicians affected by the schedule change.
- The Medical Director of Cardiology or Cath Lab Medical Director may prospectively review any case designated as urgent in order to determine the authenticity of that designation. If the case does not appear to merit urgent performance, it will be scheduled according to guidelines indicated above.

L. Emergency Cases

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- An emergent case is defined as one in which undue delay in performing diagnostic or interventional studies is the Cardiac Cath Lab is likely to result in an adverse outcome for the patient (e.g., excess morbidity or mortality). Emergent cases must meet at least one of the following conditions:
    1. Ischemic dysfunction (any of the following):
        a. Evidence of ongoing ischemia including but not limited to, rest angina (despite maximal medical therapy and/or IABP);
        b. Evolving Acute Myocardial Infarction within 24 hours of Cardiac Cath Lab Procedure; or
        c. Pulmonary edema requiring intubation;
    2. Mechanical dysfunction :
        a. Shock with or without circulatory support
- This designation is the responsibility of the physician performing the study and the Cardiac Cath Lab staff or theMedical Director of Cardiology will not question the validity of that description prospectively. The appropriate use of the emergency designation may be reviewed retrospectively by the Medical Director of Cardiology and appropriate corrective measures instituted if this option is used inappropriately.
- An emergency case will be transported to the Cardiac Cath Lab as soon as possible. During the working hours, the case in progress in the Cardiac Cath Lab should be completed as quickly as possible allowing for timely transport of the emergency case. During non-operating hours, the Cardiac Cath Lab on-call team will be notified by the administrative supervisor of the need for provision of emergency services.

M. Case cancellations

- In the event a case needs to be canceled, the physician or designee will contact the Cath Lab Charge RN, department secretary or Manager during working hours to have the case removed from the schedule. After hours cancellations must be communicated to the Cath Lab charge RN. It is the responsibility of the Cath Lab charge RN to notify the Administrative Supervisor and any other caregivers/units of the cancellation.

V. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VI. REFERENCES

A. N/A

COPY

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cath Lab Medical Director	Katherine DeSalvo: Director Medical Staff Services	08/2024
Director Critical Care Services	Lacey Cone: Director Critical Care Services	08/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Megan Giovanetti: Manager Cath Lab	08/2024

Standards

No standards are associated with this document

COPY

Status **Pending** PolicyStat ID **15750945**

Last Approved	N/A	Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Next Review	3 years after approval	Area	Human Resources

Tuition Assistance

COPY

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) provides a tuition assistance for approved educational programs to facilitate regular full-time and part-time employees to participate in advancement opportunities within SVHMC.

II. PURPOSE

A. The purpose of this policy is to set forth the process for requesting and receiving tuition assistance related to pursuit of an Associate's, Bachelor's, or Master's. degree.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. The monies will be used exclusively for tuition.

B. Tuition will be reimbursed at the completion of each course/semester subject to the agreement and reimbursement processes.

V. PROCEDURE

A. Eligibility

1. Regular full-time and regular part-time employees are eligible for consideration.
2. Approval of request will be based on the following:
    a. Performance at satisfactory level as documented in the performance

evaluation.

b. No active disciplinary action in personnel file

i. If an employee is approved for the tuition assistance program and receives disciplinary action during the course of the semester, tuition reimbursement will be declined for the period of time on active discipline.

3. If an employee terminates employment either voluntarily or involuntarily prior to completion of an approved course of study, the employee's eligibility for tuition reimbursement will terminate with the termination of his or her employment.

B. Application Agreement

1. Eligible employee must submit a completed Tuition Assistance Agreement to the Department Director prior to course start date. Incomplete applications will not be accepted.

C. Process for Application for Tuition Reimbursement

1. Tuition reimbursement limit is subject to the annual IRS limit per educational year based on a start date of semester/course with a total reimbursement limit of $10,000 during the course of employment. Eligible expenses: tuition expenses not covered by scholarships, military coverage or non-repayable grants. An itemized receipt for tuition expenses and payments must be submitted to Human Resources.
2. An official school transcript verifying course completion with a grade of "B" or higher must be submitted to Human Resources.
3. Tuition reimbursements generally meet the requirements for exclusion from income as a Working Condition Fringe Benefit under IRC §132(d). As of January 2018, reimbursements under the policy will not be subject to payroll tax withholding, with some exceptions.

D. Documentation:

1. Appendix A: Agreement
2. Appendix B: Reimbursement Application Form

VI. EDUCATION AND TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Attachments

COPY

2024 Tuition Assistance Application.pdf

2024 Tuition Reimbursement Request Form.pdf

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	06/2024

Standards

No standards are associated with this document

COPY

QUALITY AND EFFICIENT PRACTICES COMMITTEE

Minutes of the Quality and Efficient Practices Committee will be distributed at the Board Meeting

(CATHERINE CARSON)

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

Minutes of the
Personnel, Pension and Investment Committee
will be distributed at the Board Meeting

Background information supporting the
proposed recommendations from the
Committee is included in the Board Packet

(JUAN CABRERA)

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

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Divya Kishore, MD, (ii) Contract Terms for Dr. Kishore's Recruitment Agreement, and (iii) Contract Terms for Dr. Kishore's Mammography and Diagnostic Imaging Professional Services Agreement**

Executive Sponsor: Orlando Rodriguez, MD, SVH Clinics Chief Medical Officer
Gary Ray, Chief Legal Officer

Date: September 9, 2024

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of a radiologist specializing in **Mammography and Diagnostic Imaging** as a recruiting priority for SVH's service area. The current volumes of required diagnostic and breast imaging reads and mammography procedures require adding radiologists to the group. Increasing on-site radiologist coverage will decrease the demand for remote, after-hours reading services. Furthermore, the recent resignation of a full-time breast-imaging radiologist has emphasized the need for additional mammography coverage.

The recruited physician, **Divya Kishore, MD**, attended Harvard College for her undergraduate degree and received her Doctor of Medicine degree from Emory University School of Medicine in 2019. After completing her transitional year residency at Wellstar Kennestone Hospital, Dr. Kishore returned to Emory University for her Diagnostic Radiology Residency and Breast Imaging Fellowship. Dr. Kishore will be completing her training next summer and will join SVH Clinics in September 2025.

Terms and Conditions of Agreements

The proposed physician recruitment requires the execution of two types of agreements:

1. **Professional Services Agreement** Essential Terms and Conditions:

The proposed professional services agreement includes the following terms:

- Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, the physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
- Schedule. Physician shall provide full-time radiologist services to SVH patients forty scheduled weeks per year five days per week in an SVH Facility during normal business hours. This schedule includes coverage either on-site or remote one-half day each on Saturday and Sunday of every fifth weekend for Diagnostic Radiology Services.
- Compensation.
  - Base compensation of $625,000 per year
  - Extra shift compensation for shifts worked in excess of the schedule set forth above in the amount of $3,125.00 per one day shift, prorated at the amount of $390.00 per hour in the event you work less than a full shift.
- Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.

- Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
  - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
  - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
  - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.

2. **Recruitment Agreement** that provides a recruitment incentive of $50,000 which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of Dr. Kishore is aligned with our strategic priorities for the service, quality, and growth pillars. We continue to develop Salinas Valley Health Clinics infrastructure that engages our physicians in a meaningful way, promotes efficiencies in care delivery and creates opportunities for expansion of services. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by opening up access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Kishore to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for the SVH radiology service line.

The compensation proposed in these agreements have been reviewed against published industry benchmarks to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

Salinas Valley Health Administration requests that the Personnel, Pension and Investment Committee recommend to the Salinas Valley Health Board of Directors approval of the following:

1. **The Findings Supporting Recruitment of Divya Kishore, MD:**
   - That the recruitment of a mammography and diagnostic imaging radiologist to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
2. **The Contract Terms of the Recruitment Agreement for Dr. Kishore; and**
3. **The Contract Terms of the Mammography and Diagnostic Imaging Professional Services Agreement for Dr. Kishore.**

Attachments: Curriculum Vitae for Divya Kishore, MD

DIVYA KISHORE, MD

EDUCATION

Emory University School of Medicine, Atlanta, GA, 2020-2024
Diagnostic Radiology Resident, Clinical Education Track

Wellstar Kennestone Hospital, Marietta, GA, 2019-2020
Transitional Year Resident

Emory University School of Medicine, Atlanta, GA, 2015-2019
MD, Medicine

Harvard College, Cambridge, MA, 2009-2013
Bachelor of Arts in History and Science, High Honors

WORK EXPERIENCE

Beth Israel Deaconess Medical Center, Department of Neurology, Boston, MA, *Clinical Research Assistant I*, 2014- 2015
Collected and analyzed data for a study investigating the effects of obstructive sleep apnea and CPAP treatment on sleep-enhanced memory consolidation, as well as the role of the ApoE-e4 gene, for an NIH-funded research study.

Trinity Partners, LLC, *Associate Consultant*, Waltham, MA, 2013-2014
Conducted quantitative and qualitative market research for multiple projects to identify unmet medical needs. I worked with teams to forecast drug concept sales using data analytics, and recommend business solutions to clients, which included pharmaceutical companies and medical device manufacturers.

EDUCATION AND MENTORSHIP EXPERIENCES

Clinical Education Track, Department of Radiology Residency
- Deliver introductory lectures to first year radiology residents and medical students
- Created introductory modules on radiographic interpretation for third year medical students
- Work with faculty advisors to design a new radiology curriculum for medical students, including interactive, case-based experiences

5th Annual Medical Student Teaching Competition Finalist, Emory University, 2018
- Awarded audience-elected "Lightbulb Moment" award for excellence in teaching
- Delivered 8-minute presentation on medication-assisted therapy for opioid addiction
- Invited to deliver talk to Emory's internal medicine residents

Peer Mentor, Endocrine and Reproductive Systems Module, Emory University, 2018
- Led problem-based learning sessions for second-year medical students

Emory Radiology Virtual Textbook Project, Emory University, 2018
- Worked with Dr. Fred Bertino to compile radiology teaching cases, edit and consolidate case files designed to teach pathology and basic imaging to medical students

Volunteer Tutor, Beth Israel Deaconess Medical Center, 2014-2015
- Tutored employees enrolled in Introductory Biology and English Reading and Writing for Non-native Speakers courses, Bunker Hill Community College

Peer Advising Fellow, Eagle Peer Advisor, Harvard College, 2010-2013
- Served as a personal and academic mentor to 6-8 freshmen each year, worked on a team of advisors to serve as a resource to a larger group of 18-30 freshmen
- Chosen as one of 8 student leaders of the Peer Advising Program (known as "Eagles") chosen to mentor and lead trainings for 189 Peer Advisors, and improve advising resources available to freshmen

- Served on committees alongside faculty to plan College's Opening Days and award prizes to distinguished faculty members, and interviewed candidates for a College Resident Dean position

PUBLICATIONS

Kishore, D.; Horny, Michal.; Rosenkrantz, A.B.; Hemingway, J.; Hughes, D.R.; Duszak, R. *State-Level Variation in Inferior Vena Cava Filter Utilization Across Medicare and Commercially Insured Populations.* American Journal of Roentgenology. 2019; 212:1385-1392.

Trofimova, A.; **Kishore, D.;** Urquia, L.; Tewkesbury, G.; Duszak, R.; Levy, Matthew.; Kadom, N. *Imaging Utilization in Children with Headaches: Current Status and Opportunities for Improvement*. Journal of the American College of Radiology. 2020; Vol 17. Iss. 5, P574-583.

Tharp, K.; Santavicca, S.; Hughes, D.R.; **Kishore, D.;** Banja, J.D.; Duszak, R. Jr. *Characteristics of Radiologists Serving as Medical Malpractice Expert Witnesses for Defense Versus Plaintiff.* Journal of the American College of Radiology. 2022; Vol 19. Iss.7, P807-813.

Cunningham, T. J.; **Kishore, D.;** Guo, M.; Igue, M.; Malhotra, A.; Stickgold, R.; & Djonlagic, I. (2022). The Effect of Obstructive Sleep Apnea on Sleep-Dependent Emotional Memory Consolidation. *Annals of the American Thoracic Society*, 10.1513/AnnalsATS.202204-315OC. Advance online publication.

HONORS AND AWARDS

Internal Medicine Outstanding Quality Improvement/Patient Safety Project for 2019-2020, "Releasing Orders for Boarded Patients in the Emergency Department", Wellstar Kennestone Hospital, 2020

"Lightbulb Moment" Award, 5th Annual Medical Student Teaching Competition Finalist, Emory University, 2018

Senior Honors Thesis, "*Apricots, Cancer, and the Politics of Choice: The Laetrile Controversy"*, on Cancer Treatment Trial and FDA Policy; Thesis Grade: Magna Cum Laude Plus, 2013

George H. Handelman Prize for leadership in undergraduate House Life, Harvard College 2013

ORAL PRESENTATIONS

D Kishore. *Apricots, Cancer, and the Politics of Choice: The Laetrile Controversy*. J. Willis Hurst Annual Symposium 2016, Emory University, Atlanta, GA.

POSTER PRESENTATIONS

Kishore D, Parikh A, Riedesel E, Richer E. *SARS COV-2 in Children: Review of Imaging Findings*. International Pediatric Radiology Congress Annual Meeting 2021, Rome, Italy.

Kishore D, Tuburan S, Hamlin S, Christie R, Herr K. *Timely and Relevant: Innovating Daily Resident Feedback With an Integrated System Form Application*. Association of University Radiologists Annual Meeting 2021, Virtual.

Kishore D, Horny M, Hughes D, Rosenkrantz A, Duszak, R. *Declining Utilization of IVC Filters: State Level Commercial Claims Perspectives from 2009-2015*. American College of Radiology Annual Meeting 2018, Washington, DC.

Kishore, D, Hughes, D, Rosenkrantz, A, Duszak, R. *State Level Variation in IVC Filter Utilization in the Medicare Population from 2005-2015: National Trends Do Not Tell the Whole Story*. American College of Radiology Annual Meeting 2018, Washington, DC.

D Kishore, D Liu, J Cheeley. *A Case of Erythroderma in a Patient Under Duress: Staph, Plaquenil and DRESS*. Southern Hospital Medicine Conference 2017, New Orleans, LA.

D Kishore. *Apricots, Cancer, and the Politics of Choice: The Laetrile Controversy*. American Association for the History of Medicine Annual Meeting 2017, Nashville, TN.

Kishore D, Guo M, Igue M, Malhotra A, Stickgold R, Djonlagic I. Beth Israel Deaconess Medical Center, Boston, MA. *The Effect of Sleep Apnea on Emotional Memory*. SLEEP Annual Meeting 2015, Seattle, WA.

Tucker MA, Williams J, Tartaglia J, **Kishore D**, Stickgold R. Harvard Medical School, Boston, MA, USA. *Does Sleep Really Benefit Insight Formation?* SLEEP Annual Meeting 2012, Boston, MA.

ABSTRACTS

Tharp K, Santavicca S, **Kishore D**, Hughes D, Duszak R. *Characteristics of Radiologist Expert Witnesses Serving for Defense vs. Plaintiff*. American Roentgen Ray Society Annual Meeting 2022, New Orleans, LA.

D Kishore, L Urquia, K Kim, A Trofimova, N Kadom. *Radiographs in Pediatric Headache*. ASNR Annual Meeting 2017, Long Beach, CA.

L Urquia, **D Kishore**, K Kim, A Trofimova, N Kadom. *CT Imaging for Pediatric Headache*. ASNR Annual Meeting 2017, Long Beach, CA.

A Trofimova, K Kim, **D Kishore**, L Urquia, N Kadom. *Headache Imaging in Children: When and How?* ASNR Annual Meeting 2017, Long Beach, CA.

K Kim, L Urquia, **D Kishore**, A Trofimova, N Kadom. *Issues with determining appropriateness of MR imaging in pediatric headache.* ASNR Annual Meeting 2017, Long Beach, CA.

BLOG POSTS/ONLINE PUBLICATIONS

"Nobody Left", 55 Words, *Emory Medicine Magazine*, January 5, 2018. http://emorymedicinemagaz ine.emory.edu/issues/2018/winter/briefs/fifty-five-words/index.html

“Research Subjects”, *Doctors Who Create*, May 5, 2015. http://www.doctorswhocreate.com/research-subjects/

LEADERSHIP POSITIONS

Society of Skeletal Radiology, Resident Scholar, 2022

- Selected to serve as a resident representative for the Society of Skeletal Radiology.
- Awarded scholarship to attend the 2022 annual SSR meeting, and participate in hands-on ultrasound training sessions.
- Create educational syllabi on a range of topics to serve as a resource for residents and medical students.

ACR Education Subcommittee, Representative, 2021

- Collaborate with residents across the country to create a consortium of student-level cases with recorded read-outs for medical students, with the goal of increasing engagement on radiology rotations and augmenting the reading room 'shadowing' experience.

Post-COVID Innovation Task Force, Resident Representative, Clinical Subcommittee, 2021

- Collaborate with faculty and staff to examine how the Department of Radiology will adapt to clinical, staffing, and education challenges that arose in the COVID-19 pandemic.

Emory University School of Medicine:

Emory Radiology Interest Group, President, 2018-2019

- Served as a liaison between the Department of Radiology and Emory's medical student body.
- Worked with department faculty and staff to design the first annual "Introduction to Radiology" event for incoming medical students.
- Managed outreach for the 2018 Annual Medical Student Symposium (attended by 40 medical students across Georgia) by connecting with faculty and students from neighboring Georgia schools.

Student Representative, Diversity and Inclusion Committee, Emory University Department of Radiology, 2018-2019

M3 Representative, Mosaic Initiative, 2017-2019

- Worked with members of each medical school class, surgery residents, and faculty advisors to create a program that aims to bolster student resilience, destigmatize mental health issues, and connect students to mental health resources.
- Crafted IRB protocol to study effects of Mosaic programming on student mental health.

Co-President, American Medical Association's Emory University Chapter, 2016-2017.

- Represented Emory student body during AMA leadership site visits and in AMA student chapter legislation.
- Worked with Emory's Healthcare Innovation Program to review student seed grants.
- Organized and moderated discussions with visiting lecturers, including deans from Stanford and Duke University, on topics including geriatric care, quality improvement, and trends in medical education.

Lister Society Council Small Group Representative, 2015-2019

- Elected as small group representative to Society Student Government. Planned and moderated guest lecture by Pulitzer-Prize winning playwright for discussion on terminal illness and physician- patient relationship.

Harvard College:

EAGLE Peer Advisor, Harvard College Advising Programs Office, 2011–2013 (8 selected from all Peer Advisors to lead advising training, address freshmen's parents, and conduct interviews for selection to the program).

Harvard College Peer Advising Fellow, 2010–2013 (mentor to incoming freshmen).

The Seneca, Inc., Member, 2011-2013 (group dedicated to women's issues and outreach; membership by invitation).

Harvard Student Mental Health Liaison 2009-2011 (Led freshman workshops on mental health issues; connected students to mental health resources).

Harvard College in Asia Program, Vice Chair of Conference Committee 2010-2011 (planned week-long conference on "Global Healthcare: Changing Landscapes"; attended conference at Hong Kong University to study Hong Kong healthcare system).

Harvard Dharma, Discussion Chair, 2010–2011 (Hindu Philosophical Organization).

COMMUNITY SERVICE

- Spear-headed school-wide cold weather clothing drive for Clarkston Community Clinic patients, November 2016.
- Volunteered at a number of student-run clinics, including Harriet Tubman Women's clinic, Clarkston Community Clinic, and Open Door Community clinic, 2015 – 2016.
- Volunteer tutor for Beth Israel Deaconess Medical Center employees enrolled in Introductory Biology and English Reading and Writing for Non-native Speakers courses, Bunker Hill Community College, 2014 – 2015.
- Volunteer, "Pets as Therapy" program at Cambridge Rehabilitation and Nursing Center, 2011- 2013.

SKILLS

- Proficient with Microsoft Excel
- CITI trained for Social and Behavioral Research, Biomedical Research
- BLS and ACLS certified

HOBBIES/PERSONAL INTERESTS

Vinyasa yoga, baking, gardening.

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of Contract Terms Maryam Jalali, MD's Pediatrics Professional Services Agreement**

Executive Sponsor: Orlando Rodriguez, MD, SVH Clinics Chief Medical Officer
Gary Ray, Chief Legal Officer

Date: September 9, 2024

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment and retention of physicians specializing in **Pediatrics** as a priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, pediatrics specialties were recommended as top priorities for recruitment. Recruiting and retaining pediatricians will continue to support hospital call coverage for the well-newborn, and pediatric hospital call panels.

Maryam Jalali, MD, has been a member of Salinas Valley Health Medical Staff providing pediatric services in her private practice since 1996. Dr. Jalali is certified by the American Board of Pediatrics and holds an active California license. Dr. Jalali plans to close her private practice and join SVH PrimeCare in November 2024.

Terms and Conditions of Agreements

The proposed physician recruitment requires the execution of two types of agreements:

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, the physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Full-Time Schedule. Physician will be scheduled to provide physician services to clinic patients on a full-time basis, 46 weeks per year; one week of which can be allocated to continuing medical education (CME).
   - Base Compensation: $275,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $51.00 wRVU conversion factor.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Six weeks (30 days) of time off each calendar year.
     - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

The addition of Dr. Jalali to SVH Clinics is aligned with our strategic priorities the service, quality, and growth pillars. We continue to develop Salinas Valley Health Clinics infrastructure that engages our physicians in a meaningful way, promotes efficiencies in care delivery and creates opportunities for expansion of services. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by improving access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Jalali to Salinas Valley Health Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH PrimeCare.

The compensation proposed in these agreements have been reviewed against published industry benchmarks to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

Salinas Valley Health Administration requests that the Personnel, Pension and Investment Committee recommend to the Salinas Valley Health Board of Directors approval of the Contract Terms of the Pediatrics Professional Services Agreement for Maryam Jalali, MD.

Attachments: Curriculum Vitae for Maryam Jalali, MD

MARYAM JALALI, M.D.
FAAP

POST GRADUATE TRAINING

EHS Christ Hospital/University of Illinois
Department of Pediatrics
4440 W. 95th Street, Oak Lawn, Il 60453
July, 1995 to July, 1996
Pediatric Residency
Third Year

Martin Luther Kinq/Drew Medical Center
Department of Pediatrics
12021 S. Wilmington Ave., Los Angeles. co. 90059
June, 1993. to June. 1995
Pediatric Internship/Residency

University of California, Irvine
Dept. of Internal Medicine, Div. or Nephrology
101 City Drive South, Orange, Ca. 92668
Nov 1992-May 1993
Fellowship Research

MEDICAL EDUCATION

University of Health Sciences--Antigua, West Indies — MD. 8/1987-9/1991

UNDERGRADUATE EDUCATION

University of Missouri, Columbia

Post-graduate work In Pharmacology-PhD Program

Medical Technology Program, Board certified 1983-1987

LICENSURE AND CERTIFICATION

1996-to present

American Board of Pediatrics
California Licensure. Physician and Surgeon 1996 to present
Certification: American Society of Clinical Pathologists

HONORS AND AFFILIATIONS

American Academy of Pediatrics
American Board of pediatrics
Lamda Tau, National Medical Technology Honor Society
International Student Grant Recipient, University of Missouri-Columbia

EMPLOYMENT

Salinas Valley Pediatric associates

221 E. Romie Ln. Salinas, CA 93901 8/2005 to present

Salinas Pediatric Medical Group, Inc. 8/15/1996 to 7/2005

505 E. Romje Lane, Suite K Salinas, Ca 93901

University of Missouri-Columbia

Medical Technologist, Hematology Laboratory	1986-1987
Laboratory Technician, Phlebotomist	1984 to 1986

Participations in Committees at SVH to present
QI committee /pediatrics
Education committee
Vice chair pediatrics
Chair of pediatrics
Credential committee
PEG/physician electronic medical record governance committee

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Benjamin Berthet, DO, (ii) Contract Terms for Dr. Berthet's Recruitment Agreement, and (iii) Contract Terms for Dr. Berthet's Internal Medicine and Pediatrics Professional Services Agreement**

Executive Sponsor: Orlando Rodriguez, MD, SVH Clinics Chief Medical Officer
Gary Ray, Chief Legal Officer

Date: September 9, 2024

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of physicians specializing in **Internal Medicine and Pediatrics** as a recruiting priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, primary care and pediatrics specialties were recommended as top priorities for recruitment. Recruiting an internal medicine and pediatrics physician will provide additional hospital call coverage for well-newborn, and pediatric hospital call panels as well as increase primary care clinic access at SVH PrimeCare.

The recommended physician, **Benjamin Berthet, DO**, received his Doctor of Osteopathic Medicine degree in 2019 from AT Still University in Arizona. In June 2024, Dr. Berthet completed his Internal Medicine and Pediatrics residency training at the University of South Florida Morsani Program in Tampa, Florida. Dr. Berthet, a California native raised in Los Gatos, will be relocating to Monterey County where his retired parents reside and will join SVH PrimeCare in January 2025.

Terms and Conditions of Agreements

The proposed physician recruitment requires the execution of two types of agreements:

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, the physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Full-Time Schedule. Physician will be scheduled to provide physician services to clinic patients on a full-time basis, 46 weeks per year; one week of which can be allocated to continuing medical education (CME).
   - Base Compensation: $300,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $51.00 wRVU conversion factor.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Six weeks (30 days) of time off each calendar year.
     - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.

2. **Recruitment Agreement** that provides a recruitment incentive of $50,000, which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

The recruitment of Dr. Berthet is aligned with our strategic priorities the service, quality, and growth pillars. We continue to develop Salinas Valley Health Clinics infrastructure that engages our physicians in a meaningful way, promotes efficiencies in care delivery and creates opportunities for expansion of services. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by improving access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Berthet to Salinas Valley Health Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH PrimeCare.

The compensation proposed in these agreements have been reviewed against published industry benchmarks to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

Salinas Valley Health Administration requests that the Salinas Valley Health Board of Directors approve of the following:

1. **The Findings Supporting Recruitment of Benjamin Berthet, DO:**
   - That the recruitment of Internal Medicine and Pediatrics to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
2. **The Contract Terms of the Recruitment Agreement for Dr. Berthet; and**
3. **The Contract Terms of the Internal Medicine and Pediatrics Professional Services Agreement for Dr. Berthet.**

Attachments: Curriculum Vitae for Benjamin Berthet, DO

Benjamin Berthet, DO

EDUCATION

University of South Florida Morsani College of Medicine *Tampa, FL*
- Residency, Internal Medicine/Pediatrics, 2020-2024
    - Tampa General Hospital, James A. Haley VA, Moffitt Cancer Center, Johns Hopkins All Children's

A.T. Still University, School of Osteopathic Medicine in Arizona (ATSU-SOMA) *Mesa, AZ*
- Doctor of Osteopathy, 2020
- Fellowship, Pre-Doctoral Osteopathic Teaching, 2019

University of California, San Diego *La Jolla, CA*
- Bachelor of Science in Physiology and Neuroscience, 2014

RESEARCH EXPERIENCE

Research Associate *01/2021-Present Tampa, FL*

"*Osteopathic Manipulative Treatment in Permanent Atrial Fibrillation: A Pilot Study"*
- Initiated and developed a pilot study to examine the effect of OMT on permanent atrial fibrillation in coordination with a cardiologist and his research team at the James A. Haley VA

Principal Investigator *08/2018-04/2019 Mesa, AZ*

"Case Report: Self-reversal of Haglund's deformity with optimization of pelvis alignment"
- Resolution of Achilles tendinitis with Haglund's deformity using OMT alternative to surgery

Principal Investigator *A.T. Still University, SOMA ,08/2016-05/2017 Portland, OR*

"Using Resilience Training Curriculum in High School Students To Reduce The Consequences of Adversity"
- Designed and delegated eight medical students to teach resilience skills to high school students to prevent and reduce consequences of Adverse Childhood Experiences (ACEs)

Laboratory Associate *Salk Institute, 09/2011-06/2014 La Jolla, CA*
- Designed, programmed and analyzed theoretical neuroscience experiments on how visual receptive fields change with context

PUBLICATIONS

Author, *Similar Differences*, 2017
- 360-page book examining cross-cultural individual and collective thought and behavior. Dual Finalist for Multicultural Non-Fiction in the 2018 International Book Awards and 2018 Best Book Awards

AMA Medical Education Innovation, 2015
- Abstract after leading an inter-professional team to design and submit Patient Inspired Education to optimize medical education delivery

POSTERS AND ORAL PRESENTATIONS

Using Resilience Training Curriculum in High School Students To Reduce The Consequences of Adversity *AZ*
- Oral Presentation National Association of Community Health Centers (NACHC) CHI Fall 2017

- Poster Presentation NACHC CHI Fall 2017 and AOMA Conference, Spring 2017

Interprofessional Education Collaborative Case: Human Healthcare System AZ
- Collaboratively designed a Human Healthcare System model as a communication model
- Oral Presentation ATSU Fall 2015 with recognition for patient-centered care and presentation

LEADERSHIP

Citizens Anonymous: Bettering our selves and communities in 12 Steps, 2019 *AZ*
- Developing a new, 12-step program as a ~20-hour curriculum combining healthier social understanding with osteopathy to help people cope with the stress of 21st Century society

Academic Writing Intern for Osteopathic Family Physician Journal, 2018
- Performing academic peer review of submitted articles and assist in selecting articles for publication

D.O. Day at the Hill (2016) and State Legislature (2016, 2019) *Washington D.C. & Phoenix, AZ*
- Advocated medical policy to State and National Senators and House Representatives

Interprofessional curriculum, Trauma-Informed Care and ACEs, 2017 *Portland, OR*
- Adapted a curriculum to present at ATSU-SOMA for interprofessional development

Innovative Challenge, 2017 *Portland, OR*
- Advancing Care for Patients living with metastatic breast cancer. Designed Ensemble, a therapeutic online community for metastatic breast cancer patients

Betty Ford Center Summer Institute for Medical Students, 2016 *Center City, MN*
- Shadowed patients with addiction through recovery and attended daily lectures for a week

TEACHING EXPERIENCE

Residency, Teaching
- Presented 9 case conferences and board reviews

Fellowship, Teaching and OMM
- Created, prepared, and delivered lectures to 1st year medical students on Fascia, Science and Art of Osteopathy, Visceral OMM, and Autonomic OMM, and a 10-podcast series on OMM basics
- Treated own patient panel and worked with four other DOs with their patients
- Interprofessional discussion mediator between DO, PA, PT, Admissions Departments, and students for shared room use
- Hosted review and tutoring sessions
- Process improvement for overall course and Powerpoint organization
- Reviewed osteopathic texts and Harvard basic science modules as they pertain to OMM
- Interprofessional educator of osteopathy to PA program

Point-of-Care-Ultrasound
- Practiced in 5 Faculty Development courses and led 20+ sessions for 1st-year medical students

FELLOWSHIP COURSES IN OSTEOPATHIC MANIPULATIVE MEDICINE

- Biodynamics Pediatrics (24 hours)
- Biodynamics Phases 1 and 3 (48 hours)

- American Academy of Osteopathy Convocation (5 day conference)
- Biodynamics Anatomy 101 (24 hours)
- Introduction to Cranial (40 hours)
- Biodynamics Pediatrics (30 hours)

Events

- 2020-2023, Refugee Clinic, Dover Clinic (Migrant workers), Wimauma Clinic (Migrant workers), Lifestyle Medicine and Food as Medicine course
- 2019, HopeFest Phoenix (Screenings), Arizona, Japanese Friendship Garden (Gardening)
- 2018, Tzu Chi Health Fair (OMM), Arizona
- 2017, Binational Health Fair (Screenings), Oregon, Homeless shelter (Serving food), Oregon, High school student advising, Elementary student presentation, Alaska
- 2016, 8-week CBT Fall Prevention Course to seniors, Adelante Health Clinic Fair (Screenings), Arizona
- 2015, 4-weekly CHF lifestyle counseling, ACT Kids Health Fair Arizona, Pre-med mock MMI, Arizona
- 2014, 2-month village medical assistant & private school teacher grades 1-10 in Amarapuri, Nepal
- 2012, 1-week village primary care under physician supervision in May Pen, Jamaica

AWARDS

- COSGP Translating Osteopathic Understanding into Community Health 50 hours, 2016
- Student Osteopathic Medical Association New Member Scholarship for vision, 2015

PROFESSIONAL MEMBERSHIPS

- Florida Osteopathic Medical Association
- Hillsborough County Medical Association
- National Med-Peds Residents Association
- American Academy of Pediatrics Sections on Med-Peds and Osteopathic Pediatricians
- American College of Physicians
- American College of Osteopathic Internists
- American Osteopathic Association

CONFERENCES

- 2022, 2023: Osteopathic Medical Education Conference
- 2019: Northeast Regional Med-Peds Conference, American Academy of Osteopathy Convocation
- 2018: Northwest Regional PCA Fall Conference for Primary Care, Osteopathic Medical Education Conference, Warrior Spirit: Calling Upon the Ancestors to Heal Historical Trauma Conference
- 2017: Arizona Osteopathic Medical Association, National Association for Community Health Centers Community Health Institute
- 2016: Northwest Regional PCA Fall Conference for Primary Care, Osteopathic Physicians and Surgeons of Oregon, Arizona Osteopathic Medical Association

LANGUAGES

- English (fluent), French (fluent)

HOBBIES

- Exploring the outdoors by hiking, running, or biking, frisbee, traveling, movies, several genres of music, keeping up with current events, socializing with friends

FINANCE COMMITTEE

Minutes of the Finance Committee
will be distributed at the Board Meeting

Background information supporting the
proposed recommendations from the
Committee is included in the Board Packet

(JOEL HERNANDEZ LAGUNA)

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

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board of Directors Approval to Award Construction Contract to FTG Builders for the 2nd Floor Office Expansion of the Monterey Bay G.I. Consultants Medical Group Office Space at 212 San Jose Street Suites 201 and 202**

Executive Sponsor: Gary Ray, Chief Legal Officer

Date: August 23, 2024

Executive Summary

SVMHS and Monterey Bay G.I. Consultants Medical Group have been partners in the endoscopy center, Monterey Bay Endoscopy LLC, since February of 2018. In 2019, SVMHS acquired 212 San Jose Street which had ambulatory surgery suites on the first floor in suite 100 and administrative office space that could be reconfigured into medical office space on the second floor in suite 200. The success of the endoscopy center and the GI practice has resulted in a need to expand administrative support (office) areas to allow the practice to maximize its potential. Suites 201 and 202 (the balance of available tenant space on the 2nd floor) will be leased to Monterey Bay GI Consultants Medical Group, Inc. under a current fair market value lease agreement.

Background/Situation/Rationale

The project includes tenant improvements in two unfinished suites in an existing building located at 212 San Jose Street, Salinas CA for the Monterey Bay G.I. Consultants Medical Group to increase office space on the second floor. The improvements for the second level consist of a B occupancy type and do not have any special regulatory agencies involving beyond the City of Salinas planning, building, and fire departments. The cost of the tenant improvements will be amortized over the term of the lease agreement.

SVMHS publicly advertised a request for contractor bids to complete the construction services required for the project. The advertisement was circulated in the Californian and Central Coast Builder's Exchange. In addition, SVMHS performed a bid outreach to attract qualified general contractors and subcontractors in the local and regional area. A challenge with the project is the operational need to execute the work in an abbreviated timeframe. At the close of bid period on July 26, 2024 a single responsive bid from FTG Builders was received and publicly opened (Attachment 1). After staff review of the bid package submitted, SVMHS identified FTG Builders as the lowest responsible, responsive bidder. During review of the published bid elements that comprised the bid, Contractor and Owner Representation agreed value engineering efforts could reduce the bid price of $829,916 by $75,000 or more. The request to the Board is to authorize the award on the construction agreement to FTG Builders in an amount **Not-To-Exceed $754,916.00**, subject to confirmation of buy-out targets with their subcontractors and suppliers.

Timeline/Review Process to Date

September 2024 - Anticipated construction commencement
November 2024 - Project completion

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

This transaction is aligned with the strategic initiatives outlined in our most recent strategic planning work for growth, in developing partnerships that drive value for our patients.

Pillar/Goal Alignment

☐ Service ☐ People ☐ Quality ☑ Finance ☑ Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications

Key Contract Terms	Vendor: FTG Builders
1. Proposed effective date	Issuance of Notice to Proceed anticipated on September 9, 2024
2. Term of agreement	75 calendar days
3. Renewal terms	Not Applicable
4. Termination provision(s)	Provided in Bid Specifications-Part 12 of General Conditions- Section 007000
5. Payment Terms	Lump Sum
6. Annual cost	Not-To-Exceed $754,916.00
7. Cost over life of agreement	Not Applicable
8. Budgeted (indicate y/n)	Yes. Reference project budget estimate information.

Recommendation

Recommend to the SVH Board of Directors to award FTG Builders the contract for construction of the Monterey Bay G.I. Consultants Medical Group office space expansion at 212 San Jose Street 2nd Floor in an amount Not-To-Exceed $754,916.00

Attachments

- Attachment 1: Bid Package – July 26, 2024
- Attachment 2: Estimated Project Cost - August 12, 2024

BID LETTER

FOR THE SVH MBay GI Office Expansion Project at 212 San Jose 2nd Fl, Salinas CA

Pursuant to the Notice Inviting Bids, the undersigned bidder herewith submits a bid on the Bid Forms attached hereto and made a part hereof and binds itself on award by the Salinas Valley Memorial Health Care System under this bid to execute a Contract in accordance with its bid and the Contract Documents.

The Notice Inviting Bids, Instructions to Bidders, General Requirements, Supplementary Conditions, Technical Specifications, Appendices, Contract Drawings, and Addenda, if any, are made part of this bid and all provisions thereof are hereby accepted, and all representations and warranties required thereby are hereby affirmed.

This offer shall be irrevocable for a period of ninety (90) days after the date on which bids are opened.

The undersigned bidder understands that any clarification made to the above or any new and different conditions or information submitted on or with its Bid Forms, other than that requested, may render the bid non-responsive.

The undersigned, as bidder, declares that the only persons or parties interested in this bid as principals are those named herein; that this bid is made without collusion with any other person, firm or corporation and in submitting this bid, that it has carefully examined the location of the proposed work, the attached proposed form of contract, and the plans, specifications and the other Contract Documents; and agrees if this bid is accepted, that it will contract with SVMHS, on the form of contract included with these specifications, to provide all necessary labor, materials, equipment, machinery, apparatus and other means of construction, and to do all the work specified in the Contract Documents, in the manner and time therein prescribed, and according to the requirements of the Owner's Designated Representative as therein set forth, and that he will accept all full payment therefore based on the item prices set forth in its Schedule of Bid Prices.

The prices included within the Schedule of Bid Prices include all costs for labor, materials, tools, equipment, services, subcontractors, suppliers, taxes, insurance, shipment, delivery, overhead, profit and all other costs necessary to perform the work in accordance with the Contract Documents.

The undersigned bidder acknowledges receipt, understanding, and full consideration of the following addenda to the Contract Documents:

ADDENDA NOS. (if none, so state): NONE

Name of Bidder: FTG Builders Inc.

Business Address: 1565 Lafayette Street
Santa Clara, CA 95050

Phone: (669) 231-0010 Fax: _____

Contractor's License No. # 754647

License Expiration Date 04/30/2025

Classification Type A - General Engineering, B - General Building

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
SVH MBay GI Consultant Office Expansion TI
SCHEDULE OF BID PRICES

BASE BID PRICE:

Contractor shall provide all materials, labor, tools, equipment and superintendence necessary to complete this project as indicated on the construction documents for the following amount:

$ 829,916.00

END OF SECTION 00 41 00

SECTION 00 41 00

SCHEDULE OF BID PRICES

2.01 GENERAL INSTRUCTIONS

A. Bidders are directed to submit a lump sum price for all Work set forth in the Contract Documents in the space for the "Base Bid" amount in the Schedule of Bid Prices. This lump sum shall include all costs for labor, materials, tools, equipment, services, subcontractors, suppliers, taxes, insurance, shipment, delivery, overhead, profit and all other costs necessary to perform the Work in accordance with the Contract Documents.

B. If applicable, unit prices and lump sum prices must be entered in the appropriate spaces provided in the Schedule. Unit prices shall be multiplied by the Quantities shown, and the total shall be inserted in the AMOUNT column. In the event of any error or discrepancy between the Unit Price and the calculated AMOUNT, the Unit Price shall govern. Owner may correct any mathematical errors apparent on the face of the bid.

If SOLE OWNER, sign here:

I sign as sole owner of the business named above:

_____

If PARTNERSHIP, one or more partners sign here:

The undersigned certify that we are partners in the business named above and that we sign this bid with the full authority to do so:

_____

_____

If CORPORATION, execute here:

Corporate Name: FTG Builders INC.,

Incorporated under the laws of the State of CALIFORNIA

The undersigned certify that they sign this bid with the full and proper authorization so to do:

By _____	By Robert Giancola
*Signature of Authorized Official**	*Signature of Authorized Official**
CEO / PRESIDENT	Vice-President
Title	*Title*
Rodney Terra Jr.	Robert Giancola
Typewritten or Printed Name	*Typewritten or Printed Name*

If JOINT VENTURE, execute here:

Joint Venture name composed of: _____

The undersigned certify that they sign this bid with the full and proper authorization so to do:

_____	_____
*Signature of Authorized Official**	*Signature of Authorized Official**
_____	_____
Title	*Title*
_____	_____
Typewritten or Printed Name	*Typewritten or Printed Name*

*If bidder is a partnership or Joint Venture, give the full names of all partners and/or Joint Ventures in the space provided (use additional sheet if required). If bidder is a corporation, two signatures are required as follows: (1) the Chairman, President, or Vice-President and (2) the Secretary, Assistant Secretary, Chief Financial Officer or Assistant Treasurer. In the alternative, this Agreement may be executed by a single officer or a person other than an officer provided that evidence satisfactory to SVMHS is provided demonstrating that such individual is authorized to bind the corporation (example, a copy of a certified resolution from the corporation's board or a copy of the corporation's bylaws)

END OF BID LETTER

LIST OF SUBCONTRACTORS

The Bidder is required to furnish the following information in accordance with the provisions of Sections 4100 to 4114, inclusive, of the Public Contract Code of the State of California. This list and information shall include all subcontractors that will perform work, provide labor or render services to the Bidder in connection with the project in an amount in excess of one-half of one percent of the total amount of Bidder's Grand Total Bid Price.

Do not list alternative subcontractors for the same work. Use additional sheets if necessary.

NAME OF SUBCONTRACTOR	LICENSE NUMBER AND DIR REGISTRATION NO	LOCATION OF/ PLACE OF BUSINESS	PORTION OF WORK
1. A&B Fire Protection and Safety, Inc.	License #: C1327620 DIR #: 1000014918	627 Brunken Ave Ste A-2 Salinas, CA 93902	Fire Suppression
2. B.T. Mancini Co., Inc.	License #: 229210 DIR #: 1000002989	876 S Milpitas Blvd Milpitas, CA 95035	Decorative Metal / Flooring
3. C&S Flooring Systems	License #: 4857978 DIR #: PW-LR-1001187957	1001 S. 5th Street San Jose, CA 95112	Flooring
4. Central Valley Casework, Inc.	License #: 837664 DIR #: 1000024021	7567 Road 28 Madera, CA 93637	Casework
5. Expert Drywall Systems, Inc.	License #: C0616292 DIR #: 1000005747	1141 Old Bayshore Hwy Suite 30 San Jose, CA 95112	Lath and Plaster
6. Jensco Inc, dba JM Electric	License #: 376938 DIR #: 1000000800	400 Griffin St Salinas, CA 93901	Electrical
7. Kenny Rogers Plumbing, Inc.	License #: 904898 DIR #:	Boulder Creek, CA	Plumbing
8. Minton Door Company	License #: 830681 DIR #: 1000048341	1150 Elko Drive Sunnyvale, CA 94089	Doors and Windows
9. Service Metal Products, Inc.	License #: 1020458 DIR #: 1000006200	9828 Kitty Ln Oakland, CA 94603	Specialties
10. WM B. Saleh Co.	License #: C1217634 DIR #: 1000010542	407 Reservation Rd, Suite 3 Marina, CA 93933	Painting and Coating

END LIST OF SUBCONTRACTORS

LIST OF SUBCONTRACTORS

The Bidder is required to furnish the following information in accordance with the provisions of Sections 4100 to 4114, inclusive, of the Public Contract Code of the State of California. This list and information shall include all subcontractors that will perform work, provide labor or render services to the Bidder in connection with the project in an amount in excess of one-half of one percent of the total amount of Bidder's Grand Total Bid Price.

Do not list alternative subcontractors for the same work. Use additional sheets if necessary.

NAME OF SUBCONTRACTOR	LICENSE NUMBER AND DIR REGISTRATION NO	LOCATION OF/ PLACE OF BUSINESS	PORTION OF WORK
1. Val's Plumbing & Heating, Inc.	License #: 236164 DIR #: 1000002483	413 Front Street Salinas, CA 93901	Plumbing
2. [redacted]	[redacted]	[redacted]	[redacted]
3. [redacted]	[redacted]	[redacted]	[redacted]
4. CREATIVE WINDOW FASHIONS	LICENSE# 877833 DIR# 1000004467	1867 LITTLE ORCHARD ST SAN JOSE, CA. 95125	WINDOW SHADES
5. [redacted]	[redacted]	[redacted]	[redacted]
6. Bruno Electric	LICENSE# C1735095 DIR# 1000054045	1420 DEER FLAT RD. Monterey, CA. 93940	ELECTRICAL
7. [redacted]	[redacted]	[redacted]	[redacted]
8.			
9.			
10.			

END LIST OF SUBCONTRACTORS

DISQUALIFICATION QUESTIONNAIRE

The Bidder shall complete, under penalty of perjury, the following questionnaire:

Has the Bidder, any officer of the Bidder, or any employee of the Bidder who has proprietary interest in the Bidder, ever been disqualified, removed, or otherwise prevented from bidding on, or completing a federal, state, or local government project because of a violation of law or a safety regulation?

Yes _____ No NO

If the answer is yes, explain the circumstances in the following space.

NAME OF BIDDER: Rodney Terra Jr. / FTG Builders Inc.

NOTE: This questionnaire constitutes a part of the Bid, and signature on the portion of this Bid shall constitute signature on this questionnaire.

END OF DISQUALIFICATION QUESTIONNAIRE

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

Included in the Bid Price is full compensation for the requirements set forth in Section 00 86 00, INSURANCE REQUIREMENTS of the Contract Documents, including:

a) Workers' Compensation (per statutory requirement).

Policy shall include a waiver of subrogation.

b) Employer's Liability coverage.

Two Million Dollars ($2,000,000) per accident; and

Two Million Dollars ($2,000,000) each employee by disease.

c) Commercial General Liability coverage (including but not limited to premises and operations; contractual liability; personal and advertising injury; explosion, collapse, and underground coverage; products and completed operations, and; broad form property damage) of not less than:

Two Million Dollars ($2,000,000) combined single limit per occurrence or claim; and

Two Million Dollars ($2,000,000) general aggregate.

Policy shall include a Waiver of Subrogation and Additional Insured endorsement. Policy will also contain either a Cross Liability endorsement or Severability of Interests Clause.

d) Business Automobile Liability Insurance coverage of not less than:

Two Million Dollars ($2,000,000) combined single limit occurrence.

Policy shall include a Waiver of Subrogation and Additional Insured endorsement.

/ President — July 26, 2024

Signature of Bidder/Title — Date

END OF ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

BIDDER'S BOND

KNOW ALL PERSONS BY THESE PRESENTS:

That FTG Builders, Inc., as Principal, and Great American Insurance Company as Surety, are held and firmly bound unto the Salinas Valley Memorial Health Care System, hereinafter called SVMHS, in the sum of ($) 10% of Bid, being at least ten percent (10%) of the total amount of the bid, for the payment of which sum in lawful money of the United States of America to SVMHS we bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

The condition of the above obligation is such that, whereas the Principal has submitted said bid to SVMHS;

NOW, THEREFORE, if the principal is awarded a Contract by SVMHS and, within the time and in the manner required by the Specifications, enters into a written Contract with SVMHS and furnishes the requisite bond or bonds and insurance certificates, then this obligation shall become null and void, otherwise to remain in full force and effect.

In the event suit is brought upon this bond by SVMHS and judgment is recovered, the Surety shall pay all costs incurred by SVMHS in such suit, including a reasonable attorneys fee to be fixed by the Court.

Dated July 23, 2024

TO BE CONSIDERED COMPLETE, BOTH THE PRINCIPAL AND SURETY MUST SIGN THIS BIDDER'S BOND. IN ADDITION, THE SURETY'S SIGNATURE MUST BE NOTARIZED AND A COPY OF THE SURETY'S POWER OF ATTORNEY MUST BE ATTACHED.

FTG Builders, Inc.
Principal

By: Rodney E. Terra, Jr.
President

Great American Insurance Company
Surety

By: James Uhlendt, Power of Attorney

301 E. Fourth Street Cincinnati, Ohio 45202
Address of Surety

END OF BIDDERS BOND

GREAT AMERICAN INSURANCE COMPANY®

Administrative Office: 301 E 4TH STREET • CINCINNATI, OHIO 45202 • 513-369-5000 • FAX 513-723-2740

The number of persons authorized by
this power of attorney is not more than TWO

No. 0 21416

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS: That the GREAT AMERICAN INSURANCE COMPANY, a corporation organized and existing under and by virtue of the laws of the State of Ohio, does hereby nominate, constitute and appoint the person or persons named below, each individually if more than one is named, its true and lawful attorney-in-fact, for it and in its name, place and stead to execute on behalf of the said Company, as surety, any and all bonds, undertakings and contracts of suretyship, or other written obligations in the nature thereof; provided that the liability of the said Company on any such bond, undertaking or contract of suretyship executed under this authority shall not exceed the limit stated below.

Name	Address	Limit of Power
JAMES UNTIEDT	ALL OF	ALL
CYNTHIA P. CASTELLANO	SAN JOSE, CALIFORNIA	$100,000,000.00

This Power of Attorney revokes all previous powers issued on behalf of the attorney(s)-in-fact named above.

IN WITNESS WHEREOF the GREAT AMERICAN INSURANCE COMPANY has caused these presents to be signed and attested by its appropriate officers and its corporate seal hereunto affixed this 11TH day of MARCH , 2020 .

Attest

GREAT AMERICAN INSURANCE COMPANY

Assistant Secretary

Divisional Senior Vice President

MARK VICARIO (877-377-2405)

STATE OF OHIO, COUNTY OF HAMILTON - ss:

On this 11TH day of MARCH , 2020 , before me personally appeared MARK VICARIO, to me known, being duly sworn, deposes and says that he resides in Cincinnati, Ohio, that he is a Divisional Senior Vice President of the Bond Division of Great American Insurance Company, the Company described in and which executed the above instrument; that he knows the seal of the said Company; that the seal affixed to the said instrument is such corporate seal; that it was so affixed by authority of his office under the By-Laws of said Company, and that he signed his name thereto by like authority.

SUSAN A KOHORST
Notary Public
State of Ohio
My Comm. Expires
May 18, 2025

This Power of Attorney is granted by authority of the following resolutions adopted by the Board of Directors of Great American Insurance Company by unanimous written consent dated June 9, 2008.

RESOLVED: That the Divisional President, the several Divisional Senior Vice Presidents, Divisional Vice Presidents and Divisonal Assistant Vice Presidents, or any one of them, be and hereby is authorized, from time to time, to appoint one or more Attorneys-in-Fact to execute on behalf of the Company, as surety, any and all bonds, undertakings and contracts of suretyship, or other written obligations in the nature thereof; to prescribe their respective duties and the respective limits of their authority; and to revoke any such appointment at any time.

RESOLVED FURTHER: That the Company seal and the signature of any of the aforesaid officers and any Secretary or Assistant Secretary of the Company may be affixed by facsimile to any power of attorney or certificate of either given for the execution of any bond, undertaking, contract of suretyship, or other written obligation in the nature thereof, such signature and seal when so used being hereby adopted by the Company as the original signature of such officer and the original seal of the Company, to be valid and binding upon the Company with the same force and effect as though manually affixed.

CERTIFICATION

I, STEPHEN C. BERAHA, Assistant Secretary of Great American Insurance Company, do hereby certify that the foregoing Power of Attorney and the Resolutions of the Board of Directors of June 9, 2008 have not been revoked and are now in full force and effect.

Signed and sealed this 23rd day of July , 2024 .

Assistant Secretary

CALIFORNIA ACKNOWLEDGMENT **CIVIL CODE § 1189**

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Santa Clara

On 07-23-2024 before me, C Reynolds, Notary Public,
Date *Here Insert Name and Title of the Officer*

personally appeared James Untiedt
Name(s) of Signer(s)

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

C. REYNOLDS
Notary Public - California
Santa Clara County
Commission # 2418774
My Comm. Expires Oct 22, 2026

Place Notary Seal and/or Stamp Above

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

OPTIONAL

Completing this information can deter alteration of the document or fraudulent reattachment of this form to an unintended document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____	Signer's Name: _____
☐ Corporate Officer – Title(s): _____	☐ Corporate Officer – Title(s): _____
☐ Partner – ☐ Limited ☐ General	☐ Partner – ☐ Limited ☐ General
☐ Individual ☐ Attorney in Fact	☐ Individual ☐ Attorney in Fact
☐ Trustee ☐ Guardian or Conservator	☐ Trustee ☐ Guardian or Conservator
☐ Other: _____	☐ Other: _____
Signer is Representing: _____	Signer is Representing: _____

©2019 National Notary Association

NON-COLLUSION AFFIDAVIT TO BE EXECUTED BY BIDDER AND SUBMITTED WITH BID

The undersigned declares:

I am the President of FTG Builders, Inc, the party making the foregoing bid .

The bid is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation. The bid is genuine and not collusive or sham. The bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham bid. The bidder has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham bid, or to refrain from bidding. The bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the bid price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the bid price, or of that of any other bidder. All statements contained in the bid are true. The bidder has not, directly or indirectly, submitted his or her bid price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, to any corporation, partnership, company association, organization, bid depository, or to any member or agent thereof to effectuate a collusive or sham bid, and has not paid, and will not pay, any person or entity for such purpose.

Any person executing this declaration on behalf of a bidder that is a corporation, partnership, joint venture, limited liability company, limited liability partnership, or any other entity, hereby represents that he or she has full power to execute, and does execute, this declaration on behalf of the bidder.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration is executed on July 25, 2024 [date], at Santa Clara [city], California [state]."

Signature of Bidder

President / FTG Builders Inc.
Title

July 26, 2024
Date

END OF NON-COLLUSION AFFIDAVIT

BIDDER'S REQUEST FOR INFORMATION

Type in all required blanks. Include additional information on separate sheets as necessary.
Please email Word document to Owner's Representative.

Project Name: **MBay GI Office TI Expansion** BRFI Number ____

Title of Issue: _____

Contract Document Reference Pertaining to Issue:

Drawing Sheet _____ Detail _____Specification Section _____ Article/Paragraph _____

Description of Issue:

_____

_____

_____

Contractor's Proposed Solution:

_____

_____

_____

_____ _____

Contractor

Name/Company of party originating BRFI and Relationship to Contractor

_____ _____

Signature and printed name of Contractor's representative

Date

☐ Additional _____ sheets are attached.

_____

Architect's Response:

_____

_____

_____

_____ _____

For Architect & Engineer of Record

Date

Additional _____ sheets are attached.

END OF BIDDERS' REQUEST FOR INFORMATION

Attachment 2

SVH - Tenant Improvement to Suites 201 & 202 at 212 San Jose Street, Salinas

As Per Plans by WRD Architects, Dated June 11, 2024

Construction Proposal by FTG Builders, Dated July 26, 2024, adjusted per agreement, August 12, 2024

	COST CATEGORY	As Bid	Target	
Const:	Supervision	$33,600	$33,000	
	General Conditions	$33,388	$24,000	less OAC work
	Soft Demo & pre-prep	$9,910	$8,000	
	Carpentry & Material	$18,428	$18,000	
	Insulation	$7,151	$2,000	reduce scope
	Drywall	$94,717	$83,462	Brady - verify DIR
	Paint	$17,325	$17,325	
	Doors	$58,401	$55,000	
	Ceiling	$37,440	$30,000	revise scope
	Flooring & Floor Prep	$40,964	$40,964	
	Cabinetry/Counters	$29,646	$17,500	simplify scope
	Bathroom Specialties & Finishes	$17,918	$17,918	
	Appliances	$4,045	$400	by tenant
	Window Coverings	$7,500	$0	by tenant
	Mechanical	$79,251	$69,000	Neg scope w/ Vals
	Plumbing	$66,883	$60,000	Neg scope w/ Vals
	Fire Sprinkler	$21,000	$21,000	
	Fire Alarm	excl	$10,000	
	Electrical	$119,835	$100,000	Neg scope w/Bruno
	Data Cable & Terminations	excl	$0	by tenant
	Subtotal	$697,402	$607,569	
	Contractor Fees - 7%	$108,438	$88,000	ok per FTG
	Insurance = 1%	$14,093	$12,000	
	Project Bond	$9,983	$0	no bond
	Subtotal	$829,916	$707,569	
	Value Engineering buy-out contingency		$47,347	
	Subtotal - Contract NTX Amount		**$754,916**	
Soft Costs:	Architecture/Engineering	$60,000	$60,000	
	City Fees	$15,000	$15,000	
	Other Fees	$7,500	$7,500	
	Program Management	$35,000	$35,000	
	Soft Cost Contingency	$24,774	$20,000	
	Subtotal	$972,190	$892,416	
	Allowance: refresh common area	$50,000	$30,000	
	Project Contingency	$35,045	$52,584	
	Project Total for Lease Calculation	$1,057,235	**$975,000**	

Finance Committee Board Paper

Agenda Item: **Consider Recommendation for Board Approval of Lease Agreement Terms for the Office Expansion at 212 San Jose Street, 2nd Floor Salinas Between SVH and Monterey Bay G.I. Consultants Medical Group**

Executive Sponsor: Allen Radner, MD, President/Chief Executive Officer
Gary Ray, Chief Legal Officer

Date: September 18, 2024

Executive Summary

SVH and Monterey Bay G.I. Consultants Medical Group have been partners in the endoscopy center, Monterey Bay Endoscopy LLC, since February of 2018. In 2022, Monterey Bay G.I. leased office/clinic space on the 2nd floor of 212 San Jose Street which has the endoscopy center located on the first floor of the building. The success of the endoscopy center and the GI practice has resulted in a need to expand its administrative support (office) space to allow the practice to maximize its growth. Suites 201 and 202 (the balance of available tenant space on the 2nd floor) will be leased to Monterey Bay GI Consultants Medical Group, Inc. under a proposed fair market value lease agreement.

Timeline

September 23, 2024 – Request SVH Finance Committee Recommendation for Board Approval
September 26, 2024 – SVH Board of Directors Meeting/Consider Recommendation for Approval
October-November, 2024 – Completion of Tenant Improvements
December 1, 2024 – Anticipated Commencement Date of Lease Agreement

Meeting our Mission, Vision, Goals—Strategic Plan Alignment

This transaction is aligned with the strategic initiatives outlined in our most recent strategic planning work for growth, in developing healthcare clinics and programs that drive value for our patients.

Pillar/Goal Alignment: ☑ Service ☐ People ☐ Quality ☑ Finance ☑ Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications

Lease Agreement Terms for 2nd Floor, 212 San Jose Street, Salinas, CA:

1. Lease Commencement Date	Upon occupancy anticipated for December 1, 2024
2. Term of Lease	8-10 years for initial term based on final negotiation
3. Option to Extend	Two (2) five-year options
4. Payment Terms	Monthly Rent Payments
5. Initial Rent (per sq. ft.)	$2.30 per square foot (supported by FMV analysis)
6. Rentable square feet	Approximately 7,000 square feet (to be verified by CalComm)
7. Initial Rent	Approximately $16,100 per month (based on final verified rentable sq. ft.)
8. Annual Increases	After first 24 months, annual CPI adjustment 2%-5%
9. Renewal of Existing/New	New Lease adding additional space for Tenant
10. Tenant Improvements	The cost of the Tenant Improvement will be amortized over the Lease term.

Recommendation

Administration requests that the Finance Committee make a recommendation to the Board of Directors for approval (pending final review by District legal counsel of the Lease Agreement) of the lease terms presented above.

Finance Committee Board Paper

Agenda Item: **Consider Recommendation for Board Approval of Terms for a Lease and Services Agreement Between SVH and Johnny Blanchard MD Inc.**

Executive Sponsor: Allen Radner, MD, President/Chief Executive Officer
Gary Ray, Chief Legal Officer

Date: September 18, 2024

Executive Summary

Since 2015, Dr. James Dacus has operated a concierge medical practice in Monterey County through an agreement with SVH. Under the agreement, Dr. Dacus leased space and contracted for certain practice support services including staff. As Dr. Dacus is moving into retirement, he is transferring his concierge medical practice to Dr. Johnny Blanchard. Dr. Blanchard is entering into a similar fair market value Lease and Services Agreement under which he will lease certain SVH space and receive support services from SVH Clinics staff. It is a lengthy process for Dr. Blanchard to complete the transfer of the concierge practice, and securing this proposed agreement is a necessary initial step.

Timeline

September 23, 2024 – Request SVH Finance Committee Recommendation for Board Approval
September 26, 2024 – SVH Board of Directors Meeting/Consider Recommendation for Approval
October 1, 2024 – Effective Date of Agreement (Allows for moving forward with the practice transfer)
January 1, 2025 – Commencement Date for the Agreement to be determined (commencement of payments under the Agreement and full support of the practice)

Meeting our Mission, Vision, Goals—Strategic Plan Alignment

This arrangement is aligned with the strategic initiatives of SVH for growth and development of healthcare services and programs patients in our service area.

Pillar/Goal Alignment: ☑ Service ☐ People ☐ Quality ☑ Finance ☐ Growth ☑ Community

Financial/Quality/Safety/Regulatory Implications

Terms for Lease and Services Agreement for Concierge Medical Practice:

1. Lease Effective Date	October 1, 2024
2. Lease Commencement Date	TBD—anticipated for early 2025
3. Term of Lease	Five (5) years with termination without cause after 2nd Anniversary of Commencement date
4. Option to Extend	No options to extend—renegotiate after initial term
5. Payment Terms	Monthly Payments
6. Space and Services	Clinic space and support services in Salinas and Monterey four (4) days per week. Utilities and limited supplies included.
7. Initial Rent/Fee	$17,000.00 per month (supported by FMV analysis)
8. Annual Increases	Years 2 and 3: 4% increase. Years 4 and 5: CPI with floor of 3% and ceiling of 5%
9. General Terms and Conditions	General terms and conditions of agreement similar to existing agreement for a concierge medical practice.

Recommendation

Administration requests that the Finance Committee make a recommendation to the Board of Directors for approval (pending final review by District legal counsel) of the terms for a concierge medical practice Lease and Services Agreement between SVH and Johnny Blanchard MD Inc., as presented.

Board Paper: Finance Committee

Agenda Item:	**Consider Recommendation for Board Approval of KeyCare, an Epic-Based Telehealth Solution to Expand Primary Care Access via After-Hours, On-Demand Coverage**
Executive Sponsors:	Allen Radner, MD, Chief Executive Officer Orlando Rodriguez, MD, SVH CMO
Date:	September 23, 2024

Executive Summary

In order to address multiple challenges for Salinas Valley Health – including increasing provider access, ongoing provider recruitment/satisfaction and appropriate utilization of healthcare resources - we are requesting the approval of funding for the after-hours telehealth resources provided by KeyCare telehealth (video or telephone) services.

At present, there exists telehealth options for patients followed in our primary care clinics – however, these are generally limited to traditional weekday office hours. We believe this had led to discontinuity of care, inappropriate ED/urgent care utilization (which has had a significantly negative affect on our risk based provider arrangements) and provider dissatisfaction.

After review of multiple vendors we believe KeyCare (which allows review/documentation with our ambulatory EPIC platform - inclusive of previous visit data, patient preferences, pharmacy, and other important information) will mitigate inappropriate ED/urgent care utilization, and benefit our recruitment and retention challenges. We also believe this may be an eventual vehicle to expand introduction of our clinic services to patients outside our system. (These benefits, as well as a recommendation to implement expanded telehealth services, were called out in the Guidehouse: Project Sustainable Success Report.)

Rollout of this service will require an implementation plan and resources to ensure KeyCare's success. They will provide two billing models; a self-pay option, and client insurance billing with expectations of go live six months from the contract execution date.

Timeline/Review Process to Date:

April 2024:	Engaged KeyCare to understand more about their platform/offerings
September 2024:	Received Draft Contracts and Routed to Legal Department for review
October 2024:	Implementation action plan developed, including Epic build and provider insurance credentialing
Late spring 2025:	Anticipated Implementation

Strategic Plan Alignment:

A partnership with KeyCare aligns with our most recent strategic plan completed in 2021, specifically with the Growth Pillar initiative to focus and invest in Ambulatory & Primary Care Access. Additionally, the Medical Staff Development Plan, completed by ECG Management Group in January 2023 recommended the addition of 43 primary care physicians over the next three years. The additional resources will expand access for services complimenting the recruitment efforts and supporting the patient load for the established practitioners.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

<table>
<tr><th>Key Contract Terms</th><th>Vendor: KeyCare</th></tr>
<tr><td>1. Proposed effective date</td><td>October 1, 2024</td></tr>
<tr><td>2. Term of agreement</td><td>3 Year Initial Term</td></tr>
<tr><td>3. Renewal terms</td><td>After the Initial Term, Agreement will automatically renew for successive one-year terms</td></tr>
<tr><td>4. Termination provision(s)</td><td>Ninety (90) days written notice (for cause)
One hundred twenty days (120) written notice (without cause)</td></tr>
<tr><td>5. Payment Terms</td><td>Annual Maintenance Fee plus Monthly Visit Minimum Fee</td></tr>
<tr><td>6. Annual cost</td><td>Year 1:
One Time Implementation Fee, $35,000
Annual Maintenance Fee, $100,000
Monthly Visit Minimum, $19,500 (3 month Ramp-Up)
<table>
<tr><td>Month</td><td>Minimum Fees</td></tr>
<tr><td>1</td><td>$1,950</td></tr>
<tr><td>2</td><td>$5,850</td></tr>
<tr><td>3</td><td>$9,750</td></tr>
<tr><td>4+</td><td>$19,500</td></tr>
</table>
Total Year 1 Cost: $328,050.00

Year 2: $100,000 + ($19,500 * 12) = $334,000.00

Year 3: $100,000 + ($19,500 * 12) = $334,000.00</td></tr>
<tr><td>7. Cost over life of agreement</td><td>Total Cost Over 3 Years: $996,050.00</td></tr>
<tr><td>8. Budgeted (indicate y/n)</td><td>No</td></tr>
</table>

Recommendation

Salinas Valley Health Administration requests the Salinas Valley Health Board of Directors approve the terms presented for a **Virtual Health Services Agreement** with **KeyCare Inc.** in the amount of **$996,050.00 over the period of 3 years**.

CORPORATE COMPLIANCE
AND AUDIT COMMITTEE

Minutes of the
Corporate Compliance and Audit Committee
will be distributed at the Board Meeting

(JUAN CABRERA)

Salinas Valley Health

Proposed Organizational Goals

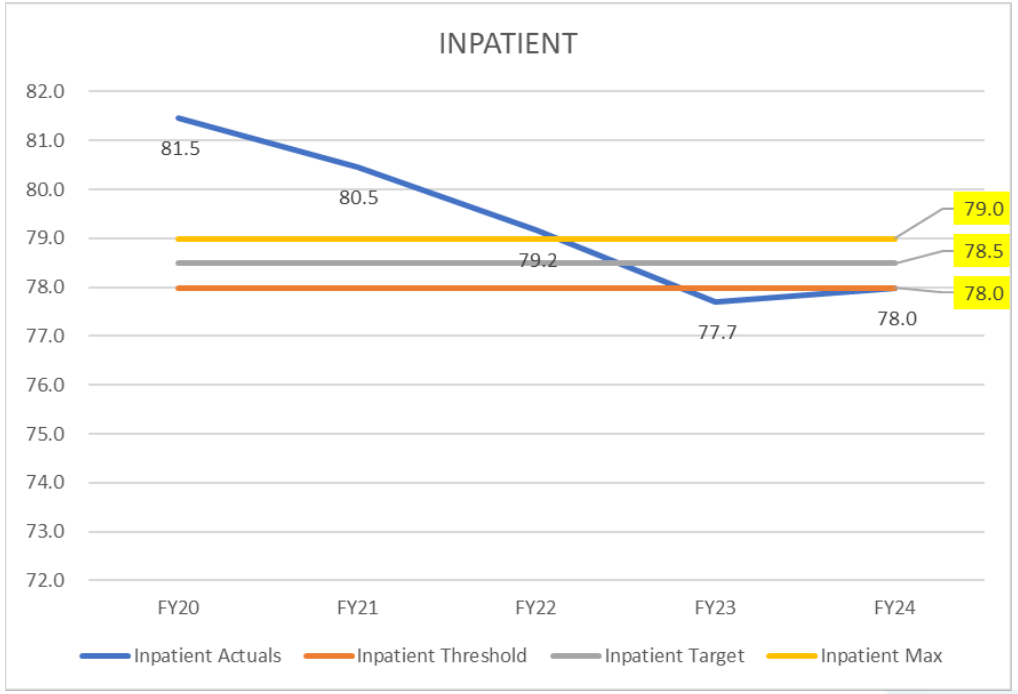
Annual Incentive Plan
Fiscal Year 2025

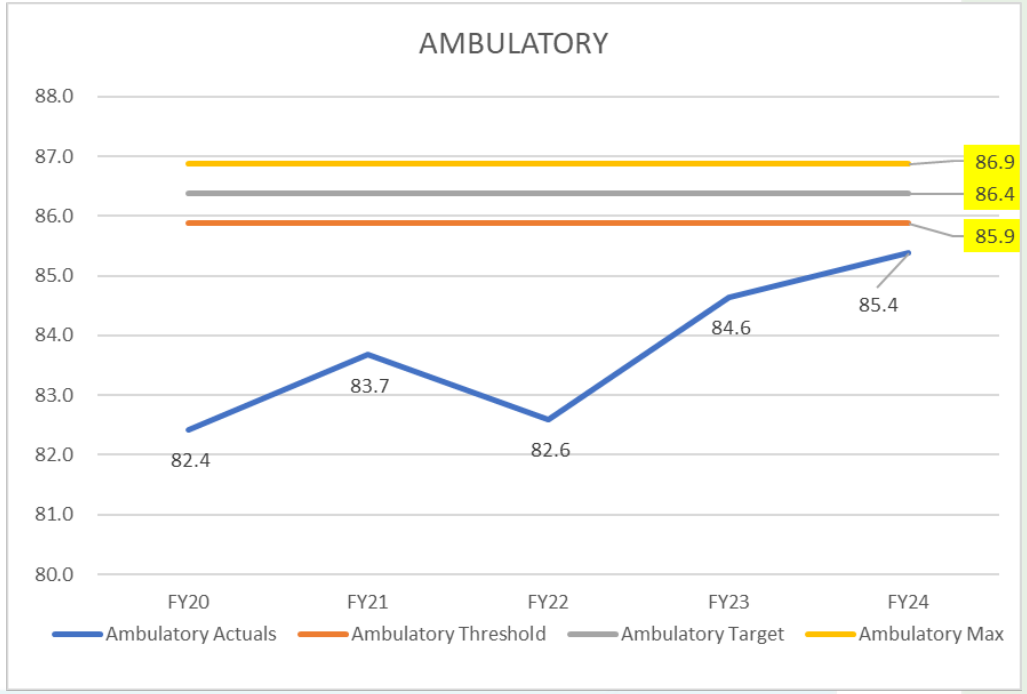
Service
FY 2025 Goals

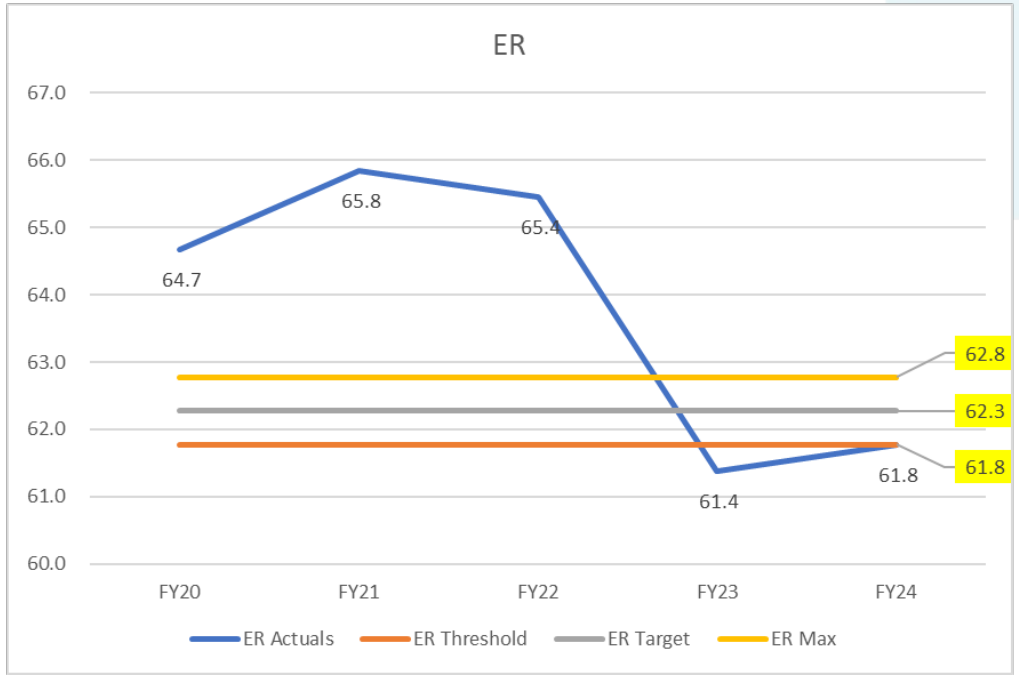
Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals THRESHOLD	TARGET	MAX	FY 2024 Baseline
	I. Service				
7.5%	Inpatient - Recommend the Hospital	78.0	78.5	79.0	78.0
7.5%	Emergency Room - Likelihood of Recommending	61.8	62.3	62.8	61.8
7.5%	Ambulatory - Recommend the Hospital	85.9	86.4	86.9	85.4
7.5%	Outpatient - Likelihood of Recommending	88.9	89.4	89.9	88.4

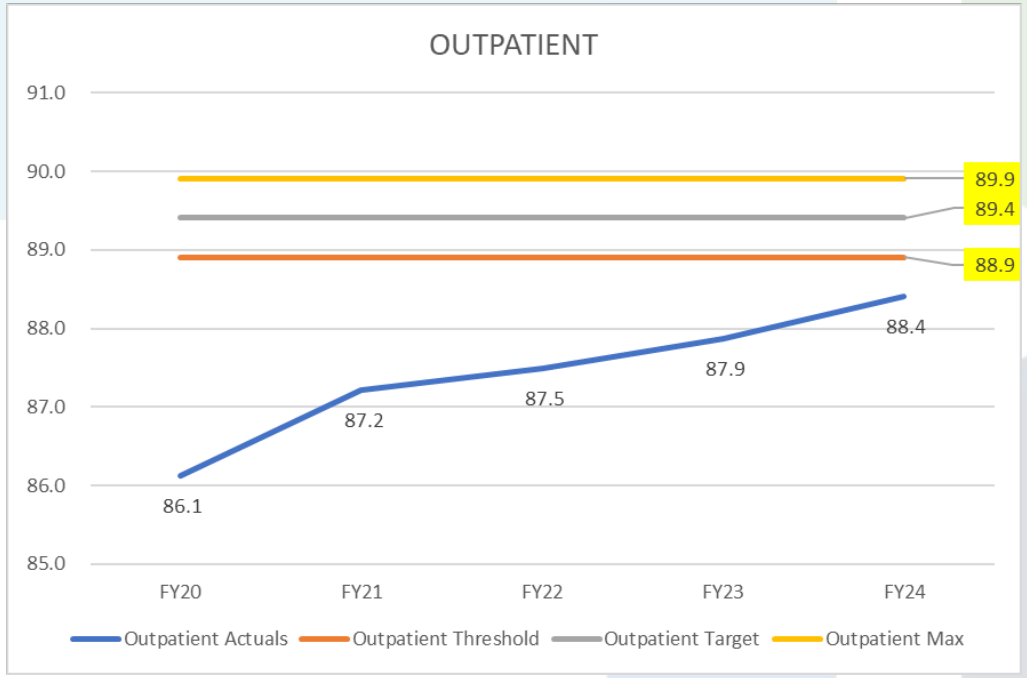
Notes / Assumptions:

- Source: Press Ganey
- Based on monthly **received date**
- Based on top box scores (highest response possible on the survey scale: Yes, Definitely Yes, Always)
- Inpatient Score FY 2024 Baseline was 78.0. Rationale: Threshold = Baseline. Target is +0.5 from baseline. Max is +1.0 from baseline.
- ER Score FY 2024 Baseline was 61.8. Rationale: Threshold = Baseline. Target is +0.5 from baseline. Max is +1.0 from baseline.
- Ambulatory Score FY 2024 Baseline was 85.4. Rationale: Threshold +0.5 from Baseline. Target is +1.0 from baseline. Max is +1.5 from baseline.
- Outpatient Score FY 2024 Baseline was 88.4. Rationale: Threshold +0.5 from Baseline. Target is +1.0 from baseline. Max is +1.5 from baseline.









NOTE: FY20 only includes 1/1/20 – 6/30/20. No data is available prior to 1/1/20.

People
FY 2025 Goals

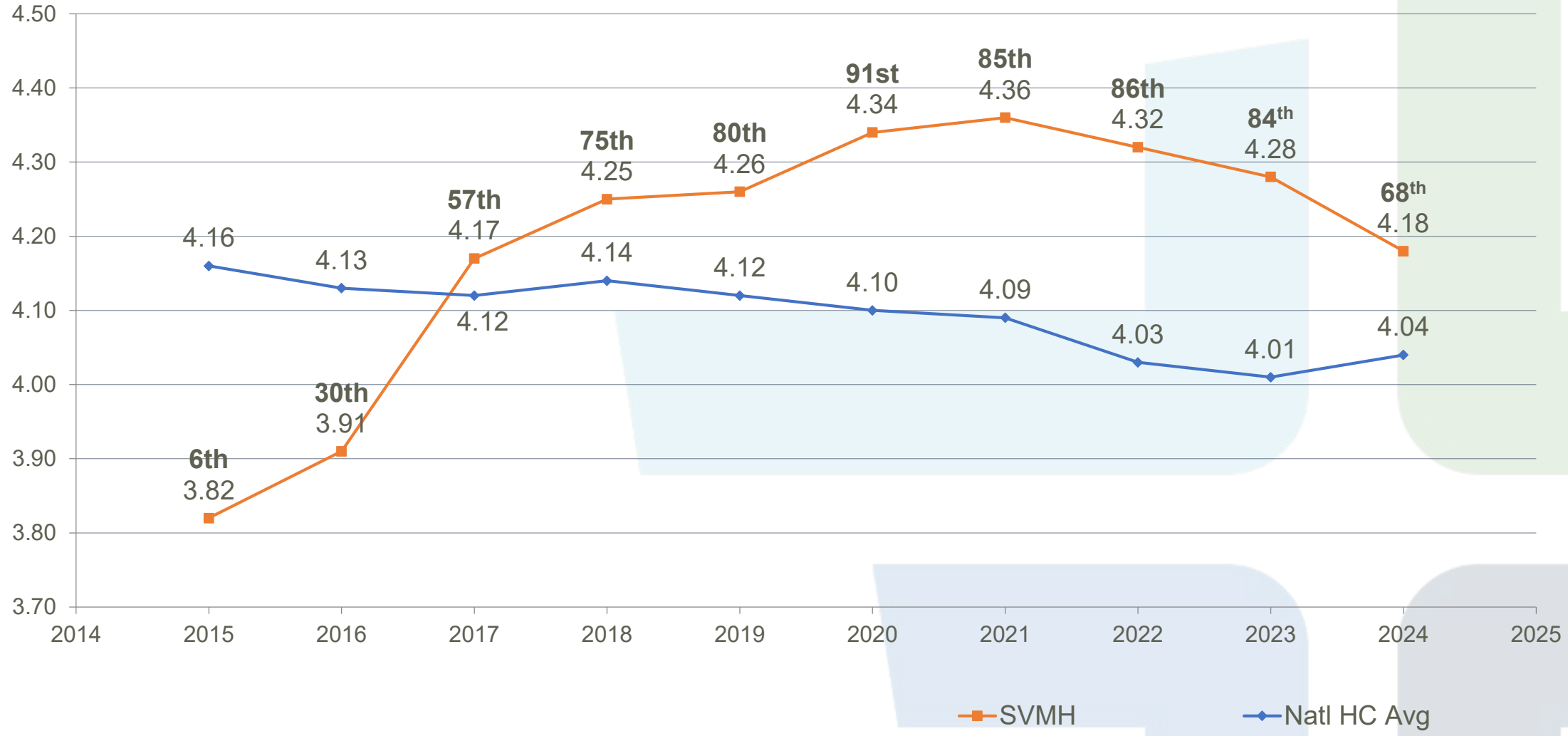
Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals THRESHOLD	TARGET	MAX	FY 2024 Baseline
	II. People				
5%	Employee Engagement Indicator Score	4.20	4.25	4.27	4.18
5%	Safety Culture Index: Prevention and Reporting	4.07	4.14	4.18	4.07
5%	Safety Culture Index: Resources and Teamwork	3.76	3.81	3.84	3.76

Notes / Assumptions:

- Source: Press Ganey
- Employee Engagement Survey results are expected to be available on or before July 31, 2025
- Achieve Employee Engagement Indicator score in the range of 4.20 to 4.27 as measured by the 2025 Employee Engagement Survey.
- Achieve Prevention and Reporting score in the range of 4.07 to 4.18 as measured by the 2025 Employee Engagement Survey, Safety Culture Index.
- Achieve Resources and Teamwork score in the range of 3.76 to 3.84 as measured by the 2025 Employee Engagement Survey, Safety Culture Index.

Engagement Trending

2024 Natl Healthcare Avg
Facilities: 3,792
Respondents: 1,378,863



Quality & Safety Processes
ER Efficiencies
FY 2025 Goals

Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals THRESHOLD	TARGET	MAX	FY 2024 Baseline
	III. Quality & Safety Processes				
	Emergency Room Efficiencies				
2.5%	**Median length of stay for non-admits (in minutes)**	**183.0**	**181.0**	**179.0**	**181.0**
2.5%	**Median time from admit decision to time of admission to nursing unit (in minutes)**	**76.0**	**74.0**	**72.0**	**74.0**

Source: Meditech

ER - LOS for Non-Admits in Minutes: Data Criteria: Calculate the median LOS in minutes for ER Outpatients for each month & YTD for cases in ER (excludes inpatients and patients leaving against medical advice or left without being seen.) Baseline = Target is based on FY 2024 Actuals. The Threshold & Maximum are 2 minute increments from the Target. **Rationale:** SVHMC ER has recently experienced a higher volume level, including a surge of patients and provider turnover. According to CMS, the latest available data from 2021 indicates that the State Rate is 196 minutes and the National Rate is 203 minutes for comparable size hospitals. The implementation of new ED modular will necessitate new patient flow process which could impact wait times / efficiency (Estimated to start October 2024).

ER - Time to Admit in Minutes: Data Criteria: Calculate the median time for inpatients from admit decision to time of admission to nursing unit in minutes (includes observation cases). Baseline = Target is based on FY 2024 Actuals. The Threshold & Maximum are 2 minute increments from the Target.

Rationale: The ER average daily census is currently averaging at about 186 patients a day compared to the baseline period of 128 (Jul21-Jan22), or a **45%** increase in ER census. We also have continued challenges with COVID and respiratory isolation. The vast increase of volume leads to limited space availability and delays. We have put forth a new initiative called the “Big 5 Handover Process”, which is a streamline handover process between the ED and nursing units, which may reduce admit time. The implementation of new ED modular will necessitate new patient flow process which could impact wait times / efficiency (Estimated to start October 2024).

Quality & Safety Processes
OR and Cath Lab Efficiencies
FY 2025 Goals

Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals THRESHOLD	TARGET	MAX	FY 2024 Baseline
	Operating Room Efficiencies				
2.5%	**Turnover Time (Wheels out / Wheels in) (in minutes)**	**31.5**	**30.5**	**29.5**	**30.8**
	Cath Lab Efficiencies				
2.5%	**First Case - On Time Start %**	**80.0%**	**85.0%**	**90.0%**	**80.4%**

OR Turnover Time Measurement: Source is from the **PICIS OR Nurse Record**. Calculate minutes elapsed between the wheels out & wheels in of the next case. Only cases where the time difference is less than or equal to 60 minutes will be included because breaks are often scheduled in a day. Due to MD availability, cases that exceed 60 threshold minutes will not count as a turnover. Excludes non-scheduled cases. Measurement applies to cases for the same physician and same room only. Data will be partition by actual date rather than previously scheduled date. **National benchmarks range from 25 to 38 minutes.** FY 2025 Goals are set at a level to continue high efficiency performance and strive to maintain sustainability at these levels as the result of upcoming changes during FY 2025: An additional 7th operating room is expected to open during September & 3 new surgeons hired during FY 2025, which means there will be more complex cases specifically for robotic & neurosurgery cases that require a longer setup and cleanup time for the room.

Cath Lab Percentage of 1st case On Time Start Time

- Source is from Meditech Community Wide Scheduling for the first case scheduled in each Cath Lab, where the scheduled time is from 7:00 am to 9:00 am
- Conscious sedation patients prepped and draped 5 minutes before the scheduled start time as measured by “Patient Ready” note charted in McKesson/CPACS
- Anesthesia patients prepped and draped within 60 minutes of scheduled start time as measured by “Patient Ready” note charted in McKesson/CPACS

Quality & Safety Processes
Hospital Acquired Conditions & Hand Hygiene
FY 2025 Goals

	Organizational Goals by Pillar	FY 2025 Proposed Goals			FY 2024 Baseline
		THRESHOLD	TARGET	MAX	
Weight					
5%	Hospital Acquired Conditions Index (Weighted Average)	0.77	0.75	0.73	0.77
5%	Hand Hygiene (Average Number of Observations Per Quarter Per Nursing Unit)	216	220	230	216

Hospital Acquired Conditions
Source: National Healthcare Safety Network (NHSN) & BD Health Insight Interface
Hospital Acquired Conditions will be measured **quarterly**

Rationale for Targets: The Threshold = FY 2024 Baseline; Max = FY 2023 Baseline; Target is the midpoint. Utilizing CMS/NHSN/Magnet benchmarks and last year's FY targets for sustainment and ongoing prevention practices. Process improvement measures for Falls, HAPIs, CLABSI, CAUTI, CDI, and SSI processes are in place. With the changes in the data methodology in FY 2024, especially with CLABSI, CAUTI, CDI & SSI, we are continuing to create consistency by re-baselining the data for FY 2025 and utilizing comparison data outcomes from FY 2023 and FY 2024.

- **Falls with injury:** NDNQI Magnet benchmark 0.5- our outcomes in FY2022 and FY2023 are meeting the benchmarks
- **HAPI—stage 2 and Deep tissue injuries are added to the CMS measures already reported (currently, stage 3,4 and unstageable events are reported)—the goal expanded. There is no current benchmark. We have already improved the outcomes in FY 2023 over FY 2021—**we are proposing to keep/sustain the current outcomes. Displayed as a rate: number of pressure injuries /over 1000 patient days.
- **CLABSI** (Central Line-Associated Bloodstream Infection), Health & Human Services 2020 Goal for CLABSI: SIR <0.50. An HAI Event can create increases above the benchmark SIR due to low utilization. Example: FY Q2 2021 1 CLABSI increased the SIR to 0.63. We will utilize a rate methodology: number of infections/ over 1000 line days. This rate is not risk-adjusted like the SIR rate is, but it provides us with the ability to display outcome measures after the close of the month instead of waiting from NHSN for benchmarked data. This is important for rapid continuous improvement work.
- **CAUTI** (Catheter Associated Urinary Tract Infection) Health & Human Services 2020 Goal for CAUTI: SIR <0.75. An HAI Event(s) can create increases above the benchmark SIR due to low utilization. Example: FY Q4 2022 1 CAUTI increased the SIR to 0.72 .We will utilize a rate methodology: number of infections/ over 1000 line days. This rate is not risk adjusted like the SIR rate is but it provides us with the ability to display outcome measures after the close of the month instead of waiting from NHSN for benchmarked data.
- **CDI** (Clostridium Difficile Infection), Health & Human Services 2020 Goal for CDI: SIR <0.70. We will utilize a rate methodology: number of infections/ over 1000 patient days. This rate is not risk adjusted like the SIR rate is but it provides us with the ability to display outcome measures after the close of the month instead of waiting from NHSN for benchmarked data.
- **SSI** (Surgical Site Infections), Health and Human Services 2020 Goal for SSI <0.70. We will utilize a rate methodology: number of infections/ over 1000 procedure days. This rate is not risk adjusted like the SIR rate is but it provides us with the ability to display outcome measures after the close of the month instead of waiting from NHSN for benchmarked data.

Hand Hygiene
Source: Hand Hygiene Auditing Tool populated by SVHMC staff. The threshold = baseline, the target is +4 & Maximum is +14 from baseline.

Finance
FY 2025 Goals

Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals			FY 2024 Baseline
		THRESHOLD	TARGET	MAX	
20%	**IV. Finance**				
	SVHMC Income from Operations (Normalized & Adjusted) ($ in Millions)	**$40,643**	**$50,803**	**$60,964**	**$74,413**
	Operating Margin (Normalized)	***6.4%***	***8.1%***	***9.7%***	***11.3%***

- Target Methodology is based on SVHMC's 100% of FY 2025 Board Approved Annual Operating Budget (in dollars).

Growth
FY 2025 Goals

Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals THRESHOLD	TARGET	MAX	FY 2024 Baseline
	V. Growth				
2.0%	Increase the scope of the Community Oncology Research Program by adding one to two New Clinical Trials	-	1	2	-
2.0%	Expand / Add one to two New Comprehensive Cancer Program Outpatient Supportive Services	-	1	2	-
2.0%	Initiation of Familial Genetic Testing for non-breast cancers	-	1	2	-
4.0%	Implementation of External TeleHealth Services in the SVH Clinic System & Average Monthly Visits during FY25Q4	*Implementation*	25	50	-

- **Increase the scope of the Community Oncology Research Program by adding 1-2 Clinical Trials:** Success measured by the number of new active Clinical Trial Agreements (CTA's) for IRB-approved oncology research protocols. Expanding the number clinical trials aligns with the Comprehensive Cancer Program's mission to advance oncology research and improve outcomes and health equity within the community. There is no Threshold (zero opportunity for Threshold Incentive). Data Source: Research Program (Terri Nielsen)
- **Expand/add Comprehensive Cancer Program Outpatient Supportive Services**: Supportive services in Cancer Care complements the care provided by oncologists. Cancer patients and their families have significant supportive needs throughout their disease trajectory. The Cancer Resource Center currently provides supportive services such as Social Work, personalized Nurse Navigator Support, Support Groups and Wig/Head Covering Program. Supportive services for consideration include lymphedema clinic, nutritional counseling, spiritual care, art therapy, etc. There is no Threshold (zero opportunity for Threshold Incentive). Data Source: Comprehensive Cancer Program.
- **Initiation of Familial Genetic Testing for non-breast cancers**: Familial genetic testing allows family members of an individual known to have an inherited gene mutation to test and determine if they need screening tests to look for cancer early or if they need to take steps to lower their risk of cancer. Familial genetic testing is offered for families of breast cancer patients with specific gene mutations. The Target is based on successful initiation of the program, while the Stretch goal will include Genetic Counseling provided as part of the service. There is no Threshold (zero opportunity for Threshold Incentive). Data Source: Myriad and Meditech Reports
- **Implementation of External TeleHealth Services in the SVH Clinic System for FY2025 Q4:** Expansion of resources via an external telehealth company. Increase access and expand provider team. Rollout will require implementation plan and resources to ensure success/adoption (insurance credentialing, patient education). Areas of emphasis: after hours and weekend coverage provided. Important to improve access for services, patient experience and reduce burden of call for physicians (provider satisfaction). External resources supplement current services provided at four SVH locations (in person and telehealth). (Not including DOD.) The Threshold will be based on successful implementation of the Telehealth Services, followed by the Target & Maximum measured by average monthly visits during Q4. Data will be provided FY2025, Q4. Data Source: Business & Development Reports

Community
FY 2025 Goals

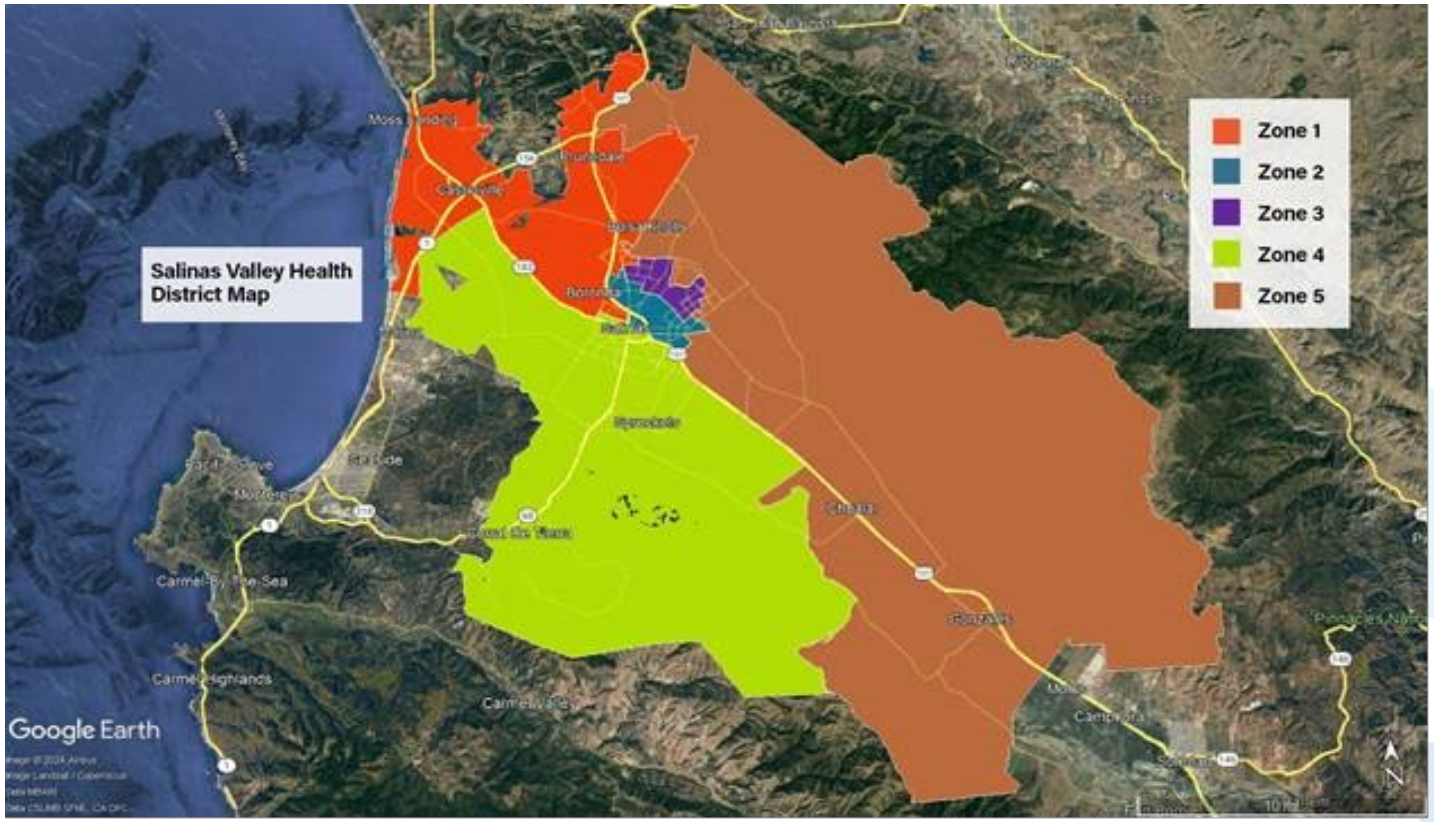
Weight	Organizational Goals by Pillar	FY 2025 Proposed Goals THRESHOLD	TARGET	MAX	FY 2024 Baseline
	VI. Community				
2.5%	**Increase community engagement through individual district zone specific events**	**3**	**5**	**6**	**-**
2.5%	**Allocation of Community Benefit funding (Increase of Percentage)**	**2%**	**4%**	**6%**	**-**

Community Pillar (Total 5%) – Increase diversified impact throughout the hospital District through community engagement and program support.

Increase community engagement through individual district zone specific events (2.5%)
- Achieved by:
  - Diversified community outreach events in each of the five District zones
  - Community health and service line promotion prioritized
  - Measured by event hosting or participation
- Threshold 3 | Target 5 | Max 6 (one in each zone to achieve max – see next slide for map)

Allocation of Community Benefit funding (2.5%)
- Diversify distribution of Community Benefit Funding to increase grants in North County and South County regions.
- Measurement is based on % increase of total funds allocated in identified areas, baseline FY24 number and development of dashboard
- Achieved by:
  - Development of a Community Funding dashboard
  - Include District funding distribution
  - Outreach to underrepresented communities to encourage aligned funding request
- Threshold: 2% increase | Target: 4% increase | Max: 6% increase

Community
FY 2025 Goals



SVHMC FY 2025 Organizational Goals

			FY 2025			FY 2024
Pillar	%	Metric	Threshold	Target	Max	Baseline
Service	7.5%	Inpatient - Recommend the Hospital	78.0	78.5	79.0	78.0
	7.5%	Emergency Room - Likelihood of Recommending	61.8	62.3	62.8	61.8
	7.5%	Ambulatory - Recommend the Hospital	85.9	86.4	86.9	85.4
	7.5%	Outpatient - Likelihood of Recommending	88.9	89.4	89.9	88.4
People	5%	Employee Indicator Score	4.20	4.25	4.27	4.18
	5%	Safety Culture Index: Prevention and Reporting	4.07	4.14	4.18	4.07
	5%	Safety Culture Index: Resources and Teamwork	3.76	3.81	3.84	3.76
Quality & Safety	2.5%	ER - Median Length of Stay for Non-Admits in minutes	183.0	181.0	179.0	181.0
	2.5%	ER - Median Time to Admit in minutes	76.0	74.0	72.0	74.0
	2.5%	OR – Turnover Time in minutes	31.5	30.5	29.5	30.8
	2.5%	Cath Lab – 1st case on time start time	80.0%	85.0%	90.0%	80.4%
	5%	Hospital Acquired Conditions - Average	0.77	0.75	0.73	0.77
	5%	Hand Hygiene	216	220	230	216
Finance	20%	SVHMC Income from Operations (Normalized)	$40,643 6.4%	$50,803 8.1%	$60,964 9.7%	$74,413 11.3%
Growth	2.0%	Increase the scope of the Community Oncology Research Program by adding 1-2 Clinical Trials	-	1	2	-
	2.0%	Expand/add Comprehensive Cancer Program Outpatient Supportive Services	-	1	2	-
	2.0%	Initiation of Familial Genetic Testing for non-breast cancers	-	1	2	-
	4.0%	Implementation of External TeleHealth Services in the SVH Clinic System & Average Monthly Visits during FY25Q4	Implementation	25	50	-
Community	2.5%	Increase community engagement through individual district zone specific events	3	5	6	-
	2.5%	Allocation of Community Benefit funding	2%	4%	6%	-

Salinas Valley Health
FY 2024 Balanced Scorecard (AIP) - Final Funding Calculations

Pillar	Measure	Weight	Threshold	Target	Max	Pace Results	Performance to Target	Payout %
Service								
	Average of IP HCAHPS Scores	15.0%	72.6	73.1	73.6	**73.0**	99.9%	14.0%
	Emergency Room Press Ganey Score	10.0%	58.0	58.5	59.0	**59.4**	101.6%	15.0%
	Average of Ambulatory HCAHPS Scores	5.0%	91.6	92.1	92.6	**92.7**	100.6%	7.5%
	Subtotal	30.0%						36.5%
People								
	Employee Indicator Score	5.0%	4.22	4.29	4.35	**4.18**	97.4%	0.0%
	Safety Culture Index: Prevention and Reporting	5.0%	4.14	4.18	4.20	**4.07**	97.4%	0.0%
	Safety Culture Index: Resources and Teamwork	5.0%	3.81	3.84	3.87	**3.76**	97.9%	0.0%
	Subtotal	15.0%						0.0%
Quality and Safety								
	ER - LOS for Non-Admits in Minutes	2.5%	186.0	183.0	180.0	**181.0**	101.1%	3.3%
	ER - Time to Admit in Minutes	2.5%	76.0	74.0	72.0	**74.0**	100.0%	2.5%
	OR - Turnover Time (Wheels out / Wheels in) (in minutes)	2.5%	31.5	30.5	29.5	**30.8**	99.1%	2.2%
	Cath Lab - Percentage of 1st Case On Time Start Time	2.5%	70.0%	75.0%	80.0%	**80.4%**	107.1%	3.8%
	Hospital Acquired Conditions Index (Weighted Total)	5.0%	4.219	3.867	3.541	**3.852**	100.4%	5.1%
	Hand Hygiene	5.0%	80.0	100.0	120.0	**216.3**	216.3%	7.5%
	Subtotal	20.0%						24.4%
Finance								
	Income from Operations ($,000's)	20.0%	$40,544	$50,681	$60,817	**$74,413**	146.8%	30.0%
Growth								
	Percentage of Medicare Patients with Post Discharge Follow Ups Within 14 Days for an IP Encounter	3.4%	67%	70%	73%	**70.7%**	101.0%	3.8%
	Robotic Assisted Surgeries	3.3%	119	124	130	**289**	233.1%	5.0%
	Expand Epic Access for Hospital Departments	3.3%	4	6	8	**12**	200.0%	5.0%
	Subtotal	10.0%						13.7%
Community								
	Employee Outreach Program Events	5.0%	1	2	3	**4**	200.0%	7.5%
						Initial Funding		**112.1%**
						Finance Regulator		**150.0%**
						Total Funding		**112.1%**

QUESTIONS / COMMENTS

APPENDIX

Non-Affiliated AIP
Business Rules and Eligibility

- The Annual Incentive Plan (AIP) year is the Fiscal Year (**July 1 – June 30)**
- **FY 2025 is July 1, 2024 through June 30, 2025**
- Planning for AIP awards occurs during the Annual Pay Planning process in early August of the Fiscal Year
- **Eligibility**: All non-affiliated employees with a minimum of 90 calendar days employed in the fiscal year in any position (union or non-union) as FT, PT, or PD.
- **Payout** is determined using eligible compensation for check dates between 7/1/24 to 6/30/25.
- **Payout** applies only to eligible compensation earned while in a non-affiliated position.
  - **Payout for Exempt:** Based on percentage of **paid** annual base salary
  - **Payout for Non-Exempt:** Based on percentage of **worked** compensation
  - If the employee changed position or incentive tier during the fiscal year, the award will be based on compensation paid in each position.
  - Award is **pro-rated** based on compensation paid in eligible positions (non-productive time while on leave of absence is excluded from calculation).
- AIP awards are to be paid on or before **September 30** following fiscal year end.
- To receive payment, employee must remain employed through June 30, 2025.
- AIP Payout % is prorated based on the weight of each metric, where Threshold is 50%, Target is 100% and Maximum is 150%.

NUHW AIP
Business Rules and Eligibility

- The Annual Incentive Plan (AIP) year is the Fiscal Year (**July 1 – June 30)**
- **FY 2025 is July 1, 2024 through June 30, 2025**
- Planning for AIP awards occurs during the Annual Pay Planning process in early August of the Fiscal Year
- **Eligibility**: NUHW-represented employees must have at least one thousand (1,000) hours in total combined compensated and drop time hours with the Hospital in the fiscal year.
- **Payout** is determined using eligible compensation for check dates between 7/1/24 to 6/30/25.
- **Payout** applies only to eligible compensation during the fiscal year earned while in a NUHW-represented position.
  - Award is based on percentage of the employee's earnings for actual hours **worked** during the fiscal year.
  - If the employee changed positions during the fiscal year, the award will be based on the earnings for worked compensation in each position.
- AIP awards are to be paid on or before **September 30** following fiscal year end.
- To receive payment, employee must remain employed through June 30, 2025.
- The target incentive compensation shall be **1.5%** for each fiscal year of the Agreement, with a minimum opportunity **0.75%** and a maximum opportunity **2.25%**
- AIP Payout % is prorated based on the weight of each metric, where Threshold is 50%, Target is 100% and Maximum is 150%.

CNA, Local39 & ESC AIP
Business Rules and Eligibility

- The Annual Incentive Plan (AIP) year is the Fiscal Year (**July 1 – June 30)**
- **FY 2025 is July 1, 2024 through June 30, 2025**
- Planning for AIP awards occurs during the Annual Pay Planning process in early August of the Fiscal Year
- **Eligibility**: CNA, Local39 & ESC -represented employees must have at least one thousand (1,000) hours in total combined compensated and drop time hours with the Hospital in the fiscal year.
- **Payout** is determined using eligible compensation for check dates between 7/1/24 to 6/30/25.
- **Payout** applies only to eligible compensation during the fiscal year earned while in a CNA, Local39 & ESC -represented position.
  - Award is based on percentage of the employee's earnings for actual hours **worked** during the fiscal year.
  - If the employee changed positions during the fiscal year, the award will be based on the earnings for worked compensation in each position.
- AIP awards are to be paid on or before **September 30** following fiscal year end.
- To receive payment, employee must remain employed through June 30, 2025.
- The target incentive compensation **1.0%** for each fiscal year of the Agreement, with a minimum opportunity **0.5%** and a maximum opportunity **1.5%**
- AIP Payout % is prorated based on the weight of each metric, where Threshold is 50%, Target is 100% and Maximum is 150%.

Salinas Valley HEALTH

Medical Executive Committee Summary – September 12, 2024

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Alapati, Sampath, MD	Radiology-Remote	Surgery	Salinas Valley Health Advanced Imaging – Non-Cardiac Diagnostic SVHMC Teleradiology
Amarasekera, Sohani, MD	Ophthalmology	Surgery	Ophthalmology
Beheshti, Nima, DO	Neurology	Medicine	Neurology
Feng, Chengyuan, MD	Neurology	Medicine	Tele-Neurology.
Flores, Sara, MD	Psychiatry	Medicine	Tele-Psychiatry
Gabe, Michael, MD	Radiology-Remote	Surgery	Salinas Valley Health Advanced Imaging – Non-Cardiac Diagnostic SVHMC Teleradiology
Graham, Kyle, MD	Ob/Gyn	Ob/Gyn	Obstetrical Hospitalist Gynecology for Obstetrical Hospitalist:
Grandison, Amber, MD	Family Medicine	Family Medicine	Family Medicine Adult Pediatric, Well Newborn Category I & II Obstetrics
Gregory, Maria, MD	Neurology	Medicine	Tele-Neurology
Guez, Ghislaine, MD	Internal Medicine	Medicine	Hospitalist - Adult:
Khazanehdari, Shahab, MD	Neurology	Medicine	Tele-Neurology
McNew, Holly, MD	Psychiatry	Medicine	Tele-Psychiatry
Rezmovits, Yingying, MD	Psychiatry	Medicine	Tele-Psychiatry
Simpson, Benjamin, MD	Neurology	Medicine	Tele-Neurology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Bagga, Pavandeep, MD	Anesthesiology	Anesthesiology	Anesthesiology
Conner, Grant, MD	Otolaryngology	Surgery	Otolaryngology
Dhillon, Jaspreet, MD	Internal Medicine	Medicine	Medicine – Active Community
Grigg, Wendell, MD	Psychiatry	Medicine	Tele-Psychiatry
Hell, Richard, MD	Gastroenterology	Medicine	Gastroenterology
Horwath, Ewald, MD	Psychiatry	Medicine	Tele-Psychiatry
Hu, Johnny, MD	Pathology	Surgery	Pathology
Jani, Atul, MD	General Surgery	Surgery	General Surgery
Liu, Cici, MD	Gyn Oncology	Ob/Gyn	Gyn Oncology Gynecology Robotic Surgery
Rodriguez, Orlando, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Sanfilipo, Michael, MD	Psychiatry	Medicine	Tele-Psychiatry
Shen, Wayne, MD	Neurology	Medicine	Neurology.
Silk, Jeremy, MD	Plastic Surgery	Surgery	Plastic and Reconstructive Surgery Hand Surgery Salinas Valley Health Wound Healing Clinic
Singh, Rakesh MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Tran, Michael, MD	Pediatric Cardiology	Pediatrics	Pediatric Cardiology Remote Pediatric Cardiology
Winter, Amy, MD	Pediatrics	Pediatrics	Pediatrics

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE
Clark, John, MD	Family Medicine	Adult Hospitalist
Healy, Mark, MD	Surgical Oncology	Special Procedures
Hershey, Allen, MD	Orthopedics	ROSA Robotic Surgery privileges

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Cammarano, Caitlin, DO	Anesthesiology	Leave of Absence effective 8/1/2024
Nakao, Zachary, MD	Emergency Medicine	Leave of Absence effective 9/1/2024

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES	RECOMMENDATION
Morris, Una, MD	Radiology	9/3/2024-11/1/2024	Locum tenens privileges for Kristen Wulff, MD.

Other Items: ***(Attached)***

ITEM	RECOMMENDATION
Ophthalmology – Clinical Privileges Delineation	Revisions to Special and Core Procedures
General Surgery – Clinical Privileges Delineation	Revisions to Oncology Core; Special and Core Procedures

Interdisciplinary Practice Committee

Applicants:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Chu, Valerie, PA-C	Cardiology	Medicine	Harlan Grogin, MD; Kanae Mukai, MD; Thomas Mustoe, MD
Finkel, Teal, PA-C	General Surgery	Surgery	Tarun Bajaj, MD; Shin Park, MD; Mario Roldan, DO; Alison Tammany, MD
Galindo, Sabrina, NP	Cardiology	Medicine	Vincent DeFilippi, MD Andreas Sakopoulos, MD

Reappointments:

APPLICANT	PRIVILEGES	COLLABORATING/SUPERVISING PHYSICIAN(S)
Kantmann, Christopher, PA-C	Emergency Medicine	Cristina Martinez, MD

Staff Status Modifications:

NAME	DEPARTMENT	STATUS
Wharram, Jennifer PA	Medicine	Resignation effective 10/3/2024.

Other Items: ***(Attached)***

Pneumococcal and Influenza Vaccine Screening and Administration Nursing Standardized Procedure
Chest Pain/Cardiovascular Nursing Standardized Procedure

Policies/Plans and Privilege Forms Recommended for Approval: ***(Attached)***

1. Blood Borne Pathogen Exposure Control Plan
2. Infection Prevention Pandemic Plan Emerging Infectious Diseases
3. Laboratory Quality Management Plan
4. MRSA Active Surveillance Screening
5. Quality Assessment and Improvement Plan
6. Retained Surgical Items

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Quality and Safety Committee Reports:
   - 2024 Healthgrades Patient Safety Excellence Award
   - Quality Improvement Reports:
     - Rehabilitation Department
     - Cardiac Catheterization Lab
     - Cardiology and Cardiac Wellness
     - Case Management – Utilization Review
   - Pharmacy & Therapeutics/Infection Prevention Committee
   - Medical/Surgical Cluster and Wound Care Program
   - Perioperative Services
   - Food/Nutrition Services
   - Respiratory Care
   - Environmental Services
   - Pathology

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings
c. Medical Staff Treasury Report September 3, 2024
d. Medical Staff Statistics Year to Date
e. Financial Update July 2024
f. HCAHPS Update September 3, 2024

Clinical Privileges Delineation
Ophthalmology

Applicant Name: _____

Ophthalmology:

To be eligible to apply for core privileges in ophthalmology, the applicant must meet the following qualifications:

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in Ophthalmologic Surgery by the American Board of Ophthalmology or the American Osteopathic Board of Ophthalmology. For Board Eligible applicants, Board Certification as defined above must occur within 7 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two (2) years post Residency must provide documentation of the performance of at least 50 ophthalmologic surgical procedures in the past 12 months.

New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privilege Statement
Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Ophthalmology core privileges
Admit, evaluate, diagnose, treat and provide consultation, order diagnostic studies and procedures and perform surgical or nonsurgical procedures on patients with ocular and visual disorders, the eyelid and orbit affecting the eye, including its related structures and visual pathways. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Remote Pediatric Ophthalmology:

To be eligible to apply remote privileges in pediatric ophthalmology, the applicant must meet the following qualifications:

All criteria outlined for Ophthalmology Core privileges above
And
Documentation of the successful performance of least 10 evaluations for retinopathy of prematurity in the past 12 months.

New applicants will be requested to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

☐ **Requested Remote Pediatric Ophthalmology Privileges** *(check box if requested)*
Read and provide formalized reports on screening examinations for retinopathy of prematurity for newborns.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 5 patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify to reapply.
AND
Be Board Certified. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Reappointment Criteria for Remote Pediatric Ophthalmology Privileges:

Applicant must provide documentation of the successful performance of at least 20 evaluations for retinopathy of prematurity over the past 24 months.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
~~***Applicant: Check box marked "R" to request privileges***~~

~~R~~	~~A~~	~~C~~	~~N~~	~~Procedure~~	~~Initial Appointment~~	~~Proctoring~~	~~Reappointment~~
				~~Moderate Sedation~~	~~Current ACLS Certification AND Signed attestation of reading SVH Sedation Protocol and learning module, AND Completion of written moderate sedation exam with minimum of 75% correct.~~	~~1~~	~~Current ACLS Certification AND Completion of written moderate sedation exam with minimum 75% correct AND Performance of at least 2 Cases~~

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~**Corneal transplants (penetrating keratoplasty)**~~	~~Successful completion of an ACGME or AOA accredited residency program in ophthalmology~~ ~~**AND**~~ ~~Successful completion of an accredited retinal fellowship training program that included performing corneal transplants.~~ ~~***Required Previous Experience:***~~ ~~Applicants must be able to demonstrate that they have performed at least 12 corneal transplant procedures in the past 12 months.~~	~~1~~	~~Performance of at least 24 corneal transplant procedures over the past 24 months~~
				Screening for Retinopathy of Prematurity	Applicants must be able to demonstrate that they have performed at least 10 evaluations for retinopathy of prematurity in the past 12 months.	**N/A**	Performance of at least 20 evaluations for retinopathy of prematurity over the past 24 months.
				Vitreo-Retinal Surgery: Scleral Buckling, Posterior Vitrectomy, Intraocular Gas Injection	Meet all criteria for Core Privileges **AND** Successful Completion of an approved Retinal Fellowship Documented Experience for applications >2 years post training	**1**	Minimum of 10 cases in 2 years
				Insertion of Glaucoma Valve with scleral and/or corneal reinforcement and patch graft	Meet all criteria for Core Privileges **AND** Successful Completion of an approved Glaucoma Fellowship Documented Experience for applications >2 years post training	**1**	Minimum of 10 cases in 2 years

Salinas Valley Health Medical Center - Ophthalmology

Core Procedure List: The following procedures are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Ophthalmology

1. Anterior vitrectomy, limbal approach
2. A and B mode ultrasound examination
3. ~~Argon Laser peripheral iridotomy, trabeculoplasty, pupilo/gonioplasty, suture lysis~~
4. ~~3.~~ Pan-retinal photocoagulation, macular photocoagulation
5. ~~4.~~ Conjunctiva surgery, including grafts, flaps, tumors, pterygium, pinguecula
6. ~~5.~~ Corneal/scleral laceration repair
7. ~~6.~~ Corneal surgery, including diathermy, traumatic repair but excluding keratoplasty, keratotomy, and refractive surgery
8. ~~7.~~ Cryotherapy for retinal tears or uncontrolled painful glaucoma
9. ~~8.~~ Glaucoma surgery with intraoperative/postoperative antimetabolite therapy, primary trabeculectomy surgery
10. ~~9.~~ Injection of intravitreal medications
11. ~~10.~~ Intra- and extracapsular cataract extraction with or without lens implant, or phacoemulsification
12. ~~11.~~ Lid and ocular adnexal surgery, including plastic procedures, chalazion, ptosis, ectroprion, repair of laceration, blepharospasm repair, tumors, flaps, enucleation, evisceration
13. ~~12.~~ Orbit surgery, including removal of the globe and contents of the orbit, enucleation, exploration by lateral orbitotomy, exenteration, blowouts, rim repairs, tumor, and foreign body removal
14. ~~Radial and/or astigmatic keratotomy~~
15. ~~13.~~ Retrobulbar or peribulbar injections for medical delivery or chemical denervation for pain control
16. ~~14.~~ Removal of anterior segment foreign body
17. ~~15.~~ ~~Strabismus surgery~~
18. ~~16.~~ Temporal artery biopsy, superficial
19. ~~17.~~ Use of local anesthetics and parenteral sedation for ophthalmologic conditions
20. ~~YAG Laser peripheral iridotomy, capsulotomy, cyclophotocoagulation, trabeculoplasty, sclerostomy lysis, posterior vitreous membranectomy~~
21. ~~18.~~ Blepharoplasty

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

_____ _____

_____ _____

Applicant Signature: Date:

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature Date

Clinical Privileges Delineation
General and Colorectal Surgery

Robotic Assisted Surgery Privileges must be requested separately.

Applicant Name: _____

GENERAL SURGERY:

Qualifications:

To be eligible to apply for core privileges in general surgery, the applicant must meet the following qualifications:

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Residency training must provide documentation of the performance of at least 100 general surgical procedures during the past 12 months.

COLORECTAL SURGERY:

Qualifications:

To be eligible to apply for core privileges in colorectal surgery, the applicant must meet the following qualifications:

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in colorectal surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Fellowship training must provide documentation of the performance of at least 50 colorectal surgical procedures during the past 24 months.

ONCOLOGIC GENERAL SURGERY:

Qualifications:

To be eligible to apply for core privileges in oncologic general surgery, the applicant must meet the following qualifications:

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board AND Successful completion of an AMBS Complex General Surgical Oncology Fellowship.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of training must provide documentation of the performance of at least 100 general surgical procedures (50 of which must be oncologic general surgery procedures) during the past 12 months.

General Privilege Statement
Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

SPECIAL REQUIREMENT:
Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; or demonstrate ongoing cancer-related education by documenting 12 CME hours annually

New applicants will be required to provide documentation of the number and types of surgical cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

☐ **General Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ **Colorectal Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages admission, workup, diagnosis and performance of surgical procedures on patients presenting with illnesses related to the colon, rectum & anus; to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ **Oncologic General Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include General Surgery core procedures, Colorectal Surgery core procedures as well as the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 5 cases per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify for reappointment.

AND

Be Board Certified. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	1	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least 2 Cases
				Insertion and management of pulmonary artery catheters	Successful completion of an accredited residency or fellowship in internal medicine, general surgery, cardiology, anesthesiology, pulmonary medicine, critical care, or family medicine; and performance of at least 10 PACs during this formal training, as primary operator **Required Previous Experience:** Active hospital practice in the chosen respective field; and performance (as the primary operator) of at least 10 PACs during the past 24 months.	1	Performance of at least 4 PACs during the past 24 months.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Sentinel Node Biopsy for Cancer~~ Added to Core Procedures	~~Documented proficiency in the standard diagnosis and surgical management of breast cancer and/or melanoma~~ ~~AND~~ ~~Successful completion of an approved course leading to the ability to evaluate the patient for and perform the sentinel node mapping procedures.~~	~~3 Retrospective Chart Reviews~~ ~~1 observation~~	~~Performance of at least 4 cases during the past 24 months.~~
				*Intermediate Laparoscopic Surgery	Must possess unrestricted privileges for open procedures **AND** Meet criteria for credentialing in basic laparoscopic general surgery **AND** Document completion of an accredited, hands-on course in laparoscopic general surgery for any one of the procedures herein defined as intermediate, or same in residency **AND** Document successful completion of at least 4 procedures in the past 24 months	1 by proctor with at minimum Intermediate Laparoscopic Surgery Privileges	Performance of at least 4 cases during the past 24 months
				Percutaneous Endoscopic Gastrostomy (PEG).	Formal fellowship training in gastroenterology or a residency in general surgery **AND** Performance of at least 5 cases during the past 24 months	1 Observation and 3 chart reviews	Performance of at least 5 cases during the past 24 months
				Laparoscopic Sleeve Gastrectomy	Unrestricted privileges to perform advanced laparoscopic surgery *(restrictions do not include initial appointment proctoring)*	5 cases observed by a surgeon with unrestricted privileges for the procedure	Performance of at least 20 cases during the past 24 months.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				*Advanced Laparoscopic Surgery	Fulfillment of criteria initially for Basic Laparoscopic privileges **AND** Document evidence of completing an accredited, hands-on course in advanced laparoscopic general surgery in the procedure requested or in three of the other advanced laparoscopic procedures, OR document having completed training and experience for such residency **AND** Document successful completion of at least 4 procedures in the past 24 months *General Surgeons who qualify for advanced laparoscopic privileges also qualify for intermediate laparoscopic privileges.	**1** by proctor with at minimum Intermediate Laparoscopic Surgery Privileges	Performance of at least 4 cases during the past 24 moths
				Esophagogastroduodenoscopy EGD	Documentation of successful completion of 50 cases in the past 24 months	**1**	Performance of at least 25 cases during the past 24 months
				Esophageal resection and reconstruction, or esophagogastrectomy, or Transhiatal Esophagectomy	Documentation of successful completion of 4 cases in the past 24 months	**1**	Performance of at least 2 cases during the past 24 months
				Colonoscopy	Documentation of successful completion of 50 cases in the past 24 months	**1**	Performance of at least 25 cases during the past 24 months
				Hysterectomy as part of general surgical procedures	Documentation of successful completion of 8 cases in the past 24 months	**1**	Performance of at least 4 cases during the past 24 months
				Regional Wound Healing Center (RWHC)	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery Privileges **AND** Be approved by the Medical Director of the RWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery privileges.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Percutaneous/Open Radiofrequency Ablation of Tumors	Successful completion of an ACGME/AOA accredited residency in general surgery, urology or otolaryngology **OR** fellowship training in oncologic general surgery, vascular surgery or interventional radiology **AND** Documentation of successful completion of 2 procedures in the past 24 months	**1**	Performance of at least 2 cases during the past 24 months AND Documentation of CME directly related to radiofrequency ablation within the past 24 months
				Use of radiofrequency for interruption of veins	Successful completion of the equipment manufacturer's training course **AND** Current unrestricted privileges in non-radiofrequency assisted deep vein interruption procedures	**1**	Performance of at least 2 cases during the past 24 months
				Radical regional lymph node dissections, including retroperitoneal, pelvic and inguinal	Documentation of successful completion of 4 cases in the past 24 months	**1**	Performance of at least 2 cases during the past 24 months
				Salpingooopherectomy	Documentation of successful completion of 8 cases in the past 24 months	**1**	Performance of at least 4 cases during the past 24 months
				FAST Scan	Completion of an accredited Surgery Residency and documentation of a minimum of 12 hours of didactic training including physics of ultrasound, sonographic instrumentation, basic interpretation (including common pitfalls) and supervised use of instrumentation in normal patients **OR** documentation of training and experience during residency.	Seven (7) FAST Scan cases must be performed and the hard copy reviewed by a radiologist. At least three (3) scans must demonstrate free fluid or blood. Initial FAST Scans will be followed by surgery or CT Scan which will provide "Gold Standard" documentation of free fluid status.	N/A
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California Stat X-Ray S&O Fluoroscopy Certification

***Core Procedure List*:** The following procedures are considered to be included in the core privileges for the specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

General Surgery

1. Amputations, above the knee, below knee, toe, transmetatarsal
2. Appendectomy
3. Biliary enteric anastomosis
4. Biliary tract resection/reconstruction
5. Breast: complete mastectomy with or without axillary lymph node dissection; excision of breast lesion, breast biopsy, incision and drainage of abscess. modified radical mastectomy, operation for gynecomastia, partial mastectomy with or without lymph node dissection, radical mastectomy, subcutaneous mastectomy including diagnosis and management of breast disorders
6. Colectomy, colotomy, colostomy
7. Proctectomy, including abdominoperineal approach
8. Correction of intestinal obstruction
9. Emergency thoracostomy
10. Enteric fistulae, management
11. Enterostomy (feeding or decompression)
12. Anal fistula and fissure procedures
13. Hemorrhoidectomy
14. Excision of thyroglossal duct cyst
15. Gastric operations for cancer (partial. or total gastrectomy)
16. Gastroduodenal surgery
17. Gastrostomy (feeding or decompression)
18. Hepatic lobectomy and insertion of infusion catheters, pumps
19. Incision and drainage of abscesses and cysts of the soft tissue
20. Biopsy of superficial lymph nodes, cutaneous and soft tissue lesions
21. Incision, excision, resection, and enterostomy of small intestine
22. Incision/drainage of perirectal abscess
23. Incision/excision of pilonidal cyst
24. Intraoral surgery, local excision
25. Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis
26. Liver biopsy (intra-operative)
27. Management of burns
28. Management of intra-abdominal trauma, including injury, observation, paracentesis, lavage
29. Management of multiple trauma
30. Management of soft tissue tumors, inflammations, and infections and necrosis
31. Open operations on gallbladder, biliary tract, bile ducts, hepatic ducts, excluding biliary tract reconstruction
32. Pancreatic pseudoscyst drainage
33. Debridement of infected pancreatic tissue
34. Nephrectomy with Urology present
35. Debridement of decubitus and stasis ulcers of the skin
36. Removal of ganglion (palm or wrist; flexor sheath)
37. Removal of Peritoneal Dialysis Catheter
38. Repair of perforated viscus (gastric, small intestine, large intestine)
~~38.~~39. Sentinel lymph node biopsy
~~39.~~40. Skin grafts (partial thickness, full thickness, split thickness)
~~40.~~41. Splenectomy (trauma, staging, therapeutic)
~~41.~~42. Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic hernias, inguinal hernias, and orchiectomy in association with hernia repair

~~42.~~43. Thoracentesis
~~43.~~44. Thyroid and parathyroid surgery
~~44.~~45. Tracheostomy
~~45.~~46. Vagotomy
~~46.~~47. Varicose vein injection, sclerotherapy, excision & ligation, interruption of deep perforator veins of the lower extremities
~~47.~~48. Insertion of central venous catheters: non-tunneled, tunneled, with or without subcutaneous ports
~~48.~~49. Arterial line placement and monitoring
~~49.~~50. Basic Laparoscopy – diagnostic, appendectomy, cholecystectomy, lysis of adhesions, Peritoneal Dialysis , feeding tubes and catheter positioning and Liver Biopsy

***Core Procedure List*:** The following procedures are considered to be included in the core privileges for the specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Colorectal Surgery

1. Abdominal procedures related to diseases of the colon, rectum and anus
2. Anorectal procedures
3. Endoscopic procedures including anoscopy, rigid sigmoidoscopy, flexible sigmoidoscopy, & total colonoscopy
4. Endoscopic rectal ultrasound
5. History & Physical
6. Operative management and post-operative care of patients with pathologic conditions involving the intestinal tract, colon, rectum, anal canal and perianal area
7. Urogynecologic procedures related to diseases of the colon, rectum and anus
8. Use of Laser
9. Vascular access procedures
10. Laparoscopic Colon Surgery
11. Laparoscopic Hernia Repair

***Core Procedure List*:** The following procedures are considered to be included in the core privileges for the specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Oncologic General Surgery

1. All core procedures for General Surgery and Colorectal Surgery
2. Hysterectomy and BSO as part of cytoreductive surgery
3. Intraoperative EGD
4. Intraoperative sigmoidoscopy

* DEFINITIONS

Intermediate laparoscopic general surgery

- Jejunostomy
- Gastrostomy
- Vagotomy
- Lymph node biopsy
- Closure perforated ulcer
- Oopherectomy and/or drainage of ovarian cyst in consultation with OB/GYN
- Hernia repair to include hiatal, umbilical, incisional and inguinal with or without graft

Advanced laparoscopic general surgery

- Bowel surgery to include resection, anastomosis, stoma, colectomy, hemicolectomy, and sigmoidectomy
- Common bile duct exploration
- Splenectomy
- Lymph node dissection
- Nephrectomy with Urologist present
- Adrenalectomy
- Gastrectomy

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

Applicant Signature: Date:

Acknowledgment of practitioner
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature _____ Date _____

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature _____ Date _____

Status **Pending** PolicyStat ID **15651381**

Last Approved: N/A
Next Review: 3 years after approval

Owner: Carla Spencer: Chief Nursing Officer
Area: Nursing Standardized Procedures

Pneumococcal and Influenza Vaccine Screening and Administration Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Pneumococcal Vaccine (Pneumovax)
B. Influenza –current, seasonal vaccine.

III. PROCEDURE

A. **Function**

1. To provide guidelines for the Registered Nurse (RN) when administering Pneumococcal and/or Influenza Vaccine(s) to the appropriate inpatient(s) as indicated per criteria set forth by the Pharmacy and Therapeutics Committee and the Medical Executive Committee.
2. To provide guidelines to the Registered Nurse when an inpatient does not fit the protocol criteria for pneumococcal vaccination but desires to be immunized.
3. **Circumstances**
    a. **Setting**
        i. Pneumococcal Vaccine indicated (if any of the following): The patient is:
            a. Inpatient or Observation status
            b. 65 years of age or older.
            c. Age 5-64 and has **any** of the following high-risk

conditions:

i. Chronic heart, lung, renal, metabolic, or liver disease, cancer, anemia, alcoholism, HIV/AIDS, sickle cell disease, cochlear implants, cerebrospinal fluid (CSF) leaks, Hodgkin's disease, organ transplant, long-term steroid use.

ii. Patient without a spleen.

iii. Immunocompromised patients.

d. Uncertain about prior vaccination status, or history unreliable and the patient meets the above criteria

ii. Influenza Vaccine **October 1 – March 31) unless directed otherwise by Infection Control / CMO)**. Vaccination indicated for all patients six months of age and older.

b. **Supervision**

i. Registered Nurses who are qualified to perform this standardized procedure will order and administer the pneumococcal and/or influenza vaccines for those patients who meet criteria.

c. **Patient Conditions**

i. Pneumococcal Vaccine **not indicated** (if any of the following):

a. Patient has received vaccine less than five (5) years ago.

b. Allergy to vaccine.

c. Previous allergic and/or neurological reaction to vaccine.

d. Patient to receive chemotherapy or radiation therapy this admission

e. Patient refused

f. Patient received bone marrow transplant within past 12 months.

ii. Influenza Vaccine **not indicated** (if any of the following):

a. Already immunized this flu season

b. Allergy to eggs

c. Serious reaction to prior influenza vaccine

d. History of Guillian-Barre Syndrome

e. Patient refused

f. Bone marrow transplant within past 12 months

4. **Database**
    a. **Subjective**
        i. During the admission process, the RN will screen all patients five (5) years of age and older to determine if they are eligible for the pneumococcal vaccine.
    b. **Objective**
        i. If the patient is uncertain about prior pneumococcal vaccination status or the patient's history is unreliable and the vaccine is indicated per protocol, the patient will be vaccinated.
5. **Diagnosis**
    a. All Inpatient / Observation status diagnosis
6. **Plan**
    a. **Treatment**
        i. Complete the vaccine screening, documenting the patient's vaccine indications and contraindications. If the patient has received the vaccine in the past 5 years, verify or enter this data in the Summary Panel of the medical record. Enter the vaccine name, date administered, and source of this information.
        ii. If the pneumonia vaccine is not indicated per protocol, enter an "N" and file.
        iii. If the pneumonia vaccine is indicated per protocol, enter a "Y". The pneumonia vaccine order will be suggested to the nurse. The nurse will submit this order and it will display on the MAR as a one time order due now.
        iv. The nurse administers the vaccine, and documents on the Medication Administration screen under the tabs "Flow sheet" and "Admin."
            a. On the Flow sheet, document the VIS date given to patient, and patient understanding.
            b. On the Admin screen document the administration site, lot number and expiration date. The responses on this screen will display on the Summary Panel with the VIS publication date and on all future visits..
        v. If the patient is screened as indicated but patient refuses
            a. The Nurse documents in MAR **Not Given** with reason code "Refused."
        vi. If the patient is screened as a candidate but has a fever or is off the unit:
            a. Leave entry on MAR– time will display and turn pink when not given.

b. Administer as soon as the fever is less than 38 or the patient returns to the unit. Document the variance reason in the Admin screen of the MAR.

b. Patient conditions requiring consultation/reportable conditions

i. If the patient requests a pneumonia vaccination but does not meet the criteria, i.e. not 65 years of age, or does not have a chronic illness, the nurse will refer the patient to their primary care physician for administration of the vaccine.

c. Education-Patient/Family

i. If the vaccine is indicated, print the Pneumonia Vaccination Information Sheet and review it with the patient.

d. **Follow-up**

i. Check if the patient incurs any reaction to the vaccine

e. **Documentation of Patient Treatment**

i. Document on the flow sheet in the MAR.

7. **Record Keeping**

a. The facility will retain the patients' record according to the Record Retention procedure.

B. **STANDARDIZED PROCEDURE FOR ADMINISTERING AND DOCUMENTING THE INFLUENZA VACCINE**

1. **Database**

a. **Subjective:**
During the admission process the RN will screen all patients six (6) months of age and older to determine if they are eligible for the influenza vaccine.

b. **Objective:**
If the patient has received a flu vaccine during the present flu season (Oct. 1 – Mar 31). Verify or enter this data in the Summary Panel of the medical record. Enter the vaccine name, date administered, and source of this information.

2. **Diagnosis**

a. All Inpatient / Observation status diagnosis

3. **Plan**

a. **Treatment**

i. If the influenza vaccine is not indicated per protocol, enter an "N" and file.

ii. If the influenza vaccine is indicated per protocol, enter a "Y" and file. The influenza vaccine order will be suggested to the nurses.

The nurse will submit this order and it will display on the MAR as a one time order due now.

iii. After administering the vaccine, the nurse documents on the Medication Administration screen under the tabs "Flow sheet" and "Admin."

    a. On the Flow sheet, document the date VIS given to patient and patient understanding.

iv. On the Admin screen document the administration site, lot number and expiration date. The responses on this screen will display on the Summary Panel with the VIS publication date and on all future visits. If the patient is screened as indicated but patient refuses:

    a. The Nurse documents in MAR **Not Given** with reason code "Refused."

v. If the patient is screened as a candidate but has a fever or is off the unit:

    a. Leave entry on MAR. Administer as soon as the fever is less than 38 or the patient returns to the units. Document the variance reason in the Admin screen of the MAR.

vi. In the event that the influenza vaccination is indicated, not documented as "refused" by the patient and not administered when the patient is hospitalized, the following procedure will apply:

    a. Nurse Director/Manager/Designee of discharging department will contact the patient via telephone within 72 hours following discharge from the hospital.

    b. Nurse Director/Manager/Designee will determine if the patient would like to return to the hospital for the vaccination.

    c. If "no", the Nurse Director/Manager/Designee will reactivate **AND** edit the influenza screening intervention indicating that the patient refused. (The Add a Note footer button can be used if a note is necessary).

    d. If "yes":

        i. The Nurse Director/Manager/Designee will notify the Employee Health Department ("Employee Health") via email (send as "high importance") with the patient's name, account number and contact telephone number.

ii. Employee Health will contact the patient to arrange for vaccination at no cost.

iii. Once patient is vaccinated, Employee Health will forward the *Influenza Consent and Vaccination* form (Attachment A) to HIM for scanning and placement in the electronic medical record.

iv. Employee Health will notify via email the Nurse Director/Manager/Designee and Clinical Informatics of the administration of the vaccine and will include the patient's name and account number.

v. Clinical Informatics will document the administration of the vaccine in the immunization section of the Summary tab after confirming the scanned documents in the electronic medical record.

vii. If the patient meets the influenza screening criteria and the physician discontinues the order **OR** an order is received to not give the vaccine, the nurse will inform the patient/family that the physician advises that the vaccine not be administered.

a. The nurse will provide the patient/family with an opportunity to refuse the vaccine.

b. If the vaccine is refused, reactivate the screening intervention if necessary and select patient refused or document in the MAR refused.

b. **Patient circumstances requiring consultation/reportable conditions**

i. If the patient shows signs of a reaction to the vaccine contact the patient's physician

c. **Education-Patient/Family**

i. If the vaccine is indicated, print the Influenza Vaccination Information Sheet and review it with the patient.

d. **Follow-Up**

i. Check if the patient incurs any reaction to the vaccine

e. **Documentation of Patient Treatment**

i. Document on the flow sheet in the MAR.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

1. In accordance with the SVHMC RN job description

B. Training

1. The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

C. Experience

1. In accordance with the established SVHMC job description.

D. Evaluation

1. Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
2. Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
3. During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule

1. Every 3 years or when practice changes are made.

B. Approval

1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. Centers for Disease Control and Prevention.
B. California Board of Registered Nursing,
C. Title 16, California Code of Regulations Section 1474
D. Medical Board of California. Title 16, Code of Regulations Section 1379

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	09/2024
IDPC	Katherine DeSalvo: Director Medical Staff Services	09/2024
P&T Committee	Genevieve delos Santos: Director Pharmacy	08/2024
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	07/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16201709**

Last Approved	N/A	Owner	David Thompson: Clinical Manager
Next Review	3 years after approval	Area	Nursing Standardized Procedures

Chest Pain/Cardiovascular Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Wong-Baker Scale: System to rate pain on a numeric scale, zero (0) to ten (10).

B. ER: Emergency Room

C. EKG: Electrocardiogram

D. IV/INT: Intravenous Therapy (saline lock) with intermittent flushes.

E. CBC: Complete Blood Count

F. CMP: Comprehensive Metabolic Panel

G. TROP: Troponin

H. sHCG: Human Chorionic Gonadotropin

I. SOB: Short of Breath

III. PROCEDURE

A. Function

1. To expedite care for patients who present to the Emergency Department (ED) with a chief complaint of chest pain or other symptoms that may be cardiovascular/cardiac in nature.

B. Circumstances

1. Setting Emergency

    a. Registered Nurses (RN) assigned to the ED may initiate orders for patients presenting with chest pain or symptoms that may be cardiac in nature prior to physician evaluation **IF:** the ED physician is not immediately available. The RN will obtain an EKG within 10 minutes. If an MD is not signed up or will not see within 30 min or a timely manner than the RN will ensure blood is drawn, order approved laboratory tests, initiate cardiac monitoring, place oxygen per protocol and place an INT with routine flushes. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.

2. Supervision

    a. Registered Nurses who are qualified to perform this standardized procedure may independently order approved laboratory tests , order an EKG, previous EKG, Oxygen Administration, and start/place an IV if patients are unstable who present with a chief complaint of chest pain or other symptoms that my be cardiac in nature and for whom meet the criteria above. Physician supervision is not required.

3. Patient Conditions

    a. Emergency Department patients who present with **any** of the following symptoms, the procedure will be initiated:

        i. **Chest Pain-** Discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. Patients may describe the pain as uncomfortable pressure, squeezing, fullness or pain.

        ii. **Pain in other areas of the upper body** – Symptoms can included pain in one or both arms, the back, neck, jaw or upper abdomen. Patient may describe the pain as deep aching and throbbing in one or both arms.

        iii. **Shortness of breath** – May occur with or without chest pain/ discomfort. May be described as breathlessness and/or inability to catch breath when waking up. It may be at rest or with exertion.

        iv. **Irregular heart rhythm**- new onset of irregular rhythm.

        v. **Swollen legs, ankles, or feet**- non-traumatic swelling of the extremities, in addition to SOB or CP or a cardiac history.

        vi. **Other signs** – These may include clammy sweating, nausea, and or fatigue and feelings or impending doom.

b. **NOTE**: Symptoms of heart attack in women are often different than in men. Women are more likely to experience shortness of breath, fatigue, nausea, and dizziness as presenting symptoms.

C. Data Base

1. Subjective

a. Prioritization and Severity of Illness

i. Patients with a chief complaint of chest pain, dizziness, SOB or dyspnea on exertion, regular heart rhythm, or non-traumatic swelling of extremities with associated SOB, CP or cardiac history that may be cardiac in nature will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

ii. History of present illness/injury/chief complaint

iii. Characteristic of Chest Pain using the Wong-Baker Pain Scale

iv. Consider conditions related to cardiac disease i.e.) pericarditis, cardiomyopathy, or coronary artery disease

v. History of cardiac surgeries/illness

2. Objective

a. Chief complaint of chest pain

i. Signs of hypovolemia

ii. Chest pain radiation, symmetry and pain upon palpation

iii. Level of consciousness

iv. Color of skin/sclera

v. Presence or absence of peripheral edema

vi. Objective signs of pain

D. Diagnosis

1. Chest pain or other symptoms that may be cardiovascular/cardiac in nature.

E. Plan

1. Treatment

a. The following laboratory tests may be ordered: CBC, CMP, Lipase, POC I-

stats as needed, Troponin I, Qualatative HCG (<50 years old), Draw extra tubes.

b. If no ED provider has signed up for the patient then the order set should be placed under "Physician Emergency". Place orders if a physician can't see within 30 min or in timely manner.

c. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION policy). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.

d. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag

e. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

f. Cardiac monitor with rhythm interpretation (rhythm strip to be mounted in patient's medical record)

2. Patient conditions requiring consultation/reportable conditions:

    a. Notify an Emergency Department physician immediately of the following:

        i. Changes in airway, breathing, circulation or altered level of consciousness.

        ii. Change in triage acuity.

            a. Patients presenting with signs and symptoms of possible ACS (acute coronary syndrome).

            b. **Note: If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, acute myocardial infarction, pulmonary embolism or spontaneous pneumothorax, Aortic Dissection, Acute CHF exacerbation in respiratory distress, pericardial tamponade, unstable arrhythmia.**

3. Education - Patient/Family

    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy.

4. Follow Up
    a. As needed to maintain continuity of care
5. Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    b. If no ED provider has signed up for the patient then the order set should be placed under 'Physician, Emergency' and will not be seen in 30 min or timely manner.
    c. Navigates to ER Nursing Orders
    d. Selects "Chest Pain/Cardiovascular Standardized Procedure"as the order source.

F. Record Keeping

1. The facility will retain the patients' record according to the RECORD RETENTION procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

1. A registered nurse who has completed orientation and has demonstrated clinical competency may perform the procedures listed in this protocol. Education will be given upon hire with a RN preceptor/designee

B. Training

1. Clinical competency must be demonstrated and approved by supervising personnel or preceptor.

C. Experience

1. Current California RN license and designated to work in ED

D. Evaluation

1. Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.
2. Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.

3. Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
4. Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

1. Review and approval every three (3) years.
2. Policy goes through the Emergency Department Physician Group every three (3) years.
3. Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
4. Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.

B. Review schedule

1. Review of policy every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

1. Approval of the standardized procedure is outlined in the electronic policy and procedure system.
2. Nursing
    a. Director of Emergency Department every three (3) years
3. Medicine
    a. Medical Director of Emergency Department every three (3) years
    b. Chair of Interdisciplinary Medical Practice Committee every three (3) years
4. Administration
    a. Chief Nursing Officer (Vice President of Patient Care Services) every three (3) years

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in

the department and available upon request.

VII. REFERENCES

A. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR, Section 1379.

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2016), 7th Edition. *Planning/interventions for myocardial infarction.*

Approval Signatures

Step Description	Approver	Date
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Owner	David Thompson: Clinical Manager	09/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14161455**

Last Approved N/A

Next Review 1 year after approval

Owner Melissa Deen: Manager Infection Prevention

Area Plans and Program

Bloodborne Pathogen Exposure Control Plan

I. SCOPE

A. Employers must implement an exposure control plan to reduce or eliminate the hazards of occupational exposure to bloodborne pathogens. The plan should contain detailed information on measures to protect employees. It should also describe how an employer will use engineering and work practice controls, personal protective clothing and equipment, employee training, medical surveillance, hepatitis B vaccinations, and other provisions as required by OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030).

B. The standard states what employers must do to protect workers who are occupationally exposed to blood or other potentially infectious materials (OPIM), as defined in the standard. That is, the standard protects workers who can reasonably anticipate coming into contact with blood or OPIM while performing their job duties.

C. **OBJECTIVES/GOALS**

D. Objectives

1. The objective of the Salinas Valley Health Medical Center (SVHMC) Bloodborne Pathogen Exposure Control Plan is to comply with the Occupational Safety and Health Administration's (OSHA) Bloodborne Pathogens Standard, 29 CFR 1910.1030, and to eliminate or minimize employee occupational exposure to blood, certain *other* bodily fluids, or other potentially infectious materials as defined below:
    a. Blood means human blood, human blood components, and products made from human blood.
    b. Bodily fluids means semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.

c. Other potentially infectious materials mean any unfixed tissue or organ (other than intact skin) from a human (living or dead), and human immunodeficiency virus (HIV)-containing cell or tissue cultures, organ cultures, and HIV- or hepatitis B virus (HBV)-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV. **Note: see--BLOOD BORNE PATHOGEN EXPOSURE GUIDELINES: EMPLOYEES, FIRST RESPONDERS, PATIENTS & VISITORS**

II. Background

OSHA requires employers to identify situations and job classifications in which employees may be exposed to blood or other potentially infectious materials, and to provide protection to these employees in the form of engineering controls, personal protective equipment, training, and risk reduction.

III. Assignment Of Responsibility

A. **Program Administrator**

Infection Prevention in collaboration with Employee Health Services shall manage the Bloodborne Pathogen Exposure Control Plan for SVHMC and maintain all records pertaining to the plan.

B. **Management**

SVHMC will provide adequate controls and equipment that, when used properly, will minimize or eliminate risk of occupational exposure to blood or other potentially infectious materials. These shall be provided at no cost to the employees. SVHMC management will ensure proper adherence to this plan through periodic audits.

C. **Supervisors**

Supervisors shall themselves follow and ensure that their employees are trained in *and* use of proper work practices, standard precautions, the use of personal protective equipment, and proper cleanup and disposal techniques.

D. **Employees**

Employees are responsible for employing proper work practices, standard precautions, and personal protective equipment and cleanup/disposal techniques as described in this plan. Employees are also responsible for reporting all exposure outlined in this plan to their direct supervisor and EHS immediately. If this is off hours and /or the direct supervisor / EHS is unavailable, then reporting is to the Administrative Supervisor.

E. **Contractors**

Contract employees such as, but not limited to medical staff members, travelers, security personnel, etc., are responsible for complying with this plan, and shall be provided the training described herein during orientation.

IV. Exposure Determination

All job classifications and locations in which employees may be expected to incur occupational exposure to blood or other potentially infections materials, based on the nature of the job or collateral duties, regardless of frequency, shall be identified and evaluated by Infection Prevention & Control / EHS. This list shall be updated as job classifications or work situations change. Exposure determination shall be made without regard to the use of personal protective equipment.

A. Category I

Job classifications in which employees are exposed to blood or other potentially infectious materials on a regular basis, and in which such exposures are considered normal course of work, fall into Category I. Outlined in this plan is a list of the types of jobs and the locations in which the work will be performed (see Attachment A).

B. Category II

Job classifications in which employees may have an occasional exposure to blood or other potentially infectious materials, and in which such exposures occur only during certain tasks or procedures that are collateral to the normal job duties, fall into Category II. Outlined in this plan is a list of the types of jobs and the locations in which the work may be performed (see Attachment B).

V. Implementation Schedule And Methodology

A. Compliance Methods

1. Standard precautions

Standard precautions (formally "universal precautions") shall be used at SVHMC to prevent contact with blood or other potentially infectious materials. All blood or other potentially infectious materials shall be considered infectious, regardless of the perceived status of the source individual.

2. Engineering Controls

The engineering and work practice controls listed below shall be used to minimize or eliminate exposure to employees at SVHMC.

a. Sharps containers, bio-safety cabinets, safety needles, needleless systems, gowns, gloves, eye protection, etc. are to be used in accordance with training and policy as a first line of protection.

The following schedule shall be followed to review the effectiveness of the engineering controls:

a. Engineering controls that assist in the prevention of exposure will be reviewed during policy review and /or earlier as needed or required by regulatory guideline changes.

Where occupational exposure remains after SVHMC institution of these controls, personal protective equipment shall also be used.

3. Needles

   Except as noted below, contaminated needles and other sharps shall not be bent, recapped, removed, sheared, or purposely broken. Contaminated sharps shall be placed immediately, or as soon as possible, after use into appropriate sharps containers. All disposable sharps containers shall be puncture resistant, labeled with a biohazard label, and leak-proof.

4. Containers for Reusable Sharps

   Contaminated sharps that are reusable shall be placed immediately, or as soon as possible, after use into appropriate sharps containers. All reusable sharps containers shall be puncture resistant, labeled with a biohazard label, and leak-proof.

   a. Sharps containers are readily available in all clinical areas at SVHMC. Environmental Service (EVS) is responsible for the removal and replacement of sharps containers. Sharps containers are to be replaced when ¾ full.

5. Sharps Injury Log

   A needle stick or sharps injury log shall be maintained by EHS and will reflect the standards of 29 CFR 1910.1030(h)(5) and will include the following information for each incident:

   a. date of incident
   b. type and brand of device involved
   c. department or area of incident occurred
   d. explanation of how of the incident occurred

   The log shall be retained for the period required by 29 CFR 1904.33, which at the time of this review is (5) years following the end of the calendar year that these records cover.

6. Hand Washing Facilities

   Hand washing facilities are made available and are readily accessible to all HCW who may incur exposure to blood or other potentially infectious materials. Where hand washing facilities are not feasible, SVHMC will provide an antiseptic alcohol based cleanser in conjunction with clean cloth/paper towels. Such areas include:

   a. Engineering office / areas, waste management disposal areas, non-clinical areas, buildings and unit are provided with SVHMC approved alcohol based hand sanitizer.

When these alternatives are used, employees shall wash their hands with soap and running water as soon as feasible.

7. Work Area Restrictions

   In work areas where there is a reasonable risk of exposure to blood or other potentially infectious materials, employees shall NOT have food, water containers without leak proof/sealed lids (examples not to be used: no disposable paper coffee cups with open lids or drink containers with straws), apply cosmetics or lip balm, or handle contact lenses. All drink containers MUST be spill proof, and each department MUST determine a location for hydration stations. Drinks are NOT allowed on equipment, including WOWs. NO Food and beverages shall be kept in refrigerators, freezers, shelves, cabinets, or on counter tops or bench tops where blood or other potentially infectious materials may be present.

   Mouth pipetting or suctioning of blood or other potentially infectious materials is *strictly prohibited.*

   All processes and procedures shall be conducted in a matter that will minimize splashing, spraying, splattering, and generation of droplets of blood or other potentially infectious materials.

   a. Covers will be used on centrifuges'; eye protection will be utilized when exposure to splashes is expected/anticipated to occur.

8. Specimens

   Each specimen of blood or other potentially infectious material shall be placed in a container that will prevent leakage during the collection, handling, processing, storage, and transport of the specimen.

   Specimen containers shall be labeled or color-coded in accordance with the requirements of the OSHA standard and per SVHMC applicable policies.

   Any specimens that could puncture a primary container shall be placed within a secondary puncture-resistant container. If outside contamination of the primary container occurs, the primary container shall be placed within a secondary container that will prevent leakage during handling, processing, storage, transport, or shipping of the specimen.

9. Contaminated Equipment

   Bio-medical services, Engineering, Materials Management and Sterile Processing shall ensure that equipment that has become contaminated with blood or other potentially infectious materials is examined prior to servicing or shipping. Contaminated equipment shall be decontaminated, unless decontamination is not feasible. Contaminated equipment shall be tagged and labeled as such.

10. Personal Protective Equipment (PPE)

    a. PPE Provision

Personal protective equipment shall be chosen based on the anticipated exposure to blood or other potentially infectious materials. Protective equipment shall be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through or reach an employees' clothing, skin, eyes, mouth, or other mucous membranes under normal and proper conditions of use and for the duration of time that the equipment will be used.

Follow AAMI levels as noted:
https://wwwn.cdc.gov/PPEInfo/Standards/Info/ANSI/AAMIPB70Class3

A list of personal protective equipment and associated tasks for SVHMC can be found in **Attachment B** of this plan.

b. PPE Use

Infection Prevention, EHS, Directors, Managers and supervisors shall ensure that employees use appropriate PPE. In cases where an employee temporarily and briefly declines to use PPE because, in the employee's professional judgment, its use may prevent delivery of healthcare or pose an increased hazard to the safety of the worker or co-worker, then the Director shall investigate and document the situation and work with EHS and IP to determine whether changes can be instituted to prevent such occurrences in the future.

c. PPE Accessibility

SVHMC shall ensure that appropriate PPE in the necessary sizes is readily accessible at the work site or is issued at no cost to employees. Hypoallergenic gloves, glove liners, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

d. PPE Cleaning, Laundering and Disposal

All garments non-disposable PPE, penetrated by blood or other potentially infectious materials shall be removed immediately or as soon as feasible. All PPE will be removed before leaving the work area. When PPE is removed, it will be placed in appropriately designated areas or containers for storage, washing, decontamination, or disposal.

All PPE will be cleaned, laundered, and disposed of by SVHMC / contracted laundry vendor, at no cost to the employees.

e. Types of PPE

    i. Gloves

    Disposable gloves are not to be washed or decontaminated for

re-sue, and are to be replaced as soon as possible when they become contaminated, or directly after use. Gloves that become torn or punctured (or their ability to function as a barrier is otherwise compromised) shall be replaced immediately or as soon as feasible.

Utility gloves may be decontaminated for re-use if the integrity of the glove is uncompromised. Utility gloves shall be disposed of properly if they are cracked; peeling, torn, punctured, or they exhibit other signs of deterioration or inability to function as a barrier without compromise.

ii. Eye and Face Protection

Masks worn in combination with eye protection devices (such as goggles or glasses with solid side shield, or chin-length face shields) are required when the occurrence of splashes, splatters, or droplets of blood or other potentially infectious materials can reasonably be anticipated to contaminate an employee's eye, nose, or mouth. Situations at SVHMC where eye and face protection is required include:

a. Any area during procedures that may expose the HCW to Blood borne pathogen to include ancillary depts. such as laboratory, diagnostic Imaging, etc.

iii. Other PPE

Additional protective clothing (such as lab coats, gowns, aprons, clinic jackets, or similar outer garments) shall be worn in instances when gross contamination can reasonably be expected. The following situations require additional protective clothing:

a. Central sterile, Laboratory, Pathology / Histology, Endoscopy, Surgery

B. Housekeeping

This facility shall be cleaned and decontaminated regularly, as needed in the event of a gross contamination and per Environmental Services dept. process / policy. All contaminated work surfaces; bins, pails, cans, and similar receptacles shall be inspected and decontaminated regularly as described in Appendix A.

Any potentially contaminated glassware shall not be picked up directly with the hands. Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where sharps are placed.

C. Regulated / Biological Waste Disposal

Disposal of all regulated /biological waste shall be in accordance with applicable federal, state, and local regulations.

1. Sharps

   Contaminated sharps shall have safety device engaged by user and discarded immediately or as soon as feasible in containers that are close-able, puncture resistant, leak proof on sides and bottom, and labeled or color-coded.

   During use, containers for contaminated sharps shall remain upright throughout use, shall be easily accessible to employees, and shall be located as close as feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (including laundry areas).

   When moving sharps containers from the area of use, the containers shall be closed /locked immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping. Sharps containers shall be placed in a secondary container if leakage of the primary container is possible. The second container shall be close-able, constructed to contain all contents, and shall prevent leakage during handling, storage, transport, or shipping. The secondary container shall be labeled or color-coded to identify its contents.

   Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner that would expose employees to the risk of percutaneous injury.

2. Other Regulated Waste

   Other regulated waste shall be placed in containers that are closeable, constructed to contain all contents, and will prevent leakage of fluids during handling, storage, transportation, or shipping.

   All waste containers shall be labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

D. Laundry

Laundry contaminated with blood or other potentially infectious materials shall be handled as little as possible. Contaminated laundry shall not be sorted or rinsed in the area of contamination and is to be placed into dirty linen. All laundry is to be considered potentially contaminated and standard precautions are to be utilized. Example: wear gloves if visibly soiled, hold laundry away from body, and place into soiled linen container.

The designated laundry facility utilizes standard precautions for blood / body fluid contamination. The facility is visited by EVS and /or Infection Prevention every year or more as indicated to assure all applicable regulatory standards are met.

VI. Hepatitis B Vaccines and Post-Exposure

Evaluation and Follow Up

A. General

SVHMC will make the Hepatitis B vaccine available to all employees who have the occupational exposure, as well as post-exposure follow up to employees who have experienced an exposure incident.

SVHMC shall ensure that all medical evaluations and procedures involved in the Hepatitis B vaccine and post-exposure follow up, including prophylaxis are:

1. made available at no cost to the employee;
2. made available to the employee at a reasonable time and place;
3. performed by or under the supervision of a licensed physician or other licensed healthcare professional; and
4. Provided in accordance with the recommendations of the United States Public Health Service, and in accordance with California Public Health guidelines. Ensure laboratory tests are conducted by an accredited laboratory at no charge to the employee.

B. Hepatitis B Vaccination

EHS, in collaboration with Infection Prevention, shall manage the Hepatitis B vaccination program.

1. Category I Employees

   The Hepatitis B vaccination shall be made available to an affected Category I employee after he or she has received training in occupational exposure and within 10 working days of initial assignment to job duties that involve exposure. Exceptions to the administration of the Hepatitis B vaccination include situations where an employee has previously received the complete Hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons or the employee documents declination.

   Participation in a pre-screening program shall not be a prerequisite for an affected employee to receive the Hepatitis B vaccination. If an employee initially declines the Hepatitis B vaccination, but later decides to accept the vaccination and is still covered under the OSHA standard, the vaccination shall then be made available.

   All employees who decline the Hepatitis B vaccination shall sign a waiver indicating their refusal as required by OSHA. SVHMC will follow guidelines for Hepatitis B vaccination imposed by the United States Public Health Service and /or the California Department of Public Health.

2. Category II Employees

   The Hepatitis B vaccination series shall be made available and administered to

Category II employees as per CDC and OSHA guidelines. All employees who decline the Hepatitis B vaccination shall sign a waiver indicating their refusal.

C. Post-Exposure Evaluation and Follow Up

Employees must report all exposure incidents to their immediate supervisor and EHS immediately or as soon as possible but within 1 hour of incident. If the exposure occurs off hours/ holiday/weekend, then the employee is to notify Administrative Supervisor immediately if EHS is unavailable. The Administrative Supervisor will investigate and document each exposure incident for follow up by EHS. Following a report of an exposure incident, the exposed employee shall immediately receive a confidential post-exposure evaluation and follow up, to be provided by EHS and /or SVHMC Emergency Department. The post-exposure evaluation and follow up shall include the following elements, at a minimum:

1. Documentation of the route of exposure, and the circumstances under which the exposure occurred.
2. Identification and documentation of the source individual, unless it can be established that identification is infeasible or prohibited by state or local law.
3. The source individual's blood shall be tested and documented as soon as feasible in order to determine Hepatitis B, Hepatitis C and HIV status.
4. When the source individual is already known to be infected with the Hepatitis B virus (HBV), Hepatitis C virus, (HCV) or human immunodeficiency virus (HIV), testing for the source individual's known HBV or HIV status need not be repeated. Hepatitis C virus testing may be indicated to determine viral load of patient at time of exposure.
5. Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.
6. The exposed employee's blood and source patient blood shall be collected as soon as feasible and rapid tested for HIV prior to administration of prophylaxis exposure medications.

Employees that contract HIV or Hepatitis shall be de-identified as a "confidentiality case" on the OSHA 300 log this information will be maintained in the employee's file as confidential. Conversion rates will be reported in IC Committee and Environment of Care.

D. Information Provided to the Healthcare Professional

After an exposure incident involving an employee, EHS, shall ensure that the employee's post-exposure evaluation is completed, and referral initiated to an MD if patient and /or source has positive results. The following is to be provided to the treating provider:

1. a copy of 29 CFR 1910.1030, OSHA's Bloodborne Pathogen Standard, with emphasis on the confidentially requirements contained therein;
2. a written description of the exposed employee's duties as they relate to the exposure incident;
3. written documentation of the route of exposure and circumstances under which the

exposure occurred;

4. results of the source individual's blood testing, if available
5. All medical records relevant to the appropriate treatment of the employee, including vaccination status.

E. Healthcare Professional's Written Opinion

EHS shall obtain and provide the exposed employee a copy of the evaluating healthcare professional's written opinion within 15 days of completion of the evaluation.

The healthcare professional's written opinion for HBV vaccination shall be limited to whether HBV vaccination is indicated for the employees, and if the employee has received said vaccination.

The healthcare professional's written opinion for post-exposure follow up shall be limited to ONLY the following information:

1. Documentation that the employee has been informed of the results of the evaluation; and
2. Documentation that the employee has been informed of any medical conditions resulting from exposure to blood or other potentially infectious materials that require further evaluation or treatment.

Other findings or diagnosis resulting from the post-exposure follow up shall remain confidential and shall not be included in the written report.

VII. Labels and Signs

Environmental Services shall ensure that biohazard labels are affixed to containers of regulated waste, refrigerators, and freezers containing blood or other potentially infectious materials. Labels shall also be affixed to any other containers used to store, transport, or ship blood or other potentially infectious materials.

The labels shall be fluorescent orange or orange-red, and shall include the universal biohazard symbol. Red bags or containers with the universal biohazard symbol may be substituted for labels. However, regulated wastes must be handled in accordance with the rules and regulations of the entity with jurisdiction. Blood products that have been released for transfusion or other clinical use are exempted from these labeling requirements.

VIII. Training

SVHMC shall ensure that training is provided to all new healthcare workers at new employee orientation. Training is provided by Infection Prevention. Training is repeated annually, or when there are any changes to tasks or procedures affecting an employee's occupational exposure. Training is interactive and shall include:

1. available copy of 29 CFR 1910.1030, OSHA's Bloodborne Pathogen Standard;
2. a discussion of the epidemiology and symptoms of Bloodborne diseases; an explanation of the modes of transmission of Bloodborne pathogens;
3. an explanation of SVHMC Bloodborne Pathogen Exposure Control Plan, and how employees can obtain a copy of the plan;
4. a description and recognition of tasks that may involve exposure;
5. an explanation of the use and limitations of the methods employed by SVHMC healthcare workers to reduce exposure (such as engineering controls, work practices, and personal protective equipment);
6. information about the types, use, location, removal, handling, decontamination, and disposal of personal protective equipment;
7. an explanation of the basis of selection of personal protective equipment;
8. information about the Hepatitis B vaccination (including efficacy, safety, method of administration, and benefits), as well as an explanation that the vaccination will be provided at no charge to the employee;
9. instruction on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;
10. an explanation of the procedures to follow if an exposure incident occurs, including the method of reporting and medical follow up;
11. information on the post-incident evaluation and follow up required for all exposure incidents; and
12. An explanation of signs, labels, and color-coding systems.

The person conducting the training shall be knowledgeable in the subject matter.

IX. Record Keeping

A. Medical Records

EHS shall maintain medical records as required by 29 CFR 1910.1020. All records shall be kept confidential and shall be retained for at least the duration of employment plus 30 years.

Medical records shall include:

1. name of the employee;
2. a copy of the employee's HBV vaccination status, including the dates of vaccination; and any other pertinent information related to ability to receive the HBV.
3. a copy of all results of examinations, medical testing, and follow-up procedures; and
4. a copy of the information provided to the healthcare professional, including a description of the employee's duties as they relate to an exposure incident, and documentation of the routes and circumstances of an exposure.
5. Training Records

SVHMC Human Resource Department / Education Department shall maintain training records for three years from the date of training. Records shall be kept in SVHMC HR Department and shall include:

- dates of the training sessions;
- contents or summary of the training;
- names and qualifications of persons conducting the training; and
- Names and job titles of all persons attending the training sessions.

B. Availability of Records

Whenever an employee (or designated representative) requests access to a record, EHS shall provide access to said employee's records in a reasonable time, place, and manner in accordance with 29 CFR 1910.1020(e). An employee (or designated representative) will only be given access to his or her own records.

C. Evaluation and Review

The Infection Prevention and Employee Health shall review this Bloodborne Exposure Control Plan for effectiveness at least annually and as needed to incorporate changes to the standard or changes in the work place.

X. References

Bill Text - AB-2537 Personal protective equipment: health care employees.

CA SB 275 refers to 90 emergency supply of PPE, but does state the below:

Bill Text - SB-275 Health Care and Essential Workers: personal protective equipment.

"(5) "Personal protective equipment" or "PPE" means protective equipment for eyes, face, head, and extremities, protective clothing, respiratory devices, and protective shields and barriers, including, but not limited to, N95 and other filtering facepiece respirators, elastomeric air-purifying respirators with appropriate particulate filters or cartridges, powered air purifying respirators, disinfecting and sterilizing devices and supplies, medical gowns and apparel, face masks, surgical masks, face shields, gloves, shoe coverings, and the equipment identified by or otherwise necessary to comply with Section 5199 of Title 8 of the California Code of Regulations."

Appendix A:

Cleaning and Decontamination Schedule Work Area/Equipment	Cleaning and Decontamination Frequency	Type of Cleaners or Supplies to be Used	Responsible Person
Trash containers	Disinfect all prior to returning to building	Hospital approved disinfectant	EVS
Red Containers	Disinfect all prior to returning to building	Hospital approved disinfectant	EVS

Large blue Recycle Containers	Disinfect when visibly dirty	Hospital approved disinfectant	EVS

Attachments

BLOODBORNE (12561)_Attachment_1390_Attachment B_Bloodborne Pathogens_Matrix of Department related Tasks_proced_2.pdf

BLOODBORNE PATHOGEN EXPOSURE CONT (12561)_Attachment_1389_Attachment A_BBP Job Titles_2021 (4).pdf

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	09/2024
Quality & Safety Committee	Aniko Kukla: Director Quality & Patient Safety	09/2024
P&T/IP Committee	Genevieve delos Santos: Director Pharmacy	09/2024
P&T/IP Committee	Kiri Golleher: Pharmacy Clinical Coordinator	08/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
EH Director	Jill Peralta Cuellar: Director Employee Health	07/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	04/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16301204**

Last Approved: N/A

Next Review: 1 year after approval

Owner: Melissa Deen: Manager Infection Prevention

Area: Plans and Program

Infection Prevention Pandemic Plan Emerging Infectious Diseases

I. SCOPE

A. "Public health emergency" is the occurrence or imminent threat of an illness, health condition, or widespread exposure to an infectious disease that poses a significant risk of substantial harm to the affected population. For the purposes of this planning effort, the health emergency shall be assumed contagious, such as influenza or another novel virus, etc.

B. This document provides guidelines for how Salinas Valley Health Medical Center (SVHMC) will respond to the event and ensure the health and safety of the organization's patient population, volunteers, employees, and providers to the greatest extent possible.

C. Emerging Infectious Disease events will be managed by activating the SVHMC EMERGENCY OPERATIONS PLAN (EOP).

II. OBJECTIVES/GOALS

Our goal is to protect our patients, families, volunteers, providers, and staff from harm resulting from exposure to an emergent infectious disease while they are in our facility.

A. **Objectives**

1. Emerging Infectious Diseases, Infection Prevention Pandemic Plan is for a community-wide infectious disease outbreak for infectious diseases that pose an imminent threat to the community, including, but not limited to, COVID-19, SARS, influenza, and the like.

B. **Goals**

1. The goals for the Emerging Infectious Diseases, Infection Prevention Pandemic Plan are developed from information gathered during routine and special risk assessment activities, alerts from the Monterey County Public Health Department (MCPHD),

California Department of Public Health (CDPH), Centers for Disease Control (CDC) and World Health Organization (WHO), annual evaluation of the previous year's program activities, the goals for this plan are:

a. SVHMC will follow guidelines and comply with all reporting requirements issued by the CDC, CMS, and State and Local Departments of Health.

III. DEFINITIONS

A. **Infectious disease** - whose incidence in humans has increased in the past two decades or threatens to increase in the near future. These diseases, which respect no national boundaries, include:

1. New infections resulting from changes or evolution of existing organisms.
2. Known infections spreading to new geographic areas or populations.
3. Previously unrecognized infections appeared in areas undergoing ecological transformation.
4. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

B. **Pandemic** - A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

C. **Isolation** - Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

D. **Quarantine** - Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. SVHMC's ability to manage known or unknown infectious diseases may be defined by the impact on the facility, such as resources, staffing, and the influx of patients. SVHMC's response would be in collaboration with local, state, and federal guidelines and requirements.
2. The plan covers the following currently known infections. Examples of Emerging Infectious Diseases are:
    a. Influenza or new novel virus
    b. Zika,
    c. Ebola,
    d. COVID-19,
    e. Dengue Fever,

f. Typhoid Fever,

g. West Nile,

h. Vaccine-preventable diseases such as Measles, Diphtheria, Pertussis, Polio, etc.

i. Other diseases that may emerge that are currently unknown.

B. **Plan Management**

1. SVHMC will utilize emerging and/or current guidelines from local county, state, and federal bodies MCPHD, CDPH, California OSHA, CDC, and WHO to implement and manage infectious diseases in our community.
2. Methods for temporary negative pressure isolation and related infrastructure support.
    a. The SVHMC Engineering Department will:
        i. Ensure that state and local legal requirements, as well as air exchange rates, are met.
        ii. refer to the guideline for creating temporary enhanced filtered environments for patient care as needed. https://www.health.state.mn.us/communities/ep/surge/infectious/airbornenegative.pdf

C. **Plan Responsibility**

1. The Emergency Management Committee is responsible for overseeing this Plan.
2. By approving this Plan, the SVHMC Board of Directors has authorized the Chairperson of the Emergency Management Committee to make necessary updates/changes to this document without prior approval to support ongoing emergency response before each review cycle.

D. **Performance Measurement**

1. The performance measurement process is one part of evaluating the effectiveness of this Plan. Performance measures have been established to measure at least one important aspect of this Plan.
2. The Emergency Management Committee evaluates the plan's scope, objectives, performance, and effectiveness on an annual basis to manage risks to the staff, visitors, and patients at Salinas Valley Health Medical Center.

E. **Orientation and Education**

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

V. REFERENCES

A. Centers for Disease Control (CDC), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID): https://www.cdc.gov/about/leadership/leaders/ncezid.html; updated February 13, 2023

B. California Department of Public Health (CDPH), Center for Infectious

Diseases: https://www.cdph.ca.gov/Programs/CID/Pages/CID.aspx, updated September 21, 2018

C. California Occupational Safety and Health (CalOSHA): https://www.dir.ca.gov/dosh/, updated 2023

D. World Health Organization (WHO): HTTPS://WWW.WHO.INT/, updated 2023

E. Monterey County Public Health Department, Communicable Disease Unit: https://www.co.monterey.ca.us/government/departments-a-h/health/public-health/communicable-disease-unit; updated March 28, 2023

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	09/2024
P&T Committee	Genevieve delos Santos: Director Pharmacy	09/2024
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	08/2024
Quality & Safety Committee	Aniko Kukla: Director Quality & Patient Safety	08/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	07/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16412917**

Last Approved	N/A
Next Review	1 year after approval
Owner	Rufael Tesfamariam: Supervisor Laboratory Technical
Area	Plans and Program

Laboratory Quality Management Plan

I. SCOPE

A. The Quality Management Plan provides a systematic means to monitor the Laboratory Services. This plan is under the umbrella of the overall Salinas Valley Health Medical Center (SVHMC) Quality and Performance Improvement Program Plan. Trends and problems are identified, and actions and resolutions implemented via integration of Quality Improvement activities between the Laboratory and other hospital departments. Departmental Quality Indicators are reported every quarter to the organization's Quality Management Department and other various interdepartmental committees. Progress is also reported to Laboratory Staff through staff meetings, huddles, email updates and postings made available on the Quality Management Bulletin Board.

B. The Laboratory subscribes to the College of American Pathologist (CAP) Proficiency Surveys and, for some tests, to the American Proficiency Institute Survey Program. The surveys cover the scope of practice for the Laboratory. The list of surveys is reviewed annually for the upcoming year. Additional surveys may be added when new tests are implemented in the Laboratory.

1. The testing personnel perform the tests on surveys using the same techniques and procedures used on patient samples, unless otherwise instructed.
2. The testing personnel performing survey procedures sign the result form and return the form to the section supervisor/lead with a copy of results.
3. A second review by the section lead or designee verifies clerical accuracy of the report form.
4. The lead or designee then faxes, mails, or electronically submits results to the proficiency organization. If results are sent via fax, document by printing a fax log.
5. The graded results from the proficiency organization are reviewed by the Laboratory Medical Director and section lead. Unacceptable survey results are investigated by

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the section lead, who documents the actions taken or the results of the investigation on the survey form. The Lead may discuss any actions with the Medical Director or designee, as indicated.

6. Any formal response (Proficiency Testing Exception Summary) for an unacceptable survey result will go to the Medical Director for review and approval before submission to the accrediting agency.
7. After results are reviewed and signed, they are filed in the individual Section Survey Binders.

II. OBJECTIVES/GOALS

Objectives

1. 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 Quality Management 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.

A. Goals

1. The goals for the Clinical Laboratory 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 tours. The goals for this Plan are:
    a. Monitoring of turn around times for significant testing
    b. Monitoring of occurrence reports involving laboratory processes
    c. Monitoring performance of Proficiency Testing in all testing areas.
    d. Patient and Staff satisfaction
    e. Laboratory Safety
    f. Adherence to National Patient Safety Goals
    g. Assessment of vendor performance
    h. Monitoring transfusion related indicators
    i. Monitoring quality of laboratory services

III. DEFINITIONS

A. CAP: College of American Pathologists
B. CPOE: Computerized Provider Order Entry

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C. ER: Emergency Room
D. FDA: Food and Drug Administration
E. IQCP: Individualized Quality Control Plans
F. LIS: Laboratory Information System
G. MEC: Medical Executive Committee
H. POC: Point of Care
I. TAT: Turn Around Time

IV. PLAN MANAGEMENT

A. Plan Elements

1. The Laboratory Department Quality Management Program includes the following components:
    a. Responsibility is assigned by lab management for establishing indicators, monitoring, evaluation, action and follow-up.
    b. Set standards and thresholds are derived from various sources. Sources include but are not limited to:
        - College of American Pathologist Accreditation Requirements
        - California State Accreditation Requirements
        - American Association of Blood Banks Requirements
        - Joint Commission Accreditation Requirements
        - Policies, procedures, and protocols of Salinas Valley Health Medical Center
        - Policies, procedures, and protocols established by the Laboratory Department
2. The scope of care is delineated for the Department of Pathology. The Laboratory consists of the following sections:
    a. Histology
    b. Microbiology
    c. Blood Bank/Immunology
    d. Hematology/Coagulation/Urinalysis
    e. Phlebotomy and Specimen Processing
    f. Chemistry/Special Chemistry/Blood Gas-Oximetry
    g. Point of Care
    h. LIS/Billing/Reference Lab
    i. Customer Satisfaction
3. Each section listed has active indicators monitored by the section supervisors/leads.

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Additionally, evaluations of laboratory accidents and occupational injury/illness are conducted on a case by case basis in conjunction with the Employee Health Department. Indicators directly affecting patient care and approved by the Department of Pathology will be reported to Medical Director ongoing. Turnaround times for selected tests from order to reporting for each section are defined at the selected Test Info in PolicyStat. Providers and or clinicians will be notified for any testing delays and appropriately documented. Indicators may be the following but may be eliminated / re-defined as necessary:

a. Histology
    - Correct identification/labeling/submission of specimens
    - Concurrent and Independent Pathologist reviews
    - Inpatient Report TAT
    - Frozen Section Diagnosis/Discrepancies

b. Microbiology
    - Acid Fast Bacilli smear TAT
    - Cerebrospinal fluid gram stain TAT
    - Blood Culture contamination rates
    - Group B Streptococcus NAA % positive rate
    - Group B Streptococcus NAA TAT
    - Positive Blood culture MD notification TAT
    - Under-filled Aerobic blood culture bottle rate
    - *Clostridioides difficile* NAA % positive rate
    - *Clostridioides difficile* NAA TAT
    - Influenza NAA % positive rate
    - Influenza NAA TAT
    - Respiratory Syncytial Virus NAA % positive rate
    - Respiratory Syncytial Virus NAA TAT
    - SARS-CoV-2 NAA % positive rate
    - SARS-CoV-2 NAA TAT
    - Verigene % agreement with Vitek 2
    - Verigene TAT
    - Monitoring of IQCP plan

c. Blood Bank
    - Blood and Blood products utilization review
        1. Includes physician case screening for transfusion appropriateness and cases sent for review to pathologists and/ or the transfusion committee.

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- Transfusion monitoring and documentation, including adverse reactions to transfusion
- Ordering practices
- Patient identification, sample collection and labeling
- Surgery history checks on early draws
- Blood and blood products availability
- Informed consents
- Quality control review (Blood Bank and Immunology)
- Pre-transfusion Hgb > 7.0
- Pre-transfusion Hgb > 8.0
- Number of units used and discarded
- Correct identification/collection and labeling of specimen (Immunology)

d. Hematology/Urinalysis/Coagulation
   - TAT reporting for selected tests
   - Monitoring critical call notification
   - Quality Control Review
   - Monitoring of IQCP plans

e. Chemistry/Special Chemistry/Blood Gas-Oximetry
   - Monitor notification of Critical Test results to MD and/or RN
   - Collection times for selected STAT collections (serial troponins, Emergency Room)
   - TAT for selected STAT tests from order to reporting
   - Quality Control management and review
   - Monitoring of Chemistry IQCP plan

f. Immunology
   - Correct identification/collection and labeling of specimens

a. Phlebotomy and Specimen Processing
   - Correct patient identification and specimen labeling
   - TAT for selected STAT collections

b. LIS/Billing
   - Correct normal ranges/tests ordered
   - Appropriate utilization of reference lab
   - Correct patient billing
   - Appropriate new test build/order

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c. POC Testing
    - Appropriate retest parameters utilized for selected tests
    - Interface result monitoring of exceptions and over range results
    - Oversight of user competency
    - Quality Control review
    - Monitoring of IQCP

d. Customer Satisfaction
    - Physicians – periodically a survey is given to physicians to gauge satisfaction of the various hospital services, including the laboratory.
    - Staff – an annual Employee Engagement Survey is given to staff
    - Patients – patients are surveyed both in written form and electronically
    - The hospital quality department has various platforms for documenting both positive and negative feedback from all customers and staff. Actions taken are recorded in these systems and monitored by the Quality Management Department. The laboratory investigates and responds to any incident that affects the department.

B. IMPLEMENTATION OF THE QUALITY ASSURANCE PLAN

1. IDENTIFICATION OF INDICATORS – The main factors used in establishing indicators in Pathology Department problem resolution are:
    a. Aspects of patient care that have a potential impact on patient outcome.
    b. Staff ability to solve the problem.
    c. Potential impact on costs.
2. Data sources used to identify indicators and to collect and organize data:
    a. Medical records
    b. Incident reports
    c. Infection control reports
    d. Committee meetings
    e. Complaints by patients, physicians, or employees
    f. Requisition reviews
    g. Observation of staff
    h. Laboratory work records
    i. Laboratory data reports
3. MONITORING:

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a. Monitoring represents the full range of services of major importance, pre-analytic, analytic and post-analytic, offered by the Laboratory Department.

b. Includes data collection representative of the quantity and quality of services offered.

4. QUALITY INDICATORS:
    a. Listed on the quarterly QA report and Dashboards.
    b. New quality indicators are developed as needed (ongoing).

5. EVALUATION:
    a. Includes any trends and/or problems.
    b. Findings should be objectively assessed in terms of cause and options for correction.
    c. Cost and magnitude of the effect on patient care should be considered.
    d. The problems or recommended actions are referred to the appropriate sources for resolution.

6. NON-CONFORMING EVENTS:
    a. When a non-conforming event occurs that results in death, permanent harm or severe temporary harm (e.g., sentinel event, medical device related adverse patient events) the laboratory will report it to the hospital Quality and Risk Management Department for investigation and reporting to the appropriate agencies.
    b. If indicated, an action plan will be developed and a Comprehensive Systemic Analysis (also known as a root cause analysis) may be performed according to hospital policy ADVERSE EVENTS - REPORTABLE to determine the cause and prevent the same or similar incident from recurring.

7. VENDOR NOTIFICATIONS:
    a. Vendor notifications in the form of defects, or issues with reagents, supplies, instruments, equipment or software that may affect patient care are stored in each respective technical area.
    b. The department leads and supervisors are responsible for evaluating the notification, taking appropriate action and responding as needed in a timely manner.
    c. For FDA Class I, Class II and Class III recalls, and any Medical Device recalls which are more urgent and possibly life-threatening, refer to hospital policy HOSPITAL RECALL PROCEDURE.

8. ACTIONS:
    a. Actions taken must be appropriate and acceptable to the hospital, to the patient community, and result in improved patient care. Actions may include but are not limited to:
        i. Education/training
        ii. Implementing new or revised procedures

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iii. Staffing changes

iv. Counseling/guidance

C. INTERDISCIPLINARY TEAMS:

1. The Laboratory Medical Director, Laboratory Director, Technical Supervisors/Leads, and various Laboratory personnel participate in interdisciplinary teams. Laboratory personnel are invited to other teams as needed to improve patient care:
    - PHARMACY AND THERAPEUTICS (ADHOC Member) – Improve patient care relating to medication safety.
    - INFECTION CONTROL – Control and monitoring of hospital acquired infections, contamination rates, and patient related infection control issues.
    - CPOE TEAM – Monitoring and improving ordering practices for physicians and other caregivers as related to the hospital services.
    - ER DEPARTMENT MEETING – Laboratory representation to discuss improvements and changes to ER patient flow.
    - CHARGEMASTER RECONCILIATION – Improvements in Billing and appropriate charges for patients.
    - QUALITY INTERDISCIPLINARY COMMITTEE (QIC) - Multidisciplinary team to improve patient care throughout the hospital.
    - COMMUNITY PRACTICE FORUM (ADHOC member) – Multidisciplinary committee to improve relations between the hospital and medical offices.
    - CODE STROKE TEAM – Monitoring and improving INR and Whole Blood BMP TAT's for Code Stroke patients.
    - ANTIBIOTIC STEWARDSHIP COMMITTEE – Multidisciplinary committee to review antibiotic administration within the hospital to ultimately reduce antibiotic resistance and cost.
    - TRANSFUSION COMMITTEE – Multidisciplinary committee to review blood product utilization.
    - SEPSIS COMMITTEE: Multidisciplinary team to review, monitor, and improve sepsis protocols.
    - PATIENT THROUGHPUT – Multidisciplinary committee that works to improve throughput and patient discharges.
    - QUALITY AND SAFETY – Provides annual report

D. Plan Management

1. The Medical Director of the Laboratory Department is responsible for the Quality Management Program overall. The Director delegates various responsibilities of the program to other Pathologists, the Laboratory Director, Laboratory Manager, Technical Supervisors, and Section Leads.

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E. Plan Responsibility

1. Technical Supervisors and section leads are responsible for developing the indicators for their areas to meet the hospital and regulatory standards. actions include: monitoring, collecting information, formulating corrective actions, documenting for their areas, and follow up actions to improve patient care.
2. The Laboratory Director is responsible for coordinating quality improvement, ensuring program actions are documented, and that consequent findings, conclusions from monitoring, evaluations, and problem-solving activities are discussed and documented in summary fashion.
3. The laboratory manager is responsible for quality management, collects all data from various sections of the laboratory and inputs them into quality management spreadsheets. A quarterly summary report is created each quarter and reported to the medical director of the department of pathology. Portions of this same report are also given to the quality management department.
4. The Laboratory Manager submits a quarterly report providing a summation of the quality indicators monitored throughout the laboratory for performance improvement. The manager also maintains monthly and quarterly quality dashboards for the laboratory. Many of the graphs and reports are posted on the quality management bulletin board in the laboratory. The report may be in statement form or use graphs to trend the information, including:
    a. Criteria Used In The Monitoring Process
    b. Outcome Of Review
    c. Actions Taken To Improve Patient Care
    d. Effectiveness Of The Indicators And Plan For Improvement

F. Performance Measurement

1. The performance measurement process is one part of the evaluation of the effectiveness of the Quality Management Plan. Performance measures have been established to measure at least one important aspect of the Quality Management Plan.
2. Annual evaluations of the Quality Management Plan and program will be done each year under the direction of Pathologists, Laboratory Director, Technical Supervisors, and Leads. New or changed indicators will be established to replace those that are complete. The yearly indicators are approved by the Medical Director.

G. Orientation and Education

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

V. REFERENCES

A. College of American Pathologists Laboratory Accreditation Standards, current version
B. California Department of Public Health, Title 22

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C. The Joint Commission Accreditation Standards, current version

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	09/2024
Quality & Safety Committee	Aniko Kukla: Director Quality & Patient Safety	09/2024
Lab Medical Dir.	Johnny Hu: PHYSICIAN	08/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Rufael Tesfamariam: Supervisor Laboratory Technical	08/2024

Standards

No standards are associated with this document

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Status **Pending** PolicyStat ID **16172749**

Last Approved	N/A	Owner	Melissa Deen: Manager Infection Prevention
Next Review	3 years after approval	Area	Infection Control

MRSA Active Surveillance Screening

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in providing an organized process to screen for methicillin-resistant *Staphylococcus aureus* (MRSA), and to comply with California Senate Bill 1058.

III. DEFINITIONS

A. **ASC -** Active Surveillance Culture **-** An active surveillance culture (ASC) is a nares culture obtained from a patient within 24 hours of admission to determine the presence of methicillin-resistant *Staphylococcus aureus (MRSA)*.

B. **Colonized or Colonization**—A pathogenic organism is present on the patient's body but does not cause any signs or symptoms of infection.

C. **Infection -** When microorganisms evade a patient's defense mechanisms and cause localized or systemic damage, sometimes requiring antimicrobial treatment.

D. **MRSA – Methicillin-resistant Staphylococcus aureus.** A type of *Staph* bacteria that is resistant to certain antibiotics that are usually used to treat *Staph* infections

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Patients that meet the criteria listed below will have a nares culture obtained at admission per California mandate.

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1. All patients admitted *or transferred* to the Intensive Care Unit (ICU), Critical Care Unit (CCU), or Neonatal Intensive Care Unit (NICU)
2. All patients who have been discharged from any general acute care hospital within 30 days before current admission.
3. All patients with ESRD who receive dialysis (hemodialysis or peritoneal dialysis) on a regularly scheduled basis.
4. All patients transferred/admitted from a skilled nursing facility or other healthcare facility.

B. At admission in the MRSA Screening, the nurse will determine if the patient meets the ASC criteria

C. If the patient meets the criteria, the nurse will order the MRSA Screen in Lab with the order source "Policy." This will be e-signed by the physician within 48 hours. The order will place the specimen to be obtained on the RN work list. Once the RN collects the specimen, the RN or UA will process the order in the electronic medical record and send the specimen to the lab. (See Attachment B.)

D. The nurse should provide the patient with the handout" MRSA Screening Information for Patients" letter to explain why the nares culture is needed. This document is available in English and Spanish. (See Attachment A.)
    1. Note: The patient may refuse MRSA ASC testing. Document the refusal in the medical record in the patient care notes.

E. Ideally, the ASC culture will be obtained upon admission. The mandate by California SB1058 can be performed before the physician signs the order and must be obtained within 24 hours of admission.

F. If the nares culture is positive for MRSA, the attending physician is responsible for informing the patient or the patient's representative as soon as possible while the patient remains inpatient.

G. The nurse caring for the patient will provide written (the "MRSA Facts and Instructions" sheet) and oral instructions on MRSA to the patient before obtaining the culture.

H. The nurse will document the MRSA education in the Medical Record system using the patient education screen.

I. Refer to the MRSA algorithm to determine if the patient requires isolation for MRSA if determined with confirmed or possible MRSA infection. See Attachment C.

J. Order Entry:
    1. MRSA Screen

K. Documentation:
    1. Document the ASC screen in MRSA Screening in the electronic medical record
    2. Document education (verbal and written) in the Education screen prior to obtaining culture. If the culture is positive for MRSA, then additional documentation will be required by the Physician and the Nurse.
        a. For patients with central-line (s) who present with positive MRSA nasal

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screen:

i. Decolonization for 5 days includes:

a. Mupirocin 2% ointment intranasally for 5 days, twice a day.

i. will require a physician's order

b. CHG Bath Daily is for all central lines (established with a central-line maintenance bundle).

i. Central Vascular Access Devices

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California Senate Bill 1058

B. Center for Disease Control and Prevention (2009). Management of Multidrug-Resistant Organisms in Healthcare Settings. Retrieved from http://www.cdc.gov/hicpac/mdro/mdro_toc.html

C. Center for Disease Control and Prevention (2007) Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf

D. CDC, MRSA: Tier 2 MRSA Prevention Strategies

E. Isolation - Standard and Transmission Based Precautions

F. Central Vascular Access Devices

Attachments

A: MRSA Screening Information for Patients

B: MRSA Active Surveillance Screening

C: MRSA Isolation Precautions

D: Active Surveillance Culture (ASC) For MRSA

Approval Signatures

Step Description	Approver	Date

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Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	09/2024
P&T/IPC	Genevieve delos Santos: Director Pharmacy	09/2024
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	08/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Melissa Deen: Manager Infection Prevention	07/2024

Standards

No standards are associated with this document

COPY

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Status **Pending** PolicyStat ID **16424980**

Last Approved N/A

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 Health Medical Center (SVHMC), under the Salinas Valley Health is to ensure that the Governing Body, medical staff and professional 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 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 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 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 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 Strategies
    - Safety and Reliability Improvement Initiatives
    - Magnet Recognition/Nurse Sensitive Indicators
    - Health Equity
    - Diagnostic Excellence and Error Prevention
    - Early Recovery After Surgery
    - Age Friendly Initiative

III. DEFINITIONS

A. CMS	Centers for Medicare and Medicaid Services
B. MEC	Medical Executive Committee
C. PIT	Process Improvement 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 (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 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 Health Medical Center 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 Health Medical Center 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 Health Medical Center. Overall responsibility rests with the Board of Directors. The Board of Directors requires review and evaluation of patient care activities by the Quality and Efficient Practices Board Committee 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.
        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. MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI program.

ii. 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.

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

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

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**

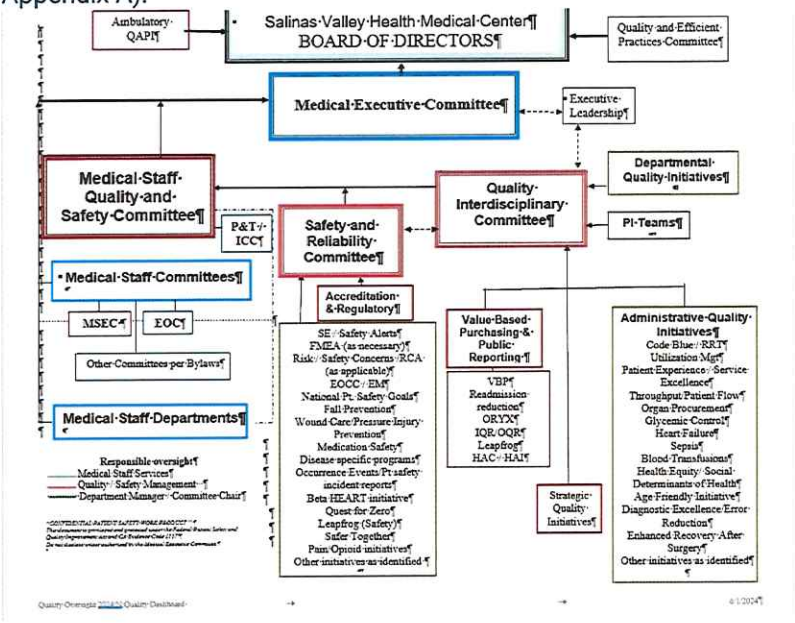
i. The Department leaders are accountable to the Organizational Leaders, QSC and the Board of Directors for the quality of care/ services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services they provide.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



D. **Performance Measurement**

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

Appendix A- Quality Oversight 2024 SVHMC-1.pdf

Quality Structure.JPG

Approval Signatures

Step Description	Approver	Date

Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	09/2024
Quality & Safety Committee	Aniko Kukla: Director Quality & Patient Safety	09/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Aniko Kukla: Director Quality & Patient Safety	08/2024

Standards

No standards are associated with this document

COPY

Status **Pending** PolicyStat ID **14804990**

Last Approved	N/A	Owner	Aisha Huebner: Director Perioperative Services
Next Review	3 years after approval	Area	Patient Care

Retained Surgical Items: Counting Sponges, Needles, Instruments, and Miscellaneous Items for Surgical/Invasive Procedures

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide physicians and staff in the prevention of retained surgical items (RSI), and prevention of sharp injuries and enhance patient safety for surgical or other invasive procedures. To guide physicians and staff on best practices for segregation and decontamination of surgical instruments.

III. DEFINITIONS

A. Cavity within a cavity: heart, major vessel, stomach, bladder, uterus.

B. Circulator: an RN who functions outside the sterile field to manage nursing care, observe and assist the team from a broad perspective, and advocate for the patient by employing critical thinking while assessing, diagnosing, planning, and evaluating the patient and procedure.

C. Miscellaneous items **examples**: lens defogger sponge, umbilical tapes, vessel loops, suture boots, mini bulldogs, vascular clamp inserts, Penrose drain used for retraction, guide wires, fetal scalp electrodes, and electrosurgical active electrodes.

D. Procedure end is after all incisions or procedural access routes have been closed in their entirety and if relevant final counts including actions to resolve discrepancy have concluded and the patient is ready to leave the procedure room.

E. Unintentionally retained surgical items (URSI): Items inadvertently left within the body after a

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procedure or vaginal birth e.g. instruments, sponges, sharps, needles, or miscellaneous items that are left within the wound after closure.

1. Exclusions: the National Quality Forum excludes items intentionally implanted and items intentionally left behind when the risk of removal exceeds the risk of retention.

F. Scrub: A team member working within the sterile field under the supervision of the physician and circulating nurse to facilitate the safe and effective conduct of invasive procedures by ensuring the environment is safe, equipment functions properly, and the procedure is conducted under conditions that maximize patient safety.

G. Sharps: needles (hypodermic and suture, free or attached to suture), knife blades and anything with a pointed tip.

H. Sponges: X-ray detectable, lint free, gauze like material used in the surgical/procedure wound or vagina to absorb or tamponade blood/fluids and to protect tissue.

1. Cottonoids: small square or rectangular sponges with tails ranging in size from. ¼" x ¼" to 1" x 3"
2. Lap tapes or lap sponges: large sponges, with a looped tail
3. Peanuts: Small circular sponges used on the end of an instrument
4. Raytecs: 4" x 4" square sponges
5. Tonsil sponges: Round sponges with long string attached
6. Vaginal packing: X-ray and RFID detectable tape, 1"x 3 yards and 2" x 3 yards or 2" x 5 yards

I. Surgical items: supplies, devices, and equipment used in and around a surgical incision or wound, to aid in the performance of the operation/procedure, to provide exposure, and to absorb blood and other body fluids. There are four (4) classes of surgical items: sponges, sharps, instruments, and miscellaneous small items.

J. RFID sponges: tagged sponges detectable with computer assisted devices

K. Wound sweep: systematic visual and manual interrogation of the wound.

IV. GENERAL INFORMATION

A. Instruments are counted for procedures, which require opening a cavity: the abdomen; thorax; or retroperitoneal and suprapubic areas; for laparoscopic procedures, which have the potential to proceed to open; and for vaginal delivery.

B. Sponges are counted for procedures in which there is potential for retention.

1. Count exemptions include cystoscopic, arthroscopic, and ophthalmologic procedures, superficial skin lesions, STSG, eye and ear canal procedures, percutaneous pinning of fractures, cardiac catheterization, finger or toe surgery.
2. When a procedure begins with uncounted sponges and the wound is enlarged, uncounted sponges should be discarded from the sterile field e.g. cardiac catheterization that proceeds to aneurysm repair or CABG.

C. Sponges may be used as wound or orifice packing material when ordered by the physician for

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hemorrhage control.

D. Items broken/fragmented during a procedure are accounted for in their entirety.If instruments, equipment, or needles break and the fragments are not located, an x-ray is obtained, unless the physician's plan is to not retrieve. This is disclosed to the patient with documentation in the medical record.

E. Counts are completed for organ procurement procedures to prevent retention of counted items in donated organs or the donor.

F. For **high risk procedures**, the physician may waive the initial count and an X-ray for potential retained surgical item is done at case conclusion.

G. For surgical removal of an unplanned retained surgical item (not packing), the item is considered a specimen and sent to Pathology.

H. Counts of instruments, sponges, and miscellaneous items are completed concurrently by the scrub person and circulator for all procedures in which there is a potential for retention. An audible count is done by the scrub for items on the sterile field and the circulator will audibly count items off the sterile field.

I. Sharps are counted for all procedures to prevent staff and patient injury.

J. Sponge count technology is used to augment the count process and does not replace the manual/verbal count.

K. Unresolved count discrepancies will have an X-ray completed to confirm the presence or absence of the missing item prior to the final closure and before the patient is moved to the next location. For patients too unstable, the X-ray is done in ICU and the physician documents the rationale.

L. The physician documents an unresolved count discrepancy or the decision to leave an item fragment and discussion of the outcome with the patient.

    1. The item type, the size and site.
    2. Patient notification including the risks and benefits of retrieval.

V. PROCEDURE

A. Summary of roles/responsibilities of team members

    1. RN circulator

        a. Actively participates in safety measures to prevent RSIs during all phases of the procedure.

        b. Knows the character and configuration of sponges, instruments, and devices that are used by the physician and assistant.

        c. Notes on the count board the placement and removal of sponges, instruments and miscellaneous items that are packed into the wound during a surgical procedure when announced by the surgical team.

        d. Initiates the count, performs count procedures in concert with the perioperative team, reports count discrepancies, and documents count reconciliation activities.

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2. Scrub person
    a. Knows the character and configuration of sponges, instruments, and devices that are used by the physician.
    b. Maintains an organized sterile field to facilitate identification of counted items.
    c. Confines and contains sharps in the specified area of the sterile field or within a sharps containment device.
    d. Maintains awareness of the location of sponges, miscellaneous items, and instruments on the sterile field during the course of the procedure.
    e. Verifies the integrity and completeness of sponges, instruments, sharps, and miscellaneous devices when they are counted and as they are returned from the sterile field.
    f. Prepares for the count process by ensuring the RN circulator can view the items to be counted.
    g. Verifies the count sheet is signed and included on the instrument cart when returned to SSPD.
3. Procedure physician
    a. Uses sponges with radiopaque indicators in the wound.
    b. Communicates the placement of sponges, instruments and miscellaneous items packed into the wound, to the perioperative team.
    c. Alerts the team to the start of the closing count process and removes unneeded sponges, miscellaneous items, and instrumentation from the procedure area.
    d. Completes a methodical wound exploration as closing counts are initiated.
    e. Prior to the end of the procedure removes items not intended to remain in the patient.
    f. Participates in resolution of an incorrect count.
    g. Orders an X-ray when count discrepancy is unresolved.
    h. Documents a count discrepancy by recording what is missing, X-ray results, and disclosure to the patient.
    i. Documents therapeutic surgical packing including the type and number of sponges used to pack, then documents the type and number when unpacked.
4. First Assistants and Physician Assistants: complete the following item numbers listed under procedure physician (1, 2, 3, 5, &6).
5. Anesthesiologist
    a. Communicates with the team during removal of throat packs, bite blocks, and other similar devices, which are inserted and removed from the oropharynx.

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B. When to count:

1. A **baseline count** by the scrub person and circulator is completed prior to the start of the procedure to establish the starting numbers for counted items.
2. **Interim counts** are initiated:
    a. As surgical items are added during the procedure.
    b. At the time of permanent scrub or circulator relief, even though all items may not be visible.
    c. Whenever requested by a team member.
3. **Cavity within a cavity count** of sponges, sharps, and miscellaneous items is initiated at closure of the cavity.
4. An **initial closing count** of sponges, sharps, and miscellaneous items is completed as wound closure begins for procedures in which the abdomen, thorax, or retroperitoneal and suprapubic areas are opened.
5. A **final closing count** of sponges, sharps, miscellaneous items, and instruments is completed at skin closure for open procedures, at procedure end for procedures done through an orifice, and after vaginal evacuation for vaginal deliveries.
6. A final count of instruments is not needed for laparoscopic procedures that do not proceed to open.The instruments must be accounted for by the scrub person at procedure conclusion.

C. The count process: general principles

1. All counts are performed with manual and verbal counts using AORN practice guidelines with circulator and scrub viewing each item being counted but scrub audibly counts items on sterile field and circulator will audibly count items not on sterile field
2. Counts may be requested by any team member at any time. Ultimately the RN circulator is responsible for ensuring counts are conducted.
3. Counted items are recorded for reference during the procedure.
    a. Instruments: on the count sheet.
    b. Sponges, sharps, and miscellaneous items: on the white count board, with each entry initialed..
4. Initial baseline counts occasionally reveal packaging inaccuracies.
    a. Discrepant sponges or needles are secured and removed from room prior to patient's arrival
    b. Instrument discrepancies are noted on the count sheet.
5. Interim counts: items added to the sterile field are
    a. Placed in an area on the sterile field where they are clearly visible.
    b. Counted and added to the count board or count sheet.
6. Surgical items dropped, discarded, or passed from the field are isolated and

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displayed for the scrub person in an area readily visible for later counting.

a. Sharps are placed on a sharps magnet pad and are not subtracted from the baseline count (AORN).

b. Instruments are placed on the SSPD return cart.

c. Sponges lost from the field are shown to the scrub and placed in the sponge counter bag.

7. Closing counts

a. Closing count sequence begins at the procedure site and immediate surrounding area and proceeds to the Mayo, back table, kick bucket, sponge bag pockets, and area for passed off or dropped items.

b. Manual/verbal closing counts are verified with the count board and the instrument count sheet and the circulator reports the results to the physician/team. The results of counts are recorded in the patient record.

c. Staff in the process of conducting final closing counts should not be interrupted or relieved and the person in charge should authorize overtime when necessary to complete the counts.

d. Staff will utilize adjunct technology for all cases that have a potential for retained RFID tagged sponges.

8. Counted items remain in the procedure rooms until the procedure is concluded and count results are finalized.

9. Trash and linen receptacles remain in the procedure room until count results are finalized.

10. Dressings provided in standard procedure packs remain sealed in their container until the final count is confirmed correct.

D. Miscellaneous procedures

1. Examples include, but are not limited to, cardiac cath lab procedures, endoscopy and endovascular procedures.

a. The procedural team ensures that equipment, instrumentation and supplies utilized during the procedure (e.g. guidewires and catheters), are intact and all pieces are accounted for when removed from the patient.

E. Documentation: Results are recorded in the procedure record.

1. For all counts - The types of counts, names of staff members completing counts, and use of the RFID detection system.

2. For incorrect counts – actions and number and type of missing items

F. Waived counts

1. High risk procedures for which the physician waives the count Examples include an emergency, in which the patient's safety could be jeopardized by a delay for counting or emergency transfer from another area in which guidewires or counted sponges were in use.

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2. In the event of a waived count:
   At delivery or procedure conclusion an RFID scan and an X-ray are completed.
   The physician and circulator document the emergency and the results of scan and X-ray

G. Incorrect counts

1. The circulator informs the procedure physician and the team of the missing item, including fragments of counted items.
2. Closure is stopped and the team participates in the search for the missing item.
3. The physician repeats the wound exploration.
4. The scrub person and assistant search the sterile field. All RFID sponges are removed from the patient to prepare for RFID scan.
5. The circulator will perform a scan of the patient when all sponges are remove. The circulator will use the RFID wand to scan trash and linen hampers as well, and searches the surrounding area.
6. When a missing item is not readily located, the circulator notifies the charge nurse and requests assistance with search.
7. Opened suture packages may not be used to reconcile a count.
8. When the item is found the count is repeated for that item.
9. If a count discrepancy persists after a thorough search, an X-ray is completed to confirm the presence or absence of the missing item prior to the final closure and before the patient is moved to the next location.
10. If the delay for the X-ray would be detrimental to a critical patient, the physician orders the X-ray to be done in ICU and documents the rationale
11. The circulator notifies the charge nurse and Diagnostic Imaging what item is missing, the location of the procedure site, and any special views deemed necessary by the physician. The circulator enters/communicates a verbal order for the appropriate x-ray under the physician's name
12. The circulator sends a sample of the RSI to the radiologist to facilitate identification (if necessary)
    When the patient has X-ray detectable packing, the packing should be removed prior to X-ray for the missing item
13. The radiologist reports his findings to the physician/team
    Any structure that cannot be clinically correlated with the patient's information or cannot be clearly articulated is treated and communicated as a critical result
14. The circulator documents the outcome of the X-ray in the incorrect count section of the procedure record and completes an occurrence report
15. For a sponge detected by X-ray and removed before the patient leaves the OR, the ultimate final count is correct

H. Unresolved count discrepancy

1. The circulator documents in the record, the item type and for non-sponges, the

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manufacturer, and completes an occurrence report

I. DOCUMENTATION

1. Case/Procedure record.
2. Electronic sponge scanning software.

VI. Therapeutic Vaginal Packing

A. There are two types of therapeutic vaginal packing that may be used in patient care:

B. Therapeutic vaginal packing for hemorrhage control.

1. Therapeutic vaginal packing for **hemorrhage control** is placed urgently prior to the sponge count reconciliation; therefore a process to identify and verify retained sponges are removed will be followed for these patient.
2. The patient will be identified with the blue id band on their wrist with the number of sponges used
3. The vaginal packing will be documented in the patient's EMR with the sponge type and number used. This must be included in the handover of care report
4. The MD will remove the packing on the nursing unit and verify the correct amount of sponges removed with the number on the blue band
5. a Labor and Delivery nurse will utilize the RFID scanning device to verify the absence of retained sponges and document the verification code from the RFID unit on the patient's EMR
6. The nurse performing the scan will remove the blue band when there is a clear RFID scan. The clear scan number shall be documented in patient's EMR

C. Therapeutic vaginal packing as a surgical dressing

1. Therapeutic vaginal packing placed as a surgical dressing is inserted after the count reconciliation and a clear RFID scan. The sponge count is documented as correct and the clear scan number documented in the surgical record.
2. The surgical nurse will place a blue ID band on the patient's wrist and note on the band the number of sponges used for the therapeutic vaginal packing
3. The sponge type, quantity, and location are documented in the surgical record as well as the perioperative handover tool
4. The surgical nurse will provide verbal handover report to the receiving PACU after the safety pause. ID verification. A special notation of the blue ID band and presence of therapeutic vaginal packing as a surgical dressing
5. The physician should document in his post-operative note the presence of the therapeutic vaginal packing as a surgical dressing and postoperative plan for removal
6. The PACU nurse will provide a verbal handover with the nurse on the patient care unit. The hand over will include the presence of the therapeutic packing as well as any other dressings that may be present. The hand over will include the presence of

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the blue ID band

7. The primary care nurse will be notified when the therapeutic vaginal packing is removed and the number of sponges. The nurse will then confirm the correct amount with the band prior to removing the blue band
8. If a discharge order is received without addressing the vaginal packing the nurse should verify the discharge plan and educational instructions for the patient regarding the vaginal packing. Verify that a follow up visit with the surgeon has been set for the patient
9. Instruct the patient that the blue band should stay on the patient until the packing is removed

VII. EDUCATION/TRAINING

A. Education and/or training is provided during orientation and as needed

B. Annual skills review

VIII. REFERENCES

A. Publications and on line sources

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Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending

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Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
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Operative and Procedural Services	Katherine DeSalvo: Director Medical Staff Services	09/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2024
Policy Owner	Carla Knight: Director Perioperative Services	07/2024

Standards

No standards are associated with this document

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