



January 17, 2025

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 HEALTH¹** will be held **THURSDAY, JANUARY 23, 2025, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.** (*Visit <https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/board-committee-meetings-virtual-link/> for Public Access Information*).

A handwritten signature in black ink, appearing to read "Allen Radner", is positioned above the printed name.

Allen Radner, MD
President/Chief Executive Officer

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

**REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY HEALTH¹**

**THURSDAY, JANUARY 23, 2025, 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** *Joel Hernandez Laguna*
2. **CLOSED SESSION** *(See Attached Closed Session Sheet Information)* *Joel Hernandez Laguna*
3. **RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *Joel Hernandez Laguna*
(Estimated time 4:30 pm)
4. **APPOINTMENT OF BOARD MEMBERS TO STANDING COMMITTEES OF THE BOARD OF DIRECTORS** *Joel Hernandez Laguna*

Appoint a Chair and Vice Chair to the Standing Committees of the Board of Directors for a two-year term.

 - A. Finance *(Monthly)*
 - B. Personnel, Pension and Investment *(Monthly)*
 - C. Quality and Efficient Practices *(Monthly)*
 - D. Community Advocacy *(Quarterly)*
 - E. Corporate Compliance and Audit *(Quarterly)*
 - F. Transformation, Strategic Planning and Governance *(Quarterly)*
5. **AWARDS & RECOGNITION** *Allen Radner, M.D.*
6. **MOBILE CLINIC UPDATE** *Orlando Rodriguez, M.D.*
Lynette Fitzgerald
7. **PUBLIC COMMENT** *Joel Hernandez Laguna*

This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.
8. **CONSENT AGENDA - GENERAL BUSINESS** *Joel Hernandez Laguna*
(Board Member may pull an item from the Consent Agenda for discussion.)
 - A. Minutes of the Annual Meeting of the Board of Directors
December 19, 2024

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

B. Policies Requiring Approval

1. Activity Blankets for the Management of patients with dementia, delirium, or encephalopathy
 2. Breast Milk Calculation/Baby Weight Scale Clinical
 3. Compliance Sanctions Review
 4. Enteral Tubes Insertion Maintenance
 5. Governmental Investigations
 6. Mandatory Reporting
 7. Medication Use
 8. Metal Detection - Emergency Department
 9. Newborn Critical Congenital Heart Disease Screen
 10. Newborn Pain, Agitation, and Sedation Management
 11. Pharmacy Sterile Compounding
 12. Respiratory Care POC Correlation
 13. Scope of Service: Critical Care
 14. Scope of Service: Facilities Management
 15. Scope of Service: Health Information Management
 16. Scope of Service: Respiratory, Neurodiagnostics and Sleep Center
 17. SVH Policy for Photography
 18. Vendor, Contractor, and Agent Participation in Hospital Compliance
- Board President Report
 - Questions to Board Vice-President/Staff
 - Public Comment
 - Board Discussion/Deliberation
 - Motion/Second
 - Action by Board/Roll Call Vote

9. BOARD MEMBER COMMENTS AND REFERRALS

Joel Hernandez Laguna

10. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the January 13, 2025 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

B. FINANCE COMMITTEE

Joel Hernandez Laguna

Minutes of the January 20, 2025 Finance Committee meeting have been provided to the Board for their review. The Financial Reports of the Finance Committee have been provided for review (informational). The following recommendations have been made to the Board.

1. Consider Board Approval of Initial Project Cost Estimate and Award Contract to John A. Martin & Associates, Inc. for the Seismic Retrofit Project.

- Questions to Committee Chair/Staff
 - Motion/Second
 - Public Comment
 - Board Discussion/Deliberation
 - Action by Board/Roll Call Vote
2. Consider Board Ratification and Approval of Competitive Solicitation and Contract Award for Epic Acute Project Training Consultant Engagement with Evergreen Healthcare Partners, Inc.
- Questions to Committee Chair/Staff
 - Motion/Second
 - Public Comment
 - Board Discussion/Deliberation
 - Action by Board/Roll Call Vote
3. Consider Board Approval of Purchase of MRI Equipment and Service Agreement From Canon for SVH Clinics Imaging Services.
- Questions to Committee Chair/Staff
 - Motion/Second
 - Public Comment
 - Board Discussion/Deliberation
 - Action by Board/Roll Call Vote

C. TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

Rolando Cabrera, M.D.

Minutes of the January 15, 2025 Transformation, Strategic Planning and Governance Committee meeting have been provided to the Board for their review. Additional Report from Committee Vice-Chair, if any.

11. CONSIDER APPROVAL OF CONTRACT TERMS OF THE FAMILY MEDICINE PROFESSIONAL SERVICES AGREEMENT FOR DOLORES PEÑA, M.D.

Timothy Albert, M.D.

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

12. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JANUARY 9, 2025, AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS:

Rakesh Singh, M.D.

A. Reports

1. Credentials Committee Report (Including the following)
 - Internal Medicine – Clinical Privileges Delineation – Revision

2. Interdisciplinary Practice Committee Report (Including the following)
 - Nursing Standardized Procedure: Nurse-Driven External Urinary Catheter Protocol

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

13. **EXTENDED CLOSED SESSION** *(if necessary)* *Joel Hernandez Laguna*
14. **RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *Joel Hernandez Laguna*
15. **ADJOURNMENT** *Joel Hernandez Laguna*

The next Regular Meeting of the Board of Directors is scheduled for
Thursday, February 27, 2025, at 4:00 p.m.

The Salinas Valley Health (SVH) Board packet is available at the Board Meeting, electronically at <https://www.salinasvalleyhealth.com/about-/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2025/>, and in the SVH Human Resources Department located at 611 Abbott Street, Suite 201, Salinas, California, 93901. All items appearing on the agenda are subject to action by the SVH Board.

Requests for a disability related modification or accommodation, including auxiliary aids or Spanish translation services, in order to attend or participate in-person at a meeting, need to be made to the Board Clerk during regular business hours at 831-759-3050 at least forty-eight (48) hours prior to the posted time for the meeting in order to enable the District to make reasonable accommodations.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS
JANUARY 23, 2025
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)

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, or

Case name unspecified: (Specify whether disclosure would jeopardize service of process or existing settlement negotiations): _____

CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION

(Government Code §54956.9(d)(2))

Significant exposure to litigation pursuant to Section 54956.9(d)(2) or (3) (Number of potential cases): One (1)

Additional information required pursuant to Section 54956.9(e): _____

THREAT TO PUBLIC SERVICES OR FACILITIES (Government Code §54957)

Under Consultation With Alysha Hyland, Chief Administrative Officer.

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

CLOSED SESSION

*(Report on Items to be
Discussed in Closed Session)*

*RECONVENE OPEN SESSION/
CLOSED SESSION REPORT*

(Meeting Chair)

SALINAS VALLEY HEALTH¹
2025-2026 APPOINTMENTS
STANDING COMMITTEES OF THE BOARD OF DIRECTORS

Monthly Meetings

Finance Committee

Chair Victor Rey, Jr.

Vice-Chair Joel Hernandez Laguna

Personnel, Pension & Investment Committee

Chair Juan Cabrera

Vice-Chair Catherine Carson

Quality and Efficient Practices Committee

Chair Catherine Carson

Vice-Chair Rolando Cabrera, M.D.

Quarterly Meetings

Community Advocacy Committee

(Quarterly Feb/May/Aug/Nov)

Chair Rolando Cabrera, M.D.

Vice-Chair Joel Hernandez Laguna

Corporate Compliance and Audit Committee

(Quarterly Mar/Jun/Sep/Nov)

Chair Juan Cabrera

Vice-Chair Catherine Carson

Transformation, Strategic Planning and Governance Committee

(Quarterly Jan/Apr/Jul/Oct)

Chair Victor Rey, Jr.

Vice-Chair Rolando Cabrera, M.D.

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AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

MOBILE CLINIC UPDATE

(VERBAL)

ORLANDO RODRIGUEZ, M.D.

LYNETTE FITZGERALD

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH¹
ANNUAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
DECEMBER 19, 2024

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

Absent: Rolando Cabrera, M.D.;

Also Present:

Allen Radner, MD, President/Chief Executive Officer

Rakesh Singh, MD, Chief of Staff

Matthew Ottone, Esq., District Legal Counsel, via teleconference

Kathie Haines, Executive Support.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Rey called the meeting to order at 4:00 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. OATHS OF OFFICE

Joel Hernandez Laguna administered the Oath of Office to Board member Elect Victor Rey, Jr.

Joel Hernandez Laguna administered the Oath of Office to Board member Elect Juan Cabrera.

3. 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 Anticipated Litigation.* The meeting recessed into Closed Session under the Closed Session Protocol at 4:04 p.m. The Board completed its business of the Closed Session at 4:32 p.m.

4. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:38 p.m. President Rey reported that in Closed Session, the Board discussed *(1) Hearings and Reports, and (2) Conference with Labor Negotiator-California Nurses Association.* The Board received and accepted the reports listed on the Closed Session agenda.

President Rey announced there is not a need for an extended closed session.

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5. ANNUAL BOARD OF DIRECTORS REPORT

Victor Rey, Jr., 2024 Board of Directors President read the following:

Annual Board of Directors Report on the Overall Performance of Salinas Valley Health for 2024

Reflecting on the past year, I am incredibly proud of our team's unwavering commitment to Salinas Valley Health. Following a nationwide search, the board appointed Dr. Allen Radner as our seventh President and CEO, ushering in a new era for our public district healthcare system. Dr. Radner, a 30-year leader at this institution, is joined by Carla Spencer as Chief Nursing Officer, Tim Albert as Chief Clinical Officer, and Alysha Hyland as Chief Administrative Officer. These leaders along with the continuing members of the executive leadership team exemplify dedication to our mission and the success of Salinas Valley Health.

Our commitment to providing quality healthcare for all, is evident in our growing clinic system, where 200 providers cared for more than 117,000 individual patients this year and we anticipate 700,000 total patient visits next year.

Our quality of care is unmatched and reached new heights in 2024 achieving numerous awards including:

- Five stars from the Centers for Medicare and Medicaid Services
- An 11th consecutive "A" rating for patient safety and
- Top maternity care rankings by U.S. News & World Report

We also took important steps forward in the look and function of our infrastructure – some of these projects are visible such our parking garage annex, facility painting and modular units for our Emergency Department. Some improvements are technology driven such as the launch of Workday, a new financial and HR platform and the Board approved investment of expanding EPIC electronic medical records to our medical center.

In addition to inpatient and outpatient experiences, the impact we are having through community outreach is enormous:

- Salinas Valley Health has served nearly 20,000 patients via our Mobile Clinic since its launch in 2020
- Our County wide Blue Zones Project reached a notable milestone this year with Salinas achieving Blue Zones Project Certification. This health and wellness initiative also expanded food access through grants and collaborations, enabling over 400 families to receive weekly produce boxes.
- We've added specific district projects like the Community Health Day in Gonzales to our array of traditional community outreach programs such Walk with a Doc, free flu clinics, and Pathways to Wellness classes.

Despite significant industry challenges nationally and locally, we are focused on our commitment to provide quality healthcare to all and addressing healthcare affordability by:

- Expanding less expensive services to clinics and outpatient settings.
- Supporting partnerships in the ambulatory surgery center and outpatient endoscopy and radiation oncology centers.
- and Exploring innovative healthcare insurance solutions such as we successfully did with the teacher's union, MCSIG, providing thousands of educators with accessible, local healthcare.

We know the clinical accolades and community impact we are having are only possible with the dedication of our more than 2,000 staff members. This month and throughout the year, we offer many benefits that celebrate the engagement and commitment of our entire team.

As we close 2024, thanks to our staff, volunteers and community support, we face the future with optimism. On behalf of the board, our district, and those we serve, we thank you for your continued dedication to Salinas Valley Health.

6. 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:

- **Sydney Blankenship/Retirement after 41 years:** Clement Miller, COO, honored Sydney Blankenship, Respiratory Care Department for 41 years as a loyal employee. It was Syd's retirement in October that actually prompted us to return to our pre-COVID tradition of honoring long-time employees at board meetings. Her last shift in RT was on October 23rd which was celebrated with a big party and lots of cake to bid farewell. Syd has been enjoying retirement including her horses and has come back for this special recognition. Syd stated she appreciated the recognition.
- **Maureen Felice, RN/Daisy Award:** Carla Spencer, CNO, honored Maureen who joined Salinas Valley Health in 2008 and has been a valued member of the team for 16 years. In that time, she has supported thousands of her colleagues with their annual health and vaccination needs and is often one of the first people new hires encounter before launching their professional careers at the organization. That role was specifically highlighted in Maureen's DAISY Award nomination stating she was the perfect nurse to have as a first encounter in an organization. Maureen gave thanks to the Daisy Foundation, the hospital and the employee health department for the nomination and award.
- **Roy Gobets/Impact Recognition:** Clement Miller, COO, honored Roy Bogets for his Museum and Valet Bench creations. Roy used his time, incredible talent and dedication to take trees from SVH campus improvement project and turn them into works of art to be enjoyed for decades to come. They are a product of the trees salvaged when we extended the parking garage, and were created by Mr. Gobets (better known to many as Tiffany DiTullio's dad), who last year was a high utilizer of SVH as a heart patient. Roy commented that his creations were a win/win, the trees didn't become firewood and got to become something else. He appreciated the opportunity to create the benches.

7. PUBLIC COMMENT:

Katie Bassler, Educator and Trustee MCSIG. Spoke about availability of providers and the cost of care and copayments. She asked for help to make the cost of care affordable.

Steve McDougall, President/MCSIG and SVFT member stated he was appreciative of contract which has been helpful. He spoke about the cost of their plan and the cost to MCSIG.

Veronica, health promoter with Monterey Health, Hospitality Workers spoke about the cost of care in Monterey County and asked for a rebate on the cost of her care.

8. CONSENT AGENDA – GENERAL BUSINESS

Recommend Board Approval of the Following:

- A. Minutes of the Regular Meeting of the Board of Directors November 21, 2024.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Hernandez Laguna, second by Director Carson, the Board of Directors approved the Consent Agenda, Item (A) as listed.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

9. REQUEST FOR RATIFICATION: SUBSTANTIVE ELEMENTS OF COLLECTIVE BARGAINING AGREEMENT BETWEEN SVMHS AND THE CALIFORNIA NURSES ASSOCIATION

Robert Andersen, Human Resources Manager, reported that Salinas Valley Memorial Healthcare System and the California Nurses Association (CNA) reached a tentative agreement on a five-year contract which was ratified by CNA membership on December 17, 2024. The following substantive financial elements of the Collective Bargaining Agreement were included in the packet.

Term: March 15, 2024 – March 14, 2028

Wages: Across the Board Wage Increases:

- 6.5% increase effective full pay period following ratification
- 5.25% increase effective at first anniversary
- 4.5% increase effective at second anniversary
- 3.75% increase effective at third anniversary

Additional 5% increase to the Staff Nurse I wage scale

Equity in some RN wage scales to match Staff Nurse II

Shift Differential: Increase in Night Shift differential to \$6.00 per hour

Education: Increase in certification bonus to \$550 for initial certification and \$450 for renewal of initial certification.

Health Plan: Medical/Rx Coverage:

Biweekly employee Medical/Rx premium:

- Employee Only: \$15 (increase \$5 each year of contract)
- Employee Plus One: \$65 (increase \$7.50 each year of contract)
- Employee and Family: \$125 (increase \$10 each year of contract)

Increase in Tier 1 and Tier 2 Deductible to \$75 and \$325 respectively.

Increase in Tier 1 and Tier 2 Individual Out of Pocket Maximum to \$850 and \$1,800 respectively.

Increase in ED copay to \$125.

Dental Coverage:

Biweekly employee Dental premium:

- Employee Only: \$5
- Employee Plus One: \$10
- Employee and Family: \$15

Increase in dental benefit to \$2,500 annually

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Great work on both sides to come to an agreement.

MOTION:

Upon motion by Director J. Cabrera, second by Director Hernandez Laguna, the Board of Directors ratifies the Collective Bargaining Agreement Between SVMHS and the California Nurses Association.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

10. ELECTION OF BOARD PRESIDENT

Board President Victor Rey Jr., announced that nominations are in order for the election of the President of the Board of Directors for a two-year term. Once elected, the President will Chair the meeting and future meetings.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Rey, second by Director J. Cabrera, the Board of Directors nominates and elects Joel Hernandez Laguna for the Office of President of the Board of Directors.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

11. ELECTION OF OFFICERS

Joel Hernandez Laguna assumed the Office of President and announced that nominations are in order for the election of Vice-President, Secretary, Treasurer, and Assistant Treasurer, to be elected by the Board of Directors for a two-year term.

OFFICE OF VICE-PRESIDENT

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None

MOTION:

Upon motion by President Laguna Hernandez, second by Director J. Cabrera, the Board of Directors nominates and elects Catherine Carson for the Office of Vice-President of the Board of Directors.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

OFFICE OF SECRETARY

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by President Laguna Hernandez, second by Director Carson, the Board of Directors nominates and elects Rolando Cabrera, M.D., for the Office of Secretary of the Board of Directors.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

OFFICE OF TREASURER

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None

MOTION:

Upon motion by Director Carson, second by Director J. Cabrera, the Board of Directors nominates and elects Victor Rey, Jr., for the Office of Treasurer of the Board of Directors.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

OFFICE OF ASSISTANT TREASURER

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director J. Cabrera, second by Director Rey, the Board of Directors nominates and elects Juan Cabrera for the Office of Assistant Treasurer of the Board of Directors.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

12. BOARD MEMBER COMMENTS AND REFERRALS

Director Juan Cabrera: Director Cabrera stated it's a great idea to recognize retiring employees with over 35 years of experience. Union negotiations are difficult and commended the negotiation team on the great work that was done to reach an agreement.

Director Catherine Carson: Director Carson stated she received tremendous patient care in the ED on December 15th. There was great teamwork and she felt like she was in great hands. She wanted to acknowledge that in 2024 it was a difficult selection process for the President/CEO position and she thinks the best candidate was selected.

Director Joel Hernandez Laguna: President Hernandez Laguna stated that 12 months ago we were in a different situation and the Board has grown a lot especially during the President/CEO search. The organization is a stronger organization, including its senior leaders. Additionally, he received a call this week from a constituent regarding an ED experience; the individual was helped quickly and after the experience here she knew how to better help her child. He thanked the executive team for coordinating the Essen Park tour on January 6th. He thanked Clement and whole staff with the ED modules project. He thanked Augustine Lopez and the financial team for their great work.

Director Victor Rey, Jr.: Director Rey stated he had the pleasure to be able to serve at the employee holiday lunch on December 11th and gave a shout out to the chefs and planners. He attended the 4th annual Christmas in Closter Park event which was fun, well attended and well run; SVH was a sponsor.

13. 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 of the December 15, 2024 meeting were provided for Board review. Director Carson stated the presentations from the Night Shift Clinical Practice Council, Spiritual Care and the Regulatory Department were interesting. The reports exemplify that no department is exempt from performance improvement and it sends the message that everyone is expected to improve. The quality

team is developing a more focused Dashboard. A special education session on Quality and Safety to help Board members understand safe patient care is planned for the next QEP meeting, January 13th.

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

A report was received from Director Juan Cabrera regarding the Personnel, Pension and Investment Committee. The minutes of the December 9, 2024 meeting were provided for Board review. The following recommendations have been made to the Board of Directors.

- 1. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Henry Sanchez Ortigoza, MD, (ii) Contract Terms for Dr. Sanchez Ortigoza's Recruitment Agreement, and (iii) Contract Terms for Dr. Sanchez Ortigoza's Hospitalist Professional Services Agreement.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson, and second by Director Rey, the Board of Directors approves:

1. The Findings Supporting Recruitment of Henry Sanchez Ortigoza, MD,
 - That the recruitment of a hospitalist 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 an appropriately qualified physician to practice in the communities served by the District;
2. The Contract Terms of the Recruitment Agreement for Dr. Sanchez Ortigoza; and
3. The Contract Terms of the Hospitalist Professional Services Agreement for Dr. Sanchez Ortigoza.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

- 2. Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Briana Gomez, MD, (ii) Contract Terms for Dr. Gomez's Recruitment Agreement, and (iii) Contract Terms for Dr. Gomez's Obstetrics and Gynecology Services Agreement**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson, and second by Director Rey, the Board of Directors approves:

1. The Findings Supporting Recruitment of Briana Gomez, MD,
 - That the recruitment of a obstetrics and gynecology physician 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 an appropriately qualified physician to practice in the communities served by the District;

2. The Contract Terms of the Recruitment Agreement for Dr. Gomez; and

3. The Contract Terms of the Obstetrics and Gynecology Professional Services Agreement for Dr. Gomez.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

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 Financial Reports of the December 16, 2024 meeting were included in the packet for review (informational). The following recommendations have been made to the Board of Directors.

1. **Consider Recommendation for Board Approval of Cepheid GeneXpert Placement Agreement**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. J. Cabrera, and second by Director Carson, the Board of Directors approves the Cepheid GeneXpert Placement Agreement in the amount of \$768,700.80 (annual expenditure of \$256,234).

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

2. **Consider Recommendation for Board Approval of the Philips MATC Software Evolution Services (SES) Five (5) Year Agreement**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director J. Cabrera, and second by Director Rey, the Board of Directors ratifies and approves the Philips MATC Software Evolution Services (SES) Agreement in the amount of \$782,945.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

3. **Consider Recommendation for Board Approval of a ‘Nurse Call – Phase 3 Upgrade’ Project, and for purchase of a medical equipment package of replacement nurse call components in support of a code compliant nurse call system in the SVH Medical Center.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Rey, and second by Director J. Cabrera, the Board of Directors approves a ‘Nurse Call Phase 3’ Project in the amount of \$2,772,043, and the purchase of a component package per Hillrom proposal dated 12/13/2024 in the amount of \$1,580,832.91.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

**14. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC)
MEETING ON DECEMBER 12, 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 December 12, 2024. A full report was provided in the Board packet.

Recommend Board Approval of the Reports as listed on the Agenda.

PUBLIC COMMENT: None.

BOARD DISCUSSION: None.

MOTION:

Upon motion by Director J. Cabrera, second by Director Carson, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report and Interdisciplinary Practice Committee Report as follows:

A. Reports

1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report Rules & Regulations

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

**15. CONSIDER BOARD RESOLUTION NO. 2024-03 AMENDING THE DISTRICT
CONFLICT OF INTEREST CODE**

Gary Ray, Chief Legal Officer, reported that Salinas Valley Memorial Healthcare System is required to review its Conflict of Interest Code on a biennial basis. Revisions to the Conflict of Interest Code included in the Board packet for the Board's consideration reflects positions eliminated, added or re-named since the last code was approved.

PUBLIC COMMENT: None.

BOARD DISCUSSION: The revisions reflect the current titles and reporting structure.

MOTION:

Upon motion by Director Carson, second by Director Rey, the Board of adopts Resolution No. 2024-03 of the Board of Directors of Salinas Valley Memorial Healthcare System Amending the Conflict of Interest Code, as presented.

ROLL CALL VOTE:

Ayes: J. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: Dr. R. Cabrera.

Motion Carried

16. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, January 23, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 5:40 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors
 From: Clement Miller, COO
 Date: January 14, 2025
 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 Board of Directors approval.

	Policy Title	Summary of Changes	Responsible Exec
Consent Agenda Policies			
1.	Activity Blankets for the Management of patients with dementia, delirium, or encephalopathy	New procedure	Clement Miller, COO
2.	Breast Milk Calculation/Baby Weight Scale Clinical	References updated.	Carla Spencer, CNO
3.	Compliance Sanctions Review	References updated	Gary Ray, Chief Legal Officer
4.	Enteral Tubes Insertion Maintenance	Minor typos corrected, references updated	Carla Spencer, CNO
5.	Governmental Investigations	No changes, routine update	Gary Ray, Chief Legal Officer
6.	Mandatory Reporting	Definition corrected	Timothy Albert, CCO
7.	Medication Use	Added the following language under B-12-b "For titratable drips with specific vital sign parameters, the RN may change the bedside monitor settings to align with the MD order" so we are covered to make changes to the Phillips monitors. Added Nuclear Medicine Technologists and Certified Nurse Anesthetists (CRNAs) to people who can administer medications	Clement Miller, COO
8.	Metal Detection - Emergency Department	New policy	Clement Miller, COO
9.	Newborn Critical Congenital Heart Disease Screen	References updated.	Carla Spencer, CNO
10.	Newborn Pain, Agitation, and Sedation Management	No changes. Regularly scheduled review.	Carla Spencer, CNO

11.	Pharmacy - Sterile Compounding	This policy and procedures will replace the existing Sterile Compounding policy (ID 12515029) and Compounding Sterile Products: Testing of Environment, Personnel and Product (ID 12516310). 1) ASTM D6978-05 nitrile gloves -- changed to ASTM D6978 nitrile gloves to reflect USP 800 2) Added: outer gloves shall be replaced between each different HD preparation 3) Replaced: carefully remove gown at the entrance of the area and hang inside out for redonning upon re-entry to "discard their gown prior to leaving" 4) combine surface sample layouts to Attachment D	Clement Miller, COO
12.	Respiratory Care POC Correlation	Step A. in procedure corrected to current practice	Clement Miller, COO
13.	Scope of Service: Critical Care	No changes. Regularly scheduled review.	Carla Spencer, CNO
14.	Scope of Service: Facilities Management	Minor typos and correction made	Clement Miller, COO
15.	Scope of Service: Health Information Management	No changes, routine update	Alysha Hyland, CAO
16.	Scope of Service: Respiratory, Neurodiagnostics and Sleep Center	Title changed to Sleep Medicine Center, minor edits to align with current practice	Clement Miller, COO
17.	SVH Policy for Photography	Changed to Policy, minor grammar corrections, reference updated	Alysha Hyland, CAO
18.	Vendor, Contractor, and Agent Participation in Hospital Compliance	Changes made to align with current process, referenced updated	Clement Miller, COO
MEC Policies			
1.	Nursing Standardized Procedure: Nurse-Driven External Urinary Catheter Protocol	New policy	Carla Spencer, CNO



Last Approved N/A
Next Review 3 years after approval

Owner Jessica Graziano:
Manager Rehab Services
Area Patient Care

Activity Blankets for the Management of patients with dementia, delirium, or encephalopathy

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To guide clinical staff on the use, indications, and contraindications of activity aprons on the inpatient hospital units as a safe addition to the standard of care when managing patients with dementia, delirium, or encephalopathy. Activity blankets are commercially available products used to occupy and distract patients with dementia, and may reduce or eliminate behaviors that result in increased nursing supervision or restraint use.

III. DEFINITIONS

- A. PT: Physical Therapy
- B. OT: Occupational Therapy
- C. RN: Nurse
- D. IV: Intravenous
- E. EMR: Electronic medical records

IV. GENERAL INFORMATION

- A. The use of the activity blanket is to reduce agitation, and reduce and/or eliminate behaviors that result in self harm, increased nursing supervision or restraints. This is a non-pharmacological approach to cognitively engage, occupy, and distract patients who have a history of dementia or delirium to reduce injury from lines (e.g., IV lines, Foley catheters, etc.) being pulled and promote rehabilitation through activity. It is hoped that the use of these

activity aprons will improve secondary outcomes such as reducing the number of Code Grays, falls, patient-induced staff injuries, and length of stay.

V. PROCEDURE

A. Assessment of patient benefit

1. Clinical staff assess the patient to determine if they are a candidate for an Activity Blanket and that there are no contraindications.
2. Clinical staff to utilize the “teach back” method to show the patient how to use the Activity Blanket.

B. Ordering the Activity Blanket

1. An order is placed in the patient's EMR for an Activity Blanket

C. Activity Blanket Use while in the hospital

1. Activity Blanket will be given to the patient to keep and are not reusable.
2. Activity Blanket come with directions on how to appropriately clean the item once discharged home
3. If soiled while in the hospital, please inform a health care team member immediately. Collaborate with the patient's family to take home the soiled item and clean it within 24 hours. If that is not possible, we will provide a replacement blanket.

D. Documentation:

1. The clinician recommending and providing the activity apron will be responsible for demonstrating use of the Activity Blanket and utilizing the "teach back" method with the patient
2. Documentation that the patient received the activity apron as well as its impact should be documented appropriately in the patient's chart.

E. Indications

1. Patients with history of delirium and/or dementia
2. Agitated patients with no history of violent behavior
3. Hypoactive delirium patients
4. Patients pulling or attempting to pull lines
5. Patients exhibiting confusion and/or disorientation

F. Contraindications

1. Active hand injuries
2. History of violent and/ or aggressive behavior
3. Suicidal Ideation
4. History of chewing or swallowing foreign objects

G. Disposal of Activity Blanket

- 1. Any activity apron left in the room would be placed in a green patient belonging bag and labeled before turning them over to Security's Lost and Found.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed.
- B. A WINTip will be created to inform hospital staff of Activity Blanket use and availability

VII. REFERENCES

A. Ruff MW, Fine A, Mandrekar J, Sweeney C, Jones LK Jr, Klaas JP. Activity Aprons for Inpatients Requiring Individual Nursing Assignment Care: A Prospective Randomized Controlled Pilot Study. Neurohospitalist. 2018;8(4):183-187. doi:10.1177/1941874418773945

B. Becklund, A. L., Rapp-McCall, L., & Nudo, J. (2021). Using weighted blankets in an inpatient mental health hospital to decrease anxiety. Journal of Integrative Medicine, 19(2), 129–134. <https://doi.org/10.1016/j.joim.2020.11.004>

Approval Signatures

Step Description

Approver

Date

ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Jessica Graziano: Manager Rehab Services	01/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Julie Johnson:
Clinical Manager
Women's and
Children's
Services

Breast Milk Calculation/Baby Weight Scale Clinical

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To guide the nurse in promoting breastfeeding in the Neonatal Intensive Care (NICU) environment.
- B. To guide staff in calculating the breast milk intake of the premature or sick infant in order to provide adequate caloric intake each feeding.

III. DEFINITIONS

- A. The Baby Weight Scale is designed to weigh an infant pre- and post-feeding. It is not designed for daily infant weight or diaper weights. The scale automatically calculates breast milk intake from pre- and post-feeding weights. The scale also converts between grams and pounds and is accurate to 2 grams (0.1 oz) for infants under 6,000 grams (12 lbs).

IV. GENERAL INFORMATION

- A. The breastfeeding mother is informed of necessity to use the baby weight scale before and after breastfeeding and how the infant may be supplemented to provide the caloric intake he/she needs per feeding.

V. PROCEDURE

- A. Prepare infant to be weighed, detach monitor cables according to infant stability, make sure area around scale is free of clutter/curtain, do not change infant diaper, clothes or blanket before or after feeding. This is important for consistent environment and scale use. (The Baby Weigh Scale automatically compensates for the weight of the blanket, wet diaper, moving

- infant, etc).
- B. Press ON/ZERO button and wait for "0" to appear. An audible beep will sound and ZERO will be on the display screen.
 - C. Place infant on scale and wait for scale to stabilize. An audible beep will sound and "LOCK" will be indicated on display screen. Press WEIGHT ENTRY button to enter before weight into scale memory. MEMORY WEIGHT will be displayed.
 - D. Remove baby from scale and record weight. DO NOT turn off scale. Feed the baby.
 - E. After breastfeeding, press the ON/ZERO button and wait for "0" to appear on display.
 - F. Place infant on scale and wait for display to stop fluctuating. LOCK is indicated, beep is heard. The value that appears on display is the baby's after weight.
 - G. Remove infant from scale. Press WEIGHT GAIN. Baby's milk intake (gm/ml's) will appear on display.
 - H. Record pre/post feed weight and follow the physician orders for supplement if needed for each feeding.
 - I. Order Entry:
 1. Lactation consult service referral
 - J. Documentation:
 1. Document before (pre) weight and after (post) weight in the electronic medical record (EMR).
 2. Document infant feeding tolerance and breastfeeding assessment in the EMR.
 3. Infant breastfeeding weight will be subtracted from total volume for the feeding. Complete the feeding per physician order with feeding method of choice.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. Medela, Inc., Baby Weight Scale (2015).
- B. Rankin, M. W., Jimenez, E. Y., Caraco, M., Collinson, M., Lostetter, L., & DuPont, T. L. (2016). Validation of Test Weighing Protocol to Estimate Enteral Feeding Volumes in Preterm Infants. *The Journal of pediatrics*, 178, 108–112. <https://doi.org/10.1016/j.jpeds.2016.08.011>
- C. Wambach, K. and Spencer, B. (2019). *Breastfeeding and human lactation*. 6th ed. Jones & Bartlett Learning.

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	01/2025
Director Women's & Children's Services	Julie Vasher: Director Women's & Children's Services	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Julie Johnson: Clinical Manager	12/2024

Standards

No standards are associated with this document

COPY



Last Approved	N/A
Next Review	3 years after approval

Owner	Gary Ray: Chief Legal Officer
Area	Administration

Compliance Sanctions Review

I. POLICY STATEMENT

- A. Any individual or contracting agency identified by Salinas Valley Health Medical Center (SVHMC) as being on a governmental sanctions or suspension list may not work for SVHMC, serve on its Medical Staff, occupy Allied Health Professional status, volunteer, or work as a vendor or contractor. Said individual(s) or agency(ies) will be suspended until such time as such sanctions/suspensions are lifted or rescinded. Orders for such non-staff referring providers shall not be acted upon and their ordering status suspended.

II. PURPOSE

- A. Salinas Valley Health Medical Center (SVHMC) demonstrates its commitment to high quality patient care and service through its financial and business management. SVHMC screens providers, employees, volunteers, independent contractors and vendors to ensure they have not been excluded from participating in federal health care programs (including Medi-Cal) or debarred from receiving federal funds.

III. DEFINITIONS

For the purposes of this policy the following definitions apply.

- A. Allied health professionals are health professionals who do not independently diagnose and prescribe treatment, but provide diagnostic procedures, therapeutic services, and patient care. Examples include respiratory therapists, radiation therapists, occupational therapists, physical therapists, and others.
- B. Exclusions are actions taken to bar or prevent participation in a state or federally funded health care program.
- C. Resolution includes review of the items identified in a screening to determine if they apply to the individual submitted and if so, ensuring that SVHMC does not employ, contract, or utilize an individual or organization that has been identified as being sanctioned.

- D. Sanctions are government actions taken to bar or exclude an individual or organization from participation in a federal health care program (including Medi-Cal) or from receiving federal funds.
- E. Screening includes submission to the applicable application or website (e.g., as described in Section V.E. and the references section of this policy) that identifies whether the prospective individual or organization has any sanctions.
- F. Verification is selecting a sample of individuals and organizations to identify whether they have been screened and resolved or reviewing documentation provided by the department responsible or the application that performs the check.

IV. GENERAL INFORMATION

- A. Federal and California law enforces civil monetary penalties against organizations that employ or contract with an individual or entity that the person/organization knows or should know is excluded from participation from the provision of items or services for which payment may be made under a federal health care program or debarred from receiving federal funds [42 U.S.C. § 1320a-7a (6); 42 C.F.R. § 1003.102(a)(2); Welfare and Institutions Code § 14043.61].
- B. SVHMC conducts sanction screenings of its providers, employees, volunteers, independent contractors (including but not limited to travelers and registry) and vendors.
- C. SVHMC takes all reasonable efforts to verify that information provided by applicants and business partners is correct. Responsibility for completion of pre-employment screening, verification, and resolution lies with the Human Resources Department for Hospital employees, travelers and registry. See [BACKGROUND CHECKS POLICY](#).

V. PROCEDURE

- A. The following table identifies the monitoring department responsible for initial and periodic screening:

Population	Initial Check	Monthly Check
Employees	Human Resources (HR)	Human Resources
Privileged Physicians and Allied Health Professionals and Non-Staff Referring Providers	Medical Staff Services	Medical Staff Services
Allied Health Professionals not Privileged with Hospital	Cypress	Cypress
Travelers	Human Resources	Human Resources
Contracted Physicians	Medical Staff Services	Medical Staff Services
Contractors (contracted party/company, not employees)	Contracts Administrator	Vendor Manager
Vendors Coming Onsite	Vendor Mate	Vendor Mate

Other Vendors with no contract	Contracts Administrator	Vendor Manager
Volunteers	Volunteer Office	Volunteer Office

- B. Vendor companies coming on site will be checked for sanctions prior to providing items or services to SVHMC. Vendor representatives will be required to register in Vendor mate, which will be used to check for sanctions.
- C. Screenings will be performed initially before an individual's first date on site or date of service to the organization, and on a monthly basis thereafter by the applicable monitoring department identified in Section V.A. of this policy.
- D. Screening processes will include (at a minimum) checking against the Department of Health and Human Services' Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE), the General Services Administration (GSA) Debarment list, California Medi-Cal Suspended and Ineligible Provider List, as noted in the reference section below.
- E. Should an individual or organization be identified with a sanction, the Compliance Officer will be advised immediately by the monitoring department identified in Section V.A. of this policy so that the appropriate action may be taken. Appropriate action may include communication to appropriate stakeholders and suspension of services performed by the individual or organization.
- F. In the event SVHMC receives payment for items or services furnished by any excluded individual or entity, SVHMC will refund all associated payments within 60 days of discovery.
- G. Periodic verification will be performed by the Internal Audit/Compliance Office and will include review of files for individuals and entities required to have a check to ensure that (a) initial screenings have been performed and (b) resolutions have been completed.
- H. The individual performing the screening will advise the Compliance Officer when a sanction is lifted. The Compliance Officer will then advise the respective department head.
- I. Documentation:
 - 1. Documentation of all initial and periodic sanctions screening will be maintained by the applicable department identified in Section V.A.1. of this policy.
 - 2. Documentation of actions taken based on sanctions identified will be maintained by the Compliance Officer and, in the case of employees, also by the Human Resources Department.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. [Office of the Inspector General \(OIG\) Exclusions Database](#)
- B. [System for Award Management \(SAM\) Exclusions Database](#)
- C. [Suspended and Ineligible Provider List Medi-Cal Exclusion List](#)

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	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2024
Policy Owner	Gary Ray: Chief Legal Officer	10/2024

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Carla Spencer:
Chief Nursing Officer
Patient Care

Enteral Tubes Insertion Maintenance

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidance for insertion and maintenance of nasogastric, orogastric, and percutaneous gastric tubes.

III. DEFINITIONS

- A. NG – Nasogastric
- B. OG – Orogastric
- C. ENFit – Enteral Fitting (a global change to make all enteral (tube feeding) devices specific to tube feeding. Includes extension sets, syringes, and all types of feeding tubes

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

- A. Tube Insertion:
 - 1. The standard feeding tube with ENFit connection will be utilized for NG feeding is the 10 Fr or 12Fr nasogastric feeding tube unless otherwise indicated by physician order.
 - 2. Tube will be marked at nares upon insertion.
 - 3. Tube placement shall be verified by checking marking at nares:

- a. Following tube insertion, once placement is confirmed with STAT Chest X-ray, the tube will be marked at the nares
 - b. Prior to each intermittent tube feeding
 - c. Every four (4) hours during continuous feeding
 - d. Anytime dislodgement suspected (i.e., vomiting, vigorous coughing)
 - e. Prior to medication administration
4. **All initial placement of naso/oral feeding tubes are verified by STAT Chest x-ray, unless otherwise indicated by physician order.** The initial tube placement x-ray will not apply to newborns.
5. Licensed staff trained in inserting **naso/oral (naso to stomach)** feeding tubes with stylet, may do so when ordered.
 - a. Assess nares prior to insertion. The insertion may be risky in patients with nasal fractures or bleeds and esophageal strictures, fistulas, varices, basilar skull fractures.
 - b. Obtain the following supplies/equipment:
 - Standard ENFit nasogastric and/or small bowel feeding tube 10Fr or 12Fr (unless otherwise ordered by physician), water soluble lubricant, tape or NG tube holder, stethoscope, 60 ml ENFit tip syringe, ENFit Y extension set, prescribed formula, feeding container, connecting tubing, and permanent marker
 - For lavage and gavage: Obtain the following supplies: Salem sump tube, Lopez valve (3-way valve), tape, stethoscope, irrigation set with 60 ml syringe, suction source
6. Determine the length of the nasogastric tube by measuring the distance from the tip of the nose to earlobe to xiphoid process of sternum. DO NOT insert excess nasogastric tubing, it will kink or curl.
 - a. Mark the total length of tube to be inserted with a small piece of tape or with permanent marker.
7. Lubricate tube tip with water-soluble lubricant. Small-bore enteral tubes may be pre-lubricated which will be activated by placing it in water.
8. Position patient in a sitting position (90°) with the head bent slightly forward. If the patient is comatose, or unable to sit up, position patient supine with the head facing directly forward and the chin aligned with the sternal notch.
9. Insert tube by passing it gently along the floor of the nostril, aiming down and back towards the ear. Once tip is in the posterior pharynx, encourage patient to swallow sips H2O or dry swallows. Stop if there is any resistance. **DO NOT USE FORCE.** Resistance may be the result of mild vagal stimulation. Wait a few seconds and gently attempt to advance tube again. Stop advancing the tube when pre-determined mark reaches nostril **REMOVE THE TUBE AT ONCE IF THE PATIENT EXHIBITS ANY SIGNS OF DISTRESS, I.E., EXCESSIVE COUGHING, CHOKING, GASPING, CYANOSIS, OR INABILITY TO VOCALIZE.**

10. ****Special Note:** When assisting the physician with nasogastric tube placement, position the patient in the right lateral decubitus position which may facilitate passage of small-bore nasogastric feeding tubes through the pylorus and into the duodenum. Small bowel passage rate may also be improved by the use of IV metoclopramide. If allowing small-bore nasogastric tube to advance using peristalsis, tape the port-end loosely to patient's cheek to facilitate passage. Confirm placement of tube by Chest x-ray before removing guidewire or stylet.

B. Confirmation of Placement:

1. **Obtain STAT Chest x-ray** to confirm placement is in the stomach/gastric
 - a. Once gastric placement confirmation obtained, if the enteral tube has a guidewire (weighted tip small bowel tube), remove the guidewire with one hand while holding the tube in place at the nostrils.
 - i. Follow MD orders after initial gastric placement to confirm placement in jejunum.
 - b. Carefully mark placement at the nares and verify placement every four (4) hours during continuous feedings and before each intermittent feeding.
 - c. Aspirating stomach contents using a ENFit 60ml syringe. If unable to obtain aspirate, position patient on left side and wait a few minutes to allow tube tip to fall below fluid level. May also manipulate tube 2-4 cm (1-2 inches) and re-attempt aspiration.
2. Tape tube securely to patient in a position that is comfortable, does not interfere with patient's vision, and does not pull or rub against any part of the nasal mucosa.
 - a. Nasogastric tubes should be secured so as not to rub the nares. This can be accomplished by allowing the tubing to hang straight out of the nose and secure with a continuous piece of tape from the bridge of the nose to the tube or by utilizing a tubing securement device.
 - i. RNs in the ICU, Progressive Care or Resource RNs may use clinical judgement to insert a Nasal Bridle Retaining System for weighted tip small bowel or nasogastric tubes that are anticipated to be place for longer periods of time.
 - ii. Contraindications:
 - Patients with nasal airway obstructions and abnormalities, facial and/or anterior cranial fractures, basilar skull fractures, patient that may pull on the device to such a degree as to cause serious injury
 - Refer to package insert/instruction booklet for placement
 - Retain package insert booklet and opening tool at bedside until removal

C. Tube Feedings:

1. Require physician nutritional order which includes:

- Specific formula and strength
 - Feeding tube type: gastric or small bowel
 - Route of delivery
 - Rate of delivery
2. ENFit tubing for tube feeding is NOT compatible with IV tubing connectors.
 3. Patient's current weight will be obtained/documented prior to initiating tube feedings and daily during administration of enteral feedings.
 4. Feeding container and connecting tubing will be changed every twenty-four (24) hours.
 5. Gastric residuals shall be checked only if ordered by a physician and held only per physicians ordered parameters.
 6. Feeding hang times are based on manufacturer's recommendations:
 - a. Twenty-four (24) hours for closed system Ready-to-Hang formulas
 - b. Eight (8) hours for ready to use formula
 - c. Four (4) hours for reconstituted formula
 7. Feeding shall be stopped during supine or head down (position) treatment (i.e., postural drainage).
 8. Initiation and maintenance of continuous feeding:
 - a. Raise head of bed and maintain at 30°-45° during feedings. ****Special Note:** If patient is in restraints, keep head of bed up at all times.
 - b. Obtain prescribed formula from Nutrition Services. Prepare and hang formula for twenty-four (24) hours if it's Closed System Ready-to-Hang formula; eight (8) hours when using a bag to delivery Ready-to-Use formula.
 - c. Label container with date and time. Prime pump and program with prescribed rate.
 9. Confirm tube placement before initiating feeding, every four (4) hours, before medication administration and any time dislodgement suspected.
 10. **Do not check residuals unless specifically ordered by physician.** If residuals are ordered to be checked, hold feeding per physician hold parameter. Never check residuals of small-bore feedings, e.g., j-tubes. Return all residuals and flush with 30ml H₂O. If tube placement ever becomes questionable, hold feedings and notify physician.
 11. Maintain patency of tube by flushing with 30ml of warm water every four (4) hours and before and after medication administration.
 12. **Never** stop delivery of feedings into small-bore intestinal tube unless ordered by physician.

D. Initiation and maintenance of bolus feeding:

1. Raise head of bed and maintain at 30°-45° for one (1) hour post feedings. For patient in restraints, maintain head of bed up for four (4) hours post feeding.
2. Confirm tube placement.
3. Administer prescribed formula: remove plunger of 50-60 ml syringe and insert tip into open end of gastric feeding tube. Pour solution into syringe and administer by gravity. Follow administration with 30ml of warm water. Clamp off feeding tube.
4. Assess/observe and monitor patient's tolerance.

E. Administration of medication or modular components into tube:

1. Obtain medication(s) from pharmacy, in liquid form whenever possible. Crush tablets and dissolve fully in warm water. **NEVER** crush enteric coated or sustained release capsules. Do NOT administer drugs via nasojejunal or j-tube unless no other medical alternative (consult with pharmacist)
 - a. Make every attempt to change medication to IV or liquid form.
2. Modular products (example: protein or wound healing products)
 - a. Flush tube with 30 ml of warm water before and after each administration of modular product.
 - b. Use ENFit compatible syringe for water flushes or administration of modular products.
3. Confirm tube placement. Administer 30ml of warm water; administer medication and follow-up with an additional 30 ml of warm water. Leave patient with head of bed up at 30°-45° for one (1) hour post medication administration. **If patient is restrained, head of bed must be raised to 45° at all times.**

F. Care of patient with ENFit NG/OG/PEG/PEJ etc tubes

1. Perform oral and nasal hygiene every shift and prn. Assess nares and nasal mucosa for skin breakdown every four (4) hours. Re-tape tube as necessary to maintain patient comfort and tube security. Comfort may be provided by lubrication of the tube at the nostril with K-Y Jelly.
2. Observe for possible complications, such as nasal septal abscess, fever, chills, sinusitis, or pain.
3. Assess and/or observe for abdominal distention, diarrhea/constipation. Listen for bowel sounds every shift.
4. Assess type and amount of drainage if applicable. Enteral devices require periodic flushing to keep them patent. It is recommended that small-bore feeding tubes be flushed with 30ml of warm water every four (4) hours during continuous feeding and before and after intermittent feedings, medications, after bolus feeds, if residuals are checked, and if feeding needs to be turned off for any length of time. Always use ENFit compatible syringes for water flushes if not able to use pump for water flushes.
5. For continuous drainage or to suction, change canister lining when needed and discard per infection control practice ([MEDICAL EQUIPMENT CARE, CLEANING AND](#)

MAINTENANCE).

6. PEG insertion site, if less than seventy-two (72) hours old, site will be cleaned daily with normal saline using aseptic technique and covered with a sterile dressing. Sites over seventy-two (72) hours old shall be cleaned daily with warm water and mild soap, and then left open to air. If a dressing is needed due to drainage, it is to be changed daily or PRN.

In the event a feeding tube becomes dislodged, **Notify MD.**

7. Should tubing become clogged: using a 30 ml or larger ENFit syringe, aspirate as much fluid as possible from the tube and discard. Fill syringe with 5 ml of warm water and attach to the end of the enteral device. Instill warm water under manual pressure for one (1) minute, using a back and forth motion with the plunger to loosen the clog. Clamp the tube five (5) to fifteen (15) minutes. Re-attempt to aspirate or flush the tube with warm water. Repeat the process if necessary.
8. Salem: Keep vent lumen above the patient's midline, otherwise it will act as a siphon.
9. Do not use any other type of liquid to attempt declogging except for warm water.

G. Tube discontinuation:

1. Inform patient and provide privacy.
2. Position patient in a sitting position (90°), if possible. Place a bath towel on patient's chest. Apply gloves and remove tape or tube holder from nose.
 - a. If Nasal Bridle Tube Retaining System is in place, cut one side of the securing string and slide the remaining secure string out of the nares. All clinical RNs may discontinue a Nasal Bridle Tube Retaining system.
3. Disconnect tube, if to suction from suction source. Pinch tube shut. This prevents tube contents from draining out during removal. If patient is able, have patient take a deep breath and hold. Withdraw tube gently but quickly. Wrap tube in towel and remove from chest. Clean nose and assist patient with oral care. Discard tube and towel in their appropriate receptacles.
4. Following removal, inspect the tube for holes or missing parts. If the tube is not intact, complete an Occurrence Report and notify physician.

H. Documentation:

1. Date and time of insertion
2. Size, type and purpose for tube
3. Methods of confirmation and tolerance of procedure
4. Length of tube remaining outside of nares (from nares to tip of hub) if a stylet was used. Condition of nares and oral mucosa before/after insertion.
5. Every shift evaluates and document.
6. Condition of nares, oral mucosa and condition of skin surrounding NG or j-tubes.
 - Patient tolerance to treatments, i.e., decompression, lavage, feeding, i.e., residuals (if ordered to be checked by MD), diarrhea

- Intake, output, weights
- Gastrointestinal status, i.e., bowel sounds, distention
- Education: Patient and family provided education regarding procedure for recognizing and reporting signs and symptoms of discomfort.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

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Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2024
Policy Owner	Carla Spencer: Chief Nursing Officer	12/2024

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerGary Ray: Chief Legal OfficerAreaAdministration

Governmental Investigations

I. POLICY STATEMENT

- A. Salinas Valley Health Medical Center (SVHMC) will fully cooperate with any government investigation and any request for information or access pursuant to a valid search warrant, subpoena, or other lawful demand. All employees, contractors, providers, vendors, volunteers, and members of governance (collectively "individuals") will remain courteous and business-like when interacting with governmental investigations or auditors, and will comply with the instructions of management for the production of information, documents, or records.

II. PURPOSE

- A. The purpose of this policy is to establish guidelines for the proper response to a contact by a Government or Law Enforcement Official and to enable SVHMC to promptly and cooperatively respond to lawful requests for information or access by Government and Law Enforcement Officials while protecting the interests of SVHMC. This policy and procedure applies to contact related to the activities of SVHMC as a whole, including hospitals and clinics.

III. DEFINITIONS

- A. **Government investigations** may include investigations by the Office of the Inspector General of the United States Department of Health and Human Services (OIG-HHS), Department of Justice (DOJ), Office of Civil Rights (OCR), United States Attorney General's Office, the Federal Bureau of Investigation (FBI), the California Attorney General Office, the Bureau of State Audit, the District Attorney, or the County Sheriff's Office, or the local Police Department. (See [OUTSIDE AGENCY INSPECTION](#) policy and procedure regarding health and safety or CMS investigations.)
- B. **Government contact** occurs when:
1. A government or law enforcement official (agent) appears in person to execute a valid search warrant, subpoena, or civil investigative demand;

2. A subpoena or civil investigative demand is received via mail, fax, or email;
 3. An agent appears in person and asks to speak with a particular person with whom the official does not have a pre-existing appointment; or
 4. An agent appears on person at the home of an individual regarding activity related to the hospital.
- C. **Civil investigative demand (CID)** is a request for records and information in connection with a federal civil investigation. It is generally issued by a government agency for a particular purpose.
- D. **Search warrant** is a legal document authorizing a government or law enforcement official to enter and search the premises.
- E. **Subpoena** is a court ordered request for documents or a request to appear in court or other legal proceedings. It is generally issued by the clerk of a court or by an attorney. It can be hand delivered, emailed, sent certified mail, or read aloud. Failure to respond to a subpoena generally results in penalties.

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. If you are approached by a government or law enforcement official requesting documents or access:
1. Be polite and courteous at all times.
 2. Request identification. Ask to see the badge or other credentials and the reason for the visit. Write down the name, title, agency/department, address, and phone number.
 3. Ask for a copy of the search warrant, subpoena, CID, or other authorized document.
 4. Once you have been shown the authorizing document, do not obstruct or interfere with the search.
 5. Contact the Operator ("0"), who will contact the Administrator on Call and the Compliance Officer. The Compliance Officer will contact Legal Counsel.
- B. Request for an interview:
1. If an agent requests an interview without a document authorizing the interview, then you have no obligation to consent to an interview.
 2. You have a right to have an attorney present at the interview. If you would like to have an SVHMC attorney present during your interview, you have the right to make that request before moving forward with the interview. SVHMC will make legal counsel available for that purpose. See [EMPLOYEES PARTICIPATING IN LITIGATION MATTERS PROCEDURE](#).
 3. Do not volunteer information or try to recall something that you do not remember or of which you have no knowledge.

4. Respond only to the questions asked.
5. You may require that the interview take place during normal business hours.
6. If you choose not to respond to questions or not to consent to an interview, the agent may have the authority to subpoena you to appear for a deposition. Should this occur, legal counsel from the hospital may be provided for the matter related to the interview.
7. Following any interview, provide the administrator on call, the Compliance Officer, and Legal Counsel with as much information about the interview and the interviewer as possible.

C. Request for documents or access:

1. Contact the administrator on call, who will contact the Compliance Officer, who will contact and Legal Counsel immediately before signing anything.
2. State that SVHMC objects to the search. Do not sign a form stating that SVHMC consents to the search.
3. Request to view and photocopy the search warrant document, subpoena, or CID. Check the document for the following:
 - a. Address on document matches the physical address being searched.
 - b. The current date is within the date range allowed by the document.
 - c. Document is signed by a judge or clerk of the court.
 - d. Specific business area or department – do not allow access to other than those locations.

D. During the search:

1. **Do not obstruct or interfere with the search.**
2. Do not consent to an expansion of the search.
3. Ask for the opportunity to copy all documents and other records seized.
4. Only speak to the agents as necessary to comply with the search warrant.
5. Do not allow physical access to areas not covered by the search document, if possible.
6. Do not alter or destroy any paper or electronic document or record that is the subject of a government investigation.
7. Walk the investigators out of the building personally
8. The Administrator on Call or Compliance Officer will:
 - a. Be aware of the documents and items specifically requested. Ensure that we do not disclose or allow documents or assets to leave the building if they are not listed on the search warrant.
 - b. Object to disclosure of items that are marked as protected by attorney-client privilege and inform Legal Counsel immediately. However, we may not prevent the agent from seizing documents.

- c. Monitor and record the manner in which the search is conducted and note in detail the precise area and files searched, time periods for the search, and names of those involved.
- d. If possible, make a list of all documents and assets searched and/or removed from the building and have the agent sign and note the date and time period during which the search was conducted.

E. Subpoenas

- 1. Legal Counsel or the Compliance Officer will coordinate disclosure of all documents. Should the Legal Counsel or the Compliance Officer not be present, keep track of all documents, assets, and information that are given.
- 2. Do not alter or destroy any paper or electronic document or record that is the subject of a government investigation.
- 3. The Compliance Officer or Legal Counsel will send out a legal hold notification to all individuals who may be in possession, custody, or control of relevant documents. The paper or electronic documents will be exempt from the records retention policy as it relates to when documents may be destroyed and the legal hold takes precedence.
- 4. The Compliance Officer will contact the Chief Strategic Communications Officer to discuss the request.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. "California Hospital Association Compliance Manual 2020"
- B. "The Complete Compliance and Ethics Manual (2018)"

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2024
Policy Owner	Gary Ray: Chief Legal Officer	10/2024

Standards

No standards are associated with this document

COPY



Last ApprovedN/ANext Review3 years after approval

OwnerKatherine DeSalvo: Director Medical Staff ServicesAreaAdministration

Mandatory Reporting

I. POLICY STATEMENT

- A. Our core values require us to provide a safe environment for patients, employees and physicians while remaining in compliance with applicable accreditation, regulatory, statutory requirements. Nothing in this policy should be interpreted to lessen or increase the rights and obligations provided by the California Business and Professions Code section 805 et seq. This policy is intended to compliment and operative in concert with the Medical Staff bylaws.

II. PURPOSE

- A. To provide procedures for the timely and appropriate reporting to the Medical Board of California or other relevant agencies in compliance with California Business and Professions Code Sections 805 and/or 805.01.

III. DEFINITIONS

- A. As used in this policy, "provider" refers to Medical Staff Members and Advanced Practice Providers.

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. The Chief Executive Officer or designee, and the Chief of Staff, shall file and 805 report with the Medical Board of California or other relevant agency **within 15 days** from the effective date on which any of the following occur as to a provider as a result of an action of the Medical Executive Committee:
 - 1. Denial of application for Medical or Allied Health membership for medical

- disciplinary cause of reason;
 2. Denial of Medical or Allied Health reappointment for medical disciplinary cause or reason;
 3. Denial of requested advancement for Medical or Allied Health staff membership for medical disciplinary cause or reason;
 4. Denial of requested privilege(s) for medical disciplinary cause or reason;
 5. Involuntary reduction of privilege(s) for medical disciplinary cause or reason;
 6. Imposition of summary suspension of Medical or Allied Health staff membership and/or privilege(s) for a period in excess of 14 days;
 7. Restrictions imposed or voluntarily accepted on Medical or Allied Health membership or privileges for a cumulative total of 30 days or more for any 12-month period, for medical disciplinary cause or reason;
 8. Revocation or termination of Medical or Allied Health Staff membership for medical disciplinary cause or reason; or
 9. Termination of privileges, including temporary privileges, for medical disciplinary cause or reason.
- B. The Chief Executive Officer or designee, and the Chief of Staff, shall file an 805 report with the Medical Board of California or other relevant agency **within 15 days** after a provider takes any of the following actions after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that the provider's application for member or privileges is denied or will be denied for a medical disciplinary cause or reason:
1. Resigns or takes a leave of absence from membership and/or privileges;
 2. Withdraws or abandons an application for membership or privileges; or
 3. Withdraws or abandons an application for renewal of membership or privileges.
- C. The Chief Executive Officer or designee, and the Chief of the Medical Staff, shall file and 805.01 report with the Medical Board of California or other relevant agency within 15 days after the Medical Executive Committee makes a final decision of recommendation regarding disciplinary action as to a provider based on its determination, after a formal investigation, that any of the acts listed below may have occurred, regardless of whether a hearing is held:
1. Incompetence or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent of in such a manner as to be dangerous or injurious to any person or to the public;
 2. The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug or alcoholic beverage to the extent of in a manner that is dangerous or injurious to himself or herself or any other person, or to the extent that such use impairs the ability of the licensee to practice safely;
 3. Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing or furnishing of controlled substances with a good faith effort prior to examination of the patient and medical reason therefor;

4. Sexual misconduct with one or more patients during a course of treatment or an examination.
- D. Following any of the actions listed in Sections A, B or C above, the Director of Medical Staff Services or designee will complete the 805 and/or 805.01 report(s) mandated by the Medical Board of California or other relevant agency, providing all of the information required and any relevant information deemed appropriate. The report will be signed by the Chief of Staff and/or the Chief Executive Officer or designee.
 - E. The 805 and/or 805.01 report(s) will be submitted to the Medical Board of California or other relevant agency, within the time frame referenced in Section A, B and C above.
 - F. The Director of Medical Staff Services will arrange for issuance of a notice to the provider enclosing a copy of the report(s) and advising the provider of the right to submit additional explanatory or exculpatory statements electronically or otherwise to the Medical Board of California or relevant agency. The notice will advise the provider that information submitted electronically will be publicly disclosed to those who request the information. The member will also be notified of hearing rights, if applicable, afforded by the Medical Staff Bylaws.
 - G. A copy of the report will be maintained in the provider's credentials file.
 - H. The Hospital will cooperate with the Medical Board of California or relevant agency in connection with any investigation arising from the report. The act of submitting the report does not act as a waiver of confidentiality and all information reported or disclosed shall be kept confidential in accordance with Hospital policy, the Medical Staff Bylaws, the California Evidence Code and the Business and Professions Code.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. California Business and Professions Code section 805 and 805.01

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	01/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Katherine DeSalvo: Director Medical Staff Services	01/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Genevieve delos Santos: Director Pharmacy
Area	Patient Care

Medication Use

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the clinicians in safely and accurately prescribing, administering and monitoring for medication therapeutic effects.

III. DEFINITIONS

- A. Order Entry: The process of entering the medication order into the computerized patient drug profile.
- B. Acknowledge: Process by which RN reviews medication order for appropriateness of clinical situation.
- C. Reject Order: The electronic message sent to pharmacy when a medication order entered into the patient's profile is not appropriate for the clinical situation or does not match the original medication order written by the physician.
- D. Pending: A MAR order status that requires further action.
- E. Unverified: Medication orders entered by a Non-pharmacist that require pharmacist verification.
- F. D/C: Discontinue medications
- G. MAR (Medication Administration Record) - The Medication Administration Record (MAR) is a real time medication record that is designed to provide online documentation of medication administration.
- H. BMV – Bedside Medication Verification
- I. DNUA – Do Not Use Abbreviation

- J. Verbal Order – orders dictated to a licensed person by a licensed independent practitioner (LIP)

IV. GENERAL INFORMATION

- A. Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient's care, and in accordance with hospital policies; medical staff bylaws, rules, and regulations; and law and regulation.
- B. Only persons authorized via their licensure/certification/scope of practice may order, dispense and/or administer medications. Medications brought in by an outside practitioner will not be authorized for use. Medication management will be a collaborative effort among all disciplines involved in medication use to ensure safe practices.
- C. Medication administration will follow the bedside medication verification (MAR/BMV) process to include scanning of the patient armband and the medication bar-code prior to administration.
- D. Medications are not dispensed without acknowledge of the patient's allergy status. In the event of an emergency and allergy status cannot be obtained, Pharmacy will dispense medication as appropriate.
- E. Control of medications between receipt by an individual health care provider and administration of the medication, including safe storage, handling, security, disposition and return to storage will be in accordance with state and federal guidelines of medication control.

V. PROCEDURE

A. Patient Specific Information

1. Pharmacy Essentials of Patient Information

- a. The following information is accessible to licensed independent practitioners and staff who participate in the management of the patient's medications.
 - 1. Age
 - 2. Sex
 - 3. Diagnosis
 - 4. Allergies
 - 5. Sensitivities
 - 6. Current Medications
 - 7. Height (when applicable)
 - 8. Weight (when applicable)
 - 9. Pregnancy and lactation information (when applicable)
 - 10. Laboratory results (when necessary)
 - 11. Other information required by the organization

2. Inpatient Medication Profile

- a. All medications ordered for a patient will be entered into the hospital's computer drug profiling system, reviewed and verified by a pharmacist. The following are exceptions:
 1. Emergencies (e.g., Code Blue)
 2. Any situation in which the patient would be harmed if the medication were not given immediately.
 3. Medications administered directly by or under the supervision of a licensed independent practitioner (LIP).
- b. Pharmacist review of medication orders includes the following:
 1. Patient allergies or potential sensitivities
 2. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking
 3. The appropriateness of the medication, dose, frequency and route of administration
 4. Therapeutic duplication
 5. Current or potential impact as indicated by laboratory values
 6. Other contraindications
 7. Variation from criteria for use
 8. Other relevant medication related issues or concerns
- c. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.
- d. Each patient drug profile will include the following patient specific information:
 1. Patient's name
 2. Room location
 3. Admitting physician
 4. Primary diagnosis
 5. Age
 6. Sex
 7. Height
 8. Weight
 9. Estimated creatinine clearance if creatinine ordered/available and other recent laboratory data
 10. Body surface area
 11. Fluid restriction status when ordered
 12. Drug allergies

13. Pregnancy and lactation information
14. Dialysis or end stage renal disease information
15. Updated information regarding each of the above will be entered on the patient drug profile.
16. Each medication entered into the drug profile must include the following:
 - i. Drug name
 - ii. Strength
 - iii. Frequency of use
 - iv. PRN orders must have an indication
 - v. Route of administration
 - vi. Start and stop dates, if applicable
17. Important notes (i.e., allergy clarifications, patient history) pertinent to the patient may be recorded on the Pharmacy profile
18. The MAR is a real time medication record that is designed to provide online documentation of medication administration.

B. Medication Ordering/Prescribing

1. All medications require an order from a person lawfully authorized to prescribe.
 - a. The following IV fluids may be ordered per hospital approved policy when associated treatments are prescribed by the physician. Nurse will indicate per policy order.
 1. Blood transfusions – Administer Normal Saline per [BLOOD AND BLOOD PRODUCT ADMINISTRATION POLICY](#)
 2. Flushes with saline or heparinized saline solution for IV lines, central venous access lines will follow policy: [CENTRAL VASCULAR ACCESS DEVICES](#)
 3. Chemotherapy tubing flushed with normal saline per [CHEMOTHERAPY ADMINISTRATION OF PARENTERAL AND ORAL ANTINEOPLASTIC AGENTS](#)
 4. Flush tubing of medications as indicated by pharmacy
 5. Nurse may hang a Normal Saline IV at max rate of 10ml/hr to facilitate IV access patency for low volume infusions (when no primary solution exists).
E.g. PCA's, titratable drips, insulin
 6. Nurse may order solutions used to maintain pressure line monitoring devices, such as Arterial lines, CVP's and Swan Ganz catheters. (either Normal Saline or Heparinized saline -2unit/ml) per policy. [CENTRAL VASCULAR ACCESS DEVICES](#)
 7. For topical anesthetic cream and intradermal injection of

lidocaine for IV site preparation, refer to. I.V. THERAPY - PERIPHERAL

2. PRN orders must be written to include the symptom or indication for use.

- a. If the order is missing the indication or symptom, the nurse or pharmacist will contact the physician for clarification.

3. Therapeutic Duplication

- a. Therapeutic Duplication is the practice of prescribing multiple medications for the same indication or purpose without clear distinction of when one medication should be given in preference over another.

1. In the event that an approved duplication in prescribing has occurred, the nurse administering the medication will give in reference to the route PO first, IV/IM second, and PR (per rectum) third.

4. Pharmacy drug protocols

- a. The Pharmacy and Therapeutics Committee will authorize pharmacists to manage and monitor the therapy of approved drugs according to protocol. Therapy is modified based on monitoring the patient's response as evaluated by the pharmacist per protocol.
- b. The Pharmacist is authorized to use the protocols only after demonstrating competency

5. Do not use abbreviations

- a. To be acceptable, only those symbols and abbreviations approved by the Pharmacy and Therapeutics (P&T) and Medical Executive (MEC) Committees may be used. Per P&T approval, those abbreviations on the "Do Not Use" list may not be used when writing medication orders nor can DNUA appear in any pre-printed order forms, MARs, H&Ps, and all other computerized documentation regarding medications. In an effort to reduce medication errors, the following abbreviations **MAY NO LONGER BE USED.** (Refer to: ATTACHMENT C)

6. Verbal/Telephone Orders (Refer to: Article X111 SVHMCS Medical Staff General Rules and Regulations)

- a. Orders dictated to a licensed person by an M.D., D.O., D.D.S., D.P.M., P.A., (authorized LIP) are known as verbal orders.
- b. Verbal orders can be given in emergency situations or situations when the authorized LIP is involved in a procedure and physically unable to enter the orders.
- c. Verbal orders or telephone orders for medications may be received by other physicians, licensed nurses, pharmacists, dietitians, respiratory care practitioners, speech therapists and physical therapists within the scope of their practice.
- d. Physician assistants may also receive and give verbal orders (including

medications and IV fluids) on a patient-specific basis from the supervising provider or pursuant to an approved protocol and as dictated by their scope of practice and clinical privileging.

- e. The person receiving the verbal order must read back and verify the order to the ordering party for verification.
- f. The verbal / telephone order must:
 - 1. Be authenticated, dated, timed, and subsequently signed by the ordering authorized LIP or by another authorized LIP responsible for the care of the patient within forty-eight (48) hours.
 - 2. The physician must remain on the line until the Telephone orders are read back and verified.
 - 3. Telephone orders should be limited to short order sets, protocols or a minimal number of individual orders necessary to initiate care

7. Therapeutic Interchange

- a. Therapeutic interchange may occur when approved by the Pharmacy and Therapeutics Committee. If a medication is interchanged, the medication as ordered by the physician and the therapeutic interchange medication will be indicated on the Medication Administration Record.

8. Order Clarification/Legibility

- a. To be acceptable, the order must include the name of the drug, the dosage and frequency of administration, indication for PRNs, the route of administration, and the date, time, and signature of the prescriber.
- b. To be acceptable, the order must be legible. An illegible medication order is defined as when two nurses/pharmacists cannot interpret the order with 100% certainty. If an order is deemed illegible, the nurse or pharmacist will contact the physician for clarification and re-write the clarified order.

9. Range Orders

- a. Medication orders containing a range in dose or a range in frequency are accepted with defined parameters.

10. PRN Orders

- a. PRN or "as needed" medication orders are acceptable based on the following criteria:
 - 1. The diagnosis, condition or indication for use of a PRN medication is documented in the medical record
 - 2. The order contains all of the elements of a complete medication order. (i.e., dose, route, frequency, etc)
 - 3. PRN orders for multiple medications or doses to treat the same indication or symptoms include, as part of the order, specific parameters or criteria for the use of each medication/dose that

clearly communicates and delineates when each medication is to be administered.

4. Medication orders with more than one route of administration (i.e. IV/PO) clearly define, as part of the order, the parameters for selecting the route of administration. (i.e. may give IV if unable to take po)

11. Herbal Products

- a. Herbal products which are not FDA approved are not included on the hospital formulary and will not be procured by the pharmacy.
- b. Patient **cannot** use their own Herbal products while in the hospital
- c. Orders for herbal products that may be appended to the patient's medication list during medication reconciliation will be discontinued by the pharmacist.
- d. The Pharmacy Department serves as a resource for potential drug/drug and food/drug interactions, and/or any other questions regarding these products.

12. Titration/Tapering of Medications

- a. **Titration:** A specific physician order is required for medications that are to be titrated. The medication may be increased or decreased to achieve the desired clinical response. The physician order must have parameters for titration. For standard IV compound concentrations, refer to PHARMACY: STERILE COMPOUNDING. The nurse will use the IV Medication Titration Guidelines. Refer to: Attachment F

1. The following are required elements for titration orders:

- i. Drug name
- ii. Dose
- iii. Maximum and minimum dose
- iv. Route
- v. Frequency
- vi. Dose calculation requirements (if applicable)
- vii. Exact strength of concentration (if applicable)
- viii. Duration (if applicable)
- ix. Special instructions (if applicable)

- b. For titratable drips with specific vital sign parameters ordered, the RN may change the bedside monitor settings to align with the MD ordered parameter.
- c. **Taper orders:** A specific physician order is required for medications that are to be tapered.
- d. Medication orders are written with a starting dose and instructions to

adjust the dose and/or frequency.

13. Pediatric Dosing of Medications

- a. All neonatal and pediatric medications dosages for pediatric patients below 50 kg are to be ordered by the prescriber as a weight based dosing parameter and then the calculated dose.
- b. The prescriber must order a complete pediatric medication order including:
 1. The name of the medication
 2. Indication, if applicable
 3. The dose, weight-based or dosage parameter utilized to calculate the dosage regimen, if applicable, such as dose per weight (mg/kg, mcg/kg, etc.)
 4. Upon receipt of the order, the pharmacists will confirm the dose ordered by utilizing SVHMC pediatric medications list, accepted neonatal or pediatric references. Any dose that falls outside a normal dosages range by more than 10% will be confirmed with the Prescriber.
 5. The following drug classes are exempted from this requirement:
 - i. Vitamins orally
 - ii. Iron preparations orally
 - iii. Topical preparations
 - iv. Vaccines
- c. A list of pediatric medications available for use is developed for the most commonly used pediatric medications at SVHMC. (Refer to: ATTACHMENT D).

C. Medication Transcription/Verification

1. **Medication Administration-** Medications that are STAT and must be given prior to the medication entry on the MAR, will automatically populate the MAR upon removal from the automated dispensing cabinet. **Medication Administration (See [AUTOMATED DISPENSING MACHINE DRUG DISTRIBUTION SYSTEM](#))**
2. **Medication Resources**
 - a. The nurse will only administer medications for which he/she has basic knowledge.
 - b. Appropriate resources for drug information include the physician, drug books, pharmacist, drug specific policy/procedure, online drug database(s).
3. **Persons Authorized To Administer Medications**
 - a. Medications must be prepared and administered by licensed or lawfully authorized personnel within the scope of their practice and their job

description. These include:

- b. Registered Nurses (RNs) who have passed the hospital medication examination.
- c. Licensed Vocational Nurses (LVNs) who have passed the hospital medication examination.
- d. Clinical Nurse Specialist (CNS)
- e. Speech Therapists
- f. Physicians
- g. Physician Assistants (PAs)
- h. Respiratory Care Practitioners (RCPs) (drugs related specifically to respiratory therapy)
- i. Physical Therapists (PTs) (certain topical medications)
- j. Certified Radiologic Technologists (CRTs) (all radiologic contrast media)
- k. Pharmacists
- l. Perfusionist
- m. Student nurses who have passed the hospital medication examination and other allied healthcare provider students (note: may administer medications within their scope of practice when done under the direct supervision of their instructor or SVHMC preceptor).
- n. Medical assistants
- o. Nuclear Medicine Technologists
- p. Certified Nurse Anesthetists (CRNAs)

4. Preparation of Medications

- a. Only medications obtained by the SVHMC Pharmacy will be used; practitioners may not use medications brought in from sources other than the hospital with the exception of :
 - 1. the patient's own FDA approved medications if not available from the hospital pharmacy
 - 2. Staff preparing medications must comply with all applicable medication policies/procedures.
 - 3. Medications should be prepared, using aseptic technique in an environment where there is adequate light, free from distractions, an uncluttered, clean work surface, and with clean hands.
- b. It is recommended that a separate work area be used for preparation to minimize the risk of contamination
- c. A filtering device (e.g., filter straw, filter needle) must be used when drawing up the contents of an ampule, to ensure that all glass particles are

removed from the medication before administration to the patient.

- d. When medications are mixed in the same syringe or container, observe the mixed solutions to ensure that no precipitate or other evidence of incompatibility has occurred.
- e. When preparing/administering medications from multi dose vials the following applies:
 - 1. All multi-dose vials **expire** 28 days from the day the vial is opened, or per the manufacturer's recommendation, whichever is shorter.
 - i. The date written on the multi-dose vial indicates the last day the medication is allowed for use.
 - 2. Exceptions:
 - i. The expiration dates for multi dose ointments, inhalers, and liquids are assigned by the manufacturer; therefore the 28 day expiration date does not apply.
 - ii. Insulin vials will be dispensed with a 28 day expiration label when dispensed from the pharmacy.
 - iii. If a MDV is entered in a patient room, then the vial, per CDC guidelines becomes a single dose vial.
 - iv. For Taylor Farms Family Health & Wellness Center vaccine management- all multi-dose vials of vaccines will be labeled with both the date of opening and the 28 day expiration date.
- f. The nurse will calculate and document the expiration date for any multi dose vial opened on the nursing unit.
- g. Single dose vials are used only **ONCE and then discarded immediately after use.**
- h. Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice.
- i. Any time one or more medications are prepared but not administered immediately, the medication container must be appropriately labeled with the following:
 - 1. Drug name, strength and amount (if not apparent from the container)
 - 2. Expiration date when not used within 24 hours
 - 3. Expiration time when expiration occurs in less than 24 hours
 - 4. For all compounded IV admixtures and parenteral nutrition formulas, the date prepared and the diluent.
- j. When the person preparing the medications is not the person administering the medication, the label **also includes** the following:

1. Patient name
2. Content
3. Beyond use date, if applicable
4. Patient location where the medication is to be delivered
5. Directions for use and any applicable accessory and cautionary statements
6. Additional information regarding medication preparation is located in the *IV Admixture* section.

k. Administration Procedure

1. The person who opens or prepares the medication should normally administer and record the administration of the medication.
2. Medication given by a physician:
 - i. If an RN prepares a dose for the physician to administer, show the physician the container and verify the dosage. The physician, or RN charts the medication.
 - ii. If recording a medication administered by a physician, the RN documents as GIVEN with an administration comment of Administered by Physician.

l. Before administering any medication the licensed person administering the medication will:

1. Discuss any unresolved, significant concerns about the medication with the patient's physician or prescriber (if different from the physician).
2. Examine and administer medications only from clearly labeled containers. If the integrity of a drug or drug package has been compromised or the labeling/packaging is confusing, it should not be used.
3. Confirm that the medication order has been acknowledged prior to administering the medication.
4. Verifies that there is no contraindication for administering the medication.
5. When a patient is NPO for test purposes or surgery, determine if medications should be given with a sip of water or held. Contact the physician for direction and orders and document accordingly.
6. Before administering PRN medications, the MAR must be checked to be sure the proper time interval has elapsed.
7. Explain what the medication is for and advise the patient or

patient's family of any potential clinically significant adverse reaction, side effects or other concerns. All medications will be considered "new" to the patient.

8. Provide a copy of the medication information sheet from an approved hospital source (i.e., Care Notes or Micromedex) as appropriate (i.e., patient/caregiver is ready/able to learn, has not already received printed materials, etc.).
9. Instruct the patient to inform the nurse immediately of any unusual responses.

m. Administer medication as follows:

1. Verify that the medication selected matches the medication and product label
2. Check the manufacturer's information printed on the medication vial, IV bag, etc. and ensures that it matches the pharmacy label for correct drug, solution, expiration date, etc.
3. Verify that the medication is stable based on visual examination for particulates, discoloration, or other loss of integrity.
4. Verify the medication is not expired.
5. Verify that no contraindications exist.
6. Verify that the correct medication is being administered to the correct patient at the proper time, in the prescribed dose, and by the correct route.
7. Discuss any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient's care, treatment and services.
8. Access the MAR to view the patient's medication profile.
9. Wash hands or use hand sanitizer upon entry into patient's room
10. Identify patient using 2 patient identifiers per hospital policy.
[PATIENT IDENTIFICATION POLICY](#)
11. Check for patient allergies and alert armband. Verify patient by scanning armband.
12. Scan medications to be administered, complete documentation screens, submit to obtain the list of medications to be given
13. Administer medications
14. File documentation
15. Stay with patient until oral medication is taken. Do NOT leave medication at the bedside.
16. Wash or use hand sanitizer upon exit of the patient's room

17. Monitor the patient's response to the medication during the course of the ongoing reassessments and treatments, Monitoring should include the patient's own perception about side effects and efficacy.
 18. If an adverse drug event occurs, follow the "Adverse Drug Reaction Program", report incident using on-line occurrence reporting program [ADVERSE DRUG REACTION PROGRAM](#)
- n. For a patient in isolation:
1. Per policy, wash hands or use hand sanitizer upon entry into patient's room.
 2. Apply personnel protective equipment as per policy. [ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS](#)
 3. Administer medications as outlined above.
 4. File documentation
 5. Remove personal protective equipment and wash or use hand sanitizer upon exit of the patient's room
 6. Use another set of gloves and sanitize WOW surface and scanner
 7. Sanitize hands again
- o. Documentation of Medications Administered
1. Medication administration is documented on the MAR. In departments where medication administration is not documented in the EMR, documentation will occur on procedural forms or department specific software. Medications not given (e.g. refused by patient, held due to vomiting), document as "Not Given" with a selected reason. Notify the physician if indicated.
- p. Document PRN medication indications and response in the electronic record.
- q. Medication orders for "HOLD"
1. Must include the amount of time the medication is to held (e.g. number of doses or number of days). If this information is not included with the "hold" order, the medication will be discontinued from the patient's medication profile.

5. **Standardized Times Of Administration for Inpatients:**

- a. Medications shall be administered in a timely manner. Depending on a variety of factors, including but not limited to, the pharmacokinetics of the prescribed medication; specific clinical applications; and patient risk factors, medications – unless otherwise noted – shall be administered at scheduled time. In order to decrease unnecessary variability in the medication administration process, medications will be administered

using established standard times as approved by P&T. Refer to:
Attachment A.

- b. The following are considered appropriate reasons for deviating from standardized times of administration:
1. Physician order for specific times. If appropriate, the pharmacist will contact the physician for clarification.
 2. Clinical indication, such as intolerance to multiple vasoactive agents thus requiring "staggered times" or when specific regimens or guidelines require deviations from standardized times.
 3. Medications which are dependent on the timing of meals, nursing staff may adjust medication administration times as appropriate.

c. Time-critical scheduled medications:

1. Time-critical scheduled medications are those for which an early or late administration of greater than thirty minutes might cause harm or have significant, negative impact on the intended therapeutic or pharmacological effect. Accordingly, scheduled medications identified under the hospital's policies and procedures as time-critical must be administered within thirty minutes before or after their scheduled dosing time, for a total window of 1 hour.
2. It is possible for a given medication to be time-critical for some patients, due to diagnosis, clinical situation, various risk factors, or therapeutic intent, but not time-critical for other patients.
3. Time-critical scheduled medications/medication types include:
 - i. Antibiotics;
 - ii. Anticoagulants;
 - iii. Insulin;
 - iv. Anticonvulsants;
 - v. Immunosuppressive agents;
 - vi. Pain medication;
 - vii. Medications prescribed for administration within a specified period of time of the medication order;
 - viii. Medications that must be administered apart from other medications for optimal therapeutic effect; or
 - ix. Medications prescribed more frequently than every 4 hours.

d. Non-time-critical scheduled medications:

1. Non-time critical scheduled medications are those for which a

longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm. For such medications greater flexibility in the timing of their administration is permissible. Specifically:

- i. Medications prescribed for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window that does not exceed 4 hours.
- ii. Medications prescribed more frequently than daily but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours

e. **Evaluation of medication administration timing policies:**

1. Medication Safety Committee should periodically evaluate their medication administration timing policies, including staff adherence to the policies, to determine whether they assure safe and effective medication administration.
- f. The first doses of medications will be administered as soon as possible after pharmacist review and entry into the patient's medication profile, and allowing adequate time for delivery (if required). Subsequent doses will be adjusted to standard times as soon as possible.
- g. When a medication order is written, the pharmacist assigns the administration schedule based on the following schedule:
 1. When there are two standardized scheduling options (indicated above as **EITHER**), the administration time will be scheduled based on the time *closest to the original order time*, or in order to stagger multiple IVPB medications due to the increased time required for administration of these medications.
 2. When a medication is ordered in between a standardized time, the pharmacist and nurse will consult the "Catch up chart" to determine whether a dose should be given or not, and when the next dose is due. Refer to: **Attachment C**
 3. When it is necessary for the medication to deviate from the standardized times of administration, the nurse may send an electronic pharmacy communication in the EMR system indicating the reason for the deviation. If the reason for deviating from the standardized time is not valid, the Pharmacy will not change the standardized administration times.
- h. The last dose of **diuretics** should be administered no later than **1730** unless otherwise ordered by physician, or patient has a urinary catheter in place.

- i. Medications ordered "**STAT**" receive priority and are dispensed to the patient within twenty (20) minutes. Medications ordered "**NOW**" are dispensed within one (1) hour. New routine orders are dispensed within four (4) hours. Initial antibiotics should be given within one (1) hour. Chemotherapy and TPN medications are never considered "STAT".
- j. Missed or Late Administration of Medications
 - 1. If a medication is not administered or is not administered within its permitted window of time, the following actions shall be taken:
 - i. Staff shall re-time administration of the next scheduled dose of medication based on the recommendations established in this policy.
 - ii. Pharmacy and/or the prescribing physician shall be contacted if staff have any concerns around re-timing of the medication.
 - iii. If the missed or late administration of a medication dose results in a significant medication error, then the attending physician is to be notified and an occurrence report generated.
- k. Use of Professional Judgment
 - 1. Staff are expected to use their professional judgment in organizing and prioritizing patient care work-loads to assure that medications are delivered in a safe and timely manner. In exercising such judgment staff must take into account the complex nature and variability among medications; the indications for which they are prescribed; the clinical situations in which they are administered; and the needs of the patients receiving them.

6. **Hazardous Medications:** Refer to [HAZARDOUS DRUG HANDLING](#)

7. **Look Alike Sound Alike Medications:**

- a. Look Alike, Sound Alike are those medications that have brand or generic names or packaging that is similar enough to make errors possible or probable. [LOOK ALIKE, SOUND ALIKE MEDICATION MANAGEMENT](#)

8. **IV Medications:**

- a. Use of an infusion pump is required for all medications, when possible.
 - 1. NICU patients require use of a soluset.
- b. When an infusion pump is used, the Guardrails® function should be implemented. Basic Infusion may be used when the medication is not available in Alaris Guardrails.
- c. Certain IV push and IV infusion medications have restricted areas of usage. IV Push & IV Infusion Medication List. Refer to: **Attachment E**

9. IV Admixtures:

a. Approved Departments For Admixing: Emergency Only

IV admixtures should only be prepared in the pharmacy, except in emergencies or when it is not feasible (for example, short product stability). If it is necessary to admix medications outside of the Pharmacy, only the following clinical departments may admix : Emergency Department, NICU (all ampicillin doses), Pediatrics (all ampicillin doses), and Surgery.

- (SUBPOINT OF 9.a): Note: The assembly of sterile products with the use of adapters (i.e., mini-bag-plus, ADD-vantage, VIAL-MATE, etc.) is not considered compounding, and is thus permitted on the nursing floors for immediate use, and the should be hung within one hour of assembly.
- b. The nurse is required to pass a competency and should contact a Pharmacist if they have any questions about the medication, dilution, rate, dose or admix procedure.

10. Pharmacy Procedures for Sterile Compounding (See [PHARMACY: STERILE COMPOUNDING: GENERAL PROCEDURES](#))

11. Self -Administration by Patient/Caregiver in Inpatient Departments

- a. Self-administration of medications (e.g., subcutaneous insulin injections, patients with insulin pumps refer to "**CARE OF PATIENT, CONTINUOUS SUBCUTANEOUS INSULIN PUMP** ") by patients is allowed under specified circumstances, but not encouraged. The competency of the patient is assessed prior to allowing patients to self-administer medications. A patient felt to be mentally or physically incompetent or incapacitated will not be allowed to self-administer medications.
- b. Specific orders for self-administration of medication by the patient must be ordered by the physician.
- c. The medication shall be clearly labeled by the Pharmacy Department.
- d. The medication shall, unless otherwise ordered, be locked in the patient's cassette.
- e. Proper administration techniques including frequency, route and dose will be reviewed with the patient by the physician, nurse or appropriate healthcare provider within their scope of practice. The patient will also be educated on how the medication is expected to perform, any side effects that may occur from taking the medication and how the patient can monitor the effects of the medications.
- f. Non-staff members who wish to administer medications, such as parents, family members or patients, must be determined competent in administration prior to the granting of approval for medication administration.

1. Competency will be assessed by the Registered Nurse.
2. Competency assessment will consist of verification by the staff member of the patient's knowledge base related to the medication and educational concepts outlined above and documented in the medical record.
3. If the non-staff member requesting to administer medications is not deemed competent to administer medications, he or she will not be allowed to do so until further education results in approval of competency.

12. Responsible Person:

- a. Attending Physician - Order for self-administration shall appear in the medical record.
- b. Attending Physician & RN - Patient shall be thoroughly instructed on how to take medication, including amount and time expected actions, side effects and results of medication, and demonstrates knowledge and understanding of same.
- c. RN - Patient education for self-administration of medication shall be documented in the medical record.
- d. An appropriate patient care provider licensed to administer medications will supervise the patient/caregiver's administration of medications and document the medication administration in the medical record and on the MAR as appropriate.
- e. **Bedside Medications for Self Administration: Inpatient Departments**
No medications may be left at the patient's bedside, with the following exceptions:
 1. Continuous infusions containing medications.
 2. The patient's physician determines that it is in the patient's best interest to arrange for the medication to be readily available in the patient's room in order to alleviate distress associated with acute or chronic exacerbations of a medical condition that the patient recognizes and usually self-medicates. An example would be a rescue inhaler for the treatment of asthma, or an inhaler used for the chronic management of chronic obstructive pulmonary disease. In such cases, a written order by the physician must be obtained and documented in the electronic medical record for reference by nursing staff. This exception does not negate that, if available, an appropriate patient care provider licensed to administer medications supervise the administration of the medication and record the administration in the medical record.
- f. **Medications Administered by Respiratory Care Practitioners (RCPs)**
 1. All medications (MedNebs and MDIs) administered by RCP's will

be reviewed by a Pharmacist prior to administration. The following are exceptions: STAT, emergencies (Code Blue), any situation in which the patient would be harmed if the medication were not given immediately, medications administered directly by or under the supervision of a physician.

2. MedNebs: For inpatients, the order will be entered onto the patient's medication profile, with a comment indicating that the medication is to be administered by the RCP. The doses are documented on the MAR.

g. Metered Dose Inhalers (MDIs) - Inpatient Procedure:

1. Respiratory Care Practitioners (RCPs) is notified of the new order.
2. The RCP will educate the patient in the proper use of the MDI while administering the first dose. It is recommended that the nurse attend the initial patient educational session. The RCP will record the dose administered on the patient's MAR and document the education provided.
3. If the patient is unable to use the inhaler properly, the RCP and nurse will collaborate to ensure that the patient is provided additional instruction.
4. All subsequent doses of MDIs will be administered by the nurse and recorded on the MAR.

h. Medicated Patches (includes controlled substances):

1. Initial Patch Application:
 - i. When applying a medicated patch:
 - ii. Remove "old" patch and cleanse the area to remove residual medication.
 - iii. Date/Time/Initial the "new" patch.
 - iv. Apply patch to the approved site as recommended by the manufacturer. (Most patches should not be applied directly over the heart).
 - v. Document on the MAR
2. Follow-up Monitoring of Patch:
 - i. Every shift: the nurse will check for patch placement.
 - ii. Document and verify type of patch, location, and integrity.
3. Discontinuation or removal of non-controlled substance patches may be documented on a separate MAR entry called "Patch Removal" that allows the nurse to document the removal
4. Topical Controlled Substance patches removed from the patient

must be properly disposed of and **not** simply discarded in a trash receptacle or Sharps container.

- i. For handling/disposal of fentanyl patches, refer to [TRANSDERMAL FENTANYL PATCH CLINICAL PROCEDURE](#)

- ii. Removal/change of patch:

- a. Using gloves, remove the topical controlled substance patch from the patient.
- b. Fold the patch into itself (i.e., adhesive to adhesive) and discard in a pharmaceutical waste container.
- c. Wasted patch requires a co-signature, documented on the MAR. Two (2) nurses, or one (1) nurse and a Pharmacist. The wastage must be observed by both persons.
- d. Follow documentation for routine change using the "Patch Removal" MAR entry as described above

5. If a controlled substance patch is to be "wasted" due to contamination or other reasons, the same process above is to be followed

13. Patient/Medication Monitoring:

a. General Requirements

1. The effects of medications on patients are monitored to assess the:
 2. Effectiveness.
 3. Minimize the occurrence of adverse events.
 4. Each patient's response relative to his or her clinical needs.
- b. The patient care provider (nurse, respiratory therapist, physical therapist, etc.) will collaborate with members of the health care team to monitor and assess the effect of medications on the patient to include but not limited to the following:
 1. Physical assessment to include the patient's physiologic responses (e.g., vital signs, intake, output, etc.).
 2. Laboratory results.
 - i. Lab values displayed on medication administration are reviewed by the nurse.
 3. Diagnostic study results.
 4. Relevant clinical documentation (i.e., progress notes, medication

administration record, etc.).

5. Patient's perception about the side effects & perceived efficacy as appropriate.

c. New medications added to the hospital formulary:

1. Pharmacy will add the following information to the electronic drug entry, if appropriate:
2. Indication
3. Common side effects
4. Monitoring parameters if needed
5. Protocol, guidelines, and staff education may be necessary for new formulary medications as determined by the Pharmacy and Therapeutics Committee.

d. Certain specific medication monitoring requirements may include, but is not limited to:

1. **Insulin**

- i. The latest MBG will display on the MAR screen upon scanning the insulin.
- ii. If no insulin dose is required, document "not given" and select no coverage from the drop down menu.
- iii. For patients receiving insulin who are scheduled to be NPO for a procedure, contact the physician for appropriate orders **before** the procedure.

2. **Antihypertensive Medications**

- i. Check the patient's blood pressure before administration. Record the blood pressure on the MAR

3. **Digoxin**

- i. Check the patient's apical pulse for one minute before administration. Record the patient's pulse on the MAR. Hold for pulse of less than 50 or bradycardia associated symptoms, or as ordered by the physician. Notify physician within 4 hours of holding Digoxin.

4. **Electrolytes**

- i. Check the patient's most recent laboratory data before administration. The most current electrolyte results will display on the MAR.

5. **Warfarin**

- i. The patient's most recent PT/INR will display on the MAR.

14. Adverse Drug Events:

- a. **Adverse Drug Reactions (ADR).** "ADVERSE DRUG REACTION PROGRAM – Refer to : # 261"
- b. Reported via Electronic Occurrence reporting process

15. Medication Errors

- a. "MEDICATION ERROR REDUCTION PROGRAM – Refer to : # 2248"
- b. Reported via Electronic Occurrence reporting process

16. Chart Check: Inpatient Departments:

- a. In an effort to ensure orders, including medications, have been processed and reviewed for appropriateness of clinical condition, nurses should perform chart checks every shift.
 - 1. Chart checks are performed each shift, shifts are defined as either 8 or 12 hours.
- b. If a discrepancy is encountered and/or medication orders are deemed inappropriate for the patient's clinical condition, the nurse will reject the medication order and contact the physician to clarify the order.
- c. When medication order or related orders have not processed, the nurse will take the appropriate measures to ensure the processing of the order.

17. Medications Brought To Hospital: Inpatient Departments: (Note: This policy excludes the medication use process in the out-patient Sleep Disorders Center and the Cardiac Rehabilitation Center at SVHMC. See policy MEDICATION RECONCILIATION)

a. Storage and Destruction

- 1. When nursing personnel receive patient medications that are not required for the patient while they are hospitalized, yet cannot be sent home the following procedure will be implemented:
 - i. Medications will be placed in a tamper-evident security bag, and sealed with the patient acting as a witness. The receipt should be noted and logged in the charting system.
 - a. In the event that the patient is an unreliable witness, the bag should be filled and sealed in the presence of two nursing personnel.
 - ii. The sealed bag should be brought to pharmacy, where the bag number is tracked and logged by pharmacy personnel, and stored in a secure manner.
 - iii. Upon discharge, the nurse retrieves the sealed medication bag from pharmacy and returns to the patient/family member
 - a. Medications not picked up from the

pharmacy will be discarded 30 days post discharge.

2. When home medications are administered in the pharmacy

- i. Medications are presented and stored in pharmacy in a white manila envelope, or similar storage container.
- i. In the event that a medication must be retrieved from a sealed bag (noted above), the bag will be opened in the presence of two pharmacy personnel, the medication retrieved, and resealed using tamper-evident technology. This entry and removal will be documented and tracked by pharmacy.
- ii. Pharmacy counts and logs the medication for patient use, and dispenses the appropriate quantity to the floor for the patient's use.
- iii. Upon Discharge, the nurse obtains the remaining quantity from pharmacy and returns to the patient.

3. **Use of Patient's Own Medications:** refer to PATIENT'S OWN MEDICATION USAGE

18. **Patient Education: Inpatient Departments**

a. **Medication Safety Education**

Whenever possible, patients should participate in ensuring medication safety. The patient should be educated to question the nurse if the medications being given do not look familiar. Instruct the patient to speak up, and ask the nurse to check and make sure the medication is correct.

b. **Medication Education**

1. Patients, families and/or significant others, as identified by the patient, will receive information about the medications being administered throughout the course of treatment. Individual medication information is available through the CareNotes system.
2. The patient will be instructed to report any problems with the medication as well as their perception of the effectiveness of the medication.
3. In non-inpatient departments, the nurse administering the medication will verbally educate the patient regarding the name of the medication, indications and any side effects that the patient may experience.

c. **Discharge Medications**

Patients will receive written and when appropriate, verbal education about the medications they will be receiving upon discharge from the hospital.

Written information is available through the CareNotes system.

19. Disposition of Medications

a. Unused/Discontinued medications

1. The nurses will return any unused and expired medications to the pharmacy by the end of their shift.
2. See [DRUG PROCUREMENT / INVENTORY CONTROL](#) for outside destruction procedure.

b. Transfer of Patient: Disposition of Medications

1. Medications stored in patient's cassette will be placed in a plastic bag with patient's name and transferred **WITH** the patient.
2. The nurse will check the refrigerator for any IV's, piggybacks and TPN's and transfer **WITH** the patient.
3. The nurse will return any discontinued **non-controlled** medications to the pharmacy by placing the medications in a plastic bag labeled with patient's name, account number and clearly marked "discontinued."
4. The discontinued medications may be placed in the secured pharmacy return bin.

c. Discharge of Patient: Disposition of Medications

1. Most commonly prescribed medications, including scheduled drugs, are stored in the Pyxis. Upon discharge of the patient, the patient's medication profile becomes inactive.
2. Patient specific medications that are not available in Pyxis will be stored in a locked medication cassette on the nursing unit. Upon discharge of the patient, these medications will be returned to the Pharmacy by the nurse responsible for discharging the patient.
 - i. The nurse will place the medications in a plastic bag and remove the cassette patient label on the outside of the cassette, and mark "patient discharged". (Patient name & account number are required for crediting information)
 - a. The nurse will then place the plastic bag in the secured pharmacy return bin.
 - ii. Medications that are unused and intact will be credited to the patient and re-used if appropriate.
 - iii. Partially used bottles or vials of medications will be disposed of consistent with current hospital policy on pharmaceutical and other waste.

20. **Medication Processes in Non-Inpatient Departments**

Unless specified as "inpatient units only", procedures within this policy apply to both inpatient and non-inpatient departments. Additionally, this policy excludes the medication use process in the out-patient Sleep Disorders Center and Cardiovascular Diagnostic Outpatient Center at SVHMC.

a. **Non-inpatient Departments:**

Diagnostic Imaging, Endoscopy, Cardiac Cath Lab, Taylor Farms Family Health and Wellness Center, Outpatient Infusion, Ryan Ranch CVDC, Mammography and the Emergency Department.

b. **Pharmacist Oversight:**

Pharmacy oversight for prescribed medications is required for patients that are in a non-inpatient department *waiting for admission or transfer to an inpatient department greater than 2 hours*. In all other instances, oversight for medication prescribing is the responsibility of the physician. The following are exceptions:

1. STAT or now orders
2. Emergencies (e.g., Code Blue)
3. Any situation in which the patient would be harmed if the medication were not given immediately
4. Medications administered directly by or under the supervision of a physician

c. **Patient Verification/Identification:**

Prior to medication administration, patient verification occurs when the patient is placed in the procedure room. The procedure for use of two identifiers, per Section "Administration Procedure" [PATIENT IDENTIFICATION POLICY](#) is required. During the procedure, verbal orders from the physician are transcribed by the nurse on to the procedural form or unit specific procedural computer program. Medication administration follows inpatient process for scanning of armband and medication where the MAR/BMV system is utilized.

d. **Documentation of Medications:**

1. The following units may require the documentation of medications in two different computer systems. In the event discrepancies in medication documentation times arise, the procedural computer program will be the official time of record.
 - i. Diagnostic Imaging: Conscious Sedation Record , MAR
 - ii. Endoscopy: Conscious Sedation Record/Provation
 - iii. OPS: PICIS Pre-op Manager, MAR
 - iv. PACU: PICIS PACU Manager
 - v. Cardiac Cath Lab: Conscious Sedation Record
 - vi. Emergency Department: MAR

- e. **Medications Brought to Hospital:**
Medications brought to the hospital: by patients who are non-inpatients will remain in the possession of the patient.
- f. **Patient Education:**
The nurse administering the medication will verbally educate the patient regarding the name of the medication, indications and any side effects that the patient may experience.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as necessary..

VII. REFERENCES

- A. ISMP
- B. TJC Medication Management Standards
- C. Tarascon Pocket Pharmacopoeia 2008 Deluxe Edition
- D. Tarascon Internal Medicine & Critical Care Pocketbook 4th Edition
- E. AHFS Drug Information 2012
- F. Lexi-Comp Online – Accessed 2/13
- G. Drug Information Handbook, 15th Edition, Lexi-comp
- H. MicroMedex Online – Accessed 2/13

Attachments

- [!\[\]\(79de0df6c6ddd2d4eb74f1cc5f48ec50_img.jpg\) A: Standardized Medication Times](#)
- [!\[\]\(d4c9768318b38eff1042b07478e20b4c_img.jpg\) B: Medication Catch Up Chart](#)
- [!\[\]\(27d314856359a9d7feca17161bc1f4a4_img.jpg\) C: Unapproved Abbreviations](#)
- [!\[\]\(d355663486c698e3972a8b93ac8b2102_img.jpg\) D: Commonly Used Pediatric Weight-Based Formulary](#)
- [!\[\]\(1858f6a9022d088c0a7eca873f99643b_img.jpg\) E - IV PUSH & IV INFUSION MEDICATION LIST FINAL 3.2024.pdf](#)
- [!\[\]\(4a9a9afe1808e44249cde903a007394f_img.jpg\) F - Adult Titration Continuous Infusions FINAL-3.2024.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	01/2025
CNO	Carla Spencer: Chief Nursing Officer	12/2024
P&TC	Genevieve delos Santos: Director Pharmacy	12/2024
P&TC	Kiri Golleher: Pharmacy Clinical Coordinator	12/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2024
Policy Owner	Genevieve delos Santos: Director Pharmacy	11/2024

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerElias Gutierrez: Manager Security ProgramAreaSecurity

Metal Detection - Emergency Department

I. POLICY STATEMENT

- A. Salinas Valley Health Medical Center (SVHMC) does not allow weapons in facility, with the exception of law enforcement officers employed by a police agency.
- B. All individuals entering the Emergency Department (ED) will be subject to search as a condition of entry and re- entry to the utilizing a metal detector. All persons, packages, bags, boxes, purses and briefcases entering and re-entering the ED are subject to search. Persons refusing search may be denied entry to the ED.

II. PURPOSE

- A. Provide for a safe environment for visitors, patients, staff, volunteers and contractors by prohibiting contraband that includes weapons and other dangerous items in Salinas Valley Health Medical Center Emergency Department (ED).

III. DEFINITIONS

- A. Contraband - any instrument, device or item likely to cause injury, death, or a safety concern to patients, visitors or staff.

IV. GENERAL INFORMATION

- A. Walk through metal detector will be placed at the entrance of the ED as directed by the Security Department and Hospital Administration.
- B. Security will be responsible for monitoring the presence of potential contraband, including weapons via metal detection and baggage search at the front of the ED.
- C. Contraband includes but is not limited to:
 - 1. Firearms and ammunition
 - 2. Explosives material

3. Knives/box cutters/razor blades/disposable razors
4. Chemical agents (mace)
5. Impact weapons (nunchaku, batons)
6. Tasers
7. Screw drivers/ice picks/knitting needles/cork screws
8. Leather Man or other tools
9. Flammable liquids
10. Alcohol based/aerosol canisters
11. Heavy chains (necklaces/bracelets excepted)
12. Syringe
13. Scissors
14. Lighters/matches
15. G.I. can opener (P-38)
16. Metal forks
17. Metal nail files/metal comb picks
18. Alcoholic beverages
19. Illegal/illicit controlled substances/drugs
20. Drug paraphernalia

V. PROCEDURE

- A. Persons requiring immediate/emergency attention will be granted immediate access and will be screened by a security officer as soon as possible upon consent of the ED staff.
- B. The walk through metal detector station will be staffed by a Security Officer and will be in operation 24 hours a day seven days a week.
 1. All Persons entering or re-entering the ED will be screened by the use of a metal detector.
- C. The Security Officer will instruct the person to empty all possessions from their person into a container prior to walking thru the metal detector.
- D. If activation occurs, Security Officer will ask the person to remove what is setting off detector and place on table.
- E. Any person going through the search procedure may decide to leave the campus at any point during the procedure without question or detainment.
- F. Law enforcement and peace officers receiving treatment in the ED and/or admitted to the hospital must surrender the weapons(s) to:
 1. A member of their department or another law enforcement agency OR
 2. The Security Manager on duty, if another police officer cannot be contacted immediately.

3. The Security Manager or Lead Officer will secure the weapon in the safe located in the security office and make every effort to contact the officers department.
 4. No employee should attempt to handle or render safe any firearm. An Occurrence Report will be completed.
- G. The inventory and release of weapons/firearms will be conducted by the Security Department.
 - H. Any persons found to be lawfully in possession of a weapon (Conceal Carry Permit) will be required to follow Cal. Pen. Code § 25140. (a) Except as otherwise provided in subdivision (b), a person shall, when leaving a handgun in an unattended vehicle, lock the handgun in the vehicle's trunk, lock the handgun in a locked container and place the container out of plain view, lock the handgun in a locked container that is permanently affixed to the vehicle's interior and not in plain view, or lock the handgun in a locked toolbox or utility box.
 - I. Questionable items that are potentially illegal shall be brought to the attention of the on duty security supervisor. The individual with the item may leave the campus without question or delay.
 - J. In addition to or apart from any action taken by the police department, any persons found to be unlawfully in possession of a weapon will be asked to leave the SVHMC premises.
 - K. Illegal weapons (firearms, nunchaku, tasers, impact weapons, chemical agents, knives) may be confiscated. The person in possession of the weapon may be detained by Security.
 - L. Firearms will be turned over to Salinas Police Department.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed.

VII. REFERENCES

- A. *Guidelines for Emergency Conditions in Health and Residential Care Facilities, 4/2021*
<https://fgiguideelines.org/resource/fgi-releases-emergency-conditions-paper-opens-comment-period-for-draft-emergency-conditions-guidelines/>

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025

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Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2024
Policy Owner	Elias Gutierrez: Manager Security Program	02/2024

Standards

No standards are associated with this document



Last Approved N/A
Next Review 3 years after approval

Owner Julie Johnson:
Clinical Manager

Area Women's and
Children's
Services

Newborn Critical Congenital Heart Disease Screen

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide nursing practice in the assessment and interpretation of newborn Critical Congenital Heart Disease (CCHD) screen testing.

III. DEFINITIONS

A. CCHD – Refers to critical congenital heart disease that requires surgical or interventional cardiologic management in the first year after birth, typically in early infancy.

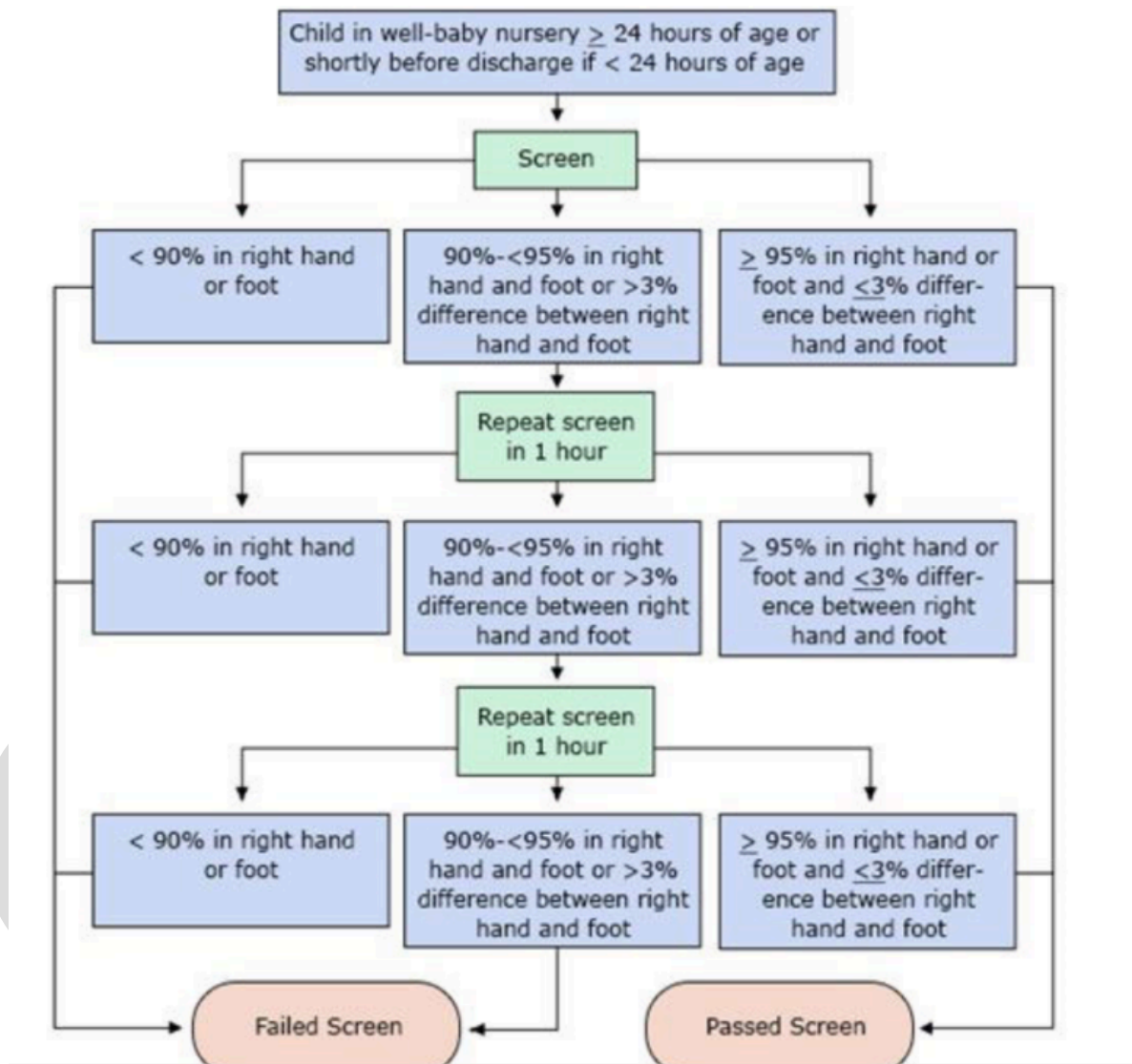
IV. GENERAL INFORMATION

- A. Each newborn will undergo universal oxygen saturation screening to assist in the detection of a potential critical congenital heart disease prior to discharge.
1. The screening is targeted toward healthy newborns in the newborn nursery.
 2. Screening should not be undertaken until 24 hours of life or as late as possible if early discharge is planned to reduce the number of false-positive results.
 3. This screen is completed by a Registered Nurse (RN).
- B. Oxygen saturations should be obtained in the right hand (preductal) and one foot (postductal).
- C. Screening that has a pulse oximetry reading of $\geq 95\%$ in either extremity with a $\leq 3\%$ absolute difference between the upper and lower extremity would be considered a "pass".
- D. Screening that has a pulse oximetry reading of 90-94% or difference of $> 3\%$ would be considered a positive screen (failed screening test) and repeated measurement would be recommended in one hour. In asymptomatic newborns who fail the screen this can be repeated a total of two times.
1. Repeated measurement should be performed in those cases in which the initial screening was positive in an effort to reduce false-positive results.

- E. Newborns with saturations <90% in right hand or foot should receive immediate evaluation.
 - 1. In the event of a positive screening result, CCHD needs to be excluded, as well as infectious and pulmonary causes.
- F. In the event of three positive screening results (failed screening tests) or a saturation of < 90%, the newborn's physician should be notified and the newborn will be transferred to NICU for observation and evaluation.
 - 1. The newborn will be evaluated for a possible diagnosis of CCHD.
 - 2. Other non-cardiac conditions that can cause cyanosis will be evaluated (i.e., pulmonary disorders, poor peripheral perfusion, persistent pulmonary hypertension, abnormal forms of hemoglobin, etc.). Poor peripheral perfusion with cyanosis from sepsis, hypoglycemia, dehydration and hypoadrenalism should be evaluated.
- G. Please note: Screening with pulse oximetry can identify a number of types of critical CHD. Many conditions other than critical CHD may present with hypoxemia and can be detected via pulse oximetry.

V. PROCEDURE

- A. Confirm the newborn is at least 24 hours of age and eligible for screening.
 - 1. For early discharge, please conduct screen as close to 24 hours of age as possible.
- B. Help the parent to calm and warm the newborn in a quiet and peaceful environment.
- C. Describe the pulse oximetry screening test to parent(s)/legal guardian(s).
- D. Place pulse oximetry probe on right hand and obtain results.
 - 1. Note results
- E. Place pulse oximetry probe on either foot and obtain results.
 - 1. Note results
- F. Determine status of screening as below:



- G. In the event of three positive screening results (failed screening tests) or a saturation of < 90%, the newborn's physician should be notified and the newborn transferred to NICU for observation and evaluation.
1. Recommended evaluation includes echocardiogram as well as further investigation into other causes i.e. infectious or pulmonary origin.
 2. The newborn assigned physician will contact the Attending Neonatologist, if clinically warranted, for observation and evaluation of the newborn in the NICU.
- H. Following the above policy, all NICU patients will also be screened prior to discharge, unless they have had an echocardiogram performed during their hospital stay.
- I. Documentation:
1. Document results and relevant communications in the electronic health record.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. American Academy of Pediatrics (2023). Newborn Screening for Critical Congenital Heart Defects (CCHD). <https://www.aap.org/en/patient-care/congenital-heart-defects/newborn-screening-for-critical-congenital-heart-defect-cchd/>
- B. Center for Disease Control. (2024). Clinical Screening and Diagnosis for Critical Congenital Heart Defects. https://www.cdc.gov/heart-defects/hcp/screening/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/heartdefects/hcp.html

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	01/2025
Director Women's & Children's Services	Julie Vasher: Director Women's & Children's Services	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Julie Johnson: Clinical Manager	12/2024

Standards

No standards are associated with this document



Last Approved N/A
Next Review 3 years after approval

Owner Julie Johnson:
Clinical Manager
Area Women's and
Children's
Services

Newborn Pain, Agitation, and Sedation Management

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To guide caregivers in providing evidence based assessment tools and effective pain relief for the neonate.
B. This Policy and Procedure serves as an adjunct to the [PAIN MANAGEMENT](#) policy

III. DEFINITIONS

- A. **NIPS (Neonatal Infant Pain Scale)** – is a multidimensional pain measurement tool used in infants, generally used in well newborn infant population to quantify the pain experience and infant response to interventions (See attachment A for scoring).
B. **N-PASS (Neonatal pain, agitation, and sedation scale)** - An age appropriate assessment and documentation methodology for ongoing infant pain and sedation, to be used in the NICU. Points are added to the premature infants score based on gestational age to compensate for their limited ability to behaviorally or physiologically communicate pain (see attachment B for scoring).
C. **Assisted Delivery**- a vaginal assisted delivery by use of vacuum or forceps.

IV. GENERAL INFORMATION

- A. Assess and document pain twice a shift with vital signs or as indicated by pain scores and/ or the clinical condition of the neonate, and after pain relieving interventions, using NPASS.
B. Painful procedures will be anticipated and a plan for prophylactic analgesic and/or non-pharmacologic pain reduction strategies will be considered.
C. Techniques that produce less pain should be used in lieu of those producing more pain.

Examples include:

1. Heel stick with a mechanical lancet, rather than a manual lancet.
2. Venipuncture blood sampling by an experienced individual, rather than heel stick.
3. Consider use of a PICC line, rather than a peripheral IV for a lengthy course of antibiotics (7-14 days).

V. PROCEDURE

A. PAIN ASSESSMENT

1. Pain assessment in the well newborn population will occur every shift, PRN, and after pain relieving interventions, using NIPS.
2. Perform routine, initial physical assessment and evaluate the newborn for painful conditions (i.e. fractures, operative deliveries).
3. Using scoring tools NIPS for well newborns (Attachment A) or N-PASS for NICU population (Attachment B), assess and quantify pain at the time vital signs are taken after pain relieving interventions and PRN. Generally:
 - a. NIPS scores greater than 4 require intervention
 - b. NPASS scores greater than 3 require intervention
 - c. SCORES SHOULD ALWAYS BE EVALUATED WITHIN THE CONTEXT OF THE CLINICAL SITUATION
4. Identify actual or potential sources of pain for the infant: surgical procedures, invasive/indwelling tubes, heel sticks, suctioning, peritonitis, fractures, and/or noxious environment.
5. Frequent pain assessments should be performed in the following situations:
 - a. Invasive tubes or lines (e.g. chest tubes) other than IVs or feeding tubes: assess every 2-4 hours.
 - b. Receiving analgesics and/or sedatives: assess every 2-4 hours.
 - c. Response to pharmacologic intervention: assess one hour after an analgesic is given for pain behaviors.
 - d. Post-operative: assess every 2 hours for 24-48 hours, then every 4 hours until off medication.
6. Provide continuous cardio-respiratory monitoring and continual pulse oximetry when using opioids or sedatives for pain relief or sedation.
7. Reassess newborns level of comfort within 30 minutes of non-pharmacologic interventions. If the level of comfort has decreased, document which measures were effective. If the level of comfort has not improved or has worsened, reassess for a possible new source of pain or ineffective interventions. Collaborate with the physician and document.
8. Pain Assessment with painful procedures
 - a. Short-lived painful procedures such as heel sticks, venipuncture, and

arterial puncture do not require pain assessment scores before, during, and after these procedures.

- b. Bedside surgical procedures such as chest tube, abdominal drain insertion, or circumcision should have pain assessment scores before and during the procedure, when possible.
 - c. Post-procedure scoring: Continue to assess pain with each vital sign assessment, as these infants will have more frequent vital signs following these procedures.
9. **Pain scores not falling as expected:** Consider additional medications or non-pharmacologic measures. Re-assess infant for additional causes of pain and agitation. Notify physician as necessary.

B. PAIN MANAGEMENT STRATEGIES

1. Implement non-pharmacologic comfort measures first if the infant has no identifiable cause for pain. These measures should be used in conjunction with analgesics if the infant has an identifiable pain source (i.e. post-op, chest tube).
2. Environmental and behavioral interventions can be used as complimentary strategies to indirectly reduce pain by decreasing noxious stimuli. Interventions can include developmental positioning (knees flexed, arms close to body, hands to mouth) reducing light and noise, containing/swaddling, clustering care, and non-nutritive sucking.
3. Optimize ventilation: babies become agitated when they are not being adequately ventilated. This should be corrected by optimizing ventilation (suctioning, adjusting ventilator settings).
4. Mechanical lancets: should be used for heel sticks.
5. Tape use should be minimized. Hydrogel, hydrocolloid, or silicon back products are preferred.
6. Use of a sucrose solution prior to the procedure as well as non-nutritive sucking during the procedure provides analgesia for procedures such as heel sticks, venipuncture, eye examinations for ROP and injections.
 - Administer sucrose within 2 to 3 minutes before an invasive procedure by dipping a pacifier into the sucrose or dropping solution via syringe onto the tongue or buccal surface and repeat 1-2min after procedure. (See [SUCROSE SOLUTION FOR PROCEDURAL PAIN](#)).
7. When available breastfeeding should be the first choice to alleviate procedural pain in neonates. During procedure with continued attention to behavioral cues of pain and stress.
8. Holding or rocking the newborn during the procedure.
9. A local anesthetic is generally used for lumbar puncture and chest tube placement. Discuss the possible use of a local anesthetic with the infant's physician prior to painful procedures. Sucrose and a pacifier may be helpful as an adjunct for pain associated with administration of the local anesthetic.

10. Except for emergent intubation during resuscitation either in the delivery room or after acute deterioration or critical illness at a later age, premedication should be used for all endotracheal intubations in newborns. Analgesic agents with rapid onset and short duration of action are preferable.
11. Skin-to-skin contact 10 - 15 minutes prior to and during the Newborn Screening procedure has been shown to be an effective intervention.
12. Negative scores without the administration of opioids/sedatives;
 - a. May indicate neurologic depression, sepsis, or other pathology.
 - b. Premature infants who have experienced prolonged untreated pain and/or stress may also appear sedated. Premature infants can become lethargic and "shut down" in response to unrelenting pain.

C. Sedation and Analgesic

1. All infant having planned sedation or analgesic should have intravenous access or immediate access to someone skilled at placing IV in the event it is needed.
2. Whenever sedation is administered the infant needs to be monitored by an RN, or physician.
3. If planned sedation and/or analgesic is needed for infants, this will occur in the NICU.
4. All necessary emergency equipment for resuscitation and intubation must be continuously available in the NICU.
5. A physician is responsible for the care of infant in the NICU during sedation. Deep sedation would only be administered by physician. And the physician must be immediately available during the procedure and until the recovery is judged adequate.
6. N-PASS Sedation Scores (see attachment B)
 - a. Levels of sedation are noted as negative scores
 - b. Desired levels of sedation vary according to the situation
 - c. Deep sedation: goal is – 10 to-5
 - d. Light sedation: goal is – 5 to -2

D. PARENT/CAREGIVER EDUCATION

1. Teach parent(s)/legal guardian(s) caregiver infant pain behaviors and include them in the assessment and treatment of their infant's pain.
2. Document parent/caregiver education in the Medical Record under newborn education. .

E. DOCUMENTATION:

1. Document pain assessment scores, prophylactic pain reduction strategies, interventions, and the infant's response in electronic health record.
2. If management is changed in response to a score: (i.e. pain medication, comfort measures, increase or decrease in medication), a response to this intervention is

documented in the same column in the next hourly space. This indicates response to the intervention 30-60 minutes after the intervention

3. Document the pain scale used.
4. Document parent education, including information letter on pain, under education. Letter found in NICU care notes.
5. Pain and sedation scores are recorded separately

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. National Association of Neonatal Nurses. (2019). *Polices, Procedures, and Competencies for Neonatal nursing Care* (6th ed.). (S. S. Bowles, Ed.) Chicago, Illinois: National Association of Neonatal Nurses.

Attachments

- [A: Neonatal Infant Pain Scale \(NIPS\)](#)
- [B: N-Pass: Neonatal Pain, Agitation, & Sedation Scale](#)

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	01/2025
Director Women's & Children's Services	Julie Vasher: Director Women's & Children's Services	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Julie Johnson: Clinical Manager	12/2024

Standards

No standards are associated with this document

COPY



Last Approved
Next Review

N/A
1 year after approval

Owner
Area

Genevieve delos Santos: Director Pharmacy
Pharmacy

Pharmacy - Sterile Compounding

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. The Salinas Valley Health Medical Center (SVHMC) Pharmacy Department shall be responsible for the safe and accurate preparation and dispensing of compounded sterile products (CSPs) in accordance with professional standards and both California State and Federal requirements.

III. DEFINITIONS

- A. ACPH - Air Changes Per Hour - The rate at which the entire volume of air within a space or room is exchanged.
- B. BSC - Biological Safety Cabinet - A ventilated cabinet with an open front and inward and downward unidirectional HEPA-filtered airflow and HEPA-filtered exhaust, which is designed to provide worker protection from exposure to airborne drugs and to provide an ISO class 5 environment for sterile compounding of hazardous drugs.
- C. BUD - Beyond-Use Date - Either the date, or hour and the date, after which a CSP must not be used, stored, or transported. The BUD is determined from the date and time that preparation of the CSP is initiated.
- D. CFU - Colony Forming Unit
- E. CR - Compounding Record
- F. CSP - Compounded Sterile Product
- G. DOP - Director of Pharmacy
- H. GFT - Gloved Fingertip and Thumb Test
- I. IP - Inpatient Pharmacy

- J. ISO class - Air quality classification from the International Organization for Standardization.
- K. LAFH - Laminar Air Flow Hood - A device that provides an ISO class 5 or better environment for sterile compounding.
- L. MFR - Master Formulation Record
- M. OIC - Outpatient Infusion Center Pharmacy
- N. PAPR - Powered Air Purifying Respirator
- O. PATT - Personal Aseptic Technique Test
- P. PEC - Primary Engineering Control - A device that provides an ISO class 5 environment for sterile compounding.
- Q. SEC - Secondary Engineering Control - The area where the PEC is placed (e.g., cleanroom suite).
- R. SVHMC - Salinas Valley Health Medical Center - General Acute Care Hospital and Other Approved Services licensed by State of California Department of Public Health (License 070000083)

IV. GENERAL INFORMATION

A. Overview & Scope

1. Sterile compounding is defined as combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug product or bulk drug substance to create a compounded sterile product (CSP).
 - a. CSP Categories -- CSP Categories are primarily based on the following: the environment or conditions where the CSP is compounded, the probability for microbial growth during the time that the CSP will be stored, and the time period within which the CSP must be used (i.e., beyond-use date or BUD).
 - i. **Category 1 CSP** - CSP using sterile ingredients and is compounded under the least controlled environmental conditions, such as when a CSP is prepared in an ISO class 5 PEC located in a classified cleanroom suite with reduced or compromised environmental controls (e.g., experiencing a loss of pressure due to prolonged power failure).
 - ii. **Category 2 CSP** - CSP using sterile ingredients and is compounded in an ISO class 5 PEC in a classified cleanroom suite that meets all the USP <797> environmental requirements.
 - iii. **Category 3 CSP** - CSP involving the use of non-sterile ingredients. The SVHMC Inpatient Pharmacy and the Outpatient Infusion Center Pharmacy shall not compound any CSP using non-sterile ingredients. Therefore, further references to Category 3 sterile compounding will not be addressed in this document.
 - b. The following preparations shall not be performed in either the SVHMC

Inpatient Pharmacy or the Outpatient Infusion Center Pharmacy and are therefore not addressed in this document:

- i. CSPs that incorporate infectious materials (e.g., BCG);
 - ii. CSPs that require manipulation of a patient's blood-derived or other biological material (e.g., autologous serum);
 - iii. CSPs that are considered an allergenic extract.
 - c. Compounding does not include mixing, reconstituting, or other such acts that are performed in accordance with directions contained in approved labeling or supplemental material as provided by the product's manufacturer. The policy and procedures herein do not apply to the preparation of a conventionally manufactured sterile product only if the following apply:
 - i. The product is prepared as a single dose for an individual patient; and
 - ii. The approved labeling includes information for the diluent, the resultant strength, the container closure system, and storage time.
- B. The SVHMC Pharmacy Department sterile compounding program will adhere to the policies and procedures described herein to ensure safe and accurate preparation and dispensing of CSPs from the cleanroom suites located at both the Inpatient Pharmacy (IP) and Outpatient Infusion Center (OIC) Pharmacy practice settings.
- C. All CSPs prepared by SVHMC are intended for patients registered for treatment at SVHMC and will not be supplied to any other location.
- D. The Director of Pharmacy (DOP) and the Designated Person(s) (i.e., Manager of Pharmacy Operations, Manager of Pharmacy Outpatient Services, and Pharmacy Operations Coordinator) will have direct oversight and ensure compliance with all aspects of the sterile compounding program at SVHMC Pharmacy Department. As such, they will be responsible and accountable for the performance and operation of the SVHMC Pharmacy Department sterile compounding program.
- E. The sterile compounding program policies and procedures will undergo, at a minimum, annual review by the DOP and/or the Designated Person(s). Any changes made to the sterile compounding policies and procedures will immediately be communicated by the DOP and/or the Designated Person(s) to all Pharmacy staff members with documented participation in the program.
- F. The SVHMC sterile compounding program policies and procedures will be rooted by the following domains: personnel competency, control of the compounding environment, ongoing evaluation of CSP quality, and proper handling, storage, and disposition of all prepared CSPs.
 - 1. Personnel Competency
 - a. Personnel training and evaluation
 - b. Personnel hygiene and adherence to established garbing requirements
 - 2. Control of the compounding environment

- a. Facilities and engineering controls
 - b. Certification and recertification
 - c. Microbial air and surface monitoring
 - d. Cleaning in the compounding areas
3. Ongoing evaluation of CSP quality
- a. Adherence to established compounding methods
 - b. Maintenance of equipment, supplies and components
 - c. Maintenance of a master formula and compounding records
 - d. Inspection and testing of compounded sterile products
 - e. Labeling requirements
 - f. Methods for assignment of beyond-use dates
 - g. Quality assurance and quality control
4. Proper handling, storage and disposition
- a. Compounded sterile product handling and storage
 - b. Allergenic extracts, infectious and biologic materials

V. PROCEDURE

A. Personnel Competency

1. Personnel training and evaluation

- a. The following Pharmacy staff members will undergo initial didactic and practical training to ensure a full understanding of the professional standards of sterile compounding prior to engaging in any unsupervised independent activities related to SVHMC Pharmacy sterile compounding program:
 - i. Designated Person(s)
 - ii. Personnel involved in the preparation and/or compounding of CSPs
 - iii. Personnel who have direct oversight of compounding personnel, including personnel who perform in-process checks or final verification of CSPs
- b. Pharmacy staff members involved in the preparation and/or compounding of CSPs must also maintain a fundamental understanding of both California State and Federal requirements related to sterile compounding prior to engaging in any unsupervised independent activities related to the sterile compounding program.
- c. All participants of the sterile compounding program must, at a minimum, complete baseline and annual competency evaluations to ensure initial and perpetual understanding of the program requirements. Competency

evaluations will include assessment of the following elements:

- i. Maintenance of satisfactory personnel hygiene requirements
 - ii. Understanding and execution of established hand hygiene and garbing requirements
 - iii. Fundamental understanding of facilities and engineering controls
 - iv. Fundamental understanding of certification and microbial monitoring
 - v. Understanding and execution of established cleaning and disinfection requirements
 - vi. Accuracy of calculations and proper utilization of a master formula recipe
 - vii. Understanding and execution of established aseptic compounding technique, including: proper use of the primary engineering control (PEC), measuring, and mixing
 - viii. Satisfactory creation of compounding records and final CSP labels
 - ix. Fundamental understanding of quality assurance and control parameters
 - x. Understanding and execution of handling and storage requirements for CSPs
- d. All competency elements will be assessed by didactic and/or practical skills evaluations under the direct supervision of the DOP and/or the Designated Person(s) with advanced training in the professional standards of sterile compounding. Competency and testing shall include:
- i. Written competency on sterile compounding procedures and pharmacy calculations
 - ii. Garbing and hand hygiene competency evaluation, including direct observation and gloved fingertip and thumb (GFT) sampling. (See *Attachment A*)
 - a. Initial Evaluation:
 - i. Must successfully complete 3 separate times and must be in succession.
 - i. Failure of any of the 3 initial garbing competency evaluations require repeat testing until personnel successfully complete 3 evaluations in a row.
 - ii. Each of the 3 initial competency evaluations must occur after performing a separate and

complete hand hygiene and full garbing procedure.

- ii. All garbing competencies must be completed with GFT sampling of both hands after garbing and a documented visual audit while performing hand hygiene and garbing procedures.

- i. GFT sampling after garbing, but before applying sterile 70% isopropyl alcohol to gloves, must be performed on donned sterile gloves on both hands in a classified area.

- iii. Failure is indicated by visual observation of improper hand hygiene and garbing procedures and/or GFT sampling that results in action levels.

- i. In the event of a failure, results must be documented and maintained. Documentation will include the following:

- i. Name of person being evaluated
 - ii. Date and time and location of sampling
 - iii. Media and components: Manufacturer, lot #, expiration date, starting temp of incubation, dates of incubation
 - iv. Results and name of observer and personnel reading and documenting results.

b. Continuing Evaluation:

- i. Must successfully complete the garbing and hand hygiene competency at least 1 time every 6 to 12 months, depending on the personnel function.
- iii. Aseptic technique competency evaluation, including direct observation, media fill testing, post-GFT and surface sampling. (See Attachment B)

- a. The aseptic technique competency must be completed successfully initially and every 6 to 12 months, depending on personnel function.
- b. Immediately following the media fill test, GFT sampling must be performed on both hands and inside of an ISO class 5 PEC.
- c. Surface sampling must also be conducted after the media fill test. (See *Attachment D*)
- d. Failure is indicated by visual turbidity. Document as stated above in GFT sampling procedure.

e. Frequency of training, competency, and testing are as follows:

Personnel Function	Training and Written Competency	Garbing and Hand Hygiene Competency (including GFT)	Aseptic Technique Competency (Media Fill with post-GFT and Surface Sampling)
Designated Person(s)	Initial and every 12 months	Initial and every 12 months	Initial and every 12 months
Compounding Personnel	Initial and every 12 months	Initial and every 6 months	Initial and every 6 months
Personnel with Direct Oversight of Compounding Personnel	Initial and every 12 months	Initial and every 12 months (unless also compounding - then every 6 months)	Initial and every 12 months (unless also compounding - then every 6 months)

The above must be successfully completed prior to personnel independently compounding CSPs and/or having direct oversight of compounding personnel. In addition, personnel with direct oversight of compounding personnel cannot compound unless they successfully meet the requirements of compounding personnel.

- f. Personnel who fail written tests or whose GFT results exceed the action levels stated in the table below or whose media fill kit shows visible turbidity or other visual manifestations of growth shall receive immediate re-instruction and re-evaluation by the Designated Person(s). If personnel fails re-testing, then they shall not be allowed to perform any independent sterile compounding activities until passing the evaluations.

Gloved Fingertip and Thumb Sampling	Action Levels (CFU, Total from both hands)
After garbing	> 0

After media fill testing	> 3

Microbial identification of the CFU is not required for either GFT or media fill testing.

- g. The Pharmacy shall maintain records of staff: orientation, training, and completion of didactic and practical skills competency evaluations for a minimum of three (3) years following completion.

2. Personnel hygiene and adherence to established garbing requirements:

- a. Any personnel entering the clean room suite, whether preparing a CSP or not, must meet the requirements in personal hygiene and garbing as described herein.

b. Preparation prior to entering the compounding area:

- i. Food (including gum and mints) and drinks must not enter the anteroom, the buffer room, or placed inside the ISO 5 PEC (i.e., LAFH and BSC).
- ii. Cosmetics are not allowed and must be removed prior to entering.
- iii. Remove all hand, wrist, and other exposed jewelry (i.e., rings, necklaces, watches, bracelets), including piercings that could interfere with garbing.
- iv. Ear buds or headphones are not allowed.
- v. Nails must be clean and neatly trimmed. Artificial nails and/or nail polish/gels are not allowed and must be removed.
- vi. Wipe eyeglasses, if worn.
- vii. Individuals must report the following conditions to the Designated Person(s), who is responsible for evaluating whether the individual should be excluded from working in the compounding area before the condition is resolved:
 - a. Rash
 - b. Recent tattoo
 - c. Oozing sore
 - d. Conjunctivitis
 - e. Active respiratory infection
- viii. Exposed skin must be minimized (i.e., covered) as much as possible when entering the cleanroom suite.

c. Personnel shall don the following PPE in an order that proceeds from those activities considered the dirtiest to those considered the cleanest:

- i. Garbing activities considered the dirtiest include donning of dedicated low-lint shoe covers, low-lint head and facial hair

covers and low-lint face masks and eye shields. Eye shields are optional unless working with irritants such as germicidal disinfectants (e.g., during scheduled monthly cleaning).

- ii. When entering the anteroom, sit on the stainless steel bench that straddles the line of demarcation. Place a shoe cover on the right or left foot, then place the right or left foot on the clean side of the line. Place a shoe cover on the opposite foot, and then place the opposite foot on the clean side of the line. It is then permissible to stand on the clean side of the line and continue with the garbing process.
- iii. Clean underneath fingernails under warm running water using a disposable nail cleaner.
- iv. Wash hands and forearms up to the elbows thoroughly for at least 30 seconds with soap and water.
- v. Dry hands and forearms up to the elbows completely with sterile, low-lint disposable wipes.
- vi. Don a disposable non-shedding gown with sleeves that fit snugly around the wrist and enclosed at the neck.
 - a. When preparing a hazardous CSP, don a disposable, non-shedding and non-permeable chemo gown.
 - b. If wearing a PAPR when cleaning, clean the equipment with sterile 70% isopropyl alcohol low-lint wipes prior to entering the anteroom and don the PAPR after gowning.
- vii. Prior to entering the positive pressure buffer room, apply and sanitize hands with waterless alcohol-based hand scrub.
- viii. **After entering the Positive Pressure buffer room:**
 - a. Don sterile non-latex, powder-free gloves just prior to using the ISO class 5 PEC (i.e., LAFH). Utmost care must be taken to not expose skin inside the ISO class 5 PEC.
 - b. Sanitize gloves with sterile 70% isopropyl alcohol immediately before compounding and regularly throughout the compounding process.
 - c. Gloves must be inspected for holes, punctures, or tears and must be replaced immediately if such defects are detected.
 - d. Personnel who find it necessary to leave the clean room shall carefully remove their gown at the entrance of the area and hang it inside out for re-donning upon re-entry.

- i. This procedure can only be done during the

same shift and only applies to gowns.

- ii. Hair covers, masks, and gloves should be discarded and new ones donned prior to re-entry.

- e. Garb worn or taken outside the confines of the clean room cannot be worn in the clean room.

ix. After entering the Negative Pressure buffer room:

- a. Only ASTM D6978 nitrile gloves may be worn when preparing chemotherapy CSPs.
 - i. Two pair of gloves must be worn at all times:
 - i. Sanitize the first pair of gloves with sterile 70% isopropyl alcohol and let air dry.
 - ii. Don the second pair of sterile ASTM D6978 non-latex, powder-free nitrile gloves over the first pair.
 - iii. Sanitize gloves with sterile 70% isopropyl alcohol immediately before compounding and regularly throughout the compounding process.
 - iv. Gloves must be inspected for holes, punctures, or tears and must be replaced immediately if such defects are detected.
 - v. Outer gloves shall be replaced between each different HD preparation.
- b. Personnel who find it necessary to leave the clean room shall discard their gown prior to leaving.
 - i. If continuously compounding, gowns should be changed every 2 to 3 hours or immediately after a spill or splash.
 - ii. Hair covers, masks, and gloves should be discarded and new ones donned prior to re-entry.
- c. Garb worn or taken outside the confines of the clean room cannot be worn in the clean room.

B. Control of the Compounding Environment

1. Facilities and engineering controls

- a. The cleanroom suite must be outfitted properly to minimize the risk of contamination of CSPs.
 - i. Sterile compounding will be conducted in a specifically designed room (i.e., cleanroom suite) that is separated from areas not directly related to compounding.
 - ii. Tacky mats will be placed outside of the entrance to the cleanroom suite. Tacky mats will never be placed inside the cleanroom suite.
 - iii. The anteroom will have a line of demarcation that separates the dirty side from the clean side of the cleanroom suite.
 - iv. The surfaces of ceilings, walls, floors, doors, door frames, fixtures, shelving, work surfaces, counters, and cabinets in the cleanroom suite must be smooth, impervious, free from cracks and crevices, and nonshedding.
 - v. Junctures between the ceiling and the walls and between the walls and the floor must be sealed to eliminate cracks and crevices.
 - vi. Walls must be made of durable materials and the integrity of the surface must be maintained.
 - vii. The buffer room must not contain plumbed water sources (i.e., sinks, floor drains, eye wash station).
 - viii. The anteroom must not contain floor drains.
- b. The cleanroom suite environment must be maintained to provide a comfortable working environment, to minimize airborne contamination, and to minimize the risk of microbial proliferation.
 - i. **Air quality**
 - a. Anteroom, positive buffer room, and negative buffer room must meet at least ISO class 7 air quality (defined as a limit of 352,000 particles sized 0.5 µm or larger per cubic meter).
 - b. LAFH and BSC shall provide an environment of at least ISO class 5 (defined as a limit of 3,520 particles sized 0.5 µm or larger per cubic meter).
 - i. In addition, the BSC and the negative buffer room must be externally vented.
 - ii. **Temperature and humidity**
 - a. Temperature should be maintained at 20°C (68°F) or cooler and a relative humidity of 60% or below.

- b. Temperature and humidity will be monitored and documented by a continuous recording device and records will be readily retrievable.
- c. Temperature and humidity will be controlled through an HVAC system.
 - i. Free-standing air conditioners or dehumidifiers shall not be used in the cleanroom suite.

iii. Air exchange

- a. A minimum of 30 total HEPA-filtered air exchanges per hour (ACPH) must be supplied to the ISO class 7 anteroom and buffer rooms.
 - i. At least 15 ACPH (out of the total 30 SCPH) must come from the HVAC through HEPA filters located in the ceiling.

iv. Pressure differentials

- a. The pressure differential between the anteroom and the unclassified area (i.e., outside the cleanroom suite) must not be less than 0.020-inch water column.
- b. A minimum differential positive pressure of 0.020-inch water column is required between the anteroom and the buffer rooms.
- c. The negative buffer room must maintain a negative pressure between 0.01 and 0.03-inch water column.
- d. A pressure differential monitoring device must be used to continuously monitor the pressure differentials.
 - i. Loss of air flow integrity will result in an alarm sounding if the anteroom door or any of the buffer room doors remain open for greater than 30 seconds. Closing the door will reset the alarm.
 - ii. Loss of air flow integrity due to a power outage:
 - i. If pressure differentials are out-of-range for greater than one hour, compounding CSPs may take place in a functioning LAFH and/or BSC (i.e., blowers are on for 30 minutes and surfaces are cleaned and sanitized). All CSPs will have a BUD of 12 hours at room temperature or 24 hours

- refrigerated (or less, if warranted).
- ii. When room pressures are back in range, pharmacy personnel will perform a terminal clean of the cleanroom suite prior to resuming assigning maximum BUDs to CSPs.
- c. Furniture, equipment and materials entering the cleanroom suite must be limited to only those necessary for performing compounding activities, must be low-shedding, and must be easily cleaned and disinfected.
 - i. No corrugated or uncoated cardboard is allowed to be brought into the cleanroom suite.
 - ii. Frequently used supplies will be removed from their boxed carton and then cleaned and disinfected with sterile 70% isopropyl alcohol prior to placing them in the pass-through for transfer into the cleanroom suite.
 - iii. Carts that are used to transport components into the cleanroom suite must be constructed from nonporous materials with cleanable casters and wheels. The entire cart, including the casters, must be cleaned and disinfected when moving a cart from the dirty side to the clean side of the anteroom.
 - iv. Equipment required for maintenance or cleaning activities (i.e., cleanroom certification equipment, air sampler, PAPR) must be cleaned and disinfected prior to entering the clean side of the anteroom.

2. Certification and recertification

- a. The cleanroom suite (i.e., anteroom, positive buffer room, negative buffer room) and PECs (i.e., LAFH and BSC) must be independently certified by a qualified contractor to ensure that the cleanroom suite meets the requirements of USP <797> standards.
 - i. Certification will be performed initially and then recertified at least every 6 months.
 - ii. Recertification must be performed if there are any changes to the cleanroom suite such as:
 - a. Redesign
 - b. Construction
 - c. Replacement or relocation of any PEC
 - d. Alteration in the configuration of the room that could affect airflow or air quality
- b. Certification and recertification must include the following components:
 - i. Airflow testing

- ii. HEPA filter integrity testing
 - iii. Total particle count testing
 - iv. Dynamic airflow smoke pattern test
 - v. Microbial air and surface sampling
- c. Results must meet the requirements of USP <797> standards.
- i. A sticker will be placed on each PEC documenting the date of inspection and that the PEC meets the ISO class 5 standards.
 - ii. A sticker will also be placed on each door documenting the date of inspection and that the air quality meets ISO class 7 standards.
- d. Corrective action plan:
- i. A corrective action plan must be implemented and documented by the Designated Person(s) in response to any out-of-range results.
 - ii. An attempt to identify any microorganism will be made with the assistance of a microbiologist.
 - iii. Corrective action plans may include repeat cleaning, facility improvements, personnel training, HEPA filter replacement, etc.
 - iv. The appropriate test(s) will be repeated to confirm that the actions taken were effective.
- e. Records will be retained for 3 years.

3. Microbiologic air and surface monitoring

- a. Microbiologic air and surface monitoring will be conducted in all classified areas during dynamic operating conditions to confirm that the required environmental quality is maintained.
- i. Microbial air and surface sampling will be performed initially and during recertification (i.e., every 6 months).
 - ii. Microbial air and surface sampling must also be performed in the following circumstances:
 - a. Certification of new facilities and equipment
 - b. After any servicing of facilities and equipment
 - c. In response to identified problems (e.g., positive growth in sterility tests of CSPs)
 - d. In response to identified trends (e.g., repeated positive gloved fingertip and thumb sampling results, failed media fill testing, or repeated observations of air or surface contamination)
 - e. In response to changes that could impact the sterile

compounding environment (e.g., change in cleaning agents)

- iii. In addition to the surface sampling performed during certification and recertification, microbial surface sampling of the cleanroom suite will be performed monthly and in conjunction with media fill testing.

b. Air sampling procedures

- i. The Designated Person(s) shall be properly trained and deemed competent in performing air sampling procedures to ensure accurate and reproducible sampling. See *Attachment C*.
- ii. All impaction air samplers must be serviced and calibrated as recommended by the manufacturer.
- iii. Evaluate colony-forming unit (CFU) counts against the action levels below and examine counts in relation to previous data to identify any trends.:

ISO Class	Air Sampling Action Levels [CFU/cubic meter (1000 liters) of air/media device]
5	> 1
7	> 10

c. Surface sampling procedures

- i. The Designated Person(s) shall be properly trained and deemed competent in performing surface sampling procedures to ensure accurate and reproducible sampling. See *Attachment D*.
- ii. The monthly surface sampling should be performed at the end of a compounding activity or shift but before the area has been cleaned and disinfected.
- iii. Evaluate CFU counts against the action levels below and examine counts in relation to previous data to identify any trends:

ISO Class	Surface Sampling Action Levels (CFU/media device)
5	> 3
7	> 5

d. Corrective action plan

- i. A corrective action plan must be implemented and documented by the Designated Person(s) in response to any CFU counts exceeding the action levels.
- ii. An attempt to identify any microorganism will be made with the assistance of a microbiologist.

- iii. Corrective action plans may include repeat cleaning, facility improvements, personnel training, HEPA filter replacement, etc.
 - iv. The appropriate test(s) will be repeated to confirm that the actions taken were effective.
- e. Records will be retained for 3 years.

4. Cleaning in the compounding areas

a. **Cleaning personnel:**

- i. All cleaning and disinfecting activities shall be performed only by trained and appropriately garbed pharmacy personnel.
- ii. Cleaning personnel may opt to use a PAPR during the monthly terminal cleaning activity.
 - a. Cleaning personnel shall be trained by the Designated Person(s) on the proper use of a PAPR prior to using it during a cleaning activity.
 - b. The PAPR must be wiped clean with sterile 70% isopropyl alcohol before introducing it into the anteroom as well as after its use and before returning it to its proper storage.

b. **Cleaning agents:**

- i. Use only organization-approved, non-corrosive cleaning and sanitizing agents.
- ii. A sterile disinfectant cleaner appropriate for the surface material and that comply with manufacturer or compendial recommendations will be used. Follow all manufacturer's recommendations on dilution and product contact time.
- iii. A sterile sporicidal cleaner will be used once a month to clean surfaces that comply with manufacturer or compendial recommendations. Follow all manufacturer's recommendations on dilution and product contact time.
- iv. Sterile 70% isopropyl alcohol must be applied:
 - a. After the application of sterile disinfectant cleaner, to remove any residue.
 - b. After the application of sterile sporicidal cleaner, to remove any residue.
 - c. Immediately before initiating compounding.
 - d. To the horizontal work surface of the PEC, including any removable work trays, at least every 30 minutes if compounding process takes 30 minutes or less. If compounding takes more than 30 minutes, compounding must not be disrupted and the work

surface must be disinfected with sterile 70% isopropyl alcohol immediately after compounding.

- v. Using sterile, low-lint, disposable wipes, wipe and sanitize supplies for use in the buffer room and in the adjacent anteroom with sterile 70% isopropyl alcohol.

c. Cleaning tools and supplies:

- i. Wipers, sponges, pads, and mop heads must be low-linting and dedicated to only use in the IV room.
- ii. Wipers, sponges, pads, and mop heads must be disposable and must be discarded after each cleaning activity.
- iii. Reusable cleaning tools must be made of cleanable materials (e.g., must not be made of wood or other porous material) and must be cleaned and disinfected before and after each use.
- iv. Reusable cleaning tools must be dedicated for use in the clean room suite and must not be removed from the area except for disposal.

d. Daily cleaning of the LAFH and BSC:

- i. If necessary, remove visible particles, debris, or residue with Sterile Water for Irrigation using sterile, low-lint, disposable wipes.
- ii. Using a sterile, low-lint, disposable wipe, apply a sterile one-step disinfectant cleaner to equipment and all interior surfaces (top to bottom, back to front) of the PEC. Ensure that the minimum contact time specified by the manufacturer is achieved.
- iii. Using a sterile, low-lint, disposable wipe, apply sterile 70% isopropyl alcohol to equipment and all interior surfaces (top to bottom, back to front) of the PEC. Allow the surface to dry completely before beginning compounding.
- iv. Discard the disposable low-linting wipes used to clean the hood after use.
- v. Document the cleaning of these areas at the beginning of each shift on the ELECTRONIC DOCUMENTATION SOFTWARE program.

e. Daily cleaning of the counter tops, passthrough chambers, garbage cans, and floors:

- i. With sterile, low-lint, disposable wipes, adequately clean and sanitize the counter tops and garbage cans prior to the end of the evening shift.
- ii. With disposable non-linting wipes, clean the floors starting with the buffer rooms and working out towards the ante room.

- a. First, clean up debris by dry mopping the floors with a designated dusting sheet.
 - b. Finish cleaning the floors by wet mopping with a sterile one-step disinfectant cleaner.
- iii. Document the daily cleaning of the counter tops and passthrough chambers on the ELECTRONIC DOCUMENTATION SOFTWARE program.
- iv. Document the daily mopping of the floors on the ELECTRONIC DOCUMENTATION SOFTWARE program.
- v. Do not mop when aseptic operations are in progress. The mopping should start in the buffer room and then move to the ante room daily and as needed. Document these cleanings on the ELECTRONIC DOCUMENTATION SOFTWARE program.

f. Monthly cleaning:

- i. Perform all of the daily cleaning as described above with a sterile sporicidal cleaner, AND:
- ii. Clean all wall surfaces of the positive and negative pressure clean rooms.
- iii. Clean all ceilings in the anteroom and buffer rooms.
- iv. Clean all metal exterior surfaces of the LAFH(s) and BSC(s).
- v. Clean chairs and stools in the IV clean room and chemo clean room.
- vi. Clean all totes and carts in the IV clean room and the chemo clean room.
 - a. Totes: Remove contents. Using a sterile, low-lint, disposable wipe with sterile sporicidal cleaner, clean the inside surfaces of the tote and then the entire exterior surfaces of the tote. Ensure manufacturer suggested contact time. Using a sterile, low-lint, disposable wipe with sterile 70% isopropyl alcohol, wipe surfaces and allow to dry. Replace contents of tote.
- vii. Clean plastic exterior surfaces of the hoods.
- viii. Document the monthly sanitization of the walls and ceiling of the anteroom and buffer room.
- ix. Empty storage shelving in the anteroom of all supplies and clean and sanitize them.
- x. Document these cleanings using the Terminal Cleaning Log.
(See Attachments E and F)

C. Compounded Sterile Product Quality

1. **Adherence to established compounding methods**

- a. The SVHMC Inpatient Pharmacy and the Outpatient Infusion Center Pharmacy shall only compound Category 1 and Category 2 CSPs in a certified ISO class 5 PEC located in a classified cleanroom suite.

b. **General access and introducing items into the SEC**

- i. Access to the cleanroom is restricted to qualified pharmacy personnel with specific responsibilities or assigned tasks in the area.
 - a. Any personnel with an upper respiratory infection or active infection of any type will not be permitted to work in the cleanroom.
 - b. Non-pharmacy personnel who are required to perform equipment maintenance or testing (e.g., SVHMC Facilities personnel, clean room suite and IV hood certification personnel) shall follow the garbing procedures set herein.

- ii. Traffic flow in and out of the clean room suite must be minimized.

c. **CSP ORDERING:**

- i. Pharmacy Preparations:
 - a. The Inpatient Pharmacy and Outpatient Infusion Center Pharmacy shall prepare ALL intravenous fluids with additives (not available in pre-mixed form) and shall supply additives for piggyback medications upon receipt of an authorized order.
 - b. Pharmacists shall interpret the order and check for incompatibility, instability, contraindications, and patient allergies.
 - c. The initial time for CSP administration shall be determined by one of the following methods:
 - i. The pharmacist will determine the start time of the IV solution when processing new orders.
 - ii. A pharmacist may call the floor to determine the administration time.
- d. Administration times for continuing CSPs shall be determined by:
 - i. CSPs shall default to the standard administration times using the guidelines set by pharmacy.
 - ii. CSPs for all antibiotics shall continue on a

schedule based on when the initial dose was given.

- iii. Large volume CSPs will automatically be scheduled in the EMR according to its rate of infusion and verified by the technician.
- iv. Orders for medications with short stabilities shall be mixed as close as possible to the time of administration.

e. If order clarification is needed, the pharmacist shall:

- i. Call the ordering physician.
- ii. Notify nursing of clarifications or changes.
- iii. Document clarifications or changes in the patient record with a read back system.

ii. STAT Orders:

- a. The Pharmacy will monitor the "STAT" queue and prioritize these indicated items as "HIGH" priority. Orders indicated as "STAT" will be processed first.
- b. Before dispensing the admixture, the pharmacist shall check the admixture prepared against the physician's order.

iii. Pharmacy Preparations Exceptions:

- a. Intensive Care Units, Surgery, Emergency Department may prepare cardiac medications (such as Norepinephrine, etc.) as defined by the organization's policy.
- b. Registered nurses (RNs) may prepare initial doses of IV solutions for emergency situations only. TJC only allows nurses to prepare doses if they are STAT orders or Pharmacy preparation is not feasible (e.g., short expiration time after admixing) as defined by the organization's policy.

d. **CSP PREPARATION:**

- i. At appropriate times the IV labels shall be generated during the 24 hour period in four batches.
- ii. All labels for the batch times indicated will be printed automatically on the appropriate printer.
 - a. Catch-up batches will print orders entered from the last batch print and the times indicated.
 - b. All orders entered after the catch-up batch should have the appropriate labels printed if the start time is

before the next scheduled batch print.

- iii. Each batch will be prepared and dispensed prior to the START TIME.
- iv. Appropriate attention shall be given to additives which must be protected from light or do not require refrigeration.
- v. No components will be discarded until a pharmacist has made the final CSP check.
- vi. Adjusting IV Schedule:
 - a. The IV Technician shall generate a daily IV reschedule report and compare all large volume CSP administration times on the nursing IV report form against administration time set by pharmacy.
 - b. If any CSP is running ahead or behind schedule, the technician shall determine new administration times and reschedule the IV as needed.
 - c. If a CSP is off schedule, nursing personnel will notify the pharmacist regarding the time change.
 - d. If the time change is for an antibiotic, the pharmacist will discuss with the nurse appropriate administration times based on the hospital's approved administration schedules. (MEDICATION USE)

e. **CSP COMPOUNDING:**

- i. Use aseptic technique to perform sterile compounding.
- ii. Use an ISO class 5 PEC (LAFH or BSC).
- iii. Prepare only one type of drug product in the ISO class 5 PEC at one time.
- iv. Reconstitute all drug additives according to the manufacturer's recommendations or a current reference. All admixtures shall have beyond-use dates that are consistent with manufacturer recommendations and USP 797 standards.
- v. Single use vials may be used up to 6 hours after opening, if stored in an ISO Class 5 PEC (LAFH or BSC) unless indicated otherwise by the manufacturer. DO NOT REMOVE from the ISO class 5 PEC.
- vi. Upon first use, initial and date multi-use sterile product containers.
- vii. Store multi-use containers under restricted access conditions and dispose of them when the beyond-use or expiration date is exceeded. Expiration dating not specifically referenced in the package insert should not exceed 28 days once the vial has been opened. Discard if suspected or visible contamination

occurs.

- viii. Initial and date reconstituted vials with the date and time of reconstitution, concentration, and date of expiration according to manufacturer's recommendations.
- ix. After preparing admixtures, thoroughly mix the contents of the container and inspect for the presence of particulate matter, evidence of incompatibility, or other defects.
- x. Dispose of sharps (including needles and syringes) in impervious labeled containers. Re-cap needles only when permitted by organization policy.
- xi. For parenteral nutrition solutions and fat emulsions, refer to the policy TPN PROTOCOL - ADULT PATIENTS.
- xii. Compounding all hazardous CSPs must be done in a BSC and requires the use of a closed system transfer device.
- xiii. Medications with stabilities equal or less than 24 hours shall be prepared as close as possible to the time of administration.

f. CSP CHECKING:

- i. The prepared label with the proper expiration date shall be attached to the syringe or CSP.
 - a. Completed admixtures have the label affixed to the solution bag leaving the manufacturer's name of the solution or medication visible.
- ii. The beyond-use date (BUD) shall follow the BUDs set for Category 1 and Category 2 CSPs unless the stability data of the drug is shorter than the established BUD.
- iii. The completed CSP and all the materials used in preparing the CSP shall be placed in the checking area. If the CSP is prepared by a pharmacy technician, then the final checking shall be performed by a pharmacist using established procedures:
 - a. A pharmacist shall check label accuracy, accuracy of the addition of all drug products or ingredients used to prepare the finished product, their volumes or quantities, before signing off on all products prepared by pharmacy technicians.
 - b. When possible, two pharmacists shall check and sign off on ALL chemotherapy, Pediatric and NICU products before the product is dispensed for administration.
 - c. In addition, the CSP shall be checked for the presence of appropriate auxiliary labels.
- iv. Any CSP concentration not specified in the standardized dilution chart shall have a "CHECK DOSAGE" sticker placed on the label

or bag.

- v. The final checked CSP shall be placed in the appropriate bin on the delivery cart.

g. DELIVERY OF CSPs:

- i. Completed CSPs are delivered to patient care areas before the intended time of administration.
 - a. CSPs are routinely delivered to care areas via the pneumatic tube system or the pharmacy delivery cart.
- ii. All chemotherapeutic agents and/or hazardous drugs are sealed in a "zip-locked" chemotherapy bag and are routinely delivered via delivery cart or pharmacy personnel.
 - a. Chemotherapeutic agents and/or hazardous drugs are never delivered via the pneumatic tube system.
- iii. CSPs shall be placed in the designated area (i.e., in the medication refrigerators or in the medication cassettes) on each nursing unit.
 - a. At the same time, the delivery person shall return all CSPs that have been placed in the delivery bin for return to the pharmacy.

h. DISCONTINUED CSPs:

- i. Nursing personnel shall:
 - a. Place discontinued unrefrigerated CSP's in the plastic bin to return to pharmacy.
 - b. Place discontinued refrigerated CSP's in the return bin in the medication refrigerator to return to pharmacy.
- ii. Upon receiving order of the discontinued CSP, a pharmacist shall discontinue the CSP and notify the I.V. room technician.

i. REDISPENSING CSPs:

- i. Return all compounded sterile products that are not used as originally intended to the pharmacy for appropriate disposition, which may be redispensed in accordance with the organization's policy.
- ii. Redispensing may occur if the compounded sterile product has been maintained under continuous refrigeration and protected from light, if required.
- iii. Redispensing may occur if initial preparation and thaw times are documented and reliable measures have been taken to prevent and detect tampering.
- iv. CSPs can be redispensed only one (1) time after the initial return

to the pharmacy if still within 48 hours of beyond use date, and within 72 hours of compounding. CSPs may not be redispensed after 72 hours unless the lot number and expiration dates of the diluent and the medication are properly recorded.

- v. CSPs cannot be re-dispensed if re-dispensing cannot be supported by the originally assigned beyond-use time.
- vi. CSPs that are ready-to-use and not activated are stable based on the manufacturer's literature.

2. **Maintenance of equipment, supplies and components**

- a. Equipment used in compounding CSPs
 - i. Equipment chosen to be used in compounding should have surfaces that are not reactive or sorptive.
- b. Supplies
 - i. Supplies used in compounding CSPs must be sterile and depyrogenated.
- c. Components
 - i. Components used in compounding CSPs must be sterile and must be FDA-approved components.

3. **Maintenance of a master formula and compounding records**

- a. A master formulation record (MFR) is a detailed record of procedures that describes how the CSP is prepared.
 - i. An MFR must be created for all CSPs prepared for more than one patient.
 - ii. All new MFRs any alterations made to an existing MFR must be reviewed and approved by the DOP and the Designated Person(s).
 - iii. An MFR must include the following:
 - a. Name, strength or activity, and dosage form of the CSP
 - b. Identities and amounts of all ingredients; if applicable, relevant characteristics of components (e.g., salt form, solubility, etc.)
 - c. Type and size of container closure system(s)
 - d. Complete instructions for preparing the CSP, including equipment, supplies, a description of the compounding steps, and any special precautions)
 - e. Physical description of the final CSP
 - f. BUD and storage requirements
 - g. Reference source to support the stability of the CSP

- h. Quality control (QC) procedures (e.g., pH testing, filter integrity testing)
 - i. Other information as needed to describe the compounding process and ensure repeatability (e.g., adjusting pH, etc.)
 - b. Compounding records (CR) documents the compounding process of each CSP.
 - i. A CR is created for all CSPs compounded at SVMHC with the use of the electronic IV workflow management system (Dose Edge™).
 - ii. The CR must include at least the following information:
 - a. Name, strength or activity, and dosage form of the CSP
 - b. Date and time of preparation of the CSP
 - c. Assigned internal identification number (e.g., prescription or order number)
 - d. A method to identify the individuals involved in the compounding process and individuals verifying the final CSP
 - e. Name of each component
 - f. Vendor, lot number, and expiration date for each component for CSPs prepared for more than one patient
 - g. Weight or volume of each component
 - h. Strength or activity of each component
 - i. Total quantity compounded
 - j. Final yield (e.g., quantity, containers, number of units)
 - k. Assigned BUD and storage requirements
 - l. Results of QC procedures (e.g., visual inspection, filter integrity, etc)
 - m. If applicable, must also include the MFR reference for the CSP and
 - n. Calculations made to determine and verify quantities and/or concentrations of components

4. **Inspection and testing of compounded sterile products**

- a. Samples of CSPs will be assayed for strength, potency, endotoxins, and sterility every 6 months.
- b. Samples may either be a Category 1 or Category 2 CSP.

- c. Results from the CSPs will be analyzed as follows:
 - i. Sterility must be negative.
 - ii. Potency must be within +/- 10% of the original compound sent.
 - iii. Endotoxin must be less than or equal to the upper limit of specification.
- d. An outside agency will be contracted to provide the results of each sample CSP.
- e. In the event that a sample's results are not in the reference range listed above, a product retest will be completed. A new sample with the same compounding personnel will be sent again for further analysis.
- f. If the second test comes back out of range, the remediation will include, at a minimum, an immediate investigation of cleaning and compounding operations as well as facilities management.
- g. CSPs that contain controlled substances shall not be selected for these assay tests.

5. **Labeling requirements:**

- a. Immediately label all admixtures including large volume parenterals (with additives) and piggyback medications with the following information:
 - i. Patient name, location, medical record number, and account number
 - ii. Names and amounts or concentrations of active ingredients added
 - iii. Name of basic parenteral solution
 - iv. Total volume
 - v. Internal lot number or reference number of the compound
 - vi. Date and time of addition
 - vii. Appropriate route of administration
 - viii. Date, time, and rate of administration
 - ix. Name or initials of compounding personnel
 - x. Name or initials of personnel who performed the final check of the product
 - a. In addition, a final "wet" initial will be written on the label prior to final dispense.
 - xi. Supplemental instructions for safe use
 - xii. Beyond-use date (BUD) of the CSP
 - xiii. Ordering physician
 - xiv. "COMPOUNDED DRUG PRODUCT" auxiliary label

b. Premixed IV solutions:

- i. Label premixed IV solutions supplied by the Pharmacy as above, except:
 - a. Do not label with a BUD unless it is shorter than the manufacturer expiration date printed on the container.
 - b. If the premixed IV is a frozen product, the label shall show the thaw date. The BUD of the thawed product can then be calculated using the thaw date.
- ii. When possible, affix labels to the IV container so that the preprinted material on the container is on the same side as the label.
- iii. To ensure that quality control checks are as accurate and effective as possible, the preprinted material must not be covered by the pharmacy label (i.e., the label will be placed on all premixed IVs such that the nurse administering the medication may see the original manufacturer label with the name of the drug visible).

c. Non-standard CSPs:

- i. Non-standard CSPs are defined as any IV solution prepared by the Pharmacy that does not have a defined standing order set in the EMR.
- ii. All non-standard CSPs are to have a "CHECK DOSAGE" sticker placed on the the IV bag/bottle.

d. Nursing labeling:

- i. Nursing labeling shall follow guidelines established by regulatory and professional standards.

6. **Methods for assignment of beyond-use dates:**

- a. The Pharmacy shall establish general guidelines for determining the maximum beyond-use dates (BUDs) of aseptically prepared CSPs and in the absence of passing a sterility test.

i. **BUD Limits for Category 1 CSPs**

Controlled Room Temperature (20 to 25°C)	Refrigerator (2 to 8°C)
≤ 12 hours	≤ 24 hours

ii. **BUD Limits for Category 2 CSPs**

Compounding Method	Controlled Room Temperature (20 to 25°C)	Refrigerator (2 to 8°C)	Freezer (minus 25 to minus

			10°C)
Aseptically prepared and prepared from only sterile starting components	4 days	10 days	45 days

Note: One (1) day is equivalent to 24 hours.

- iii. A shorter BUD must be assigned when the physical and chemical stability of the CSP is less than the BUD limit stated in the tables above (e.g., nitroprusside in NS is stable at room temperature for 24 hours and thus will have a BUD of 24 hours instead of 4 days).
 - a. Medications with stabilities equal to or less than 24 hours shall be prepared as close as possible to the time of administration.
- iv. The BUD must not exceed the shortest remaining expiration date of any of the commercially available starting components.
- v. For CSPs prepared with a compounded component, the BUD should not exceed the shortest BUD of the compounded component.

b. Immediate-Use CSPs

- i. **The immediate-use provision under California Code of Regulations (CCR), Title 16, section 1751.8(e), is intended for limited situations only. Subsection (e) states, in part: Per Intended only for those situations where there is a need for emergency or immediate patient administration of a CSP. Such "immediate use" preparations shall be compounded only in those limited situations where there is a need for immediate administrations of a sterile preparation compounded outside of an ISO class 5 environment and where failure to administer could result in loss of life or intense suffering.**
 - a. **Immediate-use CSPs shall involve not more than 3 different sterile products.**
 - b. **The quantity of an immediate-use CSP shall only be in the quantity to meet the immediate need, and the circumstance for the need shall be documented.**
 - c. **The CSP shall be labeled "FOR IMMEDIATE USE ONLY" and administration shall begin no later than one (1) hour following the start of the compounding process.**
 - d. **If administration has not begun within one (1) hour following the start of preparing the CSP, then the CSP shall be promptly, properly, and safely discarded.**

- e. **Unless immediately and completely administered by the person who prepared the CSP, or immediate and complete administration is witnessed by the preparer, the CSP shall bear a label listing patient identification information, the names and amounts of all ingredients, the name or initials of the person who prepared the CSP, and the exact one (1) hour BUD and time.**
- ii. Aseptic technique shall be used to prepare immediate-use CSPs.
- iii. Nursing Education is responsible to coordinate with the DOP and/or Designated Person(s) to provide appropriate nursing staff with initial and annual competency training for preparation of immediate-use CSPs.
 - a. Pharmacy will assist Nursing Education in providing in-service training to appropriate nursing staff regarding sterile compounding issues encountered from medication errors and other quality improvement activities.

c. Proprietary bag and vial systems

- i. **Immediate administration:** Docking and activation of proprietary bag and vial systems in accordance with the manufacturer's labeling for immediate administration to an individual patient is not considered compounding and may be performed outside of an ISO class 5 PEC.
- ii. **Future activation:** Docking and activation of proprietary bag and vial systems for future activation and administration is considered compounding and must be performed in an ISO class 5 PEC. Assigned BUDs must not be longer than those specified in manufacturer's labeling.

7. Quality assurance and quality control

a. Recalls due to equipment contamination:

- i. Whenever there is evidence of positive growth resulting from contact inoculation, swabbing, or impaction air testing, compounding shall immediately cease in the affected LAFH or BSC.
- ii. A report identifying all CSPs for the month prior to testing shall be compiled using the DoseEdge™ report writer and reviewed by the DOP and/or the Designated Person(s).
- iii. Any CSP prepared in the affected PEC shall be immediately removed from distribution and quarantined. This includes CSPs that have been delivered to the nursing units and/or CSPs compounded in batches that are subsequently stored in the

pass-through refrigerator in the Main Pharmacy.

iv. Infection Control shall be immediately notified.

b. Recalls due to personnel contamination:

- i. Whenever there is evidence of positive growth resulting from gloved fingertip and thumb sampling, the affected compounding personnel shall immediately cease all activities in the cleanroom suite.
- ii. A report identifying all compounded CSPs for the month by the affected individual prior to testing shall be compiled using the DoseEdge™ report writer and reviewed by the DOP and/or the Designated Person(s).
- iii. Any CSP prepared by the identified compounding personnel that is still available for use shall be immediately removed from distribution and quarantined. This includes CSPs that have been delivered to the nursing units and/or CSPs compounded in batches that are subsequently stored in the pass-through refrigerator in the Main Pharmacy.
- iv. The affected compounding personnel must retake and pass a media fill test before resuming activity in the cleanroom suite.
- v. Infection Control shall be immediately notified.

c. Manufactured CSP recalls:

- i. If the Pharmacy department alert system identifies that a medication has been recalled by the manufacturer or any recall database, the product shall be immediately identified and sequestered from the dispensing area.
- ii. If the recalled medication is an item that is compounded, a review of all records of compounding the item will be completed. A hospital-wide search for the recalled compound will be conducted. All items identified will be sequestered. Additionally, the California State Board of Pharmacy will be notified within 12 hours of the recall notice.
- iii. All procedures outlined in the Medication Recall Policy will be followed. *Refer to Medication Recall policy.*

d. Complaint handling

- i. All complaints regarding CSPs will be immediately investigated by the Designated Person(s).
- ii. If necessary, the CSPs will be removed immediately from any dispensing area and will be segregated until the issue has been fully investigated and/or resolved.
- iii. A record of the complaint, including the date of the complaint, the nature of the complaint, and the response to the complaint

will be documented and be maintained for 3 years.

e. Adverse event reporting

- i. Any adverse event associated with a CSP will be reported via the SVHMC safety reporting application and will be investigated fully.

D. Proper handling, storage, and disposal of CSP

1. **CSP handling and storage**

a. Maintain proper storage conditions:

- i. Pharmacy personnel must monitor drug storage areas to help ensure that CSP quality is maintained during storage.
- ii. Controlled temperature storage areas shall be monitored with a continuous temperature recording device and records must be retrievable.

a. Controlled room temperature: 20 to 25°C (68 to 77°F)

b. Controlled refrigerated temperature: 2 to 8°C (36 to 46°F)

c. Controlled freezer temperatures:

i. minus 20 to minus 10°C (minus 4 to +14°F)

ii. minus 50 to minus 15°C (minus 58 to minus 5°F)

b. Parenteral solutions, medications, supplies, and equipment used to prepare CSPs shall be stored in accordance with manufacturer or USP requirements.

c. CSPs will be sealed to prevent contamination.

d. CSPs must be stored in accordance with the conditions stated on the label.

i. CSPs are only stored in designated areas.

ii. Store CSPs in the refrigerator at all times, unless otherwise recommended by the manufacturer or other literature.

iii. Discard any CSP that is known to have been exposed to temperatures warmer than the warmest labeled limit unless appropriate documentation or direct assay data confirms its continued stability.

iv. Any CSP exposed to temperatures warmer than 40°C for more than 4 hours are to be discarded immediately.

e. Special handling:

- i. All light-sensitive CSPs and injectables shall be protected by covering or enclosing the item with a UV light-resistant bag or container.

- ii. CSPs that require refrigeration will be delivered to the appropriate nursing unit refrigerator. If administration will occur immediately, then delivery via pneumatic tube system is permissible unless it meets any of the conditions listed below.
- iii. CSPs that are susceptible to degradation if shaken vigorously shall not be delivered via the pneumatic tube system.
- iv. CSPs that contain controlled substances shall not be delivered via the pneumatic tube system.
- v. Hazardous CSPs:
 - a. All hazardous drugs shall be prepared for administration only in a BSC.
 - b. Hazardous drugs shall be stored separately from other inventory in a manner to prevent contamination and personnel exposure.
 - i. Receiving hazardous drugs will be done in a space with neutral air pressure.
 - ii. Storage of hazardous drugs will be in a negative pressure room.
 - c. Hazardous drugs shall not be delivered via the pneumatic tube system.

f. Frozen Products:

- i. Freezing of reusable sterile products:
 - a. Reusable compounded products returned to the pharmacy may be frozen for future use if suitable for the product.
 - b. Frozen products shall have a new expiration date assigned of 45 days from date of freezing or manufacture's recommendations.
 - c. Questionable products shall be discarded.
- ii. Thawing of frozen products:
 - a. Frozen products shall thaw completely and come to room temperature prior to administration.
 - b. Frozen products shall be thawed at room temperature until no crystalline particles are visible in the solution.
- iii. Identification of thawed products:
 - a. Thawed products shall be identified with a special label or mark.
 - b. Attach label: "FROZEN PRODUCT – DO NOT REFREEZE, DISCARD IF RETURNED"

- iv. Refreezing of thawed products:
 - a. Thawed products shall not be refrozen.
- v. Expiration dating of thawed products:
 - a. Thawed products shall be discarded 24 hours after thawing unless literature allows a longer retention period.
- g. Radiopharmaceutical CSPs:
 - i. SVHMC contracts all radiopharmaceutical preparation services with the Nuclear Pharmacy Division of Cardinal Health and all handling and dispensing is performed by Nuclear Medicine department.

2. **Allergenic extracts, infectious and biologic materials**

- a. The following preparations shall not be compounded in either the SVHMC Inpatient Pharmacy (IP) or the Outpatient Infusion Center (OIC) Pharmacy:
 - i. CSPs that incorporate infectious materials (e.g., BCG)
 - ii. CSPs that require manipulation of a patient's blood-derived or other biological material (e.g., autologous serum)
 - iii. CSPs that are considered an allergenic extract

VI. REFERENCES

- A. USP Chapter <797> Pharmaceutical Compounding - Sterile Preparations. Official Date 01-Nov-2023.

Attachments

- [!\[\]\(79de0df6c6ddd2d4eb74f1cc5f48ec50_img.jpg\) Attachment A - Sterile Compounding - GFT Procedures - 02.22.2024.pdf](#)
- [!\[\]\(d4c9768318b38eff1042b07478e20b4c_img.jpg\) Attachment B - Sterile Compounding - Media Fill Procedures - 02.22.2024.pdf](#)
- [!\[\]\(27d314856359a9d7feca17161bc1f4a4_img.jpg\) Attachment C - Sterile Compounding - Air Sampling Procedures - 02.22.2024.pdf](#)
- [!\[\]\(d355663486c698e3972a8b93ac8b2102_img.jpg\) Attachment D - Sterile Compounding - Surface Sampling - 02.22.2024.pdf](#)
- [!\[\]\(1858f6a9022d088c0a7eca873f99643b_img.jpg\) Attachment E - SVMHS - Inpatient Pharmacy - Terminal Cleaning Checklist - TEMPLATE.pdf](#)
- [!\[\]\(4a9a9afe1808e44249cde903a007394f_img.jpg\) Attachment F - SVMHS - Outpatient Infusion Center - Terminal Cleaning Checklist - TEMPLATE.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	01/2025
CNO	Carla Spencer: Chief Nursing Officer	12/2024
P&T	Genevieve delos Santos: Director Pharmacy	12/2024
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	12/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2024
Policy Owner	Genevieve delos Santos: Director Pharmacy	11/2024

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerLouis VillanedaSr.: Respiratory Care ManagerAreaRespiratory Care

Respiratory Care POC Correlation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To define the method for Point of Care Correlation Testing.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

- A. INSTRUMENT / METHOD CORRELATION PROCEDURE:
- On tests that are performed by more than one instrument, a correlation procedure must be performed twice annually. Since these tests may be performed using either instrument or methodology, it is important that test result correlations are performed to assure that both instruments/methods give comparable results. When test results are not comparable, primary instrument/method will be utilized. It is acceptable to use proficiency survey materials, controls or patient specimens for these correlations.

V. PROCEDURE

A. Presently, correlation testing is performed as follows:

EPOC vs. Nova Stat Profile Prime Plus

- Obtain 5 to 10 specimens.

2. Run each specimen on both instruments.
3. Record the results on the appropriate Correlation Worksheet. The worksheets are in the Instrument Correlation Binder and are titled for the instruments that are being tested.
4. Establish a mean of all instruments compared.
5. Calculate % difference between each instrument and the mean.

B. CORRELATION CALCULATIONS

Calculation: where...a = higher sum value

b= lower sum value

% Difference= $[(a - b) / a] \times 100$

C. ACCEPTABLE CORRELATION

1. If the correlation results are within acceptable limits, place the worksheet with correlation documentation in the appropriate binder.
2. Acceptability limits vary depending on the assay/analyte, refer to limits on the worksheet.

D. UNACCEPTABLE CORRELATIONS

1. If test results are outside of acceptable limits, do the following:
 - a. Identify the outlier.
 - b. Perform maintenance if applicable.
 - c. Perform linearity
2. Rerun controls, make sure they are acceptable.
3. Repeat correlation, If correlation results are still unacceptable:
 - a. Make appropriate calculated offset changes to the outlying parameters on the secondary instrument. These offset calculations will be applied so that results reflect those of the primary instrument. Repeat the correlation to confirm that results are within acceptable limits.
 - b. Notify POC coordinator / manufacturer for replacement or hotline and service.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Rehab Medical Director	Katherine DeSalvo: Director Medical Staff Services	12/2024
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2024
Policy Owner	Louis Villaneda Sr.: Respiratory Care Manager	11/2024

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
1 year after approval

Owner
Area

Lacey Cone:
Director Critical Care Services
Scopes Of Service

Scope of Service: Critical Care

I. SCOPE OF SERVICE

The Critical Care Units support the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and has designed services to meet the needs and expectations of patients, families and the community.

The purpose of the Critical Care Units are to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Critical Care Units are to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

In addition to the overall SVHMC goals and objectives, the Critical Care units develop goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of the Critical Care Units are:

- A. **1st Main Telemetry** provides monitoring and care of patients with moderate or potentially severe physiologic instability, requiring technical support including but not necessarily artificial life support. The Unit is reserved for those patients requiring less care than standard Intensive Care, but more than that which is available from a general care unit.
- B. **5 Tower Telemetry** provides care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval and display of cardiac electrical signals.
- C. **4 Tower Telemetry** provides care for and continuous cardiac monitoring of patients in a stable condition, having or suspected of having a cardiac condition or a disease requiring the electronic monitoring, recording, retrieval and display of cardiac electrical signals.

- D. **ICU/CCU** is to provide monitoring and care of critically ill patients. ICU patients may be housed in other locations during an emergency situation.
- E. **Observation Care Unit (OCU)** provides care to patients who may require clinical services while a decision is made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. OCU is also capable of providing short term care for patients requiring pre and post procedural care in the Diagnostic Imaging and interventional Cardiology procedures. Additionally, the unit provides short term care for patient requiring injections, infusions or treatments that do not meet criteria for inpatient status and will be discharged post procedure.
- F. **Heart Center** provides monitoring and care of acute inpatients that do not require intensive care, but more than what is available from the general care unit. Up to four beds are designated intensive care bed to accommodate ICU overflow.

III. DEPARTMENT OBJECTIVES

- A. To support the SVHMC and Department of Nursing objectives.
- B. To support the delivery of safe, effective, and appropriate care/service in a cost effective manner.
- C. To plan for the allocation of human/material resources.
- D. To provide high level medical and nursing management with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to as high a level of wellness as possible.
- E. To collect data about the Unit function, staff performance, and patient care for quality management purposes and continuous quality improvement.
- F. To provide a therapeutic environment appropriate for the patient population in order to promote healing of the whole person.
- G. To provide necessary expertise, technology, instrumentation and equipment for the management of patients.
- H. To provide nursing care based on the nursing process.
 - I. If not covered by SVHMC's policies, nursing follows guidelines as outlined in Lippincott Manual of Nursing Practice.
- J. To evaluate staff performance on an ongoing basis.
- K. To provide appropriate staff orientation and development.
- L. To monitor the Critical Care Units functions, staff performance and care/service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical:

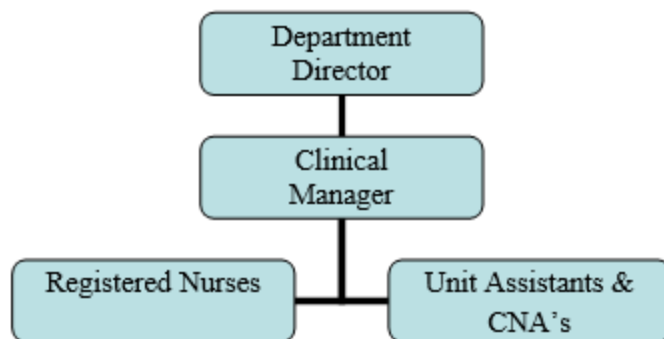
- A. The 1st Main Telemetry Unit provides care for adolescent patients, 16 years and older, along with adult and geriatric populations.

- B. The 5th Tower Telemetry Unit provides care for adolescent patients 16 years and older, along with adult and geriatric populations.
- C. The 4th Tower Telemetry Unit provides care for adolescent patients 16 years and older, along with adult and geriatric populations.
- D. The Observation Care Unit provides care for patients 16 years and older, along with adult and geriatric populations.
- E. The ICU/CCU provides care for infant, pediatric, adolescent patients, 16 years and older, along with adult and geriatric populations.
- F. The Heart Center provides care for patients 16 years and older, along with adult and geriatric populations.

V. ORGANIZATION OF THE DEPARTMENT (include organizational chart)

A. Hours of Operation:

The 1st Main Telemetry Unit, 5th Tower Telemetry Unit, 4th Tower Telemetry Unit ICU/CCU, Observation Care Telemetry Unit and the Heart Center provide services seven days a week, twenty-four hours a day.



B. Location of departments:

- 1st Main Telemetry Unit is located on the 1st floor of the main hospital between the Heart Center and the Intensive Care Unit. Rooms 107-116 have been designated as Outpatient Surgical Services.
- The 5th Tower Telemetry Unit is located in the 5th Floor Tower of the main hospital.
- The 4th Tower Telemetry Unit is located in the 4th Floor Tower of the main hospital.
- The ICU/CCU Unit is located on the 1st floor of the main hospital.
- The Observation Care Unit is located on the fifth floor of the main hospital.
- The Heart Center is located on the first floor of the hospital. Up to four beds are designated intensive care bed to accommodate ICU overflow.

C. Major Services/Modalities of care may include:

1st Main Telemetry provides care / services to patients with primary diagnoses, including but not limited to: gastrointestinal bleed, pulmonary edema, respiratory failure, COPD, renal infection, and out-of-control diabetes mellitus. The Unit also provides care for hemodynamically stable patients requiring ventilator support, vasopressor therapy, and invasive pressure monitoring (arterial/CVP lines). Modalities may include Invasive pressure monitoring- Arterial/ CVP lines and Cardiac Monitoring Therapy. The unit consists of thirteen (13) single occupancy rooms with cardiac monitoring/ telemetry capacity. Seven (7) rooms are equipped to provide renal dialysis.

5th Tower Telemetry provides care / services to patients with primary diagnoses, including but not limited to: Stroke, COPD, heart failure, pneumonia, chest pain, GI Bleeds and renal failure. Care is also provided to hemodynamically stable patient's requiring vasopressor therapy and invasive pressure monitoring (arterial/CVP lines). Modalities may include Invasive pressure monitoring- Arterial/ CVP lines and Cardiac Monitoring Therapy. All rooms provide renal dialysis. The unit consists of twelve (12) single occupancy rooms and two (2) double occupancy. Two (2) of the rooms have negative pressure isolation capabilities with an anteroom adjacent to the patient's room.

4th Tower Telemetry provides care / services to patients with primary diagnoses, including but not limited to: Stroke, COPD, heart failure, pneumonia, chest pain, GI Bleeds and renal failure. Care is also provided to hemodynamically stable patient's requiring vasopressor therapy and invasive pressure monitoring (arterial/CVP lines). Modalities may include Invasive pressure monitoring- Arterial/ CVP lines and Cardiac Monitoring Therapy. All rooms provide renal dialysis. The unit consists of eleven (11) single occupancy rooms and two (2) double occupancy. One (1) of the rooms have negative pressure isolation capabilities with an anteroom adjacent to the patient's room

D. **ICU/CCU** provides care / services to patients with primary diagnoses, including but not limited to: Acute Myocardial Infarction, Pre-Post Open Heart Surgery, Congestive Heart Failure, Acute/ Chronic Renal Failure, Acute Respiratory Failure, Anoxic Brain Injury, Cerebral Vascular Accident, Intracerebral Hemorrhage, Subdural Hemorrhage, Septicemia, Pre-Post Abdominal Surgery, Pre-Post Thoracic Surgery and Multiple Trauma. Modalities may include: Invasive Hemodynamic Monitoring/PA and Arterial Catheterization, Cardiac Monitoring, Intra-aortic Balloon Pump Monitoring and Management, Continuous Renal Replacement Therapy. The unit consists of thirteen (13) single occupancy rooms.

- The Critical Care Intensivist coordinates and leads multidisciplinary rounds on all patients, daily in ICU/CCU. They assist in the evaluation and management of the patients and may intervene in the care of the patients if necessary. The information from rounds is documented in the patient's electronic medical record and reported to the attending Physician if it is not them.
- Physicians with admitting privileges admit to ICU/CCU, however, a Critical Care Intensivist consultation is available 24 hours per day, 7 days per week. If needed, they assist the attending physician with the coordination of patient admission, discharge and/or transfer from Critical Care.
- Critical Care Intensivist have the authority to intervene and manage the care, including but not limited to ordering test, initiating treatments and performing

medically indicated procedures, for any ICU/CCU patient even if they are not the attending of record.

E.

Observation Care Unit provides care / services to patients requiring observation, treatments and pre and post procedure preparation within the scope of services at SVHMC. Patients may be admitted with primary diagnoses, including but not limited to: Chest pain or similar symptoms suggestive but not diagnostic of an acute MI, Acute asthma attack, Acute exacerbation of chronic lung disease, uncontrolled hypertension not requiring titrating drips, drug reactions, allergic reactions, dehydration requiring intravenous repletion (e.g. secondary to vomiting, diarrhea, anorexia, etc.), short term therapy such as seizure disorder requiring anticonvulsant loading, sickle cell pain crisis, transfusion of blood, abdominal pain suggesting an acute abdominal process, but not readily defined, gastrointestinal bleeding of uncertain nature of significance, infections requiring short-term parenteral antibiotic therapy (e.g., pneumonia, cellulitis, urinary tract infection). Assessments will be completed by registered nurses and reassessment will be completed for those patients monitored by telemetry every four hours or as needed and non-monitored patients will be assessed once a shift or as needed to support or facilitate the decision for admission or discharge.

Heart Center provides care / services to patients with primary diagnoses, including but not limited to: Acute Myocardial Infarction, Pre- Post PTCA, Ablation, Congestive Heart Failure, Angina, Pre-Post Pacemaker Placement, Pre-Post Automatic Implantable Cardioverter Defibrillator (AICD), COPD and Pre-Post Cardiac Surgery, Cerebral Vascular Accident (CVA). Care is also provided to hemodynamically stable patient's requiring vasopressor therapy and invasive pressure monitoring (arterial/CVP lines). Modalities may include: Invasive pressure monitoring (arterial/CVP lines) and Cardiac Monitoring. The unit consists of fifteen (15) single occupancy rooms.

VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

The inpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients. A registered nurse (RN) performs an admission assessment on patients optimally within two (2) hours of admission to the unit. The RN selects and initiates the nursing care plans within the shift of admission and updates as indicated. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders.

The Director and Clinical Manager(s) assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

The Director of the Unit is directly responsible to the Chief Nursing Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by the Manager or Nursing Leader on call, or their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. EVALUATION OF CARE

Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity and the extent to which the level of care or services provided meets the patient's needs through any one or all of the following quality improvement practices:

- A. Multidisciplinary Performance Improvement Teams
- B. Patient/ Family satisfaction surveys
- C. Focused studies
- D. Patient relation services
- E. Employee forums
- F. Staff meetings and staff input
- G. Nursing Leadership

VIII. REQUIREMENTS FOR STAFF (applicable to department)

All individuals who provide patient care services are licensed or registered (according to applicable state law and regulation) and have the appropriate training and competence.

A. Licensure / Certifications:

The basic requirements for **Registered Nurses** include:

1. Current state licensure
2. Current BLS
3. Current ACLS
4. PALS preferred (*ICU/CCU Unit*)
5. PCCN or CCRN Certification preferred
6. Basic Arrhythmia Certification.
7. Completion of competency-based orientation
8. Completion of annual competency
9. TNCC- preferred (*ICU/CCU Unit*)
10. Completion of an approved Critical Care Course or equivalent experience (*ICU/CCU Unit*)

The basic requirements for *Certified Nursing Assistants and Clinical Assistants* include:

1. Current state licensure
2. Current BLS
3. Completion of competency-based orientation

4. Completion of annual competency

The basic requirements for *Unit Assistants/Monitor Tech (UA II)* include:

1. High school diploma or equivalent
2. Current BLS
3. Basic Arrhythmia competency
4. Completion of competency-based orientation
5. Completion of annual competency

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, videoconferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives

- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance
- Feedback and requests for future topics are regularly solicited from staff via UPC referrals, email, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

IX. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan:

Staffing is based on patient volume and acuity. In the telemetry departments, the RN to patient ratio is one RN to no greater than four (4) patients. In ICU/CCU the RN to patient ratio is one RN to no greater than two (2) patients. Assignments are made by the charge nurse based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. Staff provides either total patient care or "partners" care depending on the patient needs, acuity, and the licensed staff scheduled.

In the event staffing requirements cannot be met, the unit will meet staffing requirements by utilizing the on-call system, registry, traveler and per diem RN's.

X. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.

- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

XI. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

XII. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Critical Care Units support SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, the Critical Care Units will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Attachments

 [Organization of the Department](#)

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	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Lacey Cone: Director Critical Care Services	12/2024

Standards

No standards are associated with this document



Last Approved

N/A

Next Review

1 year after approval

Owner

Laura Zerbe:
Manager
Facilities
Construction and
Plant Operatio

Area

Scopes Of
Service

Scope of Service: Facilities Management

I. SCOPE OF SERVICE

Facilities Management supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and has designed services to meet the needs and expectations of patients, families and the community

The purpose of Facilities Management is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Facilities Management is to ensure that all customers will receive high quality service in the most expedient and professional manner possible.

Facilities Management encompasses the following:

- Plant Operations and Plant Maintenance
- Safety Office
- Security
- Biomedical Engineering ([SCOPE OF SERVICE: BIOMEDICAL SERVICES](#))
- Emergency Preparedness
- Project Management

II. GOALS

In addition to the overall SVHMC goals and objectives, Facilities Management develops goals to direct short-term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of Facilities Management:

- A. Plant Operations Department will to ensure that all facilities where patients are treated and staff work will be maintained in the highest quality and safe condition. All repairs performed by the department will be done in the most expedient and professional manner possible in order to

promote safe working conditions and timely service.

- B. To provide a safe physical environment in which to facilitate the delivery of patient care and the overall maintenance/selection/replacement of facility equipment throughout the organization.
- C. To ensure compliance with all state, federal and all other applicable regulatory agencies.

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate care/service in a cost effective manner.
- C. To plan for the allocation of human/material resources.
- D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.
- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Facilities Management function, staff performance, and care/service for quality management and continuous quality improvement.

IV. POPULATION SERVED

All departments that are part of SVHMC



- A. Hours of Operation

Plant Operations and Plant Maintenance

The department offers services 24 hours a day, 7 days per week. Office hours are Monday-Friday 7:00 am-3:30 pm, with after-hours and weekend support from Boiler Watch Engineer and on-call Supervisors.

Safety Office

The Safety Office hours are Monday through Friday 8:00 am – 5:00 pm. The Environmental Health and Safety Officer can be reached during off hours by contacting the Administrative Supervisor.

Security

The department can be contacted via the hospital operator 24 hours a day, 7 days per week. Office hours are Monday-Friday 7:30 am-3:30 pm. Security can also be reached directly via extension x1946 or 5301.

Biomedical Services

Operates Monday through Friday between 6:00 am to 5:00 pm. Emergency support needs are provided for after hours, weekends, and holidays by Biomed On-Call.

B. Location of department (s)

- Plant Operations and Plant Maintenance: Hospital Basement
- Safety Office: 420 E. Romie
- Security: DRC Basement
- Biomed: DRC Basement
- Emergency Preparedness Management: Hospital Basement

C. Admission, Discharge, Transfer Criteria

N/A

D. Major Services:

The Facilities Management Department provides the following services organization-wide:

1. Maintains, repairs, and services utilities (life support systems, emergency power systems, water, compressed gases, sterilization, and elevator system and hospital equipment).
2. Maintains a safe and comfortable environment for all patients, visitors, and staff.
3. Completes work orders for repair and maintenance of the facility and its equipment.
4. Responds to the physical plant and maintenance needs of the hospital staff.
5. Maintains daily logs of essential utility systems and equipment.
6. Obtains technical support for equipment repair or modification from the manufacturer as needed.
7. Assists with Hospital Construction on renovation and building projects by preparing renovation budgets (furnishing, equipment and construction costs); developing contract documents; obtaining city/state/federal agency approvals; providing inspection services.
8. Maintains the grounds and provides landscaping services.
9. Develops and implements Life Safety and Environment of Care Programs including but not limited to:
 - a. Hazardous materials and waste management program
 - b. Safety Management Program
 - c. Fire and Life Safety Programs
 - d. Security Program
 - e. Biomedical Engineering Program
 - f. Utility Management Program
10. Provides consultative service to all SVHMC departments to assist in compliance with

environmental health and safety regulatory agencies. Works with federal, state, and local health and safety regulatory agencies.

11. Supports key programs including but not limited to employee occupational safety and infection prevention.
12. Performs environmental tours and prepares follow-up reports to ensure corrective action is completed.
13. Participates actively in emergency drills, code pink drills, haz-mat spill drills and other exercises as indicated.
14. Assists in the development and coordination of safety training for all SVHMC staff.
15. Security Program: Responds to and manages security incidences; manages surveillance technology and activities; conducts security drills as appropriate; educates hospital staff; documents incidences and risk assessments, and takes action based on data; manages employee and visitor parking.

V. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

A. N/A

VI. REQUIREMENTS FOR STAFF

A. Licensure / Certifications:

Within Plant Operations and Plant Maintenance, one of the following roles are required to maintain:

1. Medical Gas Maintenance Certification:

- Chief Engineer
- Assistant Chief Engineer
- Lead Engineer

2. Office of the State Fire Marshal Weekly Fire Pump Testing License:

- Chief Engineer
- Assistant Chief Engineer
- Lead Engineer

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from

the conferences with other staff members at in-services. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan (desired):

A. Plant Operations and Maintenance:

- Monday through Friday, Day Shift: 12
- Holidays, weekends, evening and night shifts: 2 per shift

B. Biomedical Engineering:

- Monday through Friday, Day Shift: 6
- Holidays, weekends, evening and night shifts: on call

C. Security:

- Day Shift: 8
- Evening Shift: 6
- Night Shift: 5

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is:

- A. Plant Operations and Plant Maintenance: 5
- B. Environmental Health and Safety: 1
- C. Biomedical Engineering: 4
- D. Security: 4
- E. Emergency Preparedness: 1

VIII. EVIDENCE BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

IX. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

X. PERFORMANCE IMPROVEMENT AND PATIENT

SAFETY

Facilities Management supports the SVHMC's commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Facilities Management Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
EOC	James Hively: Manager Environmental Health & Safety	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Laura Zerbe: Manager Facilities Construction and Plant Operatio	12/2024

Standards

No standards are associated with this document



Last Approved N/A
Next Review 1 year after approval

Owner Philip Katzenberger: Director HIM/ Privacy Officer
Area Scopes Of Service

Scope of Service: Health Information Management

I. SCOPE OF SERVICE

Health Information Management supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health (SVH). Designed as a support service to meet the needs and expectations of clinical staff, patients, families and the community. As the custodian of the legal medical record, HIM manages mid revenue cycle functions, organize, oversees, and protects patient health information data which includes symptoms, diagnoses, medical histories, test results and procedures.

The purpose of Health Information Management is to enhance patient services and health programs as a Salinas Valley Health Medical Center (SVHMC) provider of medical care. The goal of Health Information Management is to ensure all customers receive high quality care/service in the most expedient and professional manner possible.

II. GOALS

Health Information Management's goals are aligned with Salinas Valley Health Medical Center (SVHMC) Mission, Vision and Values objectively. Health Information Management department develops goals to direct short-term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goal of Health Information Management is to:

- A. To collect and maintain complete documentation of all information pertaining to persons presenting themselves for diagnosis and treatment in the Emergency Department, as an inpatient, or as an outpatient.

III. DEPARTMENT OBJECTIVES

- A. To support Salinas Valley Health Medical Center (SVHMC) objectives.
- B. To support the delivery of safe, effective, and appropriate care / service in a cost-effective manner.

- C. To plan for the allocation of human/material resources.
- D. To support the provision of high-quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to the highest level of wellness as possible.
- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Health Information Management function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

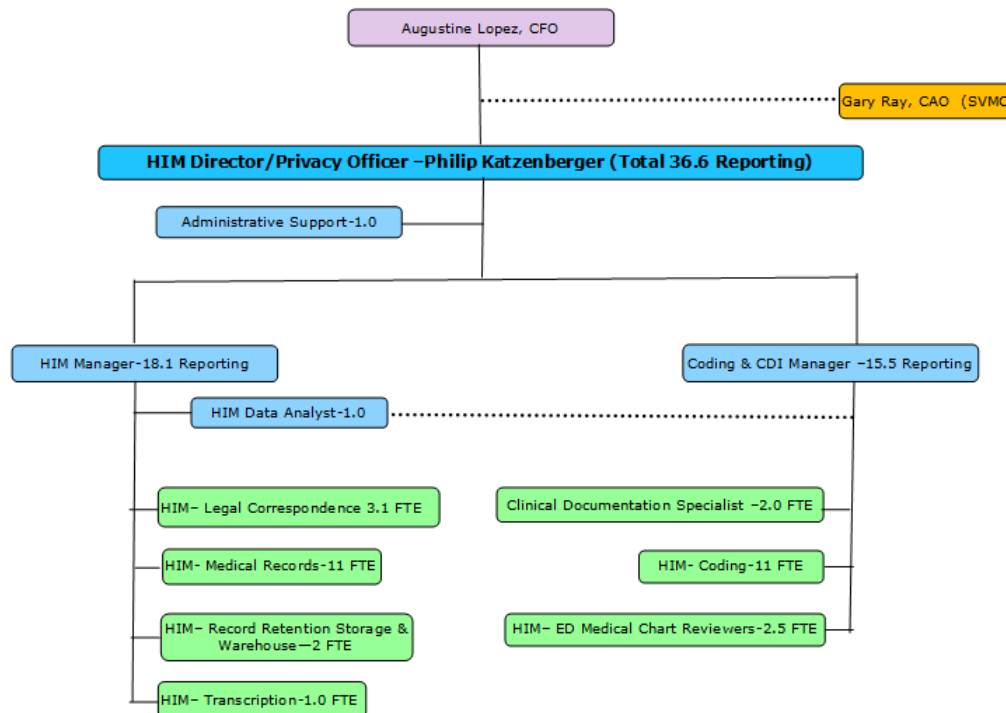
Health Information Management provides services including but not limited to: Any person who requests a medical record, including but not limited to: patients, physicians, medical facilities, authorized family members, workmen's compensation, insurance providers, lawyers, etc.

COPY

V. ORGANIZATION OF THE DEPARTMENT



HEALTH INFORMATION MANAGEMENT ORGANIZATION CHART



HIM Director/Privacy Officer –Philip Katzenberger (Total 36.6 Reporting)

A. Hours of Operation: The general hours of operation are as follows:

Medical Records:

Monday through Friday: 7:00 am to 5:00 pm

Saturday: 10:00 am to 5:00 pm

Transcription Daily: Hours vary with workload

B. Location of department: Downing Resource Center, Room 112

VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

A. The Health Information Management Department serves as the patient data information center by providing the following services:

1. Transcription
2. Storage of HIM documents (the medical record)
3. Retrieval and delivery of the medical record to authorized personnel

4. Coding and abstracting of clinical data for uses in clinical and Epidemiology studies, fiscal planning and billing
5. Clinical Documentation Integrity processes focused on the accuracy of clinical data
6. Collaboration with Case Management, Risk Management/Quality Management, Nursing, and Medical Staff in reviewing medical records for efficacy, appropriateness of care, and timeliness in order to improve patient outcomes
7. Develop and maintain systems which ensure confidentiality and security of the medical record
8. Provide statistical data both internally and externally
9. Develop and maintain policies/procedures re: the release of patient information
10. Storage of non-medical record documentation for the entire facility

B. Health Information Management staff is comprised of a management team, a medical transcriptionist, coders/abstractors, legal correspondence clerks, HIM Specialists, Clinical Documentation Improvement Specialists, Medical Recorder Reviewers and other support services as determined by the needs of the organization.

VII. REQUIREMENTS FOR STAFF

All staff are required to complete competency-based orientation and annual orientation. Coding, CDI, and management staff holding credentials complete yearly mandatory CEUs. Staff are updated and orientated to changes in healthcare industry and HIM profession.

A. Licensure / Certifications:

The basic requirements for Director of HIM/**Privacy Officer** include: Registered Health Information Administrator

The basic requirements for **Manager of CDI and Coding** include: Certified Coding Specialist and Registered Health Information Administrator or Registered Health Information Technician.

The basic requirements for **Clinical Documentation Improvement Specialist** include: Certified Clinical Documentation Specialist or Clinical Documentation Improvement Practitioner.

The basic requirement for **HIM Data Analyst** include: Associate Degree in Health Information Technology.

The basic requirements for **Coding I, II and III** include:

Coder I - Certified Coding Associate (CCA)

Coder II – Certified Coding Specialist – Physician Based (CCS-P)

Coder III – Certified Coding Specialist (CCS)

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the

population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the on-line education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-service evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan:

Assignments are made based on acuity and needs of the department, competencies of the staff, the degree of supervision required, and the level of supervision available. In the event of employee absences, workloads are shifted to provide that service which cannot wait responsible employee's return.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: 4 staff

IX. EVIDENCED BASED STANDARDS

The Salinas Valley Health Medical Center (SVHMC) staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The Salinas Valley Health Medical Center (SVHMC) staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVH has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

X. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Health Information Management supports the Salinas Valley Health Medical Center (SVHMC) commitment to continuously improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

In addition to the overall Salinas Valley Health Medical Center (SVHMC) Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, Health Information Management Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity, and the extent to which the level of care or services provided meets the patients' needs through any one or all of the following quality improvement practices:

1. Multidisciplinary performance improvement teams
2. Ongoing medical record reviews
3. Focused studies
4. Patient relations services
5. Employee forums
6. Performance monitoring for quantity and quality

Unit based measurement indicators are found within the Quality dashboard folder.

Attachments

 [Director of HIM/Privacy Officer](#)

 [Future HIM Dept.Org.Chart 6 2 2023.pub](#)

 [Image 1](#)

Approval Signatures

Step Description	Approver	Date

ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	12/2024

Standards

No standards are associated with this document

COPY



Last Approved N/A

Next Review 1 year after approval

Owner Megan Giovanetti: Director Cardiovascular Services and Sleep

Area Scopes Of Service

Scope of Service: Respiratory, Neurodiagnostics and Sleep Center

I. SCOPE OF SERVICE

The Respiratory Care, Neurodiagnostics and Sleep Center support the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and have designed services to meet the needs and expectations of patients, families and the community.

The purpose of the Respiratory Care, Neurodiagnostics and Sleep Center is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of the Respiratory Care, Neurodiagnostics and Sleep Medicine Departments is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.

II. GOALS

In addition to the overall SVHMC goals and objectives, the Respiratory Care, Neurodiagnostics and Sleep Center develop goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of Respiratory Care, Neurodiagnostics and Sleep Center are:

1. To provide therapeutic, diagnostic and educational modalities to inpatients and outpatients of all acuity levels and all age groups.
2. To provide comprehensive diagnostic testing for Neurodiagnostic and Sleep Center inpatients and outpatients, in a manner that is both cost effective and patient care oriented.
3. To provide comprehensive diagnostic testing for Neurology, sleep disorder patients and newborn hearing screening, for inpatients and outpatients of all ages, in a manner that is both cost effective and patient care oriented.

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.
- C. To plan for the allocation of human/material resources.
- D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to the highest level of wellness as possible.
- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Respiratory, Neurodiagnostics and Sleep Center function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Respiratory Care provides services for the following departments:

- 1. All Acute Inpatient Services –including Emergency Department, Pulmonary Function Testing
- 2. All Outpatient Services provided under SVHMC
- 3. Community Education
- 4. Pulmonary Rehabilitation

Neurodiagnostics and Sleep Center provide care for the following patient population in the inpatient and outpatient setting.

- 1. Sleep Center- patients 6-106 years of age.
- 2. Neurodiagnostics (AABR) newborns
- 3. Neurodiagnostics (EEG) patients of all ages.

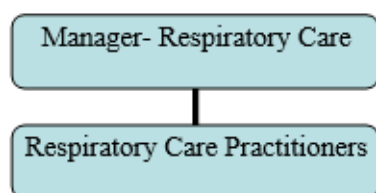
Respiratory Care provides care for infant, pediatric, adolescent, adult and geriatric patients (edit as necessary).

Sleep Center patient population consists of patients of all age groups (neonates through geriatrics). Services are provided to outpatients of all acuity levels.

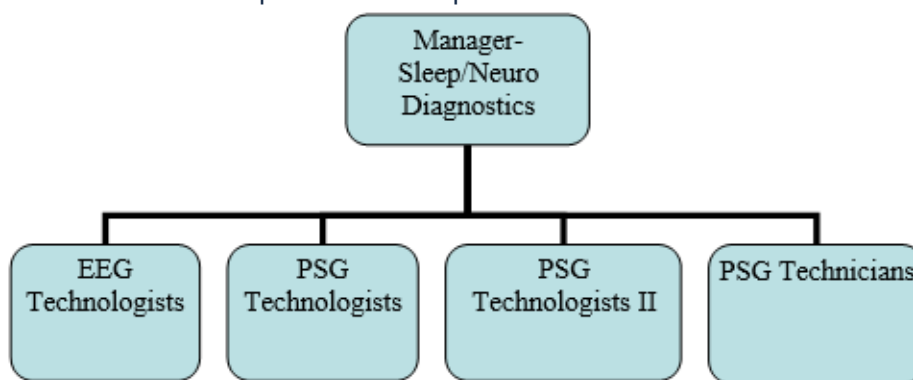
ORGANIZATION OF THE DEPARTMENT

- A. Hours of Operation
 - 1. The Respiratory Care Neurodiagnostics and Sleep Center provides services Twenty-four (24) hours/day; 365 days/year. The unit consists of one (1) pulmonary function lab and (2) offices and storage rooms. Community educational services provided include COPD (Chronic Obstructive Pulmonary Disease) and Asthma Programs. Most services are

provided for inpatients at the bedside.



2. Neurodiagnostics-EEG operates nine (9) hours, five (5) days per week for both inpatients and outpatients.
3. EEG operates nine (9) hours, five (5) days per week for both inpatients and outpatients.
4. Sleep Disorder Dept. operates twelve (12) hours, seven (6) nights per week for testing and eight (8) hours, M-F for daily operations. Sleep Disorder Lab operate twelve (12) hours, seven (6) days per week for scheduled outpatient.
5. Newborn hearing screening operates 8 hours, seven (7) days per week as needed for both inpatients and outpatients
6. Neurodiagnostics- AABR (newborn hearing) operates eight (8) hours, seven (7) days per week as needed for inpatients and outpatients.



B. Location of departments:

Inpatient EEG and newborn hearing testing is performed at patient bedside.
 Outpatient EEG testing is performed at offsite sleep center
 At 120 Wilgart Way Salinas, CA 93901

The off-site Sleep Center is a (10) bed center located at 120 Wilgart Way.

C. Admission Discharge, Transfer Criteria (if applicable)

This is an Outpatient/Ambulatory department where patients have lifetime outpatient accounts. Patients receive treatment and are "arrived" for their appointment and "departed" after treatment. If the patient requires a higher level of care 911 is called and patient is transferred to the Emergency Department.

D. Major Services / Modalities of care include:

Respiratory Care Services are provided based upon patient assessments, plans of care and medical staff orders. Therapeutic, diagnostic, educational, palliative and lifesaving modalities provided include:

1. Medication Nebulizer Treatments
2. Medication Nebulizer/Heated Aerosol Treatments
3. Metered Dose Inhaler Administration
4. Metaneb Treatments
5. Oxygen Therapy
6. Humidity Therapy
7. Postural Drainage/Chest Percussion/IPV
8. Nasotracheal/Endotracheal Suctioning
9. Code Blue/CPR Services/ RRT (Rapid Response Team)
10. BiPAP
11. CPAP
12. Pulmonary Function Studies (PFT Lab)
13. Pulmonary Function Screens (Bedside)
14. Stat ECG (after hours when ECG tech not in house)
15. Mechanical Ventilator Support / Management
16. Bedside Bronchoscopy (Assist in ICU / CCU)
17. Transport Ventilator (Adults) Internal / External
18. Bronchial Hygiene
19. Patient and Community Education
20. COPD (Chronic Obstructive Pulmonary Disease) Education Program
21. Asthma Education Programs
22. Point-of-Care Testing/Arterial Blood Gas Collection and Analysis
23. Arterial catheterization
24. Intubation
25. Metabolic studies

Patient Education (In-House)

1. Asthma
2. Acute Bronchitis
3. COPD (Chronic Obstructive Pulmonary Disease)
4. Continuous Positive Airway Pressure (CPAP)
5. Metered Dose Inhaler
6. Peak Flow Meter
7. Smoking Cessation
8. Pulmonary Rehabilitation
9. Other Respiratory education as needed by patient

Level III NICU

1. Medication Nebulizer Treatments
2. Ventilatory Support / Management
3. Surfactant Therapy
4. Intubation
5. High Risk C-Sections
6. Oxygen Therapy
7. Chest Percussion
8. NICU Transport
9. Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity, and the extent to which the level of care or services provided meets the patients' needs through any one or all of the following quality improvement practices:
10. Multidisciplinary Performance Improvement Teams

Evaluation of Services:

1. EEG/Awake
2. EEG/Asleep
3. Evoked Potentials; VEP
4. AABR, newborn hearing screening is performed to detect hearing losses in newborns so that follow-up hearing intervention can be performed
5. Attended PSG
6. Positive Airway Pressure Titration
7. Supplemental O2

V. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

- A. The Respiratory Care unit consists of one (1) pulmonary function lab and (2) offices and storage rooms. The client population consists of male/female patients of all age groups (neonates through geriatric). Most services are provided to the patient at bedside. Services are provided to outpatients and inpatients. Community educational services provided include COPD (Chronic Obstructive Pulmonary Disease) and Asthma Programs.
- B. The Respiratory Care treatment team is comprised of either registered or certified respiratory care practitioners licensed by the State of California, nursing staff, medical staff and support services according to the needs of the patient.
- C. The Senior Administrative Director and Manager assume twenty-four (24) hour responsibility for respiratory care provided at SVHMC. The leaders of this area are directly responsible to the Chief Operating Officer with oversight also provided by the Medical Director and Laboratory Director. It is the Senior Administrative Director's or their designee duty to attend all administrative and technical

functions within the department. All personnel within the department are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Senior Administrative Director or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

- D. The Neurodiagnostic Department provides diagnostic testing for epilepsy, head injuries, mental and maturation delay, spinal cord injuries, and neurology disorders/diseases. Portable EEG testing is performed at the bedside for suspected electrical cerebral silence diagnosis. Evoked potential studies test peripheral nerve conductivity, spinal nerve conductivity and cerebral cortex diseases and injuries.
- E. The Sleep Disorders Center performs diagnostic testing for a variety of sleep disorders (obstructive sleep apnea, central sleep apnea, restless leg syndrome, hypersomnias, narcolepsy, and other diagnoses). The center also performs therapeutic studies to treat obstructive sleep apnea, central apnea, and obesity-hypoventilation syndrome with positive pressure ventilation.
- F. Sleep Center Outpatient Care is delivered by a multidisciplinary team comprised of medical staff and ancillary support according to the needs of the patients. The Sleep Medicine Center Manager and Supervisor assumes twenty-four hour responsibility for all personnel and care within the department. The Manager is directly responsible to the Senior Administrative Director of Cardiopulmonary services. It is the Manager's duty to attend all administrative and technical functions within the department. In the Manager's absence, the position is filled by the Senior Administrative Director of Cardiopulmonary services or designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.
- G. AABR/EEG: A multidisciplinary team consisting of one (1) Neurodiagnostics Manager, two (2) EEG techs, and two (2) Neurodiagnostic Assistants.
- H. POLYSOMNOGRAPHY: A multidisciplinary team consisting of one (1) Sleep Center Supervisor who is a Registered Sleep Tech, and/or Respiratory Care Practitioner, ten (10) Registered Polysomnography Techs or Certified Polysomnography Techs. 1:1 patients: Certain patients will be flagged by management as 1:1 patients. This means that under normal circumstances, the tech assigned to this patient will only have this one patient. The patient populations most likely to be flagged in this manner are: Patients with severe developmental delay, patients under eight years old, patients with tracheotomies, patients with neuromuscular disorders, and certain types of non-ambulatory patients.
 - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged 1:1 that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions
- I. High Acuity Patients: Certain patients will be flagged by management as high acuity patients. This means that under normal circumstances, it is preferable to not have the tech working alone on this particular shift. The types of patients most likely to be flagged as high acuity are from the patient populations listed above in the 1:1 section, as well as patients with severe mood disorders, patients with severe anxiety, and patients at high risk for coronary events. High acuity flagging differs from 1:1 flagging in that a tech assigned a high acuity patient will not necessarily have just one patient.
 - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged high acuity that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the supervisor should you have any

questions.

VI. REQUIREMENTS FOR STAFF

All individuals who provide patient care services are licensed AND registered (according to applicable state law and regulation) and have the appropriate/adequate training and competence including how to maintain a safe work environment.

A. Licensure / Certifications:

The basic requirements for **Respiratory Care Practitioners** include:

1. License by the State of California and
2. Certified or Registered through the NBRC (National Board of Respiratory Care)
3. Current BCLS
4. Current ACLS
5. Current NRP

The basic requirements for **Supervisor** include:

1. Current BLS
2. Registered Polysomnographic Technologist (RPSGT) and/or Registered Respiratory Therapist (RRT) Certification
3. Completion of competency based orientation
4. Completion of annual education

The basic requirements for **Sleep Technologists** include:

1. Current BLS
2. Completion of competency based orientation
3. Completion of annual education

The basic requirements for **Electroencephalography (EEG) Techs and Automated Auditory Brain Stem Response (AABR) Techs** include:

1. Current BLS
2. Completion of competency based orientation
3. Completion of annual education

Education and training of PSG technician , RPSG Technologist is provided through department orientation and/or annual competencies. All sleep technicians and technologists are required to have a minimum of 10 continuing education hours a year, or 50 per 5 years. Any new technicians/ technologists to the center are required to reach 30 CE units in their first 3 years. CE units can be obtained from conferences sponsored by AASM, AAST, BRPT, RCB, or some other approved legislative body.

B. Competency

Staff are required to have routine competence assessments in concert with the unit's ages of the population and annual performance appraisals. The assessment could be in a written, demonstrated, observed or verbal form. The required competency for staff depends primarily on their work areas and duties. Once a year staff are required to complete the online education modules that have been defined by the organization.

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

The educational needs of the department are assessed through a variety of means, including:

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-services evaluation forms, and in person.

D. Continuing Education

Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of

Education.

VII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity.

General Staffing Plan:

The Respiratory Care Department flexes the staffing to meet the patient acuity level based on the number of respiratory care procedures. When respiratory care procedures exceeds the available staff, attempts are made to secure additional staffing. When necessary, overtime is used. If the variance in staffing continues, the prioritization policy will be utilized.

General Staffing Plan for Sleep Center and Neurodiagnostics

- An onsite staffing ratio of 2:1 is maintained during patient care hours.
- Flex Staffing a) a sleep technologists to patient ratio of 1:2 is the minimum for all sleep studies.
- Explanations: When units of service decrease, staff is canceled. When units of service increase, hours are rotated to cover testing. Outpatients can be rescheduled. Overtime is used only when necessary.
- AABR/EEG: A multidisciplinary team consisting of one (1) Neurodiagnostics Manager, (1) Supervisor, two (2) EEG techs.
- POLYSOMNOGRAPHY: A multidisciplinary team consisting of one (1) Sleep Center Supervisor who is a Registered Sleep Tech, and/or Respiratory Care Practitioner, ten (10) Registered Polysomnography Techs or Certified Polysomnography Techs. 1:1 patients: Certain patients will be flagged by management as 1:1 patients. This means that under normal circumstances, the tech assigned to this patient will only have this one patient. The patient populations most likely to be flagged in this manner are: Patients with severe developmental delay, patients under eight years old, patients with tracheotomies, patients with neuromuscular disorders, and certain types of non-ambulatory patients.
 - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged 1:1 that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions
- High Acuity Patients: Certain patients will be flagged by management as high acuity patients. This means that under normal circumstances, it is preferable to not have the tech working alone on this particular shift. The types of patients most likely to be flagged as high acuity are from the patient populations listed above in the 1:1 section, as well as patients with severe mood disorders, patients with severe anxiety, and patients at high risk for coronary events. High acuity flagging differs from 1:1 flagging in that a tech assigned a high acuity patient will not necessarily have just one patient.
 - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged high acuity that does not have any of the above listed conditions,

and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

The Neurodiagnostics and Sleep Center staff consists of a Manager, Supervisor, EEG technicians, RPSG technologists, and PSG therapists.

- A sleep technologists to patient ratio can be 1:1, 1:2 or 1:3 depending on prescreened acuity/age of patient.
- An onsite staffing ratio of 2:1 is maintained during patient care hours.
- Flex Staffing Explanations: When units of service decrease, staff is canceled. When units of service increase, hours are rotated to cover testing. Outpatients can be rescheduled. Overtime is used only when necessary.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: two technologists.

VIII. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service, do the right procedures, treatments, interventions, and care by following evidenced based policies and practice standards that have been established to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVHMC staff will design, implement and evaluate systems and services for care / service delivery which are consistent with a "Patient First" philosophy and which will be delivered:

- With compassion, respect and dignity for each individual without bias.
- In a manner that best meets the individualized needs of the patient.
- In a timely manner.
- Coordinated through multidisciplinary team collaboration.
- In a manner that maximizes the efficient use of financial and human resources.

SVHMC has developed administrative and clinical standards for staff practice and these are available on the internal intranet site.

IX. CONTRACTED SERVICES

Contracted services under this Scope of Service are maintained in the electronic contract management system.

X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Respiratory Care, Neurodiagnostics and Sleep Center support the SVHMC's commitment to continuously

improving the quality of patient care to the patients we serve and to an environment which encourages performance improvement within all levels of the organization. Performance improvement activities are planned in a collaborative and interdisciplinary manner, involving teams/committees that include representatives from other hospital departments as necessary. Participation in activities that support ongoing improvement and quality care is the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care / service(s) provided meet the customers' needs through any one or all of the quality improvement practices / processes determined by this organizational unit.

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Respiratory Care, Neurodiagnostics and Sleep Medicine Departments will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Unit based measurement indicators are found within the Quality dashboard folder.

Attachments

 [Manager- Respiratory Care](#)

 [Supervisor- Sleep/Neuro Diagnostics](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep	11/2024

Standards

No standards are associated with this document



Last Approved N/A
Next Review 2 years after approval

Owner Philip Katzenberger:
Director HIM/
Privacy Officer
Area Patient Care

SVH Policy for Photography

I. POLICY STATEMENT

- A. To protect the privacy of SVH employees, patients, volunteers, and visitors

II. PURPOSE

- A. To guide staff in the procedure to be followed for:
1. Photography of a patient/PHI for internal purposes of diagnosis, treatment or for the hospital's own healthcare operations.
 2. Photography of a patient/PHI for external purposes that will be heard or seen by the public (for example: commercial filming, television programs, marketing, etc.).
 3. Photography at the Patient's/Legal Representatives request.

III. DEFINITIONS

- A. Photography/photograph are meant to include video / audio or still photography, in digital or any other format, and any other means of recording and reproducing images, using video cameras, cellular telephones, tape recorders, wearable technology (e.g., Google Glasses, body cam), or other technologies capable of capturing audio or transmitting image and/or sound for monitoring purposes. This does not include medical imaging such as MRIs, CTs, Laparoscopy equipment, etc. or images of specimens.
- B. Publication means any method of displaying or distributing photographs/photography, including simply showing the photographs/photography to one or more individuals.

IV. GENERAL INFORMATION

- A. Salinas Valley Health Medical Center (SVHMC) allows photography on patients who desire to have photography taken providing the act of photography does not interfere with operations or the privacy of other individuals.

- B. Any case that differs from this policy is to be approved by Administration prior to allowing any photography.

V. PROCEDURE

- A. Before engaging in the production of photography, anyone who is not already bound by the hospital's confidentiality policy must sign a confidentiality statement to protect the patient's identity and confidential information before the production of photography.
- B. Employees are not to use their personal photography devices, such as cell phones, tablets, etc. to take photographs of patients or PHI. SVHMC is to provide equipment for the purposes of photography, exception see E.4
- C. **Patient/Legal Representative Request for Photography / Audio Recording (Includes FaceTime, Skype, Hangout, etc.):**
 - 1. **If a patient/legal representative desires to have photography and/or audio recording taken of themselves or if parents request that pictures/audio be taken of their hospitalized child (non newborn), staff may comply with this request provided the following:**
 - a. Patient is not in a two-patient room
 - b. Photography/audio does not include other patients and/or their visitors.
 - c. Staff is not to use their personal device.
 - d. The act of taking the photographs/audio does not interfere with SVHMCS operations or patient care.
 - e. Photographs/audio does not include staff or providers as they perform their job functions.

Note: California law prohibits the recording of any "confidential communication" without the consent of all parties. It is important that other patient's privacy is respected if a patient is using software programs that capture the audio of others in the room. SVHMC cannot control when and what photographs/audio is taken by the patient/family/friends. Therefore photographs/audio is not to be allowed in a two-patient room when the second patient is in the room. Photography taken without a person's consent will be requested to be destroyed. If refused, Risk Management is consulted.

If a patient/legal representative or family requests, staff and providers may at their discretion participate in group photography **if they are not providing care or performing job functions at the time of the photography**. Staff and providers are not obligated to participate in any photography that is not job related.

- D. Patients and visitors are not to Photograph the following individuals:
 - 1. Other patients and their family/visitors. (This includes situations where there are two-patients in a room.)
 - 2. Employees / LIP/ or anyone providing services for SVHMC.

E. Photography for Purposes of Patient Treatment or Health Care Operations:

1. Photography of patients for the purposes of diagnosis and treatment or for the Health System's operations is permitted if the patient has signed the "Conditions of Admission". Examples of operations include:
 - a. Patient Identification
 - b. Peer Review
 - c. Education & Training Conducted by SVHMC
2. Check the patient's medical record for a signed "Conditions of Admission". The "Conditions of Admission" is to be used as the patient's consent to photography for the purpose of treatment and operations.
3. If the "Conditions of Admission" form in the patient's medical record cannot be located or if it cannot be signed due to the patient's condition, the patient is to sign the Consent to Photography (Form #8610-021386). Again, this form is only for treatment and operations. The original is to be placed in the patient's medical record and a copy given to the patient.
4. Employees are allowed to use photography, utilizing patient's own equipment, to accomplish a specific job function, if requested by the patient / surrogate decision maker. This activity is to be approved by the unit manager / director / designee. (Example: Teaching patient how to care for a wound that is not readily visible because the wound is located on their back.)

F. Photography for Purposes Other Than Treatment or SVHMC Health Care Operations:

1. The consent and authorization of the patient or legal representative is to be obtained for any SVHMC photography that is other than for treatment and operations. Use the Consent to Photograph and Authorization for Use or Disclosure (Form #8610-021386).. Examples for use of this form:
 - a. Commercial Filming
 - b. Television/ Cable Programming
 - c. Marketing
 - d. Non internal Educational Events
 - e. Publications
2. The person who obtains the consent must explain the following:
 - a. What the particular use of the photography will be and note if the patient has any restrictions regarding the use of the photography.
 - b. The patient has the right to request cessation of the production of the photography before it is used. SVHMC will accommodate this request.
 - c. The patient has the right to rescind the consent for photography. The patient must notify SVHMC in writing and submit it to Health Information Management, 450 East Romie Lane, Salinas, CA 93901. This information is also listed for the patient on page 2 under the "My Rights" section of the Consent to Photography and Authorization for Use or Disclosure form

G. Photography of Patients by News Media or Law Enforcement Agencies

When representatives of either the news media or law enforcement agencies request to photograph a patient, such permission may be given if:

1. In the opinion of the attending physician, the patient's condition will not be jeopardized; and

The patient or legal representative consents to have the photography taken by signing the Consent to Photography and Authorization for Use or Disclosure form.

2. Law Enforcement is seeking to identify the patient. Contact Security or Risk Management to inform them of the event.

H. Consent Forms

1. The consent forms must be signed and dated by the patient or the patient's legal guardian (see [CONSENT TO SURGERY OR SPECIAL THERAPEUTIC OR DIAGNOSTIC PROCEDURE\(S\)](#)). The original consent is to be placed in the patient's medical record and a copy given to the patient.
 - a. Signature of the patient must be witnessed and the witness must sign in the space provided.
 - b. If a patient is unable to make their own medical decisions, and there is no legal representative and it becomes necessary to photograph such patient for purposes other than diagnosis or treatment, Risk Management is consulted to determine if legal counsel is needed.

2. Duration of Consent Form

New consent form is required for each new series of photography for external use and for photography taken by persons other than those named in prior consents. Consents given for the use of photography will remain valid until the patient or their legal representative withdraws the consent or restricts the authorization for future use.

I. General publication or Patient Activities

In the event photography will be used in a general publication or patient activities at SVHMC and the use of the photography was not specified at the time the photograph was taken, the patient or patient's legal representative must be contacted and given the opportunity to object. The photograph remains with the originator. The documentation of the contact will remain in the patient's medical record as to whether the patient did or did not object. The record of this contact will be filed in the patient's medical record. If consent for use cannot subsequently be obtained, the photography is to be destroyed or the non-consenting patient must be removed from the photography.

J. Photography of Newborns

Refer to Policy [PHOTOGRAPHIC, AUDIO AND VIDEO RECORDING OF CHILDBIRTH](#)

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed.

VII. REFERENCES

- A. **California Hospital Association (CHA) Consent Manual**
- B. The Joint Commission Standards Rights and Responsibilities of the Individual
- C. CMS 482.13(c)
- D. Title 22 California Code of Regulations, Section 70763
- E. Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information 45 CFR Part 164

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	12/2024

Standards

No standards are associated with this document



Last N/A
Approved
Next Review 3 years after approval

Owner Judi Melton:
Director
Materials
Management
Area Administration

Vendor, Contractor, and Agent Participation in Hospital Compliance

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. This policy applies to vendors, agents and/or representatives to assist in understanding and complying with the Salinas Valley Health Medical Center (SVHMC) Standard of Conduct and departmental policies and procedures with which they should be knowledgeable. Documentation of agreement and understanding shall be obtained via Facility Access Program prior to initiation of any new contracts and during renewal and/or re-negotiation of any contracts. All documentation will be renewed periodically unless specifically stated by contract.

III. DEFINITIONS

- A. Vendor and contractor shall encompass any business entity or individual conducting business with or at the Hospital and all individual representatives of any such business or individual.
- B. Standard of Conduct establishes guidelines for expected behavior in complying with internal and external rules and regulations. [STANDARDS OF ETHICAL BUSINESS PRACTICES](#)
- C. Access badges are electronic badges provided by the Hospital that allow access to parking facilities and passage through electronic security devices.
- D. Security badges are paper documentation provided via Facility Access Program indicating compliance with hospital policies and procedures as well as compliance with regulatory requirements.
- E. Contracted services encompass businesses, individuals and/or groups of individuals that contract with the hospital to perform or conduct specific services or processes, but are not

scheduled as part of the Hospital workforce. For example, security, scribes, perfusionists and valet parking employees provide contracted services.

IV. GENERAL INFORMATION

- A. SVHMC informs and documents agreement of vendors, contractors, agents and/or representatives as to the content, value and responsibilities of the Standard of Conduct and pertinent hospital compliance policies and procedures. SVHMC ensures business conduct is consistent with organizational values and requirements such as those deemed by regulatory agencies.
- B. Exemptions to following this process include all federal, state and local government agencies and their representatives, all accrediting bodies, financial institutions, publishers, academic institutions, legal, financial, and insurance service providers for the hospital, and professional organizations. Organizations to which the hospital makes charitable donations and/or provides financial support may be exempted at the direction of the CEO/President and/or a member of Administration for the hospital.
- C. It is preferred that vendors and/or representatives will make an appointment with the individual(s) with whom they wish to meet. All appointments must be approved by the relevant department head.
- D. Badges - Vendors are required to wear an approved **badge** prior to entering any department.
 - 1. **Hospital badge** - All hospital access badges are managed by the Human Resources department and when noticed by the Department Leader are deactivated when they are no longer needed. Human Resources manages this deactivation in accordance with established termination procedures.
 - 2. **Facility Access Program badge** - On-site representatives or agents must log onto the Facility Access Program website to print a security badge and log out each day when leaving the Hospital. Badges may only be printed at the Hospital and must be worn while on-site.
 - a. Badges may be printed at the Hospital by registering and logging into the Facility Access Program website, using designated kiosks in various departments. If working at an off-site location, Facility Access Program badge is not required, however the department director or designee is responsible for validating current credentials in Facility Access Program.
- E. Vendors and contractors requiring or needing access to any SVHMC information system is limited to authorized access only. This includes, but is not limited to, our wireless network, telecommunications infrastructure and data network. [SYSTEM AND APPLICATION SECURITY ACCESS PROCEDURE](#).
- F. Vendor compliance and performance/behavior in conducting business with and at the Hospital shall be evaluated by the contract leader/designee using the Vendor Evaluation Form in the electronic contract evaluation system. Additionally an evaluation will be completed when there is reason for concern about the practice, communications, performance or skill level for any vendor.

[CONTRACT MANAGEMENT](#)

V. PROCEDURE

A. Facility Access Program - Preregistration

1. Department director or designee to refer all new or prospective vendors and contractors to GHX for Facility Access Program registration.
2. Department director or designee ensures that on-site individuals for contracted services have completed registration with Facility Access Program and have obtained the appropriate badge. If a Hospital badge will be utilized refer to Human Resources to process in accordance with established procedures.
3. When a decision is made to do business with any vendor or contractor (that will result in invoicing and payment), the individual must complete an Accounts Payable Vendor Data Form available from the Accounting department.

B. Facility Access Program - Post-registration

1. Facility Access Program require vendor with missing or incorrect vendor badge to log in and obtain a badge at the hospital Facility Access Program kiosk prior to entering department(s) for conducting any business or meetings. Kiosks are located in Engineering and the Front Lobby of the hospital.
2. Notify department director or designee of any department specific non-compliance issues.
3. Refer any vendor who is unable to obtain a current vendor badge to Materials Management, who will be determine how to proceed with facility access.

C. Hospital access badge

1. Individuals experiencing regularly scheduled business at the hospital, being on site for 30 or more days, or experiencing special circumstances may obtain photo identification security badges from the Human Resources Department at the direction of senior management once Facility Access Program compliance is verified.
2. Obtain and complete [Vendor Badge Request Form](#) (available on intranet, STARnet) indicating date for which access is needed, what type of access is needed and the person requesting the access.
3. Forward the form to Human Resources Department. Once Facility Access Program compliance is verified, a Hospital access badge will be issued.
4. When badge is no longer required, the Department Leader will activate termination procedures and return access badge to Human Resources who will deactivate badge in accordance with Human Resources termination procedures.

D. Monitoring

1. All staff is responsible to ensure vendors wear the appropriate identification. Vendor badges will include the date, time, department visited, vendor company, individual name and photo identification.
2. Contracts and Facility Access Program reports are monitored by Department

Director (or designee) to ensure documentation is obtained and correctly maintained.

3. The Human Resources department will monitor specific vendor and contractor credentialing under their purview.

E. Documentation:

1. Documentation of participation in this policy is through the inclusion of compliance language in contracts, compliance reports from the Facility Access Program.
2. Documentation in the Facility Access Program system will provide supporting documentation of education and an attestation to the vendors' understanding of this policy.

- F. Vendors, contractors and/or agents are educated about the Hospital's compliance requirements through the Facility Access Program, and/or Human Resources. Department leaders are responsible to assure vendors are oriented to unit specific requirements.

VI. EDUCATION/TRAINING

- A. Education and/or training is provided as needed

VII. REFERENCES

- A. The Joint Commission (TJC) Security Standards
- B. Office of the Inspector General Compliance Program Guidance for Hospitals
<https://oig.hhs.gov/documents/compliance-guidance/798/cpghosp.pdf>
- C. The Heath Insurance Portability and Accountability Act of 1996 (Public Law 104-191)

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	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Judi Melton: Director Materials Management	11/2024

Standards

No standards are associated with this document

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

*QUALITY AND EFFICIENT
PRACTICES COMMITTEE*

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

(CATHERINE CARSON)

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)

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board Approval of Initial Project Cost Estimate and Award Contract to John A. Martin & Associates, Inc. for the Seismic Retrofit Project

Executive Sponsor: Clement Miller, Chief Operating Officer

Date: January 20, 2025

Executive Summary

Senate Bill 1953 (SB1953) requires all acute care hospitals that wish to remain in operation beyond January 1, 2030, to meet specific structural (SPC) and non-structural (NPC) rating. Retrofit will be required to certain elements of the hospital to meet rating requirements to remain in operation. The goal of SB1953 is to help ensure that hospital buildings are not only capable of remaining intact after a seismic event, but also capable of continued operations and can provide acute care medical services after a seismic event. John A. Martin & Associates, Inc. (JAMA) is the selected structural engineer of record (SEOR) that will be tasked to evaluate, design, and once permitted, oversee the construction/retrofit work which will be completed by a future Design-Builder. The SEOR will be assigned to the Design-Builder in a subsequent phase to be part of that team to further complete the design and retrofit work associated with Seismic Retrofit Project. The total estimated cost of Seismic Retrofit Project is \$62,500,000, inclusive of both hard and soft costs. Agreement for SEOR is included in the estimated project cost and is broken into two phases with a contract value of \$3,100,000. Bogard Construction will be SVH's representative and Kitchell CEM will be the construction manager and oversee all activities.

Background/Situation/Rationale

The Seismic Retrofit Project is set to address various structural and non-structural deficiencies in the existing main hospital, which will remain operational during all renovation work. The Project is subject to HCAI 1 jurisdiction and includes the following:

1. Seismic Retrofit of Buildings 1 and 2. Seismic retrofit of existing buildings for compliance with SPD-4D includes external strengthening around the main tower, external buttress structure and connections to roof structure around building 2, selective wall reinforcements around main tower (shear walls), pediatric addition reinforcement (3rd floor exterior shear walls and roof connection), rehab addition reinforcement (4th floor exterior shear wall and roof connection), elevator tower addition mitigation, miscellaneous localized interventions including increasing building seismic separation.
2. Non-structural Performance Category (NPC) resolution. Work includes the completion of all non-structural and structural compliance documents required for acute care facilities. Current planning desires NPC-4 or NPC-4D Level 1 compliance for areas permitted to be deferred in the Article 11 of the CBC 2019. The nonstructural performance evaluation shall require the SEOR in collaboration with others to examine the respective critical nonstructural systems and elements for the planned NPC as specified in Table 11.1, "Nonstructural Performance Categories". Elements found to be deficient will be retrofitted accordingly to meet current seismic requirements.

In addition, project will incorporate needed elements to meet NPC-5 compliance which will require planning, design and installation of multiple emergency water supply underground tanks, liquid waste and sewage storage underground tanks and upsizing of the existing fuel tank for the emergency generator to maintain electrical power capacity to supply 72 hours of power. Multiple locations for underground tanks will be required due to various points of connection to utility purveyors on campus.

3. Replacement of Rotary UPS Building (Building 17). Building 17 is approximately 475 square-foot building located on the rear of the hospital campus adjacent to the hospital's maintenance yard. Building is scheduled to be demolished and rebuilt as building would require extensive repairs to meet current seismic requirements. As such, services currently provided within building will be relocated during construction and a new structure will be built meeting current building requirements for a space that provides support to critical care areas within the hospital.

The Project in its entirety will be delivered via design-build delivery method. The Administration selected the Design-Build procurement method for delivery of the Seismic Retrofit Project for its many benefits among which is generally a more streamline design and fast-track construction process. Unlike a traditional Design, Bid, Build (DBB), the Design-Build model allows for a single contract where the contractor and design team work together as a single entity leveraging the experience of each to deliver the best possible project given a certain set of parameters. SEOR will be assigned to the Design Builder and continue as the Structural Engineer of Record throughout the design, construction, commissioning, and close-out of the project.

SEOR scope of work will be proceeding under two phases:

Phase 1: SEOR is tasked to complete the following prior to Design Builder engagement:

- a. Evaluation of existing building components as it relates to the non-structural performance category (NPC) effort to comply with Senate Bill (SB1953). The effort includes evaluation of all seismic anchorage or bracing of non-structural items within critical care areas and preparing/assembling NPC-4 and NPC-4D self-declaration packages, and NPC-4D evaluation reports for each acute care building on campus for HCAI SCU submission by the January 1, 2024, deadline. In addition, for all deficient items SEOR will complete Schematic Design which will be subsequently completed under Phase 2 with Design Builder.
- b. Construction documents and Construction Administration services for the anchorage of equipment in the Histology department in preparation of NPC-4 self-declaration.
- c. Construction documents and Construction Administration services to support the enlargement of the seismic joint between the Dietary Building and the Original Building per details on SPC-4D retrofit set.
- d. Complete Schematic Design for Buildings 1 & 2 with HCAI SCU approval of proposed retrofit to achieve SPC-4D upgrade.
- e. Structural analysis to determine alternate means of compliance for Rotary UPS building (Building 17). The alternative approach will take into consideration the Hospital's request to minimize the impact to the currently operating equipment within the building.

Phase 2: Following Design Builder engagement and selection, SEOR will become part of the Design-Builder team and with coordination with other architects/engineers will complete all design documents, prepare the structural portion of the TIO, and prepare structural construction documents for permit, provide services during construction administration, commissioning, and close-out for the following:

- a. Seismically brace below ceiling components (in five seismically separated buildings) as well as source equipment (located in various other buildings) that have deficient anchorage and require retrofit including criteria for above ceiling bracing as needed to meet Title 24 requirements.
- b. Continue structural engineering services to accomplish SPC-4D upgrades for Building 1 & 2.

Timeline/Review Process to Date:

SEOR scope of work began under the umbrella of HOK who was contracted for professional engineering design services and awarded a contract on May 18, 2016, (Master Plan Project) which included three major components with one of them being on-going seismic retrofitting of existing buildings to a new category (Seismic Performance Category 4D). Under this contract, SEOR completed studies for SPC-4D compliance of Buildings 1 & 2 which is the basis (criteria documents) for SPC related scope of work and this agreement being the continuation of those initial efforts.

Over the last several months, the Administration has further generated criteria documents outlining the parameters and goals for the project in achieving SPC & NPC compliance. Criteria documents will help inform overall project scope that will be addressed within the Seismic Retrofit project. On project completion, the hospital will meet Title 24 requirements and be able to remain in operation and continue providing services beyond January 1, 2030.

In accordance with Public Contract Code, the Administration will be proceeding with a two-step process for Design Builder selection. The first step began on October 18, 2024, with the issuance of a Request for Qualifications ("RFQ Part 1"). On November 22, 2024, the administration received submissions in response to the RFQ Part 1. The RFQ's were review by committee and using best value scoring criteria and scoring matrix to determine the three highest scoring Design Build teams. The three highest scoring Design Build teams were given the opportunity to proceed onto the next step and provide a formal proposal for the project. The Request for Qualifications – Part 2 ("RFQ Part 2") was released on December 20, 2024, and proposals are expected on February 26, 2025. The RFQ Part 2 selection committee will conduct interviews with each of the three Design Build teams and complete a best value scoring matrix

to determine the highest-ranking team. The Administration will then proceed to negotiate with the top ranked firm to provide design and construction services for the project.

Upon Board approval and execution of the Design Build agreement, selected Design Build team will proceed with completing the design documents necessary to acquire the regulatory approvals and permits from the local jurisdictions and agencies. The design process is expected to be completed by December 31, 2025 for NPC (non-structural) scope which will be followed by SPC (structural) scope in 2026.

Permitting and subsequent construction of the project is anticipated to commence in 2026 and be complete by end of calendar year 2027. Make ready work, which includes relocation of IT infrastructure in Building 17, Fire Sprinkler Retrofit, and NPC-5 related tanks may begin in late 2025 and proceed through 2027. This work is a precursor to the start of construction for the larger Seismic Retrofit work anticipated to begin in mid-2026.

All work will be part of CIP #01.1250.3273

Meeting our Mission, Vision, Goals

It is the mission of Salinas Valley Health (SVH) to provide quality healthcare to our patients and to improve the health and well-being of our community.

Pillar/Goal Alignment:

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

Financial Implications

The essential terms of the proposed Professional Services Agreement (structural engineering) are as follows:

- Phase 1 (Pre Design-Builder Engagement) Services: \$630,000.00
- Phase 2 (Post Design-Builder Engagement) Services: \$2,470,000.00
- TOTAL NOT-TO-EXCEED AMOUNT: \$3,100,000.00**

Cost for Architectural and Engineering services is included within Seismic Retrofit Project Budget with breakdown as follows:

Soft Costs: \$13,978,086

- Costs from preliminary seismic efforts
- Program and Construction Management Services
- Permit, Utility Fees (relevant Authorities Having Jurisdiction)
- Inspection and Material Testing
- Architectural and Engineering Support Services (Criteria/Bridging Documents)

Hard Costs: \$48,521,914

- Design Fees & Contingency
- Construction costs & Contingency

Total Project Budget: \$62,500,000.00

Schedule/Milestones:

October – November 2024: - Design-Builder Request for Qualification (RFQ Part 1) process.
December 2024 – February 2025: Design-Builder Request for Qualification (RFQ Part 2) process.
January 1, 2026: Complete drawing package and submittal to HCAI (NPC deadline).
January 1, 2028: Obtain building permit for NPC scope of work (NPC deadline).
January 1, 2030: Complete all construction for both SPC & NPC scope of work.

Budget: Current Seismic Retrofit project cost estimate is \$62,500,000, which aligns with prior project cost estimates presented. Following Design Builder engagement and preliminary design is complete, a new cost estimate will be generated, and a reconciliation of the budget will be completed to ensure alignment cost projections. A summary of the project cost estimate is included with this Board Paper as Attachment 2. Current actual expenditure to date on the planning and design of the project is \$3,239,045 as of end of December 2024 (part of CIP #01.1250.3273 & 01.1250.3270).

Recommendation

Consider recommendation for Board Approval (i) the total estimated project cost for the Seismic Retrofit Project in the budgeted amount of \$62,500,000 and (ii) the contract for \$3,100,000.00 to John A. Martin & Associates, Inc. for structural design services for the Seismic Retrofit Project at the main hospital campus.

Attachments

- Attachment 1: Professional Services Agreement between Salinas Valley Health and John A. Martin & Associates, Inc.
- Attachment 2: Estimated Project Cost/Budget, December 2024

Professional Service Agreement

(Structural Engineering)

THIS AGREEMENT ("Agreement") is made as of March 31, 2021 ("Effective Date") between Salinas Valley Health and John A. Martin & Associates. ("Designer") for structural engineering services ("Services") in connection with the SB 1953 non-structural compliance at the Salinas Valley Medical Center ("Project") in accordance with the Contract Documents. This Agreement supersedes Designer's former agreement with HOK Architects dated May 18, 2016, which was subsequently amended March 31, 2021 for structural retrofit (inclusive of amendments thereto).

The following Exhibits are incorporated into this Agreement by reference.

Exhibit 1	Definitions
Exhibit 2	Scope of Services
Exhibit 3	Fee Schedule and Billable Rates
Exhibit 4	Insurance Requirements

By executing this Agreement, each of the Signatories represents that he or she has authority to bind the Party on whose behalf his or her execution is made.

Salinas Valley Health:

By: _____

Allen Radner, MD,
President/CEO

Email: aradner@salinasvalleyhealth.com

Designer:

John A. Martin & Associates, Inc.

By: _____

Shane Fitzgerald, Principal

Email: fitzgerald@johnmartin.com

CA License No.: 4757 (Structural)

THE PARTIES AGREE TO THE FOLLOWING TERMS AND CONDITIONS.



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BUSINESS TERMS SHEET

Salinas Valley Health Representative	Allen Radner, MD – President/CEO aradner@salinasvalleyhealth.com
Salinas Valley Health's Project Manager	Dave Sullivan, Bogard Construction dsullivan@bogardconstruction.com (831) 246-2073
Salinas Valley Health's Construction Manager	Omar Galvan, Kitchell CEM Incorporated ogalvan@kitchell.com (415) 672-7302
Designer's Principal	Shane Fitzgerald, John A. Martin & Associates fitzgerald@johnmartin.com (213) 220-5916
ME Engineer of Record ("MEEOR")	Jon Inman, Mazzetti Jinman@mazzetti.com (415) 652-4581
Type of Service	Structural Engineering Services
Fee	\$3,100,000.00
Deliverable Schedule	See Exhibit 2
Minimum Insurance Limits for Designer	See Exhibit 4
Workers Compensation/Employers' Liability	California Statutory Limits Employers' Liability \$1,000,000 each accident
Commercial General Liability	\$1,000,000 per occurrence \$2,000,000 in aggregate \$1,000,000 personal/advertising injury
Professional Liability (E&O)	\$2,000,000 per occurrence \$5,000,000 in aggregate
Automobile	\$1,000,000 each accident



1. DEFINITIONS

1.1 Defined Terms. Defined terms and titles of Exhibits will be capitalized throughout the Agreement and any Exhibits to the Agreement. The definitions for this Agreement are set forth in alphabetical order in Exhibit 1.

2. PROJECT AND RELATIONSHIP OF THE PARTIES

2.1 Project Description. The Project is a renovation to an existing hospital, which will remain operational during all renovation work. Project will be proceeding under two phases; Phase 1 includes all of the evaluation and reporting work (pre Design-Builder engagement) and Phase 2 captures the design/construction document creation, construction, and subsequent close-out (post Design-Builder engagement). Phase 2 of the project will be assigned to future Design-Builder. The Project is subject to HCAI 1 jurisdiction and includes the following.

2.1.1 Seismic Retrofit of Buildings 1 and 2. Seismic retrofit of existing buildings for compliance with SPD-4D includes external strengthening around the main tower, external buttress structure and connections to roof structure around building 2, selective wall reinforcements around main tower (shear walls), pediatric addition reinforcement (3rd floor exterior shear walls and roof connection), rehab addition reinforcement (4th floor exterior shear wall and roof connection), elevator tower addition mitigation, miscellaneous localized interventions including increasing building seismic separation.

2.1.2 Non-structural Performance Category (NPC) resolution. Work includes the completion of all non-structural and structural compliance documents required for acute care facilities. Current planning desires NPC-4 or NPC-4D Level 1 compliance for areas permitted to be deferred in the Article 11 of the CBC 2019. The nonstructural performance evaluation shall require the Designer in collaboration with others to examine the respective critical nonstructural systems and elements for the planned NPC as specified in Table 11.1, "Nonstructural Performance Categories". Elements found to be deficient will be retrofitted accordingly to meet current seismic requirements. In addition, project will incorporate needed elements to meet NPC-5 compliance which will require planning, design and installation of multiple emergency water supply underground tanks, liquid waste and sewage storage underground tanks and evaluation of the existing emergency electrical power capacity to supply 72 hours of back up emergency power. Multiple locations for underground tanks will be required due to various points of connection to utility purveyors on campus.

2.1.3 Replacement of Rotary UPS Building (Building 17). Building 17 is approximately 475 square-foot building located on the rear of the hospital campus adjacent to the hospitals maintenance yard. Building is scheduled to be demolished and rebuilt as building would require extensive repairs to meet current seismic requirements. As such, services currently provided within building will be temporarily relocated during construction and a new structure will be built meeting current building requirements for a space that provides support to critical care areas within the hospital.

2.1.4 The Project in its entirety will be delivered via design-build delivery method. Designer will be assigned to the Design Builder and continue as the structural engineer of record throughout the design, construction, commissioning, and close-out.



2.2 Relationship of the Parties. Until Designer is assigned to the Design Builder, Designer's relationship with Salinas Valley Health is that of an independent contractor whose involvement in the Project is to provide design services, and not as an agent, fiduciary, partner, member of, subsidiary of, or otherwise affiliated with the Salinas Valley Health. Designer accepts the relationship of trust and confidence and agrees to fully cooperate with the Salinas Valley Health's Representative and Salinas Valley Health's Project Manager and Construction Manager, and to act in good faith and to exercise its skill and judgment in furthering the interests of the Salinas Valley Health. Designer will furnish efficient business administration and supervision related to coordination of its Services and will use Designer's best efforts in performing all Services in the most expeditious and economical manner consistent with the Contract Documents.

3. PROJECT TEAM AND RESPONSIBILITIES

3.1 Salinas Valley Health. Salinas Valley Health is the owner of the Project and is responsible for the following:

3.1.1 Salinas Valley Health will pay for all design review approval, entitlements, easements, assessments and fees required by governmental approval for development of the Project.

3.1.2 Salinas Valley Health's or its Construction Manager will provide the Designer with available information regarding the Project.

3.1.3 All requests for approval must be in writing to the Salinas Valley Health with a copy to the Salinas Valley Health's Project Manager and Construction Manager. Approval by Salinas Valley Health's Representative or Salinas Valley Health's Construction Manager of any Services will not relieve Designer from any of its respective obligations or liabilities for the technical or professional adequacy of its Services.

3.1.4 Salinas Valley Health reserves the right to perform administration and operations related to the Project with its own forces, and to award contracts in connection with the Project. Designer will notify the Construction Manager if any such independent action will interfere with Designer's ability to perform its Services.

3.1.5 Upon contract award of the Design Builder, Salinas Valley Health will assign this Agreement to the Design Builder, and novate any obligations for future direct payment to Designer for Services subsequent to the effective date of assignment.

3.2 Project Team Members.

3.2.1 Salinas Valley Health Representative. The Salinas Valley Health Representative is identified in the Business Terms Sheet. The Salinas Valley Health Representative is authorized to act on Salinas Valley Health's behalf and has authority to sign Amendments to this Agreement up to an amount of \$25,000 per occurrence. Any request exceeding \$25,000 will require Salinas Valley Health's Board of Directors approval and must be timely submitted to Salinas Valley Health by Designer in order to allow proper consideration during the board's regularly scheduled meetings.



3.2.2 Salinas Valley Health's Project Manager. Salinas Valley Health's Project Manager is identified in the Business Terms Sheet. The Project Manager will provide support to this Project. The Project Manager will interface with the Construction Manager and Salinas Valley Health and is responsible for coordinating campus activities that impact hospital operations. The Project Manager does not have the authority to execute Amendments to the Agreement or bind the Salinas Valley Health

3.2.3 Salinas Valley Health's Construction Manager. Salinas Valley Health's Construction Manager is identified in the Business Terms Sheet. The Construction Manager is authorized to coordinate and direct Services and act on the Salinas Valley Health's behalf with respect to the daily operations of the Project but does not have the authority to execute Amendments to the Agreement or bind the Salinas Valley Health.

3.2.4 Salinas Valley Health's MEEOR. Salinas Valley Health's mechanical/electrical engineer of record is identified in the Business Terms Sheet. The MEEOR will remain the design professional of record through preparation of the basis of design for the NPC compliance requirements as part of the criteria documents or bridging documents issued for proposal to design builder. It is anticipated that mechanical, electrical, and plumbing will be delivered through use of design build subcontractors. Designer will coordinate and collaborate with the MEEOR as necessary with respect to its Services as further defined in Exhibit 2.

3.3 Communications. Designer may communicate directly with the MEEOR but otherwise will communicate directly with, and coordinate its Services through the Construction Manager. The Construction Manager must be copied on all written communications between the MEEOR and Designer. The Project Manager must be copied on written communications. The Project Manager and Construction Manager will update Salinas Valley Health as appropriate.

4. DESIGNER'S SERVICES

4.1 Scope of Services. Designer will perform all Services described in Exhibit 2. Services generally include preliminary structural evaluation of existing facilities, field investigation to confirm existing conditions, schedule and participate in meetings with HCAI to discuss overall approach for SPC compliance, and preparation of structural narrative and basis of structural design for incorporation into the criteria documents that will be used for solicitation of Design Builder. Upon award of Design Builder, Designer will complete all design documents, prepare the structural portion of the TIO, and prepare structural Construction Documents for permit, provide Services during construction administration, commissioning, and close-out. Designer may be directed to perform additional services by Amendment, pursuant to the terms of Section 5.2.

4.1.1 Coordination. Designer will coordinate its Services with those services or work provided by the other Project Team Members.

4.1.2 Project Staffing and Key Personnel. Designer's personnel and their respective positions and billing rates are set forth in Exhibit 3. Unless otherwise requested by Salinas Valley Health, key personnel may not be removed from, or added to, the Project without the prior written consent of Salinas Valley Health except for death, disability, or departure of person from employment. If a replacement is necessary, the proposed key personnel will have



substantially equivalent or better qualifications than the form principal or employee, and all candidates are subject to final approval by Salinas Valley Health.

4.2 Principal. Designer will name a principal whose duties include, without limitation, directing and coordinating the Services of Designer. The principal will represent Designer, and all communications given to the principal will be deemed to have been delivered to Designer. The principal is identified in the Business Terms Sheet.

4.3 Licensure. Designer represents that Designer is a California state licensed professional engineer, qualified to practice structural engineering services, and is in good standing and qualified to do business in the State of California.

4.4 Standard of Care. Designer will timely perform all Services in a professional manner consistent with the degree of care of other licensed professional engineers performing structural engineering services in the State of California for projects of similar size, scope, and complexity.

4.5 Compliance with the Law. Designer will provide all notices, and perform all Services, in accordance with all Applicable Law.

4.5.1 Hospital Safety Act of 1983. This Project is subject to the Hospital Safety Act of 1983. Designer will comply with all provisions and the applicable duties under the Hospital Safety Act of 1983 to the extent applicable to its Services.

4.5.2 Conflicts. Designer will use due care to identify conflicts between the meaning and effect of all Applicable Law, including building code requirements, codes, and regulations related to the Services contemplated under this Agreement. If Designer identifies such conflicts, Designer will provide written notice to the Project Manager and Construction Manager, and recommend a resolution.

4.6 Project Standards. Designer will identify and determine the meaning and effect of applicable building code provisions and other applicable building requirements and restrictions related to its Services.

4.7 Coordination with Governmental Authorities. Designer will manage and timely coordinate required design submissions, questions, and responses to applicable Governmental Authorities.

4.8 Schedule for Performance. Time is of the essence. Designer will diligently perform its Services for in accordance with the Deliverables Schedule set forth in Article 2 of Exhibit 2. Through the design and construction process, Designer will collaborate and coordinate its Services with services or work being performed by other Project Team Members. Designer may seek an adjustment in Fee due to an extension of time per Section 5.2, if Designer is delayed in completing its Services in accordance with the Deliverable Schedule (as may be amended through executed Amendment), for reasons beyond its reasonable control and provided that such delay requires an equitable adjustment in Fee and was not due to any negligent acts, errors, or omissions of Designer. Completion of design and Construction Documents, construction administration, and close-out portion of the Services will be in accordance with Design Builder's Project schedule.



4.9 Tier Consultants. There are no tier consultants for this Project.

5. COMPENSATION

5.1 Fee. Salinas Valley Health will pay Designer the lump sum amount set forth in the Business Terms Sheet for completing the Services described in the Contract Documents, subject to adjustment for additional services per Section 5.2. Designer's Billable Rates set forth in Exhibit 3, will be used for Fee adjustments due to additional services per Section 5.2 if the additional services are performed on a time and material basis. The Billable Rates will be calculated per Section 5.3. Designer will include a reasonable allowance within the lump sum amount for the reimbursable expenses as defined in Section 5.4. To the extent there is an overage in the allowance amount, an Amendment will be issued adjusting the Fee by the amount of the overage. All unused allowance amounts will accrue 100% to Salinas Valley Health before close-out through a deduction in Fee via Amendment.

5.2 Additional Services. Changes in the Services described in the Contract Documents that are not due to any negligent act, error, or omission of the Designer or for delays in the Schedule that impact Designer's Fee per Section 4.8, will either be performed on an hourly basis per the billable rates set forth in Exhibit 3, or on an agreed lump sum basis. Designer will provide Construction Manager with written notice and a rough order of magnitude of the additional services within 5 business days of discovering facts or circumstances giving rise to the additional services. If Services are to be performed on a lump sum basis, a complete cost proposal will be submitted within an additional 8 business days. Services performed on an hourly basis are subject to the billable rates set forth in Exhibit 3 and Sections 5.3 and 5.4. Additional services will only be authorized through executed Amendment.

5.3 Billable Rates. The Billable Rates will be effective for the duration of the Project. No salaried employee is allowed to bill more than 40 hours per week unless express written consent is provided by the Salinas Valley Health. The Billable Rates include the amount paid to employees as wages, including customary benefits (health insurance, long term disability, sick leave, pension, and vacation accruals) and taxes plus the Designer's overhead and profit. Designer's overhead and profit include, among other things: (i) profit for the Services rendered on the Project; (ii) salaries and other compensation of all home office personnel who are not directly assigned to this Project and specifically included in Exhibit 2; and (iii) home office general expenses including mortgage, rent, utilities, costs for computers (including hardware, servers, plotters, printers and software), cell phone charges, internet access, digital cameras, postage, office supplies, equipment, all required insurance, etc. Designer may charge for Services performed by employees who are not listed in Exhibit 3 upon approval by Salinas Valley Health, provided that employee's billable rates are consistent with the Billable Rates for other employees from the same discipline with the same title and level of experience.

5.4 Reimbursable Expenses. Reimbursable expenses necessary to perform the Services are limited to the following. Expenses are paid at actual cost incurred by Designer, without markup, and require backup submitted with invoices.

5.4.1 Miscellaneous costs incurred in the performance of the Services if, and to the extent, approved in advance in writing by Salinas Valley Health.



5.4.2 Mileage and transit time, if beyond a 50 mile radius from employee residence or office (whichever is closer) to the job site will be reimbursed based upon the Federal vehicle mileage rate in force at the time of travel. Travel time exceeding 4 hours round trip must be approved in advance in writing by Salinas Valley Health.

5.4.3 Per diem for Designer's personnel incurred while traveling related to the Project will be based upon the GSA rate for Monterey County for the applicable year.

5.4.4 Plotting and Reproduction. The expense of reproductions, postage, and handling of drawings, specifications and other Project documents.

5.4.5 Professional and/or presentation quality renderings, if requested by the Salinas Valley Health.

5.5 Non-Reimbursable Expenses. The following costs are not reimbursable.

5.5.1 All benefits and burdens not expressly included in the Billable Rates set forth in Exhibit 3.

5.5.2 Costs due to the negligence or failure of the Designer or anyone directly or indirectly employed by Designer for whose acts Designer may be liable, to fulfill a specific responsibility under the Contract Documents.

5.5.3 All other costs not specifically included in Sections 5.3 or 5.4.

5.6 Payments. Designer will invoice the Salinas Valley Health monthly for Services performed based on the schedule of values set forth below. Salinas Valley Health will remit payment within 30 days of receipt of invoice. Invoices must be submitted to the Construction Manager with a copy to the Salinas Valley Health's Representative and the Project Manager. Salinas Valley Health is not obligated to pay, or to see that payment is made to Designer's tier-consultants except as may otherwise be required by law.

5.6.1 Schedule of Values. The schedule of values is set forth in Exhibit 3.

5.7 Right to Withhold. Salinas Valley Health's Representative or its Construction Manager may refuse to approve a payment application, in whole or in part, or, because of subsequently discovered evidence that may nullify the whole or any part of a prior payment application to the extent Salinas Valley Health or its Construction Manager determines is necessary to protect Salinas Valley Health from loss due to, among other things, failure to perform Services in accordance with the Contract Documents; disputed amounts; or reasonable doubt that the Services can be completed within the NTE Amount set forth in the Business Terms Sheet, as adjusted through approved Amendment.

5.8 No Waiver. Payment by Salinas Valley Health will not constitute approval or acceptance of any Services included in the payment application or final acceptance or approval of that portion of the Services.



5.9 Audit Rights.

5.9.1 Salinas Valley Health may audit Designer's Project records at any time throughout the duration of the Services and for a period up to 3 years after final completion of the Services upon 10 business days' written notice. The audit will take place during normal business hours and will be coordinated with Designer. Designer will produce all financial records related to the Project such as payment applications and Amendments with back-up documentation and records deemed necessary by the Salinas Valley Health or its Construction Manager to substantiate charges related to the Services. Should the audit indicate that Designer's records were fraudulently or negligently prepared or maintained, Salinas Valley Health reserves the right to seek damages and legal remedies from Designer.

5.9.2 Medicare. To the extent required, and upon written request of Salinas Valley Health, Designer and any entity providing services to the Project will make available to the Secretary of Health and Human Services or the Comptroller General, or any of their duly authorized representatives, this Agreement and all Exhibits, books, documents and records that are necessary to verify the nature and extent of the cost of the Services for a period of 4 years after completion of Services when required by Section 952 of the Omnibus Budget Reconciliation Act of 1980. Designer will require each tier-consultant to comply with this provision regardless of how the party is being compensated.

6. INSURANCE AND LIABILITY

6.1 Insurance Requirements. Designer will obtain and maintain the insurance coverage in the amounts set forth in the Business Terms Sheet and based on the terms and conditions set forth in Exhibit 4.

6.2 Defense and Indemnification. Designer will defend, indemnify, and hold the Salinas Valley Health, and its members, Board of Directors, officers and employees, and the Salinas Valley Health's Project Manager and Construction Manager harmless from and against claims, damages, losses and expenses in law or in equity (including reimbursement of reasonable legal and expert witness fees and costs), arising out of, or resulting from, Designer's negligent acts, errors, or omissions in the performance of its Services including claims, damage, loss or expense attributable to bodily injury, sickness, disease or death, or injury to or destruction of tangible property, negligent exacerbation of Hazardous Materials, infringement of intellectual property rights, or violation of the law, but only to the extent that the claims arise out of, pertain to, or relate to the negligence, recklessness, or willful misconduct of Designer or anyone employed directly or indirectly by Designer or tier-consultants in connection with the Services provided under the Agreement (as amended) and for whose acts the Designer or tier-consultants may be liable.

6.2.1 Defense. Salinas Valley Health and Designer will defend their own respective claims under Sections 6.2 at their own cost and expense until liability is determined or settlement is reached under the dispute resolution process set forth in Article 7. After determination of liability or an agreed settlement under Article 7, the Designer and its tier-consultants will reimburse Salinas Valley Health for defense costs in proportion to the extent of their proportionate share of liability or settlement amount arising from claims, demands, causes of action, damages, costs, expenses.



6.2.2 Enforcement. Nothing contained in this Article 6 will be construed to impose any obligation in conflict with current California state law. In the event of a conflict with California State law, as may be amended, the Agreement will be modified to allow indemnification by Designer to the greatest extent permitted by law.

6.3 Hazardous Materials. Designer's Services do not include addressing Hazardous Materials. Designer will comply with, and use all reasonable efforts and practices to comply with Applicable Law and good business practices regarding Hazardous Materials. To the extent that Designer discovers Hazardous Materials while performing its Services, the Designer will immediately stop the work in the affected area and notify the Salinas Valley Health and its Construction Manager and Project Manager. Services in the area will not be resumed until after written authorization from the Salinas Valley Health or its Construction Manager stating that the condition has been rendered harmless.

7. CLAIMS AND DISPUTES

7.1 Notice. Either Party may initiate the dispute resolution procedures by providing a notice of claim. All claims must include a detailed factual narrative of events fully describing the nature and circumstances giving rise to the claim, including, a detailed breakdown of the amount of damages or costs associated with the claim. Claims will be submitted within 10 days following the discovery of the occurrence of the event or condition or circumstance giving rise to the dispute, whichever is later. Under no circumstances will a claim be made if it is barred by applicable statutes of limitation or repose.

7.2 Business Negotiation. The Parties will endeavor to first resolve their disputes through business negotiation. The business negotiation will be a face-to-face business meeting between senior management for all entities involved in the claim. Legal representation is not permitted. If the dispute is not resolved through business negotiations, either Party may request mediation of the dispute in writing. All decisions will be recorded in writing and signed by the Salinas Valley Health, Designer, and other necessary parties.

7.3 Mediation. Unless the Parties mutually agree to waive mediation and proceed straight to litigation, the Parties mutually agree that if the dispute is not resolved by the conclusion of business negotiations, either Party may demand mediation of the dispute in writing. The Parties will mutually agree to a mediator within 10 business days after the disputed portion of the claim has been identified in writing. Each Party participating in the mediation will share in the fees and costs in connection with the mediation. Representatives from each Party who have authority to resolve the dispute, together with any other Party who has an interest in the dispute, will attend the mediation. All parties involved in the dispute will bear the cost of mediation equally. Before the mediation, each Party will execute a disclosure confirming that each Party understands the confidential nature of the mediation proceedings and materials pursuant to California Evidence Code section 1129. The mediation process must be completed within 100 days of the Parties' agreement to mediate, unless Salinas Valley Health and Designer mutually agree to extend the mediation period. If, as a result of the mediation, a negotiated settlement is reached, the Parties will enter into a written settlement agreement that will be enforceable in a court of competent jurisdiction.

7.4 Government Code Claim. If mediation is unsuccessful Designer must file a government claim pursuant to Government Code section 910 et seq. in order to initiate a civil



action. Designer understands that the dispute resolution process may be amended upon procurement of the Design Builder for alignment of dispute resolution procedures. Designer will cooperate with Salinas Valley Health and Design Builder with respect to reasonable request for modifications required in the dispute resolution process.

7.5 Joinder. Designer agrees to be joined in any litigation or arbitration between Salinas Valley Health and any person or entity involving a dispute that relates to the Project if claims for or against the Designer or Salinas Valley Health arise from the same, substantially the same, or interrelated facts, issues, or incidents relating to the Project, or where separate dispute resolution processes create a risk of inconsistent awards or results. To the extent a party is subject to Public Contract Code section 9204 and 20104-20104.6, Designer agrees to be joined and comply with all such procedures.

8. TERMINATION AND SUSPENSION

8.1 Suspension. Salinas Valley Health may suspend the Project at any time upon written notice to the Designer. The notice of suspension will set forth the reason for suspension and the effective date of suspension.

8.2 Termination of the Designer for Convenience. Salinas Valley Health may terminate this Agreement for convenience upon 10 calendar days' written notice at any time before completion of the Services. The notice will state the extent and effective date of termination. Designer will be entitled to receive payment for all Services properly performed through the effective date of termination based on the compensation provisions in Article 5. Designer will not be entitled to consequential damages, unabsorbed overhead, or lost profits on unperformed Services. All disputes over termination will be resolved under Article 7.

8.3 Termination of the Designer for Cause. Salinas Valley Health may terminate this Agreement for material breach of any term or conditions of the Contract Documents upon 10 business days' written notice unless Designer has commenced curing its breach to the Salinas Valley Health's satisfaction. The notice will set forth the reason for termination and the effective date of termination. If Salinas Valley Health terminates this Agreement for cause, Designer will not be entitled to further payment until the Project is completed and Salinas Valley Health is able to determine the additional costs and expenses incurred by Salinas Valley Health to satisfy any claims arising out of, or services required for, curing the breach. Further payments, if due, will be made 35 calendar days after final completion of the Project, and only to the extent that the cost of completing the Services does not exceed the remaining NTE Amount. Nothing stated in this paragraph will prevent Salinas Valley Health from pursuing and recovering any damages allowed by law from Designer arising out of the breach of the Contract Documents. If a court of competent jurisdiction deems that termination of this Agreement was wrongful or otherwise improper, the termination will be deemed a termination for convenience under Section 8.2. All disputes over termination will be resolved under Article 7.

8.4 Termination for Cause By Designer. Designer may terminate this Agreement upon 30 calendar days' written notice to the Salinas Valley Health and Salinas Valley Health's Construction Manager and Project Manager if the Salinas Valley Health fails to make payment to Designer in accordance with this Agreement and cannot provide evidence substantiating that financial arrangements have been made to make payment. Designer will be compensated by



Salinas Valley Health as if the Services were terminated by Salinas Valley Health for convenience under Section 8.2.

9. OWNERSHIP OF DOCUMENTS

9.1 Ownership of Work Product. The Construction Documents and other design documents, including drawings, design narratives, sketches, calculations, and other design documentation prepared by Designer as part of the Services ("Work Product") are being developed and furnished for use solely with respect to this Project. As such, provided that Salinas Valley Health has complied with the payment provisions in this Agreement, Salinas Valley Health will own all rights, title, and interests under Applicable Law in all Work Product. Designer will not own or claim a copyright in the Work Product prepared for the Project.

9.2 License. Designer is granted a limited, non-exclusive, royalty-free license to use and reproduce applicable portions of the Work Product prepared for use in the performance of the Services. All copies made under the license will bear the statutory copyright notice. Submittal or distribution to meet official regulatory requirements or for other purposes in connection with development of the Project will not be construed as publication in derogation of Salinas Valley Health's copyright or other intellectual property rights and interests.

9.3 Exception. Nothing contained in Sections 9.1 and 9.2 limits the rights, title, and interest of Designer's right to continue to use its respective general layout, details, design narratives, calculations, or specifications that it uses or has used on multiple projects, or new layouts, details, design narratives, or specifications that were developed during performance of the Services.

9.4 Delivery of Work Product. If Designer is terminated for convenience or cause under Article 8, Designer will provide all Work Product to Salinas Valley Health. Salinas Valley Health may continue to use the work product prepared by Designer for further development through a different licensed California state structural engineer that is under direct contract with Salinas Valley Health or Design Builder, and who will become the engineer of record with respect to completion of the Construction Documents. Salinas Valley Health will defend, indemnify and hold the Designer harmless from third party claims and causes of action arising out of future use of the design documents but only to the extent that the claims or causes of action arise from the further development of the design documents after the effective date of termination and provided that the error or omission was not present in the design documents prepared by the Designer at the time of termination; or to the extent that the claims or causes of action did not arise from negligent performance of the Services performed by Designer before termination. Salinas Valley Health agrees that Designer will be paid for all Services properly performed up to the date of termination per the payment provisions set forth in Article 5.

10. MISCELLANEOUS PROVISIONS

10.1 Confidentiality. Designer will keep information provided by the Salinas Valley Health or made available to Designer during performance of the Services confidential, and will not disclose confidential information to persons or entities other than as necessary to perform the Services.

10.2 Patient Privacy. Designer acknowledge that Salinas Valley Health will continue to be under full operation when Services are performed. Any and all patient information is



subject to protection under Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as may be amended. Designer coming into contact with patient health information are strictly prohibited from disclosure in violation of the HIPAA privacy rule.

10.3 Exclusion List. Designer certifies that neither it, nor any of its employees are currently named as an excluded entity or individual on the “List of Excluded Individuals/Entities” of the Department of Health and Human Services Office of the Inspector General (“OIG List”), the “Excluded Parties List System” of the System for Award Management (“EPLS”), the “Specially Designated Nationals List” (“SDN List”) or the “Foreign Sanctions Evaders List” (“FSE List”) of the Office of Foreign Assets Control, any State debarment or exclusion list, or any other sanctions list that would make Designer, or any of its employees ineligible to participate in any federal or state funded programs (collectively, “Lists”). Designer will immediately notify Salinas Valley Health if, at any point during this procurement, it or any of its employees is named as an excluded entity or individual on any of the Lists.

10.4 Governing Law and Venue. This Agreement will be governed and construed under the laws of the State of California without giving effect to any choice of law or rule of conflict that would cause the application of the laws of any other jurisdiction. Each of the Parties agrees that the exclusive venue for any action will be in the applicable court in Monterey County, California.

10.5 Assignment. Salinas Valley Health and Designer respectively bind themselves, their partners, successors, assignees, to the other Party to this Agreement. Designer may not assign this Agreement. Designer acknowledges and agrees that upon contract award of the Design Builder, Salinas Valley Health will assign this Agreement to Design Builder and Designer will complete all Services including construction administrative services under Design Builder. Designer will cooperate with Salinas Valley Health and execute required assignment agreements. Additionally, Salinas Valley Health may assign this Agreement to any lender in obtaining Project financing. Designer will cooperate with Salinas Valley Health and execute all required assignment and subordination agreements.

10.6 Notices. Any notice required to be given by this Agreement will be in writing and deemed effective upon: (i) the date of personal delivery, or email, if received by the addressee before 5:00 p.m. local time on a business day; (ii) 3 business days after being sent via registered or certified mail with a return receipt requested; or (iii) 1 business day after being sent by overnight commercial courier providing next-business-day delivery. Email must be evidenced by an email confirmation receipt.

Notices will be addressed to the following respective Parties:

Salinas Valley Health:

Clement Miller
Chief Operating Officer
Salinas Valley Health
450 E. Romie Lane, Salinas, CA 93901
cmiller2@salinasvalleyhealth.com

Designer:

Shane Fitzgerald, Principal
John A. Martin & Associates
1901 Harrison Street, Suite 1570
Oakland, CA 94612
fitzgerald@johnmartin.com



HansonBridgett

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10.7 Interpretation and Severability. This Agreement's terms and conditions will be interpreted according to their plain meaning, and not strictly for or against Salinas Valley Health or Designer. Any contrary rule of construction or interpretation will be of no force or effect with respect to this Agreement. If a court of competent jurisdiction finds any term or provision of this Agreement to be void or unenforceable for any reason, the term or provision will be amended to comply with the law. If a term or condition is severed, the remainder of the Agreement will remain in full force and effect to the maximum extent permitted by law and consistent with Salinas Valley Health's and Designer's overall intent.

10.8 No Third Party Beneficiaries. The Parties acknowledge and agree that the obligations of the Designer are solely for the benefit of the Salinas Valley Health and are not intended in any respect to benefit any third parties. There are no other third party beneficiaries to this Agreement.

10.9 Rights and Remedies. All rights and remedies under the Contract Documents will be cumulative and in addition to, and not in limitation of, all other rights and remedies of the Parties under the Contract Documents or otherwise available at law or in equity.

10.10 Survival. The following provisions will survive termination of this Agreement or completion of the Services: Sections 4.3, 4.4, and 5.9, and Articles 6 through 9.

10.11 Waiver. Unless otherwise indicated in this Agreement, Salinas Valley Health's and Designer's action or failure to act will not waive any right or duty they have under the Agreement, and such action or failure to act will not be an approval of or acquiescence in, a breach of the Agreement unless specifically agreed to in writing by the appropriate Signatories.

10.12 Counterparts. This Agreement may be executed in counterparts, each of which will be deemed an original. When proving this Agreement, it will only be necessary to produce or account for the counterpart signed by the Party against whom enforcement is sought. Electronic copies or photocopies of this Agreement showing the true signatures may be used for all purposes as originals.

10.13 Interest. Payments due and unpaid under this Agreement will bear interest from the date payment is due at an annual rate equal of 3.5% per annum.

10.14 Attorneys' Fees. If the Salinas Valley Health or Designer commences an action or dispute resolution process in accordance with the terms and provisions of this Agreement against the other Party for claims arising out of or in connection with the Contract Documents, the prevailing Party will be entitled to recover all reasonable attorneys' fees and costs (including charges and expenses related to the suit, expert witness, and consultants' fees) as may be determined by a court with competent jurisdiction.

10.15 Equal Employment. Pursuant to Labor Code section 1735, the Fair Employment and Housing Act (Gov. Code section 12900 et seq.), California Administrative Code, Title 2, sections 7285 et seq., Government Code sections 11135-11139.5, and other applicable law, Designer will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, age, political affiliation, marital status, or disability on this Project. Designer will take affirmative action to ensure that employees are treated during employment or training without regard to their race, color, religion, sex, national origin, age, political affiliation, marital status, or disability. Designer will maintain policies in



compliance with California state and federal law regarding equal employment opportunities through-out the duration of this Project.

10.16 Gratuities. Designer warrants that it has not offered or given any gratuities (in the form of entertainment, gifts, or otherwise) to any official, employee, or agent of the Salinas Valley Health in an attempt to secure this contract or favorable treatment in awarding, amending, or making any determinations related to the performance of the Services under this Agreement.

10.17 Conflict of Interest. Designer will comply with all applicable conflict of interest laws, including organizational conflicts of interest under Government Code section 1090.

10.18 Drug Free Workplace. Designer certifies that it has complied with Government Code section 8355 relating to a drug free workplace and will comply with the requirements included in the safety program.

10.19 Anti-Kickback. Designer will comply with the Copeland Anti-Kickback Act (18 USC 874) as supplemented in Department of Labor regulations (29 CFR Part 3). This Act provides that Designer will be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public facilities, to give up any part of the compensation to which they are otherwise entitled.

10.20 Electronic Signature. The Parties agree that a "Digital Signature" as defined under Government Code section 16.5 and California Code of Regulations section 22000 is an acceptable form of signature for written communications with MMC and will have the same force and effect as the use of a manual signature provided that the Digital Signature is: (i) unique to the person using it; (ii) capable of verification; (iii) under the sole control of the person using it; and (iv) linked to the data in such a manner that if the data are changed, the Digital Signature will be invalidated. In order to be valid, the Digital Signature must be created by an acceptable technology as defined in California Code of Regulations section 22001 et. seq.

10.21 Legal Citations. Legal citations to statutory requirements are included in the Agreement for convenience and an omission of any statutory requirement will not relieve Designer from compliance with Applicable Law.

10.22 Entire Agreement. The Contract Documents as defined in Exhibit 1 form the entire contract between the Salinas Valley Health and Designer and supersede all prior oral and other written negotiations, representations, or agreements between the Salinas Valley Health and Designer with respect to the Services performed for this Project.



Exhibit 1 – Definitions

1. **"Agreement"** means the written contract between Salinas Valley Health and Designer inclusive of all Exhibits.
2. **"Amendment"** is a document executed by the signatories that amends the terms and/or conditions of this agreement, including an extension of service milestones, or authorizing additional services, by increasing or decreasing the lump sum amount set forth in the business terms sheet. In order to be valid, an Amendment must be signed by the Salinas Valley Health's signatory and Designer's signatory.
3. **"Applicable Law"** includes all local, state, and federal laws, rules, regulations, ordinances, building code or other codes, statutes, or regulations, or lawful orders of Governmental Authorities that are relevant to proper and safe performance of the Services.
4. **"Building Information Model" ("BIM" or "Model")** is a parametric, computable representation of the Project design developed by the Design Build Team, and it includes construction details. As used in this Agreement, references to Building Information Model, BIM, or the Model, include the primary design model or models and all linked, related, affiliated, or subsidiary models developed for design, estimating, detailing, fabrication, or construction of the Project, or any portion or element of the Project. The portions of the BIM prepared by the Designers, their consultants, and the design build subcontractors are Construction Documents. The portions of the BIM prepared by contractors to illustrate means and methods for constructing, fabricating, or installing portions of the construction work are submittals, which are not Contract Documents or Construction Documents.
5. **"Billable Rates"** are the approved hourly rates set forth in Exhibit 3.
6. **"Construction Documents"** means the 2-D structural drawings and specifications developed by Designer, and assembled by the architect of record that are approved and permitted for construction by Governmental Authorities, together with those parts of the Building Information Model described as Construction Documents in the definition of Building Information Model above, any clarifications through responses to requests for information, design sketches, or other such clarifications issued post-permit, and any modifications through executed Amendment.
7. **"Contract Documents"** include Salinas Valley Health's documentation provided for the Project, the Agreement (inclusive of all exhibits), and any subsequent modifications through executed Amendment.
8. **"Deliverable Schedule"** is the milestone schedule and durations for Designer's deliverables as described in Article 2 of Exhibit 2.
9. **"Designer"** means John A. Martin & Associates, Inc.
10. **"Design Builder"** is the general contractor who Salinas Valley Health awards a design build contract to for completion of all design and construction of the Project.



11. **"Design Build Team"** includes the Design Builder, design professionals of record, consultants, subcontractors, suppliers and equipment vendors.
12. **"Effective Date"** is the date that the parties agree the Agreement was executed.
13. **"Fee"** is the lump sum amount set forth in the Business Terms Sheet that Designer will be compensated for performance of the Services, subject to adjustment only through executed Amendment for additional services.
14. **"Governmental Authority"** or **"Governmental Authorities"** means any and all federal, state, county, or municipal boards, departments, courts, offices, or agencies that have jurisdiction over the Project.
15. **"Hazardous Materials"** means any substance, product, waste, or other material of any nature that is or becomes listed, regulated or addressed under one or more of the following environmental laws: (1) CERCLA, (2) Hazardous Materials Transportation Act, (3) RCRA, (4) the Clean Water Act, (5) the Toxic Substance Control Act, (6) HSAA, (7) the California Porter-Cologne Water Quality Control Act, (8) the California Hazardous Waste Management Act, (9) the California Safe Drinking Water Act, (10) the California Waste Management Act, and (11) any other federal or state law or local ordinance concerning hazardous, toxic, or dangerous substances, wastes, or materials.
16. **"HCAI"** is the California Department of Healthcare Access and Information.
17. **"Party"** means Salinas Valley Health or Designer. **"Parties"** means both the Salinas Valley Health and Designer.
18. **"Project"** means the Salinas Valley Health Retrofit Project.
19. **"Salinas Valley Health"** is the owner of the Project.
20. **"Salinas Valley Health's Construction Manager"** or **"Construction Manager"** is identified in the Business Terms Sheet.
21. **"Salinas Valley Health's Project Manager"** or **"Project Manager"** is identified in the Business Terms Sheet.
22. **"Salinas Valley Health's Representative"** is identified in the Business Terms Sheet.
23. **"Salinas Valley Health's MEEOR"** or **"MEEOR"** is the mechanical / electrical engineer of record identified in the Business Terms Sheet.
24. **"Services"** include all structural engineering design services in connection with the SB 1953 non-structural compliance and structural compliance as more particularly described in Exhibit 2, including any additional services amended into the agreement through Amendment.
25. **"Signatory"** or **"Signatories"** are those persons authorized by Salinas Valley Health and the Designer to execute the Agreement and any Amendments.



26. "Work Product" means design narratives, feasibility studies, as-builts drawings, and other design materials including but not limited to calculations, general notes, drawings, specifications, Models, studies, reports, and information to or from HCAI regarding Project.



Exhibit 2 – Scope of Services

1. SUMMARY OF SERVICES

PHASE 1 (Pre Design-Builder Engagement)

Task #1A & 1B - NPC-4 & NPC-4D Non-CCA Self Declarations & NPC-4D/NPC-4 Evaluations
 Task #2 - NPC-4 Histology Equipment Anchorage
 Task #3.1 - SPC Seismic Joint Expansion
 Task #3.2 – SPC Building 1 & 2 (SCU approval)
 Task #4 - Rotary UPS Seismic Compliance Alternative Approach

PHASE 2 (Post Design-Builder Engagement)

Task #5 - NPC-4D & NPC-4 Equipment Anchorage (DD's, CD's & BSS Approval, CA including close-out)
 Task #6 - SPC Buildings 1 & 2 (DD's, CD's & BSS Approval, CA including close-out)
 Task #7 – Building 17 (Make Ready; SD's, DD's, CD's & BSS Approval, CA including close-out)

2. DELIVERABLE SCHEDULE

Task #1A: NPC-4 Self Declarations	- January 1, 2024 HCAI Submittal - July 1, 2024, HCAI review comments - July 1, 2026, Fire Sprinkler Retrofit Complete
Task #1B: NPC-4D Level 1 & NPC-4 – Evaluation & Response to SCU Comments.	- January 1, 2024, HCAI Submittal - July 1, 2025, HCAI review comments
Task #2: NPC-4 Histology Equipment Anchorage	June 14, 2024 HCAI BSS permit Jan 31, 2025 Construction Close-out
Task #3.1: SPC Seismic Joint Expansion	July 1, 2024 CD's complete; CA on hold with tentative start in mid-2025
Task #3.2: SPC-4D Upgrades of Building 1 & 2 Schematic Design	SCU approval by February 28, 2025
Task #4: Rotary UPS Seismic Compliance Alternative Approach Study	3-month duration (start TBD)
Design-Builder Engagement	April 30, 2025
Task #5: NPC-4D & NPC-4 (DD's, CD's, & BSS Review)	July 2026 (CD's submitted to HCAI BSS by Jan 1, 2026)
Task #5: NPC-4D & NPC-4 Construction Administration	20-months (tentative start in 2027)
Task #5: NPC-4D & NPC-4 Reconciliation Report	3-months (tentative start in 2028)
Task #6: SPC (DD's, CD's, & BSS Review)	28-months (tentative start in Aug 2025)



Task #6: SPC Construction Duration & Close-Out	24-months
Task #7: Make Ready Building 17	8 months
Task #7: Building 17 (SD's, DD's, CD's, & BSS Review)	13-months
Task #7: Building 17 Construction Administration & Close-out	12-months

3. LEGISLATIVE DEADLINES

SB1953 Compliance. 2019 CAC, Chapter 6, section 1.5.13 compliance deadlines, states after January 1, 2030, any general acute care hospital building which continues acute care operations must, at a minimum, meet the nonstructural requirements of NPC-4 or NPC-4D and NPC-5, as defined in article 11, table 11.1 or shall no longer provide acute care services.

NPC-4 or NPC-4D and NPC-5 evaluation for each acute care building on campus must be submitted to HCAI	January 1, 2024 (Nonstructural Compliance Deadline)
Retrofit Construction Documents for NPC-4 or NPC-4D and NPC-5 compliance must be submitted to HCAI	January 1, 2026
NPC Retrofit Building Permit to begin construction for NPC-4 or NPC-4D and NPC-5 compliance.	January 1, 2028

4. DETAILED SCOPE OF SERVICES

4.1 Task #1A -NPC-4 & NPC-4D Non-CCA Self Declarations

4.1.1 Work Description. Evaluation of existing building components as it relates to the non-structural performance category (NPC) effort to comply with Senate Bill (SB1953). The effort will include preparing and assembling NPC-4 and NPC-4D self-declaration packages, and NPC-4D evaluation reports for each acute care building on campus for HCAI SCU submission by the January 1, 2024, deadline.

4.1.2 Scope Breakdown. Acute care buildings designed circa 1994 or later and constructed under HCAI permit are considered non-structurally compliant and exempted from a non-structural evaluation and thus can gain NPC-4 compliance by Self Declaration pending NFPA 13 1994 Edition certification or retrofit of fire sprinklers.

4.1.3 NPC-4 Self Declarations

- (a) BLD-01641 Cardiac Center North
- (b) BLD-01642 Cardiac Center South



- (c) BLD-01643 CCU Expansion
- (d) BLD-01644 Outpatient Center (Wyman)
- (e) BLD-01645 Cath Lab Expansion

4.1.4 NPC-4D Non-CCA Self Declarations

- (a) BLD-01639 Electrical & Mechanical Building
- (b) BLD-01648 Link
- (c) BLD-03076 Administration Building
- (d) BLD-05201 Rotary UPS

4.1.5 Verify Fire Sprinkler Compliance with NFPA 13 1994 Edition

- (a) Work with Salinas Valley Health and architect to discover HCAI approved drawings showing construction of sprinkler systems comply with NFPA 13 1994 edition.
- (b) If no approved sprinkler drawings are found to comply with NFPA 13 1994 edition, Salinas Valley Health to engage sprinkler contractor to survey and identify non-compliant conditions that do not meet NFPA 13 1994 edition (Survey fees for sprinkler contractor not included in this proposal).
- (c) Designer to assist sprinkler contractor with developing retrofit drawings that address non-compliant conditions for submittal to HCAI for review and approval.
- (d) Salinas Valley Health to engage sprinkler contractor to retrofit sprinkler systems (construction fees for sprinkler contractor not included in this proposal).
- (e) Designer to provide Construction Administration services during the construction of approved retrofit scope by sprinkler contractor.

4.1.6 Scope Exclusions

- (a) Architect and Salinas Valley Health to identify all Critical Care Areas (CCA).
- (b) Architect and Salinas Valley Health to identify all on-going or planned remodel projects.
- (c) Architectural scope and fees are not included.
- (d) The only NPC effort for NPC-4D No CCA Self Declarations pertains to sprinkler compliance and the Operational Plan. Scope will only address the sprinkler compliance and the Self-Declaration Letter.



(e) Survey and construction fees for Sprinkler Contractor not included.

4.1.7 Deliverables

(a) Prepare and assemble the NPC-4 or NPC-4D self-declaration package consisting of an HCAI application and letter of self-declaration of the NPC-4 or NPC-4D compliance of the (9) buildings listed in 2.1 and 2.2 and forward to the Salinas Valley Health for review and signature.

(b) Submit NPC-4 or NPC-4D self-declaration packages to HCAI for review and approval. The letter will be accompanied by site plan identifying the building and construction matrix.

(c) Designer will respond to any HCAI comments pertaining to regulation and granting of NPC-4 or NPC-4D reclassification.

4.2 Task #1B - NPC-4 & NPC-4D Evaluation

4.2.1 Work Description. NPC-4D and NPC-4 evaluation through retrofit is a lengthy process and requires extensive data collection and field work as well as extensive review by the HCAI Seismic Compliance Unit (SCU) during the reconciliation efforts. A field survey and evaluation of all seismic anchorage or bracing of non-structural items is required for the critical care areas which were previously defined as NPC-3 compliance areas. The critical care areas have now become identified as NPC-4D. Once an acute care building is upgraded to NPC-4D compliance, the Salinas Valley Health is allowed to defer NPC-4 scope.

(a) NPC-4D Evaluation

- (i) BLD-01635 Original Building
- (ii) BLD-01636 36 Bed Addition
- (iii) BLD-01638 Dietary Addition
- (iv) BLD-01640 Central Sterile Supply

(b) NPC-4 Evaluation

(i) BLD-01639 Electrical & Mechanical Building & Associated Equipment in Energy Yard.

(1) Building must be upgraded to NPC-4 per HCAI SCU comments.

4.2.2 Scope Breakdown

(a) Campus Projects Discovery and Closure



- equipment and components.
 - (i) Establish a list of HCAI permitted projects that added
 - (ii) Determine status of relevant projects and future projects.
 - (iii) Establish a list of projects that are required to be closed with compliance.
 - (iv) Work with Salinas Valley Health to resolve and close relevant projects.
- (b) Document Discovery
 - (i) Coordinate with Salinas Valley Health to discover drawings for projects identified in 4.2.1 (a) (i).
 - (ii) Scan discovered documents and return hard copies to Salinas Valley Health.
 - (iii) Create a drawing log.
 - (iv) Coordinate with SCU to discover drawings for projects identified in 4.2.1 (a) (i) that were not obtained through the Salinas Valley Health.
 - (v) One site visit to HCAI Los Angeles office to search any physical documents.
 - (vi) Coordinate with 3rd party licensed/bonded printer to pick up, scan and return hard copies of discovered documents to HCAI.
 - (vii) Update drawing log.
 - (viii) Coordinate with Salinas Valley Health and Architect to assist with the creation of a CCA overlay for the identified buildings in 4.2.1 (a) and (b).

4.2.3 Field Survey, Evaluation & Establish Scope of Retrofit.

- (a) Designer to assist the Architect and MEP with the following:
 - (b) Architect and MEP to identify nonstructural elements for their respective discipline within each critical care area to establish an inventory to review existing drawings for anchorage and bracing details.
 - (c) MEP to identify source equipment and develop chart identifying what source equipment services each critical care area.
 - (d) Architect and MEP to review existing drawings for anchorage and bracing details for all nonstructural elements for each respective discipline.



(e) Architect and MEP to provide cutsheets for all nonstructural elements and all source equipment, which constitute the complete NPC-4D or NPC-4 inventory, that documents element and/or equipment type, weight, dimensions, center of mass and location of architectural, mechanical, plumbing, and electrical systems to develop structural calculations.

4.2.4 The field survey shall consist of:

(a) Observe OSA permitted as-built nonstructural elements anchored details to confirm compliance with the permitted detail.

(b) Survey anchorage of nonstructural elements not found on drawings and document as-built anchorage details.

4.2.5 Designer to evaluate the adequacy of the anchorage and/or seismic bracing of each nonstructural element identified in the inventory to determine compliance by one of the following:

(a) OSHPD permit

(b) OSA permit with observation.

(c) Calculation

4.2.6 Scope Exclusions

(a) Involvement of an Architect and MEP consultants may be required to assist with the documentation and data collection of the nonstructural items, and their scope and fees are not included.

(i) Plans of each Critical Care Area documenting location of nonstructural items with ID # associated with inventory prepared per paragraph 4.2.2 (viii) shall be provided by others for Designer's use during field surveys, in 8-1/2"x11" or (11"x17") format for including in the NPC-4D or NPC-4 Evaluation Report, and to be used by Design Builder.

(ii) Survey of suspended ceiling bracing and bracing of above ceiling MEP utility runs is not included in this scope. All such items shall be noted as deficient in the NPC-4D or NPC-4 Evaluation Reports and addressed as a deferred approval in the NPC-4D or NPC-4 Retrofit Construction Documents, as applicable.

(iii) Operational Plan is not included in this scope of services and shall be provided by others for inclusion in the NPC-4D Evaluation Reports.

(iv) Response(s) to HCAI SCU comment(s) on Operation Plan shall be provided by others for inclusion in Designer's Backcheck submittal.

(v) NPC-5 compliance including reports, drawings, and other related documentation is not included in this scope of services and shall be provided by others for inclusion in Designer's reconciliation report if required by HCAI.



4.2.7 Deliverables

(a) NPC-4D or NPC-4 (as applicable) Evaluation Report for each building in 8-1/2 x 11 format documenting anchorage status (compliant or deficient) determined by Section 4.2.3 above.

(b) HCAI SCU approval of NPC-4D or NPC-4 Evaluation Reports.

(c) NPC-4D or NPC-4 Retrofit Schematic Drawings (one set for each building) based on item 4.2, ready for issue to Design-Build Contractor and to include the following:

(i) SD level General Notes.

(ii) Above ceiling seismic bracing criteria and details for connecting bracing to various types of floor/roof structural systems.

(iii) Key plans defining where NPC-4D or NPC-4 deficient items occur within the subject buildings, the Central Plant, and/or other locations on campus (i.e. source equipment located in other buildings).

(iv) Two Inventory Charts, one listing all items only requiring anchor testing, the other listing all other deficient items to be retrofitted. Charts will indicate Building/room location and component properties.

4.3 Task #2 -NPC-4 Histology Equipment Anchorage

4.3.1 **Work Description.** Anchorage of nine (9) items in the Histology department of Building 8 in preparation of NPC-4 self-declaration.

4.3.2 **Scope Breakdown.** Designer will coordinate with SVH Owner Representative to identify and establish the necessary project requirements. Services will consist of providing the necessary structural engineering assistance and support, consultation, design, and detail for the project consistent with applicable codes, regulations and laws, project goals, and desired standards of quality. Deliver detailed structural plans fit for competitive bidding and construction, alongside comprehensive engineering support, consultations, design, and details. Provide sufficient structural design and Construction Documents for submission and approval from HCAI for the anchorage of nine (9) items in the Histology department.

4.3.3 Scope Assumptions

(a) As-built surveying is not included.

(b) A single design iteration of each element, coordination with design team and client, preparation of structural drawings and calculations as required for securing permit (permit by others).

(c) A single permit and set of drawings. Any revisions after permit submittal are additional services.



(d) Testing of existing materials, although not anticipated, may be required. Material testing will be performed by others.

(e) Non-structural Component Anchorage will not trigger seismic upgrade or renovation of the building lateral load resisting system.

(f) Work and structural effort are limited to structural aspects as noted above. All other engineering efforts outside of this scope are not included but can be added if deemed necessary and compensable.

4.3.4 Deliverables

(a) Structural design and Construction Documents for submission to HCAI for anchorage of nine (9) items in the Histology department.

(b) Back check meetings as required and review process with HCAI as necessary to obtain permit.

(c) Standard CA phase services including review of RFI's and shop drawings for the seismic joint.

(d) One site observation is included.

4.4 Task #3.1 - SPC Seismic Joint Expansion

4.4.1 **Work Description.** Enlargement of the seismic joint between the Dietary Building and the Original Building per details on SPC-4D retrofit set.

4.4.2 **Scope Breakdown.** Designer will coordinate with SVH Owner Representative to identify and establish the necessary project requirements. Services will consist of providing the necessary structural engineering assistance and support, consultation, design, and detail for the project consistent with applicable codes, regulations and laws, project goals, and desired standards of quality. Provide sufficient structural design and Construction Documents for submission and approval from HCAI for the enlargement of joint between Dietary Building and Original Building per details on SPC-4D retrofit set.

4.4.3 Scope Assumptions

(a) As-built surveying is not included.

(b) A single design iteration of each element, coordination with design team and client, preparation of structural drawings and calculations as required for securing permit, (permit by others).

(c) A single permit and set of drawings. Any revisions after permit submittal are additional services.

(d) Testing of existing materials, although not anticipated, may be required. Material testing will be performed by others.



(e) Non-structural Component Anchorage will not trigger seismic upgrade or renovation of the building lateral load resisting system.

(f) Work and structural effort are limited to structural aspects as noted above. All other engineering efforts outside of this scope are not included but can be added if deemed necessary and compensable.

4.4.4 Deliverables

(a) Structural drawings and calculations suitable for submittal to HCAI (submittal by others) only for the seismic joint modifications between the Dietary and Original Building of the seismic identified in the SPC-4D retrofit set.

(b) Back check meetings as required and review process with HCAI as necessary to obtain permit.

(c) Standard CA phase services including review of RFI's and shop drawings for the seismic joint.

(d) One site observation is included.

4.5 Task 3.2 - SPC-4D Upgrades of Building 1 & 2: Schematic Design

4.5.1 Work Description: Completion of SPC-4D Schematic Design for Buildings 1 and 2 with HCAI SCU approval of proposed retrofit.

4.5.2 Scope Breakdown

(a) Completion of Schematic Design review process with HCAI/SCU for both Buildings 1 and 2. Process includes:

(i) Re-analysis and supplemental calculations in response to SCU's reviews of the proposed retrofit by numerous plan reviewers (each with different opinions on analysis approach).

(ii) Complete detailing of strengthening in the Schematic Design drawings required by SCU in lieu of retrofit performance criteria (previously included).

(iii) Peer Review (by HCAI) of the proposed dampers on Building 2 (initially waived via an AMC) and resolution of review comments.

(iv) Development of Building 2 Damper Testing Program at SD stage as required by Peer Reviewer.

4.5.3 Scope Exclusions

(a) Construction Cost Estimate not part of this Scope.



(b) Work and structural effort are limited to structural aspects as noted above. All other engineering efforts outside of this scope are not included but can be added if deemed necessary and compensable.

4.5.4 Deliverables

(a) One set of Schematic Design drawings for each, Buildings 1 and 2 based on the following items approved by HCAI SCU:

- (i) Modeling and structural analysis performed by Designer
- (ii) MTCA Results submitted by Designer (performed by others)
- (iii) Geotechnical Report by others

(b) Acceptance Letter of SPC-4D Retrofit Scope from HCAI SCU for each of Buildings 1 and 2.

4.6 Task #4 - Rotary UPS Seismic Compliance Alternative Approach Study

4.6.1 Work Description. Due to the small size of the Rotary UPS building (Building 17) and the critical function of the Equipment within it, neither the proposed ASCE-41 interior seismic retrofit, nor the recently proposed demolition and rebuild approach have been deemed acceptable by the Salinas Valley Health. The alternative approach will take into consideration the Salinas Valley Health's request to minimize the impact to the currently operating equipment within the building.

4.6.2 Scope Breakdown

(a) Review the California Existing Building Code for an alternative approach to bringing the UPS building into SPC compliance without performing (or at least minimizing) the scope of Material Testing and Condition Assessment and/or the scope of demolition and rebuild.

(b) Work includes determination of HCAI requirements for preparation of As-Built drawings for the original portion of the Rotary UPS Building for which there is no documentation.

4.6.3 Scope Exclusions. This proposal represents the appropriate level of effort and scope of services for the investigation described above. Please note, this proposal does not address the following:

- (a) Consideration of vertical load-carrying systems in the structure.
- (b) Nonstructural performance of NPC-2, 3, 4, 4D, or 5 compliance levels
- (c) Development of seismic retrofit beyond conceptual level



- (d) MEP upgrades that might be required
- (e) Opinion of probable construction cost or rough estimates of such

4.6.4 Deliverables

(a) Anticipated deliverables will be an 8-1/2 x 11 written Report that compares the required HCAI process and resulting conceptual retrofit of the three approaches (ASCE-41 interior retrofit, demolition/rebuild, and alternative approach) for use by the Salinas Valley Health and selected Design-Build Contractor in deciding which approach will create the least disruption to Salinas Valley Health Services and/or will be the most economical solution. Sketches if needed to illustrate the options at a conceptual level will be included. Upon selection of the option, in coordination with Design Builder, Designer will provide Design Builder with pricing for the additional service through Amendment.

4.7 Task #5 - NPC-4D & NPC-4 Equipment Anchorage

4.7.1 Work Description. Based on the NPC-4D and NPC-4 Evaluation Reports, noted in Task #1B, there are a total of (129) below ceiling components (in four seismically separated buildings), as well as (47) pieces of source equipment (located in various other buildings) that have deficient anchorage and require retrofit (excluding Electrical and Mechanical Building). See NPC-4D Component Inventory Reports (submitted to HCAI on December 22, 2023) for component inventory and anchorage evaluation charts taken from NPC-4D Evaluation Report for each building. Designer will provide criteria for above ceiling bracing and spacing between hangers. Additionally, nonstructural elements identified as having deficient anchorage are to be retrofitted to achieve NPC-4 upgrade of Electrical and Mechanical Building.

- (a) Original Building (BLD-01635)
- (b) 36 Bed Addition (BLD-01636)
- (c) Dietary Addition (BLD-01638)
- (d) Central Sterile Supply (BLD-01640)
- (e) Electrical and Mechanical Building (BLD-01639)

This scope of work is part of Phase 2 (post Design-Builder engagement), which will be assigned to the future Design-Builder.

4.7.2 Scope Breakdown

(a) **DD, CD, HCAI BSS Plan Check & Approval.** Work includes design and detailing of components and/or equipment anchorage where none exists, retrofit of existing non-compliant anchorage, criteria for above ceiling bracing and spacing of hangers, and test criteria for existing concrete anchors required to be tension tested. Designer will coordinate and assist MEP consultant with establishing approach for components/equipment for which due



to equipment age, information needed for seismic bracing analysis is not readily available and assumptions will be needed to be made to complete analysis and bracing details.

(b) **Construction Administration Services & Close-out.** Designer will provide construction administration services and facilitate closure of the construction project with HCAI BSS.

(c) **Reconciliation Report, Final Request & Approval.** Designer will prepare and submit to HCAI SCU the required Reconciliation Report for all components and source equipment documented in:

(d) NPC-4D or NPC-4 Component Inventory Reports for the following Buildings:

(i) Original Building (BLD-01635)

(ii) 36 Bed Addition (BLD-01636)

(iii) Dietary Addition (BLD-01638)

(iv) Central Sterile Supply (BLD-01640)

(v) Electrical and Mechanical Building (BLD-01639)

(e) Preparation of final upgrade letter to HCAI SCU will be dependent on all NPC-4D or NPC-4 retrofit projects being closed in compliance.

4.7.3 Scope Exclusions

(a) MEP and utility lines above the ceilings were not evaluated but deemed deficient due to lack of access; seismic bracing will be completed by others.

(b) Seismic bracing of any existing sprinkler lines within the buildings listed above as needed to comply with NFPA-13 1994 Edition.

(c) Design/drafting effort required for the division of NPC-4D or NPC-4 Retrofit Scope into more than one permit package or multiple Increments that requires special sheet layout is not included in this Scope and shall be considered an Add Service.

4.7.4 Deliverables

(a) Provide structural anchorage calculations, plans and detail drawings, and specifications, as well as facilitate plan review and approval with HCAI.

(b) Back check meetings as required and review process with HCAI as necessary to obtain permit.



(c) Prepare and submit Reconciliation Report for all components and source equipment to HCAI SCU.

(d) Prepare and submit Final Upgrade Letter to HCAI SCU.

4.8 Task #6 - SPC – DD's, CD's & CA

4.8.1 Work Description. This project is a continuation of the structural engineering services previously provided by Designer to accomplish SPC-4D upgrades for the following acute care buildings at Salinas Valley Memorial Hospital (HCAI Facility No. 10348).:

(a) Building 1 - Original Building (BLD-01635)

(b) Building 2 - 36 Bed Addition (BLD-01636)

This scope of work is part of Phase 2 (post Design-Builder engagement), which will be assigned to the future design-builder.

4.8.2 Scope Breakdown. For each of the buildings listed above, a separate set of documents will be developed as described below based on the HCAI SCU approved SPC-4D Retrofit schematic design drawings for each building.

(a) Design Development

(i) Coordinate with the design team to assist each discipline in determining the triggered nonstructural scope caused by structural retrofit scope.

(ii) Refine structural retrofit scope to help minimize costs associated with nonstructural scope.

(iii) Develop the design of the SCU approved structural seismic retrofit (tasks completed under separate agreement).

(iv) Work product will include typical details and general notes; plans showing general type and arrangement of lateral system elements, modified existing elements and/or new elements; as well as elevations, sections and/or details of retrofitted and/or new lateral elements showing relationships to existing structural elements.

(v) Provide draft specifications, consult with the design team on secondary structural elements.

(vi) Respond to any questions by the estimator developing the structural costs.

(b) Construction Documents and BSS Plan Review



(i) Prepare the final structural calculations and the final structural Construction Documents sufficiently detailed for submittal to HCAI BSS plan review and construction of the structural retrofit.

(ii) Include final coordination with the design team which may require assisting the design team with development of an approach to phasing of construction, consideration of value-engineering by the estimator, and completion of specifications.

(iii) Review the effects of elements not designed by our office on the primary structural system and finalize any modifications required by this review.

(iv) Back check meetings as required and review process with HCAI as necessary to obtain permit.

(v) Respond to HCAI BSS review comments and if required, modify calculations and/or drawings as necessary to obtain approval.

(c) Construction Administration and Request for Upgrade

(i) Provide Construction Administration services and facilitate closure of the construction project with HCAI BSS.

(ii) Request for Upgrade to SPC-4D will be submitted by our office once the project is closed in compliance.

(iii) Site visits during CA phase are limited to 16 visits.

4.8.3 Scope Exclusions

(a) Any involvement with any of the other expansion or upgrade services for the hospital other than as outlined above.

(b) Field measuring services and any documents relative to such services.

(c) The preparation of demolition drawings for existing structures.

(d) Services relative to vertical load carrying systems.

(e) In person jobsite Project meetings outside of the site visits already included. Attendance to virtual Project meetings is included.

(f) Cost estimates.

(g) Any designing and detailing of site work exterior to and non-contiguous with the building.

(h) Inspection of existing structure for seismic damage.



- (i) Tenant improvement services.

4.8.4 Deliverables for each Building

- (a) One set of 100% design development structural drawings for review and coordination by Design Builder and Salinas Valley Health.
- (b) One set of 80% structural Construction Documents and specifications for review and coordination by Design Builder and Salinas Valley Health.
- (c) One set of 100% structural Construction Documents, specifications, and calculations for submittal to HCAI BSS for review and approval.
- (d) Back check meeting(s) as required and review process with HCAI as necessary to obtain permit
- (e) Provide Construction Administration services and facilitate closure of the construction project with HCAI BSS.
- (f) Request for Upgrade to SPC-4D will be submitted by our office once the project is closed in compliance.

4.9 Task #7 - Building 17 - Make Ready

4.9.1 Work Description. Anchorage of Electrical and Technology Equipment associated with the relocation of the Rotary UPS services from Existing Building #17 to the basement of Building #1 as described in SVH Building 17 UPS Relocation – Electrical & Technology Concept Design Narrative dated 08/23/2024.

4.9.2 Scope Breakdown. Services will consist of providing the necessary structural engineering assistance and support, consultation, design, and detail for the project consistent with applicable codes, regulations and laws, project goals, and desired standards of quality. Deliver detailed structural plans fit for competitive bidding and construction, alongside comprehensive engineering support, consultations, design, and details. Provide sufficient structural design and Construction Documents for submission and approval from HCAI.

4.9.3 Scope Qualifications

- (a) A single design iteration of each element, coordination with design team and client, preparation of structural drawings and calculations as required for securing permit (permit by others).
- (b) A single permit and set of drawings. Any revisions after permit submittal are additional services.
- (c) Anchorage of this equipment is not part of the NPC-4D upgrade for Building #1 and therefore shall be designed per current 2022 CBC.



(d) Work and structural effort are limited to structural aspects as noted above. All other engineering efforts outside of this scope are not included but can be added if deemed necessary and compensable.

4.9.4 Deliverables

(a) Structural design and Construction Documents for submission to HCAI for anchorage of new and relocated Rotary UPS equipment in basement of Building #1

(b) Back check meeting(s) as required and review process with HCAI as necessary to obtain permit.

(c) Standard CA phase services including review of RFI's and shop drawings.

(d) One site observation is included.

4.10 Task #7.1 - Building 17 – SD's, DD's, CD's & CA

4.10.1 Work Description. This Project is a continuation of the structural engineering services previously provided by Designer for the following acute care buildings at Salinas Valley Memorial Hospital (HCAI Facility No. 10348):

(a) Building 17 – Rotary UPS (BLD-05201)

This scope of work is part of Phase 2 (post Design Builder engagement), which will be assigned to the future Design Builder.

4.10.2 Scope Breakdown

(a) Schematic Design

(i) SPC-4D Seismic Upgrade will be based on the approach selected by the hospital

(ii) from the three alternatives provided in the Report at the conclusion of the

(iii) investigation described as Task #4.

(1) Seismic Retrofit Option. Develop plans and elevations/sections as needed to present proposed seismic up-grade and obtain approval from HCAI SCU.

(2) Demolish and Re-Build Option. Develop schematic plans and elevations/sections for new structure at same location and of same size, height, and of same materials as the existing structure; but structurally designed to current code.



(b) Design Development

(i) Coordinate with the design team to assist each discipline in determining the triggered nonstructural scope caused by structural retrofit scope.

(ii) Refine structural retrofit scope to help minimize costs associated with nonstructural scope.

(iii) Develop the design of the SCU approved structural seismic retrofit.

(iv) Design deliverables will include typical details and general notes; plans showing general type and arrangement of lateral system elements, modified existing elements and/or new elements; as well as elevations, sections and/or details of retrofitted and/or new lateral elements showing relationships to existing structural elements.

(v) Provide draft specifications, consult with the design team on secondary structural elements.

(vi) Respond to any questions by the estimator developing the structural costs.

(c) Construction Documents and BSS Plan Review

(i) Prepare the final structural calculations and the final structural Construction Documents sufficiently detailed for submittal to HCAI BSS plan review and construction of the structural retrofit.

(ii) Include final coordination with the design team which may require assisting the design team with development of an approach to phasing of construction, consideration of value-engineering by the estimator, and completion of specifications.

(iii) Review the effects of elements not designed by our office on the primary structural system and finalize any modifications required by this review.

(iv) Respond to HCAI BSS review comments and if required, modify calculations and/or drawings as necessary to obtain approval.

(v) Back check meeting(s) as required and review process with HCAI as necessary to obtain permit.

(d) Construction Administration and Request for Upgrade

(i) Provide Construction Administration services and facilitate closure of the construction project with HCAI BSS.

(ii) Request for Upgrade to SPC-4D will be submitted by our office once the project is closed in compliance.



- (iii) Site visits during CA phase are limited to 5 visits .

4.10.3 Scope Exclusions

- (a) Any involvement with any of the other expansion or upgrade services for Salinas Valley Health other than as outlined above.
- (b) Field measuring services and any documents relative to such services.
- (c) The preparation of demolition drawings for existing structures.
- (d) Services relative to vertical load caring systems .
- (e) In person jobsite Project meetings outside of site visits already included. Attendance to virtual Project meetings is included .
- (f) Cost estimates.
- (g) Any designing and detailing of site work exterior to and non-contiguous with the building.
- (h) Inspection of existing structure for seismic damage.
- (i) Tenant improvement services.

4.10.4 Deliverables

- (a) Designer will use Autodesk Revit to construct and document the 2D drawings used for permit and construction, LOD 300.
- (b) The 3D Bim model will be made available as a courtesy and tool/aid to the team but not part of the Construction Documents.
- (c) One set of 100% design development structural drawings for review and coordination by Design Builder and Salinas Valley Health.
- (d) One set of 80% structural Construction Documents and specifications for review and coordination by Design Builder and Salinas Valley Health.
- (e) One set of 100% structural Construction Documents, specifications, and calculations for submittal to HCAI BSS for review and approval.
- (f) Back check meeting(s) as required and review process with HCAI as necessary to obtain permit.
- (g) Provide Construction Administration services and facilitate closure of the Project with HCAI BSS.



(h) Request for upgrade to SPC-4D will be submitted by Designer once the Project is closed in compliance.



Exhibit 3 – Fee Schedule and Billable Rates

Fee Schedule:

Services	Fee
Phase 1 (Pre Design-Builder Engagement)	
Task #1A & 1B - Master Plan Retrofit / NPC Compliance & SD's for NPC-4D & NPC-4 Equipment Anchorage	\$420,000.00
Task #2 - NPC-4 Histology Equip. Anchorage	\$ 25,000.00
Task #3 - SPC 4 Compliance	
#3.1 – SPC Seismic Joint Expansion	\$10,000.00
#3.2 – SPC Bldg 1 & 2 approval by SCU (continuation of scope started with HOK)	\$130,000.00
Task #4 - Rotary UPS Seismic Compliance Alternative Approach	\$ 40,000.00
Reimbursable Expense Allowance (Phase 1)	\$5,000.00
Subtotal Phase 1	\$630,000.00
Phase 2 (Post Design-Builder Engagement)	
Task #5 - NPC-4D & NPC-4 Equipment Anchorage	
#5.1 - Design & Detailing (DD's, CD's, & BSS Review)	\$535,000.00
#5.2 - Construction Administration	\$265,000.00
#5.3 - Reconciliation Report	\$50,000.00
Task #6 - SPC Construction Documents & Construction Administration	
#6.1 - Design Development	\$340,000.00
#6.2 - Construction Documents & BSS Review	\$680,000.00
#6.3 - Construction Administration	\$340,000.00
Task #7 – Building 17	
#7.1 – Make Ready	\$45,000.00
#7.2 – SD's, DD's, CD's through permit	120,000.00
#7.3 - Construction Administration & Close-out	40,000.00
Reimbursable Expense Allowance (Phase 2)	\$55,000.00
Subtotal Phase 2	\$2,470,000.00
Total Amount	\$3,100,000.00

Designer's Billable Rates: For Services performed on a time and materials basis, time will be billed in 15 minute increments.

Position	Billable Rate/Hour
Principal / Partner	\$300
Project Principal / Director	\$265
Associate Principal	\$230
Senior Project Manager	\$215



Project Manager	\$200
Senior Project Engineer	\$175
Project Engineer	\$165
Project Designer	\$155
BIM Manager	\$215
BIM Supervisor	\$175
BIM Coordinator / BIM Technician	\$135
Technical Support Staff	\$110

Task Matrix (By Amendment)



Exhibit 4 – Insurance Requirements

1. COVERAGES REQUIRED BY DESIGN AND ITS TIER-CONSULTANTS.

1.1 Workers' Compensation. Coverage will include insurance as required by California state law and employer's liability coverage.

1.2 Commercial General Liability (CGL). Commercial general liability coverage must include combined single limits and aggregates in the amounts set forth in the Business Terms Sheet. Coverage must include, but is not limited to liability for bodily injury, sickness, disease or death, personal injury, or injury to or destruction of property including loss of use resulting therefrom, including the following: (a) Contractual Liability for liability assumed under an insured contract including the tort liability of another assumed in a business contract (this Agreement must be an insured contract); (b) Broad Form Property Damage; (c) Independent contractors; (d) Severability of interests; and (e) Cross Liability.

1.3 Automobile Liability. Commercial automobile liability insurance must be issued with each accident limits as stated in the Business Terms Sheet. This insurance must apply to bodily injury and property damage for all owned, non-owned, or hired vehicles to be used by the insured in performance of its obligations under this Agreement.

1.4 Occurrence Basis. All commercial general liability and automobile liability policies must be written on an occurrence basis.

1.5 Professional Liability. Designer must have coverage for damages caused by their respective negligent acts, errors, or omissions arising out of the performance of the Services. Designer's coverage must be in the amounts set forth in the Business Terms Sheet.

2. GENERAL PROVISIONS.

2.1. Term. All liability insurance must be in force before any Services are performed under this Agreement and must be maintained in force for 4 years following completion of the Services. Workers' compensation insurance must be in force from the inception of this Agreement through completion of the Services and final payment. In the event of cancellation or non-renewal, the reporting period during which a claim may first be made will be extended until at least 4 years after cancellation or non-renewal. Upon renewal of any required insurance that expires before completion of the Services, the applicable party must provide Salinas Valley Health with renewal certificates not less than 15 days prior to the expiration. Designer will promptly furnish copies of all required policies of insurance, including any renewal or replacement policies, within 10 days of Salinas Valley Health's written request.



2.2. Qualifications and Rating. All insurance must be placed with insurers that are admitted or licensed to issue insurance in the state of California. All insurers must maintain an A.M. Best rating of at least A- or better, and a financial classification of VIII or better.

2.3. Additional Insureds. Salinas Valley Health and its Board of Directors, affiliates, members, officers, successors and assigns, Salinas Valley Health's Construction Manager, and Salinas Valley Health's Project Manager will be named as additional insureds on all required commercial general liability and automobile policies for Services performed under or incident to this Agreement. If the additional insured has other insurance applicable to the loss, it will be on an excess or contingent basis. The amounts and types of insurance will conform to the minimum terms, conditions, and coverages of the Insurance Service Office (ISO) policies, forms, and endorsements in effect when this Agreement is executed.

2.4. Primary Insurance. All liability policies required by Designer under this Agreement are primary and non-contributory to any similar insurance maintained by Salinas Valley Health for its own respective benefit.

2.6. Waivers of Subrogation. Designer and its tier-consultants will waive all rights against Salinas Valley Health, as well as any other entities set forth in Article 2.3 for loss or damage to the extent reimbursed by any property insurance. A waiver of subrogation is effective as to a person or entity even though that person or entity would otherwise have a duty of indemnification, contractual or otherwise, did not pay the insurance premium directly or indirectly, and whether or not the person or entity had an insurable interest in the property damaged. This waiver does not apply to professional liability insurance. If any applicable policies of insurance require an endorsement or consent of the insurance company to provide for continued coverage where there is a waiver of subrogation, the owner of those policies will cause them to either provide a "blanket waiver" endorsement or a subrogation endorsement that includes the name of the Project and the location of the Project site.

2.7. Deductibles and Self-Insured Retentions. All deductibles and/or self-insured retentions are the sole responsibility of the first named insured and are not a reimbursable expense.

2.8. Evidence Prior to Final Payment. Prior to receipt of final payment under the Agreement, Designer must provide evidence that its insurance coverages are effective as required by this Exhibit 4.

2.9. Modifications Only in Writing. The coverage and limits of insurance required by this Exhibit may not be altered, modified, or changed except as expressly agreed to in writing. No course of dealing or acceptance of certificates or policies will constitute a waiver of any of these insurance requirements.



SEISMIC RETROFIT PROJECT #01.1250.3273	BUDGET	Prior Years (costs)*	FY 2025 SUBTOTAL*	FY 2026 SUBTOTAL	FY 2027 SUBTOTAL	FY 2028 SUBTOTAL	FY 2029 SUBTOTAL
PROGRAM & CONSTRUCTION MANAGEMENT	\$ 5,112,181	\$ 1,251,451	\$ 945,170	\$ 989,248	\$ 1,621,412	\$ 304,899	\$ -
PRELIMINARY DESIGN & INITIAL STUDIES	\$ 3,338,557	\$ 1,315,889	\$ 958,681	\$ 824,890	\$ 127,045	\$ 104,043	\$ 8,009
MAKE READY DESIGN & CONSTRUCTION	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
AGENCY FEES & INSPECTION	\$ 3,948,106	\$ 72,490	\$ 67,409	\$ 1,055,000	\$ 1,928,018	\$ 745,366	\$ 79,824
PROCUREMENT & FF&E	\$ 1,250,233	\$ -	\$ 33,000	\$ 83,000	\$ 761,504	\$ 278,000	\$ 94,729
PROGRAM, DESIGN & CONSTRUCTION CONTINGENCY	\$ 15,950,043	\$ -	\$ 210,000	\$ 2,770,000	\$ 7,150,000	\$ 5,349,867	\$ 470,176
DESIGN BUILDER - PRECONSTRUCTION	\$ 3,464,419	\$ -	\$ 600,000	\$ 2,550,000	\$ 314,419	\$ -	\$ -
DESIGN BUILDER - CONSTRUCTION	\$ 29,436,461	\$ -	\$ 375,000	\$ 2,075,000	\$ 12,700,000	\$ 13,650,000	\$ 636,461
Total Project Budget	\$ 62,500,000	\$ 2,639,830	\$ 3,189,260	\$ 10,347,139	\$ 24,602,398	\$ 20,432,175	\$ 1,289,199

*Reflects actuals through 12/18/2024

Board Paper: Finance Committee

Agenda Item: Board Ratification and Approval of Competitive Solicitation and Contract Award for Epic Acute Project Training Consultant Engagement with Evergreen Healthcare Partners, Inc.

Executive Sponsor: Josh Rivera, Director Enterprise Informatics
Alysha Hyland, Chief Administration Officer

Date: January 20, 2025

Executive Summary

Background/Situation

The Salinas Valley Health Board approved the Epic Acute Project in May, 2024. Included in the approval was the Total Cost of Ownership (TCO), which covered all budgeted items associated to the implementation of Epic. The budget for Epic Project consultant fees in FY25 was set at \$8,118,518. Evergreen Healthcare Partners, Inc. will provide consultant training services for the Epic Acute Project Implementation.

Timeline/Review Process to Date

- May 2024:** Salinas Valley Health Board approves the Epic Acute Project
- Aug 2024:** Salinas Valley Health's Selection Committee selects Huron Consulting Services for pre-implementation planning engagement.
- Oct 2024:** Salinas Valley Health opens Request for Proposal (RFP) for consultant services during the Epic Acute Project.
- Nov 2024:** Salinas Valley Health's Selection Committee chooses Huron Consulting Services, LLC for the Epic Acute Project consultant engagement.
- Jan 2025:** Salinas Valley Health chooses Evergreen Healthcare Partners, Inc. for Epic Acute Project training engagement.

Strategic Plan Alignment

Implementation of Epic Acute provides a unified platform for care delivery across our health system. The implementation will improve the service we are able to provide to our patients, enhance patient engagement, raise our quality of care through more robust access to data and allow for financial improvements related to better integration and population health management capabilities.

Pillar/Goal Alignment

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

Financial/Quality/Safety/Regulatory Implications

Key Contract Terms	Vendor:
1. Proposed effective date	1/1/2025
2. Term of agreement	One year engagement
3. Renewal terms	N/A
4. Termination provision(s)	30 day written notice
5. Payment Terms	Payment due 30 day once invoice is issued
6. Annual cost	\$1,325,000
7. Cost over life of agreement	\$1,325,000
8. Budgeted (indicate y/n)	Yes

Recommendation

Consider Recommendation for Board Ratification and Approval of Competitive Solicitation and Contract Award for Epic Acute Project Training Consultant Engagement with Evergreen Healthcare Partners, Inc. not to exceed \$1,325,000.

Attachments

Salinas Valley Health – Evergreen Agreement Final

INDEPENDENT CONTRACTOR AGREEMENT
FOR PROFESSIONAL SERVICES

This Independent Contractor Agreement ("Agreement") is entered into and effective on **January 1, 2024** ("Effective Date"), by and between **Salinas Valley Memorial Healthcare System**, a local health care district organized and operated pursuant to Division 23 of the California Health & Safety Code, operating as Salinas Valley Health ("SVMHS"), and **Evergreen Healthcare Partners, Inc.** ("Contractor").

RECITALS

- A. SVMHS is the owner and operator of Salinas Valley Health Medical Center, an acute care facility located at 450 East Romie Lane, Salinas, California ("Hospital").
- B. Contractor provides experienced consultants for electronic medical record implementation training services.

SVMHS and Contractor hereby agree to the following terms and conditions:

ARTICLE 1. SERVICES TO BE PERFORMED BY CONTRACTOR

- 1.1 **Services.** Contractor shall perform the services set forth in Exhibit A of this Agreement and such other services as mutually agreed upon with SVMHS from time to time ("Services"). Contractor agrees to consult with SVMHS regarding the methods and means for carrying out the Services to the extent that such Services might impact the Hospital's obligations or operations.
- 1.2 **Performance of Services.** SVMHS shall not have or exercise any control or direction over the methods by which Contractor shall perform its Services under this Agreement. The sole interest of SVMHS is to assure that Contractor's Services are performed and administered in a competent, efficient and satisfactory manner. The Services provided by Contractor under this Agreement are intended to be non-exclusive in nature, and both parties expressly reserve the right to contract with other entities for the same or similar services.
- 1.3 **Independent Contractor.** In the performance of Services under this Agreement, it is mutually understood and agreed that the parties to this Agreement are at all times acting and performing as independent contractors, and nothing in this Agreement shall be construed to create between SVMHS and Contractor an employer/employee relationship or a joint venture relationship. No offer or obligation of permanent employment with SVMHS is intended or implied in any manner by this Agreement. Contractor understands and agrees that Contractor is not entitled to and shall not receive any healthcare, retirement, workers' compensation or other benefits available to SVMHS employees.

ARTICLE 2. COMPENSATION

- 2.1 **Fees for Services.** Contractor's fee for Services provided pursuant to this Agreement shall be as specified in Exhibit A, paid on a monthly basis. Contractor's fee for Services will be fixed for the term of this Agreement or until modified by written agreement of the parties to this Agreement.
- 2.2 **Payment of Contractor Invoices.** Contractor will invoice SVMHS for Services provided under this Agreement on a monthly basis and shall include total hours worked and detail of Services provided. Contractor's invoices are payable by SVMHS within thirty (30) days of receipt by SVMHS of a complete invoice.
- 2.3 **Reimbursements.** SVMHS shall have no obligation to reimburse Contractor for reasonable business expenses incurred by Contractor during the course of performing Services under this Agreement

(including, but not limited to, training, travel expenses, mileage, transcription services) unless such expenses are approved in writing by SVMHS before the expenses are incurred by Contractor.

ARTICLE 3. TERM AND TERMINATION

- 3.1 Term. This Agreement is effective and shall commence on the Effective Date first set forth above, and will continue for a period of twelve (12) months, unless earlier terminated pursuant to the terms of this Agreement.
- 3.2 Automatic Termination. This Agreement shall terminate automatically on the occurrence of any of the following events: (i) upon the bankruptcy or insolvency of either party; or (ii) upon thirty (30) days' prior written notice by either party, with or without stating a cause or reason.

ARTICLE 4. COMPLIANCE

- 4.1 Compliance with Laws, Rules and Regulations, Compliance Program. Contractor shall provide Services in strict accordance with all applicable state and federal laws and regulations, accreditation requirements, SVMHS rules, regulations, policies and procedures, without limitation. Contractor shall comply with the SVMHS Compliance Program ("Program") and any Program policies and procedures, as applicable to the Services provided under this Agreement.
- 4.2 HIPAA Compliance. Contractor may have access to medical records and other information regarding patients of Hospital ("Protected Health Information") for the purposes of providing Services under this Agreement. Contractor may use and disclose Protected Health Information only in accordance with such purposes and subject to the restrictions in the Business Associate Agreement attached here as Exhibit B. Contractor shall maintain the confidentiality of all Protected Health Information in accordance with all applicable federal, state and local laws and regulations, including, but not limited to, the California Confidentiality of Medical Information Act and the Federal Health Insurance Portability and Accountability Act of 1996, and regulations from time to time promulgated there under ("HIPAA").

ARTICLE 5. OBLIGATIONS OF CONTRACTOR

- 5.1 Insurance Coverage. Contractor shall maintain in effect throughout the term of this Agreement:
- 5.1.1 General Liability Insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 annual aggregate; and
- 5.1.2 Comprehensive Automobile Liability Insurance in the amount of \$100,000 per occurrence and \$300,000 annual aggregate covering all motor vehicles, including owned, leased, non-owned, and hired vehicles that are or will be used in providing Services under this Agreement, with coverage that complies with California statutory insurance requirements.

Evidence of insurance coverage shall be submitted to SVMHS as of the Effective Date of this Agreement.

- 5.2 Indemnification. Each party shall indemnify, defend, and hold harmless the other party, including its officers, directors, agents, and employees, from and against any and all claims, liabilities, losses, damages, costs, or expenses (including reasonable attorneys' fees) arising out of, alleged to arise out of, or connected with the wrongful, willful, or negligent acts or omissions of the indemnifying party or its officers, employees, agents, or subcontractors in the performance of this Agreement.
- 5.3 Contractor Not Excluded. Contractor warrants that, to its knowledge, neither Contractor nor its employees or agents performing services under this Agreement have been excluded from participation in federal or state healthcare programs. If an employee/agent performing services under this Agreement is excluded, Contractor will replace that employee/agent within a reasonable

time. If Contractor is excluded, SVMHS may terminate this Agreement, without penalty and with applicable refund, upon written notice to Contractor.

ARTICLE 6. RECORDS AND CONFIDENTIALITY

- 6.1 Confidentiality. Contractor shall comply with any and all federal, state, and local laws that provide for the confidentiality of records and other information. Contractor shall not disclose any confidential records or other confidential information received from the Hospital or prepared in connection with the performance of this Agreement unless Contractor is specifically authorized in writing to disclose such records or information. Contractor shall promptly transmit to SVMHS any and all requests for disclosure of any such confidential records or information. Contractor shall not use any confidential information gained by Contractor in the performance of this Agreement except for the sole purpose of carrying out Contractor's obligations under this Agreement.
- 6.2 Access to Records. SVMHS shall have the right to examine and audit all records and documents of Contractor and its subcontractors related to services provided under this Agreement. In accordance with Section 952 of the Omnibus Reconciliation Act of 1980, Contractor agrees that the books and records of Contractor will be available to the Secretary of Department of Health and Human Services and the Comptroller General of the United States, or their duly authorized representatives, for four (4) years after termination of this Agreement. In the event that any of the Services to be performed under this Agreement are performed by any subcontractor of Contractor at a value or cost of \$10,000 or more over a twelve (12) month period, Contractor shall comply and assure that such subcontractor complies with the provisions of Section 952 of the Omnibus Reconciliation Act of 1980. This Section shall be of no force and effect if it is not required by law.
- 6.3 Exclusive Property of SVMHS. All data, files, records, documents, specifications, promotional materials and similar items relating to the business of SVMHS, whether prepared by or with the assistance of Contractor or otherwise coming into Contractor's possession shall remain the exclusive property of SVMHS and shall not be removed from SVMHS' facilities under any circumstances without the prior written consent of SVMHS.
- 6.4 Return of Records. When this Agreement expires or terminates, Contractors shall return to SVMHS any SVMHS or Hospital records which Contractor utilized or received from or through SVMHS to perform Services under this Agreement.

ARTICLE 7. GENERAL PROVISIONS

- 7.1 Entire Agreement/Amendment. This Agreement constitutes the entire agreement between the parties pertaining to the subject matter. This Agreement supersedes all prior agreements, representations and understandings of the parties pertaining to subject matter of this Agreement. No amendment or modification of this Agreement shall be binding unless in writing and signed by the parties.
- 7.2 Waiver. Any waiver of any term or condition of this Agreement must be in writing and signed by the parties. The waiver of any of the term or condition shall not be construed as a waiver of any other terms or conditions in this Agreement.
- 7.3 Assignment and Subcontracting. Contractor shall not assign, subcontract or transfer its interest or obligations in this Agreement without the prior written consent of SVMHS.
- 7.4 Successors and Assigns. This Agreement and the rights, privileges, duties and obligations of the parties hereunder, to the extent assignable or delegable, shall be binding upon and inure to the benefit of the parties and their respective successors and permitted assigns.
- 7.5 Governing Law/Venue. This Agreement shall be governed by and interpreted under the laws of the State of California. Venue shall rest in Monterey County, California.

- 7.6 Severability. If any provision of this Agreement is declared illegal, unenforceable or in conflict with any governing law, it shall not affect the validity of the remaining portion of this Agreement.
- 7.7 Notices. Any notices under this Agreement may be effected either by personal delivery in writing or by mail, registered or certified, postage prepaid with return receipt requested. Mailed notices shall be addressed to the parties at the addresses appearing at the end of this Agreement, but each party may change the address by written notice in accordance with this paragraph.

The parties have executed this Agreement to be effective as of the Effective Date first set forth above.

SVMHS

Salinas Valley Memorial Healthcare System
450 East Romie Lane, Salinas, CA 93901

By: _____

Allen Radner, MD, President/CEO

Date: _____

12-19-2024

Contractor

Evergreen Healthcare Partners, Inc.
6720 Frank Lloyd Wright Ave #200
Middleton, WI 53562

By: _____

Name: _____

Title: _____

Date: _____

DocuSigned by:

Jeff Leach

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Jeff Leach

SVP

12/18/2024

Exhibit A

Contractor Services

Consultant Personnel, Project Terms, and Pricing Terms:

Resource Name	Role	Expected Start Date	Expected End Date	Hourly Rate	Total Estimated Cost
Stacy Wade	Clin Doc Principal Trainer	01/13/2025	12/19/2025	\$125.00	\$265,000
Lisa Herrington	Willow Principal Trainer	01/13/2025	12/19/2025	\$125.00	\$265,000
Cheryl Dennison	Beacon Principal Trainer	01/13/2025	12/19/2025	\$125.00	\$265,000
Alexis MacManus	Beaker Principal Trainer	01/13/2025	12/19/2025	\$125.00	\$265,000
John Butler	HIM Principal Trainer	01/13/2025	12/19/2025	\$125.00	\$265,000

Summary of Services:

▪ Serve as an Epic Principal Trainer on the Epic implementation ▪ Support Training Manager in daily activities related to the Epic Training ▪ Complete MST build ▪ Document issues, decisions, next steps, and provide appropriate escalation ▪ Maintain proper project documentation as requested by SVMHS ▪ Manage daily activities and priorities of the Epic Training team ▪ Train, mentor, and educate on the Epic system ▪ Create Training materials and deliver instruction as required ▪ Collaborate with SVMHS and Epic team to ensure successful outcomes and knowledge transfer ▪ Work onsite or remotely as agreed upon by SVMHS and Contractor ▪ Other activities as requested and defined by SVMHS

Additional Terms

- Rates listed above are effective from the Expected Start Date to the Expected End Date (“Project Term”) and are for contracted services only; any expenses will be reimbursed per the terms of the Agreement and this Exhibit. Travel expenses will be billed separately. The project budget for the resources above is not to exceed \$1,325,000, unless written approval is provided by SVMHS. This dollar amount includes the following estimated costs:
 - Two 60-hour weeks and two 50-hour weeks, that account for increased hours during go-live and testing weeks.
 - Travel estimated at \$62,500 (assuming five weeks of travel for all five roles).
- This Agreement is dependent on SVMHS’ board ratification approval of this Agreement, anticipated in the January 23, 2025 board meeting. If the SVMHS Board of Directors does not approve this Agreement, this Agreement shall automatically terminate without cost or penalty; provided, however, that SVMHS will make payment in full for any services rendered prior to the date of termination in accordance with the rates in this Exhibit A.

EXHIBIT B

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA") is made and entered into effective January 1, 2024 ("Effective Date") by and between **Salinas Valley Memorial Healthcare System**, a California local health care district operating as Salinas Valley Health ("SVMHS"), and **Evergreen Healthcare Partners, Inc.** ("Business Associate").

RECITALS

- A. SVMHS is the owner and operator of Salinas Valley Health Medical Center, an acute care hospital located at 450 East Romie Lane, Salinas, California 93901, and is a Covered Entity ("CE") as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). SVMHS also operates a community clinic under the name "Salinas Valley Health Clinics" pursuant to section 1206(b) of the California Health and Safety Code.
- B. CE wishes to disclose certain information to BA pursuant to the terms of an agreement between the parties ("Agreement") some of which may constitute Protected Health Information ("PHI").
- C. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to their Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, ("HITECH"), regulations promulgated thereunder by the U.S. Department of Health and Human Services ("HIPAA Regulations") and other applicable state or federal laws affecting or regulating the privacy or security of health information.
- D. CE and BA intend to fully comply with the HIPAA Regulation codified at 45 C.F.R. Parts 160 and 164, Subparts A and E ("Privacy Rule") and the HIPAA Regulation codified at 45 C.F.R. Parts 160 and 164, Subparts A and C ("Security Rule").
- E. The Privacy Rule and the Security Rule require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI.

In consideration of the promises, obligations, and responsibilities under this BAA, the parties agree as follows:

- 1. Definitions: All capitalized terms used but not otherwise defined in this BAA shall have the same meaning as those terms in HIPAA.
 - a. **Breach** shall have the meaning given to such term under the HITECH Act and HIPAA Regulations [42 U.S.C. Section 17921 and 45 C.F.R. Section 164.402].
 - b. **Breach Notification Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and D.
 - c. **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including, but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.
 - d. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to 45 C.F.R. Section 160.103.
 - e. **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to 45 C.F.R. Section 164.501.
 - f. **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to 45 C.F.R. Section 164.501.
 - g. **Electronic Protected Health Information** means Protected Health Information that is maintained in or transmitted by electronic media.

- h. **Electronic Health Record** shall have the meaning given to such term under the HITECH Act, including, but not limited to 42 U.S.C. Section 17921.
- i. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to 45 C.F.R. Section 164.501.
- j. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.
- k. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. In the event BA creates, receives, maintains, or transmits electronic PHI on behalf of CE, Protected Health Information includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].
- l. **Protected Information** shall mean PHI provided by CE to BA or created, maintained, received, or transmitted by BA on CE's behalf.
- m. **Security Incident** shall have the meaning given to such term under the Security Rule, including, but not limited to 45 C.F.R. Section 164.304.
- n. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.
- o. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, 42 U.S.C. Section 17932(h) and 45 C.F.R. Section 164.402.

2. **Obligations of Business Associate**

- a. **Permitted Uses and Disclosures.** BA shall use and disclose Protected Information only for the purpose of performing BA's obligations under the Agreement and as permitted or required under the BA Agreement, or as required by law. BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or HITECH. However, BA may use Protected Information as necessary (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA or (iii) as required by law; or (iv) for Data Aggregation purposes relating to the Health Care Operation of CE. If BA discloses Protected Information to a third party, BA must obtain prior to making any such disclosure, reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this BAA and used or disclosed only as required by law or for the purposes for which it was disclosed to such third party. Third party will agree to immediately notify BA of any breaches, suspected breaches, security incidents, or unauthorized uses or disclosures of the Protected Information in accordance with paragraph 2.k. of this BAA, to the extent it has obtained knowledge of such occurrences.
- b. **Prohibited Uses and Disclosures.** BA shall not use or disclose PHI other than as permitted or required by the Agreement and this BAA, or as required by law. BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a) and 45 C.F.R. Section 164.522(a)(vi)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by HITECH, and the HIPAA Regulations; however, this prohibition shall not affect payment by CE to BA for services provided pursuant to the Agreement.
- c. **Appropriate Safeguards.** BA shall implement appropriate safeguards to prevent the use or disclosure of Protected Information other than as permitted by the Agreement or this BAA, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including 45 C.F.R. Sections 164.308, 164.310, and 164.312. BA shall comply

with policies, procedures, and Security Rule documentation requirements including 45 C.F.R. Section 164.316.

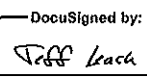
- d. **Business Associate's Subcontractors and Agents.** BA shall ensure that any agent and subcontractors that create, receive, maintain or transmit Protected Information on behalf of BA, shall agree in writing to the same restrictions and conditions that apply to BA with respect to such Protected Information and implement the safeguards required by paragraph 2.c. above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2)(ii)(D); 45 C.F.R. Section 164.308(b)]. BA shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation (see 45 C.F.R. Sections 164.530(f) and 164.530(e)(1)).
- e. **Access to Protected Information.** BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Set available to CE for inspection and copying within five (5) days of a request by CE to enable CE to fulfill its obligations under state law and the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524. If BA maintains Protected Information in electronic format, BA shall provide such information in electronic format as necessary to enable CE to fulfill its obligations under HITECH Act and HIPAA Regulations.
- f. **Amendment of PHI.** Within (10) days of a request by CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA and its agents and subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment or other documentation to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.526. If an individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request and of any approval or denial or amendment of Protected Information maintained by BA or its agents or subcontractors [45 C.F.R. Section 164.504(e)(2)(ii)(F)].
- g. **Accounting of Disclosures.** Within ten (10) days of a request by CE for an accounting of disclosures of Protected Information, BA and its agents and subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, and HITECH, as determined by CE. BA agrees to implement a process that allows an accounting to be collected and maintained by BA and its agents and subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Records for treatment, payment or health care operations are required to be collected and maintained for only three (3) years prior to the request and only to the extent that BA maintains an Electronic Health Record. At minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. If a patient submits a request for an accounting directly to BA or its agents or subcontractors, BA shall within five (5) days of the request forward it to CE in writing.
- h. **Governmental Access to Records.** BA shall make its internal practices, books, and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services for purpose of determining BA's compliance with HIPAA.
- i. **Minimum Necessary.** BA, its agents and subcontractors shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use or disclosure. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)] BA understands and agrees that the definition of "Minimum Necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary".
- j. **Data Ownership.** BA acknowledges that BA has no ownership rights with respect to the Protected Information.

- k. **Notification of Possible Breach.** BA shall notify CE within three (3) business days of any actual breach of CE's Protected Information; any use or disclosure of Protected Information not permitted by the Agreement or this BAA; any security incident (i.e., any successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system) related to CE's Protected Information, and any use or disclosure of data in violation of any applicable federal or state laws by BA or its agents or subcontractors.
- The notification shall include, to the extent possible, the identification of each individual whose unsecured Protected Information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed, as well as any other available information that CE is required to include in notification to the individual, the media, the Secretary, and any other entity under the Breach Notification Rule and any other applicable state or federal laws, including but not limited to 45 C.F.R. Section 164.404 through 45 C.F.R. Section 164.408, at the time of the notification required by this paragraph or promptly thereafter as information becomes available. BA shall take (i) prompt corrective action to cure any deficiencies and (ii) any action pertaining to unauthorized uses or disclosures required by applicable federal and state laws.
- l. **Notification Costs.** If BA experiences a breach, BA shall reimburse CE for all reasonable and actual notification costs CE incurs which arise out of any access, use, or disclosure of Protected Information by BA in violation of this BAA. Actual costs may include, costs of drafting and mailing notifications, legal costs, costs of responding to follow up questions from Individuals, the California Department of Public Health, the Secretary, and if applicable, any fines or penalties imposed on CE.
- m. **Breach Pattern or Practice by Business Associate's Subcontractor and Agents.** Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504 (e)(1)(ii); if the BA knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Agreement or this BAA or other arrangement, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the contract with the subcontractor or agent or other arrangement if feasible.
- n. **Audits, Inspection and Enforcement.** BA shall notify CE within five (5) days of learning of a request by CE, BA has become the subject of an audit, compliance review, or complaint investigation by the Office for Civil Rights or other state or federal government entity.
3. **De-Identification.** In addition to other permissible purposes, BA may be authorized to de-identify PHI, provided that de-identification is conducted in accordance with 45 CFR 164.514(a)-(c), if such de-identification is necessary for completion of the scope of services as described in the Agreement. De-identified information shall only be utilized as necessary for the completion of the scope of services as described in the Agreement.
4. **Obligations of Covered Entity.**
- a. **Notifications.** CE shall notify BA of limitation(s) in its Notice of Privacy Practices, to the extent such limitation will affect BA's permitted uses and disclosures under the Agreement and notify BA of changes in, or revocation of permission by an Individual to use or disclose PHI if such restriction affects BA's permitted uses and disclosures under the Agreement.
- b. **Minimum Necessary.** CE shall not request of nor provide BA with more PHI than what is minimally necessary for BA to perform its obligations under the Agreement. CE will not request BA to use or disclose PHI in any manner that would not be permissible under HIPAA if done by CE.
5. **Termination.**
- a. **Material Breach.** A breach by BA of any provision of this BAA, as determined by CE, shall constitute a material breach of the Agreement and shall provide grounds for termination of the Agreement, any provision in the Agreement to the contrary notwithstanding.
- b. **Judicial or Administrative Proceedings.** CE may terminate the Agreement, effective immediately if, (i) BA is named as a defendant in a criminal proceeding for a violation of HIPAA, HITECH, or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

- c. **Effect of Termination.** Upon termination of the Agreement for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections and satisfy the obligations of paragraph 2 of this BAA to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.
6. **Indemnification.** Each party ("Indemnifying Party") shall, to the full extent permitted by law, indemnify and hold harmless the other party and its directors, officers and employees from and against any and all losses, out-of-pocket costs, claims, penalties, fines, or liabilities in association with third-party claims from or related to the acts or omissions of the Indemnifying Party or its employees, directors, or agents, related to the performance or nonperformance of this BAA or a breach of HIPAA requirements. In the event the other Party does not accept a legitimate offer of settlement, the Indemnifying Party shall be responsible for such liability; damages, out-of-pocket costs and expenses in the amount contained in the offer, in a subsequent settlement, to the amount ultimately awarded by a court or tribunal whichever is less.
- This indemnification provision shall survive termination of this BAA and/or the Agreement for any reason.
7. **Limitation of Liability.** To the extent that the associated Agreement between the parties contains a provision that limits BA's liability under the Agreement, BA's obligations under this BAA, including but not limited to BA's indemnification obligations under the associated Agreement and this BAA, will be excluded from such limitation of liability.
8. **Amendment to Comply with Law.** The parties agree and acknowledge that state and federal laws relating to data security and privacy are evolving and that amendment of the BAA may be required to ensure compliance with such developments. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this BAA embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws relating to the security or confidentiality of PHI.
9. **No Third-Party Beneficiaries.** Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
10. **Interpretation.** The provisions of this BAA shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this BAA. The parties agree that any ambiguity in this BAA shall be resolved in favor of a meaning that complies and is consistent with HIPAA, HITECH, the HIPAA regulations, and other state and federal laws related to security and privacy.

The parties have duly executed this Business Associate Agreement as of the Effective Date first set forth above.

Business Associate
Evergreen Healthcare Partners, Inc.

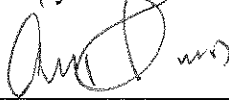
By: 
DocuSigned by:
D6F2CE12173E45A..

Print Name: Jeff Leach

Title: SVP

Date: 12/18/2024

SVMHS
Salinas Valley Memorial Healthcare System

By: 

Print Name: Allen Barden

Title: CEO

Date: 12-19-2024

CONTACTS	
PLEASE PROVIDE CONTACT INFORMATION AS REQUIRED FOR OCR AUDIT REPORTING	
COMPANY NAME	Evergreen Healthcare Partners, inc.
PRIMARY CONTACT	Rob Carr
PHONE	608-820-6910
CELL	608-820-6927
FAX	608-492-0401
ADDRESS	6720 Frank Lloyd Wright Ave #200 Middleton, WI 53562
EMAIL	rob.carr@evergreen.partners
SECONDARY CONTACT	Katie Foulks
PHONE	608-820-6910
CELL	504-234-0125
FAX	608-492-0401
ADDRESS	6720 Frank Lloyd Wright Ave #200 Middleton, WI 53562
EMAIL	katie.foulks@evergreen.partners

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval of Purchase of MRI Equipment and Service Agreement From Canon for SVH Clinics Imaging Services**

Executive Sponsor: Tim Albert, MD, MHCM, Chief Clinical Officer

Date: January 22, 2025

Executive Summary

In order to support the imaging infrastructure for Salinas Valley Health, capital updates are necessary to accommodate the growth in patient services. Salinas Valley Health Clinics operates imaging services from two locations which currently support two MRI scanners. The MRI machines are aging and the current demand for the service line is growing. The current clinic equipment supports low complexity, high volume studies such as routine body, brain, musculoskeletal, and cardiovascular imaging. The proposed equipment will support complex cardiac imaging as well as breast imaging and biopsies, expand outpatient MRI capacity, and improve patient access.

After evaluating MRI vendors, it was determined that the following two vendors aligned most appropriately with our current needs. The two competitors were Siemens and Canon because of the integration with our established imaging systems. The two systems were evaluated and it was determined by the SVH team that a Canon MRI should be installed in the SVH clinic. A standard market rate service agreement will be combined with the purchase of the equipment.

Timeline/Review Process to Date:

May 2024: Engaged vendors to review equipment and software
 June/July 2024: Received quotes from vendors for consideration
 December 2024: Final quotes selected, vendors presented contracts for legal review
 Early 2026: Anticipated Implementation

Strategic Plan Alignment:

In order to expand imaging services in our community, the new equipment will allow state of the art imaging at the outpatient clinic setting while supporting additional growth and patient access to high quality imaging services in a cost effective manner.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Key Contract Terms	Vendor: Canon Medical Systems USA, Inc.
1. Proposed effective date	February 1, 2025
2. Service Agreement Term	Sixty (60) month service agreement, \$598,250.00
3. Renewal terms	One-time purchase of Equipment; Renewable Service Agreement
4. Payment Terms	Cash – 0% down payment, 80% upon shipment net 45 days, 20% net 30 days upon completion of installation and / or availability for first use, whichever is earlier.
5. One time cost	Orian-SP – Vantage Orian SP 1.5 T MRI System \$1,385,027.00
7. Budgeted	Not budgeted, but essential for upgrade of equipment.

Recommendation

Salinas Valley Health Administration requests the SVH Board of Directors to approve the terms presented for purchasing MRI equipment for Salinas Valley Health Imaging from **Canon** in the amount of **\$1,385,027.00** and for a sixty month service agreement in an amount of **\$598,250.00**.

Financial Performance Review

December 2024

Finance Committee

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary

For the Month of December 2024

\$ in Millions	For the Month of December 2024			
			Variance fav (unfav)	
	Actual	Budget	\$VAR	%VAR
Operating Revenue	\$ 68.9	\$ 62.2	\$ 6.7	10.8%
Operating Expense	\$ 64.7	\$ 62.7	\$ (2.0)	-3.2%
Income from Operations	\$ 4.2	\$ (0.4)	\$ 4.6	1150.0%
Operating Margin %	6.1%	-0.7%	6.8%	971.43%
Non Operating Income	\$ 1.6	\$ 2.4	\$ (0.8)	-33.3%
Net Income	\$ 5.8	\$ 2.0	\$ 3.8	190.0%
Net Income Margin %	8.5%	3.3%	5.2%	157.6%

Non Operating Income includes Normalizing Items of:

- FEMA Grant funds (net) received in December \$217K

Consolidated Financial Summary

For the Month of December 2024 - Normalized

\$ in Millions	For the Month of December 2024				
			Variance fav (unfav)		
	Actual	Budget	\$VAR	%VAR	
Operating Revenue	\$ 68.9	\$ 62.2	\$ 6.7	10.8%	
Operating Expense	\$ 64.7	\$ 62.7	\$ (2.0)	-3.2%	
Income from Operations	\$ 4.2	\$ (0.4)	\$ 4.6	1150.0%	
Operating Margin %	6.1%	-0.7%	6.8%	971.43%	
Non Operating Income	\$ 1.4	\$ 2.4	\$ (1.0)	-41.7%	
Net Income	\$ 5.6	\$ 2.0	\$ 3.6	180.0%	
Net Income Margin %	8.1%	3.3%	4.8%	145.5%	

Non Operating Income excludes Normalizing Items of:

- FEMA Grant funds (net) received in December \$217K

Executive Summary: Financial Performance

Salinas Valley Health Income from Operations was \$4.2 million for the month which was favorable to budget by \$4.6M. The favorable financial performance for the month was driven by the following:

Key Favorable Performance Highlights:

- **Outpatient revenue** was favorable compared to budget by \$18M (8%), due to higher than budgeted patient volumes in the following areas:
 - **OP Surgeries** were over budget by 12% (31 cases)
 - **OP Infusion cases** were over budget by 13% (128 cases)
- **Total Inpatient Admissions** were 11% (99 admits) above budget
- **Average Daily Census** was 124 patients and favorable compared to a budget of 117
- **Average Length of Stay** was 5% favorable to budget at 3.8
- **Worked FTEs per PAADC** were 12% favorable at 5.7 on a target of 6.5
- **Cash Collections** for the month totaled \$55M which was 9% above budget

Executive Summary: Financial Performance – Cont'd

■ Key Unfavorable Performance Highlights:

- ✓ **Mammography** cases were below budget 17% (427 cases) Predominantly due to staffing issues with technologists and radiologists as a result of vacancies. Recruiting efforts have been underway as well as efforts for contracting travelers for technologists and locums for coverage of radiologists. Progress is expected to be seen on or before March/April.
- ✓ **Deliveries** were below budget 12% (14 cases)
- ✓ **Total Case Mix** was under budget by 3% at 1.56
- ✓ **OP Observation** cases were over budget by 34% (47 cases)
- ✓ **Non-Operating Income** was under budget \$0.8 million for the month on lower than budget investment income impacted by mark-to-market value adjustments. Federal interest rates declined by 25 basis points in December .

Consolidated Financial Summary

YTD December 2024

\$ in Millions	FY 2024 December YTD			
			Variance fav (unfav)	
	Actual	Budget	\$VAR	%VAR
Operating Revenue	\$ 402.3	\$ 372.3	\$ 30.0	8.1%
Operating Expense	\$ 387.0	\$ 377.9	\$ (9.1)	-2.4%
Income from Operations	\$ 15.3	\$ (5.6)	\$ 20.9	373.2%
Operating Margin %	3.8%	-1.5%	5.3%	353.3%
Non Operating Income	\$ 19.5	\$ 17.5	\$ 2.0	11.4%
Net Income	\$ 34.9	\$ 11.9	\$ 23.0	193.3%
Net Income Margin %	8.7%	3.2%	5.5%	171.9%

Non Operating Income includes Normalizing Items of:

- FEMA Grant funds (net) received YTD are \$2.8 million including \$217K in December
- FEMA Grant funds received inception to date total \$9 million

Consolidated Financial Summary

YTD December 2024 - Normalized

\$ in Millions	FY 2024 December YTD				
			Variance fav (unfav)		
	Actual	Budget	\$VAR	%VAR	
Operating Revenue	\$ 402.3	\$ 372.3	\$ 30.0	8.1%	
Operating Expense	\$ 387.0	\$ 377.9	\$ (9.1)	-2.4%	
Income from Operations	\$ 15.3	\$ (5.6)	\$ 20.9	373.2%	
Operating Margin %	3.8%	-1.5%	5.3%	353.3%	
Non Operating Income	\$ 16.7	\$ 17.5	\$ (0.8)	-4.6%	
Net Income	\$ 32.0	\$ 11.9	\$ 20.1	168.9%	
Net Income Margin %	8.0%	3.2%	4.8%	150.0%	

Non Operating Income excludes Normalizing Items of:

- FEMA Grant funds (net) received YTD are \$2.8 million including \$217K in December
- FEMA Grant funds received inception to date total \$9 million

SVHMC Revenue Highlights December 2024

Gross Revenues
were 8.5%
favorable to
budget

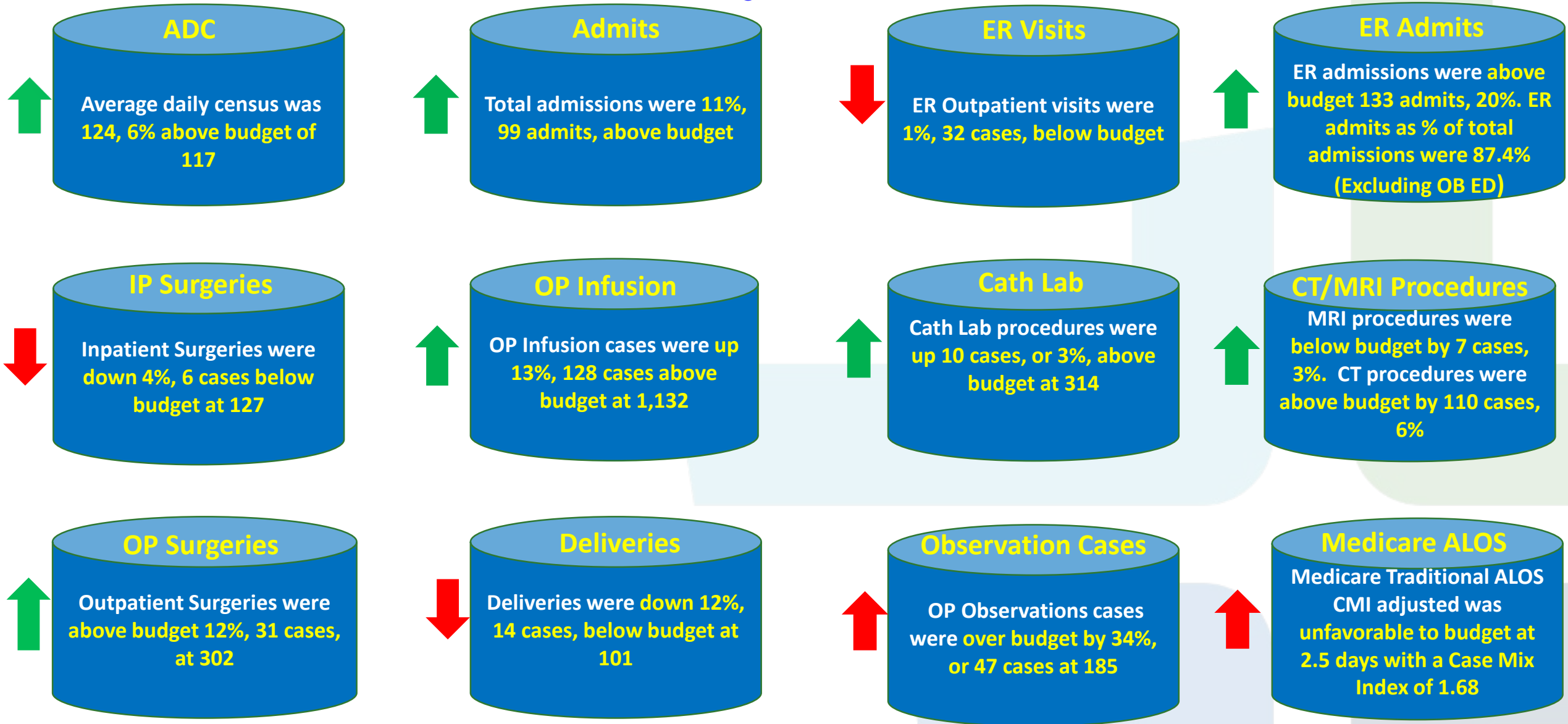
- IP Gross Revenues were 2.4% *favorable* to budget
- ED Gross Revenues were 0.1% *unfavorable* to budget
- OP Gross Revenues were 19.8% *favorable* to budget in the following areas:
 - OP Infusion
 - OP Surgery
 - CT

- Commercial: 8% *above* budget
- Medicaid: 9% *above* budget
- Medicare: 9% *above* budget

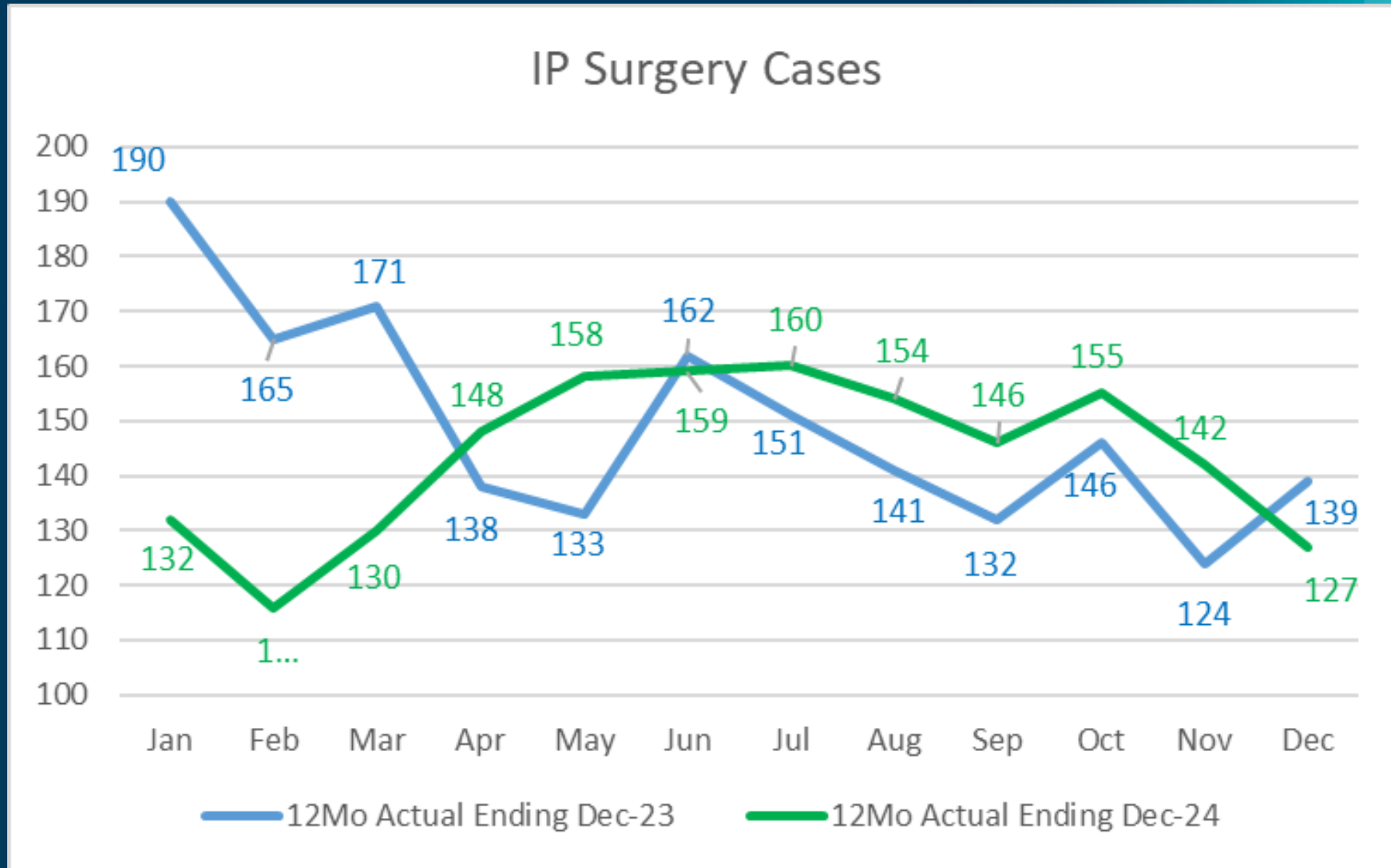
Payor Mix –Mixed

Total Net Patient
Revenues were \$57.7M,
which was *favorable* to
budget by \$6.1M or
11.8%

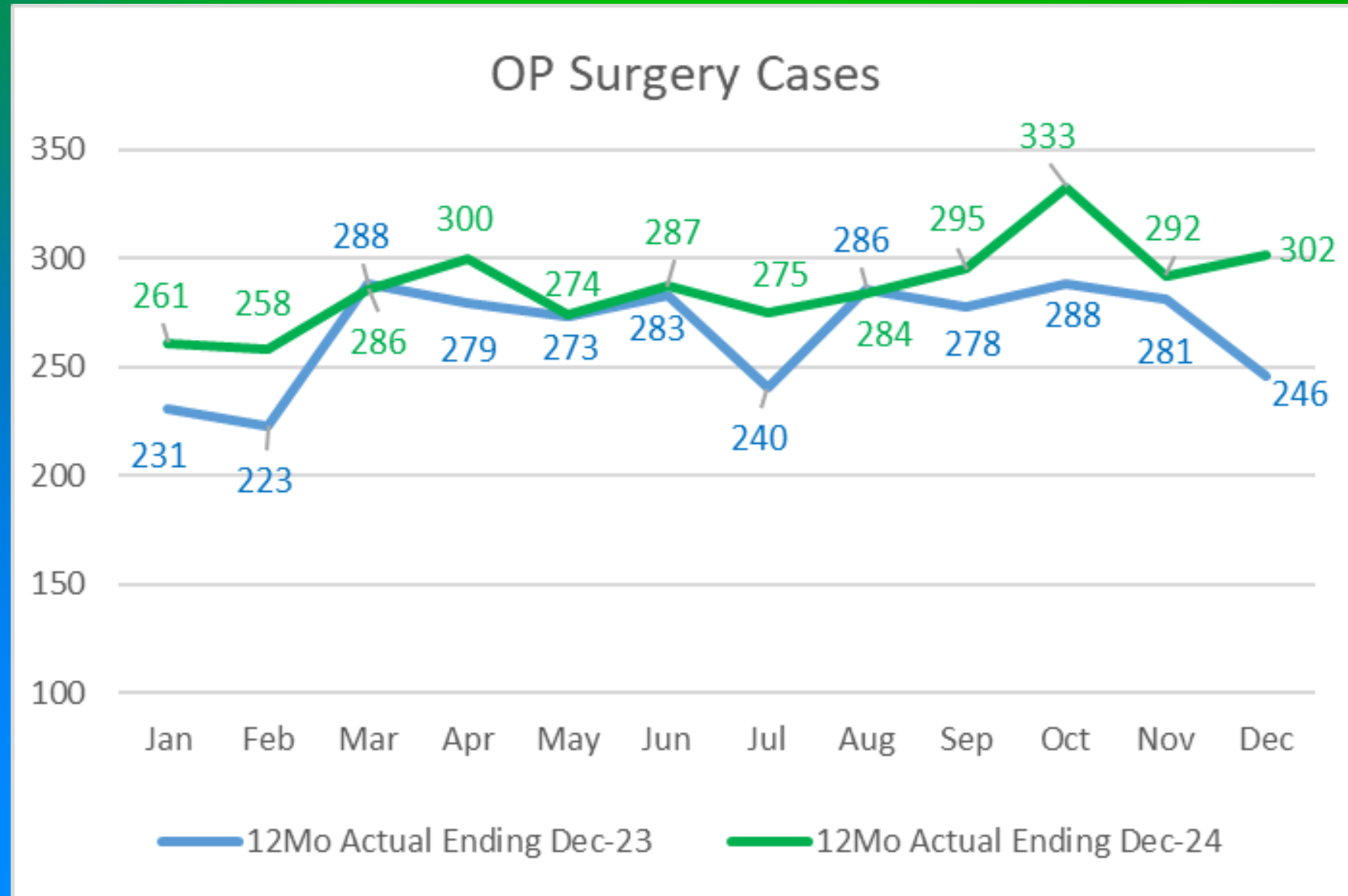
Financial Summary – December 2024



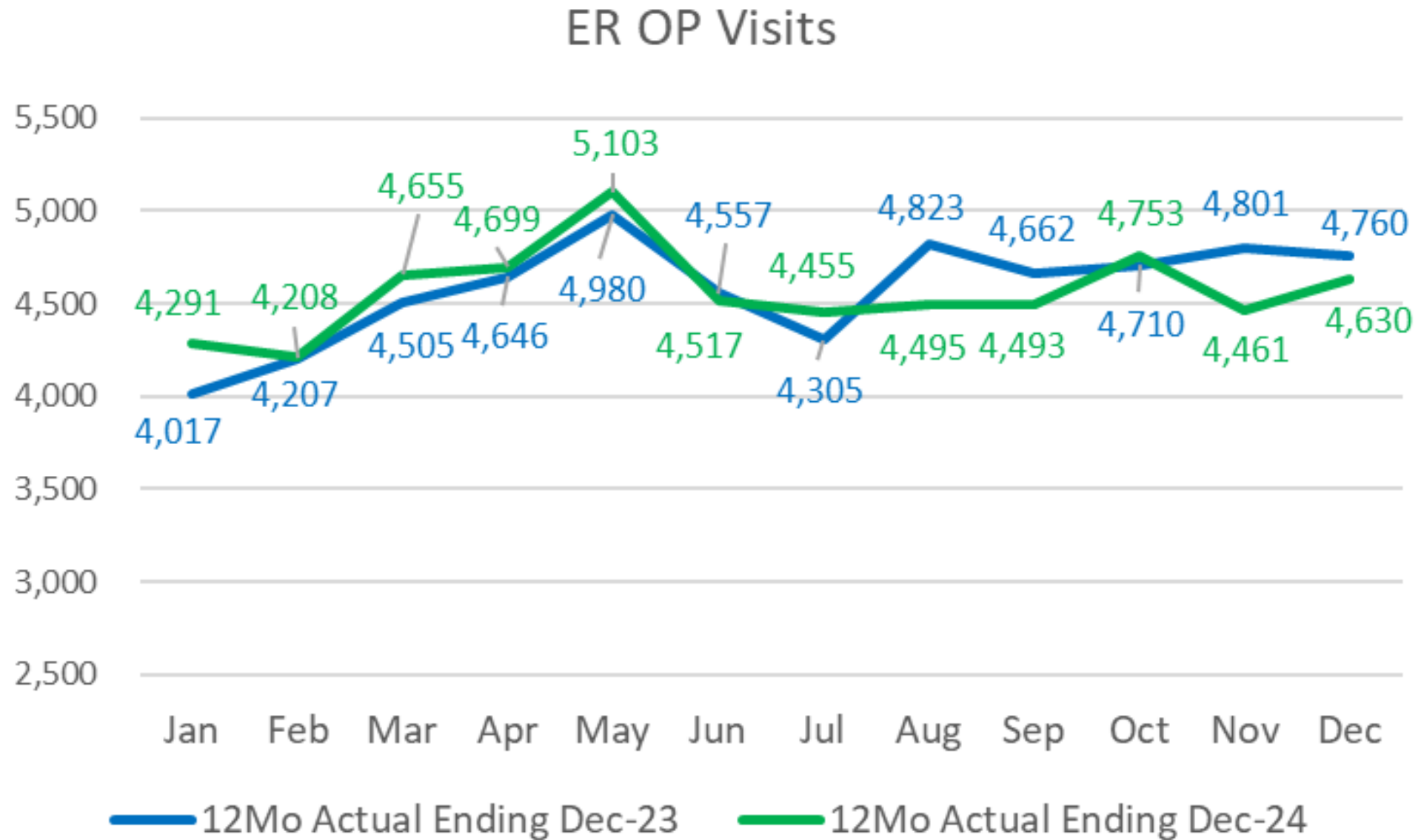
IP Surgery Cases – December 2024



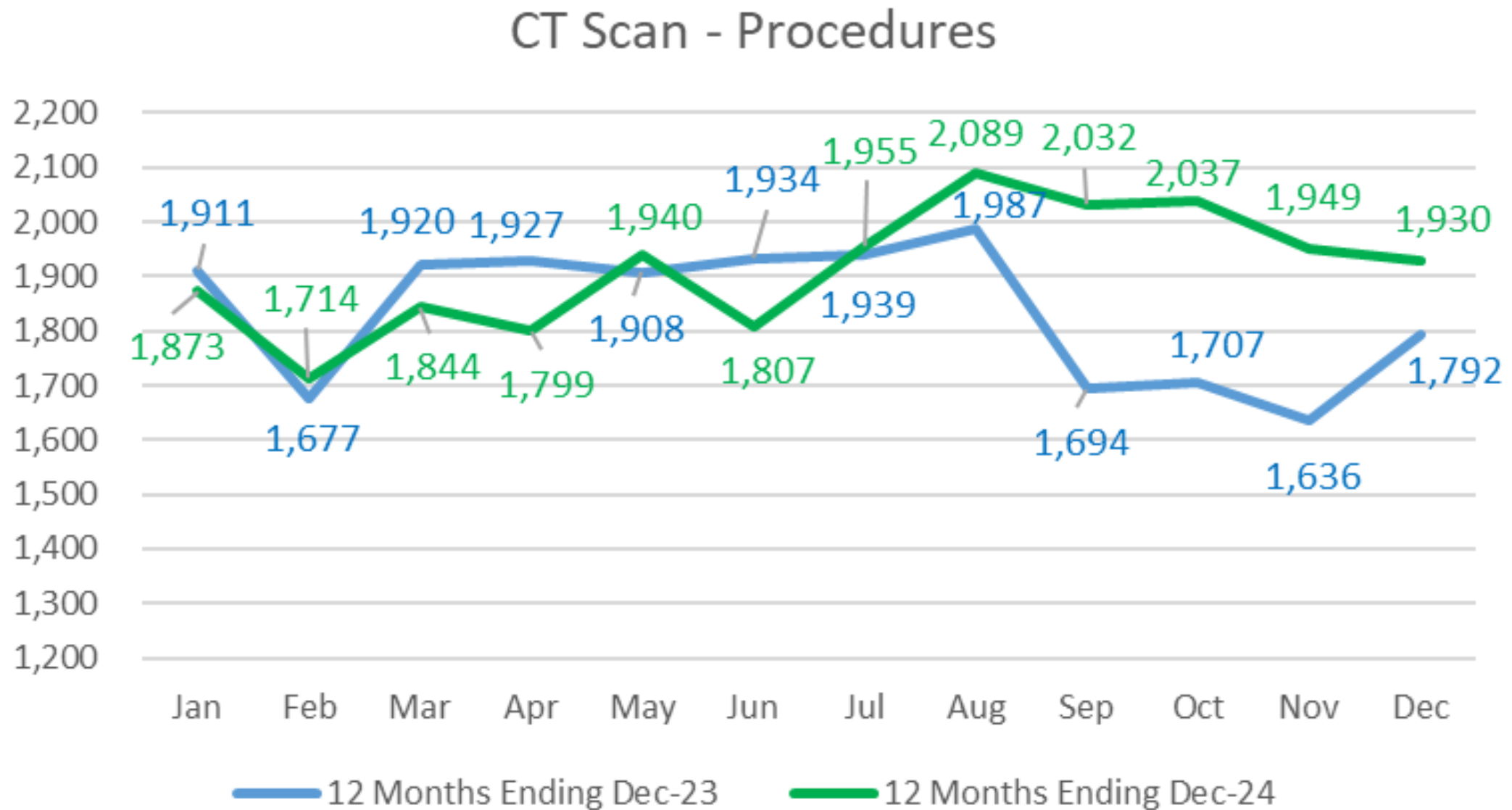
OP Surgery Cases – December 2024



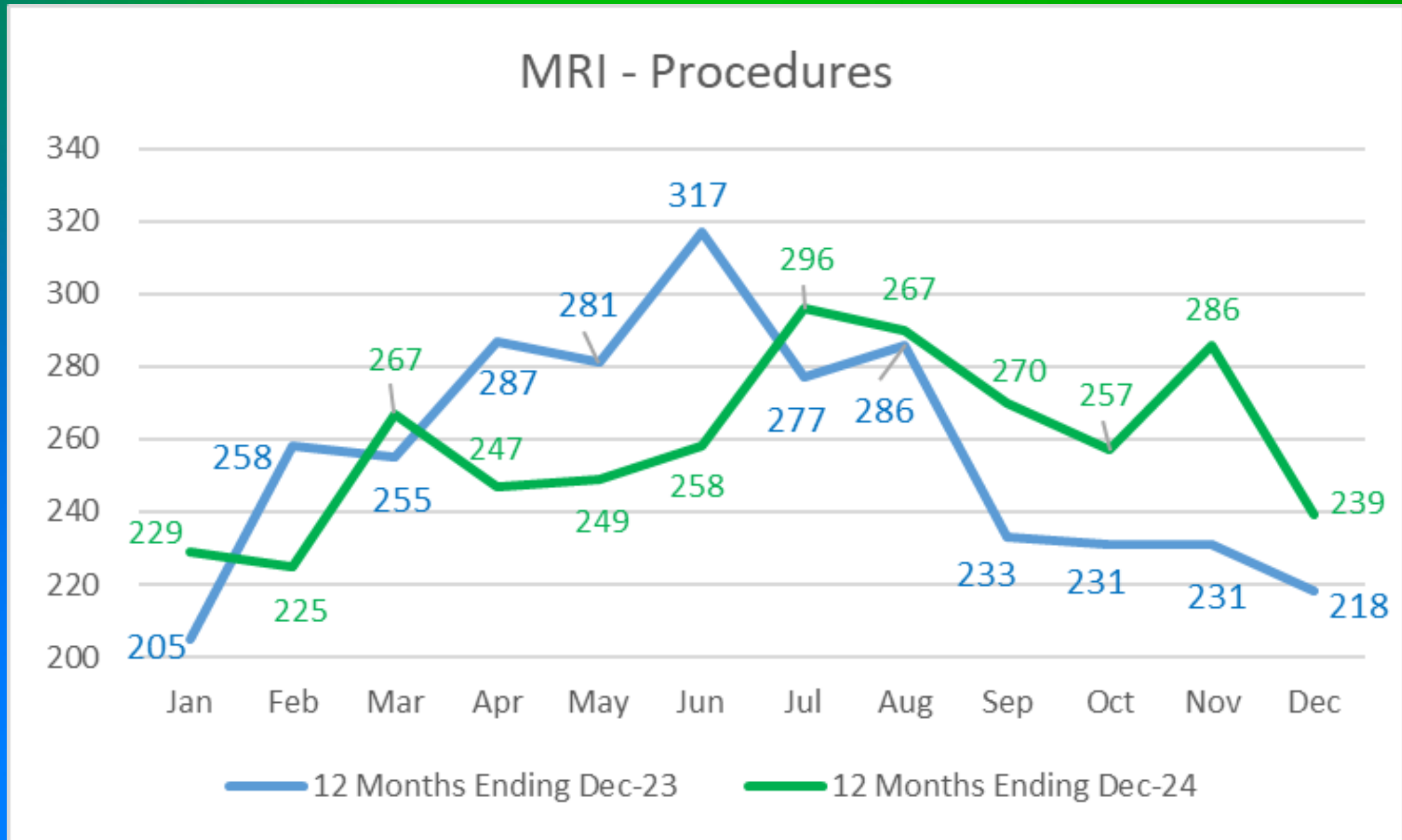
ER OP Visits – December 2024



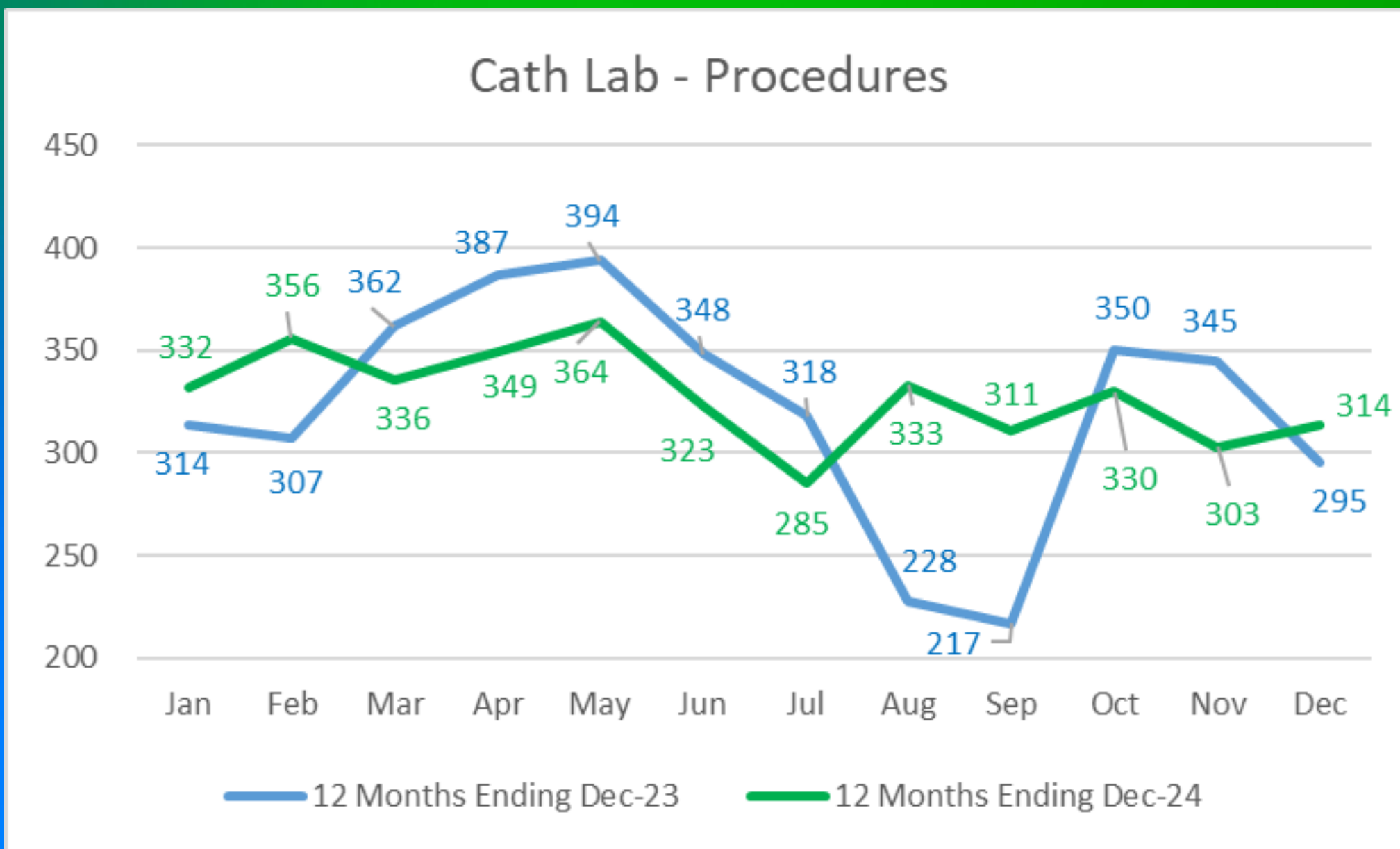
CT Scans – December 2024



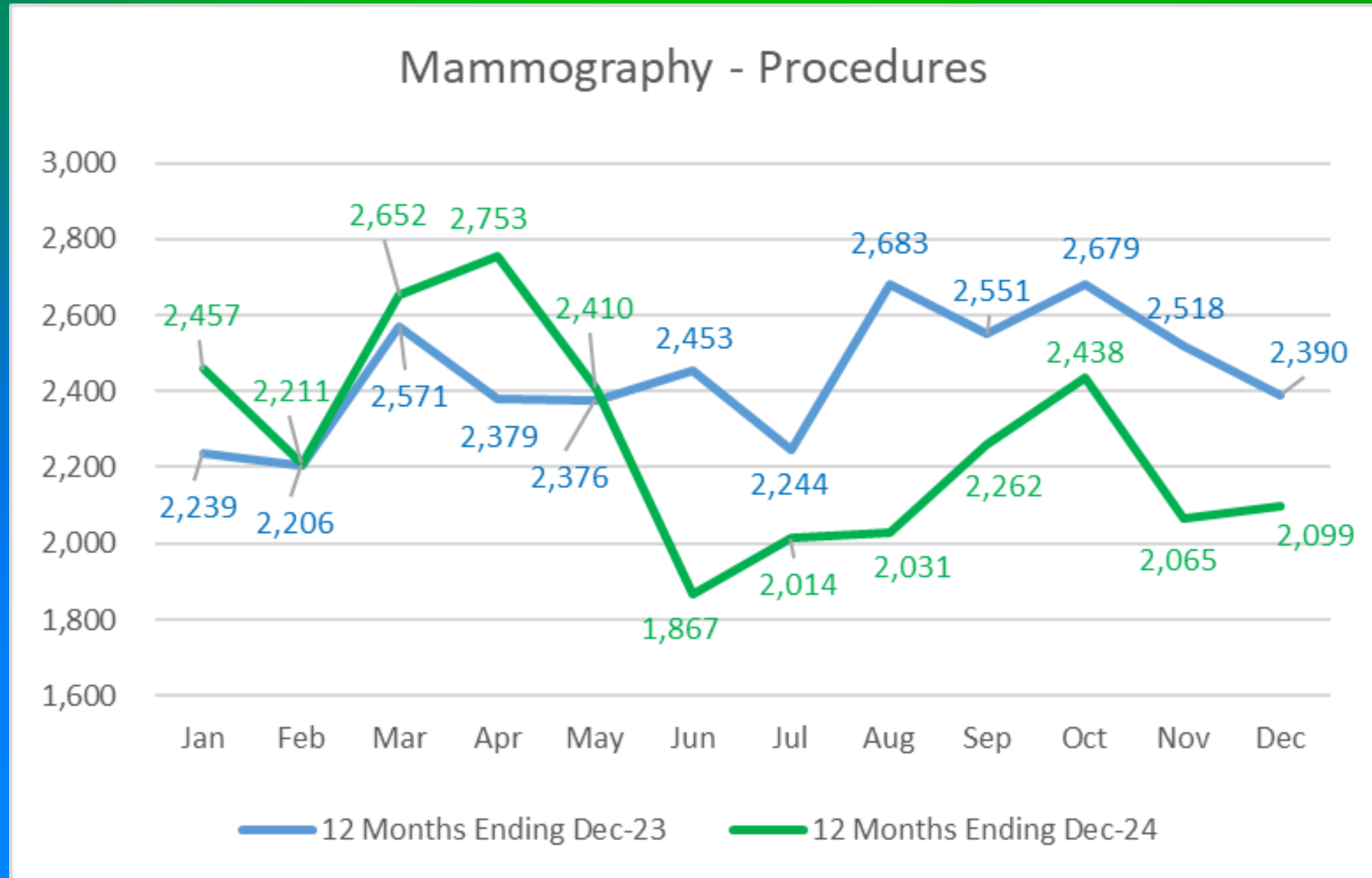
MRI – December 2024



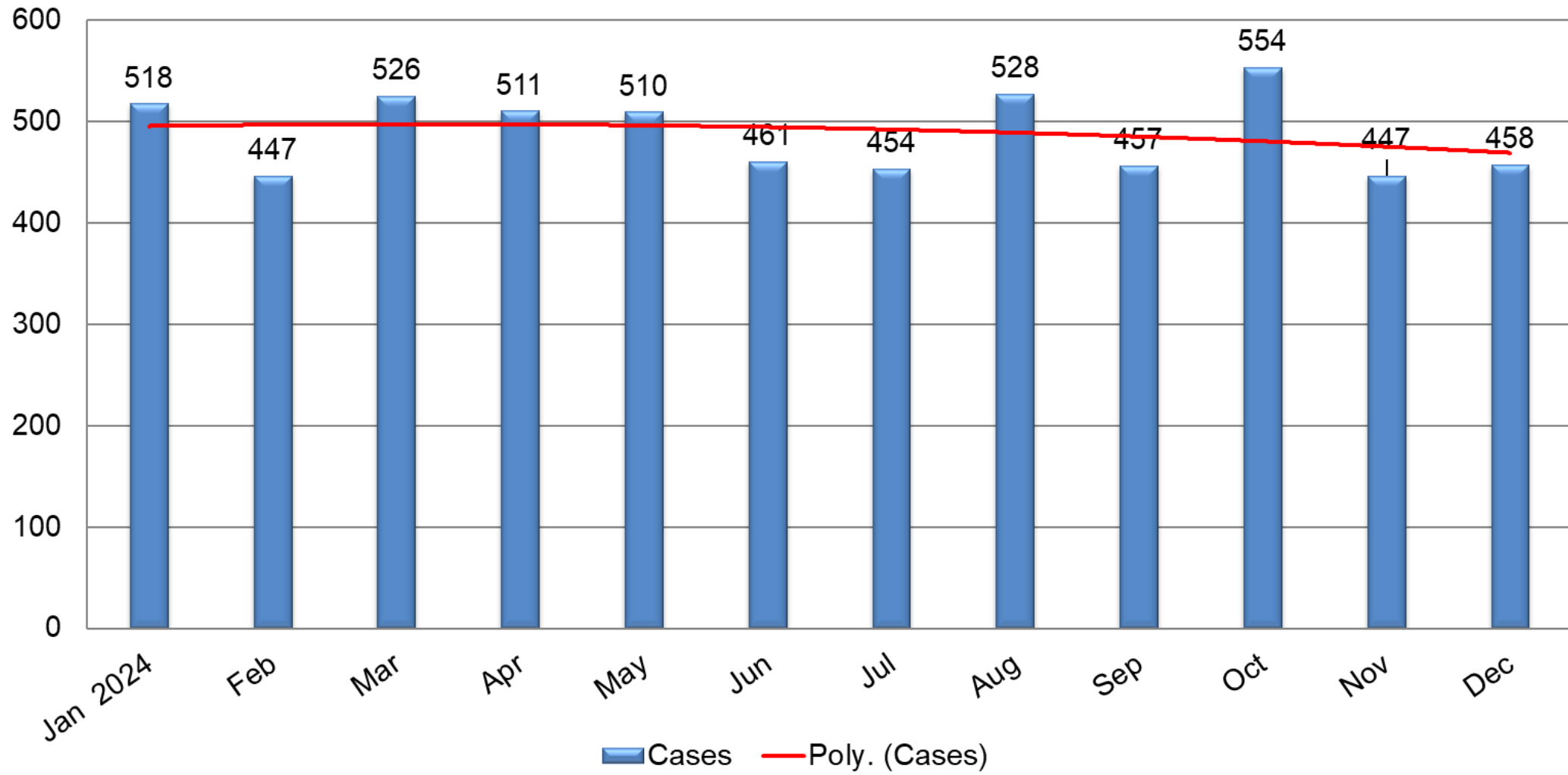
Cath Lab – December 2024



Mammography – December 2024



CDOC Cases - Rolling 12 Month Trend Jan 2024 thru Dec 2024

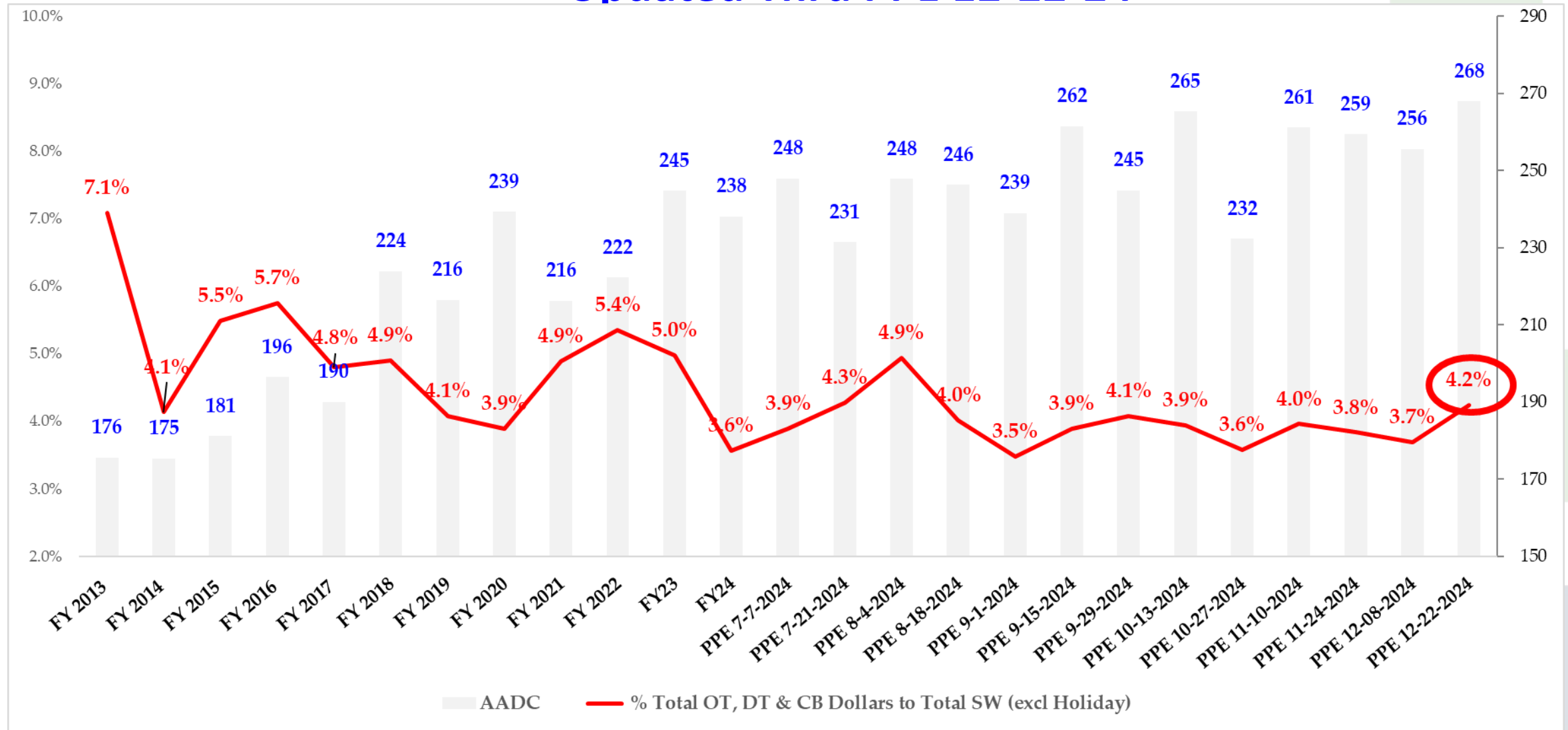


Labor Productivity – December 2024

- 1. Worked FTEs:** During the month of December, worked FTEs on a PAADC basis were 12% favorable at **5.7** with a target of **6.5**. *When reviewed on a unit-by-unit level, the variance was **91.5 FTEs positive (\$1.4m)**. The variance was driven by higher volumes in December.*
- 2. Worked FTEs** decreased from 1,595 in November to 1,473 in December. Average daily census increased by 8 compared to prior month at 124 (6% above budget).
- 3. Paid FTEs:** On a PAADC basis, paid FTEs were **11.8%** favorable to budget at **7.0 actual vs. 7.9 budget**. Paid FTEs decreased from 1,830 in November to 1,799 in December.

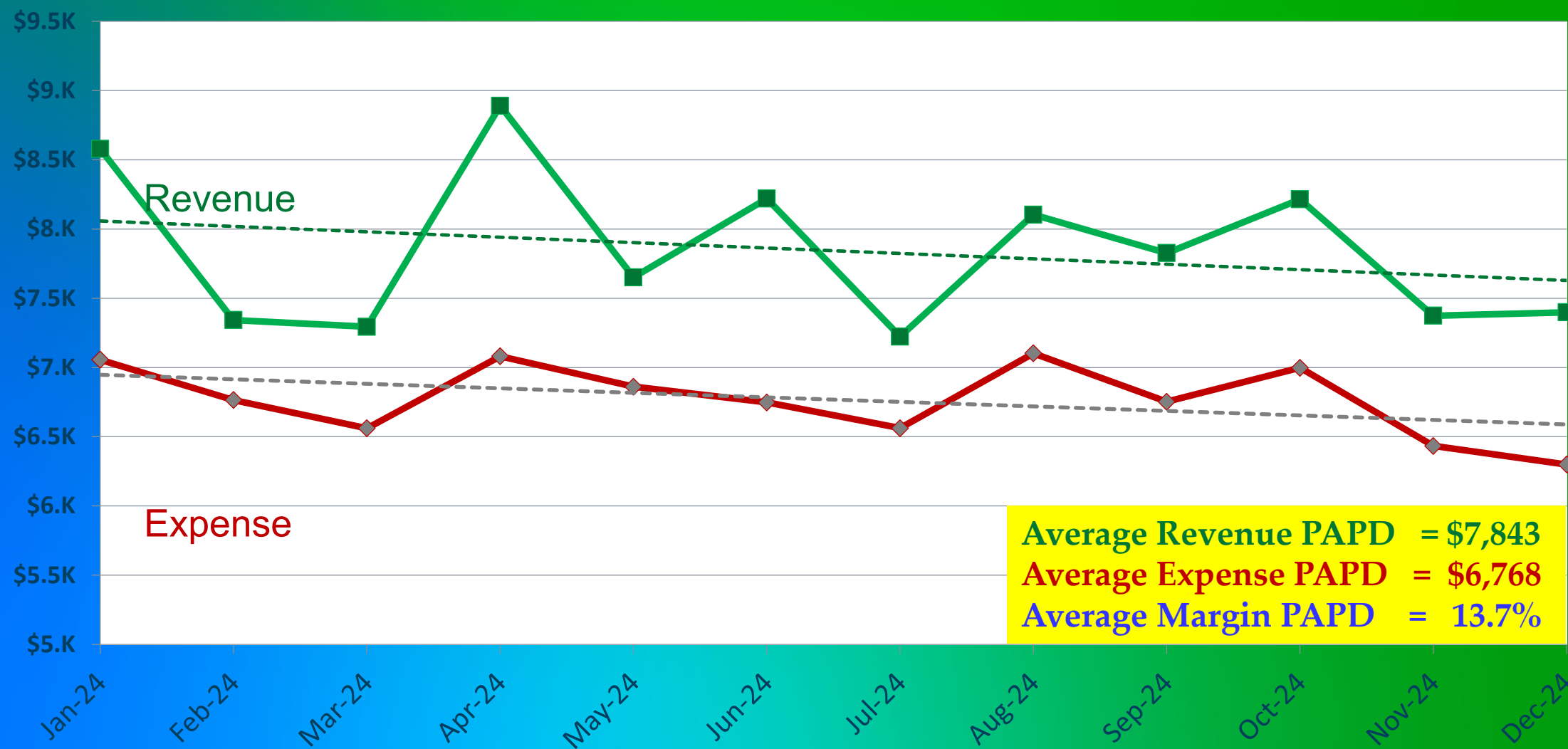
% of Total OT, DT & CB Dollars to Total S&W

Updated Thru PPE 12-22-24



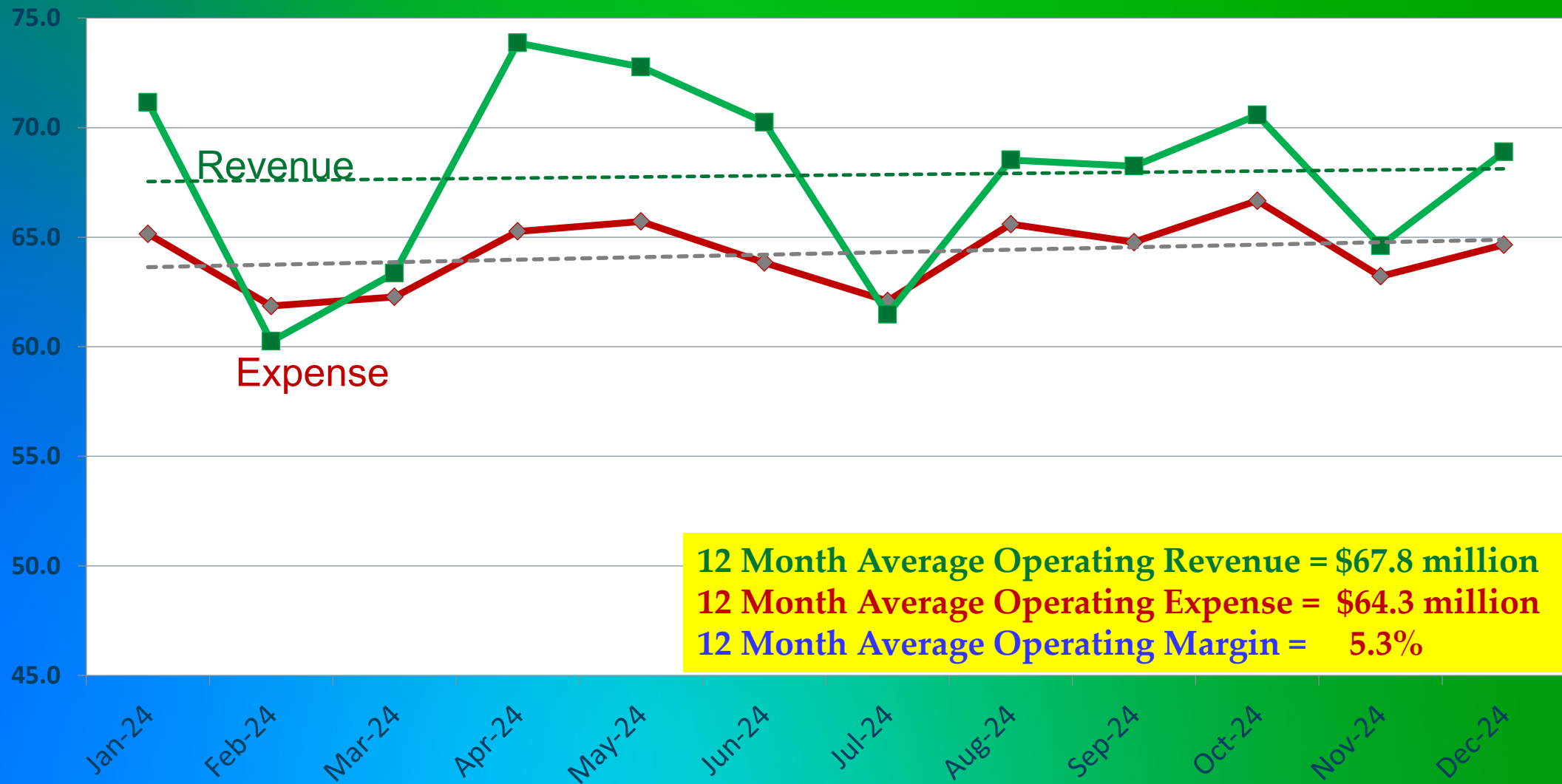
SVHMC Revenues & Expenses Per Adjusted Patient Day

Rolling 12 Months: Jan 24 to Dec 24



SVH Consolidated Revenues & Expenses

Rolling 12 Months: Jan 24 to Dec 24



Salinas Valley Health Key Financial Indicators

	YTD	SVH		S&P A+ Rated		YTD	
Statistic	12/31/24	Target	+/-	Hospitals	+/-	12/31/23	+/-
Operating Margin*	3.8%	5.0%		4.0%		-7.0%	
Total Margin*	8.0%	6.0%		6.6%		6.6%	
EBITDA Margin**	8.3%	7.4%		13.6%		-2.3%	
Days of Cash*	371	305		249		342	
Days of Accounts Payable*	50	45		-		47	
Days of Net Accounts Receivable***	62	45		49		60	
Supply Expense as % NPR	14.8%	14.0%		-		14.3%	
SWB Expense as % NPR	51.8%	53.0%		53.7%		57.2%	
Operating Expense per APD*	7,529	6,739		-		5,441	

All metrics above are consolidated for SVH except Operating Expense per APD

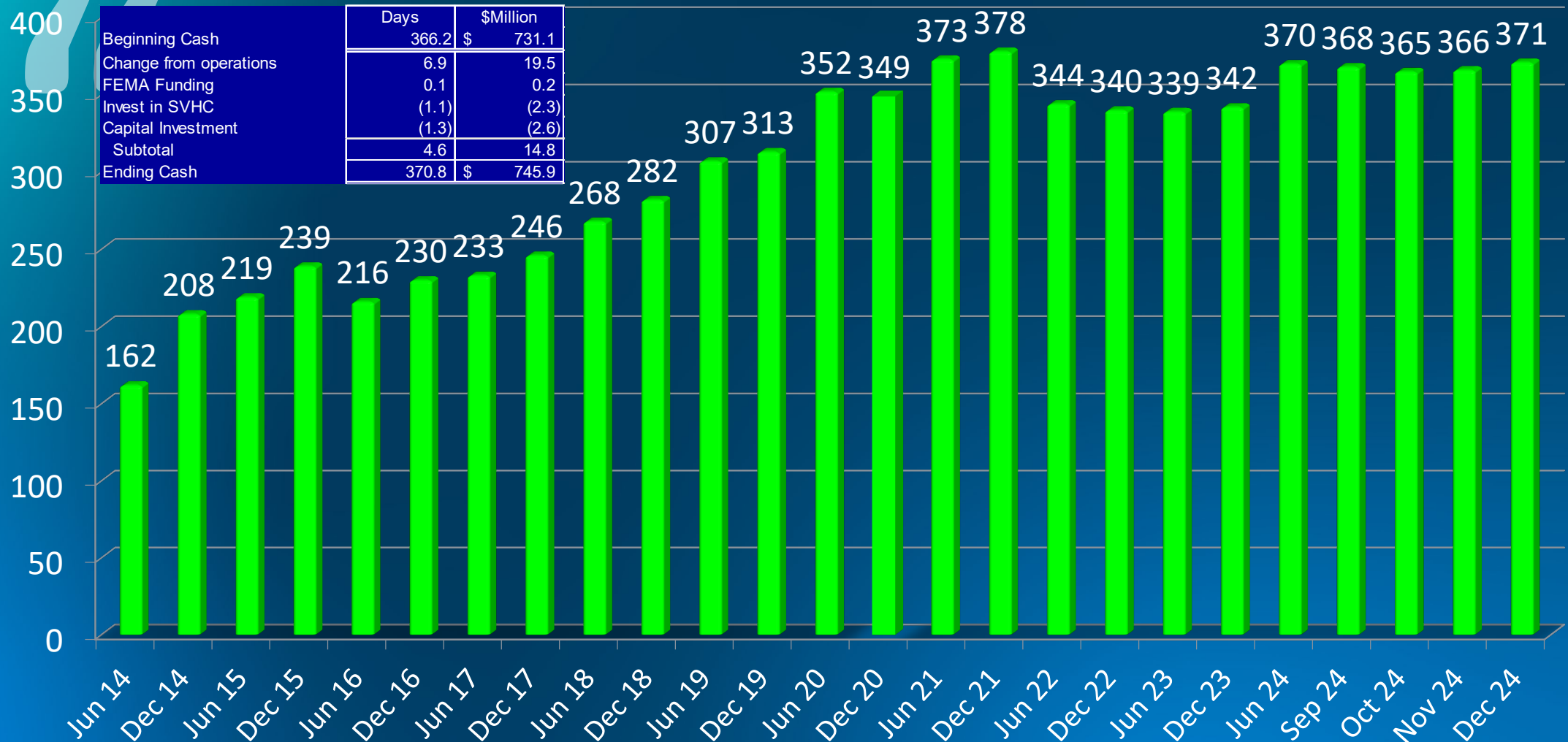
*These metrics have been adjusted for normalizing items

**Metric based on Operating Income (consistent with industry standard)

***Metric based on 365 days average net revenue (consistent with industry standard)

Salinas Valley Health

Days Cash on Hand = 371 Days (\$745.9M) - December 2024



Routine Capital Expenditures Through December 2024

Fiscal Month	FY 2025 Approved Budget *	Total Purchased Expenditures	Remaining	Project	Amount
July	1,916,667	712,780	1,203,887	ED Expansion	82,530
August	1,916,667	1,382,572	1,737,981	Nuclear Med D-Spect Camera	47,104
September	1,916,667	729,309	2,925,338	Angio Equipment Replacement	21,105
October	1,916,667	1,191,148	3,650,857	X-Ray Rooms Equipment Replacement	20,780
November	1,916,667	794,889	4,772,635	Miscellaneous	45,600
December	1,916,667	1,381,451	5,307,851	Total Improvements	217,118
January	1,916,667		7,224,518	IT Laptops, Printers, PC's and Related Equipment	349,547
February	1,916,667		9,141,184	Surgery Ultrasound	327,681
March	1,916,667		11,057,851	Pharmacy Cabinets	196,917
April	1,916,667		12,974,518	Phys and Business Dev, Auxillary Furnite and Workstations	52,100
May	1,916,667		14,891,184	Miscellaneous	238,089
June	1,916,667		16,807,851	Total Equipment	1,164,333
YTD TOTAL	23,000,000	6,192,149	16,807,851	Grand Total	1,381,451

Questions/Comments

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

	<u>Month of December,</u>		<u>Six months ended December 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Operating revenue:				
Net patient revenue	\$ 57,682,787	\$ 52,888,045	\$ 334,713,019	\$ 289,771,990
Other operating revenue	<u>1,477,702</u>	<u>1,612,340</u>	<u>8,991,127</u>	<u>7,246,740</u>
Total operating revenue	<u>59,160,489</u>	<u>54,500,385</u>	<u>343,704,146</u>	<u>297,018,730</u>
Total operating expenses	50,368,419	48,572,361	298,890,724	284,564,849
Total non-operating income	<u>(3,725,185)</u>	<u>472,100</u>	<u>(11,459,262)</u>	<u>(5,819,773)</u>
Operating and non-operating income	<u>\$ 5,066,885</u>	<u>\$ 6,400,124</u>	<u>\$ 33,354,160</u>	<u>\$ 6,634,108</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
December 31, 2024

	<u>Current year</u>	<u>Prior year</u>
ASSETS:		
Current assets	\$ 423,338,862	\$ 342,219,681
Assets whose use is limited or restricted by board	169,842,945	163,788,499
Capital assets	253,203,610	249,761,627
Other assets	298,329,470	287,888,357
Deferred pension outflows	<u>85,734,219</u>	<u>116,911,125</u>
	<u>\$ 1,230,449,106</u>	<u>\$ 1,160,569,289</u>
LIABILITIES AND EQUITY:		
Current liabilities	92,679,224	92,243,403
Long term liabilities	18,592,908	21,647,807
Lease deferred inflows	1,310,788	1,926,317
Pension liability	90,863,576	118,792,064
Net assets	<u>1,027,002,610</u>	<u>925,959,697</u>
	<u>\$ 1,230,449,106</u>	<u>\$ 1,160,569,289</u>

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

	<u>Month of December,</u>		<u>Six months ended December 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Patient days:				
By payer:				
Medicare	2,001	1,997	10,417	10,703
Medi-Cal	1,120	990	6,287	6,136
Commercial insurance	577	501	3,251	3,670
Other patient	106	158	669	643
Total patient days	<u>3,804</u>	<u>3,646</u>	<u>20,624</u>	<u>21,152</u>
Gross revenue:				
Medicare	\$ 130,456,522	\$ 112,377,689	\$ 748,325,884	\$ 657,549,721
Medi-Cal	80,210,590	70,432,469	477,798,888	406,910,614
Commercial insurance	59,124,897	59,382,383	344,554,562	316,400,725
Other patient	10,076,287	10,336,945	62,226,286	53,583,998
Gross revenue	<u>279,868,296</u>	<u>252,529,486</u>	<u>1,632,905,620</u>	<u>1,434,445,058</u>
Deductions from revenue:				
Administrative adjustment	465,665	319,397	2,080,546	1,625,910
Charity care	573,124	339,919	2,658,605	4,552,671
Contractual adjustments:				
Medicare outpatient	40,417,105	34,517,144	248,888,251	202,962,520
Medicare inpatient	53,104,830	54,614,027	284,251,682	279,174,418
Medi-Cal traditional outpatient	1,692,571	4,254,832	9,162,164	18,044,276
Medi-Cal traditional inpatient	2,792,094	4,739,170	32,791,339	28,116,409
Medi-Cal managed care outpatient	39,422,204	32,420,424	231,810,747	178,533,675
Medi-Cal managed care inpatient	28,560,165	25,988,563	155,737,339	143,882,158
Commercial insurance outpatient	26,285,753	14,355,511	159,166,396	131,435,634
Commercial insurance inpatient	22,464,170	21,057,656	130,464,096	123,803,543
Uncollectible accounts expense	5,547,100	4,205,137	32,390,140	25,312,290
Other payors	860,728	2,829,661	8,791,296	7,229,566
Deductions from revenue	<u>222,185,509</u>	<u>199,641,441</u>	<u>1,298,192,601</u>	<u>1,144,673,069</u>
Net patient revenue	<u>\$ 57,682,787</u>	<u>\$ 52,888,045</u>	<u>\$ 334,713,019</u>	<u>\$ 289,771,990</u>
Gross billed charges by patient type:				
Inpatient	\$ 134,547,601	\$ 135,188,320	\$ 764,245,078	\$ 730,087,117
Outpatient	113,903,303	87,759,834	679,195,297	528,127,246
Emergency room	31,417,392	29,581,331	189,465,245	176,230,695
Total	<u>\$ 279,868,296</u>	<u>\$ 252,529,486</u>	<u>\$ 1,632,905,620</u>	<u>\$ 1,434,445,058</u>

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

	<u>Month of December,</u>		<u>Six months ended December 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Operating revenue:				
Net patient revenue	\$ 57,682,787	\$ 52,888,045	\$ 334,713,019	\$ 289,771,990
Other operating revenue	<u>1,477,702</u>	<u>1,612,340</u>	<u>8,991,127</u>	<u>7,246,740</u>
Total operating revenue	<u>59,160,489</u>	<u>54,500,385</u>	<u>343,704,146</u>	<u>297,018,730</u>
Operating expenses:				
Salaries and wages	17,974,205	17,051,771	105,453,439	99,337,719
Compensated absences	3,078,644	2,233,673	18,572,384	17,970,675
Employee benefits	6,626,759	9,018,730	47,244,184	49,746,211
Supplies, food, and linen	9,349,330	7,673,685	51,904,880	42,911,259
Purchased department functions	3,514,572	3,300,976	23,299,429	21,541,822
Medical fees	2,705,916	2,198,126	15,041,807	15,138,980
Other fees	2,609,166	2,538,676	11,541,657	13,240,492
Depreciation	2,705,538	2,391,193	15,188,415	14,385,247
All other expense	1,804,289	2,165,531	10,644,529	10,292,444
Total operating expenses	<u>50,368,419</u>	<u>48,572,361</u>	<u>298,890,724</u>	<u>284,564,849</u>
Income from operations	<u>8,792,070</u>	<u>5,928,024</u>	<u>44,813,422</u>	<u>12,453,881</u>
Non-operating income:				
Donations	230,929	0	4,007,960	1,333,552
Property taxes	476,714	333,333	2,860,286	2,000,000
Investment income	(120,673)	4,705,508	9,762,714	17,286,322
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,312,155)	(4,566,741)	(28,090,222)	(26,439,647)
Total non-operating income	<u>(3,725,185)</u>	<u>472,100</u>	<u>(11,459,262)</u>	<u>(5,819,773)</u>
Operating and non-operating income	5,066,885	6,400,124	33,354,160	6,634,108
Net assets to begin	<u>1,021,935,725</u>	<u>919,559,573</u>	<u>993,648,450</u>	<u>919,325,589</u>
Net assets to end	<u>\$ 1,027,002,610</u>	<u>\$ 925,959,697</u>	<u>\$ 1,027,002,610</u>	<u>\$ 925,959,697</u>
Net income excluding non-recurring items	\$ 5,066,885	\$ 6,400,124	\$ 33,354,160	\$ 6,634,108
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Operating and non-operating income	<u>\$ 5,066,885</u>	<u>\$ 6,400,124</u>	<u>\$ 33,354,160</u>	<u>\$ 6,634,108</u>

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

	<u>Month of December,</u>		<u>Six months ended December 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	\$ (218,205)	\$ (220,489)	\$ (1,212,536)	\$ (1,199,679)
Neurological Clinic	(82,976)	(77,633)	(407,545)	(438,228)
Palliative Care Clinic	(104,528)	(87,747)	(661,750)	(518,552)
Surgery Clinic	(74,869)	(175,981)	(1,043,340)	(1,090,961)
Infectious Disease Clinic	(52,283)	(41,327)	(267,345)	(212,536)
Endocrinology Clinic	(200,084)	(231,840)	(1,359,967)	(1,354,971)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(594,733)	(650,667)	(3,451,126)	(3,397,421)
OB/GYN Clinic	(264,270)	(407,702)	(2,370,759)	(2,368,237)
PrimeCare Medical Group	(702,633)	(734,479)	(5,083,892)	(5,057,924)
Oncology Clinic	(411,339)	(372,590)	(2,352,939)	(1,935,226)
Cardiac Surgery	(346,864)	(304,486)	(2,062,632)	(1,909,249)
Sleep Center	(73,709)	(53,347)	(516,260)	(289,014)
Rheumatology	(66,003)	(80,654)	(452,548)	(415,328)
Precision Ortho MDs	(428,522)	(493,193)	(2,643,635)	(2,820,572)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(81,862)	(39,991)	(456,761)	(254,396)
Vaccine Clinic	0	0	0	16
Dermatology	(44,473)	(33,683)	(257,946)	(236,505)
Hospitalists	0	0	0	0
Behavioral Health	(33,173)	(47,319)	(244,889)	(254,301)
Pediatric Diabetes	(35,507)	(38,577)	(253,379)	(281,264)
Neurosurgery	(128,719)	(53,521)	(692,981)	(208,661)
Multi-Specialty-RR	15,192	(4,829)	70,817	18,563
Radiology	(299,596)	(436,182)	(1,971,647)	(1,883,797)
Salinas Family Practice	(131,189)	(136,425)	(685,213)	(832,953)
Urology	(186,437)	(170,575)	(1,154,653)	(1,006,574)
Total SVHC	(4,546,782)	(4,893,237)	(29,532,926)	(27,947,770)
Doctors on Duty	(9,276)	51,461	43,509	293,960
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	140,466	150,197	955,128	741,903
Coastal	43,460	53,298	4,646	235,686
Apex	0	0	0	0
21st Century Oncology	(0)	17,790	84,189	(11,393)
Monterey Bay Endoscopy Center	59,978	53,750	355,232	247,967
Total	<u>\$ (4,312,155)</u>	<u>\$ (4,566,741)</u>	<u>\$ (28,090,222)</u>	<u>\$ (26,439,647)</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
December 31, 2024

	<u>Current year</u>	<u>Prior year</u>
A S S E T S		
Current assets:		
Cash and cash equivalents	\$ 283,531,552	\$ 222,703,090
Patient accounts receivable, net of estimated uncollectibles of \$57,220,715	115,978,756	98,096,773
Supplies inventory at cost	9,241,513	8,196,095
Current portion of lease receivable	1,067,519	1,347,190
Other current assets	<u>13,519,522</u>	<u>11,876,533</u>
Total current assets	<u>423,338,862</u>	<u>342,219,681</u>
Assets whose use is limited or restricted by board	<u>169,842,945</u>	<u>163,788,499</u>
Capital assets:		
Land and construction in process	42,424,154	72,486,366
Other capital assets, net of depreciation	<u>210,779,456</u>	<u>177,275,261</u>
Total capital assets	<u>253,203,610</u>	<u>249,761,627</u>
Other assets:		
Right of use assets, net of amortization	6,333,251	7,151,987
Long term lease receivable	277,483	723,298
Subscription assets, net of amortization	7,891,305	8,530,817
Investment in Securities	263,993,737	252,336,815
Investment in SVMC	(2,348,584)	10,333,241
Investment in Coastal	1,757,016	1,917,327
Investment in other affiliates	21,459,497	14,285,397
Net pension asset	<u>(1,034,235)</u>	<u>(7,390,525)</u>
Total other assets	<u>298,329,470</u>	<u>287,888,357</u>
Deferred pension outflows	<u>85,734,219</u>	<u>116,911,125</u>
	<u>\$ 1,230,449,106</u>	<u>\$ 1,160,569,289</u>
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	\$ 60,921,255	\$ 60,654,038
Due to third party payers	3,635,397	5,505,983
Current portion of self-insurance liability	22,648,944	19,095,466
Current subscription liability	2,984,587	4,451,874
Current portion of lease liability	<u>2,489,041</u>	<u>2,536,043</u>
Total current liabilities	92,679,224	92,243,403
Long term portion of workers comp liability	12,078,720	13,027,333
Long term portion of lease liability	3,933,983	4,836,895
Long term subscription liability	<u>2,580,205</u>	<u>3,783,579</u>
Total liabilities	<u>111,272,132</u>	<u>113,891,211</u>
Lease deferred inflows	1,310,788	1,926,317
Pension liability	<u>90,863,576</u>	<u>118,792,064</u>
Net assets:		
Invested in capital assets, net of related debt	253,203,610	249,761,627
Unrestricted	<u>773,799,000</u>	<u>676,198,070</u>
Total net assets	<u>1,027,002,610</u>	<u>925,959,697</u>
	<u>\$ 1,230,449,106</u>	<u>\$ 1,160,569,289</u>

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

	Month of December,			Six months ended December 31,			
	Actual	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:							
Gross billed charges	\$ 279,868,296	\$ 21,955,708	8.51%	\$ 1,632,905,620	\$ 1,530,883,128	102,022,492	6.66%
Deductions from revenue	222,185,509	15,070,927	7.28%	1,298,192,601	1,225,856,484	72,336,117	5.90%
Net patient revenue	57,682,787	6,884,781	13.55%	334,713,019	305,026,643	29,686,376	9.73%
Other operating revenue	1,477,702	25,033	1.72%	8,991,127	8,716,014	275,113	3.16%
Total operating revenue	59,160,489	6,909,814	13.22%	343,704,146	313,742,657	29,961,489	9.55%
Operating expenses:							
Salaries and wages	17,974,205	918,781	5.39%	105,453,439	102,615,484	2,837,955	2.77%
Compensated absences	3,078,644	(600,782)	-16.33%	18,572,384	20,541,931	(1,969,547)	-9.59%
Employee benefits	6,626,759	(865,367)	-11.55%	47,244,184	47,285,533	(41,349)	-0.09%
Supplies, food, and linen	9,349,330	2,047,054	28.03%	51,904,880	43,341,472	8,563,408	19.76%
Purchased department functions	3,514,572	(310,712)	-8.12%	23,299,429	22,951,699	347,730	1.52%
Medical fees	2,705,916	220,279	8.86%	15,041,807	14,913,823	127,984	0.86%
Other fees	2,609,166	852,738	48.55%	11,541,657	10,470,447	1,071,210	10.23%
Depreciation	2,705,538	357,736	15.24%	15,188,415	14,100,780	1,087,635	7.71%
All other expense	1,804,289	(187,178)	-9.40%	10,644,529	11,911,040	(1,266,511)	-10.63%
Total operating expenses	50,368,419	2,432,548	5.07%	298,890,724	288,132,209	10,758,515	3.73%
Income from operations	8,792,070	4,477,266	103.77%	44,813,422	25,610,448	19,202,974	74.98%
Non-operating income:							
Donations	230,929	22,596	10.85%	4,007,960	1,250,000	2,757,960	220.64%
Property taxes	476,714	(0)	0.00%	2,860,286	2,860,286	(0)	0.00%
Investment income	(120,673)	(2,011,846)	-106.38%	9,762,714	11,347,039	(1,584,325)	-13.96%
Income from subsidiaries	(4,312,155)	811,067	-15.83%	(28,090,222)	(30,739,333)	2,649,111	-8.62%
Total non-operating income	(3,725,185)	(1,178,184)	46.26%	(11,459,262)	(15,282,008)	3,822,746	-25.01%
Operating and non-operating income	\$ 5,066,885	\$ 3,299,082	186.62%	\$ 33,354,160	\$ 10,328,440	23,025,720	222.94%

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of December and six months to date

	Month of December		Six months to date		Variance
	2023	2024	2023-24	2024-25	
NEWBORN STATISTICS					
Medi-Cal Admissions	32	31	215	209	(6)
Other Admissions	87	76	499	478	(21)
Total Admissions	119	107	714	687	(27)
Medi-Cal Patient Days	51	120	346	412	66
Other Patient Days	144	54	847	688	(159)
Total Patient Days of Care	195	174	1,193	1,100	(93)
Average Daily Census	6.3	5.6	6.5	6.0	(0.5)
Medi-Cal Average Days	1.5	3.9	1.7	2.1	0.4
Other Average Days	1.0	0.7	1.7	1.5	(0.2)
Total Average Days Stay	1.5	1.6	1.7	1.7	(0.0)
ADULTS & PEDIATRICS					
Medicare Admissions	427	391	2,247	2,252	5
Medi-Cal Admissions	308	280	1,573	1,720	147
Other Admissions	436	303	1,791	1,884	93
Total Admissions	1,171	974	5,611	5,856	245
Medicare Patient Days	1,678	1,496	9,079	8,658	(421)
Medi-Cal Patient Days	1,063	981	6,327	6,654	327
Other Patient Days	1,160	714	5,631	4,432	(1,199)
Total Patient Days of Care	3,901	3,191	21,037	19,744	(1,293)
Average Daily Census	125.8	102.9	114.3	107.3	(7.0)
Medicare Average Length of Stay	4.2	3.8	4.1	3.8	(0.2)
Medi-Cal AverageLength of Stay	3.3	3.2	3.5	3.4	(0.1)
Other Average Length of Stay	2.6	1.9	2.5	1.9	(0.6)
Total Average Length of Stay	3.4	2.9	3.3	3.0	(0.3)
Deaths	30	37	156	165	9
Total Patient Days	4,096	3,365	22,230	20,844	(1,386)
Medi-Cal Administrative Days	0	0	5	0	(5)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	0	0	5	0	(5)
Percent Non-Acute	0.00%	0.00%	0.02%	0.00%	-0.02%

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of December and six months to date

	Month of December		Six months to date		Variance
	2023	2024	2023-24	2024-25	
<u>PATIENT DAYS BY LOCATION</u>					
Level I	257	271	1,429	1,440	11
Heart Center	348	313	1,962	1,953	(9)
Monitored Beds	675	570	3,694	3,370	(324)
Single Room Maternity/Obstetrics	293	303	1,923	2,038	115
Med/Surg - Cardiovascular	923	820	4,976	5,219	243
Med/Surg - Oncology	302	271	1,658	1,618	(40)
Med/Surg - Rehab	546	469	2,720	2,797	77
Pediatrics	159	98	808	712	(96)
Nursery	195	174	1,193	1,100	(93)
Neonatal Intensive Care	142	76	795	597	(198)
<u>PERCENTAGE OF OCCUPANCY</u>					
Level I	63.77%	67.25%	59.74%	60.20%	
Heart Center	74.84%	67.31%	71.09%	70.76%	
Monitored Beds	80.65%	68.10%	74.36%	67.83%	
Single Room Maternity/Obstetrics	25.54%	26.42%	28.25%	29.94%	
Med/Surg - Cardiovascular	66.16%	58.78%	60.10%	63.03%	
Med/Surg - Oncology	74.94%	67.25%	69.31%	67.64%	
Med/Surg - Rehab	67.74%	58.19%	56.86%	58.47%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	28.49%	17.56%	24.40%	21.50%	
Nursery	38.12%	34.02%	19.65%	18.12%	
Neonatal Intensive Care	41.64%	22.29%	39.28%	29.50%	

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of December and six months to date

	Month of December		Six months to date		
	2023	2024	2023-24	2024-25	Variance
<u>DELIVERY ROOM</u>					
Total deliveries	116	123	651	683	32
C-Section deliveries	37	31	228	208	(20)
Percent of C-section deliveries	31.90%	25.20%	35.02%	30.45%	-4.57%
<u>OPERATING ROOM</u>					
In-Patient Operating Minutes	17,688	20,885	96,693	108,663	11,970
Out-Patient Operating Minutes	26,842	29,584	177,793	207,519	29,726
Total	44,530	50,469	274,486	316,182	41,696
Open Heart Surgeries	18	12	68	69	1
In-Patient Cases	111	134	694	708	14
Out-Patient Cases	274	301	1,758	1,957	199
<u>EMERGENCY ROOM</u>					
Immediate Life Saving	33	31	220	193	(27)
High Risk	870	838	4,335	5,179	844
More Than One Resource	2,926	2,736	17,153	16,733	(420)
One Resource	1,998	1,672	11,843	10,582	(1,261)
No Resources	64	62	594	464	(130)
Total	5,891	5,339	34,145	33,151	(994)

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

	<u>Month of December</u>		<u>Six months to date</u>		
	<u>2023</u>	<u>2024</u>	<u>2023-24</u>	<u>2024-25</u>	<u>Variance</u>
CENTRAL SUPPLY					
In-patient requisitions	13,803	12,340	78,342	75,023	-3,319
Out-patient requisitions	9,707	10,076	61,810	65,513	3,703
Emergency room requisitions	548	439	4,455	3,802	-653
Interdepartmental requisitions	7,278	7,476	39,603	40,525	922
Total requisitions	<u>31,336</u>	<u>30,331</u>	<u>184,210</u>	<u>184,863</u>	<u>653</u>
LABORATORY					
In-patient procedures	40,917	37,830	217,890	211,109	-6,781
Out-patient procedures	33,927	39,141	126,637	257,967	131,330
Emergency room procedures	13,411	12,842	78,182	74,711	-3,471
Total patient procedures	<u>88,255</u>	<u>89,813</u>	<u>422,709</u>	<u>543,787</u>	<u>121,078</u>
BLOOD BANK					
Units processed	<u>325</u>	<u>283</u>	<u>1,862</u>	<u>1,766</u>	<u>-96</u>
ELECTROCARDIOLOGY					
In-patient procedures	1,244	1,221	6,461	6,672	211
Out-patient procedures	409	431	2,394	2,437	43
Emergency room procedures	1,245	1,398	7,193	7,612	419
Total procedures	<u>2,898</u>	<u>3,050</u>	<u>16,048</u>	<u>16,721</u>	<u>673</u>
CATH LAB					
In-patient procedures	121	144	731	788	57
Out-patient procedures	130	112	672	760	88
Emergency room procedures	0	0	0	1	1
Total procedures	<u>251</u>	<u>256</u>	<u>1,403</u>	<u>1,549</u>	<u>146</u>
ECHO-CARDIOLOGY					
In-patient studies	446	404	2,237	2,385	148
Out-patient studies	302	340	1,625	1,972	347
Emergency room studies	0	3	7	10	3
Total studies	<u>748</u>	<u>747</u>	<u>3,869</u>	<u>4,367</u>	<u>498</u>
NEURODIAGNOSTIC					
In-patient procedures	144	117	794	795	1
Out-patient procedures	14	31	115	142	27
Emergency room procedures	0	0	0	1	1
Total procedures	<u>158</u>	<u>148</u>	<u>909</u>	<u>938</u>	<u>29</u>

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of December and six months to date

	Month of December		Six months to date		
	2023	2024	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	0	0
Out-patient procedures	225	263	1,364	1,646	282
Emergency room procedures	0	0	0	0	0
Total procedures	225	263	1,364	1,646	282
RADIOLOGY					
In-patient procedures	1,538	1,495	7,828	7,759	-69
Out-patient procedures	378	451	2,385	2,532	147
Emergency room procedures	1,488	1,613	8,962	9,372	410
Total patient procedures	3,404	3,559	19,175	19,663	488
MAGNETIC RESONANCE IMAGING					
In-patient procedures	133	160	841	1,103	262
Out-patient procedures	97	100	698	648	-50
Emergency room procedures	6	4	43	39	-4
Total procedures	236	264	1,582	1,790	208
MAMMOGRAPHY CENTER					
In-patient procedures	4,021	3,489	24,939	20,801	-4,138
Out-patient procedures	3,957	3,482	24,625	20,741	-3,884
Emergency room procedures	0	3	9	9	0
Total procedures	7,978	6,974	49,573	41,551	-8,022
NUCLEAR MEDICINE					
In-patient procedures	17	13	113	97	-16
Out-patient procedures	134	108	647	757	110
Emergency room procedures	1	0	2	2	0
Total procedures	152	121	762	856	94
PHARMACY					
In-patient prescriptions	93,636	87,235	497,415	477,786	-19,629
Out-patient prescriptions	14,682	16,674	94,024	99,718	5,694
Emergency room prescriptions	9,532	9,938	55,877	58,946	3,069
Total prescriptions	117,850	113,847	647,316	636,450	-10,866
RESPIRATORY THERAPY					
In-patient treatments	18,874	18,322	96,812	88,872	-7,940
Out-patient treatments	1,231	773	6,447	5,166	-1,281
Emergency room treatments	606	668	3,224	3,044	-180
Total patient treatments	20,711	19,763	106,483	97,082	-9,401
PHYSICAL THERAPY					
In-patient treatments	2,436	2,279	15,161	13,883	-1,278
Out-patient treatments	265	236	1,577	1,456	-121
Emergency room treatments	0	0	0	0	0
Total treatments	2,701	2,515	16,738	15,339	-1,399

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of December and six months to date

	Month of December		Six months to date		
	2023	2024	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,189	1,430	8,442	8,501	59
Out-patient procedures	212	203	1,411	1,182	-229
Emergency room procedures	0	0	0	0	0
Total procedures	1,401	1,633	9,853	9,683	-170
SPEECH THERAPY					
In-patient treatments	611	563	3,056	3,111	55
Out-patient treatments	58	39	232	204	-28
Emergency room treatments	0	0	0	0	0
Total treatments	669	602	3,288	3,315	27
CARDIAC REHABILITATION					
In-patient treatments	0	0	9	4	-5
Out-patient treatments	462	505	2,945	3,715	770
Emergency room treatments	0	0	0	1	1
Total treatments	462	505	2,954	3,720	766
CRITICAL DECISION UNIT					
Observation hours	385	292	1,798	1,498	-300
ENDOSCOPY					
In-patient procedures	84	68	442	498	56
Out-patient procedures	67	58	358	342	-16
Emergency room procedures	0	1	0	1	1
Total procedures	151	127	800	841	41
C.T. SCAN					
In-patient procedures	820	789	4,256	4,544	288
Out-patient procedures	299	457	2,127	2,944	817
Emergency room procedures	675	686	4,381	4,511	130
Total procedures	1,794	1,932	10,764	11,999	1,235
DIETARY					
Routine patient diets	14,690	16,806	104,972	94,192	-10,780
Meals to personnel	30,741	38,344	170,705	211,556	40,851
Total diets and meals	45,431	55,150	275,677	305,748	30,071
LAUNDRY AND LINEN					
Total pounds laundered	101,270	100,705	584,027	584,034	7

*TRANSFORMATION, STRATEGIC PLANNING
AND GOVERNANCE COMMITTEE*

*Minutes of the
Transformation, Strategic Planning and
Governance Committee
will be distributed at the Board Meeting*

(ROLANDO CABRERA, M.D.)

Board Paper: SVH Board of Directors

Agenda Item: **Consider Approval of Contract Terms for Dolores Peña, MD's Family Medicine Professional Services Agreement**

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

Date: January 23, 2025

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 **Family Medicine** as a priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, family medicine specialties were recommended as top priorities for recruitment. In addition, this recruitment for Taylor Farms Family Health & Wellness Center (TFFH&WC) will increase access for the underserved patient population in South Monterey County.

The recommended physician, **Dolores Peña, MD**, received her Doctor of Medicine Degree in 2019 from the Universidad Autonoma de Guadalajara School of Medicine in Jalisco, Mexico. In June 2023, Dr. Peña completed her Family Residency training at Natividad Medical Center and a Reproductive Health Care Fellowship at Planned Parenthood in Oakland. Currently, Dr. Peña is a member of Salinas Valley Health Medical Staff providing per diem family medicine services at TFFH&WC and plans to transition to a part-time SVH Clinics PSA in March 2025. She is fluent in Spanish and is dedicated to providing comprehensive care to the community of Gonzales; including prenatal care.

Terms and Conditions of Agreement

The proposed physician recruitment requires the execution of one agreement:

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.
- **Part-Time Schedule**. Physician will be scheduled to provide physician services to clinic patients on a part-time basis, 46 weeks per year; one week of which can be allocated to continuing medical education (CME).
- **Base Compensation**: \$225,000 per year as a 0.75 Full Time Equivalent (FTE)
- **Productivity Compensation**: To the extent it exceeds base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a \$51.50 wRVU conversion factor.
- **Professional Liability Insurance**. Professional liability 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. Peña to Salinas Valley Health Clinics providing services at TFFH&WC is aligned with our strategic priorities the service, quality, and growth pillars. We continue to develop SVH 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. Peña to Salinas Valley Health has been identified as a need for recruitment while also providing additional resources and coverage for TFFH&WC.

The compensation proposed in the agreement 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 the Contract Terms of the Family Medicine Professional Services Agreement for Dolores Peña, MD.

Attachments: Curriculum Vitae for Dolores Peña, MD

Dolores Peña, MD

Education

Family Medicine Residency

Natividad Medical Center- *Salinas, CA*

07/2020-6/2023

Leadership role: Chief scheduler

Reproductive Health Care Fellowship

Planned Parenthood - *Oakland, CA*

08/2022-6/2023

Universidad Autonoma de Guadalajara School of Medicine

International Medical School- *Jalisco, MX*

07/2015-06/2019

St. Mary's Regional Medical Center,

MS3 core clinical rotations -*Reno, NV*

07/2017-06/2018

Family, Internal, Psychiatry, OB/GYN, General Surgery, Pediatrics

Baptist Health Center,

MS4 elective clinical rotations- *San Antonio, TX*

07/2018-06/2019

Family, Endocrinology, Orthopedic Surgery, Ophthalmology, Emergency,

Dermatology, Rheumatology, Cardiology, Infectious Disease

University of California, Davis

Bachelor of Science, Exercise Biology/ Chicano Studies Minor

Honors Recognition*

09/2009-12/2013

Work Experience

Family Medicine Physician

Alisal Health Center- Salinas, CA

9/2023- current

Medical Assistant and Procedural Assistant

Clinica De La Raza, Women's Health - Oakland, CA

07/2019-05/2020

Clinical Scribe and Ultrasound Assistant

General Vascular Surgery Medical Group, San Leandro, CA

12/2013-06/2015

Volunteer

Health Mentorship Pipeline Program- Salinas, CA

7/2021-6/2023

Partnership with Dream Academy and Alisal High school

Nuestra Salud, Non-profit organization -Reno, NV

11/2017-2020

Initiative founded by medical students focused on disease prevention and outreach.

Awards

Quality Improvement project award -Laurel Family Practice

2021-2022

UCSF Award for Excellence in Professionalism

2022-2023

Hannon, Lauderdale, Rumbel & Santell Memorial Award for excellence in patient care, leadership, scholarship, and teaching

2022-2023

Scheduling Chief Recognition Award

2022-2023

Community Medicine Award

2022-2023

Skills

Languages: Spanish and English

Computer: Microsoft Word, Excel, Power Point, EPIC and Meditech

Personal: proactive leader, positive motivator, team collaborator, effective communicator, problem-solver, strong work ethic and community-oriented.

Medical Executive Committee Summary – January 9, 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Holz, Grant, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging -Non-Cardiac Diagnostic Radiology Teleradiology
Larsen, Melissa, MD	Ob/Gyn	Ob/Gyn	Obstetrical Hospitalist Obstetrical Hospitalist – Gynecology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Darmawan, Steve, MD	Pediatrics	Pediatrics	Pediatrics-Active Community
De, Ajanta, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology Peripheral Endovascular Cardiology
Dicus, Michael, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Garcia, Luis, MD	Maternal and Fetal Medicine	Ob/Gyn	Maternal Fetal Medicine
Goodwein, Shelley, MD	Ob/Gyn	Ob/Gyn	Obstetrical Hospitalist Obstetrical Hospitalist – Gynecology
Greene II, Michael, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Horvath, Susanna, MD	Neurology	Medicine	Tele-Neurology
Johnson, Steven, MD	Gastroenterology	Medicine	Gastroenterology
King, Phillip, DO	Internal Medicine	Medicine	Internal Medicine-Active Community
Oh, Christopher, MD	Cardiology	Medicine	Cardiology Salinas Valley Health Advanced Imaging-Cardiac Imaging Salinas Valley Health Cardiovascular Diagnostics
Reddy, Sumana, MD	Family Medicine	Family Medicine	Family Medicine Active Community
Wulff, Kristen, MD	Radiology	Surgery	Mammography

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Liu, Yang, MD	Hematology/Oncology	Advancement to Active Staff
Ruiz, James, MD	Ob/Gyn	Medical Leave of Absence effective 1/16/2025
Hazrati, Ehsan MD	Internal Medicine	Resignation effective 12/9/2024
Leyenson, Vadim, MD	Pulmonology	Resignation effective 2/1/2025
Mahendrarajah, Sulagshan, MD	Neurology	Resignation effective 12/31/2024

Privilege Modifications:

NAME	PRIVILEGE(S)	RECOMMENDATION
Blanchard, Johnny, MD	Internal Medicine	Addition of Adult Hospitalist privileges

Other Items: (Attached)

ITEM	RECOMMENDATION
Internal Medicine – Clinical Privileges Delineation - Revision	Remove Exercise Treadmill as a special procedure

Interdisciplinary Practice Committee**Reappointments:**

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Fiess, Matthew, PA-C	TFFH&W	Family Medicine	Guadalupe Arreola, MD Miguel Dorantes, MD
Hein, Lance, PA-C	Cardiothoracic & Vascular Surgery	Surgery	Vincent DeFilippi, MD Andreas Sakopoulos, MD
Shaw, Scott, PA-C	Cardiothoracic & Vascular Surgery	Surgery	Vincent DeFilippi, MD Andreas Sakopoulos, MD

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Henry, Tanisha, PA-C	Physician Assistant	Resignation effective 1/7/2025

Other Items: (Attached)

Nursing Standardized Procedure Nurse-Driven External Urinary Catheter Protocol	Recommend approval as presented

Informational Items:

I. Committee Reports:

- a. Credentials Committee
- b. Interdisciplinary Practice Committee

II. Other Reports:

- a. Summary of Executive Operations Committee Meetings
- b. Summary of Medical Staff Department/Committee Meetings December 2024
- c. Medical Staff Treasury Report January 3, 2025
- d. Medical Staff Statistics Year to Date
- e. Financial Update November 2024
- f. HCAHPS Update January 2, 2025

III. Order Sets:

- a. CRNA PEDS
- b. CRNA Adult

Salinas Valley Health Medical Center

Clinical Privileges Delineation Internal Medicine

Applicant Name: _____

Qualifications:

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

- Current certification or active participation in the examination process leading to certification in internal medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.
- OR**
- Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in internal medicine.
- AND**
- Documentation of the provision of inpatient services to at least 30 patients in the last 12 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship.
- 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.

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.

General Internal Medicine Core Privileges

Admit, evaluate, diagnose, treat and provide consultation to patients with common and complex illnesses, afflictions, diseases, and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems of the human body. The core privileges in this specialty include the procedures on the attached procedure 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 patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not be eligible for reappointment.

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 SVMH 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 two (2) Cases within the past 24 months
				Assist at Surgery	Documentation of three (3) successful cases	1-by operating surgeon	3
				Chest tube placement	Documentation of successful performance within the past 24 months	1	2
				Swan-Ganz Catheter Insertion	Documentation of successful performance within the past 24 months	1	1

Applicant: Check box marked “R” to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Insertion and Management of Pulmonary Artery Catheter	Documented successful performance of at least 50 PACs during formal training, as the primary operator OR Successful completion of an accredited residency in another field; participation in a significant Category 1 accredited continuing medical education training program in pulmonary artery catheter insertion and management AND Successful insertion and subsequent management of pulmonary artery catheters in at least 100 patients during the past 36 months. <u>Required Previous Experience:</u> Documented successful performance (as primary operator) of at least 50 PACs during the past 24 months.	1	Documented successful performance of at least 15 PACs per year, as the primary operator

Applicant: Check box marked “R” to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Ventilator Management Complicated >48 hours	For complicated* ventilation cases, the applicant must demonstrate successful completion of an accredited fellowship that provided the necessary cognitive and technical skills for full ventilator management. *More than 48 hours, or for patients defined as those having any of the following ongoing characteristics or any other of a like or similar complexity: peak ventilator pressure is greater than 40cm H2O, pH is less than 7.3, FiO2 is greater than 60%, status asthmaticus, ARDS, multi-organ failure, hemodynamic instability. <u>Required Previous Experience:</u> Successful management of at least 25 mechanical ventilation cases within the past 24 months.	1	Successful management of at least 25 mechanical ventilation cases within the past 24 months.
				~~Exercise-Treadmill~~	~~Successful completion of at least 50 ETT within the past 24 months~~ ~~AND~~ ~~current ACLS certification~~	~~N/A~~	~~Successful completion of 20 ETT procedures~~ ~~AND~~ ~~current ACLS certification~~
				EKG Reading Panel for formal reporting of interpretation	Member of the Active Status staff AND Board Certified in Cardiology (effective for applicants after 07/24/06)	N/A	Active Status and continued member in good standing of the EKG Reading Panel

Salinas Valley Memorial Healthcare System

Internal Medicine: The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills. 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

- Arthrocentesis
- Arterial Line Placement - Percutaneous
- Biopsy of superficial lymph nodes
- Breast cyst aspiration
- Burns, superficial and partial thickness
- Central Venous Line Placement
- Excision of skin and subcutaneous lesions
- Excision of cutaneous and subcutaneous tumors and nodules
- I & D abscess
- Local anesthetic techniques
- Lumbar Puncture
- Nasogastric tube placement
- Paracentesis
- Perform simple skin biopsy or excision
- Placement of anterior and posterior nasal hemostatic packing
- Preliminary interpretation of electrocardiograms, own patient
- Remove non-penetrating corneal foreign body, nasal foreign body
- Thoracentesis
- Thrombolytic therapy for stroke
- Ventilator Management Uncomplicated (<48 hours)

Applicant:

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



Last Approved N/A
Next Review 3 years after approval

Owner **Natasha Joan Limosnero:**
Clinical Nurse Educator w/o Masters

Area **Nursing Standardized Procedures**

Nurse-Driven External Urinary Catheter Protocol Nursing Standardized Procedure

A. POLICY

A. Function (s):

- To provide guidelines for the Registered Nurse (RN) regarding the indications, use, and assessment for an external urinary catheter.

B. Circumstances

- Setting
 1. All adult inpatients indicated for an external urinary catheter excluding Perinatal nursing units.
 2. The RN may initiate and/or delegate the placement of the external urinary catheter up on completing documentation of the External Urinary Catheter assessment screen.
 3. RN to reassess continuation or discontinuation of external urinary catheter every shift.
- Supervision
 1. The RN has the ability to determine the necessity/discontinuation for an external urinary catheter and depending on the RN's assessment, the RN may delegate the placement to a certified nursing assistant.
 2. Certified nursing assistants may not initiate application of external urinary catheters without RN's approval.
- Patient Condition

1. This standardized procedure applies to all adult inpatients who meet the criteria for an external urinary catheter.

B. DEFINITIONS

- A. External Urinary Catheter: A non-invasive device that is used to manage urinary incontinence. The external urinary catheter is designed to draw urine away from the body and into a collection canister, providing a non-invasive alternative to traditional indwelling urinary catheters ([UroToday, 2020.](#)).

C. PROTOCOL

A. Plan/Intervention

1. RN to assess if the patient is appropriate for an external urinary catheter (see a. and b.)
 - a. RN to document the External Urinary Catheter Indication on patient care/precautions intervention on the worklist
 - b. RN to complete the External Urinary Catheter scoring tool
 - c. For a score of 3 and above, an external urinary catheter is indicated. RN must place a physician order per policy.
 - d. If a patient has an external urinary catheter placed, the RN will assess its use every shift and as needed
2. Contraindications
 - a. Bedside Mobility Assessment Tool (BMAT) score of 3-4
 - b. Patient is combative, uncooperative, or agitated
 - c. Recent external urogenital surgery unless provider has an order
 - d. Moderate/heavy menstruations
 - e. Frequent incontinent stools and no fecal management
 - f. Urinary retention
3. Indications for use
 - a. Bedside Mobility Assessment Tool (BMAT) score 1-2
 - b. Urinary incontinence and/or frequent urination
 - c. Inability to use bedpan or urinal
 - d. Pressure Injury Stage 3-4 (buttocks, genitals, or coccyx)
 - e. Severe moisture associated skin dermatitis (MASD)
 - f. Critically ill patient requiring urine output monitoring but does not meet need for indwelling urinary catheterization
 - i. Education-Patient/Family:
 - a. Educate patient/family regarding initiation of external

urinary catheter use

- b. Instruct patient/family to report any signs and symptoms of urinary tract infection

B. RN placement of a Female External Urinary Catheter

1. Ensure wall suction or portable suction is available and in working condition
2. Attach pump tubing to a canister connector port and the connector port on the collection canister lid
3. Connect other end of collector tubing to a female external urinary catheter
4. Wash hands and don clean gloves
5. Perform perineal care and assess skin integrity
6. Separate legs, gluteus muscles and labia
7. Palpate pubic bone as anatomical marker
8. With soft gauze facing patient align distal end at gluteal cleft
9. Gently tuck soft gauze side between separated gluteus and labia
10. Connect a canister to wall suction and set to a minimum of 40mmHg continuous suction

C. Removal: Female External Urinary Catheter

1. Place the patient in supine position. Fully separate the legs, gluteus and labia
2. To avoid potential skin injury upon removal, gently pull the female external urinary catheter directly outward
3. Ensure suction is maintained while removing the female external urinary catheter
4. Assess skin integrity and perform perineal care
5. Disconnect device from suction tubing and discard device per hospital protocol and local regulations

D. RN Placement of Male External Urinary Catheter

1. Ensure wall suction or portable suction is available and in working condition
 - i. Attach pump tubing to a canister connector port and the connector port on the collection canister lid
 - ii. Connect other end of collector tubing to a male external urinary catheter
 - iii. Wash hands and don clean gloves
 - iv. If there is significant pubic hair, trim or clip the pubic hair prior to placement of the device
 - v. Perform perineal care using included wipes and assess skin integrity
 - vi. Use the included drying wipe prior to placement of the device as moisture on the skin will weaken the adhesive.

- vii. Orient the device aligning the drainage fitting towards the feet
- viii. Slide the opening of the device over the penis until close to the pelvic skin and center the penis within the opening.
- ix. Remove the adhesive liner and press the device against the pelvic skin to adhere. Ensure that the adhesive base has fully adhered around the base of the penis and that there are no air bubbles between the adhesive and the skin. The scrotum should not be placed inside the device
- x. Connect a canister to wall suction and set to a minimum of 40mmHg continuous suction

E. Removal: Male External Urinary Catheter

1. Place the patient in supine position and separate patient's legs
2. Gently remove the adhesive pad from the patient's skin in a slow, downward peeling motion
3. If necessary, use a warm, wet compress such as a wet washcloth to help loosen the adhesive. To avoid potential skin injury, never pull the device directly away from the patient, always peel in the direction from head to foot.
4. Remove the patient's penis from the wicking chamber
5. Gently remove the base adhesive by pulling the tabs down and away from the patient's penis
6. Assess skin integrity and perform perineal care
7. Disconnect device from suction tubing and discard device per hospital protocol and local regulations

F. Maintenance (Male and Female)

1. Replace the male external urinary catheter every 24 hours or if soiled with feces, blood, or semen
2. Replace the female external urinary catheter every 12 hours or if soiled with feces or blood
3. Assess the device placement and patient skin every shift and document in the EMR
4. Reassess the need for an external urinary catheter every shift

G. Documentation of Patient Treatment

1. Document assessment and placement of external urinary catheter in External Urinary Catheter Intervention.
2. Document reassessment of necessity of external urinary catheter in External Urinary Catheter intervention.
3. Document urine output in Intake and Output intervention.

D. REQUIREMENTS FOR THE REGISTERED

NURSE

Education: The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

E. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule

1. Every three 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.

F. 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 upon request.

G. REFERENCES

- A. [Definition of EUC](#)

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	01/2025
IDPC	Katherine DeSalvo: Director Medical Staff Services	01/2025
CNO	Carla Spencer: Chief Nursing Officer	01/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Natasha Joan Limosnero: Clinical Nurse Educator w/o Masters	12/2024

Standards

No standards are associated with this document

COPY

EXTENDED CLOSED SESSION
(if necessary)

*(Report on Items to be
Discussed in Closed Session)*

(Meeting Chair)

*RECONVENE OPEN SESSION/
CLOSED SESSION REPORT*

(Meeting Chair)

ADJOURNMENT

DRAFT SALINAS VALLEY HEALTH¹
QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING
COMMITTEE OF THE WHOLE
MEETING MINUTES JANUARY 13, 2025

Committee Member Attendance:

Voting Members Present: Catherine Carson, Chair, Rolando Cabrera, M.D., Vice-Chair; Clement Miller, COO, Carla Spencer, CNO, and Alison Wilson, D.O.

Voting Members Absent: None.

Advisory Non-Voting Members Present:

In Person: Timothy Albert, M.D., CCO, and Cheryl Pirozzoli, Family/ Patient Advisor.

Via WebEx: Allen Radner, M.D., President/CEO, Gary Ray, CLO, and Michelle Childs, CHRO.

Other Board Members Present, Constituting Committee of the Whole:

Via teleconference: Victor Rey, Jr.

Dr. Wilson arrived at 8:34 a.m.

Victor Rey arrived at 8:38 a.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and Committee Member Miller called the meeting to order at 8:32 a.m. in the Downing Resource Center CEO Conference Room 117.

2. PUBLIC COMMENT

None.

3. APPROVAL OF MINUTES FROM THE QUALITY AND EFFICIENT PRACTICES COMMITTEE MEETING OF DECEMBER 16, 2024.

Approve the minutes of the December 16, 2024 Quality and Efficient Practices Committee meeting. The information was included in the Committee packet.

PUBLIC COMMENT:

None

MOTION:

Upon motion by Vice-Chair Cabrera, second by Committee Member Miller, the minutes of the December 16, 2024 Quality and Efficient Practices Committee Meeting were approved as presented.

ROLL CALL VOTE:

Ayes: Chair Carson, Vice-Chair Cabrera, Miller and Spencer.

Noes: None;

Abstentions: None;

Absent: Dr. Wilson.

Motion Carried

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

4. PATIENT CARE SERVICES UPDATE: QUALITY PRACTICE COUNCIL

Carla Spencer, CNO, introduced Meghan Ackerman, BSN, RN, OCN (Co-Chair) and Rebecca Rodriguez, MSN, RN, CEN, CPHQ (Magnet Clinical Excellence Specialist) who reported the following:

- Quality Council Purpose and Council Members
- Initiatives
 - Professional Governance Quality Council Topics of the Week to continue enculturation of unit data displays with staff, inclusion in weekly huddle sheets for staff to generate discussion and enhance awareness about the topic. The Topics have generated meaningful conversations, enhanced awareness at the unit level and inspired a more data-driven culture.
 - Hand Hygiene Campaign: Includes collaboration with Melissa Deen, Manager Infection Prevention, and Marketing to develop hand hygiene posters. December 2024 data reflects 97% compliance.
 - 5 Nurse-Sensitive Magnet Data Requirements: Formalized Action Plan Process was developed. Data and enhanced staff awareness improved. Measures include falls, HAPI 2+, CAUTI, and injury falls; data was shared from May 2023 through October 2024.
- What's Ahead: Quality Topics of the Week ongoing. Action Plan Process ongoing. 2025 goals to be set in January with a goal to improve HAPI rates. The Quality Committee is going to begin looking at community nurse involvement and how it relates to the hospital.

A full report was provided in the packet.

Committee Discussion: The Quality Committee meets monthly and tracks falls, CLABSI, CAUTI, HAPI, patient experience and nurse satisfaction. Surgical site infections are addressed as necessary. Unit managers tailor the data to their unit. What drives topics? Magnet measures and feedback from nurses; data is centered around nurse sensitive indicators. Does Magnet provide suggestions for other measures? We have been surveyed once and there were no suggestions at the initial visit. There is a synergy between Magnet and quality which is functioning well at SVH.

5. QUALITY & SAFETY EDUCATION SESSION

Timothy Albert, M.D., Chief Clinical Officer, and Aniko Kukla, Director Quality and Patient Safety, provided a special education session on Quality and Safety to help Board members understand safe patient care.

2024 Update: 2024 was a year of changes and accomplishments including changes in leadership focused on quality and safety, Leapfrog Hospital Safety *Grade A*, US World News Recognition (high performing hospital in multiple categories including health equity), CMS 5-Star Recognition (47 measures), and many other quality awards throughout the year. Of note, our Quality and Safety Committee is chaired by the Vice-Chief of Staff which is not the norm throughout the country. 2025 regulation changes were reviewed. Frameworks will need to be developed to track data and gap analysis for the 2025 changes required by CMS, state-specific healthcare laws, State legislative changes, cybersecurity measures and expansion of electronic and digital measures required by CMS, TJC, and NHCN. Major planned quality and safety improvements for 2025 including development of a master plan, Epic implementation, early recovery after surgery, diagnostic safety/AHRQ participation, visual data management, implementation of age-friendly practices (includes designation), implementation of the CMS requirements of safety and health equity, and TJC recertification of the Joint, Chest Pain and Stroke Programs (February), and Commission on

Cancer (March). We have an outstanding team dedicated to providing quality care, delivered locally to everyone.

Board role/governance in Quality: The role of the Board of Directors in Quality and Safety includes engagement, education and strategies. The Institute for Healthcare Improvement (IHI) White Paper on *Framework for Effective Board Governance of Health System Quality* was presented and copies provided for the committee and all Board members. Helping Boards understand safe care was reviewed as follows: CMS CoP Requirements for Boards (section 482.21), Joint Commission requirements for Boards (EP LD 03.07.01), the scope of quality, and the importance of Board oversight. The White Paper support guides address core quality knowledge, core improvement system knowledge and Board culture and commitment are necessary to create a framework for effective governance of health system quality. Core elements of quality through a patient lens include (1) prioritize quality, (2) keep me safe, (3) provide me with the right care, (4) treat me with respect, (5) help me navigate my care and (6) help me stay well. Board governance of quality includes the Governance of Quality Online Assessment (GQA) tool which incorporates (1) Board quality culture and commitment (prioritize quality), (2) safe care (keep me safe), (3) effective care (provide the right care), (4) equitable and patient-centered care (respect), (5) timely and efficient care (navigate my care), and (6) community and population health & wellness (help me stay well).

A full report was provided in the packet and a hard copy was provided the day of the meeting.

Committee Discussion: Quality knowledge at SVH is in part due to having a nurse and physician on the Board. This presentation is excellent and it is suggested there be a special education or retreat to further educate the Board. The SVH hiring techniques and physician recruitment affects staff/physician commitment to quality. Our hospital is focused on transitions of care which affects navigating care and staying well (Mobile Clinic). A Survey Monkey is being developed to give to senior management. A safety culture is directly related to safety outcomes and financial and human cost which is a responsibility of the Board. The community should hear that we provide compassionate, safe, respectful, cost-effective care.

Next steps and IHI recommendations were reviewed to encourage a safe culture through fostering discussion, education and commitment.

6. ADJOURNMENT

There being no other business, the meeting adjourned at 9:32 a.m. The next Quality and Efficient Practices Committee Meeting is scheduled for **Tuesday, February 18, 2025** at 8:30 a.m.

Catherine Carson, Chair
Quality and Efficient Practices Committee

DRAFT SALINAS VALLEY HEALTH¹
TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE
COMMITTEE OF THE WHOLE
MEETING MINUTES JANUARY 15, 2025

Committee Member Attendance:

Voting Members Present: **Rolando Cabrera, MD**, Vice-Chair; **Allen Radner, M.D.**, President/CEO, **Gary Ray, CLO**, and **Nikolas Greenson, M.D.**, Medical Staff Member;

Absent: **Victor Rey, Jr.**, Chair;

Advisory Non-Voting Attendees Present:

In Person: Timothy Albert, M.D., Jim Gattis; Alysha Hyland, CAO, Orlando Rodriguez, M.D.;

Via Teleconference: Jib Martins, Carla Spencer, CNO;

Other Board Members Present, Constituting Committee of the Whole:

Via Teleconference: Victor Rey, Jr.

Victor Rey, Jr., attended as a non-voting member via teleconference.

Victor Rey, Jr., left the meeting at 12:22 p.m.

1. CALL TO ORDER/ROLL CALL

A quorum was present and Vice-Chair Dr. Cabrera called the meeting to order at 12:00 p.m. in the Heart Center Teleconference Room.

2. PUBLIC COMMENT

None

**3. APPROVAL OF MINUTES FROM THE TRANSFORMATION, STRATEGIC
PLANNING AND GOVERNANCE COMMITTEE MEETING OF OCTOBER 16, 2024.**

PUBLIC COMMENT:

None

MOTION:

Upon motion by Committee Member Dr. Radner, second by Committee Member Ray, the Transformation, Strategic Planning, and Governance Committee approved the minutes of the October 16, 2024 meeting, as presented.

Roll Call Vote:

Ayes: Dr. Cabrera, Dr. Radner, Ray and Dr. Greenson;

Noes: None;

Abstentions: None;

Absent: Rey.

Motion Carried.

¹ Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

4. CLOSED SESSION

Vice-Chair Dr. Cabrera announced that the item to be discussed in Closed Session is *Report Involving Trade Secret: Trade Secret, Strategic Planning, Proposed New Programs and Services*. The meeting recessed into Closed Session under the Closed Session protocol at 12:02 p.m.

5. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Committee reconvened Open Session at 1:05 p.m., Vice-Chair Dr. Cabrera reported that in Closed Session, the Committee received a *Report Involving Trade Secret: Trade Secret, Strategic Planning, Proposed New Programs and Services*. No action was taken in Closed Session.

6. ADJOURNMENT

There being no other business, the meeting was adjourned at 1:05 p.m. The Transformation, Strategic Planning, and Governance Committee meets quarterly. The next meeting is scheduled for **April 16, 2025 at 12:00**.

Rolando Cabrera, M.D., Vice-Chair
Transformation, Strategic Planning and Governance

DRAFT SALINAS VALLEY HEALTH¹
FINANCE COMMITTEE
COMMITTEE OF THE WHOLE
MEETING MINUTES JANUARY 20, 2025

Committee Member Attendance:

Voting Members Present: **Juan Cabrera**, Vice-Chair, **Allen Radner, M.D.**, President/CEO, and **Augustine Lopez**, CFO.

Voting Members Absent: **Joel Hernandez Laguna**, Chair, **Tarun Bajaj, M.D.**, Medical Staff Member.

Advisory Non-Voting Members Present:

Via teleconference: Michelle Childs, CHRO, and Carla Spencer, CNO;

In person: Tim Albert, CCO, Alysha Hyland, CAO, Clement Miller, COO, and Gary Ray, CLO.

Other Board Members Present, Constituting Committee of the Whole:

Via teleconference: Rolando Cabrera, M.D., Catherine Carson and Victor Rey, Jr.

1. CALL TO ORDER/ROLL CALL

A quorum was present and Vice-Chair Juan Cabrera, called the meeting to order at 4:06 p.m. in the CEO Conference Room.

2. PUBLIC COMMENT:

None.

3. MINUTES OF THE FINANCE COMMITTEE DECEMBER 16, 2024

Approve the minutes of the December 16, 2024 Finance Committee meeting. The information was included in the Committee packet.

COMMITTEE MEMBER DISCUSSION: None.

PUBLIC COMMENT: None.

MOTION:

Upon motion by Committee Member Dr. Radner, and second by Committee Member Lopez, the minutes of the December 16, 2024 Finance Committee were approved as presented.

ROLL CALL VOTE:

Ayes: Vice-Chair Cabrera, Lopez, Dr. Radner;

Nays: None;

Abstentions: None;

Absent: Chair Hernandez Laguna, Dr. Bajaj.

Motion Carried

4. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF INITIAL PROJECT COST ESTIMATE AND AWARD CONTRACT TO JOHN A. MARTIN & ASSOCIATES, INC. FOR THE SEISMIC RETROFIT PROJECT

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Omar Galvan of Kitchell Corporation, provided a project overview, current status, project budget/cost, and project schedule/roadmap including Senate Bill 1953 (Seismic Compliance & Safety), the goal of the bill, the compliance timeframes, major work components, retrofitting infills and bracing, immediate deadlines and proposed schedule.

A full report (including executive summary, background/situation/rationale, timeline/review process to date, Mission/Vision Goals, pillar/goal alignment, financial implications, and recommendation) was included in the packet.

COMMITTEE MEMBER DISCUSSION: None.

PUBLIC COMMENT: None.

MOTION:

Upon motion by Committee Member Lopez, and second by Committee Member Dr. Radner, the Finance Committee recommends Board of Directors approval of (i) the total estimated project cost for the Seismic Retrofit Project in the budgeted amount \$62,500,000 and (ii) the contract for \$3,100,000 to John A. Martin & Associates, Inc. for structural design services for the Seismic Retrofit Project at the main hospital campus.

ROLL CALL VOTE:

Ayes: Vice-Chair Cabrera, Lopez, Dr. Radner;

Nays: None;

Abstentions: None;

Absent: Chair Hernandez Laguna, Dr. Bajaj.

Motion Carried

5. CONSIDER BOARD RATIFICATION AND APPROVAL OF COMPETITIVE SOLICITATION AND CONTRACT AWARD FOR EPIC ACUTE PROJECT TRAINING CONSULTANT ENGAGEMENT WITH EVERGREEN HEALTHCARE PARTNERS, INC.

Alysha Hyland, CAO, reported that the Salinas Valley Health Board approved the Epic Acute Project in May, 2024. Included in the approval was the Total Cost of Ownership (TCO), which covered all budgeted items associated to the implementation of Epic. The budget for Epic Project consultant fees in FY25 was set at \$8,118,518. Evergreen Healthcare Partners, Inc. will provide consultant training services for the Epic Acute Project Implementation.

A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: None.

PUBLIC COMMENT: None.

MOTION:

Upon motion by Committee Member Dr. Radner, and second by Committee Member Lopez, the Finance Committee recommends Board of Directors Ratification and Approval of Competitive Solicitation and Contract Award for Epic Acute Project Training Consultant Engagement with Evergreen Healthcare Partners, Inc. not to exceed \$1,325,000.

ROLL CALL VOTE:

Ayes: Vice-Chair Cabrera, Lopez, Dr. Radner;

Nays: None;

Abstentions: None;

Absent: Chair Hernandez Laguna, Dr. Bajaj.

Motion Carried**6. CLOSED SESSION**

Vice-Chair Cabrera announced that the item to be discussed in Closed Session as listed on the posted Agenda is *Report Involving Trade Secrets, strategic planning/proposed new programs and services*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:31 p.m.

7. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:06 p.m. Vice-Chair Cabrera announced that in Closed Session, the Board received *Hearings/Reports: Report of FEMA Project* and a *Report Involving Trade Secrets, strategic planning/proposed new programs and services*. No action was taken.

8. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF MRI EQUIPMENT FOR SVHC

Timothy Albert, MD, CCO, reported that in order to support the imaging infrastructure for Salinas Valley Health, capital updates are necessary to accommodate the growth in patient services. Salinas Valley Health Clinics operates imaging services from two locations which currently support two MRI scanners. The MRI machines are reaching end of life and the current demand for the service line is growing. The clinic equipment supports low complexity, high volume studies such as routine body, brain, musculoskeletal, and cardiovascular imaging.

After evaluating MRI vendors, it was determined that the following two vendors aligned most appropriately with our current needs. The two competitors were Siemens and Canon because of the integration with our established imaging systems. The two systems were evaluated and it was determined by the SVH team that a Canon MRI should be installed in the SVH clinic. A standard market rate service agreement will be combined with the purchase of the equipment.

A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: This request is for SVH Clinics. This recommendation is part of a larger strategy addressing MRI usage and availability for the entire system. Patient weight capacity is 400+ which is an advantage for the community.

PUBLIC COMMENT: None.

MOTION:

Upon motion by Committee Member Dr. Radner, and second by Committee Member Lopez, the Finance Committee recommends Board of Directors approve the terms presented for purchasing

MRI equipment for Salinas Valley Health Imaging from Canon in the amount of \$1,385,027.00 and for a sixty-month service agreement in an amount not to exceed \$598,250.

ROLL CALL VOTE:

Ayes: Vice-Chair Cabrera, Lopez, Dr. Radner;

Nays: None;

Abstentions: None;

Absent: Chair Hernandez Laguna, Dr. Bajaj.

Motion Carried

9. CAPITAL SPENDING YTD DECEMBER 2024 UPDATE

An update was received from Dave Sullivan, Bogard Construction on FY25 YTD December Capital Spending,

The report on Active Projects Approved by the Board was reviewed as follows:

- Medical Center campus painting: In progress. 2 major buildings completed.
- Surgery addition plus seismic retrofit: In progress.
- Elevator modernization: In progress. Have CDPH and HCAi approvals.
- Bulk oxygen tank replacement: Completed.
- SVH rebranding/signage: On going.
- Cath Lab 3 replacement: 100% construction documents completed. Once approved will go out to bid. Trailers will be used during construction.
- Angio Suite replacement: 100% construction documents completed. Once approved will go out to bid. Trailers will be used during construction.
- 212 San Jose Street renovation Cardio/Vascular: Complete
- Epic IP Electronic Health Record (5-Yr Capital Portion): Ongoing.
- 559 Abbott Street Imaging Center X-Ray System: Completed under budget.
- Workday Financial and Supply Chain Software (Capital): Ongoing.
- X-Ray Rooms 1 & 2: 50% completed. Each room will be down separately.
- Nuclear Medicine Camera (D-Spect): Permits received and installation will start next week. 5-day project.
- 212 San Jose Street/Endoscopy: Just started.
- MRI Inpatient Building: Design in progress. 18-month project.
- Stryker Power Upgrade (OR Equipment, Capital Portion): Equipment purchased.
- Mobile unit emergency department facility: Building the interior. Need CDPH and HCAi approval prior to occupancy.
- Chiller and Lab Air Handling Unit Replacement: In design/modernizing.
- Nurse Call Phase 3: Final phase of upgrading system. Anticipate a May start.

All projects have a Board approved amount of \$97,837,372. A full report was included in the packet.

COMMITTEE MEMBER DISCUSSION: The team was thanked for their comprehensive report. The MRI project will be beneficial to our patients.

10. FINANCIAL PERFORMANCE REVIEW

An update was received from Augustine Lopez, CFO, on the Financial Performance Review for the month of December 2024. Highlights included Income from Operations \$4.2M, Net Income \$5.8M, and Days Cash on Hand of 371.

A full report including the December Summary Financials, Financial Statements, Budget Comparison, and Statistics was included in the packet for review.

COMMITTEE MEMBER DISCUSSION: None.

11. BALANCED SCORECARD

The Balanced Scorecard Summary for FY2024/November, was included in the Committee packet for committee review. Mr. Lopez, CFO, provided a review of year-end metrics and progress, with input from Carla Spencer, CNO, Aisha Hueber, Director Perioperatives services, Megan E. Giovanetti, Director Cardiovascular Services and Sleep, Tiffany DiTullio, Chief Administrative Officer/Community Wellness.

COMMITTEE MEMBER DISCUSSION: None.

12. ADJOURNMENT

There being no other business, the meeting was adjourned at 5:37 p.m. The next Finance Committee Meeting is scheduled for **Monday, February 24, 2025.**

Juan Cabrera, Vice-Chair