March 21, 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 HEALTH**[1] will be held **THURSDAY, MARCH 27, 2025, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

(V*isit* https://www.salinasvalleyhealth.com/about-us/healthcare-district-information-reports/board-of-directors/board-committee-meetings-virtual-link/ *for Public Access Information*).

Allen Radner, MD
President/Chief Executive Officer

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

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

THURSDAY, MARCH 27, 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.	**ADMINISTRATION OF OATH OF OFFICE TO ISAURA ARREGUIN, NEW BOARD MEMBER REPRESENTING ELECTORAL ZONE THREE**	*Anna Velazquez, Mayor of Soledad*
3.	**APPOINTMENTS TO OFFICER POSITION AND BOARD COMMITTEES**	*Joel Hernandez Laguna*
4.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Joel Hernandez Laguna*
5.	**RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *(Estimated time 4:45 pm)*	*Joel Hernandez Laguna*
6.	**AWARDS & RECOGNITION INCLUDING:** Healthgrades Awards presented by Nicole Patzer, Director of Quality Solutions/Healthgrades	*Allen Radner, M.D.*
7.	**PUBLIC COMMENT** This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.	*Joel Hernandez Laguna*
8.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)* A. Minutes of the Regular Meeting of the Board of Directors February 27, 2025 B. Policies Requiring Approval 1. Activities Preparatory to Research 2. Emergency Management for Mass Casualty Incidents - MCI 3. Fire Safety Management Plan 4. Injury and Illness Prevention Program Plan 5. Operative Delivery – Vaginal or Cesarean Section C. Approval of Revised Contract Matrix and Expense Matrix	*Joel Hernandez Laguna*

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

- Board President Report
- Questions to Board 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 March 17, 2025 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair.

B. **PERSONNEL, PENSION AND INVESTMENT COMMITTEE** *Catherine Carson*

Minutes of the March 17, 2025 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. Consider recommendation for Board of Directors to approve replacing target date funds within the 403(b) and 457 Plans.
    - Questions to Committee Chair/Staff
    - Motion/Second
    - Public Comment
    - Board Discussion/Deliberation
    - Action by Board/Roll Call Vote
2. Consider recommendation for Board of Directors approval of adding self-directed brokerage accounts to the 403(b) and 457 plans.
    - Questions to Committee Chair/Staff
    - Motion/Second
    - Public Comment
    - Board Discussion/Deliberation
    - Action by Board/Roll Call Vote
3. Consider Recommendation for Board Approval of Findings Supporting Recruitment of Daniel Camarillo, M.D. and Approval of the Contract Terms for Dr. Camarillo's Recruitment Agreement.
    - Questions to Committee Chair/Staff
    - Questions to Committee Chair/Staff
    - Motion/Second
    - Public Comment
    - Board Discussion/Deliberation
    - Action by Board/Roll Call Vote

4. Consider Recommendation for Board Approval of Contract Terms Jerrie Lim, M.D.'s Pediatrics Professional Services Agreement

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

C. **FINANCE COMMITTEE** *Victor Rey, Jr.*

Minutes of the March 24, 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 Recommendation for Board Approval of Project Budget and Equipment Procurement for Equipment in Conjunction with the Labor Delivery and Recovery Rooms Project.

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

2. Consider Recommendation for Board Approval of Project Budget(s) to Create Training Facilities in Support of the EPIC Platform Roll Out.

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

11. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF MARCH 13, 2025, AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Rakesh Singh, M.D.*

A. Reports

   1. Credentials Committee Report (Including the following)
      - Family Medicine-Clinical Privilege Delineation Revisions
      - Obstetrical & Gynecology-Clinical Privilege Delineation Revision
      - OB Hospitalist Clinical Privilege Delineation Revision
      - Vascular Surgery-Clinical Privilege Delineation Revisions
   2. Interdisciplinary Practice Committee Report

B. Policies/Procedures/Plans and Agreements Recommended for Approval:

1. Admission Assessment – Newborn
2. Cord Blood
3. Dispensing Oral Alcohol in the Inpatient Setting
4. Hazardous Drug Handling
5. Medication Error Reduction Program Plan
6. Medication Reconciliation
7. Transitions of Care Pharmacy Program

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

12. EXTENDED CLOSED SESSION *(if necessary)* *Joel Hernandez Laguna*

13. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION *Joel Hernandez Laguna*

14. ADJOURNMENT *Joel Hernandez Laguna*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, April 24, 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-us/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
THURSDAY, MARCH 27, 2025, 4:00 P.M.

AGENDA FOR CLOSED SESSION

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

CLOSED SESSION AGENDA ITEMS

HEARINGS/REPORTS
(Government Code §37624.3 & Health and Safety Code §§1461, 32155)

Subject matter: (Specify whether testimony/deliberation will concern staff privileges, report of medical audit committee, or report of quality assurance committee):

1. Medical Executive Committee
    - Report of the Medical Staff Executive Committee (With Comments)
2. Report of the Medical Staff Quality and Safety Committee
    - Transfusion Committee
    - Transitional Care
3. Consent Agenda:
    - Perinatal Services
    - Accreditation & Regulatory Update
    - Materials Management
    - Nursing Admin, Transporters, Interpreter Svcs, Nursing Education
    - Cath Lab
    - HIM
    - Diagnostic Imaging

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

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/
REPORT ON CLOSED SESSION

(Meeting Chair)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
FEBRUARY 27, 2025

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

Absent: None;

Also Present:
Allen Radner, MD, President/Chief Executive Officer
Rakesh Singh, MD, Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Kathie Haines, Executive Support.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:03 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, (3) Conference with Legal Counsel Existing Litigation-Araujo et al. vs. Salinas Valley Memorial Healthcare, and (4) Conference with Legal Counsel Anticipated Litigation*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:05 p.m.

The Board completed its business of the Closed Session at 4:32 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:43 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services, (3) Conference with Legal Counsel Existing Litigation-Araujo et al. vs. Salinas Valley Memorial Healthcare, and (4) Conference with Legal Counsel Anticipated Litigation*.

The Board received and accepted the reports listed on the Closed Session agenda, and no other action was taken.

President Hernandez Laguna announced there is a need for an extended closed session.

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

4. AWARDS AND RECOGNITION

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

- **American Heart Month Activities**:
  - Timothy Albert, M.D., CCO, reported that he participated in the February **Walk With A Doc** which was the first of the year and over 50 guests were in attendance. Walk With A Doc is a global program connecting our community with our local healthcare providers and Salinas Valley Health is the only official local chapter. Dr. Albert also was the Moderator for the February 26th in-person **Ask the Experts: Newest Advancements in Minimally Invasive Cardiovascular Care** with Harlan Grogin, M.D., Rikin Kadakia, M.D., and Jamil Matthews, M.D. as panelists.
  - Amanda Myer, Health Promotion Manager, reported on other heart month activities including the launch of the SVH Exercise Challenge, the February red hat campaign (handmade red hats for every baby born in February), leader led heart walks every Friday at SVH, National Wear Red Day and the peer-to-peer cardiac support group Mended Hearts on February 18th with guest speaker Vincent DeFilippi, M.D., who spoke about Ozempic and the Heart.
- Carla Spencer, CNO, reported on clinical education and ongoing engagement. The first **Donuts with Docs** of the year drew great attendance from the MedSurg team. The program started in February of 2024 after being recommended by Hospitalist Jaime Gonzalez, M.D. The event also attracted staff from other departments including Case Management, Wound Care and Patient Experience. The discussion included how to further improve communication, care coordination and teamwork. Donuts with Docs will continue each month with sessions rotating through different inpatient units. Surgical oncologist Mark Healy, MD, led two **Lunch & Learn** sessions for Salinas Valley Health staff. His presentation focused on care for patients who have had a Whipple procedure and was well attended with engagement and questions.
- On February 12, we hosted 49 high school sophomores for a **GEAR UP** (Gaining Early Awareness and Readiness for Undergraduate Programs) field trip with partner high schools--Rancho San Juan, Everett Alvarez, and North Salinas High Schools, accompanied by GEAR UP program leaders and staff. The program included eight presentations from Salinas Valley Health leaders, with a goal of introducing them to a variety of health careers.

BOARD MEMBER DISCUSSION: The Ask the Experts was a great event. President Hernandez Laguna requested Walk With A Doc events throughout the county. Great work to the planning team for the Heart Month activities.

5. BOARD RESOLUTION NO. 2025-01 COMMITTING TO PROVIDE LOCALLY DELIVERED, QUALITY HEALTHCARE TO EVERYONE, REGARDLESS OF IMMIGRATION STATUS

Matthew Ottone, Esq., District Legal Counsel, reported Resolution No. 2025-01 was included in the Board Packet for the Board's consideration. The resolution states Salinas Valley Health is committed to provide locally delivered, quality healthcare to everyone regardless of immigration status. It is requested that all four Board Members sign it to indicate full Board support.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Rey, the Board of Directors approved Board Resolution No. 2025-01 Committing to Provide Locally Delivered, Quality Healthcare to Everyone, Regardless of Immigration Status.

ROLL CALL VOTE:

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

Motion Carried

6. PUBLIC COMMENT:

None.

7. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following two policies have been removed from the Consent Agenda for consideration *Fetal Demise/ Stillborn/Neonatal Death* and *Oral Care*; the policies will return for consideration at a later date.

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors January 23, 2025

B. Minutes of the Special Meeting of the Board of Directors February 6, 2025

C. Policies Requiring Approval
    1. Capital Equipment
    2. Immigration
    3. Labor and Delivery Obstetrical Care Standards: Assessment and Documentation
    4. Maternal Transport-Tertiary Care and Transfer of Patient
    5. Medical Equipment Management Plan
    6. Newborn Thermoregulation Management
    7. NICU: IV Therapy
    8. Pre-Term Labor
    9. Scope of Service: Outpatient Infusion Center
    10. Scope of Service: Wound Management Program (WMP)
    11. Sterilization and Monitoring Standards – Autoclaves
    12. Surgical Smoke
    13. Well Newborn Discharge Criteria and Planning

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Rey, the Board of Directors approved the Consent Agenda, Items (A) through (C) as listed.

ROLL CALL VOTE:

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

Motion Carried

8. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: None.

Director Catherine Carson: Director Carson reported Personnel, Pension and Investment Committee heard HR metrics and SVH recruitment and retention is at a great level. The spring cohorts of new RN graduates is accepting 12 nurses; there were 500 applications. Director Carson went to Ask The Experts and the doctors were great and energetic. It was a good group and very educational.

Director Victor Rey, Jr.: Director Rey offered kudos for the work on heart health month activities. He attended the Walk With A Doc. The Exercise Challenge offers a great incentive to get moving. Director Rey reported he attended *Public Hospital Board Training* in San Francisco hosted by District Counsel's firm Ottone & Leach LLP. He appreciated the flyers provided of upcoming Community Days.

Director Joel Hernandez Laguna: President Hernandez Laguna thanked staff of site visit of Ensen Community Park. President Hernandez Laguna requested an update on the Board Vacancy.

- Gary Ray, Esq., CLO, and Matt Ottone, Esq., reported vacancy notices were placed in English and Spanish at six (6) locations in Zone 3. Ads have been placed in the Monterey County Herald, Monterey County Weekly and the Salinas Californian. To date there have been no applications received. In the event no one is appointed by March 25th, we can call for an election which would take place during the general November election.

President Hernandez Laguna encouraged other Board members to reach out to potential candidates.

9. 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 February 18, 2025 meeting were provided for Board review. There was an education provided by Aniko Kukla on Decoding Our Public Reputation Metrics. SVH is highly rated in safety, quality, efficient, effectiveness and patient satisfaction, and the presentation explained the steps to get there

B. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the February 24, 2025 meeting were provided for Board review. The Financial Reports of the February meeting were included in the packet for review (informational). The following recommendations were made.

Gary Ray, CLO, reported that three (3) items were voted by the Finance Committee as a recommendation to the entire Board for Approval, however there was only one board member present to vote on the items.

The Committee charter requires two board members present to vote in the affirmative for a recommendation to the entire board for approval. Therefore, these items are coming to the Board without a formal recommendation, but note that the committee did hear the matters and voted in the affirmative to recommend them to the board for approval. The SVH Board Committees are Committees of the Whole and all members can attend and participate but only the appointed Chair and Vice-Chair of the Committee can vote. Full reports were provided in the Board packet.

1. **Consider Board Approval of Sentrics Interactive Patient Care Solutions System as Sole Source Justification and Contract Award**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Rey, the Board of Directors approves Sentrics interactive patient care solutions system as sole source justification and contract award for $455,328 over a 3-year term.

ROLL CALL VOTE:

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

Motion Carried

2. **Consider Board Approval of Project Budget for the MRI Equipment Installation at 444 E. Romie Outpatient Imaging Center and Award of contract to Siemens Medical Solutions for MRI Equipment and Service Agreement.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION:

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves (i) the total estimated Project Budget for the Salinas Valley Health MRI Equipment Installation at 444 E. Romie Lane in the amount of $4,357,484.00, (ii) Award equipment contract to Siemens Medical Solutions in the amount of $2,086,764.00, and (iii) Award 5-year service contract to Siemens Medical Solutions in the amount of $712,185.00.

ROLL CALL VOTE:

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

Motion Carried

3. **Consider Board Approval of Project Budget, associated taxes and construction for the Salinas Valley Health Clinic MRI Equipment Installation & building refresh at 626 Brunken Avenue Imaging Center.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Rey, the Board of Directors approves the associated taxes and construction for the Salinas Valley Health Clinic MRI Equipment Installation at 626 Brunken Ave in the amount of $1,532,783.

ROLL CALL VOTE:

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

Motion Carried

C. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

A report was received from Director Carson regarding the Personnel, Pension and Investment Committee. The minutes of the February 24, 2025 meeting were provided for Board review noting that the agenda item requesting fund changes in the 403(b) and 457 Plans was tabled for further discussion. The following recommendation was made.

Gary Ray, CLO, reported that due to the Board vacancy, this item was voted by the Personnel, Pension and Investment Committee as a recommendation to the entire Board for Approval, however there was only one board member present to vote on the item. Therefore, this item is coming to the Board without a formal recommendation, but note that the committee did hear the matters and voted in the affirmative to recommend the item to the board for approval. A full report was provided in the Board packet.

1. **Consider Board Approval: Amendment to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Rey, the Board of Directors approves Amendment Ten to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan.

ROLL CALL VOTE:

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

Motion Carried

D. COMMUNITY ADVOCACY COMMITTEE

A report was received from Director Dr. Cabrera regarding the Community Advocacy Committee. The minutes of the February 12, 2025 meeting were provided for Board review. There are no recommendations from this committee to the Board. Director Dr. Cabrera stated there are three upcoming Community Events open to the public and Board members are encouraged to attend as follows:

- Thursday, March 6, Noon-3pm, MLK Family Resource Center
- Sunday, March 30, 10am-2pm, Marina Farmers' Market
- Sunday, April 27, 1-5pm, Castroville Day of the Child

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON FEBRUARY 13, 2025, 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 February 13, 2025. 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 Dr. Cabrera, second by Director Rey, 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 (Including the following)
        - Electrocardiogram Nursing Standardized Procedure

B. Policies/Procedures/Plans and Agreements Recommended for Approval:
    - Information Management Program Plan
    - Laboratory Critical Values
    - Temporary Involuntary Hold – 5150

ROLL CALL VOTE:

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

Motion Carried

11. EXTENDED CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Extended Closed Session are *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services.* The

meeting recessed into Closed Session under the Closed Session Protocol at 5:29 p.m. The Board completed its business of the Closed Session at 6:32 p.m.

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:32 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services*.

No action was taken.

13. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, March 27, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:34 p.m.

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Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: March 27, 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.	Activities Preparatory to Research	Corrected to procedure. Education statement changed to standard statement.	Carla Spencer, CNO
2.	Emergency Management for Mass Casualty Incidents - MCI	Triage flow updated.	Clement Miller, COO
3.	Fire Safety Management Plan	Revised authority to shut off medical gases in a fire emergency.	Clement Miller, COO
4.	Injury and Illness Prevention Program Plan	No Changes	Clement Miller, COO
5.	Operative Delivery – Vaginal or Cesarean Section	Updated references, made one spelling correction.	Carla Spencer, CNO
MEC Policies			
1.	Admission Assessment – Newborn	Approval flow assigned by Policy Committee	Carla Spencer, CNO
2.	Cord Blood	Updated specimen labeling and process for sending specimens to the laboratory	Carla Spencer, CNO
3.	Dispensing Oral Alcohol in the Inpatient Setting	New policy.	Clement Miller, COO
4.	Hazardous Drug Handling	Added USP <800> to containment requirements and to environmental & engineering control	Clement Miller, COO
5.	Medication Error Reduction Program Plan	Revised Plan Management, updated references, updated Med Safety Committee Charter	Clement Miller, COO
6.	Medication Reconciliation	Added definitions, Updated Procedure for Outpatients and for Inpatient Admission, Added "qualified individual" as one who can review medication list.	Clement Miller, COO Carla Spencer, CNO
7.	Transitions of Care Pharmacy Program	References updated.	Clement Miller, COO

Status **Pending** PolicyStat ID **16419725**

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

Activities Preparatory to Research

I. POLICY STATEMENT

A. N/A

II. PURPOSE

The purpose of this policy is to establish guidelines and procedures for conducting activities preparatory to research (APR) in compliance with the HIPAA Privacy Rule to ensure that such activities are conducted in a manner that protects the privacy and confidentiality of patients' Protected Health Information (PHI).

III. DEFINITIONS

A. Activities Preparatory to Research (APR): Activities conducted to prepare for a research study, such as designing the study, assessing the feasibility of conducting the study, or identifying potential participants. APR does not include the actual recruitment of participants or the collection of data for research purposes.

B. Protected Health Information (PHI): Individually identifiable health information that is transmitted or maintained in any form or medium by a covered entity, as defined by HIPAA.

C. HIPAA Covered Entity: An entity that is subject to HIPAA regulations, including health plans, healthcare clearinghouses, and certain healthcare providers.

IV. GENERAL INFORMATION

A. Salinas Valley Health is actively engaged in research involving human subjects. As such, the institution bears responsibility for ensuring full compliance with federal and state laws governing the conduct of human subjects research. This policy is designed to provide clear guidelines for activities preparatory to research in alignment with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, while safeguarding the privacy and

confidentiality of individuals' Protected Health Information (PHI).

B. **Authorization Requirements**
Under HIPAA, researchers may use or disclose PHI without patient authorization during APR if the following conditions are met:

- The researcher must represent that the use or disclosure is solely to prepare a research protocol or for similar purposes preparatory to research.
- The researcher must represent that no PHI will be removed from the covered entity during the course of APR.
- The researcher must represent that the PHI for which access is sought is necessary for the research purposes.

C. **Permissible Activities**
Permissible activities under APR include, but are not limited to:

- Developing research hypotheses and protocols.
- Assessing the feasibility of a research study.
- Identifying potential participants who may meet the criteria for a study, provided no contact is made with the potential participants.

D. **Prohibited Activities**: Activities that are not allowed under APR include:

- Removing or recording PHI outside the covered entity.
- Using PHI for recruitment or data collection purposes.
- Sharing PHI with any person or entity that is not part of the HIPAA covered entity.

V. PROCEDURE

A. **Researcher Responsibilities**
Researchers must submit a request to access PHI for APR to the [Institutional Review Board (IRB) / Privacy Office], including:

- A description of the research preparation activities.
- Assurance that PHI will not be removed from the premises or disclosed.
- Justification that the PHI requested is necessary for the research.
- Researchers must complete training on HIPAA regulations and institutional policies before engaging in APR.

B. **Research Oversight Committee (ROC) / Institutional Review Board (IRB) / Privacy Officer Responsibilities:** The Privacy Officer is responsible for reviewing and approving requests for APR. The office will:

- Ensure that the research activities comply with HIPAA Privacy Rule and institutional policies.
- Monitor compliance and conduct audits as necessary.
- Provide guidance and support to researchers on HIPAA-related matters.

C. **Record Keeping**

- Documentation of the IRB/Privacy Office's approval and the researcher's representations regarding the use of PHI for APR must be maintained in accordance with institutional record-keeping policies and HIPAA regulations. Documentation will be maintained by the Clinical Research Office.

D. **Compliance and Enforcement**

- Failure to comply with this policy may result in disciplinary action, up to and including termination of employment or affiliation with the institution. Non-compliance may also result in legal penalties under HIPAA.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 CFR Part 160 and Subparts A and E of Part 164.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Research Committees	Terri Nielsen: Manager Clinical Research	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Terri Nielsen: Manager Clinical Research	12/2024
ROC Coordinator	Cynthia Johnson: Contract Medical Librarian	12/2024

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16975501

Last Approved N/A

Next Review 1 year after approval

Owner Laura Zerbe: Manager Facilities Construction and Plant Operatio

Area Emergency Management

Emergency Management for Mass Casualty Incidents (MCI)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the response to a mass casualty incident.

III. DEFINITIONS

A. MCI Plan - The Emergency Management Plan for Mass Casualty Incidents (MCI plan) is for events occurring inside and outside the hospital requiring additional staff, resources, communication, and preparation and/or extraordinary expansion of services.

B. Volunteer - In the Hospital Incident Command System (HICS) framework, this refers to an individual who arrives to help with the incident. They are referred to Labor Pool for an appropriate assignment. Not to be confused with the Salinas Valley Health Volunteer Department.

C. Incident Command Team- The team leading the response to the incident, under the direction of the Incident Commander.

D. Public Information Officer (PIO) - the member of the Incident Command Team who is responsible for interfacing with the public, media, various agencies, and the private sector to meet incident-related information needs. The PIO gathers, verifies, coordinates, and disseminates accessible, meaningful, and timely information about the incident for internal and external audiences.

E. Liaison Officer- the member of the Incident Command Team who functions as the incident contact person for representatives from other agencies.

F. MHOAC - Medical and Health Operational Area Coordinator. Responsible for monitoring, ensuring, and procuring medical and health resources during a local emergency or disaster. The MHOAC is authorized to work with the Regional Disaster Medical Health Program to submit and respond to medical and health requests for resources outside of the Operational Area. The county Health

Officer and the Local Emergency Medical Services Agency Administrator may act jointly as the MHOAC, or they may jointly appoint an individual to serve in this role.

G. HICS - Hospital Incident Command System. The roles assigned during incident response that align with the National Incident Management System

H. Casualty Care Area - the alternate care area established to manage an influx of patients to the Emergency Department.

I. Job Cards - a guide for individuals assuming roles in MCI response to assist them in supporting the event.

IV. GENERAL INFORMATION

A. The Emergency Management of Mass Casualty Incidents follows the Salinas Valley Health Medical Center (SVHMC) Emergency Operations Program Plan.

B. The Emergency Management Plan for Mass Casualty program is developed, approved and maintained in consultation with representatives of the medical staff, nursing staff, administration and fire and safety experts.

C. The program covers disasters occurring in the community and widespread disasters. It provides for at least the following:

1. Availability of adequate basic utilities and supplies, including gas, water, food and essential medial and supportive materials.
2. An efficient system of notifying and assigning personnel.
3. Unified command.
4. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
5. Prompt transfer of casualties, when necessary and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definite care.
6. A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.
7. Procedures for the prompt discharge or transfer of patients already in the hospital at the time of the disaster who can be moved without jeopardy.
8. Maintaining security in order to keep relatives and curious persons out of the triage area.
9. Establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will be made to provide organized dissemination of information.

D. The program is in conformity with the California Emergency Plan of October 10, 1972 developed by the State Office of Emergency Services and the California Emergency Medical Mutual Aid Plan of March 1974 developed by the Office of Emergency Services, Department of Health.

E. This plan is reviewed at least annually and includes all areas of the Salinas Valley Health Medical Center (SVHMC) campus and surrounding buildings and offices where SVHMC staff and/or services are present.

F. There is evidence in the personnel/education files, e.g., orientation checklist or elsewhere, indicating that all new employees have been oriented to the program and procedures within a

reasonable time after commencement of their employment.

V. PROCEDURE

A. **Phases**

1. The MCI plan consists of four distinct phases:
    a. Phase I: Alert of a possible event
    b. Phase II: Activation and Management of the MCI Plan
    c. Phase III: Demobilization
    d. Phase IV: Recovery

B. **Phase I: Alert of a Possible Event**

1. Any employee who learns of an occurrence that might constitute a Mass Casualty Incident (MCI) should attempt to obtain the following information:
    a. What was the occurrence?
    b. What is the location of the occurrence?
    c. How many casualties are estimated?
    d. What type of injuries?
    e. How many victims should the hospital expect and when?
    f. The goal of Code Triage MCI is to be prepared to receive patients within 15 minutes.
2. An employee who learns of the occurrence must notify the Emergency Department at ext. 4355, Hospital Administration, or, during off hours and weekends, the on-duty Administrative Nursing Supervisor. After-hours, it is the responsibility of the Administrative Supervisor to consult with the emergency department physician and charge nurse to determine if the event requires activation of the MCI plan.

C. **Phase II: Activation of the MCI plan**

1. The following people have the authority to activate the MCI plan:
    a. Emergency Department physician,
    b. Emergency Department Director/Manager,
    c. Administrative Supervisor,
    d. Executive on site or on call.
2. Any activation of the MCI plan should also call for an activation of the Hospital Incident Command System (HICS).
3. Activation of the MCI plan may be done at 3 levels depending on the nature and significance of the event.
    a. **Level 1:** Unusual event, MCI with either mostly stable, low acuity victims or limited number of victims. Minimal to moderate response is needed. Portions of HICS may be activated.
    b. **Level 2:** Large scale event or hospital emergency that will be involving multiple

departments and will necessitate additional staff and resources. A level 2 event will likely involve multiple critical or unstable patients (or the potential for), and complicating factors such as decontamination. Moderate to full response is needed including partial to full activation of HICS.

c. **Level 3:** Major disaster that requires full activation of HICS and an "all hands on deck" response from the organization. A level 3 event will include an overwhelming number of patients, many of which will be traumas, critical, medically complicated, and worried well. It will likely include other complicating factors such as decontamination, alternate triage sites, and expanding treatment areas into other departments or outside. Assembly of tents in adjacent parking lots may also be necessary to accommodate the expansion of triage and treatment areas and staging areas. A level 3 event will likely include multiple outside agencies such as EMS, law enforcement, fire departments, media, etc. A Joint Incident Command may also be necessary in the Incident Command Center (ICC).

D. **Phase II, continued: MCI Management**

1. **Incident Commander Assignment & Code Notification**

a. Once the MCI plan has been activated, the emergency notification system will be activated at the direction of the Incident Command Team.

i. Activation of the MCI plan should be done by overhead page as "Code Triage External, MCI." It may also be announced via Everbridge mass-texting platform.

b. The on-duty Emergency Department physician, or designee, will take the lead as the **Casualty Care Unit Leader.** They will direct the response at the Casualty Care Area.

c. The **Administrative Supervisor** on duty will assume the role of Incident Commander, appoint an Incident Command Team, initiate protocols, and set objectives as appropriate.

i. A summary of suggested supporting roles and objectives is attached in **ATTACHMENT A: MCI Roadmap.** Note: objectives and roles needed may vary depending on the incident.

ii. The Administrative Supervisor on duty shall remain in the role of incident commander until relieved.

iii. This role will include management of disaster operations as outlined in the Emergency Operations Plan (EOP). This role shall not be superseded by an authority or directive from outside agencies involved with the event without consent from hospital administration.

iv. The role of the incident commander may be assumed by the CEO or other authorized On-Call Administrator upon arrival to the hospital.

2. **MCI Casualty Care Area Setup**

a. **Equipment**

i. The "MCI Response" trailer is parked near the Emergency

Department and contains supplies needed to establish an alternate care area outside the facility for a patient surge. This kit is designed such that it can be set up in approximately 15 minutes, and creates a casualty care area with a capacity of approximately 50 patients.

a. Color-coded Tents that correspond to the level of care determined at triage.

b. Color-coded carts that correspond to the level of care determined at triage. These contain PPE, materials to support documentation of patient care, triage ribbons and tags, color-coded tarps to place under the tents.

c. Job Cards Kit for MCI-specific roles in the casualty care area.

ii. Upon activation of the MCI plan the MCI supplies will be brought to the casualty care area and immediately deployed.

iii. A map showing setup configuration is attached and may be used to guide for casualty care area setup. See **ATTACHMENT B: Code External Triage MCI 15-to-50 Set Up Map.**

b. **Casualty Care Area Job Assignments**

i. Treatment Areas are anticipated to require the following direct care providers:

a. **Red:** MD, RN, RN, CA/Tech

b. **Yellow:** MD, RN, RN, CA/Tech

c. **Green:** PA, RN, CA/Tech

ii. Additional Supporting Roles (see Job Cards Kit from MCI Supply) may include:

a. Casualty Care Unit Leader (On duty ED physician)

b. Triage Unit Leader

c. Immediate Treatment Manager (Red)

d. Delayed Treatment Manager (Yellow)

e. Minor Treatment Manager (Green)

f. Expectant Manager (Black)

g. Incident Commander (Nurse Administrative Supervisor, or Admin-on-Call)

h. Safety Officer

i. Patient Registration Unit Leader (Registration department, if available)

j. Access Control Unit Leader (Security department, if available)

k. Family Reunification Unit Leader

l. Patient Tracking Manager

m. Transportation Unit Leader

iii. Individuals will familiarize themselves with their role by using job cards, by receiving information from the Incident Command Team, and reading the entirety of this procedure.

a. Note: MCI job cards are available on Starnet.

iv. Casualty Care Leader, or designee, may contact Incident Command Team if more personnel are needed to fill Casualty Care Job Assignments. The Incident Command Team may need to appoint a Labor Pool lead to provide adequate personnel to assigned roles. For more information, see "Labor Pool section", below.

c. **Triage Setup**

i. **Deploy Triage Ribbons and Triage Tags**

a. Triage Ribbons are to given to the Triage Unit Leader to assign incoming patients to an acuity category based on the START (Simple Triage and Rapid Treatment)/JumpSTART (pediatric version) models.

b. Note: the Triage Tags are to be opened and given to assigned personnel in the designated treatment areas. These tags are used for patient tracking and documenting care.

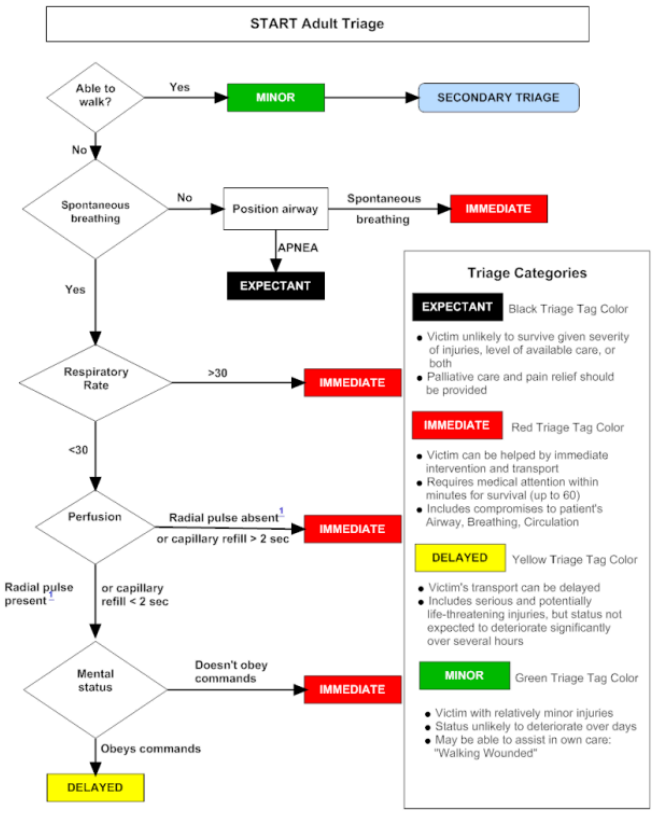
c. The Triage Ribbons and Tags are to be deployed and ready at the time of notification and activation of the MCI plan, ideally before patients arrive to the emergency department.

d. The Triage Unit, with the support of the most experienced ER physician on duty appropriate, will identify patient status and whether patients require immediate, delayed, minor, or expectant care.

ii. **START and JumpSTART Triage Algorithms**

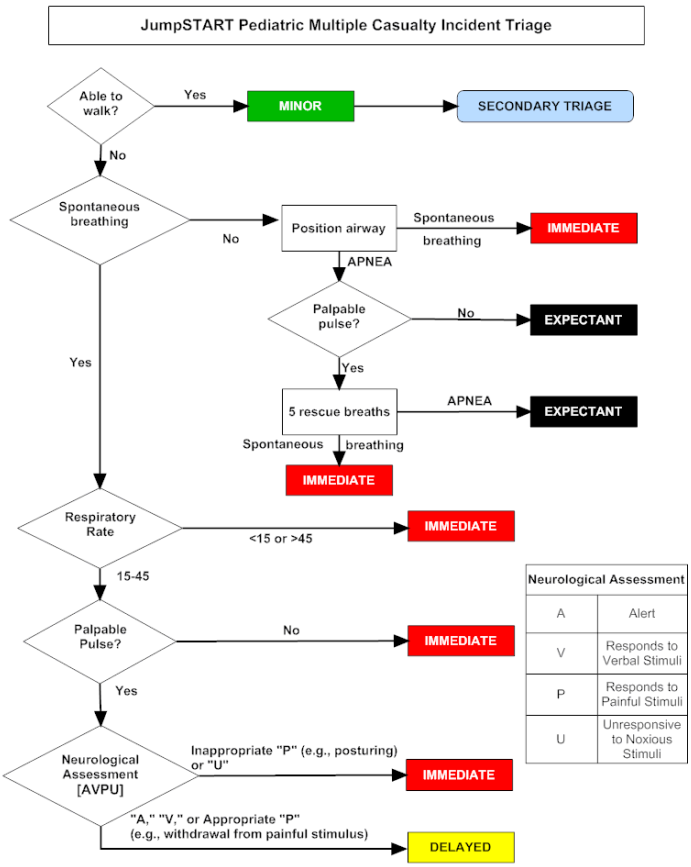
a. **START Triage (Use if the patient appears to be an adult or young adult):**

b.



c. Adopted from http://www.start-triage.com

JumpSTART (Use if the patient appears to be a child):



d. **Establish Perimeter and Control Access: Security Access Control Unit Leader**

i. When the MCI plan is activated hospital security officers should secure the following:

a. Blocking traffic to San Jose street, except for ambulance traffic and persons seeking emergency care.

b. The perimeter around the event, particularly in the event of a hazardous material exposure. This will help ensure safety of other patients, visitors and hospital personnel and avoid contamination of the treating facility.

c. Level 3 Lockdown will be initiated, unless the Incident Command Team determines another level is more appropriate for the incident.

ii. Anyone seeking medical attention shall be directed to the designated triage area.

iii. No passersby or media shall be allowed to enter the perimeter unless instructed by the Public Information Officer or designee. Media should be directed to the Media Area, located in the MRI parking lot or as designated by the Incident Command Team.

iv. All family and visitors seeking information or wishing to see loved

ones should be directed to the Family Reunification Unit Leader in the Family Assistance Center, located in DRC ABC or as assigned by Incident Command.

e. **Registration of Patients: Registration Unit Leader**
    i. During a declared MCI (activation of the MCI plan) patients involved in the MCI, regardless of their involvement, should not be registered on arrival in Meditech. Patients are sorted according to the START and JumpSTART model and tagged as appropriate with triage tags. They are to be tracked using the tracking log located in the surge kit.
    ii. Therefore, assign individuals to support patient registration at the following locations:
        a. MCI Discharge Area: Patients that have been determined stable for discharge are to be discharged from the discharge area adjacent to the treatment areas. These patients should be fully registered then discharged in Meditech at this time.
        b. Inside the ED: Patients that need ongoing complicated medical care should be moved into the Emergency Department and registered into Meditech there.

f. **Staging Area**
    i. The Casualty Care Unit leader, or designee, will identify a staging area, to which incoming equipment, materials, support staff and providers will arrive before being assigned where needed.

g. **Supporting Departments bring resources needed to support the MCI:**
    i. The following departments are encouraged to bring resources immediately to the staging area, before receiving requests from Incident Command.
        a. **Materials Management:** Additional supplies will likely be needed to the ED. Assign dedicated Materials Management personnel to the ED to bring required supplies and equipment to the ED. Materials Management has a pre-termined pick list.
        b. **Blood Bank:** The Blood Bank is alerted to the MCI by the overhead paging system and will coordinate the distribution of blood and contact outside blood banks if necessary.
        c. **Pharmacy:** Dispatches required personnel and medications to the ED. Also prepares for use of possible antidotes in Hazmat and Biohazard incidents. See job card in:
            i. **ATTACHMENT C: Pharmacy Job Card**
        d. **Radiology:** Dispatches two technicians to the ED with portable equipment if available. Postpones non-emergent

diagnostic imaging requests to accommodate the MCI response. Ensures rapid availability of CT scanner, including the outside CT scanner, ultrasound and other diagnostic imaging services.

e. **Transport Services:** Bring all available gurneys and wheel chairs to ED. See job cards in:
    i. **ATTACHMENT D: Transporter Manager Job Card**
    ii. **ATTACHMENT E: Transporter Job Card**

f. **Respiratory:** A Respiratory Care Practitioner reports to the ED and the supervisor should compile a list of available ventilators, additional oxygen tanks and nebulizer sets and report this information to the Incident Command Team.

g. **Lab services:** Should be prepared to receive a large influx of requests and deploy available phlebotomists to the treatment areas.

h. **Palliative care services, Chaplain:** may be requested through the Incident Command.

i. **Volunteer Department:** any on-duty volunteers already on-site as part of the Salinas Valley Health volunteer program will bring available wheelchairs to the staging area. For more information, see job cards in:
    i. **ATTACHMENT F: Volunteer Manager Job Card**
    ii. **ATTACHMENT G: Volunteer Department Job Card**

j. Inpatient Nursing Unit Charge Nurses: Assess staffing and resources available on the unit that may be reallocated to the Casualty Care Area or Emergency Department. Assess for potential discharges. Report to the HICS-assigned Inpatient Unit Leader. See job card in:
    i. **ATTACHMENT H: Inpatient Unit Charge Nurse Job Card**

k. The Incident Command Team, under the direction of the Incident Commander, will ensure appropriate staff and supplies are brought to the Casualty Care Area, ED, OR and other areas as needed.

h. **Establish a Discharge Staging Area**

i. A discharge staging area may be established adjacent to the Minor (Green) treatment area, and a Discharge Planner will be appointed. Patients determined to be stable for discharge will be moved to this area and will be discharged by a discharge planner. Taxi vouchers and bus passes should be considered to decongest the area. A copy of Sam's Guide to local resources is available in the MCI trailer.

3. **Open Inpatient and Surgery Capacity**
    a. Under the Operations Chief, a Medical Care Branch Director will be appointed to ensure the inpatient and procedure areas are prepared to take on an influx of patients. This may include the following activities:
        i. Conduct bed count for available inpatient beds
        ii. Work with procedure area leaders to assess readiness of OR and recovery rooms. Assess for potential cancellations.
        iii. Coordinate with inpatient units or Case Management the evaluation of patients who can be rapidly discharged from inpatient services.
        iv. If needed, open an inpatient discharge waiting area, for patients who have already been discharged and are waiting for a ride. The second floor surgery waiting room has been flagged as a suitable location for this. Staff will be assigned to the discharge lounge as appropriate to maintain patient and staff safety.

4. **Deploy Additional Support Functions**
    a. **Public Relations and News Media**
        i. At no time will the media be allowed un-escorted through any patient care or treatment area. Hospital security will direct all media to the designated media area in the Mammography parking lot, or other area as determined by the Incident Command Team. If multiple agencies and/or facilities are involved, a joint information center may be established by the Monterey County Office of Emergency Services. SVHMC's Liaison officer can request this by contacting the Monterey County MHOAC via the on-duty EMS officer at 831-235-0163.

    b. **Volunteer and Labor Pool Management**
        i. Medical volunteers (physicians, surgeons, physician assistants) will be screened for emergency credentialing and coordinated through Medical Staff Services department.
        ii. All other clinical and ancillary volunteers will be screened for emergency credentialing and coordinated through Human Resources which is represented under the Logistics section of the Hospitals Incident Command System. For more information, see policy Disaster Privilege for Clinical Volunteers, SVHMC Volunteers, Non-Clinical Volunteers, and Non-SVHMC Volunteers
        iii. Everbridge, or other communication systems, may be used to request labor pool volunteers.

    c. **Family Reunification Center**
        i. Details for establishing a Family Reunification Center are in the Emergency Management Program Plan.

E. **Phase III: De-mobilization**
    1. The Incident Command Team, under the direction of the Incident Commander, will

evaluate the status of individual units/sections and will demobilize each when deemed appropriate.

2. The Incident Command Team will authorize telecommunications to give the "Code External Triage MCI, all clear" via the overhead paging system when the event has been declared over. It is the incident commander's responsibility to call for de-escalation and to deactivate the EOP and MCI plans. The Triage/Receiving area and MCI treatment areas will be deactivated at the direction of the Incident Command Team. This shall be done only after consultation with the ED physician and ED charge nurse.
3. Clean, sanitize, return or dispose of equipment and materials as appropriate.
4. Conduct hot-wash debrief with response team. If possible, include Code Lavender Team to assess for responders' needs post incident.
5. Collect MCI documentation sheets and return to Incident Command.

F. **Phase IV: Recovery**

1. Continue to assist employees and community with psychological needs.
2. Assist employees with employee assistance programs through Human Resources department.
3. Route purchases, labor hours information to Finance Section Chief for potential FEMA reimbursement.
4. Incident Command Team will conduct a formal debrief, and will include outside agencies as appropriate.
5. Submit written evaluation of incident to Emergency Management Committee for review.
6. Replenish supplies as appropriate.
7. Integrate improvements into the Emergency Operations Plan and into departmental plans or procedures as needed.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Title 22 70413 and 70741

B. CDPH "15 'til 50 Mass Casualty Incident Toolkit". Accessed July 2023. https://cdphready.org/15-til-50-mass-casualty-incident-toolkit/

Attachments

ATTACHMENT A: MCI Roadmap

ATTACHMENT B: Code External Triage MCI 15-to-50 Set Up Map

ATTACHMENT C: Pharmacy Job Card

ATTACHMENT D: Transporter Manager Job Card

ATTACHMENT E: Transporter Job Card

ATTACHMENT F: Volunteer Manager Job Card

ATTACHMENT G: Volunteer Department Job Card

ATTACHMENT H: Inpatient Unit Charge Nurse Job Card

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
EOCC	James Hively: Manager Environmental Health & Safety	02/2025
EM Committee	James Hively: Manager Environmental Health & Safety	02/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Emergency Management Specialist	James Hively: Manager Environmental Health & Safety	01/2025
Policy Owner	Laura Zerbe: Manager Facilities Construction and Plant Operatio	12/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16948903**

Last Approved	N/A	Owner	James Hively: Manager Environmental Health & Safety
Next Review	1 year after approval	Area	Plans and Program

Fire Safety Management Plan

I. SCOPE

A. The Fire Safety Management Plan describes the methods for preventing the potential for a fire through the use of equipment and training for Salinas Valley Health Medical Center (SVHMC) The hospital and its licensed offsite locations are covered by this management plan. The Fire Safety Management Program is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, and visitors, or the environment, and protect building occupants from fire and the products of combustion for Salinas Valley Health Medical Center. The Program is also designed to assure compliance with applicable codes and regulations, as applied to the buildings and services provided at Salinas Valley Health Medical Center.

II. OBJECTIVES/GOALS

A. **Objectives**

The objective of the Fire Safety Management Program is to use information gathered from environmental tours, risk assessments is to minimize the potential for harm from fire, smoke, and other products of combustion.

B. **Goals**

The goals for the Fire Safety Management Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental tours.

III. DEFINITIONS

A. Salinas Valley Health Medical Center (SVHMC) and its licensed off site locations.

B. Interim Life Safety Measures (ILSM)

C. Statement of Conditions (SOC)

D. Environment of Care (EOC)

E. Chief Executive Officer (CEO)

F. Environmental Health and Safety – EH&S

G. The Department of Health Care Access and Information (HCAI). Formally the California Office of Statewide Health Planning and Development (OSHPD)

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. The hospital buildings are designed and maintained in compliance with law, regulation, and accreditation requirements, including compliance with the *Life Safety Code®*, 2012 Edition.
2. The fire alarm, detection, and suppression systems are designed, installed, and maintained to ensure reliable performance.
3. Staff Training is an essential part of the fire safety program.

B. **Plan Management**

1. Management Plan
    a. The organization develops, maintains and on an annual basis, evaluates the effectiveness of the Fire Safety Management Plan to effectively manage the fire safety risk to staff, visitors, and patients at SVHMC.
2. Minimize Potential for Harm
    a. The EH&S Manager or designee is responsible for managing the program for minimizing potential harm from fire, smoke, and other products of combustion. The fire protection program includes three phases.
    b. The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. SVHMC employs qualified architects and engineers to develop building and fire protection system designs. All designs are reviewed by HCAI (as a part of the construction and permitting process. A construction monitoring and building commissioning program round out the design phase.
    c. The second phase is testing, inspection, and maintenance of the fire prevention aspects of the facility. The EH&S Manager or designee is responsible for setting testing, inspection and maintenance standards and frequency based on applicable codes, equipment history, and other parameters. The work is done by SVHMC staff and contractors. The EH&S Manager or designee ensures the end product of all work maintains or improves the level of life safety in each affected area.
    d. The third phase is an active training program of fire prevention, fire safety, and fire response. The EH&S Manager or designee manages this phase of the program.

3. Surgical Safety
    a. Periodic evaluations are made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of flammable germicides or antiseptics, are established. See FIRE SAFETY FOR SURGERY, L&D, AND PROCEDURE AREAS.

4. Unobstructed Exits in Business Occupancy
    a. For those areas designated as Business Occupancy by NFPA 101® – Life Safety Code® 2012, all exits must be maintained free and unobstructed. The status of these areas will be determined routinely by the staff and during environmental tours. Storage will not be allowed in any exit lobby or exterior anteroom.

5. Fire Response Plan
    a. The FIRE RESPONSE PLAN EC#618 provides clear, specific instructions for staff responding to a fire emergency in the hospital. The FIRE RESPONSE PLAN FOR OFF-SITE locations outlines the procedures for staff to follow in the event of a fire emergency in business occupancies. Each department leader is responsible for maintaining copies of emergency procedures in a continuously accessible location.
    b. The EH&S Manager or designee and department leadership is responsible for developing and training staff on department specific emergency fire response procedures. Department leadership is responsible for providing departmental and area personnel with an orientation to emergency procedures related to their job. Additional departmental training is provided on an annual basis as part of the continuing education program or on an as-needed basis. The roles of all staff and licensed independent practitioners (LIPs) are detailed specifically in the Fire Response Plan. The roles of all staff and LIPs at and near the point of fire origin are defined. The basic plan in the organization is based on the acronym "RACER":
        i. Rescue anyone in immediate danger from the fire if safe to do so
        ii. Activate the fire alarm by a pulling fire alarm pull station and dialing 2-2-2-2 on the phone and announcing the alarm to staff. Off site location staff must call 9-911.
        iii. Contain smoke and fire by closing doors and windows
        iv. Extinguish if safe to do so
        v. Relocate and evacuate as directed.
    c. The role of all staff and LIPs away from the point of fire origin is to close doors and evaluate the situation. If the fire is in horizontally adjacent areas or in areas where relocation is planned, move patients to an adjacent smoke department if it is safe to do so.
    d. The Administrative Supervisor or Respiratory Therapy staff are responsible

for shutting off the oxygen in the area when deemed appropriate.

6. Fire Drills
    a. Fire drills are a critical tool for maintaining the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and staff. Staff participation is necessary to maintain an acceptable level of readiness and to ensure staff knowledge of the equipment and procedures necessary to protect the staff and patients. To evaluate staff knowledge, drill activities are observed, and staff is questioned about their role and responsibilities during a fire emergency nearby and elsewhere in the building.
    b. Fire drills are conducted in the hospital once per shift per quarter and scheduled at varying times of day. Fire drills are conducted every 12 months in all licensed freestanding buildings classified as business occupancies These drills are witnessed, documented, and evaluated to identify improvements that may be made. Additional drills are held as deemed appropriate.
    c. All drills will be unannounced, with the exception of those done as corrective training activities.
    d. All SVHMC staff will participate in drills, according to the fire response plan. This includes all hospital staff and all SVHMC staff in buildings where space is shared with others.
    e. Fire drills are observed and critiqued to evaluate fire safety equipment, fire safety building features and staff response. In addition, fire response knowledge is evaluated during fire drills and environmental tours.
    f. The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, fire protection equipment, and administrative compliance issues. Such improvements are evaluated during monitoring activities and the results are used to identify the effectiveness of the activities.

7. Maintaining Fire Safety Equipment and Building Features
    a. The Director of Facilities Management Services or designee is responsible for maintenance of the fire alarm and related systems. Troubleshooting fire alarm system and performing corrective and preventive testing, inspection and maintenance is performed by staff and/or an approved vendor . All testing, maintenance, inspection, and repairs are documented and reviewed by the Director of Facilities Management Services, or designee. Any fire protection feature that is not operating properly will be evaluated for the (ILSM).
    b. When appropriate, competent contractors are used to test, inspect, maintain, and repair the fire protection features. Documentation is maintained as part of the SVHMC database to assure activities are conducted as required

8. Life Safety
    a. The EH&S Manager or designee is responsible for assessing compliance of the organization with the Life Safety Code and managing the Statement of Conditions (SOC) when addressing survey-related deficiencies. In time frames defined by the hospital, the EH&S Manager performs a building assessment to determine compliance with the Life Safety Code. A quarterly report of any deficiencies identified is provided to the EOC Committee.. The organization maintains documentation of any inspections and approvals made by state or local fire agencies.
    b. Current and accurate drawings denoting features of fire safety and related square footage are maintained.
    c. The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, are either maintained or removed.
9. Managing Fire Life Safety Risks
    a. The organization has a written Interim Life Safety Measure (ILSM) policy that addresses situations when Life Safety Code deficiencies exist and cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent SVHMC compensates for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented.
    b. The Interim Life Safety Program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific plan is designed. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, etc. Affected staff are oriented and drilled, as appropriate.
    c. The EH&S Manager or designee is responsible for monitoring the effectiveness of the implementation of the appropriate ILSM. When deficiencies are identified, appropriate actions are taken to resolve the deficiencies. All monitoring and actions to resolve deficiencies are documented. All Interim Life Safety evaluations, plans, and monitoring documentation are maintained for at least three years.

C. **Plan Responsibility**

1. The Director of Facilities and Construction and the EH&S Manager or designee, in collaboration with the EOC Committee, is responsible for monitoring all aspects of the Fire Safety Management Program. The EH&S Manager advises the EOC Committee regarding fire safety issues, which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

D. **Performance Measurement**

1. On an annual basis, the EOC Committee evaluates the scope, objectives, performance, and effectiveness of the Fire Safety Management Plan to manage the fire safety risks to the staff, visitors, and patients at SVHMC

E. **Orientation and Education**

1. Education and/or training is provided as needed.

V. REFERENCES

A. The Joint Commission Standards, Environment of Care and Life Safety chapters

B. National Fire Protection Association Life Safety Code 101, 2012 edition.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	02/2025
Emergency Management	James Hively: Manager Environmental Health & Safety	02/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	James Hively: Manager Environmental Health & Safety	02/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16948896**

Last Approved	N/A
Next Review	1 year after approval
Owner	James Hively: Manager Environmental Health & Safety
Area	Plans and Program

Injury and Illness Prevention Program Plan

I. SCOPE

A. The Injury and Illness Prevention Program is to help assist staff in maintaining a safe and healthy working environment and to ensure that safety and health policies and procedures are clearly communicated and understood by all employees as well as to ensure that all employees comply with the rules and maintain a safe work environment.

II. OBJECTIVES/GOALS

A. **Objectives**

1. To guide the employees in maintaining a safe and healthy workplace and to comply with applicable laws and regulations governing workplace safety.
2. To assure that leadership and employees recognize specific potential job task hazards and their responsibilities in addressing potential hazards.

B. **Goals**

1. The goals for the **Injury and Illness Prevention Program** are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental tours. The goals for this Plan are:
    a. To increase employee knowledge of safe workplace practices and potential hazards to reduce the occurrence of occupational injury and illness

III. DEFINITIONS

A. IIPP: Injury, Illness, Prevention Program

B. IDLH: Immediately Dangerous to Life and Health

C. PPE: Personal Protective Equipment

D. **Staff: employees, volunteers, medical staff, contractors, and travelers**

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. Code of Safe Work Practices

a. **Conduct** – Employees are required to work in a safe manner displaying acceptable behavior in line with the hospitals "STAR" values. Conduct that places the employee or others at risk, or which threatens or intimidates others, is forbidden.

b. **Drugs and Alcohol** - use and/or possession of illegal drugs on hospital property are forbidden. Reporting for work while under the influence of illegal drugs including cannabis/marijuana, controlled substances or alcohol is forbidden.

c. **Housekeeping** – ensure that all fire exits and walkways remain clear of obstructions, sufficient aisle space is maintained and wheelchairs, walkers, and other equipment are stored properly and not in a manner that would hinder pedestrian traffic, access to emergency equipment or increase the likelihood of an accident/injury.

d. **Behavior** – aggressive behavior will not be tolerated and may result in termination.

e. **Incident Reporting** – report all incidents that could result in injury regardless of severity directly to your supervisor or manager as soon as possible and no more than 24 hours following the incident.

f. **Employees** must wear appropriate footwear and any other personal protective equipment required to perform the job safely such as protective gloves, eye wear and barrier masks.

g. **Respirators** -Use of any tight seal respirators such as N95, requires compliance to CAL OSHA requirements.

h. **Patient handling** – Employees are required to follow the provisions outlined in the Safe Patient Handling Policy. (SAFE PATIENT HANDLING Policy)

i. **Vehicle use** – company vehicles may not be operated by individuals that have not been approved to do so. All laws and provision related to the safe operation of a vehicle must be adhered to.

j. **Working at elevations** – only employees trained to use ladders, scissor's lifts or the like may use such equipment to operate at elevation. Employees working at elevation must also adhere to other fall prevention/ protection criteria as appropriate.

k. **Energized sources** – Employees and/or contractors hired to perform maintenance and/or repairs who work on live electrical or energized

equipment must comply with the provisions of the SVHMC Lockout/tag out program.

l. **Bloodborne pathogens** – Employees who are at risk of exposure to bodily fluids must wear the appropriate PPE and follow safe work practices and sharps safety. (BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN).

m. **Hazard Communication** – follow all provisions as outlined in the Hazard Communication Program. (HAZARDOUS MATERIALS COMMUNICATION PROGRAM).

n. **Emergency** – in the event of an emergency in the hospital call 2222 immediately. In the event of an emergency off-site, call 911.

B. **Plan Management**

1. Employee Coaching

a. On-going interaction with employees is necessary to coach them in how to properly perform job function and requires day-to-day interaction. Employees that fail to follow the code of safe work practices, policies and/or procedures will be subject to Salinas Valley Health Medical Center's (SVHMC's) progressive disciplinary policy which is outlined in the HR DISCIPLINARY POLICY.

2. Communication

a. SVHMC has a two-way communication system, which includes the following:

- Safety committee meetings no less than quarterly
- Departmental Safety Champions
- Employees can make anonymous calls on safety concerns to the Safety Officer at 831-759-1804 or Employee Health Services at 831-759-1986
- Regular huddles
- Informal communication and training
- Formal training and in-service
- One on one coaching from the immediate supervisor
- Information related to safety during new hire orientation
- Written communications in the Safety News Letter, along with other areas visible to employees throughout the facility.

b. At minimum, the communication system will include quarterly safety committee meetings, as needed in-service meetings and postings in the break room, which are required by law or for general information purposes.

3. Safety Committee Meetings

a. Safety Committee meetings are conducted minimally on a quarterly basis. The Safety Officer will be the Safety Committee Chair to ensure that the

outlined agenda and safety committee charter is adhered to. Safety champions will made up of front line employees. Safety champions will be invited to attend Safety Meetings as appropriate.

4. Assessments, Audits and Inspections
    a. SVHMC engage in a multi-pronged approach to conducting inspections, audits and assessments.
        - Safety Approach
        - Safety and/or Employee Health Services may conduct observations of work practices of individuals or departments with recommendations as needed to the department leader and employee.
        - Physical Inspections and Assessments (Environmental Tours)
        - As outlined in responsibilities; formally documented inspections and physical assessments are conducted by the Safety Officer and designated departmental representatives. Less frequent inspections may be conducted by third party safety contractors, insurance professionals, facility administrators or the risk manager and will be used to help ensure the physical safety of the staff and patients.

5. Incident Investigation Procedure
    a. Work related injuries and/or near misses are to be reported by the employee involved to their supervisors immediately following the event and by the end of the individual's shift on the day of the incident. Incident investigation will be conducted as soon as possible.

6. Hazard Correction
    a. Efforts to correct unsafe conditions that do not require capital expense and are not Immediately Dangerous to Life and Health (IDLH) will be corrected immediately upon observation if possible unless specified qualifications are unavailable at the time of the observation. If the observation is such that a specialist, maintenance or specific safety procedure is required, it is the responsibility of the Safety Officer to arrange for service or delegate it to an internal person who maintains appropriate knowledge to correct. Efforts will be documented consistent with the facility's work order system.
        - IDLH – in the event that the hazard falls within an IDLH environment, necessary means will be taken to ensure the safety of employees and patients.
        - Other specific procedures that can be used to correct hazards include, but are not limited to, the following:
            - Stopping unsafe work practices and providing retraining on proper procedures before work resumes

- Reinforcing use of and providing personal protective equipment
- Follow Lock-out/tag-out procedure
- Isolating or barricading areas that have chemical spills or other hazards to deny access until appropriate correction is made; and
- Reporting problems or hazardous conditions to a supervisor

7. **Record Keeping**
    a. The following records must be kept on file per hospital policy and according to federal, state and local requirements.
        - Environmental Tours (Safety & Hazard Identification)
        - Incident investigations
        - Safety postings and safety meeting agendas
        - Safety training checklists and related training documents
        - Exposure records, or other employee medical records

C. **Responsibilities:**

1. **Safety Officer/Risk Manager/Employee Health Services**
    a. Partners with management and stakeholders to develop and distribute safety and risk reduction programs
    b. Engages with insurance partners and environmental, health and safety consultants to help achieve corporate loss reduction, safety and compliance objectives and reduce employee injuries.
    c. Audits programs and facility implementation of safety programs
    d. Provides technical expertise to assist in the reduction of accidents and injuries
    e. Communicates program successes and/or need for new or revised risk mitigation systems, equipment, processes and the like
    f. Works with leaders as required to strive for comprehensive implementation of programs that will help reduce loss frequency and related severity of occupational accidents and injuries
    g. Communicates progress to leadership

2. **Executive Leadership Group (ELG)**
    a. Conversant in all applicable safety policies, practices and procedures outlined in this program.
    b. Ultimately responsible for the success and implementation of the IIPP in all of the areas of responsibility.
    c. Leads management team for which he/she has responsibility to ensure

compliance with initiatives that are designed to reduce occupational injuries and enhance regulatory compliance

3. **Directors:**
    a. Ultimately responsible for the success and implementation of the IIPP in their departments.
    b. Positively and actively contributes to the wellness of their employees and condition of the work environment
    c. Ensures that employees and managers operate in a safe manner and according to best practices
    d. Enforces and supports safety policies and Code of Safe work practices
    e. Participates in incident investigation as needed, in a timely manner
    f. Participates in the facility safety committee meeting as needed
    g. Communicates safety issues and concerns to the Executive leader and to the Safety and/or Risk manager as needed to mitigate high risk and/or exposure issues
    h. Develops budgets to ensure equipment is maintained to manufacturers specifications, PPE is available and employees are sufficiently trained
    i. Continuously coaches employees and disciplines for disregard of safe work practices
4. **Managers/Supervisors**
    a. Familiarize themselves with the IIPP and ensure its effective implementation with employees he/she supervises
    b. Be aware of safety considerations when introducing a new process, procedure, equipment or material to the workplace
    c. Provide support to all programs and committees whose function is to promote safety and health
    d. Actively participate in safety committees as needed
    e. Lead in conducting incident investigations to ensure that proper reports are completed and appropriate action is taken to prevent repetition
    f. Participate in incident investigations in a timely manner
    g. Conducts safety training with employees and coaches employees immediately upon recognizing failure to follow safe work practices
    h. Corrects unsafe conditions immediately and/or takes action to correct the unsafe condition
    i. Ensures that employees follow procedures to include inspection practices that ensure a safe environment, work processes and procedures and training
    j. Includes safety and employee compliance to safe work practices in all performance evaluations

5. **Employee**
    a. Understands the IIPP including safe practice policies, programs and procedures
    b. Adheres to the provisions of the IIPP and Code of Safe work practices
    c. Corrects and/or reports all unsafe conditions to management or the appropriate entity for repair
    d. Encourages co-workers to follow safe practices and leads by example
    e. Participates in safety training and safety committee meetings as appropriate
    f. Reports injuries, regardless of severity, to immediate supervisor
    g. Properly wears all required safety equipment and/or PPE.
    h. Ensuring that all equipment and PPE assigned to them are inspected periodically or as required to ensure their safe operation. Positive Air Purifying Respirators (PAPRs) assigned to the employee must be cleaned and disinfected by the employee prior to returning the PAPR to general use.

D. **Performance Measurement**
    1. Evaluation of the program will be done through the Safety Committee. The Safety Committee will review injury data and trends at each meeting.

E. **Orientation and Education**
    1. Training will be conducted as deemed necessary to reduce potential for occupational injuries and illnesses by the department leadership in consultation with the Safety Officer.

V. REFERENCES

A. Title 8, California Code of Regulations., Section 3203

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	02/2025

Emergency Management	James Hively: Manager Environmental Health & Safety	02/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	James Hively: Manager Environmental Health & Safety	01/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16302419

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

Operative Delivery: Vaginal or Cesarean Section

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in the management of a delivery assisted by the use of a vacuum device or forceps.

III. DEFINITIONS

A. Operative delivery refers to the use of forceps or a vacuum device to assist in delivery of the fetal head, typically in conjunction with maternal pushing.

B. Pop off – cup detachment.

C. Pull – number of pulls is equal to number of contractions during procedure.

D. CPD – Cephalopelvic disproportion.

IV. GENERAL INFORMATION

A. A RN who has successfully completed the competency for operative vaginal delivery and fetal monitoring should assist the physician with the set up and use of the vacuum device or forceps.

B. A NICU RN should be called to attend all operative vaginal deliveries.

V. PROCEDURE

A. **Inclusion criteria for use in vaginal delivery**

1. Cervix is fully dilated

2. Membranes are ruptured.
3. Fetal head is engaged in the pelvis
4. Position of the fetal head has been determined
5. The patient has agreed to proceed with operative delivery after being informed of the risks and benefits of the procedure
6. Empty bladder
7. Adequate analgesia
8. Fetal weight has been estimated
9. The operator is willing to abandon the trial of operative delivery, and back up plan is place in case of failure to deliver. Availability of an OR has been confirmed.
10. Neonatal team is available

B. **Exclusion Criteria for use in vaginal delivery**

1. Gestational age less than 34 weeks (vacuum).
2. Known fetal demineralizing disease (i.e. Osteogenesis Imperfecta).
3. Known fetal bleeding disorders (i.e. Hemophilia, Von Willebrand's disease, alloimmune thrombocytopenia).
4. Known fetal Collagen disorders (i.e. Marfan's Syndrome).
5. Fetal head is not engaged
6. Suspected CPD
7. Suspected malpresentation.
8. Previous failed operative vaginal delivery attempt.

C. **Exclusion criteria for use in cesarean delivery**

1. Gestational age less than 34 weeks (vacuum).
2. Known fetal demineralizing disease (i.e. Osteogenesis Imperfecta).
3. Known fetal bleeding disorders (i.e. Hemophilia, Von Willebrand's disease, alloimmune thrombocytopenia).
4. Known fetal Collagen disorders (i.e. Marfan's Syndrome).

D. **Device**

1. Should not proceed to second procedure after failure of first i.e. vacuum and then forceps or vice versa.
2. Except for outlet operative vaginal delivery, Physician or RN should notify anesthesia and ensure OR availability and appropriate staffing.

E. **Vacuum**

1. Suction pressure not to exceed 60cm/Hg (Not to exceed the "green" zone).
2. Traction should be exerted with uterine contractions.

3. Total time of application not to exceed 20 minutes.
4. Total time of maximum pressure not to exceed 10 minutes.
5. Attempts limited to 3 pulls.
6. Maximum of 2 "pop-offs" (per device manufacturer)

F. **Forceps**

1. Traction is exerted with uterine contractions.
2. Attempts limited to 3 pulls.
3. Total time of procedure should not exceed 20 minutes.

G. **Documentation**

1. Informed verbal or written consent provided and documented by Physician
2. Type of instrument used.
3. Estimated fetal weight.
4. Fetal station.
5. Time of each separate application.
6. Total time of all applications.
7. Total time of maximum pressure (the RN should document if vacuum is held at maximum pressure or if pressure is released in between contractions/pulls).
8. Amount of suction pressure.
9. Number of pulls.
10. Number of pop-offs.
11. Alternative labor strategies utilized, as applicable.
12. Time of delivery.
13. Availability of OR.
14. Documentation of contractions and FHR per FETAL HEART RATE MONITORING

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American College of Obstetricians and Gynecologists. (2020, reaffirmed 2025). Operative vaginal birth. (Practice Bulletin No. 219).

B. Clinical Innovations. (2021). Complete vacuum delivery system with PalmPump: Instructions for use. Retrieved July 26, 2024 from https://www.laborie.com/wp-content/uploads/2021/07/ART-0328-Rev02-Kiwi-IFU-New-Combined-IFU-3-24.pdf

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	03/2025
Women & Children's Service	Katherine DeSalvo: Director Medical Staff Services	03/2025
Director of WCS	Julie Vasher: Director Women's & Children's Services	02/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Daniela Jago: Clinical Manager	02/2025

Standards

No standards are associated with this document

Board Paper: Board of Directors

Agenda Item: *Consent Agenda - Approval of Revised Contract and Expense Matrix*

Executive Sponsor: Augustine Lopez, Chief Financial Officer / Scott Cleveland, Controller

Date: Thursday, March 27, 2025

Executive Summary

Dear Board of Directors:

In the recent months, we have been working on the implementation of Workday for Finance/Accounting and Supply Chain Management, which will go live on August 1, 2025. Part of the implementation is to load the Expense Approval Matrix categories by management position into Workday FIN.

To standardize and enhance our processes in Workday we are proposing the following changes:

- The CEO limits remain the same as before which was originally approved on 3/28/2024.
- We have combined some Executive positions to be in alignment with the same approval amounts.
- We have added Vice-Presidents, which is a new management category.
- We have added Managers, which was not previously addressed.
- We have also standardized the amounts for different Expense Categories so that there are six categories, which all have the same dollar amounts by position.

In addition, we have aligned the Contract Approval Matrix (attached) authority limits with the Expense Approval Matrix. This has resulted in a few changes and a simplification of the Contract Approval Matrix.

This will become effective when the board approves the Contract Approval Policy and the Expense approval Policy on Thursday, March 27, 2025.

Recommendation

Approval of Revised Contract and Expense Matrix

Attachments

1. *Revised Contract Approval Matrix*
2. *Revised Expense Approval Matrix*

Salinas Valley Health
Contract Approval Matrix
Updated / Board Approved on: Thurs 3/27/25

Reviewed: Augustine Lopez: _____
Allen B. Radner: _____

Contract Categories	Maximum contract value authority provided to Executives: Executives CHRO CNO CLO	CMO CCO	COO & CAO	CFO	President/CEO
1. All Capital	$100,000	$100,000	$200,000	$200,000	<$400,000
2. Professional Fee Agreements: Directorships, On-Call, Stipends, etc.	--	$200,000	--	--	<$400,000
3. Consultants	$100,000	$100,000	$200,000	$200,000	<$400,000
4. Contract Labor	$100,000	$100,000	$200,000	$200,000	<$400,000
5. Legal / Audit Agreements	$100,000	$100,000	$200,000	$200,000	<$400,000
6. Supplies / Group Purchasing / Distributors	--	$50,000	$200,000	No Limit	No Limit
7. Purchased Services	$100,000	$100,000	$200,000	$200,000	<$400,000
8. Maintenance & Equipment Service	$100,000	$100,000	$200,000	$200,000	<$400,000
9. Physician Recruitment Agreements	--	--	--	--	Board Approval
10. Dues/Subscrpitions/Licenses	$100,000	$100,000	$200,000	$200,000	<$400,000
11. Rental Equipment Agreements	$100,000	$100,000	$200,000	$200,000	<$400,000
12. Real Estate Lease Agreements (Note 6)	$100,000	$100,000	$200,000	$200,000	<$400,000
13. Managed Care Payor Contracts	--	--	--	No Limit	No Limit
14. Collective Bargaining Agreements	--	--	--	--	Board Approval

Note

1. New contracts with expenditures more than $25,000 must be reviewed per Competitive Solicitation Policy.
2. Any change order to an existing contract that exceeds 5% of the originally approved amount must be reviewed for compliance with the Competitive Solicitation Policy.
3. All Contracts approved by the Board, the President/CEO or his/her Executive level designee have full authority to sign contracts.
4. Director of Materials Management has authoritiy to sign supply, equipment rental, consignment contracts up to $150,000.
5. The above approval includes agreements/contracts, purchase orders, statement of work agreements, etc.
6. All real property purchases, sales, and leases need to be approved by the Board of Directors.
7. Only C-suite Executives as noted above have the authority to sign contracts.

Salinas Valley Health

Expense Approval Matrix

Updated / Board Approved on: Thurs 3/27/25

Reviewed: Augustine Lopez: _____

Allen B. Radner: _____

	Maximum expense value authority provided to:							
	Managers	Directors	VPs	Executives				
Expense Approval Matrix (Invoices, Purchase Orders, Travel)	**Managers Only**	**Directors**	**Vice Presidents**	**CHRO CNO CLO**	**CCO**	**COO & CAO**	**CFO**	**President/CEO**
Expense Category								
1. All Capital (Note 2)	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
2. Medical Fees	--	--	--	--	$ 100,000	$ 200,000	$ 200,000	>$200,000
3. Consultants	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
4. Contract Labor	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
5. Legal (Attorneys)/Audit	--	--	$ -	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
6. Supplies - All (Note 2)	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
7. Purchased Services	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
8. Maintenance/Equip Service (Note 2)	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
9. Travel/Conferences (Employee Business Expenses)	$ 1,000	$ 2,000	$ 4,000	$ 4,000	$ 4,000	$ 4,000	$ 4,000	>$4,000
10. Dues/Subscrpitions/Licenses	$ 10,000	$ 20,000	$ 50,000	$ 100,000	$ 100,000	$ 200,000	$ 200,000	>$200,000
11. Donations	--	--	--	--	--	$ 50,000	$ 50,000	>$50,000
Patient Financial Services								
12. Write-offs - Administrative	--	--	--	--	--	--	$ 300,000	>$300,000
- Bad Debt	--	--	--	--	--	--	$ 300,000	>$300,000
- Charity	--	--	--	--	--	--	$ 300,000	>$300,000

Notes:

1. New expenditures more than $25,000 must be reviewed per the Competitive Solicitation Policy.

2. Expenditures with (Note 2 above) more than $25,000 require a Materials Management Purchase Order.

3. The Director of Patient Financial Services has authority to approve Bad Debt and Charity Care write-offs up to $150,000

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)

PERSONNEL, PENSION & INVESTMENT COMMITTEE

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

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

(CATHERINE CARSON)

Salinas Valley Memorial Healthcare System 403(b) Retirement Plan

March 2025

CREATIVE PLANNING®
RETIREMENT SERVICES

Target Date Funds

Comparison: American Funds vs. Vanguard

		American Funds	Vanguard
2025 Vintage	**Portfolio Composition**		
	% US Stocks	33.9%	30.5%
	% International Stocks	12.4%	19.7%
	% Bonds	47.8%	48.2%
	% Cash	5.0%	1.6%
	Equity/Bond Portfolio		
	Average Market Cap	$153 billion	$105 billion
	Duration	5.7 years	5.7 years
	% Below Inv Grade	10%	0%

2050 Vintage	**Portfolio Composition**		
	% US Stocks	60.1%	54.7%
	% International Stocks	26.0%	34.1%
	% Bonds	9.1%	9.6%
	% Cash	4.3%	1.5%
	Equity/Bond Portfolio		
	Average Market Cap	$127 billion	$107 billion
	Duration	6.4 years	6.2 years
	% Below Inv Grade	5%	0%

Key Reasons for American Funds Outperformance vs. Vanguard

- Lower exposure to international stocks
- Emphasis on mega/large cap stocks
- Exposure to non-investment grade bonds

Source: Morningstar. Numbers may not add to 100% due to rounding or allocations are classified as "other" which are not illustrated. Key reasons listed are Creative Planning's opinion based on relevant data collected. Other factors also contributed to performance differences between the strategies

Comparison: American Funds vs. Vanguard

2025 Vintage Comparison

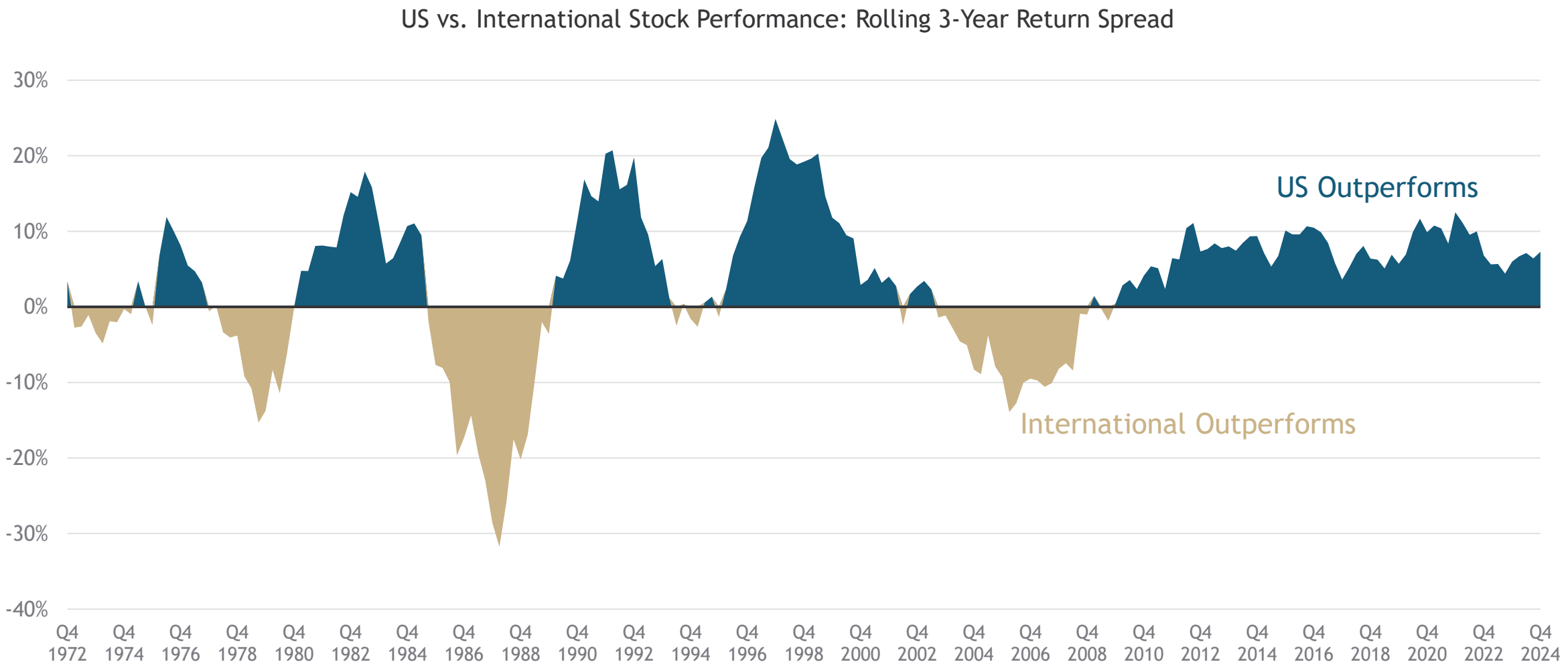
	American Funds	Vanguard
Performance		
YTD	3.42	2.46
1 year	11.34	10.21
3 year	5.07	4.69
5 year	7.76	7.04
10 year	6.76	6.28
Standard Deviation		
3 year	10.66	11.56
5 year	10.61	11.72
10 year	8.96	9.81
Share Class Info		
Share Class	R6	Investor
Expense Ratio	0.31%	0.08%

2050 Vintage Comparison

	American Funds	Vanguard
Performance		
YTD	2.63	2.65
1 year	13.27	13.31
3 year	8.33	7.82
5 year	11.76	11.35
10 year	9.51	8.63
Standard Deviation		
3 year	14.82	15.31
5 year	15.71	16.09
10 year	13.29	13.65
Share Class Info		
Share Class	R6	Investor
Expense Ratio	0.37%	0.08%

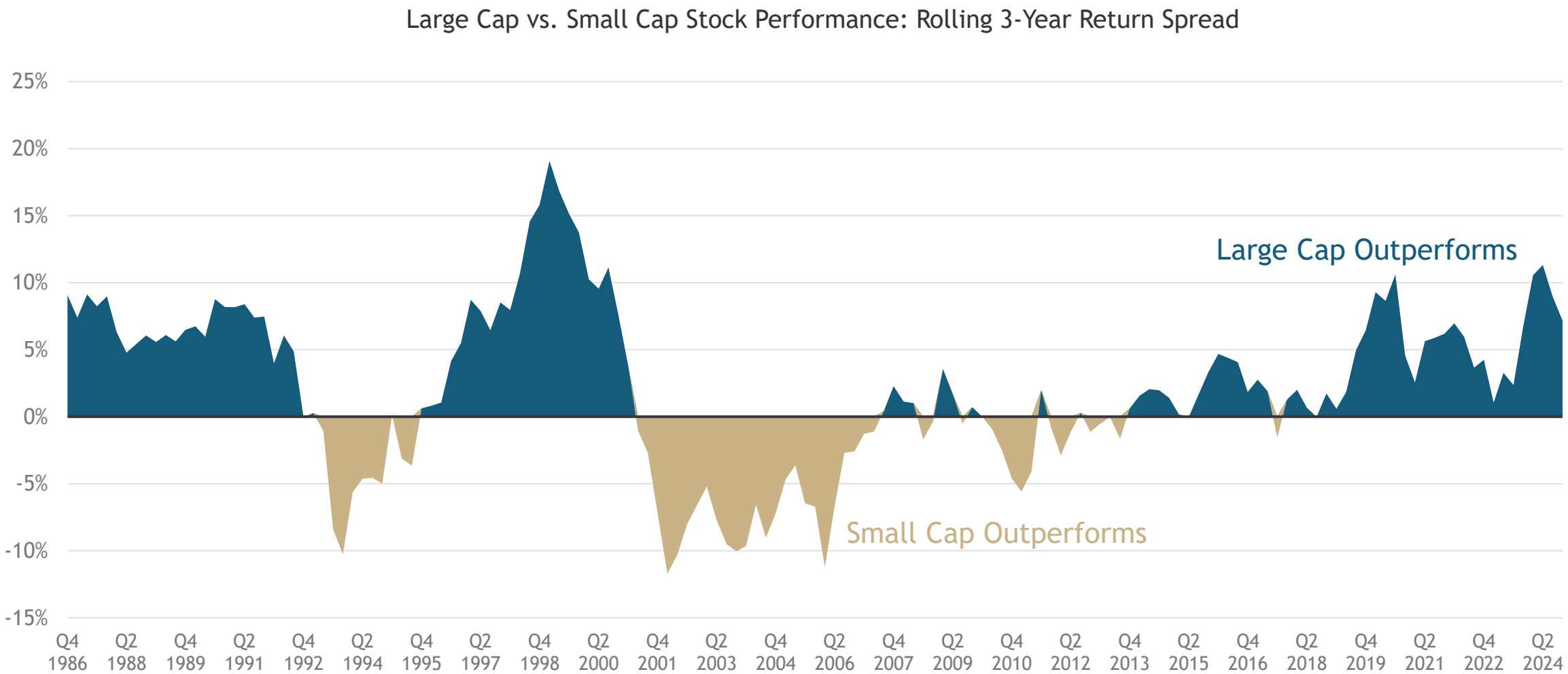
Source: Morningstar. Performance data as of 2/28/2025, all returns illustrated net of fees.

US vs. International Stocks



Source: Morningstar, quarterly return data. US stocks represented by the S&P 500 Index. International stocks represented by the MSCI EASEA (EAFE ex JAPAN) Index for periods prior to Q1 1986, and the MSCI EAFE Index thereafter. The data presented in this chart extends back to the earliest time period for which reliable data is available.

Large Cap vs. Small Cap Stocks



Source: Morningstar, quarterly return data. Large cap stocks represented by the Russell 1000 Index. Small cap stocks represented by the Russell 2000 Index. The data presented in this chart extends back to the earliest time period for which reliable data is available.

COMMITTEE RECOMMENDATION

Consider recommendation for Board of Directors to replace the American Century One Choice Target Date Funds with the American Funds Target Retirement Funds.

Rationale:

American Funds, one of the largest target date managers in the industry, offer a low-cost, actively managed approach. The series has consistently delivered competitive absolute and risk-adjusted returns over time.

Appendix – Additional Target Date Fund Data

Top 15 Target Date Providers

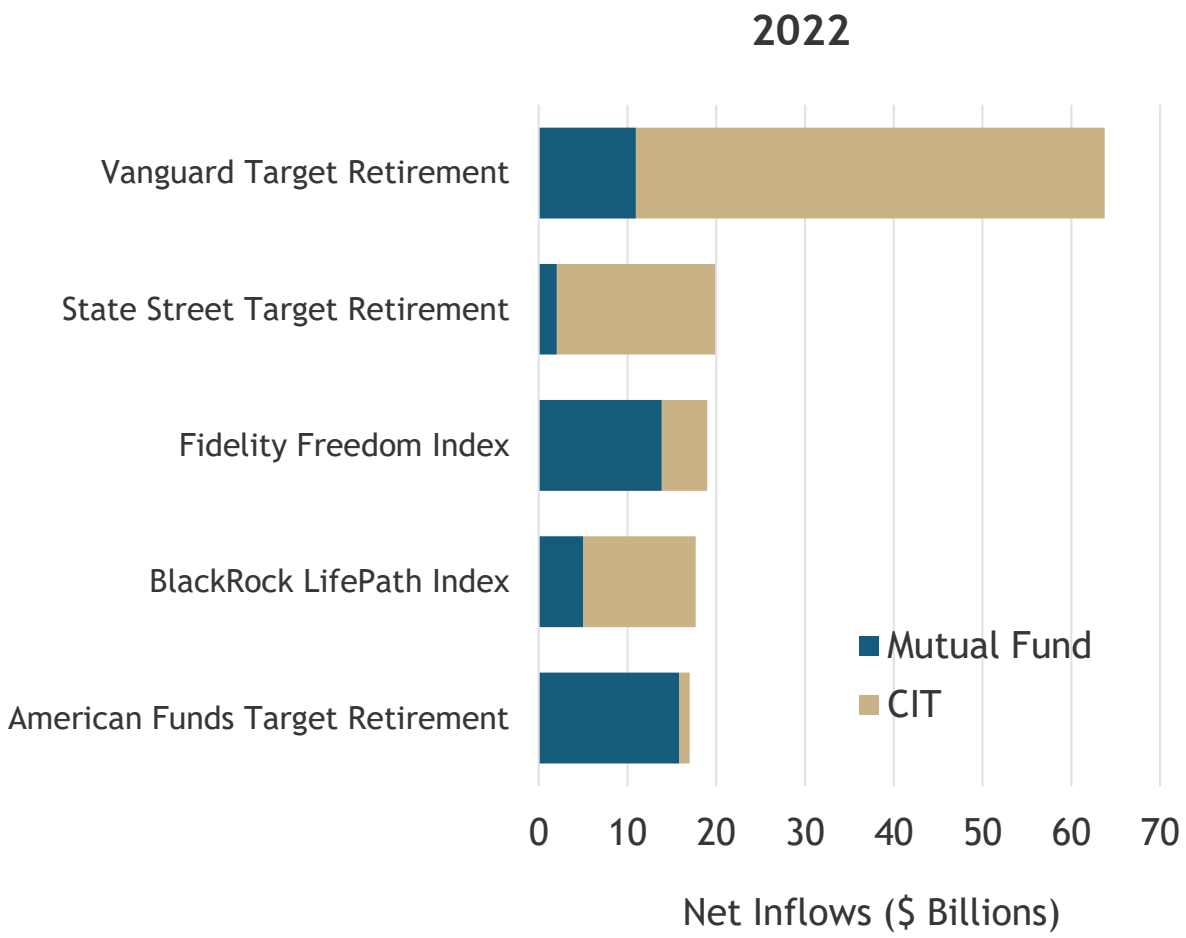
	Assets ($bil)	Market Share
Vanguard	1,288	37.1%
Fidelity	498	14.4%
T. Rowe Price	388	11.2%
BlackRock	333	9.6%
American Funds	286	8.2%
State Street	165	4.8%
JPMorgan	99	2.9%
Nuveen	91	2.6%
Principal	87	2.5%
flexPATH Strategies	39	1.1%
American Century	28	0.8%
Schwab	28	0.8%
John Hancock	18	0.5%
Voya	16	0.5%
Transamerica	9	0.3%
Top 15 Total	**3,373**	**97.3%**

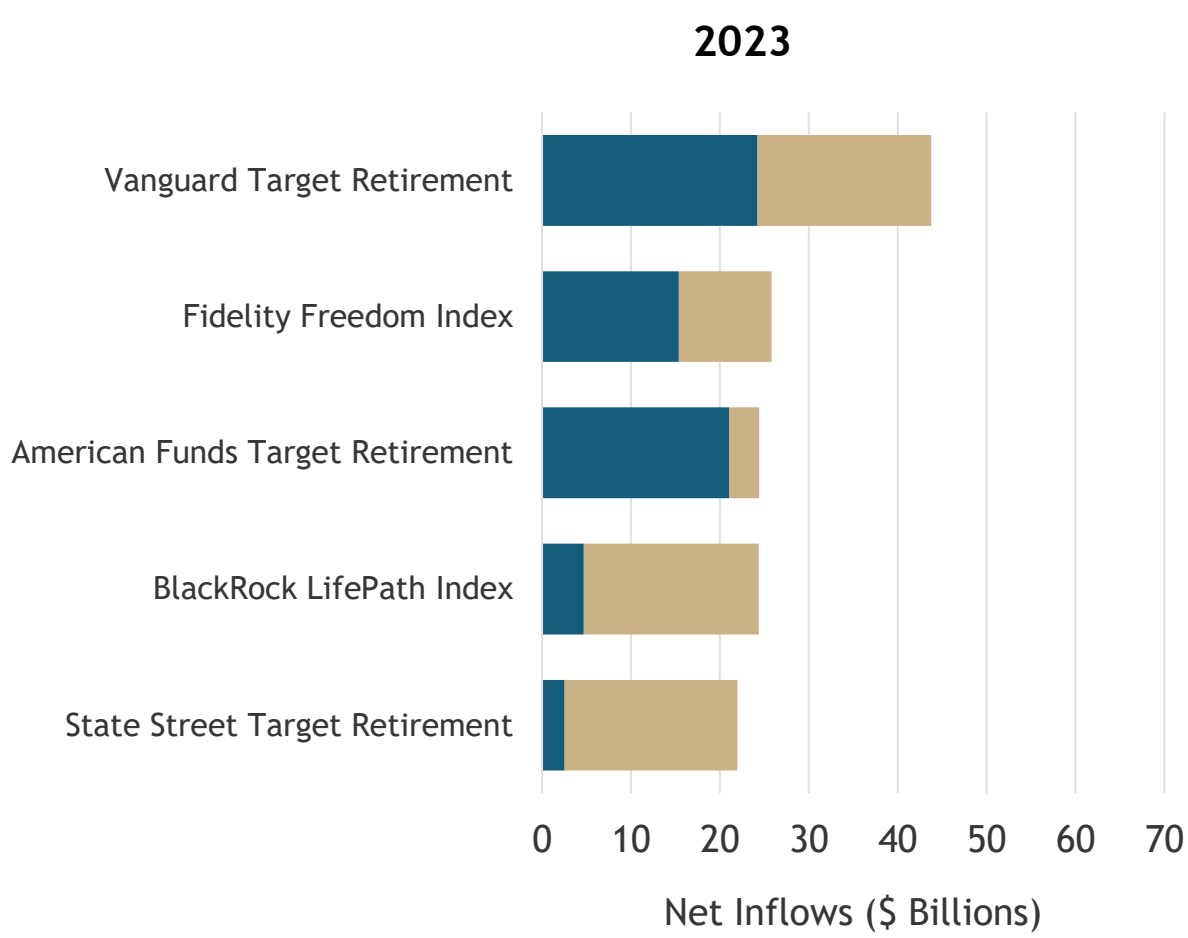
Why Does this Matter?

- Larger AUM totals create economies of scale which can lead to lower costs for investors over time
- Additionally, investment managers can invest in new personnel and research to support the strategy
- Larger AUM totals decrease liquidation risk. Since 2014, 25 mutual fund and 34 CIT target date products have been liquidated or merged away[1]

Source: Sway Research, LLC. Data as of 12/31/2023. Includes mutual funds and CITs.[1]Morningstar 2023 Target Date Landscape Report

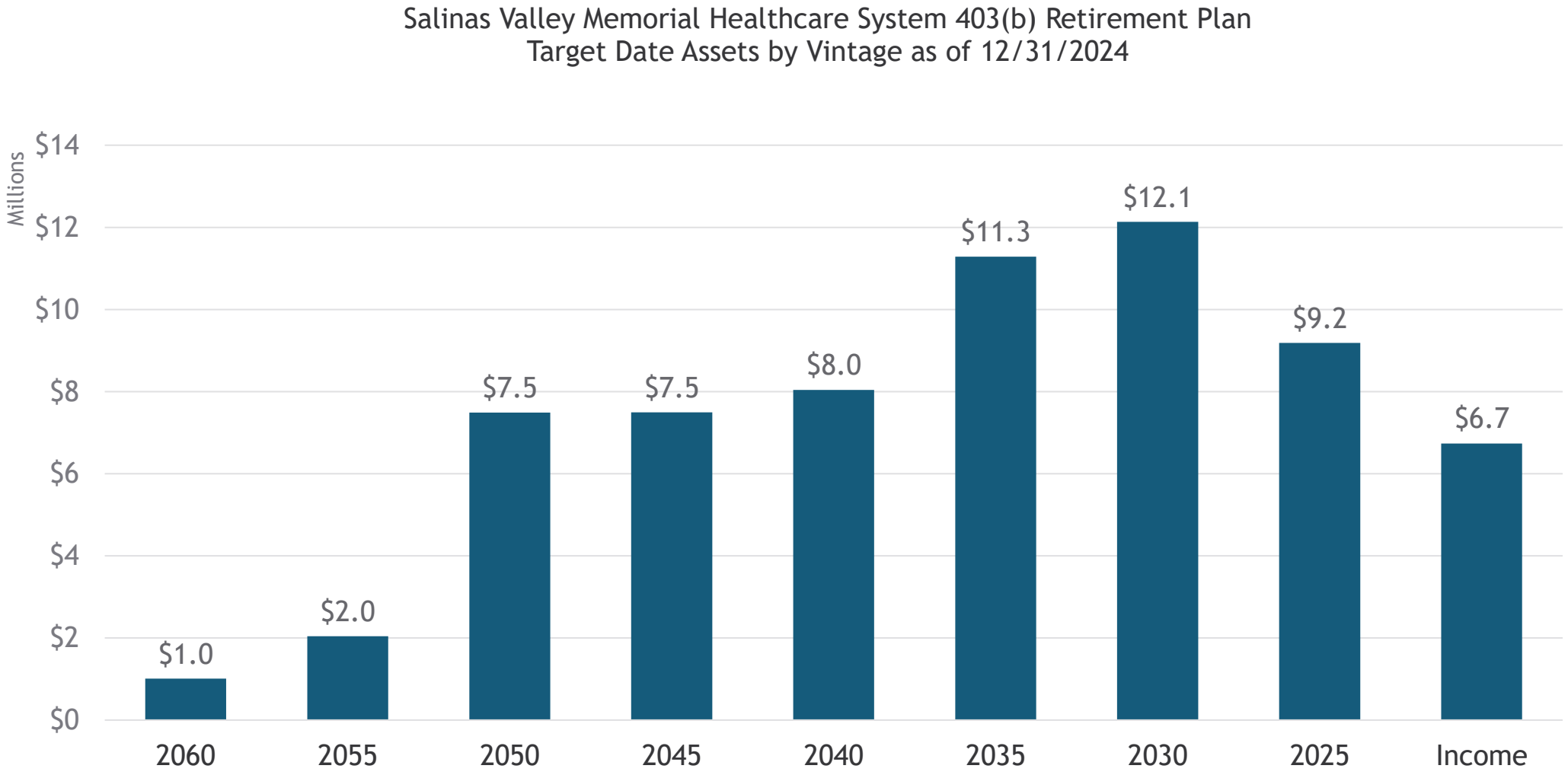
Top 5 Target Date Series by Net Inflows





Source: Morningstar 2023 Target Date Landscape Report

403(b) Target Date Assets by Vintage



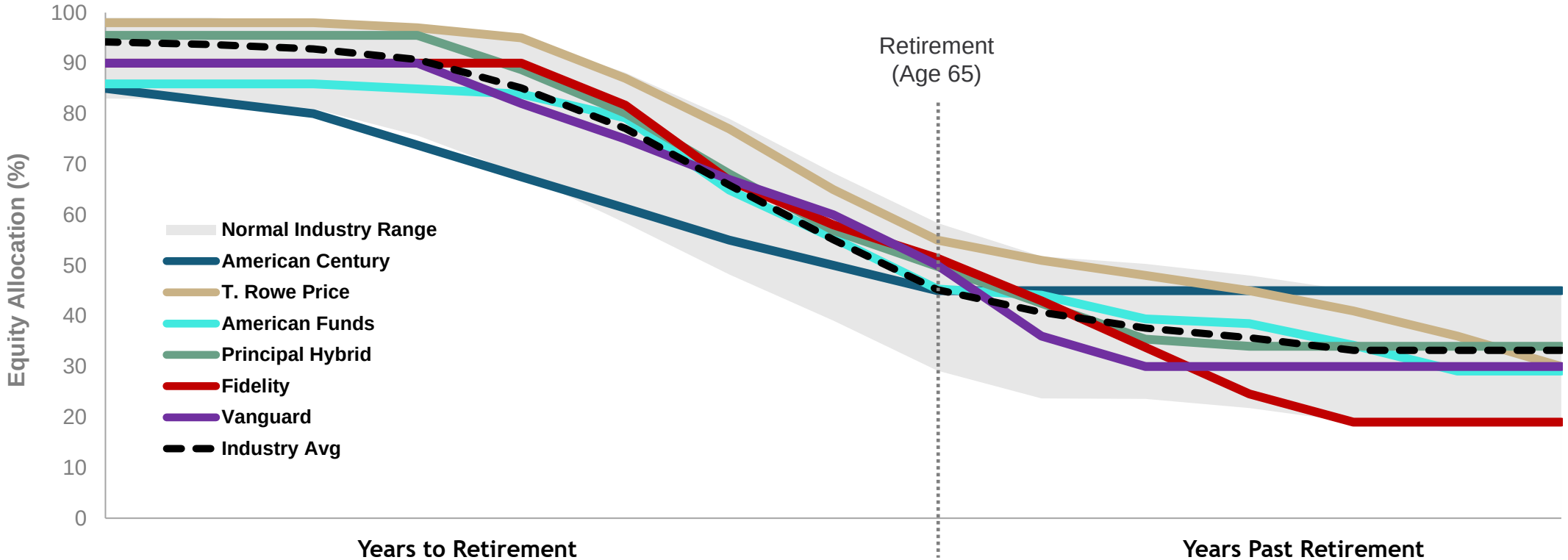
Source: Transamerica, as of 12/31/2024. Total target date assets as of 12/31/2024: $65,404,236

Target Date Fund Comparison

	American Century	T. Rowe Price	American Funds	Principal	Fidelity	Vanguard
Strategy Name	One Choice	Retirement	Target Date Retirement	Lifetime Hybrid	Freedom Index	Target Retirement
Management Style	Active	Active	Active	Hybrid	Index	Index
% Actively Managed	100%	90%	100%	32%	0%	0%
# Underlying Funds	22	26	29	14	8	5
Share Class	R6	I	R6	R6	Instl Premium*	Investor
Expense Ratio	0.40% – 0.57%	0.34% - 0.46%	0.29% - 0.39%	0.34% - 0.42%	0.08%	0.08%
Asset Weighted Expense based on 12/31/2024 Plan Assets (%)	0.48%	0.41%	0.35%	0.36%	0.08%	0.08%
Asset Weighted Expense based on 12/31/2024 Plan Assets ($)	$310,917	$268,976	$226,059	$232,966	$52,323	$52,323

Source: Morningstar, Transamerica, JPMorgan Compass Report. Total target date assets as of 12/31/2024: $65,404,236
*Premier share class priced at 0.05% available if Creative Planning engaged as 3(38) fiduciary on target date assets.

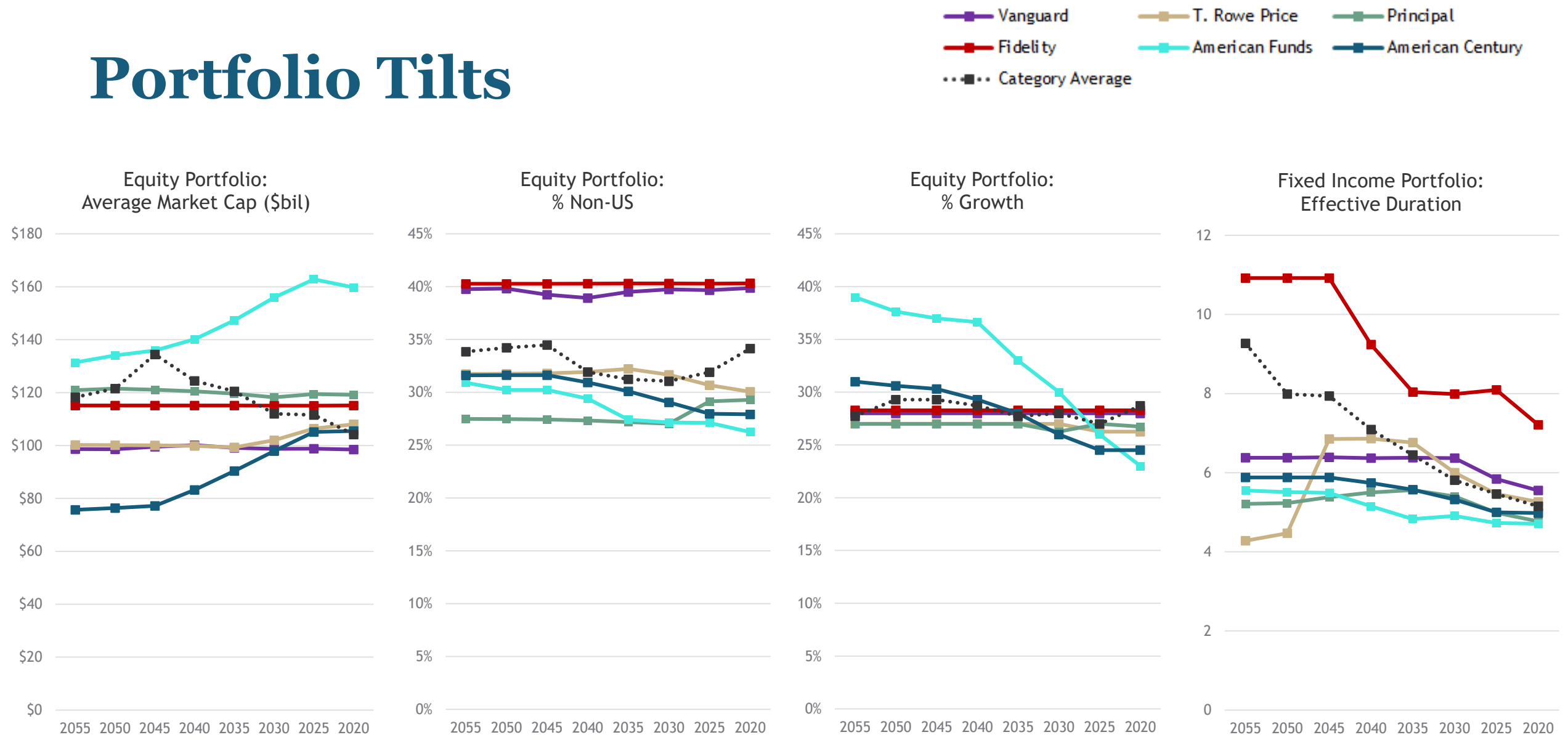
Glide Path



	40	35	30	25	20	15	10	5	0	5	10	15	20	25	30
American Century	85.0	82.5	80.0	73.8	67.5	61.3	55.0	50.0	45.0	45.0	45.0	45.0	45.0	45.0	45.0
T. Rowe Price	98.0	98.0	98.0	97.0	95.0	87.0	77.0	65.0	55.0	51.0	48.0	45.0	41.0	36.0	30.0
American Funds	85.9	85.9	85.9	84.9	83.9	79.2	64.9	55.4	45.3	44.1	39.4	38.5	34.2	29.1	29.1
Principal	95.5	95.5	95.5	95.5	88.7	80.1	68.1	56.9	49.8	42.5	35.4	34.0	34.0	34.0	34.0
Fidelity	90.0	90.0	90.0	90.0	90.0	81.7	66.8	58.0	51.4	43.0	33.8	24.6	19.0	19.0	19.0
Vanguard	90.0	90.0	90.0	90.0	82.0	75.0	67.0	60.0	50.0	36.0	30.0	30.0	30.0	30.0	30.0
Industry Average	94.2	93.7	92.8	90.7	85.1	77.1	65.9	55.1	45.2	40.7	37.6	35.7	33.2	33.2	33.2

Source: Creative Planning RFI data.

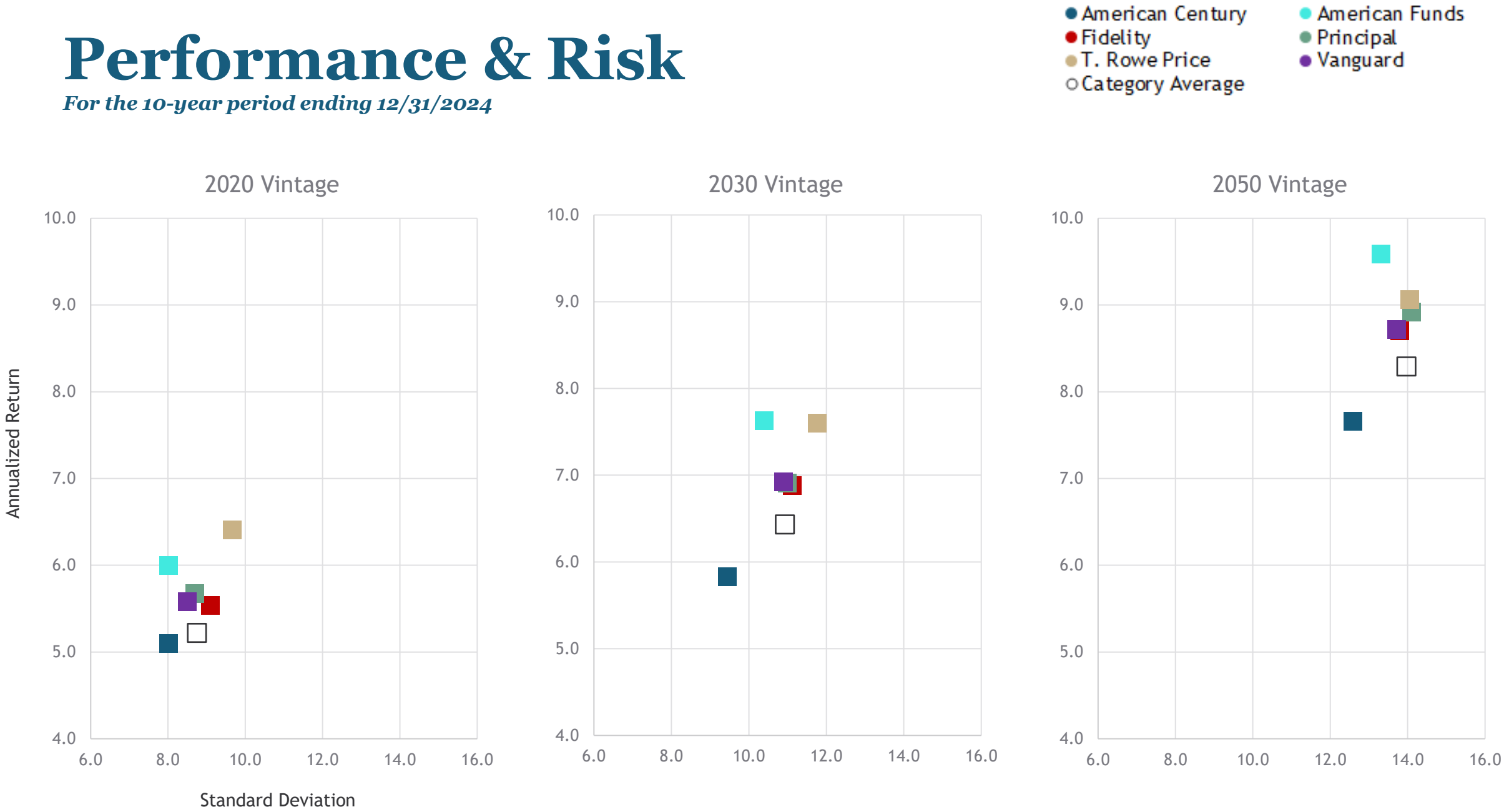
Portfolio Tilts



Source: Morningstar. Data as of 9/30/2024. Note: American Century does not have a 2020 vintage, so the Income vintage was shown instead.

Performance & Risk

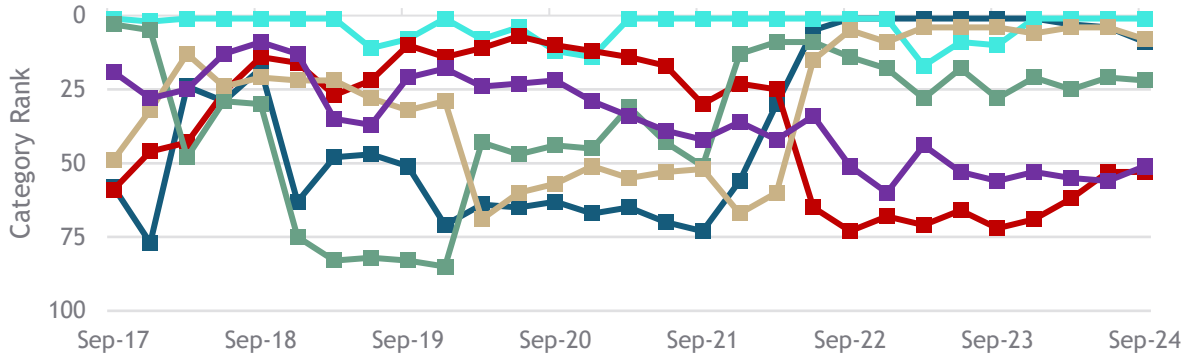
For the 10-year period ending 12/31/2024



Source: Morningstar, data as of 12/31/2024. Illustration for the 10-year period ending 12/31/2024. American Century does not have a 2020 vintage, so the Income vintage was utilized instead.

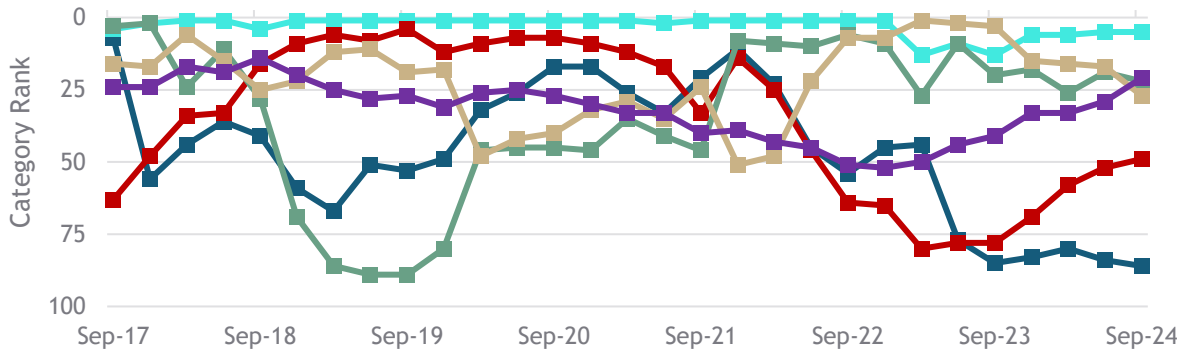
Rolling 3-Year Sharpe Ratio Rankings

2020 Vintage



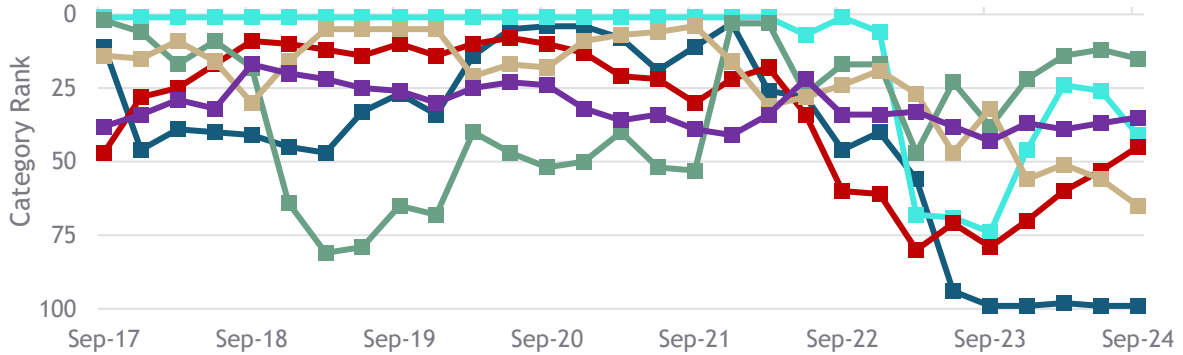
	% Time Spent in Each Quartile				
	1st	2nd	Above Median	3rd	4th
American Century One Choice In Ret R6	41%	14%	55%	41%	3%
American Funds 2020 Trgt Date Retire R6	100%	0%	100%	0%	0%
Fidelity Freedom Index 2020 Premier	45%	17%	62%	38%	0%
Principal LifeTime Hybrid 2020 R6	41%	38%	79%	7%	14%
T. Rowe Price Retirement 2020 I	52%	17%	69%	31%	0%
Vanguard Target Retirement 2020 Fund	34%	38%	72%	28%	0%

2030 Vintage



	% Time Spent in Each Quartile				
	1st	2nd	Above Median	3rd	4th
American Century One Choice 2030 R6	21%	38%	59%	21%	21%
American Funds 2030 Trgt Date Retire R6	100%	0%	100%	0%	0%
Fidelity Freedom Index 2030 Premier	48%	21%	69%	21%	10%
Principal LifeTime Hybrid 2030 R6	48%	34%	82%	3%	14%
T. Rowe Price Retirement 2030 I	69%	28%	97%	3%	0%
Vanguard Target Retirement 2030 Fund	31%	62%	93%	7%	0%

2050 Vintage



	% Time Spent in Each Quartile				
	1st	2nd	Above Median	3rd	4th
American Century One Choice 2050 R6	31%	45%	76%	3%	21%
American Funds 2050 Trgt Date Retire R6	79%	10%	89%	10%	0%
Fidelity Freedom Index 2050 Premier	55%	17%	72%	21%	7%
Principal LifeTime Hybrid 2050 R6	48%	24%	72%	21%	7%
T. Rowe Price Retirement 2050 I	66%	21%	87%	14%	0%
Vanguard Target Retirement 2050 Fund	28%	72%	100%	0%	0%

Source: Morningstar Direct. Data as of 9/30/2024. American Century does not have a 2020 vintage, so the Income vintage was utilized instead.

Thank You

This presentation is provided for general information purposes only and should not be construed as investment, tax or legal advice, and does not constitute an attorney/ client relationship. Past performance of any market results is no assurance of future performance. The information contained herein has been obtained from sources deemed reliable but is not guaranteed.

CREATIVE PLANNING®
RETIREMENT SERVICES

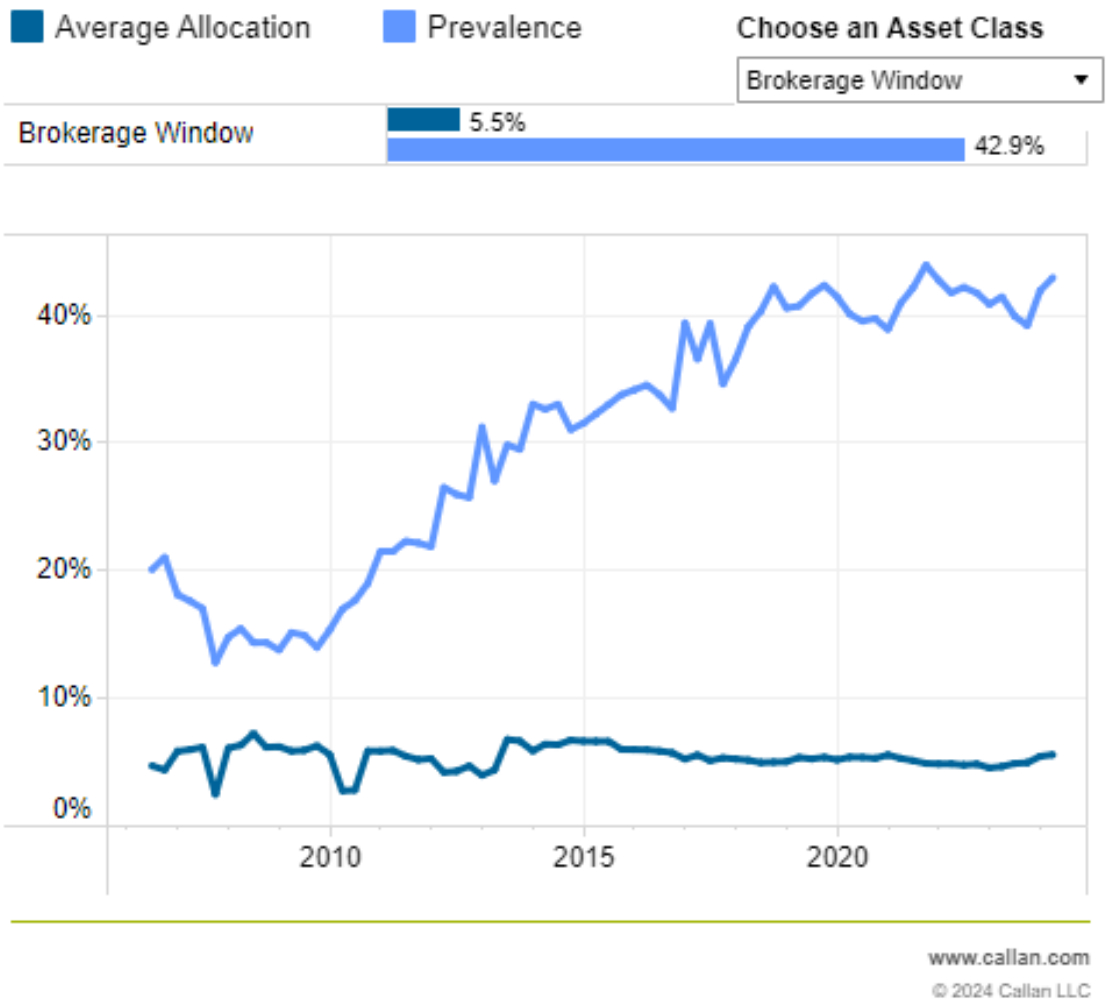
Self-Directed Brokerage Account

Which investment vehicles are currently being used by your organization in its DC plan?

	All Industries						Healthcare Organization (not for profit)					
	Overall	<$5MM	$5MM - $50MM	>$50MM-$200MM	>$200MM-$1B	>$1B	Overall	<$5MM	$5MM - $50MM	>$50MM-$200MM	>$200MM-$1B	>$1B
Mutual funds	68.0%	77.8%	52.4%	77.7%	90.3%	86.5%	73.7%	90.9%	55.9%	81.8%	100.0%	81.8%
Separate accounts	46.0%	38.7%	58.6%	33.2%	27.5%	41.2%	39.5%	45.5%	50.0%	45.5%	11.1%	18.2%
Collective investment trust	31.7%	32.6%	16.4%	36.7%	64.7%	70.3%	18.4%	27.3%	5.9%	18.2%	33.3%	36.4%
Exchange-traded funds	5.6%	7.1%	4.9%	6.6%	5.3%	4.1%	2.6%	9.1%	0.0%	9.1%	0.0%	0.0%
Self-directed brokerage window	29.8%	33.5%	17.8%	29.2%	56.5%	59.5%	31.6%	27.3%	5.9%	36.4%	77.8%	72.7%
Mutual fund window	8.7%	4.5%	5.3%	12.5%	24.2%	12.8%	2.6%	0.0%	0.0%	9.1%	11.1%	0.0%
Professionally managed account services (for participants)	47.9%	49.2%	52.6%	36.7%	42.0%	45.9%	35.5%	36.4%	50.0%	18.2%	22.2%	18.2%
None – do not use any of these investment vehicles	3.5%	8.7%	2.0%	1.2%	1.4%	2.0%	1.3%	0.0%	2.9%	0.0%	0.0%	0.0%

Source: PLANSPONSOR 2024 Defined Contribution (DC) Survey. Valid through December 2025.

Callan DC Index



Source: Callan DC Index as of 3/31/2024

Is a Brokerage Window Right for Your Participants?

THE BROKERAGE OPTIONS MAY PROVIDE ACCESS TO:

- Mutual Funds
- Exchange-Traded Funds
- Commodities
- Partnerships
- Tangible and Real Property

Evaluate Appropriateness

DOL requires fiduciaries to evaluate workforce idiosyncrasies when selecting 401(k) investments.

Examine participant demographics, behaviors and investment sophistication.

Would some participants benefit from more investment options?

Do some participants want to work with an outside investment advisor?

Prevent Stand-Alone Accounts

Limit the offer to one broker.

Record retention and document production considerations.

Participant fee disclosure requirements.

Apply Limits

Consider limiting brokerage investments to a plan account percentage or maximum dollar amount.

Some plans may allow individual stocks and bonds, but not municipal bonds, commodities, derivatives or buying on margin.

Fiduciary Responsibility

All plan participants have the right to use the brokerage window option.

You cannot limit participation to:

- Highly compensated employees.
- Those with a minimum account balance.
- Those willing to pay a fee that would effectively eliminate lower-paid participants.

Accounts are not limited to sophisticated investors.

Fiduciary Responsibility

In addition to reviewing program costs, fiduciaries have a duty to monitor provider service levels.

Fees must be reasonable and disclosed.

Fiduciary Responsibility

- Do not offer investments:
  - Causing the plan to hold assets owned outside of the U.S.
  - The plan document or IPS excludes.
  - That would cause a prohibited transaction or increase compliance difficulty.
  - That are illiquid or not permitted in IRAs.
- Be aware that certain investments may trigger UBIT obligations on the account holder.

Easiest to offer publicly traded securities only.

Designing a Good Program

SELECTING A BROKER	UPDATING DOCUMENTS	PRUDENT IMPLEMENTATION

- Conduct due diligence.
- Review service provider and document in committee minutes.
- Negotiate a favorable contract.
- Do not offer unlimited investments.
- Review system reporting capabilities.
- Confirm participant education and disclosures convey risk and fee structure.
- Negotiate provider liability for failure to satisfy agreed-upon investment limitations; include sponsor right to audit provider's operations.

Designing a Good Program

SELECTING A BROKER | **UPDATING DOCUMENTS** | PRUDENT IMPLEMENTATION

- Necessary plan amendments
  - If plan contemplates participant direction, brokerage window should be permissible.
- Revised communications
  - Different cost structure
  - Plan transaction timing
  - Other relevant matters
- Update and deliver the plan prospectus if plan is subject to SEC prospectus requirement.

Designing a Good Program

SELECTING A BROKER	UPDATING DOCUMENTS	PRUDENT IMPLEMENTATION

- Clearly communicate that SDBA investment options are not selected or monitored by fiduciaries.
- Make sure the plan contains core designated investment options.
- Consider limitations.
- Participant acknowledgement.

Designing a Good Program

SELECTING A BROKER	UPDATING DOCUMENTS	PRUDENT IMPLEMENTATION- Transamerica

- Available for 403(b) and 457 Plans:
  - 403(b): Only mutual funds are allowed due to IRS regulations
  - 457: No investment restrictions under the Internal Revenue Code, however, state law that may limit options
- Broker: Charles Schwab
- Fee: $50 annual fee (Transamerica) + applicable transaction fees

Designing a Good Program

SELECTING A BROKER	UPDATING DOCUMENTS	PRUDENT IMPLEMENTATION- Transamerica

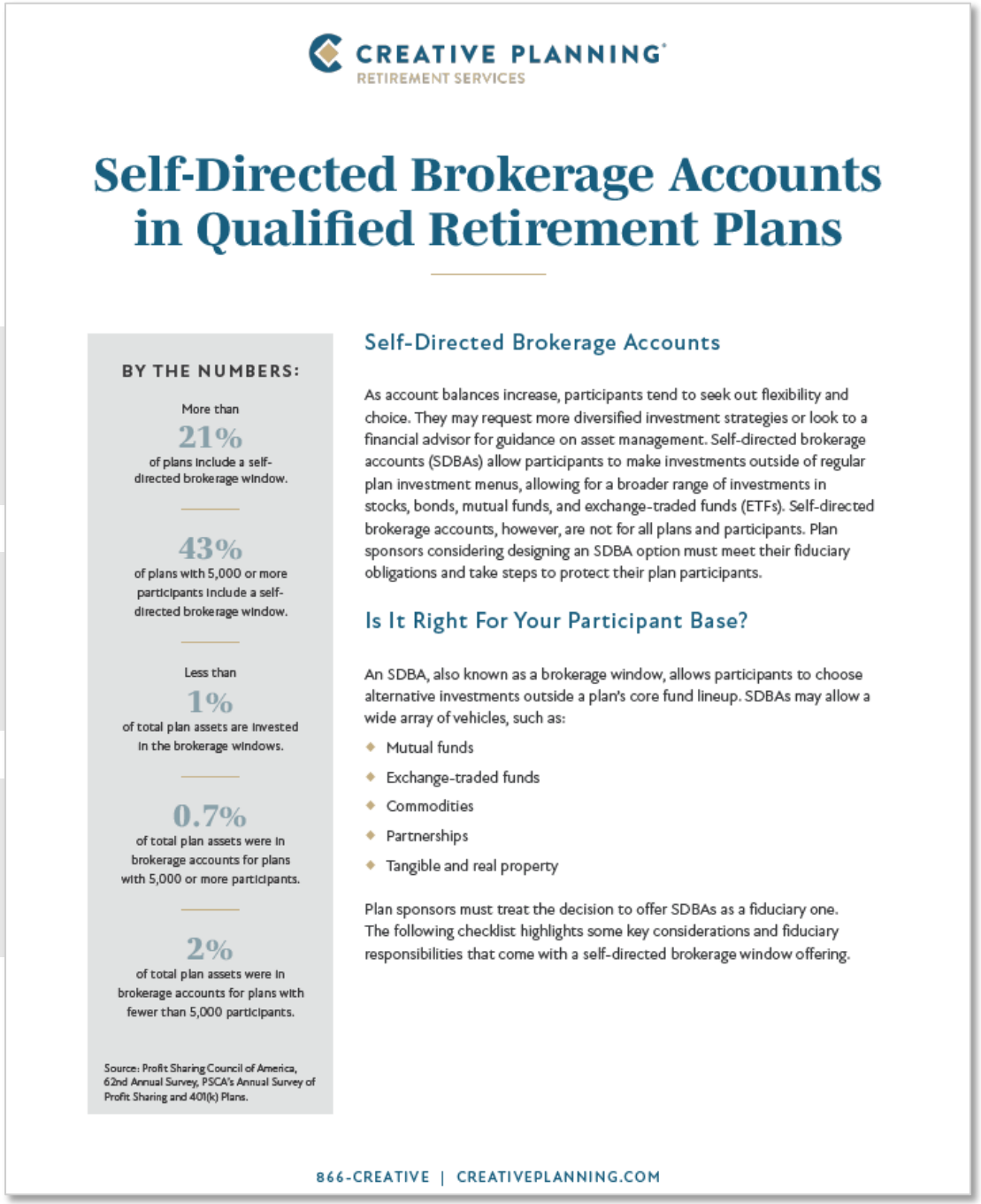
- Implementation:
  - Amend Transamerica Service Agreement
  - Complete Charles Schwab Setup form
  - Decide on implementing transfer restrictions (either $ or %)
  - 8-10 week setup process
  - Transamerica prepares employee notification

Summary

Follow a consistent fiduciary process

Document decisions

Participant education



CREATIVE PLANNING
RETIREMENT SERVICES

Self-Directed Brokerage Accounts in Qualified Retirement Plans

BY THE NUMBERS:

More than
21%
of plans include a self-directed brokerage window.

43%
of plans with 5,000 or more participants include a self-directed brokerage window.

Less than
1%
of total plan assets are invested in the brokerage windows.

0.7%
of total plan assets were in brokerage accounts for plans with 5,000 or more participants.

2%
of total plan assets were in brokerage accounts for plans with fewer than 5,000 participants.

Source: Profit Sharing Council of America, 62nd Annual Survey, PSCA's Annual Survey of Profit Sharing and 401(k) Plans.

Self-Directed Brokerage Accounts

As account balances increase, participants tend to seek out flexibility and choice. They may request more diversified investment strategies or look to a financial advisor for guidance on asset management. Self-directed brokerage accounts (SDBAs) allow participants to make investments outside of regular plan investment menus, allowing for a broader range of investments in stocks, bonds, mutual funds, and exchange-traded funds (ETFs). Self-directed brokerage accounts, however, are not for all plans and participants. Plan sponsors considering designing an SDBA option must meet their fiduciary obligations and take steps to protect their plan participants.

Is It Right For Your Participant Base?

An SDBA, also known as a brokerage window, allows participants to choose alternative investments outside a plan's core fund lineup. SDBAs may allow a wide array of vehicles, such as:

- Mutual funds
- Exchange-traded funds
- Commodities
- Partnerships
- Tangible and real property

Plan sponsors must treat the decision to offer SDBAs as a fiduciary one. The following checklist highlights some key considerations and fiduciary responsibilities that come with a self-directed brokerage window offering.

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Pros

1. **Broader Investment Choices:** An SDBA allows access to a wider range of investment options beyond the limited selection typically available in standard 403(b) plans.

2. **Greater Control:** You have more control over your investment strategy, allowing you to tailor your portfolio to your specific financial goals and risk tolerance.

3. **Diversification:** The ability to invest in a variety of asset classes can help diversify your portfolio, potentially reducing risk.

Cons

1. **Complexity and Time Commitment:** Managing an SDBA requires a significant amount of time and effort to research, select, and monitor investments. This can be challenging if you lack investment knowledge or time.

2. **Higher Risk:** With greater control comes greater responsibility. Poor investment choices can lead to significant losses, especially if you're not experienced in managing investments.

3. **Additional Fees:**
SDBAs can come with their own set of fees, such as transaction fees and account maintenance fees

4. **No Automated Rebalancing:** Unlike standard 403(b) plans that often offer automated rebalancing, you'll need to manually rebalance your portfolio, which can be time-consuming.

COMMITTEE RECOMMENDATION

Consider recommendation for Board of Directors to approve adding self-directed brokerage accounts to the 403(b) and 457 plans.

NOW YOU'RE IN CONTROL

SELF-DIRECTED SCHWAB PERSONAL CHOICE RETIREMENT ACCOUNT® (PCRA)

TRANSAMERICA®

CONTENTS

YOUR ACCOUNT, YOUR WAY

As your retirement plan provider, Transamerica is dedicated to providing the resources to help you create and maintain your investment strategy. To complement the investment options offered under your retirement plan, you may choose to open a Schwab Personal Choice Retirement Account® (PCRA).

A PCRA is a self-directed brokerage account that allows you to take charge of investing and select the individual investments you want. PCRA is designed for individuals who seek increased flexibility, more diversification, and a greater role in managing their retirement investments. By establishing a PCRA, you assume responsibility for controlling your investments. The Schwab PCRA is for knowledgeable investors who understand the risks associated with selecting their own investment choices and who are committed to staying invested for the long term.

A PCRA MAY BE APPROPRIATE FOR YOU IF:

- You have a sophisticated understanding of investment principles and the stock market
- You have the ability to research and monitor your investments
- You want to invest in a specific company or mutual fund outside of your plan's investment line up
- You are comfortable with the risk associated with making your own investment decisions
- You are willing to undertake any additional trading and maintenance costs that may apply

This guide provides general information and explains the procedures associated with establishing and maintaining your PCRA.

Through PCRA, you can access more than 8,700 no-load mutual funds from over 600 well-known fund families, including over 2,700 funds typically available only to institutional clients. Over 3,800 mutual funds are available with no-loads and no-transaction fees[1]. Other investments also include individual stocks from all the major exchanges, bonds and other fixed income investments, CDs, and money market funds. All listed ETFs, stocks and base options on the U.S. exchanges are commission-free across all mobile, automated phone and web trading channels.

You can also use Schwab Stock Slices™, a service that lets you own fractional shares (slices) of any S&P 500® company for as little as $5 each, even if their shares cost more. You can purchase up to 10 stock slices in a single transaction, and you can hold slices of as many S&P 500 companies in your portfolio as you want through multiple purchases.[3]

OPENING YOUR PCRA

1. Visit **secure2.transamerica.com**
2. Sign in to your account , click **Details** next to your plan, and go to the Messages box near the top of the page.
3. In the Messages box, click on "Schwab Personal Choice Retirement Account (PCRA)", then click the link that appears on the following page.

Please make sure to record the Retirement Plan ID and Plan Access Code displayed on this page — you'll need them for the next step!

4. Click "Sign Up With Schwab." You'll be directed to the Schwab site to complete the process.
   - From the Schwab site, enter the Retirement Plan ID, Plan Access Code from the prior page, your SocialSecurity number, and click **Submit**.
   - Accept the disclosures, paperless application, and memorandum of understanding
   - Follow the steps to complete the online PCRA application
   - Once you click **Submit**, you will receive your account number instantly on the screen
   - To set up your PCRA for online access, go to schwab.com, click the **First Time Users** tab, and then the **Register** button

In a few days you will receive an account verification kit by mail containing:

- A confirmation of your PCRA account number
- Regulatory materials pertaining to your PCRA account
- Information on transaction fees and commissions that may apply

GETTING STARTED

You will receive a PCRA Welcome brochure containing information on making the most of your PCRA account, including how to research investments, place trade orders, and monitor your account.

Once your account is open, and Transamerica has received your Schwab account number, you'll be able to transfer assets from your Transamerica core account to your Schwab PCRA account.

In addition, you can use equity, mutual fund, exchange-traded fund, and fixed income screener tools on schwab.com to help you choose investments for your account.

PCRA RESOURCES ON SCHWAB.COM

On **schwab.com**, you have access to a PCRA video, containing step-by-step instructions on researching, trading, and monitoring your PCRA. You can watch the video at **schwab.com/pcrahowto**.

You also have access to powerful proprietary research tools on **schwab.com**, including Schwab Equity Ratings™ and the Schwab Mutual Fund OneSource Select List®. In addition, Schwab provides independent, third-party research from leading providers such as Credit Suisse, Argus Research, CFRA, Morningstar®, Reuters, and MarketEdge®.

IF YOUR ASSETS WERE TRANSFERRED FROM A SELF-DIRECTED BROKERAGE ACCOUNT

To allow in-kind transfers of your retirement plan assets to Schwab, a PCRA account has been opened for you by your employer. You will receive an Account Verification Kit from Schwab containing your new PCRA account number. Once you have received your Schwab PCRA account number, you will need to complete the online Limited Power of Attorney (LPOA) form in order to begin trading within your PCRA account.

You may also call Transamerica at **800-755-5801** for more information.

TRANSFERS

TRANSFERS FROM TRANSAMERICA TO YOUR PCRA

Direct contributions to your PCRA are not permitted. Money can be invested into your PCRA through a transfer initiated from your Transamerica account. Transamerica does not impose any charges on your transfer, but certain plan options may charge redemption fees on frequent trading, which could apply if you liquidate a fund with a redemption fee in order to fund your PCRA contribution.

The initial transfer minimum to your PCRA is $1,000. The minimum for subsequent transfers is $250. Any uninvested cash is automatically swept into a Schwab cash sweep* feature in your PCRA.

Transfer requests received by 4 p.m. ET will be processed the same day. Transfer requests received after 4 p.m. ET will be processed the next business day.

Direct transfers to your PCRA from certain stable value funds may be prohibited. To transfer from a stable value fund to your PCRA, you must first transfer to another available fund, and then transfer to your PCRA after 90 days. Please contact Transamerica to confirm which funds allow direct transfers to your PCRA.

Certain transfer restrictions may apply. Please contact Transamerica at **800-755-5801** or sign in to your account at **transamerica.com/portal** to verify any restrictions.

* Benefit plan sweep accounts are generally held at Charles Schwab Bank. Settled cash balances are swept to the bank after the close of business and begin earning interest on the following Business Day. A "Business Day" is any Monday through Friday that is not a Federal Reserve Bank or New York Stock Exchange holiday.

TRANSFERS FROM YOUR PCRA TO TRANSAMERICA

As a Transamerica plan participant, you may transfer assets from your PCRA to other investment choices available through your Transamerica Plan at any time, without minimums or transfer fees.

- If you have securities in your PCRA, you must first liquidate them. You can either do this online at **schwab.com** or by calling the PCRA Call Center at **888-393-PCRA (7272)** and providing the necessary information and instructions.
- When the trades settle, Schwab will then sweep your liquidated assets into a Schwab cash sweep feature in your PCRA
- Once the PCRA liquidation has been settled at Schwab, you can choose your desired allocation for the funds by signing in to your account at **transamerica.com/portal** or calling **800-755-5801**

Once the new allocation is confirmed, the assets will be transferred to your Transamerica account. Transfers initiated by 4 p.m. ET will be processed the same day. Transfers initiated after 4 p.m. ET will be processed the next business day.

LOANS

Loans are not available from a PCRA account. If your plan offers loans, you may have to liquidate funds in your PCRA and transfer them to Transamerica to fund your loan. Loans are processed by Transamerica within usual service time frames. Tax reporting information, if applicable, will be provided by Transamerica.

IF YOU NEED TO TRANSFER FROM YOUR PCRA TO HAVE SUFFICIENT ASSETS TO INITIATE A LOAN

- Call Schwab at **888-393-PCRA (7272)** to provide the instructions to liquidate all or a portion of your PCRA assets
- Schwab will then sweep your liquidated assets into a cash sweep feature in your PCRA
- Complete and submit the appropriate request form obtained from Transamerica as instructed (once the PCRA liquidation has been settled at Schwab)

DISTRIBUTIONS

Distributions are not available from a PCRA account. If your Transamerica account does not have enough for your distribution, you may have to liquidate funds in your PCRA and transfer them to Transamerica. Distributions are processed by Transamerica within usual service time frames. Tax reporting information, if applicable, will be provided by Transamerica.

IF YOU NEED TO TRANSFER MONEY FROM YOUR PCRA TO HAVE SUFFICIENT ASSETS FOR YOUR WITHDRAWAL

- Call Schwab at **888-393-PCRA (7272)** to provide the instructions to liquidate all or a portion of your PCRA assets for your withdrawal
- Schwab will then sweep your liquidated assets into a cash sweep feature in your PCRA
- Complete and submit the appropriate distribution request form obtained from Transamerica as instructed (once the PCRA liquidation has been settled at Schwab)

DISALLOWED PURCHASES

Investment in unlisted securities, margin trades, commodities, and options are prohibited. Furthermore, if your PCRA is held in a 403(b) plan, IRS regulations allow for only mutual fund investment choices. If you direct Schwab to purchase a disallowed investment, the trade will not be placed.

FEES

Transamerica may apply an annual fee for the PCRA that will be withdrawn from your Transamerica account and will appear on your Transamerica statement. This is in addition to any other Transamerica administrative fee, if applicable. Please contact Transamerica to verify any applicable PCRA fees.

Transaction fees and trading commissions are outlined in the Charles Schwab Pricing Guide for Retirement Plan Accounts schwab.com/cbrspricingguide provided in the welcome materials you receive from Schwab after opening your account. For any questions regarding the commissions and transaction fees that Schwab charges in your PCRA account, please call Schwab at **888-393-PCRA (7272)**.

STATEMENTS

Your periodic account statement from Transamerica will show the balance in your PCRA as of the last day of the period. Schwab will also provide transaction confirmations for any activity in your PCRA, as well as a monthly statement detailing account activity. If any transactions are still in process at the end of the statement period, the statement may not reflect these transactions.

NAME AND ADDRESS CHANGES

If you change your name or address, please submit separate notifications to your employer, Schwab, and Transamerica.

- Call Transamerica at **800-755-5801** with all name and address changes.
- Call Schwab at **888-393-PCRA (7272)** to indicate any changes

CLOSING YOUR PCRA

To close your PCRA, your PCRA assets must be liquidated and then transferred to Transamerica. For more information, see the "Transfers" and "Distributions" sections of this guide.

Please also remember to contact Transamerica to close your PCRA account to avoid additional charges in the future.

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Visit: transamerica.com/portal

Contact: 800-755-5801

Diversification does not assure a profit or protect against market loss.

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Trades in no-load mutual funds available through Mutual Funds OneSource service (including Schwab Funds) as well as certain other funds, are available without transaction fees when placed through schwab.com or our automated phone channels. Schwab reserves the right to change the funds we make available without transaction fees and to reinstate fees on any funds. Funds are also subject to management fees and expenses.

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TRANSAMERICA®

Board Paper: Personnel, Pension and Investment Committee

Agenda Item:	**Consider Recommendation for Board Approval of Findings Supporting Recruitment of Daniel Camarillo, MD and Approval of the Contract Terms for Dr. Camarillo's Recruitment Agreement**
Executive Sponsor:	Tim Albert, MD, MHCM, Chief Clinical Officer Molly Heacox, Director of Clinic Services
Date:	March 10, 2025

Executive Summary

In consultation with members of the SVHMC medical staff, SVH executive management has identified the recruitment of a physician specializing in **Family Medicine** as a recruiting priority for the SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in 2023, the specialty of family medicine was recommended as a top priority for recruitment. Recruiting another family medicine physician to the community will increase primary care clinic access to the patients served in the District.

The recommended physician, **Daniel Camarillo, MD**, is certified by the American Board of Family Medicine and has been providing family medicine services since 2006. Dr. Camarillo is fluent in Spanish and currently holds an active California Medical License. Dr. Camarillo plans to join Santa Lucia Medical Group (SLMG), a community outpatient primary care practice, in the spring of 2025.

Background/Situation/Rationale

The proposed physician recruitment requires the execution of one agreement:

- **Recruitment Agreement** among SVH, SLMG, and Dr. Camarillo that provides a recruitment incentive of $40,000. The recruitment incentive will be structured as a forgivable loan over 24 months of full time service with SLMG.

Meeting our Mission, Vision, Goals & Strategic Plan Alignment:

The recruitment of Dr. Camarillo is aligned with our strategic priority for growth. We continue to support the local community physicians and the private practice offices that provide care to our patients. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by opening up access to care.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Camarillo to the community has been identified as a need for recruitment and demonstrates the support from SVH to community practices. The compensation proposed is within fair market value and commercially reasonable.

Recommendation

Administration requests that the Personnel, Pension and Investment Committee recommend to the SVH Board of Directors approval of the following **findings supporting the recruitment of a Family Medicine physician**:

- **That the recruitment of a Family Medicine physician is in the best interest of the public health of the communities served by the District; and**
- **The recruitment incentive proposed for this recruitment is necessary in order to relocate and attract an appropriately qualified physician to practice in the communities served by the District.**
- **And approval of the Contract Terms of the Recruitment Agreement for Dr. Camarillo**

Attachments: Curriculum Vitae for Daniel Camarillo, MD

CURRICULUM VITAE

DANIEL CAMARILLO, M.D.

Education

Undergraduate 1992-1997
University of California, Los Angeles
Los Angeles, California
Bachelor of Arts, History

Professional School 1998-2003
University of California, Los Angeles
David Geffen School of Medicine
Los Angeles, California
Medical Doctorate

Internship/Residency

Presbyterian Intercommunity Hospital 2003-2006
Whittier, California
Family Medicine

Certifications

California State Medical License
Issuance 12/21/04
Expires 09/30/26

American Board of Family Medicine, Diplomate
Issuance 07/22/06
Expires 12/31/26

DEA Certification
Issuance 08/14/22
Expires 08/31/25

Basic Life Support
Issuance 11/11/23
Expires 11/2025

Advanced Cardiovascular Life Support
Issuance 11/11/23
Expires 11/2025

Pediatric Advanced Life Support

Issuance 11/11/23
Expires 11/2025

EMR Fluency

Epic
Athena
Cerner

Languages

English
Spanish

Work Experience

Rancho Family Medical Group
Staff Physician. 11/01/2011-present
Provide full spectrum family medical care, except obstetrics, in the hospital, office, and in the urgent care settings.

Caceres Medical Group
Medical Director. 01/01/09-10/21/11
Staff Physician. 08/01/06-10/21/11
Practiced medicine in multiple settings including: office practice, urgent care, nursing home care, home health care supervision, hospice care, and full scope inpatient care.

Investigator. 2006-2010
Clear Vision Research

Knott Avenue Care Center, Buena Park, CA
Skilled Nursing Facility
Quality Assurance Committee
Chairman. 07/09-9/11

Anaheim Terrance Care Center, Anaheim, CA
Skilled Nursing Facility
Quality Assurance Committee
Chairman. 06/07-06/09

American Academy of Family Physicians
Residents and Students National Conference. 2002 & 2005

Attended the four-day conference for networking,
and medical student recruitment.

National Hispanic Medical Association Conference
Volunteer. 2001, 2002, 2003, 2004, 2005
Assisted on the registration tables during the four-day event.

UCLA School of Medicine
Premedical Enrichment Program
Admissions Committee. 2001
Reviewed applications and conducted interview.
Attended meetings to decide the final class.

UCLA School of Medicine
Reapplication Program
Mentor. 2002
Assisted undergraduate students applying to medical school.
UCLA School of Medicine
Tour Guide. 1999
Gave tours to applicants of the school, one hour weekly.

UCLA-Santa Monica Center
Hospital Volunteer. 1996-1997
Volunteered 4 hours per week performing patient transfers, assisted nurses, and made lab deliveries.

Research Experience

Tolerability of Nebivolol Compared to Metoprolol ER in Patients with Mild-Moderate Hypertension on Hydrochlorothiazide.

A 52-week, randomized, double-blind, parallel-group, multi-center, Phase IIIB comparing the long term safety of SYMBICORT pMDI 160/4.5ug x 2 actuations twice daily to budesonide HFA pMDI 160g x 2 actuations twice daily in adult and adolescents (≥ 12 years) African-American subjects with asthma.

A 16 week. Parallel-Group, Double-Blind, Randomized, Placebo-Controlled, Multicenter, Dose-Ranging Study to Evaluate Efficacy, Safety and Tolerability of Multiple Doses and Multiple treatment Regiments of GSKXXXX, with Byetta as an Open-Label Active Reference, in subjects with Type 2 Diabetes Mellitus.

Efficacy and Safety of 200 mcg BID Mometasone Furoate Nasal Spray (MFNS) vs Placebo as Adjunctive Treatment to Antibiotics in Relief of Symptoms of Acute Bacterial Sinusitis.

A phase III, double-blind, randomized placebo-controlled study, to evaluate the effects of RO4607381 on cardiovascular (CV) risk in stable CHD patients, with a document recent Acute Coronary Syndrome (ACS).

Tolerability of Nebivolol Compared to Metoprolol ER in Patients with Mild-Moderate Hypertension on Hydrochlorothiazide. Forest Research

A randomized, double-blind, placebo-controlled, parallel group trial of HMR1766 assessing the efficacy and safely of 3 doses of HMRI1766 (25, 100, 200mg OD) versus placebo with cilostazol, 100mg BID as a calibrator, administered for 26 weeks in patients with Peripheral Arterial Disease (PAD) Fontaine stage II Sanofi-Aventis

Metabolic Effects of Nebivolol Compared to Metoprolol ER in Hypertensive Patients with Impaired Glucose Tolerance or Impaired Fasting Glucose. Forest Research

A Double-Blind, Double-Dummy, Parallel Group, Phase 3 Efficacy And Safely of CGT-2168 Compared With Clopidogrel To Reduce Upper Gastrointestinal Events Including Bleeding and Symptomatic Ulcer Disease. Cogentus Pharmaceuticals

UCLA Short Term Training Program. 1999
Ronald Swerdloff, M.D. Harbor-UCLA, Torrance, Ca
Studied the effects of heat stress on the FAS/FASL apoptotic system in murine spermatogenesis, using immunohistochemistry and Western blot techniques.

Minority Student Research Exchange Program. 1995
Ford-Mellon Fellow
Fred W. Quimby, DVM, PhD.
College of Veterinary Medicine, Cornell University,
Ithaca, NY
Studied the effects of polychlorinated biphenyls on the Canine immune system (IgE), using ELISA and radio-immunoassay techniques.

Presentations

National Student Research Forum, University of Texas. 2000
Medical Branch, Galveston, TX

"FAS/FASL System: Does it Play a Role in Germ Cell Apoptosis"
D. Camarillo, P.N. Huynh, G. Fernando, M. Fernando, A.P. Sinha Hikim, C. Wang, and R. Swerdloff, poster presentation.

American Federation for Medical Research. 2000
Western Regional Meetings, Carmel CA

"FAS/FASL System: Does it Play a Role in Germ Cell Apoptosis"
D. Camarillo, P.N. Huynh, G. Fernando, M. Fernando, A.P. Sinha Hikim, C. Wang, and R. Swerdloff, oral presentation.

UCLA School of Medicine, Los Angeles, CA. 1999

"FAS/FASL System: Does it Play a Role in Germ Cell Apoptosis"
D. Camarillo, P.N. Huynh, G. Fernando, M. Fernando, A.P. Sinha Hikim, C. Wang, and R. Swerdloff, poster presentation.

Cornell University, Ithaca, NY. 1995

"PCB's and its Effect on Immunoglobulin Epison (IgE) Production in Dogs," D. Camarillo and F.W. Quimby, oral presentation.

Teaching Experience

Loma Linda University Family Medicine Residency Program
Loma Linda University Medical Center – Murrieta
Core Faculty. 2019-present
Precept residents in the clinic. Lead residents in hospital rounds during Family Medicine Inpatient at LLUMC Murrieta. Present didactic lectures in cardiology for family medicine residents. Attend meetings with faculty regarding resident performance, exam scores, and other resident issues that require faculty input and voting.

UC Riverside School of Medicine
Assistant Clinical Professor. 9/01/2016-present
Preceptor for medical students (at all levels) a half day, biweekly, in the office.

Rancho Family Medical Group
Medical Education, Preceptor. 2012-present
Precepted and taught pre-medical students, medical students, nurse practice students, and physician assistant students in the office practice.

Caceres Medical Group
Continuing Medical Education Coordinator. 01/01/07-10/21/11
Preceptored and mentored numerous PA students, medical students, and foreign medical graduates that interned at the office. Coordinated lecturers to visit the office and give didactic lectures on all topics of medicine.

UCLA School of Medicine
Doctoring 4 Teaching Fellow. 2001-2003
Assisted a small class of 10 medical students in discussions of the psychosocial aspect of disease presentations and the patient-physician interpersonal relationship. The class met bimonthly for 4 hours per session.

UCLA School of Medicine.
Premedical Enrichment Program
Teaching Assistant. 2001-2003
Taught 2 hour sessions, 4 days a week, to an 8 Member Class. Subjects included MCAT preparation, reading, writing, and critical thinking skills.

UCLA Department of Mathematics
MS Squared
Calculus Tutor. 2001
Taught calculus to incoming freshmen for 2 hours daily,
4 days per week.

Private tutor (Chemistry, Mathematics, and Neuroscience). 2001
Held 2 hour sessions weekly for a high school and junior college student.

UCLA Academic Advancement Program
Tutor. 1994-1998
Tutored undergraduate students in Calculus 18 hours per week.

Pioneer High School, Whittier, CA
Algebra tutor. Summer 1993
Tutored 7th graders in Algebra for 2 hours daily,
five days per week.

Professorships

Assistant Clinical Professor UC Riverside School of Medicine
2016-present

Assistant Clinical Professor Loma Linda University School of Medicine
2017-present

Core Faculty, Family Medicine Residency Program
Loma Linda University Medical Center – Murrieta
2019-present

Leadership

LLUMC Murrieta Peer Review Committee
Member, 01/2014-2017
Participate in monthly committee reviewing appointed hospital patient cases involving complications, morbidity and mortality, nursing concerns, and patient/family concerns. The committee votes on a quality score of the case, conducts hearings of physician in query, and implements disciplinary warnings and actions, as necessary, to maintain the integrity and quality of care administered at the facility.

Caceres Medical Group
Medical Director. 01/01/09-10/21/11
Directed all medical care at Caceres Medical Group in the office, hospital and skilled nursing facilities.

PIH Family Practice Residency Program
Residency Recruitment Coordinator. 2005-2006
Attended different conferences and tabled for the program. Visited various medical schools and spoke at different interests group meetings.

CAFP Advocacy and Action Workshop
Participant. 2005
Attended and 8 hour workshop that focused on helping residents and medical students become more active in health care policy advocacy.
National Network of Latin American Medical Students (NNLAMS)
American Medical Association Liaison. 2002-2003
Attended all NNLAMS meetings and teleconferences. Attended AMA meetings and open dialogue for the two groups.

Garcia Leadership Development Workshop
Participant. 2000, 2001, 2002
Annual seminar designed to develop future Latino physician leaders. The two day seminar included intensive 10 hour days of various physicians, community, and political leaders teaching on healthcare policy, practice management, HMO systems, healthcare access, and patient advocacy.

Chicano Medical Student Association (CMSA)
NNLAMS Representative. 2000-2002
Attended all meetings for both CMSA and NNLAMS. Helped facilitate dialogue between the groups for future collaborations on projects and conferences.

CMSA UCLA-DREW Chapter
Chicanos for Community Medicine (CCM) Liaison. 1998-2000
Attended all meetings of both organizations. Informed both organizations of ensuing activities. Helped established a mentorship program involving both groups. Established the Anatomy Lab Tour at UCLA School of Medicine, that allows undergraduate students to become exposed to the anatomy of the human body.

UCLA Latino Student Health Project 1996-1997
Coordinator. 1996-1997
Ran health screening at various churches and community centers. Gathered volunteers for the different projects and arranged for transportation. Organized volunteers from UCLA for a mobile clinic in Tijuana. Wrote project proposals to obtain grants from the university for the project and attend proposal hearings. Attended monthly meetings at UCLA Community Programs Office.

Professional Memberships

American Academy of Family Physicians
Member. 07/06/06-present

American Medical Association
Member. 2016-present

Community Service

Rancho Family Medical Group High School Sports Physicals
Physician Volunteer. 2012-present
Performed high school sports physicals at local high schools in Southwest Riverside County area.

Calvary Chapel Canyon Hills
Production Set Up Ministry
Chair set up volunteer. 2013-2017
Set up chairs in the main sanctuary area for Sunday morning services in the middle school auditorium in Canyon Hills, Lake Elsinore.

Pioneer High School Career Day
Speaker. 2006
Discussed becoming a physician with high school students.

University of Texas Medical Branch
Frontera de Salud, Brownsville TX
Resident Volunteer. 2006
Served the “colonia", Cameron Park, of Brownsville.
Made home visits, gave health education lectures in Spanish, and worked in three non-profit clinics in the area.

Student National Medical Association
Synergy Health Fair
Resident Volunteer. 2005
Precepted medical students at a health fair in an underserved neighborhood in Los Angeles.

Cerritos Community College Project Hope
Mentor. 2004-2005
Mentored a premedical student from a disadvantaged background.
Urban League
UCLA School of Medicine
Medical Student Panel. 2002

Banning High School, Wilmington, CA.
Career Day
Medical Student Panel. 2001

Chicano Medical Student Association.
Annual Pre-Medical Conference
Volunteer. 1999 & 2000
Worked at registration tables, gave tours of the campus, and conducted mock interviews.

Student National Medical Association (SNMA). 2000
National Conference
Volunteer. 2000
Conducted mock interviews.

Chicanos for Community Medicine
East Los Angeles College
Medical Student Panel. 2000

Chicano Medical Student Association
Lennox Health Fair, Lennox, CA
Volunteer. 1998-2000
Escorted patients and translated for them in Spanish when they were examined by resident physicians. The health fair occurred biannually.

Wilmington Health Fair
Wilmington, CA
Volunteer. 1999
Escorted patients and translated for them in Spanish when they visited the different health stations.

UCLA School of Medicine
Partnership 4 Progress.
Mentor. 1999
Mentored a group of high school kids from the disadvantaged area of Compton, CA and provided guidance in how to apply to college. This took place in a form of mixers, individual appointments and group activities.

Project of the Californias
Tijuana, Mexico
Volunteer. 1995-1997
Participated monthly in a mobile free clinic that served an impoverished community. Duties included taking histories, checking vitals, organizing the pharmacy, and dispensing medications.

Honors and Awards

Rancho Family Medical Group Quality Physician of the Year 2016

California Legislature Assembly Certificate of Recognition
In Honor of Providing Outstanding Medical Care in Riverside County
Given by Assemblywoman, Melissa A. Melendez
67th District
February 21, 2014

America's Top Family Doctors. 2007 & 2008
Consumers' Research Council of America

PIH Family Practice Residency Program. 2005
Most Improved Award
Given to the resident who showed the most improvement on the American Board of Family Medicine In-Training Exam.

UCLA School of Medicine. 2003
William G. Figueroa, M.D. Award
Given for demonstrating exceptional leadership in promoting excellence in health care delivery to undeserved communities.

UCLA School of Medicine. 2002
Hispanic Heritage Display
Profiled in a display honoring the top Latino medical students physicians, and researchers at UCLA.

California Academy of Family Physicians. 2002
Foundation Scholarship
Given to medical students interested in Family Medicine to pay for travel expenses to attend the National Conference.

UCLA School of Medicine. 2000-2001
Health Science Fellowship Grant

Chicanos for Community Medicine, UCLA Chapter. 2000
Appreciation for Leadership and Dedication Award

Western Student Medical Research Committee. 2000
Award for Excellence in Research
UCLA School of Medicine. 1998-2003
Scholarship for Disadvantaged Students

UCLA School of Medicine. 1998-1999
Fee Differential Grant

California State Senate. 1997
Senator Hilda L. Solis
Award for Improving the Quality of Life
for the residents of the 24th Senatorial District

Career Notables

Top HCC score in RFMG for 2024, with a Senior panel greater than 1100

Largest Senior panel for all of RFMG in 2024

Leader amongst physicians in RFMG in HCC scores since 2016

One of the founding physicians to establish the LLUMC Family Medicine Residency Program LLUMC-Murrieta in 2019

Board Paper: Personnel, Pension and Investment Committee

Agenda Item:	**Consider Recommendation for Board Approval of Contract Terms Jerrie Lim, MD's Pediatrics Professional Services Agreement**
Executive Sponsor:	Orlando Rodriguez, MD, SVH Clinics Chief Medical Officer Molly Heacox, Director of Clinic Services
Date:	March 10, 2025

Executive Summary

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

Jerrie Lim, MD, has been a member of Salinas Valley Health Medical Staff providing pediatric services in the community since 2000. Dr. Lim is certified by the American Board of Pediatrics and holds an active California license. Dr. Lim plans to join SVH PrimeCare in May 2025.

Terms and Conditions of Agreements

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

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

- Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, the physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
- Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
- 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 allocated to continuing medical education (CME).
- Base Compensation: $220,000 per year.
- Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $51.00 wRVU conversion factor.
- Professional Liability Insurance. Professional liability 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. Lim to SVH Clinics 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. Lim to Salinas Valley Health Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH PrimeCare. The compensation proposed in the proposed agreement has been reviewed against published industry benchmarks to confirm that the terms contemplated are fair market value and commercially reasonable.

Recommendation

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

Attachments: Curriculum Vitae for Jerrie Lim, MD

Start Date: Aug 1997 End Date: to presen

I currently oversee both the Pediatrics and OB/GYN clinics (12 providers). but my practice is predominantly clinical.

Jerrie G. Lim

Previous Positions:

Director of Pediatrics and OB/GYN
90th Medical Group
.FE Warren AFB, WY

Start Date: Aug 1996
End Date: Jul 1997

Chief of Pediatrics
90th Medical Group
FE Warren AFB, WY

Start Date: Aug 1995
End Date: Jul I996

	Staff Pediatrician 90th Medical Group FE Warren AFB, WY	Start Date: Aug 1994 End Date: Jul 1995
	Staff Pediatrician US Air Force Academy Air Force Academy, CO	Start Date: Aug 1993 End Date: Jul 1994
	Chief Resident David Grant Medical Center Travis AFB, CA	Start Date: Jul 1992 End Date: Jun 1993
Postgraduate Training:	Pediatric Residency David Grant Medical Center Travis AFB, CA	Start Date: Jul 1990 End Date: Jun 1992
	Pediatric Internship David Grant Medical Center Travis AFB, CA	Start Date: Jul 1989 End Date: Jun 1990
Education: Graduate:	Doctor of Medicine University of Texas Medical Branch Galveston, **TX**	Start Date: Aug 1985 End Date: May 1989
Undergraduate:	Bachelor of Science Baylor University Waco, TX	Start Date: Aug 1981 End Date: May 1985
Certification:	American Board of Pediatrics	Date Certified: 28 Oct 1992 Recertification Due: 31 Dec 2006
Licensure:	Medicine (California)	Date of Issue: 8 Apr 1991 Renewal Date: 31 Jan 2001
Professional Society Memberships:	Fellow American Academy of Pediatrics	

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

(VICTOR REY, JR.)

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval of Project Budget and Equipment Procurement for Equipment in conjunction with the Labor Delivery and Recovery Rooms Project**

Executive Sponsor: Clement Miller, Chief Operating Officer

Date: March 6, 2025

Executive Summary

The current birthing lights operational within the ten LDRP rooms on the medical center's second level are thirty-three years old and at end of useful life. Current project planning contemplates removal and replacement of light systems in all rooms in a phased approach to minimize operational impacts to the department. All planned renovations require plan approval and building permits from California's Department of Health Care Access and Information (HCAi).

Background/Situation/Rationale

Visualization is critical to providing safe birthing care for newborn and mom. The light is moved into place per provider preference to provide adequate visualization with an enhanced light source. The current lights are past end of life and there are no parts available to repair equipment. The replacement of the existing birthing lights requires increasing the size of the opening within the ceiling system to remove and replace the legacy systems. All new lighting controls will be installed during the renovations within the birthing rooms.

The capital improvement budget has funding to commence design in the current 2025 and commence the construction work in fiscal year 2026. A design team will be engaged to finalize the design documentation to secure the permits and complete the installation of the lights in accordance with OSHPD rules and regulations.

Timeline/Review Process to Date:

April 2025	Commence Design and Construction Document Preparation
July 2025	Complete Regulatory Agencies Review
July 2025	Commence Construction (~4 month phased project)

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

The fiscal years 2025 through 2026 plant operations capital budget allocated funding for planning, design and construction activities required to complete the design and construction process. A budget has been attached (Attachment A) summarizing the design, permitting, equipment and engineering fees for schematic design, design documentation, permitting process, contractor bidding support and construction administration services.

Total Planned Capital Budget

Project Forecast

$100,000 Fiscal Year 2025
$525,000 Fiscal Year 2026

Recommendation

Consider recommendation to Board of Directors to approve the overall project budget for Labor Delivery and Recovery Room Light Replacement Project in the amount of $625,000. In addition, we recommend approving the award of the Skytron birthing light fixtures to JM Keckler, in the amount of $156,237, as presented.

Attachments

(A) Project Budget at Conceptual Design Review Stage prepared 3/6/2025
(B) JM Keckler Equipment Procurement Proposal, Quote Q-82603-2

Salinas Valley Health (10348)

Project Cost Summary: LDRP Tower Light Replacement

Architect: SKA

Drawings: Conceptual

BOGARD CONSTRUCTION, INC.
Since 1947

Date Printed: *3/6/2025*
Version 1: *3/6/2025*
Prepared by: Dave Sullivan

	BUDGET	*Notes*
CONSTRUCTION COST - DIRECT		
Construction - Includes General Liability Insurance	$100,000	
Total Escalated Construction Cost	**$100,000**	
CONSTRUCTION COST - INDIRECT & RESERVES		
Permit/Entitlements (OSHPD Only)	$25,000	
Equipment	$250,000	
Furniture & Furnishings	$0	
Architect and Engineering Fees	$90,000	
Construction Management	$110,000	
Testing & Inspection	$25,000	
Other Misc.	-	
Project Contingencies & Escalation	$25,000	
Total Escalated Indirect & Reserves Cost	**$525,000**	
Total Project Costs	**$625,000**	

skytron

Salinas Valley Memorial Hospital

Dave Sullivan- Bogard Construction
450 E Romie Ln
Salinas, CA 93901-4098

DATE
03-05-2025

EXPIRES
07-03-2025

PRESENTED BY

J.M. KECKLER
MEDICAL COMPANY INC.

ACCOUNT MANAGER: Trina McNeil

SALINAS VALLEY MEMORIAL- LUCINA LIGHTS

Quote#: Q-82603-2

ATTENTION

Salinas Valley Memorial Hospital

450 E Romie Ln
Salinas, CA 93901-4098

Dave
Bogard Construction
dsullivan@bogardconstruction.com

Hello,

Attached is the quote that you requested. Please make your PO out to Skytron and email to trina@kecklermedical.com or fax to 209-847-4166. For additional information please contact me at 510-912-7385. Thank you for your business opportunity.

Mobile: 510-912-7385

Trina McNeil
trina@kecklermedical.com
J.M. Keckler Medical Co., Inc.

QUOTE	DATE	EXPIRES
Q-82603-2	03-05-2025	07-03-2025

ATTENTION

Salinas Valley Memorial Hospital

450 E Romie Ln
Salinas, CA 93901-4098

SALINAS VALLEY MEMORIAL- LUCINA LIGHTS

QUOTE Q-82603-2

PRICING SUMMARY

PRODUCT	QTY	LIST PRICE UNIT	LIST PRICE EXTENDED	QUOTED PRICE UNIT	QUOTED PRICE EXTENDED
Lights: Dual Recessed Lights	10	$ 16,109.00	$ 161,090.00	$ 11,517.14	$ 115,171.40
Subtotal					$ 115,171.40
Skytron One: Solutions Fees: Q82603					$ 39,625.63
Handling					$ 1,439.64
TOTAL INVESTMENT					$ 156,236.68
REQUIRED DEPOSIT					$ 0

QUOTE (Q-82603) SPECIFIC TERMS AND CONDITIONS

GPO	Vizient - 1 (1151)
ISSUE PO TO	Skytron, LLC · PO Box 888615, Grand Rapids, MI, 49588 · P: 616-656-2900 · trina@kecklermedical.com or fax to 209-847-4166
REMIT TO	Skytron, LLC · PO Box 675164, Detroit, MI, 48267-5164

QUOTE Q-82603-2

DATE 03-05-2025

EXPIRES 07-03-2025

PRICING DETAIL

LIGHTS: DUAL RECESSED LIGHTS

Reference #: C-120763-1

Ceiling Height (inches): 108

ITEM	DESCRIPTION	QTY EXTENDED	LIST PRICE UNIT	QUOTED PRICE UNIT	QUOTED PRICE EXTENDED
LCN4-PKG2	Lucina 4 Dual Light Package, consisting of two LCN4 light heads, B5-014-99 wall control, B5-014-39 Control Wand, B5-014-40 Stand for Control Wand. DOES NOT INCLUDE OPTIONAL BACK BOX.	10	$ 15,732.00	$ 11,169.72	$ 111,697.20
B5-014-41	Back Box for Lucina 4 wall controls	10	$ 102.00	$ 72.42	$ 724.20
B5-010-02-1	Sterile drape for Argos control wand, 50 per case	10	$ 275.00	$ 275.00	$ 2,750.00
TOTAL					$ 115,171.40

QUOTE Q-82603-2

DATE 03-05-2025

EXPIRES 07-03-2025

PRICING DETAIL

SKYTRON ONE: SOLUTIONS FEES: Q82603

Reference #: C-120765-4

ITEM	DESCRIPTION	QTY EXTENDED
SERV-926-14	Installation, inspection and warranty certification of recessed lighting system, single mount or up to two (2) flush ceiling mounted exam system, model series Lucna4 (2). Includes pre-installation walk through, installation and full functional testing of the system. Does not include electrical wiring, structure or wall control unit rough in. Pricing does not include weekend/after hours work.	10
SERV-927-20	Project Management	25
SERV-929-01	Mobilization of service team for site specific required service engagement. Includes all transportation of necessary support equipment/service technician(s) for required service. Does not include transportation of point of service equipment required for the engagement.	1
	PRODUCT TOTAL	$ 39,625.63

PRICING DETAIL

SOLUTIONS: DETAILS ONLY - PRICING PRESENTED IN SKYTRON ONE: SOLUTIONS FEES

ITEM	DESCRIPTION	QTY	LIST PRICE UNIT	QUOTED PRICE UNIT	QUOTED PRICE EXTENDED
PROJECT SCOPE	As you budget for this project you should include your facilities management team to review the project scope.	1	$0.00	$0.00	$0.00
STORAGE	Customer will receive the product at their facility and store until ready for installation. If storage and staging is requested of J.M. Keckler Medical then please contact your sales representative for pricing and terms.	1	$0.00	$0.00	$0.00
TOTAL					$0.00

QUOTE Q-82603-2

DATE 03-05-2025

EXPIRES 07-03-2025

TERMS AND CONDITIONS

CHANGE ORDER FEE: Change order fees, equal to five percent (5%) of order total, apply if order changes occur within 60 days prior to shipment.

CANCELLATION FEE: Eight percent (8%) cancellation fee will be invoiced or deposit will be forfeited on cancelled items of an equipment order.

DRAWING CHANGE FEE: $200.00 Drawing Revision Charge will be invoiced after 2nd submittal revision, and after 1st fabrication revision. $750.00 Fabrication Revision Charge will be invoiced if revision is within 45 days of shipping.

MINIMUM ORDER FEE: Orders with a product total less than $25.00 are subject to a $20 non-refundable minimum order fee added to the invoice.

RE-STOCKING FEE:

a. Equipment - 20% re-stocking fee will apply to all returns for credit of new equipment not yet installed, within 180 days of shipment. Refurbishment charges, if any, are calculated upon inspection of goods when received. All returns to be authorized by Skytron in advance.
b. Parts - $50.00 re-stocking fee for inspection/testing, and up to five percent (5%) of item cost for repair/refurbishing charge (not to exceed $2,500 per item). Non-warranty part returns with a List Price less than $100.00 per item are not accepted.
c. Re-Stocking policy does not supersede Skytron's North American Warranty policy, Demo policy, or Table Pad Return policy.

WORKING HOURS: All service and installation pricing is based on normal working hours: 8AM to 5PM, Monday thru Friday, excluding holidays.

UNION LABOR: Facilities requiring the use of union labor must be identified as such for quoting purposes.

SEISMIC REQUIREMENTS: Please notify Skytron's Service Manager for installations having specific seismic requirements. Skytron is not responsible for any x-raying of the floor, structural ceiling through bolting, and associated fasteners.

SERVICE CONTRACTS: A signed service contract is required for service programs included in this quote, if applicable. A preliminary evaluation of product may be required for product that has been in use for some time.

SCHEDULING AND TRADE-IN EQUIPMENT: Contact Skytron's Service Manager a minimum of 15 working days prior to desired installation date. Large and intensive projects requiring multiple phases require a minimum 60-day notice before installation commences. Notice is required for installation where trade-in equipment will be present. If required, for a fee, Skytron can disconnect and remove existing equipment.

ELECTRICAL CONNECTIONS, FINAL TIE-INS AND FINISHES: All final tie-ins of electrical connections, plumbing and media must be made by a qualified and licensed individual. Skytron does not provide final tie-in services due to local licensing regulations. Finish work (e.g. caulking and trim) is the responsibility of others. Installation of standard product moldings or trim is included in the pricing provided.

MISCELLANEOUS:

a. Unless otherwise noted, Skytron reserves the right to make product improvements, discontinue products or change prices without notice.
b. Unless otherwise noted, quoted amounts do not include freight costs and applicable taxes. Freight and tax rates in effect at time of shipment will be applied.
c. For products combining lights and equipment pendants, include installation pricing for both individual units.
d. Buyer expressly agrees that no terms and conditions shall supersede those in this quote without express, written consent of Skytron.

UV DISINFECTION, IF APPLICABLE: In order to maintain warranty on UV Disinfection products (IPT UV-C), a service contract must be purchased from Skytron, and service work performed by a Skytron Service Technician. Failure to comply with the terms of the service contract may void warranty. Service contract terms and conditions are available upon request.

TERMS AND CONDITIONS CONTINUED
VIZIENT

PAYMENT TERMS
Net thirty (30) days after date of invoice, subject to credit approval.
Shipping and Taxes are not included in this quote unless itemized above. All products are invoiced upon shipment.

WARRANTY
1 – year Parts and Labor on contracted products.
1 - year Parts and Labor on non-contracted products.
90 - days on replacement parts, spare bulbs (surgical lights), spare pads (surgical tables), supplies, and accessory items.
15 - years on sterilizer pressure vessel (steam chamber and jacket).
**In order to maintain warranty on UV Disinfection products (IPT UV-C), a service contract must be purchased from Skytron, and service work performed by a Skytron Service Technician. Failure to comply with the terms of the service contract may void warranty. Service contract terms and conditions are available upon request.*

FREIGHT TERMS
F.O.B. Destination. Freight Prepaid and Added. All shipments subject to handling charge.

DELIVERY
120 Days after receipt of order.

DEPOSIT
25% deposit required for Booms and Active RTLS upon order acceptance.
50% deposit required for Integration and custom products upon order acceptance.

CONTRACT NUMBER
CE7191 (Stainless Steel); CE7201 (Lights, Booms, Integration)
CE7211 (Tables and Accessories); CE7593 (Sterilizers)
CE7598 (Washers and Decontaminators)

I acknowledge that I have reviewed and accept the content of this quote in its entirety.

Signature _____ Printed Name _____

Date _____ Title _____

Customer Purchase Order Number _____

Billing Address _____

Delivery Address _____

QUOTE Q-82603-2 **DATE** 03-05-2025 **EXPIRES** 07-03-2025

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board Approval of Project Budget(s) to create Training Facilities in support of the EPIC platform roll out.

Executive Sponsor: Clement Miller – Chief Operating Officer

Date: March 13, 2025

Executive Summary

Salinas Valley Health has committed to deploying the EPIC platform of management and administration tools in the coming months and years. The commitment requires significant training of all staff to assure efficient and competent utilization of the newly adopted program elements. Existing conference facilities are routinely booked to capacity. Taking existing facilities away from general use to accommodate a slate of full-day Epic training sessions creates an operational challenge. We are proposing to create two new 'stand-alone' conference/training facility buildouts, one in the Garage Annex basement, one at 5 Lower Ragsdale.

The garage Annex project (CIP 01.1250.3915) patterns the new development after the DRC's existing 3-chamber conference rooms A/B/C. The new training room will include full height motorized folding partitions to create 3 individual training chambers that can retract to reestablish the larger single chamber. Video-conferencing equipment will be installed to allow remote engagement. Included in this buildout is the creation of a men's/women's bathroom 'core' off the currently improved hallway near the new elevator, those toilet facilities will also support future occupancies once the balance of the unfinished basement is developed. The budget allocation for this component is $1,950,000.

The Ryan Ranch project (CIP 01.1250.3880) takes a portion of the existing VNA tenant space and demises it from the VNA tenancy with a full height wall to become a single training room, also with remote video engagement potential. Work associated with this project includes relocating individuals that currently occupy offices and cubicles within the training room footprint and the preparations needed to accommodate the various personnel moves out of the subject area. These facilities are targeted for completion in late June/Early July 2025 to align with the training schedule established by the training staff. The budget allocation for this component is $940,000.00 The total requested budget allocation for both projects is $**2,890,000.00**

Timeline/Review Process to Date:

Late 2024:	Preliminary space analysis and concept design
Jan-March 2025:	Contracting/Procurement/Permitting
April-June 2025:	Construction & Activation activities
July 2025:	Training sessions commence

Meeting our Mission, Vision, Goals

Pillar/Goal Alignment:

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

Fiscal Year Capital Budgeting:

Both Projects expected to achieve substantial completion by July 2025

Fiscal Year 2025: $2,300,000
Fiscal Year 2026: $ 590,000

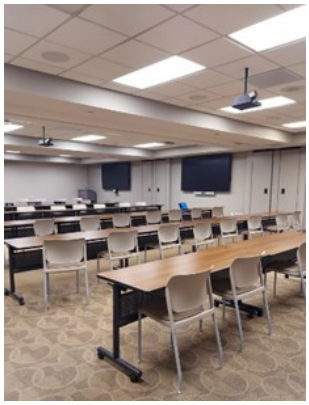
Recommendation

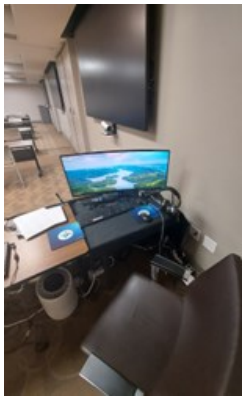
Consider recommendation for Board of Directors to approve the total estimated Project Budget(s) to create Training Facilities in support of the EPIC platform roll out in the amount of $**2,890,000.00**

Attachments

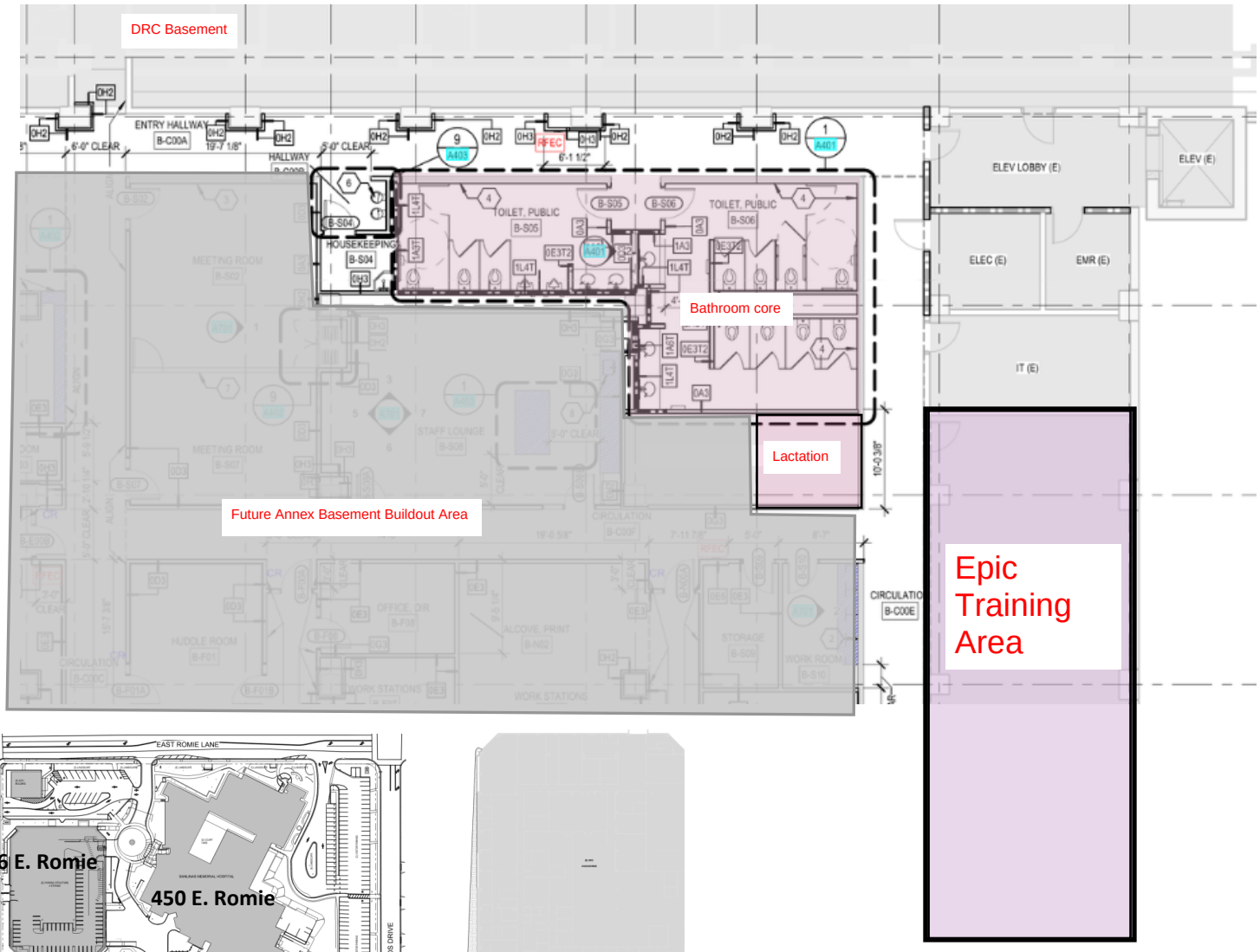
1) Attachment 'A' – 4-page schematic plan package
2) Attachment 'B' - Project Cost Budget at time of permit plan submittal

Existing Unfinished Space





Reference - Existing DRC 3-chamber Conference Area



Project Areas

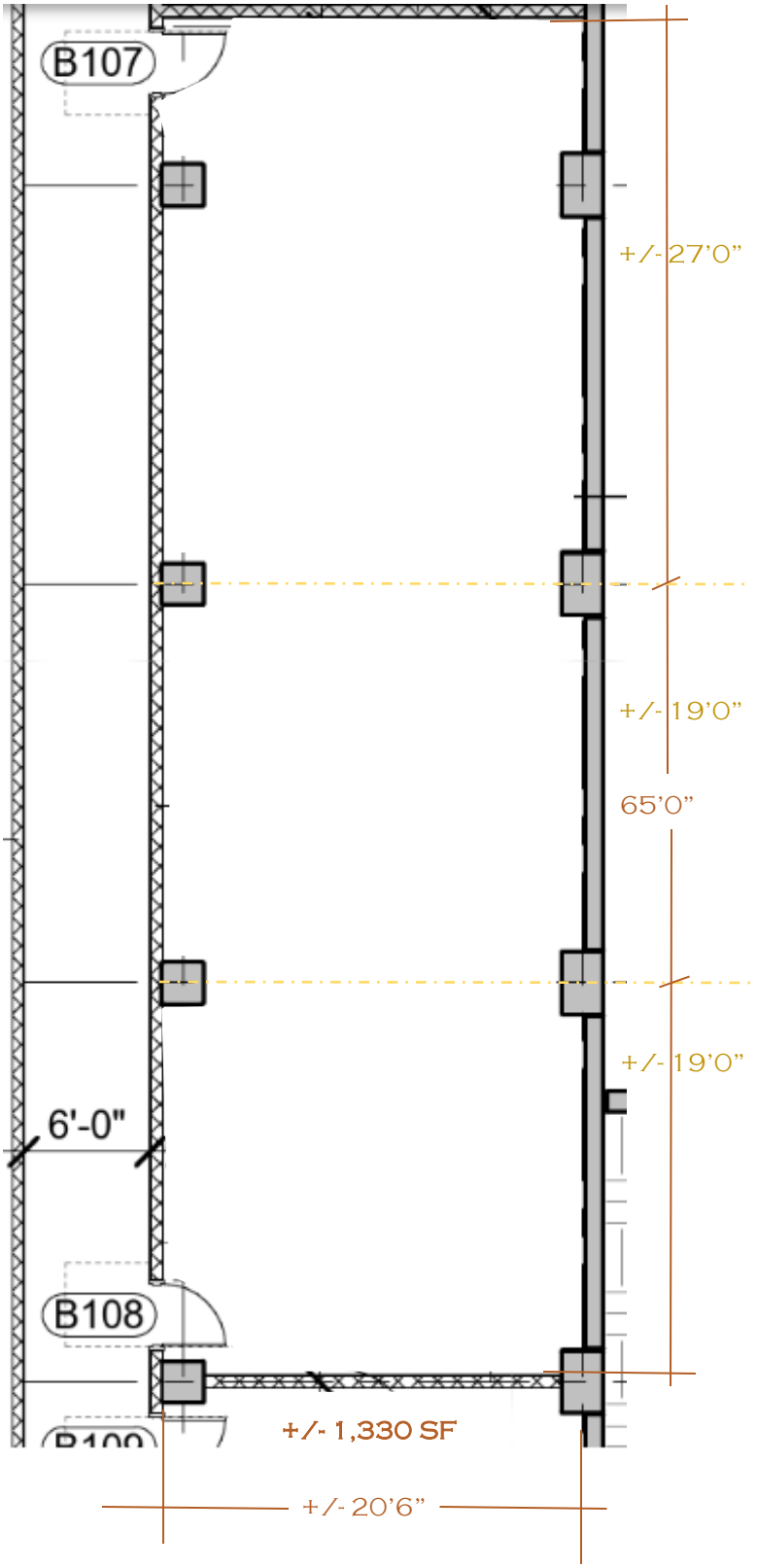
SVH Epic Training Facility Concept Package

446 E. Romie Lane
Basement Level

A
+/-550 SF

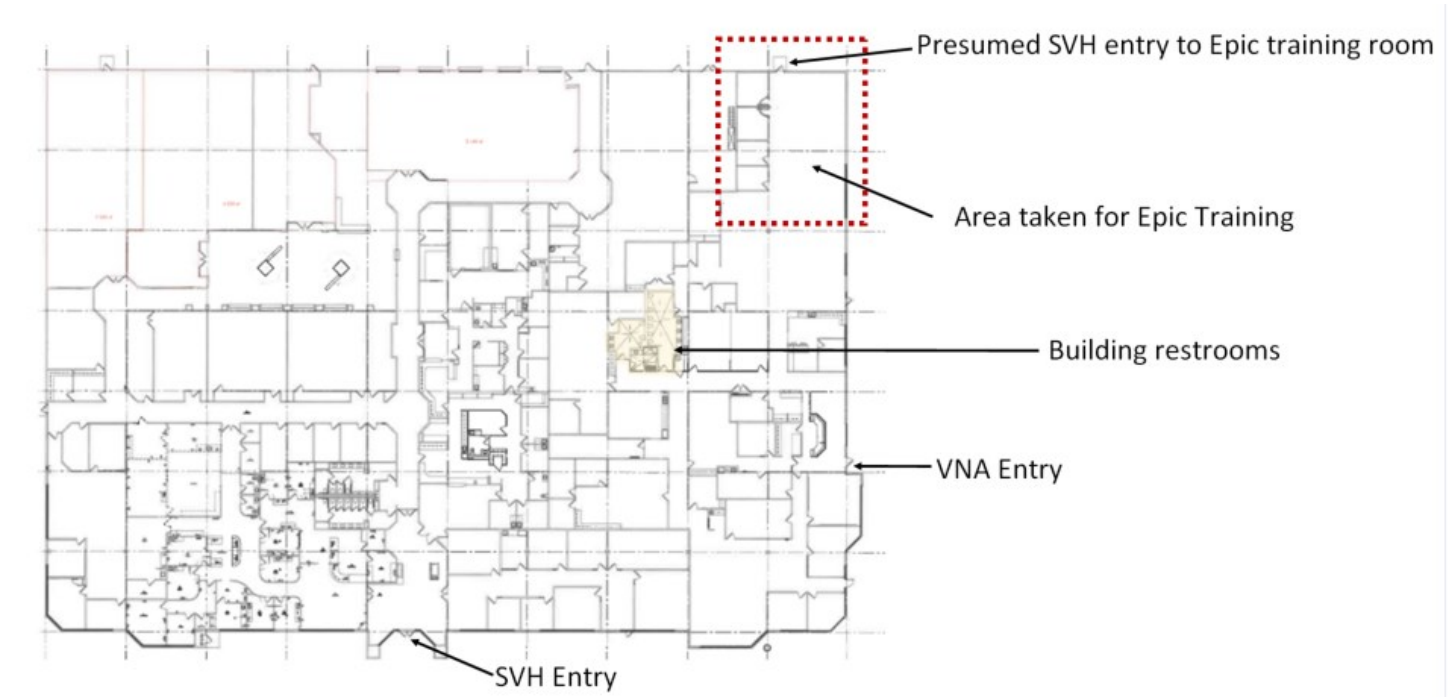
B
+/-380 SF

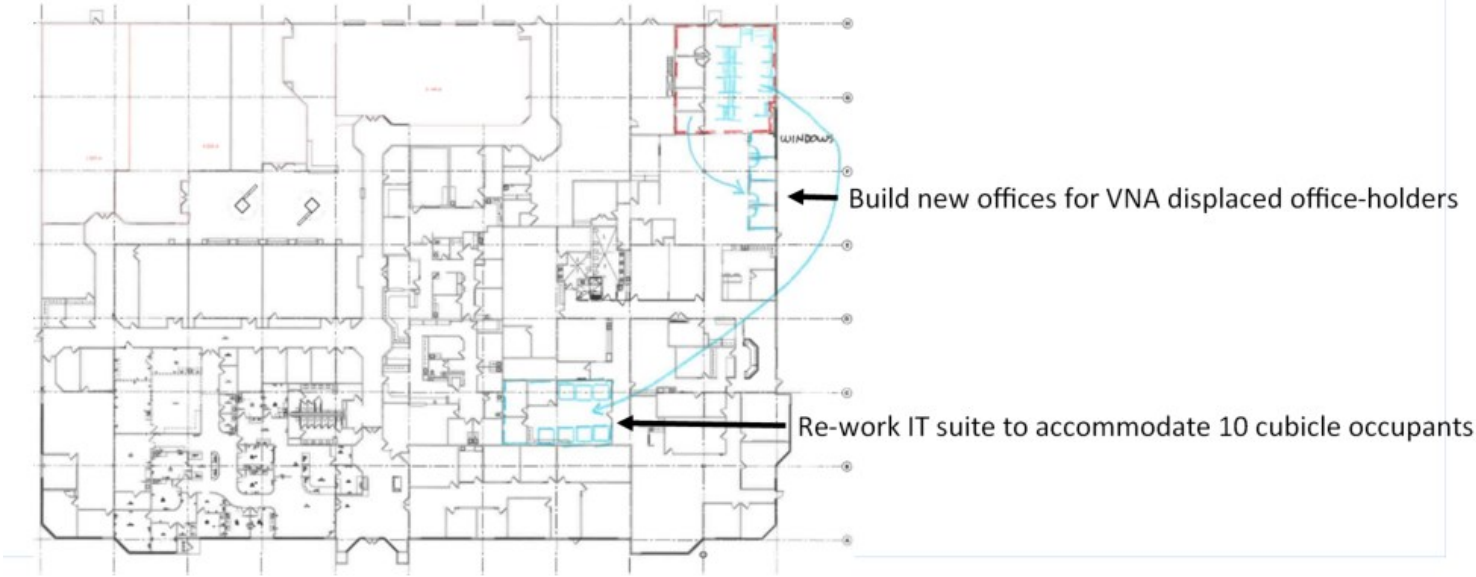
C
+/-380 SF



SVH Epic Training Facility
Concept Plan

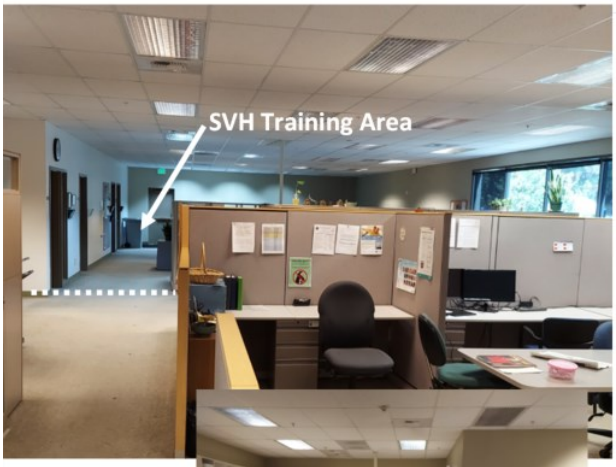
446 E. Romie Lane
Basement Level

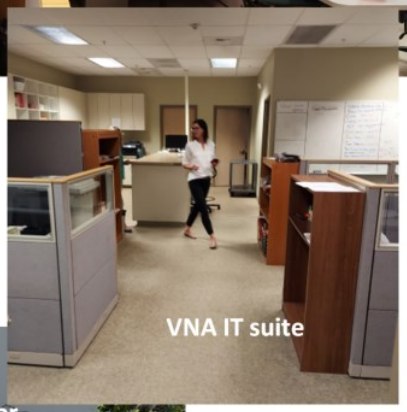


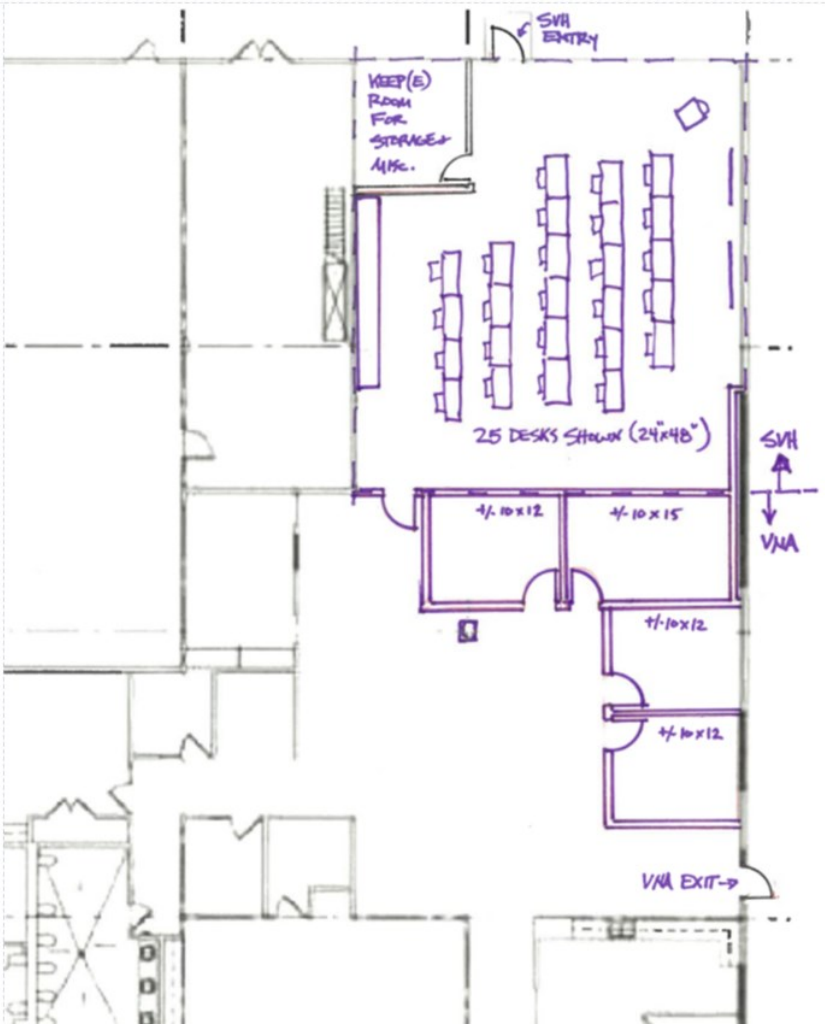


SVH Epic Training Facility
Concept Package

Make-Ready Improvements
5 Lower Ragsdale - Monterey
Inside VNA Suite







SVH Epic Training Facility
Concept Plan
5 Lower Ragsdale - Monterey
Inside VNA Suite

Preliminary Budget at Permit Plan Submission

SVH - Epic Training Facilities - Garage Annex & 5 Lower Ragsdale

March 2025

		01.1250.3915		01.1250.3880
	COST CATEGORY	**Annex Basement**		**Ryan Ranch**
Const:	Supervision	$45,000		$30,000
	General Conditions	$35,000		$15,000
	Soft Demo & pre-prep	$8,500		$15,000
	Insulation	$15,000		$3,500
	Drywall	$50,000		$28,000
	Paint	$17,000		$15,000
	Doors/Hardware	$25,000		$15,000
	Ceiling	$24,000		$15,000
	Conference Room Flooring/Floor Prep	$15,000		$10,000
	Rest Room Tile	$30,000		$0
	Cabinetry/Counters	$20,000		$10,000
	Specialties - Bathroom	$20,000		$0
	Specialties - Folding Partitions/Struct	$75,000		$0
	Specialties - Relocate SVH personnel	$0		$125,000
	FFE - Furnishings	$70,000		$60,000
	FFE - Appliance - lactation fridge	$500		$0
	FFE - IT Equipment	$100,000		$35,000
	FFE - AV Specialty Equipment	$180,000		$100,000
	Mechanical	$150,000		$24,000
	Plumbing	$150,000		$10,000
	Fire Sprinkler	$25,000		$12,000
	Electrical	$140,000		$50,000
	Fire Alarm	$20,000		$15,000
	Data Cable & Terminations	$90,000		$45,000
	Subtotal	$1,305,000		$632,500
	Contractor Fees - 7%	$91,350		$44,275
	Insurance = 1%	$13,673		$6,276
	Project Bond	$20,000		$7,500
	Subtotal	$1,430,023		$690,551
Soft Costs:	Architecture/Engineering	$130,000		$75,000
	City Fees	$30,000		$10,000
	Other Fees	$40,000		$5,000
	Program Management	$150,000		$75,000
	Subtotal	$350,000		$165,000
	Allow: common area carpet/wall repair	$10,000		$0
	Project Contingency	$159,977		$84,449
	ROM at permit submission	**$1,950,000**		**$940,000**
	Project Totals:		**$2,890,000**	

Financial Performance Review
February 2025
Finance Committee

Augustine Lopez
Chief Financial Officer

Consolidated Financial Summary
For the Month of February 2025

$ in Millions	For the Month of February 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 68.1	$ 58.8	$ 9.3	15.8%
Operating Expense	$ 67.4	$ 61.3	$ (6.1)	-10.0%
Income from Operations	**$ 0.7**	**$ (2.5)**	**$ 3.2**	**128.0%**
Operating Margin %	*1.0%*	*-4.2%*	*5.2%*	*123.81%*
Non Operating Income	$ 6.3	$ 4.1	$ 2.2	53.7%
Net Income	**$ 7.0**	**$ 1.6**	**$ 5.4**	**337.5%**
Net Income Margin %	*10.2%*	*2.7%*	*7.5%*	*277.8%*

Non Operating Income includes Normalizing Items of:
- FEMA Grant funds (net) received in February $1.2 million

Performance related to the prior month:
- Net Revenue was lower this month vs. January mostly due to 28 days in February.
  - Outpatient Infusion revenues were much lower than last month driven by fewer days.

2

Consolidated Financial Summary
For the Month of February 2025 - Normalized

$ in Millions	For the Month of February 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 68.1	$ 58.8	$ 9.3	15.8%
Operating Expense	$ 67.4	$ 61.3	$ (6.1)	-10.0%
Income from Operations	**$ 0.7**	**$ (2.5)**	**$ 3.2**	**128.0%**
Operating Margin %	*1.0%*	*-4.2%*	*5.2%*	*123.81%*
Non Operating Income	$ 5.1	$ 4.1	$ 1.0	24.4%
Net Income	**$ 5.8**	**$ 1.6**	**$ 4.2**	**262.5%**
Net Income Margin %	*8.4%*	*2.7%*	*5.7%*	*211.1%*

Non Operating Income excludes Normalizing Items of:
- FEMA Grant funds (net) received in February $1.2 million

Performance related to the prior month:
- Net Revenue was lower this month vs. January mostly due to 28 days in February.
  - ✓ Outpatient Infusion revenues were much lower than last month driven by fewer days.

Executive Summary: Financial Performance

Salinas Valley Health Income from Operations was $0.7 million for the month which was favorable to budget by $3.2M. The favorable financial performance for the month was driven by the following:

Key Favorable Performance Highlights:

- **Outpatient revenue** was favorable compared to budget by $31M (23%), due to higher than budgeted patient volumes in the following areas:
  - ➢**OP Infusion cases** were over budget by 16% (144 cases)
  - ➢**OP Surgeries** were over budget by 12% (28 cases)
  - ➢**CT Scans** were over budget 16% (269 cases)
  - ➢**Mammography** cases were over budget by 13% (304 cases)
- **Total inpatient admissions** were 22% (180 admits) above budget
- **IP surgeries** were over budget by 9% (9 cases)
- **Commercial insurance revenue** was above budget by 11%
- **Average Length of Stay** was 15% favorable to budget at 3.5 days
- **Deliveries** were up 23% (24 cases)

Executive Summary: Financial Performance – Cont'd

- **Key Unfavorable Performance Highlights:**
  - ✓ **MediCal and Medicare** patient revenue were over budget 21% and 15%, respectively
  - ✓ **Total Case Mix** was under budget by 5% at 1.53
  - ✓ **OP Observation** cases were over budget by 44% (55 cases)

5

Consolidated Financial Summary YTD February 2025

$ in Millions	FY 2025 February YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 545.6	$ 494.4	$ 51.2	10.4%
Operating Expense	$ 520.8	$ 503.6	$ (17.2)	-3.4%
Income from Operations	**$ 24.8**	**$ (9.2)**	**$ 34.0**	**369.6%**
Operating Margin %	*4.6%*	*-1.9%*	*6.5%*	*342.1%*
Non Operating Income	$ 26.4	$ 24.7	$ 1.7	6.9%
Net Income	**$ 51.2**	**$ 15.5**	**$ 35.7**	**230.3%**
Net Income Margin %	*9.4%*	*3.1%*	*6.3%*	*203.2%*

Operating Income includes the Normalizing Item of:
- CCAH Voluntary Rate Range Funds (net) Received YTD for CY 2023 totaled $4.6 Million

Non Operating Income includes Normalizing Items of:
- FEMA Grant funds (net) received YTD were $4.2 million
- FEMA Grant funds received inception to date totals $10.8 million

6

Consolidated Financial Summary YTD February 2025 - Normalized

$ in Millions	FY 2025 February YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 541.0	$ 494.4	$ 46.6	9.4%
Operating Expense	$ 520.8	$ 503.6	$ (17.2)	-3.4%
Income from Operations	**$ 20.2**	**$ (9.2)**	**$ 29.4**	**319.6%**
Operating Margin %	*3.7%*	*-1.9%*	*5.6%*	*294.7%*
Non Operating Income	$ 22.2	$ 24.7	$ (2.5)	-10.1%
Net Income	**$ 42.4**	**$ 15.5**	**$ 26.9**	**173.5%**
Net Income Margin %	*7.8%*	*3.1%*	*4.7%*	*151.6%*

Operating Income excludes the Normalizing Item of:

- CCAH Voluntary Rate Range Funds (net) Received YTD for CY 2025 totaled $4.6 Million

Non Operating Income excludes Normalizing Items of:

- FEMA Grant funds (net) received YTD were $4.2 million
- FEMA Grant funds received inception to date totals $10.8 million

SVHMC Revenue Highlights February 2025

Gross Revenues were 16.1% *favorable to budget*

- **IP Gross Revenues** were 9.3% ***favorable*** to budget
- **ED Gross Revenues** were 1.8% ***favorable*** to budget
- **OP Gross Revenues** were 30.3% ***favorable*** to budget in the following areas:
  - OP Infusion
  - OP Surgery
  - CT Procedures
  - Cath Lab

- **Commercial: 11%** *above* budget
- **Medicaid: 21%** *above* budget
- **Medicare: 15%** *above* budget

Payor Mix –Mixed

Total Net Patient Revenues were **$54.5M**, which was ***favorable*** to budget by **$7.1M** or 14.9%

Financial Summary – February 2025

ADC
Average daily census was 125, 7% above budget of 117

Admits
Total admissions were 22%, 180 admits, above budget

ER Visits
ER Outpatient visits were 4%, 184 cases, above budget

ER Admits
ER admissions were above budget 159 admits, 26%. ER admits as % of total admissions were 84.5% (Excluding OB ED)

IP Surgeries
Inpatient Surgeries were up 9%, 11 cases above budget at 131

OP Infusion
OP Infusion cases were up 16%, 144 cases above budget at 1,051

Cath Lab
Cath Lab procedures were up 13%, 35 cases above budget at 310

CT/MRI Procedures
MRI procedures were above budget by 13 cases, 6%. CT procedures were above budget by 269 cases, 16%

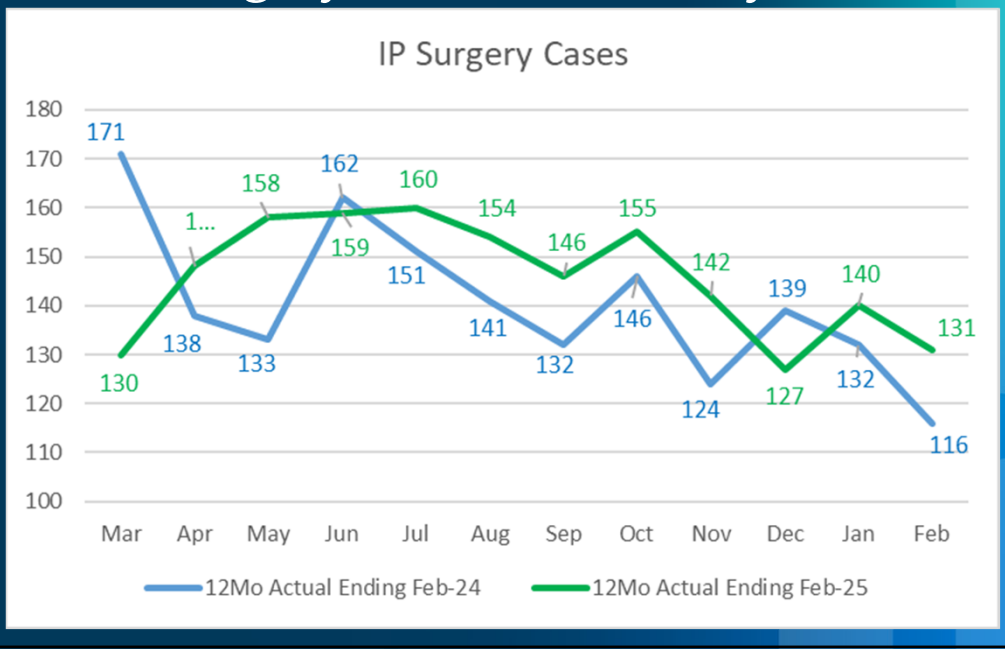
OP Surgeries
Outpatient Surgeries were above budget 12%, 28 cases, at 273

Deliveries
Deliveries were up 23%, 24 cases, above budget at 128

Observation Cases
OP Observations cases were over budget by 44%, or 55 cases at 179

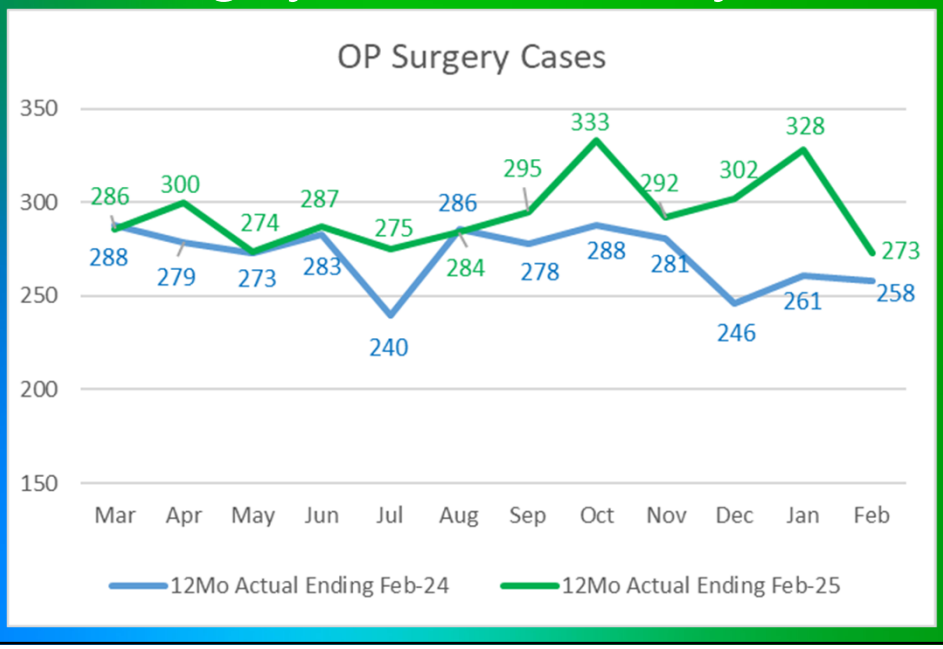
Medicare ALOS
Medicare Traditional ALOS CMI adjusted was favorable to budget at 2.0 days with a Case Mix Index of 1.65

IP Surgery Cases – February 2025



10

OP Surgery Cases – February 2025



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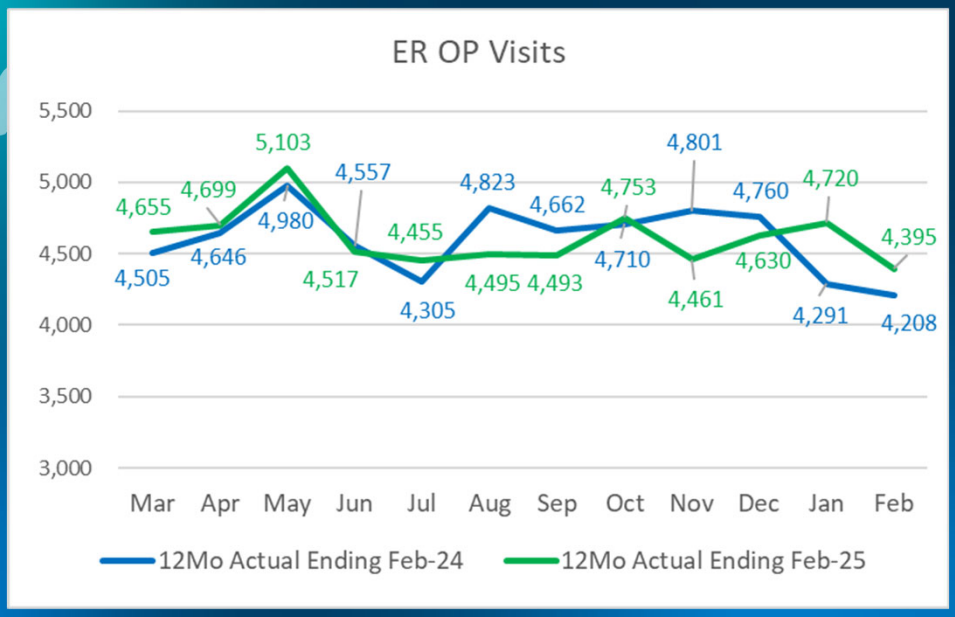
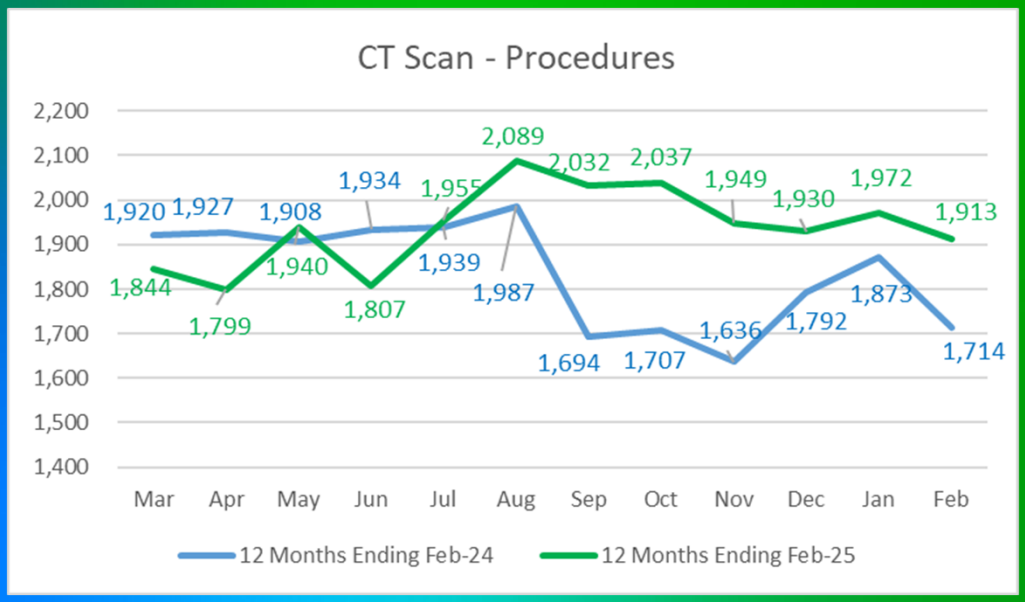
ER OP Visits – February 2025



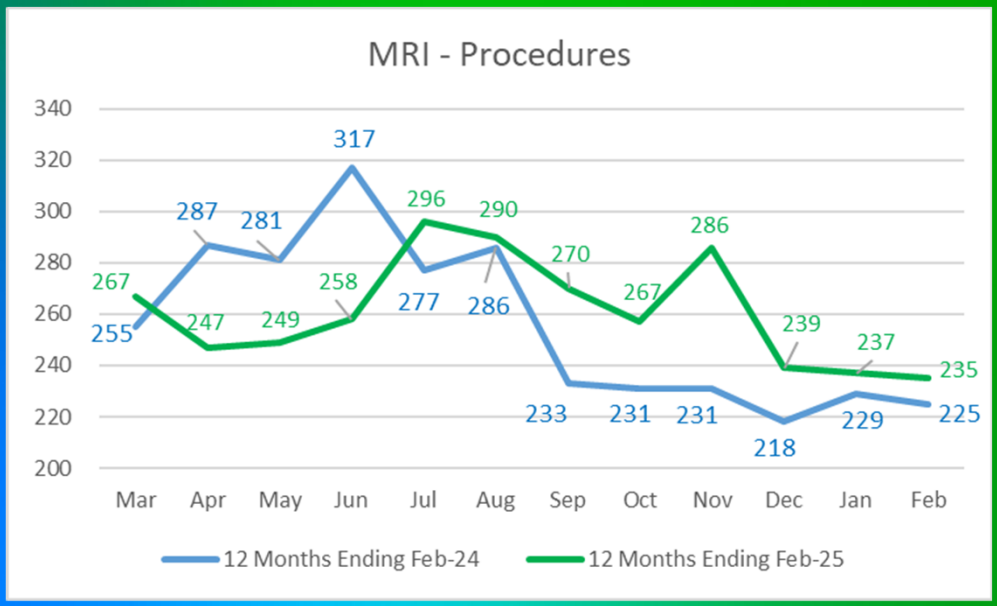
12

CT Scans – February 2025



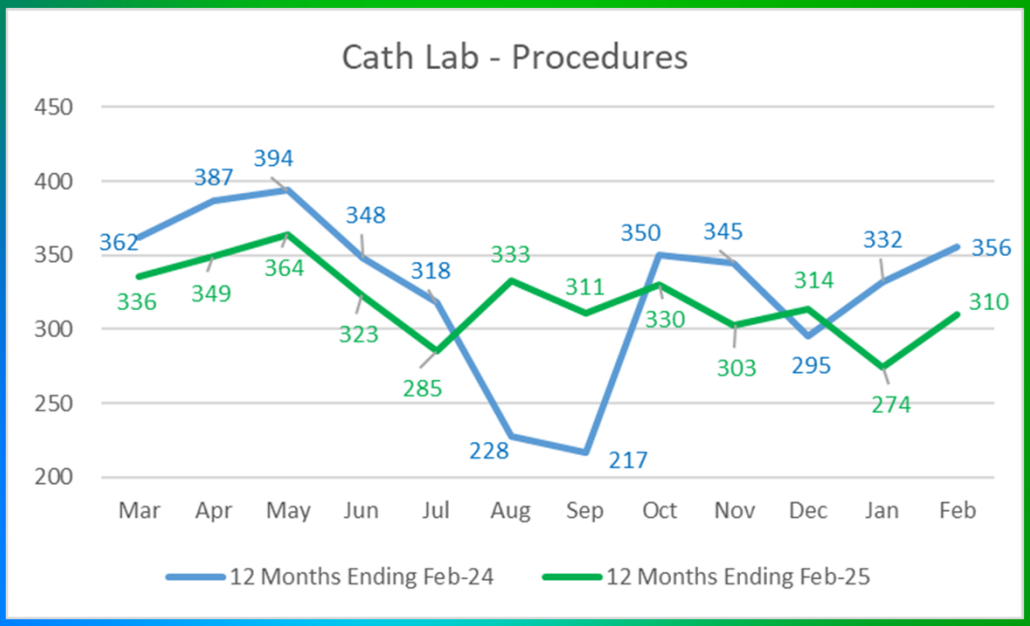
13

MRI – February 2025



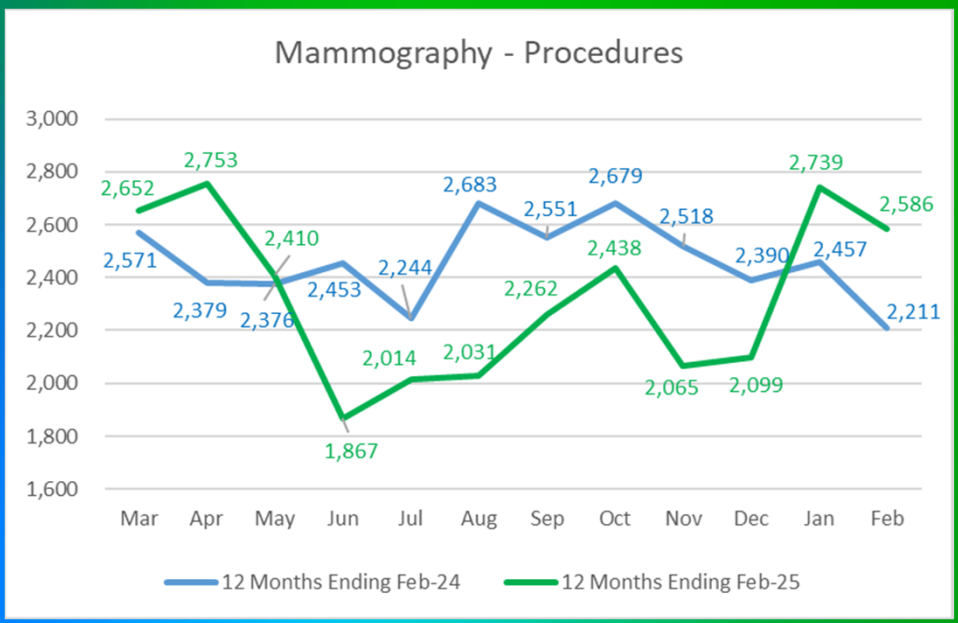
14

Cath Lab – February 2025



15

Mammography – February 2025



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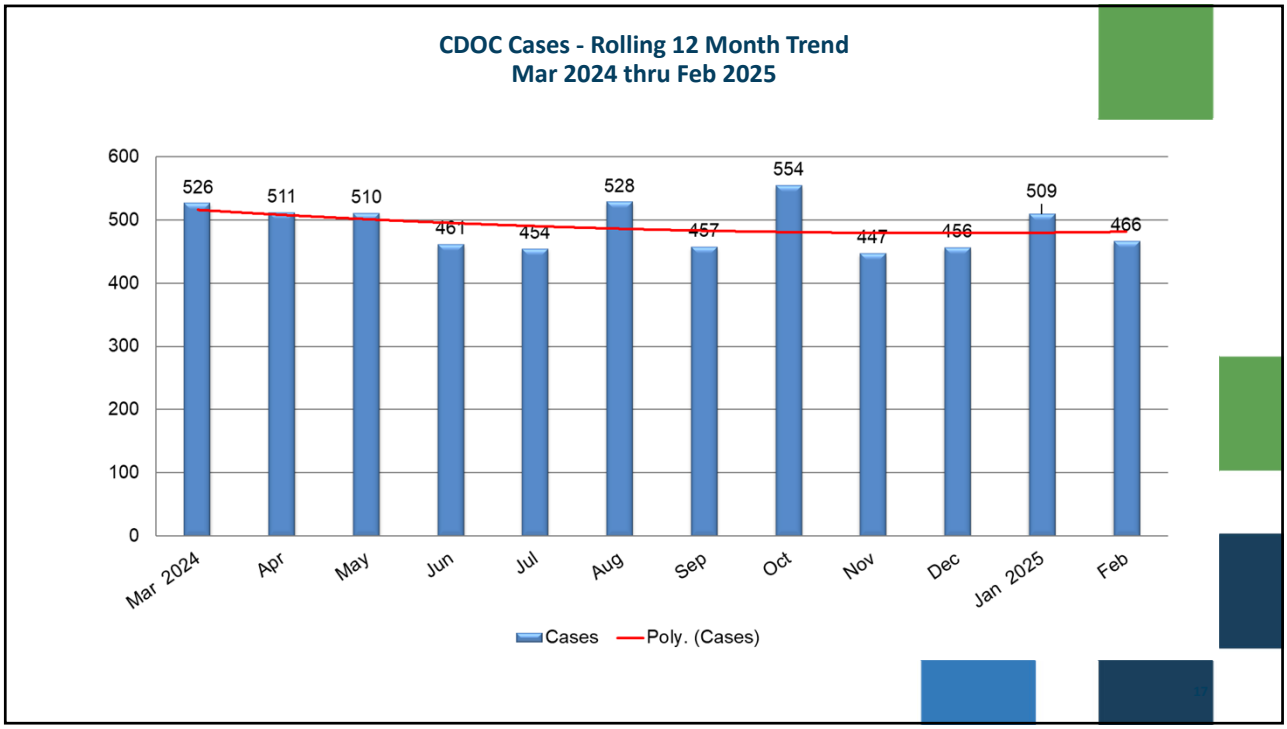
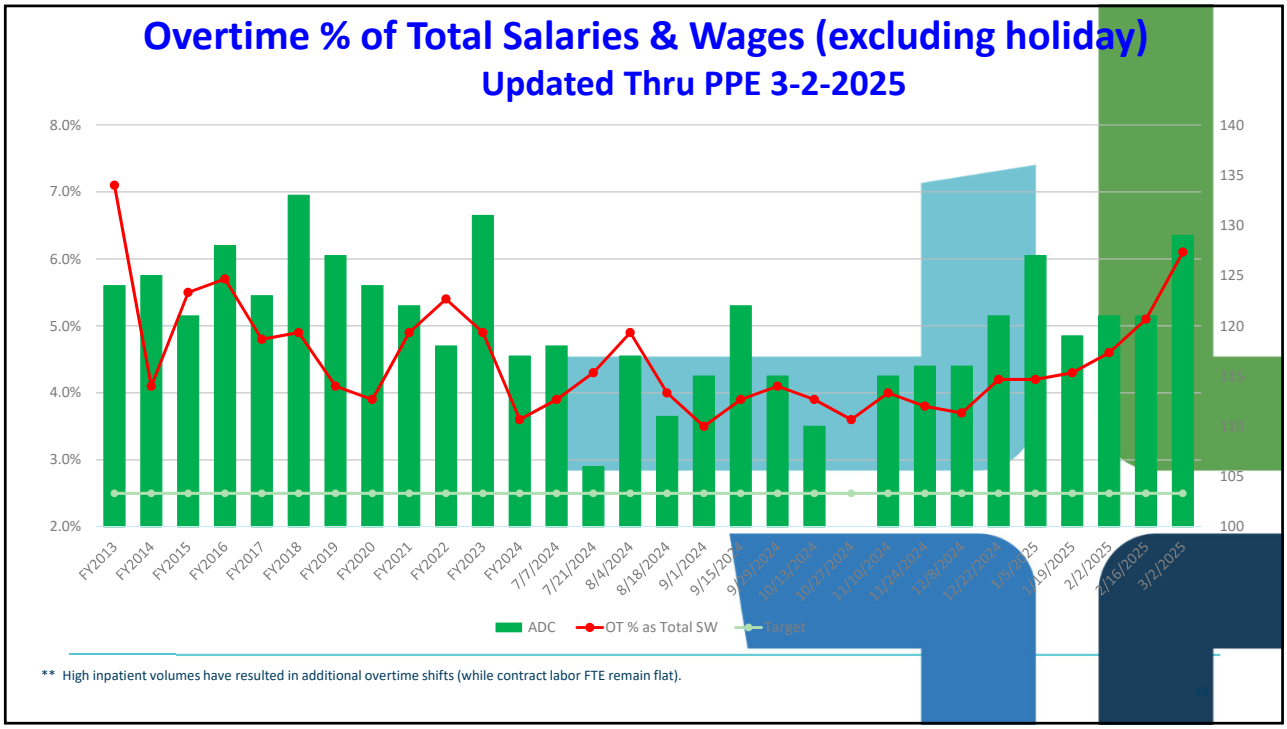
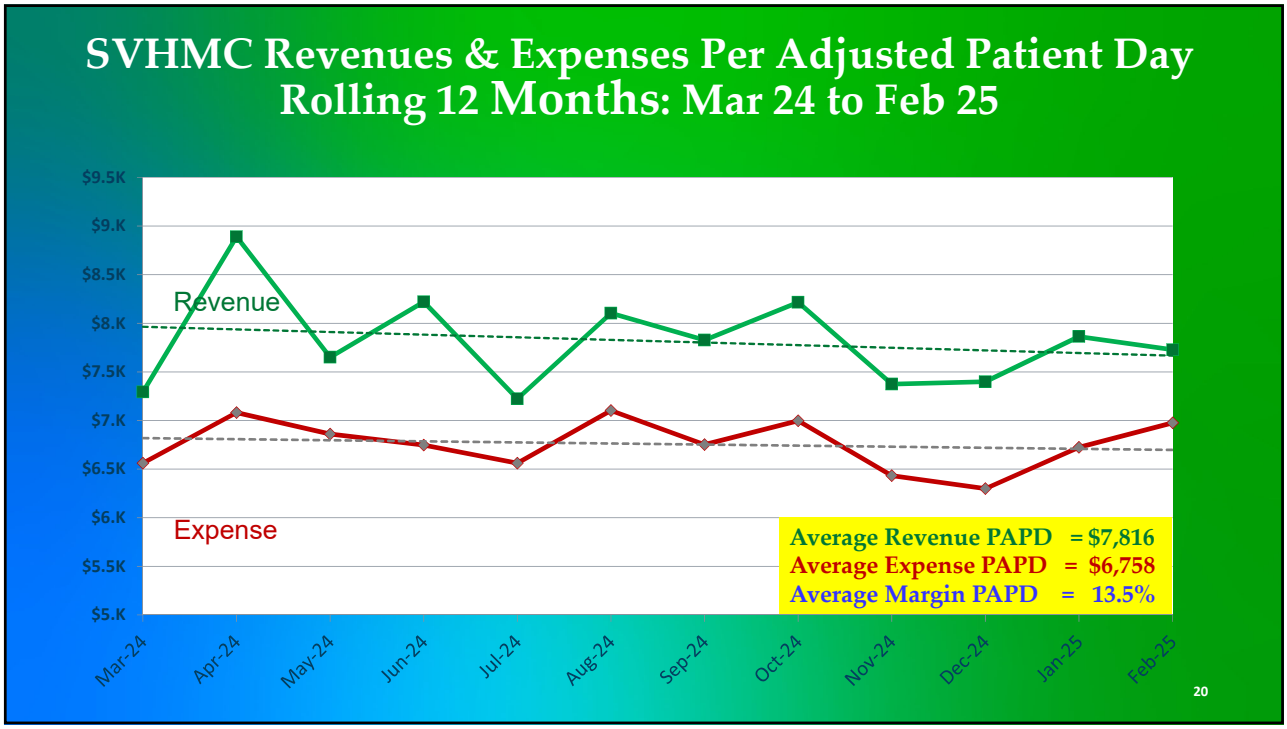


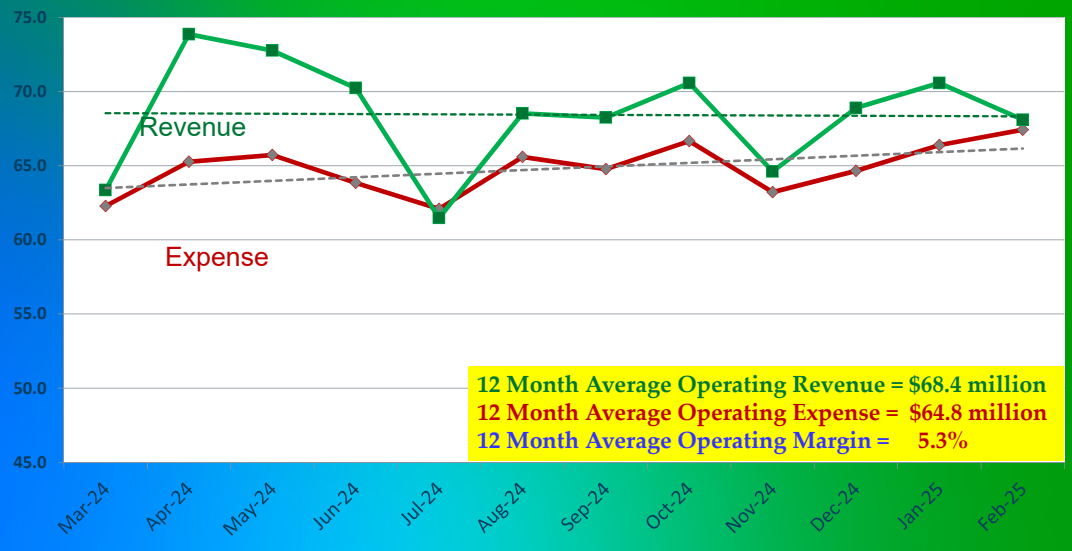
Labor Productivity – February 2025

1. **Worked FTEs:** During the month of February, worked FTEs on a PAADC basis were 6.9% favorable at **6.2** with a target of **6.7**. *When reviewed on a unit-by-unit level, the variance was **79** FTEs positive (**$1.1M**).*
2. **Worked FTEs** increased from 1,566 in January to 1,607 in February. Average daily census decreased by 7 compared to prior month at 125 (7% above budget).
3. **Paid FTEs:** On a PAADC basis, paid FTEs were **6.8%** favorable to budget at **7.1 actual vs. 7.6 budget.** Paid FTEs increased from 1,824 in January to 1,841 in February.


Overtime % of Total Salaries & Wages (excluding holiday)
Updated Thru PPE 3-2-2025
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
140
135
130
125
120
105
100
FY2013
FY2014
FY2015
FY2016
FY2017
FY2018
FY2019
FY2020
FY2021
FY2022
FY2023
FY2024
7/7/2024
7/21/2024
8/4/2024
8/18/2024
9/1/2024
ADC
OT % as Total SW
Target
** High inpatient volumes have resulted in additional overtime shifts (while contract labor FTE remain flat).


SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Mar 24 to Feb 25
$9.5K
$9.K
$8.5K
$8.K
$7.5K
$7.K
$6.5K
$6.K
$5.5K
$5.K
Revenue
Expense
Average Revenue PAPD = $7,816
Average Expense PAPD = $6,758
Average Margin PAPD = 13.5%
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
20

SVH Consolidated Revenues & Expenses Rolling 12 Months: Mar 24 to Feb 25



21

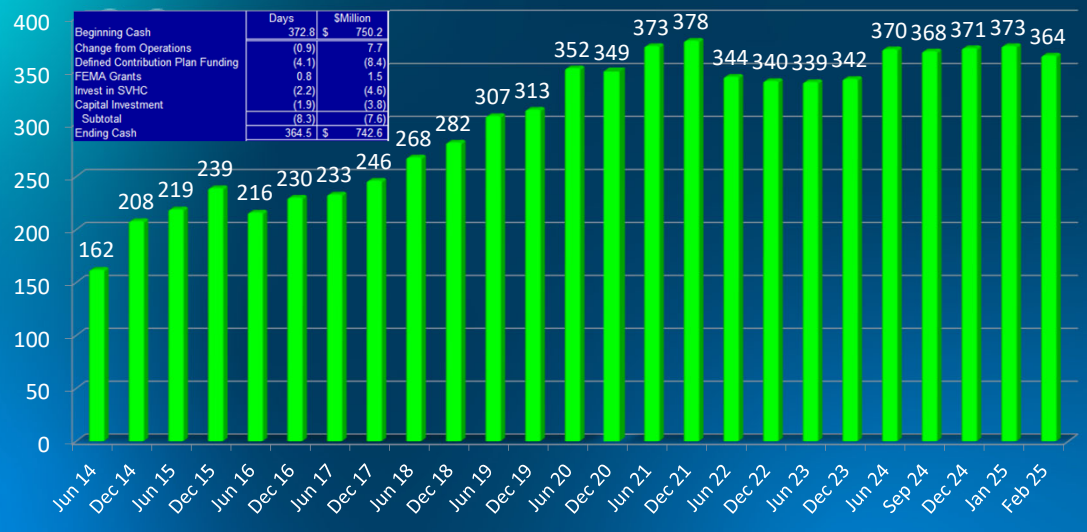
Salinas Valley Health Key Financial Indicators

Statistic	YTD 2/28/25	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 2/29/24	+/-
Operating Margin*	4.6%	5.0%		4.0%		-2.0%	
Total Margin*	9.4%	6.0%		6.6%		3.7%	
EBITDA Margin**	9.0%	7.4%		13.6%		2.8%	
Days of Cash*	364	305		249		338	
Days of Accounts Payable*	46	45		-		47	
Days of Net Accounts Receivable**	67	45		49		60	
Supply Expense as % NPR	14.6%	14.0%		-		13.9%	
SWB Expense as % NPR	52.1%	53.0%		53.7%		55.7%	
Operating Expense per APD*	6,676	6,739		-		6,731	

All metrics above are consolidated for SVH except Operating Expense per APD
*These metrics have **not** 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)

22

Salinas Valley Health
Days Cash on Hand = 364 Days ($743M) - February 2025



23

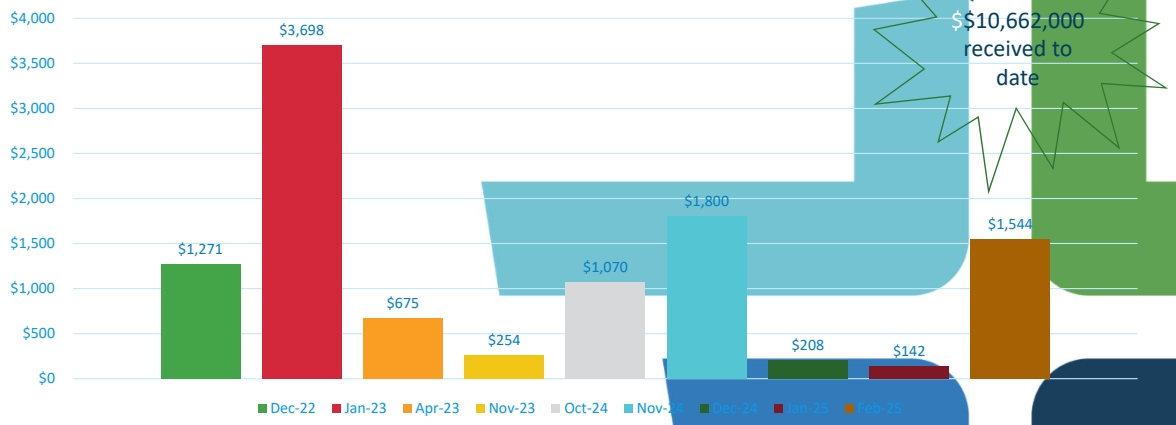
Routine Capital Expenditures
Through February 2025

Fiscal Month	FY 2025 Approved Budget *	Total Purchased Expenditures	Remaining	Project	Amount
July	1,916,667	712,780	1,203,887	Nurse Call System	31,722
August	1,916,667	1,382,572	1,737,981	Nuclear Med D-Spect Camera	10,873
September	1,916,667	729,309	2,925,338	Angio Equipment Replacement	8,116
October	1,916,667	1,191,148	3,650,857	Cath Lab Equipment Replacement	9,308
November	1,916,667	794,889	4,772,635	Miscellaneous	11,038
December	1,916,667	1,381,451	5,307,851	Total Improvements	71,057
January	1,916,667	1,565,871	5,658,646	Laboratory-Vitek MS (Mass Spectrometry)	249,225
February	1,916,667	963,787	6,611,526	Maintenance, Admin and ED Furniture	167,603
March	1,916,667		8,528,193	Surgery Stryker Power Drill Set	149,457
April	1,916,667		10,444,859	Surgery Retractor System	96,976
May	1,916,667		12,361,526	Miscellaneous	229,471
June	1,916,667		14,278,193	Total Equipment	892,730
YTD TOTAL	**23,000,000**	**8,721,808**	**14,278,193**	**Grand Total**	**963,787**

24

FEMA Funds Received to Date ($,000)

Total $10,662,000 as of March 14, 2025



$10,662,000 received to date

Questions/Comments

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
February 28, 2025

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 54,516,711	$ 51,203,565	$ 453,254,455	$ 402,589,544
Other operating revenue	1,694,161	1,165,959	12,329,327	8,741,193
Total operating revenue	56,210,872	52,369,524	465,583,782	411,330,737
Total operating expenses	50,742,628	47,158,694	401,823,202	382,673,348
Total non-operating income	1,076,135	(5,076,526)	(13,871,022)	(11,894,106)
Operating and non-operating income	$ 6,544,380	$ 134,304	$ 49,889,558	$ 16,763,282

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
February 28, 2025

	Current year	Prior year
ASSETS:		
Current assets	$ 428,751,376	$ 351,193,614
Assets whose use is limited or restricted by board	172,635,520	164,215,685
Capital assets	257,042,931	249,951,875
Other assets	306,744,310	286,832,533
Deferred pension outflows	85,734,219	116,911,125
	$ 1,250,908,356	$ 1,169,104,832
LIABILITIES AND EQUITY:		
Current liabilities	94,679,340	91,968,801
Long term liabilities	20,803,488	20,638,874
Lease deferred inflows	1,023,943	1,616,220
Pension liability	90,863,576	118,792,064
Net assets	1,043,538,009	936,088,872
	$ 1,250,908,356	$ 1,169,104,832

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
February 28, 2025

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,730	1,766	13,978	14,368
Medi-Cal	1,069	1,102	8,331	8,413
Commercial insurance	571	409	4,499	4,576
Other patient	108	38	930	821
Total patient days	3,478	3,315	27,738	28,178
Gross revenue:				
Medicare	$ 128,243,309	$ 119,729,091	$ 1,008,862,430	$ 905,779,116
Medi-Cal	82,778,197	74,556,691	645,258,201	557,562,508
Commercial insurance	56,782,245	47,886,002	464,669,241	417,279,578
Other patient	10,785,176	7,451,292	86,883,237	71,011,282
Gross revenue	278,588,927	249,623,076	2,205,673,109	1,951,632,483
Deductions from revenue:				
Administrative adjustment	121,892	283,914	2,485,144	2,513,879
Charity care	1,465,312	353,174	5,147,446	5,538,719
Contractual adjustments:				
Medicare outpatient	42,421,122	39,018,520	335,870,821	281,089,336
Medicare inpatient	51,797,958	48,184,519	387,464,602	375,545,528
Medi-Cal traditional outpatient	1,434,515	1,789,602	12,308,580	21,967,387
Medi-Cal traditional inpatient	4,763,009	4,897,607	39,573,349	38,029,780
Medi-Cal managed care outpatient	39,487,262	33,576,493	315,709,838	243,969,887
Medi-Cal managed care inpatient	29,567,261	26,646,831	209,407,799	201,180,676
Commercial insurance outpatient	26,107,623	21,391,288	212,531,551	174,394,469
Commercial insurance inpatient	20,786,028	17,829,397	175,907,775	161,393,693
Uncollectible accounts expense	5,499,453	4,350,530	43,865,877	33,909,165
Other payors	620,781	97,636	12,145,872	9,510,420
Deductions from revenue	224,072,216	198,419,512	1,752,418,654	1,549,042,940
Net patient revenue	$ 54,516,711	$ 51,203,565	$ 453,254,455	$ 402,589,544
Gross billed charges by patient type:				
Inpatient	$ 133,648,250	$ 120,101,071	$ 1,036,328,078	$ 992,014,802
Outpatient	115,163,534	100,349,331	915,498,459	725,267,074
Emergency room	29,777,143	29,172,674	253,846,572	234,350,607
Total	$ 278,588,927	$ 249,623,076	$ 2,205,673,109	$ 1,951,632,483

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
February 28, 2025

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 54,516,711	$ 51,203,565	$ 453,254,455	$ 402,589,544
Other operating revenue	1,694,161	1,165,959	12,329,327	8,741,193
Total operating revenue	56,210,872	52,369,524	465,583,782	411,330,737
Operating expenses:				
Salaries and wages	17,652,762	15,832,796	140,817,792	132,969,018
Compensated absences	2,954,067	2,754,652	25,243,808	23,918,846
Employee benefits	8,567,240	9,170,977	64,736,813	67,930,024
Supplies, food, and linen	8,966,955	7,328,460	69,239,354	57,804,224
Purchased department functions	3,730,508	3,168,633	30,784,758	28,850,148
Medical fees	2,942,924	2,510,986	20,729,844	19,909,093
Other fees	1,523,983	2,060,984	15,020,769	18,283,364
Depreciation	2,694,386	2,387,765	20,589,344	19,163,609
All other expense	1,709,803	1,943,441	14,660,720	13,845,022
Total operating expenses	50,742,628	47,158,694	401,823,202	382,673,348
Income from operations	5,468,244	5,210,830	63,760,580	28,657,389
Non-operating income:				
Donations	1,270,081	0	5,515,323	2,333,567
Property taxes	476,714	333,333	3,813,715	2,666,667
Investment income	3,985,637	15,606	13,928,137	19,989,251
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,656,297)	(5,425,465)	(37,128,197)	(36,883,591)
Total non-operating income	1,076,135	(5,076,526)	(13,871,022)	(11,894,106)
Operating and non-operating income	6,544,380	134,304	49,889,558	16,763,282
Net assets to begin	1,036,993,629	935,954,568	993,648,450	919,325,590
Net assets to end	$ 1,043,538,009	$ 936,088,872	$ 1,043,538,009	$ 936,088,872
Net income excluding non-recurring items	$ 6,544,380	$ 134,304	$ 49,889,558	$ 16,763,282
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 6,544,380	$ 134,304	$ 49,889,558	$ 16,763,282

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
February 28, 2025

	Month of February,		Eight months ended February 28,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (195,442)	$ (200,426)	$ (1,645,887)	$ (1,623,660)
Neurological Clinic	(75,500)	(62,439)	(541,693)	(581,097)
Palliative Care Clinic	(110,775)	(96,434)	(743,084)	(711,893)
Surgery Clinic	(62,010)	(180,392)	(1,188,001)	(1,478,113)
Infectious Disease Clinic	(51,795)	(48,474)	(370,104)	(301,486)
Endocrinology Clinic	(228,483)	(260,673)	(1,823,988)	(1,865,536)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(712,712)	(674,109)	(4,741,830)	(4,730,434)
OB/GYN Clinic	(380,869)	(561,826)	(3,335,715)	(3,309,726)
PrimeCare Medical Group	(776,651)	(965,779)	(6,357,736)	(7,026,706)
Oncology Clinic	(484,301)	(415,138)	(3,226,327)	(2,713,947)
Cardiac Surgery	(386,363)	(383,426)	(2,752,843)	(2,477,945)
Sleep Center	(87,831)	(88,613)	(700,715)	(432,257)
Rheumatology	(72,392)	(87,897)	(600,036)	(580,444)
Precision Ortho MDs	(567,426)	(530,556)	(3,676,417)	(3,881,821)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(94,592)	(65,157)	(610,805)	(378,799)
Vaccine Clinic	0	0	0	16
Dermatology	(35,122)	(38,272)	(332,556)	(325,157)
Hospitalists	0	0	0	0
Behavioral Health	(33,535)	(84,335)	(312,995)	(398,834)
Pediatric Diabetes	(36,506)	(46,863)	(318,750)	(368,411)
Neurosurgery	(138,556)	(84,279)	(964,188)	(325,643)
Multi-Specialty-RR	17,158	1,385	91,252	21,251
Radiology	(264,511)	(386,300)	(2,571,764)	(2,630,147)
Salinas Family Practice	(125,704)	(152,751)	(898,752)	(1,118,913)
Urology	(134,517)	(176,095)	(1,485,862)	(1,382,222)
Total SVHC	(5,038,435)	(5,588,849)	(39,108,796)	(38,621,924)
Doctors on Duty	214,582	(45,956)	153,908	325,865
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	162,118	99,780	1,304,219	1,049,041
Coastal	22,912	29,073	(55,274)	47,409
Apex	0	0	0	0
21st Century Oncology	(11,972)	50,331	169,152	3,223
Monterey Bay Endoscopy Center	(5,503)	30,156	408,595	312,795
Total	$ (4,656,297)	$ (5,425,465)	$ (37,128,197)	$ (36,883,591)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
February 28, 2025

	Current year	Prior year
ASSETS		
Current assets:		
Cash and cash equivalents	$ 274,334,444	$ 221,537,903
Patient accounts receivable, net of estimated uncollectibles of $84,355,959	128,401,204	102,081,358
Supplies inventory at cost	8,867,838	7,718,586
Current portion of lease receivable	845,963	1,131,104
Other current assets	16,301,928	18,724,663
Total current assets	428,751,376	351,193,614
Assets whose use is limited or restricted by board	172,635,520	164,215,685
Capital assets:		
Land and construction in process	46,953,903	75,825,405
Other capital assets, net of depreciation	210,089,028	174,126,470
Total capital assets	257,042,931	249,951,875
Other assets:		
Right of use assets, net of amortization	8,155,239	6,714,217
Long term lease receivable	214,212	608,766
Subscription assets, net of amortization	8,805,987	7,722,471
Investment in Securities	266,953,469	252,399,372
Investment in SVMC	941,628	13,970,071
Investment in Coastal	1,697,096	1,729,050
Investment in other affiliates	21,533,050	12,325,698
Net pension asset	(1,556,371)	(8,637,112)
Total other assets	306,744,310	286,832,533
Deferred pension outflows	85,734,219	116,911,125
	$ 1,250,908,356	$ 1,169,104,832
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable and accrued expenses	$ 61,322,090	$ 62,009,649
Due to third party payers	4,542,353	4,336,365
Current portion of self-insurance liability	22,984,197	18,839,225
Current subscription liability	3,014,765	4,299,728
Current portion of lease liability	2,815,935	2,483,835
Total current liabilities	94,679,340	91,968,801
Long term portion of workers comp liability	12,078,720	13,027,333
Long term portion of lease liability	5,331,788	4,449,212
Long term subscription liability	3,392,980	3,162,329
Total liabilities	115,482,828	112,607,676
Lease deferred inflows	1,023,943	1,616,220
Pension liability	90,863,576	118,792,064
Net assets:		
Invested in capital assets, net of related debt	257,042,931	249,951,875
Unrestricted	786,495,078	686,136,997
Total net assets	1,043,538,009	936,088,872
	$ 1,250,908,356	$ 1,169,104,832

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
February 28, 2025

	Month of February,			Eight months ended February 28,			
	Actual	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:							
Gross billed charges	$ 278,588,927	$ 38,664,928	16.12%	$ 2,205,673,109	$ 2,036,457,092	169,216,017	8.31%
Dedutions from revenue	224,072,216	32,152,613	16.75%	1,752,418,654	1,631,644,522	120,774,132	7.40%
Net patient revenue	54,516,711	6,512,316	13.57%	453,254,455	404,812,569	48,441,886	11.97%
Other operating revenue	1,694,161	241,492	16.62%	12,329,327	11,621,352	707,975	6.09%
Total operating revenue	**56,210,872**	**6,753,808**	**13.66%**	**465,583,782**	**416,433,921**	**49,149,861**	**11.80%**
Operating expenses:							
Salaries and wages	17,652,762	1,068,838	6.45%	140,817,792	136,641,507	4,176,285	3.06%
Compensated absences	2,954,067	709,217	31.59%	25,243,808	26,088,064	(844,256)	-3.24%
Employee benefits	8,567,240	812,694	10.48%	64,736,813	63,306,664	1,430,149	2.26%
Supplies, food, and linen	8,966,955	2,370,384	35.93%	69,239,354	57,240,319	11,999,035	20.96%
Purchased department functions	3,730,508	(94,771)	-2.48%	30,784,758	30,602,262	182,496	0.60%
Medical fees	2,942,924	457,287	18.40%	20,729,844	19,885,098	844,746	4.25%
Other fees	1,523,983	(130,261)	-7.87%	15,020,769	13,881,120	1,139,649	8.21%
Depreciation	2,694,386	155,497	6.12%	20,589,344	19,188,846	1,400,498	7.30%
All other expense	1,709,803	(166,078)	-8.85%	14,660,720	15,777,548	(1,116,828)	-7.08%
Total operating expenses	**50,742,628**	**5,182,806**	**11.38%**	**401,823,202**	**382,611,427**	**19,211,775**	**5.02%**
Income from operations	**5,468,244**	**1,571,002**	**40.31%**	**63,760,580**	**33,822,494**	**29,938,086**	**88.52%**
Non-operating income:							
Donations	1,270,081	1,061,748	509.64%	5,515,323	1,666,667	3,848,656	230.92%
Property taxes	476,714	(0)	0.00%	3,813,715	3,813,715	0	0.00%
Investment income	3,985,637	2,094,464	110.75%	13,928,137	15,129,385	(1,201,248)	-7.94%
Income from subsidiaries	(4,656,297)	466,925	-9.11%	(37,128,197)	(40,985,777)	3,857,580	-9.41%
Total non-operating income	**1,076,135**	**3,623,136**	**-142.25%**	**(13,871,022)**	**(20,376,010)**	**6,504,988**	**-31.92%**
Operating and non-operating income	**$ 6,544,379**	**$ 5,194,138**	**384.68%**	**$ 49,889,558**	**$ 13,446,484**	**36,443,074**	**271.02%**

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

	Month of February		Eight months to date		
	2024	2025	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	33	39	278	288	10
Other Admissions	71	89	643	673	30
Total Admissions	104	128	921	961	40
Medi-Cal Patient Days	52	66	445	542	97
Other Patient Days	111	141	1,065	998	(67)
Total Patient Days of Care	163	207	1,510	1,540	30
Average Daily Census	5.8	7.4	6.2	6.3	0.1
Medi-Cal Average Days	1.6	1.8	1.7	2.1	0.4
Other Average Days	0.8	1.5	1.7	1.5	(0.2)
Total Average Days Stay	1.6	1.6	1.7	1.7	(0.0)
ADULTS & PEDIATRICS					
Medicare Admissions	354	404	3,001	3,086	85
Medi-Cal Admissions	296	281	2,114	2,286	172
Other Admissions	349	300	2,353	2,525	172
Total Admissions	999	985	7,468	7,897	429
Medicare Patient Days	1,490	1,474	12,223	11,612	(611)
Medi-Cal Patient Days	1,090	1,106	8,610	8,804	194
Other Patient Days	771	745	7,404	6,119	(1,285)
Total Patient Days of Care	3,351	3,325	28,237	26,535	(1,702)
Average Daily Census	119.7	118.8	116.2	109.2	(7.0)
Medicare Average Length of Stay	4.3	3.8	4.1	3.8	(0.3)
Medi-Cal AverageLength of Stay	3.6	3.3	3.5	3.4	(0.2)
Other Average Length of Stay	2.3	1.9	2.5	1.9	(0.6)
Total Average Length of Stay	3.4	3.0	3.4	3.0	(0.4)
Deaths	20	26	205	213	8
Total Patient Days	3,514	3,532	29,747	28,075	(1,672)
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 February and eight months to date

	Month of February		Eight months to date		
	2024	2025	2023-24	2024-25	Variance
PATIENT DAYS BY LOCATION					
Level I	214	292	1,950	1,990	40
Heart Center	317	292	2,621	2,585	(36)
Monitored Beds	594	575	4,947	4,541	(406)
Single Room Maternity/Obstetrics	267	360	2,457	2,815	358
Med/Surg - Cardiovascular	829	839	6,655	6,949	294
Med/Surg - Oncology	264	261	2,229	2,144	(85)
Med/Surg - Rehab	423	453	3,674	3,698	24
Pediatrics	114	119	1,058	959	(99)
Nursery	163	207	1,510	1,540	30
Neonatal Intensive Care	48	134	922	854	(68)
PERCENTAGE OF OCCUPANCY					
Level I	56.76%	80.22%	61.48%	62.74%	
Heart Center	72.87%	69.52%	71.61%	70.63%	
Monitored Beds	75.86%	76.06%	75.09%	68.93%	
Single Room Maternity/Obstetrics	24.88%	34.75%	27.22%	31.18%	
Med/Surg - Cardiovascular	63.52%	66.59%	60.61%	63.29%	
Med/Surg - Oncology	70.03%	71.70%	70.27%	67.59%	
Med/Surg - Rehab	56.10%	62.23%	57.91%	58.29%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	21.84%	23.61%	24.09%	21.84%	
Nursery	34.06%	44.81%	18.75%	19.13%	
Neonatal Intensive Care	15.05%	43.51%	34.35%	31.82%	

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

	Month of February		Eight months to date		
	2024	2025	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	100	136	853	958	105
C-Section deliveries	24	45	273	304	31
Percent of C-section deliveries	24.00%	33.09%	32.00%	31.73%	-0.27%
OPERATING ROOM					
In-Patient Operating Minutes	12,783	16,604	125,698	144,050	18,352
Out-Patient Operating Minutes	29,168	32,427	233,891	275,963	42,072
Total	41,951	49,031	359,589	420,013	60,424
Open Heart Surgeries	6	9	86	91	5
In-Patient Cases	96	108	905	941	36
Out-Patient Cases	278	296	2,314	2,596	282
EMERGENCY ROOM					
Immediate Life Saving	44	42	288	268	(20)
High Risk	811	826	6,015	6,840	825
More Than One Resource	2,445	2,703	22,253	22,439	186
One Resource	1,624	1,782	15,158	14,298	(860)
No Resources	51	40	699	572	(127)
Total	4,975	5,393	44,413	44,417	4

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

	Month of February		Eight months to date		
	2024	2025	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	11,388	11,125	103,405	98,409	-4,996
Out-patient requisitions	10,467	10,123	82,498	86,549	4,051
Emergency room requisitions	648	430	5,780	4,635	-1,145
Interdepartmental requisitions	6,270	7,102	52,749	54,871	2,122
Total requisitions	28,773	28,780	244,432	244,464	32
LABORATORY					
In-patient procedures	33,969	35,774	292,671	284,764	-7,907
Out-patient procedures	39,448	43,813	207,188	350,997	143,809
Emergency room procedures	12,208	12,246	103,021	100,267	-2,754
Total patient procedures	85,625	91,833	602,880	736,028	133,148
BLOOD BANK					
Units processed	230	230	2,333	2,230	-103
ELECTROCARDIOLOGY					
In-patient procedures	1,103	1,125	8,788	8,947	159
Out-patient procedures	382	510	3,142	3,411	269
Emergency room procedures	1,297	1,310	9,740	10,297	557
Total procedures	2,782	2,945	21,670	22,655	985
CATH LAB					
In-patient procedures	132	122	973	1,053	80
Out-patient procedures	140	125	946	976	30
Emergency room procedures	0	0	0	1	1
Total procedures	272	247	1,919	2,030	111
ECHO-CARDIOLOGY					
In-patient studies	366	387	3,032	3,158	126
Out-patient studies	305	300	2,242	2,642	400
Emergency room studies	1	1	8	13	5
Total studies	672	688	5,282	5,813	531
NEURODIAGNOSTIC					
In-patient procedures	116	159	1,026	1,112	86
Out-patient procedures	23	18	151	196	45
Emergency room procedures	0	0	0	1	1
Total procedures	139	177	1,177	1,309	132

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

	Month of February		Eight months to date		
	2024	2025	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	0	0
Out-patient procedures	244	302	1,882	2,247	365
Emergency room procedures	0	0	0	0	0
Total procedures	244	302	1,882	2,247	365
RADIOLOGY					
In-patient procedures	1,218	1,325	10,486	10,415	-71
Out-patient procedures	428	461	3,209	3,509	300
Emergency room procedures	1,419	1,483	11,819	12,525	706
Total patient procedures	3,065	3,269	25,514	26,449	935
MAGNETIC RESONANCE IMAGING					
In-patient procedures	139	134	1,121	1,409	288
Out-patient procedures	99	123	895	859	-36
Emergency room procedures	1	5	50	50	0
Total procedures	239	262	2,066	2,318	252
MAMMOGRAPHY CENTER					
In-patient procedures	3,665	4,254	32,661	29,548	-3,113
Out-patient procedures	3,617	4,235	32,268	29,452	-2,816
Emergency room procedures	0	0	9	9	0
Total procedures	7,282	8,489	64,938	59,009	-5,929
NUCLEAR MEDICINE					
In-patient procedures	24	11	163	127	-36
Out-patient procedures	147	148	891	1,056	165
Emergency room procedures	0	0	2	2	0
Total procedures	171	159	1,056	1,185	129
PHARMACY					
In-patient prescriptions	78,997	77,810	674,873	636,533	-38,340
Out-patient prescriptions	15,685	16,407	125,734	133,526	7,792
Emergency room prescriptions	9,066	9,482	73,911	79,063	5,152
Total prescriptions	103,748	103,699	874,518	849,122	-25,396
RESPIRATORY THERAPY					
In-patient treatments	13,289	15,859	129,802	120,540	-9,262
Out-patient treatments	1,159	1,547	8,751	7,619	-1,132
Emergency room treatments	493	614	4,080	4,376	296
Total patient treatments	14,941	18,020	142,633	132,535	-10,098
PHYSICAL THERAPY					
In-patient treatments	2,186	2,289	19,868	18,504	-1,364
Out-patient treatments	297	326	2,139	2,068	-71
Emergency room treatments	0	0	0	0	0
Total treatments	2,483	2,615	22,007	20,572	-1,435

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

	Month of February		Eight months to date		
	2024	2025	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,420	1,610	11,403	11,651	248
Out-patient procedures	262	262	1,949	1,707	-242
Emergency room procedures	0	0	0	0	0
Total procedures	1,682	1,872	13,352	13,358	6
SPEECH THERAPY					
In-patient treatments	508	483	4,090	4,224	134
Out-patient treatments	46	59	318	304	-14
Emergency room treatments	0	0	0	0	0
Total treatments	554	542	4,408	4,528	120
CARDIAC REHABILITATION					
In-patient treatments	1	2	11	6	-5
Out-patient treatments	581	531	4,118	4,798	680
Emergency room treatments	0	0	0	1	1
Total treatments	582	533	4,129	4,805	676
CRITICAL DECISION UNIT					
Observation hours	319	199	2,540	1,985	-555
ENDOSCOPY					
In-patient procedures	83	89	605	658	53
Out-patient procedures	47	45	444	450	6
Emergency room procedures	0	0	0	2	2
Total procedures	130	134	1,049	1,110	61
C.T. SCAN					
In-patient procedures	702	741	5,739	6,045	306
Out-patient procedures	325	511	2,811	3,994	1,183
Emergency room procedures	684	665	5,797	5,848	51
Total procedures	1,711	1,917	14,347	15,887	1,540
DIETARY					
Routine patient diets	20,648	14,417	138,745	125,684	-13,061
Meals to personnel	26,488	30,048	225,902	280,075	54,173
Total diets and meals	47,136	44,465	364,647	405,759	41,112
LAUNDRY AND LINEN					
Total pounds laundered	91,546	94,732	774,597	781,868	7,271

Medical Executive Committee Summary – March 13, 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Kogan, Rosalie, MD	Internal Medicine	Medicine	Hospitalist – Adult:
Rho, Junsung, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging-Non-Cardiac Diagnostic Radiology: Remote
Singh, Gurbir, MD	Nephrology	Medicine	Nephrology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Armfield, Derek, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging-Non Cardiac Diagnostic Radiology: Remote
Bain, Lisa, MD	Neonatology	Pediatrics	Tele-Neonatology
Beck, Rachel, MD	Ob/Gyn	Ob/Gyn	Gynecology and Obstetrics
Berkowitz, Richard, MD	Radiology	Surgery	Salinas Valley Health Imaging: Diagnostic Imaging
Bernstein, Jesse, MD	Physical Medicine and Rehabilitation	Medicine	Medicine- Active Community
Bird, Christopher, MD	Neurology	Medicine	Neurology
Bonifacio, Sonia, MD	Neonatology	Pediatrics	Tele-Neonatology
Cabrera, Rolando, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Chitkara, Ritu, MD	Neonatology	Pediatrics	Tele-Neonatology
Chock, Valerie, MD	Neonatology	Pediatrics	Tele-Neonatology
Davis, Alexis, MD	Neonatology	Pediatrics	Tele-Neonatology
Fuerch, Janene, MD	Neonatology	Pediatrics	Tele-Neonatology
Grogin, Harlan, MD	Cardiac Electrophysiology	Medicine	Cardiology Cardiac Electrophysiology Salinas Valley Health Advanced Imaging – Cardiac Imaging Salinas Valley Health Cardiovascular Diagnostics
Guzman, Jose, MD	Anesthesiology	Anesthesiology	Anesthesiology
Halamek, Louis, MD	Neonatology	Pediatrics	Tele-Neonatology
Jalali, Maryam, MD	Pediatrics	Pediatrics	Pediatrics.
Kaur, Navneet, MD	Family Medicine	Medicine	Hospitalist – Adult
Kumbhat, Neha, MD	Neonatology	Pediatrics	Tele-Neonatology
Lagana, Vittorio, DPM	Podiatric Surgery	Surgery	Podiatry: Core A and Core B
Mohammad, Shuaib, MD	Interventional Radiology	Surgery	Salinas Valley Health Diagnostic Imaging Vascular and Interventional Radiology Peripheral Endovascular Radiology Salinas Valley Health Advanced Imaging – Non-Cardiac

Paik, Aimee MD	Dermatology	Medicine	Medicine – Active Community
Penalver, Alberto, MD	Psychiatry	Medicine	Tele-Psychiatry
Prince, Lawrence, MD	Neonatology	Pediatrics	Tele-Neonatology
Profit, Jochen, MD	Neonatology	Pediatrics	Tele-Neonatology
Pruthi, Asit, MD	Ophthalmology	Surgery	Ophthalmology
Ragavan, Nilima, MD	Neonatology	Pediatrics	Tele-Neonatology
Rao, Anoop, MD	Neonatology	Pediatrics	Tele-Neonatology
Reiss, Jonathan, MD	Neonatology	Pediatrics	Tele-Neonatology
Rhine, William, MD	Neonatology	Pediatrics	Tele-Neonatology
Rohira, Ashish, MD	Internal Medicine	Medicine	Hospitalist – Adult
Scala, Melissa, MD	Neonatology	Pediatrics	Tele-Neonatology.
Taylor, Colleen, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Yamada, Nicole, MD	Neonatology	Pediatrics	Tele-Neonatology

Staff Status Modifications:

NAME	SPECIALTY	STATUS
Bird, Christopher, MD	Neurology	Advance to Active Status
Lekic, Tim, MD	Tele-Neurology	Resignation effective 2/7/2025
Stahl, Mark, MD	Tele-Neurology	Resignation effective 2/14/2025

Privilege Modifications:

NAME	SPECIALTY	PRIVILEGE
Klick, Anastasia, MD	Family Medicine	Relinquished Hospitalist – Adult

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

ITEM	RECOMMENDATION
Family Medicine – Clinical Privilege Delineation Revisions	1) The addition of OB Safety Drills to Reappointment Criteria for Category I & II Obstetrics 2) The revision of Initial Appointment criteria to Category I & II Obstetrics
Obstetrical & Gynecology – Clinical Privilege Delineation Revision	Include the addition of OB Safety Drills to the Reappointment Criteria
OB Hospitalist Clinical Privilege Delineation Revision	Included the addition of OB Safety Drills to the Reappointment Criteria
Vascular Surgery – Clinical Privilege Delineation Revisions	Included the addition of Vascular Ultrasound Interpretation to Core for Vascular surgeons who completed residency training in 2015 or later as well as the addition of this privilege as a Special Procedure for those with residency training prior to 2015.

Interdisciplinary Practice Committee

Initial Appointments:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Shaffer, Kylie, NP	Gastroenterology	Medicine	Jeffrey Fiorenza, MD Daniel Luba, MD Michael Mendoza, MD

Reappointments:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Massing, Thomas, PA-C	Cardiothoracic & Vascular Surgery	Surgery	Vincent DeFilippi, MD Andreas Sakopoulos, MD

Modification/Addition of Privileges:

NAME	SPECIALTY	PRIVILEGE
Magana, Isabelle PA-C	Cardiology	Relinquished Cardiology Ambulatory Care Privileges

Policies and Plans:

1. Admission Assessment – Newborn
2. Cord Blood
3. Dispensing Oral Alcohol in the Inpatient Setting
4. Hazardous Drug Handling
5. Medication Error Reduction Program Plan
6. Medication Reconciliation
7. Transitions of Care Pharmacy Program

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Transfusion Committee
d. Quality and Safety Committee
    - Transfusion Committee
    - Patient Safety Fair

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings February 2025
c. Medical Staff Treasury Report March 10, 2025
d. Medical Staff Statistics Year to Date
e. Financial Update January 2025
f. HCAHPS Update March 3, 2025

Status **Pending** PolicyStat ID **15983653**

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

Admission Assessment - Newborn

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in providing appropriate and consistent admission and stabilization care to newborn infants.

III. DEFINITIONS

A. Focused assessment: a head to toe visual assessment that includes the five components of the APGAR score as well as vital signs.

B. APGAR Score: a simple and repeatable method to quickly and summarily assess the health of a newborn. Five criteria are scored on a scale from zero to two, and then summing up the five values provides the APGAR score at one minute of age and again at five minutes of age.

IV. GENERAL INFORMATION

A. All infants will receive the same standard admission procedures described in this policy. Stable, term infants should be admitted and recovered in the mother's room. Infants requiring a higher level of care are cared for in the NICU.

B. If a newborn requires a higher level of care or observation, Refer to NICU Policy and Procedure, ADMISSION CRITERIA FOR NEONATAL INTENSIVE CARE NURSERY CLINICAL PROCEDURE.

C. The newborn may be transitioned/observed in the NICU up to four (4) hours pending physician evaluation for return to routine care or admission to the NICU. Refer to ADMISSION CRITERIA FOR THE WELL NEWBORN (LEVEL I) NURSERY CLINICAL PROCEDURE

D. Refer to the following Policies and Procedures as needed:

1. Resuscitation: NEWBORN RESUSCITATION

2. Identification of Infants: NEONATES - IDENTIFICATION, SECURITY AND PREVENTION OF ABDUCTION

V. PROCEDURE

A. Standard Precautions

B. Equipment:

1. Servo-controlled radiant warming bed (stabilette or radiant warmer with crib)
    a. Pre-warm infant's bed prior to delivery/admission.

C. Initial Care:

1. Receive infant and dry, stimulate per NRP while physician performs delayed cord clamping. If infant is not stable and warrants resuscitative effort, transfer care to the pre-warmed radiant warmer.
2. In the delivery room, place both identification bands on infant's legs. Verify correct information prior to placement.
3. Weigh and measure infant and document in the electronic health record (EHR) after the initial skin to skin period:
    a. Weight (grams)
    b. Length (cm)
    c. Head circumference (cm)
4. Admission/Stabilization Assessments/Vital Signs:
    a. A Registered Nurse (RN) will complete a focused assessment within 15 minutes of birth. This can be accomplished while newborn is skin to skin.
    b. Repeat vital signs at least once every thirty (30) minutes until the infant's condition has remained stable for two (2) hours.
    c. Complete RAPP Assessment once every fifteen (15) minutes until the infant's condition has remained stable for two hours.
        i. Newborns being admitted or monitored in the Neonatal Intensive Care Unit, do not need RAPP assessment completed.
5. For the well newborn: A RN will complete an admission physical assessment and review of maternal history within two (2) hours of birth after initial skin to skin period.
6. Infants admitted to the NICU: A RN will complete a focused assessment upon admission with reassessments at an interval consistent with the acuity of the infant's condition. A complete physical assessment and review of maternal history is done and documented within one (1) hour of admission.
7. Assess intrauterine growth status: (LGA – Large for Gestational age, SGA – Small for Gestational Age, and gestation using a gestational age assessment tool, Estimated Date of Confinement (EDC) and growth chart as needed.
8. Evaluate the neonate's status and assess for risk factors including, but not limited

to: SGA, LGA, IUGR, Infant of Diabetic Mother, birth weight < 2250 gms, gestational age < 36.0 weeks or > 42.0 weeks, respiratory distress/disease, cardiac disease, functional anomalies, five (5) minute Apgar score < 7, extensive resuscitation, seizures or neurologic abnormalities, maternal drug exposure and sepsis.

9. Obtain bedside blood glucose levels if indicated. Refer to PERINATAL SERVICE: BLOOD GLUCOSE MANAGEMENT/TREATMENT STANDARDIZED PROCEDURE
10. Initiate Feeding
    a. Determine mother's preference to breast milk or formula feed her infant. BREASTFEEDING THE NEWBORN
    b. Assess the infant's ability to coordinate suck, swallow and breathing.
    c. Infants are encouraged to breast feed immediately after delivery based on condition.
    d. Formula feeding infants may be fed within two (2) hours of delivery.
    e. Sick or NICU infants should not be fed until condition stabilized and physician orders are written.
11. Give Vitamin K injection and Erythromycin eye ointment within 1 hour of age or as soon as initial breastfeeding session completed (per physician's order. Refer to EYE PROPHYLAXIS CLINICAL PROCEDURE.
12. Give Hepatitis B vaccine 10 mcg IM within two (2) hours of birth after parental confirmation.
13. Evaluate mother's hepatitis status and give HBIG if indicated. Refer to HEPATITIS B IMMUNOPROPHYLAXIS IN THE NEWBORN CLINICAL PROCEDURE
14. Complete infant's footprints:
    a. Use a disposable footprint set.
    b. Unstable infants will be foot-printed as their conditions allow.
15. Bath:
    a. Initial bath is to be delayed at least 8 hours after birth.
16. Bathe infant with parental assistance in order to facilitate newborn education. Bathe infant using swaddled immersion technique.
    a. Well infant cord care consists of natural drying. It is ok to immerse for bath, recommended to keep open to air after bath to facilitate drying. If soiled, clean with water soaked gauze.
17. For a newborn in the NICU, umbilical cord care may be held and normal saline soaked gauze in anticipation of possible umbilical line placement.
    a. Purpose: To use natural drying for cord care. Natural drying involves keeping the cord area clean and dry without the routine application of topical agents.
18. Wash hands before handling the umbilical cord.

19. Keep the diaper folded under the cord stump.
20. Parent Teaching
    a. Instruct parent(s)/legal guardian(s) on umbilical cord care that includes:
        i. Frequently change baby's diaper and inspect the cord.
        ii. The umbilical cord stump and surrounding skin surface can be cleaned during the initial bath and as part of routine bathing. A systematic review on newborn bathing practices found that bathing does not delay cord healing or increase infection rates in healthy term newborns
        iii. If the cord is moist or soiled, instruct them to use a clean cloth/ gauze, wash the area with soap and warm water and then wipe dry.
        iv. Fold diaper below the stump to expose to air and not to urine.
        v. If temperature permits dress baby only in diaper and loose T-shirt raised above the umbilicus.
        vi. Any necessary clothing needs to be loose fitting to avoid rubbing/irritating the cord. Avoid body style undershirts until the cord has fallen off.
21. Admission Physical Exams:
    a. Well Newborns: Infant's physician should examine the apparently normal neonate no later than twenty-four (24) hours after birth. Nursing personnel will notify newborn's physician per physician preference,
    b. Per the NEONATAL INTENSIVE CARE STRUCTURE STANDARD, infants in the NICU will be examined within one (1) hour of admission. Stable neonates admitted based on Gestational Age (i.e., 35 weeks) and/or Weight Criteria (i.e., < 2250 grams and/or SGA) may be initially evaluated after delivery/admission following discussion with the NICU Charge Nurse. Nursing personnel to notify physician of the admission and the infant's status.
22. NICU Patients:
    a. Place infant on servo-controlled intensive care radiant warmer.
    b. Place cardiorespiratory and oxygen saturation monitors on infant.
    c. Complete a systems assessment and vital signs including non-invasive blood pressure and bedside blood glucose level.
    d. If immediate need for oxygen is apparent, as indicated by cyanosis or oxygen saturation (per pulse oximeter monitor), RN may administer emergency free flow oxygen. Refer to NICU: OXYGEN ADMINISTRATION AND MONITORING.
    e. Is infant stable initiate skin to skin contact in NICU. SKIN-TO-SKIN CONTACT IN THE NICU Notify physician of infant's condition and

admission to NICU.

23. Parent Education
    a. Explain procedures and infant's condition to parents.
    b. Family involvement in the plan of care begins at the time of admission.
    c. Give welcome packet.

D. Documentation:
    1. Document assessment and interventions in the electronic health record.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Guidelines for Perinatal Care. (8th ed. Copyright October 2017). A Joint Publication of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. Association of Women's Health, Obstetric and Neonatal Nurses,(2018). Evidence-based clinical practice guideline: Cord care. Neonatal Skin Care: Evidence-Based Clinical Practice Guideline (4th ed.) Washington D.C.: AWHONN.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
NICU Med Dir	Robert Castro: PHYSICIAN	03/2025
Dept. of OB/GYN	Katherine DeSalvo: Director Medical Staff Services	02/2025
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Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Daniela Jago: Clinical Manager	12/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16212434**

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

Cord Blood

I. POLICY STATEMENT

A. All cord blood specimens sent to the Laboratory must be properly labeled. LABELING OF SPECIMENS

II. PURPOSE

A. To guide nursing personnel in proper method of obtaining a cord blood specimen.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Equipment
   1. One (1) lavender or pink top tube.
   2. Patient identification labels (newborn's label). See PATIENT IDENTIFICATION POLICY.

B. Obtaining Specimen:
   1. Contact Lab for specimen collection requirements for any tests outside of the order set.
   2. Standard Precautions
   3. The delivery RN will obtain cord blood specimen and transfer the specimen tubes as

quickly as possible to avoid coagulation.

4. The delivery RN will label the cord blood with the newborn's TBB (To Be Born) label and add their first initial and last name or Meditech Mnemonic, date and time. See LABELING OF SPECIMENS
    a. If patient labels are not available at the time the specimen has been obtained, the delivery RN will use a blank label and write the patient's name and date of birth.
        i. First initial and last name or Meditech Mnemonic of RN collecting specimen, date and time will be added to the blank label
5. For Rh negative mothers, the Newborn Admission order set will have the required lab test to be ordered.
6. For all deliveries, the delivery RN will ensure proper labeling of the cord blood specimen. The RN or OB tech will send specimen to the Laboratory.

C. Documentation: N/A

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
NICU Med Dir	Robert Castro: PHYSICIAN	03/2025
Dept. of OB/GYN	Katherine DeSalvo: Director Medical Staff Services	02/2025
Women's & Children's Service Director	Julie Vasher: Director Women's & Children's Services	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025

Policy Owner	Daniela Jago: Clinical Manager	12/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17114432**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	2 years after approval	Area	Pharmacy

Dispensing Oral Alcohol in the Inpatient Setting

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide oral alcohol for inpatients (21 years and older) at Salinas Valley Health Medical Center.

III. DEFINITIONS

A. For the purposes of this program, the definition of single-dose oral alcohol includes:
   1. Beer (12 oz)
   2. Hard liquor (1 oz)
   3. Wine (5 oz)

B. CSM: Controlled Substance Manager

C. eMAR: Electronic Medication Administration Record

D. ABC: Alcoholic Beverage Control license

IV. GENERAL INFORMATION

A. DISPENSING: Single-dose oral alcohol will be dispenced based on the discretion of providers caring for inpatients at Salinas Valley Health Medical Center. Families and visitors are not permitted to supply alcohol to the patient.

B. PROCUREMENT: Materials Management will be responsible for the purchase and procurement of single-dose oral alcohol under the hospital's ABC license.

C. STORAGE: Oral alcohol will be handled as a controlled substance. As such, the Pharmacy will

be responsible for the secure storage of single-dose oral alcohol in the CSM.

V. PROCEDURE

1. Provider will enter the order for oral alcohol using appropriate order set.
2. Pharmacist will review and verify the order set.
3. Single-dose oral alcohol will be dispensed from the CSM under a patient-specific label.
4. RN will pick up the single-dose oral alcohol from the Pharmacy.
5. Administration will be documented by scanning the patient and the associated barcode in the eMAR.
6. Waste shall be recorded and documented as per the Controlled Substance and Drug Diversion Management policy.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. California Department of Alcoholic Beverage Control: https://www.abc.ca.gov/law-and-policy/legislation/abc-act/ (Accessed on November 5, 2024).

Approval Signatures

Step Description	Approver	Date
Pharmacy & Therapuetics	Kiri Golleher: Pharmacy Clinical Coordinator	Pending
Pharmacy & Therapuetics	Genevieve delos Santos: Director Pharmacy	03/2025
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Policy Owner	Genevieve delos Santos: Director Pharmacy	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16470295**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	3 years after approval	Area	Pharmacy

Hazardous Drug Handling

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To define procedures that promote patient safety, worker safety, and environmental protection when handling hazardous drugs (HDs) (i.e. receiving, storing, compounding/manipulating, dispensing, administering, and disposing) from the point of entry into the facility to the point of disposal.

B. Personnel

- Medical Staff
- Pharmacy staff
- Nursing staff
- Clinical and non-clinical staff with potential exposure to hazardous drugs

III. DEFINITIONS

A. **Hazardous Drug (HD)**: As defined by the NIOSH Working Group, drugs considered hazardous include those that exhibit one or more of the following six characteristics in humans or animals:

- Carcinogenicity
- Teratogenicity or other developmental toxicity
- Reproductive toxicity in humans
- Organ toxicity at low doses in humans or animals
- Genotoxicity

- Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria

National Institute for Occupations Safety and Health (NIOSH) defines three groups of drugs:

- Group 1: Antineoplastic drugs (AHFS classification 10:00) [ASHP/AHFS DI 2016] These drugs represent an occupational hazard to health care workers and should always be handled with use of recommended engineering controls and personal protective equipment (PPE), regardless of their formulation (IV [intravenous], SC [subcutaneous], topical, tablet, or capsule).
- Group 2: Non-antineoplastic drugs that meet one or more of the NIOSH criteria for a hazardous drug.
- Group 3: Drugs that primarily pose a reproductive risk to men and women who are actively trying to conceive and women who are pregnant or breast feeding.

IV. GENERAL INFORMATION

A. Hazardous Drug (HD) Handling is in compliance with the adopted standards set forth in USP <800> by the California State Board of Pharmacy for *Hazardous Drugs – Handling in Healthcare Setting* and; USP <795> *Pharmaceutical Compounding Non-sterile Preparations* and USP <797>*Pharmaceutical Compounding Sterile Preparations* as appropriate.

B. The hospital identifies in writing its hazardous drugs.

C. The risks associated with handling hazardous drugs are communicated to all staff involved in accordance with the organization's Hazard Communication Program.

D. Safety Data Sheets are readily available to personnel handling HDs.

E. The hospital designates a qualified and trained individual to oversee compliance with adopted standards by the California State Board of Pharmacy for Hazardous Drug Handling standards and other applicable laws and regulations.

V. PROCEDURE

A. **Identification of Hazardous Drugs (HD)**

1. Hazardous drugs are identified based on the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings.
2. The facility maintains a list of the hazardous drugs that are handled in the hospital. **Attachment A**: Hazardous Drug List
3. The list of hazardous drugs identifies the HDs based on the three NIOSH groups.
    a. *Group 1:* Antineoplastic drugs
    b. *Group 2:* Non-antineoplastic drugs that meet one or more of the NIOSH criteria for a hazardous drug.
    c. *Group 3:* Drugs that primarily pose a reproductive risk
4. The hazardous drug list is reviewed and updated at least every 12 months and as

necessary as new drugs with hazard potential are brought into the facility.

5. New agents or dose forms used in the facility are reviewed for inclusion on the hospital's list.
6. When it is not possible to identify whether a drugs is considered hazardous, the drug is added to the hazardous drug list and managed in accordance with the appropriate category until additional information can be obtained.

B. **Containment Requirements**

1. HD active pharmaceutical ingredient (API) and antineoplastic agents requiring manipulation follow all of the containment requirements defined in USP<797> and USP <800> and adopted standards by the California State Board of Pharmacy.
2. Final dose forms that do not require additional manipulation other than counting or repacking do not require additional containment unless specified by the manufacturer, or if there are visual indicators of dust or leakage from packaging.
3. An assessment of risk is performed for other HDs to define alternate containment strategies and work place practices.

C. **Assessment of Risk**

1. The hospital performs a risk assessment for eligible hazardous drugs to determine alternate containment strategies, work place practices and required/recommended personal protective equipment (PPE).
2. The risk assessment considers at minimum:
    - Type of HD (i.e. antineoplastic, non-antineoplastic, reproductive risk only)
    - Dosage form
    - Risk of exposure
    - Packaging
    - Manipulation
3. The alternate containment strategies /work place practices determined by the assessment of risk are documented.
4. The assessment of risk is reviewed at least every 12 months and the review is documented.

D. **HD's Eligible for Risk Assessment**

1. Final dose forms of compounded HDs and commercially manufactured HDs that do not require manipulation other than counting or repacking (unless required by the manufacturer)

E. **HDs Not Eligible for Risk Assessment**

1. HD active pharmaceutical ingredients (API)
2. HD antineoplastics requiring manipulation

F. **Hazard Communication Program**

1. Employees who are in contact with any hazardous chemicals or products containing hazardous substances are informed and trained on appropriate handling and safety precautions in accordance with federal and state requirements.
2. A list of hazardous drug/substances present in the workplace is maintained.
3. Safety Data Sheets (DS's) for hazardous substances found in the workplace are maintained and readily available.
4. Documentation of employee's acknowledgement of hazardous drug risks is maintained.

G. **Responsibilities of Personnel Handling Hazardous Drugs**

1. The hospital designated qualified and trained individual understands the rationale for risk prevention policies, risk to himself and others, risk of noncompliance that may compromise safety, and responsibility to report potentially hazardous situations to the management team.
2. The individual is responsible for:
    - Developing and implementing appropriate procedures
    - Overseeing compliance
    - Ensuring competency of personnel
    - Ensuring environmental control of the storage and compounding areas
    - Overseeing facility monitoring
    - Maintenance of testing and sampling reports, including acting on results
3. All personnel who handle HDs are responsible for understanding the fundamental practices and precautions and for continually evaluating these procedures and the quality of final HDs to prevent harm to patients, minimize exposure to personnel, and minimize contamination of the work and patient-care environment.

H. **HD Handling Areas**

1. Signs designating the hazard are prominently displayed before the entrance to the HD handling areas.
2. Access to the HD handling areas is restricted to authorized personnel.
3. Designated areas are available for:
    - Receipt and unpacking
    - Storage of HDs
    - Non-sterile HD compounding
    - Sterile HD compounding

I. **Environmental & Engineering Control**

1. Environmental and engineering controls comply with local, state, and federal regulation and are in compliance with the standards set forth in USP <797> and USP <800> and adopted standards by the California State Board of Pharmacy for

Hazardous Drugs – Handling in Healthcare Settings, USP <795> *Pharmaceutical Compounding Non-sterile Preparations,* and USP <797> *Pharmaceutical Compounding Sterile Preparations*.

J. **Personal Protective Equipment (PPE)**

1. PPE is worn when handling HDs as defined in the facility SOPs based on the risk assessment of exposure and activity performed.
2. PPE is worn as defined by the SOPs during:
    - Receiving
    - Chemotherapy gloves
    - Storage
    - Transport (Chemotherapy Gloves)
    - Compounding (sterile and non-sterile)
        1. Gowns, head, hair, two pairs of shoe covers and two pairs of chemotherapy gloves are required for compounding sterile and non-sterile HDs
    - Administration
        1. Two pairs of chemotherapy gloves are required for administering antineoplastic HDs. Gowns shown to resist permeability by HDs are required when administering injectable antineoplastic HDs
    - Deactivation/decontamination, cleaning, and disinfecting
        1. Two pairs of chemotherapy gloves and impermeable disposable gown Additionally, eye protection and face shields if splashing is likely and if warranted by the activity, respiratory protection
    - Spill control
    - Waste disposal
3. PPE includes; gloves, gowns, head, hair shoe and sleeve covers, eye and face protection and respiratory protection.
4. Disposable PPE is preferred. Disposable PPE must not be re-used.
5. No Re-usable PPE will be used.
6. Gloves are American Society for Testing and Materials (ASTM) standard D6978 (or its successor) and are powder free.
7. Gowns are disposable and shown to resist permeability of HDs, close in the back, have long sleeves and closed cuffs.

K. **Receiving**

1. HDs are not unpacked from their external shipping containers in sterile compounding areas or in positive pressure areas.

2. Hazardous drugs are received in sealed, impervious plastic to segregate them from non-hazardous drugs.
3. Personal protective equipment (PPE), including chemotherapy gloves, is worn when receiving/unpacking hazardous drugs.
4. HDs are delivered to the HD storage area immediately after unpacking.
5. Prior to storing HDs, the outer surface of the product/packaging is wiped down (not sprayed) with a neutralizing solution to remove surface contaminants.
6. A spill kit is kept in the receiving area.
7. During the receiving process, each shipping container containing HDs is inspected for damage or breakage such as visible stains due to leakage or the sound of broken glass.

L. **Receiving and Handling Damaged HD Shipping Containers**

1. Damaged packages or shipping cartons are considered spills that must be reported to the designated person and managed according defined Standard Operating Procedures.
2. If damage is suspected, trained personnel wearing appropriate PPE:
    - Seal the container without opening and contact the supplier
    - If returning to the supplier, enclose the entire container in an impervious container and label as "hazardous".
    - If the container must be opened, the container is moved to a Containment Primary Engineering Control (C-PEC) and placed on a plastic backed preparation mat.
    - Remove undamaged items and wipe the outside with disposable wipes.
    - Place damaged items in an impervious container and label the outside "hazardous".
    - Dispose of in compliance with HD disposal policies.
    - The C-PEC is deactivated, decontaminated, and cleaned. The mat and all disposables are discarded as hazardous waste.
    - Segregate HDs waiting to be returned to the supplier in a designated negative pressure area.

M. **Storage**

1. Antineoplastic HDs requiring manipulation (other than counting or repackaging of final dosage forms) and any HD API are stored separately from non-HDs in an externally ventilated, negative-pressure room with at least 12 air changes per hour (ACPH).
2. Non-antineoplastic, reproductive risk only and final dosage forms of antineoplastic HDs may be stored with other inventory.
3. Drug packages, bins, shelves, and storage areas bear distinctive labels identifying those drugs requiring special handling precautions.

4. HDs are stored in bins with high fronts placed on shelves that have guards to prevent accidental falling.
5. HDs used for non-sterile compounding are not stored in sterile compounding areas.
6. Sterile and non-sterile HDs may be stored together, but HDs used for non-sterile compounding should not be stored in areas designated for sterile compounding to minimize traffic into the sterile compounding area.
7. Refrigerated antineoplastic HDs are stored in a dedicated refrigerator in a negative pressure area with at least 12 ACPH.
8. It is not recommended that hazardous drugs be stored in automated dispensing cabinets. If stored in automated dispensing cabinets, HDs have auxiliary labeling to alert staff of the need to refer to documents outlining proper handling and PPE.

N. **Preparation/Compounding**

1. *Required PPE for HD Compounding;* Gowns: head, hair, two pairs of shoe covers and two pairs of chemotherapy gloves are required for compounding sterile and non-sterile HDs
2. HDs are compounded in compliance with applicable USP standards for compounding including USP <797>.
3. Sterile and non-sterile HD compounding and HD manipulation occurs in a Containment Primary engineering control (C-PEC) inside a Containment Secondary Engineering Control (C-SEC) as defined by USP <797> and USP <800>.
4. The C-SEC used for sterile and non-sterile compounding is:
    - Externally vented
    - Physically separated (i.e., a different room from other preparation areas)
    - Has an appropriate air exchange (e.g., ACPH)
    - Negative pressure between 0.01 and 0.03 inches of water column relative to all adjacent areas
5. A sink is available for hand washing and an eyewash station and/or other emergency or safety precautions that meet applicable laws and regulations are readily available.
6. The C-PEC used for sterile compounding is not routinely used for non-sterile compounding or manipulation.
    - If occasionally used, the C-PEC is deactivated, decontaminated, cleaned, and disinfected prior to sterile compounding.
7. Disposable or clean equipment for compounding (such as mortars and pestles, and
spatulas) are dedicated for use with HDs only.
8. Closed system transfer devices (CSTD are used as a supplemental engineering control during the compounding of antineoplastic agents when the dosage form allows.

9. IV tubing is attached and primed with plain fluids before compounding antineoplastics.
10. CSTD are attached prior to removal from the C-PEC for use during administration of antineoplastic injectables.
11. Final preparation is surface decontaminated and the outer glove removed while still in the C-PEC. Labeling and placement in the containment bag for transport occurs prior to removal of the inner gloves.
12. Transport bags are not inside the C-PEC during the compounding process.
13. When compounding HD preparations in a C-PEC, a plastic-backed preparation mat is placed on the work surface of the C-PEC. The mat is changed immediately if a spill occurs and regularly during use, and is discarded at the end of the daily compounding activity.
14. Sharps containers and HD waste containers are sealed and surface decontaminated before removal from the biological safety cabinet or compounding aseptic isolator.

O. **Labeling**

1. HDs identified as requiring special HD handling precautions are clearly labeled at all times.
2. The labeling process for compounded preparations does not introduce contamination into the non-HD handling areas.

P. **Transportation**

1. HDs for transport are labeled, stored and handled in compliance with local, state and federal regulation
2. Transport personnel receive documented training on safe handling of HDs during transport and action to take in the event of a spill.
3. Pneumatic tubes systems are not used to transport any liquid HDs or any antineoplastic HDs.

Q. **Administration**

1. Two pairs of chemotherapy gloves are required for administering antineoplastic HDs. Gowns shown to resist permeability by HDs are required when administering injectable antineoplastic HDs
2. Closed system transfer devices (CSTD) are used when administering antineoplastics when the dosage form allows.
3. Administration is performed safely using protective medical devices and techniques.

R. **Disposal**

1. Personnel who perform routine custodial waste removal and cleaning activities in HD handling areas are trained in appropriate procedures to protect themselves and the environment to prevent HD contamination.

2. Disposal of all HD waste, including, but not limited to, unused HDs and trace contaminated PPE and other materials, comply with all applicable federal, state, and local regulations.

S. **Deactivation, Decontamination, Cleaning and Disinfecting**

1. Areas where HDs are handled and reusable equipment and devices are deactivated, decontaminated, and cleaned. Additionally, sterile compounding areas and devices are disinfected.
2. C-PEC with an area under the work tray are deactivated, decontaminated, and cleaned monthly.
3. Personnel who perform deactivation, decontamination, cleaning, and disinfection activities in HD handling areas are trained in appropriate procedures to protect themselves and the environment from contamination.
4. Personnel performing the cleaning will wear two pairs of chemotherapy gloves and impermeable disposable gown; additionally, eye protection and face shields if splashing is likely and if warranted by the activity, respiratory protection

T. **Deactivation**

1. Deactivation is performed to render compounds inactive or inert
2. Products with known deactivation properties (EPA registered oxidizers) are used when appropriate. Note: Avoid use when there is likelihood of adverse effects such as generation of hazardous byproducts, respiratory effects, and/or damage to surfaces.

U. **Decontamination**

1. HD residue is transferred from non-disposable surfaces to absorbent, disposable wipes, pads, or towels. Decontamination occurs:
    - Between compounding different hazardous drugs
    - Daily (when used)
    - When a spill occurs
    - Before and after certification
    - When voluntary interruption occurs
    - When (if) the ventilation tool is moved

V. **Cleaning**

1. Cleaning is performed in accordance with USP <797> requirements.
2. Cleaning is not performed while compounding activities are occurring.
3. Water, detergent, surfactants, solvents, and/or other chemicals are used to remove contaminants.
4. Cleaning products are chosen that do not introduce contaminants.
5. All materials used for cleaning are disposed of as hazardous waste.

W. **Disinfection**

1. Sterile compounding areas are disinfected after cleaning as defined by USP <797>.

X. **Spill Management**

1. Personnel authorized to clean up a spill of HDs receive training in spill management and the use of PPE and NIOSH certified respirators.
2. Spills are contained and cleaned immediately by qualified personnel wearing appropriate PPE.
3. Qualified personnel are available at all times while HDs are being handled.
4. Signs are available for restricting access to the spill area.
5. Spill kits containing the materials needed to clean HD spills are readily available in areas where HDs are routinely handled.
6. Spill materials are disposed of as hazardous waste.

Y. **Documentation and Standard Operating Procedures (SOPs)**

1. SOPs are reviewed at least every 12 months by the designated person and the review is documented.
2. SOPs for handling HDs address:
    - Hazardous Drug and NIOSH list risk assessment.
    - Receipt
    - Storage
    - Compounding
    - Use and maintenance of proper engineering controls (e.g., C-PECs, C-SECs, and CSTDs)
    - Hand hygiene and use of PPE based on activity (e.g., receipt, transport, compounding, administration, spill, and disposal)
    - Deactivation, decontamination, cleaning, and disinfection
    - Dispensing
    - Transport
    - Administering
    - Environmental monitoring (e.g., wipe sampling)
    - Disposal
    - Spill control

VI. EDUCATION/TRAINING

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

B. **Personnel Training**

Personnel handling HDs are trained based on their job functions (e.g., receipt, storage, compounding, repackaging, dispensing, administrating, and disposing of HDs). The training includes at least the following:

- Overview of the list of HDs and their risks
- Review of Standard Operating Procedures (SOPs) related to handling of HDs
- Proper use of Personal Protective Equipment (PPE)
- Proper use of equipment and devices (e.g., engineering controls)
- Response to known or suspected HD exposure
- Spill management
- Proper disposal of HDs and trace contaminated materials
- Training occurs before the employee independently handles HDs, when new HDs are brought into the facility, before new equipment is used, and when SOPs are added or change.
- Competency is assessed and documented *before* independently handling HDs and every 12 months

VII. REFERENCES

A. 2017 USP Compounding Compendium

Attachments

A: Hazardous Drug List

Hazardous Drug Assessment of Risk - Sample Alternative Containment Strategies

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	03/2025

CNO	Carla Spencer: Chief Nursing Officer	02/2025
P&T	Genevieve delos Santos: Director Pharmacy	02/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	01/2025
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

Status **Pending** PolicyStat ID **16893084**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	3 years after approval	Area	Plans and Program

Medication Error Reduction Program Plan

SCOPE

A. Since 2002, the California Department of Public Health (CDPH) has required every licensed general acute care hospital in California to establish a Medication Error Reduction Plan (MERP), referred to as the CA MERP. The Pharmacy Department, working collaboratively with the multidisciplinary Medication Safety Committee members, oversees the MERP and provides a process aimed at eliminating or significantly reducing medication-related errors.

B. Medication safety is maintained as a high priority by not only the Pharmacy Department but also the organization system wide. The Pharmacy Department takes a leadership role in evaluating and monitoring medication use throughout the institution as well as leading multidisciplinary committees on medication safety, including the Pharmacy and Therapeutics (P&T) Committee and the Medication Safety Committee, a sub-committee of the P&T Committee.

OBJECTIVES/GOALS

A. **Objectives**

1. The objectives of the MERP include actions and measurable steps targeted to achieve the goals of improving safe medication processes, eliminating or reducing medication-related errors and enhancing patient safety. Concurrent and retrospective review of clinical care is employed in determining the meaningful actions needed to promote the safe care of the patient.

A. **Goals**

1. The goal of the MERP at Salinas Valley Health Medical Center (SVHMC) is to ensure safe and accurate medication processes, while significantly reducing harmful medication-related errors, using a multifaceted approach (proactive, real-time, and retroactive), including encouraging the reporting of good catches/close calls (potential medication-related errors) to reporting medication adverse drug events, including medication errors. A robust MERP entails the identification and

implementation of methodologies to reduce medication-related errors with the goal of reducing harm and improving the quality of care and patient safety.

DEFINITIONS

A. N/A

PLAN MANAGEMENT

A. **Plan Elements**

1. The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) defines a medication error as: “any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring and use.” This standard definition is encouraged by the NCC MERP to be used by institutions and other groups to identify errors.
2. SVHMC uses methodologies to assess, improve, and evaluate medication safety processes. Examples include targeting high-leverage systems and technologies, involving interdisciplinary oversight, learning from external reports, and improving procedures and systems. These objectives include taking actionable and measurable steps targeted to achieve an impactful MERP program.
3. The framework of the MERP includes, but is not limited to the following:
    a. Maintaining a robust medication error reporting system.
    Review concurrent and retrospective features of medication use as well as identify medication system vulnerabilities that impact clinical care. Based on this review, make recommendations for improving the safety of medication-related processes by analyzing aggregate medication-related error data, adverse reaction data, and other events, using the organization’s robust electronic online Occurrence Reporting System, or other methods as indicated. Proactivly examine “good catches/close calls” in order to implement changes when needed is an essential practice to prevent medication errors.
    b. The organization’s Medication Safety Committee oversees the MERP. It is sub-committee of the Pharmacy and Therapeutics (P&T) Committee, meets every other month and analyzes actual or potential medication-related errors and advocates for actionable improvements in current procedures and systems. The Medication Safety Committee is a multidisciplinary team comprised of pharmacists, physicians, nurses, administrators, safety/quality, and risk management members, under the leadership of the Medication Safety Officer. (See Medication Safety Committee Charter.)
    c. Including thoughtfully planned implementation and reassessment of

technology to promote safe practices.

d. Employing effective and timely measurable assessments, including continuous improvement as a tool in monitoring systems, alerts, processes, and procedures.

e. Providing a proactive practice to risk identification analysis, identifying trends or patterns, to facilitate error reduction strategies. Components of the MERP include eleven (11) procedures of systems that are associated with medication use, as recommended by the Institute for Safe Medication Practices (ISMP).

f. Incorporating and learning from external medication-related error alerts, proactively ensuring system safety.

g. Including an annual review of the MERP to modify current processes and systems when needed to determine their effectiveness. When indicated, modifications to the MERP will be instituted.

B. **Plan Management**

1. REPORTING SYSTEMS AND MONITORING

a. SVHMC encourages prescribers, nurses, pharmacists, respiratory therapists, and other healthcare practitioners who identify actual and potential medication-related events to report them internally, using the organization's robust electronic online Occurrence Reporting System (WeCare). This system allows the option for anonymous reporting and shares these events to the proper parties for review and analysis.

b. The organization promotes a Just Culture of safety environment, which allows for a clear and transparent communication of errors in a nonpunitive environment, where employees are encouraged to be open about errors and near misses (good catches) and vulnerabilities in the system. Just Culture, a values-supportive system of shared responsibility, provides a framework to evaluate systems and behaviors to identify and fix these vulnerabilities in a fair and just manner. The risk may lie in flawed system design or from individual inadvertent human behavior, or a combination of both. Behaviors contributing to medication-related errors tend to fall into three main categories: human error, an inadvertent act that could happen to anyone; at-risk behavior, a risk believed to be justified because other colleagues do the same; reckless behavior, conscious disregard for the risk.

c. An annual review of the MERP is conducted, in order to assess the effectiveness of the plan for each of the eleven procedures and systems. This process is directed through the Medication Safety Committee, a sub-committee of the Physician and Therapeutics (P&T) Committee. The activities in the MERP, as well the analyses of medication errors, adverse reactions and trends, are evaluated by the Medication Safety Committee. During this review, if indicated, modifications may be made to promote positive outcomes.

d. When it is identified that healthcare employees require education in order to improve the safety of medication processes, a plan to implement the required educational programs is developed in conjunction with the appropriate department directors and the Education Department. The education may be provided in a variety of ways, including the examples listed below.

e. Medication safety information is communicated throughout the organization by multiple methods:

    i. Data is shared with the P&T Committee, Quality and Safety Committee, Medical Executive Committee, and the Board of Directors.

    ii. Recommendations are forwarded to the appropriate committee/ body for approval, including the P&T Committee, Nursing Leadership, and Education Department Director.

    iii. Focused in-services, including mandatory annual skills sessions, shift huddles, and weekly updates (emails sent to the staff from their managers) are performed.

    iv. "Written" information is communicated to the healthcare professionals within the organization via multiple mediums including, but not limited to:

        a. Organization-wide email system in which staff members are responsible for accessing and reviewing.

        b. New employee orientation, HealthStream (e-Learning) electronic online module, mandatory annual skills sessions, shift huddles, "weekly updates" sent to the staff from their managers.

        c. Weekly Information Notes (WIN Tip Sheets through email and health system intranet [STARnet]).

        d. Medical Staff quarterly department meetings, summaries of Medical Executive Committee meetings (posted on the STARnet intranet, under Physicians), as well as mass emails.

2. PROCEDURE

    a. The organization uses a multifaceted approach to proactively identify and implement methodologies to reduce medication-related errors and to improve the quality of care provided to patients. The process for identifying medication errors and risks includes prospective, concurrent (e.g., observation, including reports from staff) and retrospective review of patient care. Data is collected using the electronic online Occurrence Reporting System, an electronic online reporting system that documents adverse medication events, including medication-related errors and adverse drug reactions. Other means to identify actual or potential medication-related errors include the capture of pharmacy or nursing

interventions and the reporting of triggers.

b. Led by the Medication Safety Officer, the Medication Safety Committee members proactively review and incorporates information from the literature, peer-to-peer review of medication management systems in other hospitals, as well as external medication-related error alert sources into safety practices as an additional area of surveillance and vigilance. Examples of external reports include, but are not limited to: the Institute for Safe Medication Practices (ISMP), The Joint Commission (Sentinel Event Alert) newsletters, US Food and Drug Administration (FDA) Drug Alerts and Statements, National Alert Network, National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) Recommendations and Statements, American Society of Health-System Pharmacists (ASHP), the California State Board of Pharmacy, and the California Department of Public Health (CDPH).

c. This information is analyzed and reported to the Medication Safety Committee, providing interdisciplinary oversight, who conducts a timely review of these events, including those that have caused harm or may have the potential to cause harm. Under the leadership of the Medication Safety Officer, medication-related errors and risks are analyzed and weaknesses or deficiencies are identified. Methods employed in this analysis may include root cause analysis (RCA) and risk assessments. Once the root cause is identified, working with this multidisciplinary team is paramount to identifying and implementing appropriate solutions, including actionable changes to procedures and systems. Improvement plans then developed by the Medication Safety Committee are presented to the P&T Committee for discussion, approval, and implementation. This information is then reported to the Quality and Safety Committee, the Medical Executive Committee, and to the Board of Directors.

d. When it is identified that staff members require education in order to improve the safety of medication processes, a plan to implement the required educational programs is developed in conjunction with the appropriate Department Directors and the Education Department. Medication safety information is communicated throughout SVHMC in various ways, including:

    i. Data may be forwarded to the P&T Committee, Quality and Safety Committee, Medical Executive Committee, and to the Board of Directors.

    ii. Recommendations are forwarded to the appropriate committee/ body for approval, such as to the P&T Committee, Nursing Leadership, and Education Department Director.

    iii. Focused in-services, huddles, and/or HealthStream (electronic) education modules.

    iv. Written information may be communicated to staff via:

        a. Organization-wide email system whereby staff

members are responsible for accessing and reviewing.

b. Nursing Education modalities including new employee orientation, WIN Tip Sheets, HealthStream, mandatory annual skills sessions, shift huddles, and "weekly updates" sent to the staff from their managers.

c. Medical Staff quarterly department meetings, summaries of Medical Executive Committee meetings (posted on the STARnet intranet, under Physicians), and other updates.

e. The organization has adopted the California MERP initiatives, which include eleven (11) procedures and systems that are associated with medication use. SVHMC's Medication Use Policy provides more detailed information about these procedures and systems.

f. The organization has adopted a methodology to evaluate each of these procedures and systems in order to proactively identify actual or potential medication-related errors as well as to provide a concurrent and retrospective review to identify any weaknesses or deficiencies. The plan for each of these procedures and systems is reviewed annually to assess their effectiveness. When indicated, such as when weakness or deficiencies are found, the plan for the specific procedures and systems is modified. Improvement plans are shared with staff members and leadership for enhanced medication safety.

i. **ELEVEN (11) PROCEDURES AND SYSTEMS**

a. **Prescribing** - The process whereby a licensed or authorized prescriber orders a medication for a patient.

i. This includes order sets, order strings and individual medication orders, which are prescribed using electronic computerized provider order entry (CPOE) as well as faxed paper orders. The ordering of medications must comply with the required elements of a prescription, as mandated by the California Board of Pharmacy and The Joint Commission. During the prescribing process, medication orders must be legible; they must not contain abbreviations, inappropriate leading/trailing zeroes, ranges, and as needed (PRN) orders without indication or clear instruction of use.

b. **Prescription Order Communications** - The process where a prescription is communicated, clarified, transcribed (If necessary), and any other communications related to a prescription order. This

process may be via direct order by the provider or by means of a telephone order or verbal order to the licensed nurse/pharmacist when appropriate.

    i. This also includes communication of relevant information to the pharmacy necessary for medication order processing/ verification, such as allergies, age, current weight (using metric units), height, gender, and pertinent laboratory values. In addition, medication-related electronic alerts during prescription order entry, pharmacy validation or clinical administration related to allergies, therapeutic duplication, drug interactions, contraindications and critical laboratory values are important features that must be acknowledged during prescription order communications.

c. **Product Labeling** - Product Labeling refers to the label placed on a medication at any point in the process intended to be administered to a patient.

    i. The product label shall contain the patient's name, the location where the medication is to be delivered (e.g., the patient's room), as well as the directions for use and applicable accessory and cautionary instructions (e.g., refrigerate). This also includes the use of "Tall Man" (mixed case) lettering, "Look Alike Sound Alike" (LASA), and the notation of "High Alert" for medications designated as High Alert when feasible. The product shall contain the appropriate units, such as the metric system, where applicable.

d. **Packaging and Nomenclature** - Packaging and nomenclature include the process of preparing a product in a unit dose ready-to-administer package/ container.

    i. This includes the repackaging of bulk products to unit dose packages. Packaging may also include the use of barcodes, as applicable. Nomenclature involves the utilization of a standard unit of measurement (metric system) and approved "Tall Man "(mixed case) lettering, as well as "Look Alike Sound Alike" (LASA) designations, where applicable.

e. **Compounding** - The process of preparing a product not commercially available in the concentration ordered by the prescriber, preferably by the pharmacy.
    i. This involves utilizing a sterile compounding area as appropriate and expanding the availability of pre-made ready to use products when available. This includes employing standardized concentrations and beyond use dating pertinent to applicable rules, regulations, and laws.

f. **Dispensing** - The process of a pharmacist validating a prescriber order and selecting the correct medication to dispense to a patient, including oral, parenteral, and miscellaneous medications.
    i. This includes a process for verifying and using patient's own medications, where applicable.

g. **Distribution** - The process where a clinician obtains the medication on the unit to administer to the patient.
    i. This includes the use of automated dispensing cabinets (ADCs), emergency medication carts, as well as medication storage. The distribution process involves the pharmacy distribution system (centralized vs. decentralized) and the utilization of pharmacy satellites. Automated dispensing cabinet use provides a critical role in the distribution process. Pharmacy is responsible for the stocking of the ADCs, following requirements for Look Alike Sound Alike (LASA) and High Alert medications, monitoring medication expiration dates and temperatures, and providing a process for using the override function for selected medications. In addition, ADCs provide oversight for controlled substances, including handling, discrepancy, return, and diversion documentation and monitoring.

h. **Administration** - The process where the clinician administers the medication to the patient.
    i. This includes the use of barcode medication administration (BCMA) technology that involves the process of verification by

scanning the barcode on the medication and the patient identification wristband, providing enhanced patient safety. The process also includes the use of standard administration times, equipment modifications (such as tubing and administration sets), automated Smart Pump technology, and independent double checks (IDC) prior to medication administration as essential features to decrease adverse medication-related events.

i. **Education** - This includes education campaigns and programs targeted to any clinician involved in the medication use process.
    i. This includes tools intended to provide the clinician with medication-related information, such as UpToDate/Lexi-Comp, Micromedex, and other resources. This also includes education directed at the patient.

j. **Monitoring** - The process to monitor a particular step in the medication use process.
    i. This includes patient-specific monitoring, such as a response to a medication or pharmacokinetic drug dosing effects. This includes audits, rounds, as well as proactive, concurrent, and retrospective surveillance. Also included is the process of monitoring adverse drug events (medication errors and adverse drug reactions) and monitoring high alert or other medications with known potential for harm. In addition, monitoring includes specialists hired to review safety information on a local and national level.

k. **Use** - This encompasses all other practices, systems and procedures in the medication use process, including HIPAA (Health Insurance Portability and Accountability Act of 1996).
    i. This includes processes for handling chemotherapy or biohazard agents. This includes medication use evaluations, Core Measures, Root Cause Analysis (RCA), Failure-Mode-Effects Analysis (FMEA), and surveys. This may also include

computerized tools to review usage and document reasons for medication use. In addition, this involves the review of proper "uses" of medications, such those with off-label indications.

3. DOCUMENTATION
    a. The MERP plans developed at Salinas Valley Health since inception of the requirement are available for review.
4. SVHMC's Medication Safety Committee created a Charter to define the scope of its role in advocating for patient safety. See Attachment Medication Safety Committee Charter.

C. **Plan Responsibility**

1. The Director, Pharmacy has oversight for the implementation of the MERP Program.
2. The Chair, Pharmacy and Therapeutics Committee has oversight to assure the plan elements are initiated, implemented and monitored and actions are defined for any opportunities.
3. The Director, Pharmacy is assisted by other disciplines, including but not limited to , medical and nursing staff, dietitians and others as needed.

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of this Plan. Performance measures have been established to measure aspects of the MERP Plan.
2. On an annual basis, the Medication Safety Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at SVHMC.

E. **Orientation and Education**

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

F. SVHMC relevant policies and procedures

1. Pharmacy: Sterile Compounding: General Practices
2. Chemotherapy Administration of Parenteral and Oral Antineoplastic Agents
3. Central Vascular Access Devices
4. Hazardous Drug Handling
5. Look Alike, Sound Alike Medication Management
6. Medication Reconciliation
7. Patient's Own Medication Usage
8. Drug Procurement/Inventory Control
9. Automated Dispensing Machine Drug Distribution System

10. Transdermal Fentanyl Patch
11. Intravenous Administration of Hypertonic Sodium Chloride Solutions in Adult Patient Populations
12. Blood and Blood Product Administration
13. Patient Identification
14. Adverse Drug Reaction Program
15. Isolation - Standard and Transmission Based Precautions

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Attachments

Medication Safety Committee Charter 2023.pdf

Approval Signatures

Step Description	Approver	Date
Policy Owner	Genevieve delos Santos: Director Pharmacy	Pending

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16470342**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	3 years after approval	Area	Pharmacy

Medication Reconciliation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the process to obtain, maintain, reconcile and communicate accurate medication information for inpatients and relevant outpatients at Salinas Valley Health Medical Center (SVHMC).

III. DEFINITIONS

A. **Medication Reconciliation**: the process of compiling the most accurate list of medications that the patient is currently taking and comparing that list to the medications ordered by a prescriber to allow for the identification and resolution of discrepancies.

B. **Medication:** any prescription medication, samples, herbal remedies, vitamins, nutraceuticals, over-the-counter medications, diagnostic and contrast agents used on or administered to diagnose, treat or prevent disease or other abnormal conditions; radioactive medications, respiratory therapy treatments; parenteral nutrition; blood derivatives; intravenous solutions (plain, with electrolytes and or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug.

C. **Discrepancies:** defined as omissions, duplications, contraindications, or unclear/incomplete/ incorrect information.

D. **Qualified individual:** hospital employee or Licensed Independent Practitioner (LIP) who has met hospital requirements based upon orientation to their job description or licensing to participate in the medication reconciliation process.

E. **Outpatient settings:** locations such as Outpatient Diagnostic Imaging, Mammography Center, Wound Care Center, Cardiac Catheterization Laboratory, Cardiac Rehab Center, Outpatient Clinics/Centers on the SVHMC license, Infusion Care Services, Out-Patient Surgery (OPS) ,

Observation Care Unit (OCU), Sleep Center, and other diagnostic locations.

F. **Relevant Encounter:** an encounter in an inpatient or outpatient setting that performs medication reconciliation due to the potential or planned administration of medications or for other reasons determined as appropriate.

G. **Transition of Care:** interfacility movement of patient from SVHMC to another location (i.e. Long Term Care Facility, Home Health, Rehabilitation Facility or to another Health Care Facility).

H. **Modified Medication Reconciliation**: A revised approach to the medication reconciliation process that focuses on obtaining selective medication list or specific medications or classes of medications deemed relevant to the service being currently provided.

I. **Comprehensive medication list**: A medication list that includes the drug name, dose, route, and frequency for all the patient's medications.

J. **Selective medication list**: A medication list that may include 1) the collection of the drug name and dose, route, or frequency, 2) pertinent medications medically relevant to the provided service or setting, or 3) collection of no medication list.

IV. GENERAL INFORMATION

A. Medication reconciliation is a multidisciplinary process conducted in partnership with patients and families to ensure that medication reconciliation documentation reflects the current use of medications and is utilized to communicate accurate and complete information about the patients' medications across care transitions. A good faith effort is made to obtain this information.

B. Neonates/Newborns, who are newly delivered, are exempt from Admission Medication Reconciliation

V. PROCEDURE

A. Medication Reconciliation for Outpatient Settings

1. Information on medications the patient is currently taking will be obtained based on the information available when the patient is admitted to an outpatient setting, if possible. The comprehensive medication list would contain:
    a. Name of current medications include those taken at scheduled times and those taken on an as needed basis, including over-the-counter and herbal products.
    b. Strength, dose, frequency, route of medication
    c. The reason (purpose) for prn medications
2. The primary means of obtaining the patient's current medication information may include, but not limited to:
    a. Patient/Family/Caregiver interview
    b. Patient provided medication list
    c. Medication bottles/vials/containers

d. SVHMC Medical Records
e. Outside Medical Records
f. Surescript Database Resource (i.e. external medication history)

3. Information on medications the patient is currently taking will be documented in the electronic health record (EHR).
    a. The default medication list in all settings is the comprehensive medication list.
    b. The organization will identify specific areas to conduct a modified medication reconciliation, in which a comprehensive medication is not required. These specific areas will obtain a selective medication list.
        i. The use of selective medication list is subjective to the direction of the physician or licensed independent practitioner (LIP) of the specific area.
    c. The specific areas will conduct a modified medication reconciliation if they meet one of the following criteria:
        i. Medications are not routinely prescribed or administered in the setting.
        ii. Patient safety is not compromised by use of selective medication list.
4. A physician or qualified individual will compare the medication information the patient or family member/significant other with the medications ordered for the patient. The physician or qualified individual will review the lists for discrepancies.
5. If the patient is discharged home from the outpatient area with short-term medications (i.e. a pre-procedure medication, short term pain medication or short term course of antibiotics) and no changes are made to the patient's current medication list, the short term medications will be documented in the EHR and appropriate instructions given to the patient and/or family member/significant other, as needed.
6. If the patient is discharged with any of the following, a complete list of reconciled medications is provided to the patient and/or family member/significant other in a written format that is understandable with instructions to take the medication list to their primary care provider.
    a. Any new medications are prescribed.
    b. A prescription change for any of the patient's current, known, long-term medications,

B. **Medication Reconciliation for Inpatient Admission**

1. Medication reconciliation process is initiated by qualified individuals for patients admitted to the hospital.
2. Information on medications the patient is currently taking will be obtained based on the information available when the patient is admitted to inpatient setting or

whenever possible during the hospitalization. The comprehensive medication list would contain:

a. Name of current medications include those taken at scheduled times and those taken on an as needed basis, including over-the-counter and herbal products.

b. Strength, dose, frequency, route of medication.

c. The reason (purpose) for prn medications.

3. The primary means of obtaining the patient's current medication information may include, but not limited to:

a. Patient/Family/Caregiver interview

b. Patient provided medication list

c. Medication bottles/vials/containers

d. SVHMC Medical Records

e. Outside Medical Records

4. A comprehensive medication list of the patient should be documented in the EHR.

5. The physician or qualified individual compares the list of home medication(s) provided by the patient/knowledgeable source with the medication(s) ordered for the patient to identify and resolve discrepancies.

6. If a current medication list cannot be obtained, complete the medication history in the EHR as ***NONE KNOWN*** or ***UNOBTAINABLE***,

a. NONE KNOWN – indicates the patient denies taking any medications

b. UNOBTAINABLE – indicates unable to obtain list of patient medications

7. SVHMC Pharmacy may be contacted at any time for assistance with medication reconciliation, including but not limited to, drug interactions and dosing.

C. **Medication Reconciliation at Transfer/Postoperative**

1. When inpatients are transferred from an Intensive Care Unit (ICU-A, ICU-B, or NICU) to another inpatient unit, medication reconciliation will be completed in the EHR by the transferring physician.

a. CPOE Process for transfers from intensive care unit to another patient care unit:

i. Physician or qualified individual will complete medication reconciliation for patients being transferred in the electronic medical record using the "manage transfer" routine.

b. Paper Process/Downtime Process

i. In preparation to transfer, print a copy of the ***transfer/ postoperative medication reconciliation orders*** for the physician to review and sign. Place under the "orders" tab in the patient medical record.

ii. Completed form faxed to pharmacy by receiving unit.

D. **When an inpatient with existing medication orders goes to surgery:**

1. CPOE Process for postoperative patients:
    a. Physician or qualified individual will complete medication reconciliation for postoperative patients in the EHR using the "manage transfer" routine.
2. Paper Process/Downtime Process:
    a. Just prior to sending the patient to surgery the ***transfer/post-operative medication reconciliation orders*** will be printed and placed in the medical record.
    b. Postoperatively, the physician will review the ***transfer/post-operative medication reconciliation orders*** reconciling as appropriate.
    c. Completed form faxed to pharmacy by PACU if completed by surgeon; or faxed to pharmacy by receiving unit if completed by physician after discharge from PACU.

E. **Medication Reconciliation for Inpatients at Discharge**

1. Physician or qualified individual will review the medication list for the patient.
    a. The active medication orders should be reviewed in the EHR.
    b. The discharge order and discharge medication reconciliation should be completed in the EHR.
    c. Prescriptions should be entered and sent to the patient's preferred pharmacy electronically. If the process cannot be completed electronically, prescriptions will be called to the appropriate outside pharmacy or written prescriptions will be given to the patient.
2. Nursing should review the discharge medication orders.
    a. If discharge medication reconciliation has not been completed by the physician or designee, the discharge physician or designee should be contacted.
    b. If onsite or online medication review by the physician or designee is not possible, the Registered Nurse (RN) will print the discharge medication reconciliation form from the EMR and review the list of home medications with the physician/designee for appropriate action:
        i. Home medication is to be continued
        ii. Home medication is to be stopped
        iii. Home medication is to be reviewed with patient's primary care provider
        iv. NOTE: all medication orders will be read back per policy.
    c. The RN will review the information on the discharge medication reconciliation form with the patient. The patient's signature will be obtained on the form and a copy will be made to give to the patient and the

original is placed in the appropriate section of the patient's paper chart flagged for physician signature.

3. Patients discharged to an acute rehab facility or skilled nursing facility:
    a. Print the form *MEDS W/ADMIN (TRANSFER)* and
    b. Print the form *MEDICATIONS* (All) and Home Medication Report
    c. Above forms are provided to the skilled nursing facility in the discharge medical record packet.
4. The patient and/or family should be provided information in a written format that is understandable to the patient and includes the following:
    a. Updated list of medications the patient should be taking upon discharge from the hospital.
        i. Medications to be continued
        ii. New medications prescribed
        iii. Medications taken prior to admission that are to be stopped.
        iv. Medication information will include:
        v. Name, dose, route, frequency, and reason (purpose).
5. Education provided to the patient/family on the importance of managing their medications includes:
    a. Explaining the list of medications and written information provided at discharge.
    b. Carrying a list of medications with them in the event of emergency
    c. Providing their primary care physician with an updated list of medications.
    d. Keeping their medication information up to date with new medications, dosage changes, discontinuation and uses of over the counter medications
6. Patient/Family education is documented in the EHR.

F. **Documentation**:
    1. Documentation of medication reconciliation will be completed as noted in the contents of the policy.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. The Joint Commission's 2020 NPSGs available at https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2020/simplified_2020-hap-npsgs-eff-july-final.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	03/2025
CNO	Carla Spencer: Chief Nursing Officer	02/2025
P&T	Genevieve delos Santos: Director Pharmacy	02/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	01/2025
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

Status **Pending** PolicyStat ID **16470351**

Last Approved	N/A	Owner	Genevieve delos Santos: Director Pharmacy
Next Review	3 years after approval	Area	Plans and Program

Transitions of Care Pharmacy Program

I. SCOPE

A. To describe the role of the Pharmacy Department in conducting medication reconciliation.

B. To define the objectives and goals of the Transitions of Care Pharmacy Program.

II. OBJECTIVES/GOALS

A. **Objectives**

1. To identify medication-related problems during medication reconciliation.
2. To provide medication reconciliation during transitions of care.

B. **Goals**

1. The goals for the Transitions of Care Pharmacy Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance monitoring and environmental tours. The goals for this Transition of Care Pharmacy Program are:
    a. To prevent readmissions due to errors related to medication therapy.
    b. To prevent medication errors due to medication-related problems.

III. DEFINITIONS

A. Medication-Related Problem (MRP) – an event or situation related to the ordered medications which has the potential to negatively affect patient outcomes.

B. Mediation Home List – the list of medication(s) that the patient was taking prior to admission.

C. Medication Reconciliation (also known as "med rec") – the process of comparing a patient's medication orders to the medication home list and adjusting the orders as necessary to ensure appropriate transition of care.

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. The primary fundamental element of this plan is that the pharmacy department will participate in accurately and completely reconciling medications following the guidelines in Senate Bill 1254 during transitions of care.
2. The secondary fundamental element of this plan is that the pharmacy department will be responsible for identifying and resolving any MRPs during transitions of care.

B. **Plan Management**

1. The Transition of Care Pharmacy Program will be managed by the pharmacy department, specifically the Transitions of Care Pharmacy Coordinator

C. **Plan Responsibility**

1. The Pharmacy Department is responsible for any modifications to the Transitions of Care Pharmacy Program.

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Transition of Care Pharmacy Program. Performance measures have been established to measure at least one important aspect of the Transitions of Care Pharmacy Program.
2. On an annual basis, the pharmacy department evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at Salinas Valley Health Medical Center (SVHMC).

E. **Orientation and Education**

1. Orientation, education and/or training are provided to all pharmacy staff involved in transitions of care at SVHMC.
2. Additional training to staff will be provided on an as needed basis.

V. REFERENCES

A. Impact of medication reconciliation for improving transitions of care, Cochrane Database Syst Rev. 2018 Aug; 2018(8): CD010791. Published online 2018 Aug 23. doi: 10.1002/14651858.CD010791.pub2, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6513651/

B. Transitions of Care and Medication Reconciliation, Ashley King, PharmD, BCGP, LECOM Health, March 2018 https://lecom.edu/content/uploads/2018/02/Transitions-of-Care-A-King.pdf

C. LaCrosse, J., Mysliwiec, J., & Gramme, B. F. (2019). Board of Pharmacy. *California Regulatory Law Reporter*, *24*(1), 72-101.

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P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	01/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/2024
Policy Owner	Genevieve delos Santos: Director Pharmacy	12/2024

Standards

No standards are associated with this document

EXTENDED CLOSED SESSION

(if necessary)

(Report on Items to be

Discussed in Closed Session)

(Meeting Chair)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ADJOURNMENT