



April 18, 2025

TO: Legal Counsel

News Media

Salinas Californian

El Sol

Monterey County Herald

Monterey County Weekly

KION-TV

KSBW-TV/ABC Central Coast

KSMS/Entravision-TV

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH¹** will be held **THURSDAY, APRIL 24, 2025, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

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

A handwritten signature in black ink, appearing to read "Allen Radner", written in a cursive style.

Allen Radner, MD
President/Chief Executive Officer

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

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

**THURSDAY, APRIL 24, 2025, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C**

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

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

AGENDA

Presented By

1. **CALL TO ORDER / ROLL CALL** *Joel Hernandez Laguna*
2. **CLOSED SESSION** *(See Attached Closed Session Sheet Information)* *Joel Hernandez Laguna*
3. **RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *Joel Hernandez Laguna*
(Estimated time 4:30 pm)
4. **AWARDS & RECOGNITION** *Allen Radner, M.D.*
5. **PUBLIC COMMENT** *Joel Hernandez Laguna*

This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.
6. **CONSENT AGENDA - GENERAL BUSINESS** *Joel Hernandez Laguna*
(Board Member may pull an item from the Consent Agenda for discussion.)
 - A. Minutes of the Regular Meeting of the Board of Directors March 27, 2025
 - B. Minutes of the Special Meeting of the Board of Directors March 20, 2025
 - C. Policies/Plans Requiring Approval
 1. Cardiac Cath Lab - Regulations
 2. External Cephalic Version
 3. Fetal Demise/Stillborn/Neonatal Death
 4. Financial Assistance Program-Full Charity Care & Discount Partial Charity Care
 5. Gift Ticket and Honoraria
 6. Identity Theft Detection, Prevention & Mitigation
 7. Massive Transfusion Protocol-Nursing
 8. NICU Transport: Care Practices for Transport
 9. Observation in the Cath Lab by Emergency Medical Services Personnel
 10. Organization Plan for Provision of Care & Service
 11. RC POCT Laboratory - Arterial Blood Gas Management

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12. Scope of Service-Diagnostic Imaging
13. Scope of Service-Emergency Department
14. Scope of Service-Health Promotion
15. Scope of Service-Information Technology
16. Scope of Service-Surgical Services
17. Scope of Service-Telecommunications
18. Scope of Service-Transport
19. Specimen/Foreign Body
20. Traffic Patterns in the OR
21. Transport to/from External Healthcare Facility for Treatment
22. Trial of Labor After Cesarean (TOLAC)

EOC Plans

1. Fire Safety Management Plan
2. Hazardous Materials & Waste Management Plan (see MEC packet)
3. Safety Management Plan (see MEC packet)
4. Security Management Plan
5. Utility Management Plan

D. Lease Agreements Requiring Board Approval

1. Fifth Amendment to Lease for 345 Abbott Street, Salinas (Accounting Office)
2. First Amendment to Lease for 250 San Jose Street, Salinas (SVH Clinics-OB/GYN Clinic)
 - Board President Report
 - Questions to Board President/Staff
 - Public Comment
 - Board Discussion/Deliberation
 - Motion/Second
 - Action by Board/Roll Call Vote

7. BOARD MEMBER COMMENTS AND REFERRALS

Joel Hernandez Laguna

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the April 14, 2025 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

B. FINANCE COMMITTEE

Victor Rey, Jr.

Minutes of the April 21, 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 Purchase of Two (2) Canon X-ray Units and Service Agreement from Canon for Salinas Valley Health Clinics Imaging Services (ALBERT)

- 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 Award Contract to C. Overaa & Co. for the Seismic Compliance Project (MILLER/McCOY)
- 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 Contract Terms and Conditions for Services Agreement Between Salinas Valley Health and Prinnovo, LLC (RADNER/ALBERT/RAY)
- Questions to Committee Chair/Staff
 - Motion/Second
 - Public Comment
 - Board Discussion/Deliberation
 - Action by Board/Roll Call Vote

C. TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE

Rolando Cabrera, M.D.

Minutes of the April 16, 2025 Transformation, Strategic Planning and Governance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

9. **CONSIDER APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF SADI DALIEH, MD (ii) CONTRACT TERMS FOR DR. DALIEH'S RECRUITMENT AGREEMENT, and (iii) CONTRACT TERMS FOR DR. DALIEH'S INTERNAL MEDICINE PROFESSIONAL SERVICES AGREEMENT**

Orlando Rodriguez, M.D., CMO

Gary Ray, CLO

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

10. **REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF APRIL 10, 2025, AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS:**

Rakesh Singh, M.D.

A. Reports

1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report (Including the following)
 - Bar Code Medication Administration in Endoscopy-Nursing Standardized Procedure
 - Management of Category II (with Heightened Concern) or Category III Fetal Heart Tracings in OB Triage -Nursing Standardized Procedure

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

- Alcohol Withdrawal Treatment Guidelines
- Emergency Plan for Sterilization Failure
- Hazardous Materials Plan
- Infectious Disease Surge Tent
- Medically Indicated Deliveries – 39 weeks gestation
- Medication Override
- Medication Safety
- MRSA Active Surveillance Screening
- Non-Stress Test
- Safety Management Plan
- Questions to Chief of Staff
- Motion/Second
- Public Comment
- Board Discussion/Deliberation
- Action by Board/Roll Call Vote

11. **EXTENDED CLOSED SESSION** (*if necessary*)

Joel Hernandez Laguna

12. **RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION**

Joel Hernandez Laguna

13. **ADJOURNMENT**

Joel Hernandez Laguna

The next Regular Meeting of the Board of Directors is scheduled for
Thursday, May 22, 2025, at 4:00 p.m.

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

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

**SALINAS VALLEY HEALTH BOARD OF DIRECTORS
THURSDAY, APRIL 24, 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
 - Accreditation and Regulatory
3. Consent Agenda:
 - Environment of Care Committee Full report
 - Pharmacy and Therapeutics Committee Full report
 - Safety and Reliability Committee Full report

REPORT INVOLVING TRADE SECRET

(Government Code §37606 & Health and Safety Code § 32106)

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

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

CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION

(Government Code §54956.9(d)(2))

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

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

Initiation of litigation pursuant to Section 54956.9(d)(4) (Number of potential cases): _____

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 HEALTH¹
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
MARCH 27, 2025

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

Absent: None;

Also Present:

Allen Radner, M.D., President/Chief Executive Officer
Alison Wilson, D.O., Vice-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 4:04 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. OATH OF OFFICE

Joel Hernandez Laguna introduced Anna Velazquez, Mayor of Soledad, who administered the Oath of Office to newly appointed Board member Rosa Isaura Arreguin.

Ms. Arreguin stated she was grateful to be in this position. As a Latina she supports access to equal healthcare. The coming years will be challenging for all of us and she is looking forward to being part of the Salinas Valley Health Board of Directors.

Mayor Velazquez commented she has observed Ms. Arreguin empowering and uplifting families, uplifting other women and assisting with pathways for leadership opportunities, and assisting students to ensure equal access and opportunity. Mayor Velazquez believes Ms. Arreguin will continue with assisting to provide healthcare for all.

Bianca Salinas, Ms. Arreguin's sister-in-law, commented Isaura has been a mentor for her since she was little, that Isaura is amazing and will make Salinas Valley Health proud and offered her congratulations to Isaura.

Appointment to Board Officer Position

President Hernandez Laguna announced Ms. Arreguin will fill the office of Assistant Treasurer for a term due to expire December 2026.

Appointment to Board Committees

President Hernandez Laguna appointed Ms. Arreguin as Vice-Chair of the Personnel, Pension and Investment Committee and Vice-Chair of the Community Advocacy Committee.

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3. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, and (2) 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 4:16 p.m.

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

4. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:41 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Hearings and Reports.* The Board received and accepted the reports listed on the Closed Session agenda. No other action was taken.

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

5. 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:

BOARD MEMBER DISCUSSION:

- **STAR Award: Olga Volozhina, Inpatient Clinical Pharmacist:** Clement Miller, COO, stated that Olga joined our organization in November 2022 after graduating from pharmacy school ten years ago. She came from a community pharmacy setting and said she really wanted to be a part of a broader team caring for patients. In a relatively short amount of time, Olga has definitely had an impact. She helps out whenever she can. Olga thanked Sarah Forbes who nominating her and that it is a pleasure to work in ICU. She stated she works with amazing people who do incredible things and that she is grateful to be chosen as a STAR Award recipient and enjoys helping facilitate patient care.

BOARD MEMBER DISCUSSION: Ms. Volozhina was thanked for her dedication and contributions to patient care.

- **Certified Nurses Day, March 19th:** Stephanie Frizzell, Director Education, and Stephanie Fierro, RN/Cath Lab, explained that SVH celebrated Professional Board-Certified Registered Nurses with gifts of a bamboo cheese board with cutlery distributed to certified nurses along with a woven navy tote bag in honor of their work to go above and beyond in their commitment to patient care and professional development. Nurses from the Professional Development Council were on hand at Certified Nurses Day to share information about support provided for pursuit of nursing excellence and board certifications. Salinas Valley Health is proud to have a strong team of board-certified nurses in all specialties and roles. Certification has gone from 21% to 38% and the goal for 2025 is to increase by 1%. Certification shows nurse dedication to their practice and all nurses are encouraged to obtain Board certifications.

BOARD MEMBER DISCUSSION: Question: What are some obstacles/challenges to becoming certified? The Professional Development Counsel works 1:1 with individuals ready to take the next step to offer support and instill confidence. When interest is shown, SVH brings in instructors to offer training. Prices for the exams have risen, so the certification bonus has been increased to offset the cost of exams.

- **Healthgrades Awards:** Aniko Kukla, Director Quality and Patient Safety, introduced Nicole Patzer, Director of Quality Solutions from Healthgrades who presented three Patient Safety awards:
 - **Patient Safety Excellence Award (2025):** SVH has earned the award 3 years in a row (2023-2025). Ms. Patzer stated this is a true testament to dedication to quality care shown through clinical outcomes and patient safety.
 - **Five-Star Recipient for Hip Fracture Treatment (2025):** This award is based on clinical outcomes and statistics show Five-Star hospitals reduce complications by 54.8%.
 - **Five-Star Recipient for Treatment of Diabetic Emergencies (2025):** This award is based on clinical outcomes and statistics show Five-Star hospitals lower risk by 63.8%.

Ms. Patzer congratulated SVH leadership for providing positive impact for their community and patients.

BOARD MEMBER DISCUSSION: Ms. Patzer was thanked for coming and presenting these awards in person.

6. PUBLIC COMMENT:

Katie Bassler, Educator and Trustee MCSIG: Stated she recognizes the work of the Board providing outstanding service to the community. She thanked SVH for extending urgent care hours at SVH Clinics which provides customer service and avoids emergency room utilization. She thanked the Board for listening to public comment and responding through change.

Stephanie Alfaro of the Parenting Connection of Monterey County (Via WebEx): Commented on the doula program, and thanked the SVH Labor and Delivery department for receiving doulas with open arms. She is looking forward to collaboration.

7. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following policy has been removed from the Consent Agenda for consideration *Fire Safety Management Plan*; the policy 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 February 27, 2025
- B. Policies Requiring Approval
 - 1. Activities Preparatory to Research
 - 2. Emergency Management for Mass Casualty Incidents - MCI
 - 3. Injury and Illness Prevention Program Plan
 - 4. Operative Delivery – Vaginal or Cesarean Section

- C. Revised Contract Matrix and Expense Matrix

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Legal Counsel reported the changes to the Contract Matrix and Expense Matrix were due to some software challenges. Augustine Lopez, CFO, explained the limits are consistent with best practice and industry standards. There was discussion of *no limits* on Supplies/Group Purchasing/Distributors and Managed Care Payor Contracts. This is due to bulk invoicing on Board-

approved contracts. Additionally, there are internal controls and audits on contracts, budgets, and reviewing payment processes.

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: Arreguin, 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.: Dr. Cabrera welcomed our new Board member and thanked Ms. Arreguin for joining the team.

Director Catherine Carson: Director Carson offered congratulations to Ms. Arreguin and stated she believes that this is the first time there has been two women on the Board concurrently.

Director Victor Rey, Jr.: Director Rey thanked Ms. Arreguin for joining the Board and thanked the Ad Hoc Committee for their work in the interview and selection process. He also thanked Juan Cabrera for his years of service.

Director Joel Hernandez Laguna: President Hernandez Laguna welcomed and thanked Ms. Arreguin and stated she is welcome to reach out to any of the Board members. He stated he has received feedback from constituents and provided a compliment to the Emergency Department for the level of service provided. He complimented the L&D Department which continues to have high standards with experienced people. He stated people in the community trust the SVH Surgery Department when they have options to go elsewhere. He thanked the Executive Team for always being responsive.

Director Isaura Arreguin: Director Isaura stated she is excited to be part of the Board of Directors and happy to be part of the system. She has been a patient and agrees the hospital deserves the best awards possible.

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 March 17, 2025 meeting were provided for Board review. The committee received a report from the Magnet® director on what the Magnet® Recognition Program means to the organization and performance improvement. Additionally, there was a report from Dr. DeFilippi on the outstanding work being done by the Transfusion Committee; SVH is a leader with few complications and readmissions. There was a report by Michelle Orta, Director Continuum of Care, on Transitional Care and the exceptional efforts on reducing readmissions and coordinating provider care within 7 days of discharge. The Committee is working on revising the Dashboard to reflect meaningful data on quality measures.

B. PERSONNEL, PENSION AND INVESTMENT COMMITTEE

A report was received from Director Carson regarding the Personnel, Pension and Investment Committee. The minutes of the March 17, 2025 meeting were provided for Board review. The following recommendations were made:

- 1. Consider recommendation for Board of Directors to approve replacing target date funds within the 403(b) and 457 Plans.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: There has been a lot of work on this recommendation over two meetings. There will be additional work making this operational. It will take about 60 days from Board action to implementation. The target date fund selected has a history of strong performance.

MOTION:

Upon motion by Director Carson, and second by Director Rey, the Board of Directors approves replacing the American Century One Choice Target Date Funds with the American Funds Target Retirement Funds within the 403(b) and 457 Plans.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: None.

Motion Carried

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

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves adding self-directed brokerage accounts to the 403(b) and 457 plans.

ROLL CALL VOTE:

Ayes: Arrequin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: None.

Motion Carried

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

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: This request is for a contribution to recruitment. Compensation will be through Santa Lucia Medical Group.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves

- 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.

ROLL CALL VOTE:

Ayes: Arrequin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: None.

Motion Carried

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

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Dr. Lim has been in community as part of Pacific Coast Pediatrics which is closing its practice. She will be joining PrimeCare.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Rey, the Board of Directors approves the Contract Terms of the Pediatrics Professional Services Agreement for Jerrie Lim, M.D.

ROLL CALL VOTE:

Ayes: Arrequin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: None.

Motion Carried

C. FINANCE COMMITTEE

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

- 1. Consider Recommendation for Board Approval of Project Budget and Equipment Procurement for Equipment in Conjunction with the Labor Delivery and Recovery Rooms Project**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Arreguin, the Board of Directors approves 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.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: None.

Motion Carried

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

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Question: Is this part of the overall EPIC budget? Yes. When the EPIC go-live is complete, this will add additional meeting space on campus. Ryan Ranch spaces will be more temporary.

MOTION:

Upon motion by Director Cabrera, and second by Director Arreguin, the Board of Directors approves 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.

ROLL CALL VOTE:

Ayes: Arreguin, Dr. Cabrera, Carson, Hernandez Laguna, and Rey;

Noes: None;

Abstentions: None;

Absent: None.

Motion Carried

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON MARCH 13, 2025, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Alison Wilson, D.O., Vice-Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of March 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 Carson, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report and Interdisciplinary Practice Committee Report as follows:

A. Reports

1. Credentials Committee Report (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

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 item to be discussed in Extended Closed Session is *(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 5:27 p.m. The Board completed its business of the Closed Session at 6:56 p.m.

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:56 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, April 24, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:58 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

DRAFT SALINAS VALLEY HEALTH¹
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
MARCH 20, 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

Matthew Ottone, Esq., District Legal Counsel

Gary Ray, Chief Legal Officer

Kathie Haines, Executive Support

Public Present Via WebEx: Isaura Arreguin and Eric Mora.

1. READING OF THE NOTICE OF SPECIAL MEETING

President Hernandez Laguna read the following: A Special meeting of the Board of Directors of Salinas Valley Health¹ will be held Thursday, February 6, 2025, at 4:30 p.m., in the Heart Center Teleconference Room, Salinas Valley Health Medical Center, 450 E. Romie Lane, Salinas, California, for Report and Recommendation by Board Vacancy Ad Hoc Committee to Board of Directors; Action by Board to Fill Board Vacancy (California Government Code Section 1780).

2. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:32 p.m. in the Heart Center Teleconference Room.

3. REPORT BY VACANCY AD HOC COMMITTEE TO BOARD OF DIRECTORS

Joel Hernandez Laguna and Catherine Carson, Vacancy Ad Hoc Committee members, reported the committee met on Thursday, March 13, 2025. The committee interviewed three candidates for 45 minutes each, with questions from the Committee and from the candidates. District Legal Counsel, Matt Ottone, provided each candidate with an overview of the responsibilities of a Salinas Valley Health Board member, the term of the appointment, a list of the Board Committees and meeting commitment, and a calendar of all meetings for 2025. The candidates are Isaura Arreguin, Eric Mora and Maria Gomez.

4. CONSIDER APPOINTMENT OF DIRECTOR TO VACANCY ON THE BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH

After consideration of the responses of each of the candidates in the interview process, review of the applications, and determining which candidate would best represent the healthcare needs of Zone 3 and

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the Healthcare District, the Ad Hoc Committee recommends that the Board consider Isaura Arreguin for appointment of Director to fill the vacancy on the Board of Directors of Salinas Valley Health.

Candidate applications were distributed. District Legal Counsel, Matt W. Ottone, reported the next step is to consider the recommendation and ask questions of the Ad Hoc Committee.

Recess: The meeting recessed at 4:35 p.m. for 15 minutes to permit the Board an opportunity to review the materials submitted by each of the three candidates.

Reconvene: The Board reconvened at 4:50 p.m.

Board Discussion: Was candidate Arreguin able to commit to the anticipated time obligations? The time commitment was asked of all candidates including the monthly meetings of the Board of Directors and responsibilities of attending committee meetings. Additionally, each candidate was advised of (1) the in-person attendance requirement, (2) the time commitment to prepare for meetings, (3) monthly meeting with the President/CEO, and (4) the appointment is until December 5, 2026. When would her 1st meeting be?: The next Board meeting on March 27th at which the Oath of Office would be administered. The Board thanked the candidates who attended the meeting via WebEx.

PUBLIC COMMENT: Isaura Arreguin, present via WebEx, stated she has a flexible schedule and is committed to making the requirements as a Board Member.

MOTION:

Upon motion by Director Rey, second by Director Dr. Cabrera the Board of Directors appoints Isaura Arreguin to the Board of Directors of Salinas Valley Health, representing Zone 3 effective today, March 20, 2025.

PUBLIC COMMENT: None.

ROLL CALL VOTE:

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

Nays: None;

Abstentions: None;

Absent: None.

Motion Carried

Ms. Arreguin was apprised she is welcome to bring her family for the Oath of Office and that the Oath of Office can be administered by any elected official or judge or her choice. If she does not have a choice, the Oath of Office will be administered by the President of the Board of Directors of Salinas Valley Health, Joel Hernandez Laguna.

5. 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 5:00 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors
 From: Clement Miller, COO
 Date: April 24, 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.	Cardiac Cath Lab - Regulations	Removed CIWA-AR and replaced with new SEWs and MINDs ETOH protocol info	Carla Spencer, CNO
2.	External Cephalic Version	Minor updates.	Carla Spencer, CNO
3.	Fetal Demise/Stillborn/Neonatal Death	Minor updates.	Carla Spencer, CNO
4.	Financial Assistance Program-Full Charity Care & Discount Partial Charity Care	Updates due to state bills AB 2297 and SB 1061.	Augustine Lopez, CFO
5.	Gift Ticket and Honoraria	Minor format changes.	Gary Ray, CLO
6.	Identity Theft Detection, Prevention & Mitigation	Changes to department names & position titles.	Gary Ray, CLO
7.	Massive Transfusion Protocol-Nursing	Updates reflecting best practices and current protocol implementation guide.	Carla Spencer, CNO
8.	NICU Transport: Care Practices for Transport	Corrected Pyxis to Omnicell.	Carla Spencer, CNO
9.	Observation in the Cath Lab by Emergency Medical Services Personnel	No changes.	Clement Miller, COO
10.	Organization Plan for Provision of Care & Service	Updates reflecting title changes and best practices.	Clement Miller, COO
11.	RC POCT Laboratory - Arterial Blood Gas Management	Updated format & approval workflow.	Clement Miller, COO
12.	Scope of Service-Diagnostic Imaging	No Changes.	Clement Miller, COO
13.	Scope of Service-Emergency Department	Updated Org Chart.	Carla Spencer, CNO
14.	Scope of Service-Health Promotion	No Changes.	Tiffany DiTullio, VP
15.	Scope of Service-Information Technology	Updates reflecting best practices and updated Org Chart.	Augustine Lopez, CFO
16.	Scope of Service-Surgical Services	Minor changes. Updated reporting structure.	Alysha Hyland, CAO
17.	Scope of Service-Telecommunications	Updated Org Chart.	Augustine Lopez, CFO
18.	Scope of Service-Transport	Updated staffing plan.	Carla Spencer, CNO
19.	Specimen/Foreign Body	Revised to current practice.	Clement Miller, COO
20.	Traffic Patterns in the OR	Updated procedure and references.	Clement Miller, COO

21.	Transport to/from External Healthcare Facility for Treatment	Procedural changes.	Carla Spencer, CNO
22.	Trial of Labor After Cesarean (TOLAC)	Revised to current practice.	Carla Spencer, CNO
EOC Plans			
1.	Fire Safety Management Plan	Changes to chain of command for oxygen shut off.	Clement Miller, COO
2.	Hazardous Materials & Waste Management Plan	Included in MEC policies.	Clement Miller, COO
3.	Medical Equipment Management Plan	Current/Approved by Board 2/27/2025	Clement Miller, COO
4.	Safety Management Plan	Included in MEC policies.	Clement Miller, COO
5.	Security Management Plan	Minor changes.	Clement Miller, COO
6.	Utility Management Plan	Minor changes.	Clement Miller, COO
MEC Policies			
1.	Bar Code Medication Administration in Endoscopy-Nursing Standardized Procedure	New Standardized Procedure.	Carla Spencer, CNO
2.	Management of Category II (with Heightened Concern) or Category III Fetal Heart Tracings in OB Triage-Nursing Standardized Procedure	New Standardized Procedure.	Carla Spencer, CNO
3.	Alcohol Withdrawal Treatment Guidelines	Updated format.	Clement Miller, COO
4.	Emergency Plan for Sterilization Failure	References updated.	Timothy Albert, CCO
5.	Hazardous Materials & Waste Management Plan	Objective added.	Clement Miller, COO
6.	Infectious Disease Surge Tent-Tent Medication Box	Updated medication list and AFL references (per CDPH).	Clement Miller, COO
7.	Medically Indicated Deliveries <39 Weeks Gestation	New policy to guide in the care of patients <39 weeks gestation.	Carla Spencer, CNO
8.	Medication Override	New policy based on guidance of Medication Safety Committee.	Clement Miller, COO
9.	Medication Safety	New policy: Combines existing policies.	Clement Miller, COO
10.	MRSA Active Surveillance Screening	Updated to current process with updated MRSA decolonization, quick sheet and references.	Timothy Albert, CCO
11.	Non-Stress Test	Added SpO2 to vital sign collection in alignment with MFTI. Added physician review of NST tracing within 24 hours.	Carla Spencer, CNO
12.	Safety Management Plan	No Changes	Clement Miller, COO



Last ApprovedN/ANext Review3 years after approval

OwnerMegan Giovanetti: Director Cardiovascular Services and SleepAreaCardiology Departments

Cardiac Cath Lab - Regulations

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff with a pre-procedure protocol to ensure efficient and comprehensive pre-admission and admission processing of patients undergoing diagnostic and interventional cardiac procedures.

III. DEFINITIONS

A. PAT – Pre-Admission testing or Pre-Assessment Testing completed by Cath Lab Holding area RN

IV. GENERAL INFORMATION

A. Admission of patients for procedures in the Cardiac Cath Lab requires attention to standardized guidelines to affect maximal patient safety and comply with medical staff and administrative rules and regulations.

V. PROCEDURE

- A. Administrative Policy Manual.

1. The Cardiac Cath Lab will adhere to the Administrative Policy Manual (APM) of Salinas Valley Health Medical Center (SVHMC) in all requirements as applicable.
- B. Labs (unless emergent) as ordered by cardiologist can be done on the day of procedure.

1. Complete blood count (CBC), electrolytes, BUN, creatinine (Basic Metabolic Panel), PT and INR, are done on pre cath patients as ordered by cardiologist. A copy of laboratory results done within 72 hours preceding the scheduled procedure if they were done in the clinic shall be placed with the chart. Laboratory reports shall be in the patient's chart prior to transport to the Cath Lab.
2. An EKG done within 24 hours prior to the procedure shall be in chart when ordered by physician.

C. Records.

1. Medical Record Pre-Cath Completeness
 - a. Cardiologist and/or their physician assistant will be responsible for a complete medical record for each patient. This will include a complete history and physical (History and Physical must be dated within 30 days of procedure). An examination stating a pre-procedure diagnosis properly signed and currently dated consent which specifies the procedure to be performed and performing cardiologist and interventionist full name, appropriate laboratory, diagnostic imaging and EKG reports, as well as consultation and progress notes.
 - b. The procedure planned must be clearly documented and all relevant pre-cath orders placed. Hospital staff may not initiate preparation for procedure unless informed consent has been obtained by the physician as defined by the Bylaws, Rules & Regulations of the Medical Staff. Scheduled procedures will be delayed and possibly rescheduled if the patient record does not include an informed consent.
 - c. All pre-cath documentation (Orders, History and Physical, Labs, Informed Consent) must be received at least 24 hours in advance of the scheduled procedure

D. History and Physical

1. It is the responsibility of the cardiologist to examine the patient prior to the procedure. At this time, the cardiologist must obtain a pertinent history including explaining risks, benefits, alternatives and possible complications. The cardiologist must perform a physical examination which is to be recorded on the appropriate form with the pre-procedure diagnosis, recommendation and plan. Scheduled procedures will be delayed and possibly rescheduled if the patient record does not include a history and physical examination. Indication for the procedure must be present in the progress notes.

E. Consultation

1. Documentation in the chart must validate that the cardiologist has seen the patient within 24 hours prior to the cardiac procedure.

F. Post-Cardiac Procedure Orders

1. Immediately following the procedure, post-cardiac procedure orders will be entered via CPOE and electronically signed by the cardiologist or the internationalist.

G. Progress Notes

1. Progress notes will be legibly written or entered electronically giving evidence of the patient's condition and should give a chronological picture and analysis of the clinical course of the patient.

H. Procedure Report

1. All procedures shall be fully described by the attending cardiologist within the guidelines of the Bylaws, Rules & Regulations of the Medical Staff.

I. Access to the Cardiac Cath Lab

1. Access to the Cardiac Cath Lab will include the invasive cardiologist and the laboratory staff unless permission to observe has been granted by management and with the agreement of the invasive cardiologist performing the case.

J. Scheduling of Cases

1. Refer to [CARDIAC CATH LAB - SCHEDULING OF PROCEDURES](#)

K. Pre-Registration

1. A nurse from Cath Lab Holding area will call the patient for prep-procedure instruction as well as the review of medication instructions given to patient by their cardiologist during clinic visit.
2. An OPS pre-admit questionnaire is completed by an RN during the PAT (Pre-Assessment Testing). This includes a review of the patient's medication list.

L. Staggered Admission

1. To minimize the waiting time for the patient and to assure bed availability, the Cath Holding RN's in collaboration with Cath Lab scheduling clerk will inform patients when to arrive on the day of procedure
2. In collaboration with Cath lab scheduling clerk, Cath Lab Holding RN calls the patient the day before their scheduled procedure with a more specific time of arrival to the hospital.
3. Patient status is changed to "outpatient in bed request" to be an inpatient per cardiologist or interventionalist order.

M. Order Entry

1. Admission orders must be placed by the physician via CPOE

N. Documentation:

1. Standard of care is launched for OPS pre admit

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Cardiology Medical Director	Megan Giovanetti: Director Cardiovascular Services and Sleep	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep	01/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Daniela Jago:
Clinical Manager
Women's and
Children's
Services

External Cephalic Version

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in the management of care for the patient undergoing external cephalic version.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

- A. Prior to initiation of the procedure, the following should be verified/completed:

1. Placental location documented by the physician

2. Availability of the OR

3. Notification of anesthesia
- B. Contraindications:

1. External version is contraindicated if vaginal delivery is not an option

2. Severe oligohydramnios or ruptured membranes

3. Concern about fetal monitoring findings

4. Hyperextended fetal head

5. Significant fetal or uterine anomaly (eg, hydrocephaly, septate uterus)

6. Placental abruption

7. Multiple gestation: though may be considered for the second twin after delivery of

the first twin

C. Relative contraindications:

1. Hypertension
2. Obesity
3. Fetal growth restriction
4. Decreased amniotic fluid volume
5. Previous transverse or vertical lower uterine segment cesarean delivery

V. PROCEDURE

- A. Perform a [NON-STRESS TEST](#) (NST) to assess fetal status. Verify reactive NST or physician evaluation if FHR tracing does not meet criteria.
- B. Verify bedside ultrasound is readily available.
- C. Verify patient's Rh factor. Confirm patient received Rh_o (D) immune globulin at 28 weeks of gestation if needed.
 - Administer RhoGAM? after procedure as indicated.
- D. Ensure informed consent has been obtained by physician. Obtain signed consent for external version and possible cesarean birth.
- E. Establish IV access per physician order.
- F. Administer tocolytics per physician order.
- G. Assess fetal heart rate pattern and uterine activity following external version and ensure criteria for reactive NST.
- H. Documentation:
 1. Record patient assessment, [FETAL HEART RATE MONITORING](#),
 2. Document reactive [NON-STRESS TEST](#) pre and post procedure as well as assessing and documenting the following as indicated:
 - Abdominal pain
 - Bleeding
 - Ruptured membranes
 - Decreased fetal activity
 3. Document patient education and patient response.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American College of Obstetricians and Gynecologists. (2020, Reaffirmed, 2023). External

cephalic version. (Practice Bulletin No. 221).

B.

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	04/2025
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



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Daniela Jago:
Clinical Manager
Women's and
Children's
Services

Fetal Demise/Stillborn/Neonatal Death

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To guide the nursing staff in the appropriate care for the patient/family who has experienced a perinatal loss.

III. DEFINITIONS

- A. **Fetal Death:** Fetal death before the complete expulsion or extraction from the mother, irrespective of the duration of pregnancy. For statistical purposes, fetal deaths may be further subdivided as early fetal death (20-27 weeks of gestation) or late fetal death (28 weeks of gestation or more).
- B. **Stillbirth:** infant born at 20 weeks gestational age or greater, or greater than 400 grams if gestational age is unknown, with no signs of life.
- C. **Miscarriage (spontaneous abortion):** Fetus that dies in utero prior to 20 weeks of gestation.
- D. **Neonatal Death:** infant born at any gestational age or weight with signs of life such as the beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached, and expires after birth.
- E. **Live birth** – the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps. This applies to any gestational age.

- F. **Indeterminate length of gestation** – when the gestational age is indeterminate, the following criteria can be used to determine the proximity to the 20th week:
1. Weight of 400 grams (14.1 ounces) or more and
 2. Crown-heel length of 28 centimeters (11 inches) or more.
 3. If attending physician is unable to determine gestational age using above criteria, or if less than 20 weeks, the fetus may be sent to the pathologist for age determination.
 4. When the period of gestation is questionable, the final authority will rest with the attending physician as to how the fetus will be classified. The pathologist will make the final determination only upon request from the attending physician.

IV. GENERAL INFORMATION

- A. Care will be provided in accordance with [LABOR AND DELIVERY OBSTETRICAL STANDARDS: ASSESSMENT AND DOCUMENTATION](#)
- B. Patient's room will be identified with "Perinatal loss door card" (butterfly).
- C. All patients who experience a loss will be offered the:
1. Memory box – if patient or family declines the memory box at this time, the contents will be kept on file for one year in the identified secured cabinet located on the second floor.
 2. Written instructions [INTERPRETER/TRANSLATOR COMMUNICATION POLICY](#)
 3. Support services
- D. Do not resuscitate order [WITHDRAWING LIFE-SUSTAINING TREATMENT AND WITHHOLDING CARDIOPULMONARY RESUSCITATION](#)

V. PROCEDURE

- A. Obtain infant morgue pack from Materials Management.
- B. Identification
1. Live births at any gestational age will have a complete admission through patient registration with appropriate identification bands placed on patient
 2. For **non-live** births, **no admission or patient registration is completed**. Mother's hospital number is used for identification purposes.
 3. Mother's identification is to be placed directly on remains of fetal demise/neonatal death – preferably ankle.
- C. Obtain and record weight and length of infant.
- D. The following should be notified in the event of a fetal loss:
1. Patient's preferred spiritual support
 2. Administrative supervisor
 3. Social services

E. Hospital forms:

1. Bereavement packet
2. Release of remains
3. Salinas Valley Health Medical Center (SVHMC) authorization for autopsy (if requested by Physician or mother/father)
 - If parents requesting autopsy, there may be an associated fee.

F. Notify Administrative supervisor of all fetal demises, stillbirths and neonatal deaths.

G. The administrative supervisor will report all neonatal deaths of 20 weeks gestation and more to the California Transplant Donor Network (CTDN).

1. The administrative supervisor will report all neonatal deaths of 20 weeks gestation and more to the Monterey County Coroner's office in the following circumstances:
 - Suspicious circumstances
 - Suspected trauma related to death

H. *Fetal death 20 weeks and over (stillbirth)*

1. A certificate of fetal death is prepared in two copies.
2. For information regarding disposition and/or if the parents desire an autopsy, the administrative supervisor must be notified and will deliver the authorization for autopsy to the laboratory per [POST MORTEM-NOTIFICATION \(CORONER, DONOR NETWORK\), AUTOPSY AND RELEASE OF REMAINS](#) If an authorization for autopsy is signed, it should indicate on the form if there will be a burial.
3. If the death is to be reported to the coroner's office, the physician in attendance does not solicit an authorization for autopsy or order an autopsy without permission of the coroner.
4. If the family desires burial, nursing staff will obtain the signature on Morgue Release form. The Administrative Supervisor will obtain the signed Morgue Release and will contact the appropriate mortuary to remove the body.

I. One copy of the Certificate of fetal death is given to the funeral director and the second copy will be part of the permanent medical record of the mother.

J. ***Miscarriage (spontaneous abortion) under 20 weeks gestation***

1. Non-viable fetal demise is handled as a specimen.
2. No certificate of death is required for a fetal demise less than 20 weeks gestation

K. ***Live birth with infant dying soon after birth (neonatal death)***

1. This applies to a live birth at any gestational age.
2. A certificate of live birth and certificate of death are prepared by the HIM department in two copies each. The original is sent to the Health Department by medical records and a copy is filed in the baby's chart.
3. If parents desire an autopsy, nursing staff will obtain the signature for Authorization for Autopsy. The Administrative Supervisor will be notified and will deliver the

original, signed authorization for Autopsy to the laboratory. If an authorization for autopsy is signed, it should indicate on the form if there will be a burial.

L. Departmental responsibilities:

Nursing:

1. Responsible for determining the family's wishes in regards to burial. Provide list of local mortuaries.
2. Preparation of memory box and other remembrances.
3. Responsible for proper paperwork completion. Please make every effort to coordinate with other departments to present all paperwork at one time to minimize emotional trauma to the family.
4. Evaluate for appropriateness of cooling cot use. See Attachment A
5. After the family has adequate time to spend with the body, nursing is responsible for placing appropriate identification on the body or specimen and transport to Pathology or the Morgue.
 - a. For all deliveries (whether live birth or not) and all gestational ages an identification band is to be placed on the body/specimen. The band is to be directly on body/specimen in a manner where it is most likely to remain in place.
 - i. Non-live births – Mother's identification information
 - ii. Live births – Infant's identification information
6. Refer to policy #297 [POST MORTEM-NOTIFICATION \(CORONER, DONOR NETWORK\), AUTOPSY AND RELEASE OF REMAINS](#)

M. Documentation:

1. Live birth information in neonate's electronic health record
2. Non-live birth information in mother's electronic health record
3. Perinatal Loss Checklist in the mother's electronic health record
4. Release of remains
5. Authorization for autopsy as indicated

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. AAP & ACOG. (2017). *Perinatal Guidelines*. (8th ed). Author.

Attachments

 [A: Cooling Cot "Cuddle Cot" Instructions for Use](#)

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	04/2025
Director Women's & Children's Services	Julie Vasher: Director Women's & Children's Services	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Daniela Jago: Clinical Manager	03/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Area	Administration

Financial Assistance Program/Full Charity Care & Discount Partial Charity Care

I. POLICY STATEMENT

- A. No individual who is determined to be eligible for financial assistance will be charged more for emergency or other medically necessary care than the Amounts Generally Billed to individuals who have insurance covering such care.

II. PURPOSE

- A. California acute care hospitals must comply with Health & Safety Code requirements for written policies providing discounts and charity care to financially qualified patients. This Policy is intended to meet such legal obligations and provides for both charity care and discounts to patients who financially qualify under the terms and conditions of the Salinas Valley Health Medical Center Financial Assistance Program.
- B. The finance department has responsibility for general accounting policy and procedure. Included within this purpose is a duty to ensure the consistent timing, recording and accounting treatment of transactions at SVHMC. This includes the handling of patient accounting transactions in a manner that supports the mission and operational goals of Salinas Valley Health Medical Center.

III. DEFINITIONS

- A. **Amounts Generally Billed:** The amounts generally billed (“AGB”) for emergency or other medically necessary services to individuals eligible for Discount Partial Charity Care. SVHMC calculates the AGB for a patient using the Prospective Method as defined in the Federal Income Tax Regulations. Under the Prospective Method, AGB is calculated using the billing and coding process SVHMC would use if the individual were a Medicare fee-for-service beneficiary using the currently applicable Medicare rates provided by the Centers for Medicare & Medicaid Services.

- B. **Discount Partial Charity Care (a.k.a. Discount Payment):** Discount Partial Charity Care is defined as any charge for care that is reduced but not free for [1] any emergency or medically necessary inpatient or outpatient hospital service provided to a patient who is uninsured or underinsured and 1) desires assistance with paying their hospital bill; 2) has an income between 201% and 400% of the current federal poverty level; and 3) who has established qualification in accordance with requirements contained in the Policy. The discount will be applied against the gross charges for hospital services provided.
- C. **Emergency and Medically Necessary:** Emergency and medically necessary services are defined as any hospital emergency, inpatient, outpatient, or emergency medical care that is not entirely elective for patient comfort and/or convenience. This includes those procedures that are scheduled and the patient has minimal benefit coverage, i.e., heart procedures, infusion therapy services and chemotherapy. This generally excludes those patients with a benefit design that requires them to utilize a designated facility.
- D. **Eligibility for Financial Assistance:** Eligibility is available for any patient receiving emergency or medically necessary services whose family income is less than 400% of the current federal poverty level, if not covered by third party insurance or if covered by third party insurance and unable to pay the patient liability amount owed after insurance has paid its portion of the account. Depending upon individual patient eligibility, financial assistance may be granted for Full Charity Care or Discount Partial Charity Care. Financial assistance may be denied when the patient or other responsible family representative does not meet the SVHMC Financial Assistance Policy requirements.
- E. **Extraordinary Collection Actions:** Extraordinary Collection Actions means a collection action requiring a legal or judicial process, involving selling debt to another party, reporting adverse information to credit agencies or bureaus, or deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under SVHMC's Financial Assistance Policy. The actions that require legal or judicial process for this purpose include 1) placing a lien; 2) foreclosing on real property; 3) attaching or seizing of bank accounts or other personal property; 4) commencing a civil action against an individual; 5) taking actions that cause an individual's arrest; 6) taking actions that cause an individual to be subject to body attachment; and 7) garnishing wages.
- F. **Family:** A patient's family is defined as: 1) For persons 18 years of age and older, spouse, domestic partner and dependent children of any age, whether living at home or not; and 2) For persons under 18 years of age, parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Family accounts for the inclusion of parents when the patient is a dependent child who is not a minor.
- G. **Full Charity Care:** Full Charity Care is defined as free care for any emergency or medically necessary inpatient or outpatient hospital service provided to a patient who has an income below 200% of the current federal poverty level and is unable to pay for care and who has established qualification in accordance with requirements contained in the SVHMC Financial Assistance Policy.

[1] Does not include discounts under SVHMC's Cash Discount Policy.

IV. GENERAL INFORMATION

- A. This Financial Assistance Policy pertains to financial assistance provided by Salinas Valley Health Medical Center. Under California law, hospitals are not permitted to employ physicians and, accordingly, physician services are provided by independent physician groups not controlled by SVHMC and who are not bound by this policy. Accordingly, this Financial Assistance Policy is applicable only to hospital services provided by SVHMC and specifically excludes medical care provided by physicians who may be members of the SVHMC Medical Staff. Specifically, this Policy applies only to charges for hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat hospital patients on an emergency, inpatient or outpatient basis. For Financial Assistance regarding your emergency room physician billing please contact Salinas Valley Emergency Medical Group at (831) 649-1000. Physicians providing services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policy to provide assistance.
- B. Salinas Valley Health Medical Center (SVHMC) serves all persons in Salinas and the larger surrounding community area. As a California Healthcare District, Salinas Valley Health Medical Center is committed to providing high quality, cost effective services to our patients. SVHMC strives to meet the health care needs of all patients who seek inpatient, outpatient and emergency services and is committed to providing access to financial assistance programs when patients are uninsured or underinsured and may need help in paying their hospital bill. Providing patients with opportunities for financial assistance coverage for healthcare services is an important element in fulfilling the Salinas Valley Health Medical Center mission. This Financial Assistance Program/Full Charity Care & Discount Partial Charity Care Policy (the "Policy") defines the SVHMC Financial Assistance Program; its criteria, systems, and methods. The intent of this Policy is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and all provisions should be interpreted accordingly. Patients with disabilities may request an alternative format of the financial assistance policy by calling 831-755-0732.
- C. **FULL CHARITY CARE AND DISCOUNT PARTIAL CHARITY CARE REPORTING**
1. SVHMC will report actual Charity Care provided in accordance with regulatory requirements of the California Department of Health Care Access and Information (HCAi) as contained in the Accounting and Reporting Manual for Hospitals, Second Edition. To comply with regulation, the hospital will maintain written documentation regarding its Charity Care criteria, and for individual patients, the hospital will maintain written documentation regarding all Charity Care determinations. As required by HCAi, Charity Care provided to patients will be recorded on the basis of actual charges for services rendered.
 2. SVHMC will provide HCAi with a copy of this Financial Assistance Policy which includes the Full Charity Care and Discount Payment (Discount Partial Charity Care Payment) policies within a single document. The Financial Assistance Policy also contains: 1) all eligibility and patient qualification procedures; 2) the unified application for Full Charity Care and Discount Partial Charity Care; and 3) the review process for both Full Charity Care and Discount Partial Charity Care. These documents shall be supplied to HCAi every two years or whenever a significant

change is made. Emergency room physicians are independent of SVHMC, therefore they have their own financial assistance program.

D. APPLYING FOR FINANCIAL ASSISTANCE

1. The SVHMC Financial Assistance Program utilizes a single, unified patient application for both Full Charity Care and Discount Partial Charity Care. The process is designed to give each applicant an opportunity to receive the maximum financial assistance benefit for which they may qualify. The financial assistance application provides patient information necessary for determining patient qualification by the hospital and such information will be used to qualify the patient or family representative for maximum coverage under the SVHMC Financial Assistance Program. The application includes the office and phone number to call if the patient has any question concerning the Financial Assistance Program or applying for the same. Eligibility for discounted payments or charity care shall be determined at any time, and SVMHC shall not impose time limits for applying for charity care or discounted payments, nor deny eligibility based on the timing of a patient's application.
2. Eligible patients may qualify for the SVHMC Financial Assistance Program by following application instructions and making every reasonable effort to provide the hospital with the requested documentation and health benefits coverage information such that the hospital may make a determination of the patient's qualification for coverage under the program. In determining eligibility for financial assistance, SVHMC will not request any additional information other than the information requested in the financial assistance application. A patient seeking financial assistance, however, may voluntarily provide additional information if they so choose. Eligibility alone is not an entitlement to coverage under the SVHMC Financial Assistance Program. SVHMC must complete a process of applicant evaluation and determine coverage before Full Charity Care or Discount Partial Charity Care may be granted. The following information will be considered in determining the eligibility of the patient for Financial Assistance: patient or family income, patient's family size, family income.
3. The SVHMC Financial Assistance Program relies upon the cooperation of individual patients who may be eligible for full or partial assistance. All patients unable to demonstrate financial coverage by third party insurers will be offered an opportunity to complete the financial assistance application. In addition, uninsured patients will be offered information, assistance and referral to government sponsored programs for which they may be eligible. Insured patients who are unable to pay patient liabilities after their insurance has paid, or those who experience high medical costs, may also be eligible for financial assistance. Any patient who requests financial assistance will be asked to complete a financial assistance application.
4. Financial assistance eligibility shall be determined at any time. SVHMC shall not impose time limits for applying for charity care or discounted payments, nor deny eligibility based on the timing of a patient's application.
5. Completion of a financial assistance application provides:
 - a. Information necessary for the hospital to determine if the patient has

- income sufficient to pay for services;
 - b. Documentation useful in determining qualification for financial assistance; and
 - c. An audit trail documenting the hospital's commitment to providing financial assistance.
6. However, a completed financial assistance application is not required if SVHMC determines it has sufficient patient financial information from public sources which to make a financial assistance qualification decision. Patients deemed presumptively eligible may be documented for financial assistance as reflected in the transaction code used to adjudicate the patient's claim, including but not limited to transactions related to full charity care, partial charity care, non-covered services and payer denials.

V. PROCEDURES

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

1. Qualification for full or discount partial financial assistance shall be determined solely by the patient's and/or patient family representative's ability to pay. Qualification for financial assistance shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
2. The patient and/or patient family representative who requests assistance in meeting their financial obligation to the hospital shall make every reasonable effort to provide information necessary for the hospital to make a financial assistance qualification determination. The hospital will provide guidance and/or direct assistance to patients or their family representative as necessary to facilitate completion of program applications. Completion of the financial assistance application and submission of any or all required supplemental information may be required for establishing qualification for the Financial Assistance Program.
3. Financial Assistance Program qualification is determined after the patient and/or patient family representative establishes eligibility according to criteria contained in this Policy. While financial assistance shall not be provided on a discriminatory or arbitrary basis, the hospital retains full discretion, consistent with laws and regulations, to establish eligibility criteria and determine when a patient has provided sufficient evidence of qualification for financial assistance. SVHMC does not require to apply for Medicare, Medi-Cal, or other coverage before the patient is screened, or provided, a financial discount. However, SVHMC may require patients to participate in screening for Medi-Cal eligibility.
4. Patients or their family representative may complete an application for the Financial Assistance Program. The application and required supplemental documents are submitted to the Patient Financial Services located at 3 Rossi Cir, Ste C, Salinas, CA 93907. This office shall be clearly identified on the application instructions and a telephone number and website for patients seeking assistance in completing the application shall be provided.
5. SVHMC will provide personnel who have been trained to review financial assistance

applications for completeness and accuracy.

6. Financial assistance determination will be made only by approved hospital personnel according to the following levels of authority:
 - a. Director of Patient Financial Services: Accounts less than \$150,000.01
 - b. CFO: Accounts between \$150,000.01 and \$300,000.00
 - c. CEO: Accounts greater than \$300,000.00.
7. Accounts with a value greater than \$150,000.00 require two signatures for approval.
8. Qualification criteria are used in making each individual case determination for coverage under the SVHMC Financial Assistance Program. Financial assistance will be granted based upon each individual determination of financial need in accordance with the Financial Assistance Program eligibility criteria contained in this Policy.
9. Financial Assistance Program qualification may be granted for Full Charity Care (100% free services) or Discount Partial Charity Care (charity care of less than 100%), depending upon the patient or family representative's level of eligibility as defined in the criteria of this Financial Assistance Program Policy.
10. Once determined, Financial Assistance Program qualification will apply to the specific services and service dates for which application has been made by the patient and/or patient family representative. In cases of continuing care relating to a patient diagnosis which requires on-going, related services, the hospital, at its sole discretion, may treat continuing care as a single case for which qualification applies to all related on-going services provided by the hospital. Other pre-existing patient account balances outstanding at the time of qualification determination by the hospital may be included as eligible for write-off at the sole discretion of management.

B. Full and Discount Partial Charity Care Income Qualification Levels

1. If the patient's gross family income is 200% or less of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the entire (100%) patient liability portion of the bill for services will be written off.
2. If the patient's gross family income is between 201% and 400% of the established poverty income level, based upon current FPL Guidelines, and the patient meets all other Financial Assistance Program qualification requirements, the following will apply:
 - Patient's care is not covered by a payer. If the services are not covered by any third-party payer so that the patient ordinarily would be responsible for the full-billed charges, the patient's payment obligation will be the gross amount the Medicare program would have paid for the service if the patient were a Medicare beneficiary.
 - Patient's care is covered by a payer. If the services are covered by a third-party payer so that the patient is responsible for only a portion of the billed charges (i.e., a deductible or co-payment, or any other out of pocket costs

and medical expenses), the patient's payment obligation will be an amount equal to the difference between what insurance has paid and the gross amount that Medicare would have paid for the service if the patient were a Medicare beneficiary. If the amount paid by insurance exceeds what Medicare would have paid, the patient will have no further payment obligation.

- Out of pocket costs and medical expenses mean any expenses for medical care that are not reimbursed by insurance or a health coverage program such as Medicare copays or Medi-Cal cost sharing.

C. Payment Plans

1. When a determination of Discount Partial Charity Care has been made by the hospital, the patient shall have the option to pay any or all outstanding amount due in one lump sum payment, or through a scheduled term payment plan.
2. The hospital will discuss payment plan options with each patient that requests to make arrangements for term payments. Individual payment plans will be arranged based upon the patient's ability to pay. As a general guideline, payment plans will be structured to last no longer than 12 months. The hospital shall negotiate in good faith with the patient; however where an agreement cannot be reached regarding a payment plan the payment plan bill will require that monthly payments do not exceed 10% of a patient's family income for one month excluding deductions for "essential living expenses" "Essential living expenses are defined as expenses for any of the following: rent or house payments (including maintenance expenses), food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child and spousal support, transportation and automobile expenses (including insurance, fuel, and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses. No interest will be charged to the patient for the duration of any payment plan arranged under the provisions of the Financial Assistance Policy.
3. SVHMC is not required to reimburse a patient if: (1) it has been five years or more since the patient's last payment to hospital/debt buyer, or (2) the patient's debt was sold before January 1, 2022, in accordance with the law at the time.
4. A health savings account held by the patient or the patient's family may be considered when negotiating payment plans. SVHMC may require a patient or guarantor to pay the hospital any amount sent directly to the patient by third-party payers, including from legal settlements, judgements, or awards. SVHMC may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program.

D. Special Circumstances

1. Any evaluation for financial assistance relating to patients covered by the Medicare Program must include a reasonable analysis of all patient assets, liabilities, income and expenses, prior to eligibility qualification for the Financial Assistance Program. Such financial assistance evaluations must be made prior to service completion by SVHMC.

2. If the patient is determined to be homeless he/she will be deemed presumptively eligible for the Financial Assistance Program and Full Charity Care.
3. Patients seen in the emergency department, for whom the hospital is unable to issue a billing statement, may have the account charges written off as Charity Care. All such circumstances shall be identified on the patient's account notes as an essential part of the documentation process..

E. Other Presumptively Eligible Circumstances

1. SVHMC deems those patients that are eligible for government sponsored low-income assistance program (e.g. Medi-Cal, Healthy Families, California Children's Services and any other applicable state or local low-income program) to be indigent and presumptively eligible for Full Charity Care under this Policy. Therefore, such patients are eligible under the Financial Assistance Policy when payment is not made by the governmental program.
2. The portion of Medicare patient accounts (a) for which the patient is financially responsible (coinsurance and deductible amounts), (b) which is not covered by insurance or any other payer including Medi-Cal, and (c) which is not reimbursed by Medicare as a bad debt, may be classified as charity care if:
 - a. The patient is a beneficiary under Medi-Cal or another program serving the health care needs of low-income patients; or
 - b. The patient otherwise qualifies for financial assistance under this Policy and then only to the extent of the write-off provided for under this Policy.
3. Any patient who has an income which exceeds 400% of the FPL and experiences a catastrophic medical event may be deemed eligible for financial assistance. Such patients, who have high incomes do not qualify for routine Full Charity Care or Discount Partial Charity Care. However, consideration as a catastrophic medical event may be made on a case-by-case basis. The determination of a catastrophic medical event shall be based upon the amount of the patient liability at billed charges, and consideration of the individual's income and assets as reported at the time of occurrence. Management shall use reasonable discretion in making a determination based upon a catastrophic medical event. As a general guideline, any account with a patient liability for services rendered that exceeds \$75,000 may be considered for eligibility as a catastrophic medical event.
4. Any account returned to the hospital from a collection agency that has determined the patient or family representative does not have the resources to pay his or her bill, may be deemed eligible for Charity Care. Documentation of the patient or family representative's inability to pay for services will be maintained in the Charity Care documentation file.
5. All accounts returned from a collection agency for re-assignment from Bad Debt to Charity Care will be evaluated by hospital personnel prior to any re-classification within the hospital accounting system and records.
6. SVHMC may presumptively determine that a patient is eligible for charity care or discounted payment based on information other than that provided by the patient or based on a prior eligibility determination.

F. Dispute Resolution

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

G. Extraordinary Collection Actions

1. If a patient does not apply for financial assistance or is denied financial assistance and fails to pay their bill, the patient may be subject to various collection actions, including Extraordinary Collection Actions.
2. Notwithstanding the foregoing, neither SVHMC nor any collection agency with which it contracts shall engage in any Extraordinary Collection Actions: (1) within the first one hundred eighty (180) days of the first post-discharge statement sent to a patient, and (2) without first making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. In addition, and even if the above two conditions are satisfied, no Extraordinary Collection Actions may be taken at any time unless written notice is first provided to the patient at least 30 days in advance of initiating the intended ECAs and such notice clearly sets forth the Extraordinary Collection Action that will be taken in the event of nonpayment and also includes a copy of the Plain Language Summary of the Policy (Exhibit A). If the patient applies for financial assistance, any Extraordinary Collection Actions that may be in process will be suspended immediately pending the decision on the patient's application. If the patient is determined to be eligible for financial assistance, SVHMC will (i) refund any amount collected in excess of the revised charges within 30 days, (ii) take reasonably available measures to reverse any Extraordinary Collections Actions previously initiated, and (iii) provide a new billing statement if the patient is eligible for Discount Partial Charity Care, indicating the revised amount due, stating how the amount was determined, and stating or describing how the patient can obtain information regarding AGB.
3. SVHMC will not report adverse information about a patient's hospital debt to a consumer credit reporting agency. Per AB 2297 and SB 1061, SVHMC recognizes the sale of a patient's primary residence have been removed, liens on real property

owned by the patient, and wage garnishments are prohibited.

H. Public Notice

1. SVHMC shall widely disseminate the existence and terms of its Financial Assistance Policy throughout its service area. To that end, SVHMC shall post clear and conspicuous notices informing the public of the Financial Assistance Program in locations that are visible to the public, including but not limited to the emergency department, billing office, inpatient admission and outpatient registration areas and other common outpatient areas of the hospital. Notices shall also be posted at any location where a patient may pay their bill. Notices will include contact information on how a patient may obtain more information on financial assistance as well as where to apply for such assistance. In addition, SVHMC shall post a copy of this Policy, the Plain Language Summary and the financial assistance application on its website and make all such documents available for free download.
2. SVHMC shall include the Plain Language Summary of this policy (Exhibit A) as part of the Condition of Admission during the registration process. If the patient is not conscious or otherwise able to receive the Plain Language Summary at the time of registration, the notice shall be provided during the discharge process (or when the patient leaves the facility, if not admitted). If for any reason the patient leaves the facility without receiving the written notice, SVHMC shall mail the notice to the patient within 72 hours. In all cases SVHMC will include the Plain Language Summary) in at least one post-discharge mailing. In addition, every invoice to a patient post discharge shall include a conspicuous written notice as an insert of the Plain Language Summary that: (1) informs the patient as to the availability of financial assistance; (2) includes a phone number of the office or department that can advise patients as to the availability of financial assistance; and (3) includes a direct website address (URL) where copies of this Policy, the Plain Language Summary and the financial assistance application may be downloaded.
3. Finally, SVHMC shall make translations of this Policy, the Plain Language Summary, and the financial assistance application available in Spanish and any other language that is the primary language of the lesser of 1,000 individuals or 5% of the population of the communities served by SVHMC.

I. Confidentiality

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

J. Good Faith Requirements

1. SVHMC makes arrangements for financial assistance for qualified patients in good faith and relies on the fact that information presented by the patient or family representative is complete and accurate.
2. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, or

purposely inaccurate information has been provided by the patient or family representative. In addition, SVHMC reserves the right to seek all remedies, including but not limited to civil and criminal damages from those patients or family representatives who have provided fraudulent or purposely inaccurate information in order qualify for the SVHMC Financial Assistance Program.

K. **Documentation**

- 1. SVHMC Financial Assistance Application, Financial Assistance Worksheet and Federal Poverty Guidelines
- 2. Plain Language Summary

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. California Health and Safety Code section 127400 et seq.
- B. B. Federal Poverty Guidelines
- C. Internal Revenue Code Section 501(r)

EXHIBIT A

PLAIN LANGUAGE SUMMARY
As a vital part of its charitable mission, Salinas Valley Health Medical Center (SVHMC) serves all persons in Salinas and the larger surrounding community area and provides financial assistance for eligible hospital emergency and medically necessary services to patients who may be unable to pay their hospital bills and who apply for and meet the eligibility requirements in our Financial Assistance Policy (the “Policy”). Under the Policy, if the patient’s gross family income is 200% or less of the established Federal Poverty Level (“FPL”) and the patient meets all other Financial Assistance Program qualification requirements, the entire patient bill for hospital services will be written off. In addition, if the patient’s gross family income is between 201% and 400% of the FPL, and the patient applies for and meets all other Financial Assistance Program qualification requirements, the patient may be eligible for discounts off their financial obligations. Please note that physician services are provided by independent Medical Groups that are not employed by SVHMC and accordingly are not covered under this Policy and are billed for separately by the physician group. To apply for financial assistance, a patient must simply fill out an application form requesting financial assistance and provide the information requested in the application. The application may be obtained and filed at 3 Rossi Circle, Suite C, Salinas, CA 93907. If you prefer, you may request an application for financial assistance (as well as a copy of the Financial Assistance Policy) by mail at 3 Rossi Circle, Suite C, Salinas, CA 93907 or you may download copies for Free off the internet at https://www.svmh.com/Patients-Visitors/For-Patients/Billing-Insurance.aspx The application and the Policy are also available in Spanish if needed and requested. If you need

help obtaining or completing an application, please contact Patient Financial Services at 831-755-0732.

If you have any questions about SVHMC's Financial Assistance Policy including whether you are eligible for financial assistance and how to apply for financial assistance, please contact Patient Financial Services at 831-755-0732.

As described in greater detail in the Policy, patients eligible for financial assistance will not be charged more than the amounts generally billed for patients covered by Medicare fee for service insurance. The Financial Assistance Policy, Financial Assistance Application and this Plain Language Summary are translated into Spanish.

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration	03/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Gary Ray: Chief Legal Officer
Area	Administration

Gift, Ticket and Honoraria

I. POLICY STATEMENT

- A. **Federal Anti-Kickback Statute:** It is the policy of Salinas Valley Health Medical Center (SVHMC) to ensure full compliance with the Federal Anti-Kickback Statute, which prohibits the acceptance of any item of value (remuneration) made directly or indirectly, in cash or in kind, that may induce or reward the referral of Federal or State health care program business. The unlawful acceptance of any gifts or business courtesies from vendors or others with whom SVHMC presently conducts business – or potentially could conduct business – is strictly prohibited.
- B. **Perishable Items:** It is the policy of SVHMC that any department, clinical unit, or clinical practice may accept modest, unsolicited perishable gifts such as floral arrangements, cookies, candy or similar food items of \$500 or less per occasion, to be shared by staff members and, where possible, made available to the public. All gifts from a single source (company or individual) are subject to an annual aggregate annual limit of \$1,000.
- C. **Gifts to District:** It is the policy of SVHMC that gifts received by SVHMC or any part thereof, which are then distributed to or used by individual recipients must be used for official agency business, and must be distributed and reported as required under the Political Reform Act and FPPC Regulations.
- D. **Solicitation of Gifts:** It is the policy of SVHMC that an employee may not solicit (i.e., ask for or request) gifts unless authorized to do so for approved hospital functions, fundraisers or special events. Requests for authorization to solicit gifts will be made in writing to the Chief Philanthropy Officer..
- E. **Gifts between Employees:** It is the policy of SVHMC that gifts of a personal nature between employees are permitted, provided hospital funds are *not* utilized.

It is further the policy of SVHMC that gifts between employees that are related to a person's employment at SVHMC (e.g. for Secretary's Day, Nurses Week, etc.) are permitted, provided they are customary for the occasion, are of reasonable value given the circumstances and the persons' positions in the organization, and hospital funds are *not* utilized.

- F. **All Other Gifts:** It is the policy of SVHMC that gifts other than those described in paragraphs C through G, above, may not be accepted in the performance of any officer or employee's duties or responsibilities. This includes gifts from patients, family members of patients, vendors or business associates. However, if the recipient has a good faith belief that not accepting the gifts could impact negatively the relationship between the patient and the recipient, or the patient and SVHMC, the employee may accept the gift. Documentation of the gift must be given to the employee's supervisor and to the SVHMC Chief Philanthropy Officer using the in-kind donation form.
- G. **Honoraria:** It is the policy of SVHMC to comply with the Political Reform Act and FPPC Regulations regarding the receipt of honoraria. SVHMC Board members and those who manage public investments (individuals who are required to file statements of economic interests under Government Codes section 87200) are prohibited from receiving honoraria payments. Likewise, employees whose positions are designated under the SVHMC Conflict of Interest Code are prohibited from receiving honoraria payments from any source of gifts or income included in their disclosure categories set forth in the Conflict of Interest Code. Exceptions to the State's honoraria prohibitions for local officials, such as for income earned from a bona fide business or profession, shall apply to SVHMC officers and employees. (Government Code Section 89502.) Honoraria and reimbursements for event attendance when permitted shall be handled pursuant to the procedures set forth below.

II. PURPOSE

- A. The purpose of this policy is to ensure Salinas Valley Health Medical Center (SVHMC) Board Members, leaders and staff members comply with external regulations and internally established standards regarding the receipt and provision of gifts, tickets and honoraria. Except as set forth in Section I.B. and I.C. above, this policy covers gifts to and from internal and external parties including individuals, businesses and organizations. The policy also governs SVHMC's further distribution of tickets and passes (e.g., to sporting, cultural and community events) that are gifted to SVHMC, and SVHMC's acceptance of payments or reimbursements related to speaking or appearing at professional or educational events.

III. DEFINITIONS

- A. **"Executive Leader"** includes the following: President/Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Nursing Officer, Chief Medical Officer, Chief Strategic Communication Officer, Chief Human Resources Officer, Chief Administrative Officers, and Chief Philanthropy Officer of SVHMC.
- B. **"FPPC Regulations"** means the regulations adopted by the Fair Political Practices Commission in its role as the implementing and enforcement agency of the State's Political Reform Act. These implementations are set forth in title 2, Division 6, Sections 18109-18997 of the California Code of Regulations.
- C. **"Gifts"**: For purposes of this Policy, "Gifts" are defined and excepted as set forth in the Political Reform Act and FPPC Regulations, as they may be amended from time to time. Generally speaking, the Political Reform Act defines a "gift" as any payment or other benefit received (including food/drink, travel or travel expenses, services, and items of any type) that confers a personal benefit for which the recipient does not provide something (e.g., payment, goods or

services) of equal value. This includes a rebate or discount in the price of anything of value unless the rebate or discount is made in the regular course of business to members of the public without regard to official status.

Exceptions generally include, but are not limited to:

1. Informational materials such as books, reports, pamphlets, calendars, or periodicals.
 2. Gifts which are not used and which, within 30 days after receipt, are either returned to the donor or delivered to a nonprofit entity exempt from taxation under Section 501(c)(3) of the Internal Revenue Code, without being claimed as a charitable contribution for tax purposes.
 3. Gifts from close family members (e.g., an individual's spouse, child, parent, grandparent, grandchild, brother, sister, parent-in-law, sister-in-law, brother-in-law, nephew, niece, aunt, uncle, or first cousin, or the spouse of any such person) unless the donor is acting as an agent or intermediary for any person not covered in this paragraph.
 4. Campaign contributions to an official, as long as they comply with and are properly reported in accordance with applicable campaign finance laws.
 5. Inheritance.
 6. Personalized plaques or trophies with an individual value of less than two hundred and fifty dollars (\$250).
 7. Gifts from long-term, close personal friends or friends or colleagues from business relationships unrelated to the recipient's role as a public officer or employee.
 8. Acts of neighborliness (e.g., picking up someone's mail or feeding a pet while the recipient is on vacation) or compassion (e.g., delivering food or flowers to someone in mourning).
 9. Food, shelter, or similar assistance received in connection with a disaster relief program. Benefits must be received from a governmental agency or charity and must be available to the general public
- D. **"In-kind Donations":** In-kind gifts are contributions of good or services, other than cash. For example, in-kind donations include products such as computers, furniture, clothing, face masks, hats, food boxes or office equipment. [In-kind donation form](#)
- E. **"Honoraria"** (plural form of "honorarium") include but are not limited to payments received for making a speech, publishing an article, or attending any public or private conference, convention, meeting, social event, meal or similar gathering.
- F. **"Immediate Family"** includes spouse; registered domestic partner; any child who can be claimed as a dependent for federal tax purposes; or a child who is aged 18 to 23 years old, attends school, resides with the recipient when not attending school, and provides less than one-half of his or her own support.
- G. **"Tickets" or "Passes":** The Fair Political Practices Commission (FPPC), in interpreting the Political Reform Act, has established that "ticket" or "pass" means "admission to a facility, event, show, or performance for entertainment, amusement, recreational or similar purpose."

IV. GENERAL INFORMATION

- A. **State Gift Laws:** Directors, Officers and designated employees of SVHMC identified in the District's Conflict of Interest Code or covered by Government Code section 87200 (including public officials who manage public investments) are subject to State laws regarding the receipt and disclosure of gifts as set forth in the Political Reform Act (at Government Code Section 89503) and the FPPC Regulations. These minimum requirements are not altered by this Policy.

1. The following table applies to individuals in positions designated by the Conflict of Interest Code:

Disclosure Category	Prohibited from receiving gifts totaling > \$520 from
Required filers and 1, 2	Any single source in a calendar year
3	Any single source that provides services, supplies, materials, machinery, or equipment of the type utilized by the district
4	Any single source that is a type to receive grants or other moneys from or through SVHMC.

2. These annual limits shall automatically increase or decrease consistent with modification to the gift limit established by the FPPC every two years.
 3. This Subsection B shall not be interpreted to permit receipt of Gifts prohibited under any other provision of this Policy, such as Subsection A, above.
- B. **SVHMC Foundation:** This policy does not apply to members of the Board of Governors of SVHMC Foundation or to SVHMC employees assigned to the SVHMC Foundation in their roles and in the performance of their responsibilities for the SVHMC Foundation. As a separate 501(c)(3) with the purpose of fundraising for SVHMC, SVHMC Foundation Governors and staff are permitted to solicit and receive in-kind gifts. They also are permitted to distribute tickets and other in-kind gifts to further the goals of the SVHMC Foundation in supporting the healthcare system's mission. Possible uses include: cultivation and stewardship of donors, reward volunteers for their service, prizes and awards for employee giving campaign, represent the SVHMC Foundation at events that are donor-rich environments and represent the SVHMC Foundation at key community events where the SVHMC Foundation presence is appropriate.
- C. **Tickets and Passes:** All Tickets and Passes received by SVHMC shall be distributed and reported in accordance with this policy and relevant FPPC Regulations. The following are not considered "Gifts" under State law:
1. Tickets and Passes that are provided to a SVHMC board member or official designated in the conflict of interest code when they are received and distributed by SVHMC in compliance with related FPPC Regulations and this Policy and promote the public purposes of SVHMC.
 2. Tickets or passes distributed to or at the behest of an agency official must accomplish a stated public purpose of SVHMC.
 3. Tickets and Passes provided by a third-party so that the recipient can perform a

ceremonial role or function on behalf of the organization, as further described in related FPPC Regulations, though such Tickets and Passes must still be reported by SVHMC.

4. A Ticket or Pass when it is provided directly to the recipient from a third-party when the giver and receiver treat the ticket or pass as income consistent with applicable state and federal income tax laws.
- D. Gifts, tickets and honoraria can be perceived tools to influence SVHMC decisions and patient care, and can erode public confidence and the impartiality of decisions made by public officers, officials and employees. This policy has been adopted to guard against even the appearance of impropriety in all aspects of SVHMC's programs, services, and administration. Furthermore, this policy is intended to prevent the perceived obligations of reciprocity that can arise from the giving or accepting of gifts, tickets and honoraria.
 - E. This policy does not address SVHMC's provision of gifts and other business courtesies to physicians and other potential referral sources for the hospital.
 - F. This policy also does not address SVHMC's provision of gifts and other business courtesies to patients or potential patients.
 - G. This policy will ensure that all in-kind donations received by SVHMC will be documented, that the donor will receive proper stewardship as well as satisfying IRS tax regulations regarding donation documentation.
SVHMC recognizes that there are times when employees will be offered gifts from patients, families or business associates. There are also times when employees want to give gifts to business associates or other employees. Such gifts can create a conflict of interest, a violation of anti-kickback laws and regulations or put the hospital 501(c)(3) status in jeopardy, if not handled appropriately.
 - H. SVHMC is exempt from taxation both because it is a governmental agency and also because SVHMC has obtained separate Internal Revenue Code Section 501(c)(3) tax-exempt status. The dual status of the healthcare system requires we implement policies and procedures which satisfy the governmental requirements of both.
 - I. Fair political practices act - A public official owes a duty of loyalty and honesty to the public—similar to a trustee or fiduciary. That duty is violated when a public official makes a decision that is not motivated by his or her constituents' interests but instead by his or her personal interests. A clear example is when an official receives a personal financial gain as the result of his or her public service. Examples include bribes and kickbacks (for example, receiving money back from proceeds paid to a company that does business with a public entity, but could also be as simple as receiving lavish gifts, loans or other gratuities).
 - J. Compliance
 1. Noncompliance of this policy can result in fines from government agencies and could impact 501c3 nonprofit status of the organization
 2. Department heads will monitor their departments and ensure that policy is followed.

V. PROCEDURE

- A. As noted above, these procedures do not address gifts, tickets, or honoraria to physicians or

other potential referral sources of Salinas Valley Health Medical Center. These are the procedures for giving and receiving gifts to or from outside SVHMC in the course of business.

1. **Receiving Gifts from External Parties:** Gifts from patients or patients' families should be discouraged. In general, an employee who is offered a gift of cash or a cash equivalent should decline the gift or may suggest a donation to a charitable organization such as the SVHMC Foundation however, if the employee has a reasonable belief that refusing to accept such a gift would have a detrimental effect on a patient or SVHMC, the employee must report and forward the gift immediately to his/her Department Head. The following applies to all gifts received by employees or SVHMC in the course of business:

- a. An employee who receives a gift will notify and forward the gift to his/her Department Head, who shall determine, in cooperation with the Director of Internal Audit and Compliance (Compliance Officer), whether State disclosures are required.

All gifts except those of minimal value (see b below) must be documented using the in-kind donation form and sent to the SVHMC Foundation office. Gifts received must be used for official district business. This includes meals provided by vendors.

- b. Gifts of minimal value such as pencils, calendars, and other promotional items may be distributed and used within the receiving department.
- c. With prior approval of an Executive Leader, vendors may provide meals and other food to employees only when the vendor is providing significant education related to products or procedures, or when conducting informational business meetings and the venue is conducive to the educational purpose or meeting. Attendance records may be retained by the Department Head and forwarded to the Compliance Officer upon request. Additionally, these must be documented on the in-kind donation form and sent to the SVHMC Foundation Office.
 - i. The total value of any meal should not exceed \$50 per attendee.
 - ii. Annual value of meals provided by a single vendor shall not exceed \$500 per year without prior approval an executive leader.
 - iii. Unless gifts are being requested by the SVHMC Foundation, an employee may not solicit gifts unless approved in writing by the Chief Philanthropy Officer.
 - iv. If a gift is used to partially fund an item with a value greater than \$25,000, then the contract shall be evaluated to see if competitive solicitation is required and will have to be approved at the appropriate level.
 - v. If a Gift is provided to SVHMC for distribution at the district's discretion, the SVHMC President/CEO shall distribute the Gift in accordance with FPPC Regulations. In such case, SVHMC will maintain record of such gifts and the applicable FPPC form to document this information. If the Gift was provided other than

for distribution at SVHMC's discretion, the Department Head will decide how to handle the gift under relevant FPPC Regulations, including allowing the employee to retain it, distributing it within the department (where feasible), or forwarding it to the Compliance Officer for proper disposition.

2. **Offering or Giving Gifts to External Parties:** Under limited circumstances, gifts may be given to external parties provided that they relate to business of SVHMC, are in SVHMC's best interests and are legally and culturally acceptable. In addition they should meet the following criteria:
 - a. Cash gifts or cash equivalents, such as gift certificates, are prohibited.
 - b. The item is customary and does not create an appearance of impropriety.
 - c. Giving the gift imposes no sense of obligation on the part of either the giver or recipient.
 - d. Giving of the item is not concealed.
 - e. Giving of the item has been approved in advance and in writing by the relevant Department Head and communicated to the Compliance Officer.
 - f. Non-monetary compensation provided to referral sources or their offices (e.g., physician, physician practice) are subject to an annual limit and must be tracked centrally.
 - g. Any Board member to which we provide in kind donations or any gifts have a \$520 limit before they have to declare it in their annual Statement of Economic Interest. Board member includes immediate family, as defined in the policy.
 - h. Gifts to another organization as requested or based on a strong recommendation by a Board member and the total gifts are > \$5,000 in a calendar year from the member, the Board member must complete a "Behested Payments" form.
 - i. Prior to providing \$ or a gift card of a specific value to an employee, the gift must be discussed with Accounting to determine whether it will be taxable.

B. Giving and Receiving Gifts within SVHMC in the Course of Business

1. Gifts and cash equivalents, such as gift cards may be given to employees as incentives for program attendance, recognition of outstanding achievement or for other positive rationale.
2. If an employee receives a gift card of any specific dollar value (e.g. \$10.00 Starbucks Gift Card) from the organization the value (\$10.00) of such gift must be documented as income and taxed accordingly. This provision does not apply to coupons for specific items, such as a free drink or free meal, or discount coupons such as 10% off any purchase in the Cafeteria, Gift Shop or Starbucks. Individuals who wish to distribute gift cards or certificates of a specific value should check with accounting prior to distribution in order to determine whether the gift may be taxable.

3. If gift cards are approved for distribution from the department executive, the director is responsible to obtaining the names of employees receiving such gifts and providing the information to Accounting.

C. Ticket/Pass Distribution

This procedure section will provide procedures for the distribution of Tickets and Passes as required under State law, to ensure proper identification and use of 1) receipt of Tickets and Passes; 2) the "public purpose" to be achieved in distributing Tickets and Passes; 3) distribution of Tickets and Passes; 4) documentation and 5) public posting of the receipt and use of Tickets or Passes. Proper exercise of these procedures will exclude Tickets and Passes from required disclosure on individuals' Statements of Economic Interests.

For the purposes of this section of the policy, "official" means all positions identified in SVHMC's Conflict of Interest Code.

1. **Ticket/Pass Receipt Process:** All Tickets/Passes received by SVHMC shall be forwarded to the office of the President/CEO of SVHMC. Determination of whether to give the tickets/passes to the SVHMC Foundation for use, or to distribute internally will be at the discretion of the President/Chief Executive Officer or their designee.
2. **Public Purpose:** The distribution of Tickets or Passes by SVHMC must be in furtherance of a "public purpose." Examples of such public purpose:
 - a. To promote networking opportunities of officials with community stakeholders;
 - b. To evaluate SVHMC's ability to attract business at the locale or event, and thus to contribute to the healthcare of the community in the future;
 - c. To reward an official, employee or hospital stakeholder for his or her exemplary service to the organization or to encourage staff development;
 - d. To promote attendance at a hospital-sponsored event or event held at the hospital in order to maximize potential from concession sales; or
 - e. To reward a hospital healthcare partner for its contributions to the healthcare system or the community.
3. **Distribution:** Tickets/Passes are distributed at the discretion of the President/Chief Executive Officer. Once distributed, tickets cannot be transferred by the recipient other than to members of the official's immediate family or no more than one guest who is not a member of the official's immediate family. Gifts to an official's immediate family member are considered gifts to the official. Disproportionate use of all tickets or passes to a particular individual will not be allowed.
4. **Documentation:** SVHMC will maintain record of all Ticket/Pass distribution, and the use of Tickets and Passes by SVHMC official for ceremonial purposes, as required by FPPC Regulations and utilizing FPPC Form 802, Agency Report of Ceremonial Role Events and Ticket/Pass Distribution, to document this information. The hospital must post the FPPC Form 802 within 30 days from the distribution of each Ticket or on its Internet site and send to the FPPC by email the website link. These forms are considered public records.

D. Honoraria and Reimbursement for Professional/Educational Involvement

1. With the prior approval of the Executive Leader, employees who provide education at professional conferences and meetings may accept reimbursement for travel and hotel expenses for the date(s) of the presentation(s). Presentations must be professional and educational in nature and may not be for the sole purpose of product endorsement.
2. In such circumstances, unless prohibited above, honoraria of \$100 or less in value may be accepted from the host organization without contacting the Compliance Officer.

E. Documentation:

1. Department Heads will maintain records of all gifts given to employees of their departments when such gifts are to be reported under this Policy. Such documentation will include the type and value of each gift, the name and affiliation or position of recipient(s) and giver(s), the date of receipt and disposition, and method of disposition. All documentation should be recorded using the in-kind donation form and sent to the SVHMC Foundation office bi-weekly by the Department Head of the receiving department. SVHMC Foundation office will send a copy to the Compliance Officer and Chief of Human Resources quarterly or upon request.
2. The Education Department will maintain documentation of education done in orientation or at annual compliance training. Department directors will maintain documentation of staff training meetings.
3. Statements of Economic Interest (including gift disclosures under State law) will be handled in accordance with the SVHMC Conflict of Interest Policy.
4. The Compliance Officer will maintain record of all ticket/pass distribution as required by FPPC Regulations, including copies of all completed FPPC Forms. The Compliance Officer shall be responsible for posting completed FPPC Forms on the SVHMC website when required by State law.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. The Medicare and Medicaid Patient Protection Act of 1987 (42 U.S.C. 1320a-7b) (Anti-Kickback Statute).
- B. Political Reform Act, California Government Code §81000 et. seq.
- C. FPPC Regulations, Title 2 of the California Code of Regulations, Division 6, §18109 et seq.
- D. IRS regulations, <https://www.irs.gov/charities-non-profits/charitable-organizations/charitable-contributions-written-acknowledgments>

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Gary Ray: Chief Legal Officer	03/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Gary Ray: Chief Legal Officer
Area	Administration

Identity Theft Detection, Prevention and Mitigation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide written guidance for Salinas Valley Health Medical Center (SVHMC) to identify, detect, prevent and mitigate identity theft in connection with covered accounts, as defined in the Definitions Section III...

III. DEFINITIONS

- A. PFS – Patient Financial Services
- B. HIM – Health Information Management
- C. FTC – Federal Trade Commission
- D. **Red Flag** is a pattern, practice or specific activity that indicates the possibility of identity theft.
- E. **Covered Accounts** are defined as follows:
 - Patient business accounts that are primarily for personal, family or household purposes, that involve or are designed to permit multiple payments or transactions; and
 - Any other account for which there is a reasonably foreseeable identity theft risk to customers or the safety and soundness of the hospital, including operational, compliance, reputation, or litigation risks.
- F. **Creditor** - Equal Credit Opportunity Act (ECOA) defines the term broadly as "any person or entity that regularly extends, renews, or continues credit; any person who regularly arranges for the extension, renewal, or continuation of credit; or any assignee of an original creditor who participates in the decision to extend, renew or continue credit." Specifically, a hospital is considered a creditor if it regularly bills patients after the completion of services, including for

the remainder of medical fees not reimbursed by insurance; or if it regularly allows patients to set up payment plans after services have been rendered,

- G. **Credit** - ECOA defines credit as "the right granted by a creditor to a debtor to defer payment of debt or to incur debts and defer its payment or to purchase property or services and defer payment therefor." The definition included businesses or organizations that regularly provide goods or services first and allow consumers to pay later. It also covers businesses or organizations that regularly grant loans, arrange for loans or the extension of credit, or make credit decisions, as well as those who regularly participate in the decision to extend, renew, or continue credit, including setting the terms of credit.
- H. **Identity Theft** means the act of knowingly obtaining, possessing, buying, or using the personal identifying information of another: (1) with the intent to commit an unlawful act and (2) without the consent of the other person or (3) without the lawful authority to obtain, possess, or buy that information.

IV. GENERAL INFORMATION

- A. The Red Flags Rule was issued in 2007 under Section 114 of the Fair and Accurate Credit Transactions Act of 2003 (FACTA). It requires "financial institutions" and "creditors" with "covered accounts" (as defined in the Red Flags Rule) to develop a written program that identifies and detects the relevant warning signs, or "red flags," of identity theft (see the FTC's *Red Flags Rule*, 16 C.F.R. § 681.1). The Rule was amended in 2010 by the Red Flag Program Clarification Act of 2010, 15 USC 1681m(e)(4), Pub. L. 111-319, 124 Stat. 3457 (December 18, 2010).

V. PROCEDURE

- A. The following procedure addresses the Red Flag Rule processes through activities listed below.
 - Identify relevant Red Flags
 - Detect Red Flags
 - Respond appropriately to Red Flags detected
 - Ensure the program is updated periodically
 - Administer the program
- B. Identify Relevant Red Flags
 - 1. Examples of Red Flags that may be present from an external source include:
 - a. Alerts, notifications, or warnings from a service provider or consumer reporting agency;
 - b. Unusual or suspicious activity relating to a patient account.
 - 2. Occurrences that could be considered red flags that may be provided by a patient who believes identity theft may have occurred, include, but are not limited to:
 - a. A complaint or question from a patient based on their receipt of another individual's bill;

- b. A bill for a product or service that the patient denies receiving
- c. An explanation of benefits (EOB) for health services not received;
- d. Records showing medical treatment that is inconsistent with a physical examination or with a medical history as reported by the patient;
- e. A complaint or question from a patient about the receipt of a collection notice from a bill collector;
- f. A patient or health insurer report stating that coverage for legitimate hospital stays is denied because insurance benefits have depleted;
- g. A complaint or question from a patient about information the hospital added to a credit report.

C. Detect Red Flags.

- 1. Employees should be alert for cases of possible identity theft.
- 2. Employees who may encounter identify theft will be trained on how to detect Red Flags
- 3. All patient registration areas will review for authentication and include in each patient's file a copy of the photo identification issued by a local, state, federal, or government agency if provided.

D. Respond appropriately to Red Flags detected:

- PFS

- 1. Notify the Director PFS immediately if contacted by a patient or guarantor with complaint of receiving a bill for hospital services where the patient or guarantor alleges no services were received.
- 2. Notify the Director PFS immediately if contacted by a patient or guarantor with complaint of receiving an insurance Explanation of Benefits (EOB), where the patient or guarantor alleges no services were received.
- 3. Notify the Director PFS immediately when notified of a potential identity theft risk by a credit bureau, collection agency or other business office associated vendor.
- 4. The Director PFS / designee will conduct a preliminary investigation for each reported occurrence in order to obtain additional information. If necessary, the Director PFS may suspend all billing and collection activity on an account at any point during the investigation.
- 5. Contact the Director of HIM when necessary to initiate a duplicate record search.
- 6. Based on investigation results, recommend that the patient report the situation to the police or the FTC.
- 7. Upon completion of the preliminary investigation, Director of PFS will report all significant findings to the Internal Ethics and Compliance Committee.

- HIM
 1. Upon request, perform a search of existing patient health records in accordance with policy to determine possible duplicate record issues.
 2. If duplicate health records are identified, coordinate an appropriate response with the requesting department. Resolve all duplicate record issues.
 3. Report to results to the Internal Ethics and Compliance Committee.
- Information Technology
 1. Perform routine and non-routine information system security measures designed to prevent or detect unauthorized access.
 2. Provide support and assistance with any Red Flag investigations conducted by Patient Registration, PFS, HIM, Compliance, Finance, or Administration departments.
 3. Report all significant findings to the Internal Ethics and Compliance Committee.

E. Oversight

The Corporate Compliance and Audit Committee has oversight of this process. Reports of Red Flags investigations, detected identity theft, and resolution will be reported as a standing item at each quarterly Corporate Compliance and Audit Committee meeting.

1. The Director of Contracting and Compliance shall have the overall responsibility for development and periodic updating of the Red Flag Rule process. Records of all reports will be maintained in accordance with applicable hospital record retention policies.
2. Periodic education and reports will be presented as needed by the Director of Contracting and Compliance to the Corporate Compliance and Audit Committee of the Board.
3. The Director of Contracting and Compliance will seek guidance from legal counsel as needed to support the Red Flag Program.

F. Documentation

1. Investigations, actions and outcomes are documented by the person(s) investigating an issue. Reports may be logged in an independent document or through www.EthicsPoint.com.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American Medical Association. Protect your patients, protect your practice: What you need to know about the Red Flags Rule. Practice Management Center. Retrieved from <http://www.cms.org/uploads/red-flags-rule-edu.pdf>

- B. Fair and Accurate Credit Transactions Act of 2003 (FACTA) §114
- C. Federal Trade Commission (FTC) Rule 16 CFR Part 681.
- D. "Fighting Fraud with the Red Flags Rule: A How-to Guide for Businesses" published by the FTC.
- E. The Red Flag Program Clarification Act (Clarification Act), 15 U.S.C. 1681m(e)(4)

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Gary Ray: Chief Legal Officer	02/2025

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerCarla Spencer: Chief Nursing OfficerAreaPatient Care

Massive Transfusion Protocol -Nursing

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the nursing staff in the implementation of the Massive Transfusion Protocol (MTP).

III. DEFINITIONS

- A. ER: Emergency Room
- B. OR: Operating Room
- C. L&D: Labor and Delivery
- D. ICU: Intensive Care Unit
- E. MTP: Massive Transfusion Protocol, refers to rapid administration of large amounts of blood products in fixed ratios for the management of hemorrhagic shock (Farkas, 2021)
- F. MTP Pack: Pre-defined quantities of Packed Red Blood Cells, Platelets and Fresh Frozen Plasma
- G. PRBCs: Packed Red Blood Cells
- H. PLTs: Platelets
 - I. FFP: Fresh Frozen Plasma
- J. RRT: Rapid Response Team

IV. GENERAL INFORMATION

- A. Indications for MTP
 - 1. Traumatic Hemorrhage

2. Obstetrical Hemorrhage
 3. Operative Bleeding
 4. Gastrointestinal Hemorrhage
- B. Adult MTP
1. Greater than 50 kg
 2. Pack consists of 4 units of PRBCs, 4 units FFP, & 1 unit PLTs
- C. Pediatric MTP
1. Less than 50 kg
 2. Pack consists of 2 units of PRBCs, 2 units FFP, & 1 unit PLTs

V. PROCEDURE

- A. Activation of the MTP
1. Physician orders the MTP protocol
 2. The hospital code line 2222 is called
 - a. Communicate to the hospital operator the name of the code (MTP), location, and indicate if it is a pediatric patient
 - b. In patient care areas other than ER, ICU, L&D, and OR, also request an RRT (or Code Blue if applicable).
 3. **A call must also be placed to Blood Bank to inform them of the patient name, location, medical record number, ordering physician and name of RN to be main contact for any inquiries.**
 4. Note the activation time (must be charted on the MTP Flowsheet).
 5. Staff response:
 - a. ICU RN responds to all MTPs in the hospital except in the ER.
 - b. ER RN responds to all MTPs in the hospital and brings the rapid infuser and tubing (do not bring if responding to Main OR).
 - c. Nursing Supervisor responds to all MTPs in the hospital.
 - d. Primary RN stays in the room to assist with patient care.
- B. Orders
1. The following must be ordered in Meditech:
 - a. Massive Transfusion -Initial
 - i. This requests the first set of blood products
 - ii. Initial Lab tests required in addition to Type and Screen
Baseline – H&H, PLTC, PT/PTT, Fibrinogen, D-Dimer, ABG, K⁺ and Ionized Calcium
 - b. Massive Transfusion -Maintenance

- i. *While MTP is activated* – H&H, PLTC, PT/PTT are repeated hourly for 4 hours
 - a. May be reordered for third, fourth...set of blood products
- C. Obtaining MTP blood products:
 - 1. MTP blood products are to be picked up from Blood Bank.
 - 2. Runner must bring patient sticker or Transfusion Request Form to identify patient.
 - 3. MTP Cooler
 - a. Red part is cold for PRBC and FFP storage.
 - b. Yellow is room temperature for Platelet storage.
- D. Vital signs must be obtained every 15 minutes, at minimum, during the MTP.
- E. All blood products must be checked and verified by two licensed RNs.
- F. Platelets are not administered via the rapid infuser.
- G. Avoid hypothermia
 - 1. Consider use of rapid infuser and warming devices.
- H. If the patient is transferred to another unit, all blood products must travel with the patient.
- I. Deactivation of the MTP
 - 1. The physician will determine when to end the MTP.
 - 2. The Blood Bank must be immediately telephoned and informed of the MTP deactivation.
 - 3. All unused Blood Products are to be returned to the Blood Bank at the end of the MTP.
- J. Documentation
 - 1. MTP activation and deactivation times are recorded in the patient's electronic health record.
 - 2. Documentation of the blood product administration is manually completed on the MTP Flowsheet.
 - 3. A Copy of each MTP Flowsheet used is to be delivered to blood bank at the conclusion of the MTP. The original is to be kept in the patient chart.

VI. EDUCATION/TRAINING

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

REFERENCES

- A. Beiriger, J., Silver, D., Lu, L., & Brown, J. (2023). Transfusion management in trauma: what is current best practice? *Current Surgery Reports*, 11, 43-54.
- B. Dynamic Health. (2022). *Performing massive blood transfusion*. Retrieved October 18, 2022,

- from <https://www.dynahealth.com/nursing-skills/performing-massive-blood-transfusion>
- C. Farkas, J. (2021). *Massive transfusion protocol (MTP)*. Internet Book of Critical Care (IBCC). <https://emcrit.org/ibcc/mtp>
 - D. Jennings, L., & Watson, S. (2022, Aug. 29). Massive transfusion. In *StatPearls*. Retrieved from <https://www.ncbi.nlm.nih.gov/books/NBK499929/>
 - E. Whitaker, J. Cutler, S., & Lucena-Amaro, S. (2023). Trauma nursing 4: recognising and managing haemorrhage in trauma. *Nursing Times*, 119(2), 42-47.

Attachments

 [MTP Implementation Grid V2 REV 11.2024.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Transfusion Committee	Katherine DeSalvo: Director Medical Staff Services	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Carla Spencer: Chief Nursing Officer	01/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Karina Kessler: Clinical Manager
Area	Women's and Children's Services

NICU Transport: Care Practices for Transport

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To guide staff in providing safe inter-facility transports under the supervision and guidance of the neonatologist.
- B. To guide staff in providing optimal nursing/respiratory care using a multidisciplinary approach for transport of critical neonates.

III. DEFINITIONS

- A. NCPeTS- Northern California Perinatal Transport System
- B. CPeTS- California Perinatal Transport System
- C. CPQCC- California Perinatal Quality Control Center
- D. CCS- California Children's Services
- E. AAP- American Academy of Pediatrics
- F. AHA-American Heart Association
- G. CCR- California Code of Regulations

IV. GENERAL INFORMATION

- A. Salinas Valley Health Medical Center (SVHMC) Neonatal Intensive Care Unit (NICU) provides transport services for critically ill neonates needing to be transported from a referring hospital to the SVHMC NICU. Any infant requiring a level of care beyond that which can be provided by a hospital with which the NICU has transport agreements and/or by the Regional Perinatal Dispatch Center will be accepted, on a space and staff available basis.

- B. All neonates will be transported via ambulance in the infant transport unit.
- C. Upon acceptance of a transport from a referring hospital, the make-up of the transport team, and the ambulance code to be used, will be determined by the NICU Medical Director or CCS-paneled Neonatologist providing the neonatal transport. The transport Neonatologist will also be responsible for the oversight of the medical care of the infant during transport. The transport team shall be in attendance during the entire transport procedure.
- D. Experience/Qualifications
 - 1. NICU Transport RN:
 - a. Current California RN licensure
 - b. Current Basic Life Support certification
 - c. Completed a minimum of two (2) years' experience as a neonatal nurse.
 - d. Current Neonatal Resuscitation Program (NRP) Certification and shall function in an expanded role under standardized procedures in accordance with CCR, Title 16, Division 14, Article 7, Sections 1470-1474
 - e. Shall have advanced skills, which include but are not limited to, endotracheal intubation.
 - f. Successful completion of the NICU transport training course.
 - g. Has in-depth knowledge and skills to assess the acutely ill neonate.
 - h. Has demonstrated good verbal and written communication skills.
 - i. Has demonstrated ability to work well with staff, physicians, parents, and patients.
 - j. Has demonstrated reliability and flexibility in work schedule.
 - 2. RCP:
 - a. Current California RCP licensure
 - b. Current Basic Life Support Certification
 - c. Current NRP Advanced Provider Certification
 - d. California Children's Services qualified
 - e. Has in-depth knowledge and skills, to include endotracheal intubation, and is able to assess the acutely ill neonate.
 - f. Successful completion of the NICU transport training course.
 - g. Has demonstrated good verbal and written communication skills.
 - h. Has demonstrated ability to work well with staff, physicians, parents, and patients.
 - i. Has demonstrated reliability and flexibility in work schedule.
- E. Team Composition (as determined by the Neonatologist):
 - 1. The transport team for **Unstable** and **Potentially Unstable** infants shall include:
 - a. A Physician or a RN (functioning in an expanded role with advanced skills

as outlined in D.1.e. above in accordance with CCR, Title 16, Division 14, Article 7) and a RCP.

- b. A potentially unstable infant at the referring hospital will be evaluated by the neonatologist. The infant will be stabilized and once determined to be stable, will be transported by a transport nurse (as outlined in E.1.a. above) and a RCP.
 - c. A stable infant may be transported by a Transport RN.
- F. All procedures that can be performed on transport will be reviewed by the Transport Coordinator, the Neonatologist, the Clinical Nurse Specialist, and the NICU Respiratory Supervisor/Educator or their designated personnel annually.
- G. The transport staff will maintain skills at an annual competency.
- H. Transport staff will review QI data and plan improvement as well as participate in education related to transport processes.
- I. All transport procedures are to follow NRP Guidelines and SVHMC policies/procedures (CCS Standard, Chapter 3-25.2 – 23 + 26. 8a-b 18-1a).

V. PROCEDURE

- A. Role of the Neonatologist.
- 1. The neonatologist on call. (Approval, team make-up, ambulance code). Considering staffing and bed availability, the Medical Director will make the appropriate decision as to whether to accept the transport.
 - 2. Provide referring physician with information to assist in the stabilization of the infant until the neonatologist's arrival. Once at the referring hospital, complete the stabilization of the infant.
- B. Role of Ambulance Service:
- 1. Maintain ambulance systems, supplies, equipment and cleanliness.
 - 2. Move and guide transporter through the receiving and referring facilities.
 - 3. Lifts and locks ramp and places transporter in ambulance.
 - 4. Prepares ambulance for isolette transport.
- C. Role of the Charge Nurse, Transport RN, and Transport RCP
- 1. Charge RN will follow SVHMC Transport Checklist
 - 2. Transport RN will obtain documentation packet that includes a printed copy of the NICU medication calculations based on the weight (or estimated weight) of the patient to be transported.
 - 3. Transport RN and Transport RCP will ensure that appropriate supplies are available in the NICU transport bags.
 - 4. Transport RN will obtain medication kit from the NICU Omnicell to take on transport
 - 5. Transport RN will obtain consent from the parent(s)/legal guardian(s) upon arrival at

the referral facility.

6. Transport RN will place SVHMC ID band the patient and parent(s)/ legal guardian before leaving referral facility.
7. Transport RN will give the parent(s)/legal guardian(s) directions to SVHMC.

D. Documentation:

1. Document on Neonatal Transport Record (Assessment, Medications) and Respiratory Assessment/Ventilator Flow sheet as applicable.
2. Chart vital signs every 30 minutes and prn (monitor every 15 minutes if infant is receiving vasopressors).
3. Ensure that gray shaded areas of Neonatal Transport Record are complete (these are the required CPeTS elements for data entry).

E. SUPERVISION AND ACCOUNTABILITY

1. The Transport Nurse and RCP are supervised and held accountable to the Transport Coordinator, the Neonatologist, and attending physicians for the satisfactory completion of functions and responsibilities as they relate to the transporting of infants.

F. QUALITY ASSURANCE

1. The Medical Director of the NICU will be responsible for the transport quality assurance program. The following information will assist in assuring quality assurance and program improvement:
 - a. Data submitted to CPeTS.
 - b. Transport Chart Review – Completed by Transport Coordinator, Neonatologist, Clinical Nurse Specialist, and NICU Respiratory Supervisor/ Educator or designee during monthly chart review of transports.
 - c. Clinical Quality Review Record – Completed by transport team members.
2. The Transport Coordinator or designee will regularly attend Regional Quality Improvement (RQI) committee of NcPeTS in person or by webinar.
3. Data will be collected quarterly and shared with the transport team members to identify, and implement solutions under the guidance of the Medical Director.
4. The neonatal transport agreements shall be updated and signed annually by the medical directors of the NICU's involved in the agreement, i.e., Mid-Coastal California Perinatal Outreach Program (MCCPOP).
5. The medical director of the neonatal transport program shall be responsible for the written neonatal transport plan which shall include, but is not limited to, the following:
 - a. A summary of the neonatal transport training program.
 - b. Annual review of the transport program and annual evaluation of the members with documentation of competency in transport of the neonate by the NICU Medical Director.

- c. Set the minimum number of precepted neonatal transports for new neonatal transport team members.
- d. Maintains written records of each neonatal transport completed. These records shall be available for review by the CCS program staff. (All copies of the Neonatal Transport Records are scanned into the patient's chart and are, therefore, available electronically.)

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. National Association of Neonatal Nurses. (2019). Policies, Procedures, and Competencies for Neonatal nursing Care (6th ed.). (S. S. Bowles, Ed.) Chicago, Illinois: National Association of Neonatal Nurses.
- B. American Academy of Pediatrics (2021). Textbook of Neonatal Resuscitation (8th ed.). Elk grove Village, IL: American Heart Association and American Academy of Pediatrics
- C. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care (8th ed.) Elk Grove, IL: American Academy of Pediatrics
- D. American Academy of Pediatrics (2015). Guidelines for Air and Ground Transport of Neonatal and Pediatric Patients (4th Ed.) Elk Grove, IL: American Academy of Pediatrics.
- E. Regional Perinatal Dispatch Center, California Pediatric Quality Care Collaborative (CPQCC)
- F. Title 22- 70493(a) (i)

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	04/2025
Director of Women's and Children's Services	Julie Vasher: Director Women's & Children's Services	03/2025
NICU Medical Director	Robert Castro: PHYSICIAN	03/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Karina Kessler: Clinical Manager	03/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Megan Giovanetti:
Director
Cardiovascular Services and Sleep
Cardiology
Departments

Observation in the Cath Lab by Emergency Medical Services Personnel

I. POLICY STATEMENT

- A. EMS personnel who wish to follow their patient through the continuum of care as part of the chest pain / STEMI team may opt to observe cardiac catheterizations in the Cardiac Catheterization Lab.

II. PURPOSE

- A. The purpose of this policy is to allow Emergency Medical Services (EMS) personnel the opportunity to observe Cardiac Catheterizations on patients brought in by Ambulance for ST elevation MI (STEMI).

III. DEFINITIONS

- A. STEMI- ST elevation MI
- B. EMS- Emergency Medical Services

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. Upon arrival to the hospital with a STEMI patient, EMS personnel wishing to observe the patients cardiac catheterization will request observation from the Cath Lab team and

interventional Cardiologist.

- B. Once approval has been granted, the EMS personnel will follow the Cath Lab team members and patient into the Cardiac Cath Lab.
 - 1. Observation will occur from the Cath Lab control room only
 - 2. EMS personnel will be required to follow universal protocols upon entering the Cath Lab control room (i.e. scrub attire, caps, masks as appropriate).
- C. Cardiac Cath Lab staff members will introduce themselves and provide a brief overview of the Cath Lab environment, normal and abnormal cardiac anatomy during the case and answer any questions EMS personnel may have.
- D. Cardiac Cath Lab staff members will fill out the EMS Cath Lab Observation sheet at the end of the case and return it to the department director.
- E. Hospital privacy policies and HIPPA rules apply throughout the observation.
- F. 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
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Cardiology Medical Director	Megan Giovanetti: Director Cardiovascular Services and Sleep	01/2025
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Policy Owner

Megan Giovanetti: Director
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Sleep

11/2024

Standards

No standards are associated with this document



Last Approved N/A
Next Review 1 year after approval

Owner Clement Miller:
Chief Operating Officer
Area Plans and Program

Organization Plan for Provision of Care and Service

I. SCOPE

- A. Salinas Valley Health Medical Center (SVHMC) provides care and services to patients in a safe, effective and comparable level of care throughout the organization in accordance with patient needs and the hospital's mission and vision and in a manner designed to improve the quality of care as well as identified community needs. The care, treatment, and services are designed to ensure patient care is consensual, appropriate to the patient's specific needs, the severity level of their disease, condition, and to age-specific needs and requirements. Patient Centered Care is delivered in an interdisciplinary manner by all members of the health care team including but not limited to medical and Advanced Practice Providers, nursing staff, pharmacists, dietitians, therapists, chaplains and technicians. Collaboration is evidenced in the planning and determining of interventions regarding each patient's specific care needs and resource allocation. Each provider's particular role and responsibility is determined by his or her professional skills, competence and credentials; by the component of care, treatment and other services being provided and by relevant licensure, certification, regulation, privileges, scope of practice, and or job description.
- B. This Organizational Plan for the Provision of Care and Services outlines the components and Scopes of Service that are integral to the provision of patient care at SVHMC. The purpose of the Organizational Plan for Care and Service is to describe the framework by which the leadership of the hospital will plan, direct, coordinate, and improve the services provided to the community. This plan is based on the assumption that the hospital is a network of integrated processes and is supported by the hospital strategic plan, the departmental plans, and referenced administrative policies.

II. OBJECTIVES/GOALS

A. Objectives

1. The Mission of SVHMC is to provide quality healthcare for our patients and to improve the health and well-being of our community.
2. To accomplish this mission we will:
 - Provide and promote comprehensive quality care and services.
 - Maintain ongoing safety initiatives;
 - Care for our patients as unique and important individuals;
 - Promote a caring, concerned, compassionate healthcare delivery system

environment;

- Develop and refine an integrated delivery system;
- Maintain sound administrative and financial management;
- Support careful use of natural resources; and
- Educate the community and encourage their participation in healthcare issues.

3. The Vision of SVHMC is to be a community where good health grows through every action, in every place, for every person.

B. Goals

1. Patient Care:

- To provide timely and appropriate care and services based upon the individualized needs of the patient;
- To coordinate care utilizing interdisciplinary team collaboration that maximizes care outcomes and satisfaction;
- To provide care that assures personal dignity with respect for psychosocial, spiritual, emotional, and cultural values; Incorporate the Diversity, Equity and Inclusion principles and practices throughout SVHMC.
- To provide a safe environment while providing quality care;
- To be cost effective in the use of our financial and human resources.

2. Strategic Planning, Community Assessment, and Strategic Goals:

- SVHMC's strategic plan focuses on achieving a "continuum of care" for all services provided to our patients. As a primary source of health care services in our community, we strive to achieve this continuum in conjunction with other important performance improvement goals, objectives and performance improvement teams. In accordance with the hospital's mission and vision, and the needs of our community, a strategic plan is developed to identify priorities. The priorities of the management team are based on the need to develop new systems/processes or improve current systems/processes to best meet customer needs as determined by assessment activities and customer surveys.
- In accordance with the mission and vision of the hospital and the needs of our community, a hospital system strategic plan is developed to identify the priorities of the leadership team. The planning process includes a collaborative assessment of our customer and community needs, defining the strategic direction, yearly strategic imperatives, operational plans, and corresponding annual budgets.

III. DEFINITIONS

- A. Patient care providers are defined as actual care givers.
- B. Services include those individuals who do not provide direct patient care but come in contact with patients such as but not limited to EVS, registration clerks, Food and Nutrition Services, Facilities, Patient Financial Services, etc..
- C. SVHMC – includes all care units and services under the licensed facility.

IV. PLAN MANAGEMENT

A. Plan Elements

1. SVHMC is a 263-bed District Hospital. SVHMC provides a full range of acute care services, including inpatient and outpatient care.
2. To better serve the community, SVHMC has developed relationships with area hospitals to provide services.
3. In accordance with federal and state regulations, professional practice standards and codes, SVHMC provides the community with an extensive range of health care services including but not limited to the following services:
 - Acute Care medical and surgical Services
 - Cardiac Catheterization Laboratory Services
 - Cardiovascular Services, including Cath Lab, Cardiovascular Surgical Services, Cardiac Rehabilitation Services, Non Invasive Cardiology Services
 - Diagnostic Imaging/Nuclear Medicine Services (Inpatient & Outpatient), including Ultrasound, MRI and Cardiovascular Imaging Services
 - Emergency Services
 - Intensive Care / Coronary Care Services
 - Laboratory Services (Inpatient & Outpatient)
 - Intensive Care Newborn Nursery Services
 - Mammography
 - Neonatal and Pediatric Services
 - Pathology / Laboratory Services, including Blood bank
 - Perinatal Services, including Level 3 NICU
 - Pharmacy Services
 - Perioperative Services, Inpatient and Ambulatory Care
 - Physical/Occupational/ Speech Therapy Services
 - Respiratory Care Services
 - Rural Health – Taylor Farms family Health and Wellness Center
 - Sleep Medicine / Neurodiagnostic Services
 - Social Services
 - Wound Care Services (Inpatient & Outpatient)
 - Oncology Care Services, including outpatient Infusion Center
4. The Scope of Services is further defined in writing by each department. Each department's Scope of Service (department-specific plan) is approved by the department Director and hospital administration as appropriate.
5. All major hospital functions and services (budget, staffing, and performance assessment) are planned, implemented, and evaluated annually. The senior administrative staff plans and evaluates hospital performance in conjunction with the Board of Directors and the medical staff. Hospital-wide and departmental plans are developed to provide direction for the year.
6. Changes in patient care needs or findings from performance improvement, risk management, infection control, safety, patient safety assessments, and other internal assessments may trigger review and revision of this Plan.
7. SVHMC also works collaboratively with the community, as well as through community

organizations, to assess healthcare needs and the need for additional or improved services. A community assessment is conducted using a variety of formal and informal methods. Patients and families are interviewed through surveys. Discharge planning continually evaluates community resources and ease of access. Collaborative meetings between hospital leadership and the County Health Department to assess the needs of high-risk groups take place periodically. Data from the Health Department and other sources are used.

B. Definition of Patient Service, Patient Care, and Patient Support

1. Patient Care Services at SVHMC are provided through organized and systematic processes designed to ensure the delivery of safe, effective, and timely care and treatment. Providing patient services and the delivery of patient care requires specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, and medical sciences.

- a. **Providing Patient Services** - Patient services will be planned, coordinated, provided, delegated, and supervised by professional health care providers who recognize the unique physical, emotional, and cultural needs of each person. Patient care encompasses the recognition of disease and health, patient teaching, patient advocacy, cultural beliefs, and research.

Patient services are limited to those departments that have direct contact with patients. Inpatient care is directed and supervised by registered nurses that are responsible for patient assessment and planning patient care based on findings from the assessment. Outpatient services may have a Registered Nurse and those areas that require a RN are defined in the individual unit Scope of Service. Patient services and patient care are provided by licensed and non-licensed staff. Patient support is provided by a variety of individuals and departments, which may or may not have direct contact with the patients. They support the care provided by a variety of individuals and departments, which may or may not have direct contact with the patients, but who support the care provided by the professional staff.

- b. **Providing Patient Care** - Patient services at SVHMC occur through an organized approach designed to ensure the delivery of safe, effective and timely care and treatment. Medical Staff, Registered Nurses, Advanced Practice Providers (APP) and other members of the healthcare team function collaboratively as part of a multi-disciplinary team to meet the needs of the patient and to achieve positive patient outcomes.

The hospital's administration, management, organized medical staff, and all employees will assure that care provided to patients is of the same quality regardless of age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, gender, sexual orientation and gender identity or expression. Patients with the same health problems and care needs have the right to receive the same quality of care. Patients with the same nursing care needs receive comparable levels of nursing care throughout the hospital. Efficacy and appropriateness of procedures, treatments, interventions and care provided will be demonstrated based on patient assessments/reassessments, state-of-the-art evidence-based practice, desired outcomes and with respect for patient rights and confidentiality.

SVHMC staff will ensure that prior to providing care, treatment and services, staff obtains or renews orders from a licensed independent practitioner in accordance with professional standards of practice, laws and regulations. The staff will correctly and competently perform the right procedures, treatments, interventions and care by

following the policies, procedures and protocols that have been established to ensure patient safety.

- c. **Patient Support Services** - Other services are available and are provided to SVHMC patients to ensure patient care and services are maintained in an uninterrupted manner by coordinating organizational functions. These Patient Support Service departments provide support for the comfort and safety of the patients and that quality and efficiency of services are available. These services are integrated with the patient care services of SVHMC. Support services are provided by a variety of individuals and departments, which may not have direct patient contact, but who support the provision of patient care services.

Other hospital services are provided to ensure that patient care and services are maintained in an uninterrupted and continuous manner by coordinating identified organizational functions including leadership/management, information systems, human resources, environment, infection control, and organizational performance improvement. These services support the comfort and safety of the patient and efficiency of services available.

C. **Contracted Patient Care Services**

1. To ensure that patient care services are available in a timely manner to meet the needs of SVHMC patients, all services essential to the provision of patient care are provided to our patients either directly by SVHMC or through referral, consultation, and/or contract with approved providers. Contracted sources of patient care / services are approved by the Medical Executive Committee (MEC) and/or the Executive Leadership Group (ELG). The scope for services for these contracted services is defined in writing. SVHMC, through the responsible hospital leader and in cooperation with MEC, evaluates the contracted care, treatment, and services to determine whether they are provided according to contract, level of safety and quality the hospital expects, and according to The Joint Commission standards. The hospital leader responsible for managing the contracted service retains overall responsibility and authority for services furnished under the contract.

D. **Patient Needs and Expectations**

1. It is the intent of the patient care staff at SVHMC to provide care and services that meet or exceed patient/patient representative:
 - a. Performance of the appropriate assessments, procedures, treatments, interventions, and reassessment;
 - b. Competent, appropriate, timely and safe care;
 - c. Respect for patient rights and confidentiality;
 - d. Delivery of care and service in a manner that:
 - is compassionate, with respect and dignity for each individual without bias;
 - best meets the individualized needs of the patient;
 - is coordinated, through interdisciplinary team collaboration, to ensure timeliness, continuity, and seamless delivery of care to the greatest extent possible; and
 - maximizes the efficient use of our financial and human resources.

E. **Personnel Skill Level, Collaboration, and Integration**

1. Patient care is provided by a variety of different types of providers. Each category of patient

care giver has a job description that delineates the responsibilities of the individual. Each type of personnel is expected to function within the scope of their position. All patient care personnel will uphold the standards of the regulatory agencies. The appropriate mix of skill levels will be utilized by each department. The mix will be determined based upon patient care needs, stability and regulatory requirements.

2. It is expected that all disciplines will collaborate to ensure that the patient care provided yields the highest quality in the most cost-effective manner. Hospital Administration and Medical Staff leadership ensure that collaboration among all disciplines occurs concerning:
 - The development of patient care programs, policies, procedures and planning for patient care.
 - Organizational decision-making.
 - Organizational performance improvement.
3. The importance of a collaborative, interdisciplinary team approach, which considers the unique knowledge, judgment and skill of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integrating care. Open lines of communication need to exist between all departments providing patient care, patient services, and support services within the hospital, and as appropriate with community agencies to ensure efficient, effective, and continuous patient care. To facilitate effective interdepartmental relationships, problem solving is encouraged at the lowest levels possible within the organization. Staff should be open to addressing one another's issues and concerns and seeking mutually acceptable solutions. Managers have the authority to solve problems and seek solutions within their span of control.

F. Professional Patient Care Staff: Roles and Responsibilities:

	Assessment	Care Planning	Discharge Planning	Access to Services	Nutrition	Operative, Invasive Procedures	Patient Rights	Patient Teaching	Treatment and Meds
Physicians/APP	X	X	X	X	X	X	X	X	X
Registered Nurse	X	X	X	X	X	X	X	X	X
Pharmacists	X	X	X		X		X	X	X
Occupational Therapists	X	X	X	X			X	X	X
Physical Therapists	X	X	X	X			X	X	X
Registered Dieticians	X	X	X	X	X		X	X	
Respiratory Therapists	X	X	X				X	X	X
Social Workers	X	X	X	X			X	X	
Speech Therapists	X	X	X				X	X	X
Technologists • Medical • Radiology						X	X	X	
Case Managers	X	X	X	X			X	X	

G. Staffing Plans

1. Each department has a staffing plan that was developed based on the levels and care needs of the patients served by that department. Each department also has a plan to allow for variation of the staffing guidelines based upon individual needs of patients. Each department reviews their staffing plan annually to determine changes based on changes in utilization, types of patients, performance improvement activities and changes in customer needs/expectations. For areas where state regulations apply, such as nursing staffing ratios, those staffing plans are reviewed as defined by regulation.
2. The goal of the management of human resources function is to identify and provide the right number of competent staff to meet the needs of patients served. The Human Resources Functional Team, in collaboration with hospital leaders, monitors the effectiveness of staffing.
3. The hospital leaders carry out the following processes and the related activities to assure appropriate staffing:
 - Planning – The leaders define qualifications, competencies, and staffing necessary to fulfill the hospitals mission;
 - Providing competent staff – The leaders provide for competent staff either through hiring staff or contractual arrangements with other entities;
 - Assessing, maintaining, and improving staff competence – Ongoing, periodic competence assessment evaluates staff members' continuing abilities to perform throughout employment; and
 - Promoting self-development and learning- The leaders create a culture that fosters staff self-development and continued learning.
4. Staffing plans for clinical service departments are developed based on:
 - The hospital's mission;
 - The case mix of patients served by the hospital or department, and the degree and complexity of care required by patients and significant others;
 - The care provided by the hospital, including treatment;
 - The technology used in patient care; and
 - The expectations of the hospital, its patients and other customers.
5. The leaders use data on clinical/service indicators in combination with human resource screening indicators to assess staffing effectiveness.
 - When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes. Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, we examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation training, and education.
6. Each department has a formalized staffing plan, which will be reviewed ongoing based on the following:
 - Utilization review;
 - Employee turnover;
 - Performance assessment;
 - Improvement activities;
 - Changes in customer needs/expectations;

- Budget; and
- Regulations/Patient Safety.

H. Plan Management

1. The authority and responsibility to govern SVHMC is vested in the elected Board of Directors each of whom is a registered voter residing in the district and whose term is four years. Their authority and responsibilities are set forth in the California Local Healthcare District Act and in the District Bylaws. They are responsible for the governance of SVHMC, including Salinas Valley Health Medical Center and the Medical Staff of the Hospital. The Board's governance responsibilities include overseeing delivery of quality patient care and implementation of all policies and procedures. The Board of Directors delegates to the President/Chief Executive Officer the responsibility for day-to-day Administration of the Hospital and Healthcare System.
2. The SVHMC Medical Staff is responsible to the Board of Directors for the provision of quality patient care. The Medical Staff is composed of standing committees as well as other sub and ad hoc committees, which form the oversight functions of those credentialed by the Medical Staff.

The Board of Directors delegates certain responsibilities and authority to the medical staff, including accountability for the measurement, monitoring and maintenance of quality. The granting of medical and allied health staff privileges is subject to the Medical Staff Bylaws and Rules and Regulations. The Medical Staff Bylaws describe the framework for the organization, membership and responsibilities of the medical staff. Neither body may unilaterally amend the Medical Staff Bylaws, Rules and Regulations. The medical staff, through service lines and medical departments, contributes to the quality of care by coordinating its work with the work of those responsible for governing the organization and other leaders. The medical staff helps ensure that all medical staff members responsible for assessing, caring for, or treating patients are clinically competent and that the clinical care rendered is appropriate. They also have opportunities to contribute to the planning, budgeting, safety management, and overall quality improvement activities of the organization. The medical staff committee structure and function is described in detail in the Medical Staff By-Laws and Rules and Regulations.

3. Hospital leadership consists of the Executive Leadership Group (ELG), directors and managers. The ELG is given the authority and responsibility to operate the Hospital in all of their activities and departments, subject to the policies issued by the Board of Directors.
4. Leadership Values:
We believe:
 - That we should provide a progressive environment, using current technology that is guided by responsible stewardship to promote the highest quality patient care and employee satisfaction;
 - That we should encourage and support collaborative decision making by those who are closest to the situation, even at the risk of failure;
 - That compassion should be characterized in our day-to-day personal interactions as well as being a motivating factor in management decisions;
 - That we should be sensitive to individual need and give support, praise, and recognition to encourage personal and professional development;
 - That we should possess an energy level and personal style that empowers and inspires enthusiasm in others;
 - That we should consider suggestions and criticisms as challenges for improvement and innovation;

- That justice should be applied equitably in all employment practices and personal policies;
- That we are responsible to provide quality care and service which set community standards and exceed patient's expectations with them always the priority;
- That each patient should receive quality care that is cost-effective, competitive, based on the latest technology, and promotes safety; and
- That patient confidentiality and privacy should be preserved.

I. Plan Responsibility

1. SVHMC leadership is defined as the Board of Directors, ELG, Department Directors, Managers, Supervisors, and Medical Staff Leadership. SVHMC leadership is responsible for providing a framework for planning health care services provided by the organization based on the hospital's mission and for implementing a planning process. Planning includes development and implementation of a strategic plan, developing operational plans, establishing annual operating budgets and monitoring compliance, establishing annual capital budgets, monitoring and establishing resource allocation, and the ongoing evaluation of the plan implementation.
2. SVHMC leadership is responsible to ensure:
 - Collaboration with community leaders and organizations to design services that are appropriate to the scope and level of care required by the patients served;
 - Communication of the organization's mission, strategic goals and objectives across the organization;
 - Establishment of standards of care that all patients can expect and can be monitored through the hospital's performance improvement plan. The performance improvement plan is approved by hospital leadership and is designed to prioritize areas for improvement and re-prioritize in response to untoward and unexpected events or outcomes;
 - An integrated patient safety program;
 - A uniform delivery of patient care services are provided throughout the organization;
 - Provision of appropriate employee development and continuing education opportunities which serve to promote retention of staff and to foster excellence in care delivery and support services;
 - Appropriate direction, management and leadership of all services and/or departments;
 - An adequate number of qualified staff are available to appropriately meet the needs of the patients served;
 - Systems are in place to promote the integration of services, which support the patients' continuum of care needs in a way that makes sense to the consumer;
 - Appointment of appropriate committees, work groups, and other forums to ensure interdepartmental collaboration on issues of mutual concern and requiring multidisciplinary input;
 - Staff RNs and allied staff input is included in developing policies that impact patient care;
 - Development of policies and practices to meet the special needs of patients, including forensic patients;

- Evaluation, planning, and recommending of annual expense and capital objectives, and expense budgets based on the projected resource needs of their departments. The Department Manager is held accountable for managing and justifying their budgets and resource utilization. This includes, but is not limited to, identifying, investigating, and budgeting for new technologies that can be expected to improve the delivery of patient care, services and promote patient safety;
 - Provision of interior and exterior space suitable to the clinical services offered and the ages and other characteristics of the populations served; and
 - The staff will design, implement and evaluate systems and services for care delivery (assessments, procedures, treatments and interventions) that is consistent with the mission and philosophy of the organization.
3. The leadership team will be responsible for providing a framework for planning healthcare services provided by the organization, based on the hospital's mission, and for developing and implementing an effective planning process that defines timely and clear goals. The planning process includes a collaborative assessment of our customer and community needs, defining a long-range strategic plan, developing operational goals, establishing annual budgets, and monitoring compliance.
 4. Assuring patient rights is the responsibility of all hospital employees, contract staff, vendors, volunteers and members of the Medical Staff. Administration is accountable for assuring that appropriate policies, procedures and activities are in place to ensure all patient rights are met.

J. Performance Improvement, Patient Safety, and the Environment of Care

1. SVHMC Performance Improvement strategy will be a coordinated, comprehensive, and an ongoing effort to assess the effectiveness of care and services provided. The goals and purpose of the strategy will be to strive, within available resources, for optimal outcomes, seek continuous improvements that are consistently representative of a high standard of practice in the community, and minimize risks to the patient and facility, while providing cost-effective care/service.
2. SVHMC has an organization wide Quality and Performance Improvement (QAPI) Program Plan. This plan includes the Oversight Structure for the priorities for the coming year. The culture of SVHMC stresses the importance of patient, visitor, and staff safety. Each unit/department has performance improvement priorities that are aligned with the hospital's strategic and performance improvement plan. The QAPI Program Plan is supported by the Patient Safety Program Plan, Infection Prevention Program Plan, Risk Management Program Plan and the various Environment of Care and Emergency Management Program Plans.
3. All departments are responsible for following the hospital's plan for Improving Organizational Performance, including:
 - Planned performance assessment and improvement activities;
 - Initiating activities designed to follow-up on unusual occurrences or specific concerns/issues which may include a formalized performance improvement team;
 - Following policies and procedures for ensuring staff competency;
 - Follow-up as appropriate on patient/family complaints and patient survey results;
 - Input and feedback from patient, staff, payers and physicians to guide the improvement process; and
 - Follow-up on patient/family complaints and patient survey results.
4. The performance measurement process is one part of the evaluation of the effectiveness of

the Organization Plan for Provision of Care and Services. Performance measures have been established to measure at least one important aspect of the Organization Plan for Provision of Care. and Services.

5. The Board of Directors, administration, department leaders, and medical staff have committees with defined responsibilities. Committees, both standing and ad hoc, and performance improvement teams serve as the primary vehicles for assessing, planning, implementing, and evaluating projects and processes. Teams are both departmental and cross-functional. Formal committees are established, monitored, and evaluated by the appropriate leadership committee. Performance Improvement processes are commissioned, supported and evaluated by the Quality and Safety Committee of the medical staff.

K. Recruitment, Retention, Staff Development & Ongoing Competency

1. SVHMC is committed to the recruitment and retention of sufficient number of quality staff to insure the delivery of high quality care and service. Primary initiatives to insure the effectiveness of recruitment include:
 - Sufficient staff and budgetary resources to provide for effective recruitment and assessment of candidates.
 - Working closely with colleges and community agencies for recruitment.
 - New graduate transition programs.
2. SVHMC recognizes that the retention of competent staff is essential to the hospital's capability to provide high quality cost effective services to its customers. Towards that end, leadership has developed competitive salaries and programs for staff development.
3. Staff education is essential to the development and retention of staff. SVHMC provides orientation, continuing education, in-service education, on-the-job training, and performance improvement education. Education programs are provided to maintain competency and enrich knowledge for enhanced patient care quality and service. The hospital's annual education plan is based on; the mission of SVHMC, the case mix of patients' served, the technology used in the provision of patient care, and the identified learning needs of staff and their assessed competency needs.
4. The competence of all patient care staff is monitored through the Performance Agreements. This is monitored and evaluated through Competency-Based Evaluations, orientation, annual evaluations, and ongoing competency checks. Each position has a delineation of minimal requirements.
5. The Personnel and Pension Committee of the Board of Directors provides oversight and direction for these functions and monitor retention rates among other indicators to determine the effectiveness of the recruitment and retention efforts.

L. Supporting Documents

1. The organization has numerous documents which support the Plan for the Provision of Patient Care. These documents include but are not limited to:
 - Mission Statement
 - Vision Statement
 - Strategic Plan
 - Organization Chart
 - Capital Budget
 - Operating Budget

- Quality & Performance Improvement Program Plan
- Patient Safety Program Plan
- Environment of Care Program Plans
- Emergency Management Program Plans
- Risk Management Program Plan
- Competence Validation Process and Management of Files
- System for Monitoring Contract Services
- Scope of Services

V. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Clement Miller: Chief Operating Officer	02/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Louis Villaneda
Sr.: Respiratory Care Manager
Respiratory Care

RC POCT Laboratory - Arterial Blood Gas Management

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. The Respiratory Care POCT Lab Quality Management Plan provides a systemic overview to ensure the delivery and quality of POCT blood gas services. It outlines the organizational structure, regulatory compliance, processes, and tools utilized to ensure continual quality improvement and performance of services provided, including an individualized Quality Control Plan. (IQCP)
- B. To review the three phases of the IQCP
1. Risk Assessment
 2. Quality Control Plan
 3. Quality Assurance
 - a. Pre-analytic, Analytical, and Post-Analytic phases of the blood gas testing processes.
 - b. Risk Assessment, break down each phase into steps so that potential sources of failures and errors can be identified in all phases of testing
 - c. Analyze the information gathered to determine what control activities can be put in place to reduce potential failures and errors.

III. DEFINITIONS

- A. ABG: Arterial Blood Gas
- B. POCT: Point of Care Testing
- C. IQCP: Individualized Quality Care Plan

- D. RA: Risk Assessment
- E. RC: Respiratory Care
- F. QC: Quality Control
- G. QA: Quality Assessment

IV. GENERAL INFORMATION

- A. **Individualized Quality Control Plan: (IQCP)** The medical director is responsible for the IQCP. The IQCP is a total quality assurance approach composed of three phases.
 - B. **Risk Assessment: (RA)** The RA process will be utilized to assist in the process of identifying, evaluating, and reducing potential sources of failure and errors that could occur during the pre-analytical, analytical, and post-analytical phases of testing. The RA will analyze testing components including, but not limited to:
 - a. Specimens
 - b. Test system
 - c. Reagent
 - d. Environment
 - e. Testing personnel
1. **RA will be supported with applicable resources including, but not limited to:**
- a. Test performance specifications
 - b. Hospital and RC Lab policies and procedures
 - c. Manufacturers instructions and recommendations
 - d. Manufacturer alerts and bulletins
 - e. Instrument and troubleshooting manuals
 - f. Proficiency Testing (PT) results and performance data
 - g. Quality Control logs/data
 - h. Specimen receipt and rejection logs
 - i. Calibration data
 - j. Data obtained through verification of establishment of performance specifications
 - k. FDA alerts
 - l. Historical QC data, including QC data from previous quality control studies
 - m. Instrument correlation data
 - n. Record of compliant and corrected records
 - o. Regulatory and accreditation records
 - p. Scientific publications
 - q. Test process flow charts

- r. Testing personnel and competency records

2. The Medical director attests that:

- a. All RC POCT personnel are appropriately licensed
- b. The RC Laboratory complies with all other applicable federal, state, and local laws and regulations
- c. There have been no investigations of the RC Laboratory by any federal, state, or other regulatory body
- d. The Laboratory management will notify the CAP office whenever the Laboratory finds itself the subject of an investigation by a government entity or adverse media attention related to Laboratory performance
- e. All employees can communicate concerns about the quality of safety to management, who will investigate employee complaints
- f. All technical personnel must be assessed for competency to perform patient testing. Competency assessment records must include the six elements described below for each individual on each test system during each assessment period unless an element does not apply to the test system

C. Elements of competency:

- a. Direct observation of routine test performance, including patient /sample identification and preparation, specimen collection, specimen handling, processing, and testing
- b. Monitoring the record, reporting test results, and if applicable reporting critical results
- c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventative maintenance records
- d. Direct observation of the performance of instrument maintenance and function checks
- e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples, or external proficiency testing samples
- f. Evaluation of problem-solving skills
- g. Non-waived testing personnel: After the initial assessment, all non-waived testing personnel must be evaluated semiannually the first year and annually thereafter. Documentation of testing by the department is maintained by the supervisor and evidence of compliance is documented on the annual competency assessment form. The Laboratory Director or Laboratory designee ensures that competencies are performed on schedule by reviewing status regularly. The Medical Director designates the following individual to assess competency in the Respiratory Care Laboratory (Brandon Reed CLS Laboratory Technical Supervisor)

- D. Quality Control (QC):** The Medical Director or the Respiratory Care Coordinator designee is responsible for the development, implementation, continuous updating, and maintenance of the QCP

- a. The QCP provides a process for the immediate detection of errors that occur due to test failure, adverse environmental conditions, and operator performance. The QCP includes activities and tools to reduce the likelihood of failures and errors identified from RA, and incident reports. The QCP helps assure the accuracy and reliability of test results and that the quality of testing is adequate for patient care and is aligned with CAP and manufacturer minimum standards.
 - b. The Lab Director or designee is responsible for maintaining and reviewing the QCP with staff. The designee will review the QCP with the Medical Director and will serve as the primary point of contact for meeting and reporting the completion of QC requirements as outlined in the QCP.
 - c. Support materials include, but are not limited to: policies and procedures, competencies, checklist, E-learning, manufacturer's instructions, electronic database information/reports, and all other training materials. These materials will be made available to staff and records of all documents will be maintained in the Respiratory Care management office.
- E. **Quality Assessment (QA):** The Medical Director is responsible for providing a continuous QA process of verifying the effectiveness of the QCP including monitoring, assessing, and correcting performance involved in the pre-analytical, analytical, and post-analytical testing process including, but not limited to: components such as specimen, test system, reagents, environment, testing personnel.
- F. **QA Activities:**
- a. QC reviews
 - b. PT records
 - c. Chart reviews
 - d. Specimen rejection logs
 - e. Turnaround time reports
 - f. Complaint/Incident records
 - g. Laboratory data reports
 - h. Temperature logs
 - i. Records of preventative measures, corrective actions, and follow-up
 - j. FDA alerts
 - k. Manufacturer's alerts

V. PROCEDURE

A. Performance Measurement:

1. Evaluations of the Quality management plan will be conducted annually, and as needed under the direction of the Laboratory Medical director in consultation with the Laboratory Administrative Director, RC Lab designee, RC Management, Laboratory Coordinator, and staff.
2. Evaluation should include any trends or challenges to service or quality. Findings

should be objectively assessed in terms of cause and options for correction. The cost and magnitude of the effect on patient care should be considered and problems or recommended actions referred to the appropriate sources for resolution. All documents are archived for a minimum of two years.

B. Organization Structure and Authority:

1. The Medical Director has the overall responsibility for the Quality Management Plan. The Medical Director and/or designee approves all policies and procedures including the RC Laboratories IQCP and consults and provides direction for the RC Laboratories Risk Assessment, Quality Control Plan, and Quality Assessment activities in conjunction with the program's Administrative Director, RC Lab Director, Supervisors/Lab Coordinator, and staff. +

C. Regulatory Compliance:

1. The Laboratory Medical Director is responsible for coordinating the quality improvement activities of the Lab - ensuring the program is documented and that the findings, and conclusions from monitoring, evaluation, and problem-solving activities are discussed and documented, and that evidence-based practice and best practice standards and thresholds are set and observed which are derived from various sources including, but not limited to:
 - a. California State accreditation requirements
 - b. College of American Pathologists (CAP) & Clinical Laboratory Improvement Amendments (CLIA) accreditation requirements
 - c. Joint Commission (JC) accreditation requirements
 - d. Policies, procedures, and protocols of Salinas Valley Health Medical Center (SVHMC)
 - e. Policies, procedures, and protocols established by the RC department
 - f. Manufacturer's instructions

D. Actions and Reporting:

1. The Lab Director and Supervisors/Lab Coordinator will document any investigations and resolution of incidents or problems and conduct root cause analysis of any unexpected events involving death, serious physical or psychological injury, or risk including; near misses, and sentinel events per hospital policy. Actions include: monitoring, collecting information, formulating corrective actions, documenting, and follow-up actions to improve patient care.
2. Actions must be taken that are appropriate, and acceptable to the hospital and the patient community which results in improved patient care. Actions may include, but are not limited to:
 - a. Education/Training
 - b. Implementing new or revised procedures
 - c. Staffing changes
 - d. Counseling/Guidance

- 3. The Lab Medical Director, or designee is responsible for reporting quality improvement activities to the Medical Director and the Quality Management Department in quarterly reports including:
 - a. Criteria used in the monitoring and evaluation process
 - b. Outcome of review
 - c. Actions taken to improve patient care
 - d. Effectiveness of the indicators and plan for improvement

E. **Interdisciplinary Teams:**

- 1. The Medical Director, RC Lab Director, Supervisors/Lab Coordinator, Administration Director, and staff participate in interdisciplinary teams including, but not limited to:
 - a. Pharmacy and Therapeutics Committee
 - b. Code Blue/Rapid Response Committee
 - c. Clinical Interdisciplinary Advisory (CIA) Committee
 - d. NICU Interdisciplinary Committee
 - e. Emergency Management Committee

VI. EDUCATION/TRAINING

- A. Education and/or training is provided annually and 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
COO	Clement Miller: Chief Operating Officer	04/2025
Respiratory Medical Director	Louis Villaneda Sr.: Respiratory Care Manager	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025

Policy Owner

Louis Villaneda Sr.: Respiratory
Care Manager

02/2025

Standards

No standards are associated with this document



Last Approved N/A
Next Review 1 year after approval

Owner John Kazel:
Director Imaging Services
Area Scopes Of Service

Scope of Service: Diagnostic Imaging

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goal(s) of Diagnostic Imaging is to:

- A. Provide diagnostic and therapeutic imaging services for both inpatients and outpatients.
- B. There is sufficient equipment and supplies maintained to adequately perform the diagnostic imaging services that are offered. Proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.
- C. To plan for the allocation of human/material resources.
- D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to the

highest level of wellness as possible.

- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Diagnostic Imaging function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

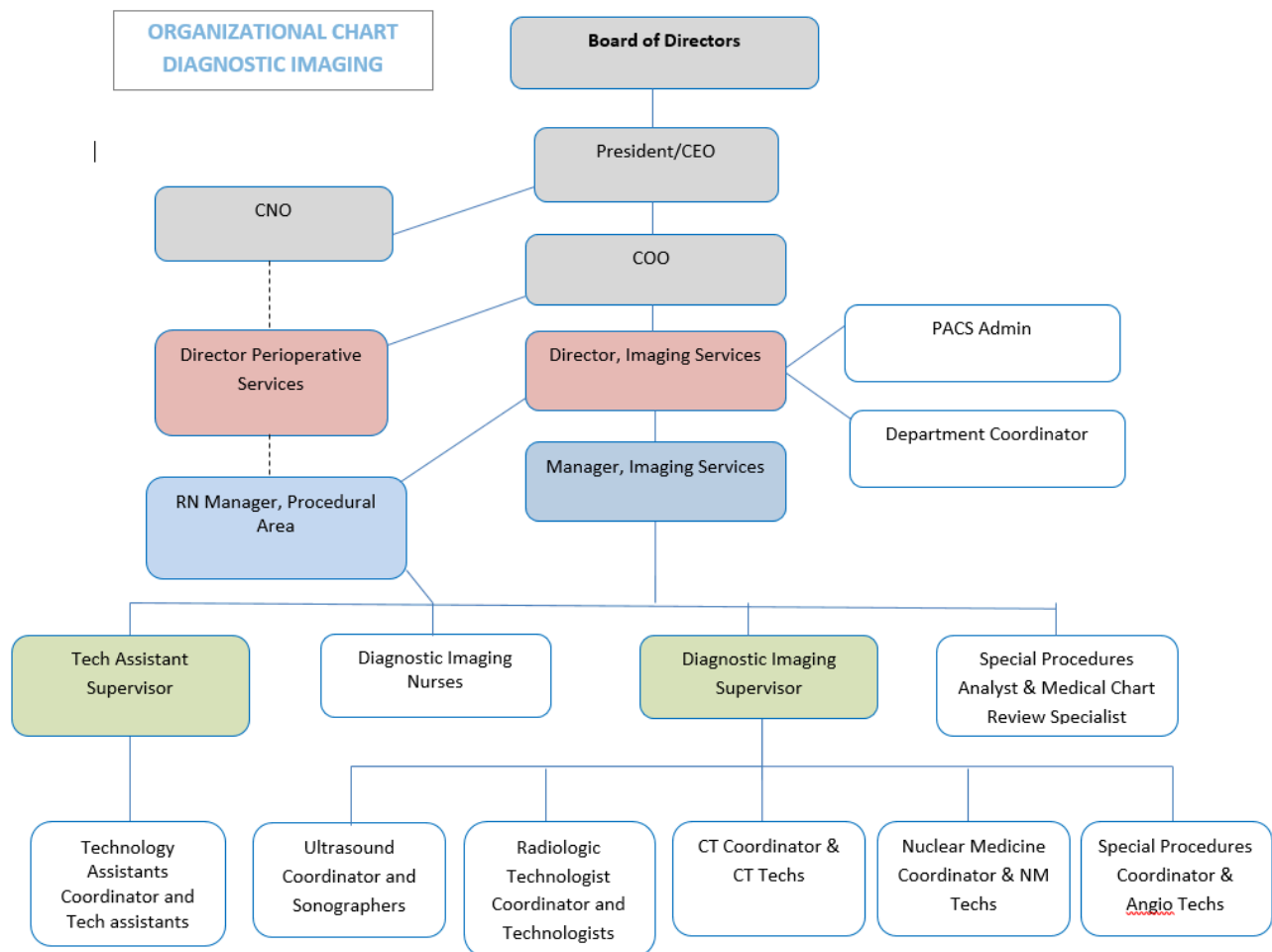
Clinical:

The Diagnostic Imaging unit provides care for infant, pediatric, adolescent, adult and geriatric patients (edit as necessary).

Non-Clinical:

N/A

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation

Main Radiology, Ultrasound and CT provide services 24 hours/day, 365 days/year. PET/CT is provided by a mobile service once a week with some variability due to holidays and needs. The remaining areas operate Monday – Friday, 7:00 am to–5:00pm. Nuclear Medicine is on call Saturday and Sunday from 8:00 am until 5:00 pm.

B. Location of department: 450 E. Romie Lane, Salinas, CA 93901

C. Admission, Discharge, Transfer Criteria (if applicable)

D. Major Services / Modalities of care may include:

The department contains the following equipment:

- One Radiographic Fluoroscopy Room
- Two General Radiographic Rooms
- Two CT scanners
- Four portable radiographic units
- Three portable c-arm fluoroscopic units
- One mini C-arm
- One portable O-arm unit
- One MRI scanner
- Five Ultrasound Machines
- Three Ultrasounds for PICC Placement
- One Spect CT Nuclear medicine camera
- One Nuclear medicine solid state detector SPECT cardiac camera
- One Interventional Suite

Diagnostic Imaging services may include:

- Selective Abdominal and Peripheral Venography (catheter)
- Selective and Sub-selective Arteriography-(catheter) Cerebral, Visceral, Extremity
- Pulmonary Angiography
- Lymphography
- Therapeutic Vascular Occlusion (Tumor, arteriovenous corrections, etc.)
- Angioplasty, Percutaneous
- Dilations, Percutaneous (bile duct, esophagus, ureter, etc.)
- Interpretation of roentgenograms (plain films) (Non-sterile)
- T-tube Cholangiography
- Biopsies (Bone, Renal Lung, Liver, etc.)
- Percutaneous Transluminal Peripheral Angioplasty
- Fistulography

- Myelography
- Drainage Procedures, Percutaneous Image-guided, e.g., Biliary Drainage, Abscess Drainage, Nephrostomy, Paracentesis, Thoracentesis
- Placement of Vena Cava Filter, Percutaneous
- Percutaneous Transhepatic Cholangiography and Biliary Drainage
- Percutaneous Cholecystotomy
- Percutaneous Catheter Placement for Tumor Treatment
- Intrathecal Chemotherapy
- Intra-Arterial Thrombolytic Therapy
- Intravenous Thrombolytic Therapy
- Central Line Placement
- Therapeutic Injection of Vasoconstriction Agents for Hemorrhage (Non-sterile)
- Placement of Endovascular Stents
- Placement of peripherally inserted central catheter (PICC)

Diagnostic Imaging provides care / services to patients with primary diagnoses, including but not limited to: Acute medical/surgical (inpatient, outpatient and observation), trauma, oncology, cardiovascular and neurological patients.

- E. Therapeutic and Diagnostic Imaging Services Modalities Offered include: General Radiology
- Computer Tomography
 - Fluoroscopy
 - Nuclear Medicine
 - Ultrasound to include vascular imaging
 - Magnetic Resonance Imaging
 - Interventional/Radiology

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

- The Diagnostic Imaging Department consists of six (6) areas: main Radiology, Ultrasound, Special Procedures, Computerized Tomography, Nuclear Medicine (with PET/CT) and Magnetic Resonance Imaging (MRI).
- Imaging exams must be ordered by Physician's, Physician's Assistants, and/or Nursing Practitioners that meet SVHMC's credentialing requirements. Technologists and Sonographers perform imaging exams according to the physician's order and under the supervision of a Radiologist. Following imaging, the radiologists dictate their interpretation. The radiologist signs the report electronically and is stored in PACS and Meditech. A copy of the report is automatically faxed to the referring physician.
- Imaging exams are stored for a period of ten (10) years, unless the patient is a minor and then the images and reports are kept on file until the patient reaches the legal age of eighteen (18) plus

three (3) years. **RECORDS RETENTION POLICY**

- D. Services related or associated to imaging include quality assurance monitoring and evaluation, quality control (including protecting patients and staff from harmful radiation), image interpretation, dictation, transcription, record filing/management, patient billing, marketing, equipment purchasing, film processing and continuing education.
- E. Portable x-ray equipment allows radiographs to be obtained in surgery, as well as medical/surgical and intensive care units.
- F. Radiologists are consultants, responsible for advising referring physicians on which imaging procedures to do and in which sequence. In addition, when an emergency physician requests images and interprets them, staff radiologists are responsible for the confirming or amending of the emergency physician's initial interpretations.
- G. The Diagnostic Imaging Services department is under the control and direct supervision of the Radiology Medical Director, certified by the American Board of Radiology and has a current license from the State of California to practice medicine, who is directly responsible to the Chief of the Medical Staff and the Board of Directors. Also, a radiologist is available by phone or in person when required.
- H. The Director of Imaging Services department is directly responsible to the Chief Operating Officer. It is the Imaging Services Director's duty to attend all administrative and technical functions within the department.
- I. All personnel within the department are under the guidance and control of the Imaging Services Director. In the Director's absence, the position is filled by the DI Manager or designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.
- J. The Imaging Director, Critical Care Director, and the Procedural Nurse Manager assume twenty-four (24) hour responsibility for nursing care provided on the unit.

VII. REQUIREMENTS FOR STAFF

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

The Unit follows guidelines of National, State and Local Regulatory Bodies. Standards of Practice are consistent with National Radiological and Nursing organizations, and the American College of Radiology (ACR).

A. Licensure / Certifications:

The basic requirements for **Radiologic Technologists and Interventional Technologists** include:

1. Current state License (CRT)
2. Current Fluoroscopy License
3. Current BCLS
4. National Registry (ARRT)(R)
5. Completion of competency based orientation
6. Completion of annual competencies

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

1. Current state licensure (CRT)
2. Current Fluoroscopy License
3. Current BCLS
4. National Registry (ARRT)(R)(CT)
5. Completion of competency based orientation
6. Completion of annual competencies

The basic requirements for **Licensed Nuclear Medicine Technologists** include:

1. Current State licensure-Certified Nuclear Medicine Technologist (CNMT)
2. National Registry (NMTCB or ARRT (N))
3. Current BCLS
4. Completion of competency based orientation
5. Completion of annual education

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

1. Ultrasound Registry for Ultrasound Technologists (RDMS)
2. Current BCLS
3. Completion of competency based orientation
4. Completion of annual education

The basic requirements for **Magnetic Resonance Imaging** include:

1. Current state licensure (CRT)
2. National Registry (ARRT) or ARMRIT
3. Current BCLS
4. Completion of competency based orientation
5. Completion of annual education

The basic requirements for **Technologist Assistant** include:

1. Current BCLS
2. No special license required
3. Completion of competency based orientation
4. Completion of annual education

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

1. Current state licensure

2. Current ACLS
3. Current BCLS
4. Current PALS
5. Completion of competency based orientation
6. Completion of annual education

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. Staff include:

- Licensed Radiologic Technologist
- Licensed Nuclear Medicine Technologist
- Licensed Sonographer
- Licensed Magnetic Resonance Imaging Technologist
- Technologist Assistant
- Registered Nurse
- RIS/PACS Administrator

The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. Patient acuity level is determined each shift to plan for staffing needs for the following shift. Patient assignments are made based upon staff skill level and total patient acuity. In the event staffing requirements cannot be met, Diagnostic Imaging will meet staffing requirements by utilizing per diem staff or overtime to cover missing technologists days and hours. On some occasions when census is exceedingly high, patients on rare circumstances will be triaged according to diagnosis, level of participation and progression.

General Staffing Plan:

1. A technologist registered by the American Registry of Radiologic Technologists and certified by the State of California is available twenty-four (24) hours per day and will assist the radiologist(s) in acquiring needed images on a referred patient. During night shifts, radiology CT technologists, and Ultrasound technologists are on duty. Radiologists are available for interpretation of images from 7:00 am till 7:00 pm. From 7:00 pm until 7:00 am, tele-radiology is utilized. The radiologist provide back-up if needed. The Emergency Department physicians can provide preliminary readings on x-ray images for emergency room patients. A Radiologist will provide a final reading of the emergency room patient image/s.
2. It is the duty of the evening and night technologists to cover all diagnostic imaging services for the department, or to call in additional help if needed. They are to be contacted by the hospital Administrative Supervisor on duty for any and all emergencies, external and internal disasters, etc. They are directly responsible to the Diagnostic Imaging Services Director at all times.
3. Minimum staffing grids include:

SHIFT _____ DAY

POSITION	M	T	W	TH	F	SA	SU
Angio	2	2	2	2	2	0	0
CT	2	2	2	2	2	1	1
X-ray	4	4	4	4	4	3	3
Supervisors	1	1	1	1	1	0	0
US	3	3	3	3	3	2	2
Nuclear Medicine	3	3	3	3	3	0*	0*
Nursing	5	5	5	5	5	2	2
Tech Assistant	7	7	7	7	7	2	2

SHIFT _____ PM

POSITION	M	T	W	TH	F	SA	SU
CT	1	1	1	1	1	1	1
Ultrasound	1	1	1	1	1	1	1
X-ray	3	3	3	3	3	3	3
Tech Assistant	1	1	1	1	1	1	1

SHIFT _____ NIGHT

POSITION	M	T	W	TH	F	SA	SU
CT	1	1	1	1	1	1	1
US	1	1	1	1	0*	0*	1
X-Ray	1	1	1	1	1	1	1

*Staff is on call

Flex Staffing Explanations: Any increased variance is dealt with by using supervisory staff, per diem, or part-time staff and overtime. Any decreased variance is address by flexing staff.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

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

X. CONTRACTED SERVICES

Alliance Imaging is contracted to provide equipment and staff for MRI and PET/CT services. Alliance imaging staff are required to be compliant through Vendormate. Other contracts are incorporated in the contract monitoring software system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Attachments

 [Image 1.PNG](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending

Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	John Kazel: Director Imaging Services	01/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
1 year after approval

Owner
Area

David Thompson:
Director Nursing
Scopes Of Service

Scope of Service: Emergency Department

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goals of the Emergency Department are:

- A. To provide comprehensive emergency services. Care is not denied or delayed based upon a patient's social, economic or insurance status.
- B. To ensure that all patients treated will receive high quality care in the most expedient and professional manner possible.
- C. There is sufficient equipment and supplies maintained to adequately perform the services that are offered to SVHMC. Also proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

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

IV. POPULATION SERVED

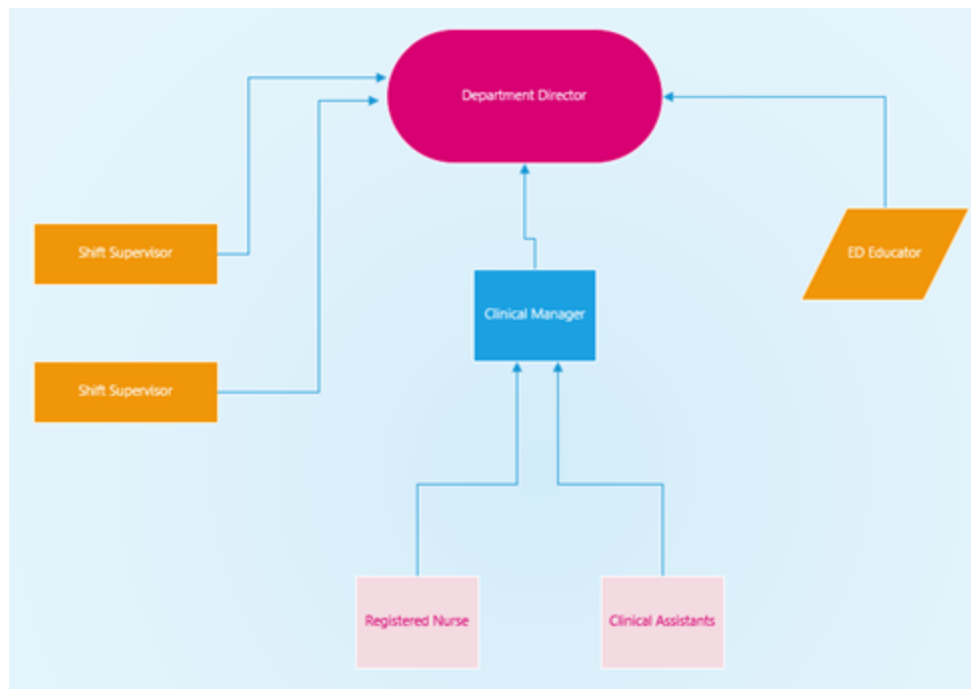
Clinical:

The Emergency Department provides care for all age groups (neonate to geriatric). Patients are triaged according to a patient classification system: Emergency Severity Index, Level 5 (ESI 1-5).

V. ORGANIZATION OF THE DEPARTMENT

- A. Hours of Operation
The Unit/Department provides services seven days a week, twenty-four hours a day.
- B. Location of department (s)
The Emergency Department is located on the first floor. During certain circumstances in which the Emergency Department may become overwhelmed by patients, or in the event the department may not be sufficient to meet patient care needs, alternate care areas may be established. This will be done in compliance with local, state, and federal regulations.
- C. Admission, Discharge, Transfer Criteria
 - 1. Patients will be admitted or discharged based on the medical decision making by the Provider (s)
 - 2. Patients will be transferred if a higher level of care is required that we do not provide.
- D. Major Services / Modalities of care may include:
A comprehensive range of acute and non-acute medical services including diagnostics, therapeutics, palliative and life-saving measures.

The Emergency Department provides care/services to patients with any diagnoses.



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

- A. The multidisciplinary treatment team consists of emergency physicians, nursing staff, physician assistants and ancillary support services according to the needs of the patient. Physicians are staffed twenty-four (24) hours/day. Medical specialists are on call twenty-four (24) hours/day. Physician assistants are scheduled and operate under the direction of the medical staff by-laws. Registered nurses experienced in Emergency Nursing will triage every patient upon arrival to the department. Care will be prioritized based upon the identified ESI level of triage classifications. Services are provided based upon patient assessments, patient preferences, plans of care, medical staff orders, and emergency standards of practice. The Emergency Department is a designated Base Hospital, STEMI Receiving and Stroke Receiving Center. Burn victims, neonatal emergencies, pediatric emergencies, microsurgical implantations, high-risk pregnancies, psychiatric emergencies or any patient whose medical needs cannot be met on site are stabilized and transferred to tertiary care facilities where they can receive definitive care.
- B. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders.
- C. The Director and Clinical Manager assume twenty-four (24) hour responsibility for nursing care provided on the Unit.
- D. The Director of the Unit is directly responsible to the Chief Nursing Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by the Manager or Nursing Leader on call or their designee. It is

his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF

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

The Unit follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with BCLS, ACLS, PALS, and ENA standards of practice.

A. Licensure / Certifications:

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

1. Current state licensure
2. Current BLS
3. Current ACLS
4. Current PALS
5. TNCC- preferred
6. Completion of competency-based orientation
7. Completion of annual competency

The basic requirements for **Clinical Assistants** include:

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

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

General Staffing Plan:

Assignments are made by the lead nurse based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is dependent on the census and acuity needs of the patients.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan

and the Quality Oversight Structure, the Emergency Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

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

Attachments

 [Image 1](#)

 [Organization of the Department](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
ED Department Meeting	Cristina Martinez: PHYSICIAN	01/2025
ED Department Meeting	David Thompson: Director Nursing	01/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	David Thompson: Director Nursing	12/2024

Standards

No standards are associated with this document



Last ApprovedN/ANext Review1 year after approval

OwnerTiffany DiTullio:
Vice President
Partner and
Community
Relations

AreaScopes Of
Service

Scope of Service: Health Promotion

I. SCOPE OF SERVICE

Health Promotion supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health and has designed services to meet the needs and expectations of patients, families and the community.

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

II. GOALS

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

The goals of Health Promotion are:

- A. To develop, implement and evaluate programs with the aim of health enhancement, wellness education and disease prevention including activities of an informational nature, as well as those whose intent is skills development and behavior modification.
- B. Programming and education offerings include lectures, workshops, coordinated fitness options, screenings, wellness programming and other health events.

III. DEPARTMENT OBJECTIVES

- A. To support Salinas Valley Health objectives.

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

IV. POPULATION SERVED

Clinical:

The Health Promotion Department provides health and wellness information to the community with a goal of connecting the population to services the health care system offers. The Health Promotion Department also coordinates classes for the community, such as Childbirth Preparation, Breastfeeding, CPR/AED and First Aid. The Health Promotion Department also partners with Salinas Valley Health Registered Nurses to offer Blood Pressure screenings at community events.

Non-Clinical:

The Health Promotion provides services including but not limited to: health and wellness programs/ classes, farmers' market programs, community lectures, wellness programming for local employers.

V. ORGANIZATION OF THE DEPARTMENT (include organizational chart)

- A. Hours of Operation
The Unit/Department provides services Monday through Friday from 8:30 a.m. to 5:00 p.m.
- B. Location of department
212 San Jose Street, Salinas, California.

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

- A. The Department purpose is to provide educational programs for the community, District and hospital staff, which enable individuals to make choices that support overall wellness and

reduce their risk of developing preventable disease while increasing their success in sustaining optimal health. The Department also works to enhance patient services and health programs that help Salinas Valley Health remain a leading provider of medical care.

- B. The Manager assumes twenty-four (24) hour responsibility for the Department.
- C. The Manager of the Department is directly responsible to the Director of Marketing. It is the Manager's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Manager of Health Promotion. In the Manager's absence, the position is filled by their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

VII. REQUIREMENTS FOR STAFF (applicable to department)

All individuals who provide Department services have the appropriate training and competence.

- A. Licensure / Certifications:
N/A
- B. Competency
N/A
- C. Identification of Educational Needs

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

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

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

- D. Continuing Education
N/A

VIII. STAFFING PLAN



Flexible hours are occasionally required; staffing requirements will be met by adjusting schedules authorizing overtime and/or utilizing temporary services.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

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

X. CONTRACTED SERVICES (as applicable)

- Contracted services under this hospital service are maintained in the electronic contract monitoring software program.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

Attachments

 [Director of Marketing](#)

Approval Signatures

Step Description	Approver	Date

Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Tiffany DiTullio: Chief Administrative Officer/ Community Wellness	12/2024

Standards

No standards are associated with this document



Last ApprovedN/A

Next Review1 year after approval

OwnerAudrey Parks:
Vice President
Information
Technology

AreaScopes Of
Service

Scope of Service: Information Technology

I. SCOPE OF SERVICE

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

Information Technology is responsible for providing and maintaining reliable, secure and effective technology services to support the healthcare system's mission of delivering high-quality and safe patient care. This policy outlines the scope of services provided by Information Technology (IT), defining boundaries of its responsibilities and expectations of service delivery.

II. GOALS

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

The goal of Information Technology is to:

- A. Align information technology services and resources with the mission of Salinas Valley Health in support of a tightly integrated healthcare delivery system while balancing security, interoperability and information sharing for purposes of providing high quality, safe and cost effective healthcare at SVHMC.

III. DEPARTMENT OBJECTIVES

- A. Cybersecurity and risk management
- B. Data management and analytics
 - 1. Application support
 - 2. To provide a tightly integrated information system to achieve meaningful use and

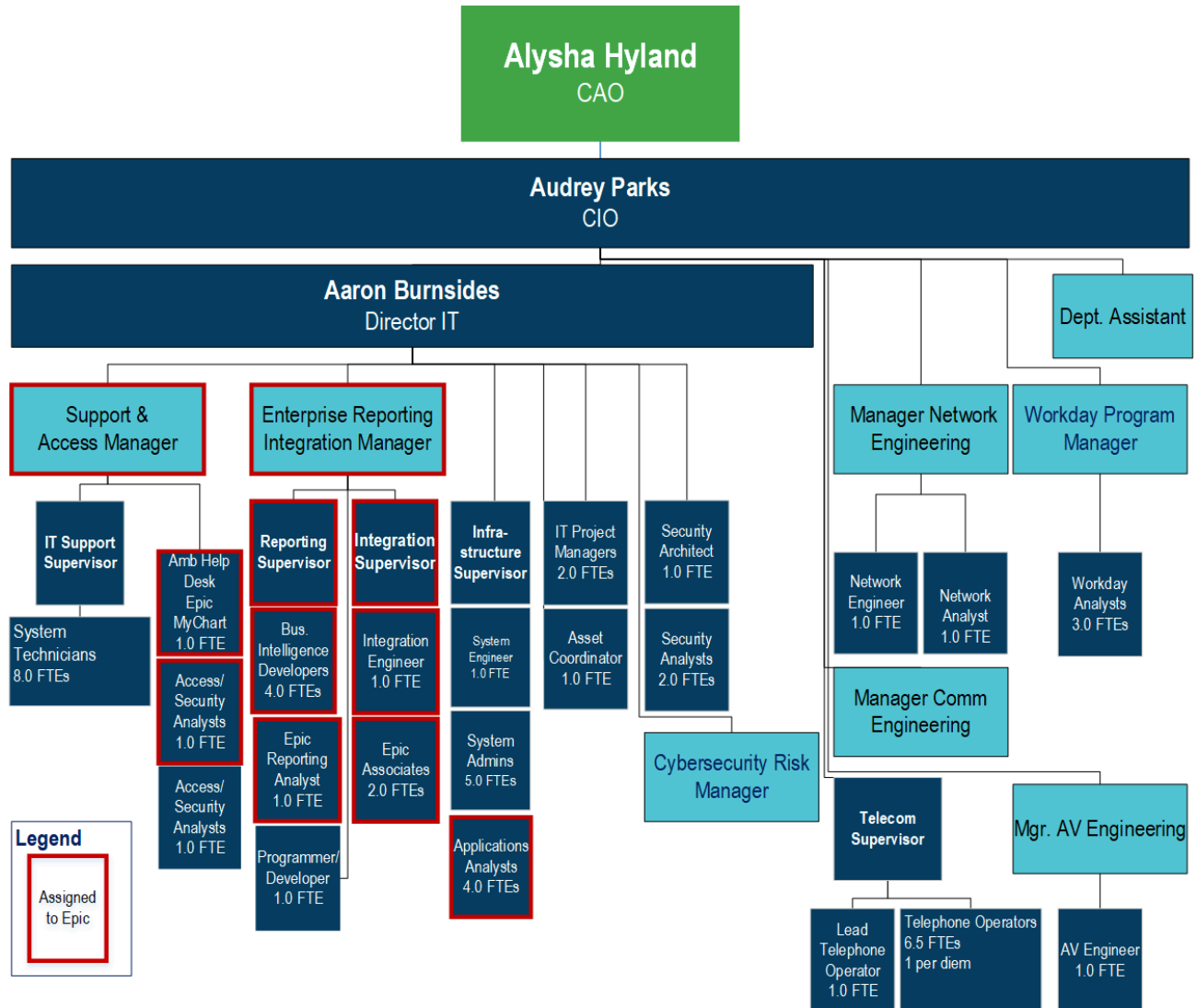
effective decision support of our healthcare delivery team, including nurses, physicians and SVHMC partners.

- C. To lead and manage information systems procurement, adoption, support, and governance strategies.
- D. Infrastructure management
- E. To evaluate staff performance on an ongoing basis to ensure appropriate training and knowledge for the information services provided by IT.
- F. Project management
- G. Help Desk and end-user support

IV. POPULATION SERVED

- 1. Internal clients
 - a. Staff
 - b. Providers
 - c. Volunteers
 - d. Students
 - e. Salinas Valley Medical Clinic staff and associates
- 2. External clients
 - a. Vendors
 - b. Contractors

V. ORGANIZATION OF THE DEPARTMENT



- A. Hours of Operation:
Information Technology (IT) is available during normal business hours with the exception of IT Help Desk and Telecommunications. These services are available 24 x 7. IT provides Help Desk services each business day from 7:00 AM to 7:00 PM. Flexible hours are occasionally required; staffing requirements will be met by authorizing overtime and/or utilizing temporary services.
- B. Location of department (s)
- 450 East Romie Lane, Salinas, CA 93901
 - 420 East Romie Lane, Salinas, CA 93901
 - 120 Wilgart Way, Salinas, CA 93901
 - 928 E. Blanco Road, Salinas, CA 93901
- C. Service request process: all requests for IT Services should be submitted through our established service request system to ensure proper tracking, prioritization and documentation of resolution of

requests.

- D. Service requests falling outside of the approved budget will require additional justification and approval.
- E. Notable exclusions for IT services include personally owned devices. However, Information Technology will provide guidance regarding secure access to organizational system and information resources.

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

- A. Information Technology serves regulatory and other Hospital wide initiatives including, but not limited to the following:
 - The Joint Commission accreditation
 - Unites States Department of Health & Human Services (HHS), Health Insurance Portability and Accountability Act (HIPAA) Security Rule
 - Centers for Medicare & Medicaid Services (CMS), Electronic Health Records (EHR) incentive program
 - Executive Steering Committee
- B. The Chief Information Officer or designee assumes twenty-four (24) hour responsibility for the department.
- C. The Chief Information Officer (CIO) is directly responsible to the Chief Administrative Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Chief Information Officer's absence, the position is filled by their designee. It is the designee's responsibility to carry out the duties of the CIO in his/her absence.

VII. REQUIREMENTS FOR STAFF

All individuals who provide Information Technology services have the appropriate training and competence. Please refer to individual job descriptions.

- A. Licensure / Certifications:

The basic requirements for the **System Technicians** and **Help Desk staff** includes a valid California Driver's License.

The Systems Security Architect and Manager of Cybersecurity Risk require Certified Information Systems Security Professional certificates.

- B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the client or customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements. General Staffing Plan:

All Information Technology staff are generally scheduled to be at work during normal business hours with two exceptions, Telecommunications and Technical Services. Telecommunications is scheduled 24 x 7 with at least one Telephone Operator per shift. Technical Services is scheduled from 7 AM to 7 PM on each business day while on-call outside of these hours.

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

- 1 Manager / Supervisor
- 1 Network Engineer
- 1 Systems Security Architect
- 2 System Technicians
- 1 Telephone Operator

Additionally, staff to support any Hospital Emergency Incident Command System (HEICS).

IX. EVIDENCED BASED STANDARDS

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

the responsibility of all staff members. Improvement activities involve department specific quality improvement activities, interdisciplinary performance improvement activities and quality control activities.

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

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

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

Attachments

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Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Audrey Parks: Chief Information Officer	02/2025

Standards

No standards are associated with this document



Last Approved

N/A

Next Review

1 year after approval

Owner

Aisha Huebner:
Director
Perioperative
Services

Area

Scopes Of
Service

Scope of Service: Surgical Services

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goals of the Surgical Services Unit are:

- A. To guide staff in the; delivery of safe, effective and appropriate care of patients. Facilitate collaboration between all healthcare providers to assure the community health care needs are met, provide services in an efficient and timely manner, continuously seek ways to improve patient outcomes, improve service, and reduce cost, maintain a work environment that is safe and supportive, promote retention and recruitment practices, maintain a high level of proficiency, utilize the Medical Staff Committees to increase collaboration and discuss operational and budgetary issues, increase utilization by promoting opportunities for new business growth and efficient use of areas, provide ongoing educational opportunities for staff growth.
- B. To provide comprehensive Peri-Anesthesia care to patients having sedation/analgesia/anesthesia for surgical, diagnostic, or therapeutic procedures.
- C. To provide comprehensive pre- and post-procedural care of patients undergoing outpatient surgical procedures, and to provide pre-procedural preparation for same-day admission patients undergoing inpatient surgical procedures.

- D. To ensure that all patients treated in the Endoscopy Unit will receive high quality service in the most expedient and professional manner possible by providing diagnostic/therapeutic modalities.
- E. There is sufficient equipment and supplies maintained to adequately perform the services that are offered to SVHMC.
- F. To ensure all equipment and instruments are processed with the highest quality of service in the most expedient and professional manner possible.

III. DEPARTMENT OBJECTIVES

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

IV. POPULATION SERVED

Perioperative, Post Anesthesia, and Out-Patient services provide care for patients of all ages and complexities except high risk newborn/pediatric cases, organ transplants and burn/grafting surgeries. The Endoscopy Unit provides care for adult and geriatric patients. SSPD provides services for infant, pediatric, adolescent, adult and geriatric patients.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation:

The Operating Room functions 24 hours a day and will schedule no more than 7 operating rooms at a time and will gradually reduce rooms starting at 1500 with the goal of reducing to one operating room by 1900 (Monday – Friday). Weekend and holidays are operated utilizing on call staffing.

The PACU provides services 0730-2300 Monday through Friday. Additional coverage is provided on call 2300-0730 Monday through Friday and from 0730 Saturday until 0730 Monday.

The Outpatient Services unit is staffed 0530-2030 Monday through Friday.

The Endoscopy Unit is open five (5) days per week, Monday through Friday, 12 hours per day from 0630 hours until 1830 hours. Endoscopy provides twenty four hour (24) on-call coverage for all other hours including weekends and holidays.

SSPD provides services seven days a week, twenty-four hours a day.

B. Location of departments:

- The Surgery Department – 1st floor of the main hospital.
- The Outpatient Surgery Unit – 1st floor of the main hospital.
- Pre-admission screening is provided in the P.A.T. department – 321 East Romie Lane, Salinas, CA 93901.
- The Endoscopy Unit - in the basement in Cislini Plaza.
- The SSPD Department – in the basement of the main hospital.

C. Admission, Discharge, Transfer Criteria:

Admission to Perioperative Services at SVHMC requires a surgeon order. SVHMC Anesthesia Protocol defines the practices and elements that must be achieved, which may include but are not limited to lab tests, diagnostic tests, cardiac or medical clearance. Current history, physical assessment and informed consent must be performed and documented by the admitting surgeon. Discharge and Transfer Criteria are defined by Phase I and II protocols.

D. Major Services / Modalities of care may include:

- General Surgery
- Cardiac (including minimally invasive)
- GU Surgery
- Neurosurgery
- Thoracic Surgery
- Vascular Surgery
- Organ Harvesting for transplants
- Ocular Surgery
- ENT/Oral/Maxillofacial Surgery
- Plastic Surgery
- Colorectal Surgery
- GYN/OB Surgery (Caesareans)
- Orthopedic Surgery
- Anesthesia
- Post Anesthesia Recovery Care

PACU provides Phase I post-anesthesia care during the immediate post-procedure period. Patients are continuously monitored, transitioning to Phase II, the inpatient setting, or the intensive care unit for continued care. The focus of care provided includes but is not limited to airway management, hemodynamic monitoring, pain and comfort management, thermoregulation, fluid management, neurologic, sensory and motor function, and surgery-specialty specific assessment and intervention. PACU also provides Phase II post-anesthesia care as needed, providing care focused on preparing the patient and family/significant other for continued care post-discharge.

All patients scheduled for Out-Patient surgical procedures undergo health screening by an RN prior to surgery. The nurse obtains the patient's medical history, medication list, indicated diagnostic tests, and results. The patient receives information and instructions about pre- and post-procedure care. The screening may be done over the phone or in person as indicated. All patients receive a complete assessment and completion of required pre-procedure education and preparation on the day of service. Anesthesia providers review patient data and complete patient assessment prior to beginning surgical procedures. Outpatient Surgery (OPS) provides Phase II post-anesthesia care following Phase I recovery in PACU. Depending on the type of anesthesia, some patients may move from the operating room directly to Phase II recovery at the discretion of the anesthesiologist. Phase II care may also be provided in the PACU as needed. Post-procedure care includes preparing the patient and family/significant other for continued care post-discharge.

The Endoscopy Unit consists of two (2) treatment rooms and three (3) recovery beds. Other areas accessed include the Surgery Department, Emergency Department and servicing in-patient care areas throughout the hospital.

Endoscopy Services provided are:

- Gastroscopy
- Bronchoscopy
- Colonoscopy
- Biopsy/Liver
- Paracentesis
- PEG insertions
- ERCP
- Sigmoidoscopy
- Proctoscopy
- Anoscopy with banding of internal hemorrhoids
- Sedation monitoring/recovery

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

Care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support, according to the needs of the patients. A registered nurse (RN) performs an admission assessment on all patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Care for patients is in accordance with currently accepted national standards.

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

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

The Outpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients.

Sterile processing services are provided by a multidisciplinary team comprised of the manager and SSPD techs according to the needs of the hospital.

VII. REQUIREMENTS FOR STAFF

All individuals who provide patient care are licensed or certified according to applicable state law and

regulation and have the appropriate training and competence.

A. Licensure / Certifications:

The basic requirements for **Registered Nurses** (RN) include:

1. Current state licensure
2. Current BLS
3. Current ACLS
4. PALS required within six months of employment
5. Certification preferred
6. Completion of competency-based orientation
7. Completion of annual competencies

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

1. Current state licensure
2. Current BCLS
3. Completion of orientation competencies
4. Completion of annual competencies
5. CNOR certification preferred

The basic requirements for **Surgical Techs** include:

1. Graduate of an approved Surgery Tech training program
2. Current BCLS
3. Completion of orientation competencies
4. Completion of annual competencies
5. CORT certification preferred

The basic requirements for **Certified Nursing Assistants** (CNA) include:

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

The basic requirements for **Unit and Clinical Assistants** include:

1. Completion of competency-based orientation
2. Completion of annual competency

The basic requirements for **Endoscopy Technicians** include:

1. Current BLS
2. Completion of competency-based orientation

The basic requirements for **SSPD Manager and SSPD Techs** include:

1. Certification through a nationally recognized program is recommended, e.g., Certification Board for Sterile Processing and Distribution (CBSPD), International Association of Healthcare Central Service Material Management (IASCSMM).
2. Current BLS
3. Completion of competency-based orientation
4. Completion of annual competency

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

- STAR Values
- Quality Assessment and Improvement Initiatives

- Strategic Planning (Goals & Objectives)
- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

General Staffing Plan:

Operating Room staffing is established based on Average Daily Census and Units of Service is Patient Days with adjustments made for changing acuity or census as well as Nurse Staffing Ratios. See the Master Staffing Plan. Staffing is adequate to service the customer population. In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: 7 Anesthesiologist, 7 Surgical Technologist, 9 Registered Nurses, 1 T3s, 1 EVS Staff, 1 Charge RN.

In the event staffing requirements cannot be met, the OR will meet staffing requirements by utilizing the on-call system, registry and per diem RN's. Authorization of overtime will also be considered.

ON-CALL TEAMS

- On-Call teams are assigned to ensure that the Operating Room is able to provide surgical services, 24 hours a day.
- General on-call team– Consists of one (1) surgeon, one (1) anesthesiologist, and two (2) surgery nurses and/or one (1) surgery nurse and one (1) surgery tech. The general on-call team nursing personnel will arrive in the department within thirty (30) minutes of notification.
- Heart call team- Consists of one (1) cardiac surgeon, one (1) cardiac anesthesiologist, one (1) Perfusionist, two (2) heart nurses and/or one (1) heart nurse and one (1) heart surgery tech.
- A certified Perfusionist meeting the established credentialing criteria (set by the Interdisciplinary Practice Committee) will be in-house for all scheduled extracorporeal bypass procedures and available on-call to meet the twenty-four (24) hours, seven days a week cardiac service responsibilities.

- E. The heart on-call nursing personnel will arrive in the department within thirty (30) minutes of notification.
- F. The nursing personnel on call will confirm contact phone numbers with the hospital operators before leaving the facility.
- G. Changes in the nursing personnel and anesthesiologist on-call assignments will be managed and documented by the surgery charge nurse during regular business hours and the nursing supervisor after hours.

PACU staffing is established based on number of procedures and Units of Service is PACU minutes with adjustments made for changing acuity or census as well as Nurse Staffing Ratios. Staffing is adequate to service the customer population. Assignments are made based on ASPAN recommended staffing guidelines, acuity, needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. Shifts are staggered throughout the day to provide the highest unit coverage during the heaviest volume periods. Staffing is adjusted to accommodate procedure case mix. The RN to patient ratio is one RN to no greater than two (2) patients in the immediate post procedure or Phase I recovery period. During the Phase I recovery period, two (2) registered nurses are in the same room at all times, one of whom is competent in Phase I post anesthesia nursing. Staffing is based on patient volume and acuity. In the event PACU staffing requirements cannot be met, this department will meet staffing requirements by utilizing cross-trained PACU staff and/or float RNs from other procedural units, float pool, and per diem RN's, Phase II recovery can be assigned to PACU as needed to assist with staffing needs. Authorization of overtime will also be considered.

Outpatient staffing is established based on number of procedures and Units of Service hours per patient with adjustments made for changing acuity or census as well as Nurse Staffing Ratios. The RN to patient ratio is one RN to no greater than three (3) patients in the immediate post-procedure or Phase II recovery period. Staffing is based on patient volume and acuity. Shifts are staggered throughout the day to provide highest unit coverage during heaviest volume periods.

In the Endoscopy Unit, the RN to patient ratio is one (1) RN and one (1) endo tech or two (2) RNs per procedure. An RN will monitor and recover sedated patient prior to unit discharge. Services are provided twenty four (24) hours per day. Staffing is based on patient volume, acuity and the needs of the patient. In the event Endoscopy Unit staffing requirements cannot be met, this department will meet staffing requirements by utilizing the on-call system, registry and per diem RN's. Authorization of overtime will also be considered. Emergency after hour care is covered by on-call coverage per contract. Sick leave is covered by per diem or overtime personnel.

SSPD assignments are made by the Manager based on the needs of the operating room and other departments, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. In the event staffing requirements cannot be met, this department will meet staffing requirements by utilizing per diem staff. Authorization of overtime will also be considered.

IX. EVIDENCED BASED STANDARDS

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

of the art practice, desired outcomes and with respect to patient rights and confidentiality.

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

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

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

X. CONTRACTED SERVICES

Contract Services under Surgical Services are located in the Contract Management Software system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Attachments

 [Image 1](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Aisha Huebner: Director Perioperative Services	03/2025

Standards

No standards are associated with this document



Last Approved

N/A

Next Review

1 year after approval

Owner

Audrey Parks:
Vice President
Information
Technology

Area

Scopes Of
Service

Scope of Service: Telecommunications

I. SCOPE OF SERVICE

Telecommunication supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health (SVH) and has designed services to meet the needs and expectations of patients, families and the community.

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

II. GOALS

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

The goals of Telecommunications Department are as follows:

- A. Provide telecommunications services to our physicians, staff, and the general public who call the main Hospital.
- B. Maintain sufficient equipment and supplies to adequately perform the telecommunications services offered to SVH patients and customers.

III. DEPARTMENT OBJECTIVES

- A. To support the objectives of Salinas Valley Health Medical Center.
- B. To support the objectives Salinas Valley Health Clinics.
- C. To deliver safe, effective, and appropriate service in a cost effective manner.
- D. To plan for the allocation of human/material resources.
- E. To collect data about the department function, staff performance, and customer service for quality

management purposes and continuous quality improvement.

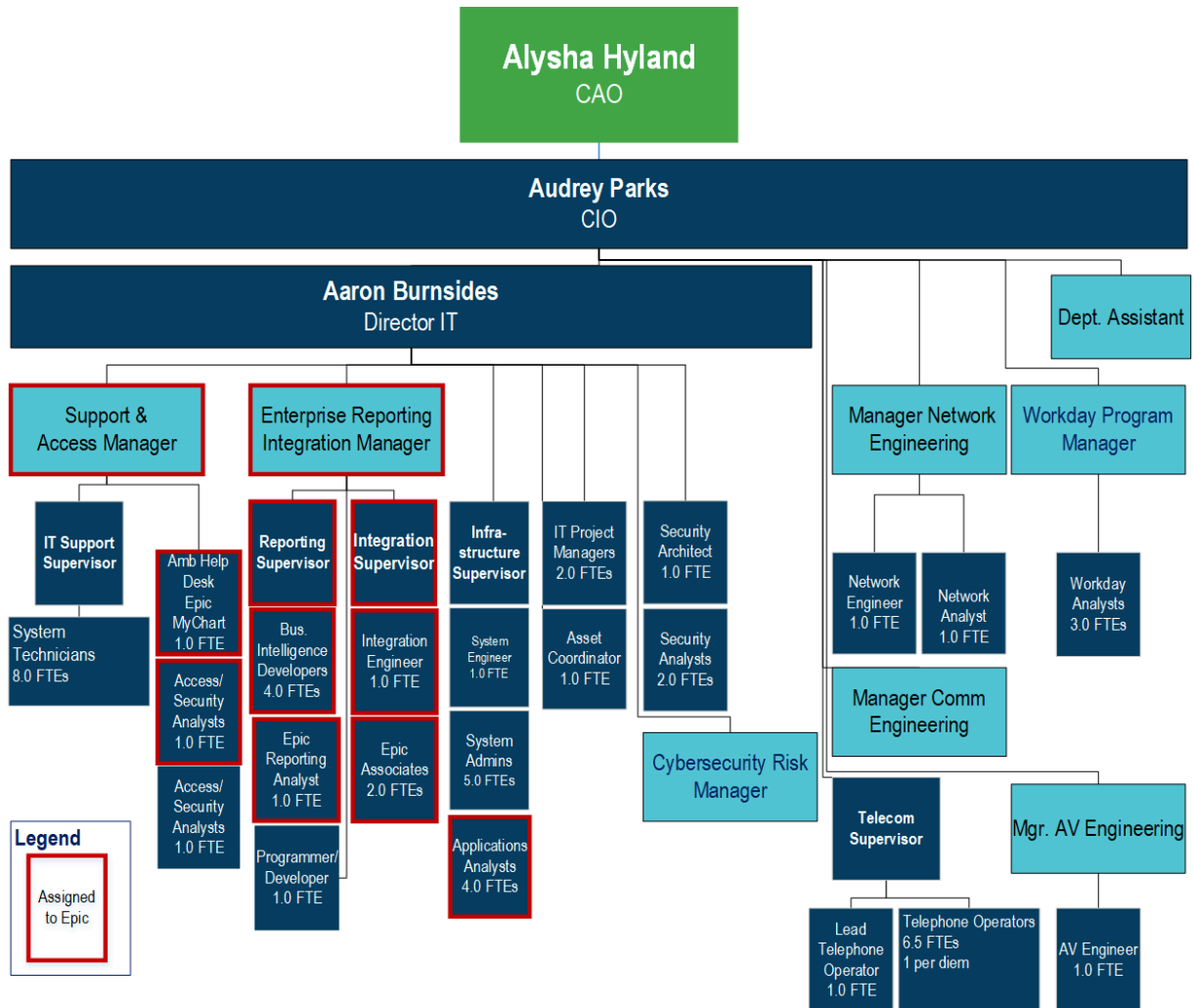
- F. To develop/implement/evaluate standards utilized in customer service and telephone etiquette.
- G. To evaluate staff performance on an ongoing basis.
- H. To provide appropriate staff orientation and development.

IV. POPULATION SERVED

Non-Clinical:

Telecommunications provides services to All Departments.

V. ORGANIZATION OF THE DEPARTMENT



- A. Hours of Operation:
Telecommunications operates 24 hours per day, seven days per week, 365 days per year. There are times where the automated teller is utilized and primarily to relieve staff for breaks during non-peak periods.
- B. Location of department:

In the basement of the Downing Resource Center with an emergency switchboard located in the Breschini Energy Plant off of San Jose Street.

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

- A. Telecommunications is part of Information Technology.
- B. Supervision of the Telecommunications group is directly responsible to the Chief Information Officer. It is the Communication Supervisor's duty to attend to all administrative and technical functions within the department.
- C. All personnel within the department are under the guidance and direction of the Telecommunications Supervisor. In the Supervisor's absence, the position is filled by the Chief Information Officer or their designee.

VII. REQUIREMENTS FOR STAFF

All individuals who provide telecommunications services have the appropriate training and competence

- A. Licensure / Certifications:
N/A
- B. Competency

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

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

- C. Identification of Educational Needs

We identify educational needs of the staff utilizing inputs such as the following:

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

- Change in regulations and licensing requirements
- Needs assessment completed by Nursing Education

The educational needs of the department are assessed through a variety of means, including, but not limited to the following:

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

General Staffing Plan:

- A. Telecommunications staffing is based on call volume and activity.
- B. Staff include:
 1. Telecommunications Supervisor
 2. Telephone Operators
- C. In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: 1 (Telephone Operator).

IX. CONTRACTED SERVICES

We maintain contracted services under this Scope of Service in the contract management system.

X. EVIDENCED BASED STANDARDS

The Salinas Valley Health staff will correctly and competently provide the right service, do the right

procedures, treatments, interventions, and care by following evidenced based policies and established practice standards to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

The SVH staff will design, implement and evaluate systems and services for care / service delivery consistent with a "Patient First" philosophy and delivered as follows:

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

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Attachments

 [b64_90af2dca-b435-4290-85bb-8df865900195](#)

 [Image 1](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Audrey Parks: Chief Information Officer	02/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
1 year after approval

Owner
Area

Marian Fox:
Clinical Manager
Scopes Of Service

Scope of Services: Transport

I. SCOPE OF SERVICE

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

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

Transport is delivered by a multidisciplinary team comprised of transporters, registered nurses, and ancillary support (RT, CNA, etc.) according to the needs of the patient. A registered nurse will accompany Telemetry patients from one location to another to maintain same level of care.

The department provides services seven days a week. Weekdays 0600-2300 and 0700-2300 on weekends.

II. GOALS

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

The goal(s) of Transport Services is to:

- A. To provide high quality transport services to inpatients and outpatients in a safe, professional, and expedient manner.
- B. Ensure proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

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

IV. POPULATION SERVED

Clinical: Transport Services provides care for infant, pediatric, adolescent, adult and geriatric patients.

Non-Clinical: N/A

Transport Services provides services including but not limited to: N/A

V. ORGANIZATION OF THE DEPARTMENT

- A. Hours of Operation
The Department provides services seven days a week; 0600-2300 weekdays and 0700-2300 on weekends
- B. Transport Services is a virtual department managed through nursing administration.
- C. Major Services / Modalities of care may include:
Patient safety during transport in collaboration with nursing staff. Transporters are trained to provide groin and body preps for cardiac catheterization or surgical procedures.

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

Care is delivered by a multidisciplinary team comprised of transporters, registered nurses and ancillary support according to the needs of the patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

VII. REQUIREMENTS FOR STAFF

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

The Department follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with BCLS.

A. Licensure / Certifications:

The basic requirements for **Transporters** include:

1. CNA Certification
2. Current BLS
3. Completion of competency-based orientation
4. Completion of annual competency

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours of care / service, to provide a safe standard of practice and meet regulatory requirements.

General Staffing Plan:

In the event of a severe emergency, patients will be transported by the clinical staff throughout the hospital similar to after hour process:

Assignments are made based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. Staffing is based on patient volume and acuity.

Staffing is established based on Average Daily Census and Units of Service is Patient Days with adjustments made for changing acuity or census. See the Master Staffing Plan. Staffing is adequate to service the customer population. In the event staffing requirements cannot be met, this department will meet staffing requirements by utilizing the on-call system, registry and RN's. Authorization of overtime will also be considered.

IX. EVIDENCED BASED STANDARDS

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

state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Attachments

 Image 1

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Policy Owner	Marian Fox: Clinical Manager	12/2024

Standards

No standards are associated with this document



Last Approved N/A
Next Review 3 years after approval

Owner Aisha Huebner:
Director
Perioperative
Services
Area Perioperative
Services

Specimen/Foreign Body

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To establish a uniform guideline for the identification, preservation, transfer, and disposition of tissues and foreign bodies removed from patients during surgery/procedures.

III. DEFINITIONS

- A. Specimens: tissue, limbs, blood, body fluids, and foreign bodies removed from a patient.
- B. Fixative: A solution used to preserve the cellular integrity of tissue submitted for pathology examination e.g. 10% Formalin.
- C. Frozen section: Small pieces of tissue (5x5x3mm), which are placed in a cryoprotective embedding medium, frozen, and then sectioned in a freezing microtome or cryostat.
- D. Permanent section: Examination of preserved and processed tissues/cells.
- E. CABG: Coronary artery bypass graft.
- F. Circulator: an RN who identifies the patient, verifies correct procedure/site and consent, initiates the Time Out, ensures supplies are ready, and delivers items to the sterile field.
- G. Scrub: the person, either RN or technician, who has scrubbed, donned sterile attire and assists the physician during the sterile procedure.
- H. Fresh: without fixative
- I. After hours: after 1530, Monday through Friday

IV. GENERAL INFORMATION

- A. The identification, transfer, and examination of specimens is a multidisciplinary responsibility involving the physician doing the procedure, the circulator, the scrub person, and the pathologist.
- B. Foreign bodies, removed for forensic purposes, must be documented and examined by a pathologist before release to a law enforcement official.
- C. The Specimen reconciliation and transfer process is initiated and controlled by Pathology through the Lead Histology Tech. Discrepancy reports are generated by the Lead Histology Tech. and reviewed at the quarterly Pathology Meetings.
- D. Anatomical parts, tissues and foreign objects/devices removed during procedures are identified, recorded and delivered to a pathologist designated by the hospital and a report of his/her findings is filed in the patient's medical record.
 - 1. Exemptions: cataracts, tubes, drains, and suture that have not contributed to patient illness, injury, or death and saphenous vein harvested for CABG.

V. PROCEDURE

- A. Specimen collection begins with assessment and pre-planning.
 - 1. The procedure schedule is consulted by the circulator, scrub, and pathologist to identify procedures for which specimens may be obtained.
 - 2. Unusual specimen requests are clarified with the physician and dialogue is initiated with a pathologist to determine special requirements.
 - 3. The type of container and fixative or transport medium is identified.
 - 4. Staff must choose the appropriate sized containers must be large enough to accommodate the specimen and enough fixative, at a 10 part fixative to 1 part specimen ratio, in rigid leak proof pre-filled containers.
 - a. The exception is limbs, which are double bagged and labeled as biohazardous material and transported as soon as possible after removal.
- B. Specimens are identified with consistent information, which includes the following:
 - 1. For both specimen **container and forms**,
 - a. Patient name.
 - b. Patient medical record number and date of birth.
 - c. Patient label when available.
 - d. Source or type of specimen and laterality, if applicable.
 - 2. **Additional container labeling**
 - a. Solution used to fix tissue when a fixative is needed
 - b. Biohazard label
 - 3. **Additional data unique to specimen forms**,

- a. Pre and post procedure diagnoses.
 - b. Date of collection.
 - c. Time of collection for blood, fluid, culture, and breast specimens.
 - d. Name of physician completing the procedure and other physicians he/she indicates should receive a copy of the specimen/pathology report.
 - e. Pertinent information discovered during the procedure.
 - f. Study requested.
 - g. Circulator's name.
 - 4. Specimens and forms not identified as described above will be rejected by Pathology and returned to the source department for corrections.
 - 5. Specimen labels are placed on the container body and not the lid.
- C. Specimens are identified: at the time of
- 1. Removal from the patient by the physician and scrub (if present):
 - a. The scrub or circulator verbally repeats back the tissue information.
 - 2. Transfer to the circulator:
 - a. The scrub if present or physician verbalizes the specimen identity and the circulator verbally confirms the information.
 - b. The circulator places a specimen label on the container and the scrub visually confirms accuracy immediately before the specimen is received.
 - c. The circulator documents the specimen in the procedure record.
 - d. The circulator prints the specimen form or hand writes the information on the form.
 - 3. Transfer to Radiology Technician:
 - a. Breast specimens placed on speci-board with specific orientation for specimen mammography. After mammogram is completed the specimen is secured and wrapped with a waterproof wrapper prior to transport to Pathology . The labeled specimen container is taken with the specimen and pathology requisition.
 - 4. Transfer to a pathologist:
 - a. The circulator and procedure physician verbally identify the specimen.
 - b. The circulator provides the labeled specimen/container and the specimen form, which is printed from the computerized record or hand written.
 - 5. Transfer to a specimen collection area on the unit or the Lab:
 - a. In the collection area of Surgery, the circulator identifies the specimen on the tracking sheet with a patient label, the number of specimens, the circulator's initials, and when a frozen section was sent indicates FS.
 - b. In other units the specimen for permanent section is taken to the Histology

Department by unit staff.

c. The specimen form accompanies the specimen.

6. Transfer to the Lab/Pathology area.

- a. A final check is completed by the technician to verify the specimen label, specimen form, and procedure schedule all confirm the specimen is correct.
- b. For Surgery, the accurately identified specimen is initialed by the Lab technician on the specimen tracking sheet.
- c. For each specimen accepted by Pathology, the technician logs the specimens into Pathology and assigns an accession number.
- d. Specimens with conflicting or missing information are returned by the technician to the source unit for correct identification.

7. For multiple specimens, each specimen is labeled and identified individually on the specimen form and procedure record.

D. Specimens for pathology: permanent and frozen section.

- 1. Anything removed from the patient during a procedure, unless exempted in the policy section, is considered a specimen e.g. tissue, limbs, foreign bodies, and implants, and must be examined by the pathologist.
- 2. The primary fixative in Surgery, Endoscopy, Diagnostic Imaging and Mammography is 10% Formalin.
 - a. The volume of fixative required to fix tissue is 10:1; less fixative results in incomplete or no fixation and ruins the tissue for examination. When in doubt about quantity, use more.
 - b. Hollow organs like the spleen do not fix well and should be taken to Pathology for fixation.
 - c. The SDS sheet for Formalin is located in [StarNet quick link for SDS](#).
- 3. Tissues, which are not fixed and are sent to Pathology fresh, include the following:
 - a. Renal and bladder stones, submitted dry.
 - b. Amputated extremities, which are too large to fix must be double bagged and labeled as biohazardous material, patient label attached, delivered to pathology and placed inside the pathology refrigerator. A pathology requisition must be placed on the counter next to the pathology refrigerator.
 - c. Muscle and nerve biopsies coordinated with a pathologist, Monday - Thursday.
 - d. Lymph node biopsies, which are fragile.
 - i. Sent immediately upon delivery to Pathology together with a pathology requisition in a sterile leak proof container.
 - ii. When cultures are ordered, the specimen is sent to microbiology

- first. Specify as Lymph Node Protocol on the pathology requisition.
 - iii. At case conclusion, the specimen is logged onto the Surgery specimen check sheet using a pre-printed patient label and lymph node protocol is noted. A printed specimen record is left with the check sheet.
 - e. Breast excisions and mastectomies. To provide opportunity for the pathologist to examine the tissue fresh as soon as it is available.
 - i. Breast tissue is not treated with fixative in Surgery.
 - ii. Pathology Department is notified when the tissue is ready for pick up from the charge nurse. Documentation of the time of tissue removal is required.
 - iii. After hours, weekends, and holidays, the specimen is placed in Formalin then per surgeon discretion notify the Pathologist on call via notification system with the surgeon name, type of specimen, and clinical reason.
 - f. Uterus tissue from the oncologic gynecologists
 - i. Uterus tissue suspicious for carcinoma is not placed in fixative in surgery.
 - ii. Pathology Department is notified when the tissue is ready for pick up from the charge nurse.
 - iii. After hours, weekends, and holidays, the specimen is placed in Formalin then per surgeon discretion notify the Pathologist on call via notification system with the surgeon name, type of specimen, and clinical reason.
4. Frozen section specimens are **not** fixed and are transferred fresh to the pathologist by the physician doing the procedure, who communicates his procedural findings directly to the pathologist.
- a. For Surgery and DI, the Pathologist is paged to the OR/procedure room where he/she receives the specimen with its identifiers.
 - b. When the frozen section is completed, the Pathologist reports the results directly to the physician and then takes the specimen to the Lab for final fixation.
 - c. The circulator indicates on the patient's record that a FS was completed and to whom it was given.
 - d. For Surgery, the circulator places a patient label on the specimen sheet in the collection area and indicates the frozen section.
5. Specimen orientation.
- a. The physician doing the procedure is responsible for communicating specimen orientation when needed.

- b. Orientation may be communicated verbally to the Pathologist or may be marked e.g. with suture and a description of the area marked, which the circulator will indicate on the pathology specimen form.
6. Gross exam is completed for teeth, hardware, and other devices.
- E. Specimens the patient and/or family want to see:
 1. The circulator notes the patient's desire on the pathology specimen form and verbally communicates that information to the Pathology unit.
 2. The pathologist may exhibit the specimen to the patient/family.
- F. Other specimens obtained during procedures e.g. cytology fluids, urine, tissue/ fluids for bacteriological exam, and prion contaminated samples.
 1. The specimens are brought to the lab fresh, without fixative.
 2. For Pathology specimens outside of working hours, the specimens are taken to the main lab for disposition.
 3. Specimens for both bacteriological and pathological exams.
 - a. Whenever possible the specimen is divided in the procedure area and placed in a sterile container for transport to Bacteriology.
 - b. For tiny specimens like pituitary tumor biopsy and culture, the specimen is sent intact to Bacteriology.
 4. For Creutzfeldt Jacob disease suspect cases, refer to the policy, [CJD PRECAUTIONS FOR UNDIAGNOSED BRAIN LESIONS, # 217.](#)
- G. Disposition of defective implants:
 1. The circulator indicates on the Pathology specimen form the need to return the implant to the source or representative.
 2. After the pathologist identifies the specimen, the implant is returned to Surgery for decontamination and terminal sterilization.
 3. The implant final disposition is noted on the procedure record and in the case of tissue on the Tissue Tracking form which is retrieved by the unit clerk/secretary.
- H. Radioactive specimens may occur in the rare instance a patient treated with radioisotopes presents for a procedure, which results in a specimen.
 1. Lymphoscintigraphy sentinel node biopsies require no special handling.
 2. All routine labeling requirements apply.
 3. Additional labeling includes:
 - a. Attachment of a radioactive material label.
 - b. The type of radioisotope and the date it was administered to the patient.
 4. Contact the pathologist immediately and he/she will consult with the Radiation Safety Officer or the alternate for recommendations and/or testing for radioactivity.
- I. Forensic specimens

1. Specimen transfers:
 - a. The Preservation of Chain of Evidence/Removal of Foreign Body form is completed by the circulating/primary care nurse transferring the evidence.
 - b. Further transfers are documented by the designee for the Lab's Anatomical Pathology Division.
 - c. Documentation includes the names of each individual handling the specimen.
2. Bullets should be handled using rubber shod instruments; metal instruments may scratch the surface interfering with later ballistics analysis.
3. Penetrating objects should be handled minimally when possible and not wiped clean in order to preserve evidence.

J. Documentation:

1. Pathology Department specimen log.
2. Surgery/procedure pathology requisition form other specimen form.
3. Surgery/procedure patient record.
4. Surgery specimen log book.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. AORN Recommended practices for specimen management. *Perioperative standards and recommended practices*. AORN, Denver, CO. 2024 issue
- B. College of American Pathologists (revised Nov 2007). Surgical specimens to be submitted for pathology examination. Retrieved from: http://www.cap.org/apps/docs/laboratory_accreditation/build/pdf/surgical_specimens.pdf
- C. National Cancer Institute. Laboratory of pathology, Safety overview and training. Radioactive specimens in histology. Retrieved from: <http://home.ncifcrf.gov/ccr/lop/intranet/PolicyManual/SafetyOverview/radioactive.asp>

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	04/2025
Medical Director	Christina Hinz: PHYSICIAN	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Aisha Huebner: Director Perioperative Services	03/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Aisha Huebner: Director Perioperative Services
Area	Patient Care

Traffic Patterns in the OR

A. POLICY STATEMENT

A. N/A

B. PURPOSE

- A. To establish traffic control patterns that protects patients and personnel from potential sources of cross-contamination related to movement into and out of the Surgery Department and individual surgery rooms.

C. DEFINITIONS

A. N/A

D. GENERAL INFORMATION

- A. Surgery suite is divided into three (3) sections with designated attire appropriate for each section and the area is posted to limit access to authorized personnel.
1. The *unrestricted area*, which includes PACU and the control desk and is demarcated from the remainder of the OR by a red line, may be entered with street clothes.
 2. The *semi-restricted area*, which includes the hallways and sterile and un-sterile storage areas, is limited to access by personnel in scrub attire.
 3. The *restricted area*, which include the OR procedure rooms and scrub sinks are limited to personnel in scrub attire to include masks when procedures are ongoing, a sterile field has been established, or hand scrubs are in progress.
- B. Medical equipment and required personal items must be decontaminated prior to entering the semi-restricted areas or restricted areas of the surgical unit.

E. PROCEDURE

A. Responsibilities

1. All OR and PACU staff participate in implementing, monitoring, and enforcing the Traffic Patterns policy. The Charge Nurse running the day-to-day operations of the OR has the responsibility for monitoring and regulating traffic flow.
2. Staff transporting gurneys and carts remain on the right side of the hallway and use caution when approaching intersections and/or swinging doors.
3. Staff ensures that equipment placed in the hallways on a temporary basis can be mobilized and is located on one side of the hall to promote movement of patients and access.

B. All medical equipment must be decontaminated using the hospital approved solution and following the required wet time for that solution prior to entering a semi-restrictive zone or restrictive zone.

C. All necessary personal items for medical staff, industry representatives, or hospital personnel must be decontaminated and stored in a hospital approved wipe-able container when entering a restricted zone. The container must be cleaned during the room turn-over process, prior to opening a new sterile field. If items are placed in a disposable plastic bag, the bag must be replaced between each surgical procedure.

D. Patients entering the surgical suite should wear clean gowns and hair covers and when on beds or gurneys should have clean linens which minimizes particulate debris in the OR.

E. Movement and numbers of personnel are minimized to those who need to be present when procedures are in progress that diminishes microbial shedding and airborne contamination.

F. Doors to OR rooms are closed except during movement in and out of the room in order to preserve the positive pressurization and decrease air turbulence.

G. The movement of clean and contaminated supplies and equipment is separated by space, time, or traffic pattern with sterile supplies protected from contamination.

H. Spills are cleaned when noted, in the interest of safety. Slippery areas are reported to the Charge Nurse.

I. Documentation: N/A

F. EDUCATION/TRAINING

A. Education and/or training is provided as needed

G. REFERENCES

A. AORN 2024. Guidelines for Perioperative Practice

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	04/2025
CNO	Carla Spencer: Chief Nursing Officer	02/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Aisha Huebner: Director Perioperative Services	01/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Marian Fox: Clinical Manager
Area	Patient Care

Transport to and from an External Healthcare Facility for Treatment

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To guide staff in ensuring continuity of patient care with external healthcare facilities and Salinas Valley Health Medical Center (SVHMC) by coordination of safe and efficient patient transport and treatment.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

- A. External healthcare facilities and SVHMC staff shall coordinate transport services, within the EMS scope of care, to and from the external healthcare facility for patients receiving treatments and/or procedures that are not available at SVHMC.
- B. SVHMC transfers patients only when a higher level of care is required or the service is not available.
- C. SVHMC has the capability to convert a standard patient room to negative pressure when necessary, negating a need for transfer.

V. PROCEDURE

- A. The external healthcare facility will notify the appropriate ambulance company and the nursing unit of the scheduled treatment/procedure time. A physician's order will be sent prior to this

appointment.

- B. The ambulance will be contacted by nursing staff as needed, to communicate any additional patient needs prior to transport (i.e., cardiac monitor, TPN, IV, IV pump, O₂). The ambulance will pick up the patient for transport to the external healthcare facility from the unit by gurney. Ambulance staff will deliver the patient to the external healthcare facility and standby until the patient is ready to return. Ambulance staff will return patient to the unit when treatment/procedure is completed
- C. The nursing staff will prepare the patient for transport at the scheduled pick-up time by:
 - 1. Completing the Consent to Transfer for Medical Treatment with the patient (Consent is valid for the length of stay)
 - 2. Assuring informed consent to surgery or special procedure has been obtained, if required.
 - 3. Converting the IV to an INT whenever possible.
 - 4. Securing tubes and lines.
 - 5. Medicating the patient, if necessary, to maintain comfort.
- D. The Registered Nurse will assess the patient prior to transport and document the assessment in the electronic medical record. Patient should be in stable condition and able to tolerate treatment and transport. A hand-off report will be provided to the ambulance staff.
- E. Upon return to the nursing unit, the Registered Nurse will reassess the patient according to the unit assessment standards and document in the electronic medical record.
- F. Documentation:
 - 1. Documentation of transport to and from the external healthcare facility will be done in the Electronic Medical Record.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. California Hospital Association Consent Manual (2020). Patient Transfer, Discharge or Temporary Absence. 12: 12.21 – 12.23, Form 9-3.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending

Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Marian Fox: Clinical Manager	03/2025

Standards

No standards are associated with this document



Last Approved N/A
Next Review 3 years after approval

Owner Daniela Jago:
Clinical Manager
Area Women's and
Children's
Services

Trial Of Labor After Cesarean (TOLAC)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To define parameters for trial of labor (TOLAC) after cesarean section (CS). This includes identifying the criteria for TOLAC, the contraindications to TOLAC and physician (OB provider) and nursing responsibilities when caring for patients attempting trial of labor after CS.

III. DEFINITIONS

- A. AROM: Artificial rupture of membranes
- B. IUFD: Intrauterine fetal demise
- C. LABOR: Admission with intent of delivery
- D. TOLAC: Trial Of Labor After Cesarean
- E. VBAC: Vaginal birth after cesarean section

IV. GENERAL INFORMATION

- A. Criteria for TOLAC:
 - 1. One prior low transverse CS or two prior low transverse CS with history of prior vaginal birth.
 - 2. Vertex presentation of fetus
 - a. Consideration for breech presentation in IUFD
 - 3. Less than 42 weeks gestational age (GA)
 - a. Clinical documentation of adequate pelvis

4. No history of:
 - a. Prior disruption of uterine wall (i.e. surgeries, accreta and its variants)
 - b. Uterine scar dehiscence
 - c. Uterine rupture
5. Induction of labor may be considered for TOLAC
 - a. Appropriate methods for TOLAC induction include:
 1. Cervical ripening balloon
 2. Pitocin per TOLAC protocol
 3. Artificial rupture of membranes (AROM)
6. Augmentation of labor may be considered for a TOLAC.
 - a. Uses of prostaglandins for cervical ripening and/or induction of labor are contraindicated in a TOLAC for a live fetus
 - b. Exception - use of prostaglandins, cervidil or misoprostol for cervical ripening or induction of labor may be used on patients with a fetal demise and a prior transverse lower segment CS for less than 28.0 weeks gestational age
7. Use of an intrauterine pressure catheter (IUPC) for judicious titration of oxytocin (Pitocin) is permissible.
8. Contraindications for TOLAC:
 - a. Greater than two previous CSs, regardless of incision location
 - b. Breech presentation or other malpresentation of fetus (consideration for IUFD)
 - c. Medical or obstetric complication that precludes vaginal delivery
 - d. Post-term pregnancy (42.0 weeks GA or greater)
 - e. Prior classical, T-shaped, other transfundal uterine surgery/scar
 - f. Contracted maternal pelvis

B. Immediately Available:

1. Physician (OB provider) and Anesthesiologist will be readily available throughout the time that a patient is in labor to provide emergency care and/or an emergency Cesarean Section (CS) if needed.
2. Immediately available can apply to OB hospitalist

C. Available Back-up Support:

1. It is the responsibility of the attending physician (OB provider) and/or anesthesiologist to ensure that arrangements have been made with another obstetrician and/or anesthesiologist for back-up coverage as needed.

V. PROCEDURE

A. The responsibilities of the physician (OB provider) for TOLAC is as follows:

1. Informed consent and the plan of management shall be documented on the prenatal record during a prenatal visit and prior to the patient's admission to the Labor and Delivery (LD) Unit.
2. The documentation in the prenatal record shall reflect the specific risks, benefits and that alternatives were discussed per the American College of Obstetricians and Gynecologists (ACOG) selection criteria for TOLAC candidacy.
 - a. This documentation shall reflect that the physician and patient are in agreement for the plan of management and the delivery mode.
 - b. If the specific VBAC consent is not available upon admission, the VBAC consent form shall be signed in the hospital by the patient, or the patient's legal authorized representative, as evidence of the informed consent process noted in the patient's prenatal record following discussion with the attending physician (OB provider).
 - i. The hospital consent is not in lieu of the informed consent process that occurs in the prenatal visit between the physician and the patient.
 - c. Documentation of the location of the prior CS incision shall be included in the plan of management on the hospital record, if not documented in the prenatal record.
 - i. If the location of the prior CS uterine scar is not available to the attending physician, the physician shall document in the plan of management why it is felt to be appropriate to continue with a TOLAC in the electronic hospital record (EHR).
 - d. The laboring patient may elect to have a repeat CS versus the documented plan of TOLAC upon admission to the LD Unit and/or at any point during her TOLAC.
3. The physician (OB provider) or OB Hospitalist will be immediately available during a patient's TOLAC. If the attending physician is occupied with another patient procedure or is otherwise unavailable, an additional physician (OB provider) must be immediately available to assume care of the patient's labor and delivery.
4. Anesthesiology is notified directly when there is a TOLAC patient on the LD Unit. The anesthesiologist must be immediately available during the patient's TOLAC with back up support available by on-call anesthesia.

B. Considerations for IUFD with previous Cesarean Section

1. In patients with a prior Cesarean section, prostaglandins can be used for patients less than 28 weeks gestation
2. If the physician (OB provider) elects to use prostaglandins, cervidil or misoprostol for cervical ripening or induction of labor for a fetal demise, the physician (OB provider)

must assess the patient prior to the start of cervical ripening within 24 hours of admission see [INDUCTION/AUGMENTATION OF LABOR AND CERVICAL RIPENING](#)

3. 2nd trimester: 18-28 weeks: 100mcg-400mcg intravaginally every 3 hours – max dose 1400 mcg (also consider same regimen for 1st trimester loss induction) may be used with previous uterine scar.

C. Nursing responsibilities for TOLAC/VBAC is as follows:

1. Verify with the patient that the informed consent discussion with the attending physician took place and ensure that all questions have been clearly answered by the physician.
2. Ensure that procedural consent for VBAC is signed and in the patient's medical record.
3. An obstetrical technician or scrub technician will be immediately available in the event a CS will be performed on a TOLAC patient.
4. Continuous electronic fetal monitoring, including maternal monitoring of uterine activity pattern is initiated and maintained during TOLAC [FETAL HEART RATE MONITORING](#).
5. If oxytocin (Pitocin) is used to induce or augment labor, low dose oxytocin administration will be used and hospital policies/procedures will be followed [INDUCTION/AUGMENTATION OF LABOR AND CERVICAL RIPENING](#)
 - a. Low dose oxytocin starting at 0.5-1 mU/min (physician's order) with incremental increases of only 1 mU/min will be used for augmentation of a TOLAC patient.
6. Labs to be obtained on admission include:
 - a. CBC
 - b. Type and screen
7. Maintain vascular access at all times during TOLAC and VBAC
8. Assess patient for signs of scar separation/uterine rupture
 - a. Variable fetal heart rate decelerations that may evolve into late decelerations
 - b. Bradycardia
 - c. Blood stained amniotic fluid
 - d. Hematuria
 - e. Vaginal bleeding
 - f. Alterations in uterine contractions
 - g. Abdominal pain that continues between contractions
 - h. Loss of fetal station on examination
9. Obstetrical Emergency:
 - a. Immediately notify the OB provider in the event of:

- i. Heavy vaginal bleeding
 - ii. Sudden increase in abdominal and/or uterine pain
 - iii. Sudden decrease in uterine baseline tone
 - iv. Evidence of fetal intolerance such as change in fetal heart rate pattern including fetal bradycardia or prolonged fetal heart rate deceleration.
 - v. Signs and/or symptoms of maternal hypovolemia-hypotension, and/or tachycardia.
 - vi. Loss of station of presenting fetal part
 - b. Initiate OB STAT emergency call OB STAT/OB STAT POSTPARTUM
 - c. Transfer patient to the operating room
- D. LD Unit Charge RN Responsibilities:
- 1. LD Charge RN will directly notify the Anesthesiologist of the admission of a labor patient for TOLAC.
 - 2. LD Charge RN will notify the Administrative Supervisor of the admission of a labor patient for TOLAC.
 - 3. LD Charge RN will notify the Neonatal Intensive Care Unit (NICU) of the admission of a labor patient for TOLAC.
- E. Documentation:
- 1. Document according to [FETAL HEART RATE MONITORING](#) - high risk category.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American College of Obstetricians and Gynecologists. (2024). Vaginal birth after cesarean section. (Practice Bulletin No. 205).
- B. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. Guidelines for Prenatal Care, 8th Edition (2017) . Author.
- C. Simpson, K., & Creehan, P. (2021). *Perinatal nursing* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

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	04/2025
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



Last ApprovedN/ANext Review1 year after approval

OwnerJames Hively: Manager Environmental Health & SafetyAreaPlans 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
SRC	Aniko Kukla: Director Quality & Patient Safety	Pending
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	04/2025
Emergency Management	James Hively: Manager Environmental Health & Safety	04/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	James Hively: Manager Environmental Health & Safety	04/2025

Standards

No standards are associated with this document



Last ApprovedN/ANext Review1 year after approval

OwnerElias Gutierrez: Manager Security ProgramAreaPlans and Program

Security Management Plan

SCOPE

1. The Security Management Plan describes the methods of providing security for people, equipment and other material through risk assessment and management for Salinas Valley Health Medical Center (SVHMC). Security incidents are often intentional. Security protects individuals and property against harm or loss, including workplace violence, theft, infant abduction, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the organization.

OBJECTIVES/GOALS

1. Objectives
 1. N/A
2. Goals
 1. The goals for the Security Management Plan are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, Incident reports and environmental tours.

DEFINITIONS

1. Environment of Care Committee (EOC)
2. Chief Executive Officer (CEO)

PLAN MANAGEMENT

1. Plan Elements

1. FUNDAMENTALS

- a. A visible security presence in the hospital helps reduce crime and increase feelings of security by patients, visitors, and staff.
- b. The assessment of risks to identify potential problems is central to reducing crime, injury, and other incidents.
- c. Analysis of security incidents provides information to predict and prevent crime, injury, and other incidents.
- d. Training hospital staff is critical to ensuring their performance. Staff is trained to recognize and report either potential or actual incidents to ensure a timely response.
- e. Staff in sensitive areas are trained about the protective measures designed for those areas and their responsibilities to assist in protection of patients, visitors, staff and property.
- f. Violence in the workplace is a growing problem in healthcare. It is necessary to develop a system wide program to address workplace violence.
- g. Regularly conduct a security and safety assessment and, using the assessment, develop, and update based on the assessment, a security plan with measures to protect personnel, patients and visitors from aggressive or violent behavior. The security and safety assessment shall examine trends of aggressive or violent behavior at the facility. SVHMC tracks incidents of aggressive or violent behavior as part of the quality assessment and improvement program and for the purposes of developing a security plan to deter and manage further aggressive or violent acts of a similar nature. The plan includes, but shall not be limited to, security considerations relating to all of the following:
 - i. Physical layout.
 - ii. Staffing.
 - iii. Security personnel availability.
 - iv. Policy and training related to appropriate responses to violent acts.
 - v. Efforts to cooperate with local law enforcement regarding violent acts in the facility.
- h. In development of this plan, SVHMC considers guidelines or standards on violence in health care facilities issued by the department, the Division of Occupational Safety and Health, and the federal Occupational Safety and Health Administration. As part of the security plan, SVHMC adopts security policies including, but not limited to, personnel training policies designed to protect personnel, patients, and visitors from aggressive or violent behavior. In developing the plan and the assessment, SVHMC consults with affected employees and members of the Hospital medical staff.

2. PROCESSES FOR MANAGING SECURITY RISKS

a. Security Risk Assessment

- i. The Security Director manages the security risk assessment process for SVHMC and off-site facilities. He is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. He assures that compliance with applicable codes and regulations, and develops and maintains the Security Management Plan. On a routine basis, the Security Manager evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the security risk of the staff, visitors, and patients at SVHMC.
- ii. SVHMC identifies security risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessment of high-risk processes, and from credible external sources such as Sentinel Event Alerts.
- iii. The risk assessment is used to evaluate the impact of the environment of care on the ability of the healthcare system to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals. The assessment will evaluate the risk from a variety of functions, including structure of the environment, the performance of everyday tasks, workplace violence, theft, infant abduction, and unrestricted access to medications.

b. Use of Risk Assessment Results

- i. A Risk Assessment is used to evaluate the impact of the environment of care on the ability of the hospital to perform clinical and business activities. Where risks are identified, the current programs and processes to manage those risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled, action must be taken to eliminate or minimize the risk. The actions may include creating new programs, processes, procedures, training programs. Monitoring programs may be developed to assure the risks have been controlled to achieve the lowest potential for adverse impact on the security of patients, staff, and visitors.

c. Identification Program

- i. The Security Director coordinates the identification program. The Sr. Administrative Director of Plant Operations and Hospital Construction along with all supervisory personnel manage enforcement of the identification program.
- ii. Hospital administration maintains policies for identification of

patients, staff, visitors, and vendors. All employees are required to display an identification badge on their upper body while on duty. Personnel who fail to properly display their identification badge may be counseled individually by their department head. Identification badges are retrieved from personnel upon termination.

- iii. Visitors to patients are expected to have identification. Visitors should be recognizable by staff. The Security Officers assist in enforcement of visitor identification policies.
- iv. Where required, patient identification is provided at the nursing unit where patients are first admitted. If a patient wristband is damaged it is replaced by the nursing staff.
- v. The VendorMate program along with Human Resources provides vendor and contractor identification. Identification badges are controlled and stored in a secure area.

d. Sensitive Areas

- i. The Security Director works with leadership to identify security sensitive areas by utilizing risk assessments and analysis of incident reports.
- ii. The following areas are currently designated as sensitive areas:
 - a. Construction Areas
 - b. Emergency Department
 - c. Human Resources
 - d. Newborn Nursery
 - e. Labor & Delivery
 - f. Pediatrics
 - g. Pharmacy
 - h. Medical Records (HIM)
 - i. ICU/CCU
 - j. IDF Closets
 - k. Surgery
 - l. Business Office
- iii. Personnel assigned to work in sensitive areas receive department level continuing education on an annual basis that focuses on special precautions or responses that pertain to their area.

e. Security Incident Procedures

- i. The Security Director coordinates the development of organization-wide written security policies and procedures, and

provides assistance to department heads in development of departmental security procedures, as requested. These policies and procedures include infant/child abduction, workplace violence, and other events that are caused by individuals from either inside or outside the organization.

- ii. Individual department heads assist in the development of department-specific security policies and procedures for risks unique to their area of responsibility. The Security Director also assists department heads in the development of new department security procedures. Organization-wide security policies and procedures are distributed to all departments. Department heads are responsible for distribution of department level policies and procedures to their staff and for ensuring enforcement of security policies and procedures. Each staff member is responsible for following security policies and procedures.
- iii. Organization-wide and departmental security policies and procedures are reviewed at least every three years. Additional interim reviews may be performed on an as-needed basis. The Security Director coordinates the triennial and interim reviews of organization-wide procedures with department heads and other appropriate staff, and works with department heads to review departmental security policies and procedures.

f. Security Incident Response

- i. Upon notification of a security incident, the Security Director, or designee will assess the situation and implement the appropriate response procedures. The Security Director will notify Administration, if necessary, to obtain additional support. Security incidents that occur in the Emergency Department will be managed initially by the Officer on Duty by following the appropriate policies and procedures for that area. The Security Director will be notified about the incident as soon as possible.
- ii. Security incidents that occur in the departments will be managed according to the departmental or facility-wide policy. The Security Director will be notified about any incident that occurs in a department as soon as possible. Additional support will be provided from the Security Office.
- iii. In the event of a child reported missing, a Code Pink, is announced over the internal page system, as well as to selected radio pagers. Designated staff responds to doors and specified areas to observe for persons with children or packages, and call Security if such cases occur. Other staff checks designated areas, document information, provide support to the parents, and staff of the unit involved.

- a. The Code Pink response procedure is tested at least once a year, and the responses documented, evaluated, critiqued, and, as appropriate, corrective activity, additional training, or program improvements are made.
- iv. Following any security incident, a written "Security Incident Report" will be filed by the Security Officer managing the incident. The Report will be reviewed by the appropriate Security Supervisor and Security Director if necessary. Any deficiencies identified in the report will be corrected. A summary of these Reports will be furnished to the Environment of Care Committee on a regular basis.
- v. Any act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code that results in injury or involves the use of a firearm or other dangerous weapon, against any on-duty hospital personnel shall be reported to the local law enforcement agency within 72 hours of the incident. Any other act of assault, as defined in Section 240 of the Penal Code, or battery, as defined in Section 242 of the Penal Code, against any on-duty hospital personnel may be reported to the local law enforcement agency within 72 hours of the incident.
- vi. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery pursuant to this section will be civilly or criminally liable for any report required. No health facility or employee of a health facility who reports a known or suspected instance of assault or battery that is authorized, but not required, will be civilly or criminally liable for the report authorized by this section unless it can be proven that a false report was made and the health facility or its employee knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any health facility or employee of a health facility who makes a report known to be false or with reckless disregard of the truth or falsity of the report shall be liable for any damages caused.

2. Plan Management

1. Evaluating the Management Plan

- a. On an annual basis, Security Director and EOC Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage the utility system risks to the staff, visitors, and patients at SVHMC.

2. Management Plan

- a. SVHMC develops and maintains and on a routine basis, evaluates the effectiveness of the Security Management Plan to effectively manage the security risk of the staff, visitors, and patients at Salinas Valley health

Medical Center.

3. Plan Responsibility

1. The Security Director, in collaboration with the Chief Operating Officer and the Environment of Care Committee, is responsible for monitoring all aspects of the Security Program.

4. Performance Measurement

1. PERFORMANCE ACTIVITIES

- a. The performance measurement process is one part of the evaluation of the effectiveness of the Security program. Performance measures are established to measure at least one important aspect of the Security Management Plan and are meant to focus on areas that need improvement or affect the overall safety of patients, staff or visitors

5. Orientation and Education

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

REFERENCES

- A. HSC Codes 1257.7 (a) (b) (c) (d), and 1257.8 (a).
- B. The Joint Commission Environment of Care Standards

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Elias Gutierrez: Manager Security Program	03/2025

Standards

No standards are associated with this document



Last Approved N/A
Next Review 1 year after approval

Owner Laura Zerbe:
Manager
Facilities
Construction and
Plant Operatio

Area Plans and
Program

Utility Management Plan

I. SCOPE

- A. The Utility Systems Program provides a process for the proper design, installation and maintenance of appropriate utility systems and equipment to support a safe patient care and treatment environment at Salinas Valley Health Medical Center (SVHMC).
- B. The Program will assure effective preparation of staff responsible for the use, maintenance, and repair of the utility systems, and manage risks associated with the operation and maintenance of utility systems. Finally, the Program is designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education, and training, and evaluation of all events that could have an adverse impact on the safety of patients or staff as applied to the building and services provided at SVHMC.

II. OBJECTIVES/GOALS

- A. Objectives
- B. The goals for the Utility Systems 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.

III. DEFINITIONS

- A. EOC: Environment of Care Committee
- B. AEM: Alternate Equipment Maintenance

IV. PLAN MANAGEMENT

- A. Plan Elements

1. Patient care providers are trained to understand how utility systems support patient care, limitations of system performance, safe operating conditions, safe work practices, and emergency clinical interventions during interruptions.
2. Hospital utility systems are highly complex. When upgrades and new installations are proposed, a multidisciplinary group approach is used to ensure that patient care needs, regulatory requirements and industry standards are met.
3. Utility systems are maintained to ensure proper operation and reduce potential for failures.
4. Emergency response procedures are required to manage utility system failures or service disruptions.

B. Plan Management

1. Processes of Managing Utility System Risks

a. Management Plan

- i. The organization develops and maintains the Utility Systems Management Plan to effectively manage the utility system risks to the staff, visitors, and patients at SVHMC.

b. Design and Maintenance of Utility Systems

- i. The Director of Facilities and Construction, Plant Operations or designee is responsible for managing the planning, design, construction, and commissioning of utility systems to meet the patient care and the operational needs of SVHMC. The construction and commissioning programs are designed to assure compliance with codes and standards, and to meet the specific needs of the occupants throughout the facility. The Director of Facilities and Construction, Plant Operations or designee is responsible for setting maintenance standards and implementing a program of planned maintenance and customer service to ensure a safe comfortable environment.

c. Utility Inventory

- i. SVHMC maintains an inventory of all operating components of the utility systems. These are categorized by potential impact to the safety of patients, staff and visitors in the event of failure. The Director, or designee, assesses systems and components to identify the appropriate maintenance strategies based on risk and impact. Added expectations of leaders and notifications to affected departments written criteria are used to identify risks associated with utility systems. Some of the risks include infections, occupant needs, and systems critical to patient care needs, including life support systems. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of the utility systems. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain

equipment.

- ii. Systems requiring a program of planned maintenance are listed as part of a maintenance inventory. The list includes operational components of utility systems maintained by in-house staff as well as equipment maintained by vendors.

d. Testing Utility Systems Prior to Initial Use

- i. The organization tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion date of the tests is documented. The Facility Director, or designee, is responsible for implementation of the program of planned inspection, testing, and maintenance.

e. Maintaining, Inspecting, and Testing Activities

- i. The Director of Facilities and Construction, Plant Operations or designee identifies in writing the activities used for maintaining, inspecting, and testing all of the operational components of the utility systems in the inventory to assure safety and equipment longevity. The determination of the appropriate activity is made as part of the initial evaluation of equipment, as well as failure trends and equipment history.
- ii. Potential activities may be selected to ensure reliable performance including:
 - a. Preventive maintenance based on manufacturer's recommendations
 - b. Reliability-centered maintenance based on equipment history
 - c. Interval-based inspections, tests, inspections, and preventive maintenance activity
 - d. Corrective maintenance based on direct observation of deficiency or failure of designated testing protocol
 - e. Metered maintenance based on manufacturer's recommendation, as applicable.
- iii. The results of assessment are used to identify appropriate maintenance strategies, and to identify which equipment may be included in preventive maintenance program.
- iv. The results of assessing the risks of failures of the utility systems are also used to identify those systems and areas for which emergency management plans are needed to assure ongoing safety of patient care as well as the safety of staff and visitors.

f. Maintenance, Inspection, and Testing Frequencies

- i. The organization identifies the activities and associated

frequencies, in writing, for inspecting, testing, and maintaining all applicable operating components of utility systems on the inventory.

- ii. Potential frequency for conducting these activities may be selected to ensure reliable performance including:
 - a. Preventive maintenance based on manufacturer's recommendations
 - b. Reliability-centered maintenance based on equipment history
 - c. Interval-based inspections
 - d. Corrective maintenance based on direct observation of deficiency or failure of designated testing protocol
 - e. Metered maintenance base on manufacturer's recommendation, as applicable.
- iii. A reference of guidelines for physical plant equipment maintenance is the American Society for Healthcare Engineering (ASHE) book Maintenance Management for Health Care Facilities.
- iv. A computerized maintenance management system is used to schedule and track timely completion of preventive maintenance activities. Added expectations of leaders and notifications to affected departments

g. Testing High-Risk Components of the Utility System

- i. All high-risk components of the utility system on the inventory are tested, maintained, and inspected. A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.
- ii. Reports of the completion rate of scheduled inspection and maintenance are presented to the EC Committee each quarter. If the rate of completion falls below 100%, there will be an analysis to determine the cause of the problem and corrective actions taken.

h. Testing Critical Components Supporting Infection Control

- i. All critical components of the utility system supporting infection control on the inventory are tested, maintained, and inspected. The completion date and the results of the activities are documented.
- ii. The required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components must have a 100% completion rate.

- iii. Reports of the completion rate of scheduled inspection and maintenance are presented to the EOC Committee each quarter. If the rate of completion falls below 100%, the Facility Director or designee will also present an analysis to determine the cause of the problem and take corrective actions. The corrective actions and retest of the systems will be documented.

i. Testing Non-High Risk Components of the Utility System

- i. All Non-high-risk utility system components on the inventory are tested, maintained, and inspected. The completion date and the results of the activities are documented.

j. Maintaining Specific Components of Utility Systems

- i. Specific inspecting, testing, and maintaining activities, and frequencies intervals for the following components of a utility system are conducted in accordance with the manufacturers' recommendations:
 - a. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers' recommendations, or otherwise establishes more stringent maintenance requirements
 - b. New operating components with insufficient maintenance history to support the use of alternative maintenances strategies.
- ii. The maintenance history used to determine the activities and frequencies may include, records provided by contractors used to service the utility systems, and information made public by nationally recognized sources. Experience of testing, maintaining, and inspecting components of the utility systems by the Facilities Management Department will also be used as history to determine the activities and frequencies required.

k. Identifying Risk Criteria Used for Inclusion in AEM program

- i. A qualified individual uses written criteria to support the determination whether it is safe to permit components of the utility systems to be maintained in an AEM program. The written criteria includes:
 - a. How the equipment is used, including the seriousness and prevalence of harm during normal use
 - b. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
 - c. Availability of alternative or back-up equipment in the event the equipment fails or malfunctions

- d. Incident history of identical or similar equipment
- e. Maintenance requirements of the equipment
- ii. Once the appropriate program is determined, the information is entered into the record for the utility system in the inventory.

l. Identifying Components Included in the AEM program

- i. The hospital identifies operating components of utility systems on the inventory that is included in an AEM program. These are reviewed by the Assistant Director at appropriate intervals.

m. Labeling Controls for Emergency Shutdown

- i. The Director of Facilities and Construction, Plant Operations, or designee is responsible for labeling the locations of critical or emergency controls for a partial or complete shutdown of the utility systems. Critical or emergency operating components of utility systems are identified on historical documents or computerized drawings. A variety of techniques such as legends, symbols, labels, numbers, and color-coding are used to identify the location and type of critical or emergency controls. The corresponding physical control is identified by a tag or other indicator attached to the device. This process is designed to provide technicians with accurate information about the function of a control before it is activated for scheduled maintenance or during an emergency.

n. Utility System Disruptions and Shutting off Malfunctioning System

- i. SVHMC has identified and implemented procedures for responding to utility system disruptions or failures. These procedures are developed to include the criteria for implementing a utility response plan. The staff is responsible for making the decisions; activities and resources used to mitigate the emergency (e. g., an emergency power system to mitigate external power failure); and preparation for the failure (e. g., flashlights, staff training about how to respond to a power failure). The response plans are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility. The recovery plans focus on return to normal conditions, and the resetting and recovery of emergency equipment and supplies.
- ii. The Utility Systems include the following:
 - a. Electrical Distribution
 - b. Emergency Power
 - c. Medical Gas
 - d. HVAC

- e. Boiler & Steam
- f. Plumbing
- g. Vertical & Horizontal Transport
- h. Vacuum Systems
- i. Communication Systems

o. Emergency Clinical Interventions

- i. SVHMC has identified and implemented emergency procedures for responding to utility system disruptions or failures that require emergency clinical interventions. This is focused on clinical staff and support staff as well. The Environment of Care Committee will assist in obtaining the necessary procedures for those utility systems that could impact on the life support equipment. The clinical staff will be trained on the proper response to the disruption of life support utility services and the method of notifying the appropriate group. The response plans are also included in a quick chart which is widely distributed and posted in a number of locations throughout the facility.

p. Emergency Repair Services

- i. SVHMC has identified and implemented procedures for the emergency repair of operational components of the utility systems. The staff has been provided with an Emergency Phone Binder located in the Engineering Shop that identifies the major utility systems and the contact information to obtain repair services. Those components that have a direct impact on patient care have been identified and repair plans developed. The staff should contact their supervisor immediately to report disruption. The supervisor, or staff member, then contacts the Plant Operations / Engineering Department who will respond to assess the situation and contact additional assistance if needed.

q. Management of Waterborne Pathogenic Agents

- i. The organization has identified and implemented processes to minimize pathogenic biological agents in cooling towers, domestic hot and cold water systems, and other aerosolizing water systems through the proactive periodic treatment of these systems.
- ii. When the monitoring program of incidents for hospital-acquired infections identifies the presence of pathogenic biological agents in water systems, the Infection Control Manager and the Director of Facilities and Construction or designee, Plant Operations collaborate to identify an effective treatment and future growth prevention program.

- iii. When an outbreak of an infectious, waterborne disease (e. g., Legionella) is identified, the SVHMC Infection Control staff notifies the Plant Operations / Engineering Department staff that treats the affected domestic water system to eliminate the hazard.
- iv. Any ornamental water fixture within the facility is periodically treated and the potential aerosol is controlled by ventilation, or other methods acceptable to the Infection Control Practitioner.

r. Maintenance of Air Pressurization, Filtration, & Filter Efficiency

- i. SVHMC designs, installs, and maintains ventilation equipment to provide appropriate pressure relationships, air-exchange rates, and filtration efficiencies for ventilation systems serving areas specially designed to control air-borne contaminants (e. g., biological agents, gases, fumes, dust).
- ii. All windows shall remain closed to ensure the proper pressure relationships are maintained throughout the facility. Closed windows also prevent pests and outside air contaminants from entering the hospital.
- iii. The air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by the Plant Operations / Engineering Department. The schedule of regular inspection of filter performance monitoring equipment, air pressure sensing equipment, and air flow rate sensors is managed by the Engineering staff.
- iv. A qualified service provider is engaged to verify volume flow rates (air exchange rates, and positive or negative pressure rates) and pressure relationships as part of the commissioning of all new building projects and major space renovations. In addition, the air volume flow rates and pressure relationships are tested periodically throughout the hospital including investigation of complaints related to indoor air quality. The results of testing are used to adjust the performance of air handling systems by changing control software parameters and mechanical or electrical controls.
- v. If system performance cannot be adjusted to meet code requirements or occupant needs, the Engineering Staff works with appropriate Infection Control and clinical staff to develop temporary management practices to mitigate issues. In addition, a recommendation for upgrading or replacing the equipment involved is prepared and submitted to the CEO and Board as appropriate.

s. Maintaining Appropriate Environment in Non-critical Areas

- i. In non-critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity. These areas include general care nursing units; clean and soiled utility rooms in acute care areas; general laboratories and pharmacy areas, diagnostic and treatment areas, food preparation areas, and other support departments.
- ii. An inventory of spaces requiring appropriate ventilation is maintained that includes the frequency and task for monitoring the environment affected. Periodic measurements pressure relationships, temperature, and humidity are taken in these areas throughout the organization at a frequency describe by the risks of that area. The frequency is reviewed periodically to determine the appropriate time-frame for monitoring.

t. Mapping Utility Systems

- i. Current documentation of the maps for distribution of all utility systems is maintained. The documents include "as-built" and record drawings, one line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations.
- ii. Hard copies of the documentation are maintained in Facility Management. Documents that are available in electronic format are maintained in the Facility Department server and are available to work stations throughout the organization.

u. Maintaining Medical Gas Storage, Manifold, and Transfer Areas

- i. Medical gas storage rooms and transfer and manifold rooms maintain the appropriate environment, including ventilation and temperature in accordance with NFPA 99-2012: 9.3.7. Indoor storage area, area containing a gas manifold and storage, such as manifold buildings for medical gases and cryogenic fluids shall be provided with natural ventilation or mechanical exhaust ventilation. The trans-filling of gas cylinder is prohibited in any compartment with patient care rooms.

v. Maintaining Emergency Power Supply Systems & Environment

- i. The emergency power supply system's equipment and environment are maintained per manufacturers' recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). The environmental condition are monitored daily during period of cold weather to insure the appropriate environmental and water-jacket temperature are maintained. This information is documented.

w. Managing Patient Risk during Repair or Maintenance Activities

- i. When performing repairs or maintenance activities, an assessment is conducted to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors. This assessment may be conducted by individuals trained in the Pre-construction or other Risk Assessment procedures. The results of the assessment, list of measures implemented to minimize or eliminate risk, and documentation of implementation of necessary measure will be documented.

2. PROCESSES MANAGING ELECTRICAL SYSTEMS

a. Providing Essential Electrical Circuitry

- i. The facility has the appropriate essential electrical systems. For those portions of the facility that was constructed since 1983, or had a change in occupancy type, or have undergone an electrical system upgrade have a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. The essential electrical system is divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. The transfer of power and operation of the automatic transfer switch are tested regularly.

b. Electrical Distribution in the organization

- i. Electrical distribution in the organization is based on the following categories:
 - a. Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required.
 - b. Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients.
 - c. Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1 1/2 hours.

c. Electrical Receptacles

- i. Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested

after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking.

d. Power Strips

- i. Special Purpose Relocatable Power Taps (SPRPT) in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used outside of a patient care vicinity, but within the patient care room, meet UL 1363. In non-patient care rooms, power strips meet other UL standards.

e. Extension Cords

- i. Extension cords are not used as a substitute for fixed wiring in a building. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was intended.

f. Wet Procedure Locations

- i. Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection.

g. Testing Line Isolation Monitors

- i. Line isolation monitors (LIM) are tested at least monthly by actuating the LIM test switch per NFPA 99, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.

h. Maintaining the Environment for Electrical Distribution

- i. The environment for the Emergency Power Supply (EPS) generator will be maintained for ventilation and temperature in accordance with NFPA 99-2012. This includes, but limited to:
 - a. The EPS shall be heated as necessary to maintain the water jacket temperature determined by the EPS manufacturer for cold start and load acceptance for

the type of EPSS.

- b. With the EPS running at rated load, ventilation airflow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer.
- c. The EPS shall be heated as necessary to maintain the water jacket and battery temperature determined by the EPS manufacturer for cold start and load acceptance for the type of EPSS.
- d. With the EPS running at rated load, ventilation air flow shall be provided to limit the maximum air temperature in the EPS room to the maximum ambient air temperature required by the EPS manufacturer.
- e. Ventilation air supply shall be from outdoors or from a source outside of the building by an exterior wall opening or from a source outside the building by a 2-hour fire-rated air transfer system.
- f. Ventilation air shall be provided to supply and discharge cooling air for radiator cooling of the EPS when running at rated load.

3. MANAGING EMERGENCY POWER SYSTEMS

- a. The Director of Facilities and Construction, Plant Operations or designee is responsible for managing a program of inspection, maintenance, and testing of the following essential electrical systems.
- b. **Emergency Electrical Power Systems**
 - i. Reliable emergency electrical power is supplied within 10 seconds of loss of "normal" power to specific the utility systems, including:
 - a. Alarm systems, as required by the Life Safety Code
 - b. Exit route and exit sign illumination, as required by the Life Safety Code
 - c. Emergency communication systems, as required by the Life Safety Code
 - d. Equipment that could cause patient harm when it fails, including life support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems
 - e. Areas in which loss of power could result in patient harm, including operating rooms, recovery rooms, obstetrical delivery rooms and nurseries
 - f. Emergency lighting at emergency generator locations

with a remote manual stop station with identifying label to prevent inadvertent or unintentional operation and a remote annunciator (powered by storage battery) located outside the generators location.

g. Elevators (at least one for non-ambulatory patients)

c. Energizing Equipment by Emergency Power

- i. Equipment designated to be powered by emergency power supply are energized by the organization's design. Staging of equipment start up is permissible.

d. Battery and Flashlight Availability

- i. Each department shall maintain an adequate supply of battery lamps and/or flashlights and replacement batteries.

e. Emergency Lighting Systems and Exit Signs

- i. The Director of Facilities and Construction, Plant Operations, or designee, is responsible for identifying all battery-powered lights installed to provide exit path illumination or for illumination of offsite patient care services.
- ii. The organization performs a functional test of emergency lighting systems and EXIT signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other EXIT signs. The test results and completion dates are documented.
- iii. Every 12 months, the organization performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 ½ hours. The results and completion dates are documented.
- iv. The annual test meets the requirements of applicable codes and standards and manufacturer recommendations. An alternate process for some systems is the annual replacement of batteries with random testing of 10% of all batteries for 1-1/2 hours. The date of the testing is recorded.

f. Emergency Power Supply Systems (SEPSS)

- i. Every quarter, the organization performs a functional test of stored emergency power supply systems (SEPSS) for 5 minutes or as specified for its class (whichever is less). The organization performs an annual test at full load for 60% of the full duration of its class. The completion dates of the tests are documented.

g. Inspecting Emergency Generator Systems

- i. At least weekly, the emergency power supply system (EPSS), including all associated components and batteries, is inspected in accordance with NFPA 110. The results and completion dates

of weekly inspections are documented.

h. Monthly 30-Minute Emergency Generator Test

- i. The Director of Facilities and Construction, Plant Operations or designee, tests emergency generators twelve times a year at intervals not less than 20 days or more than 40 days for at least 30 continuous minutes. The tests are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. The completion date of the test is documented.
- ii. Appropriate notice of each test run is forwarded to departments throughout the organization. Tests will be delayed if a critical medical procedure is underway and unanticipated failure of the essential electrical system would result in immediate life threatening conditions, but testing is conducted within the defined time frames.
- iii. Testing is conducted for at least 30 minutes under full connected load at operating temperature. The test begins with a cold start, and the cool down period is not part of the 30 continuous minutes. Testing time starts when the generator reaches defined operating conditions, generally full operating temperature of either the exhaust system, or coolant water. Appropriate testing parameters are recorded and evaluated by the Director of Facilities and Construction, Plant Operations, or designee. Any indication of performance below code requirements or expectations is immediately evaluated to determine the source of the problem and rectified.
- iv. If any diesel engine powered motor/generator is not loaded to 30% or more of its nameplate capacity during connected load tests, temperature measurements are made to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Any engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three step test process required by NFPA[®] 99 and NFPA[®] 110.

i. Tri-annual Four-hour Generator Test

- i. Additionally, all generators are tested for a minimum of four (4) continuous hours at least every three (3) years. The tests are conducted with a dynamic load of at least 30% of the nameplate rating of the generator or meet the recommendations of the manufacturers for prime mover of gas temperature. Test results and completion dates are documented.

j. Monthly Automatic Transfer Switch Test

- i. All automatic transfer switches are tested twelve times per year at intervals not less than 20 day or more than 40 days as part of the monthly generator load test. Test results and completion dates are documented. Their performance is generally verified during generator testing, as well as annual maintenance of each switch.

k. Testing Generator Fuel Quality

- i. At least annually, the organization tests the fuel quality to ASTM standards in accordance with NFPA 110-2010: 8.3.8. The test results and completion dates are documented.

4. MANAGING THE MEDICAL GAS & VACUUM SYSTEM

- a. The Director of Facilities and Construction, Plant Operations, or designee, is responsible for managing a program of inspection, maintenance, and testing of the following essential medical gas systems.
- b. Plant Operations / Engineering Department conduct a preventive maintenance (PM) program on the system at an annual frequency. The maintenance program includes inspecting, testing, and maintaining the critical components of the piped medical gas systems. Components that are maintained include the master signal panels (i. e., high and low pressure, transfer from normal to reserve indicators), area medical gas alarms, automatic pressure switches (high and low pressure), zone and main shutoff valves, flexible connectors (where installed), and medical gas outlets.
- c. The PM activity is conducted by contractors who are engaged to conduct the tests and inspections of elements that require special equipment and training. Documentation of the testing is maintained by the Plant Operations / Engineering Department.
- d. Containers, cylinders, and tanks are designed, fabricated, tested and marked in accordance with NFPA 99-2012.

i. Designation of Medical Gas Systems

- a. Medical gas, medical air, surgical vacuum, waste anesthetic gas disposal (WAGD), and air supply systems are designated as Category 1: Systems in which failure is likely to cause major injury or death to patients or caregivers.

ii. Alarm Systems

- a. All master, area, and local alarm systems used for medical gas and vacuum systems comply with the category 1–3 warning system requirements.

iii. Storage Room Requirements

- a. Locations containing only oxygen or medical air have doors labeled "Medical Gases: NO Smoking or Open Flame." Locations containing other gases have doors labeled "Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening."
 - i. A precautionary sign readable from five feet away is on each door or gate of a cylinder storage room, where the sign, at a minimum, includes the wording "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."
 - ii. Storage is planned so cylinders are used in order of which they are received from the supplier. Only gas cylinders and reusable shipping containers and their accessories are permitted to be stored in rooms containing central supply systems or gas cylinders.
 - iii. PAR levels are maintained by the Materials Management Department.

iv. Threshold Pressure for Cylinders with Integral Pressure Gauge

- a. When the organization uses cylinders with an integral pressure gauge, a threshold pressure considered empty is established when the volume of stored gases is as follows:
 - i. When more than 300 but less than 3,000 cubic feet, the storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklers) or enclosed in a cabinet of noncombustible construction having a minimum 1/2-hour fire protection rating.
 - ii. When less than 301 cubic feet in a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in

v. Maintaining Bulk Oxygen System and Connection

- a. Any above ground, bulk oxygen system is placed in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating "OXYGEN – NO SMOKING – NO OPEN FLAMES in accordance with NFPA 99.
- b. In addition, an emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to be connected in accordance with NFPA 99-2012.

vi. Testing Installed, Modified, or Repaired Systems

- a. SVHMC uses certified contractors, or specially trained staff to test and certify piped medical gas and vacuum systems when the systems are initially installed, modified, or invasively repaired. Testing includes verification that there is no cross-connection of piping and outlets; testing the piping for content purity and particulates, and verification that the pipes maintain pressure. Testing is done to demonstrate the system meets at least NFPA 99 and CGA 1 requirements. The results and completion dates are documented.

vii. Labeling Main Supply Valves

- a. The organization makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency.

viii. Handling and Transporting Gas Cylinders

- a. The organization has implemented a policy on all cylinders within the organization that includes labeling, handling and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012. See MEDICAL GAS CYLINDER

HANDLING AND STORAGE (#6024)

ix. **Transfilling Gas Cylinders**

- a. At no time is transfilling done in any patient care room. A designated area is used away from any section of the organization where patients are housed, treated, or examined. The designated area is separated by a barrier of at least one-hour–fire-resistant construction from any patient care areas. Transfilling cylinders is only of the same gas (no mixing of different compressed gases). Transfilling of liquid oxygen is only done in an area that is mechanically ventilated, with a sprinkler system, and has a ceramic or concrete flooring. Storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections NFPA 99-2012

x. **Medical Gas and Vacuum Systems Installation, Testing, and Maintenance**

- a. In time frames defined by the organization, the organization inspects, tests, and maintains critical components of piped medical gas and vacuum systems; waste anesthetic gas disposal (WAGD); and support gas systems on the inventory. This inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases and inlets and outlets. Activities, dates, and results are documented. Persons maintaining the systems are qualified by training and certification to the requirements of the American Society of Sanitary Engineers (ASSE) 6030 or 6040.
- b. Deficiencies found during testing that present a high risk to patient care will be reported immediately. Other deficiencies will be reported at the end of the testing day. Corrective action will be conducted and Respiratory Therapy will be notified. Interim patient safety measures will be implemented based on the assessment of the risk of the deficiency. The results of the assessment process, corrective actions, and interim measures will be documented.

xi. **Areas Designated for Administration of General Anesthesia**

- a. Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows:

- i. Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others.
 - ii. Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV.
- b. Areas designated for the administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are as follows:
 - i. Heating, cooling, and ventilation are in accordance with ASHRAE 170, medical supply and equipment manufacturers' instructions are considered before reducing humidity levels to those allowed by ASHRAE.
 - ii. Existing smoke control systems automatically vent smoke, prevent the recirculation of smoke originating within the surgical suite, and prevent the circulation of smoke entering the system intake, without interfering with exhaust function. New occupancies have no smoke control requirement.
 - iii. For hospitals that use Joint Commission accreditations for deemed status purposes: Existing smoke control systems are maintained according to the edition of NFPA 101 adopted by the Centers for Medicare & Medicaid Service at the time of installation.
- c. Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone box valve assemblies.
 - i. Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum

are in accordance with NFPA 101 and NFPA 99 as follows:

- ii. The essential electrical system's (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES equipment system supplies power to the ventilation system.

C. Plan Responsibility

- 1. The Chief Engineer works under the general direction of the Director of Facilities and Construction, Plant Operations. They are responsible for operation and maintenance of the utility systems and management of contractors working on the utility systems.

D. Performance Measurement

1. EVALUATING THE MANAGEMENT PLAN

- a. On an annual basis, the EOC Committee evaluate the scope, objectives, performance, and effectiveness of the Plan to manage the utility system risks to the staff, visitors, and patients at SVHMC.

2. PERFORMANCE STANDARDS

- a. The performance measurement process is one part of the evaluation of the effectiveness of the Utility Systems Program. Performance measures are established to measure at least one important aspect of the Utility Systems Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

E. Orientation and Education

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

V. REFERENCES

- A. N/A

Approval Signatures

Step Description	Approver	Date
SRC	Aniko Kukla: Director Quality & Patient Safety	Pending
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	04/2025

Emergency Management	James Hively: Manager Environmental Health & Safety	04/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Laura Zerbe: Manager Facilities Construction and Plant Operatio	04/2025

Standards

No standards are associated with this document

Board Memo: Consent Agenda Items

Consent Agenda Items for Approval (Lease Amendments):

- **Fifth Amendment to Lease for 345 Abbott Street, Salinas (Accounting Office)**
- **First Amendment to Lease for 250 San Jose Street, Salinas (SVH Clinics-OB/GYN Clinic)**

Executive: Gary Ray, SVH Chief Legal Officer

Date: April 17, 2025

Summary

Two Lease Amendments which each extend the respective Lease Agreements were completed late in the month of April. Under both of these leases, Salinas Valley Health is the tenant—SVH Accounting Office at 345 Abbott Street and Salinas Valley Health Clinics-OB/GYN at 250 San Jose Street. Both Amendments are listed on the SVH Board Consent Agenda for the Regular Board meeting on April 24, 2025.

Lease Amendment/Extension Terms

- Fifth Amendment to Lease for 345 Abbott Street, Salinas (Accounting Office)
 - ❖ Term: Three (3) years, 3/1/25 – 2/29/28
 - ❖ Rent: \$6,900 for year one of extension
 - ❖ Increases 2.5% per year
 - ❖ Abatement: One (1) month (3/1/25) totaling \$6,900

- First Amendment to Lease for 250 San Jose Street, Salinas (SVH Clinics-OB/GYN Clinic)
 - ❖ Term: Three (3) years, 5/1/25 – 4/30/28
 - ❖ Rent: \$13,106.00 for year one of extension
 - ❖ Increases: CPI with three percent (3%) cap

Recommendation

SVH Administration recommends approval of these lease amendments on the SVH Board Consent Agenda.

Attachments

1. Fifth Amendment to Lease for 345 Abbott Street, Salinas (Accounting Office)
2. First Amendment to Lease for 250 San Jose Street, Salinas (SVH Clinics-OB/GYN Clinic)

FIFTH AMENDMENT TO LEASE

This Fifth Amendment to Lease ("Fifth Amendment") is entered into effective March 1, 2025 by and between the following parties:

Lessor: THE QUINLAN FAMILY PARTNERS, LP
GAYE L. RICHARDSON
GEORGE EDWARD RICHARDSON, JR.
JOHN WILLIAM RICHARDSON
DAVID A. SANDYS, TRUSTEE OF THE
MICHAEL JOEL RICHARDSON
IRREVOCABLE TRUST
KATHERINE MARIE BLOWERS
WILLIAM EDWARD QUINLAN IV
JOSEPH STEVEN QUINLAN

Lessee: SALINAS VALLEY MEMORIAL HEALTHCARE
SYSTEM, a California Health Care District organized
and existing pursuant to Division 23 of the California
Health and Safety Code

RECITALS

- A. Lessor's predecessors-in-interest, George Richardson, Quinlan Family Partners and William E. Quinlan III, and Lessee entered into a written Lease dated December 19, 2008 and the First Amendment dated March 16, 2012, Second Amendment dated February 14, 2014, Third Amendment dated March 1, 2015, and Fourth Amendment dated March 1, 2020 executed thereafter (said lease, including any other addenda or amendments are collectively referred to as "the Lease") for approximately 3,000 square feet of office space located at 345 Abbott Street, Salinas, CA (the "Premises"), which Lease has been extended through February 28, 2025.
- B. George Richardson and William E. Quinlan III are now deceased. The parties identified above as "Lessor" are the successor owners of the Premises, and the term "Lessor as used herein, and in the Lease, shall refer to such parties.
- C. Lessor and Lessee wish to further extend the Lease pursuant to the following terms and conditions.

NOW THEREFORE, Lessor and Lessee hereby agree as follows:

1. Term. The Lease Term shall be extended for three (3) years commencing March 1, 2025 through February 29, 2028 ("Extended Term").
2. Rent. Base Rent for the Extended Term shall be as follows:

Year	Term	Monthly Rent

1	March 1, 2025 - February 28, 2026	\$6,900
2	March 1, 2026 - February 28, 2027	\$7,080
3	March 1, 2027 - February 29, 2028	\$7,260

Lessor agrees to abate Lessee's obligation to pay Base Rent during the first one (1) month of the Extended Term (or March 2025).

In addition to the Base Rent for the Extended Term, Lessee shall pay to Lessor as additional rent the sum of Two Hundred Fifty Dollars (\$250) per month for real estate taxes, insurance and sewer charges. Said sum shall be subject to annual review based upon any increase in taxes, insurance and sewer charges.

Rent shall be payable to the respective Lessor parties at the addresses and in the percentages provided to Lessee.

3. Lessor's Authorized Agent. Until otherwise notified, the Lessor parties hereby designate and authorize WILLIAM EDWARD QUINLAN IV to act on behalf of themselves with respect to administration of the Lease.

4. Approval by Lessee's Board of Directors. This Fifth Amendment is contingent upon approval by the Board of Directors of Salinas Valley Memorial Healthcare System at a duly-called and authorized meeting of the Board of Directors.

[SIGNATURE PAGE TO FOLLOW]

Except for the modifications set forth herein, all other terms and provisions of the Lease, as amended, shall remain in full force and effect.

LESSOR:

THE QUINLAN FAMILY PARTNERS, LP

By: _____

Title: _____

GAYE L. RICHARDSON

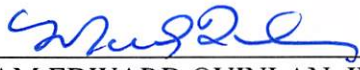
GEORGE EDWARD RICHARDSON, JR.

JOHN WILLIAM RICHARDSON

MICHAEL JOEL RICHARDSON
IRREVOCABLE TRUST

By: _____
DAVID SANDYS, TRUSTEE

KATHERINE MARIE BLOWERS



WILLIAM EDWARD QUINLAN, IV

JOSEPH STEVEN QUINLAN

LESSEE:

SALINAS VALLEY MEMORIAL
HEALTHCARE SYSTEM

By: _____

Title: _____

FIRST AMENDMENT TO LEASE

(250 San Jose Street, Salinas)

This First Amendment to Lease ("First Amendment") is entered into effective **April 15, 2025** ("Amendment Effective Date") by and between **KWN Medical Building**, a California general partnership ("Landlord"), and **Salinas Valley Memorial Healthcare System**, a local health care district under Division 23 of the California Health and Safety Code and operating as Salinas Valley Health ("Tenant"). This First Amendment is made with reference to the following facts.

RECITALS

- A. Landlord is the owner of certain land and improvements located at **250 San Jose Street, Salinas, California**. The land and the building, parking area and other improvements located on the land, constitute the "Premises."
- B. Landlord and Tenant wish to extend the Lease pursuant to the following terms and conditions.

Landlord and Tenant hereby agree as follows:

1. Term. The Lease Term shall be extended for three (3) years commencing May 1, 2025 and ending on April 30, 2028 ("Extended Term").
2. Rent. Base Rent for the Extended Term shall be as follows:

Year	Term	Monthly Rent
1	May 1, 2025 - April 30, 2026	\$13,106.00
2	May 1, 2026 - April 30, 2027	CPI, 3% cap
3	May 1, 2027 - April 30, 2028	CPI, 3% cap

3. Except for the modifications set forth in this First Amendment, all other terms and provisions of the Lease, as amended, shall remain in full force and effect.

The parties have executed this First Amendment as of the Amendment Effective Date first set forth above.

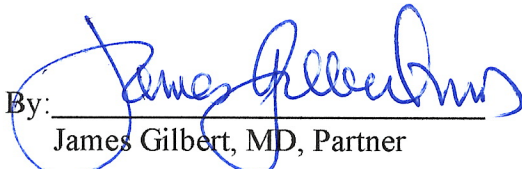
TENANT

Salinas Valley Memorial Healthcare System

By: _____
Allen Radner, MD, President/CEO

LANDLORD

KWN Medical Building

By: 
James Gilbert, MD, Partner

By: _____
Date: 250 San Jose Street (5/1/25)

Date: 4/15/25

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

*QUALITY AND EFFICIENT
PRACTICES COMMITTEE*

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

(CATHERINE CARSON)

FINANCE COMMITTEE

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

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

(VICTOR REY, JR.)

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board Approval of Purchase of Two (2) Canon X-ray Units and Service Agreement From Canon for Salinas Valley Health Clinics Imaging Services

Executive Sponsor: Timothy Albert, MD, MHCM, Chief Clinical Officer

Date: April 21, 2025

Executive Summary

We are requesting the replacement of our current radiologic equipment, which has reached the end of its operational lifespan. Given the ongoing operational challenges, we have an increase in maintenance issues; often times experiencing difficulty finding parts and an increase in our X-ray room downtime.

The current units are also equipped with outdated technology and lack of ergonomic features, which can result in significant challenges for technologists and patients. The new equipment will allow us to achieve our high standards for patient and staff experiences.

Timeline/Review Process to Date:

March 2025: Received quotes for consideration

April 2025: Request for purchase

June 2025: Anticipated Implementation

Strategic Plan Alignment:

In order to serve our patients efficiently providing timely, high quality care, the new equipment ensures we may provide quality images, ergonomic work environment and that the department can function at full capacity and meet patient demand.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Key Contract Terms	Vendor: Canon Medical Systems USA, Inc.
1. Proposed effective date	May 1, 2025
2. Service Agreement Term	Sixty (60) month service agreement, \$280,790 or \$56,158 annually
3. Renewal terms	One-time purchase of Equipment; Renewable Service Agreement
4. Payment Terms	Cash – 0% down payment, 80% upon shipment net 45 days, 20% net 30 days upon completion of installation and / or availability for first use, whichever is earlier.
5. Annual cost	One-time purchase Omnera – 500A \$506,046 for the purchase of two X-ray units inclusive of tax

	Annual monthly service fee \$56,158
6. Budgeted (indicate y/n)	Yes

Recommendation Salinas Valley Health Administration requests the SVH Board of Directors to approve the terms presented for purchasing the X-ray equipment for Salinas Valley Health Imaging from Canon in the amount of \$506,046 and for a sixty month service agreement in the amount of \$280,790.

Board Paper: Finance Committee

Agenda Item: Consider Recommendation for Board Approval to Award Contract to C. Overaa & Co. for the Seismic Compliance Project.

Executive Sponsor: Clement Miller, Chief Operating Officer
Brad McCoy, Vice President Facilities Construction & Real Estate

Date: April 21, 2025

Executive Summary

Senate Bill 1953 (SB1953) requires all acute care hospitals that wish to remain in operation beyond January 1, 2030, to meet specific structural (SPC) and non-structural (NPC) rating. Retrofit will be required to certain elements of the hospital to meet rating requirements to remain in operation. The goal of SB1953 is to help ensure that hospital buildings are not only capable of remaining intact after a seismic event, but also capable of continued operations and can provide acute care medical services after a seismic event. C. Overaa & Co. (Overaa) is the selected Design Build Entity that will be tasked to evaluate, design, secure permit(s) (Design & Preconstruction Services) and as part of a subsequent effort will provide a Guaranteed Maximum Price (GMP) for the actual construction/retrofit work (Construction Services). The total estimated cost of Seismic Compliance Project is \$62,500,000. Contract for the Design Build Entity to perform Design & Preconstruction Services is included in the estimated project cost with a contract value of \$9,075,727.00. Bogard Construction will be SVH's representative and Kitchell CEM will be the construction manager and oversee all activities.

Background/Situation/Rationale

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

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

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

3. Replacement of Rotary UPS Building (Building 17). Building 17 is approximately 475 square-foot building located on the rear of the hospital campus adjacent to the hospital's maintenance yard. Building is scheduled to be demolished and or rebuilt as building in its current state would require extensive repairs to meet current seismic requirements. As such, critical services currently housed within building will be relocated to aid in the reconstruction of building (meeting current building requirements) and or to allow the decommissioning and removal of the building from inventory.

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

Design Build Entity scope of work will be proceeding under two phases:

Phase 1: Design and Preconstruction Services

- a. Completing evaluation of existing building components as it relates to the non-structural performance category (NPC) effort to comply with Senate Bill (SB1953). The effort includes evaluation of all seismic anchorage or bracing of non-structural items in five seismically separated buildings as well as source equipment within critical care areas and preparing/assembling NPC-4 and NPC-4D self-declaration packages.
- b. Develop construction documents on or before the HCAI deadline of March 1, 2026, and obtain necessary permits. In addition, provide construction administration services for the anchorage of equipment as required to obtain NPC-4 and NPC-4D compliance to meet Title 24 requirements.
- c. Develop construction documents and obtain permit the enlargement of the seismic joint between the Dietary Building and the Original Building. Once permitted, provide construction administration services to support.
- d. Complete construction documents for Buildings 1 & 2 following HCAI SCU approval of proposed retrofit to achieve SPC-4D upgrade for both buildings.
- e. Complete structural analysis with assistance from SEOR to determine alternate means of compliance for Rotary UPS building (Building 17). The alternative approach will take into consideration request to minimize the impact to the currently operating equipment within the building.
- f. Develop construction documents for required additions (water, wastewater, and fuel tanks) to campus to obtain NPC-5 compliance.
- g. At the conclusion of the validation stage, the schematic design documents will be completed, and the Design Build Entity will prepare and submit its Guaranteed Maximum Price (GMP) and project schedule. If Salinas Valley Health and the Design Build Entity are unable to agree to the GMP and project schedule, SVH will have the option to terminate the contract for convenience and all work product developed during the validation state will be SVH's property. If a termination were to occur, SVH may take any of the following actions: (i) Solicit proposals to complete the project from firms that submitted statement of qualifications; (ii) Upon written determination that it is in the best interest of SVH, formally solicit proposal from other Design-Build Entities, and contract award shall be made on the best value basis; or (iii) Take assignment of the design services, complete the design and bid the project.

Phase 2: Construction Services

- a. Following approval of GMP by Salinas Valley Health developed in Phase 1 – agreement to project cost and delivery schedule, Design Build Entity will begin to procure remaining subcontractors who have a contract value exceeding ½ of 1 percent of the cost of the construction work included in the GMP and that were not listed in RFQ Part 1.
- b. Mobilize and set-up facilities to begin the actual work.
- c. Completing the actual work within the stipulated schedule.

Timeline/Review Process to Date:

In accordance with Public Contract Code, the Administration followed a two-step process for selection of the Design Build Entity. The first step began on June 5, 2024, with the issuance of a Request for Qualifications (RFQ) with a subsequent reissuance of "RFQ Part 1" on October 18, 2024. Outreach efforts included direct contact by Kitchell to (26) local/semi-local design build/contractors. Attendance to non-mandatory prequalification conference was attended by five Design Build Entities. On November 15, 2024, the Administration received submissions in response to the RFQ Part 1 from three firms (C. Overaa & Co.; Charles Pankow Builders; Swinerton Builders). The RFQ's were review by committee and using best value scoring criteria and scoring matrix determined that all three met the criteria as such would be given the opportunity to proceed onto the next step and provide a formal proposal for the project. The Request for Qualifications – Part 2 ("RFQ Part 2") was released on December 20, 2024, and proposals were received on February 26, 2025. During the RFQ Part 2 process, two of the three prequalified firms informed the Administration of their intent to not continue the pursuit leaving a single interested Design Build Entity (C. Overaa & Co.). The RFQ Part 2 selection committee conducted an interview with C. Overaa & Co. Design Build Team to help clarify and confirm understanding of the project requirements and approach. The Administration then proceed to negotiate with C. Overaa

& Co. to provide Design and Preconstruction Services and under a future amendment will negotiate the Construction Services portion of the project with establishment of the Guaranteed Maximum Price (GMP) for project construction work.

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

Construction of the project is anticipated to commence in mid-2026 and be complete by mid-to-end of calendar year 2027 as all work will be phased to minimize disruptions to hospital operations. Make ready work, which includes relocation of IT infrastructure in Building 17, Fire Sprinkler retrofit, and NPC-5 related tanks may begin as early as the start of Q2 of 2026. This work is a precursor to the start of construction for the larger Seismic Retrofit work anticipated to begin in mid-2026.

All work will be part of CIP #01.1250.3273

Meeting our Mission, Vision, Goals

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

Pillar/Goal Alignment:

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

Financial Implications

The essential terms of the proposed Design Build Agreement (Seismic Compliance Project) are as follows:

- *Phase 1: Design & Preconstruction Services: \$9,075,727.00 (includes \$447,591 for additional services that may be required to complete SB1953 compliance efforts).*
- *Phase 2: Construction Services: \$Via Future Amendment (establishment of the Guaranteed Maximum Price).*
TOTAL NOT-TO-EXCEED AMOUNT: \$9,075,727.00

Cost for Phase 1: Design (architectural and engineering) Services and Preconstruction Services is included within the budgeted line titled "Design Builder – Design & Preconstruction Services" with a current uncommitted budget balance of \$9,464,419. Approval of this agreement would commit \$9,075,727 and leave a balance of \$388,692 within this budget line. See Attachment #2 for budget breakdown and anticipated cashflow.

Phase 2: Construction Services budget and cost will be reconciled at the time of establishment of the Guaranteed Maximum Price. Establishment of GMP is expected in Q1 2026.

Total Project Budget: \$62,500,000.00

Schedule/Milestones:

- March 1, 2026: Complete drawing package and submittal to HCAI (NPC deadline).
- January 1, 2028: Obtain building permit for NPC scope of work (NPC deadline).
- January 1, 2030: Complete all construction for both SPC & NPC scope of work.

Budget: Current Seismic Retrofit project cost estimate is \$62,500,000, which aligns with prior project cost estimates presented. Following validation phase and preliminary design is complete, a new cost estimate will be generated, and a reconciliation of the budget will be completed to ensure alignment cost projections as the Design Build Entity provides a GMP for Construction Services. A summary of the project cost estimate is included with this Board Paper as Attachment 2. Current actual expenditure to date on the planning and design of the project is \$3,525,716 as of end of March 2025 (part of CIP #01.1250.3273 & 01.1250.3270).

Recommendation

Consider Recommendation for Board Approval to award contract in the amount of \$9,075,727.00 to C. Overaa & Co. for Phase 1: Design & Preconstruction Services for the Seismic Compliance Project at the main hospital campus.

Attachments

- Attachment 1: Design Build Agreement between Salinas Valley Health and C. Overaa & Co.
- Attachment 2: Estimated Project Cost/Budget, April 2025



DESIGN BUILD AGREEMENT Seismic Compliance Project #2

This Design Build Contract ("Contract") is made as of **April 24, 2025** ("Effective Date") by and between Salinas Valley Memorial Healthcare System operating as Salinas Valley Health, a public entity, located at 450 E Romie, Salinas, CA 93901 and **C. Overaa & Co.** ("Design Builder"), a corporation with a principal place of business located at **200 Parr Boulevard, Richmond, California, 94801** for design, construction, and commissioning ("Work") of the Seismic Compliance Project #2 ("Project") in accordance with the Contract Documents. The Parties agree to the following terms and conditions.

The following Exhibits are incorporated into this Contract by reference.

Exhibit 1	Definitions	Included
Exhibit 2	Supplemental Conditions	Included
Exhibit 3	Agreed Program	
Exhibit 3A	Project Documents	Included
Exhibit 3B	Schematic Design Documents	Included
Exhibit 3C	Construction Documents	By Amendment
Exhibit 4	Compensation	
Exhibit 4A	GMP Summary and Detailed Breakdown	By Amendment
Exhibit 4B	Qualification and Assumptions	By Amendment
Exhibit 4C	Resource Loaded Work Plan	Included
Exhibit 4D	General Requirements	Included
Exhibit 5	Project Execution	
Exhibit 5A	Proposed Schedule	Included
Exhibit 5B	Project Schedule (submitted with GMP)	By Amendment
Exhibit 6	Insurance and Bonding	
Exhibit 6A	Design Builder's Insurance Requirements	Included
Exhibit 6B	Payment and Performance Bond	By Amendment
Exhibit 6C	SVH's Insurance Requirements	Included
Exhibit 6D	Non-Collusion Affidavit	Included
Exhibit 7	SVH Provided Information	
Exhibit 7A	Site Description	Included
Exhibit 7B	Separate Consultants and Separate Contractors	Included
Exhibit 8	Conflict of Interest Policy	Included

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

Salinas Valley Health By: <u>Allen Radner, M.D., President/CEO</u>	C. Overaa & Co. By: <u>Carl Overaa, President</u> CA License No.: 106793



BUSINESS TERMS SHEET

SVH's Team	
SVH's Authorized Representative	Dr. Allen Radner, President/CEO email: aradner@salinasvalleyhealth.com
SVH's Program Manager	Dave Sullivan Bogard Construction phone: 831-246-2073 email: dsullivan@bogardconstruction.com
SVH's Construction Manager	Omar Galvan Kitchell CEM phone: 415-672-7302 email: ogalvan@kitchell.com
Design Build Team Members:	
Design Builder's Representative	Craig Jamison phone: 916-300-8288 email: craigj@overaa.com Athan Hadjimarkos phone: 510-685-1610 email: athanh@overaa.com
DPOR (structural)	Shane Fitzgerald, PE John A. Martin & Associates phone: 213-220-5916 email: fitzgerald@johnmartin.com
DPOR (architectural)	John Zorich , AIA, NCARB Dreyfuss + Blackford Architecture phone: 916-453-1234 email: jzorich@db-arch.com
DPOR (civil)	Jacob Nguyen , PE BKF Engineers phone: 408-467-9143 email: jnguyen@bkf.com
DPOR (fire sprinklers) (Design Build Subcontractor)	Jeff Awtrey, CEO Marquee Fire Protection LLC phone: 916-641-7997 email: jeff.awtrey@marqueefire.com
Design Builder's Preconstruction Project Manager	Athan Hadjimarkos phone: 510-685-1610 email: athanh@overaa.com
Design Builder's Project Manager	Todd Germain phone: 408-802-3830 email: toddg@overaa.com
Design Builder's Superintendent	Danny Sawyer phone: 510-719-3925 email: dannys@overaa.com
Design Assist Trades:	



Steel / Metals	Quang Le Olson Steel phone: 510-567-2200 email: gle@olsonsteel.com	
Mechanical & Plumbing	Ramie Barghouti ACCO - Mechanical phone: 510-857-6336 email: rbarghouti@accoes.com Tom Tredway ACCO - Plumbing phone: 510-561-6430 email: ttredway@accoes.com	
Electrical	Dalton Diaz Morrow Meadows phone: 650-207-2727 email: dadiaz@morrow-meadows.com	
Other Design Build Team Members	See, Tab 1, Project Manual	
Target Cost	\$38,000,000	
Compensation		
Guaranteed Maximum Price	By Amendment	
Design Services	\$5,024,307.00	
Preconstruction Services	\$3,603,829.00	
Design / Preconstruction Services Contingency	\$447,591.00	
Direct Construction Costs	\$TBD	
General Conditions (RLWP Preconstruction Stage)	\$351,633.00	
General Conditions (RLWP Construction Stage)	\$2,617,436.00	
General Requirements (Preconstruction Stage)	\$721,239.00	
General Requirements (Construction Stage)	\$1,191,308.00	
Design and Construction Contingency (5%)	\$TBD	
Insurance	1.0%	\$TBD
Payment and Performance Bond	0.6%	\$TBD
Fee (overhead and profit)	3.0%	\$TBD
Change Order Mark-Up		
Design Builder's Fee (overhead and profit)	3.0%	
Average Daily Rate	\$10,500 / work day for extended General Conditions and General Requirements due to adjustments in Contract Time	
Subcontractor Adjustments	15% overhead and profit on subcontracted self-performed Work. 5% profit on top of tier-subcontracted work. Tier-subcontractor overhead and profit also cannot exceed 15%.	



Schedule	
Substantial Completion Date	10/18/2027
Completion of Construction Work	12/15/2027 ("Contract Time")
Final Completion Date	1/28/2028 (CDPH issued license)
Adverse Weather Days Included in Schedule	30 work days (total)
Liquidated Damages	
0-30 days past Contract Time	\$0/day (grace period)
31-90 days past Contract Time	\$2,500/day
91 days past Contract Time and beyond	\$5,000/day
Design Builder's Minimum Insurance Limits	
Workers Compensation/Employers' Liability	Statutory Limits Employers' Liability \$1,000,000 each accident
Commercial General Liability	\$2,000,000 per occurrence \$2,000,000 personal/advertising injury \$5,000,000 general aggregate \$5,000,000 products/completed operations coverage
Contractor Professional Liability	\$1,000,000 per claim \$2,000,000 in aggregate
Contractor Pollution Liability	\$1,000,000 per claim \$10,000,000 in aggregate
Automobile Liability	\$2,000,000 each accident
Excess Liability	\$10,000,000
Tools and Equipment	Fair Market Value
Architect of Record and Structural Engineer of Record Minimum Insurance Limits	
Workers' Compensation Employers' Liability	Statutory Limits Employers' Liability \$1,000,000 each accident
Commercial General Liability	\$1,000,000 each occurrence \$2,000,000 aggregate
Automobile Liability	\$2,000,000 each accident
Professional Liability Architect and SEOR	\$2,000,000 per claim \$5,000,000 in aggregate
Valuable Papers	\$500,000
Other Design Build Team Members' Minimum Insurance Limits	
Workers' Compensation Employers' Liability	Statutory Limits Employers' Liability \$1,000,000 each accident
Commercial General Liability	\$1,000,000 per occurrence \$1,000,000 personal/advertising injury \$2,000,000 general aggregate \$2,000,000 products/completed operations coverage
Other DPOR Professional Liability	\$1,000,000 per claim



	\$2,000,000 aggregate
Pollution Liability	Per §2.5 of Exhibit 6A
Automobile Liability	\$1,000,000 each accident
Additional Insureds	SVH and its officers, board members, agents, directors, employees, special inspectors, the Program Manager, and Construction Manager
Notice per Section 21.5	SVH: Allen Radner, M.D., President / CEO 450 E Romie Lane Salinas, CA 93901 email: aradner@salinasvalleyhealth.com With Copy to: David Sullivan, Program Manager Bogard Construction email: dsullivan@bogardconstruction.com Omar Galvan, Construction Manager Kitchell, CEM email: ogalvan@kitchell.com Design Builder: Carl Overaa, President 200 Parr Boulevard Richmond, CA 94801 email: carlo@overaa.com



PROJECT MANUAL

The following forms and information will be included in the Project Manual and posted to the Project's web based portal or ftp site. Certain forms may be developed by the Project Team Members after execution of the Contract. All content is subject to approval by SVH's Construction Manager before incorporation into the Project Manual. Design Builder and its Design Professionals, Subcontractors, suppliers, and equipment vendors will adhere to the Project protocol and procedures while performing their respective portions of the Work. The most current approved Project Manual is incorporated into this Contract by reference as though set forth in full.

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2B	California Lien Waivers and Releases
2C	Consent of Surety
2D	Request for Information Form
2E	Submittal Form
2F	Daily Construction Report Form
2G	Construction Change Directive Form
2H	Change Order Forms
2I	Certificate of Substantial Completion
Tab 3	Site Logistics Plan
Tab 4	Design Builder's Safety Program
Tab 5	Traffic Control Plan
Tab 6	Quality Control Plan
Tab 7	Environmental Control Plan
Tab 8	Storm Water Pollution Prevention Plan
Tab 9	Infection Control Plan Interim Life Safety Measures Infection Control Risk Assessment Method of Procedure for Dust and Odor
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1. GENERAL

1.1 Defined Terms. Defined terms and titles of Exhibits are capitalized throughout the Contract and Exhibits. The definitions for this Contract are set forth in alphabetical order in Exhibit 1. Salinas Valley Health ("SVH") and Design Builder will be individually referred to as a Party and may be collectively referred to as the Parties.

1.2 Existing Facility. The hospital, which occupies an existing 264,493-sf, six-story building and connected structures, is classified by California Healthcare Access and Information (HCAI) as a general acute care hospital licensed for 263 beds. Bed types include perinatal, pediatric, intensive care, coronary care, intensive care (newborn), and general acute care. The buildings were constructed between 1953 and 2023. The hospital will remain operational during performance of all Work.

1.3 Project Description. This Project includes the seismic renovation of buildings 1 and 2 of the existing hospital for compliance with Structural Performance Category (SPC-4D), which includes: (i) external strengthening around the main tower, (ii) external buttress structure and connections to roof structure around building 2, (iii) selective wall reinforcements around main tower (shear walls), (iv) pediatric addition reinforcement (3rd floor exterior shear walls and roof connection) and rehab addition reinforcement (4th floor exterior shear wall and roof connection), (v) UPS building strengthening or replacement, (vi) elevator tower addition mitigation, (vii) miscellaneous localized interventions including increasing building seismic separation, and (viii) Nonstructural Performance Category (NPC) resolution. NPC 3 resolution involves evaluation and bracing of critical care areas not currently NPC 3 compliant, which includes ICU/CCU, Intensive Care and Cath Lab Recovery, Surgery, LDRP, Lab Services, Central Sterile Supply, and Diagnostic Imaging. Current planning desires NPC-4D Level 1 compliance for areas permitted to be deferred in the Article 11 of the CBC 2019. Initial non-structural evaluation was completed for each building relative to deficiencies (below ceiling) that need to be addressed to bring buildings up to NPC-4D compliance. The nonstructural performance evaluation (above ceiling) requires the Design Build Team to examine the respective critical nonstructural systems and elements for the planned NPC as specified in California Administrative Code, Chapter 6, Table 11.1, "Nonstructural Performance Categories." Including retrofit to fire sprinkler system. NPC-5 compliance will require planning, design and installation of multiple emergency water supply underground tanks, liquid waste and sewage storage underground tanks and upsizing of existing fuel storage tank for emergency electrical power capacity to supply 72 hours of back up emergency power. Multiple locations for underground tanks will be required due to various points of connection to utility purveyors on campus. The Project is subject to HCAI 1 jurisdiction.

1.4 Licensing. Design Builder must be a California state licensed general contractor. Design Professionals must all possess the appropriate California state design licenses for their particular discipline. Subcontractors must all possess the appropriate California state specialty license for their particular trade. Nothing in this Contract will require a Design Build Team Member, or any of their respective Design Professionals or Subcontractors, to perform any portion of the Work outside of their respective licenses or contrary to Applicable Law.



1.5 Standard of Care. Design Builder will perform the Work using its best skill and attention and in a timely, workman-like manner consistent with the degree of care and skill customarily exercised by prudent licensed general contractors performing design and construction services for projects of similar size, scope, quality, and complexity within the State of California. Design Services will be performed by licensed Design Professionals or Design Build Subcontractors who will be tied to the standard of care set forth in Section 6.9.2.

1.6 Financing. SVH is self-funding this Project through operating capital.

2. PROJECT TEAM AND RELATIONSHIP OF PARTIES

2.1 Project Team. The Project Team includes SVH, its Program Manager, Construction Manager, and Separate Contractors and Separate Consultants, the Design Build Team Members included in the Business Terms Sheet and identified in the Project Roster (Project Manual, **Tab 1**), and each of their respective Design Professionals and Subcontractors, inclusive of tiers.

2.2 SVH. SVH is the owner of the Project. SVH's representative is identified in the Business Terms Sheet and the Project Roster (Project Manual, **Tab 1**). SVH's Separate Contractors and Separate Consultants are identified in Exhibit 7B. SVH's role and responsibilities are described in Article 4.

2.3 Program Manager's Representative. The Program Manager's representative is identified in the Business Terms Sheet and the Project Roster (Project Manual, **Tab 1**). The Program Manager is generally responsible for facilitation and administration of campus wide projects on behalf of SVH and will coordinate with the Construction Manager with respect to this Project but does not have the authority to bind SVH or authorize changes in the Work or schedule that impact the Guaranteed Maximum Price ("GMP") and/or Contract Time.

2.4 Construction Manager's Representative. The Construction Manager's representative is identified in the Business Terms Sheet and the Project Roster (Project Manual, **Tab 1**). The Construction Manager is an advisor to SVH and does not have the authority to bind SVH or authorize changes in the Work or schedule that impact the GMP and/or Contract Time. The Construction Manager is the Design Builder's day-to-day contact and is responsible for facilitating and administering the design and construction process throughout the Project. The Construction Manager is the liaison between the Design Build Team and SVH or the Program Manager and will help coordinate other related work that is not included in Design Builder's Work, and will provide the services further described in Article 5.

2.5 Design Build Team. The Design Builder will lead the Design Build Team and is solely responsible to SVH for the sufficiency, quality, adequacy, and completeness of the Work in accordance with the Contract Documents. All Design Services will be performed by licensed Design Professionals or through Design Build Subcontractors. The initial Design Build Team Members are included in the Business Terms Sheet, and the remainder will be identified in the Project Roster (Project Manual, **Tab 1**).

2.5.1 **Structural Engineer and Fire Sprinkler Trade.** Design Builder will execute the assignment and novation agreements taking assignment of the structural engineer and fire sprinkler Design Build Subcontractor pursuant to the terms and conditions of the assignment and novation agreements. Design Builder will have to amend the Design Build Subcontractor's scope of work to include completion of design and performance of construction work.

2.6 Collaboration. Design Builder and its Design Professionals, Subcontractors, suppliers, and equipment vendors will perform their respective portions of the Work using integrated processes and tools in accordance with the Contract Documents. The Design Build Team will actively participate and collaborate with other Project Team Members to achieve best value in further developing the Project Documents (Exhibit 3A) into Construction Documents (Exhibit 3C), optimal design, increased labor efficiency, and elimination of waste and re-work through utilization of Lean Project Delivery Methods as further described in this Contract and Article 17.3 of the Supplemental Conditions (Exhibit 2). The Design Build Team Members will make meaningful commitments to SVH and the Construction Manager, and will honor their respective commitments, regarding timely and proper performance of all Work as required by the Contract Documents.

2.7 Communications. All communications with SVH will be through the Construction Manager. However, the Program Manager must be copied on all written communications to the Construction Manager. Design Builder may communicate directly with other Project Team Members in furthering the best interests of the Project but the Construction Manager must be kept apprised and copied on all written communications with other Project Team Members that potentially impact design or constructability, Governmental Authority approvals, cost or schedule.

2.8 Relationship of the Parties. Design Builder's relationship with SVH is that of an independent contractor whose involvement in the Project is to act solely in the capacity of a California state licensed general contractor performing design-build services and not as an agent, fiduciary, partner, member of, subsidiary of, or otherwise affiliated with SVH.

2.9 Good Faith and Fair Dealing. Design Builder will collaborate with SVH and other Project Team Members in delivering the best value to SVH and furthering the best interests of the Project throughout the design, construction, and commissioning process.

2.10 Responsibility. Design Builder acknowledges and agrees that it is solely responsible to SVH for the sufficiency, quality, adequacy and completeness of the Work, and that Design Builder is responsible for any acts, errors, or omissions of the Design Builder's principals, employees, agents, and/or any other parties either directly or indirectly in privity of contract with Design Builder including, but not limited to, Design Professionals, Subcontractors, suppliers, equipment vendors, and their agents and employees, and other persons performing any portion of the Work on behalf of Design Builder. Design Builder will: (i) use its best skill and judgment in furthering the interests of SVH and the Project; (ii) furnish effective and efficient design, construction management, administration, and supervision; (iii) furnish at all times an adequate supply of competent management personnel and skilled labor, and an adequate supply of materials and equipment; and (iv) perform the Work in an efficient manner using Lean Project Delivery Methods.



3. CONTRACT DOCUMENTS

3.1 Defined. The Contract Documents are defined in Exhibit 1. The Construction Documents and portions of the Building Information Model (if applicable) prepared by Design Professionals or Design Build Subcontractors are Contract Documents. The portions of the Building Information Model ("BIM") prepared by the Design Builder or its Subcontractors to illustrate means and methods for constructing, fabricating, or installing portions of the Construction Work are Submittals, which are not Contract Documents or Construction Documents. The Contract Documents are intended to be complementary and what is required by one will be construed as being required by all.

3.2 Inconsistencies. If there are conflicting requirements within or between the various Contract Documents, the Design Builder's Representative as well as representatives from the necessary Design Professionals and Design Build Subcontractors will meet with the Program Manager and Construction Manager to determine which requirements will better achieve the criteria set forth in the Project Documents (Exhibit 3A) or approved Schematic Design Documents (Exhibit 3B). If the group cannot reach an agreement by consensus, the order of precedence set forth in Sections 3.2.1 through 3.2.14 will apply. If a conflict exists between the terms set forth in the Contract Documents or any Applicable Law, the Applicable Law will control. Varying degrees of stringency among the Contract Document terms and conditions and Applicable Law are not deemed conflicts, and the most stringent requirement will govern.

- 3.2.1 Most recent executed Change Order and Amendment
- 3.2.2 Contract
- 3.2.3 Supplemental Conditions
- 3.2.4 Specifications
- 3.2.5 Drawings
- 3.2.6 Building Information Model (if applicable)
- 3.2.7 Qualifications and Assumptions (Exhibit 4B)
- 3.2.8 Project Documents and Schematic Design Documents
- 3.2.9 Written numbers over figures, unless obviously incorrect
- 3.2.10 Figured dimensions over scaled dimensions
- 3.2.11 Specific details over standard or typical details
- 3.2.12 Large-scale Drawings over small-scale Drawings
- 3.2.13 Other Exhibits to the Contract



3.2.14 Project Manual

3.3 Acknowledgment. Design Builder acknowledges that all Work will be performed at an existing and operational hospital facility. Design Builder acknowledges that it has carefully examined and understands this Contract and the other Contract Documents; has investigated the nature, locality, and visually observable features of the Project site and the conditions and difficulties under which the Work is to be performed; and enters into this Contract on the basis of its own examination, investigation, and evaluation of all such matters and not in reliance upon any opinions or representations of SVH, its Separate Consultants (including but not limited to the Program Manager and Construction Manager), or Separate Contractors other than those that are expressly set forth in the Contract Documents. Design Builder will immediately report any error, inconsistency, or omission it may discover in the Contract Documents to the Construction Manager with a copy to the Program Manager. If Design Builder observes that any of the Contract Documents are at variance with any Applicable Law in any respect, or are internally inconsistent, it will promptly notify the Construction Manager in writing with a copy to the Program Manager. If Design Builder performs any Work without having adequately reviewed the Contract Documents, knowing the Contract Documents to be contrary to Applicable Law, or knowing the Contract Documents to be internally inconsistent, and without providing written notice to the Construction Manager, it will assume full responsibility and bear all costs attributable to the violation.

4. SVH'S OBLIGATIONS

4.1 SVH's Authorized Representative. SVH's authorized representative is set forth in the Business Terms Sheet. SVH's authorized representative is authorized to approve changes in the Work that impact the GMP and/or affect the Contract Time established in the Project Schedule up to an amount of \$350,000 per occurrence with a total cumulative amount of \$900,000. Any request exceeding a cumulative amount of \$900,000 will require board of directors approval and must be timely submitted to the Construction Manager and Program Manager by the Design Builder in order to allow proper consideration during the board's regularly scheduled meetings. SVH's authorized representative will render decisions in a timely manner pertaining to documents submitted by the Design Builder and recommended by the Construction Manager in order to avoid unreasonable delay in the progress of the Work.

4.2 Project Documents. SVH provided the Project Documents set forth in Exhibit 3A, as the basis for development of the Construction Documents. Design Builder may rely on the information provided in the Project Documents but has performed its own independent site investigation in accordance with Section 3.3.

4.3 Surveying. SVH provided a utility survey and topographical map as part of the Project Documents. All other surveying that may be required is part of Design Builder's Work per Article 13 of the Supplemental Conditions (Exhibit 2).

4.4 Permits and Fees. SVH will pay the fees for the City of Salinas general building permit, HCAI permit, required governmental approvals, easements, assessments and fees required for the development, construction, use or occupancy of the Project.



4.5 Third Party Testing and Inspections. SVH will be responsible for hiring and paying for all third party testing and inspections. However, Design Builder will make arrangements for third party testing and inspection per Article 5 of the Supplemental Conditions (Exhibit 2). Design Builder is responsible for all other inspections and reports required by Applicable Law or by the Contract Documents, and the costs of these inspections or reports are included in the GMP.

4.6 Stop Payment Notice. SVH is the entity that Subcontractors and Design Professionals may serve a stop payment notice for non-payment in accordance with California law governing public work projects.

4.7 Separate Consultants and Separate Contractors. SVH reserves the right to perform work or services related to the Project with SVH's own forces, and to award separate contracts in connection with the Project that are not part of the Design Builder's Work. Design Builder will notify SVH if any such independent action will interfere with the Design Builder's ability to perform the Work under this Contract. When performing separate work or services, SVH agrees that its Separate Consultants and Separate Contractors will be subject to similar obligations as the Design Builder with respect to insurance, indemnification, safety, protection, inspections, and non-conforming work or services. SVH will remain responsible to the Design Builder for any delays to the Contract Time or cost impacts resulting from work or services performed by Separate Consultants or Separate Contractors. SVH's Separate Consultants and Separate Contractors are set forth in Exhibit 7B. Any cost and/or time impacts will be addressed through the Change Order process set forth in Article 14.

4.8 Furniture, Fixtures, and Equipment. To the extent required, SVH will timely procure all Furniture, Fixtures, and Equipment in a manner consistent with the deadlines and requirements approved by SVH and set forth in the Project Schedule. The Design Builder is responsible for coordinating with SVH and its Separate Consultants regarding procurement and installation of all FF&E.

5. CONSTRUCTION MANAGER'S ROLE

5.1 Services. The Construction Manager's role is to assist and advise SVH and its Program Manager with procurement of the Design Builder and other necessary Separate Consultants and Separate Contractors, and to help SVH oversee, facilitate, and manage the design and construction process during all Stages of the Project. Construction Manager is responsible for coordination with the Program Manager with respect to ancillary projects that may impact the Work, and between Separate Consultants and Separate Contractors and the Design Builder.

5.2 On-Site Presence and Weekly Meetings. During the Design / Preconstruction Stage, the Construction Manager will be on-site for weekly Project meetings. During the Construction Stage, Construction Manager will be on-site no less than Mondays, Wednesdays, and Fridays of each week. Construction Manager will facilitate weekly Project meetings with the Design Build Team to ensure open, clear, and direct communications and to help address any issues that may arise during design or construction. The Project meetings are the venue for the Design Build Team to identify and discuss potential risks, critical issues and actions to be taken,



and to review overall progress of the Work and schedule, as well as any discuss any outstanding Submittals or Change Orders.

5.3 Design Review. During the Design / Preconstruction Stage, Construction Manager will review the Drawings and Specifications in its capacity as a licensed general contractor to help ensure that the Construction Documents are being developed in conformance with the design intent and criteria described in the Project Documents. Construction Manager may also review and comment on any value engineering proposals or cost estimates. Notwithstanding the above, Design Builder remains solely responsible for designing and constructing the Project in conformance with the Contract Documents.

5.4 Approvals, Clarifications, Changes, and Claims. The Construction Manager will evaluate requests for approvals and clarifications, Claims, Construction Change Directives, and Change Order Requests from Design Builder, and make recommendations to SVH. Construction Manager will assist SVH in resolving Change Order disputes and other Claims (that do not involve Construction Manager), including documentation of the rationale for resolution.

5.5 Payment Application Review. Construction Manager will review applications for progress payment and final payment from Design Builder, and make recommendations to SVH regarding payment.

5.6 Schedule Review. Construction Manager will monitor Design Builder's progress against the Design Builder's current work plans and Project Schedule, review and analyze all delay and impact requests and make recommendations to SVH regarding same, collaborate with the Design Builder regarding recovery plans if required, and meet with the Project Team to determine when critical decisions are needed from SVH or others to maintain the Project Schedule.

5.7 Quality Monitoring. Construction Manager may periodically participate in inspections, track inspection reports, and direct Design Builder in resolving compliance issues. Construction Manager will monitor and verify correction of non-conforming Work on behalf of SVH as further discussed in Exhibit 2. However, Construction Manager is not required to make exhaustive or continuous on-site inspections to check the quality or quantity of the Construction Work, and Construction Manager will not have control over, charge of, or responsibility for, Design Builder's construction means, methods, techniques, sequences or procedures, or for the safety precautions and programs in connection with the Work as these are solely the Design Builder's responsibilities under the Contract Documents.

5.8 Completion and Close-Out. Construction Manager will determine whether the Work is substantially complete and will track punch-list activity, participate in start-up and commissioning, collect all required close-out documentation and record documents (including but not limited to collecting and reviewing as-built Drawings submitted by Design Builder and verification reports).



6. DESIGN BUILDER'S OBLIGATIONS

6.1 Work. Design Builder will perform all necessary design, construction, and commissioning required for the Project, and will provide all services, labor, materials, equipment, tools, and appurtenances necessary to complete the Work in accordance with the Contract Documents. Design Builder's obligations for Design Services are more specifically described in Article 8 and Design Builder's obligations for performance of the Construction Work are described in Article 9 and Exhibit 2.

6.2 Legal Compliance. Design Builder represents that it is aware of regulations and laws applicable to its operations and the performance of the Work. At its sole cost and expense, Design Builder will give all notices required by, and comply with, all Applicable Law related to the Work, including those relating to safety, Hazardous Materials, and equal employment opportunities. Design Builder will pay all local, state, and federal taxes, and all employee benefits, insurance, and contributions for Social Security and Unemployment which are measured by wages, salaries, or other remunerations paid to Design Builder's employees.

6.2.1 Enabling Statutes. The Project will be delivered utilizing progressive design-build contracting method pursuant to Health and Safety Code section 32132.5 and California Public Contract Code section 22185 et seq.

6.2.2 Hospital Safety Act of 1983. This Project is subject to the Hospital Safety Act of 1983. Design Builder acknowledges that: (i) it is familiar with all provisions and the applicable duties of a designer and contractor under the Hospital Safety Act of 1983; (ii) the Drawings and Specifications will be reviewed, approved and accepted by HCAI and permitted for construction; (iii) changes in those portions of the Work that are subject to HCAI jurisdiction will not commence without an approved HCAI Amended Construction Document if required.

6.3 Staffing Plan and Key Personnel. The staffing plan and key personnel for Design Build Team Members will be included in Exhibit 4C. Unless otherwise requested by SVH or Construction Manager, key personnel may not be removed from, or added to, the Project without prior written consent of SVH's authorized representative except in the instance of death, disability, or departure of person from employment, or other relationship with the Design Build Team. If a replacement is necessary, the proposed key personnel will have substantially equivalent or better qualifications than the former key personnel, and all candidates are subject to final approval by SVH. SVH reserves the right to remove any Design Build Team Member personnel who is considered incompetent, uncooperative, rude, or disruptive to the overall harmony of the Project Team.

6.4 Permits, Fees, and Approvals. Design Builder will assist the Construction Manager with verification that SVH has applied for and paid applicable fees and assessments, and Design Builder will file all documents, required for the approvals by Governmental Authorities for design and construction of the Project, including any required Project completion filings. Design Builder will secure and provide copies to the Construction Manager of all permits and approvals required by Governmental Authorities for execution and inspection of the Construction Work. The cost and fees associated with the general building permit(s) and third party inspection will be paid by SVH per Sections 4.4 and 4.5. All Subcontractor required



specialty permits will be procured and paid for by the Design Builder and its Subcontractors and are included in the GMP.

6.5 HCAI. The Design Builder will be responsible for the submission and coordination of all Amended Construction Document (ACD) submissions to HCAI. Design Builder will use the HCAI eServices Portal to make ACD submittals to HCAI and SVH and Construction Manager will be notified by HCAI through the eServices Portal. All changes in the approved Construction Documents (Exhibit 3C) for the Project will be approved and permitted by HCAI before proceeding with the Construction Work. Design Builder will submit Amended Construction Documents to HCAI for review and approval and will state the reason for the change, the difference in construction costs, if any, and include all necessary Drawings, Specifications and other supporting documentation. All Amended Construction Documents must be sealed and signed by the applicable DPOR before submission to HCAI. The Design Builder's DPOR will make all submissions of Amended Construction Documents in a timely manner to avoid delays in Contract Time.

6.6 Taxes and Fees. Design Builder will pay all sales, consumer, use, gross receipts, and other similar taxes legally enacted at the time of commencement of the Construction Work, and such taxes and fees are included in the GMP.

6.7 Consultants and Laboratories. Design Builder will make recommendations to the Construction Manager regarding selecting, retaining, and coordinating any additional professional services, special consultants, and testing laboratories required for the Project.

6.8 Subcontract Procurement. Design Builder represents that it has complied with the bidding requirements set forth in Public Contract Code sections 22185.6 (a) and will comply with the bidding requirements of 22185.6 (b) through (d) and Public Contract Code section 4100, et seq., for procuring any subcontracts where Subcontractor was not listed by Design Builder in its statement of qualifications and response to the request for qualifications. In addition, the Design Builder will: (i) develop bidders' interest in the Project and endeavor to have at least 3 bids for all trades; (ii) establish bidding schedules in accordance with the procurement requirements set forth in the Proposed Schedule (Exhibit 5A); (iii) develop Subcontractor scopes of work, and package and issue bidding documents to pre-qualified, interested bidders; (iv) evaluate bidder prequalification and bids to determine the best subcontractor suited for the Project in accordance with Public Contract Code section 22185.6; and (v) enter written subcontract with the most responsive, responsible bidder based on the bid criteria and pursuant to this Section 6.8. At a minimum, each subcontract must pass through provisions set forth in subsections 6.8.1 through 6.8.14 below.

6.8.1 License. All Subcontractors will be properly licensed for their respective trade. In addition, Design-Build Subcontractors must also be properly licensed for their respective portion of the Design Services per Section 6.9.1.

6.8.2 Standard of Care. Subcontractor will timely perform its respective portion of the Construction Work using its best skill and attention in a workman-like manner consistent with the degree of care customarily exercised by prudent licensed specialty contractors performing similar trade work on hospital projects of similar size, scope, and complexity within



the state of California. To the extent Subcontractor is a Design-Build Subcontractor, the standard of care set forth in Section 6.9.2 applies to Design Services.

6.8.3 Compensation. Subcontractor must be compensated on either a lump sum basis or a cost reimbursable basis subject to a guaranteed maximum price. If Subcontractor is compensated on a cost reimbursable basis with a guaranteed maximum price, the subcontract must include the Cost of the Work set forth in Article 11 and specify Subcontractor's billable rates. Subcontractor's billable rates must be calculated in accordance with Sections 11.2.1(a), 11.2.2(a), and 11.2.3, as applicable. Payments will be made in accordance with Section 12.5.

6.8.4 Audit. Lump sum contracts are not subject to audit. However, subcontracts will require subcontractors to be bound to the audit provisions set forth in Section 12.9 with respect to change orders. Subcontracts let on a cost reimbursable basis are subject to audit.

6.8.5 Third Party Beneficiary. SVH will be a third party beneficiary with respect to any Design Services performed by Design-Build Subcontractors.

6.8.6 Liability and Indemnity. Each subcontract must include similar defense, indemnity, and liability provisions as those set forth in Article 15 so that each Subcontractor has the same defense, indemnification, and liability obligations to Design Builder and SVH as Design Builder has to SVH under Article 15 arising out of or resulting from Subcontractor's portion of the Work.

6.8.7 Insurance. Design Builder will cause, through written agreement, Subcontractors to carry appropriate limits with similar types of coverage based on the insurance requirements set forth in Exhibit 6A.

6.8.8 Subcontracts must include a warranty provision similar to the one set forth in Article 17.

6.8.9 Claims and Disputes. The dispute resolution procedures set forth in Article 19 must be included.

6.8.10 Ownership of Documents. Design Builder will incorporate the provisions in Article 18 into each subcontract.

6.8.11 Assignment. Each subcontract must include an assignment provision. The assignment provision will allow for assignment of the subcontract to SVH if Design Builder is terminated and provided that SVH accepts assignment by written notification to the subcontract and Design Builder. The fire sprinkler trade contract is being assigned and novated to Design Builder per Section 2.5.1 for completion of fire sprinkler Design Services and its portion of the Construction Work.

6.8.12 Miscellaneous Provisions. The miscellaneous provisions set forth in Sections 21.1 through 21.4, 21.7 through 21.10, and 21.15.



6.8.13 Conflicting Terms. All conflicts arising out of any subcontract will be resolved in accordance with the order of precedence set forth in Section 3.2, and this Contract will take precedence over any conflicting terms and provisions in the subcontract other than terms and conditions regarding scope and compensation.

6.8.14 Exhibits. The following Exhibits must be included in the subcontract: Exhibit 1 through Exhibit 3, Exhibit 5, and Exhibit 7 through Exhibit 8.

6.9 Design Professionals. All agreements between Design Builder and its Design Professionals will be in writing and must bind each Design Professional to the Design Builder by the terms and conditions of the Contract Documents and require that each Design Professional assume toward the Design Builder all obligations and responsibilities that the Design Builder assumes toward SVH under the Contract Documents with respect to Design Services. Each Design Professional agreement will preserve and protect the rights of SVH and Design Builder under the Contract Documents with respect to the portion of the Work performed by Design Professionals so that subcontracting for such services does not prejudice SVH's rights or remedies. At a minimum, Design Builder will pass through the provisions set forth in subsections through to its Design Professionals.

6.9.1 License. All Design Professionals and Design Build Subcontractors performing Design Services will be properly licensed for their respective portion of the Design Services.

6.9.2 Standard of Care. Design Professionals and Design Build Subcontractors will timely perform their portions of the Design Services using the degree of care ordinarily used by other competent licensed architects and engineers designing projects of similar size, scope, quality and complexity within the State of California. Design Professionals and Design Build Subcontractors will sign and affix their respective professional seal on their respective portions of the Construction Documents to the extent required by Governmental Authorities.

6.9.3 Compensation. Design Professionals, who are not the SEOR or Design Build Subcontractors, must be compensated on a not-to-exceed basis based on their billable rates included in Exhibit 4C. Regardless billable rates will be used for all additional services, and billable rates must be calculated in accordance with Section 11.2.1(a). All payments will be made in accordance with Section 12.5.

(a) Audit. Stipulated sum contracts are not subject to audit. However, consultant agreements will require Design Professionals to be bound to the audit provisions set forth in Section 12.9 with respect to change orders. Design Professionals let on a cost reimbursable basis are subject to audit.

(b) Third Party Beneficiary. SVH will be a third party beneficiary with respect to the portion of Design Services provided by a Design Professional.

(c) Liability and Indemnity. To the fullest extent permitted by law, each design agreement must include similar defense and indemnification obligations to Design Builder, SVH, and the Indemnitees identified in Section 15.2 but only to the extent arising or



resulting from the negligent acts or omissions, recklessness, or willful misconduct of the Design Professional, its tier-consultants, or anyone directly or indirectly employed by any of them for whose acts Design Professional may be liable.

(d) Insurance. Design Builder will cause, through written design agreement, Design Professionals insurance as required by the Business Terms Sheet and Exhibit 6A.

(e) Ownership of Documents. The provisions in Article 18 must be included.

(f) Claims and Disputes. The dispute resolution procedures set forth in Article 19 must be included.

(g) Assignment. Each design agreement must include an assignment provision. The assignment provision will allow for assignment of the design agreement to SVH if Design Builder is terminated, and provided that SVH accepts assignment by written notification to the Design Professional and Design Builder. The structural engineer's contract is being assigned and novated to Design Builder per Section 2.5.1 for completion of the structural portion of the Design Services.

(h) Miscellaneous Provisions. The miscellaneous provisions set forth in Sections 21.1 through 21.4, 21.7 through 21.10, and 21.15.

(i) Conflicting Terms. All conflicts arising out of any design agreement will be resolved in accordance with the order of precedence set forth in Section 3.2, and this Contract (inclusive of Exhibits) will take precedence over any conflicting terms and provisions in the design agreement other than terms and conditions regarding scope of service and amount of compensation.

(j) Exhibits. The following Exhibits must be included in each design agreement and subcontract: Exhibit 1 through Exhibit 3, relevant portions of Exhibit 4C, Exhibit 5, Exhibit 7 and Exhibit 8.

7. VALIDATION STAGE

7.1 Validation and GMP. Upon execution of the Contract, the Design Build Team will collaborate with SVH and the Construction Manager to perform further joint site investigation and evaluation of all non-structural items that will necessitate seismic anchorage or bracing per NPC-4D Level 1 requirements such as suspended ceiling bracing, bracing of above MEP utility runs, Building 5 equipment (above and below) and building 1 exit corridor bracing, including development of NPC-5 components for NPC compliance; engage in Target Value Design with respect to Program Documents (Exhibit 3A) provided by SVH; and develop Schematic Design Documents per Section 7.2 discussing SPC and NPC requirements and alternative approaches to design and construct the Project taking into account the Target Cost and Contract Time set forth in the Business Terms Sheet, best value recommendations, potential constructability issues, and other risks that could jeopardize regulatory compliance and deadlines. At the



conclusion of the Validation Stage, the Schematic Design Documents will be completed, and the Design Builder will prepare and submit its GMP in accordance with Section 10.3, and Project Schedule in accordance with Section 13.3 for review and approval by SVH. Upon SVH's approval, the GMP and Project Schedule will be incorporated into the Contract by Amendment as Exhibits 4A, 4B, and 5B, respectively. To the extent that the Stages or duration expressed in the Proposed Schedule are adjusted, the Design Builder will also update the Resource Loaded Work Plan (Exhibit 4C) and General Requirements (Exhibit 4D) to reflect the amounts included in the GMP for Design Services, General Conditions, and General Requirements over the duration included in the Project Schedule (Exhibit 5B). The approved Schematic Design Documents will be incorporated into the Contract through Amendment as Exhibit 3B.

7.1.1 Go / No Go Provision. If SVH and the Design Builder are unable to agree to the GMP and Project Schedule, SVH will terminate this Contract for convenience per Section 20.2 and all work product developed during the Validation Stage will be SVH's property per Article 18. Upon termination, SVH may take any the following actions: (i) Solicit proposals to complete the Project from firms that submitted statements of qualifications pursuant to Section 22185.3; (ii) Upon written determination that it is in the best interest SVH, formally solicit proposals from other design-build entities, and contract award shall be made on a best value basis; or (iii) Take assignment of the Design Services complete the design, and bid the Project.

7.2 Schematic Design Documents. The Design Builder will cause its DPORs to prepare Schematic Design Documents based on the Project Documents set forth in Exhibit 3A, and information, surveys, and design materials developed as a result of the joint site investigation and further evaluation as described in Section 7.1. Schematic Design Documents will consist of Drawings, outline Specifications and other necessary documents illustrating the scale and relationship of Project components and will include the building layout and floor plans, sections and elevations for seismic retrofit and major building systems, as well as line diagrams and proposed equipment schedules based on the Project Documents (Exhibit 3A).

7.2.1 Reconciliation with Agreed Program. Before completing the Schematic Design Documents, the Design Builder will cause the DPORs to evaluate the SPC, NPC, and other program requirements and note any discrepancies between the regulatory requirements and the Schematic Design Documents, and request approval and direction from the Construction Manager, SVH, and HCAI (as applicable). Design Builder will prepare its GMP in accordance with Section 10.3 based on the Schematic Design Documents and its Project Schedule. If the GMP is not within the Target Cost set forth in the Business Terms Sheet, the Design Builder must provide a detailed explanation to SVH, the Program Manager, and the Construction Manager of why the Target Cost is either not achievable or provide additional Target Value Design and best value options for consideration by the Project Team in order to achieve the Target Cost.

(a) **Coordination of Steel and MEP.** Steel and mechanical, electrical, plumbing, fire protection and fire and life safety work will be coordinated through the BIM, as appropriate, to avoid obstructions, preserve head room, preserve access for maintenance, keep openings and other passageways clear, overcome interference with structural, framing, and equipment conditions, and coordinate with other trades. Other trades may also be coordinated through the Model.



7.2.2 Approval Process. The Design Builder will submit and present the following material for review and approval by the Construction Manager, and SVH: (i) floor plans; (ii) sections and elevations for seismic upgrade and major building systems; (iii) line diagrams and equipment schedules; and (iv) outline Specifications as well as a narrative describing how the design will meet the Agreed Program with respect to building performance and fitness for its intended purpose and use, subject to the standard of care set forth in Section 1.5. If SVH, the Program Manager, or Construction Manager do not approve the Schematic Design Documents, or aspects of the documents, the Design Builder will modify the Schematic Design Documents and re-submit for approval.

8. DESIGN / PRECONSTRUCTION STAGE

8.1 Development of Design. Design Builder will actively engage and collaborate with other necessary Project Team Members in the following activities throughout the entire design process and at various stages in the development of the Construction Documents (Exhibit 3C).

8.1.1 Building Information Model. The Design Build Team will establish a BIM Execution Plan in compliance with Section 16 of Exhibit 2, which will be incorporated into Tab 5 of the Project Manual. The Model will be developed in accordance with the BIM Execution Plan and will be continually updated throughout the design and construction process so that the Model is current with the actual “as-built” condition, and when completed will be the record model. To the extent that there are inconsistencies between the 2D Drawings and the Model, the Drawings, the HCAI approved 2D Drawings will govern.

8.1.2 2-D Working Drawings. The Design Builder will also produce working Drawings throughout the various stages in the development of the design and subsequent Construction Documents (Exhibit 3C).

8.1.3 Target Value Design. SVH, Construction Manager, and Design Build Team will actively engage in the Target Value Design process to provide optimal value and design during each stage of the design process, and to properly coordinate and integrate the various systems, equipment, and components to increase ease of construction while controlling Project cost and schedule. Set Based Design and Choosing By Advantages may be used to explore design alternatives and reach decisions during the design process. Cost evaluation during the Target Value Design process should include design details as they are being developed, and portions of the Construction Work that the Project Team deems necessary for accurate cost modeling. The Target Value Design process should include the following:

(a) Set Based Design. The Design Build Team will collaborate with other Project Team Members through the use of Set Based Design and Choosing By Advantages to determine the best design options and whether one design option can be achieved in a different manner for a lower cost or improved schedule without compromising the aesthetic or functional value. Proposals for alternative systems, means, methods, finishes, equipment, and the like must satisfy the Agreed Program (Exhibit 3), and result in savings of time or money in constructing or improved facilities, operations or maintenance. The DPORs will review all proposals to ascertain design feasibility, satisfaction of the Project Documents and



compatibility and compliance with Applicable Laws. Design Builder and relevant Subcontractors will review alternative proposals for constructability, schedule, and cost. SVH will rely solely on the Design Build Team's representations about the appropriateness and adequacy for implementation on the Project but proposals on design alternatives will not be incorporated into the Construction Documents without review by the Construction Manager and approval of SVH and HCAI (as may be required).

(b) **Constructability Reviews.** Design Builder and its Subcontractors will provide constructability reviews at 100% Schematic Design Documents, 50% and 100% Design Development Documents, and at 50% and 100% Construction Documents to provide clarity, consistency, constructability, and coordination among the various design disciplines' Drawings and the Subcontractors. DPORs and other necessary Project Team Members will review and respond in writing to each constructability review comment, either by recommending changes in the design or explaining why such action is unnecessary.

(c) **Cost Evaluation.** The Design Builder and its Subcontractors will provide estimating services as often as necessary to support decisions regarding scope, functionality, and design and to help ensure that the Project design is being developed within the GMP. Consistent cost evaluation will assist the Design Build Team, Construction Manager, and SVH in making decisions to the extent there are design alternatives.

8.2 HCAI. Design Builder and its DPORs will coordinate and interface with HCAI throughout performance of the Work. If applicable, the design may be released in segments in accordance with any HCAI phased review process.

8.3 Title 24. Design Builder will cause its DPOR to prepare the scope for required testing and inspections per the Testing, Inspection and Observation ("TIO") requirements described in Title 24, Part 1. The TIO requirements will be submitted to the Construction Manager, with the application for building permit forms. Design Builder will coordinate with the Construction Manager and Program Manager regarding when and to what extent tests, inspection and reports are necessary or appropriate under Title 24.

8.4 Design Development Documents. Design Builder will cause its DPORs to prepare 50% and 100% Design Development Documents based on the Project Documents (Exhibit 3A) and Schematic Design Documents set forth in Exhibit 3B. The Design Development Documents must include detailed Drawings and Specifications necessary to fix and describe the size and character of the entire Project as to design, structural, mechanical, and electrical systems, materials, and such other elements as may be appropriate to allow the Construction Manager to initiate scope compliance review(s).

8.4.1 Reconciliation. Before completing the 50% and 100% Design Development Documents, Design Builder will cause its DPORs to evaluate the programmatic requirements and note any discrepancies between the Project requirements reflected in the Project Documents and Schematic Design Documents, and the 50% or 100% Design Development Documents (as applicable), and request approval and direction from SVH, the Program Manager, and Construction Manager. Design Builder will also prepare a cost estimate per Section 8.1.3(c) confirming that the design is still within the GMP and will note any slippage



in the Project Schedule (Exhibit 5B). The Design Build Team cannot proceed to 100% Design Development Documents or Construction Documents if the design is not progressing within the GMP unless there has been a condition of change as described in Section 14.2. To the extent that there has been a slippage in the Project Schedule, Design Builder will prepare and submit a detailed recovery plan as required by Section 13.5 as part of the reconciliation.

8.4.2 Design Review. Design Builder will cause its DPORs to prepare the necessary documentation for back-check and code compliance from necessary Governmental Authorities, and to attend all meetings as required to obtain SVH, and Governmental Authority approval.

8.4.3 Approval Process. Design Builder will submit and present the following materials for review and approval by the Program Manager, Construction Manager, and SVH: (i) detailed floor plans; (ii) building sections and elevations; (iv) detailed SPC and NPC improvements; (v) Specifications. The Design Development Documents submittal will incorporate changes and corrections required by Governmental Authority under Section 8.4.2, as requested be made based on code compliance or back-check review comments.

8.5 Construction Documents. Upon approval of the 100% Design Development Documents, Design Builder will cause its DPORs to prepare 50% and 100% Drawings and Specifications to be issued for permit. The Construction Documents will consist of Drawings and Specifications setting forth in detail all necessary requirements for proper construction of the Project, as well as any subsequent approved revisions, and taking into account applicable SPC, NPC, and building code requirements. The Construction Documents will describe the quality, configuration, size, and relationships of all materials, equipment, and components to be incorporated into the Project, and will be the Drawings and Specifications submitted to all necessary Governmental Authorities for approval and permit. Design Builder will not submit the Construction Documents for permit until receipt of approval by the Construction Manager, Program Manager, and SVH.

8.5.1 Reconciliation. Before completing the 50% Construction Documents, Design Builder will cause its DPORs to evaluate the programmatic requirements and note any discrepancies between the Project requirements reflected in the Project Documents and Schematic Design Documents, and the 50% Construction Documents, and request approval and direction from SVH, the Program Manager, and Construction Manager. Design Builder will also prepare a cost estimate per Section 8.1.3(c) confirming that the design is still within the GMP and will note any slippage in the Project Schedule (Exhibit 5B). The Design Build Team cannot proceed to 100% Construction Documents if the design is not progressing within the GMP unless there has been a condition of change as described in Section 14.2. To the extent that there has been a slippage in the Project Schedule, Design Builder will prepare and submit a detailed recovery plan as required by Section 13.5 as part of the reconciliation.

8.5.2 Design Review. Design Builder will cause its DPORs to prepare the necessary documentation for back-check and code compliance from necessary Governmental Authorities, and to attend all meetings as required to obtain SVH, and Governmental Authority approval.



8.5.3 **Submission of Signed and Stamped Drawings and Specifications.** In order to obtain necessary permits and to comply with professional registration statutes, 2D Drawings, calculations and Specifications must be generated, reviewed, sealed, and submitted to reviewing Governmental Authorities. Each DPOR will sign and stamp their respective Drawings, Specifications, and calculations. By signing and sealing the Drawings and Specifications, each DPOR agrees that its portion of the Design Services are complete, coordinated, accurate, and contain directions that will enable the Design Builder and its Subcontractors to construct the Project.

8.5.4 **Permits and Approval.** Design Builder will submit the Drawings and Specifications, a summary of the calculations, and detailed calculations for the structural, HVAC, electrical, plumbing, and other specialized building systems. The applicable Governmental Authorities will be final interpreter of all code requirements, and all such decisions will be final. The Construction Documents will not be considered 100% complete until Governmental Authorities' approval has been received. Upon approval, the Design Builder will provide a copy of the permitted Drawings and Specifications for the Project to the Construction Manager, and will maintain the original permitted Drawings and Specifications at the Project site. A list of the Drawings and Specifications included in the Construction Documents will be amended into this Contract as Exhibit 3C.

8.5.5 **Substitutions.** Once Construction Documents are approved, no substitutions will be accepted on the Project unless: (i) the specified materials or equipment have been discontinued; or (ii) there is a cost savings to SVH. Substitutions that are included in the Work but not approved will be deemed non-conforming Construction Work and subject to correction under Section 5.5 of the Supplemental Conditions (Exhibit 2).

9. CONSTRUCTION STAGE

9.1 Construction Work. Design Builder is solely responsible for all construction means, methods, techniques, sequences, and procedures and for safety precautions and programs in connection with the Construction Work. Those portions of the Construction Work that Design Builder does not customarily perform with its own personnel will be performed by a Subcontractor under written subcontract pursuant to Section 6.9.

9.2 Existing Site Conditions Survey. Before commencement of the Construction Work, Design Builder will walk the site with Construction Manager and make a video recording of all existing site conditions including, but not limited to, sidewalk, roadway, utilities, landscaping, hardscaping, signage, etc. and provide video record to Construction Manager and Program Manager. This video recording will serve as a record of existing condition before commencement of the Construction Work and provide evidence of damage to any existing site conditions that require restoration.

9.3 Supervision. Design Builder will supervise and direct the Construction Work using its best skill and judgment. Design Builder will be solely responsible for all design, fabrication, shipment, delivery and coordination of all portions of the Work under the Construction Documents and all Construction Work will be performed in accordance with the Contract Documents. The Design Builder will provide a qualified superintendent at the Project



site to properly supervise all of Design Builder's employees, Subcontractors and their agents and employees, and other persons performing Construction Work and to ensure that the Construction Work is carried out in strict accordance with the Contract Documents. Design Builder's superintendent is key personnel and may not be changed without SVH written consent.

9.4 Discipline. Design Builder will enforce strict discipline and order at all times among Design Builder's employees, Design Professionals and Subcontractors and will not employ or contract with any unfit or unskilled person(s) or entities on this Project. Any person in the employ of the Design Builder or any of its Design Professionals or Subcontractors whom Program Manager, Construction Manager or SVH believes may be incompetent or unfit will be dismissed from the Project and will not be re-employed on this Project.

9.5 Coordination. All Construction Work will be coordinated and performed in accordance with the Contract Documents. The Supplemental Conditions (Exhibit 2) include additional information and requirements for field operations. Before starting each portion of the Construction Work, the Design Builder will: (i) review and compare the various Construction Documents relative to that portion of the Construction Work as well as other information furnished by SVH, Construction Manager, Design Professionals and Subcontractors that may affect proper installation of the Construction Work; (ii) field measure existing conditions related to that portion of the Construction Work; and (iii) observe any conditions at the site directly affecting that portion of the Construction Work.

9.5.1 Field Measurements. Design Builder will take field measurements to ensure proper matching and fitting of new construction with construction performed by SVH Separate Contractors and existing conditions at the Project site.

9.5.2 Submittals. All Submittals will be properly and timely submitted in accordance with Article 3 of the Supplemental Conditions (Exhibit 2).

9.6 Site Logistics. Design Builder, in collaboration with the Construction Manager will review the proposed Site Logistics Plan, make adjustments as may be required, submit revisions (if any) to the Construction Manager and Program Manager for approval. The approved Site Logistics Plan will identify areas of the Project site that will be used for trailers, deliveries, staging, ingress, egress, etc. The approved Site Logistics Plan, as updated, will be incorporated into the Project Manual as Tab 3. Adjustment to the proposed Site Logistics Plan will not be grounds for an adjustment in the GMP.

9.7 Building Layout. Design Builder is responsible for layout and provide all line and grade staking (including staking north/south and east/west gridlines) and will establish benchmarks for horizontal and vertical control per Section 13.1 of Exhibit 2.

9.8 Materials and Equipment. Storage of equipment and materials will be coordinated through the Construction Manager and in accordance with the most current, approved Site Logistics Plan. Design Builder will maintain, or cause its Subcontractors to maintain, all storage areas and will keep storage areas clean, safe, and secure.



9.8.1 Long Lead Items. Design Builder will collaborate with the other Project Team Members to establish a program to expedite ordering and delivery of materials and equipment in a timely manner and consistent with the Project Schedule.

9.8.2 Shipment and Deliveries. Before shipment, delivery, and installation of materials and equipment, Design Builder will verify the stage of completion of the applicable Construction Work with the Construction Manager to determine the availability of facilities for access, delivery, transportation, and storage, and to correlate these observations with the requirements of the Contract Documents. All shipments and deliveries will be scheduled and coordinated in accordance with the most current, approved Site Logistics Plan and Project Schedule.

9.8.3 Risk of Loss. All Construction Work stored at the Project site, or work related to the preparation or delivery of materials or equipment to the Project site, is performed exclusively at the risk of the Design Builder and will remain at the risk of the Design Builder until Final Completion. Materials and equipment stored offsite must be securely stored in a third party bonded or insured warehouse, and must be segregated and labeled "Property of Salinas Valley Health" and include the Project name, number, and address. To the extent such storage is not covered under the builder's risk policy, Design Builder will procure insurance covering the stored materials and SVH, Design Builder and its Subcontractors will be named as an additional insured under all such policies.

9.9 Maintenance. Design Builder will provide all maintenance and repairs for systems and equipment at its own costs and expense until Substantial Completion.

9.10 Cutting and Patching. Design Builder and its Subcontractors will be responsible for all cutting, fitting, or patching required to complete the Construction Work or to make its parts fit together properly. Design Builder and its Subcontractors will not damage or endanger any portion of the Construction Work, or fully or partially completed Construction Work, by cutting, patching, or otherwise altering the construction. Design Builder and its Subcontractors will not cut or otherwise alter the construction by Separate Contractors except with the prior written consent of the Construction Manager.

9.11 Testing and Inspections. Testing and inspections will be completed in accordance with Article 5 of the Supplemental Conditions (Exhibit 2).

9.12 Substantial Completion. Construction Manager will issue a certificate of Substantial Completion (Project Manual, Tab 2I) per Section 5.7 of the Supplemental Conditions (Exhibit 2) to be signed by SVH and Design Builder documenting the date when the Project or portion of the Project achieved Substantial Completion. Upon issuance of the certificate of Substantial Completion, Design Builder and its Subcontractors will diligently pursue Completion of Construction Work within 90 days in accordance with the Contract Documents.

9.13 Commissioning. Design Builder will schedule and oversee the final testing and start-up of utilities, operational systems, and equipment, and assist SVH with building commissioning in conjunction with Construction Manager and any SVH's facility and maintenance personnel, and required Subcontractors. All inspections and testing will be



conducted by special inspectors or by other Governmental Authorities (as applicable). During commissioning and before Completion of Construction Work, Design Builder, Construction Manager, and SVH will oversee Subcontractor operation, adjustment, and balancing of all equipment, and training of SVH's employees in the correct operation and maintenance of equipment.

9.14 Final Inspection and Acceptance. Final inspections and acceptance will be in accordance with Section 5.8 of the Supplemental Conditions (Exhibit 2).

9.15 Maintenance of Records. Design Builder will maintain one record copy of the Project Documents (Exhibit 3A), the approved 100% Schematic Design Documents (Exhibit 3B), 100% Design Development Documents, the 100% Construction Documents issued for permit (Exhibit 3C), all permits, and all addenda, approved Submittals, Change Orders and other modifications, and RFIs in good order and marked correctly to record changes and selections made to the Construction Documents during design and construction. All records will be available in the Design Builder's jobsite office and will be delivered to the Construction Manager at Completion of Construction Work along with any other required close-out documentation required by the Contract Documents.

9.16 Close-Out. Before Completion of Construction Work, Design Builder will transmit to the Construction Manager an electronic copy and 1 hard copy of all required as-built Drawings, the record model, operation and maintenance manuals, verified reports, warranties, and other close out documents as required by the Contract Documents. As Built changes to the Construction Documents will be reflected in the final "As Built" revision of the CAD files and the record BIM (if applicable). Such files and the BIM (if applicable) will be turned over to SVH.

10. COMPENSATION AND GUARANTEED MAXIMUM PRICE

10.1 Validation Stage. During the Validation Stage, SVH will pay Design Builder based on time and reimbursable expense basis up to the not-to-exceed amounts (NTE Amount) set forth in the Business Terms Sheet for Design Services and Preconstruction Services per the billable rates set forth in the Resource Loaded Work Plan (Exhibit 4C), which include the stipulated sum for the SEOR. The NTE Amount is only subject to adjustment through executed Change Order per Article 14. The Cost of the Work expended during the Validation Stage for Design Services and Preconstruction Services will be incorporated into the proposed GMP as separate not-to-exceed line items at the end of the Validation Stage.

10.2 Contract Price. If the GMP is approved and mutually agreed to by the Parties at the end of the Validation Stage, SVH will pay the Design Builder the Cost of the Work plus Fee up to the GMP as described in Section 10.3 for completion of the Work. The Contract Price includes any price adjustments based on fully executed Change Orders. All Work described in the Contract Documents will be included in the GMP whether or not specifically itemized in the GMP Breakdown (Exhibit 4A) or Qualifications & Assumptions (Exhibit 4B), except for items designated in the Project Documents or Schematic Design Documents to be performed "by others."



10.3 Guaranteed Maximum Price. The GMP will be incorporated into the Contract by Amendment at the conclusion of the Validation Stage as Exhibits 4A and 4B, and includes the Design Builder's Costs of the Work as defined in Section 11.1 and its Fee as further described in Section 11.6. There are no line item guarantees in the GMP (other than the NTE Amount for Design Services and NTE Amount for Preconstruction Services, as may be amended through Change Order). Any savings will remain in the GMP until Completion of Construction Work and final payment, at which point all savings will accrue to SVH. Design Builder will submit a zero dollar Change Order for SVH's written approval for transparency in modifications to the Schedule of Values (e.g. use of contingency funds, transfer from one line item to another, scope swaps) in accordance with Article 14. All costs which would cause the GMP to be exceeded will be paid solely by the Design Builder, subject only to adjustment through executed Change Order.

10.3.1 Design Services. The cost for Design Services performed by Design Professionals and Design-Build Subcontractors performing mechanical, electrical, plumbing, and fire protection will be included as a separate line item in the GMP and will be compensated on a time and reimbursable expense basis (except for SEOR) with a NTE Amount. Billable rates for Design Services must be calculated in accordance with subparagraph 11.2.1(a) and are included in the Resource Loaded Work Plan set forth in Exhibit 4C. The RLWP must be broken down by the following Stages (Validation Stage, Design / Preconstruction Stage, Construction Stage) and identify which team members are key personnel. The NTE Amount for Design Services must be subtracted from the Cost of the Work before Design Builder calculates insurance and bond costs.

10.3.2 Preconstruction Services. The cost for Preconstruction Services will be included as a separate line item in the GMP and will be compensated on a time and reimbursable expense basis with a NTE Amount. Billable rates for Preconstruction Services must be calculated in accordance with subparagraph 11.2.2(a) and are included in the Resource Loaded Work Plan set forth in Exhibit 4C during the Validation Stage and Design / Preconstruction Stage. The NTE Amount for Preconstruction Services must be subtracted from the Cost of the Work before Design Builder calculates insurance and bond costs.

10.3.3 Design / Preconstruction Services Contingency. The dollar amount included in the Business Terms Sheet for Design / Preconstruction Services Contingency may be utilized by Design Builder during investigation and evaluation of the existing conditions during the Validation Stage. Unused Design / Preconstruction Services Contingency will accrue 100% to SVH.

10.3.4 Direct Costs for Construction Work. Direct Costs for Construction Work will comply with the applicable Cost of the Work requirements set forth in Article 11 and must be broken down into separate line items by trade for the cost for all labor, materials, equipment, and appurtenances required for the Construction Work. Design Builder must include columns for materials and labor in the detailed breakdown of the GMP in order to calculate the Labor Escalation Allowance and Material Escalation Allowance. If this information is not provided, Design Builder forfeits its right to recover for Unusual Labor Escalation or Unusual Material Escalation.



(a) Labor Escalation Allowance. Design Builder will include a Labor Escalation Allowance of 5% for escalation of field labor performing Construction Work included in the GMP. Design Builder must include the estimated cost of labor broken down by trade in its GMP and must have separate back up for Design Builder's field labor included in the General Requirements. The Labor Escalation Allowance will be a separate line item in the GMP. The Labor Escalation Allowance will be reconciled during the last 6 months of construction pursuant to Section 14.11. Unusual Labor Escalation change requests must be completely transparent and all adjustments will be in accordance with Section 14.11. If the Labor Escalation Allowance is exceeded, Design Builder may request an additive Change Order for Unusual Labor Escalation per Section 14.2.1. Design Builder must request a labor cost breakdown from each trade during the procurement process and before GMP in order to be able to substantiate this Claim.

(b) Material Escalation Allowance. Because several trades will not be procured until later in the design process, the GMP includes a Material Escalation Allowance. Design Builder must include the estimated cost of materials broken down by trade in its GMP. The Material Escalation Allowance will be calculated by multiplying 8% times the sum of the estimated material costs for trade work, which is estimated based on either a material or equipment quote received at the time of GMP from a Subcontractor or supplier, or the first quarter 2025 RS Means cost index ("Cost Index") for bay area. Material escalation will be calculated as follows: (i) By comparing the actual cost at the time of procurement of the Subcontractor to the price of the material or equipment in the Cost Index; or (ii) By comparing the actual cost at the time of procurement to a supplier's material or equipment quote if a Subcontractor or supplier provided a material or equipment quote as part of its proposal to Design Builder at the time of the GMP; or (iii) By comparison of the actual cost of the material or equipment at the time of procurement of the material or equipment to the amount carried in the GMP for the material or equipment if the Cost Index does not have a price for the specific material or equipment. The Material Escalation Allowance may only be accessed by Design Builder if subcontracts, materials, and equipment are timely procured in accordance with the Project Schedule. The Material Escalation Allowance will be reconciled after all Subcontractor buy-out is completed per Section 14.12. If after completion of all Subcontractor buy-out, the Material Escalation Allowance is exhausted, the Design Builder may submit a Change Order for Unusual Material Escalation per Section 14.2.2. Design Builder is expected to request a material cost breakdown from each trade during the procurement process and before GMP.

10.3.5 Indirect Costs for Work. Indirect Costs will include Design Builder's General Conditions, General Requirements, design and construction contingency, insurance, payment and performance bond, and Fee.

(a) Design Builder's General Conditions are described in Section 11.2.2. All billable rates must be calculated in accordance with Section 11.2.2(a) and are set forth in the Resource Loaded Work Plan set forth in Exhibit 4C. The Resource Loaded Work Plan must be broken down by the Validation Stage, Design / Preconstruction Stage and the Construction Stage based on Design Builder's proposed personnel and billing rates for Preconstruction Services, and Construction Work, the percentage of time each personnel is expected to perform work or services on the Project, and duration of the Validation Stage, Design / Preconstruction Stage and Construction Stage, and include the proposed billable rates



for each staff member, and indicate which staff members are key personnel. The Resource Loaded Work Plan must calculate the estimated monthly amount for each person based on percentage of time spent on each Stage and the Project over the duration of the Project Schedule. The cost for Design Builder's General Conditions will be included as a separate line item in the GMP.

(b) Design Builder's General Requirements are described in Section 11.4 and are more particularly set forth in the General Requirements Spreadsheet set forth in Exhibit 4D. The General Requirements Spreadsheet substantiates Design Builder's cost for General Requirements spread over the duration of the Construction Stage portion of the Project Schedule.

(c) Design and Construction Contingency. Contingency for design and construction must be included in a separate line item of the GMP and may be used by the Design Builder at its discretion as a buffer to the GMP to cover situations such as unanticipated field conditions, un-estimated costs, scope gaps or subcontractor buy-out overruns, correction of design errors or omissions, re-sequencing of the Work, or acceleration to permit the Design Builder to deliver the Project within the Contract Time, and such other costs agreed to, in writing, by SVH. Use of Design Builder's contingency will be transparent through transfer of the amount of contingency used into the appropriate line item through a no cost Change Order in accordance with Article 14. Design Builder will ensure that Subcontractors do not carry contingency for the same risks. Unused construction contingency will accrue to SVH via deductive Change Order upon Completion of Construction Work. Contingency will be calculated on the NTE Amount for Design Services, Direct Costs, General Conditions and General Requirements, however the Labor Escalation Allowance and Material Escalation Allowance must be subtracted before calculating Contingency.

(d) Insurance and Bond. The cost for Design Builder's insurance and payment and performance bond must be included in separate line items of the GMP. The payment and performance bond must cover 100% of the cost of the Construction Work. Design Builder's insurance requirements are set forth in Exhibit 6A. The Change Order mark-up for insurance and bonds is stated in the Business Terms Sheet. Insurance and bonds will be calculated based on the cost of the Construction Work.

(e) Fee. Design Builder Fee is included in the GMP for Design Builder's home office overhead and profit as further defined in Section 11.6. Fee will be calculated based on the percentage set forth in the Business Terms Sheet multiplied by the subtotal of the NTE Amount for Design Services, NTE Amount for Preconstruction Services, Direct Costs for Construction Work and Indirect Costs. Design Builder's Fee is set forth in the Business Terms Sheet. Design Builder's Fee fluctuates for additive and deductive Change Orders based on the Change Order percentage set forth in the Business Terms Sheet and the Cost of the Work.

11. COST OF THE WORK

11.1 General. The term "Cost of the Work" includes costs necessarily and properly incurred by Design Builder in the performance of the Work. The Cost of the Work will be at



rates not higher than the standard paid at the place of the Project except with prior consent of SVH. The Cost of the Work includes only those items set forth in Sections 11.2 through 11.5, and only includes the price incurred by the Design Builder without any duplicative charge for items that fit into more than one category, and is subject to the compensation provisions set forth in Article 10, and the audit provisions set forth in Section 12.9. Design Builder's Fee is in addition to the Cost of the Work and subject to the requirements in Section 11.6. Design Builder will include these same provisions in all Design Professional agreements and subcontracts where the Design Professional or Subcontractor is being compensated on either a not-to-exceed basis or a guaranteed maximum price basis. These same provisions will also apply to Change Orders (including subcontract change orders), regardless of compensation model. For the purpose of Change Orders, Direct Costs include the cost of all Design Services, subcontracted work or self-performed Work but does not include Design Builder's Indirect Costs described in Section 10.3.5.

11.2 Labor and Services.

11.2.1 Design Services. Reimbursable costs for Design Professionals performing consulting or Design Services during the Validation Stage, Design / Preconstruction Stage, and Construction Stage will be charged per the billable rates set forth in Exhibit 4C. The RLWP set forth in Exhibit 4C, includes Design Professionals and Design-Build Subcontractors performing mechanical, electrical, plumbing, and fire sprinkler design costs included in the NTE Amount for Design Services. The RLWP must calculate the estimated monthly amount for each person performing Design Services on the Project over the duration of the Schedule based on the percentage of time spent during each Stage, and include the proposed billable rates for each staff member, and indicate which staff members are key personnel. The cost for all other design-build work (e.g. piles, temporary shoring, etc.) will be carried in the GMP under the appropriate Direct Cost line item for that specific trade.

(a) Billable rates for Design Services must be inclusive of any and all costs necessary for performance of the design or consulting services including basic wages, payroll taxes, and employer benefit payments for health and welfare (net of employee contribution withholding), pensions, vacations/holidays, supplemental dues, training, 401K benefits, and other benefits or payments required by law, and will include overhead, burden, and profit. Overhead and profit calculations are subject to the categories of items included in Section 11.6.1 below. Charges for Work performed by salaried personnel in excess of the 40 hour work week are not allowable, unless agreed to by SVH before the time being incurred and only in an amount agreed to by SVH as appropriate. The billable rates will be locked through end of 2025, and subject to an adjustment at the beginning of 2026. The rate adjustments will be made in January, tied to the Consumer Price Index, and cannot include salary adjustments in excess of 5% per year. Costs for annual bonuses are allowed as part of Design Professional's profit. All rates (including adjustments) must be taken into consideration as part of the GMP, and rates may be audited before execution of the Contract or any time thereafter.

11.2.2 General Conditions. General Conditions include Design Builder's employee costs for Preconstruction Services, project management, superintending, project engineering, safety, accounting, planning and scheduling, purchasing, estimating, and BIM modeler(s) who are specifically assigned to the Project, but only for that portion of employee



time required for the Construction Work. Costs for Design Builder's employees assigned to the Project will be charged per the billable rates set forth in Exhibit 4C, as calculated below. The RLWP included in Exhibit 4C must be broken down by Preconstruction Services (Validation Stage and Design / Preconstruction Stage) and Construction Work (Construction Stage), and include the proposed billable rates for each staff member, and indicate which staff members are key personnel. The RLWP in Exhibit 4C must calculate the estimated monthly amount for each person based on percentage of time spent during each Stage and the entire Project over the duration of the Schedule.

(a) Billable rates for General Conditions include basic employee compensation (hourly wages or salary without any overhead and profit) plus customary benefits including health and life insurance (net of employee contribution withholding), long term disability, accidental death/dismemberment, sick leave, 401K, pensions, vacation accruals, holidays, Social Security (FICA), Medicare (FMI), any other government required payroll taxes, unemployment insurance (FUI & SUI based upon actual rates and statutory limits), and workers' compensation. For full-time staff assigned to the Project, the base hourly rate is determined by dividing the employee's annual salary by 2,080 hours. Employees, who are not assigned on a full-time basis to the Project, should be based on their respective hourly rate and the actual amount of time spent on the Project. Note that billing rates for Preconstruction Services do not include overhead and profit as Design Builder's Fee will be taken on top of Design Services and Preconstruction Services when it develops the GMP. Charges for Work performed by salaried personnel in excess of the 40 hour work week are not allowable, unless agreed to by SVH before the time being incurred and only in an amount agreed to by SVH as appropriate. The billable rates will be locked through end of 2025, and subject to an adjustment in January of 2026. The rate adjustments will be tied to the Consumer Price Index and cannot include salary adjustments in excess of 5% per year. The billing rates cannot include annual bonuses, however Design Builder may include cost for annual bonuses in its profit. All rates must be taken into consideration as part of the GMP, and rates may be subject to audit before execution of the Contract or any time thereafter.

11.2.3 Field Labor. Field labor costs are limited to hours of labor performed by workers performing Construction Work on site or at off-site locations. The labor rates must be inclusive of basic hourly wages, payroll taxes, and employer benefit payments for health and welfare, pensions, vacations/holidays, supplemental dues, and training, plus any other benefits or payments required by law or applicable collective bargaining agreements. The labor costs associated with foremen and lead-men are included in field labor and all self-performed Construction Work will be compensated as field labor. The cost of Design Builder's field labor employees (e.g., laborers and carpenters maintaining the site) will be included in Design Builder's General Requirements (Exhibit 4D). Self-performed trade work using field labor will be carried in the GMP under the appropriate direct cost line item for that specific trade. Per diem for union labor will be pursuant to the applicable collective bargaining agreement.

11.2.4 Subcontractor Costs. Subcontractor costs include payments made to Subcontractors per their written subcontracts, provided the written subcontract conforms to the requirements of this Contract. All written subcontracts providing for compensation on a cost-reimbursable basis will include a reimbursable and non-reimbursable section that substantially incorporates the applicable provisions set forth in this Article 11 and specifically defines the



categories of services or labor and the rates in dollar amount per hour. Subcontracts must include hourly field labor rates for standard time, overtime, and double time work. Subcontractor's insurance costs are included in overhead. Overhead and profit are not included in billable rates.

11.3 Cost of Materials and Equipment Incorporated Into the Project. Cost of materials and equipment under this Section include actual costs for materials and equipment, including transportation and storage of materials and equipment incorporated or to be incorporated into a Project and including costs of materials in excess of those actually installed to allow for reasonable waste and spoilage.

11.3.1 Excess Materials and Equipment. Unused excess materials or equipment, if any, will become SVH's property at Completion of Construction Work. To the extent SVH directs Design Builder to sell excess materials or equipment, any amounts realized from the sales will be credited to SVH through the payment application process.

11.3.2 Discounts, Rebates and Refunds. Design Builder will notify SVH of available discounts, rebates and refunds. Cash discounts obtained on payments made by Design Builder will accrue to SVH.

11.4 General Requirements. The General Requirements Spreadsheet must be itemized, detailed, and include the rates being charged to the Project spread over the duration of the Project Schedule. To the extent Design Builder desires to use its own equipment, Design Builder must present rates on a daily, weekly, and monthly basis as well as quotes from vendors to the Construction Manager and Program Manager for review and recommendation to SVH. Design Builder's General Requirements will be included in Exhibit 4D and include the following categories of items.

11.4.1 The cost of Design Builder's field labor employees (e.g. carpenters and laborers maintaining the site).

11.4.2 Costs for computers, copiers, telephones, cell phone charges (which cannot exceed \$125 per month per person), communication radios (direct-connect), digital cameras, postage, office supplies, and equipment. Data processing costs are limited to the cost of personal computer hardware (including servers and printers) used in handling normal day-to-day Project administration, management and control of the Project, internet access. Software license fees incurred specifically for the Project to the extent purchase and previously approved by the Construction Manager and SVH.

11.4.3 Costs for jobsite trailers and field office space.

11.4.4 Costs for temporary utilities for construction operations such as power, water, and sanitary.

11.4.5 Costs for security, fences, and Project signage.

11.4.6 Costs associated with the Design Builder's safety program directly related to the Project, including temporary protection and barricades, first aid supplies, signage, and traffic control, and personal protective equipment required at job site. Design Builder is responsible for acquiring and using the personal protective equipment in an appropriate manner.

11.4.7 Costs, including transportation and storage, installation, maintenance, dismantling, and removal of construction materials, supplies, machinery, equipment, and small tools (not customarily owned by field labor and that cost in excess of \$1,500, that are provided by the Design Builder at the site, and fully consumed in the performance of the Construction Work). If small tools are not fully consumed, the cost less salvage value, whether sold to others or retained by the Design Builder, will be included. Salvage value will be the fair market value.

11.4.8 Rental Charges and Design Builder Owned Equipment. All rental charges for temporary facilities and equipment that are provided at the site, whether rented from the Design Builder or others, including costs for transportation, installation, fuel, lubrication, maintenance, minor repairs and replacements, dismantling, and removal. Approved rates for equipment whether owned by Design Builder or rented are set forth in Exhibit 4D. All approved equipment rates will be no more than those prevailing in the area. The aggregate rental amounts for any one piece of equipment cannot exceed 80% of its fair market value at the time it is placed in service for this Project. All rented equipment will be subject to the equipment rental terms and conditions reviewed by the Construction Manager and Program Manager and approved in advance by SVH.

11.4.9 Costs of removal and disposal of debris from the site, SWPPP, dust control, temporary roads/entrances.

11.4.10 Temporary stairs.

11.4.11 Cost for reproducing or printing documents related to the Work.

11.4.12 Costs for physical models and mock-ups requested and approved, in advance and in writing, by SVH.

11.5 Miscellaneous

11.5.1 Sales, use, or similar taxes imposed by a Governmental Authority that are related to the Work.

11.5.2 Costs for insurance coverage required under this Contract (excludes SVH provided insurance).

11.5.3 Cost of Design Builder's payment and performance bonds required under this Contract without mark-up for Fee. Subcontractor bonds or subcontractor default insurance are not a reimbursable Cost of the Work.

11.5.4 Fees and assessments for plan check, permits, licenses and inspections, and laboratory tests required by the Contract Documents and that are not paid directly by SVH,



except those related to defective or non-conforming Construction Work, or the negligence or fault of the Design Builder, or its Design Professionals or Subcontractors, for which reimbursement is excluded.

11.5.5 Deposits lost for causes other than the Design Builder's negligence or failure to fulfill its responsibility under the Contract Documents

11.5.6 Royalties and license fees paid for the use of a particular process or product required by the Contract Documents and the cost of defending any suits or Claims for infringement of patent rights arising from specific requirements of the Contract Documents that were prepared by SVH or its Separate Consultants or Separate Contractors and provided that Design Builder did not know that the use of the particular design, process, or product was an infringement, and that those portions of the Work were not designed by Design Builder, its Design Professionals, or any of its Design Build Subcontractors.

11.5.7 Costs incurred in taking action to prevent threatened damage, injury, or loss in case of an emergency that threatens the safety of persons or property.

11.5.8 Mileage and transit time, if beyond a 120 mile radius from employee residence or temporary residence to the job site, as well as any motor vehicle expenses, will be reimbursed based upon the GSA vehicle mileage rate in force at the time of travel. Anything below 120 mile radius should be included in billing rates. Reimbursement will be based on actual mileage up to a maximum reimbursable mileage of 200 miles per round trip. Travel time and mileage for travel related to the Project at locations other than the jobsite (e.g. fabricators yard, special inspector's lab, etc.), will be reimbursed at actual time spent and actual mileage per the GSA vehicle mileage rate. Regardless, the maximum reimbursement amount for transit time paid may not exceed 4 hours.

(a) Union employees will be reimbursed per their respective collective bargaining agreement based on their craft. To the extent Design Builder's field labor is non-union, field labor will be reimbursed for actual transit travel time.

(b) Design Builder's and Design Professionals salaried personnel will bill their time based on the number of hours working on the Project and may not bill travel time.

(c) Per diem for Design Builder's and Design Professional personnel as described in subsections (a) and (b) incurred is a lump sum amount of \$50.00 per day provided that the personnel was either physically at the site or in a Project related location, such as a fabrication site, for a minimum of 4 hours in a single day.

11.6 Fee. Design Builder's Fee includes overhead and profit.

11.6.1 Overhead. Overhead includes full compensation for any home office personnel who are not directly assigned to the Project or included in the billable rates; other reasonable home office overhead expenses such as rent, property tax, non-Project related insurance, utilities, office equipment (including software and hardware costs), other IT costs that are not Project-specific, depreciation on assets, employee recruitment and training, general



administrative and payroll costs, business development and marketing, relocation expenses, company vehicles (including company trucks, tool trucks, golf carts, quads, etc.) inclusive of gas and maintenance, employee commute car and truck allowances (inclusive of gas and maintenance), cell phone expenses, postage, severance pay, employee morale programs; and costs of business operations such as small tools or equipment (with purchase price of \$1,500 or less) that is customarily owned by contractors and required for their respective portion of the Construction Work, costs for professional dues, licenses, fees and taxes required by any Governmental Authorities to enable the Design Builder and its Design Professionals and Subcontractors to be qualified to do business and/or perform a portion of the Work.

11.6.2 Profit. Design Builder's profit for the Project, which may include amounts for Design Builder's employee annual bonuses, subcontractor bond costs or subcontractor default insurance (if applicable).

12. PAYMENT

12.1 Payment Applications. Design Builder will prepare and submit certified payment applications for Work performed based on the application for payment form set forth in Tab 2A of the Project Manual. The application for payment will include a Schedule of Values that is based on the line items included in the GMP Summary and Detailed Breakdown (Exhibit 4A). The period covered by each payment application will be one calendar month. The payment will be based on the percentage of Work performed through the payment application date.

12.2 Progress Payments. Payment applications will be submitted by the 25th day of the month for review by Construction Manager and will be evaluated per Section 12.2.1. Design Builder will meet with Construction Manager and Program Manager to resolve any disagreements with respect to amounts requested in the payment application. Upon review and approval, Construction Manager will make a recommendation to SVH for payment. SVH will make monthly progress payments on all undisputed Work within 45 calendar days' receipt of Design Builder's submitted application for payment. Payment of approved amounts will be made directly to Design Builder.

12.2.1 Evaluation. Before submitting the certified application for payment to SVH, Construction Manager will review and make recommendations for payment based on the supporting documentation provided by Design Builder per Section 12.2.5, and Construction Manager's observations and evaluation of the Work. Based on that review, Construction Manager will forward the certified application for payment to SVH for approval with a recommendation that SVH pay all undisputed items. An approval of an application for payment is subject to results of subsequent tests and inspections, to correction of minor deviations from the Contract Documents before Completion of Construction Work and to specific qualifications expressed by the Construction Manager or SVH. Program Manager, Construction Manager, and SVH are entitled to rely on the accuracy and completeness of the information furnished by the Design Builder and approval will not be deemed to represent that a detailed examination, audit, or arithmetic verification of the documentation submitted with the Design Builder's application for payment has been made or that exhaustive or continuous on-site inspections have been made to verify that the Work is in accordance with the Contract Documents. A recommendation for payment by Program Manager or Construction Manager or payment by



SVH does not represent that Program Manager, Construction Manager, or SVH has ascertained how or for what purpose the Design Builder has used money previously paid.

12.2.2 Retention. SVH will withhold 5% retention on the entire amount for the cost of the Construction Work included in each monthly application for payment under Public Contract Code section 22185.7. Retention will be released between 30 and 60 days after the filing of a Notice of Completion with the County Recorder, subject to withholding 150% of disputed amounts per Public Contract Code section 7107, unless SVH, in its sole discretion, agrees to release the Design Builder's retention earlier and provided that the Work has been accepted by SVH, the Program Manager, Construction Manager, IOR, HCAI, and other necessary Governmental Authorities. However, pursuant to Section 22300 of the Public Contract Code, Design Builder has the option to deposit securities with an escrow agent acceptable to SVH in substitution for retention, or for SVH to pay retentions earned directly to the escrow agent, which the Design Builder may elect by providing notice to SVH within 30 days of the Effective Date of the Contract.

12.2.3 Change Orders. Applications for payment may include requests for payment on account of changes in the Work that have been properly authorized.

12.2.4 Stored Materials and Equipment. Stored materials may be included in the application for payment provided the materials or equipment are properly stored in accordance with Section 9.8.3 and Design Builder has provided evidence that the materials are securely stored in the agreed upon location. However, payment for materials and equipment stored off-site will only be made if first approved by Construction Manager and SVH beforehand, and provided that Design Builder provides a complete invoice with a bill of sale, proof of insurance, and photographs as part of the back-up in the application for payment. The bill of sale must include the seller's name and address, the buyer's name and address, a detailed description of the materials or equipment procured, the transaction date, and location of the transaction, the amount the buyer paid and the method of payment, and the signatures of both the buyer and the seller. SVH reserves the right to issue joint checks for procurement of materials and equipment.

12.2.5 Supporting Documents. Each payment application will be accompanied by a monthly progress report per Section 1.10 of the Supplemental Conditions (Exhibit 2) and sufficient documentation supporting the Cost for Work included in the application for payment including, without limitation: (i) proof of compliance with skilled labor and trained workforce requirements and certified payroll compliance; and (ii) executed conditional waiver and release forms complying with California state law covering all Work performed during the billing period by Design Builder, and Design Build Team Members (Project Manual, Tab 2B); and (iv) certification and unconditional waivers and releases evidencing that Design Builder has paid all Design Professionals, Subcontractors, suppliers, and equipment vendors prior amounts due and owing from amounts previously received from SVH and has no knowledge of any recorded stop payment notices with respect to the Work performed, and that all Design Professionals, Subcontractors, suppliers, and equipment vendors will be paid with the proceeds for Work covered under the certified payment application.



12.2.6 No Waiver. Payment by SVH will not constitute approval or acceptance of any Work or amount included in the payment application.

12.3 Right to Withhold. The Construction Manager may refuse to recommend payment, and SVH may refuse to approve a payment application or, because of subsequently discovered evidence or subsequent observations, may nullify the whole or any part of a prior payment application to the extent the Construction Manager or SVH determines is necessary to protect the public agency from loss due to one or more of the conditions listed in Sections 12.3.1 through 12.3.12. When and to the extent the reason for withholding payment no longer applies, the withheld amount will be paid without interest.

12.3.1 Deficient Design Services or nonconforming Construction Work not remedied.

12.3.2 Third-party Claims filed against SVH or the Project or reasonable evidence indicating probable filing of Claims, unless security acceptable to SVH is provided.

12.3.3 Failure of Design Builder to provide supporting documentation as required under Section 12.2.5, or to make timely payments to Design Professionals, Subcontractors, suppliers, and equipment vendors for Design Services, labor, materials, or equipment.

12.3.4 Failure of Design Builder or its Subcontractors to comply with Skilled Work Force Requirements, prevailing wage requirements, and proper submission to the DIR.

12.3.5 Damage to SVH or its Separate Consultants or Separate Contractors if the Design Builder, or any of its Design Build Team Members are potentially liable.

12.3.6 Failure of the Work to progress in accordance with the Project Schedule and reasonable doubt (in SVH's sole discretion) that the Work can be completed within the Contract Time and/or for the remaining balance of the GMP (taking into account any Liquidated Damages under Section 13.7 that would be due and owing from Design Builder as a result of delay).

12.3.7 Failure to comply with scheduling requirements set forth in Article 13 or provide SVH and the Construction Manager with timely monthly progress reports as required under Section 1.10 of the Supplemental Conditions (Exhibit 2).

12.3.8 Failure of the Design Builder to maintain the BIM (if applicable) or update as-built documentation.

12.3.9 Failure of the Design Builder to maintain the Project Schedule or furnish Project Schedule files as required under Section 13.3.

12.3.10 Disputed amounts included in the application for payment or insufficient documentation, erroneous estimates for value of the Work performed, or other incorrect statements in a payment application.

12.3.11 Failure to keep the site premises clean and safe to the satisfaction of the Construction Manager, Program Manager, or SVH.

12.3.12 Failure to carry out the Work in accordance with any term or condition in the Contract Documents.

12.4 No Right to Stop Work. If Design Builder disputes any determination with respect to any payment application, Design Builder must nevertheless expeditiously continue to prosecute the Work, provided that undisputed amounts are timely paid. Design Builder may submit unresolved payment disputes for determination under Article 19.

12.5 Payments to Design Professionals, Subcontractors and Suppliers. Design Builder will make payment to its Design Professionals, Subcontractors and suppliers within 7 business days' receipt of a progress payment from SVH. Final payment will be made within 10 days of receipt of payment from SVH. SVH is not obligated to pay, or to see that payment is made to Design Builder's Design Professionals, Subcontractors and suppliers, except as may otherwise be required by Applicable Law. SVH reserves the right, in its sole discretion, to issue joint checks to Design Professionals, Subcontractors, suppliers or equipment vendors and Design Builder will cooperate with SVH.

12.6 Warranty of Title. Design Builder warrants that title to all Work, materials, and equipment covered by a payment application, whether incorporated into the Project or not, will pass to SVH at the time of payment, free and clear of all stop payment notices, Claims, security interests or encumbrances in favor of Design Builder and its Design Build Team Members, and other persons and entities entitled to make a Claim by reason of having provided Design Services, or labor, materials, or equipment relating to the Construction Work. If Design Builder has received payment for the Work at issue, Design Builder will defend, indemnify, and hold SVH harmless pursuant to Section 15.2.

12.7 Final Payment. Upon Completion of Construction Work, Design Builder will submit a final payment application. The Design Builder will provide the same supporting documentation as required under Section 12.2.5. As a condition precedent to final payment, Design Builder must also provide: (i) an affidavit that payrolls, bills for materials and equipment, and other indebtedness connected with the Work, for which SVH or its property might be responsible or encumbered, have been paid or otherwise satisfied; (ii) proof of completion of all punch-list items; (iii) a certificate evidencing that the insurance required by the Contract Documents to remain in force after final payment is currently in effect and a written statement that the Design Builder knows of no substantial reason that the insurance will not be renewable to cover the period required by the Contract Documents; (iv) consent of surety; (v) delivery and approval by Construction Manager of all as-built Drawings, manufacturer's warranties, Product Data, and maintenance and operations manuals, verified reports, and other close-out deliverable as required by the Contract Documents; and (vi) final conditional waivers and releases of stop payment notice rights. Final payment of all undisputed amounts will be paid no later than 30 calendar days after Completion of Construction Work. All disputed amounts will be subject to the dispute resolution process set forth in Article 19.



12.8 Waiver of Claims. Acceptance of final payment by the Design Builder constitutes a waiver of Claims for payment by Design Builder and its Design Build Team Members except for those previously made in writing and submitted per Article 19, that are identified as unsettled in the final application for payment.

12.9 Audit Rights. In accordance with Government Code Section 8546.7, records of both SVH and the Design Builder will be subject to examination and audit by the State Auditor General for a period of 4 years after final payment. Design Builder will make available to SVH any of the Design Builder's other documents related to the Work immediately upon request of SVH as set forth in Section 12.9.2. Design Builder must maintain all required records for 3 years after final payment is made and all other pending matters are closed.

12.9.1 SVH, and agencies designated by SVH (including the Comptroller General of the United States) may audit Design Builder's Project records at any time throughout the duration of the Project and for a period up to 4 years after Completion of Construction Work upon 10 business days' written notice. The audit will take place during normal business hours and will be coordinated with Design Builder, and the Design Builder will provide access to any books, documents, papers, and records of the Design Builder which are pertinent to the Contract for the purpose of making audits, examinations, excerpts and transcriptions. The Construction Manager, Program Manager, or SVH may also conduct verifications including, but not limited to, counting employees at the Project site, witnessing the distribution of payroll, verifying information and amounts through interviews and written confirmations with employees, and other Design Build Team Members. Should the audit indicate that Design Builder's records were fraudulently or negligently prepared or maintained, SVH reserves the right to seek damages and legal remedies from Design Builder in accordance with Applicable Law.

12.9.2 Availability of Records. Upon notice of audit, Design Builder will produce all Project records related to: (i) establishing the GMP and Project Schedule, as amended; (ii) Costs of the Work and all job-cost reports; (iii) procurement of Design Build Team Members; (iv) payment applications; (v) Change Orders and any back-charges, as well as any Design Build Team Member change orders (inclusive of all back-up); (vi) any Design Professional, Subcontractor, or consultant that are reimbursed on a cost reimbursable basis in accordance with the Cost of the Work; (vii) insurance cost information, as well as any information that Design Builder or other Design Build Team Members provide to SVH, the Program Manager, or Construction Manager for the purpose of confirming the accuracy of such information; and (viii) any other supporting evidence deemed necessary by the Program Manager, Construction Manager or SVH to substantiate charges related to the Work.

12.9.3 Medicare. Upon written request of SVH, the Design Builder and any entity providing Design Services, labor, materials, or equipment to the Project will make available to the Secretary of Health and Human Services or the Comptroller General, or any of their duly authorized representatives, this Contract and all Exhibits, books, documents and records that are necessary to verify the nature and extent of the Cost of the Work for a period of 4 years after Completion of Construction Work when required by Section 952 of the Omnibus Budget Reconciliation Act of 1980. Design Builder will require each Design Build Team Member to comply with this provision regardless of how the party is being compensated.



13. SCHEDULING

13.1 Contract Time. The Contract Time is the time allotted in the Project Schedule (Exhibit 5B), to achieve Substantial Completion of the Work. Design Builder's Project Schedule will be amended in the Contract at the conclusion of the Validation Stage, provided that the GMP and Project Schedule are approved by SVH. Design Builder's Proposed Project Schedule included in Exhibit 5A is an interim schedule that will be used during the Validation Stage until the Project Schedule is amended into the Contract. The Contract Time will only be extended through executed Change Order for a permitted delay per Section 13.4, and the GMP will be adjusted in accordance with the Change Order process under Article 14. The Project Schedule must comply with Section 13.3.

13.2 Commencement and Prosecution of the Work. Design Services and Preconstruction Services to be performed under the Contract Documents will commence upon execution of this Contract. Construction will commence upon a written notice to proceed issued by Construction Manager to the Design Builder. Design Builder will coordinate its Work with other work and services being performed on the Project in a manner that avoids delays, obstructions, hindrances, or any interference with the commencement, progress, or completion of the whole or any part of the Work, and in accordance with the Contract Time set forth in the Project Schedule.

13.3 Project Schedule. Design Builder's approved critical path method Project Schedule will be amended into the Contract as Exhibit 5B. Design Builder will utilize the current version of Primavera project planning software to produce the critical path method schedule. The Project Schedule will serve as the baseline schedule and establish the Contract Time. The Project Schedule coordinates and integrates all Design Services with milestone dates for completion of the Schematic Design Documents, Design Development Documents, and Construction Documents, submittal deadlines, including those associated with California Administrative Code, Title 24 for Hospital Buildings, procurement of long lead items and subcontracts, permit, commencement of Construction Work, as well as commissioning, punch-list, Substantial Completion, Completion of Construction Work, as well as any other milestone dates, including a projection for Final Completion. The Project Schedule will be broken down by phase, activity and duration and will be used to identify the sequence of activities and to track time and manpower for those activities in order to plan, organize, execute, and monitor the Work. The Project Schedule will be Design Builder's master schedule and will be used to record and report actual performance and progress, and to outline how the Design Builder plans to integrate design and construction in order to ensure accurate and timely completion of all Work. However, day-to-day activities will be planned using work plans as described in Section 13.3.1. The Project Schedule must include sufficient time for design review and approval of Submittals as required under Article 3 of the Supplemental Conditions (Exhibit 2), and should include the number of Adverse Weather days per year as defined in Exhibit 1. The Project will own all Float and unused Adverse Weather days in the Project Schedule. Design Builder will not utilize Float suppression techniques or artificial restraints, constraints, lags or durations to lessen or control the amount of total or free Float contained in the network. All coding included in the Project Schedule must be transferrable and readable by the Construction Manager, and code structure will enable a sort by activity code in the form of a summary schedule. The Design Builder is responsible for coordinating with its Design Build Team Members, and SVH's



Separate Contractors and Separate Consultants with respect to all scheduling activities and reporting of delays. However, Design Builder is not responsible for delays caused by Separate Contractors or Separate Consultants. Design Builder will provide Project Schedule updates with its monthly progress report per Section 1.10.2 of the Supplemental Conditions (Exhibit 2). Upon request by SVH or the Construction Manager, Design Builder will produce electronic copies of its Project Schedule (inclusive of updates).

13.3.1 Work Plans. Design Builder in collaboration with the Design Build Team and Construction Manager will establish work plans that include upcoming performance requirements. The work plan schedules will document all Work performed during the prior week's period and project Work to be performed during the upcoming week(s) (3-week periods). The work plans are to be used as a working tool to reflect commitments made in look ahead meetings, evaluate any upcoming constraints or schedule slippages, identify workable backlog, and collaborate on methods for labor efficiency. Work flow will be scheduled to optimize the flow of Work through the Project and reduce bottlenecks and activities that will not advance the Contract Time or other milestone dates that are included in the Project Schedule.

13.3.2 Record Schedule. Design Builder will prepare and update the record schedule from the commitment based pull schedules throughout the duration of the Project. The updated Record Schedule will document the as-built schedule and provide an accurate accounting of when the Work was performed, if there were revisions to the Project Schedule, and why such revisions were made. Design Builder will maintain and update the record schedule weekly.

13.4 Permitted Delays. If the Design Builder is delayed in the commencement, prosecution or completion of the Work by the acts or omissions of SVH, its Separate Consultants or Separate Contractors or for one of the conditions set forth in Section 14.2 and, as a direct result of the delay, the Substantial Completion Date is extended, then the Contract Time may be extended for the same period of time that the Substantial Completion Date was delayed less the duration, if any, for delays caused by the fault, or neglect, act or, omission of the Design Builder or any of its Design Build Team Members, and their respective employees ("concurrent delays"). If the Contract Time is extended, the GMP and Contract Time will be adjusted per Article 14. However, no adjustments to Contract Time or GMP will be allowed unless written notice was provided to SVH and the Construction Manager within 5 business days of commencement of the delay. The notice must briefly describe the circumstance and provide a rough estimate of the delay time per Section 14.3. Before any adjustments in Contract Time or GMP, Design Builder must demonstrate the duration of the delay through fragnet analysis after taking into account any concurrent delays, and show that the delay could not have been anticipated or avoided and that commercially available means were taken to mitigate or minimize the consequences of the delay. Delays will be measured from the effective Project Schedule in place at the time of delay. Delays of non-critical path Work will not be a basis for an extension of Contract Time or any additional compensation.

13.5 Schedule Slippage. Design Builder will notify the Construction Manager in writing with a copy to SVH's authorized representative and Program Manager within 5 days of any delay in the Project Schedule as a result of its Work and must submit a detailed recovery plan to Construction Manager for evaluation and SVH's approval. The detailed recovery plan



must be submitted within 5 days of the notice (so within 10 days from date of delay). All costs associated with the recovery will be the responsibility of the Design Builder unless the Design Builder is entitled to an extension of time under Section 13.4.

13.6 Acceleration. SVH may direct the Design Builder and its Subcontractors and Design Professionals to work overtime. If Design Builder and its Subcontractors and Design Professionals are not in default under any of the terms or provisions of this Contract, their respective subcontracts and/or agreements, or any of the other Contract Documents, SVH will pay the Design Builder for the premium portion of actual wages, and billable rates paid, if any. All overtime wages and billable rates for acceleration are subject to audit.

13.7 Liquidated Damages. The Parties acknowledge and agree that if Design Builder fails to achieve Completion of Construction Work within the Contract Time, SVH will suffer damages that are both extremely difficult and impracticable to ascertain. Therefore, SVH and Design Builder agree that, in the event Design Builder fails to achieve Completion of Construction Work within the Contract Time and if as a result of that delay the date for Completion of Construction Work is extended, Design Builder will pay to SVH as liquidated damages, and not as a penalty, the applicable amount set forth in the Business Terms Sheet until such time that Completion of Construction Work is achieved. Payment of the Liquidated Damages represents a reasonable estimate of fair compensation for losses due to delay that reasonably may be anticipated. The Parties acknowledge and agree that this liquidated damages provision will be SVH's only remedy for delay damages caused by Design Builder's failure to achieve Completion of Construction Work within the Contract Time. However, nothing contained in this Section 13.7 will preclude SVH from recovery for actual damages caused by reasons other than Design Builder's failure to timely achieve Completion of Construction Work within the Contract Time including claims for actual losses incurred due to breach of contract, negligence, errors or omissions in the Design Services, defective Construction Work, injury to persons or property, or third party claims. Design Builder acknowledges and agrees that the Liquidated Damages amount is a reasonable amount for SVH's consequential damages due to delay under the circumstances and existing as of the Effective Date of this Contract.

14. CHANGES

14.1 General. Changes in the Work will only be authorized by a minor change in the Work per Section 14.6, a Construction Change Directive ("CCD") issued per Section 14.5, or executed Change Order, and must be performed under the applicable conditions of the Contract Documents. A Change Order is a mutually agreed written order adjusting the GMP, Contract Time, or both. In order to be properly executed, Change Orders must be signed by SVH and Design Builder. An executed Change Order fully and completely resolves any Claim by Design Builder and its Design Build Team Members for additional compensation or time arising from or related to the subject of the Change Order. Timely submission of a Change Order Request ("COR") per this Article 14 is a condition precedent to Design Builder's and any of its Design Build Team Members' ability to recover for a changed condition.

14.2 Conditions for Change. Change Orders are limited to the following circumstances:



14.2.1 SVH Elected Change.

14.2.2 SVH Caused Delay.

14.2.3 Pre-Permit Change by Governmental Authorities.

14.2.4 Post Permit Change by Governmental Authorities.

14.2.5 Reconciliation of Allowance items per Section 14.10.

14.2.6 Suspension of the Work by SVH under Section 20.1.

14.2.7 Acceleration of the Project Schedule per Section 13.6.

14.2.8 An executed CCD after reconciliation of the Cost of the Work per Section 14.5.

14.2.9 Change in Applicable Law that modifies taxes and fees identified in Section 6.6.

14.2.10 Adverse Weather.

14.2.11 Force Majeure Event.

14.2.12 Unforeseen and Differing Site Conditions.

14.2.1 Unusual Labor Escalation per Section 14.11.

14.2.2 Unusual Material Escalation per Section 14.12.

14.2.3 Cost neutral Change Orders for use of contingency, line item transfers, scope swaps, etc.

14.3 Change Order Requests ("CORs"). Design Builder will submit a rough order of magnitude of the change to Construction Manager within 5 business days' receipt of the scope of a COR or discovery of facts or circumstances giving rise to a COR. Design Builder will submit a complete cost proposal, including any change in Contract Time under Section 13.4, within an additional 5 business days unless a longer period of time is needed due to design revisions arising from an SVH Elected Change or for other reasons agreed to by the Design Builder and Construction Manager in writing. All CORs must be presented to the Construction Manager with a copy to SVH's authorized representative. Either a Change Order or CCD must be executed before the expense is incurred.

14.4 Review. Construction Manager will review the COR with SVH's authorized representative within 10 business days of receipt and may request additional information and back up from the Design Builder or make recommendations to SVH for approval or denial. If SVH denies the COR, it will provide Design Builder with a written explanation. If the COR is neither accepted nor denied within the 10 business day period, it will be deemed denied by SVH



unless written notice is provided to the Design Builder that the time for review is being extended. If written notice is provided, the notice will expressly state the date by which the review will be completed. All decisions rendered by SVH will be final and binding unless a formal Claim is timely noticed per the dispute resolution procedures in Article 19.

14.5 Construction Change Directives ("CCD"). A CCD may or may not constitute a changed condition as defined under Section 14.2, and may be issued by the Construction Manager when Work must proceed before the COR can be either submitted or approved. The CCD must indicate whether the Construction Manager believes the condition constitutes a change. If the Construction Manager believes that the CCD constitutes a changed condition, the CCD must either include an estimated lump sum amount for the change or an estimate for the Cost of the Work associated with changed condition with a not-to-exceed amount, and an estimate for the number days of adjustment to the Contract Time (if applicable), subject to the conditions set forth in Section 13.4. CCDs must be signed by the Construction Manager, SVH's authorized representative, and Design Builder in order to be valid. Design Builder cannot exceed the estimated lump sum or not-to-exceed adjustment for the Cost of the Work or the estimated number of days' extension of time without providing written notice to the Construction Manager requesting further approval from SVH, or submission of COR per Section 14.3. If a CCD states that it does not constitute a changed condition and Design Builder disagrees, the Design Builder must notify the Construction Manager and submit a COR per Section 14.3. Regardless of whether a CCD is issued, failure to provide a COR as required by Section 14.3 constitutes a waiver of Claim.

14.6 Minor Changes in the Work. The Program Manager or Construction Manager may order minor changes in the Work provided such changes do not impact the GMP or Contract Time and are consistent with the Construction Documents. Minor changes will be implemented through a CCD per Section 14.5.

14.7 Pricing Methods. Methods used for determining adjustments to the GMP include: (i) mutual acceptance of a lump sum amount properly itemized for labor, services, materials, equipment, and mark-up for insurance, bond, and Fee supported by sufficient substantiating data (such as receipts, purchase orders, contracts, time reports, and other documentation reasonably required by the Construction Manager or SVH) to permit evaluation of the Cost of the Work; or (ii) on a time and material basis based on actual Cost of the Work plus Fee. Under either pricing method, Work must be broken down by Design Services (§10.3.1), Preconstruction Services (§10.3.2) Direct Costs for Construction Work (trade costs) (§10.3.4, and Indirect Costs such as additional General Conditions (§10.3.5(a)) and General Requirements (§ 10.3.5(b)), insurance and bond (§ 10.3.5(d)), and Fee (§ 10.3.5(e)), if applicable. Note that there will not be Fee mark-up on the additional bond costs. If Work is performed on a time and material basis, Design Builder will keep and present an itemized accounting for the Cost of the Work based on detailed invoices for Design Services, Preconstruction Services, and daily time tickets executed by the Construction Manager for Construction Work, material and equipment invoices, and other supporting data (such as receipts, purchase orders, contracts, time reports, and other documentation reasonably required by the Construction Manager or SVH) substantiating the amount of the Change Order.



14.7.1 Design Professional and Subcontractor Adjustments. Design Professionals overhead and profit is included in their respective billing rates set forth in Exhibit 4C. Subcontractor adjustments for Change Orders are limited to the Cost of the Work multiplied by overhead and profit as determined by subcontract. All Subcontractor field labor rates for straight time, over time, and double time must specifically be set forth in their respective subcontract. Under no circumstances will Subcontractor overhead and profit on changes exceed 15% for self-performed portions of the Work plus 5% if Subcontractor has tiers (combined overhead and profit cannot exceed 15%).

14.7.2 Average Daily Rate for Delay. If the Contract is extended per Section 13.4 during the Construction Stage, the Average Daily Rate set forth in the Business Terms Sheet will be used to cover costs for additional General Conditions and General Requirements. If the change condition includes an extension of Contract Time, Design Builder will be entitled to additional General Conditions as described in Section 11.2.2 and General Requirements as described in Section 11.4 per the Average Daily Rate set forth in the Business Terms Sheet multiplied by the number of work days of extension in the Contract Time. Note that additional General Conditions and General Requirements are not allowed unless the Contract Time is impacted by one of the changed conditions set forth in Section 14.2. The Average Daily Rate will not be used for deductive Change Orders unless there is a scope reduction that also reduces the Contract Time. The Average Daily Rate does not provide compensation for time impacts to other Design Build Team Members. Note that additional General Conditions will not be allowed unless there is an extension in Contract Time.

(a) To the extent the Contract Time is extended during the Design / Preconstruction Stage as a result of one of the conditions set forth in Section 14.2, compensation will be per the billable rates in Exhibit 4C for Design Services and Preconstruction Services multiplied by the actual time spent performing the Work during the period of the delay.

14.7.3 Payment and Performance Bond. Mark up for Design Builder's payment and performance bond will be based on the percentages set forth in the Business Terms Sheet multiplied by the cumulative sum of the additive or deductive cost of the Construction Work as defined in Sections 10.3.4 and 10.3.5. Bond mark-up is not taken on top of Design Services or Preconstruction Services included in a Change Order.

14.7.4 Insurance. Mark up for Design Builder's insurance will be based on the percentage set forth in the Business Terms Sheet multiplied by the cumulative additive or deductive sum of the Costs of the Work as defined in Article 11.

14.7.5 Fee. Design Builder's Change Order mark-up for Fee as described in Section 11.6 is the percentage set forth in the Business Terms Sheet. The Change Order percentage for mark-up for Fee is multiplied by the cumulative additive or deductive sum of the Cost of the Work as defined in Article 11.

14.8 Deductive Change Orders. The amount of credit for deductive Change Orders will be the net decrease in the Cost of the Work plus Design Builder's Fee. The amount of credit will be determined based on one of the pricing methods set forth in Section 14.7 and

subject to the terms and conditions set forth in Sections 14.7.1 through 14.7.4. When both additions and credits covering related Work are involved in a proposed change, the Change Order will be determined based on the net increase or decrease.

14.9 Contract Time. Design Builder will only be entitled to an extension of time and additional compensation for General Conditions and General Requirements if the Contract Time is extended due to a permitted delay under Section 13.4 and after evaluation of the fragnet analysis as required under Section 13.4. Calculation for additional General Conditions and General Requirements will be calculated by multiplying the Average Daily Rate per Section 14.7.1. Design Builder does not reserve a right to assert any delays in the Contract Time, cumulative impact costs, extended job site costs, extended overhead, constructive acceleration, and/or actual acceleration beyond what is allowable under Section 13.4 and timely claimed in a COR.

14.10 Allowances. To the extent Allowances are required, they will be reconciled through written Change Order upon procurement of the portion of the Construction Work identified as an Allowance in GMP Summary and Detailed Breakdown (Exhibit 4A). If the Cost of the Work exceeds the amount carried in the Allowance item, an additive Change Order will be issued increasing the GMP for the overage. If the Cost of the Work is less than the amount carried in the Allowance item, a deductive Change Order will be issued per Section 14.8, decreasing the GMP, and 100% of all unused funds will accrue to SVH.

14.11 Unusual Labor Escalation. Design Builder has included a Labor Escalation Allowance in the GMP for escalation of field labor performing Construction Work per Section 10.3.4(a). The Labor Escalation Allowance will be reconciled during the last 6 months of construction through the COR process. Unusual Labor Escalation change requests must be completely transparent and Design Builder must provide reasonable data based on the field labor amounts provided by its Subcontractors as well as amounts carried for Design Builder's field labor at the time of GMP. Failure to submit the required information to substantiate the claim will be grounds for denial. If the Cost of the Work for field labor exceeds the Labor Escalation Allowance, an additive Change Order will be issued increasing the GMP by the amount of the overage. If the Cost of the Work for field labor is less than the amount carried in the Labor Escalation Allowance, a deductive Change Order will be issued per Section 14.8, decreasing the GMP, and 100% of all unused funds will accrue to SVH. Change Orders for Unusual Labor Escalation are Fee neutral so Subcontractor overhead and profit mark-up is not allowed, and Design Builder mark-up for Fee is not allowed. The other terms in Sections 14.7.3 and 14.7.3 regarding bond and insurance are applicable. To the extent, there is a deductive Change Order, the amounts for bonds, insurance and Fee will be reduced based on the percentages set forth in the Business Terms Sheet.

14.12 Unusual Material Escalation. Upon completion of Subcontractor buy-out, the Material Escalation Allowance will be reconciled per Section 10.3.4(b) and all unused amounts will accrue to SVH. To the extent the Material Escalation Allowance is used during the buy-out, those amounts will be transferred into the appropriate line item through a cost neutral Change Order per Section 14.2.3 for transparency. Change Order adjustments for Unusual Material Escalation are subject to the requirements in Section 10.3.4(b) and will be completely transparent. Failure to submit the required information as required under Section 10.3.4(b) to



substantiate the Claim will be grounds for denial. If the Cost of the Work for materials or equipment exceed the amount carried in the Material Escalation Allowance, an additive Change Order will be issued increasing the GMP by the amount of the overage. If the Cost of the Work for material or equipment is less than the amount carried in the Material Escalation Allowance, a deductive Change Order will be issued per Section 14.8, decreasing the GMP, and 100% of all unused funds will accrue to SVH. Additive Change Orders for Unusual Material Escalation are Fee neutral so Subcontractor overhead and profit mark-up is not allowed, and Design Builder mark-up for Fee is not allowed. The other terms in Sections 14.7.3 and 14.7.3 regarding bond and insurance are applicable. To the extent, there is a deductive Change Order, the amounts for bonds, insurance and Fee will be reduced based on the percentages set forth in the Business Terms Sheet.

14.13 Disputes and Continued Performance. Disputes regarding Change Orders will be resolved in accordance with Article 19. Failure to promptly execute Work that has been authorized through either an executed Change Order, or as directed by SVH or the Construction Manager through a CCD will constitute a material breach of contract.

14.14 Omitted Work. If Design Builder omits Work that is included in the Contract Documents, SVH will have the right to withhold payment in an amount which, in the Construction Manager's or SVH's opinion, is equal to the value of Work that was omitted until the Work is performed.

14.15 Surety. All changes, additions, or omissions in the Work ordered through a CCD or Change Order are part of the Work and will be performed and furnished in strict accordance with all of the terms and provisions of the Contract Documents. Design Builder will keep its surety informed of all modifications to this Contract. The obligations of Design Builder's surety are not to be reduced, waived, or adversely affected by the issuance of Change Orders even if the Design Builder fails to inform the surety of the Change Order(s), and SVH will not be required to obtain consent of the surety.

15. LIABILITY, DEFENSE, AND INDEMNIFICATION

15.1 Negligent Design. Design Builder is liable for all damages to the extent proximately caused by design errors and omissions that do not meet the standard of care and will be liable to the same extent for any bodily injury or physical property damage caused by the defect(s). Design Builder and its DPORs will correct deficiencies in the design development or Construction Documents without charge to SVH. If correction in the Construction Documents are performed after the Construction Work is completed, the statute of limitations for causes of action arising out of negligent Design Services will recommence upon completion of the corrective Design Services but only for that portion of the Work required to correct the negligent design errors or omissions. Correction for deficient Design Services will not limit any other legal remedies that may be available to SVH to recover damages arising out of, or resulting from deficient Design Services.

15.2 Indemnification. To the fullest extent permitted by law, Design Builder will defend (with counsel acceptable to SVH), indemnify and hold SVH and the Indemnitees (as defined in Exhibit 1) harmless from and against any and all Claims, demands, causes of action,



damages, costs, expenses (including legal, expert witness, and consulting fees and costs), losses or liabilities, in law or equity, arising out of, or resulting from, negligent acts or omissions in the performance of the Work by the Design Builder, its employees, Design Professionals, Subcontractors, suppliers, equipment vendors, or anyone for whom any of them may be liable. The indemnification obligations set forth in this Section will not be limited in any way by the amount or type of damages, compensation, or benefits payable by or for Design Builder under the workers' compensation acts, disability benefit acts, or other employee benefit acts. Design Builder's indemnification and defense obligations will survive termination of the Contract and include, but are not limited to, the following types of Claims:

15.2.1 Personal Injury and Property Damage. Personal injury, including bodily injury, sickness or disease, or death to any persons, employees, or agents of Indemnitees or any third parties and/or damage to tangible property of anyone (other than the Construction Work itself and including loss of use) caused or alleged to be caused by strict liability or any actual or alleged negligent act or omission of the Design Builder, its Design Build Team Members, or anyone directly or indirectly employed by any of them for whose acts Design Builder may be liable except to the extent that the personal injury or property damage is caused by the active negligence or willful misconduct of any of the Indemnitees.

15.2.2 Breach of Contract. Breach of any material term or condition of the Contract Documents that causes damage, cost, or expense to SVH.

15.2.3 Violations of the Law. Penalties, fees, and costs imposed on account of the violation of any Applicable Law and caused by the act or omission of the Design Builder, its Design Build Team Members, or anyone directly or indirectly employed by any of them for whose acts they may be liable.

15.2.4 Safety. Bodily injury, sickness, disease, death, injury, or tangible property damage (other than to the Construction Work itself) caused, in whole or in part, from actual or alleged failure to train, initiate, maintain, or supervise safety precautions and programs in connection with the Construction Work.

15.2.5 Infringement of Intellectual Property. Infringement of any intellectual property right including patents, copyrights, or license, which may be brought against Indemnitees as a result of the Work.

15.2.6 Stop Payment Notice. Stop payment notice Claims for Work performed on the Project, including incidental or consequential damages suffered by SVH as a result of the Claim, and provided SVH has paid Design Builder for the portion of the Work at issue.

15.2.7 Insurance. Failure of Design Builder or any its Design Build Team Members to comply with the insurance requirements under this Contract and Exhibit 6A.

15.2.8 Hazardous Materials. Claims, liability, or damages arising out of, or resulting from, Design Builder's or any of its Design Build Team Member's negligent acts or omissions: (i) in the safe removal, disposal, abatement or remediation of the pre-existing Hazardous Materials, and for the clean-up, transport and disposal of those pre-existing



Hazardous Materials in accordance with Applicable Law; or (ii) that cause or permit any Hazardous Materials to be generated, released, disposed, discharged, exacerbated, or brought onto, or stored at, the Project site or used in the Work unless specified, and only if there is not a reasonable substitute for the specified material.

15.3 Duty to Defend. Design Builder will immediately upon tender defend all Claims (with counsel acceptable to SVH) as defined in Exhibit 1 and Section 15.2 at its own cost and expense and satisfy any judgment or decree that may be rendered against any Indemnatee arising out of a Claim, and reimburse Indemnatee(s) for any and all attorney's, expert witness, and consulting fees and expenses incurred in connection with the Claim or in enforcing the indemnity and defense granted by Sections 15.2 and 15.3.

15.4 Stop Payment Notice Free Obligation. If any Design Build Team Members serve, or maintains any action on or respecting, a Claim of stop payment notice relating to the Work, Design Builder will immediately procure, furnish, and record appropriate statutory release bonds that extinguish or expunge the stop payment notice provided that SVH has paid the Design Builder for that portion of the Work. If Design Builder does not timely pay its Design Build Team Members as required, then SVH may notify Design Builder's surety, settle or bond over those Claims, or take other actions necessary to prevent a default under any other agreement affecting the Project, and SVH will withhold payment to Design Builder or demand reimbursement for any substantiated amounts that were necessary to satisfy Design Builder's obligation to satisfy, discharge, or defend against the Claim. Nothing contained in this Section requires the Design Builder to provide release bonds for any valid stop payment notice or other Claim due to SVH's non-payment or a valid dispute between SVH and Design Builder.

15.5 Enforcement. Nothing contained in this Article 15 will be construed to impose any obligation in conflict with current California state law. In the event of a conflict with Civil Code section 2782, et seq., as may be amended, this Contract will be modified to allow indemnification and defense by Design Builder to the greatest extent permitted by law.

15.6 SVH's Indemnification. SVH will defend and indemnify and hold the Design Builder, and its Design Build Team Members harmless from claims or liability, including future exposure claims made by third parties, arising out of, or resulting from Hazardous Materials brought onto the site by SVH's Separate Contractors, Separate Consultants, or anyone directly or indirectly employed by any of them but only to the extent that liability did not arise from any negligent acts, errors, or omissions of, exacerbation of, or Work performed by, Design Builder, a Design Build Team Member, or their respective employees or anyone directly or indirectly employed by any of them for whom they may be liable. SVH does not owe a duty of defense and indemnification to Design Builder for the remediation and removal of pre-existing Hazardous Materials, which is included in Design Builder's Work.

16. INSURANCE AND BONDING

16.1 Design Builder's Required Insurance. Design Builder will carry the insurance required in Exhibit 6A. Design Builder will require through written agreement that its Design Professionals carry insurance per the Business Terms Sheet and in accordance with Exhibit 6A, and that Subcontractors carry similar types of insurance coverage as Design Builder at



appropriate limits for their portion of the Work, as submitted and approved by the Construction Manager. Proof of appropriate insurance, including endorsements of additional insureds for all separate policies, except for workers compensation and professional liability policies, must be submitted to the Construction Manager before commencement of the Work. Design Builder and its Design Professionals and Subcontractors will provide additional insured as required under Exhibit 6A, except for workers compensation and professional liability policies. Notwithstanding the above, SVH expressly reserves the right to consider, in its sole discretion, wrap insurance programs through an owner controlled insurance program or contractor controlled insurance program in lieu of the individual Design Build Team Members carrying separate insurance. As with all wrap programs certain insurance coverages will still need to be maintained by Design Build Team Members. If it is determined that a wrap program is in the best interest of the Project, the insurance provisions will be amended through Amendment, at the conclusion of the Validation Stage and with submission of the GMP and Project Schedule.

16.2 SVH Required Insurance. SVH will carry the insurance required in Exhibit 6C.

16.3 Payment and Performance Bond. Design Builder will execute and furnish to SVH a payment and performance bond for one hundred percent (100%) of the cost of the Construction Work in accordance with Public Contract Code section 22185.4, before commencement of the Construction Stage. The bonds will be in accordance with the forms set forth in Exhibit 6B, and will be amended into this Contract before construction commences. The surety providing the payment and performance bonds must be an admitted surety insurer, as defined in Code of Civil Procedure section 995.120, authorized to do business in the State of California, and named on the current list of "Surety Companies Acceptable on Federal Bonds" as published by the Treasury Department Circular Number 570. Failure to provide the required payment and performance bonds will constitute a default under the Contract. The cost of the bonds will be included in the GMP. All changes, additions, or omissions in the Construction Work ordered through a Change Order under Article 14 are part of the Construction Work and will be performed and furnished in strict accordance with all of the terms and provisions of the executed Change Order and other Contract Documents. Design Builder will keep its surety informed of all modifications to this Contract. The obligations of Design Builder's surety are not to be reduced, waived, or adversely affected by the issuance of Change Orders even if Design Builder fails to inform the surety of the Change Order(s), and SVH will not be required to obtain consent of the surety on behalf of Design Builder. Bonds must remain in place until all disputes are resolved between the Parties and through the Design Builder's warranty period, whichever is later.

16.4 Payment of Subcontractors and Suppliers. Without limiting the responsibilities of Design Builder and its surety under the terms of this Contract, Design Builder and its surety agree to promptly pay all lawful claims of Subcontractors, materialmen, laborers, persons, firms or corporations for labor or services performed or materials, supplies, machinery equipment, rentals, fuels, oils, tools, appliances, insurance and other items furnished, used, or consumed in connection with the prosecution of the Construction Work including Change Orders, and will indemnify and hold harmless SVH from and against all liability loss, damage and expense, including interest, costs, attorneys' fees, and expert witness fees, which SVH, the Program Manager, or Construction Manager may sustain by reason of Design Builder's or its surety's failure to do so.



17. WARRANTY

17.1 Warranty and Correction of Work. Design Builder warrants that the Construction Work will be of good quality, free from defects, and conforming to the Construction Documents, applicable building codes, and Applicable Law. For a period of 1 year commencing from the Substantial Completion Date, and for longer periods specified in the Contract Documents for certain equipment manufacturers or suppliers, Design Builder will repair or replace at its own expense any and all deficient or defective Construction Work together with any other work that is damaged during repair or replacement. If SVH's operations or use are impaired by the nonconforming Construction Work or its correction, Design Builder and its Subcontractors will use off-hours labor and timesaving procedures as SVH may request. The warranty excludes improper or insufficient maintenance, improper operation, normal wear and tear, and normal usage. Design Builder will procure Subcontractors' and manufacturers' express warranties required under the Contract Documents on SVH's behalf and will transmit the warranties to SVH through the Construction Manager before Completion of Construction Work and Project close-out. Establishment of the 1 year express warranty period for correction of Construction Work relates only to the Design Builder and its Subcontractors, suppliers, and equipment vendors specific obligation to correct defective or non-conforming Construction Work, and has no relationship to statute of limitations periods for legal claims arising from the Contract Documents. All warranties for workmanship must be submitted and approved by Construction Manager. The performance bond must remain in full force and effect throughout the warranty period (see Section 16.3).

18. OWNERSHIP OF DOCUMENTS

18.1 Design Documents. The Design Documents as defined in Exhibit 1 are being developed and furnished for use solely with respect to this Project. As such, provided that SVH has complied with the payment provisions set forth in Article 12, SVH will own and have all rights, title, and interests under Applicable Law in the Project's overall design, including the Design Documents. Design Builder and its DPORs will not own or claim a copyright in the Design Documents prepared for the Project, and may not use such documents on other projects outside the scope of the Work without written consent of SVH. Design Builder and its DPORs may each retain a record set of each of the approved Design Documents for the purpose of defense of any subsequent Claims or disputes involving the Project.

18.2 Building Information Model. If BIM is utilized on the Project, the BIM and subsidiary models used for design and construction are the property of SVH. Design Builder and its other Design Build Team Members agree to provide the Construction Manager, as a deliverable before Completion of Construction Work, the record BIM and any other BIM files that Construction Manager deems necessary. Despite the above, design elements that were created by any Design Build Team Member, before execution of this Contract, as extensions to commercially available BIM software will remain the property of the respective party that created the extension, regardless of whether it was used in the BIM for Work performed under this Contract, and SVH will hold a perpetual, non-exclusive, royalty-free license to those design elements for purposes of designing, constructing, renovating, operating, and maintaining the Project for which the BIM was created.



18.3 Licensing. The Design Build Team Members are each granted a limited, non-exclusive, royalty-free license to use and reproduce applicable portions of the Design Documents and other documents prepared for use in the performance of the Work.

18.4 Copies. All copies made under the license will bear the statutory copyright notice of SVH shown on the Construction Documents as well as any other Design Documents prepared by the Design Builder, or its DPORs. Submittal or distribution to meet official regulatory requirements or for other purposes in connection with a Project will not be construed as publication in derogation of SVH's copyright or other reserved rights and interests.

18.5 Exception. Nothing contained in Article 18 limits the ownership, rights, title, and interest of the Design Builder, or its DPOR to their respective general design details, layouts, and general concepts that each of them uses or has used on multiple projects, or to use new standard design details that were developed during design under this Contract on other projects.

18.6 Termination. Termination of the Design Builder or other member of the Design Build Team does not affect the rights of SVH under this Article 18. If Design Builder is terminated before the Design Services are completed, SVH will either: (i) take assignment of the DPORs; or (ii) hire another design professional of record who will over-stamp the Design Documents and become the architect or engineer of record (as applicable). To the extent either should occur, all parties involved in the assignment or transition of the Design Documents will cooperate with SVH, and SVH will release, indemnify, and defend the terminated parties (as applicable) from liability arising from SVH's further use of the Design Documents through new design professionals.

19. CLAIMS AND DISPUTES

19.1 Disputes. Disputes, Claims, or other matters in question between the Design Builder and SVH arising out of the Contract Documents, including breach of contract, will be subject to Public Contract Code sections 9204 and 20104-20104.6. Notice of Claim must be in compliance with Section 21.5, as well as any statutory requirements, and compliance with all Change Order procedures is a condition precedent to filing a Public Contract Code Claim pursuant to this Article 19. Any Claim submitted by Design Builder will be in writing and include the documents necessary to substantiate the Claim. All Claims must be submitted by certified mail with return receipt requested to SVH's authorized representative, with a copy to the Program Manager and Construction Manager. Failure to timely or properly submit a Claim per this Article 17 will be deemed a waiver of all right to do so.

19.2 Required Documentation. Design Builder's reasonable documentation in support of the Claim must, at a minimum include: (i) a clear, concise recital of the basis of the Claim asserted, including a designation of the provisions of the Contract Documents upon which the Claim is based; (ii) a statement as to the amount of time and/or compensation sought pursuant to the Claim; (iii) a statement regarding whether the Claim arises from an ongoing occurrence, and if so a description of the specific Work activities affected by the Claim; (iv) a fragnet analysis as required under Article 13 if Design Builder is requesting an extension in the Contract Time; (v) full and complete cost records supporting the amount of any Claim for



additional compensation; (vi) a notarized certification by the Design Builder and each Design Build Team Member included in the Claim as follows: "Under the penalty of law for perjury or falsification and with specific reference to the California False Claims Act, Government Code Section 12650 et seq., the undersigned hereby certifies that the information contained herein is a true, accurate, and complete statement of all features relating to the Claim asserted." Failure by the Design Builder and the Design Build Team Members included in the Claim to provide sufficient documentation and the notarized certification will result in denial of the Claim. SVH reserves the right to request additional documentation, or clarification of the documentation provided.

19.3 SVH's Response. Upon receipt of a Claim, SVH will conduct a reasonable review and provide a written statement to the Design Builder identifying what portion of the Claim is disputed and what portion is undisputed within 45 days of receipt of the Claim. SVH and Design Builder may, by mutual agreement, extend the 45 day time period. For any undisputed portion of a Claim, SVH will make payment within 60 days of SVH issuance of the written statement. Failure of SVH to respond to a Claim from Design Builder within the time periods described in this Section will result in the Claim being deemed rejected in its entirety.

19.4 Dispute SVH's Response; ; Informal Conference; Mediation; Section 910 Claim.. If Design Builder disputes SVH's response, or if SVH fails to respond within the time prescribed, Design Builder may demand an informal conference to meet and confer for settlement of the issues in dispute within 30 days of SVH's response or failure to respond. Within 10 business days following the meet and confer conference, SVH will provide a written statement identifying the portion of the Claim that remains in dispute. Any payment due on an undisputed portion of the Claim will be made within 60 days of the meet and confer conference. In the event that the meet and confer conference is unsuccessful, the matter will be submitted to nonbinding mediation within 60 days unless the Parties mutually agree to a later date, or agree to waive, in writing, mediation and proceed directly to litigation.

19.4.1 Failure of SVH to respond to a Claim within the time periods described above will result in the Claim being deemed rejected in its entirety. Unpaid valid Claim amounts not paid in a timely manner will bear interest at 7 percent per year.

19.4.2 If mediation is unsuccessful or if the Parties decide to proceed directly to litigation, Design Builder must file a government claim pursuant to Government Code section 910 et seq. in order to initiate a civil action.

19.5 Mediation. Unless the Parties mutually agree to waive mediation and proceed straight to litigation, the Parties will mutually agree to a mediator within 10 business days after the disputed portion of the Claim has been identified in writing. If the Parties cannot agree upon a mediator, each Party will select a mediator and those mediators will select a qualified neutral third party to mediate with regard to the disputed portion of the Claim. Each party participating in the mediation will equally share in the fees and costs in connection with the mediation.

19.6 Litigation. If mediation is unsuccessful, Design Builder must file a government claim pursuant to Government Code section 910 et seq. in order to initiate a civil action.



19.7 Joinder. Design Builder acknowledges that the Project is being constructed under a design-build project delivery method where the Design Builder is under direct contract with SVH. The Parties consent to the joinder of other necessary Project Team Members in any dispute resolution procedure, if Claims for or against the Design Builder or SVH arise from the same, substantially the same, or interrelated facts, issues, or incidents relating to the Project, or where separate dispute resolution processes create a risk of inconsistent awards or results. Design Builder failure to pass the dispute resolution process set forth in this Article 19 through via subcontract and consultant agreement to all Design Build Team Members constitutes a material breach of contract.

19.8 Enforceability. Design Builder has reviewed the dispute resolution procedures with legal counsel and agrees to the terms and conditions set forth in this Article 19. To the extent a court of competent jurisdiction finds any term or provision in this Article 19 to be void or unenforceable, the unenforceable term or provision will be severed and the remainder of the terms and provisions will remain in full force and effect. Nothing contained in this dispute resolution process prevents Design Builder or other Design Build Team Members from timely filing a civil action to foreclose on a stop payment notice or payment bond. However, the Parties agree to stipulate to a stay in the proceedings pending attempts to resolve the matter pursuant to the process defined in this Article 19.

20. TERMINATION AND SUSPENSION

20.1 Suspension. The Project may be suspended upon written notice from SVH. The written notice of suspension will set forth the reason for suspension and the effective date of suspension. If the Project is suspended by SVH and not due to any fault of the Design Builder or any of Design Build Team Members, the Design Builder will be compensated per the compensation and payment terms set forth in Articles 10 through 12 for all Work properly performed through the effective date of the suspension. If Construction Work has commenced by the effective date of suspension and the suspension requires demobilization of Design Builder, the Design Builder will also be entitled to an additional 10 work days to cease all operations and secure the Project site. Design Builder will be compensated for its General Conditions and General Requirements for the additional work days per the applicable Average Daily Rate set forth in the Business Terms Sheet. If the Project is resumed, and provided that the suspension was not caused or due to any fault or neglect of the Design Builder or any of its Design Build Team Members, then Design Builder's compensation will be equitably adjusted through Change Order under Article 14 and the Contract Time will be equitably adjusted for the additional time required to achieve Substantial Completion of the Work. If the Project has ceased for more than 120 consecutive calendar days or if all Construction Work has ceased for a period of 60 consecutive calendar days, Design Builder may terminate the Contract under Section 20.4.

20.2 SVH's Termination for Convenience. SVH may terminate this Contract for convenience upon 10 business days' written notice. The notice will state the extent and effective date of termination. Design Builder will be entitled to receive payment for all Work properly performed as of the effective date of termination based on the compensation and payment provisions set forth in Articles 10 through 12. If Construction Work has commenced as of the effective date of termination, Design Builder will also be entitled to an additional 10 work



days of General Conditions and General Requirements per the applicable Average Daily Rate set forth in the Business Terms Sheet to cease all operations and secure the site. The additional General Conditions and General Requirements will not apply if SVH already suspended the Work under Section 20.1 and Design Builder already received compensation for demobilization and securing the site. Design Builder expressly waives any Claims for consequential damages, including anticipated lost profits and unabsorbed overhead. Any dispute over the amount to be paid upon termination will be resolved in accordance with the dispute resolution procedures set forth in Article 19.

20.3 SVH's Termination for Cause. SVH may terminate this Contract upon not less than 10 calendar days' written notice if Design Builder is in breach of any term or provision of the Contract Documents and Design Builder does not commence curing its breach to the satisfaction of SVH within the same 10 calendar day time frame. The notice will set forth the reason for termination and the effective date of termination. If SVH terminates this Contract for cause, Design Builder will not be entitled to any further payments until after Completion of Construction Work. Nothing stated in this Section will prevent SVH from pursuing and recovering any damages allowed by Applicable Law from Design Builder arising out of a breach of the Contract Documents. If a court deems that termination of the Design Builder was wrongful or otherwise improper, the termination will be deemed a termination for convenience under Section 20.2. SVH's right to use design materials after termination is set forth in Article 18.

20.4 Design Builder's Termination for Cause. Design Builder may terminate this Contract upon 15 days' written notice and an additional 15 days' opportunity to commence curing, if SVH fails to make payment to the Design Builder in accordance with Article 12, and cannot provide evidence substantiating that financial arrangements have been made to make payment, or if the Project is suspended for more than 120 consecutive calendar days, or if all Construction Work has ceased for a period of 60 consecutive calendar days. Design Builder will be compensated for all Work properly performed through the effective date of termination in accordance with the compensation and payment provisions set forth in Articles 10 through 12. If the Contract is being terminated due to failure to make payment and provided that the Construction Work has commenced before the effective date of termination, the Design Builder will also be entitled to up to an additional 15 work days multiplied times the applicable Average Daily Rate set forth in the Business Terms Sheet for additional General Conditions and General Requirements necessary to cease all operations and secure the site.

21. MISCELLANEOUS PROVISIONS

21.1 Confidentiality. Design Builder will keep information provided by SVH or made available to Design Builder during performance of the Work confidential, and will not disclose confidential information to persons or entities other than as necessary to perform the Work.

21.2 Patient Privacy. Any and all patient information is subject to protection under Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as may be amended. Design Builder acknowledges that its employees, agents, Design Build Team Members, and others acting on Design Builder's behalf may come into contact with patient protected health information ("PHI") while performing Work on the Project. PHI information includes individually



identifiable information (oral, written, or electronic) about a member/patient's physical or mental health, the receipt of health care, or payment for that care, as well as individually identifiable member/patient payment, dues, enrollment, and un-enrollment information. This contact is most likely rare and brief (e.g., walking through a clinic that has patient radiological films on view boxes, overhearing conversations between physicians while performing Construction Work at the hospital, noticing a relative or acquaintance receiving treatment, etc.). It is the intent of SVH that this type of information should not be examined closer, copied, distributed, or shared. Design Builder will adopt procedures to ensure that its employees, agents, Design Build Team Members, and others acting on their behalf will not further examine, copy, distribute, or share this information. If Design Builder, or its employees, agents, Design Build Team Members, and others acting on Design Builder's behalf further examine, copy, distribute, or share this information the Design Builder must report these actions immediately to SVH within 2 business days after the event occurs. Design Builder will take all steps necessary to stop any examination of PHI and will ensure that no further violations of this contractual responsibility will occur. Design Builder will report to SVH and the Project Manager within 5 business days after giving notice of the event of the steps taken to prevent future occurrences, and provide SVH with the necessary assurances at that time. Design Builder will place similar confidentiality restrictions and HIPAA compliance requirements in agreements with its Design Build Team Members.

21.3 Governing Law. This Contract will be governed and construed under the laws of the State of California without giving effect to any choice of law or rule of conflict that would cause the application of the laws of any other jurisdiction. Each of the Parties agrees that the exclusive venue for any dispute resolution proceeding or action will be in Monterey County, California.

21.4 Assignment. SVH and Design Builder respectively bind themselves, their partners, successors, and assignees to the other Party to this Contract. Design Builder may not assign this Contract. Upon notice, SVH may assign this Contract to any lender in obtaining Project financing, and Design Builder and its Design Build Team Members will cooperate with SVH and execute required assignment and subordination agreements.

21.5 Notices. Any notice required to be given under Articles 19 or 20 will be in writing and deemed effective upon: (i) the date of personal delivery, or fax, if received by the addressee before 5:00 p.m. local time on a business day; (ii) 3 business days after being sent via registered or certified mail with a return receipt requested; or (iii) 1 business day after being sent by overnight commercial courier providing next-business-day delivery. Fax delivery must be evidenced by an automated fax confirmation. All other notices required under the Contract may be via email. Notices will be addressed to the representatives for notice identified in the Business Terms Sheet

21.6 Interpretation and Severability. This Contract's terms and conditions will be interpreted according to their plain meaning, and not strictly for or against either SVH or Design Builder. Any contrary rule of construction or interpretation will be of no force or effect with respect to this Contract. If a court of competent jurisdiction finds any term or provision of this Contract to be void or unenforceable for any reason, the term or provision will be amended to comply with Applicable Law. If a term or condition is severed, the remainder of the Contract will



remain in full force and effect to the maximum extent permitted by law and consistent with SVH's and Design Builder's overall intent.

21.7 No Third Party Beneficiaries. The Parties acknowledge and agree that the obligations of the Design Builder are solely for the benefit of SVH and the obligations of SVH under this Agreement are solely for the benefit of the Design Builder.

21.8 Time is of the Essence. Time is of the essence with respect to each and every provision of the Contract Documents and any subsequent Change Orders.

21.9 Rights and Remedies. All rights and remedies under the Contract Documents will be cumulative and in addition to, and not in limitation of, all other rights and remedies of the Parties under the Contract Documents or otherwise available at law or in equity.

21.10 Survival. The following provisions will survive termination of this Contract or completion of the Work: Sections 1.4 and 1.5, and Articles 10 through 21.

21.11 Waiver. Unless otherwise indicated in this Contract, SVH's and Design Builder's action or failure to act will not waive any right or duty it has under the Contract, and such action or failure to act will not be an approval of or acquiescence in a breach of the Contract unless specifically agreed to in writing by the Party.

21.12 Counterparts. This Contract may be executed in counterparts, each of which will be deemed an original. When proving this Contract, it will only be necessary to produce or account for the counterpart signed by the Party against whom enforcement is sought. Electronic copies or photocopies of this Contract showing the true signatures may be used for all purposes as originals.

21.13 Interest. Payments due and unpaid under this Contract that do not constitute a Claim will bear interest from the date payment is due at the rate prescribed by Applicable Law.

21.14 Attorneys' Fees. If SVH or Design Builder commences an action or dispute resolution process in accordance with the terms and provisions of this Contract against the other Party for Claims arising out of or in connection with the Contract Documents, the prevailing Party will be entitled to recover all reasonable attorneys' fees and costs (including charges and expenses related to the suit, expert witness, and consultants' fees) as may be determined by a court with competent jurisdiction.

21.15 Conflict of Interest. Design Builder will comply with SVH's Conflict of Interest Policy and Procedures set forth in Exhibit 8.

21.16 Electronic Signature. The Parties agree that an electronic signature is an acceptable form of signature for written communications between the Parties and will have the same force and effect as the use of a manual signature provided that the digital signature is: (i) unique to the person using it; (ii) capable of verification; (iii) under the sole control of the person using it; and (iv) linked to the data in such a manner that if the data are changed, the digital



signature will be invalidated. To be valid, the Digital Signature must be created by an acceptable technology as defined in California Code of Regulations section 22001 et. seq.

21.17 Legal Citations. Legal citations to statutory requirements are included in the Contract for convenience and an omission of any statutory requirement will not relieve the Design Builder from compliance with Applicable Law.

21.18 Entire Contract. The Contract Documents form the entire contract between SVH and Design Builder and supersede all prior oral and other written negotiations, representations, or agreements between SVH and Design Builder with respect to the Work performed for this Project.



SEISMIC RETROFIT PROJECT #01.1250.3273		BUDGET	Prior Years (costs)*	FY 2025 SUBTOTAL*	FY 2026 SUBTOTAL	FY 2027 SUBTOTAL	FY 2028 SUBTOTAL	FY 2029 SUBTOTAL
PROGRAM & CONSTRUCTION MANAGEMENT		\$ 5,112,181	\$ 1,251,451	\$ 867,033	\$ 969,902	\$ 1,621,412	\$ 402,383	\$ -
PRELIMINARY DESIGN & INITIAL STUDIES		\$ 3,338,557	\$ 1,315,889	\$ 658,503	\$ 1,124,303	\$ 127,045	\$ 104,808	\$ 8,009
MAKE READY DESIGN & CONSTRUCTION		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
AGENCY FEES & INSPECTION		\$ 3,948,106	\$ 72,490	\$ 71,745	\$ 1,092,823	\$ 1,928,018	\$ 703,206	\$ 79,824
PROCUREMENT & FF&E		\$ 1,250,233	\$ -	\$ 15,000	\$ 96,000	\$ 766,504	\$ 278,000	\$ 94,729
PROGRAM, DESIGN & CONSTRUCTION CONTINGENCY		\$ 9,950,043	\$ -	\$ 210,000	\$ 1,970,000	\$ 3,950,000	\$ 3,349,867	\$ 470,176
DESIGN BUILDER - DESIGN & PRECONSTRUCTION SERVICES		\$ 9,464,419	\$ -	\$ 900,000	\$ 4,700,000	\$ 2,350,000	\$ 1,514,419	\$ -
DESIGN BUILDER - CONSTRUCTION SERVICES		\$ 29,436,461	\$ -	\$ 375,000	\$ 2,075,000	\$ 12,700,000	\$ 13,650,000	\$ 636,461
Total Project Budget		\$ 62,500,000	\$ 2,639,830	\$ 3,097,281	\$ 12,028,028	\$ 23,442,979	\$ 20,002,683	\$ 1,289,199

*Reflects actuals through 3/31/2025

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval of Contract Terms and Conditions for Services Agreement Between Salinas Valley Health and Prinново, LLC**

Executive Sponsor: Allen Radner, MD, SVH President/Chief Executive Officer
Tim Albert, MD, SVH Chief Clinical Officer
Gary Ray, SVH Chief Legal Officer

Date: April 21, 2025

Executive Summary

Salinas Valley Health executives, Allen Radner, Tim Albert, and Gary Ray have had several meetings, both in-person and virtual, with the founders and executives from Prinново, LLC, to discuss opportunities to partner with SVH to develop an internal "Health Venture Office." The plan would be to form Salinas Valley Health Ventures which would embed a team of entrepreneurs to leverage untapped value in our healthcare system. The Health Venture Office would bring in business development experts who will work with SVH to pilot, validate, and license new operational and clinical partnerships/solutions that address key strategic needs and challenges within the Salinas Valley Health system. Under the services agreement presented for your consideration, Prinново would embed full-time staff (3-4 full time employees in addition to support from the Prinново central office) to operate Health Venture Office.

Value and Benefits

Early stage innovative healthcare companies value partnering with smaller more nimble organizations such as SVH. SVH views a partnership with innovative healthcare companies as an opportunity to remain at the forefront of advanced healthcare technology. Partnering with early stage companies allows for organizations to grow with technology as opposed to being changed by it. This partnering allows SVH to leverage the value it has created to improve health care, to provide better service, and to pursue an opportunity to generate a financial return. The Health Venture Office partnership provides an opportunity to grow new businesses/joint ventures that leverage new capabilities and support clinical research programs.

Timeline/Review Process to Date

January-April, 2025	Discussions/Negotiations between SVH Executives and Prinново
April 21, 2025	Review of Pertinent Services Agreement Terms and Conditions
April 24, 2025	Board Consideration/Action on Pertinent Services Agreement Terms and Conditions
April-May, 2025	Negotiation by Dr. Radner, Dr. Albert, Gary Ray, and District Legal Counsel of Final Terms and Conditions of Services Agreement with Prinново
May-June, 2025	Commencement of Services Agreement with Prinново

Services Agreement Terms and Conditions

- Prinново provides central office management, training, development, and venture office collaboration.
- The Services Agreement is for an initial term of three (3) years from the effective date, subject to any renewal as provided in the agreement.
- The Services Agreement contains standard default provisions and allows SVH to provide notice of non-renewal ninety (90) days prior to the expiration of the initial term or a renewal term of the agreement.
- At least 120 days prior to the end of the initial term or any renewal term, Prinново will provide an estimate of the expected staffing levels, service costs, and overhead costs for the following three years. SVH will have the opportunity to renew for successive 36-month periods based on these estimates.

- Prinново will hire a Venture Principal to lead the Health Venture Office within 90 days of the effective date, and will hire two Venture Managers within 60 days of hiring the Venture Principal. These individuals will relocate to the Monterey area. The Venture Managers will work closely with the Venture Principal/Managing Director to develop the portfolio for the Health Venture Office. All staffing, benefits, bonus, and promotion costs are built into the Services Agreement staffing budget.
- Staffing and overhead cost commitment in the contracts are as follows:
 - ❖ Total staffing budget of \$3,850,826. Cost estimates per year based on the assumptions above are:
 - Year 1 – \$1,014,653.
 - Year 2 - \$1,314,671.
 - Year 3 - \$1,521,503.
 - ❖ Overhead Costs for the 3-year term are estimated to be \$350,000. Overhead costs cover a variety of expenses for operation of the Health Venture Office. These overhead costs will be detailed in the Services Agreement.
- The total 3-year budget commitment under the Services Agreement with Prinново is **\$4,200,826**. As a condition of the Services Agreement, the Health Venture Office must repay the full amount of the Services Agreement to Salinas Valley Health plus a 5% preference before Prinново Health shares in its portion of the excess portfolio returns.
- The opportunities/ventures that the Health Venture Office focuses on will address a problem or need in the Salinas Valley Health system seeking to drive increased revenue/margin, efficiencies, quality and improved experiences.
- The proposed Services Agreement contains standard non-solicitation, confidentiality, audit/compliance, indemnity, and insurance provisions.
- In the event of a termination of the Services Agreement, there are “wind-down” provisions outlined in the agreement which apply following termination to allow an orderly administration of the Qualifying Investments in the Innovation Participation Agreements, New Ventures, or Joint Ventures managed by Prinново pursuant to the Services Agreement.

Recommendation

Consider Recommendation for Board Approval of the Pertinent Contract Terms and Conditions for the Services Agreement Between Salinas Valley Health and Prinново, LLC, in an Amount of Approximately \$4.2 million, with Final Services Agreement Terms and Conditions to be Negotiated by SVH Executives and District Legal Counsel.



Financial Performance Review

March 2025

Finance Committee

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary For the Month of March 2025

\$ in Millions	For the Month of March 2025				
			Variance fav (unfav)		
	Actual	Budget	\$VAR	%VAR	
Operating Revenue	\$ 64.5	\$ 64.2	\$ 0.3	0.5%	
Operating Expense	\$ 66.4	\$ 65.1	\$ (1.3)	-2.0%	
Income from Operations	\$ (1.9)	\$ (0.9)	\$ (1.0)	-111.1%	
Operating Margin %	-2.9%	-1.3%	-1.6%	-123.08%	
Non Operating Income	\$ 3.3	\$ 2.9	\$ 0.4	13.8%	
Net Income	\$ 1.4	\$ 2.0	\$ (0.6)	-30.0%	
Net Income Margin %	2.2%	3.2%	-1.0%	-31.3%	

Net loss from operations was driven by:

- ✓ Approximately \$2 million of prior period write-offs related to an assessment and clean-up of Accounts Receivable by PFS
- ✓ An overall unfavorable payor mix

Non-Operating Revenues exceeded budget due to changes in market value of investments

Normalizing Items:

- There were no normalizing items for the month of March

Executive Summary: Financial Performance

Salinas Valley Health Net Loss from Operations was \$1.9 million for the month which was unfavorable to budget by \$1.0M. The unfavorable financial performance for the month was driven by the following:

Key Unfavorable Performance Highlights:

- ✓ **Approximately \$2 million of prior period write-offs** related to an assessment and clean-up of Accounts Receivable by PFS
- ✓ **Unfavorable Payor Mix:** **Commercial** patient revenue was under budget by 4%, while **MediCal and Medicare** revenue were over budget 26% and 10%
- ✓ **Deliveries** were below budget 6% (7 cases)
- ✓ **Labor Productivity** was unfavorable for the month by 4.4%
- ✓ **Days in AR** were over target at 64 days, but improved from prior month due to higher collections, up 20% from Feb and 4% over budget

Executive Summary: Financial Performance – Cont'd

▪ Key Favorable Performance Highlights:

- **Outpatient revenue** was favorable compared to budget by \$23M (16%), due to higher than budgeted patient volumes in the following areas:
 - **OP Infusion cases** were over budget by 19% (191 cases)
 - **OP Surgeries** were over budget by 17% (46 cases)
 - **CT Scans** were over budget 6% (118 cases)
- **Total inpatient admissions** were 6% (51 admits) above budget
- **IP surgeries** were over budget by 38% (50 cases)
- **Average Length of Stay** was 8% favorable to budget at 3.7 days

Consolidated Financial Summary YTD March 2025

\$ in Millions	FY 2025 March YTD			
	Actual	Budget	Variance fav (unfav)	
			\$VAR	%VAR
Operating Revenue	\$ 610.2	\$ 558.6	\$ 51.6	9.2%
Operating Expense	\$ 587.2	\$ 568.7	\$ (18.5)	-3.3%
Income from Operations	\$ 23.0	\$ (10.1)	\$ 33.1	327.7%
Operating Margin %	3.8%	-1.8%	5.6%	311.1%
Non Operating Income	\$ 29.7	\$ 27.6	\$ 2.1	7.6%
Net Income	\$ 52.7	\$ 17.5	\$ 35.2	201.1%
Net Income Margin %	8.6%	3.1%	5.5%	177.4%

Operating Income includes the Normalizing Item of:

- CCAH Voluntary Rate Range Funds (net) Received YTD for CY 2023 totaling \$4.6 Million

Non Operating Income includes Normalizing Items of:

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

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Consolidated Financial Summary YTD March 2025 - Normalized

\$ in Millions	FY 2025 March YTD			
	Actual	Budget	Variance fav (unfav)	
			\$VAR	%VAR
Operating Revenue	\$ 605.5	\$ 558.6	\$ 46.9	8.4%
Operating Expense	\$ 587.2	\$ 568.7	\$ (18.5)	-3.3%
Income from Operations	\$ 18.3	\$ (10.1)	\$ 28.4	281.2%
Operating Margin %	3.0%	-1.8%	4.8%	266.7%
Non Operating Income **	\$ 25.5	\$ 27.6	\$ (2.1)	-7.6%
Net Income	\$ 43.8	\$ 17.5	\$ 26.3	150.3%
Net Income Margin %	7.2%	3.1%	4.1%	132.3%

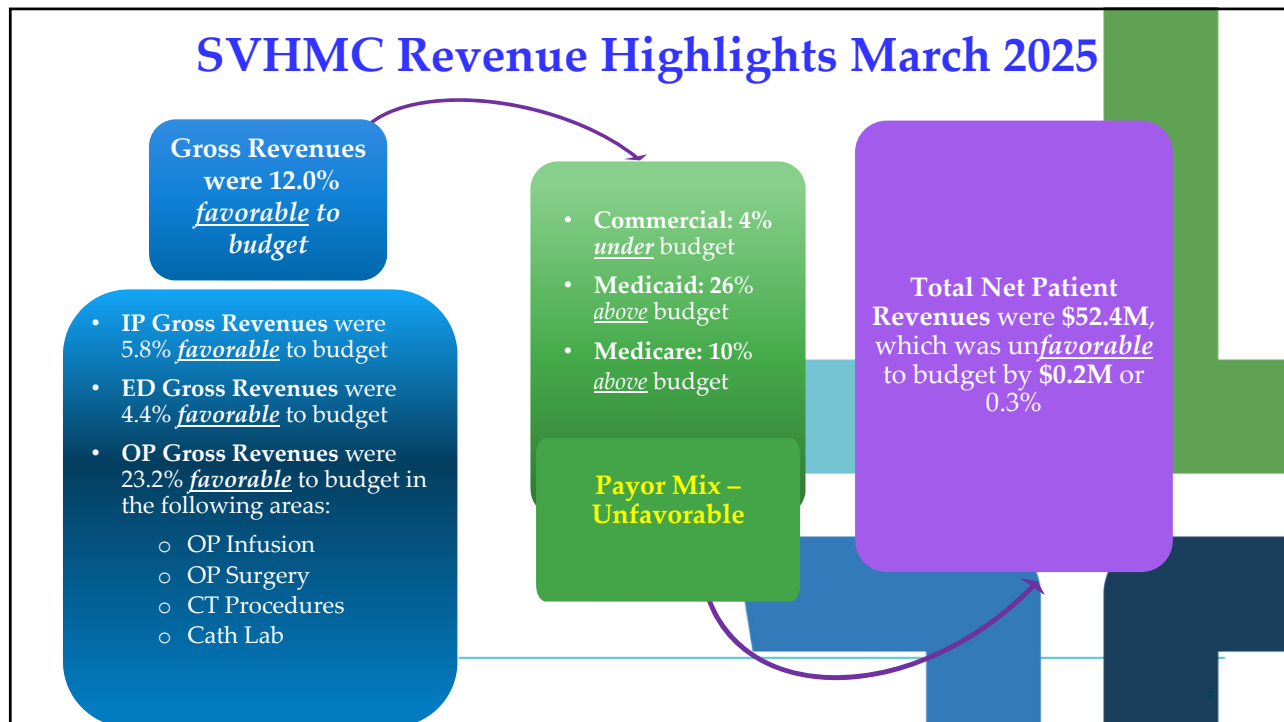
Operating Income excludes the Normalizing Item of:

- CCAH Voluntary Rate Range Funds (net) Received YTD for CY 2023 totaling \$4.6 Million

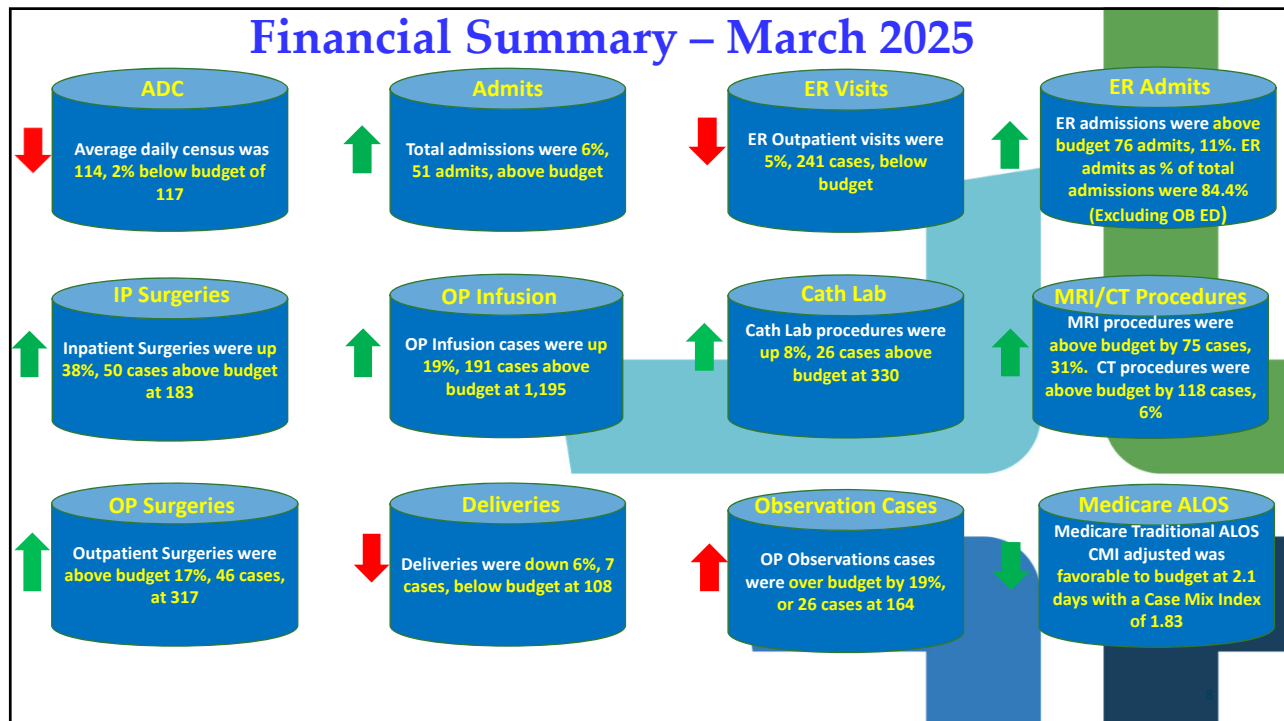
Non Operating Income excludes Normalizing Items of:

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

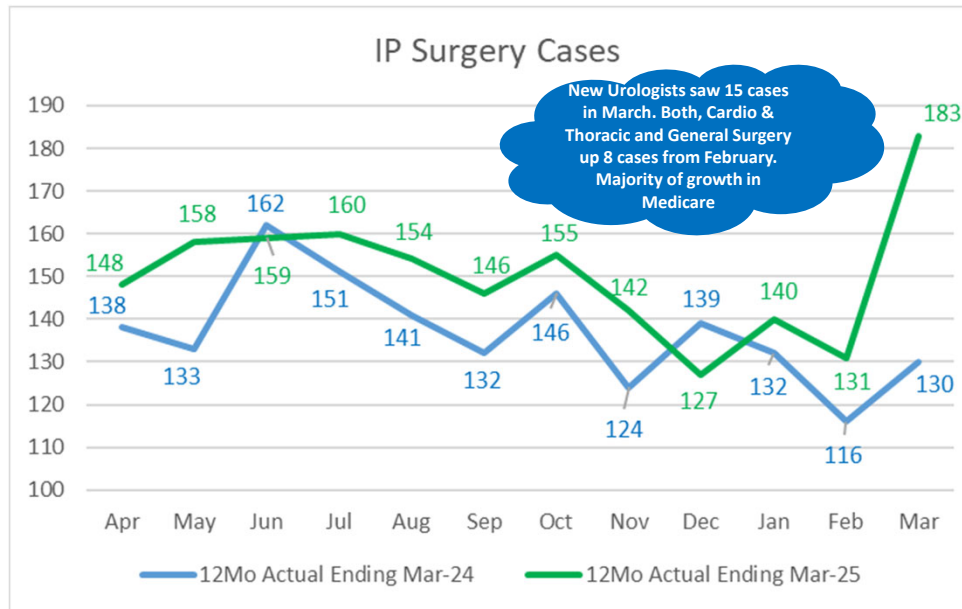
SVHMC Revenue Highlights March 2025



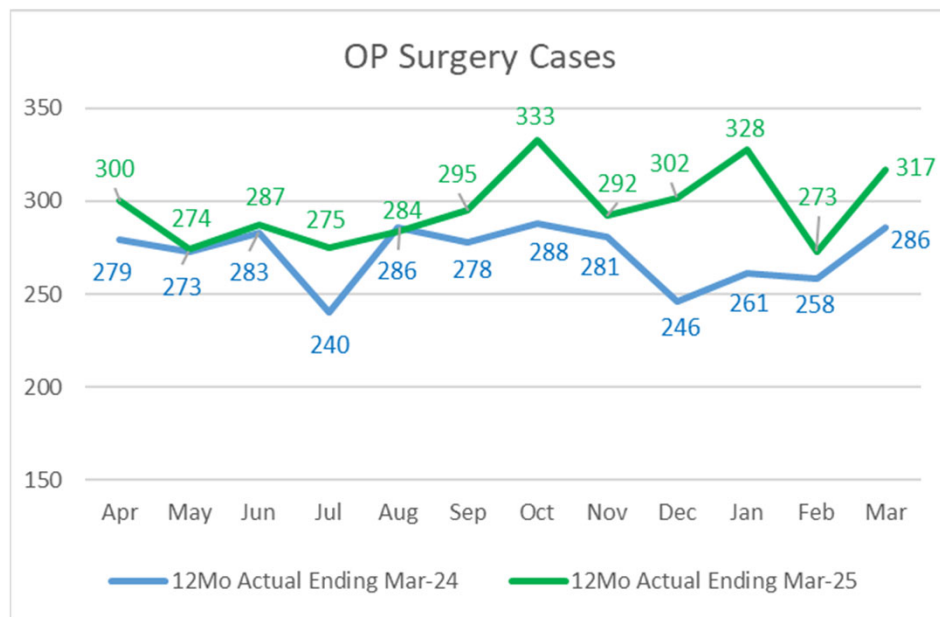
Financial Summary – March 2025



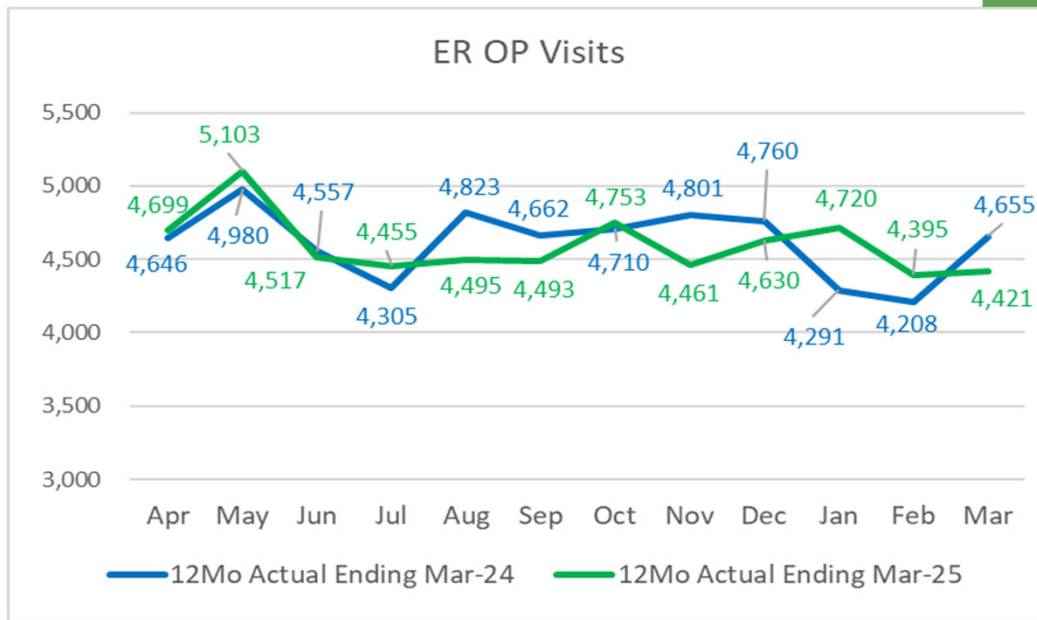
IP Surgery Cases - March 2025



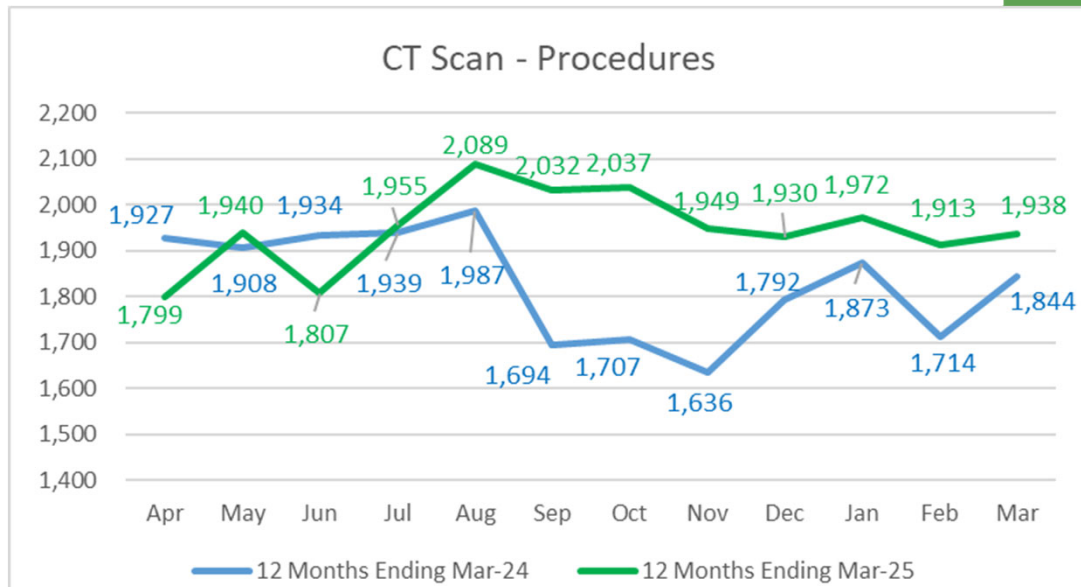
OP Surgery Cases - March 2025



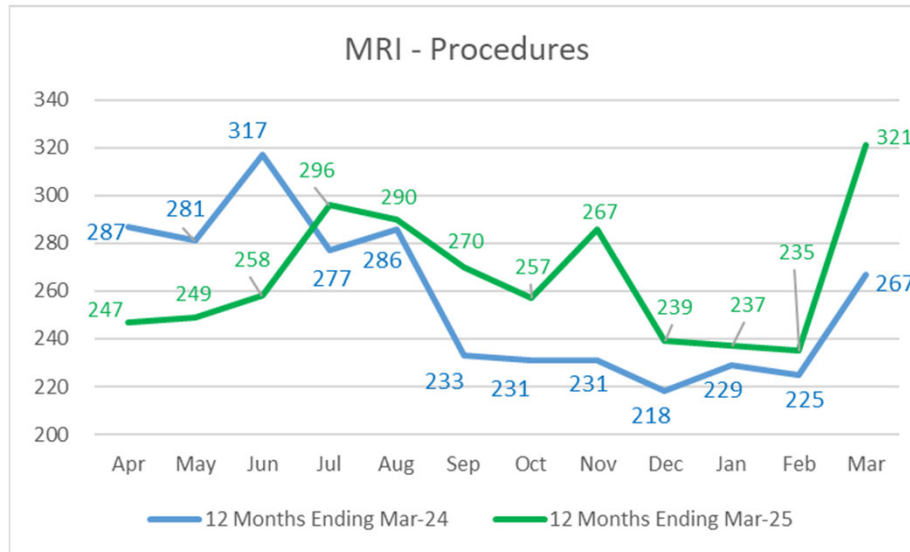
ER OP Visits- March 2025



CT Scans -March 2025

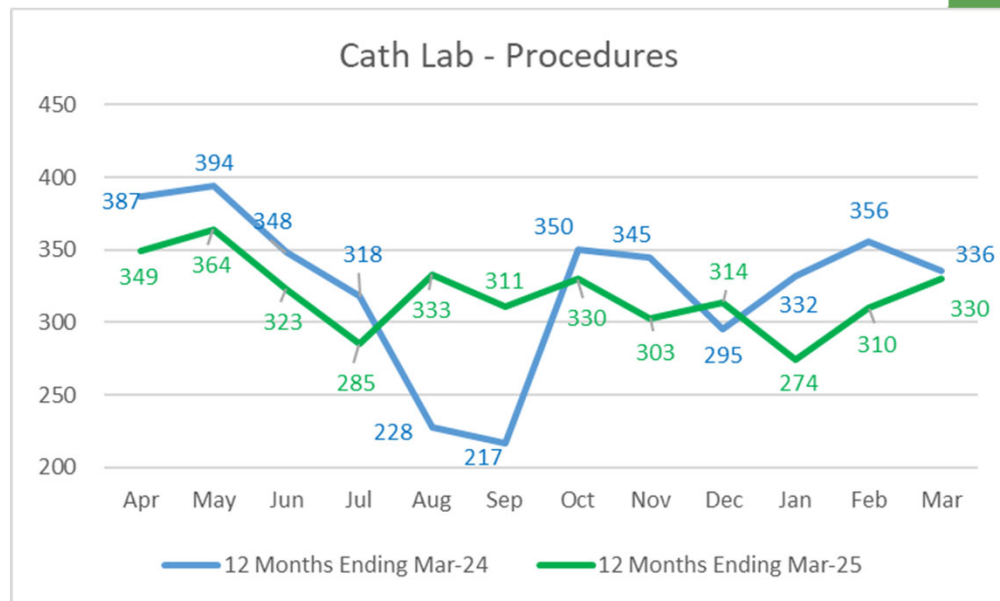


MRI -March 2025

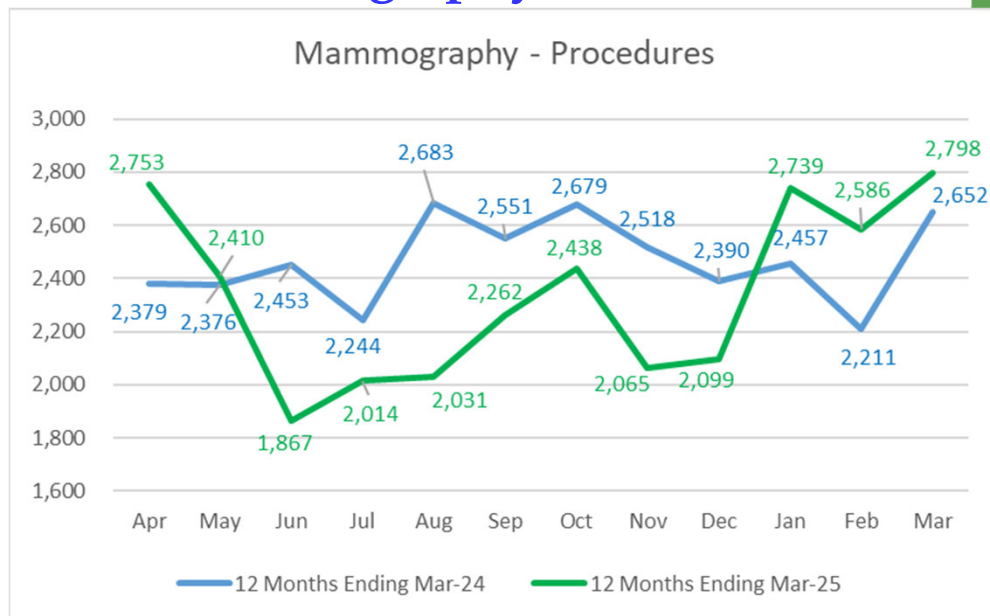


OP MRI evening shift hours at the hospital extended from 5:00PM to 10:30PM effective Feb. 20 has impacted procedure volume.

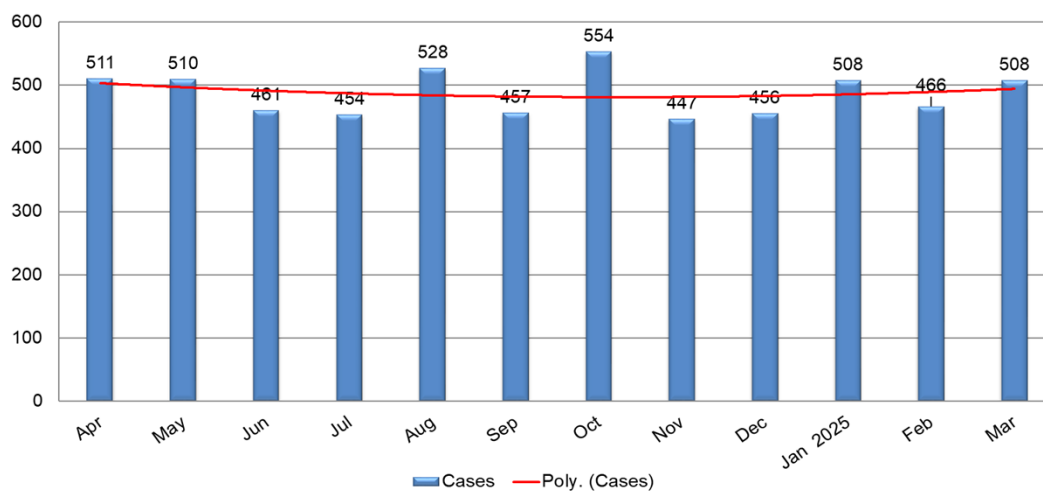
Cath Lab -March 2025



Mammography - March 2025



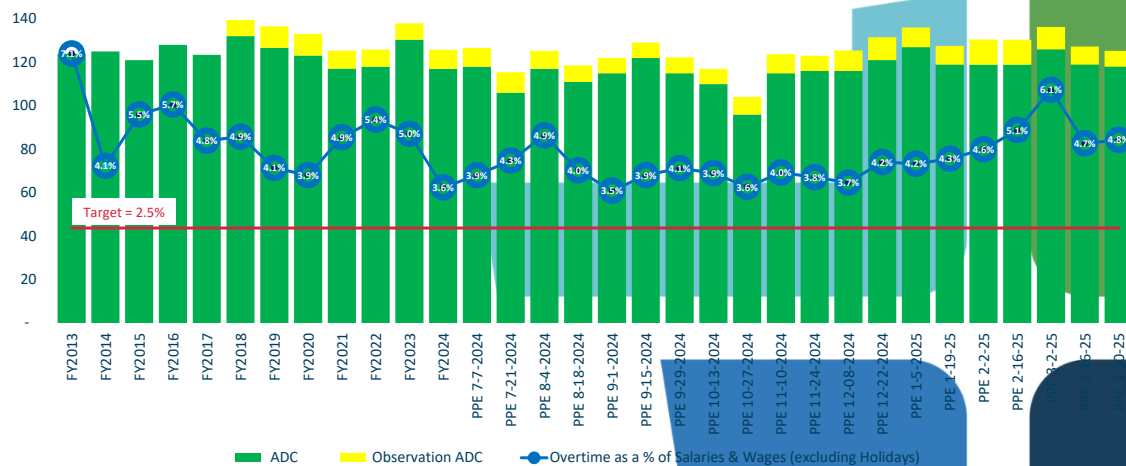
CDOC Cases - Rolling 12 Month Trend Apr 2024 thru Mar 2025



Labor Productivity – March 2025

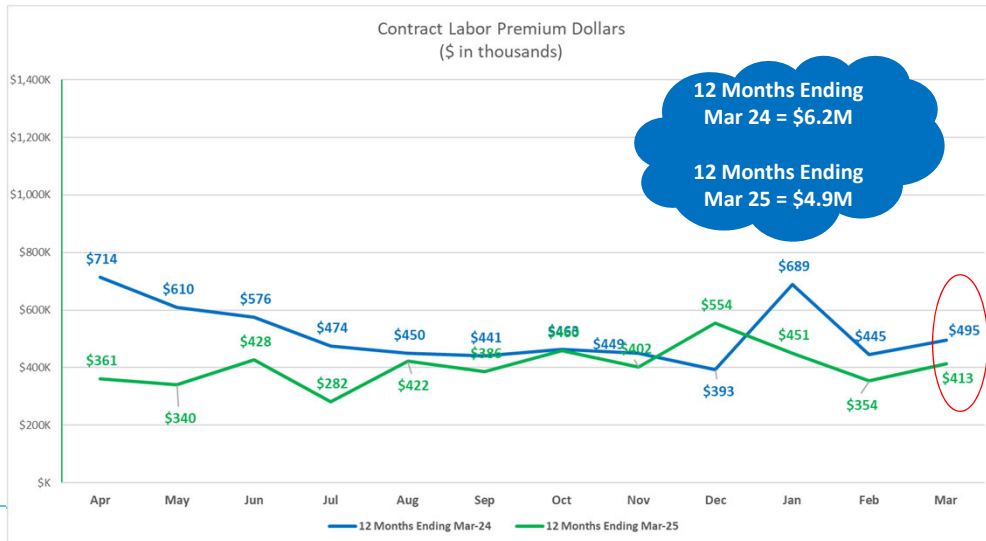
- 1. Worked FTEs:** During the month of March, worked FTEs on a PAADC basis were 4% unfavorable at **6.9** with a target of **6.6**. *When reviewed on a unit-by-unit level, the variance was 39 FTEs negative (\$0.6M). Lab was favorable 12.1 Worked FTEs. Excluding Lab, the variance would have been 51 FTEs negative (\$0.8M).*
- 2. Worked FTEs** increased from 1,607 in February to 1,635 in March. Average daily census decreased by 10 compared to prior month at 114 (2% below budget).
- 3. Paid FTEs:** On a PAADC basis, paid FTEs were **2% unfavorable** to budget at **7.8 actual vs. 7.6 budget**. Paid FTEs increased from 1,841 in February to 1,850 in March.

Overtime as a Percent of Total Salaries & Wages (excluding Holidays) Through the pay period ending March 30, 2025

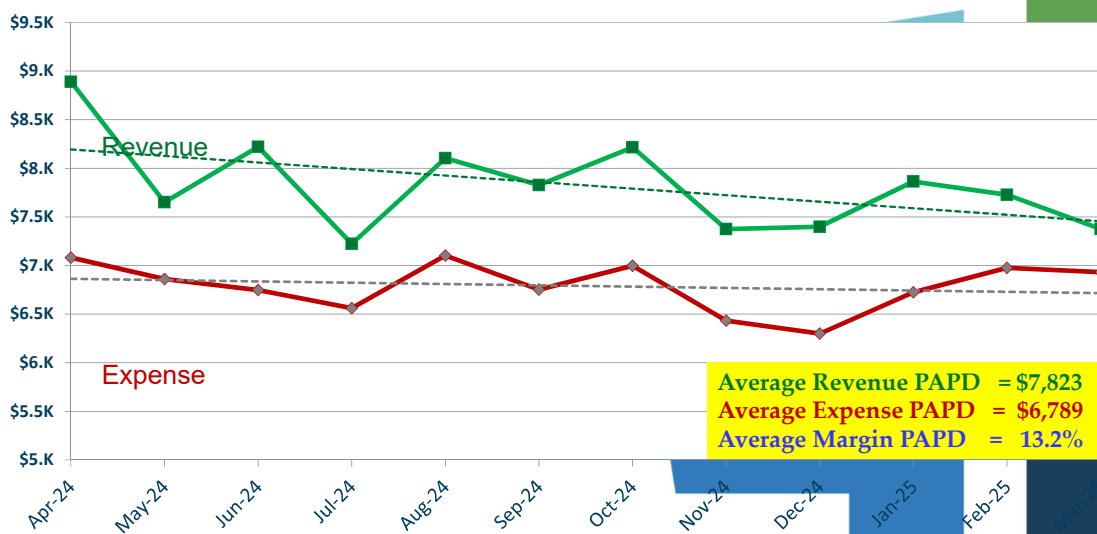


** Observation days are not available prior to FY2018 due to a server migration.

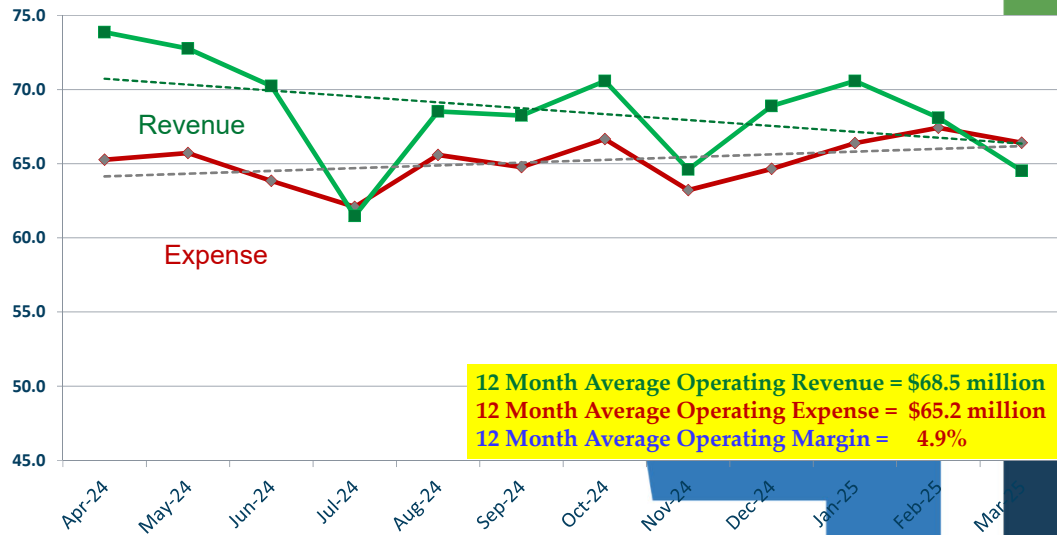
Contract Labor (Premium Cost Only) – 12 months ended 3/31/2025



SVHMC Revenues & Expenses Per Adjusted Patient Day Rolling 12 Months: Apr 24 to Mar 25



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



Salinas Valley Health Key Financial Indicators

	YTD	SVH	S&P A+ Rated		YTD	
Statistic	3/31/25	Target	+/-	Hospitals	+/-	3/31/24 +/-
Operating Margin*	3.8%	5.0%		4.0%		-1.6%
Total Margin*	8.6%	6.0%		6.6%		4.3%
EBITDA Margin**	8.3%	7.4%		13.6%		3.2%
Days of Cash*	364	305		249		338
Days of Accounts Payable*	44	45		-		43
Days of Net Accounts Receivable**	64	45		49		57
Supply Expense as % NPR	14.7%	14.0%		-		13.8%
SWB Expense as % NPR	52.0%	53.0%		53.7%		55.6%
Operating Expense per APD*	6,703	6,739		-		6,706

All metrics above are consolidated for SVH except Operating Expense per APD

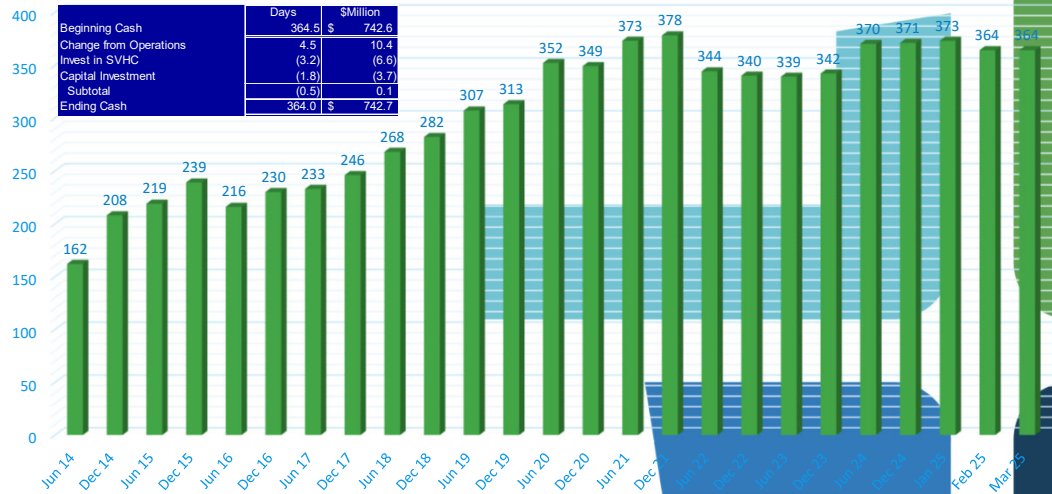
*These metrics have **not** been adjusted for normalizing items

**Metric based on Operating Income (consistent with industry standard)

***Metric based on 365 days average net revenue (consistent with industry standard)

Salinas Valley Health

Days Cash on Hand = 364 Days (\$743M) - March 2025



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Routine Capital Expenditures Through March 2025

Fiscal Month	FY 2025 Approved Budget *	Total Purchased Expenditures	Remaining	Project	Amount
July	1,916,667	712,780	1,203,887	Cath Lab Equipment Replacement	60,514
August	1,916,667	1,382,572	1,737,981	200T Chiller Replacement	14,936
September	1,916,667	729,309	2,925,338	Laboratory - Air Handler	12,732
October	1,916,667	1,191,148	3,650,857	X-Ray Equipment Replacement	12,048
November	1,916,667	794,889	4,772,635	Miscellaneous	15,298
December	1,916,667	1,381,451	5,307,851	Total Improvements	115,528
January	1,916,667	1,565,871	5,658,646	Radiology GE Healthcare C-ARM	317,172
February	1,916,667	963,787	6,611,526	PACU Workstations (8)	118,745
March	1,916,667	815,462	7,712,730	Surgery LithoClast Trilogy Lithotripter System	65,622
April	1,916,667		9,629,397	IT Imprivata Proximity USB Readers	63,683
May	1,916,667		11,546,064	Miscellaneous	134,712
June	1,916,667		13,462,730	Total Equipment	699,935
YTD TOTAL	23,000,000	9,537,270	13,462,730	Grand Total	815,462

Questions/Comments



SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
March 31, 2025

	<u>Month of March,</u>		<u>Nine months ended March 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Operating revenue:				
Net patient revenue	\$ 52,353,026	\$ 53,215,935	\$ 505,607,481	\$ 455,805,479
Other operating revenue	<u>1,943,999</u>	<u>1,120,312</u>	<u>14,273,326</u>	<u>9,861,505</u>
Total operating revenue	<u>54,297,025</u>	<u>54,336,247</u>	<u>519,880,807</u>	<u>465,666,984</u>
Total operating expenses	51,027,786	48,872,883	452,850,988	431,546,230
Total non-operating income	<u>(1,769,233)</u>	<u>(979,261)</u>	<u>(15,640,255)</u>	<u>(12,873,368)</u>
Operating and non-operating income	<u>\$ 1,500,006</u>	<u>\$ 4,484,102</u>	<u>\$ 51,389,564</u>	<u>\$ 21,247,386</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
March 31, 2025

	<u>Current year</u>	<u>Prior year</u>
ASSETS:		
Current assets	\$ 426,885,411	\$ 347,471,310
Assets whose use is limited or restricted by board	173,535,507	165,022,784
Capital assets	258,695,238	249,123,680
Other assets	305,471,725	288,659,194
Deferred pension outflows	<u>85,734,219</u>	<u>116,911,125</u>
	<u>\$ 1,250,322,100</u>	<u>\$ 1,167,188,093</u>
LIABILITIES AND EQUITY:		
Current liabilities	93,007,905	86,207,553
Long term liabilities	20,532,083	20,145,488
Lease deferred inflows	880,521	1,470,015
Pension liability	90,863,576	118,792,064
Net assets	<u>1,045,038,015</u>	<u>940,572,973</u>
	<u>\$ 1,250,322,100</u>	<u>\$ 1,167,188,093</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
March 31, 2025

	<u>Month of March,</u>		<u>Nine months ended March 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Patient days:				
By payer:				
Medicare	1,673	1,879	15,651	16,247
Medi-Cal	1,236	1,079	9,567	9,492
Commercial insurance	516	581	5,015	5,157
Other patient	146	83	1,076	904
Total patient days	<u>3,571</u>	<u>3,622</u>	<u>31,309</u>	<u>31,800</u>
Gross revenue:				
Medicare	\$ 136,059,278	\$ 119,887,840	\$ 1,144,921,709	\$ 1,025,666,956
Medi-Cal	95,909,746	79,776,827	741,167,947	637,339,335
Commercial insurance	54,615,684	55,257,136	519,284,925	472,536,714
Other patient	10,968,238	8,273,807	97,851,475	79,285,089
Gross revenue	<u>297,552,946</u>	<u>263,195,610</u>	<u>2,503,226,056</u>	<u>2,214,828,093</u>
Deductions from revenue:				
Administrative adjustment	239,181	346,040	2,724,326	2,859,919
Charity care	755,481	373,464	5,902,927	5,912,183
Contractual adjustments:				
Medicare outpatient	45,206,438	37,718,273	381,077,259	318,807,609
Medicare inpatient	52,649,954	47,565,640	440,114,556	423,111,168
Medi-Cal traditional outpatient	2,093,010	971,630	14,401,590	22,939,017
Medi-Cal traditional inpatient	6,446,445	4,959,102	46,019,794	42,988,883
Medi-Cal managed care outpatient	43,681,533	37,814,410	359,391,371	281,784,297
Medi-Cal managed care inpatient	35,396,959	27,818,484	244,804,758	228,999,160
Commercial insurance outpatient	28,582,616	23,462,287	241,114,167	197,856,757
Commercial insurance inpatient	23,685,578	23,686,650	199,593,353	185,080,344
Uncollectible accounts expense	5,597,156	4,486,287	49,463,033	38,395,451
Other payors	865,569	777,408	13,011,441	10,287,828
Deductions from revenue	<u>245,199,920</u>	<u>209,979,675</u>	<u>1,997,618,575</u>	<u>1,759,022,615</u>
Net patient revenue	<u>\$ 52,353,026</u>	<u>\$ 53,215,935</u>	<u>\$ 505,607,481</u>	<u>\$ 455,805,479</u>
Gross billed charges by patient type:				
Inpatient	\$ 143,143,265	\$ 130,200,066	\$ 1,179,471,341	\$ 1,122,214,868
Outpatient	120,598,821	102,267,009	1,036,097,280	827,534,083
Emergency room	33,810,863	30,728,535	287,657,435	265,079,142
Total	<u>\$ 297,552,949</u>	<u>\$ 263,195,610</u>	<u>\$ 2,503,226,056</u>	<u>\$ 2,214,828,093</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
March 31, 2025

	<u>Month of March,</u>		<u>Nine months ended March 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Operating revenue:				
Net patient revenue	\$ 52,353,026	\$ 53,215,935	\$ 505,607,481	\$ 455,805,479
Other operating revenue	<u>1,943,999</u>	<u>1,120,312</u>	<u>14,273,326</u>	<u>9,861,505</u>
Total operating revenue	<u>54,297,025</u>	<u>54,336,247</u>	<u>519,880,807</u>	<u>465,666,984</u>
Operating expenses:				
Salaries and wages	19,238,042	17,073,137	160,055,834	150,042,155
Compensated absences	2,871,141	3,444,168	28,114,949	27,363,015
Employee benefits	6,782,078	8,499,764	71,518,891	76,429,788
Supplies, food, and linen	8,990,542	7,582,049	78,229,896	65,386,273
Purchased department functions	4,681,833	3,716,049	35,466,591	32,566,197
Medical fees	2,324,813	2,198,594	23,054,657	22,107,686
Other fees	1,849,675	2,192,685	16,870,444	20,476,049
Depreciation	2,686,457	2,453,368	23,275,801	21,616,977
All other expense	<u>1,603,205</u>	<u>1,713,069</u>	<u>16,263,925</u>	<u>15,558,090</u>
Total operating expenses	<u>51,027,786</u>	<u>48,872,883</u>	<u>452,850,988</u>	<u>431,546,230</u>
Income from operations	<u>3,269,239</u>	<u>5,463,364</u>	<u>67,029,819</u>	<u>34,120,754</u>
Non-operating income:				
Donations	18,776	270,645	5,534,099	2,604,212
Property taxes	476,714	333,333	4,290,429	3,000,000
Investment income	2,682,245	2,531,046	16,610,382	22,520,296
Taxes and licenses	0	0	0	0
Income from subsidiaries	<u>(4,946,968)</u>	<u>(4,114,285)</u>	<u>(42,075,165)</u>	<u>(40,997,876)</u>
Total non-operating income	<u>(1,769,233)</u>	<u>(979,261)</u>	<u>(15,640,255)</u>	<u>(12,873,368)</u>
Operating and non-operating income	1,500,006	4,484,102	51,389,564	21,247,386
Net assets to begin	<u>1,043,538,009</u>	<u>936,088,871</u>	<u>993,648,450</u>	<u>919,325,587</u>
Net assets to end	<u>\$ 1,045,038,015</u>	<u>\$ 940,572,973</u>	<u>\$ 1,045,038,015</u>	<u>\$ 940,572,973</u>
Net income excluding non-recurring items	\$ 1,500,006	\$ 4,484,102	\$ 51,389,564	\$ 21,247,386
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>
Operating and non-operating income	<u>\$ 1,500,006</u>	<u>\$ 4,484,102</u>	<u>\$ 51,389,564</u>	<u>\$ 21,247,386</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
March 31, 2025

	<u>Month of March,</u>		<u>Nine months ended March 31,</u>	
	<u>current year</u>	<u>prior year</u>	<u>current year</u>	<u>prior year</u>
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	\$ (197,747)	\$ (200,041)	\$ (1,843,634)	\$ (1,823,701)
Neurological Clinic	(128,101)	(52,142)	(669,794)	(633,239)
Palliative Care Clinic	(126,271)	(104,060)	(869,355)	(815,953)
Surgery Clinic	(229,457)	(163,352)	(1,417,458)	(1,641,465)
Infectious Disease Clinic	(51,756)	(44,880)	(421,860)	(346,366)
Endocrinology Clinic	(254,621)	(219,792)	(2,078,609)	(2,085,328)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(580,600)	(452,610)	(5,322,430)	(5,183,044)
OB/GYN Clinic	(375,667)	(378,048)	(3,711,382)	(3,687,774)
PrimeCare Medical Group	(959,779)	(708,607)	(7,317,515)	(7,735,313)
Oncology Clinic	(459,160)	(386,684)	(3,685,487)	(3,100,631)
Cardiac Surgery	(396,688)	(321,568)	(3,149,531)	(2,799,513)
Sleep Center	(71,606)	(68,071)	(772,321)	(500,328)
Rheumatology	(78,206)	(70,944)	(678,242)	(651,388)
Precision Ortho MDs	(493,591)	(445,839)	(4,170,008)	(4,327,660)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(76,651)	(57,610)	(687,456)	(436,409)
Vaccine Clinic	0	0	0	16
Dermatology	(49,885)	(33,039)	(382,441)	(358,196)
Hospitalists	0	0	0	0
Behavioral Health	(32,268)	(47,622)	(345,263)	(446,456)
Pediatric Diabetes	(37,960)	(41,423)	(356,710)	(409,834)
Neurosurgery	(152,080)	(110,129)	(1,116,268)	(435,772)
Multi-Specialty-RR	15,898	2,022	107,150	23,273
Radiology	(327,797)	(155,270)	(2,899,561)	(2,785,417)
Salinas Family Practice	(110,662)	(99,587)	(1,009,414)	(1,218,500)
Urology	(92,634)	(173,391)	(1,578,496)	(1,555,613)
Total SVHC	(5,267,289)	(4,332,687)	(44,376,085)	(42,954,611)
Doctors on Duty	89,784	(39,737)	243,692	286,129
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	66,257	126,697	1,370,476	1,175,739
Coastal	46,495	48,817	(8,779)	96,226
Apex	0	0	0	0
21st Century Oncology	69,097	42,433	238,249	45,656
Monterey Bay Endoscopy Center	48,688	40,191	457,282	352,986
Total	<u>\$ (4,946,968)</u>	<u>\$ (4,114,285)</u>	<u>\$ (42,075,165)</u>	<u>\$ (40,997,876)</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
March 31, 2025

	<u>Current year</u>	<u>Prior year</u>
A S S E T S		
Current assets:		
Cash and cash equivalents	\$ 276,413,608	\$ 219,231,264
Patient accounts receivable, net of estimated uncollectibles of \$83,822,053	123,253,768	97,501,015
Supplies inventory at cost	8,739,677	7,839,589
Current portion of lease receivable	735,186	1,033,276
Other current assets	<u>17,743,171</u>	<u>21,866,166</u>
Total current assets	<u>426,885,411</u>	<u>347,471,310</u>
Assets whose use is limited or restricted by board	<u>173,535,507</u>	<u>165,022,784</u>
Capital assets:		
Land and construction in process	49,331,123	76,674,455
Other capital assets, net of depreciation	<u>209,364,115</u>	<u>172,449,225</u>
Total capital assets	<u>258,695,238</u>	<u>249,123,680</u>
Other assets:		
Right of use assets, net of amortization	8,402,941	6,958,849
Long term lease receivable	182,576	551,500
Subscription assets, net of amortization	8,564,699	7,404,479
Investment in Securities	264,896,614	253,138,221
Investment in SVMC	1,969,936	12,284,253
Investment in Coastal	1,743,591	1,777,867
Investment in other affiliates	21,528,806	12,748,330
Net pension asset	<u>(1,817,438)</u>	<u>(6,204,305)</u>
Total other assets	<u>305,471,725</u>	<u>288,659,194</u>
Deferred pension outflows	<u>85,734,219</u>	<u>116,911,125</u>
	<u>\$ 1,250,322,100</u>	<u>\$ 1,167,188,093</u>
L I A B I L I T I E S A N D N E T A S S E T S		
Current liabilities:		
Accounts payable and accrued expenses	\$ 58,415,246	\$ 54,393,470
Due to third party payers	5,812,278	4,090,793
Current portion of self-insurance liability	22,911,342	20,518,736
Current subscription liability	2,947,941	4,297,497
Current portion of lease liability	<u>2,921,098</u>	<u>2,907,057</u>
Total current liabilities	93,007,905	86,207,553
Long term portion of workers comp liability	11,809,968	13,027,333
Long term portion of lease liability	5,480,929	4,267,580
Long term subscription liability	<u>3,241,186</u>	<u>2,850,575</u>
Total liabilities	<u>113,539,988</u>	<u>106,353,041</u>
Lease deferred inflows	880,521	1,470,015
Pension liability	<u>90,863,576</u>	<u>118,792,064</u>
Net assets:		
Invested in capital assets, net of related debt	258,695,238	249,123,680
Unrestricted	<u>786,342,777</u>	<u>691,449,293</u>
Total net assets	<u>1,045,038,015</u>	<u>940,572,973</u>
	<u>\$ 1,250,322,100</u>	<u>\$ 1,167,188,093</u>

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
March 31, 2025

	Month of March,			Nine months ended March 31,			
	Actual	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:							
Gross billed charges	\$ 297,552,946	\$ 31,902,981	12.01%	\$ 2,503,226,056	\$ 2,302,107,057	201,118,999	8.74%
Deductions from revenue	245,199,920	32,197,528	15.12%	1,997,618,575	1,844,646,914	152,971,661	8.29%
Net patient revenue	52,353,026	(294,548)	-0.56%	505,607,481	457,460,143	48,147,338	10.52%
Other operating revenue	1,943,999	491,330	33.82%	14,273,326	13,074,021	1,199,305	9.17%
Total operating revenue	54,297,025	196,782	0.36%	519,880,807	470,534,164	49,346,643	10.49%
Operating expenses:							
Salaries and wages	19,238,042	744,737	4.03%	160,055,834	155,134,812	4,921,022	3.17%
Compensated absences	2,871,141	130,861	4.78%	28,114,949	28,828,344	(713,395)	-2.47%
Employee benefits	6,782,078	(1,879,539)	-21.70%	71,518,891	71,968,281	(449,390)	-0.62%
Supplies, food, and linen	8,990,542	1,688,266	23.12%	78,229,896	64,542,595	13,687,301	21.21%
Purchased department functions	4,681,833	856,549	22.39%	35,466,591	34,427,545	1,039,046	3.02%
Medical fees	2,324,813	(160,824)	-6.47%	23,054,657	22,370,735	683,922	3.06%
Other fees	1,849,675	93,247	5.31%	16,870,444	15,637,548	1,232,896	7.88%
Depreciation	2,686,457	153,357	6.05%	23,275,801	21,721,945	1,553,856	7.15%
All other expense	1,603,205	(384,308)	-19.34%	16,263,925	17,765,061	(1,501,136)	-8.45%
Total operating expenses	51,027,786	1,242,347	2.50%	452,850,988	432,396,866	20,454,122	4.73%
Income from operations	3,269,239	(1,045,565)	-24.23%	67,029,819	38,137,298	28,892,521	75.76%
Non-operating income:							
Donations	18,776	(189,557)	-90.99%	5,534,099	1,875,000	3,659,099	195.15%
Property taxes	476,714	(0)	0.00%	4,290,429	4,290,429	(0)	0.00%
Investment income	2,682,245	791,072	41.83%	16,610,382	17,020,558	(410,176)	-2.41%
Income from subsidiaries	(4,946,968)	176,254	-3.44%	(42,075,165)	(46,108,999)	4,033,834	-8.75%
Total non-operating income	(1,769,233)	777,768	-30.54%	(15,640,255)	(22,923,011)	7,282,756	-31.77%
Operating and non-operating income	\$ 1,500,006	\$ (267,796)	-15.15%	\$ 51,389,564	\$ 15,214,286	36,175,278	237.77%

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of March and nine months to date

	Month of March		Nine months to date		Variance
	2024	2025	2023-24	2024-25	
NEWBORN STATISTICS					
Medi-Cal Admissions	31	32	309	320	11
Other Admissions	74	77	717	750	33
Total Admissions	105	109	1,026	1,070	44
Medi-Cal Patient Days	45	62	490	604	114
Other Patient Days	106	126	1,171	1,124	(47)
Total Patient Days of Care	151	188	1,661	1,728	67
Average Daily Census	4.9	6.1	6.1	6.3	0.2
Medi-Cal Average Days	1.6	2.1	1.7	2.1	0.4
Other Average Days	0.7	1.8	1.7	1.5	(0.1)
Total Average Days Stay	1.5	1.8	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	362	388	3,363	3,474	111
Medi-Cal Admissions	312	285	2,395	2,571	176
Other Admissions	387	306	2,666	2,831	165
Total Admissions	1,061	979	8,424	8,876	452
Medicare Patient Days	1,509	1,432	13,732	13,044	(688)
Medi-Cal Patient Days	1,128	1,223	9,738	10,027	289
Other Patient Days	1,035	728	8,439	6,847	(1,592)
Total Patient Days of Care	3,672	3,383	31,909	29,918	(1,991)
Average Daily Census	118.5	109.1	116.5	109.2	(7.3)
Medicare Average Length of Stay	4.1	3.6	4.1	3.8	(0.4)
Medi-Cal AverageLength of Stay	3.5	3.7	3.5	3.4	(0.1)
Other Average Length of Stay	2.7	1.9	2.5	1.9	(0.6)
Total Average Length of Stay	3.4	3.1	3.4	3.0	(0.4)
Deaths	32	21	237	234	(3)
Total Patient Days	3,823	3,571	33,570	31,646	(1,924)
Medi-Cal Administrative Days	27	0	32	0	(32)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	27	0	32	0	(32)
Percent Non-Acute	0.71%	0.00%	0.10%	0.00%	-0.10%

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of March and nine months to date

	Month of March		Nine months to date		Variance
	2024	2025	2023-24	2024-25	
<u>PATIENT DAYS BY LOCATION</u>					
Level I	266	299	2,216	2,289	73
Heart Center	350	296	2,971	2,881	(90)
Monitored Beds	645	620	5,592	5,161	(431)
Single Room Maternity/Obstetrics	278	298	2,735	3,113	378
Med/Surg - Cardiovascular	933	871	7,588	7,820	232
Med/Surg - Oncology	294	289	2,523	2,433	(90)
Med/Surg - Rehab	426	489	4,100	4,187	87
Pediatrics	134	102	1,192	1,061	(131)
Nursery	151	188	1,661	1,728	67
Neonatal Intensive Care	65	119	987	973	(14)
<u>PERCENTAGE OF OCCUPANCY</u>					
Level I	66.00%	74.19%	61.99%	64.03%	
Heart Center	75.27%	63.66%	72.02%	69.84%	
Monitored Beds	77.06%	74.07%	75.31%	69.51%	
Single Room Maternity/Obstetrics	24.24%	25.98%	26.88%	30.59%	
Med/Surg - Cardiovascular	66.88%	62.44%	61.32%	63.19%	
Med/Surg - Oncology	72.95%	71.71%	70.57%	68.06%	
Med/Surg - Rehab	52.85%	60.67%	57.34%	58.56%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	24.01%	18.28%	24.08%	21.43%	
Nursery	29.52%	36.75%	18.30%	19.04%	
Neonatal Intensive Care	19.06%	34.90%	32.63%	32.17%	

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of March and nine months to date

	Month of March		Nine months to date		Variance
	2024	2025	2023-24	2024-25	
<u>DELIVERY ROOM</u>					
Total deliveries	95	106	948	1,064	116
C-Section deliveries	26	41	299	345	46
Percent of C-section deliveries	27.37%	38.68%	31.54%	32.42%	0.88%
<u>OPERATING ROOM</u>					
In-Patient Operating Minutes	15,899	23,452	141,597	167,502	25,905
Out-Patient Operating Minutes	31,837	35,872	265,728	311,835	46,107
Total	47,736	59,324	407,325	479,337	72,012
Open Heart Surgeries	13	10	99	101	2
In-Patient Cases	104	151	1,009	1,092	83
Out-Patient Cases	312	349	2,626	2,945	319
<u>EMERGENCY ROOM</u>					
Immediate Life Saving	45	38	333	306	(27)
High Risk	861	895	6,876	7,735	859
More Than One Resource	2,813	2,740	25,066	25,179	113
One Resource	1,837	1,771	16,995	16,069	(926)
No Resources	76	74	775	646	(129)
Total	5,632	5,518	50,045	49,935	(110)

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of March and nine months to date

	Month of March		Nine months to date		Variance
	2024	2025	2023-24	2024-25	
CENTRAL SUPPLY					
In-patient requisitions	12,909	12,816	116,314	111,225	-5,089
Out-patient requisitions	11,225	10,635	93,723	97,184	3,461
Emergency room requisitions	643	391	6,423	5,026	-1,397
Interdepartmental requisitions	6,898	6,957	59,647	61,828	2,181
Total requisitions	31,675	30,799	276,107	275,263	-844
LABORATORY					
In-patient procedures	35,978	36,434	328,649	321,198	-7,451
Out-patient procedures	41,866	49,750	249,054	400,747	151,693
Emergency room procedures	12,781	12,776	115,802	113,043	-2,759
Total patient procedures	90,625	98,960	693,505	834,988	141,483
BLOOD BANK					
Units processed	226	260	2,559	2,490	-69
ELECTROCARDIOLOGY					
In-patient procedures	1,090	1,143	9,878	10,090	212
Out-patient procedures	365	514	3,507	3,925	418
Emergency room procedures	1,271	1,387	11,011	11,684	673
Total procedures	2,726	3,044	24,396	25,699	1,303
CATH LAB					
In-patient procedures	148	136	1,121	1,189	68
Out-patient procedures	135	125	1,081	1,101	20
Emergency room procedures	0	1	0	2	2
Total procedures	283	262	2,202	2,292	90
ECHO-CARDIOLOGY					
In-patient studies	403	398	3,435	3,556	121
Out-patient studies	271	399	2,513	3,041	528
Emergency room studies	1	1	9	14	5
Total studies	675	798	5,957	6,611	654
NEURODIAGNOSTIC					
In-patient procedures	121	126	1,147	1,238	91
Out-patient procedures	9	27	160	223	63
Emergency room procedures	0	0	0	1	1
Total procedures	130	153	1,307	1,462	155

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of March and nine months to date

	Month of March		Nine months to date		
	2024	2025	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	0	0
Out-patient procedures	304	325	2,186	2,572	386
Emergency room procedures	0	0	0	0	0
Total procedures	304	325	2,186	2,572	386
RADIOLOGY					
In-patient procedures	1,280	1,329	11,766	11,744	-22
Out-patient procedures	420	454	3,629	3,963	334
Emergency room procedures	1,560	1,512	13,379	14,037	658
Total patient procedures	3,260	3,295	28,774	29,744	970
MAGNETIC RESONANCE IMAGING					
In-patient procedures	175	194	1,296	1,603	307
Out-patient procedures	108	147	1,003	1,006	3
Emergency room procedures	5	5	55	55	0
Total procedures	288	346	2,354	2,664	310
MAMMOGRAPHY CENTER					
In-patient procedures	4,458	4,626	37,119	34,174	-2,945
Out-patient procedures	4,447	4,596	36,715	34,048	-2,667
Emergency room procedures	0	1	9	10	1
Total procedures	8,905	9,223	73,843	68,232	-5,611
NUCLEAR MEDICINE					
In-patient procedures	14	10	177	137	-40
Out-patient procedures	126	134	1,017	1,190	173
Emergency room procedures	0	0	2	2	0
Total procedures	140	144	1,196	1,329	133
PHARMACY					
In-patient prescriptions	85,667	82,123	760,540	718,656	-41,884
Out-patient prescriptions	16,232	17,419	141,966	150,945	8,979
Emergency room prescriptions	9,847	9,816	83,758	88,879	5,121
Total prescriptions	111,746	109,358	986,264	958,480	-27,784
RESPIRATORY THERAPY					
In-patient treatments	16,356	13,169	146,158	133,709	-12,449
Out-patient treatments	1,314	929	10,065	8,548	-1,517
Emergency room treatments	441	481	4,521	4,857	336
Total patient treatments	18,111	14,579	160,744	147,114	-13,630
PHYSICAL THERAPY					
In-patient treatments	2,604	2,317	22,472	20,821	-1,651
Out-patient treatments	230	347	2,369	2,415	46
Emergency room treatments	0	0	0	0	0
Total treatments	2,834	2,664	24,841	23,236	-1,605

SALINAS VALLEY HEALTH MEDICAL CENTER

PATIENT STATISTICAL REPORT

For the month of March and nine months to date

	Month of March		Nine months to date		Variance
	2024	2025	2023-24	2024-25	
OCCUPATIONAL THERAPY					
In-patient procedures	1,378	1,538	12,781	13,189	408
Out-patient procedures	223	244	2,172	1,951	-221
Emergency room procedures	0	0	0	0	0
Total procedures	1,601	1,782	14,953	15,140	187
SPEECH THERAPY					
In-patient treatments	461	529	4,551	4,753	202
Out-patient treatments	31	34	349	338	-11
Emergency room treatments	0	0	0	0	0
Total treatments	492	563	4,900	5,091	191
CARDIAC REHABILITATION					
In-patient treatments	0	0	11	6	-5
Out-patient treatments	636	686	4,754	5,484	730
Emergency room treatments	0	0	0	1	1
Total treatments	636	686	4,765	5,491	726
CRITICAL DECISION UNIT					
Observation hours	337	271	2,877	2,256	-621
ENDOSCOPY					
In-patient procedures	87	77	692	735	43
Out-patient procedures	58	62	502	512	10
Emergency room procedures	0	2	0	4	4
Total procedures	145	141	1,194	1,251	57
C.T. SCAN					
In-patient procedures	744	798	6,483	6,843	360
Out-patient procedures	349	471	3,160	4,465	1,305
Emergency room procedures	758	671	6,555	6,519	-36
Total procedures	1,851	1,940	16,198	17,827	1,629
DIETARY					
Routine patient diets	11,561	16,875	150,306	142,559	-7,747
Meals to personnel	28,908	35,806	254,810	315,881	61,071
Total diets and meals	40,469	52,681	405,116	458,440	53,324
LAUNDRY AND LINEN					
Total pounds laundered	98,908	108,415	873,505	890,283	16,778

*TRANSFORMATION, STRATEGIC PLANNING
AND GOVERNANCE COMMITTEE*

*Minutes of the
Transformation, Strategic Planning and
Governance Committee
will be distributed at the Board Meeting*

(ROLANDO CABRERA, M.D.)

SVH Board Paper

Agenda Item: **Consider Approval of (i) Findings Supporting Recruitment of Sadi Dalieh, MD (ii) Contract Terms for Dr. Dalieh's Recruitment Agreement, and (iii) Contract Terms for Dr. Dalieh's Internal Medicine Professional Services Agreement**

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

Date: April 14, 2025

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of physicians specializing in **Internal Medicine** as a recruiting priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, Internal Medicine is recommended as a top priority for recruitment. To ensure that established primary care patients of Salinas Valley Health Clinics (SVHC) have access to after-hours care, clinic hours were expanded Monday through Friday to offer urgent care services from 5:00 p.m. to 9:00 p.m. To support this expanded service line, recruiting an additional Internal Medicine physician is imperative to meet the growing demand. Urgent care services are available to established SVHC primary care patients of all ages at the PrimeCare Salinas location.

The recommended physician, **Sadi Dalieh, MD**, received his Doctor of Medicine degree in 1989 from University of Jordan in Amman, Jordan. Dr. Dalieh completed his Internal Medicine residency training at North East Ohio College of Medicine, St. Elizabeth Medical Center in Youngstown, Ohio. Dr. Dalieh is triple Board certified in Emergency Medicine, Internal Medicine and Ambulatory Medicine and will 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.
- **Full-Time Schedule**. Physician will be scheduled to provide physician services to clinic patients on a full-time basis, 46 weeks per year; one week of which can be allocated to continuing medical education (CME).
- **Base Compensation**: \$325,000 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 \$55.00 wRVU conversion factor.
- **Professional Liability Insurance**. Professional liability is provided through BETA Healthcare Group.
- **Benefits**. Physician will be eligible for standard SVH Clinics physician benefits:
 - ❖ Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
 - ❖ Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
 - ❖ Six weeks (30 days) of time off each calendar year.
 - ❖ Continuing Medical Education (CME) annual stipend in the amount of \$2,400 paid directly to physician and reported as 1099 income.

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

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of Dr. Dalieh is aligned with our strategic priorities for the service, quality, and growth pillars. We continue to develop Salinas Valley Health Clinics infrastructure that engages our physicians in a meaningful way, promotes efficiencies in care delivery and creates opportunities for expansion of services. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by 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. Dalieh to Salinas Valley Health Clinics has been identified as a need for recruitment while also providing additional resources and coverage for SVH PrimeCare.

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

Recommendation

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

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

Attachments: Curriculum Vitae for Sadi Dalieh, MD

Sadi Dalieh, MD. MS. BCEM. FACP

United States Citizen

Board Certifications

Board Certified in Emergency Medicine

Board Certified in Internal Medicine

Board Certified in Ambulatory Medicine

Board Eligible in Addiction Medicine

Education

Doctor of Medicine (MD), August 1989

- University of Jordan/Faculty of Medicine- Amman, Jordan

Master of Science (MS) in Internal Medicine/Infectious Disease, September 1993

- The Ohio State University, Columbus, Ohio

Internal Medicine Residency, ABIM, July 1995- June 1998

North East Ohio College of Medicine, St. Elizabeth Medical Center, Youngstown, Ohio

Medical Licenses

- Massachusetts #1015810 exp. 02/04/2026
- Ohio # 35.072579 exp. 04/01/2026
- Oregon #MD154689 exp. 12/30/2025
- California C130369 exp. 02/28/2026

Certifications

- ATLS exp. 03/29/2026
- ACLS & PALS exp. 10/31/2026

Board Certifications

- American Board of Physician Specialties (ABPS) #21-EM-15698, December 2029)
- American Board of Internal Medicine (ABIM) #128866 (Aug. 2012- December 2027)

Work History

- Regional Medical Center of San Jose, CA March 2024- present
- ED Physician/Petaluma Valley Hospital/Petaluma, California (May 2019 – January 2025)
- Medical Director/ Monterey County, California Forensic Medical Group (CFMG) May 2020 - February 20, 2022
- ED Physician/St. Joseph's Medical Center/Stockton, California (May 2015 - September 2021)
- ED Physician/Lassen Banner Hospital/Susanville, California (June 2017 – June 2022)
- ED Physician/Emmanuel Hospital/Turlock, California (Nov. 2018 – June 2020)
- Medical Director, Emergency Department, Doctors Hospital of Manteca, Manteca, California (July 2014 - June 2016)
- Medical Director, Emergency Department, Austintown Medical Center, St. Elizabeth, Ohio (July 2014 – December 2017)
- Medical Director, Emergency Department, Bryan, Ohio (April 2012 – April 2015)
- Medical Director, Emergency Department, Henry County Hospital, Napoleon, Ohio (April 2012 – April 2015).

- **Roles and Responsibilities**

- Serving as an Emergency Room Doctor at various states, cities at all levels of ED trauma
- Serving on multiple committees for infection control/sepsis/stroke/quality control
- Serving as expert witness for multiple cases with multiple law firms including Douglas Malcolm MD., JD. Offices as plaintiff expert
- Review Leader for medical records reviews, quality and clinical documentation, staff education, monitoring and implementing policies for performance improvement
- Taught and trained residents, medical providers to adhere to standard of care

Hospital Affiliations

- Regional Medical center, San Jose, California (March 2024 – present)
- St. Joseph Medical Center, Stockton, California (May 2015 – 2020)
- Petaluma Valley Hospital, Petaluma, California (May 2020 – 2025)
- Banner Lassen Hospital, Susanville, California (January 2017 – 2021)
- Ashtabula County Medical Center (February 2005 – 2008)
- Trumbull Memorial Hospital, Warren, Ohio (April 2014 – December 2017)
- Doctor Hospital of Manteca, Manteca, California (July 2014 – December 2016)
- Saint Alphonsus Hospital, Ontario, Oregon (July 2015 – July 2016)
- St. Elizabeth, Austintown, Ohio (August 2014 – December 2017)
- Santiam Hospital, Santiam, Oregon (November 2015 – October 2016)
- Henry County (September 2013 – April 2014)
- Community Hospitals, Bryan and Montpelier (March 2013 – March 2015)
- Lake Health System, Lake West Hospital/Tri-point Hospital, Concord, Ohio (August 2012 – December 2015)
- Fort Hamilton (November 2011 – November 2013)
- UH Bedford Medical Center, Bedford, Ohio (July 2008 – December 2011)
- Summa Western Reserve, Cuyahoga Falls, Ohio (April 2007 – June 2009)
- Marietta Memorial Hospital (March 2006 – June 2007)
- St. Vincent Charity Hospital, Cleveland, Ohio (February 1999 – January 2014)
- Kaiser Permanente (September 1998 – January 2008)

Employers

- Self-employed at Petaluma Valley Hospital Emergency Group (May 2019 – present)
- Wellpath/ California Forensic Medical Group (May 2020 – February 2022)
- Kaiser Permanente (September 1998 – January 2008)
- UES/4M/IMM (July 2008 – December 2011) and (August 2015 – December 2017)
- Team Health (September 2011 – present)
- EMP/US Acute Care Solutions (August 2021 – December 2024)
- EmCare (August 2012- June 2018)

Research

- Infectious Disease Department/The Ohio State University, Columbus, Ohio (1991 – 1995)
- Clinical Pharmacology Department/ The Ohio State University, Columbus, Ohio (1989 – 1991)

- ED physician at multiple locations as Locum Tenants in CA, OR, MA (Jan 2014 – Jan. 2025)

Teaching Activities

- Clinical faculty, St. Joseph's Medical Center (June 2016 – present), teaching emergency medicine/family medicine residents
- Faculty at Case Western Reserve University- Clinical Instructor, Cleveland, Ohio, 2013 – December 2017)
- Teaching Internal Medicine/Family Medicine residents at Cuyahoga Fall, General Hospital (2006 – 2010)

Professional Memberships

- Fellow of American College of Physicians, FACP
- Member of American Society of Addiction Medicine (ASAM)
- Member of American Medical Association

ACP Activities

- Yearly review of Emergency Medicine Boards
- Yearly Medical Knowledge self-assessment program (MKSAP)
- Yearly review of Internal Medicine Board
- Yearly Medical Study review of Internal Medicine

Publications

1. Bacteremia with Streptococcus Pneumoniae Implications for Therapy and Prevention, *JAMA*, January 17, 1996, vol. 275, no. 3, 194-198.
2. Incidence of Community– Acquired Pneumonia Requiring Hospitalization ARCH Internal Medicine/vol. 157, August 11/25, 1997, 1709-1718

Medical Executive Committee Summary – April 10, 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Anderson-Smith, Nicole, MD	Neonatology	Pediatrics	Tele-Neonatology
Benjamin, John, MD	Neonatology	Pediatrics	Tele-Neonatology
Cole, Tyler, MD	Neurosurgery	Surgery	Neurosurgery
Eskandar-Afshari, Fatima, DO	Neonatology	Pediatrics	Tele-Neonatology
Ford, Kimberly, MD	Psychiatry	Medicine	Tele-Psychiatry
Granthom, Maria, MD	Ob/Gyn	Ob/Gyn	OB Hospitalist GYN Hospitalist
Jensen, Erik MD	Neonatology	Pediatrics	Tele-Neonatology
Litt, Jonathan, MD	Neonatology	Pediatrics	Tele-Neonatology
Maybody, Majid, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging – Non-Cardiac Diagnostic Radiology: Remote Teleradiology
Sankar, Meera, MD	Neonatology	Pediatrics	Tele-Neonatology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Aziz, Shehzad, MD	Hematology & Oncology	Medicine	Hematology/Oncology SVHMC Outpatient Infusion Center General Internal Medicine
Biehl, Kenneth, MD	Radiation Oncology	Medicine	Radiation Oncology
Breuer, Tuvia, DO	Tele-Psychiatry	Medicine	Tele-Psychiatry
Geller, Felix, MD	Tele-Psychiatry	Medicine	Tele-Psychiatry
Janda, Herjap, MD	Internal Medicine	Medicine	Hospitalist – Adult
Leonard, Kristin, DO	Family Medicine	Medicine	Hospitalist – Adult
Marquez, Elida, MD	Ob/Gyn	Ob/Gyn	Obstetrical and Gynecology
Mayer, Patricia, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Revers, Robert, MD	Internal Medicine	Medicine	Medicine – Active Community
Ryan, Martha, MD	Ophthalmology	Surgery	Ophthalmology
Subbarao, Meena, MD	Pediatrics	Pediatrics	Pediatrics – Active Community
Varma, Geetha, MD	Hematology/Oncology	Medicine	Hematology/Oncology General Internal Medicine: Core
Whisler, Charles, MD	Ophthalmology	Surgery	Ophthalmology
Zetterlund, Patrik, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology: Peripheral Endovascular Salinas Valley Health Advanced Imaging- Cardiac Imaging Salinas Valley Health Cardiovascular Diagnostics

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Dickey, James, MD	General Surgery	Senior Active to Active Community
Honegger, Judy, DO	Ob/Gyn	Active to Leave of Absence
Kim, Harold, MD	Anesthesiology	Provisional to Active Staff
Roldan, Mario, DO	General Surgery	Provisional to Active Staff
Brunson, John, MD	Tele-Radiology	Resignation effective 3/4/2025
Garcia-Rivera, Ricardo, MD	Tele-Neurology	Resignation effective 3/4/2025
Lee, Sherry, MD	Pediatrics	Resignation effective 5/2/2025
Varma, Ross, MD	Tele Radiology	Resignation effective 3/4/2025
Winter, Amy, MD	Pediatrics	Resignation effective 5/1/2025

Privilege Modifications:

NAME	SPECIALTY	PRIVILEGE CHANGE
Graham, Kyle, MD	Ob/Gyn	Obstetrical and Gynecology
Larsen, Melissa, MD	Ob/Gyn	Obstetrical and Gynecology
Ramseur, James, MD	Ob/Gyn	Obstetrical and Gynecology
Youngflesh, Kyle, DO	Family Medicine	Hospitalist - Adult

Temporary Privileges:

NAME	SPECIALTY	DATES
Cole, Tyler, MD	Neurosurgery	3/28/2025 – 3/31/2025
Ramseur, James, MD	Ob/Gyn	3/27/2025 – 3/28/2025

Interdisciplinary Practice Committee**Initial Appointments:**

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Gill, Shaminder, PA-C	Emergency Medicine	Emergency Medicine	Eric Fajardo, MD Nikolas Greenson, MD
Klay, Amanda PA-C	Orthopedics	Surgery	Bert Tardieu, MD; Kelvin Lim, MD Allen Hershey, MD; Willard Wong, MD; David Roy, MD; Matthew Griffin, MD and Justin Swan, MD
Lo, Kevin, PA-C	Surgery	Surgery	Tarun Bajaj, MD Shin Young Park, MD Alison Tammany, MD Mario Roldan, DO Mark Healy, MD

Modification/Addition of Privileges:

NAME	SPECIALTY	PRIVILEGE CHANGE
Chu, Valerie, PA-C	Cardiology	Withdrawal of Cardiology Ambulatory Care privileges
Galindo, Sabrina, NP	Cardiothoracic & Vascular Surgery	Additional Privileges: Act as first or second assist in surgery with an approved supervising physician Surgical wound closure.

Other Items: (Attached)

ITEM	RECOMMENDATION
Bar Code Medication Administration in Endoscopy-Nursing Standardized Procedure	New standardized procedure recommended for approval.
Management of Category II (with Heightened Concern) or Category III Fetal Heart Tracings in OB Triage - Nursing Standardized Procedure	New standardized procedure recommended for approval.

Policies and Plans:

1. Alcohol Withdrawal Treatment Guidelines
2. Emergency Plan for Sterilization Failure
3. Hazardous Materials Plan
4. Infectious Disease Surge Tent
5. Medically Indicated Deliveries – 39 weeks gestation
6. Medication Override
7. Medication Safety
8. MRSA Active Surveillance Screening
9. Non-Stress Test
10. Safety Management Plan

Informational Items:

I. Committee Reports:

- a. Credentials Committee
- b. Interdisciplinary Practice Committee
- c. Quality and Safety Committee
 - Beta Heart Revalidation Visit
 - Diagnostic Safety: IDEA/RAND Participation with AHRQ
 - CMS Patient Safety Structural Measure
 - Accreditation and Regulatory Update
 - Pharmacy & Therapeutics/Infection Prevention Committee Update

II. Other Reports:

- a. Title 22 Update
- b. Summary of Executive Operations Committee Meetings
- c. Summary of Medical Staff Department/Committee Meetings March 2025
- d. Medical Staff Treasury Report April 2, 2025
- e. Medical Staff Statistics Year to Date
- f. Financial Update February 2025
- g. HCAHPS Update April 3, 2025



Last ApprovedN/ANext Review3 years after approval

OwnerAisha Huebner: Director Perioperative ServicesAreaNursing Standardized Procedures

Bar Code Medication Administration in Endoscopy

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To create a standardized operating procedure that will support bar code scanning of medications during procedures in Endoscopy which will support safe medication practice.

III. DEFINITIONS

- A. ADC: Automated Dispensing Cabinet
- B. DOS: Date of Service
- C. EMR: Electronic Medical Record
- D. HCG: Human Chorionic Gonadotropin
- E. BCMA: Bar Code Medication Administration
- F. SOP: Standardized Operating Procedure

IV. GENERAL INFORMATION

- A. Nurse will enter electronic orders into EMR
- B. Electronic orders are entered under order source "Policy"
- C. Pharmacy will verify the order
- D. Physician will co-sign the order

V. PROCEDURE

- A. Urine HCG for women who have begun menstruating on DOS whether ordered by surgeon, proceduralist, or anesthesia protocol, except:

Women who have been in menopause greater than one year.

Women with prior sterilization procedure or hysterectomy.

Women who are currently menstruating

Women scheduled for missed abortion procedure.

Women with known pregnancy.

(ex. Cerclage, Cholecystectomy in a pregnant patient)

UCG's are necessary until a woman reaches menopause or any other exclusion criteria as mentioned above.

- B. Documentation: N/A

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Perioperative Services; Anesthesia Protocol

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	04/2025
IDPC	Katherine DeSalvo: Director Medical Staff Services	04/2025
P&T Committee	Genevieve delos Santos: Director Pharmacy	02/2025
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	02/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Aisha Huebner: Director Perioperative Services	01/2025

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerDaniela Jago: Clinical ManagerAreaNursing Standardized Procedures

Management of Category II (with Heightened Concern) or Category III Fetal Heart Tracings in OB Triage Nursing Standardized Procedure

I. POLICY

- A. Function
 - To provide guidance in the appropriate management of patients who present to OB ED with a FHR tracing of Category II (with heightened concern) or Category III.
- B. Circumstances
 - Setting
 - Salinas Valley Health Medical Center (SVHMC) Perinatal Services OB ED
 - Supervision
 - Physician via phone consultation
 - Patient Conditions
 - Indeterminate or Abnormal fetal heart rate tracing

II. DEFINITIONS

- A. Category II with heightened concern – Fetal heart rate tracing that does not meet criteria for category I or category III with minimal or moderate variability, recurrent decelerations, bradycardia or as appropriate from RN assessment [FETAL HEART RATE MONITORING](#)
- B. Category III – Please see [FETAL HEART RATE MONITORING](#)

III. PROCEDURE

- A. Database

Assessment of fetal status on arrival to OB ED unit

- Subjective
 1. Assess maternal perception of fetal movement
- Objective
 1. Place patient on fetal monitor and obtain fetal heart rate tracing. Refer to [FETAL HEART RATE MONITORING](#)

B. Diagnosis

- When an indeterminate (with heightened concern) or abnormal fetal heart tracing is identified upon arrival to OB Triage, initiate the following interventions:

C. Plan

- Treatment
 1. Insert IV (preferably 18 ga)
 2. LR bolus of 500 ml
 3. Position change
 4. O2 at 100%FiO2
- Patient conditions requiring consultation/reportable conditions:
 1. Notify physician of FHR tracing and interventions
- Education-Patient/Family
 1. Inform patient and support people of need for intrauterine resuscitative efforts.
- Follow-up
 1. Monitor patient response.
 2. Notify physician if further management needed, further actions per physician order.
- Documentation of Patient Treatment
 1. Fetal heart rate status, interventions completed, and patient response (maternal and fetal) [OB MEDICAL SCREEN EXAMINATION](#)

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education/Experience

- Orientation and education will be provided by a registered nurse who has shown competency in assessment and documentation of the Medical Screen Exam.

B. Experience

- A minimum of twelve months documented labor and delivery experience after

orientation period is complete for new graduate RNs.

C. Evaluation

- Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated. Initial evaluation completed by LD manager or their designee As part of orientation to OB ED Medical Screen competency, RN will demonstrate appropriate intrauterine resuscitation interventions as documented in their orientation materials.
- Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
- Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

- Standardized Procedures goes through the Family Practice Committee and OB/GYN Committee every three (3) years.
- Standardized Procedures goes through the Interdisciplinary Practice Committee (IDPC) upon creation and when changes are made.
- Chief Nursing Officer upon creation of standardized procedure and with significant changes.

B. Review Schedule

- Standardized procedure will be reviewed every three years

C. Signature of authorized Personnel Approving the Standardized Procedure and Dates

- Approval of the standardized procedure is outlined in the electronic policy and procedure system.
- Director of Women's/Children's Services, Chair of OB/GYN, Chair of Family Practice, Chair of Interdisciplinary Practice Committee, and Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

- A. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

VII. REFERENCES

- A. AWHONN. (2021). Fetal heart monitoring: Principles and practices. (6th ed.) Lyndon, A., & Wisner, K. Eds. Dubuque, IA: Kendall/Hunt.
- B. Macones, G., Hankins, G., Spong, C., Hauth, J. & Moore, T. (2008). The 2008 National institute of child health and human development workshop report on electronic fetal monitoring: Update on definitions, interpretation, and research guidelines. *Journal of Obstetric, Gynecologic and Neonatal Nurses*, 37, 510-515.
- C. Simpson, K., Creehan, P., O'Brien-Abel, N., Roth, C., & Rohan, A. (2021). *Perinatal nursing*. Philadelphia: Lippincott Williams & Wilkins.

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	04/2025
IDPC	Katherine DeSalvo: Director Medical Staff Services	04/2025
OB Dept.	Katherine DeSalvo: Director Medical Staff Services	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Daniela Jago: Clinical Manager	03/2025

Standards

No standards are associated with this document



Last Approved
Next Review

N/A
3 years after approval

Owner
Area

Lacey Cone:
Director Critical Care Services
Patient Care

Alcohol Withdrawal Treatment Guidelines

I. POLICY STATEMENT

- A. Patients with actual or potential alcohol withdrawal symptoms may be treated for those symptoms utilizing the SEWs (Medsurg) or MINDs (Progressive Care/ICU) Alcohol Withdrawal Order Set (Attachment A), upon the direction of a physician.

II. PURPOSE

- A. To guide the medical and nursing staff to promptly, adequately, and safely medicate patients at risk for or in acute alcohol withdrawal.

III. DEFINITIONS

- A. SEWs- Severity of Ethanol Withdrawal Scale
- B. MINDs- Minnesota Detoxification Scale
- C. PAWSS- Prediction of Alcohol Withdrawal Severity Scale

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. Upon admission to an inpatient unit, all adult patients age 18 and older will be screened for potential alcohol withdrawal using the PAWS Scale.
- B. Upon physician order of SEWs or MINDs Alcohol Withdrawal Order Set, the assigned licensed nursing staff will perform the SEWs or MINDs assessment and medicate the patient according to the treatment guideline orders.
 - The SEWs/MINDs assessment scores must be performed a minimum of every four

hours, per protocol, while the patient is on Alcohol Withdrawal Order Set.

- Vital signs will be done with each SEWs/MINDs assessment while the patient is on Alcohol Withdrawal Order Set.
 - Licensed nursing staff will administer alcohol withdrawal medication as ordered
- C. Patient requires monitored bed if receiving alcohol withdrawal medication intravenously.
- D. Alcohol Withdrawal Order Set and the SEWs/MINDs will be discontinued in seven (7) days or with a physician's order.
- E. Documentation:
- The SEWs/MINDs assessment is documented in the electronic medical record.
 - Document patient/family teaching completed.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Beresford TP, Ronan PJ, Taub J, Learned B, Mi Z, Anderson M. Working Toward a Gold Standard: The Severity of Ethanol Withdrawal Scale (SEWS) Versus the Clinical Institute Withdrawal Assessment Alcohol Scale (CIWA-Ar). *Alcohol Alcohol*. 2023 May 9;58(3):324-328. doi: 10.1093/alcalc/agad016. PMID: 36935201; PMCID: PMC10168711.
- B. Patel L, Beddow D, Kirven J, Smith CS, Hanovich S, Holaday K, Agboto V, St Hill CA. Outcomes of Minnesota Detoxification Scale (MINDS) Assessment With High-Dose Front Loading Diazepam Treatment for Alcohol Withdrawal in Hospitalized Patients. *Am J Med Sci*. 2022 Jan;363(1):42-47. doi: 10.1016/j.amjms.2021.10.003. Epub 2021 Oct 16. PMID: 34666063.
- C. Tidwell WP, Thomas TL, Pouliot JD, Canonico AE, Webber AJ. Treatment of Alcohol Withdrawal Syndrome: Phenobarbital vs CIWA-Ar Protocol. *Am J Crit Care*. 2018 Nov;27(6):454-460. doi: 10.4037/ajcc2018745. PMID: 30385536.

Attachments

 [MINDS flowsheet for PC_ICU final.pdf](#)

 [MINDs Scoring tool.pdf](#)

 [PAWSS scoring tool.pdf](#)

 [SEWS Flowchart for Medsurg.pdf](#)

 [SEWs Scoring Tool.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	04/2025
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	03/2025
P&T Committee	Genevieve delos Santos: Director Pharmacy	03/2025
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	02/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	01/2025
Critical Care Director	Lacey Cone: Director Critical Care Services	01/2025
Policy Owner	Lacey Cone: Director Critical Care Services	01/2025

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerJuan Gomez: Manager SSPD
AreaInfection Control

Emergency Plan for Sterilization Failure

I. POLICY STATEMENT

A. NA

II. PURPOSE

A. To assure appropriate sterilization of surgical type instruments when Salinas Valley Health Medical Center (SVHMC) capability is compromised or in an emergency situation.

III. DEFINITIONS

- A. Approved facility: any facility that holds the same CMS & AAMI standards for regulatory requirements as SVHMC.
- B. CMS: Center for Medicare & Medicaid Services
- C. AAMI: Association for the Advancement of Medical Instrumentation

IV. GENERAL INFORMATION

A. NA

V. PROCEDURE

- A. All surgical instrumentation will be appropriately cleaned prior to transportation to outside facility for processing.
- B. All surgical instrumentation that are taken to another facilities' Sterile Processing Department (SPD), will be cataloged/tracked (use approved /load sterilization log).
 - 1. The steam cycles are monitored by mechanical (printout or graphically, by measuring temperature, time and pressures), chemical and biological monitors.
 - a. Logs & copies of all the quality indicators for surgical instruments

processed will be provided to and maintained at SVHMC and the sterilizing facility.

- b. Logs of all patients that had surgical procedures with surgical instrumentation that was processed at the sterilizing facility will be provided to the SVHMC Infection Control Department for surgical site infection surveillance monitoring.

C. Transportation:

- 1. Sterile items will be placed in clear dust cover bags and transported in leak proof, solid bottom plastic bins with closed lids. If plastic bins are not available in the sizes needed, items will be double bagged in clear plastic bags.
 - a. Rational: Covered and closed carts will protect sterile items from exposure to environmental contaminants during transportation.

D. Carts and reusable covers will be cleaned with hospital approved disinfectant after each use due to possible contaminants picked up from the environment during transport.

E. Surgical instruments/trays will be closely inspected for physical damage and to ensure packaging sterility has been maintained.

- 1. Any packaging that has not been maintained will not be used.

F. Transport guidelines between locations when using vehicle on public roadways

- 1. Dedicated vehicle allowing for complete segregation between clean, sterile and contaminated.
- 2. Temperature and humidity controlled vehicle
 - a. The driver will check the temperature and humidity at time of departure & arrival. The driver will utilize SVHMC temperature and humidity log kept in SSPD for documentation.
 - i. Ranges:
 - 1. Controlled temperature between 18C and 22C (64F and 72F)
 - 2. Relative humidity between 35% and 70%
- 3. Locking device on vessels: Zip ties to prevent movement in transit.
- 4. Labeling of instrumentation sets: Instruments will be identified as Clean, Contaminated, or Sterile.
- 5. Use of appropriate PPE as needed.
- 6. Personnel transport will follow CMS & AAMI guidelines for proper handling of sterile and contaminated goods.
- 7. Thorough cleaning and decontamination of vehicle, and containment vessels will be completed after each transport.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Conner, R. *Recommendation XII: Transportation of sterile items should be controlled*. pg. 476. Perioperative Standards and Recommended Practices 2011 Edition, AORN.
- B. Pg. 58-61, pg. 70-115.
[http://www.cdc.gov/hicpac/Disinfection Sterilization/acknowledg.html](http://www.cdc.gov/hicpac/Disinfection%20Sterilization/acknowledg.html), accessed May, 06 2014.
- C. Association for the Advancement of Medical Instrumentation (AAMI). AAMI st79 6.5.
http://marketplace.aami.org/eseries/scriptcontent/docs/Preview%20Files%5CST790907_preview.pdf, accessed 05/08/2014.
- D. AAMI (Association for the Advancement of Medical Instrumentation) 3.3.3.4, for Temperature & humidity standards.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	04/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	03/2025
P&T/IPC	Genevieve delos Santos: Director Pharmacy	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Juan Gomez: Manager SSPD	02/2025

Standards

No standards are associated with this document



Last ApprovedN/ANext Review1 year after approval

OwnerJames Hively: Manager Environmental Health & SafetyAreaPlans and Program

Hazardous Materials & Waste Management Plan

I. SCOPE

- A. Hazardous Material and Waste (HazMat) Management Plan describes the methods for handling hazardous materials and waste through risk assessment and management for the Salinas Valley Health Medical Center (SVHMC) The plan addresses the risks associated with these materials that can pose a threat to the environment, staff, patients, and visitors from the variety of hazardous substances, such as radiological, chemical, or hazardous energy sources, and to minimize the risk of harm at SVHMC. The program is designed to assure compliance with applicable codes and regulations as applied to the buildings and services at SVHMC The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures.

II. OBJECTIVES/GOALS

- A. Objectives
1. The objective of the HazMat Program are to ensure that all hazardous materials are managed safely and in accordance with all applicable regulations and codes from the point of entry to any Salinas Valley Health facility through to its final use and/or disposal.
- B. Goals
1. The goals for the Hazmat Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, occurrence reports and environmental tours.

III. DEFINITIONS

- A. Hazardous Material and Waste (HazMat)

- B. Environment of Care Committee (EOC)
- C. Safety Data Sheets (SDS)
- D. Personal Protective Equipment (PPE)
- E. EHS: Environmental Health & Safety

IV. PLAN MANAGEMENT

A. Plan Elements

1. The Scope of the hazardous materials and waste management program is determined by the materials in use and the waste generated by the hospital.
2. The hazardous materials and waste are identified in the organization's inventory and the associated hazards defined as required by law or regulation in Safety Data Sheets (SDS), guidelines, good-practice recommendations, or similar available documents.
3. Safe use of hazardous materials and handling of waste requires participation by leadership, at an organizational level and a departmental level, and other appropriate staff in the design and implementation of all parts of the plan.
4. Protection from hazards requires all staff that use or are exposed to hazardous materials and waste to be educated as to the nature of the hazards and to use equipment provided for safe use and handling when working with or around hazardous materials and waste.
5. Rapid, effective response is required in the event of a spill, release, or exposure to a hazardous materials or waste. See [HAZARDOUS MATERIALS SPILL RESPONSE PROCEDURE](#)
6. Special monitoring processes or systems may be required to manage certain hazardous gases, vapors, or radiation undetectable by humans.

B. Plan Management

1. **PROCESSING FOR MANAGING THE RISK OF HAZARDOUS MATERIAL AND WASTE**
 - a. **Management Plan**
 - i. The organization develops and maintains the Hazardous Material and Waste Management Plan to effectively manage the risks of hazardous material and waste to the staff, visitors, and patients at SVHMC.
 - b. **Hazardous Materials and Waste Inventory**
 - i. The organization develops and maintains an inventory of hazardous materials and waste, including biological, radiological, chemotherapeutic, and chemicals. Each manager provides information on the hazardous materials and waste used, stored, or generated in that department. Inventories are received from each department and evaluated for completeness with assistance from the appropriate staff, including the

Radiation Safety Officer.

- ii. Information identifying the hazards and emergency responses associated with these materials and wastes are available to staff, patients, and visitor at all times from such resources as Safety Data Sheets (SDS) sheets, Centers for Disease Control (CDC) Guidelines, and Nuclear Regulatory Commission (NRC) regulations. Various methods for retrieving the information are available from the internet, fax, and/or on-line servers.

c. Spills and Exposures

- i. The EHS Manager, or designee, develops and maintains emergency procedures for the Hazardous Materials and Waste program.
- ii. SVHMC has a procedure that evaluates spills to determine if outside assistance is necessary. A minor (incidental) spill is one that can be safely cleaned up by the staff involved, with their training and personal protective equipment. If a spill kit is used, the kit contents are replaced.
- iii. A spill that exceeds the capability of the immediate staff to neutralize and clean up requires a response from outside the facility. In these cases, the area may be evacuated, ventilation controlled, and the Salinas Fire Department HAZMAT Team is called. The Salinas Fire Department takes control of the site and cleanup, or arrange for it to be cleaned up. Once determined safe, hospital staff finish the cleanup and recovery. Staff, including Environmental Services (EVS) staff, is trained to recognize the potential for a spill that is not safe to handle, and to contact their manager, and/or the Plant Operations/ Engineering Department. During off-shifts, the Administrator on Duty and the Nursing Administrative Supervisor will make the determination. Staff is cautioned to err on the side of safety, and not proceed with cleanup that exceed their training knowledge, or the PPE they have available.
- iv. Incidents involving spill kits, or a response from any outside agency are documented on Incident Report Forms.

d. Hazardous Chemical Risks

- i. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous chemical materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating Safety Data Sheets for hazards before purchase of departmental supplies to assure they are appropriate, and the least hazardous alternative practical. The department managers

work with the EHS Manager and appropriate individuals to develop procedures for handling of hazardous materials. The following materials and wastes are managed:

- a. Chemical materials are identified and ordered by department leadership. Appropriate storage space is maintained by each department, and reviewed as part of environmental tours in that area. Chemical materials are maintained in labeled containers, and staff is trained in understanding SDS, and in the appropriate and safe handling of the chemicals they use.
- b. Chemical waste is held in the hazardous waste collection yard or generating department, until arrival of the licensed hazardous waste contractor. The contractor lab packs the chemicals, completes the manifest and removes the packaged waste. The Uniform Hazardous Waste Manifest records are maintained by Safety Office. Only authorized employees of SVHMC are permitted to sign a Uniform Hazardous Waste Manifest.

e. Radioactive Risks

- i. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous radioactive materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department managers work with the Radiation Safety Officer or Infection Prevention Manager, to develop procedures for handling of radioactive materials:
 - a. Radioactive material is handled subject to the SVHMC NRC License, and their safety is managed by the Radiation Safety Officer. Materials are handled in accordance with the requirements of the facility license.
 - b. Radioactive waste is held in a 'hot room' until decayed to background, then handled as the underlying hazard of the materials for disposal. The Radiation Safety Officer manages the waste and determines when it is no longer considered a radioactive hazard.
 - c. Radioactive deliveries are escorted to the Nuclear Med Lab by security.

f. Hazardous Energy Sources

- i. Hazardous energy sources include, but not limited to, ionizing

and non-ionizing systems, and lasers will be selected and used in accordance to manufacturer's recommendation and regulatory requirements. Specific policies pertaining to operational safety and use of each hazardous energy sources are found in each department that utilizes such sources . The Department Director or a designated representative will conduct identification and evaluation of hazardous energy sources.

- ii. The primary source of hazard information will be from the manufacturer and/or supplier. Engineering controls and/or work practices should be developed to reduce exposures and potential injury. All employees involved in the operation and use of hazardous energy sources will be provided with appropriate training as part of their initial orientation. Staff will follow the procedures established in the departmental policies and procedures to identify and mitigate exposure to potential risks associated with hazardous energy sources. Department leaders will maintain required documentation including applicable regulations, required permits and licenses for each hazardous energy source.

g. Hazardous Drugs

- i. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous drugs and waste from receipt or generation through use and/or final disposal
 - a. Hazardous drugs and the materials used to prepare, administer, and control these materials are controlled and the waste materials collected for appropriate disposal. Staff using these materials are trained in the handling, and emergency response to spills or leaks.
 - b. Chemotherapeutic residual waste is handled as part of the Regulated Medical Waste stream, with additional labeling to assure appropriate incineration as final destruction. Larger than residual volumes of chemotherapeutic waste (liquids) are handled as chemical waste.
 - c. Pharmaceutical Waste is disposed of as follows:
 - i. Pharmaceutical Waste placed in Blue and White Containers is sealed in the container and removed to a designated location and removed by a certified hauler.
 - ii. Pharmaceuticals: R.C.R.A waste is dated and labeled and sealed in a black container, dated for removal and placed in a designated location and removed by a

certified hauler.

h. Hazardous Gas & Vapor Risks

- i. The EHS Manager is responsible for managing the program for monitoring hazardous gases and vapors.
- ii. If a test result was above the Cal/OSHA Permissible Exposure Limit (PEL), corrective action and additional testing will be done to ensure a safe working environment.

i. Permits, Licenses, Manifests and SDS

- i. SVHMC has obtained and maintains permits and licenses for handling and disposal of hazardous wastes, including chemical wastes and radioactive materials from the appropriate federal, state, and municipal agencies and safety data sheets for the chemical waste and hazardous medications waste.
- ii. Each shipment of hazardous waste removed from the facility is documented on a Uniform Hazardous Waste Manifest

j. Reviewing CT, PET, and MRI staff dosimetry data

- i. The results of staff dosimetry monitoring for CT, PET and NM services are reviewed at least quarterly by the Radiation Safety Officer, Diagnostic Medical Physicist, or Health Physicist to assess whether staff radiation exposure levels are "As Low As Reasonably Achievable" (ALARA) and below regulatory limits

k. Managing radiation exposures

- i. The organization monitors the radiation exposures to the appropriate staff periodically. Exposure meters or radiation monitoring badges are used to monitor the radiation dose. The Radiation Safety Officer reviews the results of the monitoring process and reports any concerns to the Radiation Safety Committee and the Environment of Care Committee when appropriate.

l. Managing general waste

- i. SVHMC has procedures for the proper management of general waste or "trash" generated throughout the facility. This includes the proper collection in the appropriate container, transportation of the waste to the storage or disposal site, and the prompt disposal of the waste. The Director of Environmental Services is responsible for this process and reports and discrepancies to the Environment of Care Committee as needed.

m. Managing regulated medical waste, including sharps

- i. The management of the disposal of regulated medical wastes is the responsibility of the Infection Prevention Manager with assistance from the Director of Environmental Services. The EVS

staff distributes and collects appropriate containers for collection of regulated medical wastes and for medical sharps. The containers are leak proof and puncture resistant. The EVS staff collects the containers and transports them to the holding room. The appropriate staff will clean up all spills of blood or body fluids. The areas affected will be cleaned following appropriate procedures for the material involved.

n. **Evaluating the Management Plan**

- i. On an annual basis, the EOC Committee evaluates the scope, objectives, performance, and effectiveness of the plan to manage the risks of hazardous materials and waste to the staff, visitors, and patients at SVHMC.**Process for Labeling Hazardous Material & Waste**

2. All hazardous materials and wastes are properly labeled. Hazardous waste container labels will include the accumulation start date.

- a. **Chemotherapeutic Waste:** Chemotherapeutic waste is placed into labeled containers (labeled with the OSHA and international symbol for carcinogenic wastes). These wastes are handled along with the red bag wastes. Bulk quantities of chemotherapeutic waste are handled as hazardous chemical waste.
- b. **Chemical Materials and Waste:** Chemical materials are labeled throughout their use, handling, and disposal. The label is on the container prior to receipt or is placed on containers when filled or mixed within the hospital. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible. In many cases the waste is labeled by the original chemical name, in other cases, where collection containers are used, the container is labeled. These labels are required by law and the vendors of chemical disposal services to maintain the identity of the materials, and if the identity is lost, the materials are tested and analyzed to identify them for proper handling and disposal.
- c. **Radioactive Materials & Waste:** Radioactive materials are labeled according to NRC, OSHA, or International agencies. Wastes are held to decay to background, when the labels are removed or covered, and wastes handled as the other hazards they may reflect. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible.

C. **Plan Responsibility**

- 1. The EHS Manager, in collaboration with the EOC, is responsible for monitoring all aspects of the HazMat Program.
 - a. CT: computerized tomography
 - b. PET: Positive Electron Tomography
 - c. MRI: Magnetic Resonance Imaging
 - d. NM: Nuclear Medicine

D. **Performance Measurement**

- 1. The performance measurement process is one part of the evaluation of the effectiveness of the Hazardous Materials Management Program. Performance measures are established to measure at least one important aspect of the Hazardous Materials Management Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

E. **Orientation and Education**

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

V. **REFERENCES**

- A. The Joint Commission Standards, Environment of Care Chapter

Approval Signatures

Step Description	Approver	Date
SRC	Aniko Kukla: Director Quality & Patient Safety	Pending
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	04/2025
Emergency Management	James Hively: Manager Environmental Health & Safety	04/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	James Hively: Manager Environmental Health & Safety	04/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	3 years after approval

Owner	Genevieve delos Santos: Director Pharmacy
Area	Pharmacy

Infectious Disease Surge Tent - Tent Medication Box

I. SPECIAL CIRCUMSTANCES

A. In response to the surge of respiratory illness throughout the State of California, Salinas Valley Health Medical Center (SVHMC) has established Infectious Disease Surge Tents located on campus property. The Pharmacy will provide access to basic emergency medications for patient administration within the Infectious Disease Surge Tents by use of a Tent Medication Box.

1. The Tent Medication Box will be stocked with basic emergency medications commonly administered in the Emergency Department. While in use, the Tent Medication Box will remain in a secured location (within the Infectious Disease Surge Tent which is bound by a secured fencing perimeter). The Tent Medication box will remain under the

supervision of Charge Nursing Staff at all times. The Tent Medication Box will remain locked until medications are withdrawn for use. The Charge Nurse on duty will be responsible for possession of the key to the Tent Medication Box. The Tent Medication Box will be stored at appropriate temperatures.

2. The Tent Medication Box shall be returned to the Inpatient Pharmacy Department daily when the Infectious Disease Surge Tents are closed for business. Per usual practice, the contents of the Tent Medication Box will be inspected and restocked daily by Pharmacy Personnel prior to return for use within the Infectious Disease Surge Tents.

a. The Tent Medication Box shall be stocked with the following medications and quantities:

1. Acetaminophen 325 mg tablets (#30)
2. Acetaminophen 32 mg/mL liquid (#20 cups / oral syringes)
3. Albuterol (90 mcg/puff) Inhaler (#2)
4. Dexamethasone 4 mg tablets (#10)
5. Dexamethasone 10 mg/mL vial (#10)
6. Ibuprofen 200 mg tablets (#30)
7. Ibuprofen 20 mg/mL liquid (#10 cups / oral syringes)
8. Ketorolac 30 mg/mL vial (#10)
9. Ondansetron 4 mg tablet (#20)
10. Ondansetron 4 mg/5mL liquid (#20)

B. The Tent Medication Box procedure shall remain in use to support the needs of the Infectious Disease Surge Tents until the time that the Tents are no longer needed or when the following waivers issued by California Department of Public Health are no longer in effect (AFL 22-30; AFL 22-33.1).

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	04/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	03/2025
P&T/IPC	Genevieve delos Santos: Director Pharmacy	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	03/2025

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerJulie Vasher: Director Women's & Children's ServicesAreaWomen's and Children's Services

Medically Indicated Deliveries <39 weeks gestation

I. POLICY STATEMENT

- A. Salinas Valley Health supports best practice recommendations provided by American College of Obstetricians and Gynecologists (ACOG) and Society for Meternal-Fetal Medicine (SMFM)by limiting deliveries less than 39 completed weeks gestation to those with approved medical complications requiring expedited delivery. Scheduled deliveries less than 39 weeks should follow these recommendations and receive approval from the designated department chair of Obstetrics.

II. PURPOSE

- A. The timing of delivery in cases with identified complications must balance the maternal and newborn risks associated with early delivery. Deferring delivery to the 39th week is not recommended if there is a medical or obstetric indication for earlier delivery.

III. DEFINITIONS

- A. ACOG - American College of Obstetricians and Gynecologists
- B. SMFM - Society for Maternal Fetal Medicine
- C. MFM - Maternal Fetal Medicine specialist

IV. GENERAL INFORMATION

- A. Scheduling deliveries via induction or Cesarean Section less than 39 weeks require approval from the designated chair of Obstetrics. Using the ACOG/SMFM criteria for recommendations of timing of delivery, these will be reviewed and approved or not approved by the chair of Obstetrics. If clear criteria is not apparent, the chair of OB may request a MFM consultation prior to approving early delivery.

V. PROCEDURE

- A. When scheduling procedure i.e. labor induction or cesarean delivery for a patient less than 39 weeks gestation, the scheduling team will request additional information including OB chair approval.
- B. For deliveries less than 39 weeks gestation, contact the chair of OB for approval based on ACOG/SMFM criteria. If not clear in guidelines, MFM consultation can assist with this decision.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American Academy of Pediatrics/The American College of Obstetricians and Gynecologists. (2017). Guidelines for Perinatal Care.8th edition. Author.
- B. American College of Obstetricians and Gynecologists; Society for Maternal-Fetal Medicine. (2024). ACOG Committee Opinion Number 831. Medically indicated late-preterm and early-term deliveries. Obstetrics & Gynecology, vol 138, no.1.

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	04/2025
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Julie Vasher: Director Women's & Children's Services	02/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	2 years after approval

Owner	Genevieve delos Santos: Director Pharmacy
Area	Pharmacy

Medication Override

I. POLICY STATEMENT

- A. This document outlines the Medication Override Policy for Salinas Valley Health

II. PURPOSE

- A. To guide staff in the use of ADC to increase medication distribution efficiency and accountability while enhancing safety of medication administration.

III. DEFINITIONS

- A. ADC: Automated Dispensing Cabinet

IV. GENERAL INFORMATION

- A. Access to ADC is provided to nurses, providers, respiratory, anesthesiologists and pharmacy personnel.
- B. Users may obtain medications from the ADC using the "override function" only in emergency or clinically urgent situations.
- C. Clinicians will chose a reason for override from the options provided by the ADC at the time of medication override.

V. PROCEDURE

- A. The Medication Safety Committee has approved the provision of a Medication Override List so that medications can be overridden and removed from the ADC prior to entry, and pharmacist review and approval of the medication order.
- B. The Medication Override List will be reviewed and approved annually by the Medication Safety Committee.

- C. Changes to the override list will be requested by submitting a completed Medication Override Request Form (Attachment A).
- D. Requests will be processed by following the Medication Override List Decision Making Algorithm (Attachment B).
- E. Controlled substances on the Medication Override List will not require a witness for withdrawal. Wasting and return of overridden controlled medications will follow standard procedure, and will be done in the presence of a witness.
- F. Override data will be saved electronically, and will be available for retrieval as needed.
- G. Pharmacy will review and reconcile the override data on a daily basis to ensure that every override is followed with a valid patient order within 48 hrs of override.
- H. If no valid order is obtained, stakeholders will be notified via Salinas Valley Health's occurrence reporting system.
- I. Override trending will periodically be reviewed with the Medication Safety Committee.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Rhodes JAM, Bondi DS, Celmins L, Hope C, Knoebel RW. Quality improvement and reconciliation process for automated dispensing cabinet medication overrides. Am J Health Syst Pharm. 2022 Feb 8;79(4):306-313. doi: 10.1093/ajhp/zxab406. PMID: 34724545.
- B. Institute of Safe Medication Practices (ISMP). Guidelines for the Safe Use of Automated Dispensing Cabinets. 2019. (https://www.ismp.org/system/files/resources/2019-11/ISMP170-ADC%20Guideline-020719_final.pdf)
- C. American Society of Hospital Pharmacist (ASHP). Inpatient Care Practitioners. Practice Resources for Automated Dispensing Cabinet Overrides. 2017. (<https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/patient-safety/patient-safety-practice-resource-for-automated-dispensing-cabinet-overrides.ashx>)

Attachments

 [Attachment A-Medication override request form.pdf](#)

 [Attachment B-Medication override algorithm.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	04/2025
CNO	Carla Spencer: Chief Nursing Officer	03/2025
P&T	Genevieve delos Santos: Director Pharmacy	02/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	02/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	02/2025

Standards

No standards are associated with this document



Last Approved	N/A
Next Review	2 years after approval

Owner	Genevieve delos Santos: Director Pharmacy
Area	Pharmacy

Medication Safety

I. POLICY STATEMENT

- A. The Medication Safety Policy outlines the topics related to medication safety practices at Salinas Valley Health Medical Center (SVHMC).
- (1) Medication Error Reporting Program
 - (2) Adverse Drug Reaction Program
 - (3) Look Alike Sound Alike Drugs
 - (4) High Alert Medications

II. PURPOSE

- A. Medication Error Reporting Program: To identify medication errors and define a process by which these errors are documented, reviewed and analyzed for process improvement and educational opportunities.
- B. Adverse drug reaction program: To provide a process for reporting, responding, documenting and trending actual or potential adverse drug reaction events at SVHMC, thereby providing a continual drug surveillance platform.
- C. High Alert Medications: To provide guidance in incorporating High Alert Medication identification in the Electronic Health Record order entry process. Additionally, establish an independent double check process when handling high alert medications.
- D. Look Alike Sound Alike medications: To guide the staff to safely manage Look Alike and Sound Alike medications consistent with National Patient Safety Goals (NPSG) and Institute of Safe Medication Practices (ISMP) guidelines.

III. DEFINITIONS

- A. eMAR: The electronic medication administration record that is used to document the administration of all medications.
- B. Occurrence Reporting System: An electronic reporting system utilized by SVHMC to document

reported patient events including medication errors, adverse drug reactions and patient relations issues.

- C. **Medication Error:** A medication error is defined 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 professions, 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.
- D. **Adverse Drug Reaction (ADR):** any noxious, undesired and unintended effect of a drug following usual doses that result in death, hospitalization, prolongation of hospital stays, discontinuation of the causative medication, treatment with another drug, significant discomfort or distress to the patient, or adversely impacts the outcome of progress of the patient's clinical condition.
- E. **High Alert Medications:** Defined as those drugs that have a high risk of causing injury if administered incorrectly, and the consequences of errors may be devastating. When procuring, storing, ordering, transcribing, preparing, dispensing, administering and/or monitoring high alert medications, measures will be taken to minimize the potential for misidentification through segregation, labeling or other means.
- F. **Independent Double Check:** An independent double check is defined as verification of the drug, dose concentration (calculations), dose rate settings, and verification of the correct patient. Independent double check is a process in which a second practitioner conducts verification. Such verification is performed independent of the first practitioner to prevent confirmation bias.
- G. **ADC: Automated Dispensing Cabinet**
- H. **Look Alike, Sound Alike (LASA):** Medicines that have brand or generic names or packaging that is similar enough to make errors possible or probable when they are dispensed to patients.
- I. **Naranjo's algorithm:** ADR classification system is used to assess various degrees of ADRs.
- J. **Just Culture:** a culture that has a clear and transparent process for evaluating errors and separating events arising from a flawed system design or inadvertent human error from those caused by reckless behavior.
Balances the need for an honest and open reporting system with employee accountability
Can help shift from blame to a creative frame of mind that seeks out and identifies the underlying systems failures.

IV. GENERAL INFORMATION

A. Medication Error Reporting Program:

1. Types of medication errors that are documented include, but not limited to:

Type of Error	Definition
Prescribing Error	Incorrect drug selection (based on indications, contraindications, know allergies, existing drug therapy, and other factors), dose, route or illegible prescriptions or medications orders that lead to errors that reaches the patient.

Omission Error	Failure to administer and ordered dose within the defined time frames of the policy.
Wrong Time Error	For medication ordered more frequently than twice daily: the medication administered more than one hour before or one hour after it is due; for those medications ordered daily or twice daily the time frame is two hours before or after the scheduled administration time.
Unauthorized Drug (Not ordered for patient)	Administration to the patient of medication not authorized by a legitimate prescriber for the patient.
Wrong Dose	Administration to the patient of a dose that is greater than or less than the amount ordered by the prescriber or administration of duplicate doses to the patient; for example, one or more dosage units in addition to those that were ordered.
Wrong Route	Administration to the patient of a drug product in a different dosage form than ordered by the prescriber.
Wrong Preparation	Drug product incorrectly formulated or manipulated before administration.
Wrong Administration Technique	Inappropriate procedure or improper technique in the administration of a drug.
Expired/deteriorated Drug	Administration of a drug that has expired or for which the physical or chemical dosage form integrity has been compromised.
Monitoring Error	Failure to use appropriate clinical or laboratory data for adequate assessment of patient response to prescribed therapy.

2. Classification of Medication Error by Severity Rating:

Level A	Circumstances or events that have the capacity to cause error
Level B	An error occurred but the error did not reach the patient (Near Miss)
Level C	An error occurred that reached the patient but did not cause patient harm
Level D	An error occurred that reached the patient and required monitoring to confirm that it resulted in no harm to the patient and/or required intervention to preclude harm
Level E	An error occurred that may have contributed to or resulted in temporary harm to the patient and required intervention

Level F	An error occurred that may have contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization.
Level G	An error occurred that may have contributed to or resulted in permanent patient harm
Level H	An error occurred that required intervention necessary to sustain life
Level I	An error occurred that may have contributed to or resulted in the patient's death
Level J	Cannot be determined

3. Medications shall be properly prescribed, dispensed, and administered in accordance with the medical staff rules and regulations, nursing and pharmacy policies related to medications.
4. All errors or events associated with the medication system or a step in the medication process shall be reported using the electronic occurrence reporting system.
5. Medication Errors shall be reported voluntarily by any licensed personnel involved in the medication process. These reports may be filed anonymously.
6. The provider must be notified as soon as reasonable following a medication error that reached the patient. The types of medication errors reported to the provider include but are not limited to:
 - a. The error involved a medication not prescribed for the patient (wrong drug)
 - b. The error involved a medication(s) that are not administered as ordered. Examples include: Wrong dose, wrong route, omitted dose, medications ordered to given STAT/NOW that are given late, and medications not given at the ordered time interval.
7. Medication Errors classified as Level E - I are considered severe and shall be disclosed and discussed with the patient and/or family per the process defined in the Disclosure of Unanticipated Outcomes policy [PolicyStat ID 14854895].
8. Severe medication errors are reported immediately, or as soon as possible, to the Unit Leader or Administrative Supervisor who will use the chain of command for initial reporting of event.

B. Adverse Drug Reaction Program:

1. The goal of the program is to define, identify, and review significant adverse drug reactions, to increase adverse drug reaction awareness and reporting by a broad range of health care professionals, to identify adverse drug reaction trends such as specific drugs or specific types of reactions and ultimately to improve patient care.
2. Assessment of the data may warrant changes in processes or systems including, but not limited to:

- a. Changes in the drug formulary
 - b. Implementation of prescribing procedures for new drugs
 - c. Modification of existing staff/patient education
3. SVHMC personnel will evaluate and report suspected adverse drug reactions in order to meet the following objectives:
- a. Benefits current patients by preventing or minimizing the consequences of ADRs.
 - b. Diagnoses may be made faster and the duration of the hospitalization shortened.
 - c. Any adverse drug reactions that are found to be as a result of a medication error will be reported following the Medication Error Reduction Plan (MERP).
 - d. Benefits future patients through improved understanding about the benefits and limitations of drug therapy. Better therapeutic decisions can be made for future patients based on knowledge and experience gained through the treatment of current patients.
 - e. Supports improved prescribing habits by raising the level of suspicion about drug-induced diseases.
 - f. The ADR program offers an interdisciplinary education experience for the entire hospital.
4. Classification of ADRs:

ADR PROBABILITY	
Highly Probable (Naranjo's Algorithm = Total Score > 9)	a. Follows a reasonable temporal sequence after a drug is given or from the time the drug concentration has been established in body fluids or tissues. b. Follows a well-known response pattern to the suspected drug. c. Lessens or disappears on stopping the drug (dechallenge). d. Reappears if the drug is restarted (rechallenge).
Probable (Naranjo's Algorithm = Total Score 5-8)	a. Follows a reasonable temporal sequence after a drug is administered. b. Follows a known response pattern to the suspected drug.

	c. Lessens or disappears on stopping the drug. d. Cannot be explained by the patient's underlying clinical state.
Possible (Naranjo's Algorithm = Total Score 1-4)	a. Follows a reasonable temporal sequence after a drug is given. b. Possibly follows a known pattern to the suspected drug. c. Could be explained by the patient's underlying clinical state or other factors or modes of therapy administered to the patient
Doubtful (Naranjo's Algorithm = Total Score < 1)	a. Does not follow a reasonable temporal sequence after a drug is given. b. Can likely be explained by the patient's underlying clinical state or other factors or modes of therapy administered to the patient.
ADR SEVERITY	
Minor (Naranjo's Algorithm= Level 1-2)	a. Does not require treatment or hospital admission or prolonged hospital stay.
Moderate (Naranjo's Algorithm= Level 3-4)	a. Discontinuation of the drug, or need for additional laboratory tests. b. Require treatment with another medication.
Severe (Naranjo's Algorithm= Level 5-7)	a. Requires admission to a critical care unit or prolong length of stay. b. Is permanently disabling. c. Contributes to the death of the patient.
ADR TYPE	
Type A	Reactions that are the result of an exaggerated, but otherwise normal, pharmacological action of a drug given in the usual therapeutic doses.
Type B	Reactions are totally aberrant effects that are not to be expected from the known pharmacological

	actions of a drug when given in the usual therapeutic doses to a patient whose body handles the drug in the normal way. This "type" includes allergic reactions.

a. ADR Preventability:

i. Preventability of the ADR is assessed using the Naranjo's Algorithm as a tool.

- a. Is the drug involved in the ADR considered inappropriate for the patient's clinical condition?
- b. Is the dose, route, or frequency of administration of this drug inappropriate for the patient's age, weight, and/or disease state(s)?
- c. Are required therapeutic drug monitoring or other laboratory tests pertaining to this drug not performed?
- d. Is there a history of allergy or previous reactions to the drug?
- e. Is the drug interaction involved in the reaction?
- f. Is a toxic serum drug concentration (or another laboratory test) determined, if appropriate?
- g. Is poor compliance involved in the reaction?

ii. An ADR associated with any patient admitted to the Emergency Department is considered as a non-preventable occurrence.

b. The following reaction(s) will clear the screening process; therefore, they may not be reported:

- i. Chemotherapy induced neutropenia, or anemia as this is an expected reaction.
Exception: Neutropenia with white count <500 will be reported as an ADR for tracking purposes.
- ii. Adverse effects of the drug which are expected, well-known reactions which do not result in changing the care of the patient. These adverse effects are those effects occurring predictably and effects whose intensity and occurrence are related to the dose. (e.g. Pruritis from narcotics or nausea/vomiting).
- iii. Disturbances totally dependent on the pathological state. (e.g. diarrhea from cancer and not from a laxative).

C. High Alert Medications:

1. N/A

D. Look Alike Sound Alike Medications:

1. N/A

V. PROCEDURE

A. Medication Error Reporting Program:

1. When a medication error occurs; the following should occur:
 - a. Evaluate the patient, if the error reached the patient.
 - b. Perform any necessary clinical interventions, within the patient care provider's scope of practice to reduce the negative effects of the identified error.
 - c. If an event occurred that resulted in the need for treatment and/or intervention and caused temporary patient harm (Level E-I):
 - i. Notify the provider who prescribed the medication as soon as possible. Record notification of physician in the medical record with any resultant orders.
 - ii. Initiate provider interventions as ordered. Record any actions and clinical interventions taken and the patient's response to same.
 - iii. Notify Department leader or Administrative Supervisor
 - d. If a drug is administered in error or omitted in error; the action taken shall be properly recorded in the patient's medical record. The entry in the patient's medical record need not indicate that an error occurred.
 - e. If the error required patient monitoring, record the observed and assessed outcome of the patient in the medical record.
 - f. A detailed report is entered in the Occurrence Reporting System, accessible via StarNet.
 - i. SVHMC supports a "Just Culture of Safety". Reporting contributes to improved patient safety and education aimed at preventing future errors. By reporting the error, others may gain an understanding of why the medication error occurred and how to prevent it in the future.
 - ii. The medication error events are electronically sent to the unit director or designee and the pharmacy for review, and resolution.
 - iii. The unit director or designee completes the review and documents relevant follow up. NOTE: Follow up with staff involved with the error is meant to be educational, not punitive.
 - g. The Medication Safety Officer or designee will complete a review of the error as follows:
 - i. An initial review of each medication error shall commence as soon as is reasonably possible, but no later than 3 business

days from the date of the medication error is discovered. Immediate actions may be necessary at this time. Completion of the investigation will follow.

- ii. The record of this review is documented in the Occurrence Reporting System.
 - iii. If the review determines the Severity Classification of Level E or higher; the error is reviewed with the Risk Manager, Patient Safety Officer, or their designee.
- h. Analysis of Medication Errors: a report analyzing the medication errors is reviewed at the Medication Safety Committee Meeting, and periodically presented at the Pharmacy & Therapeutics/Infection Prevention Committee, and Quality and Safety meeting. The analysis report will evaluate, summarize and trend findings and identify opportunities for improvement.
- i. Etiquette for writing safety reports:
- i. Should be written in the spirit of improving processes and systems to foster safe patient care.
 - ii. Be professional, factual, objective, and concise. Emotionally charged comments should be avoided.
 - iii. Focus on the patient and how the event impacted patient care. Targeting or blaming individuals using clinician names in the description should be avoided.

B. Adverse Drug Reaction Program:

1. Detection of an Adverse Drug Reaction

a. Identifying an ADR:

- i. Unexplained change in symptomatology (i.e., symptoms not suggested by current diagnosis)
- ii. Unexplained change in mental status, i.e., orientation, acuity, emotional stability, attitude.
- iii. Symptoms suggesting an allergic reaction, e.g., pruritis, skin rash, angioneurotic edema, arthralgia or arthritis, wheezing, laryngospasm, eosinophilia.
- iv. Hematologic changes (unexplained or explained), e.g., leukopenia, thrombocytopenia, eosinophilia, purpura, acute lymphadenopathy.
 - a. Leucopenia (decreased leukocytes <5000)
 - b. Eosinophilia (increased eosinophils >500)
 - c. Thrombocytopenia (decreased platelets <140000)
 - d. Purpura (purplish-red or brown discolorations of the skin due to hemorrhage into tissues)

- v. Once an ADR is suspected:
 - a. The physician should be notified immediately
 - b. Suspected medications should be held.
 - c. Adverse reactions should be documented in the patient's medical record.
 - d. If the reaction is determined to be an allergic reaction:
 - i. Apply allergy arm band and update patient medical profile.
 - ii. Inform the patient and recommend he/she is aware of the allergy.
- b.

Monitoring:

- i. This process will include a concurrent surveillance system. It may include but not be limited to:
 - a. Monitoring the use of "tracer/antidote" drugs that are used to treat common adverse drug reaction (i.e., orders for immediate doses of antihistamine, epinephrine and corticosteroids).
 - b. Continuous monitoring for trends, clusters or significant individual ADRs
 - c. Education of programs for the prevention of ADRs
 - d. Evaluation of prescribing patterns
 - e. Evaluation of patient monitoring practices
 - f. Evaluation of the ADR monitoring and reporting procedure's effect on overall and individual patient outcomes
 - g. Assessment of the safety of drug therapies, especially new drugs

c. Evaluation and Analysis:

- i. All valid ADRs are reported to the Medication Safety Committee. The following information should be available for the physicians to review for tracking and trending of problems: the drug, whether it occurred in the hospital or pre-admit, severity, type of reaction, preventable and possibly disposition.
- ii. The focus will be on identifying risk factors, trends in reporting and educational needs of the organization. Emphasis is placed on concurrent reporting which can influence patient care and result in documentation in the medical record, rather than retrospective reporting.
- iii. SEVERE reactions, and any ADR from a new drug, are reported to the Pharmacy and Therapeutics/Infection Control Committee and Quality Management Service for further review.
- iv. After review of the report, the Medication Safety Committee may choose one of the following steps:
 - a. An ADR may be reported to the FDA using the Medwatch Report Form. (Reference Form 3500A, Attachment C.)
 - b. Specific drugs may be identified for more extensive drug utilization monitoring.
 - c. Summary accepted with specific action taken as needed, i.e., information reported in the newsletter.

- v. Drugs which are frequently encountered in adverse drug reaction analysis may be targeted for more intense evaluation or education.
- d. Reporting and Documentation:
 - i. Reporting and documentation may occur via the Occurrence Reporting System.
 - ii. Reporting may be:
 - a. Spontaneous reporting
 - b. Physician or Nurse reporting to Pharmacist
 - c. Pharmacy identification
 - i. By drugs ordered for treatment of ADR or antidotes.
 - ii. Changing lab values during drug monitoring.
 - iii. Chart review of current inpatients.
 - d. Retrospective reporting by reviewing ADC activity report.
- e. Validation of ADR and follow up may include the following, but not limited to:
 - i. The Medication Safety Officer or clinical pharmacist performs chart reviews of all suspected ADRs entered via the Occurrence Reporting System. They may request a consultative review by a physician, if available.
 - ii. Follow up may include educating healthcare professionals and patients on drug effects and increase their level of awareness regarding adverse drug reaction.
 - iii. Identifying and measuring trends and institute corrective actions designed to improve patient outcomes by minimizing potential adverse drug reaction.
 - iv. Providing quality assurance/improvement screening findings for use in drug use evaluation programs.
 - v. If the Medication Safety Committee determines that the findings may be relevant to an individual's performance, the adverse drug reaction report will be forwarded to the medical service for peer review.
 - vi. The ADR summary report is also submitted to other Medical Staff Committees for review as appropriate and reported to the Board of Directors as part of the Medical Staff Performance Improvement Program.

C. High Alert Medications:

1. Independent Double Check (IDC):

- a. Prior to administration, the high alert medications must be independently double checked by two (2) RNs or by one (1) RN and a Pharmacist or Physician.
- b. Initial Check:
 - i. Confirm 5 Rights and review the medication order (if scanning available, this includes scan of patient wristband and product)
 - a. Patient name
 - b. Drug, dose, concentration, route, and time (frequency)
 - c. Lab results if applicable (with confirmation of date and time)
 - d. Monitoring parameters if applicable
 - e. Independently perform any calculations if applicable
 - ii. Verify prepared drugs (i.e., insulin infusion, etc.) against the Medication Administer Record, Patient Controlled Analgesia/ Epidural flow sheet, etc.
 - iii. Program medication pump as needed and verify pump settings to ensure that medication and concentration of product match pump library choice and the order dose/rate programmed matches the order (drug, dose, concentration, rate, volume to be infused, and volume remaining).
 - iv. Confirm that the weight programmed matches weight in order, if applicable
 - v. Ask a second clinician to perform an independent double check
 - vi. Initiate medication
 - vii. Complete documentation in the electronic medical record
- c. Independent Double Check:
 - i. Independently, confirm 5 Rights and review the medication order (if scanning available, this includes scan of patient wristband and product)
 - a. Patient name
 - b. Drug, dose, concentration, route, and time (frequency)
 - c. Lab results if applicable (with confirmation of date and time)
 - d. Monitoring parameters if applicable
 - e. Independently perform any calculations if applicable; then compare.
 - ii. Confirm pump settings are correct: Medication and

concentration of product match pump library choice and the order (drug, dose, concentration, rate, volume to be infused, and volume remaining).

- iii. Confirm that the weight programmed matches weight in order, if applicable
 - iv. The persons completing the double check on the MAR will be required to enter an electronic password upon filing the documentation of administration.
If any discrepancies were noted, both clinicians should collaborate to assess situation and determine next steps.
 - v. **Emergencies such as a cardiopulmonary arrest or near arrest do not require the independent double check procedure. **
 - vi. Medications may be added to or removed from list on an emergent and temporary basis, based on unusual drug use and shortages.
 - vii. A second pharmacist double check is required on all NICU high alert medications, and adult and pediatric chemotherapy and Total Parental Nutrition.
2. This list will be distributed to all clinical staff, and it will be made readily available on the Department of Pharmacy's intranet website.

D. Look Alike Sound Alike Medications:

- 1. The Pharmacy Department, in conjunction with nursing services and the medical staff, will develop and maintain a list of look-alike, sound-alike drugs that are stored, dispensed, and administered throughout the organization.
- 2. The list of Look Alike, Sound Alike (LASA) medications will be approved by an interdisciplinary team including medical staff, and this list will be reviewed at least annually by the Medication Safety Committee for revision and continued approval.
- 3. This list will be distributed to all clinical staff, and it will be made readily available on the Department of Pharmacy's intranet website.
- 4. Measures outlined in policies related to medication use will be undertaken to prevent medication errors related to the procurement, storage, preparation, distribution and administration of look-alike, sound-alike, and high alert medications.
- 5. All individuals that manage or utilize medications in any manner should become familiar with the hospital's LASA medications, and should be aware of the potential for error due to the look-alike, sound-alike nature.
- 6. The Medication Errors related to LASA medications during the previous year will be reviewed and analyzed for possible addition to the current LASA list.
- 7. Periodically during the year, the pharmacy director or designate will determine if any

identified look alike, sound alike or other problematic medication warrants immediate communication to P&T and the medical staff or if it should be placed in the file for annual update of the Look Alike, Sound Alike list.

8. Documentation:
 - a. Documentation will be accomplished on the eMAR using "TALLman" lettering.
 - b. Documentation on labeling (for example on Roxanol-morphine sulfate) will have the words "LOOK-SOUND ALIKE*" following the drug concentration which is found in the label contents in the EMR.
 - c. High alert medications which also may be look alike, sound alike medicines will additionally receive HIGH ALERT notifications found in the label contents section of the EMR.
 - d. All medications dispensed from the pharmacy not found in the ADC will have identifiers of look-alike sound-alike and high alert labels attached to them.
 - e. Information obtained from ISMP, FDA and/or USP regarding emerging problematic names, medicines and error prevention strategies will be incorporated into the annual review to update the look alike sound alike drug list.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. ISMP (Institute for Safe Medication Practices). ISMP List of Confused Drug Names. ISMP. August 13, 2024. Website: <https://home.ecri.org/blogs/ismmp-resources/list-of-confused-drug-names>
- B. Beta Healthcare Group: BETA*rm JUST CULTURE. Website: <https://betahg.com/risk-management-and-safety/beta-rm-just-culture/>
- C. NCC MERP (National Coordinating Council for Medication Error Reduction Plan) Web site: <http://www.nccmerp.org/>
- D. Institute for Safe Medication Practices (ISMP). ISMP List of High-Alert Medications in Acute Care Settings. ISMP; 2024. Website: <https://home.ecri.org/blogs/ismmp-resources/high-alert-medications-in-acute-care-settings>
- E. Naranjo, C.A., Busto, U., Sellers, E.M., Sandor, P., Ruiz, I., Roberts, E.A., Janecek, E., Domecq, C. and Greenblatt, D.J. (1981), A method for estimating the probability of adverse drug reactions. Clinical Pharmacology & Therapeutics, 30: 239-245. <https://doi.org/10.1038/clpt.1981.154>

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	04/2025
CNO	Carla Spencer: Chief Nursing Officer	03/2025
P&T	Genevieve delos Santos: Director Pharmacy	02/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	02/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	12/2024

Standards

No standards are associated with this document



Last Approved N/A

Next Review 3 years after approval

Owner Melissa Deen: Manager Infection Prevention

Area Infection Control

MRSA Active Surveillance Screening

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in providing an organized process to screen for methicillin-resistant *Staphylococcus aureus* (MRSA), and to comply with California Senate Bill 1058.

III. DEFINITIONS

- A. **ASC** - Active Surveillance Culture - An active surveillance culture (ASC) is a nares culture obtained from a patient within 24 hours of admission to determine the presence of methicillin-resistant *Staphylococcus aureus* (MRSA).
- B. **Colonized or Colonization**—A pathogenic organism is present on the patient's body but does not cause any signs or symptoms of infection.
- C. **Infection** - When microorganisms evade a patient's defense mechanisms and cause localized or systemic damage, sometimes requiring antimicrobial treatment.
- D. **MRSA – Methicillin-resistant Staphylococcus aureus.** A type of *Staph* bacteria that is resistant to certain antibiotics that are usually used to treat *Staph* infections

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Patients that meet the criteria listed below will have a nares culture obtained at admission per California mandate.

1. All patients admitted *or transferred* to the Intensive Care Unit (ICU), Critical Care Unit (CCU), or Neonatal Intensive Care Unit (NICU)
 2. All patients who have been discharged from any general acute care hospital within 30 days before current admission.
 3. All patients with ESRD who receive dialysis (hemodialysis or peritoneal dialysis) on a regularly scheduled basis.
 4. All patients transferred/admitted from a skilled nursing facility or other healthcare facility.
- B. At admission in the MRSA Screening, the nurse will determine if the patient meets the ASC criteria
- C. If the patient meets the criteria, the nurse will order the MRSA Screen in Lab with the order source "Policy." This will be e-signed by the physician within 48 hours. The order will place the specimen to be obtained on the RN work list. Once the RN collects the specimen, the RN or UA will process the order in the electronic medical record and send the specimen to the lab. (See Attachment B.)
- D. The nurse should provide the patient with the handout "MRSA Screening Information for Patients" letter to explain why the nares culture is needed.
1. Note: The patient may refuse MRSA ASC testing. Document the refusal in the medical record in the patient care notes.
- E. Ideally, the ASC culture will be obtained upon admission. The mandate by California SB1058 can be performed before the physician signs the order and must be obtained within 24 hours of admission.
- F. If the nares culture is positive for MRSA, the attending physician is responsible for informing the patient or the patient's representative as soon as possible while the patient remains inpatient.
- G. The nurse caring for the patient will provide written (the "MRSA Facts and Instructions" sheet) and oral instructions on MRSA to the patient before obtaining the culture.
- H. The nurse will document the MRSA education in the Medical Record system using the patient education screen.
- I. Refer to the MRSA algorithm(s) to determine if the patient requires isolation for MRSA if determined with confirmed or possible MRSA infection.
- J. Order Entry:
1. MRSA Screen
- K. Documentation:
1. Document the ASC screen in MRSA Screening in the electronic medical record
 2. Document education (verbal and written) in the Education screen prior to obtaining culture. If the culture is positive for MRSA, then additional documentation will be required by the Physician and the Nurse.
- L. For patients who present with positive MRSA nasal screen:

1. Initiate MRSA Decolonization for 5 days, which includes:
 - a. Mupirocin 2% ointment intranasally for 5 days, twice a day.
 - b. CHG Bath Daily is for 5 days.
2. MRSA decolonization order set available for the above decolonization regimen.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. California Senate Bill 1058
- B. Center for Disease Control and Prevention (2009). Management of Multidrug-Resistant Organisms in Healthcare Settings. Retrieved from http://www.cdc.gov/hicpac/mdro/mdro_toc.html
- C. Center for Disease Control and Prevention (2007) Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings. <http://www.cdc.gov/ncidod/dhqp/pdf/guidelines/Isolation2007.pdf>
- D. [CDC, MRSA: Tier 2 MRSA Prevention Strategies](#)
- E. [Isolation - Standard and Transmission Based Precautions](#)
- F. [Central Vascular Access Devices](#)

Attachments

-  [B: MRSA Active Surveillance Screening](#)
-  [MRSA ISOLATION for ACTIVE SURVEILLANCE SCREENING.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	04/2025

P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	03/2025
P&T/IPC	Genevieve delos Santos: Director Pharmacy	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Melissa Deen: Manager Infection Prevention	12/2024

Standards

No standards are associated with this document



Last ApprovedN/ANext Review3 years after approval

OwnerDaniela Jago: Clinical ManagerAreaWomen's and Children's Services

Non-Stress Test

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To outline the nursing management of antepartum patients requiring the assessment of fetal well-being using the non-stress test (NST).

III. DEFINITIONS

A. NST: Non-Stress test

IV. GENERAL INFORMATION

A. A registered nurse who has successfully completed and maintained the Fetal Monitoring competency and education will perform a NST.

V. PROCEDURE

- A. Patients should be placed in a position that achieves uterine displacement (lateral or lateral tilt). Semi-fowlers position may be used; however, if unable to obtain a reactive NST in this position, utilize lateral or lateral tilt before declaring a nonreactive NST.
- B. Obtain vital signs (BP, pulse, respirations, temperature, and SpO2).
- C. An NST is timed for up to 20 minutes until reactivity is established. The testing may be continued for an additional 20 minutes to take into account normal fetal sleep-wake cycles (total 40 minutes)

1. In a fetus ≥ 32 weeks gestation, an NST is reactive if there are two or more accelerations with a peak of at least 15 beats per minute above the baseline, lasting

- 15 seconds or more in a 20 minute period.
 2. In a fetus < 32 weeks gestation, an NST is reactive if there are two or more accelerations that peak at least 10 beats per minute above the baseline, lasting 10 seconds or more in a 20 minute period.
- D. If nonreactive, vibroacoustic stimulation should be used to attempt to elicit accelerations:
1. Place the vibroacoustic stimulator over fetal back and deliver stimulation for 1-2 seconds
 - a. This may be repeated up to 3 times, for progressively longer durations up to a maximum duration of 3 seconds
 - b. It is acceptable to use vibroacoustic stimulation per the protocol above at any point during testing, for example to expedite the testing process.
 - c. Document how many times stimulation was used and whether reactive results were obtained with its use.
- E. Categorize NST as reactive per above criteria or nonreactive if accels have not been observed per criteria.
- F. Verify NST results with another qualified RN or physician and document.
- G. Physician to review NST fetal heart rate tracings within 24 hours and document the final interpretation.
- H. Notify physician of results and follow up as advised. The physician should be notified of any other fetal heart rate (FHR) characteristics such as decelerations.
- I. Documentation:
1. Documentation will occur in accordance with the [FETAL HEART RATE MONITORING](#) using NICHD terminology.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American Academy of Pediatrics & American College of Obstetricians and Gynecologists (2017). Guidelines for Perinatal Care (8th ed). Elk Grove, IL
- B. American College of Obstetricians and Gynecologists. (2021). Antepartum Fetal Surveillance. (Practice Bulletin No. 229). Obstetrics and Gynecology.
- C. Treanor, C. (2021). Antenatal fetal assessment and testing In Lyndon, A., & Wisner, K., *Fetal Heart Monitoring Principles and Practices* (6th ed.). Kendall Hunt Publishing.

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	04/2025
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Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
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Standards

No standards are associated with this document



Last ApprovedN/ANext Review1 year after approval

OwnerJames Hively: Manager Environmental Health & SafetyAreaPlans and Program

Safety Management Plan

I. SCOPE

- A. The Safety Management Plan describes the programs used to manage a safety program to reduce the risk of injury for patients, staff and visitors for Salinas Valley Health Medical Center (SVHMC). Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or they are related to situations beyond the organization's control, such as the weather.

II. OBJECTIVES/GOALS

- A. The Objectives for the 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, Incident Reports and environmental tours.

III. DEFINITIONS

- A. EOC – Environment of Care
- B. CEO – Chief Executive Officer
- C. SVHMC – Salinas Valley Health Medical Centerand its licensed off site locations

IV. PLAN MANAGEMENT

- A. Plan Elements
 - 1. The Safety Office will provide department leadership with information and training to assist them in the development of safe working conditions and safe work practices within their area of responsibility.
 - 2. Safe working conditions and practices are established by using knowledge of safety principles to educate staff, design appropriate work environments, purchase

appropriate equipment and supplies, and monitor the implementation of the processes and policies.

3. Safety is dynamic. Regular evaluation of the environment for work practices and hazards is required to maintain a current relevant safety program. The program will change as needed to respond to identified risks, hazards and regulatory compliance issues.

B. Plan Management

1. Safety Risk Management

- a. The Environment of Care (EOC) Committee is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The EOC Committee ensures that compliance with applicable codes and regulations, as applied to the buildings and services are provided at SVHMC.

2. Safety Management Plan

- a. The organization develops, maintains and on an annual basis, evaluates the effectiveness of the Safety Management Plan to effectively manage the safety risk of the staff, visitors, and patients at SVHMC.

3. Safety Risk Assessment

- a. The EOC Committee manages the Safety risk assessment process for SVHMC. The Committee is designated to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results. The Committee ensures that compliance with applicable codes and regulations.
- b. SVHMC identifies safety risks associated with the environment of care. Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of annual proactive risk assessment of high-risk processes, and from credible external sources such as Sentinel Event Alerts.
- c. The risk assessment is used to evaluate the impact of the environment of care on the ability of the organization to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals. The assessment will evaluate the risk from a variety of functions, including structure of the environment, from the performance of everyday tasks, falls, exposures, MRI, Lasers, etc.

4. Use of Risk Assessment Results

- a. A risk assessment is used to evaluate the impact of the environment of care on the ability of the hospital to perform clinical and business activities. Where risks are identified, the current programs and processes to manage those risks are compared to the risks that have been identified. Where the identified risks are not appropriately handled, action will be

taken to eliminate or minimize the risk. The actions may be creating new programs, processes, procedures, or training programs. Monitoring programs may be developed to ensure the risks have been controlled to achieve the lowest potential for adverse impact on the safety and security of patients, staff, and visitors.

5. Maintaining Grounds & Equipment

- a. The Facilities Management Department is responsible for maintaining the lawns, plantings, drives, walks, parking areas, building exterior and roofs, etc., of all properties covered by this management plan. An inspection of the grounds is conducted on an annual basis as part of the environmental tours program
- b. The Facilities Management Department is responsible for maintaining the equipment used for grounds, such as lawnmowers/tractors, chainsaws, etc. An inspection of this equipment will be conducted at least annually and a report forwarded to the Chief Engineer.
- c. The Environmental Health and Safety Manager provides assistance and recommendations to maintain the grounds and improve the safety of patients, staff and visitors.

6. Product Notices and Recalls

- a. SVHMC ensures responses to product recalls and/or notices for various types of products including, consumer products, medical and non-medical equipment, other equipment used to operate and maintain the facility by appropriate hospital representatives. The Materials Management Department manages the process by reviewing information from the Consumer Product Safety Commission (CPSC), ECRI, FDA.. They also receive reports from manufacturers and vendors. This information is distributed to those departments identified as using or managing the products. They document the follow-up, and report the results to the EOC on a periodic basis. Critical recalls or alerts are brought to the attention of the Environmental Health and Safety Manager and Risk Manager upon receipt. The Environmental Health and Safety and Risk Manager will assist when needed to ensure effective response. For more information, see [HOSPITAL RECALL PROCEDURE](#)

7. Managing risk in the MRI environment

- a. The Radiation Safety Officer manages safety risks in the MRI environment associated with the following:
 - i. Patients who may experience claustrophobia, anxiety, or emotional distress
 - ii. Patients who may require urgent or emergent medical care
 - iii. Patients with metallic implants and devices, such as shrapnel
 - iv. Ferrous objects entering the MRI environment
 - v. Acoustic noise

8. Taking actions to minimize risk for MRI services

- a. The Radiation Safety Officer manages safety risks by doing the following:
 - i. Restricting access of everyone not trained or screened by MRI-trained staff scanner room and the area that immediately precedes the entrance to the MRI scanner room
 - ii. Making sure that this area is controlled by and under the direct supervision of MRI-trained staff
 - iii. Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI unit, by design, can have its magnetic field routinely turned on and off by the operator.

9. Prohibit Smoking

- a. SVHMC has developed and enforces a facility wide [SMOKING POLICY](#)

10. No Smoking Enforcement

- a. The hospital security team makes routine rounds of the building and grounds. They have standing orders to ensure the hospital remains a smoke-free environment.

11. Safe Interior Spaces

- a. The EOC Committee manages the safety risk assessment process for SVHMC and manages risk, coordinates risk reduction activities in the physical environment, collects deficiency information, and disseminates summaries of actions and results. The assessments of the facility safety inspections include, but limited to, lighting, furnishings and indoor air quality (including odors). The Committee ensures compliance with applicable codes and regulations.
- b. The organization designs, constructs, and maintains features of the environment to promote patient safety and will provide diagnosis, treatment and care for the appropriate needs of the patients. To provide the appropriate environment, the organization conducts planning activities and inspections of the following items:
 - i. Interior spaces shall meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
 - ii. Lighting is suitable for care, treatment, and services.
 - iii. Areas used by patients are clean and free of offensive odors.
 - iv. Furnishing and equipment are maintained to be safe and in good repair.
- c. The Environmental Health and Safety Manager manages a process of

environmental rounds designed insure a safe environment is provided. The tours evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation and education programs, and improving staff performance.

- d. The Environmental Health and Safety Manager analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.

12. Following Design and Construction Criteria

- a. When planning for new, altered, or renovated space, the organization uses one of the following design criteria: State rules and regulations, or guidelines for Design and Construction of Health Care Facilities, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE)

13. Conducting a Preconstruction Risk Assessment (PRA)

- a. When planning for demolition, construction, renovation, or general maintenance, the hospital conducts a Preconstruction Risk Assessment (PCRA) of risks that may affect care, treatment, and services. The risk elements include:
 - i. Air quality requirements
 - ii. Infection control
 - iii. Utility requirements
 - iv. Noise and vibration
 - v. Other hazards
 - vi. Life safety
- b. The appropriate individuals will conduct the risk assessment activities. SVHMC takes action based on its assessment to minimize risks during demolition, construction, or renovation. SVHMC takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance. The status of the measures are inspected or monitored at the appropriate frequency to provide the adequate patient safety protection. Periodically, the project is re-evaluated and the measures implemented adjusted to meet the current conditions. Monitoring data is maintained.

14. Conducting a Risk Assessment for Radiation Sources Before Installation

- a. Prior to installation of computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services, a medical physicist or health physicist conducts a structural shielding design assessment to specify required radiation shielding. This includes installing new imaging

equipment, replacing existing imaging equipment, or modifying rooms where ionizing radiation will be emitted or radioactive materials will be stored (such as scan rooms or hot labs). This requirement does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions. See the National Council on Radiation Protection and Measurements Report No. 147 (NCRP-147). Guidance on shielding designs and radiation protection surveys. The date of the survey and results are documented

15. Conducting a Risk Assessment for Radiation Sources After Installation

- a. After installation of computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services imaging equipment, or construction in rooms where ionizing radiation will be emitted or radioactive materials will be stored, a medical physicist or health physicist conducts a radiation protection survey to verify the adequacy of installed shielding. This survey is conducted prior to clinical use of the room. The date of the survey and results are documented
- b. This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

16. Orientation and Education

- a. All new staff will attend New Employee Orientation. New Employee Orientation addresses key issues and objectives of various areas in the Environment of Care. In addition, all staff participates in periodic safety training. Staff members, licensed independent practitioners, students, and volunteers are instructed on the everyday precautions to minimize environmental safety risks via New Employee Safety Orientation, in-services, training, or other activities. During environmental tours, unsafe practices are identified and the employee is advised of the proper procedures.
- b. Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training as needed.

17. Incident Reporting and Investigation

- a. Injuries to patients or others within the hospital's facilities are reported to the Patient Safety Officer, the appropriate manager(s) and Risk Management Department when applicable. An incident reporting system is used. The supervisor will complete an Investigation Report. The Environmental Health and Safety Manager and Employee Health will participate in the investigation whenever appropriate. Corrective actions identified through the investigation will be communicated to appropriate departments and personnel.

- b. Occupational illness and injuries are reported to Employee Health Department. Department leadership will complete an Incident Investigation Report with the employee and report findings back to Employee Health Department. Appropriate departments and personnel are contacted for corrective actions needed.
- c. Incidents of damage to the hospital property or the property of others are reported to the hospital security team and the Risk Management Department who will investigate the issue, complete a report and assess prevention options.

18. Evaluating the Management Plan

- a. On an annual basis, the EOC Committee evaluate the scope, objectives, performance, and effectiveness of this Plan to manage the safety risks to the staff, visitors, and patients at SVHMCs.

19. Identifying Opportunities to Resolve Environmental Issues

- a. The EOC Committee evaluates activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates reports and data analysis to determine if there are needs for improvement or environmental issues to resolve. When a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

20. Taking action on Opportunities to Resolve Environmental Issues

- a. The EOC Committee uses the results of data analysis and other information, including risk assessments, environmental rounds, incident analysis, regulatory changes, and other information, to identify opportunities to resolve safety issues. The organization, through the EOC Committee or other resources, takes actions on the identified opportunities to resolve environmental safety issues.
- b. The Committee evaluates changes to determine if they resolved environmental safety issues and reports performance improvement results to those responsible for analyzing environment of care issues. The Committee provides reports when appropriate to senior leadership. Leaders collaborate to assure budget and staffing resources are available to support the environmental safety program. The Committee works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objectives for improvement.

C. Plan Responsibility

- 1. The EOC Committee is responsible for monitoring all aspects of the Safety Program. The Environmental Health and Safety Manager advises the EOC Committee regarding safety issues.

D. Performance Measurement

1. Performance Monitoring and Improvement
- a. The performance measurement process is one part of the evaluation of the effectiveness of the EOC program. Performance measures are established to measure at least one important aspect of the Safety Management Plan and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

V. REFERENCES

- A. The Joint Commission standards; Environment of Care chapter

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
SRC	Aniko Kukla: Director Quality & Patient Safety	04/2025
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	04/2025
Emergency Management	James Hively: Manager Environmental Health & Safety	04/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	James Hively: Manager Environmental Health & Safety	04/2025

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