May 16, 2025

TO: Legal Counsel

News Media
Salinas Californian
El Sol
Monterey County Herald
Monterey County Weekly
KION-TV
KSBW-TV/ABC Central Coast
KSMS/Entravision-TV

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, MAY 22, 2025, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

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

Allen Radner, MD
President/Chief Executive Officer

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

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

THURSDAY, MAY 22, 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 *(Estimated time 4:30 pm)*	*Joel Hernandez Laguna*
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 *(Board Member may pull an item from the Consent Agenda for discussion.)* — *Joel Hernandez Laguna*

A. Minutes of the Regular Meeting of the Board of Directors April 24, 2025

B. Minutes of the Special Meeting of the Board of Directors April 22, 2025

C. Policies/Plans Requiring Approval

1. Adaptive Feeding Equipment
2. Administrative Adjustment
3. Administrator On-Call
4. Disruptive Persons
5. Dual Employment
6. Employment of Relatives
7. Formulary Process
8. Information Security Risk Analysis
9. LAB.PROT.GEN.1 - Aerosol Transmissible Pathogens-Pathology
10. MRI Safety
11. Nutrition Services: Cash Handling
12. Oral Care
13. Organization Plan for Provision of Care and Service
14. Registered Dietitian Diet Order Entry
15. Scope of Service: Case Management
16. Scope of Service: Diagnostic Imaging
17. Scope of Service: Employee Health
18. Scope of Service: Nursing Administration

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

19. Scope of Service: Physician and Business Development
20. Scope of Service: Social Services
21. Triage Assessment
22. Use of Ultrasound Enhancement with Echocardiography
23. Virtual Private Network

- 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. **COMMITTEE VACANCY APPOINTMENTS** *Joel Hernandez Laguna*

- Personnel, Pension & Investment Committee
- Finance Committee

B. **QUALITY AND EFFICIENT PRACTICES COMMITTEE** *Catherine Carson*

Minutes of the May 12, 2025 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

C. **PERSONNEL, PENSION & INVESTMENT COMMITTEE** *Catherine Carson*

Minutes of the May 12, 2025 Personnel, Pension & Investment Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

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

Minutes of the May 19, 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 recommendation has been made to the Board.

1. Consider Recommendation for Board Approval to Award Construction Contract to SSB Contracting for the Renovations to the DRC Annex in Support of the EPIC Training Rooms

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

2. Consider Recommendation for Board to Approve Updated Project Budget and Award Construction Contract to FTG Builders, Inc. for the Salinas Valley Health Medical Center Catheterization Laboratory and Interventional Radiology Equipment Replacement Project

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

9. REVIEW AND CONSIDERATION FOR APPROVAL OF FISCAL YEAR 2026 (FY2026) OPERATING AND CAPITAL BUDGET *Scott Cleveland*

- Questions to Committee Chair/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 MAY 8, 2025, AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Rakesh Singh, M.D.*

A. Reports

1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report

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

- Block Scheduling
- Fire Safety Management Plan
- Renal Dose Adjustment per Pharmacy Protocol
- Utility 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, June 26, 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, MAY 22, 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 to Quality & Efficient Practices Committee
   - Social Services/Case Management
   - Perioperative Services
   - Marketing/Communications
3. Medical Staff Quality and Safety Committee Consent Agenda:
   - Service Excellence
   - Perioperative Services
   - Food/Nutrition
   - Nursing Administration Department (NAD)
     - Patient Care Resources
     - Transport Department
     - Interpreter Services
   - Pt Financial Services
   - Environmental Services
   - Clinical Research
   - Taylor Farms Family Health & Wellness Center
   - Health Promotion
   - Marketing/Communications
   - Sleep Medicine

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): two (2)

Additional information required pursuant to Section 54956.9(e): n/a

Initiation of litigation pursuant to Section 54956.9(d)(4) (Number of potential cases): n/a

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
APRIL 24, 2025

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

Absent: None;

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

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:07 p.m. in the Downing Resource Center, Rooms A, B, and C.

1.1 PROPOSED ADDITION TO THE AGENDA

A request was made by President Hernandez Laguna pursuant to Government Code Section 54954.2(b)(2) to add a Resolution to the Open Session Consent Agenda. The matter requires immediate action and the need for action came to the attention of the Board subsequent to the posting of the Agenda. The addition would be *Item 6. E. Consider Resolution 2025-02 Authorizing Designated Officers to Execute Financial Institution Documents.* Copies were provided for all Board members.

Upon motion by Director Dr. Cabrera and second by Director Rey, citing the need to add one (1) Open Session Consent Agenda item which came to the attention of the Board Meeting subsequent to the Board agenda being posted, the Board of Directors approves adding to the Consent Agenda *Item 6. E. Consider Resolution 2025-02 Authorizing Designated Officers to Execute Financial Institution Documents*.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Dr. Cabrera and second by Director Rey, citing the need to add one (1) Open Session Consent Agenda item which came to the attention of the Board Meeting subsequent to the Board agenda being posted, the Board of Directors approves adding to the Consent Agenda *Item 6. E. Consider Resolution 2025-02 Authorizing Designated Officers to Execute Financial Institution Documents*.

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

ROLL CALL VOTE:

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

Motion Carried

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Reports Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services and (3) Conference with Legal Counsel – Anticipated Litigation*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:10 p.m.

The Board completed its business of the Closed Session at 4:28 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:34 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services and (3) Conference with Legal Counsel-Anticipated Litigation*. 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.

4. AWARDS AND RECOGNITION

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

BOARD MEMBER DISCUSSION:

- **DAISY Award: Weronika Paden, BSN, RNC-MMN, Mother/Baby Unit:** Carla Spencer, CNO, stated that Weronika has been with Salinas Valley Health for 11 years. Weronika's training, instincts and persistence likely saved a baby's life. A new family was all ready to be discharged. When Weronika entered the room, she did a quick evaluation and noted that the coloring on the newborn was "off." Weronika was insistent and called the newborn's physician who wrote an order for the newborn to be observed in the NICU. By the next morning the newborn was transported to Stanford Children's Hospital with Coarctation of the Aorta. This is a congenital heart defect that may not be readily apparent until the ductus arteriosis closes at about 24 hours of age. Of note the newborn passed the Critical Congenital Heart Disease Screen, so Weronika's physical assessment was of utmost importance; she did not rely on previous findings. Weronika's attention to detail and keen assessment likely prevented a tragic event for this newborn and family. The DAISY Award nomination was submitted by Julie Vasher, DNP, RNC-OB, APRN-CNS, Director of Women's & Children's Services, who wrote about the sequences of events: Weronika stated she is honored to receive the Daisy Award and that she "works with an amazing team."

- **DAISY Award: April Rose Maniwang, BSN, RN, Mother/Baby Unit:** Carla Spencer, CNO, stated that not one but two grateful patients within days of each other submitted nominations for April Rose Maniwang, BSN, RN, resulting in April Rose being our latest DAISY Award recipient. After completing her BSN at the University of Illinois Chicago, April Rose began her nursing career as a member of the Salinas Valley Health the Fall 2023 New Grad Cohort and has since joined the Mother/Baby team. While April Rose is a relatively new member of our team, many of you will recognize the last name because her mother, Rose Maniwang, retired late last year after providing outstanding care for more than 26 years in our NICU. We're so pleased the family legacy of patient care continues! April Rose stated, "It is such an honor to receive this distinguished award," and thanked her leadership team. April thanked "my mom for my inspiration."
- **Staff engagement/education/quality: Care for the Caregiver Schwartz Rounds, April 1st:** Carla Spencer, CNO, reported that a standing-room-only audience filled the DRC ABC for the first Schwartz Rounds of 2025. With a focus on *Overcoming Obstacles in the Face of Diversity*, panelists each shared a story focused on their personal experience after which the discussion opened to sharing from participants. The stories related were as diverse as the range of staff in attendance. Tears and laughter were shared along with experiences interwoven with common threads. Themes of the discussion included the importance of getting help when trying to resolve problems and how challenging situations can help build strength and resilience. Those in attendance expressed appreciation for the power of the event, which is a component of our Care for the Caregiver Program. The purpose of Schwartz Rounds is to provide a safe space for staff to talk about the emotional and social aspects of their work as well as to reduce stress and feelings of isolation while building camaraderie among team members.
- **Community Pillar:** Tiffany DiTullio, Vice President Partner and Community Relations, reported that two Community Health Days occurred in March; MLK Jr. Family Resource Center March 5th and Marina Farmers' Market March 30th. Upcoming community health days include Day of the Child Family Festival/North Monterey County Middle School on April 27th and the SVH Farmers' Market May 9th.

  BOARD MEMBER DISCUSSION: Director Arreguin: Are there plans for any Blue Zones presence in Zone 3? The BZP has relationships with many resources continually seeking alignment to develop more resources. Tiffany will contact Director Arreguin to discuss further.

5. PUBLIC COMMENT:

None.

6. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following policies has been removed from the Consent Agenda for consideration *C. 10. Organization Plan for Provision of Care & Service* and *C. 12. Scope of Service-Diagnostic Imaging.* The policies will return for consideration at a later date.

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors 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. RC POCT Laboratory - Arterial Blood Gas Management
11. Scope of Service-Emergency Department
12. Scope of Service-Health Promotion
13. Scope of Service-Information Technology
14. Scope of Service-Surgical Services
15. Scope of Service-Telecommunications
16. Scope of Service-Transport
17. Specimen/Foreign Body
18. Traffic Patterns in the OR
19. Transport to/from External Healthcare Facility for Treatment
20. 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)

E. Resolution 2025-02 Authorizing Designated Officers to Execute Financial Institution Documents

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Rey, second by Director Carson, the Board of Directors approves the Consent Agenda, Items (A) through (E) as listed.

ROLL CALL VOTE:

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

Motion Carried

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: No comment.

Director Catherine Carson: Director Carson had fun joining the Marina Farmers' Market. She has been promoting the Nancy Ausonio Breast Health Center. The Foundation Spring Fling was a great event and she had the opportunity to meet the Foundation Board.

Director Victor Rey, Jr.: No comment

Director Joel Hernandez Laguna: President Hernandez Laguna (1) thanked the Blue Zones team for pursuing activities at Ensen Community Park and looks forward to the next steps. (2) Joel has recently spent time reviewing scholarships. Out of the 48 applicants, a good majority mentioned volunteering at the hospital and referenced skills they learned volunteering. Shannon Graham, Director Volunteer & Health Career Services does tremendous work inspiring youth to look at the medical field as a career. (3) Kudos to CT scan team for their professionalism while helping to get to the root cause of some healthcare issues. (4) Regarding the current rent stabilization issue, physicians have taken their personal time to speak on behalf of some of our patients. This is a reminder that SVH extends outside the four walls of the hospital.

Director Isaura Arreguin: Director Arrequin stated she has been at SVH multiple times this week with a family member. The ED team was amazing and found the issue and (the patient) is now being treated. The ED team is "super knowledgeable and empathetic and took care of me as well as (the patient)." They felt welcomed and cared for.

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The minutes of the April 14, 2025 meeting were provided for Board review. In review, (1) Patient Care Services provided an update on the Clinical Inquiry Council. During Hospital week there will be a poster expo with 21 posters. There is a plan to market the poster expo externally. (2) There was review of the six Environment of Care (EOC) plans which are updated annually through objective review. (3) The CMS Patient Structural Measure (PSSM) is a new requirement in the Inpatient Quality Reporting Program which is designed to ensure hospitals implement a comprehensive approach to patient safety. (4) A new Dashboard format is coming soon.

B. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the April 21, 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 Purchase of Two (2) Canon X-ray Units and Service Agreement from Canon for Salinas Valley Health Clinics Imaging Services**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: What do we do with existing units? SVH is researching the opportunity to donate equipment to humanitarian projects.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves 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, 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 Award Contract to C. Overaa & Co. for the Seismic Compliance Project**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: The total estimated project is $62.5M. This project is important as it will bring SVH in compliance with State seismic standards.

MOTION:

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

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 Contract Terms and Conditions for Services Agreement Between Salinas Valley Health and Prinnovo, LLC.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Dr. Cabrera stated he would like additional discussion on this agenda item.

The item was tabled until after the Extended Closed Session.

C. TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

A report was received from Director Dr. Cabrera regarding the Transformation, Strategic Planning and Governance Committee. The minutes of the April 16, 2025 meeting were provided for Board review. There are no recommendations at this time.

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

Gary Ray, CLO, reported that it has been 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.

Dr. Radner stated this physician is semi-retired and is being recruited to help with extended hours at PrimeCare. Currently PrimeCare is open weekdays until 9:00 p.m. and effective May 2nd will be open 9-5 Saturday and Sunday.

PUBLIC COMMENT: None.

BOARD DISCUSSION: Director Rey has heard from 3-4 people who have commented about extended hours and the community is very happy. A recruitment to assist with these extended hours is excellent.

MOTION:

Upon motion by Director Carson, second by Director Arreguin, the Board of Directors approves

1. The Findings Supporting Recruitment of Sadi Dalieh, M.D.:
   - 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.

ROLL CALL VOTE:

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

Motion Carried

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

Rakesh Singh, Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of April 10, 2025. A full report was provided in the Board packet.

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

PUBLIC COMMENT: None.

BOARD DISCUSSION: None.

MOTION:

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

A. Reports

1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report (Including the following)
   - 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

ROLL CALL VOTE:

Ayes: Arreguin, 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 5:23 p.m. The Board completed its business of the Closed Session at 6:15 p.m.

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:15 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. CONSIDER RECOMMENDATION FROM THE FINANCE COMMITTEE FOR BOARD APPROVAL OF CONTRACT TERMS AND CONDITIONS FOR SERVICES AGREEMENT BETWEEN SALINAS VALLEY HEALTH AND PRINNOVO, LLC.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Carson, the Board of Directors approves of the Pertinent Contract Terms and Conditions for the Services Agreement Between Salinas Valley Health and Prinnovo, 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.

ROLL CALL VOTE:

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

Motion Carried

14. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, May 22, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:18 p.m.

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Rolando Cabrera, MD
Secretary, Board of Directors

DRAFT SALINAS VALLEY HEALTH[1]
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
APRIL 22, 2025

Board Members Present: Vice-President Catherine Carson, Isaura Arreguin, Rolando Cabrera, M.D., and Victor Rey, Jr.

Absent: President Joel Hernandez Laguna;

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

1. READING OF THE NOTICE OF SPECIAL MEETING

Vice President Carson read the following: The Special meeting of the Board of Directors Budget Workshop of Salinas Valley Health[1] will be held Tuesday, April 22, 2025, at 4:30 p.m., Downing Resource Center, Conference Rooms A, B, and C, Salinas Valley Health Medical Center, 450 E. Romie Lane, Salinas, California to discuss Closed Session: Report Involving Trade Secret: Strategic Planning, New Programs and Services.

2. CALL TO ORDER/ROLL CALL

A quorum was present and Vice-President Carson called the meeting to order at 4:33 p.m. in the Downing Resource Center, Rooms A, B, and C.

3. CLOSED SESSION

Vice-President Carson announced the item to be discussed in Closed Session as listed on the posted Agenda is *Report Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:34 p.m.

The Board completed its business of the Closed Session at 5:54 p.m.

4. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:54 p.m. Vice-President Carson reported that in Closed Session, the Board discussed *Report Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services*. The Board received and accepted the report listed on the Closed Session agenda. No other action was taken.

5. 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 5:55 p.m.

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Rolando Cabrera, MD
Secretary, Board of Directors

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

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: May 22, 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.	Adaptive Feeding Equipment	New Policy	Clement Miller, COO
2.	Administrative Adjustment	Updated adjustment code, adjustment approved by and committee name change. Link corrected.	Agustin Lopez, CFO
3.	Administrator On-Call	Changed ELG to LWG. Email addresses corrected.	Clement Miller, COO
4.	Disruptive Persons	No changes.	Carla Spencer, CNO
5.	Dual Employment	Minor updates.	Michelle Childs, CHRO
6.	Employment of Relatives	Minor verbiage changes recommended by legal counsel.	Michelle Childs, CHRO
7.	Formulary Process	Updated policy, references and attachments	Clement Miller, COO
8.	Information Security Risk Analysis	Title updates and minor updates.	Clement Miller, COO
9.	LAB.PROT.GEN.1 - Aerosol Transmissible Pathogens-Pathology	Changes to department names & position titles.	Clement Miller, COO
10.	MRI Safety	Added forensic patients, updated references; minor updates.	Clement Miller, COO
11.	NS: Cash Handling	Changed the policy of having a dual co-worker count money. Now the money will be counted by manager.	Clement Miller, COO
12.	Oral Care	Changes to policy statement, purpose, definitions, general information, procedures, education and references.	Carla Spencer, CNO
13.	Organization Plan for Provision of Care and Service	Minor update and title changes.	Clement Miller, COO
14.	Registered Dietitian Diet Order Entry	New Policy.	Clement Miller, COO
15.	Scope of Service: Case Management	No Changes.	Carla Spencer, CNO
16.	Scope of Service: Diagnostic Imaging	Added reference to Radiation Safety Program Policy.	Clement Miller, COO
17.	Scope of Service: Employee Health	Minor changes in wording and clarification of requirements. Added RN/Information System Analyst to the job tree. Department org chart corrected to more current.	Michelle Barnhart-Childs, CHRO

18.	Scope of Service: Nursing Administration	Minor changes.	Carla Spencer, CNO
19.	Scope of Service: Physician and Business Development	Scope updated to reflect new department reporting structure, including a new department organization chart.	Timothy Albert, CCO
20.	Scope of Service: Social Services	Updated Org Chart.	Carla Spencer, CNO
21.	Triage Assessment	Updated education/training and references.	Carla Spencer, CNO
22.	Use of Ultrasound Enhancement with Echocardiography	No changes	Carla Spencer, CNO
23.	Virtual Private Network	Rewrote policy to align with current best practices and discontinue the use of high-risk temporary software-based VPN usage. Branding edits made.	Alysha Hyland, CAO
MEC Policies			
1.	Block Scheduling	Added clarification of block time and loss of 0730 privileges.	Alysha Hyland, CAO
2.	Fire Safety Management Plan	Approved by Board 4-24-25. Added MEC as part of Approval Flow	Carla Spencer, CNO
3.	Renal Dose Adjustment per Pharmacy Protocol	New Policy	Clement Miller, COO
4.	Utility Management Plan	Approved by Board 4-24-25. Added MEC as part of Approval Flow	Timothy Albert, CCO

Status **Pending** PolicyStat ID **17703667**

Last Approved	N/A	Owner	Decorntae Kpou: Rehab Supervisor
Next Review	3 years after approval	Area	Rehabilitation

Adaptive Feeding Equipment

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. Feeding plays a significant role in a person's culture, identity, and overall well-being (Calvalcanti et al., 2020). Struggles with self-feeding can result in reduced oral intake, increased aspiration risk, and decreased self-efficacy (Shune, 2020). Occupational and speech therapists can address these deficits through assessment and intervention, which can include the use of adaptive equipment (Boop et al., 2017; Chen et al., 2022; Rogus-Pulia et al., 2015). Standardized utensils are provided on meal trays regardless of a patient's functional abilities, highlighting a need for more individualized solutions to improve independence with self-feeding.

III. DEFINITIONS

A. OT: Occupational Therapist or Occupational Therapy
ST: Speech Therapist or Speech Therapy
AE: Adaptive Equipment - specialized tools such as built-up utensils, weighted utensils, scoop plates, or specialized cups designed to support self-feeding and drinking
RN: Registered Nurse
CNA: Certified Nursing Assistant
NCO: Nutritional Communication Order
NS: Nutritional Services
NPP: Non-physician Practitioner (e.g. nurse practitioner, physician assistant)
EMR: Electronic Medical Record
PA: Physician Assistant

IV. GENERAL INFORMATION

A. To establish a standardized process for identifying, prescribing, and implementing adaptive equipment (AE) to support patient independence with self-feeding. By addressing feeding challenges, this policy aims to reduce risks such as aspiration, malnutrition, and decrease self-efficacy, while promoting patient well-being.

B. Adaptive equipment (AE) supports a patient's independence with self-feeding through the use of specialized tools. The tools include built-up utensils, weighted utensils, specialized cups and a scoop plate. These AE will be ordered through Occupational Therapy (OT) and/or Speech Therapy (ST) for identified patients through Nutritional Communication Order (NCO) to be placed onto patient's meal trays. Clinical staff can ensure an OT and/or ST consult is placed in the Electronic Medical Record (EMR) if they feel a patient may benefit. AE will be stored in nutritional services and maintained by rehab services.

V. PROCEDURE

A. Physician

1. OT and/or ST consults will be placed by physician/Non-physician Practitioner (NPP)/Physician Assistant (PA), if indicated, through a signed order placed in the EMR.

B. Occupational Therapist/Speech Therapist

1. The OT will evaluate and treat.
2. The ST will evaluate and treat.
3. The OT and/or ST, will place an order through NCO, pending assessment and patient needs after skilled intervention.
4. The therapist will be responsible for ensuring independence with the use of the AE by the patient, caregiver, and nursing staff before ordering for meal services.
5. A Provale cup will be placed at the bedside for water intake, for no more than 24 hours to maintain compliance with infection control guidelines.
6. The use of visual aids in the patient's room will be placed by rehab therapist to highlight the recommended AE present at bedside for meals (see Attachment. Adaptive Equipment HOB Sign_2025).

C. Nutritional Services

1. Once the order is submitted, the dietary clerks will add the items to the meal ticket. NS will include the AE on the patient's meal tray for every meal.
2. The meal tray will be delivered to the patient's room and once completed will be returned to the kitchen for cleaning according to manufacturer's guidelines.

D. Nursing

1. Registered Nurse (RN) and Certified Nursing Assistant (CNA) will be made aware of patient's needs and recommended AE.
2. Provide assistance with ensuring AE are returned to the kitchen on the meal trays,

and ensure Provale cup is replaced and returned to the kitchen within 24 hours.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Boop, C., Smith, J., & Kannenberg, K. (2017). The practice of Occupational Therapy in feeding, eating, and swallowing. American Journal of Occupational Therapy, 71, 1–13. https://doi.org/10.5014/ajot.2017.716S04

B. Cavalcanti, A., Amaral, M. F., Silva e Dutra, F. C. M., Santos, A. V. F., Licursi, L. A., & Silveira, Z. C. (2020). Adaptive eating device: Performance and satisfaction of a person with Parkinson's Disease. Canadian Journal of Occupational Therapy, 87(3), 211–220. https://doi.org/10.1177/0008417420925995

C. Chen BJ, Suolang D, Frost N, & Faigle R. (2022). Practice patterns and attitudes among speech-language pathologists treating stroke patients with dysphagia: A nationwide survey. Dysphagia, 37(6), 1715–1722. https://doi.org/10.1007/s00455-022-10432-6

D. Paul, S., & D'Amico, M. (2013). The role of occupational therapy in the management of feeding and swallowing disorders. New Zealand Journal of Occupational Therapy, 60(2), 27–31.

E. Rogus-Pulia, N., & Hind, J. (2015). Patient-centered dysphagia therapy-the critical impact of self-efficacy. Perspectives on Swallowing and Swallowing Disorders, 24(4), 146-154. doi:10.1044/sasd24.4.146

F. Shune S. E. (2020). An altered eating experience: Attitudes toward feeding assistance among younger and older adults. Rehabilitation Nursing. 45(2), 97-105. doi:10.1097/rnj.0000000000000147

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
Rehab Medical Director	Katherine DeSalvo: Director Medical Staff Services	04/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Decorntae Kpou: Rehab Supervisor	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18083631**

Origination	05/2022	Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Last Approved	N/A		
Next Review	3 years after approval	Area	Administration

Administrative Adjustment

I. POLICY STATEMENT

A. It is the policy of Salinas Valley Health Medical Center (SVHMC) to fully identify and treat all administrative and patient requests for bill adjustments equitable. All patient and administrative requests for adjustment will be reviewed by the Administrative Adjustment Committee (AAC) prior to any adjustment being performed. All patient and administrative adjustments will require approval and signature of either the CEO or CFO.

II. PURPOSE

A. To provide guidelines for the identification and management of administrative and patient complaint adjustments.

III. DEFINITIONS

A. AAC – Administrative Adjustment Committee – Committee delegated authority by the CEO to review all administrative and patient requests for adjustment to a bill in accordance with the established Committee Charter.

B. CEO – Chief Executive Officer – Makes final decisions regarding financial adjustments when AAC / CFO are unable to determine outcome.

C. CFO – Chief Financial Officer – Authorized to approve a financial adjustment after AAC review.

D. CSR – Customer Service Representative in Patient Financial Services or the Practice Manager / designee at TFFHWC

E. TFFHWC – Taylor Farms Family Health and Wellness Center

F. EHR - Electronic Health Record

IV. GENERAL INFORMATION

A. In accordance with hospital policy and State and Federal regulations, adjustments to accounts with third party payors may not be appropriate unless the total fee is discounted or reduced. Specifically, Medicare regulations prohibit the waiving of copayments and deductibles or the granting of professional courtesy adjustments. These types of adjustments could be viewed as enticements as they are not generally available to an entire population. No hospital official should offer such adjustments without the review of the Administrative Adjustment Committee.

B. Charge reversals shall occur as a result of a medical record audit where it has been determined services were (1) not rendered, or (2) duplicate charges were applied to the account, or (3) services were interrupted due to patient or equipment delay. Reversals to accounts for services charged and not rendered or interrupted services must have the review and recommendation from AAC. The CSR will review and ensure that patient requests, which result in administrative adjustments, are forwarded to the AAC, reviewed, approved and processed in accordance with the procedure.

V. PROCEDURE

A. **The following steps should be performed for patient and administrative requests for adjustment:**

1. All patient billing complaints should be directed to a CSR/designee. If the billing complaint is in relation to a perceived care concern this will be referred to the Patient Relations Department for review in accordance with the Complaint and Grievance Policy.
2. If the CSR receives a call regarding a complaint related to their bill, they will attempt to work through and resolve the issue, including those concerning duplicate, multiple or non-existent charges. If the CSR can research and reasonably resolve the issue, the CSR will document the actions taken and their resolution in the EHR B/AR module. If unable to resolve the issue the CSR will forward the concern to the AAC for adjustment recommendation.
3. The leader of the department where the complaint originated is responsible to review the details of the complaint prior to the next AAC meeting and present to the committee. AAC reviews the case / situation and decides that the bill should or should not be adjusted. All proceedings of the AAC will be documented.
4. After AAC review and agreement for approval, the Patient Financial Services Director / designee will forward the recommendation to the CFO for review. The outcome will be documented in the Patient Financial System.
5. The Patient Relations Department will assure the patient is noticed of the AAC outcome (denial and approval) for all Grievances.
6. If the billing complaint is validated and approved, the CSR/designee will open a batch, enter patients account number, enter adjustment code (AADMINFSC) and post adjustment accordingly. If the request for bill adjustment is denied this will be noted. The CSR is responsible for patient notification of all billing disputes that have

adjustments denied and approved by the AAC.
Inquiries regarding the medical necessity or challenging the delivery of service/care shall be considered a Grievance and handled per policy. Concerns may be forwarded to the Quality Management Department / Medical Staff Services for care review in accordance with the Peer Review policies.

7. Procedures specific to Taylor Farms Family Health and Wellness Center (TFFHWC)
    a. All patient and administrative requests for adjustment will be reviewed by the Practice Manager / designee and follow the steps identified above. All requests will be forwarded to the AAC for review prior to any adjustment is made.
    b. The Practice Manager / designee documents all outcomes for adjustment approval / denial in the hospital electronic financial system. The adjustment approval from the CFO / CEO will be scanned into the electronic financial system.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18120931**

Origination	09/2021	Owner	Clement Miller: Chief Operating Officer
Last Approved	N/A	Area	Administration
Next Review	3 years after approval		

Administrator On-Call

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To outline the role and responsibility of the administrator on-call for Salinas Valley Health Medical Center (SVHMC).

III. DEFINITIONS

A. Administrator on-call (AOC)

B. Leadership Working Group (LWG) – Executive Leadership Team or Designee

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. The hospital will identify a member of the hospital's leadership team to serve on an on-call basis should the need arise.

B. During evenings, nights, holidays and weekends, the on-site designated Administrator for the hospital is the Administrative Supervisor.

C. The Administrative Supervisor should be contacted first if emergency problems, questions or general questions of patient care and administration should arise.

D. A member of the hospital's leadership team is designated as the Administrator on-call (AOC) and is available on an on-call basis to assist the Administrative Supervisor should the need arise.

E. The AOC should be notified on off-shifts, weekends, and holidays by the Administrative Supervisor on duty about unusual occurrences in the conduct of Hospital business/operations. A rotating scheduling listing for AOC shall be prepared in advance and posted on STARnet for staff access.

   The AOC covers per agreed upon schedule. The AOC should provide handoff (via email or phone call) to the oncoming AOC of any pending issues. AOC's may trade on-call with one another and will ensure the following are informed of any changes: LWG members/designee (adminexecs@SVMH.com), the Hospital Operators (@salinasvalleyhealth.com), and Administrative Supervisors (adminsupervisors@salinasvalleyhealth.com).

F. The AOC should be notified about:
   1. Situations where there is a physician determination that emergency treatment is indicated, but there is an absent or questionable consent (i.e. minors, incompetent adults). The Patient Safety Officer should also be notified.
   2. Hospital-wide emergency conditions.
   3. Emergency situations outside the institution with potential impact on the Hospital.
   4. Emergency or unusual conditions in the Hospital wherein the health and welfare of patients, employees or visitors could be at risk, such as Code Red, Code Pink or any internal/external disaster codes. The Patient Safety Officer should also be notified.
   5. Situations where there is a high census, pending surge plan particularly in the ICU, NICU and ED and there are no available beds or sufficient nursing or other staff. Patients will continue to be admitted to the ED for triage and stabilization. The decision to transfer to another institution must be done on a case by case basis with input from physicians in the ICU, NICU and ED or respective area, and the Administrative Supervisor on duty.
   6. Transfer issues.

G. Notification by phone is not required for the following:
   1. Public Relations issues that would not have an adverse effect on the institution.
   2. Personnel problems that do not interfere with patient, employee, or visitor welfare.
   3. Fire drills.
   4. All requests from the news media will be handled by the Public Relations or LWG member via listing supplied to the Hospital operator.

H. The Hospital Operators will maintain contact information for the AOC and LWG.

I. Responsibilities
   1. Keep the hospital telephone operator informed of his/her whereabouts during the hours of their designated tour of responsibility.
   2. Assist and advise the Administrative Supervisor in matters pertaining to hospital policy and operations as requested.
   3. Assist and advise department managers/supervisors or other staff in matter pertaining to hospital policy and operations.

4. Implement the HICS Disaster Plan as necessary.
5. Participate in high census management telephone conference calls as scheduled.
6. Notify the communications representative of events that may draw media attention.
7. Act as liaison between SVHMC and external entities as necessary, e.g., medical care providers, California Department of Public Health, etc.
8. Consult on matters of a professional nature and contact the Chief Medical Officer, Chief Nursing Officer or Chief
9. Operating Officer on issues which might be of sufficient magnitude and importance to warrant their immediate attention.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Clement Miller: Chief Operating Officer	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18026720**

Origination	07/2019	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Disruptive Persons

I. POLICY STATEMENT

A. Behavior as outlined in this policy are considered unacceptable will not be tolerated and decisive actions will be taken to protect staff, patients and visitors.

II. PURPOSE

A. To detail the type of behavior which is unacceptable and the sanctions available in the face of such behavior, including a mechanism whereby patients/visitors who are extreme or persistent in their unacceptable behavior can, as a last resort, be discharged or excluded from the hospital.

III. DEFINITIONS

A. Disruptive Behavior – behavior by patients, family members and/or visitors which is disruptive to the patient's own care, the care of other patients, the safety of patient, staff visitors and facility operations; Conduct or comments that are inappropriate, demeaning or otherwise offensive behaviors intended to create an uncomfortable, hostile, and/or intimidating environment. These behaviors include, but are not limited to:

1. Pattern of noncompliance with care (refusal of medications, refusal of medically necessary procedures, refusal of monitoring necessary for patient safety, dictating care, firing staff, missing appointments, etc.
2. Demanding care that is not medically indicated
3. Violation of hospital policies (use of drugs, alcohol, smoking, visitors, etc.)
4. Violation of care contracts, e.g. pain, behavior.
5. Obtaining prescriptions fraudulently
6. Verbal and / or physical threat / abuse of staff, other patients / family, including excessive loud comments, swearing or offensive remarks, derogatory racial or

sexual remarks.

7. Threats of violence
8. Willful property damage / theft
9. Entering areas without permission
10. Refusal to follow directions / instructions by staff or physicians.
11. Refusal to be discharged when medically stable and or to participate in safe discharge planning (potentially impacting care / safety).
12. Refusal to meet with care providers
13. Repeated violations of Patient Responsibilities
14. Elopements / AMAs with returns
15. Excessive phone calls / emails to providers / practices

B. Care Conference – a meeting of care providers to address a patient's plan for care when disruptive behaviors are exhibited.

C. Management Team Conference – This meeting can be requested by any member of the care team in situations where a patient's behavior, after a care conference has been completed and an initial plan developed, continues to disrupt the plan for care and escalates behaviors despite attempts at interventions. This team meeting includes the necessary care providers and others (i.e. Patient Safety, Patient Experience, Risk Management, Case Management, Social Worker, etc.) in order to strategize and develop a course of action to address the continued disruptive behaviors. This might include a patient agreement, contract for behavior and care including discharge.

IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center (SVHMC) is committed to maintaining a safe workplace that is free from threats and acts of intimidation and violence from patients. Continued acts of verbal aggression, intimidation, care refusal or situations of the like may result in the patient being discharged from the facility.

B. Salinas Valley Health Medical Center (SVHMC) understands that hospitalization is a stressful event for patients. SVHMC recognizes and respects patient's rights and is committed to responding appropriately to complaints about care. Actions and interactions related to disruptive behavior will include consideration of the patient's health care needs and psychosocial issues as well as SVHMC obligation to the safety of the employees, visitors and patients and the responsible use of institutional resources.

C. SVHMC is committed to patient safety and as such has a goal to prevent or mitigate disruptive behaviors exhibited by patients that has the ability to impact their own or other patient's safety.

D. SVHMC has adopted a zero tolerance standard for Workplace Violence and is committed to maintaining a safe workplace that is free from threats and acts of intimidation and violence from patients, families and / or visitors. WORKPLACE VIOLENCE PREVENTION/SECURITY PLAN

E. This policy is a guideline and each situation will be evaluated on a case by case basis based

on the severity of the involved behavior, risk to other patients, staff and visitors and the patient themselves.

F. All written complaints will be managed according to the Complaints and Grievance Policy. COMPLAINT AND GRIEVANCES: PATIENT

G. Those patients who, in the expert judgement of the relevant clinician are not capable of making their own medical decisions are not subject to this policy. This includes:

    1. Individual who becomes abusive as a result of an illness or injury or other organic condition that places them unable to manage their behavior.
    2. Patients who are acutely mentally ill or under the influence of drugs or alcohol.

V. PROCEDURE

A. The appropriate level response to disruptive behavior is based on the level of disruption / behavior exhibited and the patients evaluation and determination of ability to make own healthcare decisions. SPECIAL INDICATORS IN THE ELECTRONIC HEALTH RECORD

B. Staff should always consider his/her safety when dealing with patients who exit unacceptable behaviors.

C. Inpatient Services – See attachment A

    1. Level 1 - consists of demanding care not required, dissatisfied and/or excessive questions about care.
        a. A Care Conference is scheduled with members of the healthcare team, Patient Experience and others as necessary. The patient should be included if possible.
        b. The plan of care is reviewed and actions defined. The team will review the plan with the patient that outlines acceptable behaviors, following the plan of care, etc.
        c. Provide the patient with a copy of the "Patient Responsibilities".
        d. Unit leaders are to assure the behaviors and actions are clearly documented.
        e. Consider Three Bears Process.
    2. Level 2 - consists of continued non-compliance or refusal to follow the plan of care as defined by the Care Conference Team, refusal to follow hospital policies, including Patient Responsibilities, intentional verbal abuse by patient / family / visitors towards any member of the healthcare team or other patients.
        a. The unit leadership meets with the patient and defines appropriate behaviors.
        b. Involve Patient Experience as necessary
        c. Contact the Patient Safety Office for direction, if needed.
        d. Security may be contacted, if needed.
    3. Level 3 – consists of continued noncompliance as in level 2, escalation of verbal

threats, physical abuse, violence and aggression.

a. Patient Safety Office / Risk Management is contacted to define the ability to complete a discharge due to non-compliance.

b. Notify Security to assist as necessary.

c. Salinas Police Department may be requested, if necessary at the direction of the Patient Safety Office / Risk Management.

D. Outpatient Services –See attachment B

1. Phone

a. Staff member on the phone with the caller should make attempts to calm the individual and determine the cause of the behavior.

b. If unsuccessful, advise the caller that the call will be terminated or refer the caller to the clinic leader.

c. Terminate the call if necessary. All further calls should be managed by the Clinic leader.

d. If the leader is unsuccessful in calming the individual, refer the caller to the Patient Relations Department.

2. Clinic visit

a. If the patient is being disruptive by raising voice or using profanity and disrupting the clinic setting, staff should contact the manager.

b. Escort the individual to a quiet area to discuss the concern. If the individual does not become calm, the manager should ask the individual to leave the clinic for the day and politely suggest that they to resolve the concern.

c. If the patient refuses to leave the clinic and behavior continues, contact the Salinas Police Department to assist with the removal of the individual.

3. In addition to the use of this policy, the patient's physician may, based on his/her judgement, at any time the disruptive behavior may be grounds to withdraw their medical care permanently. Any such decision will automatically result in the transfer of the patient's care to another clinic within the SVHMC system. The patient may continue to use the Emergency and other walk in services such as Laboratory as long as the patient abides by the Patient Responsibilities and acceptable behaviors are exhibited.

E. Documentation

1. Documentation of incidences of disruptive behavior is documented in the EHR consistently by the individual(s) who was involved and / or witnessed the event. Documentation consists of the facts surrounding the situation and includes the date / time, what disruptive behaviors were exhibited and statements made by the patient and actions taken by staff.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Attachments

A: Action Plan Inpatient Setting

B: Clinic Setting

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Carla Spencer: Chief Nursing Officer	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17353705**

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

Dual Employment

I. POLICY STATEMENT

A. It is the policy of Salinas Valley Health Medical Center (SVHMC) that employees may engage in consulting or other employment and business activities during nonworking hours away from SVHMC premises as long as such activities do not interfere with the performance of SVHMC duties or create a conflict of interest (see SVHMC CONFLICT OF INTEREST).

II. PURPOSE

A. To define the dual employment process

III. DEFINITIONS

A. "Onboarding" the processes in which new hires are integrated into the organization. It includes activities that allow new employees to complete an initial new-hire orientation process, as well as learn about the organization and its structure, culture, vision, mission and values.

IV. GENERAL INFORMATION

A. Employment with another business entity should not result in personal financial gain contingent upon continued employment with SVHMC and should not impair the employee's ability to make business decisions for SVHMC in a manner consistent with SVHMC's Standard of Conduct Policy. This prohibition includes serving as an advisor or consultant for any such organization, unless that activity is conducted as a representative of SVHMC and with the agreement of the President/Chief Executive Officer.

B. All employees must disclose in writing any outside employment or other work activity, including self-employment, to their department director/designee. The written disclosure will then be forwarded to the Human Resources Department for review and placement in personnel file. Dual employment forms are completed at new employee in-processing, if

appropriate and when employed in another job for all employees who meet the criteria.

C. This Dual Employment policy does not prevent SVHMC employees from engaging in any activity protected by the California Constitution or the California Labor Code, including without limitation those activities protected by the rights to freedom of speech and political expression, reproductive freedom, governmental petition, freedom of religion, and privacy.

V. PROCEDURE

A. Employee Onboarding:

1. During onboarding, the Human Resources designee reviews this Dual Employment Policy with employees and directs staff to the Dual Employment Notification (Attachment), if appropriate.
2. If the employee has another job, the employee completes the Notice of Dual Employment and notifies their department director/designee. The form is then sent to the Human Resources department for review of compliance with policy.

B. Current employee seeking Dual Employment:

1. If appropriate and when employed in another job, the employee who meets the criteria must complete a Dual Employment Form.
2. The employee will print the Notice of Dual Employment form Workday when contemplating obtaining dual employment.
3. Follow process in Section "A" above.

C. Documentation:

1. Dual Employment Form

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Attachments

Dual Employment Notification.pdf

Approval Signatures

Step Description	Approver	Date

Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16707359**

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

Employment of Relatives

I. POLICY STATEMENT

A. This policy will be applied throughout Salinas Valley Health Medical Center (SVHMC) in a non-discriminatory fashion:

1. Employees will not be employed in a position under the direct supervision of someone with whom they have a personal relationship, defined below.
2. SVHMC endeavors to ensure that employees are not employed in the same department, shift or facility as someone with whom they have a personal relationship if the work involves potential conflicts of interest or other hazards greater for related employees than for other persons.

II. PURPOSE

A. Salinas Valley Health Medical Center is committed to maintaining a professional work environment free of the appearance of, actual, or potential conflicts of interest, nepotism and favoritism; an environment that promotes high employee morale, is fair, equitable and safe.

III. DEFINITIONS

A. “Personal relationship” is defined as persons who are related to each other, including by blood, adoption, current or former marriage, domestic partnership or cohabitation. Cohabitation means living with another person while in a romantic relationship without being married or in a domestic partnership. "Related" includes, but is not limited to, the following relatives, mother, father, grandparent, mother-in-law, father-in-law, step-mother, step-father, registered domestic partner, or cohabitation partner, brother, sister, step siblings, brother-in-law, sister-in-law, spouse, child, step-child or child of registered domestic partner, or cohabitation partner, grandchild or grandchild of registered domestic partner, or cohabitation partner.

IV. GENERAL INFORMATION

A. Failure to adhere to this Policy or providing inaccurate information in order to circumvent this Policy will result in disciplinary action up to and including termination of employment.

V. PROCEDURE

A. Everyone involved in the selection process should review with an applicant all information provided by that applicant on the Application for Employment or Transfer to identify possible conflicts with SVHMC policy which may arise from relatives working in the same department.

B. In addition, before any employee can be considered for a position in a department that employs a relative, as explained in Section III above, approval must be received from Human Resources and the department Administrator.

C. Employees who enter into a personal relationship as defined above and who work in the same department as their spouse or registered domestic partner shall have ninety (90) days from the date of marriage to:

    1. Transfer to another department within SVHMC;
    2. Seek employment elsewhere; or
    3. Receive written approval from Human Resources and the department Administrator to work in the same department.

D. Employees who enter into a personal relationship as defined above with a Hospital-based physician and who work in the same department as their spouse or registered domestic partner or cohabitation partner shall adhere to Section C above.

E. Hospital-based physicians and their agents are not employees of the Hospital and would not be expected to transfer.

F. Failure of employees to take appropriate action as outlined above within 90 days of entering into a personal relationship may result in the employee with the least tenure, based on hire date, being terminated.

VI. EDUCATION/TRAINING

A. Education and/or training provided as needed

VII. REFERENCES

A. Conflict of Interest Policy

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	04/2025
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16470322**

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

Formulary Process

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) shall maintain a formulary or list of drugs approved by the medical staff.

II. PURPOSE

A. To describe the formulary system at Salinas Valley Health Medical Center (SVHMC) and its role in the procuring, prescribing, dispensing, administering and monitoring of drug therapy.

III. DEFINITIONS

A. There are three classifications of drugs under the formulary system. They are defined as follows:

1. **Formulary Drugs:** A formulary drug is a pharmaceutical agent which has been reviewed and accepted by the Pharmacy and Therapeutics/Infection Prevention (P&T/IP) Committee and which, in the opinion of clinicians from various departments knowledgeable and experienced in the use of the drug, is conducive to rational drug therapy, is considered essential for patient care, is cost effective, and whose therapeutic efficacy is well established.
2. **Investigational Drugs:** An investigational drug is a drug that has not yet been approved by the FDA for general use and is not commercially available. The Research Oversight Committee (ROC) is responsible for approving investigational protocols and drugs for use in the hospital. After approval of an investigational drug protocol, the ROC will inform the P&T/IP Committee of its action as per the Administration of Investigational Medications in Clinical Research policy [Policy ID 16470323].
3. **Non-Formulary Drugs:** A non-formulary drug is any drug other than those classified as formulary or investigational drugs, or a specific brand of any formulary drug that

is not stocked in the pharmacy. Non-formulary drugs will not be routinely stocked by the pharmacy but can be obtained for treatment of an individual patient as described below.

IV. GENERAL INFORMATION

A. The P&T/IP Committee routinely reviews the hospital forumlary based on emerging safety and efficacy information.

B. The P&T/IP Committee reviews all formulary additions, deletions, and modifications as requested by medical staff using the procedure outlined below.

C. Any non-formulary drug request received as per the procedure listed below, will be reviewed by the Pharmacy Clinical Coordinator and Director of Pharmacy, or their designee.

V. PROCEDURE

A. Procedure to Request for a **Non-Formulary Drug**

1. If the physician determines that the available pharmaceutical agents on formulary will not meet the needs of the patient; a *Non-Formulary Drug Request* form (Attachment A) shall be completed and submitted to the Pharmacy Clinical Coordinator, Director of Pharmacy, or their designee.
2. If there is an appropriate alternative drug on the formulary, a pharmacist under the direction of the Pharmacy Clinical Coordinator, Director of Pharmacy, or their designee shall inform the prescriber of the alternative.
3. If the *Non-Formulary Drug Request* is accepted, a pharmacy representative shall give the physician the approximate date and time when the medication will be available.

B. Procedure for **Addition, Deletion, or Modification** of a Drug to the Formulary

1. Any medical staff member may initiate a request for addition of a drug to the formulary by completing the *Formulary Request Form* (Attachment B) and *Potential Conflict of Interest Disclosure Form* (Attachment C).
2. Requests for formulary additions must be submitted at least two weeks prior to the next scheduled P&T/IP Committee meeting in order to appear on the agenda. The form must be completed in full, signed by the requesting person, and forwarded to the Pharmacy Clinical Coordinator and the Director of Pharmacy.
    a. In addition to submitting a completed form, the requestor will be asked to attend the P&T/IP Committee meeting or coordinate a substitute to appear in their place to present the request to the Committee.
3. Determination of particular dosage forms, strengths, and brand of drug will be made by the Department of Pharmacy. Selection will be based on but not limited to considerations such as bioavailability, stability, availability, and cost.

C. Selection to the Formulary will be based on the safety, efficacy, and financial considerations of the request.

D. Changes in the Formulary that may be made without P&T/IP Committee approval include but

are not limited to:

1. Substitution of a generic equivalent.
2. Deletion of products no longer commercially available.
3. Drugs recalled or withdrawn from the market.
4. Changes in commercial size or packaging.
5. Addition of a new strength or dosage form of a drug if the drug's indication, side effects, bioavailability, etc. do not differ from that of the formulary drug.

E. Medication Restrictions and Utilization Review
    1. The P&T/IP Committee may approve restrictions on the use of certain medications.
    2. If a medication is prescribed outside of the P&T/IP Committee approved parameters, the dispensing pharmacist will notify the prescriber of the medication's restrictions for use.
    3. All requests for non-approved uses of restricted drugs will be forwarded to the P&T/IP Committee for review.

F. The P&T/IP Committee will forward the decision to Medical Executive Committee (MEC) for further approval and distributing to medical staff.

G. Documentation:
    1. Formulary changes will be reviewed during the P&T/IP Committee meeting, and will be documented in the P&T/IP Committee meeting minutes.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Ciccarello C, Leber MB, Leonard MC, Nesbit T, Petrovskis MG, Pherson E, Pillen HA, Proctor C, Reddan J. ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. Am J Health Syst Pharm. 2021 May 6;78(10):907-918. doi: 10.1093/ajhp/zxab080. PMID: 33954417.

B. AMCP Partnership Forum: Principles for Sound Pharmacy and Therapeutics (P&T) Committee Practices: What's Next? J Manag Care Spec Pharm. 2020 Jan;26(1):48-53. doi: 10.18553/jmcp.2020.26.1.48. PMID: 31880220; PMCID: PMC10391133.

C. Sheldon H, Kostrzewa A, Werner S, Audley T, Biggs A, Mancuso T, Picone MF. Use of an Innovative Pharmaceutical Class Scoring Tool for Prioritized Annual Formulary Review. Innov Pharm. 2022 Dec 12;13(2):10.24926/iip.v13i2.4785. doi: 10.24926/iip.v13i2.4785. PMID: 36654702; PMCID: PMC9836755.

Attachments

Attachment A. NonFormulary Request Form.pdf

Attachment B. P&T Formulary Request Form.pdf

Attachment C. P&T Potential Conflict of Interest Disclosure Form.pdf

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	05/2025
P&T	Genevieve delos Santos: Director Pharmacy	04/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16470296**

Last Approved	N/A	Owner	Audrey Parks: Vice President Information Technology
Next Review	3 years after approval	Area	Information Technology

Information Security Risk Analysis

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) will utilize industry-standard risk analysis practices in accordance with Federal and State Law to assess risks to the confidentiality of electronic personal information. This policy applies to all departments, which collect, use, or discloses electronic personal information and/or electronic protected health information (ePHI) for any purposes. This policy's scope includes all present and future SVHMC information systems which collect, store, and/or transmit electronic personal information, as defined in Section III of this policy.

II. PURPOSE

A. This policy reflects SVHMC commitment to comply with federal and state regulations providing for reasonable and appropriate security of any electronic personal information, which may reside on SVHMC Information Systems.

B. The purpose of this policy is to define the frequency, process of assessing and analyzing information security risk at SVHMC. Information Security Risk Analysis endeavors to accurately identify actual and potential risks to individuals and the Hospital posed by the operation of information systems.

III. DEFINITIONS

A. *Electronic Personal Information*- Personally identifiable information, stored or transmitted electronically, comprising an individual's first name or first initial and last name in combination with any one or more of the following data elements: (a) Social security number. (b) Driver's license number or California Identification Card number. (c) Account number, credit or debit card number, in combination with any required security code, access code, or password that would permit access to an individual's financial accounts. For purposes of this policy, ePHI is included in the definition of electronic personal information.

1. *ePHI* – Electronic protected health information is individually identifiable health information that is transmitted by electronic media and/or maintained in electronic media.

B. *Electronic Media*:
    1. Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, CD/DVD-ROM, portable USB drive, or digital memory card.
    2. Electronic acquisition media used to collect or read information from an external source. Examples may include but are not limited to: Credit or debit card readers, badge readers, data entry points, biometric devices, keyboards or keypads, and any patient care system which collects, stores, or transmits ePHI.
    3. Transmission media used to exchange information already in electronic storage media. Examples may include but are not limited to: Public Internet, extranets or VPNs, leased lines, private networks including all SVHMC internal data networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission.

C. *Information system* – An *information system* is a discrete set of information resources organized for the collection, processing, maintenance, use, sharing, dissemination, or disposition of information. Information resources include information and related resources, such as personnel, equipment, funds, and information technology.

D. *Risk* – Risk is the likelihood that a specific threat will exploit a certain vulnerability, and the resulting impact of that event.

E. *Security measures* – Measures to reduce risk to individuals and the Hospital through the operation of information systems. These may include security policies, procedures, standards and controls, and may be technical, physical, or administrative in nature.

IV. GENERAL INFORMATION

A. Oversight of the enterprise-wide information security risk analysis program is the responsibility of the Information Technology Security group (IT Security) under direction of the HIPAA Security Officer/VP of Information Technology. IT Systems Security will coordinate with Department Directors who are responsible for the thoroughness and accuracy of self-administered analysis data and for making their personnel and systems fully available for assessment activities. Periodic enterprise-wide assessments and/or audits are conducted by an external agency.

B. Risk analysis findings will be used in conjunction with the Information Security risk management policy and process to identify, select and implement security measures to mitigate risk to SVHMC information systems containing electronic personal information.

C. All risk analysis findings are strictly confidential, not to be shared with any third parties without the expressed, written permission the President/CEO or Chief Financial Officer.

V. PROCEDURE

A. The SVHMC Information Security Risk Analysis process is comprised of three core elements:

1. Comprehensive enterprise-wide security assessments conducted by IT Security Staff under the direction of the Information Security Officer. These will be conducted on a minimum annual basis. Methodology is based on industry-standard guidelines. Industry-accredited External Contractors may be retained to assist with these activities, where applicable. Procedural guidelines and documentation for conducting these assessments are kept by the Information Security Officer.
2. Self-assessments by SVHMC information system owners/administrators. Included in this process are Department Directors whose departments own or administer systems which covered under this policy. These assessments will be on an as-needed basis, prior to system implementations and major changes or upgrades.
    a. The IT Assessment questionnaire will be completed and submitted to the Information Security Officer, including all relevant system/device documentation. This includes network diagrams, interface maps, and disaster recovery/business continuity plans. It is the system owner/ Department Director's responsibility to ensure that all information contained in the self-assessment is complete, accurate, and up-to-date. IT Systems Security will assist in the process as requested and/or required. Updated questionnaires are kept, distributed, documented, and scheduled through the Information Security Officer's office.
    b. Capital Budget Requests: Assessments of proposed systems or devices as defined in this policy will be completed prior to purchase. These requirements establish IT baselines for security, disaster recovery, supportability, and network capacity. IT Security may at any time request that a risk analysis of proposed purchases be conducted to ascertain compliance with this policy.
3. Comprehensive enterprise-wide Security Assessments may be conducted by an industry-accredited outside agency. Auditing of SVHMC IT Systems Security practices, policies, procedures, and technical controls are included in these assessments. Frequency of these assessments will be no less than once every two years or in compliance with Meaningful Use criteria.

B. In addition to scheduled risk analysis activity, IT Systems Security may conduct a risk analysis and/or assessment when environmental or operational changes occur which significantly impact the confidentiality, integrity or availability of information systems covered under this policy. Such changes may include:

1. Significant security incidents affecting covered information systems.
2. Significant new threats or risks to covered information systems.
3. Significant changes to the organizational or technical infrastructure of SVHMC which affect covered information systems.
4. Acquisition, proposed acquisition, and/or introduction of new information systems or technologies into the information technology environment.

5. Significant changes to SVHMC information security requirements or responsibilities which affect covered information systems.

C. Any and all requests for inventories, interviews, vendor contacts, information, documentation, administrator guides or system specifics made by the Information Security Officer or designee will be responded to in a timely fashion.

D. Any access needed will be provided to appropriate designees of the Security and/or Privacy Officers.

1. User level and/or system level access to any computing or communications device.
2. Access to information (electronic, hard copy, etc.) that may be produced, transmitted or stored on SVHMC equipment or premises.
3. Access to work areas (labs, offices, cubicles, storage areas, etc.).
4. Access to interactively monitor and log traffic on SVHMC networks.

E. Documentation:

1. Documentation is maintained by the office of the HIPAA Security Officer as required for compliance or as specified in this policy.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Joint Commission on Accreditation of Healthcare Organizations, Management of Information Standards.

B. Health Insurance Portability and Accountability Act (HIPAA), Administrative Simplifications, Standards for Privacy of Individually Identifiable Health Information, Part 164 – Security and Privacy, Sub Part E; Rules 164.502, 164.504.0, 164.518 (c).

C. Health Insurance Portability and Accountability Act (HIPAA) Regulatory Standards – Administrative Safeguards/Security Management Process.

D. Health Insurance Portability and Accountability Act (HIPAA) Regulatory Citation - 45 CFR 164.308(a)(1)(ii)(A).

E. State of California Senate Bill 1386, Chap. 915

F. National Institute of Standards and Technology (NIST) Special Publications 800-66 and FIPS 200

G. Centers for Medicare & Medicaid Services, Meaningful Use: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Eligible_Hospital_Information.html

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
Risk	Gary Ray: Chief Legal Officer	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Audrey Parks: Vice President Information Technology	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17569087**

Last Approved	N/A	Owner	Lori Orosco: Director Laboratory Services
Next Review	2 years after approval	Area	Laboratory - General

LAB.PROT.GEN.1 - Aerosol Transmissible Pathogens - Pathology

I. POLICY STATEMENT

A. Pursuant to the California Occupational Safety and Health Standards board Title 8, section 5199, policies and procedures are established to implement and maintain an effective program to minimize the risks of laboratory personnel exposure to Aerosol Transmissible Pathogens – Laboratory (ATP-L) at Salinas Valley Health Medical Center (SVHMC).

II. PURPOSE

A. To guide Salinas Valley Health Medical Center pathology staff in:

1. Minimizing occupational exposure to certain pathogens potentially transmitted by aerosols or droplets through engineering and work practices.
2. Utilizing effective safety plans, protective equipment, and training.
3. Annually reassessing policies and procedures for effectiveness and relevance.
4. Communicating identified hazards or exposures.

III. DEFINITIONS

A. *Aerosol Transmissible Diseases* (ATD): Diseases requiring droplet or aerosol precautions.

B. *Aerosol Transmissible Pathogens – Laboratory* (ATP-L): Pathogens potentially encountered by laboratory staff and requiring droplet or aerosol precautions.

C. *Acid Fast Bacilli* (AFB): Bacteria with acid fast staining characteristics, primarily *Mycobacterium* spp.

D. *Biological Safety Officer* (BSO): Individual qualified by training and/or experience to evaluate hazards associated with laboratory procedures involving aerosol transmissible pathogens.

E. *Biosafety Cabinet* (BSC): Biocontainment equipment providing personnel, environment, and contained materials protection.

F. *Biosafety Level* (BSL): Biocontainment precautions set forth by the CDC.

G. *Centers for Disease Control* (CDC)

H. *California Department of Public Health* (CDPH)

I. *High Efficiency Particulate Air* (HEPA) Filter: capable of removing 99.97% of particles 3µm or larger.

J. *Laboratory-acquired infection* (LAI): all infections acquired through laboratory activities, regardless of their clinical or subclinical manifestations.

K. *Monterey County Public Health Department Communicable Disease Unit* (MCPHD CDU)

L. *Risk assessment*: is the evaluation by qualified personnel of the hazards associated with any laboratory practice.

IV. GENERAL INFORMATION

A. Laboratory personnel manipulate potentially infectious materials and are consequently at risk for laboratory-acquired infections (LAIs).

B. Biosafety guidelines and laboratory classifications have been developed to help mitigate the risk of LAIs.

C. A 2002-2004 survey of clinical laboratory directors indicated approximately one-third of laboratories reported the occurrence of at least one LAI.

    1. Clinical diagnostic laboratories accounted for 45% of all laboratory-acquired infections.

    2. Shigellosis, brucellosis, and salmonellosis were the three most common LAIs. Other significant pathogens associated with LAIs were *Staphylococcus aureus, Neisseria meningitidis, Escherichia coli* O157:H7, *Coccidioides immitis, Clostridioides difficile,* and *Bacillus anthracis*.

D. Use of appropriate procedures and techniques, containment devices and facilities, and PPE can significantly reduce the risk of LAI.

E. Potential routes of LAI through droplets or aerosols include:

    1. Pipetting, pouring, non-self-contained centrifuges, vortex mixers, flaming a reusable loop, and catalase testing may generate airborne respirable size particles (<0.05 mm in diameter).

    2. Lyophilized cultures, dried materials on laboratory benches, and bacterial and fungal spores can act as droplet nuclei.

    3. Procedures and equipment that generate respirable size particles also generate larger size droplets (>0.1 mm in diameter). These larger size droplets settle out of the air, contaminating gloved hands, work surfaces, and possibly mucous membranes of the person performing the procedure.

    4. Spills, sprays, and splashes into eyes, mouth, or nose and hand-to-face actions.

5. Spills, sprays, and splashes onto skin cuts, abrasions, and dry, inflamed skin.

F. In 2009, at the beginning of the H1N1 flu pandemic, California OSHA adopted the Title 8, section 5199 standard to protect personnel in in healthcare, emergency response, corrections, public safety and laboratories from ATDs by requiring a written exposure plan.

V. PROCEDURE

A. Methods to minimize the risks of laboratory personnel exposure to pathogens, including ATP-L, and use of safe laboratory techniques, practices, equipment, and facilities.

1. Documents to refer to for additional information:
    a. LABORATORY BIO-SAFETY PLAN
    b. AEROSOL TRANSMITTED DISEASES EXPOSURE CONTROL PLAN
    c. HEALTHCARE WORKER RESPIRATORY PROTECTION PROGRAM
    d. TUBERCULOSIS (TB) PREVENTION AND CONTROL

B. Standard Laboratory Safety Practices

1. No eating or drinking.
2. No smoking.
3. No intentionally smelling culture plates.
4. No chewing gum.
5. No applying cosmetics or lip balm.
6. No fingernail biting.
7. No finger licking.
8. No mouth pipetting.
9. No manipulating contact lens.
10. Tie back long hair.
11. Never recap needles.
12. Wear a laboratory coat and surgical gloves when handling patient specimens, culture plates, tubes, or blood culture bottles.
    a. Check gloves for small cuts or tears prior to and during use.
    b. Replace gloves as needed.
13. Dispose of patient specimens, culture plates, tubes, and blood culture bottles in the appropriate biohazard containers.
    a. Keep lids closed when not in use.
    b. Biohazard containers are durable, leak-proof containers designed to be secure during transport to the disposal center managed through the SVHMC environmental waste program.
14. Used sharps MUST be disposed of in designated sharps biohazard containers.

15. Wash hands after removing gloves and always prior to leaving the laboratory.
16. Use a 1:10 dilution of bleach or other approved disinfectant for disinfecting the work area and biological spills.
    a. Leave bleach solution in contact with the spill for at least 15 minutes.
    b. Clean up with towels and dispose of used towels in an appropriate biohazard container.
17. Any culture, stocks, and other potentially infectious material not disposed of through the SVHMC environmental waste disposal system is sterilized via autoclave system prior to leaving the laboratory.
18. Disinfect work areas at the shift beginning, shift ending, and as needed.
19. Personal or items to be taken home are not allowed in the work area.
    a. Such items are to be stored in the laboratory lounge/break room.
20. Use the BSC for any procedure potentially generating aerosols.
21. Store food in lockers and the designated refrigerator for food located in the laboratory lounge/break room.
22. Use Universal Precautions
    a. Treat all patient specimens as potentially infectious.
23. Report accidents or injuries to the appropriate authorities.
    a. Notify the Laboratory Manager or Supervisor.
    b. During regular working hours, report to the employee health department.
    c. After hours, report to the nursing supervisor.
    d. Fill out an accident report.

C. Special Laboratory Practices
1. Posted signage alerts all persons entering the laboratory of potential biohazards in the work area.
2. The Employee Health Department offers all laboratory personnel the opportunity to utilize immunizations for the appropriate work place exposures that may potentially occur.
3. The Employee Health Department offers all laboratory personnel that potentially encounter airborne-isolation patients annual fit testing.
4. All laboratory personnel are provided an annual medical surveillance of their health.
5. A laboratory-specific biosafety manual is available in the Microbiology department.
6. The Laboratory Manager ensures laboratory personnel demonstrate proficiency in standard and special microbiological practices before working with BSL-2 agents.
    a. Upon hire and rotation through their assigned departments, laboratory employees are trained in relevant standard and special safety practices.
    b. New procedures or new applications to an old procedure affecting safety

practices requires each affected employee to be trained in the relevant new or altered biosafety practices and/or equipment.

7. Any potentially infectious material is placed in durable, leak proof containers during collection, handling, processing, storage, or transport within SVHMC.
8. Laboratory equipment is routinely decontaminated and after spills, splashes, or other potential contamination.
    a. Spills involving infectious materials are contained, decontaminated, and cleaned up by appropriate staff trained to handle infectious material.
    b. All equipment is decontaminated before repair, maintenance, or removal from the laboratory.
9. Incidents potentially resulting in exposure to infectious agents must be immediately evaluated and treated through the Employee Health system.
10. All exposure to infectious agent incidents must be reported to the laboratory manager.
11. Animals and plants are not permitted in the laboratory work area.
12. All procedures with the potential to generate aerosols involving potentially infectious materials with significant risk to cause harm must be conducted within a BSC and/or a sealed safety centrifuge carrier.

D. Safety Equipment (Primary Barriers and Personal Protective Equipment)
    1. SVHMC laboratory has a maintained Class 2 Biological Safety Cabinet (BSC).
        a. The BSC is utilized for procedures with a potential to create infectious aerosols or splashes. These may include:
            i. Pipetting
            ii. Tissue masceration
            iii. Vortexing
            iv. Opening containers of infectious materials
        b. The BSC is utilized during transfer of large volumes of high concentrations of infectious materials into containers for centrifuging.
    2. Centrifuging occurs in the open laboratory with sealed safety carriers.
    3. SVHMC laboratory is supplied with cleaned laboratory coats provided by the hospital laundry service.
        a. Laboratory coats must be worn when working with any potentially hazardous material.
        b. Laboratory coats are removed and left in the laboratory prior to leaving for a non-clinical area, such as the cafeteria, library, or administrative offices.
        c. Change laboratory coats whenever the currently worn coat becomes visibly soiled.
        d. Laboratory clothing are not taken home.

4. Goggles or face shields must be used for situations with potential splashes or sprays of infectious or hazardous materials.
    a. Dispose of non-reusable eye protection after use.
    b. Decontaminate disposable reusable eye protection.
    c. Personnel wearing contact lenses in the laboratory must also wear eye protection.
5. Gloves must be worn when handling hazardous materials.
    a. Alternatives to latex gloves are available for patients or employees with latex allergies.
    b. Change gloves when contaminated.
    c. Change gloves when integrity has been compromised.
    d. Remove gloves and wash hands after finishing work with hazardous materials.
    e. Remove gloves prior to leaving the laboratory work area.
    f. Do not wash or reuse disposable gloves.
    g. Dispose of used gloves according to SVHMC waste procedures.
    h. Wash hands after removing gloves.

E. Laboratory Facilities (Secondary Barriers) and Practices
1. The laboratory doors connecting to the rest of the hospital are self-closing and lockable for security.
    a. The laboratory front entrance is staffed by laboratory personnel and prevent unauthorized entry.
    b. The staff-only laboratory entrance utilizes a keypad-controlled door that automatically locks on closure.
    c. Security personnel patrol the facility grounds on a regular schedule.
2. There are eight sinks and two bathrooms for hand washing in the laboratory.
    a. There are alcohol-based hand sanitizer dispensers throughout the laboratory.
3. The laboratory is designed for easy cleaning.
    a. The floors are made of slip-resistant, non-permeable, and non-absorbent material.
    b. There are no carpets or rugs in the laboratory work area.
    c. Chairs are made of non-porous plastic and vinyl materials.
    d. The spaces between the equipment and benches are adequate to allow cleaning.
    e. Bench tops are impervious to water and resistant to heat, organic solvents, acids, alkalis, and other chemicals.

4. The laboratory has windows in various rooms.
    a. Laboratory windows are either permanent and cannot be opened or have fitted screens.
    b. The Microbiology room has no windows.
5. Biosafety cabinet (BSC) is installed in the Microbiology department.
    a. The BSC is at the furthest end from the room entryway.
    b. The BSC is certified annually for maximum effectiveness.
    c. The BSC utilizes a HEPA filtered exhaust system.
    d. Documentation of BSC annual testing is maintained.
6. Biosafety cabinet is installed in the Histology department.
    a. The BSC is certified annually for maximum effectiveness.
    b. The BSC utilizes a HEPA filtered exhaust system.
    c. Documentation of BSC annual testing is maintained.
7. Eyewash stations are located within the laboratory work area (Hematology, Blood Bank, Microbiology).
8. The Microbiology room ventilation system exhausts to the building exterior, not into the rest of the hospital facility.
    a. Microbiology is located within a self-contained ventilation unit.
    b. The Microbiology room is a negative pressure room with directional airflow towards the back of the room.
9. All laboratory waste is disposed of properly.
    a. An autoclave located in the Microbiology room is used for any items that require decontamination for cleaning and re-use.
    b. Laboratory disposable biohazardous waste is decontaminated off-site.
    c. All biohazardous waste is packaged according to applicable local, state, and federal regulations before removal from the facility.
10. Manipulation of bacterial cultures
    a. Petri plates, slants, and tubes with bacterial growth are handled only within the Microbiology room.
    b. There is no manipulation of bacterial growth from petri plates outside of the Microbiology room.
    c. Any specimen designated for bacterial culture requiring centrifugation will be centrifuged within a sealed safety centrifuge carrier.
    d. Any manipulation of a potential ATP is performed within the BSC.
    e. Patients with blood cultures signaling positive are checked for isolation status and culture length of incubation before the analyzer designated the culture bottle as positive. Specimens from patients under droplet/airborne

isolation restrictions or bottle incubation periods of 3 days or longer before signaling positive will only be manipulated within the BSC and subsequent work performed in the BSC until the identity of the organism and its potential hazard to laboratory personnel has been clarified.

11. Manipulation of fungal/yeast cultures
    a. Fungal/yeast cultures are inoculated within the Microbiology room.
    b. Fungal/yeast cultures are incubated in a designated incubator exclusive to fungal/yeast cultures.
    c. Fungal/yeast cultures are transferred to the incubator inside of plastic, screw-capped fungus culture flasks.
    d. All examining of fungus/yeast cultures is done within the Microbiology room.
    e. If during the fungal/yeast culture examination any "fuzzy" or "mold-like" organisms are observed within the flask or culture plates, the flask and/or plate is immediately taped to prevent removal of the cap/lid.
    f. There is no manipulation of mold-like fungal growth at any time while the culture is located inside of the hospital.
    g. Yeast are only manipulated within the Microbiology room.
    h. "Fuzzy" or "mold-like" organisms are sent to the Monterey County Health Department Laboratory for identification.
12. Acid Fast Bacilli (AFB) cultures
    a. AFB cultures are only inoculated with the BSC.
    b. Processing of patient specimens with orders for AFB culture require the Microbiology room door be closed during the duration of processing. A sign on the Microbiology room door indicates the door should not be opened from outside.
    c. AFB culture slants are incubated in an incubator located within the Microbiology room.
    d. AFB culture liquid-containing bottles are incubated within designated drawers of an analyzer system.
    e. The AFB culture liquid-containing bottles are made of shatterproof plastic and have a rubber plug sealed with a crimped metal ring.
    f. Any picking of potential AFB colonies for staining is done within the BSC.
    g. Any fixing of potential AFB colonies for staining is performed using a heat block located within the BSC.
    h. Any staining for AFB is performed after the slides have been heat-fixed for at least 2 hours at 65-75°C.
    i. AFB staining is only performed within the Microbiology room.
    j. There is no attempt to manipulate potential AFB colonies for identification

(other than staining).

k. All positive AFB cultures are sent to the Monterey County Health Department for identification.

F. Emergency Response Procedures for Uncontrolled Biohazardous Organism Releases within the Laboratory

1. Blood or Body Fluid Spills

a. Small amounts of blood or body fluid spills (less than 100cc)

i. Utilize standard precautions.

ii. Place absorbent materials on and around the spill (e.g. paper towels).

iii. Apply a 1:10 bleach solution until the spill area is saturated with bleach solution. Avoid splashing and creation of aerosols.

iv. Leave the bleach in contact with the spill for 15-30 minutes.

v. Remove the towels and discard into a biohazard container.

vi. Add more towels and bleach until the area is clean and dry.

vii. Clean the affected area again with 70% alcohol or DI water to prevent corrosion.

b. Blood or body fluid spills greater than 100cc

i. Use standard precautions.

ii. Place absorbent materials on and around the spill (e.g. paper towels).

iii. Apply a 1:10 bleach solution over the spilled area.

iv. Notify Environmental Services to disinfect the area by notifying the housekeeping supervisor.

v. Notify the laboratory department lead and supervisor/manager.

2. Other Biological Agents Spill **within** a Biological Safety Cabinet

a. Use standard precautions, including eye protection

b. Keep the biosafety cabinet on and wait at least 5 minutes to contain aerosols.

c. Place absorbent materials on and around the spill (e.g. paper towels).

d. Apply 1:10 dilution of bleach to the spill and allow it to sit for 15-30 minutes. Avoid splashing and creation of aerosols.

e. Remove the towels and discard into a biohazard container.

f. Check the spill tray under the front grille for any residue.

g. Dispose of waste into biohazard waste container.

h. Clean the affected area again with 70% alcohol or water to prevent corrosion.

i. Change laboratory coats.

j. Report the spill to the laboratory department lead and supervisor/ manager.

3. Other Biological Agents Spill **outside** a Biological Safety Cabinet

    a. ATP-L spill within the Microbiology room

        i. For spills involving materials suspected or known to contain an ATP-L, immediately evacuate the room and close the door.

            1. Designate a person to say and restrict room access.

        ii. If the responder feels safe doing so, don an N95 mask for further spill containment. If not, skip to the next step.

            1. Place absorbent materials on and around the spill (e.g. paper towels).
            2. Apply 1:10 dilution of bleach to the spill. Avoid splashing and creation of aerosols.
            3. Exit the room.

        iii. Dial 2222 to initiate a "Code Orange."

            1. Provide as much information as possible regarding the nature of the spill.
            2. Notify the Microbiology Lead and Laboratory Supervisor/Manager.
            3. If the Microbiology Lead or Laboratory Supervisor/ Manager is unavailable, notify Employee Health and the Administrative Supervisor regarding a potential ATP-L exposure.

        iv. Contact Environmental Services regarding the spill and request a bag to contain the laboratory coat worn during the spill.

            1. Change laboratory coat.

    b. Biological agent spills outside of the Microbiology room should not occur.

        i. Specimens from locations outside the laboratory arrive in sealed biohazard bags.

            1. Sealed biohazard bags prevent exposure to droplets or aerosols.

        ii. Specimens encountered at this facility are unlikely to contain large quantities or high concentrations of an ATP.

        iii. Only culture swabs/guaiac cards, blood, sputum, swabs collected into universal transport media (UTM), and urine specimens are permitted to be transported through the pneumatic tube system.

1. UTM and urine specimens must be "double-bagged" with two, nested biohazard bags.

iv. This facility does not receive specimens for environmental *B. anthracis* screening.

v. This facility does not receive animal specimens.

vi. Cultures and specimens sent out from this facility are packaged and transported according to "Packaging and Shipping class 6.2 Infectious Substances" standards.

vii. CLS responsible for sending out cultures and specimens have been trained and certified in packaging infectious substances.

viii. The hospital couriers transporting laboratory cultures and specimens have been trained to transport infectious substances and follow the HAZARDOUS MATERIALS SPILL RESPONSE PROCEDURE.

ix. If an ATP-L spill does occur outside of the Microbiology room, follow the HAZARDOUS MATERIALS SPILL RESPONSE PROCEDURE.

G. Signs and Symptoms of Aerosol Transmissible Diseases

1. All laboratory personnel are encouraged to seek medical evaluation for symptoms they suspect may be related to infectious agents from their work area, without fear of reprisal.

a. Signs and symptoms that may require further evaluation include:

i. Unexplained fever, cough, rash, diarrhea, vomiting, joint pain, headache, shortness of breath, or abdominal pain.

b. In the event of a work-related infection, consultation between the employee, the Employee Health department, and Laboratory Manager is necessary for proper management.

H. General Risk Assessment for Laboratory Personnel and ATP-L

1. Laboratory Personnel Roles and Potential ATP-L Exposure

a. Pathology Clerk

i. No known routine occupational exposure

b. Laboratory Aide

i. No known routine occupational exposure

c. Laboratory Technician Assistant

i. Routine blood and respiratory occupational exposure

d. Histology Technician

i. Routine blood/body fluid and respiratory specimen occupational exposure

e. Medical Laboratory Technician
    i. Routine blood/body fluid and respiratory specimen occupational exposure
f. Clinical Laboratory Scientist
    i. Routine blood/body fluid, respiratory specimen, and ATP-L culture occupational exposure
g. Pathologist
    i. Routine blood/body fluid and respiratory specimen occupational exposure
h. Laboratory Manager
    i. Routine blood/body fluid occupational exposure

2. Laboratory Procedures with Potential ATP-L Exposure
    a. Blood Bank
        i. Centrifuging
        ii. Pipetting
        iii. Blood exposure
    b. Chemistry
        i. Centrifuging
        ii. Pipetting
        iii. Blood/body fluid exposure
    c. Hematology/Coagulation
        i. Centrifuging
        ii. Pipetting
        iii. Blood/body fluid exposure
    d. Histology/Cytology
        i. Centrifuging
        ii. Pipetting
        iii. Blood/body fluid exposure
    e. Immunology
        i. Centrifuging
        ii. Pipetting
        iii. Blood exposure
    f. Microbiology
        i. Centrifuging

ii. Pipetting
iii. Vortexing
iv. Manipulating microorganisms
v. Blood/body fluid exposure
vi. Tissue maceration

g. Phlebotomy
    i. Centrifuging
    ii. Pipetting
    iii. Collecting specimens from patients
    iv. Respiratory exposure
    v. Blood exposure

h. Urinalysis
    i. Centrifuging
    ii. Pouring
    iii. Pipetting

i. Transporting specimens to laboratory
    i. Hand-delivered
    ii. Tube system
    iii. Specimens are required to be sent to the laboratory in leak proof containers with secure lids to prevent exposures.
        1. The secured specimen is transported within a sealed biohazard bag.
        2. UTM and urine must be "double-bagged" within two, nested biohazard bags.
    iv. Low risk assessment for employee exposure to ATPs-L during transportation of specimens to the lab.

j. Receiving specimens in the lab
    i. Relevant Laboratory Personnel
        1. Phlebotomists
        2. Technicians
        3. Clinical Laboratory Scientists/Technologists
        4. Histotechs
        5. Pathology clerks
        6. Laboratory aides

ii. Specimens are only received by qualified laboratory personnel.

iii. Each specimen is visibly inspected prior to opening the sealed biohazard bag for any signs of leakage.

1. If there are no signs of leakage, the specimen can be accessed and processed.

2. If the specimen shows signs of leakage and the specimen can be re-collected, then the unit responsible for the specimen's collection will be asked to re-collect another specimen.

3. If the specimen is such that re-collection is impossible or not practical, the specimen will be evaluated within the Biosafety Cabinet (BSC).

a. If the specimen can be saved and transferred to another container in a safe manner (while within the BSC), this will be done.

b. If the specimen cannot be accessed in a safe manner (even while within the BSC) or a manner that will maintain the integrity of the specimen, then notify the unit responsible for the specimen's collection that the specimen will not be processed.

iv. Low risk assessment for employees receiving specimens while utilizing appropriate techniques.

k. Processing specimens

i. Relevant Departments

1. Blood Bank

2. Chemistry

3. Hematology/Coagulation

4. Histology

5. Microbiology

6. Phlebotomy

7. Urinalysis

ii. While the following standard laboratory practices and any special laboratory practices necessary to process a laboratory specimen the risk assessment would be low.

iii. This area would be the area of relative greatest risk for aerosol pathogen transmission.

l. Sending specimens with from this laboratory to another laboratory

i. Relevant Laboratory Personnel
    1. Laboratory clerks
    2. Microbiology
        a. The microbiology technologists have been trained and certified as competent for sending Category A and Category B biohazardous substances to other facilities.

ii. Risk assessment is low for sending specimens from this laboratory to another while utilizing appropriate techniques.

m. Storing specimens
    i. Relevant Departments
        1. Blood Bank
        2. Chemistry
        3. Hematology/Coagulation
        4. Histology
        5. Microbiology
        6. Urinalysis

    ii. All stored specimens are stored within sealed containers and only for the limited time necessary to allow for additional testing requests.

    iii. Specimens are stored within the laboratory itself and are not accessible to non-laboratory personnel or visitors.

    iv. Histology specimens are fixed prior to storage.

    v. Risk assessment is low for aerosol transmissible pathogen exposure.

I. Procedures for Dealing with Specific ATP-L
    1. In addition to standard laboratory safety practices and the general risk assessment, encountering or preparing for specific ATP-L will include SVHMC Laboratory-specific risk assessments and additional special practices and/or equipment implemented.
    2. Blood collection process for patients to rule out Ebola Virus diagnosis
        a. Personnel entering the room of a suspected Ebola virus infection patient must wear gloves, gown, eye protections (goggles or face shield), and a facemask covering the entire nose and mouth. Disposable shoe and leg coverings may be needed if large amounts of body fluids are present.
        b. Phlebotomy should be limited to the minimum necessary for essential diagnostic evaluation and medical care.
        c. Specimen requirements for Ebola serology is a **minimum of 4 mL EDTA whole blood. Send specimen refrigerated.**

i. **Alternatively, 4 mL of serum may be collected and submitted frozen.**

d. Personnel with percutaneous or mucocutaneous exposure to blood, body fluids, secretions, or excretions from a patient with suspected Ebola virus should stop what they are doing and wash the affected skin surfaces with soap and water.
    i. Mucous membranes should be irrigated with copious amounts of water or eyewash solution.

e. Laboratory testing personnel must wear gloves, gown, eye protection (goggles or face shield), and a facemask covering the entire nose and mouth.
    i. Specimen containers are only accessed within a certified class II biosafety cabinet.

f. The ordering physician must first contact the MCPHD CDU at **831-755-4521**.
    i. If after hours, call **831-755-5100** and ask for the "Hazardous Materials Team."
    ii. They must also call CDC for consult prior to specimen submission. **Contact the CDC at 770-488-7100.**

g. Call World Courier 1-800-221-6600 for specimen pickup and transport. Have the courier package the specimen on ice packs for whole blood or dry ice for serum.
    i. Make sure the outside of the box specifies how to store the specimen (Frozen or Refrigerated). Package samples in Category A packaging and submit for overnight delivery.
    ii. Specimens cannot be shipped for weekend delivery unless instructed by CDC. Ship specimens to:
    Centers for Disease Control and Prevention
    RDSB/STAT Unit 70
    1600 Clifton Road NE
    Atlanta, GA 30329
    iii. Include a copy of both the CDC form 50.34 (generated through the **CDC Form 50.34 application** found on SVHMC computer **LAB1H002**) and the Viral Special Pathogens Branch supplemental form (found at https://www.cdc.gov/ncezid/dhcpp/vspb/pdf/specimen-submission-508.pdf) for EACH specimen. Form 50.34 must be filled out and printed once complete. Fax the forms to **404-639-1118** or **404-639-1509**.
    iv. Email tracking number to **spather@cdc.gov**.

3. Specimen processing and manipulation for patients under investigation or confirmed positive for SARS-CoV-2

a. Standard precautions for potentially infectious clinical specimens are utilized throughout the BSL-2 laboratory
b. Proper hand hygiene as defined by the SVHMC HAND HYGIENE Policy
c. Use of appropriate personal protective equipment
    i. PPE includes, but isn't limited to, laboratory coats or gowns, gloves, and eye protection.
d. Routine decontamination of work surfaces with 10% bleach or other approved disinfecting virucidal wipe/solution (e.g. Oxivir 1 disposable wipes)
e. Routine biohazardous waste practices apply to all specimens
    i. Refer to MEDICAL WASTE MANAGEMENT PLAN
f. Activities covered by standard precaution activities include:
    i. Processing of initial specimens
    ii. Use of automated instruments and analyzers
    iii. Staining and microscopic analysis of fixed smears
    iv. Examination of bacterial cultures
    v. Pathologic examination and processing of formalin-fixed or otherwise inactivated tissues
    vi. Packaging of patient specimens for transport to outside diagnostic/reference laboratories for additional testing
    vii. Procedures or manipulation of patient specimens that may result in aerosols include additional steps to minimize potential exposure.
    viii. Specimens from patient care areas that may offer higher than usual risk of encountering SARS-CoV-2 infection (ex. Screening/ triage tents, isolation rooms set aside for SARS-CoV-2 investigation or known positives) are transported via a visually identifiable method.
        1. Such methods can include transport in designated containers (e.g. easily decontaminated totes/latched boxes) or visually distinct biohazard bags (e.g. different color).

4. Department Specific Practices
    a. Microbiology
        i. Any procedures potentially generating aerosols (e.g. vortexing specimens, eluting nasopharyngeal or nasal swabs, etc.) are performed inside the biological safety cabinet.
            1. The BSC-2 is always in operation, the sash maintained at the manufacturer minimum recommended height,

the air flow rate checked daily to ensure proper operation, work surfaces regularly decontaminated, and periodic maintenance/certification performed.

2. Refer to LABGARD BIOLOGICAL SAFETY CABINET policy

ii. Centrifuging is performed utilizing sealed safety centrifuge carriers

1. Sealed safety centrifuge carriers are only opened and closed inside the biological safety cabinet.

b. Chemistry

i. Avoidance of exposure to potential aerosols generated through centrifuging or opening vacutainers using some form of physical barrier

1. Acceptable methods include:

a. Benchtop centrifugation and placement of blood specimens on chemistry analyzer automated track for contained decapping and transport.

b. Accessing specimens with a facemask.

c. Hematology/Coagulation

i. Avoidance of exposure to potential aerosols generated through opening vacutainers using some form of physical barrier.

1. Acceptable methods include:

a. Placement of blood specimens on the hematology/coagulation analyzer for "closed mode" testing.

b. Accessing mixed blood for smear preparation using a face shield or splash guard, using a Diff-Safe blood dispenser or equivalent.

d. Histology/Anatomic Pathology

i. Avoidance of exposure to potential aerosols generated through processing of fluid specimens for cytopathology slide preparation inside the Histology biological safety cabinet and allowing aerosols to dissipate for 10 minutes after centrifugation has completed

ii. Directly prepared smears (ex. During endoscopy procedure) are allowed to dry before any manipulation takes place

J. Documentation (This will be at the end of the procedure and if there is no specific documentation then type N/A)

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Centers for Disease Control and Prevention. (2020). Biosafety in Microbiological and Biomedical Laboratories 6th Edition. https://www.cdc.gov/labs/pdf/SF__19_308133-A_BMBL6_00-BOOK-WEB-final-3.pdf

B. Cal/OSHA. "§5199. Aerosol Transmissible Diseases." *California Code of Regulations, Title 8, Section 5199. Aerosol Transmissible Diseases.*, 5 Aug. 2009, https://www.dir.ca.gov/title8/5199.html.

C. Pence, M. A. (2021, January 11). Guide To Infection Control in the Healthcare Setting - Laboratory Areas. ISID. Retrieved April 20, 2022, from https://isid.org/guide/infectionprevention/laboratory-areas

Aerosol transmissible pathogens – Laboratory (ATPs-L)

BSL	Agent	Practices	Safety Equipment	Facility
1	Not known to cause disease in healthy adults	Standard microbiological procedures	None required	Open bench top sink required
2	Associated with human disease; hazard from autoinoculation, ingestion, or mucous membrane exposure	BSL-1 practice plus limited access, bio-hazard warning signs, sharps precautions, and a bio-safety manual defining waste decontamination or medical surveillance policies	Class I or II biosafety cabinet (BSC), splash guards and other devices to prevent splashes or aerosols; PPE inlcude lab coats, gloves, and face protection, as needed	BSL-1 plus autoclave available
3	Indigenous or exotic agents with potential aerosol transmission; disease may have serious or lethal consequences	BSL-2 practice plus controlled access, decontamination of all waste, decontamination of all clothing before laundering, baseline serum	BSL-2 safety equipment plus respiratory protection, as needed	BSL-2 plus physical separation from access corridors, self-closing double-door access, exhausted air not recirculated, negative airflow into the laboratory
4	Dangerous and exotic agents that pose high risk of life-threatening disease; aerosol transmitted	BSL-3 practices plus clothing change before entering, shower on exit, all materials decontaminated on	All procedures conducted in Class III BSC or Class I or Class II BSC in combination with full-body, air-supplied,	BSL-3 plus separate building or isolated zone, dedicated supply/exhaust, vacuum and decon system

		exit from facility	positive-pressure personnel suit	

Diseases/Pathogens Requiring Airborne Infection Isolation (Cal OSHA)

- Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax (*Bacillus anthracis*)
- Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
- Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
- Measles (rubeola)/Measles virus
- Monkeypox/Monkeypox virus
- Novel or unknown pathogens
- Severe acute respiratory syndrome (SARS)
- Smallpox (variola)/Varioloa virus
- Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
- Any other disease for which public health guidelines recommend airborne infection isolation

Diseases/Pathogens Requiring Droplet Precautions (Cal OSHA)

- Diphtheria pharyngeal
- Epiglottitis, due to Haemophilus influenzae type b
- *Haemophilus influenzae* Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children
- Influenza, human (typical seasonal variations)/influenza viruses
- Meningitis
    - *Haemophilus influenzae*, type b known or suspected
    - *Neisseria meningitidis* (meningococcal) known or suspected
- Meningococcal disease sepsis, pneumonia (see also meningitis)
- Mumps (infectious parotitis)/Mumps virus
- Mycoplasmal pneumonia
- Parvovirus B19 infection (erythema infectiosum)
- Pertussis (whooping cough)
- Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
- Pneumonia
    - Adenovirus
    - *Haemophilus influenzae* Serotype b, infants and children

        - Meningococcal Mycoplasma, primary atypical
        - *Streptococcus Group A*
    - Pneumonic plague/*Yersinia pestis*
    - Rubella virus infection (German measles)/Rubella virus
    - Severe acute respiratory syndrome (SARS)
    - Streptococcal disease (group A streptococcus)
        - Skin, wound or burn, Major
        - Pharyngitis in infants and young children
        - Pneumonia
        - Scarlet fever in infants and young children
        - Serious invasive disease
    - Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures)
    - Any other disease for which public health guidelines recommend droplet precautions

Attachments

Aerosol Transmissible Pathogens Policy for Pathology

Interim Laboratory Biosafety Guidelines for Handling and Processing Specimens Associated with Coronavirus Disease 2019 (COVID-19)

Laboratory Biosafety Guidance Related to the Novel Coronavirus (2019-nCoV)

SVMH Lab Pneumatic Tube System and UTM Risk Assessment 2502 07.pdf

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

IP/P&T	Genevieve delos Santos: Director Pharmacy	04/2025
IP/P&T	Kiri Golleher: Pharmacy Clinical Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Lori Orosco: Director Laboratory Services	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13291967**

Last Approved	N/A	Owner	Elvira Franco: Manager Diagnostic Imaging
Next Review	1 year after approval	Area	Diagnostic Imaging

MRI Safety

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To assist staff in safely performing MRI exams.

III. DEFINITIONS

A. MRI – Magnetic Resonance Imaging

B. DI – Diagnostic Imaging

C. Personnel definitions

1. Non-MR Personnel – Patients, visitors or facility staff who do not meet the criteria of level 1 or 2 MR personnel will be referred to as non-MR personnel. Specifically, non-MR personnel will be the terminology used to refer to any individual or group who has not within the previous 12 months undergone the designated formal training in MR safety issues defined by the Radiation Safety Committee.
2. Level 1 MR personnel – individuals who have passed minimum safety education efforts to ensure their own safety as they work within Zone III will be referred to as level 1 MR personnel (e.g., MRI department tech assistants, Salinas Valley Health Medical Center (SVHMC) staff).
3. Level II MR personnel – Individuals who have been more extensively trained and educated in the broader aspects of MRI safety issues including issues related to the potential for thermal loading or burns and direct neuromuscular excitation from rapidly changing gradients (e.g., MRI technologists, radiologists, cardiologists, and radiology department staff). Approved for all safety zones.

D. MRI SAFETY ZONES -This section summarizes the different zones of a SVHMC MR suite and points out specific safety issues, which are of greatest concern. At SVHMC, each MRI site is divided into four safety zones. Each zone is clearly distinguished by a predominately displayed sign on the wall or door:

- **Zone I**: is the region freely accessible to the general public and is located outside the MR environment. This is the area through which patients, health care personnel, and other employees of the MR site access the MR environment.
- **Zone II**: is the area between Zone I (Public Access) and the strictly controlled Zone III. This is the area of travel that patients are brought into directly before their procedure. Zone II is typically where MR personnel get patient histories, complete screening questions and get consents if needed.
- **Zone III:** is the Control Room (Restricted). All access to Zone III is to be strictly restricted with access to regions within it controlled by and entirely under the supervision of MR personnel. Badge access is required past this point. This zone is restricted from general public access by a reliable restricting method that can differentiate between MR personnel and non-MR personnel.
- **Zone IV**: is the MR/Magnet Room (Restricted). No individual is allowed in the scan room without being supervised by trained MR personnel. The scan room door is always locked when unattended. Only MR compatible equipment approved by the Radiation Safety Committee may be brought into Zone IV. The MR technologists must be able to directly observe and control via line of sight the entrances or access to Zone IV from their normal positions when stationed at their desks in the scan control room.
    1. Non-MR Personnel should be accompanied by, or under the immediate supervision of and visual contact with, one specifically identified level 2 MR staff for the entirety of their duration within Zone III or IV restricted regions.
    2. Level 1 and 2 MR personnel may move freely about all zones.

IV. GENERAL INFORMATION

A. Magnetic Field of MRI: The static magnetic field of the MRI system is exceptionally strong; the 1.5 T scanners generate a magnetic field that is approximately 21,000 greater than the earth's natural field. In such an environment, ferromagnetic metal objects can become airborne as projectiles. Small objects such as paper clips and hairpins have a terminal velocity of 40mph when pulled into a 1.5 T scanner's magnetic field and therefore pose a serious risk to the patient and anyone else in the scan room. The force with which projectiles are pulled toward a magnetic field is proportional to the mass of the object and distance from the magnet. Even surgical tools such as hemostats, scissors and clamps, although made of a material known as surgical stainless steel, are strongly attracted to the main magnetic field. Oxygen tanks, gurneys, floor buffing machines, and construction tools are highly magnetic and should never be brought into the scan room unless they are MRI compatible. Sand bags must also be inspected since some are filled, not with sand, but with steel shot which is highly magnetic.

- Consumer products such as pagers, cell phones, cameras and analog watches may be damaged by the magnetic field. Pacemakers may be reprogrammed or turned off

by the magnetic field. The magnet field erases credit cards with magnetic strips.

- Radio-frequency (RF) field risk: The radio-frequency field may induce currents in wires that are adjacent or on the patient, causing skin burns. It may induce currents in intracardiac leads, resulting in inadvertent cardiac pacing. Prolonged imaging may cause the patient's core body temperature to rise. In practice, significant patient heating is only encountered in infants.
- Cryogen risk: During a planned or accidental shutdown of the magnetic field, the liquid Helium in the magnet turns into gas and may escape into the scan room displacing the oxygen in the room leading to asphyxia.
- All persons coming in contact with the magnetic field should be appropriately screened for contraindications. A useful reference for determining MR compatibility is Shellock's Pocket Guide to MR Procedures and Metallic Objects. An online reference is www.mrisafety.com.
- The MRI technologist is ultimately responsible to assure patient safety prior to and during the MRI procedure.

B. PATIENT SCREENING:

- Patients entering an MRI suite for a diagnostic exam are screened for contraindications such as pacemakers, metal foreign bodies in the eyes, cranial aneurysm clips, etc.
- A standard hospital approved MRI screening form is to be filled out prior to a patient entering the Restricted Zone. It will be the responsibility of the MRI technologist to review the MRI screening form prior to allowing a patient into Zone III.
- All contraindications are to be brought to the attention of the MRI radiologist or cardiologist in-charge of the case.
- All Non-MRI Personnel (e.g., patients, volunteers, varied site employees and professionals) with implanted cardiac pacemakers, auto-defibrillators, diaphragmatic pacemakers, and/or other electromechanically activated devices on whose function the Non-MR Personnel is dependent should be precluded from Zone III.
- Patients with history of foreign bodies in the eyes will require a negative imaging of the orbits prior to being admitted to Zone III.
- Patients with a cranial aneurysm clip will require implant assessment prior to being admitted to Zone III.
- Individuals undergoing an MRI procedure must remove all readily removable metallic personal belongings and devices on or in them (e.g., watches, jewelry, body piercing if removable, contraceptive diaphragms), metallic drug delivery patches, and clothing items which may contain, metallic fasteners, hooks, zippers, loose metallic components, metallic threads, etc. It is therefore advisable to require that the patient wear a site-supplied gown.
- Patient companions entering Zone III or IV must be screened using the same criteria as the patient.

C. MRI PERSONNEL SCREENING:

- All MRI Personnel are to undergo an MRI screening process as part of their employment interview process to ensure their own safety in the MRI environment.
- A signed hospital approved screening form will be kept on file for every MRI Personnel.
- For their own protection all staff must immediately report to their supervisor any trauma, procedure, or surgery in which a ferromagnetic metallic object/device that may have been introduced within or on them. This will permit an appropriate screening to be performed upon the employee to determine the safety of permitting those MRI Personnel into the environment.

D. FORENSIC PATIENTS/PAROLEES

- Patients wearing ferromagnetic shackles or hand cuffs should have them removed and replaced with zip ties or other nonferrous restraining option before entering Zone III.
- Patients wearing RF identification or tracking bracelets should have these devices removed by qualified personnel prior to entering Zone III and should be replaced by this qualified personnel after the exam is complete in Zone II.
- Correctional officers that accompany a patient to MRI must be screened prior to entering Zone III.
- The correctional officer should be educated regarding magnetic field safety.
- Correctional officers should not bring firearms or ferromagnetic weapons into Zone III unless deemed absolutely essential for maintenance of security.
- **NOTE: Firearms with ferromagnetic components pose a potential serious threat in Zone IV.**

E. DEVICE AND OBJECT SCREENING:

- Ferrous objects, including those brought by patients, visitors, contractors, etc., should be restricted from entering Zone III, whenever practical.
- All portable metallic or partially metallic devices that are on or external to the patient (e.g., oxygen cylinders) are to be positively identified in writing as MR Unsafe or, alternatively, MR Safe or MR Conditional in the MR environment before permitting them into Zone III. For all device or object screening, verification and positive identification should be in writing. Examples of devices that need to be positively identified include fire extinguishers, oxygen tanks and aneurysm clips.
- External devices or objects demonstrated to be ferromagnetic and MR unsafe or incompatible in the MR environment may still, under specific circumstances, be brought into Zone III if for example, they are deemed by MR personnel to be necessary and appropriate for patient care. They should only be brought into Zone III if they are under the direct supervision of specifically designated level 1 or level 2 MR personnel who are thoroughly familiar with the device, its function, and the reason supporting its introduction to Zone III. The safe usage of these devices while they are present in Zone III will be the responsibility of specifically named level 1 or 2 MR personnel. These devices must be appropriately physically secured or restricted

at all times during which they are in Zone III to ensure that they do not inadvertently come too close to the MR scanner and accidentally become exposed to static magnetic fields or gradients that might result in their becoming either hazardous projectiles or no longer accurately functional.

- Never assume MR compatibility or safety information about the device if it is not clearly documented in writing. All unknown external objects or devices being considered for introduction beyond Zone II should be tested with a strong handheld magnet (1000-Gauss) and/or a handheld ferromagnetic detection device for ferromagnetic properties before permitting them entry to Zone III. The results of such testing, as well as the date, time, and name of the tester, and methodology used for that particular device, should be documented in writing. If a device has not been tested, or if its MR compatibility or safety status is unknown, it should not be permitted unrestricted access to Zone III.
- All portable metallic or partially metallic objects that are to be brought into Zone IV must be properly identified and appropriately labeled using the current FDA labeling criteria developed by ASTM International in standard ASTM F2503 (http://www.astm.org). Those items which are wholly, nonmetallic should be identified with a square green "MR Safe" label. Items which are clearly ferromagnetic should be identified as "MR Unsafe" and labeled appropriately with the corresponding round red label. Objects with an MR Conditional rating should be affixed with a triangular yellow MR Conditional label before being brought into the scan room/Zone IV.
- Only dedicated MRI safe gurneys are allowed in Zones III and IV.

F. CONTRAINDICATIONS FOR MRI - The following devices are absolutely contraindicated for MR imaging because they are magnetically, electrically, mechanically activated or affected:

- Neurostimulators
- Cochlear implants
- Bone Growth simulators
- Implantable pediatric sternum device
- Metallic foreign body in the eye

The following are relative contraindications for MR imaging:

- Intra-cranial vascular clips
- Penile implants
- Shrapnel
- Halo
- Stents (within 6 weeks of implantation)
- Pregnancy
- Pacemaker / Implantable Defibrillators (See policy - MRI SCANS FOR PATIENTS WITH CARDIAC DEVICES for exceptions).
- Implantable Drug Infusion Pumps

- Programmable shunts: patients and referring physicians must be made aware that shunts may need to be reprogrammed by their provider after the MRI.

G. PREGNANT PATIENTS AND EMPLOYEES:

- Present data have not conclusively documented any deleterious effects of MR imaging exposure on the developing fetus. Therefore, no special consideration is recommended for the first, versus any other, trimester in pregnancy. Nevertheless, as with all interventions during pregnancy, it is prudent to screen females of reproductive age for pregnancy before permitting them access to MR imaging environments. If pregnancy is established consideration should be given to reassessing the potential risks versus benefits of the pending study in determining whether the requested MR examination could safely wait to the end of the pregnancy before being performed.
- All employees in the MRI area must report their pregnancy to the supervisor of the area as soon as it is known. The pregnant employee will continue all duties required of their position, with the exception of occupying the magnet room during the acquisition of the image. There currently are no established regulatory guidelines for occupational utilization of magnetic resonance imaging systems by pregnant women.

H. PEDIATRIC PATIENTS:

- Pediatric patients requiring sedation will be performed per the SEDATION GUIDELINES.
- Pre-screening for MRI procedures should include:
    - Pre-procedural medical history and examination for each patient
    - Fasting guidelines appropriate for age
    - Intraprocedural and post procedural monitors with adaptors appropriately sized for children (MR conditional equipment)
    - Method of patient observation during procedure
    - Resuscitation equipment including oxygen delivery and suction readily available
    - Record keeping and charting per sedation policy.
    - Screening should take place with the parent or guardian and separately if warranted.
    - If a family member accompanies the pediatric patient they must be screened using the same criteria as anyone else entering Zone IV.
    - Hearing protection should be provided and its use encouraged for the patient and family member.

I. ACOUSTIC NOISE:

- As current is passed through the gradient coils during image acquisition, a significant amount of acoustic noise is created. Although these levels are anticipated to be well below the OSHA standards whereby a hearing loss prevention

program must be started (80 dB over 8 hours or half the exposure time for each additional 5 dB exposure), it can cause some reversible and irreversible effects. These effects include communication interference, patient annoyance, transient hearing loss and in patients who are susceptible to hearing impairment, permanent hearing loss. It is recommended that all patients are provided with earplugs or head phones.

J. RADIO FREQUENCY AND GRADIENT FIELDS RELATED ISSUES:

- In contrast to the main magnetic field, RF and gradients are only present during scanning. RF energy (64 MHz-between AM and FM radio) is exchanged with the patient in order to create MR images. A relatively powerful amplifier (25kW) generates this energy and software controls limit the specific absorption rate in the patient. The effects of RF absorption are the heating of the tissue and the patient's ability to dissipate excess heat. This can be expressed in terms of SAR, which is the FDA limit for RF exposure and is primarily set to avoid warming of the patient. The recommended SAR level for imaging in the US is 0.4W/kg (whole body), 3.2W/Kg (head) and 8 W/kg (small volume). The RF field is focused within the bore of the magnet and is negligible external to it.
- While software limits RF exposure to safe levels, looped conductors (e.g. wires) within the bore of the magnet can focus these RF fields, producing elevated energy deposition. These concerns are greatest on high field scanners and have been known to cause substantial burns. Accordingly, looped conductors within the bore must be avoided at all cost.
- Care should be taken to ensure that the patient's tissue do not directly come into contact with the inner bore of the magnet during the MR imaging process.
- Pads and other such insulating devices are provided for this purpose. It is also important that the patient's own tissues do not form large conductive loops.
- Therefore, care should be taken to ensure that the patient's arms and legs not be positioned in such a way as to form a large caliber loop within the bore.
- For this reason, it is preferable to instruct patients not to cross their arms or legs in the MR scanner.
- Verbal communication shall be conducted periodically throughout the exam to ensure there is no localized tissue heating. The exam will be terminated if any localized excessive tissue heating, localized redness, and/or burns are suspected by the MRI personnel or communicated to the technologist by the patient.
- A licensed independent practitioner and/or supervising radiologist must evaluate any localized excessive heated area, localized redness, burn, etc. and provide instructions for care. An occurrence report must be submitted within 24 hours.

PROCEDURE

A. The following must be performed/reviewed by the MRI technologist before each exam.

- Check documentation - The identity of the patient must be checked against the physician order.

- Relevant previous examinations are to be available prior to the scan.
- Obtain MRI Patient Medical Questionnaire (form 7140-6113) - This involves the patient or a responsible relative signing the form.
- If the MRI exam requires contrast, a Consent for Gadolinium Contrast Media (form 7140-026628) must be completed.
- For exams requiring contrast. (See DI GADOLINIUM ADMINISTRATION FOR MRI PROCEDURES).
- Inform the patient about the exam - The patient must understand that magnetic and RF fields will be used.
- Inspect for and remove ferromagnetic and magnetically sensitive items from the patient and the patient's bedding.
- Check for contraindications - A final check is to be made to make sure that there are no reasons why the examination should not be done. In particular, a history of cardiac disease (pacemaker, heart valves), aneurysm clips, and/or metal foreign bodies.
- In addition, if the patient is transported via ambulance, check for ferrous object or instruments that are contraindicated before taking the patient into the scanning room.
- Only special MRI compatible gurneys and equipment can be brought past Zone II.
- Have the patient remove footwear to avoid any metal debris.
- Check the patient during suitable intervals during the scan.
- The MRI Technologist will assist and position the patient and is responsible to perform the final check. This will include establishing that no items which could cause damage or injury to a patient are allowed within the scanning room.

B. Special Situations:
    - Patients requiring oxygen - a long tube and nasal cannula or face mask is required.
    - IV Drip - An extra length of tubing will usually be necessary if the IV is to be kept running.
    - The IV should be capped off if possible
    - A nurse should accompany the patient if the IV must be watched or if medication is being given.

C. Code Blue - The code procedure will be followed as established by hospital policy. Refer to CODE BLUE, CODE WHITE, CODE WHITE NEONATAL policy.
    - Abort scan.
    - SVHMC Campus -Dial "2222" (give exact location of the Code Blue).
    - CADI and OPIC – Call 911
    - Move the patient from the scan room to the patient holding area in Zone II outside the control room.

- Perform CPR until the code team arrives.
- Assist code team as necessary
- Document code by completing proper paperwork

D. Crash Cart – An adult and pediatric crash cart is located in Zone II in the patient holding area.
    - The crash cart is checked daily by DI staff during normal operating hours and prior to caring for a patient on an emergent basis. When the department is closed the log will reflect as such. A routine inspection is performed to ensure the crash carts are maintained and checked as required.
    - The crash carts must remain in Zone II and must not be moved into Zone III or Zone IV.

E. Code Red - If a fire is located in the MRI area: A fire in the scan room may also be a cause to quench the magnet, so the firefighting personnel can safely enter the room. (Refer to Quench Section)
    - R - Remove patients and staff from area.
    - A - Activate alarm –
        - SVHMC campus -dial "2222" (give exact location of the Code Red)
        - CADI and OPIC – Dial 911
    - C - Contain or control the fire by closing all doors to the area.
    - E – Extinguish – MRI approved extinguisher only
    - R - Relocate (evacuate scanning trailer).
    - There is a Halon extinguisher that will discharge automatically.

F. MRI Safety Concerns:
    - Safety concerns are addressed through the Radiation Safety Committee.
    - Any concerns regarding safety may be referred to any member of the committee. See RADIATION SAFETY Policy for committee members.
    - Magnetic field warning signs are posted outside of the scanner.
    - Additional warning signs are posted next to the scanning room entrance.
    - Signs are in English and Spanish.

G. QUENCHING THE MAGNET:
    - Quenching is the process whereby there is a sudden loss of absolute zero of temperature in the magnet coils, so that they cease to be super conducting and become resistive, thus eliminating the magnetic field. This results in helium escaping from the cryogen bath extremely rapidly. It may happen accidentally or can be manually instigated in the case of an emergency. Quenching may cause severe and irreparable damage to the super conducting coils, and so a manual quench should only be performed in extreme cases when the physician and service engineer are involved in the decision to quench.

- A fire in the scan room may also be a cause to quench the magnet so the firefighting personnel can safely enter the room. All systems should have helium-venting equipment, which removes the helium to the outside environment in the event of a quench. However, if this fails, helium will vent into the room and replace the oxygen. For this reason all scan rooms should contain an oxygen monitor that sounds an alarm if the oxygen falls below a certain level. Under these circumstances, immediate evacuation of the patient and personnel is necessary. If the scan room door is closed when a quench occurs and helium escapes into the scan room, the depletion of oxygen causes a critical increase in pressure in the room compared with the control area. This produces high pressure in the scan room, which may prevent opening of the door. If this should happen, the glass partition between the scan and control rooms should be broken to release the pressure. The scan room door can then be opened as usual and the patient evacuated. In such a case the patient should be immediately evacuated and evaluated for asphyxia, hypothermia and ruptured eardrums.

H. QUENCHING PROCEDURE:

- A magnet quench may occur due to machine malfunction or may be initiated. In either case, Helium gases should be released to outside air via the venting system attached to the bore.
- If the venting system fails, gases will be released into the scan room. Helium will displace oxygen. An oxygen meter is provided with a visible readout in the control room. Normal oxygen level is at 20. The meter has an audible alarm should the oxygen content in the scan room fall.
- Should gases become visible in the scan room, or if the audible alarm is heard, the patient should be evacuated from the bore and scan room immediately. The patient should then be assessed for respiratory difficulty.
- The MRI service provider should be notified immediately that a quench has occurred. Until service arrives, the scan room will remain off limits to all personnel.
- Quenches may be initialized by MR personnel only. This is a very expensive event and the decision to quench will not be made lightly.
- A quench is initiated by depressing the quench button in the scan room.
- A quench may be initiated in the event that firefighting equipment beyond the MR safe fire extinguisher is needed in the scan room. Verification of magnetic dissipation after the quench is required before fire equipment is allowed into the scan room.
- A quench may be initiated in a situation where a projectile has entered the bore and is compromising the safety of a patient or personnel.
- Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room or injuries resulting from the presence of ferromagnetic objects in the MRI scanner room need to be reported immediately to management and in the incident reporting system. Refer to policy ADVERSE EVENTS - REPORTABLE

V. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VI. REFERENCES

A. https://www.mrisafety.com/TMDL_list.php?orderby=alist_description

B. https://www.acr.org/news-and-publications/Advancing-MR-Safety-With-New-Guidelines-and-Best-Practices

C. FDA – Medwatch Program https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home

D. https://www.fda.gov/media/74201/download

E. ACR Guidance Document on MR Safe Practices:2013 https://onlinelibrary.wiley.com/doi/pdf/10.1002/jmri.24011

Attachments

Manual-on-MR-Safety 2024.pdf

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
Security Manager	Elias Gutierrez: Manager Security Program	04/2025
Di Director	John Kazel: Director Imaging Services	03/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Owner	Elvira Franco: Manager Diagnostic Imaging	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18018805**

Origination	10/2017	Owner	Eric Fierro: Director Food Services
Last Approved	N/A	Area	Nutritional Services
Next Review	3 years after approval		

NS: Cash Handling

I. POLICY STATEMENT

A. This policy provides clear procedures for the ethical, accurate, and secure handling of cash in the Nutritional Services department. All employees are expected to comply with these procedures to maintain accountability and prevent discrepancies.

II. PURPOSE

A. To protect and safeguard cash receipts, proper control, security and reconciliation daily.

B. To ensure accurate daily bank deposits while promoting transparency and elimination of personal funds to match deposits.

C. To maintain accurate records of all monetary transactions.

III. DEFINITIONS

A. **Micros:** the windows based computer program and hardware that runs the cash registers

B. **CBORD:** the company that sells and services the Micros/Odyssey software system and cash registers.

C. Till: The cash drawer used to store money, manage and protect money during business hours.

D. Deposit Slip: A document showing the total amount of money to be deposited.

IV. GENERAL INFORMATION- STAFF

A. Count and reconcile all cash at the end of each shift using department reconciliation form.

B. Employees are assigned individual register drawers. Accessing someone else's cash register drawer is not permitted.

C. All cash from till is deposited daily, once till has it's predetermined money amount satisfied.

D. Daily Deposit Safe Logs are maintained and document totals are on the reconciliation form signed.

E. Deposit slips must be completed and locked in the designated location.

F. Each day must begin with a fresh till with exact designation of money.

V. PROCEDURE

A. **Nutrition Services Manager:**

1. Coordinates all cafeteria cash handling procedures.
2. Sets up cashiers to operate cash registers.
3. Review reconciliation logs and deposit slips daily.
4. Reviews or directs research for all cash overages/shortages while notifying employees of discrepancies and having staff member sign documented overage/shortages.
5. Direct department coordinator to contact CBORD for Micros and Odyssey system issues.
6. Has oversight of the two cash registers in the cafeteria.
7. Assigns and trains a designee to maintain the above in Manager's absence.
8. Responsible for reconciliation of any cash shortages.
9. Secure all cash, deposit slip documentation and maintain the petty cash/change in safe.
10. Call in the change request order to the bank in the absence of the supervisor.

B. **Coffee Shop Supervisor:**

1. Coordinates all Coffee Shop cash handling procedures.
2. Sets up cashiers to operate cash registers.
3. Reviews daily sales reports.
4. Performs reconciliations and researches cash overages/shortages for the Coffee Shop and for Nutrition Services in the absence of the Department Coordinator.
5. Maintains the change/petty cash safe and calls in the change request order to the bank.
6. Issues change to cashiers as needed. See "change ordering" instructions
7. Conducts in-services for employees on cash handling as requested and needed.
8. Coffee Shop Supervisor and Baristas record change transactions on the Change Bank Verification Log.

C. **Supervisors:**

1. Maintains the change bank and calls in the change request order to the bank.
2. Receive, counts and record change from the bank with signatures.

3. Maintains the security of the key to the deposit safe. Participates in dual access to deposit safe in conjunction with any available staff and prepares transport deposit. Completes Daily Deposit Safe Log which records all deposits to be sent to the bank. (See Attachment F) Accesses the deposit safe in conjunction with the transport courier to pick up deposits.
4. Conduct in-services for employees on cash handling as requested and needed.
5. Maintain forms and needed supplies for cash handling.
6. Immediately notifies the Nutrition Services Manager (for the Cafeteria) or the Coffee Shop Supervisor (for Starbucks) to inform them of any shortages or missing deposits.
7. Supervisor is responsible for coaching/disciplinary actions related to any counts that are in excess of $5.00 or 2% of cash deposit.
8. Supervisors count and verify the appropriate balance of the change bank once a week and reports overage / shortage to Manager.

D. **Head Nutrition Services Aides:**

1. May be assigned to participate in cash counts by counting and verifying deposits, change verification log, daily deposit safe log and/or transport deposit.

E. **Cashiers (NS Aides, Head Aides and Barista's):**

1. All cashiers will receive key card access to the registers which must be kept on their person at all times
2. **Beginning of shift**: Initiate a "Cashiers Report" (Addendum A) by completing the top four lines and log on to the appropriate register and drawer.
    a. Date.
    b. Time in.
    c. Select am or pm.
    d. Starting cash.
    e. Enter name of cashier.
    f. Record position number.
    g. Record cashier number.
    h. Drawer number.
3. **Operate the Cash Register**
    a. Always maintain a polite and cordial demeanor while operating the cash register.
    b. Logoff cash register whenever the register is unattended.
    c. Enter sale by selecting the proper key and entering the item; the register will provide pricing. If prices are questionable see a Supervisor.
    d. Cash payment:
        i. Cashier collects money, enters the cash amount on register

screen. The cash register will calculate the correct change.

ii. Place the amount tendered on the top of the register drawer and leave it there until the change is counted and given to the customer. This way, the customer and cashier know what amount was provided to pay for the sale.

e. Payment by employee card:

i. After entering the items to be purchased, push the employee charge key and scan the employee card.

ii. Wait until the register shows that the sale was accepted before allowing employee to leave or take product before the transaction is complete in case the employee does not have enough credit to charge the purchase. If this occurs explain to the customer the credit limit of $200 per pay period and if needed ask them to see a Supervisor.

f. Payment by credit card:

i. After entering the items to be purchased and before processing the credit card, advice the customer of the amount of the sale (once the card is charged you cannot reverse the charge – See manager.)

ii. Click the credit card key and swipe the credit card (black magnetic strip should be facing the right side of the slide bar).

iii. Once the card has been swiped the register will create two receipts.

iv. The customer signs the charge slip and returns it to the cashier.

v. Once the cashier receives the signed copy, the customer is given a copy of the receipt.

g. Payment by gift card (Coffee Shop only):

i. After entering the items to be purchased, click the gift card redeem key and swipe the gift card (black magnetic strip should be facing the right side of the slide bar).

ii. Once the card has been swiped, the register reports that the transaction is complete.

iii. Cashier gives the customer a copy of the receipt.

iv. NOTE: If a purchase is made for a Starbucks gift card over $100 (either one card or multiple cards) the receipt must be printed out and signed by the cashier and either the Supervisor or another Barista to show that it has been reviewed and authorized. Receipt is to be included in the daily paper work.

h. Payment by Coupon

i. All coupons must have original signatures.

ii. After sale is totaled on the register enter the amount of the coupon as tender.

iii. If the coupon covers the sale amount, the transaction is complete.

iv. If the coupon does not cover the sale amount, collect the difference in cash, employee badge or credit card.

v. Once the transaction is complete, print the transaction tag and staple to the coupon. Collect any difference.

vi. Write "VOID" across the coupon so it cannot be used again.

4. End of shift close out preparation
    a. Print the cash register "Cashier Detail" (Addendum C) report.
    b. Remove the register drawer.
    c. Get a Register Drawer Count Sheet (Addendum B) and complete the required information at the top of the sheet.
    d. Count out the correct amount to be left in the drawer. Using a calculator add up all the change in the cash drawer, including rolled coins. Once you have your total, round down to the nearest dollar and put the excess coinage aside for your deposit.
    e. Write the rounded amount of coins on the "Register Drawer Count Sheet" (Addendum B) in the "Total Change in Drawer" spot.

Example:

Pennies	.43
Nickels	3.60
Dimes	4.70
Quarters	5.25
Coin Rolls	17.50
Total Change	31.48
Change to Deposit	**48¢**

    f. Use the coinage and cash to build the drawer to its assigned amount, using the maximum amount of ones, then fives, then tens; use twenties if needed.
    g. On the "Register Drawer Count Sheet" (Addendum B) double check your count and record the total of each denomination of bills to the left of the multiplication (x) sign.
    h. Using a calculator, multiply each denomination to arrive at a total. Write the total amount for each denomination to the right side of the column.
    i. Double check your count using a calculator.
    j. Leave the completed "Register Drawer Count Sheet" (Addendum B) in the

register drawer.

k. Complete the "Cashiers Report" (Addendum A).

l. Record your shift ending time by circling "am" or "pm".

m. You should not have any checks. However, if a Director did authorize the use of a check(s) list the check(s) (check number & amount) on the back of the "Cashiers Report" (Addendum A) and record the total amount in the space provided for checks on the front of the form.

n. Record the "Cash" from the "Cashier Detail" (Addendum C) on the "Cashiers Report" (Addendum A). This is what was rung up on the register and is the amount that you should have in actual cash in your deposit.

o. Count and record the total of each denomination to the left of the multiplication sign (x).

p. Multiply the total of each denomination times the denomination and write the total amount of cash for each to the right (use a calculator).

q. Using a calculator, total the amount of the column and write the grand total in the "Total Cash Deposit" space.

r. Prepare credit card reconciliation:

    i. Sort receipts by type of credit card.

    ii. Total the receipts for each type of credit card and record on Credit Card Reconciliation form (Addendum H) by credit card type.

    iii. Compare each credit card type total to the cash register tape to verify all cards are accounted for.

    iv. Explain any difference and report on shift report.

    v. Attach credit card receipts to credit card reconciliation and include in cashier paperwork.

F. **Perform count:**

1. Count Deposit
2. Secure drawer and deposit:

    a. Cashier to secure the drawer by returning it to the register and locking it in place. The "Register Drawer Count Sheet" (Addendum B) is left inside the cash drawer with the correct assigned drawer amount. This form is to be used by the next cashier to start their "Cashiers Report" (Addendum A) at the start of their shift.

    b. "**Deposit At / Received By**:" Record store name (Coffee Shop or Cafeteria).

    c. "**Bag Said to Contain**:" Record the amount of the deposit

    d. "**Date**:" Today's date.

    e. "**Time**:" End of shift time and indicate am or pm.

    f. Both the supervisor and the cashier sign under the "Date" space on the

flap.

g. "**From**:" Salinas Valley Health Medical Center (SVHMC) (Coffee shop or Cafeteria).

h. "**Acct #**:" from deposit slip

i. "This Bag Said to Contain:" Enter today's date and the total of the deposit.

j. Place the cash deposit and the top two copies of the Deposit Ticket (Addendum D) into the bag, tear off and detach the flap, push out the excess air and seal.

3. Cashier to collect and staple together the following reports for Nutrition Service's office:
    a. Cashiers Report (Addendum A).
    b. Cashier Detail (Addendum C).
    c. Flap from Deposit Bag (Addendum E).
4. Cashier to collect and staple the following report(s) for Accounting:
    a. Bank's Deposit Ticket (Addendum D) bottom copy.
    b. Credit card receipts.
5. Cashier to deliver reports to the department file cabinet and perform a dual person deposit in the Supervisors office safe.
    a. Place the Nutrition Service's packet in the Nutrition Services Folder in the file cabinet near the safe.
    b. Place Accounting's packet into the Accounting Folder in the file cabinet near the safe.
    c. Record the deposit drop onto the Daily Deposit Safe Log as indicated on Addendum F. Must get a second employee to witness the bag being dropped in the safe.
    d. Place the deposit into the white deposit bag (Attachment E), then place the bag into the black deposit dual-keyed safe.

       The second employee must sign the safe log indicating they have witnessed the deposit bag drop.

G. **Change Procedure:**

1. Purchasing change from the SVHMC Change Bank
    a. Cashier or person requesting change initiates the change request at the beginning or end of their shift, trying to avoid making change during the shift.
    b. Seek out a Supervisor to count out change based on the change request.
2. Supervisor and Cashier
    a. Performs a dual count of the cash being submitted by cashier to purchase

change.

b. Performs a dual count of the change being given back to the requestor.

c. Supervisor and cashier record transaction on the Change Bank Verification Log (Addendum G).

3. Maintaining cash on hand in register drawers

a. Cafeteria Cash Drawers

Island Register Drawer A	$300
Hot Line Register Drawer A	$125
Hot Line Register Drawer B	$300

b. Starbucks Cash Drawers

Register 1 A	$250
Register 1 B	$250
Register 2 A	$250
Register 2 B	$250

4. Supervisor - Purchasing Change from the Bank

a. Determines change needs and lists out prior to calling in change order

b. Remove the cash to purchase the change from the change bank and record the withdrawal on the Change Bank Verification Log

c. Using the below guideline build currency and coins to the following inventory levels.
Cafeteria:

1¢ - Pennies	30 Rolls / Two Racks	15.00
5¢ - Nickels	20 Rolls	40.00
10¢ - Dimes	25 Rolls	125.00
25¢ - Quarters	42 Rolls	420.00
$1 - Ones	500	500.00
$5 - Fives	180	900.00
Total		$2,000.00

Starbucks:

1¢ - Pennies	12 Rolls	6.00
5¢ - Nickels	22 Rolls	44.00
10¢ - Dimes	20 Rolls	100.00
25¢ - Quarters	20 Rolls	200.00
$1 - Ones	250	250.00
$5 - Fives	80	400.00

Total	$1,000.00

d. After recording the change that is needed, call the bank. The bank requests a breakdown of the amount needed by bills, rolls of coins and total. Remember when giving the business name to include Cafeteria or Starbucks at SVHMC and make sure the account number matches the department, so they know where to bring the change and where to record the transaction. Leave your name and number in case the bank has questions.

H. **Receiving Change from courier**

1. After receiving the change delivery from the courier, open the bag and verify the change, dual count is preferred.
2. Log the amount onto the change bank verification log

I. **Deposit Pick Ups**

1. Supervisor is responsible to verify that each position has recorded a deposit on the Daily Deposit Safe Log (Addendum F) or have a reason why there was not a deposit.
2. Supervisor prepares the deposit pick-up envelope by taking the Daily Deposits as noted on the Daily Deposit Safe Log placing them in a Deposit Envelope (Addendum E), labeling the envelop per instructions on the envelope, then sealing the envelope attaching the tear off receipt to the Daily Deposit Safe Log
3. The prepared deposit is stored in the change safe.
4. The Courier records pick up in the Blue Receipt Book (Addendum I):

J. **Petty Cash handling**

1. Nutrition Services Manager has sole access to the petty cash safe
2. Petty Cash is maintained at $1,500
3. When petty cash is needed issues the petty cash to the appropriate person and records the transaction on the Petty Cash Verification Log (Addendum J) and Manager and staff sign.
4. Maintains petty cash log with receipts and cash adding up to the total amount of the fund
5. For reimbursement of the petty cash fund, prepare the petty cash log (Addendum K) and take receipts and cash to the Senior Administrative Director who reconciles petty cash and submits for reimbursement.
6. When petty cash reimbursement check is received, the Nutrition Services Manager will follow the change fund procedure above.

K. **List of Addendums**

1. Addendum A through K:

Addendum	Name
A	Cashiers Report

B	Register Drawer Count Sheet
C	Cashier Detail (cash register printout)
D	Deposit Ticket (bank deposit ticket)
E	Cash Deposit Bag (White plastic bank cash bag)
F	Daily Deposit Safe Log
G	Change Bank Verification Log
H	Credit Card / Cash Deposit form
I	Courier Blue Receipt Book
J	Petty Cash Verification Log
K	Petty Cash Log

VI. EDUCATION/TRAINING

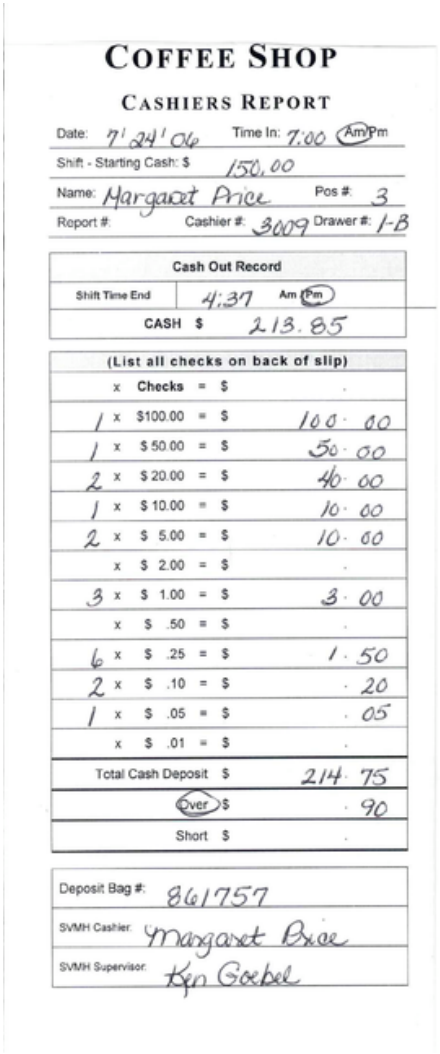
A. Education and/or training is provided as needed

VII. REFERENCES

A. Hospital Finance Guidelines

B. Internal Control Procedures Manual

Addendum A



COFFEE SHOP

CASHIERS REPORT

Date: 7/24/06 Time In: 7:00 (Am) Pm

Shift - Starting Cash: $ 150.00

Name: Margaret Price Pos #: 3

Report #: Cashier #: 3009 Drawer #: 1-B

Cash Out Record	
Shift Time End	4:37 Am (Pm)
CASH $	213.85

(List all checks on back of slip)		
x Checks = $		.
1 x $100.00 = $		100.00
1 x $ 50.00 = $		50.00
2 x $ 20.00 = $		40.00
1 x $ 10.00 = $		10.00
2 x $ 5.00 = $		10.00
x $ 2.00 = $		.
3 x $ 1.00 = $		3.00
x $ .50 = $		.
6 x $ .25 = $		1.50
2 x $ .10 = $		.20
1 x $ .05 = $		.05
x $ .01 = $		.
Total Cash Deposit $		214.75
(Over) $		.90
Short $		.

Deposit Bag #: 861757

SVMH Cashier: Margaret Price

SVMH Supervisor: Kyn Goebel

Addendum B

REGISTER DRAWER COUNT SHEET

Date: 08 / 02 /17 Time Out: 06:30 (M) PM

Name: *Ken Goebel* Pos. #:*52*

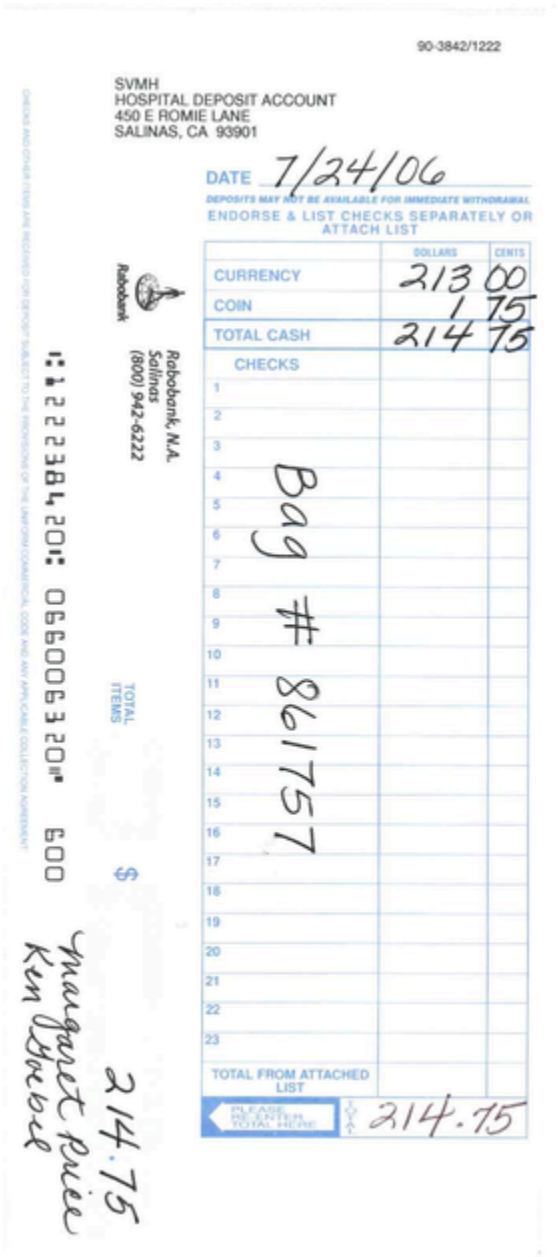
Cashier #: Drawer #: *Island A*

Change					Left in Drawer
	x	$ 1.00	= $	.	
	x	$ .50	= $	.	
12	x	$ .25	=	*$3 . 00*	*3.00*
62	x	$ .10	= $	.	*6.00*
60	x	$ .05	= $	.	*3.00*
41	x	$ .01	= $	*.41*	---
		Rolls		$.	
	x	$ .50	= $	.	
1	x	$ 2.00	=	*$2 .00*	*1.00*
2	x	$ 5.00	=	*$10 .00*	*10.00*
1	x	$10.00	=	*$10 .00*	*10.00*
		TOTAL		*$33 .61*	*33.00*
		Less change to deposit		*.61*	
		Total Change in drawer			*$33.00*
		Currency			
	x	$100.00	= $		
	x	$ 50.00	= $		
	x	$ 20.00	= $		
1	x	$ 10.00	=	*$10.00*	
7	x	$ 5.00	=	*$35.00*	
	x	$ 2.00	= $		
72	x	$ 1.00	=	*$72.00*	
		Total Currency		*$117.00*	
		Total Cash in Drawer		*$150.00*	

Cashier: *Albert* Dual Counter: *Brian*

Addendum C

Addendum D



90-3842/1222

SVMH
HOSPITAL DEPOSIT ACCOUNT
450 E ROMIE LANE
SALINAS, CA 93901

DATE 7/24/06

DEPOSITS MAY NOT BE AVAILABLE FOR IMMEDIATE WITHDRAWAL

ENDORSE & LIST CHECKS SEPARATELY OR ATTACH LIST

	DOLLARS	CENTS
CURRENCY	213	00
COIN	1	75
TOTAL CASH	214	75
CHECKS		
1		
2		
3		
4	Bag # 861757	
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
TOTAL FROM ATTACHED LIST		
PLEASE RECAPTEN TOTAL HERE	214.75	

Robobank
Robobank, N.A.
Salinas
(800) 942-6222

⑆122238420⑆ 066006320⑈ 600

TOTAL ITEMS

$

214.75
Margaret Price
Ken Yokoyama

Addendum E

Addendum F

Addendum G

Addendum H

Addendum I

Addendum J

Addendum K

Attachments

- Addendum E: Safe Lok®
- Addendum F: Daily Deposit Safe Log
- Addendum G: Change Bank Access & Verification Log
- Addendum H : Credit Card Reconciliation
- Addendum J: Petty Cash Verification Log
- Image 03
- Image 05
- Image 06

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Eric Fierro: Director Food Services	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16976912**

Last Approved	N/A	Owner	Lacey Cone: Director Critical Care Services
Next Review	3 years after approval	Area	Patient Care

Oral Care

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To create a standardized oral care practice amongst Salinas Valley Health staff involved in direct patient care, which reflects current, evidence-based practice recommendations.

B. To create a systematic approach to the provision of high quality, routine oral care.

III. DEFINITIONS

A. Oral cavity: the oral cavity includes the lips, gingivae, teeth, hard palate, buccal surfaces, tongue, and floor of the mouth.

B. Biofilm: a well-organized, cooperative community of microorganisms that form on the surfaces of the cheeks, tongue and teeth comprised of a sticky mass of proteins, lipids, glycoproteins, and glycolipids which house oral microbial communities.

C. Oral care: the mechanical removal of plaque and biofilm from the mouth by gently brushing the palate, buccal surfaces, tongue, gums, and tooth surfaces with a soft-bristled toothbrush; the use of alcohol-free antiseptic mouth rinse, and the application of oral cavity moisturizer.

D. Denture care: the removal of plaque and food debris from dentures or removable dental appliances by gently brushing the appliance with a soft-bristled toothbrush and soaking the appliance in a cleansing solution.

IV. GENERAL INFORMATION

A. An oral health assessment will be completed as part of the admission assessment and a minimum of every twelve hours using a standardized assessment tool.

1. The oral cavity will be assessed using a standardized assessment tool the Bedside

Oral Assessment (See Bedside Oral Assessment Tool).

B. All patients will receive oral care while admitted to the hospital.

C. Good oral hygiene, including regular brushing and flossing, is essential to control harmful bacteria and prevent conditions like tooth decay and gum disease.

D. Oral health can influence several serious conditions, including endocarditis and research suggests a connection between oral bacteria and cardiovascular diseases like heart disease and stroke. Gum disease is linked to complications in pregnancy, such as premature birth and low birth weight, while oral germs can contribute to pneumonia and other respiratory illnesses (Sedghi et al., 2021).

V. PROCEDURE

A. Organization adopted practice standards and procedures can be found on StarNet Quick links-Dynamic Health.

B. Independent patients, able to perform their own oral care:

1. Provide oral care supplies.
2. Teeth brushing will be performed a minimum of twice daily.
3. Instruct the patient how and when to apply mouth moisturizer.

C. Dependent patients, unable to perform their own oral care:

1. Follow standard procedure for gathering appropriate oral care supplies.
2. Position the patient's head to the side or in semi-fowlers position.
3. Provide suctioning as needed while performing oral care.
4. Oral cavity moisturizer will be applied every four hours and as needed to prevent drying of oral mucosa.

D. Denture wearing patients:

1. Denture care should be provided at the same frequency as oral care for natural teeth; dentures should be removed at night to prevent bacterial buildup and to allow for gums to rest.
2. Patients should be encouraged to wear dentures while they are awake to facilitate clear speech and nutrition.
3. At bedtime, dentures should be stored in a patient-labeled cup filled with cool water and effervescent cleaner.
4. Refer to Dynamic Health, Caring for Patients with Dentures, for step-by-step procedure.

E. Pediatric Patients:

1. For infants without teeth, gently wipe all surfaces of the oral cavity with a water moistened soft cloth.

2. For pediatric patients with teeth, brush teeth with a pediatric toothbrush and toothpaste a minimum of twice daily.
    a. Patients 3 years and younger, use a rice-grain sized smear of toothpaste.
    b. Patients older than 3 years, use a pea-sized amount of toothpaste.
3. Refer to Dynamic Health, Providing Oral Care to Hospitalized Pediatric Patients.

F. For intubated patients in the ICU and/or tracheostomy patients in the ICU and 1 Main:
    1. Chlorohexidine gluconate (CHG) will be used to provide oral care every twelve hours, in addition to standard oral care.

G. Documentation
    1. Nurse Swallow Screen will be performed and documented upon admission and as needed when a change in condition occurs.
    2. An Oral health assessment will be performed and documented by the nurse upon admission and a minimum of every twelve hours using the Bedside Oral Assessment tool.
    3. Oral Care will be performed and documented in the patient care record a minimum of every twelve hours and as indicated by oral care protocol.
    4. Frequency of oral mucosal care is driven by the Bedside Oral Assessment Score and will be documented in patient care record according to protocol frequency.
    5. Chlorohexidine Gluconate requires a physician order and is obtained through the pharmacy; CHG is scanned and documented on patient eMAR.
    6. Staff members will document refusal of oral care in patient care record.

VI. EDUCATION/TRAINING

A. Education and/or training will be provided as needed.

VII. REFERENCES

A. Abebe GM (2021) Oral Biofilm and Its Impact on Oral Health, Psychological and Social Interaction. Int J Oral Dent Health 7:127. doi.org/10.23937/2469-5734/1510127

B. Ames, Nancy & Sulima, Pawel & Yates, Jan & Mccullagh, Linda & Gollins, Sherri & Soeken, Karen & Wallen, Gwenyth. (2011). Effects of Systematic Oral Care in Critically Ill Patients: A Multicenter Study. American journal of critical care: an official publication, American Association of Critical-Care Nurses. 20. e103-14. 10.4037/ajcc2011359.

C. Barbara Quinn, Karen K. Giuliano, Dian Baker, Non-ventilator health care-associated pneumonia (NV-HAP): Best practices for prevention of NV-HAP, American Journal of Infection Control, Volume 48, Issue 5, Supplement, 2020, Pages A23-A27, ISSN 0196-6553, https://doi.org/10.1016/j.ajic.2020.03.006. (https://www.sciencedirect.com/science/article/pii/S0196655320301292)

D. Centers for Disease Control and Prevention. (2023). Non-ventilator healthcare-associated pneumonia (NV-HAP) prevention toolkit. Retrieved from: https://www.cdc.gov/hai/prevent/oral-health-toolkit.html

E. Prendergast, V., Kleiman, C., & King, M. (2013). The Bedside Oral Exam and the Barrow Oral Care Protocol: translating evidence-based oral care into practice. Intensive & critical care nursing, 29(5), 282–290. https://doi.org/10.1016/j.iccn.2013.04.

F. Sedghi, L., DiMassa, V., Harrington, A., Lynch, S. V., & Kapila, Y. L. (2021). The oral microbiome: Role of key organisms and complex networks in oral health and disease. Periodontology 2000, 87(1), 107–131. https://doi.org/10.1111/prd.12393

G. Segura A, Boulter S, Clark M, et al. Section on Oral Health. Maintaining and improving the oral health of young children. Pediatrics. 2014;134(6):1224-9. doi:10.1542/peds.2014-2984

H. Virginia Prendergast, Cindy Kleiman, Mary King, The Bedside Oral Exam and the Barrow Oral Care Protocol: Translating evidence-based oral care into practice, Intensive and Critical Care Nursing, Volume 29, Issue 5, 2013, Pages 282-290, ISSN 0964-3397, https://doi.org/10.1016/j.iccn.2013.04.001.

Attachments

Bedside Oral Assessment.docx

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	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Lacey Cone: Director Critical Care Services	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16975498**

Origination	08/2018	Owner	Clement Miller: Chief Operating Officer
Last Approved	N/A	Area	Plans and Program
Next Review	1 year after approval		

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.

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.

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 Leadership Working Group (LWG). 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	Treatmer 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 Responsibility**

1. SVHMC leadership is defined as the Board of Directors, LWG, 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 organization's QUAPI plan;
- 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.

I. **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.

J. **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
   - Organization Chart
   - 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

Status **Pending** PolicyStat ID **17704290**

Last Approved	N/A	Owner	Eric Fierro: Director Food Services
Next Review	3 years after approval	Area	Nutritional Services

Registered Dietitian Diet Order Entry

I. POLICY STATEMENT

A. The qualified Registered Dietitian Nutritionist (RDN) may write, accept, and implement nutrition-related orders within their scope of practice, as defined by the Academy of Nutrition and Dietetics. This protocol meets criteria set by the Centers for Medicare and Medicaid Services (CMS).

B. The RDN is considered qualified with current registration from the Commision on Dietetic Registration (CDR) and clinical competency as verified by the Clinical Nutrition Manager during the hiring process and through the annual performance review process.

C. RDNs serve as the nutrition experts on the interdisciplinary team to design and implement nutrition care plans according to the Nutrition Care Process.

D. The physician has direct control of patient care in all cases and at all times.

II. PURPOSE

A. To describe nutrition-related orders that can be written by a qualified Registered Dietitian.

B. To ensure RDN order writing privileges are established in accordance with, the Academy of Nutrition and Dietetics Scope of Practice, federal law/ regulations, state law, state practice acts and hospital policy.

C. To allow the RDN to provide efficient medical nutrition therapy intervention in accordance with evidence-based practices.

D. To promote the provision of safe, effective, medical nutrition therapy to positively impact the medical outcomes of hospitalized patients.

III. DEFINITIONS

A. Registered Dietitian Nutritionist (RDN); Registered Dietitian (RD)

B. Electronic Medical Record (EMR)

IV. GENERAL INFORMATION

A. **Note: Centers for Medicare & Medicaid Services, State Operations Manual, Regulations and Interpretive Guidelines for Hospitals, Condition of Participation: Food and Dietetic Services §482.28(b)(2)**- All patient diets, including therapeutic diets, must be ordered by a practitioner

responsible for the care of the patient, or by a qualified dietitian or qualified nutrition professional as authorized by the medical staff and in accordance with State law governing dietitians and nutrition professionals.

B. **Per California Code of Regulations for Hospitals, Section 70273(e)**: *"Therapeutic diets shall be provided as prescribed by a person lawfully authorized to give such an order and shall be planned, prepared and served with supervision and/or consultation from the dietitian. Persons responsible for therapeutic diets shall have sufficient knowledge of food values to make appropriate substitutions when necessary."*

C. **Per California Law, Chapter 5.65. Dietitians [2585-2586.8]**, *(b) A registered dietitian, or other nutritional professional meeting the qualifications set forth in subdivision (e) of Section 2585, may accept or transmit verbal orders or electronically transmitted orders for medical nutrition therapy from the referring physician or the physician responsible for the care of the patient in a licensed health care facility. (c) A registered dietitian, or other nutritional professional meeting the qualifications set forth in subdivision (e) of Section 2585, may order medical laboratory tests related to medical nutrition therapy services when approved by the referring physician or the physician responsible for the care of the patient.*

V. PROCEDURE

A. An authorized practitioner's diet order, electronic or written (e.g. downtime procedure) will be required for all patients admitted.

B. The RDN may accept a read back telephone order or submit orders electronically for oral diets, oral nutrition supplements, macronutrient modular preparations, enteral formulas, and nutrition consults from an authorized practitioner. The following orders may submitted by the RDN for physician approval to provide medical nutrition therapy to patients:

1. Initiate or modify therapeutic diet orders.
2. Downgrade textures, e.g. regular to chopped, due to the following (includes but not limited to): dentition, weakness, impaired ability to self feed, or patient request.
3. Add special modifications to the diet order per patient preference or dietary intolerance.
4. Order, modify, or discontinue oral nutrition supplements (Ensure Plus, Glucerna, Juven, Prosat, Kate Farms, etc.) to improve the nutritional status of patients.
5. Order and update enteral orders including the initial rate, advancement instructions, and goal rate.
6. Order Medium Chain Triglyceride oil for malabsorption.
7. Order fiber supplements when necessary.
8. Change diet orders based on SLP recommendations.
9. Order adaptive equipment utensils for meals based on rehab recommendations.
10. Order vitamins and minerals: Multivitamin, Multivitamin with minerals, Liquid Multivitamin; Vitamin C, and Zinc for wound healing; Nephro-vite for patients with renal disease; Thiamine, B12, and Folic acid. Other vitamins or minerals as needed based on increased nutrient needs or deficiencies.
11. Order nutrition laboratory data: Individual electrolytes or BMP/CMP may be ordered by the RDN if a patient is receiving nutrition support and/or is at risk for refeeding syndrome. Every effort will be made to order labs with existing orders or next draw in order to prevent multi-sticking the patient. The RDN may order a TPN panel to include a triglyceride level for patients initiated on a TPN Protocol. The RDN may also order an A1c to assess diabetes status if indicated.
12. Order a swallow evalution if the patient or family reports dysphagia.

13. Order height and weight.
14. Order or discontinue a calorie count.

C. The RDN may modify diet orders based on medical condition and clinical status, past medical history, laboratory results, medications, anthropometrics, appetite and po intake status, dentition, and/or cultural needs.

D. Orders will be entered into the EMR under the name of the authorized practitioner including date and time in addition to the name of the RDN.

E. Therapeutic diet orders will be consistent with the approved diet order manual. See Policy: Interpretation of Nutrition Care Orders (Policy Stat ID 14788345).

F. Food texture modification should be specified as indicated. A patient's food texture may be down-graded without an authorized practitioner's order to accomodate patient preference or needs.

G. The RDN will verify with an authorized pratitioner any questions or concerns regarding the patient's diet order and will document clarifications in the EMR.

H. Diet liberalization may occur at the discretion of the authorized practitioner or RDN and will be documented in the EMR. The authorized practitioner may allow outside food, and this will be documented in the EMR.

Exclusions to the above order writing privileges include:

A. Diet advancement from a liquid diet to a solid diet, unless consulted or approved by the authorized practitioner.

B. Initiate or write orders pertaining to parenteral nutrition.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. CMS.gov, Centers for Medicare & Medicaid Services, State Operations Manual, Regulations and Interpretive Guidelines for Hospitals, Condition of Participation: Food and Dietetic Services §482.28(b)(2), https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.

B. PRACTICE TIPS: Hospital Regulation - Ordering Privileges for the RDN. Academy of Nutrition and Dietetics. Commission on Dietetic Registration.

C. TITLE 22 CALIFORNIA CODE OF REGULATIONS DIVISION 5. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-19-27-Attachment-02.aspx

D. California Law: Business and Professions Code-BPC. Chapter 5.65. Dietitians [2585-2586.8]. https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=BPC&division=2.&title=&part=&chapter=5.65.&article=

E. Academy of Nutrition and Dietetics: Definition of Terms – February 2021, Accessed March 2021 https://www.eatrightpro.org/-/media/eatrightpro-files/practice/scope-standards-of-practice/academydefinitionoftermslist.pdf?la=en&hash=9C69653783C7F39EA2E0E4F9E6745A6D9343D32A

F. The Academy of Nutrition and Dietetics, Scope of Practice Framework. http://www.eatright.org/HealthProfessionals/content.aspx?id=6867.

G. Academy of Nutrition & Dietetics Scope of Practice Decision Algorithm, https://www.eatrightpro.org/-/media/eatrightpro-files/practice/scope-standards-of-practice/20190510-scope-of-practice-decision-

tool-algorithm-final.pdf?la=en&hash=5987E388A61D43EAD2690776EAC2AA1278FA4070

H. American Society for Parenteral and Enteral Nutrition and Academy of Nutrition and Dietetics; Revised 2014 Standards of Practice and Standards of Professional Performance for Registered Dietitian Nutritionists (Competent, Proficient, and Expert) in Nutrition Support; https://onlinelibrary.wiley.com/doi/full/10.1177/0884533614554264

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	05/2025
P&T Committee	Genevieve delos Santos: Director Pharmacy	04/2025
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Eric Fierro: Director Food Services	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16948852**

Last Approved	N/A	Owner	Troy Scott: Director Case Management
Next Review	1 year after approval	Area	Scopes Of Service

Scope of Service: Case Management

I. SCOPE OF SERVICE

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

The purpose of Case Management is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Case Management 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 Case Management 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 Case Management are to:

A. Realize desired patient outcome by assessing, planning and delivering the case management and social work services and by brokering services across the health care continuum, in order to assure patient centered quality care, reduce fragmentation and costs.

B. The foundation for effective case management services, provided by registered nurses, social workers, and assistive personnel includes patient advocacy, care coordination, education, transition management and utilization management.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

B. To support the Department of Nursing objectives.

C. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

D. To plan for the allocation of human/material resources.

E. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

F. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.

G. To provide high level medical and nursing management with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to as high a level of wellness as possible.

H. To provide appropriate staff orientation and development.

I. To monitor Case Management function, staff performance, and care / service for quality management and continuous quality improvement.

J. To provide information via lectures and printed material to health care professionals and the general public.

K. If not covered by SVHMC's policies, Case Management follows guidelines as outlined by the American Case Management Association, (ACMAweb.org), the Case management Society of America (CMSA.org).

IV. POPULATION SERVED

Clinical:

Case Management provides care for infant, pediatric, adolescent, adult and geriatric patients with all diagnoses.

Non-Clinical:

Case Management provides services including but not limited to:

V. ORGANIZATION OF THE DEPARTMENT

A. Hours of Operation
The Unit/Department provides services 7 days a week, 24 hours a day.

B. Location of department (s) - offices are located on every floor.

C. Admission, Discharge, Transfer Criteria (if applicable)- refer to DISCHARGE/TRANSITION PLANNING GUIDELINES

D. Major Services / Modalities of care may include:
Case Management provides care / services to patients with all diagnoses.

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

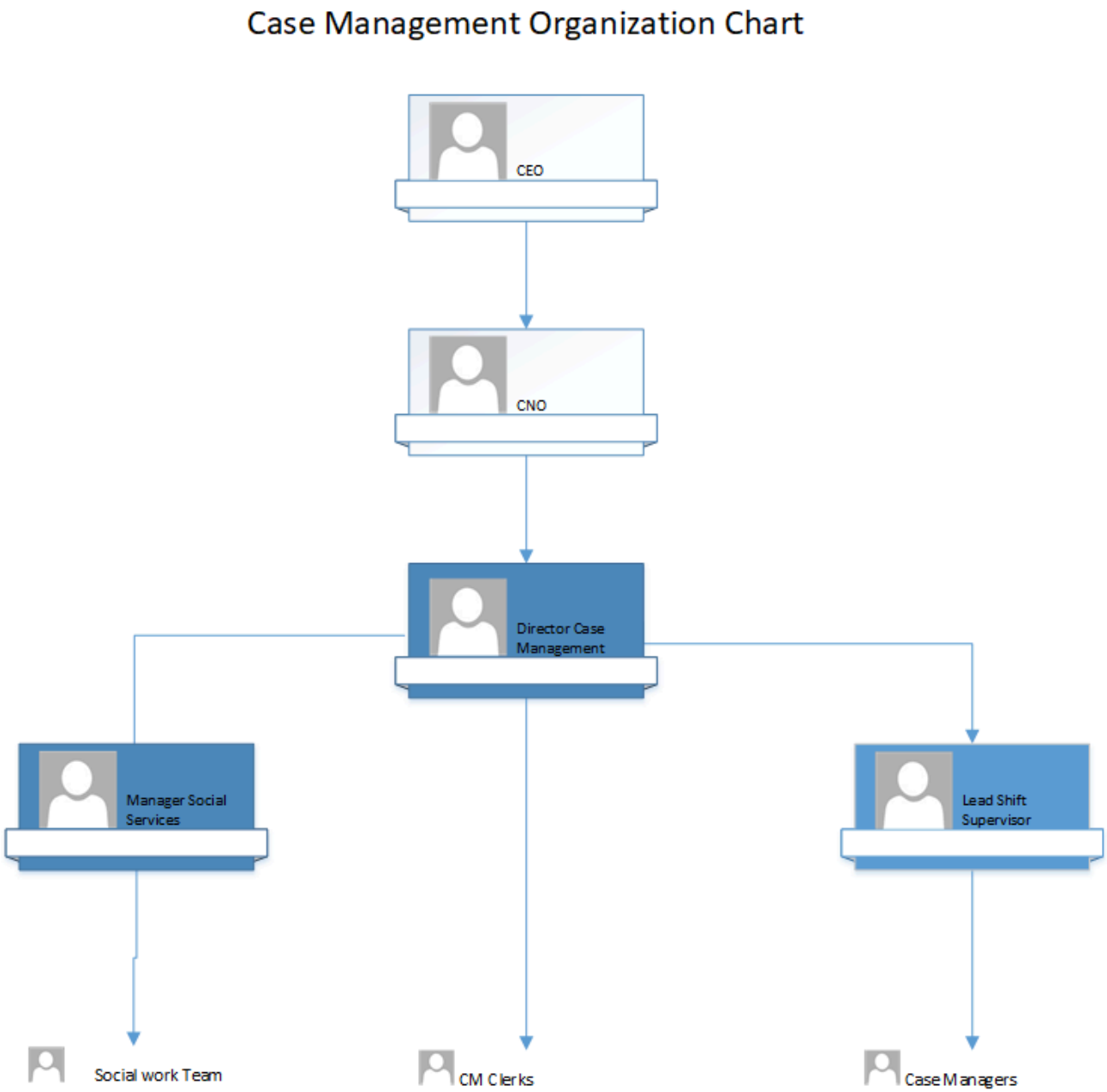
A. Case management services are provided by a multidisciplinary team comprised of registered nurses, social workers, and assistive personnel including patient advocacy, care coordination, education, transition management and utilization management. Additional services are provided

through appropriate referrals.

B. The Director or designee assume twenty-four (24) hour responsibility for case management services.

C. The Director of the Unit is directly responsible to the Chief Financial 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 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.

A. Licensure / Certifications:

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

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

The basic requirements for ***Licensed Social Workers*** include:

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

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 by the Director or designee based upon staff skill level, total patient acuity, needs of the patients, technology involved and degree of supervision required and/or available.

General Staffing Plan:

Staffing is established based on Average Daily Census and Units of Service in 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 staffing requirements cannot be met, this department will meet staffing requirements by utilizing the on-call system, registry and per diem RN's.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: There is no minimum for Case management.

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

A. N/A

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

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
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Troy Scott: Director Case Management	03/2025

Standards

No standards are associated with this document

Status Draft PolicyStat ID 18151516

Origination	01/2021	Owner	John Kazel: Director Imaging Services
Last Approved	N/A	Area	Scopes Of Service
Next Review	N/A		

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 though patient/significant other education and to restore the patient to the

highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

H. To monitor Diagnostic Imaging function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

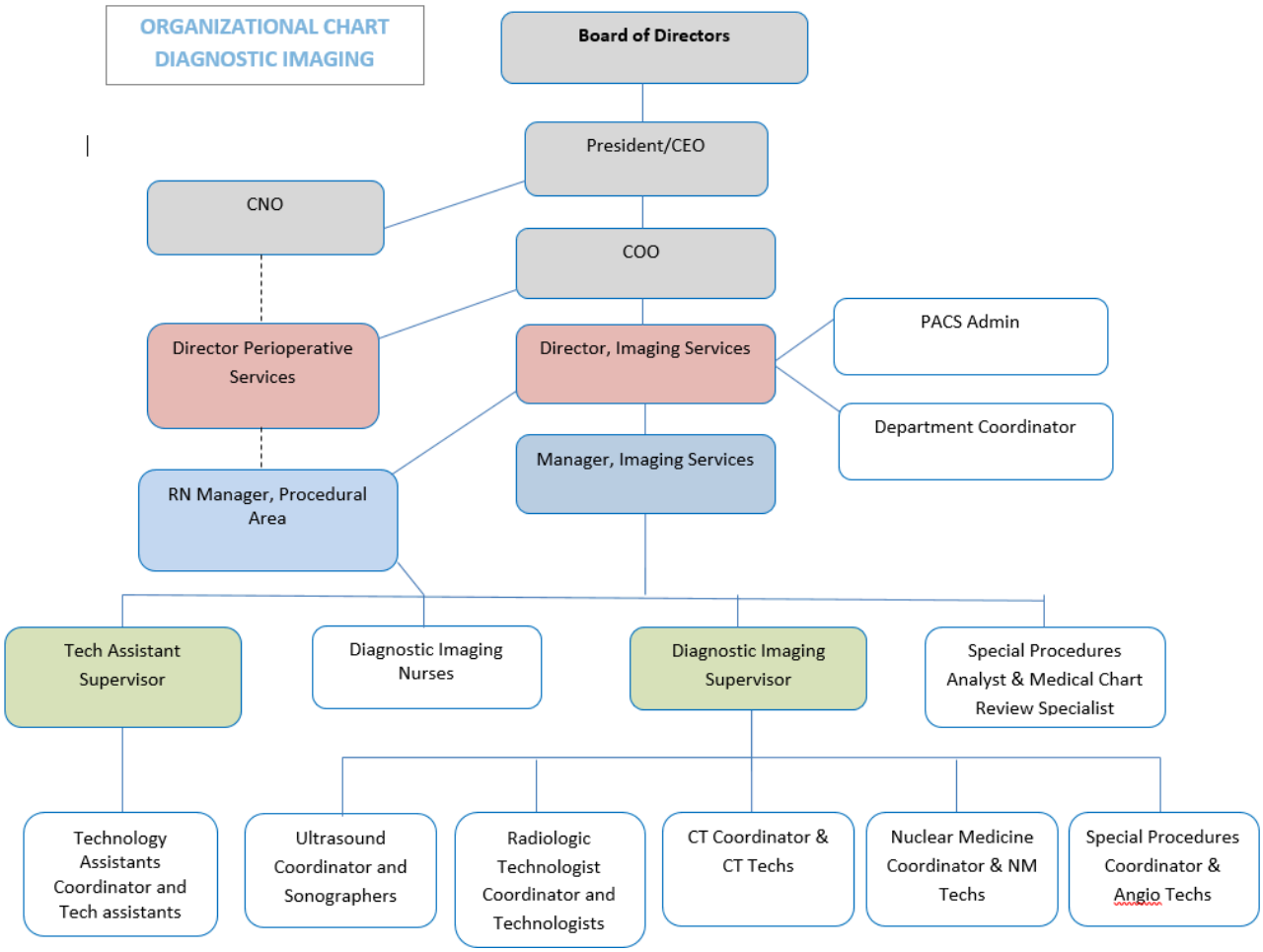
Clinical:

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

A. 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).

B. 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.

C. 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.

XII. RADIATION SAFETY

See Radiation Safety Program Policy

Attachments

Image 1.PNG

Approval Signatures

Step Description	Approver	Date

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16975500**

Origination	08/2022	Owner	Jill Peralta Cuellar: Director Employee Health
Last Approved	N/A	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Employee Health

I. SCOPE OF SERVICE

Employee Health supports the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC).

The purpose of Employee Health is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Employee Health 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, Employee Health 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 Employee Health is to:

A. Provide services to support the health and well-being of our staff.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

C. To plan for the allocation of human/material resources.

D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population in order

to promote healing of the whole person.

F. To evaluate staff performance on an ongoing basis.

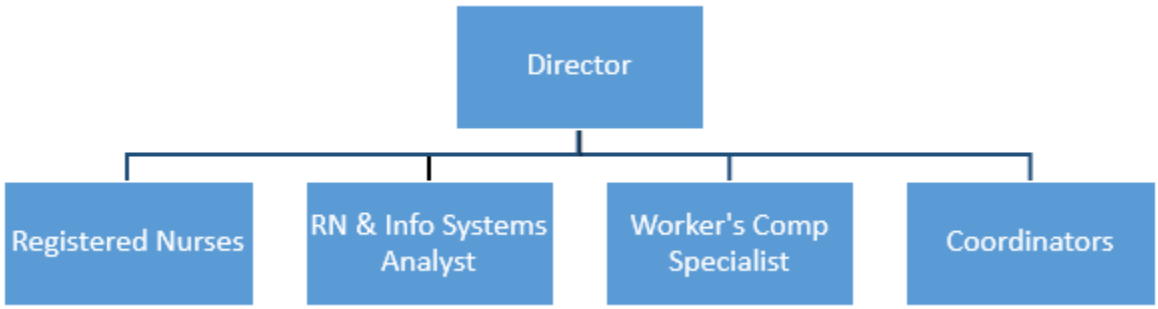
G. To provide appropriate staff orientation and development.

H. To monitor Employee Health function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED at SVHMC

1. All Departments
2. Active Medical Staff/LIP's
3. Active Volunteers
4. Active Travelers/Contractors
5. Students actively working within the hospital for training purposes during their training period.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation
Occupational/Employee Health Services is open Monday through Friday 07:30 to 16:30. Open clinic hours are:

Monday, Wednesday, Thursday: 0730 – 1630
Tuesday and Friday: 0730-1200

Hospital Administrative Supervisors are available to serve the needs of employees after hours and on week-ends and holidays. EHS leadership is available as needed through the hospital operator

B. Location of department (s) 440 East Romie Lane, Salinas, CA 93950

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

A. The Occupational/Employee Health Services Department provides access to all staff, and volunteers for the initiation and maintenance of wellness and safety.
Primary services include:

- First aid and triage for injury and illness.
- Post offer Pre-placement assessment.
- Physical tasks evaluation.
- Initial and Annual TB screening.
- Immunization program.
- Annual health assessment/screening.
- Medical Clearance for fit testing.
- Annual fit testing and training for N95 Respirator and Portable Air Purifying Respirator (PAPR).
- Temporary/Transitional Return to work programs.
- Ergonomic program management including work place and work task assessments, recommendations and education.
- Job shadowing and recommendations to department leadership to support a culture of safety.
- Case Management for both industrial and non-industrial injuries and illness.
- Industrial injury management of employees of SVHMC.
- Worker Compensation benefits coordination.
- Tracking of illness and injury trends and report out to The Worker Safety Committee.
- Staff exposure follow up. In collaboration with Infection Prevention and under the Employee Health Medical Director's guidance.
- Safe Patient Handling collaboration with the Safe Patient Handling Committee including evaluation and implementation of patient mobility equipment.

VII. REQUIREMENTS FOR STAFF

Occupational/Employee Health Services follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with standards of practice.

A. Licensure / Certifications:

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

1. BLS
2. Completion of competency-based orientation
3. COHN, COHN-S strongly recommended
4. Completion of annual competencies
5. Ability to handle fast pace, high stress situations

The basic requirements for ***Workers Comp Specialist*** include:

1. 3-5 years' experience in workers' compensation or a course of completion in workers compensations or RN with Workers Compensation/Case Management experience

2. Knowledge of OSHA, Cal OSHA and Ergonomics

3. Ability to handle fast pace, high stress situations

The basic requirements for **Department Coordinators** include:

1. Ability to perform administrative duties and support the Employee Health Department.

2. Strong Computer skills

3. Strong and professional phone skills

4. Proficient in Excel

5. Ability to handle fast pace, high stress situations

The basic requirements for **Registered Nurse/Infomation System Analyst** include:

1. Same requirements as outlined in EHS Registered Nurse. In addition:

2. Strong computer skills

3. Proficient in Excel

3. Strong analytical and problem-solving abilities

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.

Department personnel who attend educational conferences will in-service other EHS staff regarding the information learned at the conferences. Other internal and external continuing education opportunities are communicated to staff members.

Staff are encouraged to participate in organizations that support the work done in Employee/ Occupational Health.

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 Education

A. 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.

B. D. Continuing Education

C. 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 an appropriate 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:

Assignments made by the leadership of Employee Health Services are based on hospital needs, 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 will be determined and staffed accordingly.

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

Employee Health 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, Employee Health 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
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Jill Peralta Cuellar: Director Employee Health	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16975497

Origination	06/2022	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Nursing Administration

I. SCOPE OF SERVICE

Nursing Administration 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 Nursing Administration is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Nursing Administration is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible. Nursing Administration provides nursing leadership on premise 24 hours per day 7 days a week. The Administrative Supervisor under the direction of the Chief Nursing Officer/Designee is responsible for the operations of services, including determining the types and numbers of nursing personnel and staff necessary to provide nursing are for all areas of the hospital.

II. GOALS

A. The goal of Nursing Administration is to provide support and oversight for the all Nursing Services and non-clinical functions that effect patient care throughout the hospital.

B. In addition to the overall SVHMC goals and objectives, Nursing Administration develops goals to direct short term and long-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 and Department of Nursing goals. The goals will be reviewed quarterly as part of the Unit's Performance Improvement Program and will include input from Physicians, Department Directors, Clinical Nurse Managers, Staff Nurses (RN).

III. DEPARTMENT OBJECTIVES

A. To support SVHMC and Department of Nursing objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost-effective

manner.

C. To plan for the allocation of human/material resources.

D. To support the provision of high-quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population 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 Nursing Administration function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Nursing Administration through the Administrative Supervisor provides support for all clinical and non-clinical departments and is the Hospital Designee for Department Heads after hours.

V. ORGANIZATION OF THE DEPARTMENT

(Nursing Organization Chart for Nursing)

A. Hours of Operation:
Nursing Administration provides services provides 24 hours/day, 7 days/week administrative supervisor coverage and support to all hospital departments/directors in their absences.

B. Location of departments:
The Nursing Administration offices are in the basement of the Cisilini Plaza.

C. Major Services / Modalities of care may include:
Administrative Supervisor in Nursing Administration in collaboration with the nursing leaders oversees the allocation of resources to all departments on a day to day bases.

Nursing Administration consist of the Administrative Supervisor that oversees provision of resources resource department to facilitate Patient Care Resources when needed as follow but not limited to:

- Patient Care Resources (Float Pool)
- Administrative Supervisor
- Interpreting Services

Staffing Office supports the Unit Directors in their staffing responsibility to ensure safe staffing levels are maintained as patient volumes and acuities fluctuate throughout the day. The Staffing office maintains and replaces staff on a day to day shift by shift basis under the direction of the Administrative Supervisor. The Administrative Supervisor ensures compliance with regulatory statutes and reallocates resources meet the standards of safe patient care. In

addition, the staffing office provides resources needed for clinical and non-clinical resources when needed.

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

The Chief Nursing Officer assumes twenty-four (24) hour responsibility of the Department.

The Chief Nursing Officer is directly responsible to the President/CEO . It is the CNO's duty to attend all administrative and technical functions within the department and throughout the hospital as needed. All personnel within the department are under the guidance and direction of the CNO. In the CNO's absence, the position is filled by their designee.

The Administrative Supervisor facilitates problem solving, patient flow and placement, staffing oversight, and operational management.

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

1. Multidisciplinary Performance Improvement Teams
2. Patient Family Surveys
3. Focused Studies
4. Patient Relations Services
5. Employee Forums
6. Collaboration with Medical Staff

VII. REQUIREMENTS FOR STAFF (applicable to department)

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.

A. Licensure / Certifications:

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

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

The basic requirements for ***Interpreters*** include:

1. Certification in the hospital approved certification training program.

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

The department is staffed with one Administrative Supervisor 24 hours per day and 7 days a week.

Interpreter services are always staffed with a minimum of one interpreter certified in Spanish. If other interpreters are needed the Interpreter on Wheels is utilized.

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

Nursing Administration 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 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 Nursing Administration Department, in collaboration with the Professional Governance structure, 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 and Magnet structures, which are posted on all units and on the internal intranet.

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Carla Spencer: Chief Nursing Officer	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16948850**

Origination	08/2020	Owner	Timothy Albert: Chief Clinical Officer
Last Approved	N/A	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Physician and Business Development

I. SCOPE OF SERVICE

Physician and Business Development 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 Physician and Business Development is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of Physician and Business Development 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 Physician and Business Development 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 Physician and Business Development is to:

A. Promote and maintain collaborative physician, employer, payer and other healthcare provider relationships to ensure access to hospital services and care for patients and to meet community health care needs.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.

C. To plan for the allocation of human/material resources.

D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the

highest level of wellness as possible.

E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.

F. To evaluate staff performance on an ongoing basis.

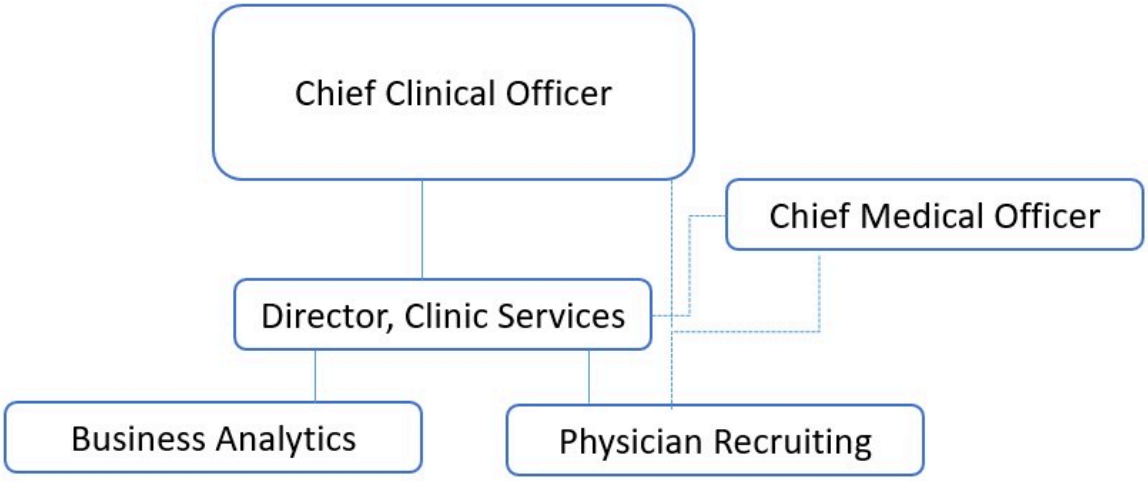
G. To provide appropriate staff orientation and development.

H. To monitor Physician and Business Development function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

The Physician and Business Development Department provides services outlined in Section VI of this Scope of Service.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation
The Unit/Department provides services Monday through Friday from 8:00 a.m. to 5:00 p.m.

B. Location of department
The Department is located in the Administrative Office Building.

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

A. The Department purpose is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The Department provides the following services:

1. Identifies, develops and maintains effective relationships with healthcare providers, business, government and community
2. Identifies and leads new business opportunities, market share expansion projects, and community service need activities
3. Identifies and develops aligned physician and Hospital integration and contracting opportunities

4. Promotes the Hospital as the leader in the provision of quality healthcare services to the public and provider community
5. Represents the Hospital in community-based collaborative planning, outreach and business development activities
6. Identifies and recommends marketing and communication activities that will build market share, enhance physician relationships and strengthen the Hospital's contracting opportunities.
7. Provides leadership and support to Hospital Directors in their efforts to meet the Hospital's service and business goals in specialty care areas and centers of excellence.
8. Serves as liaison to business, government and the public.
9. Facilitates development of health system strategic plan.
10. Serves as key resource for business planning activities related to strategic investments.

B. The Chief Clinical Officer of the department assumes twenty-four (24) hour responsibility for the Department.

C. The Chief Clinical Officer of the Department is directly responsible to the Chief Executive Officer. It is the Chief Clinical Officer'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 Chief Clinical Officer. In the Chief Clinical Officer's absence, the position is filled by 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 Department 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 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
N/A

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:

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

In the event of a severe emergency, the Chief Clinical Officer, Physician Integration and Business Development will provide the services necessary to operate the unit. Staff may be re-assigned as necessary.

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

Physician and Business Development 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, Physician and Business Development will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

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

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Timothy Albert: Chief Clinical Officer	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16515833**

Last Approved	N/A	Owner	Troy Scott: Director Case Management
Next Review	1 year after approval	Area	Scopes Of Service

Scope of Service: Social Services

I. SCOPE OF SERVICE

Social 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 Social Services is to enhance care by providing counseling support and services to vulnerable patients and their families. SVHMC remains a leading provider of medical care and this includes our commitment to the whole person, mind, body and spirit. The goal of Social Services is to help people by arranging services that mitigate risk, ensuring safety, fostering independence, and enhancing health and wellness.

II. GOALS

In addition to the overall SVHMC goals and objectives, the Social Services department develops goals to direct projects and address social determinants of health. Many of these opportunities evolve out of quality management activities. These goals have input from a variety of sources and reflect SVHMC's commitment to our patients and community as well as our annual hospital goals.

The main goals of Social Services are: 1. Provide mental health counseling and support to patients and their families. 2. Connect patients and families with resources to help them cope with illness, disability, and lifestyle changes. 3. Advocate for patient rights and ensure access to necessary health care services. 4. Assist in the coordination of care between multiple medical providers. 5. Provide referrals to community services and social support networks. 6. Develop and implement discharge plans to ensure continuity of care after hospitalization. 7. Educate patients and families about community resources, health promotion, and disease prevention. 8. Work with other hospital departments to coordinate services for patients. 9. Assist with end-of-life care planning. 10. Help patients and families access benefits and financial assistance. 11. Assessing safety, submitting required reports to appropriate community agencies tasked with investigating allegations of abuse, thus meeting mandated reporting

requirements.

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. To provide the patient and family caregivers education and support to restore the patient to the highest level of health and wellness possible.

D. To support the provision of resources designed to mitigate risk and enhance positive outcomes for patients and their family members.

E. To evaluate staff performance on an ongoing basis by providing supervision and consultation.

F. To provide appropriate staff orientation, and continuing education.

G. To collaborate with community organizations fostering cooperation and care for our patient population.

H. To monitor Social Services function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical: All Departments

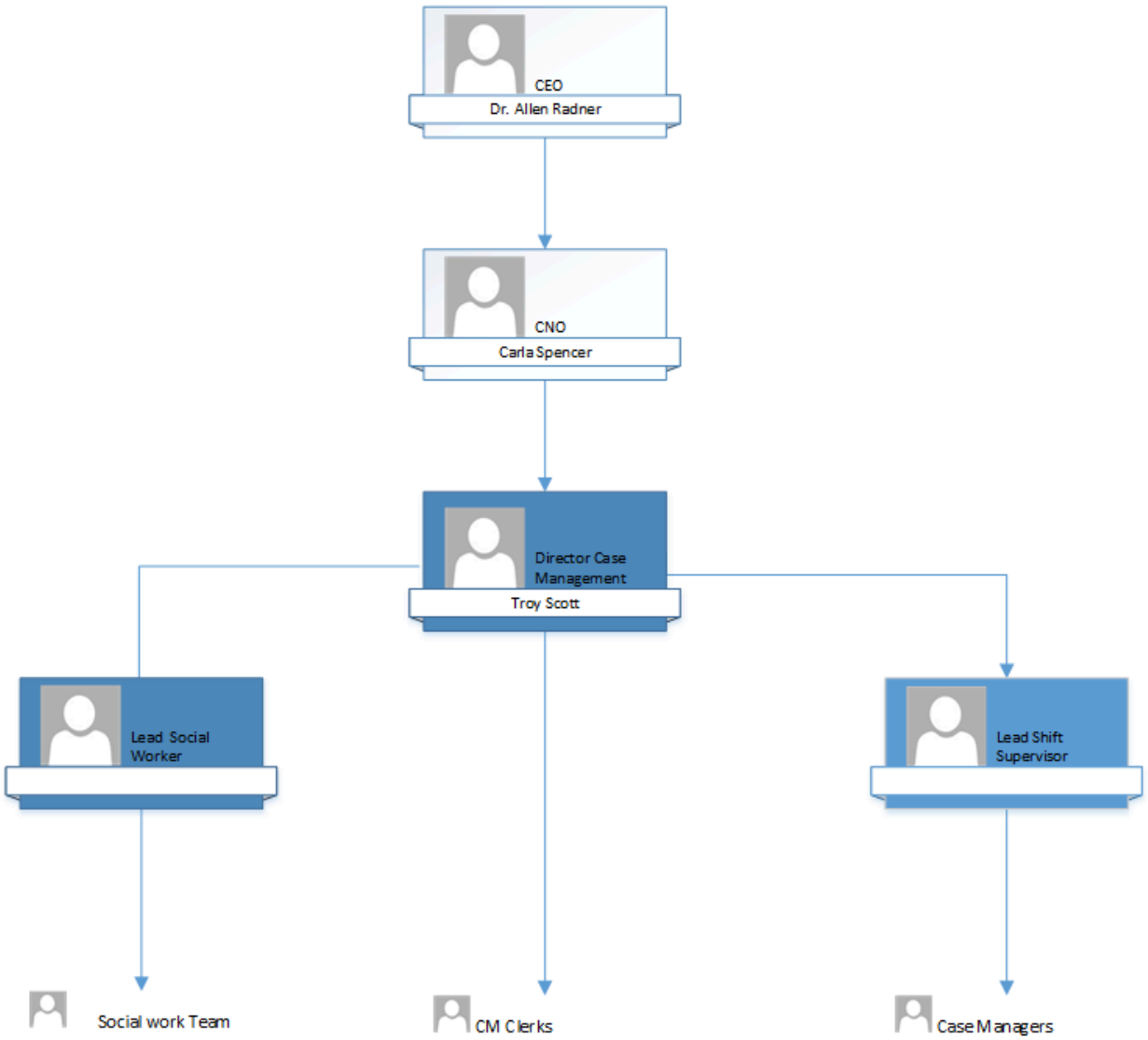
Social Services provides care for infant, pediatric, adolescent, adult and geriatric patients.

Clinical:

Social Services provides services including but not limited to:

V. ORGANIZATION OF THE DEPARTMENT

Case Management Organization Chart



A. Hours of Operation
The Unit/Department provides services daily from 8:00 a.m. to 11:00 p.m.. Weekend coverage includes Social Workers staffed in the emergency department as well as in-house. Flexible hour and weekend hours are required.

B. Location of department (s)
The administrative office is located across the street from the hospital. Social Services Manager is located on 1 Main.

C. Admission, Discharge, Transfer Criteria - N/A

D. Social Services provides care and services to patients.

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

A. Social Workers collaborate with all hospital disciplines, community services and support services in order to meet the needs of the patient/family. Services are provided based upon reason for referral, patient assessments/reassessment, plan of care, patient preferences and medical staff orders including but not limited to:

- Screening each consult using the High Risk Screening Criteria (Physician orders will be prioritized).
- Providing an initial psychosocial assessment and ongoing care as needed, with attention to long length of stay cases. All patients in the ICU and NICU will have an assessment within 48 hours.
- Providing crisis intervention, counseling support, grief support, psycho education and advocacy.
- Initiating referrals and coordinating needed services for patients and their families
- Participating in multi-disciplinary teams and patient care conferences.
- Consultation and community resources
- Mandated Abuse reporting as necessary
- Substance use disorder and mental health navigation
- Participation in Hospital Committees, i.e. Bioethics, Palliative Care, Children's Miracle Network, Community Coalitions etc.

B. The Director assumes twenty-four (24) hour responsibility for the Department.

C. The Director of the Department 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 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 Department services have the appropriate training and competence.

A. Licensure / Certifications:

The basic requirements for ***Social Worker*** includes:

1. Master's Degree in Social Work
2. License eligibility
3. Licensed Clinical Social Worker preferred.
4. Completion of competency based orientation
5. Completion of annual competency and inservice

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

1. STAR Values
2. Quality Assessment and Improvement Initiatives
3. Strategic Planning (Goals & Objectives)
4. New / emerging products and/or technologies
5. Changes in Practice
6. Regulatory Compliance
7. Licensure or certification requrements

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

D. Employee educational needs assessment at the time of hire and annually as part of developmental planning

1. Performance improvement planning, data collections and activities
2. Staff input
3. Evaluation of patient population needs
4. New services/programs/technology implemented
5. Change in the standard of practice/care
6. Change in regulations and licensing requirements
7. Needs assessment completed by Nursing Education
8. Licensure or certification requirements

E. 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 on acuity and needs of the department, competencies of the staff, the degree of supervision required, and the level of supervision available.

General Staffing Plan:

Staffing requirements will be met by authorizing overtime and/or utilizing temporary services.

In the event of a severe emergency, medical social workers are available.

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:

A. With compassion, respect and dignity for each individual without bias.
B. In a manner that best meets the individualized needs of the patient.
C. In a timely manner.
D. Coordinated through multidisciplinary team collaboration.
E. 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

Social 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, Social 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

- b64_b01eacdd-baa3-4bad-b52a-369aa8460c87
- Image 1
- Social Services Manager

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	04/2025
Policy Owner	Troy Scott: Director Case Management	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17861287**

Last Approved N/A

Next Review 3 years after approval

Owner David Thompson: Director Nursing

Area Emergency Department

Triage Assessment

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To maximize efficient patient flow and to effectively sort and prioritize patient care.

III. DEFINITIONS

A. **Emergency Severity Index (ESI)**. A clearly defined and copy-righted five level triage system designed to yield rapid, reproducible and clinically relevant stratification of ED patients into five groups.

B. **LEVEL 1** – Level 1 patients are critically ill and require immediate MD evaluation and life-saving intervention.

1. Examples of patients that fall into ESI Level I:
    a. Cardiac arrest
    b. Respiratory arrest.
    c. Severe respiratory distress.
    d. Critically injured trauma patient who presents unresponsive
    e. Overdose with a respiratory rate of 6
    f. Severe respiratory distress with agonal or gasping type respiration
    g. Severe bradycardia or tachycardia with signs of hypo-perfusion
    h. Hypotension with signs of hypo-perfusion
    i. Trauma patient who requires immediate crystalloid and/or colloid resuscitation
    j. Anaphylactic reaction

k. Baby that is flaccid
l. Unresponsive with strong odor or ETOH
m. Hypoglycemia with a change in mental status

C. **LEVEL 2** – Level 2 patients present with a high risk situation whose condition is at higher risk for deterioration or a patient who presents with symptoms suggestive of a condition requiring time sensitive treatment. Although the physician does not need to be present immediately, he or she will prioritize examining patients with ESI level 2 before lower acuity patients (ESI 3, 4, 5). Higher risk patients and more time sensitive conditions will take priority over other patients assigned at an ESI level 2. This will be done at the discretion of the emergency department physician.
    1. Examples of patients who fall into this category are:
        a. Active chest pain, suspicious for coronary syndrome
        b. Extremity with (+) deformity and (-) CSM
        c. Amputation
        d. Signs of a shock, but does not meet Level 1 criteria
        e. A possible ectopic pregnancy, hemodynamically stable
        f. A patient on chemotherapy, immunocompromised with fever
        g. A suicidal or homicidal patient
        h. Pediatric patient 1-28 days old with fever over 100.4F

D. **LEVEL 3** – Level 3 patients are predicted to require two or more resources as defined in III.G. Estimate of resources is dependent on emergency standards of care, not on current volume or acuity of patients, nurse or provider staffing, or available resources. Consider up-triage when vital signs are outside normal parameters, there is significant past medical history, or significant history of present illness.

E. **LEVEL 4** – Level 4 patients are predicted to require only one resource as defined in III.G.

F. **LEVEL 5** – Level 5 patients are predicted to require zero resources as defined in III.G.
    1. Examples of patients that fall into ESI Level 5:
        a. Work notes
        b. Ear pain, afebrile
        c. Simple wound check
        d. Prescription refills
        e. Dental pain
        f. Dressing changes
        g. Simple rash w/o fever
        h. Blood Exposure – intact skin

G. **Resources**
    1. Labs (blood, urine)
    2. Throat or wound culture

3. ECG, X-rays, CT-MRI-Ultrasound, angiography
4. IV fluids (hydration)
5. IV, IM, or nebulized medications
6. Specialty consultation
7. Simple procedure = 1 (lac repair, Foley cath)
8. Complex procedure = 2 (conscious sedation)

H. The following are NOT considered "resources" for ESI triage

1. History and physical exam (including pelvic)
2. Point-of-care testing (BG chem)
3. Saline lock
4. PO medications, Tetanus immunization, Prescription refills
5. Phone call to PCP
6. Simple wound care (dressing, recheck)
7. Crutches, splints, slings

IV. GENERAL INFORMATION

A. Triage is performed by an Emergency Department Registered Nurse (RN), who understands and is able to utilize the 5 LEVEL Emergency Severity Index Systems (ESI).

B. Competency is demonstrated and approved by supervising personnel or preceptor.

C. Triage will be performed on patients when there is a delay in performing a medical screening exam.

V. PROCEDURE

A. **Triage Process**

1. Triage is a process that may occur anywhere deemed safe and appropriate, providing all the necessary components are met. The triage process will take place twenty-four (24) hours a day, seven (7) days a week. The triage process incorporates aspects of the scientific method, diagnostic reasoning and critical thinking, as well as demonstrated competency in the ESI system. The nurse examines the patient's condition and potential for deterioration or complications, based on history and physical findings. Four (4) basic components of triage include (ENA, 1992):
    a. A visual assessment
    b. The triage history
    c. Physical assessment and vital signs as deemed necessary, based on history of present illness and clinical presentation
    d. The triage decision

B. **Visual Assessment**

1. A rapid visual assessment includes the following components:

a. Airway
b. Breathing
c. Circulation
d. Disability or neurologic status

2. The patient's general appearance and ABCD are assessed on initial contact and assessed with every interaction. Any significant deviation from normal may require immediate intervention. (If life threatening intervention is required, further assessment does not proceed until the patient receives appropriate treatment). The triage nurse must quickly respond to changes in patient conditions and to changing priorities to provide effective care for the individuals presenting to and awaiting care in the Emergency Department.

C. **Triage History**

1. The stated complaint is a brief one-line statement in the patient's words, describing the reason for seeking medical care.
2. The chief complaint is determined by the Triage RN and will guide the patient's assessment. Pertinent subjective/objective data is obtained as applicable including:
    a. Precipitating event and timing of onset of symptoms
    b. Location of problem
    c. Description of problem (nature, character, quality, severity, and effect on the patient)
    d. Mechanism of injury, if applicable
    e. Progression of symptoms from onset to arrival
    f. Past medical, surgical, pregnancy history, last normal menstrual period, immunization status, allergies, and current medications. **This data collection may be delegated to the primary RN or may be omitted if it will delay obtaining a medical screening exam.**

D. **Triage Physical Assessment**

1. Collect accurate and pertinent objective data as applicable to the patient's condition, including:
    a. Vital signs
    b. Weight must be entered in kilograms. Stated or estimated weights are not acceptable for patients under the age of twelve (12).
    c. Pain level
    d. Other assessment as judged necessary by Triage RN to aid the triage decision.

E. **The Triage Decision**

1. patients will be assigned to a LEVEL based upon the RN's triage assessment using the ESI algorithm. This categorization will guide the prioritization of care.
2. **Important to Consider**:

a. The triage RN will utilize the rapid, systematic collection of data and their assessment skill to determine ESI level.

b. Opportunity to implement pertinent independent nursing interventions such as elevation or injured limb, immediate rooming, application of dressing/ pressure to bleeding wound should be maximized.

c. Diagnostic procedure and treatments, as outlined in the Emergency Department Standardized Procedures may be implemented.

F. **Reassessment**

1. It is the responsibility of the triage RN to maintain or delegate over-sight of all patients in the waiting room.
2. After the initial triage decision is made, some patients may need to be directed to the waiting room. Any significant symptoms should be reassessed for change that could reorder the prioritization of the patient's care.
3. The triage nurse should advise patients to return to the triage area for worsening symptoms.
4. Until the patient is seen by a qualified provider, all patients will be reassessed as needed, according to standards related to ESI Level.

G. **Immediate Implications based on Triage Decision**

1. LEVEL 1 patients are immediately placed in a treatment area, protocols initiated and physicians and charge nurse notified of need for emergent evaluation.
2. LEVEL 2 – The charge nurse will be notified with regard to the status of a LEVEL 2 patient. This patient will be prioritized and placed in an appropriate treatment area before other patients with ESI levels 3, 4, or 5.
3. LEVEL 3 patients that are not placed in a treatment area will be monitored by the triage nurse. Every effort will be made to room promptly based on appropriate treatment space availability.
4. LEVEL 4 and LEVEL 5 patients will be evaluated by the Physician/Physician Assistant after LEVEL 1, LEVEL 2 and LEVEL 3 patients have been assessed and treatment is underway. Level 4 and 5 patients should be considered for placement in rapid medical care or alternate treatment areas whenever possible.
5. In the event that a treatment room is unavailable for patients designated an ESI score of one (1) or two (2), the triage RN will continue to reassess and update vital signs as appropriate for the patient's presenting emergency medical condition.

H. **Triage Overload**

1. When three (3) or more patients are pending triage, a second triage RN will be assigned. Staff breaks will be delayed if necessary until triage is safely decompressed. Triage nurses may enlist the help of Clinical Assistants to perform vital signs during triage overload.

I. **Documentation:**

1. All collected data, assessment and intervention will be documented in the EDM Electronic Patient Record.

VI. EDUCATION/TRAINING

A. **Criteria for Triage Nurse assignment**

1. At least two years of Emergency Department experience or Leadership approval

B. **Training**

1. For initial training:
    a. Completion of the 'Emergency Severity Index Triage (ESI)' Class and post-test
    b. Eight hours of orientation hours in Triage
2. Ongoing Auditing/Training:
    a. Annual Triage e-learning
    b. Ongoing training as needed
    c. Auditing
        i. Perform triage audits quarterly and provide RN feedback

VII. REFERENCES

A. ENA (1997) *Triage: Meeting the Challenge*. Park Ridge, IL: Author.

B. Gilboy N, Tanabe P, Travers DA, Rosenau AM, Eitel DR. *Emergency Severity Index, Version 4. Implementation Handbook.* AHRQ Publication No. 05-0046-2, May 2002. Agency for Healthcare Research and Quality, Rockville, MD.

C. AHA (2002) Emergency Department Overload: A growing crisis. *Medical Benefits* 19(19)8.

D. Stone, E., & Wolf, L. (2018). Triage Qualifications and Competency Position Statement. Retrieved from ENA University: https://enau.ena.org/Users/LearningActivity/LearningActivityDetail.aspx?LearningActivityID=qlnHTYj4O7tn0kaU%2BnHtIg%3D%3D&tab=4

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	05/2025
ED Service	Cristina Martinez: PHYSICIAN	04/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	David Thompson: Director Nursing	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17238555**

Last Approved	N/A
Next Review	3 years after approval
Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep
Area	Cardiology Departments

Use of Ultrasound Enhancement with Echocardiography

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. N/A

III. DEFINITIONS

A. **Ultrasound enhancing agent** is an image enhancement agent which is an injectable suspension composed of an inert gas, which is encapsulated by a synthetic blend of phospholipids or albumin. When injected into a vein the micro bubbles reflect sound waves providing improved ultrasound images of the heart.

IV. GENERAL INFORMATION

A. A physician and/or cardiac sonographer will determine the need for ultrasound enhancement based on one or more of the following criteria:

1. The use of an enhancing agent is ordered by a physician.
2. Imaging is determined to be suboptimal, if there is an inability to detect two or more contiguous segments in any three of the apical windows and improved delineation of endocardial borders at rest or with exercise is necessary to ensure completeness and quality.
3. Imaging is inadequate for quantification of chamber dimensions, volumes, ejection fraction, intra-cardiac masses, thrombi or apical abnormalities (HCM apical variant,

non-compaction, aneurysm, and pseudo-aneurysm). Inadequate Doppler signals in the systemic circulation.

V. PROCEDURE

A. The cardiac sonographer will verify the order specifies the use of an enhancing agent. If the determination for need is made by the sonographer, the order will be modified.

B. The cardiac sonographer, registered nurse or physician will review the patients' history to assess for contraindications:

1. Known or suspected hypersensitivity to perflutren
2. The setting of acute coronary syndrome
3. Acute myocardial infarction
4. Unstable heart failure

C. The cardiac sonographer, registered nurse or physician will explain the procedure to the patient.

D. Perflutren Lipid Microsphere (Definity) can be administered directly into any intravenous line (CVC, PICC, Port-a-Cath or PIV).

E. The cardiac sonographer, registered nurse or physician will administer the enhancing agent according to the manufacturer's directions.

1. Verify IV patency or coordinate with nursing to obtain IV access.
2. Cardiac Sonographer can administer via peripheral access only.
   Perflutren Lipid Microsphere (Definity)
3. Activate perflutren lipid microsphere by shaking the vial for 45 seconds using the Vialmix.
4. Draw up 8.7mL of preservative free sterile saline into a 10cc syringe.
5. Draw up the contents of the vial into the 10cc syringe with a vented vial adapter 13mm or 18 to 20 gauge needle.
6. Administer up to 1-3 mL (as directed by the sonographer) IV push of the diluted solution slowly.
7. If images are not optimal, administer an additional 1-2 mL repeating as needed until images are optimal or a total of 10mL of diluted solution has been administered (as directed by the sonographer).
8. The prepared diluted bolus of Definity can be used up to 12 hours by resuspending with 10 seconds of hand agitation
9. If the vial is activated but not used, write expiration date and time on the vial and refrigerate up to 36 hours. Follow the steps of reactivation.

F. Order Entry:

1. Echo Complete with Contrast, Echo Limited with Contrast, Stress Echo with Contrast, Stress Echo Pharmacological with Contrast, Transesophageal Echo with Contrast

G. Documentation:

1. The sonographer will document suboptimal baseline images, the use of the enhancing agent and amount administered
2. The reading cardiologist will document the use of contrast and any related events in the final echocardiography procedure report.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Bhatia, V. K., Senior, R. (2008). Contrast Echocardiography: Evidence for Clinical Use. *Journal of the American Society of Echocardiography*. (21) 409-414.

B. Porter et al. Guidelines for the Cardiac Sonographer in the Performance of Contrast Echocardiography: A Focused Update from the American Society of Echocardiography. Journal of the American Society of Echocardiography 2014; 27:797-810.

C. Porter, T.R., Mulvaugh, L.L., Abdelmoneim, S.S., (2018). Clinical Applications of Ultrasonic Enhancing Agents in Echocardiography: 2018 American Society of Echocardiography Guidelines Update. Journal of the American Society of Echocardiography, Vol 31 (Issue 3) pages 241-274.

D. Porter, T.R., Abdelmoneim, S.S., J.T., (2014). Guidelines for the Cardiac Sonographer in the Performance of Contrast Echocardiography: A Focused Update from the American Society of Echocardiography. Journal of the American Society of Echocardiography, Vol 27 (issue 8) pages 797-810.

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	04/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16809836**

Origination	08/2021	Owner	Aaron Burnsides: Director Information Technology
Last Approved	N/A	Area	Information Technology
Next Review	3 years after approval		

Virtual Private Network

I. POLICY STATEMENT

A. This policy applies to all Salinas Valley Health employees, contractors, physicians, consultants and others including all personnel affiliated with third parties utilizing VPNs to access the Salinas Valley Health network.

II. PURPOSE

A. The purpose of this policy is to provide guidelines for Remote Access via Virtual Private Network (VPN) connections to the Salinas Valley Health enterprise network.

III. DEFINITIONS

A. VPN – (Virtual Private Network) A virtual private network (VPN) is a way to use a public telecommunication infrastructure, such as the Internet, to provide remote offices or individual users with secure access to their organization's network.

B. Remote Access – Access to the Salinas Valley Health internal network via any off-site or remote connection.

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. VPN connections will only be configured on a static basis for clinics, offices, physicians, and vendor partners using point-to-point connections.

B. VPN connections must meet an operational need of Salinas Valley Health that outweighs the risk of the VPN connection.

C. VPN connections that no longer serve a business function should be terminated.

D. Access across the VPN is to be restricted to the minimum amount of access necessary.

E. The establishment of a temporary or mobile VPN is not supported or allowed. Any existing usage will be required to transition to approved remote access methods.

F. Salinas Valley Health IT will create, post, and maintain a standard with technical requirements. These requirements must be met for setting up new VPN connections.

G. General remote access for users is governed under the Salinas Valley Health Access Management of Information Systems policy.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. The Joint Commission, Information Management Standards IM.2.01.03 (the hospital maintains the security and integrity of health information), IM.2.02.03 (the hospital retrieves, disseminates, and transmits health information in usable formats.)

B. Health Insurance Portability and Accountability Act (HIPAA), Administrative Simplifications, Standards for Privacy of Individually Identifiable Health Information, Part 164 – Security and Privacy, Sub Part E; Rules 164.502, 164.504.0, 164.518 (c).

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Aaron Burnsides: Director Information Technology	04/2025

Standards

No standards are associated with this document

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

COMMITTEE VACANCIES

(VERBAL)

(HERNANDEZ LAGUNA)

QUALITY AND EFFICIENT

PRACTICES COMMITTEE

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

(CATHERINE CARSON)

PERSONNEL, PENSION & INVESTMENT COMMITTEE

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

(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 of Directors to Award Construction Contract to SSB Contracting for the Renovations to the DRC Annex in support of the EPIC Training Rooms**
Executive Sponsor:	Clement Miller, Chief Operating Officer Alysha Hyland, Chief Administrative Officer
Date:	May 9, 2025

Executive Summary

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

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

The renovations to the 5 Lower Ragsdale building involve minor renovations to optimize three existing rooms to support training staff. The renovations are anticipated to complete early September.

Facilities Management approached the Board and received approval in March 2025 for capital funding for planning, design, permitting, construction in the total amount of $2,890,000. Facilities Management is now returning to the Board to recommend award of construction contract to SSB Contracting in the amount of $1,484,108.

Background/Situation/Rationale

A publicly advertised request for contractor bids for construction services closed on May 7, 2025 and resulted in a bid from a responsible and responsive bidder, SSB Contracting. Design and engineering meetings, consultant coordination, inspections, testing and certifications will continue throughout upcoming construction to deliver the renovations in an expedited manner.

Pillar/Goal Alignment

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

Timeline

May 2025 – Commence construction
July 2025 – Complete construction of conference rooms
August 2025 – Complete construction of toilet rooms

Financial Implications

Budget: As currently programmed, the project cost estimate is $2,890,000 with funding allocated for planning, design, engineering and construction of the renovations, permitting, project contingency, design assistance from the IT team, program management, and construction service estimates required to complete the project.

Current capital budget forecast includes:
Fiscal Year 2025 - $300,000
Fiscal Year 2026 - $2,590,000

Following completion of construction closeout, the budget will be reconciled to account for actual costs.

Recommendation

Consider Recommendation for Board of Directors to award the contract for construction to SSB Contracting, Inc. in the total amount of $1,484,108.

Attachments

Attachment 1: SSB Contracting Bid Submission May 7, 2025

SECTION 00 41 00

SCHEDULE OF BID PRICES

1.01 GENERAL INSTRUCTIONS

A. Bidders are directed to submit a lump sum price for all Work set forth in the Contract Documents in the space for the "Base Bid" amount in the Schedule of Bid Prices. This lump sum shall include all costs for labor, materials, tools, equipment, services, subcontractors, suppliers, taxes, insurance, shipment, delivery, overhead, profit and all other costs necessary to perform the Work in accordance with the Contract Documents. ***Contractor should assume that activities associated with utility shutdowns (mechanical, electrical, plumbing and technology) will be required during off-hours throughout the course of the Project. Any overtime costs arising in conjunction with these activities are included in the Contractor's Base Bid.***

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

SALINAS VALLEY HEALTH
EPIC TRAINING FACILIY & RESTROOM IMPROVEMENT – DRC ANNEX BASEMENT

SCHEDULE OF BID PRICES

BASE BID – ITEM A:

Contractor shall provide any and all materials, labor, tools, equipment and superintendence necessary to complete this project for the following amount. Contractor shall provide Contractor's profit and overhead for all allowance items identified below in the Base Bid. If costs incurred exceed allowance item, Contractor shall be allowed to mark up the difference between the allowance and actual by a maximum of 5%. If the actual cost is less than the allowance item, Contractor shall credit the Owner the difference, including profit and overhead added to item "A". Base Bid pricing shall include costs of phased construction as needed to achieve completion of the work as defined in the contract documents.

Contractor shall include in their base bid sufficient funding to provide coordination and superintendence necessary to install and commission specialty packages purchased directly by the owner, to include, but not be limited to: a) low voltage cabling systems for internet, phone and access control; b) low voltage cabling & equipment installations associated with audio/visual packages (designed/furnished/installed by others); c) below carpet data cable raceways (designed/furnished/installed by others); d) fire alarm system installations (designed/furnished/installed by others) and e) folding partitions (furnished/installed by others). Owner furnished package deliveries to be coordinated to align with requirements of the Contractor's Master Schedule. Refer also to SUPPLEMENTAL CONDITION Section 00 81 00.

"A" $ 1,464,108.00

ALLOWANCE - ITEM B:

Contractor shall include an allowance of $20,000 in their bid to provide any and all materials, labor, tools, equipment, transportation and superintendence necessary to address and rectify Discovered Conditions cited by the Authority Having Jurisdiction during construction. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"B" $ **20,000.00**

COMPENSABLE DELAY AMOUNT – ITEM C:

Contractor shall provide all materials, labor, tools, equipment and superintendence necessary to complete any additional work required as a result of non-Contractor caused delays for the following amount. See also SUPPLEMENTAL CONDITION Section 00 83 00, item 1.02:

$ $2,500.00 per day x 10 days delay (est.) = "C" $ $25,000.00

GRAND TOTAL BID PRICE:

Base bid plus total (**A + B + C**)

TOTAL BID PRICE: $ 1,509,108.00

END OF SECTION 00 41 00

SECTION 00 40 00

BID FORMS

PART 1 - GENERAL

1.01 INSTRUCTIONS TO BIDDERS

A. Bid Forms shall be completed in accordance with the directions herein and the directions indicated in Section 00 10 00, "Notice Inviting Bids"; Section 00 20 00, "Instructions to Bidders"; and Section 00 41 00, "Schedule of Bid Prices," of the Contract Documents.

1.02 BID FORMS

A. Due on or before the date of Bid Opening

Each of the following Bid Forms must be completed as part of each Bidder's bid and shall be submitted before the specified time and date of the Bid Opening as identified in Section 00 10 00, "Notice Inviting Bids", of the Contract Documents.

1. Bid Letter (including acknowledgement of receipt of Addenda)
2. List of Subcontractors
3. Disqualification Questionnaire
4. Acknowledgement of Insurance Requirements
5. Bidder's Guaranty: Bidder's Bond or Irrevocable Standby Letter of Credit
6. Non-Collusion Certification
7. Bidder's Request for Information

BID LETTER
FOR THE SALINAS VALLEY MEMORIAL HOSPITAL

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

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

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

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

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

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

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

ADDENDA NOS. (if none, so state): Addenda A, 4/28/25

Name of Bidder: SSB Contracting, Inc.

Business Address: 1161 Terven Ave. Salinas, CA 95020

Phone: (831) 424.1647 Fax: (831) 424.4401

Contractor's License No. 191651

License Expiration Date 11/30/2026

Classification Type B, C-33, C-39, C-51

If SOLE OWNER, sign here:

I sign as sole owner of the business named above:

_____

If PARTNERSHIP, one or more partners sign here:

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

_____

_____

If CORPORATION, execute here:

Corporate Name: SSB Contracting, Inc.

Incorporated under the laws of the State of CA

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

By _____
*Signature of Authorized Official**

President
Title

Stephen Goldman
Typewritten or Printed Name

By _____
*Signature of Authorized Official**

Secretary
Title

Stephen Goldman
Typewritten or Printed Name

If JOINT VENTURE, execute here:

Joint Venture name composed of: _____

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

_____
*Signature of Authorized Official**

_____
Title

_____
Typewritten or Printed Name

_____
*Signature of Authorized Official**

_____
Title

_____
Typewritten or Printed Name

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

END OF BID LETTER

LIST OF SUBCONTRACTORS

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

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

NAME OF SUBCONTRACTOR	LICENSE NUMBER AND DIR REG NO.	LOCATION OF/ PLACE OF BUSINESS	PORTION OF WORK
1. Brady West, Inc.	CSLB #1098648 DIR#PW-LR-100989702	Castroville, CA	Framing, Drywall, Tbar
2. Val's Plumbing	CSLB #236164 DIR#1000002438	Salinas, CA	HVAC/Plumbing
3. D. S. Baxley, Inc.	CSLB #858554 DIR#100008534	Livermore, CA	Flooring
4. Visalia Ceramic Tile	CSLB #481599 DIR#1000000896	Visalia, CA	Tile
5. JM Electric	CSLB #376938 DIR#1000000800	Salinas, CA	Electrical
6.Monterey Struc. Steel	CSLB #846534 DIR#1000003301	Watsonville, CA	Metals
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

END LIST OF SUBCONTRACTORS

DISQUALIFICATION QUESTIONNAIRE

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

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

Yes _____ No X

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

NAME OF BIDDER: SSB Contracting, Inc.

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

END OF DISQUALIFICATION QUESTIONNAIRE

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

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

a) Workers' Compensation (per statutory requirement).

Policy shall include a waiver of subrogation.

b) Employer's Liability coverage.

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

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

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

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

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

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

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

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

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

Principal — 5/7/25

Signature of Bidder/Title — Date

END OF ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

BIDDER'S BOND

KNOW ALL PERSONS BY THESE PRESENTS:

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

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

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

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

Dated May 6th, 2025.

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

SSB Construction
Principal

By: _____

Great American Insurance Company
Surety

By: Rosa E. Rivas
Rosa E. Rivas, Attorney-In-Fact

301 E. 4th Street, Cincinnati OH 45202
Address of Surety

END OF BIDDERS BOND

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

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

State of California

County of Orange

On 05/06/2025 before me, Becky Gomez, Notary Public, personally appeared Rosa E. Rivas who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is/~~are~~ subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature~~(s)~~ on the instrument the person~~(s)~~, or the entity upon behalf of which the person~~(s)~~ acted, executed the instrument.

BECKY GOMEZ
Notary Public - California
Orange County
Commission # 2455974
My Comm. Expires Jul 30, 2027

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

WITNESS my hand and official seal.

Signature Becky Gomez
Signature of Notary Public

GREAT AMERICAN INSURANCE COMPANY®

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

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

No. 0 21795

POWER OF ATTORNEY

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

Name	Address	Limit of Power
ROSA E. RIVAS MEGHAN HANES TRACY ASTON RENATO F. REYES SAMANTHA RUSSELL	ALL OF LOS ANGELES, CALIFORNIA	ALL $100,000,000

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

IN WITNESS WHEREOF the GREAT AMERICAN INSURANCE COMPANY has caused these presents to be signed and attested by its appropriate officers and its corporate seal hereunto affixed this 12TH day of MAY , 2022

Attest

GREAT AMERICAN INSURANCE COMPANY

Assistant Secretary

Divisional Senior Vice President

MARK VICARIO (877-377-2405)

STATE OF OHIO, COUNTY OF HAMILTON - ss:

On this 12TH day of MAY , 2022 , before me personally appeared MARK VICARIO, to me known, being duly sworn, deposes and says that he resides in Cincinnati, Ohio, that he is a Divisional Senior Vice President of the Bond Division of Great American Insurance Company, the Company described in and which executed the above instrument; that he knows the seal of the said Company; that the seal affixed to the said instrument is such corporate seal; that it was so affixed by authority of his office under the By-Laws of said Company, and that he signed his name thereto by like authority.

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

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

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

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

CERTIFICATION

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

Signed and sealed this 6th day of May , 2025.

Assistant Secretary

S1029AH (03/20)

NONCOLLUSION AFFIDAVIT TO BE EXECUTED BY BIDDER AND SUBMITTED WITH BID

The undersigned declares:

I am the Principal of SSB Contracting, Inc., the party making the foregoing bid.

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

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

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration is executed on 5/7/25 [date], at Salinas [city], CA [state]."

Signature of Bidder

Principal
Title

5/7/25
Date

END OF NON-COLLUSION AFFIDAVIT

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation to the Board to Approve Updated Project Budget and Award Construction Contract to FTG Builders, Inc. for the Salinas Valley Health Medical Center Catheterization Laboratory and Interventional Radiology Equipment Replacement Project**

Executive Sponsor: Clement Miller, Chief Operating Officer
Megan Giovanetti, Director of Cardiovascular Services and Sleep Medicine
John Kazel, Director of Imaging Services

Date: May 12, 2025

Executive Summary

Facilities Management is returning to the Board to recommend approval of the original capital funding to complete the design, construction and implementation required for the Cardiac Catheterization (Cath) Lab 3 and Interventional Radiology (IR) Lab Equipment Replacement project. Fiscal years 2024, 2025, and 2026 routine capital budget allocated funding for planning, design, and construction activities. In May of 2024, the Finance Committee and Board approved funding for planning, design, and major medical equipment in the amount of $8,441,153. The total estimated project cost for the project is $11,406,437.

The Cath Lab and the Interventional Radiology Lab are critical areas for treating patients with heart disease, peripheral vascular disease and many other diseases of the vascular, gastrointestinal, hepatobiliary, genitourinary, pulmonary, and musculoskeletal system. As a ST Elevation Myocardial Infarction (STEMI) receiving center, Salinas Valley Health (SVH) is required to maintain fully operational catheterization labs. The fluoroscopy equipment in Cath Lab 3 and IR Lab has reached end of useful life and will no longer be serviceable by the vendor (Siemens) as of December 31, 2025. Current project planning encompasses full replacement of existing equipment and building components within the procedure and control rooms. All planned renovations require a building permit from California's Department of Health Care Access and Information (HCAI).

Background/Situation/Rationale

The Interventional Radiology Lab and Cath Lab 3 are operating with equipment that has reached its end of useful life. Critical fluoroscopy equipment, serviced by Siemens, will no longer be supported after December 31, 2025. Beyond the imaging systems, supporting infrastructure in the procedure and control rooms (workstations, cabinetry, storage, lighting, etc.) is outdated and inadequate for current clinical needs. A comprehensive renovation of these rooms is required to meet contemporary regulations and support the range of procedures performed, including structural heart, peripheral vascular, and cardiac catheterization. Upgrading the imaging equipment in both suites will also provide essential capacity for growth in endovascular cardiac and vascular service lines.

On March 21, 2025, a public request for contractor bids to secure construction services was advertised in the Californian and Central Coast Builder's Exchange (Attachment 1). Additionally, a bid outreach to attract all qualified general contractors and subcontractors in the local and regional areas was performed. The bid period closed on April 25, 2025, with a bid identifying FTG Builders, Inc. as the lowest responsible and responsive bidder (Attachment 2).

Materials Management facilitated negotiations with Philips Healthcare and JM Keckler to secure contracts for capital equipment. This process included a thorough due diligence review, ensuring that the obtained pricing was at or below industry standards.

Timeline/Review Process:

March 2025 – April 2025 – Bid process & contractor selection
May 2025 – Award and execute construction contract
June 2025 – Issue notice to proceed to contractor (dependent on HCAI permit issuance)
Summer 2025 – Commence IR construction activities
Fall 2025 – Complete IR construction activities and commence Cath Lab 3 construction activities
March 2026 – Complete Cath Lab 3 construction activities

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

The financial impact from preliminary design to present is driven by several key design changes and discovered conditions. Notably, suppliers are exhibiting increased caution in their proposals and commitments due to the tariff variability. To improve procedural workflows and functionality, the equipment design revised from floor-mounted to a ceiling-mounted system. Furthermore, the required upgrade of both Cath Lab 3 and IR Lab to Class 3 standards necessitates design modifications. The mechanical system redesign increases air exchanges and minimizes impacts on critical, high-demand department wide storage space. While the cost bases of another project provided a reference point, the distinct conditions encountered by this project have collectively shaped its overall design and associated costs.

Total Planned Capital Budget(s)	$11,406,437
Construction	$4,057,063
Medical & Fixed Equipment	
IR Suite (CIP 01.1250.3760)	$2,205,144
Cath Lab 3 (CIP 01.1250.3765)	$2,362,623
Non-Medical Equipment	
IR Suite (CIP 01.1250.3760)	$361,435
Cath Lab 3 (CIP 01.1250.3765)	$335,613

Recommendation

Consider recommendation to Board of Directors to (i) approve the total estimated project cost for the SVH and Catheterization Laboratory and Interventional Radiology Equipment Replacement Project(s) in the budgeted amount of $11,406,437, an increase $2,965,284 over the previous board action in the amount of $8,441,153 (ii) award the contract for construction to FTG Builders, Inc. in the total amount of $4,057,063.

Attachments:

- Attachment 1: Proof of Publication of Advertisement for Bids
- Attachment 2: FTG Builders, Inc Contracting Bid Submission April 25, 2025
- Attachment 3: Estimated Project Budget (Cath Lab 3 and IR Lab)

LocaliQ

Salinas Californian

GANNETT

PO Box 631437 Cincinnati, OH 45263-1437

AFFIDAVIT OF PUBLICATION

Accts Payable
Salinas Valley Memorial/Legals
450 E Romie Ln
Salinas CA 93901-4029

STATE OF WISCONSIN, COUNTY OF BROWN

The Salinas Californian, a newspaper published in the city of Salinas, Monterey County, State of California, and personal knowledge of the facts herein state and that the notice hereto annexed was Published in said newspapers in the issue:

03/21/2025

and that the fees charged are legal.
Sworn to and subscribed before on 03/21/2025

Legal Clerk

Notary, State of WI, County of Brown

My commission expires

Publication Cost:	$903.80	
Tax Amount:	$0.00	
Payment Cost:	$903.80	
Order No:	11139382	# of Copies:
Customer No:	1252807	0
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THIS IS NOT AN INVOICE!

Please do not use this form for payment remittance.

RYAN SPELLER
Notary Public
State of Wisconsin

ADVERTISEMENT FOR BIDS

Sealed proposals will be received by Salinas Valley Memorial Healthcare System ("SVMHS") operating as Salinas Valley Health located in Salinas, California, for the furnishing of all labor, materials, equipment and services to SVMHS necessary for and incidental to the construction of:

SALINAS VALLEY HEALTH CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

General Description. Salinas Valley Health is undertaking a comprehensive modernization project to replace imaging equipment and remodel the Catheter Laboratory (Cath Lab) and Angiography (Angio) procedure and control rooms. These facilities are located on the first floor of the Cardiac Center South and Cath Lab Expansion buildings within the main hospital. This project will be managed as a single construction effort, with two distinct project numbers and phases. The first phase will focus on remodeling the Angio procedure room, control room, and ancillary spaces. The second phase will address the Cath Lab procedure room, control room, and associated ancillary spaces. The project will include all necessary activities, coordination, materials, labor, tools, equipment, freight, transportation, superintendence, and project management required for the safe execution of the Work. The Work shall include any and all systems in support of Owner-furnished Cath Lab and Angio equipment, including structural supports, equipment anchorage, electrical and power distribution systems. The Work shall include concrete cutting, coring, filling, patching, and reinforcement per plan. The Work shall include flooring leveling, floating and prep, and flooring installation of flooring and base systems. The Work includes but is not limited to safe-off, demolition, debris and waste removal, replacement, upgrade, and adherence to infection control, temporary power, floor, wall, ceiling, structural supports and anchorage, fire proofing, mechanical, electrical and lighting, low voltage, fire alarm, nurse call, fire sprinkler, plumbing, and medical gas systems, including inspections, testing, air balancing, purity and certification of facilities, services, utilities and equipment, and restroom accessibility compliance.

Bids. Sealed bids will be received by SVMHS at the Construction Office located at 535 E Romie Lane, Suite 6, Salinas, California, until 2:00 p.m. on **April 18, 2025** at which time all bids will be publicly opened. Bids will be referred to a subsequent SVMHS Board of Directors meeting for appropriate action. All Bid Proposals shall be submitted on forms furnished by SVMHS. Bid Proposals must conform with, and be responsive to, the Bid and Contract Documents, copies of which may be obtained from SVMHS as indicated below. Only Bid Proposals submitted to SVMHS prior to the date and time set forth above for the public opening and reading of Bid Proposals shall be considered.

Note: Bids submitted orally or by telephone, electronic transmission (email) or facsimile will be considered invalid and will not be accepted. Each Bid Proposal shall be accompanied by:

1. Bid Letter (including acknowledgement of receipt of Addenda)
2. List of Subcontractors
3. Statement of Bidder's Qualifications
4. Compliance with Immigration Reform and Control Act of 1986
5. Bidder's Guaranty: Bidder's Bond or Irrevocable Standby Letter of Credit
6. Non-Collusion Certification

All information and responses of a Bidder in its Bid Proposal, and other documents accompanying the Bid Proposal, shall be complete, accurate and true. Incomplete, inaccurate, or untrue responses or information provided by a Bidder shall be grounds for SVMHS to reject such Bidder's Bid Proposal as nonresponsive.

Pre-Bid Conference. There will be a non-mandatory pre-bid conference held prior to the date of bid. The conference will take place on **March 28, 2025**, from 10:30 a.m. - 12:00 p.m., in the SVMHS Construction Office located at **535 E. Romie Lane, Suite 6, Salinas, California 93901**. Request to access the hospital for site investigation shall be coordinated through dsullivan@bogardconstruction.com. Bidders and their subcontractors are encouraged to investigate the existing conditions prior to close of the bidding period.

Questions. All requests for interpretation of the drawings and specifications or other questions regarding this project during the bidding process shall be submitted to SVMHS in writing by email with the original copy to follow by mail. No telephone questions will be accepted. All written requests for interpretation (RFIs) or correction of the Contract Documents must be received within ten (10) days of close of bid. Send all pre-bid questions and requests for interpretation to SVMHS via email at: dsullivan@bogard-construction.com.

Bid and Contract Documents. Requests for digital versions of the Documents shall be addressed to Salinas Valley Memorial Healthcare System, Attn: Dave Sullivan (dsullivan@bogardconstruction.com). The Central Coast Builder's Exchange has all bid documents available for Bidders (Visit URL: http://www.ccbabuilds.com/).

Labor & Material Payment and Performance Bonds. The successful bidder will be required to furnish a labor & material payment bond and performance bond equal to one hundred percent (100%) of the Contract Price. Each bond must meet the statutory requirements for a public construction project as set forth in California Civil Code Section 3248. The bonds shall be secured through a surety company approved by SVMHS and paid for by the Prime Contractor.

Bid Acceptance/Rejection. SVMHS reserves the right to reject any or all bids and to waive any informalities in the bidding, or in any bid received. The Contract for the Work, if awarded, will be by action of the SVMHS Board of Directors to the responsible Bidder submitting the lowest responsive Bid Proposal. If Alternate Bid Items are included in the bidding, the lowest priced Bid Proposal will be determined on the basis of the Base Bid Proposal or on the Base Bid Proposal and the combination of Alternate Bid Items selected in accordance with the applicable provisions of the Instructions for Bidders. No bid shall be withdrawn for a period of ninety (90) calendar days subsequent to the opening of bids without the consent of SVMHS.

Contractor License Classification. In accordance with the provisions of California Public Contract Code §3300, SVMHS requires that Bidders have a valid and current class B California Contractors License. Bidders must be properly licensed at the time that the Contract for the Work is awarded and at all times during the Work. Any Bidder not so duly and properly licensed shall be subject to all penalties imposed by law. No payment shall be made for work, labor, materials or services provided under the Contract for the Work unless and until the Registrar of Contractors verifies to SVMHS that the Bidder awarded the Contract is properly and duly licensed to perform the Work.

Prevailing Wage. Minimum prevailing wage rates are required to be paid for each craft, classification, or type of worker needed to execute the Contract. Copies of such minimum rates are on file at the Administration office of SVMHS, and are available to any interested party upon request. See Labor Code Section 1773 et seq.

Dated: March 19, 2025
Salinas Valley Memorial Healthcare System
A Local Health Care District
March 21 2025
LYRK0260677

SECTION 00 41 00

SCHEDULE OF BID PRICES

1.01 GENERAL INSTRUCTIONS

A. Bidders are directed to submit a lump sum price for all Work set forth in the Contract Documents in the space for the "Base Bid" amount in the Schedule of Bid Prices. This lump sum shall include all costs for labor, materials, tools, equipment, services, subcontractors, suppliers, taxes, insurance, shipment, delivery, overhead, profit and all other costs necessary to perform the Work in accordance with the Contract Documents. ***Contractor should assume that activities associated with utility shutdowns (mechanical, electrical, plumbing and technology) will be required during off-hours throughout the course of the Project. Any overtime costs arising in conjunction with these activities are included in the Contractor's Base Bid.***

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

SALINAS VALLEY HEALTH
CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT
SCHEDULE OF BID PRICES

BASE BID:

Contractor shall provide any and all materials, labor, tools, equipment and superintendence necessary to complete this project for the following amount. Contractor shall provide Contractor's profit and overhead for all allowance items identified below in the Base Bid item "A". If costs incurred exceed allowance item, Contractor shall be allowed to mark up the difference between the allowance and actual by a maximum of 5%. If the actual cost is less than the allowance item, Contractor shall credit the Owner the difference, including profit and overhead added to item "A".

"A" $ 3695063.00

ALLOWANCE ITEM B:

Contractor shall include an allowance of $70,000 in their bid to provide any and all materials, labor, tools, equipment, transportation and superintendence necessary to transport, install and commission the low voltage cabling system for internet, phone and access control. Owner shall assign the Contractor to an Owner-selected low voltage C-7 Contractor. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"B" $ **70,000.00**

ALLOWANCE ITEM C:

Contractor shall include an allowance of $90,000 in their bid to provide any and all materials, labor, equipment, transportation and superintendence necessary to install and commission the new fire alarm system supporting the project area. Owner shall assign the Contractor to an Owner-selected fire alarm Contractor for parts, smarts, field coordination and programming. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"C" $ **90,000.00**

ALLOWANCE ITEM D:

Contractor shall include an allowance of $75,000 in their bid to provide any and all materials, labor, tools, equipment, transportation and superintendence necessary to address and rectify Discovered Conditions cited by the Authority Having Jurisdiction during construction. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"D" $ **75,000.00**

ALLOWANCE ITEM E:

Contractor shall include an allowance of $25,000 in their bid to provide any and all materials, labor, tools, equipment, transportation and superintendence necessary to furnish and install access panels and isolation valves to facilitate future maintenance of utilities, as required or requested by the Owner. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"E" $ 25,000.00

ALLOWANCE ITEM F:

Contractor shall include an allowance of $90,000 in their bid to provide any and all materials, labor, tools, equipment, transportation and superintendence necessary to furnish and install future nurse call system including conduit, backboxes, blank plates, cabling, devices, through-penetrations, fire protection, shielding, supports, bracing, framing, programming, testing and certification. Owner shall assign the Contractor to Owner-selected Contractor(s) for nurse call devices, cabling, smarts and programming. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"F" $ 90,000.00

COMPENSABLE DELAY AMOUNT:

Contractor shall provide all materials, labor, tools, equipment and superintendence necessary to complete any additional work required as a result of non-Contractor caused delays for the following amount:

$ 1,200.00 per day x 10 days delay (est.) = **"G" $ 12,000.00**

GRAND TOTAL BID PRICE:

Base bid plus total (**A + B + C + D + E + F + G**)

$ 4057,063.00

END OF SECTION 00 41 00

LIST OF SUBCONTRACTORS

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

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

NAME OF SUBCONTRACTOR	LICENSE NUMBER AND DIR REG NO.	LOCATION OF/ PLACE OF BUSINESS	PORTION OF WORK
1.			
2. A&B Fire Protection and Safety, Inc.	CSLB# 643385 PWCR# 2000007881	Salinas	Fire Protection
3. Summers & Sons Electric, Inc.	CSLB# 553837 PWCR# 1000013422	San Jose	Electrical
4. Cline Glass Contractors, Inc.	CSLB# 472048 PWCR# 1000014057	Fremont	Glazing/Sliding Doors
5. NELCO Worldwide	CSLB# 121427 PWCR# 1000007173	Burlington, MA	Lead Lined Windows
6. Harry L. Murphy, Inc.	CSLB# 145985 PWCR# 1000004204	San Jose	Flooring
7. Unistrut International Corporation (Atkore)	CSLB# 908601 PWCR# 1000025946	Addison, IL	Unistrut System
8. Val's Plumbing and Heating, Inc.	CSLB# 236164 PWCR# 1000002438	Salinas	Plumbing, HVAC, Med Gas Systems
9. Minton Door Company	CSLB# 830681 PWCR# 1000006532	Sunnyvale	Doors
10. Universal Metro	CSLB# 762519 PWCR# 1000014363	Santa Fe Springs	Flooring
11. Coastwide Environmental Technologies, Inc.	CSLB# 523560 PWCR# 1000001357	Watsonville	Demolition/Abatement
12. Benchmark Steel, Inc.	CSLB# 801334 PWCR# 1000028550	Hollister	Structural Steel and Supports
13. B.T. Mancini Co. Inc.	CSLB# 229210 PWCR# 1000002989	Santa Clara	Flooring
14. J&S Metco DBA J&S Metals, Inc.	CSLB# 807257 PWCR# 1000044491	Grants Pass, OR	Lead Drywall
15. Expert Drywall Systems, Inc.	CSLB# 267480 PWCR# 1000005747	San Jose	Metal Stud Framing & Drywall

END LIST OF SUBCONTRACTORS

LIST OF SUBCONTRACTORS

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

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

NAME OF SUBCONTRACTOR	LICENSE NUMBER AND DIR REG NO.	LOCATION OF/ PLACE OF BUSINESS	PORTION OF WORK
16. Acoustic Solutions	CSLB# 920917 PWCR# 1000013257	Fresno	Ceilings/T-Bar
17. WM. B. Saleh Painting, Inc.	CSLB# 468616 PWCR# 1000010542	Fresno	Painting
18. Central Valley Casework, Inc.	CSLB# 837664 PWCR# 1000024021	Madera	Casework
19. N/A			
20. Alcal Specialty Contracting, Inc.	CSLB# 815286 PWCR# 1000000315	Sacramento	Insulation/Firestopping/ Fireproofing
21. California Roofing Co, Inc.	CSLB# 174900 PWCR# 1000007161	San Jose	Roofing
22. Bess Testlab, Inc.	CSLB# 817532 PWCR# 1000007058	Hayward	Concrete Scanning/GPR
23. Cal Med Installations, LLC	CSLB# N/A PWCR# 2000002469	Salinas	Medical Equipment Removal and Off-haul
9.			
10.			
11.			
12.			
13.			
14.			
15.			

END LIST OF SUBCONTRACTORS

BID LETTER
FOR THE SALINAS VALLEY MEMORIAL HOSPITAL

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

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

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

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

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

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

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

ADDENDA NOS. (if none, so state): A & B

Name of Bidder: FTG Builders, Inc.

Business Address: 1565 Lafayette St.
Santa Clara, CA., 95050

Phone: 669-231-0010 Fax: 669-231-0011

Contractor's License No. 754647

License Expiration Date 04/30/2027

Classification Type A & B

If SOLE OWNER, sign here:

I sign as sole owner of the business named above:

_____

If PARTNERSHIP, one or more partners sign here:

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

_____

_____

If CORPORATION, execute here:

Corporate Name: FTG Builders, Inc.

Incorporated under the laws of the State of California

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

By _____
*Signature of Authorized Official**

President
Title

Rodney E. Terra, Jr.
Typewritten or Printed Name

By _____
*Signature of Authorized Official**

Chief Financial Officer
Title

Sergio Ruiz
Typewritten or Printed Name

If JOINT VENTURE, execute here:

Joint Venture name composed of: _____

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

_____
*Signature of Authorized Official**

_____
Title

_____
Typewritten or Printed Name

_____
*Signature of Authorized Official**

_____
Title

_____
Typewritten or Printed Name

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

END OF BID LETTER

DISQUALIFICATION QUESTIONNAIRE

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

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

Yes _____ No X

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

NAME OF BIDDER: FTG Builders, Inc.

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

END OF DISQUALIFICATION QUESTIONNAIRE

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

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

a) Workers' Compensation (per statutory requirement).

Policy shall include a waiver of subrogation.

b) Employer's Liability coverage.

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

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

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

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

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

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

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

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

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

President — 04/25/2025

Signature of Bidder/Title — Date

END OF ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

BIDDER'S BOND

KNOW ALL PERSONS BY THESE PRESENTS:

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

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

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

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

Dated April 16, 2025.

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

FTG Builders, Inc.
Principal

By: _____

The Great American Insurance Company
Surety

By: _____
Jody Nelson, Attorney-In-Fact

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

END OF BIDDERS BOND

GREAT AMERICAN INSURANCE COMPANY®

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

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

No. 0 22516

POWER OF ATTORNEY

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

Name	Address	Limit of Power
JAMES UNTIEDT	BOTH OF	BOTH
JODY NELSON	SAN JOSE, CALIFORNIA	$100,000,000.00

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

IN WITNESS WHEREOF the GREAT AMERICAN INSURANCE COMPANY has caused these presents to be signed and attested by its appropriate officers and its corporate seal hereunto affixed this 29TH day of JULY , 2024 .

Attest

GREAT AMERICAN INSURANCE COMPANY

Assistant Secretary

Divisional Senior Vice President

MARK VICARIO (877-377-2405)

STATE OF OHIO, COUNTY OF HAMILTON - ss:

On this 29TH day of JULY , 2024 , before me personally appeared MARK VICARIO, to me known, being duly sworn, deposes and says that he resides in Cincinnati, Ohio, that he is a Divisional Senior Vice President of the Bond Division of Great American Insurance Company, the Company described in and which executed the above instrument; that he knows the seal of the said Company; that the seal affixed to the said instrument is such corporate seal; that it was so affixed by authority of his office under the By-Laws of said Company, and that he signed his name thereto by like authority.

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

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

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

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

CERTIFICATION

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

Signed and sealed this 16 day of April , 2025 .

Assistant Secretary

S1029AH (03/20)

CALIFORNIA ACKNOWLEDGMENT CIVIL CODE § 1189

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

State of California
County of Santa Clara

On 04-11-2025 before me, C Reynolds, Notary Public,
Date *Here Insert Name and Title of the Officer*

personally appeared Jody Nelson
Name(s) of Signer(s)

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

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

Place Notary Seal and/or Stamp Above

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

WITNESS my hand and official seal.

Signature _____
Signature of Notary Public

OPTIONAL

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

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

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

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

NONCOLLUSION AFFIDAVIT TO BE EXECUTED BY BIDDER AND SUBMITTED WITH BID

The undersigned declares:

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

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

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

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration is executed on 04/25/2025 [date], at Santa Clara [city], California [state]."

Signature of Bidder

President
Title

04/25/2025
Date

END OF NON-COLLUSION AFFIDAVIT

SALINAS VALLEY HEALTH MEDICAL CENTER

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
Salinas, California

ADDENDUM A
TO THE BID DOCUMENTS FOR
SALINAS VALLEY HEALTH CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

ISSUED: April 1, 2025

This Addendum A must be signed by the bidder and included in the bid documents submitted for this Project. Salinas Valley Memorial Healthcare System reserves the right to disregard any bid, which does not include this Addendum A. Salinas Valley Memorial Healthcare System may waive this requirement at its sole discretion.

SEE ATTACHED ADDENDUM ITEMS

Prepared By:

Shane Murphy

Shane Murphy
SVMHS Designated Representative

BIDDER'S CERTIFICATION

I acknowledge receipt of this Addendum A and accept all conditions contained herein.

Bidder's Signature

4/25/2025
Date

FTG Builders, Inc.
Name of Company

Please return this signed page to Shane Murphy at SVMH as soon as possible to confirm receipt of this addendum. Please email as a PDF to smurphy@bogardconstruction.com.

BID DOCUMENTS FOR
SALINAS VALLEY HEALTH
CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

SALINAS VALLEY HEALTH ISSUED: April 1, 2025

REVISIONS TO THE BID DOCUMENTS

DUE DATE: 2:00 PM on Friday, April 18, 2025
(NO CHANGE)

REVISIONS TO THE BID SPECIFICATIONS

1. **Attachment 1. Backcheck #1 – Angio Equipment Replacement - Plans**
   Reference attachment containing HCAI Submittal for Backcheck #1 plans.

2. **Attachment 2. Backcheck #1 – Angio Equipment Replacement - Specifications**
   Reference attachment containing HCAI Submittal for Backcheck #1 specifications.

3. **Attachment 3. Backcheck #1 – Angio Equipment Replacement - TIO**
   Reference attachment containing HCAI Submittal for Backcheck #1 TIO.

REFERENCE DOCUMENTS FOR BIDDERS

4. **Attachment 4. Non-Mandatory Pre-Bid Conference (3/28/2025)**
   a. Presentation
   b. Attendee List

5. **Attachment 5. Hazardous Materials Report**

SALINAS VALLEY HEALTH MEDICAL CENTER

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
Salinas, California

ADDENDUM B
TO THE BID DOCUMENTS FOR
SALINAS VALLEY HEALTH CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

ISSUED: April 16, 2025

This Addendum B must be signed by the bidder and included in the bid documents submitted for this Project. Salinas Valley Memorial Healthcare System reserves the right to disregard any bid, which does not include this Addendum B. Salinas Valley Memorial Healthcare System may waive this requirement at its sole discretion.

SEE ATTACHED ADDENDUM ITEMS

Prepared By:

Shane Murphy

Shane Murphy
SVMHS Designated Representative

BIDDER'S CERTIFICATION

I acknowledge receipt of this Addendum B and accept all conditions contained herein.

Bidder's Signature

4/25/2025
Date

FTG Builders, Inc.
Name of Company

Please return this signed page to Shane Murphy at SVMH as soon as possible to confirm receipt of this addendum. Please email as a PDF to smurphy@bogardconstruction.com.

BID DOCUMENTS FOR
SALINAS VALLEY HEALTH
CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

ISSUED: April 16, 2025

REVISIONS TO THE BID DOCUMENTS

DUE DATE: Friday, April 25, 2025, at 2:00 PM

REVISIONS TO THE BID SPECIFICATIONS

1. **Attachment 1. Section 00 10 00**
   Revised Page 1 Section 00 10 00 "NOTICE INVITING BIDS".

Salinas Valley Memorial Healthcare System

Project Cost Model: SVM CIP ANGIO EQ REPLACEMENT - 01.1250.3760
SVM CIP CATH LAB 3 EQ REPLACEMENT - 01.1250.3765

Architect: SKA
Subject: Budget prepared at Agency Review

Date Printed:	5/12/2025
Budget Amount:	$8,441,153
Budget Approved Date:	5/8/2024
Anticipated Completion:	Q1 FY26

Prepared by: DS/SL, Checked by

Budget Summary

			A	A1	A2
Line Item		Description	Original Budget	Budget Revisions	Current Budget
	1	**Construction**			
100		Construction	$1,450,000	$2,607,063	$4,057,063
101		Owner Contingency	$100,000	$0	$100,000
	2	**Design**			
200		Professional Fees	$703,500	$44,965	$748,465
200		Reimbursables	$3,500	$0	$3,500
		Inspections and Consultation			
300		Inspector of Record	$116,000	$0	$116,000
301		Special Inspections	$44,000	$0	$44,000
303		Testing	$0	$16,500	$16,500
	4	**AHJ Fees**			
400		HCAI Fees	$110,000	$10,554	$120,554
	5	**Soft Costs**			
502		Construction Management	$525,000	$8,540	$533,540
503		Abatement	$3,000	$0	$3,000
504		Infection Control	$0	$3,000	$3,000
	7	**FF&E**			
701		Medical Equipment	$4,503,153	$64,614	$4,567,767
702		Non-Medical Equipment	$525,000	$172,048	$697,048
703		Data & Phone Equipment	$50,000	$0	$50,000
704		Furnishings	$20,000	$6,000	$26,000
704		Hazmat	$0	$0	$0
			$0	$0	$0
9900		Project Contingency + Escalation	$288,000	$32,000	$320,000
Totals			**$8,441,153**	**$2,965,284**	**$11,406,437**

Financial Performance Review
April 2025

Finance Committee

Scott Cleveland

Interim Chief Financial Officer

Consolidated Financial Summary
For the Month of April 2025

$ in Millions	For the Month of April 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 82.9	$ 63.4	$ 19.5	30.8%
Operating Expense	$ 70.2	$ 64.3	$ (5.9)	-9.2%
Income from Operations	**$ 12.7**	**$ (0.9)**	**$ 13.6**	**1511.1%**
Operating Margin %	*15.3%*	*-1.4%*	*16.7%*	*1192.86%*
Non Operating Income	$ 4.5	$ 2.8	$ 1.7	60.7%
Net Income	**$ 17.2**	**$ 1.9**	**$ 15.3**	**805.3%**
Net Income Margin %	*20.8%*	*3.0%*	*17.8%*	*593.3%*

Income from Operation finished the month over budget due to strong outpatient volume and IGT net revenue from the QIP–DMPH 2023 of $7.0 million.

Normalizing Item included in operating income:
- IGT from the District Hospital Directed Payment Program for 2023 (net) totaling $4.8 million

Non-Operating Revenues exceeded budget due to favorable changes in market value of investments

2

Consolidated Financial Summary
For the Month of April 2025 - Normalized

$ in Millions	For the Month of April 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 78.1	$ 63.4	$ 14.7	23.2%
Operating Expense	$ 70.2	$ 64.3	$ (5.9)	-9.2%
Income from Operations	**$ 7.9**	**$ (0.9)**	**$ 8.8**	**977.8%**
Operating Margin %	*10.1%*	*-1.4%*	*11.5%*	*821.43%*
Non Operating Income	$ 4.5	$ 2.8	$ 1.7	60.7%
Net Income	**$ 12.4**	**$ 1.9**	**$ 10.5**	**552.6%**
Net Income Margin %	*15.9%*	*3.0%*	*12.9%*	*430.0%*

Normalizing Item excluded from operating income:
- IGT from the District Hospital Directed Payment Program for 2023 (net) totaling $4.8 million

Non-Operating Revenues exceeded budget due to favorable changes in market value of investments

Consolidated Financial Summary
For the Month of April 2025 – Normalized excluding QIP

$ in Millions	For the Month of April 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 71.1	$ 63.4	$ 7.7	12.1%
Operating Expense	$ 70.2	$ 64.3	$ (5.9)	-9.2%
Income from Operations	**$ 0.9**	**$ (0.9)**	**$ 1.8**	**200.0%**
Operating Margin %	*1.2%*	*-1.4%*	*2.6%*	*185.71%*
Non Operating Income	$ 4.5	$ 2.8	$ 1.7	60.7%
Net Income	**$ 5.4**	**$ 1.9**	**$ 3.5**	**184.2%**
Net Income Margin %	*7.6%*	*3.0%*	*4.6%*	*153.3%*

Normalizing Items excluded from operating income:
- IGT from the District Hospital Directed Payment Program for 2023 (net) totaling $4.8 million
- IGT net revenue from the QIP–DMPH 2023 of $7.0 million.

Non-Operating Revenues exceeded budget due to favorable changes in market value of investments

Executive Summary: Financial Performance

Salinas Valley Health Income from Operations was $12.7 million for the month which was favorable to budget by $13.6M. After Normalizing for the DHDP IGT of $4.8 million income from operations was $7.9 million. The favorable financial performance for the month was driven by the following:

Key Favorable Performance Highlights:

- ✓ **Total Admissions** were over budget by 10% (91 cases)
- ✓ **Inpatient Surgeries** were up 43% (55 cases)
- ✓ **Outpatient revenue** was favorable compared to budget by $38M (26%), due to higher than budgeted patient volumes in the following areas:
  - ➢ **OP Surgeries** were over budget by 36% (95 cases)
  - ➢ **OP Infusion cases** were over budget by 34% (327 cases)
  - ➢ **MRI Procedures** were over budget by 56% (133 cases)
  - ➢ **CT Scans** were over budget 14% (244 cases)
- ✓ **Average Length of Stay** was 7% favorable to budget at 3.7 days

Executive Summary: Financial Performance – Cont'd

- **Key Unfavorable Performance Highlights:**
  - **Supply Expense** was higher this month for patient supplies and pharmaceuticals driven by high Infusion cases and increased Surgery cases. Consolidated supply expense as a percentage of net patient revenue was 14.8% on a target of 14%.
  - **Employee Benefits** were over budget due to high claims costs in group health insurance. This was partially offset by lower pension expense.
  - **Payor Mix** was varied with higher than expected Commercial revenue, up 6%. However, Medicare and MediCal were over budget by 25% and 20%, respectively.
  - **Days in AR** were over target at 61 days, but improved from prior month due to higher collections, up 4% from March and 10% over budget
  - **Prior period** write-offs related to the assessment and clean-up of Accounts Receivable by PFS negatively impacted net revenue in April

6

Consolidated Financial Summary YTD April 2025

$ in Millions	FY 2025 April YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 693.1	$ 622.1	$ 71.0	11.4%
Operating Expense	$ 657.4	$ 633.0	$ (24.4)	-3.9%
Income from Operations	**$ 35.7**	**$ (10.9)**	**$ 46.6**	**427.5%**
Operating Margin %	*5.1%*	*-1.8%*	*6.9%*	*383.3%*
Non Operating Income	$ 34.2	$ 25.9	$ 8.3	32.0%
Net Income	**$ 69.9**	**$ 15.0**	**$ 54.9**	**366.0%**
Net Income Margin %	*10.1%*	*2.4%*	*7.7%*	*320.8%*

Operating Income includes the Normalizing Items of:

- CCAH Voluntary Rate Range Funds (net) Received YTD for CY 2023 totaling $4.6 Million
- District Hospital Direct Payment (net) for 2023 totaling $4.8 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

7

Consolidated Financial Summary YTD April 2025 - Normalized

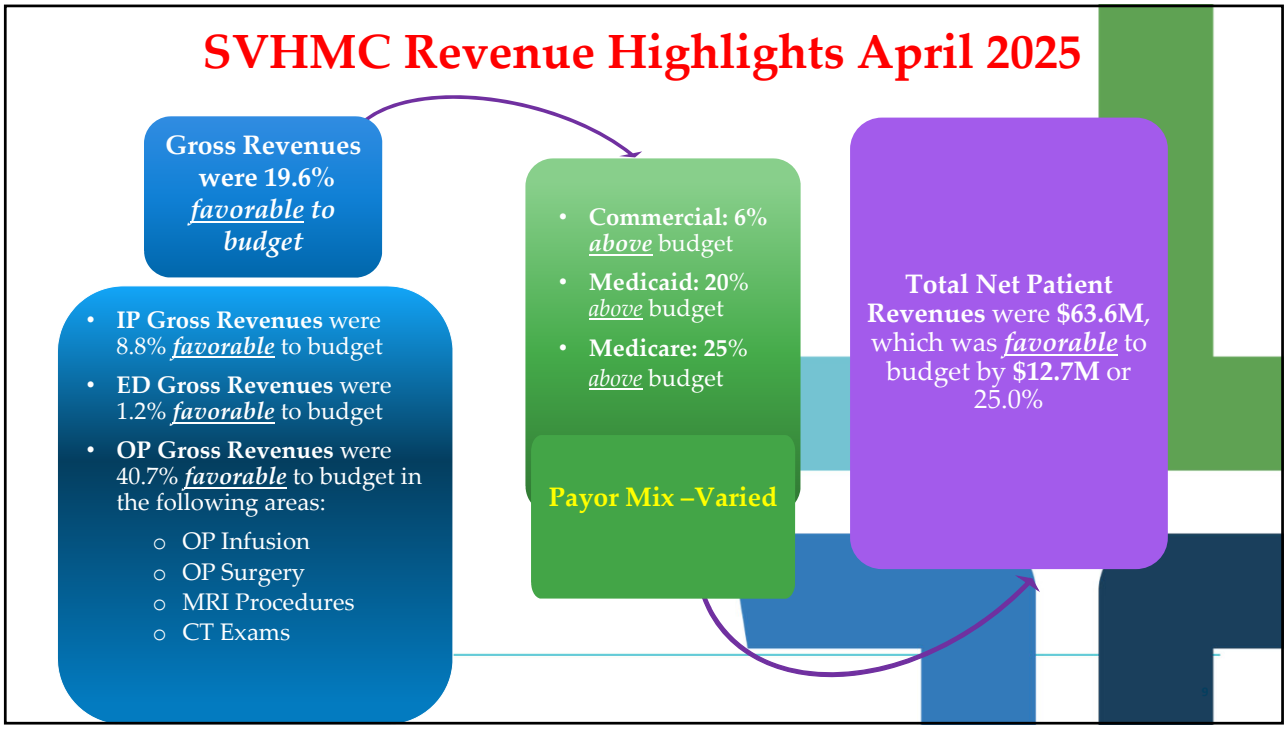
$ in Millions	FY 2025 April YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 683.6	$ 622.1	$ 61.5	9.9%
Operating Expense	$ 657.4	$ 633.0	$ (24.4)	-3.9%
Income from Operations	**$ 26.2**	**$ (10.9)**	**$ 37.1**	**340.4%**
Operating Margin %	*3.8%*	*-1.8%*	*5.6%*	*311.1%*
Non Operating Income **	$ 30.0	$ 25.9	$ 4.1	15.8%
Net Income	**$ 56.2**	**$ 15.0**	**$ 41.2**	**274.7%**
Net Income Margin %	*8.2%*	*2.4%*	*5.8%*	*241.7%*

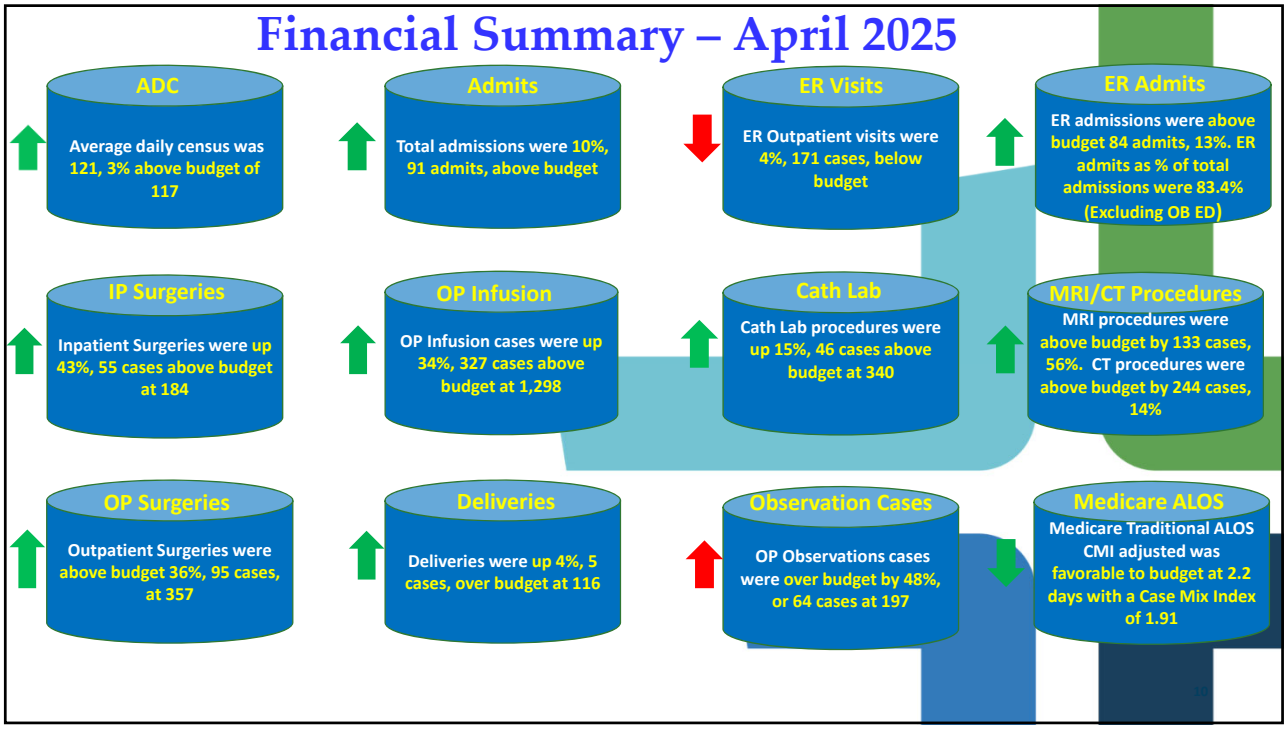
Operating Income excludes the Normalizing Items of:

- CCAH Voluntary Rate Range Funds (net) Received YTD for CY 2023 totaling $4.6 Million
- District Hospital Direct Payment (net) for 2023 totaling $4.8 million

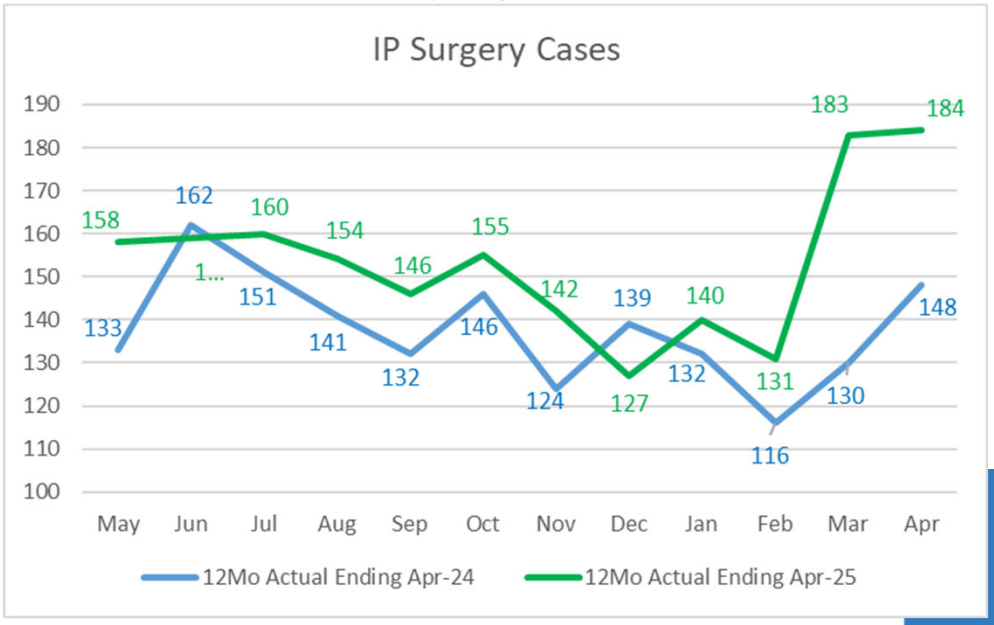
Non Operating Income excludes Normalizing Items of:

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


SVHMC Revenue Highlights April 2025
Gross Revenues were 19.6% favorable to budget
IP Gross Revenues were 8.8% favorable to budget
ED Gross Revenues were 1.2% favorable to budget
OP Gross Revenues were 40.7% favorable to budget in the following areas:
OP Infusion
OP Surgery
MRI Procedures
CT Exams
Commercial: 6% above budget
Medicaid: 20% above budget
Medicare: 25% above budget
Payor Mix –Varied
Total Net Patient Revenues were $63.6M, which was favorable to budget by $12.7M or 25.0%


Financial Summary – April 2025
ADC
Average daily census was 121, 3% above budget of 117
Admits
Total admissions were 10%, 91 admits, above budget
ER Visits
ER Outpatient visits were 4%, 171 cases, below budget
ER Admits
ER admissions were above budget 84 admits, 13%. ER admits as % of total admissions were 83.4% (Excluding OB ED)
IP Surgeries
Inpatient Surgeries were up 43%, 55 cases above budget at 184
OP Infusion
OP Infusion cases were up 34%, 327 cases above budget at 1,298
Cath Lab
Cath Lab procedures were up 15%, 46 cases above budget at 340
MRI/CT Procedures
MRI procedures were above budget by 133 cases, 56%. CT procedures were above budget by 244 cases, 14%
OP Surgeries
Outpatient Surgeries were above budget 36%, 95 cases, at 357
Deliveries
Deliveries were up 4%, 5 cases, over budget at 116
Observation Cases
OP Observations cases were over budget by 48%, or 64 cases at 197
Medicare ALOS
Medicare Traditional ALOS CMI adjusted was favorable to budget at 2.2 days with a Case Mix Index of 1.91

IP Surgery Cases - April 2025

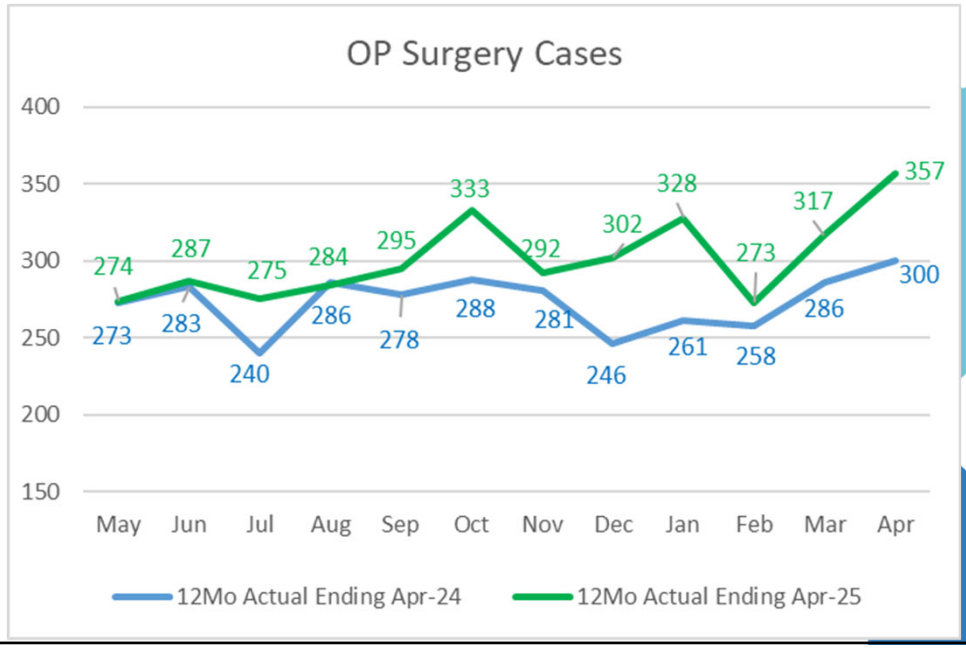


IP Surgery Cases – month variance from prior year – 36 cases higher:

Increases:

- General Surgery up 18 cases (two new providers since PY)
- Vascular up 8 cases (new surgeon in Jan)
- Ortho up 7 cases

OP Surgery Cases - April 2025

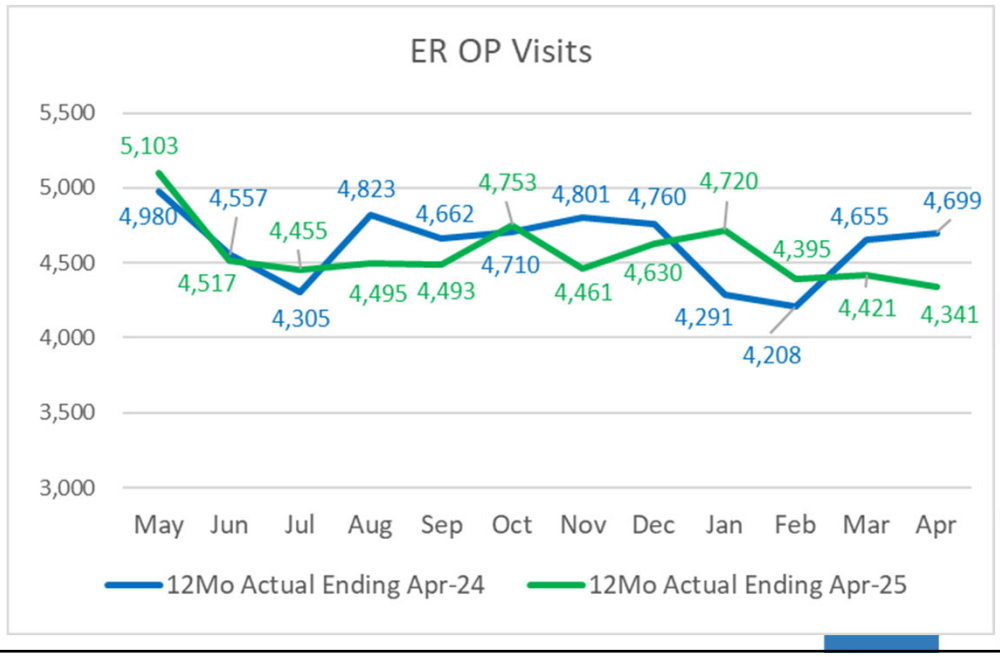


OP Surgery Cases – month variance from prior year – 57 cases higher:

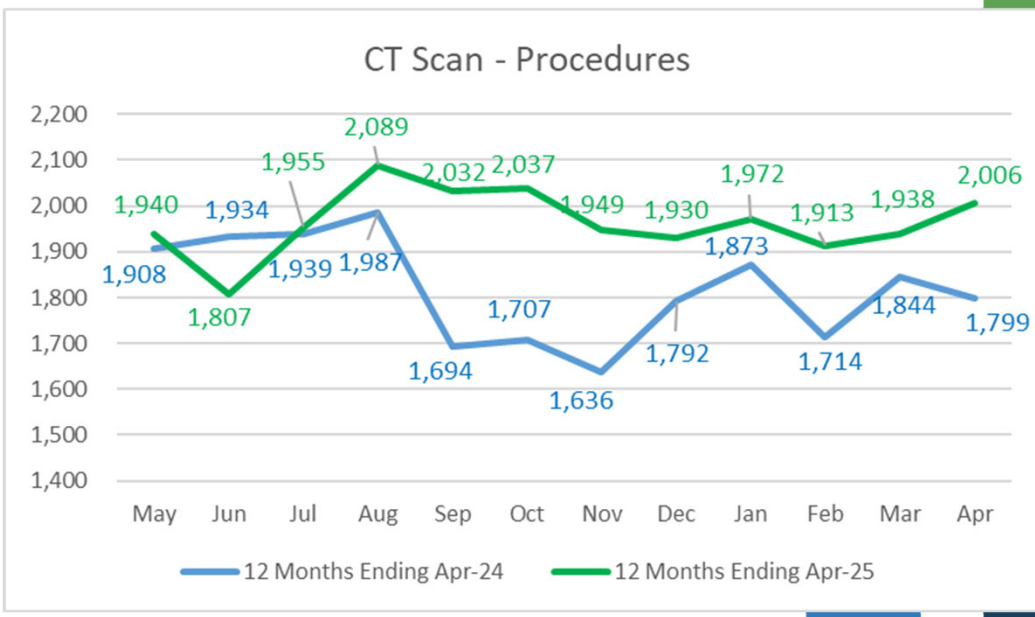
Increases:

- General Surgery up 26 cases (two new providers since PY)
- Ortho up 21 cases (Higher volumes from several surgeons)
- Cardio & Thoracic up 7 cases

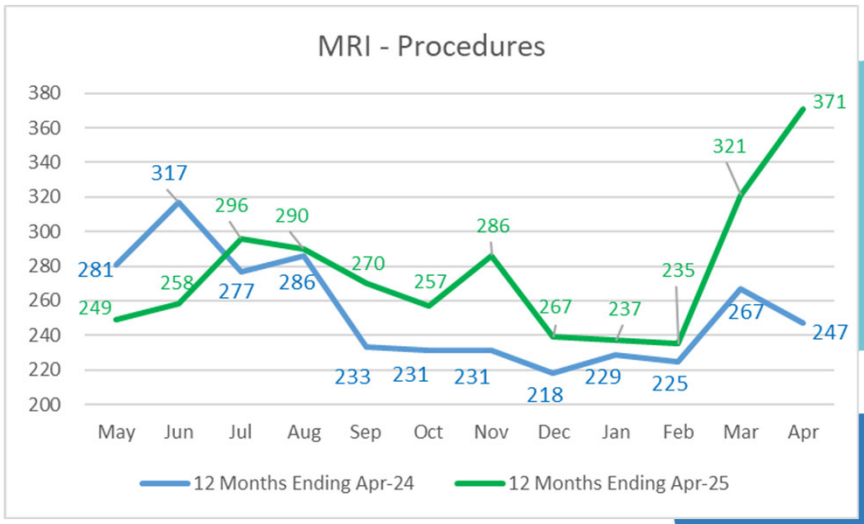
ER OP Visits- April 2025



CT Scans -April 2025

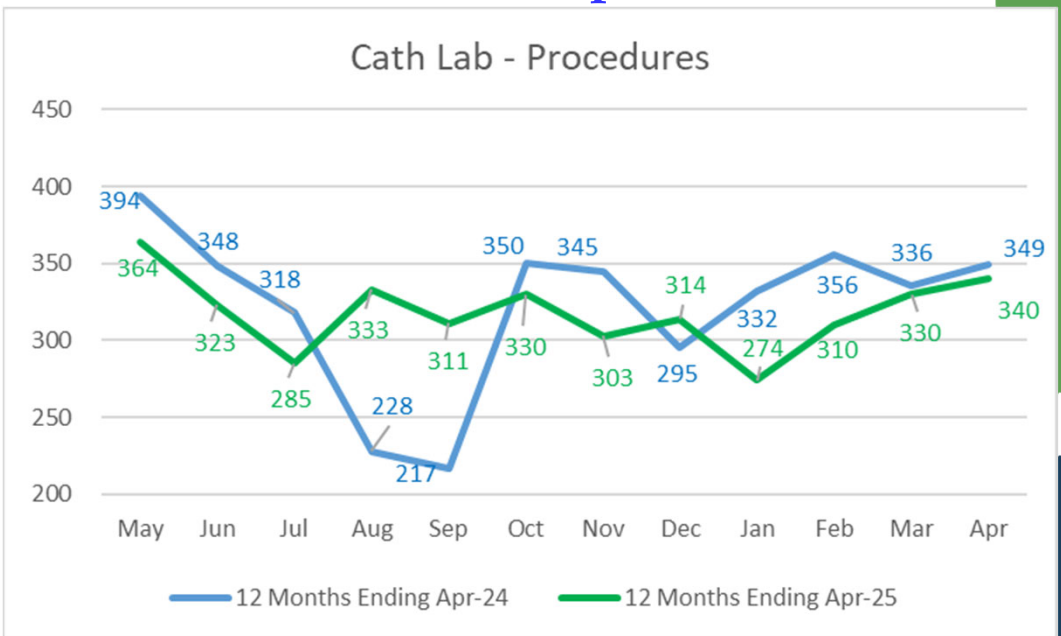


MRI -April 2025

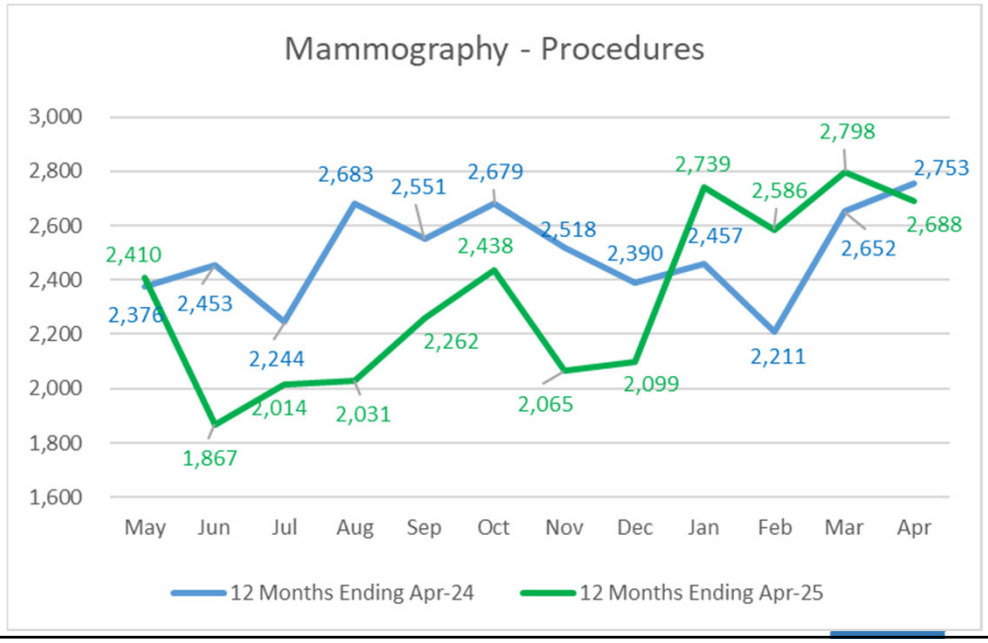


OP MRI evening shift hours at the hospital extended from 5:00PM to 10:30PM effective Feb. 20 has impacted procedure volume.

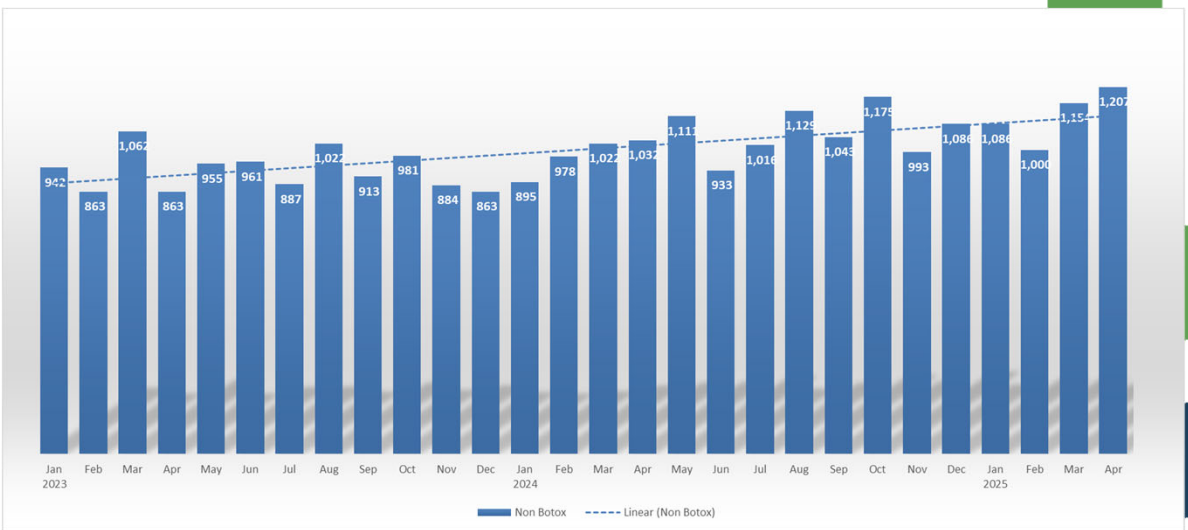
Cath Lab -April 2025



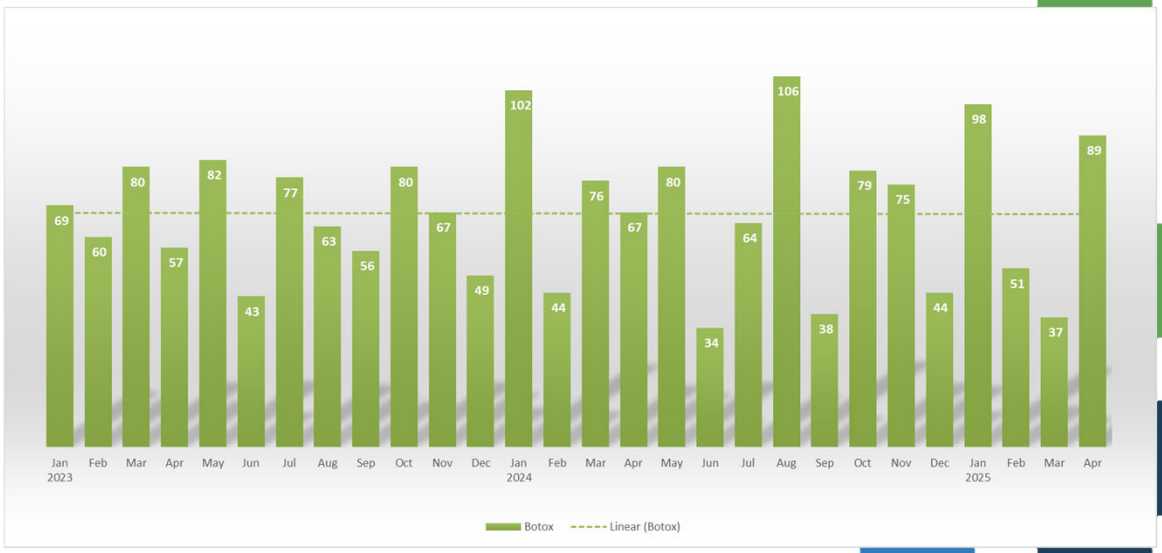
Mammography -April 2025



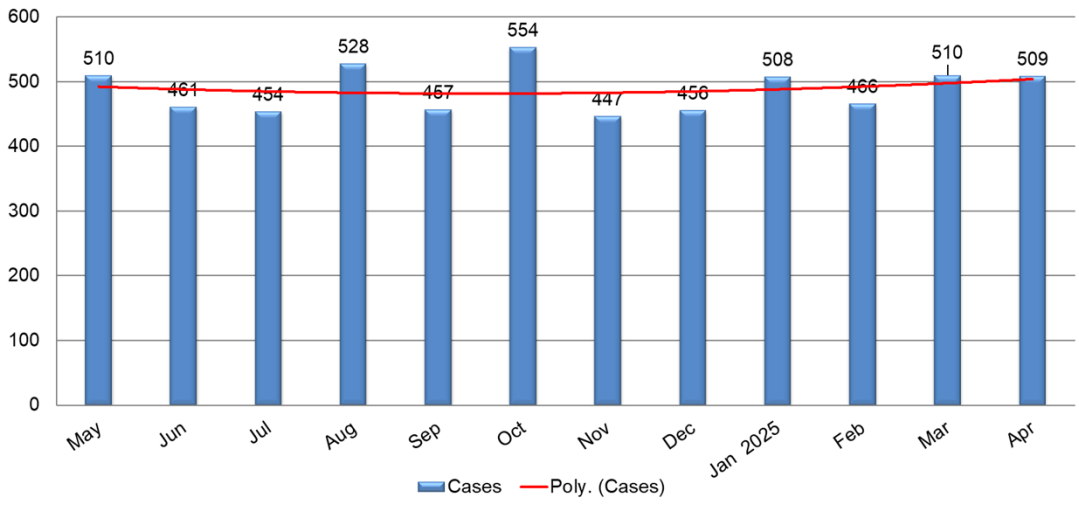
OP Infusion Treatments Jan 2023 through Apr 2025



OP Infusion Botox
Jan 2023 through Apr 2025



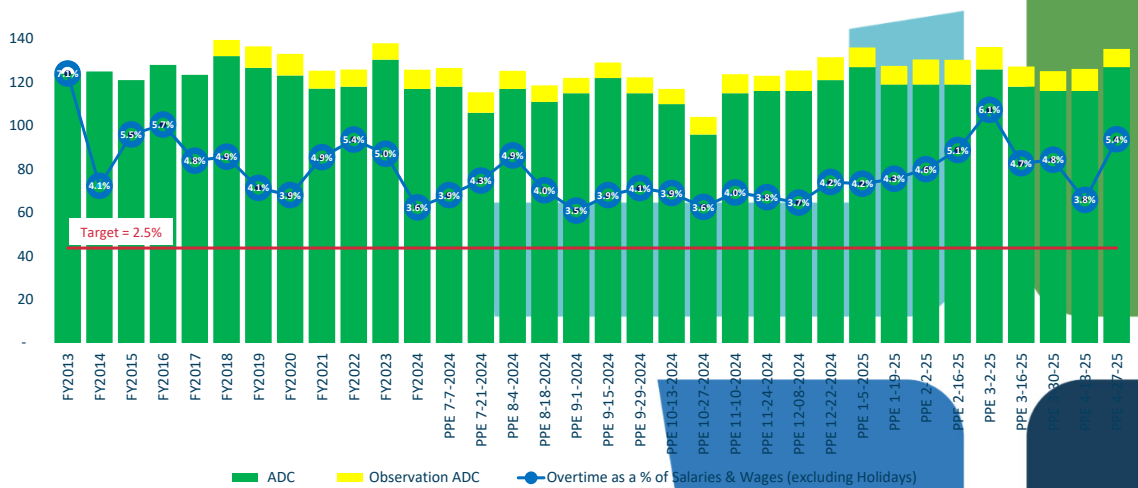
CDOC Cases - Rolling 12 Month Trend
May 2024 thru Apr 2025



Labor Productivity – April 2025

1. **Worked FTEs:** During the month of April, worked FTEs on a PAADC basis were 6% favorable at **6.3** with a target of **6.7**. *When reviewed on a unit-by-unit level, the variance was **38** FTEs negative (**$0.6M**). Lab was favorable 16.5 Worked FTEs. Excluding Lab, the variance was 21.5 FTEs negative ($0.3M).*
2. **Worked FTEs** increased from 1,635 in March to 1,642 in April. Average daily census increased by 7 compared to prior month at 121 (2% above budget).
3. **Paid FTEs:** On a PAADC basis, paid FTEs were **7%** favorable to budget at **7.2 actual vs. 7.7 budget.** Paid FTEs increased from 1,850 in March to 1,869 in April.

Overtime as a Percent of Total Salaries & Wages (excluding Holidays) Through the pay period ending April 27, 2025

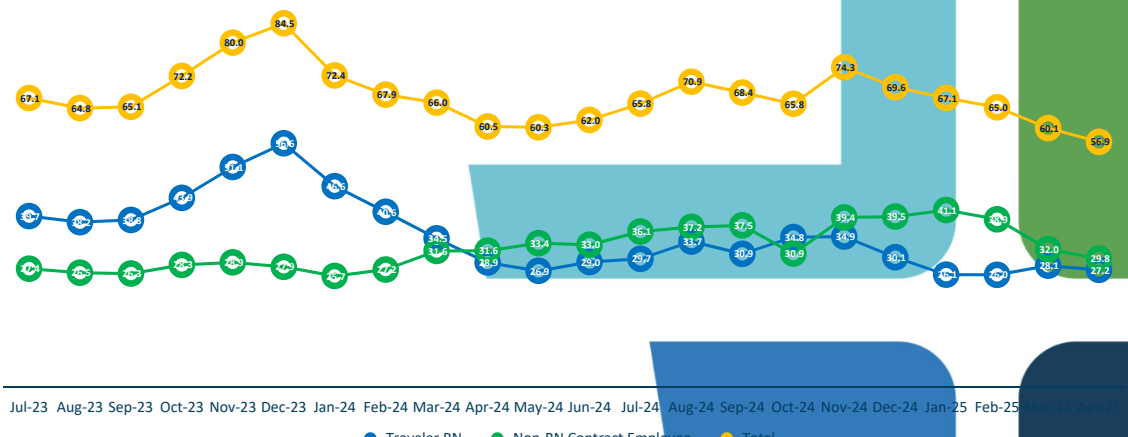


** Observation days are not available prior to FY2018 due to a server migration.
** High inpatient volumes in the last pay period have resulted in additional overtime shifts (while contract labor FTE decreased).

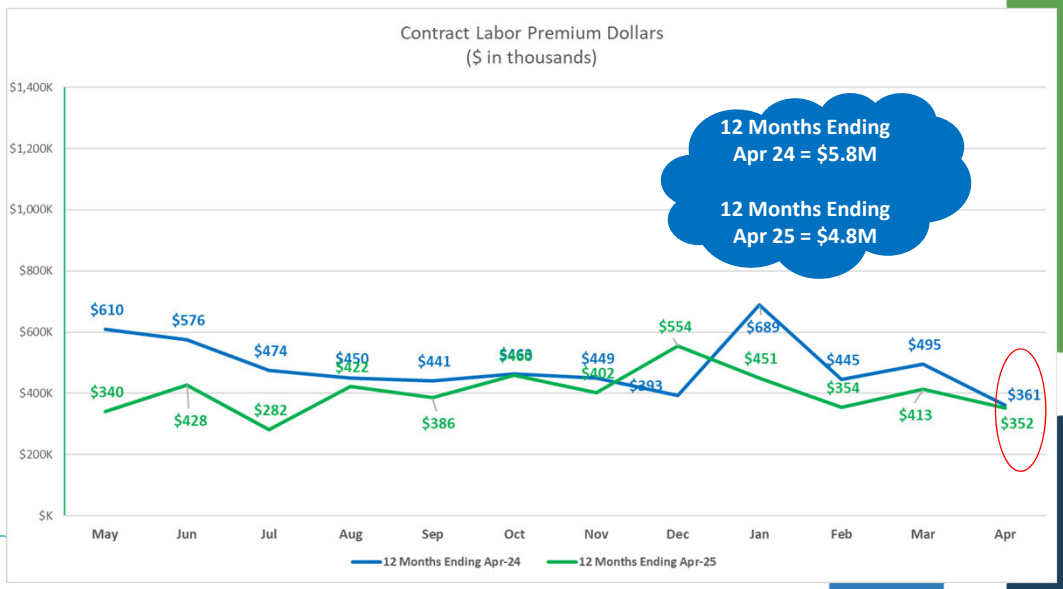
Contract Labor FTE by Month

July 2023 – April 2025

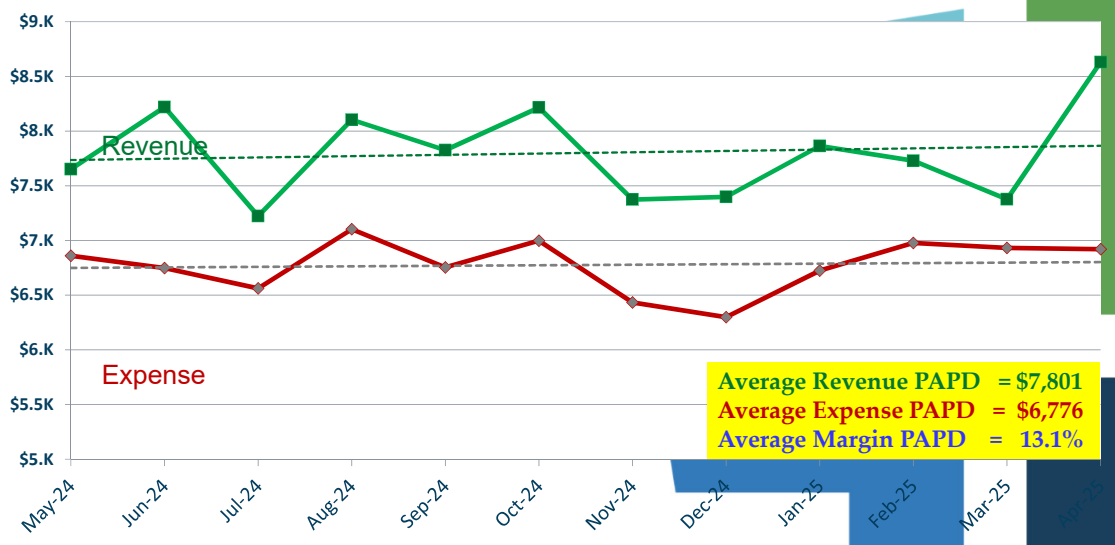
Contract labor decreased by 3.2 FTE compared to March. RN travelers decreased by 1.0 FTE while Non-RN FTE decreased 2.2 FTE.



Contract Labor (Premium Cost Only) – 12 months ended 4/30/2025

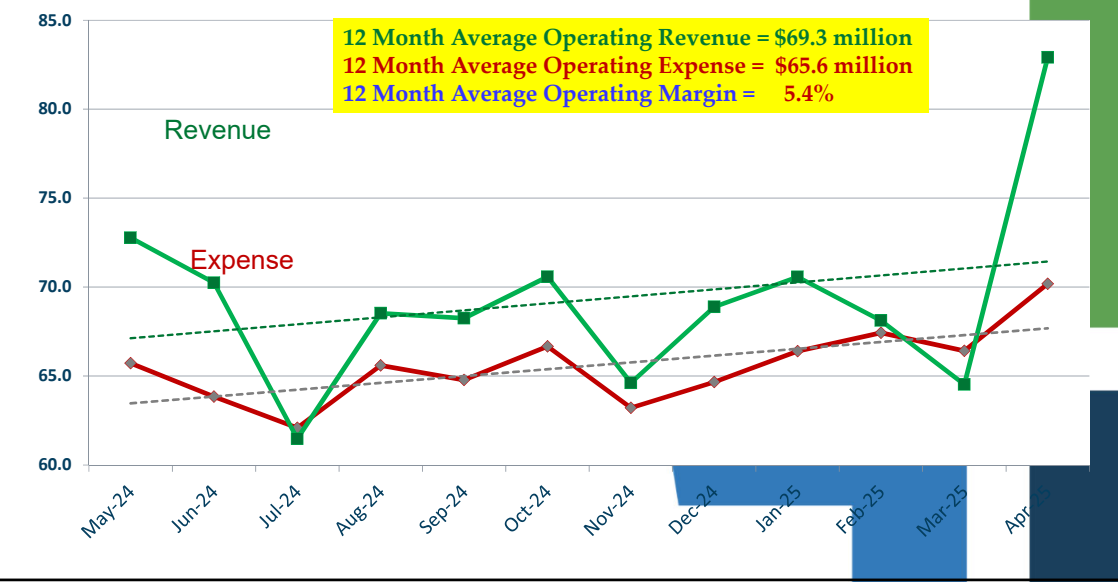


SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: May 24 to Apr 25



Average Revenue PAPD = $7,801
Average Expense PAPD = $6,776
Average Margin PAPD = 13.1%

SVH Consolidated Revenues & Expenses
Rolling 12 Months: May 24 to Apr 25



12 Month Average Operating Revenue = $69.3 million
12 Month Average Operating Expense = $65.6 million
12 Month Average Operating Margin = 5.4%

Salinas Valley Health Key Financial Indicators

Statistic	YTD 4/30/25	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 4/30/24	+/-
Operating Margin*	5.1%	5.0%		4.0%		0.8%	
Total Margin*	10.1%	6.0%		6.6%		5.7%	
EBITDA Margin**	9.5%	7.4%		13.6%		5.4%	
Days of Cash*	374	305		249		349	
Days of Accounts Payable*	46	45		-		46	
Days of Net Accounts Receivable**	61	45		49		55	
Supply Expense as % NPR	14.8%	14.0%		-		13.8%	
SWB Expense as % NPR	51.8%	53.0%		53.7%		54.4%	
Operating Expense per APD*	6,725	6,739		-		6,738	

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)

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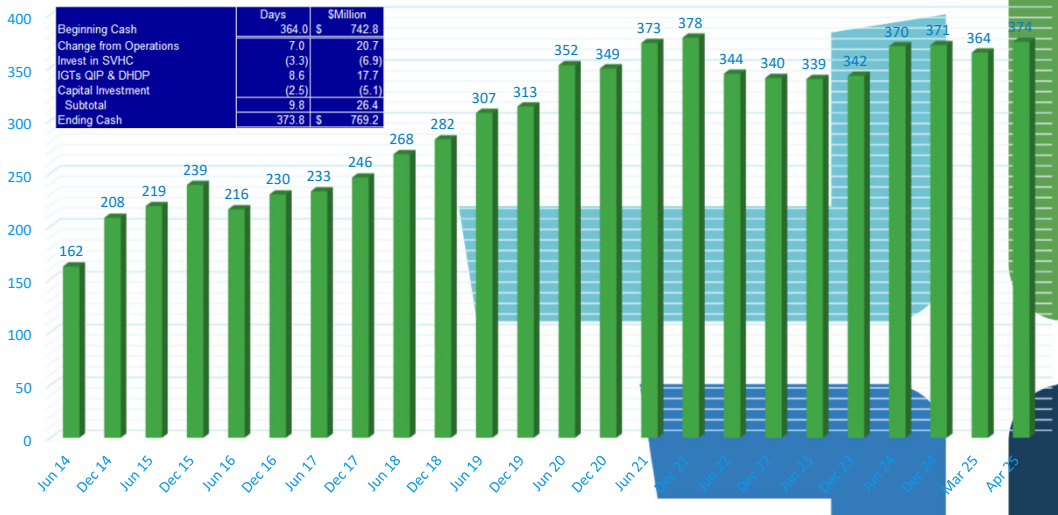
Salinas Valley Health
Days Cash on Hand = 374 Days ($769M) - April 2025

	Days	$Million
Beginning Cash	364.0	$ 742.8
Change from Operations	7.0	20.7
Invest in SVHC	(3.3)	(6.9)
IGTs QIP & DHDP	8.6	17.7
Capital Investment	(2.5)	(5.1)
Subtotal	9.8	26.4
Ending Cash	373.8	$ 769.2



Routine Capital Expenditures
Through April 2025

Fiscal Month	FY 2025 Approved Budget *	Total Purchased Expenditures	Remaining	Project	Amount
July	1,916,667	712,780	1,203,887	LDRP Light Replacement	161,641
August	1,916,667	1,382,572	1,737,981	Cath Lab Equipment Replacement	52,579
September	1,916,667	729,309	2,925,338	Angio Equipment Replacement	43,878
October	1,916,667	1,191,148	3,650,857	X-Ray Equipment Replacement	27,675
November	1,916,667	794,889	4,772,635	Miscellaneous	32,230
December	1,916,667	1,381,451	5,307,851	Total Improvements	318,002
January	1,916,667	1,565,871	5,658,646	DRC 8 Ton Liebert Cooling System	290,000
February	1,916,667	963,787	6,611,526	NICU Intellivue Monitors	261,619
March	1,916,667	815,462	7,712,730	Surgical Laser Moses 2.0	222,585
April	1,916,667	1,449,571	8,179,826	IT Laptop, Monitors and Docking Stations	73,398
May	1,916,667		10,096,493	Miscellaneous	283,967
June	1,916,667		12,013,160	Total Equipment	1,131,569
YTD TOTAL	**23,000,000**	**10,986,840**	**12,013,160**	**Grand Total**	**1,449,570**

Questions/Comments

Salinas Valley HEALTH

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SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
April 30, 2025

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 63,557,078	$ 60,518,141	$ 569,164,559	$ 516,323,620
Other operating revenue	8,622,190	7,615,190	22,895,516	17,476,695
Total operating revenue	72,179,268	68,133,331	592,060,075	533,800,315
Total operating expenses	54,181,791	50,422,614	507,032,777	481,968,847
Total non-operating income	(220,192)	(5,326,060)	(15,860,447)	(18,199,429)
Operating and non-operating income	$ 17,777,285	$ 12,384,657	$ 69,166,851	$ 33,632,039

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
April 30, 2025

	Current year	Prior year
ASSETS:		
Current assets	$ 442,738,632	$ 363,975,697
Assets whose use is limited or restricted by board	175,239,062	163,692,604
Capital assets	261,981,134	247,338,410
Other assets	305,070,993	293,238,895
Deferred pension outflows	85,734,219	116,911,125
	$ 1,270,764,040	$ 1,185,156,731
LIABILITIES AND EQUITY:		
Current liabilities	96,579,812	92,148,892
Long term liabilities	19,852,203	19,934,335
Lease deferred inflows	653,147	1,323,811
Pension liability	90,863,576	118,792,064
Net assets	1,062,815,302	952,957,629
	$ 1,270,764,040	$ 1,185,156,731

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
April 30, 2025

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,862	1,586	17,513	17,833
Medi-Cal	1,068	1,013	10,635	10,505
Commercial insurance	530	566	5,545	5,723
Other patient	153	118	1,229	1,022
Total patient days	3,613	3,283	34,922	35,083
Gross revenue:				
Medicare	$ 148,977,991	$ 116,701,700	$ 1,293,899,701	$ 1,142,368,656
Medi-Cal	87,902,310	80,519,457	829,070,257	717,858,792
Commercial insurance	58,260,598	54,859,204	577,545,523	527,395,918
Other patient	12,421,533	9,553,478	110,273,008	88,838,567
Gross revenue	307,562,432	261,633,839	2,810,788,489	2,476,461,932
Deductions from revenue:				
Administrative adjustment	188,924	206,980	2,913,250	3,066,899
Charity care	384,437	311,716	6,287,365	6,223,899
Contractual adjustments:				
Medicare outpatient	52,070,898	39,768,075	433,148,157	358,575,684
Medicare inpatient	58,499,994	43,796,091	498,614,550	466,907,260
Medi-Cal traditional outpatient	2,999,090	1,958,276	17,400,680	24,897,293
Medi-Cal traditional inpatient	(741,642)	3,171,090	45,278,152	46,159,972
Medi-Cal managed care outpatient	42,359,898	38,315,373	401,751,269	320,099,670
Medi-Cal managed care inpatient	26,983,759	23,897,809	271,788,517	252,896,969
Commercial insurance outpatient	29,930,532	24,448,212	271,044,699	222,304,969
Commercial insurance inpatient	22,452,967	18,891,959	222,046,320	203,972,303
Uncollectible accounts expense	5,818,815	5,099,551	55,281,848	43,495,003
Other payors	3,057,682	1,250,565	16,069,123	11,538,393
Deductions from revenue	244,005,354	201,115,698	2,241,623,930	1,960,138,313
Net patient revenue	$ 63,557,078	$ 60,518,141	$ 569,164,559	$ 516,323,620
Gross billed charges by patient type:				
Inpatient	$ 142,525,222	$ 121,396,270	$ 1,321,996,564	$ 1,243,611,138
Outpatient	133,292,889	108,573,818	1,169,390,169	936,107,901
Emergency room	31,744,321	31,663,751	319,401,756	296,742,893
Total	$ 307,562,432	$ 261,633,839	$ 2,810,788,489	$ 2,476,461,932

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
April 30, 2025

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 63,557,078	$ 60,518,141	$ 569,164,559	$ 516,323,620
Other operating revenue	8,622,190	7,615,190	22,895,516	17,476,695
Total operating revenue	72,179,268	68,133,331	592,060,075	533,800,315
Operating expenses:				
Salaries and wages	18,545,544	16,614,493	178,601,378	166,656,648
Compensated absences	3,030,970	2,801,687	31,145,919	30,164,702
Employee benefits	9,886,265	8,025,558	81,405,156	84,455,346
Supplies, food, and linen	11,046,333	9,011,941	89,276,229	74,398,214
Purchased department functions	3,702,917	4,195,194	39,169,508	36,761,392
Medical fees	1,914,662	2,460,917	24,969,319	24,568,603
Other fees	1,768,314	2,743,758	18,638,757	23,219,807
Depreciation	2,617,262	2,772,807	25,893,063	24,389,785
All other expense	1,669,524	1,796,259	17,933,448	17,354,350
Total operating expenses	54,181,791	50,422,614	507,032,777	481,968,847
Income from operations	17,997,477	17,710,717	85,027,298	51,831,468
Non-operating income:				
Donations	74,023	56,322	5,608,122	2,660,534
Property taxes	476,714	333,333	4,767,143	3,333,333
Investment income	4,199,541	(1,647,527)	20,809,923	20,872,769
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,970,470)	(4,068,188)	(47,045,635)	(45,066,065)
Total non-operating income	(220,192)	(5,326,060)	(15,860,447)	(18,199,429)
Operating and non-operating income	17,777,285	12,384,657	69,166,851	33,632,039
Net assets to begin	1,045,038,017	940,572,972	993,648,450	919,325,590
Net assets to end	$ 1,062,815,302	$ 952,957,629	$ 1,062,815,302	$ 952,957,629
Net income excluding non-recurring items	$ 17,777,285	$ 12,384,657	$ 69,166,851	$ 33,632,039
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ 17,777,285	$ 12,384,657	$ 69,166,851	$ 33,632,039

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
April 30, 2025

	Month of April,		Ten months ended April 30,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (183,140)	$ (184,338)	$ (2,026,774)	$ (2,008,039)
Neurological Clinic	(82,100)	(32,331)	(751,894)	(665,570)
Palliative Care Clinic	(104,538)	(105,840)	(973,893)	(921,793)
Surgery Clinic	(230,490)	(163,280)	(1,647,948)	(1,804,745)
Infectious Disease Clinic	(50,703)	(34,404)	(472,563)	(380,770)
Endocrinology Clinic	(235,931)	(185,784)	(2,314,540)	(2,271,112)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(649,868)	(474,932)	(5,972,298)	(5,657,976)
OB/GYN Clinic	(427,755)	(370,833)	(4,139,137)	(4,058,607)
PrimeCare Medical Group	(822,358)	(685,493)	(8,139,873)	(8,420,806)
Oncology Clinic	(454,754)	(397,518)	(4,140,241)	(3,498,149)
Cardiac Surgery	(360,737)	(398,354)	(3,510,268)	(3,197,867)
Sleep Center	(75,402)	(67,750)	(847,723)	(568,078)
Rheumatology	(59,839)	(58,521)	(738,081)	(709,909)
Precision Ortho MDs	(527,574)	(384,566)	(4,697,582)	(4,712,226)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(64,950)	(38,001)	(752,406)	(474,410)
Vaccine Clinic	0	0	0	16
Dermatology	(8,449)	(37,944)	(390,890)	(396,140)
Hospitalists	0	0	0	0
Behavioral Health	(34,017)	(51,209)	(379,280)	(497,665)
Pediatric Diabetes	(33,073)	(51,846)	(389,783)	(461,680)
Neurosurgery	(138,829)	(90,377)	(1,255,097)	(526,149)
Multi-Specialty-RR	24,602	7,542	131,752	30,815
Radiology	(317,520)	(284,028)	(3,217,081)	(3,069,445)
Salinas Family Practice	(99,284)	(71,318)	(1,108,698)	(1,289,818)
Urology	(156,108)	(104,078)	(1,734,604)	(1,659,691)
Total SVHC	(5,092,817)	(4,265,203)	(49,468,902)	(47,219,814)
Doctors on Duty	(148,566)	(14,994)	95,125	271,135
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	156,537	144,022	1,527,014	1,319,761
Coastal	14,499	9,088	5,720	105,314
Apex	0	0	0	0
21st Century Oncology	26,472	11,209	264,721	56,865
Monterey Bay Endoscopy Center	73,405	47,689	530,688	400,675
Total	$ (4,970,470)	$ (4,068,188)	$ (47,045,635)	$ (45,066,065)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
April 30, 2025

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 300,833,049	$ 243,116,557
Patient accounts receivable, net of estimated uncollectibles of $43,867,085	117,706,219	96,838,017
Supplies inventory at cost	8,452,851	7,787,156
Current portion of lease receivable	545,403	935,448
Other current assets	15,201,110	15,298,519
Total current assets	442,738,632	363,975,697
Assets whose use is limited or restricted by board	175,239,062	163,692,604
Capital assets:		
Land and construction in process	53,455,059	48,812,146
Other capital assets, net of depreciation	208,526,075	198,526,264
Total capital assets	261,981,134	247,338,410
Other assets:		
Right of use assets, net of amortization	8,127,650	6,730,433
Long term lease receivable	138,131	494,234
Subscription assets, net of amortization	8,257,577	6,989,307
Investment in Securities	262,635,625	254,241,866
Investment in SVMC	375,059	14,992,552
Investment in Coastal	1,758,090	1,786,955
Investment in other affiliates	21,408,832	12,178,837
Net pension asset	2,370,029	(4,175,289)
Total other assets	305,070,993	293,238,895
Deferred pension outflows	85,734,219	116,911,125
	$ 1,270,764,040	$ 1,185,156,731
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	$ 63,928,290	$ 60,114,379
Due to third party payers	4,229,378	4,998,064
Current portion of self-insurance liability	22,839,388	20,330,294
Current subscription liability	2,669,699	4,220,137
Current portion of lease liability	2,913,057	2,486,018
Total current liabilities	96,579,812	92,148,892
Long term portion of workers comp liability	11,541,217	12,935,574
Long term portion of lease liability	5,221,594	4,465,691
Long term subscription liability	3,089,392	2,533,070
Total liabilities	116,432,015	112,083,227
Lease deferred inflows	653,147	1,323,811
Pension liability	90,863,576	118,792,064
Net assets:		
Invested in capital assets, net of related debt	261,981,134	247,338,410
Unrestricted	800,834,168	705,619,219
Total net assets	1,062,815,302	952,957,629
	$ 1,270,764,040	$ 1,185,156,731

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
April 30, 2025

	Month of April,			Ten months ended April 30,			
	Actual	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:							
Gross billed charges	$ 307,562,432	$ 50,457,552	19.63%	$ 2,810,788,489	$ 2,559,211,937	251,576,552	9.83%
Dedutions from revenue	244,005,354	38,350,897	18.65%	2,241,623,930	2,050,301,371	191,322,559	9.33%
Net patient revenue	63,557,078	12,106,655	23.53%	569,164,559	508,910,566	60,253,993	11.84%
Other operating revenue	8,622,190	7,169,521	493.54%	22,895,516	14,526,690	8,368,826	57.61%
Total operating revenue	**72,179,268**	**19,276,176**	**36.44%**	**592,060,075**	**523,437,256**	**68,622,819**	**13.11%**
Operating expenses:							
Salaries and wages	18,545,544	511,677	2.84%	178,601,378	173,168,678	5,432,700	3.14%
Compensated absences	3,030,970	365,833	13.73%	31,145,919	31,493,480	(347,561)	-1.10%
Employee benefits	9,886,265	1,512,735	18.07%	81,405,156	80,341,811	1,063,345	1.32%
Supplies, food, and linen	11,046,333	3,980,149	56.33%	89,276,229	71,608,780	17,667,449	24.67%
Purchased department functions	3,702,917	(122,365)	-3.20%	39,169,508	38,252,828	916,680	2.40%
Medical fees	1,914,662	(570,975)	-22.97%	24,969,319	24,856,372	112,947	0.45%
Other fees	1,768,314	45,947	2.67%	18,638,757	17,359,915	1,278,842	7.37%
Depreciation	2,617,262	10,306	0.40%	25,893,063	24,328,902	1,564,161	6.43%
All other expense	1,669,524	(278,991)	-14.32%	17,933,448	19,713,576	(1,780,128)	-9.03%
Total operating expenses	**54,181,791**	**5,454,316**	**11.19%**	**507,032,777**	**481,124,342**	**25,908,435**	**5.38%**
Income from operations	**17,997,477**	**13,821,860**	**331.01%**	**85,027,298**	**42,312,914**	**42,714,384**	**100.95%**
Non-operating income:							
Donations	74,023	(134,310)	-64.47%	5,608,122	2,083,333	3,524,789	169.19%
Property taxes	476,714	(0)	0.00%	4,767,143	4,767,143	(0)	0.00%
Investment income	4,199,541	2,308,368	122.06%	20,809,923	18,911,732	1,898,191	10.04%
Income from subsidiaries	(4,970,470)	152,752	-2.98%	(47,045,635)	(51,232,221)	4,186,586	-8.17%
Total non-operating income	**(220,192)**	**2,326,809**	**-91.35%**	**(15,860,447)**	**(25,470,013)**	**9,609,566**	**-37.73%**
Operating and non-operating income	**$ 17,777,285**	**$ 16,148,670**	**991.56%**	**$ 69,166,851**	**$ 16,842,901**	**52,323,950**	**310.66%**

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

	Month of April		Ten months to date		
	2024	2025	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	28	36	337	356	19
Other Admissions	61	81	778	831	53
Total Admissions	89	117	1,115	1,187	72
Medi-Cal Patient Days	46	53	536	657	121
Other Patient Days	102	124	1,273	1,248	(25)
Total Patient Days of Care	148	177	1,809	1,905	96
Average Daily Census	4.9	5.9	6.0	6.3	0.3
Medi-Cal Average Days	1.8	1.7	1.7	2.0	0.3
Other Average Days	0.7	1.6	1.7	1.5	(0.1)
Total Average Days Stay	1.7	1.6	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	343	404	3,706	3,878	172
Medi-Cal Admissions	297	288	2,664	2,859	195
Other Admissions	354	299	2,959	3,130	171
Total Admissions	994	991	9,329	9,867	538
Medicare Patient Days	1,318	1,571	15,050	14,615	(435)
Medi-Cal Patient Days	1,052	1,111	10,790	11,138	348
Other Patient Days	898	701	9,337	7,548	(1,789)
Total Patient Days of Care	3,268	3,383	35,177	33,301	(1,876)
Average Daily Census	108.9	112.8	115.7	109.5	(6.2)
Medicare Average Length of Stay	3.8	4.0	4.1	3.8	(0.3)
Medi-Cal AverageLength of Stay	3.5	3.4	3.5	3.4	(0.1)
Other Average Length of Stay	2.6	1.9	2.5	1.9	(0.6)
Total Average Length of Stay	3.3	3.1	3.4	3.0	(0.4)
Deaths	29	30	266	264	(2)
Total Patient Days	3,416	3,560	36,986	35,206	(1,780)
Medi-Cal Administrative Days	24	0	56	0	(56)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	24	0	56	0	(56)
Percent Non-Acute	0.70%	0.00%	0.15%	0.00%	-0.15%

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

	Month of April		Ten months to date		
	2024	2025	2023-24	2024-25	Variance
PATIENT DAYS BY LOCATION					
Level I	262	221	2,478	2,510	32
Heart Center	283	322	3,254	3,203	(51)
Monitored Beds	585	622	6,177	5,783	(394)
Single Room Maternity/Obstetrics	220	322	2,955	3,435	480
Med/Surg - Cardiovascular	817	901	8,405	8,721	316
Med/Surg - Oncology	271	278	2,794	2,711	(83)
Med/Surg - Rehab	457	480	4,557	4,667	110
Pediatrics	113	124	1,305	1,185	(120)
Nursery	148	177	1,809	1,905	96
Neonatal Intensive Care	72	113	1,059	1,086	27
PERCENTAGE OF OCCUPANCY					
Level I	67.18%	56.67%	62.50%	63.30%	
Heart Center	62.89%	71.56%	71.13%	70.01%	
Monitored Beds	72.22%	76.79%	75.01%	70.22%	
Single Room Maternity/Obstetrics	19.82%	29.01%	26.19%	30.44%	
Med/Surg - Cardiovascular	60.52%	66.74%	61.24%	63.54%	
Med/Surg - Oncology	69.49%	71.28%	70.47%	68.37%	
Med/Surg - Rehab	58.59%	61.54%	57.47%	58.85%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	20.93%	22.96%	23.77%	21.58%	
Nursery	29.90%	35.76%	17.97%	18.93%	
Neonatal Intensive Care	21.82%	34.24%	31.56%	32.37%	

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

	Month of April		Ten months to date		
	2024	2025	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	88	118	1,036	1,182	146
C-Section deliveries	20	34	319	379	60
Percent of C-section deliveries	22.73%	28.81%	30.79%	32.06%	1.27%
OPERATING ROOM					
In-Patient Operating Minutes	19,960	25,156	161,557	192,658	31,101
Out-Patient Operating Minutes	32,124	41,126	297,852	352,961	55,109
Total	52,084	66,282	459,409	545,619	86,210
Open Heart Surgeries	14	17	113	118	5
In-Patient Cases	121	163	1,130	1,255	125
Out-Patient Cases	327	378	2,953	3,323	370
EMERGENCY ROOM					
Immediate Life Saving	39	48	372	354	(18)
High Risk	797	950	7,673	8,685	1,012
More Than One Resource	2,861	2,673	27,927	27,852	(75)
One Resource	1,891	1,712	18,886	17,781	(1,105)
No Resources	68	62	843	708	(135)
Total	5,656	5,445	55,701	55,380	(321)

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

	Month of April		Ten months to date		
	2024	2025	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	12,641	13,175	128,955	124,400	-4,555
Out-patient requisitions	11,315	11,675	105,038	108,859	3,821
Emergency room requisitions	610	442	7,033	5,468	-1,565
Interdepartmental requisitions	6,402	7,122	66,049	68,950	2,901
Total requisitions	30,968	32,414	307,075	307,677	602
LABORATORY					
In-patient procedures	33,663	36,270	362,312	357,468	-4,844
Out-patient procedures	43,836	50,136	292,890	450,883	157,993
Emergency room procedures	12,552	11,770	128,354	124,813	-3,541
Total patient procedures	90,051	98,176	783,556	933,164	149,608
BLOOD BANK					
Units processed	277	287	2,836	2,777	-59
ELECTROCARDIOLOGY					
In-patient procedures	1,110	1,255	10,988	11,345	357
Out-patient procedures	411	552	3,918	4,477	559
Emergency room procedures	1,397	1,273	12,408	12,957	549
Total procedures	2,918	3,080	27,314	28,779	1,465
CATH LAB					
In-patient procedures	103	148	1,224	1,337	113
Out-patient procedures	152	126	1,233	1,227	-6
Emergency room procedures	1	0	1	2	1
Total procedures	256	274	2,458	2,566	108
ECHO-CARDIOLOGY					
In-patient studies	372	408	3,807	3,964	157
Out-patient studies	311	401	2,824	3,442	618
Emergency room studies	0	2	9	16	7
Total studies	683	811	6,640	7,422	782
NEURODIAGNOSTIC					
In-patient procedures	114	137	1,261	1,375	114
Out-patient procedures	14	31	174	254	80
Emergency room procedures	0	0	0	1	1
Total procedures	128	168	1,435	1,630	195

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

	Month of April		Ten months to date		
	2024	2025	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	1	0	1	1
Out-patient procedures	301	298	2,487	2,870	383
Emergency room procedures	0	0	0	0	0
Total procedures	301	299	2,487	2,871	384
RADIOLOGY					
In-patient procedures	1,261	1,289	13,027	13,033	6
Out-patient procedures	428	499	4,057	4,462	405
Emergency room procedures	1,638	1,494	15,017	15,531	514
Total patient procedures	3,327	3,282	32,101	33,026	925
MAGNETIC RESONANCE IMAGING					
In-patient procedures	166	198	1,462	1,801	339
Out-patient procedures	104	193	1,107	1,199	92
Emergency room procedures	6	4	61	59	-2
Total procedures	276	395	2,630	3,059	429
MAMMOGRAPHY CENTER					
In-patient procedures	4,579	4,444	41,698	38,618	-3,080
Out-patient procedures	4,548	4,434	41,263	38,482	-2,781
Emergency room procedures	0	0	9	10	1
Total procedures	9,127	8,878	82,970	77,110	-5,860
NUCLEAR MEDICINE					
In-patient procedures	22	15	199	152	-47
Out-patient procedures	125	147	1,142	1,337	195
Emergency room procedures	1	1	3	3	0
Total procedures	148	163	1,344	1,492	148
PHARMACY					
In-patient prescriptions	76,901	82,921	837,441	801,577	-35,864
Out-patient prescriptions	16,760	18,952	158,726	169,897	11,171
Emergency room prescriptions	10,207	9,626	93,965	98,505	4,540
Total prescriptions	103,868	111,499	1,090,132	1,069,979	-20,153
RESPIRATORY THERAPY					
In-patient treatments	15,415	15,559	161,573	149,268	-12,305
Out-patient treatments	1,236	811	11,301	9,359	-1,942
Emergency room treatments	558	413	5,079	5,270	191
Total patient treatments	17,209	16,783	177,953	163,897	-14,056
PHYSICAL THERAPY					
In-patient treatments	2,490	2,170	24,962	22,991	-1,971
Out-patient treatments	231	443	2,600	2,858	258
Emergency room treatments	0	0	0	0	0
Total treatments	2,721	2,613	27,562	25,849	-1,713

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

	Month of April		Ten months to date		
	2024	2025	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,305	1,407	14,086	14,596	510
Out-patient procedures	163	342	2,335	2,293	-42
Emergency room procedures	0	0	0	0	0
Total procedures	1,468	1,749	16,421	16,889	468
SPEECH THERAPY					
In-patient treatments	437	573	4,988	5,326	338
Out-patient treatments	38	47	387	385	-2
Emergency room treatments	0	0	0	0	0
Total treatments	475	620	5,375	5,711	336
CARDIAC REHABILITATION					
In-patient treatments	0	0	11	6	-5
Out-patient treatments	719	765	5,473	6,249	776
Emergency room treatments	3	3	3	4	1
Total treatments	722	768	5,487	6,259	772
CRITICAL DECISION UNIT					
Observation hours	251	286	3,128	2,542	-586
ENDOSCOPY					
In-patient procedures	88	58	780	793	13
Out-patient procedures	65	58	567	570	3
Emergency room procedures	0	0	0	4	4
Total procedures	153	116	1,347	1,367	20
C.T. SCAN					
In-patient procedures	689	833	7,172	7,676	504
Out-patient procedures	353	478	3,513	4,943	1,430
Emergency room procedures	756	694	7,311	7,213	-98
Total procedures	1,798	2,005	17,996	19,832	1,836
DIETARY					
Routine patient diets	14,091	17,237	164,397	159,796	-4,601
Meals to personnel	30,362	34,658	285,172	350,539	65,367
Total diets and meals	44,453	51,895	449,569	510,335	60,766
LAUNDRY AND LINEN					
Total pounds laundered	93,500	102,883	967,005	993,166	26,161

"An Integrated Healthcare Delivery System"

Operating & Capital Budget
Fiscal Year 2026

***Finance Committee:** Monday May 19, 2025*

Scott Cleveland

Interim Chief Financial Officer

MISSION

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

VISION

A community where good health grows through every action, in every place, for every person.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS

JOEL HERNANDEZ LAGUNA
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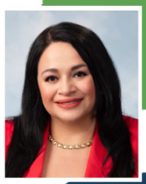
CATHERINE CARSON
VICE PRESIDENT

ROLANDO CABRERA, MD
SECRETARY

VICTOR REY JR.
TREASURER



ISAURA [illegible]
ASSISTANT TREASURER

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SVH FY26 Budget In Relation To Our Organizational Pillars

People	Service	Quality	Finance	Growth	Community
Support for recruitment and retention – FY26 plan continues to reduce utilization of contract labor	Budget continues to fund service initiatives throughout organization	SVH will continue to investment in a culture of safety. The budget will support recruitment of a patient safety manager and adoption of a team approach to creating a do-no-harm safety culture throughout the organization	A conservative plan for FY26 sets the organization up for future growth	The FY26 budget funds initiatives to ensure future growth, such as an expanded ambulatory network and expanded hours for imaging services. This includes the hiring of both primary care providers, as well as specialists.	Funding for community benefit initiatives and donations is included in the FY26 plan
Continues to support training and education for staff at all levels. Funds are fully budgeted for staff training.	Capital budget continues to fund improved facilities and modernization of equipment	The capital budget provides a significant investment in funding the transition from Meditech to Epic. The go-live date is 11/8/2025.	A larger than typical capital budget is dedicated to initiatives that will enable financial success in the future		Community events and initiatives continue to be part of the FY26 plan and are reflected in the incentive plan
Budgets includes funds for staff recognition at the department level	SVH Clinics continue to improve access to primary and specialty services	SVH is committed to providing exceptional quality care and consistently obtaining a CMS 5 star rating. Programs focused on quality continue to be funded with no reductions.	Financial stability is ensured with a conservative budget that maintains a high level of cash on hand while providing funds for large investments in Epic and facilities. SVH continues to be debt free.	The capital budget includes funding for Epic, as well as future expansions, to ensure a foundation for growth	New physician recruitments are being added in areas where community demand exists, such as Urology, Primary Care and Women's Health services
The Magnet program is fully funded as FY26 is a designation year, including travel and training for staff		Key staff are being added where needed, such as a Medication Reconciliation Pharmacy Tech and a Data Analytics and Outcomes Coordinator in the Pharmacy		SVH Clinic plans to hire 12.1 new provider FTEs and 3.0 physician extender FTEs in FY26	As a community based organization, SVH will continue to be "payor blind" as allowable by economics.

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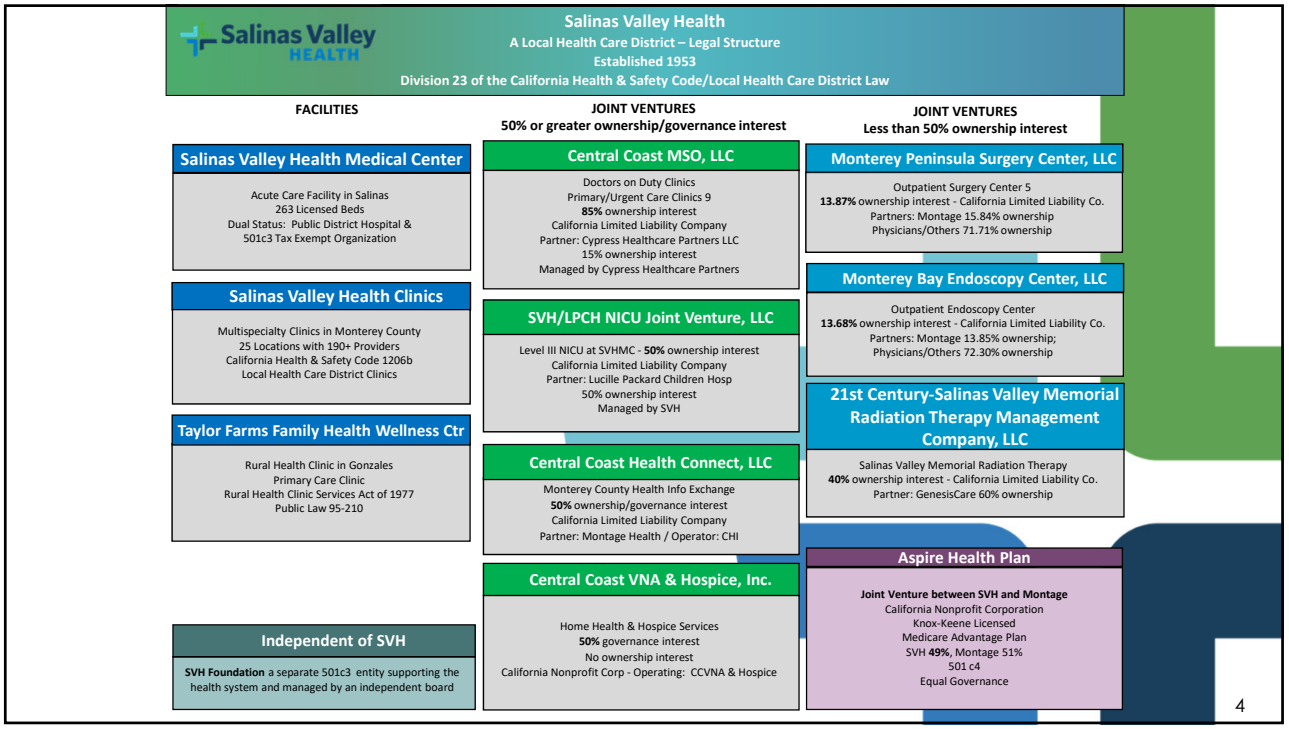

Salinas Valley Health Medical Center
Key Operating Budget Assumptions

- **Consolidated Operating Margin % : 0.4%**
- **Budget FY 2026 – Incorporates patient volumes based on current trends**

Statistic	FY 2026 Budget	FY 2025 Projected
ADC	114	114
Admissions	10,966	11,198
ALOS	3.8	3.7
IP Surgery Cases	1,719	1,756
OP Surgery Cases	3,447	3,531
Deliveries	1,536	1,331
ER Admissions	8,460	8,641
ER OP Visits	54,791	54,137
Total ER Admissions % of Admissions (excl OB ED)	85%	85%

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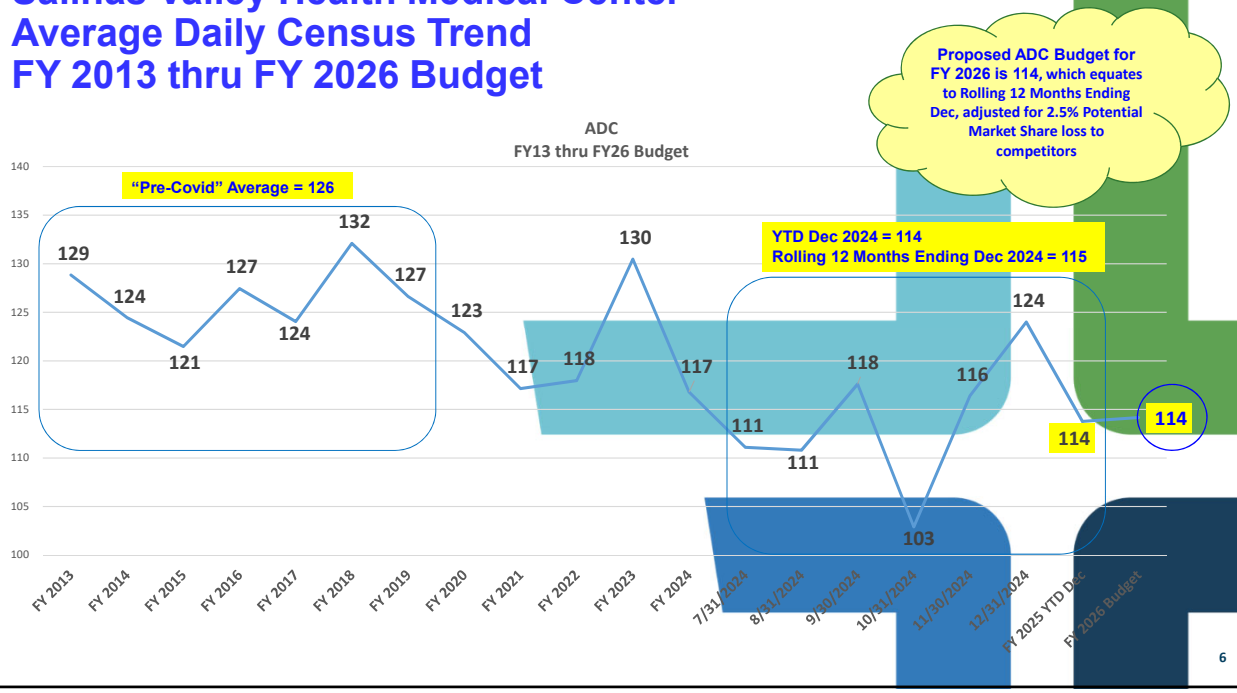
Salinas Valley Health Medical Center
Average Daily Census Trend
FY 2013 thru FY 2026 Budget



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Salinas Valley Health Clinics
Key Assumptions FY26 Budget

- **Volumes**, **Gross Charges** & **Net Revenues:** New provider ramp up period reflected, remaining same store business are generally budgeted to a normalized version of FY2025
- **Reimbursement rates:** Current yield to reflect recently negotiated contract rates for Commercial Health Plans
- **Incorporate retention/recruitment** of physicians and / or expansion of new practices and service lines
- **Incorporate negotiated rate increases** to physician professional services agreements at fair market values
- **Incorporate inflationary increases** to salaries, wages & benefits of non-physician staff, purchased services and supplies/non-labor expenses

Proposed Consolidated FY 2026 Budget Compared to FY 2025 Projection

PL SUMMARY	FY 2026 Budget CONSOLIDATED TOTAL	FY 2025 Projection CONSOLIDATED TOTAL	CONSOLIDATED Variance	% Change
GROSS PATIENT REVENUE	3,749,945,189	3,553,687,043	196,258,146	5.5%
NET PATIENT REVENUE	806,084,874	782,826,736	23,258,138	3.0%
Yield	21.5%	22.0%	-0.5%	-2.4%
OTHER REVENUE	31,013,705	38,005,010	(6,991,305)	-18.4%
TOTAL REVENUE	837,098,578	820,831,746	16,266,833	2.0%
TOTAL OPERATING EXPENSES	833,516,907	763,431,340	(70,085,567)	-9.2%
OPERATING MARGIN	3,581,671	57,400,406	(53,818,734)	-93.8%
OPERATING MARGIN %	0.4%	7.0%	-6.6%	-93.9%
EBITDA	45,265,845	92,719,193	(47,453,348)	-51.2%
EBITDA %	5.4%	11.3%	-5.9%	-52.1%
OTHER NON OPERATING INCOME	29,759,052	41,713,324	(11,954,272)	-28.7%
TOTAL MARGIN	33,340,724	99,113,730	(65,773,007)	-66.4%
TOTAL MARGIN %	4.0%	12.1%	-8.1%	-67.0%

Consolidated Operating Margin Reconciliation of Key Drivers
Explanation of <$53.8M> Change from FY25 Projected Actual to FY26 Budget

Net Revenue - Impact of Charge Increase (6% 1/1/25 & 5% 1/1/26)	$ 12,312,332
2.5% Out Migration to Competitor, Net of Expenses	$ (4,007,148)
Quality Incentive Program (QIP) Revenue - Estimated 75% of FY25	$ (1,761,423)
EPIC Inpatient Operating Expenses Eff 12/1: SWB, Supplies, Depreciation	$ (14,186,353)
Salaries Wage and Benefit: Rate increases	$ (10,810,450)
Net Incremental FTEs: New FTEs for FY26, Partial Year Vacancies, Labor Standard Changes, LOA Coverage & Other	$ (8,556,923)
Benefits: Group Health, Pension, Workers Comp & Other	$ (6,192,583)
Supply Inflationary Costs (3.0% - 5.0%)	$ (3,366,365)
IT Purchased Services (Software Licensing & Other)	$ (1,202,916)
Depreciation	$ (1,223,471)
Increase in SVH Clinics Support Costs	$ (14,928,779)
Other	$ 105,345
TOTAL	$ (53,818,734)

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Salinas Valley Health Medical Center
FY 2026 Budget Net Revenue

Net Revenue Rollforward	Amount $
FY 2025 Projected Net Revenue	**$679.3M**
Net Revenue - Impact of Charge & Rate Increase	**$12.3M**
2.5% Market Share Loss to Competitor: Net Revenue Impact effective 1/1/26	**<$6.4M>**
Expansion of Outpatient Imaging Services – Added PM Hours M-F	**$1.2M**
Total Incremental Change to Net Revenue Adjustments to Baseline	**$7.2M**
FY 2026 Budgeted Net Revenue	**$686.5M**

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Salinas Valley Health Medical Center
Potential Impact of Competitor Entering Monterey

- The budget incorporates a 2.5% market share loss Commercial & Medicare to Competitor effective 1/1/26. The Total Net Revenue Loss is <$6.3M> while the Total Direct Margin Loss is <$4.0M> as illustrated below:

6 Impact to Fiscal Year 2026 Beginning January 1, 2026 :

	Inpatient	Outpatient	Total
Cases	(97)	(1,005)	(1,102)
Days	(398)	-	(398)
ADC	(1.1)	-	(1.1)
Net Revenue	$ (3,273,897)	$ (3,078,435)	$ (6,352,332)
Direct Cost	$ 1,480,518	$ 864,665	$ 2,345,184
Total Direct Margin Loss	$ (1,793,379)	$ (2,213,770)	$ (4,007,149)

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Salinas Valley Health Medical Center
FY 2026 Budget Other Revenue

Other Revenue Rollforward	Amount $
FY 2025 Projected Other Revenue	$24.2M
Blue Zones Revenue – Contract Ends September 2025	<$1.8M>
Quality Incentive Program QIP – Assume 75%	<$1.8M>
Retail Pharmacy Sales	<$132K>
Total Incremental Change to Other Revenue Adjustments to Baseline	<$3.7M>
FY 2026 Budgeted Other Revenue	$20.6M

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Blue Zone Financial Comparison
FY2025 Projection & FY2026 Budget

	FY2025 Projection	FY2026 Budget	Variance	Notes
Sponsorship Revenue A. Montage (48%) B. Taylor Farms (4%) Total Revenue	$1,857,355 $200,000 $2,057,355	$348,600 $29,050 $377,650	($1,508,755) ($170,950) ($1,679,705)	Sponsorship revenue ending September 2025 due to internalizing program
Total Expenses (Excluding VP & Director of Government Affairs in FY2025)	$4,400,800	$1,535,749	$2,865,051	Contract ends September 2025
Net Cost to SVH	**($2,343,445)**	**($1,158,100)**	**$1,185,346**	
SVH Paid FTE	0.0	3.7	(3.7)	5 FTE effective October 1
Contracted FTE	13.0	0.0	13.0	
Total FTE	**13.0**	**3.7**	**9.3**	

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SVHC
Net Income from Operations - Roll-Forward
FY 2026 Budget

FY 2025 Projected Net Income from Operations	**(43,370,558)**
Operating Margin %	-45.7%
EPIC Cost	-
"All Other Business" :	
18 New FY26 Providers, Rate Increases, Ramp up of FY25 Providers	(11,566,265)
Eliminate One Time Grants / Primary Care First Funds (Other Revenue)	(3,362,516)
Total Change	**(14,928,781)**
FY 2026 Budgeted Net Income From Operations	**(58,299,339)**
Operating Margin %	-56.1%

SVHMC & SVHC Summary
Operating Margin "Bridge"

SVHMC Operating Margin Reconciliation	Dollar Impact
Operating Margin FY 2025 Projected	$ 104,920,118
Operating Margin % FY 2025 Projected	14.9%
SVHMC: Change in Operating Margin	$ (40,244,704)
Operating Margin FY 2026 Budget	$ 66,053,759
Operating Margin % FY 2026 Budget	9.3%

SVHC Operating Margin Reconciliation	Dollar Impact
Operating Margin FY 2025 Projected	$ (43,370,559)
Operating Margin % FY 2025 Projected	-45.7%
SVHC: Change in Operating Margin	$ (14,928,779)
Operating Margin FY 2026 Budget	$ (58,299,338)
Operating Margin % FY 2026 Budget	-56.1%

- ✓ SVHMC & SVHC Total Impact to Operating Margin = <$55.2M>
- ✓ DOD +$61K
- ✓ Foundation <$85K>

→ Total Impact to Operating Margin = <$53.8M>

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Salinas Valley Health
Key Budget Non-Operating Income Changes

Changes in Non-Operating Revenue	Amount
FY 2025 Projected Non Operating Income Loss	**$41.7M**
Donations – Increase in Foundation Donations offset by Lower Investment Returns	$1.7M
FEMA / Grants – Eliminate One Time Payments received in FY 2025	<$5.6M>
Property Taxes	$286K
Investment Earnings Budgeted at 3.0 - 3.5%	<$10.1M>
Equity in Subsidiaries	$9K
Minority Interest in Affiliates DOD	<$9K>
Total Year over Year Change	**<$12.0M>**
FY 2026 Budgeted Non Operating Income Loss	**$29.7M**

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Projected FY 2025 - Consolidated

FY 2025 Projection

PL SUMMARY	SVHMC	SVHC	DOD	Foundation	CONSOLIDATED TOTAL
GROSS PATIENT REVENUE	3,339,915,709	179,666,901	34,104,434	0	3,553,687,043
NET PATIENT REVENUE	679,302,159	81,784,183	21,740,394		782,826,736
Yield	20.3%	45.5%	63.7%	0.0%	22.0%
OTHER REVENUE	24,344,632	13,034,306	626,073		38,005,010
TOTAL REVENUE	703,646,790	94,818,489	22,366,467	0	820,831,746
TOTAL OPERATING EXPENSES	598,726,672	138,189,047	22,131,701	4,383,919	763,431,340
OPERATING MARGIN	104,920,118	(43,370,559)	234,766	(4,383,919)	57,400,406
OPERATING MARGIN %	14.9%	-45.7%	1.0%	0.0%	7.0%
EBITDA	137,905,396	(41,584,062)	781,778	(4,383,919)	92,719,193
EBITDA %	19.6%	-43.9%	3.5%	0.0%	11.3%
OTHER NON OPERATING INCOME	35,754,227	-	(35,215)	5,994,312	41,713,324
TOTAL MARGIN	140,674,345	(43,370,559)	199,551	1,610,393	99,113,730
TOTAL MARGIN %	20.0%	-45.7%	0.9%	0.0%	12.1%

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Budget FY 2026 - Consolidated

FY 2026 Budget

PL SUMMARY	SVHMC	SVHC	DOD	Foundation	CONSOLIDATED TOTAL
GROSS PATIENT REVENUE	3,511,722,726	198,927,442	39,295,021	0	3,749,945,189
NET PATIENT REVENUE	686,506,583	94,181,388	25,396,903		806,084,874
Yield	19.5%	47.3%	64.6%	0.0%	21.5%
OTHER REVENUE	20,659,546	9,671,790	682,369		31,013,705
TOTAL REVENUE	707,166,129	103,853,178	26,079,272	0	837,098,578
TOTAL OPERATING EXPENSES	641,112,370	162,152,516	25,783,426	4,468,595	833,516,907
OPERATING MARGIN	66,053,759	(58,299,338)	295,845	(4,468,595)	3,581,671
OPERATING MARGIN %	9.3%	-56.1%	1.1%	0.0%	0.4%
EBITDA	105,772,749	(56,972,190)	933,881	(4,468,595)	45,265,845
EBITDA %	15.0%	-54.9%	3.6%	0.0%	5.4%
OTHER NON OPERATING INCOME	24,045,207	-	(44,377)	5,758,222	29,759,052
TOTAL MARGIN	90,098,966	(58,299,338)	251,468	1,289,627	33,340,724
TOTAL MARGIN %	12.7%	-56.1%	1.0%	0.0%	4.0%

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Statement of Cash Flow - Consolidated
FY16 Actuals – FY26 Budget

Dollar amounts in 000's	Audited 2016	Audited 2017	Audited 2018	Audited 2019	Audited 2020	Audited 2021	Audited 2022	Audited 2023	Audited 2024	Projected 2025	Budget 2026	
Sources of cash:												
Net income (loss) from operations	31,502	43,317	70,065	69,173	89,435	70,579	46,012	27,432	28,452	57,400	3,582	▼ $53.8M
Add back depreciation	20,225	20,267	20,729	21,970	22,385	26,929	34,481	35,844	36,263	35,319	41,684	
Add back non-cash pension expense	12,900	17,860	16,800	24,300	24,069	15,463	17,500	27,783	15,875	5,800	7,200	
Sale of assets	0	0	0	0	0	7,981	(1,864)	1	1,762	0	0	
Non-operating income (loss)	9,822	6,568	15,396	9,187	24,679	14,884	(3,774)	38,662	48,542	41,713	29,759	
Change in net current assets	2,124	(541)	(18,445)	27,945	4,677	32,579	(29,549)	(32,124)	(23,027)	(19,855)	(17,921)	
Total Sources of Cash**	**76,573**	**87,471**	**104,545**	**152,575**	**165,245**	**168,415**	**62,806**	**97,598**	**107,867**	**120,378**	**64,304**	▼ $56.1M
Uses of cash:												
Capital and strategic investments	28,142	19,854	13,324	34,067	45,225	16,810	32,576	35,346	28,875	85,500	71,700	▼ $13.8M
Pension plan deposits***	12,900	22,860	20,723	27,300	26,809	22,740	68,082	24,924	12,462	12,742	22,750	
Payments on long-term debt	776	41	43	46	48	89	89	65	103	100	100	
Total uses of cash	**41,818**	**42,755**	**34,090**	**61,413**	**72,082**	**39,639**	**100,747**	**60,335**	**41,440**	**98,342**	**94,550**	▼ $3.8M
Net cash flow	**34,755**	**44,716**	**70,455**	**91,162**	**93,163**	**128,776**	**(37,941)**	**37,263**	**66,427**	**22,036**	**(30,246)**	▼ $52.3M
Beginning cash and investments	195,258	230,013	274,729	345,184	436,346	529,509	658,284	620,343	657,607	724,034	746,069	
Ending cash and investments	**230,013**	**274,729**	**345,184**	**436,346**	**529,509**	**658,284**	**620,343**	**657,607**	**724,034**	**746,069**	**715,823**	▼ $30.2M
Days cash on hand	**216**	**233**	**268**	**307**	**352**	**375**	**355**	**350**	**372**	**355**	**317**	▼ 39 days

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Salinas Valley Health
Key Financial Indicators

Statistic	S&P A+ Rated Hospitals	AUDITED 2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025 Projected	2026 Budget
Operating Margin	4.0%	4.3%	7.8%	7.1%	8.8%	12.5%	10.8%	13.5%	8.4%	6.6%	3.7%	3.7%	7.0%	0.4%
Total Margin	6.6%	7.5%	10.2%	9.3%	10.1%	14.8%	12.0%	17.2%	10.5%	6.0%	8.9%	9.9%	12.1%	4.0%
EBITDA	13.6%	13.5%	15.5%	13.9%	14.2%	18.5%	19.6%	20.6%	14.5%	10.3%	8.4%	8.4%	11.3%	5.4%
Days of Cash and Investments	249	162	219	216	233	268	269	352	374	359	350	372	355	317
Debt Service Coverage Ratio	3.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Debt to Capitalization	42.4%	0.7%	0.5%	0.3%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Days of Accounts Receivable	49.0	49.2	44.1	52.7	54.5	46.0	51.0	47.0	45.7	50.0	49.0	55.0	65.0	65.0
Supply Expense as % NPR	n/a	11.7%	11.4%	13.0%	13.2%	12.1%	11.8%	11.9%	12.1%	12.4%	12.5%	13.5%	14.6%	14.6%
SWB Expense as % NPR	53.7%	60.1%	57.8%	54.0%	52.4%	49.2%	49.5%	49.8%	50.1%	49.2%	32.1%	51.3%	50.7%	54.1%

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Unbudgeted Supplemental Government Revenues

Governmental Supplemental Payments for SVHMC

Program	Net Benefit FY 2025	Net Benefit FY 2026	Purpose	Eligibility	Allocation Driver
1. CCAH IGT - Medi-Cal Managed Care Capitation: Rate range Program Payments	3,861,215	3,861,215	Cover the shortfall in Medi-Cal Reimbursement	Non-Desigated Public Hospitals	% of Medi-Cal Managed Care Days
2. DHCS IGT - AB-113 - Traditional Medi-Cal: Rate Range Program Payments	2,120,221	2,120,221	Cover the shortfall in Medi-Cal Reimbursement	Non-Desigated Public Hospitals	% of Medi-Cal Fee for Service Days
3. Medi-Cal Quality Incentive Program-QIP (PRIME)	7,045,692	5,284,269	Improve Quality of Care	Non-Desigated Public Hospitals	% of Medi-Cal Volumes
4. AB 915 Medi-Cal Supplemental Outpatient Reimbursement for Traditional Medi-Cal	1,099,302	1,099,302	Fund OP Cost of Medi-Cal	Owned or Operated by Govt or District	Hospital Specific
5. District Hospital Directed Payment Program - New Program that will incorporate HQAF AB-239 plus additional funding	4,797,482	7,675,971	Cover the shortfall in Medi-Cal Reimbursement	Non-Desigated Public Hospitals	% of Medi-Cal Managed Care Days, ER Visits, OP Visits
Total	18,923,912	20,040,978			

Total Less QIP Already in Proj/Bud	11,878,220	14,756,709
	At 100%	At 75%
Add All Other Subsidies	11,878,220	11,067,532
Adjusted Margin $ Would Be:	69,278,626	14,649,203
Adjusted Margin % Would Be:	8.3%	1.7%

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Consolidated FY 2026 Budget Compared to FY 2025 Projection *(With Budgeting Subsidies at 75%, Projecting Subsidies at 100%)*

PL SUMMARY	FY 2026 Budget CONSOLIDATED TOTAL	FY 2025 Projection CONSOLIDATED TOTAL	CONSOLIDATED Variance	% Change
GROSS PATIENT REVENUE	3,749,945,189	3,553,687,043	196,258,146	5.5%
NET PATIENT REVENUE	817,152,406	794,704,956	22,447,450	2.8%
Yield	21.8%	22.4%	-0.6%	-2.6%
OTHER REVENUE	31,013,705	38,005,010	(6,991,305)	-18.4%
TOTAL REVENUE	848,166,110	832,709,966	15,456,145	1.9%
TOTAL OPERATING EXPENSES	833,516,907	763,431,340	(70,085,567)	-9.2%
OPERATING MARGIN	14,649,203	69,278,626	(54,629,423)	-78.9%
OPERATING MARGIN %	1.7%	8.3%	-6.6%	-79.2%
EBITDA	56,333,377	104,597,413	(48,264,036)	-46.1%
EBITDA %	6.6%	12.6%	-5.9%	-47.1%
OTHER NON OPERATING INCOME	29,759,052	41,713,324	(11,954,272)	-28.7%
TOTAL MARGIN	44,408,256	110,991,950	(66,583,695)	-60.0%
TOTAL MARGIN %	5.2%	13.3%	-8.1%	-60.7%

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FY 2026 Budget – Risks Not In Budget

- Potential loss of Medi-Cal coverage for 60,000 people in Monterey County with undocumented immigration status =➔ may lead to material increase in Bad Debt Expense.
- Congress to vote on potential $550-880 billion Medicaid cut, posing a direct threat to the well-being of 15 million Californians, including children, seniors, the disabled, pregnant women, veterans and low-income working families who rely on Medicaid for essential health care.
- Potential for continued decline in reimbursement from governmental, commercial payors including employers.
- Potential Market Share loss to competitors beyond budgeted 2.5%
- Further payor mix deterioration decline of Commercial business coupled with increase in Medi-Cal and Medicare hospital business.
- Financial dependency on Outpatient Infusion Therapy Program.
- Implications of assessed tariffs from countries outside of U.S. and inflation in supply chain / other
- OHCA potential spending targets limitation may require material decline in reimbursement.

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Strategic Growth Opportunities & Expense Savings Initiatives - Not in Budget

Growth / Revenue Initiatives

- ✓ **Contract Negotiations** with CCAH: **$10M - $30M** (Over 3 years)
  a. Quality Performance Incentives
  b. EPIC Infrastructure Funding
  c. Contract Rate Increases
- ✓ **EPIC** – Charge Capture: **$500K**
- ✓ **340B Expansion** - Supply Savings Opportunity: **$5M - $10M**
- ✓ **Innovation and Research**: **TBD**
- ✓ **Acute Rehabilitation Unit** (Exploration): **TBD**
- ✓ **Investment Growth Strategy**
  a. Transfer of Funds via a Gift / Donation to Salinas Valley Health Foundation: **TBD**
  b. Establish a separate 501(c)3 under new governance: **TBD**
- ✓ **Revenue cycle** opportunities & develop plan for improvement where needed
- ✓ **Continue renegotiating contracts** as needed with commercial payors with a focus on both hospital and clinic revenues
- ✓ **A new neurosurgeon practice** is starting to see referrals. Over the next several years, this could replace **$1m-$1.5m** of operating margin as the practice grows.
- ✓ **2 New general surgeons** have been added. This could over next 2-3 years add **$1.5 - $2.5m** to operating margin as they become established and volume increases.

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Strategic Growth Opportunities & Expense Savings Initiatives - Not in Budget

Expense Savings

- ✓ **Aspire Expense Mitigation**: **$4M**
- ✓ **New and Coordinated Services** – Oncologic Surgery, Urologic Surgery, Comprehensive Cancer Center, Vascular Surgery, Interventional Radiology: **TBD**
- ✓ **Efficiency & Utilization Work** (Laboratory, Radiology, Telemetry, Pharmacy): **$500K**
- ✓ **Employee Health Plan Management**: **$500K**
- ✓ **LPCH-SVH NICU Joint Venture** Restructure Evaluation: **$500K**
- ✓ Limitations on **HOPD Medi-Cal Access**: **$1-4M**
- ✓ **Ongoing Labor & Supply Cost Efficiencies**: **TBD**

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Salinas Valley Health
Capital Budget Summary
FY 2026

FY2026 Capital Budget Summary		
Hospital Routine Capital	$	37.4m
Hospital Strategic Capital	$	3.5m
Hospital Epic Inpatient ($64.2m over FY25-28)	$	9.1m
Hospital Seismic Upgrade ($62.5m Total, Through FY28)	$	11.3m
Clinic Capital (Strategic and SVH Clinic Routine)	$	10.5m
Total Proposed Capital Budget For FY2026	$	71.7m

APPENDIX A

Other Detail Budget Information

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Salinas Valley Health Medical Center
FY 2026 Budget FTEs Rollforward

Category	Paid FTEs	SW&B Impact ($ in millions)
FY 2025 Projected FTEs	1,851.2	
Budgeted Incremental FTEs for FY 2026:		
✓ CEO New FTEs Approved for FY 2026	27.6	$4.3
✓ New FTEs Approved before FY 2025 but not yet filled	4.5	$1.0
✓ Labor Standard Changes (Nursing, Lab, Pharmacy, Other)	18.6	$4.5
Total FTEs not in Current Run Rate	50.7	$9.8
EPIC SVH Clinic FTE Increases	8.4	$1.1
EPIC Inpatient Project: Capitalize to Operating FTEs on 12/1/25	26.3	$5.4
Total EPIC FTE Increases	34.7	$6.6
LOA's (Leave of Absences)	10.1	$1.6
Partial Year Vacancies Filled	11.0	$2.2
Closed Positions - No Backfill	(6.7)	($1.8)
Vacancy Factor	(20.0)	($3.5)
Incremental FTEs (before Volume Variance)	79.7	$14.8
Volume Variance	(9.0)	($2.0)
Total Net Increase / (Decrease)	70.7	$12.8
FY 2026 Budget FTEs	1,921.9	

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Labor Standard Changes
Nursing/Cath Lab/ Imaging/ Pharmacy/ Magnet/ Other

	Department Name	Position Title	Paid FTEs	S&W Impact	SW&B Impact
	Labor Standard Changes		**18.6**	**$ 3,198,049**	**$ 4,477,269**
6081	Med Surg Cv Exp	Staff Nurse II	2.0	$ 374,400	$ 524,160
7022	P.A.R. Exp	Staff Nurse II	1.0	$ 187,200	$ 262,080
7114	Cath Lab Exp	Cath Lab Tech I	0.6	$ 90,617	$ 126,864
7118	Cath Lab RNs	Staff Nurse II	0.5	$ 93,600	$ 131,040
7140	Diagnostic Imaging	Tech Assistant II -Radiology	0.3	$ 17,306	$ 24,228
7170	Pharmacy Exp	Clinical Pharmacist	4.2	$ 863,200	$ 1,208,480
7170	Pharmacy Exp	ED Pharmacist Program	2.2	$ 447,200	$ 626,080
7221	Speech Therapy Exp	Speech Pathologist	0.5	$ 58,110	$ 81,354
8560	Admitting Exp	Registration Float Clerk II	2.8	$ 192,192	$ 269,069
8723	Magnet Program	Staff Nurse II	4.7	$ 874,224	$ 1,223,914

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SVHMC
Budgeted Salary Wage Increases

Affiliate	FY 2025	FY 2026 Budget
NON	3% Effective: 7/1/24	**3%** Effective: 7/1/25
CNA *	6.5% Effective: 12/23/24	**5.25%** + **1%** Step Increase Effective: 12/22/25
NUHW *	3.25% + 1% Step Increase Effective: 8/5/24	**3%** + **1%** Step Increase Effective: 8/4/25
LOCAL39	3.75% Effective: 7/8/24	**3.75%** Effective: 7/1/25
ESC	**3.5%** Effective: 9/30/24	**3.0%** Effective: 9/29/25

* Incorporates 1% Step Increases Effective July 1

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Salinas Valley Health Medical Center Benefits

	FY2020	FY2021	FY2022	FY2023	FY2024	FY2025	FY2026	Variance % FY25 - FY26
FICA	$14.3	$15.0	$15.1	$16.5	$17.0	$17.7	$18.9	7.0%
Employee Health Plans	$38.4	$43.4	$46.0	$47.1	$56.6	$50.9	$56.4	10.7%
Retirement Plans	$30.3	$22.1	$21.7	$36.9	$22.9	$15.3	$17.6	15.1%
Workers Compensation	-$0.5	$1.0	$1.7	$2.8	$2.3	$4.2	$4.4	5.0%
All Other	$0.1	$0.2	$0.2	-$0.1	$0.2	$0.3	$0.3	7.8%
	$82.5	**$81.7**	**$84.7**	**$103.2**	**$99.1**	**$88.4**	**$97.7**	**10.5%**

- **FICA** impact is the result of statutory requirements function of Salaries & Wages and Compensated Absences
- **Group health insurance** is expected to increase in FY 2026 based on current trends of health plan expenditures. This also includes moving Epic inpatient costs from capitalize to operating effective 12/1/25
- **Pension and retirement** is based on actuarial assumptions
- **Workers' Comp** is based on valuation & inflation

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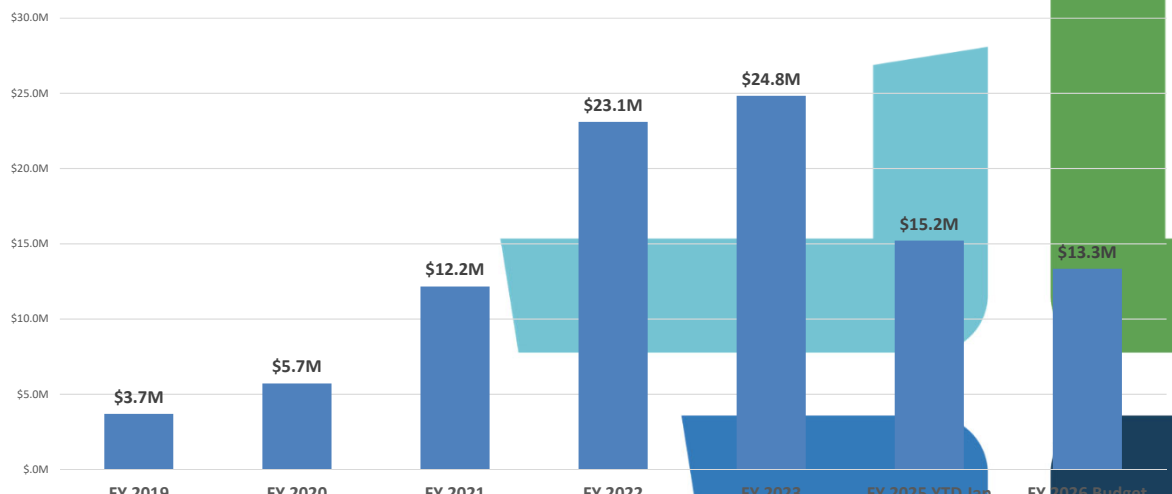
Salinas Valley Health Medical Center Contract Labor Cost per Year



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vizient

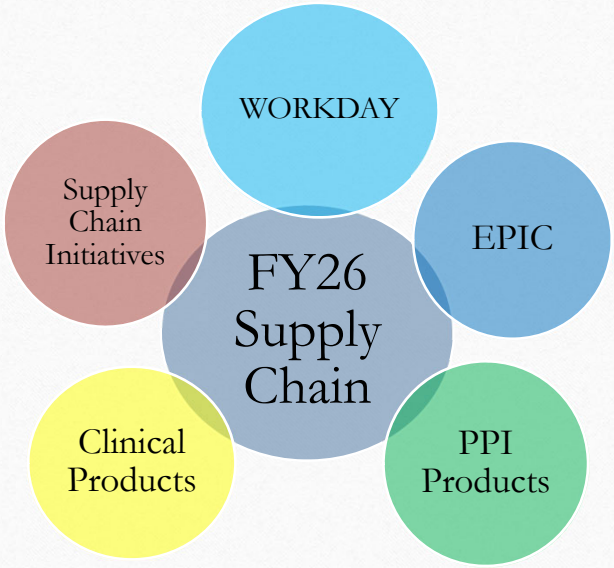
GPO - VIZIENT

Total Actual Realized Supply Savings
$15.2M ~ 9.5 Years

SUPPLY CHAIN

FY25 YTD SAVINGS: $2.2M
FY26 BUDGET $1M

- *FY25 COST AVOIDANCE 1.2M*



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WORKDAY ~ EPIC

- WORKDAY
- Item Master – 50K to 12K
- Asset Location – 20 to 2
- PAR location – Asset to Expense
- Purchase Requests
- Expense Approvals

- EPIC
- Item Master from Workday
- Supply Charge via EPIC
- Equipment orders via EPIC

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SAVINGS OPPORTUNITIES:
Supply Budget $1M
FY25 YTD $2.2M

- Physician Preference Items (PPI):
- FY25 YTD $1.8M
- Potential New $1.6M

- Clinical Items:
- FY25 YTD $442K
- Potential New $106K

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SUPPLY CHAIN INITIATIVES

- REPROCESSING $95K
- DME (BOOTS, CRUTCH, SPLINT)
- FURNITURE
- OFFICE SUPPLY
- NETWORK - WCPC
  WEST COAST PURCHASING COALITION
- ENDOMECHANICALS
- SUTURE
- NEURO
- SPINE
- UROLOGY

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WCPC SUPPLY CHAIN OPPORTUNITY $1.1M – 1.6M

Savings summary-Top 10 opportunities by savings

Contract Number	Contract Name	Hospital Spend	Performance Tier Net Savings (PR3)	Next Tier Net Savings (NX3)	Best Tier Net Savings (BST)
MS1116AJ	WCPC Zimmer Hip & Knee Implants (Matched only)	$ 1,419,222	$ 388,936	$ 471,340	$ 471,340
10010747	WCPC aptitude Stryker Orthopaedics Trauma	$ 769,232	$ (65,130)	$ 97,865	$ 290,412
10012679	WCPC aptitude Abbott Vascular Devices PV Stents	$ 384,740	$ 153,403	$ 153,403	$ 153,403
MS7531	WCPC Tela Bio Mesh	$ 387,325	$ 150,944	$ 150,944	$ 150,944
10012559	WCPC aptitude Argon Medical Devices Peripheral Vascular Products	$ 263,825	$ 107,725	$ 118,125	$ 118,125
SV4044AE	WCPC Stryker Sustainability Medical Device Reprocessing	$ 445,611	$ 112,154	$ 112,154	$ 112,154
10012786	WCPC aptitude Abbott Vascular Devices Standard Balloonsv.2	$ 241,235	$ 90,644	$ 90,644	$ 90,644
MS1144AF	WCPC Medtronic Cardiac Rhythm Management	$ 2,746,838	$ 89,179	$ 89,179	$ 89,179
10008710	WCPC aptitude BIOTRONIK Cardiac Rhythm Management 2	$ 524,019	$ 67,702	$ 67,702	$ 67,702
10000396	WCPC aptitude Zimmer Orthobiologics	$ 135,958	$ 39,163	$ 45,951	$ 56,308
		$ 7,318,005	$ 1,134,721	$ 1,397,308	$ 1,600,213

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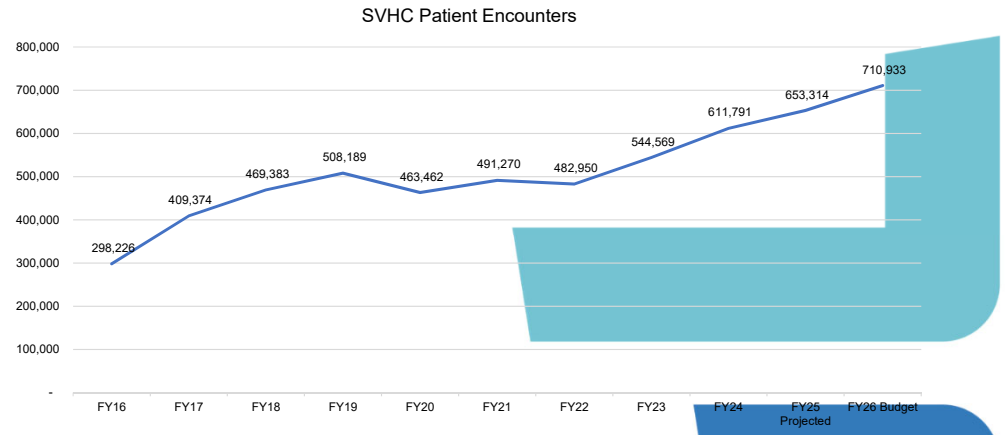
Salinas Valley HEALTH

CLINICS

SVHC Total Patient Encounters by Year



FY 2025 to FY 2026
Increase 57,619 or 8.8%

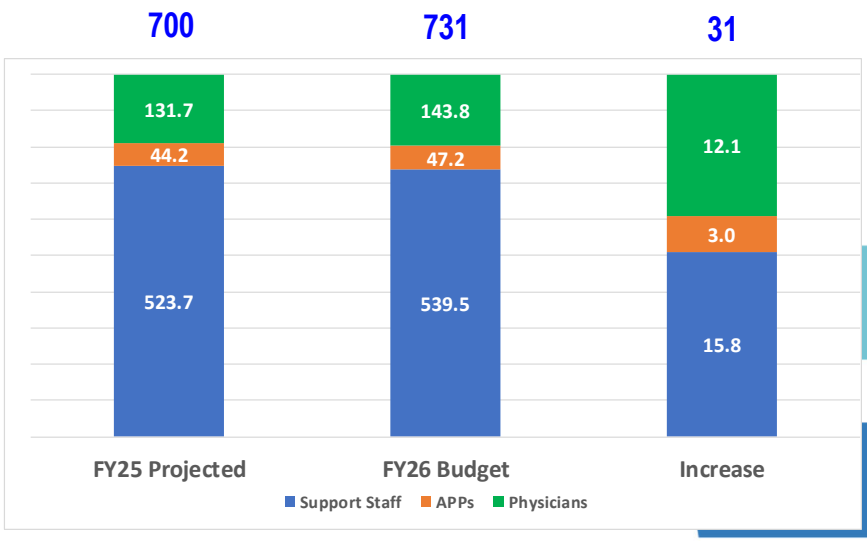
SVHC
Net Income from Operations - Roll-Forward
FY 2026 Budget

FY 2025 Projected Net Income from Operations	**(43,370,558)**
Operating Margin %	-45.7%
EPIC Cost	-
"All Other Business" :	
18 New FY26 Providers, Rate Increases, Ramp up of FY25 Providers	(11,566,265)
Eliminate One Time Grants / Primary Care First Funds (Other Revenue)	(3,362,516)
Total Change	**(14,928,781)**
FY 2026 Budgeted Net Income From Operations	**(58,299,339)**
Operating Margin %	-56.1%

SVHC Operating Budget FY 2026

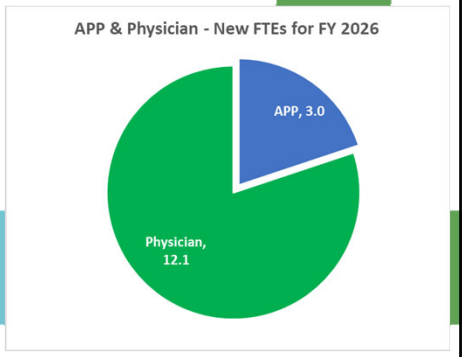
	(1) FY 2025 Projected Actuals	(2) FY 2026 Budgeted	(3) $ Change	(4) % Change
Total Patient Encounters	**653,314**	**710,933**	**57,619**	**9%**
Gross Patient Revenue	179,666,901	198,927,442	19,260,541	11%
Total Deductions	(97,882,718)	(104,746,054)	(6,863,337)	7%
Net Patient Revenue	81,784,183	94,181,387	12,397,204	15%
Yield %	46%	47%	2%	4%
Other Revenue	13,034,306	9,671,790	(3,362,516)	-26%
Total Net Revenue	***94,818,489***	***103,853,177***	***9,034,688***	***10%***
Operating Expenses				
Staff SWB	37,972,386	43,036,157	5,063,771	13%
APP SWB	8,725,474	12,180,899	3,455,425	40%
Physician SWB	58,021,246	72,028,939	14,007,693	24%
Total SWB	***104,719,106***	***127,245,995***	***22,526,889***	***22%***
Supplies	8,447,781	8,926,305	478,524	6%
Purchased Services	9,724,374	9,365,561	(358,813)	-4%
Other Fees and Services	9,675,466	10,892,035	1,216,569	13%
Utilities and Phones	1,001,567	1,023,558	21,991	2%
Property Tax and Insurance	1,765,362	1,972,034	206,672	12%
Repair & Maint/Equip Rental	1,043,490	1,374,476	330,986	32%
Rent	25,404	25,404	0	0%
Depreciation	1,786,497	1,327,148	(459,349)	-26%
Total Operating Expenses	**138,189,047**	**162,152,516**	**23,963,469**	**17%**
Operating Margin	(43,370,558)	(58,299,339)	(14,928,781)	**34%**
Operating Margin %	-45.7%	-56.1%		

SVHC – Staffing (FTEs)



SVHC Advance Practice Provider (APP) & Physicians Headcount & FTEs By Specialty

Type	Specialty	Headcount	FTEs
Advance Practice Provider (APP)	SVH Endocrinology	1	1.0
	SVH Oncology	1	1.0
	SVH General Surgery	1	1.0
Advance Practice Provider (APP) Total		**3**	**3.0**
Physician	SVH Hospitalist	1	0.8
	SVH Imaging	4	3.3
	SVH OB-GYN	3	2.3
	SVH PrimeCare Salinas	5	4.0
	SVH Rheumatology	1	0.8
	SVH Urology	1	0.8
Physician Total		**15**	**12.1**
Grand Total		**18**	**15.1**



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SVHC Operating Budget Summary for FY 2026

Increase in visits due to recruitment and new provider ramp-up

Yield based on 1/31/25, with a 2.5% decrease to account for projected Medicare and Medi-Cal/CCAH governmental funding impacts

Inflationary increases to expenses, including staff

Recruitment of providers related to growth

Total Patient Encounters	710,933
Net Patient Revenues + Other Revenues	103,853,177
Total Operating Expenses	162,152,516
Operating Loss	(58,299,339)
Operating Margin	-56.1%

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Salinas Valley HEALTH

SVH
Proposed Capital Budget
Fiscal Year 2026

Salinas Valley Health
Routine Capital Budget Summary, FY 2026

Sources of Capital - Total Capital		
General Operating Funds	$	70.7m
Foundation (allocation from estimated overall contribution)	$	1.0m
Total Sources of Capital	$	71.7m
Carryover Projects Started in FY2025 or Prior		
1 DRC - 200T Chiller Replacement (Non-IT Spaces) ($5.2m Total Capital over FY25 - FY27)	$	4.5m
2 Angio/Special Procedures Suite ($4.1m Total Capital over FY25 - FY26)	$	3.9m
3 Cath Lab 3 Replacement ($4.3m Total Capital over FY25-FY26)	$	3.9m
4 X-ray Room 1 & 2 ($3.5 m Total Capital Over FY25 - FY27)	$	2.3m
5 Lab Air Handler Replacement ($2.5M Total Capital Over FY25-27)	$	1.0m
6 Nurse Call System 3rd Phase (ICU/CCU, Imaging, Cath Labs, CT, OPS, Nuc Med) ($2.8M Total Capital Over FY25-27)	$	1.0m
7 L&D Skytron Delivery lights ($0.6m Total Capital over FY25-FY26)	$	0.5m
Subtotal Carryover Projects	$	17.2m

Salinas Valley Health
Routine Capital Budget Summary
FY 2026

	New Capital Under Consideration		
	Facilities/Construction		
1	Hospital Outpatient MRI Building MRI Replacement/Renovation ($4.1m Total Capital over FY26 - FY27)	$	3.1m
2	Roof Work, 5 Lower Ragsdale Building	$	1.5m
3	Gift Shop Relocation ($2.5m Total Capital over FY25 - FY27)	$	0.8m
4	Remodel; Part of Morgue Converted for IV Pump Cleaning and Storage	$	0.5m
5	Primary Transformer ($5.0m Total Capital over FY26 - FY27)	$	0.3m
6	Other Projects < $200k	$	0.03m
	Total New - Facilities/Construction	$	6.1m

Salinas Valley Health
Routine Capital Budget Summary, FY 2026

	New Capital Under Consideration (Continued)		
	Equipment		
1	Siemens FlexLab™ XLaboratory Automation to Interconnect Analyzers	$	1.4m
2	Par Ex - Bin Replacement, to replace exiting supply bins with weighted bins (for resupply)	$	0.9m
3	Ultrasound Systems, replace old systems (life cycle)	$	0.8m
4	Stryker Power System 9 to power Operating Room equipment	$	0.8m
5	Central Thermal Fluid Steam System (produces steam for heating in hospital, and steam for sterilizers) ($4.7m over FY26 - FY27)	$	0.7m
6	Hologic mammography Systems Hardware/Software Upgrade (life cycle)	$	0.6m
7	DRC Cooling Tower	$	0.5m
8	DRC 80 Ton Chiller (cooling for offices and warehouse)	$	0.4m
9	Microscope Operating Room - Zeiss Pentero 800 S System	$	0.4m
10	Intraaortic balloon pumps	$	0.4m
11	C-arm Replacement (Operating Room & Endoscopic Procedures)	$	0.3m
12	5 yr Hillrom Centrella Beds Project (113 Beds spread over 5 years, year 4, $1.3m Total)	$	0.3m
13	Other Projects < $200k	$	2.0m
	Total New - Equipment	$	9.5m

Salinas Valley Health
Routine Capital Budget Summary
FY 2026

	Information Technology		
1	Security, Replace internal security firewall	$	1.1m
2	Replacement/Expansion of Data Storage	$	0.6m
3	EPIC: Mobile Devices	$	0.6m
4	Server Replacement/Expansion	$	0.5m
5	User Devices, Hospital	$	0.4m
6	User Devices, Clinics	$	0.2m
7	Phone System - Migration to cloud based system with onsite backup	$	0.2m
8	Other Information Technology < $200k	$	1.0m
	Total New - Information Technology (Hospital Wide)	$	4.7m
	Total Fiscal Year 2026 Routine Capital	$	37.4m

Salinas Valley Health
Strategic Capital Budget Summary
FY 2026

Strategic Capital Targets:
Return on investment > 30%
Payback period of 4-5 years or less

	Strategic Capital Under Consideration		
1	New Emergency Room ($75m Capital Total Over FY25-FY29)	$	1.6m
2	MRI, Transition From Outside MRI ($8m Capital Total Over FY25-FY28)	$	0.7m
3	EPIC Office buildout & core restrooms - DRC ($2.0m Over FY25-26)	$	0.3m
4	Epic Training Rooms - Ryan Ranch ($1.0m Over FY25-26)	$	0.9m
	Total Hospital Strategic Capital	$	3.5m
5	North Salinas Medical Office Building (40,000 Square Feet, $25m Capital Total Over FY26 - FY28, Tentative)	$	5.0m
6	MRI Upgrade (626 Brunken, Salinas, $2.9m Capital FY25 - FY26)	$	2.4m
7	Clinic updates and equipment	$	1.0m
8	Primecare 355 Abbott Street Refresh ($1.2m over FY25 - FY26	$	1.1m
	Total Clinics Strategic Capital	$	9.5m
9	SVH Other	$	1.0m
	Total Strategic Capital Requests	$	13.9m

Salinas Valley Health
Capital Budget Summary
FY 2026

FY2026 Capital Budget Summary		
Hospital Routine Capital	$	37.4m
Hospital Strategic Capital	$	3.5m
Hospital Epic Inpatient ($64.2m over FY25-28)	$	9.1m
Hospital Seismic Upgrade ($62.5m Total, Through FY28)	$	11.3m
Clinic Capital (Strategic and SVH Clinic Routine)	$	10.5m
Total Proposed Capital Budget For FY2026	$	71.7m

Salinas Valley Health
Capital Plan Management
Fiscal Year 2026

- We will continue to manage the pace of capital spending relative to financial performance. Future capital spending will be dependent on the long term financial outlook.
- Administration will prioritize the proposed capital expenditures while staying within the overall approved spending levels in support of our days cash on hand goals.

FY 2025 Projected Actual Outperforms FY 2025 Budget

PL SUMMARY	FY 2025 Projection CONSOLIDATED TOTAL	FY 2025 Budget CONSOLIDATED TOTAL	FY 2025 Variance CONSOLIDATED TOTAL
GROSS PATIENT REVENUE	3,553,687,043	3,299,078,443	254,608,600
NET PATIENT REVENUE	782,826,736	721,345,541	61,481,195
Yield	22.0%	21.9%	0.2%
TOTAL REVENUE	820,831,746	749,107,111	71,724,635
TOTAL OPERATING EXPENSES	763,431,340	761,901,143	(1,530,197)
OPERATING MARGIN	57,400,406	(12,794,032)	70,194,438
OPERATING MARGIN %	7.0%	-1.7%	8.7%
EBITDA	92,719,193	21,890,327	70,828,866
EBITDA %	11.3%	2.9%	8.4%
OTHER NON OPERATING INCOME	41,713,324	36,127,485	5,585,839
TOTAL MARGIN	99,113,730	23,333,453	75,780,277
TOTAL MARGIN %	12.1%	3.1%	9.0%

Operating Margin, excluding governmental subsidies, except for QIP is projected to be 7.0%

Key Drivers
- ✓ Very strong financial performance
- ✓ Growth Initiatives
- ✓ Strong Outpatient Volumes & Operational Efficiencies

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FY25 YTD March
Strong Financial Performance has been driven by:

Admissions
Total admissions were 9% or 705 admits above budget

ALOS
ALOS were 11% favorable, 3.6 compared to 4.0

Collections
Collections were 12% or $48M above budget

Worked FTEs PAPD
Worked FTEs PAPD were 3% favorable, 6.3 compared to 6.5

IP Surgeries
IP Surgeries were 10% or 125 cases above budget

OP Surgeries
OP Surgeries were 11% or 277 cases above budget

Outpatient Infusion
Total Outpatient Infusion cases were 14% or 1,241 cases above budget

Outpatient Visits
Outpatient Visits were 29% or 38,698 cases above budget

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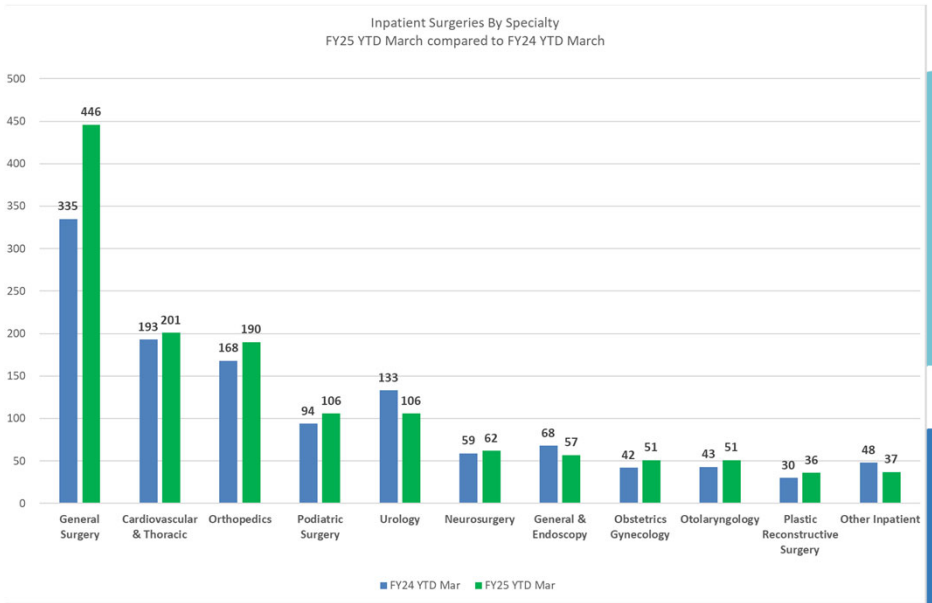
Inpatient Surgeries by Specialty
FY25 YTD March Compared to FY24 YTD March



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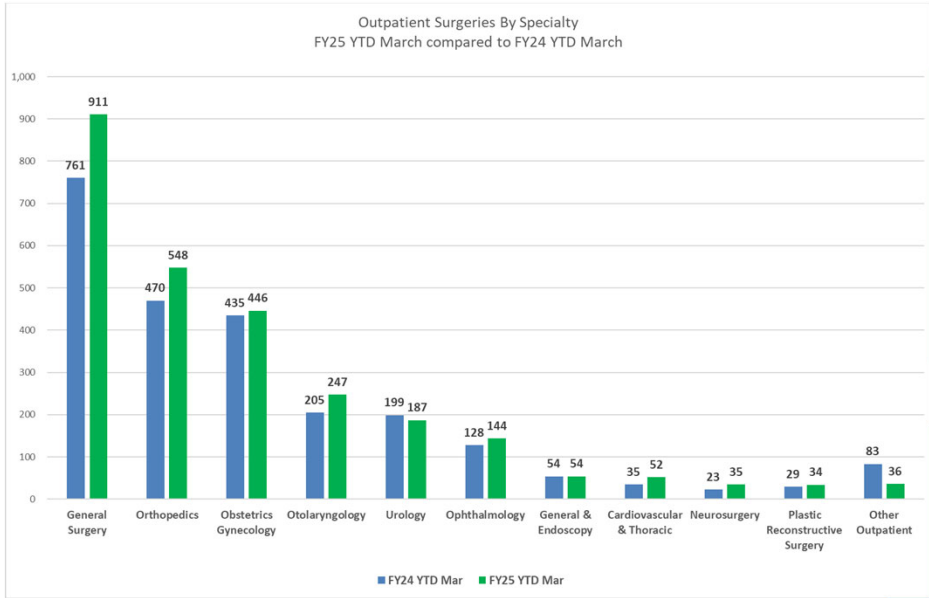
Outpatient Surgeries by Specialty
FY25 YTD March Compared to FY24 YTD March



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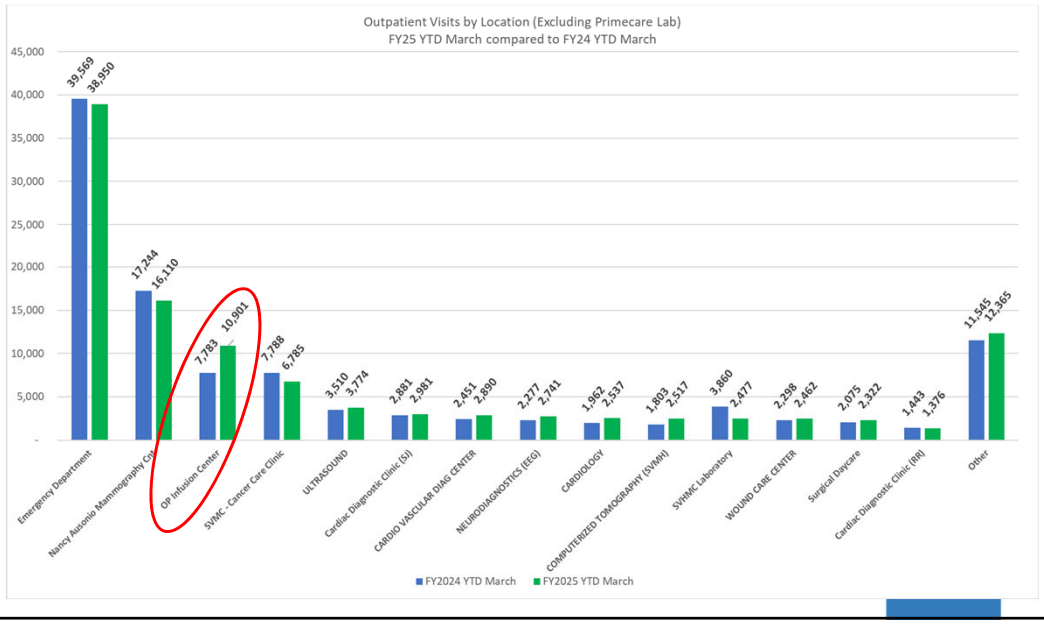
Outpatient Visits by Location
FY25 YTD March Compared to FY24 YTD March



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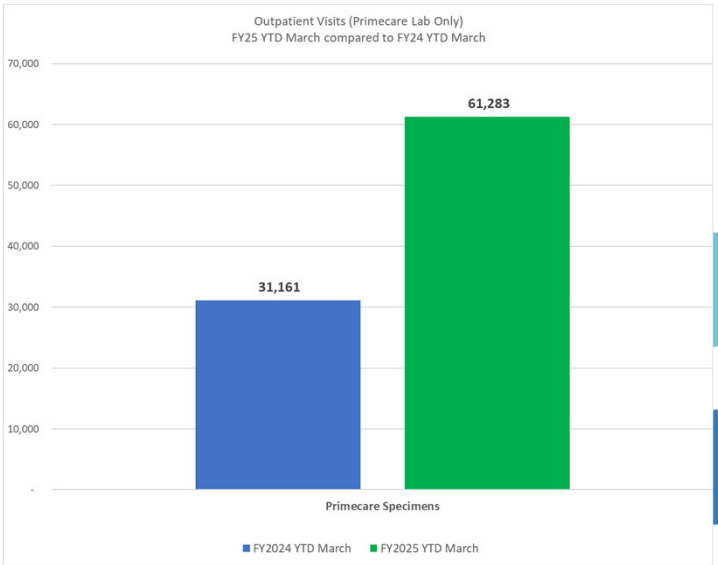
Primecare Lab Visits by Location
FY25 YTD March Compared to FY24 YTD March



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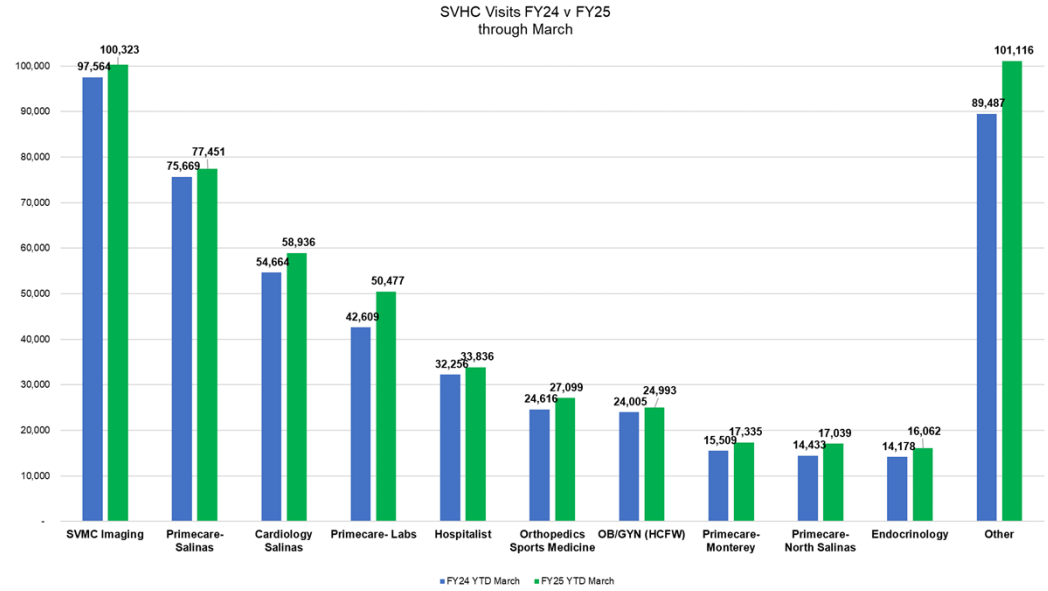
SVH Clinics Encounters by Specialty
FY25 YTD March Compared to FY24 YTD March



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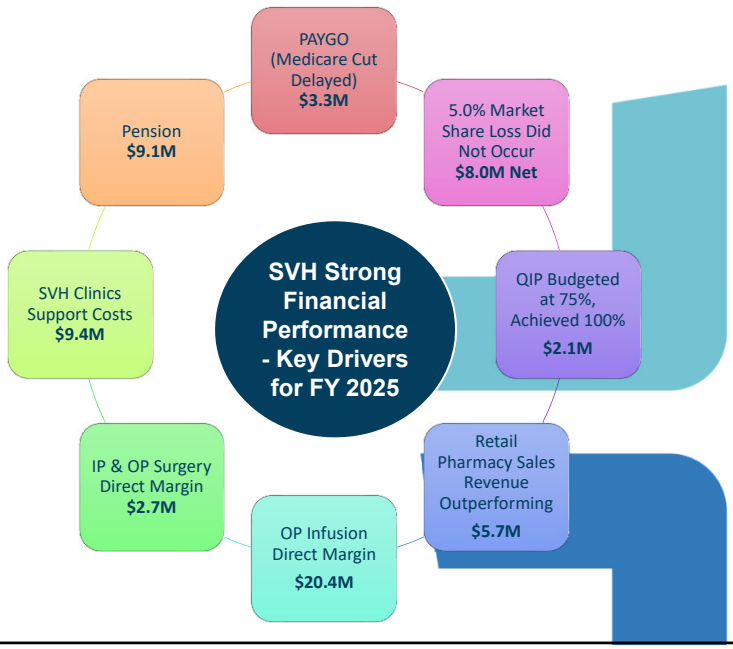
FY 2025 Operating Margin Favorable Variance to Budget $70M



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Board Recommendation

*Recommend for Board approval of the SVH Operating & Capital Budget for Fiscal Year 2026 with a Budgeted Operating Margin of **$3.6M** or **0.4%** and a Total Capital Budget of **$71.7M.***

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QUESTIONS / COMMENTS

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Medical Executive Committee Summary – May 8, 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Charmoz, Alexander, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine:
Sidhu, Deepal, MD	Anesthesiology	Anesthesiology	Anesthesiology
Yu, Yvonne, MD	Pediatrics	Pediatrics	Pediatrics – Active Community

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Adame, Mark, MD	Family Medicine	Family Medicine	Family Medicine- Active Community
Adams, Rebecca, MD	Family Medicine	Medicine	Adult Hospitalist
Baker Leyva, Sa Vanna, DO	Family Medicine	Family Medicine	Family Medicine- Active Community
Carrillo, Raymond, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Chadive, Deepika, MD	Neonatology	Pediatrics	Neonatology
Ginsburg, Jerry, MD	Cardiology	Medicine	Cardiology
Inlow, Brian, DPM	Podiatric Surgery	Surgery	Podiatry
Inlow, Deanna, DPM	Podiatric Surgery	Surgery	Surgery – Active Community
Iranmanesh, Reza, MD	Ophthalmology	Surgery	Ophthalmology
Grigg, Wendell, MD	Psychiatry	Medicine	Tele-Psychiatry
Isom, Robert, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Jordan, Adrian MD	Family Medicine	Medicine	Adult Hospitalist
Karahalios, Soteria, MD	Cardiology	Medicine	Salinas Valley Health Advanced Imaging-Cardiac Imaging
Klick, Anastasia, MD	Family Medicine	Family Medicine	Family Medicine Adult Pediatric and Well Newborn: Category I Obstetrics Category II Obstetrics Taylor Farms Family Health & Wellness Center – Active Community
Korya, Dani, MD	Neurology	Medicine	Tele-Neurology
Krishna, Gopal, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Lappen, Rhonda, MD	Pediatric Cardiology	Pediatrics	Remote Pediatric Cardiology
Le, Minh, MD	Critical Care Medicine	Medicine	Critical Care/Pulmonary Medicine General Internal Medicine
Modi, Rahul, MD	Anesthesiology	Anesthesiology	Anesthesiology
Smith, Diana MD	Psychiatry	Medicine	Tele-Psychiatry
Smith, Jennifer MD	Anesthesiology	Anesthesiology	Anesthesiology
Trieu, Chuyen, MD	Pediatrics	Pediatrics	Pediatrics – Active Community

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
McCuistion, Christine, MD	Pediatrics	Leave of Absence effective 5/5/2025 through 11/30/2025
Ngo, Khanh, MD	Anesthesiology	Emeritus Status effective 4/11/2025.
Ryan, Caroline, MD	Anesthesiology	Leave of Absence effective 1/08/2025 through 5/18/2025
Chumakova, Anastasia, MD	Tele-Neurology	Resignation effective 4/15/2025
Mandeville, Ross, MD	Tele-Neurology	Resignation effective 4/5/2025

Interdisciplinary Practice Committee

Reappointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Ramirez, Albert, PA-C	Physician Assistant: Core and Emergency Medicine	Emergency Medicine	Eric Fajardo, MD
Shamaa, Aman, PA-C	Physician Assistant Core and SVHMC Outpatient Infusion Center	Cancer Care	Shehzad Aziz, MD; Yang Liu, MD; Geetha Varma, MD; Hong Zhao, MD

Policies and Plans:

1. Block Scheduling
2. Fire Safety Management Plan
3. Renal Dose Adjustment per Pharmacy Protocol
4. Utility Management Plan

Informational Items:

I. Committee Reports:

a. Nominating Committee
b. Credentials Committee
c. Interdisciplinary Practice Committee
d. Quality and Safety Committee
    - Service Excellent – Patient Experience
    - Case Management Department

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings April 2025
c. Medical Staff Treasury Report May 2, 2025
d. Medical Staff Statistics Year to Date
e. Financial Update March 2025
f. HCAHPS Update May 1, 2025

Status **Pending** PolicyStat ID **14931197**

Origination	01/2020	Owner	Aisha Huebner: Director Perioperative Services
Last Approved	N/A	Area	Perioperative Services
Next Review	3 years after approval		

Block Scheduling

I. POLICY STATEMENT

A. Procedures will be scheduled according to elective and non-urgent, urgent, and emergent add on cases in the operating room suites, based on established criteria to expedite patient care.

II. PURPOSE

A. To provide guidelines to facilitate the scheduling of surgical procedures in the operating room to optimize utilization of resources. The block scheduling system is administered in a fair and equitable fashion to provide an efficient environment for the practice of surgery.

III. DEFINITIONS

A. **Block Scheduling:** A system of reserving specific periods of operating room time for individual and group practices based on a defined pattern of utilization.

B. **Open Time Scheduling:** Periods of operating room time unreserved and available for scheduling on a first come first serve basis.

C. **Prime Time:** Monday through Friday from 0730 until 1530.

D. **Late Rooms:** Rooms staffed after prime time to complete scheduled cases and the daily add-ons.

E. **Elective:** Surgical cases scheduled in advance into assigned block time or into open time; scheduled by 1200 hours the day before surgery.

F. **Add On:** Surgery cases scheduled after 1200 hours the day before.

G. **Add-on Categories:**

1. **Emergent, Wait Times <2 hours:**

    a. Patients who will suffer loss of life, limb or body function if not treated immediately. These procedures require that the next available room be

bumped if no OR is open..

2. **Urgent Cases, Wait Times <4-6 Hours:**
    a. Cases that should be performed within 4-6 hours. The surgeon determines the level of urgency when discussing the procedure.
3. **Non Urgent Cases, Wait Time < 24 hours:**
    a. The planned operation does not involve a sense of urgency.

H. **Release Time:** Automatic release time for unused block time converting to open time. Block release may vary per service.

I. **On Time Start (OTS)** is when the patient enters into the room **(wheels in the room)** according to the scheduled OR time. All key personnel are required to be present 15 minutes prior to the scheduled start time. Nursing personnel are completing room set up with all necessary instruments, supplies, implants and equipment; anesthesia providers must be ready to start induction, and attending surgeon must be in the department, readily available, and all required documentation, site marking completed at least 15 minutes prior to the scheduled start time. X-ray and adjunctive staff should be immediately available for preoperative x-ray and positioning.

J. **First Case Start (FCS)** for scheduled cases is 7:30 AM Monday through Friday and 8:30 AM on the 3rd Friday of the month (late start allows for OR and anesthesia in-service education). All first cases of the day are required to be in the room 5 minutes prior to the scheduled start time (7:25) for 7:30 AM start or (8:25 AM for 8:30 AM start) – cases will be considered late start if the patient is not in room by 7:25 or 8:25 respectively.
    1. Surgeon arrival time: the surgeon is expected to arrive with all documentation and site marking completed no later than 15 minutes before scheduled start.
    2. Anesthesia arrival time: The anesthesiologist must complete their preoperative patient interview by 20 minutes before the scheduled start time of the case.
    3. Patient same day surgery prep time: patient arrival will be timed to ensure the patient is ready and waiting at least 30 minutes before the scheduled start time.

K. **Turnover Time (TOT)** also called wheels out to wheels in, is the time measured between patient exit to the next patient entrance in the same operating room with the out time documented by Anesthesia and the in time documented by the Circulating RN. TOT for scheduling purposes will be calculated using procedure specific times maintained in the scheduling system.

L. **Total Case Time (TCT)** equals the total time from when the patient enters the operating room until the patient leaves the operating room. Total case time averages are maintained in the scheduling system and will be used for scheduling purposes, data management, and provided to surgeons for their review per request. Room utilization will be TCT plus set up and tear down time.

M. Cases may be scheduled in any order as long as TCT plus TOT is less than or equal to the available time, keeping in mind that longer complex cases may require more turnover time. TOT will be added to each case at a length of time that is not greater than 30 minutes.

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. **Guidelines for scheduling a surgical procedure**:

1. Procedures are scheduled at the request of the surgeon. The request to schedule an elective case may be made for the hours of operation according to assigned block or open time. These requests will be communicated to the surgery scheduling office.
2. To schedule an elective case, physicians must be credentialed and privileged according to medical staff bylaws.
3. Elective cases are to be completed Monday through Friday during the allocated block or open time. All other hours of operation are provided to accommodate only urgent/emergent cases.
4. The surgery scheduling office will process the request, assign a case number and send confirmation of the scheduled case back to the requested office.
5. Procedures will not be considered booked until the office has received the confirmed case number.
6. For scheduled procedures, the physician's average procedure time as calculated by an OR Information System will be used unless the surgeon can assure the OR that there is a special circumstance for the particular patient (i.e., in the interest of all users, we cannot "squeeze in another case" by manipulating the time allotment.) Special circumstances will require approval.
7. Add on cases will be scheduled through the scheduling office, the charge nurse or with the house supervisor accordingly:

   Scheduling office for add-ons for the following day:
   0830 hours – 1700 hours Monday - Friday
   Charge Nurse from:
   0630 hours – 2300 hours Monday – Friday
   House supervisor from:
   2300 hours – 0630 hours Monday – Thursday
   2300 hours Friday– 0700 hours Monday
   Holidays – 24 hours
8. Surgeons or the House Supervisor will fill out an add-on sheet for routine surgery cases after 2300 hours and place the form in the hot file in the OR; the cases will then be booked by the surgery schedulers upon receipt of the add-on form.
9. Surgeons booking emergent or urgent cases will speak directly to OR charge nurse during regular hours of operation or with the house supervisor after hours of operation.
10. Emergencies will be given the first available operating room.
11. When a surgeon determines that an emergency case is required and that case will

bump a case, the SURGICAL BUMP PROCEDURE will be followed.

12. Urgent cases may be performed in the block time if time is still available, however, if block time is filled the urgent case will be placed on the list of add on procedures for that day.
13. Add on procedures will be completed as open time becomes available after previously scheduled procedures.

B. **Surgery Scheduling procedure/criteria:**

1. Available operating room time will be assigned according to a block scheduling system.
2. Block is assigned by the following methods:
    a. Individual block time
    b. Group Block time
    c. Service block time
3. Surgeons with block time must first fill their weekly assigned block prior to scheduling elective outpatient procedures in open time.
4. Surgeons are requested to schedule cases within the allocated block without running over allotted time. Historical data will be used to determine estimated length of surgical cases.
5. All cases scheduled in a surgeon block, after the first case of the day are requested to follow and take the next available slot.
6. The official schedule will close for the purposes of consolidation, staff assignments and publication at 1200 hours the previous business day for the Monday through Friday schedule.
    a. Additional cases scheduled after 1200 hours will be placed on the add-on list.
7. Surgeons must provide a time available to perform the case; all attempts will be made to schedule the add-on in open time and on a first come first serve basis. Actual placement and timing of add on cases will be managed by anesthesia and the charge nurse to optimize patient needs and surgery resources.
8. Patients shall be medically cleared before they can be added to the list.
9. When a surgeon requests a start time for their first case of the day which is later than the regular scheduled start time, this later time is not guaranteed. Other surgical cases may be placed ahead of the requested late start case, which may delay the original first case request/start.
10. The surgery scheduling office or appropriate trained personnel will process this request in the surgery information system.
11. Daily operating room assignments for OR personnel will be made to provide optimal utilization of space, time, equipment and personnel.
12. Cancellations after the surgery schedule is published on the day before surgery:

a. The surgeon or designee will provide a reason for cancellation. The OR will make every effort to bring other patients in ahead of their scheduled start time to eliminate the gap created by the cancellation whenever possible.

13. After the usual hours of operation ends, only one case will be in progress at a time, except in the case of emergencies.

C. **Management of the Daily Schedule:**

1. It is a team effort to start on time and all participants of the OR team will be accountable to ensure timely starts.
2. Except in emergency situations, patients will not be taken into the operating room suite until required documentation is completed.
3. First case on time starts will be monitored.
4. If a surgeon is late (3) times in a (3) month period, the respective surgeon may lose their 0730 privileges and will not be able to schedule prior to 0900. The first loss of 7:30 privileges will be for a 1 month period, the second loss for a three month period, subsequent losses will be for a 6 month period.
5. The sources of delays will be tracked, reviewed and addressed.
6. The operating room shall proactively notify surgeons by placing calls or paging to communicate as soon as possible in the event of delays and indicate the estimated length of time before the procedure can begin.
7. The charge nurse and the anesthesiologist in charge shall collaboratively be responsible for adjusting time frames due to cancellations, delays or any unexpected time openings. Elective scheduled cases will have priority to be completed over add on cases, however, facilitating the schedule will be taken into consideration.
8. After hours, Saturday, Sunday and the Holiday schedule is staffed by the "on call" team to support urgent and emergency procedures. There is no "in house" staff during these noted times. To schedule a case the hospital nursing supervisor must be notified and the following information will be communicated:
    a. Patient Name
    b. Patient Room Number and Unit Location
    c. Name of Procedure
    d. Diagnosis
    e. Age/Gender
9. Critical Information to support the patient and case flow

D. **Block Scheduling Management:**

1. Block time which has been unscheduled will be automatically released as follows:
    a. Cardiac Surgery- 24 hours prior to close of Block
    b. All other services 7 Days prior to the close of the block
2. Release times for a block may vary based on utilization and practice requirements.

3. Individual block holders may not allocate their block time to another surgeon.
4. Surgeons who release their block two (2) weeks in advanced (ex. PTO) will not have the day negatively impact their utilization data.
5. Unused block time and released time may be used on a first come first serve basis..
6. OR Leadership is to design, implement and monitor the scheduling procedures as evidenced by:
    a. Administration of scheduling policies
    b. Allocation of block time
    c. Monitoring and adjusting block allocation based on utilization
7. To qualify for block time the requestor must demonstrate consistent utilization of the OR with 75% utilization of a proposed (4) hour block.
8. Block time will be allocated in half day or full day blocks.
9. Blocks will start at 0730 or 12:30 hours, inclusive of both half day or full day blocks.
10. Request for block time or changes in allocated block time must be requested in writing to the OR Director and OR Medical Director. The request will be evaluated based on actual OR utilization for the past (3) consecutive months.
11. Block utilization will be based on the performance of the block holder by calculating the following utilization:
    - Block Utilization % = Room utilization within the block (less approved released time) /Block hours allocated (less approved released time)
12. Room Utilization is equal to Total Case Time plus set up and tear down time.
13. Once assigned block time, the surgeon or group is expected to maintain a 75% utilization rate. Block utilization is defined as the amount of time used, not scheduled, and will include all time used in an assigned block as measured from the start of the first case in the block. No time will be counted before the block starts or after the block ends.
14. Block time may be released at any time by the block holder however, if more than 25% of block time is released in any given quarter, the surgeon or group will be notified of a potential block adjustment. It is the responsibility of the surgeon or group to release block time appropriately to ensure adequate utilization.
15. Surgeons may request block utilization reports as needed.
16. If block utilization falls below 75% in any given month, the holder will be notified that utilization does not meet minimum criteria
    a. The block holder will be given a second month to improve utilization to the target; appropriate adjustments will be made to align adjustments to actual utilization.
17. If block utilization falls below 50%, the holder will be notified and time will be reallocated.
18. All changes to block allocation will be communicated to the holder in writing.

19. The OR Executive Committee may implement one of the following options:
    a. Reduction of block
    b. Elimination of the block assignment
    c. The addition of another surgeon (same specialty) of the block
20. Appeals regarding changes to block may be made to the OR Director in writing for review. Appeals must be made within 30 days of notification that the block is to be reduced or eliminated.
21. Reinstatement of block time is not guaranteed; if re-established it may not be allocated on the same day and or time as previously held.
22. Procedures shall not be double booked at Salinas Valley Health Medical Center (SVHMC) and other surgical sites. Cases that are late at SVHMC due to a double booked time will be referred to the Medical Staff Excellence Committee and the Executive Operations Committee as a Code of Conduct Violation.

E. **Release of Block Time:**
    1. Surgeons PTO shall be communicated at least 2 weeks in advance to the Surgery Scheduling Office at Salinas Valley Health Medical Center. The Surgery Scheduler will inform the OR Information System, releasing block time for other surgeons to use.
    2. Time released at least 2 weeks ahead of time will not be counted against the surgeon for non-utilization of block time.
        a. Exception: When release time is greater than 25% of the entire block time for any given quarter, See Schedule Management in section D above.

F. **Holidays:**
    1. The OR will publish the observed holidays schedule at the beginning of each calendar year.
    2. Holidays will not be used in block utilization calculations.

G. **Scheduling Procedure/Documentation:**
    1. Documentation of the following information is completed in the surgery schedule software:
        a. Requested date of the procedure/test
        b. Request time of procedure
        c. Surgeon name.
        d. Assistant Name
        e. Procedure – Complete surgical procedure including right/left designation and exact digit wherever applicable.
        f. CPT Code
        g. Patient's full name as listed on ID, driver's license or passport.
        h. Primary language other than English

i. Social security number.
j. Date of birth
k. Gender
l. Level of care
m. Admit Type (AM, SDC, In-patient.)
n. Phone number and alternate phone number if available
o. Best time to reach patient
p. Insurance type
q. Authorization
r. Pre-op diagnosis
s. Anesthesia type requested
t. Pertinent patient information
    i. Latex sensitivity
    ii. Isolation requirements
    iii. Disabilities or learning barriers

2. Additional Information:
    a. Implants needed
    b. Request special equipment, personnel or vendor present (radiology, pathology, Laser, etc.)
    c. Blood Products-Type of blood product and number of units needed or type and screen, type and cross match.
    d. Is the patient currently in a nursing home
    e. Names of persons scheduling the case (OR and office)
    f. Faxed information for surgeon's office to supplement telephone information is recommended.

H. **Documentation:**

1. Clerks scheduling elective procedures utilize the computer system and mandatory fields must be complete before the surgical procedure is officially scheduled. Cases scheduled with partial information are considered tentative until all mandatory fields of data are completed.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. SVHMC (2019). Medical Staff Rules and Regulations, Article IX.

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	05/2025
CAO	Alysha Hyland: Chief Administrative Officer	05/2025
Department of Surgery	Katherine DeSalvo: Director Medical Staff Services	05/2025
Perioperative Medical Director	Christina Hinz: PHYSICIAN	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Aisha Huebner: Director Perioperative Services	04/2025

Standards

No standards are associated with this document

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

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

Fire Safety Management Plan

I. SCOPE

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

II. OBJECTIVES/GOALS

A. **Objectives**

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

B. **Goals**

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

III. DEFINITIONS

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

B. Interim Life Safety Measures (ILSM)

C. Statement of Conditions (SOC)

D. Environment of Care (EOC)

E. Chief Executive Officer (CEO)

F. Environmental Health and Safety – EH&S

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

IV. PLAN MANAGEMENT

A. **Plan Elements**

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

B. **Plan Management**

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

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

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

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

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

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

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

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

C. **Plan Responsibility**

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

D. **Performance Measurement**

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

E. **Orientation and Education**

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

V. REFERENCES

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

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

Approval Signatures

Step Description	Approver	Date
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

Status Active PolicyStat ID 17703614

Origination	05/2025	Owner	Genevieve delos Santos: Director Pharmacy
Last Approved	05/2025	Area	Pharmacy Protocols
Next Review	05/2026		

Renal Dose Adjustment per Pharmacy Protocol

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide standardization for adjustments of selected renally eliminated medications and to optimize medication dosing in adult patients based on estimated creatinine clearance using the Cockcroft-Gault equation.

B. To ensure timely administration of medications and reduce risk of medication accumulation while promoting efficacious dosing as supported by current evidence-based practice.

C. To define the responsibilities of SVH pharmacists in the monitoring, review, and adjustment of renally eliminated medications with new and active orders on all adult patients.

III. DEFINITIONS

A. Creatinine Clearance (CrCl): The volume of blood plasma that is cleared of creatinine per unit of time to be calculated using Cockcroft-Gault equation.

IV. GENERAL INFORMATION

A. Salinas Valley Health (SVH) pharmacists will provide dose adjustments to select renally eliminated medications. This management will be conducted in accordance with evidence-based guidelines and best practice standards alongside clinical discretion as outlined in this policy.

B. This protocol authorizes SVH clinical pharmacists to review estimated creatinine clearance in adult patients and adjust medication dose and/or administration frequency based on guidance approved by Pharmacy & Therapeutics/Infection Prevention Committee and in collaboration with physicians.

C. This protocol shall establish and maintain a list of medications and their dosing regimens approved by Pharmacy & Therapeutics/Infection Prevention Committee for dose and administration frequency adjustments based on estimated creatinine clearance (as specified in Appendix B).

D. Ordered medications which appear on the approved list, matching standard dose and frequency ranges as well as indication (when documented), shall be qualified for renal dosing per protocol. This dose conversion does not apply to medications on the approved list which are outside the standard dose and frequency ranges or alternate indications.

    1. If a medication which appears on the approved list (as specified in Appendix B) is ordered, but does not align with documented standard dose, administration frequency, or indication (when documented), the pharmacist will contact the prescriber to recommend dose or administration frequency adjustments.
    2. If a renally eliminated medication is ordered and not on the approved list (as specified in Appendix B), the pharmacist will contact the prescriber to recommend dose or administration frequency adjustments.

E. Inclusion Criteria:

    1. Patients >/= 16 years of age
    2. Patient has a serum creatinine laboratory value resulted within the past 24-hours; has stable serum creatinine as determined by current hospital stay; or is confirmed HD, CRRT, or PD patient.
    3. New or active order aligns with approved medication, route, ordered dose and frequency (See Appendix B)

F. Exclusion Criteria:

    1. Patient < 16 years old
    2. Long-term suppression antimicrobials resumed from home medications.
    3. Physician indicates in order “Do Not Adjust for Renal Impairment” or other such wording in comments section of original order.

V. PROCEDURE

A. The renal dosage adjustment protocol shall be implemented on all patients who meet inclusion criteria at time of order verification and during profile review.

B. At time of order verification the pharmacist shall perform the following:

    1. Identify selected renally eliminated mediations as designated for renal dose adjustment (see Appendix B).
    2. Assess the patient’s estimated creatinine clearance using the Cockcroft-Gault equation (see guidance in Appendix A). The pharmacist may use the EHR auto-calculated CrCl using their clinical discretion.
        a. Pharmacists will utilize clinical judgement when reviewing a patient profile.
        b. For patients complicated by circumstances where creatinine may be falsely elevated (see examples in Appendix A), the pharmacist may wait 24

hours—from time of admission or identification of complication—before making dose adjustments.

i. The pharmacist may contact the ordering provider in instances where making renal dose adjustments per protocol is complicated by clinical presentation.

ii. The pharmacist shall ensure that patients with renally eliminated medications which qualify for dose adjustment but have not undergone adjustments will be monitored by documenting in the EHR.

c. To reduce frequent dose adjustments within the first 24 hours:

i. When CrCl is within 5 mL/min of the recommended adjustment range, the patient will be continued on the higher dose.

ii. When CrCl is < 15 mL/min this variance will be reduced to 2.5 mL/min of the recommended adjustment range, the patient will be continued on the higher dose.

3. Enter the adjusted medication including labeling within the order stating "Adjusted per Renal Protocol" or other such wording, upon qualification while maintaining all other properties of the original order including but not limited to:

a. Route, ordering label comments, days of therapy, monitoring parameters.

4. Document in the EHR including but not limited to:

a. Originally ordered medication, dose, and frequency

b. Adjusted medication, dose, and frequency

c. Relevant patient data and recommendations

C. At time of retrospective patient profile medication review the pharmacist shall perform the following:

1. Review patient profiles as assigned by kinetic monitoring floor responsibilities and identify selected renally eliminated medications as designated for renal dose adjustment (see Appendix B).

a. The pharmacist will identify any previously renally dose adjusted medications through documentation in the EHR.

2. Assess the patient's estimated creatinine clearance using the Cockcroft-Gault equation (see guidance in Appendix A). The pharmacist may use the EHR auto-calculated CrCl using their clinical discretion and review laboratory trends.

a. Pharmacists will utilize clinical judgement when reviewing a patient profile.

3. Adjust selected medications appropriately based on increasing or decreasing CrCl. Enter the adjusted medication including labeling within the order stating "Adjusted per Renal Protocol" or other such wording while maintaining all other properties of the original order as indicated in B.3.a.

a. If the medication has previously been renally dose adjusted, adjustments

shall be based on originally ordered medication, dose, and frequency using the newest CrCl.

b. To reduce frequent dose adjustments after the first 24 hours:

i. If patient's subsequent CrCl remains < the recommended adjustment range, dose and/or administration frequency shall be reduced/extended to meet the patient's current CrCl as calculated by Cockcroft-Gault equation (see guidance in Appendix A).

c. The pharmacist may contact the ordering provider in instances where making renal dose adjustments per protocol is complicated by clinical presentation.

4. Document in the EHR including but not limited to:

a. Originally ordered medication, dose, and frequency

b. Adjusted medication, dose, and frequency

c. Relevant patient data and recommendations

D. Monitoring

1. The pharmacist may order or recommend the following laboratory tests under this protocol:

a. Serum Creatinine

i. Frequency as clinically appropriate.

a. For critically ill patient’s serum creatinine may be ordered or recommended every 48 hours.

b. For patients with whom serum creatinine is stable, serum creatinine may be ordered or recommended every 3 to 7 days, or as clinically appropriate.

ii. Exclusions:

a. Patients on CRRT, HD, or PD

E. Documentation

1. The pharmacist will document as outlined in the above procedures, in keeping with standards of practice for documentation while providing clinical care, and when relevant to communicate with the care team.

F. Dosing Guidelines

1. The pharmacist will follow the Dosing Guidelines in conjunction with clinical discretion to standardize management of renal dose and/or administration frequency adjustments per protocol.

2. Deviations from standard guidelines should be documented with appropriate clinical rationale and discussed with the care team prior to execution.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Hoff BM, Maker JH, Dager WE, et al. Antibiotic Dosing for critically Ill Adult patients Receiving Intermittent Hemodialysis, Prolonged Intermittent Renal Replacement Therapy, and Continuous Renal Replacement Therapy: An Update. Ann Pharmacother. 2020; 54(1):43-55

B. Kalaria S, Williford S, Guo D, et al. Optimizing ceftaroline dosing in critically ill patients undergoing continuous renal replacement therapy. Pharmacotherapy. 2021; 41(2):205-2011

C. Berry K, Postlmayr L, Shiltz D, et al. Impact of an inpatient pharmacist-driven renal dosing policy on order verification time and patient safety. Sage Open Med. 2024; 12:1-8

D. Micromedex® 2.0 (Healthcare Series), (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: http://www.micromedexsolutions.com/. Accessed: January 10, 2025

E. Medications [package insert]. Available at https://dailymed.nlm.nih.gov/dailymed/. Accessed Jan 10, 2025

Attachments

Appendix A CrCl Calculations.pdf

Appendix B Medication Table.pdf

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	05/2025
Pharmacy & Therapuetics	Genevieve delos Santos: Director Pharmacy	04/2025
Pharmacy & Therapuetics	Kiri Golleher: Pharmacy Clinical Coordinator	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17966290**

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

NFPA 99-2012.

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

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 y 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

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