June 20, 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, JUNE 26, 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, JUNE 26, 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 May 22, 2025

B. Policies/Plans Requiring Approval

1. Account Cancellation
2. Amnioinfusion
3. Application of Fetal Scalp Electrode
4. Arterial Catheter Insertion (Assist) Care and Removal
5. Automated Dispensing Cabinet
6. Cardiac Cath Lab – Regulations
7. Care of the Obstetrical Emergency Department Patient
8. Chargemaster Dictionary Maintenance
9. Electronic Provider Documentation
10. Formulary Process
11. Isolation - Strandard and Transmission Based Precautions
12. RC POCT Laboratory Safety/Chemical Hygiene Plan
13. Registration Data Accuracy
14. Scope of Service: Administration
15. Scope of Service: Cardiovascular Diagnostic and Treatment Units
16. Scope of Service: Department of Pharmacy
17. Uses and Disclosures of Protected Health Information (General)

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

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

7. REQUEST FOR RATIFICATION; SUBSTANTIVE ELEMENTS OF COLLECTIVE BARGAINING AGREEMENT BETWEEN SVMHS AND INTERNATIONAL UNION OF OPERATING ENGINEERS, STATIONARY ENGINEERS LOCAL NO. 39, AFL-CIO *Allen Radner, M.D. Robert Andersen*

- Executive Leadership Report
- Board Questions to Executive Leadership
- Motion/Second
- Public Comment
- Board Discussion/Deliberation
- Action by Board

8. BOARD MEMBER COMMENTS AND REFERRALS *Joel Hernandez Laguna*

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

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

Minutes of the June 16, 2025 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

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

Minutes of the June 16, 2025 Personnel, Pension & Investment Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. **Consider recommendation for Board approval to fund the required minimum contribution to the Salinas Valley Memorial Healthcare District Employees' Pension Plan for calendar year 2025**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote
2. **Consider recommendation for Board approval of (i) Findings supporting recruitment of Natalie Friedricks, MD, (ii) Contract terms for Dr. Friedricks' recruitment agreement, and (iii) Contract terms for Dr. Friedricks' Obstetrics and Gynecology Professional Services Agreement**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

3. **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of a Physician to Central Coast Nephrology Medical Corporation, and (ii) Contract Terms for the Recruitment Agreement**

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

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

Minutes of the June 23, 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 of Purchase of the Stryker MAKO 4 Robotic-Arm Assisted Surgery System**

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

2. **Consider Recommendation for Board Approval of Awarding a Contract for Design and Engineering Services to HDR Architecture Inc. in conjunction with the Emergency Department Replacement Project**

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

3. **Consider Recommendation for Board Approval of Competitive Solicitation and Contract Award for Epic Acute Project Go-Live Assistance Engagement with Optimum Health IT**

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

D. **CORPORATE COMPLIANCE & AUDIT COMMITTEE** *Joel Hernandez Laguna*

Minutes of the June 18, 2025 Corporate Compliance & Audit Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JUNE 12, 2025, AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Rakesh Singh, M.D.*

A. Reports

1. Credentials Committee Report (Including the following)
   - Surgery – Active Community Clinical Privilege Delineation Revision

2. Interdisciplinary Practice Committee Report (Including the following)
   - Abdominal Pain Nursing Standardized Procedure
   - Chest Pain/Cardiovascular Nursing Standardized Procedure
   - Glycemic Measurement at Point of Care Standardized Procedure
   - Nausea and Vomiting Nursing Standardized Procedure
   - Vaginal Bleeding Nursing Standardized Procedure

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

1. Authority Statement – Infection Prevention
2. Discharge Criteria OB ED
3. Endoscope Handling, Reprocessing and Storing
4. Induction/Augmentation of Labor and Cervical Ripening
5. Outsourcing Sterile Compounding
6. Reportable Diseases and Conditions

- 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, July 24, 2025, at 4:00 p.m.**

The Salinas Valley Health (SVH) Board packet is available at the Board Meeting, electronically at https://www.salinasvalleyhealth.com/about-/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, JUNE 26, 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
   - Palliative Care
   - Leapfrog Report
   - Accreditation and Regulatory
   - Pt Safety Events/RCAs
3. Medical Staff Quality and Safety Committee Consent Agenda:
   - Environment of Care Report & Safety Plans
   - Pharmacy & Therapeutics
   - Falls
   - Pathology Reviews 3-4Q 2024, 1Q 2025

CONFERENCE WITH LABOR NEGOTIATOR
(Government Code §54957.6)

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

Employee organization: (Specify name of organization representing employee or employees in question Local 39, or

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

PUBLIC EMPLOYEE PERFORMANCE EVALUATION
(Government Code §54957)

Title: (Specify position title of employee being reviewed): President/CEO

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
MAY 22, 2025

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

Absent: Joel Hernandez Laguna;

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 Vice-President Carson called the meeting to order at 4:04 p.m. in the Downing Resource Center, Rooms A, B, and C.

1.1 PROPOSED ADDITION TO THE AGENDA

A request was made pursuant to Government Code Section 54954.2(b)(2) to add the following to the Closed Session Agenda:

CONFERENCE WITH LABOR NEGOTIATOR (Government Code 54957.6)
Agency designated representative: Michelle Childs
Employee Organization: Local 39.

The matter came to the attention of the Board subsequent to the posting of the Agenda. The addition to the Closed Session Agenda requires a 2/3rds vote of the members present at the meeting.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Rey, second by Director Arreguin, the Board of Directors, citing the need to add one (1) agenda item which came to the attention of the Board subsequent to publishing of the Board agenda, the Board of Directors approves adding to the Closed Session Agenda *Conference with Labor Negotiator-Local 39*.

ROLL CALL VOTE:

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

Motion Carried

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

2. CLOSED SESSION

Vice-President Carson announced items to be discussed in Closed Session as listed on the posted and revised Agenda are *(1) Hearings and Reports, (2) Reports Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, (3) Conference with Legal Counsel – Anticipated Litigation, and (4) Conference with Labor Negotiator-Local 39*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:07 p.m.

The Board completed its business of the Closed Session at 4:30 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:31 p.m. Vice-President Carson reported that in Closed Session, the Board discussed *(1) Hearings and Reports, (2) Reports Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, (3) Conference with Legal Counsel – Anticipated Litigation, and (4) Conference with Labor Negotiator-Local 39*. The Board received and accepted the reports listed on the Closed Session agenda. No other action was taken.

Vice-President Carson 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:

- **STAR Award: Guillermina "Guille" Becerra, Cardiology Tech Assistant:** Clement Miller, COO, stated that Guille is passionate about the work she does at Salinas Valley Health and dedicated to connecting with her patients, especially those who face language barriers. Guille will soon be celebrating her 8-year anniversary as a Cardiopulmonary Tech Assistant at the Cardiovascular Diagnostic Outpatient Center. The nomination was submitted by Tonia Giampaoli, RN, who wrote that The Ryan Ranch Cardiology clinic found itself without a Tech Assistant on a busy morning and in need of support to check in patients to avoid a delay in providing care. Guille rose to the occasion and then some, jumping in without hesitation.
- **Hospital Week, May 12-16:** The week was celebrated with a full lineup of activities – neck and shoulder massages, poster expo, treats, employee gifts and the big BBQ Lunch and Awards honoring 11 outstanding individuals as well as two team awards. Karina Rusk, Director Public Relations, gave kudos to HR, ENS, NS Marketing for their event planning and coordination.
- **Employee of the Year: Isabel Paredes, Senior Buyer/Purchasing:** Karina Rusk, Director Public Relations, introduced Isabel and stated Isabel makes complex decisions and facilitates workflow with integrity, compassion and team spirit. Isabel thanked the Board for the presentation stating she was "honored to receive the award and be recognized." Isabel thanked Judi Melton, Director Materials Management, and Kyle Dixon, Manager Materials Management, and the entire Purchasing Department team.
- **Nurse of the Year: Laurel Black, MSN, RN, CCRN-ICU/CCU:** Karina Rusk, Director Public Relations, introduced Laurel and stated that Laurel exemplifies clinical excellence, quality and safety, compassion, dedication, is a clinical leader and mentor, and is involved in

the Magnet journey. Laurel thanked the Board for supporting nursing initiatives. Laurel stated she was "honored to receive the award," and thanked the "entire nursing department."

- **Physician Excellence in Service and Professionalism: Rakesh Singh, M.D., Emergency Medicine:** Karina Rusk, Director Public Relations, introduced Dr. Singh and stated that Dr. Singh has been at SVH for 20 years. He has provided in the Emergency Department (ED) wisdom, skill, and leadership. Dr. Singh stated that it is a great honor to receive this award and he recognized his "family-away-from-family," the ED. The ED has changed so much and they still work as a team. Dr. Singh thanked administration for being open and supporting the Medical Staff which helps avoid burn-out in physicians. Administration has also successfully reacted to urgent needs such as the pandemic and transitioning out of the tents. He stated, "our Administration and Board fight behind the scenes to focus on patients and doing the right thing."
- **Team Daisy**: **Emergency Department:** Dr. Radner stated the ED reflects the organization and treats a phenomenal 64K patient visits a year. The work flow and quality are unparalleled anywhere. David Thompson, ED Nursing Director stated that he joined SVH in 2020 and has "never worked with members so dedicated and motivated to do better." He is "proud to work with them. They make it easy to be in a leadership position."
- **Team STAR: Mobile Clinic:** Dr. Radner stated that the Mobile Clinic has logged 30K miles treated 20K patients and introduced Lynette Fitzgerald, Director Community Benefit. Lynette stated the team was actually serving clients at this time and she was happy and privileged to accept the award on their behalf. The Mobile Clinic has something in common with the ED, unpredictability; that they always have to be ready. She stated that the team is dedicated, compassionate, has community focus and is an amazing team; she is honored to work with them. She thanked Dr. Radner and the Board for their continued support to provide community services and represent SVH.
- **Magnet® Recognition: Four-Year Anniversary:** Carla Spencer, CNO, stated that on Monday Magnet celebrated their 4th anniversary by touring through the hospital with a celebratory cart of treats. The Magnet Department is within one week of submitting our new document (2,000 pages). We are looking forward in the coming months for rededication of our Magnet program.

5. PUBLIC COMMENT:

Linda Mendoza stated her concern about obtaining gynecological care at Salinas Valley Health Clinics, stating she was scheduled and cancelled several times delaying care. She wanted her voice to be heard.

6. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following policies has been removed from the published Consent Agenda for consideration (1) *Formulary Process* and (2) *Oral Care.* The policies will return for consideration at a later date.

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors 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. Information Security Risk Analysis
8. LAB.PROT.GEN.1 - Aerosol Transmissible Pathogens-Pathology
9. MRI Safety
10. Nutrition Services: Cash Handling
11. Organization Plan for Provision of Care and Service
12. Registered Dietitian Diet Order Entry
13. Scope of Service: Case Management
14. Scope of Service: Diagnostic Imaging
15. Scope of Service: Employee Health
16. Scope of Service: Nursing Administration
17. Scope of Service: Physician and Business Development
18. Scope of Service: Social Services
19. Triage Assessment
20. Use of Ultrasound Enhancement with Echocardiography
21. Virtual Private Network

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

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

ROLL CALL VOTE:

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

Motion Carried

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: Hospital Week was great and the posters were terrific including the *Feed Me! Evidence-Based Practices for Enteral Therapy* poster about enteral therapy and the poster on total hip replacement *Early Mobility for Primary Total Hip and Total Knee Arthroplasty Patients*. He suggested scheduling physical therapists to stay late to accommodate late schedules. It was clarified, staff is scheduled late but not overnight.

Director Catherine Carson: Director Carson enjoyed the poster expo, all of which were professional and well done.

Director Victor Rey, Jr.: (1) Attended the poster expo and was impressed with content, quality and professionalism of what was there. Hats off to exhibitors, the posters were something to be proud of.

(2) He attended the Health Explorers ceremony of young leadership in the community. He thanked Shannon Graham, Director Volunteer & Health Career Services, for this program which is an investment in our community and ultimately the hospital.

Director Isaura Arreguin: Director Isaura stated that she attended the Hospital Week BBQ and Awards Ceremony and sat with the Marketing team. She appreciates the event is inclusive with everyone no matter what position and that everyone is professional. Recently she was in the Hospital again for a family member and cannot say how grateful she is of every person, doctor, nurse and more. She is extremely appreciative.

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. COMMITTEE VACANCY APPOINTMENTS

Vice-President Carson reported that with the Chief Financial Officer's LOA and retirement in July, his voting executive member positions on the Personnel, Pension and Investment Committee and Finance Committee were vacant and needed to be filled. Scott Cleveland has been appointed as the "Interim CFO" until a new CFO is hired. Dr. Radner recommended that Scott be appointed to these Board Committee positions until SVH has a new CFO. Matt Ottone, District Legal Counsel, has advised that since all the committees are Board Committees that exist pursuant to the Board of Directors Bylaws, all committee seats are appointed by the Board President.

As Board of Directors President, Joel Hernandez Laguna, appointed Scott Cleveland to the Personnel, Pension and Investment Committee and Finance Committee effective May, 2025.

B. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The minutes of the May 12, 2025 meeting were provided for Board review. In review, (1) Patient Care Services provided an update on the Emergency Department Unit Practice Council. (2) Reports were provided on Social Services/Case Management, Perioperative Services and Marketing/Communication. (3) A new dashboard is coming soon to the Board. Director Carson complimented Environmental Services for their excellent work in keeping C-Dif occurrence at a minimum, well below national trends. There are no recommendations.

C. PERSONNEL, PENSION & INVESTMENT COMMITTEE

A report was received from Director Carson regarding the Personnel, Pension and Investment Committee. The minutes of the May 12, 2025 meeting were provided for Board review. Scott Cleveland, Interim CFO, was appointed to the Committee. The Committee (1) received an Investment Performance Report for the quarter ending March 31, 2025, of the 403(b) Plan, 457 Plan and Employee Pension Plan. (2) Finalized plan design for the Self-Directed Brokerage Account being added to the 403(b) and 457 Plans. (3) Received a report on employer contributions to the 403(b) Plan; HR will provide more information on this benefit to encourage additional participation. There are no recommendations.

D. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. Scott Cleveland, Interim CFO, was appointed to the Committee. The minutes of the May 19, 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 Board Approval to Award Construction Contract to SSB Contracting for the Renovations to the DRC Annex in Support of the EPIC Training Rooms**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: This project is timely and will complete on time and under budget.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Arreguin, the Board of Directors approves awarding the contract for construction to SSB Contracting, Inc. for the Renovations to the DRC Annex in Support of the EPIC Training Rooms in the total amount of $1,484,108.

ROLL CALL VOTE:

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

Motion Carried

2. **Consider Board Approval of an 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**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Budget modification was needed due to the scope enhancements and unforeseen conditions. This will lock in costs for both phases of the project.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Arreguin, the Board of Directors approves (i) 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, and (ii) awarding the contract for construction to FTG Builders, Inc. in the total amount of $4,057,063.

ROLL CALL VOTE:

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

Motion Carried

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

A review of the Fiscal Year 2026 (FY2026) was provided by Scott Cleveland, Interim CFO. The budget has been reviewed in the Special Meeting of the Board of Directors on April 22, 2025 and the Finance Committee on May 19, 2025.

A summary of the final budget was reviewed including:

- Key Operating Budget Assumptions
- Average Daily Census (ADC) Trends
- Proposed Capital Budget Fiscal Year 2026 summary
- Proposed Budgeted Operating Margin and Total Capital Budget

A full report was included in the packet.

PUBLIC COMMENT: None.

BOARD DISCUSSION: None

MOTION:

Upon motion by Director Dr. Cabrera, second by Director Rey, the Board of Directors approves the Salinas Valley Health Operating and 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.

ROLL CALL VOTE:

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

Motion Carried

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON MAY 8, 2025, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Rakesh Singh, M.D., Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of May 8, 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 Arreguin, 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

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

- Block Scheduling
- Fire Safety Management Plan
- Renal Dose Adjustment per Pharmacy Protocol
- Utility Management Plan Medication Override

ROLL CALL VOTE:

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

Motion Carried

11. EXTENDED CLOSED SESSION

Vice-President Carson announced items to be discussed in Extended Closed Session are *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services*, and *(2) Conference with Legal Counsel – Anticipated Litigation.* The meeting recessed into Closed Session under the Closed Session Protocol at 5:26 p.m. The Board completed its business of the Closed Session at 6:12 p.m.

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:13 p.m. Vice-President Carson reported that in Extended Closed Session, the Board discussed *(1) Reports Involving Trade Secret-Trade Secret, Strategic Planning, Proposed New Programs and Services* and *(2) Conference with Legal Counsel – Anticipated Litigation*.

No action was taken.

13. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, June 26, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:14 p.m.

_____

Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: June 26, 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.	Account Cancellation	Meditech changed to EHR.	Agustin Lopez, CFO
2.	Amnioinfusion	No Changes	Carla Spencer, CNO
3.	Application of Fetal Scalp Electrode	Minor formatting changes.	Carla Spencer, CNO
4.	Arterial Catheter Insertion (Assist) Care and Removal	No changes.	Carla Spencer, CNO
5.	Automated Dispensing Cabinet	Combined multiple policies, streamlined process, updated nomenclature.	Clement Miller, COO
6.	Cardiac Cath Lab – Regulations	Changed to procedure. Minor typos corrected.	Clement Miler, COO
7.	Care of the Obstetrical Emergency Department Patient	Added Emergency Severity Index (ESI). References reviewed and updated.	Carla Spencer, CNO
8.	Chargemaster Dictionary Maintenance	Deleted pricing policy language. Updated OSHPD to HCAi.	Agustin Lopez, CFO
9.	Electronic Provider Documentation	Meditech and EMR changed to EHR.	Agustin Lopez, CFO
10.	Formulary	Language added to outline how the organization will provide the medical staff a list of all medications on formulary, annually	Clement Miller, COO
11.	Isolation - Standard and Transmission Based Precautions	Updated isolation language and reference sheets.	Timothy Albert, M.D., CCO
12.	RC POCT Laboratory Safety/Chemical Hygiene Plan	Cal/OSHA requires all laboratories to have a Chemical Hygiene Plan. No Changes.	Clement Miller, COO
13.	Registration Data Accuracy	No changes.	Agustin Lopez, CFO
14.	Scope of Service: Administration	Edited Administration titles.	Clement Miller, COO
15.	Scope of Service: Cardiovascular Diagnostic and Treatment Units	Org Charts updated.	Clement Miller, COO
16.	Scope of Service: Department of Pharmacy	Updated org chart, pharmacy department roles. Reformatting.	Clement Miller, COO
17.	Uses and Disclosures of Protected Health Information (General)	No changes.	Agustin Lopez, CFO

MEC			
Nursing Standardized Procedures			
1.	Abdominal Pain Nursing Standardized Procedure	Changed HCG specimen collection requirement to age-based rather than menopausal based.	Carla Spencer, CNO
2.	Chest Pain/Cardiovascular Nursing Standardized Procedure	Changed age for HCG collection to bring in line with other standardized order sets.	Carla Spencer, CNO
3.	Glycemic Measurement at Point of Care Standardized Procedure	No Changes	Carla Spencer, CNO
4.	Nausea and Vomiting Nursing Standardized Procedure	Changed HCG specimen collection requirement to age-based rather than menopausal based.	Carla Spencer, CNO
5.	Vaginal Bleeding Nursing Standardized Procedure	Changed HCG specimen collection requirement to age-based rather than menopausal based.	Carla Spencer, CNO
MEC Policies/Plans			
1.	Authority Statement – Infection Prevention	No Changes	Timothy Albert, MD, CCO
2.	Discharge Criteria OBED	No Changes	Carla Spencer, CNO
3.	Endoscope Handling, Reprocessing and Storing	Updated to current practice and consultant recommendations.	Alysha Hyland, CAO
4.	Induction/Augmentation of Labor and Cervical Ripening	Changes to procedure and flow and reference updates.	Carla Spencer, CNO
5.	Outsourcing Sterile Compounding	Minor edits, verified references.	Clement Miller, COO
6.	Reportable Diseases and Conditions	Minor edits, updated references.	Timothy Albert, MD, CCO

Status **Pending** PolicyStat ID **18083654**

Origination	06/2022	Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Last Approved	N/A	Area	Patient Financial Services
Next Review	3 years after approval		

Account Cancellation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. When accounts must be merged/cancelled, measures must be taken to insure that 1) the appropriate account is cancelled or merged and 2) all documentation and demographic information is preserved as a part of the patient's medical record. This requires individual EHR application leaders to move or merge data to the appropriate account prior to the closure of any account. It may also require the transfer of clinical documentation from one account to another.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Oversight of account cancellation is the responsibility of Registration Department. The coordination of clinical departments' data is the delegated responsibility of the Registration Department Manager/Designee. A notification to any department that has documentation associated with the accounts being merged or cancelled will be sent by the Registration Manager/Designee with appropriate request.

B. In order to maintain the integrity of medical record documentation, prior to account merge/ cancellation, all data requests shall be completed using EHR allowable copy and paste, data merge or direct re-entry from the account to be merged/cancelled into the permanent record in all originating EHR applications that archive directly to the electronic legal record (ELR). This

data will then be captured on the archived report post-discharge.

C. To avoid continued use or billing of accounts while being managed for cancellation or record merge, an account note will be entered in B/AR indicating that cancellation and/or merge is pending.

V. PROCEDURE

A. Registration Department Manager/Designee notifies affected departments via e-mail when account merge/cancellation is required.

B. Registration Department Manager/Designee *staff* notifies PFS Supervisors of the accounts requiring data entry correction such as lab, pharmacy, radiology, nursing, etc.

C. PFS Supervisors reviews the account(s) and communicates with any department that may have patient charge corrections. Affected departments are required to have all correction completed within in three (3) working days.

D. If an account is created in error and there is no documentation/charges associated with the account the account will be cancelled immediately.

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 17745361

Origination	03/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Amnioinfusion

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in the management of patients who will receive an amnioinfusion.

III. DEFINITIONS

A. IUPC – Intrauterine pressure catheter

B. MVU – Montevideo units

IV. GENERAL INFORMATION

A. Amnioinfusion is appropriate for use with recurrent variable decelerations during the first stage of labor that are unresponsive to maternal position changes. Amnioinfusion is the transcervical instillation of fluid into the amniotic cavity to alleviate umbilical cord compression.

B. An intrauterine pressure catheter (IUPC) is inserted by a physician. Management of an IUPC is maintained by a qualified RN.

C. CONTRAINDICATIONS:

- Uterine anomalies
- Vaginal bleeding
- Active infections such as human immunodeficiency virus or herpes simplex virus
- Impending birth

V. PROCEDURE

A. Equipment

- Room temperature Lactated Ringers or Normal Saline (1000ml)
    - Lactated Ringers preferred
- IV tubing (pump tubing if using infusion pump)
- Labels for tubing
- Infusion pump
- Blood warmer and tubing for preterm infusion
- Chux
- Scale

B. **Set-up**

- Explain procedure to patient
- Gather necessary equipment
    - Prime and label tubing

C. **Operation**

- Place several chux under patient to absorb fluid
- After insertion, secure catheter to patient's thigh or abdomen
- Zero monitor.
    - For true zero, ensure catheter is disconnected from cable/connector and zero monitor. Uterine resting tone will not be accurate if zeroing is not done.
- Obtain baseline assessment of uterine tonus prior to initiating amnioinfusion.
- Remove yellow protective cap from catheter. Connect cable/connector to catheter
    - connection to catheter must occur after placement into uterus.
- Keep amnioinfusion port capped at all times when not infusing fluid to guard against leakage of amniotic fluid and contamination.

D. **Initiate Amnioinfusion**

- Attach room temperature IV fluid via IV tubing to insertion site or port designated "amnio" on IUPC catheter. Expect to see an artificial rise of uterine resting tone to 25-40mm/Hg due to resistance of flow with IUPC.
- If concerned with increased resting tone, may temporarily discontinue infusion until accuracy can be determined.
- Begin amnioinfusion as ordered by physician. Recommended infusion:
    1. Initial bolus: 250-500ml over 30 minutes.

2. May infuse at a rate of 100-180ml/hr until resolution of variables or a maximum of 1000ml has been infused.
3. If recurrent variables have not resolved after the infusion of 800-1000 mL of fluid, discontinue infusion and consider alternate approaches.

- Verify return of fluid. Assess abdomen for distension.
    1. Assess chux for fluid return, consider using scale to weigh wet chux
        a. 1gm = 1ml of fluid
- Maintain continuous electronic fetal monitoring.
- **Note:** If no fluid is leaking out of vagina, observe for decreased strength of contractions, increased baseline uterine tonus, or abdominal distension. If any of these are present, STOP the infusion and notify the physician.

E. **If no fluid return is observed after initial bolus, discontinue the bolus until fluid return is observed**.

F. Documentation:
    1. Document insertion of IUPC and time of initiation of amnioinfusion; amount of fluid infused, as well as returned; include patient's tolerance to procedure.
    2. Document evaluation of contractions for strength (in mm/Hg), frequency, and duration, as well as uterine resting tone.
    3. Document Fetal assessment per the FETAL HEART RATE MONITORING for the high risk patient.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. American Academy of Pediatrics & American College of Obstetricians and Gynecologists (2017). Guidelines for Perinatal Care.(8th ed). Elk Grove, IL: Authors.

B. Simpson, K.R., Creehan, PJ., O'Brien-Abel, N., Roth, C., & Rohan, A. (2021) Labor and birth. In K.R. Simpson, P.A. Creehan (Eds.), Perinatal Nursing (pp 343-444). Philadelphia: Lippincott Williams & Wilkins.

Approval Signatures

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

Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	05/2025
CNO	Carla Spencer: Chief Nursing Officer	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Daniela Jago: Clinical Manager	03/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17745211

Origination	03/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Application of Fetal Scalp Electrode

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide nursing care in the application and management of fetal scalp electrode (FSE).

III. DEFINITIONS

A. FSE – Fetal Scalp Electrode

IV. GENERAL INFORMATION

A. The fetal scalp electrode may be placed by a registered nurse when the external monitor is unable to provide the continuous detection of fetal heart rate and/or when clinically necessary.

B. Use of fetal scalp electrode is contraindicated in women who are HIV positive.

C. Relative contraindications include:

1. Active or chronic hepatitis B or C infection
2. History of herpes simplex virus with current active lesions
3. Mothers who are known hemophilia carriers when the sex of the fetus is unknown

V. PROCEDURE

A. Set-up

1. Prepare patient.
    a. Position patient in dorsal lithotomy position and provide education regarding the need for FSE placement and procedure.

2. Standard precautions.
3. Refer to Attachment A for instructions on placement

B. Discontinue

1. Prior to delivery, remove scalp electrode by rotating counterclockwise until free from fetal presenting part. DO NOT PULL the electrode from the fetal skin. Inspect spiral electrode tip when removed.
2. If spiral tip breaks refer to MEDICAL DEVICE INCIDENT REPORTING PROGRAM .

C. Documentation:

1. Document indication and placement of the FSE as well as maternal-fetal response in the electronic medical record.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. American Academy of Pediatrics and American College of Obstetrics and Gynecology. (2017). *Guidelines for perinatal care*. (8th ed.). Elk Grove, IL: Authors.

Attachments

A: Instructions on Placement

Application of Fetal Scalp Electrode

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	05/2025
CNO	Carla Spencer: Chief Nursing Officer	04/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Daniela Jago: Clinical Manager	03/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18121396

Origination	03/2022	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Arterial Catheter Insertion (Assist) Care and Removal

I. POLICY STATEMENT

N/A

II. PURPOSE

A. To guide the staff in assisting physician or trained Respiratory Therapist with the insertion of arterial catheter.

B. To guide the staff with the care and removal of arterial catheter.

III. DEFINITIONS

A. MAP: Mean Arterial Pressure

IV. GENERAL INFORMATION

A. Arterial pressure lines are used to continuously monitor blood pressure and to obtain serial blood gases or other laboratory specimens in critically ill patients.

B. The RN will demonstrate the ability to provide nursing care for the patient requiring invasive pressure monitoring.

C. The location of the arterial catheter depends on the condition of arterial vessels. The presence of dialysis shunt is a contraindication for placing an arterial catheter in the same extremity.

V. PROCEDURE

A. Equipment

- Cardiac Procedure Cart
- All-inclusive central line dressing change kit

B. Setup

- Patient and Family Education
    1. Assess patient and family understanding for arterial line insertion.
    2. Explain the insertion procedure and potential need for immobility of affected extremity.
    3. Instruct the patient to report any warmth, redness, pain, or wet feeling at the insertion site.
- Patient Assessment and Preparation
    1. Obtain informed consent if patient condition permits.
    2. Prepare pressurized monitoring system
        a. Assemble and tighten all connections on pressure tubing.
        b. Close the roller clamp and spike the 500 ml bag of Normal Saline.
        c. Attach a pressure cuff over the Normal Saline bag but DO NOT pressurize.
        d. Push the reservoir plunger to the closed and locked position. An audible click will be heard when locked.
        e. Open the one way valve.
        f. Open the roller clamp and pull the flush device (pig tail) to prime the tubing. Ensure that all of the air is removed from the tubing and stopcocks.
        g. Check the entire system for air bubbles. Tap the transducer to discharge any air bubbles.
        h. Replace the vented caps with the included non-vented caps.
        i. Pressurize the system with a pressure of 300 mmHg.
        j. Connect the tubing to the patient's catheter.
        k. Label the tubing with the date, time, and RN's initials. Change tubing and Normal Saline bag every 96 hours or PRN.

C. Operation.

- If the radial artery is to be used, assist the physician or Respiratory Therapist in performing the modified Allen test before arterial cannulation.
- Initiate "Time Out (Universal Protocol)" procedure and document.
- Assist with patient positioning and immobilization as needed during procedure.
- Place air-fluid interface of transducer at level of the phlebostatic axis (4^{th} intercostal space at the mid-axillary line)
- Level and zero the transducer
- Set alarm parameters and waveform scale. Place monitor pressure selector on

"systolic", diastolic", or "mean".

- Run an arterial line waveform strip with ECG strip and record baseline pressures.

D. Maintenance and Care

- **Zero the transducer during the initial set-up, whenever the transducer and the monitor cables are disconnected, or when the values obtained do not fit the clinical picture.**
- Assess and post an arterial waveform strip every four (4) hours.
- Assess circulation to extremity every four (4) hours and PRN.
- Check waveform. Notify physician of significant pressure changes.
    1. Troubleshoot waveform
        a. Check the patient
        b. Recalibrate at phlebostatic axis
        c. Reposition extremity
        d. Verify and adjust scale.
        e. Check line for leaks or air, remove if present.
        f. If clots are visible in tubing, remove if possible
        g. Check that the pressure bag is inflated to 300mmHg and fluid bag has fluid in it.
    2. A transducer *higher* than heart level will reflect ***false low*** pressures.
    3. A transducer *lower* than heart level will reflect ***false high*** pressures.
- Dressing
    1. Open all-inclusive central line dressing change kit to create a sterile field.
    2. Observe arterial insertion site for signs of infection
    3. Apply an occlusive transparent dressing and place a Biopatch at the insertion site using aseptic technique.
    4. Transparent dressings must be changed every 7 days, on Sunday, or as needed. Occlusive gauze dressing must be changed every 48 hours or as needed (see IV Grid attachment - CENTRAL VASCULAR ACCESS DEVICES)
    5. Discard used supplies and wash hands
- Obtaining a blood sample
    1. Silence monitor alarms.
    2. Release the plunger latch and smoothly draw the plunger to the open position until the plunger stops (12 ml) – about 1 ml/second. This will aspirate blood into the line (clearing volume).
    3. Close the one way valve.
    4. Swab the sample site.

5. Ensure that the needleless cannula is securely tightened to a direct-draw unit or syringe (before pushing it into the sample site). DO NOT use a needle (sharp or blunt) to puncture the sample site.
6. Push the needleless cannula (attached to either a direct-draw unit or syringe) into the sample site.
7. Slowly draw the blood sample.
8. Grasp the needless cannula and pull the direct-draw unit or syringe straight out after the last sample has been drawn. If using a direct-draw unit, remove the vacuum tube first.
9. Open the one way valve.
10. Reinfuse the clearing volume by pushing the plunger on the syringe until it reaches the closed position (1 ml/second). An audible click will be heard.
11. Flush the system to remove any excess blood by pulling on the pig tail.

E. Removal

- Equipment
    1. 4x4 Gauze
    2. Suture removal kit
    3. Tape
    4. Sterile scissors and sterile specimen cup if tip of catheter is to be cultured
- Turn off continuous saline infusion and turn off monitor alarms
- Close arterial catheter to patient.
- Gently remove dressings
- Use suture removal kit and remove sutures if present
- Gently remove catheter from artery and verify tip integrity. Place pressure over insertion site with a 4x4 gauze.
- Apply direct pressure for a minimum of 5 minutes or until bleeding stops.
- If culturing arterial catheter tip, without touching catheter, place tip in sterile container, snip with sterile scissors, label (date), and send to lab.
- Apply sterile gauze pads pressure dressing to site.
- Assess circulation and dressing every 5 minutes x2, then every 15 minutes x2. Remove pressure dressing in 8 hours post-bleeding at site.

F. Documentation:

- Record waveform strips every four (4) hours and PRN
- Arterial Line Management for documentation on the worklist

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Edwards Lifesciences. (2017). *VAMP plus in service card*. Retrieved March 17, 2022 from https://edwardsprod.blob.core.windows.net/media/Default/devices/monitoring/pressure%20monitoring/vamp-plus-in-service-card.pdf

B. Infusion Nurses Society, Inc. (2016). *Policies and Procedures for Infusion Nursing* (3rd Ed.)

C. Shaffer, R.B. (2017). Arterial Catheter Insertion (Assist), Care and Removal. In Wiegand, D. (Ed.) AACN Procedure Manual for Critical Care. 7th edition; St.Louis, Missouri: Elsevier Saunders.

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	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17845259**

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

Automated Dispensing Cabinet

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center shall utilize automated dispensing cabinets (ADCs) as the primary mechanism for medication distribution and control throughout the facility. The Department of Pharmacy maintains oversight of all ADCs to ensure safe medication management, regulatory compliance, and prevention of drug diversion. All healthcare personnel who access ADCs must follow established procedures for medication retrieval, documentation, and security.

II. PURPOSE

A. To establish standardized processes for the secure storage, dispensing, and documentation of medications through automated dispensing cabinets across all patient care areas.

B. To ensure all medications are dispensed in the most ready-to-administer unit dose form when commercially available, and when feasible, in unit doses that have been repackaged by the Pharmacy or licensed repackager.

C. To enhance medication safety through integrated technology solutions that support proper medication selection, documentation, and inventory control.

D. To maintain compliance with state and federal regulations regarding medication management, particularly concerning controlled substances and high-risk medications.

E. To facilitate accurate tracking and documentation of medication utilization, supporting both patient care and regulatory requirements.

F. To provide clear guidelines for ADC access, security, and user accountability that align with hospital policies and regulatory standards.

III. DEFINITIONS

A. Automated Dispensing Cabinet (ADC): A computerized medication storage and distribution device that provides controlled access and tracking of medication dispensing throughout the

healthcare facility.

IV. GENERAL INFORMATION

A. The Department of Pharmacy maintains primary responsibility for the oversight, maintenance, and management of all ADCs.

B. All inpatient medications will be dispensed by a licensed pharmacist from the Pharmacy in unit dose form when available and appropriate, upon receipt of a valid medication order from an authorized prescriber.

C. ADC access is restricted to authorized healthcare personnel based on their role and scope of practice. Access privileges are managed through collaboration between Pharmacy, Human Resources, and Information Technology.

D. The Pharmacy and Therapeutics/Infection Prevention Committee maintains oversight of medication management policies, including:

    1. Review and approval of the hospital formulary
    2. Development and maintenance of override medication lists
    3. Annual review of ADC-related policies and procedures

E. Pharmacy collaborates with nursing units and other clinical departments to establish and maintain appropriate medication stock levels based on patient population needs and usage patterns.

F. ADCs are connected to the emergency power system to ensure continuous operation during power outages.

V. PROCEDURE

A. Authorized Access

    1. The Human Resources Department and Security will notify the pharmacy regarding clearance of any staff requiring ADC access. After receiving clearance, the Department of Pharmacy will collaborate with the respective department to grant access to the new staff member.
    2. Access to ADCs can only be issued by the Department of Pharmacy.
        a. Temporary users and non-permanent users are added by the charge nurse or the nursing supervisor
    3. Access termination will be processed as follows:
        a. Voluntary Terminations - processed through Human Resource (HR) software. ADC access is automatically terminated through active directory processing.
        b. Involuntary Terminations - processed through HR software. ADC access is automatically terminated through active directory processing. If necessary, HR and/or departmental leadership should contact pharmacy for expedited termination of access as warranted.

B. Training and Education

1. Training and education will be provided by HR at orientation. Additional education will be provided by the respective department of the staff member as needed.

C. ADC Stock Management

1. The Pharmacy will run automated refill reports on a routine basis to ensure practitioners have access to medications to provide appropriate patient care.
2. A pharmacist will check all products prior to placement into an ADC unless approved otherwise by the California Board of Pharmacy (i.e., Tech-check-tech).
3. Barcode scanning technology will be used when restocking the ADC to ensure the correct medication is being stocked in the correct location.
4. Expired medications shall be removed by the technician using the expired removal med function and returned to the Pharmacy.
5. The Pharmacy will be responsible for maintaining adequate inventory of medications within ADCs.
6. Look Alike/Sound Alike medications will be segregated using designated drawers to minimize risk of error.
7. Controlled substance stocking should follow the Controlled Substance and Drug Diversion Management Policy.

D. Medication Access and Removal

1. Most medications will be dispensed from the ADC once the order has been entered and verified by a pharmacist.
    a. A limited number of overrideable medications can be accessed prior to pharmacist verification for emergency use.
    b. Refer to the Medication Override Policy for overrideable medications
2. The Medication Safety Committee will review the override medication list annually and make revisions based on:
    a. Current best practices
    b. Reports of medication events
    c. Regulatory requirements

E. Medication Administration

1. The nurse will follow ADC procedures for removing medications. The nurse must verify the inventory count when removing controlled substances and any other medication deemed appropriate by Pharmacy.
2. Medications must be withdrawn by specific unit of measure:
    a. Solid dosage forms by number of doses (e.g., 1 Percocet, 2 Tylenol #3)
    b. Liquid medications not in unit-dose packaging by milliliters (e.g., 5 mL)
    c. Specific medications like opium tincture by milligrams

F. Medication Returns

1. Medications that are unused must be returned to the Pharmacy. The medication being returned must be placed into the return bin at the ADC by nursing during the return process.
2. Controlled substances must be wasted according to Controlled Substance and Drug Diversion Management Policy

G. ADC Maintenance

1. Drawer Issues
    a. These may occur if medication packages are improperly placed in the ADC.
    b. The charge nurse should be contacted on each shift to answer questions about the ADC.
    c. The Pharmacy should be contacted if a recovery attempt is unsuccessful.
2. ADC Issues
    a. The unit or area leader should be contacted on each shift to answer questions about the ADC.
    b. If this person cannot resolve the problem, the Pharmacy should be contacted.
    c. If necessary, Pharmacy will call the vendor for service.
3. Emergency Back Up Procedure
    a. The ADC is connected to the emergency power system and should remain operational in the event there is a loss of power.
    b. If it becomes necessary to manually open the ADC for medication access, the Pharmacy Manager or designee should be contacted.
    c. Refer to Downtime Policy and handbook for additional information on downtime procedure.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Cello R, Conley M, Cooley T, et al. ASHP Guidelines on the Safe Use of Automated Dispensing Cabinets. Am J Health-Syst Pharm. 2022;79(1)

B. Institute for Safe Medication Practices. Guidelines for the Safe Use of Automated Dispensing Cabinets. Horsham, PA: Institute for Safe Medication Practices; 2019.

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

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17018235**

Origination	01/2019
Last Approved	N/A
Next Review	3 years after approval
Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep
Area	Cardiology Departments

Cardiac Cath Lab - Regulations

I. POLICY STATEMENT

A. N/A

II. PURPOSE

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

III. DEFINITIONS

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

IV. GENERAL INFORMATION

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

V. PROCEDURE

A. Administrative Policy Manual.

1. The Cardiac Cath Lab will adhere to the Administrative Policy Manual (APM) of Salinas Valley Health Medical Center (SVHMC) in all requirements as applicable.

B. Labs (unless emergent) as ordered by cardiologist can be done on the day of procedure.

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

C. Records.

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

D. History and Physical

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

E. Consultation

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

F. Post-Cardiac Procedure Orders

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

G. Progress Notes

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

H. Procedure Report

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

I. Access to the Cardiac Cath Lab

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

J. Scheduling of Cases

1. Refer to CARDIAC CATH LAB - SCHEDULING OF PROCEDURES

K. Pre-Registration

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

L. Staggered Admission

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

M. Order Entry

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

N. Documentation:

1. Standard of care is launched for OPS pre admit

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cardiology Medical Director	Megan Giovanetti: Director Cardiovascular Services and Sleep	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17745931

Origination	03/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Care of the Obstetrical Emergency Department Patient

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff of the Obstetrical Emergency Department (OB ED) in providing standardized care to patients presenting to the OB ED.

III. DEFINITIONS

A. Qualified Registered Nurse (RN): who has a minimum of one (1) year labor and delivery experience and has demonstrated competency in fetal heart monitoring interpretation.

B. ESI-Emergency Severity Index

C. MFTI-Maternal Fetal Triage Index

IV. GENERAL INFORMATION

A. Patients twenty (20) weeks gestation or greater that present to the OB ED with obstetrical complaints may be assessed and observed for up to four (4) hours in the OB ED.

B. Patients presenting to the OB ED will sign in at the OB registration desk, be admitted into the electronic documentation system and have a patient identification band applied per hospital policy. PATIENT IDENTIFICATION POLICY

C. Patients entering the OB ED care system shall be triaged utilizing the Maternal Fetal Triage Index (MFTI) system for pregnant patients and the Emergency Severity Index (ESI) for postpartum patients.

D. A Qualified Registered Nurse (RN) will perform a bedside triage assessment on patients presenting to the OB ED based upon MFTI or ESI priority.

E. The Medical Screen Exam will not be delayed for registration.

F. Fetal monitoring shall be initiated as applicable for gestational age. FETAL HEART RATE MONITORING

G. Prenatal records should be reviewed when available, or obtained as necessary.

H. The OB ED RN will be a liaison between patients/support persons/family and the OB ED Hospitalist or primary physician.

V. PROCEDURE

A. The patient and support person shall be oriented to the OB ED room, equipment and informed of expected procedure(s) to occur while in the OB ED.

B. A complete nursing assessment shall include, but is not limited to maternal physical status, fetal status, labor status, complete set of vital signs, psychosocial needs and patient interview. Appropriate documentation will be entered into the electronic health record (EHR).

C. The primary physician or OB Hospitalist shall be notified after the initial nursing assessment is completed.

D. The MFTI classification guidelines shall be utilized in triage of pregnant patients in OB ED: See Attachment A.

E. The ESI classification guidelines shall be utilized in triage of postpartum patients in OB ED: See Attachment B.

F. Documentation:

1. All procedures, treatments, interventions, medications performed and/or administered shall be entered in the EHR.
2. Patient response to and outcomes of all interventions shall be documented in the EHR.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. American Academy of Pediatrics and American College of Obstetricians and Gynecologists (2017). *Guidelines for Perinatal Care.* (8th ed). Elk Grove, IL: Authors.

B. American College of Obstetricians and Gynecologists. (2016). *Hospital-based triage of obstetric patients.* Committee Opinion 667. Reaffirmed 2023.

C. Association of Women's Health, Obstetric and Neonatal Nurses. (2015). *Maternal Fetal Triage Index*, MFTI Education course, August 2020.

D. Emergency Nurses Association. (2023). *Emergency severity index handbook.* (5th ed).

Attachments

A: Maternal Fetal Triage Index (MFTI)

B: ESI Triage Algorithm (ESI)

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	05/2025
CNO	Carla Spencer: Chief Nursing Officer	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	03/2025
Policy Owner	Daniela Jago: Clinical Manager	03/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18083588**

Origination	06/2022	Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Last Approved	N/A	Area	Patient Financial Services
Next Review	3 years after approval		

Chargemaster Dictionary Maintenance

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. Chargemaster maintenance endeavors to ensure that all information related to the provision of services and supplies is accurately collected, billed and recorded. Chargemaster development and maintenance assists in the compliance with all related payer rules, regulations and policies.

III. DEFINITIONS

A. The chargemaster is a database utilized by all departments for accurate charge generation and capture. It defines services performed and supplies provided. It also allows for appropriate selection of charges with correct CPT, HCPCS and other required codes, consistent with all payer requirements. It facilitates accurate generation of statistical information for internal and external reporting requirements.

B. CPT is Current Procedural Terminology developed by the American Medical Association used for billing medical and surgical procedures.

C. HCPCS is the Healthcare Common Procedure Coding System developed and used by Medicare for billing and reporting supplies, services and drugs not addressed by CPT.

D. UB-04 is Universal Billing form revised in 2004.

IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center (SVHMC) chargemaster facilitates accurate billing of

claims that reflect compliance with billing rules, regulations and coding guidelines for all payers.

B. Statistical data assignments in the chargemaster are consistent with State of California HCAi requirements.

C. All charges follow the Hospital REVENUE CYCLE PROCEDURE AND SUPPLY CHARGE PROCESS.

D. The integrity of the chargemaster, including all additions, deletions and updates is maintained through ongoing review processes. Oversight of chargemaster maintenance is the responsibility of the Revenue Integrity Coordinator and utilizes a team approach that includes, but is not limited to, Accounting, Patient Financial Services, Health Information Management and all departments that charge for supplies and / or services. Revenue Integrity co-ordinates with Department Managers who are responsible for insuring the accuracy and integrity of all changes made to the specific department's Chargemaster.

E. All CPT, HCPCS and other coding changes are revised as periodic updates and revisions are published. Such information is provided to the individual departments by Revenue Integrity. Update processes for each departmental section of the chargemaster shall be completed within all published time constraints. All CPT and HCPCS codes are assigned using the most current published information and are consistent with current Medicare, Medi-Cal & other payer requirements.

V. PROCEDURE

A. Complete Electronic Chargemaster Request through the CDM master module

B. Complete any pricing review. Attach copies of all worksheets within the CDM master module.

C. Complete the department's portion of the request. *Electronic.*

- Indicate action to be taken.
    1. Use A to add a new item to the chargemaster
    2. Use R to revise any portion of an existing Chargemaster entry.
    3. Use D to deactivate a chargemaster entry.
- Enter first two or three digits of department specific billing code in the charge number box.
    1. The first two digits define the department.
    2. A third or subsequent digit may be used to establish charge types within an individual department.
- Complete all information department is responsible for providing (description, charge, CPT/HCPCS code, etc.) and any statistical information if applicable. Descriptions cannot exceed 30 characters, including spaces. Descriptions exceeding 30 characters may be truncated by the Revenue Integrity Coordinator or returned to the requesting department for correction.

D. Enter the cost if known.

E. Compute and enter patient charges by applying mark-up formulas to the cost based on each

department markup formula. (Mark-up formulas are maintained by the department.

F. Assign CPT and HCPCS codes using the most current published information. They must be consistent with current Medicare, Medi-Cal and other payer requirements.
    - Assign CPT for Medicare and all other payer types in the MCR box. Include modifiers as indicated by accepted coding practice and payer requirements.
    - Use MCL box to assign Medi-Cal CPTs or HCPCS consistent with Medi-Cal publications. Assign modifiers as indicated in the Medi-Cal manual. Medi-Cal codes may be assigned by the Revenue Integrity Coordinator.

G. Assign Revenue Codes specific to UB-04 reporting requirements. The department manager/ designee may choose to assign the Revenue Code or work with Revenue Integrity Coordinator for proper assignment.

H. The comments field may be used to share information about chargemaster data entry. For example, Materials Management enters the item file number to cross reference to the Materials Management module. Clinical areas use the space to communicate the desired mnemonic to be put into ITS charge dictionaries.

I. Department Designee completes and dates electronic request prior to submission. When approval is required by department manager or director, electronic sign-off in the CDM Master module will serve as authorization of new charge creation.

J. The department revenue center general ledger code is assigned by Revenue Integrity Coordinator in accordance with Hospital Revenue and Usage, General Accounting and HCAi reporting requirements.

K. The Revenue Integrity Coordinator in coordination with the requesting department assigns the effective date.
    - Additions to the chargemaster are effective the first of the month in which the data is entered into the chargemaster dictionary.
    - To maintain data systems and billing integrity, changes in charges (dollar value) are effective the first of the next consecutive month.
    - Changes in active status, descriptions and revenue codes are effective immediately.
    - For deactivations, line items are marked for inactivation *deletion* in the chargemaster. If the individual charge has not been utilized in the past 5 years the charge code will be inactivated.

      NOTE: Known future changes in CPT/HCPCS codes can be submitted in advance and assigned a future active or deactivation date.

L. Statistical expression for the General Ledger is assigned using HCAi criteria.

M. Billing number assignment is made and the data is entered into the Chargemaster dictionary in the live environment. The test environment is maintained as well to stay consistent with live environment. The completed chargemaster build is sent back to the requesting department electronically within the CDM master module with all fields completed.

N. When applicable, an e-mail of the completed chargemaster build is forwarded to the ITS dictionary manager for entry into the department specific ITS dictionary. The ITS manager is

responsible for coordinating all ITS processes with the department manager/designee.

O. Miscellaneous billing charge codes are discouraged.

P. Data entry is completed in a timely manner to facilitate billing processes of new services and items within the 3-day charge capture period.

Q. All individuals submitting requests for chargemaster maintenance shall be educated as to the rules, regulations, policies and procedures required for its integrity. Such education shall be provided by the Revenue Integrity Coordinator at the request of the Department Manager.

R. Education includes current requirements for chargemaster integrity and accuracy in billing and the content of this policy and related policies.

S. Department specific education is provided by the Revenue Integrity for all updates in regulatory or coding requirements.

T. Documentation:

- Revenue Integrity Coordinator maintains documentation of all education and training.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Current Procedural Terminology (CPT) Manual

B. HCPCS Level II Code Book

C. Medicare Internet Only On-line Manuals (www.cms.hhs.gov/Manuals/IOM/list.asp)

D. Medi-Cal Manual http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

E. UB-04 Manual American Hospital Association

F. UB-04 Editor (Ingenix Publishing)

G. Accounting and Reporting Manual for California Hospitals (Department of Health Care Access and Information- HCAi)

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 **18121391**

Origination	03/2019	Owner	Philip Katzenberger: Director HIM/ Privacy Officer
Last Approved	N/A	Area	Health Information Management
Next Review	3 years after approval		

Electronic Provider Documentation

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) maintains a complete, accurate, reliable and integrated electronic health record (EHR) for individuals receiving care with the EHR being the primary modality for documentation.

II. PURPOSE

A. To clarify specific guidelines that pertain to direct electronic provider documentation ("PDOC") using report templates created within the hospital's electronic health information system, hereafter referred to as EHR.

III. DEFINITIONS

A. Provider: A generic term for all licensed providers of healthcare.

B. PDOC: Documentation typed or entered using voice recognition directly into the electronic medical record by the provider.

C. Template: A document that exists in a preset format and is used as a starting point to guide a healthcare provider through the documentation of a patient encounter.

D. Macro: A command in the computer or dictation application that automatically generates predetermined text.

E. Authentication: The identification of the author of a medical record entry by that author and confirmation that the contents are what the author intended.

F. HIM: Health Information Management

G. VR: Voice Recognition

IV. GENERAL INFORMATION

A. This policy applies to all providers who document in the electronic patient record at SVHMC

B. Providers generate direct electronic documentation ("PDOC") for patient encounters, such as Progress Notes, History & Physicals, Consultations, Operative/Procedure reports, Discharge/ Death Summaries. Providers may create PDOC reports by using the "Document" routine in the Provider Care Management (PCM) module directly within the EHR. The EHR is shared by all providers and staff across the continuum of care settings. Providers are responsible for ensuring the accuracy, completeness and timeliness of all clinical documentation they create in the electronic health record. Proofreading and editing are expected to be performed prior to authentication of the document by the provider.

V. PROCEDURE

A. Templates for creating documentation may be used as a prompting tool and will be available for use only after approval by the PDOC Steering Committee or designated committee.

    1. Encounter-specific documentation must be included in each report that is template based, including active selections such as:

        a. Check boxes

        b. Drop-down menus

        c. Blank lines requiring addition of new text, which may be added via typing or VR software.

B. Macros may be used within the template format, provided that they have been created by the author of the document. All information imported via macro must be specific to the individual patient encounter. Questions regarding creation and use of macros should be directed to the CMIO.

C. Copy and Paste. The practice of copying and pasting previously entered documentation can improve the efficiency and completeness of the patient record. However, documentation created by this method should be used minimally.

    1. Appropriate use of the copy and paste functionality include cases where the functionality will result in improved efficiency of data capture, timeliness, increased legibility, consistency or completeness but is clearly and easily distinguished from the original information.

    2. The deliberate act of copying and pasting any language from another physician's documentation is an indication that the documenting physician is in agreement with the contents.

    3. The information should be edited to pertain to the current document.

    4. Electronic signature by the physician is authentication of agreement with the contents.

D. Authentication. All documentation must be authenticated by the person providing services, ensuring that the information is accurate and complete prior to signing.

E. Corrections and Amendments.

1. Healthcare providers will provide a clear and comprehensive account of the care they provide to patients as soon as possible after an event has occurred. Documentation must never be completed before the event actually takes place.
2. Corrections in documentation will be referred to the Physician Support Specialist. Errors in documentation may be identified in multiple ways, such as:
    a. Quality auditing
    b. Coding services
    c. Quality/Case Management review
    d. Other discipline review
3. Entries must be corrected in such a way that the initial content is visible or retrievable so that the purpose and content of the correction is clearly understood. PDOC reports that are created electronically must be corrected by one of the following mechanisms:
    a. Add an addendum to the original document indicating the corrected information, with appropriate authentication. This is the preferred method.
    b. A signed document may be returned to Draft status for editing, provided that the error is caused by VR misinterpretation. While these errors should be corrected prior to signature, if they are identified after that, the following may be done:
        i. The documenting Provider will be called by Physician Support Specialits to inform of the incorrect VR transcription.
        ii. Upon approval of the Provider, the report will be returned to Draft status for correction and authentication.
        iii. The initial content remains retrievable in the EHR system. An audit of the original document showing the changes made is maintained within EHR.

F. Documentation: N/A

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	05/2025

Standards

No standards are associated with this document

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

Origination	08/2020	Owner	Genevieve delos Santos: Director Pharmacy
Last Approved	N/A	Area	Pharmacy
Next Review	3 years after approval		

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.
    1. On an annual basis, at the beginning of each calendar year, the medical staff department will receive a link of the entire formulary to distribute to all credentialed providers.

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	06/2025
P&T	Genevieve delos Santos: Director Pharmacy	06/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	06/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17978846

Origination	06/2017	Owner	Melissa Deen: Manager Infection Prevention
Last Approved	N/A	Area	Infection Control
Next Review	3 years after approval		

Isolation - Standard and Transmission Based Precautions

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the medical, nursing and ancillary staff that may, in the course of routine work have contact with blood and/or other potentially infectious materials (OPIM) in the implementation of Standard Precautions and Transmission Based Precautions.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Role of the Nurse and Other Direct Patient Care Providers in Implementation of Standard Precautions and Transmission Based Precautions:

1. Each nurse/direct care provider needs to evaluate his/her own interactions with the patient and use barriers as appropriate, based on anticipated contact with body substances, as opposed to the patient's diagnosis. The guidelines may be used to assist in making these judgments. There is no signage required for Standard precautions.
2. If the patient has a disease that is transmitted in whole or in part by the Airborne, Droplet, or Contact routes, the nurse or clinical staff when feasible will evaluate and educate persons/visitors wishing to enter that patient's room. Use the attached guidelines to assist with these judgments.
3. All nursing/direct care providers must know their own chickenpox, rubella and measles status, and participate as required in Hospital's TB control program.

4. All staff that have frequent contact with blood or body fluids should be immunized against Hepatitis B. Hepatitis B vaccine is offered free of charge for Hospital employees in jobs identified as bloodborne pathogen category I or II

B. The Physician's Role in Implementing Standard Precautions and Transmission-Based Precautions:

1. It is not necessary to wait for an order "isolation precautions" enter the order in the EMR per policy. If the patient has a disease or is being ruled out for a disease that requires measures beyond Standard Precautions, then an Airborne, Droplet, or Contact precautions sign will be placed on a patient's door. Patients in Reverse or Protective isolation also need a sign placed.
2. Each physician needs to evaluate his/her own interactions with the patient and must use appropriate barriers, based on anticipated contact with body substances, not the patient's diagnosis.
3. All physicians should know their own chickenpox, rubella and measles status, and it is recommended that physicians have yearly TB screening.
4. It is recommended that all physicians who have contact with blood/body fluids be immunized against Hepatitis B.

V. PROCEDURE

A. **STANDARD PRECAUTIONS**

To provide effective Infection Prevention & Control guidelines for personnel and to prevent the spread of infection, Standard Precautions will be followed by all persons at all times, regardless of the patient's diagnosis. All hospital personnel and medical staff are required to utilize the precautions as described in these guidelines.

1. Health care providers should utilize individual judgment at all times to determine when, and what kind of, barriers are required. Individuals must establish his/her own standards for consistent barrier use: these standards should be based upon the individual's skills and interactions with the patient's body substances, non-intact skin or mucous membranes.
    a. **Hand Hygiene**:
    Hand hygiene should be performed frequently and always under the following circumstances:
        i. Before having direct contact with patients.
        ii. Before donning gloves and performing an invasive procedure.
        iii. After removing gloves or other personal protective equipment.
        iv. After contact with body substances or articles/surfaces contaminated with body substances.
        After contact with patient's intact skin (i.e. taking a pulse, blood pressure, or lifting a patient).
        v. Between tasks and procedures on the same patient to prevent cross contamination of different body sites.

vi. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient.

vii. Before preparing or eating food

viii. After personal contact that may contaminate hands (covering sneeze or cough, blowing nose, using the bathroom).

ix. If hands are not visibly soiled, use an alcohol based hand gel for routinely decontaminating hands.

x. When hand are visibly soiled or contaminated, wash hands with soap and water.

b. **Gloves**:

i. Wear gloves (clean/non-sterile) when touching blood, body fluids, secretions, excretions, and contaminated items. **Put on clean gloves before contact with a patient's mucous membranes or non-intact skin.**

ii. Change gloves during patient care if the hands will move from a contaminated body site (e.g . perineum) to a clean body site (e.g. face).

iii. Remove gloves promptly after use, before touching clean items and environmental surfaces, and before going to another patient

iv. Perform hand hygiene immediately after removing gloves.

c. **Gowns/aprons**:

i. Wear a gown (clean/non-sterile) to protect skin and prevent soiling of clothing during procedures or patient-care activities that are likely to generate splashes/sprays of blood, body fluids, secretions, or excretions.

ii. Remove a soiled gown as soon as possible, before exiting the patient's room and decontaminate hands to avoid the transfer of microorganisms to other patients or the environment.

d. **Face shields, masks, goggles**:

i. Masks and/or eye protection or a face shield to protect mucous membranes of the eyes, nose, mouth during procedures and patient-care activities that are likely to generate splashes/sprays of blood, body fluids, secretions, and excretions such as trauma, surgery, delivery of newborns, intubation/suctioning, bronchoscopy, patient care of coughing patient with suspected etiology.

e. **Hoods, caps, shoe covers/boots**:

i. Use of this type of personal protective equipment is usually limited to the O.R., trauma and/or pathology department. Shoe covers should not be worn out of the work area.

ii. All single-use PPE's will be discarded in the appropriate container prior to leaving the work area.

iii. Reusable PPE's will be cleaned, laundered and/or decontaminated as needed.

f. **Removal of PPE**:

i. PPE must be removed in such a manner as to avoid touching the outside of the mask, goggles, gown and gloves, because they may be contaminated with infectious secretions from the patient.

ii. Do not touch face or eyes while wearing or removing PPE. This includes not reaching up to adjust goggles or mask. Do not touch surfaces in the patient's room before leaving.

iii. Removal of PPE is initiated while you are **INSIDE** the patient's room. Do not leave dirty PPE outside of the patient's room. Follow the steps below:

a. Break the ties of the gown by grasping the front of the gown with contaminated gloves at the waist of the gown and pull forward which will pop and release the back waist and neck of gown. If the neck closure is not released, place contaminated gloved hands at front shoulder area and gently pop the neck closure open. If the ties do not break, carefully untie the gown, taking care to NOT contaminate skin or clothing

b. Using a peeling motion, pull the gown from the shoulders. The gown will begin to turn inside out.

c. Continue to pull the gown off, again inside out, and remove your gloves as the gown is pulled over your hands.

d. Hold the removed gown and gloves away from your body and roll into a ball ensuring the potentially contaminated surface is on the inside.

e. Discard into a waste receptacle inside the patient's room.

f. Remove face shield/goggles

g. Decontaminate hands by washing or using alcohol based hand hygiene.

iv. Reference: CDC: Donning and Doffing PPE: Proper Wearing, Removal, and Disposal

g. **Patient-Care Equipment**:

i. All patient care equipment that comes in contact with skin or body fluids is to be disinfected between patients.

ii. Handle used patient-care equipment soiled with blood, body fluids, sections, and excretions in a manner that prevents contact with skin, clothing, or other surfaces.

iii. Reusable equipment is returned to Sterile Processing for decontamination. If the equipment needs to be used immediately, then use hospital approved disinfectant according to the manufacturer's instructions. Most disinfectants require the solution to be applied and allowed to sit for a specified period of time before drying.

iv. Contaminated disposable (single-use) items are disposed of in regular trash unless there is blood or body fluids in a free flowing or dripping state, in which case it is disposed of as biohazardous or medical waste (i.e. red bag).

v. If complete decontamination of equipment is not possible, the equipment must be labeled with a biohazard tag with a description of the contaminated portion of that equipment.

h. **Linen:**

i. Although soiled linen may be contaminated with microorganisms, the risk of disease transmission is minor if it is handled, transported, and laundered in a manner that avoids transfer of these microorganisms to other patients or personnel.

ii. All linen will be bagged inside the patient's room and then transported to the dirty utility room for pick-up by Environmental Services.

i. **Dishes**:

i. There are no special precautions needed for dishes, cups, or eating utensils. The combination of hot water and detergents used in hospital dishwashers is sufficient to decontaminate them. Food service personnel use gloves when handling dirty dishes.

j. **Biohazardous Waste / Specimens**:

i. All specimens from the human body are considered potentially infectious. Employees are required to use Standard precautions when handling specimens.

ii. Specimens will be placed in a leak-proof container for transport. All specimens being sent to the lab via the pneumatic tube system will be prepared according to Laboratory policy.

iii. If the outside of the specimen container is contaminated, or if there is potential for leakage, the specimen shall be placed into a second container prior to transport.

iv. All body substance spills shall be cleaned promptly with a hospital-approved disinfectant.

v. Standard precautions will be used by all personnel cleaning the spill, including the use of appropriate barriers.

k. **Reporting of Illness and Injury**:

i. Open wounds, skin irritations, etc. must be properly dressed and/or treated if the employee is to remain on duty.

ii. All infections and wounds must be reported to the supervisor, and any significant infections should be reported to Employee Health Nurse and/or Infection Prevention. Employees should not come to work when ill.

l. **Reporting of Exposures to Blood/Body Fluids (Other Potential Infectious Materials -OPIM)**:

i. All employees shall report exposure to blood and/or OPIM to Employee Health Department.

m. **Sharps Safety & Disposal**:

i. Utilize safety engineered sharps when available.

ii. Needles shall not be recapped, purposely bent, broken or removed by hand.

iii. Recapping shall be accomplished only when necessary: this shall be accomplished by a one-handed scoop method and/or mechanical recapping device. No two-handed recapping is allowed.

iv. Used sharps will be disposed of in a safe manner in a rigid, puncture-proof container, which shall be labeled with a biohazardous sign. Sharps containers will be changed when ¾ full according to Environmental Services policy.

v. Sharps containers are located in each patient room and shall be readily available in patient care areas. Sharps containers will be placed to assure that visibility of contents allows for safe disposal.

vi. The physician, nurse or technician using the needle, syringe or other sharp is responsible for placing it properly into the sharps box after use.

vii. The contracted reusable sharps container company and Environmental Services are responsible for collecting, storing and disposing of any sharps and pharmaceutical waste per Environmental Services policy.

n. **Employee Practices**:

i. Employees shall not eat, apply lip balm or cosmetics, nor adjust their contact lenses in their immediate patient care areas or nursing stations or work stations designated as patient care related.

ii. Clean up shall be performed in a manner so as to minimize splashing or aerosolization of body substances.

o. **The isolation patient, and procedures in O.R. and Imaging**.

i. For certain types of isolation, attempts should be made to schedule procedures for the last procedure of the day. If this is not possible, then time is allotted for cleaning of the room post-procedure.

B. **Transmission-Based Precautions (Airborne, Droplet & Contact and Protective)**:

1. Patients with known and/or suspected Airborne, Droplet, or Contact-spread diseases should be placed in the appropriate isolation. Refer to the attached guideline, "Isolation Precautions for Selected Infections." This guideline will enable staff to select an infection or condition and determine which precautions are needed (Airborne, Droplet, Contact, or a combination), what the infective material is, the duration of isolation, and any special information needed. Enter the order per policy.
2. When the patient is suspected and/or known to have a disease which is transmitted in whole or in part by the Airborne, Droplet, or Contact route, the nurse will place the proper sign on the patient's door, indicating personal protective equipment required by staff/visitors to enter the patient's room.
3. The Airborne, Droplet, or Contact sign becomes the prompt for visitors/staff to check with nursing before entering. It be the responsibility of the nurse/clinical support staff to monitor staff and visitors for proper use of PPE.
4. If a patient has a low WBC count or is a transplant patient, then the patient might need to be in Protective or Reverse isolation.

a. **Airborne Precautions:**
Airborne-diseases require isolation in a room capable of having negative pressure ventilation. This type of isolation is for patients known or suspected to have illnesses transmitted by Airborne Droplet nuclei (small-particle residue, 5 microns or smaller in size).

i. ***Common organisms isolated in Airborne Precautions for example are: Tuberculosis (TB), and Measles (Rubeola).***

a. **Patient Placement:**

i. Place the patient in a negative air pressure room in the appropriate level of care. Designated rooms are 329, 429, 529 & 537.

ii. Use the isolation sign indicating "Airborne Precautions".

iii. Keep the door closed at all times.

b. **Respiratory Protection:**

i. Wear respiratory protection N95 when entering the room of a patient with known or suspected airborne disease. (PAPR for any

Aerosol Generating Procedure)

ii. Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola).

c. **Patient Transport:**

i. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize the spread of organisms from the patient by placing a **regular surgical mask** on the patient.

b. **Airborne and Contact Precautions:** Airborne-diseases require isolation in a room capable of having negative pressure ventilation. This type of isolation is for patients known or suspected to have illnesses transmitted by Airborne Droplet nuclei (small-particle residue, 5 microns or smaller in size).This also includes patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient care items in the patient's environment.

i. ***Common organisms isolated in Airborne and Contact Precautions for example are: Chicken Pox, Disseminated Shingles or Immunocompromised with localized Shingles and Variola (Small Pox)*.**

a. **Patient Placement:**

i. Place the patient in a negative air pressure room in the appropriate level of care. Designated rooms are 329, 429, 529 & 537.

ii. Use the isolation sign indicating "Airborne and Contact Precautions".

iii. Keep the door closed at all times.

b. **Respiratory Protection:**

i. Wear respiratory protection N95 when entering the room of a patient with known or suspected airborne disease. (PAPR for any Aerosol Generating Procedure)

ii. Susceptible persons should not enter the room of patients known or suspected to have measles (rubeola) or varicella (chicken pox).

c. **Personal Protective Equipment**:

i. Fluid impenetrable gown
ii. Gloves
iii. N95 mask (PAPR for any Aerosol Generating Procedure)
iv. Goggles or Full Face Shield as needed, for any contact with patient, secretions, surfaces or equipment that is anticipated.
v. Remove mask, gown, gloves, goggles and wash hands or use alcohol hand gel before leaving this room.

d. **Patient Transport:**
Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize the spread of organisms from the patient by placing a **regular surgical mask** on the patient.

c. **Airborne, Contact and Eye Protection**: Airborne-diseases require isolation in a room capable of having negative pressure ventilation. This type of isolation is for patients known or suspected to have illnesses transmitted by Airborne Droplet nuclei (small-particle residue, 5 microns or smaller in size). This also includes patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient care items in the patient's environment.

i. ***Common organisms isolated in Airborne, Contact and Eye Protection examples are: SARS-COV-2 or any SARS/MERS, Ebola, Monkeypox, and any new or novel influenza.***

a. **Patient Placement**:

i. Place the patient in a negative air pressure room in the appropriate level of care. Designated rooms are 329, 429, 529 & 537.
ii. Use the isolation sign indicating "Airborne, Contact & Eye Protection Precautions".
iii. Keep the door closed at all times.

b. **Personal Protective Equipment**:

i. Fluid impenetrable gown
ii. Gloves
iii. N95 mask (PAPR for any Aerosol Generating Procedure)
iv. Goggles or Full Face Shield

v. Use above precautions for any contact with patient, secretions, surfaces or equipment that is anticipated.

vi. Remove mask, gown, gloves, goggles and wash hands or use alcohol hand gel before leaving this room.

c. **Patient Transport**:

i. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize the spread of organisms from the patient by placing a **regular surgical mask** on the patient.

ii. Special transport considerations for patients on "high flow" and/or aerosolized respiratory support/intervention. (i.e. BiPAP/CPAP, Intubation, High Flow Nasal Cannula over 6 L, etc)

iii. Reference link: Aerosol Transmitted Diseases Exposure Control Plan

d. **Droplet Precautions:**
This type of isolation is for patients known or suspected to have illnesses transmitted by large-particle Droplets.

i. ***Organisms isolated in Droplet Precautions may include Common Coronavirus (NON-SARS-COV2) strains such as 229E, HKU1, NL63, OC43, bacterial meningitis or meningitis cause unknown, seasonal influenza, parainfluenza, pertussis, pneumonic plague, mumps, rubella, etc.***

a. **Patient Placement:**

i. Place patient in a private room

ii. Place a "Droplet Precautions" sign outside the patient room.

b. **Personal Protective Equipment:**

i. Wear a earloop mask and gloves for every entry into the room

c. **Patient Transport:**

i. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize dispersal of droplets by putting a regular surgical mask on the patient.

ii. Reference Isolation quick sheet: Respiratory Viral Illness

e. **Droplet and Contact Precautions:**
This type of isolation is for patients known or suspected to have illnesses transmitted by large-particle Droplets.This also includes patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient care items in the patient's environment.

i. ***Organisms isolated in Droplet and Contact Precautions may include Adenovirus, Metapneumovirus (Human), Rhino/ Enterovirus, Respiratory Syncytial Virus (RSV), etc.***

a. **Patient Placement:**

i. Place patient in a private room

ii. Place a "Droplet Precautions" sign outside the patient room.

b. **Personal Protective Equipment:**

i. Wear a regular earloop mask

ii. Gown

iii. Gloves for every entry into the room

c. **Patient Transport:**

i. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize dispersal of droplets by putting a regular surgical mask on the patient.

ii. Reference Isolation quick sheet: Respiratory Viral Illness

f. **Contact Precautions:**
This isolation is for patients known or suspected to be infected or colonized with epidemiologically important organisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact) or indirect contact with environmental surfaces or patient care items in the patient's environment.

i. ***Organisms isolated in Contact Precautions may include multi-drug resistant bacteria (MRSA, VRE, Acinetobacter), Clostridioides difficile (CDI), Hepatitis A, E. coli 0157:H7, Rotavirus, major abscesses that cannot be contained by a dressing, etc.Scabies and Lice are also isolated in contact precautions until treatment has been completed.***

a. **Patient Placement:**

i. Place patient in a private room.

ii. Place a "Contact" or "Contact PLUS" (for CDI) sign outside the patient room.

b. **Hand Hygiene:**

i. During patient care, change gloves after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage).

ii. Remove gloves inside the room, and immediately decontaminate hands.

c. **Personal Protective Equipment:**

i. Wear a gown every time you enter the patient's room. You must wear a gown and gloves whether they are colonized or infected. If the patient has MRSA in their sputum **AND** they are coughing **AND** you will be in close contact with them, a regular mask will also be appropriate. For MRSA colonized patients, a mask is not necessary.

d. **Patient Transport:**

i. Limit the movement and transport of the patient from the room for essential purposes only. If the patient is transported out of the room, ensure that precautions are maintained to minimize the risk of transmission of organisms to other patients or the environment.

i. place a clean sheet or other physical barrier over gurney or wheelchair before transporting patient

ii. if possible, have patient put on a clean gown prior to transport

iii. The transporter should wear gown and gloves to assist the patient into and out of the wheelchair/ gurney. The PPE should then be removed prior to leaving the patient's room and hands decontaminated.

iv. When transportation is complete, thoroughly clean all surfaces of

the wheelchair/gurney with a hospital approved disinfectant.

ii. References for Isolation Quick Sheets:

a. Diarrhea Decision Tree

b. Contact Isolation Criteria

g. **Protective Respiratory Isolation:**

i. This type of isolation is for patients known to be immunocompromised and at risk for developing a serious illness if they acquire a respiratory infection. This can be ordered at the physicians discretion based on patient history and co-morbidities

a. **Patient Placement:**

i. Place patient in a private room with door closed

ii. Place a "Protective Respiratory Isolation" sign outside the patient room.

b. **Personal Protective Equipment:**

i. Regular “ear loop” Face Mask or N95

c. **Strict Handwashing**

d. **Patient Transport:**

i. Limit the movement and transport of the patient from the room to essential purposes only.

ii. If transport or movement is necessary, minimize exposure to the patient by putting a regular “ear loop” mask on the patient.

h. **Protective "Neutropenic" Precautions**
This type of isolation is for patients known to have an immunocompromised condition such as a low WBC and/or low ANC, or being a transplant patient, or on immunosuppressive medications.

i. **Patient Placement**:

a. Place patient in a private room

b. Place a "Protective Isolation" sign outside the patient room.

ii. **Personal Protective Equipment**:

a. Wear a regular surgical mask, and gloves for every entry into the room

iii. **Patient Transport**:

a. Limit the movement and transport of the patient from the room to essential purposes only. If transport or movement is necessary, minimize exposure to the patient by putting a regular surgical mask on the patient.

iv. **Special Considerations**:

a. Neutropenic precautions when Absolute Neutrophil Count (ANC) reaches 500-650, or provider preference.

b. Avoid patient exposure to all sources of stagnant water. Stagnant water provides an excellent medium for the growth of microorganisms.

c. Avoid use of respiratory therapy equipment with water reservoirs whenever possible.

d. Do not place fresh cut flowers, plants or fresh fruit baskets in the patient's room. Soil/water is a potential source of microorganisms

C. Supporting Plans/Polices:

1. Aerosol Transmitted Diseases Exposure Control Plan
2. Tuberculosis (TB) Prevention and Control
3. Bloodborne Pathogen Exposure Control Plan
4. Injury and Illness Prevention Program Plan
5. BIOMEDICAL WASTE FROM THE PATIENT ENVIRONMENT
6. MEDICAL EQUIPMENT CARE, CLEANING AND MAINTENANCE
7. Soiled Linen Handling
8. Handling Clean Linen
9. Hand Hygiene
10. Nutrition Services Infection Control
11. BIOTERRORISM READINESS PLAN
12. Infection Prevention Pandemic Plan Emerging Infectious Diseases

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

1. APIC Text of Infection Control and Epidemiology, updated 2024.
2. CDC Guidelines for Isolation Precautions for Hospitals. HICPAC Infection Control Hospital Epidemiology 2006; 17:53-80.

3. CAL-OSHA State Standard, Title 8, Chapter 4, Section 5193, January 1999.
4. CDC, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, last update September 2024
    1. CDC: Appendix A: Type and Duration of Precautions Recommended for Selected Infections and Conditions
5. CDC Guidelines for Environmental Infection Control in Healthcare Facilities, 2003.
6. CDC. Management of Multidrug-Resistant Organisms In Healthcare Settings, 2022. Multidrug-Resistant TB (MDR TB)
7. CDC: Donning and Doffing PPE: Proper Wearing, Removal, and Disposal

Attachments

- Adult Isolation Guidelines Matrix_2023.pdf
- C: Diarrhea Decision Tree
- Contact Isolation Criteria_discontinue isolation criteria_2023.pdf
- Mobilization of Patients with Isolation Precautions_RehabStaff.pdf.pdf
- Mother_BabyIsolation_Guidelines_Matrix_2023.pdf
- Out Patient Infusion_Isolation workflow.pdf
- Out Patient Surgical Services_Isolation workflow.pdf
- Outpatient Infusion_Diarrhea Decision Tree.pdf
- Outpt Infusion_Isolation.11.2024.pdf
- Pediatric Isolation Guidelines Matrix_2023.pdf
- Respiratory Viral Illnesses_2023.pdf
- SVH_Measles Update_2025.pptx
- SVHMC Isolation Reference Sheet 2024.pdf
- SVHMC_Patient Placement_2024.pdf

Approval Signatures

Step Description	Approver	Date

Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T/IPC	Genevieve delos Santos: Director Pharmacy	05/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Melissa Deen: Manager Infection Prevention	04/2025

Standards

No standards are associated with this document

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Origination	01/2021	Owner	Louis Villaneda Sr.: Respiratory Care Manager
Last Approved	N/A	Area	Plans and Program
Next Review	1 year after approval		

RC POCT Laboratory Safety/Chemical Hygiene Plan

I. SCOPE

A. Salinas Valley Health Medical Center (SVHMC) is responsible for providing a safe place of employment and for furnishing safeguards, safety devices, and methods of operation to safeguard employees. In accordance with the SVHMC Safety Plan and the Environment of Care Committee, the following is in place to protect respiratory care practitioners (RCP) from health/chemical hazards associated with performing arterial blood gas collection and analysis. It is designed to identify actual and potential employee exposure, as well as set forth responsibilities and activities to enhance employee safety. This policy, as well as the OSHA standard (1910.1450) requiring that this policy be implemented, shall be available to employees at all times.

B. All procedures (and use of chemicals and chemicals compounds) are listed, approved and reviewed in RC POCT ABG Policies: EPOC BLOOD ANALYSIS PROCEDURE

II. DEFINITIONS

A. N/A

III. PLAN MANAGEMENT

A. **Plan Elements**

1. **SAFETY EQUIPMENT/APPAREL:**

a. Personal protective equipment is the last line of defense against injury. Lines of defense may include:

i. Using proper technique, appropriate training, and methods

ii. Using engineering controls such as those listed below:

- EYEWASH Bottle – Located RC laboratory
- Fire Extinguishers - extinguishers labeled ABC can be

used for any kind of fire occurring in the Laboratory

- Face Shields - located in par level areas
- Gloves - Located throughout the hospital
- Fire Alarm- Located throughout the hospital
- Chemical Spill Kits – Located in engineering

b. POCT Supervisor shall be responsible for assuring their personnel use the protective equipment and apparel and that they use it properly.

c. The following personal protective equipment (PPE) rules shall apply to all Laboratory personnel:

- Proper protective gloves and other protective clothing shall be worn when there is potential for contact with corrosive or toxic materials or materials of unknown toxicity
- Gloves shall be selected on the basis of the materials being handled and the degree of hazard involved
- All personal protective equipment must be appropriately stored, cleaned and cared for on an ongoing basis. Cleaning is especially important after exposure to chemicals
- Prior to using any personal protective equipment, it should be thoroughly examined and inspected for unusual wear, deterioration, holes, cracks or other imperfections which could result in exposure of an employee.

2. **HOUSEKEEPING, MAINTENANCE AND INSPECTION:**

a. Hospital Environmental Services perform general housekeeping. RCP personnel, however, will be responsible for keeping their respective work areas orderly and clean.

- Waste materials shall be appropriately segregated in disposed of in appropriate receptacles.
- Spilled chemicals must be cleaned up immediately in an approved manner. (See spill control section)

3. **WASTE HANDLING AND DISPOSAL COMPLIANCE:**

a. Wastes will be handled and disposed of in a manner consistent with the hospital chemical and medical waste management program as well as Federal, State and Local regulations.

b. The goal of the waste management program is to assure minimal harm to people, other organisms, and the environment as result from the disposal of waste laboratory chemicals.

4. **CHEMICAL WASTE PICK UP – ALL HAZARDOUS CHEMICALS:**

a. Containers must be in good condition and wastes must be stored in compatible containers according to hazardous material disposal

guidelines.

b. Keep different types of wastes in separate containers.

c. Unlabeled containers of chemicals and solutions should undergo prompt disposal. If partially used, they should not be opened.

5. **GENERAL GUIDELINES:**

   a. All RCPs shall familiarize themselves with all procedures associated with the use of chemicals.

   b. The application of safety rules and safe work procedures shall be considered as important as the quality and professionalism of work performance.

   c. Supervisors at each management level shall be responsible for enforcing safety rules and safe work performance through regular performance evaluations and an application of the standard hospital disciplinary policy when infractions occur.

6. **GENERAL LABORATORY SAFETY:**

   a. Smoking is prohibited.

   b. Eating and drinking are prohibited in the technical work areas.

   c. Cosmetic application is prohibited in the technical work areas.

   d. Food is prohibited in technical refrigerators.

   e. Face shields or eye protectors must be worn when handling caustic chemical or when pouring chemicals.

   f. Shoes should be comfortable; rubber soled, and covers the entire foot.

   g. Hair shall be secured back and off the shoulders in a manner as to prevent it from coming into contact with contaminated materials or surfaces and also to prevent shedding. Hair must be kept away from any machinery. Beards must be handled in the same manner.

   h. All accidents shall be immediately reported to the immediate supervisor or lead regardless of injury severity.

   i. Always wear appropriate protective gloves when handling hazardous chemicals and wash hands thoroughly afterwards.

   j. Inspect gloves before use.

   k. Flammable liquids should be kept away from sources of ignition.

   l. Always know the exact location of all safety and emergency equipment.

   m. Report any unusual odors, vapors or smoke at once to your immediate supervisor.

   n. If you should happen to splash a caustic liquid on your skin or in your eyes, flush and/or wash the affected area immediately with copious amounts of water.

o. Never drink from a laboratory container.

p. Do not smell or taste chemicals.

q. Learn the uses and potential hazards of all equipment

r. Use equipment only for its intended purpose.

s. All containers shall be labeled & dated plainly to identify contents and provide warnings

t. Labels on original containers shall not be removed or defaced.

u. Never fill a container with a material other than that called for on the label.

v. Know the proper disposal method for chemical substances.

w. Always check with an SDS sheet when using chemical and procedures with which you are not familiar.

x. Become familiar with chemical incompatibilities. Chemicals which could react should not be stored together.

y. Refrigerators shall not be used for the storage of chemicals unless the refrigerator is specifically designed for the appropriate hazard (flammability, explosion proof lighting and electrical fixtures.)

7. **CHEMICAL PROCUREMENT, DISTRIBUTION AND STORAGE:**

    a. PROCUREMENT –All supplies are received in the central receiving area in the Materials Management (MM) Department. Refer to MM Procedures for receiving supplies.

8. **STOCKROOM/STOREROOM:**

    a. Hazardous substances should be clearly identified and segregated from other supplies or chemicals.

    b. The store room shall not be used as a preparation area, repackaging area or chemical transfer area.

9. **LABORATORY STORAGE:**

    a. Amounts permitted should be as small as practical.

    b. Exposure to heat or direct sunlight should be avoided.

10. **EMPLOYEE MEDICAL SAFETY PROGRAM:**

    a. Employees annually receive a health examination in accordance with Employee Health policies and procedures.

    b. In the event of over-exposure, exposure to a spill or leak or if an employee develops signs or symptoms associated with a hazardous chemical, they shall receive medical consultation and evaluation. This shall include follow-up medical examination thought to be necessary by the examining physician.

    c. First aid for exposure to toxic substance should be administered through the Employee Health Services. Some exposures may require immediate

treatment (Employee taken directly to the Emergency Room). Listed below are some conditions which may require immediate treatment.

- Thermal and chemical burns
- Cuts and fracture wounds from glass or metal, including possible chemical contamination
- Skin irritation by chemicals
- Poisoning by ingestion, inhalation or skin absorption
- Asphyxiation (chemical or electrical)
- Injuries to the eyes from splashed chemicals

11. **SIGNS AND LABELS (SEE ALSO HAZARD COMMUNICATION PROCEDURES):**
    a. Emergency telephone numbers of emergency personnel, internal hospital codes and home phone numbers for key laboratory personnel available in multiple locations throughout the Lab.
    b. Original chemical containers must not have original labels removed or defaced. All containers must have identity labels showing the contents of the container as well as the associated hazard.
    c. Signs showing the location of the eyewash station and other safety and first aid equipment, exits, fire alarm and fire extinguishers. Signs are also posted where special or unusual hazards exist.
    d. Special hazards throughout the laboratory shall be clearly identified with symbols and working labels. Such signs and labels as listed below:
        - flammable liquid storage
        - biological waste receptacles
        - storage areas for strong alkalis or acids
    e. Safety equipment shall also be clearly marked and identifiable.

12. **CHEMICAL/ REAGENT LABELING:**
    a. Every container in the Laboratory should be labeled, regardless of size, with the following information:
        - name of chemical as it appears on the SDS sheet
        - the strength or concentration of the chemical
        - an appropriate warning where applicable
        - "Hazardous" warning label where applicable for hazardous chemicals
    b. Any new reagent/chemical acquisition must be approved by the RC POCT Director before ordering and must have SDS data sheet on file. New reagents/chemicals that are added to arterial blood gas program must be included in an appropriate training program for that chemical.

13. **SPILLS AND ACCIDENTS:**
    a. The Laboratory Department participates in the hospital wide internal and external disaster plans. Personnel shall:
        - Be familiar with exits and evacuation routes
        - Participate in both types and drills
        - Be familiar with alarms, hospital codes and know their responsibilities with respect to these alarms and codes.
14. **CHEMICAL SPILL PROCEDURE:**
    a. The organization Hazardous materials Spill procedure will be followed.
15. **SPECIFIC HAZARDOUS CHEMICAL SPILL CONTROL INFORMATION for Common Laboratory Chemicals:**
    a. ALLERGENS: Wear suitable gloves to prevent hand contact with allergens or substances of unknown allergenic activity.

B. **Plan Responsibility**

1. The RC POCT Director / designee is responsible for ensuring that the policies and procedures contained within the Chemical Hygiene plan are followed and that appropriate protective equipment is used.
    a. Responsibilities include:
        - Ensuring that workers know and follow the chemical hygiene rules and appropriate training has been provided.
        - Determining the required level of protective equipment, availability of equipment, and ensuring it is in working order
        - Provide regular inspections including routine inspections of emergency equipment.
        - The current legal requirements concerning regulated chemicals
        - Reporting lack of compliance to the RC POCT Director or RC POCT Supervisor for corrective actions.
2. No new chemical, chemical compound or laboratory procedure may be applied without the specific prior approval of the RC POCT Laboratory Director.

C. **Training and Information**

1. All employees that perform analysis on bodily fluids are at risk must be informed about the work hazards on performing these types of analysis, the proper work procedures to follow to prevent exposures and accidents and what to do it an accident occurs. It is the intent of this department to make available as much information and literature as possible regarding the chemicals employees must work with. Personnel are encouraged to request information and utilize textbooks and reference materials to become as knowledgeable as possible regarding chemical hazards and appropriate precautions needed.
2. Textbooks and reference materials are available and are located on line using the

SDS online library and/or the Hospital Library. This can be found on the organizational intranet.

3. Other materials and information may also be found in the Laboratory Safety Manual or online. Materials found include:
    - The Laboratory Safety/Chemical Hygiene Plan
    - OSHA's Permissible Exposure Limits for Regulated Substances
    - OSHA's Laboratory Standard (CFR 1910.1450)
    - Signs and Symptoms Associated with Exposures
    - Material Safety Data Sheets/Safety Data Sheets in Lab and/or on STARnet.
4. Initial and ongoing training is provided and participation by department employees is required.
5. Information shall be provided at the time of an employee's initial assignment to a work area or prior to new exposure assignments.
6. Ongoing training will be provided as part of the facility annual training process.

IV. REFERENCES

A. National Institutes of Health (2023) Chemical Hygiene Plan retrieved from: https://ors.od.nih.gov/sr/dohs/Documents/chemical-hygiene-plan.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
Laboratory Medical Director	Johnny Hu: PHYSICIAN	04/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Louis Villaneda Sr.: Respiratory Care Manager	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18083662**

Origination	06/2022	Owner	Charlotte Wayman: Director Pt Financial Svcs/Pt Registration
Last Approved	N/A	Area	Patient Financial Services
Next Review	3 years after approval		

Registration Data Accuracy

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To ensure the accurate collection of patient information for the purpose of charge entry, medical records, patient face sheets, statistical reporting, physician and hospital billing/ collection and any other department requiring patient information at Salinas Valley Health Medical Center (SVHMC).

B. To develop standards, selected written policies and procedures, establish monitoring controls and develop training programs for standard registration processes through the organization that meet regulatory requirements.

C. To obtain and enter at point of service into the EMR system accurate and complete demographic and insurance information for all patients for treatment at SVHMC. To ensure the accuracy of patient information

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Throughout the organization, there are multiple registration areas reporting to different management leadership, who participate in following the standardized registration processes to ensure all information is being obtained at the time of patient registration. All areas will have written policies and procedures, monitoring controls, and training programs established to meet regulatory requirements as well as accuracy standards.

B. This process has been established to follow established goals in all registration areas that meet the following:
    - Compliance with regulatory requirements
    - Communication feedback of processing issues
    - Create accurate demographic database
    - Accurate documentation
    - Clean audit trail
    - Easier access to patient care

V. PROCEDURE

A. All patient demographic information will be collected and entered into the EMR system, where account information is initiated. Nthrive will enhance the accuracy of registrations in the insurance fields. Returning patients will have all information re-verified for each visit.

B. Registration data accuracy standards will be followed and monitored by all departments where patient's registration data is collected. An accuracy rate of 95% is expected in all areas. See attachment A for a list of data elements to be collected.

C. Additional forms, as required by payers, hospital policy or other mandates will be completed upon registration by the staff.

D. Compliance monitoring will be required by all registration areas and reported monthly to the Director/Designee of Registration.

E. Documentation:
    - Registration Data Elements
    - Audit Reviews

F. Employees who enter data may receive a monthly accuracy report identifying areas that need education and improvement.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. The Joint Commission IM 04.01.01.

Attachments

A: Data Entry and Auditing Standards

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 Active PolicyStat ID 14613538

Origination	09/2024	Owner	Clement Miller: Chief Operating Officer
Last Approved	09/2024	Area	Scopes Of Service
Next Review	09/2026		

Scope of Service: Administration

I. SCOPE OF SERVICE

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

The purpose of Administration is to enhance patient services and health programs that help SVH remain a leading provider of medical care. The goal of Administration 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 SVH goals and objectives, Administration will continually develop goals to direct short-term strategies and tactics that will meet the cultural needs of the organization, the commitment to cultural transformation and the realization of the Mission and Vision and strategic plan. These goals may have input from governance and staff and will be reviewed by the Board of Directors annually or as needed.

The goal of Administration is to:

Create an organizational culture of safety and excellence to deliver compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.

III. DEPARTMENT OBJECTIVES

A. To support and model the mission, vision, goals, strategic plan and ORGANIZATION PLAN FOR PROVISION OF CARE AND SERVICE of SVH.

B. To assess and articulate the organization's health particularly related to organizational culture, with the vision for the future as a highly reliable organization.

C. To oversee the actual "living" of the mission and its services in the hospital as well as in the community.

D. To direct the development of policies and programs regarding mission, vision, goal implementation, strategic planning, and evaluation.

E. To partner with leaders and staff to identify skill development needs associated with meeting the mission, vision, goals and strategic plan.

F. To support development of annual goals and objectives as they relate to meeting the mission, vision, goals and strategic plan.

G. To participate in marketing and public relation activities as appropriate to communicate and integrate mission and values.

H. To provide staff and leader orientation to assure SVH provides care and services in a safe and efficient manner.

IV. POPULATION SERVED

Clinical: N/A

Non-Clinical:

The services and impact of Administration are provided and delivered to all areas of SVH (governance and leadership, operations, patient experience, clinicians, medical staff and employees and volunteers), as well as to the community.

V. ORGANIZATION OF THE DEPARTMENT

Administration is responsible to create and maintain an overall organizational structure that outlines the departments / divisions / care units and service areas and the reporting structure of SVH. This Scope of Service for Administration under SVH applies to the licensed hospital services.

ORG CHART

A. Hours of Operation:
Administration provides services Monday through Friday from 8:00 am – 5:00 pm during normal business days. An Administrator is available on call after hours.

B. Location of department:
Administrative Office Building (AOB) at 450 E. Romie Lane, Leaders of SVH have offices located throughout the organization.

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

A. Healthcare District Electorate

Eligible voters within the boundaries of the Salinas Valley Memorial Healthcare District voted to form the District in 1947 pursuant to California Government Code Sections 32000 and following known as The Local Health Care District Act. The eligible voters elect the Board of Directors of the Healthcare District who serves staggered four year terms.

B. Salinas Valley Memorial Healthcare Board Of Directors

The authority and responsibility to govern SVH is vested in elected Board of Directors each of whom is a registered voter residing in the district and whose term is four years. Their authority and responsibilities are set forth in the California Local Healthcare District Act and in the District Bylaws. They are responsible for the governance of SVH including the Salinas Valley Health Medical Center, and the Medical Staff of the Hospital. The Board's governer's responsibilities include overseeing delivery of safe, quality patient care and implementation of all policies and procedures. The Board of Directors delegates to the President/Chief Executive Officer the responsibility for day-to-day Administration of the Healthcare System.

C. Position Appointments

Various appointees and/or officers are designated as functional appointees pursuant to federal, state and internal requirements.

D. The Administration carries appropriate authorities in the organization so as to exert influence regarding the fulfillment of the ORGANIZATION PLAN FOR PROVISION OF CARE AND SERVICE , strategic plan and mission and goals and ensures these are operational, integrated, and effective throughout the organization.

E. Administration oversees day-to-day management of SVH, subject to Board policy. There is sufficient staff, equipment and supplies maintained to adequately perform the Mission and Vision that are offered at SVH. As public district employees the Executive Leadership Group must ensure that the hospital has a safe working environment for the hospital staff.

1. **President/Chief Executive Officer**
    a. All management functions associated with the operations of the Hospital are planned, organized, directed, controlled and evaluated by the President/Chief Executive Officer (CEO) or his/her designee. The CEO is directly responsible to the Board of Directors.
    b. The CEO is the highest administrative officer for SVH, in the CEO's absence, the CEO designates another Administrator to act in their stead (Refer to ABSENCE OF PRESIDENT/CHIEF EXECUTIVE OFFICER).
    c. It is the CEO/designee responsibility to attend all administrative and technical functions within SVH.
    d. All personnel under Administration are under the guidance and direction of the CEO.
    e. The Executive Assistant to the CEO also reports to the Board of Directors.
2. **Chief Financial Officer**
    a. The Chief Financial Officer is directly responsible to the President/Chief Executive Officer for the oversight of the financial responsibilities and obligations of SVH.
3. **Chief Operating Officer**
    a. The Chief Operating Officer (COO) is directly responsible to the CEO for the oversight of all clinical and non-clinical operations not assigned to another

executive.

4. **Chief Nursing Officer**
    a. The Chief Nursing Officer (CNO) is directly responsible to the CEO for nursing care to ensure the same level of care is provided to all patients.
    b. Nurses providing direct nursing care report to a nursing Director / Manager and ultimately to the CNO. RN's not employed in areas outside of the CNO's purview report to their designated Executive Leader with oversight by the CNO for the Magnet program.
5. **Chief Clinical Officer**
    a. The Chief Medical Officer (CCO) is directly responsible to the CEO to serve as a liaison between Hospital Administration and the SVH Medical Staff and medical staff committees. The CCO also has oversight for the quality and patient safety programs as well as Disease Specific Care for SVH. The CCO is also the CEO for the Salinas Valley Health Medical Clinics.
    b. Physician leaders holding a service line directorship contract reports directly to the Chief Clinical Officer for the purposes of their directorship.
6. **Chief Administrative Officer**
    a. The Chief Administrative Officer (CAO) is directly responsible to the CEO for the oversight of Perioperative services, Information Technology, Informatics and Transitional Care
7. **Chief Strategic Communications Officer**
    a. The Chief Strategic Communications Officer is directly responsible to the CEO for internal and external communication strategy and execution, Volunteer programs and Employee Wellness.
8. **Chief Human Resources Officer**
    a. The Chief Human Resources Officer is directly responsible to the President/Chief Executive CEO for Talent Acquisition and retention and Employee Health Services.
9. **Medical Staff**
    a. The Medical Staff is responsible to the SVH Board of Directors for the provision of quality patient care in accordance with the Medical Staff Bylaws and Rules and Regulations. The Medical Staff is composed of standing committees as well as other sub and ad hoc committees, which form the oversight functions of those credentialed by the Medical Staff.
    b. There is a Joint Conference Committee of the Board of Directors which is composed of Medical Staff, members of the Board of Directors and Administrative Staff for the purpose of discussing issues of mutual interest.
10. **Directors and Managers**

a. The SVH Directors and Manager are directly responsible to their respective Executive Leader for their assigned unit / division or services for the operations of their respective area in accordance with the Scope of Care and Service.

VII. REQUIREMENTS FOR STAFF

All individuals who provide the services under Administration have the appropriate training and competence to perform their individual functions.

A. Competency

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

During the year in-services are conducted routinely. The in-services are part of the 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 as applicable. Additional teleconferences, video conferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

B. 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 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.

C. Continuing Education

Continuing education is required to maintain licensure / certifications as required by a specific job description.

VIII. STAFFING PLAN

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

General Staffing Plan:

A. During normal business hours, at least one Administrator should always be on site. However, if no Administrator is on site during normal business hours, the Administrative Supervisor is the designee.

B. During off-hours, there is an Administrator on call (Refer to ADMINISTRATOR ON-CALL).

C. If an Administrator is unable to perform his/her duties for an extended period of time, his/her duties will be divided among the remaining Administrators as defined by the CEO. During extended leaves of absence, contracted clerical support may be utilized.

In the event of a severe emergency, the minimum amount of staff required to safely operate the Administrative Offices is one Administrator and one clerical support.

IX. EVIDENCED BASED STANDARDS

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

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

- In a manner that maximizes the efficient use of financial and human resources.

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

X. CONTRACTED SERVICES

Contracts services under Administrative Services are located in the Contract Management Software system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Administration supports the SVH'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 SVH's Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, Administration may develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Approval Signatures

Step Description	Approver	Date
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2024
Policy Owner	Clement Miller: Chief Operating Officer	09/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18121397**

Origination	06/2022
Last Approved	N/A
Next Review	1 year after approval
Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep
Area	Scopes Of Service

Scope of Service: Cardiovascular Diagnostic and Treatment Units

I. SCOPE OF SERVICE

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

The purpose of the Cardiovascular Diagnostic and Treatment Units is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The goal of the Cardiovascular Diagnostic and Treatment Units 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 Cardiovascular Diagnostic and Treatment units develop goals to direct short term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of the Cardiovascular Diagnostic and Treatment Units are:

A. To provide monitoring and care of patients requiring cardiac diagnostic modalities to obtain information regarding cardiac function and status.

B. To provide comprehensive angiography, structural heart and electrophysiology services to inpatients and outpatients, including emergent and scheduled cases for diagnostic and therapeutic purposes.

C. To improve physiological status and optimize risk factor status; to improve functional independence of patients; to facilitate return to gainful employment or active retirement; to reduce

the deconditioning effects of inactivity/sedentary lifestyle; to reduce risk factors for disease progression and future cardiac events; to improve management of other chronic disease states.

D. To perform cardiac diagnostic modalities to include, Echocardiograms, Pharmacological Stress Echocardiograms, Exercise Stress Echocardiograms, Vascular ultrasound, and Nuclear Myocardial Perfusion Stress testing (Exercise and Pharmacologic) adult outpatients in order to obtain information regarding their cardiac function and status.

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 the Cardiovascular Diagnostic and Treatment Units function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical:

The Cardiology Department provides care for infant, pediatric, adolescent, adult and geriatric patients. The Department provides care to patients with primary diagnoses including, but not limited to: Chest pain, Dyspnea, murmur Acute Myocardial Infarction, Pre-Post Open Heart Surgery, Congestive Heart Failure, Acute/ Chronic Renal Failure, Acute Respiratory Failures, Anoxic Brain Injury, Septicemia, Pre-Post Abdominal Surgery, Pre-Post Thoracic Surgery and Multiple Trauma.

The Cardiac Catheterization Laboratory provides care for adult and geriatric patients only. The Department provides care to patients with primary diagnoses including, but not limited to Coronary Artery Disease, Acute Myocardial Infarction, Pre-Post Open Heart Surgery, Congestive Heart Failure, valvular disease.

The Cardiac Rehabilitation Unit provides care for patients 18 years of age through geriatric. The Department provides care to patients with primary diagnoses including, but not limited to:

1. Myocardial Infarction* (w/in the preceding 12 months for Medicare)
2. Coronary artery bypass surgery*
3. Stable angina pectoris *
4. Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting*
5. Valve replacement or repair surgery*

6. Heart or heart-lung transplant*
7. Heart Failure*
8. Peripheral Arterial Disease*

*Denotes Medicare eligible diagnosis

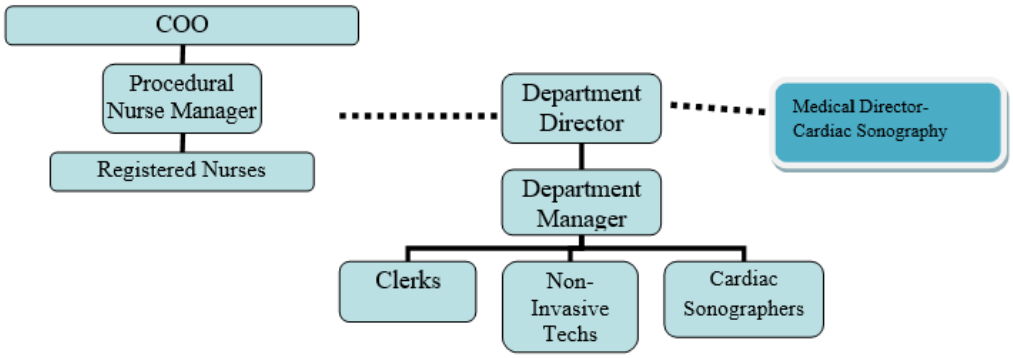
The Cardiovascular Diagnostic Outpatient Center provides care for adults 18 years and older.

The Sleep Center provides outpatient EKGs for patient 18 years and older during the hours of 0700 - 1500, Monday through Friday. Pediatric patients may be done on a case be case basis.

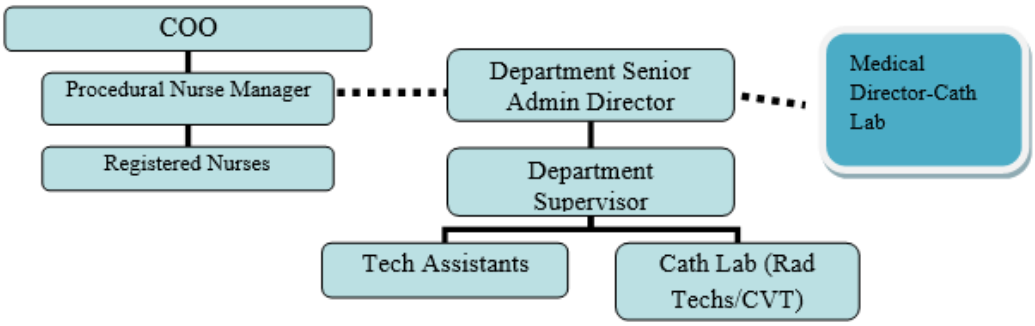
V. ORGANIZATION OF THE DEPARTMENT (include organizational chart)

A. Hours of Operation:

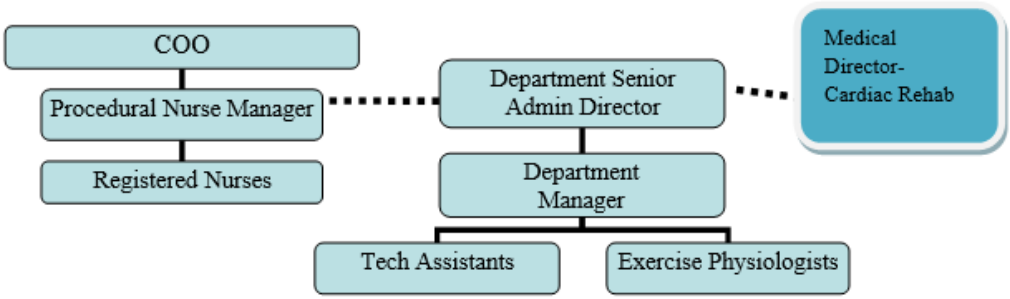
- The Cardiology department provides services seven days a week, twenty-four hours a day.



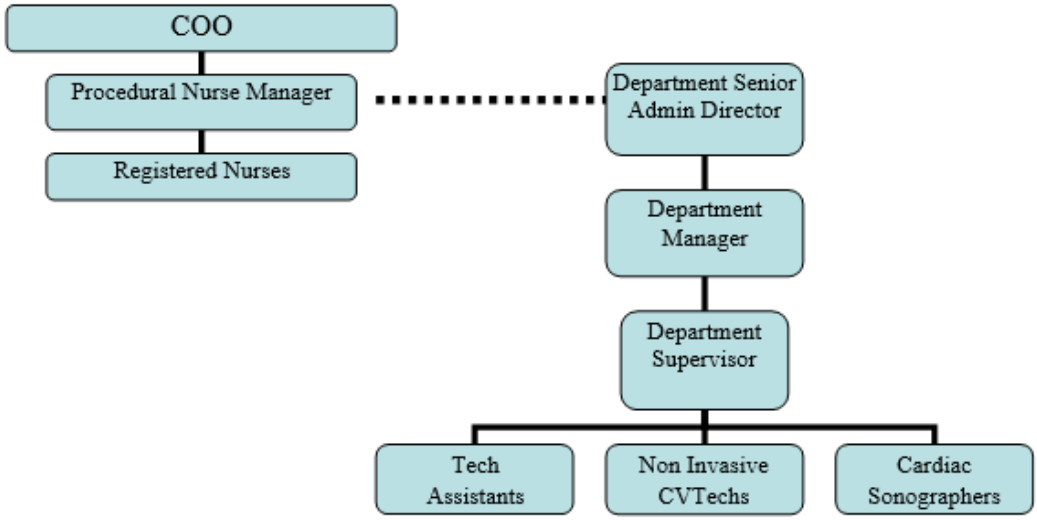
- The Cardiac Cath Lab provides services seven days a week, twenty-four hours a day.



- Cardiac Rehabilitation provides services five (5) days a week 7:30 a.m. – 4:00 p.m.



- Cardiac Diagnostic Outpatient Center hours of operation are Monday through Friday 8 AM to 4:30 PM.



B. Location of departments:
    - The Cardiology Inpatient Unit is located inside the hospital.
    - The Cardiac Cath Lab is located on the first floor of the hospital.
    - Cardiac Rehabilitation is located within the Cardiac Wellness Center in the Nathan J. Olivas Building.
    - Cardiovascular Diagnostic Outpatient Center, located at 230 San Jose St, Suite B. A satellite location is also at the Ryan Ranch Center for Advanced Diagnostic Imaging (CADI), 5 Lower Ragsdale.
C. Admission, Discharge, Transfer Criteria (if applicable)
D. Major Services / Modalities of care include:

    The Cardiology Department provides both portable, off-site (at Cardiac Rehab or Sleep Center) and department-based diagnostic modalities which include ECG's, Signal-Averaged ECG's, Exercise/ Pharmacologic Stress Tests (Thallium, Routine treadmill, Dobutamine, Lexiscan and Adenosine), Holter Monitors (Application, Scanning, and Full-Disclosure Reports), Echocardiography Studies.

    Cardiac Cath Lab diagnostic and interventional procedures include:

1. Right/left Coronary Angiography
2. Percutaneous Transluminal Coronary Angioplasty and Atherectomies/ Rotoblation
3. Intra-coronary Ultrasound
4. Temporary Pacemaker Insertions
5. Intra-aortic Balloon Pump Insertions
6. Myocardial Biopsies
7. Stent Insertions
8. Electrophysiology Studies
9. Implantable Cardioverter Defibrillator (ICD) Implants
10. Permanent Pacemaker Implants
11. Peripheral Angiograms, including Carotid Angiograms
12. Peripheral Interventions, including Carotid Stent Implantation
13. Ablations (Radio Frequency and Cryo)
14. Endovascular Aortic Stent Grafting, EVAR (Endovascular Aortic Repair)
15. Left Ventricular Assist device (Impella)
16. Transcatheter Aortic Valve Replacement (TAVR)
17. Left Atrial Appendage Occluder (LAAO) device placement
18. Transcatheter Edge to Edge Repair of the Mitral Valve (TEER)

    Cardiac Rehabilitation procedures include: EKG, Blood glucose, Blood Pressure, pulse oximetry, monitored exercise.

    The Cardiovascular Diagnostic Outpatient Center procedures performed include but not limited to: Echocardiograms, Vascular ultrasound, and Cardiac stress tests (Pharmacologic, exercise, nuclear Lexiscan and stress Echo).

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

The Cardiology Department care is delivered by a multidisciplinary team comprised of medical staff, including Medical Director of Cardiac Sonography, Cardiac Sonographers, Non-Invasive Cardiovascular techs, Registered Nurses and ancillary support according to the needs of the patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

The Associate Chief Operating Officer, Chief Operating Officer and Manager assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

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

duties of the Manager in his/her absence.

Cardiac Cath Lab care is delivered by a multidisciplinary team comprised of medical staff, including Medical Director of Cath Lab, registered nurses, radiology technologists, cardiovascular technologists and ancillary support according to the needs of the patients. A registered nurse (RN) performs an admission assessment on patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

The Associate Chief Operating Officer, Nursing Manager and Chief Operating Officer assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

The Associate Chief Operating Officer is directly responsible to the Chief Operating Officer. It is the Sr. Administrative 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 Sr. Administrative Director; Nurses are under the guidance of the Chief Operating Officer. In the Associate Chief Operating Officer's absence, the position is filled by the Cardiology Manager and or Chief Operating Officer or their designee. It is his/her responsibility to carry out the duties of the Associate Chief Operating Officer in his/her absence.

Cardiac Rehabilitation care is delivered by a multidisciplinary team comprised of the Medical Director, Department Director, Nursing Staff, Exercise Physiology Staff, Registered Dietician and support staff according to the needs of the patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

The Associate Chief Operating Officer and Cardiology Manager assume twenty-four (24) hour responsibility for care provided on the Department.

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

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

The Chief Operating Officer and Clinical Nurse Manager assume twenty-four (24) hour responsibility for nursing care provided within each department. It is the Manager's duty to attend all administrative and technical functions within the department. All Nursing personnel within the department are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Chief Operating Officer or Nursing Leader on call or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

The Associate Chief Operating Officer and Cardiology Supervisor assume twenty-four hour responsibility for all non-nursing personnel and care within the department. The Asscociate Chief Operating Officer is directly responsible to the Chief Operating Officer. It is the Cardiology Supervisor's duty to attend all administrative and technical functions within the department. All Non-nursing personnel within the department are under the guidance and direction of the Cardiology Supervisor. In the Director's absence, the position is filled by the

Cardiology Supervisor or designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF (applicable to department)

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

A. Licensure / Certifications:

The basic requirements for ***Registered Nurses*** in the Cardiology Department include:

1. Current state licensure
2. Current BLS (Basic Life Support)
3. Current ACLS (Advanced Cardiac Life Support)
4. CCRN Certification preferred (Critical Care Registered Nurse)
5. TNCC preferred (Trauma Nursing Core Course)
6. Completion of an approved Critical Care Course or equivalent experience
7. Completion of competency-based orientation
8. Completion of annual competency

The basic requirements for ***Cardiac Sonographers*** in the Cardiology Department include:

1. Current registry (RDCS or RCS) (Registered Diagnostic Cardiac Sonographer or Registered Cardiac Sonographer)
2. Current BLS (Basic Life Support)

The basic requirements for ***Non-Invasive Cardiovascular*** *Tech* in the Cardiology Department include:

1. Certificate of training or EKG course
2. Current BLS (Basic Life Support)

The basic requirements for ***Registered Nurses*** in the Cardiac Cath Lab include:

1. Current state licensure
2. Current BLS (Basic Life Support)
3. Current ACLS (Advanced Cardiac Life Support)
4. Completion of competency based orientation
5. Completion of annual competencies

The basic requirements for ***Certified Radiology Technicians (CRT)*** in the Cardiac Cath Lab include:

1. Current state licensure (including fluoroscopy licensure)
2. Current BLS (Basic Life Support)
3. Completion of competency based orientation
4. Completion of annual competencies

The basic requirements for ***Cardiovascular Technicians (CVT)*** in the Cardiac Cath Lab include:

1. Program certification
2. Current BLS
3. Completion of competencies

The basic requirements for ***Registered Nurses*** in the Cardiac Rehabilitation Unit include:

1. Current state licensure
2. Current ACLS (Advanced Cardiac Life Support)
3. Current BLS (Basic Life Support)
4. CCRP preferred (Certified Cardiac Rehab Professional)
5. Completion of competency based orientation
6. Completion of annual competencies

The basic requirements for the ***Clinical Exercise Physiologist*** in the Cardiac Rehabilitation Unit include:

1. Current ACLS preferred (Advanced Cardiac Life Support)
2. RCEP preferred (Registered Clinical Exercise Physiologist)
3. CEP preferred (Clinical Exercise Physiologist)
4. Current BLS (Basic Life Support)
5. Completion of competency based orientation
6. Completion of annual competencies

The basic requirements for the ***Registered Dietitian*** in the Cardiac Rehabilitation Unit include:

1. Registered Dietitian certification
2. Completion of competency based orientation
3. Completion of annual competencies

The basic requirements for ***Registered Nurses*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current state licensure
2. Current BLS (Basic Life Support)
3. Current ACLS (Advanced Cardiac Life Support)

4. CCRN Certification preferred (Critical Care Registered Nurse)
5. Completion of an approved Critical care Course or equivalent experience
6. Completion of competency-based orientation
7. Completion of annual education

The basic requirements for ***Cardiovascular Sonographers*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current RDCS and or RVT (Registered Diagnostic Cardiac Sonographer)
2. Current BLS (Basic Life Support)
3. Completion of competency-based orientation
4. Completion of annual competency

The basic requirements for ***Tech Assistants*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current BLS (Basic Life Support)
2. Completion of competency-based orientation
3. Completion of annual competency
4. Completion of Tech assistant competency

The basic requirements for ***Non-Invasive Cardiovascular Techs*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current BLS (Basic Life Support)
2. Completion of competency-based orientation
3. Completion of annual competency

The basic requirements for ***Nuclear Medicine Technologists*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current state licensure (CTNM) (Certified Technologist Nuclear Medicine)
2. Current national licensure (ARRT (N)), and/ or (NMTCB) (American Registry of Radiologic Technologists and/or (Nuclear Medicine Technology Certification Board)
3. Completion of competency based orientation
4. Completion of annual competencies
5. Current BLS (Basic Life Support)

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 units are 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, this department will meet staffing requirements by utilizing the on-call system, registry and per diem personnel.*

General Staffing Plan:

Staffing is based on patient volume and acuity.

The Cardiology Department assignments are made by the Manager based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available.

The Cardiac Cath lab assignments are made by the Sr. Administrative Director and Cath Lab Supervisor based on scheduled procedures and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. The RN to patient ratio is one RN per patient. On call staff is composed of a team of three, including at least one (1) RN and two (2) additional staff which may be a CRT or CVT.

Cardiac Rehabilitation unit assignments are made by the Cardiology Manager based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. A minimum of 2 trained staff members will be present in the gym during exercise therapy and one of the staff present must be an RN with ACLS certification.

Cardiovascular Diagnostic Outpatient Center assignments are made by the department Director and/or Supervisor based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Attachments

- Associate Chief Operating Officer
- Medical Director- Cardiac Rehab
- Medical Director- Cardiac Sonography
- Medical Director-Cath Lab

Approval Signatures

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

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep	05/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17845280**

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

Scope of Service: Department of Pharmacy

I. SCOPE OF SERVICE

The Department of Pharmacy's mission is to support Salinas Valley Health by elevating areas of pharmacy practice for today and for tomorrow. Our vision is to redefine pharmacy's role in the patient's journey to health and wellness.

II. GOALS

In addition to the overall SVHMC goals and objectives, the Pharmacy develops goals to direct short term projects and address opportunities evolving out of quality management initiatives. These goals shall have input from interdisciplinary staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of the Department of Pharmacy are:

A. To provide comprehensive pharmaceutical care to all patients through evidence-based drug therapy that achieves definite outcomes and improves patients' quality of life through the integration of clinical practice and effective medication therapy management.

B. To deliver clinical pharmacy services to patients and staff that support the provision of total pharmaceutical care through active participation in the healthcare team.

C. To ensure efficient procurement, distribution and control of all pharmaceuticals through implementation of effective inventory management systems and controls.

D. To maintain sufficient personnel, equipment and supplies to adequately perform pharmacy services at Salinas Valley Health Medical Center, meeting all regulatory requirements and quality standards.

E. To provide ongoing educational opportunities to pharmacists and other health care practitioners that enhance clinical knowledge and practical skills, thereby improving the quality of patient care and health outcomes.

F. To disseminate accurate, comprehensive, and timely drug information to health care

practitioners that optimizes the medication use process and promotes cost-effective patient outcomes.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives through:
    1. Implementation of organizational strategic initiatives
    2. Alignment with hospital-wide quality goals
    3. Support of quality improvement opportunities to elevate pharmacy practice
    4. Regular assessment of departmental needs for staffing and resources

B. To deliver safe, effective, and appropriate care in a cost-effective manner through:
    1. Evidence-based clinical practices
    2. Standardized workflows
    3. Resource optimization
    4. Quality metrics monitoring

C. To maintain appropriate allocation of human and material resources through:
    1. Regular workforce planning assessments
    2. Systematic resource utilization review
    3. Implementation of efficient staffing models
    4. Ongoing evaluation of departmental needs

D. To provide high-level medication management with a focus on collaborative, multi-disciplinary approaches that:
    1. Minimize adverse effects of disease processes
    2. Optimize therapeutic outcomes
    3. Support evidence-based interventions
    4. Enhance patient education and engagement
    5. Achieve desired clinical outcomes

E. To collect and analyze data regarding:
    1. Department operations
    2. Staff performance metrics
    3. Patient care outcomes
    4. Medication use patterns
    5. Quality improvement initiatives
    6. Clinical intervention impacts

F. To collaborate effectively with nursing staff to:

1. Support patient-centered medication management
2. Enhance interdisciplinary communication
3. Optimize medication administration processes
4. Promote safe medication practices
5. Facilitate care coordination

G. To implement and evaluate evidence-based practice standards in pharmaceutical services through:
    1. Regular review of current practices
    2. Implementation of best practice guidelines
    3. Continuous quality assessment
    4. Performance improvement initiatives
    5. Outcome measurement

H. To provide comprehensive staff development through:
    1. Structured orientation programs
    2. Ongoing competency assessment
    3. Professional development opportunities
    4. Clinical skills enhancement
    5. Leadership development
    6. Performance evaluation and feedback

I. To maintain compliance with all applicable:
    1. Regulatory requirements
    2. Professional standards
    3. Hospital policies
    4. Safety protocols
    5. Quality metrics

IV. POPULATION SERVED

The Department of Pharmacy provides care for all patients utilizing SVHMC services.

V. ORGANIZATION OF THE DEPARTMENT

A. Hours of Operations: The Department of Pharmacy provides services 24 hours per day, 365 days per year.

B. Organizational Structure and Roles:
    1. Leadership:
        a. Director of Pharmacy

i. Reports directly to Chief Operating Officer
ii. Oversees all aspects of pharmacy operations
iii. Manages administrative and technical functions

b. Pharmacy Operations Manager
    i. Clinical Services oversight
        a. Supervises clinical pharmacist performance
        b. Ensures staff development and competency
        c. Conducts clinical pharmacist evaluations
    ii. Operations oversight
        a. Supervises pharmacy technicians
        b. Maintains inventory management systems
        c. Oversees controlled substance records
        d. Conducts technician performance evaluations

c. Manager, Outpatient Pharmacy Services
    i. Oversees the outpatient pharmacy services and associated staff
    ii. Manages the Transitions of Care program, including the Medication Reconciliation program

d. 340B Program Manager
    i. Oversees 340B program and associated staff

e. Clinical Coordinator
    i. Coordinates clinical pharmacy programs
    ii. Develops and maintains clinical protocols
    iii. Leads clinical education initiatives
    iv. Supports research activities
    v. Facilitates interdepartmental collaboration

f. Medication Safety Officer
    i. Leads medication safety program
    ii. Coordinates adverse event reporting
    iii. Develops safety initiatives
    iv. Conducts medication use evaluations
    v. Manages safety technology systems
    vi. Provides safety education
    vii. Participates in root cause analyses

2. Clinical Pharmacists
    a. Medication therapy review and monitoring
    b. Order entry and verification
    c. Pharmacokinetic dosing
    d. Protocol-based medication management
    e. Patient counseling
    f. Drug information provision
    g. Anticoagulation therapy management
    h. Medication reconciliation
3. Support Staff
    a. Pharmacy Technicians
        i. Medication distribution activities
        ii. Inventory management
        iii. Compounding and preparation
        iv. Medication delivery
        v. Stock management
        vi. Record keeping
4. Specialized Roles
    a. Transitions of Care Coordinator: Transitions of Care program support
    b. Informatics Pharmacist Specialist: IT support
    c. Pharmacy Buyer: Procurement and inventory management
    d. Pharmacy Operations Coordinator, Inpatient and Outpatient: Operations support
    e. Technology Coordinator: Technology and automation support
    f. Charge Master: Dictionary and system maintenance
    g. Billing Clerk: Financial processing and pricing
    h. Department Coordinator: Departmental support services

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

A. **Clinical Services**

1. Clinical pharmacists establish appropriate relationships with all patients in their service areas, ensuring regular monitoring and optimization of medication therapy. This includes preventing adverse drug events, resolving drug-related problems, and maintaining continuity of care through patient education and engagement.

2. The department maintains an unwavering commitment to non-discrimination in the delivery of care. Services are provided without regard to age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, gender identity or expression, insurance status, national origin, or marital status.
3. Pharmacist skill enhancement is prioritized through the development of clinical expertise in specialized areas and implementation of evidence-based protocols. The department supports continuous professional growth through:
    a. Utilization of risk stratification tools
    b. Maintenance of current therapeutic knowledge
    c. Participation in continuing education
    d. Engagement in professional development activities

B. **Non-Clinical Services**

1. The Department shall maintain and regularly upgrade technological resources including:
    a. Computer hardware systems
    b. Pharmacy management software
    c. Clinical decision support tools
    d. Drug information databases
    e. Automated dispensing systems
    f. Inventory management systems
    g. Electronic health record interfaces
2. The Department shall systematically review and revise drug use policies to:
    a. Ensure compliance with current standards
    b. Optimize medication use processes
    c. Improve patient safety
    d. Support quality improvement initiatives
    e. Meet regulatory requirements
3. The Department shall maintain comprehensive drug information resources, including:
    a. Current reference texts
    b. Disease state management guidelines
    c. Clinical practice standards
    d. Drug monographs
    e. Evidence-based protocols
    f. Regulatory guidelines

4. The Department shall develop and maintain a searchable Intranet Hospital Formulary.
5. The Department shall support and promote electronic prescriber order entry through:
    a. System optimization
    b. User training
    c. Technical support
    d. Workflow integration
    e. Quality assurance monitoring

VII. REQUIREMENTS FOR STAFF

All individuals who provide pharmacy services shall be licensed or registered in accordance with applicable state law and regulation and shall maintain appropriate training and competence as defined herein.

A. Licensure and Certification Requirements
    1. The basic requirements for Pharmacists shall include current California State Board of Pharmacy licensure, Basic Life Support certification, and Advanced Cardiac Life Support certification where required by practice area. Additional specialty certifications may be required based on specific practice responsibilities.
    2. Pharmacy Technicians shall maintain current California State Board of Pharmacy registration and national certification, in compliance with California State Board of Pharmacy requirements. Basic Life Support certification is required for all pharmacy technicians.

B. Competency Requirements
    1. The Department shall establish and maintain comprehensive competency requirements for all pharmacy personnel. These requirements shall include demonstrated proficiency in aseptic technique, USP standards, medication safety practices, and department-specific technology systems.
    2. Clinical Pharmacists shall demonstrate advanced competency in pharmacotherapy, clinical decision making, patient assessment, and research methodology. The Department shall assess and document these competencies through direct observation, written examination, and peer review processes.
    3. Pharmacy Technicians shall demonstrate competency in sterile compounding, inventory management, medication distribution, and regulatory compliance. These competencies shall be assessed through structured evaluation processes and documented accordingly.

C. Assessment Process and Documentation
    1. The Department shall conduct routine competence assessments for all staff members. These assessments shall be performed in concert with the unit's scope of practice and documented through annual performance appraisals. Assessment methods shall include written evaluation, demonstrated proficiency, observed

performance, and verbal assessment as appropriate for specific competencies.

2. The required competency elements for each staff member shall be determined by their work areas and duties. All staff members shall complete the organization's defined online education modules annually.

D. Educational Requirements
    1. The Department shall identify educational needs through multiple assessment mechanisms, including:
    2. The Department shall conduct regular in-service training throughout the year as part of ongoing efforts to enhance performance and improve staff competencies. These educational activities shall align with the organization's strategic planning initiatives and Quality Assessment Performance Improvement (QAPI) goals.
    3. Educational priorities shall be determined based on:
    4. Strategic planning directives and organizational objectives
    5. Quality assessment and performance improvement requirements
    6. Regulatory compliance needs
    7. Practice advancement opportunities
    8. Technology implementation requirements
    9. Changes in standards of practice

E. Continuing Education
    1. All licensed and certified staff shall maintain continuing education requirements in accordance with their respective licensing and certification bodies. The Department shall support continuing education through:
        a. Structured educational programs aligned with California Board of Pharmacy requirements
        b. Regular assessment of educational effectiveness
        c. Documentation of completed activities

VIII. STAFFING PLAN

A. The Department shall maintain staffing levels appropriate to service patient care needs through a sufficient number of professional, technical, and clerical personnel. This staffing model shall ensure coverage of established operational hours while maintaining safe practice standards and meeting all regulatory requirements.

B. The Department shall determine staffing based on patient volume, procedure count, and operational activities.
    1. A comprehensive contingency staffing plan has been established to address circumstances including staff illness, planned time off, educational leave, and fluctuations in patient acuity and workload.
    2. When standard staffing requirements cannot be met, the Department shall authorize overtime to maintain appropriate coverage.

3. A licensed pharmacist shall be present in the pharmacy at all times during operational hours, in accordance with California State Board of Pharmacy requirements.
4. The Department shall maintain pharmacist-to-technician ratios in compliance with California State Board of Pharmacy regulations.
5. In the event of emergency situations, minimum staffing requirements shall be determined based on census and acuity levels while maintaining required supervision ratios.

IX. EVIDENCE BASED STANDARDS

A. The Department shall provide pharmaceutical services in accordance with evidence-based policies and practice standards. All procedures, treatments, and interventions shall be performed according to established protocols that ensure patient safety and optimal outcomes.

B. The Department shall regularly evaluate the efficacy and appropriateness of services through patient assessments, reassessments, and outcome measurements.

C. The Department shall implement and maintain systems and services aligned with SVHMC's mission and vision, ensuring patient care delivery that:

1. Demonstrates compassion, respect, and dignity without bias
2. Addresses individualized patient needs
3. Provides timely service delivery
4. Facilitates interdisciplinary collaboration
5. Optimizes resource utilization

D. All administrative and clinical practice standards are maintained on the internal intranet site for staff reference.

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

A. The Department maintains a comprehensive quality improvement program aligned with SVHMC's commitment to continuous performance improvement.This program incorporates:

1. Quality Management Structure
    a. The Department shall implement quality improvement activities through collaborative, interdisciplinary teams including representatives from relevant hospital departments. All staff members shall participate in ongoing improvement initiatives, including department-specific quality

activities, interdisciplinary performance improvement, and quality control measures.

2. Performance Improvement Processes
    a. The Department shall:
        i. Support the Medication Safety Committee in developing and implementing safety initiatives
        ii. Maintain a quality management program that evaluates medication error trends and identifies process improvement opportunities
        iii. Implement medication use process improvements that enhance patient safety
        iv. Monitor departmental performance indicators
        v. Evaluate patient care services
3. Regulatory Compliance and Program Management
    a. The Department shall:
        i. Maintain compliance with The Joint Commission Medication Management Standards
        ii. Oversee the Medication Reconciliation program
        iii. Manage the automated medication dispensing system
        iv. Direct the Antimicrobial Stewardship Program
    b. The Department shall develop and monitor performance measures through the Quality dashboard system.

Attachments

Pharmacy Org Chart update - June 2025.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	06/2025
P&T	Kiri Golleher: Pharmacy Clinical Coordinator	06/2025
P&T	Genevieve delos Santos: Director Pharmacy	06/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	06/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18269280**

Origination	06/2022	Owner	Philip Katzenberger: Director HIM/ Privacy Officer
Last Approved	N/A	Area	Health Information Management
Next Review	3 years after approval		

Uses and Disclosures of Protected Health Information (General)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To define the uses and disclosures of protected health information (PHI). To comply with state and federal regulations when disclosing PHI.

B. To protect the privacy of individual protected health information (PHI). The amount of information to be disclosed in response to a request for information is limited to the minimum necessary to perform a specific type of work or complete a function.

III. DEFINITIONS

A. PHI- Protected Health Information is individually identifiable health information that is transmitted or maintained in any media.

B. Minimum Necessary – When a provider requests, uses, or discloses PHI from another provider, it must make reasonable efforts to limit the PHI to the minimum necessary to accomplish the task.

C. Breach – The unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of PHI in a manner not permitted by the Privacy Rule.

D. Individual- The person who is the subject of PHI.

IV. GENERAL INFORMATION

A. Access, use, and disclosure of PHI is to be based on the "need to know" to perform ones job duties. Access use and disclosure of PHI without the "need to know" is a HIPAA privacy breach.

V. PROCEDURE

A. PHI may be accessed, used or disclosed for purposes of treatment, payment, or healthcare operations. Examples are:

1. Salinas Valley Health Medical Center (SVHMC) staff may access PHI to acquire information or document information for patient care and do ones job tasks.
2. Physician offices or other care providers may access PHI or request the release of PHI for continuation of patient care.
3. Insurance company may request PHI for approval of payment of claim.
4. Designated agencies may request PHI for rating of SVHMC quality initiatives.

B. PHI may **not** be accessed, used and disclosed for any purpose other than treatment, payment, or healthcare operations. Examples are:

1. SVHMC staff may not access PHI to acquire information that is not needed to provide patient care and/or do ones job tasks.
2. SVHMC staff are not to access a relative or friends medical record upon their request. Patient is to sign an Authorization for Release of PHI to give you access to the PHI and you must request the information through the HIM department or designated Release of Information Staff. Do not look in the computer system for the PHI.
3. Physician offices or other care providers may not access PHI or request the release of PHI for patients not currently under their care or part of the continuation of patient care.
4. Staff may not access their own medical information. Request copies of medical information through HIM or designated Release of Information staff.

C. PHI may be accessed, used, and disclosed for other reasons. Examples are:

1. Upon request of the patient.
2. If the request originates with a healthcare provider who has an indirect relationship with the individual such as a laboratory or pharmacy.
3. If the request is made to provide care to an inmate of a correctional facility.
4. If the request is made by a representative of an accrediting body.
5. If the request is made for the purpose of detecting healthcare fraud or abuse.
6. If the request is made for the purpose of detecting healthcare compliance.

D. Any request for PHI is to be limited to only that information needed to complete the task. This is called Minimum Necessary. Check for the needed information before granting a request.

E. Faxing PHI. Check the fax number for accuracy before using it. Do not fax to a wrong number. Check the documents for correct patient identification. Check the type of documents are correct. Do not fax the wrong documents.

F. Mailing PHI. Check the address for accuracy before using it. Do not mail documents to the wrong address. Check the documents for correct identification. Do not mail the wrong documents.

G. If the patient or patient's physician requests that the patient receive specific PHI such as a test result, nursing staff may provide the patient a copy. SVHMC Lab may provide test results to patients who frequent the Lab multiple times a month due to a serious medical condition. Any other type of request for release of PHI is to be completed through Health Information Management or designated Release of Information staff. An Authorization for Disclosure of Release of Medical Information form is to be completed by the patient or legal representative.

H. Access to PHI of friends or relatives as part of the job function is not to be performed if it is possible for a co-worker to perform the task. Request a co-worker handle the job task.

I. Each written request for PHI by parties not directly involved in the provision of patient care is to be completed by Health Information Management (HIM) or designated Release of Information staff. Documentation of the request and release of the PHI is to be logged.

J. Documentation:

1. Authorization to disclose Protected Health Information (PHI)
2. Medical record

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. 45 CFR.§§164.502, 164.514(d)

Approval Signatures

Step Description	Approver	Date
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2025
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	05/2025

Standards

No standards are associated with this document

To: Board of Directors
Salinas Valley Health

From: Robert Andersen, Human Resources Manager

CC: Allen Radner, MD, President/Chief Executive Officer
Clement Miller, Chief Operating Officer

Date: June 26, 2025

Re: Request for Ratification of Collective Bargaining Agreement between Salinas Valley Memorial Health Care District, operating as Salinas Valley Health Medical Center (SVHMC) and International Union of Operating Engineers, Stationary Engineers Local No. 39, AFL-CIO.

SVHMC and L39 have tentatively agreed on the following substantive financial elements to the existing collective bargaining agreement:

Term:	July 1, 2025 – June 30, 2029
Wages:	• 5.00% increase effective 7/7/2025 • 4.25% increase effective 7/6/2026 • 4.15% increase effective 7/5/2027 • 4.00% increase effective 7/3/2028
Pension Plan:	• 7% increase effective 7/1/2025 • 7% increase effective 7/1/2026 • 7% increase effective 7/1/2027 • 7% increase effective 7/1/2028
Training Fund:	• $40 increase effective 1/1/2026 • $40 increase effective 1/1/2027 • $40 increase effective 1/1/2028 • $40 increase effective 1/1/2029
Health and Welfare	• Increased health insurance contributions by $221 effective 7/1/2025

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

QUALITY AND EFFICIENT

PRACTICES COMMITTEE

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

(CATHERINE CARSON)

PERSONNEL, PENSION & INVESTMENT COMMITTEE

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

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

(CATHERINE CARSON)

Salinas Valley Memorial Healthcare System

Memorandum

Date: June 16, 2025

To: Personnel, Pension & Investment Committee

From: Augustine Lopez, CFO / Scott Cleveland, Controller

Re: **Calendar Year 2025 - Defined Benefit Pension Plan Funding**

The Hospital's consulting actuaries, WTW, have calculated the required minimum contribution to the Salinas Valley Memorial Healthcare District Employees' Pension Plan to be $12,000,717 for Calendar Year 2025 per the January 1, 2025 Actuarial Valuation Report. Management requests the Personnel, Pension & Investment Committee's consideration to **recommend Board approval to fund the required minimum contribution $12,000,717 to the Salinas Valley Memorial Healthcare District Employees' Pension Plan for Calendar Year 2025.**

It should be noted that, due to the timing of updating the annual actuarial valuation, management will use this total amount of $12,000,717 to estimate monthly funding amounts beginning in calendar year 2026 until we receive the 2026 Actuarial Valuation Report estimated to be available in June of 2026.

Thank you for your consideration.

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Natalie Friedricks, MD, (ii) Contract Terms for Dr. Friedricks' Recruitment Agreement, and (iii) Contract Terms for Dr. Friedricks' Obstetrics and Gynecology Professional Services Agreement**

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

Date: June 9, 2025

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of physicians specializing in **obstetrics and gynecology** as a recruiting priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of obstetrics and gynecology was recommended as a top priority for recruitment. Furthermore, the recent resignation of one of the long-standing obstetrics and gynecology physicians has emphasized the need to recruit and retain additional physicians to this service line.

The recommended physician, **Natalie Friedricks, MD**, received her Doctor of Medicine degree in 2020 at University of Southern California Keck School of Medicine. Dr. Friedricks completed her general surgery residency at the University of Washington. She currently serves as Chief Resident at Jersey Shore University Medical Center where she will finish her Obstetrics and Gynecology residency this June. Dr. Friedricks is robotically trained and speaks medical Spanish. Originally from Southern California, Dr. Friedricks is eager to relocate back to California, and she plans to join SVH Clinics in the fall of 2025.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, the physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Full-Time Schedule. Physician will be scheduled to provide physician services to clinic patients on a full-time basis, 48 weeks per year; one week of which can be allocated to continuing medical education (CME).
   - Hospital Call. Physician shall provide emergency department unassigned patient call coverage for the Obstetrics back-up and Gynecology back-up panels in equitable rotations with other credentialed physicians. Five days of call per month are included in productivity compensation. Call days in excess of 5 per month shall be paid at the presently established rate.
   - Base Compensation: $375,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $57.00 wRVU conversion factor.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.
   - Annual Incentive Plan in the amount of up to $8,000 shall be available to Physicians who meet the eligibility requirements of at least one thousand hours worked during the measurement period and a current PSA at time of payment in order to qualify.

- Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
  - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
  - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
  - Four weeks (20 days) of time off each calendar year.
  - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income. One week (5 days) off annually for CME activities.

2. **Recruitment Agreement** that provides a recruitment incentive of $100,000, which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

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

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

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

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

Recommendation

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

1. **The Findings Supporting Recruitment of Natalie Friedricks, MD:**
   - That the recruitment of an obstetrics and gynecology physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract 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. Friedricks; and**
3. **The Contract Terms of the Obstetrics and Gynecology Professional Services Agreement for Dr. Friedricks.**

Attachments

Curriculum Vitae for Natalie Friedricks, MD

Natalie Friedricks

EDUCATION

Keck School of Medicine of USC - M.D. (2020)
University of Southern California - M.S. Global Medicine (2015)
Studied Abroad: Taipei Medical University
University of Southern California - B.A. Biological Sciences (2015)
Studied Abroad: The Queen's College, Oxford University

RESIDENCY

General Surgery Internship - University of Washington – Seattle, WA 2020-2021
OBGYN Residency - Jersey Shore University Medical Center - Neptune, NJ 2021- 2025

WORK & VOLUNTEER EXPERIENCE

Medlife – *Mission Volunteer* - Cusco, Peru 2014
- Helped organize medical missions in Cusco, Peru and assisted in the operation of a mobile health clinic

Beth Israel Deaconess Medical Center – *Medical Scribe* – Boston, MA 2015 - 2016
Mending Kids International – *Medical Missions Associate* – Burbank, CA 2015
- Organized pediatric surgical missions in Guatemala and Cambodia.

Partners in Health ENGAGE – *Advocacy Lead* – Boston, MA 2015
- Worked with advocacy teams across the US to confront presidential candidates on global health issues

Project Malawi – *Research and Development Chair* 2017 - 2020
- Coordinated with and trained local community health workers, designed a thorough maternal health survey, and conducted both a primary and secondary needs assessment after building a new OR

USC Student Run Clinic – *President* 2017-2018
- Recruited and organized volunteers, confirmed clinic operation times, scheduled patients, developed and maintained all charting documents, and ensured that the clinic ran smoothly

Ethics Committee at JSUMC - *Resident Member* 2022-2024

RESEARCH

Chitipa District Department of Public Health 2017-2020 *Neeraj Sood, PhD, Faculty Mentor*
Theodore Bandawe, MD, District Health Of icer
- Performed a survey-based study of maternal and neonatal health following the creation of the first surgical operating theater in the region.
- Analyzed the effects of pre-identified risk factors on antenatal service utilization in the largest district in Northern Malawi and created new data collection strategies designed for rural and difficult to reach populations.

Department of Surgery at Keck Medical Center 2017 - 2018 *Amy Hackmann, MD, Faculty Mentor*
- Studied the effects of various systems level interventions on the rates of hospital acquired VTE in the Cardiothoracic Surgery Department of Keck Hospital of USC.

Zilkha Neurogenetic Institute Summer 2017 *Rick Friedman, MD, PhD, Faculty Mentor*
- Researched the genetic architecture of cisplatin-induced hearing loss through GWAS studies in both mouse and human populations.

Sens Research Foundation Summer 2015 *Matthew O'Connor, PhD, Research Mentor*
- Developed a novel gene therapy technique to rescue oxidation phosphorylation protein complexes in dysfunctional mitochondria.

▪ Collaborated with other research assistants to develop innovative cell-based assays to assess ATP synthase functionality and presence in cells with non-functional electron transport chains.

Jersey Shore University Medical Center 2021-2023 *Jonathon Baum, MD, Research Mentor*

▪ Worked as a team to evaluate the evolving role of ChatGPT in patient education in obstetrics

HONORS & AWARDS

Walker Foundation Scholarship, 2018, 2019
Dhablania and Kim Family Global Medicine Fellowship, 2018
National Science Foundation I-Corps Grant, 2017
Bremen Global Health Fellowship, 2017
Dornsife Scholar, 2015
Beryl J. McManus Memorial Endowed Scholarship, 2015
Resident of the Month February, 2022
Reproductive Endocrinology Resident of the Year 2022-2023

PROFESSIONAL ASSOCIATIONS

AMWA
ACS
ACOG
AAGL

PRESENTATIONS

1. **Friedricks, N**., O'Connor, PhD. Allotopic expression of ATP8 and ATP6 in rho0 cells. Poster session presented at: Rejuvenation Biotechnology Conference 2015. 2nd Annual Sens Research Foundation Conference on Rejuvenation Biotechnology. 2015 Aug 19-21; San Francisco, CA
2. **Friedricks, N**., Elsahwi, K. Robotic-assisted repair of a uterine isthmocele. Poster session presented at: JSUMC Resident Research Day. Annual JSUMC Resident Research Day. 2022 April 11; Neptune, NJ

PUBLICATIONS

1. **Friedricks, N.**, Ebner, P., Chilenga, L., Bandawe, T., Tolomiczenko, G., Alswang, J., Belshe, W., Sood, N. Utilizing mobile health and community informants to collect real-time health care data in extremely low resource environments. J Glob Health. 2020 Dec;10(2):020411. doi: 10.7189/jogh.10.020411. PMID: 33282223; PMCID: PMC7688196.
2. Boominathan, A., Vanhoozer, S., Basisty, N., Powers, K., Crampton, A. L., Wang, X., **Friedricks N.**, Schilling B., Brand, M.D., O'Connor, M. S. (2016). Stable nuclear expression of ATP8 and ATP6 genes rescues a mtDNA Complex V null mutant. *Nucleic Acids Research*. doi:10.1093/nar/gkw756
3. Wan, C., Cadiente, A., Khromchenko, K., **Friedricks, N.**, Rana, R., & Baum, J. (2023). CHATGPT: An evaluation of AI-generated responses to commonly asked pregnancy questions. *Open Journal of Obstetrics and Gynecology*, *13*(09), 1528–1546. https://doi.org/10.4236/ojog.2023.139129

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of a Physician to Central Coast Nephrology Medical Corporation, and (ii) Contract Terms for the Recruitment Agreement**

Executive Sponsor: Tim Albert, MD, Chief Clinical Officer

Date: June 9, 2025

Executive Summary

In consultation with members of the Salinas Valley Health (SVH) medical staff, and in compliance with requirements of Stark Law, SVH executive leadership has identified the recruitment of a **nephrologist** as a recruiting priority for the hospital's service area. As demonstrated in the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of nephrology is recommended as a priority for recruitment. With several of the credentialed nephrologists on SVH Medical Staff nearing retirement age, there is a need to recruit an additional nephrologist for succession planning. To support physician recruitment to the District's service area, SVH collaborates with local, independent medical groups in the recruiting process through contributions of recruitment incentives paid to physicians who relocate to our community to practice at SVH. Central Coast Nephrology Medical Corporation (CCN), a local, private practice which provides medical services and emergency department nephrology call coverage at SVH, has requested assistance from SVH in form of a recruitment incentive for one physician to join the practice.

Recruitment Incentive

The proposed physician recruitment requires the execution of a three-party Recruitment Agreement among SVH, CCN, and the recruited physician. This agreement will furnish a recruitment incentive in the amount of $50,000 paid directly to the recruited physician and will be structured as forgivable loan over two years of service at SVH.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of a nephrologist is aligned with our strategic priority for growth. SVH continues to support community physician groups that provide care to our patients in the hospital. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by increasing access to necessary care.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of a nephrologist at SVH has been identified as a need for recruitment and demonstrates the support from SVH to private medical groups. The recruitment incentives proposed for these recruitments are within fair market value and are commercially reasonable.

Recommendation

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

1. **The Findings Supporting the Recruitment of a Nephrologist to Central Coast Nephrology,**
   - The recruitment of a nephrologist is in the best interest of the public health of the communities served by the District;
   - The recruitment incentive SVH proposes for this recruitment is necessary in order to relocate and attract an appropriately qualified physician to practice in the communities served by the District; and
2. **The Contract Terms of the Recruitment Agreement**. SVH Physician Recruitment Agreement attached.

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
PHYSICIAN RECRUITMENT AGREEMENT

(*physician* and *group*)

This Physician Recruitment Agreement ("Agreement") is made effective on _____ ("Effective Date"), by and among **Salinas Valley Memorial Healthcare System**, a local health care district organized and operating pursuant to Division 23 of the California Health & Safety Code, operating as Salinas Valley Health ("SVMHS"), _____, a physician ("Physician") specializing in _____ ("Specialty"), and _____, a California professional medical corporation ("Group"). SVMHS, Physician, and Group are referred to as the "Parties" and individually as a "Party."

RECITALS

A. SVMHS owns and operates Salinas Valley Health Medical Center, a general acute care hospital located at 450 East Romie Lane, Salinas, California ("Hospital"). SVMHS provides health care services to residents of the district and surrounding communities ("Service Area"). Group is a California professional medical corporation providing medical services in the Service Area. Physician intends to practice Physician's Specialty with Group in the Service Area.

B. SVMHS has determined that there is a shortage of, and a need for, physicians specializing in Physician's Specialty in the Service Area. The shortage of such physicians jeopardizes SVMHS's ability to provide such health care services to residents of the Service Area. SVMHS also has determined that such shortage is not likely to resolve itself through market forces, but that financial support is needed if the appropriate physician is to relocate to the Service Area.

C. To facilitate its goal of providing medical services in the Service Area, SVMHS has determined that it must provide certain incentives in order to enable a physician specializing in Specialty to join a medical practice in the Service Area. SVMHS has determined that the incentives set forth in this Agreement meet a community need and promote SVMHS's mission and goal of providing health care services to all residents in the Service Area who need such care.

D. Physician is duly licensed to practice medicine in the State of California and is qualified to provide medical services in Physician's Specialty ("Professional Services"). Physician is prepared to join Group in order to practice in the Service Area and to provide Professional Services, in return for the financial assistance provided in this Agreement.

E. SVMHS has determined that the financial assistance required by Physician to relocate is justified by the benefit to patients in the Service Area. Accordingly, SVMHS is prepared to offer financial assistance to Physician under the terms and conditions set forth in this Agreement. Physician hereby acknowledges and agrees that the financial assistance provided by SVMHS under this Agreement is reasonable and not in excess of fair market value, which is not determined in a manner that takes into account the volume or value of any actual or anticipated referrals by Physician or Group to Hospital. Physician and SVMHS shall enter into an unsecured Promissory Note, attached as Exhibit A to this Agreement, for any payments made under this Agreement.

F. SVMHS, Physician, and Group wish to enter into this Agreement in order to set forth a full statement of the terms of this recruiting arrangement, which all Parties acknowledge is necessary in order to allow Physician to relocate to the Service Area and to provide Professional Services to its residents.

The Parties agree as follows:

Article 1 Duties of Physician and Group

1.1 Full-Time Practice. Physician shall conduct a full-time practice with Group in Physician's Specialty within the Service Area as determined by Hospital, with Group's practice location being _____. Physician shall commence Physician's practice with Group in accordance with this Agreement on or about _____ ("**Start Date**"). Physician shall comply with the requirements of this Agreement in order for Physician to begin practicing on the Start Date.

1.2 Services to Patients, Billing, and Collection. Physician shall provide services under this Agreement to all patients presenting at Hospital including privately insured, Medicare, Medi-Cal, and uninsured patients at a level which is at least consistent with the custom and practice in the community. Group shall be responsible for billing and collecting for Physician's Professional Services on a timely, consistent, accurate, and commercially reasonable basis.

1.3 Employment by Group. Physician has selected Group with whom Physician intends to be employed in the practice of Physician's Specialty. Physician has agreed to this employment voluntarily and without inducement or influence of SVMHS. Physician shall use reasonable, good-faith efforts to maintain this employment during the term of the Agreement. The termination of Physician's employment shall not in any way affect Physician's, Group's, or SVMHS' obligations under this Agreement.

1.4 Duties of Group. Group shall use best effort to provide Physician with a stable, productive work environment and shall take steps reasonably necessary to promote the growth of Physician's practice.

Article 2 Standards

2.1 Licensure and Board Certification. Physician shall maintain California licensure in good standing during the term of this Agreement. Physician shall be board certified or board eligible in Specialty during the term of this Agreement.

2.2 Medical Staff Standing and Hospital Regulations. Physician shall be responsible for obtaining and maintaining membership on the Hospital's Medical Staff with active Status and appropriate privileges, and shall be subject to all of the responsibilities of that membership. Subject to Section 4.4 below, in the event Physician loses active Medical Staff membership or necessary privileges, this Agreement shall terminate immediately, and any sums owed by Physician to Hospital under this Agreement shall become due and payable immediately. Physician shall at all times comply with all applicable bylaws, rules and regulations, and policies of SVMHS, Hospital, and Hospital's Medical Staff.

2.3 Corporate Compliance Program. Group and Physician shall support and comply with Hospital's Corporate Compliance Program, as applicable to this Agreement. Group and Physician shall comply with all policies and procedures adopted by Hospital in support of the Corporate Compliance Program.

Article 3 Term & Termination

3.1 Term. The term of this Agreement shall commence on the Effective Date of this Agreement and continue until the later of two (2) years from the Start Date of this Agreement, or until all sums are repaid or forgiven under the terms of this Agreement.

3.2 Immediate Termination by SVMHS. SVMHS may terminate this Agreement immediately upon the occurrence of any of the following events: (i) loss or suspension of Physician's license to practice medicine; (ii) termination of Physician's Medical Staff Membership and/or hospital/clinical privileges; (iii) Physician's failure to maintain, for any reason, Physician's Medical Staff Membership at Hospital with appropriate privileges; (iv) restriction or suspension by the Hospital Medical Staff of Physician's privileges including an administrative suspension or summary suspension of privileges; (v) Physician's conviction (final or on appeal) of a felony or any crime involving moral turpitude; or (vi) Physician's appointment of a receiver for Physician's assets, assignment for the benefit of creditors, or any relief sought by him under any bankruptcy or insolvency act. In the event SVMHS terminates this Agreement pursuant to this Section 3.2, subject to Section 4.4 below, Physician shall pay any outstanding debt to SVMHS under this Agreement and any Related Agreements.

3.3 Termination Due to Total Disability. Either Party shall have the right to terminate this Agreement in the event of total disability of Physician. Physician shall be deemed to suffer a "total disability" if Physician becomes physically or mentally incapacitated for more than three (3) months as shown by inability to perform all or substantially all of the material obligations of this Agreement, and which disability is likely, in the opinion of a physician mutually designated by Physician and SVMHS, to persist for six (6) months following the date of determination of said physician. The cost of a disability examination, if requested by SVMHS, shall be paid by SVMHS.

3.4 Termination Not Subject to Fair Hearing. It is agreed among the Parties that should this Agreement be terminated for any reason, such decision to terminate and actual termination shall apply to rights under this Agreement only and not to Physician's Medical Staff privileges or membership on the Medical Staff of Hospital. The termination of this Agreement shall not be subject to the Fair Hearing Plan of the Medical Staff Bylaws, any hearing procedures provided by Local Health Care District Law, or any other Fair Hearing procedures regarding medical staff appointments or privileges.

3.5 Effect of Termination. Following expiration or termination of the Agreement for any reason, the Parties shall cooperate in the resulting transition in a manner that serves the best interests of the patients of SVMHS. Termination of this Agreement shall have no effect on Physician's Medical Staff membership or clinical privileges at the Hospital, which will continue unless terminated in accordance with the Hospital's Medical Staff Bylaws. Termination of this Agreement shall not affect the obligation of Physician to repay money as otherwise provided in this Agreement.

Article 4 Recruitment Incentive

4.1 Recruitment Incentive. As part of the consideration for Physician entering into and complying with the terms and conditions of this Agreement and provided that Physician commences practice in the Service Area consistent with the terms of this Agreement by the Start Date, SVMHS shall pay to Physician a recruitment incentive in the amount of _____ **Dollars ($_____.00)** on or about the Effective Date of this Agreement. Physician agrees that (i) this amount is reasonable and necessary to secure Physician's relocation and Physician's services under this Agreement, (ii) this amount is not in excess of fair market value, and (iii) this amount is not made in consideration for the referral of patients by Physician or Group to SVMHS or its affiliates.

4.2 Repayment. If either Party terminates this Agreement prior to the expiration of two (2) years from the Start Date, Physician shall be obligated to repay to SVMHS a pro-rated amount of the payment advanced by SVMHS to Physician pursuant to Section 4.1 of this Agreement, plus interest at an annual rate equal to the most recent prime rate published in the Wall Street Journal (or any successor publication) from time to time ("Prime Rate"), plus one percent (1.0%), payable monthly.

For example, if this Agreement is terminated after ten (10) months, Physician shall repay to SVMHS 14/24ths of the recruitment incentive, plus ten (10) months of accrued interest at an annual rate equal to the Prime Rate, plus one percent (1.0%), payable monthly. Such repayment shall be made within ninety (90) days of the event triggering Physician's repayment obligation. If Physician fails to make such repayment to SVMHS within this ninety (90) day period, SVMHS shall have the right to increase the interest rate on the amount owed to SVMHS to the Prime Rate plus two percent (2%), beginning on the ninety-first day.

4.3 Promissory Note. At the time of payment to Physician of any amounts under this Agreement, Physician shall execute a Promissory Note substantially in the form attached to this Agreement as Exhibit A to secure repayment of any amounts paid to Physician under this Agreement which are not forgiven by SVMHS pursuant to the terms of this Agreement.

4.4 Debt Forgiveness Over Term of Agreement. If Physician has complied and is continuing to comply with all of the terms of this Agreement, SVMHS shall reduce and eliminate the debt due to SVMHS as follows: SVMHS shall forgive fifty percent (50%) of the recruitment incentive, including accrued interest, for each full year of physician services provided by Physician after the Start Date, such that the recruitment incentive will be forgiven upon the second (2nd) anniversary of Physician's Start Date.

4.5 Debt Forgiveness at Death/Disability. SVMHS shall forgive all sums advanced by SVMHS under this Agreement and accrued interest, in the event of Physician's death or permanent disability during the Term of this Agreement.

Article 5 General Provisions

5.1 Other Agreements. This Agreement may be one of several between SVMHS, Group, and/or Physician, dealing with different aspects of their relationships. SVMHS maintains a current master list of such agreements with Group and/or Physician, together with copies of the actual agreements, that is available for review by the Department of Health and Human Services in accordance with Stark Law regulations.

5.2 Referrals. Physician shall be entitled to refer patients to any hospital or other institution Physician deems qualified to deliver health care services to a particular patient. Nothing in this Agreement shall be deemed to require Physician or Group to refer patients to Hospital, and SVMHS may not terminate this Agreement because of Physician's or Group's referral decisions. No payment or other consideration is or will be made under this Agreement for the referral of patients to SVMHS or its affiliates.

5.3 Medical Staff Privileges. Throughout the term of this Agreement, and thereafter, Physician shall be permitted to maintain medical staff privileges at other area hospitals.

5.4 Waiver. The failure of SVMHS to insist in any one or more instances upon strict performance of any of the terms of this Agreement shall not be construed as a waiver or relinquishment for the future of such terms, but the same shall continue and remain in full force and effect.

5.5 Governing Law/Venue. This Agreement shall be interpreted in accordance with the laws of the State of California, and any questions arising under it shall be construed or determined in accordance with such laws. Jurisdiction and venue shall be in Monterey County, California.

5.6 Attorneys' Fees. In the event that suit is brought regarding the enforcement of the provisions of this Agreement, the prevailing Party/Parties shall be awarded its costs of suit and reasonable attorneys' fees as part of any judgment rendered.

5.7 Partial Invalidity. Should any part of this Agreement for any reason be declared invalid, such decision shall not affect the validity of the remaining portions which shall remain in effect as if this Agreement had been executed with the invalid portion eliminated.

5.8 Government Audit. Until the expiration of five (5) years after the furnishing of any services pursuant to this Agreement, Group and Physician shall make available to the Secretary of the United States Department of Health and Human Services or to the United States Comptroller General, or to any of their duly authorized representatives, upon written request of the same, this Agreement and such books, documents, and records of Group or Physician necessary to certify the nature and the reasonable cost of services of the Hospital.

5.9 Agreements between Physician and Group. Upon request by SVMHS, Group agrees to provide SVMHS with copies of its employment agreement with Physician. Nothing in Group's agreements with Physician shall be inconsistent with Physician's obligation to perform the terms and conditions of this Agreement. Group agrees that payments by SVMHS under this Agreement shall be for the benefit of Physician. Nothing in Group's agreements with Physician shall be inconsistent with the requirements Stark Law.

5.10 Income Tax Ramifications. The Parties acknowledge that Physician may incur federal and state income tax obligations from certain of the transactions provided for in this Agreement that SVMHS is required to report items of income under relevant income tax laws and regulations, and that forgiveness of debt may constitute income to Physician. It is Physician's responsibility to consult with tax advisors with respect to the filing of income tax returns and the tax treatment of items provided for in this Agreement.

5.11 Assignment. Except as otherwise agreed in writing by the SVMHS, nothing contained in this Agreement shall be construed to permit assignment or delegation by Physician of any rights or obligations under this Agreement, and any such assignment or delegation is expressly prohibited. This Agreement shall be binding upon and inure to the benefit of the successors and assigns of SVMHS.

5.12 Applicable Legal Standards. The Parties shall exercise their rights and perform their duties under this Agreement in accordance with the legal standards set forth in the United States Code, the Code of Federal Regulations, the California Health and Safety Code, the California Business and Professions Code, and any other pertinent and applicable laws, rules, regulations, and orders of the United States and the State of California and their agencies, to the extent that such laws, rules, regulations, and orders pertain to the powers, functions, and duties of SVMHS, Group, and Physician.

5.13 Confidentiality. The Parties agree that this Agreement is personal and confidential between them, and agree, unless otherwise required by law, not to release information concerning this Agreement, or any information exchanged between the Parties pursuant to this Agreement, to any person without the consent of the other Party, which consent shall not be unreasonably denied.

5.14 Notices. All communications and notices which any Party may be required or desire to give or serve upon any other Party under this Agreement shall be made in writing and shall be delivered in person or sent by registered or certified mail, return receipt requested, to the addresses below. Any Party may change its address by giving any other Parties written notice of its new address as provided in this Agreement.

SVMHS: Salinas Valley Health
Attn: President/Chief Executive Officer
450 East Romie Lane
Salinas, CA 93901

Physician:
c/o

Group:

5.15 Conditions and Effective Date. This Agreement is subject to approval by the Board of Directors of SVMHS, which approval has not been secured and is not guaranteed. This Agreement shall be effective as of the later of the date the Board approves the Agreement and the date it is signed by all Parties.

5.16 Entire Agreement/Modifications. This Agreement constitutes the entire Agreement between the Parties with respect to the subject matter and supersedes any and all prior negotiations, understandings, and agreements. All modifications to this Agreement must be in writing and signed by the Parties.

The Parties have executed this Agreement as of the Effective Date first set forth above.

SVMHS
Salinas Valley Memorial Healthcare System

By:_____ Date:_____
Allen Radner, MD President/CEO

PHYSICIAN

_____ Date:_____

GROUP

By:_____ Date:_____

EXHIBIT A

PROMISSORY NOTE
(Recruitment Incentive)

$_____.00 _____

FOR VALUE RECEIVED, the receipt of which is hereby acknowledged, _____ ("Maker") hereby promises to pay to the order of **Salinas Valley Memorial Healthcare System** ("Holder"), at the place designated by Holder, the principal sum of _____ **Dollars ($_____.00)**, plus accrued interest on such amount calculated at an annual fixed rate equal to the prime rate published on the effective date of this Promissory Note in the Wall Street Journal ("Prime Rate"), plus one percent (1%), from the date of this Promissory Note, payable in lawful money of the United States of America. Principal and interest shall be immediately due and payable to Holder on _____. Notwithstanding the foregoing, if Maker is and remains in full compliance with the **PHYSICIAN RECRUITMENT AGREEMENT** effective _____, by and between Maker and Holder ("Recruitment Agreement"), the principal and interest due under this Promissory Note shall be forgiven pursuant to the terms and conditions of the Recruitment Agreement.

This Promissory Note is unsecured. In no event shall any payment of interest or any other sum payable hereunder exceed the maximum amount permitted by applicable law. If it is established that any payment exceeding lawful limits has been received, Holder will refund such excess or, at its option, credit the excess amount to the principal due hereunder, but such payments shall not affect the obligation to make periodic payments required herein.

Maker agrees to pay, to the extent permitted by law, all costs and expenses incurred by Holder in connection with the collection and enforcement of this Promissory Note, including, but not limited to, expenses and reasonable attorneys' fees to the extent permitted by applicable law, irrespective of whether any suit or security foreclosure or court proceeding has been commenced. Maker and all endorsers and all persons liable or to become liable on this Promissory Note, and each of them, hereby waive diligence, demands, presentation for payment, notice of nonpayment, protest and notice of protest, and specifically consent to and waive notice of any renewals or extensions of this Promissory Note, or any modification or release of security for this Promissory Note, whether made to or in favor of Maker or any other person or persons, and further agree that any such action by Holder shall not affect the liability of Maker or any person liable or to become liable on this Promissory Note.

No delay or omission by Holder in exercising any remedy, right or option under this Promissory Note shall operate as a waiver of such remedy, right or option. In any event, a waiver on any one occasion shall not be construed as a waiver or bar to any such remedy, right or option on a future occasion. The invalidity of any one or more covenants, phrases, clauses, sentences or paragraphs of this Promissory Note shall not affect the remaining portions hereof, and this Promissory Note shall be construed as if such invalid covenants, phrases, clauses, sentences or paragraphs, if any, had not been included herein.

This Promissory Note is to be construed in all respects and enforced according to the laws of the State of California. This Promissory Note may not be amended or modified except by a written agreement duly executed by Maker and Holder. This Promissory Note and the obligations created hereby shall bind Maker and, to the extent applicable, Maker's respective successors and assigns, and the benefits hereof shall inure to Holder and its successors and assigns. This Promissory Note may be assigned by Holder in its sole discretion.

Any notice to Maker under this Promissory Note shall be in writing and shall be deemed to have been given upon (i) receipt, if hand delivered, (ii) transmission, if delivered by facsimile transmission, (iii) the next business day, if delivered by express overnight delivery service or (iv) the third business day following the day of deposit of such notice in U.S. certified mail, return receipt requested to the following address:

_____
_____
_____
_____

Maker has executed and delivered this Promissory Note effective as of the date first set forth above.

MAKER:_____ Date:_____

Financial Performance Review
May 2025

Finance Committee

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary
For the Month of May 2025

$ in Millions	For the Month of May 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 82.5	$ 64.5	$ 18.0	27.9%
Operating Expense	$ 68.6	$ 65.2	$ (3.4)	-5.2%
Income from Operations	**$ 13.9**	**$ (0.7)**	**$ 14.6**	**2085.7%**
Operating Margin %	*16.8%*	*-1.1%*	*17.9%*	*1627.27%*
Non Operating Income	$ (0.2)	$ 2.8	$ (3.0)	-107.1%
Net Income	**$ 13.7**	**$ 2.1**	**$ 11.6**	**552.4%**
Net Income Margin %	*16.6%*	*3.1%*	*13.5%*	*435.5%*

Normalizing Item included in operating income:

- IGT for Hospital Quality Assurance Fee Revenue for Program Year 2024 (net) totaling $4.3 million

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Consolidated Financial Summary
For the Month of May 2025 - Normalized

$ in Millions	For the Month of May 2025			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 78.2	$ 64.5	$ 13.7	21.2%
Operating Expense	$ 68.6	$ 65.2	$ (3.4)	-5.2%
Income from Operations	**$ 9.6**	**$ (0.7)**	**$ 10.3**	**1471.4%**
Operating Margin %	*12.3%*	*-1.1%*	*13.4%*	*1218.18%*
Non Operating Income	$ (0.2)	$ 2.8	$ (3.0)	-107.1%
Net Income	**$ 9.4**	**$ 2.1**	**$ 7.3**	**347.6%**
Net Income Margin %	*12.1%*	*3.1%*	*9.0%*	*290.3%*

Normalizing Item excluded from operating income:
- IGT for Hospital Quality Assurance Fee (HQAF) Revenue for Program Year 2024 (net) totaling $4.3 million

Operating Revenue was over budget due to:
- Very Strong OP Net Revenue ($8M)
- Higher than budgeted collection rate: 21% vs 20% ($1M)
- Favorable true up adjustment in collection rate ($4M)

Non-Operating Revenues were unfavorable to budget due to changes in market value of investments

Executive Summary: Financial Performance

Salinas Valley Health's Income from Operations was $13.9 million for the month which was favorable to budget by $14.6M. After normalizing for the HQAF IGT of $4.3 million income from operations was $9.6 million. The favorable financial performance for the month was driven by the following:

- ✓ **Very Strong Outpatient Revenues -** favorable to budget by $38M (26%), this equates to a favorable variance of $13M in OP Net Revenue. Key services driving this variance were:
  - ➢ **OP Infusion Program -** cases were over budget by 24% (240 cases or $4.5M net revenues)
  - ➢ **OP Surgeries –** cases were over budget by 26% (71 cases or $1M net revenues)
- ✓ **Inpatient Surgeries** were over budget by 5% (7 cases)
- ✓ **Total Admissions** were over budget by 6% (53 cases)
- ✓ **All Payor Case Mix** of 1.69 was 5% over target and Medicare CMI was also higher at 1.85 (4%) due to higher intensity cases including Pneumonia and other respiratory condition admissions.
- ✓ **Average Length of Stay** was 11% favorable to budget at 3.6 days: Medicare ALOS was also below budget by 6% despite the increase in patient acuity.

Executive Summary: Financial Performance – Cont'd

- **Key Unfavorable Performance Highlights:**
  - ✓ **Payor Mix** was varied with higher than expected Commercial revenue, up 10%. However, Medicare and MediCal were over budget by 17% and 11%, respectively.
  - ✓ **Observation cases** were over budget by 50% (206 cases)
  - ✓ **Days in AR** were over target at 64 days on continued delayed reimbursement from payors such as Anthem and Blue Shield. Collections for the month down 4% from April
  - ✓ **Mammography** was under budget 11% from target (280 cases) due to staffing issues with ultrasound and x-ray mammo technologists. Contract staff was brought in late in May to cover the shortage of available techs

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Consolidated Financial Summary YTD May 2025

$ in Millions	FY 2025 May YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 775.6	$ 686.5	$ 89.1	13.0%
Operating Expense	$ 726.0	$ 698.2	$ (27.8)	-4.0%
Income from Operations	**$ 49.6**	**$ (11.7)**	**$ 61.3**	**523.9%**
Operating Margin %	*6.4%*	*-1.7%*	*8.1%*	*476.5%*
Non Operating Income	$ 34.0	$ 33.1	$ 0.9	2.7%
Net Income	**$ 83.6**	**$ 21.4**	**$ 62.2**	**290.7%**
Net Income Margin %	*10.8%*	*3.1%*	*7.7%*	*248.4%*

Operating Income includes the Normalizing Items of:

- $4.6M - CCAH Voluntary Rate Range Funds (net) received YTD for CY 2023
- $4.8M - District Hospital Direct Payment (net) for 2023
- $4.3M - HQAF (net) for program year 2024
- **$13.7M – Total YTD**

Non Operating Income includes Normalizing Items of:

- $4.2M - FEMA Grant funds (net) received YTD
- $10.8M - FEMA Grant funds received inception to date

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Consolidated Financial Summary
YTD May 2025 - Normalized

$ in Millions	FY 2025 May YTD			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue	$ 761.9	$ 686.5	$ 75.4	11.0%
Operating Expense	$ 726.0	$ 698.2	$ (27.8)	-4.0%
Income from Operations	**$ 35.9**	**$ (11.7)**	**$ 47.6**	**406.8%**
Operating Margin %	*4.7%*	*-1.7%*	*6.4%*	*376.5%*
Non Operating Income **	$ 29.8	$ 33.1	$ (3.3)	-10.0%
Net Income	**$ 65.7**	**$ 21.4**	**$ 44.3**	**207.0%**
Net Income Margin %	*8.6%*	*3.1%*	*5.5%*	*177.4%*

Operating Income excludes the Normalizing Items of:

- $4.6M - CCAH Voluntary Rate Range Funds (net) received YTD for CY 2023
- $4.8M - District Hospital Direct Payment (net) for 2023
- $4.3M – HQAF program (net) for 2024
- **$13.7M – Total YTD**

Non Operating Income excludes Normalizing Items of:

- $4.2M - FEMA Grant funds (net) received YTD
- $10.8M - FEMA Grant funds received inception to date

SVHMC Revenue Highlights May 2025

Gross Revenues were 19.6% *favorable to budget*

- **IP Gross Revenues** were 0.0% ***even*** to budget
- **ED Gross Revenues** were 1.3% ***favorable*** to budget
- **OP Gross Revenues** were 37.5% ***favorable*** to budget in the following areas:
  - OP Infusion
  - OP Surgery
  - MRI Procedures
  - CT Exams

- **Commercial: 10%** *above* budget
- **Medicaid: 11%** *above* budget
- **Medicare: 17%** *above* budget

Payor Mix –Varied

Total Net Patient Revenues were **$68.4M**, which was ***favorable*** to budget by **$15.9M** or 30.2%

Financial Summary – May 2025

ADC
Average daily census was 111, 5% below budget of 117

Admits
Total admissions were 6%, 53 admits, above budget

ER Visits
ER Outpatient visits were 1%, 55 cases, above budget

ER Admits
ER admissions were above budget 71 admits, 11%. ER admits as % of total admissions were 84.6% (Excluding OB ED)

IP Surgeries
Inpatient Surgeries were up 5%, 7 cases above budget at 140

OP Infusion
OP Infusion cases were up 24%, 240 cases above budget at 1,244

Cath Lab
Cath Lab procedures were up 9%, 28 cases above budget at 303

MRI/CT Procedures
MRI procedures were above budget by 57 cases, 23%. CT procedures were above budget by 161 cases, 9%

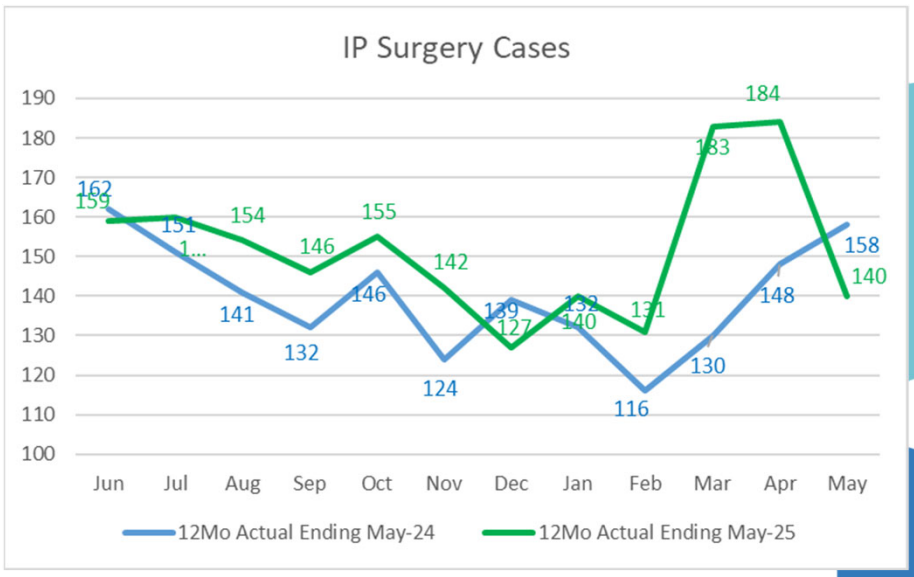
OP Surgeries
Outpatient Surgeries were above budget 26%, 71 cases, at 342

Deliveries
Deliveries were down 9%, 11 cases, below budget at 104

Observation Cases
OP Observations cases were over budget by 50%, or 68 cases at 206

Medicare ALOS
Medicare Traditional ALOS CMI adjusted was favorable to budget at 2.2 days with a Case Mix Index of 1.85

IP Surgery Cases - May 2025



IP Surgery Cases – month variance from prior year – 18 cases lower:

Increases:

- Orthopedics down 14 cases
- ENT down 4 cases

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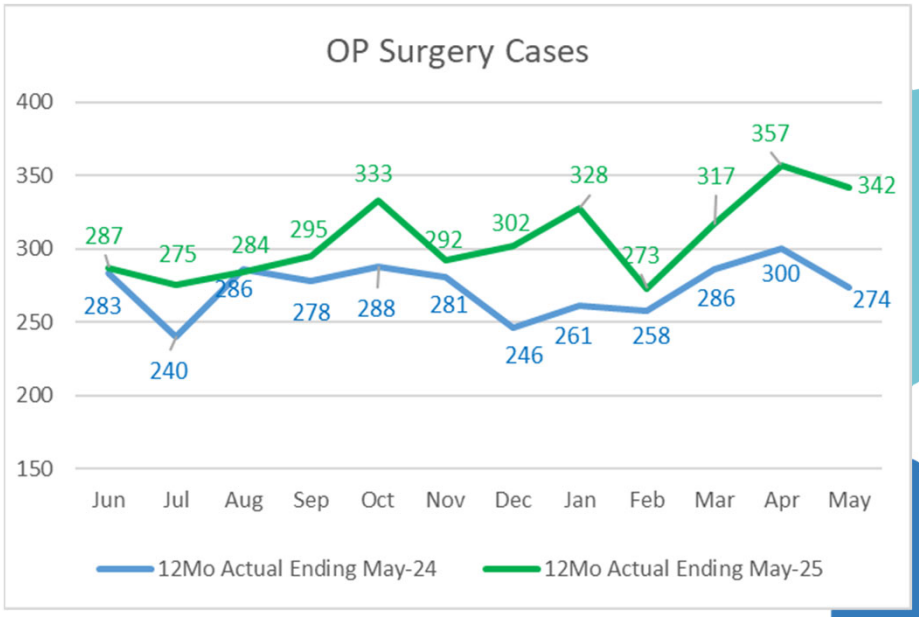
OP Surgery Cases - May 2025



OP Surgery Cases – month variance from prior year – 68 cases higher:

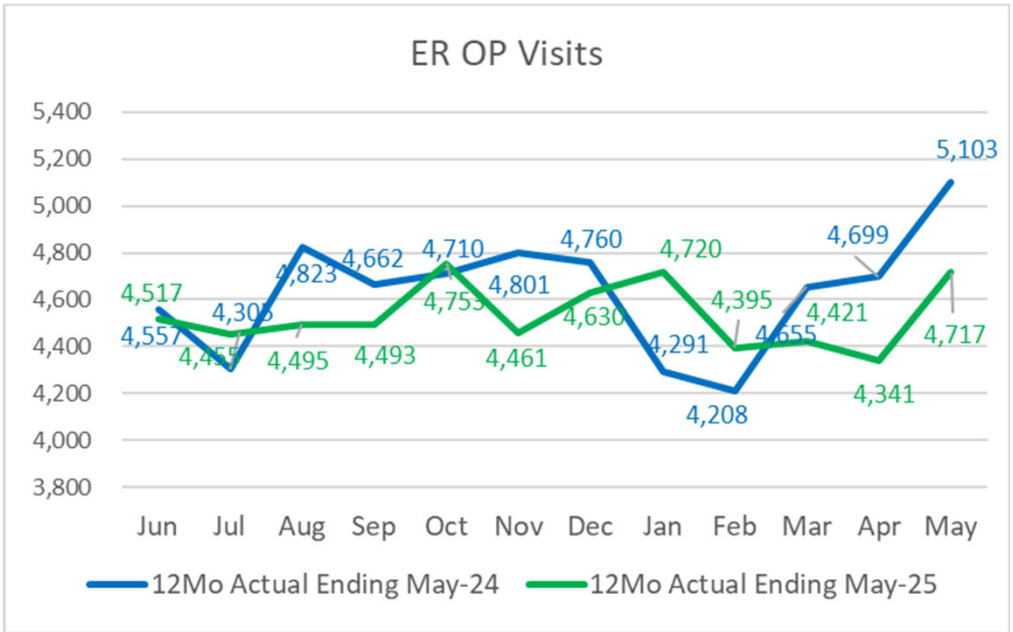
Increases:

- General Surgery up 67 cases (two new providers since PY)
- Orthopedics up 7 cases
- Vascular up 5 cases

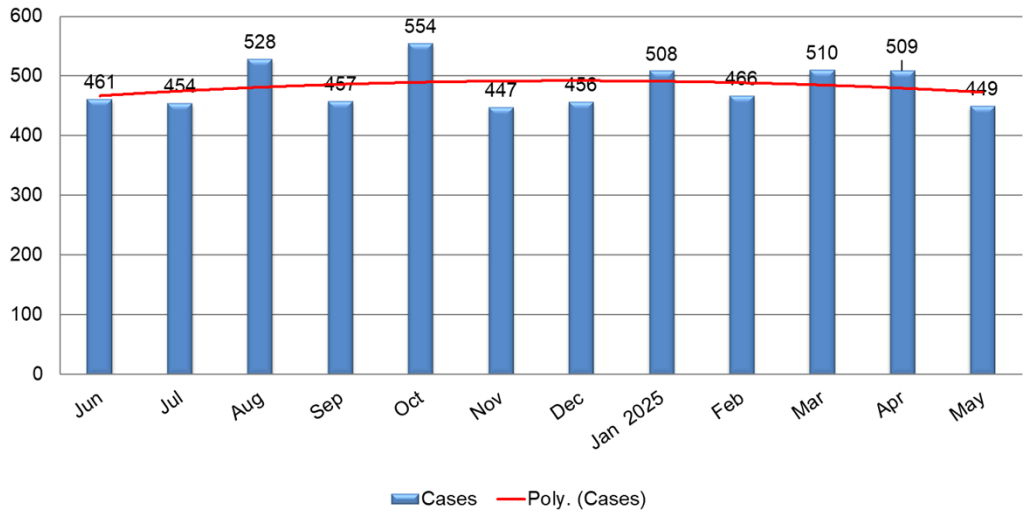
Decreases:

- ENT down 10 cases

ER OP Visits- May 2025



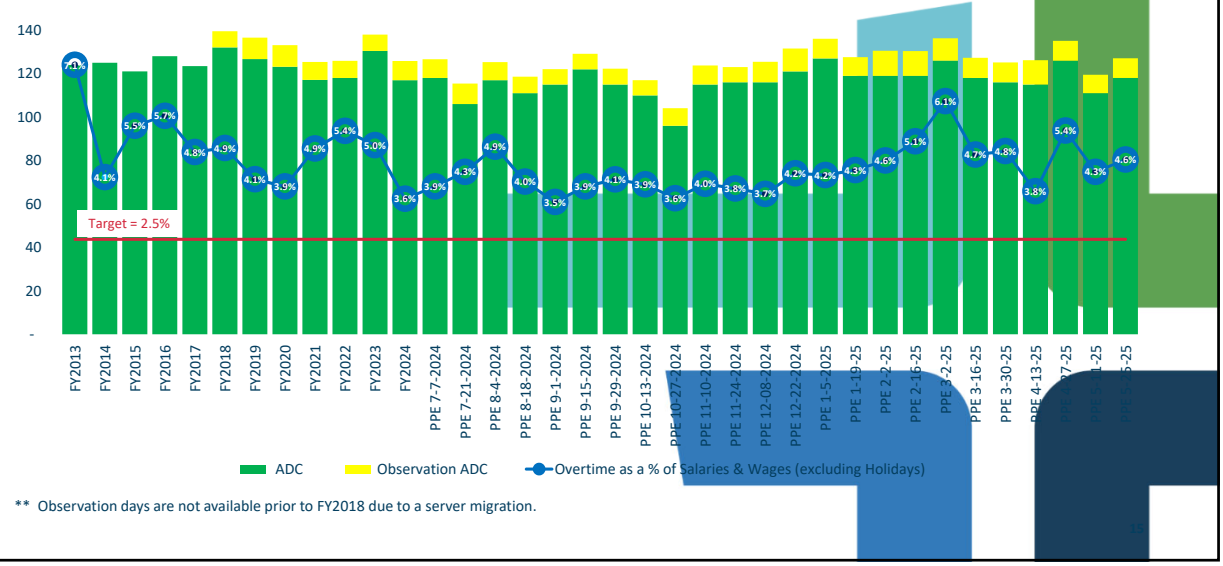
CDOC Cases - Rolling 12 Month Trend
June 2024 thru May 2025



Labor Productivity – May 2025

1. **Worked FTEs:** During the month of May, worked FTEs on a PAADC basis were 2% favorable at **6.6** with a target of **6.7**. *When reviewed on a unit-by-unit level, the variance was **33** FTEs negative (**$0.5M**). Lab was favorable 13.4 Worked FTEs. Excluding Lab, the variance was 47 FTEs negative ($0.7M).*
2. **Worked FTEs decreased** from 1,642 in April to 1,638 in May. Average daily census decreased by 10 compared to prior month at 111 (5% below budget).
3. **Paid FTEs:** On a PAADC basis, paid FTEs were **3%** favorable to budget at **7.5 actual vs. 7.8 budget.** Paid FTEs increased from 1,869 in April to 1,877 in May.

Overtime as a Percent of Total Salaries & Wages (excluding Holidays) Through the pay period ending May 25, 2025

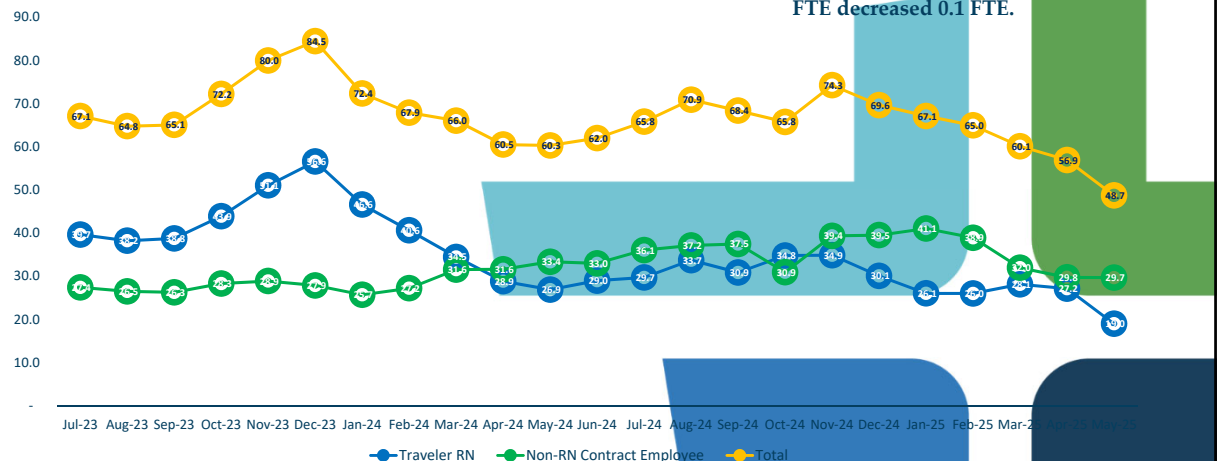


** Observation days are not available prior to FY2018 due to a server migration.

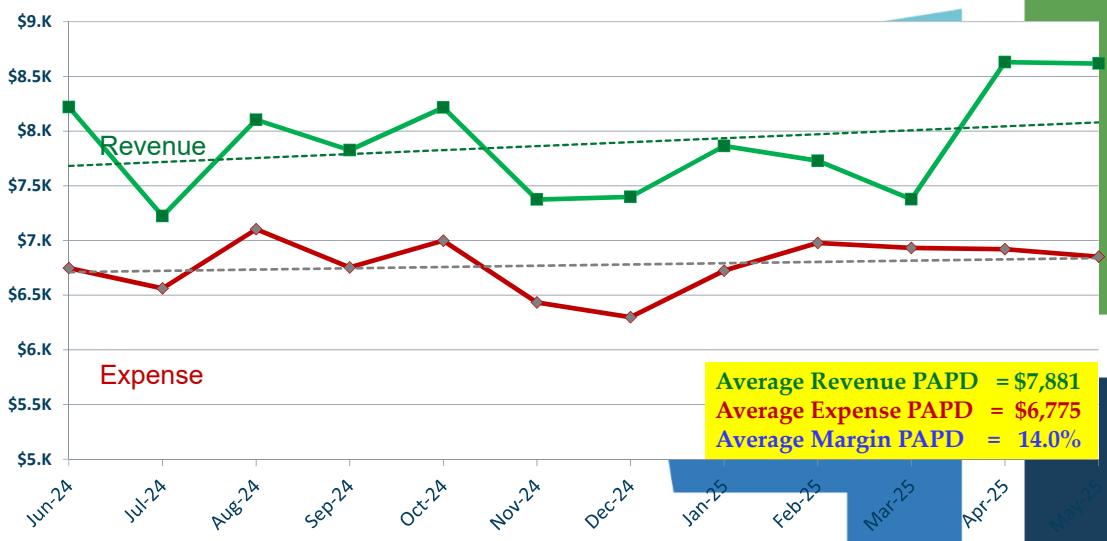
Contract Labor FTE by Month

July 2023 – May 2025

Contract labor decreased by 8.2 FTE compared to April. RN travelers decreased by 8.1 FTE while Non-RN FTE decreased 0.1 FTE.

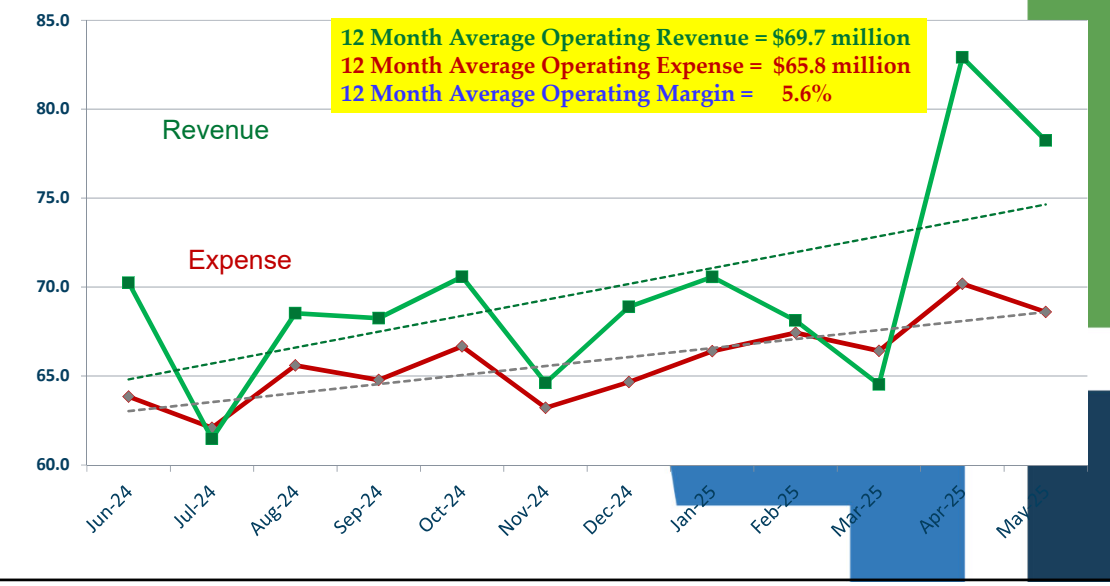


SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Jun 24 to May 25



Average Revenue PAPD = $7,881
Average Expense PAPD = $6,775
Average Margin PAPD = 14.0%

SVH Consolidated Revenues & Expenses
Rolling 12 Months: Jun 24 to May 25



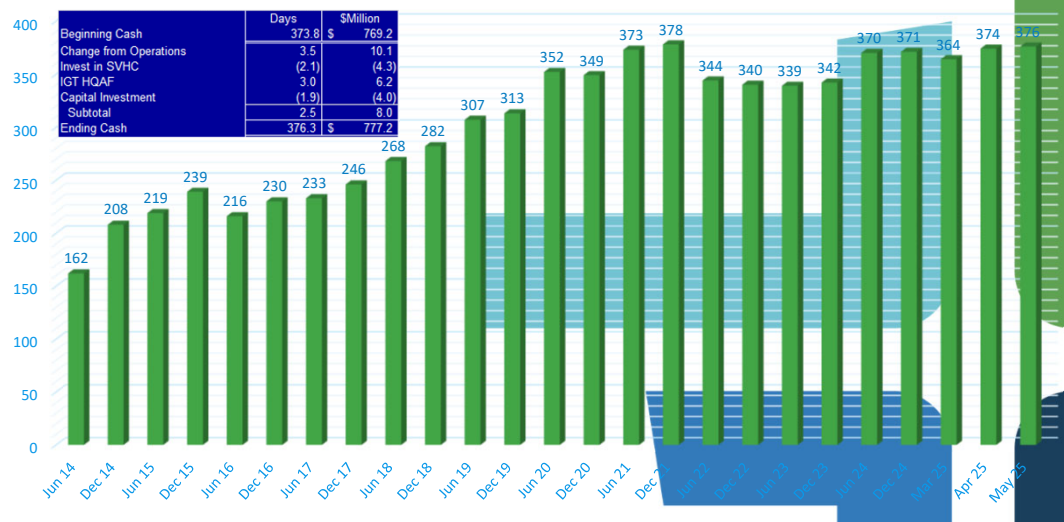
12 Month Average Operating Revenue = $69.7 million
12 Month Average Operating Expense = $65.8 million
12 Month Average Operating Margin = 5.6%

Salinas Valley Health Key Financial Indicators

Statistic	YTD 5/31/25	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 5/31/24	+/-
Operating Margin*	6.4%	5.0%		4.0%		1.7%	
Total Margin*	10.8%	6.0%		6.6%		8.4%	
EBITDA Margin**	10.7%	7.4%		13.6%		6.3%	
Days of Cash*	376	305		249		352	
Days of Accounts Payable*	47	45		-		47	
Days of Net Accounts Receivable***	64	45		49		56	
Supply Expense as % NPR	15.1%	14.0%		-		13.8%	
SWB Expense as % NPR	52.0%	53.0%		53.7%		53.8%	
Operating Expense per APD*	6,718	6,739		-		6,745	

All metrics above are consolidated for SVH except Operating Expense per APD
*These metrics have **not** been adjusted for normalizing items
**Metric based on Operating Income (consistent with industry standard)
***Metric based on 365 days average net revenue (consistent with industry standard)

Salinas Valley Health
Days Cash on Hand = 376 Days ($777M) - May 2025



Routine Capital Expenditures
Through May 2025

Fiscal Month	FY 2025 Approved Budget *	Total Purchased Expenditures	Remaining	Project	Amount
July	1,916,667	712,780	1,203,887	Angio Equipment Replacement	40,191
August	1,916,667	1,382,572	1,737,981	Lab Air Handler	30,466
September	1,916,667	729,309	2,925,338	Nuclear Med D-Spect Camera	29,020
October	1,916,667	1,191,148	3,650,857	Cath Lab 3 Equipment Replacement	20,742
November	1,916,667	794,889	4,772,635	Xray Rooms Equipment Replacement	20,040
December	1,916,667	1,381,451	5,307,851	Total Improvements	140,459
January	1,916,667	1,565,871	5,658,646	Nuclear Med D-Spect Camera	261,345
February	1,916,667	963,787	6,611,526	Cardiology 6VT-D Electronic 4D Multiplane Transesophageal Probes	65,550
March	1,916,667	815,462	7,712,730	Cath Lab Sonosite Ultrasound System	56,635
April	1,916,667	1,449,571	8,179,826	Med Surg Avasys Cameras and Installation	41,829
May	1,916,667	622,232	9,474,261	Miscellaneous	56,414
June	1,916,667		11,390,928	Total Equipment	481,773
YTD TOTAL	**23,000,000**	**11,609,072**	**11,390,928**	**Grand Total**	**622,232**

Questions/Comments

Salinas Valley HEALTH

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	53	29	390	385	(5)
Other Admissions	58	76	836	907	71
Total Admissions	111	105	1,226	1,292	66
Medi-Cal Patient Days	53	46	589	703	114
Other Patient Days	121	128	1,394	1,376	(18)
Total Patient Days of Care	174	174	1,983	2,079	96
Average Daily Census	5.6	5.6	5.9	6.2	0.3
Medi-Cal Average Days	1.7	1.6	1.7	2.0	0.3
Other Average Days	0.7	1.6	1.7	1.6	(0.1)
Total Average Days Stay	1.6	1.6	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	384	402	4,090	4,280	190
Medi-Cal Admissions	342	282	2,953	3,141	188
Other Admissions	428	296	3,329	3,426	97
Total Admissions	1,154	980	10,372	10,847	475
Medicare Patient Days	1,417	1,595	16,467	16,210	(257)
Medi-Cal Patient Days	1,081	984	11,871	12,122	251
Other Patient Days	950	669	10,287	8,217	(2,070)
Total Patient Days of Care	3,448	3,248	38,625	36,549	(2,076)
Average Daily Census	111.2	104.8	115.3	109.1	(6.2)
Medicare Average Length of Stay	3.7	3.9	4.0	3.8	(0.2)
Medi-Cal AverageLength of Stay	3.1	3.2	3.5	3.4	(0.1)
Other Average Length of Stay	2.2	1.8	2.5	1.9	(0.6)
Total Average Length of Stay	3.0	3.0	3.3	3.0	(0.3)
Deaths	29	23	295	287	(8)
Total Patient Days	3,622	3,422	40,608	38,628	(1,980)
Medi-Cal Administrative Days	342	0	398	0	(398)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	342	0	398	0	(398)
Percent Non-Acute	9.44%	0.00%	0.98%	0.00%	-0.98%

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
PATIENT DAYS BY LOCATION					
Level I	271	259	2,749	2,769	20
Heart Center	323	321	3,577	3,524	(53)
Monitored Beds	563	579	6,740	6,362	(378)
Single Room Maternity/Obstetrics	288	284	3,243	3,719	476
Med/Surg - Cardiovascular	808	906	9,213	9,627	414
Med/Surg - Oncology	260	221	3,054	2,932	(122)
Med/Surg - Rehab	485	486	5,042	5,153	111
Pediatrics	128	132	1,433	1,317	(116)
Nursery	174	174	1,983	2,079	96
Neonatal Intensive Care	102	60	1,161	1,146	(15)
PERCENTAGE OF OCCUPANCY					
Level I	67.25%	64.27%	62.93%	63.39%	
Heart Center	69.46%	69.03%	70.97%	69.92%	
Monitored Beds	67.26%	69.18%	74.29%	70.13%	
Single Room Maternity/Obstetrics	25.11%	24.76%	26.09%	29.91%	
Med/Surg - Cardiovascular	57.92%	64.95%	60.93%	63.67%	
Med/Surg - Oncology	64.52%	54.84%	69.92%	67.12%	
Med/Surg - Rehab	60.17%	60.30%	57.72%	58.99%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	22.94%	23.66%	23.69%	21.78%	
Nursery	34.02%	34.02%	17.88%	18.75%	
Neonatal Intensive Care	29.91%	17.60%	31.41%	31.01%	

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	131	100	1,167	1,282	115
C-Section deliveries	34	34	353	413	60
Percent of C-section deliveries	25.95%	34.00%	30.25%	32.22%	1.97%
OPERATING ROOM					
In-Patient Operating Minutes	17,226	16,617	178,783	209,275	30,492
Out-Patient Operating Minutes	31,447	41,195	329,299	394,156	64,857
Total	48,673	57,812	508,082	603,431	95,349
Open Heart Surgeries	13	12	126	130	4
In-Patient Cases	124	107	1,254	1,362	108
Out-Patient Cases	308	375	3,261	3,698	437
EMERGENCY ROOM					
Immediate Life Saving	35	57	407	411	4
High Risk	941	932	8,614	9,617	1,003
More Than One Resource	2,986	2,866	30,913	30,718	(195)
One Resource	2,181	1,924	21,067	19,705	(1,362)
No Resources	128	58	971	766	(205)
Total	6,271	5,837	61,972	61,217	(755)

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	12,896	11,718	141,851	136,118	-5,733
Out-patient requisitions	11,218	11,577	116,256	120,436	4,180
Emergency room requisitions	574	455	7,607	5,923	-1,684
Interdepartmental requisitions	6,756	6,841	72,805	75,791	2,986
Total requisitions	31,444	30,591	338,519	338,268	-251
LABORATORY					
In-patient procedures	35,359	37,519	397,671	394,987	-2,684
Out-patient procedures	43,356	48,979	336,246	499,862	163,616
Emergency room procedures	13,227	12,373	141,581	137,186	-4,395
Total patient procedures	91,942	98,871	875,498	1,032,035	156,537
BLOOD BANK					
Units processed	242	325	3,078	3,102	24
ELECTROCARDIOLOGY					
In-patient procedures	1,233	1,144	12,221	12,489	268
Out-patient procedures	436	549	4,354	5,026	672
Emergency room procedures	1,437	1,341	13,845	14,298	453
Total procedures	3,106	3,034	30,420	31,813	1,393
CATH LAB					
In-patient procedures	169	155	1,393	1,492	99
Out-patient procedures	132	152	1,365	1,379	14
Emergency room procedures	0	0	1	2	1
Total procedures	301	307	2,759	2,873	114
ECHO-CARDIOLOGY					
In-patient studies	408	423	4,215	4,387	172
Out-patient studies	286	269	3,110	3,711	601
Emergency room studies	4	3	13	19	6
Total studies	698	695	7,338	8,117	779
NEURODIAGNOSTIC					
In-patient procedures	136	140	1,397	1,515	118
Out-patient procedures	16	26	190	280	90
Emergency room procedures	0	0	0	1	1
Total procedures	152	166	1,587	1,796	209

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	1	1
Out-patient procedures	285	302	2,772	3,172	400
Emergency room procedures	0	0	0	0	0
Total procedures	285	302	2,772	3,173	401
RADIOLOGY					
In-patient procedures	1,357	1,237	14,384	14,270	-114
Out-patient procedures	440	473	4,497	4,935	438
Emergency room procedures	1,650	1,631	16,667	17,162	495
Total patient procedures	3,447	3,341	35,548	36,367	819
MAGNETIC RESONANCE IMAGING					
In-patient procedures	172	190	1,634	1,991	357
Out-patient procedures	94	133	1,201	1,332	131
Emergency room procedures	5	9	66	68	2
Total procedures	271	332	2,901	3,391	490
MAMMOGRAPHY CENTER					
In-patient procedures	4,056	3,728	45,754	42,346	-3,408
Out-patient procedures	4,048	3,714	45,311	42,196	-3,115
Emergency room procedures	1	2	10	12	2
Total procedures	8,105	7,444	91,075	84,554	-6,521
NUCLEAR MEDICINE					
In-patient procedures	14	14	213	166	-47
Out-patient procedures	142	144	1,284	1,481	197
Emergency room procedures	0	0	3	3	0
Total procedures	156	158	1,500	1,650	150
PHARMACY					
In-patient prescriptions	81,066	81,721	918,507	883,298	-35,209
Out-patient prescriptions	16,668	19,199	175,394	189,096	13,702
Emergency room prescriptions	10,970	10,517	104,935	109,022	4,087
Total prescriptions	108,704	111,437	1,198,836	1,181,416	-17,420
RESPIRATORY THERAPY					
In-patient treatments	14,914	12,676	176,487	161,944	-14,543
Out-patient treatments	751	921	12,052	10,280	-1,772
Emergency room treatments	530	516	5,609	5,786	177
Total patient treatments	16,195	14,113	194,148	178,010	-16,138
PHYSICAL THERAPY					
In-patient treatments	2,562	2,082	27,524	25,073	-2,451
Out-patient treatments	227	511	2,827	3,369	542
Emergency room treatments	0	0	0	0	0
Total treatments	2,789	2,593	30,351	28,442	-1,909

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,697	1,548	15,783	16,144	361
Out-patient procedures	181	442	2,516	2,735	219
Emergency room procedures	0	0	0	0	0
Total procedures	1,878	1,990	18,299	18,879	580
SPEECH THERAPY					
In-patient treatments	527	542	5,515	5,868	353
Out-patient treatments	24	51	411	436	25
Emergency room treatments	0	0	0	0	0
Total treatments	551	593	5,926	6,304	378
CARDIAC REHABILITATION					
In-patient treatments	1	3	12	9	-3
Out-patient treatments	633	613	6,106	6,862	756
Emergency room treatments	0	0	3	4	1
Total treatments	634	616	6,121	6,875	754
CRITICAL DECISION UNIT					
Observation hours	315	277	3,443	2,819	-624
ENDOSCOPY					
In-patient procedures	79	103	859	896	37
Out-patient procedures	69	57	636	627	-9
Emergency room procedures	0	0	0	4	4
Total procedures	148	160	1,495	1,527	32
C.T. SCAN					
In-patient procedures	742	734	7,914	8,410	496
Out-patient procedures	414	536	3,927	5,479	1,552
Emergency room procedures	783	714	8,094	7,927	-167
Total procedures	1,939	1,984	19,935	21,816	1,881
DIETARY					
Routine patient diets	15,469	17,338	179,866	177,134	-2,732
Meals to personnel	41,827	42,377	326,999	392,916	65,917
Total diets and meals	57,296	59,715	506,865	570,050	63,185
LAUNDRY AND LINEN					
Total pounds laundered	103,119	104,448	1,070,124	1,097,614	27,490

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
May 31, 2025

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 68,397,575	$ 60,297,688	$ 637,562,134	$ 576,621,307
Other operating revenue	2,453,835	1,550,792	25,349,352	19,027,486
Total operating revenue	70,851,410	61,848,480	662,911,486	595,648,793
Total operating expenses	52,945,617	51,363,154	559,978,393	533,332,000
Total non-operating income	(4,212,810)	1,089,779	(20,073,256)	(17,109,649)
Operating and non-operating income	$ 13,692,983	$ 11,575,105	$ 82,859,838	$ 45,207,145

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
May 31, 2025

	Current year	Prior year
ASSETS:		
Current assets	$ 444,756,256	$ 377,530,810
Assets whose use is limited or restricted by board	174,789,535	165,265,988
Capital assets	264,278,215	247,099,774
Other assets	312,496,039	293,879,766
Deferred pension outflows	85,734,219	116,911,125
	$ 1,282,054,264	$ 1,200,687,463
LIABILITIES AND EQUITY:		
Current liabilities	96,959,313	94,534,600
Long term liabilities	19,123,773	20,749,833
Lease deferred inflows	(1,400,684)	2,078,231
Pension liability	90,863,576	118,792,064
Net assets	1,076,508,286	964,532,735
	$ 1,282,054,264	$ 1,200,687,463

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
May 31, 2025

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,883	1,723	19,396	19,556
Medi-Cal	902	995	11,537	11,500
Commercial insurance	521	613	6,066	6,336
Other patient	123	127	1,352	1,149
Total patient days	3,429	3,458	38,351	38,541
Gross revenue:				
Medicare	$ 144,760,373	$ 131,374,304	$ 1,438,660,072	$ 1,273,742,960
Medi-Cal	84,433,436	80,182,659	913,503,693	798,041,451
Commercial insurance	62,416,053	59,404,125	639,961,576	586,800,043
Other patient	11,182,303	11,414,263	121,455,311	100,252,829
Gross revenue	302,792,165	282,375,350	3,113,580,652	2,758,837,283
Deductions from revenue:				
Administrative adjustment	276,626	296,208	3,189,876	3,363,107
Charity care	789,864	837,087	7,077,228	7,060,986
Contractual adjustments:				
Medicare outpatient	51,410,990	44,794,743	484,559,147	403,370,428
Medicare inpatient	54,585,825	50,358,573	553,200,375	517,265,833
Medi-Cal traditional outpatient	1,968,019	1,774,123	19,368,699	26,671,416
Medi-Cal traditional inpatient	2,840,137	1,955,649	48,118,289	48,115,621
Medi-Cal managed care outpatient	41,040,982	38,948,544	442,792,251	359,048,213
Medi-Cal managed care inpatient	23,380,282	24,373,903	295,168,799	277,270,871
Commercial insurance outpatient	28,753,901	28,453,273	299,798,601	250,758,241
Commercial insurance inpatient	21,698,029	23,188,300	243,744,348	227,160,602
Uncollectible accounts expense	6,147,947	5,413,557	61,429,794	48,908,560
Other payors	1,501,988	1,683,704	17,571,111	13,222,097
Deductions from revenue	234,394,590	222,077,663	2,476,018,518	2,182,215,975
Net patient revenue	$ 68,397,575	$ 60,297,688	$ 637,562,134	$ 576,621,307
Gross billed charges by patient type:				
Inpatient	$ 135,390,526	$ 132,707,338	$ 1,457,387,088	$ 1,376,318,476
Outpatient	134,579,728	116,285,546	1,303,969,897	1,052,393,447
Emergency room	32,821,911	33,382,467	352,223,667	330,125,360
Total	$ 302,792,165	$ 282,375,350	$ 3,113,580,652	$ 2,758,837,283

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
May 31, 2025

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 68,397,575	$ 60,297,688	$ 637,562,134	$ 576,621,307
Other operating revenue	2,453,835	1,550,792	25,349,352	19,027,486
Total operating revenue	70,851,410	61,848,480	662,911,486	595,648,793
Operating expenses:				
Salaries and wages	19,239,361	17,647,464	197,840,739	184,304,112
Compensated absences	3,456,470	3,099,766	34,602,388	33,264,468
Employee benefits	7,122,207	8,514,340	88,527,363	92,969,686
Supplies, food, and linen	10,707,671	8,375,261	99,983,900	82,773,474
Purchased department functions	3,936,286	3,793,512	43,105,794	40,554,904
Medical fees	2,405,979	3,052,297	27,375,298	27,620,900
Other fees	1,517,532	1,887,945	20,156,289	25,107,752
Depreciation	2,600,305	2,566,667	28,493,368	26,956,452
All other expense	1,959,806	2,425,902	19,893,254	19,780,252
Total operating expenses	52,945,617	51,363,154	559,978,393	533,332,000
Income from operations	17,905,793	10,485,326	102,933,093	62,316,793
Non-operating income:				
Donations	6,410	33,559	5,614,532	2,694,093
Property taxes	476,714	333,333	5,243,858	3,666,667
Investment income	(735,742)	3,925,646	20,074,181	24,798,415
Taxes and licenses	0	0	0	0
Income from subsidiaries	(3,960,192)	(3,202,759)	(51,005,827)	(48,268,824)
Total non-operating income	(4,212,810)	1,089,779	(20,073,256)	(17,109,649)
Operating and non-operating income	13,692,983	11,575,105	82,859,838	45,207,145
Net assets to begin	1,062,815,302	952,957,630	993,648,448	919,325,590
Net assets to end	$ 1,076,508,286	$ 964,532,735	$ 1,076,508,286	$ 964,532,735
Net income excluding non-recurring items	$ 13,692,983	$ 11,575,105	$ 82,859,838	$ 45,207,145
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	$ 13,692,983	$ 11,575,105	$ 82,859,838	$ 45,207,145

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
May 31, 2025

	Month of May,		Eleven months ended May 31,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (193,395)	$ (189,630)	$ (2,220,169)	$ (2,197,669)
Neurological Clinic	(61,853)	(43,074)	(813,747)	(708,644)
Palliative Care Clinic	(95,500)	(58,267)	(1,069,393)	(980,060)
Surgery Clinic	(199,146)	(166,297)	(1,847,094)	(1,971,042)
Infectious Disease Clinic	(43,768)	(37,480)	(516,331)	(418,250)
Endocrinology Clinic	(157,875)	(201,720)	(2,472,415)	(2,472,832)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(604,552)	(564,394)	(6,576,850)	(6,222,370)
OB/GYN Clinic	(344,578)	(432,205)	(4,483,715)	(4,490,812)
PrimeCare Medical Group	(886,328)	(724,596)	(9,026,201)	(9,145,402)
Oncology Clinic	(404,197)	(338,599)	(4,544,438)	(3,836,748)
Cardiac Surgery	(283,335)	(327,655)	(3,793,603)	(3,525,522)
Sleep Center	(78,626)	(86,964)	(926,349)	(655,042)
Rheumatology	(62,502)	(95,274)	(800,583)	(805,183)
Precision Ortho MDs	(431,260)	(431,095)	(5,128,842)	(5,143,321)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(70,322)	(58,576)	(822,728)	(532,986)
Vaccine Clinic	0	0	0	16
Dermatology	(14,129)	(30,810)	(405,019)	(426,950)
Hospitalists	0	0	0	0
Behavioral Health	(32,324)	(52,172)	(411,604)	(549,837)
Pediatric Diabetes	(26,659)	(33,132)	(416,442)	(494,812)
Neurosurgery	(119,476)	(102,174)	(1,374,573)	(628,323)
Multi-Specialty-RR	30,721	9,011	162,473	39,826
Radiology	(321,163)	348,185	(3,538,244)	(2,721,260)
Salinas Family Practice	(93,124)	(93,327)	(1,201,822)	(1,383,145)
Urology	(91,998)	(165,471)	(1,826,602)	(1,825,162)
Total SVHC	(4,585,389)	(3,875,716)	(54,054,291)	(51,095,530)
Doctors on Duty	493,464	376,185	588,589	647,320
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	139,336	184,647	1,666,349	1,504,408
Coastal	(50,778)	22,471	(45,058)	127,785
Apex	0	0	0	0
21st Century Oncology	(8,844)	11,209	255,877	68,074
Monterey Bay Endoscopy Center	52,019	78,444	582,707	479,119
Total	$ (3,960,192)	$ (3,202,759)	$ (51,005,827)	$ (48,268,824)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
May 31, 2025

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 300,599,442	$ 257,043,405
Patient accounts receivable, net of estimated uncollectibles of $66,130,052	123,968,644	97,728,869
Supplies inventory at cost	8,335,908	7,914,669
Current portion of lease receivable	311,567	1,680,204
Other current assets	11,540,695	13,163,664
Total current assets	444,756,256	377,530,810
Assets whose use is limited or restricted by board	174,789,535	165,265,988
Capital assets:		
Land and construction in process	56,467,596	48,472,433
Other capital assets, net of depreciation	207,810,619	198,627,341
Total capital assets	264,278,215	247,099,774
Other assets:		
Right of use assets, net of amortization	7,850,585	6,575,991
Long term lease receivable	(1,679,550)	436,190
Subscription assets, net of amortization	8,103,174	10,141,178
Investment in Securities	270,329,869	251,876,936
Investment in SVHC	2,134,542	14,992,552
Investment in Coastal	1,707,312	1,786,955
Investment in other affiliates	21,680,078	11,610,549
Net pension asset	2,370,029	(3,540,585)
Total other assets	312,496,039	293,879,766
Deferred pension outflows	85,734,219	116,911,125
	$ 1,282,054,264	$ 1,200,687,463
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	$ 64,811,108	$ 62,037,472
Due to third party payers	4,258,530	4,835,088
Current portion of self-insurance liability	22,415,848	20,917,510
Current subscription liability	2,569,847	4,271,751
Current portion of lease liability	2,903,980	2,472,779
Total current liabilities	96,959,313	94,534,600
Long term portion of workers comp liability	11,272,465	12,843,815
Long term portion of lease liability	4,961,843	4,292,243
Long term subscription liability	2,889,465	3,613,775
Total liabilities	116,083,086	115,284,433
Lease deferred inflows	(1,400,684)	2,078,231
Pension liability	90,863,576	118,792,064
Net assets:		
Invested in capital assets, net of related debt	264,278,215	247,099,774
Unrestricted	812,230,071	717,432,961
Total net assets	1,076,508,286	964,532,735
	$ 1,282,054,264	$ 1,200,687,463

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
May 31, 2025

	Month of May,			Eleven months ended May 31,			
	Actual	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:							
Gross billed charges	$ 302,792,165	$ 37,142,200	13.98%	$ 3,113,580,652	$ 2,824,861,903	288,718,749	10.22%
Dedutions from revenue	234,394,590	21,547,706	10.12%	2,476,018,518	2,263,148,255	212,870,263	9.41%
Net patient revenue	68,397,575	15,594,494	29.53%	637,562,134	561,713,647	75,848,487	13.50%
Other operating revenue	2,453,835	1,001,166	68.92%	25,349,352	15,979,359	9,369,993	58.64%
Total operating revenue	**70,851,410**	**16,595,660**	**30.59%**	**662,911,486**	**577,693,006**	**85,218,480**	**14.75%**
Operating expenses:							
Salaries and wages	19,239,361	728,619	3.94%	197,840,739	191,679,420	6,161,319	3.21%
Compensated absences	3,456,470	605,237	21.23%	34,602,388	34,344,713	257,675	0.75%
Employee benefits	7,122,207	(1,505,913)	-17.45%	88,527,363	88,969,932	(442,569)	-0.50%
Supplies, food, and linen	10,707,671	3,405,395	46.63%	99,983,900	78,911,056	21,072,844	26.70%
Purchased department functions	3,936,286	111,002	2.90%	43,105,794	42,078,111	1,027,683	2.44%
Medical fees	2,405,979	(79,658)	-3.20%	27,375,298	27,342,010	33,288	0.12%
Other fees	1,517,532	(238,896)	-13.60%	20,156,289	19,116,343	1,039,946	5.44%
Depreciation	2,600,305	4,624	0.18%	28,493,368	26,924,582	1,568,786	5.83%
All other expense	1,959,806	(25,740)	-1.30%	19,893,254	21,699,122	(1,805,868)	-8.32%
Total operating expenses	**52,945,617**	**3,004,670**	**6.02%**	**559,978,393**	**531,065,288**	**28,913,105**	**5.44%**
Income from operations	**17,905,793**	**13,590,989**	**314.99%**	**102,933,093**	**46,627,718**	**56,305,375**	**120.76%**
Non-operating income:							
Donations	6,410	(201,923)	-96.92%	5,614,532	2,291,667	3,322,865	145.00%
Property taxes	476,714	(0)	0.00%	5,243,858	5,243,858	0	0.00%
Investment income	(735,742)	(2,626,915)	-138.90%	20,074,181	20,802,905	(728,723)	-3.50%
Income from subsidiaries	(3,960,192)	1,163,030	-22.70%	(51,005,827)	(56,355,443)	5,349,616	-9.49%
Total non-operating income	**(4,212,810)**	**(1,665,808)**	**65.40%**	**(20,073,256)**	**(28,017,014)**	**7,943,758**	**-28.35%**
Operating and non-operating income	**$ 13,692,983**	**$ 11,925,181**	**674.58%**	**$ 82,859,837**	**$ 18,610,704**	**64,249,134**	**345.23%**

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	53	29	390	385	(5)
Other Admissions	58	76	836	907	71
Total Admissions	111	105	1,226	1,292	66
Medi-Cal Patient Days	53	46	589	703	114
Other Patient Days	121	128	1,394	1,376	(18)
Total Patient Days of Care	174	174	1,983	2,079	96
Average Daily Census	5.6	5.6	5.9	6.2	0.3
Medi-Cal Average Days	1.7	1.6	1.7	2.0	0.3
Other Average Days	0.7	1.6	1.7	1.6	(0.1)
Total Average Days Stay	1.6	1.6	1.7	1.7	0.0
ADULTS & PEDIATRICS					
Medicare Admissions	384	402	4,090	4,280	190
Medi-Cal Admissions	342	282	2,953	3,141	188
Other Admissions	428	296	3,329	3,426	97
Total Admissions	1,154	980	10,372	10,847	475
Medicare Patient Days	1,417	1,595	16,467	16,210	(257)
Medi-Cal Patient Days	1,081	984	11,871	12,122	251
Other Patient Days	950	669	10,287	8,217	(2,070)
Total Patient Days of Care	3,448	3,248	38,625	36,549	(2,076)
Average Daily Census	111.2	104.8	115.3	109.1	(6.2)
Medicare Average Length of Stay	3.7	3.9	4.0	3.8	(0.2)
Medi-Cal AverageLength of Stay	3.1	3.2	3.5	3.4	(0.1)
Other Average Length of Stay	2.2	1.8	2.5	1.9	(0.6)
Total Average Length of Stay	3.0	3.0	3.3	3.0	(0.3)
Deaths	29	23	295	287	(8)
Total Patient Days	3,622	3,422	40,608	38,628	(1,980)
Medi-Cal Administrative Days	342	0	398	0	(398)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	342	0	398	0	(398)
Percent Non-Acute	9.44%	0.00%	0.98%	0.00%	-0.98%

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
PATIENT DAYS BY LOCATION					
Level I	271	259	2,749	2,769	20
Heart Center	323	321	3,577	3,524	(53)
Monitored Beds	563	579	6,740	6,362	(378)
Single Room Maternity/Obstetrics	288	284	3,243	3,719	476
Med/Surg - Cardiovascular	808	906	9,213	9,627	414
Med/Surg - Oncology	260	221	3,054	2,932	(122)
Med/Surg - Rehab	485	486	5,042	5,153	111
Pediatrics	128	132	1,433	1,317	(116)
Nursery	174	174	1,983	2,079	96
Neonatal Intensive Care	102	60	1,161	1,146	(15)
PERCENTAGE OF OCCUPANCY					
Level I	67.25%	64.27%	62.93%	63.39%	
Heart Center	69.46%	69.03%	70.97%	69.92%	
Monitored Beds	67.26%	69.18%	74.29%	70.13%	
Single Room Maternity/Obstetrics	25.11%	24.76%	26.09%	29.91%	
Med/Surg - Cardiovascular	57.92%	64.95%	60.93%	63.67%	
Med/Surg - Oncology	64.52%	54.84%	69.92%	67.12%	
Med/Surg - Rehab	60.17%	60.30%	57.72%	58.99%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	22.94%	23.66%	23.69%	21.78%	
Nursery	34.02%	34.02%	17.88%	18.75%	
Neonatal Intensive Care	29.91%	17.60%	31.41%	31.01%	

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
DELIVERY ROOM					
Total deliveries	131	100	1,167	1,282	115
C-Section deliveries	34	34	353	413	60
Percent of C-section deliveries	25.95%	34.00%	30.25%	32.22%	1.97%
OPERATING ROOM					
In-Patient Operating Minutes	17,226	16,617	178,783	209,275	30,492
Out-Patient Operating Minutes	31,447	41,195	329,299	394,156	64,857
Total	48,673	57,812	508,082	603,431	95,349
Open Heart Surgeries	13	12	126	130	4
In-Patient Cases	124	107	1,254	1,362	108
Out-Patient Cases	308	375	3,261	3,698	437
EMERGENCY ROOM					
Immediate Life Saving	35	57	407	411	4
High Risk	941	932	8,614	9,617	1,003
More Than One Resource	2,986	2,866	30,913	30,718	(195)
One Resource	2,181	1,924	21,067	19,705	(1,362)
No Resources	128	58	971	766	(205)
Total	6,271	5,837	61,972	61,217	(755)

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
CENTRAL SUPPLY					
In-patient requisitions	12,896	11,718	141,851	136,118	-5,733
Out-patient requisitions	11,218	11,577	116,256	120,436	4,180
Emergency room requisitions	574	455	7,607	5,923	-1,684
Interdepartmental requisitions	6,756	6,841	72,805	75,791	2,986
Total requisitions	31,444	30,591	338,519	338,268	-251
LABORATORY					
In-patient procedures	35,359	37,519	397,671	394,987	-2,684
Out-patient procedures	43,356	48,979	336,246	499,862	163,616
Emergency room procedures	13,227	12,373	141,581	137,186	-4,395
Total patient procedures	91,942	98,871	875,498	1,032,035	156,537
BLOOD BANK					
Units processed	242	325	3,078	3,102	24
ELECTROCARDIOLOGY					
In-patient procedures	1,233	1,144	12,221	12,489	268
Out-patient procedures	436	549	4,354	5,026	672
Emergency room procedures	1,437	1,341	13,845	14,298	453
Total procedures	3,106	3,034	30,420	31,813	1,393
CATH LAB					
In-patient procedures	169	155	1,393	1,492	99
Out-patient procedures	132	152	1,365	1,379	14
Emergency room procedures	0	0	1	2	1
Total procedures	301	307	2,759	2,873	114
ECHO-CARDIOLOGY					
In-patient studies	408	423	4,215	4,387	172
Out-patient studies	286	269	3,110	3,711	601
Emergency room studies	4	3	13	19	6
Total studies	698	695	7,338	8,117	779
NEURODIAGNOSTIC					
In-patient procedures	136	140	1,397	1,515	118
Out-patient procedures	16	26	190	280	90
Emergency room procedures	0	0	0	1	1
Total procedures	152	166	1,587	1,796	209

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	1	1
Out-patient procedures	285	302	2,772	3,172	400
Emergency room procedures	0	0	0	0	0
Total procedures	285	302	2,772	3,173	401
RADIOLOGY					
In-patient procedures	1,357	1,237	14,384	14,270	-114
Out-patient procedures	440	473	4,497	4,935	438
Emergency room procedures	1,650	1,631	16,667	17,162	495
Total patient procedures	3,447	3,341	35,548	36,367	819
MAGNETIC RESONANCE IMAGING					
In-patient procedures	172	190	1,634	1,991	357
Out-patient procedures	94	133	1,201	1,332	131
Emergency room procedures	5	9	66	68	2
Total procedures	271	332	2,901	3,391	490
MAMMOGRAPHY CENTER					
In-patient procedures	4,056	3,728	45,754	42,346	-3,408
Out-patient procedures	4,048	3,714	45,311	42,196	-3,115
Emergency room procedures	1	2	10	12	2
Total procedures	8,105	7,444	91,075	84,554	-6,521
NUCLEAR MEDICINE					
In-patient procedures	14	14	213	166	-47
Out-patient procedures	142	144	1,284	1,481	197
Emergency room procedures	0	0	3	3	0
Total procedures	156	158	1,500	1,650	150
PHARMACY					
In-patient prescriptions	81,066	81,721	918,507	883,298	-35,209
Out-patient prescriptions	16,668	19,199	175,394	189,096	13,702
Emergency room prescriptions	10,970	10,517	104,935	109,022	4,087
Total prescriptions	108,704	111,437	1,198,836	1,181,416	-17,420
RESPIRATORY THERAPY					
In-patient treatments	14,914	12,676	176,487	161,944	-14,543
Out-patient treatments	751	921	12,052	10,280	-1,772
Emergency room treatments	530	516	5,609	5,786	177
Total patient treatments	16,195	14,113	194,148	178,010	-16,138
PHYSICAL THERAPY					
In-patient treatments	2,562	2,082	27,524	25,073	-2,451
Out-patient treatments	227	511	2,827	3,369	542
Emergency room treatments	0	0	0	0	0
Total treatments	2,789	2,593	30,351	28,442	-1,909

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

	Month of May		Eleven months to date		
	2024	2025	2023-24	2024-25	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,697	1,548	15,783	16,144	361
Out-patient procedures	181	442	2,516	2,735	219
Emergency room procedures	0	0	0	0	0
Total procedures	1,878	1,990	18,299	18,879	580
SPEECH THERAPY					
In-patient treatments	527	542	5,515	5,868	353
Out-patient treatments	24	51	411	436	25
Emergency room treatments	0	0	0	0	0
Total treatments	551	593	5,926	6,304	378
CARDIAC REHABILITATION					
In-patient treatments	1	3	12	9	-3
Out-patient treatments	633	613	6,106	6,862	756
Emergency room treatments	0	0	3	4	1
Total treatments	634	616	6,121	6,875	754
CRITICAL DECISION UNIT					
Observation hours	315	277	3,443	2,819	-624
ENDOSCOPY					
In-patient procedures	79	103	859	896	37
Out-patient procedures	69	57	636	627	-9
Emergency room procedures	0	0	0	4	4
Total procedures	148	160	1,495	1,527	32
C.T. SCAN					
In-patient procedures	742	734	7,914	8,410	496
Out-patient procedures	414	536	3,927	5,479	1,552
Emergency room procedures	783	714	8,094	7,927	-167
Total procedures	1,939	1,984	19,935	21,816	1,881
DIETARY					
Routine patient diets	15,469	17,338	179,866	177,134	-2,732
Meals to personnel	41,827	42,377	326,999	392,916	65,917
Total diets and meals	57,296	59,715	506,865	570,050	63,185
LAUNDRY AND LINEN					
Total pounds laundered	103,119	104,448	1,070,124	1,097,614	27,490

Board Paper: Finance Committee

Agenda Item:	Consider Recommendation for Board Approval of Purchase of The Stryker Mako 4 Robotic-Arm Assisted Surgery System
Executive Sponsor:	Alysha Hyland, CAO Aisha Huebner RN, Perioperative Services Director
Date:	June 16th, 2025

Executive Summary

Our facility is nearing the end of a successful rental agreement for the Stryker Mako 3 Robotic Arm System, which has been pivotal in supporting orthopedic surgeries. This timing presents a critical opportunity to transition to the Mako 4, the next-generation system that offers superior capabilities and long-term benefits.

Background/Situation

Technology Obsolescence of Mako 3
Stryker has confirmed that no further software or technological advancements will be made available for the Mako 3. All innovation moving forward—including key clinical applications and system enhancements—will be developed exclusively for the Mako 4. This makes the Mako 3 increasingly obsolete for our evolving clinical needs.

Advanced Clinical Capabilities of Mako 4
The Mako 4 represents a substantial upgrade with features that align with our goals of improving patient outcomes and surgical precision:

- Broader Surgical Applications: Supports total hip, partial and total knee, and spine surgeries.
- Q Guidance System: Improves intraoperative navigation across specialties.
- Improved Imaging: FP8000 camera enhances visibility and speed, vital for spine and joint procedures.
- Enhanced Tools: The MICS 3 handpiece builds on trusted legacy tools for better surgical control.
- Upcoming Software (Advanced Primary and Revision Knee): Dr. Bonano is particularly enthusiastic about integrating this into his practice to expand his surgical offerings.

Financial Incentive: Limited-Time Equity Offer
We currently have $242,400 in accumulated equity from our Mako 3 rental. Stryker is offering to apply this full amount toward the purchase of the Mako 4—a one-time opportunity.
This effectively reduces the total acquisition cost and significantly increases the return on investment.

Long-Term Cost Efficiency

- End of Recurring Rental Costs: Eliminating rental fees leads to long-term savings.
- Reduced Downtime & Increased Volume: Mako 4's faster, more efficient procedures enable greater surgical throughput.
- Faster Patient Recovery: Cases using Mako technology report shorter recovery times (e.g., 4–6 weeks vs. 3 months), which enhances patient satisfaction and supports value-based care initiatives.

Timeline/Review Process to Date:

- **June 2024:** Rental Agreement for the Mako 3 established.
- **March 2025:** Stryker presents Mako Buy-Out Proposal to SVH.
- **April – May 2025:** Contract review, negotiations, and decision to proceed.

- **May – June 2025:** Final contract negotiations completed; Axiom submission and Board preparation underway.
- **June 2025:** Requesting Board approval for acquisition of the Mako 4.

Strategic Plan Alignment:

- Investing in the Mako 4 demonstrates our commitment to clinical excellence, technological leadership, and patient-centered care.
- Enhances our ability to attract top talent and referrals in orthopedics by equipping our team with the most advanced tools available.
- Positions our facility competitively in a rapidly evolving surgical market.

Pillar/Goal Alignment:

X Service X People X Quality ☐ Finance X Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications:

Key Contract Terms	Vendor: Stryker
1. Proposed effective date	July 15, 2025
2. Term of agreement	3 Year • One-Time Mako 4 Purchase w/ 1-year initial warranty period Following Initial Warranty Period • Service Term Year 1 - $120,000 Annual Service Fee • Service Term Year 2 - $120,000 Annual Service Fee
3. Renewal terms	Notify 30 days prior to contract expiration
4. Termination provision(s)	Termination w/ 30-day prior notice.
5. Payment Terms	NET 45 Days
6. Annual cost	$549,090.50 (Capital Purchase, Including tax) $120,000 (Yr. 1) (Service) $120,000 (Yr. 2) (Service)
7. Cost over life of agreement	$549,090.50 (Capital Purchase, Including tax) $240,000 (2-Year Service) $789,090.50 (Total)
8. Budgeted (indicate y/n)	N

Recommendation

We respectfully recommend the Board of Directors approve the purchase of the Stryker Mako 4 at a total cost of $789,090.50. This capital acquisition includes the base equipment price of $549,090.50, which comes with a one-year warranty. Additionally, the agreement encompasses two years of service coverage following initial warranty, valued at $240,000, for the duration of the service term.

Attachments

(1) FIRST AMENDMENT TO EQUIPMENT RENTAL AGREEMENT

(2) Sole Source Justification Form Mako 6.16.25

FIRST AMENDMENT TO EQUIPMENT RENTAL AGREEMENT

This First Amendment to Equipment Rental Agreement ("***Amendment***") by and between Salinas Valley Memorial Healthcare System ("***Customer***") and MAKO Surgical Corp. ("**Stryker Mako**"), and Stryker Sales, LLC (both subsidiaries of Stryker Corporation and collectively referred to herein as "**Stryker**"), is made effective as of the date executed by last party below.

Recitals

WHEREAS, Customer and Stryker Mako entered into that certain Equipment Rental Agreement dated June 25, 2024, (the "***Agreement***"), whereby Customer gained access to a RIO robotic arm interactive orthopedic system (the "***Original System***");

WHEREAS, Customer now seeks to purchase from Stryker Mako a new RIO robotic arm interactive orthopedic systems (the "***New System***") pursuant to the terms contained herein and in the Agreement.

Agreement

NOW, THEREFORE, in consideration of the mutual covenants, agreements, representations and warranties contained in the Agreement and this Amendment, the parties hereby agree as follows:

1. Purchase of New System. For good and valuable consideration, the sufficiency and adequacy of which is hereby mutually acknowledged, Stryker Mako agrees to sell and Customer agrees to purchase the New System as set forth in the below table, at the price set forth below (the "**Purchase Price**") and upon the terms and conditions set forth herein and contained in the Agreement. Customer acknowledges that Customer shall be responsible for payment of all applicable federal, state, and local taxes in connection with the purchase of the New System unless a tax exemption, direct pay, or resale certificate is provided to Stryker Mako.

Mako System with Partial Knee and Total Knee Applications				
QTY.	**PART #**	**EQUIPMENT**	**List Price**	**Purchase Price**
1	**353535**	**Stryker Robotic Arm System (Mako™/RIO®)** Includes:		
1	229999	Mako 4 Robotic Arm		
1	8900-100-000	Stryker Q Guidance System		
1	700002719223	Mako 4 Accessory Kit		
1	700003243335	Mako 4 with JR User Guides		
2	700002606000	Mako MICS 3 Power Tray		
2	210480	MICS 3 Straight Sagittal Saw Attachment		
2	210490	MICS 3 Angled Sagittal Saw Attachment		
2	700002606001	Mako Standard Tray Lid		
2	700002606011	Mako Standard Double Tier Tray Case		
2	700002606012	Mako Knee Tray Top Insert	$ 1,355,000.00	$ 745,000.00
2	700002606013	Mako Knee Tray Bottom Insert		
2	700002606014	Mako Knee Tray Kit Laminate		
1	200681	MAKOplasty® CT Scan Kit		
1	**313131**	**Mako™ Partial Knee Application** Includes:		
1	100020	RESTORIS® Partial Knee Software License		
1	**212121**	**Mako™ Total Knee Application** Includes:		
1	212184	Mako™ Total Knee Software License		
1	212249	Surgeon & Surgical Staff Training, Total Knee		
1	Multiple	*Instrument Purchase Conversion		
1	203996	Freight/Installation Fee		
		Limited Time Discount		$ (242,400.00)
		TOTAL		**$ 502,600**

*Instrument Purchase Conversion. The Parties hereby agree that the instrumentation accessed with the Original System (the "**Original System Instruments**"), as detailed in the table below, shall remain at Customer's facility to be utilized with the Equipment detailed above. Upon completion of the payment of the Purchase Price of the New System as outlined in section 1, ownership and title for the Original System Instruments shall pass to Customer.

Original System Instruments		
QTY.	PART #	EQUIPMENT
2	151200	Mako Array Tray
2	151150	Stryker Leg Positioner Tray Kit
2	112230	Pelvic Array

The Parties acknowledge and agree that while Customer, via this Amendment, is purchasing that number of Mako MICS 3 Power Tray(s) Part Number 700002606000, the Mako MICS 3 Power Tray(s) remains in limited market release and is not yet generally commercially available. Upon the conclusion of Stryker Mako's limited market release, Stryker Mako shall notify Customer of the Mako MICS 3 Power Tray(s) general commercial availability and Customer shall receive the items detailed in the table below, within a commercially reasonable time at no additional cost. Upon Customer's receipt of the Mako MICS 3 Power Tray(s), Customer shall promptly return the MICS 2 handpiece(s) accessed with the Original System to Stryker Mako.

QTY.	PART #	EQUIPMENT
2	700002606000	MICS 3 Power Tray Kit

(a) New System Payment Terms. Customer elects to purchase the New System from Stryker Mako by (i) paying to Stryker Mako the purchase price as set forth in the table above or (ii) entering into a lease or rental agreement with a financing company for purchase of the Equipment at the purchase price set forth the table above. In either case, full payment of the purchase price shall be due to Stryker Mako NET 45 days from date of applicable invoice and Customer shall be responsible for ensuring full payment is made to Stryker Mako. In accordance with the terms of the Agreement, Customer shall be responsible for ensuring all remaining payments of the Initial Term (as defined in the Agreement) shall be made to Stryker Mako.

(b) Software Application Upgrade. The Parties acknowledge and agree that subject to the terms and conditions of this Agreement, Customer's purchase hereunder includes a one-time right to upgrade (the "Upgrade Right") one of Customer's Mako software applications to a new upgraded software application (the "New Application") in the event Stryker Mako makes a new software application generally available for sale within the next twelve (12) months. In the event Stryker Mako makes multiple New Applications available in the next twelve (12) months, the parties acknowledge and agree that the Upgrade Right applies only to the first New Application that Stryker Mako makes generally commercially available. Customer must exercise the Upgrade Right within ninety (90) days of notice from Stryker Mako that a New Application is generally available for sale. Notwithstanding anything contained in the foregoing, Customer acknowledges that nothing contained in this Agreement shall create any obligation on Stryker with respect to developing or releasing any New Application whether during the next twelve (12) months or otherwise and Stryker Mako makes no guarantees or promises with respect to the development or release of any New Application. In the event Stryker Mako makes a New Application available and Customer exercises its Upgrade Right, all references in the Agreement to "Equipment" or "Software" are hereby modified to incorporate and include the New Application such that all terms and conditions of the Agreement shall apply to the New Application, unless Stryker Mako notifies Customer of any required changes to the Software Schedule resulting from the New Application. In the event the Customer validly exercises the Upgrade Right, Stryker shall promptly deliver the New Application to Customer and install the New Application on Customer's Mako Equipment purchased pursuant to this Agreement, and Customer shall immediately cease further use of any superseded software application.

(c) New System Terms and Conditions. The parties agree that, unless expressly stated otherwise in this Amendment, the New System shall be sold and purchased on and subject to the same terms and conditions related to access and use as the Original System as set forth in the Agreement. All references in the Agreement to "Equipment" are modified to incorporate and include the New System such that all terms and conditions of the Agreement shall apply to the Equipment and the New System.

(d) Warranty and Service Agreement. The Parties agree that the terms of the Warranty and Service Agreement set forth in Schedule D of the Agreement is hereby deleted in its entirety and replaced with **Exhibit A**.

2. Expiration Date. Stryker Mako shall honor the terms of this Amendment, provided Customer executes this Amendment on or before July 15, 2025. Stryker Mako may, in its sole discretion, elect to install the New System following such date, but not later than ten (10) days after the Effective Date.

3. Effect; Conflict. Except as expressly provided herein, all terms and conditions set forth in the Agreement to which this Amendment applies shall remain in full force and effect. In the event of a conflict between this Amendment and the provisions of the Agreement, this Amendment shall be controlling with respect to the subject matter hereof.

4. Counterparts; Electronic Transmission. This Amendment may be executed in counterparts, each of which are deemed to be original, but both of which together constitute one and the same instrument. Copies of signatures sent by facsimile transmission or any other electronic means are deemed to be originals for purposes of execution and proof of this Amendment.

5. Defined Terms. Unless otherwise defined herein, all capitalized terms used herein shall have the same meaning as described in the Agreement.

*****

IN WITNESS WHEREOF, the parties have duly executed this Amendment to be effective as of the day and year signed by the last party below.

CUSTOMER	**STRYKER, ON BEHALF OF THE LEGAL ENTITIES LISTED HEREIN**
By: _____	By: _____
Name:_____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

EXHIBIT A
WARRANTY AND ADVANTAGE SERVICE TERMS

This Exhibit A (also referred to as these "**Warranty and Service Terms**") is hereby incorporated into the Agreement by and between Stryker Mako and Customer and relates to the warranty and maintenance of the Equipment and is otherwise subject to the terms and conditions contained elsewhere in this Agreement. In the event of a conflict between the other terms and conditions of the Agreement and of this Exhibit A, the terms and conditions of this Schedule D shall govern. Capitalized terms used herein and not defined shall have the meanings ascribed to them elsewhere in the Agreement.

1. TERM

1.1 Warranty. Stryker Mako warrants that the Equipment will be free from defects in material and workmanship (the "**Warranty**") for a period of one (1) year beginning upon delivery of the Equipment by Stryker Mako to a common carrier (the "**Initial Warranty Period**"). Stryker Mako's obligation under this Warranty shall be limited to repairing or replacing (at Stryker Mako's option, inclusive of parts and labor) any part of the Equipment which, if properly installed, used and maintained, proves defective in material or workmanship within the Initial Warranty Period, provided notice of any such defect and satisfactory proof thereof is promptly given by Customer to Stryker Mako. This Warranty does not apply to products normally consumed in operation of the Equipment or which have a normal life inherently shorter than the Initial Warranty Period.

1.2 Service. Stryker Mako will provide the Services set forth in these Warranty and Service Terms for an additional period of two (2) consecutive years beginning on the expiration of the Initial Warranty Period on the originally installed Equipment (the "**Service Period**").

2. PRICE AND PAYMENT TERMS

2.1 Warranty. There is no charge for the Services (as defined below) contained in these Warranty and Service Terms during the Initial Warranty Period.

2.2 Service. Customer shall pay to Stryker Mako an annual service fee of $120,000 the "**Annual Service Fee**") each year during the Service Period for the Services contained in these Warranty and Service Terms. At least thirty (30) days prior to the end of each year of the Service Period (excluding the last year of the Service Period), Customer must issue a Purchase Order to Stryker Mako in an amount equal to the Annual Service Fee. Stryker Mako shall invoice and Customer shall pay the Annual Service Fee within forty-five (45) days of the date of the invoice. Further, the Annual Service Fee may be increased each year on the anniversary of the first day of the Service Period by an amount not to exceed the greater of three percent (3%) or the percentage change in the Medical CPI during the immediately preceding twelve (12) month period.

2.3 Price. The price for the Services includes all parts, labor, and travel expenses, except those listed in Section 4 of these Warranty and Service Terms or set forth elsewhere herein.

3. DUTIES OF STRYKER MAKO. During the Service Term, Stryker Mako will, pursuant to these Warranty and Service Terms, provide the following services to Customer (referred to collectively as the "**Services**"):

3.1 Covered Services. Stryker Mako agrees to provide installation and maintenance, including, without limitation, Preventative Maintenance, repair or replacement of the Equipment and Software, including Equipment that is lost or damaged during transit to the Installation Location, as necessary to keep the Equipment and Software performing in accordance with its documentation, hardware reliability upgrades, and repair, or in Stryker Mako's sole discretion, replacement of broken or end of life instruments purchased by Customer, performed as applicable in Stryker Mako's sole discretion. Unless otherwise requested by Customer, all Services shall be performed only during Normal Business Hours. If Customer requests that Services be performed outside the Normal Business Hours, said Services will be furnished on a commercially reasonable efforts' basis.

3.2 Response Time. On-site response will occur within twenty-four (24) hours of Equipment downtime first being reported by Customer during Normal Business Hours unless Customer and Stryker Mako agree otherwise.

3.3 Loaners/Replacements. Should downtime of the Equipment continue for at least forty-eight (48) continuous hours, Stryker Mako will, within an additional forty-eight (48) hours, ship to Customer's facility and install, at Stryker Mako's sole expense, a loaner or replacement RIO® Robotic Arm Interactive Orthopedic system, unless Stryker Mako and Customer agree otherwise. In the event of a replacement, such replacement system may, in Stryker Mako's sole discretion, be a certified refurbished system that in Stryker Mako's sole judgment is of equal performance and quality to a new system. All replacement Equipment will be furnished on an exchange basis and the replaced system shall become the sole property of Stryker Mako.

3.4 Exchanges. If, during any consecutive three (3) month period of the Service Term, the Equipment experiences a recurring identified failure that Stryker Mako is unable to adequately repair or correct (as determined by Stryker Mako in its reasonable discretion), Stryker Mako agrees to replace the Equipment at no cost to Customer. Such Equipment may, in Stryker Mako's sole discretion, be replaced with a certified refurbished system that in Stryker Mako's sole judgement is of equal performance and quality to a new system. All replacement Equipment will be furnished on an exchange basis and exchanged Equipment shall become the sole property of Stryker Mako.

3.5 Maintenance Parts. Stryker Mako will provide all necessary replacement parts to maintain and/or repair the Equipment, except for any consumable items listed in Section 4 of these Warranty and Service Terms. Replacement parts will be either new parts or certified refurbished parts that in Stryker Mako's sole judgment are of equal performance and quality to new parts. All replacement parts will be furnished on an exchange basis and all replaced parts become the sole property of Stryker Mako.

3.6 Software Updates. Software Updates shall be included in the Services and shall, if and as applicable, be provided by Stryker Mako in a time and manner determined by Stryker Mako.

3.7 Service outside the 48 contiguous United States. Service outside the contiguous 48 U.S. states will be periodically scheduled in advance by Stryker Mako, in its sole discretion. If Customer requires an immediate response for services to be performed outside the contiguous 48 U.S. states, Customer will pay all travel expenses of Stryker Mako personnel incurred in performing such Services.

3.8 Scheduled Preventative Maintenance. Stryker Mako will provide scheduled Preventative Maintenance for the Equipment at intervals determined by Stryker Mako in its sole discretion, but not less than two (2) times per year and scheduled at mutually agreeable times with Customer.

3.9 Troubleshooting and Technical Support. Stryker Mako may troubleshoot with one or more individuals designated by Customer via telephone to resolve a problem in lieu of traveling to Customer's facility to repair the Equipment. Stryker Mako will also provide Customer access to Technical Support.

3.10 CT Validation**.** Up to three (3) CT scan equipment validations shall be provided to Customer and included in the Services.

3.11 Purchase of Surgical Scrubs. Notwithstanding anything contained in these Warranty and Service Terms to the contrary, Stryker Mako will not participate in any Customer program, procedure, vendor credentialing, policy or directive requiring Stryker Mako personnel or agents to purchase surgical scrubs from Customer, Customer designee or any third-party vendor operating in Customer's facility.

4. EXCLUSIONS FROM SERVICES. The following actions and items are excluded from the Services:

4.1 Misuse. Services required as a result of, or arising from: (i) any intentional acts or negligence of Customer's employees, agents or invitees; (ii) anyone other than Stryker Mako authorized personnel attempting to repair or service the Equipment; (iii) use of equipment or devices not provided by Stryker Mako; (iv) misuse of the Equipment, including, without limitation, use of the Equipment for any application or function for which it was not designed; or (v) the loading of third-party software without the prior written approval of Stryker Mako, including, without limitation, device drivers not approved by Stryker Mako. Requests for Services related to misuse will be billed to Customer at Stryker Mako's then-current billable rates for travel, labor, and parts.

4.2 Consumables and Accessories. Consumables and accessories are defined as Burrs, Reamer Cups, Drapes, Bone Pins, Reflective Markers, Irrigation Tubes, Checkpoints, Leg Holder Boots, and other consumables.

4.3 Upgrades. Hardware Upgrades, Software Upgrades, and Instrument Upgrades.

4.4 Electrical Work. Electrical work external to the Equipment.

4.5 Cosmetic Work. Painting or refinishing, or the furnishing of the materials for this purpose.

4.6 Moved Equipment. Maintenance required in order to repair damage resulting from Customer's transportation of the Equipment, or any event beyond Stryker Mako's control, including (by way of example and not by way of limitation) any acts of God, acts of third parties, terrorism, fires, floods, and other similar or dissimilar natural causes, riots, wars, sabotage, vandalism.

4.7 Data File Transfer and Recovery. Integrity, maintenance, archive and backup of patient data files are the sole responsibility of Customer.

5. RESPONSIBILITIES OF CUSTOMER

5.1 Access to Equipment. When Stryker Mako personnel arrive at Customer's facility, Customer will provide such personnel reasonable access to the Equipment so that they may perform the Services. Customer may be billed at prevailing hourly labor rates for lost time and travel if Stryker Mako personnel are not permitted reasonable access to the Equipment.

5.2 Service Authorization. Customer agrees to allow Stryker Mako personnel to service, update, and maintain the Equipment under the terms of these Warranty and Service Terms.

5.3 Payment Terms. Customer must pay the total amount due for the Services including all applicable federal, state and local taxes in accordance with the payment schedule set forth in these Warranty and Service Terms. Payment for Services outside Normal Business Hours or for work performed other than Services that is outside the scope of these Warranty and Service Terms will be due and payable within thirty (30) days after Customer's receipt of the applicable invoice.

5.4 Renewal. If Customer does not renew these Warranty and Service Terms to extend after the expiration of the Service Term, and subsequently requests Services in connection with the Equipment, all parts, labor, travel time and travel expenses will be billed to Customer at Stryker Mako's then-current billable rates. Customer shall notify Stryker Mako if it desires to renew these Warranty and Service Terms at least thirty (30) business days prior to the expiration of the Service Term, which renewal may be subject to execution of a separate Service Agreement by and between Stryker Mako and Customer.

5.5 Patient Data Files. Integrity, maintenance, archive and backup of patient data files are the sole responsibility of Customer.

6. EQUIPMENT LOCATION. The Equipment is located at Customer's facility as described in the Agreement. Any subsequent resale or removal to a new location without Stryker Mako's prior written approval may result in immediate cancellation of these Warranty and Service Terms by Stryker Mako in its sole discretion.

7. INSPECTION. If (i) Customer does not utilize, terminates or fails to renew these Warranty and Service Terms and (ii) Customer elects to utilize or renew these Warranty and Service Terms at least thirty (30) days after such expiration or earlier termination, Stryker Mako, with reasonable notice to Customer, shall require Customer to pay the costs and expenses of a site inspection of the Equipment, performed by Stryker Mako personnel during Normal Business Hours, to determine the operating status of the Equipment. The inspection will be billed at Stryker Mako's then-current time and materials rate.

8. DEFINITIONS. Each of the following definitions shall be equally applicable to the singular and plural forms of the terms defined. As used in this Schedule D:

8.1 "Hardware Upgrades" means major or otherwise significant upgrades, as determined in Stryker Mako's discretion, to the Equipment hardware, including, without limitation, new hardware components not offered by Stryker Mako at the time of execution of the Agreement or other technology upgrades deemed by Stryker Mako to be premium technology offerings.

8.2 "Instrument Upgrades" means major or otherwise significant upgrades, as determined in Stryker Mako's discretion, to the instrumentation, including, without limitation, new components not offered by Stryker Mako at the time of execution of the Agreement or other technology upgrades deemed by Stryker Mako to be premium technology offerings.

8.3 "Normal Business Hours" means Monday through Friday 8:00 A.M. to 5:00 P.M. local time at the location at which the Equipment is installed.

8.4 "Preventative Maintenance" means proactive, scheduled system checks and, if necessary, maintenance to ensure Equipment is operating in accordance with its documentation and published specifications.

8.5 "Service Term" means collectively the Initial Warranty Period and the Service Period.

8.6 "Software Update" means a minor iterative update to the Software that does not amount to a major addition to or enhancement of the Software or a significant feature of the Software, as determined by Mako in its sole discretion. Software Updates are generally accompanied by a change to the minor version number of the Software (e.g. TKA 2.0 to TKA 2.1).

8.7 "Software Upgrade" means a major addition to or enhancement of the Software or a significant feature of the Software, as determined by Stryker Mako in its sole discretion, including, without limitation, additions of new indications to the Software, significant user experience upgrades, and other similar additions to the Software. Software Updates are generally accompanied by a change to the major version number of the Software (e.g. TKA 1.0 to TKA 2.0), but such change is not required for a change to be considered a Software Upgrade.

8.8 "Technical Support" means hotline support that may be accessed by Customer as necessary to assist with pre, intra, or post operative technical questions regarding the performance of Equipment. Stryker Mako agrees to use reasonable efforts to resolve any such questions but does not guarantee Technical Support will resolve any particular issue or question regarding use of or performance of the Equipment.

9. **Termination.**

9.1 The Customer may terminate this Service Agreement at any time by providing written notice to Stryker Mako at least thirty (30) days prior to the intended termination date. Such termination shall be without penalty, liquidated damages, or further obligations under this Agreement, provided that such termination is not due to the Customer's breach of any material provision of this Service" Agreement.

9.2 In the event the Customer decides to upgrade its equipment, or if the equipment provided by Stryker Mako is no longer in use or is removed from the Customer's premises, the Customer may terminate this Service

Agreement without penalty. This provision applies whether the Customer elects to replace, or discontinue the use of the equipment.

Justification for Sole Source Form

To: Contract Review Committee

From: Aisha Huebner, Perioperative Services

Type of Purchase: (Check One)

☐Non-Medical, Non-Surgical Equipment/Supplies >= $25,000
☐Data Processing/Telecommunication Goods >= $25,000
X Medical/Surgical – Supplies/Equipment >= $25,000
☐Purchased Services >= $350,000

Total Cost $:	$789,090.50 (Includes sales tax and 2-year service following 1-year initial warranty)
Vendor Name:	Stryker
Agenda Item:	Mako 4

Statement of Need: My department's recommendation for sole source is based upon an objective review of the product/service required and appears to be in the best interest of SVMHS. The procurements proposed for acquisition through sole source are the only ones that can meet the district's need. I know of no conflict of interest on my part or personal involvement in any way with this request. No gratuities, favors or compromising action have taken place. Neither has my personal familiarity with particular brands, types of equipment, materials or firms been a deciding influence on my request to sole source this purchase when there are other known suppliers to exist.

Describe how this selection results in the best value to SVMHS. See typical examples below.

☐Licensed or patented product or service. No other vendor provides this. Warranty or defect correction service obligations of the consultant. **Describe.**

X Existing SVMHS equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Describe.**

SVMHS currently operates under a rental agreement for the Mako 3 robotic surgical system. As part of a recent proposal, we have been offered the opportunity to purchase the upgraded Mako 4 system, applying $242,400 in equity from previously paid rental fees toward the buyout cost.
Dr. Bonano, a key orthopedic surgeon at SVMHS, requires the Mako robotic system for his surgical procedures, as it is his preferred technology. His continued use of the Mako platform is important to maintaining both surgical volume and consistency of care within the orthopedic service line.
At the time of initiating the Mako 3 rental, SVMHS invested in compatible surgical instruments intended for long-term use with the Mako platform. These instruments remain fully compatible with the Mako 4 system, thereby preserving the utility and value of our initial investment. The capital equipment expenditures related to this purchase, paid in 2024, total $184,791.58.

☐Uniqueness of the service. **Describe.**

☐SVMHS has established a standard for this manufacturer, supplier or provider and there is only one vendor. **Describe.**

☐Factory-authorized warranty service available from only this single dealer. Sole availability at the location required. **Describe.**

☐Used item with bargain price (describe what a new item would cost). **Describe.**

☐Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, please **describe**:

By signing below, I am attesting to the accuracy and completeness of this form.

Submitter Signature Aisha D. Huebner Aisha D. Huebner (Jun 6, 2025 12:59 PDT) Date: 06/06/2025

BOARD or CEO Packet Submission Checklist
Mako 4

The original of this completed/fully signed checklist and all required supporting documents are to be hand-delivered to reviewer listed below:

X **BOARD or CEO PAPER** – required for all submissions; see attached instructions/sample

X **KEY CONTRACT TERMS** – required for all submissions – see table in Board/CEO Paper

X **CONTRACT** – negotiated final contract with vendor signature (Approval to proceed w/o vendor signature – Jon Baird)

PROCESS DOCUMENTATION – required for all submissions requiring Board/CEO review/approval per Procurement Management Policy (see policy for details; indicate which sub-category is applicable):

☐ If for **data processing/telecommunications goods/services** of $25,000 or more, check applicable option and include documentation: **CIO must review**.
- ☐ RFP documentation *unless sole source or GPO applies.*
- ☐ If Sole source – provide detailed justification
- ☐ If GPO, submit qualifying verification from Materials Management

X If for **professional/other services or medical/surgical equipment and supplies** $350,000 or more, check applicable option and include documentation:
- ☐ RFP documentation *unless sole source or GPO applies.*
- **X** If Sole source – provide detailed justification
- ☐ If GPO, submit qualifying verification from Materials Management

☐ If for **non-medical materials/supplies/Public Works** $25,000 or more, check applicable option and include documentation:
- ☐ RFP/Invitation for bids documentation
- ☐ If Sole source – provide detailed justification
- ☐ If GPO, submit qualifying verification from Materials Management

Legal counsel/Contract Administrator reviewed: No___ or Yes X By Whom: Jon Baird – ERP & Contracts Manager

SUBMITTED BY DEPARTMENT DIRECTOR OR DEPARTMENT ADMINISTRATOR:

Aisha D. Huebner Aisha D. Huebner (Jun 5, 2025 11:11 PDT)	Director, Perioperartive Services	06/05/2025
Signature	Title/Dept.	Date

REVIEWED BY: (In the following order) – If Capital; Axiom approval in lieu of signature.

CIO: (if applicable) _____ Date: _____

Director of Audit/Compliance:_____ Date: _____

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval of Awarding a Contract for Design and Engineering Services to HDR Architecture Inc. in conjunction with the Emergency Department Replacement Project**

Executive Sponsor: Clement Miller, Chief Operating Officer
Brad McCoy, Vice President – Construction, Real Estate & Facilities

Date: June 13, 2025

Executive Summary

Salinas Valley Health is pursuing a revised Master Plan that accomplishes replacement of the emergency department, increases parking infrastructure and optimizes the campus site circulation, and reconfigures the perioperative department in the areas decanted by the existing emergency department. Significant renovations to medical center's energy and civil infrastructure on and off site is anticipated to support the building expansion. The next stage in project implementation is preparation of design documents required for validating underlying master plan assumptions, securing local and state agency reviews, and bridging documents necessary to facilitate the solicitation of proposals from qualified design-builders during the implementation phase.

Background/Situation/Rationale

During the Request for Qualifications and Proposal (RFQ/RFP) process, seven (7) complete proposals from local and regional design firms were received by Salinas Valley Health. Each of the proposals were scored utilizing a tiered scoring structure. An evaluation committee comprised of Salinas Valley Health leadership and facilities management conducted a scoring of the written proposals. The three primary categories utilized in the evaluation process were:

(a) Qualifications and experience of firm
(b) Approach to providing services and project management
(c) Qualifications and experience of key personnel.

After evaluating all proposals in accordance with the criteria set forth in the RFQ/RFP, the evaluation committee shortlisted three design firms (HDR, KMD, MEI). Following an interview process of the three competing firms, it was determined HDR Architecture was the highest-ranking proposer. In accordance with the RFQ/RFP procedures, Salinas Valley Health negotiated the fees, terms and conditions of the Master Architect Agreement. The current fee proposal is consistent with industry standards of similar projects of same size and complexity within the bay area.

Master Architect's scope of services includes review of the current facility assessment, preparation of a detailed project program to assist capital planning with securing preliminary phase cost estimates, and produce schematic design documents and performance specifications for the procurement of a design build team to complete the design and construction. The Services are broken down into the following phases: (i) Program Validation Phase; (ii) Schematic Design Phase; (iii) Proposal Solicitation Phase (Design Builder). The Design Team includes the following disciplines: architectural, urban planning, parking, structural, mechanical, electrical, plumbing, civil, landscape, technology, joint trench, cost estimator and a medical equipment planner.

Timeline/Review Process to Date:

July 2025	Commence Program Validation
October 2025	Complete Detailed Project Program (Milestone 1)
November 2025	Commence Schematic Design
June 2026	Complete Schematic Design (Milestone 2)

** Current schedule indicated is preliminary project estimates at a pre-design stage of the project planning process. Following programmatic confirmation, an updated project schedule will be drafted by Facilities Management and presented to the Board in a subsequent meeting for review.*

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

The fiscal years 2026 capital budget allocated funding for planning and design activities required to complete the design and construction process. The design and engineering services will result in two key deliverables: (A) Detailed Project Program and (B) Schematic Design with Performance Specifications. The following summarizes the design and engineering fees for program validation and schematic design:

Key Contract Terms	Vendor: HDR Architecture Inc.
1. Proposed effective date	Issuance of Notice to Proceed anticipated on July 1, 2025
2. Term of agreement	12 Months for Program Validation and Schematic Design
3. Renewal terms	Not Applicable
4. Termination provision(s)	Provided in Section 11 of the Agreement
5. Cost	Total all-inclusive sum not to exceed $1,631,742 + reimbursables; During the programming and schematic design process, Executive Leadership may review and execute additional services not more than 10% of the original contract value or not in excess of $450,000. Total of amount: $2,081,742
6. Budgeted (indicate y/n)	Yes, projected routine capital has been allocated for anticipated costs in conjunction with the project and master planning.

Recommendation

Consider recommendation for approving the award of the master architect design services to HDR Architecture for the design and engineering of the Emergency Department Replacement project, in the amount of $1,631,742, as presented. Executive Leadership may review and execute additional services not more than 10% of the original contract value or not in excess of $450,000. Total of amount: $2,081,742

Attachments

(A) Master Architect Agreement
   a. Exhibit 3A – Resources Loaded Work Plan and Fee (Programming and Schematic Design)
   b. Exhibit 3B – Design Schedule

MASTER ARCHITECT AGREEMENT

THIS AGREEMENT is made as of the Effective Date between SVH and Master Architect to provide investigation, planning, programming, and criteria documents services in connection with a new emergency room department, parking garage and medical office building ("Project").

Effective Date	July 1, 2025	
SVH	Salinas Valley Health 450 E. Romie Lane Salinas, CA 93901	
Master Architect	HDR Architecture Inc. 201 California St, Suite 1500 San Francisco, CA 94111 D 415.546.4266	Architectural

The following Exhibits are incorporated into this Agreement by reference.

Exhibit 1	Definitions
Exhibit 2	Services
Exhibit 2A	SVH Provided Information
Exhibit 2B	Scope of Services
Exhibit 3	Compensation and Schedule
Exhibit 3A	Resource Loaded Work Plan
Exhibit 3B	Design Schedule
Exhibit 4	Conflict of Interest Policy

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

SVH	**Master Architect**
By:_____ Dr. Allen Radner, President/CEO	By:_____ Usman Tariq, Vice President, HDR Usman.tariq@hdrinc.com

THE PARTIES AGREE TO THE FOLLOWING TERMS AND CONDITIONS.

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BUSINESS TERMS SHEET

SVH Representative	Dr. Allen Radner, President/CEO aradner@salinasvalleyhealth.com
Construction Manager	Bogard Construction David Sullivan, Executive Vice President 831.246.2073 dsullivan@bogardconstruction.com
Master Architect's Representative	Vishal Turkar Health Principal, Associate Vice President 201 California St, Suite 1500 San Francisco, CA 94111 D 415.546.4266 M 628.224.9793 vishal.turkar@hdrinc.com
Other Design Team Members:	
Civil Engineer Whitson Engineers Richard Weber (831) 649-5225 jinman@mazzetti.com	Structural Engineer GreenLight Engineering Soon-Min Kwon 916.217.5191 skwon@greenlightengineer.com
Mechanical/Plumbing/Electrical/Technology Mazzetti Jon Inman 415.652.4581 jinman@mazzetti.com	Medical Equipment Planning Mazzetti Jon Inman 415.652.4581 jinman@mazzetti.com
Landscape Design HDR Vishal Turkar 628.224.9793 vishal.turkar@hdrinc.com	Parking Garage & Technology Watry Design Jess Mclnerney, Principal 833.917.7275 X-2714[insert email]
Joint Trench Consultant Giacalone Design Services Paul Giacalone 925.467.1740 PaulG@DryUtilityDesign.com	Cost Consultant Cumming Group Tim Brown, Senior. Director 916.276.9841 tim.brown@cumming-group.com
Project Budget	$150,000,000
Compensation (Article 7)	$1,631,742 + reimbursables NTE Amount
Estimated Duration of Services	12 months (See Exhibit 3B)
Master Architect's Minimum Insurance Limits	See, Article 9 for insurance terms
Workers Compensation/Employers' Liability	California Statutory Limits Employers' Liability $1,000,000 each accident

Commercial General Liability	$1,000,000 per occurrence $2,000,000 in aggregate $2,000,000 personal/advertising injury
Automobile	$2,000,000 each accident
Professional Liability	$2,000,000 per claim and $5,000,000 aggregate
Excess Liability Insurance	n/a
Additional Insureds	SVH and its officers, board members, agents, directors, and employees, special inspectors, and Construction Manager.
Notice per Section 13.6	**SVH:** Allen Radner, M.D., President / CEO 450 E Romie Lane Salinas, CA 93901 email: aradner@salinasvalleyhealth.com With Copy to: David Sullivan, Construction Manager Bogard Construction email: dsullivan@bogardconstruction.com **Master Architect:** Vishal Turkar, AIA, NCARB, LEED AP BD+C Health Principal, Associate Vice President 201 California St, Suite 1500 San Francisco, CA 94111 D 415.546.4266 M 628.224.9793 vishal.turkar@hdrinc.com

1. GENERAL TERMS AND REQUIREMENTS

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

1.2 Relationship of the Parties. Master Architect's relationship with SVH is that of an independent contractor whose involvement is to act in the capacity of an architect and not as an agent, fiduciary, partner, member of, subsidiary of, or otherwise affiliated with SVH.

1.3 Good Faith and Fair Dealing. The Parties agree to act in good faith with respect to furthering the interests of the Project and the performance of their respective obligations under this Agreement, and to deal fairly with one another in all matters related to this Agreement. Master Architect will perform its Services (Exhibit 2B) in an expeditious and economical manner consistent with industry practices and the Contract Documents, subject to the standard of care set forth in Section 4.4. Master Architect will provide efficient administration, coordination and supervision of its Design Team in their performance of any Services under this Agreement.

2. PROJECT DESCRIPTION

2.1 Description of Existing Facility. SVH provides healthcare and hospital services at the Salinas Valley Health Medical Center, located at 450 East Romie Lane, Salinas CA 93901 ("Hospital"). The Hospital consists of an existing 264,493 s.f., 6-story building and connected structures, constructed between 1953 and 2023. The Hospital is classified by California Healthcare Access and Information (HCAI) as a general acute care hospital licensed for 263 beds. Bed types include perinatal, pediatric, newborn and general intensive care, coronary care, and general acute care. The Hospital will remain operational during performance of all Work.

2.2 Conceptual Design, Initial Programming, and Other SVH Information. A list of the conceptual design documents and initial programming prepared by HOK and other SVH documentation are included in Exhibit 2A.

2.3 Project Description. The Project includes design and construction of a new, single-level, 44-bay, 20,000 square foot emergency department with warm shell basement which will be built adjacent to and connecting with the Hospital; renovation to optimize the configuration of the Hospital's perioperative department upon decanting the Hospital's existing emergency department; and construction of a new three-level, 150-stall parking structure across the street from the Hospital's existing main campus area. The Project is also expected to entail significant on- and off-site renovations to the Hospital's energy and civil infrastructure to support its expansion.

2.4 Enabling Statute and Delivery Method. Master Architect is hired pursuant to Government Code section 4525, et. seq. for the Services. Completion of the design and construction for the Project will be on a design build basis pursuant to Health and Safety Code section 32132.5 and California Public Contract Code section 22185, et seq.

3. PROJECT TEAM AND RELATIONSHIP OF THE PARTIES

3.1 Project Team. The Project Team includes SVH and Master Architect and its tier-consultants.

3.1.1 SVH. SVH is the owner of the Project. The SVH Representative is identified in the Business Terms Sheet. SVH's role and responsibilities are described in Article 5.

3.1.2 Construction Manager. The Construction Manager's representative is identified in the Business Terms Sheet. The Construction Manager is an advisor to SVH and does not have the authority to bind SVH or authorize changes in the Services or schedule that impact the NTE Amount and/or Contract Time. The Construction Manager's role and responsibilities are described in greater detail Article 4 and Exhibit 2B.

3.1.3 Master Architect's Representative. Master Architect's representative is set forth in the Business Terms Sheet. The Master Architect's representative's duties include, without limitation, directing and coordinating the Services of Master Architect and its other Design Team Members. Master Architect's representative will represent Master Architect throughout performance of the Services, and all communications given to Master Architect's representative will be deemed to have been delivered to Master Architect. Master Architect's representative is key personnel.

3.1.4 Other Design Team Members. The Master Architect and its other Design Team Members are identified in the Business Terms Sheet make up the Design Team. The other Design Team Members are tier-consultants to the Master Architect. Each Design Team Member's representative is set forth in the Business Terms Sheet. Master Architect and the other Design Team Members are performing the Services set forth in this Agreement.

3.2 Collaboration. Master Architect and its Design Team Members will actively participate and collaborate with SVH and the Construction Manager to review the current facility assessment, prepare a detailed Project Program to assist capital planning with securing preliminary phase funding, and produce Schematic Design Documents and performance specifications for the procurement of a design build team to complete design and construction of the Project. Master Architect and its Design Team Members will make meaningful commitments to SVH and the Construction Manager, and will honor their respective commitments, regarding timely and proper performance of all Services.

3.3 Communications. All communications with SVH will be through the Construction Manager. Master Architect does not have to copy correspondence between Master Architect and its Design Team Members. However, the Construction Manager must be kept apprised of all communications and copied on all written correspondence between Master Architect and other Project Team Members potentially impacting Project design or constructability, Governmental Authority approvals, cost or schedule.

4. SERVICES

4.1 Scope. Master Architect and its Design Team will review the current facility assessment, prepare a detailed Project Program and updated conceptual design to assist with capital planning and securing preliminary Construction Stage funding and produce Schematic Design Documents and performance specifications for the procurement of the Design Builder to complete the design and construction. Master Architect and its Design Professionals will work collaboratively with the Construction Manager to coordinate its Services. Master Architect will perform all Services as more specifically defined in Exhibit 2B. The Services are broken down into the following phases: (i) Program Validation Phase; (ii) Schematic Design Phase; (iii) Proposal Solicitation Phase (Design Builder).

4.2 Key Personnel. Key personnel for the Master Architect and its Design Team Members must be identified in the Resource Loaded Work Plan set forth in Exhibit 3A. Unless otherwise requested by SVH, key personnel may not be removed from, or added to, the staffing plan without prior written consent of SVH Representative except for death, disability, or departure of person from employment. If a replacement is necessary, the proposed key personnel will have substantially equivalent or better qualifications than the former principal or employee, and all candidates are subject to final approval by the Construction Manager and SVH Representative.

4.3 Licensing Requirements. Master Architect warrants that it is authorized to do business in the State of California and is properly licensed by all necessary Governmental Authorities for performance of Services that will be self-performed by Master Architect. Master Architect will ensure that all of its Design Team Members are properly licensed in California for their respective discipline.

4.4 Standard of Care. Master Architect and its Design Team Members will perform their respective portions of the Services in a professional manner consistent with the practice of a competent California state licensed architects or registered professional engineers of the same discipline performing design services for projects of similar size, scope, and complexity in Monterey County and the state of California.

4.5 Compliance with the Law. Master Architect will comply with Applicable Law in the performance of its Services. Master Architect acknowledges that the Project and the existing facilities of the Hospital are subject to the Hospital Safety Act of 1983. Master Architect represents that it is familiar with the provisions of the Hospital Safety Act of 1983, as amended, and all duties arising under that Act, and will perform its Services accordingly.

4.6 Facilities Standards. With respect to performance of the Services, Master Architect will identify and determine the meaning and effect of applicable building code provisions and other applicable building requirements and restrictions.

4.7 Coordination with Governmental Authorities. To the extent required, Master Architect will manage and timely coordinate required preliminary design submissions, questions, and responses to applicable Governmental Authorities.

4.8 Schedule for Performance. Master Architect and its Design Team Members will perform their respective portion of the Services in accordance with the Design Schedule set forth in Exhibit 3B.

4.9 Tier-Consultants Written Agreements. Master Architect's agreements with its Design Team Members will be in writing and will bind the tier-consultants to Master Architect to the same extent that Master Architect is bound to SVH under this Agreement. Master Architect will cause its Design Team Members to provide defense and indemnification to SVH and Master Architect with a similar provision as set forth in Article 8, and to carry similar insurance at appropriate limits in accordance with the requirements set forth in the Business Terms Sheet and Article 9. Each tier-consultant agreement will preserve and protect the rights of SVH and Master Architect with respect to the portion of the Services performed by the tier-consultant so that contracting a portion of the Services does not prejudice SVH. Tier-consultant agreements must be compensated on a not-to-exceed or lump sum basis with payments not exceeding the percentage of completion; tier-consultant agreements may not be issued on a time and expense basis without written approval by SVH's Representative.

5. SVH'S RESPONSIBILITIES

5.1 Information and Documents. SVH will provide the information set forth in Exhibit 2A, information on schedule requirements, budget constraints, SVH's objectives and goals for the Project. SVH will also provide access to additional information requested by Master Architect as appropriate.

5.2 Entitlement and Fees. If applicable, SVH will pay for all design review approval, entitlements, easements, assessments and fees required governmental approval for the Services.

5.3 SVH Representative. SVH's Representative is set forth in the Business Terms Sheet. SVH's Representative is authorized to approve changes in the Services that impact the NTE Amount and/or affect the Contract Time established in the Design Schedule up to an amount of $350,000 per occurrence. Any request for additional services exceeding an amount of $350,000 will require board of directors approval and must be timely submitted to the Construction Manager by the Master Architect in order to allow proper consideration during the board's regularly scheduled meetings. SVH's Representative will render decisions in a timely manner pertaining to additional services and documents submitted by the Master Architect and recommended by the Construction Manager in order to avoid unreasonable delay in the Design Schedule (Exhibit 3B).

5.4 Separate Contracts. SVH reserves the right to perform administration and operations related to the Services with SVH's own forces, and to award contracts in connection with the Services. Master Architect will notify SVH if any such independent action will interfere with the Master Architect's ability to perform its Services under this Agreement.

6. CONSTRUCTION MANAGER'S ROLE

6.1 Role and Responsibilities. The Construction Manager's role is to advise and assist SVH with coordination and management of the Services. The Construction Manager's

responsibilities will generally include facilitating collaboration among Project Team Members, maintaining clear and open lines of communication between Project Team Members, developing plans and processes to ensure efficient progression of the Services and retention of the design builder. The Construction Manager will be Master Architect's day-to-day contact and the liaison between the Design Team and SVH. The Construction Manager is responsible for coordination regarding any ancillary projects that may impact the Services and between SVH's separate consultants and separate contractors and the Master Architect.

6.2 Meetings. Construction Manager will facilitate Project meetings with the Design Team to ensure open, clear, and direct lines of communication and to help address any issues that may arise during **performance of the Services.** The Project meetings are the venue for the Design Team to identify and discuss potential risks, critical issues, actions to be taken, **updates to the Design Schedule,** and to review overall progress **in the Design Services**.

6.3 Monthly Invoice Review. Construction Manager will review Master Architect's monthly and final invoicing in accordance with Article 7, and make recommendations to SVH regarding payment.

6.4 Schedule Review. Construction Manager will monitor Master Architect's design progress with the Design Schedule, review and analyze requests for additional services due to delays in Services that are not caused by the Master Architect or any of it Design Team Members, collaborate with the Design Team regarding recovery plans if required, and meet with the Project Team to determine when critical decisions are needed from SVH or others in order to maintain the Design Schedule.

6.5 Additional Services. The Construction Manager will evaluate requests for additional services, and make recommendations to SVH.

7. COMPENSATION AND PAYMENT

7.1 Fee. The Master Architect will be compensated a Fee based on a time and reimbursable expense basis, up to the NTE Amount set forth in the Business Terms Sheet. The Master Architect's Fee will be based on the number of hours spent performing the Services multiplied by the billable rates set forth in the RLWP (Exhibit 3A) plus an allowance for those Reimbursable Expenses incurred as defined under Section 7.2.1, up to the NTE Amount set forth in the Business Terms Sheet. The billable rates included in the RLWP are subject to the terms and conditions set forth in Section 7.2.1. All other costs are excluded and Master Architect’s Fee for completion of the Services and the Fee cannot exceed the NTE Amount, which is only s subject to adjustment for additional services per 7.6.

7.2 Resource Loaded Work Plan. Master Architect's Resource Loaded Work Plan (Exhibit 3A) must include planned annual rate adjustments. Billable rates will be locked through December 31, 2025, and subject to adjustment beginning January 1, 2026. Billable rate adjustments made after January 1, 2026 will be tied to the Consumer Price Index, and cannot include salary adjustments in excess of 5% per year. Costs for annual bonuses are allowed as part of the Design Build Team Member's profit. Subject to those rate adjustments, Master Architect its Design Team Members will submit billable rates annually for SVH approval, which

will not be unreasonably withheld. Annual billable rate adjustments or staffing changes will not cause an increase to the NTE Amount.

7.2.1 Billable Rates include all costs direct salary expenses for employees' performance of Services including basic wages, payroll taxes, and employer benefit payments for health and welfare (net of employee contribution withholding), pensions, vacations/holidays, Social Security (FICA), Medicare (FMI) unemployment insurance (FUI & SUI), supplemental dues, training, reasonable and customary benefits or payments required by law, and will include overhead and profit.

(a) Overhead includes reasonable home office overhead expenses such as mortgage, rent or property taxes, utilities, office equipment (including software and hardware costs), maintenance costs, depreciation on assets, employee recruitment and training, general administrative and payroll costs, business development and marketing, relocation expenses, car allowances or vehicle maintenance expenses (as applicable) and cell phone expenses, postage, severance pay, employee morale programs; costs of business operations such as insurance premiums, costs for professional dues, continuing education for licensing, licenses, fees and taxes required by any governmental authorities to enable the Master Architect and its Design Team Members to be qualified to do business and/or perform their respective portion of the Services.

7.2.2 Reimbursable Expenses. All Reimbursable Expenses are listed below and will be billable at cost without markup.

(a) Design Professionals salaried personnel will bill their time based on the number of hours working on the Project and may not bill travel time.

(b) Per diem for Master Architect's personnel incurred while traveling related to the Services is a lump sum amount of $50 per day provided that the personnel was either physically at the site or in a Project related location for a minimum of 4 hours in a single day.

(c) Plotting and Reproduction. The expense of reproductions, postage, and handling of drawings, specifications and other facility documents.

(d) Professional and/or presentation quality renderings, if requested by SVH.

(e) Miscellaneous. Other costs incurred in the performance of the Services if, and to the extent, approved in advance in writing by SVH.

7.3 Payment. Master Architect will invoice SVH monthly for Services performed. The invoice will include a description of the individuals performing the Services, their job title, a description of the Services provided, and any approved Change Orders. Each payment application must be accompanied by sufficient documentation supporting Reimbursable Expenses including receipts for Reimbursable Expenses, tier-consultant invoices, and other documentation reasonably required by SVH or the Construction Manager. SVH will remit payment to the Master Architect for undisputed amounts within 30 days' receipt of invoice. If an

invoice remains unpaid for 60 days from the date of the invoice, Master Architect may charge interest on the outstanding balance from the date payment is due at an annual rate equal to 2% per annum. SVH is not obligated to pay, or to see that payment is made to Master Architect's other Design Team Members except as may otherwise be required by Applicable Law.

7.4 Right to Withhold. SVH or Construction Manager may refuse to approve a payment application, in whole or in part, or, because of subsequently discovered evidence that may nullify the whole or any part of a prior payment application to the extent the Construction Manager or SVH Representative determines it is necessary to protect SVH from loss due to, among other things, deficient Services or failure to perform Services in accordance with the Contract Documents; disputed amounts; third party claims against SVH allegedly arising from the Services; or reasonable doubt that the Services can be completed within the NTE Amount set forth in the Business Terms Sheet, as adjusted through approved Change Order per Section 7.6.

7.5 No Waiver. Payment by SVH will not constitute approval or acceptance of any Services included in the payment application or final acceptance or approval of that portion of the Services.

7.6 Additional Services. Changes in the Services described in Exhibit 2B, adjustments to the NTE Amount, or the Design Schedule in Exhibit 3B will only be authorized through executed Change Order. A Change Order signed by the Master Architect indicates the Master Architect's agreement to the adjustment in its compensation or time and fully and completely resolves any claim by Master Architect and its Design Team Members for additional compensation or time arising from or related to the additional services required. Master Architect will provide the Construction Manager written notice and a rough order of magnitude of the additional services within 5 business days of discovering facts or circumstances giving rise to the additional services. Master Architect will provide a complete cost proposal (including impacts to Design Team Members) within 10 business days of discovery. Construction Manager will review and either make a recommendation to SVH for approval; request additional information; or recommend that SVH deny the request. If the recommendation is to deny the request, Construction Manager must provide a written explanation to SVH and Master Architect. The Construction Manager's recommendation will be taken into consideration by SVH on whether to approve the request for additional services. However, Construction Manager does not have the authority to approve or deny requests for additional services as that decision is solely SVH's.

7.7 Audit Right. SVH may audit Master Architect's and its Design Team Member's project records at any time throughout the duration of the Services and before final payment upon 10 business days' written notice. The audit will take place during normal business hours and will be coordinated with Master Architect and its Design Team Members. Master Architect and its Design Team Members will produce all records related to their respective compensation and Master Architect's Fee, as amended, payment applications, as well as any other records deemed necessary by SVH to substantiate charges related to the Services. Should the audit indicate that Master Architect's or a Design Team Member's records were fraudulently or negligently prepared or maintained, SVH reserves the right to seek damages and pursue available legal remedies from Master Architect.

7.8 Medicare Audit. Upon written request of SVH, the Master Architect and its Design Team Members will make available to the Secretary of Health and Human Services or the Comptroller General or any of their duly authorized representatives this Agreement and books, documents and records of Master Architect that are necessary to verify the nature and extent of the cost of the Services provided hereunder for a period of four (4) years from the furnishing of such Services when required by Section 952 of the Omnibus Budget Reconciliation Act of 1980 and the regulations promulgated thereunder.

8. INDEMNIFICATION AND DEFENSE

8.1 Indemnification and Defense. To the fullest extent permitted by law, Master Architect will (and will cause its Design Team Members to) defend, indemnify, and hold harmless SVH, its Board of Directors, employees, affiliates, members, officers, successors and assigns ("Indemnitees") from and against any and all claims, losses, damages, liabilities, and expenses (including legal, expert witness, and consulting fees and costs) arising out of, or resulting from, the negligent performance of Services, bodily injury (including disease, sickness, and death) or damage to tangible property, but only to the extent the claims against the Indemnitees arise out of, pertain to, or relate to the negligence, recklessness, or willful misconduct of the Master Architect, its Design Team Members, their respective employees, or anyone directly or indirectly employed by Master Architect or its Design Team Members for whose acts Master Architect may be liable.

8.1.1 Defense. SVH and Master Architect will (and Master Architect will cause its Design Team Members to) defend their own respective claims under Sections 8.1 at their own cost and expense until liability is determined or settlement is reached under the dispute resolution process set forth in Article 10. After determination of liability or an agreed settlement under Article 10, the Master Architect and its Design Team Members will reimburse SVH for defense costs in proportion to the extent of their proportionate share of liability or settlement amount arising from claims, demands, causes of action, damages, costs, expenses.

8.2 Enforcement. Nothing contained in this Article 8 will be construed to impose any obligation in conflict with current California state law. In the event of a conflict with California State law, as may be amended, the Agreement will be modified to allow indemnification by Master Architect and its Design Team Members to the greatest extent permitted by Applicable Law.

9. INSURANCE

9.1 General. Before execution of this Agreement and commencement of Services, Master Architect must provide proof of the insurance coverages required by this Article 9 at the limits included in the Business Term Sheet. Minimum limits for Design Team Members are included in Section 9.11. Master Architect and its Design Team Members will maintain the required insurance coverages in the amounts set forth in the Business Terms Sheet and Section 9.11, respectively. Master Architect and its Design Team Members' insurance will comply with the following terms and conditions.

9.2 Workers' Compensation. Coverage will include insurance as required by California state law and employer's liability coverage.

9.3 Commercial General Liability (CGL). Commercial general liability coverage must include combined single limits and aggregates in the amounts as set forth in the Business Terms Sheet and Section 9.11. Coverage must include, but is not limited to liability for bodily injury, sickness, disease or death, personal injury, or injury to or destruction of property including loss of use resulting therefrom, including the following: (a) Contractual Liability for liability assumed under an insured contract including the tort liability of another assumed in a business contract (this Agreement must be an insured contract); (b) Broad Form Property Damage; (c) Independent contractors; (d) Severability of interests; and (e) Cross Liability.

9.4 Professional Liability. Master Architect and its design professionals must have coverage for damages caused by Master Architect's and its design professionals negligent acts, errors, or omissions arising out of the performance of the Services. Master Architect's coverage must be in the amounts specified in the Business Terms Sheet. Design professionals errors and omissions must be at limits per Section 9.11. Tier-consultants included as Design Team Members who are not licensed design professional do not need professional liability coverage.

9.5 Automobile Liability. Master Architect and its Design Team Members must have commercial automobile liability insurance issued on policies with each accident limits as stated in the Business Terms Sheet and Section 9.11, respectively. This insurance must apply to bodily injury and property damage for all owned, non-owned, or hired vehicles to be used by the insured in performance of its obligations under this Agreement.

9.6 Primary Insurance. All liability policies required under this Agreement are primary and non-contributory to any similar insurance maintained by SVH or the Construction Manager for their own respective benefits.

9.7 Occurrence Basis. All commercial general liability and automobile liability policies must be written on an occurrence basis.

9.8 Term. All liability insurance must be in force before commencement of Services and must be maintained in force for 4 years following completion of the Services. Workers' compensation insurance must be in force from the inception of this Agreement through completion of the Services and final payment. In the event of cancellation or non-renewal, the reporting period during which a claim may first be made will be extended until at least 4 years after cancellation or non-renewal. Upon renewal of any required insurance that expires before completion of the Services, the applicable party must provide SVH with renewal certificates not less than 15 days before expiration. Master Architect and its Design Team Members will promptly furnish copies of all required policies of insurance, including any renewal or replacement policies, within 10 days of SVH's written request.

9.9 Qualifications and Rating. All insurance must be placed with insurers that are admitted or licensed to issue insurance in the state of California. All insurers must maintain an A.M. Best rating of at least A or better, and a financial classification of VIII or better.

9.10 Additional Insureds. The additional insureds set forth in the Business Terms Sheet will be named additional insureds on all required commercial general liability and automobile policies for Services performed under or incident to this Agreement. If the additional insured has other insurance applicable to the loss, it will be on an excess or contingent basis.

The amounts and types of insurance will conform to the minimum terms, conditions, and coverages of the Insurance Service Office (ISO) policies, forms, and endorsements in effect when this Agreement is executed.

9.11 Other Design Team Members. Master Architect will require its tier-consultants to maintain workers compensation insurance at statutory rates and $1,000,000 in employer liability insurance, and to carry a minimum of $1,000,000 per claim and $2,000,000 in aggregate in professional liability coverage. Design Team Members must also carry commercial general liability in the amount of $1,000,000 per occurrence and $2,000,000 in aggregate, and automobile liability insurance at $1,000,000 each accident.

9.12 Waivers of Subrogation. Master Architect and its Design Team Members waive all rights against SVH, as well as the additional insureds set forth in the Business Terms Sheet for loss or damage to the extent reimbursed by any property insurance. A waiver of subrogation is effective as to a person or entity even though that person or entity would otherwise have a duty of indemnification, contractual or otherwise, did not pay the insurance premium directly or indirectly, and whether or not the person or entity had an insurable interest in the property damaged. This waiver does not apply to professional liability insurance. If any applicable policies of insurance require an endorsement or consent of the insurance company to provide for continued coverage where there is a waiver of subrogation, the owner of those policies will cause them to either provide a "blanket waiver" endorsement or a subrogation endorsement that includes SVH and the location of the Project.

9.13 Deductibles and Self-Insured Retentions. All deductibles and/or self-insured retentions are the sole responsibility of the first named insured and are not a reimbursable expense.

9.14 Evidence Prior to Final Payment. Before receipt of final payment under the Agreement, the Master Architect must provide evidence that its insurance coverages and its Design Team Members' coverages are effective.

9.15 Modifications Only in Writing. The coverage and limits of insurance required by this Article 9 may not be altered, modified, or changed except as expressly agreed to in writing. No course of dealing or acceptance of certificates or policies will constitute a waiver of any of these insurance requirements.

10. CLAIMS AND DISPUTES

10.1 Notice. Either Party may initiate the dispute resolution procedures by providing a notice of claim. All claims must include a detailed factual narrative of events fully describing the nature and circumstances giving rise to the claim, including, a detailed breakdown of the amount of damages or costs associated with the claim. Claims will be submitted within 10 days following the discovery of the occurrence of the event or condition or circumstance giving rise to the dispute, whichever is later. Under no circumstances will a claim be made if it is barred by applicable statutes of limitation or repose.

10.2 Continuation of the Services. Master Architect and its Design Team Members must continue to diligently perform the Services during the pendency of the claim or dispute resolution process and SVH will continue to make payments for all undisputed Services.

10.3 Business Negotiation. The parties will endeavor to first resolve their disputes through business negotiation. The business negotiation will be a face-to-face business meeting between senior management for all entities involved in the claim. SVH Representative, will coordinate and schedule the meeting within 10 business days of notice. Legal representation is not permitted. If the dispute is not resolved through business negotiations, either Party may request mediation of the dispute in writing. All decisions will be recorded in writing and signed by SVH, Master Architect, and other necessary parties. Construction Manager may attend the business negotiations with SVH and Master Architect and its Design Team Members (if applicable).

10.4 Mediation. If the dispute is not resolved by the conclusion of business negotiations, either Master Architect or SVH may demand mediation of the dispute in writing. The Parties will jointly select a mediator who is a construction attorney with at least 10 years of experience in resolving disputes regarding design and construction. Each party to the dispute will give the mediator a written statement regarding the asserted claims, and the mediator may inspect the Project and other information reasonably required to understand the factual and legal basis of the dispute. Unless mutually agreed otherwise, the mediator will schedule a mediation session within 60 calendar days of a Party's demand for mediation. Representatives from each Party who have authority to resolve the dispute, together with any other party to the dispute, will attend the mediation. All parties to the dispute will bear the cost of mediation equally. Before the mediation, each party to the dispute will execute a disclosure confirming that each understands the confidential nature of the mediation proceedings and materials pursuant to California Evidence Code section 1129. The mediation process must be completed within 30 days from the date of the mediation, unless the parties to the mediation mutually agree to extend the mediation period. If, as a result of the mediation, a negotiated settlement is reached, the parties will enter into a written settlement agreement that will be enforceable in a court of competent jurisdiction.

10.5 Government Code Claim. If mediation is unsuccessful, Master Architect must file a government claim pursuant to Government Code section 910 et seq. if it wishes to pursue its claim and initiate a civil action.

10.6 Joinder. Master Architect agrees to be joined in any litigation or alternative dispute resolution process between SVH and any person or entity involving a dispute that relates to the Project if claims for or against the Master Architect or SVH arise from the same, substantially the same, or interrelated facts, issues, or incidents relating to the Project or other Services under this Agreement, or where separate dispute resolution processes create a risk of inconsistent awards or results. Master Architect will include the dispute resolution process and joinder requirements set forth in this Article 10 in all tier-consultant agreements.

10.7 Enforceability. Master Architect reviewed the dispute resolution procedures with legal counsel and agrees to the terms and conditions set forth in this Article 10.7. To the extent a court of competent jurisdiction finds any term or provision in this Article 10.7 to be void or unenforceable, the unenforceable term or provision will be severed and the remainder of the

terms and provisions will remain in full force and effect. Nothing contained in this dispute resolution process prevents the Master Architect or its Design Team Members from timely filing a civil action to foreclose on a stop payment notice. However, the Parties agree to stipulate to a stay in the proceedings pending attempts to resolve the matter pursuant to the process defined in this Article 10.

11. TERMINATION AND SUSPENSION

11.1 Suspension. SVH may, without cause, order the Master Architect to suspend, delay, or interrupt its Services for as long as SVH may determine. If the Services are suspended for reasons other than the negligent acts or omissions of Master Architect or Design Team Members, then the Master Architect may request a Change Order per Section 7.6.

11.2 Termination of Master Architect for Convenience. SVH may terminate this Agreement for convenience upon 5 business days' written notice at any time before completion of the Services. The notice will state the extent and effective date of termination. Master Architect will be entitled to receive payment for all Services properly performed through the effective date of termination based on the compensation provisions in Article 7. All disputes over termination will be resolved under Article 10.

11.3 Termination for Cause. SVH may terminate this Agreement for cause upon 5 business days' written notice for a material breach of the terms and conditions of this Agreement unless the Master Architect commences to cure the breach within the notice period. The notice will set forth the reason for termination and the effective date of termination. All disputes over termination will be resolved under Article 10. Master Architect may terminate this Agreement for cause if SVH fails to make payment to the Master Architect and the failure to pay is not cured within 60 days of written notice.

12. OWNERSHIP OF DOCUMENTS

12.1 Ownership of Work Product. The Project Program, updated conceptual design, Schematic Design Documents, an any planning documents, drawings, criteria, design narratives, sketches, calculations, cost estimates, trenching design, and other design documentation prepared as part of the Services including for additional services ("Work Product") prepared by the Master Architect and Design Team Members are being developed and furnished for use solely with respect this Project. As such, provided that SVH has complied with the payment provisions in this Agreement, SVH will own all rights, title, and interests under Applicable Law in all Work Product. Master Architect and its Design Team Professionals will not own or claim a copyright in the Work Product prepared for the Project or any additional services incorporated into this Agreement through Change Order.

12.2 License. Master Architect and Design Team Members are each granted a limited, non-exclusive, royalty-free license to use and reproduce applicable portions of the Work Product prepared for use in the performance of the Services. All copies made under the license will bear the statutory copyright notice. Submittal or distribution to meet official regulatory requirements or for other purposes in connection with development of a project included in the Master Plan will not be construed as publication in derogation of SVH's copyright or other intellectual property rights and interests.

12.3 Exception. Nothing contained in Sections 12.1 through 12.2 limits the rights, title, and interest of the Master Architect or its Design Team Members to continue to use their respective general layout, details, design criteria, or specifications that each of them uses or has used on multiple projects, or new layouts, details, design criteria, or specifications that were developed during performance of the Services.

13. MISCELLANEOUS PROVISIONS

13.1 Confidentiality. Master Architect will keep information provided by SVH or made available to Master Architect during performance of the Services confidential, and will not disclose confidential information to persons or entities other than as necessary to perform the Services.

13.2 Patient Privacy. Any and all patient information is subject to protection under Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as may be amended. Master Architect acknowledges that its employees, agents, Design Team Members, and others acting on Master Architect's behalf may come into contact with patient protected health information ("PHI") while performing Services on the Project. PHI information includes individually identifiable information (oral, written, or electronic) about a member/patient's physical or mental health, the receipt of health care, or payment for that care, as well as individually identifiable member/patient payment, dues, enrollment, and un-enrollment information. This contact is most likely rare and brief (e.g., walking through a clinic that has patient radiological films on view boxes, overhearing conversations between physicians while performing Services at the hospital, noticing a relative or acquaintance receiving treatment, etc.). It is the intent of SVH that this type of information should not be examined closer, copied, distributed, or shared. Master Architect will adopt procedures to ensure that its employees, agents, Design Team Members, and others acting on their behalf will not further examine, copy, distribute, or share this information. If Master Architect, or its employees, agents, Design Team Members, and others acting on Master Architect's behalf further examine, copy, distribute, or share this information the Master Architect must report these actions immediately to SVH within 2 business days after the event occurs. Master Architect will take all steps necessary to stop any examination of PHI and will ensure that no further violations of this contractual responsibility will occur. Master Architect will report to SVH and the Construction Manager within 5 business days after giving notice of the event of the steps taken to prevent future occurrences, and provide SVH with the necessary assurances at that time. Master Architect will place similar confidentiality restrictions and HIPAA compliance requirements in agreements with each of its Design Team Members.

13.3 Exclusion List. Master Architect certifies that neither it, nor any of its employees, nor any tier-consultant who is proposed to provide any portion of the Services, is currently named as an excluded entity or individual on the “List of Excluded Individuals/Entities” of the Department of Health and Human Services Office of the Inspector General (“OIG List”), the “Excluded Parties List System” of the System for Award Management (“EPLS”), the “Specially Designated Nationals List” (“SDN List”) or the “Foreign Sanctions Evaders List” (“FSE List”) of the Office of Foreign Assets Control, any State debarment or exclusion list, or any other sanctions list that would make Master Architect, or any of its employees or tier-consultants ineligible to participate in any federal or state funded programs (collectively, “Lists”). Master Architect will immediately notify SVH and Construction Manager if, at any point during this

procurement, it or any of its employees, or any tier-consultant is named as an excluded entity or individual on any of the Lists.

13.4 Governing Law and Venue. This Agreement will be governed and construed under the laws of the State of California without giving effect to any choice of law or rule of conflict that would cause the application of the laws of any other jurisdiction. Each of the Parties agrees that the exclusive venue for any action will be in the applicable court in Monterey County, California.

13.5 Assignment of Contract. SVH and Master Architect respectively bind themselves, their partners, successors, assignees, and legal representatives to the other Party to this Agreement. Master Architect may not assign this Agreement. Upon notice, SVH may assign this Agreement to any lender in obtaining financing for development of the Facilities, and Master Architect and its tier-consultants will cooperate with SVH and execute required assignment and subordination agreements.

13.6 Notices. Any notice required to be given under Articles 10 or 11 will be in writing and deemed effective upon: (i) the date of personal delivery, or fax, if received by the addressee before 5:00 p.m. local time on a business day; (ii) 3 business days after being sent via registered or certified mail with a return receipt requested; or (iii) 1 business day after being sent by overnight commercial courier providing next-business-day delivery. Fax delivery must be evidenced by an automated fax confirmation. All other notices required under the Contract may be via email. Notices will be addressed to the representatives for notice identified in the Business Terms Sheet.

13.7 Conflict of Interest. Master Architect will comply with SVH's Conflict of Interest Policy set forth in Exhibit 4.

13.8 Interpretation and Severability. This Agreement's terms and conditions will be interpreted according to their plain meaning, and not strictly for or against either SVH or Master Architect. Any contrary rule of construction or interpretation will be of no force or effect with respect to this Agreement. If a court of competent jurisdiction finds any term or provision of this Agreement to be void or unenforceable for any reason, the term or provision will be amended to comply with the law. If a term or condition is severed, the remainder of the Agreement will remain in full force and effect to the maximum extent permitted by law and consistent with SVH's and Master Architect's overall intent.

13.9 Section Headings. The Section headings contained in this Agreement are for ease of reference only and will not in any way affect the meaning or interpretation of any terms or conditions of this Agreement.

13.10 No Third Party Beneficiaries. The Parties acknowledge and agree that the obligations of the Master Architect are solely for the benefit of SVH and are not intended in any respect to benefit any third parties. Nothing contained in this Agreement creates a contractual relationship with, or a cause of action in favor of, any third party against SVH or the Master Architect. SVH, however, is a third party beneficiary to all tier-consultant agreements.

13.11 Rights and Remedies. All rights and remedies under the Contract Documents will be cumulative and in addition to, and not in limitation of, all other rights and remedies of the Parties under the Contract Documents or otherwise available at law or in equity.

13.12 Survival. The following provisions will survive termination of this Agreement: Section 4.3 and 4.4 and Articles 7 through 13.

13.13 Waiver. No action or failure to act by either party waives any right or duty afforded it under the Agreement and an action or failure to act will not constitute approval of or acquiescence in a breach of contract, unless specifically agreed to in writing by the other Party.

13.14 Modifications. All modifications to the terms and conditions set forth in this Agreement must be in writing and signed by an authorized representative of both Parties.

13.15 Counterparts. This Agreement may be executed in counterparts, each of which will be deemed an original, and all of which when taken together will constitute one instrument.

13.16 Attorneys' Fees. If SVH or Master Architect commences an action or dispute resolution process in accordance with the terms and provisions of this Agreement against the other Party for claims arising out of or in connection with the Contract Documents, the prevailing Party will be entitled to recover all reasonable attorneys' fees and costs (including charges and expenses related to the suit, expert witness, and consultants' fees) as may be determined by a court with competent jurisdiction.

13.17 Equal Employment. Pursuant to Labor Code section 1735, the Fair Employment and Housing Act (Gov. Code section 12900 et seq.), California Administrative Code, Title 2, sections 7285 et seq., Government Code sections 11135-11139.5, and other Applicable Law, Master Architect will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, age, political affiliation, marital status, or disability while performing Services for SVH. Master Architect will take affirmative action to ensure that employees are treated during employment or training without regard to their race, color, religion, sex, national origin, age, political affiliation, marital status, or disability. Master Architect will maintain policies in compliance with California state and federal law regarding equal employment opportunities throughout the performance of its Services.

13.18 Gratuities. Master Architect warrants that it has not offered or given any gratuities (in the form of entertainment, gifts, or otherwise) to any official, employee, or agent of SVH in an attempt to secure this contract or favorable treatment in awarding, amending, or making any determinations related to the performance of the Services under this Agreement.

13.19 Legal Citations. Legal citations to statutory requirements are included in the Agreement for convenience and an omission of any statutory requirement will not relieve the Master Architect from compliance with Applicable Law.

13.20 Exhibits The Exhibits listed in the table of exhibits are incorporated into this Agreement by reference as though set forth in full.

13.21 Electronic Signature. The Parties agree that a "Digital Signature" as defined under Government Code section 16.5 and California Code of Regulations section 22000 is an

acceptable form of signature for written communications with SVH and will have the same force and effect as the use of a manual signature provided that the Digital Signature is: (i) unique to the person using it; (ii) capable of verification; (iii) under the sole control of the person using it; and (iv) linked to the data in such a manner that if the data are changed, the Digital Signature will be invalidated. In order to be valid, the Digital Signature must be created by an acceptable technology as defined in California Code of Regulations section 22001 et. seq.

13.22 Entire Agreement. This Agreement constitutes the entire agreement between SVH and Master Architect and supersedes any and all contemporaneous or prior oral and written negotiations, representations, or agreements by the parties with respect to the subject matter.

EXHIBIT 1

DEFINITIONS

1. **"Agreement"** means the written contract between SVH and Master Architect inclusive of all Exhibits.

2. **"Amendment"** is a document executed by the signatories on page 1 of the Agreement that amends the terms and/or conditions of this Agreement.

3. **"Applicable Law"** includes all local, state, and federal laws, rules, regulations, ordinances, building codes or other codes, statutes, or regulations, or lawful orders of Governmental Authorities that are relevant to proper performance of the Services.

4. **"Change Order"** is a written order authorizing additional services, including an extension of the Contract Time established by the Design Schedule (Exhibit 3B), by increasing or decreasing the NTE Amount. In order to be valid, a Change Order must be signed by SVH's signatory and Master Architect's signatory.

5. **"Contract Documents"** includes the Agreement (inclusive of all Exhibits) and any subsequent modifications through executed Amendments or Change Orders.

6. **"Design Team Members"** include the Master Architect's tier-consultants identified in the Business Terms Sheet.

7." **"Effective Date"** is the date that the Parties entered into the Agreement, which is set forth on Page 1 of the Agreement.

8. **"Fee"** is the amount that Master Architect will be compensated for performance of the Services, including all compensation for Master Architect's and Design Team Members' employees, plus Reimbursable Expenses, inclusive of overhead and profit.

9. **"Governmental Authority"** or **"Governmental Authorities"** means any and all federal, state, county, or municipal boards, departments, courts, offices, or agencies that are providing funding or have jurisdiction over the Project.

10. **"HCAI"** is the California Department of Health Care Access and Information.

11. **"Hospital"** means the existing hospital and facilities located at 450 E. Romie Lane, Salinas, CA 93901.

12. **"Master Architect"** means the California State licensed architect identified on page 1 of the Agreement who is responsible for performing the Services described in Exhibit 2B in accordance with the Contract Documents.

13. **"Not to Exceed Amount" or "NTE Amount"** is the maximum Fee that the Master Architect will be compensated for performance of the Services, subject to adjustment for additional services through Change Order. Reimbursable Expenses per Section 7.2.1 are included as an allowance in the NTE Amount.

14. **"Party"** means either SVH or Master Architect and "Parties" refers to SVH and Master Architect collectively.

15. **"Project"** refers to a new emergency department adjacent to and connected with the Hospital, a new parking structure across the street from the Hospital, and renovation of the Hospital's perinatal department upon removal of the existing emergency department.

16. **"Project Program"** includes design documents that define the space, quality, quantity, functionality, sustainability, aesthetic, and other requirements for the Project.

17. **"Project Team"** includes SVH and Master Architect and its Design Team Members.

18. **"Reimbursable Expenses"** are the items subject to reimbursement set forth in Section 7.2.1.

19. **"Schematic Design Documents"** will include drawings, outline specifications, and other necessary documents illustrating the scale and relationship of Project components, and will include a civil, landscaping, and preliminary layouts and floor plans, sections and elevations for major building systems, as well as line diagrams and proposed equipment schedules for each building.

20. **"Services"** are all services performed by Master Architect (inclusive of tier-consultants) under this Agreement including any additional services amended into the Agreement through executed Change Order.

21. **"SVH"** is the Salinas Valley Health District, a public entity, which is the owner of the Hospital and facilities located at 450 E. Romie Lane, Salinas, CA 93901.

22. **"SVH Representative"** is the person who acts on behalf of SVH, as set forth in Section 5.3 of the Agreement.

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EXHIBIT 2

SERVICES

Exhibit 2A – SVH Provided Information

Exhibit 2B – Scope of Services

EXHIBIT 2A

SVH PROVIDED INFORMATION

Title of Document	Date Issued
Emergency Department Planning Study	Prepared December 6, 2023 by Huddy Healthcare Solutions
Conceptual Floor Plan, Site Plan and Rendering of Hospital Expansion	Prepared December 2, 2024 by HOK
Topographic Survey of Hospital Campus	Prepared April 3, 2020 by Whitson Engineers
Aerial Photographers	Taken January 2023 during construction of parking garage annex project
Conditional Use Permit 2019-022 as amendment to 2018-010	Prepared during entitlement of parking garage annex project
Geotechnical Investigation	Prepared March 2023 by Pacific Prest Engineering

EXHIBIT 2B

SCOPE OF SERVICES

1. PROGRAM VALIDATION PHASE.

1.1 General. The Master Architect will assist SVH in the development of a detailed Project Program (DPP), to review and confirm the current program and basis of design.

1.2 Responsibilities include:

(a) Review of SVH's preliminary schematic diagram and SVH's preliminary program.

(b) Review design documents and facilities assessments recently updated, site surveys, geotechnical and other reports, environmental documents and any other documentation furnished by SVH in Exhibit 2A.

(c) Participate in two half-day charrette meetings with SVH to enable the Design Team Members to better understand SVH's goals, one in person and one by video conference, each will be attended by SVH, Construction Manager, and the Design Team Members.

(d) Evaluate community needs, capacity, staffing positions, growth projections, space demands, and requirements for operational efficiencies.

(e) Consider existing space adjacencies (flow), alternative layouts and processes, space requirements, environmental requirements, patient experience, and SVH requests.

(f) Identify any barriers or hurdles to overcome in future use of the Emergency Department.

(g) Consider phasing and relocation of services in an operational facility during renovation.

(h) Consider phasing and relocation of services in the operational facility during replacement.

(i) Review EIR, negative declaration, or other CEQA information; review survey, utility company requirements, geotechnical/geohazard reports, and other relevant documents provided by SVH in Exhibit 2A to assess design and engineering requirements. Identify any barriers or hurdles to overcome in development of the site including environmental impact reports, geotechnical issues, feasibility studies, environmental permitting issues, or other related issues for entitlement and development of the proposed Project. Provide Governmental Authorities with deliverables in support of entitlements (including but not limited to deliverables showing:

setbacks/easements, height restrictions or requirements, general building code and occupancy analysis, neighborhood concerns, and conformance with Applicable Law). Participation in community outreach meetings, and attending Governmental Authority planning meetings.

(j) Facilitate and participate in pre-development application review meeting with the City of Salinas Community Development Department and HCAI and verify all permit requirements and procedures.

(k) Participate in preliminary meetings with utility purveyors to assess Project budgets and schedule timelines.

1.3 Deliverables

(a) Provide a detailed Project Program. The detailed Project Program includes assessment of existing building systems and their impact on renovation, conceptual layout and renovation options to provide fiscally responsible program modifications and building deferred maintenance and code updates, space program and functional requirements, room data sheets/conceptual room layouts, systems criteria with technical narratives for building system components taken into consideration and a design and construction estimate of probable cost based on the detailed Project Program.

(b) Prepare updated conceptual design based on detailed Project Program. Show site traffic patterns as required or anticipated by the traffic requirements of the Project, identify the number of car parking spaces required for the new parking structure, show areas of landscaping and site furniture, and generally meet applicable Governmental Authority or other legal restrictions.

2. SCHEMATIC DESIGN AND PERFORMANCE SPECIFICATIONS PHASE

2.1 Schematic Design Documents. Master Architect and its Design Team Members will prepare Schematic Design Documents based on the approved conceptual design and the detailed Project Program. Schematic Design Documents will consist of drawings, outline specifications and other necessary documents illustrating the scale and relationship of Project components and will include a civil and landscaping plans, preliminary layouts and floor plans, sections and elevations for major building systems, as well as line diagrams and proposed equipment schedules for each building.

2.2 Reconciliation with Project Scope. Before completing the Schematic Design Documents, the Master Architect and its Design Team will evaluate the programmatic requirements and note any discrepancies between the Project requirements set forth in the detailed Project Program and SVH provided information (Exhibit 2A), the Schematic Design Documents, and update the estimated construction cost, and request approval and direction from SVH and the Construction Manager.

2.3 Design Presentation. Master Architect and its Design Team Members will provide design presentation to SVH demonstrating the design of the Project and coordination and flow with adjacent buildings.

2.4 Approval Process. The Master Architect and its Design Team Members will submit and present the following material for review and approval by SVH: (i) floor plans; (ii) site plan with larger Project site context and layout of each building; (iii) sections and elevations of the building and parking structure; (iv) line diagrams and equipment schedules for the building and parking structure; (v) outline specifications; and (vi) narratives describing how the design will meet the detailed Project Program and schematic design requirements with respect to building performance and fitness for its intended purpose and use, including narratives for the mechanical and electrical elements.

3. PROPOSAL SOLICITATION PHASE (DESIGN BUILDER)

3.1 The Master Architect and its Design Team Members will assist SVH, Construction Manager, and its legal counsel with solicitation of design build firms to complete the design and provide construction of the Project. Responsibilities include:

(a) Attendance at 2 preproposal conferences. One will be an initial meeting with all potential design build proposers. The other will include a confidential session with each potential design build team. There will not be more than 4 teams.

(b) Review and respond to design questions during the solicitation process.

(c) Review design build team proposals to assist Construction Manager and SVH in evaluating design information provided in the proposals.

4. ADD-ON SERVICES

Design Build Phase. Upon request from SVH and agreed upon terms and conditions negotiated with the Master Architect, the Master Architect and Design Team Members will assist, as needed, with peer review of drawings and specifications prepared by the design builder during the design development and construction document phases.

EXHIBIT 3

COMPENSATION AND SCHEDULE

Exhibit 3A – Resource Loaded Work Plan

Exhibit 3B – Design Schedule

EXHIBIT 3A

RESOURCE LOADED WORK PLAN

(See Attached)

EXHIBIT 3B

DESIGN SCHEDULE

(See Attached)

EXHIBIT 4

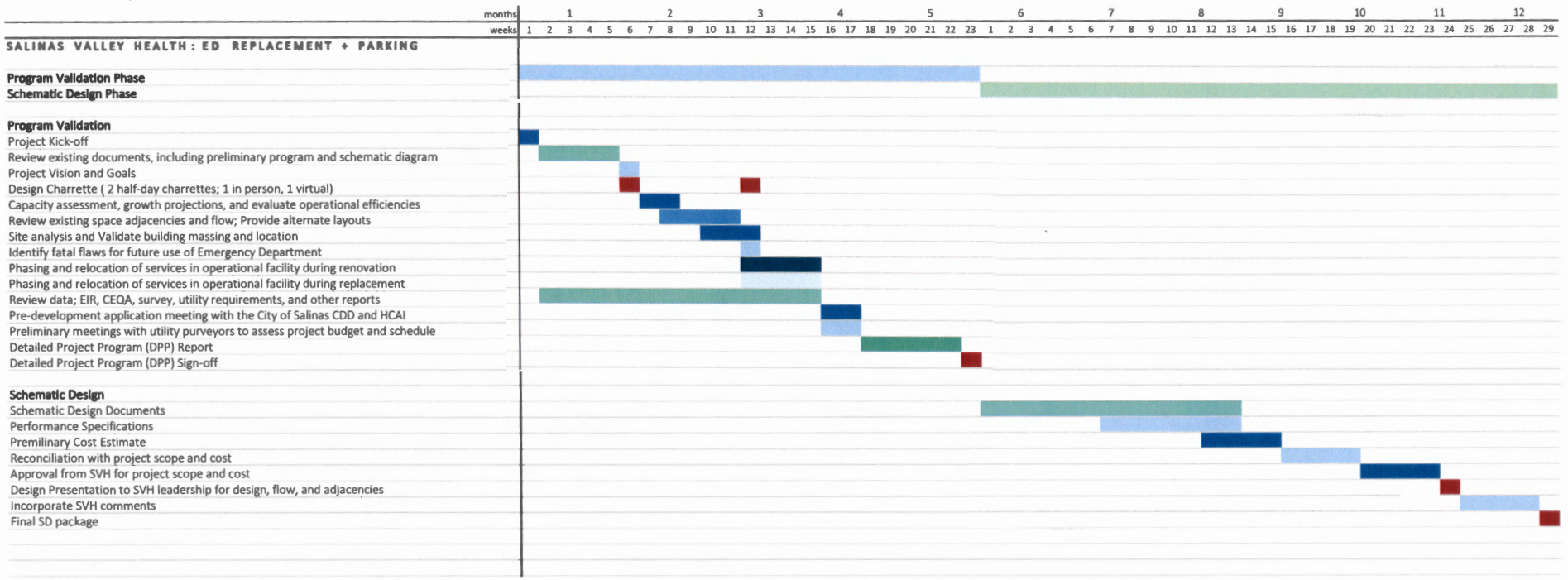
CONFLICT OF INTEREST POLICY

(See attached.)

Salinas Valley Health - Emergency Department Replacement Project
Basic Services for Programming and Schematic Design

Architecture		In-charge	Manager	Lead	Planner	Planner	Lead	Designer	Architect	Designer	Arch I	Arch II	Lead	Designer	Manager	QAQC	Hours	Phase Fee
		$344	$207	$328	$372	$220	$428	$171	$206	$233	$110	$140	$268	$155	$225	$343		
Programming																		
April - August	**Phase Hours**	40	264	40	80	280	20	240	0	0	700	0	40	80	20	8	1,812	
	Sub-Total Fee	$13,760	$54,648	$13,120	$29,760	$61,600	$8,560	$41,040	$0	$0	$77,000	$0	$10,720	$12,400	$4,500	$2,744		$ 329,852
Schematic Design																		
September - March	**Phase Hours**	60	372	16	8	60	40	120	620	80	1240	744	80	392	20	24	3,876	
	Sub-Total Fee	$20,640	$77,004	$5,248	$2,976	$13,200	$17,120	$20,520	$127,720	$18,640	$136,400	$104,160	$21,440	$60,760	$4,500	$8,232		$638,560
																HDR	**5,688**	**$ 968,412**

FIRM ROLE	FIRM NAME	FEES
Civil	Whitson	$ 176,000
Joint Trench	Giacalone	$ 12,000
Structural	GreenLight	$ 15,700
MEP, Technology	Mazzetti	$ 287,120
Medical Equipment	Mazzetti	$ 31,200
Parking Structure & Technology	Watry Design	$ 97,070
Cost Estimation	Cumming	$ 44,240
	Consultant Sub-Total	**$ 663,330**
		$ 1,631,742
	Reimbursables	$ 35,000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SALINAS VALLEY HEALTH : ED REPLACEMENT + PARKING
Program Validation Phase
Schematic Design Phase
Program Validation
Project Kick-off
Review existing documents, including preliminary program and schematic diagram
Project Vision and Goals
Design Charrette (2 half-day charrettes; 1 in person, 1 virtual)
Capacity assessment, growth projections, and evaluate operational efficiencies
Review existing space adjacencies and flow; Provide alternate layouts
Site analysis and Validate building massing and location
Identify fatal flaws for future use of Emergency Department
Phasing and relocation of services in operational facility during renovation
Phasing and relocation of services in operational facility during replacement
Review data; EIR, CEQA, survey, utility requirements, and other reports
Pre-development application meeting with the City of Salinas CDD and HCAI
Preliminary meetings with utility purveyors to assess project budget and schedule
Detailed Project Program (DPP) Report
Detailed Project Program (DPP) Sign-off
Schematic Design
Schematic Design Documents
Performance Specifications
Premilinary Cost Estimate
Reconciliation with project scope and cost
Approval from SVH for project scope and cost
Design Presentation to SVH leadership for design, flow, and adjacencies
Incorporate SVH comments
Final SD package

Board Paper: Finance Committee

Salinas Valley HEALTH

Agenda Item: **Consider Recommendation for Board Approval of Competitive Solicitation and Contract Award for Epic Acute Project Go-Live Assistance Engagement with Optimum Health IT**

Executive Sponsor: Alysha Hyland, Chief Administration Officer
Josh Rivera, Director Enterprise Informatics

Date: June 23, 2025

Executive Summary

The Salinas Valley Health Board approved the Epic Acute Project in May 2024. Included in the approval was the Total Cost of Ownership (TCO), which covered all budgeted items associated to the implementation of Epic. The budget for Epic Project go-live assistance was set at $2,079,360. The competitive solicitation covers Credential Training augmented support, At-The-Elbow (ATE) augmented support, and augmented Help Desk support.

Timeline/Review Process to Date:

May 2024: Salinas Valley Health Board approves the Epic Acute Project

May 2025: Salinas Valley Health opens Request for Proposal (RFP) for Epic Acute Go-Live Assistance for three areas: Training, At The Elbow support and Help Desk support.

June 2025: Salinas Valley Health's Selection Committee selects Optimum Healthcare IT for go-live assistance engagement.

Strategic Plan Alignment:

Implementation of Epic Acute provides a unified platform for the delivery of healthcare services throughout our health system. The implementation of Epic Acute will improve the service we to provide to our patients, enhance patient engagement, raise our quality of care through more robust access to data, and allow for financial improvements related to better integration and population health management capabilities.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

Key Contract Terms	Vendor: Optimum Health IT
1. Proposed effective date	July 1, 2025
2. Term of agreement	Four (4) month engagement
3. Renewal terms	N/A
4. Termination provision(s)	30 day written notice
5. Payment Terms	Payment due 45 day once invoice is issued
6. Annual cost	Not to exceed: $3,200,000.00
7. Cost over life of agreement	Not to exceed: $3,200,000.00 (includes travel expenses)
8. Budgeted (indicate y/n)	Yes

Recommendation

Consider Recommendation for Board Approval of Competitive Solicitation and Contract Award for Epic Acute Project Go-Live Assistance Engagement with Optimum Health IT in an amount not to exceed $3,200,000.00

Attachment:

SOW# 001 Epic Credential Trainers - Optimum Healthcare IT – SVH
SOW#002 - Optimum HIT - Epic GoLive ATE Support - Salinas Valley Health
SOW#003 - Optimum HIT - Virtual Help Desk Support - SVH

Salinas Valley Health - Statement of Work #001 - Epic Credentialed Trainers
June 13th, 2025

This Statement of Work (hereinafter "SOW") is entered into effect the 13th of June 2025, between Optimum Healthcare IT, LLC (hereinafter "Optimum") and Salinas Valley Memorial Healthcare System operating as Salinas Valley Health (hereinafter "SVH" or "Client"). This SOW is controlled and governed by the Master Services Agreement between Optimum HIT and Client dated June 18th, 2019 (the "Agreement") and is subject to the terms and conditions stated in the Master Services Agreement.

Summary and Responsibilities

- Client is seeking the staff augmentation of Epic Credentialed Trainers for their Epic implementation.
- The Epic Credentialed Trainers provided by Optimum will work with the Client's Epic Project Leadership Team and Epic Principal Trainers to deliver Epic training to Client's staff and end-users.
- All Epic Credentialed Trainers will have prior Epic Credentialed training experience, possess strong verbal and written communication skills, and can convey complex information clearly and effectively in a classroom setting.
- Epic Credentialed Trainers will have a strong understanding of healthcare and the Epic EMR system in their respective applications and be experienced learning, teaching, and utilizing software and tools related to the Epic system.
- Optimum will identify, recruit, and present Epic Credentialed Training candidates to the Client for their selection/approval and onboard them to the Clients standards
- All Epic Credentialed Trainers provided by Optimum will service the Client at the direction provided by the Client's Epic Project Leadership, Epic Training Project Management, and Epic Principal Trainers.

Client Responsibilities

The Client will provide the Epic Project Managers and Epic Principal Trainers to support the Epic Credential Trainers provided by Optimum. Client will also provide:

- Client will provide an Epic Credentialing process to ensure staff are accustomed to Client's Epic instance, workflows, and environment
- Contact information of persons involved with this project
- Reasonable access to the necessary resources from their IT and operational departments
- Appropriate remote VPN or dial-up access/Remote access for the resource provided
- Detailed schedule with advance notice to staff including locations, days, hours, and onsite vs virtual, and travel requirements

Project Timeline

This project is scheduled to begin on August 18th, 2025 and is scheduled to end on November 28th, 2028 with an option to extend. Client reserves the right to modify the schedule and resource-counts to meet the needs of their Project.

Project Team

Optimum will work in partnership with Client to build a team-roster for the Epic Training Project, in association with this SOW. A full roster, including any additions or modifications will be provided to the Client in writing. Client reserves the right to terminate or request replacement of any staff not meeting SOW standards.

Labor Costs

Optimum will bill Client for the Epic Credentialed Trainers at $82 per hour as stated in the RFP. The forecast in the table below is for projection purposes only. Optimum will only bill Client for hours worked on the project:

Role	# Resources	Week Start	Week End	# Weeks	Hours/wk.	Total hr.	Rate/hr.	Total
Credential Trainers	15	8/18/25	11/28/26	15	40	9,000	$82	$ 738,000
	15							

Travel Expenses

Optimum shall be entitled to reimbursement of its project related expenses, including costs of travel, meals, lodging and other direct project related expenses. The expense policy will allow for a per diem with no receipts based on the Monterey, California GSA per diem rate of $79. Additionally, Optimum will mirror the travel policy as described by the Client in the Master Services Agreement. The expenses in the table below are provide for forecast purposes, Optimum will only bill the Client for exact expenses generated with no mark-ups:

Epic Credentialed Trainers	Weeks	Cost Per Week	Total
15	15	$ 1,900.00	$427,500.00

Acceptance

To accept the Agreement, please sign in the space provided.

Acknowledged and accepted by Client: Salinas Valley Health

BY: _____ _____

_____

SIGNATURE TITLE DATE

Optimum HEALTHCARE IT®

Acknowledged and accepted for Optimum HIT

BY: _____ _____

_____

SIGNATURE TITLE DATE

Salinas Valley Health - Statement of Work #002 - Epic GoLive ATE Support
June 13th, 2025

This Statement of Work (hereinafter "SOW") is entered into effect the 13th of June 2025, between Optimum Healthcare IT, LLC (hereinafter "Optimum HIT") and Salinas Valley Memorial Healthcare System operating as Salinas Valley Health (hereinafter "SVH" or "Client"). This SOW is controlled and governed by the Master Services Agreement between Optimum HIT and Client dated June 18th, 2019 and is subject to the terms and conditions stated in the Master Service Agreement.

Scope of Services

- Client is seeking staffing services to augment their team and support their Epic GoLive of enterprise Epic applications for their inpatient and acute care environments
- Optimum will be responsible for the placement of approximately 100 Epic ATE Resources to support this project
- Resources will be selected by Optimum's Epic GoLive Delivery Team and will be experienced supporting Epic GoLives for the requested Epic applications to support Client's project
- Optimum will provide project management to oversee the team, track and maintain quality, and collaborate with Client management to deliver successful outcomes

Client Responsibilities

- Client will facilitate an orientation prior to GoLive for all of the Epic ATE Staff provided by Optimum
- Client will provide the final requested resource counts and associated application areas no later than 30 days prior to the Go-Live date to ensure proper onboarding and compliance processing. Any adjustments or additional resource requests after this deadline will be accommodated to the best of Optimum's Epic GoLive Delivery Team's ability, subject to resource availability and onboarding constraints.
- Client will provide access to information, related due diligence documentation, project plans, specifications and any items which are pertinent to the above scope of services
- Client will provide access to the necessary resources from their IT/Operational departments
- Client reserves the right to terminate or request replacement of any staff not meeting SOW standards.

Project Schedule

This Epic GoLive is scheduled for November 8rd, 2025 with support up to 5 weeks through December 5th, 2025. Resources will travel on November 2nd, 2025, participate in orientation November 3rd through November 7th, 2025 and begin supporting the Epic GoLive on November 8th, 2025. Taper schedule and end dates will be determined in partnership by Client and Optimum to serve the interest and success of the project.

Onboarding

Optimum shall be responsible for ensuring that all personnel provided under this SOW have successfully passed all drug testing, criminal background checks, and Optimum's standard clinical compliance requirements, aligned to industry standards.

Professional Fees

The services described in this SOW will be provided on time and materials basis in accordance with the negotiated terms in the RFP process. The total fees in the table below are an estimate - they are not a minimum or fixed fee. Actual fees will be billed according to hours worked, and may be different than the estimated amount in the table, which is for forecast purposes:

ORIENTATION

Week	Role	Start Date	End Date	# Resources	Hours	Total hr.	Rate/hr.	Total
Orientation	Activation PM	11/3/26	11/7/26	1	8	8	$0	$0
Orientation	Team Leads			3	8	24	$72	$1,728
Orientation	Go-Live ATE Support			100	8	800	$72	$57,600
				104		832	Total	$59,328

GO-LIVE SUPPORT

Week	Role	Week Start	Week End	# Resources	Hours	Total hr.	Rate/hr.	Total
Go-Live Week 1	Activation PM	11/8/25	11/15/25	1	60	60	$0	$0
Go-Live Week 1	Team Leads			3	60	180	$72	$12,960
Go-Live Week 1	Go-Live ATE Support			100	60	6000	$72	$432,000
				104		6,240	Total	$444,960

Week	Role	Week Start	Week End	# Resources	Hours	Total hr.	Rate/hr.	Total
Go-Live Week 2	Activation PM	11/16/25	11/22/25	1	60	60	$0	$0
Go-Live Week 2	Team Leads			3	60	180	$72	$12,960
Go-Live Week 2	Go-Live ATE Support			60	60	3600	$72	$259,200
				64		3,840	Total	$272,160

Week	Role	Week Start	Week End	# Resources	Hours	Total hr.	Rate/hr.	Total
Go-Live Week 2	Activation PM	11/23/25	11/29/25	1	60	60	$0	$0
Go-Live Week 2	Team Leads			3	60	180	$72	$12,960
Go-Live Week 2	Go-Live ATE Support			25	60	1500	$72	$108,000
				29		1,740	Total	$120,960

Week	Role	Week Start	Week End	# Resources	Hours	Total hr.	Rate/hr.	Total
Go-Live Week 3	Activation PM	11/30/25	12/5/25	1	60	60	$0	$0
Go-Live Week 3	Team Leads			1	60	60	$72	$4,320
Go-Live Week 3	Go-Live ATE Support			15	60	900	$72	$64,800
				17		1,020	Total	$69,120

Travel Estimate	$568,512
Go-Live Support Total	$966,528
Grand Total	$1,535,040

Overtime

Optimum has prepared this proposal based on the assumption that each go-live support resource will work up to 60 hours per week, including 20 hours of overtime per week, consistent with the RFP instructions. If Client elects to increase scheduled weekly hours beyond this threshold, rates will be subject to adjustment aligned to reflect additional overtime exposure and labor cost impact.

Travel Expenses

Optimum is entitled to reimbursement of its reasonable project related expenses, including costs of travel, meals, lodging, and other direct project related expenses. Optimum will act in a reasonable manner to minimize expenses, mirror the Client's Travel Policy. Optimum will provide Client with a report of all expenses and documentation for this project. Optimum staff will be eligible for expense reimbursement from the kick-off travel date through their completion of the project. Optimum will only bill Client for actual expenses generated with no mark-ups or additional fees. The table below is an

estimation, not a fixed fee; travel expenses may be more of less than the amount in the table below, which is provided for forecast purposes:

TRAVEL ESTIMATE

Travel Cost	% of Total	Total
Flights	13%	$ 72,100
Hotel	47%	$ 264,600
Ground Transportation	14%	$ 78,650
Incidentals	4%	$ 22,660
Per Diem	23%	$ 130,502
Total		**$ 568,512**

Travel Expense Disclaimer

Optimum will contract directly with one or more hotels and transportation resources (including shuttles and air travel) to accommodate the staff for the Go-Live. Optimum will reserve rooms and make transportation commitments based on the schedule agreed upon with Customer. Should Client decide to cancel the project or modify project dates, Optimum may incur attrition fees for rooms not used and/or cancellation or other penalties, rate increases or other charges regarding transportation commitments as a result of the schedule changes. If Client modifies their Epic GoLive date and Optimum is charged such attrition fees or incurs such penalties, rate changes or other charges, Client will reimburse Optimum for those costs.

Invoicing/Payment Schedule

Invoicing for the Project will be billed in accordance with the MSA between Client and Optimum.

Other Terms and Conditions

This Statement of Work states the entire agreement of the parties as to the subject matter hereof. This Statement of Work may only be modified in writing, signed by both parties. If you accept this Statement of Work please sign below and return the signed document to Optimum Healthcare IT, LLC., by email, lveal@optimumhit.com

Acceptance

To accept the Agreement, please sign in the space provided.

Acknowledged and accepted by Client: Salinas Valley Health System

BY: _____

_____ _____

SIGNATURE TITLE DATE

Acknowledged and accepted for Optimum HIT

BY: _____

Optimum HEALTHCARE IT®

SIGNATURE	TITLE	DATE

Salinas Valley Health - Statement of Work #003
Virtual Help Desk Support Resources
June 13th, 2025

This Statement of Work (hereinafter "SOW") is entered into effect the 13th of June 2025, between Optimum Healthcare IT, LLC (hereinafter "Optimum") and Salinas Valley Memorial Healthcare System operating as Salinas Valley Health (hereinafter "SVH" or "Client"). This SOW is controlled and governed by the Master Services Agreement between Optimum HIT and Client dated June 18th, 2019, and is subject to the terms and conditions stated in the Master Services Agreement.

Summary and Responsibilities

- Client is seeking staffing support to virtually augment their team their Virtual Help Desk Support Resources to support their Epic GoLive of enterprise Epic applications.
- Optimum will be responsible for the virtual placement of 11 Virtual Help Desk Support Resources to support this project
- Resources will be selected by Optimum's Epic GoLive Delivery Team and will be experienced supporting Epic GoLives for the requested Epic applications to support Client's project
- Optimum will provide project management to oversee the team, track and maintain quality, and collaborate with Client management to deliver successful outcomes
- Optimum will provide laptops and necessary technology and software to all staff; as well as advisory services to Client to ensure proper technical workflows are established

Client Responsibilities

- Client will partner with Optimum to set up the technical infrastructure and workflow to service calls
- Client will provide direction to facilitate access and comply with security protocols
- Client will provide access to information, related due diligence documentation, project plans, specifications and any items which are pertinent to the above scope of services
- Client will provide access to the necessary resources from their IT and operational departments
- Client will provide appropriate remote VPN / technical access if applicable
- Client reserves the right to terminate or request replacement of any staff not meeting SOW standards.

Project Schedule

- Resources will begin on November 7th, 2025 and conclude on November 15th, 2025
- Resources will be scheduled 60 hours per week, as stated in the RFP.
- 8 day-shift agents and 3 night-shift resources will be working 12-hour shifts
- Optimum and Client will work in good faith to adjust to any modifications to schedule and resource-counts
- Client may request resources to start ahead of the Epic GoLive to support the Appointment Conversion/Soft GoLive. Client and Optimum will work together in good faith to establish this service-delivery and provide documentation via email.

Labor Costs

Optimum will bill Client for the Virtual Help Desk Support Resources at $68 per hour as stated in the RFP. The forecast in the table below is for projection purposes only. Optimum will only bill Client for hours worked on the project:

Orientation

Week	Role	Start Date	End Date	# Resources	Hours	Total hr.	Rate/hr.	Total
Orientation	Help Desk Resource - Days	11/7/25	11/7/25	8	8	64	$68	$4,352
Orientation	Help Desk Resource - Nights			3	8	24	$68	$1,632
				11		88	Total	$5,984

Help Desk Support Week 1

Week	Role	Week Start	Week End	# Resources	Hours	Total hr.	Rate/hr.	Total
Go-Live Week 1	Help Desk Resource - Days	11/8/25	11/15/25	8	60	480	$68	$32,640
Go-Live Week 1	Help Desk Resource - Nights			3	60	180	$68	$12,240
				11		660	Total	$44,880

Help Desk Support Week 2

Week	Role	Week Start	Week End	# Resources	Hours	Total hr.	Rate/hr.	Total
Go-Live Week 2	Help Desk Resource - Days	11/16/25	11/22/25	8	60	480	$68	$32,640
Go-Live Week 2	Help Desk Resource - Nights			3	60	180	$68	$12,240
				11		660	Total	$44,880

Help Desk Support Total $95,744

Travel Expenses

This is a virtual team and no travel is anticipated for the staff associated with this SOW. In the event travel is requested, Optimum shall be entitled to reimbursement of its project related expenses, including costs of travel, meals, lodging and other direct project related expenses.

Acknowledged and accepted by Client: Salinas Valley Health

BY: _____ _____

_____

SIGNATURE TITLE DATE

Acknowledged and accepted for Optimum HIT

BY: _____ _____

_____

SIGNATURE TITLE DATE

BOARD Submission Checklist
Epic Acute Project – Go-Live Assistance

The original of this completed/fully signed checklist and all required supporting documents are to be hand-delivered to reviewer listed below:

✓ **BOARD or CEO PAPER** – required for all submissions; see attached instructions/sample

✓ **KEY CONTRACT TERMS** – required for all submissions – see table in Board/CEO Paper

✓ **CONTRACT** – negotiated final contract with vendor signature

✓ **PROCUREMENT PROCESS DOCUMENTATION** – required for all submissions requiring Board/CEO review/approval per Procurement Management Policy (see policy for details; indicate which sub-category is applicable):

✓ If for **data processing/telecommunications goods/services** of $25,000 or more, check applicable option and include documentation: **CIO must review.**
- ✓ RFP documentation *unless sole source or GPO applies.*
- ☐ If Sole source – provide detailed justification
- ☐ If GPO, submit qualifying verification from Materials Management

☐ If for **professional/other services or medical/surgical equipment and supplies** $350,000 or more, check applicable option and include documentation:
- ☐ RFP documentation *unless sole source or GPO applies.*
- ☐ If Sole source – provide detailed justification
- ☐ If GPO, submit qualifying verification from Materials Management

☐ If for **non-medical materials/supplies/Public Works** $25,000 or more, check applicable option and include documentation:
- ☐ RFP/Invitation for bids documentation
- ☐ If Sole source – provide detailed justification
- ☐ If GPO, submit qualifying verification from Materials Management

Legal counsel/Contract Administrator reviewed: No___ or Yes X By Whom: Natalie James

SUBMITTED BY DEPARTMENT DIRECTOR OR DEPARTMENT ADMINISTRATOR:

Joshua Rivera (Jun 13, 2025 16:19 PDT) — Signature

Director Enterprise Informatics — Title/Dept.

06/13/2025
6/10/2025 — Date

REVIEWED BY: (In the following order) – If Capital; Axiom approval in lieu of signature.

CIO: (if applicable) Audrey Parks — Date: 06/13/2025

Director of Audit/Compliance: Dora Ratcliff RN MBA
Dora Ratcliff RN MBA (Jun 16, 2025 13:44 PDT) — Date: 06/16/2025

CORPORATE COMPLIANCE & AUDIT COMMITTEE

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

(JOEL HERNANDEZ LAGUNA)

Medical Executive Committee Summary – June 12 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Nordloff, Timothy, MD, DDS	Oral/Maxillofacial Surgery	Surgery	Oral/Maxillofacial Surgery
Zheng, Jasper, MD	Pathology	Surgery	Pathology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Blum, Martha, MD	Infectious Disease	Medicine	Infectious Disease General Internal Medicine
De Guzman, Liane, DO	Internal Medicine	Medicine	Hospitalist – Adult
Fernandez, Robert, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Gallegos, Daniel, MD	Family Medicine	Family Medicine	Family Medicine – Active Community
Hindi, Yousef, MD	Cardiology	Medicine	Cardiology Salinas Valley Health Advanced Imaging-Cardiac Imaging Salinas Valley Health Cardiovascular Diagnostics
Holloway, Jamila, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Lee, Elaine, DO	Family Medicine	Medicine	Hospitalist – Adult
Lin, Bruce, MD	Radiology	Surgery	Salinas Valley Health Imaging Salinas Valley Health Advanced Imaging-Non-Cardiac Diagnostic Radiology
Shu, Fred, MD	Radiology	Surgery	Remote Radiology Salinas Valley Health Advanced Imaging – Remote Non-Cardiac Diagnostic Radiology
Silva, Natali, MD	Family Medicine	Medicine	Hospitalist – Adult

Privilege Modifications:

NAME	SPECIALTY	PRIVILEGE CHANGE
Sunde, Douglas, MD	Plastic Surgery	Surgery Active Community – Surgical Assisting

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Ching, Jason MD	Tele-Neurology	Resignation effective 2/21/2025
Garcia, Erika, MD	Family Medicine	Recommend advancement to Active Staff
Hay, Sunthara, DO	Ob/Gyn	Resignation effective 6/30/2025
Kramer, Erik, MD	Emergency Medicine	Recommend advancement to Active Staff
Parsons, David, MD	Gastroenterology	Recommend advancement to Active Staff
Sangha, Maheep, MD	Gastroenterology	Recommend advancement to Active Staff
Smith, Diana, MD	Tele-Psychiatry	Resignation effective 5/9/2025

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

ITEM	RECOMMENDATION
Surgery – Active Community Clinical Privilege Delineation Revision	The Committee recommended approval of the revisions consisting of the removal of Surgical Assisting Only, Dentoalveolar Surgery and Use of Fluoroscopy as special procedures.

Interdisciplinary Practice Committee

Initial Appointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Helderle, Morgan, PA-C	Physician Assistant	Surgery	Tarun Bajaj, MD Mark Healy, MD Mario Roldan, DO

Reappointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Petronijevic, Nicholas PA-C	Physician Assistant	Surgery	Bert Tardieu, MD John Bonano, MD David Roy, MD Matthew Griffin, MD Justin Swan, MD Willard Wong, MD
Shearing (Worthington), Tiffany, PA-C	Physician Assistant	Surgery	Vincent DeFilippi, MD Andreas Sakopoulos, MD
White, Melissa, PA-C	Physician Assistant	Emergency Medicine	Cristina Martinez, MD

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Duran, Jacob, PA-C	Physician Assistant **- Cardiology**	Resignation effective 5/16/2025
Mander, Tracy, PA-C	Physician Assistant – Emergency Medicine	Resignation effective 5/27/2025

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

ITEM	RECOMMENDATION
Nursing Standardized Procedures	Recommend approval: • Abdominal Pain Nursing Standardized Procedure • Cardiovascular Nursing Standardized Procedure • Glycemic Measurement at Point of Care Standardized Procedure • Nausea and Vomiting Nursing Standardized Procedure • Vaginal Bleeding Nursing Standardized Procedure

Policies and Plans:

1. Authority Statement – Infection Prevention
2. Discharge Criteria OBED
3. Endoscope Handling – Reprocessing and Storing
4. Induction-Augmentation of Labor and Cervical Ripening
5. Outsourcing Sterile Compounding
6. Reportable Diseases and Conditions

Informational Items:

I. Committee Reports:

a. Nominating Committee – Medical Staff Officers 10/01/25 – 09/30/27
b. Credentials Committee
c. Interdisciplinary Practice Committee
d. Medical Staff Excellence Committee
e. Quality and Safety Committee
    - Accreditation & Regulatory Update
    - Pharmacy & Therapeutics/Infection Prevention Committee
    - Safety Events
    - Leapfrog Updates
    - Environment of Care Report
    - Falls/Mobility Committee Report

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings May 2025
c. Medical Staff Treasury Report June 5, 2025
d. Medical Staff Statistics Year to Date
e. Financial Update April 2025
f. HCAHPS Update June 4, 2025

Clinical Privileges Delineation
Surgery – Active Community

Applicant Name: _____

Qualifications:

ACTIVE COMMUNITY SURGERY PRIVILEGES:
To be eligible to apply for Active Community privileges in Surgery, the applicant must meet the following qualifications:

Successful completion of an accredited ACGME, AOA, or APMB accredited post-graduate training program in at least one of the specialties listed below:

1. Cardiac Surgery
2. Dentistry
3. General Surgery
4. Neurosurgery
5. Ophthalmology
6. Oral/Maxillofacial Surgery
7. Orthopaedic Surgery
8. Otolaryngology
9. Plastic & Reconstructive Surgery
10. Podiatry
11. Thoracic Surgery
12. Urology
13. Vascular Surgery

Privileges are available only to those applicants who qualify and apply for Active Community Status membership.

ACTIVE COMMUNITY PRIVILEGES
Active Community privileges are reserved for physicians with office based practices who do not routinely provide care in the acute hospital setting.

Active Community Core Procedures for Surgery: Applicant please check box next to privilege you are requesting.

☐ **Ordering of outpatient diagnostics tests**
(No volume associated proctoring or reappointment criteria associated with this privilege)

Special Procedures/Privileges

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~**Surgical Assisting Only**~~ ~~(*Designation as Co-Surgeon is not allowed*)~~	~~Successful completion of an approved surgical or surgical associated residency training program~~ ~~**AND**~~ ~~Applicant must be able to document that he or she has assisted in at least 12 surgical procedures as first assistant or primary surgeon within the past 24 months.~~	~~1~~	~~Applicant must provide reasonable evidence of current ability to perform requested privileges~~ ~~**AND**~~ ~~Document the performance of at least six (6) surgical procedures as first assistant or primary surgeon within the past 24 months~~
				~~**Dentoalveolar Surgery**: surgical extractions, removal of impacted teeth, surgical exposure of impacted teeth~~	~~DDS or DMD or (MD plus DDS or DMD)~~ ~~**AND**~~ ~~Successful completion of an accredited post-graduate training program in oral and maxillofacial surgery that included training for procedures of the soft and hard tissues~~	~~1~~	~~Applicant must provide reasonable evidence of current ability to perform requested privileges~~ ~~**AND**~~ ~~Document the performance of at least five (5) surgical procedures within the past 24 months~~

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Use of Fluoroscopy~~	~~Current California State X-Ray S&O Fluoroscopy Certification~~	~~None~~	~~Current California State X-Ray S&O Fluoroscopy Certification~~

Acknowledgment of practitioner

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

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

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

Applicant Signature _____ Date _____

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

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

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

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

Department Chair Signature _____ Date _____

Status Pending PolicyStat ID 18075116

Origination	04/2022	Owner	David Thompson: Director Nursing
Last Approved	N/A	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Abdominal Pain Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. CBC : Complete Blood Count
B. CMP: Comprehensive Metabolic Panel
C. HCG: Quantitative Serum Pregnancy Test
D. Draw Extra: Extra serum tubes collected in anticipation of blood test being added on at a later time.
E. ED: Emergency Department
F. INT: Intravenous Therapy (saline lock) with intermittent flushes
G. UA: Urinalysis
H. ODT: Oral Disintegrating Tablet

III. PROCEDURE

A. Function
   - To expedite care for patients who present to the Emergency Department with a chief complaint of abdominal pain

B. Circumstances
   - Setting
     1. Registered nurses in the ED may order the following labs:
        a. For patient's eighteen (18) years of age and over with a complaint of abdominal pain order: CBC, CMP, POC I-stats as

needed, serum HCG (patients 18-55 years of age), Lipase, DRAW EXTRA, UA and culture if needed, Zofran 4 mg ODT (oral disintegrating tablet) X1 dose may be given.

b. For patient's ten (10) years of age to eighteen (18) years of age Zofran 4 mg ODT (oral disintegrating tablet) X1 dose may be given if continuing to feel sick. UA and culture if needed.

c. For patient's less than ten (10) years of age follow the age and weight based Zofran protocol:

    i. One (1) year to ten (10) years: 0.1mg/kg liquid PO max 4 mg x1. If weight based dose is 4 mg can give the ODT instead. For patients, only if continuing to vomit. On patients over three (3) years of age and older obtain UA and culture if needed.

d. If patient 40 years of age or older and complaining of epigastric/ upper abdominal pain, TROPONIN should be ordered and an EKG done

e. Place INT if vital signs unstable, persistent vomiting, sever pain/ distress and concern of life threating condition

- Supervision

1. Registered Nurses who are qualified to perform this standardized procedure may independently order blood work on patients who present with a chief complaint of abdominal pain, and for whom meet the criteria above. Physician supervision is not required.

- Patient Conditions

1. Emergency Department patients who meet the following criteria:

a. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.

b. Chief complaint of abdominal pain

c. Patients not signed up by a physician or will not see within 30 min or a timely manner

C. Database

- Subjective:

1. Prioritization and Severity of Illness

a. Patients eighteen years of age and older with the chief complaint of abdominal pain will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

b. History of present illness/injury/chief complaint
c. Have patient point with one finger to most painful location
d. Consider conditions related to gastrointestinal, genitourinary, or reproductive systems.
    i. Female: determine last normal menstrual period
    ii. Male: assess for possible testicular torsion.
e. History of abdominal surgeries/illnesses
f. History of diarrhea, constipation, nausea, or vomiting
g. Pain description

- Objective:
    1. Chief complaint of abdominal pain
        a. Signs of hypovolemia
        b. Signs of peritoneal irritation
        c. Inability to ambulate or sit
        d. Color of skin/sclera
        e. Odors
        f. Objective signs of pain

D. Diagnosis
- Abdominal pain

E. Plan
- Treatment
    1. If the ED physician is not signed up or will see the patient within 30 min or a timely manner the order set should be placed under 'Physician, Emergency'
    2. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE. (see PATIENT IDENTIFICATION POLICY)
    3. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag
    4. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.
- Patient conditions requiring consultation/reportable conditions
    1. **Immediately notify an Emergency Department physician of the following:**

a. Changes in airway, breathing, circulation or altered level of consciousness.

b. Change in triage acuity.

Note: if the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, suspected mesenteric ischemia, Ruptured appendix/peritonitis, ruptured ectopic, ovarian/ tsticular torsion, incarcerated hernia, DKA, severe pain or severe dehydration or c/o ACS.

- Education - Patient/Family
    1. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy
- Follow Up
    1. As needed to maintain continuity of care
- Documentation of Patient Treatment
    1. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    2. The ED RN initiating the standardized procedure will document the following: "CBC, CMP, LIPASE, DRAW EXTRA, UA, HCG Qualitative, urine HCG (if appropriate) ordered per "standardized procedure" in the patient record. EKG and TROPONIN if over forty (40) years of age with upper abdominal pain.
    3. Enters "supervising ED physician as ordering provider per policy.
    4. Navigates to ER Nursing Orders.
    5. Selects "ABD Pain-Standardized Procedure" order set.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education and Training
    - The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

B. Experience
    - Current California RN license and designated to work in ED

C. Evaluation
    - Initial: at 3 months, 6 months, and 12 months by the nurse manager through

feedback from colleagues, physicians, and chart review during performance period being evaluated.

- Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
- Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
- Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

- Policy goes through the Emergency Department Physician Group every three (3) years.
- Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
- Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.

B. Review schedule

- Review of policy occurs every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

- Approval of the standardized procedure is outlined in the electronic policy and procedure system.
    1. Director of Emergency Department, Medical Director of Emergency Department, Chair of Interdisciplinary Practice Committee, and Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

VII. REFERENCES

A. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR, Section 1379.

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2007), 6th Edition- Emergency management involving assessment of the abdomen 47, 159-186

C. Marx, J., Hockberger, R.WS., & Walls, R. M. (Eds). (2002). Rosen's emergency medicine:

Concepts and clinical practice (5th ed). St Louis, MO: Mosby

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
EM Dept.	Cristina Martinez: PHYSICIAN	05/2025
EM Dept.	David Thompson: Director Nursing	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	David Thompson: Director Nursing	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18075181

Origination	06/2022	Owner	David Thompson: Director Nursing
Last Approved	N/A	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Chest Pain/Cardiovascular Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Wong-Baker Scale: System to rate pain on a numeric scale, zero (0) to ten (10).

B. ER: Emergency Room

C. EKG: Electrocardiogram

D. IV/INT: Intravenous Therapy (saline lock) with intermittent flushes.

E. CBC: Complete Blood Count

F. CMP: Comprehensive Metabolic Panel

G. TROP: Troponin

H. sHCG: Human Chorionic Gonadotropin

I. SOB: Short of Breath

III. PROCEDURE

A. Function

1. To expedite care for patients who present to the Emergency Department (ED) with a chief complaint of chest pain or other symptoms that may be cardiovascular/cardiac in nature.

B. Circumstances

1. Setting Emergency

    a. Registered Nurses (RN) assigned to the ED may initiate orders for patients presenting with chest pain or symptoms that may be cardiac in nature prior to physician evaluation **IF:** the ED physician is not immediately available. The RN will obtain an EKG within 10 minutes. If an MD is not signed up or will not see within 30 min or a timely manner than the RN will ensure blood is drawn, order approved laboratory tests, initiate cardiac monitoring, place oxygen per protocol and place an INT with routine flushes. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.

2. Supervision

    a. Registered Nurses who are qualified to perform this standardized procedure may independently order approved laboratory tests , order an EKG, previous EKG, Oxygen Administration, and start/place an IV if patients are unstable who present with a chief complaint of chest pain or other symptoms that my be cardiac in nature and for whom meet the criteria above. Physician supervision is not required.

3. Patient Conditions

    a. Emergency Department patients who present with **any** of the following symptoms, the procedure will be initiated:

        i. **Chest Pain-** Discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. Patients may describe the pain as uncomfortable pressure, squeezing, fullness or pain.

        ii. **Pain in other areas of the upper body** – Symptoms can included pain in one or both arms, the back, neck, jaw or upper abdomen. Patient may describe the pain as deep aching and throbbing in one or both arms.

        iii. **Shortness of breath** – May occur with or without chest pain/ discomfort. May be described as breathlessness and/or inability to catch breath when waking up. It may be at rest or with exertion.

        iv. **Irregular heart rhythm**- new onset of irregular rhythm.

        v. **Swollen legs, ankles, or feet**- non-traumatic swelling of the extremities, in addition to SOB or CP or a cardiac history.

        vi. **Other signs** – These may include clammy sweating, nausea, and or fatigue and feelings or impending doom.

b. **NOTE**: Symptoms of heart attack in women are often different than in men. Women are more likely to experience shortness of breath, fatigue, nausea, and dizziness as presenting symptoms.

C. Data Base

1. Subjective

a. Prioritization and Severity of Illness

i. Patients with a chief complaint of chest pain, dizziness, SOB or dyspnea on exertion, regular heart rhythm, or non-traumatic swelling of extremities with associated SOB, CP or cardiac history that may be cardiac in nature will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

ii. History of present illness/injury/chief complaint

iii. Characteristic of Chest Pain using the Wong-Baker Pain Scale

iv. Consider conditions related to cardiac disease i.e.) pericarditis, cardiomyopathy, or coronary artery disease

v. History of cardiac surgeries/illness

2. Objective

a. Chief complaint of chest pain

i. Signs of hypovolemia

ii. Chest pain radiation, symmetry and pain upon palpation

iii. Level of consciousness

iv. Color of skin/sclera

v. Presence or absence of peripheral edema

vi. Objective signs of pain

D. Diagnosis

1. Chest pain or other symptoms that may be cardiovascular/cardiac in nature.

E. Plan

1. Treatment

a. The following laboratory tests may be ordered: CBC, CMP, Lipase, POC I-

stats as needed, Troponin I, Qualatative HCG (for patients 18-55 years old), Draw extra tubes.

b. If no ED provider has signed up for the patient then the order set should be placed under "Physician Emergency". Place orders if a physician can't see within 30 min or in timely manner.

c. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION policy). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.

d. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag

e. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

f. Cardiac monitor with rhythm interpretation (rhythm strip to be mounted in patient's medical record)

2. Patient conditions requiring consultation/reportable conditions:

    a. Notify an Emergency Department physician immediately of the following:

        i. Changes in airway, breathing, circulation or altered level of consciousness.

        ii. Change in triage acuity.

            a. Patients presenting with signs and symptoms of possible ACS (acute coronary syndrome).

            b. **Note: If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, acute myocardial infarction, pulmonary embolism or spontaneous pneumothorax, Aortic Dissection, Acute CHF exacerbation in respiratory distress, pericardial tamponade, unstable arrhythmia.**

3. Education - Patient/Family

    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy.

4. Follow Up
    a. As needed to maintain continuity of care
5. Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    b. If no ED provider has signed up for the patient then the order set should be placed under 'Physician, Emergency' and will not be seen in 30 min or timely manner.
    c. Navigates to ER Nursing Orders
    d. Selects "Chest Pain/Cardiovascular Standardized Procedure"as the order source.

F. Record Keeping

1. The facility will retain the patients' record according to the RECORD RETENTION procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

1. A registered nurse who has completed orientation and has demonstrated clinical competency may perform the procedures listed in this protocol. Education will be given upon hire with a RN preceptor/designee

B. Training

1. Clinical competency must be demonstrated and approved by supervising personnel or preceptor.

C. Experience

1. Current California RN license and designated to work in ED

D. Evaluation

1. Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.
2. Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.

3. Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
4. Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

1. Review and approval every three (3) years.
2. Policy goes through the Emergency Department Physician Group every three (3) years.
3. Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
4. Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.

B. Review schedule

1. Review of policy every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

1. Approval of the standardized procedure is outlined in the electronic policy and procedure system.
2. Nursing
    a. Director of Emergency Department every three (3) years
3. Medicine
    a. Medical Director of Emergency Department every three (3) years
    b. Chair of Interdisciplinary Medical Practice Committee every three (3) years
4. Administration
    a. Chief Nursing Officer (Vice President of Patient Care Services) every three (3) years

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in

the department and available upon request.

VII. REFERENCES

A. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR, Section 1379.

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2016), 7th Edition. *Planning/interventions for myocardial infarction.*

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
EM Dept.	Cristina Martinez: PHYSICIAN	05/2025
EM Dept.	David Thompson: Director Nursing	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	David Thompson: Director Nursing	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18121387

Origination	04/2022	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Glycemic Measurement at Point of Care Standardized Procedure

I. POLICY

A. Function (s)

- To optimize glycemic control for all adult patients (greater than or equal to 14 years of age) admitted to the hospital regardless of admission diagnoses (with the exception of palliative/comfort care and obstetric patients with prenatal care who already undergo diabetes screening).
- To provide a guide for the Registered Nurse (RN) regarding glycemic measurement at the Point-of-Care Testing (POCT).

B. Circumstances

- Setting: All adult inpatients with the exception of those receiving palliative/comfort care and obstetric patients with prenatal care who already undergo diabetes screening.
    1. The inpatient RN may initiate a POCT glycemic measurement at the time of patient admission to the inpatient unit.
    2. The inpatient RN may order a Glycated Hemoglobin (A1C) when an admission POCT result is > 180 mg/dL and the patient has not had an A1C within the past 90 days documented within the patient's medical record. If a laboratory-drawn blood glucose test has already been ordered by the physician, this result may be used in place of a POCT measurement for A1C screening.
- Supervision
    1. The Registered Nurse who is trained and certified in glycemic measurement at the point of care can initiate a POCT glycemic measure

and place an order for an A1C for those patients who meet the criteria.

- Patient Conditions
    1. This standardized procedure applies to newly admitted adult patients.

II. DEFINITIONS

- Glycated Hemoglobin (A1C): a test that shows the amount of glucose that's attached to the red blood cell and is proportional to the amount of glucose in the blood.
- Point-of-Care Testing (POCT): the performance / analysis of a clinical specimen (blood) near the site of patient care Bedside Glucose Monitoring
- AOT: Add-on lab test
- BMP: Base Metabolic Panel
- CMP: Comprehensive Metabolic Panel

III. PROCEDURE

A. Database

- Subjective:
    1. During the admission process the inpatient RN will perform a POCT glycemic measurement. If the result is > 180 mg/dL, an A1C will be ordered if the patient has not had one performed (and the result available for review in the documentation system) within the past 90 days.
    2. If a laboratory-drawn blood glucose test has already been ordered by the physician (e.g. as part of a BMP or CMP), the laboratory reported blood glucose value can be used for A1C screening in place of a POCT measurement.

- Objective
    1. All newly admitted adult patients will have a POCT glycemic measurement performed with the following exceptions:
        a. Palliative/comfort care patients are excluded from this procedure.
        b. Laboratory-drawn blood glucose tests ordered by the physician may be used for A1C screening in place of a POCT glycemic measurement.
        c. Obstetric patients with prenatal care who already undergo diabetes screening are excluded from this procedure as well.

B. Diagnosis

- Applies to all diagnoses except patients admitted with palliative care orders.

C. Plan

- Treatment

1. Perform POCT glycemic measurement within eight hours of admission. If the physician has already ordered a laboratory-drawn blood glucose test, a POCT test will not be needed for the purposes of this policy.
2. If POCT BG > 180 mg/dL, place a lab order for A1C in CPOE with order source per "policy." This will be a routine lab order and can be ordered as an AOT (add-on lab test) to a previous viable blood sample or with the next day's labs. The A1C will NOT be ordered with a STAT priority for this procedure. If laboratory has a patient blood sample stored that is viable, the A1C may be ordered as an AOT (add-on lab test).

- Patient conditions requiring consultation/reportable conditions:
    1. Notify physician of result if A1C > 9%
- Education-Patient/Family
    1. Explain to patient and family of reason for POCT. To identify and begin treatment for Diabetes or pre-Diabetes and to assess glycemic control in those with pre-existing diagnoses.
- Documentation of Patient Treatment
    1. Document result of POCT in the Admission MBG intervention.
    2. Order the A1C when POCT >180.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education & Training
- The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

B. Experience
- Current California RN License
- Certified in POCT per the POINT OF CARE TESTING CLINICAL PROCEDURE

C. Evaluation
- Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.
- Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
- Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
- Demonstrated knowledge of procedure through clinical performance

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method
    - Standardized procedure goes through Interdisciplinary Practice Committee (IDP) and Chief Nursing Officer upon creation and with significant changes

B. Review Schedule
    - Every three years

C. Signatures of Authorized Personnel Approving the Standardized Procedure and Dates
    - Approval of the standardized procedure is outlined in the electronic policy and procedure system.
    - Nursing
        1. Chair of Policy and Procedure
    - Medicine
        1. Chair Interdisciplinary Practice Committee
    - Administration
        1. Chief Nursing Officer

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

VII. REFERENCES

A. Management of Hyperglycemia in Hospitalized Adult Patients in Non-Critical Care Settings: An Endocrine Society Clinical Practice Guideline. The Journal of clinical endocrinology and metabolism, July 2022, 107(8), 2101–2128.

B. American Diabetes Association, 16. Diabetes Care in the Hospital: *Standards of Care in Diabetes—2023*. *Diabetes Care* 1 January 2023; 46 (Supplement_1): S267–S278.

Approval Signatures

Step Description	Approver	Date

Department of Medicine	Katherine DeSalvo: Director Medical Staff Services	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	Carla Spencer: Chief Nursing Officer	05/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18075200

Origination	07/2024	Owner	David Thompson: Director Nursing
Last Approved	N/A	Area	Emergency Department
Next Review	3 years after approval		

Nausea and Vomiting Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. CBC: Complete Blood Count
B. CMP: Comprehensive Metabolic Panel
C. Director of Nursing: Nursing Director responsible for a nursing unit or cluster of units.
D. Draw Extra: Extra serum tubes collected in anticipation of blood test being added on at a later time.
E. ED: Emergency Department
F. HCG: Qualitative Serum Pregnancy Test
G. IV: Intravenous
H. ODT: Oral Disintegrating Tablet
I. POC: Point of Care
J. RN: Registered Nurse
K. UA: Urinalysis
L. EKG: Electrocardiogram
M. INT: Intravenous therapy (saline lock) with intermittent flushes

III. PROCEDURE

A. Function
    1. To expedite care for patients who present to the Emergency Department with a chief complaint of nausea and vomiting:

B. Circumstances

1. Setting
    a. Registered nurses in the ED may order the following labs for patient's eighteen (18) years of age and over with a complaint of nausea and vomiting: CBC, CMP, POC I-stats as needed, serum Qualitative HCG (for female patients 18-55 years old), Lipase, Draw EXTRA, UA and urine culture. If over forty (40) years of age, order an EKG and if having upper abdominal pain order a TROPONIN
    b. Registered nurses in the ED may order Zofran based on the following age and weight based protocol:
        i. One (1) year to ten (10) years: 0.1mg/kg liquid PO max 4 mg X1. If weight based dose is 4 mg can give the ODT instead. For patients, only if continuing to vomit.
        ii. Over ten (10) years old to adult: 4 mg ODT PO X1
2. Precautions:
    a. Cardiovascular:
        i. QT prolongation and Torsade De Pointes have been reported; monitoring recommended in patients with electrolyte abnormalities (eg., hypokalemia or hypomagnesemia), congestive heart failure, bradyarrhythmias, and concomitant use of QT prolonging medications.
    b. Gastrointestinal:
        i. Use caution following abdominal surgery or chemotherapy-induced nausea and vomiting as it may mask progressive ileus, gastric distension, or both
3. Contraindications:
    a. Cardiovascular:
        i. Congenital long QT syndrome: Do NOT ADMINISTER
        ii. Known allergy: DO NOT ADMINISTER
4. Supervision
    a. Registered nurses who are qualified to perform this standardized procedure may independently order blood work and initiate IV therapy to patients who present with a chief complaint of nausea and vomiting, and for whom meet the above criteria. Physician supervision is not required.
    b. Physician supervision is not required.
5. Patient Conditions
    a. Emergency Department patients who meet the following criteria:
        i. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing

and IV therapy is questionable/concerning.

ii. Patients one (1) year of age and over follow age and weight based Zofran protocol above.

iii. Chief complaint of nausea and vomiting

iv. Will not be seen by physician within 30 min or in a timely manner and a physician is not already signed up for them.

a. Change in triage acuity

C. Database

1. Subjective

a. Prioritization and Severity of Illness

i. Patients One (1) year of age and older with the chief complaint of nausea and vomiting will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating their medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see Triage Assessment)

ii. History of present illness/injury/chief complaint

iii. Have patient point with one finger to most painful location if applicable

iv. Consider conditions related to gastrointestinal, genitourinary, or reproductive systems.

a. Female: determine last normal menstrual period.

v. History of ingestions or poisoning

vi. Last meal eaten

vii. Fever

2. Objective

a. Chief complaint of nausea and vomiting

i. Signs of hypovolemia

ii. Signs of peritoneal irritation

iii. Inability to ambulate or sit

iv. Color of skin/sclera

v. Odors

vi. Objective signs of pain

D. Diagnosis

1. Nausea and Vomiting

E. Plan

1. Treatment

    a. The order must be placed under the name 'Physician, Emergency'

    b. The blood and urine specimens must be labeled accurately with the patient's name and account number, at the patient's bedside in accordance with the patient identification process (see PATIENT IDENTIFICATION POLICY).

    c. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hzard specimen bag

    d. Specimens collected by the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

2. Patient conditions requiring consultation/reportable conditions:
    a. Immediately notify an Emergency Department physician of the following:
        i. Changes in airway, breathing, circulation or altered level of consciousness
        ii. Change in triage acuity
        iii. If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY. Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, suspected mesenteric ischemia, Ruptured appendix/peritonitis, ruptured ectopic, incarcerated hernia, severe dehydration, severe pain, and DKA.

3. Education-Patient/Family
    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy if applicable.

4. Follow-up
    a. As needed to maintain continuity of care

5. Documentation of Patient Treatment
    a. The order must be placed under the name of the supervising ED physician. If a different provider is later assigned to the patient, the orders will be transferred to the provider assigned.

    b. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.

    c. The ED RN initiating the standardized procedure will document the following: "CBC, CMP, LIPASE, DRAW EXTRA, UA, serum Qualitative HCG, urine HCG (if appropriate), IV and EKG if appropiate per "standardized procedure" in the patient record

d. Enters 'Physician, Emergency as ordering provider per policy
e. Navigates to ED Nursing Orders
f. Selects "Nausea and Vomiting" order set

6. Record Keeping
    a. The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
    1. The RN completes an intial review of the Standardized Procedure with an evaluation of knowledge

B. Training
    1. The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

C. Experience
    1. Current California RN license and designated to work in the ED.

D. Evaluation
    1. Initial: During the initial orientation process RNs are educated to this Standardized Procedure and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this Standardized Procedure two (2) times prior to be deemed competent.
    2. Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
    3. During the annual RN performance appraisal process any areas of this Standardized Procedure not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method
    1. Policy goes through ED Physician Group every three (3) years.
    2. Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
    3. Chief Nursing Officer (Vice President of Patient Services) upon creation of policy and with significant changes.

B. Review Schedule

1. Review of policy occurs every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

1. Approval of the standardized procedure is outlined in the electronic policy and procedure system.

a. Director Emergency Department, Medical Director of Emergency Department, Chair of Interdisciplinary Practice Committee, and Chief Nursing Officer.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. Adams, M., & Urban, C. Q. (2013). Pharmacology: Connections to Nursing Practice. Prentice Hall. 479, 1019, 1104-1105

B. California Board of Registered Nursing,Title 16, California Code of Regulations Section 1474; Medical Board of California. Title 16, Code of Regulations Section 1379

C. Emergency Nurses Association: Emergency Nursing Core Curriculum (2007), 6th Edition-Emergency management involving assessment of the abdomen 47, 159-186

D. Marx, J., Hockbergner, R. WS., & Walls, R. M. (Eds). (2002). Rosen's Emergency Medicine: Concepts and Clinical Practice (5th ed). St Louis, MO: Mosby

E. Reeves, J.J; Shannon, M.W.; & Fleisher, G. R.: Ondansetron Decreases Vomiting Associated with Acute Gastroenteritis: a randomized, controlled trial. Pediatrics (2002) 109:e62.

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
EM Dept.	Cristina Martinez: PHYSICIAN	05/2025
EM Dept.	David Thompson: Director Nursing	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025

Policy Owner	David Thompson: Director Nursing	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18075147

Origination	05/2017	Owner	David Thompson: Director Nursing
Last Approved	N/A	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Vaginal Bleeding Nursing Standardized Procedure

I. POLICY

A. N/A

II. DEFINITIONS

A. Blood Type and Rh factor (Type and Rh)
B. CBC: Complete Blood Count
C. CMP: Comprehensive Metabolic Panel
D. Director of Nursing – Nursing Director responsible for a nursing unit or cluster of units.
E. HCG: Qualitative Serum Human Chorionic Gonadotropin
F. SP – Standardized Procedure
G. UA: Urinalysis
H. ED: Emergency Department

III. PROCEDURE

A. Function
    1. A registered nurse may start an IV and order blood work prior to a patient examination by a physician for Chief Complaint of vaginal bleeding.

B. Circumstances
    1. Setting
        a. Registered Nurses (RNs) assigned to the Emergency Department (ED) may initiate orders for patients presenting with vaginal bleeding prior to physician evaluation IF: the ED physician is not immediately available. The RN will ensure blood is drawn, order approved laboratory tests, and an INT

with routine flushes will be placed if the patient is unstable. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.

2. Supervision
    a. Registered Nurses, who are employed in the Emergency Department and have successfully completed the Patient's with Vaginal Bleeding competency, are qualified to perform this standardized procedure and may order CBC, sHCG, Type and Rh, when vital signs are within normal limits initiate IV resuscitation if vital signs are abnormal, to the patients presenting with the chief complaint of vaginal bleeding and whom meet criteria.
    b. Registered nurses in the ED may order the following labs for patient's eighteen (18) years of age and over with a complaint of vaginal bleeding: CBC, CMP, serum HCG (for patients 18-55 years old), Draw EXTRA, Type (ABO/RH Profile), UA and culture if needed, INT placement if patient unstable.
    c. If patient is under eighteen (18) years of age and confirms she is pregnant, then order above labs.
    d. If patient under eighteen (18) years of age and denies pregnancy than order UA with reflex culture and urine pregnancy
3. Patient Conditions
    a. If the patient has not been seen in the ED within the previous 24 hours for the same complaint and/or the need for blood testing and IV therapy is questionable/concerning.

C. Database
- Subjective
    1. Patients with the chief complaint of vaginal bleeding will be triaged and prioritized according to accepted triage policy based on the severity of their vaginal bleeding using the Emergency Severity Index (ESI) 5 Level Triage. (See TRIAGE ASSESSMENT)
        a. Spontaneous abortion (miscarriage) is the loss of a pregnancy before viability of the fetus defined as 20 weeks gestation. Spontaneous abortion should be considered in any woman of childbearing age who presents to the emergency department with vaginal bleeding. Spontaneous abortions are commonly categorized as threatened, inevitable, incomplete, missed, or septic.
        b. An ectopic pregnancy (EP) could cause vaginal bleeding in pregnant women. EP intrudes into the tubal wall too deeply or grows too large, it can rupture the tube and can be life-threatening due to risk of hemorrhage.
        c. Menopausal or women of a geriatric age, malignant disease

should always be considered. Postmenopausal hormonal changes may be responsible for dysfunctional uterine bleeding (DUB). Patients in this age group with vaginal bleeding are at increased risk for uterine cancer.

d. Young females less than typical age of menarche (11 years of age to 12 years of age) with vaginal bleeding and severe pain/ distress consider assault, keep in clothes and get a physician immediately.

2. All patients presenting with chief complaint of vaginal bleeding and characteristics using numerical or Wong Baker pain scale.
    a. Onset of vaginal bleeding and potential cause (what happened)
    b. Last normal menstrual period (LNMP) and location of pain, if present.
    c. Duration of vaginal bleeding
    d. Characteristics of vaginal bleeding: amount, color, presence of clots/tissue. Number of full pads/tampons used (each holds approximately 30 ml of blood).
    e. Alleviating or aggravating factors
    f. Radiation of pain
    g. Treatment before arriving to the Emergency Department.
    h. Positive pregnancy test: date and method (serum or urine).
    i. Fatigue, dizziness, lightheadedness, syncope
    j. Contraceptive history
    k. Reproductive history, total number of pregnancies, live births spontaneous/therapeutic abortion(s) (gravida, para, SAB/TAB)
    l. Recent trauma or surgery
    m. Recent sexual intercourse
    n. Fever, recent birth-vaginal/c-section?

- Objective
    1. Patients with vaginal bleeding will be assessed for the following
        a. Level of consciousness, behavior, affect
        b. Abnormal vital signs
        c. Skin, color; moist or dry
        d. Gait
        e. Quality and Quantity of vaginal bleeding, color, amount, passage of clots or tissue
        f. Presence or absence of pain/cramping and location of pain

g. Palpation of abdomen for tenderness
h. Auscultation for Fetal Heart Tones

D. Diagnosis

- Vaginal bleeding caused by: Differential diagnosis:
    1. Spontaneous abortion from a nonviable fetus
    2. Ectopic pregnancy invading the tubal wall
    3. Uterine dysfunction
    4. Endocrine imbalance
    5. Sexual assault/abuse or maltreatment
    6. Malignant disease
- Assess fro the following:
    1. Deficient fluid volume
    2. Anticipatory grieving
- Plan
    1. Treatment
        a. Patient must have an accurate name-band in place before blood work is drawn.
        b. When initiating an IV infusion the RN will label the blood tubes accurately by using the hospital approved patient identification process (see PATIENT IDENTIFICATION POLICY). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.
        c. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag.
        d. Specimens will be handed to a phlebotomist or transported to lab in person or through the pneumatic tube system
        e. If no supervising ED physician has signed up for patient or not seen in 30 min or timely manner, order sets should be placed under "Physician, Emergency".
        f. The ED RN will assess the patient presenting with vaginal bleeding according the standardized policy and procedure of Vaginal Bleeding.
            i. The ED RN will initiate IV therapy when the following is present:
                1. Moderate to heavy vaginal bleeding present
                2. Skin signs are cool, pale, and moist
                3. Systolic blood pressure (SPB) of 100 or less and/or heart rate of greater than 100.

4. If specimens are obtained patient label must be taken to the bedside and verified with the patient using the two (2) Patient Identifiers (patient name and medical record number).

2. Patient conditions requiring consultation:
    a. If the patient appears unstable and/or life threatening condition is identified: the ED RN will notify the ED physician **IMMEDIATELY**.
    b. Heavy bleeding present with skin signs of cool, pale and moist.
    c. Vital signs critical less than 100 SBP and heart rate greater than 100.
    d. Changes in airway, breathing, circulation, or altered level of consciousness
    e. Change in triage acuity
3. Education-Patient/Family
    a. Educate on processes of the Emergency Department
        i. Why patient must remain NPO status until results
        ii. Explain the need for blood work and initiation of blood work
        iii. Explain the procedure of vaginal exam
        iv. Explain what medication given and why
        v. Education that patient did not do anything wrong, that miscarriage or threatened miscarriage it is not the patient's fault
        vi. Educate on receiving RhoGAM, if woman is Rh-negative
    b. Educating for threatened abortion
        i. Maintain bed rest for 24 to 48 hours or until bleeding subsides
        ii. Educate on the need for bed rest and pelvic rest (no sexual intercourse, do not place anything inside the vagina) until bleeding and cramping stop
        iii. Use sanitary pads only; avoid tampons
        iv. Return to the Emergency Department if bleeding or pain increases or you develop a fever
        v. Save any clots or tissue that passes and bring to the emergency department or follow-up physician
        vi. Ensure appropriate follow-up care with obstetrician/gynecologist.

c. Education for complete abortion
    i. Mild abdominal pain/cramping is common for several days
    ii. Use sanitary pads only; avoid tampons
    iii. Take temperature four times a day
    iv. Pelvic rest
    v. Ensure follow-up care with obstetrician/gynecologist.
    vi. Activity as tolerated
    vii. Return to the emergency department if temperature is higher than 100.6 F, bleeding, pain, or foul-smelling discharge occurs or increases

d. Follow up
    i. Reassessment and reevaluation of vaginal bleeding every two (2) hours or more frequently according to the patient severity and amount of vaginal bleeding and accordance with the Emergency Department Policy and Procedure: Assessment/Reassessment (see STANDARDS OF CARE- EMERGENCY DEPARTMENT)

e. Documentation of Patient Treatment
    i. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
        1. The ED RN initiating the standardized procedure will document the following: CBC, CMP, UA, sHCG, Type and Rh, and IV therapy ordered per "standardized procedure" in the electronic medical record.
        2. Enters "Physician, Emergency' per policy.
        3. Navigates to New Sets.
        4. Selects "ER Nursing Orders" order set
        5. Selects appropriate order.

- Record Keeping
    1. The facility will retain the patients' record according to the Record Retention procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

1. In accordance with the SVHMC RN job description

B. Training

1. Competency assessed during orientation.

C. Experience

- In accordance with the established SVHMC job description

D. Evaluation

- Initial: During the initial orientation process RNs are educated to this SP and complete a review with their preceptor. This is documented on the Department Specific Orientation Checklist and maintained in the office of the Director of Nursing. The RN is required to implement this SP two (2) times prior to be deemed competent.
- Ongoing: At least every 3 years competency will be re-assessed via annual skills assessment.
- During the annual RN performance appraisal process any areas of this SP not meeting requirements will be reviewed with the RN and a plan will be defined if necessary

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Review Schedule

1. Every 3 years or when practice changes are made.

B. Approval

1. The electronic policy and procedure system maintains tracking of initiation, review and approval of this SP including the Interdisciplinary Practice Committee, Medical Executive Committee and the Board of Directors.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department / cluster Nursing Director's office and available upon request.

VII. REFERENCES

A. California Board of Registered Nursing,
B. Title 16, California Code of Regulations Section 1474
C. Medical Board of California. Title 16, Code of Regulations Section 1379
D. Emergency Nurses Association: Emergency Nursing Core Curriculum (2000)

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
EM Dept.	Cristina Martinez: PHYSICIAN	05/2025
EM Dept.	David Thompson: Director Nursing	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	05/2025
Policy Owner	David Thompson: Director Nursing	04/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17904279**

Origination	06/2022	Owner	Melissa Deen: Manager Infection Prevention
Last Approved	N/A	Area	Infection Control
Next Review	3 years after approval		

Authority Statement

I. POLICY STATEMENT

A. The Infection Prevention Manager and or Director / Infection Preventionist and the Infectious Disease Medical Director, through the authority of the Pharmacy & Therapeutics /Infection Prevention & Control Committee, have the authority to institute appropriate control measures when danger to a patient or personnel is reasonably felt to be present.

II. PURPOSE

A. To define the scope of authority of the Infection Prevention Manager and or Director / Department.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Examples of such measures include:

1. Institution of appropriate isolation precautions, in accordance with current standards and /or the Isolation policies and procedures.
2. Initiation of culture and sensitivity testing as determined
3. Initiation of studies needed to identify the source, reservoir and /or mode of transmission of an outbreak of health care associated infections; and
4. Initiation of other control measure as deemed necessary based on surveillance findings and reports of infections and infection potential among patients, visitors, venders, contract workers and personnel of Salinas Valley Health Medical Center (SVHMC).
5. Develop a system for identifying, reporting, investigating, and controlling infections

and communicable diseases of patients and personnel within the hospital, including both healthcare–associated infections and community-acquired infections.

6. Develop, implement and evaluate the hospital-wide infection prevention and control program with persons administratively and clinically responsible for inpatient and outpatient departments and services, as well as, non-patient-care support staff, such as maintenance and housekeeping staff (i.e. corrective action plans in affected problem areas).
7. Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer.
8. Verify that all regulatory standards and patient safety initiatives are implemented and evaluated as dictated by CMS, TJC, CDPH, etc.

V. PROCEDURE

A. N/A

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. The Joint Commission (2020). *Hospital accreditation standards*. Infection Prevention and control. Oakbrook Terrace, IL: The Joint Commission Resources, Inc.

B. Association of Professionals in Infection Control & Epidemiology (APIC) (2021). Chapter 2*:* Standards and authority of infection prevention and control. CMS Conditions of Participation

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T/IPC	Genevieve delos Santos: Director Pharmacy	05/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025

Policy Owner	Melissa Deen: Manager Infection Prevention	04/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17388108

Origination	03/2022	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Discharge Criteria from OB ED

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in identifying the required parameters for safe discharge from the OB ED.

III. DEFINITIONS

A. OB ED: Obstetrical Emergency Department

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Patients are discharged from the OB ED only upon the order of a primary physician or the OB Hospitalist.

B. Discharge shall only occur after:

1. Discharge instructions (written and verbal) have been given and understood by the patient and/or significant other
2. All necessary prescriptions have been entered into the electronic medical record (EMR) for "E-Prescribe" or a written prescription has been given to the patient.
3. School/work excuses have been provided where indicated.
4. Proper referral(s) have been provided where indicated.

C. All OB ED patients shall sign a copy of instructions and a copy will be maintained in the

patient's EMR.

D. OB ED patients who have received a medical screening exam by an OB Hospitalist may be discharged to the office of their primary care provider if they have one, or shall be referred to a physician for a post-discharge follow up appointment where indicated.

E. Patients presenting to the OB ED may refuse a medical screening exam by the OB Hospitalist or primary care physician. If so, they will be requested to sign an "Informed Consent to Refuse Medical Screening Exam."

F. Patients receiving any injection (intramuscular) shall be observed in the OB ED for twenty (20) minutes after the injection to be monitored for signs and symptoms of an allergic reaction.

    1. If no reaction occurs, the patient may be discharged with appropriate instructions and referrals where indicated.
    2. If a reaction occurs, the physician will be notified and the patient will be treated as necessary.
    3. Any patient receiving injections (intravenous or intramuscular) such as narcotics and/or pain medications shall be discharged only if the patient has a responsible person to drive them home.
        a. Discharge instructions shall also include information pertaining to the medications administered in the OB ED that may impair motor function.

G. Patients who are in police custody may be discharged to the police with appropriate instructions.

H. Any patient under the influence of alcohol and/or other substances shall not be discharged unless they have met the discharge criteria and have proper transportation.

    1. Discharge Criteria:
        a. Protective reflexes intact
        b. Vital signs stable
        c. Alert and oriented
        d. Accompanied by a responsible adult

I. All COBRA/EMTALA rules and regulations shall be followed for patients transferred to another facility. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA)

J. Documentation:

    1. OB Disposition Assessment
    2. OB Vital Signs Assessment
    3. Date and Time of departure

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A.

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	02/2025
Policy Owner	Daniela Jago: Clinical Manager	02/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16470335

Origination	04/2021	Owner	Aisha Huebner: Director Perioperative Services
Last Approved	N/A	Area	Infection Control
Next Review	3 years after approval		

Endoscope Handling, Reprocessing and Storing

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To assure proper processing of endoscopes between patients.

III. DEFINITIONS

A. AER – Automated Endoscope Reprocessor

B. EPA – Environmental Protection Agency

C. IFU – Instructions for Use.

D. PPE – Personal Protective Equipment

IV. GENERAL INFORMATION

A. SVHMC will follow current manufacturer guidelines for use & maintenance of Automated Endoscope Repressor (AER).

V. PROCEDURE

A. Personal Protective Equipment (PPE)

1. All Salinas Valley Health Medical Center (SVHMC) healthcare workers involved in the processing of endoscopes and ancillary equipment will wear gloves, fluid resistant gowns face protection and protective eyewear.
2. Hands will be washed just prior to donning and after doffing of PPE.

B. Scope Cleaning

1. Decontamination of endoscopes begins at the end of procedure. The cleaning is done in accordance with the "Point of Use Decontamination" competency.
2. Immediately after use, the contaminated endoscope will have water with detergent suctioned through it until secretions and debris are no longer present in the water. The air water channel will be cleared by depressing the air/water valve. The exterior of the endoscope will be wiped down with a sponge soaked with hospital approved detergent per manufacturer's guidelines. Remove suction and biopsy valves from the scope.
3. An enzyme detergent will be utilized for cleaning all endoscopes and accessories, following the manufacturer's guidelines for use.
4. EPA-registered liquid sterilants/disinfectant solution and hospital approved high level disinfectant per manufacturer's recommendations for reprocessing of endoscopes, will be utilized for all endoscopes and compatible accessories for high level disinfection.
5. All endoscopes and accessories will be thoroughly cleaned prior to application of any method of high-level disinfection and/or sterilization.

   All endoscopes and accessories will be inspected for damage and/or water leaks and will be removed from service if damage has occurred that renders the equipment inoperable or poses a threat to the well-being of patients.

C. Procedure for Decontamination of Endoscopes

1. **All endoscopes will be cleaned at termination of procedure using the hospital approved detergent/disinfectant per manufacturer's guidelines as described in the point of use competency.** DISINFECTION OF INSTRUMENTS/SCOPES **#586**
2. Manual Cleaning
    a. The endoscopes will be cleaned in accordance to the endoscope manual cleaning competency. The manufacturers IFU are followed for each model of endoscope.
    b. Add enzymatic cleaner to the designated sink, at the 10 gallon sink line (follow manufacturer guidelines of enzymatic cleaner for concentration, i.e. pumps per gallon).
    c. Using the impregnated 4x4 gauze thoroughly wash the entire length of the endoscope tube, beginning with the area nearest the control body.
    d. Utilizing a cleaning brush, clean the various orifices until clean. Insert the brush through the biopsy channel and brush the entire length of the channel. When the brush protrudes from the distal end of the insertion tube, clean the brush in the cleaning solution and withdraw the brush. This process should be repeated at least twice or until no particulate matter is noted on the brush. Repeat the procedure for cord and the distance from the suction channel to the biopsy channel.
3. Test for cleaning efficacy
    a. The cleaning efficacy will be tested prior to placing endoscopes in the

AER.

b. The ChannelCheck, 3-in-1 Residual Soil Test for Internal Channels will be used to detect any internal channel exposed to protein, hemoglobin and/or carbohydrate during clinical use.

c. Testing is conducted after cleaning and prior to disinfection/sterilization.

d. ChannelCheck will be used to monitor internal channel of endoscopes for cleaning efficacy, following the manufacturer's guidlenes for use.

4. Use AER in accordance with manufacturer's IFU and AER competency to "high level" disinfect endoscopes.

D. Transport (pre and post procedure)

1. **PRE-PROCEDURE**

a. Obtain a clean cart, transport bin, and a pack of scope liners (clear, green, and red).

b. Perform hand hygiene procedure prior to donning gloves and PPE.

c. Open the pack of scope liners and line the transport bin with the clear liner.

d. Pick up the clean scope by its distal head and place it into the transport bin.

e. Place the red liner into the transport bin, cover the bin by placing the green liner over the top, making sure that the bin is tightly sealed.

f. Transport the scope using the clean cart to the procedure site.

g. Re-perform hand hygiene procedure, don clean gloves and PPE, and attach suction and biopsy valves to the scopes prior to the procedure.

2. **POST-PROCEDURE**

a. After procedure, please follow the "Point of Use" competency "Scope Cleaning."

b. Remove the red liner (to be used later to cover the bin).

c. Place dirty scope, including the suction and biopsy valves, into the transport bin.

d. Remove gloves and PPE and perform hand hygiene.

e. Cover the transport bin by placing the red biohazard marked red liner over the top of the bin, making sure a tight seal has been established.

f. Transport scope back into the Processing Room following the proper workflow for reprocessing.

E. Storage

1. Flexible endoscopes should be stored in a manner that protects the device from damage and minimizes microbial contamination.

a. Flexible endoscopes should be stored in a closed cabinet with:

- Venting that allows air circulation through lumens around the flexible endoscopes;
- Internal surfaces composed of cleanable materials;
- Adequate height to allow flexible endoscopes to hang without touching the bottom of the cabinet, and
- Sufficient space for storage of multiple endoscopes without touching;
- Hanging in a secure vertical position;
- With all removable endoscopes components (e.g. valve mechanisms, biopsy valve covers, irrigation tubes) detached;
- With all accessories removed; and
- With scopes protectors applied if the protector does not interfere with the flexible endoscopes hanging straight or restrict the air movement around the channel openings.

b. Flexible endoscopes should not be stored in the original shipment cases.

c. Flexible endoscopes should be reprocessed before each use if unused for more than seven days.

d. Flexible endoscopes should be reprocessed before use if evidence of improper drying exits (e.g. evidence of discoloration, wet spots, or stains, or soil in the storage cabinet) when the scope is removed from storage.

e. Storage cabinets should be cleaned and disinfected with an EPA registered disinfectant when visibly soiled and on a weekly or monthly basis.

F. Documentation:

1. Daily checks and prior to use checks will be documented daily and kept readily available in room where cleaning & disinfection and scope buddy are being used.
2. A unit designated RN will check documentation daily and will do unannounced spot checks weekly.
3. All SVHMC employees responsible for endoscope reprocessing will receive in-depth training on cleaning and processing endoscopes and accessories (per manufacturer guidelines) as part of the orientation to the department.
4. All SVHMC employees responsible for endoscope reprocessing will have an annual competency skills review with a nurse competency tester.
5. A company representative from the manufacturer(s) may be scheduled to come out annually and give an in-service on endoscope reprocessing for existing SVHMC staff who require annual re-education.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Society of Gastroenterologist (AGA). "Multi-society guideline on reprocessing flexible gastrointestinal endoscopes: 2011"

B. Society of Gastroenterology Nurses and Associates, Inc. "Standards of Infection Control In Reprocessing of Flexible Gastrointestinal Endoscopes"

C. CDC Guidelines for Disinfection and Sterilization in Healthcare Facilities

https://www.cdc.gov/infectioncontrol/pdf/guidelines/disinfection-guidelines-H.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T/IPC	Genevieve delos Santos: Director Pharmacy	05/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	05/2025
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 16470353

Origination	08/2021	Owner	Daniela Jago: Clinical Manager
Last Approved	N/A	Area	Women's and Children's Services
Next Review	3 years after approval		

Induction/Augmentation of Labor and Cervical Ripening

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in the nursing management of patients being prepared for labor through the use of cervical ripening agents and patients undergoing induction/augmentation of labor.

III. DEFINITIONS

A. ***Induction of labor***- stimulation of uterine contractions before the onset of spontaneous labor for the purpose of accomplishing a vaginal birth

B. ***Augmentation of labor***- stimulation of uterine contractions when spontaneous contractions have failed to result in progressive cervical dilation or descent of the fetus

C. ***Tachysystole-*** Greater than 5 contractions in a 10 minute period, averaged over a 30 minute period. The term tachysystole applies to both spontaneous and stimulated labor. The clinical response to tachysystole may differ depending on whether contractions are spontaneous or stimulated. It should always be qualified as to the presence or absence of FHR decelerations, and qualified as to the quality of contractions. Quality of contractions should be verified as moderate to strong via palpation or Montevideo units. (This is to avoid the label of tachysystole in situations in the latent phase of labor where high-frequency low amplitude contractions are present, and are often dysfunctional).

    1. Evaluation of uterine activity should also include a response to contractions lasting ≥ 120 seconds, or relaxation time between UCs of ≤ 60 seconds.

D. ***Adequate labor-*** Regular uterine contractions q 2-5 min lasting 40-60 sec, moderate to strong via palpation, with increasing maternal discomfort. In patients undergoing induction of labor, cervical change of 0.5-1cm/hr in active labor indicates that labor is progressing and that oxytocin administration is adequate.

E. ***Definitions of abnormal labor:***

1. ***First stage of labor:*** **Cervical dilation of 6 centimeters should be considered the threshold for the active phase of most women in labor. Prior to 6 cm, active progress should not be applied.**
   Cesarean delivery for active phase arrest in the first stage of labor should be reserved for women at or beyond 6 cm of dilation with ruptured membranes who fail to progress despite 4 hours of adequate uterine activity, or at least 6 hours of oxytocin administration with inadequate uterine activity and no cervical change.
2. ***Second stage of labor***: Before diagnosing arrest of labor in the second stage, if the maternal and fetal conditions permit, allow for the following:
   a. At least 2 hours of pushing in multiparous women
   b. At least 3 hours of pushing in nulliparous women.
   c. Longer durations may be appropriate on an individual basis (eg, with the use of epidural analgesia or fetal malposition as long as progress is being documented)
3. *Failed induction of labor:* If the maternal and fetal status allow, cesarean deliveries for failed induction of labor in the latent phase can be avoided by allowing longer durations of the latent phase.
   a. Up to 24 hours or longer and requiring that oxytocin be administered for at least 12-18 hours after membrane rupture deeming the induction a failure.

F. ***MVU –*** Montevideo units

G. ***PROM*** – Premature rupture of membranes

H. ***IUPC –*** Intrauterine pressure catheter

Note: See FETAL HEART RATE MONITORING for definition of fetal heart rate patterns and evaluation of contraction pattern

IV. GENERAL INFORMATION

A. Cervical Ripening or Induction/Augmentation of labor will be initiated after the physician has evaluated the patient; determined that the induction/augmentation is beneficial to both the mother and the fetus; and recorded the indication, obtained informed consent, and established a plan of care.

B. It is strongly recommended that the provider verify elements contained in attachment A prior to proceeding with induction of labor with oxytocin.

C. Salinas Valley Health Medical Center (SVHMC) supports the ACOG guidelines for elective inductions and encourage 39 weeks completed gestation (37-38 weeks for multiples).

1. At time of induction scheduling, fetal lung maturity will be verified based on any of the following criteria:
   a. Fetal heart tones documented for 30 weeks by Doppler
   b. 36 weeks since positive serum or urine HCG performed by qualified

laboratory

c. Ultrasound measurement of crown-rump length obtained at ≤ 13 6/7 weeks supports gestational age of at least 39 weeks (ACOG, 2014)

d. If pregnancy resulted from assisted reproductive technology (ART), an ART-derived gestational age of ≥ 39 weeks (37-38 weeks for multiples).

V. PROCEDURE

A. Indications for induction of labor are not absolute and should take into account maternal conditions, gestational age, cervical status and other factors. Following are **examples** of maternal or fetal conditions that *may* be indications for induction of labor:

1. Chorioamnionitis (intra-amniotic infection)
2. Fetal demise
3. Hypertensive disorders of pregnancy
4. Premature rupture of membranes
5. Postterm pregnancy
6. Maternal medical conditions
7. Fetal compromise

B. Vertex presentation will be confirmed and documented either by vaginal exam or ultrasound prior to initiation of cervical ripening procedure or administration of oxytocin.

C. *Augmentation* of labor should only be undertaken after both the maternal pelvis and fetal presentation have been assessed.

D. A 20 minute fetal heart tracing will be obtained prior to administration of induction/cervical ripening agents.

E. FHR tracing should meet the criteria for Category I prior to cervical ripening or oxytocin administration (see FETAL HEART RATE MONITORING for definition of categories). If the FHR does not meet the criteria for Category I and it is determined and documented by the physician that the benefits of the induction outweigh the risk, the induction may proceed.

F. The Registered Nurse (RN) should assess cervical status utilizing the Bishop Score and document these findings prior to initiation of induction and with redosing of induction medications

	Factors to be Assessed				
Bishop Score	**Dilation (cm)**	**Effacement (%)**	**Station**	**Cervical Consistency**	**Position of Cervix**
0	Closed	0-30	-3	Firm	Posterior
1	1-2	40-50	-2	Moderate	Midposition
2	3-4	60-70	-1, 0	Soft	Anterior
3	5 or more	80 or more	+1, +2	___	___

G. For management of indeterminate or abnormal fetal heart rate see FETAL HEART RATE

MONITORING.

H. **Cervical Ripening**

1. Requires a physician evaluation prior to administration of first dose of cervical ripening agent
2. For patients with PROM, prostaglandins (misoprostol, Cervidil) may be used for cervical ripening,
3. Misoprostol – maximum 5-6 doses per 24 hours (off label use)
    a. After 24 hours, use alternate methods for cervical ripening
    b. Patients being administered Misoprostol should have continuous fetal monitoring for two hours after dose administration; then per FETAL HEART RATE MONITORING
    c. For the vaginal route, patients should remain in a lateral recumbent position for at least 30 minutes after misoprostol insertion.
    d. Redosing: withhold next dose if one of the following occurs:
        i. Adequate contraction pattern with ≥3 contractions in 10 minutes
        ii. Bishop score ≥ 8
        iii. Cervix 80% and 3 cm dilation
        iv. Category II FHR tracing with heightened concern or category III FHR tracing. Hold further doses and notify physician
        v. Uterine tachysystole (defined as >5 contractions in 10 minutes averaged over 30 minutes)
            - Should tachysystole occur, implement:
                - Turn the patient to the left lateral position, initiate IV fluid bolus. Notify provider as needed. Call for help as needed.
                - If no resolution or if tachysystole is associated with a category II FHR tracing with heightened concern or a category III FHR tracing, notify provider.
                - Consider terbutaline 0.25 mg subcutaneously (requires physician order)
    e. Oxytocin may be administered four hours after the last dose of Misoprostol
    f. Fetal demise consideration:
        i. 2nd trimester: 18-28 weeks: 100mcg-400mcg intravaginally every 3 hours – max dose 2000 mcg (or five doses)
            a. Also consider same regimen for 1st trimester loss induction.
            b. May be used with previous uterine scar.

c. If the delivery is not complete after 5 doses, the woman may be allowed to rest for 12 hours before starting the cycle again.

ii. 3rd trimester: > 28 weeks: 25 mcg intravaginally every 3-6 hours (not recommended for use with a previous uterine scar after 28 weeks).

iii. In patients with a prior Cesarean section, prostaglandins can be used for less than 28 weeks. See VAGINAL BIRTH AFTER CESAREAN SECTION (VBAC)

I. **Cervidil**

1. Patients being administered Cervidil will have continuous fetal monitoring while the vaginal insert is in place and for a minimum of 15 minutes after removal
    a. Patient will remain in a lateral recumbent position for 2 hours after Cervidil insertion
2. Remove Cervidil:
    a. After 12 hours
    b. Onset of labor has occurred
    c. Category III fetal heart rate tracing or Category II tracing with heightened concern.
    d. Tachysystole as defined (not responsive to hydration and position change)
3. Oxytocin may be administered 30 minutes after removal of vaginal insert

J. **Mechanical dilation**

1. Balloon catheters for mechanical dilation will only be inserted by the physician and may remain in place for eight to 12 hours. Refer to CERVICAL RIPENING BALLOON

K. **Oxytocin Induction/Augmentation**

1. A Bishop Score ≥ 6 must be confirmed and documented in the medical record prior to initiation of oxytocin for non-medically indicated induction.
2. Pre-oxytocin checklist is to be completed prior to initiation of induction (See attachment A)
3. In use oxytocin checklist is to be completed every 30 minutes during oxytocin infusion. (See attachment C)
4. Oxytocin is not to be used as a mainline IV medication during labor and should be piggybacked into the mainline IV at the port most proximal to the patient. Label IV line to identify Oxytocin infusing.
5. Oxytocin is a high alert drug and will undergo independent RN double check at initiation as well as at handover. Documentation is done in the Labor and Delivery software.
6. Oxytocin will always be administered using an infusion pump, utilizing the smart

pump infusion device.

7. Oxytocin titration by the RN is based upon maternal-fetal response. This includes decreasing the dosage rate or discontinuing the medication when deterioration of fetal status is present or tachysystole occurs and increasing the dosage rate when uterine activity and labor progress are inadequate.
8. Oxytocin may be increased to a maximum dose of 20 milliunits/min. A bedside evaluation by the physician is needed to increase the Oxytocin beyond 20 milliunits/min
9. When augmenting Trial of Labor after Cesarean Section (TOLAC) patients, initiate oxytocin at minimal rate (0.5 mu/min) and titrate by lower increment of 1 mu/min.
10. See attachment B for ***Oxytocin titration guidelines*** based on fetal status.
11. In the event of uterine tachysystole as a result of Oxytocin administration, follow the Management of ***Oxytocin Induced Tachysystole Algorithm***, Attachment D.
12. Resumption of Oxytocin after resolution of tachysystole
    a. If oxytocin has been discontinued for less than 30 minutes, the FHR is normal, and contraction frequency, intensity and duration are normal, resume oxytocin at no more than half the rate that caused the tachysystole and gradually increase the rate as appropriate based on maternal fetal status.
    b. If oxytocin is off for more than 30 minutes, restart at the initial dose ordered.

L. Documentation:
    1. Documentation will occur in accordance with the FETAL HEART RATE MONITORING.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American College of Obstetricians and Gynecologists. (2017). Second-trimester abortion. (Practice Bulletin 135).

B. Clark, S., Knox, E., Rice-Simpson, K., & Hankins, G. (2015). Quality improvement opportunities in intrapartum care in *Towards improving pregnancy outcomes III.* March of Dimes.

C. Physician's Digital Reference. Misoprostol. Retrieved December 10, 2024 from https://www.pdr.net/drug-summary/Cytotec-misoprostol-1044

D. Simpson, K. (2020). *Cervical ripening and labor induction and augmentation.* (5th ed.). Washington D.C.: AWHONN.

E. Simpson, K. (2021). Physiologic interventions for fetal heart rate patterns, in A. Lyndon & K. Wisner (Eds.), *Fetal heart monitoring: Principles and practices.* (6th ed., pp. 155-178). Association of Women's Health, Obstetric and Neonatal Nurses.

Attachments

- A: Pre-Oxytocin/Induction Checklist for Women with Term Singleton Babies
- B: Oxytocin Dosing
- C: Oxytocin in Use Checklist
- D: Management of Oxytocin Induced Tachysystole

Approval Signatures

Step Description	Approver	Date
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Owner	Daniela Jago: Clinical Manager	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16470287

Origination	05/2021	Owner	Genevieve delos Santos: Director Pharmacy
Last Approved	N/A	Area	Pharmacy
Next Review	3 years after approval		

Outsourcing Sterile Compounding

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To establish guidelines for selection and quality review of outsourced sterile compounding services.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Proposals (RFPs) are evaluated and a decision to outsource sterile compounding services is collaborative and may involve as appropriate, the Governing Body, Chief Executive Officer (CEO), Chief Nursing Officer, Chief Financial Officer (CFO), Chief Operating Officer (COO), Chief Clinical Officer (COO), the Chief of the Medical Staff, the Chair of the Pharmacy and Therapeutics Committee, the Director of Nursing, the Director of Pharmacy, legal counsel and department heads.

B. Based on the compounding vendor's assessment results and the nature of the product(s), the medical staff (via the Pharmacy and Therapeutics Committee or equivalent), in conjunction with hospital leadership, determines when and if disclosure of the compounding source prior to medication administration is required.

C. The organization will not contract to outsource the preparation of copies of commercial products available on the current market.

D. When the organization deems it necessary to contract with an outsourced sterile compounding vendor for services, the Pharmacy Services will only contact FDA registered

503B outsourcing facilities. These approved facilities by both the FDA and the California state board of pharmacy will be contacted with the request of proposal (RFP).

V. PROCEDURE

A. Proposals and Required Documents

1. The prospective compounding vendor will submit or have available upon request the following information with their proposals:
    a. A brief history of the compounding vendor and service, including its mission, vision, and values.
    b. The location of the compounding vendor's offices and other facilities that would provide services to the organization.
    c. The compounding vendor's regular business hours or hours of operation and emergency and after-hours contact information.
    d. Assurance that all pharmacists employed at the compounding facility are licensed and competent as required by state and federal rules and regulations
    e. Evidence of the following documentation regarding the compounding vendor:
        i. Proof of current liability insurance.
        ii. Current accreditation or certification certificates, if applicable.
        iii. State pharmacy and/or wholesaler licensure and other appropriate licenses.
        iv. Licensure documents if the compounding facility is registered with FDA as a drug manufacturer or device manufacturer.
        v. Current DEA registration as a manufacturer or wholesaler.
        vi. Licensure of pharmacists employed and verification that there is documented training and competency assessments on file and available for review.
        vii. Registration of pharmacy technicians employed and verification that there is documented training and competency assessments on file and available for review, if applicable.
        viii. Pharmacist and pharmacy technician training manuals on file and available for review.
        ix. Standard operating procedures manual on file and available for review.
        x. Policies and procedures for sterility testing on file and available for review
        xi. Policies and procedures for pyrogen and endotoxins testing on file and available for review, if applicable
        xii. Examples of the quality control reports include trending reports

for the last year as well as detailed reports for the last quarter.

xiii. Stability and sterility documents and clinical references, as well as any materials that are used to determine beyond-use dates

2. A history of the results of all accreditation or regulatory surveys conducted of the compounding vendor's sites, including copies of significant regulatory actions.
3. Experience (e.g., years of experience in providing sterile compounding services, total number of clients served current number of clients).
4. A list of the services that the compounding vendor can provide and the normal terms of service, including but not limited to delivery cycles, availability and cost of emergency preparation and delivery, remedies for failure to perform to the contract and the infrastructure available for electronic ordering.
5. A list of the sterile compounding services that the compounding vendor cannot provide and the reasons for its inability to provide them.
6. Disclosure as to whether the compounding vendor has had product liability lawsuits filed against it for preparations it compounded. If so, the vendor's disclose of the suites and the outcome (e.g. favorable for or against the company).
7. A description of the compounding vendor's formal procedures for conducting recalls and a listing of their product recall history to include date of recall, description on preparations, and reason for the recall.

B. Evaluation and Selection

1. Proposals are evaluated and compared with respect to services, experience, quality and safety standards, references and cost. The compounding vendor must at a minimum be able to:
    a. Provide assurance that each compounded sterile preparation meets applicable state and federal labeling requirements and is sterile and free of pyrogens, endotoxins and unintended particulate matter, according to professionally established and accepted quality monitoring data.
    b. If compounding high risk level preparations, provide documentation of the end product testing processes used to determine that compounded sterile preparations are sterile and free of pyrogens, endotoxins, and unintended particulate matter.
    c. Deliver preparations in tamper-resistant packaging and in containers that will maintain proper storage temperature and (when required) protection from light during delivery and storage.
    d. Provide, upon request, batch records for any compounded sterile preparation.
    e. Provide quarterly information on its compliance with contract requirements and other quality assurance programs.

C. Contract Negotiation and Agreement

1. The contract clearly describes all aspects of the outsourcing agreement and is executed as defined by organizational policy.

2. Review of the proposal and clarification of contract provisions includes the Director of Pharmacy Services and, as indicated, the organization's risk management and legal counsel.
3. The contract agreement and sterile compounding vendor is reviewed and approved by medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

D. Evaluation of Sterile Compounding Vendor's Performance
    1. On a regular basis as part of the organization's quality assurance program, the sterile compounding vendor's performance and compliance with the terms of the contract are evaluated.
    2. Based on quarterly quality reports submitted by the vendor, Pharmacy Services in collaboration with other key hospital leadership will perform objective and subjective evaluations of the measurable standards of performance specified in the contract.
    3. Annually, or more frequently if indicated by performance outcomes, a summary of the sterile compounding vendor's performance expectations and outcomes are reported to and reviewed by the medical staff as a function of the Pharmacy and Therapeutics Committee and/or Medical Executive Committee.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Society of Health System Pharmacists ASHP Guidelines on Outsourcing Sterile Am J Health-System Pharm. Volume 72, Issue 19, 1 October 2015 Pages 1664- 1675
B. Pharmacy Compounding Accreditation Board (PCAB) Accreditation Manual (Accessed December 2019)
C. American Society of Health System Pharmacists Sterile Compounding Resource Center (Accessed December 2019)
D. The Joint Commission Standards MM.02.01.01; LD.04.03.09
E. Center for Medicare and Medicaid Services (CMS) §482.25(b)(9); §482.12(e)
F. Healthcare Facility Accreditation Program (HFAP) 25.01.11

Approval Signatures

Step Description	Approver	Date
Policy Owner	Genevieve delos Santos: Director Pharmacy	Pending

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17904277

Origination	05/2022	Owner	Melissa Deen: Manager Infection Prevention
Last Approved	N/A	Area	Infection Control
Next Review	3 years after approval		

Reportable Disease and Conditions

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To notify the Monterey County Public Health Department (MCPHD) of cases or suspected cases of certain diseases and unusual conditions required by law.

B. To notify local health officers when any person is bitten by an animal of a species subject to rabies whether or not the animal is suspected of having rabies.

C. To notify the Department of Health Services Licensing and Certification Program for outbreaks or unusual occurrences.

III. DEFINITIONS

A. Monterey County Public Health Department (MCPHD)

IV. GENERAL INFORMATION

A. Required disease reporting under Title 17, California Code of Regulations (CCR) 2500 and) will be the responsibility of Infection Prevention.

B. Unusual conditions or outbreaks are reported to the local health officer by the Infection Control Department.

C. Immediate required reporting under Title 17, California Code of Regulations 2505 will be the responsibility of the Lab/ Pathology Department with Communicable Disease Report (CMR) submitted by Infection Prevention.

D. Animal Bites reported under Title 17 section 2606 should be reported by Emergency Department personnel.

E. All animal bites reports will be faxed to Monterey County Animal Services Division. Report forms for bites that occurred within the City of Salinas will be forwarded by the County to Salinas Animal Control.

V. PROCEDURE

A. If healthcare personnel are aware of the diagnosis and are unsure if it has been reported, they shall notify the Infection Prevention Department for follow up (x 1858).

B. Confidential Morbidity Reports (CMRs) are forwarded to: Monterey County Health Department Epidemiology, Department of Health Services, State of California based on the urgency reporting requirements determined by the California Code of Regulations.

- Report immediately by telephone.
- Report by fax, telephone, or mail within one working day.
- Report by fax, telephone, or mail with seven calendar days of identification.

C. **Laboratory Reports**

- The laboratory is required to report any case when examination of a specimen indicates it is one of the communicable diseases listed below. The report is made to the Director of the Monterey County Health Department either by telephone or by sending a copy of the laboratory report within 24 hours of the report.
- Lab personnel will immediately notify Infection Prevention and/or Infectious Disease MD of any positive reported disease listed below (#1) as "immediate notification by telephone".

1. Diseases to which immediate telephone notification applies are:
    a. Anthrax, human or animal
    b. Botulism (infant, foodborne, wound, other)
    c. Brucellosis, human (all *Brucella* spp.)
    d. Cholera
    e. Ciguatera Fish Poisoning
    f. Coronavirus Disease 2019 (COVID-19)
    g. Dengue
    h. Diphtheria
    i. Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
    j. *Escherichia coli*: shiga toxin producing (STEC) including *E.coli* O157
    k. Hantavirus Infections
    l. Hemolytic Uremic Syndrome
    m. Measles (Rubeola)
    n. Meningococcal Infections

o. Paralytic Shellfish Poisoning
p. Plague, human or animal
q. Rabies, human or animal
r. Scombroid Fish Poisoning
s. Severe Acute Respiratory
t. Syndrome (SARS)
u. Shiga toxin (detected in feces)
v. Smallpox (Variola)
w. Tularemia, human
x. Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lass, and Marburg viruses)
y. Yellow Fever
z. Occurrences of Any Unusual Diseases
aa. Outbreaks of Any Diseases (including diseases not listed in Title 17 Section 2500)

2. Diseases to which notification within one day of identification applies are:
    a. Amebiasis
    b. Babesiosis
    c. Campylobacteriosis
    d. Chickenpox (Varicella) (only hospitalizations and deaths)
    e. Cryptosporidiosis
    f. Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
    g. Foodborne Disease
    h. *Haemophilus influenzae*, Invasive Disease (<15 years of age)
    i. Hepatitis A
    j. Listeriosis
    k. Malaria
    l. Meningitis, Specify Etiology: Viral,
    m. Bacterial, Fungal, Parasitic
    n. Pertussis (Whooping Cough)
    o. Poliovirus Infection
    p. Psittacosis, human
    q. Q Fever
    r. Relapsing Fever
    s. Salmonellosis (Other than Typhoid Fever)

t. Shigellosis

u. *Staphylococcus aureus* Infection (only in a case resulting in death or admission to an ICU in a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year and did not have an indwelling catheter or percutaneous medical device at the time of culture)

v. Streptococcal Infections (outbreaks of any type and individual cases in food handlers and dairy workers only)

w. Syphilis

x. Trichinosis

y. Tuberculosis

z. Typhoid Fever, Cases and Carriers

aa. Varicella, Hospitalizations/Deaths

ab. *Vibrio* Infections

ac. West Nile Virus (WNV) Infection

ad. Yersiniosis

D. **Animal Bites**

- All ED personnel who take information or make a report on a bite case are reminded to get the following information:
    1. Was the bite provoked?
    2. What kind of animal - dog, cat, skunk, bat, etc., did the biting?
    3. Type of breed of biting animal:
        a. Dog – breed, sex, color, size (small, medium, large)
        b. Cat – color size, stray or pet?
        c. Other animal – species, wild, pet?
        d. Location of animal – be specific as to address and telephone number of animal's owner. If animal is at large, please indicate. If animal is dead, so indicate and advise holding under refrigeration.

E. Face Bites should be reported immediately by telephone or fax.

F. Documentation:

1. A summary of reportable diseases or unusual condition, animal bites and/or exposures sent to the Monterey County Public Health Department will be maintained in Infection Prevention Department, and reported to the Infection Control Committee at least annually.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Title 17, California Code of Regulations (CCR) - Reportable Diseases and conditions

1. **General:** https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/ReportableDiseases.pdf, Updated August 2022
2. Selected Communicable Diseases: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/IDBGuidanceforManagingSelectCommunicableDiseases.aspx, Updated September 3, 2024
3. **Laboratories:** https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/LabReportableDiseases.pdf, Updated March 2024
4. **Notification of Animal Bites:** https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/IDBGuidanceforCALHJs-Rabies.pdf, Updated June 2023

Attachments

LabReportableDiseases.pdf

ReportableDiseases.pdf

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T/IPC	Genevieve delos Santos: Director Pharmacy	05/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	05/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	04/2025
Policy Owner	Melissa Deen: Manager Infection Prevention	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