November 14, 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, NOVEMBER 20, 2025, AT 4:00 P.M., CISLINI PLAZA BOARD ROOM, 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, NOVEMBER 20, 2025, 4:00 P.M.
CISLINI PLAZA BOARD ROOM
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** This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.	*Joel Hernandez Laguna*
6.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)*	*Joel Hernandez Laguna*

A. Minutes of Regular Meeting of the Board of Directors October 23, 2025
B. Policies/Plans Requiring Approval
   1. Account Balance Adjustments –Taylor Farms Family Health & Wellness Center (TFFHWC)
   2. Advance Beneficiary Notice Processing – TFFHWC
   3. Complaint and Grievances – Patient
   4. Data Protection
   5. Denied Claims Processing - TFFHWC
   6. Departmental Charge Reversal Request Adjustments - TFFHWC
   7. Internal Defibrillation (Assist)
   8. Medical Waste Management Plan
   9. Mobile Device Management for Workday Mobile App
   10. Obstetrical Care Standards: Assessment and Documentation
   11. Patient Registration - Patient Identification - TFFHWC
   12. Percutaneous Ventricular Assist Device Implantation (Clinical)
   13. Refund: Taylor Farms Family Health & Wellness Center
   14. Scope of Service: Diagnostic Imaging
   15. Secure Configuration
   16. Small Balance Adjustment - TFFHWC
   17. Spiritual Care Services
   18. Tuition Assistance

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

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE *Catherine Carson*

Minutes of the November 17, 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 November 10, 2025 Personnel, Pension and 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 OF (i) FINDINGS SUPPORTING RECRUITMENT OF ARMANDO CERVANTES, M.D., (ii) CONTRACT TERMS FOR DR. CERVANTES' RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. CERVANTES' FAMILY MEDICINE PROFESSIONAL SERVICES AGREEMENT**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

2. **CONSIDER RECOMMENDATIONS FOR BOARD APPROVAL OF AMENDMENTS TO THE (i) SVMHS 403(B) RETIREMENT PLAN, THE (ii) 403(B) TAX DEFERRED SALARY REDUCTION PLAN AND THE (iii) 457(B) RETIREMENT PLAN AND ADOPTION OF BOARD RESOLUTION NO. 2025-03 OF THE BOARD OF DIRECTORS OF SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM APPROVING AMENDMENTS TO THE 403(B) RETIREMENT PLAN, 403(B) TAX DEFERRED SALARY REDUCTION PLAN AND 457 DEFERRED COMPENSATION PLAN**
   - 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 November 17, 2025 Finance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

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

Minutes of the November 12, 2025 Corporate Compliance & Audit 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 OF DIRECTORS APPROVAL OF THE YEARS ENDED 2025 AND 2024 DRAFT AUDITED FINANCIAL STATEMENTS FOR SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

2. **CONSIDER RECOMMENDATION FOR BOARD OF DIRECTORS APPROVAL OF THE YEARS ENDED 2024 AND 2023 DRAFT AUDITED FINANCIAL STATEMENTS FOR SALINAS VALLEY MEMORIAL HEALTHCARE DISTRICT EMPLOYEE'S PENSION PLAN**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

E. COMMUNITY ADVOCACY COMMITTEE *Rolando Cabrera, M. D.*

Minutes of the November 5, 2025 Community Advocacy Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF NOVEMBER 13, 2025 AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Alison Wilson, D.O.*

A. Reports
   1. Credentials Committee Report (Including the following)
      - Family Medicine – Clinical Privileges Delineation
      - Hospitalist – Adult – Clinical Privileges Delineation
      - Cardiology – Clinical Privileges Delineation
      - Salinas Valley Health Nancy Ausonio Breast Health Center – Clinical Privileges Delineation

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

B. Policies/Procedures/Plans and Charter Recommended for Approval:
1. Adult Parenteral Nutrition Protocol
2. DI Thoracentesis Under Ultrasound Guidance
3. Employee Exposures & Prevention Plans: Specific Disease Exposures and Work Restrictions
4. Information Management Program Plan
5. Inpatient Criteria for Chemotherapy and Immunotherapy Administration
6. Medication Use
7. Medical Staff Excellence Committee (MSEC) Charter

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

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

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

12. ADJOURNMENT — *Joel Hernandez Laguna*

The next Annual Meeting of the Board of Directors is scheduled for **Thursday, December 18, 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, NOVEMBER 20, 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 Medical Staff Quality and Safety Committee
    - Accreditation and Regulatory Report
    - Consent Agenda
        - Sepsis
        - Organ/Tissue Procurement
        - Respiratory Care
        - Transporters and Interpreters
        - Cardiovascular Service Line
        - Case Management/Utilization Management
        - Taylor Farms Family Health and Wellness Center

CONFERENCE WITH LEGAL COUNSEL-ANTICIPATED LITIGATION

(Government Code §54956.9(d)(2))

Significant exposure to litigation pursuant to paragraph (2) or (3) of subdivision (d) of Section 54956.9: (Specify number of potential cases): One

Additional information required pursuant to Section 54956.9(e): Attorney General of the State of California

REPORT INVOLVING TRADE SECRET

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

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

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

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
OCTOBER 23, 2025

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

Absent: Rolando Cabrera, M.D.

Also Present:
Allen Radner, M.D., President/Chief Executive Officer
Vincent DeFilippi, M.D.
Matthew Ottone, Esq., District Legal Counsel
Hanna Hitchcock, Esq.
Kathie Haines, Executive Support.

Rolando Cabrera, M.D., attended Via WebEx as a non-voting member.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:01 p.m. in the Cislini Plaza Board Room.

2. CLOSED SESSION

President Joel Hernandez Laguna announced the item to be discussed in Closed Session as listed on the posted Agenda is *Hearings and Reports*.

The meeting recessed into Closed Session under the Closed Session Protocol at 4:04 p.m.

The Board completed its business of the Closed Session at 4:20 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:31 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *Hearings and Reports*. The Board received and accepted the reports listed on the Closed Session agenda. No other action was taken.

President Hernandez Laguna announced there is no 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:

- **Haynes Charitable Foundation:** Melissa Gross, Interim Director Foundation, introduced Mike Haynes, representing the Haynes Charitable Foundation, and recognized the Haynes Charitable Foundation for their generosity, recognizing $1 Million in lifetime philanthropic support to the

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

Salinas Valley Health Foundation. Mike and his wife Gina were presented with an award in recognition. Mike expressed his thanks for the recognition stating that his father said, "what you take out, you want to give back," and that is the philosophy of the Haynes Charitable Foundation

- **35 Year Retirement Recognition: Susan Pilat, R.T., R:** Megan Giovanetti, Director Cardiovascular Services and Sleep, honored Sue for her dedication to Salinas Valley Health for 35 years with light and humanity and wished her well in retirement. Sue stated, "It has been an honor to say I've worked here and I've worked with an incredible team."
- **DAISY Award: Heather Barigian, BSN, RN, PCCN, Telemetry Towers:** Carla Spencer, CNO, introduced Heather who was nominated by a patient for her exceptional clinical practice and exceeding expectations in providing compassionate, patient-centered care. Heather said it is an honor, that she has been at SVH for 10 years and "I love where I work." Joel thanked Heather for her compassion; which makes SVH the place of choice for patients to receive their care.
- **STAR Award: Tito Abalos:** Clement Miller, COO, introduced Tito who was nominated for doing his job well, quickly and in a friendly and respectful manner. Tito has been a great member of the team. Tito said, "Thank you; I'm honored and grateful for the award and I couldn't have done it without the team." He thanked his leadership team for guiding him and inspiring him.
- **Harvest Cup Tournament:** Claudia Pizarro-Villalobos, Director Marketing & Communications, reported the SVH had three (3) teams in the tournament; the proceeds of the tournament will help build out the Salinas Regional Soccer Complex. SVH received the Spirit Award.

5. PUBLIC COMMENT: None.

6. CONSENT AGENDA – GENERAL BUSINESS

Recommend Board Approval of the Following:

A. Minutes of Special Meeting of the Board of Directors September 24, 2025
B. Minutes of Regular Meeting of the Board of Directors September 25, 2025
C. Policies/Plans Requiring Approval
    1. Adult Sepsis Management
    2. Business Continuity Access (EHR Downtime)
    3. Cardiac Cath Lab Emergency On-Call Procedure with Support Personnel Backup
    4. Cardiac Catheterization Patient Care
    5. Carotid Artery Stenting
    6. Complete Decongestive Therapy for Management of Lymphedema
    7. Echocardiography Lab Quality Assurance/Quality Review Process and Correlation
    8. Instrument Preventative Maintenance
    9. Magnesium Sulfate in the Obstetric Patient
    10. Maternal and Newborn Substance Abuse Evaluation
    11. Neonatal Medication Administration
    12. Newborn Abandonment
    13. NICU Family Centered Care/Patient Participation
    14. Pharmacy – Sterile Compounding
    15. Scope of Service: Clinical Research Program
    16. Sedation for the Mechanically Ventilated Adult

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None

MOTION:
Upon motion by Director Carson, second by Director Arreguin, the Board of Directors approves the Consent Agenda, Items (A) through (C) as listed.

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

Motion Carried

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Catherine Carson: Director Carson attended the State of the Region Conference at which Dr. Radner was the keynote speaker; he did a great job. Iftikhar Hussain, CFO, provided a great update on Managed Care, which has to do with the survival of healthcare. She requested an educational Board meeting on population health and value-based care.

Director Victor Rey, Jr.: Director Rey referred/requested administration to consider being a sponsor to the annual Christmas in Closter Park. He also attended State of the Region Conference.

Director Isaura Arreguin: Director Arreguin also attended the State of the Region Conference and thought it was great for others to hear about challenges of the medical system. She also thanked the Epic team for their planning and training.

Director Joel Hernandez Laguna: Director Hernandez Laguna commented that as a large workforce in Salinas, SVH is an economic force in the county shaping the economy. He referred/requested administration to work with local partners in workforce development. He attended the Salinas Valley Chamber Legacy of Leadership event. He has concerns about the future of Medicare and Medicaid and residents receiving preventative care. He also requests Board education on two topics: AI and population health.

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Carson regarding the Quality and Efficient Practices Committee. The minutes of the October 13, 2025 meeting were provided for Board review. Director Carson stated the presentations were: (1) Patient Care Services update on the Pediatric Unit Practice Council, (2) the CMS Action Plan Improvement Report, (3) Patient Experience, (4) Patient Safety Structural Updates (PSEC), and (5) a draft new dashboard format with key metrics was reviewed. The Consent agenda included reports as listed on the Board of Directors Hearings and Reports Consent Agenda. There are no recommendations.

B. PERSONNEL, PENSION & INVESTMENT COMMITTEE

A report was received from Director Carson regarding the Personnel, Pension and Investment Committee. The minutes of the October 13, 2025 meeting were provided for Board review. Director Carson stated there was a presentation on the Employee Group Health Plan.

The following recommendation was made.

1. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF MARTIN KAMPER, M.D., (ii) CONTRACT TERMS FOR DR. KAMPER'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. KAMPER'S PULMONARY AND CRITICAL CARE PROFESSIONAL SERVICES AGREEMENT**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: It was noted that Dr. Kamper's wife is a gastroenterologist and also considering practicing at Salinas Valley Health.

MOTION:

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

1. The Findings Supporting Recruitment of Martin Kamper, M.D.:
   - That the recruitment of pulmonary and critical care 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. Kamper; and
3. The Contract Terms of the Pulmonary and Critical Care Professional Services Agreement for Dr. Kamper.

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

Motion Carried

C. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the October 20, 2025 meeting were provided for Board review. The September Financial Reports will be presented in November due to the Workday program implementation.

The following recommendations were made.

1. **CONSIDER RECOMMENDATION FOR BOARD OF DIRECTORS APPROVAL TO AWARD CONSTRUCTION CONTRACT TO C. OVERAA & CO. FOR THE SALINAS VALLEY HEALTH X-RAY ROOM 1 & 2 EQUIPMENT REPLACEMENT PROJECT**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:
Upon motion by Director Carson, and second by Director Arreguin, the Board of Directors to awards the construction contract to C. Overaa & Co. for the SVH X-Ray Room 1 & 2 Equipment Replacement project in the total amount of $499,750.00.

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

Motion Carried

2. **CONSIDER RECOMMENDATION FOR BOARD OF DIRECTORS APPROVAL OF PURCHASE OF SEVEN (7) CANON ULTRASOUND UNITS AND ASSOCIATED FORTY-EIGHT-MONTH SERVICE AGREEMENT FOR SALINAS VALLEY HEALTH CLINICS IMAGING AND SALINAS VALLEY HEALTH OBSTETRICS & GYNECOLOGY**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:
Upon motion by Director Carson, and second by Director Arreguin, the Board of Directors approves the terms presented for purchasing the ultrasound equipment for Salinas Valley Health Imaging and Obstetrics & Gynecology from Canon in the amount of $770,904 and for a forty-eight-month service agreement in the amount of $252,000.

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

Motion Carried

D. TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE

A report was received from Director Rey regarding the Transformation, Strategic Planning and Governance Committee. The minutes of the October 15, 2025 meeting were provided for Board review. There are no recommendations.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON OCTOBER 9, 2025, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING:

Vincent DeFilippi, M.D., reviewed the reports of the Medical Executive Committee (MEC) meeting of October 9, 2025. A full report was provided in the Board packet.

Recommend Board Approval of the following Reports and Policies as listed on the Agenda.

PUBLIC COMMENT: None.

BOARD DISCUSSION: None.

MOTION:
Upon motion by Director Rey, second by Director Carson, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report and Interdisciplinary Practice Committee Report and approves the policy as follows:

A. Reports
    1. Credentials Committee Report
    2. Interdisciplinary Practice Committee Report

B. Policies/Procedures/Plans and Agreements Recommended for Approval:
    1. Aerosol Transmitted Diseases Exposure Control Plan
    2. Bioterrorism Readiness Plan
    3. Laboratory Critical Call Values
    4. Respiratory Virus (Influenza) Pandemic Plan

C. Other Items (Informational)
    1. Medical Staff Excellence Committee (MSEC) Charter Update

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

Motion Carried

10. BOARD EDUCATION:

Gary Ray, CLO, reported planning has begun for a Board retreat in the new year. Additionally, he spoke about the restructure of Board support.

BOARD DISCUSSION: There have been transitions on the Board and in senior leadership. Planning a retreat is a good start to assess how the Board is doing and make the organization stronger. Directors Hernandez Laguna and Dr. Cabrera were appointed to review the strategy, agenda, and focus of the retreat. He requested that when Board members receive assessments/surveys, to please complete them in a timely manner.

11. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, November 20, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 5:41 p.m.

_____
Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors

From: Brenda Inman, VP Quality and Risk

Date: November 20, 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 Balance Adjustments - TFFHWC	No changes. Regularly scheduled review.	Timothy Albert, CCO
2.	Advance Beneficiary Notice Processing - TFFHWC	No changes. Regularly scheduled review.	Timothy Albert, CCO
3.	Complaint and Grievances - Patient	References updated. Regularly scheduled review.	Carla Spencer, CNO
4.	Data Protection	References updated. Regularly scheduled review.	Alysha Hyland, CAO
5.	Denied Claims Processing - TFFHWC	No changes. Regularly scheduled review.	Timothy Albert, CCO
6.	Departmental Charge Reversal Request Adjustments - TFFHWC	No changes. Regularly scheduled review.	Timothy Albert, CCO
7.	Internal Defibrillation (Assist)	Minor typos and formatting changes corrected. References updated. Regularly scheduled review.	Carla Spencer, CNO
8.	Medical Waste Management Plan	No changes. Regularly scheduled review.	Clement Miller, COO
9.	Mobile Device Management for Workday Mobile App	New policy	Alysha Hyland, CAO
10.	Obstetrical Care Standards: Assessment and Documentation	Wording cleaned up. Regularly scheduled review.	Carla Spencer, CNO
11.	Patient Registration - Patient Identification - TFFHWC	Minor typos corrected. Regularly scheduled review.	Timothy Albert, CCO
12.	Percutaneous Ventricular Assist Device Implantation (Clinical)	Changes made to align with updated processes and technology. Additional definitions added.	Carla Spencer, CNO
13.	Refund: Taylor Farms Family Health & Wellness Center	Additional definitions added. Minor typos corrected.	Timothy Albert, CCO
14.	Scope of Service: Diagnostic Imaging	Minor typos corrected. Regularly scheduled review.	Clement Miller, COO
15.	Secure Configuration	References updated. Regularly scheduled review.	Alysha Hyland, CAO
16.	Small Balance Adjustment - TFFHWC	No changes. Regularly scheduled review.	Timothy Albert, CCO
17.	Spiritual Care Services	Meditech replaced with HER. Reference updated.	Timothy Albert, CCO
18.	Tuition Assistance	Formatting and minor typos corrected.	Michelle Barnhart Childs, CHRO

Status Pending PolicyStat ID 18635490

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Account Balance Adjustments - TFFH

I. POLICY STATEMENT

A. It is the policy of Taylor Farms Family Health & Wellness Center (TFFHWC) to ensure accurate and appropriate account balance adjustments. Patient responsibility amounts should be waived or reduced solely on patient financial need. The waiving or reduction of co-payment or deductible amounts, the inappropriate posting of allowances or adjustments for select patients, employees or physicians could constitute a violation of regulations.

II. PURPOSE

A. The purpose of this policy is to provide guidelines for entire or partial account balance adjustments including, but not limited to, administrative, patient complaint, charity care, bad debt, departmental request, bankruptcy and share of cost.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. The Billing Staff and Practice Manager will perform all requested and identified adjustments. Adjustment parameters vary by type and circumstance, therefore specific procedures, by process, support this policy and should be referenced for additional information. The procedures to be referenced are:

ADMINISTRATIVE AND PATIENT
COMPLAINT ADJUSTMENTS

BANKRUPTCY ADJUSTMENTS

PROBATE ADJUSTMENTS

DEPARTMENTAL CHARGE REVERSAL REQUEST ADJUSTMENTS

NON REIMBURSED CLAIMS AND CHARGE ADJUSTMENTS

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Taylor Farms Family Health & Wellness Center Policy and Procedure Manual.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief Financial Officer	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18635485**

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Advance Beneficiary Notice Processing - TFFH

I. POLICY

A. N/A

II. PURPOSE

A. To comply with Medicare regulations requiring that the patient be informed, prior to receiving services, that Medicare may not cover the requested service. All Medicare patients must receive sufficient explanation that they could, or will be responsible for payment, and a signed waiver must be obtained from the patient (or the person acting on the patient's behalf) attesting to the above.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. An Advance Beneficiary Notice (ABN) should be attained from Medicare beneficiaries, prior to rendering services, when ordered tests/services will not be covered because they do not meet the Medicare coverage guidelines. All Advance Beneficiary Notices will be obtained in accordance with Medicare requirements.

B. Taylor Farms Family Health & Wellness Center (TFFHWC) will use a standard ABN form. Each ABN will be in writing and clearly identify the following:

1. Name/identification of the beneficiary
2. Date of service
3. Medical necessity statement
4. Specific item/service that will not/may not be covered

5. Perceived reason for non-coverage, i.e.
6. Service exceeds frequency within established timeframe
7. Service not usually covered by Medicare
8. Service is considered experimental
9. Service is considered routine screening
10. Service may not be covered due to medical necessity
11. Beneficiary agreement statement
12. Date and signature of the beneficiary

C. Use of a blanket ABN is prohibited.

D. All completed ABNs will be maintained in the appropriate patient account record according to the record retention guidelines.

V. PROCEDURE

A. Responsibility for Obtaining ABN

Health care providers ordering services must review the patient's diagnosis, sign, symptom, or disease for medical necessity (according to LMRP and National Coverage Limitations) when processing outpatient orders for Medicare beneficiaries.

Beneficiary refusal
When a Medicare beneficiary demands that services are provided and refuses to sign the ABN form, another employee witness should sign the ABN form and note that the beneficiary refused to sign.

Patient Financial Services
At the time of billing, the Billing Staff will review documents in the patient accounting file as to the receipt of a signed ABN for known uncovered services.

- When the services do not meet medical necessity guidelines and an ABN has been obtained prior to rendering the non-covered services, the clinic will bill Medicare as usual and these services will be reported in the non-covered column. Bill these services to the patient (or secondary insurance).
- When the services do not meet medical necessity guidelines and an ABN has been obtained prior to rendering the non-covered services, the clinic will balance bill the patient for the non-covered services after receiving an Explanation of Benefits from Medicare.
- When the services do not meet medical necessity guidelines and an ABN has not been obtained prior to rendering the non-covered services, write off
- the charges as non-covered/non-allowable (not as Medicare Collection status expenses).

B. Monitoring

- Corporate Compliance and the Billing Department will be responsible for periodic audits of the above-mentioned reports and processes. Those employees who are not in compliance with this policy may be counseled in accordance with the Clinic disciplinary process.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Medicare Carriers Manual 7300.5

B. Medicare Hospital Manual 295.1; 296.2; 299; 299.1; 460

C. Fiscal Intermediary Local Medical Review Policies

D. Medicare Coverage Issues Manual

E. Medicare Intermediary Manual - PM A-99-49, Nov. 1999 – Reporting and Acceptance of Non-covered Charges

F. 42 CFR 411.404, Criteria for Determining That A Beneficiary knew that Services Were Excluded From Coverage as Custodial Care or As Not Reasonable and Necessary

G. SSA 1879 42 USC 1395 Limitation on liability where claims are disallowed

H. HOSPT 406, Waiver of Liability Provision

I. HOSPT 295.1 Notifying Patient of Non-coverage

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief Financial Officer	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18961255

Origination	12/2019	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Administration
Next Review	3 years after approval		

Complaint and Grievances - Patient

I. POLICY STATEMENT

A. It is the policy of Salinas Valley Health Medical Center (SVHMC) to implement practices to manage patient concerns related to the care and services they receive. It is also organization policy to assure that grievances or complaints are communicated in a timely, consistent manner to the appropriate departments for investigation, problem resolution and follow-up.

II. PURPOSE

A. To provide a uniform process for investigating, evaluating, responding to and resolving complaints / grievances made by patients and/or their representatives. This is a system-wide program. It applies to all care settings and departments under SVHMC.

III. DEFINITIONS

A. **Complaint:** An initial informal communication, expressed by the patient or their representative during the admission or visit, expressing dissatisfaction with the care, treatment, environmental conditions, or other aspects of their visit. A complaint is considered resolved when a patient is satisfied with the action(s) taken.

- If a patient care complaint cannot be resolved at the time of the complaint by staff present, the flow in Attachment A is initiated.

B. **Grievance:** A formal or informal written or verbal complaint that is made to the hospital by a patient or their representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by the staff present) abuse, or neglect, issues related to the hospital compliance with the CMS Hospital Conditions of Participation (CoP), or a Medicare beneficiary billing complaint related to rights and limitations provided by 42 CFR 489.

- A written complaint is always a grievance whether inpatient, outpatient, released/ discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with the Condition of Participation. (email

and fax are considered written as long as information is available for a response).

- All verbal and written complaints regarding abuse, neglect, patient harm are considered a grievance.
- Information obtained from patient satisfaction surveys does not meet the definition of a grievance unless the:
    1. Patient writes or attaches a complaint on the survey and requests resolution.
    2. Patient writes or attaches a complaint to the survey but has not requested resolution this will be treated as a complaint..
- Whenever the patient or representative requests their complaint be handled as a formal complaint or grievance or when the patient requests a response from the hospital.

C. **Staff Present:** Includes any hospital staff member at the time of the complaint who can quickly be at the patient's location (i.e. Primary Care Nurse, Charge Nurse, Director or Manager, Administrative Supervisor, Nursing Administration, Patient Relations) to resolve the patient's complaint.

D. **Patient Representative:** Person authorized by the patient to act on their behalf to resolve a complaint / grievance.

E. **Complaint Resolution:** When the patient is satisfied with the actions taken on their behalf.

F. **Mammography Serious Adverse Event:** Is defined as an unqualified personnel performing or interpreting mammograms; missed diagnosis or poor image quality.

IV. GENERAL INFORMATION

A. The data collected regarding patient grievances, as well as other complaints that are not defined as grievances will be periodically reported through the Quality and Safety Committee and to the Board of Directors.

B. Patient Complaints or Grievances that are not immediately resolved by staff present will be documented in the electronic occurrence reporting system under the Patient Relations module.

C. Complaints or grievances involving members of the hospital medical staff are forwarded to the Medical Staff Office for review, investigation and follow-up.

D. The Service Excellence Committee membership includes representatives from Quality and Patient Safety, Risk Management, Nursing, Patient Experience and other members of the healthcare team as needed and meets on an as needed basis, but at least every quarter.

E. SVHMC provides patients and/or their representative's information on their right to file a complaint/grievance.

F. SVHMC does not consider billing issues as grievances.

G. If someone other than the patient/patient's surrogate decision maker files a complaint/ grievance, SVHMC will obtain authorization from the patient before discussing any Protected Health Information.

H. Acknowledgement letter is sent to the patient or patient's representative within 7 business days of receipt of the grievance.
    - Acknowledgement letter for the Taylor Farms Family Health and Wellness Center is sent to the patient or patient's representative within 5 business days of receipt of the grievance.
    - If circumstances prevent resolution completion within 7 days, a written notice will be sent with additional information and expected date of resolution every 45 days.

I. Mammography complaints are managed in accordance with California Code of Regulations, Title 17, §30317.70 Consumer Complaints. All unresolved serious complaints will be reported to the Department of Consumer Affairs.

J. Concerns raised from patient related to Salinas Valley Medical Clinic are referred to the Director for Clinic Operations for appropriate and timely follow-up in accordance with this policy.

K. SVHMC encourages and allows patients/designated family members / representatives to voice concerns and recommend changes freely without being subject to coercion, discrimination, reprisal or unreasonable interruption of care.
The SVHMC Board of Directors, by approval of this policy, has delegated the oversight and responsibility for implementing the complaints/grievances management to the interdisciplinary Service Excellence Committee.

V. PROCEDURE

A. Informing the Patient of the Complaint / Grievance Process:
    - Patients and family are informed that they may report grievances and complaints directly to CMS State enforcement agency and/or Joint Commission (Physician complaints to The Medical Board) and this may be accomplished regardless of whether or not the internal reporting has occurred. Written materials are provided as appropriate to Rights and Responsibilities Brochure, Informational Handout etc.).
    - Taylor Farms Family Health and Wellness Center patients and family may also file a complaint with the Accreditor, The Compliance Team, Inc.

B. Filing a complaint:
    - Complaints given to staff members by patients or their representatives should be addressed in a timely manner and an attempt to resolve the issue should be made. If resolution is achieved then no further action is required. The Patient Experience team may be requested to assist in complaint resolution.

C. Filing a Grievance:
    - Patients may file verbally, in writing, by phone, by letter / email / FAX, web, text, or by requesting response on post-discharge patient satisfaction survey.
    - Staff who receives a grievance should listen to the concern, obtain the person's phone number and refer them to the Patient Relations Department at 755-0709 (x1709). Place this information in the Occurrence Reporting System under Patient Relations.

D. Responding to Complaints / Grievances: **(See Attachment A)**

- Staff present should follow the guidelines in the Complaint / Grievance process map.
- When / if complaints are not immediately resolved and become grievances, staff present should escalate following the guidelines of the process map.

E. Response and Final Resolution of a Grievance:

- Patient Relations:

1. Further actions during resolution process include but are not limited to the following:
    a. Unresolved issues / questions will be referred to the involved department directors for further investigation and information regarding what has been done related to the issue and this information will be entered into the electronic occurrence reporting system.
    b. Refer and request response from physicians and/or staff on behavioral and attitude grievances.
    c. Refer Quality of Care cases to the Medical Staff or Nursing Excellence Committee(s) for Peer Review.
    d. Refer cases of potential claims to Risk Manager and Liability carrier.
    e. Refer Privacy / HIPPA cases to Privacy Officer.
    f. Review billing only complaints to determine if criteria are met to be considered a "grievance". If not, refer case to Accounting for handling.
    g. Refer cases based on discrimination to the Quality and Patient Safety Department who will coordinate the investigation and response efforts with involved departments.
2. After investigation is completed, a final written response will be sent to the patient that will include the following:
    a. Name of Hospital Contact person.
    b. Steps / actions taken on behalf of the individual to investigate.
    c. Results of the investigation.
    d. Decision regarding the hospital regarding grievance.
    e. Date of completion of the grievance process (date that the letter is sent).
3. Notices from insurance agencies regarding quality of care concerns are managed by Quality Services and are not considered a grievance.
4. Concerns received from state or regulatory agencies will be investigated and managed in accordance with the established Regulatory process and

are not considered a grievance.

F. Unsatisfactory Response to Resolution:

- If the patient and / or their representative do not feel that their complaint / grievance was resolved to their satisfaction, and the organization feels they have taken appropriate reasonable actions on the patient's behalf in order to resolve the complaint/grievance, the patient will be reminded of their right to file a complaint / grievance with federal, state, or regulatory agencies and the organization will consider the complaint/grievance closed.
- For Unsatisfactory Response to Resolution for Mammography complaints, the patient may file with the American College of Radiology.(ACR)
  Director Breast Imaging Accreditation Programs
  American College of Radiology
  1891 Preston While Drive
  Reston VA 2019
  Fax: (703) 648-9176
- For Unsatisfactory Response to Resolution for the Taylor Farms Family Health and Wellness Center, the patient / family may file with The Compliance Team, Inc., via their website at www.thecomplianceteam.org or via phone 1-888-291-5353.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. CMS Conditions of Participation Patient Rights
B. Title 22, Division 5, Article 7, Chapter 1, Section 70707.
C. CHA Consent Manual.
D. U.S. Department of Health and Human Services regulations (45 C.F.R. Part 84) Section 504 of the Rehabilitation Act of 1973 as amended (29 U.S.C. 794).
E. Title 17, Section 30317.70
F. MQSA Final Regulations, Section 21 CFR 900.12(h)

Attachments

A: Complaint/Grievance Process Map

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Carla Spencer: Chief Nursing Officer	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18822789**

Origination	N/A	Owner	Aaron Burnsides: Director Information Technology
Last Approved	N/A	Area	Cybersecurity Program
Next Review	3 years after approval		

Data Protection

I. POLICY STATEMENT

A. Salinas Valley Health is committed to implementing policies, procedures, and controls that protect the confidentiality, integrity, and availability of data.

II. PURPOSE

A. The intent of this document is to establish appropriate processes, controls, and standards that work together to effectively manage the cybersecurity risk that the organization is exposed to that impacts the confidentiality, integrity, and availability of Salinas Valley Health's systems. The management of these risks is necessary in order to safeguard the organization's ongoing operations and ensure compliance with regulatory requirements.

B. All of the cybersecurity policies utilized by Salinas Valley Health are intended to manage risk. This Risk Management policy focuses on risks related to data protection and classification.

III. DEFINITIONS

A. DLP - Data Loss Prevention – technology and processes to detect and prevent data exfiltration.

B. Encryption at Rest - Protection of stored data through encryption.

C. Encryption in Transit - Protection of data while moving over networks.

D. Immutable Backups - Backups that cannot be altered or deleted for a defined period.

E. PHI - Protected Health Information as defined by HIPAA.

F. PII - Personally Identifiable Information - Information that can be used to identify an individual, such as names and addresses.

G. RBAC - Role-Based Access Control – A method of restricting system access based on a user's role within the organization.

H. SaaS - A software delivery model in which applications are hosted by a third-party provider and

accessed over the internet.

IV. GENERAL INFORMATION

A. This document falls under the scope of the Cybersecurity Governance policy.

B. **Scope**

1. The scope of this policy is the entire organization including the hospital and clinics.

V. PROCEDURE

A. **Activities and Outcomes**

1. The Salinas Valley Health Security Program must develop and publish procedures, plans, and standards that meet the requirements of the policies governing cybersecurity. In order to achieve the outcome of managed and reduced risk, the following policies, processes, and activities, related to data management must be implemented and maintained:

    a. Records Retention (Owned by Privacy & Compliance Officers)
    b. Data Confidentiality
    c. Email Retention
    d. Acceptable Use Policy
    e. Destruction of Storage Media Policy
    f. Data Protection - Information System Management
    g. Access Management of Information Systems
    h. Device and Media Control
    i. Data Inventory
    j. Log Management
    k. Data Loss Prevention
    l. IT & Informatics Change Control

B. **Required Controls**

1. The above published procedures, plans, and standards in conjunction with the other cybersecurity policies and procedures of the Security Program must establish the below controls. The control sets are required to be established, implemented, and matured under the general direction of Director, Information Technology to security program target levels.

    a. Establish and Maintain a Data Management Process (2025)
    b. Establish and Maintain a Data Inventory (2025)
    c. Establish and Maintain a Standard for Role-Based Access (2025)
    d. Establish and Maintain Data Retention (2025)
    e. Establish and Maintain a Process for Secure Data Disposal (2025)

f. Establish and Maintain a Standard for End-User Device Encryption (2025)
g. Establish and Maintain a Documentation Repository for Data Flows (2026)
h. Establish and Maintain a Standard for Removable Media (2026)
i. Establish and Maintain a Standard for Sensitive Data in Transit (2026)
j. Establish and Maintain a Standard for Sensitive Data at Rest (2026)
k. Establish and Maintain a Process for Data Segmentation (2026)
l. Establish and Maintain a Process for Data Loss Prevention (2027)
m. Establish and Maintain a Standard for the Logging of Sensitive Data Access (2027)

C. Data Backups
    1. Data for servers and information systems must exist, be encrypted, and tested regularly.
        a. Backups strategy should follow a defense-in-depth model by utilizing a combination of:
            i. Storage Snapshots
            ii. Traditional Backups
            iii. Database Backups
            iv. Off-site Retention
            v. Immutable copies
        b. Backups & Recovery are managed under the Disaster Recovery & Incident Response Policy, Plans, Procedures, & Standards.

D. **Permanent KPI**
    1. Percentage of end user devices encrypted at rest.
    2. Percentage of servers and VMs encrypted at rest.
    3. Percentage of SVH hosted web servers with encryption forced.
    4. Percentage of systems with current (within 3 years) data flow documentation.
    5. Percentage of systems with completed data inventory records.
        a. These KPI are to be reported to the cybersecurity governance council and administration as required under the cybersecurity governance policy quarterly. Performance metrics from this policy should be considered in annual improvement planning, resourcing, and strategic direction to drive continual improvement Findings are used to adjust asset management scope as necessary.
        b. Other KPI may be assigned under the Cybersecurity KPI Procedure.

E. Documentation
    1. This policy is intended to define, establish, or support the following HIPAA & NIST CSF, and CIS controls:

2.

Description	Control ID (NIST CSF / HIPAA / CIS)	How Implemented
Data management process	NIST CSF ID.GV-03, ID.RA-01 / HIPAA §164.308(a)(1)(ii)(A) / CIS 3.1	Required under Section V.B.1.a: Establish and Maintain a Data Management Process (2025).
Data inventory	NIST CSF ID.AM-01, ID.AM-05 / HIPAA §164.308(a)(1)(ii)(A) / CIS 3.2	Required under Section V.B.1.b: Establish and Maintain a Data Inventory (2025).
Role-based access (RBAC/ ACLs)	NIST CSF PR.AA-03 / HIPAA §164.312(a)(1) / CIS 3.3	Required under Section V.B.1.c: Establish and Maintain a Standard for Role-Based Access (2025).
Data retention	NIST CSF PR.DS-05 / HIPAA §164.310(d)(2)(i) / CIS 3.4	Required under Section V.B.1.d: Establish and Maintain Data Retention (2025).
Secure data disposal	NIST CSF PR.DS-03 / HIPAA §164.310(d)(2)(ii) / CIS 3.5	Required under Section V.B.1.e: Establish and Maintain a Process for Secure Data Disposal (2025).
End-user device encryption	NIST CSF PR.DS-01 / HIPAA §164.312(a)(2)(iv) / CIS 3.6	Required under Section V.B.1.f: Establish and Maintain a Standard for End-User Device Encryption (2025).
Sensitive data in transit	NIST CSF PR.DS-02 / HIPAA §164.312(e)(1) / CIS 3.7	Required under Section V.B.1.i: Establish and Maintain a Standard for Sensitive Data in Transit (2026).
Sensitive data at rest	NIST CSF PR.DS-01 / HIPAA §164.312(a)(2)(iv) / CIS 3.8	Required under Section V.B.1.j: Establish and Maintain a Standard for Sensitive Data at Rest (2026).
Data Loss Prevention (DLP)	NIST CSF PR.DS-06 / HIPAA §164.312(e)(1) / CIS 3.10	Required under Section V.B.1.l: Establish and Maintain a Process for Data Loss Prevention (2027).
Logging of sensitive data access	NIST CSF DE.CM-07 / HIPAA §164.312(b) / CIS 3.11	Required under Section V.B.1.m: Establish and Maintain a Standard for Logging of Sensitive Data Access (2027).

Description	Control ID (NIST CSF / HIPAA / CIS)	How Implemented
Data backups	NIST CSF PR.IP-04 / HIPAA §164.308(a)(7)(ii)(B) / CIS 11.3 (cross-control)	Section V.C: Data must exist, be encrypted, tested regularly; layered backup model defined.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. HIPAA Security Rule, 45 CFR §164.308(a)(6) (Security Incident Procedures)

B. HIPAA Security Rule, 45 CFR §164.308(a)(7) (Contingency Planning)

C. NIST Cybersecurity Framework (CSF) v2.0 – Recover (RC), Respond (RS), and Govern (GV) Functions

D. Center for Internet Security Controls V.8

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	10/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	10/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18635488**

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Denied Claims Processing - TFFH

I. POLICY STATEMENT

A. Tracking, monitoring and reporting denials enables Taylor Farms Family Health & Wellness Center (TFFHWC) management to identify patterns and potential challenges.

II. PURPOSE

A. To establish guidelines for identifying, tracking, and reporting denial of claims and to ensure appropriate resolution of operational issues and reimbursement of services rendered to patients.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. This procedure shall include all contracted and non-contracted payors, in addition to Federal (Medicare) and State (Medi-Cal) sponsored programs.

B. **Receipt of Denials (Patient Financial Services & Case Management)**

1. Denials will be received in Patient Billing and Collections Department through Remittance Advices, Explanation of Benefits (EOB) or correspondence from the individual payors. If any denials are detected the Billing and Collections staff will work diligently to address the denial through appeals, disputes and corrected billing.
2. The Billing Staff will review the denial and determine reason for denial. They will

process the denials by entering a zero pay line and the denial reason into e-MDs. Any appeals, disputes or corrected billing should be done and noted in the invoice notes section. Invoice note should include reference numbers, phone and fax info with brief description of what was done. Charges will remain out to the insurance until we have a response to the appeal. We will appeal more than one time if needed. If it is determined services will not be covered by the insurance and we have exhausted the appeals process, the balance due will be transferred to the patient's responsibility. If the denial was the clinic's responsibility, the balance due will be written off and not transferred to the patient.

C. Documentation: N/A

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief Financial Officer	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18635484

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Departmental Charge Reversal Request Adjustments - TFFHWC

I. POLICY STATEMENT

A. It is the policy of Taylor Farms Family Health & Wellness Center (TFFHWC) that all departmental requests for charge reversal will be posted in accordance with regulatory requirements and will be documented within the e-MDs System. In accordance with clinic policy and State and Federal regulations, departmental requests for charge reversals may not be appropriate. No clinic employee or practice manager will offer charge reversals without providing appropriate documentation.

II. PURPOSE

A. The purpose of this policy is to provide guidelines for the management of departmental requests for charge reversals.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Billing Staff receives Request for Charge Reversals from the clinic for the following general reasons:

1. A duplicate service or procedure was inadvertently charged for, but not performed.
2. The procedure or service required repeating due to professional, technical or other

reasons.

3. The results of the service or procedure were not determinable due to equipment malfunction.

B. It will be the Billing Staff's responsibility to prepare the necessary documentation and forward it to the Practice Manager for approval. The documentation will include, but not be limited to, Patient Name, Patient Account Number, Date of Service and Reason for Reversal. After all paperwork is complete and approved, the paperwork should be forwarded to Cypress for processing.

C. The Billing Staff will document these actions in the e-MDs System and perform the appropriate charge reversal.

D. Documentation: N/A

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief Financial Officer	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18609605

Origination	07/2015	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Internal Defibrillation (Assist)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the ICU/CCU or surgical RN in assisting the cardiac surgeon with internal defibrillation.

III. DEFINITIONS

A. Internal defibrillation is achieved by delivering an electric current directly to the myocardial surface via special paddles through an open sternotomy or a thoracotomy. The goal for defibrillation is to restore coordinated electrical and mechanical pumping action of the heart, resulting in restored cardiac output, tissue perfusion, and oxygenation.

B. Energy requirements for internal defibrillation usually range from 5 to 20 joules for biphasic defibrillator and 10-20 joules for monophasic defibrillator.

IV. GENERAL INFORMATION

A. This procedure is performed by the Cardiac Surgeon and/or Physician Assistant.

B. ICU/CCU RN who has successfully completed the "Care of Post-Operative Cardiac Surgery Patient", will assist with this procedure.

C. Surgical Open-Heart nurses may be available for support.

V. PROCEDURE

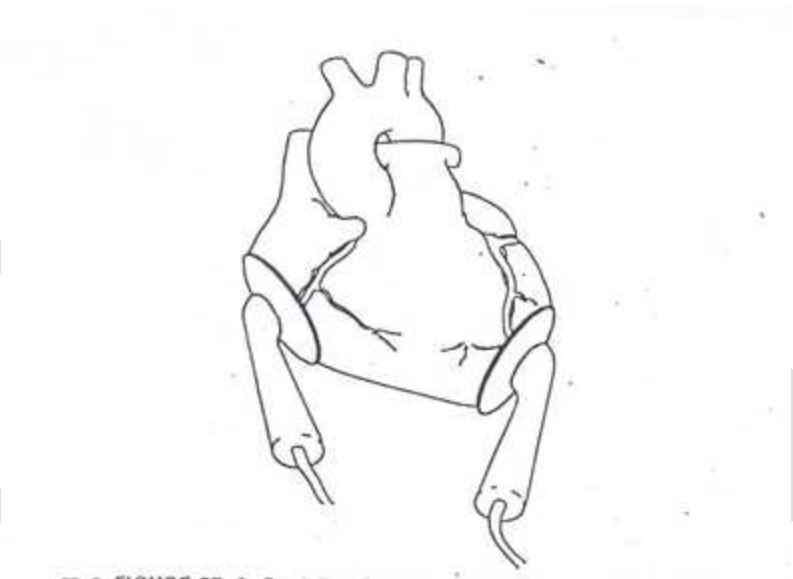
A. Equipment

1. Open thoracotomy or sternotomy tray (open chest cart)

2. Defibrillator
3. Crash cart

B. Operation

1. Initiate BLS. Whenever possible, external defibrillation should be attempted first.
2. Open chest cart at the bedside.
3. Assist surgeon with emergent open sternotomy – see EMERGENT OPEN STERNOTOMY (ASSIST), Policy.
4. Connect the internal paddles to the defibrillator. Once the physician has positioned the internal paddles on the heart, charge as prescribed (usually 5-20 joules, defaults at 10 joules).



■ ● FIGURE 37–1. Paddle placement for internal defibrillation. (From Kinkade S, Lohrman JE. *Critical Care Nursing Procedures: A Team Approach*. Philadelphia, Pa: B.C. Decker; 1990.)

5. State "all clear" and visually verify that all personnel are clear of contact with the patient, bed, and equipment.
6. Physician presses button on paddle to fire defibrillator.
7. Assess for the presence of pulse and observe for conversion of dysrhythmia.
8. If first attempt is unsuccessful, immediately recharge paddles and deliver the next shock.
9. If unsuccessful, continue algorhythm for V-fib, or pulseless V-tach or as directed by the cardiac surgeon.

C. Maintenance/Care

1. When stable, prepare for transport to surgery as directed by cardiac surgeon.

D. Documentation:

1. Nursing measures implemented to prepare patient for defibrillation, including joules used and the number of attempts made in nursing notes
2. Print out ECG tracings depicting defibrillations and cardiac events before, during and after defibrillation.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Schakenbach, L.: Defibrillation (Internal), (2017), *AACN Procedure Manual for Critical Care*, 7th ed., (pp. 337 – 342), In Weigand, D. (ed.) , St Louis, Missouri, Elsevier Saunders.

B. Brand J, McDonald A, Dunning J. Management of cardiac arrest following cardiac surgery. BJA Educ. 2018 Jan;18(1):16-22. doi: 10.1016/j.bjae.2017.11.002. Epub 2017 Nov 21. PMID: 33456790; PMCID: PMC7807979.

C. Magid DJ, Aziz K, Cheng A, Hazinski MF, Hoover AV, Mahgoub M, Panchal AR, Sasson C, Topjian AA, Rodriguez AJ, Donoghue A, Berg KM, Lee HC, Raymond TT, Lavonas EJ. Part 2: Evidence Evaluation and Guidelines Development: 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation. 2020 Oct 20;142(16_suppl_2):S358-S365. doi: 10.1161/CIR.0000000000000898. Epub 2020 Oct 21. PMID: 33081525.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cardiology Medical Director	Megan Giovanetti: Director Cardiovascular Services and Sleep	10/2025
CNO	Carla Spencer: Chief Nursing Officer	09/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2025
Policy Owner	Carla Spencer: Chief Nursing Officer	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **16948840**

Origination	01/2022	Owner	Christa Mc Dowell: Director Environmental Services
Last Approved	N/A	Area	Plans and Program
Next Review	1 year after approval		

Medical Waste Management Plan

I. SCOPE

A. Salinas Valley Health Medical Center (SVHMC) Medical Waste Management Plan follows the State of California Medical Waste Management Act. This document provides the guidance for SVHMC to meet the intent of the act by establishing procedures for the proper handling, storage, transportation and treatment of medical waste.

B. SVHMC does generate radioactive waste. See Environmental Services/Biohazardous, Chemotherapeutic and Radioactive Waste Handling for further information.

C. SVHMC does not:

1. Treat medical waste on site nor does it receive from off-site
2. Is not a certified medical waste hauler; therefore, waste will only be hauled to a treatment facility that is used by our certified waste hauler
3. Does not operate a common storage facility
4. Does not have a Limited Quality Hauling Exemption

II. OBJECTIVES/GOALS

A. To develop a system that addresses the definitions and identification of medical waste from the point of generation to the point of proper disposal and removal from the facility.

B. To establish procedures for proper handling, and storage of medical waste.

C. To maintain contracts for transportation and off-site treatment medical waste.

D. To insure the policies and procedures related to medical waste management are reviewed, revised and approved at least annually by the appropriate committees.

E. To provide education and supervision of hospital personnel to eliminate or minimize the risk of personnel exposure to or contamination by untreated medical waste.

F. To meet the guidelines of the State of California Medical Waste Management Act.

III. DEFINITIONS

A. Biomedical waste / Regulated Medical Waste- (As defined by Section 117635 of the California Medical Waste Management Act)

1. Laboratory waste, including, but not limited to all of the following:

   a. Human or animal specimen cultures from medical and pathology laboratories.

   b. Cultures and stocks of infectious agents from research and industrial laboratories.

   c. Wastes from the production of bacteria, viruses, spores, discarded live and attenuated vaccines used in human health care or research, discarded animal vaccines, and culture dishes and devices used to transfer, inoculate, and mix cultures.

   d. Human surgery specimens or tissues removed at surgery or autopsy, which are suspected by the attending physician and surgeon or dentist of being contaminated with infectious agents known to be contagious to humans

   e. Animal parts, tissues, fluids or carcasses suspected by the attending veterinarian of being contaminated with infectious agents known to be contagious to humans

   f. Waste, which at the point of transport from the generator's site, at the point of disposal, or thereafter, contains recognizable fluid blood, fluid blood products, containers or equipment containing blood that is fluid, or blood from animals known to be infected with diseases which are highly communicable to humans.

   g. Waste containing discarded materials contaminated with excretion, exudates, or secretions from humans or animals that are required to be isolated by the infection control staff, the attending physician and surgeon, the attending veterinarian, or the local health officer, to protect others from highly communicable diseases or diseases of animals that are highly communicable to humans.

   h. Waste which is hazardous only because it is comprised of human surgery specimens or tissues which have been fixed in formaldehyde or other fixatives, or only because the waste is contaminated through contact with, or having previously contained, chemotherapeutic agents, including, but not limited to, gloves, disposable gowns, towels, and intravenous solution bags and attached tubing which are empty.

2. Biohazardous bags: A disposable red bag that is impervious to moisture and has strength sufficient to preclude ripping, tearing or bursting under normal conditions of usage and handling of the waste-filled bag. A Biohazardous bag shall be constructed of material of sufficient single thickness strength to pass the 165-gram dropped dart

impact resistance test as prescribed by Standard D 1709-85 of the American Society for Testing and Materials and certified by the bag manufacturer.

3. Biologicals: Medicinal preparations made from living organisms and their products, including but not limited to, serums, vaccines, antigens, and antitoxins.
4. Biological Waste: Animal or human specimens/tissues and/or cell cultures that are not defined as "Medical Waste".
5. Hazardous Waste: Any material (other than Medical or Radioactive waste) that is considered hazardous by appropriate regulations, by reason of being explosive, flammable, toxic, corrosive, oxidizing, irritant, carcinogenic, or otherwise harmful, and is likely to cause injury.
6. Biomedical Waste: Waste that includes fluid blood or material of a biological origin with known or suspected infectious components and meets both of the following requirements:
    a. Waste that is generated or produced as a result of any of the following requirements:
        i. Diagnosis, treatment, or immunization of human beings or animals.
        ii. Research pertaining to the diagnosis, treatment, or immunization of human beings, or animals.
        iii. The production or testing of biologicals.
    b. The waste is either of the following:
        i. Biomedical waste
        ii. Sharps waste
    c. Biomedical Waste:
        i. Waste containing microbiological specimens sent to a laboratory for analysis
        ii. Human surgery specimens or tissues removed at surgery or autopsy, which are suspected by the attending physician or surgeon or dentist of being contaminated with infectious agents known to be contagious to humans.
        iii. Waste, which at the point of transport from the site of origin contains recognizable fluid blood (e.g. blood saturated drapes, sponges, any item so saturated with blood that upon compacting would exude blood in any form, any container or equipment for disposal that contains liquid blood).
        iv. In addition to the above, waste soiled with body fluids from isolation precautions deemed highly communicable by the Infection Control Committee.
        v. Laboratory wastes, including cultures of infectious agents, which pose a substantial threat to health due to their volume

and virulence.

vi. Equipment, instruments, utensils, and other disposable materials that are likely to transmit infectious agents from the rooms of humans, or procedures suspected or diagnosed being highly communicable by the Infection Control Committee.

vii. Any other material which in the determination of the Infection Control Committee/designee presents a significant danger of infection because it is contaminated or suspect of being contaminated with infectious material.

d. Medical Waste does not include any of the following:

i. Waste generated in food processing or biotechnology that does not contain an infectious agent.

ii. Urine, feces, saliva, sputum, nasal secretions, sweat, tears, and vomitus unless they contain fluid blood, or are from humans who are required to be isolated by Infection Control due to highly communicable diseases.

iii. Waste which is not biohazardous, such as paper towels, paper products, articles containing non-fluid blood, and other medical solid waste products commonly found in the facilities of medical waste generators.

iv. Hazardous waste, radioactive waste, pharmaceutical, or household waste.

7. Pathology Waste: Human surgery specimens or tissues, which have been fixed in formaldehyde or other fixatives: recognizable human anatomical parts with the exception of teeth not deemed infectious by the attending physician and surgeon or dentist.
8. Radioactive Waste: Waste that emits ionizing radiation spontaneously.
9. Sharps Waste: Any device having acute rigid corners, edges, or protuberances capable of cutting or piercing, including, but not limited to all of the following:
    a. Hypodermic needles, hypodermic needles with syringes, safety enhanced needles, needles with attached tubing, syringes, syringes contaminated with biohazardous waste, acupuncture needles, epidural needles, introducers, catheterization wires
    b. Blades, broken glass items, such as Pasteur pipettes, and blood vials contaminated with biohazardous waste.
10. Treated Medical Waste: Medical waste that has been treated in accordance with Chapter * (commencing with Section 118215, and that is not otherwise hazardous shall thereafter be considered solid waste as defined in Section 40191 of the Medical Waste Management Act and not medical waste.

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. SVHMC Medical Waste Management Plan has been developed to ensure the health and safety of all employees by establishing policies and procedures that minimize waste as well as potential exposure from untreated medical waste.

B. **Plan Management**

1. Administrative Requirements
    a. This facility is considered a large quantity generator.
        i. Generates 2000 pounds or more of medical waste per month.
    b. SVHMC is an acute care facility annually registered with Monterey County Environmental Health Agency.
    c. The registration /Medical Waste Management Plan includes:
        i. Generator:
        SVHMC
        450 East Romie Lane
        Salinas, CA 93901
        Attention: Senior Administrative Director, Nutrition & Environmental Services: Ken Goebel
        ii. Medical Waste Generated
        12 -180 barrels (Tissue/chemo -Stericycle)
        24,000 – 150,000 pounds annually (Stericycle)
        iii. Type Of Treatment Used On Site;None
        iv. Medical Waste Management Services:
        Stericycle, Inc.
        1345 Doolittle Dr. Ste C
        San Leandro, CA 94577
        v. Certification that the information is complete and accurate.
        vi. Updated registration application is required within 30 days of changes to any information of the registration form.
        vii. Application for renewal of the registration shall be filed with the enforcement agency not less than 90 days prior to the expiration date.
        viii. Renewal or registration is required on an annual basis and is the responsibility of the Nutritional/Environmental Services Senior Administrative Director to coordinate.
        ix. As a large quantity generator, this facility shall be subject to at least annual inspection by the enforcement agency.
2. Certification Statement: Approval of this policy certifies the information in the SVHMC to be accurate and complete.

3. Containment, Labeling and Storage Requirements for Medical Waste
    a. Medical Waste
        i. All medical waste is contained separately from other types of waste at the point of generation by the use of red biohazardous bags
        ii. Medical waste shall be contained in RED biohazard bags or rigid puncture resistant red containers.
        iii. All containers shall be labeled with Biohazardous Waste, on all visible sides, and/or the international biohazard symbol.
        iv. All containers must be covered by a tight-fitting lid, which is removed only while the container is being filled or emptied.
        v. The waste container should not exceed being ¾ full. Lids must fit tightly at all times.
        RED biohazard bags, hereafter referred to as RED bags, are disposable plastic bags impervious to moisture and meet the 165 gram dropped dart impact resistance test. The bags are labeled with "Biohazardous Waste" and the international biohazard symbol.
        vi. Double bagging with RED bags will be utilized only when visible soiling has contaminated the exterior of the bag.
        vii. All RED bags should be tied securely using ties or a goose neck knot to prevent spilling or leaking of contents during storage, handling or transport.

    b. Sharps Waste
        i. Sharp shall be disposed of in "Sharps Containers" which are rigid, puncture resistant when sealed, labeled with the international biohazard symbol, maintained in an upright position
        ii. Only sharp waste may be disposed of sharps containers
        iii. ¾ full sharp containers shall have a secure locking closure device.
        iv. Sharps containers are placed in red rigid transport containers and picked up by Environmental Services personnel for processing.
        v. Sharps waste is disposed of in sharps containers as close to site of use as possible.
        vi. Inpatient rooms have wall-mounted sharps container" system where appropriate.
        vii. Other direct patient care areas: wall-mounted red, rigid puncture resistant sharps container.
        viii. Sharps containers ready for disposal may not be stored by EVS

for more than 30 days without written approval of the enforcement agency (Monterey Public Health)

c. Pathological Waste
    i. Pathology waste is placed in red biohazard bags and deposited into a secondary container with the words pathology waste visible on the exterior.
    ii. Placentas are maintained per policy in the SRMC soiled utility room freezer, red bagged then placed in a secondary rigid container per the contracted waste hauler.
    iii. Once the specimens are deemed waste, they shall not be stored for more than ninety days at temperatures below 0 degrees C.
    iv. Pathology waste must be disposed of by internment or incineration:

d. Environmental Control
    i. Biomedical waste is transported via closed cart/container to the storage area.
    ii. Biomedical was waste shall not be contained or stored at any onsite location, for more than seven (7) days at > 32 Fahrenheit.
    iii. Environmental Services personnel obtain biomedical waste from in-house area, twice during the day and once on the evening and night shift.
    iv. Environmental Services personnel transport all waste to the designated storage areas in a closed cart via the shortest route through the hospital.
    v. Environmental Services personnel are responsible to know and are trained at hire and receive annual refresher education:
        a. Where disposal supplies are located
        b. Purpose, use, location and limitations of personnel protective clothing and equipment;
        c. Emergency procedures in the event of a spill, accident or emergency occurrence.
    vi. Environmental Services personnel, under the direction and supervision of the Department Manager, are responsible for cleaning and maintenance of equipment utilized.
    vii. Carts are washed, decontaminated when visibly soiled, utilizing approved disinfectants and per departmental procedure using hot water for a minimum of fifteen seconds.
    viii. Exposure to chemical sanitizer by rinsing with or immersion in, one of the following for a minimum of three minutes, hypochlorite solution (500 ppm available chlorine) or Quaternary

ammonium solution (400 ppm active agent).

ix. All red containers are exchanged with the contractor and are clean upon arrival.

x. Decontamination methods for leaks or spills include

xi. Environmental Services personnel utilizing the appropriate disinfectant for the area immediately clean any leak or spill of a medical waste.

xii. Prior to decontamination, don personal protective equipment

xiii. For assistance: call the Environmental Services Supervisor on duty

e. Storage Areas

i. Closed locking doors secure the in house-holding/storage areas. Signage on the doors has the universal biohazardous warning signs.

ii. The external locked storage area is marked with warning signs on the doors.

iii. The posted warning signs are in English will read, "CAUTION - BIOHAZARDOUS WASTE STORAGE AREA - UNAUTHORIZED PERSONS KEEP OUT," and in Spanish, "CUIDADO - ZONA DE RESIDUOS – BIOLOGICOS PELIGROSOS – PROHIBIDA LA ENTRADA A PERSONAS NO AUTHORIZADAS."

iv. The warning signs are legible from a distance of at least 25 feet.

v. Biohazardous waste is placed directly into a tightly lidded container at site of collection /disposal

vi. Tissue and specimens are sent to a reference laboratory that is responsible for processing and disposal.

vii. Body parts/limbs are stored in the morgue, until decision has been made regarding disposition.

f. Transportation Requirements

i. Medical waste haulers must be registered hazardous waste haulers. SVHMC does not haul waste. Waste is removed / transported by contract service.

ii. Copies of registrations are obtained by Nutritional/ Environmental Services on an annual basis.

iii. SVHMC contract service for medical waste:
Stericycle, Inc.
1345 Doolittle Dr. Ste C
San Leandro, CA 94577

iv. Medical waste shall be separated from other waste in the same vehicle by use of containers or barriers. Hazardous waste

haulers shall use leak-resistant, fully enclosed, rigid containers in vehicle compartments.

v. Medical waste may only be transported to:

a. A permitted medical waste treatment;
A transfer station;

vi. Individual's manually loading or unloading medical waste shall wear protective clothing: gloves and coveralls or lab coats, provided by the employer.

vii. The registered hazardous waste hauler shall complete a tracking document for all medical waste hauled off site for treatment.

viii. SVHMC maintains tracking documents and treatment records for 3 years.

ix. The tracking document shall include:

a. The name, address and telephone number of the contracted medical waste hauler;

b. Type and quantity of medical waste transported;

c. Generators name;

d. Name, address, telephone number and signature of authorized representative of permitted facility receiving the waste.

e. All manifests (recites) from the registered haulers are maintained in a logbook in Plant Operations.

f. All original documents are returned signed by the medial waste treatment facility when the waste has been rendered noninfectious and land filled and placed with the recite (pink copy) in the logbook.

g. Treatment

i. Liquid or semi-liquid medical waste, that is not a biohazard waste, should be disposed of via discharge to public sewer system.

ii. Identified medical waste is transported off site for appropriate treatment.

iii. RED bagged medical waste Sharps container

iv. Tissue and specimens are sent to a reference laboratory for examination and disposed of by that facility

v. The hazardous waste hauler shall maintain a copy of the tracking documents for three (3) years.

C. **Plan Responsibility**

1. SVHMC President and CEO delegates' specific responsibility to the Safety Officer,

Hazardous Materials Committee Chairperson, Director of Environmental Services and the Director of Infection Prevention & Control are responsible for the assurance of a comprehensive, flexible, integrated Medical Waste Management Program. Including but not limited to assuring that the Medical Waste Management Plan is compatible with federal, state and local requirements.

2. The Infection Prevention Manager is responsible for establishing priorities for the investigation or resolution of identified issues with medical waste and shall refer these priority settings to the appropriate department, committee(s) or individuals as needed.
3. The Pharmacy and Therapeutics/Infection Control Committee/ Manager of Infection Prevention is responsible for the reviewing/consulting of all policies and procedures relating to the operation of the Medical Waste Management Program. The Senior Administrative Director of Environmental Services is responsible for evaluating the effectiveness of the program. The Senior Administrative Director of Nutrition/ Environmental Services in conjunction with the Infection Prevention Department is responsible for reporting its findings and recommendations to the Safety Committee and to the Governing Board.
4. The Senior Administrative Director of Nutrition/Environment Services / and Manager of Infection Prevention are responsible for assuring the annual review of all policies and procedures related to the management of medical waste. The Senior Administrative Director of Nutritional/Environmental Services is also the contact person and responsible for maintaining a file of all reports submitted, and for preparing an annual summary for the Chief Executive Officer, Environment of Care Committee, Quality and Safety Committee and the Governing Board.
5. All personnel where medical waste is generated and/or handled are responsible for observing ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS and using personal protective equipment to minimize risk of exposure to untreated medical waste.
6. Environmental Services personnel, under the supervision and direction of the Department Supervisors are responsible for transporting, storage, and proper disposal of all medical waste.
7. Transportation and off- site treatment of medical waste will be contracted to a regional service for total medical waste management and treatment disposal services.
8. Enforcement is necessary for the safe day-to-day operation, management and coordination of a Medical Waste Management Plan, the principal ingredients for enforcement of this plan will be:
    a. Education of staff on policies and procedures.
    b. Coordinated enforcement with outside agencies;
    c. Review and evaluation of individual case reports of incidents and/or accidents;
        i. Establishment and maintenance of a record keeping system;
        ii. Implementation of all measures outlined in this plan including an

emergency action plan in the event of disruption of service as the result of a natural disaster or an equipment failure.

iii. Systematic follow-up to assure compliance with the different segments of the plan;

iv. Evaluation and revision of the plan as deemed necessary.

D. **Performance Measurements**

1. The organization establishes annual Medical Waste Management performance improvement goals which are reported quarterly to the appropriate committees and evaluated for effectiveness at least annually. The goals are revised as necessary to assure that we are achieving and maintaining desired improvements.
2. All hospital personnel receive information on the Medical Waste Management Plan at new employee orientation then annually thereafter. EVS and Engineering staff may receive additional training per department protocol. Information will include differentiation of medical and solid waste, safe handling of waste, spill and exposure procedures, storage, transport, and off-site treatment information that meets with the hospital's goal to be ecologically minded. This will be accomplished through the hospital and departmental orientation program.
3. Personnel working directly with medical waste will be trained in the handling and disposing of these wastes.
4. Specific training to the employee's own departmental hazards will be conducted at the time of their initial unit orientation, and annually thereafter. This will be the responsibility of the department manager.
5. Training and education will include:
    a. Medical Waste Management Plan;
    b. Identification of medical waste in their respective departments and/or associated procedures performed;
    c. Definition of medical waste;
    d. Explanation of labeling system, medical waste containment and disposal.
6. Emergency Plan
    a. Personnel Exposures or Contamination
        i. Remove the exposed or contaminated personnel from the contaminated area, unless it is unsafe to do so due to the medical condition of the victim or potential hazard to the rescuer.
        ii. If the incident occurs during normal working hours, notify supervisor who will notify Employee Health Services and/or Infection Control. Off shifts and weekends call the Administrative Supervisor.
        iii. Proceed to the nearest emergency eyewash/shower to flush contamination from the eyes and skin.

iv. If medical assistance is needed:

a. Dial 2-2-2-2 and administer first aid as appropriate.

b. Remove any contaminated clothing

c. Stand by to provide information and assistance to emergency response personnel.

7. Contamination of Equipment and Facilities

a. DO NOT attempt any cleanup or decontamination procedures alone or without wearing Personal Protective Equipment (PPE), including respiratory protection. Unless the spill is minor and well defined do not clean up the material without Environmental Services Supervisor and Employee Health Services and /or Infection Prevention approval.

b. Avoid spreading contamination by limiting access to the contaminated equipment or area only to individuals who are properly protected and trained to respond to all types of hazards that exist (e.g., biological, radioactive and chemical).

c. Report details and request assistance by contacting Employee Health Services if the incident is during normal working hours. If the incident occurs after hours contact the Administrative Supervisor.

d. If the spill involves a liquid, place absorbent material on the spill and decontaminate with an approved disinfectant for a minimum or a 30-minute contact time.

e. If sharps are involved, pickup using a mechanical means, such as tongs, forceps, or dustpan and broom. Do not use your hands to pick up any sharp items, even if gloves are worn.

f. Decontaminate the equipment and area under Employee Health Services or Infection Prevention direction using appropriate methods.

g. Stand by to provide emergency information and assistance to emergency response personnel.

8. Release to the Environment (air, water, soil)

a. Stop the release, if safe to do so and you are trained to do so

b. Follow procedures described above for contamination of equipment and facility. Procurement of Equipment/Supplies

c. When availability of equipment fails to meet the needs for safe storage of medical waste alternative methods of storage will be implemented. These methods will be determined in conjunctions with the haulers and will be based on the need. Such methods will be approved by the Directors of Engineering, Infection Control and Environmental Services.

d. Medical waste can be stored at temperatures greater than 32°F (0°C) for up to seven days prior to treatment.

9. Natural Disasters

a. In the event of a natural disaster efforts/equipment failures previously defined by MOUs with the contracted medical waste service provider will generate additional equipment and services to meet the needs of the institution. Efforts to minimize medical waste will be made by personnel until procurement.

b. Additional contingency for emergency situations (natural disasters, etc.) would be to contact the Monterey County Department of Emergency Services, Environmental Health division and Local Solid Waste Management Services for guidance and

10. Segregation Incident

    a. In the event that regulated medical waste is mixed into the regular waste stream the following steps will be taken to minimize the effect and educate staff to prevent future occurrences:

    b. Initial Response: On site leadership responds immediately to minimize environmental risk, quarantine contamination and gather initial details.

    c. The Root Cause Analysis: Safety Officer, EVS Director, Risk Management, and Infection Prevention Manager, Regulatory Director and HazMat Chair Person may form a Root Cause Analysis Team:

        i. Investigate the incident to include but not be limited to:

            a. The review and revision of policies and procedures as appropriate to identify areas of opportunity.

            b. Opportunities in the area of staffing and training

        ii. Develop action steps to include but not be limited to education, facility upgrades and equipment repairs to prevent reoccurrence.

        iii. Plan to monitor action steps to completion including auditing program.

        iv. Notification of appropriate regulatory entities if necessary (i.e. Department of Health/Environmental Health Division, CDPH, etc.)

11. Reference SVHMC Policies

    a. ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS

    b. HAZARDOUS MATERIALS COMMUNICATION

    c. BIOMEDICAL WASTE FROM THE PATIENT ENVIRONMENT

    d. Disposal of Bio Hazardous Waste Emergency Department / ER

    e. Environmental Services/Biohazardous, Chemotherapeutic and Radioactive Waste Handling

    f. Environmental Services/ Advanced Waste Totes Disposal / ES

    g. Lab Safety Manual, Infection Control

    h. BLOODBORNE PATHOGEN EXPOSURE CONTROL PLAN

i. BLOOD BORNE PATHOGEN EXPOSURE GUIDELINES: EMPLOYEES, FIRST RESPONDERS, PATIENTS & VISITORS

E. **Orientation and Education**

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

V. REFERENCES

A. California Medical Waste Management Act. January 2012

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2025
QSC	Aniko Kukla: Director Quality & Patient Safety	10/2025
Infection Prevention/P&T	Genevieve delos Santos: Director Pharmacy	09/2025
Infection Prevention/P&T	Kiri Golleher: Pharmacy Clinical Coordinator	09/2025
Environment of Care Committee	James Hively: Manager Environmental Health & Safety	12/2024
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2024
Policy Owner	Christa Mc Dowell: Director Environmental Services	11/2024

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19123871**

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

Mobile Device Management for Workday Mobile App

I. POLICY STATEMENT

A. This policy provides guidelines on how the Salinas Valley Health issued mobile devices using the Workday Mobile application are managed. These mobile devices use the Android operating system.

II. PURPOSE

A. This policy outlines the governance framework for the management, use, and security of the organization's Salinas Valley Health issued mobile devices which are used to access Workday Mobile application for inventory management. The mobile devices that are issued by Salinas Valley Health with the Workday Mobile application are Android-based mobile devices and cannot be managed to a degree that fully meets our systems security requirements. This policy and procedure provide an outline of how the devices will be managed in alignment with organizational privacy, security and staff management requirements.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Scope

1. This policy applies to all users accessing Workday via the Workday Mobile Application for functions related to Workday Supply Chain functions.

B. Eligibility and Device Requirements

1. Requirement Details
2. Eligibility: Users must be active employees or approved by Supply Chain leadership

to use the Workday Mobile application (app).

3. Device type: Android operating system is the standard for use with the Workday Mobile app for supply chain management.
4. Security controls – policy and procedure:
    a. Each device is intended to be issued to and used by a single individual. These mobile devices are not intended to be in kiosk mode or shared.
    b. No unapproved applications are permitted for installation on the Salinas Valley Health issued devices for use with Workday Mobile app.
    c. No other wifi network should be used by the Salinas Valley Health issued device other than the Salinas Valley Health wifi networks. The “svmh-xlate” wifi network is approved for use with the Workday Mobile app for inventory management purposes.
    d. Periodic review of the device configuration will be conducted by Supply Chain Management leadership and documented for record keeping and compliance tracking with this policy and procedure. The records should contain the device ID, to whom the device is issued, the date the audit was performed and by whom the audit was performed.
    e. The person to whom the device is issued should immediately report any defects, damage or performance issues with the device to their manager or Information Technology’s Help Desk, HelpDesk@salinasvalleyhealth.com.

C. Staff Education
    1. Supply Chain Management will provide training to staff related to use of the Salinas Valley Health issued device and the Workday Mobile application.

D. Related policies
    1. Acceptable Use of Information Systems

V. PROCEDURE

A. **Onboarding and Offboarding**
    1. **Onboarding**
        a. Eligible staff will receive a Salinas Valley Health issued mobile device approved for use for the Workday Mobile app. This device has an Android operating system.
        b. Acceptable Use policy applies.
        c. No unauthorized installation or removal of software is allowed by staff outside of Information Technology.
        d. Use of the device is for the strict purposes stated in this policy and procedure.
        e. Each device is issued to one individual at a time. These are not intended to be used as shared devices.

2. **Offboarding**
    a. In the event of separation, the device will be returned to the Supply Chain Management team member.
    b. Access to and use of the mobile device may change as a result of transfer of roles.

B. **Auditing and Monitoring**

1. Supply Chain Management will periodically review use of the device for compliance with this policy's stated purpose.
2. Review for unauthorized installation or alteration of the device and its installed software.
3. Periodic software updates and patches to the operating system. Information Technology recommends once every two weeks. Supply Chain may find a rotating schedule to review with the more than fifteen (15) hand held devices to be more manageable.
4. Enforcement: Failure to comply with this policy may result in disciplinary action, up to and including termination of employment or contract.

C. **Review**

1. This policy will be reviewed and updated at least annually, or as needed, to reflect changes in technology, regulations, or organizational needs.
2. Exceptions: Any exceptions to this policy must be formally requested in writing to the Communications Engineering Manager and approved by the VP of Information Technology (IT) or the Director of IT.

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	11/2025

Policy Owner	Audrey Parks: Vice President Information Technology	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18643643**

Origination	07/2022
Last Approved	N/A
Next Review	3 years after approval
Owner	Julie Vasher: Director Women's & Children's Services
Area	Women's and Children's Services

Obstetrical Care Standards: Assessment and Documentation

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the nursing care of the patient on Mother/Baby to include Postpartum, Gynecological and other patients as assigned. These standards will provide a template for assessment, documentation and the development of an individualized nursing plan of care.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. An admission assessment will occur upon patient's arrival to unit. This will include physical and psychosocial assessments. Needs will be identified and a plan of care will be established to meet the patient's preferences and abilities. Anticipated discharge needs will be continually assessed during patient stay. The admission assessment will be completed by the Registered Nurse.

V. PROCEDURE

A. Patients will have a visual inspection performed upon transfer from another unit to include vital signs and assessment for any visible signs of distress; if stable, a complete assessment will be completed per ADMISSION ASSESSMENT & RE-ASSESSMENT

B. An admission assessment of the newborn patient's biophysical and psychological status and identification of the needs, will be completed per ADMISSION ASSESSMENT & RE-ASSESSMENT.

C. **Maternal Assessment**

1. Complete total systems review as per ADMISSION ASSESSMENT & RE-ASSESSMENT
2. Assessment and documentation per electronic health record.
3. Assess patient's level of understanding related to admission diagnosis and plan of care. Provide education associated with identified needs.
4. Self Care – assess patient's ability to carry out activities of daily living.
5. Case Management/Need for Continuing Care – RN will collaborate with Case Coordinator as needed based on individual patient assessment, to develop a goal-oriented plan to meet the patient's needs upon discharge.
6. Home health agency referral will be made as appropriate.
7. Age Appropriate (Developmental) – assess placement on the age continuum and apply the concepts of key characteristics when developing the plan of care.
    a. Age groups defined:
        i. Neonate: 1-28 days
        ii. Pediatric: <14 years
        iii. Adolescent: 14-19 years
        iv. Adult: 19-45 years
        v. Senescent: 45-65 years
8. PATIENT IDENTIFICATION POLICY

D. **Newborn Assessment**

An assessment should be completed each shift to include but not limited to the following:

1. Refer to:
    a. HYPERBILIRUBINEMIA-INFANT MANAGEMENT & TREATMENT
2. Nutrition
    a. BREASTFEEDING THE NEWBORN Refer to PERINATAL SERVICE: BLOOD GLUCOSE MANAGEMENT/TREATMENT STANDARDIZED PROCEDURE
3. Weights
    a. Daily weight on 2300-0700 shift. Infants delivering on the 1500-2300 shift after 2000 are not reweighed until the following night.
4. Safety/security
    a. NEONATES - IDENTIFICATION, SECURITY AND PREVENTION OF ABDUCTION

5. Comfort/pain
    a. NEWBORN PAIN, AGITATION, AND SEDATION MANAGEMENT
6. Case Management/Need for Continuing Care – RN will collaborate with Case Coordinator as needed based on individual patient assessment, to develop a goal-oriented plan to meet the patient's needs upon discharge.
7. Home health agency referral will be made as appropriate.
8. Age Appropriate (Developmental) – assess placement on the age continuum and apply the concepts of key characteristics when developing the plan of care.

E. **Documentation:**

1. **MATERNAL/GYN**

Documentation	Frequency
Acuity	Q shift
Maternal assessment	Once a shift; recovery from vaginal delivery assessment included
Admission Assessment	Within 2 hours of arrival
Transfer Assessment (includes post-delivery patients)	Within 4 hours of arrival
Post-surgical patient focused/complete assessment	Upon arrival from PACU Q 30 minutes x 2 Q 1 hour x 2 Q 4 hours x 2
Pain assessment	Once a shift and PRN
IV Site	Twice a shift
Epidural/Spinal Site	Q 4 hours x 24 hours
Education	Q shift and PRN
Patient care	Q shift
Care plans	Review care plans and document to interventions and outcomes Q shift; verify target dates
Recovery vital signs: Vaginal delivery (refer to LABOR AND DELIVERY OBSTETRICAL STANDARDS: ASSESSMENT AND DOCUMENTATION)	Verify point of recovery with L&D RN Q 15 minutes x 8 Q 30 minutes x 2 Q 1 hour x 2 and PRN

Documentation	Frequency
Post surgical	Upon arrival from PACU Q 30 minutes x 2 Q 1 hour x 2 Q 4 hour x 2
Intake & Output	Q shift and per patient condition

2. **NEWBORN**

Documentation	Frequency
Newborn assessment	Q shift
Admission assessment	Within 2 hours of admission
Newborn first bath	At least 8 hours after birth; vital signs stable. Bathe soon after birth for maternal HIV, Hepatitis B, Hepatitis C
Jaundice Levels	6 hours, 12 hours, 18 hours, 24 hours after birth; then Q shift
Education	Q shift and PRN
Intake & Output	At each occurrence
Nutrition	Breastfeeding observation x 1 Q shift; Bottle feeding observation x 1 Q shift and PRN
Care plans	Review care plans and document to interventions and outcomes Q shift; verify target dates

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). AAP/ACOG.

B. Simpson, K., & Creehan, P.(2020) Perinatal Nursing. (5th ed.) Philadelphia: Lippincott Williams & Wilkins.

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Julie Vasher: Director Women's & Children's Services	09/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18635481

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Patient Registration - Patient Identification - TFFH

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To ensure that patients are properly registered with legal name following registration standard of name.

III. DEFINITIONS

A. e-MD -

IV. GENERAL INFORMATION

A. Registration of patients legal name will ensure that patient can be linked in our Master Patient Index (MPI). This link will ensure that patient medical history follows patient for all visits. Documents referred to for identify patient's legal name are Drivers License, Temporary Resident Card, Military ID card, DMV ID or other form of a legal document patient may provide.

V. PROCEDURE

A. Taylor Farms Family Health & Wellness Center (TFFHWC) staff at time of registration will request copy of patients legal ID, as of 10/01 this document will be scanned into patients registration. Patients can be advised that due to issues of identify theft that having their ID scanned & linked to their file will assure that the correct patient is being registered at time of service. At time of registration scanned ID will appear on registration as it is linked to patients account.
Registrar will do the following:

1. Images on file "must" be opened & reviewed to validate that person presenting for

registration matches ID of file & linked to correct patient.

2. If patient is **unable** to provide legal ID document, registration will reflect this on patient's account, notes section.
3. If patient "**declines**" to allow ID card to be scanned. Registrar will ensure to inform patient as to why we are requesting to scan but will comply with patients request & make note patients refusal into notes section. Immediate supervisor should be made aware of occurrence.

B. The patient's name will be entered into e-MDs as it shown on the patient's Legal ID, Driver's License, Temporary Resident Card, Military ID, or other form of legal document.
    1. In instances where patient advises that legal document they provided does not reflect legal name registration will take into consideration factors of
        a. Patient's **First name** misspelled (ie. Angelic should be Angelica)
        b. Patient's **Last name** misspelled (ie. Cortec should be Cortez)
        c. **First Name** reflects verbiage of 'Ma" this verbiage represents the name MARIA & should be included as part of pts First Name
        d. Patient recently had a name change due to marriage or divorce. Patient will be requested to provide legal document that reflects change.
    2. In cases where patient is persistent in having their name listed differently than what is on legal ID Contact your immediate supervisor for direction.
    3. In cases where patient presents with documents order under a different last name identified then what registration has identified as patients legal name, the patient is informed that the patient's registration must be performed under legal name.
    4. In cases where patients is currently being seen by the physician & legal name is identified to be different than what patient was registered as, prior to changing name contact your immediate supervisor.
        a. It may be determined not to change name until after the patient has been discharged.
        b. Name change is not reflected on any legal document in our records then family must provide legal document is reflecting legal name before any changes are name. Immediate notification to supervisor for direction.
    5. In situations where the clinic staff suspects patient presenting for registration is providing fraudulent information the registration clerk **is not** to confront patient with suspicion but will ensure to notify your immediate supervisor
    6. TFFHWC staff at time of registration identifies that the Social Security Number (SS#) provided by patient is flagged in computer system as already being linked to another patient, will do the following:
        a. Re-verify SS# provided by patient to ensure that a typo of digit did not occur.
        b. At this time patient will not be advised of discrepancy as it must be validated that the other patient linked to SS# is not a typo of digit.

7. TFFHWC clerk or staff will notify registration supervisor immediately, by Taskman.
    a. When supervisor is on duty then this will be done verbally
    b. When supervisor is not on duty then a notification in writing will be made to supervisor so that issue can be looked into upon next working day. This step is important to ensure that duplication issue is looked into & resolved.
    c. Supervisor will review patients registration & account of other patient linked to SS#. Supervisor will decide which acct needs to be changed.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18211084

Origination	10/2020	Owner	Amy Grimsley: Clinical Manager
Last Approved	N/A	Area	Patient Care
Next Review	3 years after approval		

Percutaneous Ventricular Assist Device Implantation (Clinical)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in the safe use of the Percutaneous Ventricular Assist Device (Impella CP. 5.5 or RP).

III. DEFINITIONS

A. Impella- Left Ventricular assist device that is inserted percutaneously
B. CCL- Cardiac Cath Lab
C. ICU- Intensive Care Unit
D. OR- Operating Room
E. PVAD- Percutaneous Ventricular Assist Device
F. ACT- Activated Clotting Time
G. CP 5.5 and RP- type of percutaneous ventricular assist device interface
H. CVP- Central Venous Pressure
I. PCWP- Pulmonary Capillary Wedge Pressure
J. PAP- Pulmonary Artery Pressure
K. CPR- Cardiopulmonary Resusitation

IV. GENERAL INFORMATION

A. Percutaneous Ventricular Assist Device (Impella) may be placed in CCL or OR. The device may be maintained in the ICU.

B. **CONSIDERATIONS**

- The Percutaneous Ventricular Assist Device ® partial left ventricular-assistance therapy is designed to increase coronary artery perfusion, increase systemic perfusion, decrease myocardial workload, and decrease preload and afterload. It achieves improvement in microvascular perfusion by physically lowering the left ventricular end-diastolic pressure so that the subendocardial capillaries can more easily perfuse
- The Percutaneous Ventricular Assist Device CP, 5.5 and RP are percutaneously inserted:
    1. via the femoral artery under fluoroscopy and advanced retrograde through the aorta and across the aortic valve, OR
    2. via cut down directly into the ascending Aorta and across the Aortic valve, or
       via axillary cut down and placed through a graft conduit
- The CP device has an arterial line integrated into the pump that is designed to reflect aortic arch systolic and diastolic pressures. This is required to verify placement, but should not be used for pressure monitoring as there is no ability to zero and calibrate it.
- The 5.5 is only a surgical device and inserted in the OR, not CCL. The 5.5 provides up to 6L/min of flow.
- The RP is indicated up to 14 days of use and facilitates biventricular support in the setting of cardiogenic shock related to Right Ventricular dysfunction.
- The Percutaneous Ventricular Assist Device ® system uses a purge system with concentrated dextrose and sodium bicarbonate delivered under high pressure to prevent blood from entering the motor, and to keep the motor turning at high speed. The purge system must be maintained continuously, or the pump will fail.
- Prior to Percutaneous Ventricular Assist Device insertion, the cardiologist, the interventional cardiologist, or Cardiovascular (CV) surgeon (or their designee) will notify the cardiac catheterization lab (CCL) or Operating Room OR, anesthesia, circulatory support, the cardiac surgeon, and the ICU charge nurse to coordinate needed assistance and convene a brief huddle or phone conversation.
- Patient care will be managed by the cardiologist, the interventional cardiologist, or CV surgeon. The cardiac surgeon or vascular surgery consultant may be contacted for vascular/surgical issues.
- ABIOMED may be contacted for additional issues via their 24 hour support line at: 800-422-8666. The Abiomed Rep is able to access and view our device screens and settings remotely in real time for troubleshooting purposes.
- For patients leaving the CCL or operating room with a Percutaneous Ventricular

Assist Device, admission to ICU is required with a 1:1 staffing ratio.

- Device repositioning is performed only by trained physicians (cardiologists, intervention cardiologists, cardiothoracic surgeons)
    1. Optimal placement of the CP and 5.5 device inlet is approximately 3.5 cm-4cm below the aortic valve, as indicated via echocardiography in the parasternal long axis view (TTE) or long axis view (TEE), only.
    2. Optimal positioning of the RP device is obtained via Chest Xray (CXR) to identify the landmark where the Pulmonary artery (PA) line crosses the RP device. Once placement is confirmed via CXR, the guidewire is removed and the RP may not be repositioned further.
- CP and 5.5 pump speed should be maintained (>/= P2 level in performance mode) when the device is in correct position, unless the physician is at the bedside to remove the device.
- RP pump speed should be maintained >/=P6 level in performance mode when device is in correct position, unless physician is at bedside performing a trial wean.
- Resuscitative measures, including external chest compressions and defibrillation, should be administered according to standard criteria during Percutaneous Ventricular Assist Device support unless ordered by the physician.
    1. During chest compressions: decrease flow rate to (P2 in performance mode) for CP, 5.5 or RP devices.
    2. During defibrillation: the Percutaneous Ventricular Assist Device system does not have to be stopped or unplugged to defibrillate. Do not touch catheter, cables, or console during defibrillation.
        a. After successful defibrillation and resuscitation,
            i. obtain an echocardiogram fro CP or 5.5 devices to verify pump position and return to previous P-level
            ii. Obtain a CXR for RP device to verify pump position and return to previous P-level
- Do not hold the 'ON' key longer than 3 seconds during operation; this causes the console to go into emergency STOP mode.
- The Percutaneous Ventricular Assist Device is latex-free, and is NOT compatible with MRI/MRA.

C. **POTENTIAL COMPLICATIONS:**

- Complications of Percutaneous Ventricular Assist Device support may include hemolysis, ventricular and atrial arrhythmias, perforation, cardiac tamponade, stroke, thrombocytopenia, vascular injury, device malfunction, or access site complications such as bleeding, hematoma, and infection.

V. PROCEDURE

A. **INITIAL ASSESSMENT AND SETTINGS**

- The CCL nurse will perform a head-to-toe assessment of the patient with the treating Cardiologist including a review of the Percutaneous Ventricular Assist Device settings, orders, site assessment (including length/depth of Percutaneous Ventricular Assist Device placement) and Touhy-Borst valve lock status.
- If the CP or 5.5 device was inserted, a bedside echocardiogram should be performed on arrival to the ICU to confirm device placement following transport, within 3 hours.
    - If a RP device was inserted, a bedside CXR should be performed upon arrival to ICU to confirm device placement following transport
- Vital signs, hemodynamics, access site, distal pulses, and device parameters are assessed every 15 minutes X 4, every 30 minutes X 2, and then hourly when clinically stable for the duration of Percutaneous Ventricular Assist Device support, and more frequently as needed.
- Optimal hemodynamics during support require an adequate circulating blood volume as indicated by a CVP > 12 mmHg and PCWP > 16 mmHg, or as otherwise ordered.
- Pump flow rates are indicated on the console in L/min and/or performance levels (P0-P9). The pump speed is adjusted to maintain pump flow rates > 1.5L/min (> P2) at all times, using the lowest P level possible to generate the highest flow rate. P levels of P3–P8 are recommended for CP and 5.5, and P6-P9 for RP. However, flow rates should be lowered to 1.5 L/min (P2) during catheter repositioning, when troubleshooting suction alarms, and during CPR.

B. **PUMP PURGE SYSTEM**

- Ongoing pump lubrication is required via a continuous, fluid filled purge system integrated with the Automated Percutaneous Ventricular Assist Device Controller (AIC).
- The AIC automatically adjusts itself to maintain the desired purge pressure of 300 – 1100 mmHg. Alarms will sound if the purge pressure is outside of this range.
- The recommended concentration for purge fluid is D5w 1000ml with 25 mEq Sodium Bicarbonate continuous infusion via the yellow check valve sidearm of PVAD device.
- Do not use saline in the purge fluid as it corrodes the pump. The fluid viscosity may be adjusted to optimize pump flow rates (↓viscosity will ↑flow).
- Change purge fluid bag every 24 hours and purge cassette every 96 hours
- A purge pressure alarm is potentially life threatening – low purge pressure may allow blood to enter the motor which can form thrombus and emboli. To troubleshoot:

Low Purge Flow **Purge flow rate < 2 cc/hr** **High Pressure >1100mmHg**	**Look for kinks in tubing, sidearm, or catheter** **Reduce concentration/viscosity of purge fluid**
Low Purge Pressure **Purge pressure < 300mmHg**	**Look for leak in tubing, sidearm, or catheter** **Increase concentration/viscosity of purge fluid**

Purge flow rate > 30 cc/hr	

- When replacing the purge cassette, the process must be completed within 90 seconds . The Impella catheter may be damaged if replacement takes longer than 2 minutes. A replacement cassette is stored in the basket of the device. CCL will stock basket
- Use a true arterial line or non-invasive cuff for blood pressure assessment and patient management. The arterial pressure displayed by the Percutaneous Ventricular Assist Device console is a reflected pressure of the aorta with the 5.5 and CP device, (used for catheter positioning only) and not an accurate arterial pressure. Do NOT treat the patient based on this number **Automatic Integrated Console information:**
    1. Do not block the cooling vents of the power supply.
    2. When unplugged, the Percutaneous Ventricular Assist Device console will operate for about 60 minutes when fully charged.
    3. Holding down the console's ON key for more than 3 seconds during operation will cause the device to go into emergency STOP mode.
    4. The "Home" screen displays the following information:
        - Alarm conditions, when present (at top)
        - Catheter position (central display) shows heart illustration with positioning
        - Flow rate/P level, purge system, and power supply information (bottom)

Alarm Conditions:

Alarm conditions will appear on the display and are color coded by severity: white = advisory, yellow = serious, red = critical. Alarms provide troubleshooting measures:

1. Percutaneous Ventricular Assist Device position wrong: notify MD to verify and reposition stat.
2. Reduced flow: check position, assess patient's volume status, ↓ flow setting if persistent
3. Suction: If the pump is completely emptying the left ventricle, it can 'suck-down' around the catheter, but will open back up once there is additional blood filling the space.
    - Assess the patient's volume status, administer fluid replacement as appropriate
    - Verify catheter position
    - Consider reducing pump flow rates if persistent
    - Assess right heart failure

C. **ANTICOAGULATION & LABORATORY ASSESSMENTS:**

- Anti-coagulation is required for the duration of Percutaneous Ventricular Assist Device support. In cardiac cath lab, maintain ACT at 250 seconds during Impella ® insertion and per procedural guidelines.

ICU CARE

- Once patient is admitted to ICU, monitor post procedure ACT q 1hr until ACT is within goal range of 160-180 seconds.

PURGE Solution

- **SODIUM BICARBONATE**
  - The recommended purge solution is 25 mEq/L of Sodium Bicarbonate in D5W 1000ml continuous infusion via the yellow check valve sidearm of device. If purge solution unavailable temporarily, D5W must be infused until sodium bicarbonate is available

- 1.

SYSTEMIC HEPARIN- SYSTEMIC ANTICOAGULATION will be provided with systemic heparin

- Begin systemic heparin infusion per MD order if ACT <150 for 2 hours
- Check ACT every 2 hour
- Goal is to maintain an ACT of 160 - 180.
- No initial heparin bolus
- Initial rate and adjustment for SYSTEMIC Heparin 25,000 units/500ml (50 units/ml):

◦ Initial Infusion	300 units/hr
◦ ACT less than 160	Increase by 100 units/hr
◦ ACT 160-180	NO CHANGE
◦ ACT greater than 180	Decrease infusion by 100 units/hr
◦ ACT greater than 200	Decrease infusion by 200 units/hr

- Monitor PTT, CBC, CMP, CMP, Liver enzymes and Plasma Free Hemoglobin (PFHb) levels per physician's orders. If patient develops signs of hemolysis (blood in urine, hemolyzed lab samples, ↑PFHb), contact the cardiologist or interventional cardiologist. Hemolysis may indicate the device is not optimally placed within the ventricle or the patient requires additional fluid volume. Notify cardiologist or interventional cardiologist of falling platelet count; evaluate for Heparin Induced

Thrombocytopenia (HIT) as appropriate. HIT should be confirmed with positive ELISA test and positive serotonin release test.

1. Resource for HIT positive patient direct thrombin inhibitor protocols: http://www.abiomed.us/npi-search

D. **PATIENT CARE ISSUES**

- ABIOMED may be contacted for additional issues via their 24 hour support line at: 800-422-8666. The Abiomed Rep is able to access and view our device screens and settings remotely in real time for troubleshooting purposes.
- Maintain head of bed (HOB) at or below 30° at all times and avoid groin flexion. Do NOT torque chest or hips. Patient may be log-rolled.
- Avoid tension/movement of device; maintain strict bed rest and use a knee immobilizer if necessary to maintain a straight leg on the side of the access site.
- Monitor access site/pedal pulses for bleeding, hematoma, infection.
- Bladder catheter recommended for all patients unless contraindicated.
- Sterile dressing change of femoral insertion site per hospital protocol and PRN if dressing becomes compromised or site appears wet or soiled. Use additional staff to stabilize catheter and monitor Impella device position throughout dressing change.
- Change purge fluid bag every 24 hours. Change purge cassette every 96 hours..
- With increased blood flow from the supported left heart, the right heart may be overwhelmed, monitor for s/s right heart failure: ↓ pump flow, suction alarms, ↑CVP, ↑PAP, liver dysfunction. Initiate supportive care as appropriate.

E. **DEVICE WEANING AND REMOVAL:**

- Weaning from the Percutaneous Ventricular Assist Device must be coordinated with the physician who is managing the patient.
- **CP or 5.5**
    - Maintain Impella ® Catheter P-level at P-2 or above until the catheter is ready to be removed from the left ventricle.
    - Remove all heparin from system 2 hours prior to removal. Replace purge bag with plain D5W.
    - Decrease pump speed per physician orders and assess tolerance:
        - Rapid wean(Cath Lab): ↓ performance level by 2 levels q15 minutes (ie, P6 to P4 to P2)
    - Maintain at P2 for 10 minutes. If patient remains stable notify the physician.
        1. Gradual wean (ICU): ↓ performance level by 2 levels q2 – 3 hours
    - Maintain at P2 for 2 – 3 hours. If patient remains stable, notify the physician.
        1. Adjust anticoagulation as ordered; achieve ACT < 150sec prior to

introducer removal.

- **The MD will remove the Impella device.**
    1. When the MD arrives at the bedside, decrease to P1.
- As soon as the MD pulls the catheter back into the aorta, decrease to P0. Note: Do not decrease to P0 until the distal tip of the Impella is in the aorta. Disconnect the white power plug from the front of the console.
- Following percutaneous device removal, hemostasis can be achieved by either manual hold 40 continuous minutes or per hospital protocol until homeostasis achieved.

- **RP**
    - Maintain Impella RP catheter at P6 or above until physician is at bedside to perform a trial wean of Impella RP and view ECHO to confirm right ventricle (RV) contractility.
    - To perform a trial wean:
        - Decrease to P-2 temporarily
        - Record the VAD flow. P-level, CVP, ECHO parameters and hemodynamics
        - After 15-20 Min and no adverse effect, the process can be continued and further weaning can be undertaken.
        - Once RV contractility is confirmed, resume previous P-level and initiate slow wean
    - To perform a Slow Wean
        - Once trial wean above is performed with physician at bedside, decrease by 2 P-levels every 2-3 hours and monitor patient hemodynamics as ordered by physician.
    - While weaning always maintain flow >1.5 L/min until removal of Impella RP device
        - If flows are </= 1.5 L/min, >/=20 min, consider increasing ACT to >/=250 seconds.
    - The Impella RP device is ready to be removed when the weaning steps are complete and the ACT is </= 150 seconds.

- In the event the patient needs to be transferred to a higher level of care at another facility, the patient will be transported on the Impella device with the critical care transport team. The critical care transport team will return the device to our facility after the transport.

F. **REPORTABLE CONDITIONS:**

- The patient develops signs of hemolysis or thrombocytopenia.
- Mal-position of the device.

- Purge pressure alarms that cannot be corrected.
- Suction alarms that cannot be corrected without decreasing flow rates.
- Loss of distal pulses to device entry site.

G. Initiate the Percutaneous Ventricular Assist Device Flow sheet in the Electronic Health Record (EHR).

H. Document hourly and PRN during entire course of Percutaneous Ventricular Assist Device support in the Percutaneous Ventricular Assist Device (Impella) Flow sheet in EHR.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Percutaneous Ventricular Assist Device Instructions for Use for the Percutaneous Ventricular Assist Device 2.5, CP, and 5.0 Circulatory Support System, Abiomed 2020

B. Percutaneous Ventricular Assist Device 2.5, CP, and 5.0 Circulatory Support System Quick Reference Guide, Abiomed 2020

C. Abiomed. Impella Program Protocols & Tools. Retreived on May 16, 2023 from https://www.heartrecovery.com/products-and-services/impella/impella-cp-with-smartassist.

Attachments

A: Percutaneous Ventricular Assist Device Insertion Criteria

B: Direct Thrombin Inhibitors in Percutaneous Ventricular Assist Device Purge Pressure Solution

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cath Lab Medical Director - Dr. Zetterlan	Megan Giovanetti: Director Cardiovascular Services and Sleep	10/2025

Director Critical Care Services	Frank Mensah: Interim Director Critical Care Services	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2025
Policy Owner	Amy Grimsley: Clinical Manager	08/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18635476

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Refund: Taylor Farms Family Health & Wellness

I. POLICY STATEMENT

A. Patient accounts with credit balances or over payments must be researched and analyzed promptly. Accounts with credit balances or potential overpayment discrepancies should be resolved within sixty (60) days following the date the credit balance was created. The specific payers' rules and time frames for processing must be followed.

II. PURPOSE

A. To establish guidelines for resolving credit balances and over payments to facilitate timely refunds of any confirmed over payments.

III. DEFINITIONS

A. eMD -

B. EOB - explanation of benefits

C. DOS - Date of Service

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Once the reason for the credit balance or overpayment discrepancy has been ascertained, proceed as follows:

1. If the credit balance was caused by a posting error such as duplicate contractual entries, misapplied charges, credit or incorrect patient adjustment, correct the adjustment.

2. If the credit balance remains following correction of the posting error, ascertain the party (guarantor, insurance payer) entitled to the refund.
3. Refund the credit balance promptly to the appropriate patient, guarantor or insurance in accordance with any regulations or contractual agreements that apply to the processing of the refund.
4. If refund is due to the insurance, Billing Staff should contact insurance to notify them of the overpayment and see if insurance can process the overpayment for a take back/offset. If the insurance is unable to process as an offset, continue process to issue a refund check.
5. eMDs balance report and collection module will be the primary source utilized by the Billing Staff to identify credit balance accounts that are not caught at the time of posting.

B. Patient Refund Procedure:

1. Billing Staff should verify that there are no other related accounts that have a balance due. If there are other accounts with a balance, an adjustment transfer for the credit should be entered.
2. Once the credit balance is verified, the Billing Staff will print the invoice showing the credit balance. If there are multiple invoices with credits, each invoice number should be listed with the corresponding dollar amount. Add all of the credits and list the TOTAL refund due.
3. Refunds will be issued directly to the patient or account guarantor, if patient is a minor.
4. On the invoice, write PATIENT REFUND and forward to Billing Supervisor.
5. Billing Staff will place a note on the invoice Patient Refund Requested.
6. All refunds will be entered into eMDs by Billing Supervisor. Each batch of refunds will balance to the till reconciliation report and sent to accounting department to issue the checks.
7. Refund requests should be in accounting no later than the 20th of each month.
8. All refund checks will be issued by the end of the month.
9. Completed checks will be given to Billing Supervisor for review. Once reviewed, the refund checks will be mailed to the patient or account guarantor.

C. Insurance Refund Procedure:

1. Billing Staff will obtain all pertinent documents (EOBs, refund letter and invoice). Print the invoice, write INSURANCE REFUND and the correct insurance company name, address for the refund check to be sent to. Refund letter generated from eMDs will pull the insurance company name and address as it is listed in the account. There may be a different address for refunds that will need to be change on the letter. Billing Staff will need to fill in the DOS, refund amount and mark the reason for the refund.
2. Billing Staff should have the refund packet in this order:

a. Invoice with INSURANCE REFUND and refund address
b. Original refund letter with all EOBs stapled to letter
c. Copy of refund letter with copies of EOBs staples to the letter
d. Paper clip together then forwarded to the Billing Supervisor

3. Billing staff to place a note on the invoice – Insurance Refund Requested.
4. Billing Supervisor will review documentation and determine if the refund is valid. If there is a problem with the entries or the refund paperwork, it will go back to the Billing staff member who requested the refund. Once everything is verified and refund is due it will be entered into eMDs by Billing Supervisor. Each batch of refunds will balance to the till reconciliation report and sent to accounting to issue the checks.
5. Refund requests should be in accounting no later than the 20th of each month.
6. All refund checks will be issued by the end of the month.
7. Insurance refund checks will be copied. Original check and refund letter packet will be sent to insurance. Copies will be kept with refund batch filed by month at billing office.

D. Documentation: N/A

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Board	Iftikhar Hussain: Chief Financial Officer	11/2025
CFO	Iftikhar Hussain: Chief Financial Officer	10/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19006236**

Origination	01/2021	Owner	John Kazel: Director Imaging Services
Last Approved	N/A	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Diagnostic Imaging

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goal(s) of Diagnostic Imaging is to:

A. Provide diagnostic and therapeutic imaging services for both inpatients and outpatients.

B. There is sufficient equipment and supplies maintained to adequately perform the diagnostic imaging services that are offered. Proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

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

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

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

highest level of wellness as possible.

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

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

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

IV. POPULATION SERVED

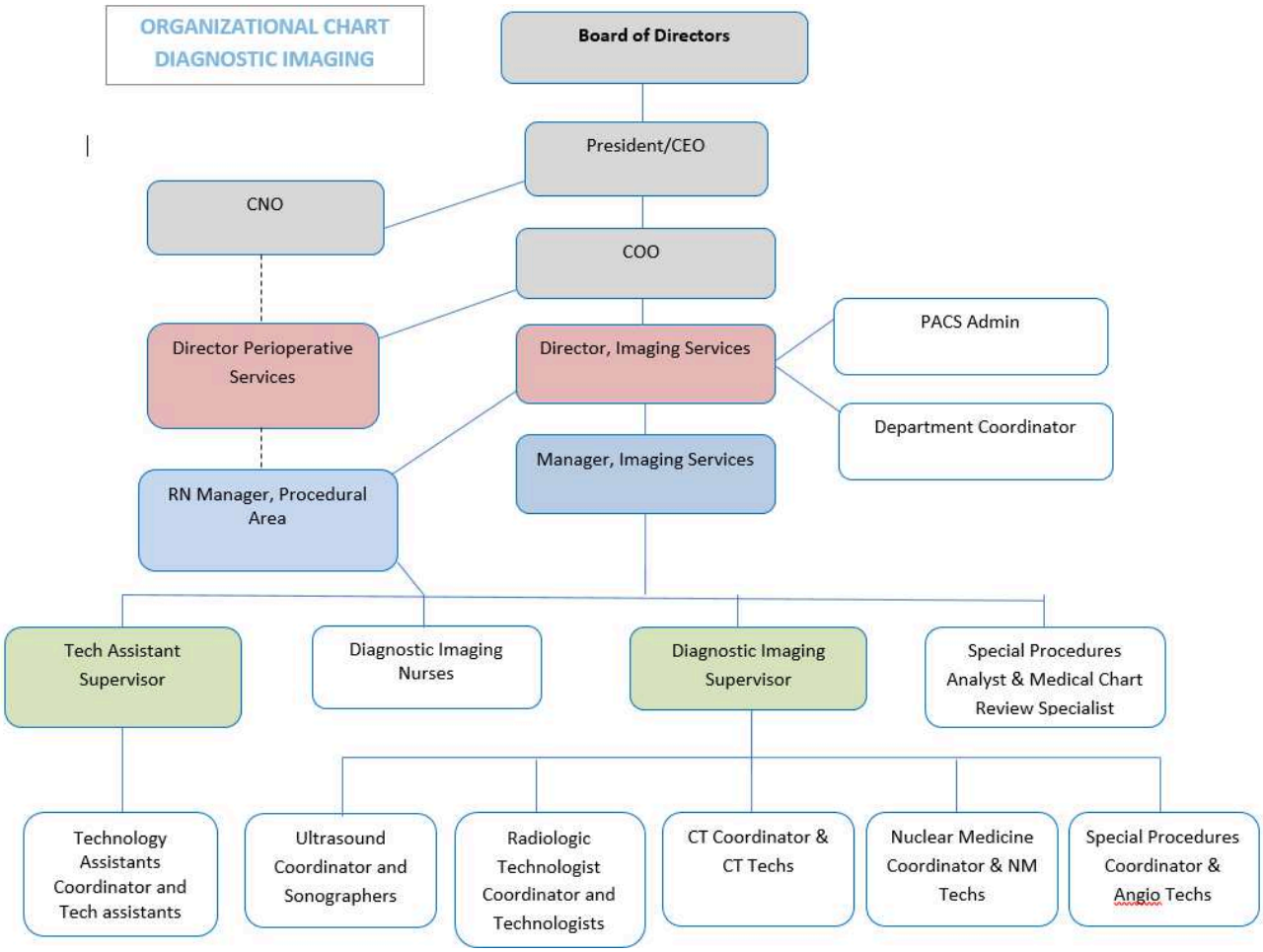
Clinical:

The Diagnostic Imaging unit provides care for infant, pediatric, adolescent, adult and geriatric patients.

Non-Clinical:

N/A

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation

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

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

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

D. Major Services / Modalities of care may include:

The department contains the following equipment:

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

Diagnostic Imaging services may include:

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

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

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

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

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

A. The Diagnostic Imaging Department consists of six (6) areas: main Radiology, Ultrasound, Special Procedures, Computerized Tomography, Nuclear Medicine (with PET/CT), and Magnetic Resonance Imaging (MRI).

B. Imaging exams must be ordered by Physician's, Physician's Assistants, and/or Nursing Practitioners that meet SVHMC's credentialing requirements. Technologists and Sonographers perform imaging exams according to the physician's order and under the supervision of a Radiologist. Following imaging, the radiologists dictate their interpretation. The radiologist signs the report electronically and is stored in PACS and Electronic Health Record (EHR). A copy of the report is automatically faxed to the referring physician.

C. Imaging exams are stored for a period of ten (10) years, unless the patient is a minor and then the images and reports are kept on file until the patient reaches the legal age of eighteen (18) plus

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

D. Services related or associated to imaging include quality assurance monitoring and evaluation, quality control (including protecting patients and staff from harmful radiation), image interpretation, dictation, transcription, record filing/management, patient billing, marketing, equipment purchasing, film processing and continuing education.

E. Portable x-ray equipment allows radiographs to be obtained in surgery, as well as medical/surgical and intensive care units.

F. Radiologists are consultants, responsible for advising referring physicians on which imaging procedures to do and in which sequence. In addition, when an emergency physician requests images and interprets them, staff radiologists are responsible for the confirming or amending of the emergency physician's initial interpretations.

G. The Diagnostic Imaging Services department is under the control and direct supervision of the Radiology Medical Director, certified by the American Board of Radiology and has a current license from the State of California to practice medicine, who is directly responsible to the Chief of the Medical Staff and the Board of Directors. Also, a radiologist is available by phone or in person when required.

H. The Director of Imaging Services department is directly responsible to the Chief Operating Officer. It is the Imaging Services Director's duty to attend all administrative and technical functions within the department.

I. All personnel within the department are under the guidance and control of the Imaging Services Director. In the Director's absence, the position is filled by the DI Manager or designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

J. The Imaging Director, Critical Care Director, and the Procedural Nurse Manager assume twenty-four (24) hour responsibility for nursing care provided on the unit.

VII. REQUIREMENTS FOR STAFF

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

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

A. Licensure / Certifications:

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

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

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

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

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

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

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

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

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

1. Current State Licensure (CRT)
2. National Registry (ARRT) or ARMRIT
3. Current BLS
4. Completion of competency based orientation
5. Completion of annual education

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

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

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

1. Current State Licensure

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

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

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

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

General Staffing Plan:

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

SHIFT_____DAY

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

SHIFT_____PM

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

SHIFT_____NIGHT

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

*Staff is on call

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

IX. EVIDENCED BASED STANDARDS

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

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

XII. RADIATION SAFETY

See Radiation Safety Program Policy

Attachments

Image 1.PNG

Approval Signatures

Step Description	Approver	Date

Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	John Kazel: Director Imaging Services	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18948724**

Origination	N/A	Owner	Aaron Burnsides: Director Information Technology
Last Approved	N/A	Area	Cybersecurity Program
Next Review	3 years after approval		

Secure Configuration

I. POLICY STATEMENT

A. Salinas Valley Health will implement policies, standards, and controls, that provide a reasonably secure configuration for connected technology assets.

II. PURPOSE

A. The intent of this document is to establish appropriate processes, controls, and standards that work together to effectively manage the cybersecurity risk that the organization is exposed to that impacts the confidentiality, integrity, and availability of Salinas Valley Health's systems. The management of these risks is necessary in order to safeguard the organization's ongoing operations and ensure compliance with regulatory requirements.

B. All of the cybersecurity policies utilized by Salinas Valley Health are intended to manage risk. This Secure Configuration Policy focuses on managing the risks that can be mitigated by maintaining a secure configuration.

III. DEFINITIONS

A. **Baseline Configuration** – The approved set of settings and controls that must be applied to technology assets and systems as specified by SVH standards.

B. **Compliance** – The percentage of applicable controls or standards that a system or device meets, with full compliance as the target and ≥85% as the acceptable threshold.

C. **Remediation** – The process of correcting non-compliant systems through lifecycle replacement, image management, group policy management, vulnerability management, risk handling, or change control.

D. **Standards** – The individual technology-specific hardening documents (e.g., Windows Client Standard, VMware Standard, Medical Device Standard) that establish secure configurations.

E. **Validation** – The process of confirming that systems meet baseline configurations through

automated tools or annual sampling.

F. **Risk Management Process** – The formal process for documenting, reviewing, and approving exceptions for systems that cannot meet acceptable compliance.

G. **SQL** – Structured Query Language, used for relational database management systems referenced in the SQL Database Standard.

H. **IOT** – Internet of Things, referring to connected smart devices and sensors covered under the IOT / Other Device Standard.

I. **PAM** – Privileged Access Management, the security practice of managing and controlling privileged accounts as referenced in the PAM Standard.

J. **UCS** – Unified Computing System, Cisco's converged server platform referenced in the Cisco UCS Standard.

K. **DNS** – Domain Name System, referenced in the requirement to configure trusted DNS servers on enterprise assets.

L. **GPO** – Group Policy Object, a Microsoft technology referenced as a remediation mechanism for managing configuration compliance.

IV. GENERAL INFORMATION

A. This document falls under the scope of the Cybersecurity Governance policy.

B. **Scope**

1. The scope of this policy is the entire organization including the hospital and clinics.

C. **Out of Scope**

1. Systems externally hosted and not managed or controlled by Salinas Valley Health.

D. **Remediation**

1. Devices out of compliance with expectations are prioritized and remediated through the following activities:
    a. Lifecycle Replacement
    b. Image Management
    c. Group Policy Management
    d. Vulnerability Management
    e. Risk Handling Process
    f. Change Control Process
    g. Assigned Projects & Work Efforts

V. PROCEDURE

A. **Activities and Outcomes**

1. The Salinas Valley Health Security Program must develop and share policies, procedures, and standards that establish baseline security configurations for assets

and information systems.

a. Windows Client Standard(2025)
b. Windows Server Standard(2025)
c. SQL Database Standard(2025)
d. Vendor Managed Server Standard(2026)
e. Printer Standard (2025)
f. IOT / Other Device Standard (2026)
g. Apple IOS Device Standard (2025)
h. VMware Infrastructure Standard (2025)
i. VMware Horizon Standard (2025)
j. Cisco UCS Standard (2025)
k. Checkpoint Firewall Standard (2025)
l. Pure Storage / SAN Standard (2025)
m. Guest Network Standard (2025)
n. Network – Switch Standard (2026)
o. Network – Wireless Standard (2026)
p. Telephone System Standard (2026)
q. Information Systems Standard (2025)
r. Endpoint Firewall Standard (2026)
s. Server Firewall Standard (2026)
t. Application Allow Listing Standard (2026)
u. Veeam Standard (2025)
v. Exchange / Email Standard (2026)
w. Web Browser Management Standard (2025)
x. Antimalware Standard (2026)
y. PAM Standard (2025)
z. IIS Web Server Standard (2025)
aa. Microsoft Office Standard (2026)
ab. Medical Device Standard (2026)
ac. Duo Standard (2026)
ad. Work-From-Home Device Standard (2026)

B. Validation

1. Baseline configuration assessments should be performed automatically, where possible, using security auditing tools licensed by the organization. Standards not able to be automatically assessed by the cybersecurity team should be assessed

using sampling at least annually.

C. **Enforcement**

1. Target compliance for systems is full compliance with applicable standards.
2. Acceptable compliance is above 85% compliance to applicable standards.
3. Technical controls for systems out of compliance will generally be handled through the vulnerability management process for triage and prioritization. Systems with no path to acceptable compliance should be handled through the risk management process. Systems may need to be targeted for remediation along with vendor lifecycles for systems that cannot be changed (medical devices, etc.).

D. **Required Controls**

1. The established policies and standards must address and establish the following controls:
    a. Establish and Maintain a Secure Configuration Process (2025)
    b. Establish and Maintain a Secure Configuration Process for Network Infrastructure (2025)
    c. Implement and Manage a Firewall on Servers (2026)
    d. Implement and Manage a Firewall on End-User Devices (2026)
    e. Securely Manage Enterprise Assets and Software (2026)
    f. Manage Default Accounts on Enterprise Assets and Software (2026)
    g. Uninstall or Disable Unnecessary Services on Enterprise Assets and Software (2026)
    h. Configure Trusted DNS Servers on Enterprise Assets (2026)
    i. Enforce Automatic Device Lockout on Portable End-User Devices (2027)
    j. Enforce Remote Wipe Capability on Portable End-User Devices (2027)

E. **Performance Tracking**

1. Performance tracking is performed under the direction of the Performance Indicator Standard.

F. **Improvement**

1. Standards are to be reviewed annually for improvement and relevance by the Cybersecurity Risk Manager.

G. **Documentation**

1. This policy is intended to define, establish, or support the following HIPAA & NIST CSF controls:

a.

PR.PS-01	Configuration management practices are established and applied
PR.IP-1	A baseline configuration of information technology/

	industrial control systems is created and maintained
PR.IP-3	Configuration change control processes are in place
164.310(c)	Workstation security
164.312(b)	Audit controls

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. HIPAA Security Rule, 45 CFR §164.308(a)(6) (Security Incident Procedures)

B. HIPAA Security Rule, 45 CFR §164.308(a)(7) (Contingency Planning)

C. NIST Cybersecurity Framework (CSF) v2.0 – Recover (RC), Respond (RS), and Govern (GV) Functions

D. CIS Critical Security Controls v8 – Controls 11 (Data Recovery) and 17 (Incident Response Management)

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	10/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	10/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18635479**

Origination	10/2015	Owner	Mary Heacox: Director Clinic Services
Last Approved	N/A	Area	TFFHWC
Next Review	3 years after approval		

Small Balance Adjustment - TFFH

I. POLICY STATEMENT

A. It is the policy of Taylor Farms Family Health & Wellness Center to fully identify and treat all small balance adjustments equitably.

II. PURPOSE

A. The purpose of this policy is to provide guidelines for the identification and management of small balance adjustments $7.50 or less.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. POSITIVE BALANCES:

1. All charges on an account will be submitted to the appropriate payers for payment. If no payment is received within 45-60 days the Billing Staff will review the account and follow up with insurance to ensure proper payment. Any balance left after all the insurances have processed the claim will become the patient's or the guarantor's responsibility. Balance will be changed to PVP status.
2. When an account has a balance of $7.50 or less it will be reviewed for possible small balance adjustment by the Billing Staff. Billing Staff should check for posting errors, other account balances and if the patient has any upcoming appointments scheduled.

3. Any small balance requests will be reviewed by Billing Supervisor. Once it is determined to be a valid small balance and the patient has no other account balances and no upcoming appointments, the adjustment (ASMA) will be entered.

B. CREDIT BALANCES:

1. On a monthly basis the Billing Staff will review credit balance accounts for possible refund. Billing Staff will also check to see if there are any other related accounts that have a balance due and make the adjustment transfer. If the patient has an upcoming appointment scheduled, the credit will remain on the account for future use.
2. If no other balances are found and there are no future appointments scheduled, the Billing Staff will adjust the credit balances between -$0.01 and -$10.00 for any account with the exception of Medicare, Medi-Cal or Tricare. Adjustment code (ASMA) with a negative dollar amount.

C. Documentation: N/A

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Kathryn Haines: Administrative Assistant - PD	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief Financial Officer	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Mary Heacox: Director Clinic Services	10/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18121389

Origination	03/2022	Owner	Lilia Meraz Gottfried: Director Clinical Development
Last Approved	N/A	Area	Administration
Next Review	3 years after approval		

Spiritual Care Services

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in understanding the process by which spiritual care is provided for and accessed by patients, families, staff, physicians, and communities served by the Salinas Valley Health Medical Center (SVHMC).

B. To ensure that the diverse religious, spiritual, and cultural beliefs of patients, their families, and staff are addressed in the provision of spiritual care at SVHMC.

C. To protect our patients' right to privacy and confidentiality with respect to spiritual care visits and interventions.

D. To guide the staff by clarifying the process for documenting spiritual care interventions.

E. To provide grief support and grief/loss resources to patients, families and staff who have experienced a recent loss.

III. DEFINITIONS

A. Spiritual/Spirituality: The non-physical dimension of human beings that develops concepts and beliefs about personal meaning, value, purpose, and transcendent connections with a Supreme Being, others, and/or self.

B. Spiritual Care: Of or relating to care that seeks to empower individuals from diverse religions and cultures with meaning, value, purpose, and transcendent connections to a Supreme Being, others, and/or self, a sense of hope beyond the grave

C. Supreme Being: God, ultimate reality, transcendent power, divine figure, or ideology which is the object of personal belief and commitment.

D. Spiritual Care Services: Of or relating to the provision of spiritual care as a part of an

interdisciplinary healthcare team.

E. Spiritual Care Volunteer: A member of the community clergy and/or lay minister approved by the leader of their church or faith group, oriented and trained by SVHMC Volunteer Services.

F. Chaplain Intern: A Spiritual Care volunteer that is currently enrolled in a certified Clinical Pastoral Education course and is supervised by the Chaplain and oriented and trained by Volunteer Services.

G. Ritual/Sacrament: Of or relating to a sacred act or ritual that reflects or symbolizes a personally-held religious, spiritual, or cultural belief.

H. Culture: A system of symbols that is shared, learned, and passed on through generations of a social group. It is a process rather than a static entity and changes over time.

I. EHR: Electronic Health Record

IV. GENERAL INFORMATION

A. The Spiritual Care Department:

1. Develops, implements, and oversees spiritual care services in cooperation and collaboration with applicable clinical disciplines.
2. Facilitates the spiritual care requests made by patients or family, staff, or medical staff on the patients' behalf.

B. Spiritual Care will be delivered with dignity and respect while honoring the religious, spiritual and cultural preferences of patients, their families, and staff members.

C. Every attempt will be made to facilitate a patient request for a specific spiritual care provider from their own faith tradition and will be facilitated during regular visiting hours or in an emergency, regardless of whether the provider is a registered Spiritual Care Volunteer.

D. For patients requesting spiritual care, but without a specific preference, every effort will be made to arrange for a visit by the hospital Chaplain and/or a registered Spiritual Care Volunteer. Other community clergy may be called if Chaplain is unavailable and no registered volunteer is available within a reasonable timeframe.

E. The Spiritual Care department is a source of compassionate Spiritual support and counseling that is available to patients, family members and staff. The Spiritual Care department will help select, screen and orient Spiritual Care Volunteers, in collaboration with the Volunteer Services department, to assist in the provision of spiritual support at SVHMC. After Volunteer orientation the chaplain will continue to provide ongoing training.

V. PROCEDURE

A. Spiritual Care Volunteers will generally visit patients from their own congregation or faith tradition.

B. In circumstances where the Chaplain and/or a volunteer is asked to provide spiritual care to persons of diverse faith traditions, s/he will use spiritually inclusive language and refrain from imposing personally held religious beliefs, spiritual practices, or theologically biased language.

C. Chaplain and Spiritual Care Volunteers will serve patients, their families, and staff without

discrimination, regardless of religion, race, culture, gender, age, disability, or sexual orientation.

D. Chaplain and Spiritual Care Volunteers will offer assistance in notifying the appropriate community clergy or other spiritual care provider per patient request.

E. Chaplain and/or Spiritual Care Volunteers will facilitate, when appropriate, the provision of specific rituals and sacraments per patient request.

F. All Spiritual Care Volunteers are asked to report visits to the Concierge for tracking purposes. They will fill out a Spiritual Care Documentation form and return it to the concierge for secure placement and to be scanned into patient medical record. End of Life visits and sacraments must be reported to the patient's nurse or charge nurse for appropriate documentation in the patient medical record.

G. Accessing Spiritual Care

    1. By Staff

        a. Between the hours of 7:30 a.m.-8 p.m.:

            i. Those who have access to EHR Order Entry may make an Order Entry for routine requests. The category is Consultations and order name is ***Consult Spiritual Care***. The referral will email to the Chaplain and Concierge distribution list, and be addressed during business hours.

            ii. The patient TV system has a request link in the "I Need" section. Staff may use this feature to request spiritual support on behalf of the patient.

            iii. Call the Concierge/Guest Services at x1170 or x2939

        b. For Emergency requests between 8 p.m.-7:30 a.m.:

            i. Call the Administrative Supervisor who will call the patient's minister or faith group representative, Spiritual Care Volunteer, or Catholic Priest. A list of registered Spiritual Care Volunteers is shared with Volunteer Services and Administrative Supervisors in the Employee Portal.

    2. By Patients

        a. At the time of admission, patients will be asked if they have a religious or congregation preference. If so, this preference will be documented in the electronic record.

        b. Patients who do have a religious preference will be asked if they would like to receive a Pastoral visit from our Chaplain or Spiritual Care volunteer.

        c. Patients who do not wish to be visited, but later decide they would like to be visited may ask their nurse for assistance in notifying the hospital Chaplain (ext. 3025) or Concierge Services (ext. 1170). Alternatively, patients may enter their request in the "I Need" section of their TV system.

H. Hours of Operation

    1. Monday through Sunday 7:30am to 8pm

a. Urgent requests should be made by calling Concierge Services at ext. 1170 or ext. 2939. Concierge will coordinate with Chaplain.

b. Non Urgent requests should be made via EHR Spiritual Care Consult

2. Monday through Sunday 8:00pm to 7:30am

a. Urgent requests should be made by calling Nursing Supervisor

b. Non Urgent requests should be submitted via EHR Spiritual Care Consult

I. Community Spiritual Care Volunteers/Other community faith group representatives

1. Volunteer Services will register, orient and supervise, in collaboration with Spiritual Care Services, local faith community representatives who would like to be Spiritual Care volunteers.
2. Only those community Spiritual Care volunteers who are registered, oriented and trained to the hospital's policies and procedures will have access to their faith community patient list, have reasonable after-hours access to their members who are patients, be provided an I.D. badge, and access to designated parking.
3. Other local faith community Spiritual Care representatives who are not registered will not have access to any patient care lists, will not receive an ID badge, but will be permitted to visit members of their local faith group congregation during normal visiting hours, or as requested by the Hospital Chaplain
4. Spiritual Care Volunteers, local faith community Spiritual Care representatives, or any other spiritual care providers are not permitted to go from room to room or from patient to patient unless requested by staff or medical staff. However, they may visit patients in the same or adjacent room if personally requested by that patient or their family.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Joint commission Standards, PC.01.2.1; PC.02.02.13, EP 1; RI.01.01.01; RI.01.02.01

Approval Signatures

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

ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Lilia Meraz Gottfried: Director Clinical Development	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17883849**

Origination	01/2019	Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Last Approved	N/A	Area	Human Resources
Next Review	3 years after approval		

Tuition Assistance

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) provides a tuition assistance for approved educational programs to facilitate regular full-time and part-time employees to participate in advancement opportunities within SVHMC.

II. PURPOSE

A. The purpose of this policy is to set forth the process for requesting and receiving tuition assistance related to pursuit of an Associate's, Bachelor's, or Master's. degree.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. The monies will be used exclusively for tuition.

B. Tuition will be reimbursed at the completion of each course/semester subject to the agreement and reimbursement processes.

V. PROCEDURE

A. Eligibility

1. Regular full-time and regular part-time employees are eligible for consideration.
2. Approval of request will be based on the following:
    a. Performance at satisfactory level as documented in the performance

evaluation.

b. No active disciplinary action

i. To be eligible for tuition reimbursement, an employee must remain in good standing and not have an active disciplinary action on file at any point during the academic term for which reimbursement is requested.

c. Degree for which employee is seeking pertains to the role they currently hold, or an SVHMC role the employee is seeking to obtain upon graduation.

d. Employee has done due diligence to ensure institution they are attending is accredited and will result in an Associates, Bachelors or Masters.

3. If an employee terminates employment either voluntarily or involuntarily prior to completion of an approved course of study, the employee's eligibility for tuition reimbursement will terminate with the termination of his or her employment.

B. Application

1. Eligible employee must submit a completed Tuition Assistance Application to the Department Director and ensure it is fully executed prior to course start date. Incomplete applications will not be accepted.

C. Process to Request Tuition Reimbursement

1. The tuition reimbursement limit is subject to the IRS limit per calendar year. There is a lifetime reimbursement maximum of $10,000 per employee. Eligible expenses: tuition expenses not covered by scholarships, military coverage or non-repayable grants. An itemized receipt for tuition expenses and payments must be submitted to Human Resources.

2. An official school transcript verifying course completion with a grade of "B" or higher must be submitted to Human Resources.

3. Tuition reimbursements generally meet the requirements for exclusion from income as a Working Condition Fringe Benefit under IRC §132(d). As of January 2018, reimbursements under the policy will not be subject to payroll tax withholding, with some exceptions.

D. Documentation:

1. Appendix A: Tuition Assistance Application

2. Appendix B: Tuition Reimbursement Request Form

VI. EDUCATION AND TRAINING

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

VII. REFERENCES

A. N/A

Attachments

Tuition Assistance Application.docx

Tuition Reimbursement Request Form.docx

Approval Signatures

Step Description	Approver	Date
Board Approval	Kathryn Haines: Administrative Assistant - PD	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
ELG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	09/2025

Standards

No standards are associated with this document

BOARD MEMBER COMMENTS

AND REFERRALS

(VERBAL)

QUALITY AND EFFICIENT

PRACTICES COMMITTEE

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

(CATHERINE CARSON)

PERSONNEL, PENSION & INVESTMENT COMMITTEE

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

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

(CATHERINE CARSON)

Board Paper: Personnel, Pension and Investment Committee

Agenda Item:	**Consider Approval of (i) Findings Supporting Recruitment of Armando Cervantes, MD (ii) Contract Terms for Dr. Cervantes' Recruitment Agreement, and (iii) Contract Terms for Dr. Cervantes' Family Medicine Professional Services Agreement**
Executive Sponsor:	Orlando Rodriguez, MD, Chief Medical Officer Molly Heacox, Director of Clinic Services
Date:	November 3, 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 **family medicine** as a recruiting priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, family medicine is recommended as a top priority for recruitment. To ensure that established primary care patients of Salinas Valley Health Clinics (SVHC) have access to after-hours care, clinic hours were expanded weekdays from 5:00 p.m. to 9:00 p.m. and weekends 9:00 a.m. to 6:00 p.m. to offer urgent care services. With plans to continue to expand hours January 2026. To support this expanded service line, recruiting an additional family medicine physician is imperative to meet the growing demand. Urgent care services are available to established SVHC primary care patients of all ages at the PrimeCare Salinas location.

The recommended physician, **Armando Cervantes, MD,** received his Doctor of Medicine degree in 2020 from the University of Iowa Carver College of Medicine and completed his training at the Kaweah Health Family Medicine Residency Program in Visalia, CA. Since his training in 2023, Dr. Cervantes has been providing primary care, wound care and urgent care services in the Bay Area. Dr. Cervantes is fluent in Spanish and will join SVH PrimeCare in December 2025.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics. Pursuant to California law, the physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term: PSA is for a term of two years, with annual compensation reported on an IRS W-2 Form.
   - Full-Time Schedule. Physician will be scheduled to provide physician services to clinic patients on a full-time basis, 46 weeks per year; one week of which can be allocated to continuing medical education (CME).
   - Base Compensation: $325,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for work Relative Value Units (wRVU) productivity compensation at a $55.00 wRVU conversion factor.
   - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403(b) plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Six weeks (30 days) of time off each calendar year.
     - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.

2. **Recruitment Agreement** that provides a recruitment incentive of $50,000, which is structured as forgivable loan over two (2) years of service.

Meeting our Mission, Vision, Goals Strategic Plan Alignment:

The recruitment of Dr. Cervantes is aligned with our strategic priorities for the service, quality, and safety 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:

☒ **Quality & Safety** ☐ **People** ☐ **Operations** ☐ **Finance** ☒ **Growth** ☐ **Community**

Financial/Quality/Safety/Regulatory Implications

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

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

Recommendation

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

1. **The Findings Supporting Recruitment of Armando Cervantes, MD:**
   - That the recruitment of family medicine to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
   - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;
2. **The Contract Terms of the Recruitment Agreement for Dr. Cervantes; and**
3. **The Contract Terms of the Family Medicine Professional Services Agreement for Dr. Cervantes.**

Attachments: Curriculum Vitae for Armando Cervantes, MD

Armando Cervantes, M.D.

Professional Summary

Bilingual, Family Medicine board-certified physician fluent in Spanish. Founder and operator of an independent medical corporation specializing in comprehensive wound care and urgent care services. Highly skilled in performing a broad range of in-office procedures while delivering efficient, evidence-based, and compassionate care. Demonstrated ability to work autonomously while managing diverse patient populations, with a strong commitment to quality, patient-centered outcomes.

Board Certifications & Licensure

Family Medicine Board Certification, November 2023

Physician and Surgeon's License (California**)**, Issued 07/13/2023 | Expires 09/30/2027

Clinical Experience

Urgent Care | Wound Care
Cervantes Medical Corporation, San Jose, CA
December 2024 – Present

- Provide comprehensive urgent care and advanced wound management services, performing a wide range of in-office procedures with efficiency and precision.
- Independently manage patient evaluation, diagnosis, treatment, and specialty referrals.
- Utilize Spanish fluency to deliver culturally competent care, enhancing access and trust among a diverse patient population.

Family Medicine | Primary Care
Top Care Medical Group, San Jose, CA
January 2024 – November 2024

- Served as the sole physician at the office location, independently overseeing all clinical operations and patient care.
- Delivered preventive care and chronic disease management to a diverse patient panel.
- Streamlined workflows to improve efficiency while maintaining high standards of care quality.
- Applied bilingual communication skills to strengthen patient understanding, compliance, and satisfaction.

Other Professional Experience

Biology Professor
College of the Sequoias, Visalia, CA — August 2023 – December 2023
Taught collegiate-level biology, demonstrating advanced subject matter expertise, effective communication, and curriculum delivery.

Owner | Aile Assisted Living
Tulare, CA — March 2023 – March 2024
Directed all operational and administrative aspects of an assisted living facility business, emphasizing leadership, compliance, and quality care delivery.

Skills:

Clinical Skills:
Urgent care procedures (I&D, suturing, casting, joint injections, toenail removal, pelvic exams, ear lavage, splinting); wound care management and debridement; EKG and X-ray interpretation; critical care and diagnostic evaluation; telemedicine.

Electronic Medical Record:
Proficient with Epic, Cerner, eClinicalWorks

Languages:
Fluent in Spanish (professional proficiency).

Education and Residency:

Family Medicine Resident
June, 2020 – August 2023
Kaweah Health, Visalia, CA

University of Iowa Carver College of Medicine
August 2016 – May 2020
Doctor of Medicine

Publications & Educational Contributions

Published Author: Authored peer-reviewed articles indexed in PubMed (PMID) and NCBI Bookshelf (NBK).

CME Instructor: Contributor and instructor for StatPearls continuing medical education modules.

MOC & CPD Contributor: Contributor to Maintenance of Certification programs for the Royal College of Physicians and Surgeons of Canada and Continuing Professional Development initiatives for the Association of Surgeons of Great Britain and Ireland.

Educational Content Developer: Created question banks and educational materials for Board Review, residency, and fellowship training programs.

Memorandum

To: Personnel, Pension and Investment Committee
From: Michelle Childs, Chief Human Resources Officer
Date: November 7, 2025
Re: Recommendation for Board Approval – Approval of Amendments to the SVMHS 403(b) Retirement Plan, the 403(b) Tax Deferred Salary Reduction Plan and the 457(b) Retirement Plan

BACKGROUND

The SECURE 2.0 Act of 2022 (SECURE 2.0) made several changes to the catch-up contribution provisions under section 414(v) of the Internal Revenue Code ("Code"). To provide participants under the SVMHS 403(b) Retirement Plan, the 403(b) Tax Deferred Salary Reduction Plan, and the 457(b) Retirement Plan ("Plans") with the maximum deferral opportunity, we recommend the adoption of amendments to the Plans.

SECURE 2.0 provided for increased catch-up contributions for participants who reach age 60 but not age 64 in a calendar year. The increased catch-up is 150% of the regular catch-up contribution (e.g., $11,250 for 2025). The Plans will be amended to provide for increased catch-up contributions for this group of participants effective as of January 1, 2025.

SECURE 2.0 required that catch-up contributions for employees over age 50 in a calendar year must be Roth (post-tax) contributions for employees with more than $145,000 of FICA wages in the previous calendar year. The effective date of this provision was previously extended until January 1, 2026. On September 16, 2025, the Internal Revenue Service issued final regulations that relate to catch-up contributions made by participants in Code section 401(k), 403(b) and 457(b) plans. The effective date for compliance with this provision of SECURE 2.0 was not further extended, but the final regulations provide for a reasonable good faith compliance through January 1, 2027.

For the Plans to provide high earners with the ability to make catch-up contributions, the Plans must provide for Roth deferrals. The 403(b) Retirement Plan was previously amended to provide for Roth deferrals, but the 403(b) Tax Deferred Salary Reduction Plan and the 457(b) Retirement Plan must be amended effective as of January 1, 2026 to provide for Roth deferrals.

Effective as of January 1, 2026, the Plans will be further amended to add the requirement under SECURE 2.0 that catch-up contributions for high earners will be classified as Roth deferrals. To use the correction options under the regulations, the Plans will state that any catch-up contributions for high earners will be deemed Roth deferrals. The regulations require that if high earners do not wish to have their catch-up contributions classified as Roth, they must be provided with the opportunity to change a prior election. Any Roth deferrals deferred in the calendar year

by a high earner may be used to satisfy the Roth catch-up requirement. In addition, if a plan provides for Roth catch-up contributions for high earners, all participants must be able to have their catch-up contributions classified as Roth deferrals.

If errors occur, the amendments provide for the reclassification of pre-tax deferrals as Roth before the W-2s are issued. If W-2s have already been issued, pre-tax deferrals will be reclassified as Roth in an In-Plan Roth Conversion and reported on Form 1099R.

A participant in the 403(b) Tax Deferred Salary Reduction Plan with more than 15 years of service may also be eligible for the special Code section 403(b) catch-up contribution. A participant in the 457(b) Retirement Plan may also be eligible for the increased deferrals under the last three years of participation provision. The regulations provide that these increased deferrals will not be subject to the Roth catch-up requirement for high earners and will be considered before any age-based catch-up contributions.

The amendment to the 403(b) Tax Deferred Salary Reduction Plan was also revised to update the current providers to the Plan.

AMENDMENTS

Below is a summary of the attached amendments:

Amendment to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan:

This amendment addresses the following changes:

(i) Effective as of January 1, 2025, added provisions to allow for the increased catch-up limit for Participants who would reach age 60 but not age 64 by the end of the calendar year;

(ii) Effective as of January 1, 2026, as required under Code section 414(v)(7), added the requirement that catch-up contributions be classified as Roth Elective Deferrals for Participants whose wages for the preceding calendar year exceed $145,000 as adjusted by the IRS for cost-of-living increases; and

(iii) Effective as of January 1, 2026, added the allowed correction options for Code section 414(v)(7) failures.

Amendment to the Salinas Valley Memorial Healthcare System 403(b) Tax Deferred Salary Reduction Plan:

This amendment addresses the following changes:

(i) Effective as of January 1, 2025, added provisions to allow for the increased catch-up limit for Participants who would reach age 60 but not age 64 by the end of the calendar year;

(ii) Effective as of January 1, 2026, added provisions to allow Roth Elective Deferrals, Roth Rollovers, and In-Plan Roth Conversions;

(iii) Effective as of January 1, 2026, as required under Code section 414(v)(7), added the requirement that catch-up contributions be classified as Roth Elective Deferrals for Participants whose wages for the preceding calendar year exceed $145,000 as adjusted by the IRS for cost-of-living increases;

(iv) Effective as of January 1, 2026, added the allowed correction options for Code section 414(v)(7) failures; and

(v) Updated the current Providers under the Plan.

Amendment to the Salinas Valley Memorial Healthcare District 457(b) Retirement Plan:

This amendment addresses the following changes:

(i) Effective as of January 1, 2025, added provisions to allow for the increased catch-up limit for Participants who would reach age 60 but not age 64 by the end of the calendar year;

(ii) Effective as of January 1, 2026, added provisions to allow for Roth Deferred Compensation, Roth Rollovers, and In-Plan Roth Conversions;

(iii) Effective as of January 1, 2026, as required under Code section 414(v)(7), added the requirement that catch-up contributions be classified as Roth Deferred Compensation for Participants whose wages for the preceding calendar year exceed $145,000 as adjusted by the IRS for cost-of-living increases; and

(iv) Effective as of January 1, 2026, added the allowed correction options for Code section 414(v)(7) failures.

RECOMMENDATION

Request that the Board of SVMHS approve the attached Amendments to the Plans.

RESOLUTION NO. 2025-03
OF THE BOARD OF DIRECTORS OF
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

APPROVAL OF AMENDMENTS TO THE
403(b) RETIREMENT PLAN, 403(b) TAX DEFERRED SALARY REDUCTION PLAN
AND 457 DEFERRED COMPENSATION PLAN

WHEREAS, Salinas Valley Memorial Healthcare System is a public health care district organized and operated pursuant to Division 23 of the California Health and Safety Code ("District"); and

WHEREAS, the District's Board of Directors previously adopted the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan ("403(b) Retirement Plan"), the Salinas Valley Memorial Healthcare System 403(b) Tax Deferred Salary Reduction Plan ("403(b) TD Plan"), and the Salinas Valley Memorial Healthcare District 457 Deferred Compensation Plan ("457 Plan"), (collectively referred to as the "Plans"); and

WHEREAS, Internal Revenue Code section 414(v)(7) as added by the SECURE 2.0 Act of 2022 (SECURE 2.0) required that effective as of January 1, 2026, catch-up contributions for participants over age 50 in a calendar year must be Roth after-tax contributions for employees with more than $145,000 of FICA wages in the previous calendar year; and

WHEREAS, the District's Board of Directors has been advised that the Plan must be amended to comply with certain provisions of SECURE 2.0 to continue to provide age based catch-up contributions under the Plans for certain high-earner participants; and

WHEREAS, the 403(b) TD Plan and the 457 Plan do not currently provide Roth after-tax contributions and certain high earner participants will no longer be able to make age-based catch-up contributions to these plans unless Roth after-tax contributions are added to the plans; and

WHEREAS, effective as of January 1, 2025, SECURE 2.0 further provided for increased catch-up contributions for participants who reach age 60 but not age 64 in a calendar year.

NOW, THEREFORE, BE IT RESOLVED, ORDERED AND DIRECTED THAT:

1. The 403(b) Retirement Plan shall be amended to:

   (i) Effective as of January 1, 2025, allow for the increased catch-up limit for Participants who would reach age 60 but not age 64 by the end of the calendar year;

   (ii) Effective as of January 1, 2026, require that catch-up contributions be deemed Roth after-tax elective deferrals for Participants whose wages for the preceding calendar year exceed $145,000 as adjusted by the IRS for cost-of-living increases; and

   (iii) Effective as of January 1, 2026, add the allowed correction options for Code section 414(v)(7) failures.

2. The 403(b) TD Plan shall be amended to:

   (i) Effective as of January 1, 2025, allow for the increased catch-up limit for Participants who would reach age 60 but not age 64 by the end of the calendar year;

   (ii) Effective as of January 1, 2026, allow Roth Elective Deferrals, Roth Rollovers, and In-Plan Roth Conversions;

   (iii) Effective as of January 1, 2026, require that catch-up contributions be deemed Roth after-tax elective deferrals for Participants whose wages for the preceding calendar year exceed $145,000 as adjusted by the IRS for cost-of-living increases;

   (iv) Effective as of January 1, 2026, add the allowed correction options for Code section 414(v)(7) failures; and

   (v) Update the current Providers under the Plan.

3. The 457 Plan shall be amended to:

   (i) Effective as of January 1, 2025, allow for the increased catch-up limit for Participants who would reach age 60 but not age 64 by the end of the calendar year;

   (ii) Effective as of January 1, 2026, allow for Roth Deferred Compensation, Roth Rollovers, and In-Plan Roth Conversions;

   (iii) Effective as of January 1, 2026, require that catch-up contributions be deemed Roth after-tax deferred compensation for Participants whose wages for the preceding calendar year exceed $145,000 as adjusted by the IRS for cost-of-living increases; and

   (iv) Effective as of January 1, 2026, add the allowed correction options for Code section 414(v)(7) failures.

4. The President and Secretary of the Board of Directors of the District are authorized to execute any and all amendments and documents and to take any and all other actions deemed necessary or appropriate to effectuate the intent of this Resolution, including notifying employees of the District of the adoption of amendments to the Plans.

This Resolution was adopted at a Regular Meeting of the Board of Directors of the District on November ___, 2025, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

_____
Board Secretary
Salinas Valley Memorial Healthcare System

AMENDMENT TO THE
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
403(b) RETIREMENT PLAN

This Amendment (Amendment) to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan (Plan) is adopted by the Salinas Valley Memorial Healthcare System (Employer), to be effective as set forth below.

RECITALS

A. The Employer adopted the Plan, effective as of June 1, 2011.

B. The Employer now wishes to amend the Plan to add the following Plan provisions:

(i) As required under Code section 414(v)(7), the classification of catch-up contributions as Roth Elective Contributions for Participants whose wages as defined in Code section 3121(a) for the preceding calendar year from the Employer exceed one hundred forty-five thousand dollars ($145,000) as adjusted for cost-of-living increases;

(ii) The correction options for Code section 414(v)(7) failures; and

(iii) The increased catch-up limit for Participants who would attain age sixty (60) but not age sixty-four (64) by the end of a calendar year.

OPERATIVE PROVISIONS

Now, therefore, the Employer hereby amends the Plan, effective as of January 1, 2026, except as otherwise indicated, as follows:

1. Subsection D, "Age Fifty Catch-Up Contributions," of section 4.01, "Employer Contributions – Elective Contributions," is amended in its entirety to read as follows:

D. Catch-Up Contributions.

1. Each Participant who would attain age fifty (50) by the end of the calendar year shall be eligible to make catch-up contributions up to the dollar amount in effect under Code section 414(v)(2)(B)(i).

2. Effective as of January 1, 2025, each Participant who would attain age sixty (60) but does not attain age sixty-four (64) before the end of the calendar year shall be eligible to make catch-up contributions up to the greater of (i) ten thousand dollars ($10,000) or one hundred fifty percent (150%) of the dollar amount in effect under Code section 414(v)(2)(B)(i).

3. In accordance with the requirements of Code section 414(v)(7) and the Treasury Regulations thereunder, a Participant whose wages, as defined in Code section 3121(a) for the preceding calendar year from the Employer, exceed one hundred forty five thousand dollars ($145,000) as adjusted for cost of living increases, is deemed to have irrevocably designated any Elective Contributions that are catch-up contributions under this subsection D as Roth Elective Contributions, not excludable from the Participant's gross income and held in the Participant's Roth Elective Account. If the Participant's wages are determined to exceed the above-wage limitation, the Employer shall provide the Participant with an effective opportunity to make a new election that is different than the deemed election.

4. If a Participant who is subject to the requirements of paragraph 3, above, has made any Roth Elective Contributions during the calendar year, such Roth Elective Contributions may be included to satisfy the requirements of Code section 414(v)(7).

5. In addition, any catch-up eligible Participant may elect to have catch-up contributions be Roth Elective Contributions.

6. Catch-up contributions shall not be taken into account for purposes of the provisions of this Plan implementing the requirements of Code section 402(g) or Code section 415.

2. Article 6, "Limitations On Contributions And Benefits," is amended by adding the following Section 6.05, "Correction Of Code Section 414(v)(7) Failure," at the end of the Article to read as follows:

6.05 <u>Correction Of Code Section 414(v)(7) Failure</u>.

A. If an Elective Contribution fails to be a catch-up contribution under Code section 414(v)(1) because the Pre-Tax Elective Contribution is not designated as a Roth Elective Contribution in accordance

with the requirements of Code section 414(v)(7), the failure may be corrected in accordance with one of the following two methods:

1. Transferring the catch-up contribution (adjusted for earnings and losses in accordance with Treasury Regulations section 1.402(g)-1(e)(5)) from the Participant's Pre-Tax Elective Account to the Participant's Roth Elective Account and reporting the contribution (not adjusted for earnings and losses) as an Elective Contribution that is a designated Roth Elective Contribution on the Participant's Form W-2 for the calendar year in which the Pre-Tax Elective Contribution was originally excluded from the Participant's gross income. However, this correction may be used only if the Participant's Form W-2 for that Plan Year has not been filed or furnished to the Participant.

2 Directly rolling over the Elective Contribution that would be catch-up contributions as if they had been designated Roth Elective Contributions (adjusted for earnings and losses in accordance with Treasury Regulations section 1.402(g)-1(e)(5)) from the Participant's Pre-Tax Elective Account to the Participant's In-Plan Roth Conversion Account and reporting the direct rollover on Form 1099-R for the calendar year of the rollover.

B. The same correction method under subsection A must apply for similarly situated Participants, and the selection of which correction will apply may not be based on the investment returns earned in Participants' Accounts.

C. To use the correction methods in subsection A, the Employer must have in place practices and procedures to result in compliance with Code section 414(v)(7) at the time the Elective Contribution is made.

D. If the amount of the Participant's Pre-Tax Elective Contribution that was required to be designated as a Roth Elective Contribution does not exceed two-hundred fifty dollars ($250) the Code section 414(v)(7) failure is not required to be corrected, and the Pre-Tax Elective Contribution is treated as a catch-up contribution under Code section 414(v).

3. All Plan references to the "Age-Fifty Catch-Up Contributions section," are changed to "Catch-Up Contributions section."

All other provisions of the Plan as in effect prior to this Amendment shall remain unchanged by this Amendment.

Executed this _____ day of _____, 2025.

SALINAS VALLEY MEMORIAL
HEALTHCARE SYSTEM

By: _____

Title: _____

AMENDMENT TO THE
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
403(b) TAX DEFERRED SALARY REDUCTION PLAN

This Amendment (Amendment) to the Salinas Valley Memorial Healthcare System 403(b) Tax Deferred Salary Reduction (Plan) is adopted by the Salinas Valley Memorial Healthcare System (Employer), to be effective as set forth below.

RECITALS

A. The Employer has previously established a retirement plan pursuant to section 403(b) of the Internal Revenue Code of 1986, as amended (Code), under which its eligible employees may defer a portion of their compensation pursuant to a cash or deferred arrangement.

B. The Employer is a governmental employer under Code section 414(d) and also exempt from taxation under Code section 501(c)(3).

C. Effective as of January 1, 2009, the Employer established a written plan in the form and operation that satisfies Code section 403(b) and the Treasury regulations thereunder.

D. The Employer now wishes to amend the Plan to add the following Plan provisions:

(i) To allow for Roth Elective Contributions, Roth Rollovers, and In-Plan Roth Conversions;

(ii) As required under Code section 414(v)(7), the classification of catch-up contributions as Roth Elective Contributions for Participants whose wages as defined in Code section 3121(a) for the preceding calendar year from the Employer exceed one hundred forty-five thousand dollars ($145,000) as adjusted for cost-of-living increases;

(iii) The correction options for Code section 414(v)(7) failures; and

(iv) The increased catch-up limit for Participants who would attain age sixty (60) but not age sixty-four (64) by the end of a calendar year.

OPERATIVE PROVISIONS

Now, therefore, the Employer hereby amends the Plan, effective as of January 1, 2026, except as otherwise indicated, as follows:

1. Subsection A, "Elective Account," of section 2.01, "Account," is amended to read as follows:

A. Pre-Tax Elective Account.

"Pre-Tax Elective Account" means the account maintained by a Provider for a Participant representing Pre-Tax Elective Contributions, if any, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

2. Section 2.01, "Account," is amended by adding the following subsections C, D and E to the end of the section to read as follows:

C. Roth Elective Account.

"Roth Elective Account" means the account maintained by a Provider for a Participant representing Roth Elective Contributions, if any, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

D. Roth Rollover Account.

"Roth Rollover Account" means the account maintained by a Provider for a Participant representing rollover contributions from a Roth elective account of another plan in accordance with the Rollover Contributions section, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

E. In-Plan Roth Conversion Account.

"In-Plan Roth Conversion Account" means the account maintained by a Provider for a Participant representing the amounts, if any, that the Participant has converted to Roth contributions described in Code section 402A pursuant to the In-Plan Roth Conversions section, below, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

3. Paragraph 1, "Includible Compensation In General," of subsection B, "Includible Compensation," of section 2.05, "Compensation And Includible Compensation," is amended by adding the following at the end of the paragraph to read as follows:

Any Roth contribution as described in Code section 402A is includible in the gross income of the Employee.

4. Section 2.08, "Elective Deferrals," is amended by adding the following subsection F at the end of the section to read as follows:

F. Any Roth *contribution as described in Code section 402A.*

5. Article 2, "General Definitions," is amended by adding the following sections 2.25 and 2.26 at the end of the Article to read as follows:

2.25 Pre-Tax Elective Contributions.

"Pre-Tax Elective Contributions" means those contributions made to the Plan by the Employer that were subject to the cash or deferred election under the Employer Contributions – Elective Contributions section, below, and were not designated as Roth Elective Contributions.

2.26 Roth Elective Contributions.

"Roth Elective Contributions" means those contributions made to the Plan by the Employer that were subject to the cash or deferred election under the Employer Contributions – Roth Elective Contributions subsection, below.

6. Subsection D, "Age Fifty Catch-Up Contributions," of section 4.01, "Employer Contributions – Elective Contributions," is amended in its entirety to read as follows:

D. Age Based Catch-Up Contributions.

1. Each Participant who would attain age fifty (50) by the end of the calendar year shall be eligible to make catch-up contributions up to the dollar amount in effect under Code section 414(v)(2)(B)(i).

2. Effective as of January 1, 2025, each Participant who would attain age sixty (60) but does not attain age sixty-four (64) before the end of the calendar year shall be eligible to make catch-up contributions up to the greater of (i) ten thousand dollars ($10,000) or one hundred fifty percent (150%) of the dollar amount in effect under Code section 414(v)(2)(B)(i).

3. In accordance with the requirements of Code section 414(v)(7) and the Treasury Regulations thereunder, a Participant whose wages, as defined in Code section 3121(a) for the preceding calendar year from the Employer, exceed one hundred forty five thousand dollars ($145,000) as

adjusted for cost of living increases, is deemed to have irrevocably designated any Elective Contributions that are catch-up contributions under this subsection D as Roth Elective Contributions, not excludable from the Participant's gross income and held in the Participant's Roth Elective Account. If the Participant's wages are determined to exceed the above-wage limitation, the Employer shall provide the Participant with an effective opportunity to make a new election that is different than the deemed election.

4. *If a Participant who is subject to the requirements of paragraph 3, above, has made any Roth Elective Contributions during the calendar year, such Roth Elective Contributions may be included to satisfy the requirements of Code section 414(v)(7).*

5. *In addition, any catch-up eligible Participant may elect to have age based catch-up contributions be Roth Elective Contributions.*

6. *Age based catch-up contributions shall not be taken into account for purposes of the provisions of this Plan implementing the requirements of Code section 402(g) or Code section 415.*

7. *Any catch-up amount contributed for a Plan Year by a Participant who is eligible for both the age based catch-up contributions under this subsection D and the special Code section 403(b) catch-up contributions under the Special Code Section 403(b) Catch-Up Contributions subsection, below, is treated first as an amount contributed as a special Code section 403(b) catch-up to the extent a special Code section 403(b) catch-up is permitted and then as an amount contributed as a catch-up contribution under this subsection D to the extent permitted.*

7. Paragraph 5 of subsection E, "Special Code section 403(b) Catch-Up Contributions," of section 4.01, "Employer Contributions – Elective Contributions," is amended to read as follows:

5. Any catch-up amount contributed for a Plan Year by a Participant who is eligible for both the special Code section 403(b) catch-up under this subsection E and the age based catch-up contribution under the Age Based Catch-Up Contributions subsection above, is treated first as an amount contributed as a special Code section 403(b) catch-up to the extent a special Code section 403(b)

catch-up is permitted and then as an amount contributed under the Age Based Catch-Up Contributions section, above to the extent permitted.

8. Section 4.01, "Employer Contributions – Elective Contributions," is amended by adding the following subsection F to the end of the section to read as follows:

F. Roth Elective Contributions.

1. The Plan will accept Elective Contributions by the Employer that are Roth contributions described in Code section 402A (i.e., both (i) designated irrevocably by the Participant at the time of the cash or deferred election as a Roth Elective Contributions that is being made in lieu of all or a portion of the Pre-Tax Elective Contributions the Participant is otherwise eligible to make under the Plan, and (ii) treated by the Employer as includible in the Participant's income at the time the Participant would have received that amount in cash if the Participant had not made a cash or deferred election).

2. A Participant's Roth Elective Contributions will be allocated to the Participant's Roth Elective Account. No contributions other than Roth Elective Contributions and no earnings other than earnings on Roth Elective Contributions shall be credited to a Participant's Roth Elective Account.

3. Unless specifically stated otherwise, Roth Elective Contributions will be treated as Elective Contributions for all purposes under the Plan.

9. Section 4.02, "Rollover Contributions," is amended to read as follows:

4.02 Rollover Contributions.

A. To the extent provided in an Individual Agreement, there may be transferred to the Provider, subject to the approval of the Provider, by means of an Eligible Rollover Distribution, all or any of the assets held (whether by a trustee, custodian or otherwise) on behalf of an Eligible Retirement Plan that is maintained for the benefit of any person who is or is about to become a Participant in this Plan. Prior to accepting any such rollover contribution, the Provider may require that the Participant or Employee establish to the satisfaction of the Provider that the amount to be rolled over to the Plan is an Eligible Rollover Distribution from an Eligible Retirement Plan.

B. To the extent provided in an Individual Agreement, there may be transferred to the Provider, subject to the approval of the Provider, a direct rollover from another Roth elective deferral account under another plan as described in Code section 402A(e)(1); provided, however, that:

1. The rollover is permitted under the rules of Code section 402(c);

2. The other plan must provide to the Provider either (i) a statement indicating the first year of the five (5) taxable-year period described in Code section 402A(d)(2)(B) and the portion of the distribution that is attributable to investment in the contract under Code section 72 or (ii) a statement that the distribution is a qualified distribution as described in Code section 402A(d)(2); and

3. The direct rollover shall be held in the separate Roth Rollover Account.

10. Section 5.03, "Allocation Of Elective Contributions," is amended to read as follows:

5.03. Allocation Of Elective Contributions.

A. Pre-Tax Elective Contributions shall be allocated among the Pre-Tax Elective Accounts of those Participants making the election for a contribution to this Plan under the Employer Contributions – Elective Contributions section, above, in the amount so elected by each Participant. Pre-Tax Elective Contributions, if any, will be allocated as soon as administratively feasible following the last day of each payroll period during the Plan Year.

B. Roth Elective Contributions shall be allocated to the Roth Elective Accounts of those Participants electing to make Roth Elective Contributions to this Plan under the Employer Contributions – Elective Contributions section, above, in the amount so elected by each Participant. No contributions other than Roth Elective Contributions will be credited to a Participant's Roth Elective Account. Roth Elective Contributions, if any, will be allocated as soon as administratively feasible following the last day of each payroll period during the Plan Year.

11. Paragraph 5 of subsection C of section 6.04, "Maximum Amount Of Elective Deferrals," is amended to read as follows:

5. Notwithstanding any other provision of the Plan, Excess Elective Deferrals, plus any income and minus any loss also allocable thereto, shall be distributed no later than April 15 to any Participant to whose account Excess Elective Deferrals were assigned for the preceding year and who claims Excess Elective Deferrals for such taxable year. A Participant may designate the extent to which the distribution of the Excess Elective Deferrals is composed of Pre-Tax Elective Contributions and Roth Elective Contributions, but only to the extent such types of deferrals were made for the year. If a Participant does not designate which type of Elective Contributions is to be distributed, the Plan will distribute Pre-Tax Elective Contributions first.

12. Paragraph 7 of subsection C of section 6.04, "Maximum Amount Of Elective Deferrals," is amended to read as follows:

7. Excess Elective Deferrals that are distributed to the Participant for a taxable *year shall be adjusted for any income or loss up to the end of such taxable year. The income or loss allocable to Excess Elective Deferrals is determined as follows:*

a. Income or loss allocable to the Participant's Pre-Tax Elective Account for the taxable year shall be multiplied by a fraction, the numerator of which is such Participant's Excess Elective Deferrals for the taxable year attributable to the Participant's Pre-Tax Elective Contributions for the taxable year, as determined under paragraph 5, above, and the denominator of which is the sum of (i) the Participant's Pre-Tax Elective Account as of the beginning of the taxable year plus (ii) any additional Pre-Tax Elective Contributions for the taxable year;

b. Income or loss allocable to the Participant's Roth Elective Account for the taxable year shall be multiplied by a fraction, the numerator of which is such Participant's Excess Elective Deferrals for the taxable year attributable to the Participant's Roth Elective Contributions for the taxable year, as determined under paragraph 5, above, and the denominator of which is the sum of (i) the Participant's Roth Elective Account as of the beginning of the taxable year plus (ii) any additional Roth Elective Contributions for the taxable year; and

c. Income or loss allocable to the period between the end of the taxable year and the date of distribution shall be disregarded in determining income or loss.

13. Article 6, "Limitations On Contributions And Benefits," is amended by adding the following Section 6.05, "Correction Of Code Section 414(v)(7) Failure," at the end of the Article to read as follows:

6.05. Correction Of Code Section 414(v)(7) Failure.

A. If an Elective Contribution fails to be a catch-up contribution under Code section 414(v)(1) because the Pre-Tax Elective Contribution is not designated as a Roth Elective Contribution in accordance with the requirements of Code section 414(v)(7), the failure may be corrected in accordance with one of the following two methods:

1. Transferring the catch-up contribution (adjusted for earnings and losses in accordance with Treasury Regulations section 1.402(g)-1(e)(5)) from the Participant's Pre-Tax Elective Account to the Participant's Roth Elective Account and reporting the contribution (not adjusted for earnings and losses) as an Elective Contribution that is a designated Roth Elective Contribution on the Participant's Form W-2 for the calendar year in which the Pre-Tax Elective Contribution was originally excluded from the Participant's gross income. However, this correction may be used only if the Participant's Form W-2 for that Plan Year has not been filed or furnished to the Participant.

2 Directly rolling over the Elective Contribution that would be catch-up contributions as if they had been designated Roth Elective Contributions (adjusted for earnings and losses in accordance with Treasury Regulations section 1.402(g)-1(e)(5)) from the Participant's Pre-Tax Elective Account to the Participant's In-Plan Roth Conversion Account and reporting the direct rollover on Form 1099-R for the calendar year of the rollover.

B. The same correction method under subsection A must apply for similarly situated Participants, and the selection of which correction will apply may not be based on the investment returns earned in Participants' Accounts.

C. To use the correction methods in subsection A, the Employer must have in place practices and procedures to result in compliance with Code section 414(v)(7) at the time the Elective Contribution is made.

D. If the amount of the Participant's Pre-Tax Elective Contribution that was required to be designated as a Roth Elective Contribution does not exceed two-hundred fifty dollars ($250) the Code section 414(v)(7) failure is not required to be corrected, and the Pre-Tax Elective Contribution is treated as a catch-up contribution under Code section 414(v).

14. Section 7.01, "Full Vesting," is amended to read as follows:

A Participant shall be fully Vested at all times in the Participant's Pre-Tax Elective Account, Roth Elective Account, Rollover Account, Roth Rollover Account, and In-Plan Roth Conversion Account, if applicable.

15. Subsection E, "Eligible Rollover Distributions," of section 10.02, "Method Of Payment Of Benefits," is amended by adding the following paragraph 4 at the end of the subsections to read as follows:

4. Notwithstanding *any of the provisions of this Eligible Rollover Distributions subsection, a direct rollover of a distribution from a Roth Elective Account under the Plan will be made only to another Roth elective deferral account under an applicable retirement plan described in Code section 402A(e)(1) or to a Roth IRA (as defined below) and only to the extent the rollover is permitted under the rules of Code section 402(c). For purposes of this provision, a "Roth IRA" is defined as an individual retirement plan described in Code section 7701(a)(37) which is designated as a Roth IRA at the time of establishment in such manner as required by the Code and the regulations thereunder.*

16. Article 10, "Payment Of Benefits," is amended by adding the following section 10.10, "Distribution Of Designated Roth Accounts," to read as follows:

10.10. <u>Distributions Of Designated Roth Accounts</u>.

A. Any Qualified Distribution, as defined below, from a Participant's Roth Elective Account or Roth Rollover Account, other than a distribution of any excess deferral under Code section 402(g)(2), and any income on the excess deferral or

contribution, shall not be includible in such Participant's gross income.

B. A "Qualified Distribution" is a distribution in accordance with Code section 408A(d)(2)(A) (without regard to clause (iv) thereof). A payment or distribution from a Roth Elective Account or Roth Rollover Account shall not be treated as a qualified distribution if such payment or distribution is made within the five (5) taxable year period beginning with the earlier of

1. The first taxable year for which the individual made a Roth Elective Contribution to the Participant's Roth Elective Account under the Plan, or

2. If a rollover contribution was made to the Participant's Roth Rollover Account from a designated Roth account previously established for such individual under another applicable retirement plan, the first taxable year for which the individual made a designated Roth contribution to such previously established account.

17. Article 10, "Payment Of Benefits," is amended by adding new section 10.11, "In-Plan Roth Conversions," to read as follows:

10.11. <u>In-Plan Roth Conversions</u>.

A Participant may convert, in an "In-Plan Roth Conversion," any portion of the Participant's Account, other than a Roth Elective Account or Roth Rollover Account, to an In-Plan Roth Conversion Account pursuant to Code section 402A(c)(4) and the following:

A. This section shall apply to a deceased Participant's beneficiary if the beneficiary is the Participant's surviving spouse and to an alternate payee who is a spouse or a former spouse of the Participant, as if such an individual were the Participant.

B. A Participant loan may not be distributed as part of an In-Plan Roth Conversion.

C. A Participant must include in gross income the taxable amount of an In-Plan Roth Conversion in the taxable year when the conversion occurs.

D. The distribution restrictions normally applicable to a Participant's Roth Elective Account do not apply to the extent that the In-Plan Roth Conversion is from a contribution source that is not otherwise subject to the distribution restrictions applicable to a Participant's Roth Elective Account.

E. Any distribution restrictions that otherwise apply with respect to a specific contribution source will continue to apply if such contribution source is converted as part of an In-Plan Roth Conversion.

F. Any election to make an In-Plan Roth Conversion may not be changed after the In-Plan Roth Conversion is completed.

18. All Plan references to the "Age-Fifty Catch-Up Contributions," are changed to "Age Based Catch-Up Contributions."

19. The attachment to the Plan listing the Providers is revised to read as follows:

Providers to
The Salinas Valley Memorial Healthcare System
403(b) Tax Deferred Salary Reductions Plan

ASPire Financial Services
Corebridge Financial (formerly AIG Retirement Service-VALIC)
Lincoln National Life Insurance Company
Metropolitan Life Insurance Company
National Life Group
Security Benefit Group

All other provisions of the Plan as in effect prior to this Amendment shall remain unchanged by this Amendment.

Executed this _____ day of _____, 2025.

SALINAS VALLEY MEMORIAL
HEALTHCARE SYSTEM

By: _____

Title: _____

AMENDMENT TO THE
SALINAS VALLEY MEMORIAL HEALTHCARE DISTRICT
457(b) RETIREMENT PLAN

This Amendment (Amendment) to the Salinas Valley Memorial Healthcare District Section 457 Deferred Compensation Plan (Plan) is adopted by the Salinas Valley Memorial Healthcare System (Employer), to be effective as set forth below.

RECITALS

A. The Employer is a governmental employer that is an eligible employer within the meaning of section 457(e)(1)(A) of the Internal Revenue Code of 1986, as amended (Code).

B. As of July 1, 2005, the Employer established a deferred compensation plan that is an eligible deferred compensation plan pursuant to Code section 457(b), under which the Employer's eligible employee may defer a portion of their compensation.

C. The Employer now wishes to amend the Plan to add the following Plan provisions:

(i) To allow for Roth Deferred Compensation, Roth Rollovers, and In-Plan Roth Conversions;

(ii) As required under Code section 414(v)(7), the classification of catch-up contributions as Roth Deferred Compensation for Participants whose wages as defined in Code section 3121(a) for the preceding calendar year from the Employer exceed one hundred forty-five thousand dollars ($145,000) as adjusted for cost-of-living increases;

(iii) The correction options for Code section 414(v)(7) failures; and

(iv) The increased catch-up limit for Participants who would attain age sixty (60) but not age sixty-four (64) by the end of a calendar year.

OPERATIVE PROVISIONS

Now, therefore, the Employer hereby amends the Plan, effective as of January 1, 2026, except as otherwise indicated, as follows:

1. Subsection A, "Deferred Compensation Account," of section 2.01, "Account," is amended to read as follows:

A. *Pre-Tax Deferred Compensation Account.*

"Pre-Tax Deferred Compensation Account" means the account maintained by the investment provider for each Participant representing Pre-Tax Deferred Compensation, if any, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

2. Section 2.01, "Account," is amended by adding the following subsections C, D and E to the end of the section to read as follows:

C. *Roth Deferred Compensation Account.*

"Roth Deferred Compensation Account" means the account maintained by the investment provider for a Participant representing Roth Deferred Compensation, if any, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

D. *Roth Rollover Account.*

"Roth Rollover Account" means the account maintained by the investment provider for a Participant representing rollover contributions from a Roth elective account of another plan in accordance with the Rollover Contributions section, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

E. *In-Plan Roth Conversion Account.*

"In-Plan Roth Conversion Account" means the account maintained by the investment provider for a Participant representing the amounts, if any, that the Participant has converted to Roth contributions described in Code section 402A pursuant to the In-Plan Roth Conversions section, below, adjusted for withdrawals, income, expenses, and realized and unrealized gains and losses attributable thereto.

3. Paragraph 1, "Includible Compensation In General," of subsection B, "Includible Compensation," of section 2.05, "Compensation And Includible Compensation," is amended by adding the following at the end of the paragraph to read as follows:

Any Roth contribution as described in Code section 402A is includible in the gross income of the Employee.

4. Section 2.06, “Deferred Compensation,” is amended by adding the following at the end of the Section to read as follows:

Deferred Compensation could consist of Pre-Tax Deferred Compensation and Roth Deferred Compensation.

5. Article 2, "General Definitions," is amended by adding the following sections 2.26 and 2.27 at the end of the Article to read as follows:

2.26 Pre-Tax Deferred Compensation.

"Pre-Tax Deferred Compensation" means those contributions made to the Plan by the Employer that were subject to the cash or deferred election under the Employer Contributions – Deferred Compensation section, below, and were not designated as Roth Deferred Compensation.

2.27 Roth Deferred Compensation.

"Roth Deferred Compensation" means those contributions made to the Plan by the Employer that were subject to the cash or deferred election under the Roth Deferred Compensation subsection below.

6. Section 4.01, "Employer Contributions – Deferred Compensation," is amended by adding the following subsection D to the end of the section to read as follows:

D. Roth Deferred Compensation.

1. The Plan will accept Deferred Compensation by the Employer that are Roth contributions described in Code section 402A (i.e., both (i) designated irrevocably by the Participant at the time of the cash or deferred election as Roth Deferred Compensation that is being made in lieu of all or a portion of the Pre-Tax Deferred Compensation the Participant is otherwise eligible to make under the Plan, and (ii) treated by the Employer as includible in the Participant's income at the time the Participant would have received that amount in cash if the Participant had not made a cash or deferred election).

2. A Participant's Roth Deferred Compensation will be allocated to the Participant's Roth Deferred Compensation Account. No contributions other than Roth Deferred Compensation and no earnings other than earnings on Roth

Deferred Compensation shall be credited to a Participant's Roth Deferred Compensation Account.

3. Unless specifically stated otherwise, Roth Deferred Compensation will be treated as Deferred Compensation for all purposes under the Plan.

7. Section 4.02, "Rollover Contributions," is amended to read as follows:

4.02 Rollover Contributions.

A. There may be transferred to the Trustee, subject to the approval of the Trustee, and, if deemed advisable by the Administrator by means of an Eligible Rollover Distribution, all or any of the assets held (whether by a trustee, custodian or otherwise) on behalf of an Eligible Retirement Plan that is maintained for the benefit of any person who is or is about to become a Participant in this Plan. Prior to accepting any such rollover contribution, the Administrator may require that the Participant or Employee establish to the satisfaction of the Administrator that the amount to be rolled over to the Plan is an Eligible Rollover Distribution from an Eligible Retirement Plan.

B. This Plan will accept a direct rollover from another Roth elective deferral account under another plan as described in Code section 402A(e)(1); provided, however, that:

1. The rollover is permitted under the rules of Code section 402(c);

2. The other plan must provide to the Administrator either (i) a statement indicating the first year of the five (5) taxable-year period described in Code section 402A(d)(2)(B) and the portion of the distribution that is attributable to investment in the contract under Code section 72 or (ii) a statement that the distribution is a qualified distribution as described in Code section 402A(d)(2); and

3. The direct rollover shall be held in the separate Roth Rollover Account.

8. Section 5.03, "Allocation Of Deferred Compensation," is amended to read as follows:

5.03. Allocation Of Deferred Compensation.

A. Pre-Tax Deferred Compensation shall be allocated among the Pre-Tax Deferred Compensation Accounts of those Participants making the election for a contribution to this Plan under the Employer Contributions – Deferred Compensation section, above, in the amount so elected by each Participant. Pre-Tax Deferred Compensation, if any, will be allocated as soon as administratively feasible following the last day of each payroll period during the Plan Year.

B. Roth Deferred Compensation shall be allocated to the Roth Deferred Compensation Accounts of those Participants electing to make Roth Deferred Compensation to this Plan under the Employer Contributions – Deferred Compensation section, above, in the amount so elected by each Participant. No contributions other than Roth Deferred Compensation will be credited to a Participant's Roth Deferred Compensation Account. Roth Deferred Compensation, if any, will be allocated as soon as administratively feasible following the last day of each payroll period during the Plan Year.

9. Section 6.03, “Limitations – Age Fifty Catch-Up Contributions,” is amended to read as follows:

6.03. Limitations – Catch-Up Contributions.

A. If a Participant (i) would be at least age fifty (50) by the end of a calendar year and (ii) cannot make any other elective deferral, as defined in Code section 414(u)(2)(C), for the year by reason of any limitation or restriction set forth in Code section 414(v)(3) or comparable limitation or restriction contained in the Plan, the Participant may defer additional Deferred Compensation in excess of the limitation specified in the Limitations In General section, above, not in excess of the lesser of:

1. Seven thousand five hundred dollars ($7,500) or such larger amount as may be permitted by the Secretary of the Treasury pursuant to Code section 414(v)(2)(C); or

2. *The excess (if any) of (i) one hundred percent (100%) of the Participant's Includible Compensation for the year over (ii) any other elective deferrals, as defined in Code section 414(u)(2)(C), for the year that is made without regard to Code section 414(v).*

B. *Effective as of January 1, 2025, each Participant who would attain age sixty (60) but does not attain age sixty-four (64) before the end of the calendar year shall be eligible to make catch-up contributions up to the greater of (i) ten thousand dollars ($10,000) or one hundred fifty percent (150%) of the dollar amount in effect under Code section 414(v)(2)(B)(i).*

C. *In accordance with the requirements of Code section 414(v)(7) and the Treasury Regulations thereunder, a Participant whose wages, as defined in Code section 3121(a) for the preceding calendar year from the Employer, exceed one hundred forty five thousand dollars ($145,000) as adjusted for cost of living increases, is deemed to have irrevocably designated any Pre-Tax Deferred Compensation that are catch-up contributions under this Limitations – Catch-Up Contributions section as Roth Deferred Compensation, not excludable from the Participant's gross income and held in the Participant's Roth Deferred Compensation Account. If the Participant's wages are determined to exceed the above-wage limitation, the Employer shall provide the Participant with an effective opportunity to make a new election that is different than the deemed election.*

D. *If a Participant who is subject to the requirements of subsection C, above, has made any Roth Deferred Compensation during the calendar year, such Roth Deferred Compensation may be included to satisfy the requirements of Code section 414(v)(7).*

E. *In addition, any catch-up eligible Participant may elect to have catch-up contributions be Roth Deferred Compensation.*

F. *Catch-up contributions shall not be taken into account for purposes of the provisions of this Plan implementing the requirements of Code section 457(e)(15).*

G. Notwithstanding the above, the provisions of this section shall not apply if (i) the limitations under the Limitations – Last Three Years Of Participation section, above, apply to the Participant for the year and (ii) the sum of the Participant's limitations under the Limitations In General section, above, and this Limitations – Catch-Up Contributions section do not exceed the limitation under the Limitations – Last Three Years Of Participation section, above.

10. Subsection B of section 6.04, "Distribution Of Excess Deferred Compensation," is amended by adding the following paragraph 4 at the end to read as follows:

4. A Participant may designate the extent to which the distribution of the Excess Deferred Compensation is composed of Pre-Tax Deferred Compensation and Roth Deferred Compensation, but only to the extent such types of deferred compensation were made for the year. If a Participant does not designate which type of Deferred Compensation is to be distributed, the Plan will distribute Pre-Tax Deferred Compensation first.

11. Article 6, "Limitations On Contributions And Benefits," is amended by adding the following Section 6.05, "Correction Of Code Section 414(v)(7) Failure," at the end of the Article to read as follows:

6.05 Correction *Of Code Section 414(v)(7) Failure*.

A. If elective Deferred Compensation fails to be a catch-up contribution under Code section 414(v)(1) because the Pre-Tax Deferred Compensation is not designated as a Roth Deferred Compensation in accordance with the requirements of Code section 414(v)(7), the failure may be corrected in accordance with one of the following two (2) methods:

1. Transferring the catch-up contribution (adjusted for earnings and losses in accordance with Treasury Regulations section 1.402(g)-1(e)(5)) from the Participant's Pre-Tax Deferred Compensation Account to the Participant's Roth Deferred Compensation Account and reporting the contribution (not adjusted for earnings and losses) as Deferred Compensation that is designated Roth Deferred Compensation on the Participant's Form W-2 for the calendar year in which the Pre-Tax

Deferred Compensation was originally excluded from the Participant's gross income. However, this correction may be used only if the Participant's Form W-2 for that Plan Year has not been filed or furnished to the Participant.

2 Directly rolling over the Deferred Compensation that would be catch-up contributions as if they had been designated Roth Deferred Compensation (adjusted for earnings and losses in accordance with Treasury Regulations section 1.402(g)-1(e)(5)) from the Participant's Pre-Tax Deferred Compensation Account to the Participant's In-Plan Roth Conversion Account and reporting the direct rollover on Form 1099-R for the calendar year of the rollover.

B. The same correction method under subsection A must apply for similarly situated Participants, and the selection of which correction will apply may not be based on the investment returns earned in Participants' Accounts.

C. To use the correction methods in subsection A, the Employer must have in place practices and procedures to result in compliance with Code section 414(v)(7) at the time the Deferred Compensation is made.

D. If the amount of the Participant's Pre-Tax Deferred Compensation that was required to be designated as a Roth Deferred Compensation does not exceed two-hundred fifty dollars ($250), the Code section 414(v)(7) failure is not required to be corrected, and the Pre-Tax Deferred Compensation is treated as a catch-up contribution under Code section 414(v).

12. Subsection D, "Eligible Rollover Distributions," of section 10.02, "Method Of Payment Of Benefits," is amended by adding the following paragraph 4 at the end of the subsections to read as follows:

4. Notwithstanding any of the provisions of this Eligible Rollover Distributions subsection, a direct rollover of a distribution from a Roth Deferred Compensation Account under the Plan will be made only to another Roth elective deferral account under an applicable retirement plan described in Code section 402A(e)(1) or to a Roth IRA (as defined below) and only to the extent the rollover is permitted under the rules of Code section 402(c). For purposes of this provision, a "Roth IRA" is defined as an individual retirement

plan described in Code section 7701(a)(37) which is designated as a Roth IRA at the time of establishment in such manner as required by the Code and the regulations thereunder.

13. Article 10, "Payment Of Benefits," is amended by adding the following section 10.13, "Distribution Of Designated Roth Accounts," to read as follows:

10.13. Distributions Of Designated Roth Accounts.

A. Any Qualified Distribution, as defined below, from a Participant's Roth Deferred Compensation Account or Roth Rollover Account, other than a distribution of any excess deferred compensation under Code section 402(g)(2), and any income on the excess deferred compensation, shall not be includible in such Participant's gross income.

B. A "Qualified Distribution" is a distribution in accordance with Code section 408A(d)(2)(A) (without regard to clause (iv) thereof). A payment or distribution from a Roth Deferred Compensation Account or Roth Rollover Account shall not be treated as a qualified distribution if such payment or distribution is made within the five (5) taxable-year period beginning with the earlier of

1. The first taxable year for which the individual made Roth Deferred Compensation to the Participant's Roth Deferred Compensation Account under the Plan, or

2. If a rollover contribution was made to the Participant's Roth Rollover Account from a designated Roth account previously established for such individual under another applicable retirement plan, the first taxable year for which the individual made a designated Roth contribution to such previously established account.

14. Article 10, "Payment Of Benefits," is amended by adding new section 10.14, "In-Plan Roth Conversions," to read as follows:

10.14 In-Plan Roth Conversions.

A Participant may convert, in an "In-Plan Roth Conversion," any portion of the Participant's Account, other than a Roth Deferred Compensation Account or Roth Rollover Account, to an In-Plan

Roth Conversion Account pursuant to Code section 402A(c)(4) and the following:

A. This section shall apply to a deceased Participant's beneficiary if the beneficiary is the Participant's surviving spouse and to an alternate payee who is a spouse or a former spouse of the Participant, as if such an individual were the Participant.

B. A Participant loan may not be distributed as part of an In-Plan Roth Conversion.

C. A Participant must include in gross income the taxable amount of an In-Plan Roth Conversion in the taxable year when the conversion occurs.

D. The distribution restrictions normally applicable to a Participant's Roth Deferred Compensation Account do not apply to the extent that the In-Plan Roth Conversion is from a contribution source that is not otherwise subject to the distribution restrictions applicable to a Participant's Roth Deferred Compensation Account.

E. Any distribution restrictions that otherwise apply with respect to a specific contribution source will continue to apply if such contribution source is converted as part of an In-Plan Roth Conversion.

F. Any election to make an In-Plan Roth Conversion may not be changed after the In-Plan Roth Conversion is completed.

15. All Plan references to “Age-Fifty Catch-Up Contributions,” are changed to “Catch-Up Contributions.”

All other provisions of the Plan as in effect prior to this Amendment shall remain unchanged by this Amendment.

Executed this _____ day of _____, 2025.

SALINAS VALLEY MEMORIAL
HEALTHCARE SYSTEM

By: _____

Title: _____

SVH Defined Contribution Plans

Personnel, Pension, and Investment Committee

November 10, 2025

Retirement Plans

Plan	Administrator	Eligible Participants	Employer Contribution
SVMHS 403(b) Retirement Plan	Transamerica	• Employees not affiliated with a union (Non-affiliated) • ESC-Local 20	• Basic (5%) • Matching (3-8%)
SVMHS 403(b) Tax Deferred Salary Reduction Plan	Omni/TSA	• CNA • Local 39 • NUHW	N/A
457(b) Retirement Plan	Transamerica Omni/TSA	As differentiated above per administrator	N/A
Salinas Valley Memorial Healthcare District Employees Pension Plan	Transamerica	• CNA • NUHW	Classic: 100% PEPRA: 50% *(employee contributes 50% of normal cost)*

Plan Changes

WHY

- Secure Act 2.0
- Provide maximum deferral opportunity

WHAT

- Add Roth (post-tax)
- Increased Contributions: Age 60 but not age 64
- Roth Elective Deferrals for high income earners' ($145K +) catch up contributions
- Correction Procedures

Communication

- Benefits Fair
- Newsletter
- Individual notification to High Income Earners
- STAR News

FINANCE COMMITTEE

Minutes of the Finance Committee
will be distributed at the Board Meeting

(VICTOR REY, JR.)

Financial Performance Review

September 2025

Finance Committee

Iftikhar Hussain

Chief Financial Officer

Consolidated Financial Results
September 2025

Month				$ in Millions	YTD			
		Variance fav (unfav)					Variance fav (unfav)	
Actual	Budget	$	%		Actual	Budget	$	%
$ 70.3	$ 68.5	$ 1.8	2.6%	Operating Revenue	$ 215.5	$ 208.3	$ 7.2	3.5%
67.5	67.1	(0.4)	-0.6%	Operating Expense	206.9	203.5	(3.4)	-1.7%
2.8	**1.4**	**1.4**	**100.0%**	**Income from Operations**	**8.6**	**4.8**	**3.8**	**79.2%**
3.9%	*2.1%*	*1.8%*	*85.71%*	*Operating Margin %*	*4.0%*	*2.3%*	*1.7%*	*73.9%*
				Op. margin % full year target		*3.0%*		
1.7	2.5	(0.8)	-32.0%	Non Operating Income	8.6	7.4	1.2	16.2%
4.5	**3.9**	**0.6**	**15.4%**	**Net Income**	**17.2**	**12.2**	**5.0**	**41.0%**
6.3%	*5.7%*	*0.6%*	*10.5%*	*Net Income Margin %*	*8.0%*	*5.9%*	*2.1%*	*35.6%*

No Normalizing Items

Key Financial Indicators

Indicator Metric		YTD 9/30/2025	Budget	S&P A+ Rated	YTD Prior Year
Operating Margin*		4.0%	0.4%	4.0%	2.9%
Total Margin*		8.0%	4.0%	6.6%	12.4%
EBITDA Margin**		8.0%	5.4%	13.6%	7.4%
Days of Cash*		373	317	249	368
Days of Accounts Payable*		44	45	-	45
Days of Net Accounts Receivable***		67	60	49	65
Supply Expense as % NPR		14.8%	14.6%	-	14.4%
SWB Expense as % NPR		51.7%	54.1%	53.7%	53.1%
Operating Expense per APD*		7,505	7,205	-	6,712

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)

Volume Summary – September 2025

Sept Act	Sept Bud	Variance	Key Statistics	YTD Sept	YTD Sept Bud	Variance2
			Inpatient			
96	114	-16%	ADC	101	114	-11%
883	901	-2%	Admissions	2,731	2,764	-1%
107	126	-15%	Deliveries	324	387	-16%
2.1	2.3	-9%	Medicare Traditional ALOS CMI Adjusted	2.0	2.3	-13%
1.70	1.75	-3%	Medicare Traditional Case Mix	1.76	1.75	1%
			Emergency Room			
4,545	4,503	1%	ER OP Visits	13,502	13,810	-2%
688	695	-1%	ER IP Admissions	2,110	2,132	-1%
			Procedures			
154	141	9%	IP Surgeries	473	433	9%
311	283	10%	OP Surgeries	978	869	13%
334	323	3%	Cath Lab	967	990	-2%
1,212	1,121	8%	OP Infusion Cases	3,886	3,437	13%
340	392	-13%	MRI Procedures	944	1,201	-21%
2,246	2,098	7%	CT Scans	6,448	6,434	0%
			Observation Cases			
208	148	41%	Obs Cases	616	453	36%

Executive Summary: September Financial Performance

Salinas Valley Health's Income from Operations was $2.8 million for the month which was favorable to budget by $1.4M due to strong payor mix and outpatient volume

Volume and Acuity:

- **Admissions and Census**
  - **Admissions** were under budget by 2% (18 cases)
  - ADC was 16% below budget due to lower length of stay
  - **Average Length of Stay** was 17% favorable to budget at 3.3 days
  - **Medicare Case Mix Adjusted Average Length of Stay** was favorable by 17% at 2.0 days
- **All Payor Case Mix** of 1.59 was 2% over budget
- **Surgeries** were over budget by 9% (13 cases)
- **Deliveries** were under budget by 15% (19 cases)
- **Cath Lab** – cases were over budget by 4% (11 cases)
- **Outpatient Revenues -** favorable to budget by $5M (3%), Key services driving this variance were:
  - **OP Infusion Program -** cases were over budget by 8% (91 cases)
  - **OP Surgeries –** cases were over budget by 10% (28 cases)
  - **Observation cases** were over budget by 41% (60 cases)
- **MRI Procedures** were under budget by 13% (52 cases) but higher than prior year

5

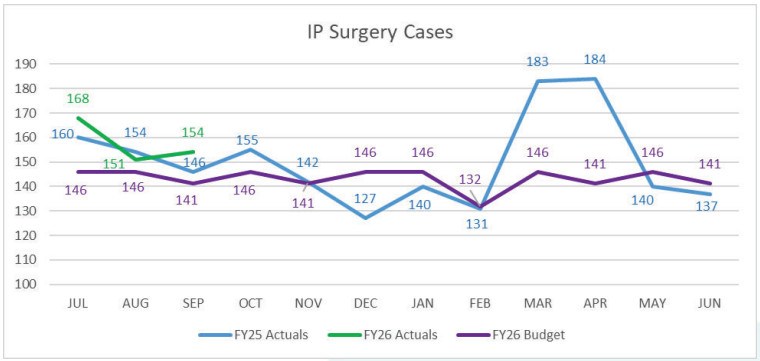
Executive Summary: September Financial Performance – Continued

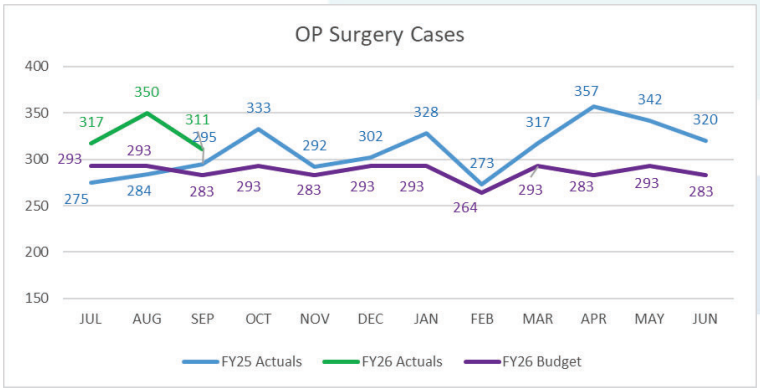
Cost and Utilization:

- **Paid FTEs per Adjusted ADC** were 11% unfavorable to budget at 8.6 actual vs. 7.8 budget due low ADC and EPIC preparation
- Worked FTEs on a per Adjusted ADC basis were **-15%** unfavorable at **7.4** - compared to a target of **6.4**
- **Payor Mix** was favorable with higher than expected Commercial revenue, up 9%. Medicare was down 7%; While Medi-Cal was over budget by 5%
- **Non-Operating Income** was under budget $0.8 Million driven by lower interest rates
- **Days in AR** at 67 is trending over target due to slow paying insurance providers
- **Days Cash on Hand** at 373 was up 3% from August due to favorable operating margin

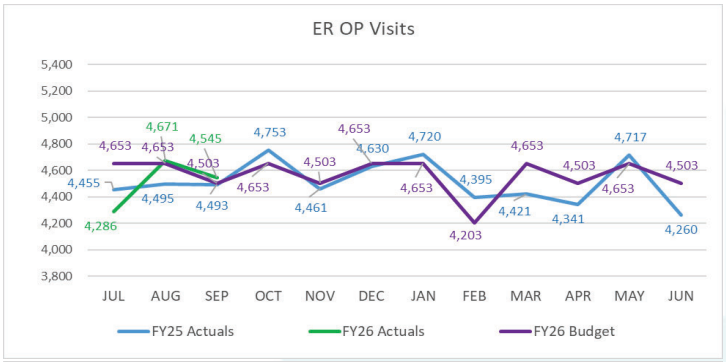
6

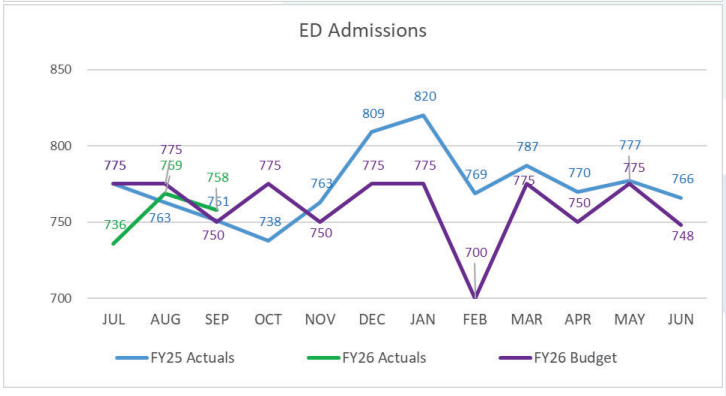
Volume Trends - Surgery Cases



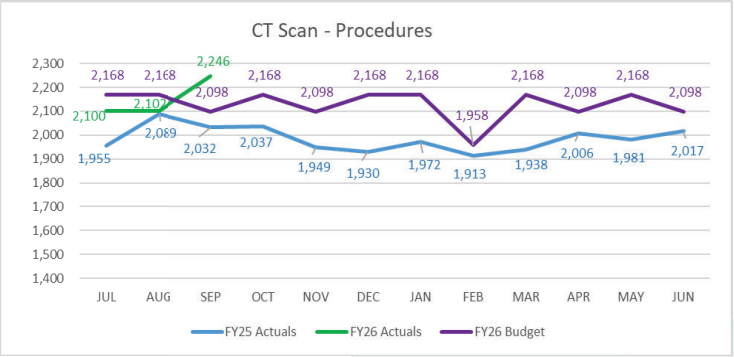


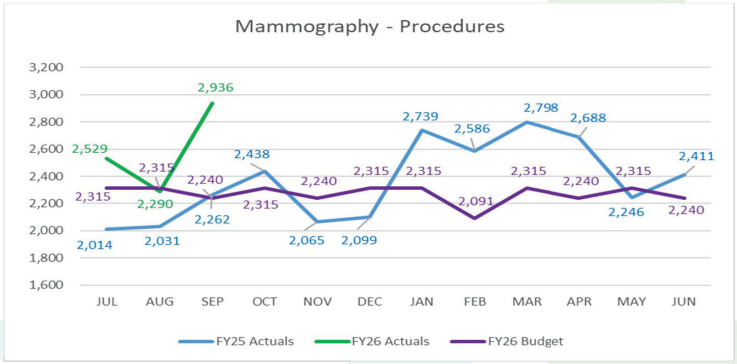
Volume Trends - ER Visits

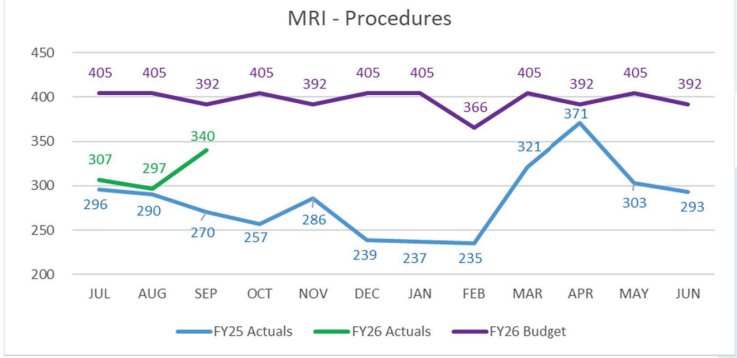




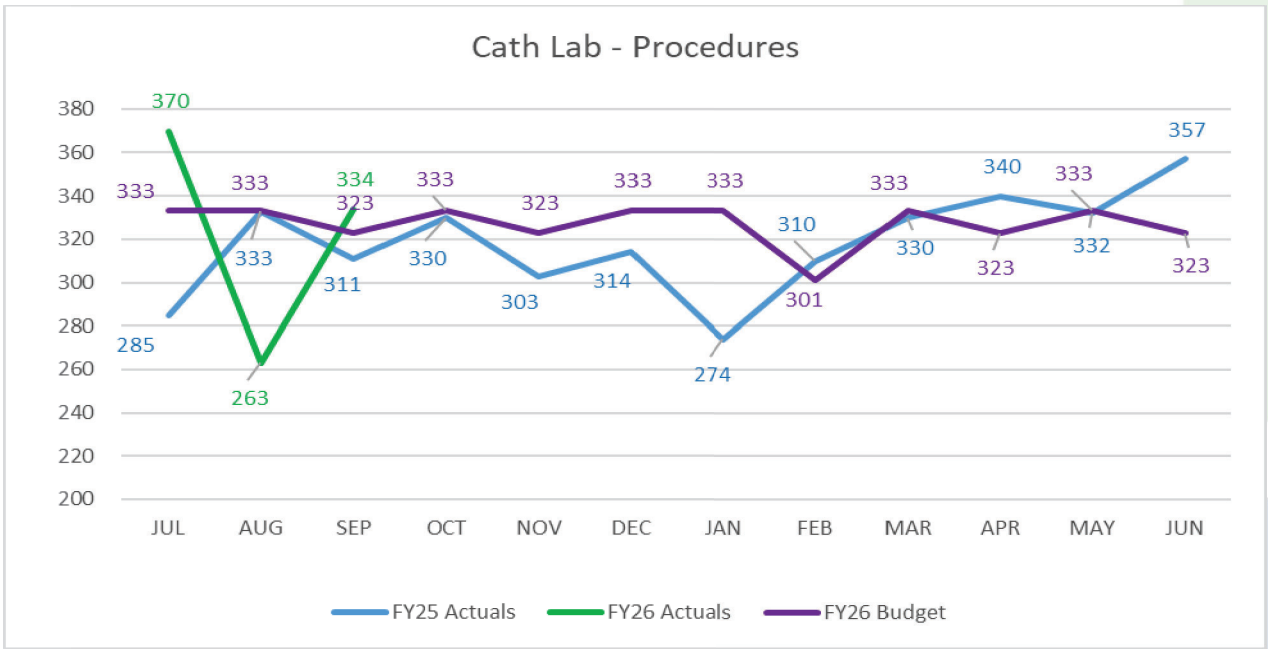
Volume Trends - Imaging



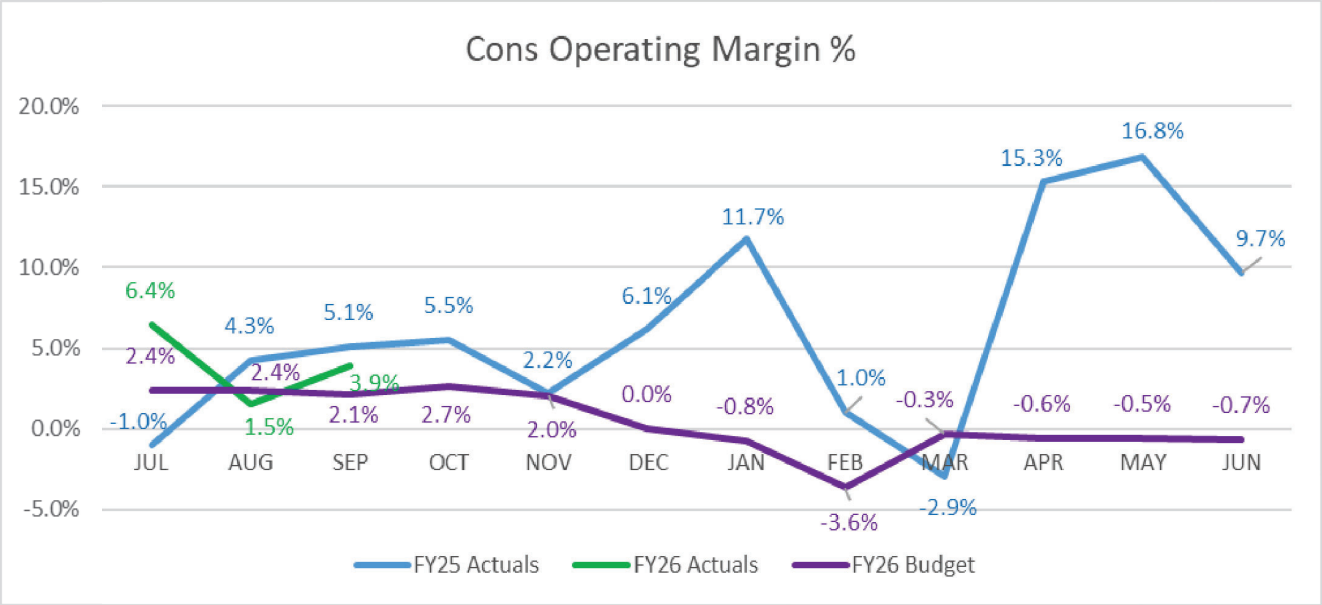




Volume Trends - Cath Lab

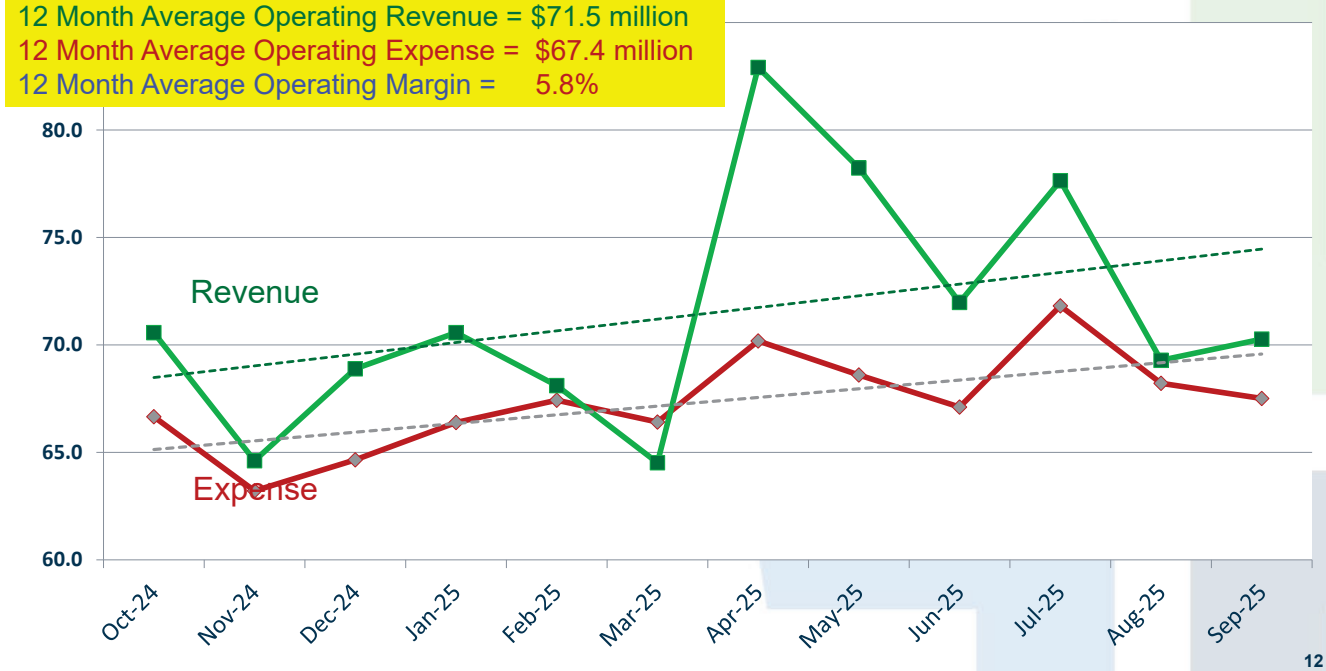


Consolidated Operating Margin

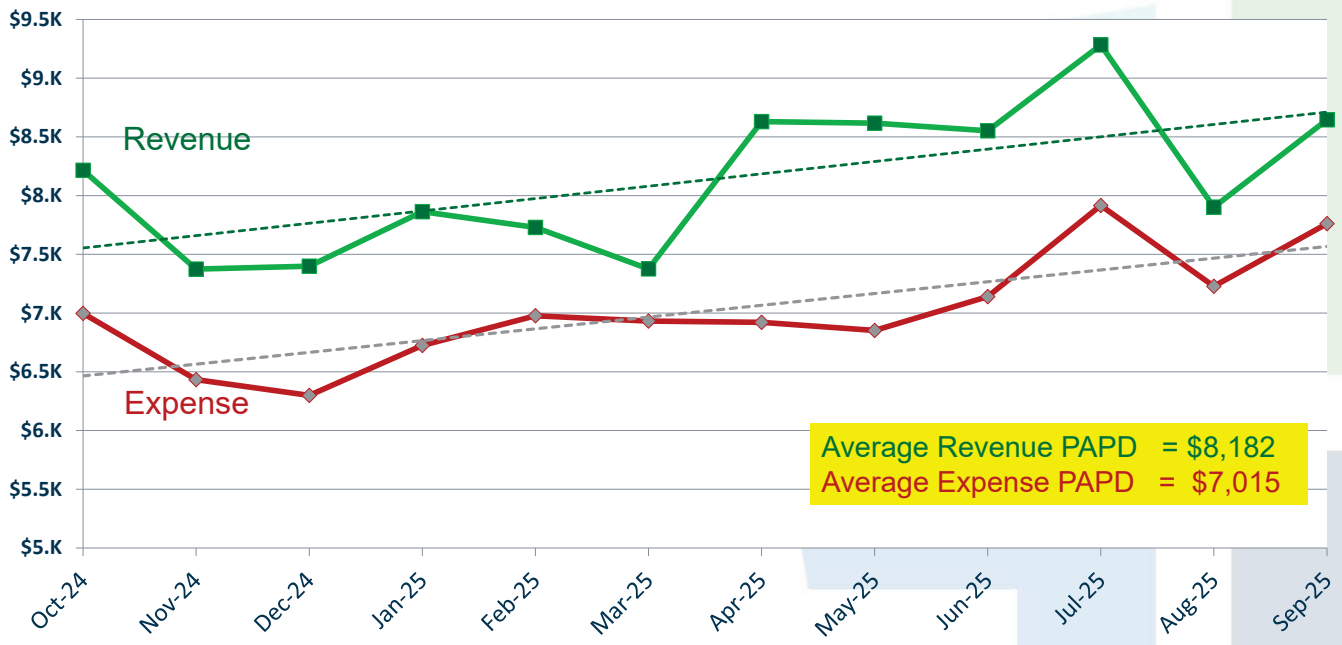


Consolidated Revenues & Expenses Rolling 12 Months: Oct 24 to September 25

12 Month Average Operating Revenue = $71.5 million
12 Month Average Operating Expense = $67.4 million
12 Month Average Operating Margin = 5.8%



Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Oct 24 to September 25

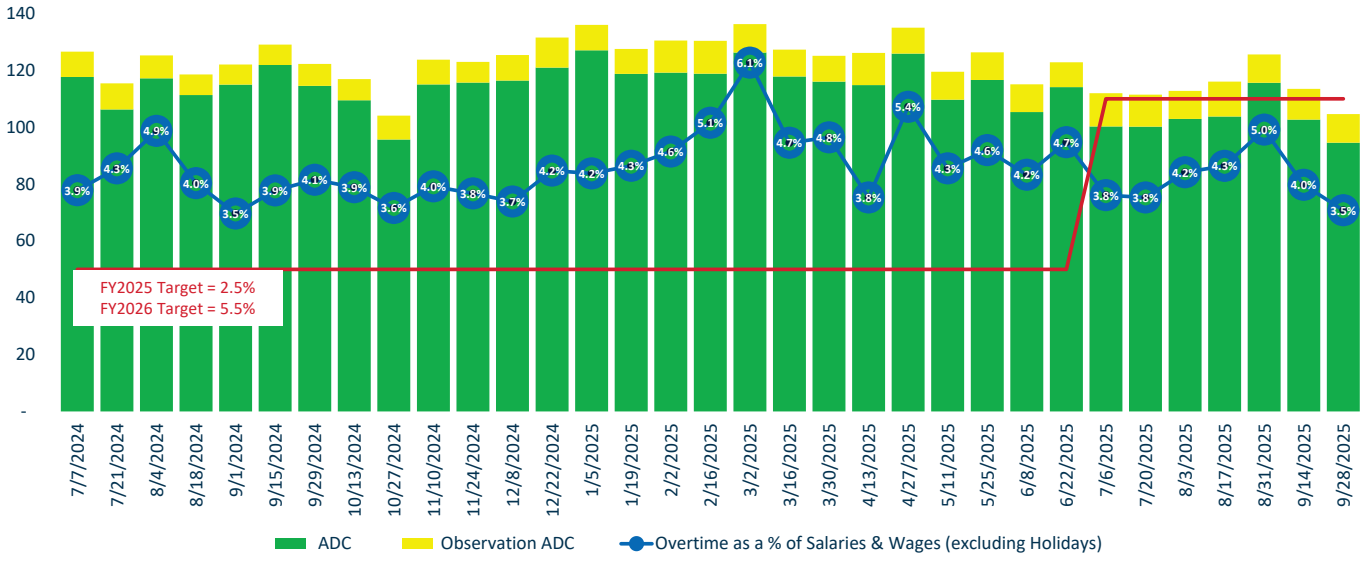


13

Overtime as a Percent of Total Salaries & Wages

(excluding Holidays)

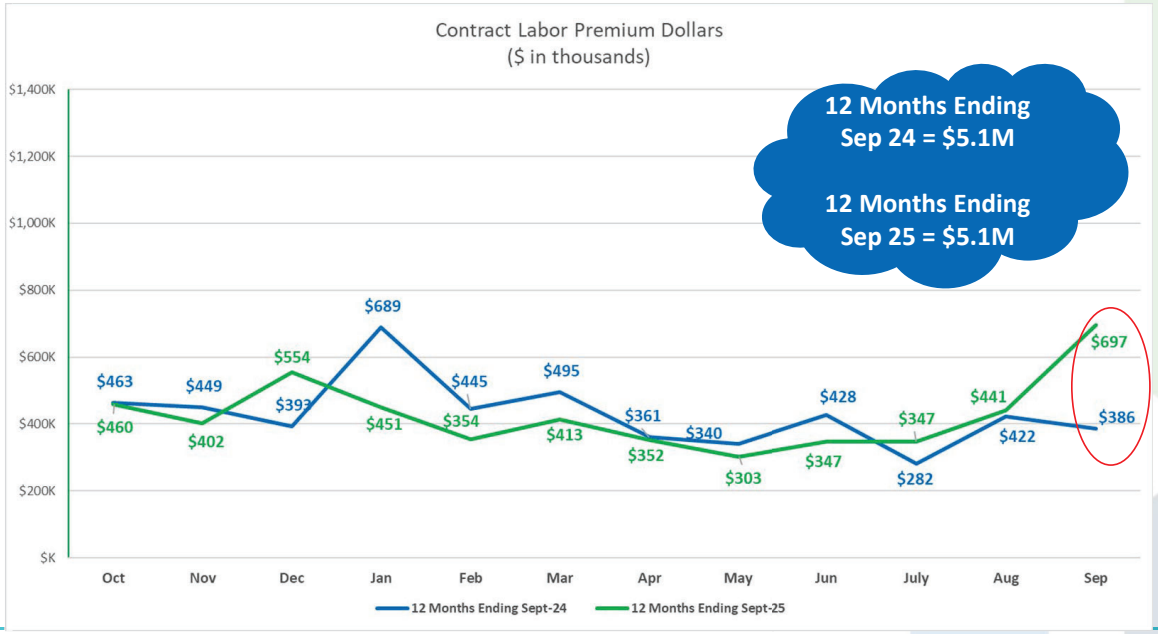
Through the pay period ending September 28, 2025



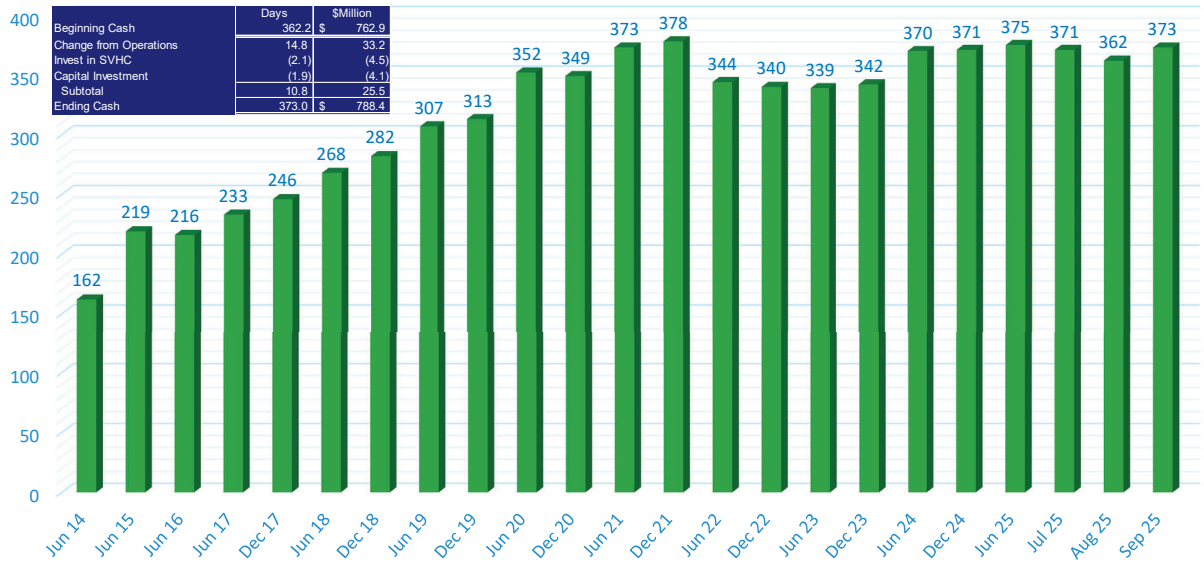
** Observation days are not available prior to FY2018 due to a server migration.

14

Contract Labor Premium Cost – 12 months ended 9/30/2025



Days Cash on Hand = 373 Days ($788M) - September 2025



Questions/Comments

Salinas Valley HEALTH

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
September 30 ,2025

	Month of September		Three months ended September 30	
	Current Year	Prior Year	Current Period YTD	Prior Year YTD
Operating revenue:				
Net patient revenue	$ 56,617,458	$ 56,596,510	$ 177,464,614	$ 164,526,098
Other operating revenue	1,904,058	1,583,880	5,721,919	4,450,918
Total operating revenue	58,521,516	58,180,390	183,186,533	168,977,016
Total operating expenses	52,534,382	50,202,538	162,490,943	148,959,386
Total non-operating income	(1,916,578)	2,433,633	(4,493,464)	3,870,026
Operating and non-operating income	**$ 4,070,556**	**$ 10,411,485**	**$ 16,202,126**	**$ 23,887,655**

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
September 30, 2025

	Current year	Prior year
Current assets	$ 460,203,676	$ 403,758,194
Assets whose use is limited or restricted by board	178,442,407	171,640,720
Capital assets	248,217,457	251,409,346
Other assets	369,384,512	307,173,646
Deferred pension outflows	55,438,539	85,734,219
	$1,311,686,591	$1,219,716,125
LIABILITIES AND EQUITY:		
Current liabilities	$ 97,808,441	$ 89,962,831
Long term liabilities	23,379,051	19,612,558
Lease deferred inflows	2,351,602	1,741,055
Pension liability	79,394,685	90,863,576
Net assets	1,108,752,811	1,017,536,106
	$1,311,686,591	$1,219,716,125

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
September 30, 2025

Current Year	Prior Year		Current YTD	Prior YTD
		Patients days:		
		By payer:		
1,183	1,699	Medicare	4,321	5,109
988	986	Medi-Cal	2,931	3,068
569	640	Commercial insurance	1,634	1,725
111	158	Other patient	407	357
2,851	3,483	Total patient days	9,293	10,259
		Gross revenue:		
120,358,076	119,207,380	Medicare	390,611,326	371,480,360
86,665,890	76,820,884	Medi-Cal	253,390,476	237,211,543
65,216,309	60,177,883	Commercial Insurance	189,326,176	173,022,836
11,337,561	11,562,294	Other patient	37,951,284	33,223,846
283,577,836	**267,768,442**	**Gross revenue**	**871,279,262**	**814,938,586**
		Deductions from revenue:		
227,889	39,378	Administrative adjustments	650,144	601,027
1,694,884	31,105	Charity care	2,795,461	1,413,813
		Contractual adjustments:		
48,741,248	40,710,701	Medicare outpatient	150,468,541	125,719,948
38,937,688	43,662,225	Medicare inpatient	135,683,221	140,053,819
1,781,757	1,932,272	Medi-Cal traditional outpatient	4,174,793	4,711,278
4,919,638	6,239,352	Medi-Cal traditional inpatient	13,544,980	19,956,409
42,005,388	37,013,501	Medi-Cal managed care outpatient	129,067,370	114,545,433
29,144,213	24,282,868	Medi-Cal managed care inpatient	81,894,613	74,841,498
28,785,874	25,190,978	Commercial insurance outpatient	83,551,788	77,314,207
17,728,952	23,816,247	Commercial insurance inpatient	60,200,363	69,428,810
6,302,813	5,341,125	Uncollectible accounts expense	18,530,806	15,840,500
6,690,034	2,912,181	Other payors	13,252,568	5,985,745
226,960,378	**211,171,932**	**Deductions from revenue**	**693,814,648**	**650,412,488**
56,617,458	**56,596,510**	**Net patient revenue**	**177,464,614**	**164,526,098**
		Gross billed charges patient type:		
120,107,004	127,083,409	Inpatient	381,265,089	387,574,720
126,906,337	108,305,543	Outpatient	382,965,075	330,900,512
36,564,495	32,379,490	Emergency room	107,049,098	96,463,353
283,577,836	**267,768,442**	**Total**	**871,279,262**	**814,938,586**

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
September 30, 2025

Month of September			Three months ended September 30		
Current Year	**Prior Year**		**Current Year**	**Prior Year**	
		Operating revenue:			
$ 283,577,836	$ 267,768,442	Gross billed charges	$ 871,279,262	$ 814,938,586	
226,960,378	211,171,932	Deductions from revenue	693,814,648	650,412,488	
56,617,458	**56,596,510**	**Net patient revenue**	**177,464,614**	**164,526,098**	
1,904,058	1,583,880	Other operating revenue	5,721,919	4,450,918	
58,521,516	**58,180,390**	**Total operating revenue**	**183,186,533**	**168,977,016**	
		Operating expenses:			
18,523,025	17,378,044	Salaries and wages	56,718,550	52,069,744	
3,338,350	2,643,970	Compensated absences	9,699,589	9,693,098	
5,726,117	8,918,863	Employee benefits	24,496,793	25,348,968	
8,751,975	8,103,526	Supplies, food, and linen	27,603,824	25,089,913	
4,851,399	4,081,477	Purchased department functions	13,204,509	11,496,401	
2,828,357	2,759,834	Medical Fees	8,213,641	7,151,865	
3,955,048	2,011,541	Other Fees	7,927,403	5,020,631	
2,810,229	2,500,920	Depreciation	7,974,874	7,457,897	
1,749,883	1,804,363	All other expense	6,651,759	5,630,870	
52,534,382	**50,202,538**	**Total Operating expenses**	**162,490,943**	**148,959,386**	
5,987,134	**7,977,852**	**Income from operations**	**20,695,590**	**20,017,630**	
		Non-operating Income:			
43,935	773,392	Donations	587,752	1,046,513	
500,550	476,714	Property taxes	1,501,650	1,430,143	
572,948	5,426,658	Investment Income	4,536,813	15,022,572	
(3,034,011)	(4,243,131)	Income from subsidiaries	(11,119,679)	(13,629,202)	
(1,916,578)	**2,433,633**	**Total non-operating income**	**(4,493,464)**	**3,870,026**	
$ 4,070,556	**$ 10,411,485**	**Operating and non-operating income**	**$ 16,202,126**	**$ 23,887,655**	

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
September 30, 2025

	Current Year	Prior Year
ASSETS		
Current assets:		
Cash and Cash Equivalents	$ 303,367,846	$ 263,540,497
Patient accounts receivable, net of estimated uncollectibles	134,071,897	116,734,506
Supplies inventory at cost	5,595,942	8,587,084
Current portion of lease receivable	312,258	1,399,852
Other current assets	16,855,733	13,496,254
Total current assets	460,203,676	403,758,194
Assets whose use is limited or restricted by board	178,442,407	171,640,720
Capital assets:		
Land and construction in process	45,005,048	47,412,443
Other capital assets, net of depreciation	203,212,409	203,996,903
Total capital assets	248,217,457	251,409,346
Other assets:		
Right of use assets, net of amortization	11,139,898	7,005,059
Long term lease receivable	1,991,625	372,390
Subscription assets, net of amortization	36,347,989	9,004,109
Investment in securities	273,610,222	265,671,311
Investment in SVMC	2,765,352	1,878,977
Investment in Aspire/CHI/Coastal	1,757,620	1,775,896
Investment in other affiliates	21,325,566	21,716,935
Net Pension Asset	19,914,067	(783,204)
Goodwill	532,173	532,173
Total other assets	369,384,512	307,173,646
Deferred Pension Outflows	55,438,539	85,734,219
Total assets	$ 1,311,686,591	$ 1,219,716,125
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable and accrued expenses	$ 65,847,712	$ 57,667,421
Due to third party payors	4,535,371	3,689,071
Current portion of self-insurance liability	21,812,825	22,445,550
Current subscription liability	1,898,049	3,595,446
Current portion of lease liability	3,714,484	2,565,343
Total current liabilities	97,808,441	89,962,831
Long term portion of workers comp liability	11,655,972	12,078,720
Long term portion of lease liability	7,867,705	4,511,988
Long term subscription liability	3,855,374	3,021,850
Total Liabilities	121,187,492	109,575,389
Lease deferred inflows	2,351,602	1,741,055
Pension Liability	79,394,685	90,863,576
Net Assets:		
Invested in capital assets, net of related debt	248,217,457	251,409,346
Unrestricted	860,535,354	766,126,759
Total Net Assets	1,108,752,811	1,017,536,106
Total liabilities and net assets	$ 1,311,686,591	$ 1,219,716,125

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - ('000)
September 30, 2025

Actuals	Budget	$ Variance	% Variance		Actuals YTD	Budget YTD	$ Variance YTD	% Variance YTD
				Operating revenue:				
283,577,836	281,698,118	1,879,717	-0.7%	Gross billed charges	871,279,262	863,633,091	7,646,171	-0.9%
226,960,378	225,609,245	1,351,133	0.6%	Deductions from revenue	693,814,648	692,667,470	1,147,178	-0.2%
56,617,458	**56,088,874**	**528,584**	**-0.9%**	**Net patient revenue**	**177,464,614**	**170,965,621**	**6,498,993**	**-3.8%**
1,904,058	1,721,629	182,429	-10.6%	Other operating revenue	5,721,919	5,164,886	557,032	-10.8%
58,521,516	**57,810,502**	**(711,013.38)**	**1.2%**	**Total operating revenue**	**183,186,533**	**176,130,508**	**(7,056,025)**	**4.0%**
				Operating expenses:				
18,523,025	18,236,154	286,871	1.6%	Salaries and wages	56,718,550	55,473,998	1,244,552	-2.2%
3,338,350	3,623,784	(285,435)	-7.9%	Compensated absences	9,699,589	11,211,316	(1,511,727)	13.5%
5,726,117	7,801,863	(2,075,745)	-26.6%	Employee benefits	24,496,793	23,882,136	614,657	-2.6%
8,751,975	8,746,192	5,783	0.1%	Supplies, food, and linen	27,603,824	26,817,114	786,710	-2.9%
4,851,399	4,494,768	356,631	7.9%	Purchased department functions	13,204,509	13,506,425	(301,916)	-2.2%
2,828,357	2,611,447	216,909	8.3%	Medical Fees	8,213,641	7,841,844	371,797	-4.7%
3,955,048	1,471,730	2,483,318	168.7%	Other Fees	7,927,403	4,478,377	3,449,026	-77.0%
2,810,229	2,573,491	236,738	9.2%	Depreciation	7,974,874	7,685,242	289,632	-3.8%
1,749,883	2,025,175	(275,293)	-13.6%	All other expense	6,651,759	6,130,343	521,416	8.5%
52,534,382	**51,584,605**	**949,777**	**1.8%**	**Total Operating expenses**	**162,490,943**	**157,026,796**	**5,464,147**	**-3.5%**
5,987,134	**6,225,898**	**238,764**	**-3.8%**	**Income from operations**	**20,695,590**	**19,103,712**	**(1,591,878)**	**-8.3%**
				Non-operating Income:				
43,935	216,667	(172,731)	79.7%	Donations	587,752	650,000	(62,248)	9.6%
500,550	500,550	-	0.0%	Property taxes	1,501,650	1,501,650	-	0.0%
572,948	1,241,994	(669,046)	53.9%	Investment Income	4,536,813	3,727,494	854,394	-22.9%
(3,034,011)	(4,575,371)	1,541,360	33.7%	Income from subsidiaries	(11,119,679)	(13,708,897)	2,589,218	18.9%
(1,916,578)	**(2,616,160)**	**699,582**	**26.7%**	**Total non-operating income**	**(4,493,464)**	**(7,829,753)**	**3,336,289**	**42.6%**
4,070,556	**3,609,738**	**(460,819)**	**12.8%**	**Operating and non-operating income**	**16,202,126**	**11,273,959**	**(4,928,167)**	**43.7%**

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

Month of September			Third months to date		
2024	2025		2024-25	2025-26	Variance
		NEWBORN STATISTICS			
40	37	Medi-Cal Admissions	109	101	(8)
92	73	Other Admissions	252	230	(22)
132	110	Total Admissions	361	331	(30)
64	59	Medi-Cal Patient Days	248	162	(86)
145	132	Other Patient Days	331	370	39
209	191	Total Patient Days of Care	579	532	(47)
7.0	6.4	Average Daily Census	6.3	5.8	(0.5)
1.6	1.7	Medi-Cal Average Days	2.4	1.7	(0.7)
1.2	1.8	Other Average Days	1.3	1.6	0.3
1.5	1.8	Total Average Days Stay	1.6	1.7	0.0
		ADULTS & PEDIATRICS			
354	327	Medicare Admissions	1,106	1,053	(53)
310	322	Medi-Cal Admissions	855	869	14
445	256	Other Admissions	974	860	(114)
1,109	905	Total Admissions	2,935	2,782	(153)
1,391	1,024	Medicare Patient Days	4,224	3,623	(601)
1,130	1,098	Medi-Cal Patient Days	3,283	3,239	(44)
941	761	Other Patient Days	2,825	2,138	(687)
3,462	2,883	Total Patient Days of Care	10,332	9,000	(1,332)
115.4	96.1	Average Daily Census	112.3	97.8	(14.5)
3.9	3.1	Medicare Average Length of Stay	3.8	3.4	(0.4)
3.4	3.0	Medi-Cal AverageLength of Stay	3.3	3.1	(0.2)
2.1	2.4	Other Average Length of Stay	2.3	2.1	(0.2)
3.0	2.8	Total Average Length of Stay	3.1	2.9	(0.2)
22	21	Deaths	76	59	(17)
3,671	3,074	Total Patient Days	10,911	9,532	(1,379)
0	0	Medi-Cal Administrative Days	0	0	0
0	0	Medicare SNF Days	0	0	0
0	0	Over-Utilization Days	0	0	0
0	0	Total Non-Acute Days	0	0	0
0.00%	0.00%	Percent Non-Acute	0.00%	0.00%	0.00%

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

Month of September			Third months to date		
2024	2025		2024-25	2025-26	Variance
		PATIENT DAYS BY LOCATION			
180	161	Level I	721	581	(140)
337	283	Heart Center	986	899	(87)
592	464	Monitored Beds	1,737	1,513	(224)
379	370	Single Room Maternity/Obstetrics	1,069	958	(111)
870	725	Med/Surg - Cardiovascular	2,504	2,253	(251)
282	257	Med/Surg - Oncology	819	677	(142)
413	413	Med/Surg - Rehab	1,364	1,344	(20)
135	104	Pediatrics	337	357	20
209	191	Nursery	579	532	(47)
132	106	Neonatal Intensive Care	339	418	79
		PERCENTAGE OF OCCUPANCY			
46.15%	41.28%	Level I	60.28%	48.58%	
74.89%	62.89%	Heart Center	71.45%	65.14%	
73.09%	57.28%	Monitored Beds	69.93%	60.91%	
34.14%	33.33%	Single Room Maternity/Obstetrics	31.40%	28.14%	
64.44%	53.70%	Med/Surg - Cardiovascular	60.48%	54.42%	
72.31%	65.90%	Med/Surg - Oncology	68.48%	56.61%	
52.95%	52.95%	Med/Surg - Rehab	57.02%	56.19%	
0.00%	0.00%	Med/Surg - Observation Care Unit	0.00%	0.00%	
25.00%	19.26%	Pediatrics	20.35%	21.56%	
42.22%	38.59%	Nursery	19.07%	17.52%	
40.00%	32.12%	Neonatal Intensive Care	33.50%	41.30%	

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

Month of September			Third months to date		
2024	2025		2024-25	2025-26	Variance
		DELIVERY ROOM			
139	119	Total deliveries	370	322	(48)
43	35	C-Section deliveries	111	97	(14)
30.94%	29.41%	Percent of C-section deliveries	30.00%	30.12%	0.12%
		OPERATING ROOM			
18,781	19,565	In-Patient Operating Minutes	59,211	57,470	(1,741)
33,959	39,792	Out-Patient Operating Minutes	96,108	115,492	19,384
52,740	59,357	Total	155,319	172,962	17,643
13	15	Open Heart Surgeries	37	38	1
119	123	In-Patient Cases	381	375	(6)
322	342	Out-Patient Cases	933	1,076	143
		EMERGENCY ROOM			
27	43	Immediate Life Saving	90	131	41
923	884	High Risk	2,671	2,641	(30)
2,797	2,897	More Than One Resource	8,204	8,614	410
1,675	1,643	One Resource	5,033	4,893	(140)
86	64	No Resources	221	201	(20)
5,508	5,531	**Total**	16,219	16,480	261

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

Month of September			Third months to date		
2024	2025		2024-25	2025-26	Variance
		CENTRAL SUPPLY			
12,955	7,113	In-patient requisitions	39,216	28,588	-10,628
11,223	9,586	Out-patient requisitions	32,794	31,943	-851
707	302	Emergency room requisitions	2,497	1,125	-1,372
6,717	6,200	Interdepartmental requisitions	19,855	19,172	-683
31,602	23,201	Total requisitions	94,362	80,828	-13,534
		LABORATORY			
34,599	30,741	In-patient procedures	105,778	98,587	-7,191
42,097	51,590	Out-patient procedures	131,570	150,521	18,951
12,503	13,783	Emergency room procedures	37,544	40,580	3,036
89,199	96,114	Total patient procedures	274,892	289,688	14,796
		BLOOD BANK			
341	288	Units processed	806	853	47
		ELECTROCARDIOLOGY			
1,038	1,052	In-patient procedures	3,317	3,377	60
391	608	Out-patient procedures	1,173	1,746	573
1,263	1,455	Emergency room procedures	3,812	4,344	532
2,692	3,115	Total procedures	8,302	9,467	1,165
		CATH LAB			
119	126	In-patient procedures	389	381	-8
140	144	Out-patient procedures	389	436	47
0	0	Emergency room procedures	0	0	0
259	270	Total procedures	778	817	39
		ECHO-CARDIOLOGY			
385	400	In-patient studies	1,229	1,217	-12
287	414	Out-patient studies	1,006	1,352	346
1	1	Emergency room studies	4	4	0
673	815	Total studies	2,239	2,573	334
		NEURODIAGNOSTIC			
150	127	In-patient procedures	414	385	-29
27	19	Out-patient procedures	68	71	3
0	0	Emergency room procedures	0	1	1
177	146	Total procedures	482	457	-25

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

Month of September			Third months to date		
2024	2025		2024-25	2025-26	Variance
		SLEEP CENTER			
0	0	In-patient procedures	0	0	0
287	320	Out-patient procedures	825	950	125
0	0	Emergency room procedures	0	0	0
287	320	Total procedures	825	950	125
		RADIOLOGY			
1,166	1,084	In-patient procedures	3,823	3,543	-280
375	480	Out-patient procedures	1,238	1,377	139
1,534	1,547	Emergency room procedures	4,710	4,582	-128
3,075	3,111	Total patient procedures	9,771	9,502	-269
		MAGNETIC RESONANCE IMAGING			
177	192	In-patient procedures	565	647	82
103	159	Out-patient procedures	338	372	34
8	15	Emergency room procedures	20	25	5
288	366	Total procedures	923	1,044	121
		MAMMOGRAPHY CENTER			
3,625	4,823	In-patient procedures	9,958	12,770	2,812
3,610	4,806	Out-patient procedures	9,923	12,716	2,793
2	0	Emergency room procedures	3	4	1
7,237	9,629	Total procedures	19,884	25,490	5,606
		NUCLEAR MEDICINE			
10	17	In-patient procedures	55	49	-6
127	136	Out-patient procedures	383	430	47
2	0	Emergency room procedures	2	1	-1
139	153	Total procedures	440	480	40
		PHARMACY			
79,308	66,760	In-patient prescriptions	242,171	212,957	-29,214
16,745	18,910	Out-patient prescriptions	49,474	56,093	6,619
10,185	11,008	Emergency room prescriptions	29,326	32,014	2,688
106,238	96,678	Total prescriptions	320,971	301,064	-19,907
		RESPIRATORY THERAPY			
13,679	11,095	In-patient treatments	43,210	35,522	-7,688
903	493	Out-patient treatments	2,663	1,286	-1,377
559	1,077	Emergency room treatments	1,288	2,899	1,611
15,141	12,665	Total patient treatments	47,161	39,707	-7,454
		PHYSICAL THERAPY			
2,512	2,003	In-patient treatments	7,195	6,478	-717
218	617	Out-patient treatments	746	1,565	819
0	0	Emergency room treatments	0	3	3
2,730	2,620	Total treatments	7,941	8,046	105

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

Month of September			Third months to date		
2024	2025		2024-25	2025-26	Variance
		OCCUPATIONAL THERAPY			
1,325	981	In-patient procedures	4,397	3,696	-701
183	504	Out-patient procedures	604	1,281	677
0	0	Emergency room procedures	0	0	0
1,508	1,485	Total procedures	5,001	4,977	-24
		SPEECH THERAPY			
423	428	In-patient treatments	1,433	1,605	172
36	87	Out-patient treatments	99	250	151
0	1	Emergency room treatments	0	1	1
459	516	Total treatments	1,532	1,856	324
		CARDIAC REHABILITATION			
0	0	In-patient treatments	2	3	1
601	609	Out-patient treatments	1,927	1,884	-43
1	2	Emergency room treatments	1	3	2
602	611	Total treatments	1,930	1,890	-40
		CRITICAL DECISION UNIT			
263	114	Observation hours	757	569	-188
		ENDOSCOPY			
101	71	In-patient procedures	269	242	-27
55	62	Out-patient procedures	164	185	21
0	0	Emergency room procedures	0	1	1
156	133	Total procedures	433	428	-5
		C.T. SCAN			
734	718	In-patient procedures	2,277	2,291	14
517	689	Out-patient procedures	1,452	1,664	212
787	848	Emergency room procedures	2,352	2,491	139
2,038	2,255	Total procedures	6,081	6,446	365
		DIETARY			
16,362	15,504	Routine patient diets	46,194	47,825	1,631
31,934	36,184	Meals to personnel	100,075	103,825	3,750
48,296	51,688	Total diets and meals	146,269	151,650	5,381
		LAUNDRY AND LINEN			
96,343	95,191	Total pounds laundered	286,056	306,857	20,801

CORPORATE COMPLIANCE & AUDIT COMMITTEE

Minutes of the Corporate Compliance & Audit Committee will be distributed at the Board Meeting

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

(JOEL HERNANDEZ LAGUNA)

bakertilly

Salinas Valley Health

2025 Audit Results

Agenda

1. Scope of Services
2. Auditor Opinions & Reports
3. Significant Risks Identified
4. Communication with Those Charged with Governance
5. Consolidated Statements of Net Position
6. Consolidated Operations
7. Other Information

Scope of Services

Relationships between Baker Tilly and Salinas Valley Memorial Healthcare System (Salinas Valley Health):

Annual Audit

- Annual consolidated financial statement audit as of and for the year ended June 30, 2025
- Annual Single Audit for the year ended June 30, 2025

Non-Attest Services

- Assist management with drafting the consolidated financial statements and footnotes as of and for the year ended June 30, 2025
- Assist management with drafting the auditee portion of the OMB Data Collection Form for the year ending June 30, 2025

Auditor Opinions & Reports

Auditor Report on the Consolidated Financial Statements

Unmodified Opinion

Consolidated financial statements are presented fairly and in accordance with US generally accepted accounting principles (GAAP)

Emphasis of matter – GASB 101

Other Auditor Reports

Report of Independent Auditors on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

- No financial reporting findings
- No compliance findings

Report of Independent Auditors on Compliance for the Major Federal Program; Report on Internal Control Over Compliance; and Report on the Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

- No control findings
- No compliance findings

2025 Single Audit

- Schedule of Expenditures of Federal Awards for the year ended June 30, 2025 is fairly stated in all material respects in relation to the financial statements as a whole
- One major program was subject to testing this year: FEMA program
- No reportable internal control findings were identified
- No reportable instances of noncompliance were identified
- No questioned costs were required to be reported
- An unmodified opinion is anticipated to be issued as soon as the 2025 OMB Compliance Supplement is released

Significant Risks Identified

During the audit, we identified the following:

Significant Risks	Procedures
Valuation of patient accounts receivable	- Tie out of reserving schedules - Zero Balance Accounts (“ZBA”) analysis - Lookback analysis & subsequent collections analysis
Revenue recognition	- Hospital patient revenue analysis & cut-off analysis - Journal entry testing focusing on revenue reversals
Management override of controls	- Inquiries of accounting and operational personnel - Perform risk assessment procedure - Test of design and operational effectiveness of financial reporting controls - Testing of risk-based manual journal entry selections

Hospital Patient Accounts Receivable – trend analysis

($ in 000's)	2025	2024	2023	2022	2021
Net Patient Accounts Receivable	$ 129,755	$ 111,334	$ 85,106	$ 83,766	$ 70,975
Subsequent Cash Receipts 2 months after 6/30	$ 70,232	$ 60,833	$ 55,127	$ 53,349	$ 55,047
% Collected 2 months after 6/30	54%	55%	65%	64%	66%
Exposure 2 months' collections	$ 59,523	$ 50,501	$ 29,979	$ 30,417	$ 15,928
Collected 14 months after 6/30	n/a	$ 115,005	$ 86,285	$ 89,091	$ 83,550
% Collected 14 months after 6/30	n/a	103%	101%	106%	118%

Communication with Those Charged with Governance

Our Responsibility Under US Generally Accepted Auditing Standards and *Government Auditing Standards*

1. To express our opinion on whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with GAAP. However, our audit doesn't relieve you or management of your responsibilities.

2. To perform an audit in accordance with generally accepted auditing standards issued by the AICPA as well as *Government Auditing Standards* issued by the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

3. To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4. To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However,
we aren't required to design procedures for the purpose of identifying other matters to communicate to you.

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the audit committee is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine the audit committee is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there's a lack of authoritative guidance or consensus.

OUR COMMENTS

Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the System are described in the footnotes to the consolidated financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. During fiscal year 2025, the System adopted Governmental Accounting Standards Board Statement No. 101, *Compensated Absences*. See Notes 2 and 17 for impact of adoption. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2025.

We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Management Judgments & Accounting Estimates

The audit committee should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basis for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

Management's judgments and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and don't materially misstate the consolidated financial statements.

Significant management estimates impacting the consolidated financial statements include the following:
contractual allowances related to net patient service revenue, provision for uncollectible accounts, fair market values of investments, uninsured losses for professional liability, minimum pension liability, workers' compensation liability, post-retirement medical benefits liability, valuation of gift annuities and beneficial interest in charitable remainder unitrusts, useful lives of capital assets, discount rate for leases, useful lives of right of use assets, deferred inflows of resources, probability of accumulated leave being used or settled and the timing of those payments related to calculation of employee sick leave accrual, subscription term of subscription assets, and discount rates used for subscription liabilities.
We deemed them to be reasonable.

Management Judgments & Accounting Estimates

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

The disclosures in the consolidated financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users; The most sensitive disclosures affecting the consolidated financial statements were disclosures relating to significant concentration of net patient accounts receivable, investments and fair value of investments, capital assets, employee benefit plans, post-retirement medical benefits, insurance plans, bonds payable, leases, and subscription-based IT arrangements.

Other Items

- Significant Unusual Transactions
- Significant Difficulties Encountered During the Audit
- Disagreements With Management
- Circumstances that affect the form and content of the auditor's report
- Other findings or issues arising from the audit that are, in the auditor’s professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process
- Corrected and uncorrected misstatements
- Management’s consultation with other accountants

OUR COMMENTS

No significant unusual transactions or other required communication matters were identified during our audit of the entity’s financial statements.

Deficiencies in Internal Control

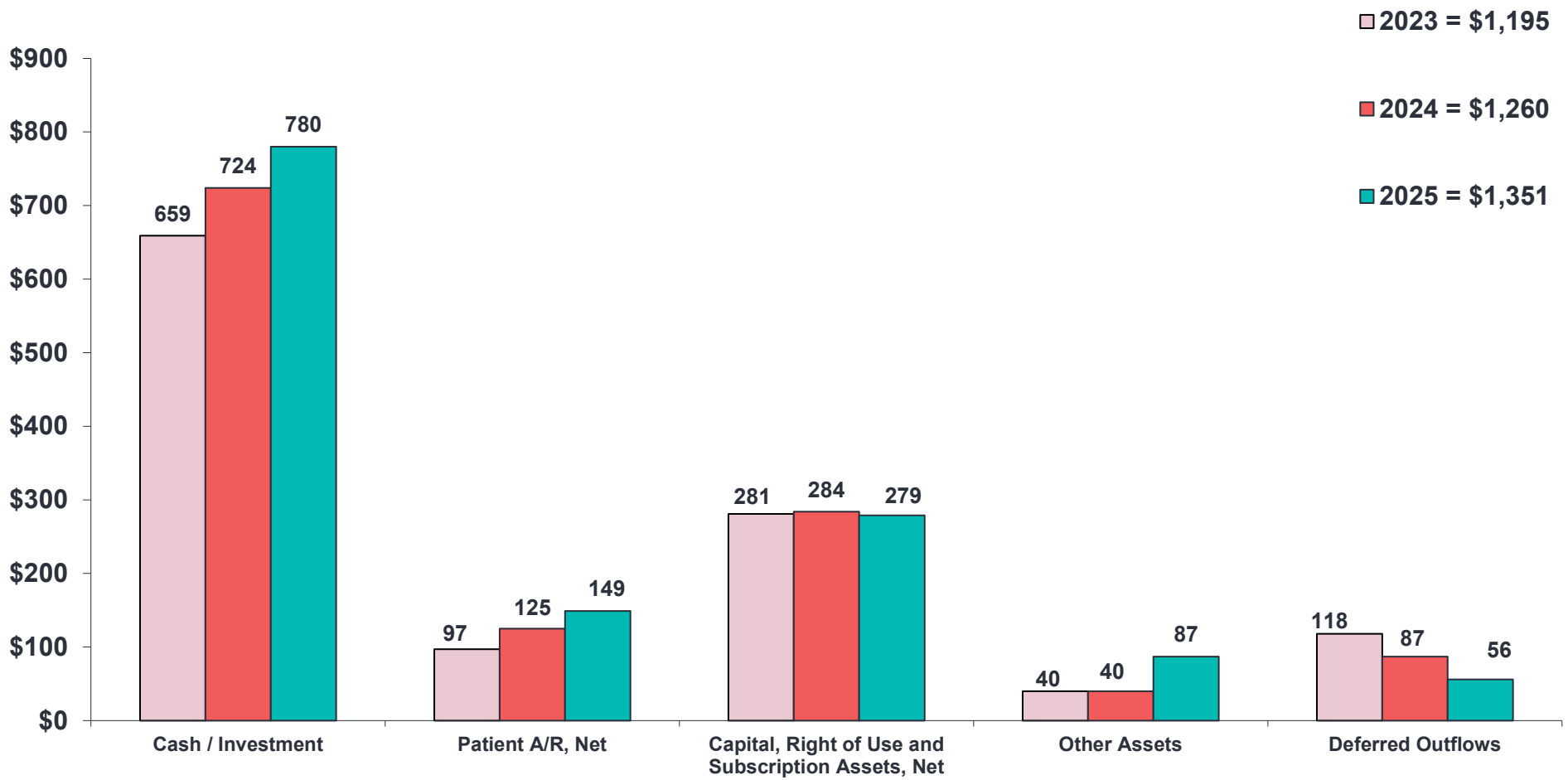
Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the audit committee.

OUR COMMENTS

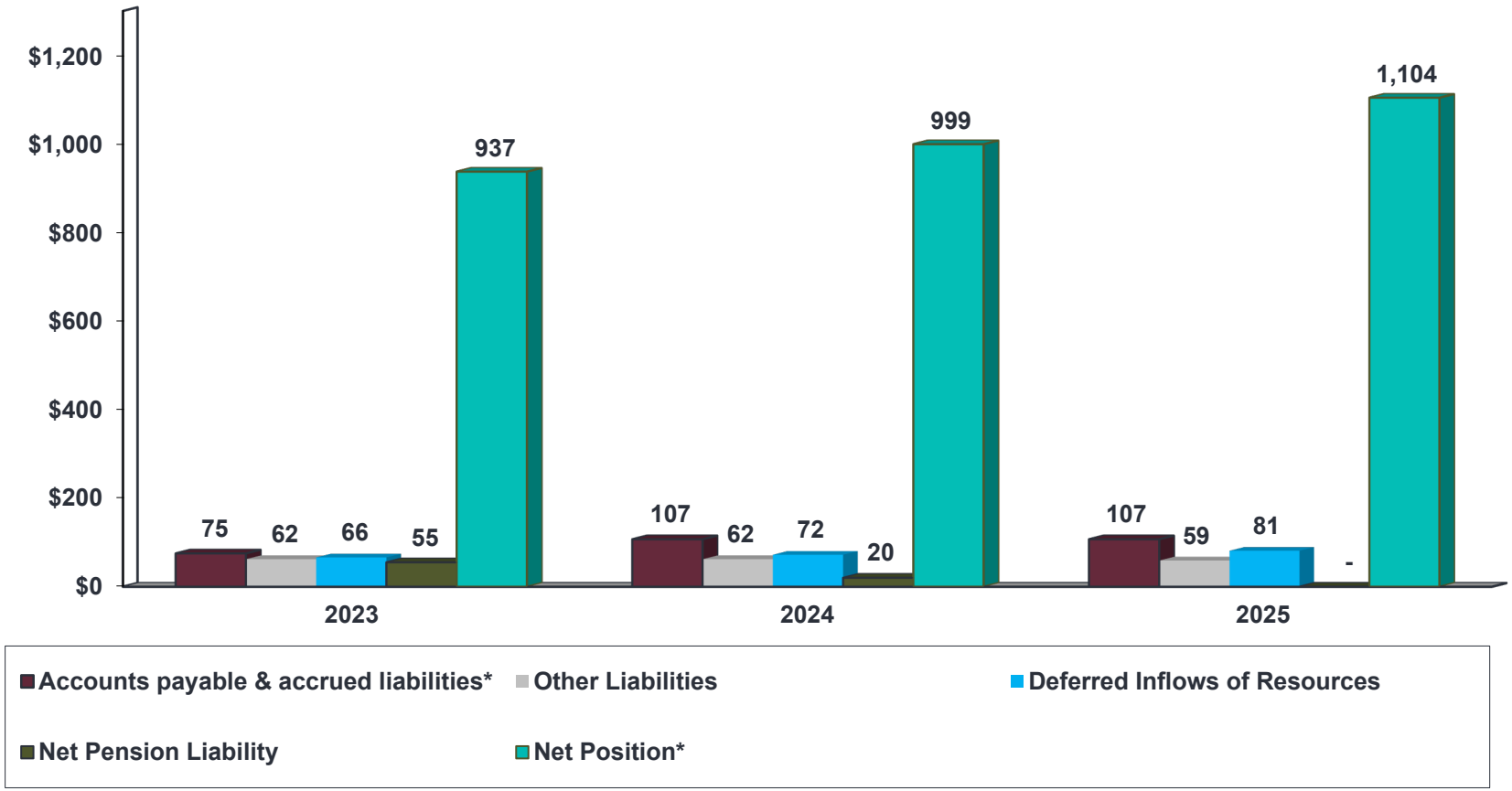
- Material weakness
  - None noted
- Significant deficiencies and non-compliance
  - Nothing to communicate

Consolidated Statements of Net Position

Assets and Deferred Outflows (in millions)



Liabilities, Deferred Inflows, and Net Position (in millions)

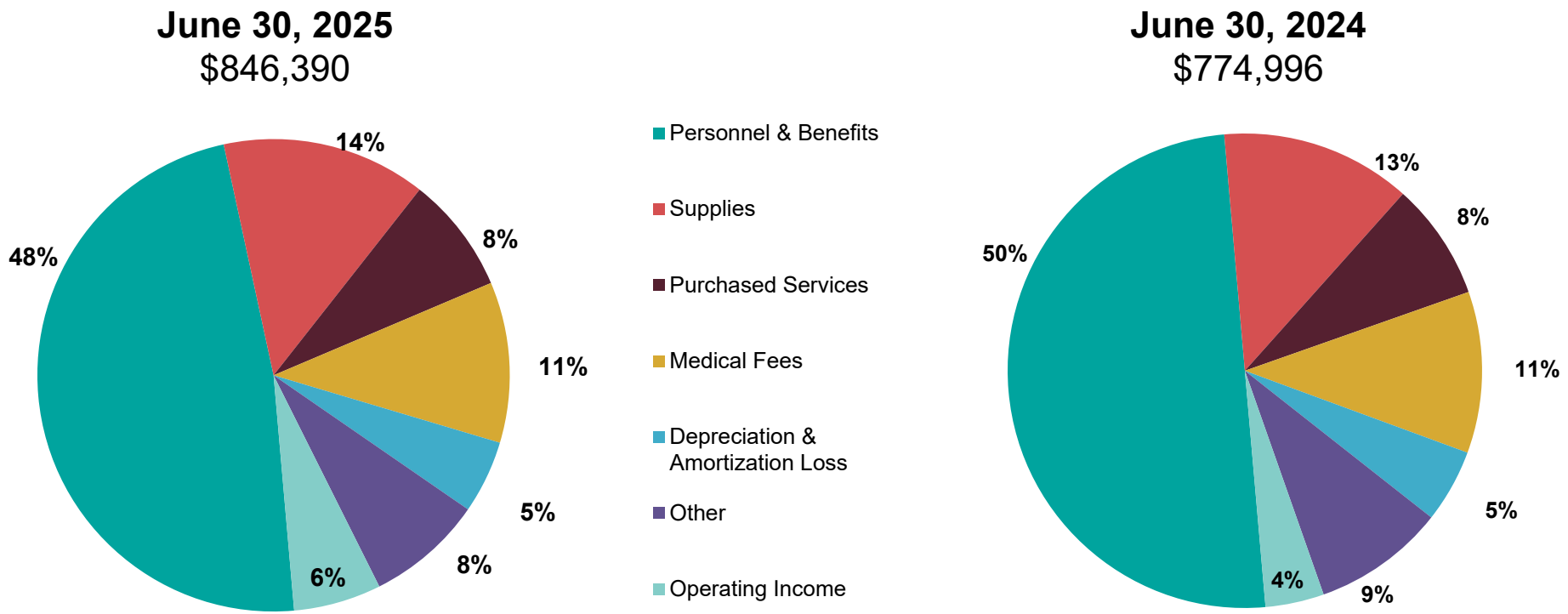


*restated for adoption of GASB 101

Consolidated Operations

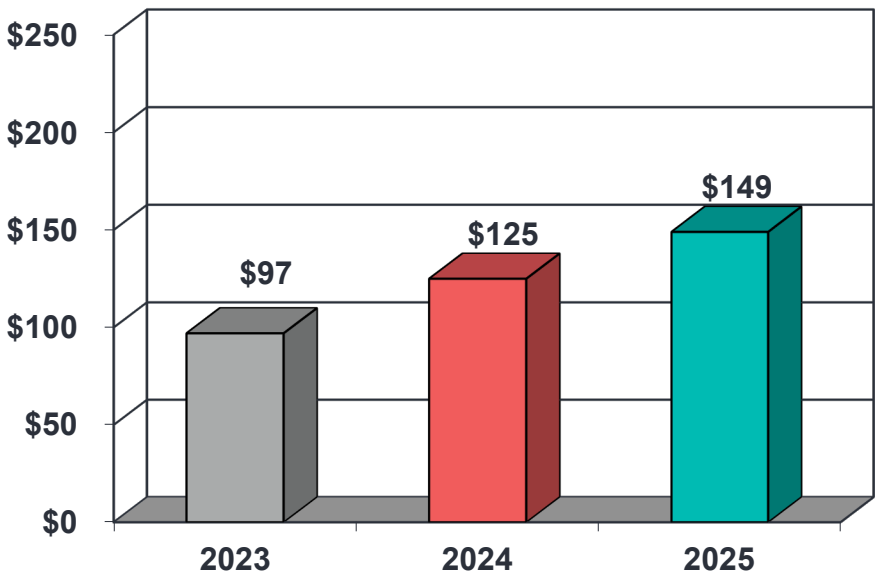
Income Statements Year to Year Comparison

Total Operating Revenues (in thousands)

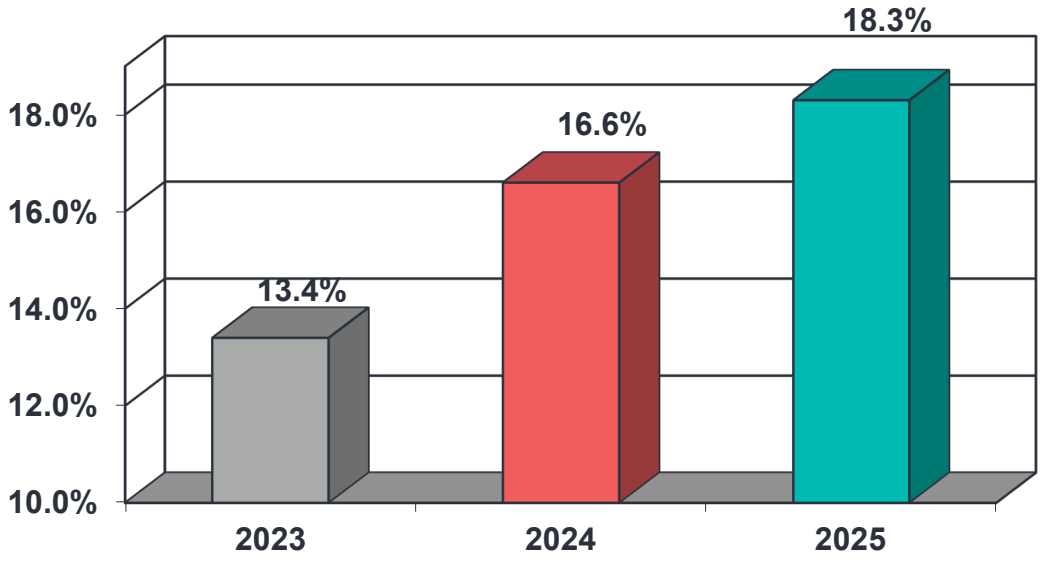


Net Patient Service Accounts Receivable

Dollars (in millions)

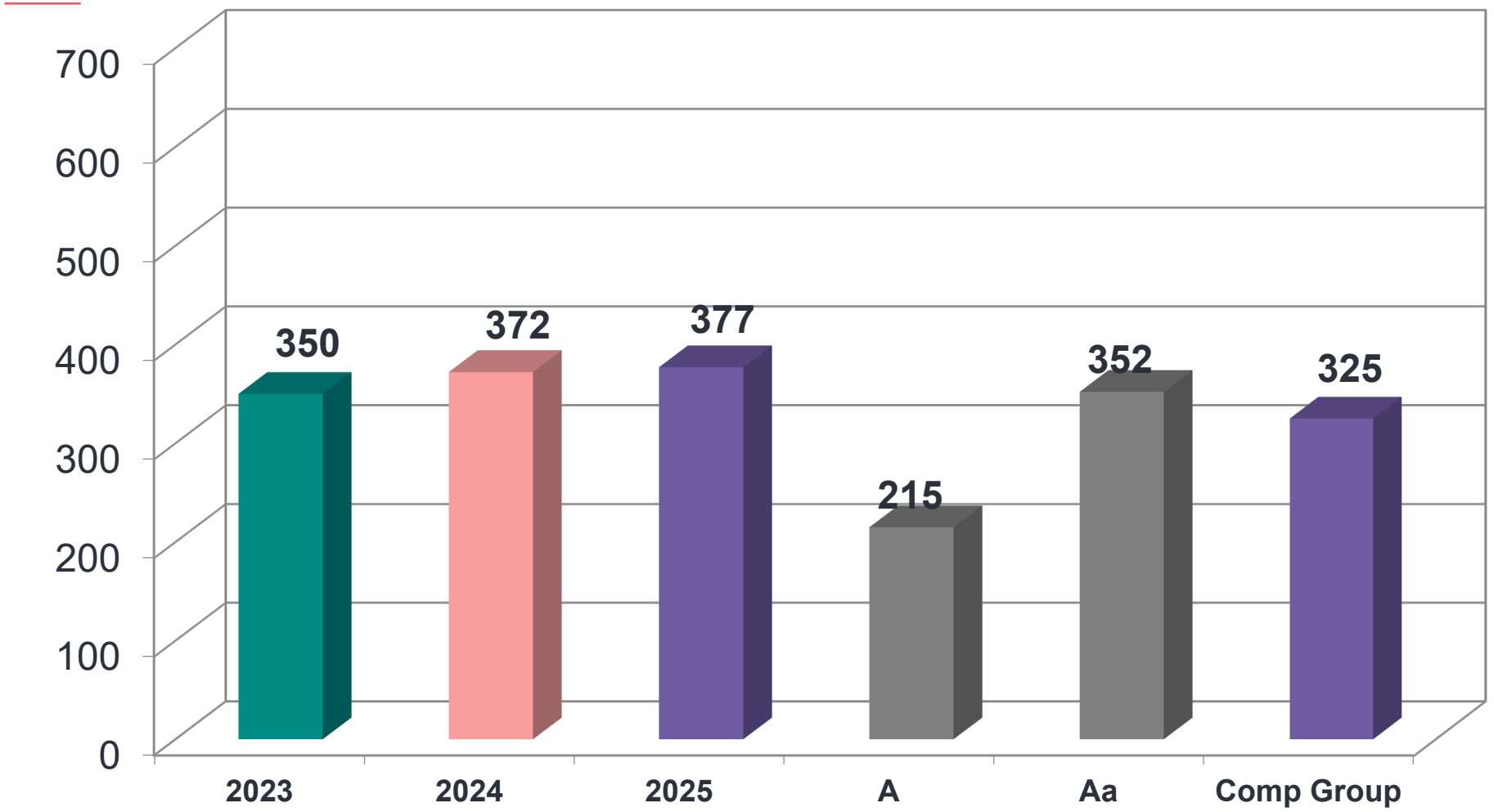


% Net Revenues



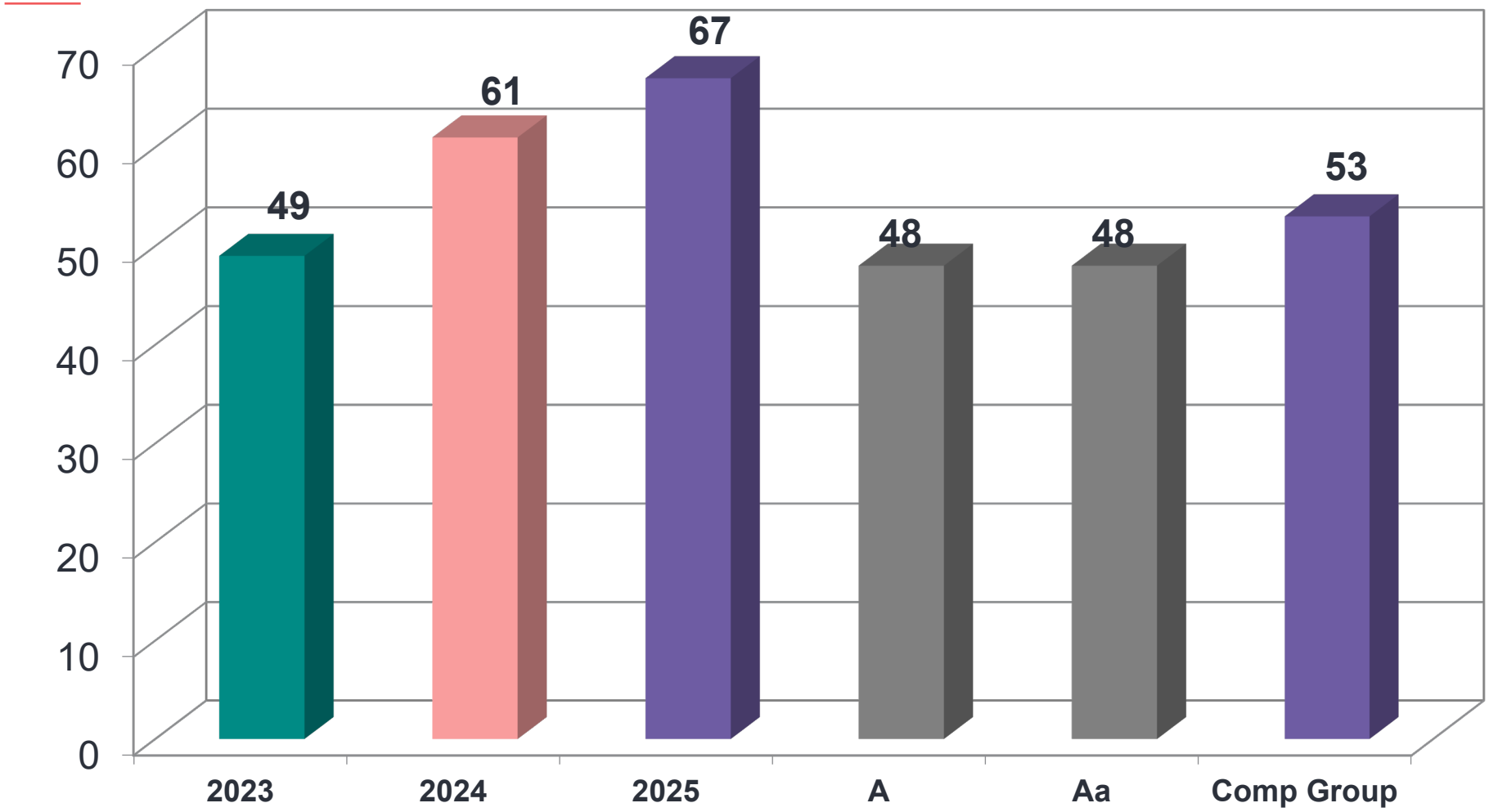
Other Information

Days Unrestricted Cash and Investments



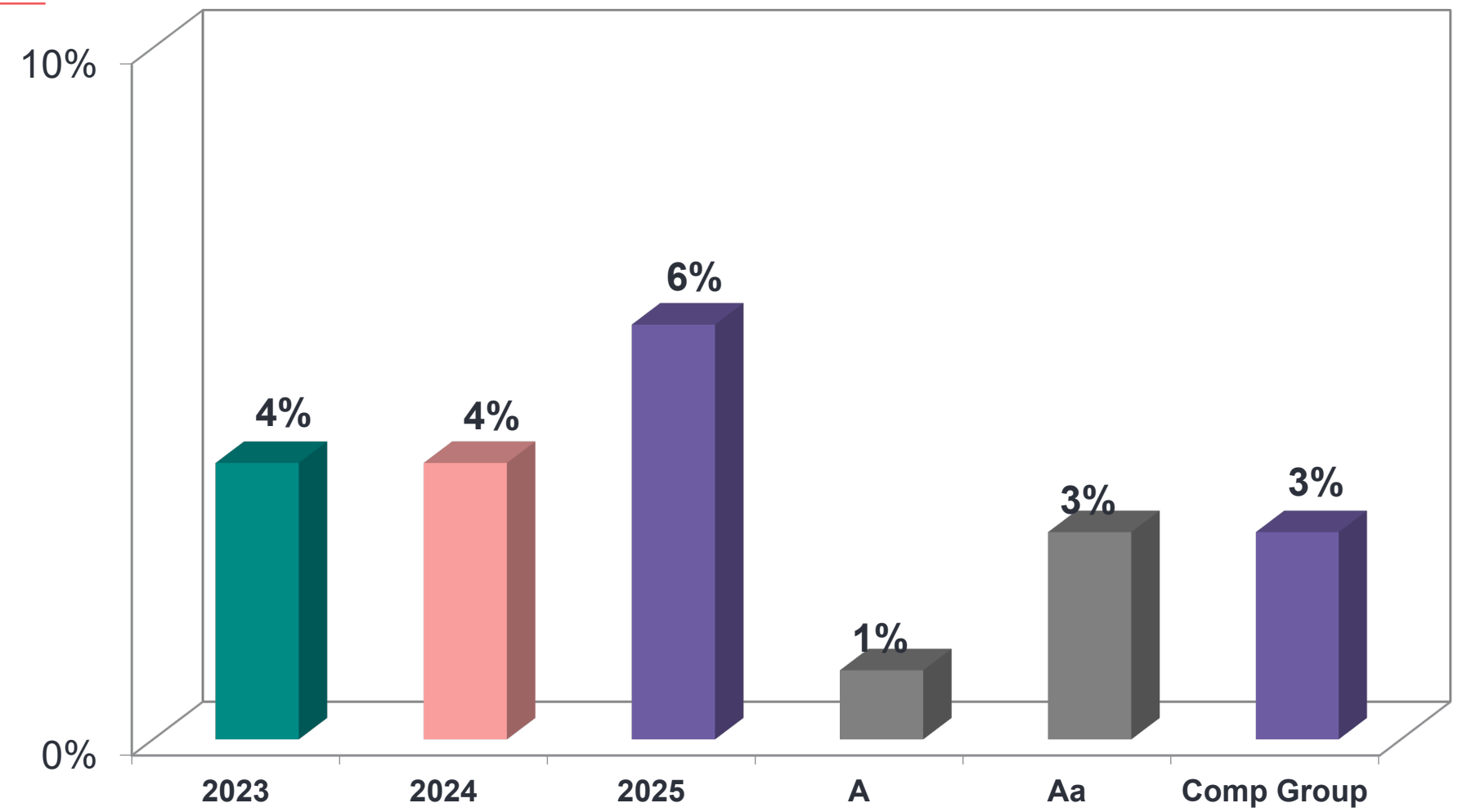
Fitch Ratings: *Fiscal Year 2024*
Not-for-Profit Health Care Medians August 2025

Days in Accounts Receivable



Fitch Ratings: *Fiscal Year 2024*
Not-for-Profit Health Care Medians August 2025

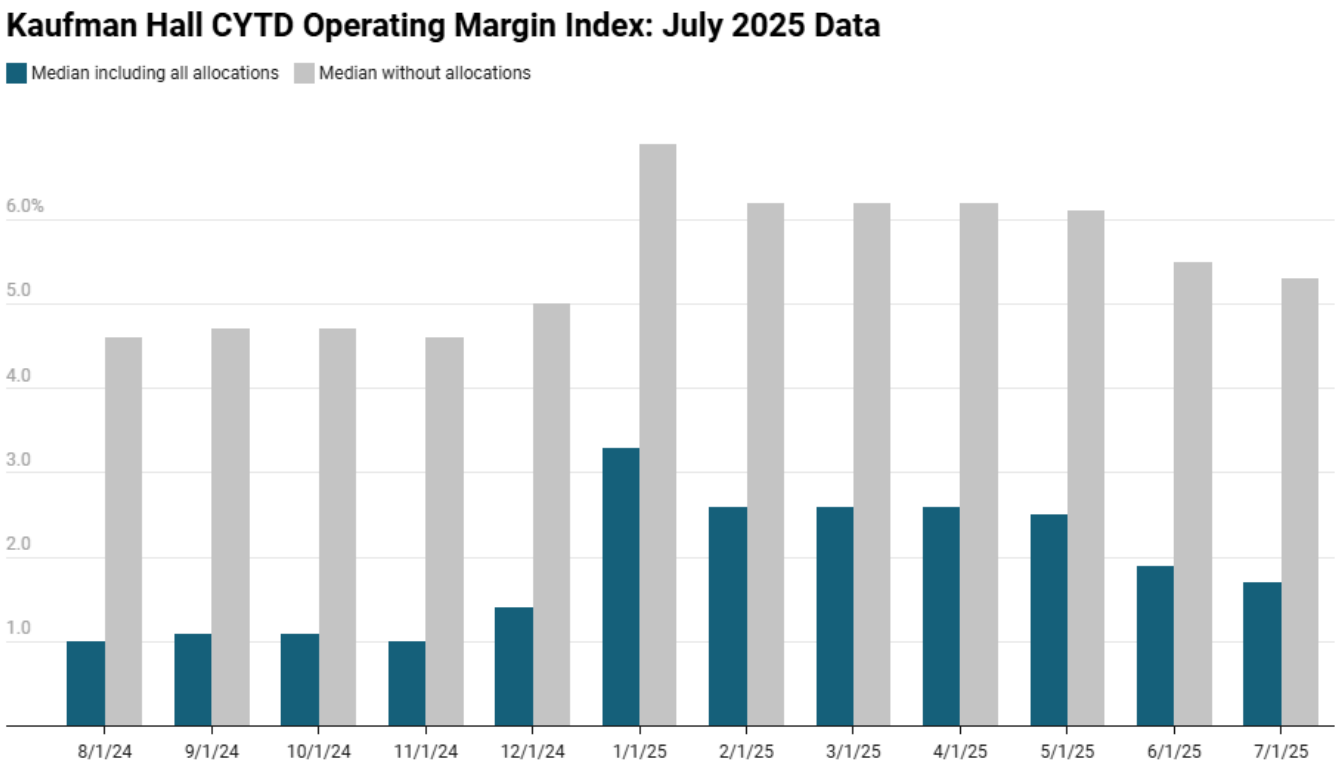
Operating Margin (Operating Income/Total Revenue)



**Comp Group Operating Margin ranges from (6.3%) to 10.4% with 4 positive margin and 1 negative margins*

Fitch Ratings: *Fiscal Year 2024 Not-for-Profit Health Care Medians August 2025*

Operating Margin Index



Source: *National Hospital Flash Report,* July 2025, Kaufman Hall

GASB Accounting Updates

- GASB Statement No. 103, *Financial Reporting Model Improvements*. Effective for the System beginning July 1, 2025.
- GASB Statement No. 104, *Disclosure of Certain Capital Assets*. Effective for the System beginning July 1, 2025.

Your Service Team

Kimberly Sokoloff
Lead Audit Principal

Kimberly.Sokoloff@bakertill.com
(925) 952-2506

Chris Pritchard
Relationship Principal

Chris.Pritchard@bakertilly.com

(415) 677-8262

Katherine Djiauw
Audit Director

Katherine.Djiauw@bakertilly.com
(415) 677-8294

Nini Pham
Audit Manager

Nini.Pham@bakertilly.com
(415) 677-8347

bakertilly

About Baker Tilly

Committed to health care

The demand for vital health care services continues to rise amid a multitude of challenges that impact the quality, accessibility, and efficiency of care.

From helping you comply with new regulations to easing your tax burden to exploring new care models, our dedicated health care professionals have the experience and expertise to help you navigate a complex new world.

Nearly
6,500
HEALTH CARE CLIENTS
across the nation

Nearly
500
PROFESSIONALS
specializing
in health care

More than
60
PRINCIPALS
specializing
in health care

LEADERSHIP INVOLVEMENT
with AICPA Health Care Expert Panel and HFMA National Principles and Practice Board

As of June 3, 2025, Baker Tilly and Moss Adams have merged. The statistics provided are combined unless otherwise noted and are based on data currently available. Actual counts may vary slightly and will be finalized during the integration process.

Hospitals & health systems

Our dedicated health care professionals offer personal, senior-level attention to help you strengthen your finances and operations.

We serve a broad range of clients across the nation. We leverage our deep knowledge of both the national health care marketplace and local and regional competitive environments to provide customized solutions that can make a difference to your organization.

More than
1,200
HOSPITAL CLIENTS
across the nation

Nearly
500
PROFESSIONALS
specializing
in health care

More than
60
PRINCIPALS
specializing
in health care

As of June 3, 2025, Baker Tilly and Moss Adams have merged. The statistics provided are combined unless otherwise noted and are based on data currently available. Actual counts may vary slightly and will be finalized during the integration process.

Health care advisory services

Audit and tax are vital. But you have complex needs that go beyond these core functions. Our dedicated health care consulting team provides a range of services to address all your emerging needs—both now and in the future.

Health care consulting

STRATEGY & INTEGRATION

- Provider risk analysis, contracting & operational design
- M&A support
- Feasibility studies
- Market intelligence & benchmarking
- Strategic planning & implementation
- Managed care assessment & negotiation
- Service line enhancement & analyses

INFORMATION TECHNOLOGY

- HIPAA security & privacy
- Network security & penetration testing
- HITRUST assessment & certification
- Disaster recovery planning
- PCI DSS audits
- SOC pre-audit gap analysis & readiness
- SOC audits

PROVIDER REIMBURSEMENT ENTERPRISE SERVICES

- Medicare & medicaid
- Provider-based licensure & certification
- Medical education
- Uncompensated care
- Wage index reviews
- Contract compliance

OPERATIONAL IMPROVEMENT

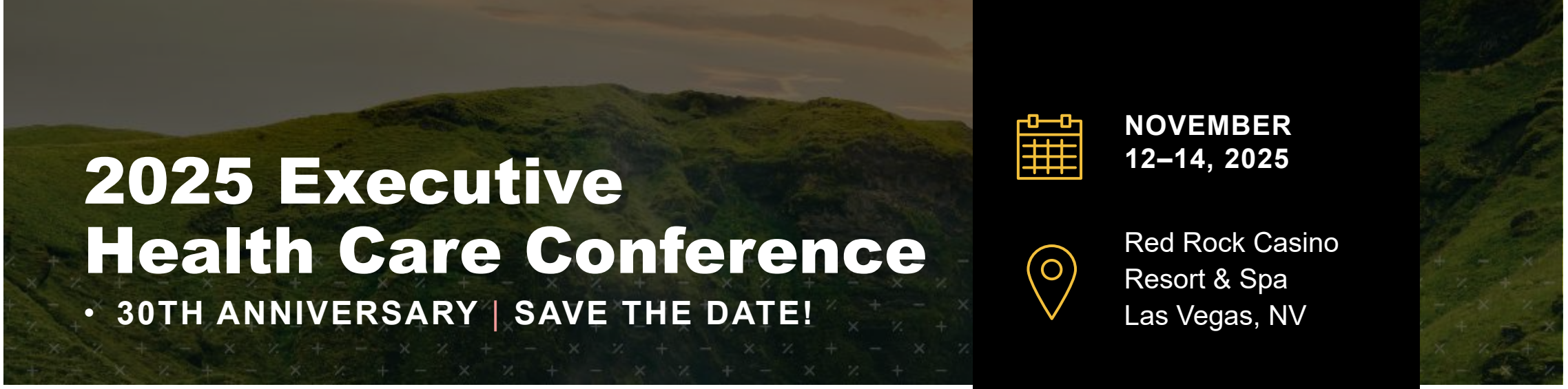
- Revenue cycle enhancement
- Claims recovery
- Litigation support
- Employer health benefits
- Financial turnaround
- Performance excellence
- Valuations

GOVERNMENT COMPLIANCE

- Regulatory compliance
- Coding validation
- Coding department redesign
- EHR internal controls
- Corporate compliance

LEAN TRANSFORMATION

- 3P & innovation
- Lean strategic planning & strategy deployment (hoshin kanri)
- Lean management systems & operations
- Quality & patient safety
- Internal infrastructure development



2025 Executive Health Care Conference

• 30TH ANNIVERSARY | SAVE THE DATE!

NOVEMBER
12–14, 2025

Red Rock Casino
Resort & Spa
Las Vegas, NV

REGISTRATION NOW OPEN

Join C-suite professionals from across the health care ecosystem to discuss the state of the industry and prepare leaders for 2026.

HIGHLIGHTS

Nov 12: Women's Executive Health Care Leadership Forum

Nov 13: State of the Union
Political Point-Counterpoints
Reception with Keynotes

Nov 14: Economic Forecast

MOSSADAMS × bakertilly

Keynote Speakers

Chiquita Brooks-LaSure
Former CMS Administrator
The Century Foundation

Alex Azar
Former United States Secretary of
Health and Human Services

Chris Sununu
Former Governor
of New Hampshire

Tim Ryan
Former U.S. Congressman

Susan Dentzer
President & CEO
America's Physician Group

Bradford Koles Jr.
Vice President
Advisory Board Company

Report of Independent Auditors and
Consolidated Financial Statements with
Supplementary Information

Salinas Valley Memorial Healthcare System

June 30, 2025 and 2024

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Management's Discussion and Analysis

Salinas Valley Memorial Healthcare System
Management's Discussion and Analysis
As of and for the Years Ended June 30, 2025, 2024, and 2023

INTRODUCTION

This section of Salinas Valley Memorial Healthcare System's (Salinas Valley Health or SVH) annual financial report provides an overview of SVH's financial activities as of and for the year ended June 30, 2025, with comparative financial information as of and for the years ended June 30, 2024 and 2023. Additionally, this section provides an overview of the financial activities of the Salinas Valley Memorial Healthcare District Employees Pension Plan (the Plan or Fiduciary) as of and for the year ended June 30, 2025, with comparative financial information as of and for the years ended June 30, 2024 and 2023.

MANAGEMENT'S DISCUSSION AND ANALYSIS – Salinas Valley Health

General Salinas Valley Health Description

The Salinas Valley Memorial Hospital, now known as Salinas Valley Health Medical Center as part of SVH, was formed in 1947 pursuant to California Health and Safety Code Section 32000 and follows Healthcare District Law. The authority and responsibility to govern SVH is vested in a five-member elected Board of Directors from zones within the Hospital District. Opened in 1953, SVH is dedicated as a memorial to those brave men and women who gave their lives in World War II to preserve our American heritage. We honor their memory by our commitment to our mission: "to provide quality healthcare to our patients and to improve the health and well-being of our community."

SVH is anchored by Salinas Valley Health Medical Center (the Hospital), an acute care facility licensed for 263 beds. As one of the area's largest employers, the Hospital has a staff of approximately 2,100 people and is recognized as a leader in providing nationally recognized quality care. Principal services include a comprehensive heart program providing advanced diagnostics and treatments such as those in its structural heart program, heart catheterization labs, and heart surgical suites; and orthopedic, perinatal, and oncology services. Collaboration is an important operating principle for SVH in such key areas as:

- SVH's Level III Neonatal Intensive Care Unit and Perinatal Diagnostic Center, which are operated in a joint venture with Stanford Children's Health;
- The Madison Clinic for Pediatric Diabetes, a partnership with UCSF;
- Aspire Health Plan, a local Medicare Advantage program in Monterey County;
- Taylor Family Farms Health and Wellness Center (Rural Health Clinic);
- Blue Zones Project Monterey County, dedicated to building a community where people live longer and healthier lives.
- SVH includes Salinas Valley Health Clinics, a multi-location clinic expanding access to primary and specialty care. SVH includes nine urgent care locations and a system-wide information network.

Overview of the Consolidated Financial Statements

The financial report consists of two parts – management's discussion and analysis (this section), and the consolidated financial statements together with the related notes, as mandated by certain pronouncements of the Governmental Accounting Standards Board (GASB). The consolidated financial statements present information about SVH's financial position and results of operations, as well as cash flows for the respective fiscal years, presented on a consolidated basis whereby the consolidated financial statements include the accounts of all affiliates owned 50% or more for which day-to-day operations are managed by SVH. The consolidated financial statements also include explanatory notes, which are an integral part of the consolidated financial statements.

Components of the Basic Consolidated Financial Statements

The consolidated statement of net position displays the assets, deferred outflows, liabilities, deferred inflows, and resulting net position of SVH as of the end of the fiscal year. Separate amounts of net position are reported for each of the classes of net position: (a) restricted – nonexpendable (expendable earnings only), (b) restricted – expendable (expendable by Board action for donor designation), (c) unrestricted net position, and (d) invested in capital assets, net of related debt. Net position classifications are based on the existence or absence of donor-imposed or other third-party restrictions.

Unrestricted net position generally results from providing or agreeing to provide healthcare services, receiving unrestricted contributions and grants, receiving income from investing in income-producing assets minus expenses incurred to provide healthcare services, providing other community benefits, and performing administrative functions. The limits on the use of unrestricted net position are broad, resulting from the California Government Code, which regulates the environment in which SVH operates, as well as limits resulting from contractual agreements with suppliers, creditors, and others in the ordinary course of business. Information about the nature and amounts of different types of restrictions are provided either by reporting the amounts in the consolidated financial statements or by including relevant details in the notes to the consolidated financial statements.

Financial Highlights

The following table illustrates comparable statistics (excluding newborns) for the year ended June 30, 2025, as compared to the years ended June 30, 2024 and 2023:

	Year Ended June 30,			Change	
	2025	2024	2023	2025/2024	2024/2023
Admissions	11,642	11,015	11,808	627	(793)
Average daily census	115	117	130	(2)	(13)
Average length of stay	4	4	4	-	-
Patient days					
Medicare	21,013	21,375	23,421	(362)	(2,046)
Managed care	6,930	7,634	8,590	(704)	(956)
Medi-Cal and CCAH	12,523	12,535	13,892	(12)	(1,357)
Other	1,465	1,208	1,435	257	(227)
Total patient days	41,931	42,752	47,338	(821)	(4,586)
Outpatient visits					
Hospital outpatients	80,516	67,092	60,316	13,424	6,776
Laboratory	88,266	57,619	7,430	30,647	50,189
Emergency room	63,175	64,522	65,873	(1,347)	(1,351)
Total outpatient visits	231,957	189,233	133,619	42,724	55,614

As shown above, patient days decreased 2.0% during 2025 from the levels of the prior year. Outpatient visits increased 22.6% during 2025, from the levels of the prior year, with an increase in hospital outpatient visits and laboratory visits, and a decrease in emergency room patients. The increase in total outpatient visits in 2025 is largely due to laboratory visits which have increased substantially due to Salinas Valley Health Clinic lab tests being referred to Salinas Valley Health Medical Center which started in October of 2023, and to increases in outpatient surgery, catheterization laboratory and most outpatient areas.

Abbreviated Consolidated Statements of Net Position

The following abbreviated consolidated statements of net position compare the balances as of June 30, 2025, to that of June 30, 2024 and 2023 (in thousands):

	As of June 30,			Change	
	2025	2024 (as restated)	2023	2025/2024	2024/2023
Current assets:					
Cash and cash equivalents	$ 312,848	$ 273,204	$ 335,989	$ 39,644	$ (62,785)
Patient accounts receivable, net	148,799	124,912	97,434	23,887	27,478
Other	190,972	151,279	85,886	39,693	65,393
Total current assets	652,619	549,395	519,309	103,224	30,086
Board-designated funds	176,241	166,414	157,875	9,827	8,539
Capital assets, net	256,027	259,854	256,235	(3,827)	3,619
Other assets, net	210,458	197,825	143,852	12,633	53,973
Total assets	1,295,345	1,173,488	1,077,271	121,857	96,217
Deferred outflows	56,077	86,622	118,048	(30,545)	(31,426)
Total assets and deferred outflows	$ 1,351,422	$ 1,260,110	$ 1,195,319	$ 91,312	$ 64,791
Current liabilities	$ 134,053	$ 137,392	$ 101,993	$ (3,339)	$ 35,399
Noncurrent liabilities	30,622	51,124	89,839	(20,502)	(38,715)
Deferred inflows	81,836	72,278	66,000	9,558	6,278
Total liabilities and deferred inflows	246,511	260,794	257,832	(14,283)	2,962
Net position:					
Invested in capital assets, net	256,777	260,205	254,730	(3,428)	5,475
Reserved for minority interest	(8,929)	(6,629)	(4,705)	(2,300)	(1,924)
Restricted - expendable	3,940	4,581	5,602	(641)	(1,021)
Restricted - nonexpendable	1,232	1,268	1,205	(36)	63
Unrestricted	851,891	739,891	680,655	112,000	59,236
Total net position	1,104,911	999,316	937,487	105,595	61,829
Total liabilities, deferred inflows, and net position	$ 1,351,422	$ 1,260,110	$ 1,195,319	$ 91,312	$ 64,791

Analysis – 2025 and 2024

Total current assets increased by $103.2 million in 2025, compared to 2024, due primarily to an increase in other current assets consisting primarily of the current portion of investments in marketable securities previously held in cash savings and patient accounts receivables attributed to an increase in untimely payments from commercial payers. There are ongoing collection efforts to address this matter. Additional prepaid assets pertaining to costs paid in advance for subscription-based information technology arrangements (SBITAs) whose terms have not yet begun also led to an increase in 2025 compared to 2024.

Board-designated funds increased by $9.8 million in 2025 as compared to 2024 due to incoming transfers from the operating account. Capital assets, net decreased by $3.8 million in 2025 as compared to 2024, due primarily to depreciation expense incurred in excess of capital asset acquisitions. Other assets increased by $12.6 million, primarily due to an increase in net pension assets.

Current liabilities decreased by $3.3 million in 2025, primarily due to decreases in accounts payable and accrued expenses. Noncurrent liabilities decreased by $20.5 million in 2025, primarily due to a decrease in the net pension liability.

Analysis – 2024 and 2023

Total current assets increased by $30.1 million in 2024, compared to 2023, due primarily to an increase in cash and cash equivalents partially offset by a decrease in short-term investments within other current assets.

Board-designated funds increased by $8.5 million in 2024, compared to 2023, due to incoming transfers from the operating account. Capital assets, net, increased by $3.6 million in 2024 as compared to 2023, due primarily to capital asset acquisitions in excess of depreciation expense incurred. Other assets increased by $54.0 million, primarily due to an increase in long-term investments.

SVH adopted GASB Statement No. 101, *Compensated Absences* (GASB No. 101), during the fiscal year ended June 30, 2025, applied retrospectively as of July 1, 2023. SVH evaluated the total liability pertaining to employee leave, and as a result, SVH recognized additional current liabilities of $16.9 million in its consolidated statements of net position. Noncurrent liabilities decreased by $38.7 million in 2024, primarily due to a decrease in the net pension liability.

Abbreviated Consolidated Statements of Revenues, Expenses, and Changes in Net Position

The following abbreviated consolidated statements of revenues, expenses, and changes in net position and detail summary of net patient service revenues compare the activity for the year ended June 30, 2025, to that of the years ended June 30, 2024 and 2023 (in thousands):

	Year Ended June 30,			Change	
	2025	2024 (as restated)	2023	2025/2024	2024/2023
Net patient service revenues	$ 814,635	$ 752,195	$ 726,870	$ 62,440	$ 25,325
Other revenues	31,719	22,801	22,478	8,918	323
Total operating revenues	846,354	774,996	749,348	71,358	25,648
Total operating expenses	(794,705)	(745,960)	(721,916)	(48,745)	(24,044)
Operating income	51,649	29,036	27,432	22,613	1,604
Total nonoperating income (loss), net	53,946	50,271	39,199	3,675	11,072
Increase in net position	$ 105,595	$ 79,307	$ 66,631	$ 26,288	$ 12,676

	Year Ended June 30,			Change	
	2025	2024 (as restated)	2023	2025/2024	2024/2023
Net patient service revenues	$ 814,635	$ 752,195	$ 726,870	$ 62,440	$ 25,325
Other revenues	31,719	22,801	22,478	8,918	323
Total operating revenues	846,354	774,996	749,348	71,358	25,648
Total operating expenses	(794,705)	(745,960)	(721,916)	(48,745)	(24,044)
Operating income	51,649	29,036	27,432	22,613	1,604
Total nonoperating income (loss), net	53,946	50,271	39,199	3,675	11,072
Increase in net position	$ 105,595	$ 79,307	$ 66,631	$ 26,288	$ 12,676
Net position, beginning of year	999,316	937,487	870,856	61,829	66,631
Cumulative effect of restatement	-	(17,478)	-	17,478	$ (17,478)
Net position, beginning of year, as restated	999,316	920,009	870,856	79,307	49,153
Net position, end of year	$ 1,104,911	$ 999,316	$ 937,487	$ 105,595	$ 61,829

Analysis – 2025 and 2024

Operating revenues increased by 9.2% in 2025 as compared to 2024, driven primarily by net patient service revenues. Net patient service revenues in 2025 increased by $62.4 million to $814.6 million from $752.2 million in 2024. Management attributes the change in net patient service revenues during 2025 to growth in outpatient volumes.

Operating expenses increased in 2025 by approximately $48.7 million or 6.5% over 2024 primarily from increases in salaries and wages, and supplies and medical fees required for services to increased patient volumes. Operating income in 2025 increased by $22.6 million to $51.7 million from $29.0 million for 2024.

Nonoperating income, net for 2025 was $53.9 million as compared to $50.3 million in 2024. An increase in investment income on newly acquired marketable securities drove the change in nonoperating income for 2025 compared to 2024. Increase in net position as a percentage of total operating revenues was 12.5% for 2025, compared to 10.2% for 2024.

Analysis – 2024 and 2023

Operating revenues increased by 3.4% in 2024 as compared to 2023, driven primarily by net patient service revenues. Net patient service revenues in 2024 increased by $25.3 million to $752.2 million from $726.9 million in 2023. Management attributes the change in net patient service revenues to a return to normalized Hospital operations during 2024 including growth in outpatient volumes.

Operating expenses increased in 2024 by approximately $24.0 million or 3.3% over 2023, primarily from increases in salaries, wages, and benefits at the Hospital. The implementation of GASB No. 101 resulted in a decrease of $0.5 million of operating expenses; however the cumulative effect of adjustments to beginning net position was $17.4 million, resulting in an overall net impact to ending net position of $16.9 million. Operating income for 2024 increased by $1.6 million to $29.0 million from $27.4 million for 2023.

Nonoperating income, net, for 2024 was $50.3 million as compared to $39.2 million in 2023. An increase in investment income on newly acquired marketable securities drove the change in nonoperating income for 2024 compared to 2023. Increase in net position as a percentage of total operating revenues was 10.2% for 2024, compared to 8.9% for 2023.

Net Patient Service Revenues

Net patient service revenues by funding source for 2025, 2024, and 2023 (in thousands) were as follows:

	Year Ended June 30,			Change	
	2025	2024	2023	2025/2024	2024/2023
Payor					
Hospital operations:					
Medicare	$ 184,226	$ 172,162	$ 174,595	$ 12,064	$ (2,433)
Managed care	357,431	333,913	322,294	23,518	11,619
Medi-Cal and CCAH	118,707	108,042	104,474	10,665	3,568
Other	32,233	26,664	23,916	5,569	2,748
Consolidated subsidiaries	122,038	111,414	101,591	10,624	9,823
Total net patient service revenues	$ 814,635	$ 752,195	$ 726,870	$ 62,440	$ 25,325

Net patient service revenues increased by 8.3% in 2025, compared to 2024. Net patient service revenues increased by 3.5% in 2024, as compared to 2023.

Liquidity and Other Key Ratios

Following is a table showing liquidity and other key ratios for the fiscal year ended June 30, 2025, as compared to June 30, 2024 and 2023:

	Year Ended June 30,		
	2025	2024	2023
Liquidity ratios			
Current ratio	4.9	4.0	5.1
Days of revenue in patient accounts receivable	66.7	60.6	48.9
Margins			
Operating income to total operating revenues	6.1%	3.7%	3.7%
Increase in net position (net income) to total operating revenues	12.5%	10.2%	8.9%
Return on total net position	9.6%	7.9%	7.1%

SVH's current ratio (ratio of current assets to current liabilities) increased from 2024 to 2025, while it decreased substantially year over year from 2023 and 2024. The increase in the current ratio in 2025 was attributed to interest earnings and increases in cash and cash equivalents and short term investments. The decrease in the current ratio in 2024 was attributed to purchase of investments in securities funded by cash previously held in bank savings.

Other Operational Information

Significant operational issues impacting SVH in the near and long term include the following:

Physician Recruitment

Anticipated physician retirement and the growth of the local community have caused SVH to continue its emphasis on physician recruitment in 2025, which will be a continuing issue for SVH in the next several years. In order to keep the facility in the forefront of medical excellence, SVH has adopted a recruitment program to attract physicians in various specialties to the area.

As financial pressures continue to impact SVH and all other healthcare providers in California and the rest of the country, we look for additional investment opportunities in healthcare operations and facilities to supplement and enhance our programs. Through this strategy we are continuing to augment our core activity with partnerships and other forms of alliances with physicians (within the constraints of the law), to continue to have the necessary resources to provide the local community with state-of-the-art healthcare facilities.

Management Focus

It is the mission of Salinas Valley Health to provide quality healthcare to our patients and to improve the health and well-being of our community. Our vision is to be a center of excellence where an inspired team delivers compassionate and culturally sensitive care, outstanding quality, and an exceptional patient experience.

To carry out this mission and vision, we must have the best professionals, personnel, state-of-the-art equipment, facilities, services, supplies, and infrastructure. We focus on the following:

- Investing only in resources and services that enhance or supplement our core mission.
- Managing our resources by utilizing measurable objectives that tie to our core mission and holding management accountable for continuing performance improvements.

Federal and State Net Revenue Estimates

Entities doing business with governmental payors, including Medicare and Medicaid (Medi-Cal in California), are subject to risks unique to the government-contracting environment that are difficult to anticipate and quantify. Revenues are subject to adjustment as a result of examination by government agencies as well as auditors, contractors, and intermediaries retained by the federal, state, or local governments (collectively, Government Agents). Resolution of such audits or reviews often extends (and in some cases does not even commence until) several years beyond the year in which services were rendered and/or fees received.

Moreover, different Government Agents frequently interpret government regulations and other requirements differently. For example, Government Agents might disagree on a patient's principal medical diagnosis, the appropriate code for a clinical procedure, or many other matters. Such disagreements might have a significant effect on the ultimate payout due from the government to fully recoup sums already paid. Governmental agencies may make changes in program interpretations, requirements, or conditions of participation, some of which may have implications for amounts previously estimated. In addition to varying interpretation and evolving codification of the regulations, standards of supporting documentation and required data are subject to wide variation.

In accordance with generally accepted accounting principles, to account for the uncertainty around Medicare and Medicaid revenues, SVH estimates the amount of revenue that will ultimately be received under the Medicare and Medi-Cal programs.

California Intergovernmental Transfers Received

Section 14164 of the California Welfare & Institutions Code provides for transfers between participating hospitals and the State Department of Healthcare Services to be used as a portion of the nonfederal share of providing services to Medi-Cal recipients. SVH received $17.9 million, $23.8 million, and $9.7 million net funding under this program in the years ended June 30, 2025, 2024, and 2023, respectively.

Charity Care and Community Funding

SVH delivered charity care, community benefits, and unreimbursed patient care totaling $168 million, $155 million, and $160 million in the years ended June 30, 2025, 2024, and 2023, respectively. SVH has made additional investments in the community, in alignment with our Community Health Needs Assessment (CHNA), develop collaborative community partnerships that create a lasting impact on the well-being of our community by optimizing the environment in which people live, work, learn, and play.

Cautionary Note Regarding Forward-Looking Statements

Certain information provided by SVH, including written as outlined above or oral statements made by its representatives, may contain forward-looking statements as defined in the Private Securities Litigation Reform Act of 1995. All statements, other than statements of historical facts, which address activities, events, or developments that SVH expects or anticipates will or may occur in the future, contain forward-looking information.

MANAGEMENT'S DISCUSSION AND ANALYSIS – FIDUCIARY

Overview

The Salinas Valley Memorial Healthcare District Employees Pension Plan (the Plan) was established in November 1966 by the Salinas Valley Memorial Healthcare District (now known as Salinas Valley Health or SVH) and has been amended from time to time since that date, as further described below. The Plan provides retirement, disability, and death benefits to permanent employees of SVH with union representation based on the employee's years of service, age, and annual compensation during covered employment.

General Plan Description

The Plan was amended effective January 1, 2004, to provide that the benefit formula be equal to 2.45% of the participant's earnings in a plan year. The benefit formula was previously 2.25% of the participant's earnings in a plan year (for plan years 2000 through 2003).

Participation in the Plan was frozen effective March 31, 2011, for nonunion employees. These employees are entitled to benefits earned before that date but do not accrue further benefits under the Plan.

The Plan was amended effective January 1, 2013, to comply with the applicable provisions of the California Public Employees' Pension Reform Act of 2013 (PEPRA). These provisions include limitations on pensionable compensation and retirement benefits and contribution provisions, including the establishment of participant contributions, for new participants who are hired on or after January 1, 2013, and meet the eligibility and vesting requirements of the Plan.

The Plan was amended and restated effective January 1, 2016, to update the Plan for legislative changes according to PEPRA and to remove the three-year service requirement to participate in the Plan for eligible employees.

The Plan's policies allow investments consisting of fixed income and equity marketable securities, and money market funds. The Plan's investments are held in a portfolio of registered investment companies (mutual funds). Benefit payments to members and beneficiaries continue to increase each year due to the increased number of retirees and beneficiaries receiving benefits.

Plan documents contain a more detailed description of the Plan's provisions and should be referred to for a more complete understanding of the terms of the Plan. Copies of the appropriate documents are available through the administrative offices of SVH.

Overview of the Basic Fiduciary Financial Statements – Salinas Valley Memorial Healthcare District Employees Pension Plan

The basic fiduciary financial statements present information about the Plan's fiduciary net position and changes in its fiduciary net position. The basic fiduciary financial statements also include notes to explain some of the information in the fiduciary financial statements and to provide more details. The notes are followed by a section of required supplementary information that displays additional detail information not in the basic fiduciary financial statements, but which is required by the pronouncements of the GASB and relate to funding progress and required contributions. The statement of fiduciary net position displays the assets (at fair value), liabilities, and resulting net position of the Plan as of the end of the fiscal year. The statement of changes in fiduciary net position reflects the employer contributions and investment return, net of investment expenses, less benefits paid.

Financial Analysis of the Plan

Total contributions have either matched or exceeded the actuarially determined contribution amounts since 2015, due to decisions made by the SVH's Board of Directors to fund the Plan at amounts equal or above actuarially determined contributions.

Abbreviated Fiduciary Financial Statements – Salinas Valley Memorial Healthcare District Employees Pension Plan

The following are abbreviated statements of fiduciary net position as of June 30, 2025, 2024, and 2023 (in thousands):

	As of June 30,			Change	
	2025	2024	2023	2025/2024	2024/2023
Cash and investments	$ 515,636	$ 459,539	$ 403,720	$ 56,097	$ 55,819
Net position held in trust for pension benefits	$ 515,636	$ 459,539	$ 403,720	$ 56,097	$ 55,819

The following are abbreviated statements of changes in fiduciary net position as of June 30, 2025, 2024, and 2023 (in thousands):

	Year Ended June 30,			Change	
	2025	2024	2023	2025/2024	2024/2023
Investment income (loss), net	$ 63,511	$ 62,101	$ (83,746)	$ 1,410	$ 145,847
Employer contributions	12,603	11,270	61,579	1,333	(50,309)
Member contributions	2,800	2,506	2,578	294	(72)
Benefit payments to members and beneficiaries	(22,703)	(19,962)	(18,961)	(2,741)	(1,001)
Administrative expenses	(114)	(96)	(105)	(18)	9
Net change in fiduciary net position	$ 56,097	$ 55,819	$ (38,655)	$ 278	$ 94,474

Analysis – 2025 and 2024

During 2025, the net position held in trust for pension benefits increased by approximately 12.2%, compared to 2024. Employer contributions were $12.6 million in 2025 compared to $11.3 million in 2024. Benefit payments were $22.6 million in 2025 compared to $20.0 million in 2024. Net investment income was $63.5 million in 2025 compared to $62.1 million in 2024.

Analysis – 2024 and 2023

During 2024, the net position held in trust for pension benefits increased by approximately 13.8%, compared to 2023. Employer contributions were $11.3 million in 2024 compared to $61.6 million in 2023. Benefit payments were $20.0 million in 2024 compared to $19.0 million in 2023. Net investment income was $62.1 million in 2024 compared to net investment loss of $83.7 million in 2023.

Report of Independent Auditors

The Board of Directors
Salinas Valley Memorial Healthcare System

Report on the Audit of the Financial Statements

Opinion

We have audited the consolidated financial statements of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System (the System) as of and for the years ended June 30, 2025 and 2024, and the related notes to the consolidated financial statements, which collectively comprise the System's consolidated financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the aggregate remaining fund information of the System as of June 30, 2025 and 2024, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for twelve months beyond the consolidated financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS and the California Code of Regulations, Title 2, Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – Change in Accounting Principle

As discussed in Note 2 and 17 to the consolidated financial statements, effective July 1, 2024, the System adopted GASB Statement No. 101, *Compensated Absences*, requiring retroactive application.

Accordingly, the fiscal year 2024 consolidated financial statements have been restated to apply this new accounting standard. Our opinion on the consolidated financial statements is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis on pages 1 to 12 and supplemental pension and post-retirement benefit information on page 64 be presented to supplement the consolidated financial statements. Such information is the responsibility of management and, although not a part of the consolidated financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements that collectively comprise the System's consolidated financial statements. The consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position on pages 59 to 61 are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

The accompanying supplemental schedule of community benefit on page 62 has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

San Francisco, California
November 21, 2025

Consolidated Financial Statements

Salinas Valley Memorial Healthcare System
Consolidated Statements of Net Position
June 30, 2025 and 2024
(in Thousands)

	2025	2024 (as restated)
ASSETS AND DEFERRED OUTFLOWS		
CURRENT ASSETS		
Cash and cash equivalents	$ 312,848	$ 273,204
Patient accounts receivable, net of estimated uncollectibles of $65,015 and $55,096 at June 30, 2025 and 2024, respectively	148,799	124,912
Short-term investments	142,779	127,818
Supplies inventory	8,357	7,763
Lease receivable, current portion	436	785
Other current assets	39,400	14,913
Total current assets	652,619	549,395
BOARD-DESIGNATED FUNDS	176,241	166,414
CAPITAL ASSETS		
Nondepreciable	40,835	44,528
Depreciable, net	215,192	215,326
Total capital assets, net	256,027	259,854
OTHER ASSETS		
Right-of-use assets, net of amortization	15,387	14,000
Subscription assets, net of amortization	8,060	10,207
Lease receivable, net of current portion	2,041	467
Long-term investments	148,417	156,598
Investments in affiliates	15,176	14,987
Net pension asset	19,774	-
Other long-term assets	1,603	1,566
Total other assets	210,458	197,825
Total assets	1,295,345	1,173,488
DEFERRED OUTFLOWS – ACTUARIAL	55,439	85,734
DEFERRED OUTFLOWS – GOODWILL	638	888
Total deferred outflows	56,077	86,622
Total assets and deferred outflows	$ 1,351,422	$ 1,260,110

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Net Position
June 30, 2025 and 2024
(in Thousands)

	2025	2024 (as restated)
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION		
CURRENT LIABILITIES		
Notes payable, current portion	$ 109	$ 104
Accounts payable	18,335	20,037
Accrued expenses	86,910	87,073
Estimated third-party payor settlements	4,491	3,689
Lease liabilities, current portion	4,694	4,336
Subscription liabilities, current portion	2,780	4,228
Self-insurance liabilities, current portion	16,734	17,925
Total current liabilities	134,053	137,392
NET PENSION LIABILITY	-	19,697
NET POST-RETIREMENT MEDICAL BENEFITS LIABILITY	3,852	4,160
NOTES PAYABLE, net of current portion	440	548
LEASE LIABILITIES, net of current portion	11,798	11,179
SUBSCRIPTION LIABILITIES, net of current portion	2,876	3,461
SELF-INSURANCE LIABILITIES, net of current portion	11,656	12,079
Total liabilities	164,675	188,516
DEFERRED INFLOWS – ACTUARIAL	79,395	71,166
DEFERRED INFLOWS – LEASES	2,441	1,112
Total deferred inflows	81,836	72,278
Total liabilities and deferred inflows	246,511	260,794
NET POSITION		
Invested in capital assets, net of related debt	256,777	260,205
Reserved for minority interest	(8,929)	(6,629)
Restricted – expendable	3,940	4,581
Restricted – nonexpendable	1,232	1,268
Unrestricted	851,891	739,891
Total net position	1,104,911	999,316
Total liabilities, deferred inflows, and net position	$ 1,351,422	$ 1,260,110

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2025 and 2024
(in Thousands)

	2025	2024 (as restated)
OPERATING REVENUES		
Net patient service revenues	$ 814,635	$ 752,195
Other revenues	31,719	22,801
Total operating revenues	846,354	774,996
OPERATING EXPENSES		
Salaries and wages	258,364	238,285
Compensated absences	42,791	39,823
Employee benefits	106,053	107,065
Supplies	120,465	101,259
Purchased services	67,611	64,825
Medical fees	93,600	85,854
Other fees	41,497	44,191
Depreciation and amortization	37,280	36,263
Other expenses	27,044	28,395
Total operating expenses	794,705	745,960
Operating income	51,649	29,036
NONOPERATING REVENUES AND EXPENSES		
Grants and contributions	9,027	3,753
Property tax revenue	6,384	5,680
Investment income, net	42,800	39,603
Provision for credit losses	(13,618)	(5,447)
Gain on disposal of capital assets	116	157
Income from investments in affiliates	2,490	2,422
Other	4,605	2,374
Nonoperating income, net	51,804	48,542
INCOME BEFORE MINORITY INTEREST	103,453	77,578
MINORITY INTEREST IN INCOME OF CONSOLIDATED AFFILIATES	2,142	1,729
INCREASE IN NET POSITION	105,595	79,307
NET POSITION, beginning of year	999,316	937,487
CUMULATIVE EFFECT OF RESTATEMENT (note 17)	-	(17,478)
NET POSITION, beginning of year, as restated	999,316	920,009
NET POSITION, end of year	$ 1,104,911	$ 999,316

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Cash Flows
Years Ended June 30, 2025 and 2024
(in Thousands)

	2025	2024 (as restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash received from patients and third-party payors	$ 724,192	$ 681,638
Cash paid to employees for services	(445,069)	(378,918)
Cash paid to suppliers for goods and services	(277,393)	(267,031)
Other receipts from operations	31,719	22,801
Net cash provided by operating activities	33,449	58,490
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Proceeds from property taxes levied by the County	6,384	5,680
Grants and donations received	9,027	3,753
Net cash provided by noncapital financing activities	15,411	9,433
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(23,836)	(31,819)
Proceeds from sale of capital assets	405	1,762
Proceeds from lease receivable	2,681	1,184
Payments on lease liabilities	(4,834)	(5,735)
Payments on subscription liabilities	(5,268)	(7,743)
Principal payments on notes payable	(103)	(103)
Net cash used in capital and related financing activities	(30,955)	(42,454)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchases of investments	(302,068)	(615,819)
Proceeds from sales of investments	338,088	535,789
Changes in board-designated funds	(9,827)	(8,539)
Other nonoperating distribution	(6,600)	(1,711)
Distribution from minority interest in affiliates, net	2,146	2,026
Net cash provided by (used in) investing activities	21,739	(88,254)
NET CHANGE IN CASH AND CASH EQUIVALENTS	39,644	(62,785)
CASH AND CASH EQUIVALENTS, beginning of year	273,204	335,989
CASH AND CASH EQUIVALENTS, end of year	$ 312,848	$ 273,204

See accompanying notes.

Salinas Valley Memorial Healthcare System
Consolidated Statements of Cash Flows
Years Ended June 30, 2025 and 2024
(in Thousands)

	2025	2024
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 51,649	$ 29,036
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	37,280	36,263
Provision for doubtful accounts	67,358	41,364
Net (gain) loss on disposal of capital and subscription assets	(116)	306
Changes in operating assets and liabilities:		
Patient accounts receivable, net	(91,245)	(68,842)
Lease receivable	(3,906)	-
Supplies and other assets	(25,118)	(467)
Net pension asset	(39,471)	(35,314)
Deferred outflows	30,545	31,426
Deferred inflows	9,558	6,278
Accounts payable and accrued expenses	(1,865)	14,299
Self-insurance liabilities	(1,922)	4,262
Estimated third-party payor settlements	802	(1,715)
Right-of-use assets/lease liabilities	(100)	1,594
Net cash provided by operating activities	$ 33,449	$ 58,490
SUPPLEMENTAL DISCLOSURE OF NONCASH INVESTING AND FINANCING ACTIVITY		
Noncash acquisition of ROU assets	$ 5,911	$ 4,575
Noncash acquisition of subscription assets	$ 3,235	$ 5,086

See accompanying notes.

Salinas Valley Memorial Healthcare System
Employees' Pension Plan – Statements of Fiduciary Net Position
June 30, 2025 and 2024
(in Thousands)

	2025	2024
ASSETS		
Investments, at fair value		
Mutual funds	$ 515,636	$ 459,539
NET POSITION HELD IN TRUST FOR PENSION BENEFITS	$ 515,636	$ 459,539

See accompanying notes.

Salinas Valley Memorial Healthcare System
Statements of Changes in Fiduciary Net Position
Years Ended June 30, 2025 and 2024
(in Thousands)

	2025	2024
ADDITIONS		
Investment income		
Net appreciation in fair value of investments	$ 51,590	$ 50,748
Dividends	11,921	11,353
Net investment income	63,511	62,101
Contributions		
Employer	12,603	11,270
Members	2,800	2,506
Total contributions	15,403	13,776
Total additions	78,914	75,877
DEDUCTIONS		
Benefit payments	22,703	19,962
Administrative expenses	114	96
Total deductions	22,817	20,058
NET CHANGE IN NET POSITION	56,097	55,819
NET POSITION HELD IN TRUST FOR PENSION BENEFITS, beginning of year	459,539	403,720
NET POSITION HELD IN TRUST FOR PENSION BENEFITS, end of year	$ 515,636	$ 459,539

See accompanying notes.

Note 1 – Organization

The Salinas Valley Memorial Healthcare System (Salinas Valley Health or SVH) is a special district created in 1947, administered by a Board of Directors elected by the registered voters of the Hospital District (the District). SVH is a political subdivision of the State of California and operates the Salinas Valley Memorial Hospital (Salinas Valley Health Medical Center or SVHMC or the Hospital) and Subsidiaries.

The consolidated SVH includes an 85% interest in a partnership, Central Coast Medical Service Organization (CCMSO), an outpatient medical clinic organization; 100% of Salinas Valley Memorial Hospital Foundation (the Foundation), which is authorized to solicit contributions on the Hospital's behalf; 100% of Salinas Valley Health Clinics (SVHC), a multi-specialty physician practice; and 50% of a joint venture with Lucille Packard Children's Hospital to operate the Neonatal Intensive Care Unit in the Hospital (SVMH-LPCH NICU JV).

Fiduciary plan description – The Plan is a single-employer noncontributory employee retirement system established by SVH. SVH is a political subdivision that was organized under the provisions of the Health and Safety Code of the State of California. Permanent employees of SVH with union representation are eligible to participate in the Plan upon the later of their employment commencement date or reaching the age of 21.

The Plan provides retirement, disability, and death benefits based on the employee's years of service, age, and annual compensation during covered employment. Plan provisions and all other requirements are established by SVH's five-member Board of Directors (the Board), which has been elected by the registered voters of the District.

Effective March 31, 2011, participation of nonunion employees in the Plan was frozen. Nonunion employees are entitled to benefits earned before March 31, 2011, but do not accrue further benefits under the Plan.

Effective January 1, 2013, the Plan was amended to adopt the applicable provisions of the California Public Employees' Pension Reform Act of 2013 (PEPRA).

The above description of the Plan provides only general information. Participants should refer to the plan document for a more complete description of the Plan's provisions.

Note 2 – Summary of Significant Accounting Policies

Principles of consolidation – The consolidated financial statements include the accounts of SVHMC and all subsidiaries that are controlled and owned more than 50% for which day-to-day operations are managed by SVH. All intercompany accounts and transactions are eliminated upon consolidation. Investments for which SVH has 50% or less ownership and over which SVH does not have control are recorded using the equity method. Minority interest represents the proportionate share of the equity in affiliates that is attributable to the minority owners.

Acquired businesses are included in the consolidated financial statements from the date of acquisition.

Basis of accounting – The accompanying consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) as prescribed by the Governmental Accounting Standards Board (GASB) using the economic resources measurement focus; the accrual basis of accounting; the California Code of Regulations, Title 2, Section 1131, State Controller's *Minimum Audit Requirements* for California Special Districts; and the State Controller's Office prescribed reporting guidelines. In addition, these statements follow GAAP applicable to the healthcare industry, which are included in the American Institute of Certified Public Accountants' *Audit and Accounting Guide, Healthcare Entities*, to the extent that these principles do not contradict GASB standards.

SVH utilizes the proprietary fund method of accounting whereby revenues and expenses are recognized on the accrual basis and consolidated financial statements are prepared using the economic resources measurement focus.

New accounting pronouncements – In May 2024, the GASB issued Statement No. 103, *Financial Reporting Model Improvements,* which enhances the effectiveness of financial reporting models for governments. The objective of this statement is to improve key components of the financial reporting model to enhance its effectiveness in providing information that is essential for decision making and assessing a government's accountability. This statement also addresses certain application issues. This statement is effective for fiscal years beginning after June 15, 2025. SVH is currently assessing the potential impact of this statement on its consolidated financial statements.

In September 2024, the GASB issued Statement No. 104, *Disclosure of Certain Capital Assets*. This Statement requires separate disclosure of certain capital assets in the notes, such as lease, intangible right-to-use (ROU), and subscription assets, each by major class. It also establishes new disclosure requirements for capital assets that a government has decided to sell and for which a sale is probable within one year. This Statement is effective for fiscal years beginning after June 15, 2025, with retroactive application required upon adoption. SVH is currently evaluating the impact of the adoption of this standard on its consolidated financial statements.

Use of estimates – The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenues and expenses during the reporting period. The most significant estimates relate to patient accounts receivable allowances, amounts due to third-party payors, self-insurance liabilities, employee benefit costs including pension, useful lives of capital assets, discount rate for leases, useful lives of ROU assets, deferred inflows of resources, probability of accumulated leave being used or settled and the timing of those payments related to calculation of employee sick leave accrual, subscription term of subscription assets, and discount rates used for subscription liabilities. Actual results could differ from those estimates.

Fair value of financial instruments – Unless otherwise indicated, the fair value of all reported assets and liabilities that represents financial instruments approximates their carrying values. SVH's policy is to recognize transfers in and transfers out of Levels 1, 2, and 3 as of the end of the reporting period. See Note 5 for further discussion of fair value measurements in the consolidated financial statements.

Cash and cash equivalents – Cash and cash equivalents include investments in highly liquid debt instruments with an initial maturity of three months or less, excluding amounts whose use is limited by Board designation or other arrangements. Cash and cash equivalents also include investments in the Local Agency Investment Fund (LAIF), the State Treasurer's pooled investment program, and values participants' shares on an amortized cost basis.

Supplies inventory – Supply inventories are valued at the lower of cost (first-in, first-out method) or market.

Lease receivable – SVH's lease receivable is measured at the present value of lease payments expected to be received during the lease term. Under the lease agreement, SVH may receive variable lease payments that are dependent upon the lessee's revenue. The variable payments are recorded as an inflow of resources in the period the payment is received. The deferred inflow of resources is recorded at the initiation of each lease in an amount equal to the initial recording of the lease receivable. The deferred inflows of resources are amortized using the effective-interest method over the term of each lease.

Investments – U.S. Treasury securities, federal agency debt securities, corporate notes, and equity securities, which are reported as board-designated funds and investments, are carried at fair value based on published market values, as quoted on a recognized exchange or an industry standard pricing service. Short-term investments in commercial paper, certificates of deposit, and money market accounts are recorded at amortized cost, which approximates market value. Mutual funds are carried at fair value based on the fund's current share price. These investments are subject to various risks, such as interest rate, market, and credit risks.

Investment transactions are recorded on the date the investments are purchased or sold (trade date). Realized gains or losses are recorded as the difference between the proceeds from the sale and the cost of the investment sold.

Board-designated funds – Board-designated funds include assets set aside by the Board of Directors for future capital improvements or for certain contingencies, over which the Board retains control and may at its discretion subsequently use for other purposes, and assets held by trustees under agreements with third parties.

Capital assets – Capital asset acquisitions are recorded at cost. Capital assets donated for SVH operations are recorded at fair value at the date of receipt. Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed on the straight-line method. Equipment under lease is amortized on the straight-line method over the shorter period of the lease term or the estimated useful life of the equipment. Such amortization is included in depreciation and amortization in the consolidated financial statements. SVH capitalizes all purchases of computers and copiers over $5 thousand, general acquisitions over $5 thousand, and group purchases over $25 thousand. Depreciation expense is computed using the straight-line method over the estimated useful lives of the assets as follows:

Land improvements	20 to 40 years
Buildings and improvements	20 to 40 years
Moveable equipment	3 to 20 years

Upon disposition or retirement of capital assets, the undepreciated cost basis less proceeds from sale, if any, are reflected in nonoperating gains and losses in the period of disposition.

SVH evaluates prominent events or changes in circumstances affecting capital assets to determine whether impairment of a capital asset has occurred. Impairment losses on capital assets are measured using the method that best reflects the diminished service utility of the capital asset. Management evaluates prominent events or changes in circumstances to determine whether an impairment loss should be recognized. There were no impairment losses during the years ended June 30, 2025 and 2024.

Right-of-use assets – SVH has recorded ROU assets in accordance with GASB Statement No. 87, *Leases* (GASB No. 87). The ROU assets are initially measured at an amount equal to the initial measurement of the related lease liability, plus any lease payments made prior to the lease term and ancillary charges necessary to place the lease into service, less any lease incentives received. The ROU assets are amortized on a straight-line basis over the life of the related lease. See Note 13 for further discussion of ROU assets.

Subscription assets – SVH has recorded subscription assets in accordance with GASB Statement No. 96, *Subscription-Based Information Technology Arrangements* (GASB No. 96). The subscription assets are initially measured at an amount equal to the initial measurement of the sum of the related subscription liability, any contract payments made to the subscription-based IT arrangement (SBITA) vendor at subscription term commencement, and any capitalizable initial implementation costs, less any incentive payments received from the vendor at the subscription term commencement. Subscription assets are amortized on a straight-line basis over the shorter of the subscription term or the useful life of the underlying assets. See Note 14 for further discussion of subscription assets.

Deferred outflows and inflows – SVH records deferred outflows or inflows of resources in its consolidated financial statements for consumption or acquisition of its consolidated net position that is applicable to future reporting periods. These consolidated financial statement elements are distinct from assets and liabilities. The table below reflects the components of deferred outflows and inflows as of June 30, in thousands:

	2025	2024
Deferred outflows - actuarial		
Pension	$ 54,708	$ 84,902
Post-retirement medical plans	731	832
Total deferred outflows - actuarial	55,439	85,734
Deferred outflows - goodwill	638	888
Total deferred outflows	$ 56,077	$ 86,622
Deferred inflows - actuarial		
Pension	$ 77,507	$ 69,533
Post-retirement medical plans	1,888	1,633
Total deferred inflows - actuarial	79,395	71,166
Deferred inflows - leases	2,441	1,112
Total deferred inflows	$ 81,836	$ 72,278

Accrued expenses – SVH recognizes accrued expenses when an obligation for goods or services has been incurred, but not yet paid as of year-end. Accrued expenses at year-end primarily consists of various operating expenses payable to vendors, as well as payroll-related liabilities and compensated absences. See Note 12 for further discussion on compensated absences.

Lease liabilities – SVH recognizes lease contracts or equivalents that have a term exceeding one year and the cumulative undiscounted future payments on the contract exceeding $50 thousand that meet the definition of an other-than-short-term lease. Lease liabilities are recorded as the present value of the undiscounted future lease payments. SVH uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using SVH's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract. Short-term lease payments for leases with an original term of one year or less are expensed as incurred. See Note 13 for further discussion of lease liabilities.

Subscription liabilities – SVH has recorded subscription liabilities in accordance with GASB No. 96. SVH recognizes SBITA contracts or equivalents that have a term exceeding one year and the cumulative future payments on the contract exceeding $50 thousand that meet the definition of an other-than-short-term SBITA. Subscription liabilities are initially measured at an amount equal to the present value of the undiscounted future payments under the SBITA. SVH uses a discount rate that is explicitly stated or implicit in the contract to determine the value of the subscription liability. When a readily determinable discount rate is not available, the discount rate is determined using SVH's incremental borrowing rate at start of the subscription term for a similar asset type and term length to the contract. As variable payments based upon the use of the underlying subscription asset are not fixed in nature, such amounts are excluded from subscription liabilities. Short-term subscription payments with an original subscription term of one year or less are expensed as incurred. See Note 14 for further discussion of subscription liabilities.

Risk management – SVH is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; employee health and accident benefits; and medical malpractice. SVH utilizes both commercial insurance and self-insurance for claims arising from such matters. SVH is self-insured for workers' compensation claims, professional liability, and health benefits. Settled claims have not exceeded SVH's policy limits in any of the past three fiscal years.

Self-insurance plans – SVH is self-insured for workers' compensation benefits for employees. An actuarial estimate is accrued based on an expected, undiscounted estimate as of June 30, 2025 and 2024.

SVH is a member of and participates in a professional liability self-insurance program through BETA Healthcare Group (BETA), a joint powers authority whose members include district and private not-for-profit hospitals and county facilities in California. Amounts paid by each member to BETA represent actuarially determined assessments of claims payable and estimated incurred-but-not-reported claims that are adjusted periodically based on the claims experience for each member at each hospital. Claims in excess of specified amounts are the responsibility of individual program participants.

SVH provides eligible employees with health benefits through a self-insured program. The liability for claims arising from this program is estimated based upon historical experience and trending information.

Net position – Net position is required to be classified for accounting and reporting purposes in the following categories:

- *Invested in capital assets, net of related debt* – Capital assets, net of accumulated depreciation, subscription assets and right of use assets, net, reduced by outstanding principal balances of debt (including subscription and lease liabilities) attributable to the acquisition, construction, or improvement of those assets.

- *Reserved for minority interest* – Net position of legally separate organization attributable to other participants.

- *Restricted* – SVH classifies net position resulting from transactions with purpose restrictions as restricted net assets until the resources are used for the specific purpose or for as long as the provider requires the resources to remain intact.
    - *Expendable* – Net position whose use by SVH is subject to externally imposed restrictions that can be fulfilled by actions of SVH pursuant to those restrictions or that expire by the passage of time.
    - *Nonexpendable* – Net position that includes donor restricted requirements to invest the principal portion in perpetuity.

- *Unrestricted* – Net position that is neither restricted nor invested in capital assets, net of related debt. Unrestricted net position may be designated for specific purposes by management or the Board of Directors.

Statements of revenues, expenses, and changes in net position – For purposes of display, transactions deemed by management to be ongoing, major, or central to the provision of healthcare services are reported as operating revenues and expenses. Peripheral or incidental transactions, including investment income, interest expense, and gains or losses on the disposal of capital assets, are reported as nonoperating income and expense.

Net patient service revenues – Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors including Medicare and Medi-Cal, and others for services rendered, including estimated retroactive audit adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Laws and regulations governing the Medicare and Medi-Cal programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates may change by a material amount in the near term.

Grants and contributions – For the years ended June 30, 2025 and 2024, SVH was obligated and received approximately $5.2 million and $254,000, respectively, in Disaster Relief Funds from the Federal Emergency Management Agency and has recognized this in grant and contribution revenue in the consolidated statements of revenues, expenses, and changes in net position.

Charity care – SVH provides care without charge or at less than its established rates to patients who meet certain criteria under its charity care policy. Because SVH does not pursue collection of amounts determined to qualify as charity care, such amounts are not included in net patient service revenues. Cost of services rendered to patients who qualified for financial assistance under SVH's charity care policy, calculated using the cost-to-charge ratio, totaled $1.3 million and $1.4 million for the years ended June 30, 2025 and 2024, respectively.

Property taxes – SVH, as part of a California special district, receives property taxes that are assessed by Monterey County. Such amounts are recorded within nonoperating income in the consolidated statements of revenues, expenses, and changes in net position.

Aspire Health Plan – SVH provided funding to Aspire Health Plan, a California nonprofit mutual benefit corporation that operates a Medicare Advantage plan, in exchange for a 49% membership voting interest. Initial funding of $1.5 million was reported as other long-term assets in the consolidated statement of net position as of June 30, 2017. Additional funding of $14.0 million and $5.8 million was included within nonoperating expenses in the consolidated statements of revenue, expense, and changes in net position, for the years ended June 30, 2025 and 2024, respectively, due to the uncertain nature of repayments of ongoing funding.

Concentration of credit risk – SVH is highly dependent upon government programs and nongovernmental third-party payors for its revenues. Net patient service revenue from Medicare amounted to 23% and negotiated third-party payors amounted to 44% of total net patient service revenues for both years ended June 30, 2025 and 2024. Significant concentrations of net patient accounts receivable include Medicare at 18% and 14% and negotiated third-party payors at 70% and 71% at June 30, 2025 and 2024, respectively.

Income taxes – SVH, being a governmental entity, is therefore tax-exempt. All of its consolidated subsidiaries are either not-for-profit corporations or partnerships and are, therefore, not subject to income taxes.

Reclassifications – Certain reclassifications of prior year's balances have been made to conform with the current year presentation. Such reclassifications did not affect the total increase in net position or total current or long-term assets or liabilities. The restatement related to the adoption of GASB Statement No. 101, which resulted in adjustments to beginning net position and expense, is separately disclosed in Note 17.

Note 3 – Net Patient Service Revenues

Net patient service revenues for the years ended June 30 consisted of the following, in thousands:

	2025	2024
Gross patient service revenues		
Routine inpatient services	$ 461,464	$ 439,283
Ancillary services	2,536,372	2,198,393
Outpatient services	609,230	580,622
Total gross patient service revenues	3,607,066	3,218,298
Deductions from gross patient service revenues		
Contractual allowance for statutory and negotiated rates	(2,717,369)	(2,417,329)
Provision for doubtful accounts	(67,358)	(41,364)
Charity care	(7,704)	(7,410)
Net patient service revenues	$ 814,635	$ 752,195

SVHMC has agreements with third-party payors that provide for payments to SVHMC at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare – Medicare patient revenues include traditional reimbursement under Title XVIII of the Social Security Act. Inpatient acute care services rendered to Medicare program beneficiaries are paid at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors. Medicare reimburses hospitals for covered outpatient services rendered to its beneficiaries by way of an outpatient prospective payment system based upon ambulatory payment classifications.

Certain inpatient and outpatient pass-through costs related to Medicare beneficiaries are paid based on a cost reimbursement methodology. SVHMC is reimbursed for cost reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by SVHMC and audits thereof by the Medicare administrative contractor. SVHMC's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with SVHMC. SVHMC's Medicare cost reports have been audited by the Medicare administrative contractor through June 30, 2021.

Medi-Cal – Medi-Cal patient revenues include traditional reimbursement under the California State Department of Health Services for patients covered under Title XIX of the Social Security Act. Inpatient services rendered to Medi-Cal program beneficiaries are reimbursed under a contract at prospectively determined negotiated per diem rates. Outpatient services are reimbursed based on a schedule of maximum allowances. For certain inpatient services, SVHMC is reimbursed at a tentative rate with final settlement determined after submission of annual cost reports by SVHMC and audits thereof by Medi-Cal. SVHMC's Medi-Cal cost reports have been audited by Medi-Cal through June 30, 2021.

Other – SVHMC has entered into agreements with numerous nongovernment third-party payors to provide patient care to beneficiaries under a variety of payment arrangements. These include arrangements with commercial insurance companies, including workers' compensation plans, which reimburse SVHMC at a percentage of SVHMC's charges.

Billings relating to services rendered are recorded as net patient service revenues in the period in which the service is performed, net of contractual and other allowances that represent differences between gross charges and the estimated receipts under such programs. Net patient service revenues are reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. Receivables for patient care are also reduced for allowances for uncollectible accounts.

The process for estimating the ultimate collection of receivables involves significant assumptions and judgments. Account balances are written off against the allowance when management determines it is probable the receivable will not be recovered. The use of historical collection and payor reimbursement experience is an integral part of the estimation of reserves for uncollectible accounts. Revisions in reserves for uncollectible accounts estimates are recorded as an adjustment to the provision for bad debts.

At the current time there is uncertainty about reimbursements from government programs. The Centers for Medicare & Medicaid Services has proposed reductions in rates, which would result in a decrease in Medicare reimbursements. The state budget contains healthcare budget cuts that may affect reimbursements for noncontracted Medi-Cal services. The ultimate outcome of these proposals and other market changes cannot presently be determined.

Under Assembly Bill 1383 of 2009, as amended by Assembly Bill 1653 on September 8, 2010 (collectively, the Bill), which establishes a hospital fee program, SVH is exempt from the quality assurance fee but is eligible for supplemental payments under the second part of the Bill, and received $4.2 million and $9.7 million, respectively, in the years ended June 30, 2025 and 2024, as included in net patient service revenue in the accompanying consolidated statements of revenues, expenses, and changes in net position.

Note 4 – Cash, Cash Equivalents, Investments, and Board-Designated Funds

As of June 30, cash and cash equivalents, investments, and board-designated funds, at fair value, consisted of the following, in thousands:

	2025	2024
Cash and cash equivalents	$ 312,848	$ 273,204
Short-term investments	142,779	127,818
Board-designated funds	176,241	166,414
Long-term investments	148,417	156,598
Total	$ 780,285	$ 724,034

As of June 30, board-designated funds, at fair value, have been set aside as follows, in thousands:

	2025	2024
By Board for capital improvements	$ 176,241	$ 166,324
By agreement with secured vendor	-	90
Total	$ 176,241	$ 166,414

As of June 30, 2025, maturities for SVH's holdings were as follows, in thousands:

	Fair Value	No Maturity	12 Months or Less	13 to 24 Months	25 to 60 Months
Cash and cash equivalents	$ 312,848	$ 312,848	$ -	$ -	$ -
U.S. Treasury notes	54,392	-	54,392	-	-
Municipal notes	26,324	-	14,137	2,434	9,753
Corporate notes	86,299	-	23,276	-	63,023
Commercial paper	15,017	-	15,017	-	-
Federal agency notes	83,390	-	63,261	-	20,129
Bank certificates of deposit	90	-	90	-	-
Money market accounts	5,373	5,373	-	-	-
Mutual funds	18,202	18,202	-	-	-
Government securities	178,350	-	-	-	178,350
Total	$ 780,285	$ 336,423	$ 170,173	$ 2,434	$ 271,255

As of June 30, 2024, maturities for SVH's holdings were as follows, in thousands:

	Fair Value	No Maturity	12 Months or Less	13 to 24 Months	25 to 60 Months
Cash and cash equivalents	$ 273,204	$ 273,204	$ -	$ -	$ -
U.S. Treasury notes	34,845	-	34,845	-	-
Municipal notes	38,536	-	31,817	2,817	3,902
Corporate notes	74,284	-	37,661	20,965	15,658
Commercial paper	9,972	-	9,972	-	-
Federal agency notes	67,721	-	14,701	-	53,020
Bank certificates of deposit	90	-	90	-	-
Money market accounts	5,834	5,834	-	-	-
Mutual funds	20,230	20,230	-	-	-
Government securities	199,318	-	14,446	6,051	178,821
Total	$ 724,034	$ 299,268	$ 143,532	$ 29,833	$ 251,401

The following table below identifies the investment types that are authorized for SVHMC by the California Government Code (or SVHMC's investment policy, where more restrictive). There are no restrictions over the maximum percentage that one investment can represent of the total portfolio, nor any restrictions over the maximum amount of investment in any one issuer. The Foundation and CCMSO are not required to follow the California Government Code.

Authorized Investment Type	Maturity
U.S. Treasury obligations	5 years
U.S. agency securities	5 years
Corporate bonds	5 years
Commercial paper	180 days
Mutual funds	N/A
Money market mutual funds	N/A

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. One of the ways that SVH manages its exposure to interest rate risk is by purchasing a combination of shorter-term and longer-term investments and by maintaining fully liquid investments as needed to fund operations.

Credit risk – Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization such as Moody's or S&P.

The following table illustrates the fair value and associated credit ratings of investments held by SVH at June 30, 2025 and 2024, in thousands:

Ratings	Fair Value at June 30, 2025	2024
A+ /A / A- / A-1+ / A1 / A2 / A3	$ 159,834	$ 108,705
AAA / AA+ / AA / AA- / AA1 / AA2 / AA3	274,508	286,695
BBB+	4,945	12,631
SP-1+	-	4,000
NA	4,484	9,890
NR	336,514	302,113
Total	$ 780,285	$ 724,034

Concentration of credit risk – The investment policy of SVH contains no limitation on the amount that can be invested in any one issuer beyond that stipulated by the California Government Code.

Custodial credit risk – Custodial credit risk for deposits is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The custodial credit risk for investments is the risk that, in the event of the failure of the counterparty (e.g., broker-dealer) to a transaction, a government will not be able to recover the value of its investment or collateral securities that are in the possession of another party.

The California Government Code and SVHMC's investment policy do not contain legal or policy requirements that would limit the exposure to custodial risk for deposits or investments, other than the following provision for deposits: the California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depositor regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by public agencies. This requirement does not apply to the consolidated subsidiaries of SVH.

As of June 30, 2025 and 2024, approximately $11.9 million and $7.5 million, respectively, of SVH's consolidated subsidiaries' deposits with financial institutions in excess of federal depositor insurance limits were held in accounts not subject to collateralization. SVH's securities are registered under the specific entity's name by the custodial bank as an agent for SVH. Other types of investments represent ownership interests that do not exist in physical or book-entry form. As a result, management considers custodial credit risk to be remote.

Note 5 – Fair Value Measurement

Fair value is defined as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A fair value hierarchy is also established, which requires an entity to maximize the use of observable inputs and minimize the use of unobservable inputs when measuring fair value.

The following describes the three levels of inputs that may be used to measure fair value under GASB Statement No. 72, *Fair Value Measurement and Application*:

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Observable inputs other than Level 1 prices, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 – Unobservable inputs that are supported by little or no market activity and that are significant to the fair value of the assets or liabilities.

The following is a description of the valuation methodologies used for instruments measured at fair value on a recurring basis and recognized in the consolidated statements of net position at June 30, 2025 and 2024, as well as the general classification of such instruments pursuant to the valuation hierarchy:

Mutual funds – Valued at the net asset value of shares held by SVH and are valued at the closing price reported on the active market on which the individual securities are traded.

Municipal notes, government securities, corporate notes, U.S. Treasury notes, other fixed income, and federal agency notes – Valued using pricing models maximizing the use of observable inputs for similar securities, which includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

The following tables present the assets measured at fair value on a recurring basis in the accompanying consolidated statements of net position at June 30, 2025 and 2024, as stratified by fair value hierarchy level, in thousands:

Description	Level 1	Level 2	Level 3	June 30, 2025
Investments by fair value level				
U.S. Treasury notes	$ 54,392	$ -	$ -	$ 54,392
Municipal notes	26,324	-	-	26,324
Corporate notes	86,299	-	-	86,299
Federal agency notes	83,390	-	-	83,390
Mutual funds	18,202	-	-	18,202
Government securities	178,350	-	-	178,350
Total by fair value level	$ 446,957	$ -	$ -	446,957
Cash equivalents				
Local agency investment fund				102
Cash holdings				312,746
Total cash equivalents				312,848
Commercial paper				15,017
Bank certificates of deposit				90
Money market accounts				5,373
Total investments				$ 780,285

Description	Level 1	Level 2	Level 3	June 30, 2024
Investments by fair value level				
U.S. Treasury notes	$ 34,845	$ -	$ -	$ 34,845
Municipal notes	38,536	-	-	38,536
Corporate notes	74,284	-	-	74,284
Federal agency notes	67,721	-	-	67,721
Mutual funds	20,230	-	-	20,230
Government securities	199,318	-	-	199,318
Total by fair value level	$ 434,934	$ -	$ -	434,934
Cash equivalents				
Local agency investment fund				94
Cash holdings				273,110
Total cash equivalents				273,204
Commercial paper				9,972
Bank certificates of deposit				90
Money market accounts				5,834
Total investments				$ 724,034

Fiduciary – Employees' Pension Plan – The following tables present the assets measured at fair value on a recurring basis in the accompanying fiduciary statements of net position at June 30, 2025 and 2024, as stratified by fair value hierarchy level, in thousands:

June 30, 2025	Level 1	Level 2	Level 3	Total
Mutual funds				
Equity securities	$ 166,167	$ -	$ -	$ 166,167
Fixed income	349,469	-	-	349,469
Total	$ 515,636	$ -	$ -	$ 515,636

June 30, 2024	Level 1	Level 2	Level 3	Total
Mutual funds				
Equity securities	$ 326,465	$ -	$ -	$ 326,465
Fixed income	133,074	-	-	133,074
Total	$ 459,539	$ -	$ -	$ 459,539

Note 6 – Capital Assets, Net

The following table summarizes SVH's capital asset activity during the year ended June 30, 2025, in thousands:

	June 30, 2024	Increases	Decreases	Transfers	June 30, 2025
Capital assets not depreciated					
Land	$ 26,059	$ -	$ -	$ -	$ 26,059
Construction in progress	18,469	11,114	-	(14,807)	14,776
Total capital assets not depreciated	44,528	11,114	-	(14,807)	40,835
Capital assets being depreciated/amortized					
Buildings and improvements	424,647	496	(19)	14,763	439,887
Movable equipment	252,219	12,224	(3,400)	44	261,087
Intangibles	4,594	2	-	-	4,596
Land improvements	2,080	-	-	-	2,080
Total capital assets being depreciated	683,540	12,722	(3,419)	14,807	707,650
Less accumulated depreciation and amortization for					
Buildings and improvements	253,687	13,531	-	-	267,218
Movable equipment	207,326	13,754	(3,131)	-	217,949
Intangibles	5,579	38	-	-	5,617
Land improvements	1,622	52	-	-	1,674
Total accumulated depreciation and amortization	468,214	27,375	(3,131)	-	492,458
Total capital assets being depreciated, net	215,326	(14,653)	(288)	14,807	215,192
Capital assets, net	$ 259,854	$ (3,539)	$ (288)	$ -	$ 256,027

The following table summarizes SVH's capital asset activity during the year ended June 30, 2024, in thousands:

	June 30, 2023	Increases	Decreases	Transfers	June 30, 2024
Capital assets not depreciated					
Land	$ 26,059	$ -	$ -	$ -	$ 26,059
Construction in progress	34,008	22,157	(1,530)	(36,166)	18,469
Total capital assets not depreciated	60,067	22,157	(1,530)	(36,166)	44,528
Capital assets being depreciated/amortized					
Buildings and improvements	389,392	171	-	35,084	424,647
Moveable equipment	241,938	9,471	(272)	1,082	252,219
Intangibles	4,574	20	-	-	4,594
Land improvements	2,080	-	-	-	2,080
Total capital assets being depreciated	637,984	9,662	(272)	36,166	683,540
Less accumulated depreciation and amortization for					
Buildings and improvements	241,803	11,884	-	-	253,687
Movable equipment	193,135	14,388	(197)	-	207,326
Intangibles	5,306	273	-	-	5,579
Land improvements	1,572	50	-	-	1,622
Total accumulated depreciation and amortization	441,816	26,595	(197)	-	468,214
Total capital assets being depreciated, net	196,168	(16,933)	(75)	36,166	215,326
Capital assets, net	$ 256,235	$ 5,224	$ (1,605)	$ -	$ 259,854

SVH reached an agreement with the State of California to meet the California Hospital Seismic Safety Act (SB1953) by retrofitting and strengthening the existing building. These improvements will result in compliance with SB1953 until January 1, 2030.

Note 7 – Investments in Affiliates

SVH has the following investments in joint ventures, which are accounted for in accordance with GASB Statement No. 14, *The Financial Reporting Entity*:

- Community Health Innovations, LLC (CHI), an integrated population health initiative.
- Monterey Peninsula Surgery Center (MPSC), a partnership that operates an outpatient Surgery Center.
- Monterey Bay Endoscopy Center, LLC (MBEC), an outpatient diagnostic center for gastroenterology procedures.
- 21st Century Oncology (MRKS), a partnership with MRKS, Inc. (the successor organization after the bankruptcy of Genesis Care), a partnership to provide outpatient cancer care.

- Mood Health (MOOD HEALTH), equity investment in a start-up company specializing in using technology to help provide psychiatry and therapy and is used by Salinas Valley Health patients.

- Salinas Valley Health Ventures, LLC (SVHV), a limited liability company organized to identify innovative solutions that address the needs and top strategic aims of SVH.

The following table summarizes the percentage interest of and balance of investments in affiliates (in thousands) at June 30, 2025 and 2024:

	Percentage Interest		Investment Balance	
Affiliate	2025	2024	2025	2024
CHI	49%	49%	$ 1,686	$ 1,877
MPSC	12%	12%	7,138	7,156
MRKS	40%	40%	2,935	2,605
MBEC	14%	14%	1,917	1,849
MOOD HEALTH	6%	6%	1,500	1,500
			$ 15,176	$ 14,987

Financial information for these affiliates can be obtained from SVH at 450 E. Romie, Salinas, California 93901.

Note 8 – Related-Party Transactions

Central Coast VNA & Hospice, Inc., leases building space from SVH and paid rent in the amount of $325 thousand and $318 thousand during the years ended June 30, 2025 and 2024, respectively.

The Salinas Valley Memorial Hospital Service League (Service League) is an organization formed for the benefit of SVHMC. Expenses paid by SVHMC on behalf of the Service League during the years ended June 30, 2025 and 2024, totaled $1.8 million and $2.1 million, respectively.

Note 9 – Self-Insurance Liability

SVHMC is self-insured for workers' compensation claims. Estimated losses of $14.2 million and $14.6 million have been accrued under actuarially determined calculations at June 30, 2025 and 2024, of which approximately $2.6 million and $2.5 million are considered current liabilities, respectively.

The following is a summary of changes in workers' compensation self-insurance liabilities for June 30, 2025 and 2024, in thousands:

	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2025	$ 14,552	$ 3,338	$ (3,681)	$ 14,209	$ 2,553
2024	$ 15,523	$ 2,938	$ (3,909)	$ 14,552	$ 2,474

SVHMC is self-insured for employee medical coverage. The estimated liability for employee medical coverage claims incurred but not reported is based on historical claims experience and is considered a current liability. The balances at June 30, 2025 and 2024, were approximately $10.9 million and $12.8 million, respectively, included in self-insurance liabilities, current portion in the consolidated statements of net position.

SVHMC maintains a $40.0 million claims-made medical malpractice policy with BETA, a shared risk pool for California hospital districts. Membership of the Board of BETA is comprised of management of district hospitals. Hospital premiums are established annually based on the experience of the pool and SVHMC. SVHMC paid premiums of approximately $1.8 million and $1.6 million to BETA for the years ended June 30, 2025 and 2024, respectively. SVHMC's policy with BETA is renewed every 12 months; the most recent renewal date was July 1, 2023. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term but reported subsequently will be uninsured. SVHMC may purchase extended reporting endorsements upon cancellation. The length of the reporting endorsement is not limited. As SVHMC has retained risk for claims incurred during the policy period that are not reported prior to the expiration of the policy, the liability for such retained medical malpractice risk has been recorded on SVH's consolidated financial statements. Such liability has been actuarially determined, is considered a current liability, and at June 30, 2025 and 2024, was approximately $3.3 million and $2.7 million, respectively.

Note 10 – Notes Payable, Net

The following table summarizes activity in notes payable, net, during the year ended June 30, 2025, in thousands:

	June 30, 2024	Decreases	June 30, 2025 Total	June 30, 2025 Current Portion	June 30, 2025 Long-Term Portion
Note payable, due in monthly installments of approximately $10 thousand including interest at 3.99%, with balance due in 2030, collateralized by specified property.	$ 652	$ (103)	$ 549	$ 109	$ 440
	652	$ (103)	549	$ 109	$ 440
Less: current portion	104		109		
Notes payable, net of current portion	$ 548		$ 440		

The following table summarizes activity in notes payable, net, during the year ended June 30, 2024, in thousands:

	June 30, 2023	Decreases	June 30, 2024 Total	June 30, 2024 Current Portion	June 30, 2024 Long-Term Portion
Note payable, due in monthly installments of approximately $10 thousand including interest at 3.99%, with balance due in 2030, collateralized by specified property.	$ 755	$ (103)	$ 652	$ 104	$ 548
	755	$ (103)	652	$ 104	$ 548
Less: current portion	101		104		
Notes payable, net of current portion	$ 654		$ 548		

Certain bank loans contain clauses that allow the bank to accelerate the amount due, without objective criteria (subjective acceleration clauses); management considers the likelihood of these clauses being invoked to be remote and has therefore classified this debt as current and noncurrent based on scheduled payment due dates.

Future debt service payments for each of the five fiscal years subsequent to June 30, 2025, and thereafter are as follows, in thousands:

Years Ending June 30,	Principal	Interest	Total
2026	$ 109	$ 20	$ 129
2027	114	16	130
2028	118	11	129
2029	123	6	129
2030	85	1	86
Total	$ 549	$ 54	$ 603

Note 11 – Employee Benefit Plans

Salinas Valley Memorial Healthcare District employees' pension plans – All permanent employees, including executive management, are eligible to participate in appropriate pension plans sponsored by SVHMC (the Plans).

Under the various plans sponsored by SVHMC, permanent employees can participate after completing three years of service and reaching the age of 21 and, in other cases, eligible employees can participate after one year of service. The Plans are single employer defined benefit retirement plans administered by SVHMC. The Plans also provide retirement, disability, and death benefits based on the employee's years of service, age, and annual compensation during covered employment. Employees generally vest after five years of service, are eligible to receive benefits after ten years and may receive early retirement benefits at age 50 with 15 years of service. Normal retirement is at age 65 with at least ten years of service. In other cases, employees are not eligible to receive benefits until reaching normal retirement at age 65 or an agreed-upon date of retirement beyond age 65. Effective March 31, 2011, the Plans were amended to cease further benefit accruals for nonunion employees. These benefit provisions and all other requirements are established by the District's Board of Directors. Separate financial statements are issued for the Salinas Valley Memorial Healthcare District employees' pension plan.

Contributions – The Plan directs SVH to make contributions based on actuarially determined contribution amounts. SVH reserves the right to suspend or reduce contributions to the Plan at any time, upon appropriate action by the Board. In accordance with PEPRA, certain members are required to make contributions based on a percentage of their eligible compensation to the Plan.

Benefits – The benefit formula payable to a participant who retires on his or her normal retirement date of age 65 shall be a monthly benefit for the life of the member. The benefit payable to a participant is computed as 2.45% of the participant's earnings during a year of credited service, as defined by the Plan, multiplied by the number of years of credited service for the participant.

In accordance with the provisions of PEPRA, certain participants hired after January 1, 2013, who retire at their normal retirement age of age 65, shall receive a retirement benefit computed as 2.30% of the participant's final annual compensation multiplied by their number of years of service in the Plan.

A participant who has attained age 52, completed 15 years of service, and five years of plan participation may elect early retirement on the first day of any month prior to the participant's normal retirement date, with certain defined-benefit reductions. A participant may elect to receive benefits in the form of a single life annuity, alternate annuity option, certain period option, or Social Security adjustment option, as defined in the plan document. Upon the death of a participant who is currently employed by SVH and prior to commencement of payments of benefits under this Plan, death benefits are distributed to the designated beneficiary.

Vesting – Employees are eligible to receive benefits after a minimum of ten years of service. Participants may receive early retirement benefits after a minimum of 15 years of service.

Plan termination – SVH expects to continue the Plan indefinitely but reserves the right to terminate the Plan at any time by appropriate action. In the event of such termination, each affected employee shall become 100% vested in the participant's accrued benefit.

Summary of Significant Accounting Policies – Fiduciary

Basis of accounting – The Plan's financial statements have been prepared in accordance with GAAP as applied to governmental units, using the accrual basis of accounting. The GASB is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

Use of estimates – The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein, disclosure of contingent assets and liabilities, and the actuarial value of assets and actuarial accrued liability at the date of the financial statements. Actual results could differ from those estimates.

Investment valuation – Investments are reported at fair value. Securities traded on national exchanges are valued at the last reported sales price on the last business day of the plan year. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Income recognition – Purchases and sales of investments are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Net appreciation (depreciation) in fair value of investments consists of both the realized gains and losses and unrealized appreciation and depreciation of those investments.

Benefit payments – Benefit payments to participants are recorded when paid.

Administrative expenses – The Plan's administrative expenses are paid either by the Plan or SVH, as provided by the plan document. Certain expenses for the general administration of the Plan are paid directly by SVH and are excluded from the fiduciary financial statements. Certain investment-related expenses are included in investment income within the accompanying statements of changes in fiduciary net position.

SVHMC's net pension asset was reported as of June 30, 2025 and 2024, as determined by an actuarial valuation measured as of December 31, 2024 and 2023, rolled forward to June 30, 2025 and 2024, respectively.

Employer contributions – Employer contributions are determined by SVH's Board of Directors each year based on the actuarially determined required contribution amount calculated by the Plan's independent actuary. The actuarially determined required contribution is determined as part of an actuarial valuation on January 1 of each year, using the traditional unit credit actuarial cost method. Actuarially determined contribution amounts were $12.6 million and $11.3 million for the years ended June 30, 2025 and 2024, respectively, all of which were contributed to the Plan as directed and approved by the Board. SVH, at the decision of the Board of Directors, contributed amounts greater than the actuarially determined contribution amounts. During the years ended June 30, 2025 and 2024, actual contributions were $12.6 million and $11.3 million, respectively, representing excesses of $0 for both years.

Pension expense – Pension expense for SVHMC's Plan is based upon GASB Statement No. 68, *Accounting and Financial Reporting for Pensions—An Amendment of GASB Statement 27* (GASB No. 68). SVHMC's funding policy is to contribute to the plans based on actuarial estimates of the annual required contributions, calculated using the traditional unit credit cost method.

Participant data for the Plan, as of the measurement dates, as follows:

	January 1, 2025	January 1, 2024
Active	1,423	1,372
Inactive	253	220
Retired and beneficiaries	862	820
Vested terminated	416	423
Total participants	2,954	2,835

Components of pension cost and deferred outflows and inflows of resources as calculated under the requirements of GASB No. 68 are as follows, in thousands:

	June 30, 2025	June 30, 2024
Deferred outflows – actuarial		
Difference between expected and actual experience	$ 1,720	$ 2,384
Changes in assumptions	688	7,393
Net difference between projected and actual earnings on pension plan investments	45,929	68,893
Contribution to the pension plan after measurement date	6,371	6,232
Total	$ 54,708	$ 84,902
Deferred inflows – actuarial		
Difference between expected and actual experience	$ 2,925	$ 4,634
Changes in assumptions	7,111	7,979
Net difference between projected and actual earnings on pension plan investments	52,804	41,587
Additional pension expense recognition	14,667	15,333
Total	$ 77,507	$ 69,533

Amounts reported as deferred outflows – actuarial and deferred inflows – actuarial to pensions (net) will be recognized in pension expense as follows, in thousands:

Years Ending June 30,	
2026	$ (2,161)
2027	(1,528)
2028	(17,318)
2029	(7,174)
2030	(336)
Thereafter	(653)
	$ (29,170)

The following table summarizes changes in pension liability for fiscal years ended June 30, 2025 and 2024, with a measurement date of January 1, 2025 and 2024, respectively, in thousands:

	2025	2024
Total pension liability		
Service cost	$ 10,868	$ 10,277
Interest on total pension liability	31,123	29,843
Difference between expected and actual experience	(1,045)	152
Changes of assumptions	(1,757)	-
Benefit payments	(22,563)	(19,767)
Net change in total pension liability	16,626	20,505
Total pension liability, beginning of year	479,236	458,731
Total pension liability, end of year	$ 495,862	$ 479,236

The following table summarizes the net pension liability at June 30, 2025 and 2024, as well as other required disclosures of financial measures, in thousands:

	2025	2024
Total pension liability	$ 495,862	$ 479,236
Plan fiduciary net position	(515,636)	(459,539)
Net pension (asset) liability	$ (19,774)	$ 19,697
Plan fiduciary net position as a percentage of the total pension (asset) liability	103.99%	95.89%
Covered-employee payroll	$ 154,690	$ 151,837
Plan net pension (asset) liability as of a percentage of covered-employee payroll	(-12.78%)	12.97%

The following table summarizes the actuarial assumptions used to determine net pension liability and plan fiduciary net position as of June 30, 2025 and 2024:

Valuation date	Actuarially determined contributions are calculated as of January 1, the first day of the fiscal year in which the contributions are reported
Methods and assumptions used	
Actuarial cost method	Entry age normal
Inflation	2.25%
Salary increases	6.50% or 3.00% depending on affiliation, including inflation, plus step increases
Investment rate of return	6.50%, net of investment expense, including inflation
Retirement age:	
Normal retirement	65
Early retirement	50 and 15 years of vesting service
Mortality	PubG-2016 Generational Mortality Table for Males & Females, projected using MP-2021

The following table summarizes the impact of a 1% change in discount rate on the value of the net pension (asset) liability at June 30, 2025 and 2024, in thousands:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
June 30, 2025	$ 44,077	$ (19,774)	$ (73,136)
June 30, 2024	$ 82,388	$ 19,697	$ (32,612)

Defined benefit post-retirement medical plans – SVHMC administers single-employer defined benefit healthcare reimbursement plans providing limited reimbursement for health insurance premiums paid by members of two bargaining units who retire early from their retirement date until they are eligible for Medicare. Benefit provisions are established through negotiations between SVHMC and the bargaining units and are renegotiated when bargaining agreements expire. The retiree health plans do not issue publicly available financial reports.

SVHMC funds the benefits on a pay-as-you-go basis. During the years ended June 30, 2025 and 2024, SVHMC contributed $132 thousand and $258 thousand, respectively, to fund benefits.

At June 30, the following employees were covered by SVHMC:

	2025	2024
Active employees	1,250	1,250
Retirees receiving benefits	87	87
Total plan participants	1,337	1,337

Components of post-retirement medical benefits expense, as calculated under the requirements of GASB No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* (GASB No. 75), were as follows as of June 30, in thousands:

	2025	2024
Service cost	$ 160	$ 144
Interest	156	164
Differences between expected and actual experience	(78)	(47)
Changes of assumptions	(33)	(29)
Total post-retirement medical benefits expense	$ 205	$ 232

Deferred inflows and outflows of resources to post-retirement medical benefits under GASB No. 75 are as follows as of June 30, in thousands:

	2025	2024
Deferred outflows of resources as of June 30		
Difference between expected and actual experience	$ 303	$ 343
Changes in assumptions	428	489
Total	$ 731	$ 832
Deferred inflows of resources as of June 30		
Difference between expected and actual experience	$ 1,150	$ 841
Changes in assumptions	738	792
Total	$ 1,888	$ 1,633

Amounts reported as deferred outflows and inflows of resources to post-retirement medical benefits will be recognized in post-retirement medical benefits expense as follows for the years ending June 30, in thousands:

Years Ending June 30,	
2026	$ (111)
2027	(111)
2028	(111)
2029	(111)
2030	(111)
Thereafter	(602)
	$ (1,157)

The following table summarizes changes in post-retirement medical benefits liability, reflected as other long-term liabilities on the consolidated statements of net position, as of June 30, 2025 and 2024, with a measurement date of June 30, 2024 and 2023, respectively, in thousands:

	2025	2024
Service cost	$ 160	$ 144
Interest	156	164
Differences between expected and actual experience	(440)	11
Changes in assumptions	(52)	98
Contributions – employer	(132)	(258)
Net change	(308)	159
Net post-retirement medical benefits liability, beginning of year	4,160	4,001
Net post-retirement medical benefits liability, end of year	$ 3,852	$ 4,160

The following table summarizes the actuarial assumptions used to determine net post-retirement medical benefits liability as of June 30, 2025 and 2024:

Valuation Date	June 30, 2023
Actuarial cost method	Entry Age Normal
Asset valuation method	Not applicable
Actuarial assumptions	
Compensation increases (needed for the Entry Age Normal cost method)	3.25%
Mortality	Base table: PubG-2016; Mortality Improvement Scale – MP-2021
Discount rate	3.93%
Healthcare cost trend rates	6.25% for 2025, graded to 5.50% for year 2028 and beyond for ages pre-65

The following table summarizes the impact of a 1% change in discount rate on the value of the post-retirement medical benefits liability at June 30, 2025 and 2024, in thousands:

	1% Decrease	Current Discount Rate	1% Increase
June 30, 2025	$ 4,078	$ 3,852	$ 3,636
June 30, 2024	$ 4,391	$ 4,160	$ 3,938

The following table summarizes the impact of a 1% change in healthcare cost trend rate on the value of the post-retirement medical benefits liability at June 30, 2025 and 2024, in thousands:

	1% Decrease	Current Cost Trend Rate	1% Increase
June 30, 2025	$ 3,807	$ 3,852	$ 3,891
June 30, 2024	$ 4,110	$ 4,160	$ 4,204

Note 12 – Compensated Absences

The employees of SVH can earn paid leave at varying rates depending on the length of service and job classification. Earned paid leave consists of vacation and holiday pay, which vests to the employee immediately, and sick leave, which is available to the employee only for absences for valid medical reasons. Employees can accumulate up to two years' accruals of paid leave. Upon termination, unused earned paid leave balances are paid in full.

Effective July 1, 2024, SVH retroactively adopted GASB Statement No. 101, *Compensated Absences*, to establish a unified model for recognizing and measuring the liability for employee leave, such as vacation and sick leave, that is attributable to services rendered, accumulates, and is more likely than not to be used or settled. The liability is generally measured using the employee's pay rate as of the consolidated financial statement date and includes directly and incrementally associated salary-related payments. This change in accounting policy resulted in a restatement of beginning net position as of July 1, 2023, of $17.4 million and a gain on benefits recorded for the fiscal year ended June 30, 2024, of $0.5 million. The disclosure of the compensated absences liability in the footnotes shows the net change during the period, with SVH no longer disclosing gross changes or the funds typically used for liquidation. See Note 17 for restatement footnote.

The following is a summary of changes in compensated absences transactions, as included in accrued expenses in the consolidated statements of net position, for the years ended June 30 (in thousands):

	Beginning Balance	Net change	Ending Balance	Current Portion
2025	$ 37,350	$ 1,835	$ 39,185	$ 39,185
2024	$ 38,941	$ (1,591)	$ 37,350	$ 37,350

Note 13 – Leases

As discussed in Note 2, SVH recognizes ROU assets and lease liabilities at lease inception in an amount equal to the present value of the undiscounted future minimum lease payments. SVH uses a discount rate that is explicitly stated or implicit in the contract. When a readily determinable discount rate is not available, the discount rate is determined using SVH's incremental borrowing rate at start of the lease for a similar asset type and term length to the contract.

SVH is a lessee for various noncancelable leases of office space and equipment with lease terms through 2031. During the years ended June 30, 2025 and 2024, there were no residual value guarantees included in the measurement of SVH's lease liabilities, and SVH did not incur any commitments at the commencement of any leases. There were no amounts recognized as variable lease payments as lease expense in the consolidated statements of changes of revenues, expenses, and net position during the years ended June 30, 2025 and 2024. SVH incurred no termination penalties during the years ended June 30, 2025 and 2024.

The following tables summarize ROU asset activity during the years ended June 30, 2025 and 2024, in thousands:

June 30, 2025	Beginning Balance	Increases	Decreases	Ending Balance
Right-of-use assets	$ 32,301	$ 6,204	$ (293)	$ 38,212
Less accumulated amortization	(18,301)	(4,524)	-	(22,825)
Right-of-use assets, net	$ 14,000	$ 1,680	$ (293)	$ 15,387

June 30, 2024	Beginning Balance	Increases	Decreases	Ending Balance
Right-of-use assets	$ 26,643	$ 5,905	$ (247)	$ 32,301
Less accumulated amortization	(12,720)	(4,497)	(1,084)	(18,301)
Right-of-use assets, net	$ 13,923	$ 1,408	$ (1,331)	$ 14,000

During the years ended June 30, 2025 and 2024, SVH recognized $4,524 thousand and $4,497 thousand, respectively, in amortization expense included within depreciation and amortization expense in the consolidated statements of revenues, expenses, and changes in net position.

The following table summarizes lease liability activity during the years ended June 30, 2025 and 2024, in thousands:

Year Ended June 30,	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2025	$ 15,515	$ 5,811	$ (4,834)	$ 16,492	$ 4,694
2024	$ 15,117	$ 6,133	$ (5,735)	$ 15,515	$ 4,336

SVH's future principal and interest lease payments under lease agreements as of June 30, 2025, were as follows, in thousands:

Years Ending June 30,	Principal	Interest	Total
2026	$ 4,694	$ 712	$ 5,406
2027	4,258	497	4,755
2028	3,041	308	3,349
2029	2,346	164	2,510
2030	1,832	59	1,891
2031-2035	321	49	370
Total	$ 16,492	$ 1,789	$ 18,281

SVH evaluated the ROU assets for impairment and determined no impairment occurred during the years ended June 30, 2025 and 2024.

SVH is also a lessor for noncancelable leases of office space with lease terms through 2026. For the years ended June 30, 2025 and 2024, SVH recognized $1,401 thousand and $1,106 thousand, respectively, in lease revenue released from the deferred inflows of resources related to the office lease included in other revenue within the consolidated statements of revenues, expenses, and changes in net position. No inflows of resources were recognized in the year related to termination penalties or residual value guarantees during fiscal years ended June 30, 2025 and 2024.

Note 14 – Subscription-Based Information Technology Arrangements

As discussed in Note 2, SVH accounts for SBITAs in accordance with GASB No. 96. SVH has entered into various SBITAs, with ranging maturities extending until 2030. During the years ended June 30, 2025 and 2024, total payments under SBITAs were $5.1 million and $6.1 million, respectively. Additionally, the SVH incurred no variable SBITA expenses during the years ended June 30, 2025 and 2024.

The following tables summarize subscription asset activity during the years ended June 30, 2025 and 2024, in thousands:

June 30, 2025	Beginning Balance	Increases	Decreases	Ending Balance
Subscription assets	$ 24,616	$ 3,235	$ (279)	$ 27,572
Less accumulated amortization	(14,409)	(5,382)	279	(19,512)
Subscription assets, net	$ 10,207	$ (2,147)	$ -	$ 8,060

June 30, 2024	Beginning Balance	Increases	Decreases	Ending Balance
Subscription assets	$ 20,280	$ 5,086	$ (750)	$ 24,616
Less accumulated amortization	(9,525)	(5,171)	287	(14,409)
Subscription assets, net	$ 10,755	$ (85)	$ (463)	$ 10,207

The following table summarizes subscription liability activity during the years ended June 30, 2025 and 2024, in thousands:

Year Ended June 30,	Beginning Balance	Increases	Decreases	Ending Balance	Current Portion
2025	$ 7,689	$ 3,235	$ (5,268)	$ 5,656	$ 2,780
2024	$ 10,346	$ 5,086	$ (7,743)	$ 7,689	$ 4,228

SVH's future principal and interest payments under SBITAs as of June 30, 2025, were as follows, in thousands:

Years Ending June 30,	Principal	Interest	Total
2026	$ 2,780	$ 320	$ 3,100
2027	1,334	205	1,539
2028	1,054	115	1,169
2029	488	43	531
2030	-	-	-
Total	$ 5,656	$ 683	$ 6,339

SVH evaluated the SBITAs for impairment and determined no impairment occurred during the years ended June 30, 2025 and 2024.

Note 15 – Commitments and Contingencies

Litigation – SVH is involved in litigation related to various matters. In the opinion of management, after consultation with legal counsel, the outcome of these matters will not have a material adverse effect on SVH's consolidated financial position.

Compliance – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations can be subject to government review and interpretation, as well as regulatory actions. Recently, government activity has increased with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. SVH is subject to such regulatory reviews, and, while these reviews may result in repayments and/or civil remedies, management believes, based on its current knowledge and information, that such repayments and/or civil remedies would not have a material effect on SVH's consolidated financial position.

Regulatory environment – The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, and government healthcare program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Recently, government activity has increased with respect to investigations and allegations concerning possible violations of fraud and abuse statutes and regulations by healthcare providers. Violations of these laws and regulations could result in expulsion from government healthcare programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. While no regulatory inquiries have been made, compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

Note 16 – Subsequent Events

Subsequent events are events or transactions that occur after the date of the consolidated statement of net position, but before the date the consolidated financial statements are available to be issued. SVH recognizes in the consolidated financial statements the effects of all subsequent events that provide additional evidence about conditions that existed at the date of the consolidated statement of net position, including the estimates inherent in the process of preparing the consolidated financial statements. SVH's consolidated financial statements do not recognize subsequent events that provide evidence about conditions that did not exist at the date of the consolidated statement of net position but arose after the date of the consolidated statement of net position and before the consolidated financial statements are available to be issued.

Note 17 – Restatement

The adoption of GASB 101 resulted in adjustments to the prior period consolidated financial statements as follows at June 30, 2024:

	As previously presented	Adjustment	As restated
Statement of net position			
Liabilities, deferred inflows, and net position:			
Accrued expenses	$ 70,179	$ 16,894	$ 87,073
Net position, end of year	$ 1,016,210	$ (16,894)	$ 999,316
Statements of revenues, expenses and changes in net position:			
Compensated absences	$ 40,407	$ (584)	$ 39,823
Income from operations	$ 28,452	$ 584	$ 29,036
Increase in net position	$ 78,723	$ 584	$ 79,307

Supplementary Information

Salinas Valley Memorial Healthcare System
Consolidating Statement of Net Position
June 30, 2025
(in Thousands)

	SVHMC/SVHC	Central Coast Medical Service Organization	Salinas Valley Memorial Hospital Foundation	SVMH-LPCH NICU JV	Eliminations Increase (Decrease)	Salinas Valley Memorial Healthcare System
ASSETS AND DEFERRED OUTFLOWS						
CURRENT ASSETS						
Cash and cash equivalents	$ 305,975	$ 4,230	$ 2,643	$ -	$ -	$ 312,848
Patient accounts receivable, net of estimated uncollectibles of $65,015	147,363	1,436	-	-	-	148,799
Short-term investments	142,779	-	-	-	-	142,779
Supplies inventory	8,202	155	-	-	-	8,357
Lease receivable, current portion	436	-	-	-	-	436
Other current assets	38,217	1,204	2	-	(23)	39,400
Total current assets	642,972	7,025	2,645	-	(23)	652,619
BOARD-DESIGNATED FUNDS	176,241	-	-	-	-	176,241
CAPITAL ASSETS						
Nondepreciable	39,644	1,191	-	-	-	40,835
Depreciable, net	211,509	2,795	-	888	-	215,192
Total capital assets, net	251,153	3,986	-	888	-	256,027
OTHER ASSETS						
Right-of-use assets, net of amortization	12,467	2,920	-	-	-	15,387
Subscription assets, net of amortization	8,060	-	-	-	-	8,060
Lease receivable, net of current portion	2,041	-	-	-	-	2,041
Long-term investments	129,066	-	19,351	-	-	148,417
Investments in affiliates	24,072	-	-	-	(8,896)	15,176
Net pension asset	19,774	-	-	-	-	19,774
Other long-term assets	-	1,086	517	-	-	1,603
Total other assets	195,480	4,006	19,868	-	(8,896)	210,458
Total assets	1,265,846	15,017	22,513	888	(8,919)	1,295,345
DEFERRED OUTFLOWS - ACTUARIAL	55,439	-	-	-	-	55,439
DEFERRED OUTFLOWS - GOODWILL	638	-	-	-	-	638
Total deferred outflows	56,077	-	-	-	-	56,077
Total assets and deferred outflows	$ 1,321,923	$ 15,017	$ 22,513	$ 888	$ (8,919)	$ 1,351,422

See report of independent auditors.

Salinas Valley Memorial Healthcare System
Consolidating Statement of Net Position
June 30, 2025
(in Thousands)

	SVHMC/SVHC	Central Coast Medical Service Organization	Salinas Valley Memorial Hospital Foundation	SVMH-LPCH NICU JV	Eliminations Increase (Decrease)	Salinas Valley Memorial Healthcare System
LIABILITIES, DEFERRED INFLOWS, AND NET POSITION (DEFICIT)						
CURRENT LIABILITIES						
Notes payable, current portion	$ -	$ 132	$ -	$ -	$ (23)	$ 109
Accounts payable	18,021	189	125	-	-	18,335
Accrued expenses	84,346	2,550	14	-	-	86,910
Estimated third-party payor settlements	4,491	-	-	-	-	4,491
Lease liabilities, current portion	3,890	804	-	-	-	4,694
Subscription liabilities, current portion	2,780	-	-	-	-	2,780
Self-insurance liabilities, current portion	16,734	-	-	-	-	16,734
Total current liabilities	130,262	3,675	139	-	(23)	134,053
NET POST-RETIREMENT MEDICAL BENEFITS LIABILITY	3,852	-	-	-	-	3,852
NOTES PAYABLE, net of current portion	-	440	-	-	-	440
LEASE LIABILITIES, net of current portion	8,929	2,869	-	-	-	11,798
SUBSCRIPTION LIABILITIES, net of current portion	2,876	-	-	-	-	2,876
SELF-INSURANCE LIABILITIES, net of current portion	11,656	-	-	-	-	11,656
Total liabilities	157,575	6,984	139	-	(23)	164,675
DEFERRED INFLOWS - ACTUARIAL	79,395	-	-	-	-	79,395
DEFERRED INFLOWS - LEASES	2,441	-	-	-	-	2,441
Total deferred inflows	81,836	-	-	-	-	81,836
Total liabilities and deferred inflows	239,411	6,984	139	-	(23)	246,511
NET POSITION (DEFICIT)						
Invested in capital assets, net of related debt	253,205	2,661	-	888	23	256,777
Reserved for minority interest	-	-	-	-	(8,929)	(8,929)
Restricted - expendable	-	-	3,940	-	-	3,940
Restricted - nonexpendable	-	-	1,232	-	-	1,232
Unrestricted	829,307	5,372	17,202	-	10	851,891
Total net position (deficit)	1,082,512	8,033	22,374	888	(8,896)	1,104,911
Total liabilities, deferred inflows, and net position (deficit)	$ 1,321,923	$ 15,017	$ 22,513	$ 888	$ (8,919)	$ 1,351,422

See report of independent auditors.

Salinas Valley Memorial Healthcare System
Consolidating Statement of Revenues, Expenses, and Changes in Net Position
Year Ended June 30, 2025
(in Thousands)

	SVHMC/SVHC	Central Coast Medical Service Organization	Salinas Valley Memorial Hospital Foundation	SVMH-LPCH NICU JV	Eliminations Increase (Decrease)	Salinas Valley Memorial Healthcare System
OPERATING REVENUES						
Net patient service revenues	$ 782,168	$ 25,430	$ -	$ 7,037	$ -	$ 814,635
Other revenues	31,719	-	-	-	-	31,719
Total operating revenues	813,887	25,430	-	7,037	-	846,354
OPERATING EXPENSES						
Salaries and wages	242,458	11,235	-	4,671	-	258,364
Compensated absences	40,730	1,132	-	929	-	42,791
Employee benefits	102,197	1,994	-	1,862	-	106,053
Supplies	118,211	1,788	-	466	-	120,465
Purchased services	66,597	868	1,680	146	(1,680)	67,611
Medical fees	86,838	3,861	-	2,901	-	93,600
Other fees	40,130	1,289	-	78	-	41,497
Depreciation and amortization	35,438	1,507	-	335	-	37,280
Other expenses	24,148	1,920	2,870	128	(2,022)	27,044
Total operating expenses	756,747	25,594	4,550	11,516	(3,702)	794,705
Operating income (loss)	57,140	(164)	(4,550)	(4,479)	3,702	51,649
NONOPERATING REVENUES AND EXPENSES						
Grants and contributions	9,027	-	3,702	-	(3,702)	9,027
Property tax revenue	6,384	-	-	-	-	6,384
Investment income, net	40,699	14	2,087	-	-	42,800
(Provision for) reversal of credit losses	(14,045)	427	-	-	-	(13,618)
(Loss) gain on disposal of capital assets	(36)	152	-	-	-	116
Income from investments in affiliates	802	-	-	-	1,688	2,490
Other	4,216	218	(23)	-	194	4,605
Nonoperating (loss) income, net	47,047	811	5,766	-	(1,820)	51,804
Income (loss) before minority interest	104,187	647	1,216	(4,479)	1,882	103,453
CAPITAL TRANSFERS	-	(1,050)	-	4,754	(3,704)	-
MINORITY INTEREST IN NET INCOME OF CONSOLIDATED AFFILIATES	-	-	-	-	2,142	2,142
INCREASE (DECREASE) IN NET POSITION	104,187	(403)	1,216	275	320	105,595
NET POSITION (DEFICIT), beginning of year, as previously reported	995,219	8,436	21,158	613	(9,216)	1,016,210
Cumulative effect of restatement	(16,894)	-	-	-	-	(16,894)
NET POSITION (DEFICIT), beginning of year, as restated	978,325	8,436	21,158	613	(9,216)	999,316
NET POSITION (DEFICIT), end of year	$ 1,082,512	$ 8,033	$ 22,374	$ 888	$ (8,896)	$ 1,104,911

See report of independent auditors.

Salinas Valley Memorial Healthcare System
Supplementary Schedule of Community Benefit (Unaudited)
Year Ended June 30, 2025

SVH maintains records to identify and monitor the level of direct community benefit it provides. These records include the charges forgone for providing the patient care furnished under its charity care policy. For the years ended June 30, 2025 and 2024, the estimated costs of providing community benefit in excess of reimbursement from governmental programs were as follows, in thousands:

	2025	2024
Unpaid costs of Medi-Cal programs	$ 154,012	$ 143,211
Indigent charity care and bad debt	13,092	11,362
	$ 167,104	$ 154,573

In furtherance of its purpose to benefit the community, SVH provides numerous other services to the community for which charges are not generated and revenues have not been accounted for in the accompanying consolidated financial statements. The services include health-related programming and education that reached over 37,000 people in the community and participation in health fairs that reached over 7,000 people. The estimated costs of Medicare programs in excess of reimbursement from Medicare were $197.7 million and $188.7 million for the years ended June 30, 2025 and 2024, respectively.

SVH also provides services to the community through the operations of the Service League. Services provided by volunteers of the Service League, free of charge to the community, include assistance and counseling to patients and visitors, daily personal contact with members of the community who are living alone, career counseling and programs for local students, spiritual care volunteers representing many local faith community congregations, palliative care program assistance, and provision of scholarship awards to qualifying students in the medical professions. During the years ended June 30, 2025 and 2024, these volunteers contributed approximately 20,574 and 15,179 hours, respectively, in providing these services, the value of which is not recorded in the accompanying consolidated financial statements.

Required Supplementary Information

Salinas Valley Memorial Healthcare System
Supplementary Pension and Post Employment Benefit Information
June 30, 2025 and 2024
(in Thousands)

Defined Benefit Pension Plan

The following table summarizes the number of total plan participants at June 30:

	2025	2024
Number of active members	1,423	1,372
Number of frozen active participants	253	220
Number of retired members and beneficiaries	862	820
Number of vested terminated members	416	423
	2,954	2,835

The following table summarizes the funding status of the defined benefit pension plan at various measurement dates, in thousands:

Year Ended	Actuarially Determined Contribution	Actual Employer Contribution	Contribution (Excess) Deficiency	Covered Payroll	Contribution as a Percentage of Covered Payroll
December 31, 2015	$ 12,147	$ 17,190	$ (5,043)	$ 121,074	14.20%
December 31, 2016	$ 11,970	$ 16,970	$ (5,000)	$ 130,810	12.97%
December 31, 2017	$ 12,883	$ 19,883	$ (7,000)	$ 108,395	18.34%
December 31, 2018	$ 11,927	$ 21,927	$ (10,000)	$ 112,353	19.52%
December 31, 2019	$ 11,809	$ 26,809	$ (15,000)	$ 119,261	22.48%
December 31, 2020	$ 18,766	$ 23,766	$ (5,000)	$ 127,771	18.60%
December 31, 2021	$ 13,127	$ 23,127	$ (10,000)	$ 138,820	16.66%
December 31, 2022	$ 10,158	$ 61,580	$ (51,422)	$ 142,050	43.35%
December 31, 2023	$ 11,270	$ 11,270	$ -	$ 151,837	7.42%
December 31, 2024	$ 12,603	$ 12,603	$ -	$ 154,690	8.15%

Supplemental post-retirement benefit information – As of June 30, 2025 and 2024, post-retirement medical benefits plan's fiduciary net position as a percentage of the total OPEB liability is 0% for both years.

The covered payroll for the active population eligible to participate in the post-retirement medical benefits plan is $154.7 million and $151.8 million for 2025 and 2024, respectively. The net post-retirement medical benefits asset for the fiscal year ended June 30, 2025 is $19.8 million. The net post-retirement medical liability for the fiscal year ended June 30, 2024, is $19.7 million. The net post-retirement medical benefits asset and liability as a percentage of covered-employee payroll, as of the same time period, was -12.78% and 12.97%, respectively.

Reports of Independent Auditors and
Consolidated Financial Statements with
Supplementary Information

Salinas Valley Memorial Healthcare System

June 30, 2025 and 2024

Table of Contents

Report of Independent Auditors

The Board of Directors
Salinas Valley Memorial Healthcare System

Report on the Audit of the Financial Statements

Opinions

We have audited the consolidated financial statements of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System (the System) as of and for the years ended June 30, 2025 and 2024, and the related notes to the consolidated financial statements, which collectively comprise the System's consolidated financial statements as listed in the table of contents.

In our opinion, the accompanying consolidated financial statements referred to above present fairly, in all material respects, the respective financial position of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System as of June 30, 2025 and 2024, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the California Code of Regulations, Title 2, Section 1131.2, State Controller's Minimum Audit Requirements for California Special Systems. For the year ended June 30, 2025, we also conducted our audit in accordance with the standards applicable to financial audits contained in *Government Auditing Standards* (*Government Auditing Standards*) issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the System and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the consolidated financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for twelve months beyond the consolidated financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the consolidated financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the consolidated financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the consolidated financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the consolidated financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the System's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control–related matters that we identified during the audit.

Emphasis of Matter – New Accounting Standard

As discussed in Note 2 and 17 to the consolidated financial statements, effective July 1, 2024, the System adopted GASB Statement No. 101, *Compensated Absences*, requiring retroactive application.

Accordingly, the fiscal year 2024 consolidated financial statements have been restated to apply this new accounting standard. Our opinion on the consolidated financial statements is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis, supplemental pension and post-retirement benefit information be presented to supplement the consolidated financial statements. Such information is the responsibility of management and, although not a part of the consolidated financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the consolidated financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries; the consolidated financial statements; and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the consolidated financial statements that collectively comprise the System's consolidated financial statements. The consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position are presented for purposes of additional analysis and are not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the accompanying consolidating statement of net position and consolidating statement of revenues, expenses, and changes in net position are fairly stated, in all material respects, in relation to the consolidated financial statements as a whole.

The accompanying supplemental schedule of community benefit has not been subjected to the auditing procedures applied in the audit of the consolidated financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated November 21, 2025, on our consideration of the System's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control over financial reporting and compliance.

San Francisco, California
November 21 2025

Salinas Valley Memorial Healthcare System
Schedule of Expenditures of Federal Awards
Year Ended June 30, 2025

Federal Grantor/Pass - Through Grantor/Program or Cluster Title	Federal Assistance Listing Number	Pass-Through Entity Identifying Number	Federal Expenditures
U.S. Department of Homeland Security			
Pass-Through Programs From The California Governor's Office of Emergency Services:			
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3314 (2945)	108,404
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3315 (2767)	310,899
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3503 (0703)	635,880
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3414 (1279)	441,915
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3418 (1414)	722,530
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-2689 (1761)	102,144
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3317 (2559)	464,799
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3641 (3242)	1,544,352
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3558 (2995)	207,935
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3632 (3374)	142,248
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-3328 (3255)	414,199
COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)	97.036	OR-4482DR-2946 (3223)	61,215
Total U.S. Department of Homeland Security			5,156,520
Total Expenditures of Federal Awards			$ 5,156,520

See accompanying notes to schedule of expenditures of federal awards.

Salinas Valley Memorial Healthcare System
Notes to Schedule of Expenditures of Federal Awards
Year Ended June 30, 2025

Note 1 – Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the federal grant activity of Salinas Valley Memorial Healthcare System ("Salinas Valley Health" or "SVH"), under programs of the federal government for the year ended June 30, 2025. The information in the Schedule is presented in accordance with the requirements of theTitle 2 U.S. *Code of Federal Regulations* ("CFR"), Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of SVH, it is not intended to, and does not, present the financial position, changes in net position, or cash flows of SVH. The Schedule includes expenditures of federal awards from Salinas Valley Health (Taxpayer Identification Number 94-6004020).

The Schedule includes $5,156,520 of expenditures for U.S. Department of Homeland Security Disaster Grants – Public Assistance (Presidentially Declared Disasters) Assistance Listing No. 97.036. These awards were approved during the year ended June 30, 2025, and relate to expenditures that were incurred during the years ended June 30, 2023, 2022, 2021, and 2020.

Note 2 – Summary of Significant Accounting Policies

Expenditures reported on the schedule of expenditures of federal awards are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. SVH has elected not to use the 10% de minimis indirect cost rate allowed under the Uniform Guidance.

Note 3 – Subrecipients

SVH did not provide federal awards to subrecipients during the year ended June 30, 2025.

Required Supplementary Information

Report of Independent Auditors on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Board of Directors
Salinas Valley Memorial Healthcare System

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Salinas Valley Memorial Healthcare System (the System), which comprise the consolidated statements of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System as of and for the year ended June 30, 2025, and the related notes to the financial statements, which collectively comprise Salinas Valley Memorial Healthcare System's consolidated financial statements as listed in the table of contents, and the related notes to the consolidated financial statements, and have issued our report thereon dated November 21, 2025.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered the System's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control. Accordingly, we do not express an opinion on the effectiveness of the System's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the System's consolidated financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the System's consolidated financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the consolidated financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the System's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the System's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

San Francisco, California
November 21, 2025

Report of Independent Auditors on Compliance for the Major Federal Program and Report on Internal Control over Compliance; and Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

The Board of Directors
Salinas Valley Memorial Healthcare System

Report on Compliance for the Major Federal Program

Opinion on the Major Federal Program

We have audited Salinas Valley Memorial Healthcare System's compliance with the types of compliance requirements identified as subject to audit in the Office of Management and Budget *Compliance Supplement* that could have a direct and material effect on the Salinas Valley Memorial Healthcare System's major federal program for the year ended June 30, 2025. Salinas Valley Memorial Healthcare System's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

In our opinion, Salinas Valley Memorial Healthcare System complied, in all material respects, with the compliance requirements referred to above that could have a direct and material effect on the major federal program for the year ended June 30, 2025.

Basis for Opinion on the Major Federal Program

We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America (GAAS), the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States *(Government Auditing Standards)*; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200*, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Our responsibilities under those standards and the Uniform Guidance are further described in the Auditor's Responsibilities for the Audit of Compliance section of our report.

We are required to be independent of Salinas Valley Memorial Healthcare System and to meet our other ethical responsibilities, in accordance with relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion on compliance for its major federal program. Our audit does not provide a legal determination of Salinas Valley Memorial Healthcare System's compliance with the compliance requirements referred to above.

Responsibilities of Management for Compliance

Management is responsible for compliance with the requirements referred to above and for the design, implementation, and maintenance of effective internal control over compliance with the requirements of laws, statutes, regulations, rules, and provisions of contracts or grant agreements applicable to Salinas Valley Memorial Healthcare System's federal program.

Auditor's Responsibilities for the Audit of Compliance

Our objectives are to obtain reasonable assurance about whether material noncompliance with the compliance requirements referred to above occurred, whether due to fraud or error, and express an opinion on Salinas Valley Memorial Healthcare System's compliance based on our audit. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS, *Government Auditing Standards*, and the Uniform Guidance will always detect material noncompliance when it exists. The risk of not detecting material noncompliance resulting from fraud is higher than for that resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Noncompliance with the compliance requirements referred to above is considered material, if there is a substantial likelihood that, individually or in the aggregate, it would influence the judgment made by a reasonable user of the report on compliance about Salinas Valley Memorial Healthcare System's compliance with the requirements of the major federal program as a whole.

In performing an audit in accordance with GAAS, *Government Auditing Standards,* and the Uniform Guidance, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material noncompliance, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding Salinas Valley Memorial Healthcare System's compliance with the compliance requirements referred to above and performing such other procedures as we considered necessary in the circumstances.
- Obtain an understanding of Salinas Valley Memorial Healthcare System's internal control over compliance relevant to the audit in order to design audit procedures that are appropriate in the circumstances and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of Salinas Valley Memorial Healthcare System's internal control over compliance. Accordingly, no such opinion is expressed.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and any significant deficiencies and material weaknesses in internal control over compliance that we identified during the audit.

Report on Internal Control Over Compliance

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the Auditor's Responsibilities for the Audit of Compliance section above and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies in internal control over compliance. Given these limitations, during our audit we did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses, as defined above. However, material weaknesses or significant deficiencies in internal control over compliance may exist that were not identified.

Our audit was not designed for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, no such opinion is expressed.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Report on Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

We have audited the financial statements of Salinas Valley Memorial Healthcare System as of and for the year ended June 30, 2025, and have issued our report thereon dated _____, 2025, which contained an unmodified opinion on those consolidated financial statements. Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by the Uniform Guidance and is not a required part of the consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the consolidated financial statements. The information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the schedule of expenditures of federal awards is fairly stated in all material respects in relation to the consolidated financial statements as a whole.

San Francisco, California
December XX, 2025

Section I – Summary of Auditor's Results

Financial Statements

Type of auditor's report issued on whether the financial statements audited were prepared in accordance with GAAP: *Unmodified*

Internal control over financial reporting:

- Material weakness(es) identified? ☐Yes ☒ No
- Significant deficiency(ies) identified? ☐Yes ☒ None reported

Noncompliance material to financial statements noted? ☐Yes ☒ No

Federal Awards

Internal control over major federal programs:

- Material weakness(es) identified? ☐Yes ☒ No
- Significant deficiency(ies) identified? ☐Yes ☒ None reported

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? ☐Yes ☒ No

Identification of the Major Federal Program and Type of Auditor's Report Issued on Compliance for the Major Federal Program:

Federal Assistance Listing Number	*Name of Federal Program or Cluster*	*Type of Auditor's Report Issued on Compliance for the Major Federal Program*
97.036	*COVID-19 Disaster Grants - Public Assistance (Presidentially Declared Disasters)*	*Unmodified*

Dollar threshold used to distinguish between type A and type B programs: $750,000

Auditee qualified as low-risk auditee? ☐Yes ☒ No

Section II – Financial Statement Findings

None reported.

Section III – Federal Award Findings and Questioned Costs

No findings noted.

Communications with the Board of Directors

Salinas Valley Memorial Healthcare System

June 30, 2025

Communications with the Board of Directors

The Board of Directors
Salinas Valley Memorial Healthcare System

We have audited the consolidated financial statements of the business-type activities and the aggregate remaining fund information of Salinas Valley Memorial Healthcare System (the System) as of and for the year ended June 30, 2025, and have issued our report thereon dated November 21, 2025. Professional standards require that we provide you with the following information related to our audit.

Our Responsibility Under Auditing Standards Generally Accepted in the United States of America and Government Auditing Standards

As stated in our engagement letter dated December 12, 2024, we are responsible for forming and expressing an opinion about whether the consolidated financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the consolidated financial statements does not relieve you or management of your responsibilities.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS), Government Auditing Standards (GAS), and the California Code of Regulations, Title 2 Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. As part of an audit conducted in accordance with the standards, we exercise professional judgment and maintain professional skepticism throughout the audit.

An audit of financial statements includes consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the System's internal control over financial reporting. Accordingly, we considered the System's internal control solely for the purposes of determining our audit procedures and not to provide assurance concerning such internal control.

We are also responsible for communicating significant matters related to the consolidated financial statement audit that, in our professional judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

The supplementary information was subject to certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the consolidated financial statements or to the consolidated financial statements themselves.

Planned Scope and Timing of the Audit

We performed the audit according to the planned scope and timing previously communicated to you in our engagement letter dated December 12, 2024 and during our planning meeting with you on June 18, 2025.

Significant Audit Findings and Issues

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the System are described in Note 2 to the consolidated financial statements. In 2025, the System adopted Governmental Accounting Standards Board ("GASB") Statement No. 101, *Compensated Absences*. No other new accounting policies were adopted and there were no changes in the application of existing policies during 2025. We noted no transactions entered into by the System during the year for which there is a lack of authoritative guidance or consensus. There are no significant transactions that have been recognized in the consolidated financial statements in a different period than when the transaction occurred.

Significant Accounting Estimates

Accounting estimates are an integral part of the consolidated financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the consolidated financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting the consolidated financial statements were:

- Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. We evaluated the key factors and assumptions used to develop the estimated net realizable amounts and determined that it is reasonable in relation to the consolidated financial statements taken as a whole.
- The System provides care to patients without requiring collateral or other security. Patient charges not covered by a third-party payor are billed directly to the patient if it is determined that the patient has the ability to pay. A provision for uncollectible accounts is recognized based on management's estimate of amounts that ultimately may be uncollectible. We evaluated the key factors and assumptions used to develop the provision for uncollectible accounts and determined that it is reasonable in relation to the consolidated financial statements taken as a whole.
- Management's estimate of the fair market values of investments in the absence of readily-determinable fair values is based on information provided by the fund managers. We have gained an understanding of management's estimate methodology and examined the documentation supporting this methodology. We evaluated the key factors and assumptions used to develop the fair market value of investments. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- The System is self-insured for workers' compensation benefits for employees. An actuarial estimate is accrued based on an expected, undiscounted estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- The System provides eligible employees with health benefits through a self-insured program. The liability for claims arising from this program is estimated based upon historical experience and trending. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- The useful lives of capital assets have been estimated based on the intended use and are within accounting principles generally accepted in the United States of America. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.

- Management's estimate of the net pension liability is actuarially determined using assumptions on the long-term rate of return on pension plan assets, the discount rate used to determine the present value of benefit obligations. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- Management's estimated liability for post-retirement medical benefits is actuarially determined using assumptions on the discount rate and the health care cost trend rate used to determine the present value of benefit obligations, and the rate of compensation increases. These assumptions are provided by management. We have evaluated the key factors and assumptions used to develop the estimate. We found management's basis to be reasonable in relation to the consolidated financial statements taken as a whole.
- Management's estimates of the discount rate, useful lives, lease terms related to the System's operating lease right of use assets, lease liabilities, lease receivable, and deferred inflows of resources - leases. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the System's consolidated financial statements taken as a whole.
- Management's estimates of the discount rate, useful lives, and subscription terms related to the System's subscription assets and subscription liabilities. We have gained an understanding of management's key factors and assumptions and examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the System's consolidated financial statements taken as a whole.
- Management's estimates of the probability of accumulated leave being used or settled and the timing of those payments for sick leave accrual. We have gained an understanding of management's key factors and assumptions and have examined the documentation supporting the estimates. We found management's basis to be reasonable in relation to the System's consolidated financial statements taken as a whole.

Actual results could differ from these estimates. In accordance with accounting principles generally accepted in the Unites States of America, any change in these estimates is reflected in the consolidated financial statements in the year of change.

Financial Statement Disclosures

The disclosures in the consolidated financial statements are consistent, clear, and understandable. Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the consolidated financial statements were disclosures relating to significant concentration of net patient accounts receivable, investments and fair value of investments, capital assets, employee benefit plans, post-retirement medical benefits, insurance plans, leases, and subscription-based information technology arrangements.

Significant Unusual Transactions

We encountered no significant unusual transactions during our audit of the System's consolidated financial statements.

Significant Difficulties Encountered in Performing the Audit

Professional standards require us to inform you of any significant difficulties encountered in performing the audit. No significant difficulties were encountered during our audit of the System's consolidated financial statements.

Disagreements with Management

For purposes of this letter, professional standards define a disagreement with management as a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the consolidated financial statements or the auditor's report. No such disagreements arose during the course of our audit.

Circumstances that Affect the Form and Content of the Auditor's Report

There may be circumstances in which we would consider it necessary to include additional information in the auditor's report in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS), Government Auditing Standards (GAS), and the California Code of Regulations, Title 2 Section 1131.2, State Controller's *Minimum Audit Requirements* for California Special Districts. There were no circumstances that affected the form and content of the auditor's report.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all factual and judgmental misstatements identified during the audit, other than those that are trivial, and communicate them to the appropriate level of management. There were no corrected or uncorrected misstatements the effects of which, as determined by management, are material, both individually and in the aggregate, to the consolidated financial statements as a whole.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November 21, 2025.

Management Consultation with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the System's consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Significant Audit Findings or Issues

We are required to communicate to you other findings or issues arising from the audit that are, in our professional judgment, significant and relevant to your oversight of the financial reporting process. There were no such items identified.

This information is intended solely for the use of the Board of Directors and management of the System, and is not intended to be, and should not be, used by anyone other than these specified parties.

San Francisco, California
November 21, 2025

Salinas Valley Memorial Healthcare District Employees Pension Plan

2024 Audit Results

Report to Corporate Compliance and Audit Committee

November 12, 2025

Scope of Services

We performed the following services for Salinas Valley Memorial Healthcare District Employees Pension Plan:

Annual Audit

- Audit report on the financial statements for the year ended December 31, 2024
- Report will be dated following management and committee approval
- Unmodified opinion: financial statements are presented fairly in accordance with accounting principles generally accepted in the United States of America

Non-Attestation Service

- Baker Tilly assisted management with drafting the Plan's financial statements and required supplementary information

Pension Financial Highlights

	2022	2023	2024
Total pension liability (a)	**$ 458,730,891**	**$ 479,235,862**	**$ 495,862,717**
Plan fiduciary net position			
Employer contributions	$ 61,579,392	$ 11,269,905	$ 12,602,713
Member contributions	2,577,706	2,506,514	2,800,377
Net investment income (loss)	(83,884,411)	61,892,945	63,371,929
Administrative expense	(92,272)	(83,035)	(113,752)
Benefit payments	(18,835,673)	(19,767,150)	(22,563,484)
Net change in plan fiduciary net position	(38,655,258)	55,819,179	56,097,783
Plan fiduciary net position			
Beginning of year	442,374,774	403,719,516	459,538,695
End of year (b)	**$ 403,719,516**	**$ 459,538,695**	**$ 515,636,478**
System net pension liability (asset) (a) - (b)	**$ 55,011,375**	**$ 19,697,167**	**$ (19,773,761)**
Funded status (GASB basis)	**88.0%**	**95.9%**	**104.0%**

Areas of Audit Emphasis

Our audit of the pension plan included the following areas of emphasis:

Audit emphasis areas	Procedures
Existence and valuation of investments and investment earnings	• Tested due diligence, ongoing monitoring and financial close controls • Confirmed with investment custodian and tested investment valuation, trading, and earnings
Actuarial valuation assumptions, GASB No. 67 measurements, and underlying census data	• Tested completeness and accuracy of census data used • Verified assumptions used in the valuation and measurements including changes in assumptions
Management override of controls	• Tested significant transaction cycles and the financial close process with consideration of potential management override of internal controls

Required Communications with Audit Committee

- Plan descriptions and significant accounting policies are summarized in footnotes to the financial statements
- The financial statement disclosures are consistent, clear, and understandable
- No material weaknesses reported
- No proposed adjusting entries or uncorrected misstatements noted
- Written and oral representations to be received from management
- No disagreements with management
- New accounting standards were adopted (GASB Statement No. 101 and 102) No impact on the Plan's financial statements.

Required Communications with Audit Committee, continued

- Consultation with other independent auditors (none of which we are aware)
- No difficulties encountered during the audit
- Illegal acts (none noted)
- Consideration of fraud in a financial statement audit
  - Procedures performed included journal entry testing and interviews of personnel
- Baker Tilly is independent with respect to the Plan and its sponsoring employer

Your Service Team

Kory Hoggan
Engagement Principal

Kory.Hoggan@bakertilly.com
(505) 878-7214

Aaron Hamilton
Concurring Reviewer

Jason Lu
Assurance Senior Manager

Philip Baiamonte
Assurance Manager

THANK YOU

Report of Independent Auditors and
Financial Statements with
Required Supplementary Information

Salinas Valley Memorial Healthcare District
Employees Pension Plan

December 31, 2024 and 2023

Table of Contents

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Management's Discussion and Analysis

This section of Salinas Valley Memorial Healthcare District Employees Pension Plan's (the Plan's) annual financial report presents the management discussion and analysis of the Plan's financial performance as of and for the years ended December 31, 2024 and 2023. This section also includes selected comparative information as of and for the year ended December 31, 2022. It should be read in conjunction with the Plan's annual audited financial statements, which follow this section.

Overview – The Plan was established in November 1966 by the Salinas Valley Memorial Healthcare District (now known as the Salinas Valley Memorial Healthcare System or the System) and has been amended from time to time since that date, as further described below. The Plan provides retirement, disability, and death benefits to permanent employees of the System with union representation based on the employee's years of service, age, and annual compensation during covered employment.

Plan background – The Plan was amended effective January 1, 2004, to provide that the benefit formula be equal to 2.45% of the participant's earnings in a plan year. The benefit formula was previously 2.25% of the participant's earnings in a plan year (for plan years 2000 through 2003).

Participation in the Plan was frozen effective March 31, 2011, for nonunion employees. These employees are entitled to benefits earned before that date but do not accrue further benefits under the Plan.

The Plan was amended effective January 1, 2013, to comply with the applicable provisions of the California Public Employees' Pension Reform Act of 2013 (PEPRA). These provisions include limitations on pensionable compensation and retirement benefits and contribution provisions, including the establishment of participant contributions, for new participants who are hired on or after January 1, 2013, and meet the eligibility and vesting requirements of the Plan.

The Plan was amended and restated effective January 1, 2016, to update the Plan for legislative changes according to PEPRA and to remove the three-year service requirement to participate in the Plan for eligible employees.

Plan documents contain a more detailed description of the Plan's provisions and should be referred to for a more complete understanding of the terms of the Plan. Copies of the appropriate documents are available through the administrative offices of the System.

Financial highlights – During the year ended December 31, 2024, the net position held in trust for pension benefits increased by approximately 12%. Employer contributions were $12.6 million in 2024 compared to $11.3 million in 2023 and $61.6 million in 2022. Benefit payments were $22.7 million during 2024 compared to $20.0 million during 2023 and $19.0 million in 2022. Net investment income was $63.5 million during 2024 compared to $62.1 million during 2023 and a net investment loss of $83.7 million in 2022.

Financial analysis – Total contributions have exceeded the actuarially determined contribution amounts since 2015, due to decisions made by the System's Board of Directors to fund the Plan at amounts above actuarially determined contributions. During the year ended December 31, 2024, the System's Board of Directors approved and funded employer contributions totaling $12,602,713 to the Plan.

Actuarial measurement – The actuarial cost method used to attribute the actuarial present value of projected benefit payments of each plan member is the entry age cost method. Under the entry age cost method, the actuarial present value of the projected benefits for each individual included in the actuarial valuation is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit ages. The portion of this actuarial present value allocated to a valuation year is called the normal cost. The portion of this actuarial present value not provided for at a valuation date by the actuarial present value of future normal costs is the actuarial accrued liability.

The System's net pension (asset) liability is calculated as the total pension liability, defined as the portion of the actuarial present value of projected benefit payments that is attributed to past periods of member service, less the Plan's fiduciary net position. The following presents a comparison of the components of the net position (asset) liability as of December 31:

	2024	2023	2022
Total pension liability	$ 495,862,717	$ 479,235,862	$ 458,730,891
Plan fiduciary net position	(515,636,478)	(459,538,695)	(403,719,516)
System's net pension (asset) liability	$ (19,773,761)	$ 19,697,167	$ 55,011,375
System's fiduciary net position as a percentage of total pension liability	103.99%	95.89%	88.01%

Overview of the financial statements – The financial statements consist of three parts: management's discussion and analysis (this section), the basic financial statements together with the related notes, and required supplementary information, as mandated by certain pronouncements of the Governmental Accounting Standards Board (GASB).

The basic financial statements present information about the Plan's fiduciary net position and changes in fiduciary net position for the respective years. The basic financial statements also include notes to explain some of the information in the financial statements and to provide more details. The notes are followed by a section of required supplementary information that displays additional detail information not in the basic financial statements, but which is required by the pronouncements of the GASB and relate to funding progress and required contributions.

The statement of fiduciary net position displays the assets and liabilities and resulting net position of the Plan as of the end of the year. All assets are valued at fair value.

The following are abbreviated statements of fiduciary net position (in thousands) as of December 31:

	2024	2023	2022
Cash and investments	$ 515,636	$ 459,539	$ 403,720

During the years ended December 31, 2024 and 2023, the Plan's fiduciary net position increased by 12% and 14%, respectively. The Plan's policies allow investments consisting of fixed income securities, equity securities, and money market funds. The Plan's investments are held in a portfolio of registered investment companies (mutual funds).

The statement of changes in fiduciary net position reflects the employer contributions and investment return, net of investment expenses, less benefits paid. Changes in fiduciary net position are summarized as follows (in thousands) for the years ended December 31:

	2024	2023	2022
Investment income (loss), net	$ 63,512	$ 62,101	$ (83,746)
Employer contributions	12,603	11,270	61,579
Member contributions	2,800	2,507	2,578
Benefit payments to members and beneficiaries	(22,704)	(19,962)	(18,961)
Administrative expenses	(114)	(96)	(106)
Change in fiduciary net position	$ 56,097	$ 55,820	$ (38,656)

The change in fiduciary net position during the years ended December 31, 2024, 2023 and 2022 is due primarily to the employer contributions made each year and the investment income (loss) from the performance of equity markets during each year. Benefit payments to members and beneficiaries continue to increase each year due to the increased number of retirees and beneficiaries receiving benefits.

Financial Statements

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Statements of Fiduciary Net Position
December 31, 2024 and 2023

	2024	2023
ASSETS		
Investments, at fair value		
Mutual funds	$ 515,636,478	$ 459,538,695
NET POSITION HELD IN TRUST FOR PENSION BENEFITS	$ 515,636,478	$ 459,538,695

See accompanying notes to these financial statements.

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Statements of Changes in Fiduciary Net Position
Years Ended December 31, 2024 and 2023

	2024	2023
ADDITIONS		
Investment income		
Net appreciation in fair value of investments	$ 51,590,893	$ 50,748,380
Dividends	11,921,449	11,352,580
Total investment income	63,512,342	62,100,960
Contributions		
Employer	12,602,713	11,269,905
Members	2,800,377	2,506,514
Total contributions	15,403,090	13,776,419
Net additions	78,915,432	75,877,379
DEDUCTIONS		
Benefit payments	22,703,897	19,961,806
Administrative expenses	113,752	96,394
Total deductions	22,817,649	20,058,200
CHANGE IN NET POSITION	56,097,783	55,819,179
NET POSITION HELD IN TRUST FOR PENSION BENEFITS		
Beginning of the year	459,538,695	403,719,516
End of the year	$ 515,636,478	$ 459,538,695

See accompanying notes to these financial statements.

Note 1 – Description of the Plan

General – The following description of Salinas Valley Memorial Healthcare District Employees Pension Plan (the Plan) provides only general information. Participants should refer to the plan document for a more complete description of the Plan's provisions.

The Plan is a single-employer noncontributory employee retirement system established by Salinas Valley Memorial Healthcare System (the System). The System is a political subdivision that was organized under the provisions of the Health and Safety Code of the State of California. Permanent employees of the System with union representation are eligible to participate in the Plan upon the later of their employment commencement date or reaching the age of 21.

The Plan provides retirement, disability, and death benefits based on the employee's years of service, age, and annual compensation during covered employment. Plan provisions and all other requirements are established by the System's five-member Board of Directors (the Board), which has been elected by the registered voters in the District.

Effective March 31, 2011, participation in the Plan for nonunion employees was frozen. Nonunion employees are entitled to benefits earned before March 31, 2011, but do not accrue further benefits under the Plan.

Effective January 1, 2013, the Plan was amended to adopt the applicable provisions of the California Public Employees' Pension Reform Act of 2013 (PEPRA).

Membership in the Plan consists of the following:

	December 31,	
	2024	2023
Active members		
Number of active members under and over the normal retirement age	1,423	1,372
Nonactive members and other beneficiaries receiving benefits		
Number of retirees and beneficiaries	862	816
Number terminated with vested benefits	416	423
Inactive members	253	220
	2,954	2,831

Contributions – The Plan directs the System to make contributions based on actuarially determined contribution amounts. The System reserves the right to suspend or reduce contributions to the Plan at any time, upon appropriate action by the Board. In accordance with PEPRA, certain members are required to make contributions based on a percentage of their eligible compensation to the Plan.

Benefits – The benefit formula payable to a participant who retires on his or her normal retirement date of age 65 shall be a monthly benefit for the life of the member. The benefit payable to a participant is computed as 2.45% of the participant's earnings during a year of credited service, as defined by the Plan, multiplied by the number of years of credited service for the participant.

In accordance with the provisions of PEPRA, certain participants hired after January 1, 2013, who retire at their normal retirement age of age 65, shall receive a retirement benefit computed as 2.30% of the participant's final annual compensation multiplied by their number of years of service in the Plan.

A participant who has attained age 52 and completed 15 years of service and 5 years of plan participation may elect early retirement on the first day of any month prior to the participant's normal retirement date, with certain defined-benefit reductions. A participant may elect to receive benefits in the form of a single life annuity, alternate annuity option, certain period option, or social security adjustment option, as defined in the plan document. Upon the death of a participant who is currently employed by the System and prior to commencement of payments of benefits under this Plan, death benefits are distributed to the designated beneficiary.

Vesting – Employees are eligible to receive benefits after a minimum of ten years of service. Participants may receive early retirement benefits with 15 years of service.

Plan termination – The System expects to continue the Plan indefinitely but reserves the right to terminate the Plan at any time by appropriate action. In the event of such termination, each affected employee shall become 100% vested in the participant's accrued benefit.

Note 2 – Summary of Significant Accounting Policies

Basis of accounting – The Plan's financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America as applied to governmental units, using the accrual basis of accounting. The Governmental Accounting Standards Board (GASB) is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

Use of estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, and changes therein, disclosure of contingent assets and liabilities, and the total pension liability at the date of the financial statements. Actual results could differ from those estimates.

Investment valuation – Investments are reported at fair value. Securities traded on national exchanges are valued at the last reported sales price on the last business day of the plan year. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

Income recognition – Purchases and sales of investments are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Net appreciation in fair value of investments consists of both the realized gains and losses and unrealized appreciation and depreciation of those investments.

Benefit payments – Benefit payments to participants are recorded when paid.

Administrative expenses – The Plan's administrative expenses are paid either by the Plan or the System, as provided by the plan document. Certain expenses for the general administration of the Plan are paid directly by the System and are excluded from these financial statements. Certain investment related expenses are included in investment income presented in the accompanying statements of changes in fiduciary net position.

Note 3 – Investments

Investment policy – The Personnel and Pension Committee, appointed by the System's Board of Directors, is responsible for the oversight of the Plan's investments and investment policy. The investment policy presents ranges for investment types as follows:

Domestic and international equities	65%
Fixed income securities and cash equivalents	35%

The investment policy specifically prohibits investments in short sales, margin purchases, private placements, derivatives, commodities, and annuities.

Investments – As of December 31, the Plan's investments are summarized as follows:

	2024		2023	
	Fair Value	%	Fair Value	%
Mutual funds				
Domestic equity	$ 323,289,315	63%	$ 200,330,828	44%
Fixed income	166,166,784	32%	133,074,347	29%
Real estate fund	26,180,379	5%	24,513,705	5%
International equity	-	0%	101,619,815	22%
	$ 515,636,478	100%	$ 459,538,695	100%

Fair value measurements – The Plan uses a framework for measuring fair value that provides a hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3).

The three levels of the fair value hierarchy are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities the Plan has the ability to access.

Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; and inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

Following is a description of the valuation technique used for assets measured at fair value. There have been no changes in the techniques used at December 31, 2024 or 2023.

Mutual funds – Shares held in registered investment companies (mutual funds) are valued at the daily closing price as reported by the fund. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The funds held by the Plan are deemed to be actively traded. Mutual funds held by the Plan are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission.

The following tables disclose the fair value hierarchy of the Plan's assets by level:

	December 31, 2024	Fair Value Measurements		
		Level 1	Level 2	Level 3
Mutual funds				
Equity securities	$ 349,469,694	$ 349,469,694	$ -	$ -
Fixed income	166,166,784	166,166,784	-	-
	$ 515,636,478	$ 515,636,478	$ -	$ -

	December 31, 2023	Fair Value Measurements		
		Level 1	Level 2	Level 3
Mutual funds				
Equity securities	$ 326,464,348	$ 326,464,348	$ -	$ -
Fixed income	133,074,347	133,074,347	-	-
	$ 459,538,695	$ 459,538,695	$ -	$ -

Annual Money-weighted rate of return – During the years ended December 31, 2024 and 2023, the annual money-weighted rate of return on the Plan's investments, net of investment expenses, was 13.90% and 15.45%, respectively. The annual money-weighted rate of return expresses investment performance, net of investment fees, adjusted for the changing amounts actually invested.

Investment risk factors – There are many factors that can affect the value of investments. Some factors including custodial credit risk, concentration of credit risk, and foreign currency risk, may affect both equity and fixed income securities. Equity securities respond to such factors as economic conditions, individual company earnings performance, and market liquidity, while fixed income securities are particularly sensitive to credit risks and changes in interest rates. The Plan manages its investment risk factors by diversifying its portfolio through investments in a group annuity contract that invests in various registered investment companies, and U.S. and international equity securities, which are all readily marketable.

The fixed income portfolio consists of shares held in various mutual funds with underlying investments in fixed and variable rate U.S Government and corporate securities. There are no restrictions to the Plan's ability to sell shares in these mutual funds on any given trading date.

Interest rate risk – Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of investments. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The prices of fixed income securities with a longer time to maturity, measured by effective duration, tend to be more sensitive to changes in interest rates and more volatile than those with shorter durations.

The Plan holds fixed income investments in various mutual funds with underlying investments in fixed and variable rate securities. There are no restrictions to the Plan's ability to sell shares in these mutual funds on any given trading date, which mitigates the interest rate risk of the underlying securities.

Credit risk – Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. The Plan held fixed income investments in various mutual funds with underlying investments in fixed and variable rate securities.

Custodial credit risk – Custodial credit risk is the risk that in the event of the failure of the investment custodian, the Plan will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. As of December 31, 2024 and 2023, the Plan's investments are held by third-party safekeeping custodians selected by the Board and registered in the Plan's name. As a result, management believes custodial credit risk is remote.

Concentration of credit risk – Concentration of credit risk is the risk associated with a lack of diversification, such as having substantial investments with a few individual issuers, thereby exposing the Plan to greater risks resulting from adverse economic, political, regulatory, geographic, or credit developments. As of December 31, 2024 and 2023, the Plan's investments are entirely held in mutual funds with diversified holdings in underlying investments.

Note 4 – Employer Contributions

Employer contributions are determined by the System's Board of Directors each year based on the actuarially required contribution amount calculated by the Plan's independent actuary. The actuarially determined contribution is determined as part of an actuarial valuation on January 1 of each year, using the traditional unit credit actuarial cost method. Actuarially determined contribution amounts were $12,601,903 and $11,269,905 for the years ended December 31, 2024 and 2023, respectively, and contributed to the Plan as directed and approved by the Board of Directors.

Note 5 – System Net Pension Liability

The components of the net pension liability of the System were as follows as of December 31:

	2024	2023
Total pension liability	$ 495,862,717	$ 479,235,862
Plan fiduciary net position	(515,636,478)	(459,538,695)
System net pension (asset) liability	$ (19,773,761)	$ 19,697,167
Plan fiduciary net position as a percentage of total pension liability (funded status)	103.99%	95.89%

Note 6 – Actuarial Methods and Significant Assumptions

The total pension liability was determined as part of actuarial valuations as of December 31, 2024 and 2023, respectively, using actuarial methods and assumptions in accordance with GASB No. 67, *Financial Reporting for Pension Plans*. The total pension liability was calculated using the entry age cost method and PubG-2016 Generational Mortality Tables projected using MP-2021 and the Pub-G-2010 Generational Mortality Tables projected using MP-2021 as of December 31, 2024 and 2023, respectively. The actuarial assumptions included (a) 6.50% investment long-term expected rate of return, net of investment expenses and (b) projected salary increases of 3.50% plus merit for Certified Nursing Assistants (CNA) and 3.75% plus merit for National Union of Healthcare Workers (NUHW).

Long-term expected rate of return – The long-term expected rate of return on the Plan's investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of investment expense and inflation) are developed for a hypothetical investment portfolio allocation of 65% equity and 35% fixed income. These ranges are combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage and by adding expected inflation at a long-term inflation rate of 2.25%.

As of December 31, 2024 and 2023, the long-term expected rates of return for each major investment class in the Plan's portfolio are as follows:

Investment Class	Long-Term Expected Rate of Return	
	2024	2023
Domestic equity		
U.S. large cap equity	6.8%	8.0%
U.S. mid cap equity	7.1%	N/A
U.S. small cap equity	7.6%	9.0%
International		
Equity	7.3%	8.0%
Emerging market equity	8.0%	9.0%
Alternative		
Real estate investment trust	5.8%	8.0%
Commodities	5.3%	5.0%
Money market	N/A	2.0%
Private equity	9.3%	N/A
Private credit	8.5%	N/A
Fixed income		
High yield bonds	6.2%	6.5%
Core bonds	N/A	4.0%
Long-term corporate bonds	N/A	6.0%
Short-term bonds	N/A	2.5%
Treasury bonds	4.3%	N/A
US agg	4.5%	N/A
US TIPS	4.3%	N/A
Global ex US	4.0%	N/A
Emerging markets	6.3%	N/A

Discount rate – As of December 31, 2024 and 2023, the discount rate used to measure the total pension liability was 6.50%, based on the expected rate of return on pension plan investments. Based on the stated assumptions and the projection of cash flows, the Plan's fiduciary net position and future contributions were projected to be available to finance all projected future benefit payments of current pension plan members. Therefore, the long-term expected rate of return on Plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

Sensitivity of the net pension liability to changes in the discount rate – The following presents the net pension liability of the System, calculated using the discount rate of 6.50%, as well as what the System's net pension liability would be if it were calculated using a discount rate that is 1% point lower (5.50%) or 1% point higher (7.50%) than the current rate:

	1% Decrease (5.50%)	Current Discount Rate (6.50%)	1% Increase (7.50%)
System net pension liability	$ 44,076,609	$ (19,773,761)	$ (73,135,684)

Note 7 – Tax Status

The Internal Revenue Service has determined and informed the System by a letter dated March 21, 2017, that the Plan is designed in accordance with the applicable sections of the Internal Revenue Code (IRC). Management believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC and is not subject to federal income taxes.

Note 8 – Risks and Uncertainties

The Plan invests in various investment securities. Investment securities are exposed to various risks such as interest rate, market, and credit risks (see Note 3). Due to the level of risk associated with certain investment securities, it is at least reasonably possible that changes in the values of investment securities will occur in the near term and that such changes could materially affect the amounts reported in the statement of net position available for benefits.

Plan contributions are made, and the total pension liability is reported based on certain assumptions pertaining to interest rates, inflation rates, and member demographics, all of which are subject to change. Due to uncertainties inherent in the estimations and assumptions process, it is at least reasonably possible that changes in these estimates and assumptions in the near-term would be material to the financial statements.

Required Supplementary Information

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Schedules of Changes in Employer Net Pension (Asset) Liability and Related Ratios

	Year Ended December 31,									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Total pension liability										
Service cost	$ 10,867,968	$ 10,276,815	$ 10,507,936	$ 9,971,347	$ 9,739,474	$ 8,353,779	$ 8,078,739	$ 7,171,959	$ 7,005,009	$ 7,743,929
Interest on total pension liability	31,123,436	29,843,069	28,712,023	27,964,724	26,944,092	25,007,386	24,405,221	22,569,994	21,000,849	19,178,200
Change of benefit terms	-	-	-	-	(201,797)	-	-	-	-	-
Difference between expected and actual experience	(1,044,507)	152,237	(2,138,473)	4,182,887	(3,872,216)	(8,841,924)	(3,353,687)	(3,076,492)	4,487,813	(280,070)
Changes in actuarial assumptions	(1,756,558)	-	-	(13,644,957)	(1,835,817)	36,231,315	14,767,302	11,277,838	2,602,234	(1,465,873)
Benefit payments	(22,563,484)	(19,767,150)	(18,835,673)	(16,232,653)	(14,266,188)	(12,525,484)	(11,578,811)	(10,404,996)	(8,726,267)	(7,762,380)
Net change in total pension liability	16,626,855	20,504,971	18,245,813	12,241,348	16,507,548	48,225,072	32,318,764	27,538,303	26,369,638	17,413,806
Total pension liability										
Beginning of year	479,235,862	458,730,891	440,485,078	428,243,730	411,736,182	363,511,110	331,192,346	303,654,043	277,284,405	259,870,599
End of year (a)	$ 495,862,717	$ 479,235,862	$ 458,730,891	$ 440,485,078	$ 428,243,730	$ 411,736,182	$ 363,511,110	$ 331,192,346	$ 303,654,043	$ 277,284,405
Plan fiduciary net position										
Employer contributions	$ 12,602,713	$ 11,269,905	$ 61,579,392	$ 23,126,725	$ 23,765,862	$ 26,808,785	$ 21,927,309	$ 19,883,437	$ 16,938,956	$ 17,189,514
Member contributions	2,800,377	2,506,514	2,577,706	2,673,070	1,975,665	1,593,730	1,209,498	840,013	474,659	-
Net investment income (loss)	63,371,929	61,892,945	(83,884,411)	47,033,347	43,530,843	52,346,352	(13,802,482)	32,509,516	8,198,171	1,301,163
Administrative expenses	(113,752)	(83,035)	(92,272)	(111,880)	(115,720)	(115,586)	(112,397)	(109,194)	(64,788)	-
Benefit payments	(22,563,484)	(19,767,150)	(18,835,673)	(16,352,414)	(14,266,188)	(12,525,484)	(11,578,811)	(10,404,996)	(8,726,267)	(7,762,380)
Net change in plan fiduciary net position	56,097,783	55,819,179	(38,655,258)	56,368,848	54,890,462	68,107,797	(2,356,883)	42,718,776	16,820,731	10,728,297
Plan fiduciary net position										
Beginning of year	459,538,695	403,719,516	442,374,774	386,005,926	331,115,464	263,007,667	265,364,550	222,645,774	205,825,043	195,096,746
End of year (b)	$ 515,636,478	$ 459,538,695	$ 403,719,516	$ 442,374,774	$ 386,005,926	$ 331,115,464	$ 263,007,667	$ 265,364,550	$ 222,645,774	$ 205,825,043
Employer net pension (asset) liability (a) - (b)	$ (19,773,761)	$ 19,697,167	$ 55,011,375	$ (1,889,696)	$ 42,237,804	$ 80,620,718	$ 100,503,443	$ 65,827,796	$ 81,008,269	$ 71,459,362
Discount rate	6.5%	6.5%	6.5%	6.5%	6.5%	7.0%	7.5%	7.5%	7.5%	7.5%
Plan fiduciary net position as percentage of total pension liability	103.99%	95.89%	88.01%	100.43%	90.14%	80.42%	72.35%	80.12%	73.32%	74.23%
Covered payroll	$ 154,689,696	$ 151,837,187	$ 142,049,836	$ 138,819,740	$ 127,771,097	$ 119,260,723	$ 112,353,126	$ 108,395,254	$ 95,639,978	$ 92,759,619
Net pension (asset) liability as percentage of covered payroll	-12.78%	12.97%	38.73%	-1.36%	33.06%	67.60%	89.45%	60.73%	84.70%	77.04%

Notes to schedule

Changes in actuarial assumptions with significant impact on the total pension liability include discount rate changes and the following:

1) For 2018, the salary scale changed from 4.0% to 3.5% plus merit (CNA) and 3.75% plus merit (NUHW).
2) For 2017, the plan was amended for legislative changes according to PEPRA and to remove the three-year service requirement to participate for eligible employees.

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Schedules of Employer Contributions

Year Ended December 31,	Actuarially Determined Contribution	Actual Employer Contribution	Contribution Excess	Covered Payroll	Contribution as a % of Covered Payroll
2024	$ 12,602,713	$ 12,602,713	$ -	$ 154,689,696	8.15%
2023	11,269,905	11,269,905	-	151,837,187	7.42%
2022	10,157,917	61,579,392	51,421,475	142,049,836	43.35%
2021	13,126,725	23,126,725	10,000,000	138,819,740	16.66%
2020	18,765,859	23,765,862	5,000,003	127,771,097	18.60%
2019	11,808,783	26,808,785	15,000,002	119,260,723	22.48%
2018	11,927,309	21,927,309	10,000,000	112,353,126	19.52%
2017	12,883,435	19,883,437	7,000,002	108,395,254	18.34%
2016	11,970,458	16,938,956	4,968,498	95,639,978	17.71%
2015	12,146,278	17,189,514	5,043,236	92,759,619	18.53%

Notes to schedule

Valuation date	Actuarially determined contributions are calculated as of January 1, the first day of the fiscal year in which the contributions are reported.
Methods and assumptions used	
Actuarial cost method	Entry Age
Inflation	2.25%
Salary increases	2015 - 2017: 3.75% (NUHW) and 4.00% (CNA), including inflation 3.75% plus merit increases (NUHW) and 4.00% plus merit increases (CNA) 2018 - 2024: 3.75% (NUHW) and 3.50%(CNA), including inflation 3.75% plus merit increases (NUHW) and 3.50% plus merit increases (CNA)
Investment rate of return	2015 - 2017: 7.50%, net of investment expense, including inflation 2018: 7.00%, net of investment expense, including inflation 2019 - 2024: 6.50%, net of investment expense, including inflation
Retirement age	
Normal retirement	65
Early retirement	Classic participant: 50 and 15 years of vesting service New participant: 52 and 15 years of vesting service
Mortality	2015 - 2017: RP-2000 Mortality Table for Males and Females, projected to 2033 2018: RP-2014 Mortality Table for Males and Females, projected to 2033 2019: PubG-2010 Generational Mortality Tables for Males and Females, projected using MP-2019 2020: PubG-2010 Generational Mortality Tables for Males and Females, projected using MP-2020 2021 - 2023: PubG-2010 Generational Mortality Tables for Males and Females, projected using MP-2021 2024: PubG-2016 Generational Mortality Tables for Males and Females, projected using MP-2021

Salinas Valley Memorial Healthcare District
Employees Pension Plan
Schedules of Investment Returns

	Year Ended December 31,									
	2024	2023	2022	2021	2020	2019	2018	2017	2016	2015
Annual money-weighted rate of return, net of investment expenses	13.90%	15.45%	-18.04%	12.01%	12.92%	19.53%	-5.11%	14.22%	3.74%	0.68%

COMMUNITY ADVOCACY COMMITTEE

Minutes of the
Community Advocacy Committee
will be distributed at the Board Meeting

(Rolando Cabrera, M.D.)

Medical Executive Committee Summary – November 13, 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Gomez, Briana, MD	Ob/Gyn	Ob/Gyn	Obstetrics & Gynecology Robotic Surgery: daVinci.
Leyenson, Vadim, MD	Critical Care	Medicine	Critical Care/Pulmonary Medicine
Ngo, Tam, MD	Family Medicine	Medicine	Adult Hospitalist
Rane, Manas, MD	Internal Medicine	Medicine	Medicine – Active Community

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Al-Louzi, Omar, MD	Neurology	Medicine	Tele-Neurology
Bhat, Arvind, MD	Internal Medicine	Medicine	Adult Hospitalist
Bottari, Brenden, MD	Interventional Radiology	Surgery	Salinas Valley Health Imaging Diagnostic Imaging Vascular and Interventional Radiology Peripheral Endovascular Salinas Valley Health Advanced Imaging- Non-Cardiac Diagnostic Radiology
Castro, Robert, MD	Neonatology	Family Medicine/ Pediatrics	Neonatology
Chen, Kevin, MD	Ophthalmology	Surgery	Ophthalmology
Ferguson, Catherine, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Giedt, W. Reid, MD	Pediatrics	Family Medicine/ Pediatrics	Pediatrics
Glaser, Anne, MD	Radiology	Surgery	Salinas Valley Health Advanced Imaging – Remote Teleradiology/Radiology Salinas Valley Health Imaging Remote Radiology
Gonzalez, Jaime, MD	Family Medicine	Medicine	Adult Hospitalist
Kanter, Gregory, MD	Urogynecology	Ob/Gyn	Urogynecology Robotic Surgery: DaVinci Gynecology; Urogynecology
Kaur, Gurvinder, MD	Neurosurgery	Surgery	Neurological Surgery
Keller, David, MD	Infectious Disease	Medicine	Infectious Disease General Internal Medicine: Core
Klimberg, Nicholas, MD	Critical Care Medicine	Medicine	Critical Care/Pulmonary Medicine
Kumar, Rajiv, MD	Radiology	Surgery	Salinas Valley Health Advanced Imaging – Remote Teleradiology/Radiology Salinas Valley Health Imaging Remote Radiology
Locke, Erica, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine

Matthews, Jamil, MD	Vascular Surgery	Surgery	Vascular Surgery Peripheral Endovascular
Mendoza, Matthew, MD	Gastroenterology	Medicine	Gastroenterology Taylor Farms Family Health & Wellness Center – Ambulatory Procedure Privileges
Noel, Katherine, MD	Ob/Gyn	Ob/Gyn	Obstetrics & Gynecology
Nowak, Kenneth, ND	Otolaryngology	Surgery	Otolaryngology
Regwan, Steven, DO	Cardiology	Medicine	Cardiology Salinas Valley Health Cardiovascular Diagnostics Salinas Valley Health Advanced Imaging- Cardiac Imaging Taylor Farms Family Health and Wellness Center
Rincon, Freddy, MD	Neurology	Medicine	Tele-Neurology
Rodnick, Jeffrey, MD	Radiation Oncology	Medicine	Radiation Oncology
Rodriguez, Juan, MD	Interventional Radiology	Surgery	Salinas Valley Health Imaging Salinas Valley Health Advanced Imaging- Non-Cardiac Diagnostic Radiology
Wilson, Alison, DO	Family Medicine	Medicine	Adult Hospitalist

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE MODIFICATION
Lew, James, MD	Family Medicine	Requesting to relinquish Obstetrical I & II privileges effective 10/1/2025.
Stemerman, Amy, MD	Radiology	Requesting new privilege – Breast Lesion Cryoablation

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Albert, Timothy, MD	Cardiology	Recommend advancement to Active Staff
Beeravolu, Lakshmi, MD	Tele-Neurology	Resignation effective 10/12/2025
Berthet, Benjamin, MD	Pediatrics	Recommend advancement to Active Staff
Bidar, Maziar, MD	Ophthalmology	Recommend advancement to Active Staff
Blanchard, Jonny, MD	Internal Medicine	Recommend advancement to Active Staff
Ginsburg, Jerry, MD	Cardiology	Requesting Emeritus effective 11/30/2025
Kerwin, Lewis, MD	Tele-Psychiatry	Resignation effective 9/25/2025
Matthews, Jamil, MD	Vascular Surgery	Recommend advancement to Active Staff
McCuistion, Christine, MD	Pediatrics	Resignation effective 11/30/2025
Ramseur, James, MD	Ob/Gyn	Resignation effective 10/24/2025
Ryazanova, Alina, MD	Tele-Neurology	Resignation effective 8/8/2025
Shin, Daniel, MD	Radiology	Recommend advancement to Active Staff
Wilson, Hugh, MD	Pathology	Requesting Emeritus effective 11/30/2025

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES
Movahed, Mohammad, MD	Cardiology	10/20/2025-11/18/2025 12/1/2025 – 12/30/2025

Additional Items: ***(Attached)***

A. Family Medicine – Clinical Privilege Delineation	The Committee recommended approval of the revision to the clinical privilege delineation for Family Medicine to Obstetrical I&II Qualifications and removing the Policy for Level I Obstetrics Back-up.

B. Hospitalist – Adult – Clinical Privilege Delineation	The Committee recommended approval of the revision removing all Special Privileges and placing Core Procedures within the Hospitalist Core Privileges section.
C. Cardiology – Clinical Privilege Delineation	The Committee recommended approval of the revision adding Transcatheter Tricuspid Valve Repair (TriClip) to special privileges.
D. Salinas Valley Health Nancy Ausonio Breast Health Center – Clinical Privilege Delineation	The Committee recommended approval of the revision adding Breast Lesion Cryoablation to special privileges.

Interdisciplinary Practice Committee

Initial Appointments:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Ayala Garcia, Marisol, PA-C	Taylor Farms Family Health & Wellness Center	Family Medicine	Erika Garcia, MD

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

Nurse Driven Urinary Catheter Removal Protocol Nursing Standardized Procedure	Review of revisions: updated verbiage of electronic health record system.

Policies and Plans:

1. Adult parenteral Nutrition Protocol
2. DI Thoracentesis Under Ultrasound Guidance
3. Employee Exposures & Prevention Plans
4. Information Management Program Plan
5. Inpatient Criteria for Chemotherapy and Immunotherapy Administration
6. Medication Use

Rules and Regulations: ***(Attached)***

Medical Staff Excellence Committee (MSEC) Charter update is presented to the Board of Directors for approval having been approved by the Medical Executive Committee and by a vote of the General Medical Staff.

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Quality and Safety Committee
d. Medical Staff Excellence Committee

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings October 2025
c. Medical Staff Treasury Report November 6, 2025
d. Medical Staff Statistics Year to Date
e. Financial Update September 2025
f. Executive Updates
g. HCAHPS Update November 4, 2025

Clinical Privileges Delineation Form
Family Medicine

Applicant Name: _____

To be eligible to apply for core privileges in Family Medicine, the applicant must meet the following qualifications:

Qualifications for Adult Family Medicine Privileges:

A. Current certification or active participation in the examination process leading to certification in Family Medicine by the American Board of Family Medicine or the American Osteopathic Board of Family Practice OR Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in family medicine.
AND

B. Documentation of the provision of inpatient care for at least 24 adult patients as the attending physician or senior resident during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship.

General Privilege Statement

Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Adult Family Medicine Core Privileges

☐ **Requested**

Admit, evaluate, diagnose and treat patients for common illnesses and injuries including disorders common to old age. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Pediatric and Well Newborn Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above
AND
Documentation of the provision of inpatient care for at least 20 hospitalized pediatric/newborn patients during the past 24 months. Competency criteria requires that 5 of these patients be pediatric patients or, at a minimum, the applicant must have provided inpatient care for at least 3 pediatric patients in conjunction with documentation 5 hours of Category 1 CME on acute care pediatric medicine during the past 24 months
OR

B. Demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Pediatric and Well Newborn Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat pediatric and well newborn patients with conditions of mild to moderate degree without immediate threat to life. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Well Newborn Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above
AND

B. Documentation of the provision of inpatient care for at least 20 hospitalized well newborn patients during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Well Newborn Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat well newborn patients.

Qualifications for Pediatric Family Medicine Privileges:

A. Meet All qualifications for Adult Family Medicine privileges under A above
AND

B. Documentation of the provision of inpatient care for at least 24 hospitalized pediatric patients during the past 24 months or demonstration of successful participation in a hospital-affiliated formalized residency or special clinical fellowship in the past 24 months.

Family Medicine Pediatric Core Privileges ***(check box if requesting)***

☐ **Requested**

Admit, evaluate, diagnose and treat pediatric patients (with exceptions of newborns), with conditions of mild to moderate degree without immediate threat to life. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Family Medicine Category I Obstetrical Privileges:

A. All qualifications for Adult Family Medicine.
AND

B. Documentation of successful completion of an obstetric rotation during training with at least 75 vaginal deliveries under supervision during training
OR

C. Documentation of at least 25 vaginal deliveries (including vaginal deliveries performed or supervised by the applicant) in the past 24 months if out of training 2 years or more.
AND

D. Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

Family Medicine Category I Obstetrical Privileges ***(check box if requesting)***

☐ **Requested**

Core Procedures/Diagnoses: Admit, evaluate, diagnose, treat and provide consultation to obstetrical patients, to include management of ~~normal~~ pregnancy, labor and delivery, as well as expected complications or obstetrical emergencies.

~~**Applicants without C-Section privileges are required to make arrangements for C-Section Back-Up for all deliveries in the event that a C-Section is needed.**~~

Note: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Qualifications for Family Medicine Category II Obstetrical Privileges

A. All qualifications for Adult Family Medicine ~~and Category I Obstetrical Privileges~~
AND

B. Documentation of successful completion of a full **1 year** exclusive experience on an obstetric unit with at least **75 vaginal** deliveries (including vaginal deliveries performed or supervised by the applicant), and **75 cesarean sections** as primary surgeon with supervision during training or in practice
OR

C. Documentation of successful completion of a full **1 year** exclusive experience on an obstetric unit , documentation of at least 25 vaginal deliveries (including vaginal deliveries performed or supervised by the applicant) and 20 cesarean sections (as primary surgeon or as supervising physician) in the past 24 months if out of training 2 years or greater.
AND

D. Completion of an American Completion of an American College of Obstetricians and Gynecologists (ACOG) endorsed fetal monitoring strip interpretation course that includes NICHD nomenclature within three months of appointment

Family Medicine Category II Obstetrical Privileges *(check box if requesting)*

☐ **Requested**

Core Procedures/Diagnoses: All core privileges under Category I as well as the following: Admit, evaluate, diagnose, treat and provide consultation to obstetrical patients, to include management of normal and complex pregnancy, labor and delivery, as well as expected complications or obstetrical emergencies. Applicants for this category are required to qualify for and request special procedure privileges for C-Sections.

Note: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts. Terms are as defined by ACOG.

Core Proctoring Requirements:
Core proctoring requirements include direct observation or concurrent review of the first cases as follows:

Adult Family Medicine Core:	1 Adult Admission
Pediatric & Well Newborn Core:	1 Pediatric Admission and 1 Well Newborn
Well Newborn Core:	1 Well Newborn
Family Medicine Pediatrics Core:	1 Pediatric Admission
Family Medicine Obstetrics:	2 Deliveries – 1 of which must be C-section if C-Section privileges are requested.

Reappointment Criteria for Core Privileges:
Applicant must provide documentation of the provision of the following within the past 24 months:

Adult Family Medicine Core:	20 hospitalized patients
Pediatric & Well Newborn Core:	20 hospitalized pediatric/newborn patients 5 of which must be pediatric or 3 and 5 hours Category 1 CME
Well Newborn Core:	20 hospitalized well newborn patients
Family Medicine Pediatrics Core:	24 hospitalized pediatric patients
Family Medicine Obstetrics I:	25 vaginal deliveries **AND** Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment) **AND** Document annual participation in at least one OB patient safety drill facilitated by SVH Perinatal Services. (Effective October 1, 2025) assessed at the time of reappointment.
Family Medicine Obstetrics II:	25 vaginal deliveries w/10 C-sections **AND** Participation in the annual assessment of EFM (electronic fetal monitoring) principles (assessed at the time of reappointment) **AND** Document annual participation in at least one OB patient safety drill facilitated by SVH Perinatal Services. (Effective October 1, 2025) assessed at the time of reappointment.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written conscious sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification AND** Completion of written conscious sedation exam with minimum 75% correct **AND** Performance of at least 2 Cases

Gynecologic Special Procedure Privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Dilation and Curettage of the Uterus (Diagnostic)	Performance of at least 10 procedures during the previous 24 month period	**1**	Performance of at least 2 procedures during the previous 24 month period
				Dilation and Curettage of the Uterus for abortion <12 weeks (TAB, SAB)	Performance of at least 10 procedures during the previous 24 month period	**1**	Performance of at least 2 procedures during the previous 24 month period

Special Obstetrical Procedures

Qualifications:

Following completion of Family Practice residency and completion of a one year obstetric fellowship in an accredited Family Practice Obstetric Fellowship Training Program, and a letter of positive recommendation from the Chief of this program certifying training and competence to perform privileges requested

Other Requirements:

Deliveries with placenta previa require an assistant with unrestricted hysterectomy privileges

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Cesarean Section *Assistant Required*	Meet criteria for Category II Family Medicine Obstetrical Privileges **AND** Provide documentation of the successful completion of at least 30 C-sections within the past 24 months.	**2**	Performance of at least 10 procedures during the previous 24 month period
				Outlet and Low forceps delivery	Performance of at least 5 procedures during the previous 24 month period	**1**	Performance of at least 1 procedure during the previous 24 month period
				External Cephalic Version	Cesarean Section privileges are required	**1**	Maintenance of Cesarean Section privileges
				Amniocentesis-3rd Trimester	Performance of at least 5 procedures during the previous 24 month period	**1**	Performance of at least 1 procedure during the previous 24 month period

Category 1 Pediatric Special Procedures – See Appendix for Description of Conditions in this Category

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Newborn Circumcision	Documentation of successful completion of at least 5 in the previous 24 months	**1**	Documentation of successful completion of at least 2 in the previous 2 years

Salinas Valley Health Medical Center

Core Procedure List: The following procedures are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Family Medicine Adult

1. Assisting at Surgery
2. Arthrocentesis
3. I&D abscess
4. I&D hemorrhoids
5. Biopsy of superficial lymph nodes
6. Breast cyst aspiration
7. Burns, superficial and partial thickness
8. Excision of skin and subcutaneous lesions
9. Initial interpretation of electrocardiograms
10. Local anesthetic techniques
11. Lumbar puncture
12. Management of ICU and CCU patients with consultation
13. Manage uncomplicated minor closed fractures and uncomplicated dislocations
14. Paracentesis
15. Placement of anterior and posterior nasal hemostatic packing
16. Peripheral nerve blocks
17. Remove non-penetrating corneal foreign body, nasal foreign body
18. Repair of lacerations, including those requiring more than one layer of closure
19. Suprapubic bladder aspiration
20. Thoracentesis
21. Thrombolytic therapy for stroke
22. Vasectomy
23. Venous cut down

Family Medicine Pediatrics

1. Suture uncomplicated lacerations
2. I&D abscess
3. Perform simple skin biopsy or excision
4. Remove non-penetrating corneal foreign body
5. Manage uncomplicated minor closed fractures and uncomplicated dislocations
6. Lumbar puncture
7. Care of newborn infants above 2250 gm and >36 weeks
8. Ventilator management with consultation while awaiting transfer (not to exceed 12 hours after which care is automatically transferred to the Pulmonologist)

Family Medicine Obstetrics – Level I

1. Management of labor and cephalic delivery
2. Administration of fetal lung maturity inducers
3. Amnio infusion
4. Amniotomy
5. Application of internal fetal and uterine monitors
6. Management of pregnancy inclusive of but not limited to such conditions as preeclampsia/pregnancy-induced hypertension >32 weeks, third trimester bleeding, preterm premature rupture of membranes >32 weeks, premature labor >32 weeks, gestational and preexisting diabetes, polyhydramnios, oligohydramnios, and fetal demise at any gestational age.
7. Management of preterm premature rupture of membranes < 32 weeks, premature labor < 32 weeks, preeclampsia/pregnancy-induced hypertension < 32 weeks, and vaginal bleeding at any gestational age in consultation with a Maternal Fetal Medicine Specialist.

8. Manual removal of placenta
9. Vacuum Extraction
10. Hemorrhage ante/intra & postpartum
11. Induction and augmentation of labor
12. Repair of vaginal 1st/2nd/3rd degree perineal, and cervical lacerations
13. Ultrasound Exam for Placental location, presentation or Amniotic fluid ~~only~~
14. Local and pudendal anesthesia
15. Episiotomy and Repair
16. Treatment of hyperemesis gravidarum

Family Medicine Obstetrics – Level II

1. Postpartum surgical sterilization
2. Twins - Vaginal Vertex/Vertex
3. Twins - Other Presentation
4. Repair of 4th degree perineal lacerations
5. Cephalic forceps Outlet

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

_____ _____

_____
Signature:

_____
Date

POLICY FOR LEVEL I FAMILY MEDICINE OBSTETRICAL PRIVILEGES
Back-Up, Consultation and Transfer

The following policy pertains to all Family Medicine physicians applying for Level I Obstetrical privileges.

DEFINITION OF BACK-UP PHYSICIAN:
The Back-Up Physician can only be a Family Physician with Level II unrestricted Obstetrical privileges or an Obstetrician with unrestricted obstetrical privileges. Perinatologists are not eligible to be Back-Up Physicians. The ED On-Call Physician for Obstetrics cannot be the Back-Up physician by default. Back-Up coverage can only be made through prior arrangement with that physician.

1. **GENERAL POLICY**: As a prerequisite to obtaining Level I Family Medicine Obstetrical privileges, all Family Medicine applicants are required to have an Obstetrician or Family Physician with Level II Obstetrical privileges as Back-Up who has agreed to provide obstetrical back up in the event the needs of the patient exceed their obstetrical privileges for the 2 year appointment periods. At no time should a Level I Family Medicine Physician continue in the practice of obstetrics without a designated Back-Up Physician. If the reported Back-Up Physician relationship changes at any point within the 2 year appointment period, a new Back-Up Physician designate must be reported to the Medical Staff Services Department immediately.

    a. The Family Physician and Back-Up Physician have mutually developed and agreed upon clear guidelines for consultation, co-management and transfer of care.

    b. The basic template for those guidelines is the Level I Obstetrical privileges for Family Physicians

    c. A Level I Family physician may have more than one designated Back-Up Physician listed, however, a specific Back-Up Physician must be designated and identified for each case.

    d. The Back-Up Physician can designate an alternate Back-Up Physician on a case by case basis only by mutual consent of the newly designated Back-Up Physician and the Level I Family Physician.

    e. Because serving as a Back-Up Physician is an assumption of risk and liability, the Back-Up Physician CANNOT be assigned the task or designated the task by an Employer, Department Chair, Hospital Administrator, or Chief of Staff without the consent of the Physician providing these services.

2. **PRIVILEGING AND REAPPOINTMENT**: The Back-Up Physician must be clearly identified and acknowledged at the time of application for and renewal of privileges with the Medical Staff Services Department.

    a. The Back-Up Physician's name and contact information shall be included with the application. (see attached attestation form)

    b. The Back-Up Physician must provide written acknowledgement of acceptance of this responsibility for the specific physician on the attestations form.

    c. Without cause, either the Level I Family Physician or Back-Up Physician may terminate the agreement at any time. Should this occur, the Level I Family Physician and Back-Up Physician must immediately report this termination to the Medical Staff Services Department (Mon-Fri, 8am – 4:30) or to the Nursing Supervisor outside of normal business hours..

3. **LABOR AND DELIVERY NURSING**: The Labor and Delivery Nursing station will access the names of all Family Physicians with Level I Obstetrical privileges and their corresponding Back-Up through the medical staff privileges in the Meditech system

4. **ADMISSION TO LABOR AND DELIVERY**:

If the Back-Up Physician is not available or declines to provide Back-Up, the Level I Physician must transfer care to a Level II Family physician, Obstetrician, or another Level I Physician with appropriate Back-Up; or the Chair of the Department of Family Medicine or Ob/Gyn must intervene to arrive at a safe and appropriate solution

5. CONSULTATION, TRANSFER AND CO-MANAGEMENT OF PATIENTS

a. Any discussion with the Back-Up Physician must be documented in the chart by the Level I Physician

b. If the status of the patient exceeds Level I Family Medicine Obstetrical privileges, the care of the patient must be transferred to and accepted by the designated Back-Up Physician.

c. The Level I Physician must document transfer of care to the Back-Up Physician by order and note in the chart

d. The Back-Up Physician must document acceptance of the transfer of care in the chart through either a dictated or handwritten consultation note

e. The patient may be co-managed by the Back-Up Physician and Level 1 Physician, if acceptable by the Back-Up Physician.

6. VIOLATION OF POLICY

Violations of this policy will be reported to the Medical Staff Excellence Committee, the Chairs of the Family Medicine and Ob/Gyn Departments and to the Chief Medical Officer for review and action.

FAMILY MEDICINE
LEVEL I OBSTETRICS
BACK-UP ATTESTATION

The following physician has agreed to provide obstetrical Back-Up for hospitalized patients at Salinas Valley Health Medical Center (SVH) for the Family Medicine physician noted below.

Without cause, either the Level I Family Physician or Back-Up Physician may terminate the agreement at any time. The Level I Family Physician and Back-Up Physician but must immediately report this termination to the Medical Staff Services Department or to the Administrative Nursing Supervisor outside of normal business hours (Mon-Fri, 8am – 4:30).

Applicant Attestation:
I understand that I am required to have at least one Back-Up physician with Level II Family Medicine Obstetrical Privileges or full Obstetrical Privileges in order to qualify for Level I Family Medicine Obstetrical Privileges at SVMH. I understand that the Back-Up physician must be on staff in good standing with unrestricted privileges at SVMH. In the event that the needs of my hospitalized obstetrical patients exceed the privileges that I have been granted, the physician listed below has agreed to provide back up for me for the current reappointment period.

I understand that, should the status of any of these physicians change such that they would be unable to provide this Back-Up coverage, it is my responsibility to notify the Medical Staff Services Department immediately and to subsequently secure a replacement for that physician.

_____ _____
Physician's Signature Date

_____
Physician's Typed or Printed Name

Back Up Physician Attestation:

I have agreed to provide Back-Up coverage as outlined in the Medical Staff Back-Up, Consultation and Referral Policy for Family Medicine Physicians with Level 1 Obstetrical Privileges:

_____ _____
Physician's Signature Date

_____
Physician's Typed or Printed Name

_____
Physician's Contact Information

Salinas Valley Health Medical Center

Clinical Privileges Delineation
Adult Hospitalist

Applicant Name: _____

Qualifications:

To be eligible to apply for core privileges as a Hospitalist, the applicant must meet the following qualifications:

- Current certification or active participation in the examination process leading to certification by the American Board of Internal Medicine, the American Osteopathic Board of Internal Medicine, the American Board of Family Medicine or the American Osteopathic Board of Family Practice.

OR

- Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in Internal Medicine or Family Medicine.

AND

- Documentation of the provision of inpatient services to at least 40 hospitalized in-patients in the last 12 months or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship.
- New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privilege Statement

Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Hospitalist Core Privileges

- ~~Admit, evaluate, diagnose, treat and provide consultation to patients with common and complex illnesses, afflictions, diseases, and functional disorders of the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems of the human body. Core privileges also include Thrombolytic therapy for stroke with Neurology consultation/co-management and Management of ICU and CCU patients with consultation, as needed and Telehealth services. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.~~

Hospitalist Core Privileges

Admit, evaluate, diagnose, treat, and provide consultation for patients with common and complex medical conditions involving the circulatory, respiratory, digestive, endocrine, metabolic, musculoskeletal, hematopoietic, and eliminative systems. Includes ICU/CCU management with consultation as needed, thrombolytic therapy for stroke with neurology co-management, and telehealth services. Procedural privileges

include arthrocentesis, arterial/central line placement, CXR/ECG interpretation, incision and drainage, management of superficial/partial-thickness burns, excision or biopsy of cutaneous/subcutaneous lesions, local anesthesia, lumbar puncture, uncomplicated fracture and dislocation management, NG/OG tube placement, paracentesis, peripheral nerve blocks, nasal packing, point-of-care ultrasound (diagnostic and procedural), removal of corneal and nasal foreign bodies, laceration repair (including multilayer closure), and thoracentesis.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 40 in-patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify to reapply.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(**R**)=Requested (**A**)=Recommended as Requested (**C**)=Recommended w/Conditions (**N**)=Not Recommended.

Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Moderate Sedation~~	~~**Current ACLS Certification AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.~~	~~**1**~~	~~**Current ACLS Certification AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months~~
				~~Chest tube placement~~	~~Documentation of successful performance in the previous 2 years.~~	~~**1**~~	~~**2**~~
				~~Swan-Ganz Catheter Insertion~~	~~Documentation of successful performance in the previous 2 years~~	~~**1**~~	~~**1**~~

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Insertion and Management of Pulmonary Artery Catheter~~	~~Documented successful performance of at least 50 PACs during formal training, as the primary operator~~ ~~**OR**~~ ~~Successful completion of an accredited residency in another field; participation in a significant Category 1 accredited continuing medical education training program in pulmonary artery catheter insertion and management~~ ~~**AND**~~ ~~Successful insertion and subsequent management of pulmonary artery catheters in at least 100 patients during the past 36 months.~~ ~~**Required Previous Experience:**~~ ~~Documented successful performance (as primary operator) of at least 50 PACs during the past 24 months.~~	~~**1**~~	~~Documented successful performance of at least 15 PACs per year, as the primary operator~~

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Ventilator Management~~ ~~Complicated >48 hours~~	~~For complicated* ventilation cases, the applicant must demonstrate successful completion of an accredited fellowship that provided the necessary cognitive and technical skills for full ventilator management. *More than 48 hours, or for patients defined as those having any of the following ongoing characteristics or any other of a like or similar complexity: peak ventilator pressure is greater than 40cm H20,pH is less than 7.3, Fi02 is greater than 60^, status asthmaticus, ARDS, multi-organ failure, hemodynamic instability.~~ ~~**Required Previous Experience:**~~ ~~Successful management of at least 25 mechanical ventilation cases in the past 24 months.~~	~~**1**~~	~~Successful management of at least 25 mechanical ventilation cases within the past 24 months.~~
				~~Exercise Treadmill~~	~~Successful completion of at least 50 ETT in the previous 2 years~~ ~~**AND**~~ ~~current ACLS certification~~	~~**N/A**~~	~~Successful completion of 20 ETT procedures within the past 24 months~~ ~~**AND**~~ ~~current ACLS certification~~

Salinas Valley Memorial Healthcare System

Hospitalists: The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Vice President of Medical Affairs and/or the Chief of Staff

- **Arthrocentesis** (diagnostic and therapeutic joint aspiration/injection)
- **Arterial Line Placement** – Percutaneous
- Basic airway management (bag-mask ventilation, oral/nasal airway placement)
- Central Venous Line Placement – **Is this the same Central venous cather (Below)??**
- Central venous catheter insertion (internal jugular, subclavian, femoral)
- Chest radiograph (CXR) interpretation
- Incision and drainage **(I&D)** of skin and soft tissue abscesses **abscess**
- I&D hemorrhoids
- Biopsy of superficial lymph nodes
- Breast cyst aspiration
- **Burns**: Initial management of , superficial and partial-thickness burns
- Excision or biopsy of cutaneous of skin and subcutaneous lesions, tumors, or nodules
- Excision of cutaneous and subcutaneous tumors and nodules – **SAME AS Perform simple skin biopsy or excision??**
- Focused diagnostic POCUS (cardiac, lung and abdominal)
- **Initial interpretation of electrocardiograms** (ECG/EKG)
- Intraosseous access
- **Local anesthetic** infiltration **techniques**
- **Lumbar puncture**
- **Manage uncomplicated minor closed fractures**
- Manage and uncomplicated dislocations
- **Nasogastric** or gastric **tube placement**
- **Paracentesis**
- **Peripheral nerve blocks**
- **Placement of anterior and posterior nasal hemostatic packing**
- **Perform simple skin biopsy or excision** of cutaneous and subcutaneous tumors and nodules
- Point-of-care ultrasound (POCUS) for diagnostic purposes (cardiac, lung, and abdominal) or procedure guiddance (vascular access, paracentesis, thoracentesis and lumbar puncture)
- Preliminary interpretation of electrocardiograms, own patient
- **Remov**eal of **non-penetrating corneal foreign body,**
- Removal of **nasal foreign body**
- **Repair of lacerations, including** multi-layer closure those requiring more than one layer of closure
- Suprapubic bladder aspiration
- **Thoracentesis**
- **Ventilator Management Uncomplicated (<48 hours)**
- Venous cutdown

Applicant:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

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

Salinas Valley Health Medical Center
Clinical Privileges Delineation
Cardiology

Applicant Name: _____

New applicants for all categories will be required to provide documentation of the number and type of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

Eligibility Criteria:
To be eligible to apply for core privileges in Cardiology, the applicant must meet the following qualifications:

Current certification in internal medicine and active participation in the examination process leading to subspecialty certification or subspecialty certification in cardiovascular medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine with Special Qualifications in Cardiology.

OR

• Successful completion of an ACGME- or AOA- accredited post-graduate training program in cardiovascular medicine.

AND

• Documentation of active cardiology practice in an accredited hospital or healthcare facility for at least two (2) years or demonstrate successful participation in a hospital-affiliated formalized residency or special clinical fellowship.

General Privilege Statement

Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Cardiology Core Privileges

Admit, evaluate, diagnose, treat and provide consultation to patients presenting with diseases of the heart, lungs, and blood vessels and manage complex cardiac conditions such as heart attacks, and life-threatening, abnormal heartbeat rhythms. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills; advanced cardiac life support (ACLS), cardioversion, insertion and management of central venous and pulmonary artery catheters, use of thrombolytic agents, pericardiocentesis, echocardiography interpretation including stress echocardiography and trans esophageal echocardiography, Holter monitoring, treadmill testing, including radio nuclide studies, temporary transvenous pacemaker placement, intra-aortic balloon pump placement, and electrical cardioversion. **Note:** The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Maintenance of Privilege: To be eligible to renew privileges in cardiovascular disease (cardiology), the applicant must demonstrate current competence and an adequate volume of experience of at least one hundred (100) patients reflective of the scope of privileges requested, within the past 24 months based on results of ongoing professional practice evaluation and outcome.

Interventional Cardiology Core Privileges

☐ **Requested**

Qualifications: Same as for Cardiology Core above plus a one-year fellowship program in interventional cardiology and eligibility for subspecialty certification in interventional cardiology. Applicants must provide documentation of 125 successful interventional procedures in the past 2 years.

Maintenance of Privilege: Applicants must demonstrate the maintenance of competence by evidence of the performance of at least 50 interventional procedures over the reappointment cycle.

Core Privileges: Admit, evaluate, treat and provide consultation to patients with acute and chronic coronary artery disease, acute coronary syndromes and valvular heart disease including the provision of consultation, including but not limited to chronic ischemic heart disease, acute and stable ischemic syndromes, and valvular heart disease and technical procedures and medications to treat abnormalities that impair the function of the heart. Care of patients in the cardiac care units, emergency department or other intensive care units. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Cardiac Electrophysiology Core Privileges

☐ **Requested**

Qualifications: Successful completion of an ACGME-or AOA-accredited training program in cardiology followed by completion of an accredited training program in Clinical Cardiac Electrophysiology (CCEP). Documentation of the successful performance of at least 150 intracardiac procedures during the past 12 months.

Maintenance of Privileges: Applicants must be able to demonstrate the maintenance of competence by evidence of the performance of at least 150 intracardiac procedures over the reappointment cycle. In addition, continuing education related to CCEP should be required

Core Privileges: Admit, evaluate, treat and provide consultation to acute and chronically ill patients with a variety of heart rhythm disorders; including but not limited to sinus node dysfunction, atrioventricular (AV) and intraventricular block, and supraventricular and ventricular tachyarrhythmias; clinical conditions of unexplained syncope, aborted sudden cardiac death, palpitations, Wolff-Parkinson-White (WRW) syndrome, and long QT syndrome, care of patients in the cardiac care unit, emergency room, or other intensive care settings, care of patient in the cardiac care unit, emergency room, or other invasive settings; before and after an electrophysiologic procedure; with temporary and permanent pacemakers; with postoperative arrhythmias and care of patients with ICDs. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Peripheral Endovascular Core Privileges

☐ **Requested** Core Privileges in this specialty include the procedure on the attached list and such other procedure that are extension of the same techniques and skills

All candidates for interventional privileges must qualify for vascular interventions based on fellowship or experience. The candidate shall have spent a minimum of twelve months of full time experience in invasive laboratory and have performed a minimum of diagnostic peripheral angiographic studies and/or peripheral intervention cases listed below in the capacity of primary operator. The candidate must provide the Credentials Committee with documentation of specific procedure and patient for each case. For documentation purposes, the Credentials Committee will consider only the number of procedures, not the number of lesions, as counting toward the candidate's eligibility. The fellowship must also include intensive training in all aspects of a body of knowledge

Cardiologists: Documentation of a successful completion of a (3) three year fellowship which included peripheral angiography training with peripheral intervention training as part of a fourth year fellowship.
Radiologists: Documentation of the inclusion of angiographic training during a residency program with the addition of peripheral intervention training during a minimum (1) one year fellowship.
Vascular Surgeons: Documentation of the successful completion of a vascular fellowship of at least (1) one year in duration with catheter directed techniques as part of the fellowship.

Core Proctoring Requirements for All Categories:

Core proctoring requirements include direct observation or concurrent review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVHMC Sedation Protocol and learning module **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				Implantation of Cardiac Defibrillator For Non-Cardiac Electrophysiologists	Current IBHRE CCDS Certification **AND** Documentation of the successful completion of 12 ICD implant procedures within the past 24 months (IBHRE: International Board of Heart Rhythm Examiners) (CCDS: Certified Cardiac Device Specialist)	1	**Current IBHRE CCDS Certification** **AND** Performance of at least 12 cases within the past 24 months
				Implantable Cardiac Defibrillator Generator Change Only For Non-Cardiac Electrophysiologists	Documentation of the successful completion of 12 of the following procedures – the majority of which must have been ICD Generator Changes: Permanent pacemaker placement ICD Implantation ICD Generator Change	1	Performance of a least 12 cases within the past 24 months

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Myocardial Perfusion Imaging **Interpretation and Supervision**	Certification in nuclear cardiology by the Certification Board of Nuclear Cardiology (CBNC) **OR** Board certified in cardiology and completion of a minimum of a four (4) month training program in nuclear cardiology (1995 or later) **OR** Board certified in Nuclear Medicine **OR** Board certified in radiology with at least four (4) months of nuclear cardiology training **OR** Board certified in radiology with at least one (1) year of nuclear cardiology practice experience with independent interpretation of at least 600 nuclear cardiology studies **AND** Documentation of having read at least 30 cardiac nuclear studies within the past 24 months.	**1**	Read at least 30 cardiac nuclear studies within the past 24 months
				Laser Lead Extraction	Documentation of successful completion of approved course for utilization of laser **AND** Successful completion of five (5) laser lead extraction procedures performed with the laser vendor company trainer.	**First 3 Retrospectively Reviewed**	Performance of at least two (2) procedures within the past 24 months.
				Permanent Pacemaker Insertion For Non-Electro Physiologists	Successful completion of 12 Pacemaker procedures within the past 12 months	**1**	Performance of at last 24 procedures within the past 24 month.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Cardiac & Vascular MRI ***(includes coronary calcium scoring)***	Successful completion of an ACGME-approved cardiovascular disease fellowship, a general radiology residency, or a nuclear medicine program with documentation of at least three (3) months full time training in CMR (Cardiac Magnetic Resonance) **AND** Documentation of having interpreted at least 150 CMR studies (50 in which the candidate was physically present and involved in the acquisition and interpretation of the case **AND** at least 25% of which were vascular) **Policy - Limited to:** Aorta and upper extremity arteries Extracranial cerebrovascular arteries Pelvic and lower limb arteries Renal arteries Mesenteric arteries MR peripheral venography	**5**	Conduct and interpret 50 CMR exams within the past 24 months **AND** 10 hours of CME in CMR within the past 24 months
				Diagnostic Cardiovascular And Peripheral Vascular Ultrasound	Current unrestricted Cardiology Privileges **AND** 200 peripheral vascular ultrasound cases in the past 24 months **AND** 15 hours of CME relevant to cardiac imaging	**1**	200 vascular ultrasound cases within the past 24 months

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Coronary CT Angiography ***(includes coronary calcium scoring)***	**Basic education**: MD or DO **AND** **Minimum formal training** Successful completion of an ACGME-/AOA-accredited postgraduate program in radiology, nuclear medicine, or cardiovascular disease **AND** Documentation of: 8-weeks of cumulative training in Coronary CT Angiography 150 contrast Coronary CT Angiograms*, 50 for which the applicant was present, acquired and interpreted the exam **OR** 150 contrast Coronary CT Angiograms*, 50 for which the applicant was present, acquired and interpreted the exam **AND** 20 hours of CCT CME hours **Required previous experience:** Applicants 2 years or more post formal training must be able to document the successful performance and interpretation of at least 50 cardiac CT angiograms within the past 24 months*	The first three (3) Coronary CT Angiograms will be quality reviewed by another physician with unrestricted Coronary CT Angiography privileges.	Applicants must be able to demonstrate that they have maintained competence by documenting that they have • Successfully performed and interpreted at least 20 Coronary CT Angiograms over that reappointment cycle, and • 20 hours of Category 1 CME on CCT every 36 months In the event that an otherwise qualified applicant does not meet the volume criteria for reappointment, the use of over-reads, reviewed and accepted by the Department Chair, may be counted as activity

*Coronary calcium scoring does not qualify as meeting these requirements

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Carotid Angioplasty Stenting	Applicant must be a Board Certified (or board qualified) Endovascular Trained Surgeon (cardiovascular, vascular, neurosurgeon), Subspecialty Interventional Trained Board Certified (or board qualified) Cardiologist, or Board Certified (or board qualified) Interventional Radiologist **AND** Be Advanced Cardiac Life Support (ACLS) Certified **AND** Documented successful completion of 25 carotid endovascular interventions as principal operator, training or experience as defined below: Training: completion of a dedicated vascular training program with participation in a minimum of 25 carotid interventions, ten (10) as primary operator. **OR** Experience: Documented previous experience of participation in a minimum of 25 carotid interventions, ten (10) as primary operator, with prior attendance at 2 live demonstration education courses on peripheral vascular technique with clear emphasis on carotid therapy.	First five (5) cases must be performed in the presence of a certified* proctor	Operator must perform a minimum of ten (10) carotid interventions within the past 24 months with acceptable complication rate as reported in peer-reviewed literature
				Implantable Pressure Sensor/Monitor (CardioMEMS System)	Qualification for Cardiology Core Privileges **AND** An additional one (1) year fellowship program in cardiac electrophysiology, interventional or invasive cardiology	First three (3) cases	Performance of at least three (3) procedures within the past 24 months

*A certified proctor is defined as an individual that has been approved by the designated device manufacture

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Transcatheter Aortic Valve Replacement (TAVR)	A. Board eligible/certified in Interventional Cardiology or Cardiothoracic Surgery B. Physician must provide documentation of product-specific vendor training within the last six (6) months; **AND** Documentation of one (1) observed case and two (2) completed simulations (performed in training). **OR** C. Applicants who have recently (within the past one year) completed residency/ fellowship training must submit a letter from the program director attesting to their competency to perform TAVR procedures as primary interventionalist/surgeon; **AND** Provide case logs documenting experience in 6 cases as primary interventionalist/ surgeon. **OR** D. Document current experience which must include six (6) cases as primary interventionalist/surgeon within the previous twelve (12) months	The first five (5) Transfemoral TAVR cases must be concurrently supervised. (Additional proctored cases may be requested at the discretion of the proctor or department chair.) **Qualified Proctors include:** 1. Vendor-representative physician proctors • Cardiovascular surgeons / interventional cardiologists on staff who have completed twenty (20) unsupervised TAVR procedures **AND** • Extensive experience in the recognition and management of intra-procedural complications and advanced troubleshooting skills 2. Other physicians with documented unsupervised TAVR privileges.	A. Twelve (12) successful TAVR cases as primary or assistant interventionalist in the two (2) years period preceding reappointment; **OR** B. Retraining within the last six (6) months with documented completion of at least one (1) observed case and two (2) simulations.
Both a cardiovascular surgeon and an interventional cardiologist with TAVR privileges must be present at each case performed.							

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Transcatheter Mitral Valve Repair (TMVR) ***MitraClip***	A. Board eligible/certified in Interventional Cardiology or Cardiothoracic Surgery **AND** B. Documentation of current experience in transeptal technique **AND** C. Documentation of current privileges for PFO/ASD percutaneous closure D. Physician must provide documentation of **product-specific vendor training** within the last six (6) months; **AND** E. Documentation of one (1) observed case and two (2) completed simulations (done in training). **OR** F. Applicants who have recently (within the past one (1) year) completed a dedicated interventional fellowship must submit a letter from the residency/fellowship program director attesting to their competency to perform TMVR repair procedures as primary interventionalist/surgeon; **AND** Provide case logs documenting experience in six (6) cases as primary interventionalist/ surgeon. **OR** Documentation of current experience which must include six (6) cases as primary interventionalist/surgeon over the previous twelve (12) months	First Five (5) cases	Ten (10) successful cases as primary interventionalist/ surgeon within the previous 24 months.

Transcatheter Tricuspid Valve Repair ***TriClip*** **Or** **TriClip Transcatheter Edge-to-Edge Repair (TEER**	A. Board eligible/certified in Interventional Cardiology. ~~or Cardiothoracic Surgery~~ **AND** B. Documentation of current experience in transeptal technique **AND** C. Documentation of current privileges for PFO/ASD percutaneous closure D. Physician must provide documentation of **product-specific vendor training** within the last six (6) months; **AND** E. Documentation of one (1) observed case and two (2) completed simulations (done in training). **OR** F. Applicants who have recently (within the past one (1) year) completed a dedicated interventional fellowship must submit a letter from the residency/fellowship program director attesting to their competency to perform TMVR repair procedures as primary interventionalist/surgeon; **AND** Provide case logs documenting experience in six (6) cases as primary interventionalist/ surgeon. **OR** Documentation of current experience which must include six (6) cases as primary interventionalist/surgeon over the previous twelve (12) months	~~First Five (5) cases~~ Retrospective review of three (3) cases.	~~Ten (10) successful cases as primary interventionalist/ surgeon within the previous 24 months.~~ Eight (8) Transcatheter Repairs within the previous 24 months.
Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification

SVHMC Peripheral Vascular Interventions Privileging Criteria:

Qualification by Fellowship Training:

Cardiologists: three (3) year fellowship which includes peripheral angiography training with peripheral intervention training as part of a fourth (4) year fellowship.
Radiologists: the inclusion of angiographic training during a residency program with the addition of peripheral intervention training during a minimum of a one (1) year fellowship.
Vascular Surgeons: completion of a vascular fellowship of at least one year's duration with catheter directed techniques as part of the fellowship.

All candidates for interventional privileges must qualify for vascular interventions based on fellowship or experience. The candidate shall have spent a minimum of twelve months of full time experience in invasive laboratory and have performed a minimum of diagnostic peripheral angiographic studies and/or peripheral intervention cases listed below in the capacity of primary operator. The candidate must provide the Credentials Committee with documentation of specific procedure and patient for each case. For documentation purposes, the Credentials Committee will consider only the number of procedures, not the number of lesions, as counting toward the candidate's eligibility. The fellowship must also include intensive training in all aspects of a body of knowledge.

Percutaneous Vascular Interventions:

Percutaneous transluminal angioplasty which will include endovascular stent placement, atherectomy, rotablation, and other techniques that may involve the following:

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Aortic Stent Placement With or Without Stent Graft **Policy Statement:** Individuals who fulfill 1 or 2 below, but not both, will be required to have an individual present who possesses the outstanding privilege(s). 1. Aortography and endovascular privileges. 2. Privileges to repair an abdominal aortic aneurysm	Document successful completion of the stent manufacturer's training course.	**1 (first case)**	Must perform a minimum of one (1) aortic stent graft within the past 24 months

Other Vascular Interventions:

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Thoracic Endovascular Stenting **<u>Protocol:</u>** **Procedure must be performed in an Operating Room setting with angiography and fluoroscopy capability, AND** **An individual with Cardiothoracic or Vascular Surgery at SVHMC privileges must be present in the operating room during the procedure.**	Applicant must be ABMS Board Certified or Board Qualified in Cardiac, Thoracic or Vascular Surgery with documented Endovascular Training or Board Certified or Board Qualified in Interventional Cardiology or Interventional Radiology, **AND** Possess current privileges for aortic stent graft placement at SVHMC **AND** Document successful completion of the manufacturer's required training for use of the thoracic stent	Proctoring required on the first three (3) cases by a proctor certified by the stent manufacturer*	Must perform a minimum two (2) thoracic endovascular stent procedures within the past 24 months.
				Percutaneous Implantation of Short Term Mechanical Circulatory Support Device	Unrestricted clinical privileges in Cardiology or Cardiothoracic Surgery **AND** Current Fluoroscopy Certification* **AND** Onsite orientation by the device manufacturer representative *Fluoroscopy certification required only for providers performing this procedure in the Cardiac Catheterization Lab. Procedures performed in the Operating Room are undertaken using echo guidance	**1** Retrospective review of one Implantation case	**N/A**

* A certified proctor is defined as an individual that has been approved by the designated device manufacturer.

Other Vascular Interventions:
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Percutaneous Implantation of Permanent Mechanical Device for Left Atrial Appendage Occlusion - Watchman	Unrestricted clinical privileges in Interventional Cardiology or Cardiac Electrophysiology **AND** Documentation of 25 Trans Septal Sticks **AND** Current Fluoroscopy Certification* **AND** Onsite orientation by the device manufacturer representative *Fluoroscopy certification required only for providers performing this procedure in the Cardiac Catheterization Lab. Procedures performed in the Operating Room are undertaken using echo guidance	**1** (by a certified proctor)	**N/A**
				Percutaneous Catheter Placement for Extracorporeal Membrane Oxygenation (ECMO) prior to patient transfer	Unrestricted clinical privileges in Peripheral Vascular Interventional Cardiology **AND** Documentation of three (3) successful cases within the past 24 months Fluoroscopy certification required only for providers performing this procedure in the Cardiac Catheterization Lab. Procedures performed in the Operating Room are undertaken using echo guidance.	**1** Retrospective Review	Must perform one (1) within the past 24 months

* A certified proctor is defined as an individual that has been approved by the designated device manufacturer.

Salinas Valley Memorial Healthcare System

Core Procedure List: The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Vice President of Medical Affairs and/or the Chief of Staff

Cardiology

1. Abdominal paracentesis
2. Arterial line placement
3. Cardioversion, electrical, elective
4. CDI (color Doppler imaging) non-invasive hemodynamic monitoring
5. Central line placement
6. Diagnostic cardiac catheterization
7. Endomyocardial biopsy
8. Infusion and management of Gp IIb/IIIa agents
9. Insertion and management of pulmonary artery catheters
10. Intra-aortic balloon pump insertion and management
11. Intravenous thrombolytic therapy
12. Intubation
13. Pericardiocentesis
14. Temporary pacemaker insertion
15. Thoracentesis
16. Tilt table
17. Transthoracic echocardiography
18. Ventilator management

Interventional Cardiology

1. Coronary atherectomy
2. Cerebral/Carotid angiography
3. Coronary angioplasty
4. Directional coronary atherectomy
5. Doppler and flow wire insertion
6. Intracoronary Doppler and flow wire
7. Intracoronary infusion of pharmacological agents including thrombolytics
8. Intracoronary mechanical thrombectomy
9. Intracoronary stents
10. Intravascular ultrasound of coronaries
11. Coronary occlusion coil or other embolization particle administration
12. Patient placement on and management of corporeal bypass
13. Percutaneous balloon valvuloplasty
14. Percutaneous transluminal coronary angioplasty
15. Permanent venous port placement
16. Pulmonary angiography
17. Venography peripheral or central

Clinical Cardiac Electrophysiology

1. AICD implantation
2. Interpretation of results of noninvasive testing relevant to arrhythmia diagnoses and treatment
3. Performance and interpretation of invasive electrophysiologic testing
4. Performance of therapeutic catheter ablation procedures
5. Performance of or assisting in the implantation of cardioverter defibrillators and pacemakers
6. Interpretation of activation sequence mapping recordings; invasive intracardiac
7. Permanent pacemaker insertion, single/dual chamber, biventricular
8. Venography peripheral or central

Peripheral Endovascular Core Procedures:

1. Lower extremity angiography (below the iliac)
2. Upper extremity arteriography (beyond vertebral arteries)
3. Brachiocephalic arteriography (arch and extra cranial, carotid and vertebral arteries)
4. Venography – Peripheral or Central
5. Renal Arteriography
6. Stent Grafting: Includes iliac vessels, renal vessels, lower extremities, visceral, brachiocephalic and subclavia brachial. Excludes arch, intracranial and extra cranial carotid and vertebral arteries.
7. Thrombolytic therapy
8. Embolization therapy
9. Arterial and venous embolectomy
10. Visceral Arteriography
11. Visceral Stenting

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

_____ _____

_____
Signature:

_____
Date

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

Department Chair Signature Date

Clinical Privileges Delineation
Salinas Valley Health Nancy Ausonio Breast Health Center
Mammography Screening

Applicant Name: _____

QUALIFICATIONS:

To be eligible to apply for core privileges in mammography, the applicant must meet the following qualifications:

Minimum formal training:

- The applicant must be able to demonstrate successful completion of a residency program in radiology; and
- The applicant must also document a minimum of three months of formal training in reading mammograms with instruction in medical radiation physics, radiation effects, and radiation protection; and
- The applicant must be able to document 60 hours of Category 1 CME in mammography at least 15 which must have been acquired within the previous three (3) years

Required previous experience:

- The applicant must be able to document sufficient numbers of studies to meet MQSA requirements for volume of studies read.
- Applicant must document successful completion of CME for the previous two years in keeping with continuing experience and educational requirements outlined in the Mammography Quality Standards Act (MQSA).

New applicants will be requested to provide documentation of the number and types of hospital cases within the past 24 months. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privilege Statement

Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws. Core privileges include the interpretation of bone density imaging performed at the Mammography Center.

☐ **Remote Mammography Reading: Check if Requesting**

Include Mammography reading privileges above under current contractural agreement to provide remote radiology services designated with Salinas Valley Health Imaging. Privileges include interpretation of diagnostic studies performed at the Mammography Center.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:
Applicant must provide reasonable evidence of current ability to perform requested privileges;

- The applicant must be able to document sufficient numbers of studies to meet MQSA requirements for volume of studies read.
- The applicant must also provide documentation of an adequate volume and type of CME for the previous two years in keeping with continuing experience and educational requirements in the Mammography Quality Standards Act (MQSA).

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended

Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVHMC Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				Stereotactic Core-Cut Breast Biopsy	Documentation of qualification as an interpreting physician under MQSA; **AND** Documentation of at least three (3) hours of Category 1 CME in stereotactic breast biopsy within the past three (3) years; **AND** Documentation of at least 15 hours of CME within the past 36 months in breast imaging, including benign and malignant breast disease; **AND** Performance of at least 12 stereotactic breast biopsies within the past year as primary physician	**1**	Continued documentation of qualification as an interpreting physician under MQSA; **AND** Performance of at least 12 stereotactic breast biopsies as primary physician within the past 12 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	**N/A**	Current California State X-Ray S&O Fluoroscopy Certification
				Breast Lesion Cryoablation	Unrestricted privileges for Stereotactic/Mammography and Ultrasound Guided breast procedures **AND** Documentation of successful completion of an ACGME/ACCME accredited course in cryoablation using ultrasound guidance in advanced interventional breast imaging **AND** Observation (in-person or virtual) of one (1) Cryoablation procedure **OR** Documentation of training during Residency/Fellowship within the past 24 months with performance of one (1) procedure.	**1**	Continued documentation of qualification as an interpreting physician under MQSA; **AND** Performance of one (1) procedure within the past 24 months.

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 **18643640**

Origination	07/2022	Owner	Carla Spencer: Chief Nursing Officer
Last Approved	N/A	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Nurse Driven Urinary Catheter Removal Protocol Nursing Standardized Procedure

I. POLICY

A. Function (s)

- To provide guidelines for the Registered Nurse (RN) regarding the removal and post-removal assessment of indwelling urinary catheters.

B. Circumstances

- Setting
    1. All inpatient nursing units ordering the Nurse Driven Catheter Removal within the **Urinary Catheter Manage Order**.
    2. The RN may initiate the removal of the urinary catheter upon completing documentation of the Urinary Catheter Assessment and determining if patient meets catheter continuation criteria.
    3. Providers may determine their own management of urinary catheter removal by selecting NO on the Nurse Driven Protocol field within the **Urinary Catheter Manage Order**. In this case, the urinary catheter removal is Physician driven and NOT nurse driven; however, the nurse continues to document in the Urinary Catheter Assessment daily.
- Supervision
    1. The RN who is trained to perform the standardized procedure may discontinue the indwelling urinary catheter after determining catheter does not meet continuation criteria when a Nurse Driven Catheter Removal is present in the **Urinary Catheter Manage Order.**
- Patient Conditions

1. This standardized procedure applies to all inpatients that have a **Urinary Catheter Manage Order** that specifies catheter removal via Nurse Driven Protocol. The following are reasons for catheter placement:
    - Acute Urinary retention
    - End of life care
    - ICU patient on diuretics
    - Measure accurate output (q2hr)
    - Epidural
    - Urinary obstruction
    - Pelvic fractures
    - Stage 3-4 pressure injury
    - Surgical procedure/urological
    - Invasive procedure
    - Unstable lumbar spine

II. DEFINITIONS

A. Indwelling Urinary Catheter-- A flexible plastic tube (a catheter) inserted into the bladder that remains ("dwells") there to provide continuous urinary drainage. The principal type of indwelling bladder catheter is the "Foley" which has a balloon on the bladder end (www.medicinenet.com/script/main/art.asp?articlekey=14403).

III. PROTOCOL

A. Database

- Subjective
    1. History of present illness/chief complaint
    2. Consider conditions related to genitourinary system (urinary retention/ obstruction, urological surgeries, etc.)
    3. Review plan of care (palliative care, strict intake and output)
    4. Review current orders
- Objective
    1. All patients who have an indwelling urinary catheter and who have a **Urinary Catheter Manage Order** that specifies catheter may be removed by the nurse driven protocol.

B. Diagnosis

- Applies to all conditions except those listed that meet criteria for continuation of the urinary catheter (see Patient Condition section).

C. Plan

- Treatment
    1. Patients requiring placement of a urinary catheter should have a **Urinary Catheter Place** and a **Urinary Catheter Manage Order.**
    2. Patients with a urinary catheter placed in surgery or those with a pre-existing urinary catheter (Present on Admission), should have a **Urinary Catheter Manage Order**.
    3. The **Urinary Catheter Place Order** will generate the **Urinary Catheter Placement Intervention** on the nursing Worklist.
    4. The **Urinary Catheter Manage Order requires** the Provider to select whether or not the urinary catheter is to be removed by the Nurse Driven Protocol. This order also generates the **Urinary Catheter Assessment** on the nursing Worklist.
    5. When the urinary catheter is placed, the RN documents in the **Urinary Catheter Placement Assessment**. The **Date and Time of Insertion** are required to initiate the calculation for elapsed time of placement (This excludes areas where the Electronic Health Record (EHR) is not the primary documentation system).
    6. The RN performs the Urinary Catheter Assessment twice a day at 0500 and 1200 on patients who have an indwelling urinary catheter. This assessment requires the **Date and Time of Insertion**. The RN may recall these fields. If the catheter was placed in the OR or PACU, the RN can review the record (located under the NOTES/Picis or Reports/Centricity) to find the date and approximate time of placement. If the catheter was present on admission and the patient/family/medical record provides the approximate date and time of insertion, select **Known** and enter the approximate date and time of insertion. If unable to determine date and time of placement, select **Unknown,** and use date and time of admission.
    7. If criteria for continuing the urinary catheter are NOT met, the RN discontinues the catheter and documents the **Date and Time of Removal**.
        - Removal of urinary catheter should be performed within 1-2 hours of urinary catheter assessment
    8. If patient meets criteria for continuation of the catheter, the appropriate reason is selected.
    9. If the physician places an order for the urinary catheter to be discontinued at any given point, the nurse documents the **Date and Time of Removal** in the **Urinary Catheter Manage Assessment**.
    10. If a Urinary Catheter is in place and the **Urinary Catheter Manage Order** specifies the catheter is **NOT** to be removed by the nurse driven protocol, the nurse continues to document on the Urinary Catheter Assessment daily. **This documentation is critical to communicating the elapsed time of catheter placement. Note:** The Date and Time of Insertion as well as the elapsed time flow to physician documentation.
    11. The documentation of the urinary catheter removal generates a **Post**

Catheter Removal Assessment on the nursing Worklist. The RN assesses for spontaneous voiding as well as criteria for performing a bladder scan. Selection of any the following criteria, generates the **Bladder Scan Assessment**:

- Patient is uncomfortable at any time whether voiding or not
- Patient has urge to void but unable to void
- Patient is incontinent
- Patient has not voided in 6 hours

12. The RN performs the following based on the bladder scan findings:
    - If the patient is uncomfortable or has the urge to void and the and the bladder scan volume is >400 ml
        - Straight cath the patient x1 then notify physician if patient is unable to void adequately
        - If bladder scan volume is >600 ml, contact physician
        - Record intake and output volume with each void and catheterization
    - Patient conditions requiring consultation/reportable conditions:
        1. If the patient has an indwelling urinary catheter and a **Urinary Catheter Manage Order** has not been ordered, contact the physician and obtain the order. Physician must indicate if it is to be removed by the Nurse Driven Protocol and the Reason to Place.
        2. If the patient has an indwelling urinary catheter that does NOT meet continuation criteria but physician has NOT selected the Nurse Driven Protocol, then contact the physician to communicate assessment finding. **Catheters should not be in place any longer than necessary**.
            - Collaboration with physicians should take place for indwelling urinary catheters in place >72 hours.
        3. If bladder scan volume is greater than 600 ml, contact physician.
        4. Signs and symptoms of urinary tract infection.

- Education-Patient/Family
    1. Instruct patient/family to report any signs and symptoms of urinary tract infection.
    2. Instruct patient/family to report any discomfort/pain and/or inability to void post catheter removal.

- Follow-up
    1. Monitor patient's intake and output.
    2. Check patient's ability to void post catheter removal. The **Post Urinary Catheter Assessment** will display in the Worklist to be addressed every 2 hours. The assessment should be completed once the patient voids or when one of the other options is selected.
    3. Perform bladder scan if indicated as listed above under C (11, 12).
- Documentation of Patient Treatment
    1. Document placement of catheter in the Urinary Catheter Placement Assessment.
    2. Document catheter assessment and date and time of removal in Urinary Catheter Assessment.
    3. Document ability to void in Post Catheter Removal Assessment.
    4. Document bladder scanner results (if appropriate) in Bladder Scanner Assessment.
    5. Document urine output in Intake and Output intervention.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education
- The RN completes an initial review of the Standardized Procedure with an evaluation of knowledge.

B. Training
- Clinical competency must be demonstrated and approved by preceptor/designee.

C. Experience
- Current California RN license.

D. Initial and Ongoing Evaluation
- Demonstrates knowledge of procedure through clinical performance

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method
- Review and approval every (3) years.
- Policy goes through the Interdisciplinary Practice Committee (IDPC) upon creation of policy and when changes are made.
- Chief Nursing Officer upon creation of policy and with significant changes.

1. Review Schedule

- Every (3) years

B. Signatures of Authorized Personnel Approving the Standardized Procedure and Dates

- Nursing
    1. Director of Clinical Informatics
- Medicine
    1. Chair of Interdisciplinary Practice Committee every (3) years.
- Administration
    1. Chief Nursing Officer every (3) years.

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. Records are kept electronically in Education Department Computer system and in nursing unit's education file.

VII. REFERENCES

A. http://nursingworld.org/ANA-CAUTI-Prevention-Tool
B. https://www.cdc.gov/HAI/pdfs/toolkits/CAUTItoolkit_3_10.pdf
C. https://www.ahrq.gov/professionals/quality-patient-safety/hais/tools/cauti-hospitals/index.html
D. http://www.ajicjournal.org/article/S0196-6553(13)00662-7/abstract

Attachments

Nurse Driven Urinary Catheter Removal Protocol

Approval Signatures

Step Description	Approver	Date
IDPC	Katherine DeSalvo: Director Medical Staff Services	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025

Policy Owner	Carla Spencer: Chief Nursing Officer	08/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14873210

Origination	09/2021	Owner	Genevieve delos Santos: Director Pharmacy
Last Approved	N/A	Area	Pharmacy Protocols
Next Review	3 years after approval		

Adult Parenteral Nutrition Protocol

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. Salinas Valley Health (SVH) pharmacists will manage parenteral nutrition upon provider request. This management will be conducted in accordance with evidence-based guidelines and best practice standards as outlined in this protocol.

B. To provide standardization for initiation and maintenance of parenteral nutrition by pharmacist's management in collaboration with clinical dietitians.

C. To allow clinical pharmacists to replete electrolytes externally from the PN.

III. DEFINITIONS

A. Parenteral Nutrition (PN) – Sterile intravenous solution that is given directly into the blood stream via catheter, bypassing the digestive system and providing fluids, calories, protein, carbohydrates, fats, vitamins, and minerals to meet nutritional needs.

B. Sliding Scale Insulin (SSI) – Step-wise insulin dosing corresponding to pre-defined blood glucose ranges at intervals defined by the provider.

C. Macronutrients – Generalized term to define nutrients administered intravenously to patients needed in large quantity with three broad classes: proteins, carbohydrates, and fats.

D. Electrolytes – Essential minerals including sodium, calcium, chloride, magnesium, potassium, acetate, phosphorous

E. Micronutrients – Generalized term used to define trace elements and vitamins essential in nutrition.

F. Multi-Chamber Bag Parenteral Nutrition (MCB-PN) – a commercially available, pre-packaged solution containing macronutrients +/- electrolytes. These bags have multiple chambers that

are separated until activated, allowing the components to mix prior to administration.

IV. GENERAL INFORMATION

A. This protocol authorizes SVH clinical pharmacists to manage electrolytes for adult patients on parenteral nutrition, in collaboration with physicians, dietitians, and nursing staff. Patients with active orders for the Parenteral Nutrition Protocol will be followed collaboratively by SVH clinical pharmacists and SVH clinical dietitians.

B. Inclusion criteria:

1. Patient > 18 years old AND
2. Patient meets one or more of the following PN Indications and adequate enteral intake is not anticipated for 7 days or greater:
    a. Intestinal Failure
    b. Intestinal Insufficiency
    c. Contraindication to Enteral Access
3. Active Nutrition Consult

C. Exclusion criteria

1. Patient < 18 years old
2. Peripheral Parenteral Nutrition

V. PROCEDURE

A. Physician/Ordering Provider Responsibility

1. Order Central Line access and confirm placement of central line prior to ordering Parenteral Nutrition Protocol per Pharmacy
2. Initiate the protocol as appropriate for eligible patients.
3. Provide necessary patient information.
4. Initiate adequate insulin management through orders in EHR alongside hypoglycemia protocols.
5. Maintain oversight of patient care, protocol implementation, and discontinuation.

B. Pharmacist Responsibility:

1. Review patient's chart to ensure the appropriateness of Adult Parenteral Nutrition Protocol per Pharmacy.
    a. If the patient does not meet the above criteria, the pharmacist and clinical dietician shall coordinate to contact the primary physician.
2. Collaborate with clinical dietician to determine macronutrient and micronutrient recommendations.
    a. The pharmacist may order relevant laboratory tests.
    b. The pharmacist may order adjuvant potassium, magnesium, phosphorus,

and calcium replacement external to the PN utilizing electrolyte replacement nomograms (See Attachment A).

i. See secondary inclusion and exclusion criteria as defined in Attachment A.

c. The pharmacist may recommend to the primary physician adjuvant potassium, magnesium, phosphorus, and calcium replacement external to the PN utilizing clinical judgement.

3. Order PN and lipids through EHR for patient. When clinically appropriate, the pharmacist shall prioritize initiation of PN utilizing SVH standard MCB-PN formulations.
    a. The pharmacist shall calculate electrolytes and other additives.
    b. Orders shall be cross-checked by a secondary pharmacist to ensure safety and appropriateness.
    c. Custom TPN formulas that cannot be supplied by SVH Pharmacy shall be written and transcribed into a contracted 503A outsourced admixture pharmacy.
        i. Orders must be entered no later than 1200 daily.
    d. Patient's admitting with an actively infusing PN may complete the remainder of the bag, if clinically appropriate, prior to initiating new orders. (See Patient's Own Medication Usage Policy).
        i. The pharmacist shall attempt to identify the patient's current PN formula and continue if clinically appropriate.
4. Document in the EHR:
    a. Including but not limited to: relevant patient data, current therapy, and recommendations
    b. Update relevant status boards or communication tools as needed for care team coordination.
5. Monitoring patient's clinical status and laboratory values, adjusting PN formula as appropriate.

C. Dietary Responsibility:
1. Determine appropriate patient specific macronutrients based on review of weight, laboratory data, vascular access, current nutritional assessment, and other pertinent patient specific clinical information.
    a. The clinical dietician shall complete an initial assessment of appropriateness for PN.
    b. If the patient does not meet the above criteria, the clinical dietician and pharmacist shall coordinate to contact the primary physician.
2. Calculate macro-nutrition and provide recommendations to meet patient's nutritional needs, documented in the EHR.

3. Maintain an evaluation of the patient's tolerance to and need for the PN regimen.
4. Adjust the nutritional regimen and provide recommendations documented in the EHR as clinically relevant.
5. Communicate significant changes in patient nutrition goals to the physician and pharmacist.
6. Review the appropriateness of PN as a nutrition modality and make recommendations for transition to enteral nutrition when appropriate.

D. Monitoring

1. The pharmacist may order or recommend the following laboratory tests under this protocol:
    a. TPN Panel
        i. Shall be ordered at baseline—if Base Metabolic Panel and Hepatic Function Panel are not present within the previous 24 hours.
        ii. Shall be ordered every 7 days in place of Base Metabolic Panel
    b. Base Metabolic Panel
        i. Shall be ordered daily, unless a TPN Panel is scheduled.
        ii. The pharmacist may determine that daily monitoring is no longer needed if clinically appropriate.
    c. Magnesium, Phosphate
        i. Shall be ordered daily.
        ii. The pharmacist may determine that daily monitoring is no longer needed if clinically appropriate
    d. CBC
        i. Shall by ordered every 7 days

E. Documentation

1. The clinical dietician will document recommendations and interventions in the EHR.
2. The pharmacist will document as outlined in the above procedures and when relevant to communicate with the care team.

F. Dosing Guidelines

1. The pharmacist will follow clinical discretion to optimize management of electrolytes and minimize adverse drug reactions.
2. Dosing Guideline nomograms for external electrolyte replacement will be utilized on eligible patients in conjunction with clinical discretion to standardize management of electrolyte replacement external to parenteral nutrition.
3. Deviations from standard guidelines should be documented with appropriate clinical rationale and discussed with the care team prior to execution.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Compher C, Bingham A, McCall M, et al. Guidelines for the provision of nutrition support therapy in the adult critically ill patient: The American Society for Parenteral and Enteral Nutrition. *Journal of Parenteral and Enteral Nutrition*. January 2022; 46(1): 12-41

B. Ukleja A, Gilbert K, Mogensen KM, et al. Standards for Nutrition Support: Adult Hospitalized Patients. *Nutrition in Clinical Practice*. December 2018; 33(6):906-920

C. Worthington P, Balint J, Bechtold M, et al. When is Parenteral Nutrition Appropriate? *Jounral of Parenteral and Enteral Nutrition*. March 2017; 41(3):324-377

D. Lesser MNR, Lesser LI. Nutrition Support Therapy. *American Family Physician*. December 2021; 104(6): 580-588A

E. Bulloch MN, Cardinale-King M, Cogle S, et al. Correction of Electrolyte Abnormalities in Critically Ill Patients. *Intensive Care Research*. January 2024; 4:19-37

F. Tucker AM. Parenteral Nutrition Micronutrients: Electrolytes, Vitamins, and Trace Elements. Presented at: ASHP Midyear Clinical Meeting & Exhibition; December 2016; Las Vegas, Nevada. Available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/Clinical-Pharmacy-Resources/Nutrition-Support/2016-MCM/MCM16-335-Strategies-for-Successful-Parenteral-nutrition.pdf Accessed Septermber 2025

G. Desgagnes N, King JA, Kline GA, et al. Use of Albumin-Adjusted Calcium Measurements in Clinical Practice. *JAMA Network Open*. January 2025; 8(1):e2455251

Attachments

- Attachment - CLINIMIX Calcium Phosphate Solubility.pdf
- Attachment - CLINIMIX CLINIMIX E Stability with Additives.pdf
- Attachment - CLINIMIX E Calcium Phosphate Solubility.pdf
- Attachment A - SVH Guide for Electrolye Replacement.pdf
- Attachment Clinimix & Clinimix E Macro & Micronutrient Infusion Rate Chart.pdf

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
P&T Committee	Genevieve delos Santos: Director Pharmacy	10/2025
P&T Committee	Kiri Golleher: Pharmacy Clinical Coordinator	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	09/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16893074

Origination	09/2021	Owner	John Kazel: Director Imaging Services
Last Approved	N/A	Area	Diagnostic Imaging
Next Review	3 years after approval		

DI Thoracentesis Under Ultrasound Guidance

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To establish criteria to assess and care for patients having an US guided thoracentesis and to ensure effective management of that patient.

III. DEFINITIONS

A. US: Ultrasound
B. RT: Radiologic Technologist
C. RN: Registered Nurse
D. PT: Prothrombin
E. PTT: Partial Thromboplastin time
F. INR: International Normalized Ratio
G. Pltc: Platelet count
H. NPO: Nothing by Os (mouth)
I. IR: Interventional Radiologist
J. DI: Diagnostic Imaging
K. TA: Technologist Assistant

IV. GENERAL INFORMATION

A. Patients in diagnostic Imaging Department requiring a Thoracentesis will be assessed and evaluated by a RN and/or Sonographer pre, intra and post procedure.

V. PROCEDURE

A. Pre-procedure

1. Identify patient using two of the following identifiers
    - Name
    - Medical Record number
    - Birth Date
2. Verify allergies
3. Review Drs. Order for procedure
4. Review home medications with patient/family, report to IR if patient is taking any blood thinning medication.
5. Laboratory staff to obtain any blood work studies ordered by IR.
6. DI RN or Sonographer to obtain a standard consent for procedure.
7. IR to sign all appropriate paperwork as required by current Salinas Valley Health Medical Center (SVHMC) policy and procedure.
8. DI RN or Sonographer to document patient's vital signs and current medications on Patient Screening/Universal Protocol form (8720-027066).

B. **Outpatients:**

1. Patients scheduled for procedure using the current DI Scheduling System
2. TA to obtain the following information when scheduling a patient for thoracentesis
3. Establish whether the thoracentesis is diagnostic or therapeutic
    a. For diagnostic study, obtain orders for laboratory tests that are needed.
    b. Request ordering physician to fax DI the current list of medications that the patient is taking.
    c. Once current medication fax is received make sure that the DI charge nurse and Sonographer is given a copy.
    d. DI RN to review home medication list and report to IR.
        i. If the patient is taking anticoagulants, make IR aware.

C. **Inpatients:**

1. Patients are scheduled for procedure using current hospital scheduling system
2. Once requisition prints the DI charge RN will be notified.
3. DI RN or Sonographer will review patients chart/EMR for blood thinning medication and current laboratory data (PT,PTT.INR, and Pltc), and any antibiotic therapy.
4. DI RN caring for the patient or Sonographer will report to IR any blood thinner medications the patient is taking or any abnormal laboratory tests.
5. Diagnostic Thoracentesis:

a. RN to obtain needed laboratory tests from doctors order in chart.

b. In the event that a DI RN is unavailable (weekends, after hours) the US tech will screen the patient using the *Patient Screening/Universal Protocol* sheet, by obtaining information from patients RN and/or chart and inform IR of patients' blood thinners and abnormal laboratory tests.

D. Intra Procedure

1. Sonographer to scan appropriate site as indicated by physician order.
2. Sonographer to prepare appropriate supplies and equipment for procedure.
3. IR to mark appropriate site per current SVHMC policy and protocol.
4. DI RN, US tech or IR to perform and document **Time-Out** prior to the start of the procedure on Patient Screening/Universal Protocol form (8720-027066).
5. Sonographer to monitor and remain with the patient during the draining process if required.
6. Sonographer to assist IR with thoracentesis as needed.
7. Sonographer, RN or Specials Tech II, and IR to remain with the patient during the draining process.
8. DI RN to assist procedure as requested by Sonographer.
9. Qualified DI staff to remove drainage catheter from patient.

E. Post-Procedure

1. Sonographer or qualified DI staff to fill appropriate vials for laboratory tests.
2. Sonographer or qualified DI staff to enter laboratory orders into Medi-Tech.
3. Sonographer or qualified DI staff to deliver pleural fluid samples to the laboratory.
4. Sonographer or qualified DI staff to enter post x-ray as ordered into RIS.
5. Sonographer to obtain post drainage scan as ordered.
6. DI RN or Sonographer to obtain post procedure vital signs and document in progress notes form 8700-6365, when appropriate.
7. Sonographer to document amount, color, and consistency of drainage in progress note form 8700-6365 when appropriate.

F. Documentation:

1. Patient Screening/Universal Protocol form 8720-27066
2. Anti-Coagulant Parameters

VI. EDUCATION/ TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. **National Patient Safety Goals, Joint Commission,** Universal Protocol, Marking the Procedural site, 2021

B. Core Curriculum for Radiologic and Imaging Nurses (3rd Edition 2014)

C. American College Radiology (2018) **Practice guidelines for Specifications and Performance of Image Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections (PDAFC) in Adults.**

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
DI Medical Director	Michael Basse: PHYSICIAN	08/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2025
Policy Owner	John Kazel: Director Imaging Services	07/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18773248

Origination	08/2022	Owner	Melissa Deen: Manager Infection Prevention
Last Approved	N/A	Area	Infection Control
Next Review	3 years after approval		

Employee Exposures & Prevention Plans: Specific Disease Exposures and Work Restrictions

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To establish clear guidelines for Salinas Valley Health Medical Center (SVHMC) Employee Health and Emergency Departments in managing exposures involving staff, providers, and volunteers.

B. This policy outlines the steps to take when an exposure occurs, ensures all affected personnel receive appropriate evaluation and support, and provides up-to-date guidance on communicable disease risks and related work restrictions for all SVHMC employees, medical staff, and volunteers.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center, Support Documents

1. SVHMC Blood Borne Pathogen Exposure Guidelines
    a. Aerosol Transmitted Diseases Exposure Control Plan
2. Tuberculosis (TB) Prevention and Control
3. Healthcare Worker Immunizations & Immunity Requirements
4. Healthcare Worker Respiratory Protection Program Plan

V. PROCEDURE

A. CHICKEN POX (Varicella); HERPES ZOSTER (Shingles)

1. Any person with knowledge of patient or employee with Varicella or Herpes Zoster is to notify the Employee Health and Infection Prevention department(s) by telephone or written memo.
2. A valid exposure to Varicella (Chicken Pox) is defined as "chickenpox susceptible person having direct contact with an infected person's respiratory tract secretions or vesicular lesions for a minimum of five minutes, starting within 48 hours prior to the onset of the rash (vesicles) and extending through the time of the rash, until all lesions are dry and crusted. Patients with Chickenpox should be placed on Airborne and Contact Precautions until all lesions are dry and crusted.
3. A valid exposure to Herpes Zoster (Shingles) is defined as Chickenpox-susceptible person having direct contact with person with eruptive (moist, weeping) lesions.
4. When appropriate, a list of employees or patients with significant exposure will be compiled by the Manager and sent to Employee Health and Infection Prevention.
5. Either the patient care unit's manager or Infection Prevention will inform physicians of the patients exposed.
6. Each employee determined to have a valid work exposure will be instructed to follow up with Employee Health, relating in detail their exposure to Varicella.
7. On the instructions of Employee Health, employees will have blood drawn for determination of their Varicella Zoster Virus (VZV) antibody status if not done previously. If a negative titer was obtained more than 30 days prior to the exposure, or if an employee is unsure of their Varicella history, they will be tested.
8. **Recommendations**
    a. For asymptomatic healthcare personnel *with* evidence of immunity to varicella,
        i. Postexposure prophylaxis is not necessary.
        ii. Work restrictions are not necessary.
        iii. Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure.
    b. Reference link:
        i. Prevention of Varicella Recommendations of the Advisory Committee on Immunization Practices (ACIP)
    c. For asymptomatic healthcare personnel *without* evidence of immunity to varicella who have an exposure to varicella (chickenpox) or disseminated or localized herpes zoster (shingles):
        i. Administer postexposure prophylaxis in accordance with CDC and ACIP recommendations

ii. Exclude from work from the 8th day after the first exposure through the 21st day after the last exposure.

a. Work restrictions are not necessary for healthcare personnel who received one dose of the varicella vaccine prior to exposure if they receive the second dose of vaccine within 5 days after exposure.

i. Implement daily monitoring for signs and symptoms of varicella from the 8th day after the first exposure through the 21st day after the last exposure.

b. If varicella-zoster immune globulin is administered as postexposure prophylaxis, exclude from work from the 8th day after the first exposure through the 28th day after the last exposure.

iii. Reference link:

a. CDC, Varicella Outbreak Identification, Investigation, & Control

b. CDC Manual for the Surveillance of Vaccine Preventable Diseases, Chapter 17 Varicella, updated November 21, 2024

d. For healthcare personnel with varicella (chickenpox), exclude from work until all lesions have dried and crusted; or, for those who only have non-vesicular lesions that do not crust, exclude from work until no new lesions appear within a 24-hour period.

e. For healthcare personnel with disseminated herpes zoster (shingles) or for immunocompromised healthcare personnel with localized herpes zoster until disseminated disease has been ruled out, exclude from work until all lesions have dried and crusted.

f. For immunocompetent healthcare personnel who have localized herpes zoster (shingles), including vaccine-strain herpes zoster, and for immunocompromised healthcare personnel who have localized herpes zoster and have had disseminated disease ruled out:

i. Cover all lesions and, when feasible, exclude from direct care of patients at high risk for severe varicella (e.g., in protective environments) until all lesions are dried and crusted.

ii. If lesions cannot be covered (e.g., on the hands or face), exclude from work until all lesions have dried and crusted.

g. **Reference link:**

i. CDC Infection Control in Healthcare Personnel: Epidemiology and Control of Selected, Summary of Recommendations, updated January 31, 2025

9. Varicella Zoster Immune Globulin (VZIG), VZIG may be considered for the following:
    a. Varicella-zoster immune globulin is recommended for people exposed to varicella or herpes zoster who cannot receive varicella vaccine. These include people:
        i. That lack evidence of immunity to varicella.
        ii. Whose exposure is likely to result in infection.
        iii. At high risk for severe varicella.
    b. Varicella-zoster immune globulin can prevent varicella from developing or lessen the severity of the disease.
    c. The varicella-zoster immune globulin product licensed for use in the United States is VariZIG™. VariZIG should be given as soon as possible after exposure to VZV. It can be given within 10 days of exposure. VariZIG is commercially available from a broad network of specialty distributors in the United States.
    d. Reference links:
        a. Clinical Guidance for People at Risk for Severe Varicella, updated April 24, 2024
            a. Updated Recommendations for Use of VariZIG — United States, 2013
            b. List of VariZIG distributors

B. CONJUNCTIVITIS
1. Viral Conjunctivitis:
    a. Exclude healthcare workers from work if they exhibit:
        i. Preauricular lymphadenopathy (tenderness in front of the ears)
        ii. Fever > 38°C (100.4°F)
        iii. Recommendations or restrictions by a physician
        iv. Eye drainage (active discharge)
    b. If adenoviral conjunctivitis is diagnosed:
        i. Healthcare workers may return to work only after being medically cleared by a physician, as adenovirus can remain infectious for 7 days or longer
        ii. Strict adherence to hand hygiene and environmental cleaning is essential to prevent transmission.
2. Bacterial Conjunctivitis**:**
    a. Restrict healthcare workers with epidemic keratoconjunctivitis or purulent conjunctivitis (caused by organisms such as *Neisseria gonorrhoeae* or *Chlamydia trachomatis*) from patient care and from entering patient care environments for the duration of symptoms.

b. Exclude from work until:
    i. Eye discharge (constant tearing or purulent drainage) has ceased
    ii. At least 24 hours have passed since the start of effective antimicrobial therapy
c. Workers may return to duty once the criteria above are met, as outlined in the CDC clinical overview.

3. Reference link: Clinical Overview of Pink Eye (Conjunctivitis) | Conjunctivitis (Pink Eye) | CDC

C. CYTOMEGALOVIRUS (CMV)

1. Transmission of CMV occurs through deposition of infectious body fluids (e.g., urine, saliva, blood, tears, semen, breast milk) from an infected source person onto the mucus membranes of a susceptible host. Several case reports suggest that HCPs who developed primary CMV infection did not acquire it from the infected children for whom they provided care, based on genomic analyses of isolates. Hence, occupational transmission of CMV in healthcare settings may be very rare.
    a. No work restrictions are necessary for employees with CMV-related illnesses.
    b. Work restrictions are not necessary for healthcare personnel with active cytomegalovirus infection.
    c. Seronegative pregnant employees do not require reassignment as a method of reducing CMV exposure.
        i. Reference link: CDC, Special Populations: Pregnant Healthcare Personnel, Updated January 31, 2025
2. Reference link: CDC, Cytomegalovirus, updated November 7, 2024

D. HERPES SIMPLEX INFECTION

1. Employees with primary or recurrent orofacial Herpes Simplex infections, will be evaluated on a case by case basis to assess the potential for transmission to high-risk patients, e.g., neonates, ICU patients, patients with severe burns or eczema, and severely immunocompromised patients (lesions which are active in the vesicular, draining phase). Employees with Herpes Simplex infections of fingers or hands (Herpetic Whitlow), are not permitted direct contact with any patient until lesions are healed.
2. Employees that develop cutaneous lesions, including Herpes Simplex infections, are to report to their manager, for assessment.
3. The manager, in consultation with Employee Health or a physician, will determine the work status of the employee. At the discretion of Employee Health, a physician's release may be requested.

E. HUMAN BITE MANAGEMENT

1. Within one to two hours of a human bite, the employee must complete an accident report and report to Employee Health or the Administrative Supervisor.
2. An initial examination will determine the need for antibiotic administration and further medical care.
3. Reference link:
    a. CDPH, CDPH IDB Guidance for Managing Select Communicable Diseases, HUMAN AND ANIMAL RABIES, updated June 2023

F. BACTERIAL MENINGITIS

1. Neisseria meningitidis is probably transmitted by large droplets; the incubation period is 2-10 days, and patients infected with N. meningitidis are rendered noninfectious by 24 hours of effective therapy.
2. A valid exposure is defined as intensive, unprotected (i.e. not wearing a mask) or intimate contact with nasopharyngeal secretions (i.e. mouth-to-mouth resuscitation, endotracheal intubation or suctioning) of a patient with known or highly suspected meningitis caused by Neisseria meningitidis or Haemophilis influenzae.
3. Antibiotic prophylaxis recommended:
    a. Mouth-to-mouth resuscitation or unprotected contact (not wearing mask or face shield) during endotracheal intubation.
    b. Household contacts, especially young children.
    c. Consideration of prophylaxis for child care or school contact is at the direction of the Monterey Public Health Department. In an outbreak or cluster, antibiotic prophylaxis for individuals other than those at high risk should be administered only after consultation with local public health authorities.
    d. Direct exposure to the index patient's secretions through kissing, sharing toothbrushes, or eating utensils.
    e. Casual contact: no history of direct exposure to the index patient's oral secretions (e.g., school or workmate).
    f. Routine patient care completed using standard precautions.
    g. Indirect contact: no direct contact with the index patient, but has contact with an individual who had a bona fide exposure (secondary transmission).
4. The Employee Health medical director or an Emergency Department physician, in accordance with guidelines on file, will prescribe prophylaxis, preferably within 24 hours of exposure. Prophylaxis should be initiated within 72 hours after exposure occurs.
5. The Infection Preventionist is available for consultation. Cases of personnel exposure will be discussed with the Chief Medical Officer and/or Infectious Disease Medical Director whenever possible to assess the need for prophylaxis.
6. Antimicrobial prophylaxis shall be offered immediately to personnel who have had intensive, unprotected contact with an infected patient. If prophylaxis is deemed

necessary, treatment shall not necessarily await results of antimicrobial sensitivity testing.

7. Personnel with meningococcal infection should be excluded from duty until 24 hours after the start of effective therapy.
8. Antibiotic Prophylaxis for N. meningitidis disease:
    a. Adults and children 9 years of age and older:
        i. Ciprofloxacin or levofloxacin 500 mg orally as a single dose.
    b. Alternative adult regimens and children 1 month of age and older:
        i. Ceftriaxone 5 mg/kg administered once intramuscularly.
        ii. Rifampin 10 mg/kg orally every 12 hours for a total of 4 doses.
    c. Children less than 1 month of age:
        i. Rifampin 5 mg/kg orally every 12 hours for a total of 4 doses.
    d. Pregnancy
        i. Ceftriaxone 5 mg/kg administered once intramuscularly.
9. Antibiotic Prophylaxis for H. influenza disease - post-exposure prophylaxis is recommended for health care workers who meet the above definition of exposure and have frequent or ongoing contact with children who are less than 2 years of age.
    a. Adults and children 1 month of age or older:
        i. Rifampin 20 mg/kg (maximum 600 mg/day) orally once daily for 4 days.
    b. Children less than 1 month of age:
        i. Rifampin 10 mg/kg orally once daily for 4 days.

****Note: Only bacterial meningitis (e.g.**, N. meningitidis or H. influenza) requires **prophylaxis. ****

10. **References:**
    a. Chapter 14: Meningococcal Disease | Pink Book | CDC
    b. Chapter 8: Meningococcal Disease | Manual for the Surveillance of Vaccine-Preventable Diseases | CDC
    c. Red Book Pediatric Infectious Diseases 33rd Edition 2024 Section 3 -Summaries of Infectious Diseases
        i. Haemophilus Influenzae Infection Pages 400-409
        ii. Meningococcal Infections Pages 585-599

G. MUMPS (INFECTIOUS PAROTITIS)

1. A valid exposure is defined as face-to-face contact with an infected person for a minimum of five minutes, starting within 48 hours prior to overt Parotitis and

extending for nine days after symptoms appear.

2. Mumps exposed employees are not to be assigned to care for patients with Mumps.
3. **Recommendations:**
    a. For asymptomatic healthcare personnel *with* presumptive evidence of immunity to mumps
    who have an exposure to mumps:
        i. Work restrictions are not necessary.
        ii. Implement daily monitoring for signs and symptoms of mumps from the 10th day after their first
        exposure through the 25th day after their last exposure.
        iii. Reference link:
            a. TABLE 3. Acceptable presumptive evidence of immunity to measles, rubella, and mumps*
    b. For asymptomatic healthcare personnel *without* presumptive evidence of immunity to mumps who have an exposure to mumps:
        i. Exclude from work from the 10th day after their first exposure through the 25th day after their last exposure.
        ii. Work restrictions are not necessary for healthcare personnel who received the first dose of MMR vaccine prior to exposure:
            a. They should receive their second dose of the MMR vaccine as soon as possible (at least 28 days after their first dose).
            b. Implement daily monitoring for signs and symptoms of mumps infection from the 10th day after their first exposure through the 25th day after their last exposure.
    c. For healthcare personnel with known or suspected mumps, exclude from work for 5 days after the onset
    of parotitis.
    d. For healthcare personnel with known or suspected mumps, but without parotitis, exclude from work for
    5 days after onset of their first symptom.
    e. During a mumps outbreak, administer mumps vaccine to healthcare personnel in accordance with CDC
    and ACIP recommendations (https://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/mmr.html).
4. Reference link:
    a. Summary of Recommendations from the Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (2024) guideline.

H. PEDICULOSIS (Lice)

1. Employees having direct contact (e.g., head to head or shoulder to shoulder) with infected patients or their personal items (e.g., clothing or headgear) should be evaluated by Employee Health Services (EHS) or the Emergency Department if EHS is closed for treatment consideration. Healthcare personnel exposed to patients with pediculosis do not require treatment unless they show evidence of infestation.
2. Employee Health identification is made by visual inspection of the lice or eggs on the infested person, either with the naked eye or with the assistance of a handheld magnifying lens or microscope.
3. When an occupational exposure occurs, Infection Prevention should be notified as soon as possible. Infection Prevention will review the source patient's medical record and notify units/departments in which exposure may have occurred.
4. Personnel, in which treatment is deemed appropriate, should be given a prescription for 1% permethrin cream rinse (NIX) applied according to the manufacturer's directions. The employee should be provided with a Lice Information Sheet for further information.
5. Personnel with lice should be restricted from patient contact until treated and observed to be free of adult and immature lice.
6. If symptoms do not subside after initial treatment, personnel should be advised to report to EH for further evaluation and retreatment consideration.
7. The primary care provider of the employee should perform diagnosis and treatment of a non-occupational exposure to lice. The inpatient Pharmacy will not provide therapy for non-occupational exposures.
8. The following recommendations are aimed at preventing exposure of health care providers to pediculosis.
    a. Patients suspected or confirmed as having pediculosis should be placed on Contact Precautions until 24 hours after application of an appropriate pediculocide.
    b. Gloves and a long-sleeved gown should be worn for direct patient contact before and during application of the topical agent.
    c. For head lice or pubic lice, do not bathe the patient before treatment. Instead, apply the shampoo or lotion liberally to the affected area for the amount of time specified on the package insert, then rinse thoroughly as previously stated. The patient's comb/brush should be cleaned with hot (130 degrees F), soapy water for 5-10 minutes.
    d. Bed linen should be changed immediately after application of the topical agent for bed patients and during a shower for those patients who are able. Linen should be placed in a plastic laundry bag.
    e. Nursing should notify the patient's family. If possible, send the patient's clothing home, and instruct as follows:
        i. Launder bed linens and washable clothing in HOT water and dry in a hot dryer for at least 20 minutes. Dry clean or press those

items of clothing that cannot be laundered with a hot iron.

ii. Thoroughly vacuum carpets, upholstered furniture, and mattresses.

iii. Toys should be washed in hot, soapy water if possible. Stuffed toys may be placed in a hot dryer for 20 minutes.

iv. Wigs and hairpieces should be shampooed.

v. Items that cannot be washed should be sealed in a plastic bag for two weeks.

vi. Additional nursing considerations:

1. Do not apply to open areas or acutely inflamed skin, or to eyes, mucous membranes, or urethral meatus.
2. Notify the physician immediately if skin irritation or hypersensitivity develops.
3. In pregnant patients, the patient's obstetrician should be consulted before treatment.
4. Use caution in the treatment of infants and small children.
5. Do not let infants or children suck thumbs/fingers after application of medication.

9. Reference:
   a. About Head Lice | Lice | CDC
   b. Treatment of Head Lice | Lice | CDC

I. PERTUSSIS (Whooping Cough)

1. A valid exposure to Pertussis (Whooping Cough) is defined as having prolonged contact (i.e., performing a physical examination, suctioning, intubating feeding, bathing or other procedures requiring close interaction) with the patient without a mask and the patient is a confirmed or highly suspected pertussis case.
   a. Infection Prevention is to be notified immediately of any confirmed or suspected pertussis patients, so that verification of the exposure and follow up of exposed employees can be initiated as soon as possible.
   b. Infection Prevention will review information on the patient to verify physician and/or laboratory diagnosis or suspicion of pertussis.
   c. Infection Prevention will notify Managers of the confirmed/suspected pertussis patient and Managers will forward a list of potentially exposed employees to Employee Health.
   d. Post-exposure follow-up for employees will be coordinated through Employee Health. Potentially exposed employees (i.e., those employees whose names appear on the exposure list) will be contacted by Employee Health to determine each employee's exposure status and to instruct the employee about symptoms suggestive of pertussis and/or need for

medications.

e. The pertussis incubation period is defined as, beginning on the 6th day after the 1st day of employee exposure to pertussis through the 20th day following the last day of exposure.

f. **Recommendations:**

i. For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and are likely to interact with persons at increased risk for severe pertussis:

a. Administer postexposure prophylaxis.

b. If not receiving postexposure prophylaxis, restrict from contact (e.g., furlough, duty restriction, or reassignment) with patients and other persons at increased risk for severe pertussis for 21 days after the last exposure.

ii. For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and are not likely to interact with persons at increased risk for severe pertussis:

a. Administer postexposure prophylaxis, OR

iii. Implement daily monitoring for 21 days after the last exposure for development of signs and symptoms of pertussis.

iv. For asymptomatic healthcare personnel, regardless of vaccination status, who have an exposure to pertussis and who have preexisting health conditions that may be exacerbated by a pertussis infection:

a. Administer postexposure prophylaxis.

v. Exclude symptomatic healthcare personnel with known or suspected pertussis from work for 21 days from the onset of cough, or until 5 days after the start of effective antimicrobial therapy.

vi. Work restrictions are not necessary for asymptomatic healthcare personnel who have an exposure to pertussis and receive postexposure prophylaxis, regardless of their risk for interaction with persons at increased risk for severe pertussis.

2. Reference link:

a. Summary of Recommendations from the Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (2024) guideline.

J. RUBELLA (GERMAN MEASLES)

1. A valid exposure is defined as face to face contact and/or in the same airspace for more than 5 minutes starting 2-5 days before and at least 5-7 days after onset of rash in an infected person.
2. Immune Globulin may be considered for susceptible pregnant women exposed to Rubella, otherwise no prophylactic measures are needed after the exposure.
3. Rubella-susceptible personnel are to be immunized with Measles/Rubella (MMR) vaccine. The contraindications for vaccination are:
    a. Pregnant or contemplating pregnancy within 3 months.
    b. Immunocompromised condition
    c. Allergic to eggs or neomycin
    d. Recipient of Immune Globulin (IG) within the preceding 3 months
4. Rubella-susceptible employees are not to be assigned to care for patients with Rubella.
5. **Recommendations:**
    a. For asymptomatic healthcare personnel ***with*** presumptive evidence of immunity to rubella who have an exposure to rubella:
        i. Work restrictions are not necessary.
        ii. Implement daily monitoring for signs and symptoms of rubella from the 7th day after their first exposure through the 23rd day after their last exposure.
        iii. TABLE 3. Acceptable presumptive evidence of immunity to measles, rubella, and mumps
    b. For asymptomatic healthcare personnel ***without*** presumptive evidence of immunity to rubella who have an exposure to rubella, exclude from work from the 7th day after their first exposure through the 23rd day after their last exposure.
    c. For healthcare personnel with known or suspected rubella, exclude from work for 7 days after the rash appears.
6. Reference link:
    a. Summary of Recommendations from the Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (2024) guideline.

K. RUBEOLA (MEASLES)

1. HCP exposures to measles in a healthcare setting are defined as spending any amount of time while unprotected (i.e., not wearing recommended respiratory protection):
    a. For asymptomatic healthcare personnel with presumptive evidence of

immunity to measles who have an exposure to measles:

b. Post-exposure prophylaxis is not necessary.

c. Work restrictions are not necessary.

d. Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure.

2. For asymptomatic healthcare personnel without presumptive evidence of immunity to measles who have an exposure to measles:

    a. Administer postexposure prophylaxis per CDC and ACIP recommendations

    b. Exclude from work from the 5th day after their first exposure through the 21st day after their last exposure, regardless of receipt of postexposure prophylaxis.

    c. Work restrictions are not necessary for healthcare personnel who received the first dose of the MMR vaccine before exposure:

        i. They should receive their second dose of MMR vaccine as soon as possible (at least 28 days after their first dose).

        ii. Implement daily monitoring for signs and symptoms of measles from the 5th day after their first exposure through the 21st day after their last exposure.

3. For healthcare personnel with known or suspected measles, exclude from work for 4 days after the rash appears.

4. For immunocompromised healthcare personnel with known or suspected measles, exclude them from work for the duration of their illness.

5. During a measles outbreak, give the measles vaccine to healthcare personnel following CDC and ACIP recommendations.

6. Employees who are pregnant or have received Immune Globulin (IG) should be vaccinated as soon as possible, either after delivery or three months following IG.

7. Contraindications for the measles vaccine are as follows:

    a. Pregnant or planning to become pregnant within the next 3 months.

    b. Immunocompromised condition,

    c. Allergic to eggs or neomycin,

    d. Recipient of Immune Globulin (IG) within the preceding 3 months

8. Reference link:

    a. CDC, Appendix A: Considerations when Evaluating a Person for Exposure to Measles in a Healthcare Setting. Updated July 10, 2025

L. SARS-COV-2

1. A valid exposure is defined as being within 6 feet for a cumulative total of 15

minutes or more over a 24-hour period with someone with SARS-CoV-2 infection, and *without* personal protective equipment (PPE) regular respiratory mask or N95 (PAPR) with face shield/eye protection.

2. Due to constant changes in guidelines from the CDC and CDPH, current employee exposure guidelines will be placed in attachments.
3. Reference link:
    a. Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, updated March 18,2024

M. SCABIES

1. A valid exposure is defined as close (skin-to-skin) contact with untreated, symptomatic Scabies infested person.
2. Asymptomatic employees who have had direct skin contact with untreated Scabies infested persons may be treated prophylactically.
3. Treatment of symptomatic employees: Clinical Care of Scabies, updated December 18, 2023
4. References:
    a. CDC, About Scabies

N. SHINGLES (See Chicken Pox/Herpes Zoster)

O. SYPHILIS

1. At the time of exposure, employees exposed to blood/body fluids of patient with untreated Syphilis, have the option of receiving oral or parenteral prophylactic treatment, or receiving nothing.
2. Syphilis serology test will be done initially and at 6 weeks post exposure on the employee.
3. Treatment guidelines: CDC, STI treatment guidelines, 2021
4. References:
    a. CDPH STI Clinical Guidelines and Tools, updated April 30, 2025

P. TUBERCULOSIS

1. Definition of Significant Exposure:
    a. A significant exposure is defined as being present in the same room with a patient with active TB without the use of appropriate respiratory protection (i.e., a fit-tested N95 or higher-level respirator) for at least 10 minutes within a 24-hour period, during a time when airborne precautions were not in place. Brief exposures may also be evaluated based on the clinical situation and the procedures performed (e.g., aerosol-generating procedures).
2. Exposure List and Notification:
    a. The department manager or supervisor will compile a list of all employees who were potentially exposed to the patient during the period when

airborne precautions were not observed. This list should be sent promptly to Employee Health Services (EHS) for further action and follow-up.

3. Patient Diagnosis and Follow-Up:
    a. If the patient is confirmed to have *Mycobacterium tuberculosis* infection (by culture or nucleic acid amplification test), the following steps will be taken:
        i. Baseline Evaluation (As Soon As Possible After Exposure):
            a. All exposed healthcare personnel should undergo baseline TB screening, which includes:
            b. A risk assessment for TB
            c. Symptom evaluation for active TB (e.g., cough, fever, night sweats, weight loss)
            d. TB testing using either the Tuberculin Skin Test (TST, PPD) or an Interferon-Gamma Release Assay (IGRA), per CDC recommendations source.
        ii. Baseline chest x-ray is indicated only for those with symptoms or a newly positive TB test.

4. Follow-Up Testing
    a. For healthcare workers who test negative on initial TB screening (TST or IGRA):
        i. Repeat TB testing is recommended 8-10 weeks after the last known exposure (12 weeks maximum) source.
        ii. Employees will be counseled based on the results.
5. For workers with a previous positive TB test or prior diagnosis of latent TB infection:
    a. A symptom evaluation and medical questionnaire should be completed 8-10 weeks after exposure.
    b. Repeat TB testing or chest x-ray is not required unless symptoms of active TB are present.
6. Management Based on Results:
    a. If the follow-up TB test is negative and no symptoms are present, the employee returns to their standard TB screening schedule.
    b. If the follow-up TB test is positive, or if new symptoms develop, the employee must receive a chest x-ray and further clinical evaluation.
        i. Employees with abnormal chest x-ray findings or symptoms of TB:
            a. Must not return to work until cleared as non-infectious by a designated EHS physician.
            b. Will be referred for appropriate medical care and, if

indicated, prescribed prophylactic treatment.

c. May be required to provide physician clearance before resuming work duties.

7. Symptomatic Employees:
    a. Any employee who develops symptoms of TB at any stage must be evaluated promptly by a healthcare provider, as coordinated via EHS, and may require further diagnostic testing and treatment.The employee might be requested to provide a clearance from a physician.
8. Reference links:
    a. CDC: Exposure to Tuberculosis, March 25, 2024
    b. CDC: About Work-related Tuberculosis, updated April 2, 2024
    c. CDC: Clinical Testing Guidance for Tuberculosis: Health Care Personnel, updated December 15, 2023
        i. Frequency of Tuberculosis Screening and Testing for Health Care Personnel

Q. VARICELLA (See Chicken Pox)

R. Documentation:
1. An Exposure Surveillance Form must be completed for each exposed employee for tracking and documentation purposes.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Chapter 102. Occupation Health, Surveillance, Prevention and Control of Infection. APIC Text of Infection Control and Epidemiology, Washington, DC: APIC, April 21, 2021.

B. Control of Communicable Diseases Manual 21st Edition, Published 06/2022, ISBN:978-0-87553-323-0

C. Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections, updated January 31, 2025

D. Summary of Recommendations from the Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients (2024) guideline., updated January 31, 2025
1. CDC PDF copy: https://www.cdc.gov/infection-control/media/pdfs/Guideline-IC-HCP-H.pdf

E. Infection Control in Healthcare Personnel: Infrastructure and Routine Practices, updated April 12, 2024

F. Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for

Occupational Infection Prevention and Control Services, October 25, 2019

G. Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, updated March 18,2024, updated September 23, 2022

H. Infection Control Guidance: SARS-CoV-2, updated June 24, 2024, updated May 8, 2023

I. American Academy of Pediatrics. Red Book: 2024 Report of the Committee on Infectious Diseases. 33rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2024. Section 3 - Summaries of Infectious Diseases: Haemophilus Influenzae Infection, pp. 400-409; Meningococcal Infections, pp. 585-599.

Attachments

EH Active Comm Dx Quick Guide_2025.docx

EH Post Exposure Quick Sheet_2025.docx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2025
P&T/IPC	Genevieve delos Santos: Director Pharmacy	10/2025
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	10/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2025
Policy Owner	Melissa Deen: Manager Infection Prevention	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18743400**

Origination	02/2022	Owner	Audrey Parks: Vice President Information Technology
Last Approved	N/A	Area	Plans and Program
Next Review	1 year after approval		

Information Management Program Plan

I. SCOPE

A. The primary purpose of the Information Management Plan is to provide a framework for the planning and designing of information management processes to meet Salinas Valley Health's internal and external information needs is critical for accuracy and completeness of data, integrity, and accessibility of data to meet our mission and objectives. This policy applies to all staff utilizing Salinas Valley Health information systems in conducting business on behalf of the healthcare system.

II. OBJECTIVES/GOALS

A. The following comprehensive needs assessment factors are considered, as appropriate, in the development of an Information Management Plan in order to improve the flow of information and implement solutions at Salinas Valley Health (SVH):

1. The healthcare system's size, structure, and complexity; the needs of information users, including and amongst governance, administration, leaders, and employees, departments, services, and programs, patients and patients' families, outside services and contractors, payers, purchasers and employers, regulatory, licensing and accrediting bodies while taking into consideration timely and easy access to complete information throughout SVH as allowed by law and our internal policies and procedures;
2. The needs of information to support new construction and remodeling efforts as well as decision making processes;
3. The systems and processes needed to ensure patient safety;
4. The systems and processes needed to maintain compliance, privacy, security and integrity of health information that protects against loss, inappropriate access, damage, unauthorized alteration, unintentional change and accidental destruction;
5. The data and information that the healthcare system's needs to support planning;

6. The data and information that is needed within and among departments, services and programs;
7. The data and information that is needed for participation in national research or their databases and education;
8. The relevant national and state guidelines for data set parity and data connectivity in interfacing information systems in order to use comparative data to collaborate and pursue improvement opportunities;
9. The healthcare system's internal and external transmission requirements needed to provide safe, quality care;
10. The healthcare system's reporting needs over time;
11. The data and information needed for effective continuous performance improvement;
12. The data and information the hospital needs to compare current performance with past performance;
13. The technology that is appropriate (good technical fit, sustainable, reliable);
14. The technology that is affordable;
15. The needs to support customers and suppliers relationships;
16. The data and information the hospital needs to enhance cost-effectiveness;
17. The data and information that are needed to enhance work flow and how data enters, flows within, and leaves the organization;
18. The information that is required to support clinical and administrative decision making;
19. The planning of expansion or redesign of any services;
20. The planning of staffing and material resource allocation needed to maintain effectiveness;
21. Long-range plans that are likely to affect the hospital's information needs; and
22. The technology needed for information storage and feedback.
23. In order to guide this organization in the development of processes for managing information, SVH assesses its information management needs based on the following considerations:
24. Goals which include Performance Indicators within our Pillars as follows: People, Quality, Service, Finance, Growth, Community
25. Patient Safety Considerations;
26. Scope, Quality and Complexity of Care, Treatments and Services;
27. Identification of barriers to effective communication among caregivers

III. DEFINITIONS

N/A

IV. PLAN MANAGEMENT

Information system planning is performed for both strategic and operational support and encompasses both clinical and administrative data. Strategic planning, which includes but is not limited to, assessment, selection, integration of use and use of information management systems for delivery of care, treatment and services, is under the overview of the Chief Executive Officer, executive leadership and receives input from the Information Technology, Enterprise Informatics, and medical staff leadership.

The executive leardership determines the priority of information systems implementations based on strategic, regulatory, risk management and other needs of the organization. Project steering committees consist of managers, supervisors, other staff and consultants, as appropriate, representing the users and other stakeholders of the solutions under consideration. Needs assessments are conducted in accordance with Information Technology procedures. Recommendations are evaluated and pursued according to SVH practice and policy with the approval of the executive leadership and as appropriate, the Board of Directors.

A. CONTINUITY OF INFORMATION MANAGEMENT PROCESSES

1. Information Technology policies and procedures include the following plans, policies and procedures for managing interruptions to its information processes. These work in coordination with the Emergency Management Program Plan (https://svmh.policystat.com/policy/16695353/latest) and Hospital Incident Command System.
    a. Information Management Disaster Recover Plan, https://svmh.policystat.com/policy/13104565/latest
    b. Data Backup Plan, https://svmh.policystat.com/policy/14522295/latest
    c. Incident Response Plan,
2. The plan for managing of interruptions is tested for effectiveness periodically as needed in order to maintain access to information needed for patient care, treatment and services. Also, through this process strengths and weaknesses are assessed of existing manual and automated systems

B. INFORMATION TECHNOLOGY

1. SVHMC Information Technology (IT) coordinates the collection, processing, and reporting of data in support of reliable, efficient flow of information.
2. IT and Enterprise Informatics staff oversee the daily operation of core hospital information management systems, systems security, technical services, application support, infrastructure support, network engineering, and communications.
3. IT also assists other departments and affiliate organizational with planning and implementation of new information systems and information technologies.
4. IT is responsible for reviewing and approving technology acquisitions and changes to the Electronic Legal/Medical Records systems (Epic and Meditech) and the enterprise resource planning system (Workday).

C. CURRENT INFORMATION ENVIRONMENT

1. Data Center
    a. Controls for the Data Center include temperature, fire suppression and physical security.
    b. Temperature controls follow best practices, http://www.cisco.com/c/en/us/solutions/collateral/data-center-virtualization/unified-computing/white paper c11-680202.pdf, with temperature alerts programmed to trigger at temperatures above 85°F. The best practices references 80.6°F, however, as part of our energy conservation initiative, we have allowed for alerts to be sent at 85°F. http://www.pge.com/includes/docs/pdfs/mybusiness/energysavingsrebates/incentivesbyindustry/DataCenters_BestPractices.pdf
    c. Per Hospital's Master Plan document, we use National Fire Protection Association (NFPA) standards for fire suppression. http://www.nfpa.org/codes-and-standards/document-information-pages?mode=code&code=75
    d. Badge access is enabled for the Data Center. Requests for access are reviewed and approved by the Sr. Administrative Director of IT. Access is revoked upon termination or disabling of user account.
2. Hardware Technology:
    a. SVH IT maintains hardware standards in the daily operations of the information and network environment. Current standards include Cisco servers, Cisco networking and communications equipment, Lenovo desktops, laptops, Howard Medical workstations on wheels, HP printers, and Apple mobile (smartphone, tablet) devices.
    b. We have implemented Pure Storage SANs (storage area networks), in our data centers to optimize for high availability, operational continuance and disaster recovery.
3. Software Technology (sample list, not a comprehensive listing):

APPLICATION NAME ACQUISITION	DATE	VENDOR SOURCE
3M Encoder	1994	3M
Ambulatory Electronic Medical Record	2019	Epic
Bed Management	2015	McKesson
Patient Billing/Accounts Receivable	1992	Meditech
Capital Budgeting	2018	Axiom
Contracts Management	2024	Workday Strategic Sourcing
Cost Accounting	2016	StrataJazz

Data Repository	2001	Meditech
Electronic Medical / Health Record (EMR/EHR)	2025	Epic
Enterprise Resource Planning	2024	Workday
Offline EMR Solution	2016	iPeople Offline
Electronic Legal Record	1998	Meditech
Electronic Legal Record	2025	Epic
Electronic Medical Record	2001	Meditech
Electronic Medical Record	2025	Epic
Employee Health EMR	2019	Axion Health
Fixed Assets	1992	Meditech
General Ledger	1992	Meditech
HR Document Management	2018	GRM Visual Vault
Health Information Organization	2025	Supporting Communities Health Information Organization (SCHIO)
Human Capital Management	2023	Workday
Integration Engine	2008	Orion Rhapsody
Medication Dispensing	2022	Omnicell
Mobile Specimen Collection	2016	Stryker (formerly Vocera)
Nutrition Services and Food Services	2009	CBORD
Patient Portal - Ambulatory	2019	Epic MyChart
Patient Portal - Acute	2024	Epic MyChart
Patient Rounding	2017	Huron MyRounding
Payroll	2023	Workday
Physician Credentialing	2017	MDStaff
Picture Archiving & Communications	2007	Change Healthcare
Quality Reporting	2016	Acmeware, Medisolv
Secure Messaging	2018	TigerConnect
Time and Attendance, Staffing and Scheduling	1995	Symplr (formerly API)
Surgical Procedure System	2011	Picis
Wound Care EMR	2012	Net Health Systems

D. TECHNICAL SERVICES

1. Salinas Valley Health staff, contractors, physicians and other information systems'

clients utilize a variety of computer systems (e.g. workstations, laptops, tablets, workstations on wheels) to manage information.

2. Information Technology assists departments in the needs and systems security assessment, selection, acquisition and implementation of these technologies. Information systems related purchases are budgeted by and processed through IT.

E. SYSTEMS AND INFORMATION SECURITY

1. Information Technology policies and procedures include protection of data from intentional or unintentional destruction, modification or disclosure.
2. The Health Information Management (HIM) department's policies and procedures address confidentiality and privacy of patient information.
3. HIPAA privacy and security education is part of the Hospital's training, education and orientation programs.
4. Information Technology policies require users to have individual User ID and security code to access SVHMC information systems.
5. Some of the user's responsibilities include the following. Please refer to the System and Application Security Access Procedure, https://svmh.policytech.com/dotNet/documents/?docid=12529.
    a. The user will use their assigned unique network credentials to access the network to perform their job functions. System and application accounts are requested per Hospital policy and are generally processed through application leaders and system owners. These application owners or system leaders are not necessarily in Information Technology.
    b. The user must keep their credentials confidential and secure. Users accept responsibility for access to the system by anyone else if the electronic device is logged on with uniquely assigned credentials.
    c. Individuals with system access are required to adhere to the Acceptable Use of Information Systems policy. https://svmh.policytech.com/dotNet/documents/?docid=9171
    d. The user must log off the electronic device when work is completed or when the device is unattended.
6. Examples of Information Technology responsibilities include account administration for the domain, EMR systems, and remote access.
    a. Access will be assigned for the standard set of functions required for the user's job description or per role-based access.
    b. If additional access is required, the need will be requested by the employee's manager consistent with the established Hospital policies.

V. REFERENCES

A. Access Management of Information Systems, https://svmh.policystat.com/policy/12735880/latest

B. Granting Access to Electronic Medical Information, https://svmh.policystat.com/policy/13986177/latest

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
QSC	Aniko Kukla: Director Quality & Patient Safety	10/2025
CAO	Alysha Hyland: Chief Administrative Officer	10/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2025
Policy Owner	Audrey Parks: Vice President Information Technology	08/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18991880

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

Inpatient Criteria for Chemotherapy and Immunotherapy Administration

I. POLICY STATEMENT

A. All inpatients with orders for injectable chemotherapy or immunotherapy must meet the defined criteria for administration of the ordered medication.

II. PURPOSE

A. The purpose of this policy is to define the criteria for patients to receive chemotherapy or immunotherapy in the inpatient setting.

III. DEFINITIONS

A. Chemotherapy: Treatment that uses drugs to stop the growth of cancer cells, either by killing the cells or by stopping them from dividing.

B. Immunotherapy: A type of therapy that uses substances to stimulate or suppress the immune system to help the body fight cancer, infection, and other diseases.

IV. GENERAL INFORMATION

A. Most injectable chemotherapy and immunotherapy can be administered safely and effectively in an outpatient setting. However, some of these medications may be administered in an inpatient setting because of the risk of certain toxicities or the presence of patient comorbidities.

V. PROCEDURE

A. Site of care optimization

1. All efforts will be made to arrange for treatment to be given in the outpatient setting

for all patients, including those patients with a new cancer diagnosis or those who are hospitalized during a time when their outpatient regimen is normally scheduled.

2. Immune checkpoint inhibitors (i.e., pembrolizumab, nivolumab) will be restricted to outpatient use.

B. The workflow to address inpatient chemo requests will follow the steps outlined in *Attachment A*.

C. Patients meeting one or more of the following criteria under the four categories below may be administered chemotherapy or immunotherapy as an inpatient:

1. Malignancy diagnosis requiring emergent therapy:
    a. High-grade, rapidly progressive lymphoma with a large tumor burden and/or evidence of end-organ toxicity or altered mental status;
    b. Acute or chronic leukemia, with evidence of end-organ toxicity or altered mental status;
    c. Other oncologic emergencies that may require emergent chemotherapy to manage in the acute setting:
        i. Spinal cord compression
        ii. Superior vena cava syndrome
        iii. Disseminated intravascular coagulation (DIC)

2. Disease symptom management:
    a. Any presenting symptom that is thought to be due to disease burden or significant end organ involvement or compromise, such as but not limited to:
        i. Tumor causing current or impending gastointestinal (GI), gastrourinary (GU), or pulmonary obstruction

3. Patient-specific risk factors (i.e., risk factors that may increase the risk of complications if chemotherapy is given in the outpatient setting):
    a. High risk of tumor lysis syndrome requiring prophylaxis or presenting with tumor lysis syndrome requiring treatment
    b. Requirement for more frequent laboratory monitoring that is not practical in the outpatient setting
    c. Patients receiving novel regimens that require continuous monitoring and potential treatment for cytokine release syndrome (CRS) and/or immune effector cell-associated neurotoxicity syndrome (ICANS)
    d. Patients with a history of severe hypersensitivity or infusion reactions resulting in discontinuation of therapy and/or admission for treatment or monitoring, which may include desensitization infusions that require increased monitoring
    e. Incarcerated patients, if regimen is a multi-day regimen and/or requires continuous chemotherapy infusion.

4. Drug regimens that require inpatient monitoring or complex administration over multiple days, such as but not limited to:
    a. R-EPOCH or DA-EPOCH: Requiring coordination of multiple infusions or multiple drugs over 96 hours
    b. High-dose methotrexate (≥ 500 mg/m^2) with leucovorin rescue: Requiring close monitoring of serum methotrexate level
    c. High-dose ifosfamide (> 1 g/m^2/day): Requiring close monitoring of serum electrolytes and urine pH
    d. Hyper-CVAD: Requiring coordination of multiple infusions or multiple drugs over 96 hours and requiring close monitoring of serum methotrexate levels

D. The Utilization Management Committee will evaluate requests for inpatient chemotherapy and/or immunotherapy in the following situations:
    1. The patient does not meet any of the inpatient criteria outlined above;
    2. The medication being requested is restricted to outpatient use only;
    3. The medication is a non-formulary item and has not been evaluated nor approved by the Pharmacy & Therapeutics/Infection Prevention (P&T/IP) Committee;
    4. The patient's primary disease or comorbidities will prolong hospitalization and delaying chemotherapy until patient is discharged will cause clinical deterioration.

E. The Utilization Management Committee will be an ad hoc committee under the P&T/IP Committee that will evaluate requests as below:
    1. Members will include the following: Pharmacy representative (Director of Pharmacy or designee), Oncology provider representative, Chief Operating Officer, Chief Clinical Officer, Oncology Nursing representative (Director of Med/Surg/Oncology or designee).
    2. Pharmacy representative will schedule a meeting with the ad hoc committee to review the request.
    3. The ordering provider must be available to provide the rationale behind their request to the committee.
    4. A response with the final decision will be provided within 24 to 48 hours of receiving the request.

F. Documentation: The Utilization Management Committee will document all requests that are reviewed.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Foster AE, Reeves DJ. Inpatient Antineoplastic Medication Administration And Associated Drug Costs: Institution of a Hospital Policy Limiting Inpatient Administration. P T. 2017

Jun;42(6):388-393. PMID: 28579726; PMCID: PMC5440100.

B. Hennes ER, Reed M, Mably M, Jared J, Bergsbaken JJ, Deming D, Callander N, O'Regan R. Implementation of a chemotherapy stewardship process. Am J Health Syst Pharm. 2020 Jul 23;77(15):1243-1248. doi: 10.1093/ajhp/zxaa157. PMID: 32620961.

C. Ami K. Patel et al.Outcomes of Immune Checkpoint Inhibitor Administration in Hospitalized Patients With Solid Tumor Malignancies. JCO Oncol Pract 19, e298-e305(2023). DOI:10.1200/OP.22.00256

Attachments

Attachment A - Algorithm - Criteria for Inpatient Chemo.pdf

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
Pharmacy & Therapuetics	Kiri Golleher: Pharmacy Clinical Coordinator	10/2025
Pharmacy & Therapuetics	Genevieve delos Santos: Director Pharmacy	09/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18994491**

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

Medication Use

I. POLICY STATEMENT

A. Salinas Valley Health (SVH) is committed to ensuring safe, effective, and appropriate medication management throughout all patient care areas. This policy establishes standardized procedures for medication ordering, preparation, dispensing, administration, documentation, and monitoring in compliance with applicable laws, regulations, and standards of practice.

II. PURPOSE

A. To provide comprehensive guidelines for clinicians in safely and accurately prescribing, preparing, dispensing, administering, documenting, and monitoring medications and their therapeutic effects. This policy establishes standardized procedures for the entire medication use process to ensure patient safety, promote regulatory compliance, and prevent medication errors.

III. DEFINITIONS

A. Acknowledge: Process by which a Registered Nurse (RN) reviews medication order for appropriateness in the clinical situation.

B. Adverse Drug Reaction (ADR): Any unexpected, unintended, undesired, or excessive response to a medication that requires discontinuing or modifying the medication therapy, necessitates admission to a hospital, or prolongs an existing hospital stay.

C. Automated Dispensing Cabinet (ADC): A computerized drug storage device that provides controlled dispensing, tracking, and charging of medications.

D. Basal Rate: Continuous infusions of insulin programmed to keep blood glucose stable between meals and during the night; the amount of insulin required to maintain a normal metabolic state when fasting.

E. Bedside Glucose Monitoring (BGM): Blood obtained from the patient and measured

immediately at the point of care.

F. Bedside Medication Verification (BMV): Scanning process used to confirm right patient, right medication, right dose, right time, and right route prior to medication administration.

G. Black Box Warning: Required information provided by the manufacturer that identifies potential serious or life-threatening risks associated with a medication.

H. Concentrated Electrolyte Solutions: Products containing elements such as sodium, potassium, magnesium, or calcium that exceed physiologic concentrations and require dilution prior to administration.

I. Controlled Substance: Medications classified as Schedule I through V by the United States Drug Enforcement Agency (DEA) and/or applicable state law based on their potential for abuse and dependence.

J. Correction Insulin: Small adjustments of short-acting insulin given at meals when pre-prandial blood glucose levels are above target range.

K. D/C: Discontinue medications.

L. Discrepancy: A difference between expected inventory levels and actual inventory levels in automated dispensing machines.

M. Drug Diversion: Intentional and unauthorized use, theft, or transfer of controlled substances from legitimate medical purposes.

N. FDA: Food and Drug Administration.

O. High-Alert Medication: Medications that bear a heightened risk of causing significant patient harm when used in error.

P. Insulin-to-Carbohydrate Ratio: The amount of insulin required to cover a given number of carbohydrates.

Q. Look-Alike Sound-Alike Medications: Medications with names that sound or look similar, increasing the risk of medication errors.

R. MAR (Medication Administration Record): The real-time medication record designed to provide online documentation of medication administration.

S. Multi-Dose Vial (MDV): A vial of medication that contains more than one dose and is intended for multiple uses.

T. Order Entry: The process of entering medication orders into the computerized patient drug profile.

U. Pending: A MAR order status that requires further action.

V. Prandial (Bolus) Insulin: Insulin used to replace natural mealtime insulin to cover the rise in blood glucose due to carbohydrate intake.

W. PRN: Pro re nata; as needed medication order.

X. Reject Order: The electronic message sent to pharmacy when a medication order entered into the patient's profile is not appropriate for the clinical situation or does not match the original medication order.

Y. Sensitivity Factor: Number that represents how many milligrams per deciliter one unit of insulin will lower blood glucose.

Z. Therapeutic Duplication: The practice of prescribing multiple medications for the same indication without clear distinction of when one medication should be given in preference over another.

AA. Unverified: Medication orders entered by a non-pharmacist that require pharmacist verification.

AB. Verbal Order: Orders dictated to a licensed individual by a licensed independent practitioner (LIP).

IV. GENERAL INFORMATION

I. Medication Management Authority

A. All medications must be prepared and administered in accordance with orders from a licensed independent practitioner or other authorized prescriber responsible for the patient's care.

B. Medication management activities must comply with hospital policies, medical staff bylaws, rules and regulations, and applicable laws.

C. Only personnel authorized through their licensure, certification, and scope of practice may order, dispense, or administer medications.

II. Medication Safety Systems

A. The hospital maintains electronic systems for medication ordering, dispensing, and administration to enhance safety and reduce the risk of errors.

B. All medication administration must utilize bedside medication verification processes, including patient identification and medication barcode scanning.

C. The pharmacy department reviews all medication orders for appropriateness prior to dispensing, except in emergency situations or when review would cause clinically significant delay.

III. Documentation Requirements

A. All aspects of medication management require complete and accurate documentation in the electronic health record.

B. Documentation must include, at minimum:

- Order verification and review
- Dispensing activities
- Administration details
- Patient monitoring and response
- Any deviations from standard processes

IV. Medication Storage and Security

A. All medications must be stored under proper conditions regarding temperature, light, and security as specified by the manufacturer and regulatory requirements.

B. Access to medication storage areas is limited to authorized personnel.

C. Regular monitoring and documentation of storage conditions occurs according to hospital procedures.

V. Quality and Safety Monitoring

A. The hospital maintains ongoing surveillance of the medication use process through:
   - Regular audits and inspections
   - Medication error reporting and analysis
   - Process improvement initiatives
   - Staff competency assessment

B. The Pharmacy and Therapeutics Committee provides oversight of medication management practices and approves related policies and procedures.

V. PROCEDURE

I. Patient-Specific Information Management

A. Required Patient Information
   - The following patient-specific information must be maintained, accessible, and reviewed by all practitioners involved in medication management processes:
     1. Demographics (age, sex, weight, height)
     2. Clinical data (diagnosis, pregnancy/lactation status when applicable)
     3. Safety parameters (allergies, sensitivities)
     4. Medication profile (current medications, including home medications)
     5. Relevant laboratory values and diagnostic results
     6. Special considerations (renal function, hepatic status, fluid restrictions)

B. Medication Profile Management
   - All medication orders must be entered into the electronic medication profile system and undergo pharmacist review prior to dispensing except in the following circumstances:
     1. Emergency situations requiring immediate intervention
     2. Situations where delay would cause patient harm
     3. Direct administration by or under immediate supervision of a licensed practitioner

C. Pharmacist Review Requirements
   - Medication order review must include assessment of:
     1. Patient-specific factors (allergies, contraindications)
     2. Medication-specific factors (appropriateness of drug, dose, route, frequency)

3. Interaction potential (drug-drug, drug-food, drug-disease)
4. Therapeutic duplication
5. Laboratory value implications f. Compliance with formulary and use criteria

- Any identified concerns must be resolved with the prescriber before dispensing

D. Documentation Standards

- Medication profiles must include comprehensive order information:
  1. Complete drug identification (name, strength, formulation)
  2. Administration parameters (frequency, route, duration)
  3. Specific indication for all PRN medications
  4. Therapy start and stop parameters when applicable
  5. Special administration instructions
- Clinical interventions, clarifications, and modifications must be documented in the electronic health record

II. Medication Ordering and Prescribing

A. Order Authorization Requirements

1. All medications require an order from a person lawfully authorized to prescribe.
2. Orders must be complete, legible, and contain all required elements.
3. Clinical staff may independently order certain fluids and agents per approved protocols when associated treatments are prescribed by a physician including but not limited to:
   a. Blood transfusion supportive fluids
   b. Line maintenance solutions including saline or heparinized saline flushes
   c. Chemotherapy administration adjunct fluids
   d. Medication tubing flushes as specified by pharmacy
   e. Normal Saline maintenance infusions at maximum rate of 10ml per hour for low-volume infusion patency
   f. Hemodynamic monitoring line maintenance solutions
   g. Local anesthetic preparations for vascular access procedures

B. Prescription Elements

1. Medication orders must contain sufficient elements to ensure accurate interpretation, safe preparation, and appropriate administration. Orders lacking essential components require clarification through established communication channels prior to implementation.
2. Elements of a Complete Medication Order:
   a. Patient full name and identifier

b. Medication name (generic preferred)
c. Dose, clearly expressed in metric units
d. Route of administration
e. Frequency or rate of administration
f. Indication for all PRN medications
g. Prescriber signature, date, and time
h. When applicable:
    i. Concentration (Hospital-approved standard concentrations apply)
    ii. Rate of administration
    iii. Taper parameters, dose adjustment(s) and frequency
    iv. Duration of therapy
    v. Indication for use included as part of the order for:
        a. PRN orders that can be used to treat multiple symptoms
        b. Antibiotic orders
        c. Chemotherapy orders
        d. Hospital-defined sound-alike/look-alike medications orders
        e. Other medication orders as defined by the hospital

3. Look-Alike or Sound-Alike Medication Orders
    a. Prescribers are encouraged to provide an indication for use when ordering look- alike or sound-alike medications

C. Special Order Types
    1. As-Needed (PRN) Orders
        a. Multiple Medications for the Same Indication
            i. PRN orders for multiple medications to treat the same indication or symptoms include, as part of the order, specific parameters or criteria for the use of each medication that clearly communicates and delineates when each medication may be administered.
            ii. PRN orders for multiple medications or doses for different severity of symptoms include, as part of the order, parameters or criteria for the use of each medication and dose prescribed. Each order is linked to severity of symptom parameters.
            iii. PRN orders for multiple medications or doses with the same indication that are not clearly defined as stated above are clarified with the prescriber to avoid therapeutic duplication.

iv. PRN orders for more than two psychotropic medications for the same indication are not acceptable and must be clarified with the prescriber prior to implementation.

v. Previous PRN orders for the same medication are discontinued by pharmacy.

b. Multiple Routes of Administration

i. Medication orders with more than one route of administration (e.g., IV/PO) include specific instructions for selecting the route of administration.

a. Example: Zofran 4 mg PO every 8 hours as needed for nausea and vomiting. Zofran 4 mg IV every 8 hours as needed for nausea if unable to tolerate PO.

ii. Medication orders with more than one route of administration are entered into the system as two separate and distinct orders. Orders are linked (or referenced) to prevent duplications in treatment.

iii. Medication orders with more than one route of administration that do not include specific directions for delineating the route of administration require

2. Range Order

a. Orders permitting dose or frequency ranges must include clinical decision-making parameters and documentation requirements to ensure appropriate therapeutic management.

b. Range in Dose

i. Medication orders that contain a range in dose are initiated using the lowest dose or per hospital approved pain management protocol.

ii. If the initial dose is sub-optimal, repeat the initial dose (within the dose range) and follow the dosing interval. Repeat dose must be within 30 minutes of the initial dose for injections and 60 minutes for orals.

c. Range in Frequency

i. Medication orders with a range in dosing interval are interpreted, transcribed, and implemented using the *shortest dosing interval*.

d. Subsequent Doses

i. If the patient has previously received and tolerated the medication, and the patient's clinical condition warrants; the initial and subsequent doses may be at a higher or lower dose within the dose range.

ii. Note: The assessment of need must be documented in the

medical record.

iii. If symptoms are not controlled or the patient's clinical status changes, a new order is required.

3. Titration and Tapering Orders
    a. Medication orders that include dose/rate titration or dose/rate tapering are allowed and are valid medication orders if the orders meet all the requirements defined by this policy.
    b. Medication orders to titrate or taper a dose/rate must include, as part of the order, clear instructions for administration of the medication.
    c. Elements of a Complete Medication Titration Order
        i. Medication titration orders must include all the following elements to be a complete order:
            a. Medication name
            b. Route of administration
            c. Initial rate of infusion (dose/unit of time)
            d. Incremental units to increase or decrease the rate or dose (e.g., titrate 'up to')
            e. How often the rate or dose can be changes
            f. Maximum rate or dose (e.g., titrate 'up to')
            g. Objective clinical measures used to guide the changes (e.g., blood pressure, Richmond Agitation–Sedation Scale (RASS), and the Confusion Assessment Method (CAM).)
            h. Note: The method/scale used to assess the clinical measures does not have to reside in the titration order itself but may be a separate order in the medical record.
        ii. Medication titration orders that do not contain the required elements listed above are incomplete and must be clarified with the prescriber.
        iii. The prescriber must be notified to obtain new orders if dose limits (minimum or maximum) are out of range and clinical goal(s) are not achieved.
    d. Pausing and Restarting Titrated Medication Infusions
        i. Infusions may be intermittently paused when the patient's physiological parameters no longer meet the infusion criteria.
        ii. Note: Pausing an infusion based on patient response is not the same as discontinuing the infusion.
        iii. Infusions may be restarted based on assessed pharmacological

parameters following an order specifying how to restart. Options include but are not limited to:

a. Restart at last infusion rate
b. Restart at the rate in the order for the initial starting rate
c. Restart at XX% of the last infusion rate
d. Obtain a new order from the provider >

e. Discontinuing Medication Titration Orders
    i. Medication titration orders are only discontinued (removed) form the medication administration record (MAR) pursuant to:
        a. An order from the physician or other authorized provider to discontinue the medication (e.g. original order may state discontinue a paused medication infusion after xx timeframe or similar wording)

f. Medication Taper Orders
    i. Taper orders include as part of the order:
        a. The amount the dose/rate is to be decreased per dosing interval
        b. The time frame or frequency for the dose/rate reduction (e.g. every 30 minutes)
        c. The total number of dose/rate reductions or duration of therapy (e.g. x 3 doses or for 12 hours)
    ii. Orders for tapering medications that do not contain specific dose reduction instructions and frequency require clarification with the prescriber.

4. Pediatric Weight-Based Dosing Orders
    a. Medication orders for specified patient populations require appropriate dosing parameters to ensure safe therapeutic administration. Alternative dosing methodologies must follow established organizational protocols.
    b. All medication orders for patients below 50 kg require weight-based dosing parameters
    c. Metric units are used for ordering and dispensing oral liquids. Orders by teaspoons, etc. are not accepted and require clarification.
    d. Patient Weight and Dosing Parameter Requirement
        i. In addition to the required elements of a complete medication order, pediatric weight-based medication orders require:
            a. Access to the patient's current weight listed in kilograms (kg) and body surface area (BSA) when applicable.

b. The weight-based dosing parameter used to calculate the dose (e.g., mg/kg, mg/m2 etc.).

ii. Pediatric weight-based medication orders without these parameters are considered incomplete orders and require clarification.

a. The patient care provider is contacted for order clarification.

e. Exempted medications include:

i. Oral vitamins

ii. Oral iron preparations

iii. Topical preparations

iv. Vaccines

v. And other dosage forms or medications that are not dosed by weight

D. Verbal and Telephone Orders

1. Verbal and telephone orders must be limited to appropriate clinical circumstances as defined by organizational standards. Reception, verification, documentation, and authentication processes must comply with regulatory requirements and organizational procedures.
2. Limited to situations where:
   a. Emergency circumstances exist
   b. The prescriber is involved in a procedure
   c. Immediate clinical necessity is demonstrated
   d. May be received only by:
      i. Registered nurses
      ii. Pharmacists
      iii. Respiratory care practitioners
      iv. Other licensed professionals within their scope of practice
         a. Require read-back verification by the receiving practitioner
         b. Must be authenticated by the ordering prescriber or responsible practitioner within 48 hours
         c. e. Documentation must include:
         d. Prescriber name
         e. Recipient name and credentials
         f. Date and time received
         g. Indication that read-back verification occurred

E. Non-FDA Approved Medication Uses
    1. Medications prescribed for non-FDA approved indications must:
        a. Have supporting documentation from standard medical literature
        b. Be reviewed by a pharmacist prior to dispensing
        c. Be approved by the Pharmacy and Therapeutics Committee chairperson when safety concerns exist
    2. The pharmacy may withhold medication until appropriate safety review is completed for uses with potential harmful effects
    3. Documentation requirements include:
        a. Non-FDA Approved Use form completion
        b. Supporting medical literature citation
        c. Clinical rationale
        d. Safety monitoring parameters

F. Use of Herbal Products
    1. Non-FDA approved herbal products are not included on the hospital formulary
    2. Patient-owned herbal products are not permitted for use during hospitalization
    3. Herbal products listed during medication reconciliation will be discontinued and documented
    4. Pharmacy will provide drug interaction information for herbal products upon request

G. High-Alert Medications and Black Box Warnings
    1. Medications with FDA Black Box Warnings require:
        a. Specific monitoring parameters as defined in the electronic health record
        b. Documentation of warning acknowledgment by prescriber when indicated
        c. Implementation of required safety measures prior to administration
    2. Pharmacists must verify the indication prior to dispensing high-alert medications
    3. Clinical indication and safety criteria must be documented in the medication profile

H. Therapeutic Interchange
    1. May occur only for medications approved by the Pharmacy and Therapeutics Committee
    2. Requires documentation of both the ordered medication and the therapeutic alternative
    3. Notification to the prescriber occurs according to approved protocols

I. Order Clarification and Legibility
    1. Illegible orders (defined as when two healthcare professionals cannot interpret with 100% certainty) require prescriber clarification

2. Incomplete orders require resolution prior to implementation
3. Clarified orders must be documented in the electronic health record

III. Medication Selection and Procurement

A. Formulary Management
   1. The Pharmacy and Therapeutics Committee maintains authority for evaluating and approving medications for inclusion in the organizational formulary.
   2. The formulary system ensures medications available for use meet established standards for safety, efficacy, and cost-effectiveness while promoting evidence-based prescribing practices.

B. Selection Criteria Standards
   1. Medication selection decisions must incorporate comprehensive evaluation of therapeutic benefits, safety profiles, cost considerations, and operational impact.
   2. The evaluation process must utilize current scientific evidence, recognized clinical guidelines, and institutional usage patterns to inform formulary decisions.

C. Procurement
   1. Medication procurement must follow established supply chain protocols that ensure product integrity, regulatory compliance, and continuity of care. All medications must be obtained through authorized distribution channels with appropriate pedigree documentation per regulatory requirements.

D. Therapeutic Alternatives Management
   1. Therapeutic interchange may occur only within parameters established by the Pharmacy and Therapeutics Committee.
   2. Such interchange requires documented clinical equivalence, established conversion protocols, and appropriate prescriber notification mechanisms according to organizational procedures.

E. Non-Formulary Medication Management
   1. Non-formulary medications require appropriate clinical justification, review by pharmacy leadership, and approval through established organizational protocols.
   2. Documentation of clinical necessity must be maintained in accordance with institutional standards.

F. Drug Sample Restrictions
   1. Distribution of drug samples within SVH is prohibited except in specified clinical areas under direct physician oversight.
      a. Samples may be dispensed directly by physicians in their private practice in designated clinic areas, with appropriate documentation of distribution.
   2. Hospital personnel may not distribute samples to clinic patients under any circumstances.

G. Special Procurement Categories

1. Investigational medications, emergency-use medications, and shortage medications require specialized procurement processes that ensure appropriate regulatory compliance, clinical oversight, and distribution control according to organizational protocols.

IV. Medication Brought Into the Hospital – Patient's Own Medication

A. Medication brought into the facility are not authorized for administration unless they can be positively identified, and the quality, integrity, and source (if applicable) are not questionable.

B. Medications brought into the facility that are not labeled in accordance with federal and state rules and regulations for prescription labeling (e.g., herbal supplements) or are not consistent with the patient's current medication order (e.g., different dose or directions for use), are not authorized for use.

C. Medication brought into the facility are not authorized for administration unless they can be positively identified, and the quality, integrity, and source (if applicable) are not questionable.

D. Medications brought into the facility that are not labeled in accordance with federal and state rules and regulations for prescription labeling (e.g., herbal supplements) or are not consistent with the patient's current medication order (e.g., different dose or directions for use), are not authorized for use.

1. Prescriber Responsibilities
    a. A complete medication order from an authorized provider is required to administer a medication. An order requesting to use the patient's own medication(s) is entered into the patient's chart/medical record.
    b. Use of authorized medications brought into the facility by the LIP are:
        i. Administered by, or under the direct supervision of, the LIP; or
        ii. A complete medication order is required for administration.

2. Nursing Responsibilities
    a. Notifies the Pharmacy Department
    b. Securely stores medication authorized for use in the designated secure location on the patient care unit or patient room.
    c. Requests the patient's family/representative (if authorized by the patient) remove medications that are not going to be used from the facility.
    d. Documents the process in the patient's record.
    e. At discharge, retrieves and returns the patient's own medications to the patient unless the patient chooses to surrender the medication.

3. Pharmacist Responsibilities
    a. Verifies the identity of the medication prior to entering/verifying the medication order in the order entry system.
    b. Checks the medication label for compliance with federal and state labeling requirements and compares to the prescriber's order.

c. Assesses the medication for applicable FDA Risk Evaluation and Mitigation Strategies (REMS) and initiates verification of applicable requirements (e.g., patient registry, required labs, etc.).

d. Assesses the medication for listing as a NIOSH Hazardous Drug and initiates appropriate requirements, as applicable (e.g., storage, PPE, etc.).

e. Notifies the ordering provider of any discrepancies.

f. Reviews and enters/verifies the order in the order entry system as 'patient own medication supply' or similar order type generating no charge.

g. Indicates/documents that the medication is verified and authorized for use (e.g., using a label, adding a bar code or a notation in the order entry system).

E. Storage

1. When patient's medications are not required during hospitalization:

a. Medications will be placed in a tamper-evident security bag and sealed with the patient acting as witness

i. If the patient is an unreliable witness, the bag should be filled and sealed with two nursing personnel present

b. The receipt will be logged in the electronic health record

c. The sealed bag will be delivered to pharmacy where it will be:

i. Tracked and logged by pharmacy personnel

ii. Stored securely according to medication requirements

d. Upon discharge, the nurse retrieves the sealed medication bag from pharmacy and returns it to the patient or family member

e. Medications not picked up from pharmacy will be discarded 30 days post-discharge according to appropriate disposal procedures

F. Use of Patient's Own Medications

1. Patient's own medications may be administered under the following conditions:

a. The medication is not available from the hospital pharmacy

b. The medication has been identified and verified by a pharmacist

c. The medication is in the original, properly labeled container

d. The medication appears to be in good condition

e. A valid medication order exists in the patient's medical record

f. The medication is critical to the patient's care

2. Process for using patient's own medications:

a. Medications are stored in pharmacy in appropriate container

b. Pharmacy counts and logs the medication for patient use

c. Pharmacy dispenses appropriate quantity to the nursing unit
d. Administration follows standard medication administration procedures
e. Documentation occurs in the electronic MAR
f. Upon discharge, remaining medications are returned to the patient

3. Prohibited medications include:
    a. Non-FDA approved herbal products
    b. Expired medications
    c. Medications in unlabeled containers
    d. Medications with altered appearance or suspicious characteristics
    e. Controlled substances, except in specific authorized circumstances
4. When home medications need to be used during hospitalization:
    a. If a medication must be retrieved from a sealed bag:
        i. The bag will be opened by pharmacy personnel with appropriate witnessing
        ii. The medication will be retrieved and the bag resealed using tamper-evident technology
        iii. Entry and removal will be documented and tracked by pharmacy

V. Medication Storage and Security

A. General Requirements
1. Security and oversight of medications, particularly controlled substances, will be managed by the Pharmacy Department in accordance with federal, state, and local laws.
2. Pharmacy personnel on duty will protect the Pharmacy assets and records and guard against theft or diversion of medications.
3. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.
4. Non-pharmacy personnel will only be allowed access to the Pharmacy with supervision by pharmacy staff.

B. Storage Condition Standards
1. Medications present in patient care areas should be locked utilizing, but not limited to, any of the following:
    a. Automated dispensing machines (ADMs)
    b. Lockable medication cassettes
    c. Lockable receiving and return boxes

d. Lockable refrigerators
e. Lockable cabinets and drawers
f. Lockable plastic wall boxes

2. Emergency crash cart medications must be locked within the crash cart or code bag.
3. Access to ADMs is limited and will be granted by Pharmacy Leadership

C. Refrigerated Medications
1. Refrigerated medications must be stored in refrigerators designated for medication storage.
2. Controlled substances requiring refrigeration are stored in a refrigerator attached to a Controlled Substance Manager or ADM.
3. When a refrigerated controlled substance is stored to an ADM without a refrigerator attached, the drug will be appropriately labeled, including appropriate room temperature beyond-use dating.
4. Refrigerator temperatures must be monitored and documented according to pharmacy procedures.

D. Medication Expiration Management
1. Medications shall not be kept in stock after the expiration date on the label, and no contaminated or deteriorated drugs shall be available for use.
2. All expired medications will be placed in an area designated and labeled for expired medications in the pharmacy.
3. Expired medications in patient care areas:
a. Checked once a month by Pharmacy during unit inspections.
b. Expired medications should be returned to the Pharmacy.
4. Multi-dose vial management:
a. All multi-dose vials expire 28 days from the day the vial is opened, or per the manufacturer's recommendation, whichever is shorter.
b. The date written on the multi-dose vial indicates the last day the medication is allowed for use.
c. Exceptions include:
i. Multi-dose ointments, inhalers, and liquids assigned expiration dates by the manufacturer
ii. Insulin vials dispensed with a 28-day expiration label
iii. If a multi-dose vial is entered in a patient room, then the vial becomes a single-dose vial per infection control guidelines
5. Single-dose vials are used only ONCE and then discarded immediately after use.

E. Controlled Substance Storage Requirements

1. Controlled substances must be secured in accordance with DEA regulations and institutional policies. Storage systems must include restricted access mechanisms, perpetual inventory capabilities, and documentation of all transactions. Refer to the Controlled Substance and Drug Diversion Management Policy for comprehensive requirements.

F. Medication Return and Disposal

1. Unused or discontinued medications will be returned to the pharmacy by the end of the nursing shift.

G. Temperature Monitoring Requirements

1. All medication storage areas must maintain appropriate temperature monitoring with alert systems for excursions beyond acceptable parameters.
2. Documentation of temperature monitoring must be maintained according to regulatory requirements and organizational standards.

H. Emergency Medication Access

1. Emergency medications must be readily accessible in appropriate clinical areas while maintaining necessary security controls.

I. Medication Recall Management

1. Recall notifications may be received via direct mail, e-mail, the wholesaler's notification, and/or a written or electronic FDA Safety Alert or recall notification.
2. Upon receiving notification of a drug/medication related device recall, a purchase history review for the recalled product(s) is conducted. Purchase history review is done for each potential acquisition source (i.e., wholesalers, 340B accounts, manufactures, direct purchase transactions, local purchase/transfer transactions, etc.)
    a. If purchase history review indicates recalled product(s) as purchased, initiate area search /inspections and notify pharmacy leadership.
    b. If there is no purchase history, document action taken in the Electronic Recall Management System.
3. Inspection
    a. Area search/inspections are initiated when purchase history review indicates that the recalled product(s) was purchased or obtained.
    b. Run inventory reports for automated dispensing cabinets (ADCs) to identify storage locations.
    c. Identify floor stock locations outside of an automated dispensing cabinet including nursing units, ancillary patient care areas, outpatient care areas, materials management/central supply, code carts and emergency boxes, outpatient clinics, etc.
    d. Inspect pharmacy and pharmacy satellites.
    e. Inspect all identified areas where the recalled medication/device may be

stored.

f. Search patient profiles, compounding and repackaging records, when applicable.

g. Retrieve and return affected products to the pharmacy for final disposition.

4. Product Replacement

   a. Quarantine recalled products in a clearly identified designated area separate from active stock.

   b. Box and label recalled products "Product Recall - Awaiting Disposition - DO NOT USE" (or similar).

   c. Follow the manufacturer's/recall notice specifications for returning or managing the disposition of the recalled products.

5. Communication

   a. When a medication/device is recalled by the FDA or discontinued by a manufacturer for safety reasons, and the affected product has been identified in the facility/health system; individual practitioners and other healthcare professionals ordering, dispensing and/or administering/using the recalled product are notified. Notification may be by any mechanism that ensures the appropriate individuals are informed (e.g., memorandum, letter, newsletter, e-mail, etc.)

   b. When indicated, patients who may have been affected by the recall (i.e., received the recalled medication/product) are identified and informed of the recall or discontinuation.

   c. Medications/devices recalled for safety reasons are reported to the Pharmacy and Therapeutics (P&T) Committee or equivalent medical staff committee.

6. Documentation

   a. Documentation includes:

   b. Product information

   c. Recall number, if available

   d. Recall classification, if available

   e. Purchase history review

   f. Areas searched/inspected

   g. Notification or inspection of clinics or off-site hospital locations

   h. Notification of recipient if recalled product(s) was shared, borrowed or loaned

   i. Actions executed

   j. Date action completed

   k. Signature of individual verifying actions completed

VI. Medication Transcription and Verification

A. Ordering Entry Process

1. All medication orders must be entered into the hospital's electronic medication profile system and undergo pharmacist review prior to dispensing except in the following circumstances:
    a. Emergency situations (e.g., Code Blue)
    b. Any situation in which the patient would be harmed if the medication were not given immediately
    c. Medications administered directly by or under the supervision of a licensed independent practitioner (LIP)
2. The individual entering medication orders must ensure the following elements are correctly captured:
    a. Complete patient identification
    b. Complete medication identification (name, strength, formulation)
    c. Complete dosing parameters (dose, frequency, route, duration)
    d. Special administration instructions
    e. Therapeutic indication for PRN medications

B. Order Clarification Process

1. When a medication order requires clarification, the following process must be followed:
    a. Document the specific element requiring clarification
    b. Contact the prescriber through approved communication channels
    c. Document the clarification received
    d. Proceed with order verification based on the clarified information

C. Verification Standards for High-Risk Medications

1. High-alert medications require enhanced verification procedures including:
    a. Independent double-check of order entry
    b. Verification of appropriate monitoring parameters
    c. Assessment of patient-specific risk factors
    d. Confirmation of appropriate dosing calculations
2. Medications with FDA Black Box Warnings require:
    a. Verification that the prescriber is aware of the warning
    b. Confirmation that appropriate monitoring will be implemented
    c. Documentation of required safety measures
3. Concentrated electrolyte solutions require verification of:

a. Appropriate indication for use
b. Appropriate dilution parameters
c. Safe administration rate
d. Required monitoring protocol

D. Clinical Verification Components
1. Medication order verification must include evaluation of:
a. Therapeutic appropriateness relative to patient condition and clinical objectives
b. Dosing appropriateness considering patient characteristics including age, weight, organ function, and concomitant conditions
c. Compatibility with existing medication regimen including potential interactions
d. Contraindication assessment including allergies, previous adverse reactions, and clinical restrictions
e. Appropriate monitoring parameters for therapy management

E. Technology Utilization Standards
1. Electronic medication management systems must incorporate verification safeguards including:
a. Clinical decision support
b. Alert mechanisms
c. Documentation capabilities.
2. System utilization must comply with organizational protocols for maintaining the integrity of the medication use process.

F. Drug Protocol Management
1. The Pharmacy and Therapeutics Committee will authorize pharmacists to manage and monitor the therapy of approved drugs according to established protocols.
2. Pharmacists must demonstrate competency prior to utilizing approved protocols.
3. Protocol-based modifications to therapy must be documented in the patient's medical record.

G. Verification Documentation Requirements
1. Documentation of verification activities must maintain a comprehensive record of clinical review, interventions, clarifications, and modifications according to professional practice standards and regulatory requirements.

H. Emergency Medication Verification
1. In emergency situations where pre-administration verification is not possible:
a. Emergency medication access is permitted through defined override

procedures

b. Documentation of the emergency situation is required

c. Retrospective pharmacist review must occur within 24 hours

2. Procedures for emergency medication access must be established in collaboration with the Pharmacy and Therapeutics Committee.

VII. Medication Dispensing and Return

A. Individuals Authorized to Prepare, Dispense, Transfer or Make Labeling Changes to Medications

1. Medication preparation and dispensing is restricted to a licensed pharmacist or to a designee (i.e., technician, intern) under the supervision of a pharmacist.
2. Only a pharmacist, or authorized pharmacy personnel under the supervision of a pharmacist, may fill and label containers from which medications are distributed or dispensed, make labeling changes, or transfer medications to different containers.

B. Preparation and Dispensing Areas

1. Medication preparation and dispensing areas are clean and orderly.
2. Food and/or drinks are prohibited in medication storage, preparation, and dispensing areas to prevent occupational exposure to hazardous or infectious materials and potential contamination of work surfaces.

C. Amounts to Dispense

1. The pharmacy dispenses enough doses to last until the next scheduled delivery or fill.
2. The amount dispensed is sufficient to meet patient needs and to minimize the potential for diversion.

D. Dispensing in Ready-To-Administer Forms

1. Medications are dispensed in the most ready-to-administer forms commercially available and, to the extent practical, in unit doses that are packaged by the pharmacy or licensed repackager.
2. Oral liquids are dispensed in commercially available unit dose cups or are repackaged by the pharmacy in an oral syringe/cup/dropper.
3. Oral syringes are prepared in limited quantities to meet immediate patient care needs.
4. Oral liquid dosing devices (oral syringes/cups/droppers) display only the metric scale.

E. Labeling

1. Any medication or medication container (i.e., syringe, bag, bottle, tube, jar, etc.) that is prepared but not immediately administered must be labeled in accordance with this policy.
2. Label Contents

a. At a minimum ALL medication labels include:
    i. Medication name, strength and amount (if not apparent from the container)
    ii. Expiration date or beyond-use date, when not used within 24 hours
    iii. Expiration date or beyond-use date and time, if expiration occurs in less than 24 hours
    iv. The date prepared and diluent for all compounded IV admixtures and parenteral nutrition

b. When preparing individualized medications for more than one patient or when the person preparing a medication is not the person administering the medication, the label must also include:
    i. The patient's name
    ii. The location where the medication is to be delivered
    iii. Directions for use and applicable accessory or cautionary instructions

3. Pharmacy Labeling Requirements
    a. Labels prepared by the pharmacy are typed or printed.
    b. Medications are labeled with sufficient information to initiate recalls and other controls as needed (i.e., lot numbers, batch numbers, etc.)
    c. To the extent feasible, labels are affixed directly to the immediate container and not to an overwrap such as a box, foil wrap, or plastic bag. In cases where the physical characteristics of the immediate container of the medication do not permit full labeling, a partial label containing, at a minimum, the patient's name and location may be placed on the container and the complete labeling applied to an appropriate outer container.

4. Patient-specific medications dispensed from the pharmacy, including compounded IV admixtures and parenteral nutrition, contain, at a minimum, the following information on the label:
    a. The patient's name and location
    b. The prescriber's name
    c. The proprietary and/or nonproprietary name of the medication
    d. Medication strength or concentration
    e. Dose
    f. Dosage form
    g. Bar-code when using Bar-code Medication Administration (BCMA)
    h. Lot number or pharmacy control number
    i. Manufacturer or distributor (if not evident from a proprietary name or from

pharmacy repackaging/compounding records)

j. Expiration date or beyond-use date

k. Expiration or beyond-use date and time, when expiration occurs in less than 24 hours

l. Date prepared and diluent on all compounded IV admixtures and parenteral nutrition

m. Quantity dispensed

n. Infusion rate, if IV and if applicable

o. Directions for use and any applicable cautionary statements (e.g., “requires refrigeration,” “for intramuscular use only”, “protect from light”)

p. Hazardous drugs that require special handling precautions are identified and labeled as such. Labeling includes a cautionary statement, e.g., "Hazardous Drug- Observe Safety Precautions” or similar wording.

VIII. Medication Administration

A. Medications are administered by authorized licensed independent practitioners and clinical staff that are authorized to do so by State and Federal law and hospital policy.

B. Personnel Authorized to Administer Medication

1. Registered Nurses (RNs)
2. Licensed Vocational Nurses (LVNs)
3. Clinical Nurse Specialists (CNS)
4. Speech Therapists (within scope of practice)
5. Physicians
6. Physician Assistants (PAs)
7. Respiratory Care Practitioners (RCPs) (drugs related specifically to respiratory therapy)
8. Physical Therapists (PTs) (certain topical medications)
9. Certified Radiologic Technologists (CRTs) (radiologic contrast media)
10. Pharmacists
11. Perfusionists
12. Nuclear Medicine Technicians
13. Students under direct supervision of instructor or preceptor
14. Medical assistants (within scope of practice)
15. Certified Registered Nurse Anesthetist (CRNA)

C. Training and Competency Assessment

1. Personnel authorized to administer medications receive training during orientation and ongoing education as needed about topics related to safe medication handling,

preparation, administration, and patient monitoring. Topics may include but not limited to:

a. Safe handling, preparation and administration of medications.

b. Knowledge of the indications for use, potential side effects, drug interactions, compatibility, and dose limits

c. Equipment devices, special procedures, and/or techniques required for medication administration

D. Procedure

1. Do not use medication dispensed to or labeled for another patient.
2. Prepare medications for one patient at a time.
3. Prepare medications in a clean, functionally separate area designated for medication preparation.
4. Keep unit-dose packages intact until immediately prior to administration.
5. Wear personal protective equipment (PPE) when handling and administering chemotherapy and other hazardous drugs as defined by the facility.
6. Use a filter straw or needle to withdraw medications from an ampule. If a filter needle is used, it must be replaced with a new needle before administering the medication.
7. Administer medications immediately after the medication is prepared without a break in process or appropriately label the medication
8. Solid Oral Dosage Forms: Assess solid oral dosage forms that need to be crushed or split prior to administration for suitability.
    a. Do not crush or split enteric coated and sustained release products.
    b. Only split tablets with a functional score.
        i. Note: For unscored tablets, consult with the pharmacist.
    c. Wear personal protective equipment (PPE) when crushing or splitting solid oral dosage forms that are identified as hazardous and require PPE.
    d. Clean tablet splitting and crushing devices before and after each use and/or use a plastic sleeve to minimize the potential for cross contamination of products. Alternately, patient dedicated devices may be used.
    e. Do not save unused tablet portions. Immediately discard unused portion in accordance with the facility's pharmaceutical waste management procedures. Any unused portion of a controlled substance must be wasted with a witness and documented per hospital policy.
    f. Contact pharmacy for guidance or to discuss alternatives when needed.
9. Before administering a medication, the authorized individual administering the medication completes the following:
    a. Right Medication: Verifies the medication selected for administration is correct based on the medication order and product label.

i. Visually inspects the medication for potential loss of integrity (i.e., no particulates or discoloration).

ii. Verifies the medication has not expired or is past its beyond-use-date (BUD).

iii. Note: Beyond-use-dates for compounded sterile products apply up to the time a medication is administered. BUD does not apply to the duration of administration (i.e., a medication that is infusing does not need to be changed/discontinued when it reaches the BUD.)

b. Verifies there is no contraindication with respect to allergy, sensitivity, or diagnosis.

c. Right Dose: Verifies the medication is administered in the correct dose and the dose does not reflect an unsafe dosage level (i.e., a dose that is too high or too low).

d. Right Route: Verifies the medication is administered by the correct route and the route is appropriate for the medication and patient.

i. For IV medications, verify the type of IV access is appropriate for the medication and patient.

ii. For medication administration via an enteral route (e.g., G-tube, NG-tube, J-tube, etc.) the order must indicate the route of administration.

e. Right Time: Verifies the medication is administered at the appropriate time, to ensure adherence to the prescribed frequency and time of administration.

i. Discusses any unresolved, significant concerns about the medication with the prescriber, pharmacist, and/or relevant staff involved with the patient's care.

f. For newly ordered medications, educates the patient, or if appropriate, the patient's family about the drug name, indication for use, and potential clinically significant adverse effects; instructing the patient/family to notify the nursing staff of any adverse reactions event (e.g., difficulty breathing). Documents patient education per hospital policy.

g. If applicable, advises the patient and/or the patient's representative about the patient assessment and monitoring process which might include awakening the patient in order to assess the effects of the medication.

h. Right Patient: Positively identify the patient before administering the medication. Check the patient's identification with two hospital approved identifiers (i.e., name band, date of birth, patient specific number, photograph) and ask the patient (when possible) to state his/her name and date of birth. If barcode medication administration is utilized, scan the patient's wristband for confirmation prior to proceeding.

i. Note: Patient room number is NEVER used as an identifier.

i. Double checks the order if the patient questions or expresses doubts about a medication, dose, administration route, technique, or purpose.

j. Properly position the patient, if necessary, before administering the medication.

k. Administer the medication. Offer additional liquid for oral medications if appropriate.

l. Observe the patient take the medication. Stay with the patient until he/she has swallowed the medication.

m. Right Documentation: Document the exact time the medication is administered. Do not document prior to administration.

n. Return unused intact (sealed) medications to the patient's supply, automated dispensing cabinet (ADC) or pharmacy per hospital policy.

o. Discard unusable medications per hospital policy.

p. Isolate defective or questionable medications and return them to the pharmacy.

10. For comfort care or palliative care patients:
    a. If it is a medication that requires monitoring per the medication use policy, it is up to the discretion of the provider to continue that medication on non-telemetry units.

IX. Specialized Medication Handling

A. *Insulin Management*

1. All insulin must be independently double-checked by two qualified healthcare practitioners prior to administration, in accordance with High-Alert Medication protocols.
2. Documentation of insulin administration and Bedside Glucose Monitoring (BGM) must comply with organizational standards for high-alert medication monitoring.
3. Practitioner Responsibilities
    a. Physician
        i. Complete appropriate insulin order set based on patient's insulin needs
        ii. Review BGM records and insulin orders daily
        iii. Adjust insulin regimens based on glycemic control assessment
        iv. Specify appropriate parameters for insulin administration and dose adjustments
    b. Registered Nurse
        i. Obtain BGM pre-prandial (before meals) unless otherwise ordered
        ii. Confirm beyond-use date on newly accessed insulin vials

iii. Discard insulin vials according to 28-day beyond-use date protocol

iv. Prepare insulin and label syringe with patient name and insulin dosages

v. Administer insulin according to prescriber's order

vi. Review BGM/serum glucose levels as ordered

vii. Document insulin administration with exact time and injection site location

c. Dietitians

i. Provide diet education for hospitalized diabetic patients

ii. Assist with carbohydrate counting when ordered by physician or requested by patient or nursing staff

B. *Continuous Subcutaneous Insulin Infusion (CSII) Pump Management*

1. Authorized Use

a. Patients may continue insulin therapy via CSII pump during hospitalization with physician order

b. Patient must demonstrate knowledge of safe self-administration of insulin

c. Patient must be alert, physically capable, able to properly work pump functions, and willing to manage the pump

2. Contraindication for CSII Self-Management

a. Altered state of consciousness (including medications that could alter consciousness)

b. Disorientation to person, place, or time

c. Physical, cognitive, or behavioral problems precluding self-management

d. Diabetic ketoacidosis (DKA) or hyperosmolar hyperglycemia

e. Conditions warranting IV insulin administration

f. Critical illness

g. Suicidal ideation

h. Inability/unwillingness to provide essential information about pump and insulin doses

i. Unwillingness to sign pump management agreement

j. Inability to provide needed pump supplies during hospitalization

3. Required Consultations

a. Endocrinologist consultation must be ordered for all patients admitted with insulin pump

b. Standard insulin pump order sets must be utilized when prescribing self-

management

4. Discontinue Parameters
    a. The insulin pump shall be discontinued and alternative insulin orders obtained when:
        i. Patient management presents a threat to health/safety or patient becomes incapacitated
        ii. Patient exhibits any contraindications during ongoing assessment
        iii. Insulin pump malfunctions and cannot be remedied within one hour
        iv. Insulin pump is temporarily halted for longer than one hour
        v. Patient has two consecutive blood glucose values >240 mg/dL not reduced by:
            a. Change of insertion site/tubing
            b. Adjustment with insulin administration dosing
            c. Changes in insulin pump settings as ordered
        vi. When discontinued:
            a. Insulin pump must be labeled with patient identification
            b. Pump should be sent home with responsible family member when possible
            c. If unable to send home, labeled pump should be sent to pharmacy for storage
            d. Location of discontinued pump must be documented in electronic medical record
            e. Alternative insulin therapy must be implemented immediately to avoid hyperglycemia
        vii. Admission Procedure
            a. Initial Assessment Requirements
                i. Document presence of insulin pump, brand name, and insulin type
                ii. Obtain pump-prescribing physician and primary care center contact information
                iii. Notify admitting physician and obtain order to initiate insulin pump order set
                iv. Ensure endocrinologist consultation and dietitian assessment orders
                v. Provide diabetic education

vi. Notify pharmacy of patient admission

b. Pharmacy Verification

i. Pharmacist verifies physician orders for insulin use

ii. Pharmacist provides correct medication labeling for infusion set

iii. Note: Due to insulin pump delivery mechanics, reservoir/cartridge labeling may not be possible

C. *Concentrated Electrolyte Solutions*

1. Storage

a. Concentrated electrolyte solutions shall be stored exclusively within the Pharmacy Department

i. Within pharmacy, concentrated electrolytes shall be stored in a physically separate area designated for IV compounding and admixture

ii. Products shall be segregated from other medications and from each other to prevent selection errors

iii. Warning labels identifying high-alert status shall be prominently affixed to all containers

iv. Solutions shall be stored in accordance with manufacturer temperature specifications

b. These solutions shall not be available in patient care area stock supplies to prevent inadvertent use in undiluted form

c. Restricted access shall be maintained with solutions clearly labeled

2. Preparation

a. Concentrated electrolyte solutions shall be mixed exclusively by Pharmacy staff

b. Nursing staff shall not prepare or mix solutions containing concentrated electrolytes for intravenous patient use

c. Standardized dilution protocols shall be followed for all preparations

d. All admixtures shall undergo pharmacist verification prior to dispensing

e. Administration

i. Administration shall proceed in accordance with established rate guidelines

ii. Double verification of patient, solution, and rate shall be performed prior to administration

iii. Patients receiving concentrated electrolyte infusions require

regular monitoring of vital signs and laboratory values

iv. Rate adjustments require prescriber orders with specified parameters

3. Exceptions for concentrated electrolyte solutions:
    a. NICU crash cart
        i. Calcium Gluconate
    b. Adult crash cart
        i. Magnesium Sulfate
        ii. Calcium Chloride
    c. Concentrated electrolyte solutions are available to the anesthesiologist/ Nurse Anesthetist and physician staff:
        i. Magnesium Sulfate
        ii. Calcium Chloride
        iii. All concentrated electrolytes in this unit will include appropriate **high alert** labeling precautions to prevent misidentification for other similarly packaged medications.

D. *Therapeutic Leech Management*

1. Authorized Utilization
    a. Therapeutic leeches (Hirudo medicinalis) may be applied exclusively by trained personnel on tissues suffering from impaired venous circulation
    b. Application must occur under appropriate supervision, typically by a Plastic Surgeon
    c. Utilization requires thorough documentation of clinical necessity and anticipated therapeutic outcomes
    d. Treatment goals must be clearly established prior to initiation of therapy
2. Procurement
    a. Leeches shall be obtained exclusively through the Pharmacy Department
    b. Requests must include:
        i. Patient identifiers
        ii. Clinical indication
        iii. Prescribing physician
        iv. Anticipated treatment duration
    c. Pharmacy shall maintain appropriate storage conditions for therapeutic leeches
3. Preparation
    a. Required equipment:

i. Leeches
ii. Hirudo salt
iii. Sterile water
iv. Covered container with 70% alcohol solution labeled with patient name
v. Scissors
vi. Appropriate dressing materials
vii. Contact information (1-800-645-3569) for clinical consultation

b. Cleanse patient's skin thoroughly with soap and water
c. Remove all substances with strong odor or taste (e.g., operative prep solutions, saline)
d. Rinse cleansed areas with plain water
e. Create appropriate barrier to prevent leech wandering:
    i. Option 1: Cut 1 cm hole in dampened gauze square and place over treatment area
    ii. Option 2: Use small sterile inverted plastic graduate to confine leech until feeding begins
f. Application
    i. Direct leech's head to the treatment area
    ii. Attachment typically occurs quickly (30-60 seconds)
    iii. If attachment resistance occurs:
        a. Create small needle prick to produce tiny blood droplet
        b. Consider alternate leech specimen
        c. Note: Persistent resistance may indicate poor arterial supply
    iv. Once attached, leech typically remains in place until fully engorged
    v. Monitor site continuously to ensure leech has not relocated
    vi. Document exact time of application
g. Duration
    i. Leeches typically remain attached for 30-60 minutes at congested sites
    ii. Premature detachment may occur with inadequate blood supply
    iii. Prevent unintended migration through:
        a. Physical containment
        b. Pre-cut holes in "Op-Site" dressing applied to

treatment area

iv. Leeches detach spontaneously when satiated and will not reattach

h. Care of Post-Bite Wounds
    i. Apply firm pressure for persistent oozing
    ii. Notify physician if bleeding cannot be controlled
    iii. Observe site for:
        a. Infection
        b. Excessive bleeding
        c. Signs of adverse reaction
    iv. Each site must be encouraged to bleed through gentle removal of forming clots
    v. Clinical response of treated tissue requires close observation
    vi. Regular monitoring of hemoglobin levels required during active treatment

i. Infection Prevention
    i. Treatment area requires regular observation for local infection
    ii. Swab cultures obtained if clinical signs of infection present
    iii. Prophylactic antibiotics may be indicated in immunocompromised patients
    iv. Aeromonas hydrophilia is common pathogen (present in up to 20% of cases)
    v. Document all monitoring parameters and infection prevention measures

j. Termination of Therapy
    i. Active sucking leech becomes engorged within 15-20 minutes then falls off
    ii. Never forcibly remove attached leech (may result in foreign body retention)
    iii. Allow natural detachment to prevent infection and retained secretory structures

k. Other Information
    i. Each bite wound continues to ooze up to 50 mL blood for 24-48 hours
    ii. Adjust number of bite wounds based on clinical requirements
    iii. Multiple bites may produce significant blood loss (e.g., 6 bites

could drain 300 mL)

iv. Treatment typically required for 3-5 days until collateral circulation develops

v. Some cases may require treatment up to 10 days

E. *Inhaled Epoprotenol (Flolan) Administration*

1. Scope of Practice

a. Inhaled epoprostenol (Flolan®) administration is restricted exclusively to:

i. Anesthesia services

ii. Cardiology services

iii. Cardiac surgery services

iv. Critical care services

v. Pulmonary services

b. Administration must occur solely within intensive care units or operating room environments

c. Off-label utilization requires thorough documentation of clinical rationale and evidence-based justification

2. Approved Clinical Indications

a. Severe Pulmonary Hypertension, defined by either:

i. Echocardiographic evidence of moderate to severe right ventricular dysfunction with right atrial/ventricular enlargement; and/or

ii. Pulmonary artery catheter derived data meeting the following parameters:

iii. Mean pulmonary arterial pressure (mPAP) >25 mmHg

iv. Right atrial pressure (RAP) >15 mmHg

v. Cardiac index (CI) <2.0 L/min/m^2

vi. Pulmonary vascular resistance (PVR) >250 dynes·sec/cm^5 or >3 Wood units

b. Complicated Cardiac Surgery with concurrent:

i. Severe pulmonary hypertension

ii. Right ventricular failure

iii. Decreased cardiac output as assessed by echocardiography or pulmonary artery catheterization

c. Acute Respiratory Distress Syndrome (ARDS) with:

i. Mechanical ventilation dependency

ii. Pulmonary hypertension and/or persistent hypoxia (PaO_2/FiO_2

<200)

iii. Inadequate response to maximal ventilator optimization strategies

3. Dosing and Administration
    a. Dosing
        i. Initial dose: 0.05 mcg/kg/minute based on:
            a. Ideal body weight (IBW) when actual weight exceeds IBW
            b. Actual body weight when this value is less than IBW
        ii. Calculation formulas:
            a. IBW (male) = 50 kg + 2.3 kg (height in inches – 60)
            b. IBW (female) = 45.5 kg + 2.3 kg (height in inches - 60)
        iii. Maximum dose: 0.05 mcg/kg/minute (doses exceeding this parameter have not demonstrated improved clinical response)
    b. Titration
        i. Downward titration should be initiated every one hour as clinically tolerated
        ii. Minimum effective dose: 0.01 mcg/kg/minute
        iii. Dose reduction parameters:
            a. Incremental adjustments not to exceed 0.01 mcg/kg/minute every 30 minutes
            b. Physician-specified tolerance parameters must be documented
            c. Resume previously tolerated dose if negative response occurs
    c. Administration
        i. Delivery exclusively via continuous nebulization
        ii. Required equipment:
            a. Aerogen Solo Nebulizer in closed heated humidified system
            b. Mechanical ventilator or heated humidified high-flow nasal cannula
            c. Double bacteria filters on exhalation limb
            d. Vented IV tubing sets
            e. Alaris infusion pump with syringe module
        iii. Solution concentration: 30 mcg/mL (1.5 mg/50 mL)

iv. Solution protection requirements: Shield from direct light

4. Initial Response to Therapy
    a. Beneficial response typically evident within 10 minutes of initiation
    b. Positive response indicators include:
        i. 20% increase in PaO_2 or mixed venous O_2 saturation
        ii. 20% reduction in mean pulmonary arterial pressure
        iii. Measurable increase in cardiac index
        iv. Echocardiographic evidence of improved right ventricular function
    c. Negative response indicators:
        i. Decline in P ratio by >25%
        ii. Hemodynamic instability
        iii. Worsening right ventricular function
5. Monitoring
    a. Baseline assessment prior to initiation
    b. Post-initiation evaluation at 30 minutes
    c. Reassessment 30 minutes following any dose adjustment
    d. Ongoing monitoring every two hours thereafter
    e. Comprehensive therapy reassessment every 24 hours
    f. Assessment criteria includes:
        i. Oxygenation parameters (PaO_2, SpO_2, PaO_2/FiO_2 ratio)
        ii. Hemodynamic measurements (when available):
            a. Pulmonary artery pressure
            b. Pulmonary vascular resistance
            c. Right ventricular ejection fraction
            d. Right ventricular end-diastolic volume
    g. All complications must be documented and immediately reported to attending physician
6. Weaning and Discontinuation
    a. Treatment Duration Determination
        i. Based exclusively on documented clinical response
        ii. Consider weaning if no clinical response observed within 2 hours of administration
        iii. Prioritize establishment of minimal effective dose while ensuring patient safety

b. Discontinuation
    i. Obtain attending physician authorization prior to discontinuation
    ii. Maintain minimum effective dose (0.01 mcg/kg/minute) for minimum 2 hours
    iii. Proceed with discontinuation only if no negative response observed
    iv. Strictly avoid abrupt withdrawal to prevent rebound hypoxemia and pulmonary hypertension
    v. Continue monitoring for 30-60 minutes post-discontinuation

7. Responsibilities
    a. Respiratory Care Practitioner
        i. Verify and document physician's order
        ii. Ensure delivery exclusively within authorized care environments
        iii. Maintain appropriate delivery system configuration
        iv. Change epoprostenol IV tubing every 48 hours
        v. Ensure solution protection from direct light
        vi. Coordinate with pharmacy for timely medication resupply
        vii. Document all dose adjustments and syringe exchanges in electronic medication administration record
        viii. Utilize transport ventilator when patient movement required
        ix. Maintain continuous epoprostenol delivery without interruption
    b. Nursing
        i. Monitor epoprostenol pump and promptly report alarms to Respiratory Care Practitioner
        ii. Coordinate with RCP regarding pharmacy notification for resupply (minimum 2 hours prior to depletion)
        iii. Ensure nebulizer maintains upright vertical position at all times
        iv. Document specified parameters:
            a. SpO_2 and FiO_2 prior to initiation
            b. Values at minimum 30-minute intervals post-initiation and following dose changes
            c. Continued monitoring every 2 hours throughout therapy
            d. Post-discontinuation monitoring for 30-60 minutes
        v. Document additional parameters when available:
            a. PaO_2

b. mPAP
c. CVP
d. CO/CI

vi. Immediately notify RCP of acute parameter changes or altered patient condition

c. Pharmacy

i. Compound and hand-deliver epoprostenol syringes STAT upon receipt of order

ii. Preparation specifications:

a. Concentration: 30 mcg/mL (1.5 mg/50 mL)
b. Dispensing container: 60 mL syringe
c. Diluent restriction: Exclusively Flolan® diluent without substitution

iii. Labeling requirements:

a. Patient identification
b. REFRIGERATE auxiliary label
c. FOR INHALATION ONLY auxiliary label

iv. Light protection: Dispense in brown bag

v. Storage requirements:

a. Refrigeration prior to administration
b. Stability limitations: 8 hours at room temperature, 48 hours refrigerated

vi. Prepare and deliver additional syringes upon clinical request (minimum 2 hours prior to current infusion completion)

F. *Transdermal Fentanyl Patch*

1. Approved Indications

a. Transdermal fentanyl patches are indicated exclusively for the management of chronic pain in patients who:

i. Require continuous opioid administration

ii. Have pain that cannot be adequately managed with non-opioid analgesics, combination products, or short-acting opioid formulations

iii. Have demonstrated tolerance to opioid therapy

b. Therapy must be initiated only after thorough clinical assessment documenting appropriateness of continuous opioid delivery system

2. Contraindications

a. Management of acute pain or post-operative pain (including outpatient surgical procedures)
b. Mild or intermittent pain responsive to alternative therapies
c. Opioid non-tolerant patients (due to risk of serious or life-threatening hypoventilation)
d. Patients under 2 years of age
e. Administration via PRN or "as needed" ordering is prohibited

3. Restrictions
    a. Transdermal fentanyl patches shall not be available as override medications in automated dispensing units
    b. Patches shall be subject to restricted access ordering and dispensing protocols
    c. Utilization requires pharmacist verification of appropriate indication prior to dispensing

4. Required Prescribing Criteria
    a. All orders for fentanyl patches must be evaluated by a pharmacist according to the following criteria:
        i. Verification of persistent, moderate to severe chronic pain requiring continuous, around-the-clock opioid administration
        ii. Confirmation that pain is unrelieved by alternative analgesic approaches
        iii. Documentation of opioid tolerance defined as:
        iv. Taking for one week or longer at least:
            a. 60 mg oral morphine daily, or
            b. 30 mg oral oxycodone daily, or
            c. 8 mg oral hydromorphone daily, or
            d. 25 mg oral oxymorphone daily, or
            e. 60 mg oral hydrocodone daily, or
            f. An equianalgesic dose of another opioid
    b. Initiation
        i. Initial dosing must be calculated based on current 24-hour opioid requirements
        ii. Equianalgesic conversion tables must be consulted when converting from non-fentanyl opioids
        iii. Dose selection must incorporate:
            a. Age considerations
            b. Comorbid conditions

c. Concomitant medications
d. Respiratory status

iv. Initial prescription duration should not exceed 72 hours to facilitate adequate response assessment

c. Dose Adjustment

i. Dose titration must not occur more frequently than every 72 hours

ii. Breakthrough pain during initial therapy requires supplemental short-acting analgesics, not additional patches

iii. Dose increases should not exceed 25-50% of previous dose

iv. Each adjustment requires reassessment of:

a. Analgesic efficacy
b. Adverse effects
c. Functional status

5. Verification

a. Pharmacist must verify indication prior to dispensing through review of:

i. Admission data

ii. Consultation with nursing staff

iii. Patient interview when necessary

iv. Direct prescriber communication when required

b. Documentation must include:

i. Indication verification

ii. Opioid tolerance assessment

iii. Contraindication screening

iv. Clinical intervention notations

c. Patients failing to meet all criteria are ineligible for transdermal fentanyl therapy during hospitalization

6. Administration

a. Prior to application

i. Remove old patch and cleanse area to remove residual medication

ii. Select appropriate non-irritated, non-irradiated skin site

iii. Avoid areas with excessive hair (clip, don't shave if necessary)

iv. Ensure skin is completely dry before application

b. Technique

i. Date/time/initial new patch on outer surface (never write on portion contacting skin)
ii. Apply to flat surface such as chest, back, flank, or upper arm
iii. Do not apply directly over the heart
iv. Firmly press patch in place for 30 seconds to ensure adhesion
v. Wash hands immediately after handling patch

c. Monitoring
i. Every shift assessment must include:
a. Verification of patch presence and integrity
b. Documentation of patch location
c. Assessment of application site for irritation
d. Evaluation of respiratory status (minimum respiratory rate parameters)
e. Pain control assessment
f. Sedation level measurement

d. Rotation Requirements
i. New applications must utilize different anatomical sites
ii. Minimum 7-day rotation cycle before returning to previously used site
iii. Site rotation must be systematically documented
iv. Skin integrity assessment required prior to each application

7. Removal and Disposal
a. Discontinuation
i. Two licensed personnel (RN, LVN, physician, or pharmacist) must witness patch removal
ii. Personnel must wear gloves during removal process
iii. Removed patch must be folded adhesive-side together immediately upon removal
iv. Folded patch must be placed directly into appropriate pharmaceutical waste container
v. Disposal must never occur in regular trash receptacles or sharps containers

X. Medication Waste Management

A. Pharmaceutical Waste Management Plan
1. A licensed reverse distributor that is contracted to manage the disposal of outdated/ unusable pharmaceuticals.

2. Partially used pharmaceuticals discarded by the facility are evaluated for hazardous waste status.
3. Hazardous pharmaceutical waste (HPW) disposal is contracted to a hazardous waste disposal transporter permitted and insured to transport and manage hazardous waste.
4. HPW is not discarded into a drain (sewering or flushing).
5. HPW is not mixed with biomedical waste disposal except where unavoidable as part of the medication administration process.
6. Employees are trained to ensure they can identify, minimize, and properly handle pharmaceutical wastes.
7. The pharmacy assists with identifying waste-regulated drugs to aid in communicating proper disposition and processing to ensure proper disposal. (Examples include labeling, notation on medication administration records, and clinical alerts in the automated dispensing units.)
8. Pharmaceutical waste is managed by disposing waste in the appropriate color-coded containers per the facility's waste management program.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. California State Board of Pharmacy. *2025 lawbook for pharmacy*. Sacramento (CA): California Department of Consumer Affairs; 2025. Available from: https://www.pharmacy.ca.gov

B. Institute for Safe Medication Practices (ISMP). *2024–2025 ISMP targeted medication safety best practices for hospitals*. Horsham, PA: Institute for Safe Medication Practices; 2024. Available from: https://www.ismp.org

C. Joint Commission International. *Joint Commission International accreditation standards for hospitals: including standards for academic medical center hospitals*. 8th ed. Oak Brook (IL): Joint Commission International; 2024.

Attachments

A _ Libre Pro Sensor.pdf

B_ Dose Conversion References.pdf

C_ Inhaled Epoprostenol Dosing Delivery Chart.pdf

- D_ Commonly Used Pediatric Weight-Based Formulary.pdf
- E IV PUSH IV INFUSION MEDICATION LIST 9.2023 DRAFT WITH PROCEDURAL.docx
- F_ Unapproved Abbreviations.pdf
- G_ Intravenous Medications Monitoring and Restrictions.pdf
- H_ Standardized Medication Administration Time Catch Up Chart.pdf
- I_Standardized Medication Administration Times.pdf

Approval Signatures

Step Description	Approver	Date
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
Pharmacy & Therapuetics	Kiri Golleher: Pharmacy Clinical Coordinator	10/2025
Pharmacy & Therapuetics	Genevieve delos Santos: Director Pharmacy	09/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	09/2025

Standards

No standards are associated with this document

Attachment B
Medical Staff Excellence Committee (MSEC) Charter

The Medical Staff Excellence Committee (MSEC) is responsible for evaluating and improving Medical Staff and Advanced Practice Provider performance in the following areas:

- Technical Quality: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
- Patient Safety/Patient Rights: Cooperation with patient safety and rights, rules and procedures
- Resource Use: Effective and efficient use of Hospital resources
- In defining Medical Staff / Advanced Practice Provider indicators the following processes will be evaluated:
    - Patient Care
    - Knowledge based practice
    - Systems based practice
    - Interpersonal
    - Practice based learning
    - Professionalism

The following areas are considered outside the Committee's scope:

- Individual Medical Staff / Advanced Practice Provider member behavior incidents
- Credentialing and privileging recommendations
- System issues or concerns related to Health Information Management, Utilization Management, Blood Management, Medication Formulary and other policies requiring Medical Staff approval.

Responsibilities

Evaluation of Individual Cases

- Perform initial review of all cases requiring Medical Staff / Advanced Practice Provider member peer review. Cases are identified based on review indicators, ongoing Departmental audits or through referrals to Medical Staff Services or directly to MSEC.
- Obtain reviews and recommendations from internal or external specialists when required.
- Communicate with the practitioner involved with the case to obtain input prior to making determinations.
- Make recommendations regarding facility performance improvement (PI) opportunities based on individual case review.

Evaluation of Rate and Rule Indicators

- Perform regular review of adverse patterns, trends and outlier status for rate indicators relevant to all dimensions of practitioner performance. The purpose of this review is to determine if additional analysis or focus reviews are needed. This function may be delegated to an individual member of the committee or to a subcommittee.
- Identify performance improvement opportunities if additional analysis or focus reviews are needed and refer to the appropriate Hospital committee.

External Peer Review

Either the MSEC or MEC will make determinations on the need for external peer review. No practitioner can require the Medical Staff to obtain external peer review if it is not deemed appropriate by the MEC or MSEC. Circumstances for external peer review may include:

- Litigation - when dealing with the potential for a lawsuit.

- Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
- Lack of internal expertise – When no one on the Medical Staff has adequate expertise in the specialty under review;
- When the only practitioners on Medical Staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as describe above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the MSEC, MEC or Board of Directors or adequately mitigated.

The role of the MSEC is to assure that when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed. This will be accomplished through the following:

- Communicate individual improvement opportunities to the appropriate Department Chair, who with the assistance of the MSEC Chair or designee, develops an improvement plan.
- Communicate system improvement opportunities to the appropriate Hospital committee/personnel.
- Track responses and improvement plans as requested/required.
- Report to the MEC regularly regarding actions taken to improve care. If a practitioner does not respond to requests from the MSEC or the Department Chair for meeting or discussion regarding the need for performance improvement, this lack of response will be forwarded to the MEC for further actions. This lack of response will be incorporated in to the final case summary.

Measurement System Management

- Review department specific indicators with Department Chairs at least annually to determine if revisions are necessary. Medical Staff Services reviews and evaluates screening tools and referral systems ongoing for effectiveness in collaboration with the Department Chairs and recommends changes to the MSEC and MEC.
- In coordination with the Department Chairs and Credentials Committee, define the appropriate content and format for performance feedback reports.
- Requests for modification of indicators, criteria or focused studies for evaluating practitioner performance will be submitted to Medical Staff Services who will then submit for MSEC review and approval.

Membership

The Chair of the MSEC will be appointed by the Chief of Staff and approved by the MEC for a term of two years. The Chair may serve an unlimited number of consecutive terms. The Chair will be an ex-officio member of the MEC without vote.

The MSEC will be comprised of the Chair and representatives from each of the following Service Lines:

- 3 Representatives: Medicine and Primary Care Services (Medicine, Cardiology, Family Practice, Emergency Medicine). At least one representative will be from the Hospitalist Service.
- 3 Representatives: Operative and Procedural Services (Surgery, GYN, Gastroenterology, Interventional Cardiology, Anesthesiology, Radiology, Pathology).
- 2 Representatives: Women's and Children's Services (Obstetrics, Pediatrics, Family Medicine with OB and/or Pediatric privileges).
- Three additional at large representatives, one of which will be an Advanced Practice Provider practitioner, will be appointed to enhance the specialty balance and expertise available to the committee. Medical Staff members from other specialties may be requested to review cases and be invited to the meeting as needed when the committee does not have the Medical Staff expertise with current members.

Ex-officio members of the MSEC may include the Chief of Staff, Chief Clinical Officer, and Medical Staff Services support staff, without voting rights.

The MSEC members will be recommended by the Chief of Staff in consultation with the MSEC Chair and Department Chairs and approved by the MEC. Voting members are appointed from the active, provisional or consulting staff categories and will serve for a three-year term.

Committee members who wish to be removed will send a written request to their respective Department Chair or to the MSEC Chair. The Department Chair or MSEC Chair will notify the Chief of Staff with recommendations for replacement.

Committee members will be expected to attend at least two thirds of the committee meetings over a twelve-month period to maintain membership and to participate in educational programs to increase their knowledge and skills in performing the Committee's responsibilities.

Meetings

The committee will meet at least 10 times per year with a summary of the meeting reported to the MEC. A quorum for purposes of making case determinations will be based on the presence of 50% of the voting seated committee members for which there are filled seats.

Reporting

The MSEC will report to Medical Executive Committee.

Attachment C: Case Review Process

Action	Case Review Process	Timeline - Guidelines
Case Identification	Screening Worklists: Patient case review worklists for appropriate review are obtained from a Hospital database system. Referrals: Referrals from occurrence reports, Case Management, patient relations, or other formal or informal requests for review are preliminarily screened to determine if they qualify for case review based on Medical Staff review indicators.	Worklists are run by the Medical Staff Services Department (MSS) for discharges occur within a given month within 3 weeks after the end of that month. Cases referred within 2 days of receipt of referral by the appropriate department and are preliminarily screened within 2 working days of receipt.
Case Screening	Cases are reviewed to determine if peer review is required. If peer review required, the MSS completes the initial section of the case review form, including providing the reviewer with a brief case summary of key clinical milestones and identification of key questions for the reviewer. If the MSS needs clarification of the Medical Staff review criteria, it will contact the MSEC Chair or designee. If the Chair feels a case does not meet current review indicator criteria but is of sufficient concern, the Chair will present the issue to the MSEC which will determine whether the case qualifies for review.	MSS will perform the initial screen and determine the need for peer review following identification of or receipt of a case referral. Potential cases for review not meeting current review indicators will be presented at the next MSEC meeting to determine if the issue qualifies for case review and whether a new or modified review indicator should be adopted to handle similar cases in the future.
MSEC Reviewer Assignment	Cases will be assigned for initial review as appropriate by the MSS. Whenever possible, the number of cases to be reviewed will be equally distributed among all MSEC members.	MSS will assign the initial reviewer at the time of screening when case is determined to require MSEC review. Committee members are informed of their case reviews approximately two weeks prior to the scheduled committee meeting.
MSEC Review	The assigned MSEC reviewer will review the case and complete required sections of the peer review module for the individual whose care is being reviewed. If the review is not completed, the MSS will contact the reviewer to obtain the additional information.	MSEC review will be completed within 14 days of assigning case to the reviewer. If the assigned reviewer is unable to perform the review within 14 days, the reviewer will contact the MSS within 1 week of the assignment.
Additional Review Needed	If the initial reviewer determines the case is solely a technical issue outside of the reviewer's expertise, the reviewer will inform the MSS and request the MSEC Chair, or designee to assign an appropriate second reviewer. The second reviewer will be a member of the committee if the committee has a member with the specific expertise without significant conflict of interest.	Second review to be completed within 14 days of assigning chart unless difficulty is encountered obtaining 2nd reviewer.

Action	Case Review Process	Timeline - Guidelines
Completed Case Review	Completed reviews will be submitted to the MSS by the MSEC reviewer immediately upon completion. Only completed peer review will be placed on the MSEC agenda. Late or incomplete reviews will be deferred to the next meeting.	Case reviews completed by MSEC reviewers submitted to the MSS department past the required 14 day completion timeframe (less than two business days/end of business on Friday before the Tuesday committee meeting prior to the MSEC will be reported to the MSEC Chair. Late completion will be tracked.
Initial Reviews Rated Quality of Care Appropriate	Reviews indicating appropriate provider care are reported to the MSEC for summary approval. The MSEC Chair will review the summary of these cases with the peer review support staff prior to the committee meeting. If there are any concerns with the scoring, the chair will discuss the case with the reviewer. If any concerns still exist, the case will be presented to the MSEC for discussion.	Reviews indicating appropriate physician care are approved at the meeting.
Initial Reviews Rated Opportunity for Improvement, Inappropriate Care or Reviewer Uncertain	Reviews indicating potential inappropriate care or reviewer uncertain and desires committee input are presented to the MSEC for discussion and confirmation or change in preliminary scoring. If the committee feels that care may be inappropriate or an opportunity for improvement exists, it will communicate with the involved practitioner(s) via secure email. The involved physician or advanced-practice provider is informed of the key questions regarding the case and asked to respond in writing only.	Individual under review will respond to committee within 2 weeks. If no response, the provider will be notified (rule violation for non-response to MSEC request) and the committee will finalize rating based on the available information. The MSS department will contact the provider by phone if failed to respond to determine if provider was unavailable due to special circumstances.
Additional Clarification from the Provider	If after the initial written response, the MSEC determines it needs further clarification, it may request the practitioner for a second written response.	Clarification responses will be provided by the next MSEC meeting or the MSEC may finalize rating based on the available information.
Committee Final Disposition for Cases with Inquiry Letters	Following receipt of the provider's response or, if the response timeframe has lapsed, the MSEC will make the final determination of the overall provider care and, if the care is rated outside of current practice standards, identify the provider care issues. The MSEC will also determine whether the communication back the individual provides sufficient education for improvement. If additional education is deemed necessary, MSEC will involve the Department Chair as described below.	Final case determinations will be made by collective agreement of the MSEC members.
Communicating Findings to Individuals	Reviewed physicians or Advanced Practice Providers are informed of the decision by send secure email.	Outcome letters are sent to physician or Advanced Practice Provider within 30 days of the MSEC meeting. .

Action	Case Review Process	Timeline - Guidelines
Tracking Review Findings	The MSS Department will enter the results of all final review findings into the database for tracking.	Case outcomes are tracked in individual physician/Advanced Practice Provider report cards in the peer review database.
Improvement Plan Development	If the results of either case reviews or analysis of rate or rule indicator trends indicate a need for individual provider performance improvement, the issue will be referred to the appropriate Department Chair. The MSEC Chair and the Department Chair, and if requested, the CMO, will work together to create and implement the improvement action plan.	The Department Chair and the MSEC Chair will create and implement the improvement plan within 30 days of the MSEC decision, or as soon as reasonably possible. When requested by the committee, the MSS Department will track the improvement implementation and the date implemented and will report back to the MSEC. A 6-month follow up will be sent from MSEC to the Department Chair to determine if further action is needed or if the event that triggered the action plan has been resolved.
Medical Executive Committee involvement	If MSEC Chair or Department Chair need assistance with the improvement, they will discuss the issue with the MEC Chair for resolution. Recommendations that may result in "adverse action" (*e.g.*, restriction of privileges or membership) will be addressed in accordance with procedures in the Medical Staff Bylaws and Rules.	The MSEC Chair will discuss any need for assistance with the MEC Chair within 30 days of the MSEC decision.
Referrals to Quality and Safety Committee	For those cases determined to have potential opportunities for improving system performance or potential issues with nursing care, the MSEC Chair will communicate the issue to the appropriate Hospital committee or person.	The Hospital committee or person receiving the referral will discuss the issue and communicate action plan to the MSEC committee.
High-Risk Cases	For cases meeting the organizations sentinel event criteria, timely processing of practitioner-specific information is necessary to ensure patient safety. Sentinel Events requiring peer review, will have immediate review by the MSEC Chair or designee. Additional information (such as a literature search, second opinion, or external peer review) may be necessary before making a decision on action.	Initial MSEC review will be performed within three (3) working days of case identification, with committee discussion at the next MSEC meeting or within 30 days of the event if there is not regularly scheduled meeting within 30 days. If additional information is needed, the timelines may be extended after approval from the Governing Body or its designee or the MEC.

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