December 12, 2025

AMENDED NOTICE

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 annual meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, DECEMBER 18, 2025, AT 4:00 P.M., DOWNING RESOURCE CENTER, CONFERENCE ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA and CAM. DEL LAGO S/N, 59750, TANGANCICURARO DE ARISTA, MICHOACAN, MEXICO.**

(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

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

THURSDAY, DECEMBER 18, 2025, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C,
Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California, &
Cam. Del Lago S/N, 59750, Tangancicuaro de Arista, Michoacan, Mexico

(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.	**ANNUAL BOARD OF DIRECTORS REPORT**	*Joel Hernandez Laguna*
5.	**AWARDS & RECOGNITION**	*Allen Radner, M.D.*
6.	**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*
7.	**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 November 20, 2025
B. Policies/Plans Requiring Approval
    1. Cybersecurity Governance
    2. Cybersecurity Risk Management
    3. Incident Response & Disaster Recovery
    4. Informatics & IT Change Control
    5. PCI Security Compliance
    6. Scope of Service: Education Department
    7. Vulnerability Management

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

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

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

9. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE *Catherine Carson*

Minutes of the December 15, 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 December 16, 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 APPROVAL OF MEMORANDUM OF UNDERSTANDING BETWEEN SVH AND HARTNELL COMMUNITY COLLEGE DISTRICT TO PROVIDE A GRANT IN THE AMOUNT OF $1,473,000.00 OVER A THREE (3) YEAR PERIOD TO SUPPORT THE HARTNELL COLLEGE NURSING PROGRAM.**
   - 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 December 15, 2025 Finance 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 OVERALL PROJECT FUNDING AND AWARD CONSTRUCTION CONTRACT TO AMERICAN CHILLER SERVICE, INC FOR THE SALINAS VALLEY HEALTH DRC CHILLER & COOLING TOWER REPLACEMENT PROJECT**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF DECEMBER 11, 2025 AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Alison Wilson, D.O.*

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

B. Policies/Procedures/Plans and Agreements Recommended for Approval:
   1. Adult Parenteral Nutrition Protocol – Updated

C. Other Items (Informational)
   1. Medical Staff Bylaws Administrative Clarification Article 3.2.3 – Updated language to identify low volume providers.
   2. Advanced Practice Provider Rules and Regulations – Update to align with changed in California Stat regulations

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

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

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

13. ADJOURNMENT *Joel Hernandez Laguna*

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, January 22, 2026, 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 831-759-3208 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, DECEMBER 18, 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
    - Quality & Safety Board Dashboard Review
    - Consent Agenda
        - Update: Recruitment of Director of Quality and Safety

REPORT INVOLVING TRADE SECRET

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

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

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

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION

(Meeting Chair)

ANNUAL
BOARD OF DIRECTORS REPORT

(Board President)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
NOVEMBER 20, 2025

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

Absent: None.

Also Present:
Allen Radner, M.D., President/Chief Executive Officer
Alison Wilson, D.O., Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Hanna Hitchcock, Esq.

Isaura Arreguin arrived at 5:51 pm.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:05 p.m. in the Cislini Plaza Board Room.

1.1 PROPOSED ADDITION TO THE AGENDA

A request was made by President Hernandez Laguna pursuant to Government Code Section 54954.2(b)(2) to add an item to the Open Session Consent Agenda. The matter requires immediate action and the need for action came to the attention of the Board subsequent to the posting of the Agenda. The addition would be *Item 6. C. Consider Resolution 2025-04 Authorizing Designated Officers to Execute Financial Institution Documents.* Copies were provided for all Board members.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:
Upon motion by Director Carson and second by Director Dr. Cabrera, citing the need to add one (1) Open Session Consent Agenda item which came to the attention of the Board Meeting subsequent to the Board Agenda being posted, the Board of Directors approves adding to the Consent Agenda *Item 6. C. Consider Resolution 2025-04 Authorizing Designated Officers to Execute Financial Institution Documents*.

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

Motion Carried

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

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Hearings and Reports, (2) Conference with Legal Counsel – Anticipated Litigation – Attorney General of the State of California (3) Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, and (4) Public Employee Performance Evaluation: President/CEO*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:07 p.m. The Board completed its business of the Closed Session at 4:31 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:34 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Hearings and Reports, and (2) Conference with Legal Counsel – Anticipated Litigation – Attorney General of the State of California.* The Board received and accepted the reports listed on the Closed Session agenda. No other reportable action was taken.

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

4. AWARDS AND RECOGNITION

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

- **DAISY Award: Lizette Rosales, BSN, RN:** Carla Spencer, CNO, introduced Lizette Rosales who was nominated by a fellow Staff Nurse for her exceptional care. Lizette was recognized for going above and beyond in the care of the patient and the patient's family. Her fellow staff nurse commended Lizette as a hero.
- **AOHP Hospital Award & Scholarship:** Michelle Barnhart Childs, CHRO, reports that The Association of Occupational Health Professionals (AOHP) honored Salinas Valley Health for exemplary work to promote health, safety and well-being of our employees. Michelle also introduced Jill Peralta-Cuellar, BSN, RN, PHN, COEE, who received the Joyce Safian Scholarship Award.
- **Community Flu Clinics & TFFHWC 10th Anniversary:** Tiffany DiTullio, Vice President, Partner and Community Relations, reported on the total number of vaccines administered and the success of the Taylor Farms Family Health & Wellness Center anniversary celebration. She specially recognized the Employee Health team and partner community organizations for their support of the clinics.
- **Epic Launch:** Dr. Radner spoke about the Epic Go-Live on November 8 and commended staff engagement for making this Go-Live a success. Special thanks to Josh Rivera, Alysha Hyland, Carla Spencer, and Clement Miller for their work on the Epic Go-Live.
- **Quality Recognition:** Director Carson announced SVH has received the following awards: "A" Hospital Safety Grade from The Leapfrog Group, and 5-Star Rank from The Centers for Medicare & Medicaid Services. Director Carson also specially recognized Aniko Kukla for her excellent work in this area.

5. PUBLIC COMMENT: None.

6. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following policy has been removed for consideration from the published Consent Agenda: (1) Medical Waste Management Plan. This policy will return for consideration at a later date.

Recommend Board Approval of the Following:

A. Minutes of the Regular Meeting of the Board of Directors 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. Mobile Device Management for Workday Mobile App
    9. Obstetrical Care Standards: Assessment and Documentation
    10. Patient Registration - Patient Identification - TFFHWC
    11. Percutaneous Ventricular Assist Device Implantation (Clinical)
    12. Refund: Taylor Farms Family Health & Wellness Center
    13. Scope of Service: Diagnostic Imaging
    14. Secure Configuration
    15. Small Balance Adjustment - TFFHWC
    16. Spiritual Care Services
    17. Tuition Assistance

C. Resolution 2025-04 Authorizing Designated Officers to Execute Financial Institution Documents

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

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

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

Motion Carried

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: Director Dr. Cabrera recognized fellow Director Isaura Arreguin for completing the Leadership Monterey County program. He also applauded the Epic rollout and wished everyone a Happy Thanksgiving.
Director Catherine Carson: Director Carson congratulated the whole organization on the Epic installation. She commented that out of all the electronic health record systems she has seen throughout the years, SVH's Epic implementation is the best one yet.
Director Victor Rey, Jr.: Director Rey reported that he attended the SVH Foundation Mixer to kick off the "Every Minute Matters" campaign to fundraise for a state-of-the-art Emergency Department and he

thanked the Foundation for hosting the event. Director Rey also reported that he attended an event with the Pebble Beach Foundation where the SVH Foundation was presented with the funds raised from the Concours d'Elegance event.

Director Isaura Arreguin: None.

Director Hernandez Laguna: Director Hernandez Laguna shared that he had a positive conversation with the Mayor of Salinas Dennis Donohue regarding the Prinnovo innovation venture. He also commended SVH for its continued commitment to Medi-Cal enrollment. He applauded the Epic rollout and the success of the Gonzales vaccine clinic. Director Hernandez Laguna also reported that he participated on a panel for the Salinas Inclusive Economic Development Initiative.

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 November 10, 2025 meeting were provided for Board review. Director Carson stated the presentations were: (1) Patient Care Services update on the Perioperative Services Unit Based Practice Council, (2) Perioperative Services and ERAS program updates, (3) Women's and Children's Services report, and (4) Age Friendly Program Update. 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 & Investment Committee. The minutes of the November 10, 2025 meeting were provided for Board review.

The following recommendations were made.

1. **CONSIDER RECOMMENDATION FOR BOARD 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**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Hernandez Laguna noted the importance of Dr. Cervantes having a long history of serving patients in California and commented that Dr. Cervantes is bilingual.

MOTION:

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

1. The Findings Supporting Recruitment of Armando Cervantes, M.D.:
   - That the recruitment of a family medicine 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. Cervantes; and
3. The Contract Terms of the Family Medicine Professional Services Agreement for Dr. Cervantes.

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

Motion Carried

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**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Dr. Cabrera thanked Michelle Barnhart Childs for her clear presentation on this item.

MOTION:

Upon motion by Director Dr. Cabrera, and second by Director Rey, the Board of Directors approves the following presented items:

1. Amendment to the Salinas Valley Memorial Healthcare System 403(b) Retirement Plan
2. Amendment to the Salinas Valley Memorial Healthcare System 403(b) Tax Deferred Salary Reduction Plan
3. Amendment to the Salinas Valley Memorial Healthcare System 457(b) Retirement Plan
4. 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(b) Deferred Compensation Plan.

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

Motion Carried

C. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the November 17, 2025 meeting were provided for Board review. The Financial Reports of the meeting were included in the packet for review (informational). There are no recommendations.

D. CORPORATE COMPLIANCE & AUDIT COMMITTEE

A report was received from Director Hernandez Laguna regarding the Corporate Compliance & Audit Committee. The minutes of the November 12, 2025 meeting were provided for Board review.

The following recommendations were made.

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**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:
Upon motion by Director Carson, and second by Director Rey, the Board of Directors approves the years ended 2025 and 2024 draft audited financial statements for Salinas Valley Memorial Healthcare System.

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

Motion Carried

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**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Hernandez Laguna commended the finance team for their work during the audits.

MOTION:
Upon motion by Director Carson, and second by Director Rey, the Board of Directors approves the years ended 2024 and 2023 draft audited financial statements for Salinas Valley Memorial Healthcare District Employee's Pension Plan.

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

Motion Carried

E. COMMUNITY ADVOCACY COMMITTEE

A report was received from Director Cabrera regarding the Community Advocacy Committee. The minutes of the November 5, 2025 meeting were provided for Board review. Director Cabrera stated the presentations were: (1) Medi-Cal Enrollment Changes Community Impact and SVH Advocacy Strategy, (2) Salinas Valley Health Foundation Update, and (3) SVH Mobile Clinic Vaccines for Children (VFC) Program Report. There are no recommendations.

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

Alison Wilson, D.O., Chief of Staff, reviewed the reports of the Medical Executive Committee (MEC) meeting of November 13, 2025. A full report was provided in the Board packet. The MEC recommends for Board Approval the following Reports and Policy as listed on the Agenda.

It was noted the following policies have been removed for consideration from the published Agenda under Item 9(B) Policies/Procedures/Plans and Charter Recommended for Approval: (1) Adult Parenteral Nutrition Protocol, and (2) Information Management Program Plan. These policies will return for consideration at a later date.

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 policies as follows:

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. DI Thoracentesis Under Ultrasound Guidance
   2. Employee Exposures & Prevention Plans: Specific Disease Exposures and Work Restrictions
   3. Inpatient Criteria for Chemotherapy and Immunotherapy Administration
   4. Medication Use
   5. Medical Staff Excellence Committee (MSEC) Charter

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

Motion Carried

10. EXTENDED CLOSED SESSION
President Hernandez Laguna announced items to be discussed in Extended Closed Session are *(1) Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Public Employee Performance Evaluation: President/CEO.* The meeting recessed into Closed Session under the Closed Session Protocol at 5:30 p.m. The Board completed its business of the Closed Session at 6:53 p.m.

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION
The Board reconvened Open Session at 6:55 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *(1) Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, and (2) Public Employee Performance Evaluation: President/CEO.* No action was taken.

12. ADJOURNMENT
The next Annual Meeting of the Board of Directors is scheduled for **Thursday, December 18, 2025, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:55 p.m.

_____
Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors

From: Brenda Inman, VP Quality and Risk

Date: December 18, 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.	Cybersecurity Governance	New policy. Policy Committee added details to references and moved education statements to general information.	Alysha Hyland, CAO
2.	Cybersecurity Risk Management	New policy. Policy Committee added details to references.	Alysha Hyland, CAO
3.	Incident Response & Disaster Recovery	New policy. Policy Committee edited education statement.	Alysha Hyland, CAO
4.	Informatics & IT Change Control	New policy. Policy Committee edited education statement. Definitions cleaned up. CAB voting structure updated.	Alysha Hyland, CAO
5.	PCI Security Compliance	New policy.	Alysha Hyland, CAO
6.	Scope of Service: Education Department	Annual review. Typo corrected. Org chart updates. Formatting corrected. Staff titles updated.	Carla Spencer, CNO
7.	Vulnerability Management	New policy.	Alysha Hyland, CAO

Status **Pending** PolicyStat ID **18863231**

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

Cybersecurity Governance

I. POLICY STATEMENT

A. Salinas Valley Health shall maintain a cybersecurity program that implements practices and standards designed to safeguard the confidentiality, integrity, and availability of all records and information systems under its responsibility.

II. PURPOSE

A. This policy defines and governs the Cybersecurity Program of Salinas Valley Health. The program is responsible for developing, implementing, and reporting on the processes, controls, and standards necessary to manage cybersecurity risk across the organization. Managing these risks safeguards the organization's operations and ensures compliance with applicable regulatory requirements.

B. The core goal of cybersecurity is the effective management of risk inherent to information systems and technology. Achieving this requires an integrated approach that combines people, processes, and technology. Success depends on a collective commitment to objective standards and adherence to guiding principles that direct cybersecurity decisions and practices.

C. Guiding principles of the Salinas Valley Health Cybersecurity Program:

1. Maintain Risk at Acceptable Levels
    a. Cybersecurity risk shall be continuously identified, assessed, and managed to remain within levels acceptable to the organization.
2. Ensure Visibility of Risk.
    a. Cybersecurity risks shall be measured, monitored, and reported so that the executive team and governance bodies have clear and timely visibility.
3. Balance Security with Operations

a. Cybersecurity practices shall incorporate awareness of clinical, business, and operational needs to ensure protections support without hindering core services.

4. Engage Stakeholders in Decisions
    a. Appropriate stakeholders, including executive leadership, compliance, informatics, and operational leaders, shall be involved in significant cybersecurity decisions.

5. Plan, Communicate, and Improve
    a. Cybersecurity strategies and plans that affect operations shall be clearly documented, communicated, maintained, and improved through continuous review.

6. Manage Resources Effectively
    a. Cybersecurity activities shall effectively leverage available resources, time, and technology to maximize organizational resilience.

7. Prioritize High-Risk Areas
    a. A baseline level of security shall be established across the enterprise, with focused attention and enhanced controls applied to the highest-risk areas.

8. Adopt Zero Trust Principles
    a. Enforcement of appropriate and least-privilege access.
    b. Network and system segmentation appropriate to risk.
    c. Assumption of potential compromise in design and monitoring.
    d. Rigorous verification and validation of users, devices, and activities.

III. DEFINITIONS

A. **Availability** – The assurance that information and systems are accessible and usable upon demand by an authorized person.

B. **Business Associate Agreement (BAA)** – A written contract between Salinas Valley Health and a third party that will process, store, or transmit protected health information (PHI) on behalf of the organization, as required by HIPAA.

C. **CIS Controls v8** – A prescriptive framework of technical safeguards and best practices maintained by the Center for Internet Security, used by Salinas Valley Health as the primary control set to support implementation of the NIST Cybersecurity Framework.

D. **CIRCIA (Cyber Incident Reporting for Critical Infrastructure Act of 2022)** – Federal law requiring covered entities in critical infrastructure sectors, including healthcare, to report certain cybersecurity incidents and ransomware payments to the Cybersecurity and Infrastructure Security Agency (CISA).

E. **Confidentiality** – The property that data or information is not made available or disclosed to unauthorized persons or processes.

F. **Cybersecurity Governance** – The framework of policies, standards, procedures, and oversight activities that direct and control how cybersecurity is managed across the organization.

G. **Cybersecurity Key Performance Indicators (KPIs)** – Metrics used to measure the performance and effectiveness of cybersecurity processes or controls (e.g., patching timeliness, phishing click rate).

H. **Cybersecurity Key Risk Indicators (KRIs)** – Metrics used to measure exposure to risk or the likelihood of adverse cybersecurity events (e.g., number of unmitigated high vulnerabilities, number of unauthorized access attempts).

I. **Exception** – A documented and approved deviation from an established cybersecurity policy, standard, or control, following the organization's risk management process.

J. **HIPAA Security Rule** – Federal regulation (45 CFR §164.302–318) that establishes standards to protect the confidentiality, integrity, and availability of electronic protected health information (ePHI).

K. **HITECH Act** – Federal law that promotes the adoption and meaningful use of health information technology and strengthens HIPAA privacy and security protections.

L. **HHS 405(d) (Health Industry Cybersecurity Practices: Managing Threats and Protecting Patients)** – Federal guidance developed under Section 405(d) of the Cybersecurity Act of 2015, providing practical cybersecurity best practices for the healthcare sector.

M. **HPH Cybersecurity Performance Goals (CPGs)** – Cybersecurity best practices published by the Department of Health and Human Services for the Healthcare and Public Health sector.

N. **Integrity** – The property of safeguarding the accuracy and completeness of data and information processing.

O. **Maturity Scoring** – The process of evaluating the organization's cybersecurity practices against a defined maturity model (e.g., NIST CSF Implementation Tiers) to measure progress over time.

P. **NIST Cybersecurity Framework (CSF) 2.0** – A voluntary framework developed by the National Institute of Standards and Technology that provides an overarching structure for managing and improving cybersecurity risk.

Q. **NIST SP 800-53r5** – A catalog of security and privacy controls for federal information systems and organizations, referenced by Salinas Valley Health for additional guidance in control selection.

R. **NIST SP 800-66r2** – Implementation guidance for the HIPAA Security Rule, published by the National Institute of Standards and Technology.

S. **ONC Security Risk Assessment (SRA) Tool** – A tool published by the Office of the National Coordinator for Health IT (ONC) and the Office for Civil Rights (OCR) to help covered entities assess risks to ePHI.

T. **Protected Health Information (PHI)** – Individually identifiable health information, including demographic and clinical data, that relates to the past, present, or future health condition of an individual and is regulated under HIPAA.

U. **Residual Risk** – The remaining level of risk after security measures and controls have been applied.

V. **Risk Acceptance** – Formal acknowledgement and approval by authorized leadership to tolerate a specific level of residual risk.

W. **Risk Register** – The official record maintained by Salinas Valley Health that identifies, tracks, and manages cybersecurity risks, their evaluations, mitigations, and acceptance status.

IV. GENERAL INFORMATION

A. The intent of this document is to establish the governance framework for cybersecurity activities across the organization, ensuring that roles, responsibilities, policies, and oversight processes are clearly defined and consistently applied.

B. Governance – The Cybersecurity Awareness & Training Management Policy establishes detailed requirements for workforce cybersecurity education, including frequency, delivery methods, and content.

C. Expectations – At a minimum, all workforce members shall complete security training upon hire and annually thereafter. Role-based training shall be provided for staff with elevated or specialized responsibilities (e.g., system administrators, executives).

D. Awareness Activities – Ongoing awareness efforts, such as phishing simulations or targeted campaigns, shall be conducted periodically to reinforce learning.

E. Compliance Alignment – These requirements support the HIPAA Security Rule §164.308(a)(5), which mandates a security awareness and training program for all workforce members.

V. PROCEDURE

A. **Management**

1. Under the general direction of the HIPAA Security Officer, the Director of Information Technology is responsible for the management of the Cybersecurity Program and staff assigned to cybersecurity.
2. A cybersecurity governance committee is to be established to include stakeholders from the Executive team, IT, Informatics, and Compliance. This committee is to meet at least quarterly or as needed. The committee serves as a review for general direction and recommendations for the security program. Decisions that have a high impact to the organization should be escalated to the executive team for review. Changes adopted should be saved for awareness according to Change Management Policy.
3. The Chief Administrative Officer, having responsibility over IT & Informatics, is responsible for reporting to the executive team and the Board of Directors on the state and performance of the Cybersecurity Program at least annually. This report shall include performance tracking, future objectives, and a review of resource needs. In addition, outstanding exceptional and very-high risks from the risk register shall be reported to the Board of Directors as part of the annual Cybersecurity Program review.

B. **Performance Management**

It is the expectation of the executive team that the Cybersecurity Program will continuously mature, standardize, measure, and improve its ability to manage measured risk. To support

this expectation, the Cybersecurity Performance Indicator Standard shall publish the organization's key performance indicators (KPIs) and key risk indicators (KRIs) for cybersecurity.

1. **Internal Assessments**
    a. Selected Key Performance and Risk Indicators (KPI)(KRI) should be published with other security standards and reviewed for updates and process improvement at least annually.
        i. KPI/KRI metrics are to be reported quarterly to the cybersecurity governance committee, though some underlying assessments will only be performed annually.
        ii. Selected KPI and KRI must cover each of the major cybersecurity domains.
        iii. The removal of formally tracked KPI must be approved by the cybersecurity governance committee.
    b. Status of implementation of selected security controls is to be tracked and reported quarterly.
    c. Status of implementation of selected/required standards is to be tracked and reported quarterly.
    d. Status of vulnerabilities is to be tracked and reported monthly.
2. **External Assessments**
    a. An annual security assessment must be completed by a reputable third-party company.
        i. The scoring of the security program's maturity against selected standards should be assessed.
        ii. This assessment should include any required regulatory compliance assessments.
    b. A penetration test (or equivalent red/blue/purple team exercise) using external assessors should be conducted annually.
        i. May or may not be included in the general external assessment.
3. General progress and status should also be updated at least quarterly to the Chief Administrative Officer.

C. **Cybersecurity Policy, Procedure, and Standards Enforcement**

1. **Exceptions**
    a. Exceptions to SVH cybersecurity policies may be approved by members of the Executive Team for systems under their responsibility.
    b. All exceptions must be documented in writing and processed through the Cybersecurity Risk Management policy and procedure.
    c. The Cybersecurity Risk Management policy governs enforcement,

exception handling, and risk acceptance activities.

d. All approved exceptions will be tracked for review by the Cybersecurity governance committee and management.

2. **Violations**

a. Violations of cybersecurity policies by individuals shall be reported to department directors or the Executive Team, as appropriate.

b. Repeated or negligent violations are subject to discipline under the SVH Discipline Administration Policy.

c. Intentional circumvention of security controls constitutes a serious violation and is subject to disciplinary action up to and including termination.

D. **Policies**

1. The cybersecurity program is required to develop, implement, and maintain a set of policies, standards, and procedures that collectively govern the organization's cybersecurity practices. These shall be developed in alignment with the domains listed below and phased. Where policies do not yet exist, interim controls shall be documented and used until formal policies and standards are approved.
2. The development and approval of these policies shall be prioritized according to organizational risk, with foundational governance, risk management, asset management, secure configuration, and incident response policies implemented first, followed by supporting domain policies and documents.

a. Cybersecurity Risk Management

b. IT Hardware & Software Asset Management

c. Data Protection & Classification Management

d. Secure Configuration Management

e. Identity & Access Management

f. Vulnerability Management

g. Log & Auditing Management

h. Security Technology Management

i. Disaster Recovery & Incident Response Management

j. Network Infrastructure Management

k. Cybersecurity Awareness & Training Management

l. Service Provider & Supply Chain Cybersecurity Management

m. Development Security

n. Performance Indicator Standard

3. This governance policy and the listed policies will supersede any conflicting or prior policies, procedures, or standards where there are any conflicts related to cybersecurity. Where older documents are identified, they should be brought to the

attention of the Cybersecurity Risk Manager for reconciliation.

4. These Policies must be posted with other organizational policies along with links to the locations of supporting plans, standards, and procedures which are to be maintained and improved over time. This policy and other cybersecurity polices are required to be reviewed at the frequency determined by the SVH Policy and Procedure Management Policy or more frequently as needed for operational improvements and regulatory changes.
5. Protecting privacy and confidentiality is a core objective of the Cybersecurity Program. In cases of overlap, policies under the authority of the Privacy Officer take precedence on matters of privacy, while cybersecurity policies govern technical and operational security controls.

E. **Framework**

1. Salinas Valley Health adopts the NIST Cybersecurity Framework (CSF) 2.0 as the overarching structure for its Cybersecurity Program. The CSF shall guide the development, implementation, and management of cybersecurity policies, standards, and procedures.
2. Because the CSF does not prescribe specific technical controls, Salinas Valley Health also adopts the CIS Controls (v8) as the primary control set to support implementation of CSF functions and categories.
3. Where risks extend beyond the scope of the CSF or CIS Controls — such as medical device management or other specialized domains — additional frameworks (e.g., NIST SP 800-53, HHS 405(d), FDA guidance) may be referenced to inform control selection.
4. The selection of these frameworks is intended to guide the development of a Cybersecurity Program that supports Salinas Valley Health's needs for risk management, regulatory compliance, and operational effectiveness, while allowing tailoring to the organization's unique environment.
5. Governance authority resides with Salinas Valley Health's senior management and its approved policies, standards, and procedures rather than with the external frameworks themselves. Compliance is measured against these approved documents as well as interim controls established under D.1.

F. **Stakeholders**

1. The specific needs and expectations of Salinas Valley Health stakeholders are to be considered in the creation of cybersecurity policies and controls.
    a. Patients - Ensure the confidentiality of health information and the availability of clinical and patient-facing systems.
    b. Community - Preserve organizational trust and reputation through effective cybersecurity practices.
    c. Providers & Staff - Support the availability and reliability of systems necessary for clinical and business operations.
    d. Referring Providers - Provide secure, appropriate access and reliable delivery of patient data.

e. Administration - Maintain operational continuity, regulatory compliance, and effective risk reduction.

f. Partners & Vendors– Ensure that third-party systems and services meet security and availability requirements.

G. **Compliance Intent**

1. It is the intent of this policy and the Cybersecurity Program to ensure that Salinas Valley Health's cybersecurity controls and practices are aligned with applicable legal and regulatory requirements. Specifically, this policy seeks to:

    a. Safeguard ePHI by selecting and implementing security practices and controls that adequately protect confidentiality, integrity, and availability.

    b. Guide compliance strategies that are appropriate to the size, complexity, and structure of the organization.

    c. Apply best practices in the development and implementation of a risk management program.

    d. Maintain documentation that demonstrates effective compliance with the HIPAA Security Rule and related regulatory requirements.

H. **Legal and Regulatory Framework for Cybersecurity**

1. Salinas Valley Health shall take applicable legal and regulatory requirements into consideration when creating cybersecurity policies, procedures, and controls. These include, but are not limited to:

2. Statutory and Regulatory Requirements

    a. HIPAA Security Rule

    b. HITECH Act

    c. Cyber Incident Reporting for Critical Infrastructure Act (CIRCIA) of 2022

3. Regulatory and Best Practice Guidance

    a. HHS 405(d) Health Industry Cybersecurity Practices (HICP)

    b. The Joint Commission requirements for information security and availability

    c. FDA guidance for medical device cybersecurity

    d. HHS Telehealth guidance for telemedicine

    e. Healthcare and Public Health (HPH) Cybersecurity Performance Goals

    f. NIST SP 800-66r2 (HIPAA Security Rule implementation guidance)

    g. NIST SP 800-53r5 (security and privacy controls for federal information systems)

    h. ONC Security Risk Assessment Tool

4. Contractual obligations

    a. Contractual requirements related to cybersecurity shall be incorporated

into SVH policies and controls, unless they are already exceeded by existing requirements. Vendor-specific requirements shall be documented in the standards or other system-specific documentation.

5. Privacy Requirements
    a. Legal requirements related to privacy often overlap with cybersecurity but are governed under separate privacy policies at Salinas Valley Health.

I. **Legal Requirement Mapping**

1. The Cybersecurity Program shall maintain and periodically review a control map that demonstrates how SVH cybersecurity policies, standards, and procedures meet or exceed the requirements of the HIPAA Security Rule and other applicable legal or regulatory obligations. This mapping is maintained in the "Cybersecurity Legal Control Mapping" document and serves as a reference for compliance monitoring, audits, and governance reviews.

J. **Procurement of Information Technology**

All acquisitions of information systems, software, information processing services, and network-connected hardware must be evaluated for cybersecurity risk and assessed for their ability to meet Salinas Valley Health's security requirements prior to procurement.

1. Risk Evaluation – Procurements not meeting Salinas Valley Health's cybersecurity requirements shall be evaluated with the vendor for potential compensating controls. If residual risk remains high (or greater) after this evaluation, the risk must be formally accepted by the requesting area's senior executive before the procurement proceeds.
2. Governance Alignment – Risk evaluation and acceptance shall follow the process defined in the Cybersecurity Risk Management Policy.
3. Supply Chain Controls – Detailed requirements for new systems are established in the Service Provider & Supply Chain Cybersecurity Management Policy, including items acquired under capital or operating budgets, leases, trials, demos, or loaned equipment. A Business Associate Agreement (BAA) must be fully executed before any third party is permitted to process, store, or transmit PHI on behalf of Salinas Valley Health.
4. Pre-Approved Assets – The procurement of additional copies of software or hardware that have already been approved does not require a new cybersecurity evaluation.
5. Other Procurement Requirements – All IT procurements must also comply with applicable Salinas Valley Health procurement and contracting requirements.

K. **Risk Management**

1. Although all cybersecurity policies are designed to reduce and manage risk, the formal process for identifying, evaluating, and handling specific risks is defined in the Cybersecurity Risk Management Policy and Procedure. That policy establishes the methods for risk assessment, risk response (avoid, mitigate, transfer, accept), documentation in the risk register, and approval of exceptions.

L. **Business Impact Analysis (BIA)**

1. The Information Technology department shall create, maintain, and periodically update (annually or on major changes) a Business Impact Analysis (BIA) that documents:
    a. Critical IT infrastructure and information systems in use by Salinas Valley Health.
    b. The operational and clinical impact of disruption to each system.
    c. Dependencies between systems and supporting infrastructure.
    d. The relative priority for restoration of systems and services in the event of a disaster.
    e. Recovery objectives, as appropriate, to support disaster recovery and continuity planning.
    f. The BIA shall serve as a foundational reference for the organization's Disaster Recovery and Business Continuity Plans.
        i. Prioritization and criticalities will be submitted for review and approval from the COO and CAO as part of the updating of the Disaster Recovery Plan managed under the Incident Response and Disaster Recovery Policy.

M. **Resources**

1. Salinas Valley Health is committed to providing the staffing, technology, and processes necessary to manage cybersecurity in a sustainable and cost-effective manner. Resources shall be allocated to ensure the program meets its stated risk management objectives and supports the protection of patient care, regulatory compliance, and organizational resilience. Resource review will be performed annually or as requirements change.

N. **Reporting**

1. Staff and other users shall report suspected cybersecurity incidents, risks, or policy violations through their supervisory chain or by using the pathways defined in the SVH Non-Compliance Reporting and Response Policy.
2. Reporting is expected to align with Salinas Valley Health's Just Culture principles: staff are encouraged to report concerns without fear of retaliation, with the understanding that reports will be handled fairly, consistently, and with a focus on learning and system improvement. Intentional misconduct or negligence, however, remains subject to disciplinary action.

O. **Continuous Improvement**

This policy establishes the expectation that the organization demonstrates measurable continuous improvement related to cybersecurity. The program shall incorporate the results of assessments, performance indicators, and risk analysis into annual planning and strategic updates.

1. Outcomes from internal KPIs/KRIs, external assessments, penetration tests, and maturity scoring are reviewed at least annually for adjustments to the overall

program. Generally progress is reported quarterly for most measures.

2. Adjustments to cybersecurity strategy, policies, and standards are made based on regulatory changes, assessment findings, and organizational priorities.
3. Updates to acceptable risk tolerance and program objectives are documented and communicated to senior leadership and the Board of Directors.
4. An annual cybersecurity improvement plan is developed by the Director of Information Technology that prioritizes remediation, maturity advancement, and alignment of resources with identified risks.
5. Detailed procedures for collecting, analyzing, and applying improvement feedback are defined in subordinate policies and standards (e.g., Risk Management Policy, Performance Indicator Standard).

P. **Documentation**

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

GV.OC-01	The organizational mission is understood and informs cybersecurity risk management
GV.OC-02	Internal and external stakeholders are understood, and their needs and expectations regarding cybersecurity risk management are understood and considered
GV.OC-03	Legal, regulatory, and contractual requirements regarding cybersecurity - including privacy and civil liberties obligations - are understood and managed
GV.OC-04	Critical objectives, capabilities, and services that stakeholders depend on or expect from the organization are understood and communicated
GV.OC-05	Outcomes, capabilities, and services that the organization depends on are understood and communicated
GV.RM-01	Risk management objectives are established and agreed to by organizational stakeholders
GV.RR-03	Adequate resources are allocated commensurate with cybersecurity risk strategy, roles and responsibilities, and policies
ID.IM-04	Cybersecurity plans that affect operations are established, communicated, maintained, and improved

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. This policy is supported by the legal and regulatory authorities identified in Section J: Legal and Regulatory Framework for Cybersecurity and the definitions in Section B: Definitions. Key

reference frameworks include:

B. HIPAA Security Rule, 45 CFR §164.308(a)(6) (Security Incident Procedures)
C. HIPAA Security Rule, 45 CFR §164.308(a)(7) (Contingency Planning)
D. NIST Cybersecurity Framework (CSF) v2.0 – Recover (RC), Respond (RS), and Govern (GV) Functions
E. CIS Critical Security Controls v8 – Controls 11 (Data Recovery) and 17 (Incident Response Management)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	11/12/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	11/11/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/27/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/20/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/17/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18886855**

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

Cybersecurity Risk Management

I. POLICY STATEMENT

A. Salinas Valley Health establishes this Cybersecurity Risk Management Policy to define how cybersecurity risks will be identified, managed, and governed across the organization.

II. PURPOSE

A. To ensure that appropriate processes, controls, and standards work together to effectively manage cybersecurity risks that may impact the confidentiality, integrity, and availability of Salinas Valley Health's systems and information.

B. The management of cybersecurity risk is essential to safeguarding the organization's ongoing operations, supporting patient safety, and ensuring compliance with applicable regulatory requirements. While all cybersecurity policies at Salinas Valley Health contribute to risk reduction, this policy specifically governs the identification, reporting, communication, handling, and processing of cybersecurity risks.

III. DEFINITIONS

A. **Business Associate (BA):** A person or entity, as defined under HIPAA, that performs functions or services involving the use or disclosure of protected health information on behalf of Salinas Valley Health.

B. **Confidentiality, Integrity, and Availability (CIA):** The three core principles of information security. Confidentiality protects data from unauthorized access; integrity ensures accuracy and trustworthiness; availability ensures systems and data are accessible when needed.

C. **Exception:** A documented deviation from established Salinas Valley Health cybersecurity policies or standards that has been formally reviewed and approved through the risk acceptance process.

D. **Health Insurance Portability and Accountability Act (HIPAA):** A U.S. federal law that, among

other provisions, establishes the Security Rule, which requires covered entities to implement safeguards to protect the confidentiality, integrity, and availability of electronic protected health information (ePHI).

E. **Key Performance Indicators (KPIs):** Metrics used to measure the performance and effectiveness of cybersecurity processes and program objectives.

F. **Key Risk Indicators (KRIs):** Metrics used to measure the likelihood, impact, or exposure of cybersecurity risks, often tied to leading indicators of potential adverse events.

G. **National Institute of Standards and Technology (NIST):** A U.S. federal agency that develops standards, guidelines, and best practices for information security and risk management.

H. **NIST Cybersecurity Framework (CSF):** A framework developed by NIST that provides functions, categories, and subcategories to guide organizations in managing and reducing cybersecurity risks.

I. **Promoting Interoperability (PI) / Merit-Based Incentive Payment System (MIPS) Security Risk Analysis:** A CMS program requirement that hospitals and clinicians conduct or review a security risk analysis of certified EHR technology (CEHRT) annually to support compliance with HIPAA §164.308(a)(1).

J. **Residual Risk:** The level of risk that remains after safeguards and controls have been applied.

K. **Risk Acceptance:** A formal decision by authorized executives to acknowledge and approve the residual risk associated with a system, process, or exception.

L. **Risk Register:** The authoritative log of identified cybersecurity risks, including their probability, impact, status, and assigned risk response.

M. **Risk Tolerance:** The level and types of cybersecurity risk that Salinas Valley Health is willing to accept in pursuit of its operational objectives, as defined in this policy.

IV. GENERAL INFORMATION

A. This policy operates under the authority of the Cybersecurity Governance Policy, which establishes the overall framework for cybersecurity program oversight at Salinas Valley Health.

B. This and other cybersecurity policies are required to be reviewed at the frequency established by the SVH Policy and Procedure Management Policy, or more frequently when operational improvements or regulatory changes require updates.

C. Scope

1. This policy applies across Salinas Valley Health, including all workforce members, departments, information systems, data processing services, and network-connected devices, whether onsite or externally hosted. It also applies to contracts, vendors, and Business Associates as defined under HIPAA, where cybersecurity risk affects organizational operations, patient care, or regulatory compliance.

V. PROCEDURE

A. **Activities & Outcomes**

The Salinas Valley Health Cybersecurity Program shall establish and maintain processes,

standards, and procedures that operationalize this policy. To achieve the outcome of managed and reduced risk, the following activities must be carried out:

1. **Risk Registry**
   A centralized risk registry shall be maintained to track identified risks, including their probability, impact, and mitigation status. The registry will be used to guide prioritization of risk response activities and provide visibility for governance reporting. Access shall be limited to those with a business need-to-know.
2. **Risk Handling & Remediation**
   A formal risk handling process for information systems shall be implemented and maintained, drawing from the NIST Risk Management Framework and tailored to the organization's size and complexity. This process governs risk identification, analysis, treatment, monitoring, and acceptance for information systems. Risks not reduced to an acceptable level must be formally documented and approved through the risk acceptance process defined in this policy.

   Other risk handling activities and projects to address widespread or specific risks may also be utilized where deemed appropriate by the Director, Information Technology.
3. **Performance and Risk Indicators**
   Key performance indicators (KPIs) and key risk indicators (KRIs) shall be maintained to measure the effectiveness of the Cybersecurity Program and provide ongoing insight into areas of elevated risk. These indicators shall be reviewed and approved by the Cybersecurity Governance Council, and updated as necessary to reflect changing threats, technologies, and priorities.
4. **Change Management**
   The risk to operations from configuration changes to infrastructure and applications must be managed. IT & Informatics must create, publish, and maintain a change management process. Making changes without following the established process or authorization is subject to disciplinary action

B. **Risk Responses**

1. Cybersecurity risk management at Salinas Valley Health aligns with the risk response strategies defined in the Enterprise Risk Management Program — avoidance, reduction, and acceptance — and additionally recognizes transfer as a valid strategy within the cybersecurity domain.
2. **Acceptance** – Formally acknowledging and accepting a residual risk that remains after reasonable safeguards are applied, typically when the cost or feasibility of further reduction is disproportionate to the potential impact.
   Avoidance – Taking actions to eliminate the risk entirely, such as discontinuing or not adopting a technology or process that introduces unacceptable risk.
3. **Reduction** (Mitigation) – Implementing safeguards to reduce the likelihood or impact of a risk to an acceptable level.
4. **Transfer** – In addition to the enterprise strategies, cybersecurity risks may also be managed by transferring some portion of financial or operational exposure to a third party, such as through cyber insurance or contractual agreements.

5. Material risk responses not already addressed or tracked through approved organizational processes (e.g., vulnerability management, secure configuration, performance tracking, or the risk handling process) shall be documented in the risk register. Risks that remain above the organization's defined tolerance must be formally reviewed and approved through the established risk acceptance and escalation process.

C. **Risk Tolerance**

1. Salinas Valley Health maintains a low tolerance for cybersecurity risks that may impact patient care, safety, or regulatory compliance. Recognizing that some residual risks are inherent in the use of information systems and technology, the Cybersecurity Program is designed to progressively reduce aggregate risk over time and ensure risks are managed through governance oversight.
2. Adherence to this tolerance shall be monitored continuously through the risk management process and reported as part of the annual cybersecurity program review. Targets and performance metrics are outlined in the Performance Indicator Standard.

D. **Risk Intelligence**

1. Salinas Valley Health shall establish and maintain a risk intelligence process to ensure timely receipt, evaluation, and action on cybersecurity threat information from vendors, government agencies, industry sources, and Information Sharing and Analysis Centers (ISACs).
2. Threat intelligence with potential implications for Salinas Valley Health shall be reviewed and assessed for organizational impact.
3. Routine items (e.g., scheduled software updates) shall be addressed under the Vulnerability Management Policy and related procedures.
4. Intelligence indicating a material or immediate threat to operations shall be escalated promptly to appropriate leadership for analysis and response.

E. **Exceptions & Risk Acceptance Process**

1. It is recognized that risk management standards may, at times, conflict with operational needs. When an information system or technology cannot fully meet Salinas Valley Health standards, the cybersecurity team may recommend compensating controls to reduce risk to an acceptable level.
2. If residual risk remains above acceptable tolerance, formal exception and risk acceptance must be obtained:
    a. Department-level exceptions may be approved by the senior executive responsible for that department.
    b. Exceptions involving enterprise-wide systems must be escalated to the Chief Administrative Officer.
    c. Exceptions resulting in very-high residual risk must also be approved by the Chief Executive Officer.
3. All new information systems must undergo a cybersecurity risk assessment and risk

acceptance prior to acquisition or contracting.

4. Risk acceptance decisions and approved compensating controls must be documented, retained, and periodically reviewed.
5. Unmitigated risks that are not formally accepted shall be escalated to the Cybersecurity Governance Council or the Chief Administrative Officer.
6. Outstanding exceptional risks shall be reported to the Board as part of the annual cybersecurity program review.

F. **Risk Calculations**
Risk calculation methodologies and scales are to be approved by the Director, Information Technology for measuring risk from vulnerability management, risk handling process, and Key Performance and Risk Indicators. These are to be documented in the Performance Indicator Standard.

G. **Remediation Prioritization**
Cybersecurity risks shall generally be addressed in order of severity, with priority given to risks that directly affect patient care, safety, regulatory compliance, or multiple systems. Recognizing that risk management activities may involve interdependencies, remediation plans may sequence the resolution of lower-risk items first when necessary to enable or support the treatment of higher-risk issues.

H. **External Assessment**
In accordance with the Cybersecurity Governance Policy, Salinas Valley Health shall conduct an external assessment by a reputable third party on at least an annual basis to evaluate cybersecurity maturity and risks.
The scope of this assessment shall include, at a minimum:

1. The Security Risk Analysis required under the HIPAA Security Rule (§164.308(a)(1)) and the Promoting Interoperability/MIPS program, including evaluation of Certified EHR Technology and safeguards for electronic protected health information (ePHI).
2. Review of the cybersecurity program's maturity, risks, and alignment with Salinas Valley Health policies, standards, and governance expectations.
3. Continuity of methodology shall be maintained where possible to provide insight into year-over-year improvements and areas requiring further attention.

I. **Feedback Loops & Planning**
Salinas Valley Health shall incorporate the outcomes of risk management activities, assessments, and performance indicators into continuous improvement planning for the cybersecurity program.

1. A formal planning process shall be conducted on at least an annual basis, and as needed, to review outstanding risks, determine appropriate responses, and prioritize improvement activities.
2. This process shall result in an annual cybersecurity improvement plan that is aligned with organizational strategy, risk tolerance, and regulatory requirements.
3. Progress against the plan shall be tracked and communicated to the cybersecurity council.

J. **Capacity Planning**
Salinas Valley Health IT shall conduct capacity and availability planning at least annually to ensure critical infrastructure can meet operational and emergency needs. This planning shall be aligned with risk management processes and financial planning cycles, supporting the confidentiality, integrity, and availability of organizational systems.

K. **Engagement with Law Enforcement**

Engagement with law enforcement to report a cyber-crime on behalf of Salinas Valley Health must only occur in consultation with the Chief Legal Officer (CLO) and Chief Administrative Officer (CAO). See contact information in the Incident Response Plan.

L. **Physical Environment**
Risks to (or resulting from) the physical environment should be incorporated into monitoring practices and controls. Physical security is managed under the Security Management Plan and other policies. Utility and environmental availability are managed under the Utilities Management Plan and other policies.

M. Documentation

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

164.308(a)(1)	Risk Analysis
164.308(a)(1)	Risk Management
GV.RM-03	Cybersecurity risk management activities and outcomes are included in enterprise risk management processes
GV.RM-04	Strategic direction that describes appropriate risk response options is established and communicated
GV.RM-05	Lines of communication across the organization are established for cybersecurity risks, including risks from suppliers and other third parties
GV.RM-06	A standardized method for calculating, documenting, categorizing, and prioritizing cybersecurity risks is established and communicated
GV.RM-07	Strategic opportunities (i.e., positive risks) are characterized and are included in organizational cybersecurity risk discussions
GV.PO-01	Policy for managing cybersecurity risks is established based on organizational context, cybersecurity strategy, and priorities and is communicated and enforced
GV.PO-02	Policy for managing cybersecurity risks is reviewed, updated, communicated, and enforced to reflect changes

2.

	in requirements, threats, technology, and organizational mission
GV.OV-01	Cybersecurity risk management strategy outcomes are reviewed to inform and adjust strategy and direction
GV.OV-02	The cybersecurity risk management strategy is reviewed and adjusted to ensure coverage of organizational requirements and risks
GV.OV-03	Organizational cybersecurity risk management performance is measured and reviewed for adjustments needed
ID.RA-05	Threats, vulnerabilities, likelihoods, and impacts are used to understand inherent risk and inform risk response prioritization
ID.RA-06	Risk responses are chosen from the available options, prioritized, planned, tracked, and communicated
ID.RA-07	Changes and exceptions are managed, assessed for risk impact, recorded, and tracked
ID.IM-03	Improvements are identified from execution of operational processes, procedures, and activities
PR.IR-04	Adequate resource capacity to ensure availability is maintained
DE.CM-02	The physical environment is monitored to find potentially adverse events

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	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	11/12/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	11/11/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/23/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/20/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/17/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18941842**

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

Incident Response & Disaster Recovery

I. POLICY STATEMENT

A. Salinas Valley Health requires and maintains a comprehensive Incident Response (IR) and Disaster Recovery (DR) program to ensure timely detection, containment, and restoration of technology services following disruptions.

II. PURPOSE

A. This policy defines governance, accountability, and reporting requirements, while detailed recovery and response procedures are maintained in under the documents required by this policy.

B. The purpose of this policy is to:

1. Ensure that Salinas Valley Health has a structured, coordinated approach to responding to technology incidents and restoring systems after a disaster.
2. Align IR/DR activities with regulatory requirements, including HIPAA §164.308(a)(6) (Security Incident Procedures) and §164.308(a)(7) (Contingency Planning).
3. Provide a governance framework that integrates the Incident Response Plan, Disaster Recovery Plan, and the general Hospital Emergency Management Program Plan (HICS).
4. Establish requirements for ongoing testing, performance measurement (KPIs), and continuous improvement of IR/DR processes.
5. Support patient safety, operational continuity, and organizational resilience through timely and effective recovery of technology services.

III. DEFINITIONS

A. Business Impact Analysis (BIA): The assessment process used to identify critical systems,

dependencies, and maximum tolerable downtime to set recovery objectives.

B. Disaster Recovery (DR): The restoration of IT systems and services following a significant disruption or disaster, with the goal of meeting defined Recovery Time Objectives (RTO) and Recovery Point Objectives (RPO).

C. Downtime Procedures: Predefined manual or alternate processes that ensure continuity of clinical and business operations until IT systems are restored.

D. Health Insurance Portability and Accountability Act (HIPAA): The U.S. federal law that establishes requirements for protecting the confidentiality, integrity, and availability of electronic protected health information (ePHI). The HIPAA Security Rule (§164.308, §164.310, §164.312) includes specific requirements for contingency planning, incident response, and audit controls that are supported by this policy.

E. Hospital Incident Command System (HICS): The hospital-wide command and control structure activated during major incidents or disasters; IT IR/DR activities align under HICS when activated.

F. Incident Response (IR): The structured process of detecting, analyzing, containing, eradicating, and recovering from cybersecurity or technology events that disrupt services.

G. Key Performance Indicators (KPIs): Metrics defined in this policy to measure effectiveness of IR/DR processes, including completion of recovery exercises and adherence to RTO/RPO.

H. Recovery Point Objective (RPO): The maximum acceptable amount of data loss measured in time (for example, last backup or snapshot point).

I. Recovery Time Objective (RTO): The maximum tolerable duration of downtime for a system before it causes unacceptable impact to patient care or business operations.

J. Salinas Valley Health (SVH)

K. System Owner: The business or clinical leader accountable for defining operational requirements (including RTO) for a given system.

IV. GENERAL INFORMATION

A. This policy falls under the Cybersecurity Governance Policy.

B. Roles & Responsibilities

1. Chief Administrative Officer – Executive decision authority during recovery. Approves final RTO and RPO. Approves IR/DR Plans.
2. Vice President, Information Technology – Approves IR/DR plans and associated play books.
3. Director, Information Technology – Approves IR/DR plans and play books. Provides operational oversight.
4. Manager, Cybersecurity Risk – Maintains and updates IR/DR plans and play books. Tracks and reports KPIs.
5. IT Systems Team - Maintains backup mechanisms, recovery plans, and recovery infrastructure.
6. System Owners - Defines and updates as needed the Recovery Time Objective.

C. Recovery Point Objectives

1. RPO values for SVH hosted systems are determined for internal systems by assigned system criticality for operational consistency.
2. RPO values are to be recorded in the Disaster Recovery Plan.
3. RPO for vendor-managed systems are determined by the obligations of the contract.

D. Recovery Time Objectives

1. Recovery Time Objectives are determined by system owners based on the impact to operations. IT is to inquire from system owners the RTO for each application. If IT is not provided with a response, a value will be assigned based on the assigned criticality of the application under guidelines found in the Disaster Recovery Plan.
2. RTO values are subject to approval and re-prioritization from administration.
3. Recovery order for SVH hosted systems is to be determined based on an evaluation of criticality tier, dependencies, and RTO. The Chief Administrative Officer may reassign recovery priorities to align with operational needs.
4. RTO values do not necessarily align with the technical ability to recovery in the expected time, which is determined by technology capacity, the scope of disaster, and budgeted capabilities.

E. Emergency Management Alignment

1. IT Incident Response & Disaster Recovery plans and play books must be aligned with the Hospital's Emergency Management Program Plan.
2. Incident Response and Disaster Recovery plans must be written in a way that:
    a. Is able to operate both under and independent of the activation of the Emergency Management Program Plan's Hospital Incident Command Center (HICS).
    b. Guides the triage of major incidents and outages to conclusion or activation of HICS.
    c. Integrates Information Technology and Informatics resources and responses.

V. PROCEDURE

A. IT is required to compile and maintain the following documents:

1. IT Incident Response Plan
    a. Cybersecurity Incident Supplement
2. Disaster Recovery Plan
    a. (SVH Hosted) System Recovery Run Books
3. Data Backup Plan
4. Data Backup Architecture
5. Specific Incident Playbooks

a. Ransomware Playbook
b. Internet Outage Playbook
c. Network Downtime Playbook

B. Requirements
1. Incident Response and Disaster Recovery Plans must be updated annually or upon major changes that would impact the feasibility of these plans.

C. Testing & Exercises
1. Recovery exercises must be conducted to test the Disaster Recovery Plan and technical ability to recover SVH hosted systems.
a. Tier 5 tested annually.
b. Tier 4 tested every 2 years.
c. Tier 1–3 tested at least every 3 years
d. Results for most recent recovery documented to the BIA.
e. Recovery documentation saved to Cybersecurity site on Starnet for tracking.
2. Incident Response exercises (tabletops, simulations) must be conducted at least annually.
a. Incident Response exercises are to be saved to Cybersecurity site on Starnet for tracking.
3. Fail-over and fail-back between locations is expected for regular patching and maintenance of underlying enterprise systems.

D. Performance Tracking
1. Performance tracking for Disaster Recovery and Incident Response are reported in accordance with the Performance Indicator Standard.

E. Exceptions
1. Exceptions to this policy or planned deviations in backup & recovery must be documented and escalated under the process outlined in the Cybersecurity Risk Management Policy if they exceed the allowed risk tolerance and compensating controls do not adjust risk to acceptable levels.
2. This policy is subordinate to the Emergency Management Program Plan on activation of the incident command system. Alternate direction may be given by the Incident Command Team in order to handle active disasters.
3. Some deviation to Incident and Recovery plans is expected at the direction of IT & Organizational leadership in consideration of the specifics of each disaster.
a. Chief Administrative Officer
b. Vice President, Information Technology
c. Director, Enterprise Informatics

d. Director, Information Technology.

e. Hospital Incident Commander

F. Capacity Planning

1. Information Technology is required to plan, budget, implement, and maintain capacity (server, storage, networking, power, cooling) for emergency operations and recovery for all SVH hosted information systems.
2. Information Technology is to maintain off-site capacity that is capable of running tier 3-5 applications at a minimum.
    a. Off-site design is for "hot" site recovery.
    b. Off-site best case scenario RPO should be less than 15 minutes.
    c. Off-site best case RTO should be less than 4 hours.

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	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	11/12/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	11/11/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/22/2025

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/20/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/17/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18750334**

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

Informatics & IT Change Control

I. POLICY STATEMENT

A. It is the policy of Salinas Valley Health to ensure that all changes to Epic, other core clinical systems, and the supporting infrastructure are planned, reviewed, approved, implemented, and documented in a controlled and standardized manner to safeguard clinical operations and maintain the continuity of patient care.

II. PURPOSE

A. The purpose of this policy is to establish a standardized approach for managing changes to Epic, other core clinical systems, and IT infrastructure in order to minimize risk, maintain system integrity, and ensure uninterrupted clinical operations. A consistent and controlled change management process supports patient safety, regulatory compliance, operational efficiency, and effective communication across technical, clinical, and operational teams.

III. DEFINITIONS

A. CAB - Change Advisory Board - Approval board for changes requiring review.

B. Change Freeze - A defined period during which no non-critical changes are allowed in production.

C. Content Management Ticket - An Epic system tracking item used to document, manage, and approve build changes prior to their movement into production via Data Courier.

D. Data Courier - An Epic tool that moves configuration changes between non-production and production environments.

E. EMR - Electronic Medical Record.

F. HIPAA - Health Insurance Portability and Accountability Act.

G. INI - Epic Initialization File (Configuration settings file).

H. ITIL - Information Technology Infrastructure Library (Best Practices).

I. Peer Review - The review of a proposed change by a qualified individual who is not the primary implementer.

IV. GENERAL INFORMATION

A. Changes to Epic, other core clinical systems, and their supporting infrastructure can have a direct impact on patient care, clinical workflows, and regulatory compliance. Unplanned or poorly coordinated changes may result in downtime, data integrity issues, security vulnerabilities, or workflow disruptions.

To prevent these risks, all changes within the scope of this policy must follow a standardized change management process that includes assessment, approval, scheduling, communication, implementation, and post-change review. This process is overseen by the Change Advisory Board (CAB) to ensure appropriate stakeholder involvement, risk mitigation, and alignment with organizational priorities and maintenance windows.

The policy is intended to align with industry best practices, including ITIL change management principles, and supports compliance with applicable regulations such as the HIPAA Security Rule and other state and federal requirements.

B. Categories of Change

To ensure appropriate review, oversight, and quality control, all changes covered by this policy require peer review prior to approval or implementation, regardless of category. Peer review must be performed by a qualified individual who is not the primary change implementer, and the review must be documented in the change record.

C. Changes are classified as follows:

1. IT Minor Change – Changes with minimal risk or impact do not require Change Advisory Board (CAB) review. Notification to the CAB is required prior to implementation, and peer review must be completed before the change is executed. Must be recorded in the ITIL change management tool (FreshService). Changes will be automatically approved from a CAB perspective. Changes documented under this category may be challenged and require review by the CAB.
    a. Changes orchestrated in the repair or recovery of infrastructure or in response to an information system downtime under the incident response or disaster recovery plans are to be documented in this category for awareness and documentation.
    b. Interface changes to production systems are to be documented here.
2. IT Major Change – Significant changes to IT infrastructure, integrations, or configurations to other clinical applications that have potential impact on clinical systems or workflows. Including changes requiring clinical system downtimes other than routine maintenance windows. Requires CAB review and approval, as well as documented peer review prior to implementation. Must be recorded in FreshService.
    a. Replay of interface messages is a major or emergency change.

3. Epic Green Change – Changes within Epic limited to specific INIs on the "Green List" designated as low-risk. These are considered safe to implement without CAB approval but still require documented peer review. Must be documented in the associated Content Management ticket in Epic.
4. Epic Yellow Change – Changes within Epic to INIs on the "Yellow List" that require review and approval from the INI owner or owning group, in addition to documented peer review. Must be documented in the associated Content Management ticket in Epic.
5. Epic Red Change – Changes within Epic to INIs on the "Red List" that always require CAB review and approval, as well as documented peer review. Must be recorded in FreshService and documented in the associated Content Management ticket in Epic. The current INI risk classification list ("Green," "Yellow," and "Red") is maintained by Enterprise Informatics and linked here: [Insert Link to INI Listing].

D. Documented changes using Freshservice should trigger appropriate notifications to the CAB and IT/Informatics teams.

E. Minimal risk are changes not expected to cause measurable impact to operations or patient care.

1. No Expected Downtime – The change can be performed without service interruption to production systems, including Epic and other core clinical systems.
2. No Workflow Impact – No changes to end-user workflows, screen layouts, or functionality requiring training or communication.
3. Reversible Without Impact – The change can be rolled back quickly without residual issues if problems occur.
4. No Security or Compliance Risk – The change does not alter security configurations, access permissions, audit logging, or protected health information (PHI) handling.
5. Follows an Approved Standard – The change follows an existing, approved, and documented procedure or build standard.

F. The Change Control Group may reclassify an INI's risk ranking, with any changes requiring ratification from the Director, Enterprise Informatics.

G. Change Control Requirement

1. Change control is required for moving any item into Epic Production unless other approved temporary change management or freeze controls are in place.
2. The Director of IT and the Director of Enterprise Informatics have the authority to initiate a change freeze or to temporarily modify the Change Management process when operational requirements demand it, such as during major upgrades, planned outages, disaster recovery operations, or other significant events.
3. Any temporary modifications or freeze periods must be clearly communicated to all impacted teams, documented in the change management records (if available), and include defined start and end dates. Once the freeze period or temporary process ends, the standard Change Management process will resume.

H. Change Advisory Board (CAB) Makeup

All Epic teams are expected to provide representation to change management. Every change requiring CAB approval must have **13** votes of approval. Of these, 7 votes must be from the designated team managers or their approved designee.

Managers must designate staff who directly or indirectly report to them and who are able to speak knowledgeably and authoritatively on behalf of their assigned area. The CAB will not be able to approve items requiring a vote without a quorum. Alternative staff will need to be pulled into the meeting.

Required Members of CAB for Quorum:

1. Epic Revenue Cycle Manager (or approved designee)
2. Epic Clinical Applications Manager (or approved designee)
3. Epic Ancillary Applications Manager (or approved designee)
4. Epic Ambulatory & Lab Manager (or approved designee)
5. Epic Training Manager (or approved designee)
6. IT Support Manager (or approved designee)
7. IT Reporting & Integration Manager (or approved designee)
8. Any IT/Informatics Staff
9. Any IT/Informatics Staff
10. Any IT/Informatics Staff
11. Any IT/Informatics Staff
12. Any IT/Informatics Staff
13. Any IT/Informatics Staff

I. Emergency changes for emergent problems, patient safety, emergencies, downtimes, or off-hours may be approved by:

1. Director, Enterprise Informatics
2. Director, Information Technology
3. Hospital Incident Commander (if the emergency command center activated)
4. IT / Informatics Incident Response Lead (related to scope of incident)

J. Exemptions from Change control include individual changes for:

1. User administration
    a. Mass-changes to records
2. Device provisioning/replacement
3. Standard, fully automated processes
4. Peripheral replacements
5. Non-production system changes

6. Standard downtime windows for routine updates & patching

V. PROCEDURE

A. All CAB change requests must be submitted using the Freshservice change request template that matches the type of change being requested. Correct template use is required to ensure proper routing, review, and approval.

B. Available Templates:

1. Epic Major Configuration Change Request – For Epic “Red” changes and any Epic change requiring CAB approval.
2. Epic Minor Configuration Change Request – For documenting changes that can only be done in production (that are not otherwise red). Also for documentation of Epic “Green” or “Yellow” changes during change freeze periods.
3. IT Major Change Request – For IT infrastructure, other clinical systems, or system changes requiring CAB review and approval.
4. IT Minor Change Request – For low-risk IT changes or other clinical system changes requiring notification only.
5. Emergency Change Request - For emergency changes meeting the above criteria.

C. Submission Requirements:

1. Select the appropriate template in Freshservice based on change category.
2. Provide all relevant details in the form, including business justification, impact assessment, back-out plan, testing evidence, proposed implementation date/time, and any communication channels needed for changes requiring wider notification, training, or downtime announcements.
    a. Communication channels include but are not limited to:
        i. Tip Sheets
        ii. Email
        iii. Distribution to Management
        iv. Learning home dashboard updates
        v. Formal training
3. Ensure peer review is completed and documented before submission.
4. Requests must be submitted no later than 30 minutes before the scheduled CAB meeting to be eligible for review. If no changes are submitted by that time, the CAB meeting will be canceled.
5. For all Epic change management items, all supporting change documentation must be saved to the Content Management ticket prior to moving the change into the Epic Production environment via Data Courier.

D. Review & Process Improvement

1. All changes that are rolled back from production, must be reviewed by the CAB as a

process improvement activity.

2. All changes that cause unexpected disruption or downtime must be reviewed by the CAB as a process improvement activity
3. Process improvement review should be performed at least annually to review the effectiveness of the process. Feedback from the CAB team to improve this process should be taken into account for process improvement. Metrics regarding emergency changes and channels utilized should be reviewed during this process.
4. Periodic reviews of the data courier process and change management process to ensure process is being followed is required to be performed by the Epic Security team at least quarterly but also as needed. Data moves without properly documented authorization are to be reported to the change initiator's manager.

E. 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 Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	11/12/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	11/11/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/22/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/20/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/17/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18825318**

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

PCI Security Compliance

I. POLICY STATEMENT

A. Salinas Valley Health is committed to implementing necessary policies, procedures, and controls that meet the contractual obligations for implementing and maintaining PCI Compliance.

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 policy is intended to establish controls that meet PCI level 4 P2PE requirements.

III. DEFINITIONS

A. **Cardholder Data (CHD)** – Primary Account Number (PAN) and any associated cardholder name, expiration date, and service code as defined by PCI DSS.

B. **Cardholder Data Environment (CDE)** – The people, processes, and technology that store, process, or transmit cardholder data, or any system connected to such components.

C. **Encryption** – Process of converting information into a secure format that cannot be read without a decryption key.

D. **KPI** - Key performance indicators

E. **PAN (Primary Account Number)** – The unique payment card number that identifies the issuer and cardholder account.

F. **PCI DSS (Payment Card Industry Data Security Standard)** – The global standard established by the PCI Security Standards Council to protect cardholder data.

G. **P2PE (Point-to-Point Encryption)** – A PCI-approved encryption methodology that ensures cardholder data is encrypted immediately upon capture and remains encrypted until received by the secure decryption environment of the payment processor.

H. **PCI SSC (PCI Security Standards Council)** – The governing body that develops and manages the PCI DSS and related standards.

I. **Salinas Valley Health (SVH)**

J. **System Owner** – The individual responsible for a given information system.

K. **Tokenization** – Replacement of a cardholder's PAN with a surrogate value (token) that has no value if exposed.

IV. GENERAL INFORMATION

A. This document falls under the Data Protection policy. Exceptions and gaps to requirements must be handled under the process in the Cybersecurity Risk Managment policy.

B. **Scope**

1. The scope of this policy is the entire organization including the hospital and clinics for all applications that take credit card payment.

C. **Out of Scope**

1. This policy does not apply to the use of Salinas Valley Health credit cards issued to staff for purchasing items and services from other organizations.

D. **Roles and Responsibilities**

1. Cybersecurity Risk Manager: Oversees auditing, reporting, and escalation.
2. System Owners: Ensure remediations are implemented in a timely manner.
3. Compliance: Review annual reports and help ensure remedation activiies are completed.
4. Department Leadership: Departments with staff that handle credit card payments must ensure staff are appropriately trained and monitor devices for tampering.

V. PROCEDURE

A. **Required Controls**
This policy requires that the following controls are established and be maintained by Salinas Valley Health.

B. **Activities and Outcomes**

The Salinas Valley Health Security Program is responsible for managing policies, procedures, and standards that establish baseline security practices for PCI compliance.

1. An annual PCI self-assessment with audit elements must be completed annually by the Cybersecurity Risk Manager or another designated by Director, Information

Technology. Each completed PCI self-assessment must be reviewed by the Director of Compliance and by the HIPAA Security Officer.

2. This policy must be inspected annually prior to or as part of the PCI self-assessment. It must also be reviewed for needed changes with any new bank or gateway system contract. The policy should be reviewed for any major changes to card payment processing by Salinas Valley Health.
3. Updates to this policy must be sent to managers and staff that process or oversee credit card payments and to those that support them from an IT, compliance, or cybersecurity perspective.
4. An informational flyer should be posted at each SVH location that processes card payments with the required information and activities.
5. Any breach should be handled using organization breach policies.
6. Systems that process or transmit card information should be scanned no less than quarterly.
    a. Only end-to-end encrypted terminals are to be used for the capture of credit card data, so this requirement should not generally apply to any systems.
7. Devices that connect to terminals that process card payments must be identified in inventory.

C. **Data Protection**

1. Card account numbers may not be saved to any computer, server, or database managed by Salinas Valley Health.
2. Card account numbers may only be entered by staff using secure terminals into systems approved for PCI data.
3. SVH managed information systems should not save any card account data. Only tokens.
4. The only systems approved at SVH for retaining card account numbers are portals provided by the merchant bank or gateway provider.
5. Card account numbers must be encrypted from the source device to the destination.
6. Receipts and paper (other than manual paper collection imprints) must mask all but the last 4 digits of the card.
7. Any manual paper collection imprints are securely destroyed after the card transaction is authorized.
8. Any paper notes from phone authorizations containing card numbers must be destroyed after the card transaction is authorized.
9. No reports with full account numbers from the bank or gateway should be downloaded or saved into the Salinas Valley Health network or devices.
10. Card account numbers must never be emailed.
11. Card account numbers must not be entered using standard computer keyboards.

12. Access to payment gateways and banks containing card information must be limited to staff having a clear need to know.

D. **Card Reader Devices**

1. Only PCI-listed P2PE devices may be used for card payment collection or data entry.
2. Ethernet card payment devices must be firewalled from receiving traffic from the internet.
3. An inventory of all credit card devices used by Salinas Valley Health must be maintained by IT/Informatics.
4. Devices must be added to the inventory prior to deployment and prior to destruction. Including:
    a. Made/model
    b. Location
    c. Serial number or other unique identification
5. Only authorized Salinas Valley Health staff may remove or replace devices.
    a. SVH IT Security
    b. SVH IT Technicians, Analysts, Administrators, and Engineers.
    c. SVH IT Management
    d. Cypress IT Technicians
6. Departments using card-reader devices must have procedures to periodically inspect the devices for signs of tampering or substitution. Any suspected tampering must result in disconnection of the device and immediately be reported to helpdesk@salinasvalleyhealth.com .
7. Tamper-resistant seals must be affixed to each device.
8. Devices should be reviewed annually as part of PCI self-assessment or external assessment.

E. **Other Requirements**

1. A listing of contracts and formal contact information must be kept for each merchant/gateway utilized by the Cybersecurity Risk Manager.
2. All contracts with PCI elements must be reviewed by IT and Compliance prior to execution.
3. All contracts with PCI elements must be saved to the hospital contract management system and viewable by IT and Compliance.
4. Service provider contracts

F. **Permanent KPI**

1. PCI Self Assessment or External Assessment completed in the prior 14 months.
2. Percentage of Devices Inspected during assessment
3. These KPI are to be reported to the cybersecurity governance council and

administration as required under the cybersecurity governance policy. Performance metrics from this policy should be considered in annual improvement planning, resourcing, and strategic direction to drive continual improvement.

4. Other KPI may be assigned under the Cybersecurity KPI Procedure

G. **Exception Handling**

1. Requirements for exceptions and risk handling for systems with significant deviation from standards should be escalated through the risk management process outlined in the Cybersecurity Risk Management Policy.

H. **Documentation**

1. This policy is intended to define, establish, or support the following PCI P2PE assessment criteria:

a.

2G	All payment processing is via the validated PCI P2PE hardware.
2G	The only systems in the merchant environment that store, process or transmit account data are the Point of Interaction (POI) devices that are approved for use with the validated and PCI-listed P2PE solution.
2G	Merchant does not otherwise receive or transmit cardholder data electronically.
2G	Merchant verifies there is no legacy storage of electronic cardholder data in the environment.
2G	If Merchant does store cardholder data, such data is only in paper reports or copies of paper receipts and is not received electronically
2G	Merchant has implemented all controls in the P2PE Instruction Manual (PIM) provided by the P2PE Solution Provider.
3.1.a	Is data storage amount and retention time limited to that required for legal, regulatory, and/or business requirements? – N/A – Not Stored
3.1.b	Are there defined processes in place for securely deleting cardholder data when no longer needed for legal, regulatory, and/or business reasons? – N/A – Not Stored
3.1.c	Are there specific retention requirements for cardholder data? – N/A – Not Stored

3.1.d	Is there a quarterly process for identifying and securely deleting stored cardholder data that exceeds defined retention requirements? – N/A – Not Stored
3.1.e	Does all stored cardholder data meet the requirements defined in the data-retention policy? – N/A – Not Stored
3.2.2	For all paper storage, the card verification code or value (three-digit or four-digit number printed on the front or back of a payment card) is not stored after authorization? • Yes
3.7	Are security policies and operational procedures for protecting stored cardholder data • Yes
9.5	Are all media physically secured (including but not limited to computers, removable electronic media, paper receipts, paper reports, and faxes)? • N/A – Not Stored
9.8	Is all media destroyed when it is no longer needed for business or legal reasons? • N/A – Not Stored
9.9.a	Do policies and procedures require that a list of such devices be maintained? • Yes
9.9.b	Do policies and procedures require that devices are periodically inspected to look for tampering or substitution? • Yes
9.9.1.a	a) Does the list of devices include the following? - Make, model of device - Location of device (for example, the address of the site or facility where the device is located) - Device serial number or other method of unique identification. - Yes

9.9.1.b	Is the list accurate and up to date? • Yes
9.9.1.c	Is the list of devices updated when devices are added, relocated, decommissioned, etc.? • Yes
9.9.2.a	Are device surfaces periodically inspected to detect tampering (for example, addition of card skimmers to devices), or substitution (for example, by checking the serial number or other device characteristics to verify it has not been swapped with a fraudulent device) as follows? • Yes
9.9.2.b	Are personnel aware of procedures for inspecting devices? • Yes
9.9.3	Do training materials for personnel at point-of-sale locations include the following? - Verify the identity of any third-party persons claiming to be repair or maintenance personnel, prior to granting them access to modify or troubleshoot devices. - Do not install, replace, or return devices without verification. - Be aware of suspicious behavior around devices (for example, attempts by unknown persons to unplug or open devices). - Report suspicious behavior and indications of device tampering or substitution to appropriate personnel (for example, to a manager or security officer). • Yes
9.10	Are security policies and operational procedures for restricting physical access to cardholder data: ▪ Documented ▪ In use ▪ Known to all affected parties? • Yes
12.1	Is a security policy established, published, maintained, and disseminated to all relevant personnel?

	• Yes
12.1.1	Is the security policy reviewed at least annually and updated when the environment changes? • Yes
12.4	Do security policy and procedures clearly define information security responsibilities for all personnel? • Yes
12.5	Are the following information security management responsibilities formally assigned to an individual or team • Yes
12.5.3	Establishing, documenting, and distributing security incident response and escalation procedures to ensure timely and effective handling of all situations? • Yes
12.6	Is a formal security awareness program in place to make all personnel aware of the cardholder data security policy and procedures? • Yes
12.8.1	Is a list of service providers maintained, including a description of the service(s) provided? • Yes
12.8.2	Is a written agreement maintained that includes an acknowledgment that the service providers are responsible for the security of cardholder data the service providers possess or otherwise store, process, or transmit on behalf of the customer, or to the extent that they could impact the security of the customer's cardholder data environment? • Yes
12.8.3	Is there an established process for engaging service providers, including proper due diligence prior to engagement?

	• Yes
12.8.4	Is a program maintained to monitor service providers' PCI DSS compliance status at least annually? • Yes
12.8.5	Is information maintained about which PCI DSS requirements are managed by each service provider, and which are managed by the entity? • Yes
12.10.1	Has an incident response plan been created to be implemented in the event of system breach? • Yes

I. Training provided

1. Cashiers / Frontline Staff
    a. How to properly use PCI-approved terminals.
    b. Prohibition on entering card numbers into computers manually.
    c. Secure destruction of paper imprints or authorization notes.
    d. Routinely inspect devices.
    e. Recognizing signs of device tampering or substitution.
    f. Procedure to immediately report suspected tampering (e.g., helpdesk escalation).
2. IT / Security / Informatics Staff
    a. Inventory management of card devices (make, model, serial number, location).
    b. Applying tamper seals and logging inspections.
    c. Ensuring card devices are firewalled from the internet.
    d. Quarterly scanning of systems that could process/transmit CHD.
    e. Access control for gateways and encryption enforcement.
    f. Incident response procedures specific to PCI incidents (e.g., compromise of a payment terminal).
3. Compliance / Risk / Contract Owners
    a. Maintaining a list of service providers & contracts.
    b. Monitoring PCI compliance annually.
    c. Reviewing and monitoring contracts with PCI elements.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. PCI P2PE Requirements

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	11/12/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	11/11/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/23/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/20/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/17/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **17903822**

Origination	5/27/2022	Owner	Stephanie Frizzell: Director Education
Approved	N/A	Area	Scopes Of Service
Expires	1 year after approval		

Scope of Service: Education Department

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goals of the Education Department are:

A. To plan, coordinate, implement, and evaluate programs which meet the needs of all hospital employees.

B. To assist the hospital in achieving and maintaining a high standard of exemplary patient care through education, training, competency and professional development.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

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

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

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

highest level of wellness possible.

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

F. To evaluate staff performance on an ongoing basis.

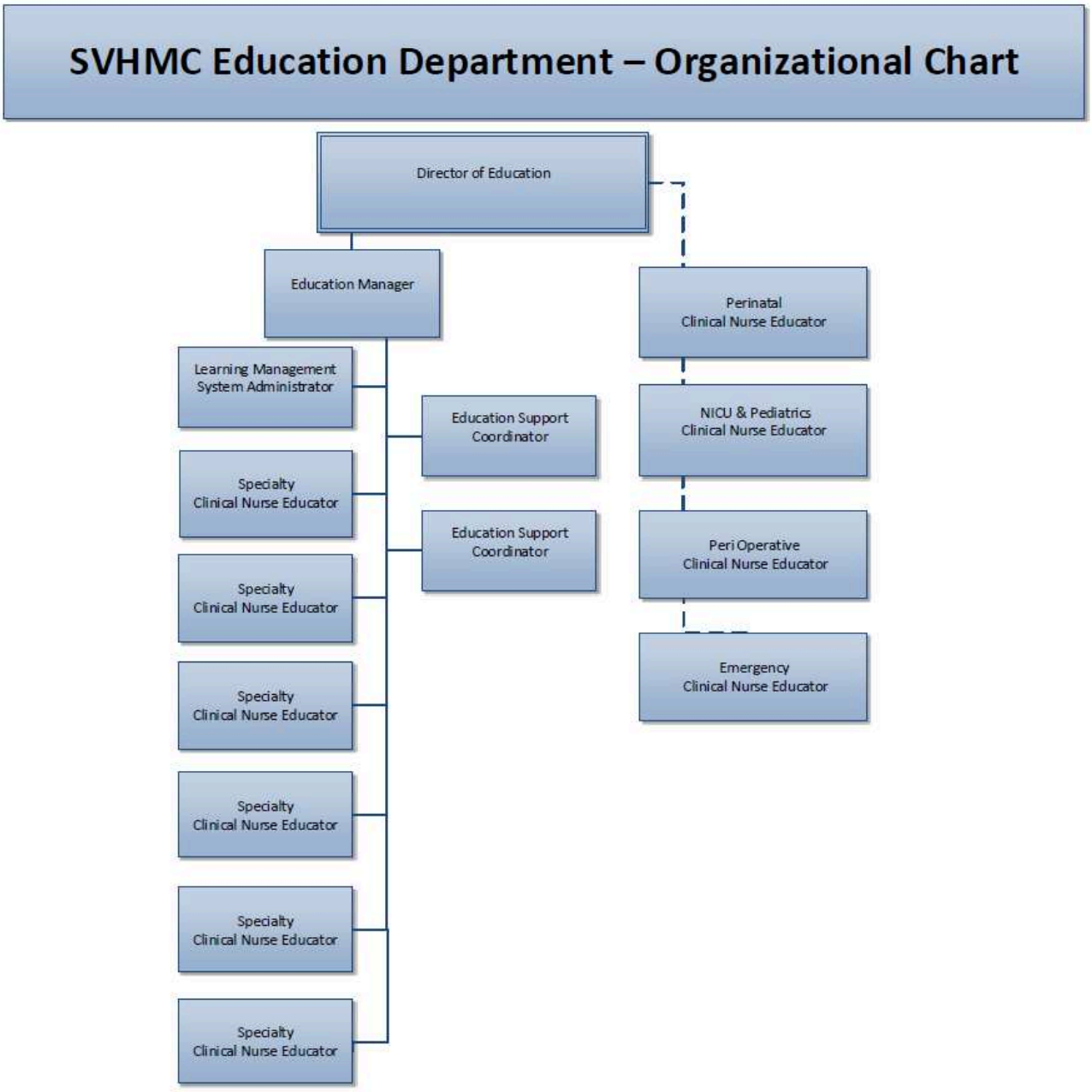
G. To provide appropriate staff orientation and development.

H. To monitor the Education Department function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

The Education Department provides services organization wide.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation:
The Unit/Department provides services Monday through Friday 0730-1630 and other hours as pre-scheduled. Flexible hours scheduling to facilitate pre-scheduled classes and unit-based in-services.

B. Location of department(s):
611 Abbott St. Suite 201, Salinas CA 93901

C. Major Services / Modalities of care may include:

1. Support SVHMC goals and objectives
2. Needs Assessment

3. Collaborate in the provision of appropriate staff orientation, competency validation and ongoing staff development
4. Advances in Healthcare Management and Technology
5. Support Performance Improvement Teams
6. Support Hospital Safety Management Programs
7. Support Peer Review (as appropriate)
8. Support Infection Control Activities
9. Patient Population Specific Education
10. Individual Staff Needs
11. Referrals from Hospital Committees
12. Age Appropriate and Developmental Needs of the Patient Population

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

A. The Department provides organization-wide educational programs that support the Hospital's mission, vision and values statement including:

1. Orientation
2. Continuing Education
3. Nursing Competency Programs
4. Standardized Procedure Training
5. Preceptor Programs
6. Community Education
7. Safety Programs (For hospital personnel, agency and contract)
8. Computer Programs
9. Computer Training (EHR)
10. Equipment Competency Programs
11. Life Safety Certification Programs (CPR, ACLS, PALS, NRP, etc.)
12. Department Educational Programs

The Education Director oversees the operations and staff of the Education Department and reports to the Chief Nursing Officer.

VII. REQUIREMENTS FOR STAFF

A. Licensure / Certifications:

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

1. Current State Licensure

2. Current BLS
3. Non-affiliated, Masters prepared preferred. Affiliated, Bachelors prepared, Masters preferred.
4. Completion of competency based orientation
5. Completion of annual competencies
6. Specialty certification preferred

The basic requirements for ***Education Support Coordinator*** & ***Learning Management System Administrator*** include:

1. Completion of competency based orientation
2. Completion of annual competency
3. Completion of computer/desk training

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:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The unit is staffed with a sufficient number of professional, technical and clerical personnel to permit coverage of established hours service.

General Staffing Plan:

Education Department is fixed staffing with additional utilization of staff nurses for specific classes/ programs

The Skill mix includes RN's, and clerical support.

Assignments are made based on the needs of the department, competencies of the staff, the degree of supervision required, and the level of supervision available.

IX. EVIDENCED BASED STANDARDS

The SVHMC staff will correctly and competently provide the right service by following evidenced based policies and practice standards that have been established..

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, the Education 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 provided by the Quality Council.

Attachments

Image 1

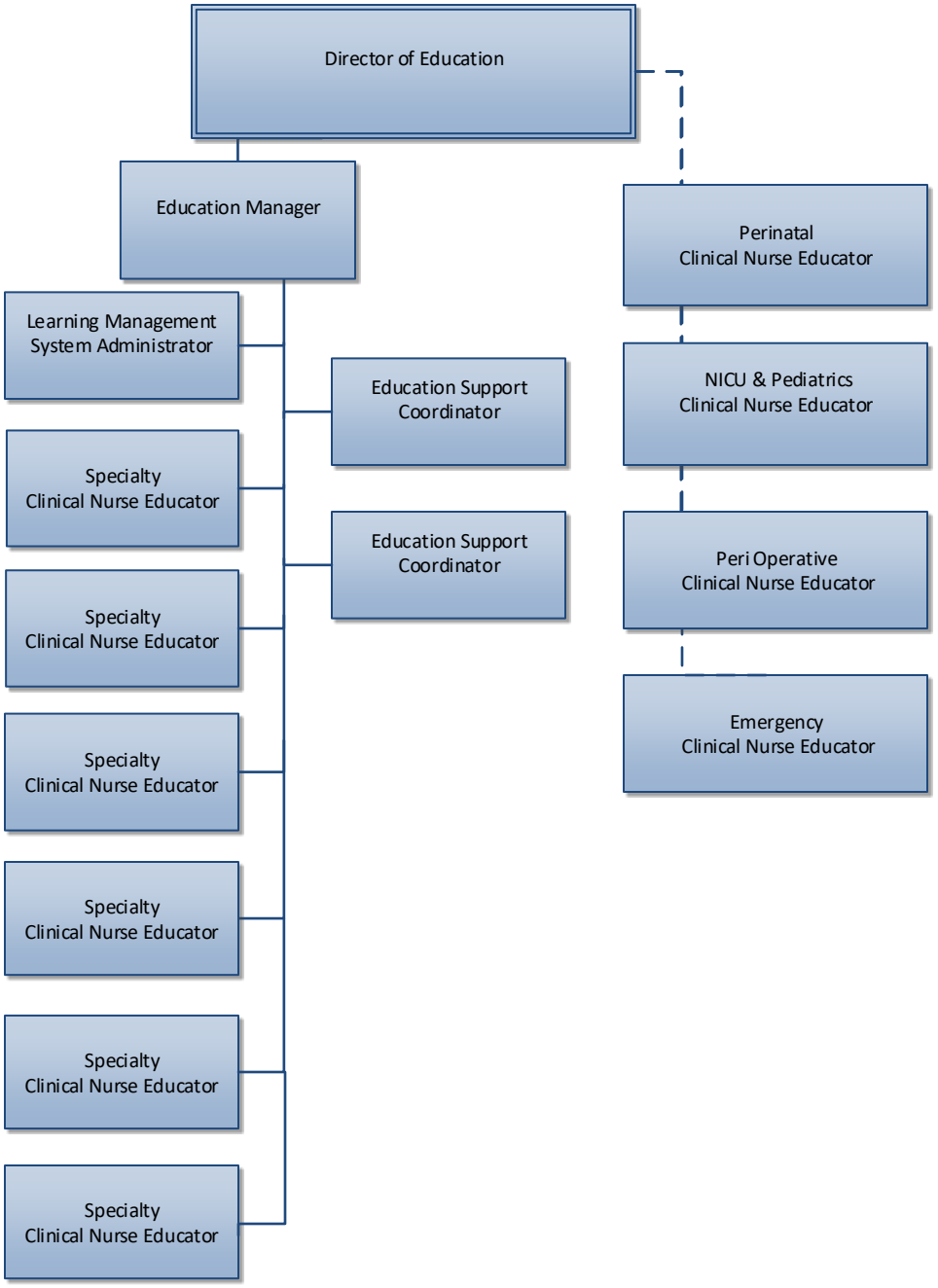
Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	11/18/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/10/2025
Policy Owner	Stephanie Frizzell: Director Education	10/10/2025

Standards

No standards are associated with this document

SVHMC Education Department – Organizational Chart



Status **Pending** PolicyStat ID **18870977**

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

Vulnerability Management

I. POLICY STATEMENT

A. Salinas Valley Health is committed to proactively identifying and remediating vulnerabilities to protect the confidentiality, integrity, and availability of its information systems.

II. PURPOSE

A. This policy establishes roles, responsibilities, and expectations for timely response to discovered vulnerabilities in accordance with regulatory requirements and cybersecurity best practices.

B. 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.

C. All of the cybersecurity policies utilized by Salinas Valley Health are intended to manage risk. The intent of this policy is to lower the risk of adverse cybersecurity incidents by identifying, evaluating, prioritizing, remediating, and reporting vulnerabilities in a timely and consistent manner

III. DEFINITIONS

A. **Biomed (Biomedical Devices)** – Clinical equipment and devices used for patient care that include embedded computing and networking capabilities. These devices often require coordination with vendors for patching and may have regulatory constraints by the FDA.

B. **CIS (Center for Internet Security)** – A nonprofit organization that publishes globally recognized best practices for securing IT systems and data, including the CIS Critical Security Controls.

C. **Compensating Control** – A security control implemented to mitigate risk when the preferred or primary control (e.g., a patch) cannot be applied. These controls must be formally risk accepted and reduce risk to an acceptable level.

D. **CVSS (Common Vulnerability Scoring System)** – An open framework for communicating the characteristics and severity of software vulnerabilities, scored from 0.0 (least severe) to 10.0 (most severe).

E. **Exploitation** – The act of taking advantage of a vulnerability by an attacker or malicious process to gain unauthorized access or cause harm.

F. **HIPAA (Health Insurance Portability and Accountability Act)** – U.S. federal law that, among other provisions, establishes requirements for safeguarding the confidentiality, integrity, and availability of electronic protected health information (ePHI).

G. **IoT (Internet of Things)** – Network-connected devices, often non-traditional IT assets (e.g., sensors, cameras, or smart devices), that can introduce cybersecurity vulnerabilities if not properly managed.

H. **IT (Information Technology)**

I. **NIST (National Institute of Standards and Technology)** – A U.S. federal agency that develops cybersecurity standards and frameworks, including the NIST Cybersecurity Framework (CSF).

J. **RA (Risk Acceptance)** – A formal decision by organizational leadership to accept the risk posed by a known vulnerability that cannot be reasonably remediated, documented through the SVH Cybersecurity Risk Management process.

K. **Scanning Methodologies** – Techniques used to detect vulnerabilities in systems, including agent-based scanning (locally installed sensors), active scanning (network probes), passive scanning (traffic analysis), and credentialed scanning (authenticated access to assess system state).

L. **SVH (Salinas Valley Health)** – The healthcare organization covered by this policy.
Vulnerability – A weakness in an information system, system security procedures, internal controls, or implementation that could be exploited to compromise the confidentiality, integrity, or availability of information or systems.

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 that are externally hosted and/or not managed or controlled by Salinas Valley Health.
2. Guest devices connected to the guest networks.

D. **Roles and Responsibilities**

1. Cybersecurity Risk Manager: Oversees vulnerability scanning, reporting, and escalation.

2. System Owners: Ensure remediations are implemented in a timely manner by providing support and downtime windows where required. IT Security will provide insight into the cybersecurity state of their systems.
3. IT Infrastructure Team: Applies patches, configuration changes, and compensating controls.
4. Information System Managers & Biomed: Coordinate with vendors & IT for patching.

V. PROCEDURE

A. **Risk Prioritization**

1. Risks should generally be addressed by those most critical, taking common risk scores (CVSS) into account. Clinical impact and asset classification will modify prioritization. Vulnerabilities with active exploits will be given higher priority. Vulnerabilities that are not exploitable due to other compensating controls will be deprioritized. Low priority items may be accepted as risks or addressed as able.
2. Specific current operational targets are documented in the Performance Indicator Standard.

B. **Vulnerability Scanning**

1. The Cybersecurity Program shall maintain a Vulnerability Scanning Standard that governs the scope, frequency, and methodology of scanning for SVH systems and devices. All systems in scope of this policy must be scanned in accordance with that standard.

C. **Vulnerability Patching**

1. The Cybersecurity Program shall maintain a Vulnerability Patching Standard that governs the identification, testing, and application of security patches across SVH systems and devices. All systems in scope of this policy must be patched in accordance with that standard. Exceptions must be documented and managed through the Risk Management process.

D. **Remediation Activities**

1. The Cybersecurity Program shall publish and maintain a Vulnerability Remediation Standard that defines requirements for addressing identified vulnerabilities. Remediation activities must be performed in accordance with this standard and remain aligned with the SVH Secure Configuration Policy & Standards and the SVH IT & Informatics Change Control Process. Software that is vulnerable and cannot be patched should be considered for replacement under life cycle management processes.

E. **Deployment Planning**

1. Deployments of remediation solutions should generally be incremental and spaced in such a way to limit the clinical and business impact of remediation activities to the organization. SVH IT must publish and maintain a standard phased deployment order.
2. The potential risk from deploying a remediation should be less than the potential risk

from not remediating a vulnerability.

F. **Required Controls**

1. Vulnerability Management processes and standards must establish the following controls:
    a. Establish and Maintain a Vulnerability Management Process
    b. Establish and Maintain a Remediation Process
    c. Perform Automated Operating System Patch Management
    d. Perform Automated Application Patch Management
    e. Perform Automated Vulnerability Scans of Internal Enterprise Assets
    f. Perform Automated Vulnerability Scans of Externally-Exposed Enterprise Assets
    g. Remediate Detected Vulnerabilities

G. **Biomedical & IOT Devices**

1. The Cybersecurity team will work with Biomed, Engineering, Security, and other departments to address identified vulnerabilities in these devices.
2. The Cybersecurity team will report on Biomedical and IOT devices in addition to IT system vulnerabilities.

H. **Reporting and Governance Oversight**

1. A monthly vulnerability report will be submitted to the Cybersecurity Governance Council. The Director, Information Technology will set general targets for vulnerability metrics as part of ongoing improvement activities. These targets should be communicated to the Governance Council for ratification and communicated in updates

I. **Performance Tracking**

1. Performance will be tracked using key performance and risk indicators, as defined in the Cybersecurity Performance Indicator Standard. Vulnerability updates are required to be provided monthly to the Cybersecurity Governance Committee.

J. **Exception Handling**

1. Requirements for exceptions and risk handling for systems with significant deviation from standards should be escalated through the risk management process outlined in the Cybersecurity Risk Management Policy.

K. **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

ID.RA-01	Vulnerabilities in assets are identified, validated, and recorded.
ID.RA-02	Threats, vulnerabilities, likelihoods, and impacts are used to determine risk.
ID.RA-03	Internal and external threats to the organization are identified and recorded.
ID.RA-04	Vulnerabilities are identified and documented.
ID.RA-05	Threats, vulnerabilities, likelihoods, and impacts are used to understand inherent risk and inform risk response prioritization.
ID.RA-06	Risk responses are chosen from available options, prioritized, planned, tracked, and communicated.
ID.RA-07	Changes and exceptions are managed, assessed for risk impact, recorded, and tracked.
ID.RA-08	Vulnerabilities are prioritized for mitigation based on organizational risk criteria.
PR.PS-02	Software is maintained, replaced, and removed commensurate with risk.
PR.PS-03	Vulnerabilities in platform software and firmware are identified and managed.
164.308(a)(1)(ii)(A)	Risk Analysis – Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI.
164.308(a)(1)(ii)(B)	Risk Management – Implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level.
164.308(a)(8)	Evaluation – Perform periodic technical and

	nontechnical evaluations in response to environmental or operational changes affecting ePHI security.

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	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CAO	Alysha Hyland: Chief Administrative Officer	11/12/2025
VP Information Technology	Audrey Parks: Vice President Information Technology	11/11/2025
Cyber Security Risk Manager	Brian McCarthy: Cybersecurity Risk Manager	10/23/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/20/2025
Policy Owner	Aaron Burnsides: Director Information Technology	10/17/2025

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 recommendations from the Committee is included in the Board Packet

(CATHERINE CARSON)

Board Paper: Personnel, Pension, and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of Hartnell Community College Proposal to Support the Hartnell College Nursing Program**

Executive Sponsor: Allen Radner, MD, President/CEO
Carla Spencer, MSN, RN, CNO

Date: December 8, 2025

Executive Summary

Hartnell Community College District has submitted a request for continued partnership and funding for the Hartnell College Nursing. Hartnell College is requesting a grant in the amount of $1,473,000 over a three (3) year period. Salinas Valley Health and Hartnell College have prepare an Memorandum of Understanding (MOU) setting forth the terms and conditions of the proposed grant funding.

Background/Situation/Rationale

Salinas Valley Health has a long history of partnership with Hartnell College and its Nursing Program, which is vital to the staffing needs of our organization and other local providers. Ongoing support from SVH to Hartnell College over the years has enabled the Nursing Program to attract and retain accomplished staff that has resulted in a high quality program. The purpose of the grant by Salinas Valley Health to Hartnell is to provide financial assistance to improve and expand the Hartnell Nursing Program. The professional and financial support provided by SVH will help Hartnell College address many of the challenges facing the Nursing Program.

Timeline/Review Process to Date

Summer, 2025: Request for funding of Nursing Program submitted by Hartnell to Salinas Valley Health
Fall, 2025: Negotiation of terms and conditions of grant and preparation of MOU
December 16, 2025: Presentation to the SVH Personnel, Pension, and Investment Committee
December 18, 2025: Request for SVH Board Approval of Grant and MOU

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

Salinas Valley Health's mission to provide quality care and improve the health of the community is supported through a high caliber staff of clinical professionals. Hartnell College has proven an exceptional partner in providing the training necessary to develop nursing students to the level required to meet SVH Medical Center standards.

Pillar/Goal Alignment

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

Financial/Quality/Safety/Regulatory Implications

Granting the Hartnell request as submitted would cost our organization $1,473,000.00 over three (3) years as follows:

	2026	2027	2028
	$460,000	$491,000	$522,000
Total Grant Over 3 Years:			**$1,473,000**

Recommendation

SVH Administration requests a recommendation from the Personnel, Pension, and Investment Committee to the SVH Board of Directors to approve the Memorandum of Understanding between SVH and Hartnell Community College District to provide a grant in the amount of $1,473,000.00 over a three (3) year period to support the Hartnell College Nursing Program.

Attachments: SVH-Hartnell Memorandum of Understanding

MEMORANDUM OF UNDERSTANDING

Between
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
and
HARTNELL COMMUNITY COLLEGE DISTRICT

This Memorandum of Understanding ("MOU") is made and entered into as of **January 1, 2026** ("Effective Date"), by and between **Salinas Valley Memorial Healthcare System** ("SVMHS" or the "District"), a public health care district organized and operated pursuant to Division 23 of the California Health and Safety Code, operating as Salinas Valley Health, and **Hartnell Community College District** ("Hartnell"), a community college district, to provide a grant to support the Hartnell College Nursing Program.

RECITALS

A. SVMHS is the owner and operator of Salinas Valley Health Medical Center, an acute care hospital located at 450 East Romie Lane, Salinas, California ("Hospital").

B. Hartnell is the owner and operator of Hartnell Community College, located at 411 Central Avenue, Salinas, California, which operates the Hartnell College Nursing Program, an academic program to educate and train Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs) for entry-level nursing positions in local health care facilities (the "Nursing Program").

C. SVMHS has determined that it is in the best interest of the District to provide assistance to develop a nurse training school affiliated with Hospital in order to benefit the District.

D. SVMHS is authorized pursuant to California Health and Safety Code Section 32121 to enter into joint ventures, partnerships, or other such legal vehicles to carry out its purposes.

E. SVMHS is authorized by the California Health and Safety Code to make contributions and grants to the Hartnell Nursing Program, which is an important resource for educating and training nurses in the area and attracting them to health care facilities in the District.

F. SVMHS assumes no responsibility for the direction or operation of the Nursing Program and its interest is limited to providing financial resources to support the Nursing Program. Hartnell is solely responsible for the direction and administration of the Nursing Program.

G. It is to the mutual benefit of the parties that the Nursing Program be adequately funded to provide qualified RN and LVN candidates for positions in health care facilities in the District.

H. The parties intend that this MOU shall set forth the responsibilities of each party, and the terms and conditions of the agreement regarding the grant of funds for the Nursing Program.

AGREEMENT

1. Purpose of Grant

The purpose of the grant by SVMHS to Hartnell is to provide financial assistance to improve and expand the Nursing Program. The professional and financial support provided by SVMHS will help Hartnell address the challenges facing the Nursing Program. By working together, SVMHS and Hartnell intend to strengthen the Nursing Program to provide the community with excellent RNs and LVNs to work in local health care facilities.

2. Amount of Grant

The grant of funds from SVMHS to Hartnell for the Nursing Program under this MOU shall be as reviewed and approved by both the Joint Oversight Committee and the SVMHS Board of Directors as specified in Section 4, below. It is estimated that the category spend and annual budget will be consistent with the table below:

Category / Line Item	2026	2027	2028
Faculty			
Nursing Faculty Salaries	$280,000.00	$290,000.00	$300,000.00
Faculty Development	$20,000.00	$21,000.00	$22,000.00
Leadership			
Leadership Faculty	$80,000.00	$90,000.00	$100,000.00
Administrative Support	$25,000.00	$28,000.00	$31,000.00
Other			
Clinical Supplies	$30,000.00	$32,000.00	$34,000.00
Student Scholarships	$25,000.00	$30,000.00	$35,000.00
TOTAL	**$460,000.00**	**$491,000.00**	**$522,000.00**
Three Year Term - Total Eligible Grant:			**$1,473,000.00**

3. Joint Oversight Committee

A Joint Oversight Committee consisting of members from SVMHS and Hartnell will be created to review the progress made on the improvements to the Nursing Program and to oversee the distribution of the grant funds to Hartnell.

- **Composition:** The Joint Oversight Committee shall consist of no more than six (6) members. The President/CEO of SVMHS will appoint three (3) members, and the Superintendent/President of Hartnell will appoint three (3) members. The President/CEO of SVMHS and Superintendent/President of Hartnell shall appoint the chairperson.
- **Meetings:** The Joint Oversight Committee will meet quarterly to review reports submitted by Hartnell and shall prepare an annual report for the SVMHS Board.
- **Agenda:** The agenda shall include but not limited to the following: program updates, clinical placement/operations, financial/resource review and strategic initiatives.
- **Annual Report:** The Joint Oversight Committee will report directly to the SVMHS Board of Directors and will provide the same annual report to the Hartnell Board of Trustees for its information.

4. Annual Budget and Estimated Payment Schedule

Each Academic Year during the term of this MOU, Hartnell will submit to SVMHS a detailed budget for the Nursing Program ("Annual Budget") and an estimated annual payment ("Payment"). The Joint Oversight Committee will review and submit both to the SVMHS Board of Directors for approval. Grant funding shall only be provided to Hartnell upon approval of the Annual Budget and Payment Schedule by the SVMHS Board of Directors.

5. Payment of Grant Funds

Annually, Hartnell will submit to the Joint Oversight Committee a request for funds required for the Nursing Program as outlined in this agreement. Upon approval, funds will be disbursed to the Hartnell College Foundation, which shall in turn distribute the funds to Hartnell accordingly.

6. Financial/Accounting Reports

Hartnell will provide quarterly financial reports showing Nursing Program expenditures and a narrative progress report. The Joint Oversight Committee will review and determine compliance with the approved plan.

7. SVMHS Board Authority

The SVMHS Board of Directors, in its sole discretion, will make the final decision whether to approve distributions of grant funds. The Board reserves the right to increase, decrease, or discontinue distributions at any time.

8. Term of MOU

This MOU shall commence on the Effective Date and continue for three (3) years. Continuation of funding will be subject to annual review and approval by the SVMHS Board, based on Hartnell's submission of an updated budget, payment schedule, and action plan.

9. Return of Unused Grant Funds

Upon expiration of this MOU, any unused or uncommitted grant funds shall be returned to SVMHS.

SIGNATURES

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

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

HARTNELL COMMUNITY COLLEGE DISTRICT

By: _____
Name: _____
Title: _____
Date: _____

Hartnell Nursing Partnership

Carla Spencer, MSN, RN, NEA-BC
Chief Nursing Officer
December 8, 2025

Current/Future State of Nursing

Category	Key Facts
Vacancy Rates	-- 63,720 RN shortage by 2030
Nursing School Challenges	- 78,000 qualified applicants turned away (2022) - ~2,000 faculty vacancies - CA vacancy >30% with faculty funding threats
Outlook	- Enrollment rising but bottlenecks remain -Hospital/Nursing school partnerships essential - Strategic investment in faculty & infrastructure critical

Hartnell College History

- Nursing
  - Fully accredited through Accreditation Commission for Education in Nursing (ACEN)
  - Full-time, 4 semester cohort model with up to **50** students each
  - NCLEX pass rates average over 90%
  - Center for Nursing & Health Sciences- opened 2022
    - Funded by Measure T bonds and **$3 million from SVH (2019-2024)**

Current Relationship

Clinical placement for students	• Support all four semesters • On average support over 30 students in 19 departments
Staffing	• 10 SVH RN's serve as clinical or lecture instructors
Mock interviews	• SVH Leaders participate in a mock interview session with all 4th semester students for job preparation
New Graduate RN program	• Two cohorts per year (spring/fall) • **Average # RN's hired- 17** • Average % Hartnell students- 70%

Current Proposal

- Financial Support- 1st payment- July, 2026 as part of a formal partnership. 3 year term
- Initial Request for $3M
- Proposal:

Category / Line Item	2026	2027	2028
Faculty			
Nursing Faculty Salaries	$280,000.00	$290,000.00	$300,000.00
Faculty Development	$20,000.00	$21,000.00	$22,000.00
Leadership			
Leadership Faculty	$80,000.00	$90,000.00	$100,000.00
Administrative Support	$25,000.00	$28,000.00	$31,000.00
Other			
Clinical Supplies	$30,000.00	$32,000.00	$34,000.00
Student Scholarships	$25,000.00	$30,000.00	$35,000.00
TOTAL	**$460,000.00**	**$491,000.00**	**$522,000.00**

Three Year Term - Total Eligible Grant $1,473,000.00

- As part of MOU - Development of Joint Oversight Committee
  - Program updates- Enrollment/attrition
  - Clinical placements/operations
  - Financial/resource review
  - Strategic initiatives

Planned Formal Announcement / Event

References

U.S. Bureau of Health Workforce (HRSA) – Nursing Workforce Projections

2020–2035https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Nursing-Workforce-Projections-Factsheet.pdf

American Association of Colleges of Nursing (AACN) – Enrollment and Faculty Shortages

https://www.aacnnursing.org/news-data/all-news/new-aacn-data-points-to-enrollment-challenges-facing-us-schools-of-nursing

AP News – Nursing Faculty and Enrollment Bottlenecks

https://apnews.com/article/be533b153cef33c6cb47f5b38787b9cf

San Francisco Chronicle – California Nursing Program Shortages and Vacancy Rates

https://www.sfchronicle.com/opinion/openforum/article/nurse-program-shortage-california-20238376.php

JAMA Health Forum (2024) – Projected Nursing Workforce to 2035

https://jamanetwork.com/journals/jama-health-forum/fullarticle/2815057

FINANCE COMMITTEE

Minutes of the Finance Committee will be distributed at the Board Meeting

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

(VICTOR REY, JR.)

Financial Performance Review

October 2025

Finance Committee

Iftikhar Hussain

Chief Financial Officer

Consolidated Financial Results
October 2025

Month				$ in Millions	YTD			
		Variance fav (unfav)					Variance fav (unfav)	
Actual	Budget	$	%		Actual	Budget	$	%
$ 78.0	$ 70.5	$ 7.5	10.6%	Operating Revenue	$ 293.5	$ 278.8	$ 14.7	5.3%
74.5	68.6	(5.9)	-8.6%	Operating Expense	281.5	272.2	(9.3)	-3.4%
3.5	**1.9**	**1.6**	**84.2%**	**Income from Operations**	**12.0**	**6.6**	**5.4**	**81.8%**
4.5%	*2.7%*	*1.8%*	*66.67%*	*Operating Margin %*	*4.1%*	*2.4%*	*1.7%*	*70.8%*
				Op. margin % full year target		*3.0%*		
1.5	2.5	(1.0)	-40.0%	Non Operating Income	10.0	9.9	0.1	1.0%
5.0	**4.4**	**0.6**	**13.6%**	**Net Income**	**22.0**	**16.5**	**5.5**	**33.3%**
6.4%	*6.2%*	*0.2%*	*3.2%*	*Net Income Margin %*	*7.5%*	*5.9%*	*1.6%*	*27.1%*

October results include $7.8 million in supplemental payments

Key Financial Indicators

Indicator Metric		YTD 10/31/2025	Budget	S&P A+ Rated	YTD Prior Year
Operating Margin*		4.1%	0.4%	4.0%	3.6%
Total Margin*		7.5%	4.0%	6.6%	9.3%
EBITDA Margin**		8.1%	5.4%	13.6%	8.0%
Days of Cash*		376	317	249	365
Days of Accounts Payable*		47	45	-	45
Days of Net Accounts Receivable***		68	60	49	61
Supply Expense as % NPR		15.3%	14.6%	-	14.3%
SWB Expense as % NPR		52.9%	54.1%	53.7%	53.0%
Operating Expense per APD*		7,477	7,205	-	6,778

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 – October 2025

Oct Act	Oct Bud	Variance		Key Statistics	YTD Oct	YTD Oct Bud	Variance YTD
				Inpatient			
109	114	↓	-4%	ADC	103	114	↓ -10%
965	931	↑	4%	Admissions	3,696	3,695	↑ 0%
105	130	↓	-19%	Deliveries	429	518	↓ -17%
2.1	2.3	↑	-9%	Medicare Traditional ALOS CMI Adjusted	2.1	2.3	↑ -9%
1.69	1.75	↓	-3%	Medicare Traditional Case Mix	1.75	1.75	↑ 0%
				Emergency Room			
4,688	4,653	↑	1%	ER OP Visits	18,190	18,464	↓ -1%
756	719	↑	5%	ER IP Admissions	2,866	2,851	↑ 1%
				Procedures			
161	146	↑	10%	IP Surgeries	634	579	↑ 9%
348	293	↑	19%	OP Surgeries	1,326	1,162	↑ 14%
341	333	↑	2%	Cath Lab	1,308	1,323	↓ -1%
1,333	1,158	↑	15%	OP Infusion Cases	5,219	4,595	↑ 14%
265	405	↓	-35%	MRI Procedures	1,209	1,606	↓ -25%
2,198	2,168	↑	1%	CT Scans	8,646	8,602	↑ 1%
				Observation Cases			
212	152	↑	39%	Obs Cases	828	605	↑ 37%

Executive Summary: October Financial Performance

Salinas Valley Health's Income from Operations was $3.5 million for the month which was favorable to budget by $1.6M due to strong payor mix and outpatient volume

Volume and Acuity:

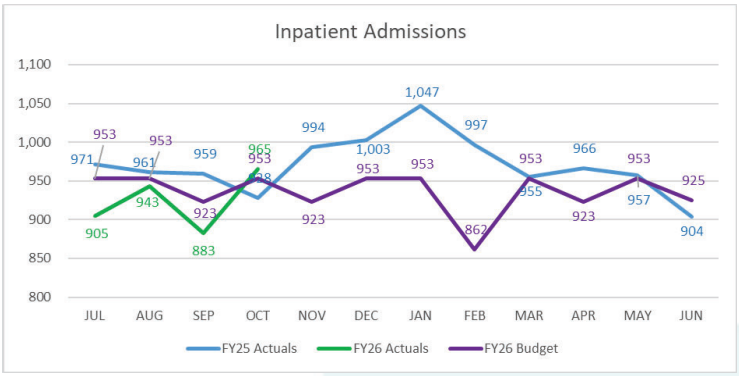
- **Admissions and Census**
  - **Admissions** over budget by 4% (34 cases)
  - **ADC** was 4% below budget due to lower length of stay
  - **Average Length of Stay** was 8% favorable to budget at 3.5 days
  - **Medicare Case Mix Adjusted Average Length of Stay** was favorable by 10% at 2.1 days
- **All Payor Case Mix** of 1.54 was 1% under budget
- **Surgeries** were over budget by 10% (15 cases)
- **Deliveries** were under budget by 20% (25 cases)
- **Cath Lab** – cases were over budget by 2% (8 cases)
- **Outpatient Revenues -** favorable to budget by $20M (12%), Key services driving this variance were:
  - **OP Infusion Program -** cases were over budget by 15% (175 cases)
  - **OP Surgeries –** cases were over budget by 19% (55 cases)
  - **Observation cases** were over budget by 39% (60 cases)
- **MRI Procedures** were under budget by 35% (140 cases) but higher than prior year

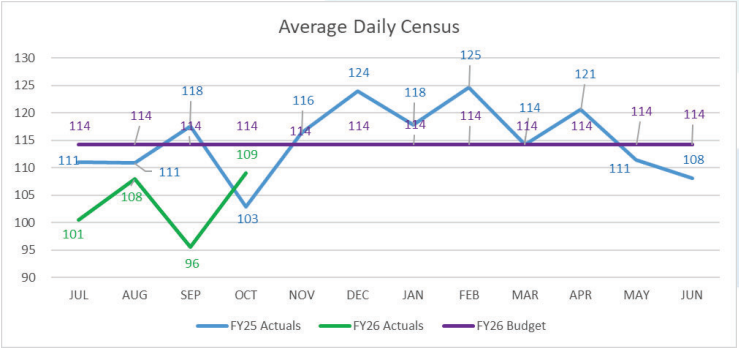
Executive Summary: October Financial Performance – Continued

Cost and Utilization:

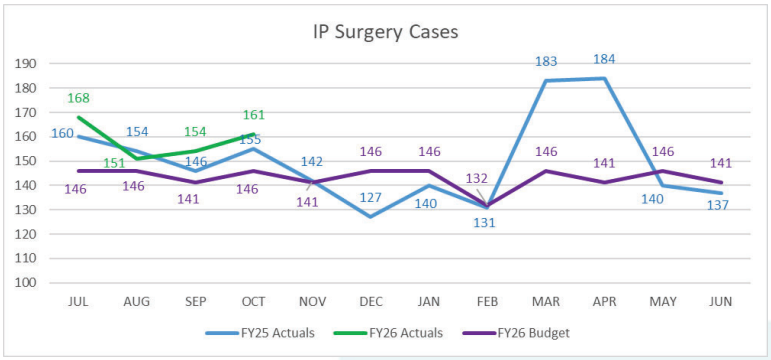
- **Worked FTEs** on a per Adjusted ADC basis were **1%** unfavorable at **6.6** - compared to a target of **6.5**
- **Payor Mix** was favorable with higher than expected Commercial revenue, up 15%. Medi-Cal was up 6%; While Medicare was flat to target
- **Non-Operating Income** was under budget $1.0 Million driven by lower interest rates and light donation income
- **Days in AR** at 68 is trending over target due to slow paying insurance providers
- **Days Cash on Hand** at 376 is up 3% from Oct 2024 due to favorable operating margin
- **Operating Expenses per APD** for the month were over budget by 5.8% due to higher labor costs including SWB and contract labor attributed to the Epic and Workday Projects

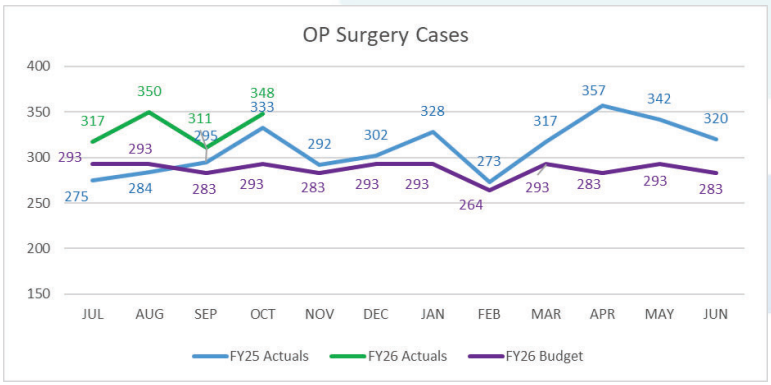
Volume Trends – Admissions & ADC



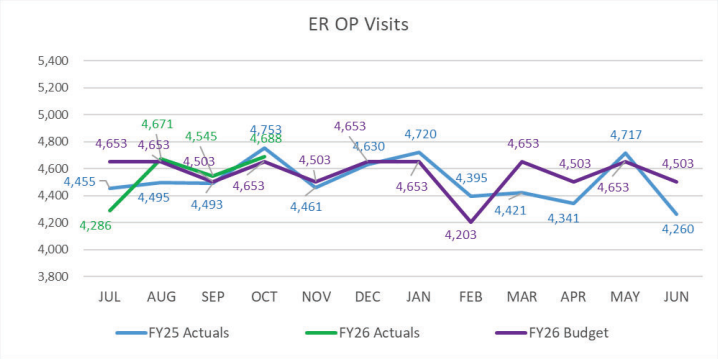


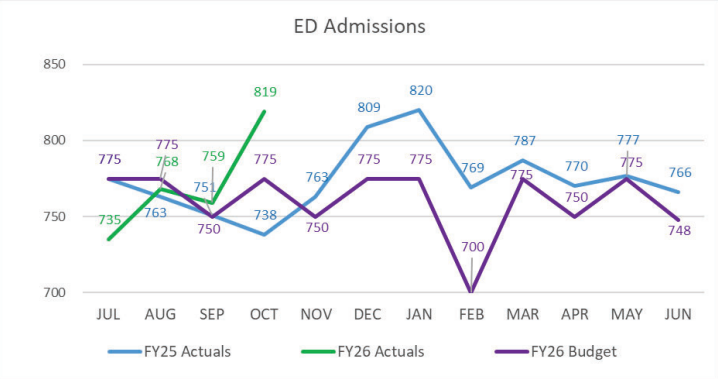
Volume Trends - Surgery Cases



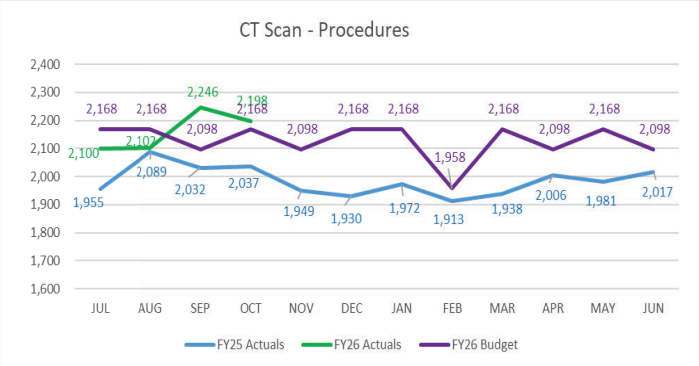


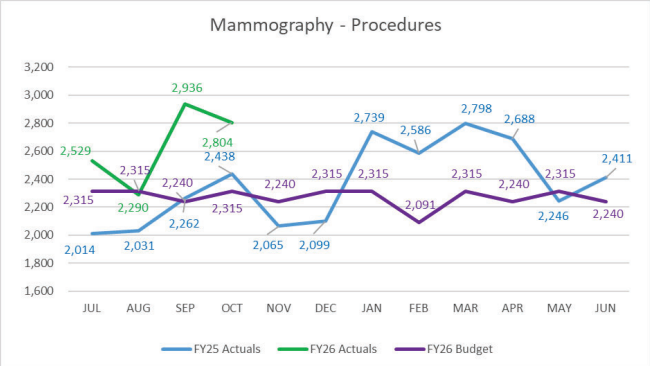
Volume Trends - ER Visits

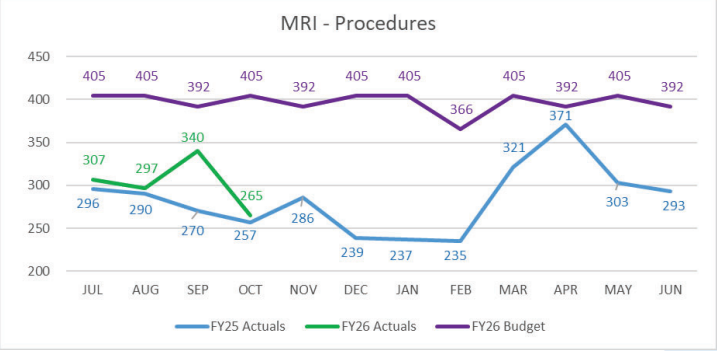




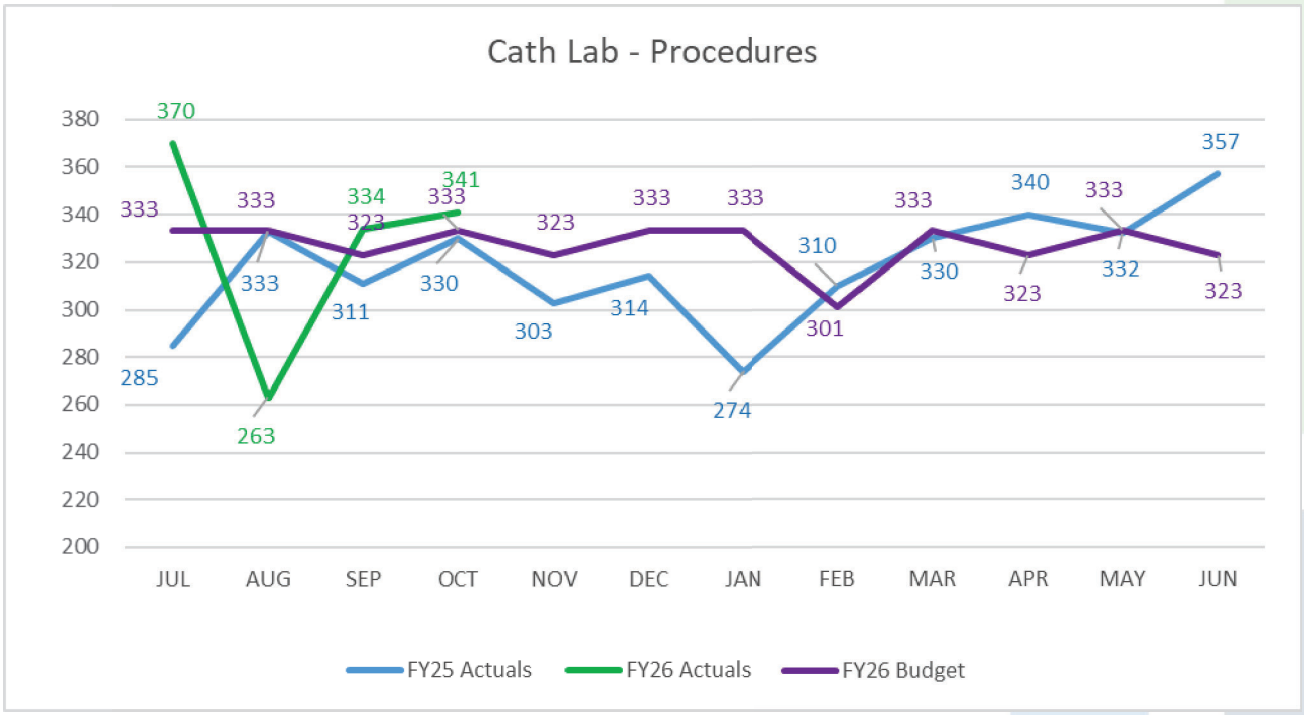
Volume Trends - Imaging





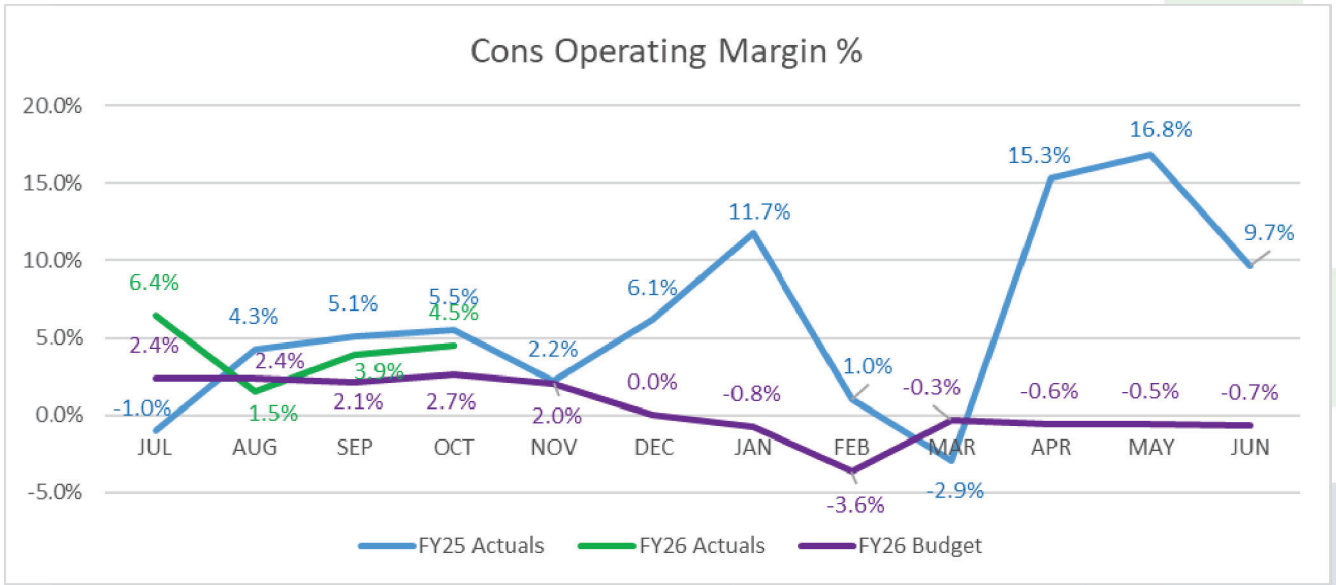


Volume Trends - Cath Lab



11

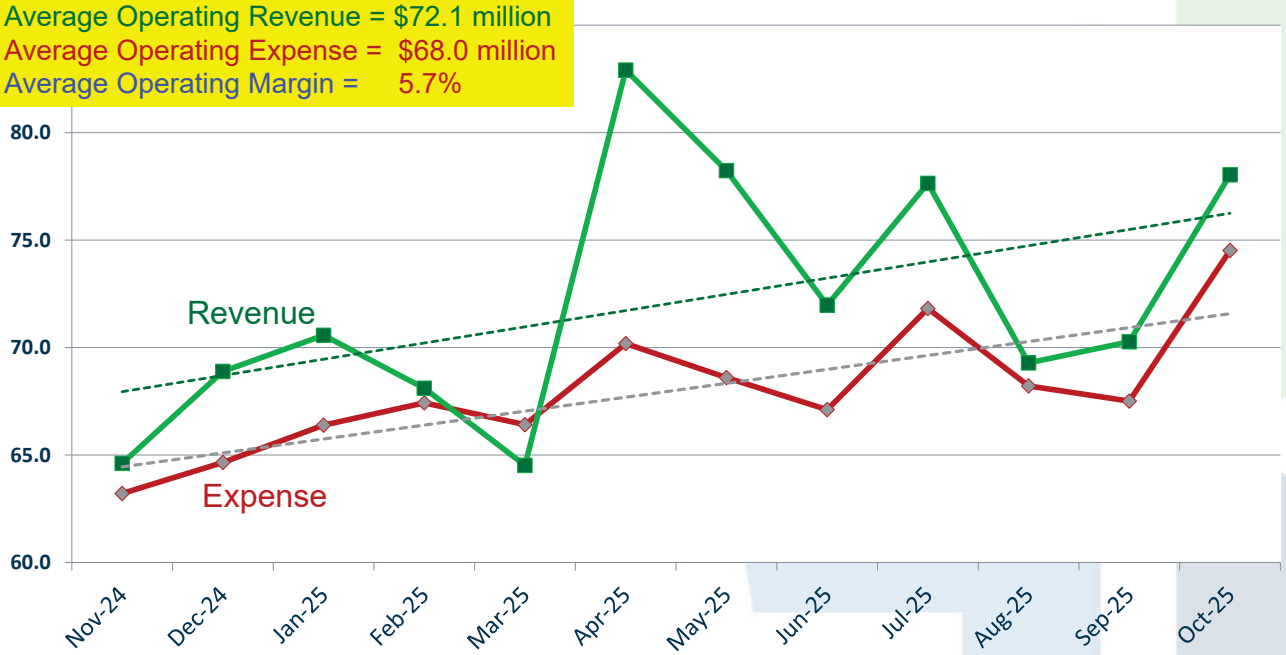
Consolidated Operating Margin



12

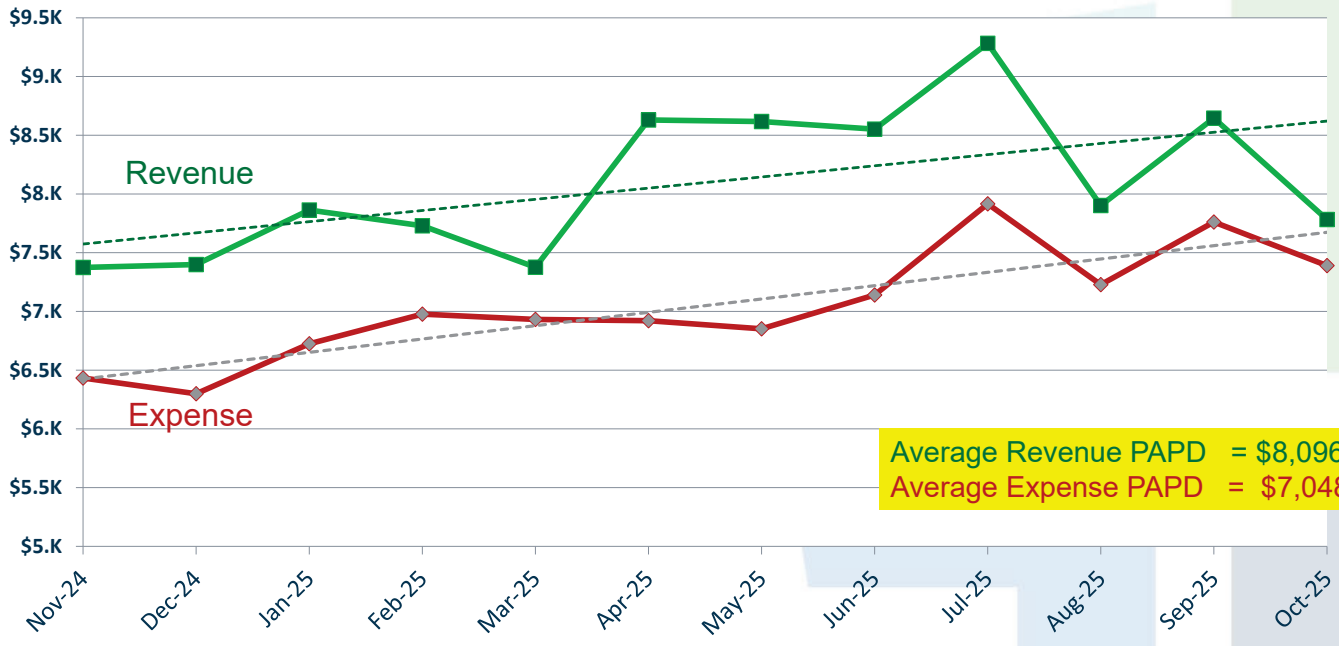
Consolidated Revenues & Expenses
Rolling 12 Months: Nov 24 to October 25

12 Month Average Operating Revenue = $72.1 million
12 Month Average Operating Expense = $68.0 million
12 Month Average Operating Margin = 5.7%



13

Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Nov 24 to October 25



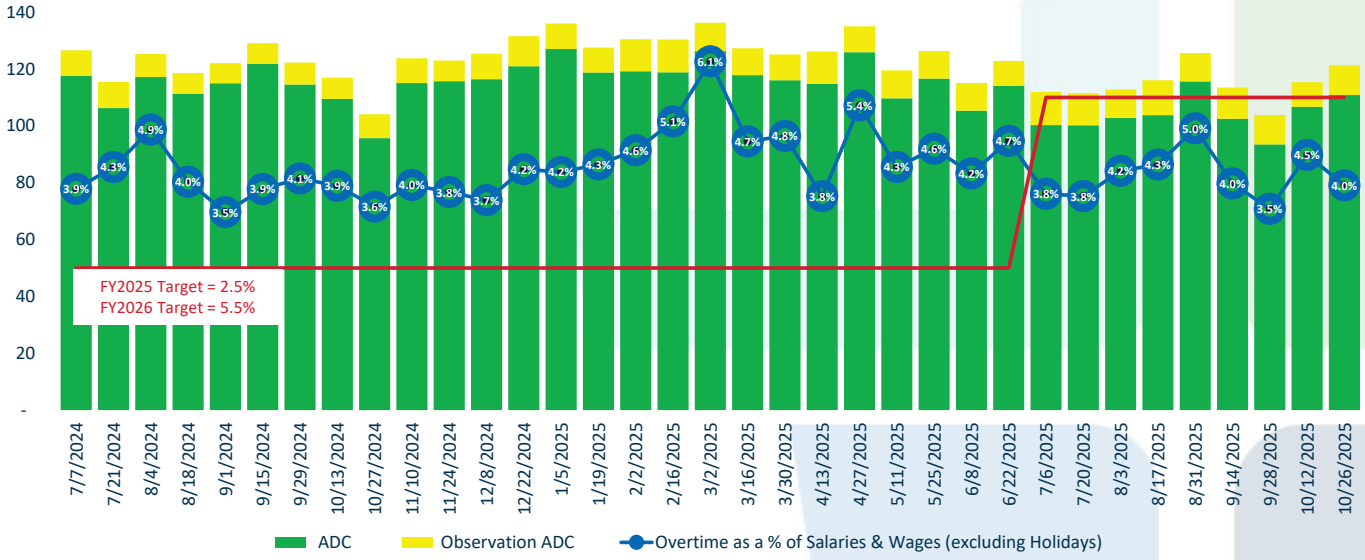
Average Revenue PAPD = $8,096
Average Expense PAPD = $7,048

14

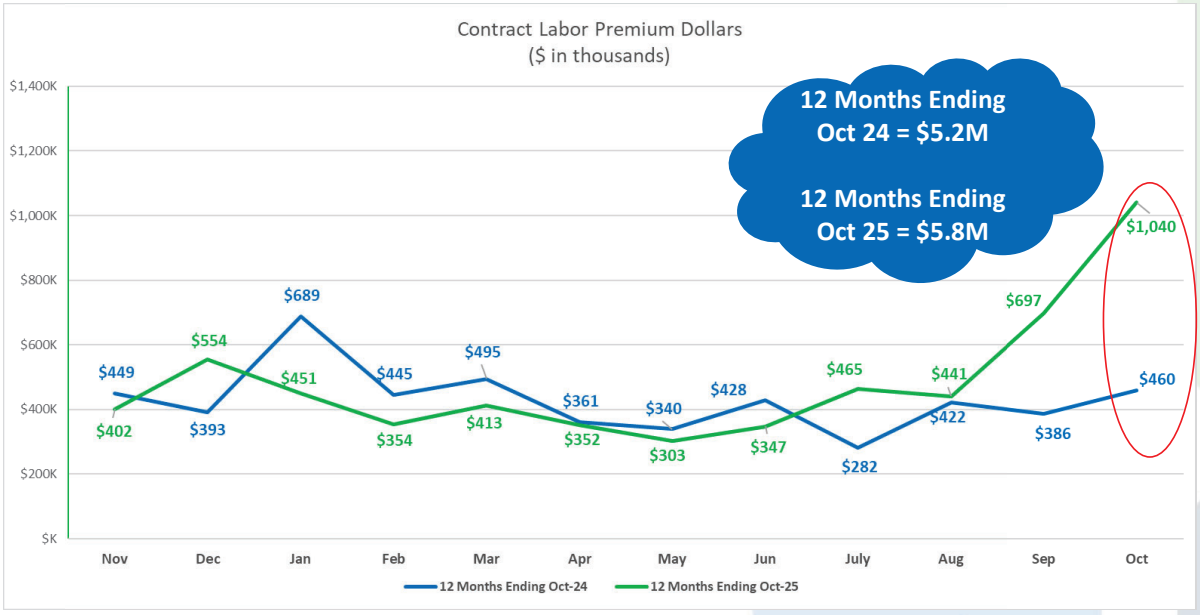
Overtime as a Percent of Total Salaries & Wages

(excluding Holidays)

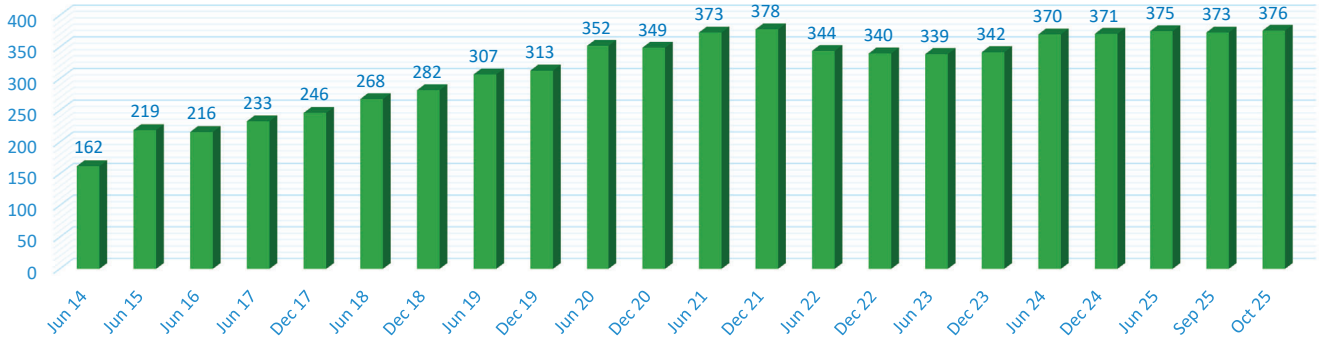
Through the pay period ending October 26, 2025

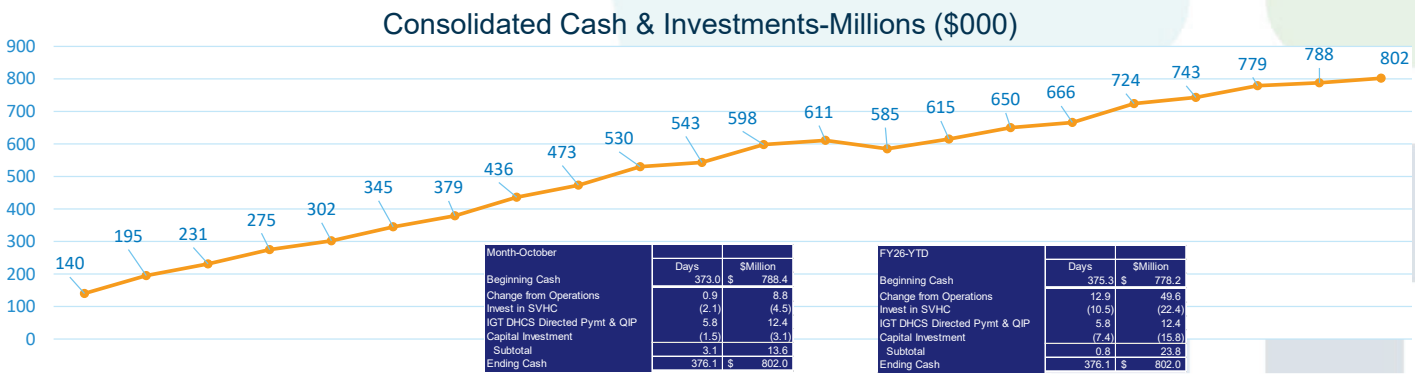


Contract Labor Premium Cost – 12 months ended 10/31/2025



Days Cash on Hand = 376 Days ($802M) - October 2025





Month-October	Days	$Million
Beginning Cash	373.0	$ 788.4
Change from Operations	0.9	8.8
Invest in SVHC	(2.1)	(4.5)
IGT DHCS Directed Pymt & QIP	5.8	12.4
Capital Investment	(1.5)	(3.1)
Subtotal	3.1	13.6
Ending Cash	376.1	$ 802.0

FY26-YTD	Days	$Million
Beginning Cash	375.3	$ 778.2
Change from Operations	12.9	49.6
Invest in SVHC	(10.5)	(22.4)
IGT DHCS Directed Pymt & QIP	5.8	12.4
Capital Investment	(7.4)	(15.8)
Subtotal	0.8	23.8
Ending Cash	376.1	$ 802.0

Questions/Comments

Salinas Valley HEALTH

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
October 31 ,2025

	Month of October		Three months ended October 31	
	Current Year	Prior Year	Current Period YTD	Prior Year YTD
Operating revenue:				
Net patient revenue	$ 62,074,983	$ 59,686,015	$ 239,539,597	$ 224,212,113
Other operating revenue	4,727,907	1,384,449	10,449,825	5,835,367
Total operating revenue	66,802,889	61,070,464	249,989,422	230,047,480
Total operating expenses	59,328,075	52,020,721	221,819,018	200,980,107
Total non-operating income	(2,748,033)	(9,085,204)	(7,241,497)	(5,215,178)
Operating and non-operating income	**$ 4,726,781**	**$ (35,460)**	**$ 20,928,907**	**$ 23,852,195**

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
October 31 ,2025

	Current year	Prior year
Current assets	$ 467,726,335	$ 408,152,387
Assets whose use is limited or restricted by board	179,194,817	169,484,999
Capital assets	249,248,822	251,735,690
Other assets	373,759,717	304,327,503
Deferred pension outflows	55,438,539	85,734,219
	$1,325,368,230	$1,219,434,798
LIABILITIES AND EQUITY:		
Current liabilities	$ 107,362,865	$ 90,203,089
Long term liabilities	22,838,976	19,269,855
Lease deferred inflows	2,292,108	1,597,633
Pension liability	79,394,685	90,863,576
Net assets	1,113,479,596	1,017,500,645
	$1,325,368,230	$1,219,434,798

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
October 31, 2025

Current Year	Prior Year		Current YTD	Prior YTD
		Patients days:		
		By payer:		
1,577	1,535	Medicare	5,939	6,656
952	1,058	Medi-Cal	3,910	4,148
760	511	Commercial insurance	2,482	2,430
121	82	Other patient	509	408
3,410	3,186	Total patient days	12,840	13,642
		Gross revenue:		
132,855,210	124,948,897	Medicare	523,466,536	496,429,257
89,848,969	84,090,174	Medi-Cal	343,239,444	321,301,717
70,722,339	59,843,842	Commercial Insurance	260,048,516	232,866,679
11,336,772	9,958,979	Other patient	49,288,056	43,182,825
304,763,290	**278,841,892**	**Gross revenue**	**1,176,042,552**	**1,093,780,477**
		Deductions from revenue:		
412,106	107,129	Administrative adjustments	1,062,257	708,157
1,256,585	285,450	Charity care	4,052,047	1,699,263
		Contractual adjustments:		
51,460,146	43,748,804	Medicare outpatient	201,928,688	169,468,752
47,932,762	43,110,669	Medicare inpatient	183,615,983	183,164,488
918,174	1,384,951	Medi-Cal traditional outpatient	5,092,968	6,096,229
(251,588)	5,298,827	Medi-Cal traditional inpatient	13,293,391	25,255,236
48,488,505	42,614,473	Medi-Cal managed care outpatient	177,555,875	157,159,906
27,669,000	25,980,646	Medi-Cal managed care inpatient	109,563,612	100,822,144
31,948,450	29,500,251	Commercial insurance outpatient	115,500,238	106,814,458
19,076,353	20,017,265	Commercial insurance inpatient	79,276,716	89,446,075
6,699,468	5,936,342	Uncollectible accounts expense	25,230,274	21,776,842
7,078,345	1,171,070	Other payors	20,330,913	7,156,815
242,688,307	**219,155,877**	**Deductions from revenue**	**936,502,962**	**869,568,364**
62,074,983	**59,686,015**	**Net patient revenue**	**239,539,590**	**224,212,113**
		Gross billed charges patient type:		
128,726,644	119,609,802	Inpatient	509,991,733	507,184,523
140,930,789	126,291,443	Outpatient	523,895,864	457,191,955
35,105,857	32,940,646	Emergency room	142,154,955	129,403,999
304,763,290	**278,841,892**	**Total**	**1,176,042,552**	**1,093,780,477**

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
October 31, 2025

Month of October			Three months ended October 31		
Current Year	**Prior Year**		**Current Year**	**Prior Year**	
		Operating revenue:			
$ 304,763,290	$ 278,841,892	Gross billed charges	$ 1,176,042,552	$ 1,093,780,477	
242,688,307	219,155,877	Deductions from revenue	936,502,955	869,568,364	
62,074,983	**59,686,015**	**Net patient revenue**	**239,539,597**	**224,212,113**	
4,727,907	1,384,449	Other operating revenue	10,449,825	5,835,367	
66,802,889	**61,070,464**	**Total operating revenue**	**249,989,422**	**230,047,480**	
		Operating expenses:			
20,147,806	17,840,445	Salaries and wages	76,866,355	69,910,189	
3,879,925	3,199,695	Compensated absences	13,579,514	12,892,793	
9,197,767	9,686,002	Employee benefits	33,694,560	35,034,970	
10,209,665	8,766,666	Supplies, food, and linen	37,813,489	33,856,578	
4,811,731	3,976,874	Purchased department functions	18,016,241	15,473,276	
2,628,254	2,526,919	Medical Fees	10,841,896	9,678,784	
3,396,746	2,053,422	Other Fees	11,324,149	7,074,053	
2,808,099	2,510,650	Depreciation	10,782,973	9,968,547	
2,248,082	1,460,048	All other expense	8,899,842	7,090,918	
59,328,075	**52,020,721**	**Total Operating expenses**	**221,819,018**	**200,980,107**	
7,474,814	**9,049,743**	**Income from operations**	**28,170,404**	**29,067,373**	
		Non-operating Income:			
9,908	1,290,259	Donations	597,660	2,336,771	
500,550	476,714	Property taxes	2,002,200	1,906,857	
750,562	(5,849,629)	Investment Income	5,287,375	9,172,943	
(4,009,053)	(5,002,548)	Income from subsidiaries	(15,128,732)	(18,631,749)	
(2,748,033)	**(9,085,204)**	**Total non-operating income**	**(7,241,497)**	**(5,215,178)**	
$ 4,726,781	**$ (35,460)**	**Operating and non-operating income**	**$ 20,928,907**	**$ 23,852,195**	

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
October 31, 2025

	Current Year	Prior Year
ASSETS		
Current assets:		
Cash and Cash Equivalents	$ 314,751,701	$ 270,021,236
Patient accounts receivable, net of estimated uncollectibles	134,364,803	112,900,273
Supplies inventory at cost	5,787,876	9,846,357
Current portion of lease receivable	270,803	1,289,074
Other current assets	12,551,152	14,095,447
Total current assets	467,726,335	408,152,387
Assets whose use is limited or restricted by board	179,194,817	169,484,999
Capital assets:		
Land and construction in process	47,514,598	48,502,455
Other capital assets, net of depreciation	201,734,224	203,233,235
Total capital assets	249,248,822	251,735,690
Other assets:		
Right of use assets, net of amortization	10,795,452	6,786,470
Long term lease receivable	1,974,781	340,754
Subscription assets, net of amortization	39,180,322	8,533,482
Investment in securities	276,086,562	262,705,786
Investment in SVMC	2,397,282	2,815,247
Investment in Aspire/CHI/Coastal	1,770,630	1,804,972
Investment in other affiliates	21,061,680	21,852,891
Net Pension Asset	19,960,835	(1,044,272)
Goodwill	532,173	532,173
Total other assets	373,759,717	304,327,503
Deferred Pension Outflows	55,438,539	85,734,219
Total assets	$ 1,325,368,230	$ 1,219,434,798
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable and accrued expenses	$ 75,060,078	$ 58,133,800
Due to third party payors	4,622,068	3,689,071
Current portion of self-insurance liability	22,086,881	22,468,642
Current subscription liability	1,901,002	3,374,059
Current portion of lease liability	3,692,836	2,537,518
Total current liabilities	107,362,865	90,203,089
Long term portion of workers comp liability	11,655,972	12,078,720
Long term portion of lease liability	7,558,585	4,315,611
Long term subscription liability	3,624,420	2,875,524
Total Liabilities	130,201,842	109,472,944
Lease deferred inflows	2,292,108	1,597,633
Pension Liability	79,394,685	90,863,576
Net Assets:		
Invested in capital assets, net of related debt	249,248,822	251,735,690
Unrestricted	864,230,774	765,764,955
Total Net Assets	1,113,479,596	1,017,500,645
Total liabilities and net assets	$ 1,325,368,230	$ 1,219,434,798

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - ('000)
October 31, 2025

Actuals	Budget	$ Variance	% Variance		Actuals YTD	Budget YTD	$ Variance YTD	% Variance YTD
				Operating revenue:				
304,763,290	290,967,486	13,795,804	-4.7%	Gross billed charges	1,176,042,552	1,154,600,577	21,441,975	-1.9%
242,688,307	233,425,273	9,263,034	4.0%	Deductions from revenue	936,502,955	926,092,743	10,410,213	-1.1%
62,074,983	**57,542,213**	**4,532,769**	**-7.9%**	**Net patient revenue**	**239,539,597**	**228,507,835**	**11,031,762**	**-4.8%**
4,727,907	1,721,629	3,006,278	-174.6%	Other operating revenue	10,449,825	6,886,515	3,563,310	-51.7%
66,802,889	**59,263,842**	**(7,539,046.99)**	**12.7%**	**Total operating revenue**	**249,989,422**	**235,394,350**	**(14,595,072)**	**6.2%**
				Operating expenses:				
20,147,806	19,230,840	916,966	4.8%	Salaries and wages	76,866,355	74,704,838	2,161,518	-2.9%
3,879,925	3,346,890	533,035	15.9%	Compensated absences	13,579,514	14,558,206	(978,692)	6.7%
9,197,767	8,024,287	1,173,481	14.6%	Employee benefits	33,694,560	31,906,423	1,788,138	-5.6%
10,209,665	9,035,461	1,174,204	13.0%	Supplies, food, and linen	37,813,489	35,852,575	1,960,914	-5.5%
4,811,731	4,505,829	305,902	6.8%	Purchased department functions	18,016,241	18,012,254	3,986	0.0%
2,628,254	2,615,198	13,056	0.5%	Medical Fees	10,841,896	10,457,043	384,853	-3.7%
3,396,746	1,495,564	1,901,182	127.1%	Other Fees	11,324,149	5,973,941	5,350,208	-89.6%
2,808,099	2,570,775	237,324	9.2%	Depreciation	10,782,973	10,256,017	526,956	-5.1%
2,248,082	1,998,880	249,202	12.5%	All other expense	8,899,842	8,129,223	770,618	9.5%
59,328,075	**52,823,723**	**6,504,352**	**12.3%**	**Total Operating expenses**	**221,819,018**	**209,850,520**	**11,968,499**	**-5.7%**
7,474,814	**6,440,119**	**(1,034,695)**	**16.1%**	**Income from operations**	**28,170,404**	**25,543,830**	**(2,626,574)**	**-10.3%**
				Non-operating Income:				
9,908	216,667	(206,759)	95.4%	Donations	597,660	866,667	(269,007)	31.0%
500,550	500,550	-	0.0%	Property taxes	2,002,200	2,002,200	-	0.0%
750,562	1,242,265	(491,703)	39.6%	Investment Income	5,287,375	4,969,759	317,616	-6.4%
(4,009,053)	(4,351,469)	342,416	7.9%	Income from subsidiaries	(15,128,732)	(18,060,366)	2,931,634	16.2%
(2,748,033)	**(2,391,987)**	**(356,046)**	**-14.9%**	**Total non-operating income**	**(7,241,497)**	**(10,221,740)**	**2,980,243**	**29.2%**
4,726,781	**4,048,131**	**(678,649)**	**16.8%**	**Operating and non-operating income**	**20,928,907**	**15,322,091**	**(5,606,817)**	**36.6%**

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

Month of October			Fourth months to date		
2024	2025		2024-25	2025-26	Variance
		NEWBORN STATISTICS			
33	29	Medi-Cal Admissions	142	130	(12)
68	77	Other Admissions	320	307	(13)
101	106	Total Admissions	462	437	(25)
56	44	Medi-Cal Patient Days	304	206	(98)
107	113	Other Patient Days	438	483	45
163	157	Total Patient Days of Care	742	689	(53)
5.3	5.1	Average Daily Census	6.0	5.6	(0.4)
1.9	1.7	Medi-Cal Average Days	2.3	1.7	(0.6)
1.0	1.6	Other Average Days	1.4	1.6	0.2
1.7	1.6	Total Average Days Stay	1.6	1.6	0.0
		ADULTS & PEDIATRICS			
348	327	Medicare Admissions	1,454	1,380	(74)
327	330	Medi-Cal Admissions	1,149	1,199	50
373	323	Other Admissions	1,279	1,183	(96)
1,048	980	Total Admissions	3,882	3,762	(120)
1,255	1,359	Medicare Patient Days	5,479	4,982	(497)
1,128	1,024	Medi-Cal Patient Days	4,411	4,263	(148)
733	754	Other Patient Days	3,558	2,892	(666)
3,116	3,137	Total Patient Days of Care	13,448	12,137	(1,311)
100.5	101.2	Average Daily Census	109.3	98.7	(10.7)
3.6	3.6	Medicare Average Length of Stay	3.8	3.5	(0.3)
3.4	3.1	Medi-Cal AverageLength of Stay	3.4	3.1	(0.3)
2.0	2.0	Other Average Length of Stay	2.2	2.1	(0.1)
3.0	2.9	Total Average Length of Stay	3.1	2.9	(0.2)
23	18	Deaths	99	77	(22)
3,279	3,294	Total Patient Days	14,190	12,826	(1,364)
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 October and fourth months to date

Month of October			Fourth months to date		
2024	2025		2024-25	2025-26	Variance
		PATIENT DAYS BY LOCATION			
217	168	Level I	938	749	(189)
302	317	Heart Center	1,288	1,216	(72)
454	516	Monitored Beds	2,191	2,029	(162)
302	352	Single Room Maternity/Obstetrics	1,371	1,310	(61)
816	812	Med/Surg - Cardiovascular	3,320	3,065	(255)
216	278	Med/Surg - Oncology	1,035	955	(80)
461	484	Med/Surg - Rehab	1,825	1,828	3
107	112	Pediatrics	444	469	25
163	157	Nursery	742	689	(53)
120	98	Neonatal Intensive Care	459	516	57
		PERCENTAGE OF OCCUPANCY			
53.85%	41.69%	Level I	58.66%	46.84%	
64.95%	68.17%	Heart Center	69.81%	65.91%	
54.24%	61.65%	Monitored Beds	65.97%	61.10%	
26.33%	30.69%	Single Room Maternity/Obstetrics	30.13%	28.78%	
58.49%	58.21%	Med/Surg - Cardiovascular	59.98%	55.37%	
53.60%	68.98%	Med/Surg - Oncology	64.73%	59.72%	
57.20%	60.05%	Med/Surg - Rehab	57.07%	57.16%	
0.00%	0.00%	Med/Surg - Observation Care Unit	0.00%	0.00%	
19.18%	20.07%	Pediatrics	20.05%	21.18%	
31.87%	30.69%	Nursery	18.28%	16.97%	
35.19%	28.74%	Neonatal Intensive Care	33.92%	38.14%	

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

Month of October			Fourth months to date		
2024	2025		2024-25	2025-26	Variance
		DELIVERY ROOM			
101	96	Total deliveries	471	418	(53)
32	20	C-Section deliveries	143	117	(26)
31.68%	20.83%	Percent of C-section deliveries	30.36%	27.99%	-2.37%
		OPERATING ROOM			
16,832	19,425	In-Patient Operating Minutes	76,043	76,895	852
39,004	40,021	Out-Patient Operating Minutes	135,112	155,513	20,401
55,836	59,446	Total	211,155	232,408	21,253
13	8	Open Heart Surgeries	50	46	(4)
120	133	In-Patient Cases	501	508	7
368	376	Out-Patient Cases	1,301	1,452	151
		EMERGENCY ROOM			
34	21	Immediate Life Saving	124	152	28
815	925	High Risk	3,486	3,566	80
2,940	2,885	More Than One Resource	11,144	11,499	355
1,875	1,780	One Resource	6,908	6,673	(235)
62	64	No Resources	283	265	(18)
5,726	5,675	**Total**	21,945	22,155	210

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

Month of October			Fourth months to date		
2024	2025		2024-25	2025-26	Variance
		CENTRAL SUPPLY			
11,683	6,633	In-patient requisitions	50,899	35,221	-15,678
12,306	10,019	Out-patient requisitions	45,100	41,962	-3,138
500	408	Emergency room requisitions	2,997	1,533	-1,464
6,214	6,925	Interdepartmental requisitions	26,069	26,097	28
30,703	23,985	Total requisitions	125,065	104,813	-20,252
		LABORATORY			
32,821	34,669	In-patient procedures	138,599	133,256	-5,343
47,796	50,041	Out-patient procedures	179,366	200,562	21,196
12,405	13,210	Emergency room procedures	49,949	53,790	3,841
93,022	97,920	Total patient procedures	367,914	387,608	19,694
		BLOOD BANK			
398	308	Units processed	1,204	1,161	-43
		ELECTROCARDIOLOGY			
1,049	1,154	In-patient procedures	4,366	4,531	165
432	584	Out-patient procedures	1,605	2,330	725
1,252	1,397	Emergency room procedures	5,064	5,741	677
2,733	3,135	Total procedures	11,035	12,602	1,567
		CATH LAB			
129	152	In-patient procedures	518	533	15
132	135	Out-patient procedures	521	571	50
1	0	Emergency room procedures	1	0	-1
262	287	Total procedures	1,040	1,104	64
		ECHO-CARDIOLOGY			
370	450	In-patient studies	1,599	1,667	68
327	427	Out-patient studies	1,333	1,779	446
2	4	Emergency room studies	6	8	2
699	881	Total studies	2,938	3,454	516
		NEURODIAGNOSTIC			
123	112	In-patient procedures	537	497	-40
27	24	Out-patient procedures	95	95	0
0	0	Emergency room procedures	0	1	1
150	136	Total procedures	632	593	-39

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

Month of October			Fourth months to date		
2024	2025		2024-25	2025-26	Variance
		SLEEP CENTER			
0	0	In-patient procedures	0	0	0
311	351	Out-patient procedures	1,136	1,301	165
0	0	Emergency room procedures	0	0	0
311	351	Total procedures	1,136	1,301	165
		RADIOLOGY			
1,184	1,198	In-patient procedures	5,007	4,741	-266
448	450	Out-patient procedures	1,686	1,827	141
1,545	1,630	Emergency room procedures	6,255	6,212	-43
3,177	3,278	Total patient procedures	12,948	12,780	-168
		MAGNETIC RESONANCE IMAGING			
160	193	In-patient procedures	725	840	115
116	85	Out-patient procedures	454	457	3
6	14	Emergency room procedures	26	39	13
282	292	Total procedures	1,205	1,336	131
		MAMMOGRAPHY CENTER			
3,948	4,625	In-patient procedures	13,906	17,395	3,489
3,944	4,610	Out-patient procedures	13,867	17,326	3,459
0	3	Emergency room procedures	3	7	4
7,892	9,238	Total procedures	27,776	34,728	6,952
		NUCLEAR MEDICINE			
15	25	In-patient procedures	70	74	4
157	164	Out-patient procedures	540	594	54
0	0	Emergency room procedures	2	1	-1
172	189	Total procedures	612	669	57
		PHARMACY			
72,090	74,900	In-patient prescriptions	314,261	287,857	-26,404
18,313	19,401	Out-patient prescriptions	67,787	75,494	7,707
10,295	10,900	Emergency room prescriptions	39,621	42,914	3,293
100,698	105,201	Total prescriptions	421,669	406,265	-15,404
		RESPIRATORY THERAPY			
12,719	11,391	In-patient treatments	55,929	46,913	-9,016
908	664	Out-patient treatments	3,571	1,950	-1,621
459	478	Emergency room treatments	1,747	3,377	1,630
14,086	12,533	Total patient treatments	61,247	52,240	-9,007
		PHYSICAL THERAPY			
2,129	2,073	In-patient treatments	9,324	8,551	-773
245	584	Out-patient treatments	991	2,149	1,158
0	0	Emergency room treatments	0	3	3
2,374	2,657	Total treatments	10,315	10,703	388

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

Month of October			Fourth months to date		
2024	2025		2024-25	2025-26	Variance
		OCCUPATIONAL THERAPY			
1,263	1,106	In-patient procedures	5,660	4,802	-858
204	604	Out-patient procedures	808	1,885	1,077
0	0	Emergency room procedures	0	0	0
1,467	1,710	Total procedures	6,468	6,687	219
		SPEECH THERAPY			
478	480	In-patient treatments	1,911	2,085	174
31	63	Out-patient treatments	130	313	183
0	0	Emergency room treatments	0	1	1
509	543	Total treatments	2,041	2,399	358
		CARDIAC REHABILITATION			
1	3	In-patient treatments	3	6	3
691	659	Out-patient treatments	2,618	2,543	-75
0	0	Emergency room treatments	1	3	2
692	662	Total treatments	2,622	2,552	-70
		CRITICAL DECISION UNIT			
234	300	Observation hours	991	869	-122
		ENDOSCOPY			
77	90	In-patient procedures	346	332	-14
54	75	Out-patient procedures	218	260	42
0	1	Emergency room procedures	0	2	2
131	166	Total procedures	564	594	30
		C.T. SCAN			
690	789	In-patient procedures	2,967	3,080	113
552	567	Out-patient procedures	2,004	2,231	227
794	838	Emergency room procedures	3,146	3,329	183
2,036	2,194	Total procedures	8,117	8,640	523
		DIETARY			
15,596	17,018	Routine patient diets	61,790	64,843	3,053
33,520	34,772	Meals to personnel	133,595	138,597	5,002
49,116	51,790	Total diets and meals	195,385	203,440	8,055
		LAUNDRY AND LINEN			
96,315	108,223	Total pounds laundered	382,371	415,080	32,709

Board Paper: Finance Committee

Agenda Item:	**Consider Recommendation for Board Approval of Overall Project Funding and Award Construction Contract to American Chiller Service, Inc for the Salinas Valley Health DRC Chiller & Cooling Tower Replacement Project**
Executive Sponsor:	Clement Miller, Chief Operating Officer Brad McCoy, Vice President of Facilities, Construction and Real Estate
Date:	December 15, 2025

Executive Summary:

Facilities Management is pursuing activities to replace the existing 70-ton chiller and cooling tower assembly in the Downing Resource Center (DRC) at 450 E. Romie Lane with a new 80-ton chiller and cooling tower assembly. Approval for comprehensive project funding in the total estimated amount of **$1,169,000** and award of construction contract to American Chiller Service in the amount of **$838,258** is being requested.

Background/Situation/Rationale:

The existing cooling tower and chiller, installed in 1993, were originally scheduled to be repaired in place, mitigating the need for board approval. To carry out this work, the engineering team partnered with Val's Plumbing to expedite the repair process. However, after multiple additional service calls, the team decided it was more effective to replace—and upsize—the equipment to meet both current and future demands. This led to a request to the finance committee in September for approval of the replacement project. After receiving questions from the committee, the team recognized that the request had been submitted without completing the required competitive bidding process. As a result, the item was withdrawn from the September agenda, and the project was resubmitted through the competitive bidding process, ultimately generating three timely competitive bids from qualified contractors.

Proposed upgrades to the chiller and cooling tower assembly include: (A) new 80-ton nominal chiller, (B) new cooling tower and discharge plenum, (C) two new chilled water pumps, (D) two new condenser water pumps, (E) new air and dirt separator connection to the existing expansion tank, (F) new chilled water supply piping, chilled water return piping, condenser water supply piping, condenser water return piping, treated water supply piping, and treated water return piping to points of connection, (G) new refrigerant leak detection system, (H) modification of existing housekeeping pads and new code-required seismic connections, and (I) integration of new equipment into the existing Siemens Building Management System.

Bidding documents and specifications were prepared by Cole Breit Engineering. The bid was advertised in the Salinas Californian, plans and specs were made available to the Central Coast Builder's exchange, 5 prospective bidders showed interest, 4 bidders made site visits, and 3 qualified bids were received in a timely fashion. The apparent lowest qualified bid was received by American Chiller Service, San Leandro CA, a firm that is also engaged to perform service/repair work at another area of the Salinas Valley Health Medical Center. Electrical work shall be bid separately but performed at the same time as the equipment replacement.

Timeline/Review Process to Date:

December 2025: Anticipated Award of Construction and Project Funding
April 2026: Commence with construction activities.
May 2026: Project and administrative closeout.

Pillar/Goal Alignment:

x Service ☐ People x Quality ☐ Finance ☐ Growth ☐ Community

Financial/Quality/Safety/Regulatory Implications

Key Contract Terms	Contractor: American Chiller Service
1. Proposed effective date	Issuance of Notice to Proceed anticipated on January 5, 2026.
2. Term of agreement	131 calendar days
3. Renewal terms	Not Applicable
4. Termination provision(s)	Provided in Bid Specifications-Part 12 of General Conditions- Section 007000
5. Payment Terms	Lump Sum
6. Compensation	**$838,258.00**
7. Cost over life of agreement	Not Applicable
8. Budgeted (indicate y/n)	Yes, FY 26 capital budget was for $936,955, the outstanding $232,045 will be paid through capital project funding that was previously approved but later pulled from the FY26 capital plan.

Recommendation:

Consider recommendation to Board of Directors (i) to approve the total estimated project cost for the SVH DRC Chiller & Cooling Tower Replacement Project in the amount of $1,169,000.00 and (ii) award construction contract to American Chiller Service for the SVH DRC Chiller & Cooling Tower Replacement Project in the amount $838,258.00.

Attachments:

(1) Project Budget - prepared December 15, 2025 at procurement phase.
(2) Bid Summary
(3) Bid Package – American Chiller Service

Salinas Valley Health

Project Cost Summary: SVH DRC 80-Ton Chiller & Cooling Tower Replacement
Architect/Engineering: WRD Architects/Cole-Breit/Aurum
Budget Generated at Procurement Phase
Budget Date: *12/10/2025*
Print Date: *12/10/2025*

Attachment 1

BUDGET SUMMARY				
Line Item		**Description**	**Original Budget**	**Notes**
	1	**Construction**		
0100		Construction Contract - Mechanical	$838,258	American Chiller - Public Bid Process
		Construction Contract - Electrical	$75,000	RFP Process
	2	**Design**		
0201		Professional Fees - T&M	$94,000	Architectural & Consulting Engineers
	3	**Inspections and Consultation**		
0301		Special Inspections	$10,000	allow
0303		Testing and Monitoring(Hazardous Materials)	$10,000	allow
	4	**Agency Fees**		
0400		City of Salinas + MBARD	$15,000	Agency Fees - allow
	5	**Soft Costs**		
0502		Construction Management - PM/CM	$50,000	Program Management
		Subtotal	$1,092,258	
	99	**Contingency**		
9900		General Project Contingency: +/- 7%	$76,742	Owner Held Contingency
Totals			**$1,169,000**	

SALINAS VALLEY HEALTH
SALINAS VALLEY HEALTH MEDICAL CENTER
450 E. Romie Lane, Salinas, CA 93901

DRC CHILLER & COOLING TOWER REPLACEMENT
Project ID 2026-905

Attachment 2

****DRAFT** BID RESULT SUMMARY**
DATE: December 09, 2025
BID TIME: 2:00 PM
BID OPENING: 535 E Romie Lane, Suite 6, Salinas, CA 93901

	Contractor	Contact	Email Address	Phone Number	Base Bid + Allowances	Comments
1	America Chiller Service - San Leandro**				$838,258.00	
2	Val's - Salinas				$926,427.00	
3	Mesa Energy Systems - San Leandro				$927,036.00	
4	FM Booth				no bid	
	** Apparent Low Bidder	Notes: All bidders correctly listed, and all listed Siemens for controls. All bidders visited site.				
	SVMHS reserves the right to reject any or all bids and to wavie any informalities in the bidding, or in any bid received.					

	Documents Accompanying Bid	Contractor 1	Contractor 2**	Contractor 3	Contractor 4
A	Bid Letter	X	X	X	
B	Addenda 1 & 2	X	X	X	
C	List of Subcontracotrs	X	X	X	
D	Disqualification Questionnaire	X	X	X	
E	Insurance Requirements	X	X	X	
F	Bid Bond	X	X	X	
G	Non-Collusion Affidavit	X	X	X	

Attachment 3

SECTION 00 40 00

BID FORMS

PART 1 - GENERAL

1.01 INSTRUCTIONS TO BIDDERS

A. Bid Forms shall be completed in accordance with the directions herein and the directions indicated in Section 00 10 00, "Notice Inviting Bids"; Section 00 20 00, "Instructions to Bidders"; and Section 00 41 00, “Schedule of Bid Prices,” of the Contract Documents.

1.02 BID FORMS

A. Due on or before the date of Bid Opening

Each of the following Bid Forms must be completed as part of each Bidder’s bid and shall be submitted before the specified time and date of the Bid Opening as identified in Section 00 10 00, “Notice Inviting Bids”, of the Contract Documents.

1. Bid Letter (including acknowledgement of receipt of Addenda)
2. List of Subcontractors
3. Disqualification Questionnaire
4. Acknowledgement of Insurance Requirements
5. Bidder’s Guaranty: Bidder’s Bond or Irrevocable Standby Letter of Credit
6. Non-Collusion Certification
7. Bidder’s Request for Information

BID LETTER
FOR SALINAS VALLEY HEALTH

SVH DRC 80-TON CHILLER & COOLING TOWER REPLACEMENT

Pursuant to the Notice Inviting Bids, the undersigned bidder herewith submits a bid on the Bid Forms attached hereto and made a part hereof, and binds itself on award by Salinas Valley Health under this bid to execute a Contract in accordance with its bid and the Contract Documents.

The Notice Inviting Bids, Instructions to Bidders, General Requirements, Supplementary Conditions, Technical Specifications, Appendices, Contract Drawings, and Addenda, if any, are made part of this bid and all provisions thereof are hereby accepted, and all representations and warranties required thereby are hereby affirmed.

This offer shall be irrevocable for a period of ninety (90) days after the date on which bids are opened.

The undersigned bidder understands that any clarification made to the above or any new and different conditions or information submitted on or with its Bid Forms, other than that requested, may render the bid non-responsive.

The undersigned, as bidder, declares that the only persons or parties interested in this bid as principals are those named herein; that this bid is made without collusion with any other person, firm or corporation and in submitting this bid, that it has carefully examined the location of the proposed work, the attached proposed form of contract, and the plans, specifications and the other Contract Documents; and agrees if this bid is accepted, that it will contract with SVH, on the form of contract included with these specifications, to provide all necessary labor, materials, equipment, machinery, apparatus and other means of construction, and to do all the work specified in the Contract Documents, in the manner and time therein prescribed, and according to the requirements of the Owner's Designated Representative as therein set forth, and that he will accept all full payment therefore based on the item prices set forth in its Schedule of Bid Prices.

The prices included within the Schedule of Bid Prices include all costs for labor, materials, tools, equipment, services, subcontractors, suppliers, taxes, insurance, shipment, delivery, overhead, profit and all other costs necessary to perform the work in accordance with the Contract Documents.

The undersigned bidder acknowledges receipt, understanding, and full consideration of the following addenda to the Contract Documents:

ADDENDA NOS. (if none, so state): 1 and 2

Name of Bidder: American Chiller Service

Business Address: 743 Thornton St

San Leandro CA 94577

Phone: 510-686-1111 Fax: 510-686-1234

Contractor's License No. 605046

License Expiration Date 10/31/2026

Classification Type

If SOLE OWNER, sign here:

I sign as sole owner of the business named above:

_____

If PARTNERSHIP, one or more partners sign here:

The undersigned certify that we are partners in the business named above and that we sign this bid with the full authority to do so:

_____

_____

If CORPORATION, execute here:

Corporate Name: AMERICAN CHILLER SERVICE, INC.

Incorporated under the laws of the State of CALIFORNIA

The undersigned certify that they sign this bid with the full and proper authorization so to do:

By _____ By _____

*Signature of Authorized Official** *Signature of Authorized Official**

PRESIDENT / CEO VICE PRESIDENT

Title *Title*

DANIEL JOHNSON KEVIN JOHNSON

Typewritten or Printed Name *Typewritten or Printed Name*

If JOINT VENTURE, execute here:

Joint Venture name composed of: _____

The undersigned certify that they sign this bid with the full and proper authorization so to do:

_____ _____

*Signature of Authorized Official** *Signature of Authorized Official**

_____ _____

Title *Title*

_____ _____

Typewritten or Printed Name *Typewritten or Printed Name*

*If bidder is a partnership or Joint Venture, give the full names of all partners and/or Joint Ventures in the space provided (use additional sheet if required). If bidder is a corporation, two signatures are required as follows: (1) the Chairman, President, or Vice-President and (2) the Secretary, Assistant Secretary, Chief Financial Officer or Assistant Treasurer. In the alternative, this Agreement may be executed by a single officer or a person other than an officer provided that evidence satisfactory to SVH is provided demonstrating that such individual is authorized to bind the corporation (example, a copy of a certified resolution from the corporation's board or a copy of the corporation's bylaws)

END OF BID LETTER

LIST OF SUBCONTRACTORS

The Bidder is required to furnish the following information in accordance with the provisions of Sections 4100 to 4114, inclusive, of the Public Contract Code of the State of California. This list and information shall include all subcontractors that will perform work, provide labor or render services to the Bidder in connection with the project in an amount in excess of one-half of one percent of the total amount of Bidder's Grand Total Bid Price.

Do not list alternative subcontractors for the same work. Use additional sheets if necessary.

NAME OF SUBCONTRACTOR	LICENSE NUMBER AND DIR REG NO.	LOCATION OF/ PLACE OF BUSINESS	PORTION OF WORK
1. THERMAL SYSTEMS MECHANICAL INSULATION INC	CLSB 85398 DIR 1000040298	Sheridan CA	Insulation
2. Hatton Crane and Rigging	CLSB 683819 DIR 1000019666	Hayward CA	Crane
3. Electrical Services Company	CLSB 410561 DIR 1000033814	Oakland CA	Electrical
4. Siemens	CLSB 758796 DIR 1000002447	Fremont CA	Controls
5. Carter Air Balance	CLSB 725518 DIR 1000025683	Napa CA	Test and Balance
6.			
7.			
8.			
9.			
10.			

END LIST OF SUBCONTRACTORS

DISQUALIFICATION QUESTIONNAIRE

The Bidder shall complete, under penalty of perjury, the following questionnaire:

Has the Bidder, any officer of the Bidder, or any employee of the Bidder who has proprietary interest in the Bidder, ever been disqualified, removed, or otherwise prevented from bidding on, or completing a federal, state, or local government project because of a violation of law or a safety regulation?

Yes _____ No X

If the answer is yes, explain the circumstances in the following space.

NAME OF BIDDER: American Chiller Service

NOTE: This questionnaire constitutes a part of the Bid, and signature on the portion of this Bid shall constitute signature on this questionnaire.

END OF DISQUALIFICATION QUESTIONNAIRE

ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

Included in the Bid Price is full compensation for the requirements set forth in Section 00 86 00, INSURANCE REQUIREMENTS of the Contract Documents, including:

a) Workers' Compensation (per statutory requirement).

Policy shall include a waiver of subrogation.

b) Employer's Liability coverage.

Two Million Dollars ($2,000,000) per accident; and

Two Million Dollars ($2,000,000) each employee by disease.

c) Commercial General Liability coverage (including but not limited to premises and operations; contractual liability; personal and advertising injury; explosion, collapse, and underground coverage; products and completed operations, and; broad form property damage) of not less than:

Two Million Dollars ($2,000,000) combined single limit per occurrence or claim; and

Two Million Dollars ($2,000,000) general aggregate.

Policy shall include a Waiver of Subrogation and Additional Insured endorsement. Policy will also contain either a Cross Liability endorsement or Severability of Interests Clause.

d) Business Automobile Liability Insurance coverage of not less than:

Two Million Dollars ($2,000,000) combined single limit occurrence.

Policy shall include a Waiver of Subrogation and Additional Insured endorsement.

Signature of Bidder/Title
KEVIN JOHNSON, VICE PRESIDENT

12/8/2025
Date

END OF ACKNOWLEDGEMENT OF INSURANCE REQUIREMENTS

BIDDER'S BOND

KNOW ALL PERSONS BY THESE PRESENTS:

That American Chiller Service, Inc., as Principal, and Western Surety Company, as Surety, are held and firmly bound unto Salinas Valley Health, hereinafter called SVH, in the sum of ($) Ten Percent of Total Amount Bid (10% of Total Amount Bid), being at least ten percent (10%) of the total amount of the bid, for the payment of which sum in lawful money of the United States of America to SVH we bind ourselves, our heirs, executors, administrators, successors and assigns, jointly and severally, firmly by these presents.

The condition of the above obligation is such that, whereas the Principal has submitted said bid to SVH;

NOW, THEREFORE, if the principal is awarded a Contract by SVH and, within the time and in the manner required by the Specifications, enters into a written Contract with SVH and furnishes the requisite bond or bonds and insurance certificates, then this obligation shall become null and void, otherwise to remain in full force and effect.

In the event suit is brought upon this bond by SVH and judgment is recovered, the Surety shall pay all costs incurred by SVH in such suit, including a reasonable attorneys fee to be fixed by the Court.

Dated December 4, 2025.

TO BE CONSIDERED COMPLETE, BOTH THE PRINCIPAL AND SURETY MUST SIGN THIS BIDDER'S BOND. IN ADDITION, THE SURETY'S SIGNATURE MUST BE NOTARIZED AND A COPY OF THE SURETY'S POWER OF ATTORNEY MUST BE ATTACHED.

American Chiller Service, Inc.
Principal

By: _____

Western Surety Company
Surety

By: _____
Susan Fournier, Attorney-in-Fact

151 N. Franklin Street, CHICAGO, IL 60606
Address of Surety

END OF BIDDERS BOND

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California
County of Sacramento)

On DEC 0 4 2025 before me, Victoria Catherine Madore, Notary Public
(insert name and title of the officer)

personally appeared Susan Fournier,
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

VICTORIA CATHERINE MADORE
Notary Public - California
Sacramento County
Commission # 2512846
My Comm. Expires Feb 22, 2029

Signature _____ (Seal)

Western Surety Company

POWER OF ATTORNEY APPOINTING INDIVIDUAL ATTORNEY-IN-FACT

Know All Men By These Presents, That WESTERN SURETY COMPANY, a South Dakota corporation, is a duly organized and existing corporation having its principal office in the City of Sioux Falls, and State of South Dakota, and that it does by virtue of the signature and seal herein affixed hereby make, constitute and appoint

Susan Fournier, John T Page, Ryan Tash, Individually

of Rancho Cordova, CA, its true and lawful Attorney(s)-in-Fact with full power and authority hereby conferred to sign, seal and execute for and on its behalf bonds, undertakings and other obligatory instruments of similar nature

- In Unlimited Amounts -

and to bind it thereby as fully and to the same extent as if such instruments were signed by a duly authorized officer of the corporation and all the acts of said Attorney, pursuant to the authority hereby given, are hereby ratified and confirmed.

This Power of Attorney is made and executed pursuant to and by authority of the By-Law printed on the reverse hereof, duly adopted, as indicated, by the shareholders of the corporation.

In Witness Whereof, WESTERN SURETY COMPANY has caused these presents to be signed by its Vice President and its corporate seal to be hereto affixed on this 18th day of April, 2021.

WESTERN SURETY COMPANY

Paul T. Bruflat, Vice President

State of South Dakota
County of Minnehaha } ss

On this 18th day of April, 2021, before me personally came Paul T. Bruflat, to me known, who, being by me duly sworn, did depose and say: that he resides in the City of Sioux Falls, State of South Dakota; that he is the Vice President of WESTERN SURETY COMPANY described in and which executed the above instrument; that he knows the seal of said corporation; that the seal affixed to the said instrument is such corporate seal; that it was so affixed pursuant to authority given by the Board of Directors of said corporation and that he signed his name thereto pursuant to like authority, and acknowledges same to be the act and deed of said corporation.

My commission expires

March 2, 2026

M. BENT
NOTARY PUBLIC
SOUTH DAKOTA

M. Bent, Notary Public

CERTIFICATE

I, L. Nelson, Assistant Secretary of WESTERN SURETY COMPANY do hereby certify that the Power of Attorney hereinabove set forth is still in force, and further certify that the By-Law of the corporation printed on the reverse hereof is still in force. In testimony whereof I have hereunto subscribed my name and affixed the seal of the said corporation this 4th day of December, 2025

WESTERN SURETY COMPANY

L. Nelson, Assistant Secretary

Form F4280-7-2012

Go to www.cnasurety.com > Owner / Obligee Services > Validate Bond Coverage, if you want to verify bond authenticity.

NONCOLLUSION AFFIDAVIT TO BE EXECUTED BY BIDDER AND SUBMITTED WITH BID

The undersigned declares:

I am the VICE PRESIDENT of AMERICAN CHILLER SERVICE, INC., the party making the foregoing bid.

The bid is not made in the interest of, or on behalf of, any undisclosed person, partnership, company, association, organization, or corporation. The bid is genuine and not collusive or sham. The bidder has not directly or indirectly induced or solicited any other bidder to put in a false or sham bid. The bidder has not directly or indirectly colluded, conspired, connived, or agreed with any bidder or anyone else to put in a sham bid, or to refrain from bidding. The bidder has not in any manner, directly or indirectly, sought by agreement, communication, or conference with anyone to fix the bid price of the bidder or any other bidder, or to fix any overhead, profit, or cost element of the bid price, or of that of any other bidder. All statements contained in the bid are true. The bidder has not, directly or indirectly, submitted his or her bid price or any breakdown thereof, or the contents thereof, or divulged information or data relative thereto, to any corporation, partnership, company association, organization, bid depository, or to any member or agent thereof to effectuate a collusive or sham bid, and has not paid, and will not pay, any person or entity for such purpose.

Any person executing this declaration on behalf of a bidder that is a corporation, partnership, joint venture, limited liability company, limited liability partnership, or any other entity, hereby represents that he or she has full power to execute, and does execute, this declaration on behalf of the bidder.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration is executed on 12/8/2025 [date], at San Leandro [city], California [state]."

Signature of Bidder KEVIN JOHNSON

VICE PRESIDENT
Title

12/8/2025
Date

END OF NON-COLLUSION AFFIDAVIT

BIDDER'S REQUEST FOR INFORMATION

Type in all required blanks. Include additional information on separate sheets as necessary.
Please email Word document to Owner's Representative.

Project Name: SVH DRC Chiller & Cooling Tower Replacement

SVH Project ID: 2026-905 BRFI Number____ Bidder's Tracking Number ____

Title of Issue: _____

Contract Document Reference Pertaining to Issue:

Drawing Sheet _____ Detail _____Specification Section _____ Article/Paragraph _____

Description of Issue:

_____

_____

_____

Contractor's Proposed Solution:

_____

_____

_____

_____ _____

Contractor Name/Company of party originating BRFI and Relationship to Contractor

_____ _____

Signature and printed name of Contractor's representative Date

☐ Additional _____ sheets are attached.

_____

Architect's Response:

_____

_____

_____

_____ _____

For Architect & Engineer of Record Date

Additional _____ sheets are attached.

END OF BIDDER'S REQUEST FOR INFORMATION

SALINAS VALLEY HEALTH
SVH DRC 80-TON CHILLER & COOLING TOWER REPLACEMENT
SCHEDULE OF BID PRICES

BASE BID:

Contractor shall provide all materials, labor, tools, equipment and superintendence necessary to complete this project for the following amount. Contractor shall provide Contractor's profit and overhead for all allowance items identified below in the Base Bid item "A". If costs incurred exceed allowance item, Contractor shall be allowed to markup the difference between the allowance and actual by a maximum of 5%. If the actual cost is less than the allowance item, Contractor shall credit the Owner the difference, including profit and overhead added to item "A".

"A" $ 768,258.00

ALLOWANCE ITEM B:

Contractor shall include an allowance of $35,000 in their bid to provide all labor, equipment, transportation and superintendence necessary to provide a modular, temporary chiller of equal capacity to connect to the existing system for ten (10) working days while the chiller replacement is occurring. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"B" $ 35,000.00

ALLOWANCE ITEM C:

Contractor shall include an allowance of $20,000 in their bid to provide all labor, equipment, transportation and superintendence necessary to provide an exhaust fan to maintain ventilation of the room due to design-build refrigeration monitoring and alarm system. Only provide if required by code. Contractor shall submit complete documentation of costs incurred for this work during the project and any remaining balance will be adjusted by deductive change order credited back to the Owner. All profit and overhead for this allowance item shall be provided for in item "A".

"C" $ 20,000.00

COMPENSABLE DELAY AMOUNT:

Contractor shall provide all materials, labor, tools, equipment and superintendence necessary to complete any additional work required as a result of non-Contractor caused delays for the following amount:

$ 1500 per day x 10 days delay (est.) = **"D"** $ 15,000.00

GRAND TOTAL BID PRICE:

Base bid plus total (**A + B + C + D**)

$ 838,258.00

SALINAS VALLEY HEALTH

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
Salinas, California

ADDENDUM 1
TO THE
BID DOCUMENTS FOR SVH DRC CHILLER & COOLING TOWER REPLACEMENT PROJECT

ISSUED: DECEMBER 3, 2025

This Addendum 1 must be signed by the bidder and included in the bid documents submitted for this Project. Salinas Valley Health reserves the right to disregard any bid, which does not include this Addendum 1. Salinas Valley Health may waive this requirement at its sole discretion.

SEE ATTACHED ADDENDUM ITEM

Prepared By:

Brianna Jesse
SVH Designated Representative

BIDDER'S CERTIFICATION

I acknowledge receipt of this Addendum A and accept all conditions contained herein.

Bidder's Signature KEVIN JOHNSON, VP

12/8/2025
Date

AMERICAN CHILLER SERVICE, INC.
Name of Company

Please return this signed page to Brianna Jesse at SVH as soon as possible and include with Bid Forms to confirm receipt of this addendum. Please email as a PDF to bjesse@bogardconstruction.com.

BID DOCUMENTS FOR SVH DRC CHILLER & COOLING TOWER REPLACEMENT PROJECT
ISSUED: DECEMBER 3, 2025

I. Drawings

Changes to the drawings include the following:

1. Replace Sheet MP001 LEGENDS & NOTES - MECHANICAL & PLUMBING with attached Sheet MP001 LEGENDS & NOTES - MECHANICAL & PLUMBING Addendum 1.
2. Replace Sheet MP101 OVERALL SITE PLAN - MECHANICAL & PLUMBING with attached Sheet MP101 OVERALL SITE PLAN - MECHANICAL & PLUMBING Addendum 1.
3. Replace Sheet MP201 FLOOR PLAN - MECHANICAL & PLUMBING - DEMO with attached Sheet MP201 FLOOR PLAN - MECHANICAL & PLUMBING - DEMO Addendum 1.
4. Replace Sheet MP202 FLOOR PLAN - MECHANICAL & PLUMBING – NEW with attached Sheet MP202 FLOOR PLAN - MECHANICAL & PLUMBING – NEW Addendum 1.
5. Replace Sheet MP401 PIPING DIAGRAM & SCHEDULES - MECHANICAL & PLUMBING with attached Sheet MP401 PIPING DIAGRAM & SCHEDULES - MECHANICAL & PLUMBING Addendum 1.
6. Replace Sheet MP601 DETAILS - MECHANICAL & PLUMBING with attached Sheet MP601 DETAILS - MECHANICAL & PLUMBING Addendum 1.

II. Specifications - Not Applicable

III. Clarifications - Not Applicable

SALINAS VALLEY HEALTH

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
Salinas, California

ADDENDUM 2
TO THE
BID DOCUMENTS FOR SVH DRC CHILLER & COOLING TOWER REPLACEMENT PROJECT

ISSUED: DECEMBER 4, 2025

This Addendum 2 must be signed by the bidder and included in the bid documents submitted for this Project. Salinas Valley Health reserves the right to disregard any bid, which does not include this Addendum 2. Salinas Valley Health may waive this requirement at its sole discretion.

SEE ATTACHED ADDENDUM ITEM

Prepared By:

Brianna Jesse
SVH Designated Representative

BIDDER'S CERTIFICATION

I acknowledge receipt of this Addendum A and accept all conditions contained herein.

Bidder's Signature KEVIN JOHNSON, VP

12/8/2025
Date

AMERICAN CHILLER SERVICE, INC.
Name of Company

Please return this signed page to Brianna Jesse at SVH as soon as possible and include with Bid Forms to confirm receipt of this addendum. Please email as a PDF to bjesse@bogardconstruction.com.

BID DOCUMENTS FOR SVH DRC CHILLER & COOLING TOWER REPLACEMENT PROJECT
ISSUED: DECEMBER 4, 2025

I. Drawings

Changes to the drawings include the following:

1. Replace Sheet MP401 PIPING DIAGRAM & SCHEDULES - MECHANICAL & PLUMBING with attached Sheet MP401 PIPING DIAGRAM & SCHEDULES - MECHANICAL & PLUMBING Addendum 2.

II. Specifications - Not Applicable

III. Clarifications - Not Applicable

Salinas Valley HEALTH

Medical Executive Committee Summary – December 11, 2025

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Hamzoian, Haroutiun, MD	Neurology	Medicine	Tele-Neurology
Ko, David, MD	Neurology	Medicine	Tele-Neurology
Munshi, Dipti, MD	Internal Medicine	Medicine	Adult Hospitalist
Patel, Viren, MD	Neurology	Medicine	Tele-Neurology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Apaydin, Aytac, MD	Urology	Surgery	Urology
Boddy, Mark, MD	Maternal Fetal Medicine	Ob/Gyn	Maternal Fetal Medicine
Delgado, Victor, MD	Family Medicine	Medicine	Adult Hospitalist
Fiorenza, Jeffrey, MD	Gastroenterology	Medicine	Gastroenterology General Internal Medicine
Jones, Kenneth, MD	Ob/Gyn	Ob/Gyn	Obstetrics and Gynecology
Kaufman, Bruce, DO	Internal Medicine	Medicine	Adult Hospitalist
Kruszynska, Yolanta, MD	Endocrinology	Medicine	Medicine – Active Community
Phan, Dennis, MD	Nephrology	Medicine	Nephrology General Internal Medicine
Rangel Ventura, Francis, MD	Family Medicine	Family Medicine/ Pediatrics	Taylor Farms Family Health & Wellness Center – Active Community
Rode, Martha, MD	Maternal Fetal Medicine	Ob/Gyn	Maternal Fetal Medicine
Semer, Nadine, MD	Palliative Medicine	Medicine	Palliative Medicine SVH Outpatient Infusion Center
Tonkin, Gabriel, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE MODIFICATION
Ajam, Firas, MD	Electrophysiology	Addition of Watchman
De, Ajanta, MD	Interventional Cardiology	Addition of TriClip
Wulff, Kristen, MD	Radiology	Addition of Breast Lesion Cryoablation
Zetterlund, Patrik, MD	Interventional Cardiology	Addition of TriClip

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Grigg, Wendell, MD	Psychiatry	Resignation effective 10/28/2025
Lilja, James, MD	Gynecology Oncology	Resignation effective 12/31/2025
Rathore, Sunil, MD	Neurology	Resignation effective 11/21/2025
Santiago-Vergara, Diana Liliana, MD	Psychiatry	Resignation effective 10/31/2025
Tung, Christie, MD	Neurology	Resignation effective 11/20/2025
Zanevchic, Carolina, MD	Medicine	Resignation effective 12/19/2025

Interdisciplinary Practice Committee

Initial Appointments:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Mazdeh, Fariba, PMHNP	Psychiatry Nurse Practitioner	Medicine	Nagib Chowdhury, MD
O'Neill, Kristy, PMHNP	Psychiatry Nurse Practitioner	Medicine	Nagib Chowdhury, MD
Williams, Nicole, PMHNP	Psychiatry Nurse Practitioner	Medicine	Nagib Chowdhury, MD

Reappointments:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Johns, Elena, DNP	Outpatient Infusion	Medicine	Nadine Semer, MD Kyle Youngflesh, DO
Newman, Dana, PA-C	Emergency Medicine	Emergency Medicine	Erica Locke, MD David Ramos, MD

Other Items:

Revised APP Rules and Regulations	Effective January 1, 2026, Assembly Bill 1501 will allow a supervising physician to supervise up to eight (8) physician assistants at a time in all health care settings. The APP Rules and Regulations have been updated from the current 1:4 ratio to 1:8.

Policies and Plans: Adult Parenteral Nutrition Protocol - updated

Rules and Regulations: ***(Attached)***

1. Medical Staff Bylaws Administrative Clarification Article 3.2.3 – Updated language to identify low volume providers.
2. Advanced Practice Provider Rules and Regulations – Update to align with changed in California Stat regulations

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 November 2025
c. Medical Staff Treasury Report December 2, 2025
d. Medical Staff Statistics Year to Date
e. Financial Update October 2025
f. Executive Updates
g. HCAHPS Update December 4, 2025

Status Pending PolicyStat ID 19342230

Origination	9/8/2021	Owner	Genevieve delos Santos: Director Pharmacy
Approved	N/A	Area	Pharmacy Protocols
Expires	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 September 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

H.

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 or IPC	Genevieve delos Santos: Director Pharmacy	11/24/2025
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	11/24/2025
Clinical Nutrion Manager	Jennifer Nader: Manager Clinical Nutrition	11/21/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/20/2025
Policy Owner	Genevieve delos Santos: Director Pharmacy	11/20/2025

Standards

No standards are associated with this document

CLINIMIX Calcium Phosphate Solubility (3.1)

CLINIMIX is indicated as a source of calories and protein for patients requiring parenteral nutrition when oral or enteral nutrition is not possible, insufficient, or contraindicated. CLINIMIX may be used to treat negative nitrogen balance in patients.[1]

Please refer to the full Prescribing Information for CLINIMIX Injection.

In the preparation of PN solutions, various ingredients may be used, including calcium and phosphate salts. Baxter Healthcare Corporation has established a set of solubility curves for parenteral nutrition solutions prepared using CLINIMIX Injections. The solubility information produced from these studies may be used as a tool to aid pharmacists in their evaluation of acceptable calcium/phosphate quantities for admixtures prepared using CLINIMIX Injections.

The interaction of calcium and phosphate in parenteral nutrition solutions is a complex phenomenon which can be affected by many parameters, including solution pH, form of calcium salt used, the final concentration of amino acids, dextrose, calcium and phosphate, order of mixing, storage temperature, length of storage, and the addition of other additives. Since the formation of a calcium phosphate precipitate in an admixture is complex, the compatibility of calcium and phosphate in parenteral nutrition products is typically studied empirically by preparing test solutions with varying concentrations of calcium and phosphate, followed by a thorough examination of the prepared solutions for evidence of a precipitate.[2]

In our studies, five different formulations were evaluated: CLINIMIX 4.25/5, CLINIMIX 5/15, CLINIMIX 6/5, CLINIMIX 8/10, and CLINIMIX 8/14. Table 1 illustrates the amino acid and dextrose concentrations and inherent electrolyte content after activating the peel seal and admixing the CLINIMIX Injections. **It was determined to test the lowest dextrose concentration for each of the varying amino acid concentrations, with the exception of the 8% amino acid concentration, to represent all formulations with the same amino acid concentration. For example, data for the CLINIMIX 5/15 can be used as a reference for other formulations of CLINIMIX with a final amino acid concentration of 5%, such as CLINIMIX 5/20.**[3a,b]

Table 1: CLINIMIX Injections (contents after activation)

Amino acid concentration	Dextrose Concentration	Acetate (mEq/L)	Chloride (mEq/L)
4.25%	5%	37	17
5%	15%	42	20
6%	5%	53	24
8%	10%	71	32
8%	14%	71	32

Based on actual use by clinicians, formulations were supplemented with various electrolytes commonly used in parenteral nutrition, including calcium gluconate, potassium phosphate, magnesium sulfate, sodium chloride, and potassium chloride, to achieve nutritionally relevant formulas typically seen, as described in Table 2. To mimic actual product usage, the pH of the test solutions was not adjusted. It should be noted that because the addition of electrolytes and sterile water to the CLINIMIX formulations lowered the final concentration of the admixed solutions, the test formulas in the study were prepared such that the volumetric addition of all additives lowered the final concentration of the amino acid and dextrose by approximately 20%.

Table 2: Final Electrolyte Concentrations after Additions to CLINIMIX Injections

	CLINIMIX 4.25/5	CLINIMIX 5/15	CLINIMIX 6/5	CLINIMIX 8/10	CLINIMIX 8/14
Calcium	Varies	Varies	Varies	Varies	Varies
Phosphate	Varies	Varies	Varies	Varies	Varies
Sodium	150 mEq/L	150 mEq/L	150 mEq/L	150 mEq/L	150 mEq/L
Potassium	80 mEq/L	80 mEq/L	80 mEq/L	80 mEq/L	80 mEq/L
Magnesium	5 mEq/L	5 mEq/L	5 mEq/L	5 mEq/L	5 mEq/L
Acetate	30 mEq/L	34 mEq/L	42.4 mEq/L	56.8mEq/L	56.8mEq/L
Chloride	Varies	Varies	Varies	Varies	Varies

Samples were prepared with targeted concentrations of phosphates ranging from 0 to 40 mMol/ L and 0-50 mEq/L for calcium. The order of additions was: sodium chloride, potassium chloride, potassium phosphate, magnesium sulfate, and finally calcium gluconate for all samples. The samples were mixed and stored either under short-term storage of 48 hour (24 hours at 25° C followed by 24 hours at 40° C), or long-term storage of 11 days (24 hours at 25° C followed by 9 days at 5° C, followed by an additional 24 hours at 25° C). After removal from storage, samples were inverted prior to testing. Although visual, instrumental, and microscopic examinations were conducted, the calcium and phosphate solubility curves provided represent data obtained from the microscopic analysis only.[3a,b]

During the microscopic analysis, approximately 50mL of solution from each sample was filtered (1 micron or finer pore size) and collected. Only crystalline particulate matter collected on the test membrane, were counted microscopically against the following limits:[3a,b]

Acceptance Criteria - Not more than 12 particles / mL $\geq$ 10 μm
Not more than 2 particles / mL $\geq$ 25 μm

Please note that the acceptance criteria in our studies, based on microscopic examination are consistent with the current USP <788> Microscopic Particle Limits for Large Volume Injections.[4]

Results

The results of these studies are presented in Table 3, and the attached solubility curves represented in Figures 1 through 5.[3a,b]

Table 3: Calcium Phosphate Solubility curve data points for CLINIMIX Injection formulations

CLINIMIX 4.25/5		CLINIMIX 5/15	
Calcium (mEq/L)	Phosphate (mMol/L)	Calcium (mEq/L)	Phosphate (mMol/L)
42.9	2.5	39.9	6.0
20.3	4.0	25.3	7.0
15.7	5.0	15.2	10
8.8	10	11.5	15
7	15	10.2	20
6.1	20	9.6	25
5.6	25	9.2	30
5.3	30	9	35
5.1	35	8.8	40
4.9	40	8.6	45
4.8	45	8.5	50
4.7	50		

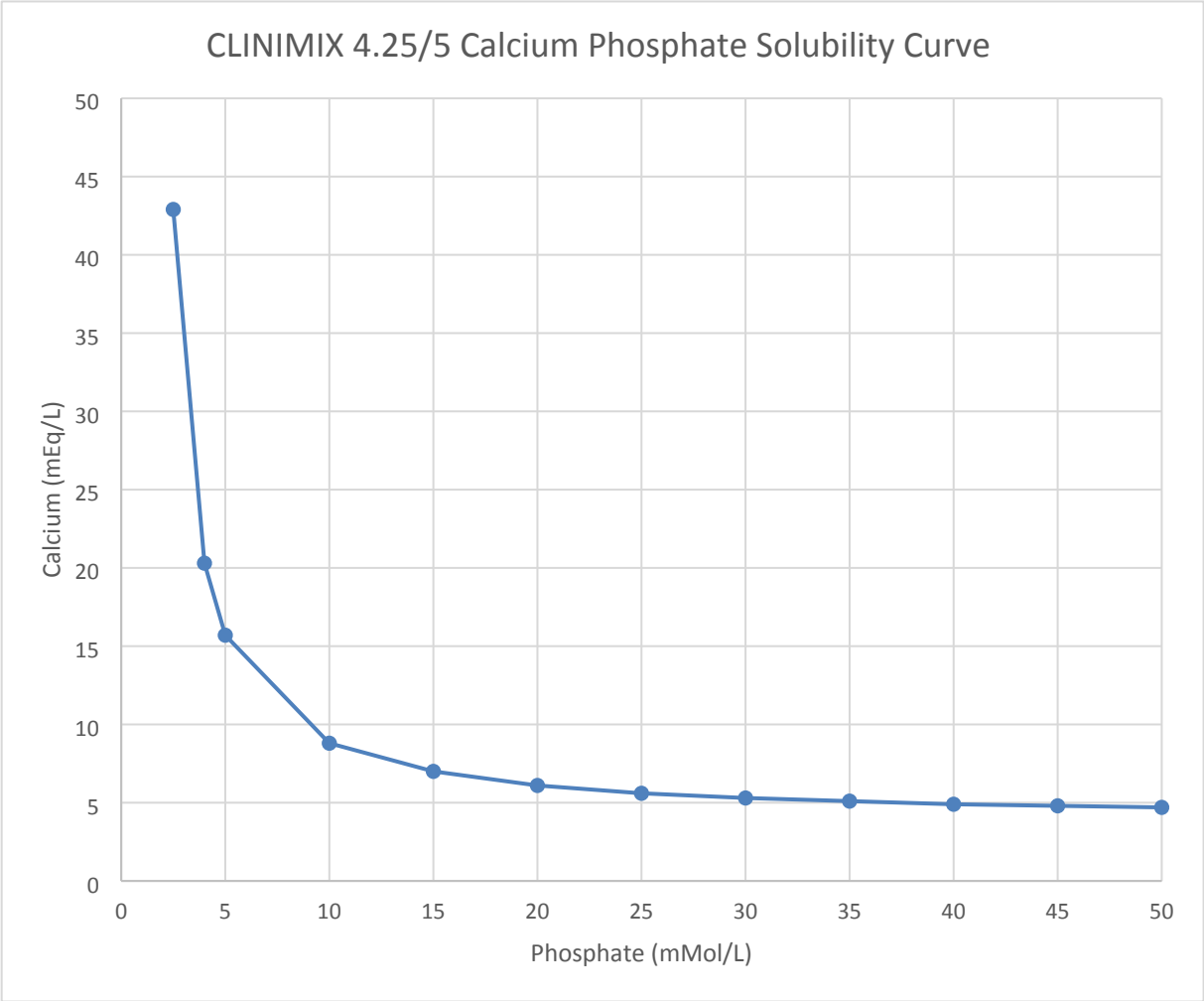
CLINIMIX 6/5		CLINIMIX 8/10		CLINIMIX 8/14	
Calcium (mEq/L)	Phosphate (mMol/L)	Calcium (mEq/L)	Phosphate (mMol/L)	Calcium (mEq/L)	Phosphate (mMol/L)
50	6.1	50	6.7	50	10.6
47.5	6.5	47.9	7	46.7	11
44.4	7	44.8	7.5	40.5	12
41.6	7.5	42	8	35.7	13
39.2	8	39.5	8.5	32	14
37	8.5	37.3	9	28.9	15
35	9	35.3	9.5	19.5	20
33.2	9.5	33.5	10	14.7	25
31.5	10	30.4	11	11.7	30
28.6	11	27.8	12	9.8	35
26.2	12	25.5	13	8.3	40
24.1	13	23.6	14	7.3	45
22.2	14	21.9	15	6.4	50
20.6	15	16	20		
14.8	20	12.4	25		
11.2	25	10	30		
8.8	30	8.3	35		
7	35	7	40		
5.7	40	6	45		
4.6	45	5.2	50		
3.8	50				

A statistical analysis of the data applying logistic regression was used to generate the derived calcium phosphate solubility curves illustrated in Figures 1 through 5 using the data in Table 3. The solubility curves represent concentrations at which there is 5% probability of exceeding the defined acceptance criteria - suggesting there is a 95% probability that the data points on the curve did not exceed the acceptance criteria.[3a,b]

One could conclude that data points in the area to the left and/or below each curve represent concentrations of calcium and phosphate that are less likely to precipitate, while data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). While the certainty of the compatibility results may be relatively great at the extremes of the concentrations, it is somewhat less near the compatibility boundary. These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.[1]

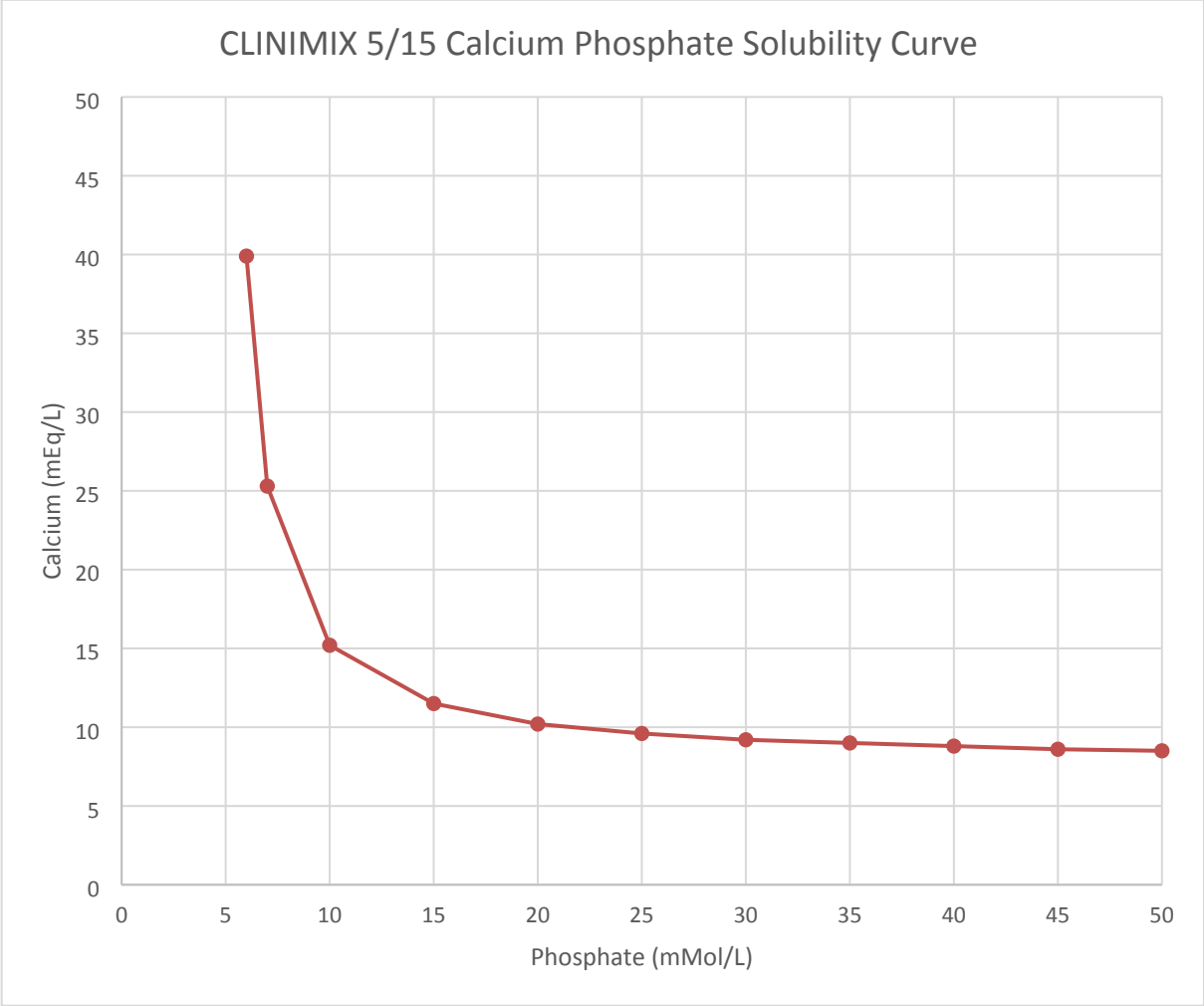
Due to the unpredictable nature of precipitation events near the solubility curve, and the complex interactions which may affect the formation of calcium phosphate crystals in the wide variety of admixtures, good clinical practice should be used when formulating any PN admixtures. It is important that all PN admixtures are visually inspected for evidence of precipitation and filtered prior to patient administration.

Figure 1: Calcium Phosphate Solubility Curves for CLINIMIX 4.25/5



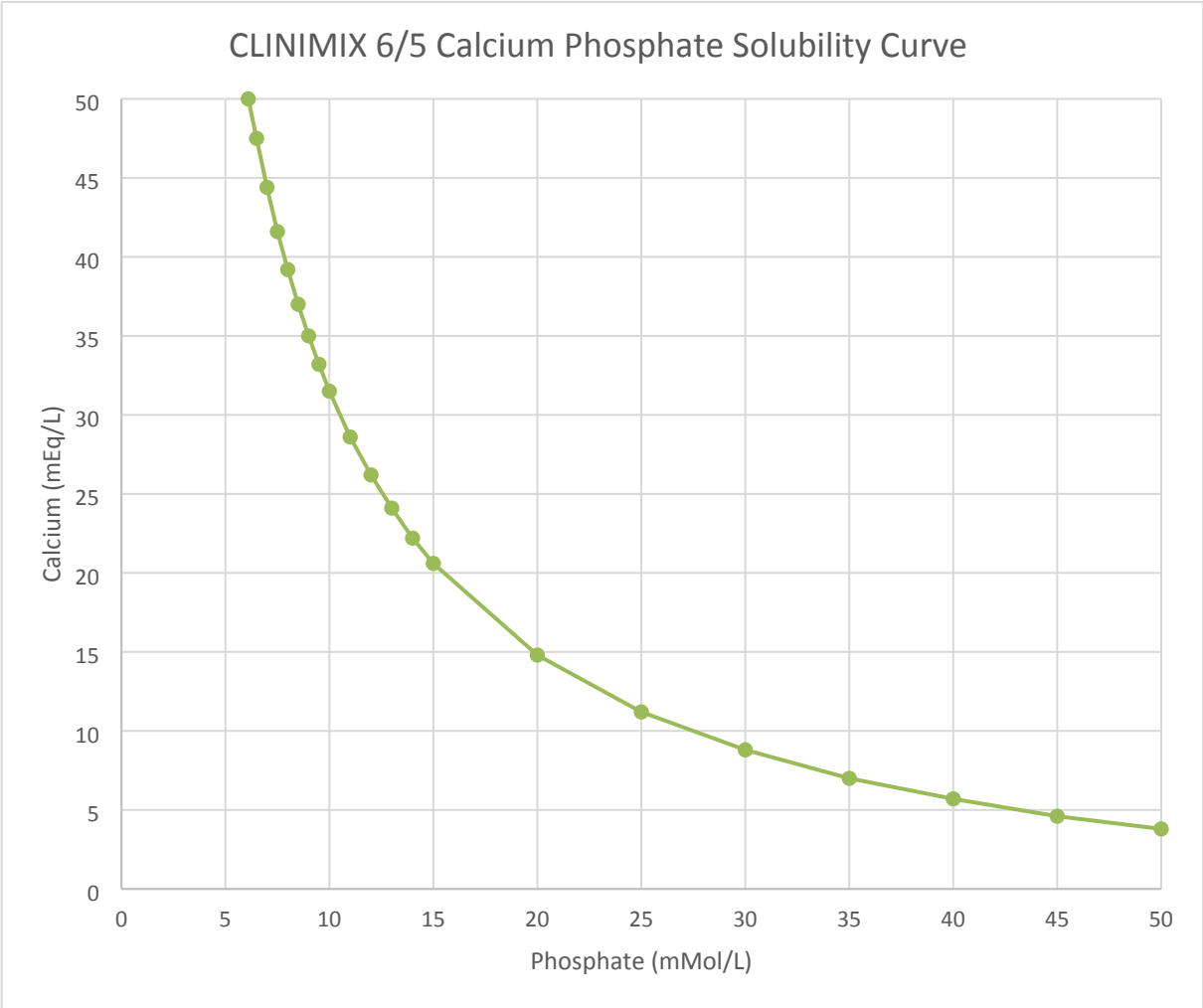
The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 2: Calcium Phosphate Solubility Curves for CLINIMIX 5/15



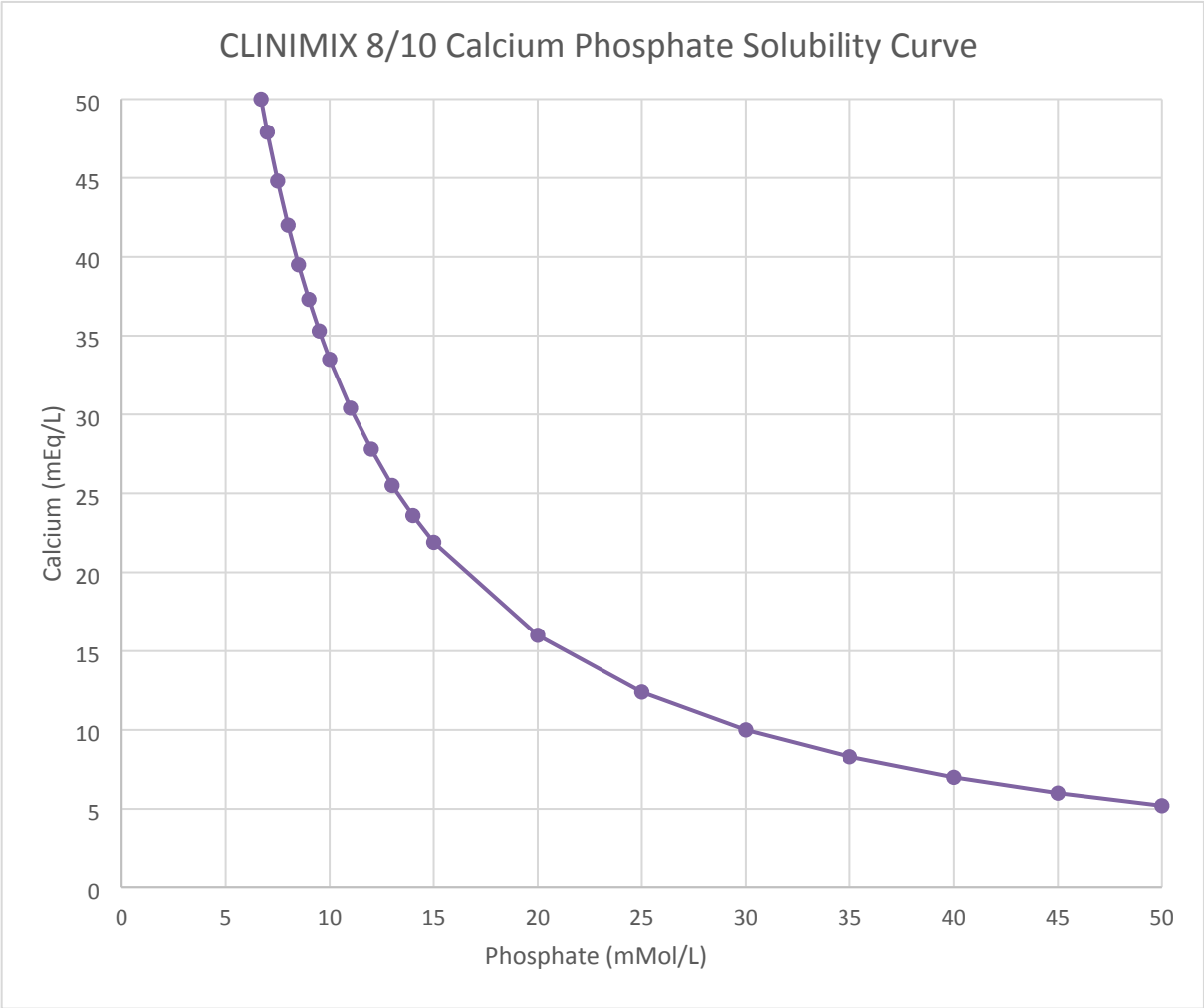
The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 3: Calcium Phosphate Solubility Curves for CLINIMIX 6/5



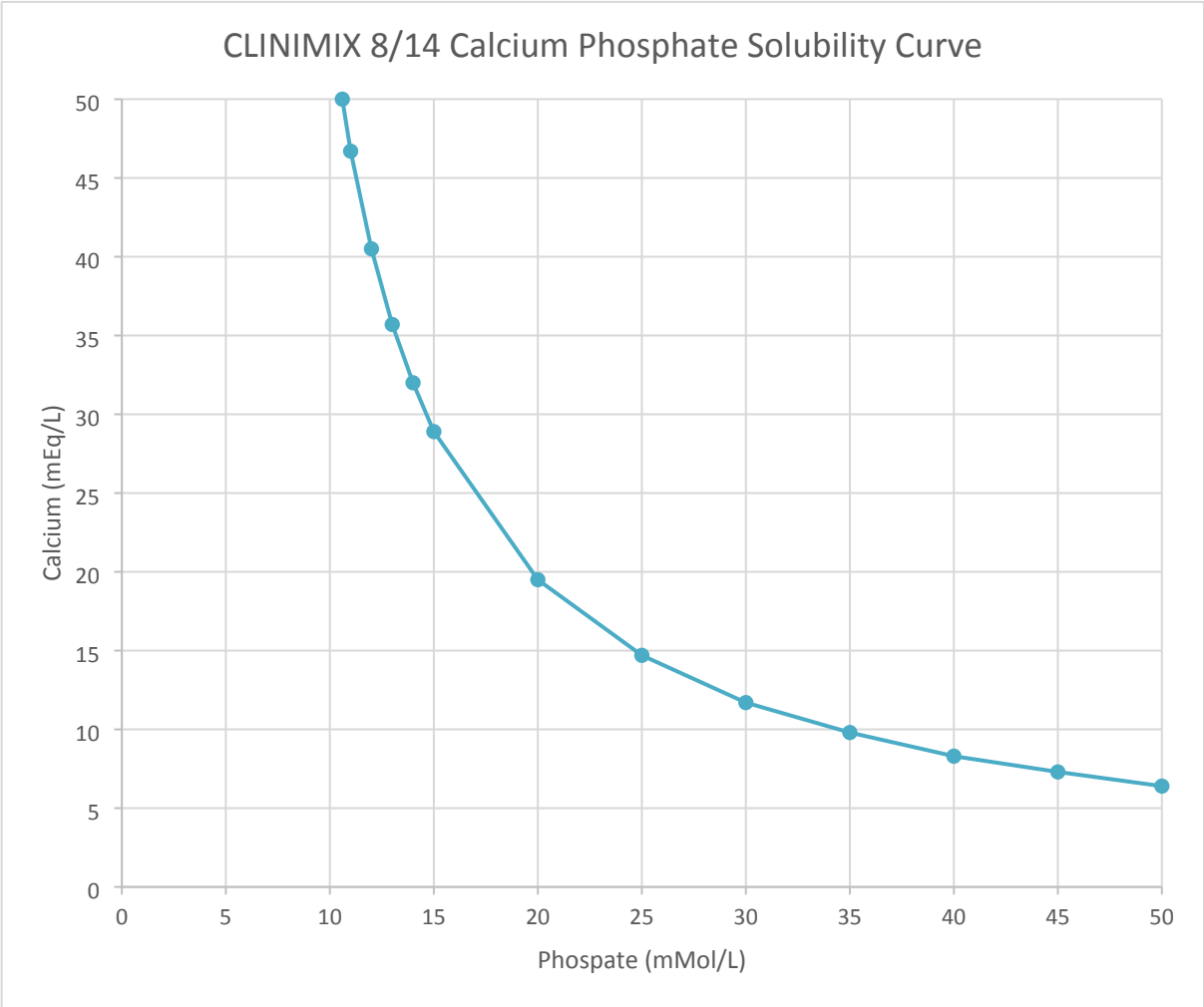
The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 4: Calcium Phosphate Solubility Curves for CLINIMIX 8/10



The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 5: Calcium Phosphate Solubility Curves for CLINIMIX 8/14



The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

This information is intended to provide pertinent data to assist you in forming your own conclusions and is not to be considered as medical advice. The information contained in this letter is applicable to products approved or cleared in the United States of America, unless specifically noted. Baxter does not advocate the use of its products outside of approved labeling. Please refer to Instructions for Use or Prescribing Information. This letter is provided as a service to Baxter customers, and it may not be reproduced without the prior written permission of Baxter Healthcare Corporation.

References:

1. CLINIMIX E Injection Prescribing Information.
2. Trissel LA, Canada T. Calcium and Phosphate Compatibility in Parenteral Nutrition. TriPharma Communications, Houston, Texas 2001. Pgs ix –xv, 141-154.
3. [a,b] Baxter internal data on file.
4. U.S. Pharmacopeia, *The National Formulary*, USP 43-NF38 <788> Particulate Matter in Injections. Official as 1-May-2013. Accessed April 13, 2023.

Baxter

CLINIMIX CLINIMIX E Stability with Additives (1.1)

CLINIMIX (Amino Acids in Dextrose) Injection and CLINIMIX E (Amino Acids with Electrolytes in Dextrose with Calcium) Injection is indicated as a source of calories and protein for patients requiring parenteral nutrition when oral or enteral nutrition is not possible, insufficient, or contraindicated. CLINIMIX and CLINIMIX E may be used to treat negative nitrogen balance in patients.[1]

Please refer to the full prescribing information for CLINIMIX and CLINIMIX E.

Per the FDA approved prescribing information:

> ***Storage After Removal of Overwrap:***
> *Once removed from the protective overwrap, mixed (peel seal activated) or unmixed (peel seal intact) CLINIMIX solutions may be stored under refrigeration for up to 9 days.*[1]
>
> ***Storage Once any Additive is Added:***
> *Lipids and/or additives can be introduced to the container after opening seal between chambers. Because additives may be incompatible, evaluate all additions to the plastic container for compatibility. Activate chambers of container prior to introduction of additives. Mix thoroughly when additives have been introduced.*
>
> *Use promptly after mixing. Any storage with additives should be under refrigeration and limited to a brief period of time, less than 24 hours. After removal from refrigeration, use promptly and complete the infusion within 24 hours. Any remaining mixture must be discarded*.[1]

The information contained within this letter has not been approved by the FDA.

The stability and compatibility of added ingredients to CLINIMIX and CLINIMIX E is generally the same as that assigned to a compounded parenteral nutrition solution, utilizing TRAVASOL as the amino acid solution. Evaluation of resulting compatibilities and stabilities may include consulting clinical sources such as Trissel's Handbook of Injectable Drugs and/or King's Guide to Parenteral Admixtures.

Baxter has performed studies, summarized in the attachments, that may serve as guidance in the clinical evaluation of the compatibility and stability of Parenteral Admixtures containing CLINIMIX and CLINIMIX E. It is at the clinical discretion of the end user to determine if the information can assist in determining the stability of CLINIMIX and/ or CLINIMIX E after adding additives. The solubility and stability information provided from these studies may be used as a tool to aid pharmacists in their evaluation of acceptable electrolyte quantities for admixtures prepared using CLINIMIX and CLINIMIX E.

- CLINOLIPID TNA Stability with CLINIMIX/CLINIMIX E
- CLINIMIX E Calcium Phosphate Solubility
- CLINIMIX Calcium Phosphate Solubility

Clinical judgement should be used, and clinical guidelines followed when adding ingredients to CLINIMIX or CLINIMIX E admixtures. It is important that all admixtures are visually inspected for evidence of precipitation and filtered prior to patient administration.

The integrity of the additive ports on CLINIMIX and CLINIMIX E, with respect to their ability to reseal after multiple punctures with a needle, has been studied and the maximum number of punctures that they can sustain were determined to be 10 times with an 18 to 22 gauge needle.[2]

As with any IV container maintaining sterility of the final product after puncture of the additive port is dependent on many factors, including the maintenance of sterile technique during compounding and compliance of the compounding environment to ISO 5 standards. While both products have been

validated for multiple additions via the additive port, it is the responsibility of the end user to ensure proper technique is followed for sterility assurance.

Baxter recommends protecting Parenteral Nutrition (PN) admixtures from light and use of an in-line filter for administration, please refer to the respective product labeling for further guidance regarding administration.

This information is intended to provide pertinent data to assist you in forming your own conclusions and is not to be considered as medical advice. The information contained in this letter is applicable to products approved or cleared in the United States of America, unless specifically noted. Baxter does not advocate the use of its products outside of approved labeling. Please refer to Instructions for Use or Prescribing Information. This letter is provided as a service to Baxter customers, and it may not be reproduced without the prior written permission of Baxter Healthcare Corporation.

References:

1. CLINIMIX (Amino Acids in Dextrose) Injection and CLINIMIX E (Amino Acids with Electrolytes in Dextrose with Calcium) Injection Prescribing Information.

2. Baxter internal data on file.

CLINIMIX E Calcium Phosphate Solubility (3.1)

CLINIMIX E is indicated as a source of calories, protein, and electrolytes for patients requiring parenteral nutrition when oral or enteral nutrition is not possible, insufficient, or contraindicated. CLINIMIX E may be used to treat negative nitrogen balance in patients.[1]

Please refer to the full Prescribing Information for CLINIMIX E.

In the preparation of PN solutions, various ingredients may be used, including calcium and phosphate salts. Baxter Healthcare Corporation has established a set of solubility curves for parenteral nutrition solutions prepared using CLINIMIX E Injections. The solubility information produced from these studies may be used as a tool to aid pharmacists in their evaluation of acceptable calcium/phosphate quantities for admixtures prepared using CLINIMIX E Injections.

The interaction of calcium and phosphate in parenteral nutrition solutions is a complex phenomenon which can be affected by many parameters, including solution pH, form of calcium salt used, the final concentration of amino acids, dextrose, calcium and phosphate, order of mixing, storage temperature, length of storage, and the addition of other additives. Since the formation of a calcium phosphate precipitate in an admixture is complex, the compatibility of calcium and phosphate in parenteral nutrition products is typically studied empirically by preparing test solutions with varying concentrations of calcium and phosphate, followed by a thorough examination of the prepared solutions for evidence of a precipitate.[2]

In our studies, five different formulations were evaluated: CLINIMIX E 2.75/5, CLINIMIX E 4.25/5, CLINIMIX E 5/15, CLINIMIX E 8/10, and CLINIMIX E 8/14. Table 1 illustrates the amino acid and dextrose concentrations and inherent electrolyte content after activating the peel seal and admixing the CLINIMIX E Injections. **It was determined to test the lowest dextrose concentration for each of the varying amino acid concentrations, with exception of the 8% amino acid concentration, to represent all formulations with the same amino acid concentration. For example, data for the CLINIMIX E 5/15 can be used as a reference for other formulations of CLINIMIX E with a final amino acid concentration of 5%, such as CLINIMIX E 5/20.** [3a,b]

Table 1: CLINIMIX E Injections (contents after activation)

Amino acid concentration	Dextrose Concentration	Sodium (mEq/L)	Potassium (mEq/L)	Magnesium (mEq/L)	Calcium (mEq/L)	Phosphate (mMol/L)	Acetate (mEq/L)	Chloride (mEq/L)
2.75%	5%	35	30	5	4.5	15	51	39
4.25%	5%	35	30	5	4.5	15	70	39
5%	15%	35	30	5	4.5	15	80	39
8%	10%	35	30	5	4.5	15	83	76
8%	14%	35	30	5	4.5	15	83	76

Based on actual use by clinicians, formulations were supplemented with various electrolytes commonly used in parenteral nutrition, including calcium gluconate, potassium phosphate, magnesium sulfate, sodium chloride, and potassium chloride, to achieve nutritionally relevant formulas typically seen, as described in Table 2. To mimic actual product usage, the pH of the test solutions was not adjusted. It should be noted that because the addition of electrolytes and sterile water to the CLINIMIX E formulations lowered the final concentration of the admixed solutions, the test formulas in the study were prepared such that the volumetric addition of all additives lowered the final concentration of the amino acid and dextrose by approximately 20%.

Table 2: Final Electrolyte Concentrations after Additions to CLINIMIX E Injections

	CLINIMIX E 2.75/5	CLINIMIX E 4.25/5	CLINIMIX E 5/15	CLINIMIX E 8/10	CLINIMIX E 8/14
Calcium	Varies	Varies	Varies	Varies	Varies
Phosphate	Varies	Varies	Varies	Varies	Varies
Sodium	150 mEq/L	150 mEq/L	150 mEq/L	150 mEq/L	150 mEq/L
Potassium	80 mEq/L	80 mEq/L	80 mEq/L	80 mEq/L	80 mEq/L
Magnesium	5 mEq/L	5 mEq/L	5 mEq/L	5 mEq/L	5 mEq/L
Acetate	41 mEq/L	41 mEq/L	64 mEq/L	66.4 mEq/L	66.4 mEq/L
Chloride	Varies	Varies	Varies	Varies	Varies

Samples were prepared with targeted concentrations of phosphates ranging from 12 to 50 mMol/ L and 3 to 40 mEq/L for calcium. Some of these targeted phosphate and calcium concentrations are lower than the inherent values of phosphate and calcium in CLINIMIX E formulations as stated in Table 1 because the addition of electrolytes and sterile water lowered the final concentration of the admixed solutions.

The order of additions was: sodium chloride, potassium chloride, potassium phosphate, magnesium sulfate, and finally calcium gluconate for all samples. The samples were mixed and stored either under short-term storage of 48 hours (24 hours at 25° C followed 24 hours at 40° C), or long-term storage of 11 days (24 hours at 25° C followed by 9 days at 5° C, followed by an additional 24 hours at 25° C). After removal from storage, samples were inverted prior to testing. Although visual, instrumental, and microscopic examinations were conducted, the calcium and phosphate solubility curves provided represent data obtained from the microscopic analysis only.[3a,b]

During the microscopic analysis, approximately 50 mL of solution from each sample was filtered (1 micron or finer pore size) and collected. Only crystalline particulate matter collected on the test membrane were counted microscopically against the following limits:[3a,b]

Acceptance Criteria - Not more than 12 particles / mL $\geq$ 10 μm

Not more than 2particles / mL $\geq$ 25 μm

Please note that the acceptance criteria in our study, based on microscopic examination, are consistent with the current USP <788> Microscopic Particle Limits for Large Volume Injections.[4]

Results

The results of these studies are presented in Table 3, and the attached solubility curves represented in Figures 1 through 5.[3a,b] To be clear, the concentrations of calcium and phosphate in Table 3 lists the **total** concentration of calcium and phosphate that were analyzed, and these data points include the ion contributions of each that are already present in CLINIMIX E formulations.

Table 3: Calcium Phosphate Solubility curve data points for CLINIMIX E Injection formulations

CLINIMIX E 2.75/5		CLINIMIX E 4.25/5		CLINIMIX E 5/15	
Calcium (mEq/L)	Phosphate (mMol/L)	Calcium (mEq/L)	Phosphate (mMol/L)	Calcium (mEq/L)	Phosphate (mMol/L)
26.7	12	15	12	20.6	12
23.8	13	13.7	13	19.3	13
21.4	14	12.7	14	18.1	14
19.4	15	11.7	15	17.1	15
12.9	20	8.7	20	13	20
9.3	25	6.9	25	10.1	25
6.9	30	5.8	30	8.1	30
5.4	35	5	35	6.5	35
4.2	40	4.4	40	5.3	40
3.3	45	4	45	4.3	45
2.6	50	3.6	50	3.4	50

CLINIMIX E 8/10		CLINIMIX E 8/14	
Calcium (mEq/L)	Phosphate (mMol/L)	Calcium (mEq/L)	Phosphate (mMol/L)
39.8	12	38.8	12
34.8	13	34.4	13
31.0	14	30.9	14
27.9	15	28.0	15
18.9	20	19.4	20
14.5	25	14.9	25
11.9	30	12.3	30
10.1	35	10.5	35
8.9	40	9.2	40
8.0	45	8.2	45
7.2	50	7.4	50

Since there are calcium and phosphate ions already present in CLINIMIX E, one must take these inherent ion contributions into consideration and subtract them from the data points in Table 3 to determine the additional amounts of calcium and phosphate that can be added to CLINIMIX E formulations, while remaining within the total concentration of each solubility break-point as listed in Table 3.

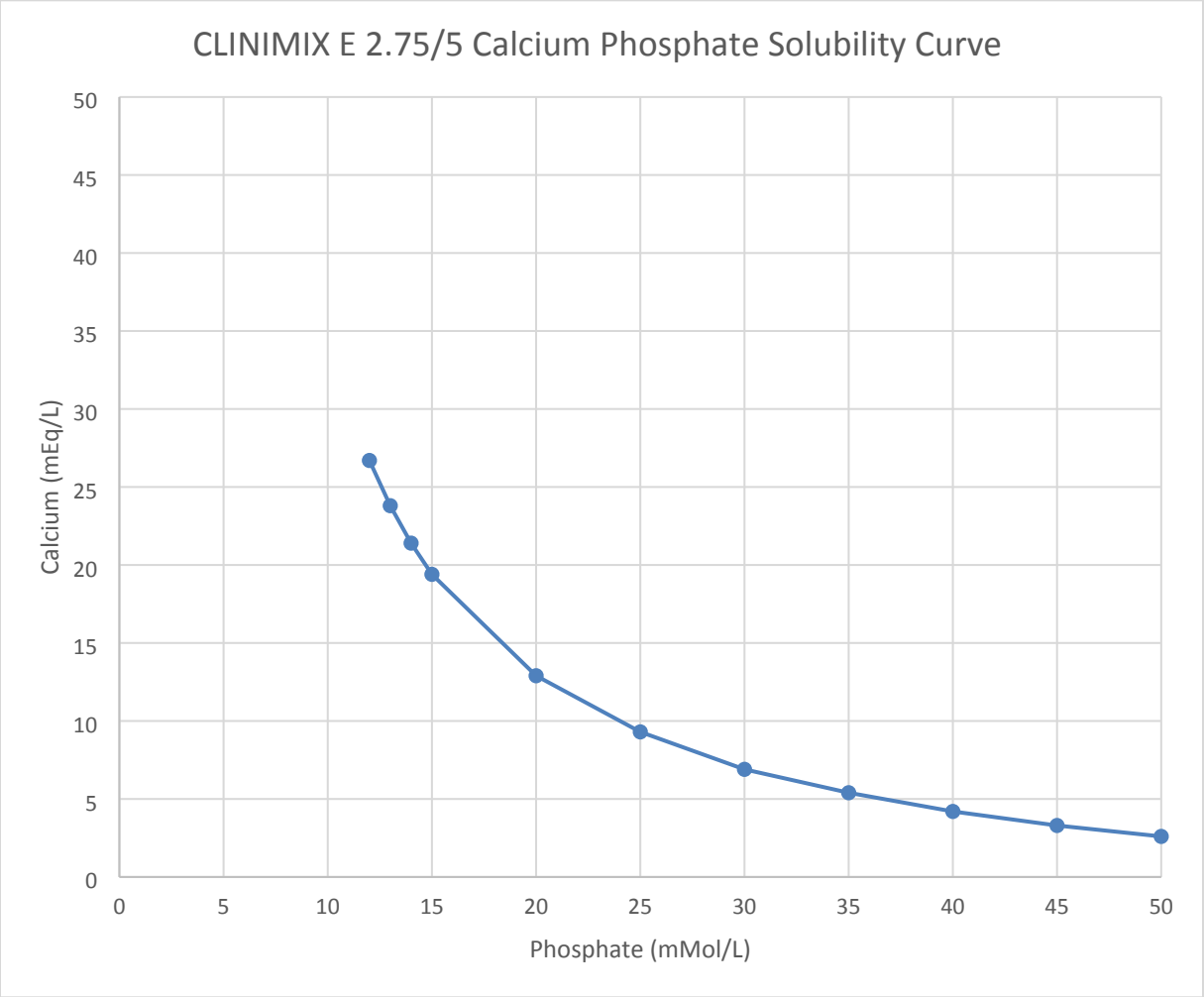
For example, in the column labeled CLINIMIX E 5/15, in the 5th row of data points (13 mEq/L of calcium, 20 mMol/L phosphate), since there are 4.5 mEq/L of calcium and 15 mMol/L of phosphate in CLINIMIX E, one would conclude that an additional 8.5 mEq/L of calcium (13 mEq/L – 4.5 mEq/L) and 5 mMol/L of phosphate (20 mMol/L – 15 mMol/L) could be added to the CLINIMIX E 5/15 solutions.

A statistical analysis of the data applying logistic regression was used to generate the derived calcium phosphate solubility curves illustrated in Figures 1 through 5, using the data in Table 3. The solubility curves represent concentrations of calcium and phosphate at which there is 5% probability of exceeding the defined acceptance criteria, suggesting there is a 95% probability that the data points on the curve did not exceed the acceptance criteria.[3a,b]

One could conclude that data points in the area to the left and/or below each curve represent concentrations of calcium and phosphate that are less likely to precipitate, while data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). While the certainty of the compatibility results may be relatively great at the extremes of the concentrations, it is somewhat less near the compatibility boundary. These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.[2]

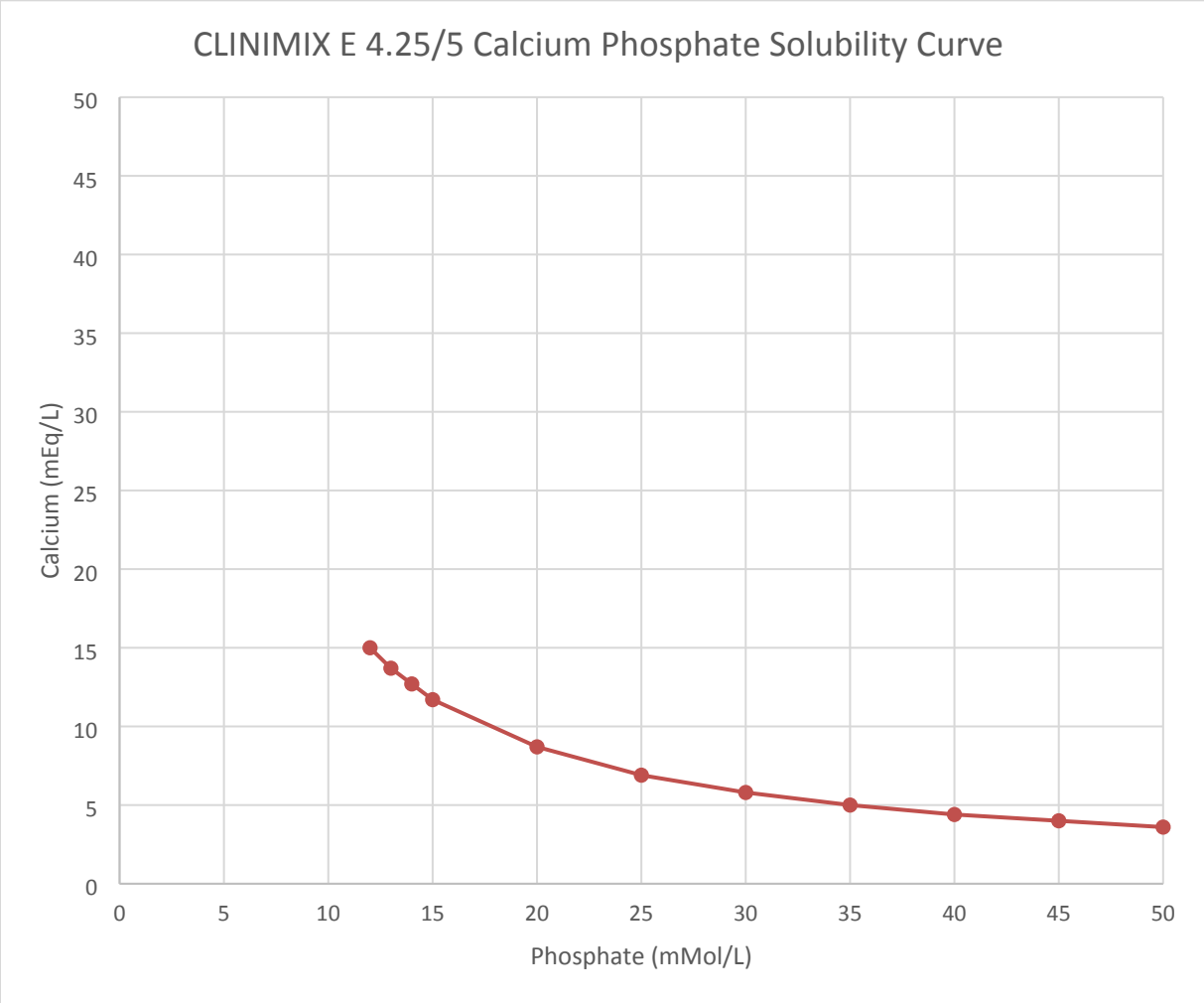
Due to the unpredictable nature of precipitation events near the solubility curve, and the complex interactions which may affect the formation of calcium phosphate crystals in the wide variety of admixtures, good clinical practice should be used when formulating any PN admixtures. It is important that all PN admixtures are visually inspected for evidence of precipitation and filtered prior to patient administration. Baxter recommends protecting PN admixtures from light and use of an in-line filter for administration, please refer to the respective product labeling for further guidance regarding administration.

Figure 1: Calcium Phosphate Solubility Curves for CLINIMIX E 2.75/5



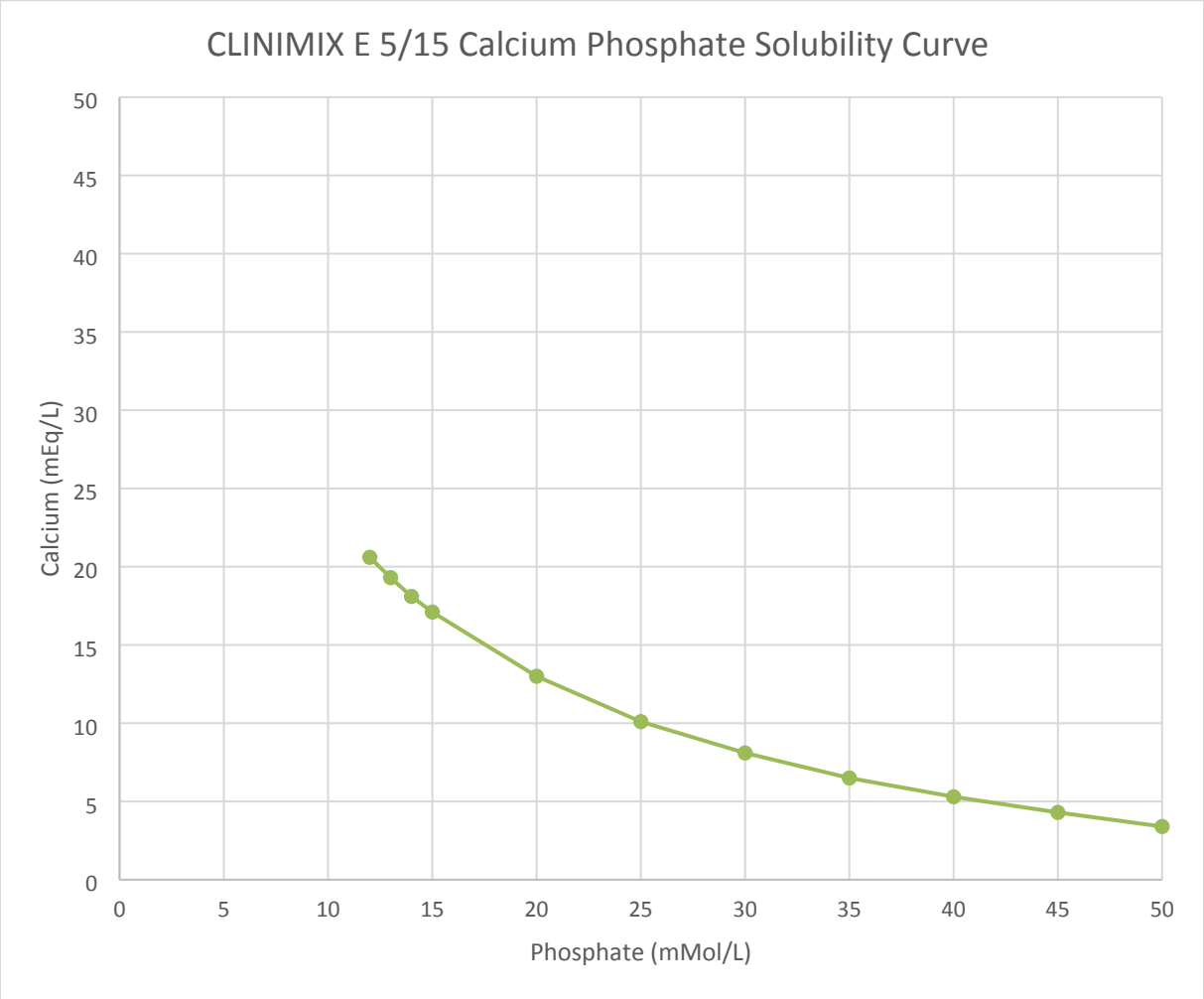
The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 2: Calcium Phosphate Solubility Curves for CLINIMIX E 4.25/5



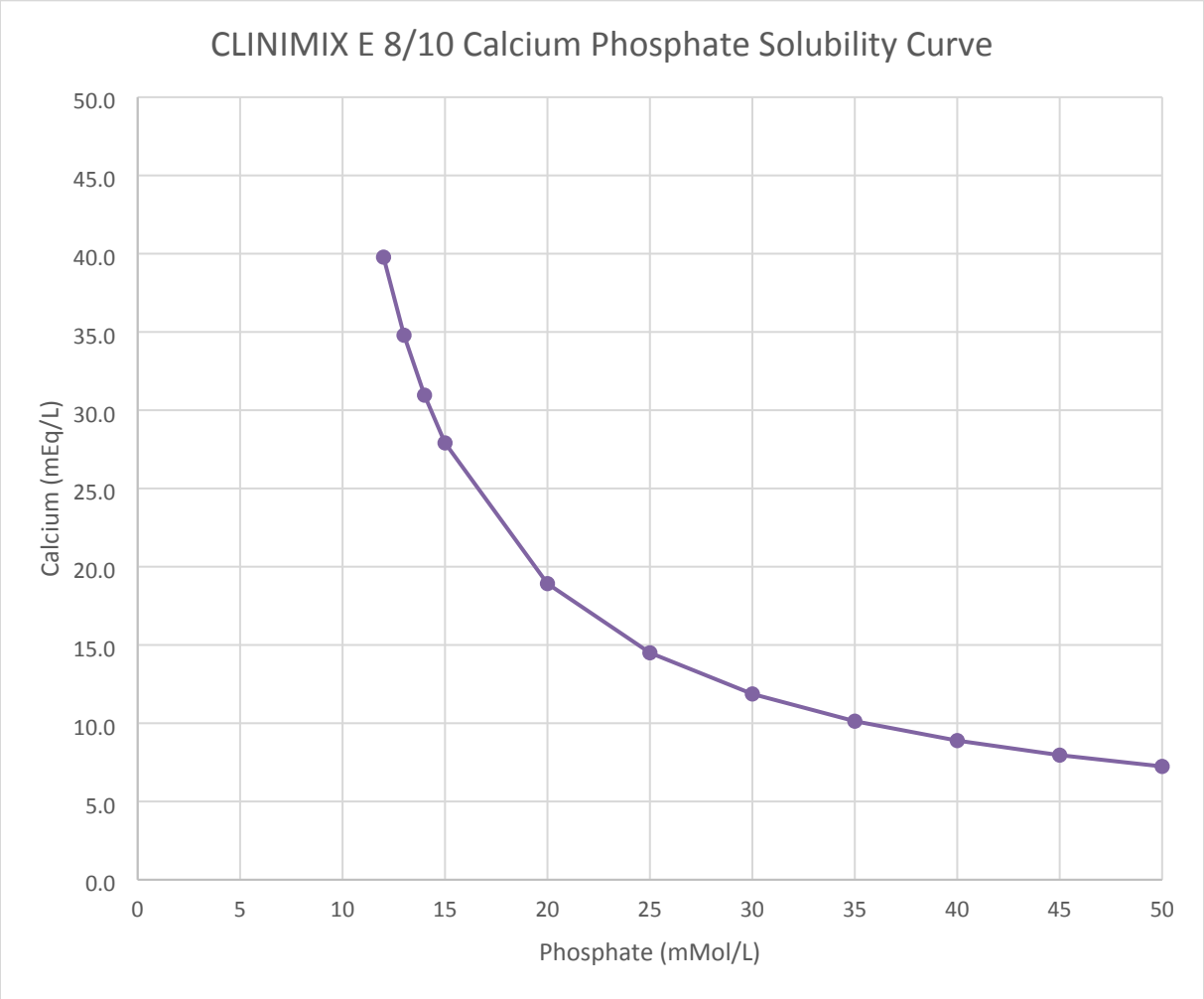
The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 3: Calcium Phosphate Solubility Curves for CLINIMIX E 5/15



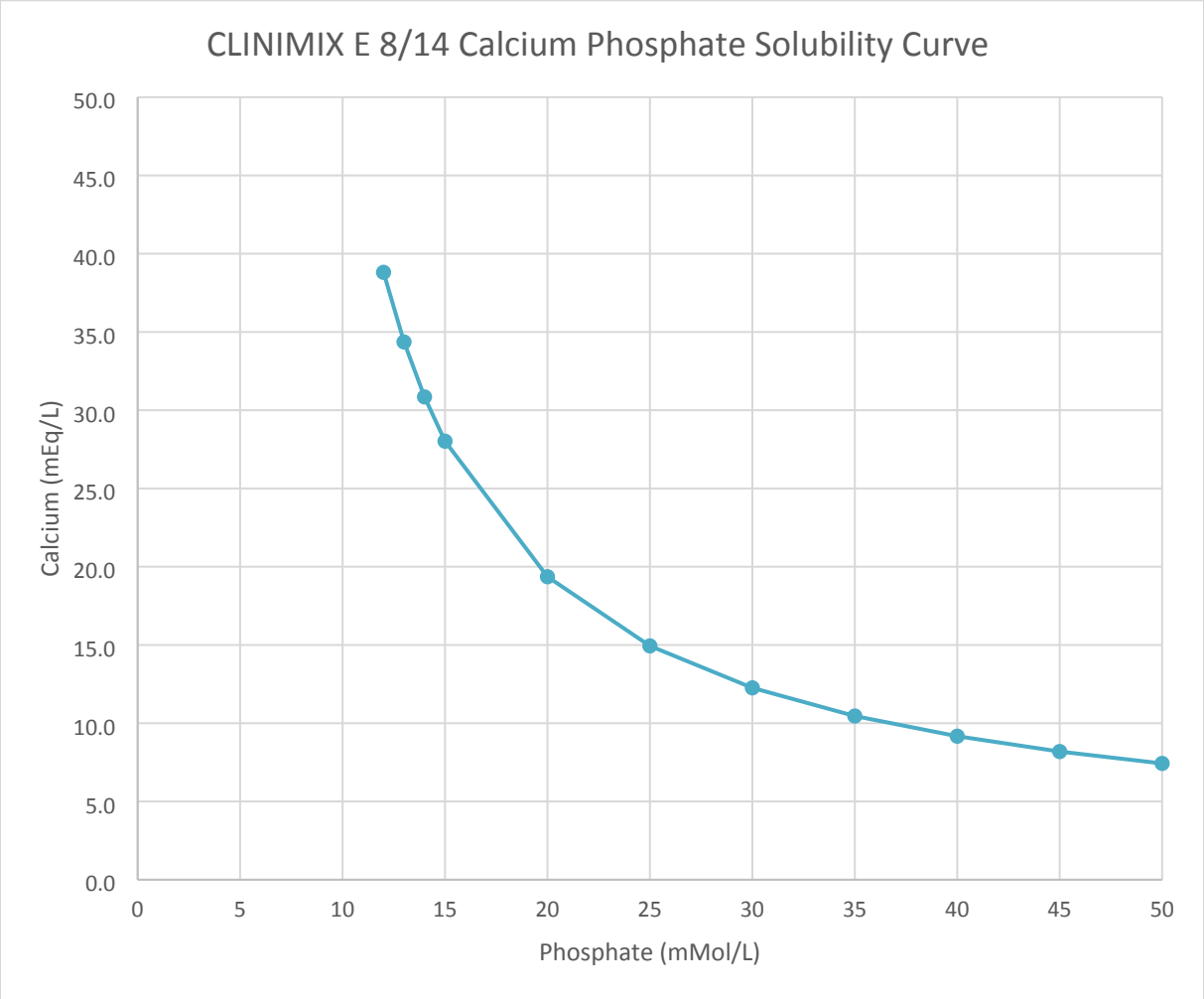
The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 4: Calcium Phosphate Solubility Curves for CLINIMIX E 8/10



The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

Figure 5: Calcium Phosphate Solubility Curves for CLINIMIX E 8/14



The area to the left and/or below each curve represents concentrations of calcium and phosphate that are less likely to precipitate, and data points to the right and/or above each curve represent concentrations of calcium and phosphate that are more likely to precipitate (Incompatibility Zone). These solubility curves are meant to serve as only a guide and are not intended to replace good clinical judgment.

This information is intended to provide pertinent data to assist you in forming your own conclusions and is not to be considered as medical advice. The information contained in this letter is applicable to products approved or cleared in the United States of America, unless specifically noted. Baxter does not advocate the use of its products outside of approved labeling. Please refer to Instructions for Use or Prescribing Information. This letter is provided as a service to Baxter customers, and it may not be reproduced without the prior written permission of Baxter Healthcare Corporation.

References:

1. CLINIMIX E Injection Prescribing Information.

2. Trissel LA, Canada T. Calcium and Phosphate Compatibility in Parenteral Nutrition. TriPharma Communications, Houston, Texas 2001. Page ix-xv, 141-154.

3. [a,b] Baxter internal data on file.

4. U.S. Pharmacopeia, *The National Formulary*, USP 43-NF38 <788> Particulate Matter in Injections. Official as 1-May-2013. Accessed April 13, 2023.

GUIDE FOR ADJUNCTIVE PHARMACY DRIVEN ELECTROLYTE REPLACEMENT

This guide is intended to provide standardization for electrolyte replacement and management in the setting of patients receiving Parenteral Nutrition (PN) per Pharmacy under prescriptive authority of the Adult Parenteral Nutrition Protocol, in collaboration with clinical dieticians.

The suggested electrolyte replacement doses and laboratory monitoring frequency may not be appropriate in all patients and the pharmacist shall employ clinical judgement when using this guide.

I. CRITERIA FOR ADJUNCTIVE EXTERNAL ELECTROLYTE REPLACEMENT:

A. Inclusion Criteria:
   1. Active PN Protocol per Pharmacy orders

B. Exclusion Criteria:
   1. Hemodialysis/Peritoneal Dialysis
   2. Acute Kidney Injury
   3. Serum Creatinine > 2 mg/dL or CrCl < 30 mL/min
   4. Chronic Adrenal Insufficiency
   5. Diabetic Ketoacidosis
   6. Rhabdomyolysis

C. Note for use:
   1. If the patient meets any exclusion criteria, the pharmacist may still offer recommendations for timely electrolyte replacement outside of PN. These recommendations are subject to provider approval.

II. LABORATORY MONITORING GUIDE

A. Baseline Laboratory Results:
   1. If patient is non-acute and does not have significant electrolyte abnormalities, baseline labs may be from within 24 hours prior to PN initiation.
   2. If patient is acute, baseline labs must be drawn the day of PN Initiation.

B. Initial Phase:
   1. Defined as the time prior to being a Stable Inpatient.

C. Critical Illness:
   1. ASPEN and SCCM provide guidelines indicating that the critically ill ICU population is not homogenous, and electrolyte management should consider individual patient variability.

D. Stable Inpatient:
   1. Defined as a patient receiving consistent intravenous PN, who is clinically stable and requires long-term PN support.

Parameter	Baseline	Initiation Phase	Critical Illness	Stable Inpatient
CBC with Differential	✓		Every 7 Days	Every 7 Days
TPN Panel	✓		Every 7 Days	Every 7 Days
BMP		Daily X 3 Days*	Daily	1-3 X Weekly
Magnesium	✓	Daily X 3 Days*	Daily	1-3 X Weekly
Phosphorus	✓	Daily X 3 Days*	Daily	1-3 X Weekly
Blood Glucose (Part of BMP)ǂ	✓	Daily X 3 Days*	Daily	1-3 X Weekly

***Frequency Daily X 3 Days or Until Stable**
ǂExcludes POC Glucose. See Physician/Ordering Provider Responsibilities regarding Insulin management.
Once weekly: TPN Panel shall replace BMP, Magnesium, and Phosphorus.

GUIDE FOR ADJUNCTIVE PHARMACY DRIVEN ELECTROLYTE REPLACEMENT

If…	Then…
K < 4.0; Phosphorus > 2.5; + Cardiac Monitor	See Table 1.1
K < 4.0; Phosphorus > 2.5; Non-Cardiac Monitor	See Table 1.2
K < 4.0; Phosphorus < 2.5; + Cardiac Monitor	See Table 1.4; Do not exceed recommended potassium replacement (Table 1.1) when utilizing KPhos
K < 4.0; Phosphorus < 2.5; Non-Cardiac Monitor	See Table 1.4; Do not exceed recommended potassium replacement (Table 1.2) when utilizing KPhos
Magnesium < 1.9	See Table 1.3
K > 4.0; Phosphorus < 2.5	See Table 1.4
Corrected Calcium < 8.5	See Table 1.5

POTASSIUM REPLACEMENT FOR CARDIAC MONITORED PATIENTS		
Serum K	**Replacement**	**Recheck Level**
3.5 – 3.9	20 mEq Potassium Chloride	AM Labs
3.3 – 3.5	40 mEq Potassium Chloride	AM Labs
2.5 – 3.2	60 mEq Potassium Chloride	Recheck 2 HR Post Replacement
< 2.5	80 mEq Potassium Chloride + Notify MD	Recheck 2 HR Post Replacement

Table 1.1
Replacement algorithm for Patients with Cardiac Monitoring
Serum K anticipated to increase by ~ 0.2 mEq/L for each 20 mEq IV KCl infused

POTASSIUM REPLACEMENT NOMOGRAM FOR NON-CARDIAC MONITORED PATIENTS		
Serum K	**Replacement**	**Recheck Level**
3.0 – 3.9	20 mEq Potassium Chloride	AM Labs
2.5 – 2.9	40 mEq Potassium Chloride	Recheck 2 HR Post Replacement
< 2.5	60 mEq Potassium Chloride + Notify MD	Recheck 2 HR Post Replacement

Table 1.2
Replacement algorithm for Non-Cardiac Monitored Patients
Serum K anticipated to increase by ~ 0.2 mEq/L for each 20 mEq IV KCl infused

MAGNESIUM REPLACEMENT NOMOGRAM		
Serum Magnesium (mg/dL)	**Replacement**	**Recheck Level**
1.5 – 1.8	2 gm Magnesium Sulfate	AM Labs
1.2 – 1.4	4 gm Magnesium Sulfate	Recheck 2 HR after replacement
< 1.2	4 gm Magnesium Sulfate + Notify MD	Recheck 2 HR after replacement

Table 1.3
Initiate magnesium replacement 1 HOUR prior to potassium replacement or calcium replacement

PHOSPHORUS REPLACEMENT NOMOGRAM		
Serum Phosphorus	**Replacement**	**Recheck Level**
2.0 – 2.5	10 mmol Phosphate IV	AM Labs
1.1 – 1.9	20 mmol Phosphate IV	Recheck 2 HR after replacement
< 1.1	30 mmol Phosphate IV + Notify MD	Recheck 2 HR after replacement

Table 1.4
If both potassium and phosphorus replacement required, utilize K Phos. If no potassium replacement is required, or would exceed recommended replacement following the potassium nomogram, utilize Na Phos.
Potassium Phosphate = 3 mmol Phosphorus and 4.4 mEq potassium/mL
MAX Infusion Rate: Sodium Phosphate 7.5 mmol phosphorus/hour; Potassium Phosphate 6.5 mmol phosphorus/hour
****Do not infuse phosphate in the same intravenous line with calcium-containing solutions.**

GUIDE FOR ADJUNCTIVE PHARMACY DRIVEN ELECTROLYTE REPLACEMENT

CALCIUM REPLACEMENT NOMOGRAM		
Serum Calcium (mg/dL)	**Replacement**	**Recheck Level**
8 – 8.4	1 gm Calcium Gluconate	AM Labs
7.5 – 7.9	2 gm Calcium Gluconate	Recheck 2 HR after replacement
< 7.5	3 gm Calcium Gluconate + Notify MD	Recheck 2 HR after replacement

Table 1.5
Use unadjusted calcium as the alternative to ionized calcium
Hyperphosphatemia should be corrected prior to administration of calcium replacement
****Do not infuse calcium in the same intravenous line with phosphorus-containing solutions**

Baxter

Clinimix
AMINO ACID IN DEXTROSE INJECTION

Clinimix E
AMINO ACIDS WITH ELECTROLYTES IN DEXTROSE WITH CALCIUM INJECTIONS

FDA APPROVED

Macronutrient & Micronutrient Infusion Rate Chart

INDICATIONS

CLINIMIX (amino acids in dextrose) Injections and CLINIMIX E (amino acids with electrolytes in dextrose with calcium) Injections are indicated as a source of calories and protein (and electrolytes for CLINIMIX E) for patients requiring parenteral nutrition when oral or enteral nutrition is not possible, insufficient, or contraindicated. CLINIMIX and CLINIMIX E may be used to treat negative nitrogen balance in patients.

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

IMPORTANT RISK INFORMATION

- CLINIMIX and CLINIMIX E Injections are contraindicated in patients with known hypersensitivity to one or more amino acids or dextrose; in patients with inborn errors of amino acid metabolism due to risk of severe metabolic and neurologic complications; and in patients with pulmonary edema or acidosis due to low cardiac output. In addition, CLINIMIX E is contraindicated in neonates (less than 28 days of age) receiving concomitant treatment with ceftriaxone, even if separate infusion lines are used, due to the risk of fatal ceftriaxone calcium salt precipitation in the neonate's bloodstream.
- Pulmonary vascular precipitates causing pulmonary vascular emboli and pulmonary distress have been reported in patients receiving parenteral nutrition. Excessive addition of calcium and phosphate increases the risk of the formation of calcium phosphate precipitates. The solution should be inspected for precipitates before admixing, after admixing, and again before administration. If signs of pulmonary distress occur, stop the infusion and initiate a medical evaluation.
- Precipitation of ceftriaxone-calcium can occur when ceftriaxone is mixed with CLINIMIX E, in the same intravenous administration line. Do not administer ceftriaxone simultaneously with CLINIMIX E via a Y-site.
- Stop infusion immediately and treat patient accordingly if signs or symptoms of a hypersensitivity reaction develop.
- Monitor for signs and symptoms of early infections.
- Refeeding severely undernourished patients may result in refeeding syndrome. Thiamine deficiency and fluid retention may also develop. Monitor severely undernourished patients and slowly increase nutrient intakes.
- CLINIMIX and CLINIMIX E solutions containing more than 5% dextrose have an osmolarity of ≥ 900 mOsm/L and must be infused through a central catheter.
- CLINIMIX and CLINIMIX E contain no more than 25 mcg/L of aluminum which may reach toxic levels with prolonged administration in patients with renal impairment. Preterm infants are at greater risk because their kidneys are immature, and they require large amounts of calcium and phosphate solutions which contain aluminum. Patients with renal impairment, including preterm infants, who receive parenteral levels of aluminum at greater than 4 to 5 mcg/kg/day, accumulate aluminum at levels associated with central nervous system and bone toxicity. Tissue loading may occur at even lower rates of administration.
- Parenteral Nutrition Associated Liver Disease (PNALD) has been reported in patients who receive parenteral nutrition for extended periods of time, especially preterm infants. If CLINIMIX and CLINIMIX E treated patients develop liver test abnormalities consider discontinuation or dosage reduction.
- Use CLINIMIX and CLINIMIX E with caution in patients with cardiac insufficiency or renal impairment due to increased risk of electrolyte and fluid volume imbalance.
- Monitor renal and liver function parameters, ammonia levels, fluid and electrolyte status, serum osmolarity, blood glucose, blood count and coagulation parameters throughout treatment. In situations of severely elevated electrolyte levels, stop CLINIMIX and CLINIMIX E until levels have been corrected.
- Adverse reactions include diuresis, extravasation, glycosuria, hyperglycemia, and hyperosmolar coma.

Please see accompanying Package Inserts for full Prescribing Information

4.25/5

Baxter
Clinimix
AMINO ACID IN DEXTROSE INJECTION

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	31	122	36	122	245	27	12
35	840	36	143	42	143	286	31	14
40	960	41	163	48	163	326	36	16
42	1000	43	170	50	170	340	37	17
45	1080	46	184	54	184	367	40	18
50	1200	51	204	60	204	408	44	20
55	1320	56	224	66	224	449	49	22
60	1440	61	245	72	245	490	53	24
63	1500	64	255	75	255	510	56	26
65	1560	66	265	78	265	530	58	27
70	1680	71	286	84	286	571	62	29
75	1800	77	306	90	306	612	67	31
80	1920	82	326	96	326	653	71	33
83	2000	85	340	100	340	680	74	34
85	2040	87	347	102	347	694	75	35
90	2160	92	367	108	367	734	80	37
95	2280	97	388	114	388	775	84	39
100	2400	102	408	120	408	816	89	41
105	2520	107	428	126	428	857	93	43
110	2640	112	449	132	449	898	98	45
115	2760	117	469	138	469	938	102	47
120	2880	122	490	144	490	979	107	49
125	3000	128	510	150	510	1020	111	51

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

4.25/10

Baxter
Clinimix
AMINO ACID IN DEXTROSE INJECTION

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	31	122	72	245	367	27	12
35	840	36	143	84	286	428	31	14
40	960	41	163	96	326	490	36	16
42	1000	43	170	100	340	510	37	17
45	1080	46	184	108	367	551	40	18
50	1200	51	204	120	408	612	44	20
55	1320	56	224	132	449	673	49	22
60	1440	61	245	144	490	734	53	24
63	1500	64	255	150	510	765	56	26
65	1560	66	265	156	530	796	58	27
70	1680	71	286	168	571	857	62	29
75	1800	77	306	180	612	918	67	31
80	1920	82	326	192	653	979	71	33
82	2000	85	340	200	680	1020	74	34
85	2040	87	347	204	694	1040	75	35
90	2160	92	367	216	734	1102	80	37
95	2280	97	388	228	775	1163	84	39
100	2400	102	408	240	816	1224	89	41
105	2520	107	428	252	857	1285	93	43
110	2640	112	449	264	898	1346	98	45
115	2760	117	469	276	938	1408	102	47
120	2880	122	490	288	979	1469	107	49
125	3000	128	510	300	1020	1530	111	51

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	36	144	108	367	511	30	14
35	840	42	168	126	428	596	35	17
40	960	48	192	144	490	682	40	19
42	1000	50	200	150	510	710	42	20
45	1080	54	216	162	551	767	45	22
50	1200	60	240	180	612	852	50	24
55	1320	66	264	198	673	937	55	26
60	1440	72	288	216	734	1022	60	29
63	1500	75	300	225	765	1065	63	30
65	1560	78	312	234	796	1108	66	31
70	1680	84	336	252	857	1193	71	34
75	1800	90	360	270	918	1278	76	36
80	1920	96	384	288	979	1363	81	38
82	2000	100	400	300	1020	1420	84	40
85	2040	102	408	306	1040	1448	86	41
90	2160	108	432	324	1102	1534	91	43
95	2280	114	456	342	1163	1619	96	46
100	2400	120	480	360	1224	1704	101	48
105	2520	126	504	378	1285	1789	106	50
110	2640	132	528	396	1346	1874	111	53
115	2760	138	552	414	1408	1960	116	55
120	2880	144	576	432	1469	2045	121	58
125	3000	150	600	450	1530	2130	126	60

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	36	144	144	490	634	30	14
35	840	42	168	168	571	739	35	17
40	960	48	192	192	653	845	40	19
42	1000	50	200	200	680	880	42	20
45	1080	54	216	216	734	950	45	22
50	1200	60	240	240	816	1056	50	24
55	1320	66	264	264	898	1162	55	26
60	1440	72	288	288	979	1267	60	29
63	1500	75	300	300	1020	1320	63	30
65	1560	78	312	312	1061	1373	66	31
70	1680	84	336	336	1142	1478	71	34
75	1800	90	360	360	1224	1584	76	36
80	1920	96	384	384	1306	1690	81	38
82	2000	100	400	400	1360	1760	84	40
85	2040	102	408	408	1387	1795	86	41
90	2160	108	432	432	1469	1901	91	43
95	2280	114	456	456	1550	2006	96	46
100	2400	120	480	480	1632	2112	101	48
105	2520	126	504	504	1714	2218	106	50
110	2640	132	528	528	1795	2323	111	53
115	2760	138	552	552	1877	2429	116	55
120	2880	144	576	576	1958	2534	121	58
125	3000	150	600	600	2040	2640	126	60

Baxter
Clinimix
AMINO ACID IN DEXTROSE INJECTION

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	43	173	36	122	295	38	17
35	840	50	202	42	143	344	45	20
40	960	58	230	48	163	394	51	23
42	1001	60	240	50	170	410	53	24
45	1080	65	259	54	184	443	57	26
50	1200	72	288	60	204	492	64	29
55	1320	79	317	66	224	541	70	32
60	1440	86	346	72	245	590	76	35
63	1500	90	360	75	255	615	80	36
65	1560	94	374	78	265	640	83	37
70	1680	101	403	84	286	689	89	40
75	1800	108	432	90	306	738	95	43
80	1920	115	461	96	326	787	102	46
82	1999	120	480	100	340	820	106	48
85	2040	122	490	102	347	836	108	49
90	2160	130	518	108	367	886	114	52
95	2280	137	547	114	388	935	121	55
100	2400	144	576	120	408	984	127	58
105	2520	151	605	126	428	1033	134	60
110	2640	158	634	132	449	1082	140	63
115	2760	166	662	138	469	1132	146	66
120	2880	173	691	144	490	1181	153	69
125	3000	180	720	150	510	1230	159	72

Baxter
Clinimix
AMINO ACID IN DEXTROSE INJECTION

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	58	230	72	247	477	51	23
35	840	67	269	84	288	557	60	27
40	960	77	307	96	329	636	68	31
42	1001	80	320	100	343	664	71	32
45	1080	86	346	108	370	716	77	35
50	1200	96	384	120	412	796	85	38
55	1320	106	422	132	453	875	94	42
60	1440	115	461	144	494	955	102	46
63	1500	120	480	150	515	995	107	48
65	1560	125	499	156	535	1034	111	50
70	1680	134	538	168	576	1114	119	54
75	1800	144	576	180	617	1193	128	58
80	1920	154	614	192	659	1273	136	61
82	1999	160	640	200	686	1325	142	64
85	2040	163	653	204	700	1353	145	65
90	2160	173	691	216	741	1432	153	69
95	2280	182	730	228	782	1512	162	73
100	2400	192	768	240	823	1591	170	77
105	2520	202	806	252	864	1671	179	81
110	2640	211	845	264	906	1750	187	84
115	2760	221	883	276	947	1830	196	88
120	2880	230	922	288	988	1909	204	92
125	3000	240	960	300	1029	1989	213	96

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Acetate provided	mEq/d Chloride provided
30	720	58	230	101	343	574	51	23
35	840	67	269	118	401	669	60	27
40	960	77	307	134	458	765	68	1
42	1001	80	320	140	477	798	71	32
45	1080	86	346	151	515	861	77	35
50	1200	96	384	168	572	956	85	38
55	1320	106	422	185	630	1052	94	42
60	1440	115	461	202	687	1148	102	46
63	1500	120	480	210	716	1196	107	48
65	1560	125	499	218	744	1243	111	50
70	1680	134	538	235	801	1339	119	54
75	1800	144	576	252	859	1435	128	58
80	1920	154	614	269	916	1530	136	61
82	1999	160	640	280	954	1593	142	64
85	2040	163	653	26	973	1626	145	65
90	2160	173	691	302	1030	1722	153	69
95	2280	182	730	319	1088	1817	162	73
100	2400	192	768	336	1145	1913	170	77
105	2520	202	806	353	1202	2008	179	81
110	2640	211	845	370	1259	2104	187	84
115	2760	221	883	386	1317	2200	196	88
120	2880	230	922	403	1374	2295	204	92
125	3000	240	960	420	1431	2391	213	96

2.75/5

Baxter
Clinimix E
AMINO ACIDS WITH ELECTROLYTES IN DEXTROSE WITH CALCIUM INJECTIONS

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	20	79	36	122	202	25	22	4	3	11	37	28
35	840	23	92	42	143	235	29	25	4	4	13	43	33
40	960	26	106	48	163	269	34	29	5	4	14	49	37
42	1000	28	110	50	170	280	35	30	5	5	15	51	39
45	1080	30	119	54	184	302	38	32	5	5	16	55	42
50	1200	33	132	60	204	336	42	36	6	5	18	61	47
55	1320	36	145	66	224	370	46	40	7	6	20	67	51
60	1440	40	158	72	245	403	50	43	7	6	22	73	56
63	1500	41	165	75	255	420	53	45	8	7	23	77	59
65	1560	43	172	78	265	437	55	47	8	7	23	80	61
70	1680	46	185	84	286	470	59	50	8	8	25	86	66
75	1800	50	198	90	306	504	63	54	9	8	27	92	70
80	1920	53	211	96	326	538	67	58	10	9	29	98	75
82	2000	55	220	100	340	560	70	60	10	9	30	102	78
85	2040	56	224	102	347	571	71	61	10	9	31	104	80
90	2160	59	238	108	367	605	76	65	11	10	32	110	84
95	2280	63	251	114	388	638	80	68	11	10	34	116	89
100	2400	66	264	120	408	672	84	72	12	11	36	122	94
105	2520	69	277	126	428	706	88	76	13	11	38	129	98
110	2640	73	290	132	449	739	92	79	13	12	40	135	103
115	2760	76	304	138	469	773	97	83	14	12	41	141	108
120	2880	79	317	144	490	806	101	86	14	13	43	147	112
125	3000	83	330	150	510	840	105	90	15	14	45	153	117

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

4.25/5

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	31	122	36	122	245	25	22	4	3	11	50	28
35	840	36	143	42	143	286	29	25	4	4	13	59	33
40	960	41	163	48	163	326	34	29	5	4	14	67	37
42	1000	43	170	50	170	340	35	30	5	5	15	70	39
45	1080	46	184	54	184	367	38	32	5	5	16	76	42
50	1200	51	204	60	204	408	42	36	6	5	18	84	47
55	1320	56	224	66	224	449	46	40	7	6	20	92	51
60	1440	61	245	72	245	490	50	43	7	6	22	101	56
63	1500	64	255	75	255	510	53	45	8	7	23	105	59
65	1560	66	265	78	265	530	55	47	8	7	23	109	61
70	1680	71	286	84	286	571	59	50	8	8	25	118	66
75	1800	77	306	90	306	612	63	54	9	8	27	126	70
80	1920	82	326	96	326	653	67	58	10	9	29	134	75
82	2000	85	340	100	340	680	70	60	10	9	30	140	78
85	2040	87	347	102	347	694	71	61	10	9	31	143	80
90	2160	92	367	108	367	734	76	65	11	10	32	151	84
95	2280	97	388	114	388	775	80	68	11	10	34	160	89
100	2400	102	408	120	408	816	84	72	12	11	36	168	94
105	2520	107	428	126	428	857	88	76	13	11	38	176	98
110	2640	112	449	132	449	898	92	79	13	12	40	185	103
115	2760	117	469	138	469	938	97	83	14	12	41	193	108
120	2880	122	490	144	490	979	101	86	14	13	43	202	112
125	3000	128	510	150	510	1020	105	90	15	14	45	210	117

4.25/10

Baxter
Clinimix E
AMINO ACIDS WITH ELECTROLYTES IN DEXTROSE WITH CALCIUM INJECTIONS

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	31	122	72	245	367	25	22	4	3	11	50	28
35	840	36	143	84	286	428	29	25	4	4	13	59	33
40	960	41	163	96	326	490	34	29	5	4	14	67	37
42	1000	43	170	100	340	510	35	30	5	5	15	70	39
45	1080	46	184	108	367	551	38	32	5	5	16	76	42
50	1200	51	204	120	408	612	42	36	6	5	18	84	47
55	1320	56	224	132	449	673	46	40	7	6	20	92	51
60	1440	61	245	144	490	734	50	43	7	6	22	101	56
63	1500	64	255	150	510	765	53	45	8	7	23	105	59
65	1560	66	265	156	530	796	55	47	8	7	23	109	61
70	1680	71	286	168	571	857	59	50	8	8	25	118	66
75	1800	77	306	180	612	918	63	54	9	8	27	126	70
80	1920	82	326	192	653	979	67	58	10	9	29	134	75
82	2000	85	340	200	680	1020	70	60	10	9	30	140	78
85	2040	87	347	204	694	1040	71	61	10	9	31	143	80
90	2160	92	367	216	734	1102	76	65	11	10	32	151	84
95	2280	97	388	228	775	1163	80	68	11	10	34	160	89
100	2400	102	408	240	816	1224	84	72	12	11	36	168	94
105	2520	107	428	252	857	1285	88	76	13	11	38	176	98
110	2640	112	449	264	898	1346	92	79	13	12	40	185	103
115	2760	117	469	276	938	1408	97	83	14	12	41	193	108
120	2880	122	490	288	979	1469	101	86	14	13	43	202	112
125	3000	128	510	300	1020	1530	105	90	15	14	45	210	117

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

5/15

Baxter
Clinimix E
AMINO ACIDS WITH ELECTROLYTES IN DEXTROSE WITH CALCIUM INJECTIONS

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	36	144	108	367	511	25	22	4	3	11	58	28
35	840	42	168	126	428	596	29	25	4	4	13	67	33
40	960	48	192	144	490	682	34	29	5	4	14	77	37
42	1000	50	200	150	510	710	35	30	5	5	15	80	39
45	1080	54	216	162	551	767	38	32	5	5	16	86	42
50	1200	60	240	180	612	852	42	36	6	5	18	96	47
55	1320	66	264	198	673	937	46	40	7	6	20	106	51
60	1440	72	288	216	734	1022	50	43	7	6	22	115	56
63	1500	75	300	225	765	1065	53	45	8	7	23	120	59
65	1560	78	312	234	796	1108	55	47	8	7	23	125	61
70	1680	84	336	252	857	1193	59	50	8	8	25	134	66
75	1800	90	360	270	918	1278	63	54	9	8	27	144	70
80	1920	96	384	288	979	1363	67	58	10	9	29	154	75
82	2000	100	400	300	1020	1420	70	60	10	9	30	160	78
85	2040	102	408	306	1040	1448	71	61	10	9	31	163	80
90	2160	108	432	324	1102	1534	76	65	11	10	32	173	84
95	2280	114	456	342	1163	1619	80	68	11	10	34	182	89
100	2400	120	480	360	1224	1704	84	72	12	11	36	192	94
105	2520	126	504	378	1285	1789	88	76	13	11	38	202	98
110	2640	132	528	396	1346	1874	92	79	13	12	40	211	103
115	2760	138	552	414	1408	1960	97	83	14	12	41	221	108
120	2880	144	576	432	1469	2045	101	86	14	13	43	230	112
125	3000	150	600	450	1530	2130	105	90	15	14	45	240	117

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

5/20

Baxter
Clinimix E
AMINO ACIDS WITH ELECTROLYTES IN DEXTROSE WITH CALCIUM INJECTIONS

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	36	144	144	490	634	25	22	4	3	11	58	28
35	840	42	168	168	571	739	29	25	4	4	13	67	33
40	960	48	192	192	653	845	34	29	5	4	14	77	37
42	1000	50	200	200	680	880	35	30	5	5	15	80	39
45	1080	54	216	216	734	950	38	32	5	5	16	86	42
50	1200	60	240	240	816	1056	42	36	6	5	18	96	47
55	1320	66	264	264	898	1162	46	40	7	6	20	106	51
60	1440	72	288	288	979	1267	50	43	7	6	22	115	56
63	1500	75	300	300	1020	1320	53	45	8	7	23	120	59
65	1560	78	312	312	1061	1373	55	47	8	7	23	125	61
70	1680	84	336	336	1142	1478	59	50	8	8	25	134	66
75	1800	90	360	360	1224	1584	63	54	9	8	27	144	70
80	1920	96	384	384	1306	1690	67	58	10	9	29	154	75
82	2000	100	400	400	1360	1760	70	60	10	9	30	160	78
85	2040	102	408	408	1387	1795	71	61	10	9	31	163	80
90	2160	108	432	432	1469	1901	76	65	11	10	32	173	84
95	2280	114	456	456	1550	2006	80	68	11	10	34	182	89
100	2400	120	480	480	1632	2112	84	72	12	11	36	192	94
105	2520	126	504	504	1714	2218	88	76	13	11	38	202	98
110	2640	132	528	528	1795	2323	92	79	13	12	40	211	103
115	2760	138	552	552	1877	2429	97	83	14	12	41	221	108
120	2880	144	576	576	1958	2534	101	86	14	13	43	230	112
125	3000	150	600	600	2040	2640	105	90	15	14	45	240	117

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	58	230	72	247	477	25	22	4	3	11	60	55
35	840	67	269	84	288	557	29	25	4	4	13	70	64
40	960	77	307	96	329	636	34	29	5	4	14	80	73
42	1001	80	320	100	343	664	35	30	5	5	15	83	76
45	1080	86	346	108	370	716	38	32	5	5	16	90	82
50	1200	96	384	120	412	796	42	36	6	5	18	100	91
55	1320	106	422	132	453	875	46	40	7	6	20	110	100
60	1440	115	461	144	494	955	50	43	7	6	22	120	109
63	1500	120	480	150	515	995	53	45	8	7	23	125	114
65	1560	125	499	156	535	1034	55	47	8	7	23	129	119
70	1680	134	538	168	576	1114	59	50	8	8	25	139	128
75	1800	144	576	180	617	1193	63	54	9	8	27	149	137
80	1920	154	614	192	659	1273	67	58	10	9	29	159	146
82	1999	160	640	200	686	1325	70	60	10	9	30	166	152
85	2040	163	653	204	700	1353	71	61	10	9	31	169	155
90	2160	173	691	216	741	1432	76	65	11	10	32	179	164
95	2280	182	730	228	782	1512	80	68	11	10	34	189	173
100	2400	192	768	240	823	1591	84	72	12	11	36	199	182
105	2520	202	806	252	864	1671	88	76	13	11	38	209	192
110	2640	211	845	264	905	1750	92	79	13	12	40	219	201
115	2760	221	883	276	947	1830	97	83	14	12	41	229	210
120	2880	230	922	288	988	1909	101	86	14	13	43	239	219
125	3000	240	960	300	1029	1989	105	90	15	14	45	249	228

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

Rate mL/hr	24 hour volume (mL)	Grams of Amino Acids	kcal from Amino Acids	Grams of Dextrose	kcal from Dextrose	Total kcal	mEq/d Na+ provided	mEq/d K+ provided	mEq/d Mg++ provided	mEq/d Ca++ provided	mMol/d PO4- provided	mEq/d Acetate provided	mEq/d Chloride provided
30	720	58	230	101	343	574	25	22	4	3	11	60	55
35	840	67	269	118	401	669	29	25	4	4	13	70	64
40	960	77	307	134	458	765	34	29	5	4	14	80	73
42	1000	80	320	140	477	798	35	30	5	5	15	83	76
45	1080	86	346	151	515	861	38	32	5	5	16	90	82
50	1200	96	384	168	572	956	42	36	6	5	18	100	91
55	1320	106	422	185	630	1052	46	40	7	6	20	110	100
60	1440	115	461	202	687	1148	50	43	7	6	21	120	109
63	1500	120	480	210	716	1196	53	45	8	7	23	125	114
65	1560	125	499	218	744	1243	55	47	8	7	23	129	119
70	1680	134	538	235	801	1339	59	50	8.	8	25	139	128
75	1800	144	576	252	859	1435	63	54	9	8	27	149	137
80	1920	154	614	269	916	1530	67	58	10	9	29	159	146
82	1999	160	640	280	954	1593	70	60	10	9	30	166	152
85	2040	163	653	286	973	1626	71	61	10	9	31	169	155
90	2160	173	691	302	1030	1722	76	65	11	10	32	179	164
95	2280	182	730	319	1088	1817	80	68	11	10.	34	189	173
100	2400	192	768	336	1145	1913	84	72	12	11	36	199	182
105	2520	202	806	353	1202	2008	88	76	13	11	38	209	192
110	2640	211	845	370	1259	2104	92	79	13	12	40	219	201
115	2760	220	883	386	1317	2200	97	83	14	12	41	229	210
120	2880	230	922	403	1374	2295	101	86	14	13	43	239	219
125	3000	240	960	420	1431	2391	105	90	15	14	45	249	228

Please see Indications and Important Risk Information on the inside front cover.
Please see accompanying full Prescribing Information.

Baxter

For more information, contact Medical Information
at 1-800-933-0303
or email MedInfo@baxter.com

Please see Indications and Important Risk Information on inside page
Please see accompanying Package Inserts for full Prescribing Information

USMP/78/14-0014(5) 5/20

Baxter Healthcare Corporation
One Baxter Parkway
Deerfield, IL 60015

www.baxter.com

3.10 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, or upon direction of the Board of Directors as set forth in Section 6.1.8, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

3.2.3 RELINQUISHMENT OF ACTIVE STAFF STATUS

The failure of an Active Staff member to meet the objective requirements of Section 3.2.1(a-c) shall be deemed a voluntary relinquishment of Active Staff status and the member shall automatically be transferred to the appropriate staff category, if any, for which the member is eligible. Such tranfers may apply to low volume physicians or Advanced Practice Providers who do not meet privileging criteria at reappointment. In the event that the member is not eligible for any other category, their Medical Staff membership shall automatically terminate at the end of their current term of appointment. No such transfer or termination shall be subject to the provisions of Article VII.

5.2.2 BASIS FOR PRIVILEGE DETERMINATIONS

a. Not all clinical privileges are exercised at this Hospital (and not all Hospital privileges may be exercised in all settings of the Hospital). Requests for privileges not exercised at this Hospital may be denied solely on that ground. Any such denial shall not be subject to the provisions of Article VII. Privileges that are specified for certain Hospital settings may only be exercised in those specific settings.

b. Requests for clinical privileges shall be evaluated on the basis of the member's licensure, education, training, experience, demonstrated professional competence and judgment, clinical performance (as confirmed by peers knowledgeable of the applicant's professional performance), health status, and the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

c. The burden of providing sufficient information to evaluate a request for privileges rests with the applicant. The provisions of Section 4.2 apply to requests for privileges.

d. The decision to grant or deny a privilege and/or to renew an existing privilege is an objective evidence-based process involving review of physician specific information pertaining to patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and evidence of systems based practice.

ARTICLE VIII
DEPENDENT PRACTITIONERS

8.1 DEFINITION

Dependent Practitioners are licensed or certified in the State of California and are not authorized the independent exercise of clinical privileges at Salinas Valley Health. Dependent Practitioners may only provide patient care services as defined in the APP specific clinical privileges.

8.2 CATEGORIES

The following categories of Dependent Practitioners authorized to provide patient care at Salinas Valley Health are:

a. Nurse Practitioner (NP)
b. Physician Assistant (PA)
c. Psychiatric Mental Health Nurse Practitioner (PMHNP)

8.3 RESPONSIBILITIES/ PREROGATIVES

The Dependent Practitioner:

a. Must meet and abide by all requirements of these APP Rules and Regulations, Medical Staff Bylaws, Medical Staff Rules and Regulations, and Hospital policies.

b. Must provide a written supervising physician agreement that is signed and dated by both the APP and the supervising physician.

8.4 SUPERVISION

a. No physician shall supervise more than ~~four (4)~~ eight (8) APP's.

b. The APP must function in a reasonable proximity to the supervising physician and the supervising physician or designee must be available either in person or by electronic communication. A supervising physician shall delegate to an APP only those tasks and procedures consistent with the supervising physician's specialty or usual and customary practice.

c. The physician must physically see each admitted patient prior to admission and prior to discharge. Thereafter, the supervising physician shall examine the patient the same day (or within 24 hours) as care is given by the APP to an in-patient.

d. In the case of a patient proceeding to the Operating Room, physician review and countersignature of an H&P completed by an APP must be completed prior to surgery. A note must be made by the supervising physician and must include a summary of the pertinent details of the history, important physical findings, the planned surgery, the rationale for the surgery, and documentation that the procedure has been explained to the patient by the supervising physician. The duty to obtain informed consent cannot be delegated to an APP.

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