January 16, 2026

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, JANUARY 22, 2026, AT 4:00 P.M., DOWNING RESOURCE CENTER, CONFERENCE ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA.**

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

Allen Radner, MD
President/Chief Executive Officer

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

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

THURSDAY, JANUARY 22, 2026, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C,
Salinas Valley Health Medical Center
450 E. Romie Lane, Salinas, California

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

	AGENDA	*Presented By*
1.	**CALL TO ORDER / ROLL CALL**	*Joel Hernandez Laguna*
2.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Joel Hernandez Laguna*
3.	**RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION** *(Estimated time 4:30 pm)*	*Joel Hernandez Laguna*
4.	**AWARDS & RECOGNITION**	*Allen Radner, M.D.*
5.	**PUBLIC COMMENT** This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.	*Joel Hernandez Laguna*
6.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)*	*Joel Hernandez Laguna*

A. Minutes of Annual Meeting of the Board of Directors December 18, 2025
B. Policies/Plans Requiring Approval
    1. Diagnostic Imaging Technologist Protocol–Based Modification of Imaging Orders (Epic Radiant)
    2. Isolette Cleaning
    3. Non Affiliated Employee Grievance
    4. Scope of Service: Human Resources
    5. Scope of Service: Medical Surgical Nursing Services
    6. Supervision of Stress Testing by Non-Physician Staff

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

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

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

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE *Catherine Carson*

Minutes of the January 12, 2026 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 January 12, 2026 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. The following recommendations has been made to the Board.

1. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF INGRID HSIUNG, MD, (ii) CONTRACT TERMS FOR DR. HSIUNG'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. HSIUNG'S CARDIAC ELECTROPHYSIOLOGY & CARDIOLOGY PROFESSIONAL SERVICES AGREEMENT**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

2. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF LAUREN BERRY, MD, (ii) CONTRACT TERMS FOR DR. BERRY'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. BERRY'S RHEUMATOLOGY PROFESSIONAL SERVICES AGREEMENT**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

3. **CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF SECOND AMENDMENT TO THE SALINAS VALLEY MEMORIAL HEALTHCARE DISTRICT EMPLOYEE PENSION PLAN**
   - Questions to Committee Chair/Staff
   - Motion/Second
   - Public Comment
   - Board Discussion/Deliberation
   - Action by Board/Roll Call Vote

C. FINANCE COMMITTEE *Victor Rey, Jr.*

Minutes of the January 19, 2026 Finance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

D. TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE *Victor Rey, Jr.*

Minutes of the January 19, 2026 Finance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JANUARY 8, 2026 AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS: *Alison Wilson, D.O.*

A. Reports
   1. Credentials Committee Report (Including the following)
      - Vascular Surgery – Clinical Privileges Delineation
   2. Interdisciplinary Practice Committee Report

B. Policies/Procedures/Plans and Agreements Recommended for Approval:
   1. Aerosol Transmitted Diseases Exposure Control Plan
   2. Infection Prevention Pandemic Plan Emerging Infectious Diseases
   3. Infection Prevention Program Plan

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

10. CONSIDERATION OF RESOLUTION 2026-01 AUTHORIZING ELIGIBLE SUBSIDIARY BODIES OF THE BOARD OF DIRECTORS TO CONDUCT MEETINGS VIA TELECONFERENCE IN ACCORDANCE WITH CALIFORNIA GOVERNMENT CODE SECTION 54953.8.6. *Joel Hernandez Laguna*

- Questions to Committee Chair/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, February 26, 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-us/healthcare-district-information-reports/board-of-directors/meeting-agendas-packets/2026/, 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, JANUARY 22, 2026, 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

CONFERENCE WITH REAL PROPERTY NEGOTIATORS

(Government Code §54956.8)
Property: (Specify street address, or if no street address, the parcel number or other unique reference, of the real property under negotiation): 1188 Padre Drive, Salinas, CA
Agency negotiator: (Specify names of negotiators attending the closed session): Allen Radner, MD
Negotiating parties: (Specify name of party (not agent): M2S Inc
Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both): Agreement Terms

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
        - Quality Incentive Program

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)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH[1]
ANNUAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
DECEMBER 18, 2025

Board Members Present: President Joel Hernandez Laguna; Vice-President Catherine Carson; Rolando Cabrera, M.D.; Victor Rey, Jr.; and Isaura Arreguin, appearing via teleconference pursuant to Government Code Section 54953(b)(3).

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.

1. CALL TO ORDER/ROLL CALL

A quorum was present and President Hernandez Laguna called the meeting to order at 4:07 p.m. in the Downing Resource Center, Conference Rooms A, B, & C, and via teleconference at Cam. Del Lago S/N, 59750, Tangancicuaro de Arista, Michoacan, Mexico.

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *Hearings and Reports, and Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:09 p.m. The Board completed its business of the Closed Session at 4:34 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:38 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *Hearings and Reports, and Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services.* The Board received and accepted the reports listed on the Closed Session agenda. No action was taken.

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

4. ANNUAL BOARD OF DIRECTORS REPORT

Joel Hernandez Laguna, 2025 Board of Directors President, presented the **Annual Board of Directors Report on the Overall Performance of Salinas Valley Health for 2025.** The full report is available in the Board packet and a summary is provided below.

President Hernandez Laguna reported that as 2025 concludes, the organization takes the opportunity to express gratitude, reflect on accomplishments, and acknowledge both the challenges faced and those ahead. He stated that throughout the year, the organization remained committed to providing high-quality healthcare, focusing on patient outcomes, operational strength, and fiscal responsibility.

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

He highlighted that the organization maintained national recognition, including a Leapfrog Safety "A," strong CMS ratings, designation as a High Performing Hospital for Maternity Care by *U.S. News & World Report*, and the Healthgrades Patient Safety Excellence Award. He emphasized that expanding community access remained a priority, with growth in telehealth services, after-hours and weekend urgent care, orthopedic programs, and outreach initiatives to support Medi-Cal coverage. He also noted that Monterey County became the only county in California to receive Blue Zones Certification.

He reported significant clinical and operational advancements, including the introduction of the Da Vinci 5 surgical robot and new procedures in the Comprehensive Cancer Center. He highlighted the successful implementation of *Epic* in the inpatient setting, which unified clinical systems, improved quality, and supported financial stability. He also noted the expansion of *Workday*, the Healing @ Home initiative, and continued growth of the "Meds to Beds" program.

He concluded that, looking ahead to 2026, the organization remains focused on balancing community needs with fiscal responsibility, navigating challenges such as reduced government funding and rising insurance costs, and advancing its mission of health, hope, and healing for all.

5. AWARDS AND RECOGNITION

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

- **39 Year Retirement Recognition: Nathanielle Aruiza, Medical Lab Tech:** Clement Miller, COO, honored Nathanielle for her dedication to Salinas Valley Health for the past 39 years. Referred to as "Stat Nat", Nathanielle was quickly promoted through the ranks upon joining SVH, and she is celebrated for her hard work and positive attitude through the years.
- **35 Year Retirement Recognition: Kathie Haines, Administrative Assistant:** Gary Ray, CLO, honored Kathie for her dedication to Salinas Valley Health for a total of 35 years of service in multiple roles, coming out of retirement not once, not twice, but four times to serve the Board of Directors. Kathie has also served for over twenty years as a volunteer for SVH and continues to volunteer in her retirement. Kathie commented that she has seen the hospital grow tremendously in her time here and she commended the Board and staff for their excellent work.

6. PUBLIC COMMENT: None.

7. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following policy has been removed for consideration from the published Consent Agenda: (1) Informatics & IT Change Control. 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 November 20, 2025
B. Policies/Plans Requiring Approval
    1. Cybersecurity Governance
    2. Cybersecurity Risk Management
    3. Incident Response & Disaster Recovery
    4. PCI Security Compliance
    5. Scope of Service: Education Department
    6. Vulnerability Management

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

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

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

Motion Carried.

8. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: Director Dr. Cabrera wished everyone happy holidays and thanked everyone for a great year.
Director Catherine Carson: Director Carson commented on SVH's participation at the Institute for Health Improvement conference this year, and she is already looking forward to next year's conference.
Director Victor Rey, Jr.: Director Rey highlighted the 5th annual Christmas in Closter Park event in Salinas, in which SVH was a key sponsor. Director Rey also commented that he met the new ASPIRE CEO Bob Bush and re-welcomed him to the community.
Director Isaura Arreguin: Director Arreguin wished everyone happy holidays with their loved ones. She commented on 2025 being a challenging year but overall she is grateful and proud to be a part of SVH.
Director Hernandez Laguna: Director Hernandez Laguna also spoke to SVH's support of Christmas at Closter Park. Director Hernandez Laguna highlighted the new Christmas lighting tradition at the SVH lobby. He also announced that Monterey County Gives is underway and encouraged support for the SVH Emergency Department campaign. Finally, Director Hernandez Laguna announced that the Board is planning a Board retreat in early 2026.

9. 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 December 15, 2025 meeting were provided for Board review. Director Carson stated the presentations were: (1) Patient Care Services Update on the Night Shift Practice Council, (2) Epic Clinical Acute Applications Report, and (3) 2026 Regulatory Quality and Safety Changes. 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 December 16, 2025 meeting were provided for Board review.

The following recommendations were made.

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.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: President Hernandez Laguna commented positively on the oversight committee, grant reporting process, and student scholarship opportunities incorporated within the MOU and grant.

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

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

Motion Carried.

C. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the November 15, 2025 meeting were provided for Board review. The Financial Reports of the meeting were included in the packet for review (informational).

The following recommendation was made.

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.**

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

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

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

Motion Carried.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON DECEMBER 11, 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 December 11, 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.

PUBLIC COMMENT: None.

BOARD DISCUSSION: Dr. Cabrera thanked Dr. Wilson for her confidence in the reports.

MOTION:
Upon motion by Director Dr. Cabrera and second by Director Rey, 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
    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.

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

Motion Carried

11. EXTENDED CLOSED SESSION
President Hernandez Laguna announced items to be discussed in Extended Closed Session are *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services.* The meeting recessed into Closed Session under the Closed Session Protocol at 5:25 p.m. The Board completed its business of the Closed Session at 6:20 p.m.

12. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION
The Board reconvened Open Session at 6:22 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services.* No action was taken.

13. ADJOURNMENT
The next Regular Meeting of the Board of Directors is scheduled for **Thursday, January 22, 2026, at 4:00 p.m.** There being no further business, the meeting was adjourned at 6:23 p.m.

_____
Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors

From: Brenda Inman, VP Quality and Risk

Date: January 22, 2026

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.	Diagnostic Imaging Technologist Protocol–Based Modification of Imaging Orders (Epic Radiant)	New Policy to support Imaging Epic Radiant process/workflow related change that allows imaging technologists to modify exam orders as per medical director approved protocol.	Clement Miller, COO
2.	Isolette Cleaning	Added IFU and ES procedure for isolette cleaning and infection.	Clement Miller, COO
3.	Non Affiliated Employee Grievance	Form attached. Regularly scheduled review.	Michelle Barnhart Childs, CHRO
4.	Scope of Service: Human Resources	Formatting corrections. Regularly scheduled review.	Michelle Barnhart Childs, CHRO
5.	Scope of Service: Medical Surgical Nursing Services	Form attached. Regularly scheduled review.	Carla Spencer, CNO
6.	Supervision of Stress Testing by Non-Physician Staff	Corrected titles and added definitions.	Clement Miller, COO

Status Pending PolicyStat ID 18949325

Origination	11/30/2027
Approved	N/A
Expires	11/30/2027
Owner	John Kazel: Director Imaging Services
Area	Diagnostic Imaging

Diagnostic Imaging Technologist Protocol–Based Modification of Imaging Orders (Epic Radiant)

I. POLICY STATEMENT

A. Salinas Valley Health authorizes licensed imaging technologists to adjust exam orders in Epic Radiant strictly per approved protocols, documenting the protocol and reason via the Modify Order workflow.

II. PURPOSE

A. To authorize licensed imaging technologists to modify a physician's imaging order under approved radiology protocols in Epic Radiant while meeting regulatory, accreditation, and professional standards.

III. DEFINITIONS

A. **Protocol-based modification:** Changing an order **only** as specified in a pre-approved radiology protocol/standing order (e.g., w/ vs w/o contrast, body part/side specificity, splitting combined studies, sequencing).

B. **Radiologist protocol:** A modality- and indication-specific set of instructions approved by the Radiology Department and Medical Director that maps common indications to the correct exam parameters.

IV. GENERAL INFORMATION

A. Context of When Imaging Technologist Can Modify Orders

1. Contrast selection per protocol.
2. Correcting exam specificity (laterality/body part) when the clinical indication is clear and the protocol defines the correct exam.

3. Splitting/combining studies when defined in protocol.
4. Adding/removing limited sequences or views per protocol.

B. **Out of Technologist scope without provider/radiologist contact**: new clinical indications, significant scope changes (e.g., CT chest instead of abdomen when not in protocol), or any scenario excluded by protocol.

V. PROCEDURE

A. Order Modification and Documentation in EPIC Radiant

1. Use the “Modify Order/Tech Mod” workflow to change the order only within protocol limits.
2. Required fields: Protocol name, reason for modification, and selecting technologist.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. ASRT Practice Standards for Medical Imaging and Radiation Therapy.

B. ACR Practice Parameter for Communication of Diagnostic Imaging Requests.

C. Joint Commission guidance regarding protocols/standing orders and documentation/ authentication.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
COO	Clement Miller: Chief Operating Officer	12/9/2025
DI Medical Director	Michael Basse: PHYSICIAN	11/26/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/10/2025
Policy Owner	John Kazel: Director Imaging Services	11/5/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18975596**

Origination	1/10/2020
Approved	N/A
Expires	3 years after approval
Owner	Armando Hernandez Jr: Manager Environmental Services
Area	Environmental Services

Isolette Cleaning

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To establish the frequency and procedure for cleaning isolettes.

III. DEFINITIONS

A. An isolette is an enclosed piece of equipment that is used to hold premature or "at risk" infants during their stay in the NICU.

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. Nursing staff will remove and dispose of the soiled linen before the isolette is cleaned by Environmental Services staff.

B. Nursing staff will notify Environmental Services when an isolette needs to be cleaned.

C. Equipment and Supplies Needed:

Supplies:	***Equipment:***
Germicidal Detergent	"Equipment Cleaned" Tags
Cleaning Cloths	

A. **Step-Based Cleaning and Disinfection Procedure – Giraffe Omni Bed**
(Per IFU Manual)

1. **Step 1: Preparation**
    a. Ensure the Omni Bed is not in use by a patient.
    b. Perform hand hygiene and don appropriate PPE (gloves, gown, mask, as needed).
    c. Gather all required cleaning and disinfectant products (approved hospital disinfectant, e.g., Virex), clean cloths, and disposable wipes.
    d. Prepare a designated work area with enough space for bed disassembly and separation of "dirty" and "clean" parts (GE Healthcare Poster).
2. **Step 2: Initial Bed Setup**
    a. Move the Omni Bed to the work area.
    b. Level the mattress and adjust the base height for comfortable cleaning.
    c. Turn the standby power ON, raise the canopy (if present), then turn the standby power OFF and unplug the bed from power.
    d. Remove all patient linens and disposable care items (Ohmeda User Manual).
3. **Step 3: Disassembly**
    a. Remove rubber porthole irises, porthole grommets, tubing management grommets, humidifier reservoir and lid, and any other removable accessories per IFU.
    b. Place all removable parts in the designated “dirty” area.
4. **Step 4: Cleaning Removable Parts**
    a. Submerge removable parts in the recommended disinfectant solution and observe the specified dwell time (see disinfectant label for exact duration).
    b. After soaking, rinse thoroughly with clean water if required by disinfectant instructions.
    c. Allow parts to air dry completely.
5. **Step 5: Cleaning Bed Surfaces**
    a. Change gloves after performing hand hygiene.
    b. Using a clean, damp cloth with approved disinfectant, thoroughly wipe down:
    c. Mattress surface
    d. Chassis base
    e. Canopy/hood (inside and out)
    f. Control panel (avoid excess liquid)
    g. Skin temperature probes and all exterior surfaces

h. Ensure surfaces remain wet for the required dwell time.

6. **Step 6: Reassembly**
    a. Perform hand hygiene and change gloves.
    b. Ensure all components are completely dry before reassembling the Omni Bed.
    c. Reinstall all accessories and reattach components per the manufacturer's instructions.
7. **Step 7: Final Steps**
    a. Place clean linens on the mattress.
    b. Cover Omni Bed as needed.
    c. Return all cleaning/disinfectant products to their designated storage area. If products are left behind by others, notify pharmacy staff.
    d. Ensure device is ready for safe patient use.

B. **Reminders**
1. Nursing staff will replace the air filter as needed.
2. Report damage or broken parts to the supervisor of the unit.
3. Cover the isolette with a plastic equipment cover then return it to the unit's designated area, taking care not to bump it against walls or doorways.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Ohmeda Giraffe Omni Bed Incubator, User Manuel
B. Cleaning and Disinfection Guidelines for ™ OmniBed™ Carestation™

Attachments

- ES Observation Based Competency - NICU Giraffe Omnibed Cleaning.docx
- Giraffe_Carestation_Cleaning_Poster_Pages.pdf
- Ohmeda Giraffe OmniBed Incubator - User manual.pdf

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	12/23/2025
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	12/16/2025
EVS Director	Christa Mc Dowell: Director Environmental Services	11/21/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/12/2025
Policy Owner	Armando Hernandez Jr: Manager Environmental Services	11/12/2025

oneSOURCE Documents

GE Giraffe Incubator Carestation CS1 Incubator User Manual Last Revised: *** Invalid template variable ***

GE Healthcare Giraffe Infant Incubator Operator's Manual Last Revised: *** Invalid template variable ***

GE Healthcare Giraffe OmniBed Infant Incubator/Warmer End of Service Support Letter Last Revised: *** Invalid template variable ***

Standards

No standards are associated with this document

Status Pending PolicyStat ID 19053425

Origination	4/1/2019	Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Approved	N/A		
Expires	3 years after approval	Area	Administration

Non Affiliated Employee Grievance

I. POLICY STATEMENT

A. The Hospital recognizes that early settlement of grievances is essential to sound employee-employer relations. Further, Salinas Valley Health Medical Center (SVHMC) seeks to establish a satisfactory method for the settlement of grievances for employees. In presenting a grievance, you are assured freedom from restraint, interference, discrimination or reprisal.

II. PURPOSE

A. The purpose of the Non-Affiliated Employee Grievance Procedure is to communicate the steps used in resolving a grievance for SVHMC employees not affiliated with a union.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

A. SCOPE OF GRIEVANCE PROCEDURE

1. A grievance may only be filed if it relates to:
    a. A management interpretation or application of SVHMC policies, which directly applies to non-affiliated employees and adversely affects the employee's wages, hours or working conditions.
    b. Full-time and part-time non-affiliated employees.

2. Specifically excluded from the grievance procedure are:
    a. Issues concerning a Board of Directors resolution, motion, action or an amendment thereto;
    b. Temporary employees;
    c. Introductory non-affiliated employees: initial 90 days
    d. Per Diem employees

B. GRIEVANCES CONCERNING DISCHARGE

1. In the case of a grievance concerning discharge, you must submit the grievance at Step 3 within seven (7) calendar days of the date of discharge.

C. GRIEVANCE PROCEDURE STEPS

1. The grievance procedure shall consist of the following steps, each of which must be completed prior to any request for further consideration of the matter. Grievances must be submitted within the established time limit at each step or the employee shall waive the right to them.
2. **Step 1: Informal Discussion**
    a. Supervisor
        i. If you believe you have a problem or grievance relating to your work situation, you may file a written request for a meeting with your immediate supervisor within five (5) calendar days of the occurrence, or discovery of the occurrence, which gives rise to the problem. The immediate supervisor shall meet with you and discuss the problem in an effort to clarify the issue and to cooperatively work toward settlement. The immediate supervisor shall have ten (10) calendar days from the date of request of the grievance to respond in writing.
3. **Step 2: Formal Grievance**
    a. Department Director/Designee
        i. If the problem is not settled through informal discussion, you may formally submit a grievance to their Director/Designee with a copy to the head of Human Resources and the President/Chief Executive Officer no later than thirty (30) calendar days from the occurrence or discovery of the occurrence, which gave rise to the problem. The ***Hospital Employee Grievance Form may be used.*** Such submission shall be in writing and shall contain the following information which:
            i. Identifies the employee.
            ii. Contains the specific nature of the grievance.
            iii. Indicates the date, time and place of the occurrence.
            iv. States the rule, law, regulation or policy alleged to have been violated, improperly interpreted, applied or

misapplied.

v. Indicates the consideration given or steps taken to secure resolution, including the date of informal discussion. (Step 1)

vi. States the corrective action desired and,

vii. Indicates the date of submission for any formal resolution.

b. After receipt of the written grievance, the department director/designee should schedule a meeting with you. The department director/designee will give you a written decision within ten (10) working days of receipt of the grievance.

4. **Step 3: President/Chief Executive Officer**

   a. If the grievance is not settled under Step 2, it may be appealed to the SVHMC President/Chief Executive Officer/Designee. The grievance shall be submitted within ten (10) calendar days of receipt of the written decision from Step 2. Such grievance appeal shall include all information as required in Step 2, as well as a copy of the written decision of the department head and any rebuttal. The President/Chief Executive Officer/Designee may consult with you, or schedule a hearing in which you will be given the opportunity to present evidence and witnesses. The President/Chief Executive Officer/Designee shall give you a written decision. You may also provide any rebuttal to the department head's decision.

5. **Step 4: Personnel Committee – Hearing Officer**

   a. If the grievance is not settled under Step 3, it may be appealed to the Personnel, Pension and Investment Committee, except as provided below. The grievance shall be submitted within seven (7) calendar days of receipt of the written decision from Step 3 to the President/Chief Executive Officer/Designee. Such grievance appeal shall include all information as required at Step 3, as well as a copy of the President/Chief Executive Officer's decision and any rebuttal. A grievance hearing will be conducted as soon as practical following the submission of the grievance to Step 4. The Personnel, Pension, and Investment Committee, at its discretion, may conduct the grievance hearing or may appoint an impartial Hearing Officer to conduct the grievance hearing.

   b. The Hearing Officer shall make an advisory recommendation for resolution of the grievance to the Personnel, Pension and Investment Committee. Regardless of which hearing process is used, the Personnel, Pension and Investment Committee will make a decision for the resolution of the grievance which shall be final and binding on all parties.

6. Grievances Concerning Warning Notices and Employee Evaluations

   a. Grievances pertaining to employee written warning notices that do not involve suspension or discharge, will not be processed beyond Step 3.

b. Grievances pertaining to employee evaluations with an overall rating of Low Performer will not be processed beyond Step 3.

c. Grievances pertaining to employee evaluations with an overall rating of Solid Performer will not be accepted.

D. TIMELY RESPONSE ON GRIEVANCES

1. If you do not present your grievance or do not appeal the decision rendered regarding your grievance within the time limits, the grievance shall be considered resolved and not eligible for further appeal.
2. If your supervisor or department director does not respond within the time limit provided, you may proceed, within the prescribed time limits, to the next step of the grievance procedure.

E. GRIEVANCE PROCEDURAL EXCEPTIONS

1. Grievances may, by mutual agreement, be referred back for further consideration or discussion to a prior step or advanced to a higher step of the grievance procedure. Mutual agreement shall mean that the President/CEO/designee and the employee have reached a written agreement.
2. Time limits specified in the processing of grievances may be waived by mutual agreement. Mutual agreement shall mean that the President/CEO/designee and the aggrieved have reached a written agreement.

F. DOCUMENTATION:

1. Reference Non Affiliated Employee Grievance Form

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Attachments

Non Affiliated Employee Grievance Form

Approval Signatures

Step Description	Approver	Date

Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	1/5/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/25/2025
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	11/25/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18121394

Origination	7/2/2021
Approved	N/A
Expires	1 year after approval
Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Area	Scopes Of Service

Scope of Service: Human Resources

I. SCOPE OF SERVICE

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

The purpose of Human Resources is to support SVHMC business strategies and mission, to provide quality healthcare to our patients and to improve the health and well-being of our community.

II. GOALS

The Human Resources department develops programs and initiatives to support the organization's business and talent strategies. These programs and initiatives are designed in collaboration with stakeholders and HR customers to ensure business alignment.

III. DEPARTMENT OBJECTIVES

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

B. Define an HR strategy to support SVHMC strategy and business objectives.

C. Support the Recruitment, onboarding, orientation, development and retention of staff to support business objectives.

D. Design processes for performance management and development.

E. Define a total rewards program, including compensation, benefits, retirement, and recognition.

F. Provide support in the areas of leave of absence, employee relations, general HR inquiries, mobility, and HR record retention.

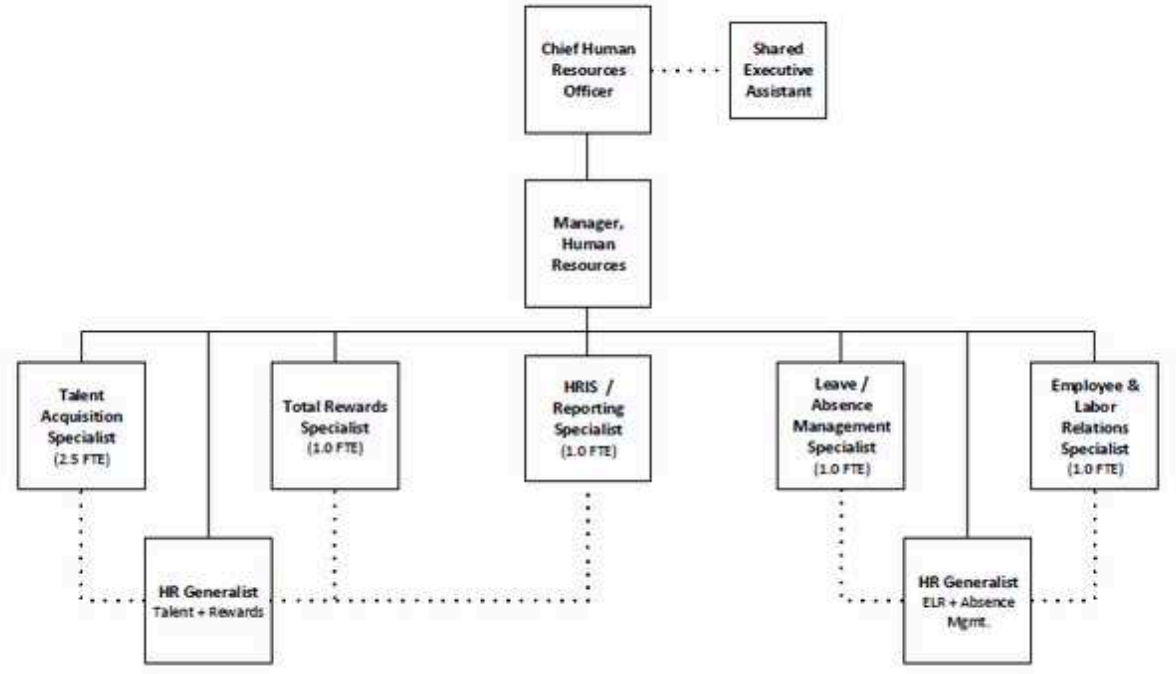
G. Manage HR policies, HR community on STARnet and HR compliance and regulatory

requirements.

IV. POPULATION SERVED

A. The Department provides human resources services to all departments in the organization.

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation:
Monday-–Friday 8:00am - 4:00pm.

B. Location of department:
611 Abbott Street, Salinas CA 93901

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

A. The primary services provided include but are not limited to the following:

1. Talent Acquisition – Sourcing, Recruitment, Transfers and Contingent Staffing.
2. Total Rewards – Compensation, Benefits, Retirement and Recognition.
3. Employee Relations – Employee and Labor Relations, Communications, Policy Management, Discipline, Grievance Procedures, Bargaining and Exit Management.
4. Leave and Absence Management – Leave Administration, Absence Management and Interactive Process.

5. HR Operations – General HR Services including: HR files, general inquiries and licensure tracking.
6. HR Reporting, Information Management and Compliance – Record Management, Reporting, Dashboards and HR regulatory requirements.
7. Talent Management – Learning, Leadership Development, Organization Development, Workforce Planning and Succession Planning.

VII. REQUIREMENTS FOR STAFF

All staff are required to complete competency based orientation and annual competencies.

A. Competency

Once a year staff are required to complete the online education modules that have been defined by the organization.

Trainings are conducted routinely. The trainings are part of the department's on-going efforts to educate staff and further enhance performance and improve staff competencies. Department staff 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.

B. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

1. Annually as part of developmental planning
2. As part of the annual performance management process.
3. New services/programs/technology implemented
4. Change in regulations and licensing requirements
5. Feedback and requests for future topics are regularly solicited from staff.

VIII. STAFFING PLAN

The department is staffed with a sufficient number of professional and clerical staff to support the facilities human resources needs.

IX. CONTRACTED SERVICES

The department is staffed with a sufficient number of contract staff (when applicable) to support the facilities human resources needs. Requirements above apply.

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

X. PERFORMANCE IMPROVEMENT AND

PATIENT SAFETY

Human Resources 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, Human Resources Department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	1/5/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/11/2025
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	11/25/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 16948846

Origination	6/26/2020	Owner	Agnes Lalata: Director Medical/ Surgical Services
Approved	N/A	Area	Scopes Of Service
Expires	1 year after approval		

Scope of Service: Medical Surgical Nursing Services

I. SCOPE OF SERVICE

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

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

A. The goal of the *Medical/Surgical Units are* to provide monitoring and care of a variety of acutely ill medical/surgical patients, including oncology specialties and comprehensive service to post op patients with an emphasis on orthopedic and spinal surgery patients

III. DEPARTMENT OBJECTIVES

1. To support SVHMC objectives.
2. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.
3. To plan for the allocation of human/material resources.
4. To support the provision of high quality service with a focus on a collaborative, multi-

disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

5. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
6. To evaluate staff performance on an ongoing basis.
7. To provide appropriate staff orientation and development.
8. To monitor the Medical Surgical Unit function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Medical Surgical Services provides care for adult and geriatric patients.

V. ORGANIZATION OF THE DEPARTMENT

(Nursing Organizational Chart for Nursing)

1. Hours of Operation:

   Medical Surgical Services division provides care seven days a week, twenty-four hours a day.

2. Location of departments:

   Medical Surgical type patients are primary cared on the 3rd and fourth floors of the hospital with a primary focus of Oncology patients cared on 3Tower and Surgical post op. patients on the 4th floor main. General Acute Medical Surgical patients are primarily on the 3rd floor.

3. Major Services / Modalities of care may include:

   The Med Surg Unit provides care to patients with medical primary diagnoses including, but not limited to: Acute/Chronic Renal Failure, Diabetic, CVA and post-surgical patients.

   Modalities may include:

   a. Wound care
   b. Peripheral and central line management
   c. Management of patients w/ CVA.

4.

   The Ortho Neuro Spine Center specializes in care of patients with primary diagnoses including, but not limited to: Orthopedic surgery including total joint replacements of hip and knee, Neuro/Spinal surgery including laminectomies, fusions of the spine, craniotomies and fractures.

   Modalities may include:

   a. Continuous oxygen monitoring

b. Traction
c. Cooling therapy
d. Specialized pain management

5. The Comprehensive Cancer Center provides care to patients with cancer related diagnoses including, but not limited to: leukemia, lymphoma, tumors, aplastic anemia, medical disease, surgical management, palliative and terminal care measures for patients transitioning into a Hospice setting.

   Modalities may include:

   a. Chemotherapy
   b. Transfusions
   c. Pain management
   d. Palliative and end-of-life care
   e. Medical/Surgical Oncology Interventions
   f. Bone Marrow Aspirations
   g. Transfusions
   h. Management Of Neutropenic Patients

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

1. The inpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients. A registered nurse (RN) performs an admission assessment on patients within two (2) hour of admission. The RN selects and initiates the nursing care plans within the shift of admission and updates as indicated. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate.
2. The Director and Clinical Manager(s) assume twenty-four (24) hour responsibility for nursing care provided on the Unit.
3. The Director of the Unit is directly responsible to the Chief Nursing Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by the Manager or Nursing Leader on call or their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF (applicable to department)

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

national, state and local regulatory bodies. Standards of practices are consistent with BLS and other nationally recognized standards of care.

1. Licensure / Certifications:

   The basic requirements for ***Registered Nurses*** include:
2. Current state licensure
3. Current BLS
4. Completion of competency-based orientation
5. Completion of annual competency
6. Medical Surgical Nursing Certification preferred
7. The basic requirements for ***Registered Nurses in the Ortho Neuro Spine Unit*** include:
    a. Current state licensure
    b. Current BLS
    c. Completion of competency-based orientation
    d. Completion of orthopedic patient care competency
    e. Completion of annual competency
    f. Orthopedic Nursing certification preferred.
8. The basic requirements for ***Registered Nurses in the Comprehensive Cancer Center*** include:
    a. Current state licensure
    b. Current BLS
    c. Chemotherapy/Biotherapy certification required
    d. Completion of competency-based orientation
    e. Completion of annual competencies
    f. Oncology certified nurse preferred
9. The basic requirements for ***Certified Nursing Assistants*** include:
    a. Current state licensure
    b. Current BLS
    c. Completion of competency-based orientation
    d. Completion of annual competency
10. The basic requirements for ***Unit Assistants*** include:
    a. Completion of competency-based orientation
    b. Completion of annual competencies
    c. Completion of computer desk training
11. 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.

12. 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

13. 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

14. Feedback and requests for future topics are regularly solicited from staff via e-mail, surveys, in-service evaluation forms, and in person.
15. Continuing Education - Continuing education is required to maintain licensure / certifications. Additional in-services and continuing education programs are provided to staff in cooperation with the Department of Education.

VIII. STAFFING PLAN

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

General Staffing Plan: Assignments are made by the lead nurse based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. The RN to patient ratio is one RN to no greater than five (5) patients. The RN to patient ratio receiving Chemotherapy Infusion is one RN to four patients.

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

In the event of a severe emergency, the unit follows surge-plan guidelines to adequately meet the needs of the patients on the unit. The department maintains compliance with California staff regulations and federal regulations for Emergency Events.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

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

system.

Dialysis services are managed through the Electronic Tracking system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	1/6/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	1/2/2026
Policy Owner	Agnes Lalata: Director Medical/Surgical Services	10/21/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 17892262

Origination	1/11/2019	Owner	Sherri Arias: Procedural Nurse Manager
Approved	N/A	Area	Patient Care
Expires	3 years after approval		

Supervision of Stress Testing by Non-Physician Staff

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. Training guide for Non Physician supervised stress test.

III. DEFINITIONS

A. Direct Supervision- Physician or LIP is in the room with the patient

B. General Supervision- Physician or LIP is in the vicinity and immediately reachable by phone or page

C. Non-pysician staff- Registered Nurse

IV. GENERAL INFORMATION

A. The Non-physician staff will demonstrate competency in exercise testing prior to supervising stress tests including but not limited to knowledge of indications for stress testing, adverse reactions to exercise and or pharmaceuticals used during stress testing and knowledge of end-points based on patient symptoms and electrocardiogram changes.

B. The non-physician staff will maintain competency by performing a minimum of 50 stress tests a year and maintaining all required certifications and licenses.

C. The assigned physician is responsible for the final stress test report.

V. PROCEDURE

A. Before supervising stress tests, the Non-Physician staff will have the following qualifications: Advanced Cardiac Life Support (ACLS), Basic Life Support (BLS), and specific training and

skills in cardiovascular disease assessment, rhythm management (basic 12 lead EKG) and/or exercise physiology (CCEP- Certified Clinical Exercise Physiologist and or CCES Certified Clinical Exercise Specialist). The Non-Physician staff will also have completed 200 physician or physician assistant co-supervised stress tests prior to supervising stress tests independently.

B. Prior to a stress test being supervised by a non-physician staff the patient must be screened for risk assessment. Screening should include cardiovascular history, general medical conditions and circumstances and signs or symptoms that warrant direct physician supervision.

    1. The following conditions require direct physician supervision and are considered high risk: moderate to severe Aortic stenosis, moderate to severe Mitral stenosis, Hypertrophic Obstructive Cardiomyopathy, history of malignant or exertional arrhythmias, history of exertional syncope or pre-syncope, intra cardiac shunts, genetic channel opathies, patient presenting within seven (7) days of myocardial infarction or other acute coronary syndrome, severe left ventricular dysfunction, severe pulmonary arterial hypertension, and potential instability resulting from non-cardiovascular comorbidities (e.g., frailty, dehydration, orthopedic limitations, chronic obstructive lung disease)
    2. The non-physician staff will be familiar with the conditions requiring direct physician supervision and be able to distinguish when direct physician supervision is required.
    3. All other tests supervised by the non-physician staff will have general supervision by the physician.
    4. All patients in the high risk category will have stress testing performed at the hospital under direct physician supervision

C. Consent for procedure is obtained per hospital policy CONSENT TO SURGERY OR SPECIAL THERAPEUTIC OR DIAGNOSTIC PROCEDURE(S). The non-physician staff is responsible for monitoring the patient's condition and electrocardiogram during the stress test.

    1. Any adverse events will be reported to the assigned physician
    2. In the outpatient setting, established emergency response policies will be followed (i.e. calling 911) if an emergency should arise

D. Documentation: The Non-Physician staff will document any pertinent information on the CASE stress system for review by the assigned physician.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. Meyers, J., Forman, D., Balady, G., (2014) Supervision of Exercise Testing by Nonphysicians. A Scientific Statement From the American Heart Association. Circulation.2014;(130): 1014-1027

B. Rodgers, G., Ayanian, J., Balady, G., (2000) American College of Cardiology/American Heart Association Clinical Competence Statement on Stress Testing. Circulation. 2000; (102):

1726-1738

C. REGADENOSON MYOCARDIAL PERFUSION STRESS TEST (LEXISCAN)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	12/9/2025
Cardiology Medical Director	Katherine DeSalvo: Director Medical Staff Services	12/4/2025
DI Director	John Kazel: Director Imaging Services	11/5/2025
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/16/2025
Policy Owner	Sherri Arias: Procedural Nurse Manager	8/21/2025

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 (i) Findings Supporting Recruitment of Ingrid Hsiung, MD, (ii) Contract Terms for Dr. Hsiung's Recruitment Agreement, and (iii) Contract Terms for Dr. Hsiung's Cardiac Electrophysiology & Cardiology Professional Services Agreement**

Executive Sponsor: Tim Albert, MD, Chief Clinical Officer
Molly Heacox, Director of Clinic Services

Date: January 12, 2026

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of a physician specializing in **cardiology and cardiac electrophysiology** as a recruiting priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of cardiology was recommended as a priority for recruitment. Additionally, the sudden and unexpected passing of an SVH Clinics cardiac electrophysiologist emphasizes the need for additional cardiology and cardiac electrophysiology coverage.

The recommended physician, **Ingrid Hsiung, MD**, received her Doctor of Medicine degree in 2011 from University of Missouri at Kansas City, School of Medicine. Dr. Hsiung completed her Internal Medicine Residency from Cleveland Clinic Foundation in Cleveland, OH, followed by her Cardiology Fellowship at Baylor Scott & White Heart Hospital in Plano, Texas. She will complete her Cardiac Electrophysiology Fellowship at University of Southern California in June 2026. Dr. Hsiung is eager to set down roots in the community with her family and plans to join SVH in August 2026.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). Physician will be a contracted as a physician under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics – Cardiology. Pursuant to California law, physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term. Physician's PSA will be for a term of three (3) years, and annual compensation will be reported on an IRS W-2 Form as a contracted physician.
   - Full-Time Schedule. Physician will be scheduled to provide physician services to clinic patients on a full-time basis, 48 weeks per year; one week of which can be allocated to continuing medical education (CME).
   - Base Compensation: Physician's base compensation will be in the amount of $750,000 per year.
   - Productivity Compensation: To the extent it exceeds the base salary, physician is eligible for Work Relative Value Units (wRVU) productivity compensation at a $68.00 wRVU conversion factor.
   - Schedule. Physician shall provide Physician Services to Clinic patients on a full-time basis, 36 scheduled patient care hours per week, forty-eight weeks per year in a Clinic setting, one workweek of which can be allocated to continuing medical education (CME).
   - Call Coverage. Physician shall provide hospital emergency department and unassigned patient call coverage for the General Cardiology call panel. Productivity compensation includes up to 5 days of hospital call coverage per month. Payment for call days in excess of 5 days per month, will be compensated at the presently established rate for the General Cardiology call panel.

- Annual Incentive Plan. Physician will be eligible to participate in an Annual Performance Incentive Bonus Plan with 1000 hours worked during the annual measurement period.
  - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
    - Access to SVH Health Plan for you and your qualified dependents. Premiums are projected based on 15% of SVH cost.
    - Access to SVH 403(b) and 457 retirement plans. Five percent (5%) base contribution to 403b plan that vests after three years. This contribution is capped at the limits set by Federal law.
    - Four work weeks (20 days) of time off per year, accruing equally throughout the year.
    - CME annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income. One work week (5 days) off annually for CME related activities.
  - Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.

2. **Recruitment Agreement** that provides a recruitment incentive of $90,000, which is structured as forgivable loan over three years of service.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

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

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Hsiung to Salinas Valley Health Clinics has been identified as a need for recruitment while also providing additional resources and coverage for cardiology service line.

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

Recommendation

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

1. **The Findings Supporting Recruitment of Ingrid Hsiung, MD:**
   - That the recruitment of cardiac electrophysiology 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. Hsiung; and**
3. **The Contract Terms of the Cardiac Electrophysiology Professional Services Agreement for Dr. Hsiung.**

Attachments

Curriculum Vitae for Ingrid Hsiung, MD

INGRID HSIUNG, MD

Career Objectives
I'm looking for a full-time position in private or hybrid practice as an electrophysiologist (EP) proceduralist.

Based on my EP fellowship experience thus far, my skill set would include the usual ablations (atrial fibrillation, flutter, SVT), left atrial appendage occlusion, devices (traditional pacemakers, left bundle, CRT-P/D, ICD, dual chamber leadless), and laser/mechanical lead extractions (provided there is a way to arrange for CT surgical backup and help with scheduling). I would also be willing to do VT ablation (substrate modification) if there is a need. I speak fluent Mandarin Chinese (native speaker) with patients about their procedures, and would be happy to do so in practice.

Education
University of Southern California, Los Angeles, CA – Electrophysiology fellowship 2024 – 2026
- Program Director - Ivan Ho, MD

Baylor Scott & White Heart Hospital, Plano, TX – Cardiology fellowship, 2021 – 2024
- Program Director - Molly Szerlip, MD

Cleveland Clinic Foundation – Internal medicine residency, Cleveland, OH 2018 – 2021
Rush University Medical Center – Pathology residency, Chicago, IL 2017 – 2018
University of Missouri at Kansas City (UMKC), School of Medicine, Kansas City, MO 2011 – 2017
- Bachelor's of Arts (BA) and Medical Degree (MD)

Illinois Mathematics and Science Academy (IMSA), Aurora, IL 2008 – 2011
Waubonsie Valley High School, Aurora, IL (class rank: 2 out of 940) 2007 – 2008
Naperville Chinese School, Naperville, IL 1999 – 2008
- Valedictorian for all 9 years, graduated one year early.
- Learn how to speak, read, write, and understand traditional Mandarin Chinese.

Membership in Professional Societies
Heart Rhythm Society (HRS)
- Accepted to HRS GLOWE (Growth and Leadership Opportunity for Women in Electrophysiology) Class of 2026
- Abstract reviewer for HRS 2024 meeting
- Volunteer for HRS 2023 meeting

American College of Cardiology (ACC)
Gold Humanism Honor Society (GHHS)
- Co-chair for Soap for Hope campaign (2016)
- Grant recipient for Pilot study in Psychosocial Support Group for Sudden Cardiac Death survivors (2022-2023)

American Medical Association (AMA) 2011 – Present
- Secretary for UMKC Chapter, 2014-2015
- Delegate representing UMKC in AMA's Medical Student Section (MSS) at the AMA 2015 Annual meeting, Chicago, IL, June 4-6, 2015
- Member of the national Committee on Scientific Issues, 2015 - 2016

Ohio State Medical Association
- Delegate representing Resident and Fellow Section for planned annual meeting in Columbus, OH, March 20-22, 2020.

Missouri State Medical Association (MSMA)
- Secretary of the MSMA's Medical Student Section (MSS), serving on MSS Governing Council, 2015-2016

Alpha Phi Omega, Alpha Eta Chapter National Service Fraternity
- Fundraising Chair for Pledge Class, Fall 2011
- Fundraising Chair for Alpha Eta Chapter, Fall 2012

Christian Medical & Dental Association

Teaching activities

Cleveland Clinic Lerner College of Medicine of Case Western Reserve University

- Faculty appointment: Clinical Instructor of Medicine 2019-2021
- Cleveland Clinic Longitudinal Clerkship Longitudinal Didactics on Health Systems Science 2018
    - Provided feedback and direction on monthly blog didactic sessions to 9 students throughout the year
- Grading for Concept Appraisals (CAPPs)/Problem Solving Essays, Years 1 & 2 2020

Rush University Medical Center, Pathology course 2017-2018

- Served as instructor for 1h sessions, teaching pathoophysiology and reviewing microscope slides with 20-30 second year medical students in the core Pathology course 2-3 times during the year

University of Missouri – Kansas City, School of Medicine 2015-2017

- During my M3-M4 years of medical school, served as formal senior mentor to a single M1-M2 student, both on 4 months of daily inpatient general medicine rotation and 2 years of weekly outpatient medicine longitudinal clinic
- Responsible for teaching junior medical student physical exam, differential diagnosis, patient bedside manner, good studying habits

University of Missouri – Kansas City, Writing Studio 2012-2016

- Led and developed workshops on various writing topics, including short essays, writing CV, and personal statements

Aurora Leadership Institute, Illinois Math and Science Academy, Aurora, IL 2010-2011

- Served as instructor for a group of 8 middle school students during a 10 week course on leadership qualities, team dynamics, and creating/implementing a community improvement project
- Designed didactics modules and activities specifically regarding team dynamics

Bibliography of publications

EP Considerations in Ebstein's Anomaly. Hsiung, I., Fatunde, B., Srivasthan, K., Madhavan, M., & Majdalany, D. *J. Pers. Med.* 2024, *14*(11), 1113; **https://doi.org/10.3390/jpm14111113**

Situational Assessment of Stroke and Bleeding Risk [in Atrial Fibrillation]. Cardionerds Podcast. Khan, H., Fuentes, S., Hsiung, I., Arps, K., & Goyal, A.. (2023, June 05)
URL:
https://www.cardionerds.com/309-atrial-fibrillation-situational-assessment-of-stroke-and-bleeding-risk-with-dr-hafiza-khan/

Hsiung, I.. (2022, March 11). Arrhythmia Management in Pregnancy: A Brief Review. Texas American College of Cardiology: Electrophysiology Section Newsletter.

Hsiung, I.. (2023, July 05). Heart Rate Variability (Interview Q&A through American College of Cardiology). Publication Status: Published.
URL: https://www.everydayhealth.com/

Left Main Protection During Transcatheter Aortic Valve Replacement With a Balloon-Expandable Valve. Hsiung, Ingrid…Kapadia, Samir. JSCAI 2022. DOI
https://doi.org/10.1016/j.jscai.2022.100339

Congenitally Corrected-Transposition of the Great Arteries (ccTGA): Basic Imaging Findings and Management. Barry, Timothy, Hsiung, Ingrid…Majdalany, David. Journal of Radiology Nursing 2023. DOI
https://doi.org/10.1016/j.jradnu.2022.12.004

D-Transposition of the Great Arteries (d-TGA): Management, Complications, and Basic Imaging Findings. Hsiung, Ingrid… Majdalany, David. Journal of Radiology Nursing 2020. Volume 39, Issue 4, DOI https://doi.org/10.1016/j.jradnu.2020.07.003

Temporal Trends of Transcatheter Mitral Valve Edge to Edge Repair (MitraClip) Short Term Outcomes in United States: A Nationwide representative study

- Third author.
- Revising and to submit

Research letter (in response to) Age-Related Variations in Takotsubo Syndrome in the United States

- Submitted to Journal of the American College of Cardiology

"Resolution #405 – Decreasing screen time and increasing outdoor activity to offset myopia onset and progression in school children. *American Medical Association,* House of Delegates 2017 Annual Meeting. June 2017.

- Presented at AMA 2017 annual meeting, Chicago, IL, June 14, 2017.

"Music with a side of midazolam." *Kansas City Medicine.* Kansas City Medical Society. January 2016.

- Required reading for the course, Music and Medicine – which fulfills graduation requirements for medical humanities – taught by Dr. Stuart Munro at the UMKC School of Medicine, June 2016.

"Great expectations unmet by food labeling." *Kansas City Medicine.* Kansas City Medical Society. April 2016.

"Resolution #15 - Increasing consumer awareness of front of package labeling systems." *Missouri State Medical Association* 157th House of Delegates Resolution Actions. April 2015.

- First author.
- Presented at MSMA 2015 annual meeting, Kansas City, MO, April 18, 2015.

"Renal effect of triolein in a rat model of fat embolism syndrome." *Journal of FASEB* vol. 29 no. 1, Supplement 927.11, April 2015. Available at http://www.fasebj.org/content/29/1_Supplement/927.11

- First author.

"The shingles vaccine (Zostavax®), in a nutshell." *A Life Ahead.* January 2015. Available at http://www.alifeahead.com/2015/01/23/shingles-vaccine/

"Your health should come first." *Chicago Dental Society.* February 2010. Available at http://www.cds.org/News/Blog.aspx?id=2782&blogid=222

Peer Reviewed Journal Articles/Abstracts (Other than Published)

Carlson, E., Robinson, K., Hsiung I., Hale, S., Banwait, J., Khan, H., Hutcheson, K. . Evaluation of access to female cardiothoracic surgeons by geographical region. Journal of Thoracic and Cardiovascular Surgery.
Publication Status: Under Review.

Hsiung, I., Goldar, G., Ghobrial, J., & Rampersad, P.. Late presenting patent ductus arteriosus with Eisenmenger physiology: a case report". European Heart Journal: Case Reports.
Publication Status: Under Review.

Research Experience

Pilot study in support group for Sudden Cardiac Death (SCD) Survivors

- Obtained Baylor IRB approval and grant support (from Gold Humanism Honor Society) in starting a research project - Pilot Study in Improving Psychosocial Support for Survivors of Sudden Cardiac Death. Currently, there is a lack of local, on-the-ground psychosocial support for SCD survivors (particularly, those who have been appropriately shocked by their implantable cardiac defibrillator (ICD) in the North Texas/Dallas area. I worked with EP Dr Ali Yousif and EP Dr Kamala Tamirisa for this project. We developed session curriculum based on prior studies' of what ICD shock survivors would like to see in a support group session. We aimed to quantify how helpful the sessions were by administering the Quality of Life Scale, originally developed by Flanagan, JC in 1982 and validated by Burckhardt CS in 2003. We held 3 meetings during the time of the study (including content like developing a "shock plan" and strategies to cope with anxiety). Group participants included medical students, patients, and families.
- Presented at Texas ACC annual meeting in 2023

Degree of Device-Related Tricuspid Regurgitation with a Smaller Lumen Lead - undergoing statistical analysis at Baylor Scott & White

- Undergoing statistical analysis at Baylor Scott & White

Arrhythmogenic Mitral Annular Disjunction Improved After Mitral Valve Surgery [Poster presented]. Hsiung, I., Deville, B., Smith, R., & Wang, Z.. (2023, March 06). American College of Cardiology's 72nd Annual Scientific Meeting/New Orleans, LA .

Abnormal Nuclear Myocardial Perfusion Testing Attributed to Previous Gunshot Wound [Poster presented]. Hsiung, I., Nguyen M., & Sayfo, S.. (2023, March 04). American College of Cardiology's 72nd Annual Scientific Meeting/New Orleans, LA, .

Lead Extraction of Fractured and Migrated Venous Port [Poster presented]. Hsiung, I., Yousif, A., & Deville, B.. (2022, October 08). Texas Chapter of American College of Cardiology Annual Meeting/San Antonio, TX, .

"Improving Depression Monitoring and Intervention in the Primary Care Setting Through Increased Use of the PHQ-9"

- Scholarly Activity Day, Cleveland Clinic, Cleveland, OH, May 27, 2020. Poster.

"Gender Based Disparities For Congestive Heart Failure Readmission Following Trans Catheter Aortic Valve Replacement: A Single Center Study"

- American College of Cardiology's 69th Annual Scientific, Chicago, IL, March 28 - 30, 2020. Poster.

Case report – Patent ductus arteriosus complicated by Eisenmenger syndrome in a 22-year-old adult

- Adult congenital heart disease conference, Bethesda Marriott, Bethesda, MD, October 4-5, 2019. Poster.

"Outcomes for artegraft when autologous saphenous vein grafts are not an option" 2015-2016
Midwest Aortic & Vascular Institute, Kansas City, MO.

"How many patients do not make an appointment with the sleep clinic after referral by their PCP." 2014-2016
University of Missouri at Kansas City, School of Medicine, Kansas City, MO.

- Grand Rounds, UMKC School of Medicine, Kansas City, MO, November 18, 2014. Oral Presentation.
- UMKC Research Summit, Student Union, Kansas City, MO, April 13, 2016. Poster.
- 3rd Annual Vijay Babu Rayudu Quality and Patient Safety Day, UMKC School of Medicine, Kansas City, MO, May 13, 2016. Oral Presentation.
    - Travel award, $500 by the judging committee

"Renal effect of triolein in a rat model of fat embolism syndrome." 2014 - 2015
University of Missouri at Kansas City, School of Medicine, Kansas City, MO.

- Experimental Biology Annual Convention, Boston Convention Center, Boston, MA, March 31, 2015. Poster.
- UMKC Research Summit, Atterbury Student Success Center, Kansas City, MO, April 2, 2015. Poster.

"Synthesis and isomerization of macrocyclic azobenzene polymers." 2012 - 2013
University of Missouri at Kansas City, Dept. of Chemistry, Kansas City, MO.

- UMKC Undergraduate Research Symposium, Atterbury Student Success Center, Kansas City, MO, April 19, 2013. Poster.

"Interactions between the endosteal and vascular niche." 2011
City of Hope Cancer Center, Department of Stem cell & Leukemia, Duarte, CA.

- Eugene and Ruth Roberts Summer Student Academy, Cooper Auditorium at City of Hope, Duarte, CA, August 3, 2011. Poster.

"Role of Src family kinases in SDF-1/CXCR-4-mediated progenitor cell homing." 2010-2011
Northwestern University, Feinberg School of Medicine, Chicago, IL.

- IMSAloquium: Student Investigation Showcase, Aurora, IL, April 21, 2011. Poster.

"Molecular mechanisms of bone marrow stem-cell maintenance and mobilization." 2009-2010
Northwestern University, Feinberg School of Medicine, Chicago, IL.

- IMSAloquium: Student Investigation Showcase, Aurora, IL, April 28, 2010. Poster.

Writing Activities & Awards

Writing Consultant, UMKC Writing Studio 2012 – 2017

- Hiring Committee, Spring 2013
- Workshop Chair for "Unpacking the Prompt" at the Greater Kansas City Writing Center Project annual retreat, Kansas City, MO, August 24, 2013.
- Workshop chair for "Let's Talk Tutoring - an introduction to verbal and nonverbal communication" at the Greater Kansas City Writing Center Project retreat, Kansas City, MO, August 23, 2014.

Acronym, IMSA's student newspaper, Opinions & Special Features Writer 2009 – 2011

Chicago Dental Society Blogging Contest Winner 2010

- Wrote an article titled "Your health should come first" about the supposed detrimental effects of soda

Volunteer Experience

Music Therapy Volunteer, Piano

Belmont Village, Oak Park, IL 2018

Saint Luke's Hospice House, Kansas City, MO. 2015 - 2017

- Play classical piano music for hour-long sessions 2-3 times per month
- Pianist for the annual Celebration of Life service, Grace and Holy Trinity Cathedral, May 14, 2015.
- Scheduled to be the pianist for the annual Christmas Eve candlelight service, December 24, 2016.

Other Awards/Accomplishments

Teaching, community outreach and medical policy are two of my passions. I was awarded a grant from Gold Humanism Honor Society (2022-2023) to establish a support group for patients with ICD who undergo shocks. This support group was the first of its kind in the Dallas, TX area –I hope to start and sustain a SCD support group wherever I establish my practice.

In June 2017, the AMA's House of Delegates moved to accept a public health policy that I co-authored, titled "Decreasing Screen Time and Increasing Outdoor Activity to Offset Childhood Myopia." In 2015, I authored a policy titled "Increasing consumer awareness of front of package labeling systems", passed by the Missouri State Medical Association 157th House of Delegates.

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of (i) Findings Supporting Recruitment of Lauren Berry, MD, (ii) Contract Terms for Dr. Berry's Recruitment Agreement, and (iii) Contract Terms for Dr. Berry's Rheumatology Professional Services Agreement**

Executive Sponsor: Orlando Rodriguez, MD, Chief Medical Officer
Molly Heacox, Director of Clinic Services

Date: January 12, 2026

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of a physician specializing in **rheumatology** as a recruiting priority for SVH's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of rheumatology was recommended as a priority for recruitment. In addition, the current new patient appointment wait time for rheumatology is over two months.

The recommended physician, **Lauren Berry, MD**, received her Doctor of Medicine degree in 2019 from the Royal College of Surgeons in Dublin, Ireland. Dr. Berry completed her Internal Medicine residency at Cleveland Clinic Foundation in Ohio and her Rheumatology Fellowship at the Medical University of South Carolina in Charleston. Since the completion of her training, Dr. Berry has been practicing rheumatology for an orthopedic practice in Green Bay, Wisconsin. A native of San Luis Obispo County, Dr. Berry is eager to return to the Central Coast and join SVH Clinics in June 2026.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement**. Essential Terms and Conditions:
   - Professional Services Agreement (PSA). PSA. Physician will be a contracted as a physician under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics – Rheumatology. Pursuant to California law, physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
   - Term. Physician's PSA will be for a term of 2 years, and annual compensation will be reported on an IRS W-2 Form as a contracted physician.
   - Full-Time Schedule. Physician shall provide physician services to clinic patients on a full-time basis, 34 scheduled patient care hours plus 4 hours of administration time per week, 48 weeks per year in a clinic setting; one work week of which can be allocated to continuing medical education.
   - Base Compensation. Physician's base compensation will be in the amount of $325,000.00 per year
   - Productivity Compensation. To the extent it exceeds the base salary, physician is eligible for Work Relative Value Unit (wRVU) productivity compensation at a $57.00 wRVU conversion factor.
   - Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
     - Access to SVH Health Plan for you and your qualified dependents. Your premiums are projected based on 15% of SVH cost.
     - Access to SVH 403(b) and 457 retirement plans. Five percent (5%) base contribution to 403b plan that vests after three years. This contribution is capped at the limits set by Federal law.
     - Four work weeks (20 days) of time off per year, accruing equally throughout the year.
     - CME annual stipend in the amount of $2,400 paid directly to you and reported as 1099 income. You will receive one work week (5 days) off per year for CME activities.

- Professional Liability Insurance. Professional liability is provided through BETA Healthcare Group.

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

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

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

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Berry to Salinas Valley Health Clinics has been identified as a need for recruitment while also providing additional resources and coverage for rheumatology service line.

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

Recommendation

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

1. **The Findings Supporting Recruitment of Lauren Berry, MD:**
   - That the recruitment of rheumatology 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. Berry; and**
3. **The Contract Terms of the Rheumatology Professional Services Agreement for Dr. Berry.**

Attachments

Curriculum Vitae for Lauren Berry, MD

LAUREN BERRY, MD

EDUCATION/TRAINING

2022 – 2024	Medical University of South Carolina (Charleston, SC) Rheumatology Fellowship
2019 – 2022	Cleveland Clinic Foundation (Cleveland, OH) Internal Medicine Internship and Residency
2015 – 2019	Royal College of Surgeons in Ireland (Dublin, Ireland) Honours Degrees of Bachelor of Medicine, Surgery & Obstetrics (MB, BCh, BAO), LRCP&SI *Award:* Tom Lynch Medal (awarded to third year Psychiatry student with overall highest mark in the final examination)
2012 – 2014	University of Vermont (Burlington, VT) Post-baccalaureate Pre-medical Program
2011 – 2012	Cardiff University (Cardiff, United Kingdom) M.A. in International Relations and Global Communications Management
2006 – 2010	University of California, Berkeley (Berkeley, CA) B.A. in ISF: Contemporary International Relations *Award:* California Alumni Association Leadership Scholar (2006-2008), Fleischmann Award

BOARD CERTIFICATION AND LICENSING

American Board of Internal Medicine – 2022

Upcoming ABIM Rheumatology Boards in 10/2025

Currently licensed in WI

PROFESSIONAL EXPERIENCE

Rheumatologist
Orthopedic and Sports Medicine Specialists (OSMS) - Green Bay, WI
September 2024 - present

EDUCATIONAL & RESEARCH ACTIVITIES

September 2023	MUSC Rheumatology Division Rounds, Presenter *Ophthalmologic Manifestations of Rheumatic Disease*
September 2023	Immunology Rounds, Presenter *T cell Mediated Immunity: Activation and Effector Mechanisms*
June 2023	Immunology Rounds, Presenter *Pathogenesis of SLE*
April 2023	South Carolina Rheumatism Society Annual Meeting Case presentation – *Fever of Unknown Origin*
March 2023	MUSC Rheumatology Division Rounds, Presenter *A Review of Lyme Disease and Lyme Arthritis*
January 2023	MUSC Rheumatology Division Rounds, Presenter *Adult Onset Still's Disease Review and Case Discussion*
2020 – 2022	Hospital Medicine Track, Cleveland Clinic This track provides hospital-focused clinical and educational activities for residents interested in hospital during the PGY-2 and 3 years. Program themes include: Quality and Patient Safety Elective, Perioperative Medicine, Transitions of Care, Business of Hospital Medicine, and Teaching and Leadership. Program also includes completion of preceptorship rotation at community hospital.
September 2020	Morbidity & Mortality Conference Presentation Performed a root cause analysis on unsafe MICU to regular nursing floor transfer and presented the findings at M&M conference.
August 2020 – April 2021	Quality Improvement project *Reducing inappropriate PPI prescriptions in resident PCP clinics.*
August 2020	Quality and Patient Safety Education Program Completed courses in Quality Improvement, Safety Event Reporting System, Error and Root Cause Analysis Process. QPS project also completed.
March-April 2020	Cleveland Clinic "Just-In-Time" Modules Project developed for educational review modules for non-ICU and non-medicine staff redeployment during the initial Covid-19 outbreak. Co-wrote modules on management of gout, management of septic arthritis, management of endocrine emergencies, and inpatient management of thyroid disorders.
March 2020	Intern Case Conference *Right-sided endocarditis in patient with IV drug use*

August 2019 – April 2020 Quality Improvement project
Improving problem list accuracy among residents' PCP clinic panels

PUBLICATIONS

Ouyang, Ben, Lucy Dx Li, Joanne Mount, Alainna J. Jamal, Lauren Berry, Carmine Simone, Marcus Law, and Rw Melissa Tai. (2017), Incidence and Characteristics of Needlestick Injuries Among Medical Trainees at a Community Teaching Hospital: A Cross-Sectional Study. *Journal of Occupational Health* 59,1: 63-73.

PROFESSIONAL MEMBERSHIPS

American College of Rheumatology
American Medical Association
American College of Physicians

Memorandum

To: Personnel, Pension and Investment Committee
From: Michelle Childs, Chief Human Resources Officer
Date: January 7, 2026
Re: Recommendation for Board Approval – Approval of Second Amendment to the Salinas Valley Memorial Healthcare District Employees Pension Plan (Plan)

Under the Plan, "New Participants" who elect to receive payout of their pension contributions may, under certain circumstances, choose to restore their pension benefit by repaying those funds. However, the Plan does not clearly explain the repayment parameters and requirements.

This amendment establishes how a rehired New Participant may restore their previously earned pension benefit, if all of the following conditions are met:

- The employee is rehired within five years of separating employment.
- The employee repays the full amount of the contributions they previously withdrew.
- The repayment must be made in one lump sum, including interest.
- The interest rate is based on 120% of the federal mid-term rate, compounded annually.
- The full repayment must be completed within five years of rehire or by December 31, 2030—whichever is later.

Once repayment is made in full under these terms, the employee's prior pension benefit is reinstated. No other pension plan provisions are changed.

This change applies to all New Participants covered by the PEPRA provisions, including those who left employment before January 1, 2026.

All other provisions of the pension plan remain unchanged.

RECOMMENDATION

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

SECOND AMENDMENT
TO THE
SALINAS VALLEY MEMORIAL HEALTHCARE DISTRICT
EMPLOYEES PENSION PLAN

(2016 Restatement)

This Second Amendment (Amendment) to the Salinas Valley Memorial Healthcare District Employees Pension Plan (Plan) is adopted by Salinas Valley Memorial Healthcare System (Employer) to be effective on the date specified below.

RECITALS

WHEREAS:

A. The Employer originally established the Plan for all eligible Employees and their beneficiaries, effective as of November 1, 1966.

B. Since it established the Plan, the Employer has amended and restated the Plan on several occasions and most recently as of January 1, 2016.

C. Effective as of April 1, 2020, the Employer amended the Plan to (i) provide an option to terminated New Participants with at least five (5) Years Of Service, but less than ten (10) Years Of Service to receive their accumulated required contributions distributed from the Plan in lieu of having death benefits paid to their beneficiaries, (ii) change the timing of the distributions, and (iii) add provisions regarding the benefits of Employees who change status from ineligible to eligible.

D. The Employer now wishes to amend the Plan to provide the repayment requirements of previously distributed, accumulated contributions upon the rehire of a New Participant in order to have benefits reinstated.

OPERATIVE PROVISIONS

Effective as of January 1, 2026, the Plan is hereby amended as follows:

1. The last sentence of subsection J of section 13.11, "New Participant PEPRA Contributions," is amended to read as follows:

> *If a New Participant received a distribution of the New Participant's accumulated required contributions and is rehired no more than five (5) years after Severance From Employment, the New Participant may repay the full amount of the distribution in accordance with the provisions of subsection P, below, and have the New Participant's benefit reinstated.*

2. The last sentence of subsection O of section 13.11, "New Participant PEPRA Contributions," is amended to read as follows:

> *If a New Participant received a distribution of the New Participant's accumulated required contributions and is rehired no more than five (5) years after Severance From Employment, the New Participant may repay the full amount of the distribution, in accordance with the provisions of subsection P, below, and have the New Participant's benefit reinstated.*

3. Section 13.11, "New Participant PEPRA Contributions, is amended by adding the following subsection P at the end to read as follows:

> *P. A New Participant shall be permitted to reinstate the New Participant's Accrued Benefit under the Plan that the New Participant forfeited by virtue of the withdrawal of the New Participant's accumulated required contributions provided that: (i) the New Participant repaid (or repays) in a single sum all amounts previously withdrawn plus interest of one hundred twenty percent (120%) of the Federal mid-term rate compounded annually from the date of the return of contributions through the date of repayment; and (ii) the amount due was (or is) paid in full by the later of (a) five (5) years of the New Participant's resumption of employment, or (b) December 31, 2030.*

4. This Amendment is effective as of January 1 2026, but shall apply to all New Participants as defined in the PEPRA Article, including a New Participant who had a Severance From Employment before January 1, 2026.

In all other respects, the Plan is hereby ratified, approved and confirmed.
In witness whereof, the Employer has executed and adopted this Amendment on the _____ day of January, 2026.

SALINAS VALLEY MEMORIAL
HEALTHCARE SYSTEM

By:_____

Title:_____

FINANCE COMMITTEE

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

(VICTOR REY, JR.)

Financial Performance Review

November 2025

Finance Committee

Iftikhar Hussain

Chief Financial Officer

Consolidated Financial Results
November 2025

Month				$ in Millions	YTD			
		Variance fav (unfav)					Variance fav (unfav)	
Actual	Budget	$	%		Actual	Budget	$	%
$ 68.9	$ 67.3	$ 1.6	2.4%	Operating Revenue	$ 362.5	$ 346.1	$ 16.4	4.7%
68.0	65.9	(2.1)	-3.2%	Operating Expense	349.4	338.1	(11.3)	-3.3%
0.9	**1.4**	**(0.5)**	**-35.7%**	**Income from Operations**	**13.1**	**8.0**	**5.1**	**63.8%**
1.4%	*2.0%*	*-0.6%*	*-30.00%*	*Operating Margin %*	*3.6%*	*2.3%*	*1.3%*	*56.5%*
				Op. margin % full year target		*3.0%*		
2.9	2.5	0.4	16.0%	Non Operating Income	12.9	12.4	0.5	4.0%
3.8	**3.9**	**(0.1)**	**-2.6%**	**Net Income**	**26.0**	**20.4**	**5.6**	**27.5%**
5.5%	*5.7%*	*-0.2%*	*-3.5%*	*Net Income Margin %*	*7.2%*	*5.9%*	*1.3%*	*22.0%*

Results for the year include $7.8 million in supplemental payments

Key Financial Indicators

Indicator Metric		YTD 11/30/2025	Budget	S&P A+ Rated	YTD Prior Year
Operating Margin*		3.6%	0.4%	4.0%	3.3%
Total Margin*		7.2%	4.0%	6.6%	8.7%
EBITDA Margin**		7.8%	5.4%	13.6%	7.7%
Days of Cash*		362	317	249	366
Days of Accounts Payable*		45	45	-	46
Days of Net Accounts Receivable***		70	60	49	62
Supply Expense as % NPR		14.8%	14.6%	-	14.6%
Labor Expense as % NPR		53.5%	54.1%	53.7%	52.7%
Operating Expense per APD*		7,560	7,205	-	6,702

All metrics above are consolidated for SVH except Operating Expense per APD

Volume Summary – November 2025

Actual	Prior Year	Nov Bud	Bud Var	Key Statistics	YTD	YTD-PY	YTD Nov Bud	YTD Bud Var
				Inpatient				
117	116	114	3%	ADC	106	112	114	-7%
1,032	994	901	15%	Admissions	4,732	4,813	4,597	3%
124	121	126	-2%	Deliveries	553	572	644	-14%
1.9	2.3	2.3	-17%	Medicare Traditional ALOS CMI Adjusted	2.0	2.3	2.3	-13%
1.59	1.71	1.75	-9%	Medicare Traditional Case Mix	1.71	1.76	1.75	-2%
				Emergency Room				
4,159	4,461	4,503	-8%	ER OP Visits	22,351	22,657	22,967	-3%
790	767	695	14%	ER IP Admissions	3,660	3,703	3,546	3%
				Procedures				
159	142	141	13%	IP Surgeries	793	757	721	10%
248	292	283	-12%	OP Surgeries	1,575	1,479	1,445	9%
282	303	323	-13%	Cath Lab	1,583	1,562	1,646	-4%
1,331	1,072	1,121	19%	OP Infusion Cases	6,491	5,742	5,716	14%
333	286	392	-15%	MRI Procedures	1,542	1,399	1,997	-23%
1,918	1,949	2,098	-9%	CT Scans	10,564	10,062	10,700	-1%
				Observation Cases				
162	135	148	9%	Obs Cases	991	720	753	32%

Executive Summary: November Financial Performance

Salinas Valley Health's Income from Operations was $0.9 million for the month which was unfavorable to budget by $0.5M due to lower outpatient volumes

Volume and Acuity:

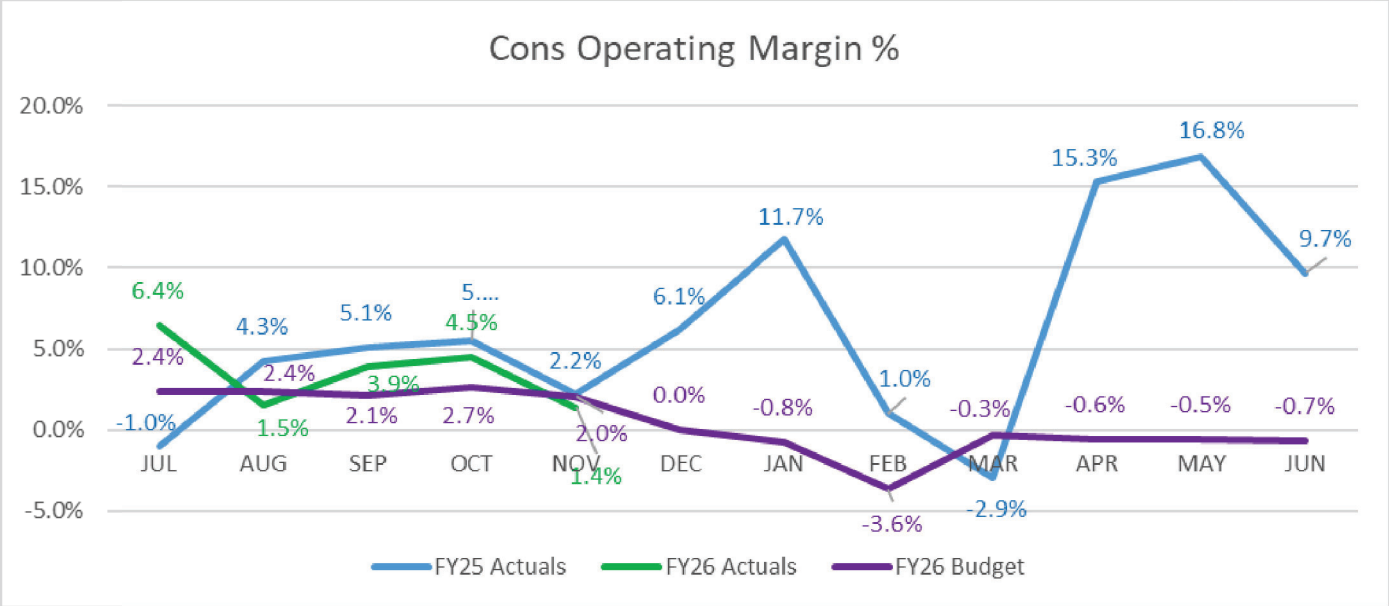
- **Admissions and Census**
  - **Admissions** over budget by 15% (131 cases)
  - **ADC** was 2% above budget
  - **Average Length of Stay** was 11% favorable to budget at 3.4 days
  - **Medicare Case Mix Adjusted Average Length of Stay** was favorable by 24% at 1.9 days
- **IP Surgeries** were over budget by 13% (18 cases)
- **Deliveries** were under budget by 2% (2 cases)
- **Cath Lab** – cases were under budget by 13% (41 cases)
- **Outpatient Revenues -** unfavorable to budget by $14M (9%), Key services driving this variance were:
  - **OP Infusion Program -** cases were over budget by 19% (210 cases)
  - **Observation cases** were over budget by 10% (14 cases)

Executive Summary: November Financial Performance – Continued

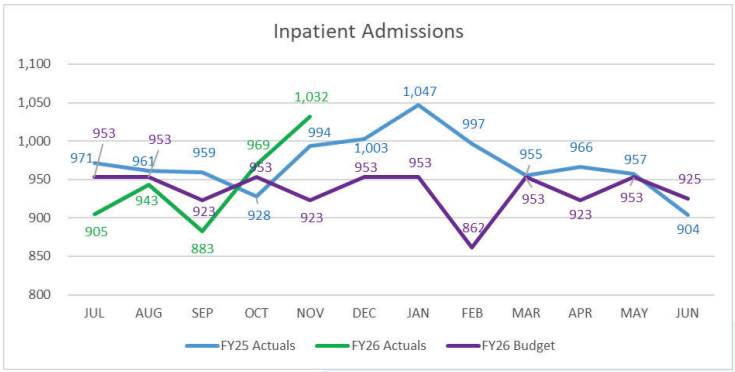
Cost and Utilization:

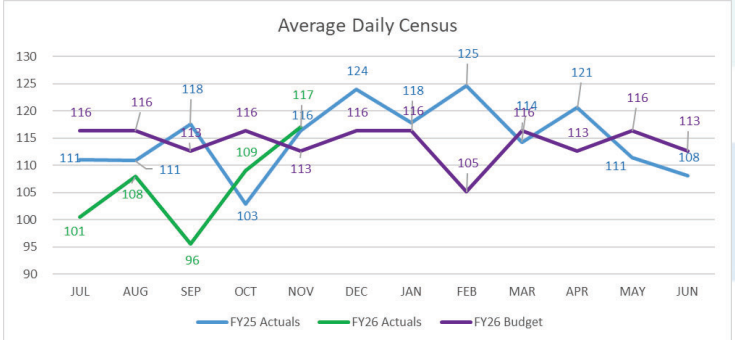
- **Worked FTEs** on a per Adjusted ADC basis were **14%** unfavorable at **7.4** - compared to a target of **6.5**
- **Payor Mix** was unfavorable with higher Medicare and lower commercial mix
- **Non-Operating Income** was over budget $0.4 Million driven by higher investment income
- **Days in AR** at **70** is trending over target due EPIC go live and high legacy balances due to slow paying insurance providers
- **Days Cash on Hand** at 362 is down from October due to lower outpatient revenue

Consolidated Operating Margin

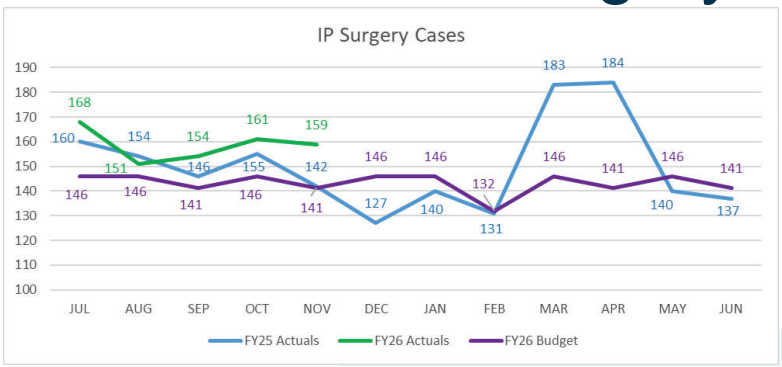


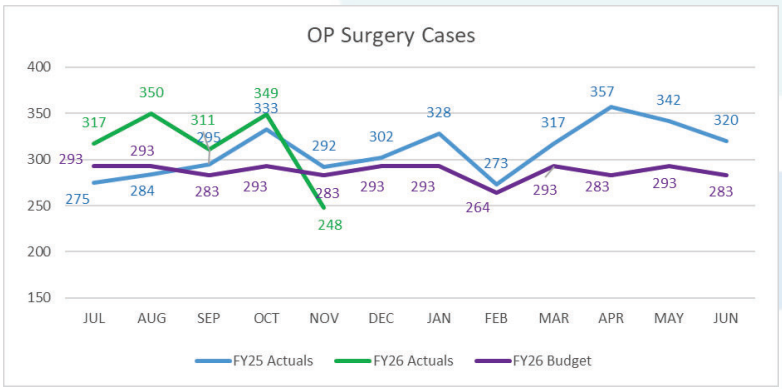
Volume Trends – Admissions & ADC



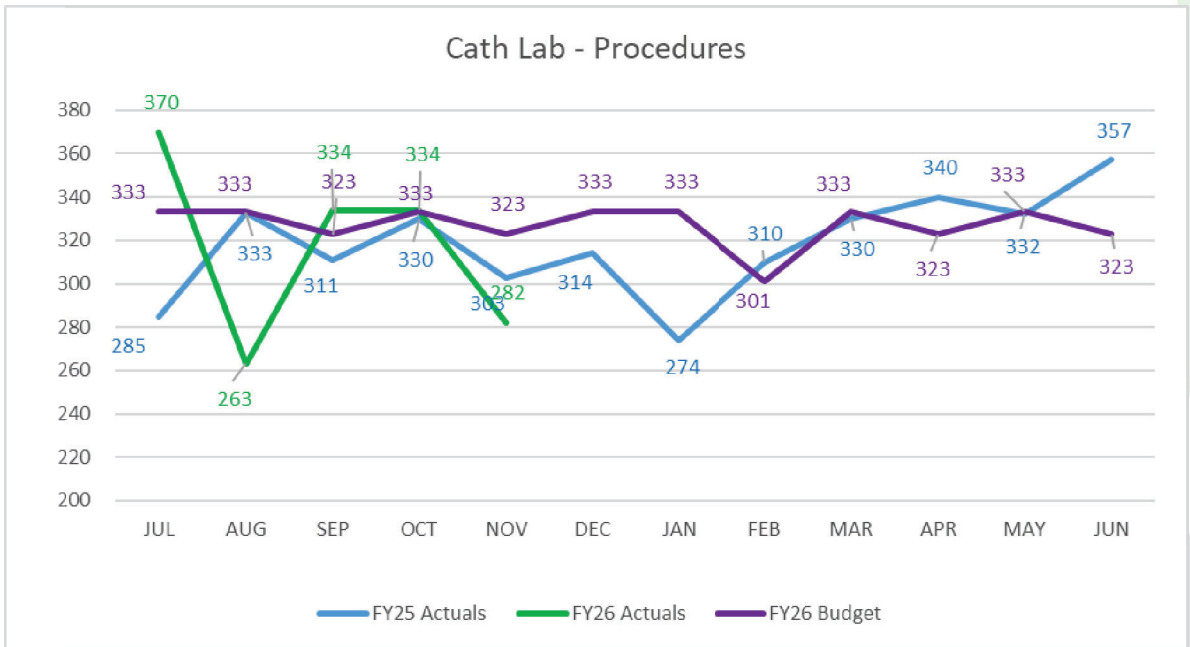


Volume Trends - Surgery Cases

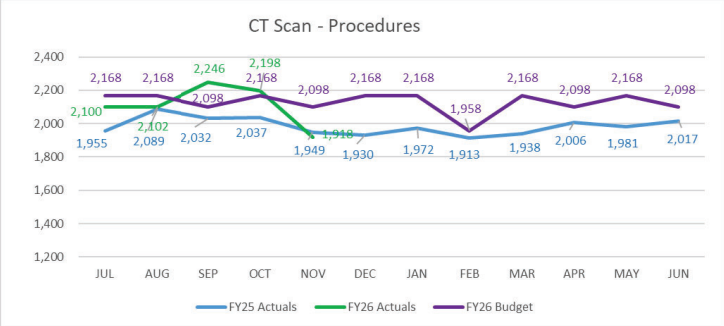


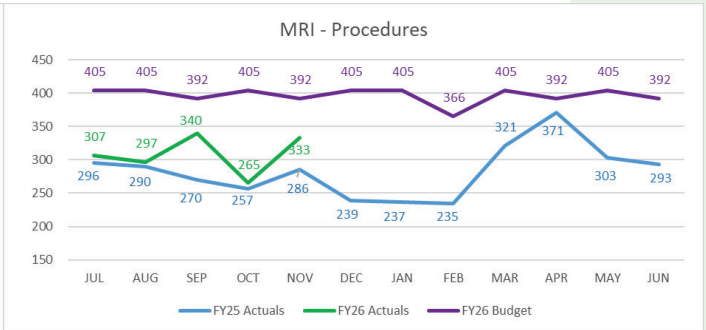


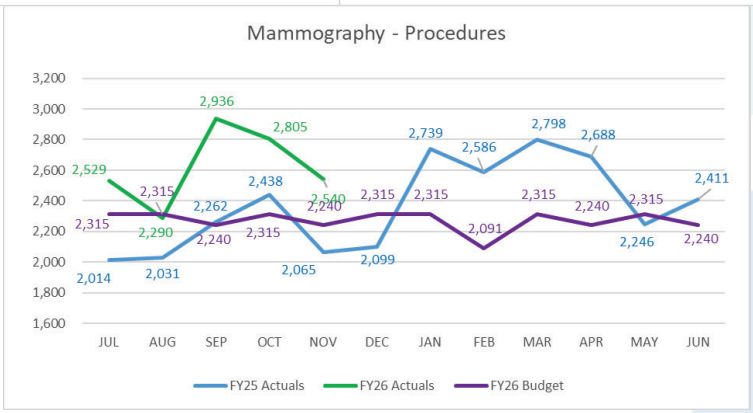
Volume Trends - Cath Lab



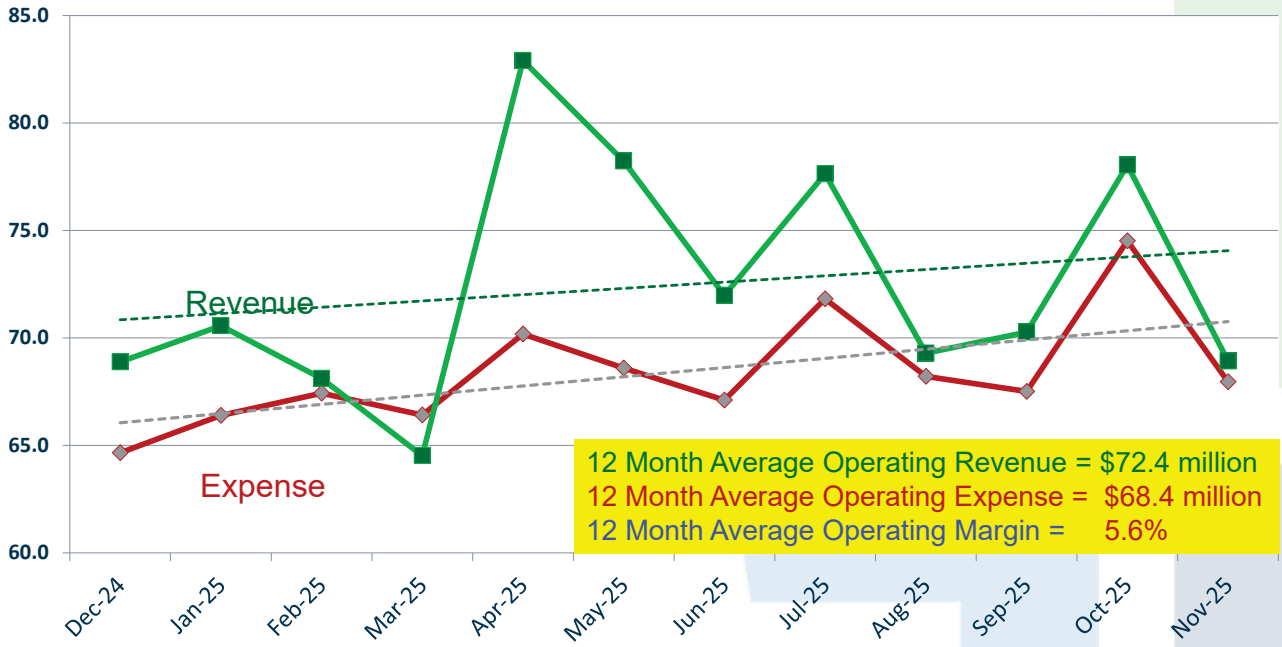
Volume Trends - Imaging



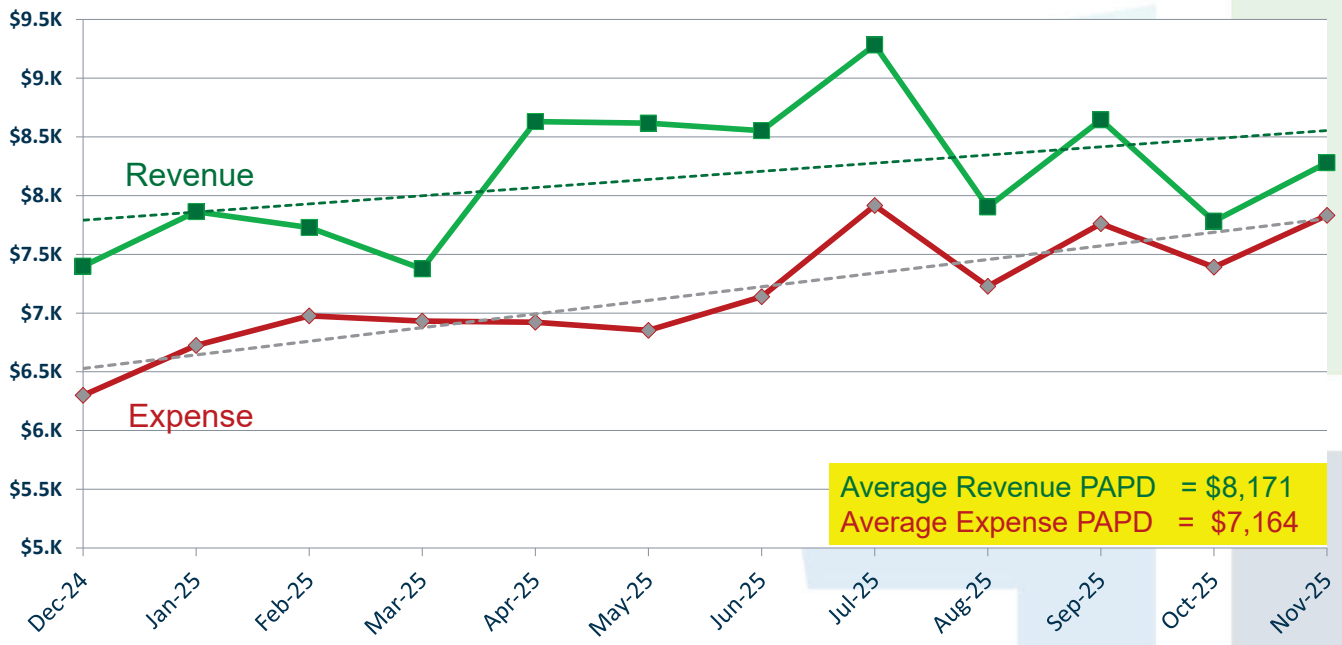




Consolidated Revenues & Expenses Rolling 12 Months: Dec 24 to November 25

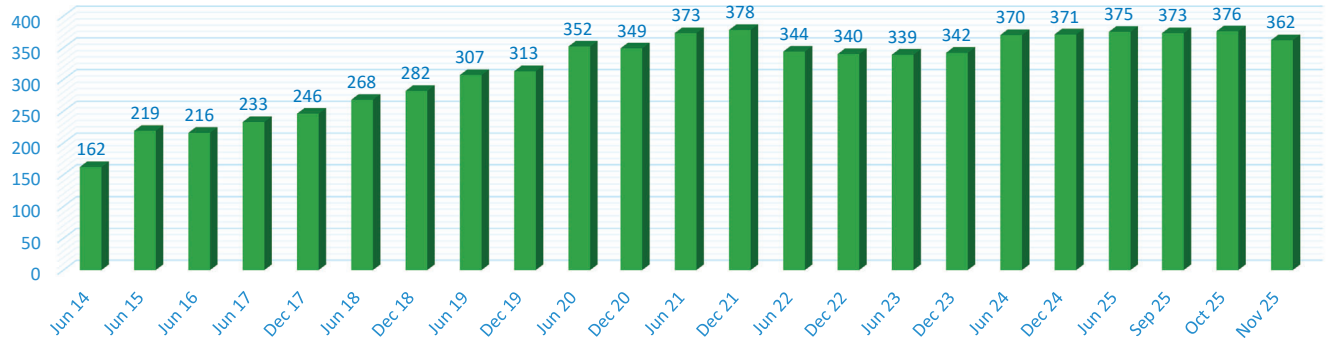


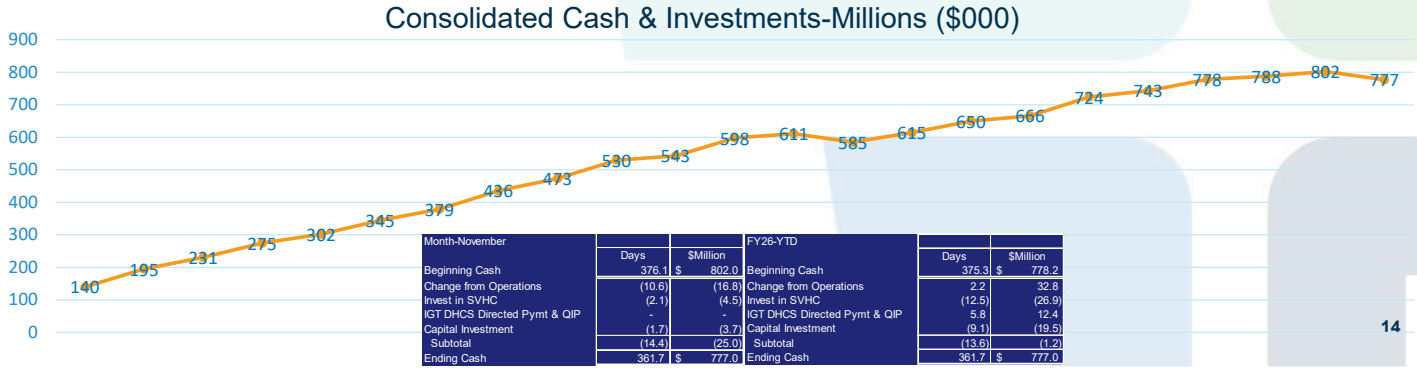
Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Dec 24 to November 25



13

Days Cash on Hand = 362 Days ($777M) - November 2025





Month-November	Days	$Million
Beginning Cash	376.1	$ 802.0
Change from Operations	(10.6)	(16.8)
Invest in SVHC	(2.1)	(4.5)
IGT DHCS Directed Pymt & QIP	-	-
Capital Investment	(1.7)	(3.7)
Subtotal	(14.4)	(25.0)
Ending Cash	361.7	$ 777.0

FY26-YTD	Days	$Million
Beginning Cash	375.3	$ 778.2
Change from Operations	2.2	32.8
Invest in SVHC	(12.5)	(26.9)
IGT DHCS Directed Pymt & QIP	5.8	12.4
Capital Investment	(9.1)	(19.5)
Subtotal	(13.6)	(1.2)
Ending Cash	361.7	$ 777.0

14

Questions/Comments

Salinas Valley HEALTH

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
November 30 ,2025

	Month of October		Three months ended October 31	
	Current Year	Prior Year	Current Period YTD	Prior Year YTD
Operating revenue:				
Net patient revenue	$ 57,112,810	$ 52,818,119	$ 296,652,407	$ 277,030,232
Other operating revenue	1,455,727	1,678,059	11,905,552	7,513,426
Total operating revenue	58,568,537	54,496,178	308,557,959	284,543,658
Total operating expenses	55,401,967	47,542,197	277,220,985	248,522,304
Total non-operating income	605,797	(2,518,900)	(6,635,700)	(7,734,078)
Operating and non-operating income	**$ 3,772,367**	**$ 4,435,081**	**$ 24,701,274**	**$ 28,287,276**

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
November 30 ,2025

	Current year	Prior year
Current assets	$ 455,037,216	$ 415,359,456
Assets whose use is limited or restricted by board	180,281,177	170,341,240
Capital assets	245,426,155	252,876,192
Other assets	391,299,541	303,686,204
Deferred pension outflows	55,438,539	85,734,219
	$1,327,482,628	$1,227,997,310
LIABILITIES AND EQUITY:		
Current liabilities	$ 104,207,886	$ 94,816,646
Long term liabilities	40,985,549	18,927,151
Lease deferred inflows	2,773,567	1,454,210
Pension liability	79,394,685	90,863,576
Net assets	1,100,120,941	1,021,935,726
	$1,327,482,628	$1,227,997,310

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
November 30, 2025

Current Year	Prior Year		Current YTD	Prior YTD
		Patients days:		
		By payer:		
1,634	1,782	Medicare	7,532	8,438
1,103	1,031	Medi-Cal	4,986	5,179
660	554	Commercial insurance	3,054	2,984
110	102	Other patient	638	510
3,507	3,469	Total patient days	16,210	17,111
		Gross revenue:		
126,603,284	121,440,105	Medicare	650,069,820	617,869,362
82,940,834	76,286,581	Medi-Cal	426,180,278	397,588,298
53,549,005	52,562,987	Commercial Insurance	313,597,520	285,429,666
9,635,448	8,967,174	Other patient	58,923,504	52,149,999
272,728,570	**259,256,847**	**Gross revenue**	**1,448,771,122**	**1,353,037,325**
		Deductions from revenue:		
649,533	67,992	Administrative adjustments	1,711,789	776,149
368,017	386,218	Charity care	4,420,064	2,085,481
		Contractual adjustments:		
39,717,301	39,733,278	Medicare outpatient	241,645,989	209,202,030
50,634,769	48,090,211	Medicare inpatient	234,250,752	231,254,699
1,298,074	1,373,363	Medi-Cal traditional outpatient	6,391,042	7,469,593
4,116,314	4,744,010	Medi-Cal traditional inpatient	17,409,706	29,999,245
36,108,721	35,228,638	Medi-Cal managed care outpatient	213,664,596	192,388,544
29,894,765	26,355,030	Medi-Cal managed care inpatient	139,458,377	127,177,174
20,065,697	26,066,185	Commercial insurance outpatient	135,565,935	132,880,643
19,302,732	18,553,851	Commercial insurance inpatient	98,579,448	107,999,926
5,339,955	5,066,198	Uncollectible accounts expense	30,570,229	26,843,040
8,112,374	773,754	Other payors	28,443,288	7,930,568
215,608,252	**206,438,728**	**Deductions from revenue**	**1,152,111,214**	**1,076,007,093**
57,120,318	**52,818,119**	**Net patient revenue**	**296,659,908**	**277,030,232**
		Gross billed charges patient type:		
137,246,462	122,512,955	Inpatient	647,238,195	629,697,477
102,148,525	108,100,039	Outpatient	626,044,388	565,291,994
33,333,584	28,643,854	Emergency room	175,488,539	158,047,853
272,728,570	**259,256,847**	**Total**	**1,448,771,122**	**1,353,037,325**

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
November 30, 2025

Month of November			Three months ended November 30		
Current Year	**Prior Year**		**Current Year**	**Prior Year**	
		Operating revenue:			
$ 272,728,570	$ 259,256,847	Gross billed charges	$ 1,448,771,122	$ 1,353,037,325	
215,615,760	206,438,728	Deductions from revenue	1,152,118,716	1,076,007,093	
57,112,810	**52,818,119**	**Net patient revenue**	**296,652,407**	**277,030,232**	
1,455,727	1,678,059	Other operating revenue	11,905,552	7,513,426	
58,568,537	**54,496,178**	**Total operating revenue**	**308,557,959**	**284,543,658**	
		Operating expenses:			
21,002,815	17,569,045	Salaries and wages	97,869,171	87,479,234	
3,824,097	2,600,947	Compensated absences	17,403,611	15,493,740	
6,616,053	5,582,454	Employee benefits	40,310,613	40,617,424	
8,626,827	8,698,971	Supplies, food, and linen	46,440,316	42,555,550	
4,151,658	4,311,582	Purchased department functions	22,167,898	19,784,857	
3,084,125	2,657,108	Medical Fees	13,926,021	12,335,891	
3,365,285	1,858,438	Other Fees	14,689,433	8,932,491	
3,273,683	2,514,330	Depreciation	14,056,656	12,482,877	
1,457,423	1,749,322	All other expense	10,357,265	8,840,240	
55,401,967	**47,542,197**	**Total Operating expenses**	**277,220,985**	**248,522,304**	
3,166,570	**6,953,981**	**Income from operations**	**31,336,974**	**36,021,354**	
		Non-operating Income:			
0	1,440,260	Donations	597,660	3,777,031	
500,550	476,714	Property taxes	2,502,750	2,383,572	
2,115,613	710,444	Investment Income	7,402,988	9,883,387	
(2,010,366)	(5,146,318)	Income from subsidiaries	(17,139,098)	(23,778,067)	
605,797	**(2,518,900)**	**Total non-operating income**	**(6,635,700)**	**(7,734,078)**	
$ 3,772,367	**$ 4,435,081**	**Operating and non-operating income**	**$ 24,701,274**	**$ 28,287,276**	

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
November 30, 2025

	Current Year	Prior Year
ASSETS		
Current assets:		
Cash and Cash Equivalents	$ 287,599,960	$ 272,442,319
Patient accounts receivable, net of estimated uncollectibles	144,522,665	115,458,745
Supplies inventory at cost	5,631,215	9,632,064
Current portion of lease receivable	561,953	1,178,296
Other current assets	16,721,424	16,648,031
Total current assets	455,037,216	415,359,456
Assets whose use is limited or restricted by board	180,281,177	170,341,240
Capital assets:		
Land and construction in process	45,272,769	51,097,321
Other capital assets, net of depreciation	200,153,386	201,778,872
Total capital assets	245,426,155	252,876,192
Other assets:		
Right of use assets, net of amortization	10,447,996	6,567,880
Long term lease receivable	2,266,288	309,119
Subscription assets, net of amortization	53,701,722	8,062,855
Investment in securities	277,832,333	263,849,216
Investment in SVMC	3,898,550	2,212,885
Investment in Aspire/CHI/Coastal	1,734,595	1,838,557
Investment in other affiliates	20,878,280	21,618,859
Net Pension Asset	20,007,604	(1,305,340)
Goodwill	532,173	532,173
Total other assets	391,299,541	303,686,204
Deferred Pension Outflows	55,438,539	85,734,219
Total assets	$ 1,327,482,628	$ 1,227,997,310
LIABILITIES AND NET ASSETS		
Current liabilities:		
Accounts payable and accrued expenses	65,816,717	62,908,512
Due to third party payors	4,729,625	3,689,368
Current portion of self-insurance liability	21,430,185	22,556,402
Current subscription liability	3,481,036	3,152,672
Current portion of lease liability	3,671,455	2,509,692
Current portion of compensated absences	5,078,868	-
Total current liabilities	104,207,886	94,816,646
Long term portion of workers comp liability	11,655,972	12,078,720
Long term portion of lease liability	7,256,986	4,119,234
Long term subscription liability	10,020,437	2,729,198
Long term portion of compensated absences	12,052,154	-
Total Liabilities	145,193,435	113,743,797
Lease deferred inflows	2,773,567	1,454,210
Pension Liability	79,394,685	90,863,576
Net Assets:		
Invested in capital assets, net of related debt	245,426,155	252,876,192
Unrestricted	854,694,786	769,059,534
Total Net Assets	1,100,120,941	1,021,935,726
Total liabilities and net assets	$ 1,327,482,628	$ 1,227,997,310

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - ('000)
November 30, 2025

Actuals	Budget	$ Variance	% Variance		Actuals YTD	Budget YTD	$ Variance YTD	% Variance
				Operating revenue:				
272,728,570	281,698,118	(8,969,548)	3.2%	Gross billed charges	1,448,771,122	1,436,298,696	12,472,427	-0.9%
215,615,760	225,917,643	(10,301,883)	-4.6%	Deductions from revenue	1,152,118,716	1,152,010,386	108,330	0.0%
57,112,810	**55,780,475**	**1,332,335**	**-2.4%**	**Net patient revenue**	**296,652,407**	**284,288,310**	**12,364,097**	**-4.3%**
1,455,727	1,721,629	(265,902)	15.4%	Other operating revenue	11,905,552	8,608,144	3,297,408	-38.3%
58,568,537	**57,502,104**	**(1,066,433)**	**1.9%**	**Total operating revenue**	**308,557,959**	**292,896,454**	**(15,661,505)**	**5.3%**
				Operating expenses:				
21,002,815	18,549,747	2,453,068	13.2%	Salaries and wages	97,869,171	93,254,585	4,614,586	-4.9%
3,824,097	3,340,030	484,067	14.5%	Compensated absences	17,403,611	17,898,236	(494,625)	2.8%
6,616,053	7,544,441	(928,388)	-12.3%	Employee benefits	40,310,613	39,450,864	859,749	-2.2%
8,626,827	8,746,192	(119,365)	-1.4%	Supplies, food, and linen	46,440,316	44,598,767	1,841,550	-4.1%
4,151,658	4,494,768	(343,110)	-7.6%	Purchased department functions	22,167,898	22,507,022	(339,124)	-1.5%
3,084,125	2,611,447	472,678	18.1%	Medical Fees	13,926,021	13,068,490	857,531	-6.6%
3,365,285	1,463,970	1,901,315	129.9%	Other Fees	14,689,433	7,437,910	7,251,523	-97.5%
3,273,683	2,562,021	711,663	27.8%	Depreciation	14,056,656	12,818,038	1,238,618	-9.7%
1,457,423	1,963,593	(506,170)	-25.8%	All other expense	10,357,265	10,092,817	264,448	2.6%
55,401,967	**51,276,209**	**4,125,758**	**8.0%**	**Total Operating expenses**	**277,220,985**	**261,126,728**	**16,094,257**	**-6.2%**
3,166,570	**6,225,895**	**3,059,325**	**-49.1%**	**Income from operations**	**31,336,974**	**31,769,725**	**432,751**	**1.4%**
				Non-operating Income:				
0	216,667	(216,667)	100.0%	Donations	597,660	1,083,333	(485,674)	44.8%
500,550	500,550	-	0.0%	Property taxes	2,502,750	2,502,750	-	0.0%
2,115,613	1,242,414	873,198	-70.3%	Investment Income	7,402,988	6,212,174	1,190,814	-19.2%
(2,010,366)	(4,645,293)	2,634,927	56.7%	Income from subsidiaries	(17,139,098)	(22,705,659)	5,566,561	24.5%
605,797	**(2,685,662)**	**3,291,459**	**122.6%**	**Total non-operating income**	**(6,635,700)**	**(12,907,402)**	**6,271,702**	**48.6%**
3,772,367	**3,540,233**	**(232,134)**	**6.6%**	**Operating and non-operating income**	**24,701,274**	**18,862,324**	**(5,838,951)**	**31.0%**

TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

Minutes of the
Transformation, Strategic Planning and
Governance Committee
will be distributed at the Board Meeting

(VICTOR REY, JR.)

Salinas Valley HEALTH

Medical Executive Committee Summary – January 8, 2026

Items for Board Approval

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Fedora, Rissa, DO	Psychiatry	Medicine	Tele-Psychiatry
Giron, Aitala, MD	Psychiatry	Medicine	Tele-Psychiatry
Hoyos Gomez, Tatiana, MD	Surgical Critical Care and General Surgery	Surgery	General Surgery Robotic Surgery
Hsu, Patrick, DO	Emergency Medicine	Emergency Medicine	Emergency Medicine
Jensen, Jacob, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Tanski, Daryl, MD	Psychiatry	Medicine	Tele-Psychiatry
Zamora, Jesus, MD	Radiology	Surgery	Salinas Valley Health Remote Radiology Salinas Valley Health Advanced Imaging: Non-Cardiac Diagnostic - Remote Radiology

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Ahmad, Omar, MD	Infectious Disease	Medicine	Infectious Disease Remote Infectious Disease
Ajoc, Jose, MD	Family Medicine	Medicine	Adult Hospital: Core
Firooznia, Nilofar, MD	Radiology	Surgery	Salinas Valley Health Advanced Imaging – Remote Teleradiology/ Radiology Salinas Valley Health Imaging Remote Radiology Salinas Valley Health Nancy Ausonio Breast Health Center Remote Mammography Reading
Gerber, Richard, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology Salinas Valley Health Cardiovascular Diagnostics Salinas Valley Health Advanced Imaging-Cardiac Imaging
Greene, Douglas, MD	Anesthesiology	Anesthesiology	Anesthesiology
Hawthorne, Kinji, MD	Infectious Disease	Medicine	Remote Infectious Disease
Kim, Richard, MD	Ophthalmology	Surgery	Ophthalmology
Liu, Yang, MD	Hematology & Oncology	Medicine	Hematology Medical Oncology SVHMC Outpatient Infusion Center
May, Megan, MD	Nephrology	Medicine	Nephrology
Mudge, Dawn, MD	Internal Medicine	Medicine	Adult Hospitalist
Navarro, Misty, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Ozoigbo, Guguamobi, MD	Anesthesiology	Anesthesiology	Anesthesiology
Panchal, Dhanu, MD	Physical Medicine and Rehabilitation	Medicine	Medicine- Active Community

Shah, Pir, MD	Interventional Cardiology	Medicine	Cardiology Interventional Cardiology
Shawo, Alexandra, MD	Internal Medicine	Medicine	Adult Hospitalist
Von Berg, Marc, MD	Anesthesiology	Anesthesiology	Anesthesiology
Wong, Angela, MD	Family Medicine	Family Medicine	Family Medicine Active Community

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE MODIFICATION
Friedricks, Natalie, MD	Ob/Gyn	Addition of: Colpoplasty, Repair of rectocele, enterocele, cystocele, or pelvic prolapse (to include sphincteroplasty) Umbilical hernia repair
Shin, Daniel, MD	Radiology	Addition of Moderate Sedation

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Dacus, James, MD	Internal Medicine	Active to Active Community
Larsen, Melissa, MD	Ob/Gyn	Advancement to Active Staff
Waingold, Andrea, MD	Anesthesiology	Advancement to Active Staff
Aachi, Vankat, MD	Tele-Neurology	Resignation effective 2/1/2026
Fowler, Martin, DO	Tele-Neurology	Resignation effective 12/19/2025
Gomez, Briana, MD	Ob/Gyn	Resignation effective 12/2/2025
Kallini, Joseph, MD	Tele-Radiology	Resignation effective 12/29/2025
Sidhu, Deepal, MD	Anesthesiology	Resignation effective 12/31/2025

Temporary Privileges:

NAME	SPECIALTY	DATES
Hsu, Patrik, DO	Emergency Medicine	12/4/2025-1/2/2026 1/5/2026-1/6/2026
Jensen, Jacob, MD	Emergency Medicine	12/12/2025-1/10/2026

Other Items: ***(Attached)***

Vascular Surgery – Clinical Privileges Delineation	Revision updates both Special and Core Procedures.

Interdisciplinary Practice Committee

Initial Appointments:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Benitez, Tanya, NP	Nurse Practitioner	Medicine	Hong Zhao, MD
Miller, David, PA-C	Physician Assistant	Medicine	Steven Regwan, DO

Policies and Plans:

1. Aerosol Transmitted Diseases Exposure Control Plan
2. Infection Prevention Pandemic Plan Emerging Infectious Diseases
3. Infection Prevention Program Plan

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Quality and Safety Committee

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings December 2025
c. Medical Staff Treasury Report December 24, 2025
d. Medical Staff Statistics Year to Date
e. Financial Update November 2025
f. Executive Updates
g. HCAHPS Update December 31, 2025

Clinical Privileges Delineation
Vascular Surgery

Applicant Name: _____

Qualifications:

To be eligible to apply for core privileges in Vascular Surgery, the applicant must meet the following qualifications:

~~*Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.*~~

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in vascular surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 7 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:
Once certified by a recognized Board, the Medical Staff Member must remain certified as a condition for Medical Staff privileges. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period shall result in automatic suspension of Medical Staff privileges.

Applicants more than two years out of Residency training must provide documentation of the performance of 50 vascular surgery procedures within the past 12 months, the majority being of a reconstructive nature excluding cardiac surgery.

New applicants will be required to provide documentation of the number and types of hospital cases during the past 24 months. Applicants have the burden of producing information deemed adequate by the Medical Staff for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

General Privileges Statement:
Clinically privileged individuals who have been determined to meet criteria within their practice specialty are permitted to admit, evaluate, diagnose, treat, and provide consultation independent of patient age, and where applicable, provide surgical and therapeutic treatment within the scope of those clinical privileges and to perform other procedures that are extensions of those same techniques and skills. In the event of an emergency, any credentialed individual is permitted to do everything reasonably possible regardless of department, staff status or clinical privileges, to save the life of a patient or to save a patient from serious harm as is outlined in the Medical Staff Bylaws.

Vascular Surgery Core Privileges

Admit, evaluate, diagnose, provide consultation and treat patients with diseases/disorders of the arterial, venous, and lymphatic circulatory systems, excluding the intracranial vessels or the heart. The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skills.

Peripheral Endovascular Core Privileges

All candidates for interventional privileges must qualify for vascular interventions based on fellowship or experience. The candidate shall have spent a minimum of twelve months of full time experience in invasive laboratory and have performed a minimum of diagnostic peripheral angiographic studies and/or peripheral intervention cases listed below in the capacity of primary operator. The candidate must provide the Credentials Committee with documentation of specific procedure and patient for each case. For documentation purposes, the Credentials Committee will consider only the number of procedures, not the number of lesions, as counting toward the candidate's eligibility. The fellowship must also include intensive training in all aspects of a body of knowledge

Peripheral Endovascular

☐ **Requested**

The core privileges in this specialty include the procedure on the attached list and such other procedure that are extension of the same techniques and skills

Cardiologists: Documentation of a successful completion of a (3) three year fellowship which included peripheral angiography training with peripheral intervention training as part of a fourth year fellowship.

Radiologists: Documentation of the inclusion of angiographic training during a residency program with the addition of peripheral intervention training during a minimum (1) one year fellowship.

Vascular Surgeons: Documentation of the successful completion of a vascular fellowship of at least (1) one year in duration with catheter directed techniques as part of the fellowship.

Core Proctoring Requirements:

Core proctoring requirements include direct observation or concurrent and/or retrospective review as per proctoring policy contained in the Medical Staff General Rules and Regulations.

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; 50 vascular surgery procedures ~~–~~within the past 24 months, the majority being of a reconstructive nature excluding cardiac surgery.

AND

Be Board Certified. If the Medical Staff member's board certification lapses for any reason, they shall have a grace period of two (2) years from the expiration date to regain board certification. Failure to regain board certification within the specified time period may result in suspension of Medical Staff privileges.

~~Board certification/eligibility requirements are applicable to new privilege requests after the Board of Directors approval of these revisions on September 28, 2017.~~

Special Procedures/Privileges

Qualifications: To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth below.

Proctoring of Special Procedure Privileges: These special procedure-proctoring requirements must be met in addition to the core proctoring requirements described on page one of this privilege form.

Renewal of Privileges at Reappointment: In the event a physician has not performed a requested special procedure privilege during the reappointment period, the privilege will not be granted.

Applicant: Place a check mark in the (R) column for each privilege requested. New applicants must provide documentation of the number and types of hospital cases during the past 24 months.

(R)=Requested **(A)**=Recommended as Requested **(C)**=Recommended w/Conditions **(N)**=Not Recommended
Note: If recommendations for clinical privileges include a condition, modification or are not recommended, the specific condition and reason for same must be stated on the last page of this form.
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				~~Endovascular Laser Treatment (EVLT)~~	~~Successful completion of an ACGME or AOA accredited training program within the previous five (5) years which included supervised training in the diagnosis and treatment of varicose veins and training in interpreting ultrasound examinations of the legs. Applicants must demonstrate completion of training in EVLT, which included the performance/interpretation of 20 EVLT procedures within the previous two (2) years.~~	~~1~~	~~Documentation of the successful performance and or interpretation of at least 20 EVLT procedures annually.~~

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Endovascular Surgery (excludes cerebrovascular) Includes us of laser (EVLT)	Documentation of specific training during residency, fellowship or preceptorship **AND** Documentation of successful completion of 50 procedures within the past 24 months	**1**	Documentation of the successful performance of at least 25 procedures within the past 24 months
				Percutaneous Arterial and Venous Embolectomy	Documentation of successful completion of five (5) procedures in the past 4 years	**1**	Documentation of the successful performance of at least two (2) procedures within the past 24 months
				Use of radiofrequency for interruption of veins	Successful completion of the equipment manufacturer's training course **AND** Current unrestricted privileges in non-radiofrequency assisted deep vein interruption procedures	**1**	Performance of at least two (2) cases within the past 24 months
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification
				Vascular Ultrasound Interpretation (Physicians who completed residency **prior to 2015**) Residency completed in **2015 or later**, privilege listed in core	Current unrestricted Vascular Privileges **AND** 200 peripheral vascular ultrasound cases within the past 24 months **AND** 15 hours of CME relevant to vascular imaging	**1**	200 vascular ultrasound cases within the past 24 months

SVH Peripheral Endovascular Privileging Criteria:

Qualification by Fellowship Training:

Cardiologists: three year fellowship which includes peripheral angiography training with peripheral intervention training as part of a fourth year fellowship.
Radiologists: the inclusion of angiographic training during a residency program with the addition of peripheral intervention training during a minimum of a one year fellowship.
Vascular Surgeons: completion of a vascular fellowship of at least one year=s duration with catheter directed techniques as part of the fellowship.
All candidates for interventional privileges must qualify for vascular interventions based on fellowship or experience. The candidate shall have spent a minimum of twelve months of full time experience in invasive laboratory and have performed a minimum of diagnostic peripheral angiographic studies and/or peripheral intervention cases listed below in the capacity of primary operator. The candidate must provide the Credentials Committee with documentation of specific procedure and patient for each case. For documentation purposes, the Credentials Committee will consider only the number of procedures, not the number of lesions, as counting toward the candidate=s eligibility. The fellowship must also include intensive training in all aspects of a body of knowledge.
Applicant: Check box marked "R" to request privileges

Peripheral Endovascular Procedures							
R	**A**	**C**	**N**	**Procedures**	**Initial Appointment**	**Proctoring**	**Reappointment**
				Cerebral angiography	Documentation of successful completion of 40 procedures in the past four (4) years.	**1**	Documentation of successful completion of 20 procedures within the past 24 months.
				~~Dialysis graft~~ CORE???? It is for Peripheral Cardiology	~~Documentation of successful completion of 25 procedures in the past four (4) years.~~	~~1~~	~~Documentation of successful completion of 12 procedures within the past 24 months.~~

Percutaneous Vascular Interventions:
Percutaneous transluminal angioplasty which will include endovascular stent placement, atherectomy, rotablation, and other techniques that may involve the following:
Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedures	Initial Appointment	Proctoring	Reappointment
				Aortic Stent Placement With or Without Stent Graft **Policy Statement:** Individuals who fulfill 1 or 2 below, but not both, will be required to have an individual present who possesses the outstanding privilege(s). 1. Aortography and endovascular privileges. 2. Privileges to repair an abdominal aortic aneurysm	Document successful completion of the stent manufacturer's training course.	**1** **(first case)**	Must perform a minimum of one (1) aortic stent graft within the past 24 months

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Carotid Angioplasty Stenting	Applicant must be a Board Certified (or board qualified) Endovascular Trained Surgeon (cardiovascular, vascular, neurosurgeon), Subspecialty Interventional Trained Board Certified (or board qualified) Cardiologist, or Board Certified (or board qualified) Interventional Radiologist **AND** Be Advanced Cardiac Life Support (ACLS) Certified **AND** Document training, experience ~~or apprenticeship as defined below:~~ Training: completion of a dedicated vascular training program with participation in a minimum of 25 carotid interventions, ten (10) as primary operator. **OR** Experience: Documented previous experience of participation in a minimum of 25 carotid interventions, ten (10) as primary operator, with prior attendance at two (2) live demonstration education courses on peripheral vascular technique with clear emphasis on carotid therapy. ~~**OR**~~ ~~Apprenticeship: Under certified proctor*, proctorship shall consist of joint performance of at least 25 carotid interventions as co-principle operator. Required attendance at a Minimum of two (2) live demonstration/ education courses on peripheral vascular technique with clear emphasis on carotid therapy.~~	~~"Experience": First five (5) cases must be performed in the presence of a certified* proctor~~ ~~"Apprenticeship" First five (5) solo cases must be performed in the presence of a certified* proctor.~~ 1 First Case	Operator must perform a minimum of ten (10) carotid interventions ~~per year with acceptable complication rate as reported in peer reviewed literature~~in the past 24 months

*A certified proctor is defined as an individual that has been approved by the designated device manufacturer

Other Vascular Interventions:

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Percutaneous vena cava filter	Documentation of successful completion of eight (8) procedures within the past four (4) years.	**1**	Documentation of successful completion of two (2) procedures within the past 24 months.
				Transjugular intrahepatic portosystemic shunt (TIPS)	Documentation of successful completion of three (3) procedures within the past four (4) years.	**1**	Documentation of successful completion of one (1) procedures within the past 24 months.
				Thoracic Endovascular Stenting ~~**Protocol:**~~ ~~Procedure must be performed in an Operating Room setting with angiography and fluoroscopy capability,~~ ~~**AND**~~ ~~An individual with Cardiothoracic or Vascular Surgery at SVMH privileges must be present in the operating room during the procedure.~~	Applicant must be ABMS Board Certified or Board Qualified in Cardiac, Thoracic or Vascular Surgery with documented Endovascular Training or Board Certified or Board Qualified in Interventional Cardiology or Interventional Radiology, **AND** Possess current privileges for aortic stent graft placement at SVH **AND** Document successful completion of the manufacturer's required training for use of the thoracic stent	~~Proctoring required on the first three (3) cases by a proctor certified by the stent manufacturer*~~ **1** **First Case**	Must perform a minimum of four (4) aortic stent graft procedures, two (2) of which must be thoracic endovascular stent procedures within the past 24 months.

* A certified proctor is defined as an individual that has been approved by the designated device manufacturer

Salinas Valley Health Medical Center

Core Procedure List: The following procedures are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Department Chair, Chief Medical Officer and/or the Chief of Staff

Vascular Surgery Core Procedures:

1. Amputations, upper extremity, lower extremity or digit
2. Aneurysm repair, abdominal aorta and peripheral vessels emergent and elective
3. Angioplasty, femoral, iliac – intraoperative
4. Aortic procedures
5. Arteriovenous fistula or shunt
6. Arteriography/Venography
7. Bypass grafting all vessels excluding coronary and intracranial vessels
8. Carotid Endarterectomy
9. Central venous access catheters and ports
10. Cervical, thoracic or lumbar sympathectomy
11. Diagnostic biopsy or other diagnostic procedures on blood vessels
~~11.~~12. Dialysis graft placement
~~12.~~13. Embolectomy or thrombectomy for all vessels excluding coronary and intra cranial vessels
~~13.~~14. Endarterectomy for all vessels excluding coronary and intra cranial vessels
~~14.~~15. Extra cranial carotid and vertebral artery surgery
~~15.~~16. Hemodialysis access procedures
~~16.~~17. Intraoperative angiography
~~17.~~18. Median Sternotomy for Vessel Reconstruction
~~18.~~19. Other major open peripheral vascular arterial and venous reconstructions
~~19.~~20. Reconstruction, resection, repair of major vessels with anastomosis or replacement (excluding cardiopulmonary, intracranial)
~~20.~~21. Revascularization – upper extremity, lower extremity, renal, visceral artery
~~21.~~22. Split thickness skin graft
~~22.~~23. Temporal artery biopsy
~~23.~~24. Thoracic outlet decompression procedures including rib resection
~~24.~~25. Thoracotomy
~~25.~~26. Thoracoabdominal Aortic Aneurysm
27. Use of Laser
28. Vascular Ultrasound Interpretation ~~(Physicians must have completed residency training in 2015 or later)~~
~~26.~~
~~27.~~29. Vein ligation and stripping
~~28.~~30. Venous reconstruction

Peripheral Endovascular Core Procedures:

1. Lower extremity angiography (below the iliac)
2. Upper extremity arteriography (beyond vertebral arteries)
3. Brachiocephalic arteriography (arch and extra cranial, carotid and vertebral arteries)
4. Venography – Peripheral or Central
5. Renal Arteriography
6. Stent Grafting: Includes iliac vessels, renal vessels, lower extremities, visceral, brachiocephalic and subclavia brachial. Excludes arch, intracranial and extra cranial carotid and vertebral arteries.
7. Thrombolytic therapy
8. Embolization therapy
9. Arterial and venous Embolectomy
10. Visceral Mesenteric stent placement

Applicant: Complete this section only if you do not wish to apply for any of the specific core procedures listed for Vascular Surgery above:

Please indicate any privilege on this list you would like to ***delete or change*** by writing them in the space provided below. Requests for deletions or changes will be reviewed and considered by the Department Chair, Credentials Committee and Medical Executive Committee. Deletion of any specific core procedure does not preclude mandatory requirement for Emergency Room call.

_____ _____

_____ _____

_____ _____

Signature: Date:

Acknowledgment of practitioner

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at Salinas Valley Health Medical Center. I further submit that I have no health problems that could affect my ability to perform the privileges I am request. I also understand that:

(a) In exercising any clinical privileges granted, I am constrained by hospital and medical staff Bylaws, Rules and Regulations, and policies applicable generally and any applicable to the particular situation,

(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

_____ _____

Applicant Signature Date

*****Department Chair's Recommendation*****

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

☐ Recommend all requested privileges
☐ Recommend all requested privileges with the following conditions/modifications:
☐ Do not recommend the following requested privileges:

Privilege	Condition/Modification/Explanation
1.	
2.	
3.	
4.	
Notes:	

_____ _____

Department Chair Signature Date

Status **Active** PolicyStat ID **16440599**

Origination	1/12/2022	Owner	Melissa Deen: Manager Infection Prevention
Approved	12/18/2025		
Expires	12/18/2026	Area	Plans and Program

Aerosol Transmitted Diseases Exposure Control Plan

I. SCOPE

A. An aerosol-transmissible disease (ATD) is a disease that is transmitted either by inhalation of infectious particles/droplets or direct contact with the particles/droplets with mucous membranes in the respiratory tract or eyes. Salinas Valley Health Medical Center (SVHMC) employees may have occupational exposure to ATDs in the course of conducting their job duties. Following California Code of Regulations, title 8, section 5199, Aerosol Transmissible Diseases, SVHMC has implemented this written exposure control plan to reduce employees' risk of contracting these infections, so that SVHMC may respond in an appropriate and timely manner when exposure incidents occur.

II. DEFINITIONS

A. For purposes of this plan, the term "employee" represents all persons who engage in or affect patient care.

B. **Aerosol transmissible disease (ATD) or aerosol transmissible pathogen (ATP)**: A disease or pathogen for which droplet precautions or airborne isolation are recommended.

C. **Aerosol transmissible pathogen – laboratory (ATP-L)**: A disease or pathogen for which droplet precautions or airborne isolation are required (refer to Appendix B).

D. **Airborne infection isolation (AII)**: Infection control procedures as described in Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis in* Health-Care Settings. These procedures are designed to reduce the risk of transmission of airborne infectious pathogens and apply to patients known or suspected to be infected with epidemiologically important pathogens that can be transmitted by the airborne route.

E. **Airborne infection isolation room or area (AIIR):** A room, area, booth, tent, or other enclosure that is maintained at negative pressure to adjacent areas in order to control the spread of aerosolized *M. tuberculosis* and other airborne infectious pathogens and that meets the requirements stated in engineering controls of this plan.

F. **Airborne infectious disease (AirID):** Either: (1) an aerosol transmissible disease transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the disease agent for which the CDC or CDPH recommends AII, or (2) the disease process caused by a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that the pathogen is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

G. **Airborne infectious pathogen (AirIP):** Either: (1) an aerosol transmissible pathogen transmitted through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the infectious agent, and for which the CDC or CDPH recommends AII, or (2) a novel or unknown pathogen for which there is no evidence to rule out with reasonable certainty the possibility that it is transmissible through dissemination of airborne droplet nuclei, small particle aerosols, or dust particles containing the novel or unknown pathogen.

H. **Droplet precautions**: Infection control procedures as described in CDC Guideline for Transmission-based Precautions designed to reduce the risk of transmission of infectious agents through contact of the conjunctivae or the mucous membranes of the nose or mouth of a susceptible person with large-particle droplets (larger than 5 µm in size) containing microorganisms generated from a person who has a clinical disease or who is a carrier of the microorganism

I. **Electronic Health Record (EHR)**

J. **Exposure incident**: An event in which all of the following has occurred: (1) An employee has been exposed to an individual who is a case or suspected case of a reportable ATD, or to a work area or to equipment that is reasonably expected to contain ATPs associated with a reportable ATD; and (2) The exposure occurred without the benefit of applicable exposure controls required by this section, and (3) It reasonably appears from circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

K. **Guideline for Isolation Precautions:** The Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007, CDC

L. **Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health- Care Settings:** The Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, December 2005, CDC

M. **Health care provider**: A physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist

N. **Health care worker**: A person who works in a health care facility, service or operation

O. **High hazard procedures**: Procedures performed on a person who is a case or suspected case of an aerosol transmissible disease or on a specimen suspected of containing an ATP-L, in which the potential for being exposed to aerosol transmissible pathogens is increased due to the reasonably anticipated generation of aerosolized pathogens. Such procedures include, but are not limited to, sputum induction, bronchoscopy, aerosolized administration of pentamidine or other medications, and pulmonary function testing. High Hazard Procedures also include, but are not limited to, autopsy, clinical, surgical and laboratory procedures that may aerosolize pathogens

P. **Individually identifiable medical information** means medical information that includes or contains any element of personal identifying information enough to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the individual's identity

Q. **Infection Preventionist (IP):** An infection control professional who is knowledgeable about infection control practices, including routes of transmission, isolation precautions and the investigation of exposure incidents

R. **Infectious:** Having the ability to transmit TB or ATD/ATP to other people via respiratory droplet nuclei, fomites, or during autopsy

S. **Initial treatment**: Treatment provided at the time of the first contact a health care provider has with a person who is potentially an AirID case or suspected case. Initial treatment does not include high-hazard procedures

T. **Laboratory**: A facility or operation in a facility where the manipulation of specimens or microorganisms is performed for the purpose of diagnosing disease or identifying disease agents, conducting research or experimentation on microorganisms, replicating microorganisms for distribution or related support activities for these processes

U. **Local health officer**: The health officer for the local jurisdiction responsible for receiving and/or sending reports of communicable diseases, as defined in Title 17, CCR
**NOTE: Title 17, Section 2500 of CCR requires that reports be made to the local health officer for the jurisdiction where the patient resides.*

V. ***M. tuberculosis* (TB or *M. tb*) means *Mycobacterium tuberculosis***: The scientific name of the bacterium that causes tuberculosis

W. **Negative pressure**: The relative air pressure difference between two areas. The pressure in a containment room or area that is under negative pressure is lower than adjacent areas, which keeps air from flowing out of the containment room or area and into adjacent rooms or areas

X. **NIOSH**: The National Institute for Occupational Safety and Health

Y. **Novel or unknown ATP**: A pathogen capable of causing serious human disease meeting the following criteria:

1. There is credible evidence that the pathogen is transmissible to humans by airborne and/or droplet transmission and;
2. The disease agent is:
    a. A newly recognized pathogen, or
    b. A newly recognized variant of a known pathogen and there is reason to believe that the variant differs significantly from the known pathogen in virulence or transmissibility, or
    c. A recognized pathogen that has been recently introduced into the human population, or
    d. A not yet identified pathogen

Z. **NOTE*: Variants of seasonal influenza virus that typically are not considered novel or unknown ATPs. Pandemic influenza strains that have not been fully characterized are novel pathogens.

AA. **Occupational exposure**: Exposure from work activity or working conditions that is reasonably anticipated to create an elevated risk of contracting any disease caused by ATPs if protective measures are not in place. In this context, "elevated" means higher than what is considered ordinary for employees having direct contact with the general public outside of the facilities, service categories and operations listed in subsection (a)(1) of this standard.
Occupational exposure is presumed to exist to some extent in each of the facilities, services and operations listed in subsection (a)(1)(A) through (a)(1)(H) of the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases. Whether a particular employee has, occupational exposure depends on the tasks, activities, and environment of the employee, and therefore, some employees of a covered employer may have no occupational exposure. For example, occupational exposure typically does not exist where a hospital employee works only in an office environment separated from patient care facilities or works only in other areas separate from those where the risk of ATD transmission, whether from patients or contaminated items, would be elevated without protective measures. It is the task of employers covered by this standard to identify those employees who have occupational exposure so that appropriate protective measures can be implemented to protect them as required. Employee activities that involve having contact with or being within exposure range of cases or suspected cases of ATD, are always considered to cause occupational exposure. Similarly, employee activities that involve contact with, or routinely being within exposure range of, at-risk populations are considered to cause occupational exposure. Employees working in laboratory areas in which ATP are handled or reasonably anticipated to be present are also considered to have occupational exposure

AB. **Physician or other licensed health care professional (PLHCP)** means an individual whose legally permitted scope or practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all health care services required by this section.

AC. **PPD (Purified Protein Derivative):** The substance used in a skin test to determine presence of hypersensitivity to tuberculin protein, signifying exposure to the organism

AD. **IGRA (Interferon Gamma Release Assay):** A blood test that screens for tuberculosis (TB) bacteria

AE. **Referral**: The directing or transferring of a possible ATD case to another facility, service or operation for the purposes of transport, diagnosis, treatment, isolation, housing or care.

AF. **Reportable aerosol transmissible disease (RATD)**: A disease or condition which a health officer, in accordance with Title 17 CCR, Division 1, Chapter 4, and which meets the definition of an aerosol transmissible disease (ATD)

AG. **Respirator**: A device which has met the requirements of 42 CFR Part 84, has been designed to protect the wearer from inhalation of harmful atmospheres, and has been approved by NIOSH for the purpose for which it is used

AH. **Respiratory Hygiene/Cough Etiquette in Health Care Settings: Respiratory Hygiene/Cough Etiquette in Health Care Settings,** CDC, November 4, 2004, which is hereby, incorporated by reference for the sole purpose of establishing requirements for source control procedures

AI. **Risk:** The likelihood of an individual acquiring or having acquired TB by virtue of behavior, underlying medical condition, occupation, international travel, personal contact or

socioeconomic conditions

AJ. **Screening (health care provider):** The initial assessment of persons who are potentially AirID or ATD cases by a health care provider in order to determine whether they need airborne infection isolation or need to be referred for further medical evaluation or treatment to make that determination. Screening does not include diagnostic testing

AK. **Screening (non-health care provider):** The identification of potential ATD cases through readily observable signs and the self-report of patients or clients. Screening does not include diagnostic testing

AL. **Significant exposure:** An exposure to a source of ATPs or ATP-L in which the circumstances of the exposure make the transmission of a disease sufficiently likely that the employee requires further evaluation by a PLHCP

AM. **Source control measures:** The use of procedures, engineering controls, and other devices or materials to minimize the spread of airborne particles and droplets from an individual who has or exhibits signs or symptoms of having an ATD, such as persistent coughing

AN. **Surge:** A rapid expansion beyond normal services to meet the increased demand for qualified personnel, medical care, equipment, and public health services in the event of an epidemic, public health emergency, or disaster

AO. **Susceptible person:** A person who is at risk of acquiring an infection due to a lack of immunity as determined by a PLHCP in accordance with current CDC or California Department of Health guidelines

AP. **Suspected case:** Either of the following:

1. A person whom a health care provider believes, after weighing signs, symptoms, and/or laboratory evidence to probably have a disease or condition listed in Section
    a. IV. A. 6 of the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases

2. A person who is considered a probable case, or an epidemiologically- linked case, or who has supportive laboratory findings under the most recent communicable disease surveillance case definition established by CDC and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements as applied to a particular disease or condition listed in Section IV. A. 6 of the California Code of Regulations, Title 8, Section 5199, Aerosol Transmissible Diseases

AQ. **TB or *M. tb***: The organism *Mycobacterium tuberculosis*, the causative agent of the infection which leads to disease of people infected

AR. **TB conversion**: A change from negative to positive as indicated by TB test results, based upon current CDC or California Department of Public Health guidelines for interpretation of the TB test

AS. **TB transmission**: The spread of TB from one person to another. This occurs via the airborne route by inhalation of droplet nuclei, small (1-5 micron) residual of aerosols suspended in air exhaled by a person with active disease. Most TB is transmitted by patients not known to have active disease, but who in fact have cavitary, pulmonary, laryngeal disease, by coughing, speaking, singing, or spitting. Individuals with exposure to air contaminated in such a way have a risk of acquisition of organisms proportionate to the degree of contamination of the air and

the total volume of that air inhaled. Highest risk of acquisition is in household settings, or enclosed locations of poor ventilation, such as shelters, aircraft or older engineered facilities

AT. **Treatment**: The use of chemotherapy to kill ATD in patients or employees with disease, including chemoprophylaxis

AU. **Test for Tuberculosis Infection (TB Test)**: Any test, including the tuberculin skin test (TST) and blood assays for M. Tuberculosis (BAMT) such as interferon gamma release assays (IGRA) which: (1) has been approved by the Food and Drug Administration for the purposes of detecting tuberculosis infection, and (2) is recommended by the CDC for testing for TB infection in the environment in which it is uses, and (3) is administered, performed, analyzed and evaluated in accordance with those approvals and guidelines

AV. **Tuberculosis (TB or *M. tb*)**: A disease caused by *M. tuberculosis*

III. PLAN MANAGEMENT

A. **Plan Elements**

1. LIST OF ALL HIGH HAZARD PROCEDURES AND JOB CLASSIFICATIONS

a. High hazard procedures are procedures performed on an ATD case or suspected case where the potential for being exposed to an aerosol transmissible pathogen (ATP) is increased due to the reasonably anticipated generation of aerosolized pathogens. A procedure is also considered high hazard if generation of aerosolized pathogens is reasonably anticipated when performed on a laboratory specimen suspected of containing an aerosol transmissible pathogen-laboratory (ATP-L).

i. A Powered Air Purifying Respirator (PAPR) is required upon entering an airborne isolation room (AIIR) for high hazard procedures with patients with suspected or confirmed diseases transmitted via the airborne route

ii. PAPR, eye protection (per employee preference), gloves, fluid resistant gown hand hygiene and an AIIR room* are required during a high hazard procedure on a patient with a suspected or confirmed aerosol transmissible infectious disease (AirID). Where no AII room or area is available and the treating physician determines that it would be detrimental to the patient's condition to delay performing the procedure, high hazard procedures may be conducted in other areas. In that case, employees working in the room or area where the procedure is performed shall use all necessary personal respiratory protection and personal protective equipment. The physicians determination shall be documented and reviewed annually.
Reference/link: Aerosol Transmitted Diseases Pathogens list
Reference/ link: ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS

b. SVHMC has complied a list of all high hazard procedures performed at

c. this facility, conducted a risk assessment for these high hazard procedures, analyzed job classification and job tasks that employees perform and operations with potential exposure, including required PPE for each task, see table below:

High Hazard Procedure	Job Classifications & Operations With Potential Exposure	Required PPE
Endotracheal Intubation/ Extubation	Physicians, Nursing, Respiratory Therapy, Phlebotomy, Diagnostic Imaging	PAPR or higher (AirID)
Airway Surgeries (e.g., ENT, thoracic, transsphenoidal surgeries)	Physicians, Nursing, Respiratory Therapy, Cardiac Perfusionist	PAPR or higher (AirID)
Chest Compressions	Physicians, Nursing, Respiratory Therapy, Phlebotomy	PAPR or higher (AirID)
Nebulization	Physicians, Respiratory Therapy, Nursing	PAPR or higher (AirID)
High Flow oxygen, including nasal cannula at >6L or 15L	Physicians, Respiratory Therapy, Nursing	PAPR or higher (AirID)
Non-invasive positive pressure ventilation (e.g. CPAP, BiPAP)	Physicians, Respiratory Therapy, Nursing	PAPR or higher (AirID)
Oscillatory ventilation	Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)
Bronchoscopy	Endoscopy/ OR Clinical Staff, Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)
Sputum Induction	Physicians, Respiratory Therapy, Nursing	PAPR or higher (AirID)
Open suctioning of tracheostomy or Endotracheal tube	Physicians, Respiratory Therapy, Nursing	PAPR or higher (AirID)
Manual ventilation (e.g. bag-mask ventilation before intubation) and Ventilator circuit manipulation	Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)

Disconnecting patient from ventilator	Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)
Upper endoscopy (including transesophageal echocardiogram)	Endoscopy/ OR Clinical Staff, Diagnostic Imaging Clinical Staff, Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)
Endoscopy	Endoscopy/ OR Clinical Staff, Diagnostic Imaging Clinical Staff , Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)
Venturi mask with cool aerosol humidification	Physicians, Nursing, Respiratory Therapy	PAPR or higher (AirID)
All other surgical, lab or clinical procedure that aerosolizes pathogens		

The following are not considered aerosol-generating:

- Non-rebreather, face mask, or face tent up to 15L
- Humidified trach mask up to 20L with in-line suction
- Routine trach care (e.g., replacing trach mask, changing trach dressing)
- In-line suctioning of endotracheal tube
- Routine Venturi mask without humidification
- Coughing
- Suctioning of oropharynx
- Tracheostomy change
- Cesarean delivery, post-partum hemorrhage, second stage of labor
- Nasopharyngeal swab
- Proning is not inherently aerosol-generating but aerosols are possible if the endotracheal tube becomes disconnected during the proning process

B. **Plan Management**

1. LIST OF ALL ASSIGNMENTS OR TASKS REQUIRING PERSONAL OR RESPIRATORY PROTECTION

    a. SVHMC utilizes feasible engineering controls and work practice controls to reduce employee exposure to aerosol transmissible pathogens. However, when those controls are not sufficient, SVHMC provides personal protection or respiratory protection to the employees performing those tasks. In some cases, the minimum requirement of an N95 respirator is

sufficient, but in other cases, higher-level protection is required, such as a powered air-purifying respirator (PAPR).

b. SVHMC requires employees to wear personal or respiratory protection when conducting certain assignments or tasks in certain SVHMC Staff Roles for protection against ATD.
Reference/link: SVHMC Job Titles 2024-2025

2. METHODS OF IMPLEMENTATION

a. SVHMC's methods of implementing requirements for engineering and work practice controls, PPE, respiratory protection, medical services, training, and record-keeping are described below.

b. **Engineering and Work Practice Controls, and PPE**

i. The best method to control employee exposure to ATPs is to use engineering controls and work practice controls. If those do not provide sufficient protection, then SVHMC provides personal protective equipment (PPE) and/or respiratory protection and ensures that employees use them. For some tasks, use of both respiratory protection and engineering or work practice controls may be required.

ii. Work practices will be implemented in accordance with Appendix A of section 5199, which categorizes pathogens as requiring airborne and/or droplet precautions. Where Appendix A does not address the exposure, SVHMC will use protections in accordance with the CDC Guideline for Isolation Precautions for droplet and contact precautions. For airborne precautions, procedures will be in accordance with the CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings.
Reference/link: CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings.

iii. SVHMC uses the following types of engineering and work practice controls to protect employees from ATD exposures: use of AIIR rooms and converting standard patient rooms to an AIIR by installing a portable HEPA filter device, and balancing the HVAC airflow to achieve negative pressure, when necessary.
Reference/link: ISOLATION - STANDARD AND TRANSMISSION BASED PRECAUTIONS

iv. When working with an AirID or suspected AirID patient, employees will properly wear personal protective equipment. Job classifications are categorized into three categories (see **SVHMC Job Titles 2024-2025** for a table of job classifications in which an occupational exposure for occupational exposure to ATD):

a. **CATEGORY I – HAVE EXPOSURE:** Job classifications in which **ALL** employees have potential occupational

exposure to ATD/ATP

b. **CATEGORY II – POTENTIAL EXPOSURE:** Job classifications in which **SOME** employees have potential occupational exposure to ATD/ATP

c. **CATEGORY III – NO EXPOSURE:** Job classifications in which **NO** employees have occupational exposure to ATD/ATP. Job classifications not listed are considered to be category III.

i. **Reference/link: SVHMC Job Titles 2024-2025**

v. Surfaces may become contaminated with ATPs after contact with individuals with AirID. Contaminated surfaces enable the spread of infectious disease agents and can be a source of infection to employees until they are cleaned and disinfected. SVHMC ensures that employees use appropriate EPA-registered disinfectant(s) to clean and disinfect the following surfaces, including equipment as soon as feasible after contact with infectious persons (*include types of surfaces and equipment to be disinfected, and the period*):
Reference/link:

a. MEDICAL EQUIPMENT CARE, CLEANING AND MAINTENANCE

b. SPECIAL PROCEDURES ROOMS/AREAS - PROCEDURE

c. STEP BASE CLEANING PROCEDURE

d. TERMINAL CLEANING OF SURGICAL SUITES PROCEDURE

e. PATIENT ROOM CLEANING - DISCHARGE/TRANSFER PROCEDURE

f. PATIENT ROOM CLEANING - OCCUPIED PROCEDURE

g. PATIENT ROOM ISOLATION PROCEDURE

h. PEDIATRIC DEPARTMENT CLEANING PROCEDURE

i. PERSONAL PROTECTION EQUIPMENT - CARE & USE PROCEDURE

c. **Engineering Controls**

i. AirID cases or suspected cased shall be identified and these individuals shall be:

a. Provided with disposable tissues and hand hygiene materials and masked or placed in such a manner that contact with employees who are not wearing respiratory protection is eliminated or minimized until transfer or placement in an AII room or area can be

accomplished and;

b. Placed in an AII room or area or transferred to a facility with AII rooms or areas.

ii. If admission is required, the transfer to an airborne infection isolation room or other suitable area within the facility shall occur within 5 hours of identification.

iii. If Airborne Infection Isolation Rooms (AIIR)s are not available to accommodate a transfer in the facility, SVHMC will follow our procedures to transfer AirID cases and suspected cases to an AIIR at another facility. The procedures are described in detail in the "Referral and Transfer of AirID Cases" section of this program.

iv. Exceptions:

a. Where it is not feasible to provide AII rooms or areas to individuals suspected or confirmed to be infected with, or carriers of novel or unknown ATPs, then SVHMC shall provide other effective control measures to reduce the risk of transmission to employees, which shall include the use of respiratory protection.

b. Where the treating physician determines that transfer would be detrimental to a patient's condition, the patient need not be transferred. In that case, the facility shall ensure that employees use respirator protection when entering the room or area housing the individual. The patient's condition shall be reviewed at least every 24 hours to determine if transfer is safe, and the determination shall be recorded. Once transfer is determined to be safe, transfer must be made within the time period set forth above.

v. High hazard procedures shall be conducted in AII rooms or areas, such as a ventilated booth or tent. Persons not performing the procedures shall be excluded from the area, unless they use the respiratory and personal protective equipment required for employees performing these procedures.

a. Exception- Where no AII room or area is available and the treating physician determines that it would be detrimental to the patient's condition to delay performing the procedure, high hazard procedures may be conducted in other areas. In that case, employers working in the room or area where the procedure is performed shall use respiratory protection and all necessary personal protective equipment.

vi. **The location(s) of airborne infection isolation rooms:** 329, 429, 529, 537

vii. Airborne infection isolation rooms must be kept at a negative pressure (at least -0.01"H_2O) to prevent pathogens from escaping to the adjacent hallway or other rooms. The ventilation rate will be 12 air changes per hour (ACH). If AIIRs are unable to actually supply 12 ACH so SVHMC attains the required ventilation rate by using a ventilation rate of minimum of 6 or 12 ACH supplemented by the following additional air cleaning technology. Portable ventilation unit with HEPA filtration. If an AIIR is capable of switching between negative pressure mode and normal ventilation mode, SVHMC will ensure that it is switched to negative pressure mode before transferring an AirID patient to the room.

viii. **Reference/link**:

   a. Air Exchange Process

   b. TUBERCULOSIS (TB) PREVENTION AND CONTROL

ix. During the time that an AIIR is used for airborne infection isolation, the doors and windows will be kept closed except when the doors are opened for entering and exiting the room to achieve the required level of negative pressure.

x. During the time that an AIIR is being used for isolation of an AirID patient, SVHMC performs daily checks of the airflow using a vaneometer or other equally effective method to ensure that the room is under negative pressure. To accomplish this, SVHMC uses the following procedure:

xi. If using an electronic device to conduct the visual check, SVHMC ensures that it shows the direction of airflow at the required level (at least -0.01" H2O). SVHMC also calibrates the instrument annually. This is done only for our permanently dedicated AIIRs.

xii. Siemens Building Technologies Division l Fire Life Safety performs inspection and maintenance on our airborne infection isolation rooms monitors. This includes monitoring the performance of the system, including exhaust, recirculation filter loading, and leakage. This is performed at least annually, whenever filters are changed, and more often if necessary to maintain effectiveness.

xiii. If any problems are found, SVHMC ensures that they are corrected in a reasonable period of time. If the problem(s) prevent the room from providing effective airborne infection isolation, then SVHMC will not use the room for that purpose until the condition is corrected.

xiv. If HEPA filters are used, SVHMC change the filters on the

following schedule:

xv. **Reference/link**:

a. ENGINEERING/BIOMEDICAL MAINTENANCE WORK ORDERS PROCEDURE

b. SCOPE OF SERVICE: BIOMEDICAL SERVICES

xvi. SVHMC also ensures that the AIIR and accompanying ductwork are installed in a manner consistent with requirements so that the equipment run properly and the air exhausts properly, away from people and HVAC air intakes, so to not inadvertently expose more people to contaminants.

xvii. When an AirID case or suspected case vacates an AIIR room or area, SVHMC will ensure that the AIIR is ventilated for the minimum amount of time required for 99.9% of potential airborne contaminants to be exhausted or filtered from the air prior to allowing anyone to enter without respiratory protection. At 12 air changes per hour, this requires running the ventilation system with no one in the room for a minimum of 30 minutes prior. Our policy is to ventilate the AIIR for 30 to 60 minutes.

xviii. **Reference/Link:**

a. TUBERCULOSIS (TB) PREVENTION AND CONTROL

b. CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings

d. **Respiratory Protection**

i. When employees must wear respiratory protection to guard against aerosol transmissible pathogens, SVHMC ensures that they only use NIOSH-certified respirators that are approved for that purpose in accordance with the Respiratory Protection Program.
Reference/link: HEALTHCARE WORKER RESPIRATORY PROTECTION PROGRAM

ii. In most situations where respiratory protection is needed, SVHMC will ensure that employees use a respirator at least as protective as an N95 filtering face piece respirator. However, for high hazard procedures (aerosol-generating procedures) performed on AirID cases or suspected cases, SVHMC will utilize PAPRs with high-efficiency particulate air (HEPA) filters or equivalent or better unless SVHMC determines that this would interfere with the success of the procedure or task.

iii. If SVHMC determines that use of a PAPR would interfere with the success of a particular procedure or task, SVHMC will conduct a risk assessment to document this determination. Each case will be determined on a case-by-case basis in

collaboration with Environmental Health & Safety Manager, Infection Prevention/Infectious Diseases, and Employee Health Director. The case reviews will be maintained in accordance with the CHA Records Retention Schedule.

iv. All determinations will be reviewed during the annual ATD exposure control plan review; this will be performed through the Environment of Care Committee (EOCC).

v. SVHMC stays apprised of current recommendations for specific diseases, such as Ebola and makes respiratory controls available as appropriate to the disease.

vi. SVHMC provides N95 and/or PAPR for employees during high hazard procedures performed on patients requiring droplet precautions.

vii. The diseases requiring droplet precautions use of respiratory protection when conducting high hazard procedures includes (this is a dynamic list and other will be included as necessary: **Reference/Link**: Aerosol Transmitted Diseases, Pathogens List

viii. SVHMC provides N95 and/or PAPR for employees during high-hazard procedures performed on airborne infectious disease cases or suspected cases.

ix. SVHMC requires employees to wear respirators at least as effective as N95 filtering facepiece respirators when conducting certain procedures on or around ATD patients, as required by section 5199. Even when that standard does not require a respirator, such as in the case of high-hazard procedures performed on patients requiring droplet precautions, SVHMC evaluates each situation, including the pathogens, to determine whether to require respiratory protection. The following represents the types of respirators available to employees when required.

x.

Procedure	Type(s) of Respiratory Protection Used
Entering AIIR in use for airborne infection isolation	PAPR preferred, N95 if PAPR not available or impedes patient care.
Being present during the performance of procedures or services for an AirID case or suspected case	PAPR preferred, N95 if PAPR not available or impedes patient care
Repairing, replacing, or maintaining air systems or equipment that may	PAPR preferred, N95 if PAPR not available

contain or generate aerosolized pathogens	or impedes patient care
Working in an area occupied by an AirID case or suspected case	PAPR preferred, N95 if PAPR not available or impedes patient care
Decontaminating an area after an AirID case or suspected case has left the area or being present during the decontamination	PAPR preferred, N95 if PAPR not available or impedes patient care
Entering an AIIR while it is being ventilated after an AirID case or suspected case has vacated	PAPR preferred, N95 if PAPR not available or impedes patient care
Working in a residence where an AirID case or suspected case is known to be present	PAPR preferred, N95 if PAPR not available or impedes patient care
Being present during the performance of aerosol generating procedures on cadavers that are suspected of, or confirmed as, being infected with aerosol transmissible pathogens	PAPR preferred, N95 if PAPR not available or impedes patient care
Transporting an AirID case or suspected case within the facility.	PAPR preferred, N95 if PAPR not available or impedes patient care

xi. SVHMC does not require or permit employees to wear a respirator when operating a vehicle if the respirator may interfere with the safe operation of the vehicle. SVHMC will provide these other means of protection where feasible (e.g., barriers or source control measures): N95

xii. Before having our employees, use a respirator, SVHMC will provide them with a no-cost medical evaluation designed to determine if they are medically capable of SVHMC wearing a respirator without overburdening them. This will be completed before the employee is fit tested.

e. **Medical Evaluations for Respirator Use**

i. For employees who will wear respirators (minimum of N95 or PAPR) solely for protection against aerosol transmissible pathogens, SVHMC provides the medical evaluation to employees by using the Respirator Medical Evaluation

Questionnaire completed through Employee Health electronic health record.

ii. SVHMC will have the medical evaluation questionnaire reviewed by a licensed health care provider (PLHCP) in Employee Health or other designated PLHCP (RN, Nurse Practitioner, MD)
If employees need a follow-up examination based on the questionnaire responses, SVHMC will request follow up with their primary care physician or SVHMC occupational health provider.

f. **FIT Tests**

i. SVHMC conducts fit testing for employees before they are required to wear a respirator. An employee's fit testing will be performed using the same size, make, model, and style of respirator that the employee would actually wear. The fit test will be performed under the supervision of Employee Health:

ii. Fit testing at SVHMC is performed using a qualitative method. If fit testing single use respirators for multiple employees, SVHMC will ensure that each employee is fit tested using a new respirator.

iii. SVHMC conducts fit tests for each employee according to the following schedule:

a. At the time of initial fitting;

b. When a different size, make, model, or style of respirator is used;

c. At least annually thereafter; and

d. When the employee reports, or when SVHMC, a physician or other licensed health care provider (PLHCP), supervisor, or program administrator makes visual observations of changes in the employee's physical condition that could affect respirator fit, such as facial scarring, dental changes, cosmetic surgery, or obvious change in body weight.

iv. If, after passing a fit test, an employee reports, that the respirator is not acceptable, SVHMC will evaluate with the employee to determine the most acceptable respirator.

v. SVHMC provides employees with training on the following topics:

a. Why the respirator is necessary and how improper fit, usage, or maintenance can compromise the protective effect of the respirator.

b. What the limitations and capabilities of the respirator are.

c. How to use the respirator effectively in emergencies, including situations in which the respirator malfunctions.

d. How to inspect, put on and remove, use, and check the seals of the respirator.

e. What the procedures are for maintenance and storage of the respirator.

f. How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators.

g. Information on vaccinations.

h. N95 respirator vs. surgical mask

i. Respiratory re-use

vi. This training is provided to employees if required to wear a respirator initially and annually thereafter. SVHMC retrains employees as necessary but at least if changes in the workplace or the initial type of respirator is obsolete.

g. **Laboratory Operations**

i. SVHMC employees engaged in laboratory operations that include procedures that may aerosolize transmissible pathogens-laboratory (ATP-L) follow LABORATORY AEROSOL TRANSMISSIBLE PATHOGENS POLICY - OSHA.

ii. SVHMC has conducted a risk assessment in accordance with the Bio-Safety in Microbiological and Biomedical Laboratories (BMBL).

h. **Summary of Control Measures**

i. The table in Attachment C (Matrix of Department related Tasks & Procedure Involving Occupational Exposure & Exposure Controls for Aerosol Transmitted Diseases) summarizes the control measures we use in each operation or work area in which occupational exposures may occur.

i. **Source Control Measures**

i. Early identification of ATD cases or suspected cases is critical to ensure that employees have as little unprotected contact as possible, thereby reducing the risk of becoming infected.

ii. If SVHMC observes respiratory infection symptoms in a patient or other person, utilize source control measures to protect our employees from contracting the illness. These include a combination of engineering controls, such as placing the patient in a separate room or area; procedures, such as providing and having the suspected ATD case wear a surgical mask; and work practice controls, such as limiting contact with the suspected

ATD person.

iii. SVHMC is a fixed-site health care facility, and has incorporated the recommendations contained in the CDC's Respiratory Hygiene/Cough Etiquette in Health Care Settings.
Reference/link: Respiratory Hygiene/Cough Etiquette in Health Care Settings.

iv. SVHMC utilizes the following source control measures to prevent the spread of aerosol-transmissible pathogens:

a. Visual alerts (*e.g., signs telling people to cover their cough*):

i. Posters at major entry points, respiratory hygiene stations, and station signs throughout high traffic areas in the facility.

ii. Signage at the entrances requesting patients and persons accompanying them to inform the receptionist if they have a persistent cough.

b. SVHMC place the visual alerts at the following entrances and other locations (list locations if applicable): Hospital Main Lobby/waiting area, ED entrance/waiting area, Out-patient surgery waiting area, all waiting rooms for out-patient testing (Lab, Diagnostic imaging, etc.) and off-site locations waiting areas (Sleep Center, Wound Care Center, Infusion Center, CDOC, Cardiac Rehabilitation, Mammography, Taylor Farms)

c. Tissues provided in waiting areas, waste receptacle in waiting areas, handwashing facilities including soap and water accessible to patients and visitors, and alcohol-based hand sanitizer or other antiseptic hand wash in waiting areas.

d. Provide individuals exhibiting symptoms of aerosol transmissible disease with a surgical or procedure mask, instruct them in proper use, and limit contact with said individuals.

e. Separate symptomatic individuals from others in the same room by distance (at least 3 to 6 feet away from others).

v. SVHMC ensures the concierge staff, and reception staff who may be the first employees to encounter a patient or other person entering the facility, are knowledgeable in observing for signs and symptoms of ATD.

vi. Other source control methods / procedures include the following

policies and/or procedures:

a. VISITOR POLICY
b. Hospital Screening/Visitor Management Process

j. **Contract Employees**

i. SVHMC is required to provide information about infectious disease hazards to contractors who provide us with temporary or contract employees who may be reasonably anticipated to have occupational exposure so that these employers may take precautions to protect their employees. The electronic Vendor software system is utilized to assure contractors / vendors have review the required documents and upload vaccination status. **Reference/link**: VENDOR, CONTRACTOR, AND AGENT PARTICIPATION IN HOSPITAL COMPLIANCE PROGRAM

k. **Referral and Transfer of AirID Cases to Airborne Infection Isolation Rooms (AIIR) or Facilities**

i. In order to best protect employees from contracting infections from AirID or suspected persons, SVHMC strives to identify these individuals as quickly as possible.

ii. After identifying an individual as an AirID or suspected, SVHMC will continue to use the previously described source control measures and isolate the patient by masking them or placing them in a location where they will not contact employees who are not wearing respiratory protection until they can be transferred to an airborne infection isolation room (AIIR).

iii. SVHMC takes the following measures to reduce the risk of ATD transmission to our employees. This includes constant observation of standard precautions as well as other protective measures.

iv. In the Emergency Department, SVHMC temporarily isolates the person requiring airborne isolation in rooms 19 and 20, which are equipped with a large industrial Hepa filter that vents outside. Once admitted, SVHMC places the individual in an airborne infection isolation room or area as soon as one of the following inpatient rooms are available: 329, 429, 529, and 537.

v. SVHMC employees wear NIOSH-certified N95 filtering face piece or PAPR hood with P100 filter when entering the room.

vi. If an Airborne Infection Isolation Room (AIIR) is not available, SVHMC assesses current occupancy and transfers a non-infectious patient to a non AIIR. If no AIIR is available, the patient will be placed in a private room with a HEPA filter. If SVHMC has maximized resources and has no other available AIIR or HEPA filters, then a request for transfer to another facility will be initiated.

vii. The goal is to transfer to another facility within 5 hours of identification, unless SVHMC documents, at the end of the 5 hour period and at least every 24 hours thereafter, the following:

a. Case Management, or designee, will facilitate the transfer of the patient and documents:

i. There are no AII room or area available within that jurisdiction.

ii. Reasonable efforts have been made to contact establishments outside of the jurisdiction.

iii. All applicable measures recommended by the local health officer or the Infection Control PLHCP have been implemented.

b. All personnel who enter the room or area housing the individual are provided with, and use, appropriate personal protective equipment and respirator protection.

c. In the event that there are no available accepting facilities, then SVHMC will continue to arrange transfers until successful or patient condition changes.

d. SVHMC will document and maintain a transfer attempt in the Electronic Medical Record and/or All-scripts.

viii. The Administrative Supervisor contacts the Infection Prevention Department or designee for any Airborne Infectious Disease (AirID) suspected case. Infection Prevention will contact the local health officer.

a. The phone number for the local health officer is 831-755-4521

ix. These are the names and contact information for facilities with AIIR or areas within the local area that will be contacted in the event of referral

x.

Facility	Contact Information
Natividad Medical Center	Transfer Center (855) 445-7872
Hazel Hawkins	ED: 831-636-2640
	Hazel Hawkins House Supervisor (Inpt Transfers): 831-902-0482
CHOMP	831-624-5311 (Ask for House Supervisor)
Mee Memorial	ED: 831-385-7220

	Mee Memorial House Supervisor (Inpt Transfers): 831-821-1634
Dominican Hospital	Transfer Center 855-455-7872

xi. These are the names and contact information for facilities with AIIR or areas outside the local jurisdiction that will be contacted in the event of referral and no AII rooms are available within our local jurisdiction.

xii.

Facility	Contact Information
UCSF Transfer Center	415-353-9166
Stanford Transfer Center	800-800-1551
Santa Clara VMC Transfer Center	408-885-4495

xiii. **There are two exceptions to the requirement to transfer an AirID patient to an AIIR:**

a. Where it is not feasible to provide AII rooms or areas to individuals suspected or confirmed to be infected with or carriers of novel or unknown aerosol transmissible pathogens (ATPs), the employer must provide other effective control measures to reduce the risk of transmission to employees, which must include the use of respiratory protection in accordance with subsection (g) and section 5144, Respiratory Protection.

b. Where the treating physician determines that transfer would be detrimental to a patient's condition, the patient need not be transferred. In that case, the facility must ensure that employees use respiratory protection when entering the room or area housing the patient. The patient's condition must be reviewed at least every 24 hours to determine if transfer is safe, and the determination must be recorded as described in the Plan, in accordance with subsection (d)(2)(G). Once transfer is determined to be safe, transfer must be made within the time period set forth in subsection (e)(5)(B).

i. Decisions not to transfer a patient for AII

i. SVHMC will maintain records of any decisions not to transfer a patient to another facility for AII for medical reasons. The following will be documented in the patient's chart:

i. Name of the physician determining that the patient was not able to be transferred.

ii. Date and time of the initial decision.

iii. Date and time of each daily review and identity of the person(s) who performed them.

iv. This summary record will not include a patient's individually identifiable medical information. SVHMC will retain these records according to the Records Retention Policy.

xiv. All transfers to external facilities will be completed in compliance with the following policies/procedures:

a. INTRAFACILITY TRANSPORT - NEWBORN CLINICAL PROCEDURE

b. MATERNAL TRANSPORT-TERTIARY CARE AND TRANSFER OF PATIENT

c. NICU TRANSPORT: CARE PRACTICES FOR TRANSPORT

d. EMTALA

l. **Medical Services**

i. SVHMC provides employees with no cost medical services in-house, that include vaccinations, TB testing, and post-exposure medical services and follow-up. Employees will be sent to:

a. Employee Health Services or Administrative Nursing Supervisor, Emergency Department, other designated care provider. Details about the medical services related to ATDs that SVHMC offers to employees are in the "Medical Services" section of this written plan.

b. **Reference/link**:

i. EMPLOYEE HEALTH SERVICES

ii. EMPLOYEES EXPOSURES & PREVENTION PLANS: SPECIFIC DISEASE EXPOSURES AND WORK RESTRICTIONS

iii. HEALTHCARE WORKER IMMUNIZATIONS & IMMUNITY REQUIREMENTS

ii. SVHMC provides medical services at no cost to our employees who have occupational exposure to aerosol transmissible disease. These medical services, including vaccinations, tests, examinations, evaluations, determinations, procedures, and medical management and follow-up, will meet the following conditions:

a. Performed by or under the supervision of a physician or other licensed health care provider (PLHCP).

b. Provided according to applicable public health guidelines.

c. Provided in a manner that ensures the confidentially of employees and patients.

d. Notification to employees who had significant exposure of the date(s), time and nature of the exposure.

iii. **Vaccinations**

a. Vaccination is a safe, effective, and reliable method of controlling the spread of infectious diseases where a vaccine is available. When the number of susceptible health care workers is decreased by vaccination, it also helps to prevent transmission of illness to patients and others. Therefore, vaccinations are available to employees at no cost during their work hours and encourages employees to receive them.

b. Employees are not required to participate in a prescreening serology program prior to receiving a vaccine unless applicable public health guidelines recommend prescreening prior to administration of the vaccine. Vaccinations are available to employees after they receive training and within 10 working days of initial assignment unless one of the following conditions exists:

i. The employee has previously received the recommended vaccination(s) and is not due to receive another vaccination dose.

ii. A PLHCP has determined that the employee is immune in accordance with applicable public health guidelines.

iii. The vaccine(s) is contraindicated for medical reasons.

iv.

Vaccine	Schedule
Influenza	**One dose annually**
Measles	**Two doses**
Mumps	**Two doses**
Rubella	**One dose**
Tetanus, Diphtheria, and Acellular Pertussis (Tdap)	**One dose, booster as recommended**
Varicella-zoster (VZV)	**Two doses**
COVID-19	**Schedule per CDC/CDPH guidelines**

v. **Reference/link**: HEALTHCARE WORKER IMMUNIZATIONS & IMMUNITY REQUIREMENTS

c. SVHMC shall make additional vaccine doses available to employees within 120 days of the issuance of new applicable public health guidelines recommending the additional dose.

d. SVHMC shall not make participation in a prescreening serology program a prerequisite for receiving a vaccine, unless applicable public health guideline recommends this prescreening prior to administration of the vaccine.

e. If the employee initially decline a vaccination but, at a later date, while still covered under 8 CCR 5199, decides to accept the vaccination, then SVHMC shall make the vaccination available within 10 working days of receiving a written request from the employee.

f. SVHMC shall ensure that employees who decline to accept a recommended and offered vaccination sign the declination statement for each offered vaccine.

g. SVHMC requests the PLHCP administering a vaccination tor determining immunity to provide only the following information to the employee:

i. The employee's name and employee identifier.

ii. The date of the vaccine dose or determination of immunity.

iii. Whether the employee is immune to the

disease, and whether there are any specific restrictions on the employee's exposure or ability to receive the vaccine.

iv. Whether an additional vaccination dose is required, and if so, the date the additional vaccination dose should be provided.

h. EXCEPTION: Where SVHMC cannot implement these procedures because of the lack of availability of vaccine, then SVHMC shall document efforts made to obtain the vaccine in a timely manner and inform employees of the status of the vaccine availability, including when the vaccine is likely to become available. SVHMC shall check on the availability of the vaccine every 60 calendar days and inform employees when the vaccine becomes available.

i. EHS manages all employee vaccinations, including declinations, with information maintained in the EHS electronic medical record system. Employees receiving vaccinations at another facility will be requested to supply vaccination records and may be required to complete the SVHMC Declination form

iv. **LTBI Assessment**

a. A latent tuberculosis infection (LTBI) is a condition when the individual infected with the M. tuberculosis bacteria does not exhibit symptoms and cannot spread the infection to others. However, approximately 5 to 10% of these people will develop active, potentially contagious TB disease if untreated. LTBI screening helps to ensure that employees are provided with appropriate treatment for new TB infections and to identify previously unidentified occupational exposures.

b. Latent TB infection screening (the TB skin test, TB blood test, and TB screening questionnaire) is offered annually to all employees with reasonably foreseeable occupational exposures to ATD, including. those whose occupational exposure risk is greater than that of employees in public contact operations that are not included within the scope of the ATD standard.

c. Employee Health Services, in collaboration with Infection Diseases is responsible for implementing the TB screening procedures.

d. Employees with a baseline positive TB test will receive an annual symptom screening questionnaire. If

questionnaire results indicate further testing is needed, SVHMC offers that employee a follow up screening (PPD or chest x-ray) using the following procedures:

i. If an employee experiences a TB conversion, SVHMC refers them to the following:
    i. PLHCP knowledgeable about TB for evaluation, which may include SVHMC occupational health provider, an infectious disease provider or their primary care physician.

ii. In the event of a TB conversion, EHS will:
    i. Provide the PLHCP employee's TB test records. If EHS / Infection Prevention has identified the source of the infection, the PLHCP will be provided available diagnostic test results including drug susceptibility patterns relating to the source patient.
    ii. The PLHCP, with the employee's consent, performs any necessary diagnostic tests and informs the employee about appropriate treatment options.

iii. The PLHCP determines if the employee is an active TB case or suspected case, and to do all of the following, if the employee is a case or suspected case:
    i. Inform the employee and the local Health Officer in accordance with title 17.
    ii. Consult with the local Health Officer to define infection control recommendations related to the employee's activity in the workplace, including precautionary removal. SVHMC complies with local Health Officer Recommendations for additional testing as applicable. Informs EHS of the recommendations.
    iii. The person who will receive

information from the PLHCP regarding infection control recommendations related to employees who are TB cases or suspected cases is Employee Health leadership/designee and/or Infection Prevention Manager/designee, who will then communicate the recommendations to the following managers or staff members, if applicable:

i. All clinical and non-clinical Directors/Managers, will communicate to the employees in their department.

iv. In the event of a TB conversion, SVHMC will also record the case on the Cal/OSHA Form 300 Log of Work-Related Injuries and Illnesses by placing a check in the "respiratory condition" column and entering "privacy case" in the space normally used for the employee's name. SVHMC will also investigate the circumstances of the conversion and correct any deficiencies in the procedures, engineering controls, or PPE.

iv. List the job titles and roles of staff involved in investigating the circumstances of the conversion and correcting deficiencies that may have led to the conversion: ATD Exposure Control Plan administrator(s), infection prevention manager/officer, employee health leader/coordinator, environmental health & safety manager; Clinical and non-clinical Directors and Managers will interview the employee(s), and review relevant patient records.

i. SVHMC will also document the investigation using the following

procedure: See below section for exposure incidents.

v. For all RATD and ATP-L exposure incidents, the written opinion will consist of only the following information:

i. The employee's test status or applicable RATD test status for the exposure of concern.

ii. The employee's infectivity status.

iii. A statement that the employee has been informed of the results of the medical evaluation and has been offered any applicable vaccinations, prophylaxis, or treatment.

iv. A statement that the employee has been told about any medical conditions resulting from exposure to RATD, or ATP-L that requires further evaluation and/or treatment and that the employee has been informed of treatment options.

v. Any recommendations for precautionary removal from the employee's regular assignment.

3. EXPOSURE INCIDENTS

a. In the event of an exposure incident, it is critical to inform exposed employees quickly and provide medical services in a timely manner to mitigate the severity of illness and limit the spread of infection.

b. An exposure incident is defined in this plan as an event where all of the following have occurred:

i. An employee has been exposed to an individual who is a case or suspected case of a reportable ATD (RATD) or to a work area or equipment that is reasonably expected to contain an aerosol transmissible pathogen associated with a reportable ATD.

ii. The exposure occurred without the benefit of applicable exposure controls required by the ATD standard.

iii. It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation.

iv. A reportable ATD (RATD) is an aerosol transmissible disease

that a health care provider is required to report to the local health officer.
Reference/Link: Aerosol Transmitted Diseases Pathogens List

c. In the context of this plan, a "health care provider" is a physician, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, an infection control practitioner, a medical examiner, or a dentist.

    i. The California Department of Public Health, Division of Communicable Disease Control home page includes the current list of RATDs. Contact information for the local health departments are also available on the CDPH page for the California Conference of Local Health Officers.

    ii. SVHMC is a health care provider. Therefore, when SVHMC determines that a person is an RATD case or suspected case, SVHMC will report the case to the local health officer, in accordance with title 17, observing the different time deadlines for different diseases.

    iii. Person responsible for reporting cases to the local health officer:

        a. Infection Prevention Manager/Director and/or Infection Prevention Coordinator.

        b. Contact information for the local health officer: 831-755-4521

    iv. SVHMC is required to notify our own employees who had significant exposure to the ATD case or suspected case. First, SVHMC conduct an analysis of the exposure scenario to determine which of our employees had significant exposure. This analysis will be completed within a time frame reasonable for the specific disease, but no later than 72 hours after either our report to the local health officer or our receipt of notification internally from SVHMC employee/department, or from another facility or local health officer of the exposure.

    v. The person responsible for conducting this analysis is:

        a. Infection Prevention Manager/Director in collaboration with Employee Health Manager/Director. Reviewed with Medical Director(s) of Infection Prevention and/or Employee Health.

    vi. Our procedures for conducting this analysis are as follows:

        a. Send an email to department leadership of affected departments and have each leader identify all the employees in their department(s) who may have been exposed;

        b. Leader(s) review records to see which employee(s)

had contact with the ATD case or suspected case;

c. Leader interviews employee(s), then submits line listing of exposed employees to Employee Health via email.

d. Employee health reviews information from each leader, interviews the employee(s) if needed, determines level of exposure based on leader/ employee information, then contacts each employee by email and/or phone, then determines exposure plan for that individual exposed.

e. Employee Health will refer an exposed employee based on the determination by PLHCP for testing, treatment and/or monitoring.

vii. SVHMC will document the analysis, recording the names and any other employee identifier used at the workplace of persons who SVHMC included in the analysis. SVHMC will also document the name of the person who made the determination and the identity of any PLHCP making the determination. This is our procedure for this documentation:

a. If the analysis determines that neither of the following conditions exist for an employee, then that employee does not require post-exposure follow-up, and SVHMC will also document the basis for the determination:

b. The employee did not have significant exposure.

c. Physician or other licensed health care provider (PLHCP) determined that the employee is immune to the infection.

viii. This is our procedure to document any determination that an employee does not require post-exposure follow-up:

a. Documentation will be in one or more of the following areas depending on if the exposure involves one or a group of employees:

i. Documentation of exposure follow up in shared electronic report accessible by Infection Prevention, Employee Health and Infection Prevention MD for review.

ii. Documentation in the employee EHR in Employee Health

ix. SVHMC will make the exposure analysis available to the local health officer upon request.

x. SVHMC will also determine, to the extent that the information is available in our records, whether any employees of other

employers may have been exposed to the case or suspected case. If so, SVHMC will notify the other employer(s) within a reasonable time-frame but no later than 72 hours after the report to the local health officer. This allows the other employer(s) time to conduct their own analysis to determine which of their employees had significant exposure and to provide their employee(s) with timely, effective medical intervention to prevent disease or mitigate the disease course.

xi. See the "Communicating with Other Employers Regarding Exposure Incidents" section below for our procedures to notify other employers that their employees may have had significant exposure while working at our facility.

xii. Upon determining which of our own employees had significant exposure, SVHMC will notify them of the date, time, and nature of their exposure, within a time-frame reasonable for the specific disease but no later than 96 hours of becoming aware of the potential exposure.

xiii. Notification to our employees who had significant exposure may occur by one or more of the follows communications:

   a. Department leader's notification to their staff regarding potential exposure and communication pending from Employee Health Services.
   b. Email notification sent via Employee Health EHR with instructions.
   c. Phone communication to those determined to have high-risk exposures by Employee Health.

xiv. As soon as feasible, SVHMC will provide all of our employees who had a significant exposure a post-exposure medical evaluation by a PLHCP knowledgeable about the specific disease, including appropriate vaccination, prophylaxis, and treatment.

xv. SVHMC will notify employees that they have the right to decline to receive the medical evaluation from us, and SVHMC will ensure that the employee receives post-exposure evaluation and follow-up from an outside PLHCP.

xvi. SVHMC will send employees to one or more of the following PLHCP for post-exposure medical evaluation and follow-up unless the employee declines Employee Health Services, Administrative Nursing Supervisor, Infection Prevention, Emergency Department, Occupational Health Provider or other designated PLHCP.

xvii. Employee Health Services RN or other designated healthcare provider will provide the following information to the PLHCP:

a. A description of the exposed employee's duties as they relate to the exposure incident;
The circumstances under which the exposure incident occurred;

b. Any available diagnostic test results, including drug susceptibility pattern or other information relating to the source of exposure that could assist in the medical management of the employee;

c. All of the employer's medical records for the employee that are relevant to the management of the employee.

xviii. SVHMC will request from the evaluating PLHCP an opinion on whether precautionary removal from the employee's regular job assignment is necessary to prevent the employee from spreading the disease agent and what type of alternative work assignment may be provided. SVHMC will request that any recommendation for precautionary removal be made immediately by phone, fax, and secure email and/or in writing.

xix. The person responsible for requesting and obtaining medical recommendation/opinion is:

a. Employee Health Services, or designee

xx. SVHMC will obtain and provide the employee a copy of the PLHCP written opinion within 15 working days of completion of all required medical evaluations.

xxi. If the PLHCP or local health officer recommends precautionary removal due to a related ATD exposure:

a. Workplace exposure: will follow the workers compensation process.

b. Non-work place exposure: will follow SVHMC medical leave process.

4. EVALUATION OF EXPOSURE INCIDENTS

a. After ensuring that the exposed employees receive required medical evaluations and follow-up, SVHMC will also investigate the exposure incidents to determine the cause and to revise existing procedures in order to prevent recurrence of the incidents.

b. The person who will conduct the evaluation of exposure incidents is Infection Prevention & Employee Health.

c. Our procedures to evaluate exposure incidents to determine causation and identify ways to prevent future exposures are as follows (*e.g., interviewing exposed employees, inspecting equipment that may have been involved, reviewing whether procedures SVHMC are followed*):
Reference/link: OUTBREAK INVESTIGATION

d. Upon completion of the evaluation, SVHMC will also revise our procedures to ensure that similar exposure incidents do not occur again. These are our procedures to revise our ATD exposure control plan:

   i. RISK MANAGEMENT PLAN

   ii. SAFETY MANAGEMENT PLAN

5. PROCEDURES TO COMMUNICATE WITH OUR EMPLOYEES AND OTHER EMPLOYERS REGARDING INFECTIOUS DISEASE STATUS OF PATIENTS

   a. To ensure our employees use appropriate precautions, SVHMC will communicate with them regarding the suspected or confirmed infectious disease status of persons to whom they are exposed in the course of their duties. SVHMC will also communicate this status with other employers whose employees SVHMC are also exposed to the individual, such as those involved with transportation or care of the patient.

   b. To communicate with our own staff, SVHMC use the following procedures:

      i. Making notes in the patient's chart and maintaining a policy that our employees are to check the patient's chart before proceeding with their tasks.

      ii. Staff huddle at the start of each shift where patient infectious status will be discussed.

      iii. When SVHMC place a patient in isolation, SVHMC communicate the isolation status of the patient with employees and visitors by posting a sign at the room. SVHMC also make a note of the isolation precautions in the patient's chart so that if the patient is transferred to another department, such as Radiology, then those employees in the other department will be notified of the extra precautions required.

      iv. To communicate with other employers regarding the infectious disease status of patients, SVHMC implement the following procedures: Infection Prevention will notify other employers and report to local county public health department.

   c. Communicating with Other Employers Regarding Exposure Incidents

      i. Upon establishing that a patient is a reportable ATD case or suspected case, SVHMC will determine whether any employees of other employers had contact with the individual, using the following procedure: Department Leaders/Infection Prevention notifies employers

      ii. Upon making that determination, SVHMC will notify the other employer(s) within a time-frame that will allow reasonable time for them to promptly investigate to identify employees who had significant exposure and for those employee(s) to receive effective medical intervention. SVHMC will make the notification no later than 72 hours after our report to the local health officer.

iii. Our notification will include the following information:
    a. Date and time of the potential exposure.
    b. The nature of the potential exposure.
    c. Any other information that is necessary for the other employer(s) to evaluate the potential exposure of their employees.
    d. The contact information for the diagnosing PLHCP.

iv. The notification will not include the identity of the employee (source) patient due to privacy laws.

v. Our procedure to notify other employers that their employees may have had contact with an ATD case or suspected case, verbal or written notification based on level of risk, notification is completed by Department Leader and/or Infection Prevention.

vi. This is our procedure to notify health care providers and receive notification from them regarding the disease status of patients referred or transferred between SVHMC our facilities or care, in accordance with subsection (h) of 8 CCR 5199:

vii. **Reference/link**:
    a. ADMISSION-PATIENT PLACEMENT GUIDELINES
    b. TRANSPORT OF PATIENTS TO AND FROM AN EXTERNAL HEALTHCARE FACILITY FOR TREATMENT

6. ENSURING ADEQUATE SUPPLY OF PPE AND OTHER EQUIPMENT
    a. To ensure that employees SVHMC wear the required PPE, such as gowns, gloves, and respiratory protection, SVHMC must ensure that SVHMC have adequate supplies under normal operations and in foreseeable emergencies.
    b. These PPE will be stocked by Materials Management and supplied to our employees using the following procedure: Standard PPE such as Gloves, Gowns, and Eye protection is stocked throughout the hospital by Materials Management. Disease Specific PPE such as Impervious gowns, N95 Respirators, and signage is stocked in Isolation Carts by Materials Management staff and ordered as needed. In the event that bulk product is needed, Materials Management will supply a bulk PPE cart and maintain stock daily.
        i. **Reference/Link:**
            a. ORDERING SUPPLIES FROM MATERIALS MANAGEMENT
            b. PURCHASE ORDER AND PURCHASE ORDER REQUISITION
    c. These are our procedures for maintaining adequate supplies of PPE:

Materials Management keeps an average of 7 days on hand of all PPE at the main campus. Materials Management also keep an Emergency Supply of PPE at our off-site warehouse. The amount of PPE at the off-site warehouse meets the standards outlined in AB2537 and SB275.

7. RECORD KEEPING

a. To ensure that SVHMC are taking all necessary steps to protect our employees, SVHMC are required to keep various records, including employee health records, training records, and other records of implementation of this ATD Exposure Control Plan.

b. Medical records will be kept confidential. Employees will have access to their own health records. Anyone with written consent of the employee, Cal/OSHA representatives, NIOSH, and the local health officer will also be given access to employee health records in accordance with applicable regulations.

c. SVHMC will keep all required health records for each employee with occupational exposure, including the following information:

d. The employee's name and any other employee identifier used at our workplace.

e. The employee's vaccination status for all vaccines.

f. All PLHCP's written opinions and results of TB assessments.

g. A copy of the information regarding an exposure incident that was provided to the PLHCP.

h. SVHMC will retain these records for the duration of the employee's employment plus 30 years. These records will be kept separately from the employee's non-medical personnel health records. This is how employees may request copies of their records: employees can submit requests in writing to employee health department and/or employees have limited access through the employee health electronic health record. These records are kept separately from their personnel records in Human Resources.

i. SVHMC maintains records per hospital policy and according to federal, state and local requirements.

j.

Record	Location of Record
Vaccination status of employees including any signed declinations	EHS EHR
Employee medical screening/ evaluation/results	EHS EHR
Results of annual employee TB assessments	EHS EHR
Copies of information regarding exposure incidents provided to	Notifications from IP in share drive; N Drive QMS IP, Exposures

the PLHCP	folder; N
Training records	Health stream (online education), Dept. Records, Education Department, Employee Health EHR
Record of annual review of ATD Exposure Control Plan	Policy Tech by leaders, new hire orientation and annual online education, real-time education by dept. leaders
Records of exposure incidents (exposure analysis; any determinations of no post-exposure follow-up needed)	Kept in shared drive/files for EH, IP, EHS and infectious Disease providers
Records of unavailability of vaccines	Pharmacy
Records of unavailability of AII rooms or areas	Administration Supervisors
Records of decisions not to transfer a patient to another facility for AII due to medical reasons	EHR of the individual patient(s)
Records of inspection, testing, and maintenance of non-disposable engineering controls including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems	Facilities/Engineering Department
Records of the respiratory protection program policy and/or program changes	Policy Tech
Determinations that a PAPR would interfere with successful performance of certain high hazard tasks	Occurrence reporting system

k. **Vaccination Records**

   i. SVHMC is required to keep vaccination records for all employees with occupational exposure. This includes both records of vaccinations that SVHMC provide them and that the employees supplied to employee health prior to employment with our organization. These records also include any signed declination forms for those vaccinations that are not deemed

mandatory by SVHMC, local or federal agencies.

ii. SVHMC ensure that SVHMC obtain employee ATD vaccination records prior to their employment, all staff are required to provide appropriate documentation of immunizations/immunity status to Employee Health.

iii. These are our procedures for keeping records of ATD vaccinations that SVHMC provide to our employees, in their employee health EHR.

l. **Copy of Information Given to PLHCP Regarding Exposure Incidents**

i. SVHMC will also ensure to keep a copy of the information SVHMC give to the PLHCP related to exposure incidents, following these procedures and storing the records in the following manner:

m. **Training Records**

i. SVHMC education department and/or department leader(s) will keep documentation of all trainings provided to our employees regarding ATD. Each training record will include the following information:

a. The date(s) of the training.

b. The contents or a summary of the training.

c. The names and qualifications of persons conducting the training or designee to respond to interactive questions.

d. The names and job titles of all persons attending the training.

ii. SVHMC will retain these records for three years from the date the training occurred.

n. **Annual review of our ATD Exposure Control Plan**

i. Records of annual review of the ATD Exposure Control Plan will include the following information:

a. Names of the people conducting the review.

b. Dates the review was conducted and completed.

c. Names and work areas of employees involved.

d. Summary of the conclusions.

ii. SVHMC will retain the record for three years using the following: all information for the above is in our policy management software.

o. **Records of Exposure incidents**

i. In addition to maintaining medical records of employees involved in exposure incidents, SVHMC will maintain the following documentation of exposure incidents:

a. The date(s) of the exposure incident.

b. The names, and any other employee identifiers used in the workplace, of employees who SVHMC are included in the exposure evaluation.

c. The disease or pathogen to which employees may have been exposed.

d. The name and job title of the person performing the evaluation.

e. The identity of any local health officer and/or PLHCP consulted.

f. The date of the evaluation.

g. The date of contact and contact information for any other employer who either notified the employer or was notified by the employer regarding potential employee exposure.

ii. SVHMC will maintain these records according to hospital policy and federal, state and local guidelines. Exposure records will be kept separately from human resources and personnel files.

p. **Records of Unavailability of vaccines**

i. SVHMC will retain records of the unavailability of vaccines. These shall include the following information:

a. Name of the person who determined that the vaccine was not available.

b. Name and affiliation of the person providing the vaccine availability information.

c. Date of the contact.

ii. The person responsible for maintaining these records is Pharmacy Department Manager/Director

iii. SVHMC will retain these records for three years, using the following: All unavailable medications including vaccines are reported to the PT/IC Committee.

q. **Records Unavailability of AII rooms or areas**

i. Any time SVHMC require an AII room or area but are unable to locate an available one, SVHMC will document the unavailability. In these cases, SVHMC will record the following information:

a. Name of the person who determined that an AII room or area was not available.

b. Names and the affiliation of persons contacted for transfer possibilities.

c. Date of contacting the persons for transfer possibilities.

d. Name and contact information for the local health officer providing assistance.

e. Times and dates of contacting the local health officer.

ii. SVHMC will not record a patient's individually identifiable medical information as a part of this record. SVHMC will retain these records for three years.

r. **Records of Decisions Not to Transfer a Patient to Another Facility for All for Medical Reasons**

i. Records of decisions not to transfer a patient to another facility for All for Medical reasons shall be documented:

a. In the patient's EHR

b. A summary shall be provided to the plan administrator providing only the name of the physician determining that the patient was not able to be transferred, the date and time of the initial decision and the date, time and identity of the person(s) who performed each daily review.

c. The summary record, which shall not contain a patient's individually identifiable medical information, shall be retained for three years.

s. **Records Inspection, testing, and maintenance of non-disposable engineering controls**

i. SVHMC will maintain records of inspection, testing, and maintenance of non-disposable engineering controls, including ventilation and other air handling systems, air filtration systems, containment equipment, biological safety cabinets, and waste treatment systems.

ii. SVHMC will maintain these records for a minimum of five years, including the following information:

a. Name(s) and affiliation(s) of the person(s) performing the test, inspection or maintenance.

b. Date. Any significant findings and actions that SVHMC has taken.

iii. SVHMC will use the following procedures to maintain these records: Procedures are defined Preventative Maintenance schedules and assigned Work Orders for repairs. All documentation is inputted into our CMMP (Computerized

Maintenance Management Program) and kept for a minimum of 5 years.

t. **Records of Respiratory protection program**

i. SVHMC will establish and maintain records of our respiratory protection program. These include records of employee health evaluations, fit test records, and training records.
Reference/link:
HEALTHCARE WORKER RESPIRATORY PROTECTION PROGRAM

8. OBTAINING ACTIVE INVOLVEMENT OF EMPLOYEES TO UPDATE THE PLAN

a. As part of our annual review process to update this ATD Exposure Control Plan, SVHMC obtain the active involvement of employees and not just managers and supervisors. Active involvement means more than merely having a form available that employees can fill out at their leisure.

b. These are our procedures to obtain the active involvement of employees:

i. With respect to the procedures performed in their respective work areas or departments by actively asking employees for input in meetings,

ii. Solicit input during annual trainings,

a. SVHMC will provide annual employee education of this plan with opportunity for questions and recommendations of this plan by the employees, provided by our online education system.

b. These recommendations made by employee (s), will be reviewed and used in the annual review of this plan. Workplace Safety Committee will oversee this process.

9. SURGE PROCEDURES

a. Our employees will provide services in surge conditions, such as large outbreaks of aerosol transmissible disease or release of a biological agent. When the event arises, SVHMC will implement the surge procedures described below.

b. When our employees provide services during surge conditions, SVHMC will ensure that the following work practices are followed:
Reference/link: EMERGENCY OPERATIONS PLAN

c. During these responses, SVHMC will set up the following kinds of decontamination facilities: SVHMC have a decontamination trailer located outside the ER that can decontaminate up to 3 people at a time.

d. The decontamination facilities will be located in the following areas: See above answer.

e. SVHMC will also ensure that our employees have adequate types and supplies of respiratory protection, gloves, shoe covers, Tyvek suits, and

any other PPE:

i. Materials Management keeps an average of 7 days on hand of all PPE at the main campus. Materials Management also keep an Emergency Supply of PPE at our offsite warehouse.

ii. The amount of PPE at the offsite warehouse meets the standards outlined in AB2537 and SB275. In addition, SVHMC keep all Class A respirators, Tyvek suits, etc. in our Emergency Management Trailer.

a. **Reference/link:**

i. EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS (MCI), INCLUDING DECONTAMINATION

ii. BIOTERRORISM READINESS PLAN

iii. Infection Prevention Pandemic Plan Emerging Infectious Diseases

f. Even during periods when there are no surge conditions, SVHMC will implement the following procedures so that if surge conditions do arise, SVHMC will have adequate supplies of all necessary PPE (i.e., stockpiling, procurement methods): Materials Management maintains a 7-day supply of all equipment except for PPE covered by SB275/AB2537 for which they keep a 45-day supply.

g. The PPE and respiratory protection will be stored in the following areas of our facility:

i. Emergency Preparedness Supplies in designated areas.

h. This is how SVHMC ensure that the protective equipment will be accessible to employees when needed during surge procedures: Generally, they will be retrieved and distributed per the EOP plan (or you could say under the direction of the Incident Command)

i. Emergency Liaison Officer via our Incident Command Center is in charge of communicating our activities with the local and regional emergency response agencies. These are our procedures for interacting with the local and regional emergency plan: The Incident Commander, or designee, would be in charge of this. SVHMC are members of the Monterey County Healthcare Coalition and SVHMC have a few key communication pathways to rely on:

i. Is to call the Monterey County MOHOAC, and

ii. SVHMC can use the READYNET portal via the ED Charge Nurses to reach out to the other hospitals and facilities in our county.

iii. SVHMC can also communicate with these entities using the 800-megawatt radio system via the ED Charge Nurses.

C. **Plan Responsibility**

1. **Designation of Responsibility**
    a. The administrator of the ATD Exposure Control Plan is the Infection Prevention Manager in collaboration with Clinical Leaders, Environmental Health and Safety Officer and Employee Health Manager.

2.

POSITION/COMMITTEE RESPONSIBLE	RESPONSIBILITY
SVHMC Executive Leadership	Responsible to assure adequate resources have been designated to implement the ATD Program in accordance with the Plan.
Infection Prevention (IP) Manager	The facility's IP manager is responsible for the establishment, implementation, and maintenance of the ATD plan and infection control and prevention procedures. The administrator has the authority to perform in this role and is knowledgeable in infection control principles and practices. Assist the Education Department with the development of the employee training program In collaboration with the Employee Health and Safety managers, review and revise as necessary Exposure Control Plan (ECP) at least annually.
IP Specialist, Safety Specialist and Employee Health Services (EHS) Staff	Perform risk assessment(s) annually Support Leaders in implementing the plan.
Pharmacy and Therapeutics / IC (IP) Committee	Review and approve ATD Exposure Control Plan
EHS Leadership	The EHS Director has the authority to act on behalf of the IP Manager to administer the plan if the IP Manager is not available Develop and administer the TB screening program for employees and volunteers Support the EHS team on performing respirator fit testing upon hire and thereafter in accordance with OSHA regulations Develop and administer the Vaccination/ Immunization Program for employees and volunteers Maintain employee vaccination, fit testing, medical evaluation and exposure records for the designated period as required.
Environmental Health and Safety Manager	Assures appropriate patient care policies and procedures are developed and implemented. HEALTHCARE WORKER RESPIRATORY

	PROTECTION PROGRAM
Emergency Management Committee	Under the Environmental Health and Safety Manager, administers the Surge Plan, Disaster Plan and disaster training LABORATORY DISRUPTION OF SERVICES/ DISASTER PLAN NUTRITION SERVICES DISASTER PLAN INFORMATION MANAGEMENT DISASTER RECOVERY
Director of Clinical Laboratory	Assures Laboratory Safety Policies & Procedures specific to Aerosolizing Transmitting Procedures are in place and staff have been trained. LABORATORY AEROSOL TRANSMISSIBLE PATHOGENS POLICY - OSHA
Director of Materials Management	Ensure an adequate supply of Personal Protective Equipment) PPE and other equipment necessary to minimize employee exposures in normal operations and in foreseeable emergencies
Human Resources/ Education Department(s)	Provide and document initial ATD education and annual training thereafter. Collaborates with the IP Manager / designee and department leaders for additional education as deemed necessary.
Department Directors /Managers	Monitor compliance with Exposure Control Plan and report compliance issues for resolution.
Respiratory Therapy and Pulmonary Department	Maintains adequate supply of oxygen needed equipment such as, oxygen tubing, face masks, ventilators, etc.
Biomedical Engineering	Maintain PAPRs including checking filters and replacing filters according to manufacturer's specifications,
Engineering / Facilities Department	Ensures facility-engineering controls are in place. Monitor and maintain engineering controls (e.g. negative pressure room alarms and required testing).

3. Employees are considered to have occupational exposure to ATD if their work activity or work conditions are reasonably anticipated to present an elevated risk of contracting these diseases without protective measures in place. "Elevated," means higher than what is considered ordinary for other employees who have direct contact

with the general public in occupations that are not covered under the scope of this standard, such as bus drivers and retail employees.

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Quality and Safety. Performance measures have been established to measure at least one important aspect of the Safety Program. (Add additional information if needed - Do not list performance metrics)
2. On an annual basis, the Environment of Care Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at SVHMC.

E. **Orientation and Education**

1. Orientation, education and/or training is provided on an as needed basis.
2. SVHMC provides training to our employees (based on appropriate content and vocabulary to the education level, literacy and language needs), who have potential for occupational exposure to aerosol transmissible diseases according to the following schedule:
    a. At the time of initial assignment to tasks where occupational exposure may take place, and annually thereafter.
3. When changes, such as introduction of new engineering or work practice controls, modification of tasks or procedures or institution of new tasks or procedures, affect the employee's occupational exposure or control measures. The additional training may be limited to addressing the new exposures or control measures as necessary.
4. This training may be provided by one or more of the following method(s):
    a. On-line training with opportunity to ask questions.
    b. In person training with opportunity for questions and answer.
    c. Staff Meetings through the department
    d. 1 to 1 training through individual department
5. SVHMC will train all of our employees who have been determined to have potential occupational exposure to ATPs, as listed at the beginning of this program. This training will be provided to employees in those job categories when they are initially assigned to tasks where they may have occupational exposure and at least annually thereafter.
6. SVHMC ensure employees receive initial training during new employee orientation prior to initial start date.
7. SVHMC ensure employees receive their training on an annual basis through on-line training modules.
8. SVHMC ensures training materials appropriate in content and vocabulary to the educational level, literacy, and language of employees will be used.
9. If employees are absent on the day of their scheduled training, SVHMC use the following procedure to ensure that they receive a make-up training: All employees

are required to complete annual training/competencies within 30 days of returning to work.

10. The trainings will include an opportunity for employees to ask questions:
    a. The trainings are provided in-person and questions are answered SVHMC during the training by the instructor, who is knowledgeable in the subject matter as it relates to our workplace and who is also knowledgeable in our ATD Exposure Control Plan.
    b. The trainings are given on-line but SVHMC have ensured that all required topics are covered and that interactive questions are answered SVHMC within 24 hours by a person who is knowledgeable in the subject matter as it relates to our workplace and who is knowledgeable in our ATD Exposure Control Plan.
    c. The person or department assigned to answer SVHMC questions related to the training is: Nursing Education, and/or Infection Prevention Department and/or Employee Health Department Leader(s).
11. Training includes the following:
    a. An accessible copy of the regulatory text of this standard and an explanation of its contents.
    b. A general explanation of ATDs including the signs and symptoms of ATDs that require further medical evaluation.
    c. An explanation of the modes of transmission of ATDs and applicable source control procedures.
    d. An explanation of the employer's ATD Exposure Control Plan and/or Biosafety Plan, and the means by which the employee can obtain a copy of the written plan and how they can provide input as to its effectiveness.
    e. An explanation of the appropriate methods for recognizing tasks and other activities that may expose the employee to ATDs.
    f. An explanation of the use and limitations of methods that will prevent or reduce exposure to ATDs including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
    g. An explanation of the basis for selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal of the items of personal protective equipment employees will use.
    h. A description of the employer's TB surveillance procedures, including the information that persons who are immune-compromised may have a false negative test for LTBI.
        i. EXCEPTION: Research and production laboratories do not need to include training on surveillance for LTBI if *M. tuberculosis* containing materials are not reasonably anticipated to be present in the laboratory.

i. Training meeting the requirements of Section 5144(k) of these orders for employees whose assignment includes the use of a respirator.

j. Information on the vaccines made available by the employer, including information on their efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge.

k. An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident, the medical follow-up that will be made available, and post-exposure evaluation.

l. Information on the employer's surge plan as it pertains to the duties that employees will perform.
As applicable, this training shall cover the plan for surge receiving and treatment of patients, patient isolation

m. procedures, surge procedures for handling of specimens, including specimens from persons who may have been contaminated as the result of a release of a biological agent, how to access supplies needed for the response including personal protective equipment and respirators, decontamination facilities and procedures, and how to coordinate with emergency response personnel from other agencies.
Reference/link: Emergency Operations Plan

IV. REFERENCES

A. Safety

1. 8 CCR 5199: https://www.dir.ca.gov/title8/5199.html
2. California Code of Regulations, Title 8, Section 5144. Respiratory Protective Equipment
3. Joint Commission Comprehensive Accreditation Manual for Hospitals
    - Environment of Care Chapter
    - Infection Prevention and Control Chapter

B. Employee Health

1. CalOSHA, COVID-19 Resources

C. Infection Prevention

1. California Conference of Local Health Officers (CCLHO) Contact Information
2. California Local Health Department Contact Information for Communicable Disease Reporting
3. CDPH Division of Communicable Disease Control Homepage
4. CDPH Guide to Respirator Use in Health Care – a Toolkit for Program Administrators
5. CDPH Healthcare-Associated Infections Program - Effective Cleaning Strategies
6. CDPH Respirator Use in Health Care – a Toolkit for Program Administrators

7. CDC Clinical Testing Guidance for Tuberculosis: Tuberculin Skin Test
8. CDC Guidelines for Environmental Infection Control in Health-Care Facilities
9. CDC Isolation Precautions Guideline
10. CDC Tuberculosis Infection Control
11. CDC "Pink Book" - Epidemiology and Prevention of Vaccine-Preventable Diseases
12. CDC Recommended Vaccines for Healthcare Workers
13. CDC Respiratory Hygiene/Cough Etiquette in Healthcare Settings
14. Selected EPA-registered Disinfectants
15. OSHA Respiratory Protection Program Toolkit for Hospitals
16. Title 17 CCR Division 1, Chapter 4, Reporting to the Local Health Authority

Attachments

- A: COVID Procedure for PAPR Use.docx
- Attachment A_SVH ATD Job Titles_2024-2025.pdf
- B: Aerosol Transmitted Diseases Exposure Disease Pathogen List
- C: Matrix of Department Related Tasks & Procedure Involving Occupational Exposure & Exposure Controls for Aerosol Transmitted Diseases

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	12/18/2025
MEC	Katherine DeSalvo: Director Medical Staff Services	12/18/2025
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	12/12/2025
Emergency Management	Sophia Sanchez: Emergency Preparedness Coordinator	12/9/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/15/2025

Policy Owner	Melissa Deen: Manager Infection Prevention	10/15/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18634815**

Origination	1/1/2021
Approved	N/A
Expires	1 year after approval
Owner	Melissa Deen: Manager Infection Prevention
Area	Plans and Program

Infection Prevention Pandemic Plan Emerging Infectious Diseases

I. SCOPE

A. "Public health emergency" is the occurrence or imminent threat of an illness, health condition, or widespread exposure to an infectious disease that poses a significant risk of substantial harm to the affected population. For the purposes of this planning effort, the health emergency shall be assumed contagious, such as influenza or another novel virus, etc.

B. This document provides guidelines for how Salinas Valley Health Medical Center (SVHMC) will respond to the event and ensure the health and safety of the organization's patient population, volunteers, employees, and providers to the greatest extent possible.

C. Emerging Infectious Disease events will be managed by activating the SVHMC EMERGENCY OPERATIONS PLAN (EOP).

II. OBJECTIVES/GOALS

Our goal is to protect our patients, families, volunteers, providers, and staff from harm resulting from exposure to an emergent infectious disease while they are in our facility.

A. **Objectives**

1. Emerging Infectious Diseases, Infection Prevention Pandemic Plan is for a community-wide infectious disease outbreak for infectious diseases that pose an imminent threat to the community, including, but not limited to, COVID-19, SARS, influenza, and the like.

B. **Goals**

1. The goals for the Emerging Infectious Diseases, Infection Prevention Pandemic Plan are developed from information gathered during routine and special risk assessment activities, alerts from the Monterey County Public Health Department (MCPHD),

California Department of Public Health (CDPH), Centers for Disease Control (CDC) and World Health Organization (WHO), annual evaluation of the previous year's program activities, the goals for this plan are:

a. SVHMC will follow guidelines and comply with all reporting requirements issued by the CDC, Center for Medicaid/Medicare Services (CMS), and State and Local Departments of Health.

III. DEFINITIONS

A. **Infectious disease** - whose incidence in humans has increased in the past two decades or threatens to increase in the near future. These diseases, which respect no national boundaries, include:

1. New infections resulting from changes or evolution of existing organisms.
2. Known infections spreading to new geographic areas or populations.
3. Previously unrecognized infections appeared in areas undergoing ecological transformation.
4. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures

B. **Pandemic** - A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

C. **Isolation** - Separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease.

D. **Quarantine** - Separation of an individual or group reasonably suspected to have been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

IV. PLAN MANAGEMENT

A. **Plan Elements**

1. SVHMC's ability to manage known or unknown infectious diseases may be defined by the impact on the facility, such as resources, staffing, and the influx of patients. SVHMC's response would be in collaboration with local, state, and federal guidelines and requirements.
2. The plan covers the following currently known infections. Examples of Emerging Infectious Diseases are:
    a. Influenza or new novel virus
    b. Zika,
    c. Ebola,
    d. COVID-19,
    e. Dengue Fever,

f. Typhoid Fever,

g. West Nile,

h. Vaccine-preventable diseases such as Measles, Diphtheria, Pertussis, Polio, etc.

i. Other diseases that may emerge that are currently unknown.

B. **Plan Management**

1. SVHMC will utilize emerging and/or current guidelines from local county, state, and federal bodies MCPHD, CDPH, California OSHA, CDC, and WHO to implement and manage infectious diseases in our community.
2. Methods for temporary negative pressure isolation and related infrastructure support.
    a. The SVHMC Engineering Department will:
        i. Ensure that state and local legal requirements, as well as air exchange rates, are met.
        ii. Refer to the guideline for creating temporary enhanced filtered environments for patient care as needed: Office of Emergency Preparedness Healthcare Systems Preparedness Program;Airborne Infectious Disease Management Methods for Temporary Negative Pressure Isolation

C. **Plan Responsibility**

1. The Emergency Management Committee is responsible for overseeing this Plan.
2. By approving this Plan, the SVHMC Board of Directors has authorized the Chairperson of the Emergency Management Committee to make necessary updates/changes to this document without prior approval to support ongoing emergency response before each review cycle.

D. **Performance Measurement**

1. The performance measurement process is one part of evaluating the effectiveness of this Plan. Performance measures have been established to measure at least one important aspect of this Plan.
2. The Emergency Management Committee evaluates the plan's scope, objectives, performance, and effectiveness on an annual basis to manage risks to the staff, visitors, and patients at Salinas Valley Health Medical Center.

E. **Orientation and Education**

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

V. REFERENCES

A. Centers for Disease Control (CDC), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID): updated January 18, 2024

B. California Department of Public Health (CDPH):Office of Infectious Disease Preparedness &

Response, updated August 6, 2024

C. California Occupational Safety and Health (CalOSHA), updated 2025
D. World Health Organization (WHO): Emergencies, updated 2025
E. Monterey County Public Health Department, Communicable Disease Unit, updated June 17, 2025
F. County of Monterey Department of Emergency Management, updated 2025

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	1/13/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	12/16/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	9/2/2025
Policy Owner	Melissa Deen: Manager Infection Prevention	7/30/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18982035**

Origination	1/1/2021
Approved	N/A
Expires	1/1/2026
Owner	Melissa Deen: Manager Infection Prevention
Area	Plans and Program

Infection Prevention Program Plan

I. PURPOSE

A. This plan describes the infection control program of Salinas Valley Health Medical Center (SVHMC) and Out-patient clinics, which is designed to provide for the coordination of all infection surveillance prevention activities and to deliver safe, cost-effective care to our patients, staff, visitors, and others in the healthcare environment (with emphasis on populations at high risk of infection). The program is designed to prevent and reduce hospital-associated infections and provide information and support to all staff regarding the principles and practices of Infection Prevention (IP) to support the development of a safe environment for all who enter the facility. The Infection Prevention Plan will be reviewed annually to determine its effectiveness in meeting the program's goals.

B. The plan provides oversight to the:

1. Completion and evaluation of the Infection Prevention Risk Assessment
2. Establishment of Infection Prevention Goals
3. Identification of Surveillance Activities
4. Review of Infection Prevention Data
5. Preparation of emergency management activities to deal with the surge of agents/ individuals
6. Education of all staff to ensure a broad understanding of Infection Prevention strategies and individual requirements

C. The Plan guides all components of the hospital governing board, medical staff, administration, management, and staff, including clinical and non-clinical services, obtaining excellent patient outcomes that reduce the impact of healthcare-associated infections.

II. INFECTION CONTROL SCOPE OF SERVICES/ PROCESSES/STRUCTURE

A. **Geographic location and community environment**

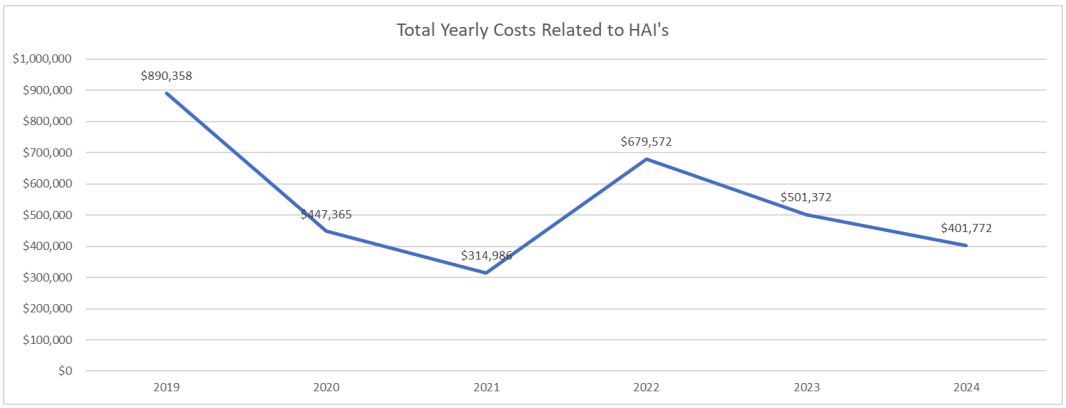
1. SVHMC is part of Salinas Valley Health, an integrated network of healthcare programs and services. At its center is a 263-bed, level 2 public district hospital employing approximately 2,300 full-time staff, located in Salinas in Monterey County on California's central coast. Salinas Valley Health operates a range of specialty clinics throughout the region, with most situated near the main hospital campus. Key specialized programs include the Comprehensive Community Cancer Program, Joint Replacement Center, Regional Spine Center, Women and Children Center, Salinas Valley Health Clinic, Stroke Center, Taylor Farms Family Health and Wellness Center in Gonzales, Outpatient Infusion Center, and the Regional Wound Healing Center. The hospital features a Level III Neonatal Intensive Care Unit (NICU) and a recently expanded Level II Emergency Department.
2. For the 2024 calendar year, SVHMC recorded 18,659 hospital admissions and 42,256 patient days. Emergency services handled 65,543 visits, while operating room (OR) surgical services performed 1,895 cases, averaging about 5.19 cases daily.

B. Salinas Valley Health reports quality, safety, and infection control data to state and federal agencies, with performance data available on platforms such as the California Department of Public Health Hospital-Acquired Infections dashboard and Medicare's Care Compare. The hospital continues to meet rigorous reporting standards and participates in nationwide benchmarking for infection prevention, patient safety, and quality of care.

1. **Infection Prevention Financial Data Summary,** This summary uses cost estimates from the Agency for Healthcare Research and Quality (AHRQ) National Scorecard Report 2017 and more recent studies, including Zhang, Helen L., et al. Costs are estimated per event for Hospital-Acquired Conditions (HACs) or Hospital-Acquired Infections (HAIs).
2. **Estimated Costs per HAI Event (using recent high-quality estimates):**
    a. Catheter-Associated Urinary Tract Infection (CAUTI): $13,793 per event (medRxiv)
    b. Central-line Associated Bloodstream Infection (CLABSI): $48,000 per event (CDC)
    c. Surgical Site Infection (SSI): $31,000 per event (AHRQ)
    d. C. difficile Infection (CDI): $24,400 per event (AHRQ)

Year	CAUTI (events/cost)	CLABSI (events/cost)	SSI (events/cost)	CDI (events/cost)	Total Yearly Cost
2019	6 / $82,758	2 / $96,000	8 / $248,000	19 / $463,600	$890,358
2020	5 / $68,965	1 / $48,000	2 / $62,000	11 / $268,400	$447,365
2021	2 / $27,586	1 / $48,000	3 / $93,000	6 / $146,400	$314,986
2022	4 / $55,172	1 / $48,000	6 / $186,000	16 / $390,400	$679,572
2023	4 / $55,172	2 / $96,000	5 / $155,000	8 / $195,200	$501,372
2024	4 / $55,172	2 / $96,000	1 / $31,000	9 / $219,600	$401,772

3. **Summary Statement:** HAC/HAI costs have decreased significantly from $890,358 in 2019 to $401,772 in 2024. Salinas Valley Health Medical Center's performance improvement measures for HAC/HAIs have made a substantial impact, nearly halving the annual financial burden associated with these infections.



C. SVHMC serves Monterey County communities, which include Salinas, Seaside, Monterey, Soledad, Marina, Prunedale, Greenfield, Pacific Grove, King City, Gonzalez, and all other surrounding communities. SVHMC serves adjacent communities, such as Watsonville, Santa Cruz, San José, Big Sur, and Aptos. The Monterey County area is surrounded by hills, mountains, streams, and the Pacific Ocean 15 miles to the west. The economy is primarily based on tourism and agriculture in the coastal regions of the Salinas River Valley.

D. **Population and Demographics (2025)**

1. As of 2025, Monterey County's estimated population is approximately 438,000, showing modest growth. The county remains majority Hispanic/Latino, making up about 60% of the population, while the rest consists of White (about 28%), Asian (6%), African American (2.5%), and other or multiracial groups. The largest city and county seat remains Salinas, with an estimated population of 159,000. The patient population at SVHMC continues to be highly diverse, including residents, people experiencing homelessness, immigrants, and seasonal farm workers. Spanish remains the dominant language spoken at home, with Tagalog and indigenous languages also present in smaller numbers.

E. **Income**

1. Monterey County's median household income in 2025 is estimated to be around $95,000, reflecting a slight recovery from the dip seen during the early 2020s but still below pre-pandemic highs.

F. **Communicable Disease Trends (2025),** According to the Monterey County Communicable Disease Dashboard and recent public health reports:

1. **Chlamydia**: Rates have stabilized in 2025 after previous increases, but Monterey County remains above the state average, with an incidence rate close to 495 per 100,000 people.
2. **Syphilis**: The county continues to face elevated rates, especially among women of childbearing age, with public health alerts issued in late 2024 and early 2025 in response to local outbreaks (Monterey County Public Health).
3. **Gonorrhea**: Rates remain higher than state averages, with the bulk of cases in the 15-29 age group.
4. **Valley Fever (Coccidioidomycosis)**: There has been a significant rise in cases in 2025, with Monterey County reporting 348 cases through July, marking a dramatic increase from prior years (CDPH).
5. **Respiratory Illnesses**: Seasonal surges of RSV, influenza, and COVID-19 continue, with

the 2024–2025 season seeing a moderate increase in pediatric hospitalizations and guidance issued for vaccine boosters and preventive measures.

6. **Tuberculosis**: Rates have remained steady, with most cases in older adults and among Hispanic and African American populations.
7. **Enteric Illnesses**: Campylobacteriosis, salmonellosis, and shigellosis persist as the most frequently reported, primarily affecting children under 15.

G. **Public Health Response (2025)**

1. Monterey County Public Health and the California Department of Public Health continue to issue timely alerts and guidance for healthcare providers to manage outbreaks, promote vaccination, and implement evidence-based infection control practices. The region remains vigilant against new and re-emerging infectious disease threats, including respiratory viruses, Valley Fever, and sexually transmitted infections (Monterey County Communicable Disease Dashboard).
2. These ongoing trends highlight the importance of SVHMC's commitment to infection prevention and population health outreach, in close collaboration with local, state, and national health authorities.

H. The hospital has identified the Infection Prevention Manager as the individual with clinical authority over the infection prevention program. The Infection Preventionist (IP) is a qualified individual who manages the ongoing infection prevention program. Qualifications include appropriate education and training, and obtaining & maintaining certification (CIC) in infection control.

I. The Infection Preventionist's role is ongoing, with regular oversight and collaborative efforts in surveillance, specific environmental monitoring, continuous quality improvement, consultation, committee involvement, outbreak and isolation management, and regulatory compliance and education.

J. The infection prevention function reports to the Senior Administrative Director of Quality & Safety, who reports to the Chief Medical Officer and the SVHMC Administration. Responsibilities of the infection Preventionist include, but are not limited to:

1. Managing the Infection Prevention Program under the direction of the Pharmacy & Therapeutics/Infection Prevention Committee.
2. Collecting and coordinating data collection, tabulation, and reporting of healthcare-associated and communicable infections
3. Facilitating the ongoing monitoring of the effectiveness of prevention/control activities and interventions
4. Educating selected patients, families, and hospital staff about infection prevention principles
5. Serving as a consultant to patients, employees, physicians, and other licensed independent practitioners, contract service workers, volunteers, students, visitors, and community agencies
6. Taking action on recommendations of the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee
7. Surveillance Rounds in clinical areas
8. Active Participation in the Antimicrobial Stewardship Program

K. The Medical Staff Committee is a multidisciplinary team that sanctions the Pharmacy & Therapeutics/Infection Prevention Committee. The Medical Director for Infection Prevention is an Infectious Disease Physician and Committee member. The IP Medical Director works collaboratively with the infection preventionist to administer and manage the infection control program. The committee membership is responsible for developing and implementing strategies for components/functions of the Infection Prevention Program. It includes representation from the Medical Staff, Administration, Nursing Service, Safety, Physician Office Practices, Laboratory, Performance Improvement, EVS, Operating Room, Pharmacy, and Community Health. Determining the effectiveness of the key processes for preventing infections is an ongoing function of the Committee. Pharmacy & Therapeutics/Infection Prevention Committee meeting minutes are reported to the Medical Staff Committee, then to SVHMC Administration and Board of Directors to assess the adequacy of resources allocated to support infection prevention activities.

III. AUTHORITY

A. Integration of Hospital Components and Functions into Infection, Prevention Activities:

1. Infection prevention is integrated into clinical departments. Clinical departments identify department-specific infection prevention concerns. Department-specific infection prevention policies are developed from the concerns. Each department's specific infection prevention policies are reviewed/ revised every three years. The department director/manager or designee and infection preventionist discuss proposed revisions before submitting them to the Pharmacy & Therapeutics/Infection Prevention Committee for approval. After approval, the policies are reviewed and approved by the Medical Staff, the SVHMC Administration, and the Board of Directors. Once final approval is obtained, the infection preventionist communicates decisions to the department director/manager. Before implementation, major policy revisions or changes are discussed at the Pharmacy & Therapeutics/Infection Prevention Committee and Quality Interdisciplinary Committee.
2. Infection Prevention Policies are developed to guide the practice and provide consistency in applying principles throughout the organization. These policies are available on the SVHMC Intra-net called the "STAR net" and are communicated to staff upon hire, yearly, during safety and leadership meetings, and as updates or changes occur.

IV. DEFINITIONS

N/A

V. STRATEGIES

A. Risk Assessment

1. An annual assessment/reassessment is conducted to determine the presence and changing needs of the organization and surrounding community to assist in the design and development of appropriate facility-specific strategies to address the unique and emerging characteristics of the hospital environment. The hospital evaluates risk for the transmission and acquisition of infectious agents throughout the hospital and is based on the collection of the following information:
2. Identify risks for transmission of infectious diseases based on patient/community demographics, medical services provided, and epidemiological trends.
    a. The characteristics of the population served

b. The results of the hospital's infection prevention data

3. The Risk Assessment is completed on at least an annual basis or whenever significant changes are noted to occur in any of the above-stated criteria.
    a. Once the risks are identified, the organization prioritizes those of epidemiological significance.
    b. The tool was revised to precisely capture the risk of acquiring or transmitting central line bloodstream infections, multi-drug resistant organisms and surgical site infections, and catheter-associated urinary tract infections.

B. Strategies to Address the Prioritized Risks

Specific strategies are developed and implemented to address the prioritized risks. These strategies may include policy and procedure establishment, surveillance and monitoring activities, education and training programs, environmental and engineering controls, or combinations thereof.

1. General Scope and Activities of the Infection Control Program
    a. Maintenance of a sanitary physical environment, including but not limited to high and low-level disinfection
    b. Management of staff, physicians, and other personnel, including but not limited to screening for exposure and immunity to infectious diseases
    c. Mitigation of risk associated with patient infections present on admission
    d. Mitigation of risks contributing to healthcare-associated infections
    e. Active surveillance
    f. Communication/coordination with outside agencies
    g. Pandemic Management
2. Active Surveillance
    a. Key Infection Control Surveillance Indicators for 2025:
        i. Based on the population served and current regulatory guidance (CDC NHSN, CDPH, The Joint Commission), the following high-priority indicators will guide infection prevention surveillance activities in 2025:
            a. Healthcare-onset Central Line-Associated Bloodstream Infections (CLABSI)
            b. Healthcare-onset Catheter-Associated Urinary Tract Infections (CAUTI)
            c. Central Line Insertion Practices (CLIP) compliance monitoring and reporting requirements have been removed in 2025
            d. Healthcare-onset Multi-Drug Resistant Organisms (MDROs), including:
                i. Facility-wide Clostridioides difficile (C. diff)
                ii. Facility-wide Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream

infections

iii. Facility-wide Vancomycin-resistant Enterococci (VRE) bloodstream infections

ii. MDRO admission and discharge screening and surveillance, including compliance with California Senate Bill 1058 for MRSA

iii. Surgical Site Infections (SSI) as designated by CDPH and CMS, reported via NHSN

iv. Employee and healthcare worker vaccination data reporting (e.g., SARS-CoV-2, influenza) per CMS and NHSN requirements

v. Reporting of SARS-CoV-2 outbreaks in healthcare personnel per CDPH and Cal/OSHA mandates

vi. Reporting of CDPH notifiable diseases, including seasonal influenza and active tuberculosis

vii. Environment of Care surveillance rounds to assess potential infection risks

viii. Ongoing hand hygiene monitoring and feedback

ix. Surveillance methods in 2025 leverage real-time EHR data, daily interdisciplinary rounding, ongoing review of laboratory results, and direct referrals from clinical, case management, and medical staff. These efforts are designed to ensure rapid detection, investigation, and response to all potential infection risks across the organization.

x. The CDC/NHSN definitions are used to determine the presence of nosocomial infection. The comprehensive data collection process is based on current scientific knowledge, accepted practice guidelines, and all applicable laws and regulations. NHSN is the database where all events (infections) are credited and conferred rights to all mandated agencies (i.e., CDPH, CMS, etc.)

C. Regulatory Agencies and Guidelines

1. In addition, administrative involvement and the Pharmacy & Therapeutics/Infection Prevention Committee and Physical Environment Committee facilitate the committee's/function's role as a compliance body, assuring guidelines and standards of regulatory and accreditation organizations are applied consistently throughout the organization. Guidelines and standards of the Occupational Safety and Health Administration (OSHA), The Joint Commission, the Center for Medicare and Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC), National Healthcare Safety Network (NHSN), The Association for Practitioners in Infection Control and Epidemiology (APIC), and California Department of Public Health (CDPH), state and federal laws are integrated into the organization's infection prevention policies as they are developed and compliance is monitored ongoing.

D. Role of the Infection Preventionist

1. The infection preventionist (IP) is a systems-level department and leader who blends real-time infection surveillance, regulatory compliance, and organizational risk management. The IP uses advanced analytics, digital reporting tools, and evidence-

based strategies to drive safety and quality improvement throughout the healthcare environment.

a. Surveillance, Analysis, and Response:
    i. Conducts ongoing, data-driven surveillance using electronic health records, predictive analytics, and AI-powered tools to identify clusters and trends in healthcare-associated infections (HAIs).
    ii. Rapidly evaluates and investigates outbreaks or unusual infection patterns, coordinating with clinical teams to implement containment and corrective actions.
    iii. Maintains robust formal and informal communication systems to promptly flag and escalate infection risks to leadership and front-line teams.

b. Policy Development and Program Oversight:
    i. Develops, reviews, and updates the Infection Prevention Plan to align with the latest CDC, APIC, Joint Commission, and state/federal regulatory guidance.
    ii. Defines the scope, structure, and metrics of the Infection Prevention Department, ensuring integration with quality, safety, and risk management programs.
    iii. Collaborates with department leaders to co-design and implement unit-specific infection prevention protocols, focusing on high-risk areas and emerging threats (including multidrug-resistant organisms and novel pathogens).
    iv. Monitors and supports organizational compliance with all regulatory and accrediting requirements, including NHSN reporting and public health mandates.

c. Consultation and Partnership:
    i. Serves as a subject matter expert for all hospital departments, providing consultation on risk assessments, process improvement, and outbreak response.
    ii. Assists departments in defining their infection prevention roles, supporting the development of tailored policies and training programs.
    iii. Partners with administrative and financial leaders to identify cost-effective strategies for infection reduction, supporting both patient safety and fiscal health.

d. Collaboration with Employee Health:
    i. Works closely with the Employee Health Department to prevent and manage occupational exposures, immunizations, and communicable disease events.
    ii. Receives, documents, and reports all cases of infectious diseases in staff, supporting prompt intervention and regulatory compliance.

iii. Provides guidance on return-to-work criteria and post-exposure protocols in accordance with CDC and state/local health authority recommendations.

e. Education and Training:

i. Designs and delivers ongoing, multi-modal education for all hospital staff (including physicians, nurses, allied health professionals, volunteers, students, and contractors) on best practices in infection prevention and control.

ii. Utilizes e-learning and real-time feedback to reinforce safe practices and competency.

f. Public Health Liaison:

i. Functions as the primary liaison between the hospital and local, state, and federal public health agencies.

ii. Ensures timely reporting of notifiable diseases, participates in regional preparedness initiatives, and coordinates response to public health emergencies.

E. Outbreak Management

1. Outbreaks may be identified during surveillance activities. The infection control practitioner is authorized to take immediate action to control any outbreak, utilizing sound epidemiologic principles in investigating its origin and root cause analysis. See policy OUTBREAK INVESTIGATION.

F. Definitions Used in Identifying Healthcare-Associated Infections

1. The CDC/NHSN provides definitions for healthcare-associated infections to create statistics that are as comparable as possible to statistics cited in the literature. The CDC/NHSN updates the definitions biannually. It must be noted that the CDC/NHSN definitions are statistical, NOT clinical. Therefore, a clinical situation that warrants treatment may not always meet the CDC/NHSN definition of HAI.

G. Integration of the Infection Control Program Into SVHMC'S Performance Improvement Program

1. The infection prevention program is fully integrated with the hospital's overall process for assessing and improving organizational performance. Risks, rates, and trends in healthcare-associated infections are tracked over time. This information is used to strengthen prevention activities and to reduce nosocomial infection rates to the lowest possible levels. The infection prevention program collaborates with the employee health program to reduce the transmission of infections, including vaccine-preventable infections, from patients to staff and from staff to patients. Employee health data is also aggregated, tracked, and trended over time to identify opportunities for improvement.

2. Management systems, including staff and data systems, assist in achieving these objectives. Such systems support activities, including data collection, analysis, interpretation, and presentation of findings using statistical tools. Findings from the Pharmacy & Therapeutics/Infection Prevention Committee are provided to the Quality & Safety Committee, Medical Staff Committee, the SVHMC Administration, and Board of Directors

3. The following infection prevention information is currently reported at least quarterly

through the organization's performance improvement (PI) activities:

a. CPDH Reportable Diseases, including Seasonal Influenza and Active Tuberculosis patients
b. Catheter-Associated Urinary Tract Infections (CAUTI)
c. Central Line-Associated Bloodstream Infections (CLABSI)
d. Central Line Insertion Practices (CLIP) & Compliance
e. Multi-Drug Resistant Organisms (MDRO) rates :
    i. Clostridioides difficile Surveillance Facility-wide,
    ii. MRSA Bloodstream Infections Facility-wide
    iii. VRE Bloodstream Infections Facility-wide
f. Hand Hygiene Facility-wide
g. Surgical Site Infections (per NHSN guidelines) on Cardiac (CBGB/CBGC), Caesarian Sections, Total Hip, Total Knee, Colectomy, Hysterectomy

4. See Attachments: Risk Assessment Grid and Correlating Performance Improvement Plan

H. Goals

1. Based on the Risk Assessment, SVHMC establishes annual goals to reflect the current trends and environmental factors of the hospital and community. The following goals are established yearly, and additional goals are established as needed based on the ongoing assessments, surveillance, circumstances, and data trends, which shall include:
    a. *Data based on 2015 baseline, d*ecrease **CAUTI** hospital-wide from SIR 0.559 in 2023 to 0.665 in 2024.
        i. *Re-baseline to 2022 data, shows significant data changes:* CAUTI hospital-wide from SIR 0.788 in 2023 to 0.937 in 2024.
        ii. *HHS Goal for 2024-2028, SIR goal below 0.75*
    b. *Data based on 2015 baseline, d*ecrease **CLABSI** hospital-wide SIR from 0.381 in 2023 to 0.471 in 2024.
        i. *Re-baseline to 2022 data, shows significant data changes:* CLABSI hospital-wide from SIR 0.489 in 2023 to 0.605 in 2024.
        ii. *HHS Goal for 2024-2028, SIR goal below 0.6*
    c. Decrease Utilization of Central Lines and Foley Catheters.
    d. *Data based on 2015 baseline,* **Clostridioides difficile (CDI)**: There will be an ongoing reduction in facility-wide SIR from 0.299 in 2023 to 0.354 in 2024.
        i. *Re-baseline to 2022 data, shows significant data changes:* CDI hospital-wide from SIR 0.688 in 2023 to 0.831 in 2024.
        ii. *HHS Goal for 2024-2028, SIR goal below 0.80*
    e. Sustain Hand Hygiene compliance rate >80%.
    f. *Data based on 2015 baseline,* **Surgical Site Infection (SSI)** hospital-wide SIR from 0.608 in 2023 to 0.117 in 2024.

i. *HHS Goal for 2024-2028, SIR goal below 0.5*

g. Surgical Site Infection (SSI) reduction by implementing an SSI prevention bundle.

h. Decrease the possible transmission of infection on portable equipment, reusable equipment, etc., by evaluating EVS standards of practice and implementing tools to aid in improving EVS processes.

i. Evaluating and monitoring High and Low-Level Disinfection processes hospital-wide.

j. Environment of Care Surveillance

I. Emergency Preparedness and Management

1. Infection Preventionist(s) participate in the hospital-wide emergency plan via the Hospital Incident Command System (HICS). In the HICS system, a Biological / Infectious Disease Medical Specialist will be called in as needed by the Incident Commander.
2. Multiple established resources exist in the event of an influx of potentially infectious patients. The hospital is part of the Monterey County Emergency Response System and has an Emergency Manual for all regional hospitals, listing resources regarding infectious patients, including those related to bioterrorism. The Infection Prevention Department works collaboratively with the local and state health departments, which serve as resources.
3. The infection prevention department regularly receives updates from the local and state health departments regarding emerging infections in the community and state, as well as surge capacity and syndrome surveillance. The syndromes monitored are asthma, diarrhea, gastroenteritis, vomiting, fever, rash, sepsis / septic shock, and chicken pox.
4. The hospital communicates this information to licensed independent practitioners and staff if patterns are identified. Medical Staff would be notified and communicate the information to the medical providers via the staff structure. The nursing staff also has a similar structure; the Chief Nursing Officer would be notified, and information would be communicated to nursing directors and unit managers, who would then communicate it to staff. The hospital has an education department that can assist, if needed, in staff education.
5. The hospital has developed processes for high consequence infectious diseases (HCID) that details the hospital's planned response to an influx of infectious patients. The plan addresses infection prevention practices for patients, post-exposure management, management of large-scale exposures, post-incident debriefing, laboratory support, and CDC information if needed. If needed, the hospital has a nurse-staffing plan that can be implemented to care for patients over an extended period.
6. Supporting documents:
    a. EMERGING INFECTIOUS DISEASES INFECTION PREVENTION PANDEMIC PLAN
    b. ISOLATION - STANDARD AND TRANSMISSION-BASED PRECAUTIONS
    c. EMPLOYEES EXPOSURES & PREVENTION PLANS: SPECIFIC DISEASE EXPOSURES AND WORK RESTRICTIONS
    d. EMERGENCY OPERATIONS PLAN
    e. INFLUENZA PANDEMIC PLAN

f. Aerosol Transmitted Diseases Exposure Control Plan

g. INFECTION PREVENTION AUTHORITY STATEMENT

h. High Consequence Infectious Diseases (HCID) Plan

VI. ORIENTATION AND EDUCATION

A. Orientation, education, and training is provided on an as-needed basis.

VII. DOCUMENTATION

A. Annual Evaluation of Plan

1. The Infection Prevention Performance Improvement Report is updated/reviewed quarterly at Pharmacy & Therapeutics/Infection Prevention Committee meetings. New risks or changes in priorities are identified throughout the year. At the end of each year, the outcomes of each identified goal are determined and considered for inclusion in next year's plan. The revised Plan is taken to the Pharmacy & Therapeutics/Infection Prevention Committee and Environment of Care Committee for final revisions and approval.

VIII. REFERENCES

A. The Joint Commission Infection Prevention and Control

B. Title 22 Infection Control Program 70739

C. APIC Text of Epidemiology and Infection Control and Epidemiology, Association for Professionals in Infection Control and Epidemiology (APIC), Inc., 2025

D. National Healthcare Safety Network (NHSN) Patient Safety Component Manual January 2025

E. California Department of Public Health, Communicable Disease Data.

F. Monterey County Health Department, Data Share

G. US Census Bureau, 2020

H. ***NHSN Reports***, the webpage contains reports organized by the year of data included in the report. The annual reports include the Antimicrobial Resistance Reports, National and State-specific Healthcare-Associated Infections Progress Reports, and additional NHSN reports and resources; 2004 to 2020. https://www.cdc.gov/nhsn/datastat/index.html.

I. The NHSN Standardized Infection Ratio (SIR), A Guide to the SIR. Updated 02/2021. https://www.cdc.gov/nhsn/pdfs/ps-analysis-resources/nhsn-sir-guide.pdf

J. Estimating the Additional Hospital Inpatient Cost and Mortality Associated With Selected Hospital-Acquired Conditions, 2017. https://www.ahrq.gov/hai/pfp/haccost2017-results.html

K. Zhang, Helen L., et al. "A 7-Year Analysis of Attributable Costs of Healthcare-Associated Infections in a Network of Community Hospitals in the Southeastern United States." *Duke Center for Antimicrobial Stewardship and Infection Prevention*, Duke University Medical Center, 2023.North Carolina

L. Average CAUTI Cost (medRxiv)

M. CLABSI Cost (CDC)

N. Monterey County Communicable Disease Dashboard
O. California Department of Public Health: Valley Fever Data Publications
P. Monterey County Health Department

Attachments

2025_2026 IP Risk Assessment Analysis.xls

2025_2026 Risk Assessment PI Plan.doc

a-7-year-analysis-of-attributable-costs-of-healthcare-associated-infections-in-a-network-of-community-hospitals-in-the-southeastern-united-states.pdf

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	1/13/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	12/16/2025
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/29/2025
Policy Owner	Melissa Deen: Manager Infection Prevention	10/1/2025

Standards

Standard Body: A.1.a

Chapter: General Entrance List

Standard Body: IC.04.01.01 EP05

Chapter: Infection Prevention and Control (IC)

RESOLUTION WILL

BE PROVIDED

RESOLUTION NO. 2026-01
OF THE BOARD OF DIRECTORS OF
SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
AUTHORIZING ELIGIBLE SUBSIDIARY BODIES OF THE BOARD OF DIRECTORS TO CONDUCT MEETINGS VIA TELECONFERENCE IN ACCORDANCE WITH CALIFORNIA GOVERNMENT CODE SECTION 54953.8.6

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

WHEREAS, the District Board of Directors is committed to preserving and nurturing public access and participation in its meetings;

WHEREAS, all meetings of the District's governing body and subsidiary bodies thereof are open and public, as required by The Ralph M. Brown Act ("Brown Act"), so that members of the public may attend, participate, and observe the District's public meetings;

WHEREAS, the Brown Act, Government Code Section 54953.8.6, was adopted and became effective January 1, 2026, which provides for subsidiary bodies of the governing body of the public entities to permit, under certain circumstances, members of subsidiary bodies to participate in meetings via teleconference;

WHEREAS, the Board of Directors has considered the circumstances of each of the Board committees, and have determined that the following Committees of the Board of Directors qualify under Government Code Section 54953.8.6(b)(1) as "eligible subsidiary bodies":

- Pension, Personnel and Investment Committee
- Quality & Efficient Practices Committee
- Transformation, Strategic Planning and Governance Committee
- Community Advocacy Committee
- Corporate Compliance and Audit Committee;

WHEREAS, the Board of Directors has determined that teleconference meetings of the aforementioned subsidiary bodies will enhance public access to meetings of said Committees; and the District since 2020 has implemented WebEx Meeting capability for each of said Committees to permit members of the public the ability to attend the meetings by posting the applicable connection information on the agenda for each of the Committee meetings;

WHEREAS, it is the intent of the Board of Directors to ensure that the public will continue to be made aware of the availability of remote participation, including audiovisual or telephonic by providing such information on connectivity on the Committee agendas;

WHEREAS, the Board of Directors has also determined that continued availability of connectively by teleconference of said Committees meetings will promote the attraction, retention, and diversity of eligible subsidiary body members;

WHEREAS, the Board of Directors determines that said subsidiary bodies act in an advisory capacity, and that all recommendations from said committees are presented for action by the Board of Directors at a regularly scheduled meetings of the Board within sixty (60) days from the date of the advisory body's meeting;

WHEREAS, the Board of Directors acknowledges that pursuant to Government Code Section 54953.8.6 this authorization shall remain in effect for a period of no more than six (6) months from the date of the Resolution, but may be renewed by further Board Action;

NOW THEREFORE IT IS HEREBY ORDERED AND DIRECTED THAT:

1. Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

2. Remote Teleconference Meetings of Eligible Subsidiary Bodies. The District Board of Directors hereby authorizes the following Board Committees to meet via teleconference in accordance with Government Code Section 54953.8.6 for the period of January 22, 2026 to July 22, 2026, and authorize the President/CEO and District staff to take all necessary actions to carry out the intent and purpose of this Resolution:

   - Pension, Personnel and Investment Committee
   - Quality & Efficient Practices Committee
   - Transformation, Strategic Planning and Governance Committee
   - Community Advocacy Committee
   - Corporate Compliance and Audit Committee

This Resolution was adopted at a duly noticed Regular Meeting of the Board of Directors of the District on January 22, 2026, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

_____
Board Member
Salinas Valley Memorial Healthcare System

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