



July 17, 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 HEALTH¹** will be held **THURSDAY, JULY 23, 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.**

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

A handwritten signature in black ink, appearing to read "Allen Radner", is positioned above the printed name.

Allen Radner, MD

President/Chief Executive Officer

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

**REGULAR MEETING OF THE BOARD OF DIRECTORS
SALINAS VALLEY HEALTH¹**

**THURSDAY, JULY 23, 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 | <i>Joel Hernandez Laguna</i> |
| 2. CLOSED SESSION <i>(See Attached Closed Session Sheet Information)</i> | <i>Joel Hernandez Laguna</i> |
| 3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION
<i>(Estimated time 4:30 pm)</i> | <i>Joel Hernandez Laguna</i> |
| 4. AWARDS & RECOGNITION | <i>Allen Radner, M.D.</i> |
| 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. | <i>Joel Hernandez Laguna</i> |
| 6. CONSENT AGENDA - GENERAL BUSINESS <i>(Board Member may pull an item from the Consent Agenda for discussion.)</i> | <i>Joel Hernandez Laguna</i> |
| A. Minutes of the Regular Meeting of the Board of Directors June 25, 2026 | |
| B. Policies/Plans Requiring Approval | |
| 1. Attendance Guidelines | |
| 2. Biomedical Waste from the Patient Environment | |
| 3. Breast Milk Expression Via Electric Breast Pump Clinical | |
| 4. Business Plan | |
| 5. Capital Equipment | |
| 6. Chemotherapy Certificate and Recertification | |
| 7. Dress Code | |
| 8. Expense Approval Matrix | |
| 9. Family Sick | |
| 10. Fire Safety Management Plan | |
| 11. Guidelines for Performing Transesophageal Echocardiograms | |
| 12. Guidelines for the Non-Invasive Cardiovascular Technologist (EKG Tech) Performing Electrocardiograms in the Emergency Department | |
| 13. HIPAA Sanctions | |
| 14. Infant Car Seat Challenge | |
| 15. MUSE System Downtime Scheduled and Non-Scheduled | |
| 16. NICU: Non-Nutritive Breastfeeding | |
| 17. Outpatient Lactation Service | |

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

18. Performing Adult ECG's, Right-Sided ECG's, ECG's for Dextrocardia Presentation, and Rhythm Strips
19. PTO Cash Out
20. Scope of Service: Physician and Business Development
21. Scope of Service: Respiratory Care Department
22. Scope of Service: Supply Chain
23. Uses and Disclosures of Protected Health Information (PHI)
24. SVHMC Fiscal Years 2026-2028 CHNA Implementation Strategy

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

7. BOARD MEMBER COMMENTS AND REFERRALS

Joel Hernandez Laguna

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the July 13, 2026 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF THE SVH RISK MANAGEMENT PLAN

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

B. FINANCE COMMITTEE

Victor Rey, Jr.

Minutes of the July 20, 2026 Finance Committee meeting have been provided to the Board for their review. The following recommendation has been made to the Board.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF A 5-YEAR AGREEMENT WITH HILLROM FOR THE VOALTE NURSE CALL SERVICES PROGRAM

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

**C. TRANSFORMATION, STRATEGIC PLANNING &
GOVERNANCE COMMITTEE**

Victor Rey, Jr.

Minutes of the July 15, 2026 Transformation, Strategic Planning & Governance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

9. CONSIDER APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF PHILLIP ABARCA, MD, (ii) CONTRACT TERMS FOR DR. ABARCA'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. ABARCA'S NON-INVASIVE CARDIOLOGY PROFESSIONAL SERVICES AGREEMENT

Timothy Albert, M.D.

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

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF JULY 9, 2026 AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS:

Alison Wilson, D.O.

A. Reports

1. Credentials Committee Report (Including the following)
 - Revision of General Surgery, Oncologic General Surgery and Colorectal Surgery Privilege Delineation
 - Revision of Taylor Farms Family Health & Wellness Center Privilege Delineation
2. Interdisciplinary Practice Committee Report

**B. Policies/Procedures/Plans and General Rules/Regulations
Recommended for Approval:**

1. Parenteral Anticoagulation-Heparin Dosing per Pharmacy Protocol
 2. 13.6-1 Standardized Procedures
- Chief of Staff Report
 - Questions to Chief of Staff
 - Motion/Second
 - Public Comment
 - Board Discussion/Deliberation
 - Action by Board/Roll Call Vote

11. 2026 EMPLOYEE ENGAGEMENT SURVEY RESULTS REVIEW

*Michelle Barnhart
Childs*

12. EXTENDED CLOSED SESSION (if necessary)

Joel Hernandez Laguna

13. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

Joel Hernandez Laguna

14. ADJOURNMENT

Joel Hernandez Laguna

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, August 27, 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, JULY 23, 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

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
 - Quality and Safety Board Dashboard Review

REPORT INVOLVING TRADE SECRET

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

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

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

CONFERENCE WITH 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): Imjin Parkway & 3rd Avenue, Marina, CA

Agency negotiator: (Specify names of negotiators attending the closed session): Gary Ray and Matthew Ottone

Negotiating parties: (Specify name of party (not agent): To Be Determined

Under negotiation: (Specify whether instruction to negotiator will concern price, terms of payment, or both): Price & Terms

PUBLIC EMPLOYEE PERFORMANCE EVALUATION

(Government Code §54957)

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

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

CLOSED SESSION

*(Report on Items to be
Discussed in Closed Session)*

*RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION*

(Meeting Chair)

AWARDS AND RECOGNITION

(Verbal)

(DR. RADNER)

PUBLIC COMMENT

DRAFT SALINAS VALLEY HEALTH¹
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
JUNE 25, 2026

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

Absent: Rolando Cabrera, M.D.

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 4:03 p.m. in the Downing Resource Center, Conference Rooms A, B, & C.

2. CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *Hearings and Reports, Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, Conference with Labor Negotiator – National Union of Healthcare Workers (NUHW)* and *Public Employee Performance Evaluation – President/CEO*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:04 p.m. The Board completed its business of the Closed Session at 4:29 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:32 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *Hearings and Reports, Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services, and Conference with Labor Negotiator – National Union of Healthcare Workers (NUHW)*. The Board received and accepted the reports as presented. No action was taken.

4. AWARDS AND RECOGNITION

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

- **Marketing Awards:** Claudia Villalobos, Director Marketing & Communications, presented the Healthcare AD Awards received by SVH. She particularly highlighted recognition of SVH's Vaccinations Save Lives Campaign.
- **38 Year Retirement: Maria Torres:** Clement Miller, COO, honored Maria for her dedication to Salinas Valley Health over the last 38 years in the rehab department. Maria shared it has been a great adventure and she will be back soon to treat her department to breakfast.

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

5. PUBLIC COMMENT: None.

6. CONSENT AGENDA – GENERAL BUSINESS

It was noted the following policy/plan has been removed for consideration from the published Consent Agenda: (1) Family Sick. This policy/plan 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 May 28, 2026
- B. Minutes of the Special Meeting of the Board of Directors June 2, 2026
- C. Policies/Plans Requiring Approval
 - 1. Assignment of Patient Care Staff
 - 2. Breast Massage, Hand Expression
 - 3. Breast Milk Expression Via Electric Breast Pump Clinical
 - 4. Capital Budget Planning Purchase
 - 5. Community Funding
 - 6. Disruptive Persons
 - 7. Emergent Open Sternotomy (Assist)
 - 8. Hospital Meditation Room Utilization
 - 9. Oxygen Administration and Monitoring – NICU
 - 10. Records Retention
 - 11. Results of Tests and Diagnostic(s)
 - 12. Visitors
 - 13. Workplace Violence Prevention/Security
 - 14. IV Therapy - Peripheral
- D. Reporting and Settlement of Litigation and Claims

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Arreguin and second by Director Carson, the Board of Directors approves the Consent Agenda, Items (A) through (D) as listed above.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: Absent.

Director Catherine Carson: Commented that she attended the Blood Cancer United Visionaries of the Year Grand Finale event and specially recognized Clement Miller, COO for his leadership in this event over the years.

Director Victor Rey, Jr.: Shared a story from a friend who was recently treated at the Salinas Valley Medical Center, who applauded the SVH staff as exceptionally caring and compassionate.

Director Isaura Arreguin: None.

Director Hernandez Laguna: Thanked Brad McCoy and Clement Miller on their Emergency Department project presentation. Shared that he was invited to speak to students participating in the Summer Health Institute and was very impressed with the students' passion and curiosity. Noted that it is important for SVH staff to engage with the community by serving on local nonprofit boards. Finally, he shared that his nephew was born just a few days ago at the Salinas Valley Medical Center and his family members reported on the wonderful care provided.

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Carson regarding the Quality and Efficient Practices Committee. The minutes of the June 15, 2026 meeting were provided for Board review. Director Carson stated that the presentations were: Patient Care Services Update – Perioperative Clinical Practice Council, Quality & Safety Updates: Sepsis, Enhanced Recovery After Surgery Updates, Readmissions, & Transitional Care. Director Carson also noted there was a report given on ERAS (Early Recovery After Surgery). 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 June 15, 2026 meeting were provided for Board review. The following recommendations were made.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF ROSHAN RAO, MD (ii) CONTRACT TERMS FOR DR. RAO'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. RAO'S FAMILY MEDICINE PROFESSIONAL SERVICES AGREEMENT

STAFF REPORT: Dr. Orlando Rodriguez, CMO reported that there is a great need for primary care services in the communities served by SVH. Dr. Rao is currently finishing his family medicine residency in Tennessee and will be joining SVH in the fall.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Arreguin and second by Director Rey, the Board of Directors makes the following findings:

1. The Findings Supporting Recruitment of Roshan Rao, MD:
 - That the recruitment of family medicine physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
 - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

Based on the findings as outlined above, the Board approves the following:

1. The Contract Terms of the Recruitment Agreement for Dr. Rao; and
2. The Contract Terms of the Family Medicine Professional Services Agreement for Dr. Rao.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

2. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF ITZEL VAZQUEZ, MD, (ii) CONTRACT TERMS FOR DR. VAZQUEZ'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. VAZQUEZ'S SLEEP MEDICINE PROFESSIONAL SERVICES AGREEMENT

STAFF REPORT: Dr. Orlando Rodriguez reported that sleep medicine is another area of great need, as demonstrated by numerous monthly referrals to the specialty. Dr. Vazquez is bilingual and will be working primarily at the Taylor Farms Family Health and Wellness Center.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Hernandez Laguna asked a general question about contributions to the SVH 403(b) retirement plan and its vesting schedule. Dr. Rodriguez and Gary Ray, CLO explained the employer contribution is a percentage of the base compensation up to the maximum amount allowed by federal law and that the plan vests after three years of employment.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors makes the following findings:

1. The Findings Supporting Recruitment of Itzel Vazquez, MD:
 - That the recruitment of sleep medicine physician to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and
 - That the recruitment benefits and incentives the hospital proposes for the recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

Based on the findings as outlined above, the Board approves the following:

1. The Contract Terms of the Recruitment Agreement for Dr. Vazquez; and
2. The Contract Terms of the Sleep Medicine Professional Services Agreement for Dr. Vazquez.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;
Absent: Dr. Cabrera.

Motion Carried.

3. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF (i) FINDINGS SUPPORTING RECRUITMENT OF ANDREW LAUWAGIE, MD, (ii) CONTRACT TERMS FOR DR. LAUWAGIE'S RECRUITMENT AGREEMENT, AND (iii) CONTRACT TERMS FOR DR. LAUWAGIE'S UROLOGY PROFESSIONAL SERVICES AGREEMENT

STAFF REPORT: Dr. Tim Albert, CCO reported that Dr. Lauwagie will be one of two new recruits in urology, which is a specialty of substantial demand in the community. Dr. Lauwagie is expected to join SVH in September 2027. Dr. Albert explained that early recruitment is required for this specialty due to a national shortage in urologists.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Rey and second by Director Arreguin, the Board of Directors makes the following findings:

1. The Findings Supporting Recruitment of Andrew Lauwagie, MD:
 - That the recruitment of urologist 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;

Based on the findings as outlined above, the Board approves the following:

1. The Contract Terms of the Recruitment Agreement for Dr. Lauwagie; and
2. The Contract Terms of the Urology Professional Services Agreement for Dr. Lauwagie.

ROLL CALL VOTE:

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

Motion Carried.

4. CONSIDER RECOMMENDATION FOR BOARD APPROVAL TO NOT FUND THE SALINAS VALLEY MEMORIAL HEALTHCARE DISTRICT EMPLOYEES' PENSION PLAN FOR FISCAL YEAR 2027 BASED ON THE RESULTS OF THE 2026 PENSION VALUATION AND THE PLAN'S SURPLUS POSITION

STAFF REPORT: None.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Carson reported that the Salinas Valley Memorial Healthcare District Employees' Pension Plan has a \$49 million surplus position and the pension plan is 109% funded. SVH's consulting actuaries provided their professional opinion that SVH does not need to contribute the typical annual amount to the plan this year due to this surplus position. Director Hernandez Laguna asked if failure to fund the plan violates any agreement or law. Dr. Radner answered that the mandatory annual funding amount was met simply by the plan's growth in investments.

MOTION:

Upon motion by Director Arreguin and second by Director Rey, the Board of Directors approves to not fund the Salinas Valley Memorial Healthcare District Employees' Pension Plan for fiscal year 2027.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

C. CORPORATE COMPLIANCE & AUDIT COMMITTEE

A report was received from Director Hernandez Laguna regarding the Corporate Compliance & Audit Committee. The minutes of the June 17, 2026 meeting were provided for Board review. There are no recommendations.

D. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the June 22, 2026 meeting were provided for Board review. The Financial Reports of the meeting were included in the packet for review (informational).

The following recommendations were made.

**1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF
CYBERSECURITY CONSOLIDATION THROUGH CDW GOVERNMENT, A
SUPPLIER OF SALINAS VALLEY HEALTH'S GROUP PURCHASING
ORGANIZATION AND CONTRACT AWARD**

STAFF REPORT: Audrey Parks, VP of Information Technology, reported that this proposal will consolidate four current cybersecurity products into one contract, which consolidation will provide significant savings to SVH. Best pricing was obtained through the group purchasing organization.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors approves the cybersecurity product consolidation through CDW, Salinas Valley Health's group purchasing organization, in the amount of \$1,282,053 over the next three years through June 30, 2029.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

2. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF MICROSOFT ENTERPRISE AGREEMENT RENEWAL AS SOLE SOURCE AND CONTRACT AWARD

STAFF REPORT: Audrey Parks reported that this proposal is a renewal of SVH's contract with Microsoft for another three-year term.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors approves the Microsoft Enterprise Agreement Renewal as a sole source contract award in the amount of \$3,391,335.54 over the next three years through June 30, 2029.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

3. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF THE CISCO WEBEX CLOUD MIGRATION AS SOLE SOURCE JUSTIFICATION AND CONTRACT AWARD

STAFF REPORT: Audrey Parks reported that this proposal seeks to migrate SVH's on-premise phone management system to a cloud-hosted platform, which will provide advanced functions and features as well as improve overall customer experience.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: Director Hernandez Laguna commented positively on the proposed integration's increased efficiency, reducing call handling times and improving customer

service. Director Hernandez Laguna asked a question about implementation timing. Audrey Parks reported this is approximately a nine-month implementation process.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors approves the Cisco Webex cloud migration as sole source justification and contract award in the amount of \$4,110,527 over the next five years through August 31, 2031 subject to final contract negotiation.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

**4. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF CONTRACT
AWARD TO RL DATIX FOR RL 360 MODULES**

STAFF REPORT: Dr. Albert reported that this contract concerns a risk and compliance software provider, intended to provide support in patient safety areas. This contract is a seven-year agreement to expand current services provided by the vendor.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors approves the Contract Award to RL Datix for RL 360 Modules in the amount of \$2,230,255 over the life of the agreement.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

**9. REVIEW AND CONSIDERATION FOR APPROVAL OF FISCAL YEAR 2027 (FY2027)
OPERATING AND CAPITAL BUDGET**

STAFF REPORT: Iftikhar Hussain, CFO, summarized key points of the FY2027 Operating and Capital Budget. Key assumptions underpinning the FY2027 budget include expected growth in commercial revenue, while overall revenue is projected to remain nearly flat due to the impact of H.R. 1 and SVH's establishment of a twenty-five percent (25%) reserve intended to cover costs previously funded through supplemental payments during this period of uncertainty surrounding the

implementation of H.R. 1. Wages are expected to grow. Key assumptions regarding non-operating income are as follows: investment income is expected to increase due to interest rate increases; Aspire Joint Venture terms have been restructured and improved; and SVH now has higher equity in the Monterey Peninsula Surgery Center.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: The Board members commented that they had previously reviewed much of this material at the Special Board meeting / Budget Workshop on June 2, 2026.

MOTION:

Upon motion by Director Carson and second by Director Arreguin, the Board of Directors approves the Fiscal Year 2027 (FY2027) Operating and Capital Budget.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON JUNE 11, 2026, 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 June 11, 2026. A full report was provided in the Board packet.

The MEC recommends for Board Approval of the following Reports and Policies/Procedures/Plans and Agreements as listed below.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: It was noted the following Policy/Procedure/Plan and Agreement has been removed for consideration from the published Agenda: (1) Laboratory Critical Call Values. This policy/plan will return for consideration at a later date.

MOTION:

Upon motion by Director Carson and second by Director Rey, the Board of Directors receives and accepts the Medical Executive Committee Credentials Committee Report, Interdisciplinary Practice Committee Report, and Policies/Procedures/Plans and Agreements as listed in (A) through (B) below:

A. Reports

1. Credentials Committee Report (Including the following)
 - Family Medicine – Clinical Privileges Delineation
 - Ob Hospitalist – Clinical Privileges Delineation
 - Ob/Gyn – Clinical Privilege Delineation
2. Interdisciplinary Practice Committee Report

- B. Policies/Procedures/Plans and Agreements
 - 1. Personal Protective Equipment (PPE)- All Staff

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

11. CONSIDERATION OF RESOLUTION NO. 2026-05: ORDERING 2026 GENERAL ELECTION FOR SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM; REQUESTING THE COUNTY ELECTIONS DEPARTMENT TO CONDUCT THE ELECTION; REQUESTING CONSOLIDATION OF THE ELECTION WITH STATEWIDE GENERAL ELECTION; AND AUTHORIZING PUBLICATION OF NOTICE OF ELECTION

STAFF REPORT: Matthew W. Ottone, District Legal Counsel, briefed the Board on the requirements of the Government Code and Health and Safety Code, which require the Board to order the election of the Board seats coming up for regular election in 2026, as well as the election for a two-year term for the Zone 3 seat. This Resolution also proposes consolidating the District election with the statewide general election, requests the Monterey County Elections Department to conduct the election on behalf of the District, and authorizes publication of notice of the election.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: The Board members clarified the limited term of Director Arreguin's current appointment to the Zone 3 seat and that the election to this seat in the 2026 General Election is for a two-year term to complete the term that began in 2024 and was vacated in 2025, consistent with the provisions the Government Code and Health and Safety Code.

MOTION:

Upon motion by Director Rey and second by Director Arreguin, the Board of Directors approves the attached resolution: Resolution No. 2026-05.

ROLL CALL VOTE:

Ayes: Arreguin, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Dr. Cabrera.

Motion Carried.

12. DISCUSSION REGARDING SUPPLY CHAIN CHALLENGES

Clement Miller, COO, provided an update on current supply chain challenges resulting from the Medline warehouse fire. On June 11, 2026, a fire destroyed the warehouse containing 3 months' worth of inventory for SVH. The Tracy distribution center supported hospitals/healthcare centers throughout the region, including SVH, Natividad, Mee Memorial, Montage, and Monterey Peninsula Surgery

Center. The incident resulted in lost supplies and vehicles that transported those supplies. The incident is under investigation. SVH is working with Medline to mitigate damages by obtaining supplies from other facilities. Supply packs containing supplies specific to certain procedures and physicians are being used in different ways because custom packs are no longer available. For example, packs are being sourced from alternate vendors, substitutes are being utilized, and custom packs are being created on-site using other available packs. For supplies that cannot be substituted, SVH and Medline are working to find different vendors. SVH has put together a command center that meets daily to track critical supplies, report out on shipments received, and communicate with staff directly on supply needs. A team is also meeting to monitor surgical cases and supply needs. Medline is undertaking mitigation efforts and expects to return to normal operations in mid to late July.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION. Director Carson asked if any surgeries have been canceled; no surgeries have been canceled to date as a result of the supply chain challenges. Director Rey mentioned the supply chain challenges that occurred during the COVID-19 pandemic and commented positively on the dynamic response by SVH in both the past instance and the current one.

13. EXTENDED CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Extended Closed Session are *Public Employee Performance Evaluation – President/CEO*. The meeting recessed into Closed Session under the Closed Session Protocol at 6:02 p.m. The Board completed its business of the Closed Session at 6:57 p.m.

14. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:57 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *Public Employee Performance Evaluation – President/CEO*. No action was taken.

15. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for Thursday, **July 23, 2026**, at 4:00 p.m. There being no further business, the meeting was adjourned at 6:57 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors
 From: Brenda Inman, VP Quality and Risk
 Date: July 23, 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.	Attendance Guidelines	Definitions added. Policy links moved from reference to general information. Section removed for attendance to be noted in annual evaluations.	Michelle Barnhart Childs, CHRO
2.	Biomedical Waste from the Patient Environment	Policy rewritten for better clarification of process.	Timothy Albert, CCO
3.	Breast Milk Expression Via Electric Breast Pump Clinical	Equipment reference updated to align with Workday implementation. Handwashing statement added.	Carla Spencer, CNO
4.	Business Plan	Material Management changed to Supply Chain.	Iftikhar Hussain, CFO
5.	Capital Equipment	Guidelines updated to current.	Iftikhar Hussain, CFO
6.	Chemotherapy Certificate and Recertification	Updated Policy Statement to align with chemo certification requirements. This updated version breaks out IP and OPI chemo nurse's competency. It also speaks to the need for specialty areas such as DI and/or OR to develop their own specialty guidelines.	Carla Spencer, CNO
7.	Dress Code	Policy link added.	Michelle Barnhart Childs, CHRO
8.	Expense Approval Matrix	Managers added to authorizers. Clarifications and additions to process to align with current practice.	Iftikhar Hussain, CFO
9.	Family Sick	Addition of "designated person" to eligible persons staff can use PTO to care for.	Michelle Barnhart Childs, CHRO
10.	Fire Safety Management Plan	EOC changed to PE per new JC chapter title. Minor additions to fire prevention for clarification of process.	Clement Miller, COO
11.	Guidelines for Performing Transesophageal Echocardiograms	Updated medical record to epic/anesthesia now documents in TEE report. Added a new step in the procedure to include verification of lidocaine allergy status	Clement Miller, COO

	Policy Title	Summary of Changes	Responsible Exec
		prior to the procedure. Updated references to reflect current guidelines and sources.	
12.	Guidelines for the Non-Invasive Cardiovascular Technologist (EKG Tech) Performing Electrocardiograms in the Emergency Department	No changes. Regularly scheduled review.	Clement Miller, COO
13.	HIPAA Sanctions	Added references. Added 3 levels of discipline. Add type of breaches and disclosures. Updated to more modern language. Data Lost Protection (DLP) added.	Iftikhar Hussain, CFO
14.	Infant Car Seat Challenge	No changes. Regularly scheduled review.	Carla Spencer, CNO
15.	MUSE System Downtime Scheduled and Non-Scheduled	No changes. Regularly scheduled review.	Clement Miller, COO
16.	NICU: Non-Nutritive Breastfeeding	Typos corrected. References updated.	Carla Spencer, CNO
17.	Outpatient Lactation Service	Regularly scheduled review. References updated.	Carla Spencer, CNO
18.	Performing Adult ECG's, Right-Sided ECG's, ECG's for Dextrocardia Presentation, and Rhythm Strips	Definition added. Updated rhythm strip process.	Clement Miller, COO
19.	PTO Cash Out	Policy statement added. Definitions added. Formatting corrected. Procedure steps corrected to current process.	Michelle Barnhart Childs, CHRO
20.	Scope of Service: Physician and Business Development	Regularly scheduled review. Removed needs assessment completed by Nursing Education.	Timothy Albert, CCO
21.	Scope of Service: Respiratory Care Department	SCHMO corrected to SVHMC. Regularly scheduled review.	Clement Miller, COO
22.	Scope of Service: Supply Chain	Regularly scheduled review. Minor edits/typos corrected.	Clement Miller, COO
23.	Uses and Disclosures of Protected Health Information (PHI)	New 2024 final Rule. Added and updated definitions. Added prohibited disclosure, mandatory Attestation needed "not for prohibited purpose". Alignment 42 CFR part 2 - Substance Use Disorder (SUD) applies to Chemical Dependency section language, allows a single patient consent for all future TPO involving SUD records. SUD exceptions to accounting disclosure permits the redisclosure of SUD. Digital health - CMIA -data expands to include reproductive and mental health data collection by mobile apps and digital services. Electronic Firewall - mandate technical safeguards preventing unauthorized automated exports of reproductive health data to out of state federal entities.	Iftikhar Hussain, CFO

	Policy Title	Summary of Changes	Responsible Exec
MEC			
Nursing Standardized Procedures			
1.	None		
MEC Policies/Plans			
1.	Parenteral Anticoagulation - Heparin Dosing per Pharmacy Protocol	Updated Heparin Protocol that was not present in Policy Stat. Notable changes include: update to aPTT ranges, update to ACS bolus doses based on current guidelines, removal of Ultra-Low intensity for Anti-Xa monitoring.	Clement Miller, COO
Board Policies			
1.	None		



Origination 3/25/2020
Approved N/A
Expires 3 years after approval

Owner Michelle Barnhart
Childs: Chief Human Resources Officer
Area Human Resources

Attendance Guidelines

I. POLICY STATEMENT

- A. Salinas Valley Health Medical Center (SVHMC) has established that a consistent attendance standard is essential to maintain continuity among the employees in delivering services to its customers, i.e., patients, physicians, community and co-workers. Unscheduled time off by an employee creates a severe impact on their ability to perform up to their job expectations.

II. PURPOSE

- A. To ensure that Hospital employees are treated fairly and equitably related to their attendance and to standardize corrective action for employees when their attendance fails to comply with Salinas Valley Health Medical Center standards.

III. DEFINITIONS

- A. Occurrence of unscheduled time off – see Section IV.F
B. Patterns of unscheduled time off – see Section IV.I
C. Tardiness is defined as arrival to work after scheduled start time. If arrival is after thirty (30) minutes from scheduled start time, it will be considered unscheduled time off.
D. Year is defined as a rolling twelve (12) months.
E. PTO - Paid Time Off
F. NUHW - National Union of Healthcare Workers

IV. GENERAL INFORMATION

- A. Employees should not automatically assume that absenteeism is permissible merely because they have sufficient sick pay benefits available to cover all or a portion of their time off. The employer may determine that absenteeism is unacceptable if, based on all the facts and circumstances, it is found disruptive to the employer, co-workers or customers. Each case must be evaluated based on the surrounding facts and circumstances. Absenteeism that is determined to be unacceptable may lead to disciplinary action up to and including the possibility of immediate termination.
- B. This policy is specifically geared to provide corrective guidance to the employee who is exhibiting an attendance and/or tardiness problem and to provide discipline to the employee who fails to improve his/her attendance or tardiness after counseling.
- C. This policy is intended to comply with all regulatory and statutory rights, including but not limited to the Family Medical Leave Act, the California Family Rights Act, the Pregnancy Disability Act, the Americans with Disabilities Act (ADA), and Workers' Compensation-related laws.
- D. Unscheduled time off related to or covered by regulatory or statutory leave rights, bereavement, jury duty, military service, or industrial injury/illness shall not be considered as an occurrence of unscheduled time off.
- E. The Hospital attendance standard is:
 - 1. No more than six (6) separate occurrences of unscheduled time off in a twelve (12) month rolling calendar period;
 - 2. No more than eighteen (18) separate occurrences of tardiness in a twelve (12) month rolling calendar period as defined in Section III.
 - 3. No pattern of unscheduled time off indicating abuse of paid or unpaid time off.
- F. An occurrence of unscheduled time off is defined as any time off, not scheduled in advance and approved by the employee's supervisor, taken for sick leave or personal reasons (e.g., car trouble, sick calls, childcare problems, unscheduled appointments, etc.) whether such day(s) is paid or unpaid.
- G. PTO of up to three (3) days used by NUHW members for the purpose of attending funerals or handling affairs immediately associated with the death of an aunt, uncle, niece, or nephew shall be considered unscheduled for the purpose of the PTO incentive, but will not be counted as an Attendance Occurrence.
- H. An occurrence of tardiness is defined as one (1) incident of tardiness within a pay period. An employee may incur more than one (1) tardy in a pay period.
 - 1. Tardiness, as defined in Section III, will be treated separately from the six (6) initial occurrences of unscheduled time off.
- I. A pattern of unscheduled time off indicating abuse of paid or unpaid time off shall include, but not be limited to:
 - 1. Patterns of unscheduled time off before or after scheduled days off, greater than three (3) times per year. Consideration will be given for per diem and part-time employees.

2. Pattern of missing two (2) consecutive days, greater than four (4) times a year.
 3. Taking time off without sufficient sick time in the bank, more than three (3) times in a year.
 4. A consistent pattern of unscheduled time off on one or both days of a scheduled work weekend. A consistent pattern of unscheduled weekend absences shall include:
 - a. One (1) or more unscheduled weekend absences per month in two (2) or more consecutive months or
 - b. More than three (3) occurrences of unscheduled weekend time off in any year.
- J. Once an employee is in active discipline for two or more of the following, (a) unscheduled time off, (b) tardiness, and (c) patterns, all occurrences of unscheduled time off, tardiness and patterns will be combined when attendance is reviewed and progressive discipline is invoked.
- K. Employees in Disciplinary Action:
1. If an employee is in disciplinary action, progressive discipline will occur as outlined below.
 2. Special Circumstances
 - a. Special circumstances may also include mitigating factors that may require discipline of a lesser severity when considered together with other factors such as performance, other disciplinary actions within the past two (2) years and/or life-threatening health issues.
 3. In the case of special circumstances, or when multiple incidents of unscheduled time off and/or tardiness occur simultaneously, one or more steps may be omitted and more severe discipline imposed (e.g., suspension or termination).
 4. Once an employee is in progressive discipline, his/her individual action plan will be specific to what constitutes the next progressive disciplinary action:
 - a. **For tardiness.** The action plan shall state two (2) occurrences of tardiness as defined in Section III may lead to further disciplinary action.
 - b. **For pattern of unscheduled time off.** The action plan shall state that any further patterns of unscheduled time off, as outlined in Section IV.I, may lead to further disciplinary action
 - c. **For occurrences of unscheduled time off.** The action plan shall state that more than one (1) unscheduled absence in the subsequent two (2) months, more than two (2) unscheduled absences in the subsequent four (4) months, more than three (3) absences in the subsequent six (6) months, more than four (4) unscheduled absences in the subsequent eight (8) months, more than five (5) absences in the subsequent ten (10) months, more than six (6) absences in the subsequent twelve (12) months, more than seven (7) absences in the subsequent fourteen (14) months, more than eight (8) unscheduled absences in the subsequent sixteen (16) months, or more than nine (9) unscheduled absences in the subsequent eighteen (18) months may lead to further disciplinary action.

L. Progressive Disciplinary Process

1. The Department Director/Designee will endeavor to provide notice to an employee prior to the employee reaching disciplinary level. However, it remains the employee's responsibility to monitor occurrences.
2. The Department Director/Designee shall consult with the Human Resources Department prior to proceeding with any discipline. Union representation, when requested, is required during the disciplinary session.

The employee will work with the Department Director/Designee to identify acceptable and efficient methods for improving his/her attendance in an action plan.

3. Documentation of Verbal Counseling. This will occur between the employee and the Department Director/Designee when an employee has had more than six (6) separate occurrences of unscheduled time off, or more than eighteen (18) separate occurrences of tardiness, or unacceptable patterns of unscheduled time off during a rolling twelve (12) month period. This will remain active in the employee's HR file for six (6) months.
4. **First Warning Notice.** This may occur if an employee has not improved his/her attendance within a six-month period after issuance of a Documentation of Verbal Counseling. This discipline will remain active in the employee's HR file for twelve (12) months.
5. **Second Warning Notice/Suspension.** This may occur if an employee has not improved their attendance within an eighteen-month period after issuance of a First Warning Notice. The presence of the Human Resources Director/designee is required during the disciplinary session. A Record of Disciplinary Action form must accompany the Second Warning Notice, defining the three (3) dates of suspension without pay. This discipline will remain active in the employee's HR file for eighteen (18) months (unless otherwise noted in the .
6. **Third Warning Notice/Termination.** This may occur as a result of failure to demonstrate any improvement in the frequency and/ or pattern of unscheduled time off and/or tardiness over a defined period of time. The presence of the Human Resources Director/designee is required during the disciplinary session.

M. Policy References: [FAMILY SICK](#), [DISCIPLINARY POLICY](#)

V. PROCEDURE

- A. Attendance records will be maintained by the Department Director/Designee, and will provide information regarding dates, hours and number of occurrences as well as reasons for unscheduled time off.
- B. The Department Director/Designee will monitor patterns of unscheduled time off and/or tardiness.
- C. The Department Director/Designee may address attendance as part of the employee's annual performance evaluation, but not as a substitute for disciplinary action.
- D. Management follow-up is essential to ensure attendance issues are addressed in a consistent and timely manner.

1. If an employee's attendance is not acceptable, management and the employee will work together to enable the employee to identify efficient methods and/or means of improving attendance in a written plan.
 2. If, at any time, the employee's attendance has the potential to be greater than the Hospital standard for unscheduled time off and/or tardiness as stated above, the Department Director/Designee may conduct an interim review with the employee and counsel him/her on his/her attendance/punctuality.
- E. Progressive disciplinary action begins at such time as unscheduled time off, tardiness, and/or patterns are identified as defined above. If the Department Director/Designee believes there is reasonable doubt as to the validity of the unscheduled time off and/or tardiness due to such things as, but not limited to, illness, they may require the employee to furnish reasonable proof, which may include such things as a doctor's certificate of physical disability sufficient to justify the employee's time off from work for the period claimed.
- F. Proof of unscheduled time off, outside of the holiday season, is required for three (3) or more missed shifts. The documentation must be dated for the missed shift(s). Failure to provide proper documentation upon return from absence will result in disciplinary action at the level of Documentation of Verbal Counseling.
- G. Because of the impact of absences and the inability to replace staff during the holiday season, employees who are unable to work as scheduled between the day before Thanksgiving and the day after New Years are required to provide evidence of unavailability. Such evidence may include, but is not limited to, a physician's note for self, family sick, or auto towing bill. The documentation must be dated for the missed shift(s). Individuals who do not submit the required note upon return from absence will be subject to disciplinary action at the level of First Warning Notice.
- H. Employees must personally notify their supervisor (unless other arrangements have been made with the Department Director/Designee) on a daily basis, according to departmental policy or appropriate union contract, at least two (2) hours prior to the start of each scheduled shift assignment if they intend to be off work, unless they have previously provided a valid medical excuse.
- I. Failure to report to work without notice when scheduled will subject the employee to a Documentation of Verbal Counseling, unless progressive discipline is warranted.
- J. Unauthorized unscheduled time off of three (3) or more consecutive workdays without notification constitutes job abandonment and is cause for immediate termination.
- K. An employee returning to work after three (3) or more days or after an authorized illness/disability must provide a medical note/release to their department prior to their return to work. Failure to comply may affect his/her ability to return to work and may result in disciplinary action.
- L. An employee who fails to report to work, ready to work, at the scheduled start time is considered to be tardy. An employee who fails to badge in (i.e. missed badging) and does not report to their supervisor prior to the start of the scheduled shift will be considered tardy if they are already in a disciplinary action for tardiness.
- M. After requesting time off and being denied that request, including the vacation bid process, if an employee calls in and will be unavailable for work as scheduled due to illness or other emergency (i.e. disabled vehicle), they will be required to provide proof of the reason for the

absence such as a doctor's note or towing bill. It is the sole responsibility of the employee to provide such proof.

1. Failure to provide such proof will result in disciplinary action at the level of First Warning Notice for Attendance, *if* the employee is not already on disciplinary action for attendance.
 - a. If the employee is already on disciplinary action for attendance, the occurrence described in Section IV.L, will result in the employee receiving the next level of discipline in the progressive disciplinary actions attendance.

N. Documentation: API Attendance Records - Monitored and reviewed each pay period

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Collective Bargaining Agreements
- B. Non-Affiliated Employee Information Handbook

Approval Signatures

Step Description

Approver

Date

LWG

Rebecca Alaga: Regulatory/
Accreditation Coordinator

Pending

Policy Committee

Rebecca Alaga: Regulatory/
Accreditation Coordinator

7/10/2026

Policy Owner

Michelle Barnhart Childs: Chief
Human Resources Officer

7/10/2026

Standards

No standards are associated with this document



Origination10/13/2014

ApprovedN/A

Expires3 years after approval

OwnerBrenda Inman: Vice President Quality and Risk Management

AreaInfection Control

Biomedical Waste from the Patient Environment

I. POLICY STATEMENT

- A. Salinas Valley Health Medical Center (SVHMC) is committed to managing medical waste—including biohazardous and sharps waste—in strict accordance with federal, state, and local regulations to protect patients, staff, and the environment.

II. PURPOSE

- A. To provide clear procedures for the safe handling, segregation, containment, storage, transportation, and disposal of medical waste (biohazardous and sharps) within patient care and support areas, in compliance with current laws and standards.

III. DEFINITIONS

- A. Biohazardous (Biomedical) Waste: Waste that may pose a risk of infection to humans, including but not limited to:
1. Pathological and surgical specimens (tissues, organs, placentas, body parts)
 2. Blood and blood products (including containers or equipment contaminated with blood)
 3. Microbiological laboratory waste (cultures, stocks, devices used to transfer/ inoculate/mix cultures, discarded live or attenuated vaccines)
 4. Waste containing excretions, exudates, or secretions from isolation patients as required by Infection Prevention
 5. Dialysis waste (e.g., arterial lines, dialyzer membranes)

- B. Sharps Waste: Any item capable of puncturing or cutting skin, including but not limited to:
 - 1. Disposable needles, syringes (with or without needles), scalpels, broken glass, pipettes, blood vials, and similar items
- C. Other Relevant Waste Streams:
 - 1. Pharmaceutical waste: Partially used or expired medications and related items (see separate policy for pharmaceutical waste)
 - 2. Non-hazardous fluid waste: Liquids not designated as hazardous or biohazardous (see procedure below).

IV. GENERAL INFORMATION

- A. SVHMC follows the Medical Waste Management Act (California Health and Safety Code Sections 117600–118360), OSHA Bloodborne Pathogens Standard (29 CFR 1910.1030), and California Biomedical Waste Requirements (Title 22, CCR).
- B. Medical waste is segregated at the point of generation, properly contained, labeled, and secured for disposal.
- C. A licensed medical waste management contractor provides transport, treatment (autoclaving or incineration), and final disposal.
- D. All containers and transport vehicles must display the International Biohazard Symbol and appropriate labeling.
- E. All staff involved in handling medical waste must receive education and training consistent with regulatory requirements.
- F. A contracted Medical Waste Management Service will provide for:
 - 1. Transportation for medical waste processing.
 - 2. Treatment and final disposal of waste residue.
 - 3. Furnishing the medical waste container liners.
 - 4. Cleaning and disinfection of containers after waste disposal.
 - 5. Medical waste manifesting and trading.
 - 6. Educational services on the proper handling and disposal of medical waste.
- G. See: "[MEDICAL WASTE MANAGEMENT PLAN](#)" for vendor information and the process of disposal within the system.

V. PROCEDURE

- A. Segregation and Containment
 - 1. Sharps Waste:
 - a. Dispose of all sharps immediately after use in rigid, leak-proof, puncture-resistant, and tightly lidded sharps containers located as close as possible to the point of use.

- b. Do not recap, bend, break, or otherwise manipulate needles by hand. If recapping is necessary, use the one-handed scoop technique.
 - c. When a sharps container is approximately three-quarters full, secure the lid and notify Environmental Services for removal and replacement.
- 2. Biohazardous Waste (Other than Sharps):
 - a. Place in red biohazard bags meeting strength and tear-resistance standards, labeled with the International Biohazard Symbol.
 - b. Securely tie bags to prevent leakage.
 - c. Place red bags in rigid, covered secondary containers for transport and storage.
- 3. Pathological Waste (e.g., tissues, placentas):
 - a. Double-bag in red biohazard bags and store in a designated refrigerated or frozen area pending contractor pickup, per Placenta Release and Pathology Waste policies.
- 4. Pharmaceutical Waste:
 - a. Place unusable or expired pharmaceutical items in blue/white RCRA (Resource Conservation and Recovery Act) containers for hazardous pharmaceuticals or as otherwise directed by pharmacy/service guidelines.
- 5. Non-hazardous Fluid Waste:
 - a. Carefully pour non-hazardous liquid waste down the drain, or add a solidifier and dispose of the solidified material in regular trash as appropriate.

B. Handling and transportation

- 1. Staff must wear appropriate Personal Protective Equipment (PPE), (gloves, protective eye wear) when handling or transporting medical waste.
- 2. Transport medical waste separately from regular waste, using designated, leak-proof, fully enclosed carts or vehicle compartments labeled "Biohazardous Waste" or marked with an International Biohazard symbol (Title 22, Section 66840).
- 3. All waste movement should minimize the risk of spills or exposure and follow the shortest, safest route to the Medical Waste Storage area.

C. Disposal of Waste from Patient Care Areas

- 1. Regular trash: Use for non-infectious waste (e.g., wrappers, packaging, non-saturated dressings).
- 2. Biohazardous waste: Use red bags and containers for saturated dressings, blood-soaked items, and regulated medical waste.
- 3. Sharps: Use only sharps containers.
- 4. Pharmaceutical waste: Use blue/white RCRA containers.

5. Pathological waste: Store per policy for contractor pickup.

D. Special Area Guidance

1. OB/GYN: Dispose of diapers and packaging in regular trash. Double-bag placentas for contracted removal.
2. Operating Room/Autopsy: Dispose of blood- or body-fluid-saturated materials in red biohazard bags/containers; use regular trash for wrappers/packaging.
3. Wound Dressings: Small dressings may be enclosed in gloves and disposed of in regular trash if not grossly saturated. Grossly saturated dressings go in red biohazard bags/containers.
4. All waste is to be contained at its source. Saturated/soiled dressings that are "dripping" blood/body fluids will be placed into a red bag and placed into a red container in the soiled utility room or designated area.
 - a. Full sharps containers are to be placed in the rigid container marked "Sharps Only." If the container is full, call the Environmental Services Department to have it removed and an empty container provided.
 - b. Body parts are not to be disposed of in red containers, but are placed in the morgue refrigerator and handled by a Certified Carrier. Placentas are placed in the freezer on the unit and released in accordance with the [PLACENTA RELEASE](#) policy.

E. Storage and Removal

1. Store medical waste in a secure, labeled area until picked up by an authorized vendor.
2. Maintain regular collection schedules to prevent accumulation. Emergency pickups may be requested 24/7 if necessary.
3. All red-bagged waste and full sharps containers must be covered during transport within the facility.
4. Waste may not remain uncovered or unattended in public or unsecured areas.

F. Cleaning and Maintenance

1. Waste carts must be cleaned and disinfected daily.
2. Storage pad and compactor areas are maintained in accordance with Environmental Services protocols.

G. Documentation:

1. Environmental Services will maintain manifests and tracking documentation for all regulated medical waste shipments as required by law.
 - a. Records must be available for inspection by regulatory agencies.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. California Department of Public Health. (2024). Medical Waste Management Act, California Health and Safety Code Sections 117600–118360. Retrieved from, <https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/MedicalWasteManagementAct.pdf>

Occupational Safety and Health Administration. (2025). Bloodborne Pathogens Standard, 29 CFR 1910.1030. Retrieved from, <https://www.osha.gov/bloodborne-pathogens>

California Department of Toxic Substances Control. (2023). Biomedical Waste Requirements—Title 22, California Code of Regulations. Retrieved from <https://dtsc.ca.gov/regulated-waste/medical-waste/>

Monterey Regional Waste Management District. (2026). Medical and Biohazardous Waste Disposal Guidelines. Retrieved from <https://www.mrwmd.org/medical-waste>

Approval Signatures

Step Description	Approver	Date
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	6/16/2026
VP Emergency Management Safety Security	Jeffrey Wardwell: Vice President Emergency Management Safety Securit	6/3/2026
IP	Melissa Deen: Manager Infection Prevention	3/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	3/10/2026
Policy Owner	Melissa Deen: Manager Infection Prevention	3/10/2026

Standards

No standards are associated with this document

COPY



Origination 3/25/2020
Approved N/A
Expires 3 years after approval

Owner Julie Johnson:
Clinical Manager
Area Women's and Children's Services

Breast Milk Expression Via Electric Breast Pump Clinical

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To guide staff in provision and use of the electric breast pump in the event the mother and infant are separated, or the infant is a poor feeder.

III. DEFINITIONS

- A. *Medela Symphony* electric breast pump. The pump has a pre-programmed chip for the *Initiate* and *Maintain* pump modes.

IV. GENERAL INFORMATION

- A. If mother and infant are separated, milk expression with a hospital grade electric breast pump should be implemented as soon as the mother has recovered sufficiently to begin pumping, preferably within 6 hours of birth.
- B. Encourage expression to relieve breast engorgement or assist in softening the areola before the infant latches on.

V. PROCEDURE

- A. Equipment
- Obtain the Medela Symphony electric breast pump.

- Obtain Pump Log from Mother-Baby Nurse Station
- Dish soap. Obtain from 2nd floor or NICU PAR supply room.
- Breast pump parts (Breast Milk Initiation kit) from the PAR supply room or place Workday inventory requisition to Supply Chain.
- Obtain storage bottles. Select small, 30 ml bottles, during the first 24-48 after delivery. Provide 80 ml bottles once mature milk is in.
 1. Pre-packaged bottles or plastic bottles with an air tight seal. Do not use if seal is broken or package open.
 2. Designed for one-time use.
- The Mother Baby (baby transferred to another hospital) unit will use the preprinted labels from infant chart. Instruct the mother to write in the date and time milk was expressed in ink on the label.
- NICU and PEDS unit will use the preprinted breast milk labels obtained from pharmacy. Instruct the mother to write in the date and time milk was expressed in ink on the label.

B. Set-up

- Standard Precautions.
- Provide privacy.
- Plug in electric pump.
- Assemble breast pump parts according to manufacturer directions. Provide mother with a copy of the manufacturer's instructions and encourage her to read them and ask questions.
- Explain the pump settings (*Initiate* and *Maintain*) and suction pressure adjustment.
- Provide education to mother and family on electric breast pump use/care, length and time of *Initiate* setting and when to change to the *Maintain* setting.
 1. *Initiate* setting should be used until the mother is expressing >20 ml of colostrum for three consecutive pump sessions, but no later than five (5) days.
 2. *Maintain* setting should be used after the *Initiate* setting.
 3. Follow manufacture instructions attached to the pump.

C. Operation

- Encourage and reinforce the importance of hand washing prior to hand expression or anytime handling breast pump or breast milk.
- Position mother for comfort in a relaxed sitting position.
- Refer to [BREAST MASSAGE, HAND EXPRESSION CLINICAL PROCEDURE](#)
- Explain how to position breast pump parts for use with double or single pump set.
- The electric breast pump will automatically turn on with the lowest suction pressure setting. Educate mother how to turn on the *Initiate* mode and adjust the suction

pressure per her comfort level. The suction setting of the pump will **not** increase the amount of milk obtained. The *Initiate setting* has a pre-set pump suction and cycle. Educate mother on adjusting suction pressure as needed.

- Frequency of pumping sessions should imitate what a healthy newborn would be doing at the breast. The interval between pumping sessions should not exceed three hours from the beginning of the expression session to the beginning of the next session, ideally eight or more times in a twenty-four (24) hour period. RN to assess the beginning of a pump session each shift for pump set-up, suction level and educational needs.
- Return any pumped milk to the NICU or Pediatric refrigerator as soon as possible, no later than four (4) hours with the label on bottle, date and time of expression to be written on the label with a ink pen. Refer to BREAST MILK, DONOR HUMAN MILK, CONCENTRATED HUMAN MILK FORTIFIER STORAGE, FREEZING AND DEFROSTING.
- Milk that is not correctly labeled will not be accepted for storage or administered to infant.
- Breast pump parts that have come in to contact with breast milk must be washed with warm soapy water and air dried after each use.

D. Documentation

- Each shift document use of pump in mother's Electronic Medical Record (EMR).
- Education given to mother will be charted in the EMR; milk collection, storage and transport, how the mother makes breast milk, community resources for lactation support after discharge, handouts or booklets given to mother/family.

VI. EDUCATION/TRAINING

- A. Education and/or training upon hire and is provided as needed

VII. REFERENCES

- A. Academy of Breastfeeding Medicine. (2017) Protocol #8: *Human Milk Storage Information for home use for healthy full-term infants*. DOI: 10.1089/bfm.2017.29047.aje
- B. Human Milk Banking Association of North America. (2019). *Best practice for expressing, storing, and handling human milk in hospitals, homes, and child care settings*. 4th ed.
- C. Lawrence, R. A. and Lawrence, R.M. (2022). *Breastfeeding A guide for the medical profession*. Philadelphia: Elsevier Mosby.
- D. Medela Inc. (2016). *Symphony breast pump manufacture instruction*. McHenry IL.

Approval Signatures

Step Description

Approver

Date

Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Chair Dep OBGYN	Katherine DeSalvo: Director Medical Staff Services	7/7/2026
CNO	Carla Spencer: Chief Nursing Officer	7/6/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/25/2026
Policy Owner	Julie Johnson: Clinical Manager	6/24/2026

Standards

No standards are associated with this document

COPY



Origination10/27/2011

ApprovedN/A

Expires3 years after approval

OwnerMeredith Peterson: Director Financial Planning & Decision Support

AreaAdministration

Business Plan

I. POLICY STATEMENT

- A. Financial pro-formas and financial business case assessments will be developed by the Finance Department for any new programs, services, capital purchases or joint ventures with a one year capital and operating cost in excess of \$100,000 or annual gross charges in excess of \$300,000.

II. PURPOSE

- A. The purpose of this policy is to ensure, through the implementation of prudent and reasonable controls, that Salinas Valley Health Medical Center (SVHMC) has an established process for financial and strategic planning evaluation of new projects which require significant capital or operating commitment.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

- A. Any exceptions to this process can be made in writing at the direction of the CFO or CEO due to extenuating circumstances or need for specific external knowledge. In those cases, the external consultant must meet with the CFO to provide their assumption and methodology for approval prior to start of work.
- B. All approved projects become a component of the Strategic Financial Plan.

V. PROCEDURE

- A. The project sponsor will gather the necessary strategic and financial information to provide to the Executive Leadership Group and follow the attached process in order to make a decision on the requested capital and operating investments.
- B. Project Categories - Projects and procedures will be broken down into the following categories:
 - 1. Hospital owned health care services
 - a. New
 - b. Replacement
 - c. Acquisition
 - d. Divesture
 - 2. Joint venture based health care services
 - a. New
 - b. Renewal
 - c. Acquisition
 - d. Divesture
 - 3. Capital
 - a. New Capital
 - b. Replacement Capital
 - Real Estate
 - a. Investments
 - b. Divesture
 - 4. Non-health care based services
 - a. New
 - b. Renewal
 - c. Acquisition
 - d. Divesture
- C. Assumptions Development
 - 1. A business plan will be developed to assess the financial impact of capital investments and ongoing operations for new services. The analysis must forecast both the Operating Statement and Cash Flow impact over the first 5 years of any program using the following guidelines:
 - a. Capital Spending - Equipment: The project sponsor will work with Supply Chain and potential vendors to gather all of the acquisition costs of potential capital. Any individual capital item in excess of \$100,000 must have an assessment done by an external organization such as ECRI or

MDBuyline. The estimated costs should include freight and sales tax.

- b. Facilities Costs: The project sponsor will work with facilities to determine the upfront and ongoing space costs needed for the new program. Estimates should include building modification or improvement costs.
- c. Volumes: The project sponsor should work with Business Development to gather data on volumes for the program. Sources should be documented for future reference. Any projects that impacts volumes and with capital investment in excess of \$200,000 must have volume forecasts signed off by the Business Development Executive.
- d. Billing codes: The project sponsor should gather and document the necessary billing codes, including MSDRG, HCPCs and ICD-9 codes to support reimbursement review signed off by CDM manager.
- e. Payor Mix: The project sponsor should gather and document information to support estimation of the payor mix for the new program or service.
- f. Labor: The project sponsor should gather information on the necessary direct and indirect staffing to support the new program. For new job codes, the sponsor will work with Human Resources for pay rate and benefit assumptions.
- g. Supplies: The project sponsor will work with Supply Chain and/or Pharmacy and potential suppliers to estimate the cost of the direct supplies that will be used in the new program.
Other operating costs: All other direct operating costs should be identified, including non-medical supplies, software and hardware maintenance, insurance, medical directors, consulting or any other specific program costs.
- h. Reimbursement: The project sponsor will work with Finance to develop reimbursement assumptions.
- i. Inflation: Inflation factors must be developed for each of the categories above that are not contractually fixed at base levels. Inflation factors will be clearly outlined in the business case and will be part of the Executive approval process.
- j. Risk: The project sponsor must identify the most significant risk factors of the project, including current and near-term future competitors, technological obsolescence or other critical factors impacting the assumptions over time. Exit or mitigation strategies should be developed to factor into financial assumptions.
- k. Clear definition of problem or opportunity with all solutions analyzed, culminating a recommendation or plan.

D. Financial Forecasts

- 1. Finance will develop a cash flow forecast comparing alternatives, including doing nothing. The incremental benefit will be calculated by comparing the alternatives. When evaluating the "status quo option" consideration should be given to decreases related to competition or obsolescence.

E. Business Plan Outline

1. For all new hospital owned or joint venture based health care services, the project sponsor needs to generate a Business Plan Outline in a clear and understandable format.

F. Risk Evaluation

1. The Project Sponsor will work with Finance to identify the most significant risk factors in the assumptions. The business plan will be built on the best estimate for all assumptions. In addition, the business plan must be assessed to determine variances in key assumptions, i.e. volumes above or below estimates by 20%.

G. Financial Evaluation

1. Upon completion of the project, any project with year one total expense in excess of \$150,000 must be evaluated using the following criteria (not all criteria may be applicable).
 - a. Net Investment Requirement
 - Payback Period
 - Annual impact on Operating Margin
 - Net Present Value
 - Internal Rate of Return
 - EBIDA
 - Key Financial Variable Risk Sensitivity

H. Process

1. The Project Sponsor will request a new business plan from Finance. All of the required source data and references will be provided to finance and planning to include in the assumptions document.
2. Finance will review the request and develop a list of questions and information required for the analysis.
3. Once the business plans have been reviewed and approved between Finance and the Project Sponsor, the Project Sponsor will present the business case to the Executive Leadership Group (or designee) for approval.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. N/A

Approval Signatures

Step Description

Approver

Date

LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Meredith Peterson: Director Financial Planning & Decision Support	5/5/2026

Standards

No standards are associated with this document

COPY



Origination 6/29/2018
Approved N/A
Expires 3 years after approval

Owner Scott
Cleveland:
Controller
Area Administration

Capital Equipment

I. POLICY STATEMENT

- A. It is Salinas Valley Health (SVH) policy to capitalize all equipment that meet the following requirements:
- Equipment has a useful life in excess of one year as defined in the AHA Guideline for Useful Life of Equipment.
 - Computer Systems and Copiers/Printers costing \$5,000 or greater (computer system, include monitor and computer, copiers/printers include any accessories). including taxes and freight.
 - Equipment costing \$5,000 or greater including taxes and freight.
 - Multiple items less than \$5,000 individually but totaling more than \$25,000 when purchased as a set: For items such as surgical trays where individual instruments do not meet the capital requirement of \$5,000 each, but together equal \$25,000 or greater, will be capitalized. Also similar items with an individual cost of less than \$5,000 but aggregate value of more than \$25,000 (10 tables at \$3,000 each = \$30,000) will be capitalized.
 - **Non-budgeted capital item:** Non-budgeted capital items must be approved by your Executive and/or CEO.

II. PURPOSE

- A. To provide guidance on implementing GASB 34 - Fixed Asset Accounting System as it relates to Capital Equipment.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

- A. Once the equipment has been determined to be Capital Equipment, the requesting party must complete the Budgeting and Approval of Capital Purchases request in Axiom (see Policy [CAPITAL BUDGET PLANNING PURCHASE](#)).
- B. Competitive Solicitation is required for:
1. Data processing/telecommunications goods/services of \$25,000 or greater
 2. Professional/other services or medical/surgical equipment and supplies \$400,000 or greater
 3. Non-medical materials/supplies/Public Works \$25,000 or greater
- C. When Competitive Solicitation is needed, based on quote dollar amount, include one of the following with capital request:
(see Policy [COMPETITIVE SOLICITATION](#) for CEO packet document requirements)
1. RFP documentation (at least two bids with score card, showing vendor selection).
 2. If Sole source – provide detailed justification on the Sole Source Form.
 3. If GPO, submit qualifying verification from Supply Chain.
- D. Any special construction/accommodation necessary to install the equipment must be included in the request.
- E. Expenditures totaling \$400,000 or greater will require Board review and approval.
(see Policy [COMPETITIVE SOLICITATION](#) for Board packet document requirements)

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

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

Policy Committee

Rebecca Alaga: Regulatory/
Accreditation Coordinator

6/19/2026

Policy Owner

Scott Cleveland: Controller

4/29/2026

Standards

No standards are associated with this document

COPY



Origination 7/1/2022
Approved N/A
Expires 3 years after approval

Owner **Thelma Baker:**
Director
Comprehensive
Cancer
Program and
Wound He

Area **Patient Care**

Chemotherapy Certificate and Recertification

I. POLICY STATEMENT

- A. All Outpatient Infusion and Inpatient Oncology Unit nurses who administer chemotherapy and immunotherapy must maintain current, approved oncology education, obtain and maintain their chemo certificate through the ONS and initiate and maintain validated clinical competency to ensure safe, high-quality patient care. Chemo care and management in specialty individualized treatment areas (such as intrathecal chemotherapy in DI or intravesicular in OR), or locations that provide drug specific treatments (such as Methotrexate for ectopic pregnancy given in ED or GYN) must develop individualized safe practice guidelines and competencies specific to the the specialty use or route the chemotherapy is being given for.
- B. To outline the requirements for the education, training and competency needed to promote safe administration of chemotherapy and immunotherapy agents.

II. PURPOSE

- A. To outline the requirements for certification needed to promote safe administration of chemotherapy and biotherapy agents.

III. DEFINITIONS

- A. ONS - Oncology Nursing Society
- B. ONCC- Oncology Nursing Certification Corporation
- C. OPED - Optional Education

IV. GENERAL INFORMATION

- A. The administration of chemotherapy is complex and requires education and clinical preparation for its safe administration, handling, disposal and management of toxicities.
1. **Outpatient Infusion:** All nurses must complete the required education and competency prior to end of unit orientation.
 2. **Inpatient Oncology:** All nurses must complete the required education and competency within one (1) year of employment into the unit (unless otherwise specified by the department leader).

V. PROCEDURE

A. EDUCATION: INITIAL CHEMO CERTIFICATE

1. New to chemotherapy (no experience) and more than six (6) months of nursing experience.
 - a. Take the "ONS Fundamentals of Chemotherapy Immunotherapy Administration Course".
2. Have previously given chemotherapy or held a chemo certificate.
 - a. Take the "ONS/ONCC Chemotherapy Immunotherapy Certificate" Course.
 - b. Provide proof of current chemo certificate (verified through ONS).
3. If an individual is unable to pass the assigned course, their leader will work with the nurse to create an individualized development plan and time line for completion.

B. COMPETENCY:

1. **Outpatient Infusion and Inpatient Oncology:**
 - a. Complete all chemo competency checklists, reviews, and sign-offs with their preceptor.
 - b. Demonstrate the administration of three (3) chemotherapy agents - one vesicant plus two (2) non-vesicants under the direct supervision of a chemo-certified nurse (refer to attachment A).
2. If unable to successfully complete the competency administration requirement, an "Employee Development Plan" can be formulated by the director or designee and the employee. **Only upon verified ONS certificate and successful demonstration of administration of chemotherapy agents as described above, are staff approved to administer chemotherapy agents to patients.**

C. RE-CERTIFICATION:

1. Individuals who have previously taken the "ONS Fundamentals of Chemotherapy Immunotherapy Administration Course" should now take the "ONS/ONCC Chemotherapy Immunotherapy Certificate".
2. Individuals who have previously taken the "ONS/ONCC Chemotherapy

Immunotherapy Certificate”, should now take the “ONS/ONCC Chemotherapy Immunotherapy Certificate Renewal course” .

3. All nurses giving chemotherapy & immunotherapy must take the next level course or renew their chemo certificate every two (2) years.
4. Once chemo certificate is obtained it must not lapse.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

REFERENCES:

American College of Surgeons. *Commission on Cancer Standards for Accreditation*, October 2025.
Standard 4.2: Oncology Nursing Credentials.

Olsen, M., LeFebvre, K., Walker, S., and Prechtel Dunphy, Elizabeth. (2022-2025). *Chemotherapy and Immunotherapy Guidelines and Recommendations for Practice (Second Edition)*. Pittsburgh: Oncology Nursing Society.

Attachments

[C. Chemotherapy Procedural Checklist SignOff V1 Draft.docx](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	6/19/2026
Cancer Committee	Thelma Baker: Director Comprehensive Cancer Program and Wound He	6/16/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	5/28/2026
Policy Owner	Thelma Baker: Director Comprehensive Cancer Program and Wound He	4/15/2026

Standards

No standards are associated with this document

COPY



Origination8/10/2015

ApprovedN/A

Expires3 years after approval

OwnerMichelle Barnhart Childs: Chief Human Resources Officer

AreaAdministration

Dress Code

I. POLICY STATEMENT

- A. It is the responsibility of the Department Director/Designee to monitor and enforce the Dress Code Policy. Any employee found in violation of the policy will be sent home without pay. Continued non-compliance will result in disciplinary action, up to and including termination.

II. PURPOSE

- A. Salinas Valley Health Medical Center (SVHMC) relies on employees to dress professionally to enhance quality care and effective performance. The purpose of this policy is to outline the professional image that is expected from employees.

III. DEFINITIONS

- A. N/A

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. Specific classifications and departments may have additional policy statements regarding appropriate attire for their employees to prevent interference with infection control and/or similar requirements.
- B. Identification badges with a photo must be worn above waist level at all times. Lanyards are prohibited as they may cause a potential safety hazard.

- C. Employees should be clean and well-groomed in appearance when arriving at work. Clothing, hair, make-up and accessories must be neat, clean and professional in appearance.
- D. The following are examples of inappropriate articles of clothing and are not to be worn in a professional environment:
1. Blue jeans or other denim clothing (unless approved by Administration)
 2. Stretch or lycra pants or similar type of exercise wear
 3. Shorts or capri pants
 4. Articles of clothing such as tank tops or sundresses which show bare shoulders
 5. Clothing which allows undergarments to be seen.
- E. Shoes/Hosiery
1. Shoes should be clean and polished.
 2. For safety and professional appearance, foot thongs/flip flops cannot be worn at the Hospital.
 3. Sandals and open-toed shoes shall not be worn in patient care areas, where needles, IVs, and other sharp instruments are utilized, or in areas where human fluids may be spilled.
 4. For hygienic reasons, hose, socks, and/or stockings must be worn at all times in patient care areas.
 5. Shoes with rubber soles are recommended to minimize noise in patient care areas.
- F. Jewelry
1. Ear piercing is acceptable in the Hospital environment. Nose piercing, eyebrow piercing, body piercing, lip piercing, or tongue piercing jewelry may not be displayed in the Hospital environment.
 2. For safety reasons, employees working with patients, equipment, or electronic instruments must not wear any jewelry that dangles or is loose fitting.
 3. In newborn patient areas, plain wedding bands may be worn. Rings with mounted stones create infection hazard concerns and should not be worn.
 4. Any jewelry that makes noise must be avoided in patient care areas.
- G. Appearance:
1. Photo identification badges issued by the hospital must be worn at all times in a manner visible to patients, above the waist. Refer to policy [TIME AND ATTENDANCE AND BADGING](#) .
 2. The Hospital prohibits exposed tattoos that negatively target protected classes, are gang-related, or are violent in nature.
 3. Longer hair styles (shoulder length and longer) that may interfere with patient interaction, job performance, or work with equipment or materials must be pulled back or secured for employee and patient safety.
 4. Natural fingernails are to be kept clean, trimmed and should be less than 1/4 inch past the fingertip so they do not interfere with safe patient care or a staff members'

ability to perform his/her duties. Nail polish must not be chipped or cracked due to the potential for harboring pathogens. In order to conform to national healthcare standards, long natural fingernails, longer than 1/8 inch beyond the fingertips, are prohibited for individuals who are direct patient care providers.

5. In accordance with the Center for Disease Control (CDC) guidelines, last modified on October 12, 2007, the Infection Control Committee (ICC) action , states "No artificial nails/ enhancements/tips may be worn by any employee with direct patient care responsibilities."

H. Fragrances

1. Employees should refrain from wearing fragrances such as perfume, lotion, cologne, and aftershave since exposure to fragrances can be a problem for many patients, visitors, and employees.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Center for Disease Control Guidelines
- B. Infection Control Committee Meeting Minutes, May 27, 2003
- C. The Joint Commission Guidelines LD.03.01.01 EP

Approval Signatures

Step Description	Approver	Date
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	6/16/2026

Standards

No standards are associated with this document



Origination3/27/2013

ApprovedN/A

Expires3 years after approval

OwnerScott Cleveland: Controller

AreaAdministration

Expense Approval Matrix

I. POLICY STATEMENT

- A. It is Salinas Valley Health (SVH) policy to delegate certain signing authority to Managers, Directors, Executives, or their respected designees when on PTO, LOA, and MLOA for more than one week - for operating and capital expenditures. The attached "Expense Approval Matrix" provides the limit of authority for each expense category for various levels of hospital management.
- B. The Board of Directors of Salinas Valley Health may delegate expense authorization authority to the President/Chief Executive Officer and other Expense Approvers (HSC Section 32121). Such delegation has been issued consistent with the specifics and limitations detailed in the Expense Approval Matrix document attached below.

II. PURPOSE

- A. To provide authority limits to management personnel for operating and capital equipment expenditures. To ensure that operating and capital equipment expenditures (budgeted or unbudgeted) are in line with the overall hospital mission, and its financial and strategic plans. Expense Approvers are responsible to review and approve significant operating and capital expenditures to ensure that these expenditures are necessary to meet the overall mission of the District and its financial and strategic plans.

III. DEFINITIONS

- A. Expenses Approvers: Managers, Directors and Executives as specified in the Expense Approval Matrix.

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. All Expense Approvers are required to provide General Accounting a copy of their signature and their designee, e.g. Executive, Vice President, Director, Asst. Director and Manager).
- B. The Expense Approver will need to enter a Delegation in Workday in order to delegate signature authority to their one up designee and for what time period. The designee is only authorized to sign when the Expense Approver is on an extended leave from the facility (e.g. on vacation, LOA, MLOA, etc.).
- C. Expense Approvers cannot approve their own expenses. These expenses must be approved by their immediate Leader.
- D. Board approved Contracts/Projects allow CEO to hold final sign off on these expenditures.
- E. No facsimile or rubber stamps are authorized.
- F. General Accounting and Supply Chain staff will utilize Expense Approval Matrix within Workday to process purchase order requests or invoices for payment. Documents that do not have the appropriate signatures will be returned to the originating party for follow up. (Note: Purchase Order Request will not be processed or invoices paid without the appropriate signatures.)
- G. There will be no combination or division of transactions into two or more parts in order to evade limits of authority.
- H. Unbudgeted Capital Equipment items must be approved by the President/CEO and/or appropriate Executive per the Matrix. As part of the request for an unbudgeted item, the Expense Approver will review with their Executive an option to substitute an approved budgeted item with an equivalent dollar amount to maintain budget neutrality. If this is not possible, the Expense Approver must request funds from the President/CEO's contingency fund for the item to be approved. Expense Approvers are allowed to substitute like kind capital equipment within their budgeted dollars with the approval of the appropriate Executive.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. N/A

Attachments

 [Salinas Valley Health Expense Approval Matrix Updated 05 15 25.pdf](#)

Approval Signatures

Step Description	Approver	Date
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Scott Cleveland: Controller	4/29/2026

Standards

No standards are associated with this document

COPY



Origination 1/3/2017
Approved N/A
Expires 3 years after approval

Owner Michelle Barnhart
Childs: Chief Human Resources Officer
Area Administration

Family Sick

I. POLICY STATEMENT

- A. Eligible employees may use up to one half of their annual accrued Sick (for affiliated staff) or PTO (for non-affiliated staff) entitlement in any calendar year in connection with the diagnosis, care or treatment of an existing health condition, or the preventive care of an employee's eligible family member or designated person. These hours must be in the employee's Sick or PTO bank respectively in order to qualify. For example:
1. If an employee accrues twelve (12) days per year of sick time, the employee may use six (6) accrued days for Family Sick.
 2. If an employee has greater than one year's accrual in her/his bank of sick hours, she/he may use only one-half of the hours that she/he would accrue in one calendar year.

II. PURPOSE

- A. To ensure that all Hospital employees understand their rights under California law, which allows employees to use a portion of their accrued sick bank for purposes other than their own illness.

III. DEFINITIONS

- A. "Family Member" is defined as a spouse, child, parent, grandparent, grandchild, sibling or registered domestic partner.
- B. "Spouse" is defined as a current husband or wife.
- C. "Child" (regardless of age), is defined as a biological child, adopted child, foster child, stepchild, grandchild, a legal ward, a child of a registered domestic partner, or a child or a

person standing in loco parentis.

- D. "Parent" is defined as biological parents as well as step-parents and parents-in-law.
- E. "Grandparent" is defined as the parent of one's father or mother.
- F. "Sibling" is defined as each of two or more children having one or both parents in common; a brother or sister.
- G. "Registered domestic partner" as established in California and validated with the Declaration of Domestic Partnership with the Secretary of State.
- H. "Designated person" is defined as any individual related by blood or whose association with the employee is equivalent of a family relationship. Limited to one designated person per rolling 12-month period

IV. GENERAL INFORMATION

- A. All restrictions and conditions placed on an employee for use of sick leave shall also apply to the use of Family Sick leave.
- B. This allowance does not extend the maximum period of leave to which an employee is entitled under the California Family Rights Act (Section 12945.2 of the Government Code) or under the Federal Family and Medical Leave Act of 1993 (29 U.S.C. §§ 2606 et seq.) (reference Human Resources/LEAVE OF ABSENCE).
- C. Use of Family Sick as described herein does not count as an occurrence under the Attendance Guidelines (Reference APM – Human Resources /ATTENDANCE GUIDELINES) until such time as the employee's Family Sick allotment is exhausted. Thereafter, any absence in connection with the diagnosis, care or treatment of an existing health condition, or the preventive care of an employee's eligible family member will be counted as an occurrence.
- D. The requested amount of Family Sick allotment must be available in the employee's sick or PTO bank for the absence not to be counted as an occurrence.
- E. Non-benefitted employees (i.e. per diem) are not covered under the Family Sick Policy.

V. PROCEDURE

- A. If the employee is, or will be, absent from work for three (3) days or greater, s/he must provide a physician's note to her/his Department Director/Designee documenting the absence was in connection with the diagnosis, care or treatment of an existing health condition, or the preventive care of an employee's eligible family member.
- B. Department Director/Designee will monitor the amount of time taken by each employee in connection with the diagnosis, care or treatment of an existing health condition, or the preventive care of an employee's eligible family member.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. [Labor Code Section 233](#) - CA Kin Care Law

- B. [Labor Code Section 245.5](#) - Definition of a Family Member and Designated Person
- C. [Labor Code Section 246.5](#) - Permitted Uses
- D. [The California Family Rights Act \(CFRA\)](#)
- E. [Federal Family and Medical Leave Act](#)

Approval Signatures

Step Description	Approver	Date
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/13/2026
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	7/10/2026

Standards

No standards are associated with this document



Origination1/1/2022

ApprovedN/A

Expires1 year after approval

OwnerJeffrey Wardwell: Vice President Emergency Management Safety Security

AreaPlans and Program

Fire Safety Management Plan

I. SCOPE

- A. The Fire Safety Management Plan describes the methods for preventing the potential for a fire through the use of equipment and training for Salinas Valley Health Medical Center (SVHMC). The hospital and its licensed offsite locations are covered by this management plan. The Fire Safety Management Program is designed to assure appropriate, effective response to fire emergency situations that could affect the safety of patients, staff, and visitors, or the environment, and protect building occupants from fire and the products of combustion for Salinas Valley Health Medical Center. The Program is also designed to assure compliance with applicable codes and regulations, as applied to the buildings and services provided at Salinas Valley Health Medical Center.

II. OBJECTIVES/GOALS

A. Objectives

The objective of the Fire Safety Management Program is to use information gathered from environmental tours, risk assessments is to minimize the potential for harm from fire, smoke, and other products of combustion.

B. Goals

The goals for the Fire Safety Management Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, reports and environmental tours.

III. DEFINITIONS

- A. Salinas Valley Health Medical Center (SVHMC) and its licensed off site locations.
- B. Interim Life Safety Measures (ILSM)
- C. Statement of Conditions (SOC)
- D. Physical Environment (PE)
- E. Chief Executive Officer (CEO)
- F. Environmental Health and Safety – EH&S
- G. The Department of Health Care Access and Information (HCAI). Formally the California Office of Statewide Health Planning and Development (OSHPD)

IV. PLAN MANAGEMENT

A. Plan Elements

1. The hospital buildings are designed and maintained in compliance with law, regulation, and accreditation requirements, including compliance with the *Life Safety Code*[®], 2012 Edition.
2. The fire alarm, detection, and suppression systems are designed, installed, and maintained to ensure reliable performance.
3. Staff Training is an essential part of the fire safety program.

B. Plan Management

1. Management Plan

- a. The organization develops, maintains and on an annual basis, evaluates the effectiveness of the Fire Safety Management Plan to effectively manage the fire safety risk to staff, visitors, and patients at SVHMC.

2. Fire Prevention

- a. The EH&S Manager or designee is responsible for managing the program for minimizing potential harm from fire, smoke, and other products of combustion. The fire protection program includes three phases.
- b. The first phase is the design of buildings and spaces to assure compliance with current local, state, and national building and fire codes. SVHMC employs qualified architects and engineers to develop building and fire protection system designs. All designs are reviewed by HCAI (as a part of the construction and permitting process. A construction monitoring and building commissioning program round out the design phase.
- c. The second phase is testing, inspection, and maintenance of the fire prevention aspects of the facility. This includes the fire detection system, standpipe and hose systems, automatic sprinkler system, fixed extinguishing system (dry chemical, gas agents), fixed fire extinguishing systems (water spray), and foam-water sprinkler system. The EH&S

Manager or designee is responsible for setting testing, inspection and maintenance standards and frequency based on applicable codes, equipment history, and other parameters. The work is done by SVHMC staff and contractors. The EH&S Manager or designee ensures the end product of all work maintains or improves the level of life safety in each affected area.

- d. The third phase is an active training program of fire prevention, fire safety, and fire response. The EH&S Manager or designee manages this phase of the program.

3. Surgical Safety

- a. Periodic evaluations are made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of flammable germicides or antiseptics, are established. See [FIRE SAFETY FOR SURGERY, L&D, AND PROCEDURE AREAS.](#)

4. Unobstructed Exits in Business Occupancy

- a. For those areas designated as Business Occupancy by NFPA 101[®] – Life Safety Code[®] 2012, all exits must be maintained free and unobstructed. The status of these areas will be determined routinely by the staff and during environmental tours. Storage will not be allowed in any exit lobby or exterior anteroom.

5. Fire Response Plan

- a. The [FIRE RESPONSE PLAN EC#618](#) provides clear, specific instructions for staff responding to a fire emergency in the hospital. The FIRE RESPONSE PLAN FOR OFF-SITE locations outlines the procedures for staff to follow in the event of a fire emergency in business occupancies. Each department leader is responsible for maintaining copies of emergency procedures in a continuously accessible location.
- b. The EH&S Manager or designee and department leadership is responsible for developing and training staff on department specific emergency fire response procedures. Department leadership is responsible for providing departmental and area personnel with an orientation to emergency procedures related to their job. Additional departmental training is provided on an annual basis as part of the continuing education program or on an as-needed basis. The roles of all staff and licensed independent practitioners (LIPs) are detailed specifically in the Fire Response Plan. The roles of all staff and LIPs at and near the point of fire origin are defined. The basic plan in the organization is based on the acronym "RACER":
 - i. Rescue anyone in immediate danger from the fire if safe to do so
 - ii. Activate the fire alarm by a pulling fire alarm pull station and dialing 2-2-2-2 on the phone and announcing the alarm to staff. Off-site location staff must call 9-911.

- iii. Contain smoke and fire by closing doors and windows
 - iv. Extinguish if safe to do so
 - v. Relocate and evacuate as directed.
- c. The role of all staff and LIPs away from the point of fire origin is to close doors and evaluate the situation. If the fire is in horizontally adjacent areas or in areas where relocation is planned, move patients to an adjacent smoke department if it is safe to do so.
 - d. The Administrative Supervisor or Respiratory Therapy staff are responsible for shutting off the oxygen in the area when deemed appropriate.

6. Fire Drills

- a. Fire drills are a critical tool for maintaining the readiness of staff to respond to a fire emergency and to minimize the likelihood of injury to patients, visitors and staff. Staff participation is necessary to maintain an acceptable level of readiness and to ensure staff knowledge of the equipment and procedures necessary to protect the staff and patients. To evaluate staff knowledge, drill activities are observed, and staff is questioned about their role and responsibilities during a fire emergency nearby and elsewhere in the building.
- b. Fire drills are conducted in the hospital once per shift per quarter and scheduled at varying times of day. Fire drills are conducted every 12 months in all licensed freestanding buildings classified as business occupancies. These drills are witnessed, documented, and evaluated to identify improvements that may be made. Additional drills are held as deemed appropriate.
- c. All drills will be unannounced, with the exception of those done as corrective training activities.
- d. All SVHMC staff will participate in drills, according to the fire response plan. This includes all hospital staff and all SVHMC staff in buildings where space is shared with others.
- e. Fire drills are observed and critiqued to evaluate fire safety equipment, fire safety building features and staff response. In addition, fire response knowledge is evaluated during fire drills and environmental tours.
- f. The results of the critique and evaluation of drills and evaluation of staff knowledge are used to identify improvements needed in training programs, fire protection equipment, and administrative compliance issues. Such improvements are evaluated during monitoring activities and the results are used to identify the effectiveness of the activities.

7. Maintaining Fire Safety Equipment and Building Features

- a. The Director of Facilities Management Services or designee is responsible for maintenance of the fire alarm and related systems. Troubleshooting fire alarm system and performing corrective and preventive testing, inspection and maintenance is performed by staff and/or an approved

vendor. All testing, maintenance, inspection, and repairs are documented and reviewed by the Director of Facilities Management Services, or designee. Any fire protection feature that is not operating properly will be evaluated for the (ILSM).

- b. When appropriate, competent contractors are used to test, inspect, maintain, and repair the fire protection features. Documentation is maintained as part of the SVHMC database to assure activities are conducted as required

8. Life Safety

- a. The EH&S Manager or designee is responsible for assessing compliance of the organization with the Life Safety Code and managing the Statement of Conditions (SOC) when addressing survey-related deficiencies. In time frames defined by the hospital, the EH&S Manager performs a building assessment to determine compliance with the Life Safety Code. A quarterly report of any deficiencies identified is provided to the EOC Committee.. The organization maintains documentation of any inspections and approvals made by state or local fire agencies.
- b. Current and accurate drawings denoting features of fire safety and related square footage are maintained.
- c. The hospital does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, are either maintained or removed.

9. Managing Fire Life Safety Risks

- a. The organization has a written Interim Life Safety Measure (ILSM) policy that addresses situations when Life Safety Code deficiencies exist and cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent SVHMC compensates for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented.
- b. The Interim Life Safety Program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific plan is designed. The implementation may include training, installation of engineering controls, posting of temporary advisory signs, etc. Affected staff are oriented and drilled, as appropriate.
- c. The EH&S Manager or designee is responsible for monitoring the effectiveness of the implementation of the appropriate ILSM. When deficiencies are identified, appropriate actions are taken to resolve the deficiencies. All monitoring and actions to resolve deficiencies are documented. All Interim Life Safety evaluations, plans, and monitoring documentation are maintained for at least three years.
- d. Portable fire extinguishers are inspected monthly and maintained annually.

- e. Staff members are responsible for responding to a fire emergency and are provided education and the opportunity to participate in fire safety training.

C. Plan Responsibility

- 1. The Director of Facilities and Construction and the EH&S Manager or designee, in collaboration with the EOC Committee, is responsible for monitoring all aspects of the Fire Safety Management Program. The EH&S Manager advises the EOC Committee regarding fire safety issues, which may necessitate changes to policies and procedures, orientation or education, or expenditure of funds.

D. Performance Measurement

- 1. On an annual basis, the EOC Committee evaluates the scope, objectives, performance, and effectiveness of the Fire Safety Management Plan to manage the fire safety risks to the staff, visitors, and patients at SVHMC

E. Orientation and Education

- 1. Education and/or training is provided as needed.

V. REFERENCES

- A. Joint Commission Standards, Physical Environment chapters
- B. National Fire Protection Association Life Safety Code 101, 2012 edition.

Approval Signatures

Step Description	Approver	Date
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
EOC	Jeffrey Wardwell: Vice President Emergency Management Safety Securit	7/13/2026
VP Safety	Jeffrey Wardwell: Vice President Emergency Management Safety Securit	7/10/2026
Director Employee Health	Jill Peralta Cuellar: Director Employee Health	7/10/2026
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Jeffrey Wardwell: Vice President Emergency	6/3/2026

Standards

No standards are associated with this document

COPY



Origination 3/10/2017
Approved N/A
Expires 3 years after approval

Owner Marissa Gonzalez:
Manager
Cardiology
Clinical

Area Cardiology
Departments

Guidelines for Performing Transesophageal Echocardiograms

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To provide guidelines for the Cardiac Sonographer and Registered Nurse in pre-procedure, procedural care and post-procedure recovery of Transesophageal echocardiogram (TEE) patients. The Cardiac Sonographer will assist the Cardiologist, Cardiac Surgeon or Anesthesiologist in imaging, identifying, and measuring cardiac structures such as: blood flow, defects, foreign bodies, tumors, masses and aneurysms during a TEE in order to assist in their treatment decisions.

III. DEFINITIONS

- A. Transesophageal echocardiogram is defined as an invasive echocardiogram in which ultrasound waves are emitted from an ultrasound probe in the esophagus to create moving images of the heart.
- B. EHR - Electronic Health Record

IV. GENERAL INFORMATION

- A. The cardiac sonographer will assist in performing all invasive TEE's in a timely, professional manner while working with physicians and other health care professionals to provide quality diagnostic testing.
- B. Order Entry

1. Inpatient TEE Order Set or Outpatient TEE Order Set.

V. PROCEDURE

A. Use universal precautions.

B. Outpatient TEE's :

1. Assemble equipment and supplies needed for the study.
2. Supplies needed at the bedside:
 - a. Electrodes
 - b. Lidocaine Hydrochloride Jelly 2%
 - c. Lidocaine Viscous 2%
 - d. Gel
 - e. Hurracaine Spray
 - f. E-Z Bite Guard
 - g. Tongue Depressors
 - h. Portable Suction with yankauer and catheters
 - i. Nasal Cannula with EtCO₂ for oxygen delivery and capnography monitoring.
 - j. Place patient on cardiac monitor with EKG, NIBP, SPO₂, EtCO₂ for continuous monitoring.
 - k. Obtain initial EKG strip and mount to EKG paper.
 - l. Insert peripheral IV with NS per CPOE.
3. Lidocaine allergy status will be verified prior to the procedure to confirm whether the patient has any known allergy or adverse reaction.
4. The pre-procedure work-list will be completed and/or reviewed for NPO status, allergies, medications, any significant labs, vital signs.
5. Make sure the patient has been NPO for a minimum of six (6) hours
6. Patient informed consent will be obtained.
7. Have patient remove dentures/partials and place in labeled container.
8. Bring to bedside medications ordered for procedure (topical numbing agents, lidocaine jelly for TEE probe and sedation medications.
9. Once the patient is prepped and ready, notify the performing cardiologist that the patient is ready.
10. When Cardiologist arrives, RN and MD will perform Universal Protocol according to hospital policy. (see [UNIVERSAL PROTOCOL: PREVENTION OF WRONG PERSON, PROCEDURE, SITE SURGERY OR INVASIVE PROCEDURES POLICY](#)).
11. The RN will administer sedation medications according to MD orders.
12. The RN will continuously monitor patient and document vital signs, cardiac rhythm

and level of consciousness every 5 minutes or more as indicated during procedure on the nursing record or electronic chart.

13. The sonographer will capture all relevant images throughout the procedure.
14. After completion of study, unhook the electrodes from the ECHO machine, remove the TEE probe, pre clean with enzyme sponge and place in the designated container for transport to SSPD.
15. The sonographer will take the TEE probe to SSPD for cleaning.
16. The patient will be recovered (see [SEDATION GUIDELINES](#)) with monitoring vital signs every 15 minutes for a minimum of one hour post last sedation medication dose given.
17. Document all medications given or not given in the MAR.
18. Patient may be discharged when there is a discharge order from the physician and discharge criteria have been met.
19. Discontinue IV and give patient/family post-procedure discharge instructions.
20. (See [SEDATION GUIDELINES](#)).

C. Operating Room TEEs :

1. The Cardiac sonographer assigned to do the TEE in the OR will call the OR to determine when the case will be performed. Should there be a change in time from the originally scheduled time, it will be the responsibility of the sonographer to maintain contact with the OR to determine the new case time.
2. Before entering the OR, all cardiac sonographers are required to be in scrubs. No street clothes are to be worn in the OR.
3. Use the main surgery entrance. Surgical cap, shoe covers, and mask are required and will be worn prior to proceeding into the designated OR suite.
4. Once the patient is in the OR suite and when the anesthesiologist and nursing team have finished prepping the patient, bring the echo machine into the room and position it at the patient's left side.
5. Prior to insertion of the probe, apply ultrasound jelly on the tip of the probe. Assist the physician with inserting the probe by holding the control end of the transducer (if requested).
6. Notify Cardiologist that he is needed in the OR for the initial imaging study if instructed to by the anesthesiologist.
7. On completion of the initial imaging pre-op study, ask the circulating nurses to call the cardiology department when post-op imaging is required. The sonographer is also responsible for maintaining contact with the OR staff to determine when post-op imaging will be needed.

D. Inpatient TEE's s:

1. Physician Orders (EHR) will be noted or acknowledged.
2. Follow PROCEDURE section IV and gather supplies.
3. The patient will be recovered (see [SEDATION GUIDELINES](#)) with monitoring vital

signs every 15 minutes for a minimum of one hour post last sedation medication dose given.

4. Document in the MAR all medications given or not given.
5. Do not discontinue IV or discharge patient.
6. Patient may resume diet in 2-3 hours per in-patient orders.

E. Documentation:

1. All findings will be documented in the final TEE report by the performing cardiologist or anesthesiologist.
2. Probe used is logged by patient MR# probe serial number by sonographer.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American Society of Echocardiography, & Society of Cardiovascular Anesthesiologists. (2014). *Guidelines for performing a comprehensive transesophageal echocardiographic examination. Journal of the American Society of Echocardiography*, 27(9), 921–964. <https://doi.org/10.1016/j.echo.2014.07.001>
- B. American Society of Anesthesiologists. (2018). *Practice guidelines for moderate procedural sedation and analgesia. Anesthesiology*, 128(3), 437–479.
- C. O'Rourke, M. C., Goldstein, S., & Mendenhall, B. R. (2023). *Transesophageal echocardiogram*. In *StatPearls*. StatPearls Publishing. <https://www.ncbi.nlm.nih.gov/books/NBK442026/>
- D. Wiegand, D. J. (2021). *AACN procedure manual for high-acuity, progressive, and critical care* (8th ed.). Elsevier.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cardio Medical Director - Dr. Mukai	Kanae Mukai: Physician	6/23/2026
COO	Clement Miller: Chief Operating Officer	6/19/2026
Director of Cardiovascular Services	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Committee	Rebecca Alaga: Regulatory/	6/19/2026

Policy Owner

Accreditation Coordinator

Marissa Gonzalez: Manager
Cardiology Clinical

6/19/2026

Standards

No standards are associated with this document

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Origination 3/10/2017
Approved N/A
Expires 3 years after approval

Owner Marissa Gonzalez:
Manager Cardiology Clinical
Area Cardiology Departments

Guidelines for the Non-Invasive Cardiovascular Technologist (EKG Tech) Performing Electrocardiograms in the Emergency Department

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. The purpose of this policy is to provide guidelines for the non-invasive cardiovascular technician when performing Electrocardiograms (EKG/ECG) in the emergency department.

III. DEFINITIONS

- A. EKG- 12 lead electrocardiogram
- B. STEMI – ST elevation myocardial infarction

IV. GENERAL INFORMATION

A. All non-invasive cardiovascular technologists (EKG techs) assigned to the Emergency department for their shift will follow the procedure listed below in section V of this document.

V. PROCEDURE

- A. Emergency department assignments are rotated amongst all current staff on the EKG schedule.
- B. When assigned to the Emergency department, the tech will be provided a wireless phone

(#5262).

- C. Upon arrival to the Emergency department, the tech will synchronize the clocks on the EKG machines with the Emergency department atomic clock and initial the log.
 - 1. This process must be performed at least once per day.
- D. The tech assigned to the Emergency department will stay in the Emergency department whenever possible in order to respond to STAT's, Code STEMI's and chest pain patients in a timely manner (EKG within 10 minutes of patient arrival).
 - 1. After performing an EKG for a code STEMI or Chest Pain, the EKG tech will stamp the EKG with the "Time/ Reviewed By" stamp and hand off the EKG to the first available ER physician for timely review.
 - 2. Critical test findings will be immediately reported to the Cardiologist on-call per the Critical Test policy.
 - 3. The EKG tech will immediately upload the EKG to MUSE so that it is readily available for review by other chest pain/STEMI team members.
- E. The ED tracker should be open and visible to the EKG tech whenever possible to ensure orders are received and acknowledged.
 - 1. In the event that the tech has to leave the Emergency department, the tech will communicate to the charge RN or designee to communicate via wireless phone for any new orders.
 - 2. In the event that there are multiple Code STEMI's or STAT's at the same time, the EKG tech will call the Cardiology department for assistance from other staff members.

F. Documentation: N/A

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. N/A

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cardio Medical Director - Dr. Mukai	Kanae Mukai: Physician	6/23/2026

COO	Clement Miller: Chief Operating Officer	6/19/2026
Director of Cardiovascular Services	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Marissa Gonzalez: Manager Cardiology Clinical	6/19/2026

Standards

No standards are associated with this document

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Expires3 years after approval

OwnerPhilip Katzenberger: Director HIM/ Privacy Officer

AreaHealth Information Management

HIPAA Sanctions

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To set forth the sanctions against Salinas Valley Health (SVH) workforce who fail to comply with the HIPAA-related security, privacy, and transaction policies and procedures of SVH.

III. DEFINITIONS

- A. Workforce: Employees, volunteers, trainees and other persons whose conduct in the performance of work for SVH is under the direct control of whether or not they are paid by SVH. 45 C.F.R. § 160.103.

IV. GENERAL INFORMATION

- A. Compliance shall align with the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule (2013) and the California Confidentiality of Medical Information Act (CMIA), SVH and its workforce must safeguard the security and privacy of Protected Health Information (PHI). Failure to safeguard PHI may result in harm to patients. It also may result in institutional liability for Salinas Valley Health (SVH) and personal liability (civil and criminal) for individual members of SVH workforce. PHI must be protected to fulfill legal duties of SVH and to protect SVH, and members of its workforce from potential legal liability. To protect PHI, SVH adopts and implements security and privacy policies and procedures to keep PHI safe against a wide range of hazards, including unauthorized creation, access, use, disclosure, modification, destruction, or denial of access to PHI. Breach of SVH's security and privacy policies by a

member of the workforce is subject to formal discipline. This policy describes in general terms how sanctions are applied as part of this discipline.

V. PROCEDURE

A. A breach in information security and privacy may occur when a member of the workforce violates:

- The HIPAA statute or its implementing rules and regulations;
- Other applicable federal laws and regulations relating to the security and privacy of PHI and the technology and business processes related (among other things) to PHI;
- Laws or regulations of the State of California (or other governmental entities with applicable jurisdiction in California) governing the security or privacy of PHI;
- SVH's policies and procedures governing the safeguarding, use, or disclosure of PHI.
NOTE: SVH's policies and procedures refer to other institutional policies implementing a wide range of specific HIPAA rules and regulations issued by the U.S. Department of Health and Human Services.

B. Nature of security and privacy breaches warranting sanctions:

1.

- Breaches may result from careless or willful acts or omissions. A breach may include misrepresentation, other false pretenses, or malice. It may result in a technical violation of a law or internal policy or procedure (one that causes no harm to patients), or it may result in substantial damage to patients, to SVH or to third parties. In applying sanctions, SVH may consider, among other things, the cause of the breach, the motivation for the breach, and the effect of the breach on patients or others.
- Sanctions for a breach may lead to termination of employment. 1. Specific breach examples include, but are not limited to, the following: accessing PHI for which one has no business purpose

2. Disclosing PHI through unencrypted or unsecured means such as sending via unencrypted email. (Adher to Automated Data Loss Prevention, DLP, by typing "sendsecure" in the subject line will force auto-encryption of emails sent from SVH.com).

- a. Inputting PHI or proprietary hospital data into unauthorized Generative AI tools, i.e. public Chatbots.
- b. The use of unauthorized shadow IT, i.e. personal cloud storage or unapproved messaging apps, to transmit or store PHI.

3. Handing printed materials containing PHI to the incorrect patient.

- A particular breach may require rapid response for SVH to prevent a further or continuing breach, or to mitigate the effects of the breach. Among other things, rapid response to a breach may require terminating access to PHI for certain members of the workforce for an interim period. In some instances, termination of access may be part of the incident response rather than (or in addition to) application of sanctions. For

example, a preliminary or interim revocation of PHI access rights as part of an incident response may later become permanent as part of application of sanctions.

- Among other things, a security or privacy breach may trigger SVH's decision to report the breach to law enforcement authorities or to health oversight or other regulatory agencies (such as the Department of Health and Human Services). Refer to Administrative Policy # 6652 [USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION \(PHI\)](#)
- A security or privacy breach also may result in criminal prosecution by federal or state authorities, or in a civil lawsuit in which one or more members of SVH's workforce may be named as an individual defendant. In such a case, it is possible that one or more individuals may face personal criminal or civil liability, separate from the liability that SVH may face.

C. Sanctions for breaches of SVH's security and privacy policies:

SVH will take disciplinary action according to its existing policies governing workforce conduct and standards, for example, as described in the Medical Staff Rules and Regulations, SVH Employee Handbook and SVH [DISCIPLINARY POLICY](#).

- Level 1 (Unintentional): Careless handling or lack of awareness. Sanction: Retraining and written warning.
 - Level 2 (Intentional/Non-Malicious): "Snooping" on a coworker, neighbor, or one's own record. Sanction: Suspension and/or Final Written Warning.
 - Level 3 (Malicious/Financial Gain): Selling PHI, identity theft, or using PHI for personal harm. Sanction: Immediate termination and referral to law enforcement.
- A. In circumstances where expedited action is required for purposes of incident response or mitigation, SVH can be expected to apply expedited processes under its existing policies as well as preliminary or interim security and privacy measures as outlined in Section 3d, e, and f, above.
- B. SVH's privacy and security policies rely on many overlapping mechanisms to create a security and privacy safety net. Among other things, SVH relies on all its workforce members to stay alert and to report violations or potential violations of SVH's security and privacy policies and procedures. This is an affirmative obligation of all SVH's workforce members. Therefore, a workforce member who fails to report a known breach, or to immediately report suspected breaches to the Privacy Officer or via the Anonymous Compliance Hotline, may face disciplinary action up to and including termination of employment, contract, or work other relationship.
- C. SVH will maintain a written or electronic record of any sanction that is applied for six years from the date of its imposition or the date it was last in effect, whichever is later.
- D. Sanctions will not apply to a member of SVH workforce as a result of that person:
- Filing a complaint with the Secretary, U.S. Department of Health and Human Services as described in 45 C.F.R. § 160.306 (a),(b); testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under Part C of Title XI; opposing any act or practice made unlawful by Subpart E (Privacy

of Individually Identifiable Health Information, 45 C.F.R. § 164.534), provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of PHI violation of Subpart E; or

- Believing in good faith that SVH has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions furnished by SVH potentially endangers one or more patients, workers, or the public; **and** the disclosure is to:
 1. A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity;
 2. An attorney retained by or on behalf of the workforce member for the purpose of determining the legal options of the workforce member with regard to the conduct described above; or
- Being the victim of a criminal act and disclosing PHI to a law enforcement official, as long as:
 1. The PHI disclosed is about the suspected perpetrator of the criminal act; and
 2. The PHI disclosed is limited to the information listed in 45 C.F.R. § 164.512(f)(2)(i), as follows (and does not include any PHI relating to the individual's DNA or DNA analysis, dental records, or typing, samples, or analysis of body fluids or tissue):
 - a. Name and address
 - a. Date and place of birth
 - b. ABO blood type and rh factor
 - c. Type of injury
 - d. Date and time of treatment
 - e. Date and time of death, if applicable
 - f. A description of distinguishing physical characteristics, including height, weight, gender, race, hair and eye color, presence or absence of facial hair (beard or moustache), scars, and tattoos.

E. Sanctions still may be properly applied to a member of SVH's workforce if there is a reason to do so that is independent of the reasons listed above in this section.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Security and Electronic Signature Standards; Proposed Rule; 45 C.F.R. Part 142,

§142.308(a)(10)(iii)

- B. Standards for Privacy of Individually Identifiable Health Information; C.F.R. §164.308(a)(1)(ii)(C), §164.502(j), §164.512(f)(2), §164.530(e)
- C. California Civil Code § 56.36 (CMIA penalties)
- D. HITECH Act, 42 U.S.C. § 17931

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief Financial Officer	7/10/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	5/5/2026

Standards

No standards are associated with this document



Origination 6/6/2022
Approved N/A
Expires 3 years after approval

Owner Julie Johnson: Clinical Manager
Area Women's and Children's Services

Infant Car Seat Challenge

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the RN in assessing premature or at-risk infants for the ability to tolerate positioning in a car safety seat prior to discharge.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

- A. Infants at risk for respiratory compromise while sitting in a car seat will have a car seat test prior to discharge. The typical at risk infants have at least one of the following criteria:
1. All infants born at less than 37 weeks gestational age
 2. Oxygen dependence and/or mild to moderate chronic lung disease.
 3. Home apnea monitor.
 4. Other medical conditions (i.e.; hydrocephalus).

- B. The car seat test will be done by a RN within 7 days of planned discharge. If the infant passes the test but is not discharged on planned date the test does not need to be repeated.
1. Parent(s)/guardian(s) will be asked to bring in their own car seat in order to complete the testing. Parent(s)/guardian(s) who do not own a car seat and will be traveling by public transportation will not be expected to participate.
- C. Equipment
1. Car seat to be used on discharge.
 2. Blankets as needed.
 3. **NICU:** Cardio-respiratory monitor and O₂. Saturation monitors.
 4. **MB:** Oxygen saturation monitor. Heart correlation to saturation monitor is accomplished by auscultation whenever saturations fall below 94% to determine if patient has associated bradycardia.
 5. Large crib or secure table top to hold car seat.
- D. The RN will arrange for the parent(s)/guardian(s) to bring the car seat to the NICU/MB.
- E. The car seat test may be conducted after a feeding to avoid disturbing the infant's rest.
- F. The RN will secure the infant in the car seat at a 45 degree angle and buckle the straps and retainer clip according to the manufacturer's recommendations. The RN may teach the parent how to adjust the straps to fit the infant. Blanket rolls may be used to maintain the infant's head in neutral position to prevent airway obstruction.
- G. Infants are attached to cardiorespiratory (NICU) and or oxygen saturation monitors (MB) with alarms set.
- H. The infant will be monitored for a period of 90 to 120 minutes or the duration of the car ride home, whichever is longer.
- I. The infant is considered to have passed the car seat test if they do not demonstrate:
1. Apnea (cessation of breathing for >20 seconds)
 2. Oxygen desaturation (<90 %)
 3. Bradycardia (<80 bpm)
- J. If apnea, oxygen desaturation or bradycardia occur:
1. The test results are reviewed with the pediatrician/ Family Medicine physician/ neonatologist.
 2. Parent(s)/guardian(s) are encouraged to consider an alternative to the car seat, such as a car bed. Information for purchasing a car bed is provided for the parent(s)/guardian(s).
- K. Documentation:
1. Document pass or fail for the car seat challenge test in the electronic health record.
 2. Nursing documentation includes:
 - a. Date and time test performed.
 - b. Document baseline heart rate, respiratory rate and oxygen saturation.

- c. Test results.
- d. Any interventions used to enable the infant to pass the test, i.e. blanket roll, tilting seat.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

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

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	7/6/2026
NICU Medical Director	Robert Castro: PHYSICIAN	6/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/8/2026
Policy Owner	Julie Johnson: Clinical Manager	6/8/2026

Standards

No standards are associated with this document



Origination 3/27/2017
Approved N/A
Expires 3 years after approval

Owner Marissa Gonzalez:
Manager
Cardiology
Clinical

Area Cardiology
Departments

MUSE System Downtime Scheduled and Non-Scheduled

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. The purpose of this policy is to provide guidance for Cardiology staff, in the event of a MUSE system failure or downtime.

III. DEFINITIONS

- A. MUSE – ECG database

IV. GENERAL INFORMATION

- A. In the event of a MUSE system failure or scheduled downtime the Cardiology staff will follow the procedure outlined in section V of this document.

V. PROCEDURE

- A. For unscheduled and scheduled downtime
1. Identify the problem and notify the Cardiology Supervisor and/or Assistant Director.
 2. Hold all the editing and downloading of ECG's until the system is back up.
 3. Move to manual, paper based distribution of ECG's during downtime.
 4. When notified by the Cardiology Supervisor or the Assistant Director that the system is back up, process any editing or downloading that has been held.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. N/A

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cardio Medical Director - Dr. Mukai	Kanae Mukai: Physician	6/23/2026
COO	Clement Miller: Chief Operating Officer	6/19/2026
Director of Cardiovascular Services	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Marissa Gonzalez: Manager Cardiology Clinical	6/19/2026

Standards

No standards are associated with this document



Origination 3/25/2020
Approved N/A
Expires 3 years after approval

Owner Karina Kessler:
Clinical Manager
Area Women's and Children's Services

NICU: Non-Nutritive Breastfeeding

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide staff guidelines for non-nutritive breastfeeding (NNB) for the premature or ill infants in the Neonatal Intensive Care Unit (NICU)

III. DEFINITIONS

- A. **Non-nutritive breastfeeding (NNB)**, also called "dry" breastfeeding is breastfeeding after a mother has completed her pumping routine to empty her breasts' before putting the infant to breast.
- B. **Stable** is defined as infants who are not requiring frequent changes of respiratory support, with vital signs in normal ranges for the infant, who can tolerate brief handling with acceptable oxygen saturation levels. Infants on low dose dopamine may be considered stable if frequent adjustments of dosage are not required.
- C. **Skin-to-skin contact (STSC)** is when the infant, dressed only in a diaper and a hat, are placed against the parent (or other person designated by parent), chest in a prone, upright position.

IV. GENERAL INFORMATION

- A. Infants are put to an "emptied" breast as a transition from skin-to-skin contact to nutritive breastfeeding. NNB allows the infant to stimulate the mother's breasts while preventing a rapid flow of milk from a full breast when the infant's suck/swallow/breathe reflexes are mature. This provides positioning and latching opportunities with minimal volume intake.

- B. NNB improves mothers' milk supply and improves duration of breastfeeding post-discharge.
- C. Infants may be simultaneously gavage fed during NNB.
- D. Infant eligible for NNB include:
 - Stable premature infants of any weight or gestational age.
 - Respiratory status stable. Oxygen saturation levels within ordered parameters.
 - All lines are well secured including (Peripherally Inserted Central Catheter (PICC), Umbilical Artery catheter/Umbilical Venous Catheter (UAC/UVC).
- E. Infants doing NNB will have continuous cardiorespiratory and oximetry monitoring with the following exceptions. If the infant is stable off oximetry, it is not necessary to initiate oximetry for NNB.
- F. NNB may be attempted before, during and/or after gavage feeding, whichever works best for the infant.

V. PROCEDURE

- A. Provide privacy as requested.
- B. Mother may remove or wear bra and open blouse.
- C. Infant may be swaddled or with diaper and hat as for STSC. If only a diaper and hat, place warm blanket over infant and mother once infant is latched on.
- D. RN, lactation consultant (LC), or occupational/physical therapist (OT/PT) can assist mother in positioning the infant for breastfeeding.
- E. Record vital signs prior to and upon return to isolette as ordered. Monitor skin temperature of infant <1000 grams via electronic skin temperature reading on isolette.
- F. Start with 30-60 minutes, once daily and increase frequency and time as tolerated.
- G. Order entry:
 - Lactation consultant referral.
- H. Documentation
 - Document infant NN feeding in EMR
 - Document parent education and interaction in EMR.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. California Perinatal Quality Care Collaborative. (2023). Nutritional support of the very low birth weight infant: A CPQCC quality improvement toolkit (Revised 2018; updated October 2023). California Perinatal Quality Care Collaborative.
- B. Wambach, K., and Spencer, B. (2026). Breastfeeding and human lactation. 7th ed. Jones and Bartlett Learning.

- C. National Association of Neonatal Nurses. (2025). The use of human milk and breastfeeding in the neonatal intensive care unit.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Chair Dep OBGYN	Katherine DeSalvo: Director Medical Staff Services	7/13/2026
CNO	Carla Spencer: Chief Nursing Officer	7/10/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Julie Johnson: Clinical Manager	7/7/2026

Standards

No standards are associated with this document



Origination 3/25/2020
Approved N/A
Expires 3 years after approval

Owner Julie Johnson:
Clinical Manager
Area Women's and Children's Services

Outpatient Lactation Service

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To guide staff in the lactation outpatient service provided as a community service to mothers and infants needing to be evaluated, educated and assisted by International Board Certified Lactation Consultant (IBCLC) for establishment and maintenance of successful breastfeeding.

III. DEFINITIONS

- A. IBCLC – International Board Certified Lactation Consultant demonstrates specialized knowledge and clinical expertise in breastfeeding and human lactation and is certified by the International Board of Lactation Consultant Examiners (IBLCE).
- B. Clinical competencies encompass the responsibilities/activities that are part of the IBCLC's practice. The aim of these clinical competencies is to inform the public of the field in which the IBCLCs can provide safe, competent and evidence-based care. It is understood that the IBCLC will practice within the boundaries of their training, expertise, culture and setting.
- C. Lactation Service/Salinas Valley Health Medical Center (SVHMC) uphold the WHO/UNICEF "Ten Steps to Successful Breastfeeding". The Ten Steps to Successful Breastfeeding form the basis of the Baby Friendly Hospital Initiative. Baby Friendly hospitals and birth centers also uphold the International Code of Marketing of Breast Milk Substitutes by offering parents support, education, and educational materials that promote the use of human milk rather than other infant food or drinks, and by refusing to accept or distribute free or subsidized supplies of breast milk substitutes, supplies, and other feeding devices.

IV. GENERAL INFORMATION

- A. The Outpatient Lactation Service may assess breastfeeding mothers and infants through obtaining a history, performing a physical assessment, and evaluation of infant feeding.
- B. The IBCLC will observe for signs of jaundice, nipple pain, milk transfer, plugged ducts, mastitis, candidiasis, and/or other breast symptoms, and breast pump use if applicable.
- C. The IBCLC may communicate with primary care physician through phone conversation, Tiger Connect, or EMR of assessment and plan of care.
- D. Referrals to Lactation Service will be from community health care providers, self – referral by client, or by inpatient care providers desiring infant/maternal follow up for adequate latch, milk transfer, nipple pain, breast engorgement, breast/nipple anomalies or breast surgery, pumping and storage, or other concerns.

V. PROCEDURE

- A. Assessment of and appropriate history taking of the breastfeeding dyad. Discuss with mother the feeding history from time of delivery of infant and any feeding plan set up in the hospital care setting.
- B. Implementation of appropriate feeding plan. Provide appropriate oral and written instructions and/or demonstrate appropriate interventions and techniques.
- C. Facilitate referral to health care professionals, community services, and culturally sensitive support groups as needed.
- D. Use of equipment appropriately; assure cleanliness of equipment, discuss risks and benefits of recommended equipment, evaluate safety and effectiveness.
- E. The primary medical provider may be notified in the event of possible mastitis and candida overgrowth, jaundice, excessive weight loss, and any other medical concern.
- F. In the event a mother does not have primary care provider she will be given written assessment, plan, and follow up information to take with her to her next clinic visit.
- G. Documentation
 - The Outpatient Lactation Assessment screen will be utilized for charting on any mother/infant lactation service visit.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. International Board of Lactation Consultant Examiners. Scope of practice for International Board Certified Lactation Consultant. <https://iblce.org/wp-content/uploads/2018/12/scope-of-practice-2018.pdf>
- B. International Lactation Consultant Association. <https://ilca.org/resources/>
International Board of Lactation Consultant Examiners. Code of Professional Conduct for

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Chair Dep OBGYN	Katherine DeSalvo: Director Medical Staff Services	7/7/2026
CNO	Carla Spencer: Chief Nursing Officer	7/6/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/1/2026
Policy Owner	Julie Johnson: Clinical Manager	6/17/2026

Standards

No standards are associated with this document



Origination 3/27/2017
Approved N/A
Expires 3 years after approval

Owner Marissa Gonzalez:
Manager
Cardiology Clinical
Area Cardiology Departments

Performing Adult ECG's, Right-Sided ECG's, ECG's for Dextrocardia Presentation, and Rhythm Strips

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To assist the non-invasive cardiovascular technician with performing normal 12 lead ECG's, right-sided ECG's, Rhythm Strips and ECG's on patients presenting with dextrocardia.

III. DEFINITIONS

A. ECG/EKG - electrocardiogram

B. Right Sided Lead Placement is defined as follows:

1. The right chest leads are V3R, V4R, V5R, and V6R. The positive electrodes for these leads are in the same position on the right side of the chest as their counterparts on the left side. Lead V4R is the most useful of the right chest leads in the emergency setting. It is used to evaluate risk in patients with acute inferior myocardial infarction. **(Only the chest leads change their position in right-sided ECG's. The limb leads remain in original standard placement).**

C. Dextrocardia is defined as follows: Placement of the heart to the right, usually as one of two kinds:

1. Dextroposition in which the heart is simply displaced to the right
2. Cardiac Heterotaxia, in which there is complete transposition of the right and left chambers, the heart thus presenting a mirror picture of the normal anatomic location.

- a. (All leads change their position for patient's diagnosed with Dextrocardia. The limb leads are also reversed).

IV. GENERAL INFORMATION

- A. In order to ensure accurate lead placement for patients presenting with dextrocardia, those in need of a right-sided ECG, and normal left sided 12 lead ECG's or rhythm strips, the non-invasive cardiovascular technician will follow the procedures outlined below.

V. PROCEDURE

A. STANDARD ADULT ECG

1. Enter order in the electronic medical record as "**ECG**" for a 12 lead EKG, if the requisition has not already been provided to you. Enter all patient data from the requisition in the ECG cart. If no requisition is available, enter as much information as possible. **NEVER RUN A TOTALLY BLANK ECG.** You may edit the rest of the information at a later time.
2. Use age-appropriate communication skills to educate the patient before starting the procedure.
3. Observe universal precautions.
4. It may be necessary to shave the male patient's chest using a prep razor. Obtain verbal consent or acknowledgement from the patient prior to shaving.
5. Use standard lead placement. The placement of the precordial electrodes are to be placed in this manner:
 - a. V1 and V2 are on either side of the sternum at the fourth left intercostal space.
 - b. V3 is halfway between V2 and V4.
 - c. V4 is at the midclavicular line, fifth intercostal space.
 - d. V5 and V6 are placed in the anterior and midaxillary lines respectively. To identify the placement for V6, locate the fifth intercostal space at the sternal border and draw an imaginary line across the chest to the midaxillary line.
 - e. Limb leads should be placed on the patient's arms and legs. If unable to access the arms or legs, place near the patient's left and right clavicle and below the rib cage to the right and left sides.
6. Record 12 lead ECG.
 - a. Be sure to minimize any artifact before saving the ECG.
7. If there are **serious findings** on the tracing, give the ECG to the RN or physician immediately.
 - a. Follow hospital policy for [CRITICAL RESULTS OF TESTS AND DIAGNOSTIC PROCEDURES](#).
8. Unhook the patient and return any removed/moved items back to their original

location.

9. Clean all leads and return ECG cart to its original location.
10. **If the patient is an isolation patient, perform an immediate thorough cleaning of all equipment in direct contact with the patient. If you are paged to another call, you must:**
 - a. **Finish cleaning the cart before responding to the other call, or**
 - b. **Request assistance from another technician to cover the other call and finish cleaning the cart.**

B. RHYTHM STRIP

1. Select "**Leads**" and choose leads V1, II and V5, unless otherwise specified by the attending physician.
2. Run 3 pages of rhythm strips and file in the patient's chart.
3. The order must specify "Rhythm Strip", not EKG. If you have performed an EKG and rhythm strip, you will need 2 orders; one indicating "EKG" and 1 indicating "Rhythm Strip".
4. Follow the steps outlined above in section A of this document for unhooking the patient and completing the test.

C. RIGHT- SIDED ECG

1. Refer to the definition as stated above under section III. DEFINITIONS.
 - a. **Enter the diagnosis as "RIGHT-SIDED ECG".**
 - b. The precordial leads are to be placed in the same position on the right side of the chest as their counterparts on the left.
 - c. **Place the limb leads in the Standard Adult ECG position.** Only the precordial leads change position.
 - d. Record 12 lead ECG.
 - e. File the unconfirmed ECG in the patient's chart. **Highlight the diagnosis "Right-Sided ECG".**
 - f. Follow the steps outlined above in section A of this document for unhooking the patient and completing the test.

D. ECG PLACEMENT FOR THE PATIENT WITH DEXTROCARDIA

1. Refer to the definition as stated above in section III. DEFINITIONS.
2. **Enter the diagnosis as "Dextrocardia, R-Sided ECG"**
3. The precordial leads are to be placed in the same position on the right side of the chest as their counterparts on the left.
4. **REVERSE LIMB LEAD PLACEMENT IS USED.**
 - a. **Right leg lead goes on left leg.**
 - b. **Left leg lead goes on right leg.**
 - c. **Right arm lead goes on left arm.**

- d. **Left arm lead goes on right arm.**
5. Record 12 lead ECG.
6. File the ECG in the patient's chart.
7. Follow the steps outlined above in section A of this document for unhooking the patient and completing the test

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. **Mac 360 Resting ECG Analysis System** operator's manual.
- B. **Electrocardiography for Healthcare Professional**, Kathryn Booth and Thomas E. O' Brien, McGraw Hill Education, Fifth Edition, Chapter 4, Pages 90-126

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cardio Medical Director - Dr. Mukai	Kanae Mukai: Physician	6/23/2026
COO	Clement Miller: Chief Operating Officer	6/19/2026
Director of Cardiovascular Services	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Marissa Gonzalez: Manager Cardiology Clinical	6/19/2026

Standards

No standards are associated with this document



Origination6/26/2020

ApprovedN/A

Expires3 years after approval

OwnerMichelle Barnhart Childs: Chief Human Resources Officer

AreaAdministration

PTO Cash Out

I. POLICY STATEMENT

- A. The Hospital is committed to supporting your optimal work/life balance by providing Paid Time Off (PTO), while also offering flexibility in how you use your benefits. This policy allows eligible employees to cash out a portion of their accrued PTO hours. To comply with IRS regulations, PTO can be cashed out in two ways: through an Elective Cash-Out chosen the year prior, or through a Hardship Cash-Out in the event of an unforeseen financial emergency.

II. PURPOSE

- A. The Hospital encourages employees to take time away from work using their PTO for optimal work/life balance. It is the intention of this policy to provide employees with more flexibility in utilizing their time-off benefits consistent with all applicable laws and regulations.

III. DEFINITIONS

IRS - Internal Revenue Service

FTE - Full-time equivalent

IV. GENERAL INFORMATION

- A. Cash-outs are restricted to the following categories:
1. Elective Cash-Out
- a. Employees may elect to cash out a minimum of sixteen (16) hours of PTO in the next calendar year (the Cash Out Year). Elections must be made in the year prior to the Cash Out Year (the Election Year). The maximum

number of hours that can be cashed out is 100 percent of the PTO hours that the employee can accrue in the Cash Out Year if the employee works his or her FTE in the Cash Out Year.

- b. If an employee elects to have a cash-out, beginning on the January 1st pay period of the Cash Out Year, all hours accrued will be banked and held until the employee accrues the PTO hours requested in his or her cash-out election. Once the PTO hours elected for cash out are fully accrued, the Hospital will process the cash out. The same process shall apply to a second cash out, if elected, and will commence when the PTO hours set for the first elected cash out have been fully accrued.
- c. The amount to be cashed out cannot be more than what has been accrued in the Cash Out Year as of the date of the cash out, regardless of the employee's PTO total balance.
- d. To be eligible for an elective cash-out, employees must have a minimum of eighty (80) hours of PTO in their PTO bank as of December 31 the last pay period in the Election Year.
- e. The employee may elect to receive no more than two cash-outs in a Cash Out Year. Once a cash-out has been elected, it is irrevocable.
- f. The employee must make a new election for each calendar year.
- g. Elections for cash-outs must be made using the Elective PTO Cash Out form in accordance with annual program guidelines set by the Hospital each year. No exceptions will be made.
- h. It is an employee's responsibility to allow enough PTO hours in their bank to cover holidays, vacation, sick days, and emergencies. An insufficient PTO balance may result in disciplinary action.
- i. The Human Resources department will send communication to employees with dates for the elective PTO cash-out process each year.

2. Hardship Cash-Out

- a. In compliance with IRS guidance on PTO cash-outs, employees will be allowed to cash out PTO in the event of an unforeseen financial emergency. An unforeseen financial emergency is one in which:
 - i. an employee can demonstrate s/he has a real financial emergency caused by an event beyond his/her control;
 - ii. it would result in serious financial hardship if the cash payment were not made; and
 - iii. the amount of cash payment is limited to the amount necessary to meet the emergency.
- a. At least 16 hours of accrued PTO must be cashed out at one time and the employee must be left with a balance of at least 40 hours in PTO accruals.
- b. The request for PTO cash out must be made on a PTO Cash Out Request Form and submitted, with

substantiating documentation as outlined on the form, to the Human Resources department for approval.

- c. PTO may not be cashed out if the request is made in the same pay period that a disciplinary action (suspension) has occurred.

3. Elective and Hardship Cash-Out Provisions

- a. No shift differential shall be paid on PTO cash outs.
- b. The rate paid to the employee will be the employee's rate at the time of the actual cash-out.
- c. A separate check will be issued, on the installment date/pay date(s) specified by the employee, along with the regular paycheck. There will be no handwritten checks or "rush" checks for PTO cash out.
- d. See [Paid Time Off \(PTO\) - Affiliated Employees](#) and [Paid Time Off \(PTO\) - Non-Affiliated](#) policies for more details.

V. PROCEDURE

- A. All requests must be made by completing the Request Elective Cash Out form within the Absence application in Workday.
- B. The Human Resources department will review the request for eligibility and approval. After approval, the request form will be sent to the Accounting/Payroll department for processing.
- C. If transferring to a per diem position or terminating employment, all PTO hours will be cashed out as of the transfer or termination date.
- D. If an employee does not have enough PTO hours accrued to fulfill the elected cash-out amount, all PTO hours accrued in the Cash Out Year will be paid out at the end of the Cash Out year.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. N/A

Approval Signatures

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

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	6/16/2026

Standards

No standards are associated with this document

COPY



Origination 8/28/2020
Approved N/A
Expires 1 year after approval

Owner Timothy Albert: Chief Clinical Officer
Area Scopes Of Service

Scope of Service: Physician and Business Development

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goal of Physician and Business Development is to:

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

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.
- C. To plan for the allocation of human/material resources.
- D. To support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and

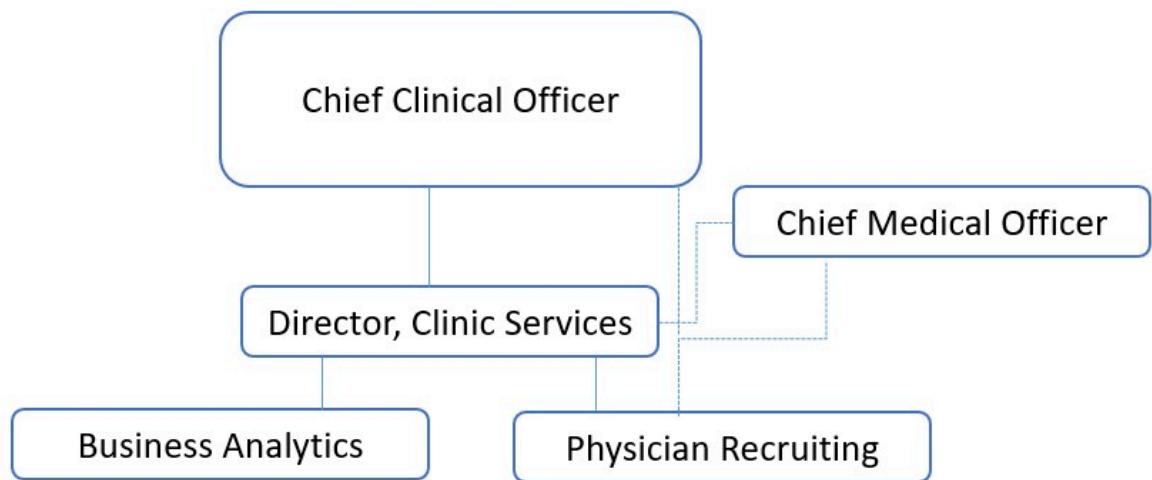
surgical interventions though patient/significant other education and to restore the patient to the highest level of wellness as possible.

- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Physician and Business Development function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

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

V. ORGANIZATION OF THE DEPARTMENT



- A. Hours of Operation
The Unit/Department provides services Monday through Friday from 8:00 a.m. to 5:00 p.m.
- B. Location of department
The Department is located in the Administrative Office Building.

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

- A. The Department purpose is to enhance patient services and health programs that help SVHMC remain a leading provider of medical care. The Department provides the following services:
 - 1. Identifies, develops and maintains effective relationships with healthcare providers, business, government and community
 - 2. Identifies and leads new business opportunities, market share expansion projects, and community service need activities
 - 3. Identifies and develops aligned physician and Hospital integration and contracting opportunities

4. Promotes the Hospital as the leader in the provision of quality healthcare services to the public and provider community
 5. Represents the Hospital in community-based collaborative planning, outreach and business development activities
 6. Identifies and recommends marketing and communication activities that will build market share, enhance physician relationships and strengthen the Hospital's contracting opportunities.
 7. Provides leadership and support to Hospital Directors in their efforts to meet the Hospital's service and business goals in specialty care areas and centers of excellence.
 8. Serves as liaison to business, government and the public.
 9. Facilitates development of health system strategic plan.
 10. Serves as key resource for business planning activities related to strategic investments.
- B. The Chief Clinical Officer of the department assumes twenty-four (24) hour responsibility for the Department.
- C. The Chief Clinical Officer of the Department is directly responsible to the Chief Executive Officer. It is the Chief Clinical Officer's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Chief Clinical Officer. In the Chief Clinical Officer's absence, the position is filled by their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF

All individuals who provide Department services have the appropriate training and competence.

A. Licensure / Certifications:

N/A

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

- Employee educational needs assessment at the time of hire and annually as part of

- developmental planning
- Performance improvement planning, data collections and activities
- Staff input
- Evaluation of patient population needs
- New services/programs/technology implemented
- Change in the standard of practice/care
- Change in regulations and licensing requirements

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

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

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

- D. Continuing Education
N/A

VIII. STAFFING PLAN

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

General Staffing Plan:

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

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

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Approval Signatures

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

Policy Committee

Rebecca Alaga: Regulatory/
Accreditation Coordinator

6/19/2026

Policy Owner

Timothy Albert: Chief Clinical
Officer

4/28/2026

Standards

No standards are associated with this document

COPY



Origination	N/A
Approved	N/A
Expires	3 years after approval

Owner	Louis Villaneda Sr.: Respiratory Care Manager
Area	Respiratory Care

Scope of Service: Respiratory Care Department

I. SCOPE OF SERVICE

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

The purpose of the Respiratory Care department is to enhance patient services and health programs that help Salinas Valley Health Medical Center remain a leading provider of medical care. The goal of Respiratory Care is to ensure that all customers will receive high-quality care/service in the most expedient and professional manner possible.

II. GOALS

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

The goal(s) of Respiratory Care are:

1. Provide comprehensive respiratory services to patients of all age groups.
2. The department is responsible for the assessment, treatment, management, and education of patients with cardiopulmonary disorders in accordance with physicians' orders, clinical protocols, and evidence-based practice.

III. DEPARTMENT OBJECTIVES

- A. To support Salinas Valley Health Medical Center's objectives.
- B. To support the delivery of safe, effective, and appropriate care/service in a cost-effective manner.
- C. To plan for the allocation of human/material resources.
- D. To support the provision of high-quality service with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to the highest level of wellness as possible.
- E. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- F. To evaluate staff performance on an ongoing basis.
- G. To provide appropriate staff orientation and development.
- H. To monitor Respiratory function, staff performance, and care/service for quality management and continuous quality improvement.

IV. POPULATION SERVED

- Neonatal
- Pediatric
- Adolescent
- Adult
- Geriatric

V. ORGANIZATION OF THE DEPARTMENT

- A. Department Personnel
 - 1. Manager
 - 2. NICU Educator
 - 3. Adult Educator/Supervisor
 - 4. Respiratory Care Practitioners
- B. Hours of Operation
 - 1. The department provides services twenty-four (24) hours a day, 365 days/year
- C. The department consists of:
 - 1. One (1) department
 - 2. One (1) Pulmonary Function Lab,
 - 3. Two (2) offices
 - 4. Two (2) storage rooms.

- D. Medication Administration
- E. Airway Clearance Therapy
- F. Pulmonary Diagnostics
- G. Airways Management Assistance
- H. Patient and Family Education

VI. SCOPE OF SERVICES PROVIDED

A. Airway Management

1. Initiation, setup, and calibration of invasive mechanical ventilation
2. Continuous monitoring and adjustment of ventilator settings
3. Implementation of ventilator weaning protocols
4. Discontinuation of mechanical ventilation (extubation support)
5. Troubleshooting ventilator-related issues and alarms

B. Non-Invasive Ventilatory Support

1. Setup, initiation, and management of:
 - a. Bi-level Positive Airway Pressure (BiPAP)
 - b. Continuous Positive Airway Pressure (CPAP)
 - c. Other non-invasive respiratory support modalities
2. Monitoring patient tolerance and response
3. Adjustment of therapy based on clinical assessment

C. Medication Administration

1. Administration of aerosolized medications via:
 - a. Nebulizers
 - b. Metered-dose inhalers (MDIs)
 - c. Dry powder inhalers (DPIs)
2. Evaluation of therapeutic effectiveness and adverse reactions

D. Airway Clearance Therapy

1. Chest physiotherapy (CPT)
2. Positive expiratory pressure (PEP) Therapy
3. Suctioning (nasopharyngeal, endotracheal, tracheostomy)
4. Cough assist devices

E. Pulmonary Diagnostics

1. Performance of pulmonary function testing, including:
 - a. Spirometry

- b. Lung volumes
 - c. Diffusion Capacity
 - d. Methacholine Challenge
- 2. Arterial blood gas (ABG) sampling and analysis
- 3. Venous blood gas (VBG) sampling and analysis
- 4. Interpretation assistance and reporting of results
- F. Airway Management Assistance
 - 1. Assistance with endotracheal intubation
 - 2. Preparation of airway management equipment
 - 3. Bronchoscopy support and assistance
 - 4. Code Blue Team
 - 5. Rapid Response Team
- G. Patient and Family Education
 - 1. Education for patients and caregivers on:
 - a. Asthma management
 - b. COPD management
 - c. Medications
 - d. Proper inhaler and device use
 - e. Smoking Cessation
 - 2. Development of individualized care plans and discharge teaching
- H. Patient Care Areas Served
 - 1. Neonatal Intensive Care Unit (NICU) Level III
 - 2. Intensive Care Unit (ICU)
 - 3. Coronary Care Unit (CCU)
 - 4. Progressive Care Units
 - 5. General Medical - Surgical Units
 - 6. Emergency Department

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

- A. The Respiratory Care department consists of one (1) pulmonary function lab, two (2) offices, and storage rooms. The client population consists of female/male patients of all age groups (neonates through geriatrics). Most services are provided to the patient at the bedside. Services are provided to inpatients and outpatients. Community educational services provided

include COPD (Chronic Obstructive Pulmonary Disease) and Asthma programs.

- B. The Respiratory Care team is comprised of both registered and certified respiratory care practitioners licensed by the State of California.
- C. The Senior Administrative Director and Manager assume twenty-four (24) hour responsibility for respiratory care provided at SVHMC. The leaders of this area are directly responsible to the Chief Administrative Officer, with oversight also provided by the Medical Director and Laboratory Director. It is the Senior Administrative Director's, or the designee's, duty to attend to all administrative and technical functions within the department. All department personnel are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Senior Administrative Director or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

VII. REQUIREMENTS FOR STAFF

All individuals who provide patient care services are licensed and registered (according to applicable state law and regulation) and have the appropriate/adequate training and compliance, including how to maintain a safe work environment.

- A. Licensure / Certifications: The basic requirements for Respiratory Care Practitioners include:
 - 1. Certified or Registered through the NBRC (National Board of Respiratory Care)
 - 2. Licensed by the State of California (Department of Consumer Affairs)
 - 3. Current BLS
 - 4. Current ACLS
 - 5. Current NRP
- B. The basic requirements for a Supervisor include:
 - 1. Registered through the NBRC (National Board of Respiratory Care)
 - 2. Licensed by the State of California (Department of Consumer Affairs)
 - 3. Current BLS
 - 4. Current ACLS
 - 5. Current NRP
- C. Competency

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

During the year, in-services are conducted routinely. The in-services are part of the department's ongoing 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, videoconferences, and speakers are scheduled for staff on occasion. Other

internal and external continuing education opportunities are communicated to staff members.

D. Identification of Educational Needs

1. Staff educational needs are identified utilizing a variety of input:

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

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

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

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

E. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The department is staffed with a sufficient number of professional, technical, and clerical personnel to cover established hours of care/service, maintain 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:

- Licensed Respiratory Care Practitioners (RCPs) provide services 24 hours a day, 7 days per week.
- Staff are trained and competent in all modalities of care provided

- The Pulmonary Diagnostics Laboratory provides services Monday through Friday, 07:00 - 1930

The Respiratory Care department flexes the staffing to meet the patient acuity level based on the number of respiratory care procedures. When respiratory care procedures exceed the available staff, attempts are made to secure additional staffing. When necessary, overtime is used. If the variance continues, the prioritization policy will be utilized.

Flex Staffing:

When the respiratory acuity decreases, staffing is adjusted to maintain a safe standard of practice and meet regulatory requirements.

IX. EVIDENCE-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 that 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.
- Promptly.
- Timely
- 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, which are available on the internal intranet site.

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

improvement and quality care is the responsibility of all staff members. Improvement activities involve department-specific quality improvement activities, interdisciplinary performance improvement activities, and quality control activities.

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

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

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

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
COO	Clement Miller: Chief Operating Officer	6/30/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/29/2026
Policy Owner	Louis Villaneda Sr.: Respiratory Care Manager	6/29/2026

Standards

No standards are associated with this document



Origination	10/23/2020	Owner	Judi Melton:
Approved	N/A		Director
Expires	1 year after approval		Supply Chain
		Area	Scopes Of Service

Scope of Service: Supply Chain

I. SCOPE OF SERVICE

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

The Management of the Sourcing, Procurement, Value Analysis, Purchasing, Contracts, Inventory Control, Supply and Equipment Distribution, Mailroom and Courier Logistics.

The responsibility for the purchase of all products, supplies, forms, furniture, equipment, vehicles and services at SVHMC.

Our mission is to cooperatively develop and execute sourcing strategies with SVHMC departments for products, equipment and services that meet or exceed the healthcare systems requirements, and to perform these services to the highest ethical and professional standards.

- Provides leadership through contract negotiations, supplier management and conversion to modern e-commerce purchasing technologies.
- Assists departments in maintaining compliance to all healthcare system policies regarding contracting and purchasing.
- Assists departments in contracting to maintain compliance to all applicable regulations

II. GOALS

In addition to the overall SVHMC goals and objectives, The Supply Chain Department oversees the relationships between SVHMC and its suppliers and insuring that all aspects of our relationships are held to the highest ethical and professional standards. Our suppliers contribute significantly to the ongoing success of SVHMC and Supply Chain in turn actively supports our suppliers and helps them achieve their objectives. The Supplier Diversity program, which promotes commerce with small,

disadvantaged and diversity owned businesses, is one example of this support.

The goals of Supply Chain Management are:

- A. To develop, maintain, purchase and coordinate supplies and equipment organization-wide to ensure adequate and timely delivery to support patient and hospital needs.

III. DEPARTMENT OBJECTIVES

The following products and services are managed by Procurement Services:

- Capital Equipment purchases/lease/rental
- Consultants, Contractors and Professional Services (non-construction related)
- Forms and Printing services
- Furniture and interior design services
- Laboratory equipment and services
- Freight/Logistics services
- Maintenance / Repair / Operations (MRO) supplies and services
- Maintenance Service contracts
- Office supplies
- Vehicles and transportation services
- Mailroom and Courier services
- Supply and Equipment Distribution
- Clinical gases
- Clinical Patient supplies
- GPO and Local contract management
 1. Review, process and issue Purchase Orders (PO)
 2. Prepare and issue PO change orders
 3. Reconcile PO invoice discrepancies
 4. Prepare and issue Requests For Proposals (RFP)
 5. Determine optimal ordering method to meet requirements at lowest possible cost
 6. Analyze quotations and proposals
- Evaluate and select suppliers
- Evaluate performance of suppliers and related competencies / training requirements
- Negotiate and review contracts
- Terminate contracts
- Participate in development of customer project specifications and standards
- Negotiate and execute equipment leases and rentals
- Conduct training sessions for Procurement programs and systems
- Identify cost reduction opportunities including:

1. off-contract spending
 2. tier maximization
 3. product and process standardization
- Conduct price/cost analyses
 - Participate in shared/group purchasing and manage GPO relationships
 - Schedule purchases and deliveries
 - Determine modes of transportation and carriers
 - Negotiate adjustments with suppliers
 - Administer Workday SCM module
 - Administer Symplr Value Analysis - GreenLight Product Request workflow

IV. POPULATION SERVED

All populations served.

V. ORGANIZATION OF THE DEPARTMENT

See attachment A for Department Org Chart

- A. Hours of Operation
The Procurement Office provides services Monday through Friday 8 a.m. to 4 p.m.
The Supply and Equipment staff provide services 24/7, Monday through Sunday, including holidays
- B. Location of department
The basement of the Downing Resource Center.

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

- A. The personnel assignment classifications:
 - **Director** - The Chief Operating Officer (COO) of the healthcare system has delegated specific responsibilities for the administration of procurement policies and procedures to the Director of Supply Chain:
 1. The authority to make purchases from allocated departmental budgets for services or materials is delegated by the signature of the departmental leader in Workday on each Purchase Requisition. Approval to spend budgeted per the Expense Approval Matrix policy
 2. Director has primary responsibility for leading, controlling, planning, organizing and evaluating the timely, effective and efficient delivery of the department's operations on a 24-hour basis. Through the incorporation of the Hospital's goals and objectives, this position is responsible for ensuring that the department performs to the highest possible standard within the resources made available, thus ensuring the delivery of quality

care and service to patients, staff and visitors. The Director acts as a role model, has accountability for the departmental/organizational budgets and Position Control for the department, ensures the consistent application of the Hospital's policies and procedures and fosters teamwork within and between areas of responsibility. The Director is also responsible for promoting specialized knowledge and skills through the support of staff education and professional development.

3. In the Director's absence, the position is filled by their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

- **Managers/Supervisor** – Oversees Supply Chain staff to ensure smooth and efficient warehouse/equipment distribution, ERP (Workday SCM system, Procurement and Contracts operation on a 24-hour basis. This is to include, warehouse staff, equipment staff, mailroom, courier, inventory and buyers. As directed, purchases materials, supplies and equipment. Researches and selects products according to quality, price and service ability. Negotiates contracts and price agreements. Maintains files regarding price lists, catalogs and other pertinent information. Works with the Hospitals Group Purchasing Organization. Functions as a person who will analyze, assess and streamline operations processes including planning, leading and driving projects. Informs user departments of substitute products, back orders, delays in shipments and out of stock items. Value Analysis Program - Coordination of new product/change product requests.
- **Contract Specialists** – develop, review, and process – from initial request to contract execution – Supply, (Consignment, Lease, Pricing) Capital, purchase services, equipment service, and IT (Software, Support and service) contracts. Handles administrative tasks, as well as respond to internal and external correspondence following established company policies. Maintains contract files and other pertinent information. Attends in-services and meetings as required. Works closely with department leadership in completing project. They comply with SVHMC policies, procedures and regulatory requirements.
- **Buyers** – are assigned by commodity or to specific groups of departments. Process all order requisitions, confirmations, and manage all delivery, quality and price issues with suppliers. Buyers also negotiate prices, terms and conditions with non-contract suppliers for spot purchases and assist departments in finding suppliers for non-contract purchases.
- **Inventory Specialists** – Contributes to the efficient operation of the department by ordering, PAR replenishment and monitoring distribution of supplies and equipment for Preoperative (Surgery, Outpatient services, PACU, Sterile Processing), Interventional Radiology and Cardiology-Structural Heart.
- **Supply and Equipment Technicians** –
 - Supply
Receives, delivers, checks and stocks equipment and supplies, conducts inventories and fills internal supply requisitions to assist in the reception and distribution of equipment and supplies in the warehouse and par level areas
 - Equipment
Cleans, process supplies, instruments, carts and equipment for all departments of the hospital.

- **Mailroom/Couriers** - Provides mail and courier service to SVHMC.

VII. REQUIREMENTS FOR STAFF

All individuals who provide Department services have the appropriate training and competence. The Supply Chain Department is comprised of director, managers, supervisor, buyers, supply and equipment technicians, inventory specialist, contract specialists and mail couriers.

There is no certification process required for these roles, with the exception of forklift driving, which is required for individuals utilizing a forklift.

A. Competency

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

During the year in-services are conducted routinely. The in-services are part of the 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.

B. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

- STAR Values
- Quality Assessment and Improvement Initiatives
- Strategic Planning (Goals & Objectives)

- New / emerging products and/or technologies
- Changes in Practice
- Regulatory Compliance

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

C. 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.

General Staffing Plan:

Supply Chain shifts schedules and workload to accommodate outside vendor delivery schedules and to ensure a minimum staffing. We achieve our required staffing by appropriate scheduling, altering schedules as needed when possible, utilization of per diem staff and when necessary authorization of overtime.

- Supply Chain Supply Technicians may work as Mailroom/Courier and Equipment Technicians may work as Supply Technicians to achieve optimal staffing.

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is:
20

IX. EVIDENCE BASED STANDARDS

Supply Chain department will deliver the **right** product, in the **right** quantity and the **right** condition, to the **right** place at the **right** time for the **right** customer at the **right** price.

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Supply Chain 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 Supply Chain department will develop measures to direct short-term projects and deal with problem issues evolving out of quality management activities.

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

Attachments

 [A: SC Scope of Service Org chart.docx](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
COO	Clement Miller: Chief Operating Officer	6/19/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Judi Melton: Director Supply Chain	4/29/2026

Standards

No standards are associated with this document



Origination 3/29/2021
Approved N/A
Expires 3 years after approval

Owner Philip Katzenberger:
Director HIM/
Privacy Officer

Area Health Information Management

Uses and Disclosures of Protected Health Information (PHI)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidance in protecting the privacy of the patient's Protected Health Information (PHI).

III. DEFINITIONS

- A. **Disclosure** – The release, transfer, provision of access to or divulging in of information outside of entity holding the information.
- B. **PHI** - Protected Health Information is Individually-identifiable Health Information that is transmitted or maintained in any media. There is an exception when the PHI is covered by or described in the Family Educational Rights and Privacy Act, or employment records held by Salinas Valley Health Medical Center (SVHMC). PHI includes "medical information" as defined by the California Confidentiality of Medical Information Act (CMIA), which extends to information regarding an individual's mental or reproductive health collected by social media, mobile applications, or other digital services.
- C. **Individual** – The person who is the subject of PHI.
- D. **Individually-Identifiable Health Information** – Information that is a subset of health information (including demographic information collected from an individual) and:
 - 1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
 - 2. Relates to the past, present, or future physical or mental health or condition of an

individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and

- a. That identifies the individual; or
 - b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- E. **Minimum Necessary** – When a provider requests, uses, or discloses PHI from another provider, it must make reasonable efforts to limit the PHI to the minimum necessary to accomplish the task.
- F. **Breach** – The unauthorized acquisition, access, use or disclosure of PHI which compromises the security or privacy of PHI in a manner not permitted by the Privacy Rule.
- G. **Amendment** – An addition to an individual's PHI.
- H. **Designated Record Set** - The medical and billing records maintained by or for SVHMC; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by a health plan; or records used, in whole or in part to make decisions about individuals treatment or determining financial responsibility. This does not include monitoring by electrocardiograms, electroencephalograms or electromyography, nor bedside monitoring devices unless those devices upload the data to the electronic health record. CA Health & Safety Code 123100-123149.5; 45 CFR 164.501.
- I. **Workforce Members** - Employees, volunteers, trainees, and other persons whose conduct in the performance of work for SVHMC is under the direct control of SVHMC, whether or not they are paid by SVHMC or a business associate.
- J. **Business Associate** – (BA) Generally, a person or entity who performs functions or activities on behalf of or for SVHMC that involves the use or disclosure of protected health information. Refer to 45 CFR 160.103 and CHA Privacy Manual for a more complete definition.
- K. **Data Use Agreement** – (DUA) An agreement into which a covered entity enters into with the intended recipient of a limited data set that establishes the ways in which the information in the limited data set may be used and how it will be protected.
- L. **Limited Data Set** – (LDS) Protected health information that excludes specific identifiers of the individual, and of relatives, employers or household members of the individual as defined in the HIPAA Privacy Rule.
- M. **Organized Healthcare Agreement** - (OHCA) A clinically integrated setting in which individuals typically receive healthcare from more than one provider, such as in a hospital. Example: the OHCA created by the Medical Staff of SVHMC.
- N. **Unsecured PHI** – Protected Health Information that is not encrypted and rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the California State Law or by the Secretary of the Department of Health and Human Services (HHS). In accordance with CA AB 352, SVH implements technical safeguards (i.e., electronic firewalls) within its Electronic Health Record (EHR) to prevent the automated or unauthorized export of reproductive health services information to out-of-state entities or federal law enforcement.
- O. **Provider** - SVHMC Medical Staff members and affiliates.
- P. **Use** - The sharing, employment, application, utilization, examination, or analysis of individually-identifiable health information by workforce members and providers of the entity that creates

and maintains the information.

- Q. **Health Care Operations** – Activity of the Covered Entity performed to run their business (covered functions). Refer to Section N.17 of this policy for a more expanded discussion of the definition and CHA Section on Health Care Operations under HIPAA vs. CMIA.
- R. **Chemical Dependency** – Alcoholism and drug addiction; the compulsively repeated alteration of brain chemistry by means of a toxin in order to produce temporary relief from frustration, grief or pain quickly without changing the thoughts or behavior that cause these negative feelings. SVH aligns the protection of Substance Use Disorder (SUD) records with HIPAA Privacy Rule standards. Once a patient provides a single written consent for treatment, payment, and health care operations (TPO), SVH and its business associates may use and disclose SUD records for these purposes as they would other PHI. Recipients of SUD records via this consent may further re-disclose the records in accordance with HIPAA regulations.
- S. **Mental Illness** – Medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning. Serious mental illnesses include: depression; schizophrenia; bipolar disorder, obsessive compulsive disorder (OCD); panic disorder; post-traumatic stress disorder (PTSD); and borderline personality disorder. The Diagnostic and Statistical Manual of Mental Disorders (DSM) which is the American Psychiatric Association's standard reference for psychiatry includes over 400 different definitions of mental disorders.
- T. **Sexually transmitted disease (STD)** – Diseases that are spread through sexual intimacy such as vaginal intercourse, oral sex, anal sex or sometimes skin to skin contact. STDs include: chlamydia; gonorrhea; syphilis; human papilloma virus (HPV); genital herpes; hepatitis B; human immunodeficiency virus (HIV); acquired immune deficiency syndrome (AIDS); pubic lice; scabies; and pelvic inflammatory disease (PID).
- U. **Substance Abuse** – A patterned use of a substance in which the user consumes the substance in amounts or with methods neither approved nor supervised by medical professionals. Some of the drugs most often associated with the term include alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, methaqualone and opioids. SVH aligns the protection of Substance Use Disorder (SUD) records with HIPAA Privacy Rule standards. Once a patient provides a single written consent for treatment, payment, and health care operations (TPO), SVH and its business associates may use and disclose SUD records for these purposes as they would other PHI. Recipients of SUD records via this consent may further re-disclose the records in accordance with HIPAA regulations.
- V. **Reproductive Health Care** - Health care that affects the reproductive system or the reproductive well-being of an individual, including but not limited to: contraception; preconception care; maternity care; infertility treatment; and services related to the termination of pregnancy.
- W. **Adult** – An individual age 18 or older or an emancipated minor.
- X. **Competent** – Having the ability to comprehend needs and risks.
- Y. **Emancipated Minor** – An individual who has been declared emancipated by the court; a minor who entered into a valid marriage or domestic partnership, whether or not the marriage or domestic partnership has been dissolved; or a minor on active duty with the armed forces of the United States.
- Z. **Secretary** – The Secretary of Health and Human Services (HHS) or any other officer or

employee of HHS to whom the authority involved has been delegated.

- AA. **Individual Review Board (IRB)** – A committee that has been formally designated to approve, monitor and review research involving humans.
- AB. **Qualified Protective Order** – An order of a court or of an administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding that prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested, and requires the return to the covered entity or the destruction of the PHI, including all copies made, at the end of the litigation or proceeding.
- AC. **Psychotherapy Notes** – Notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.
- AD. **More Stringent** – With respect to the rights of an individual who is the subject of the individually identifiable health information regarding access, permits greater rights of access. With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and remedies, provides the greater amount of information. With respect to any other matter, provides greater privacy protection for the individual who is the subject of the individually identifiable health information except as required by the Secretary of Health and Human Services in connection with determining whether a covered entity or business associate is in compliance with HIPAA.
- AE. **Contrary** – When used to compare a provision of state law to HIPAA, contrary means SVHMC would find it impossible to comply with both the state and federal requirements, or the provisions of state law stand as an obstacle to the accomplishment and execution of the full purposes and objectives of the Privacy Rule.
- AF. **CMIA** – Confidentiality of Medical Information Act. Civil Code Section 56. CMIA is California's primary health information confidentiality law for non-mental health patients, and also covers mental health patient information that is not covered by the Laterman-Petris Short (LPS) Act. HIPAA regulations preempt contrary state law, with certain exceptions.
- AG. **Treatment** – The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- AH. **Payment** – Activities undertaken by a health care provider or health plan to obtain or provide reimbursement for the provision of health care or a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan.
- AI. **Marketing** – A communication about a product or service that encourages recipients of the communication to purchase or use the product or service.
- AJ. **Financial Remuneration** – A direct or indirect payment from or on behalf of a third party whose product or service is being described. Direct or indirect payment does not include any payment for treatment of an individual.
- AK. **Record** – Any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for SVHMC.

IV. GENERAL INFORMATION

- A. Forms to be used with this policy are located at STARnet / HIM / Forms
- B. Forms may be modified to reflect proper provider identification and customization as needed. Some forms are samples directly from the California Hospital Association.
- C. Do not change the intent/content of the form.
- D. Refer to the current California Hospital Association Privacy Manual as a reference. This manual is written with both HIPAA and CMIA law in mind.
- E. The purpose of this policy is to define the uses and disclosures of protected health information (PHI). To comply with state and federal regulations.

V. PROCEDURE

- A. **ACCOUNTING OF DISCLOSURES** – HIPAA gives Individuals or their personal representatives the right to an accounting of how their PHI outside of SVHMC has been disclosed for up to 6 years prior to the Individual's request. The accounting must be requested in writing. In an attempt to be specific on behalf of the Individual, ask the Individual questions that may identify the specific area of concern. 45 CFR 164.528
 - 1. Exceptions to the accounting of disclosures:
 - a. Disclosures to carry out treatment, payment, or hospital operations.
 - b. Disclosures made to the individual who is the subject of the PHI, or the individual's personal representative.
 - c. Disclosures that are incidental to a permitted disclosure, e.g. the patient in one bed overhears the conversation between physician and patient in the next bed.
 - d. Disclosures made pursuant to the patient's authorization.
 - e. Disclosures from the facility's directory.
 - f. Disclosures of PHI to family, friends and others involved in the patient's care, appropriate to their involvement.
 - g. Disclosures used to notify a family member, personal representative or other person of the individual's location, general condition or death.
 - h. Disclosures to authorized federal officials for the conduct of lawful intelligence and security, protective services, or investigations.
 - i. Prohibited Disclosures: SVH is prohibited from using or disclosing PHI for the purpose of investigating or imposing liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care. For requests related to judicial proceedings, law enforcement, or health oversight, SVH must obtain a signed Attestation from the requester confirming the request is not for a prohibited purpose.
 - j. Disclosures to a correctional institution or law enforcement official that has custody of the patient.

- k. Disclosures of de-identified data or a limited data set.
- l. PHI disclosed prior to the date of compliance to this policy.

2. Maintaining an Accounting

- a. Providers must account for the following disclosures of PHI when made without a HIPAA-compliant authorization from the patient:
 - i. In connection with judicial and administrative proceedings (for example, a subpoena or a court order).
 - ii. For public health activities and reporting (for example, births, deaths, communicable diseases, lapses of consciousness, pesticide illness, burn and smoke inhalation injuries, cancer registry).
 - iii. To the FDA (for example, medical device malfunctions, adverse events, vaccine reactions, lookback, post market surveillance).
 - iv. To report injuries by firearms, assaultive or abusive conduct.
 - v. About victims of abuse, neglect, domestic violence.
 - vi. For health oversight activities (unless for treatment, payment or healthcare operations).
 - vii. To a law enforcement official pursuant to order, search warrant, regarding crime on premises, for identification and locating suspect and fugitives.
 - viii. To coroners, medical examiners, funeral directors.
 - ix. For cadaveric organ, eye or tissue donation.
 - x. For certain specialized government functions (military and veterans activities, national security and intelligence activities, protective services, correctional institutions and other law enforcement custodial situations)
 - xi. For workers' compensation purposes.
 - xii. To or by business associates (and regarding their disclosures) unless for TPO.
 - xiii. To researchers.
 - xiv. To the Secretary of U.S. Department of Health and Human Services.
 - xv. To avert a serious threat to health or safety.
 - xvi. Disclosures required by law.
 - xvii. Unlawful and unauthorized disclosures (breaches).

3. Content of the Accounting

- a. For each disclosure, the accounting of disclosure entry must include: the date of the disclosure; the name of the entity or person who received the PHI; and if known, the address of the entity or person; a brief description

of the PHI disclosed; and a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure or Individual may be given a copy of the request for disclosure.

- b. If SVHMC has made multiple disclosures of PHI to the same person or entity for a single purpose, the accounting may, with respect to such multiple disclosures provide the required information for the first disclosure during the accounting period, the frequency, periodicity, or number of disclosures made during the accounting period; and the date of the last such disclosure during the accounting period.
- c. RESEARCH: Special rules apply to accounting related to research based on an IRB or privacy board waiver of individual authorization, the provision of access to a researcher using only records of deceased individuals. Legal counsel should be consulted.

If SVHMC has made disclosures of PHI for a particular research purpose for more than 50 individuals, the accounting may, with respect to such disclosure for which PHI about the individual may have been included provide:

- i. The name of the protocol or research activity;
- ii. A description in plain language of the research protocol or other research activity including the purpose of the of the research and the criteria for selecting particular records;
- iii. A brief description of the type of PHI disclosed;
- iv. The date or period of time during which such disclosures occurred, or may have occurred, including the date of the last such disclosure during the accounting period;
- v. The name, address, and telephone number of the entity that sponsored the research and the researcher to whom the information was disclosed; and
- vi. A statement that the PHI of the individual may or may not have been disclosed for a particular protocol or research activity.
- vii. If SVHMC provides an accounting, and if it is reasonably likely that the PHI of the individual was disclosed for such a research protocol activity, SVHMC shall, at the request of the individual, assist in contacting the entity that sponsored the research and the researcher.

4. Requesting an Accounting

- a. SVHMC will provide an individual who requests an accounting of disclosures a *Request for An Accounting of Disclosure* form. Refer the individual to Health Information Management staff or Manager of the Clinical Practice to obtain the form.
- b. The individual accepting the completed authorization form will take reasonable steps to verify the identity of the individual. If the individual is unknown to the workforce member, the workforce member will:

- i. Verify the requestor's signature matches one on file or verify the individual's identity by examining government issued photo identification.
- ii. The individual accepting a completed authorization form will verify the form is filled out completely and will obtain missing information before the requestor leaves the hospital or clinic.
- iii. The authorization form will be routed or given to the Privacy Officer who will be responsible for processing the request.

5. Providing the Accounting

- a. The Privacy Officer will provide the requesting individual or personal representative with a written accounting of disclosures that occurred during the six years (or such shorter time period) at the request of the individual, including disclosures to or by business associates within 60 days of the request with the following exceptions:
- b. The personal representative can be denied access to the accounting if SVHMC has a reasonable belief that the individual has been or may be subject to domestic violence, abuse, or neglect by the personal representative and in the exercise of professional judgment decides that it is not in the best interest of the individual to treat the person in question as the individual's personal representative.
- c. Disclosures made to health oversight agencies or law enforcement officials shall be temporarily excluded from an accounting if SVHMC has been notified by the oversight agency or law enforcement official that providing a client or personal representative with an accounting of the disclosures made to them could impede the progress of their activities (e.g. fraud investigation or investigation of possible criminal activities when a client should not be aware of such scrutiny). Such request from a health oversight agency or law enforcement official should be in writing; however, an oral request may be accepted with stipulations, as noted below. Suspensions requested in writing shall remain in effect for the duration specified in the written request, unless the request for suspension is rescinded earlier by the health oversight agency or law enforcement official.
- d. If a health oversight organization or law enforcement official requests this temporary suspension orally, SVHMC shall perform the following:
 - i. Document the statement including the identity of the agency or official making the statement;
 - ii. Temporarily exclude from the accounting of disclosures those disclosures made to an oversight agency or law enforcement official based upon the oral information in the statement; and
 - iii. Limit the temporary exclusion to no more than 30 days from the date of the oral statement unless a written statement is submitted during that time specifying the duration.
 - iv. If SVHMC is unable to provide the accounting within 60 days, it

may extend the time by no more than 30 days provided that:

1. Within the first 60 days it provides the individual with a written statement of the reasons for the delay and the date by which it will provide the accounting.
 2. SVHMC can have only the one 30 day extension.
- e. A *Response to Request for an Accounting of Disclosures* form may be used to respond to the individual or personal representative if needed.
- i. Refer to a list of recommended "Disclosures That Must Be Accounted For" as assistance from the California Hospital Association.
 - ii. The Privacy Officer will provide the individual or personal representative with the first accounting at no charge. The Privacy Officer may impose a reasonable cost based fee for subsequent accountings.
 - iii. The Privacy Officer or designee will record on the accounting request their signature, title, the date, and a note that the accounting was provided.
 - iv. HIM/Medical Records will retain the request and the accounting in the individual's record for not less than six years from the date the accounting was provided.
 - v. The request and disposition will also be logged in an Accounting of Disclosures Log maintained by the Privacy Officer. (The log is not required by law, but will make demonstration of compliance easier should SVHMC be audited)

B. AMENDMENT OF PROTECTED HEALTH INFORMATION – HIPAA gives Individuals a right to request an amendment to their protected health information (PHI). The process of making an amendment is to be processed by the Health Information Management Department or Clinic Manager.

1. SVHMC may deny the request if it determines that the protected health information (PHI) that is the subject of the request:
 - a. Was not created by SVHMC , unless the individual provides a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
 - b. Is not part of the designated record set (DRS);
 - c. Would not be available for inspection by the individual under HIPAA section 164.524 (restriction on access to records); or
 - d. Is accurate and complete.
2. An employee or medical staff member who is a patient has the same rights to request an amendment; however, they must adhere to the same procedures as any other patient.
3. SVHMC workforce members will provide the individual who requests a correction to his or her PHI with:

- a. *A Request to Amend Protected Health Information* form.
 - b. Assistance in completing the form at individual's request.
- 4. Deciding Whether to Grant or Deny the Amendment
 - a. Upon receipt of the completed Request to Amend PHI form, the Privacy Officer/Clinic Manager or designee will review the request and in consultation with other individuals as appropriate (e.g. the author of the entry) will decide whether to accept or deny the requested amendment.
 - b. The Privacy Officer/Clinic Manager, or designee will act on the individual's request for an amendment as promptly as required under the circumstances but no later than 60 days after receipt of the request. If SVHMC is unable to act on the amendment request within the 60 days, SVHMC may extend the time for such action by no more than 30 days, provided:
 - c. That within the 60 days, SVHMC provides the individual with a written statement of the reasons for the delay, the date by which SVHMC will complete its action on the requests;
 - d. SVHMC may have only one such extension of time for action on a request for an amendment.
- 5. Accepting the Amendment- If the request is accepted, the author, Privacy Officer/ Clinic Manager or designee will:
 - a. Identify the records in the designated record set affected by the amendment.
 - b. Append the amendment or create a link or notation indicating where the amendment is located.
 - c. SVHMC must notify persons identified by the individual as having received protected health information about the individual and needing the amendment; (Refer to the "Notification of Amendment to Protected Health Information" form) and
 - d. Persons, including business associates, that the covered entity knows have the protected health information that is the subject of the amendment and that may have relied or could foreseeably rely on such information to the detriment of the individual.
- 6. Denying the Amendment

SVHMC may deny the request to amend as indicated in the Policy above. If SVHMC denies the requested amendment, in whole or in part, it must provide the individual with a written denial letter that outlines clearly:

 - a. The basis for the denial.
 - b. The individual's right to submit a "Statement of Disagreement" to the SVHMC and how to file such a statement.
 - c. A statement that, if the individual does not submit a "Statement of Disagreement," the individual may request that SVHMC include the amendment request and the denial with all future disclosures of the PHI

that is the subject of the amendment request.

- d. A description of how the individual may complain to SVHMC or the Secretary of DHHS. The description of how to complain to SVHMC must include the name or title and telephone number of the contact person or office that is designated to receive complaints.
- e. Review the amendment request forms for assistance.

7. Statement of Disagreement

- a. SVHMC must allow an individual to submit a written statement disagreeing with the denial and the basis of the disagreement. The form titled *"Statement of Disagreement/Request to Include Amendment Request and Denial with Future Disclosures"* can be given to the individual to help.

8. Subsequent Disclosures of Information Related to a Denial or a Request to Amend

- a. Designated HIM or Clinic staff will identify the record that is the subject of the disputed amendment and append or otherwise link the request for amendment, the denial of the request, the statement of disagreement (if any) and the rebuttal (if any) to the record.
- b. If a statement of disagreement has been submitted, SVHMC must include this information with any subsequent disclosure of the PHI to which the disagreement relates.
- c. If a statement of disagreement has not been submitted, the provider must include the request for amendment and the denial with any subsequent disclosure of PHI, but only if the individual has requested that the provider do this.
- d. If a subsequent disclosure is made using a standard transaction that does not permit the additional material to be included with the disclosure, the provider may separately transmit this material.

9. SVHMC Receives an Amendment from another Covered Entity

- a. When SVHMC is informed by another covered entity of an amendment to an individual's PHI, SVHMC will append or otherwise provide a link from the PHI to the location of the amendment.

- 10. Documentation of amendment requests and their disposition, all correspondence, forms, etc. will be retained in the patient's record. California Health and Safety Code Section 123111 does not provide for the HIPAA six year retention period since the request for addendum is to be included in the medical record and its retention period.

C. DISPOSING & DESTRUCTION OF PHI AND CONFIDENTIAL INFORMATION

- 1. SVHMC is to dispose and destroy all paper, floppy disk, CDs and any other medium that may or may not contain PHI or other confidential matter.
- 2. For hard drive destruction and disposal, contact Information Technology and refer to [DATA CONFIDENTIALITY](#). Information Technology advises against storing sensitive data on local workstation hard drives in order to protect the security and integrity of

the data.

3. All paper, floppy disk or CDs with PHI or confidential information will be disposed of in the designated locked grey shred bins.
4. Once paper documents, floppy disk or CDs are placed in the shred bin it should be considered shredded at that point. The following are the steps taken when a document or item is accidentally discarded and the shred bin needs to be opened:
 - a. Department management or Administrative Supervisor will be called for approval of need to open shred bin. Consider if the document can be recreated.
 - b. Call the Security Office. The shred bin will be opened by a Security Officer. The Security Officer is to remain on location until the shred bin can be locked.
 - c. An Occurrence Report is to be completed by Security.
5. HIM Department will maintain the vendors shred schedule. Contact them regarding any shred box pickup issues.
6. Once the process is complete, a receipt of destruction for each shred bin will be received from the shred company. The receipt of destruction is then kept on file by the HIM Department and retained according to the [RECORDS RETENTION POLICY](#)

D. CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS OR LOCATION REQUEST -

Individuals may request that we communicate with them through alternative means or at an alternative location.

1. Any request for alternative means of communication will be forwarded to the Privacy Officer for the Hospital or the Clinic Manager.
2. The Individual will be provided a "*Request for Alternative Means of Confidential Communications*" form. If the Individual does not use this form, they must provide their request in writing.
3. If the individual is not known by the workforce member, the workforce member will:
 - a. Verify the signature matches one on file; or
 - b. Verify the individual's identity by examining government issued photo identification.
4. The Privacy Officer or Clinic Manager is to determine the reasonableness if the request. SVHMC may condition the provision of a reasonable accommodation on how payment will be handled and specification of an alternative address or other method of contact. SVHMC may not inquire as for the reason of the request.
5. Inform the individual if SVHMC can accommodate the request.
6. SVHMC has to ensure the PHI is communicated via the alternative means or location. If this cannot be ensured, do not agree to the request.
7. The Individuals request is to be filed in the medical record and kept for the record retention period.
8. A log may be maintained to use as a quick reference. This is not required but will make documentation of compliance easier to track.

- E. **CREATION OF LIMITED DATA SETS** – (LDS) HIPAA provides the use and disclosure of a LDS in connection with research, public health or health care operations without a patient's authorization.

Any request for a LDS will require a Data Use Agreement or equivalent language in the contract/agreement and is to be directed to the SVHMC Privacy Officer except for LDS needed for the Clinical Trials Department. The Data Use Agreement is to be filed in the Contract Software System with the contract agreements and maintained for a period of not less than 6 years. Include the following language that:

1. Limits use and disclosure of the LDS to research, public health or health care operations.
2. Establishes who is permitted to use or receive the LDS.
3. Establishes permitted uses and disclosures by the LDS recipient.
4. Provides that the LDS recipient will:
 - a. Not use or further disclose the information other than as permitted by the agreement or as otherwise required by law
 - b. Use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the agreement
 - c. Report to the SVHMC Privacy Officer any use or disclosure of the information not provided for by the agreement of which it becomes aware
 - d. Ensure that any agents, including a subcontractor, to whom it provides the LDS agrees to the same restrictions and conditions that apply to the recipient with respect to such information
 - e. Not re-identify the information or contact the individuals.
5. The Privacy Officer will make arrangements internally or with a Business Associate to produce the PHI that excludes the following identifiers of the Individual, relatives of the Individual, employers and household members:
 - a. Names
 - b. Street or P.O. Address
 - c. Telephone numbers
 - d. Fax numbers
 - e. Electronic mail addresses
 - f. Social Security numbers
 - g. Medical record numbers
 - h. Health plan beneficiary numbers
 - i. Account numbers
 - j. Certificate/license numbers
 - k. Vehicle identifiers and serial numbers, including license plate numbers

- l. Device identifiers and serial numbers
 - m. Web Universal Resource Locators (URLs)
 - n. Internet Protocol (IP) addresses
 - o. Biometric identifiers including voice and fingerprints
 - p. Full face photographic images and comparable images
6. Violation of Privacy Regulations regarding LDS. If SVHMC knows of a pattern of activity or practice of the recipient that is in violation or material breach of the Data Use Agreement or contract/agreement, unless SVHMC takes reasonable steps to cure the breach or end the violation, as applicable, and if such steps are unsuccessful:
- a. Discontinues disclosure of PHI to the recipient; and
 - b. Reports the problem to the DHHS secretary.
7. If a covered entity is the LDS recipient, violation of the agreement is considered a violation of the privacy regulation by such recipient. Refer to [45 C.F.R. Section 164.514(e)(4)(iii)].

F. BREACH INVESTIGATION AND RESPONSE – SVHMC will investigate and assess all potential breaches of PHI and mitigate to the extent practicable harm to affected individuals, determine whether notification to affected individuals or other third parties is required, and provide notification.

- 1. The SVHMC Breach Response Team will consist of the Privacy Officer/Designee, Senior Administrative Director Quality Management, and Chief Human Resources Officer/Designee, and department/clinic management. As appropriate the Chief Information Officer, IT Security Officer, Compliance Officer, Risk Manager and other staff will be included in the team.
- 2. Any SVHMC workforce member who becomes aware of a potential breach of PHI will notify his/her supervisor of the suspected breach immediately.
- 3. The SVHMC workforce member or supervisor will document the facts related to the potential breach by completing an Occurrence Report in the Managing Events software and contact the Privacy Officer/designee as soon as possible.
- 4. Any medical staff member or business associate who becomes aware of a breach to SVHMC PHI will notify the SVHMC Privacy Officer/Designee.
- 5. A breach is considered discovered as of the first day on which the breach is known by SVHMC . This requirement does not include the offending workforce member knowing about the event and not telling another workforce member about the event.
- 6. Preliminary Investigation.
 - a. The Privacy Officer/Designee will interview as appropriate anyone having knowledge of the potential breach, and document findings on the HIPAA Questions form and as needed the HIPAA Breach Decision Tool and Risk Assessment Documentation form. There will be consideration of at least the following risk factors:
 - i. The nature and extent of the PHI involved, including the types of

- identifiers and the likelihood of re-identification.
 - ii. The unauthorized person who used the PHI or to whom the disclosure was made.
 - iii. Whether the PHI was actually acquired or viewed and the extent to which the risk to the PHI has been mitigated.
7. No Breach of PHI. If the breach assessment indicates there was no breach, and a HIPAA Breach Decision Tool & Risk Assessment was not used, any documentation generated will be maintained in the Privacy Office and retained for 2 years.
8. Breach of PHI/No Breach of Computer System. If the breach investigation and assessment indicates there is a breach of PHI, but the breach did not occur as a result of a problem related to computer technology, the Privacy Officer/Designee will:
- a. Pull together an Incident Response Team appropriate to the breach.
 - b. Lead the team in development, implementation and oversight of an action plan that:
 - i. Notifies the individual(s), California Department of Public Health (CDPH), HHS and media as required in the HIPAA Breach Notification Rule.
 - ii. Mitigates to the extent practicable, any harmful effects of the breach.
 - iii. Improves processes to minimize the possibility of recurrences.
 - iv. Applies sanctions in accordance with the Sanction Policy or Business Associate Agreement.
 - c. Log the event in the Event Tracker and maintain investigation and assessment documentation in the Occurrence Reporting system.
9. Breach of PHI Involving Computer System. If the breach investigation and assessment indicate there has been a breach in security of the computer system, the Privacy Officer and Security Officer will:
- a. Pull together an Incident Response Team appropriate to the breach.
 - b. Lead the team in development, implementation and oversight of an action plan that:
 - c. Notifies the individual(s), California Department of Public Health (CDPH), HHS and media as required in the HIPAA Breach Notification Rule.
 - d. Addresses the computer technology or security issue.
 - e. Mitigates to the extent practicable, any harmful effects of the breach.
 - f. Improves processes to minimize the possibility of recurrences.
 - g. Applies sanctions in accordance with the Sanction Policy or Business Associate Agreement.
 - h. Log the event in the Event Tracker and maintain investigation and assessment documentation in the Occurrence Reporting system.

10. Documentation of event and supporting documentation maintained for 6 years.
45CFR 164.402

G. BREACH NOTIFICATION – TIMELINE FOR REPORTING A breach is considered discovered as of the first day on which the breach is known by SVHMC . This requirement does not include the offending workforce member knowing about the event and not telling another workforce member about the event.

1. SVHMC. A breach of unsecured PHI is to be reported to California Department of Public Health (CDPH) and to the patient or their personal representative within 15 business days of discovering the breach.
 - a. The breach reporting letter, letter to the patient and additional information should be made to the hospital's CDPH Licensing and Certification district office. A list of district offices may be found at: <http://www.cdph.ca.gov/CERTLIC/FACILITIES/Pages/LCDistrictOffices.aspx>.
 - b. Content of reporting letter to CDPH. Include the following:
 - i. Date and time of reported incident
 - ii. Facility Name
 - iii. Facility address/location
 - iv. Facility contact person
 - v. General Information about the circumstances surrounding the breach
 - c. Any additional information needed to make the determination for an onsite investigation may be included in an attached memo.
2. SVHMC Reporting to DHHS. If a breach involves fewer than 500 patients, the breaches discovered in a calendar year must be submitted within 60 days after the end of each calendar year. The deadline is March 1st in most years, February 29th in leap year. Report as specified at www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html. DHHS requires Individuals to be notified as soon as possible but less than 60 days.
3. SVHMC . If a determination regarding an event cannot be completed within the 15 business days, a decision needs to be made regarding the reporting to CDPH. This decision is to be documented well and may be needed in an appeal. The fine for late reporting is \$100 a day per patient.
4. SVHMC . Law enforcement request for delayed reporting, notification, or posting. If a law enforcement agency or official determines that a notification, notice, or posting would impede a criminal investigation or cause damage to national security, the organization must delay the activity. Note that CA does not have a provision for delayed reporting at the request of law enforcement.
 - a. The law enforcement agency or official may provide a **written or oral statement** that notifying the patient would likely impede the agency's investigation of the breach. A date upon which the delay must end needs to be provided. The delay is not to exceed 60 days after a written request or 30 days after an oral request is made.

- b. If the law enforcement agency or official provided an **oral request/statement**, do the following:
 - i. Document the oral statement, including the identity of the law enforcement agency or official making the oral statement. Document the date of the oral statement.
 - ii. Limit the delay in reporting the breach to the date specified in the oral statement, not to exceed 30 days from the date of the oral request.
- c. A law enforcement agency or official may request an extension of the delay. SVHMC is to receive a written declaration that there exists a bona fide, ongoing, significant criminal investigation or serious wrongdoing related to the unlawful or unauthorized access to, use or disclosure of a patient's medical information and that notification of patients will undermine the law enforcement agency's investigation. The written statement must specify a date upon which the delay must end. This date cannot be beyond 60 days after the "end" date of the original delay request.

5. Notification to Individual:

- a. SVHMC. Notification to CDPH and patient is to proceed no later than 15 business days after the date designated as the end of the delay.
 - b. SVHMC. Notification to the patient is to be as soon as possible but less than 60 days after the date designated as the end of the delay.
6. Individual Notification. Written notice must be in plain language at an appropriate reading level with clear syntax and language with no extraneous materials. Americans with disabilities Act (ADA) and Limited English Proficiency (LEP) requirement must be met.
- a. Written notification is to be provided to the patient or if the patient is deceased, the next of kin or personal representative. If the patient is incapacitated/incompetent, the notification is to be sent to the personal representative.

7. Content of the Patient/Legal Representative Notification:

- a. Brief description of the breach and the date of the discovery of the breach.
- b. Description of the types of unsecured PHI involved in the breach.
- c. Steps individuals should take to protect themselves from potential harm resulting from the breach.
- d. Brief description of what SVHMC is doing to investigate the breach, to mitigate harm to the individual(s) and to protect against any further breaches; and
- e. Contact procedures for individuals to ask questions or learn additional information, which shall include a toll free telephone number, an e-mail address, web site, or postal address.

8. Means of Notification

- a. The individual whose information was breached must be notified by first class mail sent to the individual's last known address, or if the individual agrees to electronic notice and such agreement has not been withdrawn, by encrypted electronic mail.
- b. If SVHMC knows the individual is deceased and has the address of the next of kin or personal representative, written notice by first class mail to either the next of kin or personal representative may be provided in one or more mailings as information is available.
- c. E-mail notification is not permitted if the patient is deceased.
- d. If patient or their representative will not provide address or email address, SVHMC may telephone patient to come pick up the notification letter. If patient cannot do this, provide the contents over the phone. Document well. 78 Fed. Reg. 5566, 5651, Jan. 25, 2013.
- e. Substitute Notice – In the case where there is insufficient or out-of-date contact information:
 - i. For less than ten (10) individuals that precludes direct written notification to the individual, a substitute form of notice shall be provided such as a telephone call.
 - ii. In the case that there are ten (10) or more individuals for which there is insufficient or out of date contact information and contact information is not obtained:
 1. Post a conspicuous notice for 90 days on the home page of the SVHMC website; or
 2. Provide notice in a major print or broadcast media in the geographic area where the individuals affected by the breach likely reside.
 3. Include a toll-free number that remains active for at least 90 days.
 4. Work with Administration and Marketing regarding wording.

9. Breaches affecting >500 Individuals.

- a. The Privacy Officer/designee will work with the Compliance Officer, HIPAA Team and Director of Public Relations, and others as needed when there is a breach within the same state or jurisdiction.
- b. A press release containing the same information provided in the notice to the individual will be authored and sent to prominent media outlets within 15 business days of the discovery of the breach.
- c. Provide direct written notice to the Individual as described earlier in this policy.
- d. Report via the Office for Civil Rights breach portal without unreasonable delay and in no case later than 60 days of when the breach was

discovered. 45 CFR 164.400; HITECH 13402, 17932

- e. If event is a data compromise, check CA CIPA and notification to CA Attorney General. Civil Code 1798.82.

H. **MINIMUM NECESSARY** – Providers and workforce members acting on behalf of SVHMC must always use only the minimum amount of information necessary to accomplish the intended purpose of the access, use and /or disclosure of PHI.

1. Minimum necessary, in regards to system access, will be sustained through authorization, access, and audit controls (role-based access) and should be implemented for all systems that contain identifiable patient information. Providers and workforce members with system access may only access what they need to perform their job functions.
2. SVHMC must identify classes of providers and workforce members who need access to PHI to carry out their job function by the following:
 - a. List the categories of providers and workforce members within the organization.
 - b. Identify the degree (level) of PHI that each category of provider and workforce member is permitted to access.
3. The following categories of Providers and workforce members are permitted unrestricted access to PHI for the purpose of providing patient care or healthcare operations:
 - a. Attending physician
 - b. Consulting physicians (medical, surgical and specialists)
 - c. Nursing personnel (example: registered and licensed nurses and nursing assistants)
 - d. Clinical support staff (example: Unit Assistants, Clinical Informatics)
 - e. Health Information Management Personnel
 - f. Quality Management
 - g. Case Management, Disease Management, Infection Control
 - h. Clinical Administrative Management & Support Staff
4. The following categories of Providers and workforce members are permitted access to restricted PHI for the purposes of providing an element of patient care or healthcare operations:
 - a. Laboratory
 - b. Diagnostic Imaging
 - c. Pharmacy
 - d. Social Services
 - e. Clinical Nutrition Services & Nutrition Services Staff
 - f. Patient Financial Services
 - g. Registration

- h. Compliance & Auditing
 - i. Information Technology
 - j. Financial & Data Support
 - k. Non Clinical Administrative Management and Support Staff
 - l. Volunteers
 - m. Professional Program Students, Interns, Residents
5. The following categories of workforce members are not permitted access to PHI:
- a. Security
 - b. Environmental Services
 - c. Engineering
6. Providers and workforce members with unrestricted access to PHI are limited to use and disclosure of information for which they are responsible for the provision of health care.
7. Providers and workforce members with restricted access to PHI are expected to request permission to view the information that is necessary to achieve the purpose of providing the element of healthcare. The Privacy Officer/designee will review the requests on an individual basis.
8. Providers and workforce members are not permitted to access PHI for those individuals whom they are not responsible for providing care. This means that a provider or workforce member is not permitted to review PHI of a patient in another care area, review PHI of a friend or relative, review PHI upon request of another patient, or a patient from whom payment is not expected for healthcare services (as in the case of physicians, etc.). Access to PHI of friends or relatives as part of the job function is not to be performed if it is possible for a co-worker to perform the task. Request a coworker handle the job task.
9. Providers and workforce members may not access their own medical information except as allowable through the Patient Portal.
10. Providers may be granted access to PHI if needed for their treatment, payment or operations as defined in the [GRANTING ACCESS TO ELECTRONIC MEDICAL INFORMATION](#).
11. SVHMC may provide limited PHI if requested for research purposes and according to the policies on research activities.
12. Providers and workforce members may not use, release or request an entire medical record unless the entire record is identified as being the minimal amount of information needed to accomplish the intended purpose.
13. SVHMC may rely on the judgment of the party requesting the disclosure as to the minimum amount of information that is needed. The reliance is permitted when the request is made by:
- a. A public official or agency who states that the information requested is the minimum necessary for a purpose permitted under 45 CFR 164.512 of the Rule, such as for public health purposes.

- b. Another covered entity.
- c. A professional who is workforce member or business associate who states that the information requested is the minimum necessary for the stated purpose(s); or researcher with appropriate documentation from an Institutional Review Board (IRB) or Privacy Board. The Rule does not require such reliance, however, and SVHMC may exercise discretion to make its own minimum necessary determination for disclosures to which the standard applies.

14. The minimum necessary requirement does not apply to:

- a. Disclosures to or requests by a health care provider for treatment.
- b. Uses or disclosures made to individuals.
- c. Uses or disclosures made pursuant to an authorization.
- d. Health insurance agency with whom patient has coverage, or health information clearinghouse or if requested by a business associate for the purpose of providing professional services to the healthcare system/patient.
- e. Disclosures made to the Secretary of DHHS for an investigation or compliance review.
- f. Other uses or disclosures that are required by law under 45 C.F.R Section 164.512 (a)-e.g. where a state or other law requires disclosure, such as disclosure pursuant to a subpoena or court order, for workers' compensation purposes, or any other use or disclosure of PHI that is enforceable in a court of law.
- g. Uses or disclosure required for the provider to comply with HIPAA.
- h. Limited data sets and de-identified information.

15. Anyone needing assistance applying the minimum necessary standard should contact their supervisor or the Director of HIM/Privacy Officer/Designee.

I. **BUSINESS ASSOCIATE AGREEMENT** – SVHMC may require the services of a third party to administer operations. SVHMC will obtain from its business associates (BA) reasonable assurance that the (PHI) SVHMC discloses to its BA will be appropriately safeguarded and used or disclosed only as required by law or for the purpose for which it was disclosed.

- 1. The Privacy Officer will work with Administration and legal counsel to ensure SVHMC has a business associate agreement (BAA) that complies with the requirements of the Health Insurance Portability and Accountability Act's Privacy Rule and any subsequent Federal or State law on the subject.
- 2. Any contract or agreement where patient information will be accessed, used, or disclosed will be evaluated for the need of a BAA by the Privacy Officer. Any question if a BAA is needed, contact the Privacy Officer.

[HIPAA BAA List](#)

[BAA Decision Tree](#)

[BAA Provisions Checklist](#)

3. Refer to the Privacy Officer any BAA agreements wherein the vendor wants to use their own language or proposes changes to the SVHMC BAA language.
4. The Privacy Officer will compare the proposed language with HIPAA's requirements and discuss and work through with stakeholders language change proposals.
5. The signed BAA must be secured with the service contract prior to the provision of services by the vendor or payment for services by SVHMC .
6. A BAA must have a related contract or agreement. It cannot be a stand- alone document.
7. On receipt of a signed BAA, the signed contract or agreement and BAA are scanned into the contracting software central repository.
8. The scanned or hard copy will be retained no less than the expiration of the BA contract plus six years.
9. If and when a material change in the BAA language is necessary, the Privacy Officer will coordinate acquisition of the revised BAA for all BAs.
10. Breach of BAA.
 - a. SVHMC shall investigate compliance with the BAA and contract/ agreement if a complaint is made that the BA has violated the terms of the contract or if presented with information that contains substantial and credible evidence of a violation.
 - b. In the event of a breach, the SVHMC should procure in writing an immediate assurance from the BA that the problem has been corrected.
 - c. If after determining a BA is in breach of contract and the hospital finds it not feasible to terminate the contract, the hospital shall notify the Secretary of Health and Human Services.
11. Out of Office Coverage: If Privacy Officer is out of the office, send BAA to the Director of Internal Audit and Compliance for review and approval.
12. BAA Sign Off: The BAA is to be signed by whoever has the authority to sign the contract/agreement.
13. All Senior Management Team members responsible for contracts will be responsible to ensure that BAs have been identified and that the appropriate BAA or BA language is in place by the effective date.

J. PRIVACY COMPLAINTS / WAIVER OF RIGHTS - Individuals who have questions about SVHMC privacy practices or believe their privacy rights have been violated may contact or file a complaint with the Privacy Officer/designee.

1. When the Privacy Officer/designee is unavailable, staff may collect relevant information from the individual, and communicate that information to the Privacy Officer/designee via the Occurrence Reporting System or internal e-mail.
2. If a complaint is reported verbally, try to obtain it in writing via e-mail, fax, or mail. The reason for this is to ensure all the information is accurate and obtained for use in the investigation.
3. The Privacy Officer/designee will work with colleagues and leadership to investigate

the complaint, and evaluate the need for sanctions, opportunities to improve policy, process, education and training, and communication.

4. The Privacy Officer/designee will document in the Privacy Investigation log and/or Occurrence Reporting System each complaint and its resolution.
5. SVHMC may not require individuals to waive their rights to file a complaint with DHHS or to waive any of their other privacy rights as a condition for treatment, payment, enrollment in a health plan, or eligibility for benefits. 45 CFT 164.530(h)
6. The Privacy Officer will retain information for not less than 6 years, information about each complaint, investigative findings and action taken.

K. USES & DISCLOSURES REQUIRING AN OPPORTUNITY FOR THE PATIENT TO AGREE OR TO OBJECT - SVHMC may use or disclose (PHI) provided that the patient is informed in advance of the use or disclosure and has the opportunity to agree to or prohibit or restrict the use or disclosure. SVHMC may orally inform the patient of and obtain the patient's oral agreement or objection to a use or disclosure covered in this section. (164.510). Misuse of PHI carries penalties and sanctions. Refer to [HIPAA SANCTIONS](#) and [DISCIPLINE ADMINISTRATION](#) policies.

1. Use and Disclosure of PHI for Involvement in the Patient's Care and Notification Purposes.

- a. SVHMC may disclose to a family member, or other relative, or a close personal friend of the patient, or any other person identified by the patient, PHI directly relevant to such person's involvement with the patients' health care or payment related to the patient's health care.
- b. SVHMC may use or disclose PHI to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the patient, or another person responsible for the care of the patient of the patient's location, general condition, or death.

c. Section a and b above must comply with the sections below.

- i. **Uses and Disclosure with The Patient Present** - SVHMC may disclose to the family member, personal representative, or another person responsible for the patient's care, the patient's location and general condition, if the individual is present, and has the capacity to make health care decisions and SVHMC:
 1. Obtains the patient's agreement;
 2. Provides the patient with the opportunity to object to the disclosure and the patient does not express an objection; or
 3. Reasonably infers from the circumstances that the patient does not object to the disclosure.
- ii. **Limited Uses and Disclosures When Patient is Not Present or Cannot Agree or Object** - If the patient is not present, or the opportunity to agree or object cannot practicably be provide because of the patient's incapacity or an emergency circumstance, SVHMC may in the exercise of professional

judgment, determine whether the disclosure is in the best interests of the patient and if so disclose only the PHI that is directly relevant to the person's involvement with the patient's care or payment related to the patient's health care or needed for notification purposes.

SVHMC may use professional judgment and its experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to act on behalf of the patient to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

- iii. **Disaster Relief Purposes** – SVHMC may use or disclose PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating with such entities the uses or disclosures to notify, or assist in the notification of (including identifying or locating), a family member, a personal representative of the patient, or another person responsible for the care of the patient of the patient's location, general condition, or death, to the extent that SVHMC, in the exercise of professional judgment, determines that the requirements do not interfere with the ability to respond to the emergency circumstances.
- d. Basic information including the patient's name, city of residence, age, sex, and general condition (see general condition listing in Section L, [Media and Public Release of PHI](#) may be disclosed.
- e. **However, If patient is present** and has the capacity to make health care decisions and unless SVHMC determines that the following requirements interfere with the ability to respond to the emergency circumstances, SVHMC must follow the steps below before disclosing the information.
 - i. Obtain the patient's agreement, or
 - ii. Provide the patient with the opportunity to object to the disclosure (if the patient objects, no disclosure may be made); or
 - iii. Reasonably infer from the circumstances based on the exercise of professional judgment that the patient does not object to the disclosure.
- f. **If patient is not present** or is unable to agree or object to the use or disclosure due to incapacity or an emergency circumstance, the SVHMC may determine whether the disclosure is in the best interest of the patient and, if so, disclose only the PHI that is directly relevant to the disaster relief organization's involvement with the individual's health care.
- g. It is best to notify next-of-kin before releasing patient information, in disaster situations involving multiple casualties it may be necessary to share patient information with other hospitals and/or rescue/relief organizations prior to next-of-kin being contacted. (Normally, obtain legal

representative authorization prior to making any disclosure.)

2. **Patient is Deceased** - If the patient is deceased, SVHMC may disclose to a family member, personal representative or another person responsible for the patient's care or payment for health care prior to the patient's death, PHI of the patient that is relevant to such person's involvement, the patient's location and the fact the patient is deceased, unless doing so is inconsistent with any prior expressed preference of the individual known to SVHMC. Refer to Section Q on Authorization of Use and Disclosure.
3. **SVHMC Directory** – A Patient Directory is provided for use by Concierge Staff and others as needed. This directory includes patient name and location.
 - a. The patient or their legal representative has the opportunity to object to use and disclosure of their PHI in the Patient Directory by choosing to become a Confidential patient at registration or at any time during their stay. 164.520(e)
 - b. Patient's location is provided if the information is requested by patient name.
 - c. Any inquiry regarding a Confidential patient will receive an "we have no patient by that name" response.
 - d. In an emergency, if the patient does not have the opportunity to object, use the previous patient preference and in the exercise of professional judgment, what is in the patient's best interest.
 - e. Upon full registration or when practicable to do so, provide the patient the opportunity to object to the Patient Directory listing and the option to become Confidential. CFR 164.520(e)
4. **Clergy Services** – A patient's religious preference is collected at registration. During the Nursing Assessment, patient agreement or objection regarding pastoral visits is documented in the patient's medical record. SVHMC clergy will receive a notice with the patient's agreement or objection regarding a clergy visit. Any further notification to clergy is at the patient's request.

L. MEDIA AND PUBLIC RELEASE OF PATIENT INFORMATION –

SVHMC will not disclose protected health information (PHI) to the media except as permitted by federal and state laws and regulations. All requests for information from the media will be referred to the Public Relations Department.

1. The Public Relations Department has the responsibility of notifying Administration (Chief Strategic Communications Officer), Security and Administrative Supervisor if media is scheduled to be on the premises. All members of the media will be escorted by the Public Relations Department or authorized designee.
2. Employees need to notify Public Relations immediately if members of the media arrive at the hospital and are not accompanied by designated hospital personnel.
3. Public Relations will not release any information about "confidential" patients.
4. Public Relations will not release any information to the media regarding attending physician's name without the permission of the physician (as well as the patient).

5. Any inquiry must be by patient name. If patient is not Confidential, the following Basic Information that does not communicate specific medical information, may be used. Basic Information is defined to include:
 - a. The patient's name, age and sex.
 - b. The general condition of the patient. Definition of General Condition:
 - i. UNDETERMINED – Patient waiting physician assessment.
 - ii. GOOD – Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are excellent.
 - iii. FAIR – Vital signs are stable and within normal limits. Patient is conscious but may be uncomfortable. Indicators are favorable.
 - iv. SERIOUS – Vital signs may be unstable and not within normal limits. Patient is acutely ill. Indicators are questionable.
 - v. CRITICAL – Vital signs are unstable and not within normal limits. Patient may be unconscious. Indicators are unfavorable.
 - vi. DECEASED – Announcement of death is not to be made by the SVHMC. Obtain the patient's legal representative's authorization prior to making any announcement or providing any information.
6. HIPAA requires an authorization for release of a general description/nature of the reason for treatment, such as an injury, a burn, poisoning, or some other condition. This is considered medical information.
7. Patient Location should not be released to the media.
8. SVHMC may disclose that a patient was treated and released.
9. SVHMC must obtain a written authorization before media may use photographs, videotape, and interview a patient.
 - a. For CA Civil Code, although the Act states that "basic information" includes any information that is NOT "medical information" (Civil Code Section 56.06 (b)), it is NOT advisable to release information other than those items listed above, unless the patient specifically authorizes the release of other information.
10. **Disaster Situations** – Requirements for releasing patient information do not change. Media must have a patient's name before any information can be released as described above.
11. SVHMC may tell the media the number of patients that have been brought to our facility by:
 - a. Gender
 - b. Age group (adults, teens, children, etc.)
 - c. General cause of treatment need (an explosion, earthquake, etc.) as long as it is not identifiable to a specific person.
12. The Secretary of DHHS may issue a waiver for release of specific patient

information. Note, there is no process to waive penalties for violations of state health information privacy laws.

M. NOTICE OF PRIVACY PRACTICES – The Notice of Privacy Practices (NPP) ensures the patient's right to adequate notice of the uses and disclosures of (PHI) that may be made by SVHMC . It also describes the patient's rights, and the organization's legal duties with respect to PHI.

1. The Privacy Officer will ensure that the NPP meets the content requirements of the HIPAA Privacy Rule and will promptly revise, post and distribute the NPP when there is a material change in uses or disclosures, or legislation/regulation that changes its required content.
2. Whenever the NPP is revised, the Privacy Officer will coordinate replacement of the NPP on the organization's web site, where posted in registration areas, and where paper copies are made available to individuals by Registration staff.
3. The Privacy Officer will maintain a copy of each version of the NPP with its effective dates. Each NPP version will be retained not less than six years from the date it becomes obsolete.
4. Whenever the NPP is revised, the Privacy Officer will coordinate replacement of the NPP on the organization's web site, where posted in registration areas, and where paper copies are made available to individuals by Registration staff.
5. Responsibilities of Registration Leadership and Staff:
 - a. Registration Leadership will ensure that Registration Staff have the procedures, training and oversight necessary to ensure distribution of the NPP.
 - b. Registration staff will provide the notice:
 - i. No later than the date of the first service delivery or in an emergency treatment situation, as soon as reasonably practicable.
 - ii. Electronically and concurrently if the first service is delivered electronically.
 - c. When acknowledgement of the NPP cannot be obtained, the registration staff member will document good faith efforts to obtain acknowledgement and the reason why the acknowledgement was not obtained.
 - d. The Registration staff will file the acknowledgement in the designated location in the individual's record.

N. RELEASES - NO AUTHORIZATION REQUIRED - SVHMC may use or disclose PHI without a valid written authorization from the Individual only as specified in CMIA and HIPAA as follows:

1. When the information has been de-identified (See Section on De-identification of PHI).
2. To the individual or their legal representative; however, to validate identity of the individual and provide written evidence, ask for an Authorization for Disclosure or Use of Medical Information form to be completed if possible.

3. For its own treatment, payment, or healthcare operations. See section below on Operations for an expanded discussion.
4. To another covered entity for treatment. PHI can be disclosed to health care providers, health care service plans, contractors, or other health care professionals and facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a licensed health facility.
5. To another covered entity for payment activities of the receiving entity.
6. To another covered entity for health care operations if each entity has had a relationship with the individual and the information pertains to that relationship and the purpose is listed in paragraph (a) or (b) of the expanded definition of health care operations as described in item #15 below, or use or disclosure and in accordance with the minimum necessary standard (See Section on Minimum Necessary standard).
7. To another covered entity for detection of fraud and abuse or compliance with regulations.
8. A provider participating in an "organized health care arrangement" (as defined by HIPAA) may disclose patient information to other participants in the arrangement for any health care operations activities of the organized health care arrangement. (Example: hospital and medical staff share PHI for credentialing, quality assurance, and other peer review activities.
9. To Law Enforcement Officer who is trying to identify or find patient. Only disclose the information as displayed in Facility Directory. Any other information requires a subpoena.
See Section AA of this policy re: Law Enforcement.
10. When the use or disclosure is required by law.
11. To Business Associates with whom SVHMC has a valid business associate agreement.
12. To a health oversight agency or public health authority authorized by law to investigate or otherwise oversee relevant conduct or conditions of SVHMC or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by SVHMC .
13. To an attorney retained by or on behalf of a workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to unlawful business practices.
14. To law enforcement by a workforce member who is the victim of a criminal act provided that the information is about the suspected perpetrator of the criminal act and the information disclosed is limited to: the name and address; date and place of birth; social security number; ABO blood type and Rh factor; type of injury; date and time of treatment; date and time of death, if applicable; and description of distinguishing physical characteristics including: height; weight; gender; race, hair and eye color; presence or absence of facial hair; scars and tattoos.

15. To the following without obtaining special authorization:
 - a. Coroners or medical examiners
 - b. Organ procurement (Donor Network)
 - c. As part of a research project
16. Probate Court Investigator for Guardianship/Conservatorship Proceedings. CMIA permits medical information to be disclosed, HIPAA does not. HIPAA permits disclosure for judicial or administrative proceedings if there is an order from the court or administrative tribunal compelling disclosure; or in response to a subpoena, discovery request, or other lawful process. The patient notice process is to be followed.
17. Healthcare Operations. The following is an expanded review of the definition of Operations and means any of the following activities:
 - a. Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalized knowledge is not the primary purpose of any studies resulting from such activities; patient safety activities (as defined in 42 CFR 3.20); population-based activities relating to improving health or reducing health care costs; protocol development, case management and care coordination; contacting of health care providers and patients with information about treatment alternatives; and related functions that do not include treatment.
 - b. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities.
 - c. Except as prohibited under 45 CFR section 164.502(a)(5)(i), underwriting enrollment, premium rating, and other activities related to the creation, renewal, or replacement of a contract to health insurance or health benefits, and ceding, securing, or placing a contract for re-insurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance), provided that the requirements of section 45 CFR 164.514(g) are met, if applicable.
 - d. Conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse detection and compliance programs.
 - e. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.
 - f. Business management and general administrative activities of the entity, including, but not limited to:

- i. Management activities relating to implementation of and compliance with the requirements of this subchapter.
- ii. Customer service including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer
- iii. Resolution of internal grievances.
- iv. The sale, transfer, merger, or consolidation of all or part of a covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- v. Consistent with the applicable requirements of 45 CFR 164.514 creating de-identified health information or a limited data set, and fundraising for the benefit of the covered entity.

18. Provider and Ancillary Department Release of PHI – Hospital Only

- a. Physicians – Physicians can release PHI to the Individual as needed. Physicians are not to provide Individuals with complete copies of their medical records. Refer Individuals to the HIM Department.
- b. Releases to Providers – Any provider who states they are actively treating the patient has a right to PHI. Log any release that is not part of the normal documentation process. Refer any other release to HIM.

19. Payment – PHI is to be disclosed only to the extent necessary to determine responsibility for payment and secure payment. Payment activities must be related to the individual to whom health care is provided, and they include, but are not limited to:

- a. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefits claims;
- b. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- c. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess-of-loss insurance) and related health care data processing;
- d. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness or care or justification of charges;
- e. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
- f. Disclosure to consumer reporting agencies of and of the following PHI relating to collection of premiums or reimbursement:
 - i. Name and address;
 - ii. Date of birth;

- iii. Social Security number;
- iv. Payment history;
- v. Account number; an
- vi. Name and address of the health care provider and/or health plan.

- O. **RELEASE NEEDING AUTHORIZATION REQUIRED** – Individuals have a right to access and obtain health information about themselves in a designated record set (DSR). There are rare exceptions to access as discussed in Section Y.

SVHMC will obtain a valid written authorization prior to using or disclosing an individual's PHI, unless the use and disclosure is otherwise permitted (ex: TPO) or required by federal or state law. The use or disclosure of the PHI will be consistent with the purpose of authorization received. **Also refer to Release of Information – HIM Procedure.**

1. SVHMC workforce members will provide an Individual requesting copies of his/her records for themselves or copies be sent to a 3rd party with either:
 - a. The Authorization for Use or Disclosure of Health Information form used to request copies of records and directions for completing and submitting the form;
 - b. Instructions for obtaining the form on the SVHMC web site; or
 - c. Directions to the HIM/Medical Records Department in the Hospital or the front desk in a Clinic.
2. The staff member accepting a written authorization will review the document to make sure the authorization clearly specifies what the individual wants used or disclosed and that it is signed and dated.
3. The staff member accepting the authorization will give the authorization to the HIM/ Medical Records Department or designated Clinic staff. Staff will also review the authorization to ensure it contains the required content.
 - a. Validate the Individual's identity with a valid legal identification card with photo. Ensure signature on the authorization matches the one on file.
 - b. Obtain or validate phone number for contact information.
 - c. Make a copy of the requested information (when applicable).
 - d. Mailing or making arrangements to securely transmit or provide the information to the specified recipient.
 - e. Recording the disclosure in the release of information software application.
 - f. Scanning the authorization into the Individual's record.
4. HIM or the designated Clinic staff will return an incomplete or invalid authorization to the individual with an explanation and directions for correcting and resubmitting the authorization.
5. The authorization will be retained in the patient's record according to the record

retention policy but no less than 6 years from the expiration date.

6. Data Format.

- a. If the requested information is maintained in one or more electronic designated record sets and the individual requests an electronic copy, SVHMC must provide the PHI in the electronic form and format requested if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by SVHMC and the individual.
- b. If the requested information is maintained in one or more electronic designated record sets and the individual requests the information be transmitted to another person designated by the individual, SVHMC will encourage the individual to access the information via the secure patient portal, or if unavailable or unacceptable will send the information in an encrypted format so as to protect the information from unauthorized disclosure during transmission.

7. Inmate PHI. Request from Inmate of Correctional Facility.

- a. Release of medical records, after authenticating the signature of the patient, are releasable to the patient or authorized designee. See Section Y for denial of a request for records.
- b. Financial billing statements are the property of the State of California and not releasable by the SVHMC unless authorized by the State.

8. Deceased Records. An expired patient's record may be released to:

- a. The executor of the estate of a person who has a will
- b. The administrator of the estate (Court appointed individual) of a person who does not have a will
- c. Trustee under revocable living trust.
- d. A beneficiary of the estate (i.e., someone who stands to receive property from the estate by virtue of either a Will or Durable Power of Attorney, the laws of inheritance); life insurance beneficiary.
- e. If none of the above apply, disclosure may be made to family member or other person involved in patient's care (Advance Directive) or payment for care prior to death and PHI is relevant to such involvement. This is not allowed if inconsistent with patient's prior expressed preference. Use the following as guidance:
 - i. Spouse
 - ii. Adult Children
 - iii. Parents
 - iv. Adult Siblings
 - v. Adult Grandchildren
 - vi. Grandparents
- f. Any Individual requesting records of a deceased patient is to provide a

Death Certificate, proof of their identity, and proof of one of the above items.

- g. A conservator or an agent appointed under an Advance Directive does not have general authority to sign an authorization for release of information following the patient's death.

9. **Minors** – Personal Representative of a minor may act on the patient's behalf:

- i. Parent
 - ii. Guardian
 - iii. Other person in loco parentis (person acting as parent)
-
- a. However, The laws governing who may disclose a minor's medical information correspond to the laws governing who may consent to the treatment that the information covers.
 - b. Refer to the California Hospital Association: Consent Requirements for Medical Treatment of Minors.
 - c. In instances where the minor has the authority to consent to medical treatment, the minor is the person authorized to have access to the records regarding the treatment, and to decide to whom the records may be released. This is true even when parent or other legal representative solicits and consents to the treatment.
 - d. There may be times when the minor is requesting that the parent or other legal representative be treated as the minor's personal representative. Verify this with the minor.
 - e. Parental right may not be denied to a parent solely because that parent is not the minor's custodial parent. However, the parent does not have the right to access medical records where the minor has the legal authority to consent to the treatment. The request is to be denied.
 - f. Step Parents. Step Parents have no rights to receive medical records or medical information. Refer them back to the minor's parent.
 - g. Check the medical record carefully. A wrong release will be a HIPAA Breach. Parts of the medical record can be based on the minor's authority and other parts of the medical record can be under the parent or legal representative authority.

10. **Foster Parent Request.**

- a. Do not release PHI to foster parents unless they have a court order or have the consent of the child's legal custodian. Review documents for limitations on disclosure of PHI. Release only relevant information to treatment in question.
- b. If foster parent has the child on a temporary basis before a detention hearing has been held, there is no right to PHI. The request must come from CDPH Social Services.

- c. File a copy of the court documents into the medical record.

11. Ancillary Release of PHI – Hospital Only

- a. Nursing - If the patient or patient's physician requests that the patient receive specific PHI such as a test result, nursing staff may provide the patient a copy. Document the event in the medical record. Staff are to ensure there is a valid authorization that has not expired in the patient's medical record completed by the patient or legal representative. If the patient is being cared for at the time of request and is standing in front of you, documentation may be given without completing the authorization form.
- b. Lab – Staff may provide test results to patients who frequent the Lab multiple times a month due to a serious medical condition. Any other type of request for release of PHI is to be completed through HIM. Staff are to ensure there is a valid authorization that has not expire in the patient's medical record completed by the patient or legal representative.
- c. Diagnostic Imaging – On occasion there will be a need to provide test results to the Individual. Staff are to ensure there is a valid authorization that has not expired in the medical record completed by the patient or legal representative. Any other type of request for release of PHI is to be completed through HIM.

- 12. Redisclosure of PHI.** A recipient of medical information obtained pursuant to patient authorization or under a discretionary disclosure permitted under the CMIA may not further disclose the information to any other 3rd party unless the patient authorized the further disclosure or the use or disclosure is otherwise specifically permitted by law. Thus, the CMIA's restrictions apply not only to information created by a hospital in the course of rendering services, but also to patient records that the hospital obtains from other sources.

- 13. Attorney.** Disclosure to an attorney in response to an authorization will be referred to the HIM/Medical Record Department at the hospital and the practice manager at the clinics. The Risk Manager is to be notified of any authorization that suggests the possibility that legal action may be brought against SVHMC , one of its physicians or affiliates.

- a. Refer to CHA Manual section 5.14 for more information on ROI to attorneys.

- 14. Psychotherapy Notes** – HIPAA provides the concept of Psychotherapy Notes. Psychotherapy Notes require a separate authorization for just the Psychotherapy each release. To see the list of exceptions to that authorization requirement other than PTO, refer to the CHA Privacy Manual.

- 15. HIV** – An authorization is required identifying the release of HIV test results specifically and an authorization is required for each release. HIV Disease does not need special authorization. See the [RELEASE OF INFORMATION - HIM](#)

- 16. California Pre-Empt HIPAA Requiring an Authorization** - The following situations require a patient authorization before releasing medical records. HIPAA allows

release of information but California does not recognize such a request.

- a. Exception would be if separate federal law expressly requires or permits. CFR164.512 (k)
 - i. Disclosure of PHI involving certain military and veterans activities (e.g., disclosure of information about armed services personnel to military authorities for activities deemed necessary by the authorities.)
 - ii. Disclosure of PHI to authorized federal officials conducting lawful intelligence, counter intelligence, or other national security activities
 - iii. Disclosure of PHI to allow appropriate governmental agencies to provide protective services for government officials
 - iv. Disclosures to Funeral Directors. CFR 164.512(g)
 - v. Certain disclosures to Employer if:
 - a. SVHMC is retained by employer to provide health care to patient in course of evaluating workplace or determining whether patient has a work-related illness or injury
 - b. PHI disclosed consists of such findings
 - c. Employer needs information to comply with OSHA laws, and
 - d. Provider gives specific notice to employee or posts a general notice at workplace. 45 CFR 164.512(b)(1)(v)

17. **Workforce Access to Their Own PHI.** Members of SVHMC 's workforce or are permitted to access and/or obtain a copy of their own protected health information (PHI) only when adhering to the same procedures outlines above as required of any individual who is not a SVHMC workforce member.

P. **VALID AUTHORIZATION** – SVHMC will provide the Individual a valid authorization form called **Authorization For Disclosure or Use of Medical Information.** Designated HIM Department or Clinic staff will review the authorization to ensure that it is valid and complete and meets the following requirements:

1. Authorization is in plain language and printed in > 14 point typeface on SVHMC stationary or name of SVHMC is clearly identified. CA Civil Code 56.11a.
2. The name or other identification of the person(s), or class of persons authorized to make the requested use or disclosure
3. The name or other specific identification of the person(s) or class of persons to whom SVHMC may make the requested use or disclosure
4. A description of the information to be used or disclosed
5. A description of the purpose of the requested use or disclosure
6. The date on which the authorization expires
7. The signature of the patient or the patient's legal representative and date signed. If

someone other than the patient is signing the authorization form, that individual's relationship to the patient must be stated.

8. Notification of the patient's or patient's personal representative right to revoke the authorization in writing, the exceptions to the right to revoke and a description of how the individual may exercise the right to revoke the authorization.
9. Notification of SVHMC 's inability to condition treatment on whether or not the individual signs the authorization
10. Statement that the recipient of the PHI under the authorization is prohibited from re-disclosing the information, except with a written authorization or as specifically required or permitted by law. [CA Civil Code 56.13 superseding HIPAA.]
11. Notification to the individual of their right to receive a copy of the authorization when SVHMC requests an authorization for use or disclosure of PHI. [HIPAA supersedes 45 CFR 164.508(c)(4).
12. Authorizations for use or disclosure of chemical dependency, mental illness, and sexually transmitted disease must explicitly state that that information can be used or disclosed pursuant to the authorization.
13. Expiration date is provided if other than the one year date provided with authorization.
14. An authorization is not valid if the document submitted has any of the following defects:
 - a. The expiration date has passed [CA Civil Code 56.11(h) supersedes]
 - b. The authorization was not filled out completely (ex. Signature & date)
 - c. The authorization is known by SVHMC to have been revoked
 - d. Material information in the authorization is known by SVHMC to be false
15. An authorization cannot be combined with another kind of document except when the authorization is for use and disclosure of information for research and a consent to participate in the same research.

Q. WHO MAY AUTHORIZE USE/DISCLOSURE AND EXERCISE PATIENT RIGHTS

1. The person who may authorize disclosure of protected health information (PHI) or exercise the patient's information privacy rights under federal and state law is the same person who can consent to medical treatment. That person is the competent adult patient, emancipated minor patient, or the minor patient provided the right to consent to treatment for a specific condition under applicable state law.
2. An individual exercising an adult patient's rights must make decisions in accordance with the patient's instructions or, if those wishes are not known, authorize the access, use or disclosure or exercise the HIPAA privacy right, in the patient's best interest.
3. Generally speaking, no representative may authorize disclosure or exercise the patient's privacy rights under HIPAA if a person of higher priority has refused to give such authorization or if there are two or more individuals in the same class and the decision is not unanimous among all available members of that class.

4. SVHMC may reply on the representation or declarations of a person claiming to be a relative responsible for the care of a patient if SVHMC does not have actual notice that the information is false.
5. Adults:

When the adult patient or emancipated minor is incapable of authorizing disclosure or exercising his/her privacy rights under HIPAA, members of one of the following classes of person may exercise those rights on behalf of the patient in the following order of priority:

- a. Appointed guardian
 - b. Durable power of attorney encompassing the authority to make health care decisions
 - c. Advance Healthcare Directive Agent
 - d. Person legally obligated to financially support adult patient
 - e. The patient's spouse
 - f. Children of the patient who are at least 18 years of age
 - g. Parents of the patient
 - h. Adult brothers and sisters of the patient
 - i. Any relative who represents himself or herself to be an appropriate, responsible person to act under the circumstances
 - j. Any other competent individual representing himself or herself to be responsible for the health care of such person.
6. Minors - Persons who may authorize disclosure of PHI or exercise the patient's privacy rights when a minor is not competent because of age are as follows:
 - a. The parent, appointed guardian or legal representative
 - b. A person authorized by the court to consent to medical care
 - c. Either parent of the minor
 - d. The individual to whom the minor's parent has given a signed authorization to make health care decisions for the minor patient
 - e. A competent adult representing himself to be a relative responsible for the health care of the minor patient or a competent adult who has signed and dated a declaration under penalty of perjury.

Minors afforded rights to consent for a specific treatment or condition under state law also have the right to authorize disclosure to others (including the parent or legal representative). Refer to the **Medical Treatment of Minors Chart**. The minor may designate the parent or legal representative to be treated as the minor's personal representative and therefore have access to PHI.

Billing for minor services: The minor's parents or guardian is generally responsible for the payment of treatment. However, parents of a minor are not financially

responsible for healthcare or related services to which the minor may legally consent. (Exception is emancipated minors living in the home of the parent(s) or parents are participating in counseling with the minor.) Welfare and Institutions Code Section 14010

Medi-Cal "minor consent" program "sensitive services" enrolls minors and parents will not be contacted. Healthcare services covered are pregnancy, family planning, abortion, sexual assault, STD, mental health outpatient treatment and substance abuse treatment. It is acceptable to bill insurance companies, even if the parent is the named subscriber on the policy; payers are required to provide the minor's confidentiality.

SVHMC may deny access to the minors PHI if it is determined that access to the record would have a detrimental effect on the SVHMC professional relationship with the minor, or the minor's physical safety or psychological well-being. The decision as to whether or not to make the minor's records available will not result in any liability to the provider, unless the decision is found to be in bad faith.

Situations where SVHMC must provide specific information to the parents:

- a. Self-Sufficient Minors: Provider may (but is not required to) inform the minor's parents or guardian of treatment given or needed with or without the minor's consent, if the minor has told SVHMC where the parents or guardian may be contacted. Exercise caution for privacy rights of minor.
- b. Sexual Assault: SVHMC must attempt to contact the minor's parents or guardian, unless the professional person reasonably believes that the parent(s) or guardian committed the sexual assault on the minor.
- c. Substance Abuse Diagnosis and Treatment: Where the parent or guardian has sought the treatment and the minor receives the treatment, the physician must disclose information regarding the treatment to the parents or guardian upon request, even where the minor objects. Requests are to be directed to the minor's physician for disclosure.
- d. Noncustodial Parent: Access to records and PHI may not be denied to a parent solely because that parent is to the minor's custodial parent. However, noncustodial parents (or custodial parents) do not have the right to access where the minor has the legal authority to consent to the treatment. See **Medical Treatment of Minors Chart**. Family Code section 3025.
- e. Dependent Children of the Juvenile Court and Mental Health/ Psychotherapy Records: Refer to California Health Information Privacy Manual.
- f. Social Worker, Probation Officer, or Foster Care Public Health Nurse or other person legally authorized to have custody or care of a minor may receive PHI for the purpose of coordinating healthcare services and medical treatment. Psychotherapy notes may not be released. Minor must be a dependent child or ward of the juvenile court.
- g. Dependent Child of the court may have legal counsel access records for

the purpose of legal representation.

- h. Foster Parent: Access to records depends on placement with the foster parent:
 - i. By court order or with the consent of the child's legal custodians;
or
 - ii. On a temporary basis before a detention hearing has been held
 - i. Abandoned or Safely Surrendered Newborns: No information may be disclosed by any personnel regarding a parent or other person who surrenders a newborn pursuant to the safe surrender law.
7. Deceased - The following persons in descending order of priority may authorize disclosure or exercise the individual's privacy rights under HIPAA.
- a. Executor of the estate
 - b. Trustee under Revocable Living Trust or Beneficiary
 - c. Court appointed individual
 - d. Living Will and Durable Power of Attorney if the document authorizes the individual to make such decisions
 - e. Spouse
 - f. Adult children
 - g. Parents
 - h. Adult siblings
 - i. Adult grandchildren
 - j. Grandparents

Patient attorney is not a "personal representative" for obtaining medical records.

- R. **SECRETARY OF HEALTH & HUMAN SERVICES** – SVHMC and its BAs will submit compliance reports containing the information, including PHI, the Secretary determines necessary to determine whether SVHMC or its BAs have complied or are complying with the Privacy, Security and Breach Notification Rules.
- 1. SVHMC and its BAs will permit access by the Secretary during normal business hours.
 - 2. The Privacy Officer will be provided with and will respond fully to written requests by the Secretary.
 - 3. The Privacy Officer will record on the Secretary's request for information document, the information disclosed, the date the information was disclosed, the recipient, the Privacy Officer's name and title.
 - 4. The Privacy Officer will be notified, will accompany, and will see that the Secretary's needs are addressed if/when there is an onsite visit made by the Secretary to investigate a privacy related complaint or a compliance review of SVHMC or its BAs.
 - 5. Executive Leadership Group, Risk Management, and the HIPAA Team will be notified

as soon as possible.

6. The Secretary's request and information about the disposition of the request will be retained in the patient's record for not less than 6 years from the date the disclosure was made.

S. FAMILY / RELATIVE / CLOSE PERSONAL FRIEND / OTHER PERSON IDENTIFIED BY

INDIVIDUAL - SVHMC may disclose to a family member, other relative, close personal friend of the individual, or any other person identified by the individual, PHI directly relevant to such person's involvement with the individual's health care or payment related to the individual's health care.

1. Individual Present - SVHMC may disclose to the family member, relative, close personal friend, or other person identified by the individual, PHI relevant to such person's involvement if the individual is present, or otherwise available prior to a use or disclosure and has the capacity to make health care decisions and:
 - a. Provides the individual with the opportunity to object to the disclosure and the individual agrees to the disclosure or does not express an objection; or
 - b. Reasonably infers from the circumstances that the individual does not object to the disclosure.
 - c. Under these circumstances, for example:
 - i. A doctor may give information about a patient's mobility limitations to a friend driving the patient home.
 - ii. A hospital may discuss an elderly patient's payment options with her adult daughter.
 - iii. A doctor may instruct a patient's roommate about proper medicine dosage when she comes to pick up her friend from the hospital.
 - iv. A physician may discuss a patient's treatment with the patient in the presence of a friend when the patient brings the friend to a medical appointment and asks if the friend can come into the treatment room.
2. Individual Not Present or Cannot Agree or Object - If the individual is not present, or the opportunity to agree or object cannot practicably be provided because of the individual's incapacity or an emergency circumstance, SVHMC may use professional judgment and experience with common practice, to make reasonable inferences about whether a disclosure is in the best interests of the individual. When doing so, SVHMC may disclose only the PHI that is directly relevant to the person's involvement with the individual's care or payment related to the individual's health care.
 - a. Under these circumstances, examples include:
 - i. A physician informs the patient's spouse, who accompanied her to the emergency room that his wife has suffered a heart attack and provide periodic updates as to the patient's progress and prognosis.
 - ii. A doctor, consistent with professional judgment, discusses an

incapacitated patient's condition with a family member over the phone.

- iii. A hospital provides information that would allow the individual to pick up filled prescriptions and medical supplies.

- 3. Individual Deceased - If the individual is deceased, SVHMC may disclose to a "beneficiary" according to a "will" or a "personal representative" as an executor, administrator, or a person who performs substantially the same function. Refer to the Section Q on "Authorization Required, if the patient is deceased.

T. USE OF PATIENT'S PIN – SVHMC ONLY - The use of a patient PIN provides a method through which a patient can authorize the release of basic health information to designated individuals in person or over the telephone.

Information will not be released regarding patients who have requested a "Confidential Status" or is a Forensic patient.

1. Upon Admission, the patient will be assigned a unique code number- the last 4 digits of their account number. This confidential code (PIN Number) will be printed in English or Spanish upon admission by staff on the nursing unit.
2. Patients unable to make healthcare decisions (unconscious or demented, etc.)
 - a. When the emergency contact or next of kin cannot be verified, PHI may be shared with family, friends, or other individuals as long as the RN determines based on professional judgment, it is in the best interest of the Individual.
 - b. In these cases, staff should always verify that the individual requesting the information has a relationship with the patient and is involved in the care of the patient.
 - c. When patients are unable to make healthcare decisions, nursing staff will provide the PIN number to the next of kin/caregiver or guardian.
 - d. Also, in these types of scenarios staff should rely on the emergency contact information that has been specified on the Registration sheets.
 - e. If you have any questions, contact the Administrative Supervisor.
3. When possible, calls regarding a patient should be transferred to the patient's room, to enable the patient to speak directly to the caller.
4. When releasing information at the bedside to the patients when visitors are present, staff should respect the patients right to privacy by verifying with the patient if discussing their care in front of the visitor is ok.
5. The RN will discuss the purpose of the PIN Number with the patient and leave the form with the patient. (Mother /Baby Unit shall follow this policy when releasing information on the mother/surrogate in a language they understand.
6. The PIN Number Form provides a brief explanation of the health info that can be given to persons who provide this code when asking health questions. The PIN Number form will also be automatically printed to the unit's designated printer when the RN completes the Admission History queries. This second form may be filed in

the consent files section of the patients' record. The Emergency Room shall follow practices established in that department based on patient needs and emergency situations.

7. Patients will also be instructed that any person(s) asking about the patient's health who does not provide the PIN Number will be told only the patient's room number and a one word description of their condition (good, fair, serious, critical) The nursing staff may offer to transfer the telephone call to the patient's room or direct the individual to the patient's room.
8. When an individual telephones the nursing unit or approaches the nursing unit requesting information regarding a patient the following needs to be provided before any information can be divulged:
 - a. The person's identification (relationship to patient)
 - b. PIN Number

U. REQUEST FOR RESTRICTIONS

1. A patient may request for restrictions on uses or disclosures for:
 - a. Treatment, Payment, or Healthcare Operations
 - b. Disclosure to individuals involved in patient's care or notification purposes
CFR 164.522
2. SVHMC is not required to agree to a request for restrictions.
3. If SVHMC agrees to a restriction, it must honor the request and ensure restriction until such time as the restriction is terminated by the Individual or by SVHMC .
 - a. Emergency Treatment. SVHMC may not use or disclose PHI in violation of a restriction except that, if the individual who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide emergency treatment, SVHMC may use the restricted PHI or may disclose such information to a health care provider to provide treatment to the individual. If restricted PHI is disclosed to a health care provider for emergency treatment, SVHMC must request that such health care provider not further use or disclose the information.
 - b. Requests for restrictions to SVHMC health care exchanges must be made directly by the individual to the exchange. Contact HIM Department for assistance.
 - c. SVHMC workforce members will provide an individual who requests a restriction to the way his/her PHI is used or disclosed with either:
 - i. A request for Restriction form
 - ii. Directions to the HIM/Medical Records Department in the Hospital or front desk at the Clinic.
 - d. The workforce member accepting the completed Request for Restriction will take reasonable steps to verify the identity of the Individual. If the Individual is unknown to the workforce member, the workforce member will:

- i. Verify the requestor's signature matches one on file; or
 - ii. Verify the individual's identity by examining government issued photo identification.
- e. The workforce member accepting a completed Request for Restriction form will verify the form is filled out completely and will obtain missing information before the requestor leaves the Hospital or Clinic.
- f. The Request for Restriction form will be routed or given to the Privacy Officer/Designee who will be responsible for processing the request.
- g. The Privacy Officer/Designee will work with colleagues at SVHMC to determine the reasonableness of any non-required restriction request.
- h. Once a decision is made, the Privacy Officer/Designee will notify the requestor as to the decision.
- i. The Individual's request will be filed in the Individual's record with a notation as to the date, name of the Privacy Officer/Designee, and disposition of the request.
- j. The request and disposition will also be logged in a Request for Restrictions of Uses and Disclosures Log maintained by the Privacy Officer/Designee. (The log is not required by law but will make demonstration of compliance easier should SVHMC be audited.)
- k. SVHMC may terminate its agreement to a restriction if:
 - i. The Individual agrees to or requests the termination in writing. (The individual may use the Request for Restriction form for this purpose.)
 - ii. The Individual agrees verbally and the agreement is documented in the individual's record.
 - iii. The restriction pertained to a health plan when the Individual (or another party other than the health plan) paid the bill for the health care item or service in full.
 - iv. SVHMC informs the Individual that it is terminating its agreement to a restriction except that such termination is only effective with respect to PHI created or received after it has so informed the Individual.
- l. Documentation of the request for restriction and disposition will be retained for not less than six years from when the restriction was last in effect. File the documentation with the patient's non-legal portion of the medical record.
- m. Documentation of any termination will be retained for not less than six years from when the restriction was last in effect. File the documentation with the patient's non-legal portion of the medical record.

V. SUBPOENA OR DISCOVERY REQUEST - For SVHMC, all subpoenas and discovery requests for PHI will be referred to the HIM/Medical Record Department for appropriate processing. For

SVMC, all Subpoenas and discovery requests for PHI are to be referred to the practice manager for appropriate processing with a Release of Information vendor. On receipt of the subpoenas or discovery request, the designated HIM/Medical Records staff will ensure the subpoena or discovery request:

1. Directs SVHMC or a SVHMC physician to disclose an individual's PHI; and
2. Is accompanied by a valid authorization; or
3. Is accompanied by a written statement and supporting documentation demonstrating:
 - a. The requestor has made a good faith attempt to provide written notice to the individual; and
 - b. The notice to the individual included sufficient information about the litigation or proceeding to permit the individual to raise an objection to the court; and
 - c. The time for the patient to raise objections to the court has elapsed and no objections were filed, or all objections filed have been resolved by the court and the disclosures being sought are consistent with such resolution; or
 - d. Is accompanied by a written statement and supporting documentation demonstrating:
 - i. The parties to the dispute giving rise to the request for information have agreed to a qualified protective order and have presented it to the court; or
 - ii. The requestor has sought a qualified protective order from the court.
4. Information received or generated by a program subject to the Confidentiality of Alcohol and Drug Abuse Patient Record Rule will be disclosed only in response to a valid authorization specific to those records or a Court Order that imposes safeguards for the information once disclosed by SVHMC .
5. If/when the proper documentation is secured, the designate HIM/Medical records staff will:
 - a. Consult SVHMC 's legal counsel with any questions or concerns they may have.
 - b. Notify Risk Management if/when the subpoena suggests the possibility of a claim against SVHMC , one of its physicians or affiliates.
 - c. Determine whether a copy of an original paper record needs to be generated and the original locked up to prevent tampering.
 - d. Determine whether a second copy of all information is required by the SVHMC s attorney.
 - e. Coordinate acquisition of the required PHI content that HIM/Medical Records is unable to produce.
 - f. Make copies of only that information expressly authorized by the subpoena or discovery request.

- g. Note the disclosure on the subpoena or discovery request with a signature and date.
- h. Record the disclosure in the release of information software application.
- i. Scan the subpoena or discovery request into the individual's record; and
- j. Make arrangements to mail or securely transmit or transport the required information to the designated recipient.

6. Refer to the **RELEASE OF INFORMATION - HIM** .

The following is more detailed information regarding subpoenas.

The laws governing the validity of the subpoena and compliance with it vary according to the type of proceeding and whether it occurs under state or federal jurisdiction. Copies of CA subpoena forms may be found at www.courts.ca.gov/forms.

1. When served with a subpoena, identify what kind received:
 - a. The entity which issued the subpoena
 - State Court
 - i. State Administrative Agency
 - ii. Federal Court
 - iii. Federal Administrative Agency; and
 - b. The type of proceeding for which it was issued
 - i. Civil action
 - ii. Administrative Agency Hearing or Investigation
 - iii. Criminal Action
2. PHI Exempt from Subpoenas:
 - a. HIV test results. These require an authorization from the patient for each release or a court order.
 - b. Test results for rhesus blood type, hepatitis B and HIV performed pursuant to Health and Safety Code sections 125080 and 125085 (Prenatal Testing) and protected from disclosure under Health and Safety Code Section 125105. These require an authorization from the patient.
 - c. Information requested by Law Enforcement Officers.
3. Civil Subpoenas
 - a. Validity of Subpoena. Determine the validity of the subpoena. The subpoena must be properly served, appropriately designates the hospital or clinic/practice, and, when required is accompanied by the certification of notice to the patient and meets the time requirements specified for production.
 - b. A subpoena is to be served to the hospital or clinic/practice in person. A subpoena sent by mail has not been properly served. Contact the party

who requested subpoena and object.

- c. When necessary, the witness fee and mileage are to be paid if employee appears at court.
- d. Subpoena Duces Tecum. This subpoena is for the delivery of records to court and must specify the exact documents to be produced. The patient is to be clearly identified in the subpoena and the records requested identifies that particular patient.
- e. Affidavit. The civil subpoena must be accompanied by an affidavit or declaration of the requesting attorney or other witness. Check for the following documentation in the affidavit:
 - i. Description of the facts showing there is "good cause" for the production of records and a description of how the records are "material" to the issues involved in the case;
 - ii. Directions on how the documents are to be produced; and
 - iii. State that SVHMC has the desired records in its possession or under our control.
- f. Personal Appearance. The personal attendance of the qualified custodian (HIM Staff or Clinic Management) of the patient record and production of the original records is required if the subpoena duces tecum contain a clause which reads:
 - i. "The personal attendance of the custodian or other qualified witness and the production of the original records is required by this subpoena. The procedure authorized pursuant to subdivision (b) of Evidence Code Section 1560 and Evidence Code Sections 1561 and 1562 will not be deemed sufficient compliance with this subpoena."

4. Deposition Subpoena for Production of Business Records.

- a. This subpoena will tell SVHMC whether we are to deliver a copy of the requested records to a deposition officer (at SVHMC or elsewhere) or we are to make the records available for copying by the attorney's representative. This subpoena cannot require the personal appearance of a SVHMC representative (custodian of the medical records).
- b. Before delivering these records, attach an affidavit of the "custodian of records".
- c. The affidavit from the requesting party or declaration is not required for a deposition subpoena.

5. Deposition Subpoena for Personal Appearance and Production of Documents and Things.

- a. This subpoena will request the personal appearance of an SVHMC representative (custodian of medical records) and provide instructions.
- b. The affidavit or declaration is not required for a deposition subpoena.

6. Discovery Request. If a Discovery Request is accompanied by a court order, a Notice to the patient is not required.
7. Copy Service. The subpoenaing party can direct SVHMC to make the records available for inspection or copying by the party's attorney, the attorney's representative, or deposition officer. Evidence Code Section 1560 requires SVHMC to give a photocopy service, upon request, an appointment of not less than 6 continuous hours on a date requested for the copying of the records requested by subpoena. The copy service must provide at least 5 business days' advance notice. If needed, staff may require more than the 5 days' notice.

The use of the copy service is at the discretion of the subpoenaing party and is not an option for SVHMC , unless superseded by some other legal requirement such as mental health records.

8. Notice to the patient.
 - a. CA State Law. CA Code of Civil Procedure Section 1985.3. This applies only when the subpoena is served in connection with a state civil action or proceeding and in certain state administrative action or proceedings. It does not apply in criminal actions or in federal proceedings (ex. Cases in the U.S. District Court or out-of-state court) Section 1985.3 preempts HIPAA in cases where it applies. Otherwise HIPAA procedures for Notice or Protective Order are to be followed.
 - b. **Authorization for release of records.** Part of the Notice process for Section 1985.3 is the production of patient authorization by the subpoenaing party.
 - i. The patient can sign an authorization to release their records; or
 - ii. The patient's attorney of record can sign the authorization to release the patient's records. (HIPAA does not recognize an attorney of record to be a representative who may authorize the disclosure of patient records. Contact Risk Management regarding the attorney signature.)
 - iii. The authorization form must provide SVHMC patient signature and date, states that the patient or his or her attorney authorizes the release of records to the subpoenaing party.
 - iv. If the Attorney authorized the release, the authorization needs to include a statement that the attorney represents the patient.
 - v. If the authorization is not received before the date of production of the records, contact the subpoenaing party stating the records will not be produces until a proper authorization is received by SVHMC .
 - c. **Proof of Service.** Another part of the Notice process for Section 1985.3 is the Proof of Service provided by the subpoenaing party. The Proof of Service is to attest the service of documents and include four items:
 - i. Subpoena;

- ii. Supporting Affidavit;
 - iii. Proof of Service of Subpoena on SVHMC ; and
 - iv. Notice to the patient/attorney within the required time period. Which is before SVHMC is required to produce records. A subpoena that requires records before the end of the applicable waiting period is defective.
 - 1. If SVHMC does not receive a Proof of Service listing all four items, contact the subpoenaing party stating that the records cannot be release until SVHMC receives a proper Proof of Service.
 - 2. A Deposition subpoena served upon SVHMC must be accompanied by the patient's written authorization for release of the records or a copy of the Proof of Service of the Notice to the patient.
- d. **Notice time requirement.** Notice is to be provided to the patient by the subpoenaing party for state civil and administrative proceeding.
- i. A copy of the subpoena and if applicable, supporting affidavit or declaration is to be provided as well.
 - ii. This Notice to the patient is to be completed at least 10 days before the date SVHMC is to produce the patient's records, and at least 5 days prior to service of the subpoena upon SVHMC .
 - iii. The timeline for the Notice can be extended by an additional 5 days if the Notice is served on the patient by mail at a CA address.
 - iv. The timeline for the Notice can be extended by an additional 10 days if served on the patient by mail at an address in another state.
 - v. The timeline for the Notice can be extended by an additional 20 days if served on the patient by mail at an address in a foreign country.
- e. **Waiting Period.** The waiting period is designed to give the patient an opportunity to assert any objection to the release of records. The records may be released before the expiration of the waiting period if the patient (or his/her attorney of record) explicitly consents to the release of records. The patient's (or attorney) authorization is to be in writing and state that the patient has no objections and consents to the release of records pursuant to the subpoena. This allows the records to then be released before the expiration of the waiting time period.
- i. Patient is Party to Lawsuit. If the patient is a party to the lawsuit, the Notice and supporting documents can be sent to the patient's attorney.
 - ii. Patient is Subpoenaing Party. If the subpoenaing party is the patient, the Notice to the Consumer document is not required.

iii. The Notice to the patient is to state that:

1. Records about the patient are being sought from the hospital named in the subpoena;
2. If the patient objects to the hospital releasing the records, the patient must file papers with the court or serve a written objection prior to the date specified in the subpoena for production of the records; and
3. If the party who is seeking the records will not agree in writing to cancel or limit the subpoena, the patient should consult with an attorney about how he or she may protect his or her interests and right of privacy.
4. The form used by CA is called the "Notice to Consumer or Employee and Objection".

f. **Failure to Object.** Failure of the patient to object to the disclosure of records after being given Notice serves as a waiver of the physician-patient privilege.

g. **Objection.** If the patient wishes to object to the production of records pursuant to a subpoena duces tecum, the patient is to do one of the following:

- i. If the patient is party to the civil action subpoena, the patient should bring a motion to quash or modify the subpoena prior to the date of production and give notice to SVHMC and the disposition officer at least 5 days prior to production
- ii. If the patient is not a party to the civil action subpoena, the patient may, prior to the date of production, serve on the requesting party and SVHMC a written objection that specifies the specific grounds on which production of the records should be prohibited.

iii. After motion to quash, objection, or request to modify the subpoena, SVHMC is not required to produce the records except upon order of the court in which the action is pending or upon agreement of the persons affected (patient, requesting party, and SVHMC).

iv. If the patient calls the hospital or clinic indicating that they are unsure about whether they will object to the release of records or if the patient indicates that they plan to object to the release of records, do not release the records according to the subpoena duces tecum until the waiting period has expired and release only if:

1. SVHMC has not received notice that the patient has brought a motion under Code of Civil Procedure Section 1987 to quash or modify the subpoena, and
2. SVHMC has received from the subpoenaing party a

written statement or other documentation that no objections to the production of records was filed or that any objections were resolved and the disclosure requested is consistent with the resolution.

h. Withholding Compliance with Subpoena Upon Notification of Written Objection or Pending Motion to Quash or Modify Subpoena.

- i. If SVHMC receives notice that the patient has brought a motion to quash or to modify the subpoena, or SVHMC has received a written objection to production of records from the patient, the records should not be released.
- ii. Once the motion to quash or modify the subpoena has happened, the court in which the action is pending can order the release of the patient's records, or
- iii. The parties and the patient can come to agreement and request the release of the records.
- iv. Require a written copy of the parties/patient agreement before disclosing the records.

i. HIPAA Notice to the Patient.

- i. HIPAA permits the disclosure of medical information in response to a subpoena, discovery request, or other lawful process that is not accompanied by an order of a court or administrative tribunal if:
 1. SVHMC has received documentation from the party seeking the information that it has Noticed the Individual who is the subject of the PHI that has been requested; or
 2. SVHMC has received documentation from the party seeking the information that it has made reasonable efforts to secure a qualified protective order meeting HIPAA requirements.
- ii. The subpoenaing party must provide written documentation proving the Notice has the following information:
 1. The party requesting records has made a good faith attempt to provide written notice to the individual (or, if the individual's location is unknown, to mail a notice to the individual's last known address);
 2. The notice included sufficient information about the litigation or proceeding in which the PHI is requested to permit the individual to raise an objection to the court or administrative tribunal; and
 3. The time to the individual to raise objections to the court or administrative tribunal has elapsed, and

4. No objections were filed; or
 5. All objections filed by the individual have been resolved by the court or the administrative tribunal and the disclosures being sought are consistent with such resolution.
- iii. The Individual cannot raise their objections to SVHMC . Objections are to be raised before the court of other body having jurisdiction over the proceedings. Refer the patient to their attorney.
 - iv. Also, the subpoenaing party must provide a written statement or other documentation notifying SVHMC of the following:
 1. No objections to the production of records were filed, or
 2. The objections were resolved and the disclosure requested is consistent with the final resolution.

Note: If the patient does not object and the deadline as stated in the subpoena has past, OCR considers this "satisfactory assurance" the documentation has been provided to SVHMC .

- v. Timeline for production of records under HIPAA. The party seeking records has provided adequate documentation of compliance with HIPAA requirements for notice or qualified protective order, the time for compliance with the subpoena is the following:
 1. Subpoena Duces Tecum (non-deposition subpoena): the subpoena must itself must allow SVHMC reasonable time for preparation and travel to the place of attendance; no exact time limits are established.
 2. Deposition Subpoena for Production of Business Records: production cannot be demanded earlier than 20 days after issuance of the subpoena, or 15 days after it is served on SVHMC , whichever date is later.
 3. Deposition Subpoena for Personal Appearance and Production of Documents and Things: no specific time requirements are established; SVHMC must have "a reasonable opportunity" to locate
9. **SVHMC is Party to the Action.** Any documents received that involve any part of SVHMC are to be forwarded to Risk Management. Risk Management will provide instructions on what is needed to comply with request.
 10. **Protective Order vs. Notice.** A Protective Order for PHI is an order from a court or administrative tribunal or a stipulation by the parties to the litigation or administrative proceeding.

- a. HIPAA allows a Protective Order to be used instead of the Notification to the Individual. In this situation, SVHMC is to receive from the party requesting the PHI a written statement and accompanying documentation demonstrating:
 - i. The parties to the dispute giving rise to the request for PHI have agreed to a qualified protective order and have presented it to the court or administrative tribunal with jurisdiction over the dispute; or
 - ii. The party seeking the PHI has requested a qualified protective order from such court or administrative tribunal.
- b. Protective Order under CA Code of Civil Procedure Section 1985.3.
 - i. Requires that the subpoenaing party give notice of the subpoena to the patient or their attorney. This requirement applies only when the subpoena is served in connection with a state civil action or proceeding and in certain state administrative proceedings.
 - ii. If the Protective Order is in regarding to a criminal action or federal proceeding, the requirement for the subpoenaing party to give notice does not apply.
- c. For the order to be "qualified", SVHMC needs the following documentation to be included in the order:
 - i. Statement that prohibits the parties from using or disclosing the PHI for any purpose other than the litigation or proceeding for which such information was requested; and
 - ii. Requires the return to the covered entity or destruction of the PHI (including all copies made) at the end of the litigation or proceeding.

11. **Improper Subpoena.** If the subpoena fails to comply with the legal requirements as discussed in the sections above, the staff should notify the subpoenaing party that, on the basis that the subpoena is defective, SVHMC will not comply with the subpoena.

- a. If staff communicate with the subpoenaing party via phone, document the conversation and ask for then to provide a confirmation of the conversation in writing. If the subpoenaing party cannot be reached by phone, written notification is appropriate. Form "Response to Subpoena Duces Tecum" (CHA Form 16-3) may be used to confirm a phone conversation and/or provide such notification to a subpoenaing party.

12. **Administrative Agency Subpoena.**

- a. Subpoena for Hearing. The subpoena must also include an affidavit like the one used in a civil procedure.
- b. Investigatory Subpoena. These subpoenas should include a declaration that explains the purpose for which the records a sought. There is also to

be a notice to the patient process. Contact Risk Management if SVHMC receives an investigatory subpoena to determine what requirements apply.

- c. Witness Fees are the same for administrative agency proceedings as those for civil actions in state courts. Refer to the California Hospital Association section on FEES for up to date rates and when fees should be paid.
- d. Service of Subpoena. The administrative subpoena can be served in person, or delivered by certified mail with the return receipt requested; or by messenger. Service by messenger requires SVHMC to acknowledge receipt of the subpoena to the sender by telephone, mail, or in person. In person method will require staff to use some identifying information like a date of birth or driver's license number.

13. Criminal Actions in State Courts.

- a. Criminal Trial Subpoena. The subpoena to compel the attendance of a witness and the production of documents at a criminal trial is to have a statement that describes the required books, papers or documents. The affidavit must be attached to the subpoena.
- b. Servicing of Subpoena. Subpoena served in connection with a criminal proceeding may be served either by mail or by any person (except the defendant). SVHMC is to acknowledge receipt of the subpoena to the sender by phone, mail, over the internet by email or by completion of the sender's online form, or in person and identifies himself or herself by reference to his or her date of birth and driver's license number of Department of Motor Vehicles identification card number.
 - i. Document the identifying information provided to the sender in the ROI module.
 - ii. Failure to comply with a subpoena served and acknowledged in accordance with Penal Code Section 1328d may be punished as contempt by a court, although an arrest warrant may not be issued on this basis.
 - iii. Disclosure of PHI to Law Enforcement. Refer to the section on Disclosure of PHI to Law Enforcement Officers and Court Orders.
 - 1. Records that are sealed and addressed to the courts, and hence are not directly disclosed to the law enforcement officials, may be released to the law enforcement officials for delivery to the court.
 - iv. HIPAA requirement for attempts to provide notice to the patient or to obtain a qualified protective order does apply.
- c. Search Warrant. Records may be produced in a criminal investigation pursuant to a valid search warrant.

14. Federal Courts and Federal Administrative Agencies. A subpoena duces tecum issued for federal requirements as similar to the requirement for state civil

proceedings. The subpoena is to specify the articular documents sought. Contact Risk Management and follow their instructions. HIPAA requirement for reasonable attempts to provide notice to the patient or to obtain a qualified protective order does apply.

15. Privileged and Confidential Information (including Communications). When records are sought for use in a legal proceeding, the Evidence Code provides special privileges to the physician-patient relationship and the patient records. Consequently, access to records protected by physician-patient privileges must be sought in accordance with the applicable provision of the Evidence Code.

a. Information that is privileged:

- i. includes information transmitted in confidence between the patient and the physician or psychotherapist and during the course of their relationship;
- ii. Includes information obtained by an examination;
- iii. Includes a diagnosis made, even if uncommunicated;
- iv. Includes advice given by the physician or psychotherapist in the course of the relationship.

b. Holder of privilege:

- i. Patient is primary holder of the privilege right.
- ii. If patient is a minor or not competent, the holder may be the patient's guardian or conservator.
- iii. If patient is deceased, the holder is:
 1. The "Beneficiary" as in an heir or a person who will receive money or property from the estate of the deceased patient.
 2. The "Personal Representative" as an executor, administrator, administrator with the will annexed, successor personal representative, public administrator acting pursuant to Probate Code Section 7660, special administrator, or a person who performs substantially the same functions under the law of another jurisdiction governing the person's status in Probate Code Section 58.

c. Other individuals can claim the privilege to prohibit disclosure of confidential communications:

- i. Any person authorized by the holder of the privilege to claim the privilege; or
- ii. The person who was the physician or psychotherapist at the time of the communication. This person must claim the privilege on behalf of an absent privilege holder unless otherwise instructed by a person authorized to permit disclosure; or
- iii. Legal counsel for a child who has been adjudged to be a

dependent child of the court under Welfare and Institutions Code Section 300 (but the child's informed consent is required if the child is found by the court to be of sufficient age and maturity to give informed consent)

- iv. If the patient died leaving no conservator or personal representative, there are some limits on these persons claiming the privilege. Seek advice of Risk Management.
- d. Waiving the Privilege. A holder of the privilege may give up the privilege by disclosing a significant part of the communication or by consenting to disclosure by someone else. Consent to disclosure is implied if the holder fails to claim the privilege in any proceeding in which the holder could claim the privilege.
 - i. Exceptions. There are a number of situations in which these privileges cannot be claimed to prevent disclosure of confidential information. Consult Risk Management.
 - ii. Notice to Patient. If the party who caused the subpoena to be issued is not required to notify the patient of the subpoena and SVHMC is unable to notify either the patient or the physician because neither can be located, consult Risk Management before responding to the subpoena.

W. **COURT ORDER** - For SVHMC, all court orders requiring production of PHI will be referred to the HIM/Medical Record Department for appropriate processing. For SVMC, all court orders requiring production of PHI will be referred to the practice manager for appropriate processing with a Release of Information Vendor.

- 1. On receipt of a court order from a court or administrative tribunal, the designated HIM/Medical Records staff will verify that the order:
 - a. Is signed by a judge;
 - b. Directs a SVHMC physician to disclose an individual's PHI;
- 2. A court order does not need to be accompanied by an authorization.
- 3. The designated HIM/Medical Records staff will:
 - a. Coordinate acquisition of the required PHI content that HIM/Medical Records is unable to produce;
 - b. Make copies of only that information expressly authorized by the order;
 - c. Note the disclosure on the court order with a signature and date;
 - d. Record the disclosure in the release of information software application;
 - e. Scan the court order into the individual's record; and
 - f. Make arrangements to mail, or securely transmit or transport the required information to the designated recipient if investigators are not present to receive records.

X. **RESEARCH** - Prior to using or disclosing PHI for research purposes, SVHMC will obtain either the individual's written authorization, or a copy of the Institutional Review Board's explicit

permission to forego patient authorization. Refer to the Manager of Research Programs.

Y. DENYING INDIVIDUAL'S REQUEST TO ACCESS OR OBTAIN COPIES OF OWN PHI

1. SVHMC may deny individuals access to the health information maintained about them in a designated record set (DRS) in the relatively few situations described below CFR 164.524:
 - a. The information is psychotherapy notes.
 - b. The information was compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding.
 - c. CA Health and Safety Code 1233110 (a)(h) supersedes HIPAA.
 - d. N/A in CA. The individual is an inmate and access to the information would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other inmates, or the safety of any officer, employee, or other person at the correctional institution or responsible for transporting the inmate.
 - e. The information was created or maintained in the course of research that includes treatment and the individual consented to a temporary suspension of their right to access as long as they are participating in the research. (The individual's right of access will be reinstated upon completion of the research.)
 - f. The information was obtained from someone other than a health care provider under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information. CA Health & Safety Code 123105 (d)
 - g. A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
 - h. The protected health information (PHI) makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.
 - i. The request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.
2. Any SVHMC workforce member contemplating making a denial of health information to a patient or legal representative will contact the Privacy Officer/ Designee.
3. To the extent possible, SVHMC will segregate health care information to which access will be denied, from information to which access cannot be denied and permit the individual to examine or obtain a copy of the disclosable information.

4. The Privacy Officer will work with the workforce member to apply the concepts of the contrary and more stringent requirements in HIPAA, as well as federal and state laws and regulations related to denials.
5. If SVHMC denies the patient's request in whole or in part, the Privacy Officer will provide the individual with a written denial within 5 days of receipt of the request. CA Health & Safety Code 123110(a) The denial will be in plain language and include:
 - a. The basis for the denial;
 - b. If applicable a statement of the individual's rights to have the decision reviewed and a description of how the individual may exercise their review rights; and
 - c. A description of how the individual may complain to SVHMC or the Secretary of HHS.
6. If the individual requests a review of the denial, SVHMC will appoint a licensed health care professional who was not directly involved in the denial, to review the decision within a reasonably period of time.
7. SVHMC will then provide written notice to the individual of the determination and take other action as required to carry out the reviewing official's determination.

Z. PSYCHOTHERAPY - Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

1. Third Party Request. Medical information may not be released related to a patient's participation in outpatient treatment with a psychotherapist unless the requestor of the information submits a special written request (described below) to the clinic/ practice and to the patient within 30 days of the release of information. (Patient's may sign a written waiver.) Refer to Civil Code Section 56.104.
2. The requirement for a special written request applies to medical information that "specifically relates to the patient's participation in outpatient treatment with a psychotherapist". Thus any reference in the hospital's or physician's record to the fact that the patient received outpatient mental health treatment may require the special written request.
 - a. Maintain a list of offices where Psychotherapy is practices. There is a list of who (types of individuals) is or reasonably believed by the patient to be a Psychotherapist at Civil Code Section 56.104; Evidence Code Section 1010.
3. Required Elements of the Written Request:
 - a. The signature of the person requesting the information or an authorized agent of the entity requesting the information.
 - b. The specific information relating to a patient's participation in outpatient treatment with a psychotherapist being requested and its specific intended use or uses.
4. The length of time during which the information will be kept before being disposed

of or destroyed. The person or entity that requested the information may extend this time frame if it notifies clinic/practice. The notification of the extension must include the specific reason for the extension, the intended use or uses of the information during the extended time and the expected date of the destruction of the information.

5. A statement that the information will not be used for any purpose other than its intended use.
6. A statement that person or entity requesting the information will destroy the information and all copies in its possession or control, will cause to be destroyed, or will return the information and all copies before or immediately after the stated time frame.
7. If patient has signed a Written Wavier, the waiver letter is to be signed by the patient and received by the clinic/practice notifying us of the waiver. Note: If the patient is a minor or incompetent, the law does not say who should sign the waiver letter.
8. Patient Request. If a patient request release of all of his/her mental health information to a 3rd party, including psychotherapy notes, the disclosure requires two authorizations – one for the mental health information and a second for the psychotherapy notes. HIPAA prevails over state law.
9. Exception to obtaining the separate authorization for any use or disclosure of psychotherapy notes:
 - a. To carry out treatment, payment or health care operations in any of the following cases:
 - i. Use by the originator of the psychotherapy notes for treatment;
 - ii. Use or disclosure by the clinic/practice for its own training programs in which students, trainees or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; or
 - iii. Use or disclosure by the clinic/practice to defend itself in legal action or other proceeding brought by the Individual;
 - b. Use or disclosure that is required by the Secretary of DHHS to investigate or determine compliance with the requirements of HIPAA;
 - c. Use or disclosure is required by law. This includes reporting child or elder adult abuse, responding to subpoenas, and complying with similar requirements;
 - d. Use or disclosure for health oversight activities related to the originator of the notes, such as licensure or disciplinary actions, fraud investigations, etc.
 - e. Disclosure to a coroner or medical examiner to identify a deceased person, determine a cause of death, or other duties authorized by law;
 - f. Use or disclosure where necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat. Notify Risk Management of the issue

being acted upon.

AA. RELEASE OF PHI TO LAW ENFORCEMENT OFFICERS

1. Disclosure With a Patient Authorization. Information and records may be disclosed to law enforcement officers due to a written authorization by the patient or the patient's legal representative.
2. Disclosure Without a Patient Authorization. Law enforcement official under Penal Code sections 1543-1545 means the California Attorney General, every district attorney, and every agency expressly authorized by law to investigate or prosecute law violators. The Penal Code is to be used instead of Civil Code Section 56.30(g).
 - a. Information that must be disclosed to law enforcement officers – SVHMC is required to make oral and written reports to local authorities in the following situations involving persons who:
 - i. Have a physical injury resulting from a firearm or assaultive or abusive conduct;
 - ii. May be victims of child abuse;
 - iii. Have an injury or condition resulting from neglect or abuse of patient transferred from another health facility;
 - iv. May be victims of sexual assault, including rape;
 - v. Have injured or threatened on-duty hospital personnel; or
 - vi. May be victims of elder or dependent adult abuse.
 - b. The above information may also be provided upon request of the law enforcement officers.
 - c. Subpoena with Court Order. If SVHMC is provided with a subpoena and a court order, information may be disclosed as authorized.
 - d. Search Warrant. Contact Risk Management and follow their instructions regarding release to a "special master" vs. law enforcement officer.
 - e. Information Generated Pursuant to the Request of Law Enforcement Officers. Law enforcement officers may bring an arrestee to the hospital and request that hospital personnel evaluate the arrestee in order to determine whether it is appropriate to incarcerate him or her, or perform procedures in order to gather evidence (under influence of alcohol or drugs). Initially it must be determined whether it is appropriate for hospital personnel to perform the requested procedure. If procedures are performed, the hospital must then determine whether the information obtained as a result of the performance of such procedures should be released to law enforcement personnel.

CA is stricter than HIPAA. Consult Risk Management. Reference Chapter 5, Law Enforcement section, of the CHA Manual. Also if information requested includes HIV test results, consult chapter 4 of CHA Manual.

AB. DE-IDENTIFICATION & RE-IDENTIFICATION PHI - 164.514

De-Identification: Occasionally PHI will need to be used in a De-Identified Format. SVHMC may

use or disclose PHI to create information that is not individually identifiable. PHI must meet the standards listed in the procedure in order to qualify as de-identified.

PHI becomes de-identified when the PHI cannot identify an Individual and there is no reasonable basis to believe that the health information can be used to identify an Individual. The health information is then considered "not individually identifiable health information". For health information to be considered as "not individually identifiable health information", the following must apply:

1. A person with appropriate knowledge and experience with statistical and scientific principles/methods for rendering the health information "not individually identifiable" determines that the risk is very small and that the information could be used, alone or in combination with other reasonably available information, by a recipient to identify an Individual who is a subject of information; and
2. Documentation the method and results of the analysis justifies the determination that the information is "not individually identifiable"; or
3. The following identifiers must be removed from the PHI. These identifiers apply to information about the Individual and relatives, employers, or any household members of the Individual:
 - a. Names
 - b. All geographic subdivisions smaller than a state. This includes street address, city, county, zip code, and their equivalent geocodes. Exception is the first three digits of the zip code, if according to the current publicly available from the Bureau of the Census;
 - i. The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people, and
 - ii. The initial three digits of a zip code for all such geographic units containing 20,000 fewer people is changed to 000.
 - c. All elements of dates (except year) for dates directly related to an Individual, including the birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be assigned into a single category of age 90 or older.
 - d. Telephone number
 - e. Fax numbers
 - f. Electronic Mail Address
 - g. Social Security Numbers
 - h. Medical Record Numbers
 - i. Health Plan Beneficiary Numbers
 - j. Account Numbers
 - k. Certificate/License Number
 - l. Vehicle Identifiers and Serial Numbers, Including License Plate Numbers

- m. Device identifiers and Serial numbers
- n. Web Universal Resource Location (URLs)
- o. Internet Protocol (IP) Address Numbers
- p. Biometric Identifiers, Including Finger and Voice Prints
- q. Full Face Photographic Images And Any Comparable Images
- r. Any Other Unique Identifying Number, Characteristic, or Code (Except As Permitted By the Re-Identification Procedure) and
- s. SVHMC does not have actual knowledge that the information could be used alone or in combination with other information to identify an individual who is a subject of the information.

4. Re-identification of the PHI.

- a. For the purposes of re-identification of the data when needed, a code or other means of record identification may be assigned to allow re-identification.
- b. The code used or other means of record identification is not to be derived from or related to the information about the individual and is not otherwise capable of being translated so as to identify the individual; and
- c. SVHMC cannot use or disclose the code or other means of record identification for any other purpose, and shall not disclose the mechanism for re-identification.

AC. **RELEASE TO AN ATTORNEY** – Patients occasionally engage attorneys to advise, advocate, or negotiate with other parties on their behalf. Outside of the subpoena, discovery request, or court order process, a patient may request disclosure of PHI to an attorney.

- 1. Any release of PHI is to include only that information required by the signed patient authorization.
- 2. When the requesting attorney has employed a professional photocopier as his or her representative to obtain or review the records on the attorney's behalf, no copying may be done by SVHMC or its business associate. Presentation of a valid authorization is sufficient proof that the agent is the attorney's representative.
- 3. On receipt of valid authorization signed by the patient or patient's legal representative, SVHMC will process and disclose the requested records within five to 10 days.
- 4. The HIM/Medical Records workforce member or Clinic Manager will notify the Risk Manager of any request for PHI that signals possible litigation against SVHMC , its affiliates or clinicians.
- 5. Fees. Refer to the [RELEASE OF INFORMATION - HIM](#) Subpoena Section for current applicable fees.

AD. **SALE OF PHI** – SVHMC and our business associates may not sell PHI.

- 1. Sale of PHI is directly or indirectly receiving remuneration from or on behalf of the recipient of the PHI in exchange for the PHI.

2. Sale of PHI does not include the disclosure of PHI:
 - a. For public health purposes.
 - b. For use per a Limited Data Set.
 - c. For research purposes. However, SVHMC does not participate in remuneration for PHI in research.
 - d. For treatment and payment purposes pursuant to a consent or authorization.
 - e. For the sale, transfer, merger, or consolidation of all or part of the covered entity and for related due diligence regarding PHI needed by other participants in the organized health care arrangement for any health care operations activity of the organized health care arrangement.
 - f. To or by a business associate for activities that the business associate undertakes on behalf of a covered entity, or on behalf of a business associate in the case of a subcontractor, and only the remuneration provided is by the covered entity to the business associate, or by the business associate to the subcontractor, if applicable, for the performance of such activities.
 - g. To an individual when requested through access or an accounting.
 - h. Required by law for public health activities, reporting abuse, neglect or domestic violence, health oversight, judicial and administrative proceedings and law enforcement purposes.
 - i. For any other purpose permitted by 164.502(a)(5)(ii) where the only remuneration received by the covered entity or business associate is a reasonable, cost-based fee to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by other law.

AE. **MARKETING** - SVHMC will not use or disclose a patients Protected Health Information (PHI) for marketing purposes without prior authorization by the patient.

1. HIPAA and CMIA allow some exceptions to the authorization requirement. The preemption rule permits a use or disclosure only if it falls within an exception under both HIPAA & CMIA.
2. SVHMC will analyze each proposed use or disclosure for marketing purposes keeping the requirements of each law (HIPAA & CMIA) in mind, to determine whether the proposed use or disclosure violates either or both laws.
3. If a question arises about whether disclosure is permissible, an authorization from the individual or the individuals 'representative is the safe course of action.
4. A blanket authorization for marketing is not permitted.
5. If a patient's photograph will be used for marketing purposes, it is required that SVHMC will obtain written consent of the patient, which specifically grants permission for such marketing uses.
6. Marketing is permitted without a patient authorization if the communication it makes to patients describes a health-related product or service provided by SVHMC

that is for the purposes of:

- a. Treating the patient
 - b. Case management or care coordination of the patient (e.g., for directing or recommending alternative treatments, therapies, healthcare providers, or
 - c. care settings).
7. If marketing is to be conducted in a face-to-face meeting with the patient, SVHMC may, but is not required to, obtain a written authorization from the patient prior to the marketing meeting.
 8. If a promotional gift of nominal value (e.g. a pen or glass with the SVHMC logo or name embossed on it) is given or sent to the patient, SVHMC may, but is not required to, obtain a written authorization from the patient prior to providing or sending the promotional gift.
 9. If the Marketing is going to involve financial remuneration from a third party, the patient authorization must state that such remuneration is involved.⁴⁵ C.F.R. Sections 164.501 (definition of "marketing"); 164.508(a)(3)&(c)(1)(iii) Civil Code Sections 56.05 (f) and 56.10(d) & 3344
 10. The SVHMC Marketing Department will maintain a copy of all consents obtained for the purpose of marketing.
 11. All documentation will be maintained for a period of six years.
 12. Documentation will be maintained in the office of the Marketing Director.

AF. **INSPECTION OF RECORD BY INDIVIDUAL.** If the Individual wishes to inspect his/her entire record rather than merely that which is available on the patient portal or by receiving a paper or electronic copy, hospital HIM or the appropriate Clinic Manager will arrange a convenient time, place and qualified workforce member(s) to work with the individual as the individual inspects his/her record. Refer to Section Y regarding denial of access requests. Notify Risk Management or the Quality department. Risk Management or Quality may prefer to work with the Individual.

SVHMC must respond and allow the patient to inspect the records within 5 working days. (CA requirement) This can be done within normal business hours of operation.

1. Upon request, the SVHMC workforce member assisting the Individual will provide an explanation of any code or abbreviation used in the medical record.
 - a. The SVHMC workforce member providing the information or access to the Individual will note on the authorization the date on which the information was disclosed, record their own name and title.
 - b. The SVHMC workforce member providing the information or access to the Individual will ensure the disclosure is recorded in the release of information tracking software. Contact HIM or appropriate individual in the Clinic.
 - c. The SVHMC workforce member will ensure scanning into the electronic record the authorization form.
2. A patient who is a minor shall be entitled to inspect their record pertaining only to

health care of a type for which the minor is lawfully authorized to consent. The inspection shall be conducted by the Individual or their personal representative requesting the inspection, who may be accompanied by one other person of his or her choosing.

3. A patient may request another person to accompany them during the inspection.

AG. **HIPAA TRAINING** - SVHMC will train its workforce members regarding the privacy and security policies and procedures as appropriate for the workforce members to carry out their job functions. 45 CFR 164.530(b)(1).

1. New hires will have HIPAA privacy and security included in the new hire orientation program.
2. Additional training will be provided when laws, procedures or policies are changed.
3. Additional training will be provided as appropriate to job duty changes.
4. Documentation of training is tracked through the Health Stream Learning program and department records.

AH. **FUNDRAISING** - SVHMC may use or disclose PHI to a business associate or an institutionally-related foundation to raise funds for the benefit of SVHMC and/or Salinas Valley Health Clinics (SVHC). 42 USC 17936; 45 CFR 164.514(f)

1. The PHI used or disclosed pursuant to this policy and procedure will be at the discretion of the HIM Director/Privacy Officer and shall be limited to the minimum necessary and no more than the following:
 - a. Demographic information, including name, address, other contact information, age, gender, and date of birth;
 - b. Dates of healthcare provided;
 - c. Department or Service (for example, cardiology, surgery, oncology, obstetrics, etc.);
 - d. Treating physician;
 - e. Outcome Information (for example, death, suboptimal outcome, successfully treated);
2. All fundraising efforts using PHI will be coordinated through SVHMC Foundation ("SVHMC Foundation").
3. SVHMC's Notice of Privacy Practices must state that SVHMC may use or disclose PHI for fundraising purposes.
4. Each fundraising communication (written or verbal) must include a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
5. SVHMC may offer an opt-out for a specific fundraising campaign only, or for all fundraising campaigns undertaken by the SVHMC Foundation.
6. The method for an individual to opt-out of receiving fundraising communications must be simple, quick, and inexpensive, such as pre-printed post cards, toll-free phone number, or e-mail addresses. Upon receipt and processing of an opt-out request, no fundraising communications may be sent by SVHMC or the SVHMC

Foundation.

7. It is not acceptable to require the patient to send a letter in order to opt out.
8. The SVHMC Foundation will put systems and processes in place to manage lag times between compiling fundraising lists and solicitations.
9. SVHMC will not condition treatment on the individuals' choice regarding the receipt of fundraising communications.
10. The SVHMC foundation may provide a method for individuals to opt back in to receiving fundraising communications.
11. The SVHMC Foundation shall maintain logs of individuals who choose to opt out of fundraising activities.
12. All documentation is required to be maintained for a period of six (6) years.
13. Documentation will be maintained by the SVHMC Foundation.

AI. ANTI-INTIMIDATION AND ANTI-RETALIATION

1. Neither SVHMC, members of its workforce or medical staff will threaten, intimidate, coerce, harass, discriminate against or take any other retaliatory action against any individual or other person for:
 - a. Filing a privacy or security related complaint
 - b. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing under HIPAA's Administrative Simplification Rules; or
 - c. Opposing any act or practice made unlawful by HIPAA's Administrative Simplification Rules, providing the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of PHI in violation of the HIPAA Administrative Simplification Rules.
2. Any workforce member who observes an intimidating or retaliatory act on the part of another SVHMC workforce member, medical staff member or business associate will call this policy to that individual's attention immediately so that the individual can rectify the situation.
3. If/when such action is not practical, or the situation is not immediately rectified by the offending workforce member, medical staff member or business associate, the observing workforce member will contact his/her manager or the Compliance Officer immediately.
4. Any individual who thinks they have been intimidated, threatened, coerced, discriminated against or otherwise retaliated against for exercising rights or participating in a process provided for by the HIPAA Privacy Rule should be directed to the Compliance Officer.
5. The SVHMC leader with whom an observation or complaint related to intimidation or retaliation is communicated may consult with the Compliance Officer and/or take those actions needed to correct the situation.
6. If/when appropriate, the offending workforce member or medical staff member will

be educated, counseled or sanctioned.

7. If/when appropriate, the offending business associate will be educated, counseled and/or their contract terminated in accordance with the business associate agreement.

VI. EDUCATION/TRAINING

- A. Education and/or training provided as needed

VII. REFERENCES

- A. California Hospital Association Privacy Manual
- B. HIPAA Privacy Rule 45 CFR 154.514, 160.103, 160.310, 160.202, 162.923, 164.308(b), 164.501, 164.512, 164.512(e), 164.526, 164.528, 164.502(g)(5), 164.502(f)(g)(j), 164.506, 164.508, 164.522(a)(b), 164.530(d)(j)(e), 160.103, 164.514(e), 164.514(d), 164.400 to 164.414, 164.510, 164.520, 165.502(2)(ii), 164.502(c), 164.524
- C. Information Practices Act Civil Code Sections 1798.80 – 1798.84
- D. DHHS Guidance on Destruction Methods & CMIA Civil Code, Section 56.36
- E. California Health and Safety Code, Patient Access to Health Records Law, Division 106, Part 1, Chapter 1, Section 123100-123149.5; Section 123111, 1280.15
- F. California Confidentiality of Medical Information Act
- G. California Emancipation of Minors Law, Div.11, Part 6, Chapter 1, §7000
- H. Confidentiality of Alcohol and Drug Abuse Patient Records, 45 CFR, Part 2
- I. HHS/Office for Civil Rights/Website FAQ "Does the HIPAA Privacy Rule permit a doctor to discuss a patient's health status, treatment, or payment arrangements with the patient's family and friends?" Created 11/3/03. Reviewed 7/26/13.
- J. California Probate Code Section 24 and Section 58.
- K. HHS Regulations for the Protection of Human Subjects, 45 CFR, Part 46.
- L. FDA Regulations on Protection of Human Subjects, 21 CFR, Parts 50 and 56.
- M. Physician-Patient Privilege – Evidence Code section 994
- N. Psychotherapist-patient Privilege – Evidence Code Section 1014

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CFO	Iftikhar Hussain: Chief	6/30/2026

	Financial Officer	
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Philip Katzenberger: Director HIM/Privacy Officer	4/24/2026

Standards

No standards are associated with this document

COPY

CHNA Implementation Strategy Report

Consent Agenda: **Board Adoption of 2025 Community Health Needs Assessment and Salinas Valley Health Medical Center Implementation Strategy**

Executive Sponsor: Allen Radner, MD, President/CEO

Meeting Date: July 23, 2026

Executive Summary

Salinas Valley Health Medical Center, in collaboration with the other three hospitals in Monterey County, County of Monterey Health Department, California State University Monterey Bay, Central California Alliance for Health, United Way Monterey County, and the Hospital Council of Northern California, acted on behalf of the Monterey County Health Needs Collaborative. The purpose of the Collaborative was to complete the 2025 Community Health Needs Assessment (CHNA), which is the culmination of months of research into the pressing health needs of our community.

In addition to the CHNA, Salinas Valley Health Medical Center has created an Implementation Strategy Report (ISR) to address community health issues described in the CHNA. The CHNA has previously been reviewed by the Community Advocacy Committee and presented to full Board. Board member input, along with input from the executive team and clinical leadership has resulted in the formation of the ISR.

Background

In order to comply with IRS regulations, every three years Salinas Valley Health Medical Center is required to document our community benefit activities in a CHNA and an accompanying ISR. Beyond the governmental requirement to complete a CHNA and ISR, Salinas Valley Health Medical Center's strategic planning process and community funding priorities are informed by its CHNA.

Attachments

Salinas Valley Health Medical Center Implementation Strategy Report

Salinas Valley Health Medical Center Fiscal Years 2026–2028 CHNA Implementation Strategy

General Information

Contact Person:	Allen Radner, MD, President/CEO
Years the Plan Refers to:	Fiscal Years 2026–2028
Date Written Plan Was Adopted by Authorized Governing Body:	XX
Authorized Governing Body that Adopted the Written Plan:	Salinas Valley Health Board of Directors
Name and EIN of Hospital Organization	Salinas Valley Health Medical Center
Operating Hospital Facility:	EIN 94-6004020
Address of Hospital Organization:	450 East Romie Lane Salinas, CA 93901

Table of Contents

General Information	1
I. About Salinas Valley Health	3
COMMUNITY HEALTH INITIATIVES	3
II. Salinas Valley Health’s Service Area	4
III. Purpose of Implementation Strategy	5
IV. List of Community Health Needs Identified in the 2025 CHNA	6
2025 COMMUNITY HEALTH NEEDS LIST	6
V. Those Involved in the Implementation Strategy (IS) Development	7
VI. Health Needs that Salinas Valley Health Plans to Address	7
A. PROCESS AND CRITERIA TO SELECT HEALTH NEEDS	7
B. DESCRIPTION OF HEALTH NEEDS THAT SALINAS VALLEY HEALTH PLANS TO ADDRESS	7
Access to Health Care Services	
Cancer	
Healthy Lifestyles	
Heart Disease & Stroke	
VII. Salinas Valley Health’s Implementation Strategy	9
VIII. Evaluation Plans	18
IX. Health Needs that Salinas Valley Health Does Not Plan to Address	18

I. About Salinas Valley Health

Salinas Valley Memorial Healthcare System, a California Local Health Care District operating as Salinas Valley Health (SVH), is an integrated network of healthcare programs, services, and facilities that serves tens of thousands of people each year throughout Monterey County and surrounding areas. Opened in 1953, Salinas Valley Health Medical Center (SVHMC) anchors SVH's medical facilities. Licensed for 263 beds, this acute-care medical center features many medical specialties that enable people to advanced medical care without having to travel out of the area. The medical center employs approximately 2,200 people and has a medical staff of 300 board-certified physicians across a range of specialties.

Mission: To provide quality healthcare to our patients and to improve the health and wellbeing of our community.

Vision: A community where good health grows through every action, in every place, for every person.

COMMUNITY HEALTH INITIATIVES

Salinas Valley Health Mobile Clinic

Delivering free medical care directly where it is needed most, the SVH Mobile Clinic has improved access to quality medical services in Monterey County. In addition to primary and preventive care, community health advocates support the health and social needs of patients, helping them navigate services and provide supplies for those in financial need: blood pressure and glucose test kits; grocery and gas cards; stuffed animals and pajamas for children. Since launching in 2020, the Mobile Clinic recently surpassed 22,000 annual patient visits. The Mobile Clinic breaks through common barriers to healthcare, such as expense, travel and access. Its use of diverse resources is helping improve care-coordination, well-being and health outcomes for some of our most vulnerable populations. SVH collaborates with two Family Resource Centers, two local high schools and other entities in low income areas. It partners with the Food Bank for Monterey County to distribute food three days a week and in July 2025 met high standards to become an approved Vaccines for Children (VFC) provider.

Live Well Project

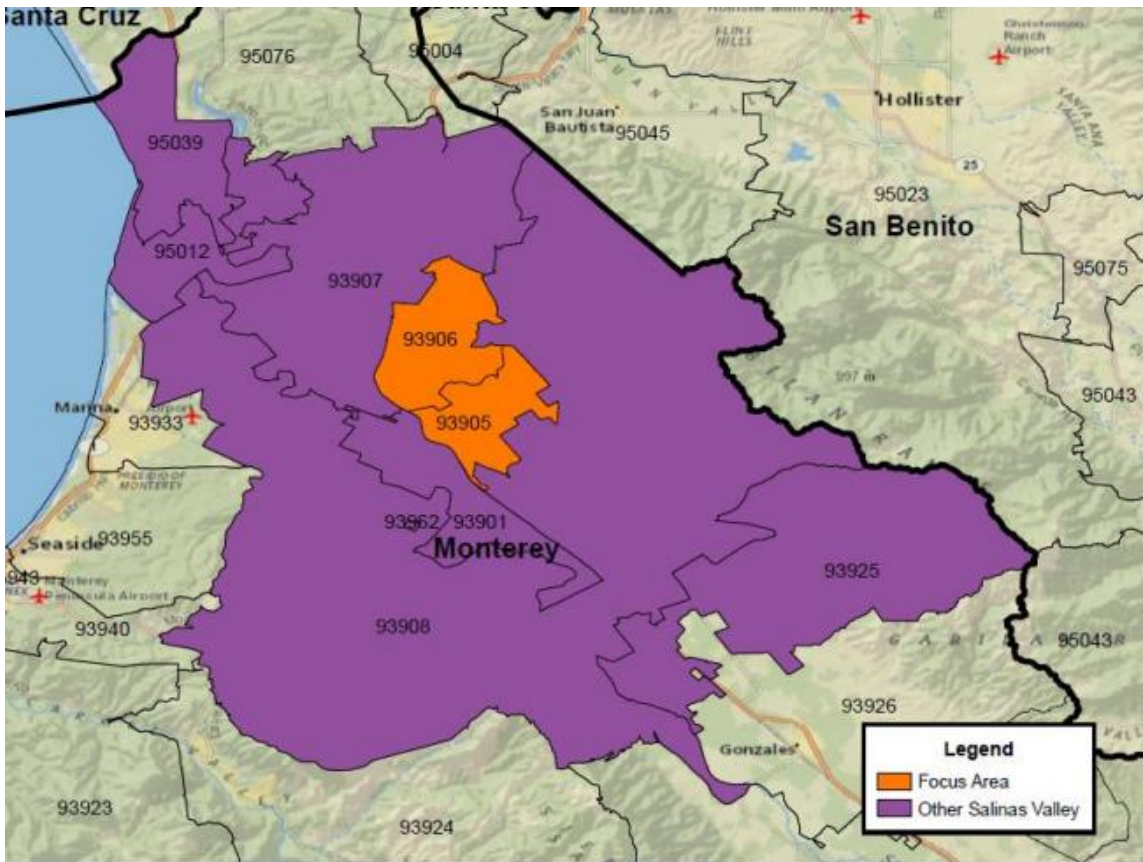
The SVH Live Well Project, formally known as Blue Zones Project Monterey County, builds changes in our community that make the healthy choice easy. The transformative health initiative engages a cross section of stakeholders including worksites, schools, faith-based organizations, restaurants, and grocery stores and takes a systemic approach to improved well-being through policy, design, and collaboration. Live Well Project has a designated team at SVH addressing goals and advancing the certification work done as Blue Zones Project Monterey County.

Health Education and Awareness Classes

Improving access to services and providing powerful opportunities for connection and support, our health education and awareness classes help our community rise in good health and well-being. In-person and virtual classes offer a wealth of resources – from preparing for a new baby to diabetes foot care, nutrition services for cancer survivors, support groups for cardiac patients, seminars on legal issues for life planning, meditation classes and more. Our medical providers have frank conversations community members during *Walk With a Doc* events. *Ask the Experts* presentations and podcasts share in-depth information on medical advances and common health concerns. Student programs ranging from fourth grade to post-secondary school inspire our future healthcare professionals. Outreach beyond the walls of our campus is fundamental in everything we do to support our community.

II. Salinas Valley Health’s Service Area

The Internal Revenue Service defines the “community served” as individuals who live within the medical center’s service area. This includes all residents in a defined geographic area and does not exclude low-income or underserved populations. According to its 2025 CHNA report, Salinas Valley Health’s community is its service area, composed of ZIP Codes 93901, 93905, 93906, 93907, 93908, 93925, 93962, 95012, and 95039. The map below shows the service area in purple, as well as a more central “focus area” in orange, representing geographies of particular concern to SVH.



The population in the **SVHMC Service Area** is predominately Hispanic or Latino (74%) with 16% White and 10% diverse races represented by Asian/Pacific Islander, Black, American Native and Multiple races.¹

The same census data indicates 42% of the population in the SVHMC Service Area is low income as defined by those living under 200% of the federal poverty level, based on guidelines established by the U.S. Department of Health and Human Service. Forty percent of survey respondents in the SVHMC service area reported they do not have cash on hand to cover a \$400 emergency expense, a greater percentage than U.S. respondents (34%).²

SVH also works collaboratively with its community partners in Monterey County in the larger county-wide eco-system. While emphasis is placed on the SVHMC service area, it is important to understand regional data. Monterey County comprises 12 cities, eight census-designated places, and large areas of unincorporated rural land. In 2025, the Census Bureau estimates population at 436,000. The ethnic makeup of **Monterey County** is highly diverse—more than half (55%) of Monterey County residents are Hispanic or Latino. Diverse races including Asian/Pacific Islander, Black, American Native and multiple races make up 11% of the population; 37% are White.³

III. Purpose of Implementation Strategy

This Implementation Strategy (IS) Report describes Salinas Valley Health's planned response to the needs identified through the 2025 Community Health Needs Assessment (CHNA) process. It fulfills Section 1.501(r)-3 of the IRS regulations governing nonprofit hospitals, even though the SVH Medical Center is part of a publicly owned local health care district. SVH operates to deliver local, quality care to everyone in the region. Subsection (c) pertains to implementation strategy specifically, and its requirements include a description of the health needs that the hospital will and will not address. Pursuant to these requirements, the following descriptions of the actions (strategies) to take include the anticipated impact of the strategies, the resources SVH plans to commit to address the health needs, and any planned collaboration between the medical center and other facilities or organizations in addressing the health needs.

For information about SVH's 2025 CHNA process and for a copy of the 2025 CHNA report, visit salinasvalleyhealth.com/chna.

¹ US Census Bureau, 2016-2020 American Community Survey and 2025 PRC Community Health Survey, PRC, Inc.

² 2025 PRC Community Health Survey, PRC, Inc. and 2025 PRC National Health Survey

³ US Census Bureau, 2016-2020 American Community Survey and 2025 PRC Community Health Survey, PRC, Inc.

IV. List of Community Health Needs Identified in the 2025 CHNA

The 2025 CHNA assessed community health needs by gathering input through online surveys from persons representing the broad interests of the community, including ratings of the degree to which various health issues were a problem in the community. In addition, quantitative (statistical) data were analyzed to identify poor health outcomes and health trends. The CHNA study team⁴ compiled statistical data and provided comparisons against statewide averages and rates. The CHNA findings indicate that chronic disease, access to care, and social determinants of health continue to significantly impact health outcomes across the region.

Significant health needs, for the purposes of the 2025 CHNA, were determined after consideration of various criteria, including: standing in comparison with benchmark data (particularly national data); identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. The list of needs also takes into account those issues of greatest concern to the community leaders (key constituents) who provided input during the CHNA process.

The 2025 CHNA identified a total of 12 health needs⁵. In October 2025, a variety of community leaders totaling 116 evaluated, discussed, and prioritized the identified health needs, which are listed below in community prioritization order. The health need prioritization process is described in more detail in SVH's CHNA report. The SVH Executive Team at SVH then selected the health needs that Salinas Valley Health will address during FY2026–2028. The health need selection process is described in Section VI of this report and prioritized those focus areas in which Salinas Valley Health is uniquely positioned to have impact.

2025 COMMUNITY HEALTH NEEDS LIST

- 1. Diabetes**
- 2. Access to Healthcare Services**
- 3. Nutrition, Physical Activity, & Weight**
- 4. Mental Health**
- 5. Heart Disease & Stroke**
- 6. Substance Use**
- 7. Cancer**
- 8. Housing**
- 9. Infant Health & Family Planning**
- 10. Injury & Violence**

⁴ The study team was composed of Salinas Valley Health, Montage Health, County of Monterey Health Department, Mee Memorial Healthcare System, Natividad, California State University Monterey Bay, Central California Alliance for Health and United Way Monterey County.

⁵ Monterey County CHNA page 15

- 11. Respiratory Disease
- 12. Tobacco Use

V. Those Involved in the Implementation Strategy (IS) Development

After extensive dialogue among the Executive Leadership Team along with input from elected members of the Board of Directors and clinical service line directors, SVH selected the health needs to address for 2026-2028 and developed the Implementation Strategy (IS).

VI. Health Needs that Salinas Valley Health Plans to Address

A. PROCESS AND CRITERIA USED TO SELECT HEALTH NEEDS

Key stakeholders from SVH met in November 2025 and January 2026 to review the 2025 SVH CHNA, assess results and discuss prioritization. At its February 9, 2026 meeting, the Leadership Working Group reviewed CHNA highlights and next steps. On February 18, 2026, a report was presented to the Community Advocacy Committee comprised of elected members of the Board of Directors, all of which contributed to the final IS. SVH, by consensus, selected four of the health needs that had been identified. The selected needs are listed below in alphabetical order.

1. Access to Healthcare Services
2. Cancer
3. Healthy Lifestyles
4. Heart Disease & Stroke

For the purposes of this IS, SVH merged Diabetes and Nutrition, Physical Activity, & Weight into one need named “Healthy Lifestyles” in order to better express the topics on which it will focus in addressing the needs.

B. DESCRIPTION OF HEALTH NEEDS THAT SALINAS VALLEY HEALTH PLANS TO ADDRESS

ACCESS TO HEALTHCARE SERVICES

Community survey data and key informant data continually rank healthcare access and delivery as a top concern, citing persistent barriers to care and the need for expanded primary care access. These barriers contribute to delayed care, lower utilization of preventive services, and increased reliance on emergency departments. The major topics of this feedback included:

- Lack of providers
- Primary care physician ratio

- Limited appointment availability
- Cost of care and insurance coverage gaps
- Geographic distance, transportation
- Low Health Literacy [Focus Area ZIP Codes]

While not addressed in the CHNA, the SVH Executive Team is concerned that the impact of HR 1 will result in increase in the number of uninsured community members, further reducing utilization of preventative care and a likely increase in the reliance on emergency room treatment.

CANCER

Cancer continues to be a leading cause of death in Monterey County and according to CDC data from July 2025, deaths attributed to cancer are statistically equal to deaths attributed to heart disease. While screening data is generally more favorable in SVH focus areas than in Monterey County as a whole, in the two cancer screening opportunities cited below, SVH and the County are below Healthy People 2030 targets. The CHNA identified ongoing gaps in:

- Breast cancer screening
- Cervical cancer screening
- Access to early detection services

Despite improvements in some areas, disparities persist in screening rates and outcomes, particularly among underserved populations. Increasing access to screening and early detection remains critical to reducing cancer related mortality. With major investments in creating a comprehensive cancer program to serve the community, SVH is in a unique position to address this leading cause of death.

HEALTHY LIFESTYLES

Survey data and key Informants identified overweight and obesity among adults and children as a major health concern contributing to diabetes and chronic disease. The major topics of their feedback on these needs included:

- Significant proportions of residents reporting inadequate physical activity
- Barriers to accessing fresh and healthy foods
- High consumption of sugar-sweetened beverages
- Prevalence of diabetes in the county
- Issues of health equity: BIPOC (Black, Indigenous People of Color) and south county residents identified as at increased risk for adverse health outcomes

Statistical data did not meet Healthy People 2030 benchmarks or had a declining trend in areas of diabetes, pre-diabetes and kidney disease deaths.

HEART DISEASE AND STROKE

The CHNA reveals heart disease and stroke remain among the leading cause of death in the region. The CHNA identified the high prevalence of associated risk factors, including:

- High blood pressure
- High cholesterol
- Poor nutrition
- Physical inactivity

These conditions are largely preventable through education, early detection, and lifestyle interventions. Increasing awareness and improving access to preventable care are critical to reducing cardiovascular disease burden.

VII. Salinas Valley Health's Implementation Strategy

The federal government requires nonprofit hospitals to complete an Implementation Strategy Report, or ISR. The ISR is a companion to the CHNA, in that it describes how hospitals will use community benefit and other resources to address priority health needs in their service areas. This ISR fulfills federal requirements. Specifically, the ISR must detail:

- Which of the priority health needs will be directly addressed by the hospital as part of its implementation strategy, and which top health needs will not be addressed (and justification)
- The actions, programs, and resources the hospital intends to commit to address the selected health needs
- The anticipated impact of these actions
- Any planned collaboration between the hospital and other hospitals or organizations

The goals and strategies proposed to address the chosen needs are described in the section below. SVH will implement these strategies through a combination of intentional resource allocation, program development or expansion of existing programs, grants, sponsorships, partnerships, and in-kind support to community-based organizations, community health centers, or clinics. Associated indicators of anticipated impact are listed for each goal.

SVH's definition of "community health" includes not only the physical health of both counties' residents, but also broader social and environmental determinants of health (such as access to and delivery of health care, affordable housing, child care, education, and employment). This more inclusive definition reflects the understanding that myriad factors impact community health. SVH is committed to supporting community health improvement through strategies that address both upstream (social determinants of health) and downstream (health condition) interventions.

HEALTH NEED 1: ACCESS TO HEALTHCARE SERVICES

Long-Term Goal: Improve Access to affordable, high quality healthcare services for our community members.

Goal	Strategies	Anticipated Impact
1.A Decrease barriers to accessing healthcare	i. Support health care clinics and related programs in close geographic proximity to populations of low socioeconomic status ii. Support Salinas Valley Health physicians serving in community clinics iii. Support education on appropriate utilization iv. Provide low cost alternatives to emergency or after-hours care access v. Support mobile health clinic program vi. Optimize Vaccines for Children (VFC) Program vii. Pursue Vaccines for Adults (VFA) opportunity viii. Support community health fairs, virtual health education sessions, and vaccination clinics ix. Pursue innovative technology that supports patient engagement strategies x. Develop strategy for MyChart enrollment and engagement xi. Leverage technology to improve care coordination	a. Increased number of community members served b. Increased access to preventative care c. Reduced unnecessary ED visits/hospitalizations d. Increased vaccination rates e. Increase school readiness in children f. Decreased outbreaks of vaccine-preventable diseases g. Number of patients served in urgent care, in person and Telehealth h. Increased awareness of patient engagement strategies for prevention of chronic disease i. Increase patient enrollment in MyChart j. Increase patient utilization and engagement in MyChart
1.B Ensure future supply of health care providers	i. Provide training to health care professionals (e.g., Hartnell College nursing program, CSUMB program) ii. Support pipeline programs for healthcare careers	a. Increased number of qualified providers in the community focused on community-based practices b. Standard of care raised

Goal	Strategies	Anticipated Impact
	iii. Support the recruitment of healthcare providers to the area	c. Reduction in wait time for patient appointments d. Expand specialty care access in underserved population
1.C Address financial barriers to access	i. Continue to provide uncompensated Medi-Cal care to Medi-Cal patients ii. Provide financial assistance to reduce health care cost barriers to care for low-income individuals iii. Support organizations or programs assisting with insurance enrollment, including community outreach about insurance iv. Continually evaluate opportunities for low-cost alternatives for care v. Support redetermination program for qualified patients vi. Expand access to lower cost alternatives for services, with a focus on outpatient options vii. Support and collaborate with organizations that provide transportation for healthcare needs, such as post discharge travel, and transit to/from preventative care appointments	a. Reduced health care cost barriers for vulnerable populations b. Improved health insurance rates (% of people with health insurance) c. Reduction in transportation barrier for medical appointments

HEALTH NEED 2: CANCER

Long-Term Goal: Increase community prevention awareness, access and early detection of cancer.

Goal	Strategies	Anticipated Impact
2.A Continue/expand access to programs and services that prevent and/or support early detection of cancer	i. Expand access to programs and services that raise awareness on chronic disease prevention, such as cancer (e.g., healthy eating, active living programs) ii. Expand access to programs and services that address early detection iii. Expand access to programs and services the support cancer screening iv. Explore a genetic screening campaign v. Continue to grow Oncology Health Coordinator role and community presence	a. Improved access to free community education and programs b. Increased number of early detection cancers c. Increase number of people screened for cancer d. Increase number of people who utilize genetic screening
2.B Continue/expand services for those diagnosed with cancer	i. Expand access to programs and services that support cancer patients (ex. Lipstick Angels) ii. Expand access to programs and services that support care givers of cancer patients	a. Improved access to cancer support services b. Increased number of participants in cancer support services

Goal	Strategies	Anticipated Impact
	iii. Expand access to programs and services that support cancer survivors, i.e. Survivorship Initiatives iv. Expand Community Partnerships for aligned patient support	c. Increase number of caregiver services utilized d. Increased awareness and utilization of community services

HEALTH NEED 3: HEALTHY LIFESTYLES

Long-Term Goal: Increase ability of community members to live healthy lifestyles, including a focus on prevention and treatment programs for diabetes.

Goal	Strategies	Anticipated Impact
3.A Increase access to high-quality, affordable, healthy foods for vulnerable populations	i. Expand capacity of existing food access programs, including those specifically addressing health care-related food access (e.g., Fresh Produce Rx, Food is Medicine) ii. Support additional, culturally relevant food access programs iii. Support implementation of healthy food policies in schools and the county at large iv. Support food education with healthy community cooking demonstrations	a. Improved access to high-quality, affordable, healthy foods b. Reduced proportion of individuals who are food insecure c. Improved associated health outcomes d. Increased knowledge related to healthy food preparation

Goal	Strategies	Anticipated Impact
	v. Support expanding partnerships with Community Based Organizations to expand free produce programming vi. Support ongoing implementation of Double Up Food Bucks in Monterey County	e. Increase enrollment on food incentive benefit programs
3.B Increase access to affordable exercise areas and options	i. Support/expand interventions and practices aimed at reducing recreational, sedentary screen time among community members (e.g., expand access to free/low-cost community exercise classes) ii. Advocate for the development and maintenance of trails, parks, bike paths, etc. especially in low-income/ rural communities iii. Support community awareness of Park Rx Program iv. Provide free outdoor community exercise programming	a. Improved access to exercise for low-income individuals b. Increased proportion of individuals who are physically fit c. Increased awareness and utilization of Monterey County parks d. Increased number of community members participating in Pathways programming e. Improved associated health outcomes
3.C Increase education and initiatives related to healthy lifestyles	i. Participate in health fairs and other opportunities for health screening and education (which include follow-up) ii. Support community health workers (CHAs) in health education, and as outreach, enrollment, and information agents to increase healthy behaviors iii. Support/expand community well-being initiatives promoting healthy lifestyles	a. Increased knowledge about healthy behaviors b. Increased participation in free community programming c. Improved health outcomes, particularly related to health disparities

Goal	Strategies	Anticipated Impact
	iv. Align with Community Schools to increase awareness of programming v. Support development and implementation of curriculum aligned nutrition curriculum in school districts	d. Increased participation in early childhood nutrition education
3.D Reduce uncontrolled chronic diseases such as prediabetes and diabetes	i. Support/expand initiatives and programs for diabetes and obesity prevention (e.g., screenings, diabetes and diabetes-prevention education, treatment) ii. Support/expand initiatives and programs that provide intervention strategies for chronic disease to include aligned diabetes prevention and education campaign iii. Expand free and low-cost access to diabetes service line prevention and education programming iv. Expand culturally relevant healthy food demonstrations, fun food experiences and recipe development throughout the Salinas Valley Health service area	a. Increased knowledge about healthy behaviors b. Increased number of screenings for diabetes c. Increased engagement in prevention education programming d. Improved health outcomes, particularly related to health disparities e. Improved knowledge and capacity for healthy food preparation

HEALTH NEED 4: HEART DISEASE & STROKE

Long-Term Goal: Increase community prevention awareness, access and early detection of heart disease & stroke.

Goal	Strategies	Anticipated Impact
4.A Increase awareness and education programming of healthy lifestyle interventions for preventable chronic disease	i. Support and expand healthy eating/healthy lifestyle community programming ii. Expand offerings in both English and Spanish for nutrition education iii. Participate in health fairs and other opportunities for health screening and education (which include follow-up) iv. Support community health workers (CHAs) in health education, and as outreach, enrollment, and information agents to increase healthy behaviors v. Expand locations of healthy lifestyle programming to increase access in underserved communities and throughout our service area vi. Implement patient engagement and education platforms, such as Mytonomy, to educate on risk factor modification, prevention and procedures	a. Improved patient engagement in preventative health b. Increased access as a result of additional programming c. Improved health outcomes, particularly related to health disparities d. Increased knowledge about healthy behaviors e. Increased participation in education and prevention programming f. Increased knowledge and engagement among patient population
4.B Increase access to affordable exercise areas and options	i. Support/expand interventions and practices aimed at reducing recreational and sedentary screen time among community members	a. Improved access to exercise for low-income individuals b. Increased proportion of individuals who are physically fit

Goal	Strategies	Anticipated Impact
	ii. Expand access to free/low-cost community exercise opportunities iii. Identify partners to support sustained physical activity upon completion of cardiac associated rehabilitation (Ex. YMCA partnership) iv. Advocate for the development and maintenance of trails, parks, bike paths, etc. especially in low-income/ rural communities v. Expand ParkRx partnerships to increase awareness and utilization by community members	c. Improved associated health outcomes d. Increased utilization of Monterey County parks
4.C Increase knowledge of risk factors and screening for heart disease, hypertension and stroke	i. Develop a bilingual and culturally relevant stroke awareness campaign ii. Develop a bilingual and culturally relevant campaign to increase awareness and screening for hypertension iii. Evaluate current cardiac related campaigns for bilingual comprehension and retention iv. Focus on cardiac related conditions and stroke in community outreach, with a strategic alignment in underserved areas	a. Increased awareness of stroke signs, symptoms b. Increased awareness of preventative options for stroke c. Increase awareness of prevention options for hypertension

VIII. Evaluation Plans

SVH will monitor and evaluate the strategies described above for the purpose of tracking the implementation of those strategies as well as to document the anticipated impact. When working with partners through our Community Benefit Funding, SVH will track the number of grants made, dollars spent, and number of people reached/served. In addition, SVH will require grantees to track and report outcomes/impact, including behavioral and physical health outcomes as appropriate.

Evaluation efforts will include both process and outcome measures aligned with the goals and anticipated impacts identified in Section VII. These measures may include:

- Utilization of primary and preventive care services
- Participation in community-based programs
- Preventive screening rates (e.g., cancer, hypertension)
- Patient engagement metrics, including use of digital tools
- Clinical indicators related to chronic disease management

Data sources will include internal program data, electronic health records, community partner reports, and publicly available health data. Where appropriate, SVH will compare results to state and national benchmarks.

Regular internal reviews will be conducted to assess program effectiveness, identify opportunities for improvement, and ensure alignment with organizational priorities and community needs. Strategies may be adjusted throughout the implementation period to improve outcomes and responsiveness.

SVH will also continue to collaborate with community partners to gather feedback and evaluate the impact of programs at the community level. Findings will inform future planning efforts, including subsequent CHNAs and Implementation Strategies.

IX. Health Needs that Salinas Valley Health Does Not Plan to Address

As described in Section VI(A) of this report, SVH will address the four health needs that met all of the selection criteria. SVH will not address the following identified health needs:

The 2025 CHNA identified a broad range of significant health needs within Monterey County, including mental health, substance use, housing, infant health and family planning, injury and violence, respiratory disease and tobacco use.

While these needs are critical to overall community health, Salinas Valley Health has chosen to focus its resources on four priority areas for Fiscal Years 2026–2028: Access to Healthcare Services, Cancer, Healthy Lifestyles, and Heart Disease & Stroke.

The decision to not prioritize the other needs within this IS is based on several factors, including:

- Alignment with organizational expertise and clinical capabilities
- Availability of resources
- Potential to achieve measurable impact within the three-year period
- Presence of other organizations and collaborative entities actively addressing these issues

SVH remains committed to supporting these broader needs through targeted programs currently in place, participation in community partnerships, collaboration with local agencies, and referral and care coordination efforts that connect individuals to appropriate services.

These needs will continue to be monitored and may be addressed in future Implementation Strategies as community conditions evolve.

Mental Health: While not prioritized in this IS, SVH has prioritized this health need in the past and remains active in addressing mental health needs in the community by securing and promoting telehealth mental health services for adults and children. SVH also promotes better mental health through our many healthy lifestyle programs, classes, and events and provides support for other community non-profits with expertise and resources focused on the topic.

Substance Use: SVH decided to focus on higher impact community health needs however SVH was an early adopter of the Prescribe Safe program and participates in the Quad County Coalition of Prescribe Safe; SVH is active in the California Bridge Collaborative; the Clinical Team is engaged in the Tri-County EMS Buprenorphine program; a SVH Magnet driven nursing practice council created a new 2025 protocol to update the ICU's alcohol withdrawal program supported by clinical evidence; and the work of SVH Case Management and Social Services teams have dedicated experts in substance use disorder to coordinate care and programs for patients in need of community based resources.

Housing: This topic is outside of SVH's core competencies or mission and the medical center feels it can have greater impact through partnerships of support where appropriate with those who have proven expertise in the housing and land use arena.

Infant Health & Family Planning: SVH is better positioned to address drivers of this need via healthcare access and delivery strategies. Additionally, this need was of lower priority to the community than the needs selected to be addressed by SVH. However, it is important to note the SVH Labor/Delivery and Mother/Baby units are very active in the community as it relates to maternal and infant health, every year leading a diaper collection campaign and community distribution of diapers to underserved communities.

Injury & Violence: This need was of lower priority to the community than the needs selected to be addressed by SVH. SVH, however, provides education materials on the leading cause of injuries - falls. Clinical teams especially counsel at risk patients and families on fall prevention strategies.

Respiratory Disease: While SVH chose to prioritize more community health needs impacting a greater percentage of residents, it is worth noting that SVH launched and hosts Monterey County's only Asthma Day Camp, a week long summer program started 40 years ago at SVH to help children better manage their asthma in a supportive, fun and supervised learning environment.

Tobacco Use: This health topic was viewed as the lowest priority by key stakeholders and survey results indicate the prevalence in the SVHMC Service area is very low with 94% of all respondents indicating they do not smoke at all and only 3% of respondents indicating they smoke cigarettes daily.

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*

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

(CATHERINE CARSON)



Origination	1/1/2022	Owner	Donathon Rodriguez:
Approved	N/A		Manager
Expires	1 year after approval		Risk
		Area	Plans and Program

Risk Management Plan

I. SCOPE

- A. Risk Management in health care promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value.
- B. The Risk Management Plan is enacted to protect Salinas Valley Health Medical Center and all entities under their purview against the adverse consequences of accidental losses, regardless of source, effectively managing losses that may occur, and to enhance the continuous improvement of patient care services in a safe health care environment. The plan applies to all departments, programs and services. The scope of the plan encompasses the patient population, employees, visitors, volunteers, students and other individuals providing services, including medical staff, and aligns with the mission, vision and values of the organization.
- C. The CEO and Board of Directors have given the authority to the Risk Management Department to implement, monitor and track the elements of the Risk Management Plan.
- D. The Risk Management Plan establishes an approach to monitoring, evaluating, and managing risks throughout the organization, and follows guiding principles included here:
 - 1. Advance safe and trusted healthcare
 - 2. Manage uncertainty
 - 3. Maximize value protection and creation
 - 4. Encourage multidisciplinary accountability
 - 5. Optimize organizational readiness
 - 6. Promote an organizational culture which will positively impact the reporting of adverse events and create an environment wherein employees feel safe to report all adverse events
 - 7. Utilize data/metrics to prioritize risks

8. Align risk decisions with organizational strategy and goals
- E. Salinas Valley Health supports a Just Culture philosophy and approach to adverse event investigation and response and has adopted the BETA Healthcare Group Just Culture Algorithm for responding to the behaviors of their employees in a fair and just manner. See "Attachment A".

II. OBJECTIVES/GOALS

- A. In order to approach the process of Risk Management systematically and to achieve organizational goals, Salinas Valley Health utilizes the following four-step model for Risk Management
 1. Identification of risk
 2. Analysis of identified risk
 3. Response strategy and actions taken
 4. Evaluation and monitoring of responses and actions taken
- B. This model assists in setting priorities for Risk Management activities and ensures a comprehensive Risk Management effort. Any single strategy or combination of the above Risk Management strategies may be employed to best manage a given situation.
- C. **Risk Identification:**
 1. Risk Identification is the process whereby awareness of risks in the health care environment that constitute potential loss exposures for the facility are identified.
 2. The following information services may be utilized to identify potential risks:
 - a. Identification of trends through the incident reporting system
 - b. Patient, visitor, staff and physician reports and interviews
 - c. Performance improvement functions and assessments
 - d. Peer review activities
- D. **Risk Analysis:**
 1. Risk Analysis is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. These factors establish the seriousness of a risk and will guide leadership in the selection of an appropriate risk treatment strategy. Risk scoring/ranking, harm scales, or other assessment methods may be utilized.
- E. **Risk Response:**
 1. Risk response refers to the range of choices available in handling a given risk. Risk response strategies include the following:
 - a. Risk prevention techniques are used to reduce the probability that a risk will occur. Examples include facility inspections, educational initiatives, policy changes, and use of evidence-based clinical pathways and protocols.
 - b. Risk reduction actions will reduce value loss once an event has occurred.

Some examples are rapid event response processes, using empathy and disclosure to manage adverse events, system redesign, and procedure revisions.

- c. Risk avoidance are actions taken to remove the risk by not allowing a process or service to occur. This option may be used if unable to identify a response that would reduce risk to an acceptable level or severity.
- d. Risk retaining/acceptance involves assuming the potential value loss associated with a given risk and making plans to accept the outcome.
- e. Risk transfer/sharing includes techniques to reduce severity of risk by transferring or otherwise sharing a portion of the risk. This may be done through means such as insurance contracts, hold-harmless, or indemnification agreements.

F. Risk Management Evaluation:

- 1. An evaluation of the effectiveness of the techniques employed to identify, analyze and respond to risks are assessed and further action are taken when warranted. If improvement and/or resolution of the risk are evident, additional follow-up will be done at predetermined intervals to evaluate continued improvement. This evaluation is in concert with the Salinas Valley Health Patient Safety Plan and Quality Assessment and Performance Improvement Plan.

III. PLAN MANAGEMENT

A. Risk Domains & Framework

- 1. The Risk Management Plan is concerned with a variety of issues and situations that hold the potential for liability, or that may be related to value creation and protection for the hospital/organization. It addresses the following domains of risk as applicable:
 - a. **Operational:** The business of healthcare is the delivery of care that is safe, timely, effective, efficient, and patient-centered within diverse populations. Operational risks relate to those risks resulting from inadequate or failed internal processes, people, or systems that affect business operations. Included are risks related to: adverse event management, credentialing and staffing, documentation, chain of command, and deviation from accepted best practice.
 - b. **Clinical/Patient Safety:** Risks associated with the delivery of care to patients and other healthcare customers. Clinical risks include: failure to follow evidence based practice, medication errors, hospital acquired conditions (HAC), serious safety events (SSE), and others.
 - c. **Strategic:** Risks associated with the focus and direction of the organization. Because the rapid pace of change can create unpredictability, risks included within the strategic domain are associated with brand, reputation, competition, failure to adapt to changing times, health reform or customer priorities. Managed care relationships/ partnerships, conflict of interest, marketing and sales, media relations, mergers, acquisitions, divestitures, joint ventures, affiliations and other

business arrangements, and contract administration are other areas generally considered as potential strategic risks.

- d. **Financial:** Decisions that affect the financial sustainability of the organization, access to capital or external financial ratings through business relationships or the timing and recognition of revenue and expenses make up this domain. Risks might include: costs associated with malpractice, litigation, insurance, capital structure, credit and interest rate fluctuations, foreign exchange, growth in programs and facilities, capital equipment, corporate compliance (fraud and abuse), accounts receivable, days of cash on hand, capitation contracts, and billing and collection.
- e. **Human Capital:** This domain refers to the organization's workforce. This is an important issue in today's tight labor and economic markets. Focus is made on the need to maintain a safe work environment that is non-discriminatory and non-hostile, and to reduce the risk of injury and illness.
- f. **Legal/Regulatory:** Risk within this domain incorporates the failure to identify, manage and monitor legal, regulatory, and statutory mandates on a local, state and federal level. Such risks are generally associated with fraud and abuse, licensure, accreditation, product liability, management liability, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and Conditions for Coverage (CfC), as well as issues related to intellectual property.
- g. **Technology:** This domain covers machines, hardware, equipment, devices and tools, but can also include techniques, systems and methods of organization. Healthcare has seen an explosion in the use of technology for clinical diagnosis and treatment, training and education, information storage and retrieval, and asset preservation. Examples also include Electronic Health Records (EHR) and Meaningful Use, social networking and cyber liability.
- h. **Hazard:** This domain covers assets and their value. Traditionally, insurable hazard risk has related to natural exposure and business interruption. Specific risks can also include risk related to: facility management, facility age, parking (lighting, location, and security), valuables, construction/renovation, earthquakes, windstorms, tornadoes, floods, fires.

B. Plan Elements

- 1. Plan elements, although not all may be under the direct accountability /responsibility of the Risk Management Department, include but are not limited to the following:
 - a. Investigation of cause of adverse occurrences to assess and determine how similar occurrences might be averted, review patterns and trends, control loss related to the adverse occurrence, and identify areas for performance improvement.
 - b. Reporting and response coordination of events that meet BETA Healthcare criteria of a "HEART Event" or "Claim".
 - c. Assessment of premises/property for potentially hazardous conditions

which may present unnecessary risk to employees, patients, and visitors and make risk recommendations.

- d. Participation in policy and procedure review to update, amend, edit, and revise to reflect appropriate care, legislative requirements, and minimize or prevent liability ramifications.
- e. Participation in response during regulatory investigations.
- f. Organization and/or facilitation of educational programs on risk management topics to promote awareness of risk management and safe practices.
- g. Report Effectiveness - Periodic risk management and patient safety reports are provided by the various areas previously described in this Policy to assess the effectiveness of their monitoring. Outcome evaluations are conducted and reported annually as part of the Quality and Safety Committee of the Medical Staff. An ad hoc, multidisciplinary Patient Safety Advisory Committee is available to review, analyze, and monitor certain patient safety events.
- h. Claims Management - Assists with the management of claims against Salinas Valley Health in a timely, organized, manner. The Risk Management Department participates and supports investigating complaints, grievances, safety related events, incidents and actual or potential claims by a process protected from discovery. Safety Events or Claims presenting serious exposure are reported immediately to the appropriate individuals. Concerns and events may be investigated and resolved with the assistance of Quality & Risk Management leaders, Chief Legal Officer, affected departments, staff, administration, physicians, and patient/family as needed. The results of the findings are provided to the appropriate individuals or committee. Matters involving care provided by the physician are forwarded to the Medical Staff Department for further review and response as indicated.
- i. Annually, the Risk Management Department shall provide the CEO, General Counsel, and the Quality and Efficient Practices Committee of the Board of Directors a report of all pending claims, litigation and settlements.

C. Plan Responsibility

- 1. Everyone in the organization has a responsibility for risk management.
- 2. The Chief Executive Officer is ultimately responsible to assure the implementation of the Risk Management Plan.
- 3. The Risk Manager under the authority of the Vice President of Quality & Risk Management, and in coordination with the Chief Legal Officer, is responsible for the implementation of the Risk Management Plan. The Risk Manager and the Patient Safety Officer and Vice President of Medical Affairs may collaborate with other departments and leaders such as Human Resources, Employee Health, Infection Prevention, Quality Management, Patient Safety, Accreditation and Regulatory, Emergency Management, Safety, Security, Medical Staff Services and others to adhere to the goal of the Plan as needed.

4. All leadership supports the risk management philosophy, promotes compliance with our risk aversion, and manages risks within their areas of responsibility consistent with risk tolerances. These leaders are also responsible for executing risk management in accordance with established directives, policies, procedures and protocols as outlined by Salinas Valley Health.
5. The Board of Directors provides important oversight of risk management, and is aware of and concurs with key risk determinations.
6. A number of external parties, such as customers, vendors, business partners, external auditors, regulators, and financial analysts often provide information useful in supporting risk management, but they are not responsible for the effectiveness of, nor are they a part of, this plan.

D. Confidentiality

1. Confidentiality shall be in effect for all Risk Management activities.
2. All communication and documentation generated as part of the Risk Management Plan are to be confidential and subject to the state and federal laws protecting such documents from discovery, including Attorney: Client Privileges and Patient Safety Work Product as applicable. It is the intent of this Risk Management Plan to apply all existing legal standards and state or federal statutes to provide protection to the documents, proceedings, and individuals involved in the plan.
3. The Vice President of Quality & Risk Management, and the Quality and Safety Committee of the Medical Staff are responsible for the oversight of the Risk Management Plan. All information, data, reports, minutes, or memoranda relating to the implementation of this Risk Management Plan are solely for use in the course of internal quality control for the purpose of reducing morbidity and mortality and improving the environment of care.
4. Any and all documents and records that are part of the internal Risk Management Plan as well as the proceedings, reports and records from any of the involved committees, shall be maintained in a confidential manner. Disclosure to any judicial or administrative proceedings will occur only under court order or legal mandate and in accordance with the Patient Safety Work Product protections.

E. Performance Measurement

1. The performance measurement process is one part of the evaluation of the effectiveness of the Risk Management Plan. Performance measures may be established to measure at least one important aspect of the Risk Management Plan.
2. On an annual basis, the Risk Manager, Vice President of Quality & Risk Management and the Quality and Safety Committee evaluates the scope, objectives, performance, and effectiveness of the Plan to manage risks to the staff, visitors, and patients at Salinas Valley Health.

F. Orientation and Education

1. The Risk Management Plan includes events to promote and support Risk Management initiatives and principles. Related content is provided for new employees at initial hospital orientation, and annually thereafter. This Plan also includes ongoing evaluation and response to identified education and training needs

- for this and other groups (staff, volunteers, physicians, students, other).
2. A key responsibility of the Risk Manager is to participate in and/or to facilitate events and education that promote the reporting of adverse events, and which support an environment wherein employees feel safe to report all adverse events.

IV. REFERENCES

- A. American Society for Health Care Risk Management. (2020). Health care enterprise risk management playbook: An ERM guide for health care professionals (2nd ed.). American Hospital Association
- B. California Evidence Code 1157
- C. Patient Safety and Quality Improvement Act of 2005; 42 U.S.C. 299b-21

Attachments

 [Attachment A: Just Culture Algorithm.pdf](#)

Approval Signatures

Step Description	Approver	Date
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Owner	Donathon Rodriguez: Manager Risk	7/7/2026

Standards

No standards are associated with this document

FINANCE COMMITTEE

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

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

(VICTOR REY, JR.)

Board Paper: Finance Committee

Agenda Item: **Consider Recommendation for Board Approval of a 5-Year Agreement with Hillrom for the Voalte Nurse Call Services Program**

Executive Sponsor: Clement Miller, Chief Operating Officer

Meeting Date: July 20, 2026

Executive Summary

The proposed agreement with Hillrom for the Voalte Nurse Call Services Program caps the annual price increases at **three percent (3.0%)**, providing predictable pricing and reducing long-term cost escalation. Historically, Salinas Valley Health has renewed this service agreement on a one-year basis. Under those renewals, Hillrom has typically proposed annual price increases of five percent (5.0%). While the organization has periodically negotiated lower increases, those reductions have not been consistently achievable and require annual renegotiation. By transitioning to a five-year agreement, the organization secures a maximum annual increase of three percent for the duration of the contract. This approach provides greater budget certainty, reduces administrative effort associated with yearly contract negotiations, and protects the organization from higher recurring cost increases. SVH Administration recommends approval of the five-year agreement with Hillrom as a fiscally responsible strategy that provides long-term pricing stability while supporting the continued maintenance and reliability of the Voalte Nurse Call Services Program.

Background/Situation

The Nurse Call Services Program supports critical communication systems used throughout Salinas Valley Health Medical Center's nursing units and is essential to daily patient care operations. The organization has no plans to replace or transition away from this platform in the foreseeable future, making ongoing service and maintenance a long-term operational necessity. Given the continued reliance on this equipment, a multi-year service agreement provides an opportunity to secure stable pricing, ensure uninterrupted vendor support, and align contract terms with the anticipated lifecycle of the Nurse Call system.

Timeline/Review Process

During the **2026–2027 renewal review** for the Nurse Call Services Program, it was identified that Hillrom had routinely applied annual renewal increases above typical CPI-based expectations. Historically, the organization has renewed this service agreement on a one-year basis, requiring annual negotiations to mitigate proposed increases. While SVH has successfully negotiated reductions in certain years, the ability to consistently secure favorable pricing has varied. Following negotiations with Hillrom, SVH secured a proposed five-year service agreement with annual increases capped at 3%, compared to the historical renewal increases of approximately 5%.

July 20, 2026 Presentation to the SVH Finance Committee and request for recommendation to the SVH Board for approval.

July 23, 2026 Consideration for approval of Hillrom Agreement by the SVH Board of Directors.

Strategic Plan Alignment

The Hillrom agreement supports SVH's strategic priorities by promoting financial stewardship, improving budget predictability, and ensuring the continued reliability of critical Nurse Call Services that support patient care operations.

Pillar/Goal Alignment

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

Key Contract Terms	Vendor: Hillrom, WSS ID No. 2370
1. Proposed effective date	June 1, 2026
2. Term of agreement	Five (5) Years
3. Renewal terms	N/A
4. Termination provision(s)	None
5. Payment Terms	Paid Annually, Net 30 Upon Invoice
6. Annual cost	Varies based on 3% annual increase: Year 1 (2026-2027): USD 135,699.87 Year 2 (2027-2028): USD 158,710.59 Year 3 (2028-2029): USD 163,471.90 Year 4 (2029-2030): USD 168,376.07 Year 5 (2030-2031): USD 173,427.35
7. Cost over life of agreement	\$799,685.78
8. Budgeted (indicate y/n)	Yes, Routinely Renewed Every Year

Recommendation

SVH Administration requests the Finance Committee to recommend to the SVH Board of Directors approval of the five-year agreement with Hillrom for the Voalte Nurse Call Services Program at a cost in the amount of \$799,685.78.

Attachments

- Hillrom Quote No. CRYQ607949GPA52126-01
- Sole Source Justification



Prepared for:

Salinas Valley Memorial Health Care System
450 E Romie Ln
Salinas, CA 93901



Voalte Nurse Call

NC GOLD+ RCB

YEAR 1-5 PAID ANNUALLY

Casey Gretkowski
Hillrom Clinical Workflow Solutions
1-470-550-9828 phone

casey_gretkowski@baxter.com

Account Number	607949
Proposal Number	CRYQ607949GPA52126-01
Proposal Date	7/8/2026
Proposal Expiration	10/6/2026
Proposal Type	Renewal

This proposal is valid for 60 days from the proposal date.

Payment Terms are Net 30



Voalte® Nurse Call Services Program

Protecting Patients with ProActive Services

Hill-Rom's Voalte® Nurse Call is designed to protect patients by anticipating care. Like any Health IT product, it requires software upgrades, technical support and maintenance. The below service offerings are designed to ensure your facility is supported every step of the way.

PLAN DETAILS*	SILVER	GOLD	GOLD+	PLATINUM
Software Upgrades	✓	✓	✓	✓
Remote Clinical Upgrade & Consulting Hours **	✓	✓	✓	✓
Onsite Clinical Consulting & Optimization		1 day	1 day	3 days
Technical Training and Certification	✓			
24/7/365 Tech Support	✓	✓	✓	✓
System Configuration Changes	✓	✓	✓	✓
Annual Business Update	✓	✓	✓	✓
Access to Customer Portal	✓	✓	✓	✓
System Security Certificate Updates	✓	✓	✓	✓
Onsite Field Dispatch		✓	✓	✓
Annual Preventive Maintenance		✓	✓	✓
Parts Coverage (Including Labor)		✓	✓	✓
CenTrak RTLS Battery Maintenance (2x/yr)			✓	✓
Quarterly Business Reviews				✓

*The Silver Services Package is essential to continue to receive software maintenance services as set forth in your facility's purchase documents.

**Hours vary by plan.

The Voalte Nurse Call Services Program is governed by: (1) this Proposal; (2) the Voalte Nurse Call Services Program Terms and Conditions available at www.hillrom.com/en/products/care-comms-nurse-call/care-comms-terms/ (the “Terms”); and (3) the Voalte Nurse Call Services Program Details available at www.hillrom.com/serviceoptions/nursecall/ (these documents are collectively referred to herein as the “Services Agreement”). The Terms apply to the term of the Voalte Nurse Call Services Program contemplated by this Proposal, any subsequent renewal term, and any other Voalte Nurse Call Services Program purchased by Customer. The Terms will be deemed incorporated by reference into any subsequent proposals entered into by and between Hill-Rom Company, Inc. (“Hillrom”) and Customer with respect to a Voalte Nurse Call Services Program.

Hillrom will invoice Customer annually under the Services Agreement. By signing this Proposal, you represent and warrant that you are authorized to accept the terms of the Services Agreement on behalf of Customer.

Upon Customer’s signature hereto, the Services Agreement shall constitute legal, valid, and binding obligations of Hillrom and Customer.

CUSTOMER:

607949
Salinas Valley Memorial Health Care System
450 E Romie Ln
Salinas, CA 93901

Signature:

Name:

Title:

Date:



YEAR 1-5 PAID ANNUALLY

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

607949

CRYQ607949GPA52126-01

DEPARTMENT	RCBs	ASBCs	GRS10s	NC GOLD+ 6/1/2026- 5/31/2027	YEAR 2 6/1/2027- 5/31/2028	YEAR 3 6/1/2028- 5/31/2029	YEAR 4 6/1/2029- 5/31/2030	YEAR 5 6/1/2030- 5/31/2031
Emergency Dept	18	19	0	\$ 6,572.51	\$ 6,901.14	\$ 7,246.19	\$ 7,608.50	\$ 7,988.93
Main	234	213	20	\$ 110,748.47	\$ 116,285.89	\$ 122,100.19	\$ 128,205.20	\$ 134,615.46
Tower	51	40	6	\$ 25,300.72	\$ 26,565.76	\$ 27,894.04	\$ 29,288.75	\$ 30,753.18
TOTALS	303	272	26	\$ 142,621.70	\$ 149,752.79	\$ 157,240.42	\$ 165,102.45	\$ 173,357.57
COVERED UNDER WARRANTY				\$ (18,388.08)	\$ -	\$ -	\$ -	\$ -
ADDITIONAL FEATURES				\$ 11,466.25	\$ 12,039.56	\$ 12,641.54	\$ 13,273.62	\$ 13,937.30
MULTIYEAR SAVINGS				\$ -	\$ (3,081.76)	\$ (6,410.06)	\$ (10,000.00)	\$ (13,867.52)
*GRAND TOTAL				\$ 135,699.87	\$ 158,710.59	\$ 163,471.90	\$ 168,376.07	\$ 173,427.35

*Counts will be assessed on a per annum basis and trued up to account for any changes in install base.

ADDITIONAL FEATURES					
STAFF ASSIGNMENT	PATIENT SAFETY	ADT	WIRELESS	OUTBOUND	INBOUND
NO	NO	YES	YES	NO	NO

1069 State Route 46 East, Batesville IN 47006

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SALINAS VALLEY MEMORIAL

SALINAS VALLEY MEMORIAL

HEALTHCARE SYSTEM

607949

CAMPUS	FLOOR OR DEPARTMENT	NURSING UNIT	RCB3	RCB2	RCB1	ASBC	GRS10H	GRS10
Salinas Valley Memorial Hospital	Emergency Dept	Main ED			8	9		
Salinas Valley Memorial Hospital	Emergency Dept	Tynan ED Control	3	2	5	10		
Salinas Valley Memorial Hospital	Main	0FL Endo	4				1	
Salinas Valley Memorial Hospital	Main	0FL NUC Med	4				1	
Salinas Valley Memorial Hospital	Main	1FL Cath Lab	3				1	
Salinas Valley Memorial Hospital	Main	1FL Cath Lab Holding	6			10	1	
Salinas Valley Memorial Hospital	Main	1FL CCU - ICU	10			9	2	
Salinas Valley Memorial Hospital	Main	1FL CTScan NUC	12				1	
Salinas Valley Memorial Hospital	Main	1FL Heart Center	16			15		1
Salinas Valley Memorial Hospital	Main	1FL PACU	5				1	
Salinas Valley Memorial Hospital	Main	1FL Surgery	5				1	
Salinas Valley Memorial Hospital	Main	1FL Telemetry	29			23		2
Salinas Valley Memorial Hospital	Main	2FL LDRP Tower	12			10	1	
Salinas Valley Memorial Hospital	Main	2FL Mother-Baby	21			20	1	
Salinas Valley Memorial Hospital	Main	2FL NICU	6				1	
Salinas Valley Memorial Hospital	Main	2FL OBED	7			8	1	
Salinas Valley Memorial Hospital	Main	3 FL Main MedSurg	2	21		33		1
Salinas Valley Memorial Hospital	Main	3 FL PEDS		15		19		1
Salinas Valley Memorial Hospital	Main	4 FL Main MedSurg		30		33		1
Salinas Valley Memorial Hospital	Main	5 FL Main	26			33		1
Salinas Valley Memorial Hospital	Tower	3FL Tower MedSurg	3	14		13		2
Salinas Valley Memorial Hospital	Tower	4FL Tower Oncology	1	16		13	1	1
Salinas Valley Memorial Hospital	Tower	5th Tower	17			14		2
TOTALS			192	98	13	272	14	12
SUMMARY			303			272	26	

CARE COMMUNICATIONS PRODUCTS
SERVICES TERMS AND CONDITIONS

- 1. Scope; Entire Agreement.** These Care Communications Products Services Terms and Conditions apply to the maintenance, repair, support, and other services (the “Services Programs”) offered by Hill-Rom Company, Inc. (“Hillrom”) for its Care Communications Products, which include Voalte Nurse Call, Voalte Patient Safety, Voalte Patient Safety - Falls Protocol, Enterprise Reporting Model, Enterprise Reporting Model+, and Hillrom Precision Locating (collectively referred to herein as the “Products”). The Services Program for each Product is detailed in a Services Program Details document for such Product, a current copy of which shall be provided to Customer upon request. The following documents, listed in order of precedence in the event of any inconsistency among them, constitute the agreement between Hillrom and Customer with respect to the Services Programs (“Agreement”): (i) proposals executed by Hillrom and Customer; (ii) these Care Communications Products Services Terms and Conditions; and (iii) the Services Programs Details. To the extent Hillrom and Customer do not execute a proposal, Customer’s acceptance of any services performed by Hillrom signifies Customer’s acceptance of the terms of the Agreement. The Agreement represents the entire agreement between Hillrom and Customer with respect to the Services Programs and supersedes any other oral or written agreement between Hillrom and Customer. The Agreement will prevail over any conflicting terms in Customer’s purchase order and may only be modified in a writing signed by both parties.
- 2. Effective Date.** The effective date of the Agreement is as provided in Hillrom’s proposal.
- 3. Initial Term and Renewal.** Unless otherwise specified in Hillrom’s proposal, the initial term of each Services Program is eighteen (18) months commencing on shipment of the applicable Product and each renewal term of a Services Program is twelve (12) months. Each Services Program may be renewed upon Hillrom’s and Customer’s execution of a renewal proposal, or, in the absence of a renewal proposal, upon Customer’s timely payment of a renewal term invoice issued by Hillrom. Any entitlements not used during the applicable term of a Services Program do not roll over to the subsequent term. For the avoidance of doubt, the Agreement applies to the initial term and each renewal term of a Services Program and is deemed incorporated by reference into any proposals or Customer purchase orders for the Services Program.
- 4. Payment Terms.** Customer must pay the annual fee for each Services Program in full in advance; the annual fee is not refundable. The fee does not include any applicable sales, use or other taxes payable by Customer. Payment is due net thirty (30) days from invoice date. Unless waived by Hillrom in writing, undisputed overdue invoices shall be subject to an overdue payment charge equal to the lesser of 1.5% per month or the maximum rate allowed by law. Customer agrees to pay Hillrom for any and all costs and expenses (including, without limitation, reasonable attorneys’ fees) incurred by Hillrom to collect any amounts owed to it. Customer may be obligated to accurately reflect and/or report any discount, rebate, or reduction in price in its costs claimed or charges made to federal (e.g., Medicare) or state (e.g., Medicaid) health care programs requiring such disclosure, and Hillrom’s invoices may not reflect Customer’s net cost. Customer may make written request to Hillrom in the event it requires additional information to meet applicable reporting or disclosure obligations.
- 5. Suspension of Performance.** If Customer fails to comply with the net thirty (30) days payment term for a Services Program, Hillrom may suspend the performance of services under such Services Program upon ten (10) days’ written notice unless (i) Hillrom receives full payment, or (ii) the parties agree in writing to alternative payment arrangements. Hillrom reserves the right to cancel a Services Program upon written notice to Customer with immediate effect if Customer fails to rectify its non-payment or continues to default on its payment obligation.
- 6. Exclusions; Cancellation.** The Services Programs do not cover damage to or failure of covered Products, equipment, or software caused by, in whole or in part, the following as determined by Hillrom in its sole discretion: (i) modification or upgrade, improper repair, or relocation by anyone other than Hillrom; (ii) misuse or improper use, including failure to comply properly with routine maintenance requirements specified in the directions for use or service manual; (iii) natural disasters, extreme weather, or other catastrophe; (iv) cybersecurity incidents; (v) loss of, or fluctuation in, electrical power, air conditioning or humidity control; (vi) failure or refusal to implement software changes or updates; or (vii) use of non-Hillrom accessories, replacement parts, and/or third-party software not authorized in writing by Hillrom. In addition, the Services Programs do not cover Products, equipment, or software with missing or altered serial numbers. Pursuant to this Section 6, if Customer or any third party modifies any covered Product, Hillrom may immediately cancel the Services Program for the modified Product by giving five (5) days’ written notice of cancellation.
- 7. Data.** Customer hereby acknowledges and agrees that Hillrom has the right to collect, store, process, maintain, upload, sync, transmit, share, disclose, aggregate, analyze, and use service and diagnostic data created, generated, stored, and/or transmitted by the covered Products and software and accessed by Hillrom personnel in connection with providing services under the Services Programs (“Data”). Hillrom shall own all right, title, and interest in and to such Data and any

aggregations, analyses, reports, programs, and output based on or including such Data (“Derivative Data”) and has the right to retain all such Data and Derivative Data after termination of the Services Programs. Customer acknowledges and agrees that Hillrom, its affiliates, and its contracted third parties has the right to use and disclose the Data for any lawful purpose including, without limitation: (i) benchmarking and analysis of workflow and Data to identify system improvements, efficiency improvements, quality improvements, increase cost efficiencies, and product development; (ii) in-depth analysis of the specifics of errors for better understanding of errors and error situations to help understand and reduce their incidence; (iii) to facilitate better technical support and customer support to avoid machine downtime and/or return and replacement of given hardware modules; (iv) investigate changes in ordering patterns that could yield opportunities to define new warning limits, formulary ingredients, and label templates; provided that, to the extent that any Data contains “Protected Health Information” as that term is defined by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (“HIPAA”), Hillrom’s use and disclosure of such data shall be governed by the business associate agreement/addendum between the Parties; and (v) to facilitate the provision of functionality for the covered Products and software, and any other lawful purpose, including but not limited to, performance optimization, quality assurance, software updates, subscription services, and other services (if any) provided to Customer, or to otherwise improve Hillrom’s products, services, or technologies. Hillrom acknowledges that: CUSTOMER SHALL HAVE NO LIABILITY FOR HILLROM’S USE, RETENTION OR DISCLOSURE OF ANY DATA OR THE ACCURACY OF SUCH DATA.

- 8. Non-Solicitation.** To the extent permitted by applicable law, during the term of the Services Programs and for a period of six (6) months following its expiration or cancellation, Customer agrees that it will not directly or indirectly: (i) induce any individual who has provided services to Customer on behalf of Hillrom within the 6-month period immediately preceding the expiration or cancellation of the Services Programs to terminate his/her relationship with Hillrom; or (ii) assist, coordinate, or otherwise offer employment to, employ, or retain as an independent contractor any individual who was employed by Hillrom at any time during the 6-month period immediately preceding the offer, employment, or retention without first paying to Hillrom a finder’s fee equal to 50% of the annual fee for the Services Programs. The foregoing restrictions do not prohibit Customer from placing any general advertisements for employees or hiring individuals who respond to such general advertisements so long as such general advertisements are not directed to any individuals who have provided services to services to Customer on behalf of Hillrom.
- 9. Warranty.** Hillrom warrants that it will perform services in a reasonably timely, professional, and workmanlike manner using trained and qualified personnel capable of performing services in accordance with industry standards. Hillrom’s exclusive obligation, and Customer’s exclusive remedy, for breach of the foregoing warranty is re-performance of defective services. THE FOREGOING WARRANTY CONSTITUTES THE SOLE WARRANTY MADE BY HILLROM AND IS IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED OR STATUTORY, INCLUDING, BUT NOT LIMITED TO, THE IMPLIED WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, AND ALL OTHER REMEDIES. NO EMPLOYEE OR REPRESENTATIVE OF HILLROM IS AUTHORIZED TO MODIFY THIS WARRANTY IN ANY WAY OR GRANT ANY OTHER WARRANTY.
- 10. Limitation of Liability.** Hillrom will not be liable for loss or damages because of delays or nonperformance resulting from any cause beyond Hillrom’s reasonable foresight or control. Any delays will extend Hillrom’s period of performance under the Services Programs. IN NO EVENT AND UNDER NO LEGAL THEORY – WHETHER IN TORT (INCLUDING NEGLIGENCE), CONTRACT, WARRANTY, PRODUCTS LIABILITY, OR OTHERWISE - WILL HILLROM BE LIABLE TO CUSTOMER OR ANY THIRD PARTY FOR ANY SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR INDIRECT DAMAGES, INCLUDING, WITHOUT LIMITATION, LOSS OF PROFITS (WHETHER DIRECT OR INDIRECT), LOSS OF GOODWILL, BUSINESS INTERRUPTION, OR LOSS OR CORRUPTION OF DATA, OR ANY EXEMPLARY OR PUNITIVE DAMAGES. IN NO EVENT WILL HILLROM’S AGGREGATE LIABILITY TO CUSTOMER OR ANY THIRD PARTY FOR DIRECT DAMAGES ARISING OUT OF THE SERVICES PROGRAMS OR THESE CARE COMMUNICATION PRODUCTS SERVICES TERMS AND CONDITIONS, REGARDLESS OF THE FORM OF ACTION AND REGARDLESS OF THE NUMBER OF CLAIMS MADE, EXCEED THE FEE FOR THE SERVICES PROGRAMS PAID OR PAYABLE BY CUSTOMER FOR THE 12-MONTH PERIOD IN WHICH THE FIRST EVENT GIVING RISE TO SUCH DAMAGES OCCURRED. THIS SECTION 10 IS INDEPENDENT OF ANY OTHER LIMITATION OF LIABILITY AND REFLECTS AN ALLOCATION OF RISK SEPARATE FROM PROVISIONS SPECIFYING OR LIMITING A PARTY’S REMEDIES.
- 11. General.** Hillrom and Customer shall comply at all times with applicable federal and state laws and regulations. Customer may assign the Agreement upon notice to Hillrom. The Agreement will be governed by and construed under the laws of the State of Illinois without reference to its conflicts of law principles. The provisions of these Care Communication Products Services Terms and Conditions that by their nature are intended to survive the expiration or cancellation of the Services Programs and the Agreement, including Section 7, Section 8, and Section 9, will survive the expiration or cancellation of the Services Programs and the Agreement.

12. Confidentiality. During the term of this Agreement, if either party receives from the other party information marked “confidential” or similar legend, or, if not in written form, information that is identified as confidential at the time of disclosure, or information, whether or not marked or identified as confidential at the time of disclosure, that the receiving Party knows or should know is nonpublic, commercially sensitive, trade secret, or proprietary and thus confidential (“Confidential Information”), the receiving party shall not use such Confidential Information except in the performance of this Agreement, and shall protect such Confidential Information in the same manner as it treats its own confidential information (using at least commercially reasonable efforts). The receiving party shall give Confidential Information only to those of its employees and agents who have a need to know and who are subject to obligations of confidentiality at least as stringent as those contained in this Agreement. This Agreement imposes no obligation upon the receiving party with respect to information that the receiving party can prove: (i) was in the receiving party's rightful possession on or before receipt from the disclosing party, free of any obligation to keep it confidential; (ii) is or becomes a matter of public knowledge through no action or inaction of the receiving party; or (iii) is rightfully received by the receiving party from a third party without a duty of confidentiality. If the receiving party receives a request or demand to disclose all or any part of Confidential Information under the terms of a subpoena or order issued by a court of competent jurisdiction or authorized governmental agency, the receiving party may comply with such request or demand only if the receiving party: (a) asserts the privileged and confidential nature of Confidential Information against the third party seeking disclosure; (b) promptly notifies the disclosing party in writing of any such requirement or order to disclose prior to the disclosure of Confidential Information; and (c) upon the disclosing party's request and at the disclosing party's expense, reasonably cooperates with the disclosing party to protect against any such disclosure and/or obtain a protective order narrowing the scope of such disclosure and/or use of Confidential Information. Upon expiration or termination of this Agreement, or at any time upon the disclosing party's written request, the receiving party shall destroy and provide written certification to the disclosing party of such destruction, or return to the disclosing party, all Confidential Information, including, without limitation, all memoranda, reports, analyses, notes, and other tangible embodiments prepared by the receiving party based on or including the disclosing party's Confidential Information. Destruction or return of Confidential Information by the receiving party includes expunging and destroying all Confidential Information in electronic form residing on any computer, server, or other device or medium in its possession, custody or control.

Justification for Sole Source Form

To: Contract Review Committee

From: Laura Zerbe, Director of Plant Operations

Type of Purchase:

- ☐ Data Processing/Telecommunication Goods/Service of \$25,000 or more
☒ Purchase Service, Medical/Surgical – Supplies/Equipment of \$400,000 or more
☐ Non-Medical materials/supplies/Public Works of \$25,000 or more

Total Cost \$:	USD 799,685.78
Vendor Name:	Hillrom
Agenda Item:	Consider Recommendation for Board Approval of 5-Year Voalte Nurse Call Services Program

Statement of Need: My department's recommendation for sole source is based upon an objective review of the product/service required and appears to be in the best interest of SVHMC. The procurements proposed for acquisition through sole source are the only ones that can meet the district's need. I know of no conflict of interest on my part or personal involvement in any way with this request. No gratuities, favors or compromising action have taken place. Neither has my personal familiarity with particular brands, types of equipment, materials or firms been a deciding influence on my request to sole source this purchase when there are other known suppliers to exist.

Describe how this selection results in the best value to SVHMC. See typical examples below (Check one).

☐ Licensed or patented product or service. No other vendor provides this. Warranty or defect correction service obligations of the consultant. **Describe.**

☒ Existing SVHMC equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Description:** The Nurse Call Services Program supports SVHMC's existing nurse call infrastructure currently installed throughout patient care areas. The organization has an established equipment inventory, service history, and operational processes associated with this system. Continued support from Hillrom ensures ongoing maintenance, troubleshooting, and service continuity for existing nurse call equipment without requiring replacement of the current platform or implementation of a new system.

☐ Uniqueness of the service. **Describe.**

☐ SVHMC has established a standard for this manufacturer, supplier or provider and there is only one vendor. **Describe.**

☐ Factory-authorized warranty service available from only this single dealer. Sole availability at the location required. **Describe.**

☐ Used item with bargain price (describe what a new item would cost). **Describe.**

☐ Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, please **describe:**

By signing below, I am attesting to the accuracy and completeness of this form.

Submitter Signature  Date: 7/14/26

Financial Performance Review

May 2026

Finance Committee

Iftikhar Hussain
Chief Financial Officer

Consolidated Financial Results May 2026

Month					\$ in Millions	YTD				
May			Bud Variance (unfav)			May			Bud Variance (unfav)	
Actual	Budget	Prior Year	\$	%		Actual	Budget	Prior Year	\$	%
\$ 63.2	\$ 71.5	\$ 68.1	\$ (8.3)	-11.6%	Operating Revenue	\$ 795.3	\$ 766.9	\$ 545.6	\$ 28.4	3.7%
69.0	71.9	67.4	2.9	4.0%	Operating Expense	773.2	762.8	520.8	(10.4)	-1.4%
(5.8)	(0.4)	0.7	(5.4)	-1350.0%	Income from Operations	22.1	4.1	24.8	18.0	439.0%
-9.2%	-0.5%	1.0%	-8.7%	-1740.00%	Operating Margin %	2.8%	0.5%	4.6%	2.3%	460.0%
					Op. margin % full year target		3.0%			
1.6	2.5	6.3	(0.9)	-36.0%	Non Operating Income	17.7	27.3	26.4	(9.6)	-35.2%
(4.2)	2.1	7.0	(6.3)	-300.0%	Net Income	39.8	31.4	51.2	8.4	26.8%
-6.7%	2.9%	10.2%	-9.6%	-331.03%	Net Income Margin %	5.0%	4.1%	9.4%	0.9%	22.0%

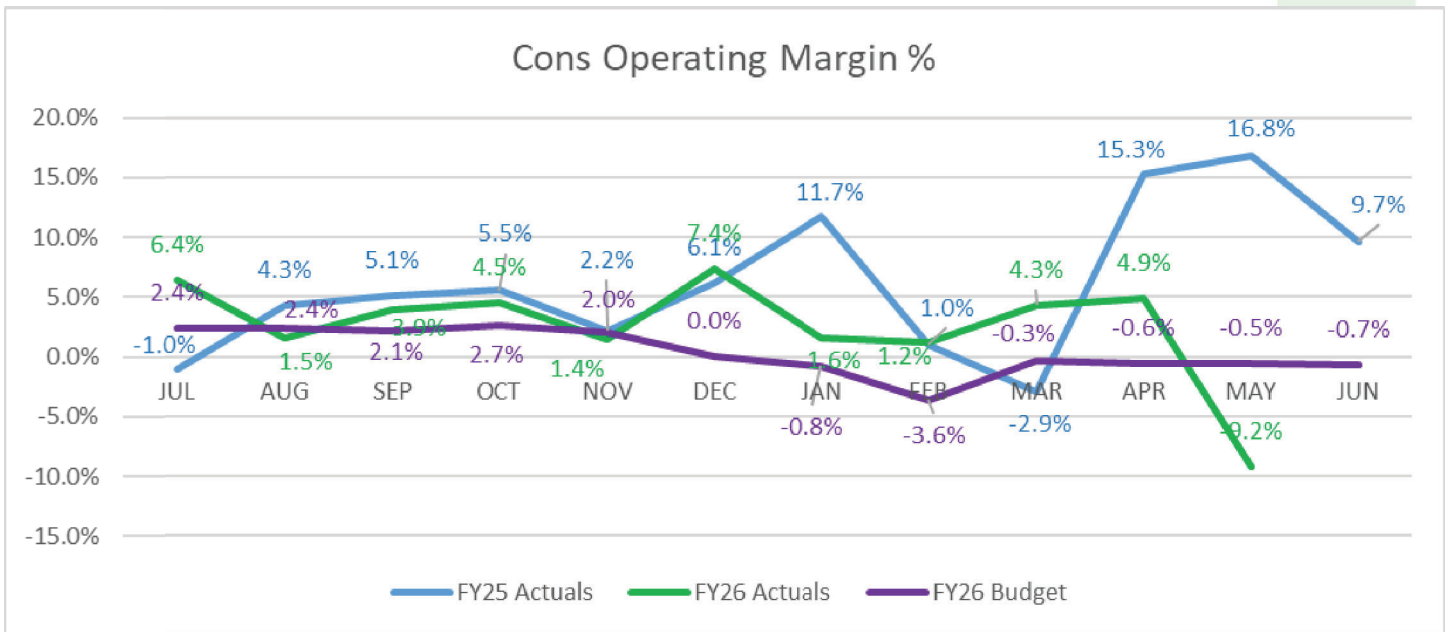
Supplemental Payments

\$1 million during May

\$33 million YTD

\$5.3 million unfavorable net revenue correction in May related to commercial payor grouping

Consolidated Operating Margin



3

Key Financial Indicators

Indicator Metric		YTD 5/31/2026	Budget	S&P A+ Rated	YTD Prior Year
Operating Margin*		2.8%	0.4%	4.0%	6.4%
Total Margin*		5.0%	4.0%	6.6%	10.8%
EBITDA Margin**		7.8%	5.4%	13.6%	10.7%
Days of Cash*		358	317	249	377
Days of Accounts Payable*		46	45	-	47
Days of Net Accounts Receivable***		77	60	49	64
Supply Expense as % NPR		15.2%	14.6%	-	15.1%
Labor Expense as % NPR		51.7%	55.7%	53.7%	52.0%
Operating Expense per APD*		7,427	7,205	-	6,718

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

*These metrics have **not** been adjusted for normalizing items

**Metric based on Operating Income (consistent with industry standard)

***Metric based on 365 days average net revenue (consistent with industry standard)

4

Executive Summary

- In May, an additional \$5.3 million contractual reserve was recorded following adoption of Epic reimbursement trends which revealed the commercial and miscellaneous financial class was under reserved due to new estimates of recent collection rates for local prison claims that average payments of only 13% of charges since November 2025.
- Admissions and Census
 - YTD Admissions and Observations are 1.6% higher than PY
 - YTD ADC is 7% lower than PY due to length of stay improvement
 - May Admissions of 1,069 was a new high for FY26
 - YTD ER volumes are down 3% from PY.
- Deliveries have decreased consistent with demographic trends
- Cath Lab – YTD cases are up 2% from PY but were down in May impacting outpatient revenue
- Procedure Volumes for the year are stable.
 - Strong growth in Infusion services, up 10% from PY
 - Surgical volume was lower for the month of May down 13% from PY impacting revenue. YTD Surgeries off 2% from PY

5

Executive Summary: May Financial Performance – Continued

Cost and Utilization:

- Worked FTEs** on a per Adjusted ADC basis were **10%** unfavorable at **7.4** - compared to a target of **6.8**
- Payor Mix** was close to budget with commercial charges down 4% from budget
- Non-Operating Income** was under budget by \$0.9 million due to timing of donations income and lower than projected investment income.
- Days in AR** at 77 down 2 days from April on higher cash collections up 2% from budget in May.
- Days Cash on Hand** decreased to 358 days due to \$6.5 million capital spending

Key Metrics	Prior 3 Months			Current Month		Year-To-Date	
	Feb-26 Actual	Mar-26 Actual	Apr-26 Actual	May-26 Actuals	May-26 Budget	FY26 YTD Actuals	FY25 YTD Prior Year Actuals
Total Gross Revenue	\$ 286,944	\$ 313,675	\$ 298,735	\$ 299,504	\$ 305,516	\$ 3,214,080	\$ 3,113,581
Medicare %	47%	49%	47%	46%	46%	46%	46%
Medicaid %	29%	29%	28%	29%	29%	29%	29%
Commercial %	21%	19%	19%	21%	21%	21%	21%
All Other %	4%	4%	5%	4%	4%	4%	4%

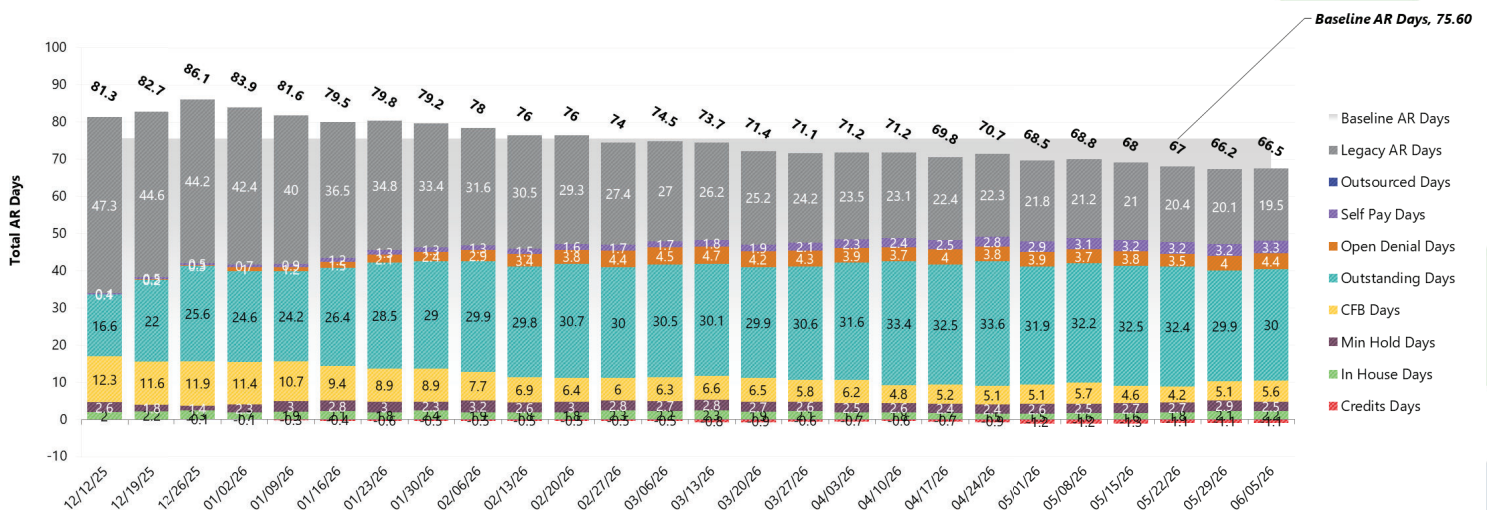
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Volume Summary – May 2026

Actual	Prior Year	May Bud	Bud Var	Key Statistics	YTD	YTD-PY	YTD May Bud	YTD Bud Var
Inpatient								
109	111	114	↓	-4% ADC	108	116	114	↓ -5%
1,069	957	931	↑	15% Admissions	10,701	10,738	10,064	↑ 6%
110	104	130	↓	-15% Deliveries	1,162	1,270	1,410	↓ -18%
2.1	2.2	2.3	↓	-9% Medicare Traditional ALOS CMI Adjusted	2.1	2.2	2.3	↓ -10%
1.77	1.85	1.75	↑	1% Medicare Traditional Case Mix	1.74	1.76	1.75	↓ -1%
Emergency Room								
4,524	4,717	4,653	↓	-3% ER OP Visits	48,552	49,881	50,288	↓ -3%
849	745	719	↑	18% ER IP Admissions	8,389	8,307	7,765	↑ 8%
Procedures								
159	140	146	↑	9% IP Surgeries	1,677	1,662	1,578	↑ 6%
259	342	293	↓	-12% OP Surgeries	3,291	3,398	3,164	↑ 4%
272	332	333	↓	-18% Cath Lab	3,522	3,462	3,603	↓ -2%
1,225	1,244	1,158	↑	6% OP Infusion Cases	13,736	12,848	12,515	↑ 10%
374	303	405	↓	-8% MRI Procedures	3,683	3,105	4,373	↓ -16%
2,273	1,981	2,168	↑	5% CT Scans	22,504	21,802	23,429	↓ -4%
Observation Cases								
163	206	152	↑	7% Obs Cases	2,069	1,832	1,648	↑ 26%

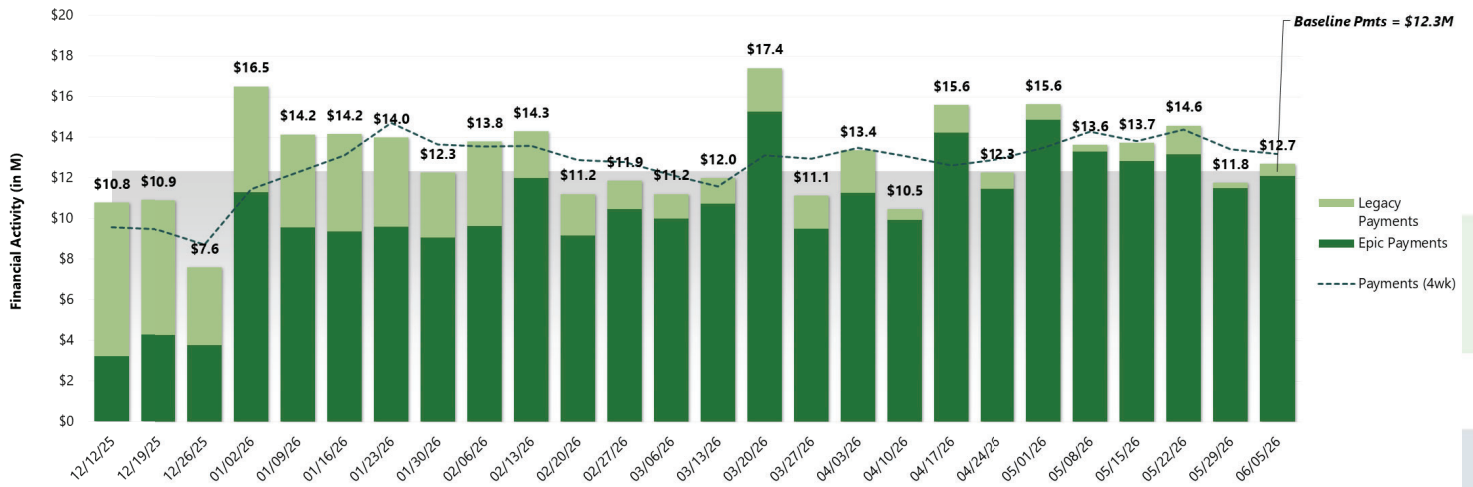
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Accounts Receivable – AR Days Trend



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Accounts Receivable –Payment Trend



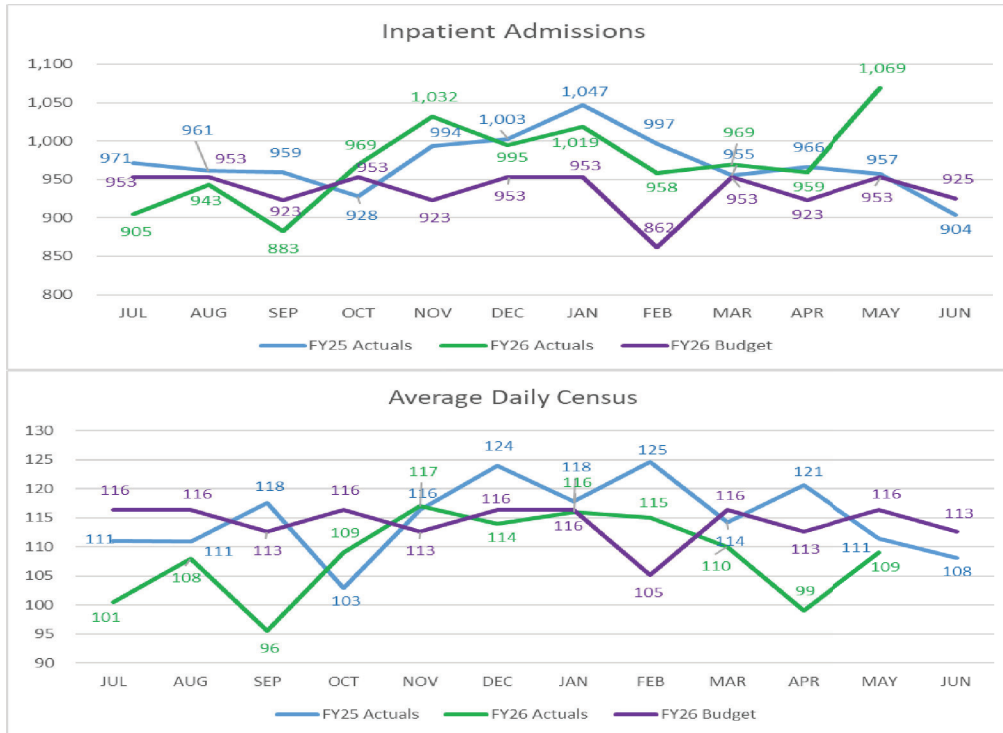
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Medi-Cal and Other Supplemental Payments

FY 2026					
Date	Payor	Description	Total Amount	Regular	One Time
Oct 2025	CAAH	Direct Payment Program (net) Phase 2- CY 2023	4,474,778	4,474,778	
Oct 2025	CAAH	DMPH-Quality Incentive Payment CY 2024 Interim	3,326,677	3,326,677	
Dec 2025	CAAH	CAAH-EPIC Training & Implementation	12,000,000		12,000,000
Jan 2026	CAAH	Voluntary Rate Range-CY 2024 (net)	5,579,554	5,579,554	
Apr 2026	CAAH	Medi-Cal Quality Incentive Program (net)	2,944,592	2,944,592	
Apr 2026	CAAH	Direct Payment Program (net) Phase 1- CY 2024	3,902,248	3,902,248	
May 2026	DHCS	Medi-Cal OP Supplemental (net) CY 2024-25	955,663	955,663	
June 2026 Projection	DHCS	Medi-Cal Rate range	2,218,743	2,218,743	
Total FY 2026			35,402,255	23,402,255	12,000,000
FY 2025					
Date	Payor	Description	Amount	Regular	One Time
Jan 2025	CAAH	Voluntary Rate Range-CY 2023 (net)	4,639,758	4,639,758	
Apr 2025	CAAH	Medi-Cal Quality Incentive Program (net)	7,045,692	7,045,692	
Apr 2025	DHCS	Medi-Cal OP Supplemental (net) CY 2023-24	1,398,017	1,398,017	
Apr 2025	CAAH	Direct Payment Program (net) Phase 1- CY 2023	4,797,482	4,797,482	
May 2025	CAAH	NDPH HQAF (net) Program Year-2024	4,270,850	4,270,850	
Jun 2025	DHCS	Medi-Cal Rate Range (net) CY 2024-25	2,305,245	2,305,245	
Multiple Dates	FEMA	Grant Funds (net) FY2025	6,260,697		6,260,697
Total FY 2025			30,717,741	24,457,044	6,260,697

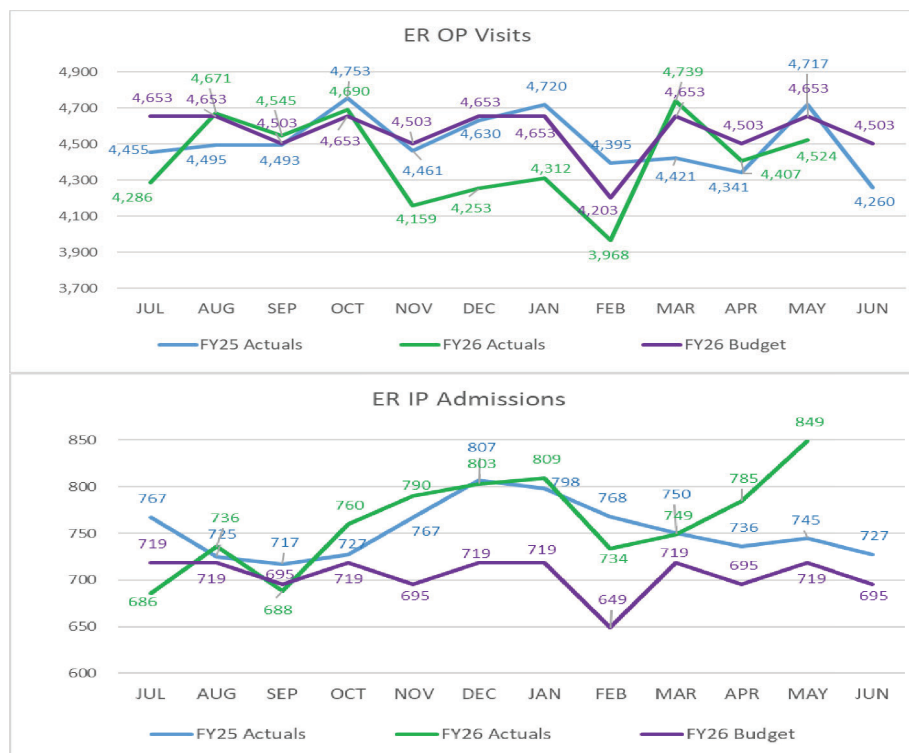
10

Volume Trends – Admissions & ADC



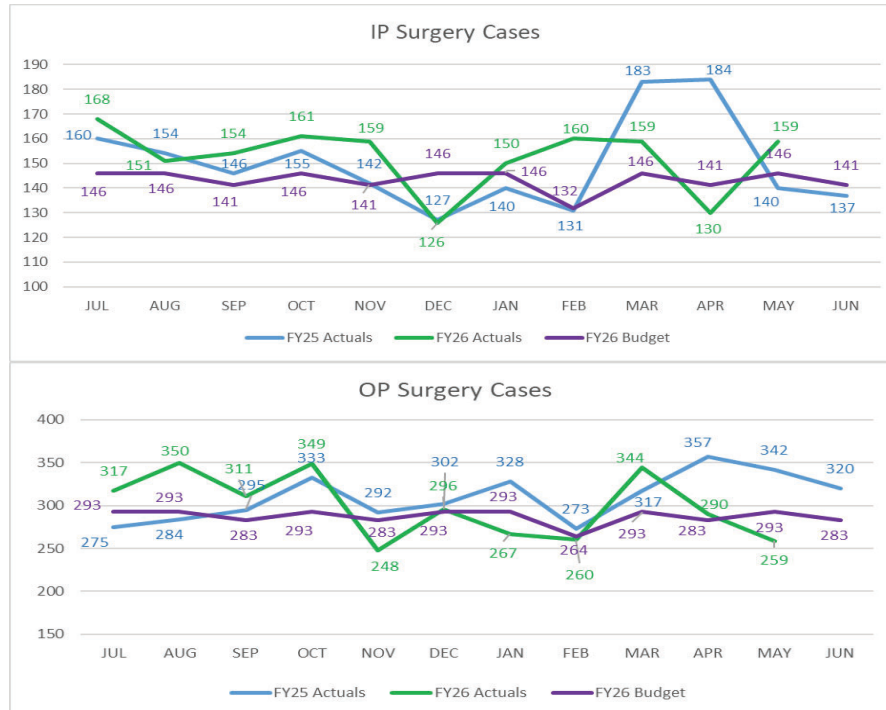
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Volume Trends – ER



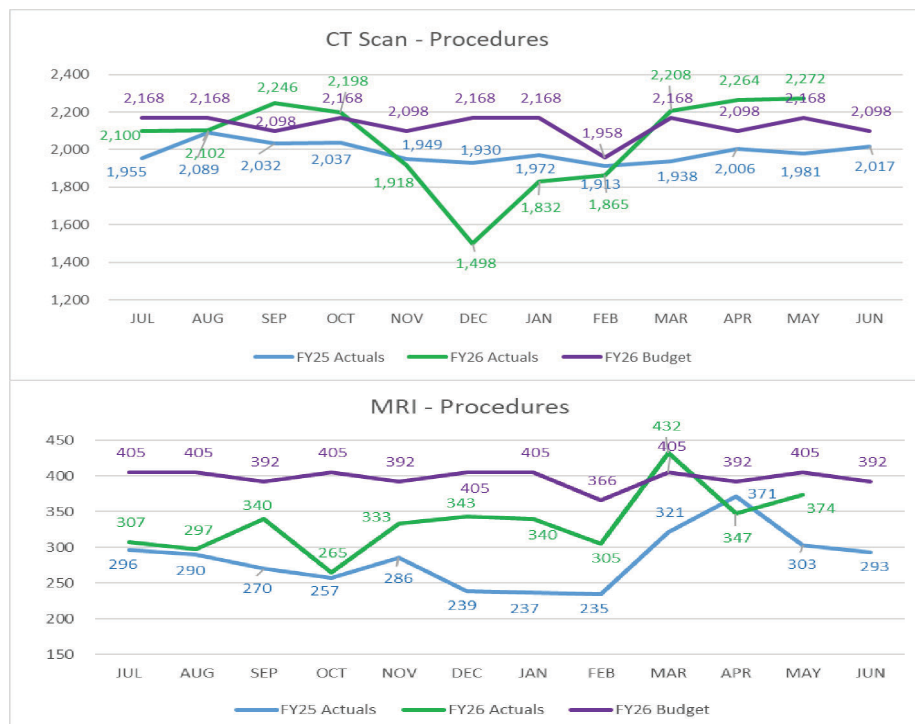
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Volume Trends - Surgery Cases



13

Volume Trends - Imaging



14

Labor Productivity Key Indicators

Current Month					Year-to-Date			
Prior Year	Actual	Budget	Variance (in FTE)		Prior Year	Actual	Budget	Variance (in FTE)
1,697.5	1,785.4	1,660.1	(125.3 FTE)	Worked FTE	1,621.1	1,709.3	1,613.4	(95.9 FTE)
4.4%	4.5%	4.4%	(0.6 FTE)	Overtime as a % of Worked Hours	4.6%	4.4%	4.6%	3.2 FTE
2.9%	4.3%	2.9%	(23.7 FTE)	Contract Labor as a % of Worked Hours	3.5%	5.9%	3.1%	(48.1 FTE)

15

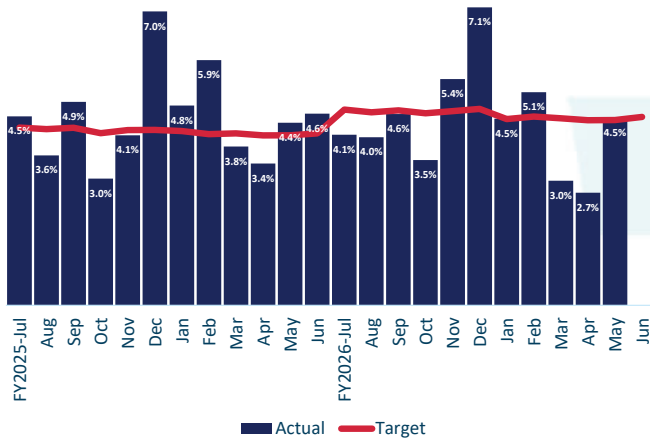
Labor Productivity As of May 2026 Year-to-Date

- **Worked FTE:** Worked FTE is unfavorable to budget by 96 on a year-to-date basis. The variance is primarily driven by:
 - Higher Epic readiness and go live costs
 - Imaging Services: Expanded hours in mammography and internalizing MRI services have led to unbudgeted FTE growth.
 - Cyber security, Workday and system analyst positions were not added to the budget resulting in a negative variance of 13.3 FTE.
- **Contract Labor:** Contract labor usage is over budget by 5.9% on a year-to-date basis.
 - The increase was driven by the Epic implementation and filling roles that have been challenging to recruit. However, the usage has decreased over the last few months after the Epic implementation was completed.

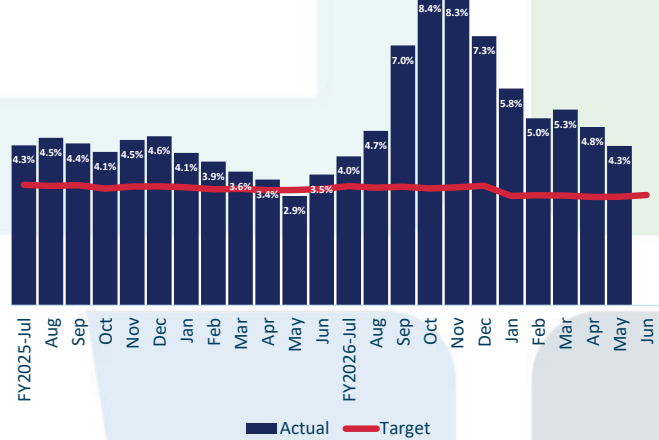
16

Overtime & Contract Labor Trends

Overtime as a Percent of Worked FTE

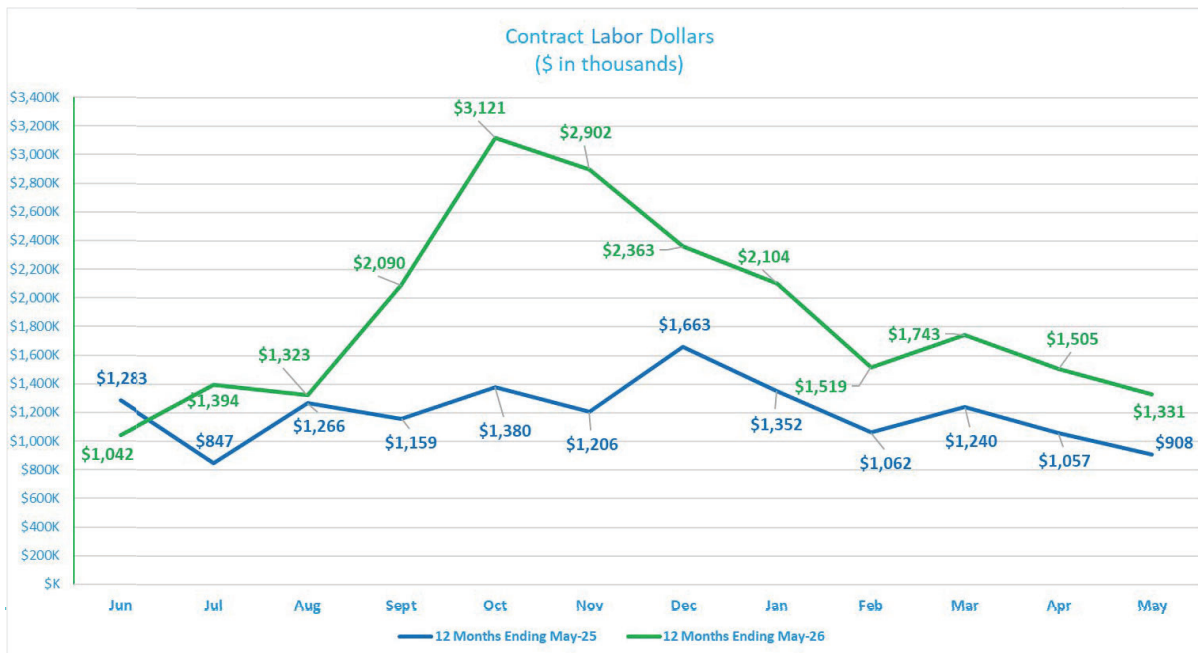


Contract Labor as a Percent of Worked FTE



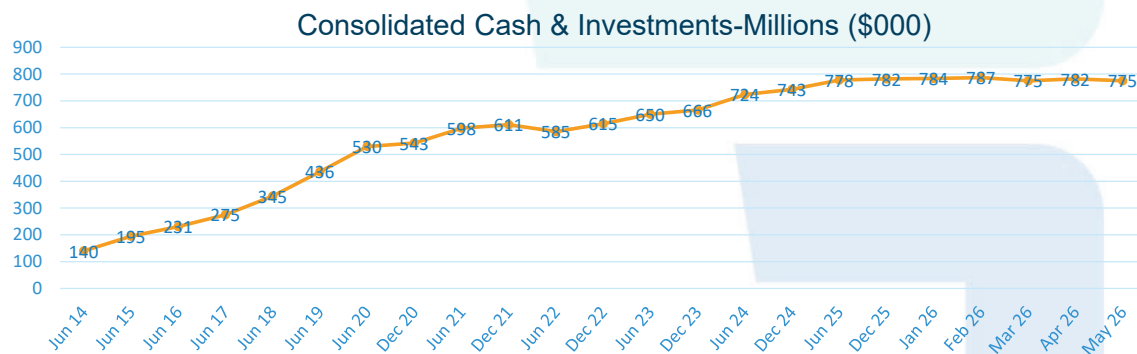
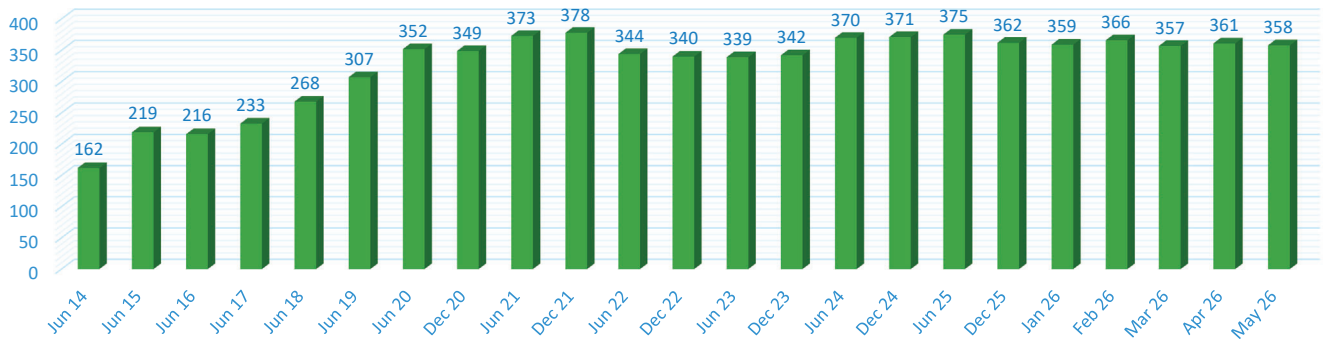
17

Contract Labor Trends



18

Days Cash on Hand = 358 Days (\$775M) - May 2026



19

Sources and Uses of Cash

Salinas Valley Health - Consolidated			
Change in Days Cash on Hand			
	May		YTD
	Days	Dollars	Days Dollars
Sources of cash (inflow):			
Net income (loss) from operations	(2.7)	(5,835,703)	10.1 21,939,487
Add back depreciation/amortization	1.8	3,915,412	17.7 38,300,433
Non-operating income (loss)	0.7	1,613,740	8.7 18,780,571
Decrease (increase) in supplies inventory-SVHMC	0.2	408,553	1.2 2,565,896
Decrease (increase) in right of use lease assets	-	-	1.5 3,225,895
Increase (decrease) in SVHMC SBITA/Lease Liability	(0.1)	(260,816)	5.9 12,714,342
Total sources of cash (inflow)	(0.1)	(158,813)	45.0 97,526,623
Uses of cash (outflow):			
Increase (decrease) in net patient accounts receivable SVHMC	(3.6)	(7,808,315)	3.7 7,985,553
Increase (decrease) in SBITA Renewals	0.2	472,389	9.5 20,622,076
Capital and strategic investments	3.0	6,487,626	22.7 49,183,868
Increase (decrease) Pension plan	1.4	3,007,922	5.6 12,172,558
Increase (decrease) in other current assets SVHMC	2.2	4,670,886	0.6 1,312,812
Increase (decrease) Investment in Non-Consolidating Affiliate	(0.0)	(7,266)	1.9 4,070,115
Decrease (increase) in SVHMC accounts pay & accrued exp-SVHMC	0.1	257,953	3.4 7,382,322
Miscellaneous	0.1	134,135	0.1 209,630
Total uses of cash	3.3	7,215,329	47.5 102,938,934
Net cash flow	(3.4)	(7,374,143)	(2.5) (5,412,310)
Beginning cash and investments	361.1	782,424,192	360.2 780,462,360
Ending cash and investments	357.7	775,050,050	357.7 775,050,050

Capital Expenditures Includes:

Epic Acute Installation	\$ -	\$ 16,999,761
1188 Padre Drive Purchase and Renovation	7,802,505	7,802,505
Master Plan Retro Fit	36,795	3,710,487
5 Lower Ragsdale - Roof Replacement	28,939	2,453,698
Training Rooms Basement Annex	15,452	1,887,141
Angio/Special Procedures Suite	111,809	1,569,710

20

Questions/Comments

*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.)

SVH Board Paper

Agenda Item: **Consider Approval of (i) Findings Supporting Recruitment of Phillip Abarca, MD, (ii) Contract Terms for Dr. Abarca's Recruitment Agreement, and (iii) Contract Terms for Dr. Abarca's Non-Invasive Cardiology Professional Services Agreement**

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

Date: July 23, 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 **non-invasive cardiology** as a recruiting priority for SVH's service area. Based on the ECG Management Group's Medical Staff Development Plan, the specialty of cardiology is recommended as a high priority for recruitment. Recruiting an additional cardiologist is essential to improving access to quality, leading-edge cardiovascular care and ensuring patients can receive timely care and treatment within the community.

The recommended physician, **Phillip Abarca, MD**, received his Doctor of Medicine and Masters of Public Health degrees from University Southern California (USC) Keck School of Medicine. Dr. Abarca continued at USC for his internal medicine residency and expects to complete his cardiovascular fellowship in 2027. Dr. Abarca is certified by the American Board of Internal Medicine and holds an active California medical license. He plans to relocate to the community with his family and join SVH Clinics in September 2027.

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 two 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 six hundred twenty thousand dollars (\$620,000) 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 sixty-eight dollar (\$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 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 two thousand four hundred dollars (\$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.
- **Recruitment Agreement** that provides a recruitment incentive of sixty thousand dollars (\$60,000), which is structured as forgivable loan over two years of service and paid as follows:
 - ❖ Residency Stipend. Commencing in August of 2026, physician will receive monthly fellowship stipend payments in the amount of two thousand five hundred dollars (\$2,500) paid over twelve months for a total of thirty thousand dollars (\$30,000).
 - ❖ Commencement of Services. Physician will receive the remaining thirty thousand dollars (\$30,000) of the recruitment incentive on or about the physician's established start date with SVH.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

The recruitment of Dr. Abarca 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. Abarca 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 Salinas Valley Health Board of Directors approve of the following:

1. **The Findings Supporting Recruitment of Phillip Abarca, MD:**
 - That the recruitment of a non-invasive cardiologist 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. Abarca; and**
3. **The Contract Terms of the Non-Invasive Cardiology Professional Services Agreement for Dr. Abarca.**

Attachments

Curriculum Vitae for Phillip Abarca, MD

Curriculum Vitae

Phillip Abarca, MD MPH

Cardiovascular Medicine Fellow, Class of 2027 - LA General/Keck School of Medicine of USC

Education

University of Southern California Fellowship – Cardiovascular Medicine	2024-
Los Angeles General Medical Center Health System Leader Fellow	2023-2024
University of Southern California Residency Program – Internal Medicine	2020-2023
Keck School of Medicine of USC Doctor of Medicine Masters in Public Health	2014-2020
Cornell University Major: Human Development Concentration: Social and Personality Development	2010-2013

Medical Licensure

California Medical Board – License # A187519

Professional Experience/Positions

LAGMC+USC Committee of Interns and Resident Patient Care Fund - Division Representative	2024 - 2025
2024 ACC Quality Summit - Abstract Reviewer	2024
Health System Leader Fellow - Professional training program with structured curriculum focusing on quality improvement, leadership development, hospital safety, and healthcare systems while continuing to	2023-2024

practice as a hospitalist at a large safety-net academic medical center. Roles and experiences include task force leader focusing on code safety improvement, participation in quality, safety, and executive meetings across the LA County healthcare system, interdisciplinary work throughout the medical center on quality improvement, collaborating with other organizations to host a patient safety poster fair, and educating the center on quality and safety efforts through lectures and QI projects.

Advisory Board Panel Member – Pfizer Inc - Member of consultant advisory panel for ATTR-CM	2023
Unit Medical Director - Telemetry unit medical director at Los Angeles General Medical Center	2023-2024
LAC+USC Committee of Interns and Resident QI Committee -Member	2020-2023, 2024 - current
Cancer Epidemiology, Biomarkers & Prevention - Reviewer	2018
Journal of Student Run Clinics - Reviewer	2016-2017
USC Student Run Clinic -President; Executive Board Member	2016-2017
Bravo High School Mentorship Program -Mentor	2016-2017
USC Cardiology Student Interest Group -Co-President	2016-2017
Pre-Professional Association Towards Careers in Health- PATCH -Head of the First Aid Committee -Executive Board member of largest pre-health society on Cornell campus	2012-2013

Active Research

Resident Co-Investigator- The Effects of Medication Regimen Complexity on Heart Failure Readmissions in an Underserved Population 2021-present

Mentor and PI: Michael Fong, MD - Keck School of Medicine, Department of Medicine, Division of Cardiovascular Medicine

Research Grants Awarded

LAC+USC CIR Quality Improvement Research Fund 2021-2022
- Assessing the effects of standing weight scales on the management of acute decompensated heart failure – \$13,000

Lectures

Clinical Excellence Series – *Heart Failure Guideline Updates* 12/4/2023

Grand Rounds – *Advanced Heart Failure: Identification and Indications for Referral.* 4/13/2022

Intramural Presentations

Keck School of Medicine Quality Curriculum – *FMEA Analysis* 3/4/2024

Blue Service Lecture Series – *Congestive Heart Failure* 10/12/2023

Blue Service Lecture Series – *Acute Kidney Injury* 7/13/2023

USC Internal Medicine Intern Procedures Workshop- Instructor 7/2023

Primary Care Adult East Clinic Didactic – *Diet and Exercise Recommendations in Diabetes Mellitus* 8/3/2022

Goldstein Morning Report – *Visceral Kaposi Sarcoma* 1/24/2022

Intern Morning Report – *Fulminant Myocarditis due to Murine Typhus* 4/16/2021

Primary Care Adult East Clinic Didactic – *Hypokalemia* 11/6/2020

Primary Care Adult East Clinic Didactic – *Prostate Cancer Screening* 11/6/2020

PUBLICATIONS – POSTER PRESENTATIONS

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https://www.ahajournals.org/doi/10.1161/circ.152.suppl_3.4367802

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https://www.ahajournals.org/doi/10.1161/circ.152.suppl_3.4363107

Abarca, P., Li, J. P., Saffarian, M. M., Patel, S. V., Hashmi, S., Nattiv, J., Fong, M., Pizula, J., Banankhah, P., Vaidya, A. S., Wolfson, A. M., & DePasquale, E. C. (2021). Outcomes in Heart Transplant (HT) in Patients Receiving Inotropes Following UNOS Heart Allocation Policy Changes. ISHLT 2021, The Journal of Heart and Lung Transplantation, 40(4, Supplement), S221–S222.
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Abarca, P., Patel, S. V., Li, J. P., Saffarian, M. M., Singhal, P., Liu, G., Grazette, L., Pizula, J., Banankhah, P., Vaidya, A. S., Wolfson, A. M., & DePasquale, E. C. (2021). Post-Heart Transplant Outcomes in Patients with Hypertrophic Cardiomyopathy (HCM) before and after the 2018 UNOS Heart Allocation Policy Change. The Journal of Heart and Lung Transplantation, 40(4, Supplement), S223.
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Abarca PA, Zia S. Assessing differences in professionalism definitions between pre-clerkship medical students and attending physicians. In: Medical Student Research Forum and Poster Day; April 4 2017.

On S, **Abarca PA**, Sophonsri A, Purdy K, Forest C. Patient Satisfaction with Interprofessional Team Based Care in a Student Run Free Clinic. In: STFM Conference on Medical Student Education. Anaheim, CA; 2017.

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Skoll D, **Abarca P**, Pham V, Das A, Mantini C, Tun H, Van Herle H, Wolfson A, Fong M. Accuracy and correlation of bed and standing scale weights in monitoring volume status in heart failure patients. *Future Cardiology*. Published online May 6, 2024. doi:[10.1080/14796678.2024.2340919](https://doi.org/10.1080/14796678.2024.2340919)

Lisberg, A.D., Tucker, A., Goldman, J.W., Wolf, B., Carroll, J., Hardy, A., Morris, K., Linares, P., Adame, C., Spiegel, M.L., Wells, C., McKenzie, J., Ledezma, B., Mendenhall, M., **Abarca, P.**, Bornazyan, K., Hunt, J., Moghadam, N., Chong, N., Nameth, D., Marx, C., Madrigal, J., Vangala, S., Shaverdian, N., Elashoff, D.A., Garon, E.B. "Treatment Related Adverse Events Predict Improved Clinical Outcome in NSCLC Patients on KEYNOTE-001 at a Single Center." *Cancer Immunology Research*, January 1, 2018, canimm.0063.2016.

Spiegel, M. L., Goldman, J. W., Wolf, B. R., Nameth, D. J., Grogan, T. R., Lisberg, A. E., Wong, D. J. L., Ledezma, B. A., Mendenhall, M. A., Genshaft, S. J., Gutierrez, A. J., Abtin, F., Wallace, W. Dean., Adame, C. R., McKenzie, J. R., **Abarca, P. A.**, Li, A. J., Strunck, J. L., Famenini, S., Carroll, J. M., Tucker, D. A., Sauer, L. M., Moghadam, N. M., Elashoff, D. A., Abaya, C. D., Brennan, M. B. and Garon, E. B. (2017), Non-small cell lung cancer clinical trials requiring biopsies with biomarker-specific results for enrollment provide unique challenges. *Cancer*, 123: 4800–4807. doi:10.1002/cncr.31056

Gaut D, Sim MS, Yue Y, Wolf BR, **Abarca PA**, Carroll JM, Goldman JW, Garon EB. "Clinical Implications of the T790M Mutation in Disease Characteristics and Treatment Response in Patients With Epidermal Growth Factor Receptor (EGFR)-Mutated Non-Small-Cell Lung Cancer (NSCLC)." *Clinical Lung Cancer*. 2017 Jun 20.

Garon EB, **Abarca PA**, Strunck JL, Nameth D, Neumann C, Wolf B, et al. Clinical Trials in Non-Small Cell Lung Cancer with Biomarker-Driven Treatment Allocation: Ready or Not, Here We Come. *Crit Rev Oncog*. 2015 Jan 1;20(5–6):339–47.

Garcia-Gathright JI, Oh A, **Abarca PA**, Han M, Sago W, Spiegel ML, et al. Representing and extracting lung cancer study metadata: study objective and study design. *Comput Biol Med*. 2015 Mar 1;58:63–72.

PUBLICATIONS-ABSTRACTS

Accuracy and correlation of bed and standing scale weights in monitoring volume status in heart failure patients. WCAC 2025, Vienna Austria. July 8, 2025.

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Saffarian, M. M., Yang, K., Sharma, A., **Abarca, P. A.**, Wolfson, A. M., Vaidya, A. S., & DePasquale, E. C. (2021). Comparison of Sixth-Month Post-Transplant Survival before and after Implementation of the 2018 UNOS Allocation Policy Change in Patients with Restrictive Cardiomyopathy. *The Journal of Heart and Lung Transplantation*, 40(4, Supplement), S256.

<https://doi.org/10.1016/j.healun.2021.01.731>

Zhang, J., Lum, C., **Abarca, P.**, Salimbangon, A., Genyk, P., Wolfson, A., Vaidya, A., & DePasquale, E. C. (2021). Outcomes in Hypertrophic Cardiomyopathy before and after the UNOS Allocation System Change. *The Journal of Heart and Lung Transplantation*, 40(4, Supplement), S251–S252.

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Outcomes in Patients Supported with Extracorporeal Membrane Oxygenation before and after the UNOS Policy Allocation Change. *The Journal of Heart and Lung Transplantation*, 40(4, Supplement), S277. <https://doi.org/10.1016/j.healun.2021.01.787>

Li, J. P., Kingsford, P., Hashmi, S., Onwuzurike, J., Genyk, P., Liu, G., Saffarian, M., Yang, K., **Abarca, P.**, Singhal, P., Sharma, A., Miller, S., Patel, S., Miklin, D., Lum, C., Salimbangon, A., Jr, R. L., Lee, A., Nattiv, J., ... Vaidya, A. S. (2021). One-year before and after UNOS Status Change Effect on ECMO as a Bridge to Heart Transplant. *The Journal of Heart and Lung Transplantation*, 40(4), S83–S84. <https://doi.org/10.1016/j.healun.2021.01.1943>

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Nameth DJ, Goldman JW, Wolf BR, Wong DJL, Ledezma BA, Mendenhall MA, Oshodi O, Carrasco SR, Adame CR, **Abarca PA**. Evaluating causes of screen failure (SF) in non-small cell lung cancer (NSCLC) clinical trials requiring specific biomarker (BioM) results for enrollment. In: 2015 ASCO Annual Meeting. Chicago: *Journal of Clinical Oncology*; 2015. p. 7517.

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M.N. Macias, E. Garon, **P. Abarca**, B. Ramirez, P. Cha. Pilot study: Assessing if a previously validated questionnaire, Index of Clinical Trial Understanding (ICTU), measures understanding in elderly patients with metastatic Non-Small Cell Lung Cancer (NSCLC). SIOG 2013; Oct 24-26, Copenhagen, Denmark.

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Medical Executive Committee Summary – July 9, 2026

Items for Board Approval

Credentials Committee

Initial Appointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Devulapalli, Pushpa, MD	Nephrology	Medicine	Nephrology
Elguindy, Yehia, MD	Radiology	Surgery	Salinas Valley Health Remote Radiology Salinas Valley Health Advanced Imaging - Remote Radiology
Farzan, Arash, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Gregor, David, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Leiva Salinas, Carlos, MD	Radiology	Surgery	Salinas Valley Health Remote Radiology Salinas Valley Health Advanced Imaging - Remote Radiology
Motamedi, Neda, MD	Psychiatry	Medicine	Tele-Psychiatry
Munn, Charles, MD	Radiology	Surgery	Remote Mammography
Nardine, Timothy, MD	Ob/Gyn	Ob/Gyn	Obstetrical Hospitalist Gynecologic Hospitalist
Petrea, Rodica , MD	Neurology	Medicine	Tele-Neurology
Witt, Maxwell, MD	Infectious Disease	Medicine	Remote Infectious Disease

Reappointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Beheshti, Nima, DO	Neurology	Medicine	Neurology
Brunet, Russell, DO	Family Medicine	Family Medicine/ Pediatrics	Family Medicine Pediatric and Well Newborn Category I and II Obstetrics
Dhillon, Jaspreet, MD	Internal Medicine	Medicine	Medicine – Active Community
Flores, Sara MD	Psychiatry	Medicine	Tele-Psychiatry
Freeman, Heidi, MD	Ob/Gyn	Ob/Gyn	OB Hospitalist Obstetrics OB Hospitalist Gynecology
Gabe, Michael, MD	Radiology	Surgery	Salinas Valley Health Remote Radiology Salinas Valley Health Advanced Imaging - Remote Radiology
Graham, Kyle, MD	Ob/Gyn	Ob/Gyn	OB Hospitalist Obstetrics
Guez, Ghislaine, MD	Internal Medicine	Medicine	Adult Hospitalist
Healy, Mark, MD	Surgical Oncology	Surgery	General Surgery Colorectal Surgery Oncologic General Surgery Robotic Surgery
Jani, Atul, MD	General Surgery	Surgery	General Surgery
Kowalczyk, Kathie, MD	Neurology	Medicine	Tele-Neurology

Overall, Trenton, DO	Neurology	Medicine	Tele-Neurology
Rezmovits, Yingying, MD	Psychiatry	Medicine	Tele-Psychiatry
Rodriguez, Orlando, MD	Family Medicine	Family Medicine/ Pediatrics	Family Medicine- Active Community
Shen, Wayne, MD	Neurology	Medicine	Neurology
Silk, Jeremy, MD	Plastic Surgery	Surgery	Plastic and Reconstructive Surgery
Singh, Rakesh, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE
Berthet, Benjamin, DO	Internal Medicine	Addition of Adult Hospitalist privileges
Panchal, Dhanu, MD	Physical Medicine/ Rehabilitation	Addition of Core Physical Medicine & Rehabilitation privileges

Temporary Privileges:

APPLICANT	SPECIALTY	DATES
Farzan, Arash, MD	Emergency Medicine	7/2/2026-7/23/2026

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Ajam, Firas, MD	Cardiac Electrophysiology	Recommend advancement to Active status
Baho, Sammy, MD	Anesthesiology	Recommend advancement to Active status
Dejanovic, Ilja, MD	Interventional Cardiology	Recommend advancement to Active status
Greene, Michael, MD	Emergency Medicine	Leave of Absence effective 8/1/2026 through 12/31/2026
Panchal, Dhanu, MD	Physical Medicine/ Rehabilitation	Active Community to Consulting
Sanchez-Ortigoza, Henry, MD	Family Medicine	Recommend advancement to Active status
Stevens, Megan, MD	Internal Medicine	Recommend advancement to Active status
Carlson, Steven, MD	Pathology	Resignation effective 7/31/2026
Chaudhry, Haider, MD	Tele-Neurology	Resignation effective 6/11/2026
Safvi, Amjad, MD	Tele-Radiology	Resignation effective 5/26/2026
Singh, Gurbir, MD	Nephrology	Resignation effective 7/2/2026

Other Items: (Attached)

Revision of General Surgery, Oncologic General Surgery and Colorectal Surgery Privilege Delineation	Moving PEG from special privileges to Oncologic General Surgery core procedures.
Revision of Taylor Farms Family Health & Wellness Center Privilege Delineation	Addition of Dermatology and Neurology core privileges

Interdisciplinary Practice Committee

Initial Appointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Celestino, Heidi, PA-C	Cardiology	Medicine	Christopher Oh, MD
Ladd, Gideon, PA-C	Cardiothoracic/ Vascular Surgery	Surgery	Vincent DeFilippi, MD; Andreas Sakopoulos, MD Jamil Matthews, MD

Reappointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Baez, Ivan, PA-C	Cardiothoracic/ Vascular Surgery	Surgery	Vincent DeFilippi, MD; Andreas Sakopoulos, MD

Finkel, Teale, PA-C	Surgery	Surgery	Tarun Bajaj, MD Mark Healy, MD Shin Young Park, MD Mario Roldan, MD Alison Tammany, MD
Shay, Deidra, NP	Family Medicine	Medicine	Rikin Kadakia, MD

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Battle, Hailey, PMHNP	Tele-Psychiatry	Resignation effective 5/04/2026
Calero Bellorin, Eyda, NP	Taylor Farms Family Health & Wellness Center	Resignation effective 7/18/2026
Shipley, Lara, NP	Gastroenterology	Leave of absence effective 7/11/2026

Policies/Procedures/Plans:

Parenteral Anticoagulation-Heparin Dosing per Pharmacy Protocol

Bylaws/General Rules and Regulations:

Having been approved by a vote of the General Medical Staff, the following amendment is forwarded to the Board of Directors for ratification:

General Rules and Regulations Article 13.6 Amendment:

13.6 Standardized Procedures

13.6-1 Standardized Procedures: Under pre-prescribed clinical situations Standardized Nursing Procedures may be implemented per hospital policy. ~~Treatment protocols and preprinted order sets~~ Standardized Procedures must be approved by the Interdisciplinary Practice Committee (IDPC), Medical Executive Committee and the Board of Directors. -Pharmacy & Therapeutics Committee approval should be obtained prior to IDPC review when appropriate.

Informational Items:

I. Committee Reports:

- a. Credentials Committee
- b. Interdisciplinary Practice Committee

II. Other Reports:

- a. Summary of Executive Operations Committee Meetings
- b. Summary of Medical Staff Department/Committee Meetings June 2026
- c. Medical Staff Statistics Year to Date
- d. Financial Update May 2026
- e. Executive Updates
- f. HCAHPS Update July 7, 2026



**Clinical Privileges Delineation
General Surgery, Oncology General Surgery
And
Colorectal Surgery**

Robotic Assisted Surgery Privileges must be requested separately.

Applicant Name: _____

GENERAL SURGERY:

Qualifications:

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

Board Certification:

Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general 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 5 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 at least 100 general surgical procedures during the past 12 months.

COLORECTAL SURGERY:

Qualifications:

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

Board Certification:

Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in colorectal 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 5 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 Fellowship training must provide documentation of the performance of at least 50 colorectal surgical procedures during the past 24 months.

ONCOLOGIC GENERAL SURGERY:

Qualifications:

To be eligible to apply for core privileges in oncologic general surgery, the applicant must meet the following qualifications:

Board Certification:

Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general 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 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board AND Successful completion of an AMBS Complex General Surgical Oncology Fellowship.

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 at least 100 general surgical procedures (50 of which must be oncologic general surgery procedures) during the past 12 months.

General Privilege Statement

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

SPECIAL REQUIREMENT:

Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; or demonstrate ongoing cancer-related education by documenting 12 CME hours annually

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

☐ **General Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ **Colorectal Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages admission, workup, diagnosis and performance of surgical procedures on patients presenting with illnesses related to the colon, rectum & anus; to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ **Oncologic General Surgery Core privileges**

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include General Surgery core procedures, Colorectal Surgery core procedures as well as the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Core Proctoring Requirements:

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

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 5 cases per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify for reappointment.

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 shall result in automatic 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.

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
				Insertion and management of pulmonary artery catheters	Successful completion of an accredited residency or fellowship in internal medicine, general surgery, cardiology, anesthesiology, pulmonary medicine, critical care, or family medicine; and performance of at least 10 PACs during this formal training, as primary operator Required Previous Experience: Active hospital practice in the chosen respective field; and performance (as the primary operator) of at least 10 PACs within the past 24 months.	1	Performance of at least four (4) PACs within the past 24 months.

Applicant: Check box marked “R” to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				~~Percutaneous Endoscopic Gastrostomy (PEG).~~	~~Formal fellowship training in gastroenterology or a residency in general surgery~~ ~~AND~~ ~~Performance of at least five (5) cases within the past 24 months~~	~~1~~ ~~Observation~~ ~~and 3 chart reviews~~	~~Performance of at least five (5) cases during the past 24 months~~
				Laparoscopic Sleeve Gastrectomy	Unrestricted privileges to perform advanced laparoscopic surgery (restrictions do not include initial appointment proctoring)	5 cases observed by a surgeon with unrestricted privileges for the procedure	Performance of at least 20 cases within the past 24 months.
				Esophagogastroduodenoscopy EGD	Documentation of successful completion of 50 cases within the past 24 months	1	Performance of at least 25 cases within the past 24 months
				Esophageal resection and reconstruction, or esophagogastrctomy, or Transhiatal Esophagectomy	Documentation of successful completion of four (4) cases within the past 24 months	1	Performance of at least two (2) cases within the past 24 months
				Colonoscopy	Documentation of successful completion of 50 cases within the past 24 months	1	Performance of at least 25 cases within the past 24 months
				Hysterectomy as part of general surgical procedures	Documentation of successful completion of eight (8) cases within the past 24 months	1	Performance of at least four (4) cases within the past 24 months
				Salinas Valley Health Wound Healing Clinic (SVHWHC)	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery Privileges AND Be approved by the Medical Director of the SVHWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery privileges.

Applicant: Check box marked “R” to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Percutaneous/Open Radiofrequency Ablation of Tumors	Successful completion of an ACGME/AOA accredited residency in general surgery, urology or otolaryngology OR Fellowship training in oncologic general surgery, vascular surgery or interventional radiology AND Documentation of successful completion of two (2) procedures within the past 24 months	1	Performance of at least two (2) cases within the past 24 months AND Documentation of CME directly related to radiofrequency ablation 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
				Radical regional lymph node dissections, including retroperitoneal, pelvic and inguinal	Documentation of successful completion of four (4) cases within the past 24 months	1	Performance of at least two (2) cases within the past 24 months
				Salpingoophorectomy	Documentation of successful completion of eight (8) cases within the past 24 months	1	Performance of at least four (4) cases within the past 24 months
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification.	None	Current California Stat X-Ray S&O Fluoroscopy Certification

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

General Surgery

1. Amputations, above the knee, below knee, toe, transmetatarsal
2. Appendectomy
3. Biliary enteric anastomosis
4. Biliary tract resection/reconstruction
5. Breast: complete mastectomy with or without axillary lymph node dissection; excision of breast lesion, breast biopsy, incision and drainage of abscess. modified radical mastectomy, operation for gynecomastia, partial mastectomy with or without lymph node dissection, radical mastectomy, subcutaneous mastectomy including diagnosis and management of breast disorders
6. Colectomy, colotomy, colostomy
7. Proctectomy, including abdominoperineal approach
8. Correction of intestinal obstruction
9. Emergency thoracostomy
10. Enteric fistulae, management
11. Enterostomy (feeding or decompression)
12. Anal fistula and fissure procedures (includes use of radiofrequency)
13. Hemorrhoidectomy
14. Excision of thyroglossal duct cyst
15. Gastric operations for cancer (partial. or total gastrectomy)
16. Gastroduodenal surgery
17. Gastrostomy (feeding or decompression)
18. Hepatic lobectomy and insertion of infusion catheters, pumps
19. Incision and drainage of abscesses and cysts of the soft tissue
20. Biopsy of superficial lymph nodes, cutaneous and soft tissue lesions
21. Incision, excision, resection, and enterostomy of small intestine
22. Incision/drainage of perirectal abscess
23. Incision/excision of pilonidal cyst
24. Intraoral surgery, local excision
25. Laparoscopic General and Colorectal Surgery
26. Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis
27. Liver biopsy (intra-operative)
28. Management of burns
29. Management of intra-abdominal trauma, including injury, observation, paracentesis, lavage
30. Management of multiple trauma
31. Management of soft tissue tumors, inflammations, and infections and necrosis
32. Open operations on gallbladder, biliary tract, bile ducts, hepatic ducts, excluding biliary tract reconstruction
33. Pancreatic pseudocyst drainage
34. Debridement of infected pancreatic tissue
35. Nephrectomy with Urology present
36. Debridement of decubitus and stasis ulcers of the skin
37. Removal of ganglion (palm or wrist; flexor sheath)

38. Removal of Peritoneal Dialysis Catheter
39. Repair of perforated viscus (gastric, small intestine, large intestine)
40. Sentinal lymph node biopsy
41. Vagotomy
42. Skin grafts (partial thickness, full thickness, split thickness)
43. Splenectomy (trauma, staging, therapeutic)
44. Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic hernias, inguinal hernias, and orchiectomy in association with hernia repair
45. Thoracentesis
46. Thyroid and parathyroid surgery
47. Tracheostomy
48. Varicose vein injection, sclerotherapy, excision & ligation, interruption of deep perforator veins of the lower extremities
49. Insertion of central venous catheters: non-tunneled, tunneled, with or without subcutaneous ports
50. Arterial line placement and monitoring
51. Basic Laparoscopic Surgery – diagnostic, appendectomy, cholecystectomy, lysis of adhesions, Peritoneal Dialysis , feeding tubes and catheter positioning and Liver Biopsy
52. Intermediate Laparoscopic Surgery – Jejunostomy, Gastrostomy, Vagotomy, Lymph node biopsy, Closure perforated ulcer, Oophorectomy and/or drainage of ovarian cyst in consultation with OB/GYN, Hernia repair to include hiatal, umbilical, incisional and inguinal with or without graft
53. Advanced Laparoscopic Surgery – Bowel surgery to include resection, anastomosis, stoma, colectomy, hemicolectomy, and sigmoidectomy, Common bile duct exploration, Splenectomy, Lymph node dissection, Nephrectomy with Urologist present, Adrenalectomy and Gastrectomy

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

Colorectal Surgery

1. All core procedures for General Surgery
2. Abdominal procedures related to diseases of the colon, rectum and anus
3. Anorectal procedures
4. Endoscopic procedures including anoscopy, rigid sigmoidoscopy, flexible sigmoidoscopy, & total colonoscopy
5. Endoscopic rectal ultrasound
6. History & Physical
7. Operative management and post-operative care of patients with pathologic conditions involving the intestinal tract, colon, rectum, anal canal and perianal area
8. Urogynecologic procedures related to diseases of the colon, rectum and anus
9. Use of Laser
10. Vascular access procedures
11. Laparoscopic Colon Surgery
12. Laparoscopic Hernia Repair

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

Oncologic General Surgery

- 1. All core procedures for General Surgery and Colorectal Surgery
- 2. Hysterectomy and BSO as part of cytoreductive surgery
- 3. Intraoperative EGD
- 4. Intraoperative sigmoidoscopy
- 4.5. Percutaneous Endoscopic Gastrostomy (PEG)

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

Applicant 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



**Salinas Valley Health Taylor Farms Family Health & Wellness Center
(TFFH&WC)
Delineation of Ambulatory Procedural Privileges**

Applicant Name: _____

Qualifications:

- Membership with unrestricted privileges at Salinas Valley Health Medical Center in:
 - Cardiology
 - [Dermatology](#)
 - Endocrinology/Diabetes Care
 - Gastroenterology
 - General Surgery
 - [Neurology](#)
 - Orthopedic Surgery
 - Obstetrics and Gynecology
 - Podiatry
 - Pulmonology
 - Rheumatology
 - Sleep Medicine
- Evidence of current BLS Certification (at minimum)

General Privilege Statement

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

Applicant Check Box to Request Privileges:

☐

Cardiology Core Privileges:

Assess, evaluate, diagnose, treat and provide consultation to patients presenting to TFFHWC with diseases of the heart, lungs, and blood vessels and manage complex cardiac conditions such as atherosclerosis, heart failure, acute coronary syndromes, coronary and valvular heart disease, and life threatening cardiac arrhythmias.. Other core procedures include ECG interpretation, transthoracic echocardiography and electrocardiology monitoring interpretation.

☐

Dematology Core Privileges:

Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC, with benign and malignant disorders of the integumentary system (epidermis, dermis, subcutaneous tissue, hair, nails, mouth, external genitalia and cutaneous glands) as well as sexually transmitted diseases. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills diagnosis and treatment of skin cancers, melanomas, moles, and other tumors of the skin, the management of contact dermatitis and other allergic and nonallergic skin disorders, and management of cosmetic disorders of the skin such as hair loss and scars and the skin changes associated with aging, including consultation and the performance of the following procedures:

- [Simple excision and repair](#)
- [Skin and nail biopsy](#)
- [Scalp surgery](#)

**Endocrinology Core Privileges:**

Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC with injuries, or disorders of the endocrine glands such as thyroid and adrenal glands, and metabolic and nutritional disorders, diabetes mellitus, calcium and bone disorders, pituitary diseases, and menstrual and sexual problems. Interpretation of immunoassays; and radionuclide, ultrasound, radiologic, and other imaging studies and basic laboratory techniques. Performance of fine needle aspiration of the thyroid.

**Gastroenterology Core Privileges:**

Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC with diseases, injuries, and disorders of the digestive organs including the stomach, bowels, liver and gallbladder, and related structures such as the esophagus, and pancreas-

☐**General Surgery Core Privileges:**

Assess, evaluate, diagnose, consult, and provide pre and post-operative care to patients who present to TFFHWC, to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Core privileges include wound care, biopsies, incision & drainage and such other procedures that are extensions of the same techniques and skills.

☐**Neurology Core Privileges:**

Assess, evaluate, diagnose, treat, and provide consultation to patients who present to TFFHWC, with diseases, disorders or impaired function of the brain, spinal cord, peripheral nerves, muscles, and autonomic nervous system, including their coverings, blood vessels, and other effector tissue, such as muscle. The core privileges in this specialty include procedures that are extensions of the same techniques and skills; autonomic testing, EEG interpretation, somatosensory evoked responses, auditory evoked responses, and visual evoked responses, ~~thrombolytic therapy for stroke and lumbar puncture.~~

☐**Orthopedic Surgery Core Privileges:**

Assess, evaluate, diagnose, provide consultation and care to patients who present to TFFHWC, to correct or treat various conditions, illnesses and injuries of the extremities, spine, and associated structures by medical and physical means including but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the hands, feet, knee, hip, shoulder, and elbow including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. Core privileges include wound care, biopsies and such other procedures that are extensions of the same techniques and skills.

☐**Obstetrics/Gynecology Core Privileges:**

Assess, evaluate, diagnose, treat and provide consultation to pregnant (≥ 12 week pregnancy) patients who present to TFFHWC and provide medical care of the female reproductive system, including major medical diseases that are complicating factors in pregnancy.

☐**Podiatry Core Privileges:**

Assess, evaluate and treat patients who present to TFFHWC with podiatric problems/conditions of the digital, forefoot, and simple rearfoot to include all soft tissue and bony procedures involving the phalanges and metatarsal bones distal to the tarso-metatarsal joint; all soft tissue and bony procedures involving the cuneiform, navicular, and cuboid bones distal to the midtarsal joint. Core privileges include wound care, incision & drainage and such other procedures that are extensions of the same techniques and skills.

☐**Pulmonology Core Privileges:**

Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC respiratory and chest-related disorders spanning the entire respiratory system, including the lungs, airways, pleura, and mediastinum.

☐**Rheumatology Core Privileges:**

Assess, evaluate, diagnose, treat and provide consultation to patients presenting to TFFHWC with diseases of the joints, muscle, bones and tendons including but not limited to arthritis, back pain, muscle strains, common athletic injuries, auto-immune vasculitis and auto-immune collagen diseases. Other core procedures include diagnostic aspiration of synovial fluid from diarthrodial joints, bursae, and tenosynovial structures and therapeutic injection of diarthrodial joints, bursae, tenosynovial structures and entheses, arthrocentesis.



Sleep Medicine Core Privileges:

Evaluate, diagnose, provide consultation and treat patients presenting with conditions or disorders of sleep, e.g., sleep-disordered breathing, circadian rhythm disorders, insomnia, parasomnias, narcolepsy, restless leg syndrome. The core privileges in this specialty include the procedures and such other procedures that are extensions of the same techniques and skills:

- polysomnography (PSG) (including sleep stage scoring),
- multiple sleep latency testing (MSLT),
- actigraphy,
- sleep log interpretation,
- home/ambulatory testing,
- maintenance of wakefulness testing (MWT),
- oximetry,
- monitoring with interpretations of EKG, EEG, EOG, EMG, Airflow, Oxygen, saturation, limb movements, thoracic and abdominal movements, CPAP/BiPAP , ASV and VADAPT titration.

Core Proctoring Requirements:

Proctoring is waived for those applicants who have successfully completed the Provisional Staff proctoring requirements at SVHMC.

Reappointment Criteria for Core Privileges:

- Documentation of a 20 patient contacts within the past 24 months at TFFH&WC or Salinas Valley Health.
- Membership with unrestricted privileges at Salinas Valley Health Medical Center in:
 - Cardiology
 - Endocrinology/Diabetes Care
 - Gastroenterology
 - General Surgery
 - Orthopedic Surgery
 - Obstetrics and Gynecology
 - Podiatry
 - Pulmonology
 - Sleep Medicine
 - Rheumatology
- Evidence of current BLS Certification (at minimum)

ACKNOWLEDGEMENT OF THE PRACTITIONER:

I have requested only those privileges for which my education, training, current experience and demonstrated performance I am qualified to perform, and that I wish to exercise at [Taylor Farms Family Health & Wellness Center](#) ~~Salinas Valley Health Medical Center~~, and I understand that in exercising clinical privileges granted, I am constrained by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation; 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.

Signature of Applicant: _____ Date: _____

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

*****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



Origination N/A
Approved N/A
Expires 1 year after approval

Owner Genevieve delos Santos:
Director
Pharmacy
Area Pharmacy
Protocols

Parenteral Anticoagulation - Heparin Dosing per Pharmacy Protocol

I. POLICY STATEMENT

- A. Salinas Valley Health Medical Center (SVHMC) pharmacists are authorized to manage heparin infusion therapy upon provider request and to continue management per protocol, including initiation, dosing, monitoring, and dose adjustment. This management will be conducted in accordance with evidence-based guidelines and best practice standards as outlined in this policy.

II. PURPOSE

- A. To standardize pharmacist management of intravenous unfractionated heparin (UFH), including initiation and maintenance.
- B. To ensure safe and effective anticoagulation therapy while minimizing potential risk of adverse events associated with heparin.
- C. To optimize therapeutic outcomes through pharmacist-directed dosing, monitoring, and adjustment of heparin therapy.

III. DEFINITIONS

- A. Anti-Factor Xa (Anti-Xa) assay: A functional assay that facilitates the measurement of antithrombin-catalyzed inhibition of factor Xa by unfractionated heparin (UFH) in plasma used to monitor anticoagulation therapy.
- B. Activated Partial Thromboplastin (aPTT) Clotting Time: A blood coagulation test measuring the time required in seconds for clot formation. Used to evaluate the activity of the intrinsic pathway of the clotting cascade. May be used to monitor unfractionated heparin therapy.
- C. International Normalized Ratio (INR): A standardized measure of blood coagulation and the preferred parameter for monitoring patients receiving vitamin K antagonists.
- D. Heparin-Induced Thrombocytopenia (HIT): An immune-mediated adverse reaction to heparin products characterized by a significant decrease in platelet count and a paradoxical hypercoagulable state.

IV. GENERAL INFORMATION

- A. This protocol authorizes SVHMC clinical pharmacists to, upon consulted request, initiate and manage

intravenous unfractionated heparin (UFH) for adult patients. Pharmacist management shall be based on guidance approved by Pharmacy & Therapeutics/Infection Prevention Committee and in collaboration with physicians and nursing staff.

- B. This protocol establishes and maintains dosing guidance for initiation, monitoring, and dose adjustments based on evidence-based guidelines and clinical practice (see Appendix A). It serves as clinical guideline and does not supersede clinical judgment.
- C. Consults for pharmacist-managed heparin infusion shall include indication and physician assessment of hemorrhagic or thrombotic risk.
- D. Inclusion Criteria:
 - 1. Patients > 18 years old
- E. Exclusion Criteria:
 - 1. Patients < 18 years old
 - 2. Contraindication to heparin therapy, including but not limited to:
 - a. Hypersensitivity to heparin products
 - b. Avoidance of pork products
 - c. Active bleeding
 - d. History of Heparin-Induced Thrombocytopenia (HIT)
 - e. Coagulopathies (e.g. thrombocytopenia with platelet count < 50,000)
 - f. Tenecteplase or Alteplase within previous 24 hours for the indication of ischemic stroke.

V. PROCEDURE

- A. Physician/Ordering Provider Responsibility
 - 1. Initiate the protocol for eligible patients.
 - 2. Provide necessary patient information including indication and assessment of hemorrhagic risk vs. thrombotic risks.
 - a. Heparin infusion monitoring goals shall be determined by indication and risk as outlined in Appendix A.
 - 3. Maintain oversight of patient care, protocol implementation, and discontinuation.
 - a. The provider may discontinue the protocol at any time; pharmacy will stop all corresponding monitoring and medication orders per protocol.
- B. Pharmacist Responsibility:
 - 1. Review patient's chart to ensure the appropriateness for Intravenous Heparin Dosing Protocol per Pharmacy.
 - a. If the patient does not meet the above criteria, the pharmacist shall contact the primary physician.
 - 2. Confirm that baseline laboratory tests are available.
 - a. If baseline platelet count is < 50,000 or INR is > 1.5, the pharmacist shall obtain

confirmed provider acknowledgment prior to initiating heparin

3. Determine initial weight-based dosing per indication using the established guideline (See Appendix A).
4. Order all necessary baseline laboratory testing, heparin boluses, and heparin infusion through EHR per protocol.
5. Utilize Anti-Xa Monitoring Goals in all patients except in the following instances where aPTT shall be preferred:
 - a. Hyperbilirubinemia > 6.6 mg/dL
 - b. Hypertriglyceridemia > 360 mg/dL
 - c. Use of direct oral anticoagulants within the past 72 hours and baseline Anti-Xa is greater than 0.7 units/mL.
 - d. Patients is assessed by physician to have greater thrombotic risk and baseline Anti-Xa is greater than 0.7 units/mL
 - e. Heparin Indication is EKOS (ultrasound-accelerated thrombolysis)
6. Communicate heparin dosing and monitoring goals to the care team via the Electronic Health Record (EHR)
 - a. Documentation shall include but is not limited to:
 - i. Dose initiation, monitoring assessments, rate changes
 - ii. Relevant patient specific information
7. Monitor patient's clinical status and laboratory values; adjust heparin management as clinically indicated.
 - a. Notify nursing for all additional boluses, holds, or rate changes.
 - b. Confirm signs and symptoms of bleeding or clotting with nursing as clinically appropriate.

C. Nursing Responsibility:

1. Implement heparin boluses, heparin infusion holds, and heparin infusion rate changes as directed by the pharmacist.
2. Conduct and report necessary patient monitoring.
3. Communicate significant changes in patient status to the physician and pharmacist.

D. Monitoring

1. The pharmacist may order the following laboratory tests under this protocol:
 - a. Coagulation Panel
 - i. At baseline; previously obtained results within the past 24 hours may be used if clinically appropriate, at the discretion of the pharmacist.
 - b. Anti-Xa Assay
 - i. At baseline; previously obtained results within the past 24 hours may be used if clinically appropriate, at the discretion of the pharmacist.
 - ii. Thereafter, at least daily as clinically indicated (see Appendix A).

c. aPTT

- i. At baseline; previously obtained results within the past 24 hours may be used if clinically appropriate, at the discretion of the pharmacist.
- ii. Subsequent aPTT monitoring is required only when the patient meets Anti-Xa Assay exception criteria: at least daily as clinically indicated (see Appendix A).

d. Complete Blood Count (CBC)

- i. At baseline; previously obtained results within the past 24 hours may be used if clinically appropriate, at the discretion of the pharmacist.
- ii. Repeat every 3 days as clinically indicated

e. Triglycerides and Bilirubin

- i. Ordered when Anti-Xa Assay levels are suspected to be spuriously elevated per clinical judgement.

E. Documentation

1. The pharmacist will document all heparin infusion management as outlined in the above procedures, in keeping with standards of practice for documentation while providing clinical care, and when relevant to communicate with the care team.

F. Dosing Guidelines

1. The pharmacist will follow dosing guidelines outlined in Appendix A and in conjunction with clinical judgment as appropriate to optimize heparin infusion management and minimize adverse drug events.
2. Deviations from standard guidelines should be documented with appropriate clinical rationale and discussed with the care team prior to execution.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Creager MA, Barnes GD, Giri J, et al. AHA/ACC/ACCP/ACEP/CHEST/SCAI/SHM/SIR/SVM/SVN Guideline for Evaluation and management of Acute Pulmonary Embolism in Adults: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. Feb 2026; 153(12): e977-1051
- B. Rao SV, O'Donoghue ML, Ruel M, et al. 2025 ACC/AHA/ACEP/NAEMSP/SCAI Guideline for the Management of Patients With Acute Coronary Syndromes: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. Apr 2025; 151(13): e771-862
- C. Raschke RA, Reilly BM, Guidry JR, et al. The weight-based heparin dosing nomogram compared with a "standard care" nomogram. A randomized controlled trial. *Ann Intern Med*. Nov 1993; 119(9): 874-81
- D. Joglar JA, Chung MK, Armbruster AL, et al. 2023 ACC/AHA/ACCP/HRS Guideline for the Diagnosis and Management of Atrial Fibrillation: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. Jan 2024: 124(1); e1-156

- E. Hellerslia V, Mehta P, Rudd K. Transition of Anticoagulants 2019. *ACForum.org*. March 2019. Accessed February 2026. https://acforum-excellence.org/Resource-Center/resource_files/1322-2019-03-08-101259.pdf
- F. Prabhakaran S, Gonzalez NR, Zachrison KS, et al. AHA/ASA 2026 Guideline for the Early Management of Patients with Acute Ischemic Stroke: A Guideline From the American Heart Association/American Stroke Association. *Stroke*. Mar 2026; 57: e1-119
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- H. Floroff CK, Palm NM, Steinber DH, et al. Higher Max Doses and Infusion Rates compared with Standard UFH Therapy are associated with Adequate AC w/o Increased Bleeding in Both Obese and Non-obese Patients with CV Indications. *Pharmacotherapy*. 2017; 37(4):393-400.
- I. Riney JN, Hollands JM, Smith JR, et al. Identifying optimal initial infusion rates for UFH in morbidly obese patients. *Ann Pharmacotherapy*. 2010; 44(7-8):1141-51
- J. Recommended Doses of Anticoagulant/Antithrombotic Therapies for Patients with Atrial Fibrillation. *American College of Cardiology Foundation*. Sept 2012. Accessed February 2026. https://www.acc.org/~media/Files/Migration%20Content/Quality%20and%20Clinical%20Trials/AFib%20Toolkit/Drugs/Drugs%202/5_AF_TK_AnticoagulantDosingTable_3_7_2013.pdf#:~:text=Clinical%20Notes%3A,stroke%2C%20oral%20anticoagulation%20is%20recommended.

Attachments

[Appendix A - Heparin Nomogram.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	7/9/2026
CNO	Carla Spencer: Chief Nursing Officer	6/11/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	5/26/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	5/26/2026
Policy Owner	Genevieve delos Santos: Director Pharmacy	4/6/2026

Standards

No standards are associated with this document

COPY

*2026 EMPLOYEE ENGAGEMENT
SURVEY RESULTS REVIEW*

(VERBAL REPORT)

(Michelle Barnhart Childs)

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