



August 21, 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, AUGUST 27, 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, AUGUST 27, 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 July 23, 2026 | |
| B. Policies/Plans Requiring Approval | |
| 1. Canine Visitation | |
| 2. CT Dose Compliance | |
| 3. Humanitarian Use Devices | |
| 4. IT Purchase and Lifecycle Management | |
| 5. Job Observation/Shadowing | |
| 6. Nursing Excellence / Peer Review | |
| 7. Order Mode | |
| 8. Palliative Care Services | |
| 9. Pharmacologic Stress Test with Modifications for Exercise | |
| 10. Reprocessing Single Use Devices | |
| 11. Roles of Research Institutional Official and Human Research Protections Administrator | |
| 12. Scope of Service: Clinical Research Program | |
| 13. Scope of Service: Communications | |
| 14. Scope of Service: Information Technology | |
| 15. Scope of Services: Transport | |
| 16. Shipping of Hazardous Materials for Clinical Research Studies at SVHMC | |
| 17. Transthoracic Echocardiogram Protocol for the Adult Patient | |

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

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

7. BOARD MEMBER COMMENTS AND REFERRALS

Joel Hernandez Laguna

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

Catherine Carson

Minutes of the August 17, 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 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PLAN (QAPI)

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

B. PERSONNEL, PENSION & INVESTMENT COMMITTEE

Catherine Carson

Minutes of the August 17, 2026 Personnel, Pension and Investment Committee meeting have been provided to the Board for review. The following recommendation has been made to the Board.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF CONTRACT TERMS FOR JESSICA RAMIREZ, MD'S HOSPITALIST MEDICINE PROFESSIONAL SERVICES AGREEMENT

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

C. FINANCE COMMITTEE

Victor Rey, Jr.

Minutes of the August 24, 2026 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board.

1. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF RENEWAL OF THE MEDTRONIC SERVICE AND SUPPORT AGREEMENT FOR THE O-ARM O2 SURGICAL IMAGING SYSTEM AND STEALTHSTATION S8 NEUROSURGICAL NAVIGATION SYSTEM

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

2. CONSIDER RECOMMENDATION FOR BOARD APPROVAL OF HEALTHSTREAM (LEARNING MANAGEMENT SYSTEM) CONTRACT RENEWAL

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

D. COMMUNITY ADVOCACY COMMITTEE

Rolando Cabrera, M.D.

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

9. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF AUGUST 13, 2026 AND RECOMMENDATIONS FOR THE FOLLOWING BOARD APPROVALS:

Alison Wilson, D.O.

A. Reports

1. Credentials Committee Report (Including the following)
 - Taylor Farms Family Health & Wellness Center – Delineation of Ambulatory Privileges
2. Interdisciplinary Practice Committee Report (Including the following)
 - Revised Privilege Form: PA- TFFH&WC

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

1. Laboratory Critical Call Values
2. Physician Orders for Life Sustaining Treatment (POLST)
3. Renal Dose Adjustment per Pharmacy Protocol
4. Risk Management Plan

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

10. EXTENDED CLOSED SESSION *(if necessary)*

Joel Hernandez Laguna

11. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

Joel Hernandez Laguna

12. ORAL REPORT OF PROPOSED COMPENSATION TO PUBLIC AGENCY EMPLOYEE PRIOR TO FINAL ACTION PURSUANT TO GOVERNMENT CODE SECTION 54953(D)(3)(A)

Joel Hernandez Laguna

13. CONSIDERATION FOR APPROVAL OF EMPLOYMENT AGREEMENT – PRESIDENT/CHIEF EXECUTIVE OFFICER

*Matt Ottone
District Legal Counsel*

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

14. ADJOURNMENT

Joel Hernandez Laguna

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, September 24, 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, AUGUST 27, 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 LABOR NEGOTIATOR

(Government Code §54957.6)

Agency designated representative: (Specify name of designated representatives attending the closed session): Robert Andersen

Employee organization: (Specify name of organization representing employee or employees in question): National Union of Healthcare Workers (NUHW)

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

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
JULY 23, 2026

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

Absent: Isaura Arreguin.

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 4:02 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 Real Property Negotiators, and Public Employee Performance Evaluation*. The meeting recessed into Closed Session under the Closed Session Protocol at 4:03 p.m. The Board completed its business of the Closed Session at 4:27 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 4:34 p.m. President Hernandez Laguna reported that in Closed Session, the Board discussed *Hearings and Reports* and *Conference with Real Property Negotiators*. 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:

- **35 Year Retirement: Yolanda Newstrom:** Clement Miller, COO, recognized Yolanda for her dedication to Salinas Valley Health over the last 35 years. Yolanda shared her journey through various departments at SVH during her tenure, fond memories of working with Dr. Radner, and how great it has been to see the organization grow over the years.

5. PUBLIC COMMENT: None.

6. CONSENT AGENDA – GENERAL BUSINESS

¹Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Recommend Board Approval of the Following:

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
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

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: President Hernandez Laguna and Director Carson asked whether family sick time and/or cashed out PTO is transferable to another person? Michelle Barnhart Childs, CHRO, answered that neither is transferable under current or proposed policy. President Hernandez Laguna asked what counts as financial hardship for purposes of PTO Cash Out policy? Michelle responded that strict federal regulations dictate what qualifies as a financial hardship. An important element is that the financial hardship must be unforeseen; therefore, something like an unforeseen eviction may qualify but expected things like student loan repayments typically do not.

MOTION:

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

ROLL CALL VOTE:

Ayes: Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Arreguin.

Motion Carried.

7. BOARD MEMBER COMMENTS AND REFERRALS

Director Rolando Cabrera, M.D.: None.

Director Catherine Carson: Director Carson commented that she attended the Salinas Rodeo this month and shared that it was a very fun community event.

Director Victor Rey, Jr.: None.

Director Isaura Arreguin: Absent.

Director Hernandez Laguna: President Hernandez Laguna gave kudos to Karina Rusk for a great job on recent articles and promotion of SVH's Medical Adventure Camp.

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 July 13, 2026 meeting were provided for Board review. Director Carson stated that the presentations were: Patient Care Services Update – Critical Care Unit Practice Council, Quality & Safety Updates: Contract Performance Evaluations, Complaints and Grievances, Emergency Department and Risk Management Plan. The following recommendation was made.

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

STAFF REPORT: None.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

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

ROLL CALL VOTE:

Ayes: Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Arreguin.

Motion Carried.

B. FINANCE COMMITTEE

A report was received from Director Rey regarding the Finance Committee. The minutes of the July 20, 2026 meeting were provided for Board review. The Financial Reports of the meeting were included in the packet for review (informational). The following recommendation was made.

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

STAFF REPORT: None.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

Upon motion by Director Carson and second by Director Dr. Cabrera, the Board of Directors approves the five-year agreement with Hillrom for the Voalte Nurse Call Services Program at a cost in the amount of \$799,685.78.

ROLL CALL VOTE:

Ayes: Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Arreguin.

Motion Carried.

C. TRANSFORMATION, STRATEGIC PLANNING & GOVERNANCE COMMITTEE

A report was received from Director Rey regarding the Transformation, Strategic Planning & Governance Committee. The minutes of the July 15, 2026 meeting were provided for Board review. There are no recommendations.

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

STAFF REPORT: Tim Albert, MD, Chief Clinical Officer reported that Dr. Abarca will be filling a need in the area of cardiology at the clinics.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: None.

MOTION:

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

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;

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

1. The Contract Terms of the Recruitment Agreement for Dr. Abarca; and
2. The Contract Terms of the Non-Invasive Cardiology Professional Services Agreement for Dr. Abarca.

ROLL CALL VOTE:

Ayes: Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;

Absent: Arreguin.

Motion Carried.

10. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON JULY 9, 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 July 9, 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: None.

MOTION:

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

- 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
 1. Parenteral Anticoagulation-Heparin Dosing per Pharmacy Protocol
 2. 13.6-1 Standardized Procedures

ROLL CALL VOTE:

Ayes: Dr. Cabrera, Carson, Hernandez Laguna, Rey;

Nays: None;

Abstentions: None;
Absent: Arreguin.

Motion Carried.

11. 2026 EMPLOYEE ENGAGEMENT SURVEY RESULTS REVIEW

Michelle Barnhart Childs, Chief Human Resources Officer, presented the results of the 2026 Employee Engagement Survey. Michelle reviewed the Engagement Trending and Safety Culture Prevention & Reporting Trending charts, as well as the organization's performance in Safety Culture Prevention & Reporting and Key Drivers. She concluded with an overview of the next steps following the survey.

PUBLIC COMMENT: None.

BOARD MEMBER DISCUSSION: The Board asked about next steps: there will be debriefs at the department level to discuss the survey results, areas of strength, and areas of improvement. President Hernandez Laguna asked whether answers to a specific survey question can be broken down and analyzed based lengths of employment of the survey-takers. Department leaders can look at general engagement levels based on tenure levels but it is not broken down based on specific questions.

12. EXTENDED CLOSED SESSION

President Hernandez Laguna announced items to be discussed in Extended Closed Session are *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services*, and *Public Employee Performance Evaluation*. The meeting recessed into Closed Session under the Closed Session Protocol at 5:13 p.m. The Board completed its business of the Closed Session at 6:40 p.m.

13. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 6:42 p.m. President Hernandez Laguna reported that in Extended Closed Session, the Board discussed *Report Involving Trade Secret – Trade Secret, Strategic Planning, Proposed New Programs and Services* and *Public Employee Performance*. No action was taken.

14. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for Thursday, **August 27, 2026**, at 4:00 p.m. There being no further business, the meeting was adjourned at 6:42 p.m.

Rolando Cabrera, MD
Secretary, Board of Directors

Memorandum

To: Board of Directors
 From: Brenda Inman, VP Quality and Risk
 Date: August 27, 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.	Canine Visitation	Regularly scheduled review. Addition of “certifying agency”.	Alysha Hyland, CAO
2.	CT Dose Compliance	Regularly scheduled review. Policy link repaired.	Clement Miller, COO
3.	Humanitarian Use Devices	Regularly scheduled review. Changed Materials Management to Supply Chain.	Carla Spencer, CNO
4.	IT Purchase and Lifecycle Management	Material Management changed to Supply Chain. Added procurement of IT Assets, software, service - items governed by this policy require pre-approval with required forms as needed by Information Technology before placing requisitions into Workday. Procurement of upgrades to existing or new information systems are subject to review by IT for a cybersecurity risk assessment. System upgrades or new procurements that have an information technology component such as, but not limited to, access management, handling and storage of Salinas Valley Health data, integrations and reporting, should be evaluated by IT for technical feasibility, risk management and resource planning.	Alysha Hyland, CAO
5.	Job Observation/Shadowing	Changed Internship to Work. Experience/Service Learning to avoid confusion with HR programs. Changed "student" to shadower, individual, or participant, to be more inclusive of actual participants, many of whom are not currently in school. Changed individual applicant age to 18 and added clarification that they may not be supervised by family members Added clarification that staff may not	Alysha Hyland, CAO

	Policy Title	Summary of Changes	Responsible Exec
		shadow or volunteer in their home department or similar role. Removed some details by stating consistent with volunteer standards so we don't have to update the policy if those items change. Added section for Salinas Valley Clinic staff.	
6.	Nursing Excellence / Peer Review	Edited for clarity, sentence structure and flow, and to eliminate redundancy.	Carla Spencer, CNO
7.	Order Mode	Updated to meet Epic terminology and functionality. References updated.	Alysha Hyland, CAO
8.	Palliative Care Services	Retired policy completely rewritten to align with current process.	Carla Spencer, CNO
9.	Pharmacologic Stress Test with Modifications for Exercise	Added statement requiring verification of patient allergies to pharmacologic stress agents at the beginning of the procedure. Reference updated.	Michelle Barnhart Childs, CHRO
10.	Reprocessing Single Use Devices	Changed Materials Management to Supply Chain.	Clement Miller, COO
11.	Roles of Research Institutional Official and Human Research Protections Administrator	Regularly scheduled review. No changes made.	Timothy Albert, CCO
12.	Scope of Service: Clinical Research Program	Material Management changed to Supply Chain.	Timothy Albert, CCO
13.	Scope of Service: Communications	Telecommunications changed to Communication. Org chart updated. Removed reference under 'Competency' related to unit's patients.	Alysha Hyland, CAO
14.	Scope of Service: Information Technology	Org IT chart updated. Titles corrected. Minor typos corrected. Updates to certification requirements and competency. Changed "Telecommunications" to "Communications." Changed "Security Analyst" to "Cybersecurity Staff." Removed reference under 'Competency' related to unit's patients.	Alysha Hyland, CAO
15.	Scope of Services: Transport	Regularly scheduled review. No changes made.	Carla Spencer, CNO
16.	Shipping of Hazardous Materials for Clinical Research Studies at SVHMC	Changed Materials Management to Supply Chain. Formatting changes.	Timothy Albert, CCO
17.	Transthoracic Echocardiogram Protocol for the Adult Patient	Regularly scheduled review. Formatting corrections made. References updated.	Clement Miller, COO

	Policy Title	Summary of Changes	Responsible Exec
MEC			
Nursing Standardized Procedures			
1.	None		
MEC Policies/Plans			
1.	Laboratory Critical Call Values	Major updates made to align with current process.	Clement Miller, COO
2.	Physician Orders for Life Sustaining Treatment (POLST)	Complete rewrite with the input of multiple Medical Staff and Committees.	Alysha Hyland, CAO
3.	Renal Dose Adjustment per Pharmacy Protocol	Regularly scheduled review. No changes made.	Clement Miller, COO
4.	Risk Management Plan	Complete rewrite with input from Legal, Risk and Board member.	Carla Spencer, CNO
Board Policies			
1.	None		



Origination5/31/2017

ApprovedN/A

Expires3 years after approval

OwnerShannon Graham: Director Volunteer & Health Career Services

AreaVolunteer Services

Canine Visitation

I. POLICY STATEMENT

- A. Animal visitation on the campus of Salinas Valley Health Medical Center (SVHMC) is permitted only under controlled conditions to specific service animals (canines/dogs) or Pet Therapy.

II. PURPOSE

- A. To guide the staff, Security and Volunteers in;
1. Facilitating animal assisted activities and therapy for hospitalized patients.
 2. Preventing unsanitary conditions, minimize risk of transmission of infectious diseases, and reduce exposure and injury to patients, visitors, and employees during an animal visit.

III. DEFINITIONS

- A. Pet Therapy: Utilizes trained animals and handlers to achieve specific physical, social, cognitive, and emotional goals with patients. Extensive studies have demonstrated the benefits of pet therapy programs in hospitals as they have been found to: increase mental and physical awareness through sensory stimulation, decrease stress and tension, increase motivation by stimulating past, present or new interests especially in the elderly.

Certified Pet Therapy Dogs: Dogs that have met the requirements of a certifying agency, such as Therapy Dogs International and have documentation following examinations and procedures: general check of physical appearance, examination for and treatment of intestinal parasites, heartworm test and flea treatment. For adult dogs and puppies vaccination against; Rabies, Distemper, Hepatitis, leptospirosis, Para influenza, and Parvovirus (DHLPP) for puppies

and adult dogs. (See Attachment A)

- B. Canine (Pet) Visitation: a request made by a patient or family member for visitation by the patient's pet to provide emotion or comfort support.
- C. Handler: The individual responsible for the service animal (patient) or other individual assigned by the patient or the Pet Therapy Volunteer.
- D. Service Animal: Service dogs are dogs that have been individually trained to perform a specific task for individuals who have disabilities such as mobility issues, visual impairment (blindness), hearing impairment (deafness), seizures, diabetes, PTSD, autism, epilepsy, multiple sclerosis (MS), and other physical/mental disabilities. The service dog helps an individual in performing the particular tasks that they would otherwise be unable to perform without the service dog. See the policy [SERVICE ANIMALS](#)
- E. Companion animal / Emotional support dogs: help individuals with emotional problems such as anxiety, depression, bipolar/mood disorders, panic attacks, fear/phobias and other emotional/psychological conditions by providing comfort and support.

IV. GENERAL INFORMATION

- A. Animals will be on a leash and under constant control of a Pet Therapy Volunteer or Handler.
- B. Special circumstances may apply to allow other pet visitation and those situations shall be evaluated on a case-by-case basis in consultation with the patient's attending physician, the department manager/designee, and the Infection Control Manager/ designee.
- C. The Medical Center's Infection Prevention & Control Department should be consulted to perform a risk assessment with the pet therapy program manager prior to changing the pet therapy program.
- D. Healthcare workers will perform hand hygiene (soap and water or alcohol-based hand rub) before and after any animal contact.

V. PROCEDURE

- A. Pet Therapy visitation is arranged by Volunteer Services and only "Certified" dogs will be allowed. Please note or distinguish that this category is for SVHMC Pet Therapy Volunteers only.
- B. Animal handlers must have all required immunizations, restrict contact of their animal to patient(s) visited and prevent the animal from having contact with invasive devices.
- C. The dog handler of the "Certified Pet Therapy" dogs will register at the Concierge desk in the main lobby.
- D. Therapy Handlers and dogs will use the service elevator system to each of the floors to avoid public contact and assure smooth and safe entry and exit for each visit.
- E. No dogs shall be permitted in areas where sterility of items or environment is necessary. These prohibited areas include but are not limited to: Perioperative areas, Pharmacy, Labor & Delivery and Newborn Nursery, Special Procedure areas or any food preparation areas. Visitation in other areas will be on a case by case basis.
- F. Medium and small dogs may be placed on a chair or on the bed- a disposable pad must be spread to cover the fabric or linens. The animal must be maintained on the disposable pad. If

- the animal has been placed on the bed linens must be changed after the visit.
- G. Patients appropriate for pet therapy visits will be identified and visits documented as part of the interdisciplinary planning process.
 - H. Patients in isolation precautions or allergies to pets will not be allowed to touch or handle the animals.
 - I. Patients with open wounds will have their wounds covered prior to the visit.
 - J. Patients and staff will wash their hands with soap and water or use an alcohol-based product after contact with animals. **Healthcare workers will assist the patients as needed.**
 - K. Environmental cleaning after an elimination mishap:
 - 1. Care should be taken to avoid contact with animal urine or feces. Initial clean-up is the responsibility of the Pet Therapy Handler. Notify EVS for clean-up of these substances from environmental surfaces using gloves. The surface should then be disinfected with a hospital-approved disinfectant.
 - 2. Disposal is in a red biohazardous bag or using the hopper.
 - 3. Fabric or carpet areas will be vacuumed with a HEPA-filtered vacuum after clean up by Environmental Services. If there has been soiling with feces or urine, the area will be cleaned using an approved Environmental Services cleaning product.
 - L. Visits by pets owned by patients or family members, although generally prohibited, will be considered individually by the Infection Control Manager/Designee and strictly supervised.
 - 1. If approval for a personal pet visit is granted, all requirements noted above for Pet Therapy animals apply.
 - M. Immediately report any incident of aggression, biting or scratching by an animal to the Infection Control Manager. Promptly notify the patient's physician for orders as necessary. Complete a report in the electronic occurrence reporting system.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Title III, Americans with Disabilities, Section 36.302
- B. Darling, Kathleen T. APIC- Animals Visiting Healthcare Facilities. Chapter 68, 2009
- C. Infection Control Experts Outline Guidance for Animal Visitations in Hospitals; The Society for Healthcare Epidemiology of America (SHEA); Infection Control & Hospital Epidemiology; March 3, 2015

Attachments

 [A: Canine Visitation](#)

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	8/4/2026
Regulatory	Kerry Sommers: Director Accreditation and Regulatory Compliance	7/10/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/8/2026
Policy Owner	Shannon Graham: Director Volunteer & Health Career Services	6/8/2026

Standards

No standards are associated with this document



Origination	12/11/2015
Approved	N/A
Expires	3 years after approval

Owner	John Kazel: Director Imaging Services
Area	Diagnostic Imaging

CT Dose Compliance

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the staff in adhering to California dose reporting law, Senate bill 1237 and minimizing radiation dose to our patients by utilizing dose optimization techniques.

III. DEFINITIONS

- A. Computed Tomography (CT) – Computer processed x-rays that provide "virtual" slices through anatomy.
- B. Computed tomography dose index volume (CTDIvol)-A dose index that represents CT scanner output as measured with a phantom expressed in mGy's.
- C. DLP – dose length product = CTDI volume x the scan length = average radiation dose over the x, y, and z axis.
- D. Milligray (mGy) – SI unit of radiation absorbed dose
- E. Millisievert (mSv) – SI unit of equivalent dose, effective dose, and operational dose quantities.
- F. CDPH RHB– California Department of Public Health -Radiologic Health Branch
- G. PACS – (Picture Archiving and Communications System) where images and reports are stored, reported and viewed.
- H. Electronic Health Record (EHR)- Radiology information system
- I. RSO – (Radiation Safety Officer) - A radiation safety officer is the person is holds the responsibility for radiation safety within an organization.
- J. Qualified Medical Physicist – Has earned a master's and/or doctoral degree in physics,

medical physics, biophysics, radiological physics, medical health physics, or equivalent disciplines from an accredited college or university and has been granted certification in a specific subfield.

IV. GENERAL INFORMATION

- A. Excessive radiation dose exposure to patients from diagnostic CT must be monitored and in some cases could require reporting to the CDPH as well as the referring physician and patient affected.
- B. Dose optimization protocols will be used to reduce patient dose.

V. PROCEDURE

- A. For all CT exams, the protocol page that contains the dose report will be sent electronically to PACS.
 - 1. The radiation dose in CTDI(vol) and DLP will be entered in the patient's exam report.
- B. Except for an event that results from patient movement or interference, the following events must be reported in the Salinas Valley Health Medical Center SVHMC occurrence reporting system immediately upon discovery:
 - 1. A repeat CT scan due to equipment malfunction
 - 2. A CT scan of the wrong patient
 - 3. A CT scan of the wrong body part
 - 4. A CT or therapeutic dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose equivalent that is the result of radiation to a known pregnant individual unless a qualified physician specifically approved the dose to the embryo or fetus in advance.
- C. Once a report has been submitted in the occurrence reporting system, Diagnostic Imaging management and the RSO/alternate RSO will validate the report and forward the scan information to our contracted Qualified Medical Physicist to review the dose values and ascertain if the doses have been exceeded.
- D. The CDPH must be notified of any events listed under section A if the physicist deems the exam dose has been exceeded, no later than five business days after discovery and 1) provide notification of the event to the department and the referring physician of the person subject to the event; and 2) provide written notification to the person who is the subject of the event no later than fifteen business days after the discovery of the event described in section A.
- E. To ensure compliance attachments A-D are designed to **assist** the institution by **alerting** the user to scenarios that might exceed action levels by converting the state's threshold dose reporting levels into CT dose values that are actually reported by the CT scanner. Except for scans of **known pregnant** women (fetal dose threshold), it is unlikely that the notification dose limits would be exceeded in most clinical scenarios.
 - 1. The "threshold" values are guidelines only and should be considered as investigatory thresholds to engage a Qualified Medical Physicist to determine if reporting is required.

F. Repeat CT (potential reportable event):

1. Attachment A will be used to determine if a reportable event may have occurred for "Effective Dose" threshold based on the age of patient, and exam type. If the threshold has not been exceeded the event will be considered a non-reportable event.
2. If DLP values in attachment A have been exceeded, use Attachment B to determine if the organ dose threshold (mGy) has been exceeded.
3. If the organ dose threshold has been exceeded then Attachment C will be used to determine if the skin dose threshold (mGy) has been exceeded.
4. If all three thresholds have been exceeded a Qualified Medical Physicist will be notified to determine if reporting is required.
5. If so, appropriate reporting guidelines/timeframes will be followed per SB 1237.

G. Wrong body part/patient:

1. Attachments A-C will be used to determine if the event may be a reportable event. If **one** of the three thresholds is exceeded then a Health Physicist will be notified to determine if the "event" was indeed a reportable event. If so, appropriate reporting guidelines/timeframes will be followed per SB 1237.

H. Fetal Dose:

1. Attachment D will be used to determine if a reportable event may have occurred to a known pregnant individual. If the threshold is exceeded then a Health Physicist will be notified to determine if the event is a reportable event. See [PREGNANT WORKER and PATIENT - RADIATION SAFETY](#).

I. The following strategies are used to reduce radiation dose to our patients:

1. Proper positioning of patients for their exam
2. Utilizing the correct protocol for the exam
 - a. If technologist is unsure about order and/or protocol they should consult with a physician
 - b. Omit precontrast exams if possible. All with and without exams that are not listed in approved CT protocols must be reviewed by a Radiologist before scanning.
3. Technologist will consult with physician before repeating a scan
 - a. consider US or MRI
4. Delayed kidneys will not be performed on pediatric patients unless requested by Radiologist
5. Protocols on scanner are setup utilizing radiation reducing software.
6. High dose cases are sent to Radimetrics for review.

J. Documentation:

1. SVHMC Occurrence Reporting System

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. California Health and safety code, SB 1237 Section 115111, 115112, and 115113.
- B. California Clinical and Academic Medical Physicists (C-CAMP)- Computed Tomography Dose Limit Reporting Guidelines for Section 3-115113

Attachments

- [A: Patient Effective Dose Threshold: 50 mSv](#)
- [B: Organ Dose Threshold: 500 mSv](#)
- [C: Skin Dose Threshold: 500 mSv](#)
- [D: Fetal Dose Threshold: 50 mSv](#)

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Radiation Safety Committee	Todd Rippley: Clinical Coordinator - Nuc Med	8/6/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/24/2026
Policy Owner	John Kazel: Director Imaging Services	6/1/2026

Standards

No standards are associated with this document



Origination 11/18/2014
Approved N/A
Expires 3 years after approval

Owner Terri Nielsen:
Manager Clinical Research

Area Clinical Research

Humanitarian Use Devices

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidance to SVHMC on a HUD that is administered to or implanted in a patient and to provide guidance related to required IRB approvals of a HUD before and after administration or implantation of the device.

III. DEFINITIONS

- A. **Humanitarian Device Exemption** - A humanitarian device exemption (HDE) is submitted by the medical device manufacturer for FDA review and approval. The purpose of HDE is, to the extent consistent with the protection of the public health and safety and with ethical standards, to encourage the discovery and use of devices intended to benefit patients in the treatment or diagnosis of diseases or conditions that affect not more than 8,000 individuals in the United States.
1. The HDE provision was added to the FD&C Act by the Safe Medical Devices Act of 1990 and included, among other things, **a prohibition on profits from sale** of HUDs and a requirement that before "use" of a HUD to treat or diagnose patients at a facility, an IRB must approve such use. For purposes of this guidance, approving the "use" of a HUD (as opposed to approving the "investigational use" or a "clinical investigation" of a device) refers to use of the HUD in the course of routine clinical care to treat or diagnose patients. Subsequent amendments to the FD&C Act have added important flexibility to the HDE program while retaining the purpose of encouraging the discovery of medical devices **for use in limited patient populations**.

- B. **Humanitarian Device Exemption Holder** – this is the medical device manufacturing company providing the device. The company providing the device is responsible for ensuring that the HUD is only used in facilities having an IRB or Central IRB agreement constituted and acting in accordance with 45 CFR Part 56. The medical device manufacturing company is required to maintain records of the names, addresses of the facilities to which the HUD has been shipped, and is required to maintain copies of correspondence with reviewing IRBs as well as any other information required by the reviewing IRB or FDA.
- C. **Humanitarian Use Device** - HUDs are medical devices intended to benefit patients in the treatment or diagnosis of diseases or conditions that affect or are manifested in not more than 8,000 individuals in the United States per year.
- D. **Humanitarian Use Device IRB Approval** - a HUD may only be used in facilities that have established, in accordance with FDA regulations, an IRB review process to approve the use of the HUD before the device is administered to humans. IRBs which oversee the use of a HUD should be constituted and act in accordance with the FDA's regulations governing IRBs (21 CFR part 56), including responsibility for continuing review of use of the device. The FDA does not believe the law intends to require IRB review and approval for each individual use of the HUD. The FDA has interpreted the law to permit the IRB to approve the use of the device in general, use of the device for groups of patients meeting certain criteria, or use of the device under a treatment protocol.
- E. **Institutional Review Board (IRB)** - Under FDA regulations, an IRB is an appropriately constituted group that has been formally designated to review and monitor biomedical research involving human subjects. In accordance with FDA regulations, an IRB has the authority to approve, require modifications in (to secure approval), or disapprove research. This group review serves an important role in the protection of the rights and welfare of human research subjects.
- F. **Research** - means "a systematic investigation, including development, testing, and evaluation, designed to develop or contribute to generalizable knowledge." Activities which meet this definition constitute research for the purposes of this policy, whether or not they are supported under a program which is considered research for other purposes, 45 CFR 46.102(d).
***Humanitarian Use Devices are not research as defined by 45 CFR 46.102(d).** IRB review is required to ensure that the humanitarian use devices administered to or implanted in a patient under this program are compliant with the laws and regulations governing such devices.
- G. **Principal Investigator:** When applied to a Humanitarian Use Device at SVHMC, the PI is the lead physician responsible for the specific HUD at SVHMC. As such, the PI credentials are submitted to the IRB along with the HUD protocol and supporting regulatory documents.
- H. **User Facility:** For this policy, the User Facility is SVHMC.

IV. GENERAL INFORMATION

- A. Applies to all Salinas Valley Health Medical Center (SVHMC) Physicians, departments and staff engaged in the use, or potential use, of Humanitarian Use Devices (HUD) under an FDA-granted Humanitarian Device Exemption (HDE).
- B. **Institutional Review Board:** The IRB of Record for HUDs at SVHMC is Western Institutional Review Board (WIRB)-Copernicus Group ("WCG IRB"), with whom SVHMC holds a current Institutional Reliance Agreement. The use of a HUD within its approved labeling **does not**

constitute research. SVHMC Clinical Research Department must ensure that IRB review and approval of a HUD is received before the HUD is administered to or implanted in a patient.

- C. **Adverse Event Reporting:** All adverse events, whether expected or not, must be reported and evaluated in accordance with Medical Device Reporting requirements in 21 CFR part 803. Device manufacturers and user facilities are required to submit medical device reports to the FDA and to the "IRB of record" (i.e., the IRB that oversees use of the HUD at the facility where the adverse event occurred) after HDE approval. At SVHMC, the **implanting/prescribing/treating physician** documents the AE and the staff (RN or technician) notifies the Research Manager, who then submits the AE report to the IRB and the device manufacturer.
- D. **Informed Consent:** Neither federal law nor FDA regulations require informed consent from patients who are treated or diagnosed with an HDE-approved HUD in the course of their clinical care.
- E. **Information for Patients:** An IRB or appropriate local committee (SVHMC Research Oversight Committee) may choose to require that patients receive certain information (similar to package insert) about the HUD when the committee approves use of the HUD for clinical care at a facility.
- F. **Emergency Use:** When the physician determines it is an emergency situation and the physician determines approval cannot be obtained in time to prevent serious harm or death to the patient, IRB pre-approval is not required. Following the procedure, the user facility must report the Emergency Use of the HUD to the IRB of Record.

V. PROCEDURE

- A. The SVHMC Clinical Research Department must communicate to the Medical Staff and Facility Staff that Humanitarian Use Devices require IRB approval prior to being administered to or implanted in a patient.
- B. All products presented for purchase to SVHMC should be identified as **FDA-approved** or **non FDA-approved**, or **holding an HDE**. Since a variety of Physicians may present products for purchase, the ordering individual may be instructed by the Clinical Research Manager and / or Supply Chain to clarify FDA approval status from the requesting individual as a final check.
- C. Prior to a request for purchase of a HUD or before a purchase order for a HUD is executed, the SVHMC IRB of Record (WCG IRB) must first review and approve the use of the HUD at the institution (21 CFR 814.124(a)). It is up to the reviewing IRB to determine if informed consent is required. Informed consent is addressed in Section 520(m) of the HDE act and the act does not require that informed consent be obtained before a HUD is used.
 - 1. FDA has decided that a humanitarian device exemption, which provides for temporary marketing approval, does not constitute "research" or an "investigation," which would normally require informed consent. The IRB does not need to review and approve individual uses of a HUD. As long as the use of the HUD is within the FDA-approved indication, the IRB may approve use of the device however it sees fit. That is, the IRB may approve use of the HUD without any further restrictions, use of the device under a protocol, or use of the device on a case-by-case basis.
- D. Once the HUD is approved via the IRB process, the purchase of the HUD may take place for an amount that does not exceed the costs of research and development, fabrication, and distribution as reported by the HDE holder to the FDA in their application.

- E. When the HUD is received at the facility and ready for administration or implantation, all physicians and staff must be in compliance with IRB instructions related to approval and use of the HUD.
- F. DOCUMENTATION
 - 1. Each incidence of HUD administration or implantation must be reported to the Clinical Research Department for tracking and determination of IRB notification per FDA and IRB reporting requirements.
 - 2. The administration or implantation of a HUD will be documented by the treating Physician in the patient's electronic medical record.
- G. Education and/or training for a specific HUD is provided to the Physician and User Facility by the device manufacturer.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Guidance for Industry - Food and Drug Administration - Humanitarian Use Device (HUD) Designations, Revision 1 issued: September 5, 2019: <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/humanitarian-use-device-hud-designations>
- B. Humanitarian Device Exemption (HDE) Program Guidance for Industry and Food and Drug Administration Staff Document issued on September 6, 2019: <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/humanitarian-device-exemption-hde-program>

Attachments

 [A: Sample WIRB Certificate of Approval at SVMHS](#)

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CCO	Timothy Albert: Chief Clinical Officer	7/29/2026
Research Oversight Committee	Cynthia Johnson: Contract Medical Librarian	7/29/2026

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Terri Nielsen: Manager Clinical Research	5/5/2026

Standards

No standards are associated with this document

COPY



Origination 11/3/2010
Approved N/A
Expires 3 years after approval

Owner Audrey Parks: Vice President Information Technology
Area Information Technology

IT Purchase and Lifecycle Management

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To establish Salinas Valley Health (SVH) standards for requesting, evaluating, purchasing, installing and maintaining information systems equipment and assets on the Hospital voice and data infrastructure.
- B. Excluded from this procedure are systems directly related to patient care, i.e., biomedical devices, monitoring, imaging, patient invasive and non-invasive systems and technologies, with the exception of such systems which connect to the SVHMC data network, which must be evaluated by Information Technology (IT) prior to purchase.

III. DEFINITIONS

- A. *Telephony Devices* – Communication, often two-way, via electronic transmission of data. Telephony devices include equipment used to carry out electronic transmission of voice and data such as smartphones, telephones, and fax machines.
- B. Information systems assets may include, but is not limited to, assets used for processing, storing, viewing or transmitting information for hospital business purposes. Software is also considered an information systems asset.

IV. GENERAL INFORMATION

- A. This procedure is for requesting and ordering any computer related hardware, software, and associated device(s) that are established within the guidelines of this policy.

- B. This procedure applies to all SVH staff and this procedure should be followed when requesting purchase of any information systems and technologies involving computing hardware, software, subscription services or similar. Contact and discuss with Information Technology (IT) Help Desk if there are any questions. (831) 755-0738 or HelpDesk@salinasvalleyhealth.com

V. PROCEDURE

A. Budgeting

1. Department leaders who are budgeting for net new FTEs must notify IT upon approval, to ensure that computing assets can be budgeted in advance by IT.
2. Non-capital information systems and assets may be requested by e-mailing the Information Technology Help Desk, HelpDesk@svmh.com, or calling (831) 755-0738. Refer to the "Capital Equipment" policy for capital equipment guidelines.
 - Equipment which has not reached the end of its useful life.
 - Equipment which has been abused, mis-handled, or otherwise treated poorly.
 - Equipment which is outside of the standard IT-issued computing hardware.

B. Request, Evaluation, and Approval

1. When upgrading equipment, IT will evaluate any assets that are obsolete then notify both General Accounting and Supply Chain in accordance with Leadership/ Evaluation of Hospital property for surplus and/or disposal.
2. Procurement of IT Assets, Software, Service - items governed by this policy require pre-approval with required forms as needed by Information Technology before placing requisitions into Workday.
 - a. Procurement of upgrades to existing or new information systems are subject to review by IT for a cybersecurity risk assessment.
 - b. System upgrades or new procurements that have an information technology component such as, but not limited to, access management, handling and storage of Salinas Valley Health data, integrations and reporting, should be evaluated by IT for technical feasibility, risk management and resource planning.
3. This policy is subject to Hospital procurement policies and procedures and shall not conflict with or supersede them.

C. Maintenance

1. Minimal measures of maintenance are the responsibility of the assigned user and/or departments.
2. IT is responsible for Windows patches of any Hospital-issued devices.
3. Staff is expected to exercise reasonable care and safe use of Hospital equipment. Report any service requests to the Help Desk immediately at (831) 755-0738 or HelpDesk@salinasvalleyhealth.com.

4. Sanitizing wipes for keyboard and mouse peripherals are available through Supply Chain.

D. Personal Computer Maintenance Guidelines

1. It is the responsibility of the end user departments to maintain these minimal measures of maintenance.

Desktop Computers:

- a. Keyboards and mice may either be wiped down with SVH approved cleaning wipes.
- b. Monitors (screens) must only be cleaned with a soft, slightly damp cloth to remove dust, and/or with SVH approved cleaning wipes. Sani-Cloth AF3 or other harsh cleaners should be avoided when cleaning monitors.
- c. Barcode scanners: Wireless barcode scanners may be cleaned with Sani-Cloth AF3 or other Level 3 cleaner, but must be allowed to dry completely before replacing in the cradle. The scanner cradle may be cleaned with an alcohol-based wipe if necessary and allowed to dry completely. Both scanner and cradle must be completely dry before scanner is placed back into the charge cradle.
- d. Computers/CPUs: All CPUs must be kept off the floor. The outside of the CPU may be wiped with a dusting cloth to remove outside dust. Make sure that air intakes and fans are free from dust and blockages. Do not attempt to service anything in the interior of the computer chassis, under any circumstances. No food or drinks are allowed at the workstation.
- e. Workstations on Wheels (WOWs): Keep WOWs plugged in when not in use. Adjust all WOWs to proper ergonomic positions prior to use. Contact Employee Health for any questions about ergonomic adjustment. Do not overfill drawers with material, do not keep liquids in the drawers.
- f. Printers: It is the department's responsibility to order and replace the toner/ink in the printer. Do not overfill paper trays as doing so may interfere with proper functioning of the printer. Use both hands to gently close paper trays, do not slam the trays shut.
- g. Tablets/phones: Use only SVH approved cleaning wipes.

- E. This policy may be reviewed with new or existing employees and affiliates during General Orientation, Education, or by specially scheduled in-services, e.g. [STANDARDS OF ETHICAL BUSINESS PRACTICES](#) , [COMPLIANCE AND ETHICS PROGRAM PLAN](#) , etc.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. The Joint Commission:

1. IM01.01.01: Health IT and Procurement Continuity: Hospital plans for managing

information. Information Management: Purchases must ensure hardware and software support accurate, secure, and accessible patient data.

2. IM02.01.01: The hospital protects the privacy and security of health information. Systems need built-in privacy protections and safeguards against unauthorized access, loss, or tampering.

B. Capital Equipment Policy, <https://svmh.policystat.com/policy/17434590/latest>.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/24/2026
Policy Owner	Audrey Parks: Vice President Information Technology	7/16/2026

Standards

No standards are associated with this document



Origination 3/30/2020
Approved N/A
Expires 3 years after approval

Owner Shannon Graham:
Director
Volunteer & Health
Career Services
Area Volunteer Services

Job Observation/Shadowing

I. POLICY STATEMENT

- A. Salinas Valley Health Medical Center (SVHMC) encourages and promotes healthcare as a profession.
- B. This policy covers:
 - 1. Individuals volunteering in a non-clinical capacity, such as clerical or administrative experience or within an established volunteer role.
 - 2. Individuals applying strictly for observation. Any requests for hands-on experience must be facilitated by the Education Department and will only be considered for students attending an educational institution with which the hospital has an educational agreement/contract.
- C. After approval and in processing, participant will be assigned to an individual staff member or physician during each observation shift.
- D. Job Observation/Shadow Participants must be a minimum of 16 years of age; 18 years or older is preferred.
- E. Job Observation participants which are not part of a school partnership such as ROP, etc. must be a minimum of 18 years of age and cannot be supervised by a family member.
- F. Salinas Valley Medical Center staff are eligible to participate; however, they may not observe or volunteer in their home department or in a similar role.

II. PURPOSE

- A. The purpose of this policy is to develop standards, procedures, and mechanisms for individuals to perform clinical/job observation or non-clinical volunteer work experience at SVHMC.

III. DEFINITIONS

- A. Job Observation/Shadow: Participants perform observational duties only. No patient care activities are permitted. This policy does not cover students requiring hands-on activity for school credit (i.e. nursing, diagnostic imaging, laboratory scientist). Students requesting hands-on experience must register with the Education Department as outlined in [–STUDENT AFFILIATIONS](#) policy.
- B. Volunteer Work Experience/Service Learning: Participants performing non-clinical duties as outlined in their volunteer position description and directed/supervised by SVHMC Volunteer Services or designated department manager.
- C. Educational Institution: School including High School, Community College, University, or Trade School in which student is receiving course credit or certificate of achievement in defined field of study.
- D. Observation Tours: Groups or individuals may visit departments to observe for brief periods in a guided tour. Tours may be coordinated by Volunteer Services or individual departments with approval of department Manager or Director. All tour participants must comply with the guidelines in [–HOSPITAL TOURS](#) policy, including completion of the Release from Liability form, signed by a Parent or Guardian if the participant is under 18 years of age.
- E. ROP – Regional Occupation Programs
- F. SHI - Summer Health Institute is a program facilitated by Volunteer Services Department.

IV. GENERAL INFORMATION

- A. Job Observation/Shadow Participants
 - 1. SVHMC provides training to participants and/or participant advisors (i.e. instructor, internship coordinator) via orientation class or self study orientation consistent with standards for volunteers and facilitates Employee Health and Background clearance, which must be completed at the expense of the participant.
 - 2. Once orientation and screening are complete, Volunteer Services will confirm with participant and host that they are now eligible to schedule their shift(s).
 - 3. Participants will receive hospital ID badge and record hours utilizing the Volunteer Services tracking system (Vysys) while onsite during scheduled shifts.
- B. Volunteer Work Experience and Service Learners
 - 1. Following volunteer orientation and completion of clearance requirements training will be provided by assigned department based on assigned role, including any specific learning objectives.

V. PROCEDURE

A. Job Observation/Shadow Participants:

1. Part of an organized program, such as R.O.P., Rotary Program, or Health Academy:
 - a. Selection/Screening: Participants are referred by instructor or program coordinator. In lieu of a background check, school maintains liability for participant behavior as part of an organized educational activity. Participants must meet established health screening and general orientation requirements consistent with volunteers.
 - b. Instructor coordinates capacity and dates with Volunteer Services Department, which verifies department availability with the department Manager/Director.
 - c. Instructor verifies participants' eligibility based on course expectations and Salinas Valley Health Medical Center standards.
 - d. All participants must have an ID badge issued by SVMHC or their school program clearly identifying them as a Job Observation/Shadow participant.
 - e. Volunteer Services provides list of departments in which students may shadow. The instructor/program coordinator makes participant assignments based on available departments and appropriate for participant interest.
 - f. While at SVMHC participants must comply with professional dress standards.
2. Individual requests:
 - a. Shadowing applicants submit a Job Observation/Shadow Application and one-page summary of goals and objectives including career interest, project requirements, and staff time commitment, accompanied by Educational Referral Form signed by current or recent teacher, counselor, or supervisor. If requesting to observe/shadow a physician, a signed referral form from physician who has agreed to host is required.
 - b. Volunteer Services Department, after consultation with the Education Department and director/manager of requested department, notifies student of the status of their requests and, if approved, facilitates on boarding process. If placement in requested department is approved by department director and education department, Volunteer Services will notify applicant of the following requirements:
 - i. Orientation will be provided via in-person class or self-study consistent with volunteer standards.

- ii. Health screening requirements must be completed at the applicant's expense and validated by Employee Health Services.
 - iii. Background screening requirements must meet the same standards as a volunteer, at the applicant's expense. Consent forms and procedures for submission are available from Volunteer Services Department.
 - c. After completion of health screening, background screening, and orientation, participant will be issued a photo ID and scheduling will be coordinated by department, based on availability.
- 3. For Active Volunteers, Program Participants, or SVHMC Staff
 - a. Active volunteers or employees requesting to shadow must complete the shadow application and referrals as outlined above.
 - b. Active volunteers, employees and program participants with above requirements completed may submit documentation of annual training, current Employee Health Clearance and completed background clearance to satisfy requirements for participation. After approval of application, they will receive appropriate ID badge and be scheduled for job shadowing of short duration, at the discretion of Volunteer Services and their desired department or physician.
- B. For longer term assignments or requests beyond strictly observing, Volunteer Services and the department may create a volunteer position description, outlining the learning objectives and non-clinical tasks to be performed. For clinical experience, student will be referred to Education Department for consideration. For Volunteer Work Experience:
 - 1. Participants complete volunteer application and interview during which they describe their educational goals, learning objectives, and time line.
 - 2. Once placement is approved, Volunteer Services Department will assign participant to existing volunteer role or work with department to draft a position description/ scope of service and facilitate the on boarding process consistent with the current volunteer standards.
 - 3. For participants requesting credit as part of a course in which they are enrolled, if request is not aligned with existing volunteer service area, Volunteer Services Department will consult with the Education Department to confirm current educational institution affiliation and to facilitate the on boarding process, if approved.
 - 4. Scheduling and supervision, including performance evaluations required by the participant's school, will be completed by the department in which the student is performing the assignment.
 - 5. Verification of hours will be completed by the Volunteer Services Department.

C. Documentation:

1. SVHMC requires documentation of application, department approval, orientation, background clearance, Employee Health clearance and position specific training, if applicable, to be completed by all participants prior to first shift.
 - a. Detailed documentation for groups is maintained by instructor, with summary of eligible participants on file with Volunteer Services. Documentation for individual participants is retained by Volunteer Services Department.

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
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Shannon Graham: Director Volunteer & Health Career Services	6/16/2026

Standards

No standards are associated with this document



Origination 3/7/2016
Approved N/A
Expires 3 years after approval

Owner Kirsten Wisner:
Director
Magnet Program
Area Nursing Administrative

Nursing Excellence / Peer Review

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To ensure the highest quality care and identification of system-level opportunities to improve care.

B. Goals

1. Improve the quality of care
2. Monitor performance
3. Identify opportunities for performance improvement
4. Identify system process issues
5. Monitor significant trends by analyzing aggregate data
6. Promote the recognition of exemplary care
7. Assure that the process for peer review is clearly defined, fair, defensible, timely

III. DEFINITIONS

A. Peer Review

Nursing peer review is the process wherein registered nurses systematically evaluate the quality of nursing care provided at the individual and team level, measured against professional standards (Haag-Heitman & George, 2011).

Peer review is conducted using multiple sources of information, including:

1. The review of individual cases
2. The review of aggregated data
3. Occurrence reports and sentinel event data
4. Data reflecting compliance rates with policies and professional standards

Individual and team performance is evaluated against evidence-based standards of care. Through this process, system-level issues are identified and feedback is given to individuals and teams to support improvement. For specialty-specific clinical issues, such as evaluating the technique of a specialized procedure, a peer is an individual who is well trained and competent in that specialty.

Subject matter expertise required for a provider to be considered a peer for peer reviews performed by or on behalf of the Nursing Excellence Committee (NEC) will be determined by the NEC.

- B. The American Nurses Association (ANA) principles for nursing peer review should be used when conducting peer review (Haag-Heitman & George, 2011)
1. A peer is someone of the same rank.
 2. Peer review is practice-focused.
 3. Feedback is timely, routine, and a continuous expectation.
 4. Peer review fosters a continuous learning culture of patient safety and best practice.
 5. Feedback is not anonymous.
 6. Feedback incorporates the nurse's developmental stage.

C. Conflict of Interest

A conflict of interest exists if a reviewer is not able to render an unbiased opinion. Conflict of interests include the reviewer/nurse being directly involved in the case, being related to the nurse/s under review, or being related to the patient/s cared for in the case.

It is the obligation of the reviewer to disclose to the NEC any potential conflicts. The NEC determines whether the conflict would prevent the individual from participating or the extent of the individual's participation. Individuals determined to have a conflict may not be present during peer review discussions or decisions other than to provide information if requested.

IV. GENERAL INFORMATION

- A. All peer review information is privileged and confidential in accordance with organizational policy, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
- B. The involved nurse and team will receive specific feedback on a case-by-case basis.
- C. Peer review and other quality information concerning a nurse will be maintained in a secure area and kept separate from the individual's employment file. Nurse-specific peer review

information consists of information related to:

- Performance data for that team or individual nurse
- The nurse's (or nurses') role in sentinel events, significant incidents, or near misses
- Correspondence to the involved stakeholders regarding commendations, comments regarding practice performance, or corrective action

D. Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a nursing leader or medical center employee. Information access will be limited to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to nurse-specific peer review information and only for improvement efforts:

- The NEC
- Chief Nursing Officer (CNO)
- Nursing Director/Manager
- Quality Management Director
- Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)
- Individuals with a legitimate purpose for access as determined by the medical center's board of directors

E. No copies of peer review documents will be created and distributed unless authorized by the CNO.

V. PROCEDURE

1. Circumstances requiring peer review:

Peer review is conducted on an ongoing basis and reported to the NEC for review and recommendations. The procedure for conducting peer review is described below. Triggers for peer review may be identified through:

- Reporting processes such as occurrence reports
- When there is an unusual individual case or clinical pattern of care identified during a quality review

2. Participants in the review process:

- Unless otherwise specified, committee members shall be appointed for a term of two (2) years. To maintain continuity, committee appointments will stagger to maintain expertise among committee membership.
- Participants in the review process will be selected according to practices established by the NEC and organizational policies and procedures.
- The NEC will provide opportunities for feedback from nursing staff who can provide insight and clarification about the event under review. Nurses who are involved in the case will be invited to participate in the review, which may include email communications, attendance at the NEC case review or other meetings, and through

informal conversations with NEC members.

- In the event of a conflict of interest or circumstances that would suggest a biased review, the NEC and nursing leadership will determine who will participate in the process.
3. Peer review will be conducted by the NEC in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality Management department and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.
 4. Statutory Authority

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. Sections 11101, et seq. and California Evidence Code Section 1157.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Haag-Heitman, B. & George, V. (2011). *Peer review in nursing: Principles for successful practice*. Sudbury, MA: Jones and Bartlett.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Carla Spencer: Chief Nursing Officer	7/14/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/13/2026
Policy Owner	Kirsten Wisner: Director Magnet Program	7/10/2026

Standards

No standards are associated with this document



Origination 3/4/2021
Approved N/A
Expires 3 years after approval

Owner Randy Richards:
Epic Acute Clinical Application Manager
Area Patient Care

Order Mode

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. The purpose of this policy is to provide direction for the selection of the appropriate order mode when entering orders in the EHR (Electronic Health Record).

III. DEFINITIONS

- A. *Orders*—Medications, treatments, procedures, or other patient care directives that are communicated as oral, written, or electronic communications between authorized provider and authorized recipient.
- B. *Order Mode* — The method by which an order is initiated and entered into the electronic health record (EHR), reflecting the source of authority for the order—either direct communication from a licensed provider (e.g., verbal or telephone) or execution of a pre-approved protocol, or standing procedure.

IV. GENERAL INFORMATION

A. N/A

V. PROCEDURE

- A. Orders entered in the EHR require the appropriate order mode selection.
- B. Order entry in the EHR requires the selection of an Authorizing Provider and an Order Mode any time an order is entered.

- The Provider is the licensed individual with ordering privileges who enters the order or who provides the order.
- Order modes are defined to facilitate proper selection for the order origin and to provide an accurate audit trail.
- The Order Mode is the initiation of the order and can include any of the following types:
 1. Standard - Used when a clinician is placing their own orders.
 2. Verbal with readback – Oral orders given by Provider in the presence of the recipient (see [TELEPHONE AND VERBAL PHYSICIAN ORDERS](#)).
 3. Telephone with readback – Oral orders given by Provider via telephone.
 4. Transcribed from paper – Orders written on order sheets or order sets on paper.
 5. Ordered during downtime - Used when a user is entering orders that were given while the system was down.
 6. Per protocol: cosign required - Used when a clinician places orders approved by Salinas Valley Health Medical Center (SVHMC) defined as standardized procedure or otherwise defined in policy and the Authorizing provider needs to review the order
 7. Per protocol: no cosign required - Used when a clinician places orders approved by Salinas Valley Health Medical Center (SVHMC) defined as standardized procedure or otherwise defined in policy and the Authorizing provider does not need to review the order
- C. Order modes dictate whether orders flow to a Provider's queue for electronic signature.
 - The order modes listed below require an electronic signature from the Provider:
 1. Verbal with readback
 2. Telephone with readback
 3. Per protocol: cosign required
- D. Order modes that do NOT require an electronic signature from a Provider:
 1. Standard
 2. Transcribed from paper
 3. Per protocol: no cosign required
 4. Ordered during downtime

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. The Joint Commission (2025). *Hospital Accreditation Standards*. RC 01.02.01.
- B. The Joint Commission (2026). *Hospital Accreditation Standards*. RC 11.02.01.
- C. The Joint Commission (2026). *Hospital Accreditation Standards*. RC 12.02.01.

Attachments

 [A_Order Mode.docx](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	8/4/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/27/2026
Policy Owner	Randy Richards: Epic Acute Clinical Application Manager	7/27/2026

Standards

No standards are associated with this document



Origination 10/29/2021
Approved N/A
Expires 3 years after approval

Owner Michelle Orta:
Director
Continuum
of Care

Area Patient Care

Palliative Care Services

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in accessing palliative care services for patients with serious or life-threatening illness who would benefit from interdisciplinary palliative care support.

III. DEFINITIONS

- A. **Palliative Care:** patient-centered interdisciplinary care oriented toward physical and emotional symptom management, and honoring the wishes and goals of patients and their families. It may be utilized at any age or stage of serious illness. It is often used in conjunction with curative treatments to optimize quality of life and to improve communication and informed decision-making. Palliative care does not require a specific prognosis, nor that a patient is near end of life.
- B. **ACP:** (Advanced Care Planning) discussing, writing down, and sharing personal values and choices for future treatment. Identifying surrogate decision maker; and establishing the patient's goals of care for treatments or procedures which align with their wishes.
- C. **POLST:** (Physician Orders for Life-Sustaining Treatment) a portable medical order form detailing a preference for CPR, medical interventions, and artificial nutrition.
- D. **EHR:** (Electronic Health Record) an electronic version of a patient's medical history, that is maintained by the provider over time.

IV. GENERAL INFORMATION

- A. Palliative Medicine Services are made up of an interdisciplinary team including providers (physician or advance practice practitioners), nurses, social workers, chaplains, and other ancillary staff and volunteers as available.
1. Inpatient Palliative Medicine Services are available on site for patients being seen or admitted to the medical center.
 - a. Outpatient Palliative Medicine Services are available off site by referral to the Salinas Valley Health Palliative Medicine Clinic.
 2. Palliative Medicine support is offered in the following areas as needed:
 - a. Management of disease specific symptoms such as (but not limited to) pain, shortness of breath, anxiety, fatigue, constipation, nausea, loss of appetite, problems with sleep, etc.
 - b. Communication with the patient and family and education about the patient's illness, prognosis, and treatment choices and assist with medical decision-making.
 - c. Culturally sensitive emotional, psychosocial, and spiritual support.
 - d. Assistance with coordination of care among care team members and across care settings.
 - e. Ongoing development of prognostic awareness and facilitation of legacy work
 3. Staff will facilitate access to Palliative Medicine Services for appropriate patients and families.
 - a. Appropriate patients include those patients with a serious, life-limiting illness which impacts the patient's quality of life without consideration of the patient's age or stage of illness.
 - i. Serious, life-limiting illnesses include (but are not limited to) cancer, heart failure, renal disease, pulmonary disease, liver disease, advancing neurological disease including dementia, Parkinson's, and ALS.

V. PROCEDURE

- A. Primary Palliative Care and identification of patients in need of specialty palliative care services
1. Primary Palliative Care includes clinical competency in whole-person care of complex patients with serious illness, with an emphasis on:

- a. Understanding and caring for the patient in the context of their life, family and community, and their own goals, values, and preferences
- b. Providing clear communication regarding diagnosis, prognosis, and risks and benefits of treatment options
- c. Advance care planning, including goals of care conversations, identification of surrogate decision-makers, and completion of ACP forms including advance directives and POLST forms when appropriate
- d. Providing empathetic emotionally, culturally, and spiritually sensitive care for the patient and their family
- e. Providing effective pain and other symptom management

B. Identification of patients who may benefit from specialty Palliative Medicine services

- 1. Any inpatient or outpatient with a serious or potentially life-limiting illness that may benefit from a higher level of care in the above domains of education, decision-making, prognostic awareness, complex care navigation, symptom management, psychological, spiritual, or emotional support may be considered for palliative care referral.
- 2. Identification of these patients is made by the care team, including medical providers, nursing, spiritual care, and social work, depending on the setting.
- 3. Patients who may benefit from Palliative Medicine consultation are identified by hospitalists and case management team in daily case management rounds.
- 4. Palliative physicians participate in multidisciplinary ICU rounds to identify patients who may benefit from Palliative Medicine services.
- 5. Recommendations for appropriate supportive services for all tumor board patients are made regularly by the Palliative Medicine team.
- 6. All stage IV cancer patients are referred to Palliative Medicine through the use of EHR protocols.

C. Inpatient Palliative Medicine referral:

- 1. A referral to the Palliative Care Team (i.e. Palliative Care Nurse and Palliative Care Social Worker) does not require a formal physician order and can come from a patient, family or staff request.
- 2. A referral to the Palliative Medicine Physician must be initiated from provider to provider.
- 3. All Palliative Medicine referrals are reviewed by a Palliative Medicine team member to identify appropriateness for palliative medicine involvement.
 - a. If the palliative medicine team member determines that an initial

assessment or continued follow-up is not appropriate, the team member will discuss these findings with the care team and discontinue the referral.

4. For appropriate referrals, initial and subsequent assessments are carried out through patient, family and care team interviews/ conferences, review of medical records, discussion with other providers, physical examination, laboratory and diagnostic evaluation, and additional procedures as needed.
5. Patients are regularly reassessed for appropriateness of ongoing support and will remain on services for as long as palliative care needs remain.
 - a. If deemed no longer appropriate for Palliative Medicine services, Palliative Medicine services will refer the patient back to their primary care physician.
 - b. If new needs arise after Palliative Medicine services are no longer following, a subsequent Palliative Medicine referral can be entered to initiate re-engagement of Palliative Medicine services.

D. Outpatient Palliative Medicine Referral:

1. Outpatient Palliative Care Services are available to appropriate patients and their families and/or caregivers by referral to the outpatient palliative care clinic.
 - a. Appropriate patients include those patients at any age or stage of serious illness undergoing palliative and/or curative treatments; including (but not limited to) patients with cancer, heart failure, renal disease, pulmonary disease, liver disease, advancing neurological disease including dementia, Parkinson's, and ALS.
2. Outpatient referrals may be entered into the EMR at any time prior to or shortly after discharge from the hospital.
 - a. Ambulatory clinics may refer appropriate patients directly to the outpatient clinic by sending a referral via EHR or fax.
3. The Palliative Medicine Clinic will review and follow up with referred patients after discharge from the hospital to schedule as appropriate.

E. Documentation:

1. After each encounter, a consultation or progress note will be documented in the medical record.

VI. EDUCATION/TRAINING

- A. The Palliative Medicine Service provides primary Palliative Care education to Salinas Valley Health staff, including medical providers, nurses, CNAs, social workers, and physical/occupational/speech therapy services through:

1. Registered nurse and CNA new hire training, yearly education requirements, periodic educational materials, and one-on-one case-focused training as needed
 - a. Quarterly hospitalist didactic topic sessions and group forum, along with ongoing guidance of medical staff as needed.
 - i. Quarterly collaborative provider sessions with Oncology and Palliative Care medical staff
 - ii. Periodic collaborative sessions with therapy disciplines
 - iii. Ongoing direct collaboration with social workers in care of hospitalizes patients.
 - iv. Other initiatives as specific needs are identified.

VII. REFERENCES

- A. The National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th edition (2018) ; https://www.nationalcoalitionhpc.org/wp-content/uploads/2020/07/NCHPCNCPGuidelines_4thED_web_FINAL.pdf

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Palliative Care Medical Director	Kyle Youngflesh: Physician	8/11/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/4/2026
Policy Owner	Michelle Orta: Director Continuum of Care	8/4/2026

Standards

No standards are associated with this document



Origination 9/13/2019
Approved N/A
Expires 3 years after approval

Owner **Marissa Gonzalez:**
Manager
Cardiology
Clinical

Area **Cardiology**
Departments

Pharmacologic Stress Test with Modifications for Exercise

I. POLICY STATEMENT

- A. N/A.

II. PURPOSE

- A. To assist the non-invasive cardiovascular technician in the evaluation of the patient's cardiac status during a pharmacologic stress test with modifications for the addition of exercise when necessary.

III. DEFINITIONS

- A. Pharmacologic stress test: a stress test that includes the use of a pharmacologic agent to stress the heart.

IV. GENERAL INFORMATION

- A. N/A

V. PROCEDURE

- A. Prior to patient preparation, the cardiology nurse will obtain the patient's consent
- B. Check for patient allergies to pharmacologic stress agents (e.g., adenosine, dipyridamole/ Persantine, regadenoson/Lexiscan, dopamine/dobutamine) prior to administration.
- C. If not already done, the non-invasive cardiovascular technologist will enter an order in the Electronic Health Record (EHR).
- D. Provide appropriate education regarding the stress test and answer any questions the patient

may have.

- E. Begin patient preparation
 - 1. Observe universal precautions
 - 2. Using alcohol, moisten 4X4 gauze pad and vigorously rub the areas of electrode placement until the skin is lightly pink
 - 3. Using abrasive pad, briefly go over the previously prepped areas
 - 4. Place electrodes in the appropriate area following 12 lead ECG application
 - 5. Re-prep area if electrode does not appear to have good contact with the skin
 - 6. Attach lead wires to electrodes.
- F. Connect the patient to the blood pressure monitor.
- G. Enter patient demographics on the stress test machine
 - 1. Select "New Test"
 - 2. Select "Order List"
 - 3. Select Patient from order list.
 - 4. Select appropriate protocol
 - 5. Press "Pre-Test"
 - 6. Enter all test information
- H. While in **Pretest** phase, record the "Diagnostic ECG".
- I. Record Supine blood pressure and Supine 12 lead ECG.
- J. Begin the test when the physician or the cardiology nurse gives approval to start the test
- K. When instructed by the physician or the cardiology nurse, phase into Exercise when infusion of the medication begins. Note: If the attending cardiologist would like to enhance the test with the use of the treadmill for exercise, the non-invasive cardiovascular technologist will assist the patient on the treadmill if necessary.
- L. The Nuclear Medicine Technologist will inject the isotope at the appropriate time.
- M. The non-invasive cardiovascular technologist is responsible for entering all blood pressure data into the stress test machine (every two to three minutes or as instructed by the physician or nurse).
- N. Capture any arrhythmias with the "recall" button
- O. When the nurse/NM technologist notifies you that the infusion is complete, phase into **Recovery** and continue to monitor the patient. When instructed by the physician or the cardiology nurse phase into **Test End**.
- P. Disconnect the patient from the stress test machine; do not disconnect the patient from the Blood Pressure Monitor, as the nurse will continue to monitor the patient.
- Q. After the physician has completed their interpretation, transfer the test to MUSE. If a PA or cardiology nurse is supervising the test Export to MUSE for the attending cardiologist to read.
- R. **Indications for Terminating the Stress Test:**
Absolute

1. Drop in Systolic blood pressure of > 10 mm Hg from baseline despite an increase in workload, when accompanied by other evidence of ischemia
2. Moderate to severe angina
3. Increasing nervous system symptoms (eg, ataxia, dizziness, or near-syncope)
4. Signs of poor perfusion (cyanosis or palor)
5. Technical difficulties in monitoring ECG or blood pressure
6. Patient desire to stop
7. Sustained Ventricular Tachycardia
8. ST elevation (≥ 1.0 mm) in leads without diagnostic Q waves

S. Relative Indications:

1. Drop in systolic blood pressure of (≥ 10 mmHg from baseline blood pressure despite an increase in workload, in the absence of other evidence of ischemia
 2. ST or QRS changes such as excessive ST depression (> 2 mm of horizontal or downsloping ST segment depression) or marked axis shift
 3. Arrhythmias other than sustained ventricular tachycardia, including multifocal PVC's, triplets of PVC's, supraventricular tachycardia, heart block or bradyarrhythmias.
 4. Fatigue, shortness of breath, wheezing, leg cramps, or claudication.
 5. Development of bundle branch block or IVCD that cannot be distinguished from ventricular tachycardia
 6. Increasing chest pain
 7. Hypertensive response
- T. For Cardiology hospital patients, in the event that a patient develops any of the symptoms listed above in section V, Indications for terminating exercise, the performing physician or the cardiology nurse and stress test team will immediately attend to the patient and call the Rapid Response Team (ext. 2222) or a code blue (by dialing 0) at the performing cardiologists direction. For the Cardiovascular Outpatient Center, call 911.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. American College of Cardiology (ACC), & American Heart Association (AHA). (2021). 2021 ACC/AHA guidelines for exercise testing. *Journal of the American College of Cardiology*, 77(4), e61-e72. <https://doi.org/10.1016/j.jacc.2020.11.051>
- B. Task Force on Practice Guidelines (Committee on Exercise Testing) (2018) Gibbons, R., Balady, G., Bricker, T., Chaitman, B., Fletcher, G., Frolicher, V., Et.al.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Cath Lab Medical Director - Dr. Zetterland	Megan Giovanetti: Director Cardiovascular Services and Sleep	7/14/2026
COO	Clement Miller: Chief Operating Officer	6/8/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/8/2026
Policy Owner	Marissa Gonzalez: Manager Cardiology Clinical	6/8/2026

Standards

No standards are associated with this document



Origination 7/11/2012
Approved N/A
Expires 3 years after approval

Owner Aisha Huebner:
Director
Perioperative
Services

Area Infection
Control

Reprocessing Single Use Devices

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide guidelines in utilizing a 3rd party for reprocessing/remanufacturing single use devices.

III. DEFINITIONS

- A. FDA: US Food and Drug Administration.
- B. Reprocessing: an FDA regulated manufacturing process by which medical devices labeled for single use are cleaned, refurbished, tested, and sterilized resulting in a device safe for reuse.
- C. Reprocessing company: a company registered with the FDA to reprocess single use medical devices for patient use during sterile procedures. The reprocessors are subject to the regulatory requirements applicable to the original manufacturer and follow the FDA Guidance Document, *Enforcement priorities for single use devices reprocessed by third parties and hospitals*.
- D. SUD: single use medical device.
- E. 510(k) – Section 510(k) of the Food, Drug, and Cosmetic Act requires device manufacturers, who must register, to notify FDA of their intent to market a medical device in advance, in order for the FDA to review and clear that device for marketing.

IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center (SVHMC) is committed to complying with all federal

regulations, including the Food and Drug Administration's Enforcement Priorities for Single Use Devices Reprocessed by Third Parties and Hospitals.

- B. SUDs are reprocessed by an FDA approved/ registered reprocessing facility upon approval of that facility by the Infection Control/Risk Management, Surgical Executive, and Medical Executive Committees.
- C. SUDs are not reprocessed in the Surgical Sterile Reprocessing Department at SVHMC.
- D. The reprocessor will submit confirmation of FDA annual inspection and certification to Supply Chain, Surgery, and Infection Prevention and Control.
- E. The Supply Chain staff functions as the liaison between SVHMC and the reprocessor to promote coordination of the program/problem resolution.
- F. Reprocessed device failures are reported as described in the procedure section.
- G. Neurosurgical single use devices (SUDs) are excluded from reprocessing.

V. PROCEDURE

A. Reprocessing vendor responsibilities

1. Assistance with identification of SUDs approved for reprocessing is provided upon request.
2. An updated list of the reprocessor's FDA approved 510k SUDs should be provided annually to Supply Chain, Surgery, and Infection Prevention and Control.
3. SUD rigid "biohazardous/reprocessing only" labeled collection receptacles are provided by the reprocessor's account service representative for use at predetermined locations.
 - a. Used device bins: in procedure rooms and other areas as requested by the department directors.
 - b. Opened/unused device bins: in a centralized location on each unit.
 - c. Shipping containers:
 - i. In one centralized location for ease of collection and identification.
 - ii. Labeled as required by the FDA: "BIOHAZARD Medical Device Collection Only".
 - iii. The reprocessor's account service representative will collect and ship the collection bins.
4. Collection and shipping should occur on an agreed upon schedule.
5. Reprocessed SUDs packaging will be clearly labeled with the vendor's identification.
6. The reprocessing vendor will send a list of reprocessed items available and rejected to Supply Chain on a mutually acceptable schedule.
7. A detailed summary utilization report for SUDs sent for reprocessing should be sent to each director of the user departments and Supply Chain.
8. A quality assurance program should be maintained for the following:

- a. Tracking the number of reprocessing cycles undergone by each device.
 - b. Logging complaints and reporting to the user, the results of the assessment of device failure or process problems.
9. A summary of the 510k clearance for a specific device will be sent to the department directors when requested.
10. Upon introduction of the reprocessing program, education for SVHMC staff and physicians related to the science, safety, and processes associated with reprocessing will be provided when requested by SVHMC.

B. SVHMC responsibilities

1. Staff should use the provided collection bins as indicated on the bins
 - a. For opened/unused SUDs.
 - b. For collection of used SUDs. Other metal and plastic devices may be placed in this container and will be sent by the reprocessor for recycling.
 - i. Needles and knife blades are excluded.
 - ii. Neurosurgical devices are excluded.
 - c. Bins should be maintained free of trash
2. Staff should encourage use of reprocessed SUDs before opening original manufacturer supplied products.
3. The Infection Control Committee oversees the reprocessing program.
 - a. The Directors of Supply Chain, Infection Prevention and Control and departments utilizing reprocessed SUDs e.g. Surgery, Cath Lab, and DI report utilization, occurrences, and additions to the SUDs program.
 - b. Summaries of Infection Control Committee activities, related to reprocessed SUDs, should be provided to physician and leadership committees.
4. The designation of which SUDs will be reprocessed is made by the directors of individual departments and Supply Chain.
 - a. Only devices listed by the reprocessor as having FDA 510k approval and pre-determined cost effectiveness are selected.
 - b. Individual directors maintain records of rationale for approval or rejection of devices considered for the SUDs reprocessing program.
5. The Supply Chain Director provides guidance for the following:
 - a. Coordination and execution of the reprocessing program.
 - b. Facilitation of system problem resolution.
6. The department directors collaborate with the reprocessor regarding
 - a. Timely removal and shipment of SUDs by the reprocessor.
 - b. Maintenance of stock of reprocessed SUDs.

C. Reprocessed SUD failure

1. Failure without patient injury.

- a. The staff involved with the procedure save the SUD and packaging in a bag labeled infectious material.
- b. The circulating RN/designee completes an occurrence report and notifies the charge person who alerts the Supply Chain team.
- c. Supply Chain notifies the reprocessor and obtains a device complaint form, which is completed by Supply Chain and returned with the SUD to the reprocessor.

2. Failure with patient injury.

- a. The staff members involved with the procedure save the SUD and packaging.
- b. The circulating RN/designee completes an occurrence report and notifies the charge person who alerts the directors of the department in which the injury occurred and Risk Management.
- c. The circulating RN/designee quarantines the SUD until release has been authorized by Risk Management.
- d. Risk Management notifies the reprocessor.

D. Documentation: N/A

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

- A. AORN. (2011). Guidance statement: Reuse of single use devices (2006), *Perioperative Standards and Recommended Practices*, (pp. 645-651). Denver, CO: AORN.
- B. U.S. Department of Health and Human Services, FDA U.S. Food and Drug Administration. (Document issued: July 30, 2001). Labeling recommendations for single-use devices reprocessed by third parties and hospitals; Final guidance for industry and FDA. Retrieved on 07/11/11 from <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm071058.htm>
- C. U.S. Department of Health and Human Services, FDA U.S. Food and Drug Administration. (Document issued: August 14, 2000). Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals. Retrieved on 07/11/11 from <http://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm107164.htm>
- D. U.S. Government Accountability Office. (January 2008). Report to the Committee on Oversight and Government Reform, House of Representatives. Reprocessed single-use medical devices. GSAO 08-147. Retrieved on 07/15/11 from <http://www.gao.gov/htext/d08147.html>

Approval Signatures

Step Description	Approver	Date
BoardApproval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
P&T/IPC	Kiri Golleher: Pharmacy Clinical Coordinator	8/4/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Aisha Huebner: Director Perioperative Services	6/24/2026

Standards

No standards are associated with this document

COPY



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

Owner	Terri Nielsen: Manager Clinical Research
Area	Clinical Research

Roles of Research Institutional Official and Human Research Protections Administrator

I. POLICY STATEMENT

- A. Salinas Valley Health is an institution engaged in research involving human subjects. Salinas Valley Memorial Healthcare System (dba Salinas Valley Health) is registered with the Office of Human Research Protections (OHRP) under a Federal wide Assurance (FWA) of Compliance, FWA # 00007215. The Salinas Valley Health Clinics (SVHC) are listed as component institutions under the SVMHS FWA.

II. PURPOSE

- A. To define and outline the responsibilities of two key oversight roles—Institutional Official (IO) and Human Research Protections Administrator (HRPA)—in ensuring the ethical conduct and regulatory compliance of human subjects research conducted on Salinas Valley Health premises.

III. DEFINITIONS

- A. Research Oversight Committee (ROC) - Salinas Valley Health's Human Research Protection Program (HRPP), a Sub-Committee of the Pharmacy & Therapeutics / Infection Control Committee (Medical Staff Bylaws section 10.14).

IV. GENERAL INFORMATION

- A. This policy applies to all company-affiliated locations (e.g., hospitals, medical clinics, administrative offices, etc.) engaged in exempt and non-exempt human subjects research under the U.S. Department of Health and Human Services (DHHS) Office for Human Research Protections (OHRP) regulations.

V. PROCEDURE

A. Identifying the Key Roles

1. The institution will designate two separate individuals to fulfill the roles of Institutional Officer and Human Research Protections Administrator.
2. The roles of IO and HRPA shall not be held by the same individual.
3. The IO shall not serve as a voting member of the Research Oversight Committee.
4. The Institutional Official shall receive copies of ROC meeting minutes and other significant reports necessary to support institutional oversight responsibilities.
5. The IO and HRPA shall collaborate to support the institution's Human Research Protection Program (HRPP) while maintaining appropriate separation between executive oversight responsibilities and day-to-day research administration activities.

B. Institutional Official (IO)

1. Purpose of Role

- a. Promotes a culture of conscience and ethical conduct in human subject research at the highest institutional level.
- b. Authorizes necessary administrative or legal actions to protect human research participants.
- c. Appoints the HRPA.

2. Criteria for Selection of IO

- a. A high-level facility official with a commitment to the ethical principles outlined in the Belmont Report and compliance with regulatory standards. Has authority to oversee the institution's research compliance programs. This person is usually the CEO, CCO, CMO, Ethics and Compliance Officer, or other high-ranking individual with authority to allocate institutional resources and support compliance activities.
- b. Unless otherwise designated in writing, the facility's CEO shall serve as the Institutional Official.

3. IO Role Responsibilities

- a. Oversees compliance with the Federal-wide Assurance (FWA) with the U.S. DHHS. The IO may delegate this responsibility to the HRPA.:
 - i. Ensures the institutional FWA is updated before expiration.
 - ii. Ensures the FWA is updated within 90 days of changes to the facility's legal name, the Human Protections Administrator, or

the Signatory Official.

- b. Ensures sufficient resources and institutional support to maintain a robust human subjects protection program.
- c. Maintains current CITI Program Institutional Official training, with renewal required every three (3) years.

C. Human Research Protections Administrator (HRPA)

1. Purpose of Role

- a. Serves as primary contact (for federal agencies, research participants, investigators, IRBs, etc.) for routine matters pertaining to human subject protections.
- b. Performs other activities pertaining to human subject protection as delegated by the Institutional Official.
- c. Ensures effective communication and coordination among stakeholders involved in human subjects protections, including investigators, research staff, IRBs, and federal agencies.
- d. Role of HRP is typically fulfilled by the Clinical Research Program manager as delegated by the IO.

2. HRP Role Responsibilities

- a. Maintains current CITI Program training, with renewal required every three (3) years, as follows:
 - i. HSR - IRB Members
 - ii. HSR - BIOMEDICAL Research
 - iii. GCP - Clinical Trials with Investigational Drugs and Medical Devices (U.S. FDA Focus)
 - iv. GCP - Social, Behavioral or Educational Research
- b. Ensures the ROC review of requests for determinations of whether an activity qualifies as research under the Common Rule, research not involving human subjects, and research exempt from IRB oversight.
- c. Validates IRB review by obtaining and/or maintaining copies of IRB approval letters.
- d. Maintains active and legacy research protocol databases.
- e. Advises key leadership on matters regarding research with human subjects.
- f. Provides local context and community attitudes information about

research to external IRBs.

- g. In conjunction with the IO, ensures that requirements regarding reporting to federal agencies is satisfied (i.e. unanticipated problems involving risks to human subjects or others, IRB actions/study terminations, etc.)
- h. Coordinates and periodically evaluates activities to enhance the public's understanding of clinical research via outreach activities proportional to the size and complexity of the research program. This can be as simple as providing pamphlets/brochures/website-links but can also be health fairs, coordinating our giving educational presentations, etc.

3. Criteria for HRP selection

- a. Possesses extensive knowledge and experience in the area of human subjects protections, including applicable regulations, ethical principles, and institutional policies.
- b. Demonstrates effective communication and organizational skills to liaise with diverse stakeholders.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. U.S. Department of Health and Human Services (HHS) at 45 CFR part 46
- B. Update or Renew a Federalwide Assurance (FWA) - Instructions: <https://www.hhs.gov/ohrp/register-irbs-and-obtain-fwass/fwass/update-renew-fwa/index.html>

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CCO	Timothy Albert: Chief Clinical Officer	7/29/2026
Research Oversight Committee	Cynthia Johnson: Contract Medical Librarian	7/29/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/24/2026

Standards

No standards are associated with this document

COPY



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

Owner Terri Nielsen:
 Manager
 Clinical
 Research
 Area Scopes Of
 Service

Scope of Service: Clinical Research Program

I. SCOPE OF SERVICE

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

The purpose of the Clinical Research Program is to enhance patient services and health programs that help SVH remain a leading provider of medical care.

II. GOALS

The Clinical Research Program develops goals to to enhance patient services that help SVH remain a leading provider of medical care. We do so by maintaining a diverse portfolio of clinical research protocols that align with our patient population.

The Clinical Research Program provides support, leadership, and regulatory oversight of high quality, ethical human research conducted on SVH premises, inclusive of the SVH Clinics, to support outpatients who have consented or are considering consent to participate in IRB-approved clinical research protocols and the principal investigators who wish to conduct research involving human subjects.

III. DEPARTMENT OBJECTIVES

- A. Support the SVH research community in the conduct of ethical clinical research and human subject protection in compliance with the required federal, state, and local regulations.
- B. Meet or exceed the educational standards established by the leading professional associations such as the Society of Clinical Research Associates (SOCRA) and the Association of Clinical Research Professionals (ACRP), to support the provision of high quality service with a focus on a collaborative, multi-disciplinary approach to support clinical research protocol compliance.
- C. To provide research education and training, develop policy and processes, and lead quality improvement efforts in areas of clinical trial management.

- D. To create an interdisciplinary collaborative environment in our organization, fostering best practices in the conduct of clinical research.
- E. To provide consultation on questions related to regulations and standards of practice governing human research.
- F. Community engagement: Educating the public about clinical research may help raise general awareness about the important role this research plays in safeguarding health and quality of life. Staff are available to volunteer for community education on clinical trials.
- G. ADDENDUM for compliance with the American College of Surgeons Commission on Cancer (ACS CoC) STANDARD 9.1: Clinical Research Accrual:⁸
 - 1. The National Comprehensive Cancer Network (NCCN) and the American College of Surgeons Commission on Cancer place a high value on cancer clinical trials. The NCCN Guidelines for all cancers are footnoted as follows: "NCCN believes that the best management of any cancer patient is in a clinical trial. Participation in clinical trials is especially encouraged." To implement the NCCN best practice guideline, the research staff screen 100% of patients seen at the Salinas Valley Health Cancer Care Clinic for eligibility in our cancer clinical trials. Research staff notify the treating oncologist of potentially eligible patients. If the physician refers the patient to Research Team, a Clinical Research Coordinator will reach out to the patient to begin the informed consent process.
 - 2. Patients are provided with clinical research information in easily accessible formats. Brochures are available in the Cancer Resource Center and the Salinas Valley Health Cancer Care Clinic in print, and digitally on the Salinas Valley Health public website. The Cancer Clinical Trials Brochure is provided in English, and in Spanish using an ISO-certified translation service. Additional venues of community information on clinical trials, such as are Salinas Valley Health public events, may be utilized so long as any public-facing clinical research information is approved by the governing research oversight body (IRB or ROC). The clinical research coordinator(s) are available Monday through Friday during regular business hours to answer research-related questions from patients and their family members.

IV. POPULATION SERVED

- A. The patient population includes research participants currently consented on an IRB-approved research protocol at SVH, and prospective research participants who may be eligible to enroll in current IRB-approved research protocols at SVH. In addition to patients who are receiving care from SVH, research participants may include employees and / or members of the community.
- B. The Clinical Research Program provides support to physician investigators who conduct, or wish to conduct, investigational drug or device trials under U.S. FDA oversight. Areas of support include clinical trial contract administration, research budget development with insurance coverage analyses, IRB submissions and correspondence, research regulatory compliance, management of external research audits and CAPA plans if indicated.
- C. Research involving human subjects at Salinas Valley Health falls in one of two categories: (1) biomedical, evaluating under FDA oversight the efficacy and safety of investigational drugs or devices; or (2) social-behavioral-educational, which applies the behavioral and social sciences to the study of humans and is not under FDA oversight.
- D. Note: SVH provides medical care to the forensic population of a California state prison, and this vulnerable population is categorically excluded from research participation at SVH: "Inasmuch as

prisoners may be under constraints because of their incarceration which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate as subjects in research, it is the purpose of this subpart to provide additional safeguards for the protection of prisoners involved in activities to which this subpart is applicable." (46 CFR 46.302)

V. DEPARTMENT INFORMATION

- A. Hours of Operation:
The Clinical Research Program provides services Monday through Friday from 8:00 a.m. to 5:00 p.m. Flexible hours are occasionally required; staffing requirements will be met by authorizing overtime and/or utilizing temporary services.
- B. Location of department:
450 E. Romie Lane, Salinas, CA 93901.
- C. Admission, Discharge, Transfer Criteria (not applicable)
- D. Major Services - not a patient care department

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

- A. Salinas Valley Health, inclusive of the SVH Clinics, is an institution engaged in research involving human subjects. Salinas Valley Health, as a Research Institution, bears responsibility for compliance with federal and California laws and regulations governing the conduct of such research. The Department of Health and Human Services (DHHS) and the Food and Drug Administration (FDA) provide the regulations for the performance of biomedical research activities involving human subjects. The FDA monitors biomedical research through review of required reports from investigators, sponsors, institutions and IRBs, as well as through a program of on-site inspections and audits.
- B. Salinas Valley Memorial Healthcare System (dba Salinas Valley Health) is registered with the Office of Human Research Protections (OHRP) under a Federal wide Assurance of Compliance: FWA # 00007215. The Salinas Valley Health Clinics (SVHC) are listed as component institutions under SVMHS FWA#00007215.
- C. SVH follows clinical research Good Clinical Practices (GCPs). GCPs are the international ethical and scientific quality standard for designing, conducting, monitoring, recording, auditing, analyzing and reporting trials that involve the participation of human subjects.
- D. The Clinical Research Program reports to the Research Program Manager. The Research Program reports to the Chief Medical Officer service line. It is the Research Program Manager's duty to attend all administrative and technical functions within the Clinical Research Program. All personnel within the Clinical Research Program are under the guidance and direction of the Research Program Manager. In the Manager's absence, the Chief Medical Officer fills the position.
- E. COMPLEXITY OF CARE PROVIDED:

SVH is a public health care district organized and operating pursuant to Division 23 of the California Health and Safety Code. Its Research Program is a community-based research site, and as such does not conduct Phase I "first in humans" research protocols. Phase II, Phase III and Phase IV protocols are evaluated and considered based on complexity as part of the pre-IRB feasibility assessment conducted by the Research Oversight Committee (ROC). Prior to ROC review, the Research Manager coordinates the feasibility assessment with relevant SVH

stakeholders and ensures protocols are aligned with current patient population, organizational mission, and available resources.

F. SVH ROC:

The ROC is Salinas Valley Health's Human Research Protection Program (HRPP), and is a Sub-Committee of the Pharmacy & Therapeutics / Infection Control Committee (Medical Staff Bylaws section 10.14).

G. The ROC reviews and approves research proposals by:

1. Considering how the research benefits the patient population that our district serves (Local Context)
2. Evaluating if the proposed research is compatible with the mission and vision of SVH
3. Directing the Research Program Manager to gather multidisciplinary teams to coordinate the health care district resources needed to complete research.

H. INSTITUTIONAL REVIEW BOARD (IRB) STRUCTURE FOR SVH:

Research at SVH is governed by two bodies to provide research oversight and guidance: (1) the ROC and (2) an external Institutional Review Board of Record. SVH does not have an in-house IRB, but has adopted the model that relies on an external, centralized Institutional Review Board (IRB) review process. "An IRB that is at a different location from the research site can review the research, provided that the IRB is competent to understand the local context of the research. As stated in 21 CFR 56.107(a), this would require sensitivity to community attitudes and the ability to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice."¹

- I. The IRB of Record for a biomedical research protocol is required to (1) have an institutional Reliance Agreement (RA) with SVH, (2) be registered with OHRP, and (3) hold current accreditation with the Association for the Accreditation of Human Research Protection Programs (AAHRPP). The RA sets forth the IRB's responsibilities and SVH's responsibilities, with a shared responsibility for Local Context Review.¹ SVH can have as many IRBs of Record as needed to support its research objectives, but must list each central IRB (with whom it holds a valid RA) under its FWA with the Office of Human Research Protections.

1. These are the 3 external IRB Reliance Agreements most frequently used at Salinas Valley Health:
 - a. Advarra IRB
 - b. WCG IRB
 - c. National Cancer Institute (NCI) CIRB

J. Research that may be exempt from IRB oversight:

At SVH, an IRB (with or without a reliance agreement with SVH) must make the determination of exemption from IRB oversight, approval and continuing review.

Under 45 CFR 46.101 (b), there are 6 categories of non-FDA regulated research for which an IRB will grant an exemption. Typically, the types of research at SVH that qualify for exemption are in Category 2 and Category 4.

Refer to Attachment: "Categories of Research that May be Exempt Under 46 CFR 14.101(b)."

K. Under this IRB oversight model, the ROC provides the mechanism to:

1. Ensure meaningful consideration of relevant local factors in conjunction with any central IRB with whom Salinas Valley Health holds an active Institutional Reliance Agreement in a shared responsibility for Local Context Review.
 - a. Addendum to this Scope of Service policy upholding the "Authorization Agreement and Division of Responsibilities Between the NCI Central Institutional Review Board and Salinas Valley Memorial Healthcare System (the Signatory Institution)" is as follows:
 - b. Excerpt from NCI CIRB Authorization Agreement: Salinas Valley Health ensures the safe and appropriate performance of the research at the Signatory Institution and at all Component Institutions (the Salinas Valley Health Clinics). This includes, but is not limited to:

Contractual Responsibility	Responsible party within our organization
Ensuring the initial and ongoing qualifications of investigators and research staff	Research Manager
Overseeing the conduct of the research	Principal Investigator in collaboration with the Research Manager
Monitoring protocol compliance	The ROC in collaboration with the Principal Investigator and the Research Manager
Maintaining compliance with state, local, or institutional requirements related to the protection of human subjects	Principal Investigator, Research Manager and Clinical Research Coordinators
Providing a mechanism to receive and address concerns from local study participants and others about the conduct of the research	The ROC, Salinas Valley Health's HRPP
Investigating, managing, and providing notification to the NCI CIRB of any study-specific incidence, experience, or outcome that seems to rise to the level of an unanticipated problem and/or serious or continuing noncompliance. When notifying the NCI CIRB of a potential unanticipated problem and/or serious or continuing noncompliance, the institution must provide a plan to manage the incident, experience, or outcome, including measures to prevent similar occurrence	Research Manager, Principal Investigators and Clinical Research Coordinators

NOTE: As part of ensuring safe and appropriate performance of research, the Signatory Institution has the authority to observe any aspect of the research

process including observing the consent process. The NCI CIRB retains the authority to direct this to be done when necessary.

2. Receive new research project proposals at SVH, to ensure alignment and harmony with the institution's mission and goals in advance of IRB submission, ensuring compliance with relevant local, state and federal laws and regulations.
3. Provide the SVH HRPP a venue to receive and review research-related reports. Some examples are: (a) adverse events, (b) research subject communications, and (c) current clinical trial accruals and closures.
4. The ROC also provides the venue for the SVH to uphold its institutional responsibility and authority to stop any current research conducted on SVH premises.

L. Composition

The ROC is composed of medical staff, clinical research, compliance, nursing, quality assurance, risk management, regulatory, and community members as required for submitted agenda item review. Ad hoc, non-voting representatives from applicable departments or services will be invited when research affecting the department or service will be discussed. The following roles are required to be identified by DHHS OHRP for the SVH ROC's HRPP:

1. Conflicts of Interests Officer: Corporate Compliance Director
2. HRPP Administrator: Executive Leader over Research Program
3. Organizational Signatory Official: Chief Medical Officer

M. Duties

1. To serve as the HRPP for Salinas Valley Health. The Committee meets regularly to review interim status reports submitted by the clinical research team on all active clinical trials under IRB oversight (with subjects in treatment or follow-up) pertaining to accrual, closure, research-related adverse events, protocol deviations, protocol violations, Good Clinical Practice noncompliance, and any change in the status of any principal investigator conducting research on Salinas Valley Health premises.
2. Review all proposed clinical/biomedical research protocols conducted on Salinas Valley Health premises prior to their submission for external Institutional Review Board approval. This review shall include hearing presentations by principal investigators seeking approval of studies. Evaluation of proposed studies shall consider matters of local context, such as applicable state and local laws/standards, consistency with institutional policy and capacity (i.e., staffing and resources), and consideration of local subjects.
3. Review all proposed Social Behavioral / Educational (SBE) Research conducted on Salinas Valley Health premises prior to being submitted for external Institutional Review Board approval. This review shall include hearing presentations by principal investigators seeking approval of studies. Evaluation of proposed studies shall consider matters of local context, such as applicable state and local laws/standards, consistency with institutional policy and capacity (i.e., staffing and resources), and consideration of local subjects. Proposed studies will be considered on a first-come, first-served basis.
4. Review all proposed Retrospective Records Review research prior to initiation. This may include hearing presentations by researchers seeking approval of studies.
5. Review all other research, evidence-based practice (EBP), quality improvement (QI)

- projects, and performance improvement (PI) projects and data management plans, which are all subject to HIPAA review.
6. Review all content that references SVH clinical research, clinical trials, or any specific clinical or social behavioral research under the oversight of the ROC, prior to its publication internally and externally.
 7. Facilitate referral to Research Manager any Research / Non-Research Determinations and Exempt Research Determinations in collaboration with external commercial IRB of record.
 8. Facilitate referral to Privacy Officer to Review / approve all projects with patient data collection, use and/or disclosure. Purpose: process for HIM to document HIPAA compliance for Salinas Valley Health, and identify/provide HIPAA compliance training needs as needed. Documentation is then available for external audit is needed.
 9. Review all proposed Humanitarian Use Device protocols prior to submission. This may include consideration of intended patient population at SVH, principal investigator credentialing, IRB submission, facilitating HUD PI and staff training with the device manufacturer, and coordination of cost analysis in collaboration with Supply Chain.
 10. In its role as HRPP, the ROC follows AAHRPP Level 0 criteria.²
 11. Serves as the venue to receive and address concerns from study participants and/or family members, community members and others about the conduct of research at Salinas Valley Health. The Salinas Valley Health Ethics Hotline is made available to our research participants in English and Spanish for identified or anonymous reporting.
 - a. Addendum for **"Authorization Agreement and Division of Responsibilities Between the NCI Central Institutional Review Board and the Signatory Institution:"** The study participant is provided, on the research informed consent form, four (4) mechanisms to address concerns about the conduct of the research at Salinas Valley Health: 1) Phone number for the Salinas Valley Health Principal Investigator that is available 24 hours/day, 7 days/week; 2) Phone number for clinical research staff available Monday-Friday during business hours; 3) Phone number for the NCI CIRB; and 4) Phone number for the Salinas Valley Health **Ethics Line** accessible to research participants and family members 24/7. These 4 methods to address any questions are explained to research participants as part of the research informed consent process.
 12. Monitor protocol compliance of all research at SVH.
 - a. Addendum for the PURCHASE SERVICES AGREEMENT between Salinas Valley Health and ECOG-ACRIN Cancer Research Group, our Master Clinical Trials Agreement for NCI-sponsored protocols: the Committee receives the report of the ECOG-ACRIN site monitoring Audit, which is conducted by the NCI National Clinical Trials Network (NCTN) and its Clinical Trials Monitoring Branch (CTMB) a minimum of every 3 years, and can be done at the discretion of NCTN at any intervening time with proper notice. The research staff uphold the NCTN and ECOG-ACRIN regulations and guidelines for protocol compliance. Areas of audit are: Regulatory, Study Drug Accountability and Clinical Case review.⁵
 13. The Committee receives reports regarding any:

- a. research-related serious adverse events involving participants enrolled at Salinas Valley Health
 - b. research protocol violations
 - c. clinical research Good Clinical Practice noncompliance
 - d. change in approved status of any principal investigator conducting research on SVH premises
14. The Committee delegates to the Research Program Manager the responsibility for verifying and collecting documentation of investigator credentials, licenses, curriculum vitae, human subject protections training and financial conflicts of interest disclosure; these are presented by the Manager to the ROC for approval.
 15. The Committee evaluates and recommends policy, procedure and other guidelines related to the research program.
 16. The Committee has directed that prior to submitting a new clinical trial to the IRB of Record, departmental feasibility assessment is required by means of a signature approval from department heads. An exception: oncology clinical trial feasibility is conducted in collaboration with the current Oncology Research Medical Director.

N. Meetings

1. The Committee shall meet as often as necessary, but at least quarterly.
2. The Committee shall maintain a record of its proceedings and shall report its activities to the Chief Medical Officer at least semiannually and the SVH Board of Directors at least annually.
3. The ROC Coordinator, functioning similarly to a Institutional Review Board (IRB) coordinator, plays a crucial role in managing the administrative and operational aspects of research oversight. They report to the ROC Chair and function under the direction of the Research Program Manager.

VII. REQUIREMENTS FOR STAFF

All individuals who provide Clinical Research Program services have the appropriate training and competence.

- A. Investigators: Prior to conducting research at SVH, Investigators in good standing³ must:
 1. Complete all training required by SVH and the protocol sponsor, including current certification of training in Human Subjects Protection and Good Clinical Practice (ICH and/or U.S. FDA standards).
 2. Submit the proposed study through the ROC process and the IRB of Record
 3. Receive approval from both governing bodies; report quarterly to ROC until final closure of study with the IRB.
- B. The Research Program Manager assumes twenty-four (24) hour responsibility for the Clinical Research Program.
- C. Clinical Research Coordinators: Prior to coordinating human subjects research at SVH, Clinical Research Coordinators must:
 1. Complete all training required by SVH and the protocol sponsor.

2. Document Investigator and sponsor approval by signing the Delegation of Authority Log.
3. Clinical Research Coordinators who are Registered Nurses are required to hold current California RN license.
4. Clinical Research Coordinators regardless of clinical experience are required to have:
 - a. Current Collaborative Institutional Training Initiative ("CITI") Program certificate of completion for 2 modules: (1) Protection of Human Subjects in Biomedical Research and (2) Good Clinical Practice (GCP) ICH E6
 - b. Current basic life support training certificate
 - c. Current International Air Transport Association (IATA) approved training in Shipping & Handling of Dangerous Goods
 - d. When qualified with 2 years' experience: certification in coordination of clinical research from accredited professional research organization: SOCRA or ACRP. (for example: CCRP, CCRA, and CCRC)

D. Administrative assistants are required to have:

1. Completion of competency-based department orientation
2. Completion of annual competency
3. Completion of computer competency and Microsoft Office Suite

E. Competency

Staff are required to have research competence in tasks necessary to serve our patient population. The required competency for staff depends primarily on their work areas and duties. Competency is assessed by the manager throughout the year on an as-needed basis, then summarized at the annual employee evaluation. Once a year staff are required to complete the on-line education modules that have been defined by the organization.

During the year, clinical research professional development activities and education are implemented for all department staff. This professional development is 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.

F. 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.

G. Continuing Education

Continuing education is required to maintain licenses / 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:

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

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

- A. Contracted services under this Scope of Service are maintained in Salinas Valley Health's electronic contract management system.
- B. Research financial and accounting support, statistician support, and other operational support may be acquired from time to time via professional services agreements with external vendors.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, the Clinical Research Program 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.

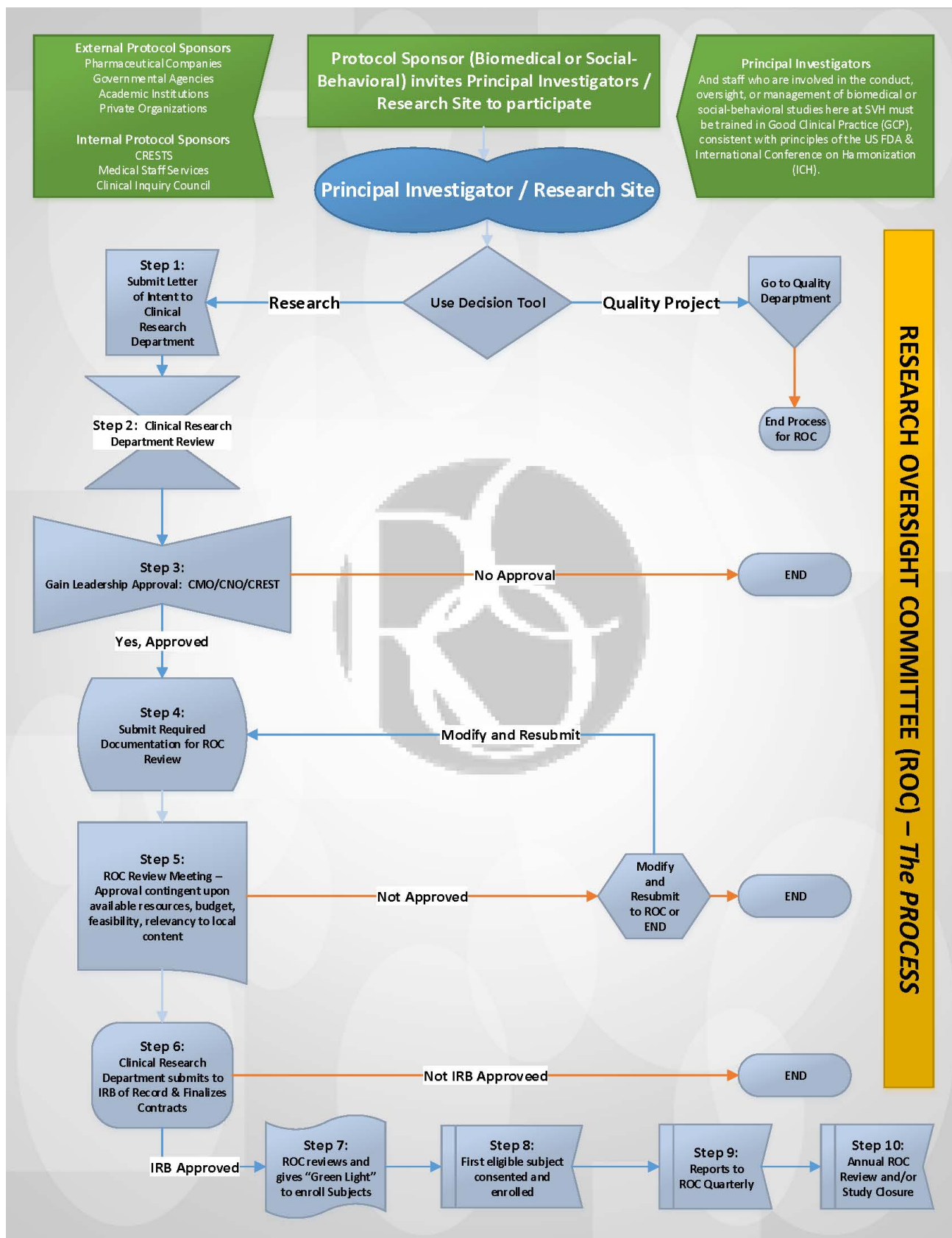
References:

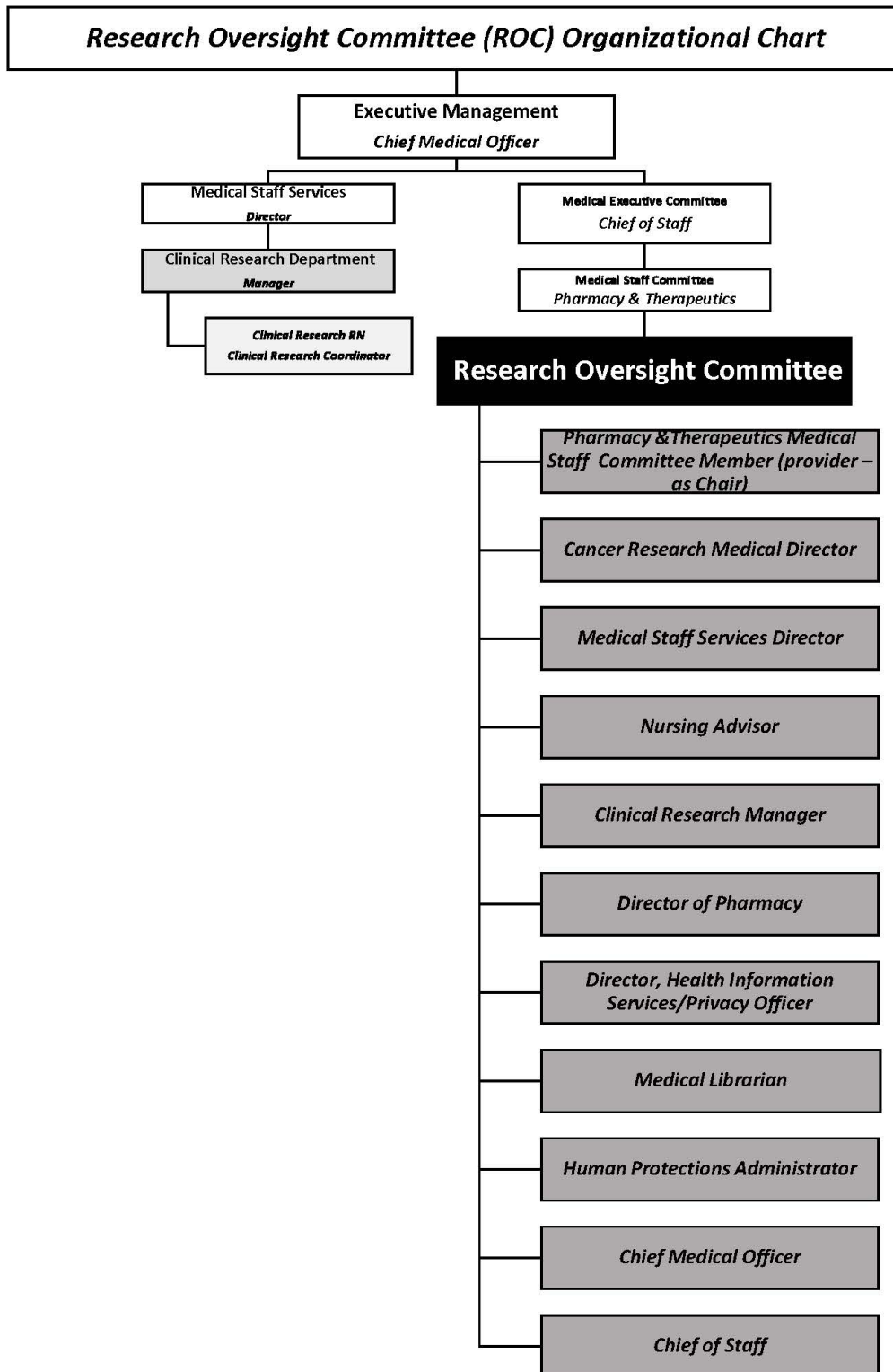
1. FDA Guidance document: "Using a Centralized IRB Review Process in Multicenter Clinical Trials," accessed on May 22, 2018: <http://www.fda.gov/RegulatoryInformation/Guidances/ucm127004.htm>
2. AAHRPP Level 0 criteria.
 - a. Accessed at: <https://www.aahrpp.org/>
3. U.S. Food and Drug Administration. 2017. Information Sheet Guidance for IRBs, Clinical Investigators, and Sponsors – FDA Inspections of Clinical Investigators. <https://www.fda.gov/ScienceResearch/SpecialTopics/RunningClinicalTrials/GuidancesInformationSheetsandNotices/ucm113709.htm>
4. ECOG-ACRIN Manual of Operations, v.6.2
 - a. The ECOG-ACRIN Cancer Research Group is a multidisciplinary, membership-based scientific organization that designs and conducts biomarker-driven cancer research involving adults who have or are at risk of developing cancer. ECOG-ACRIN has been awarded a grant by the National Cancer Institute as a member of NCI Clinical Trials

Network (NCTN).

- b. SVH has a master agreement with ECOG-ACRIN that allows our organization to open NCI-sponsored cancer protocols in Salinas, as an aligned affiliate of the Stanford Cancer Institute, an NCI Main Institution and grant awardee.
5. NCI Guidelines For Auditing Clinical Trials for the NCI National Clinical Trials Network (NCTN) Program, Community Clinical Oncology Program (CCOP) / NCI Community Oncology Research Program (NCORP) and Research Bases, v. 13
 - a. See link: <https://ctep.cancer.gov/branches/ctmb/>
6. Research advisory for California law: see Health & Safety Code Section 24172 (Calif. Experimental Subject's Bill of Rights), California Civil Code Section 56.11 (Font size requirement for HIPAA Authorization language must be 14 pt.). Accessed on May 24 2018 at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=24172.&lawCode=HSC
7. Office for Human Research Protections. Frequently Asked Questions (FAQs). Accessed June 2018 from: <https://www.hhs.gov/ohrp/regulations-and-policy/guidance/faq/index.html>
8. American College of Surgeons Commission on Cancer (ACS CoC) 2020 Standards for Accreditation - Optimal Resources for Cancer Care. Accessed on March 18, 2024 at: <https://www.facs.org/quality-programs/cancer-programs/commission-on-cancer/standards-and-resources/>

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Attachments

 [Categories of Research that may be Exempt under 45 CFR 46.101\(b\)](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Terri Nielsen: Manager Clinical Research	6/30/2026

Standards

No standards are associated with this document



Origination 7/2/2021
Approved N/A
Expires 1 year after approval

Owner Audrey Parks: Vice President Information Technology
Area Scopes Of Service

Scope of Service: Communications

I. SCOPE OF SERVICE

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

The purpose of Communications is to enhance patient services and health programs that help SVH remain a leading provider of medical care. The goal of Communications 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 goals and objectives of Salinas Valley Health, Communications develops goals to direct short-term projects and address opportunities evolving out of quality management activities. These goals will have input from other staff and leaders as appropriate and reflect commitment to annual hospital goals.

The goals of Communications Department are as follows:

- A. Provide Communications services to our physicians, staff, and the general public who call the main Hospital.
- B. Maintain sufficient equipment and supplies to adequately perform the Communications services offered to SVH patients and customers.

III. DEPARTMENT OBJECTIVES

- A. To support the objectives of Salinas Valley Health Medical Center.
- B. To support the objectives Salinas Valley Health Clinics.
- C. To deliver safe, effective, and appropriate service in a cost effective manner.
- D. To plan for the allocation of human/material resources.

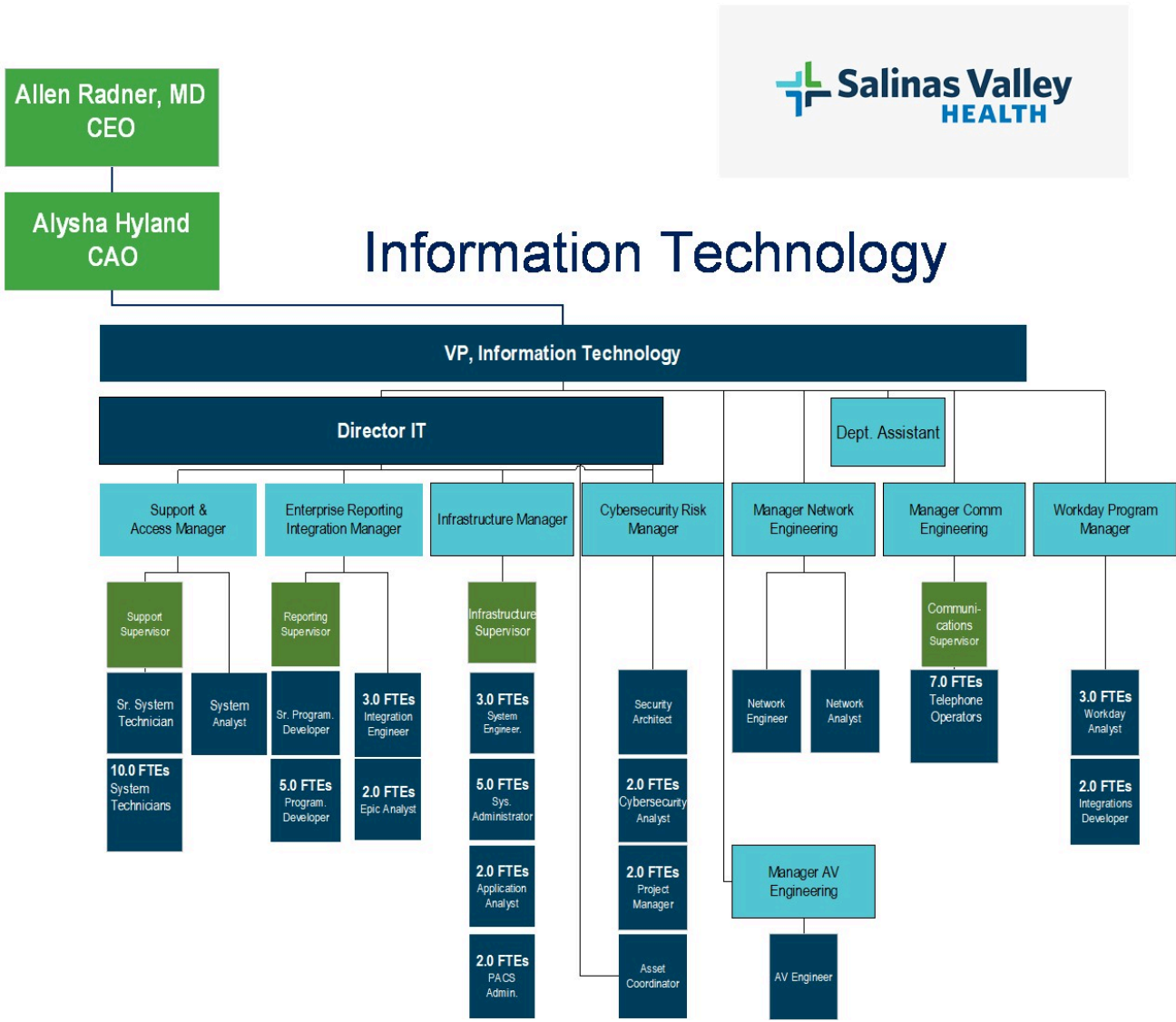
- E. To collect data about the department function, staff performance, and customer service for quality management purposes and continuous quality improvement.
- F. To develop/implement/evaluate standards utilized in customer service and telephone etiquette.
- G. To evaluate staff performance on an ongoing basis.
- H. To provide appropriate staff orientation and development.

IV. POPULATION SERVED

Non-Clinical:

Communications provides services to All Departments.

V. ORGANIZATION OF THE DEPARTMENT



- A. Hours of Operation:
Communications operates 24 hours per day, seven days per week, 365 days per year. There are times where the automated teller is utilized and primarily to relieve staff for breaks during non-peak

periods.

B. Location of department:

In the basement of the Downing Resource Center with an emergency switchboard located in the Breschini Energy Plant off of San Jose Street.

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

- A. Communications is part of Information Technology.
- B. Supervision of the Communications group is directly responsible to the Chief Information Officer. It is the Communication Supervisor's duty to attend to all administrative and technical functions within the department.
- C. All personnel within the department are under the guidance and direction of the Communications Supervisor. In the Supervisor's absence, the position is filled by the Chief Information Officer or their designee.

VII. REQUIREMENTS FOR STAFF

All individuals who provide Communications services have the appropriate training and competence

A. Licensure / Certifications:
N/A

B. Competency

Staff are required to have 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 required by the organization.

During the year, in-services are routinely conducted. 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. We communicate other internal and external continuing education opportunities to staff members.

C. Identification of Educational Needs

We identify educational needs of the staff utilizing inputs such as the following:

- 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, but not limited to the following:

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The 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:

- A. Communications staffing is based on call volume and activity.
- B. Staff include:
 1. Communications Supervisor
 2. Telephone Operators
- C. In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: 1 (Telephone Operator).

IX. CONTRACTED SERVICES

We maintain contracted services under this Scope of Service in the contract management system.

X. EVIDENCED BASED STANDARDS

The Salinas Valley Health staff will correctly and competently provide the right service, do the right

procedures, treatments, interventions, and care by following evidenced based policies and established practice standards to ensure patient safety. Efficacy and appropriateness of procedures, treatments, interventions, and care provided will be demonstrated based on patient assessments/reassessments, state of the art practice, desired outcomes and with respect to patient rights and confidentiality.

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

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

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

The Communications supports Salinas Valley Health'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.

We evaluate systems and services 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 Salinas Valley Health Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure, Communications 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

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 [Image 1](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Audrey Parks: Vice President Information Technology	6/16/2026

Standards

No standards are associated with this document

COPY



Origination 8/27/2021
Approved N/A
Expires 1 year after approval

Owner Audrey Parks: Vice President Information Technology
Area Scopes Of Service

Scope of Service: Information Technology

I. SCOPE OF SERVICE

Information Technology 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.

Information Technology is responsible for providing and maintaining reliable, secure and effective technology services to support the healthcare system's mission of delivering high-quality and safe patient care. This policy outlines the scope of services provided by Information Technology (IT), defining boundaries of its responsibilities and expectations of service delivery.

II. GOALS

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

The goal of Information Technology is to:

- A. Align information technology services and resources with the mission of Salinas Valley Health in support of a tightly integrated healthcare delivery system while balancing security, interoperability and information sharing for purposes of providing high quality, safe and cost effective healthcare at SVHMC.

III. DEPARTMENT OBJECTIVES

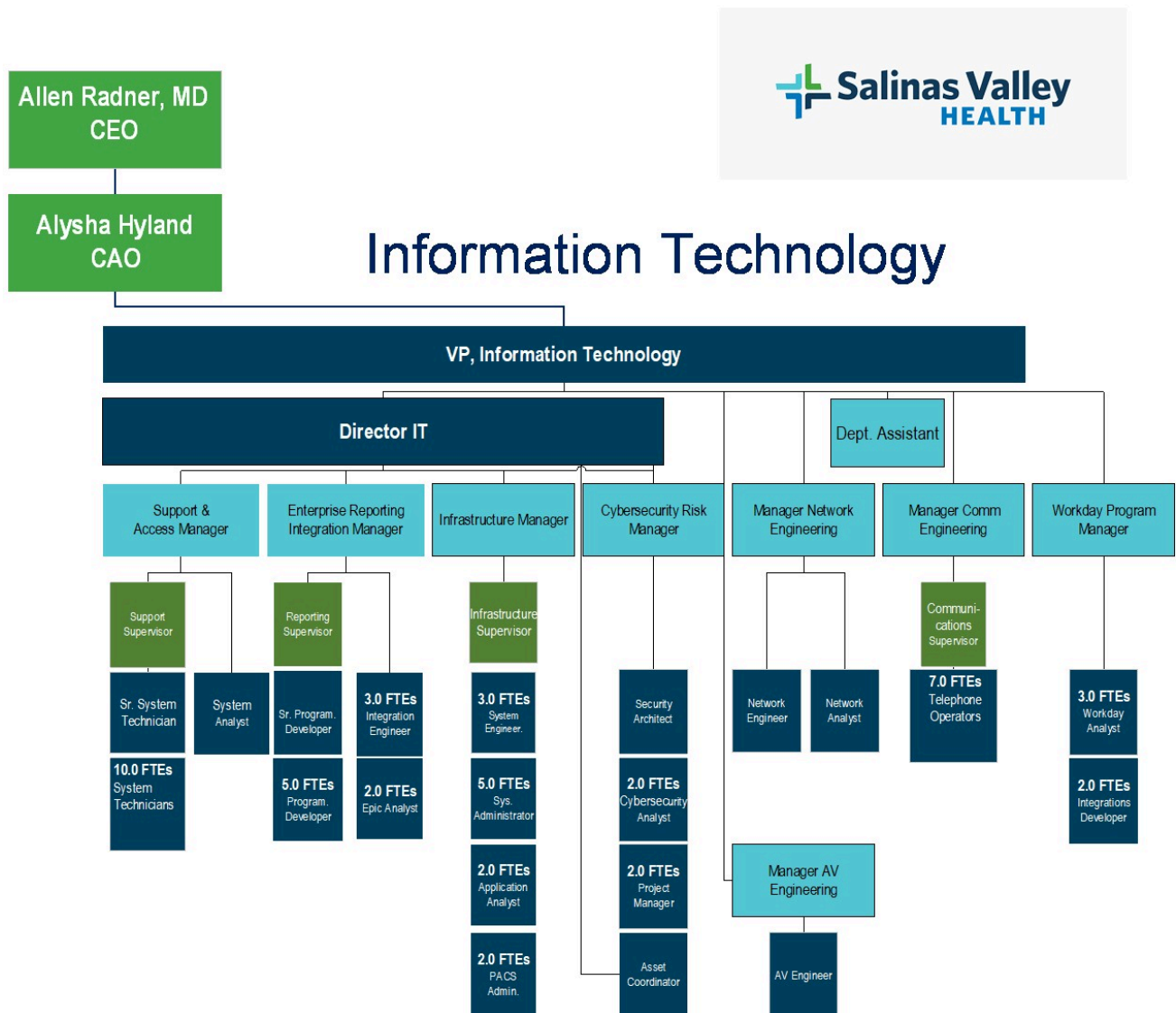
- A. Cybersecurity and risk management
- B. Data management and analytics
 - 1. Application support

2. To provide a tightly integrated information system to achieve meaningful use and effective decision support of our healthcare delivery team, including nurses, physicians and SVHMC partners.
- C. To lead and manage information systems procurement, adoption, support, and governance strategies.
- D. Infrastructure management
- E. To evaluate staff performance on an ongoing basis to ensure appropriate training and knowledge for the information services provided by IT.
- F. Project management
- G. Help Desk and end-user support

IV. POPULATION SERVED

1. Internal clients
 - a. Staff
 - b. Providers
 - c. Volunteers
 - d. Students
 - e. Salinas Valley Medical Clinic staff and associates
2. External clients
 - a. Vendors
 - b. Contractors

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation:

Information Technology (IT) is available during normal business hours with the exception of IT Help Desk and Communications. These services are available 24 x 7. IT provides Help Desk services each business day from 7:00 AM to 7:00 PM. Flexible hours are occasionally required; staffing requirements will be met by authorizing overtime and/or utilizing temporary services.

B. Location of department (s)

- 450 East Romie Lane, Salinas, CA 93901
- 420 East Romie Lane, Salinas, CA 93901
- 120 Wilgart Way, Salinas, CA 93901
- 928 E. Blanco Road, Salinas, CA 93901

C. Service request process: all requests for IT Services should be submitted through our established service request system to ensure proper tracking, prioritization and documentation of resolution of

requests.

- D. Service requests falling outside of the approved budget will require additional justification and approval.
- E. Notable exclusions for IT services include personally owned devices. However, Information Technology will provide guidance regarding secure access to organizational system and information resources.

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

- A. Information Technology serves regulatory and other Hospital wide initiatives including, but not limited to the following:
 - The Joint Commission accreditation
 - Unites States Department of Health & Human Services (HHS), Health Insurance Portability and Accountability Act (HIPAA) Security Rule
 - Centers for Medicare & Medicaid Services (CMS), Electronic Health Records (EHR) incentive program
 - Executive Steering Committee
- B. The Vice President of Information Technology or designee assumes twenty-four (24) hour responsibility for the department.
- C. The Vice President of Information Technology (VP, IT) is directly responsible to the Chief Administrative Officer. It is the VP, IT'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 VP of IT. In the VP of IT's absence, the position is filled by their designee. It is the designee's responsibility to carry out the duties of the VP of IT in his/her absence.

VII. REQUIREMENTS FOR STAFF

All individuals who provide Information Technology services have the appropriate training and competence. Please refer to individual job descriptions.

- A. Licensure / Certifications:

The basic requirement for the **System Technicians** and **Help Desk staff** includes a valid California Driver's License.

The **Systems Security staff** and **Cybersecurity Risk Manager** require Certified Information Systems Security Professional certificates.

- B. Competency

Staff are required to have 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.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the client or 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:

All Information Technology staff are generally scheduled to be at work during normal business hours with two exceptions, Communications and Technical Services. Communications is scheduled 24 x 7 with at least one Communications Operator per shift. Technical Services is scheduled from 7 AM to 7 PM on each

business day while on-call outside of these hours.

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

1 Manager / Supervisor

1 Network Engineer

1 Cybersecurity Analyst

2 System Technicians

1 Communications Operator

Additionally, key staff to support any effected critical applications and the Hospital Emergency Incident Command System (HEICS).

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.

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

Information Technology 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 needs of clients or patients 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, Information Technology 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

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Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Audrey Parks: Vice President Information Technology	6/16/2026

Standards

No standards are associated with this document



Origination7/24/2020

ApprovedN/A

Expires1 year after approval

OwnerMarian Fox:
Clinical
Manager

AreaScopes Of
Service

Scope of Services: Transport

I. SCOPE OF SERVICE

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

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

Transport is delivered by a multidisciplinary team comprised of transporters, registered nurses, and ancillary support (RT, CNA, etc.) according to the needs of the patient. A registered nurse will accompany Telemetry patients from one location to another to maintain same level of care.

The department provides services seven days a week. Weekdays 0600-2300 and 0700-2300 on weekends.

II. GOALS

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

The goal(s) of Transport Services is to:

- A. To provide high quality transport services to inpatients and outpatients in a safe, professional, and expedient manner.
- B. Ensure proper resuscitative and monitoring equipment is immediately available.

III. DEPARTMENT OBJECTIVES

- A. To support SVHMC objectives.
- B. To support the delivery of safe, effective, and appropriate care / service in a cost effective manner.
- C. To 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.
- D. To support the provision of a therapeutic environment appropriate for the population in order to promote healing of the whole person.
- E. To evaluate staff performance on an ongoing basis.
- F. To provide appropriate staff orientation and development.
- G. To monitor Transport Services function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical: Transport Services provides care for infant, pediatric, adolescent, adult and geriatric patients.

Non-Clinical: N/A

Transport Services provides services including but not limited to: N/A

V. ORGANIZATION OF THE DEPARTMENT

- A. Hours of Operation
The Department provides services seven days a week; 0600-2300 weekdays and 0700-2300 on weekends
- B. Transport Services is a virtual department managed through nursing administration.
- C. Major Services / Modalities of care may include:
Patient safety during transport in collaboration with nursing staff. Transporters are trained to provide groin and body preps for cardiac catheterization or surgical procedures.

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

Care is delivered by a multidisciplinary team comprised of transporters, registered nurses and ancillary support according to the needs of the patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

VII. REQUIREMENTS FOR STAFF

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

The Department follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with BCLS.

A. Licensure / Certifications:

The basic requirements for **Transporters** include:

1. CNA Certification
2. Current BLS
3. Completion of competency-based orientation
4. Completion of annual competency

B. Competency

Staff are required to have routine competence assessments 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, videoconferences, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The 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:

In the event of a severe emergency, patients will be transported by the clinical staff throughout the hospital similar to after hour process:

Assignments are made based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. Staffing is based on patient volume and acuity.

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

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

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

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

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Transport Services 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

 [Image 1](#)

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
LWG	Rebecca Alaga: Regulatory/ Accreditation Coordinator	8/17/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/31/2026
Policy Owner	Marian Fox: Clinical Manager	6/16/2026

Standards

No standards are associated with this document

COPY



Origination 10/1/2021
Approved N/A
Expires 3 years after approval

Owner Terri Nielsen:
Manager Clinical Research
Area Clinical Research

Shipping of Hazardous Materials for Clinical Research Studies at SVHMC

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To describe the requirements for shipping of dangerous goods/hazardous materials.

III. DEFINITIONS

- A. Dangerous goods, hazardous materials and infectious substances (blood and blood products) have the same meaning. Dangerous Goods are articles or substances which are capable of posing a significant risk to health, safety or property when transported including infectious substances, diagnostic specimens (including excreta, secret, blood, blood components, tissue and tissue fluids), biologic products and dry ice.
- B. DOT – Department of Transportation
- C. IATA – International Air Transportation Association – the trade association of the major airlines.
- D. DGR – Dangerous Goods Regulations
- E. CFR – Code of Federal Regulations
- F. Class 6, Division 6.2 Definitions are found at 49 CFR §173.134
 - 1. Class 6, Division 6.2, **Category B** - An infectious substance that is not in a form generally capable of causing permanent disability or life-threatening or fatal disease in otherwise healthy humans or animals when exposure to it occurs. This includes Category B infectious substances transported for diagnostic or investigational

purposes. A Category B infectious substance must be described as "Biological substance, Category B" and assigned identification number **UN 3373**.

2. Class 6, Division 6.2, **Category A**: An infectious substance in a form capable of causing permanent disability or life-threatening or fatal disease in otherwise healthy humans or animals when exposure to it occurs. An exposure occurs when an infectious substance is released outside of its protective packaging, resulting in physical contact with humans or animals. Salinas Valley Health Medical Center (SVHMC) DOES NOT CONDUCT CLINICAL TRIALS INVOLVING Category A Infectious Substances.

IV. GENERAL INFORMATION

- A. This process applies to all clinical research personnel who handle, prepare for transport, or cause dangerous goods to be transported. Research staff shall not transport unpackaged hazardous materials in private vehicles, facility-owned vehicles or via any other mode of transportation.
- B. It is the Research Site's responsibility to assure that employees are adequately trained. Staff who will be dealing with the shipment of hazardous materials must complete appropriate education prior to engaging in the packaging and shipment of hazardous materials.

V. PROCEDURE

- A. Prior to conducting the clinical investigation, the principal investigator and/or staff will be trained and certified for shipment of Class 6.2 hazardous goods. Employees who package substances classified by the Department of Transportation as Class 6.2 Category B Infectious Substances for shipment receive training consistent with the applicable regulations (49 CFR §171-180, 42 CFR 72). SVHMC does not conduct clinical trials involving Category A Infectious Substances, but Clinical Research Coordinators are required to be trained for shipment of BOTH and able to differentiate the two classes.
- B. Only personnel who have completed approved educational programs may perform this function. Documentation of required education shall be maintained in the Research Department staff education file. During the site initiation or training for a new study, the Research Manager / designee will obtain from the Sponsor any information specific to the handling of hazardous materials for the study, including the procurement and shipping of dangerous goods, and / or specimens or materials that require dry ice. The Research Manager / Designee will obtain the proper packaging or shipping materials, containers, labels and account numbers that meet the requirements of the regulations. In most cases, the study Sponsor will provide the specimen collection and shipping materials. Alternatively, the clinical trial agreement (such as NCI sponsored trials with ECOG-ACRIN) may require that SVHMC Research Program provide the specimen collection and shipping materials.
- C. The shipper of hazardous materials (in this case, the SVHMC Research Department) will classify, identify, package, mark, label and document shipments for transport by air or surface according to the regulations.
- D. The principal investigator or Clinical Research Coordinator will maintain appropriate records by keeping copies of the Shipper's Declaration and Waybill in the study files for each shipment.
- E. If dry ice is needed, it will be ordered through SVHMC Supply Chain, with a minimum of 24

hours' notice prior to the anticipated shipment date. All routine research specimen shipments will be made Monday through Thursday, via an overnight courier such as FedEx or UPS.

- F. The Clinical Research Coordinator will arrange for and track the specimen shipment through Delivery and maintain such documentation in the research participant's investigative site file.
- G. Documentation:
 - 1. Study related roles and duties will be documented in Delegation of Authority Logs and Signature Logs as required by individual studies/protocols.
 - 2. Records related to shipping of hazardous materials shall be maintained per CFR 49 and local guidelines in addition to study protocol requirements.
 - 3. Copy of all shipping documents will be kept with study materials.

VI. EDUCATION/TRAINING

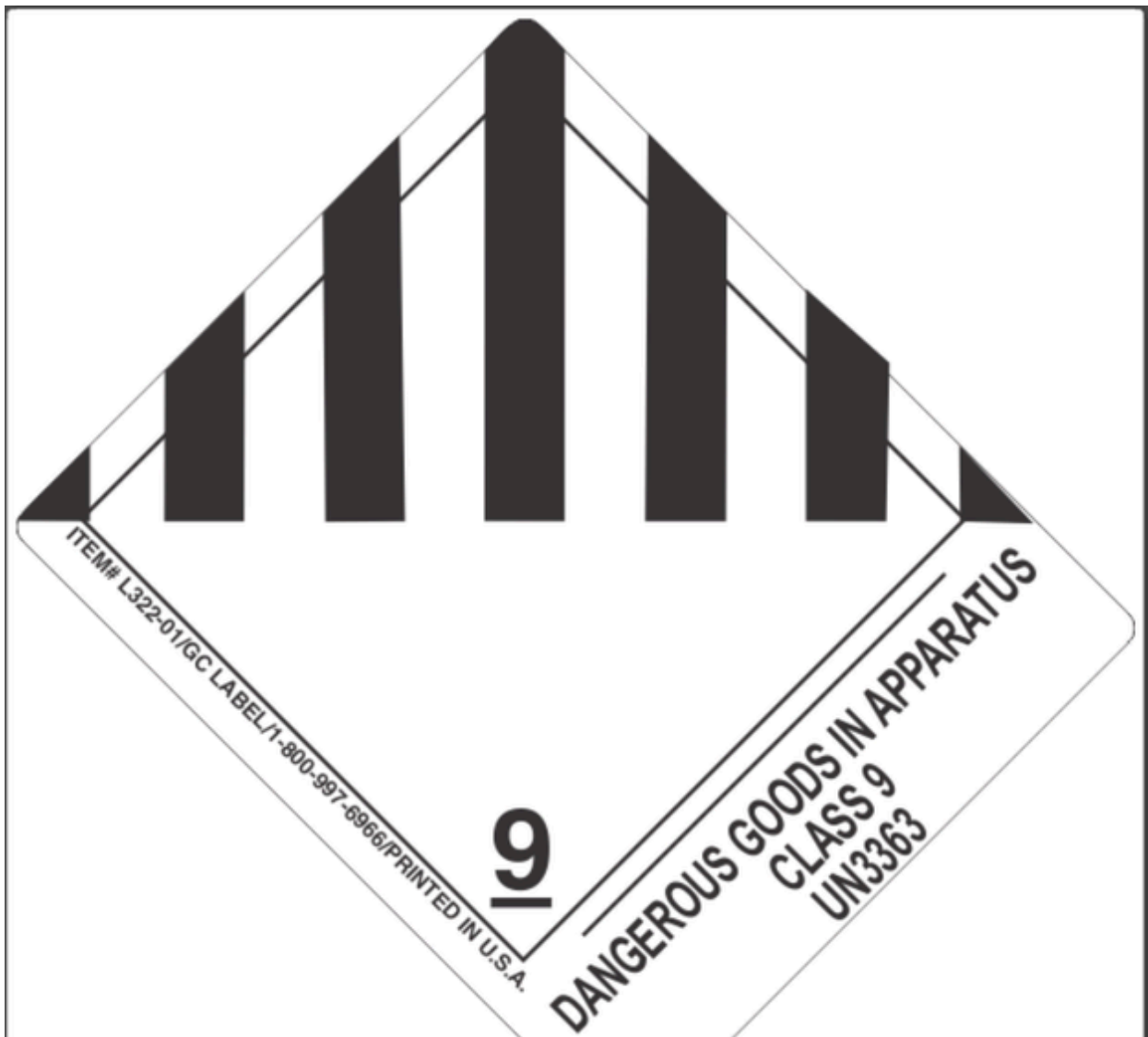
- A. Education and/ or training is provided as necessary.

VII. REFERENCES

- A. US Department of Transportation PHMSA. 49 CFR§17 - §173.199 Category B Infectious substances. Retrieved June 21, 2021 from: <https://www.govinfo.gov/content/pkg/CFR-2010-title49-vol2/pdf/CFR-2010-title49-vol2-sec173-199.pdf>

Table 1. Sample of required UN3363 Label for Category B Shipping box:

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Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CCO	Timothy Albert: Chief Clinical Officer/Chief Innovation Officer	8/4/2026
Research Oversight Committee	Cynthia Johnson: Contract Medical Librarian	7/29/2026
Policy Committee	Rebecca Alaga: Regulatory/	7/10/2026

Policy Owner

Accreditation Coordinator

Terri Nielsen: Manager Clinical
Research

5/5/2026

Standards

No standards are associated with this document

COPY



Origination 1/4/2022
Approved N/A
Expires 2 years after approval

Owner **Megan Giovanetti:**
Director
Cardiovascular Services and Sleep

Area **Cardiology Departments**

Transthoracic Echocardiogram Protocol for the Adult Patient

I. POLICY STATEMENT

A. N/A

II. PURPOSE

- A. To provide guidelines for the Cardiac Sonographer to ensure completeness of the transthoracic echocardiogram, optimally image, identify, measure and determine functionality of cardiac structures.

III. DEFINITIONS

A. 2D	two dimensional
B. AV	aortic valve
C. MV	mitral valve
D. TV	tricuspid valve
E. PV	pulmonic valve
F. PA	pulmonary artery
G. PLAX	parasternal long axis
H. PSAX	parasternal short axis
I. LVOT	left ventricular outflow tract
J. IVS	inter-ventricular septum

K. LVID	left ventricle internal dimension
L. LVPW	left ventricular posterior wall
M. TR	tricuspid regurgitation
N. MR	mitral regurgitation
O. PI	pulmonic insufficiency
P. RVSP	right ventricular systolic pressure
Q. PHT	pressure half-time
R. AS	aortic stenosis
S. MS	mitral stenosis
T. EF	ejection fraction
U. PW	pulsed wave
V. CW	continuous wave
W. IVC	inferior vena cava
X. SSN	suprasternal notch
Y. RAP	right atrial pressure
Z. SAM	Systolic anterior motion

IV. GENERAL INFORMATION

- A. The cardiac sonographer will perform all transthoracic echocardiograms in a timely, professional manner while working with physicians and other health care professionals to provide quality diagnostic testing.
- B. The cardiac sonographer will follow the transthoracic echocardiogram protocol of this document to the best of their ability.

V. PROCEDURE

A. Pre-Exam Preparation:

1. Review order, verify indication, clarify with physician if necessary
2. Check for previous studies, review key elements, co-morbidities
3. Enter patient demographic information from pick-list query or enter manually (name, medical record number, DOB (Date of birth), height, weight, blood pressure)

B. Exam Preparation:

1. The patient should be correctly identified by two patient identifiers prior to beginning exam.
2. Use Universal Precautions.
3. The patient should be hooked up to a three lead ECG (Electrocardiogram) and rolled into the left lateral decubitus position to begin the exam. Use 2 beat capture for patients in sinus rhythm. Use 3 beat capture for patients with any irregular rhythm. A

continuous loop capture of 5-10 seconds is used for bubble studies.

4. All exams should include the standard views. The technologist may vary the sequence and content under technically difficult circumstances or life threatening situations. Such changes should be noted before the exam is reviewed by the cardiologist.
5. In the event that certain views cannot be obtained, every effort should be made by the technologist to complete the exam (i.e. consider use of contrast agent, off axis images, etc.).
6. All measurements are to be made using 2D. M-Mode may be used to demonstrate certain pathology (SAM, pre-closure AV, septal bounce, etc.).
7. Optimize 2D images, color Doppler, and spectral Doppler:
 - a. Narrow sector to optimize frame rate
 - b. Adjust sweep speed to optimize modality: respirophasic changes, timing measurements, Doppler measurements.
 - c. Use proper settings of scale, gain, filter, compress, and reject when applying Doppler and color flow Doppler.
 - d. All measurements to be frozen and acquired.

C. Standard views and measurements protocol:

1. Parasternal Long Axis:

- a. 2D at increased depth to look for pericardial and pleural effusions
- b. 2D capture at decreased depth
- c. Color flow Doppler of AV, MV and ventricular septum (ventricular septum should be interrogated from at least one view: PLAX, PSAX, apical-4, subcostal)
- d. 2D ascending aorta in modified long axis. Measure aortic root at sinuses, inner edge to inner edge. Measure ascending aorta leading edge to leading edge.
- e. Use zoom to view the AV, MV and LVOT
- f. Measure the LVOT diameter in systole as pathology indicates.
- g. 2D measurements at the level of the chordae of IVSd, LVIDd, LVPWd, LVIDs.

2. Right Ventricular Outflow (if obtainable):

- a. 2D with and without color flow Doppler

3. Right Ventricular Inflow:

- a. 2D with and without color flow Doppler
- b. If TR is present, CW Doppler through the jet and measure for RVSP

4. Parasternal Short Axis: AV level:

- a. 2D with and without color flow (AV, PV, TV)

- b. Color flow Doppler of the IAS (should be interrogated in at least one view: PSAX, apical-4, subcostal)
- c. Angle superiorly to view the PA bifurcation
- d. PW Doppler through the PA/PV, VTI of RVOT, CW of PA/PV
- e. If TR is present, CW Doppler through the jet and measure for RVSP

5. Parasternal Short Axis/Left Ventricle:

- a. 2D at the basal/MV, papillary muscle and apical levels
- b. Color Doppler at the MV level in the presence of MV disease as needed

6. Apical Four Chamber:

- a. 2D with and without color flow Doppler over MV, TV, IVS, IAS
- b. PW of the MV at leaflet tips, measure E and A wave velocities, deceleration time, perform valsalva maneuver when necessary to clarify diastology interpretation
- c. PW Doppler of at least one pulmonary vein
- d. Tissue Doppler of septal and lateral mitral annulus, when possible, measure E' for E/E' ratio
- e. If TR is present, CW Doppler through the jet and measure for RVSP
- f. Trace left ventricular volumes in diastole and systole for Simpson's biplane ejection fraction (preferred method for EF calculation whenever possible)
- g. Trace right and left atrial volumes at end systole
- h. In an RV focused apical-4 view, measure the mid portion of the RV in diastole

7. Apical Five Chamber:

- a. 2D with and without color flow Doppler of the AV
- b. PW Doppler LVOT
- c. CW Doppler AV

8. Apical Two Chamber:

- a. 2D with and without color flow Doppler of the MV
- b. Trace left ventricular volumes in diastole and systole for Simpson's biplane ejection fraction
- c. Trace left atrial volume for biplane indexed volume

9. Apical Three Chamber/ Apical Long Axis:

- a. 2D with and without color Doppler of the MV and AV

10. Subcostal View and IVC:

- a. Increase depth to look for effusions
- b. Color Doppler of the IAS, IVS

- c. 2D of the inferior vena cava and hepatic vein, record loop or M-mode of expiration and inspiration, measure IVC diameter
- d. Color Doppler of the IVC and hepatic vein as needed
- e. PW Doppler of the hepatic vein as needed
- f. 2D of the abdominal aorta when possible, color Doppler as needed
- g. PW Doppler of descending aorta as needed
- h. Perform 2D, color Doppler in subcostal short axis as needed

11. Suprasternal Notch (as needed):

- a. 2D and color Doppler of the aortic arch and upper descending aorta as needed
- b. CW/Pedoff Doppler as needed
- c. SVC flow when IVC not obtained from subcostal view

12. Right Parasternal (aortic stenosis cases only):

- a. Position patient right lateral decubitus
- b. CW/Pedoff Doppler as needed

13. 4D:

- a. Acquire images for full volume ejection fraction when possible and as needed (regional wall motion abnormality, cardiomyopathy, chemotherapy, etc.)
- b. Acquire images as an adjunct to 2D imaging as pathology indicates

14. AFI:

- a. Acquire 2D apical-4, apical-2, apical long or 4D triplane for calculation of global longitudinal strain as needed (required for all chemotherapy patients when possible)

15. Saline Contrast:

- a. Perform saline contrast for all procedures with stroke or TIA as indication if <60 years of age, unknown reason for RV and RA dilation, suspected atrial septal defect

16. Ultrasound Enhancing Agent

- a. Determine the need for ultrasound enhancement agent (UEA), refer to Policy 1101. [USE OF ULTRASOUND ENHANCEMENT WITH ECHOCARDIOGRAPHY](#)
- b. Acquire enhanced 2D images and Doppler data as needed.

D. Documentation

- 1. Cardiac Sonographers will document preliminary echocardiogram findings in the PACS for reading cardiology physician review only. Sonographer prepared preliminary reports are not distributed under any circumstance.

2. Any potential life-threatening findings will be communicated immediately to the reading cardiologist.
3. Any critical test results will be communicated to the reading cardiologist as required according to the CRITICAL RESULTS OF TESTS AND DIAGNOSTIC PROCEDURES #28.

E. Specific Pathology

1. Aortic Stenosis

- a. With Zoom, measure LVOT diameter in PLAX view
- b. In Apical-5 view, obtain and trace the PW Doppler of the aortic outflow paying close attention to proper sample volume placement
- c. In Apical-5 view obtain and trace the CW Doppler of aortic flow for calculation of aortic valve area by the continuity equation
- d. In Apical long axis view perform PW and CW Doppler of the aortic flow
- e. Utilize the Pedoff probe (dedicated non-imaging probe) to obtain the highest velocity of the aortic flow from apex, suprasternal notch and right parasternal
- f. In PSAX planimeter the aortic valve area whenever possible
- g. In the SSN view 2D image the arch, color Doppler the arch and descending aorta, CW Doppler the descending aorta
- h. Measure and report peak and mean gradients, non-dimensional severity index, aortic valve area by the continuity equation and by aortic valve area by planimetry

2. Aortic Regurgitation

- a. Image the morphology of the regurgitation and co-existing pathologies (AS, coarctation, bicuspid AV, etc.)
- b. Measure deceleration slope for deceleration time calculation from CW Doppler in apical 4 or apical long axis views
- c. Measure vena contracta and JH/LVOT from PLAX
- d. Perform PW Doppler in the descending aorta (subcostal or SSN views) to evaluate for diastolic flow reversal when greater than mild regurgitation

3. Prosthetic Aortic Valve

- a. Size, type and date of implantation of the prosthesis should be noted in the report when available
- b. Measure and report peak velocity, mean gradient, acceleration time and dimensionless index with CW Doppler from apical-5, apical long axis, right parasternal and SSN
- c. Investigate for regurgitation and peri-prosthetic leaks with color Doppler

4. Pulmonic Stenosis

- a. Measure and report peak and mean gradient with CW Doppler from PSAX

or right ventricular outflow view

5. Mitral Stenosis

- a. Image the morphology of the valve including subvalvular apparatus, utilize the Zoom feature
- b. Using CW Doppler trace the mitral inflow for peak and mean gradients
- c. Using CW Doppler measure deceleration slope for pressure half-time
- d. In PSAX planimeter the mitral valve area whenever possible

6. Mitral Regurgitation

- a. Image the morphology of the regurgitation, utilize the Zoom feature
- b. Demonstrate the origin and direction of the regurgitation with color Doppler
- c. For mitral regurgitation that is moderate or more, consider quantification by PISA
- d. Obtain pulmonary venous flow with focus on systolic component when possible

7. Prosthetic Mitral Valve

- a. Size, type and date of implantation of the prosthesis should be noted in the report when available
- b. Using CW Doppler measure and report peak gradient, mean gradient and PHT
- c. Investigate for regurgitation and peri-prosthetic leaks with color Doppler

F. Tricuspid Regurgitation

1. Image the morphology of the regurgitation
2. Demonstrate the origin and direction of the regurgitation with color Doppler
3. Use CW Doppler and measure peak regurgitant velocity for the estimation of RVSP from numerous views (RV inflow, PSAX, apical-4)

G. RVSP/PASP Calculation

1. Image and measure the IVC using 2D or M-mode for estimation of right atrial pressure:
2. IVC normal in size, normal inspiratory collapse, RAP 3mmHg
3. IVC normal in size, poor inspiratory collapse, RAP 3-8mmHg
4. IVC dilated in size, normal inspiratory collapse, RAP 8mmHg
5. IVC dilated in size, poor inspiratory collapse, RAP 15mmHg
6. Use the highest CW Doppler tricuspid regurgitation velocity obtained from multiple views to estimate RV-RA gradient using Modified Bernoulli equation
7. If severe TR is present, perform 2D, color Doppler and PW Doppler of the hepatic vein for systolic flow reversal

H. Pericardial Effusion

1. If cardiac tamponade is in question, use 2D and M-mode, in multiple views to evaluate for RV and RA chamber collapse
2. Image the IVC
3. Using PW Doppler and the respirometer evaluate for changes in inspiration and expiration
 - a. TV E wave inflow increase with the first beat of expiration of at least 30% (exp-insp/exp)
 - b. MV E wave inflow decrease with the first beat of expiration of at least 60% (exp-insp/exp)
 - c. increase in RV chamber size with inspiration
 - d. Decrease in LV chamber size with inspiration
 - e. Hepatic vein flow blunting or reversal of diastolic flows in expiration
4. Optimize sweep speeds and scale to best demonstrate waveforms and respirophasic changes

I. Constrictive Pericarditis

1. Use 2D and M-mode in multiple views to evaluate abnormal septal motion
2. Image the IVC
3. Using PW Doppler and the respirometer evaluate for changes in inspiration and expiration:
 - a. TV E wave inflow decrease with the first beat of expiration of at least 40%
 - b. MV E wave inflow usually increases with first beat of expiration
 - c. Hepatic vein diastolic flow reversal increases in expiration
4. Tissue Doppler of both septal and lateral mitral annulus (lateral velocity will not be higher than septal)
5. PW Doppler of hepatic venous flow
 - a. S and D velocities increase with inspiration
 - b. D wave decreases with expiration
 - c. pronounced or increased diastolic flow reversals
 - d. CW Doppler of Pulmonic insufficiency demonstrates an abrupt decline after early diastole and remains low
6. Transcatheter Aortic Valve Replacement or Rapid Deployment Aortic Valve Replacement
 - a. Size, type and date of implantation of the prosthesis should be noted in the report when available
 - b. Measure and report peak velocity, mean gradient, acceleration time and dimensionless index with CW Doppler from apical-5, apical long axis, right parasternal and SSN

- c. Investigate for regurgitation, peri-prosthetic leaks and degree of annular sealing with Color Doppler
 - d. Using Color Doppler assess interatrial septum for evidence of persistent shunt
7. Left Atrial Appendage Occluder Device
- a. Using 2D assess device for stability, migration, and erosion into surrounding structures
 - b. Using 2D assess atrial surface of device for thrombus
 - c. Using Color Doppler assess for peri-device leak
 - d. Using Color Doppler assess interatrial septum for evidence of persistent shunt
 - e. Using PW Doppler check for disruption of transmitral flow
 - f. Using PW Doppler assess pulmonary vein flow (particularly LUPV)

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. Recommendations for the Evaluation of Left Ventricular Diastolic Function by Echocardiography: An Update from the American Society of Echocardiography and the European Association of Cardiovascular Imaging, JASE, April 2016
- B. Recommendations on the Echocardiographic Assessment of Aortic Valve Stenosis: A Focused Update from the European Association of Cardiovascular Imaging and the American Society of Echocardiography, JASE, April 2017
- C. Guidelines for the Evaluation of Valvular Regurgitation After Percutaneous Valve Repair or Replacement, JASE, April 2019
- D. Clinical Applications of Ultrasonic Enhancing Agents (UEA) in Echocardiography 2018 Update, JASE, March 2018
- E. **Guidelines for the Standardization of Adult Echocardiography Reporting: Recommendations From the American Society of Echocardiography, JASE, September 2025**

Approval Signatures

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

Cath Lab Medical Director - Dr. Zetterland	Megan Giovanetti: Director Cardiovascular Services and Sleep	7/14/2026
COO	Clement Miller: Chief Operating Officer	6/9/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/9/2026
Policy Owner	Megan Giovanetti: Director Cardiovascular Services and Sleep	6/9/2026

Standards

No standards are associated with this document

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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

Approved N/A

Expires N/A

Owner Brenda
Inman: Vice
President
Quality and
Risk
Management

Area Plans and
Program

Quality Assessment and Performance Improvement Plan

I. SCOPE/PURPOSE

- A. The Purpose of the Organizational Quality Assessment and Performance Improvement (QAPI) Plan at Salinas Valley Health Medical Center (SVHMC) is to ensure that the Governing Body, Medical Staff, and professional services personnel consistently strive to deliver safe, effective, and optimal patient care in an environment that minimizes risk. The QAPI Plan serves as the framework for developing, implementing, and sustaining an effective, organization-wide, data-driven quality assessment and performance improvement program. This program uses a planned, systematic, and interdisciplinary approach to improving the care, treatment, and services provided across the organization.
- B. This organization-wide plan applies to the clinical services identified in the grid below, including services provided directly by the organization and those delivered through contractual agreements and other arrangements.

Category	Services Provided
Main Hospital Campus	Inpatient Acute Care: General, Perinatal, NICU Level III, Pediatric, CCU, ICU, Telemetry; Procedural: Perioperative Services (Inpatient & Ambulatory Care), Cardiac Catheterization, Cardiovascular Services, Rehab Services, Emergency Services; Diagnostic and Support: Diagnostic Imaging/Nuclear Medicine Services (Inpatient & Outpatient), including Ultrasound, MRI, and Cardiovascular Imaging, Laboratory Services (Inpatient & Outpatient), Pathology including Blood Bank, Pharmacy (Inpatient & Outpatient), Respiratory Care Services
Mobile Modalities - Main Hospital Campus	Lithotripsy; PET/Nuclear Medicine; Interventional Radiology; MRI; Temporary Outpatient Modular Units
Outpatient/Specialty Clinics	Outpatient services across Monterey, Salinas, and Gonzales, including Primary Care; Infusion; Imaging; Wound Care; Breast Health; Cardiac Services; Sleep Services, Rehab Services, Sleep Medicine

- C. The QAPI Program is designed to foster an environment where patient care and services are continuously improved, professional performance and employee competence are strengthened, and operational systems function efficiently. Through an integrated, interdisciplinary process, patient care and the processes that influence patient outcomes are routinely measured, assessed, and improved to achieve optimal results.
- D. The Board of Directors, Medical Staff, organizational leaders and all personnel share accountability for the quality of care and services provided at the organization. They are collectively responsible for supporting a culture of safety, transparency, and continuous improvement. The QAPI Program is designed to align with and support the organizational mission, vision and values.
- E. In concert with the organizational QAPI Program, professional nursing practice care at Salinas Valley Health Medical Center is guided by a Professional Practice Model, developed by the nursing staff. The nursing mission is to heal, protect, empower and teach. The nursing vision is to be an innovative leader in nursing excellence - a place where patients choose to come and nurses want to practice. Other components of the Professional Practice Model include shared governance, respectful, collaborative professional relationship, recognition and reward for professional nursing development and a care delivery model which embraces a relationship-based, collaborative approach emphasizing partnerships with our colleagues, patients, families and the community. Clinical Nurses, ancillary staff, support staff and medical staff participate in quality committees to make interprofessional decisions at the organizational level to improve processes and quality of the care. These decision-making committees include committees in Administrative Quality; Safety and Reliability; Shared Governance and ad hoc subcommittees where nursing sensitive measures and nursing practice initiatives are incorporated into the overall organizational performance improvement.

II. OBJECTIVES/GOALS

A. Objectives

- 1. The organizational QAPI program includes an overall assessment of the efficacy of performance improvement activities with a focus on continually improving care provided and on patient safety practices conducted throughout the organization. The program encompasses elements of the mission, vision, values and organizational strategic objectives and consists of performance improvement, patient safety and quality control activities. Indicators are objective based on current knowledge and experience, and are structured to produce statistically valid, data driven measures of care provided. This mechanism also provides for evaluation of improvements and the stability of the improvement over time when appropriate.
- 2. The QAPI Plan includes data collection, data aggregation and analysis of patterns or trends, identifying and managing adverse events, improving performance, patient safety and reducing risk of adverse/sentinel events, and conducting proactive risk reduction activities, including processes that involve the Medical Staff as well as clinical and support services. The QAPI program is implemented in conjunction with the organizational PATIENT SAFETY PROGRAM PLAN and the RISK MANAGEMENT PLAN

B. Goals

- 1. The goals for the QAPI Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, and performance monitoring and environmental monitoring.

2. Annually the organization defines at least one improvement priority. In collaboration with organizational strategic objectives, the following priorities have been established for FY 2027:
 - Annual Quality and Safety Pillar Strategic Initiatives
 - Patient Perception of Care, Services and Treatment
 - Patient Flow Initiatives
 - Magnet Recognition/Nurse Sensitive Indicators
 - Early Recovery After Surgery
 - Age Friendly Initiative

III. DEFINITIONS

A. CMS	Centers for Medicare and Medicaid Services
B. MEC	Medical Executive Committee
C. PI	Process Improvement
D. QAPI	Quality Assessment and Performance Improvement
E. QSC	Quality and Safety Committee of the Medical Staff

IV. PLAN MANAGEMENT

A. Plan Elements

I. Measuring Performance

a. Data Collection

The Board of Directors, in collaboration with medical staff and hospital administrative leaders, establish priorities ensuring that performance improvement activities reflect the complexity of the organization and the services provided. Data collected for high priority processes are used to monitor the stability of existing processes, identify opportunities for improvement, and implement changes that lead to sustainability. The program is expected to show improvement in measures for which there is evidence that patient outcomes will be improved and medical errors will be reduced. The following are categories of data collected and analyzed. The identified areas of data listed below are not intended to be an all-inclusive. The Board of Directors and Leadership may identify additional data elements at any time based on the organization's priorities, emerging risks, identified areas of opportunity or regulatory requirements.

- Clinical Quality Measures: Evidence-based metrics such as sepsis bundle compliance, stroke care, NTSV C-section rate, readmissions, and mortality indicators.
- CMS electronic Clinical Quality Measures (eCQM's)
- Patient Safety Events: Falls, pressure injuries, adverse events, near misses, other safety indicators and root-cause analysis outcomes.

- Patient Flow and Throughput: Emergency department throughput, operating room utilization, discharge efficiency, and length of stay.
- Patient Experience: HCAHPS results, complaints, grievances, and service recovery outcomes.
- Staff Competency and Performance: Credentialing, privileging, peer review, and training compliance.
- Resource Utilization: As identified by Executive Leadership and the Board of Directors.
- Population Health Measures: Preventive care rates, chronic disease management, and community health indicators, health care disparity and Age Friendly Initiative.
- Regulatory and Accreditation Compliance: audit findings, tracer results, and corrective action implementation.
- Processes and data as defined in the organizations Infection Control Program, Environment of Care Program, and Patient Safety Program, Medication Management Plan.
- Required data for regulatory bodies and clinical registries such as the Joint Commission, CMS, OSHA and the FDA, AHA and ACC.
- Data submitted to or received from Medicare quality reporting and quality performance programs, including but not limited to hospital readmissions and hospital-acquired conditions.

2. Assessing Performance

a. Data Compilation and Analysis

Data aggregation and analysis are conducted to transform raw data into meaningful information that supports organizational decision-making. Data are systematically collected, aggregated, and analyzed to monitor the effectiveness and safety of services, evaluate the quality of care provided, and assess performance levels, patterns, and trends across the organization. These activities support the performance improvement initiatives and ensure that opportunities are identified in a timely and reliable manner.

Consistent with the organization's Professional Governance model, data are transparently shared with leaders, interprofessional teams, and Professional Governance councils. Clinical nurses and other frontline team members participate in the review, interpretation, and application of performance data to identify opportunities for improvement, develop evidence-based interventions, and evaluate the effectiveness of actions taken.

- Data aggregation is performed at a frequency appropriate to the activity, process, or measure being monitored.
- Statistical tools and techniques are used, when appropriate, to display, analyze and interpret data.
- Data are analyzed and compared internally over time and externally with other sources of information when available.
- Comparative benchmarking data are used to assess variation in performance, identify best practices, establish performance

targets, and determine whether performance falls outside expected levels.

- v. Performance data are reviewed through the organization's Professional Governance structure, leadership committees, and interprofessional teams, as appropriate, to support shared decision-making, promote accountability for professional practice, and guide evidence-based performance improvement initiatives.
- vi. An intensive analysis is conducted when data identify undesirable patterns or trends, or when significant patient safety events occur that warrant further evaluation. The analysis identifies contributing factors, system opportunities, and corrective actions, with ongoing monitoring to evaluate the effectiveness of implemented improvements.
- vii. Results of data analysis, benchmarking, and intensive analyses are used to identify, prioritize, implement, and sustain performance improvement initiatives. Outcomes are communicated through the appropriate leadership, quality, and Professional Governance structures to promote organizational learning, transparency, and continuous improvement.

3. Improving Performance

- a. Data is collected, analyzed and integrated into performance improvement initiatives. Performance improvement initiatives may be organization-wide in scope or targeted to specific areas, departments and services, or focused on select populations. The Board of Directors, in collaboration with medical staff and hospital leaders, establish priorities for improvement opportunities and requests action be taken on those priorities.
 - Information from data analysis including data from new or modified services is used to identify and implement changes that will improve performance and patient safety.
 - Improvement strategies are evaluated to confirm that they have resulted in improvement, and are tracked to ensure that improvements are sustained.
 - Additional actions are taken when the improvements do not achieve or sustain the desired outcomes.
 - Changes that will reduce the risk of sentinel events are identified and implemented.

4. Identifying and Managing Adverse or Unexpected Occurrences

- a. Processes for identifying and managing sentinel events are defined in the organization wide [ADVERSE EVENTS - REPORTABLE](#).

5. Proactive Risk Reduction Program

- a. SVHMC is dedicated to preventing harm to patients, visitors and staff. This is supported and encouraged through internal reporting in order to identify potential system or process failures. The organization is committed to utilizing proactive risk assessments to identify potential hazards, analyze their likely hood and impact and develop strategies to prevent and mitigate harm before incidents occur. At a minimum of every 18 months the hospital selects one high-risk process and conducts a proactive risk assessment.

6. Priority Patient Population

- a. The priority patient populations are based on high-risk, high volume, high risk/low volume and/or problem prone areas with consideration of the incidence, prevalence and severity of problems in those areas which may affect patient outcomes, safety and quality of care.

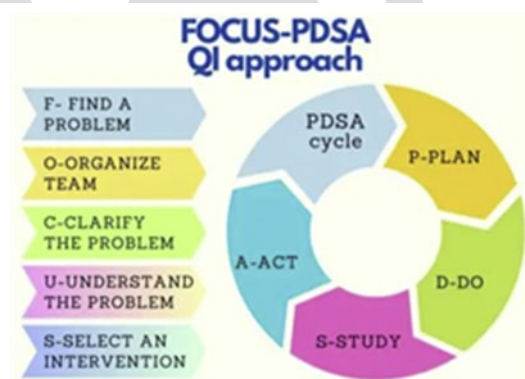
7. Analysis of Staffing

- a. When undesirable patterns, trends or variations in performance related to the safety or quality of care are identified from data analysis or a single undesirable event, the adequacy of staffing (number, skill mix, competency), including nurse staffing is analyzed for possible cause. Additionally, processes related to work flow, competency assessment, credentialing, supervision of staff, orientation, training and education may also be analyzed.
- b. When analysis reveals a problem with the adequacy of staffing, the QSC is informed of the results of the analysis and actions taken to resolve the identified problem(s).

B. Plan Management

I. Performance/Process Improvement Model

- a. SVHMC utilizes a wide range of systematic and structured problem-solving approaches to plan, design, measure, assess and improve organizational performance/processes. Methodologies include Lean for Healthcare, FOCUS – PDCA and Rapid Cycle Improvement.
 - FOCUS – PDCA.
 - F** – Find a process to improve.
 - O** – Organize a team that understands the process.
 - C** – Clarify how the current process works.
 - U** – Understand the causes of process variation, the "root cause".
 - S** – Select changes that will improve the process.
 - P** – Plan how the changes will be implemented.
 - D** – Do/implement the plan.
 - S** – Study the results of the improvement plan by collecting post-implementation data.
 - A** – Act on the findings of post-implementation data by standardizing the process or testing another change.



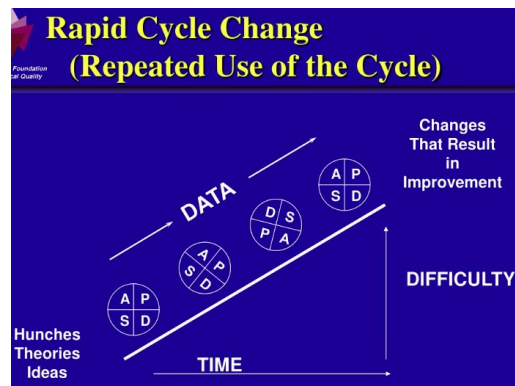
- Systems Redesign
Utilizes concepts such as eliminating waste, process mapping, one piece flow; just in time, standardization, and workload leveling.

- Rapid Cycle Improvement/Kaizen

When appropriate, the *rapid cycle improvement* process may be utilized.

The advantages of the rapid cycle improvement process include:

- Using a small sample to test a proposed change idea quickly.
- Testing ideas side by side with existing processes.
- Testing many ideas quickly. Build upon the success of the previous test.
- Providing opportunities for failures without impacting performance.
- Minimizing resistance to successful change.



C. Plan Responsibility

I. Performance / Process Improvement Structure

- The Quality Oversight Structure defines the organization framework through which quality, patient safety, and performance improvement activities are coordinated, monitored, evaluated, and decentralized. The structure ensures that all service lines and disciplines are active members in the QAPI in addition to ensuring accountability at all levels within the organization. Each department and service line supports the SVHMC's commitment to continuously improve the quality of patient care to the patient's we serve and to an environment which encourages performance improvement within all levels of the organization. Systems and services are evaluated to determine their timeliness, appropriateness, necessity and the extent to which the care or service provided meets the customer's needs. This is articulated in each department and service line's Scope of Service.
- The annual reporting calendar is developed and maintained by the Quality Department. Key components include but are not limited to; required reporting, committee reviews, performance dashboards and regulatory submissions. The calendar is reviewed on a regular basis and updated to meet the changing needs of the organization, regulatory requirements or when performance initiatives shift or evolve.
- Governing Board**
 - The Board of Directors holds ultimate responsibility for the organization's performance-improvement program and ensures that all activities reflect the complexity of the hospital's structure, services, and patient populations. This responsibility encompasses

all patient-care- services-inpatient, outpatient, and ambulatory-licensed under the organization, including those delivered through contracts or other arrangements.

- ii. Performance-improvement efforts emphasize indicators that support improved health outcomes and the prevention and reduction of medical errors.
- iii. The Board assigns the Quality and Efficiency Practices Board Committee to evaluate and enhance the quality and efficiency of patient care. While the Board retains ultimate oversight, it delegates operational authority for performance-improvement activities to the Medical Staff and Hospital Leadership.
- iv. In exercising its supervising responsibility, the Board:
 - 1. Reviews and approves the QAPI, Risk Management and Patient Safety Program Plans.
 - 2. Reviews periodic reports on findings, actions, and results of program activities, including input from the populations served via results of patient experience data.
 - 3. Reviews reports on the following: all system or process failures; the number and type of sentinel events; whether the patients and the families were informed of the event; results of analyses related to adequacy of staffing; all actions taken to improve safety, both proactively and in response to actual occurrences.
 - 4. Assesses the QAPI, Risk Management and Patient Safety Programs' effectiveness and efficiency and required modification, as necessary.
 - 5. Provides resources and support for performance improvement, change management, patient safety and risk management functions related to the quality and safety of patient care, including sufficient staff, access to information and training throughout the hospital.

d. Medical Executive Committee (MEC)

- i. MEC authorizes the establishment of an interdisciplinary Quality and Safety Committee to implement the QAPI program.
- ii. MEC is accountable to the Board of Directors for the oversight of performance improvement activities to ensure that one level of care is rendered to all patients. This responsibility extends across all patient-care settings- including inpatient, outpatient, and ambulatory services-licensed under the organization, as well as services delivered through contracts or other arrangements.
- iii. The Medical Staff participates in developing measures to evaluate care systematically. Their participation may be in individual departments, medical staff committees, or on interdepartmental or interdisciplinary process/performance improvement teams.

- iv. The Medical Staff departments review and evaluate the results of ongoing measures that include the medical staff review functions as well as risk management, patient safety, infection control, case management, and organizational planning.
- v. The Medical Staff has established the Medical Staff Excellence Committee to ensure that the hospital, through the activities of its medical staff, assess the Ongoing Professional Practice Evaluation of individuals granted clinical privileges and uses the results of such assessments to improve care, and when necessary, conduct Focused Professional Practice Evaluations. The goals of the Medical Excellence Committee are to:
 - Improve the quality of care provided by individual practitioners
 - Monitor the ongoing performance of practitioners who have privileges
 - Identify opportunities for performance improvement
 - Monitor significant trends by analyzing aggregate data
 - Assure that the process for peer review is clearly defined, fair, defensible, timely and useful
 - Evaluation the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.

e. Organizational Executives and Vice-Presidents

- i. Set expectations for performance/process improvement.
- ii. Lead the development of performance/process improvement initiatives.
- iii. Participate in processes to improve hospital performance as indicated.
- iv. Ensure participation from key stakeholders in all performance/ process improvement activities.
- v. Monitor contracted services by establishing expectations for the performance of the contracted services.
- vi. Ensure that new or modified processes or services incorporate the following:
 - Needs and/or expectations of patients, staff and all identified key stakeholders.
 - Results of performance improvement activities, when applicable.
 - Information about potential risk to patients, when applicable.
 - Every new service must have a proactive risk assessment completed before opening.
 - Current knowledge and/or best practice
 - Information about sentinel events, if applicable

- Testing and analysis to determine whether the proposed design or redesign will have a positive impact
- vii. Ensure that an integrated patient safety program is implemented throughout the organization.
- viii. Establish and maintain operational linkages between risk management activities related to patient care and safety, and performance improvement activities.
- ix. Review results from key financial indicators in order to ensure overall financial stability.
- x. Ensure compliance with state and federal laws, and the Joint Commission regulations/standards.

f. Support Service Departments/Department Directors

- i. The department leaders are accountable to the organizational executives, QSC and the Board of Directors for the quality of care/ services and performance of their staff and departments. Departments participate in the systematic measurement and assessment of the quality of care/services provided. The Department Directors:
 - a. Promote the development of standards of care and measures to assess the quality of care/services rendered in their departments.
 - b. Monitor the processes in their areas, which affect patient safety, care, outcomes and the patient's perception of care received.
 - c. Promote the integration of their department's performance improvement activities with those of other support services and the Medical Staff through participation in performance improvement teams.
 - d. Report the results of applicable performance improvement activities in accordance with the established Quality Oversight Structure. (see Appendix A).

D. Performance Measurement

- 1. The performance measurement process is one part of the evaluation of the effectiveness of the QAPI Program Plan. Performance measures have been established to measure important aspects of care. Leaders are responsible to determine what measures will be evaluated at least annually and updated/revised ongoing as compliance is sustained.
- 2. To ensure that the appropriate approach to planning processes of improvement; setting priorities for improvement; assessing performance systematically; implementing improvement activities based on assessment and maintaining achieved improvements, the organizational QAPI program is evaluated for effectiveness at least annually and revised as necessary.
- 3. **Confidentiality**
 - a. All information related to performance improvement and patient safety activities performed by the Medical Staff or hospital personnel in accordance

with this plan are confidential and protected under the Patient Safety Work Product and California Evidence Code 1157.

- b. Some information may be disseminated on a "need to know basis" as required by agencies such as federal review agencies, regulatory bodies, the National Practitioners Data Bank, or any individual or agency that proves a "need to know" as approved by the Medical Executive Committee, Organizational Executives, and/or the Governing Body.
- c. HIPAA regulations will be followed.

E. **Orientation and Education**

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

V. REFERENCES

- A. Joint Commission
- B. Title 22 (CDPH)
- C. CMS Conditions of Participation

Attachments

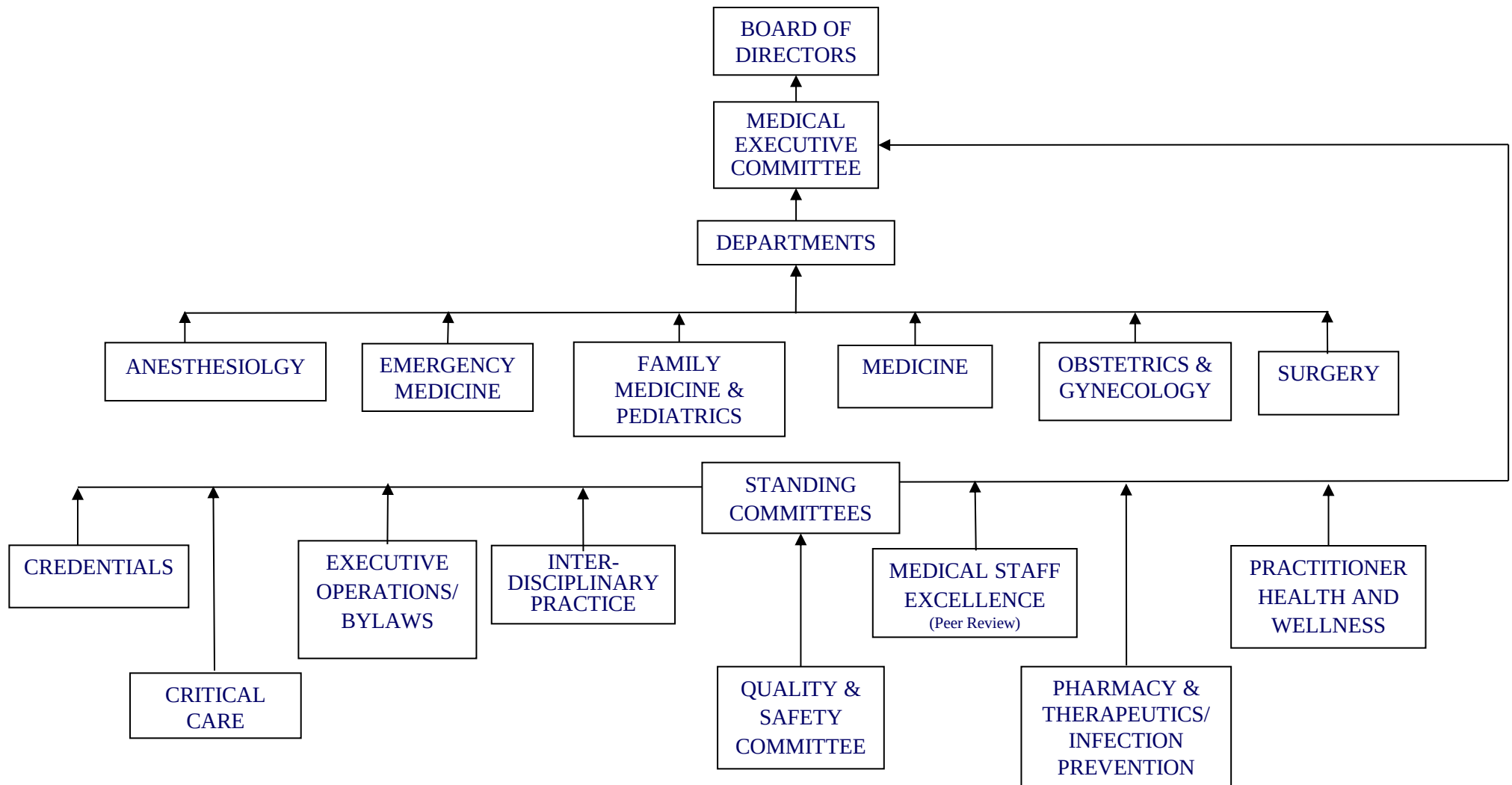
- ☐ [Medical Staff Organizational Chart 03-28-26.pdf](#)

Approval Signatures

Step	Description	Approver	Date
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Standards

No standards are associated with this document



Family Medicine/Pediatrics Dept: Pediatric Cardiology, Neonatology, Pediatric Allergy

Medicine Dept: Cardiology, Critical Care, Dermatology, Palliative Medicine, Rheumatology, Nephrology, Sleep Medicine, Internal Medicine, Radiation Oncology, Physical Med & Rehab, Psychiatry, Pain Medicine, Infectious Diseases, Hem/Onc, GI, Endocrinology, Neurology

Surgery Dept: Ortho, Pathology, Podiatry, Vascular, Ophthalmology, Gen Surg, ENT, Colorectal, Surg Onc, Radiology, Urology, Plastics, OMFS, Neurosurgery, Dentistry

*PERSONNEL, PENSION & INVESTMENT
COMMITTEE*

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

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

(CATHERINE CARSON)

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: Consider Recommendation for Board Approval of Contract Terms for Jessica Ramirez, MD's Hospitalist Medicine Professional Services Agreement

Executive Sponsor: Tim Albert, MD, MHCM, Chief Clinical Officer
Rakesh Singh, MD, Vice President of Medical Affairs
Molly Heacox, Director of Clinic Services

Date: August 17, 2026

Executive Summary

The Salinas Valley Health (SVH) **hospitalist medicine services** program at Salinas Valley Health Medical Center operates under Salinas Valley Health Clinics (SVHC) and focuses on increasing patient and referring-provider satisfaction and improved retention of hospitalist physician staff. Due to the continued growth of the SVH Medical Center adult daily census, the need to staff and retain well-qualified, credentialed hospitalists to the program remains a high priority.

Jessica Ramirez, MD has been an active member of the SVH Medical Staff since 2025 providing hospitalist coverage on an as-needed and as-available basis. In October of 2026, Dr. Ramirez plans to transition to become a full-time member of the SVH Hospitalist Medicine team providing services as outlined in the schedule below.

Terms and Conditions of Agreements

The proposed physician recruitment requires the execution of the following agreement:

1. **Professional Services Agreement** Essential Terms and Conditions:

- **Professional Services Agreement (PSA)** Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics – Hospitalist Medicine. Pursuant to California law, the Physician will not be an employee of SVH or SVH Clinics but rather a contracted physician.
- **Term.** PSA is for a term of two years with annual compensation reported on an IRS W-2 Form as a contracted physician.
- **Schedule.** Physician will provide services under the PSA on as a 1.0 Full Time Equivalent (FTE).
 - ❖ Schedule expectation for 1.0 FTE of fifteen (15) twelve-hour (12 hour) shifts per month and no less than one hundred eighty (180) twelve-hour (12-hour) shifts per year.
- **Compensation:**
 - ❖ Physician shall earn one hundred eighty-five dollars (\$185.00) per hour for services during the hours of 7am-7pm; two hundred dollars (\$200.00) per hour during the hours of 7pm-7am
 - ❖ Physician shall earn an additional seventy dollars (\$70.00) per hour for each shift worked in excess of one hundred eighty (180) twelve-hour (12-hour) shifts per year.
 - ❖ Physician shall earn an eight hundred ten-dollar (\$810.00) stipend per shift for providing emergency remote surge coverage and processing admissions remotely during peak census times.
- **Annual Incentive Plan** in the amount of up to fifteen thousand dollars (\$15,000) shall be available to physicians who meet the eligibility requirements of at least one thousand (1,000) hours worked during the measurement period and a current PSA at time of payment in order to qualify.

- Benefits. Physician will be eligible for standard SVH Clinics physician benefits:
 - ❖ Access to SVH Health Plan for physician and qualified dependents. Physician premiums are projected based on fifteen percent (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.
 - ❖ CME annual stipend in the amount of two thousand four hundred dollars (\$2,400) paid directly to you and reported as 1099 income.
- Professional Liability Insurance. Professional liability shall be provided through BETA Healthcare Group.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

The transition to full-time to retain Dr. Ramirez 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 transition of Dr. Ramirez to Salinas Valley Health Clinics has been identified as a need for providing stable resources and inpatient coverage for SVH Hospitalist Medicine.

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

Recommendation

Salinas Valley Health Administration requests that the Personnel, Pension and Investment Committee recommend to the Salinas Valley Health Board of Directors approval of the Contract Terms of the Hospitalist Medicine Professional Services Agreement for Dr. Ramirez.

Attachments

- Curriculum Vitae for Jessica Ramirez, MD

Jessica E. Ramirez, MD

Education and Training

Residency, Internal Medicine – Florida Atlantic University, Boca Raton, FL, 2018
M.D., Doctor of Medicine – St. George's University School of Medicine, Grenada, 2015
M.A., Sociology (Health and Illness) – San Jose State University, San Jose, CA, 2011
B.S., Health Science – University of California at Santa Cruz, Santa Cruz, CA, 2006

Licensure

California Medical License (A152554)
Florida Medical License (ME133531)

Certification

American Board of Internal Medicine, 2018–current
Aviation Medical Examiner, Southern Region, 2018

Work Experience

Hospitalist – Natividad Medical Center – Salinas, CA 11/2024 – Present

- Provide comprehensive inpatient care and hospitalist services, including admissions, diagnosis, treatment, and coordination with multidisciplinary teams for optimal patient outcomes.
- Participate in quality improvement initiatives and hospital committee activities to enhance clinical care delivery.

Hospitalist – Holy Cross Health – Sound Physicians 05/2023 – 10/2024

- Responsible for providing acute care and medical management of hospitalized patients, from admitting, daily management of patients, coordination of consultants.

Hospitalist – JFK Medical Center – Accountable Care Hospitalist Group 01/2021 – 12/2022

- Full time Hospitalist responsible for the care, work-up, diagnosis, and treatment of general medical problems of hospitalized patients including consults from specialties.

Hospitalist – Cleveland Clinic Indian River Hospital 08/2018 – 10/2022

- Responsible for the care, work-up, diagnosis, and treatment of general medical problems of hospitalized patients including consults from specialties.

Teaching Faculty – FSU-Cleveland Clinic Indian River Hospital 08/2018 – 08/2019

- Involved in teaching and supervising third and fourth year medical students.

Tissue Bank Research Assistant – Stanford University School of Medicine 02/2007 – 06/2011

- Responsible for managing the Blood and Marrow transplantation tissue bank. Worked with patient management and research teams on research projects and improving quality control methods.

Accreditations

- BLS/ACLS
- ECFMG certified

Additional languages

Spanish (fluent written and spoken)

FINANCE COMMITTEE

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

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

(VICTOR REY, JR.)

Finance Committee Board Paper

Agenda Item: Consider Recommendation for Board Approval of Renewal of the Medtronic Service and Support Agreement for the O-Arm O2 Surgical Imaging System and StealthStation S8 Neurosurgical Navigation System

Executive Sponsor: Alysha Hyland, Chief Administrative Officer

Date: August 24, 2026

Executive Summary

The Perioperative Services Department requests Board approval of Amendment No. 1 to the existing Medtronic Service and Support Agreement for the O-Arm O2 Surgical Imaging System and StealthStation S8 Neurosurgical Navigation System. The amendment extends the current agreement for an additional three-year term from August 17, 2026, through August 16, 2029, at an annual cost of \$139,100, for a total contract value of \$417,300. Approval will ensure continued manufacturer service and support for these critical surgical systems utilized in Neurosurgery, Spine, and ENT procedures.

Background/Situation

The proposed renewal represents an annual increase of \$5,130 (3.8%) compared to the current agreement, with a total three-year increase of \$15,390. The renewal provides continued manufacturer service and support while protecting the organization's investment in critical surgical imaging and navigation technology while ensuring continued system reliability.

Timeline/Review Process to Date

- **June 2026** – Renewal discussions initiated with Medtronic
- **July 2026** – Renewal terms negotiated and agreement finalized
- **August 2026** – Finance Committee and Board approval requested for renewal of the Medtronic Service and Support Agreement

Strategic Plan Alignment

Renewal of the Medtronic Service and Support Agreement will support the organization's strategic commitment to delivering high-quality surgical care by ensuring continued manufacturer support for critical intraoperative imaging and navigation technology. The agreement helps maintain operational reliability, minimizes equipment downtime, and protects the organization's capital investment

Pillar/Goal Alignment

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

Financial/Quality/Safety/Regulatory Implications

Key Contract Terms	Vendor: Medtronic
1. Proposed effective date	8/17/2026
2. Term of agreement/Renewal	3-year extension, 8/17/2026 to 8/16/2029
4. Termination provision(s)	Either party may terminate the agreement without cause upon thirty (30) days' prior written notice.
5. Payment Terms	Net 45 Days after the invoice date
6. Annual cost	\$139,100.00
7. Cost over life of agreement	\$417,300.00
8. Budgeted (indicate y/n)	Y

Recommendation

SVH Administration requests that the Finance Committee make a recommendation to the SVH Board of Directors to approve Amendment No. 1 to the Medtronic Service and Support Agreement for the O-Arm O2 Surgical Imaging System and StealthStation S8 Neurosurgical Navigation System, extending the agreement for a three-year term in the amount of \$417,300, subject to final legal review.

Attachments

- Amendment No. 1 to the Medtronic Service and Support Agreement
- Medtronic Checklist for Competitive Solicitation
- Sole Source Justification Form

**SERVICE AND SUPPORT AGREEMENT
AMENDMENT NO. 1**

Date: 06/16/2026

Quote #: SSA-329100-0001109381-1-0

This SERVICE AND SUPPORT AGREEMENT AMENDMENT ("SSA Amendment") is entered into by Medtronic USA, Inc., for its Enabling Technologies Products ("MEDTRONIC") with a business address of 2700 Crescent Drive, Lafayette, CO, 80026 and Salinas Valley Memorial Healthcare System, ("Customer"), with a business address of 450 East Romie Lane, Salinas CA, 93901-4098, UNITED STATES. MEDTRONIC and Customer are sometimes referred to herein individually as a "Party" and collectively as the "Parties".

RECITALS

WHEREAS, the Parties have previously entered into an agreement having an effective date of 07/12/2022 (the "Agreement") under which MEDTRONIC provides service and support to Customer for previously purchased products and

WHEREAS, the parties now desire to extend the Term of the Agreement and amend the Agreement as set forth below:

AGREEMENT

NOW THEREFORE, in consideration of the promises and of the mutual covenants herein, the Parties agree that the Agreement shall be and is hereby amended and modified as follows:

Capitalized terms used herein shall have the same meaning as defined in the Agreement.

1. Term and Pricing. The Parties hereby extend the Term and Pricing as listed below. Upon expiration of the amended Term, the Parties agree to evaluate and consider an additional Amendment. Any additional Term will be upon mutual agreement of the Parties.

2. Option(s):

MEDTRONIC offers to sell the Services (as described below and defined in the Agreement) to Customer. Please indicate the option below ("Term"):

☒ **Option 1: Three (3) year renewal term. Effective: 08/17/2026 - 08/16/2029.**

System Serial #	System Type	Current Expire Date	Part Number	Contract Price	QTY	Year 1 Price	Year 2 Price	Year 3 Price
C3184	O-Arm O2	08/16/2026	SERVICEC1-O2MCT10	\$89,100.00	1	\$73,200.00	\$73,200.00	\$73,200.00
N30880290	S8 with EM	08/16/2026	SERVICEC1-S8MCT22	\$73,300.00	1	\$65,900.00	\$65,900.00	\$65,900.00
Invoiced annually, as follows:						\$139,100.00	\$139,100.00	\$139,100.00

Total Price of Option: \$417,300.00 (\$139,100.00 invoiced annually)

3. **Order of Precedence.** In the event of any inconsistency between the terms of this Amendment and the terms of the Agreement, the terms of this Amendment shall control.

4. Except as specified above, all the terms and conditions of the Agreement shall remain as before.

IN WITNESS WHEREOF, the parties have executed this SSA Amendment as of the dates below.

**MEDTRONIC USA, INC., FOR ITS
ENABLING TECHNOLOGIES PRODUCTS**

Salinas Valley Memorial Healthcare System

Signature: _____

Signature: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

BOARD or CEO Packet Submission Checklist
Renewal of the Medtronic Service and Support Agreement for the O-Arm O2 Surgical Imaging System and StealthStation S8 Neurosurgical Navigation System

The original of this completed/fully signed checklist and all required supporting documents are to be hand-delivered to reviewer listed below:

- ☒ **BOARD or CEO PAPER** – required for all submissions; see attached instructions/sample
- ☒ **KEY CONTRACT TERMS** – required for all submissions – see table in Board/CEO Paper
- ☒ **CONTRACT** – negotiated final contract with vendor signature
- ☒ **PROCUREMENT PROCESS DOCUMENTATION** – required for all submissions requiring Board/CEO review/approval per Procurement Management Policy (see policy for details; indicate which sub-category is applicable):
 - ☐ If for **data processing/telecommunications goods/services** of \$25,000 or more, check applicable option and include documentation: **VP IT must review.**
 - ☐ RFP documentation *unless sole source or GPO applies.*
 - ☐ If Sole source – provide detailed justification
 - ☐ If GPO, submit qualifying verification from Materials Management
 - ☒ If for **professional/other services or medical/surgical equipment and supplies** \$400,000 or more, check applicable option and include documentation:
 - ☐ RFP documentation *unless sole source or GPO applies.*
 - ☒ If Sole source – provide detailed justification
 - ☐ If GPO, submit qualifying verification from Materials Management
 - ☐ If for **non-medical materials/supplies/Public Works** \$25,000 or more, check applicable option and include documentation:
 - ☐ RFP/Invitation for bids documentation
 - ☐ If Sole source – provide detailed justification
 - ☐ If GPO, submit qualifying verification from Materials Management

Legal counsel/Contract Administrator/Specialist reviewed: No ___ or Yes ☒ By Whom: Leo Partido

SUBMITTED BY DEPARTMENT DIRECTOR OR DEPARTMENT ADMINISTRATOR:

<u>Aisha D. Huebner</u> Aisha D. Huebner (Aug 18, 2026 14:09:35 PDT)	Director of Perioperative Services	08/18/2026
Signature	Title/Dept.	Date

REVIEWED BY: (In the following order) – If Capital; Axiom approval in lieu of signature.

VP IT: (if applicable) _____ Date: _____

Director Supply Chain: _____ Date: _____

Justification for Sole Source Form

To: Contract Review Committee

From: Aisha Huebner, Director, Perioperative Services

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 \$:	\$417,300 for the three-year term (\$139,100 annually)
Vendor Name:	Medtronic
Agenda Item:	Renewal of the Medtronic Service and Support Agreement for the O-Arm O2 Surgical Imaging System and StealthStation S8 Neurosurgical Navigation System

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. **Describe.**
- ☐ 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.**

Salinas Valley Health currently owns and operates the Medtronic O-Arm O2 Surgical Imaging System and StealthStation S8 Neurosurgical Navigation System. Medtronic is the original equipment manufacturer and the sole authorized provider of manufacturer-certified service, proprietary software support, and OEM replacement parts for these systems. Renewing the existing agreement maintains continuity of support, system reliability, and protection of the organization's investment. No equivalent manufacturer-authorized service alternative is available.

- ☐ Used item with bargain price (describe what a new item would cost). **Describe.**
- ☐ Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, please **describe:**

By signing below, I am attesting to the accuracy and completeness of this form.

Submitter Signature Aisha D. Huebner Date: 08/18/2026
Aisha D. Huebner (Aug 18, 2026 14:10:14 PDT)

Finance Committee Board Paper

Agenda Item: **Consider Recommendation for Board Approval of HealthStream (Learning Management System) Contract Renewal**

Executive Sponsor: Carla Spencer, MSN, RN, NEA-BC Chief Nursing Officer

Date: August 24, 2026

Executive Summary

HealthStream is our Learning Management System (LMS) vendor and primary platform for delivering ongoing, just-in-time, and annual regulatory education. Our primary HealthStream agreement is approaching renewal, providing an opportunity to strategically consolidate our broader HealthStream portfolio under a single contract.

In addition to regulatory education, HealthStream supports several critical workforce development, clinical competency, point-of-care, class management, and accreditation functions across the organization, including:

- **Specialized Courseware:** HealthStream- and third-party-developed courseware supporting regulatory and required education (HIPAA & Sexual Harassment content)
- **Checklist Management:** Real-time support for skills validation and point-of-care competency assessment.
- **Dynamic Health Skills & Decision Support:** Clinical resources and decision support tools available to staff at the point of care.
- **Jane AI:** Supports nursing transition-to-practice programs.
- **Residency Program:** Supports the New Graduate Nurse Residency Program, including data collection and benchmarking to ensure alignment with Practice Transition Accreditation Program (PTAP) standards and support redesignation and ongoing program quality.
- **ePortfolio:** Supports ongoing Magnet with Distinction accreditation efforts through continuous collection of BSN-or-higher degree and board certification data, enabling action planning and progress toward Magnet goals.

To proactively address the upcoming renewal, we initiated planning to consolidate these HealthStream contracts into the primary agreement. This approach is intended to streamline contract management, maintain continuity across critical capabilities, and leverage the combined scope of services to achieve cost savings.

Timeline/Review Process to Date:

- | | |
|-----------|--|
| 2/11/2026 | Meeting with HealthStream to discuss initiatives and organizational needs |
| 3/26/2026 | Budgetary planning to incorporate existing HealthStream products |
| 4/21/2026 | Budget meetings with finance team & final budget approval |
| 7/2026 | Final reviews of content with SME to ensure the product meets the need |
| 7/2026 | Meeting with HealthStream to finalize products to be included in agreement |
| 8/10/2026 | Meeting with HealthStream to confirm final pricing |
| 8/14/2026 | Final order form/agreement provided |

Strategic Plan Alignment:

Quality/Safety: Strengthens regulatory compliance, clinical competency, skills validation, and point-of-care decision support to promote safe, high-quality care.

People: Supports workforce development through nursing residency and transition-to-practice programs, competency management, and professional development resources that promote workforce readiness and retention.

Finance: Optimizes technology investment through contract consolidation and cost savings while supporting workforce retention. HealthStream-enabled residency, transition-to-practice, competency, and professional development programs help retain both new graduate and established staff, reducing the financial impact associated with turnover, recruitment, and replacement.

Growth: Supports PTAP and Magnet with Distinction objectives through residency program benchmarking, professional credential and education data, and capabilities that inform action planning and continuous program improvement.

Community: Supports consistent education and workforce readiness across the organization's ambulatory and clinic settings through Epic onboarding and ongoing education for clinic staff.

Pillar/Goal Alignment:

X Quality/Safety **X People** ☐ **Operations** **X Finance** **X Growth** **X Community/Service**

Key Contract Terms	Vendor:
1. Proposed effective date	9/1/2026
2. Term of agreement	36 Months
3. Renewal terms	Governed by the MSA – One year automatic renewal at 105% unless termed 90 days prior to the end of the subscription. Renewal info on page 3 of MSA.
4. Termination provision(s)	Termination for cause clause included in MSA. Termination info on page 3 of MSA.
5. Payment Terms	30 days from invoice. Outlined in MSA pg. 1
6. Annual cost	Year 1- \$188,714.02; Year 2- \$195,309.02; Year 3- \$187,935.52
7. Cost over life of agreement	\$571,958.56 (over 3 years)
8. Budgeted (indicate y/n)	Yes

Recommendation

Consider recommendation for Board Approval of HealthStream (Learning Management System) contract renewal for the term of 3-years in the total amount of \$571,958.56.

Attachments

- Justification for Sole Source
- Order Form
- Master Service Agreement

Justification for Sole Source Form

To: Contract Review Committee

From: Stephanie Frizzell, Education Department

Type of Purchase: (Check One)

- ☒ X 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

<i>Total Cost \$:</i>	\$571,958.56
<i>Vendor Name:</i>	HealthStream
<i>Agenda Item:</i>	Master Contract Renewal

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.**

☒ X Existing SVHMC equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Describe.** Existing enterprise HealthStream platform and associated applications currently in use across hospital and clinic settings for regulatory education, Epic training, competency validation, workforce development, class management, and accreditation data management.

☒ X Uniqueness of the service. **Describe.** HealthStream offers an integrated platform of workforce education, competency, clinical support, transition-to-practice, and accreditation capabilities within a single platform. This scope enables the organization to connect learning, competency, professional development, and workforce data across the employee lifecycle while supporting strategic priorities in quality, people, finance, and growth.

☐ 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.**

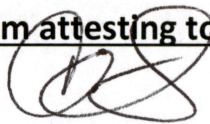
☐ Used item with bargain price (describe what a new item would cost). **Describe.**

☐ 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

A handwritten signature in black ink, consisting of a stylized 'R' or 'B' followed by a flourish.

Date:

8/18/2026

BOARD or CEO Packet Submission Checklist
HealthStream Renewal Agreement

The original of this completed/fully signed checklist and all required supporting documents are to be hand-delivered to reviewer listed below:

- ☒ **BOARD or CEO PAPER** – required for all submissions; see attached instructions/sample
- ☒ **KEY CONTRACT TERMS** – required for all submissions – see table in Board/CEO Paper
- ☒ **CONTRACT** – negotiated final contract with vendor signature
- ☒ **PROCUREMENT PROCESS DOCUMENTATION** – required for all submissions requiring Board/CEO review/approval per Procurement Management Policy (see policy for details; indicate which sub-category is applicable):

X If for data processing/telecommunications goods/services of \$25,000 or more, check applicable option and include documentation: **VP IT must review.**

☐ RFP documentation *unless sole source or GPO applies. (2 vendor bid minimum)*

X If Sole source – provide detailed justification

☐ If GPO, submit qualifying verification from Supply Chain

☐ If for professional/other services or medical/surgical equipment and supplies \$400,000 or more, check applicable option and include documentation:

☐ RFP documentation *unless sole source or GPO applies. (2 vendor bid minimum)*

☐ If Sole source – provide detailed justification

☐ If GPO, submit qualifying verification from Supply Chain

☐ If for non-medical materials/supplies/Public Works \$25,000 or more, check applicable option and include documentation:

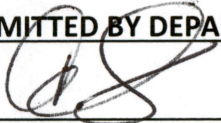
☐ RFP/Invitation for bids documentation (2 vendor bid minimum)

☐ If Sole source – provide detailed justification

☐ If GPO, submit qualifying verification from Supply Chain

Legal counsel/Contract Administrator/Specialist reviewed: No ___ or Yes ___ By Whom: _____

SUBMITTED BY DEPARTMENT DIRECTOR OR DEPARTMENT ADMINISTRATOR:



Signature

CNO / Administration

Title/Dept.

8/18/2026

Date

REVIEWED BY: (In the following order) – If Capital; Axiom approval in lieu of signature.

VP IT: (if applicable) _____

Date: _____

Director Supply Chain: _____

Date: _____

Submitted Date August 17, 2026

Order Number ORD-0839957

P.O. Number

Tax Exempt? No

Customer Information **Name** Salinas Valley Memorial Healthcare System
Address PO BOX 3827
Salinas, CA 93912-3827

Primary Contact **Name** Stephanie Frizzell
Email sfrizzell@salinasvalleyhealth.com
Phone 831-757-4333 x2854

Billing Contact **Name** Stephanie Frizzell
Email sfrizzell@salinasvalleyhealth.com
Phone 831-757-4333 x2854

HealthStream Information **Name** HealthStream, Inc.
Address 500 11th Avenue North
Suite 850
Nashville, TN 37203

HealthStream Contact **Name** Alysha Galvis
Email alysha.galvis@healthstream.com
Phone 615-424-7458

ORDER DETAILS – The pricing set forth in this Order Form, including any applicable discounts, shall expire if this Order Form is not signed and returned to HealthStream on or before 5:00PM Central Time on August 27, 2026.

Product, Software, or Service	Billing Frequency	Quantity	Term (Months)	Year 1 Unit Price	Year 1 Total	Year 2 Total	Year 3 Total
Clinical Dashboard	Annually	835	36	\$2.75	\$2,296.25	\$2,379.75	\$2,463.25
Dynamic Health Skills & Decision Support	Annually	263	36	\$281.49	\$74,031.87	\$76,622.42	\$79,305.02
hStream for Learning	Annually	3000	36	\$6.28	\$18,840.00	\$19,500.00	\$20,190.00
HealthStream Learning Center (HLC)	Annually	3000	36	\$7.15	\$21,450.00	\$22,200.00	\$22,980.00
HLC Administrator Training - Web-Based	UpFront	2	1	\$0.00	\$0.00		
Checklist	Annually	800	36	\$8.87	\$7,096.00	\$7,344.00	\$7,608.00
Insights+	Annually	3000	36	\$2.95	\$8,850.00	\$9,150.00	\$9,480.00
Jane AI	Annually	20	33	\$139.34	\$2,786.80	\$2,884.20	\$2,239.05
HealthStream Nurse Residency	Annually	35	36	\$660.66	\$23,123.10	\$23,932.65	\$24,770.20
HealthStream ComplyQ	Annually	2400	31	\$12.60	\$30,240.00	\$31,296.00	\$18,900.00
Annual Total:					\$188,714.02	\$195,309.02	\$187,935.52

Total Order Value: \$571,958.56

Unless set forth in the Order Details above, the Term and invoicing under this Order Form for each Product or Software commences upon Activation. For purposes of this Order Form, "Activation" shall mean that the Product or Software is first made available by HealthStream for access by Customer or its Users. For renewal purchases, the Term and invoicing will begin following the expiration of the then current term.

Product, Software, or Service Specific Terms

hStream for Learning

hStream is the platform that connects everything in the HealthStream ecosystem and includes applications, services, content, discounts, and other benefits (collectively the "hStream Benefits"). A subscription to hStream for Learning is required for each User accessing any hStream for Learning powered product. The current list of hStream for Learning powered products is [here](#). The current hStream Benefits are listed [here](#). The list of hStream Benefits may change from time to time. hStream for Learning stores individual User learning, education and employment data to, among other things, render a digital portfolio for the benefit of the Customer and each individual User. Customer acknowledges that HealthStream may provide Users with a copy of their individual profile data for accreditation, licensing and the User's personal use.

HealthStream Learning Center with Authoring Center and SCORM Import Tool (HLC)

HealthStream Learning Center ('HLC') shall mean access by Customer to HealthStream's web-based Learning Management System. This Learning Management System enables Customer to deliver a variety of learning activities, create assignments, and generate configurable reports.

Specific features of the HLC include:

- Software as a Service ('SaaS') delivery model where HealthStream provides hardware, hosting, and site maintenance
- Authoring Center (see details below)
- SCORM Import Tool (see details below)
- Ability to create, distribute, and manage on-line content
- Ability to schedule and manage live events such as classroom-based education
- Group courses into curriculums
- Customizable catalog functionality
- Assignment engine that enables administrators to assign learning to various users
- Assessment tool for creating tests and evaluations
- Customizable CE certificate creation
- Transcript functionality
- Configurable and schedulable reports
- Support Services provided via email and telephone between the hours of 7 am and 7 pm Central time Monday through Friday, excluding HealthStream published holidays

The Authoring Center product includes the following items:

- Access to a secure hosting environment integrated into the HealthStream Learning Center for storing and launching HTML and other web enabled content. A list of supported file types is listed in the Authoring Center Policies attached below.
- Access to HealthStream's HTML Editor tool for creating HTML course pages that can be played and distributed through the HealthStream learning Center.
- Access to the Content Management feature that allows the organization to manage and create content for use in the HealthStream Authoring Center.
- Access to HealthStream's Public Courseware Exchange that enables an organization to post and make copies of courses created by other organizations.

By purchasing the HLC, Customer agrees to abide by HealthStream's Authoring Center policies. HealthStream reserves the right to amend and update these policies from time to time and will communicate any changes to Customer as appropriate.

HealthStream Authoring Center Policies and Guidelines As of March, 2014

To ensure high performance standards for clients, HealthStream has adopted the following policies and guidelines for our HLC platform to:

- Protect all customers from loading files that could threaten the integrity of the HLC.
- Ensure the highest performance possible for our customer's authoring experience.
- Prevent unauthorized use of the site, such as posting protected intellectual property without the owner's permission, use of the FTP site as non-authoring asset file storage, or use of files that are, in general, not being used in authored courses.

These guidelines and policies will protect your organization's investment in authored courses and provide for the best possible end-user experience.

Policies

- No single file uploaded to the HealthStream authoring servers may be larger than 25 megabytes. Also, no course 'page' can contain assets that total more than 25 megabytes. The total disk space required by the entire course may be larger than 25 megabytes, but no single file or page can be. This policy ensures that course pages load in a timely manner for an optimal end user experience.
- All files uploaded to HealthStream's authoring servers (authoring FTP sites) must be on the HealthStream approved file types list. This policy exists to protect all users of the HLC from the potential damage caused by malicious or carelessly constructed content. HealthStream amends our list of allowable file types from time

to time and will communicate any additions or deletions from the list by updating a copy of these Authoring Policies found in the on-line help section of the HLC. Please see 'Allowable file types for authored content' below for the current list of allowable files.

- All content must be self-authored and for internal purposes only. Except for content from the A.D.A.M. resource library, content may not be purchased from a third party and uploaded to the Authoring Center without prior written approval from HealthStream, which will be in HealthStream's sole discretion. Further, content uploaded to the Authoring Center should be for internal business purposes only and not for any commercial purposes related to your organization. HealthStream makes no representations or warranties regarding the availability, functionality, security, or performance of any third party content uploaded to or accessed via the Authoring Center as permitted by these policies.
- Only assets that will be used in authored courses may be uploaded to the HealthStream servers. Do not use HealthStream's Authoring Center for general file storage or for other unauthorized purposes.
- Any assets loaded to HealthStream's servers that are or may be out of compliance with the policies detailed above may be deleted at HealthStream's sole discretion.
- Courses that invoke communication features, such as email or ftp, must use standard http/https and sftp/ftp ports and must require no server side technologies such as smtp, asp, Cold Fusion, etc.
- Customers are responsible for keeping back-up copies of all assets published to the Authoring Center. In the event that HealthStream deletes a needed file for a policy violation, restoring this file is the responsibility of the customer. Authoring servers should be used for content delivery and should NOT be the only servers where your files exist.

Allowable file types for authored content

HealthStream reserves the right to delete files that are not of these types for the protection of all authoring customers. Please contact HealthStream Customer Service if you have any questions about these allowable file types.

- .au, audio/basic
- .css, text/css
- .doc, .
- .docm;
- .docx,
- .dotm application/vnd.msword
- .dotx
- .flv, video/x-flv
- .gif, image/gif
- .htm, text/html
- .html, text/html
- .jar, application/java-archive
- .jpe, image/jpeg
- .jpeg, image/jpeg
- .jpg, image/jpeg
- .js, application/x-javascript
- .mov - quicktime movie
- .mp2, video/mpeg
- .mp3, audio/mpeg
- .mp4
- .mpa, video/mpeg
- .mpv2, video/mpeg

- .pdf, application/pdf
- .png, image/png
- .potm - PowerPoint 2007 Macro-Enabled XML Template
- .potx - PowerPoint 2007 XML Template
- .ppam - PowerPoint 2007 Macro-Enabled XML Add-In
- .ppsm - PowerPoint 2007 Macro-Enabled XML Show
- .pspx - PowerPoint 2007 XML Show
- .ppt, .pptx, application/vnd.ms-powerpoint
- .pptm - PowerPoint 2007 Macro-Enabled XML Presentation
- .pptx - PowerPoint 2007 XML Presentation
- .swf, application/x-shockwave-flash
- .txt, text/plain
- .vsd, .vss, application/visio
- .xhtml, text/html
- .xlam - Excel 2007 XML Macro-Enabled Add-In
- .xls, .xlsx, application/vnd.ms-excel
- .xlsb - Excel 2007 binary workbook (BIFF12)
- .xlsm - Excel 2007 XML Macro-Enabled Workbook
- .xlsx - Excel 2007 XML-Enabled Sheet
- .xltn - Excel 2007 XML Macro-Enabled Template
- .ltx - Excel 2007 XML Template
- .xml, text/html
- .xsd, text/html
- .zip, application/zip (Only when transporting SCORM packages)

SCORM Import Tool Policies and Guidelines

HealthStream's SCORM Import Tool allows Customers to import SCORM conformant content packages to the HLC for use as course material. SCORM is an acronym for 'Sharable Content Object Reference Model.' This learning industry standard is overseen by Advanced Distributed Learning, a research group sponsored by the United States Department of Defense. After import, SCORM content objects are available from the HLC as an Authored SCORM Learning Activity.

Usage Restrictions

- SCORM packages must be standard zip files
- SCORM packages must be less than 100 megabytes.
- The SCORM Package Import Feature may not be used to import 3rd party courses without express written permission from HealthStream.
- The Customer is responsible for providing conformant SCORM packages prior to using the SCORM Package Import Feature. HealthStream strongly recommends that the Customer use the free SCORM package testing application called 'TestTrack' that is available at www.scorm.com to test SCORM packages for conformance prior to using HealthStream's SCORM Import Tool.

HealthStream does not provide support for content created using instructional design creation tools not sold and provided by HealthStream.

HealthStream Administrator Training – Learning (Webinar)

HealthStream will provide training seats via Webinar format as set forth in the Order Details above. Customer may send additional personnel at the standard fee per person or purchase additional seats for training during the term of this Order Form.

Customer may enroll administrators in HealthStream Learning Administrator Training via webinar.

Webinar training consists of 15 hours of webinar instruction broken into several topic areas, with recommended participation in the following order:

- HealthStream Learning - Fundamentals (two (2) two (2)-hour sessions)
- HealthStream Learning - Learning Development (two (2) two (2)-hour sessions)
- HealthStream Learning - Class Management (one (1) two (2)-hour session)
- HealthStream Learning - Enterprise Functionality (one (1) one (1)-hour session)
- HealthStream Learning - Authoring Center (one (1) two (2)-hour session)
- HealthStream Learning - CE Credit Management (one (1) two (2)-hour session)

Checklist

Checklist helps ensure safe, quality care and improve patient outcomes by standardizing processes, measuring skill proficiency, and validating staff compliance to organizational policies.

Jane AI

Jane AI includes these features/components: Personalized Assignment Workflows, Knowledge Assessments, Personalized Competency Scorecard, Personalized Recommendations and Development Paths, an 1800+ course Interdisciplinary CE Library, AI Critical Thinking Assessments, Skills Self-Evaluations, Integration with the HealthStream Learning Center and hStream platform, and User-Access to their CE transcripts.

A 5 Mbps internet connection (download speed) at a minimum is required to utilize this product.

Product utilization is metered by the number of unique Users who use the content and features of JaneAI listed above, as measured during the period between anniversaries of the activation of the product.

HealthStream retains the sole discretion to replace or remove individual courses offered as part of JaneAI in order to maintain the highest quality content libraries.

HealthStream ComplyQ

HealthStream ComplyQ provides data-driven actionable insights to identify risk areas and address critical compliance outcomes. Optional assessments identify compliance gaps and areas of risk at the individual level and automatically assign compliance content based on assessment performance.

Compliance requirements can vary across healthcare organizations. Provision of information on regulatory standards in these courses does not certify that the courses wholly or partially address all respective guidelines, standards, and measures that affect a given organization. This courseware is intended to provide a foundation for compliance training to healthcare employees, however it is the responsibility of each organization to review all regulatory courses to determine how the information meets their respective needs. HealthStream makes no representations or warranties that any particular course fulfills the regulatory compliance requirement of any particular healthcare organization, as it is the organization's responsibility to make such final determinations regarding regulatory compliance requirements.

EBSCO Dynamic Health Skills and Clinical Decision Support

The Minimum Browser Requirements for EBSCO interfaces are as follows:

- Internet Explorer 8.0 or later. Effective July 1, 2017, EBSCO will stop supporting Internet Explorer 8.0 and 9.0, due to security risks. Until 2017 all currently existing functionality, as of May 2016, that is supported in IE 8.0 and 9.0 will continue to be supported, however all newly released services and features will only be supported in IE 10.0 or higher.
- FireFox Latest version plus one previous version
- Safari Latest version plus one previous version
- Google Chrome Latest version plus one previous version

*JavaScript and cookies need to be enabled

Additional information related to technical requirements can be found here:http://support.ebsco.com/knowledge_base/detail.php?id=25

There are a number methods for authentication that an institution can be chose from:

- IP Address
- Patterned IDs
- Patron ID files
- Referring URL
- User ID and Password
- Cookie
- OpenAthens
- Shibboleth
- HTTPS
- Personal User
- Guest Access

Additional information related to authentication can be found here:http://support.ebscohost.com/knowledge_base/detail.php?topic=996&id=3572&page=1.

Training

HealthStream will provide the following onboarding and training materials for both administrators and end users –

- eLearning Training Modules (available as HealthStream courseware)
- Training tutorial for EBSCO Health native application (available as HealthStream courseware)

EBSCO Health provides training the following training options on their native application. These can be planned and coordinated with the EBSCO Health Success Manager or by contacting customersuccess@ebSCO.com.

- On-Demand Training
- Regularly Scheduled WebEx Training Sessions
- Customized WebEx Training Sessions

"Quantity" as set for in the Dynamic Health Order Details above is based on the number of licensed beds.

Additional Terms and Conditions

1. For applicable credentialing products/subscriptions only:
 - a. "Quantity" refers to the number of Providers (as defined herein) being monitored via the respective products/subscription in the Order Details above. "Provider(s)" means individuals, employees, consultants, contractors, clients or agents who are designated by Customer to be verified or a unique provider with an "active" record status in any of Customer's facilities. Providers shall be considered a User per the terms of the MSA (as defined herein). The number of administrative end-users available to Customer ("Administrators") is unlimited. The use of the Software by Users and Administrators is governed by the terms of the MSA. This Section does not apply to the V12 product(s).
 - b. Fair Credit Reporting Act (FCRA): To the extent the FCRA applies as related to applicable credentialing products/subscriptions, Customer hereby authorizes HealthStream to act as its authorized representative to independently verify all information regarding a User's credentials and qualifications from original sources, designated equivalent sources when a primary source designates another organization as its agent or from entities that maintain specific credentials information identical to the information of the primary source and to provide such information to the Customer on the User's behalf. Customer will have the sole responsibility for making determinations as to whether the User will be granted membership and/or privileges with the

Customer. The Customer has the responsibility to review User Credentialing Information and to immediately report to HealthStream any non-compliant verifications.

To the extent that FCRA applies, Customer certifies that it has taken or will take timely all appropriate steps to comply with the requirements of the FCRA, which shall include but not be limited to:

- Confirming it has a Permissible Purpose for which the Consumer Information will be used and that such information will not be used for any other purpose.
- Certifying that it is a verified entity that is permitted to do business for the Permissible Purpose for which the Consumer Information is provided.
- Confirming that it has (a) obtained written authorization from the individual whose Consumer Information is being requested; (b) provided the individual the required FCRA disclosure in writing; (c) notifying the individual that the Consumer Information requested for employment purposes will be used only for lawful purposes.

For purposes of this FCRA compliance certification, all capitalized terms shall have the same meaning as in the FCRA.

2. Notwithstanding the applicable section of the Agreement (as defined below and including agreements between Customer and a HealthStream-owned entity) outlining the material breach cure period, the cure period for a Customer's failure to make payment within the payment deadline as outlined in the applicable Agreement shall be thirty (30) days.

This Order Form, including all attachments and exhibits hereto, and the use of the Service(s) ordered shall be governed in all cases by the Master Services Agreement (the "Agreement" or "MSA") between Customer and HealthStream, Inc., as amended. Effective September 1, 2023, VerityStream, Inc. merged with HealthStream, Inc. If applicable, any reference to VerityStream, Inc. in the MSA shall mean HealthStream, Inc.

This Order Form is intended by both parties to run for the full term as set forth in the Order Details table above. In the event the Agreement is terminated or expires prior to the expiration of the full term set forth above for each Software or Service, the term of each Software or Service license, or the subscription to the Software or Services shall also expire at that time and the Customer will not recover any fees paid in advance for the applicable Product(s), Software, or Service(s) for any part of the term or quantity for that Software, Service(s), or Product(s) that go unused, except as otherwise provided in the Agreement.

IN WITNESS WHEREOF, and intending to be legally bound hereby, each party hereto warrants and represents that this Order Form has been duly authorized by all necessary corporate action and that this Order Form has been duly executed by and constitutes a valid and binding agreement of that party.

HealthStream Inc.

Salinas Valley Memorial Healthcare System

By: Sneha Oakley

By: _____

Print Name: Sneha Oakley

Print Name: _____

Print Title: General Counsel

Date: 08/17/2026

Print Title: _____

Date: _____

Master Services Agreement



This Master Services Agreement ("**Agreement**") is entered into and effective as of July 24, 2015 ("**Effective Date**") by and between **HealthStream, Inc.**, a Tennessee corporation, having its principal place of business at 209 10th Avenue South, Suite 450, Nashville, Tennessee 37203 ("**HealthStream**") and Salinas Valley Memorial Healthcare Systems, having its principal place of business at 450 E Romie Ln, Salinas, CA, 93901 ("**Customer**"). Unless otherwise specified herein, this Agreement shall supersede any and all previous master services or similar agreement(s) between HealthStream and Customer.

For good and valuable consideration, the receipt and sufficiency of which is acknowledged, the parties agree as follows:

1. Definitions.

"**Online Service(s)**" means certain Service(s) provided by HealthStream to Users over the Internet or other similar computer networks (excluding courseware).

"**Order Form**" means the ordering documents, including any order forms or project specification outlines (PSOs), representing the initial purchase of any Services as well as any subsequent purchases agreed to between the parties in writing from time to time, that are signed under this Agreement and deemed incorporated into Exhibit A. Customer has designated those entities set forth on Exhibit B as additional purchasers with the authority to enter into Order Forms under this Agreement and bind Customer.

"**Service(s)**" means all service(s) provided by HealthStream, including but not limited to Online Service(s).

"**Users**" means Customer's employees, consultants, contractors, clients or agents who are authorized to use the Online Service(s) and have been supplied user identifications and passwords by Customer (or by HealthStream at Customer's request).

2. Provision of Service(s). HealthStream shall make the Service(s) available to Customer pursuant to the terms and conditions set forth in this Agreement and any and all Order Forms executed under this Agreement from time to time.

3. Use of Online Service(s).

3.1 Dependent Online Service(s). Certain Online Service(s) including, without limitation, courseware services, authoring services, and dictionary services (collectively the "**Dependent Online Services**"), require other Online Service(s) including, without limitation, Learning Center (in one of several versions) and Competency Center (collectively the "**Required Online Services**"), to be licensed by Customer to enable the Customer to use the Dependent Online Services. HealthStream may require and Customer shall agree to contract for, license and purchase at least the minimum level of Required Online Services as determined from HealthStream from time to time as a pre-requisite to contracting for, licensing and purchasing the Dependent Online Services. All relationships between Required Online Services and Dependent Online Services shall be detailed in the applicable Order Form(s).

3.2 HealthStream Responsibilities. HealthStream shall: (a) provide telephone and online standard support to designated representatives of Customer; and (b) use commercially reasonable efforts to make the Online Service(s) generally available 24 hours a day, 7 days a week, except for: (i) planned downtime; or (ii) any unavailability caused by circumstances beyond HealthStream's reasonable control, including without limitation, acts of God, acts of government, flood, fire, earthquakes, civil unrest, acts of terror, strikes or other labor problems (other than those involving HealthStream employees), computer, telecommunications, Internet service provider or hosting facility failures or delays involving hardware, software or power systems not within HealthStream's possession or reasonable control, and network intrusions or denial of service attacks.

3.3 Customer Responsibilities. Customer is responsible for all activities that occur under Customer's User accounts. Customer shall:

(a) have sole responsibility for the accuracy, quality, integrity, legality, reliability, and appropriateness of all Customer Data; (b) use commercially reasonable efforts to prevent unauthorized access to, or use of, the Online Service(s), and notify HealthStream promptly of any unauthorized use; and (c) comply with all applicable local, state, federal, and foreign laws in using the Online Service(s) and, if using the Online Service(s) outside of the United States, not use the Online Service(s) in a manner that would violate any federal or state laws of the United States if conducted in the United States.

3.4 Use Guidelines. Customer shall use the Online Service(s) solely for its internal business purposes as contemplated by this Agreement and shall not: (a) license, sublicense, sell, resell, rent, lease, transfer, assign, distribute, time share or otherwise commercially exploit or make the Online Service(s) available to any third party, other than as contemplated by this Agreement; (b) send spam or otherwise duplicative or unsolicited messages in violation of applicable laws; (c) send or store infringing, obscene, threatening, libelous, or otherwise unlawful or tortious material, including material harmful to children or violative of third party privacy rights; (d) send or store material containing software viruses, worms, Trojan horses or other harmful computer code, files, scripts, agents or programs; (e) interfere with or disrupt the integrity or performance of the Online Service(s) or the data contained in the Online Service(s); or (f) attempt to gain unauthorized access to the Online Service(s) or its related systems or networks.

4. Fees & Payment.

Fees. Customer shall pay all fees specified in all executed Order Forms. In the case of Online Service(s) and except as otherwise provided: (a) fees are based on the number of User subscriptions purchased in the relevant Order Form, not the extent of actual usage; (b) fees are non-refundable; (c) the number of User subscriptions purchased cannot be decreased during the relevant subscription term stated on the Order Form; and (d) User subscriptions are for named Users and cannot be shared or used by more than one User but may be reassigned from time to time to new Users replacing former Users who have terminated an employment or some other prior relationship with Customer, changed job status or function, or otherwise no longer require ongoing use of the Service. Unless otherwise specified in the relevant Order Form, (a) the term of the transferred User subscriptions shall be coterminous with the expiration of the then current subscription term; and (b) pricing for the transferred User subscriptions shall be the same as that for the pre-existing subscriptions. HealthStream shall have the right at all times to review and audit the number of Users for any Online Service and to bill Customer for any Users in excess of that number of properly licensed and paid Users under all Order Forms and subscriptions.

4.1 Invoicing & Payment; Suspension of Service. Customer shall maintain complete and accurate billing and contact information with HealthStream at all times. Fees for the Service(s) will be invoiced in advance and otherwise in accordance with the terms set forth in the relevant Order Form. Unless otherwise stated in the Order Form, charges are due 30 days from the invoice date and all payments made under this Agreement shall be in United States dollars. Any payment not received from Customer by the due date may accrue (except with respect to charges then under reasonable and good faith dispute), at HealthStream's discretion, late charges at the rate of 1.5% of the outstanding balance per month, or the maximum rate permitted by law, whichever is lower, from the date the payment was due until the date

paid. If Customer's account is thirty (30) days or more overdue (except with respect to charges then under reasonable and good faith dispute), in addition to any of its other rights or remedies, HealthStream reserves the right to suspend the Service(s) provided to Customer, without liability to Customer, until the overdue amounts are paid in full.

4.2 Taxes. Unless otherwise stated, HealthStream's fees do not include any local, state, federal or foreign taxes, levies or duties of any nature ("Taxes"). Customer is responsible for paying all Taxes, excluding only taxes based on HealthStream's income. If HealthStream has the legal obligation to pay or collect Taxes for which Customer is responsible under this section, the appropriate amount shall be invoiced to and paid by Customer unless Customer provides HealthStream with a valid tax exemption certificate authorized by the appropriate taxing authority.

5. Proprietary Rights.

5.1 Reservation of Rights. Customer acknowledges that in providing the Service(s), HealthStream utilizes (a) the HealthStream name, the HealthStream logo, the HealthStream domain name, the product and service names associated with the Service(s), and other trademarks and service marks; (b) certain audio and visual information, documents, software and other works of authorship; (c) certain processes including, but not limited to, HealthStream's databases, questionnaires, market research procedures, tabulation procedures, creative processes, statistical methods, and production methods; and (d) other technology, software, hardware, products, processes, algorithms, user interfaces, know-how and other trade secrets, techniques, designs, inventions and other tangible or intangible technical material or information (collectively, "HealthStream IP") and that the HealthStream IP is covered by intellectual property rights owned or licensed by HealthStream (collectively, "HealthStream IP Rights"). Other than as expressly set forth in this Agreement, no license or other rights in or to the HealthStream IP or HealthStream IP Rights are granted to Customer, and all licenses and rights are expressly reserved.

5.2 License Grant. HealthStream grants Customer and its Users a worldwide, non-exclusive, non-transferable, non-sublicenseable right to access and use the Online Service(s) in accordance with the terms of this Agreement.

5.3 Restrictions. Customer shall not (a) modify, copy or create derivative works based on the Service(s) or HealthStream IP; (b) create Internet "links" to or from the Online Service(s), or "frame" or "mirror" any content forming part of the Online Service(s), other than on Customer's own intranet; or (c) disassemble, reverse engineer, or decompile the Service(s) or HealthStream IP, or access it in order to build a similar or competitive product or service or copy any ideas, features, functions or graphics of the Service(s).

5.4 Customer Data. As between HealthStream and Customer, all data obtained by HealthStream from Customer through the provision of the Service(s) (collectively, the "Customer Data") is owned exclusively by Customer. Customer grants HealthStream an unrestricted, royalty-free, irrevocable license to maintain and distribute aggregated compilations of Customer Data ("Aggregated Data") and to use such Aggregated Data for future studies and reports; provided, however, that the Aggregated Data will not reveal any personal information or the identity of Customer. HealthStream may distribute certain Customer Data to licensing and accreditation organizations for the benefit of Users. HealthStream will release the minimum data required to adequately credit Users for educational activities completed. All Customer Data may be copied, displayed, published and otherwise used by the Customer; provided, however, that Customer hereby agrees that it shall not utilize or present the Customer Data in any manner that materially misrepresents the Customer Data. HealthStream shall hold all completed survey instruments prepared in connection with the Service(s) for which HealthStream distributes surveys on behalf of Customer for a period of 90 days following delivery of such survey instruments, after which time all survey instruments shall be destroyed, although HealthStream shall maintain electronic copies of the survey data.

5.5 Suggestions. HealthStream shall have a royalty-free, worldwide, perpetual license to use or incorporate into the Service(s) any

suggestions, ideas, enhancement requests, feedback, recommendations or other information provided by Customer or its Users relating to the Service(s).

6. Confidentiality.

6.1 Definition of Confidential Information. As used in this Agreement, "Confidential Information" means all confidential and proprietary information of a party ("Disclosing Party") disclosed to the other party ("Receiving Party"), whether orally or in writing, that is designated as confidential or that reasonably should be understood to be confidential given the nature of the information and the circumstances of disclosure including, without limitation, the terms and conditions of this Agreement (including pricing and other terms reflected in all Order Forms under this Agreement), the Customer Data, the Service(s), the HealthStream IP, business and marketing plans, technology and technical information, product designs, and business processes. Confidential Information (except for Customer Data) shall not include any information that: (a) is or becomes generally known to the public without breach of any obligation owed to the Disclosing Party; (b) was known to the Receiving Party prior to its disclosure by the Disclosing Party without breach of any obligation owed to the Disclosing Party; (c) was independently developed by the Receiving Party without breach of any obligation owed to the Disclosing Party; or (d) is received from a third party without breach of any obligation owed to the Disclosing Party.

6.2 Confidentiality. The Receiving Party shall not disclose or use any Confidential Information of the Disclosing Party for any purpose outside the scope of this Agreement. Each party agrees to protect the confidentiality of the Confidential Information of the other party in the same manner that it protects the confidentiality of its own proprietary and confidential information of like kind, but in no event shall either party exercise less than reasonable care in protecting the Confidential Information. If the Receiving Party is compelled by law to disclose Confidential Information of the Disclosing Party, it shall provide the Disclosing Party with prior notice of the compelled disclosure (to the extent legally permitted) and reasonable assistance, at Disclosing Party's cost, if the Disclosing Party wishes to contest the disclosure.

6.3 Remedies. If the Receiving Party discloses or uses (or threatens to disclose or use) any Confidential Information of the Disclosing Party in breach of this Section 6, the Disclosing Party shall have the right, in addition to any other remedies available to it, to seek injunctive relief to enjoin the acts, it being specifically acknowledged by the parties that any other available remedies are inadequate.

7. Warranties & Disclaimers.

7.1 Warranties.

(a) **General.** Each party represents and warrants that it has the legal power to enter into this Agreement. HealthStream represents and warrants that (i) it will provide the Service(s) in a manner consistent with general industry standards reasonably applicable to the provision of the Service; (ii) it owns or otherwise has sufficient rights to the Service(s) and the HealthStream IP to grant the rights and licenses granted in this Agreement; (iii) it will perform the Services in a skillful, professional, workmanlike and competent manner by qualified personnel; (iv) the Service(s) and HealthStream IP do not infringe any intellectual property rights of any third party. During the term of this Agreement, (i) the Online Service(s) shall perform materially in accordance with any applicable user guides or specifications; and (ii) the functionality of the Online Service(s) will not be materially decreased from that available as of the Effective Date. Customer agrees that its purchase of the Online Service(s) is not contingent upon the delivery of any future functionality or features nor is it dependent upon any oral or written public comments made by HealthStream with respect to future functionality or features.

(b) Customer Research Data Limited Warranty.

HealthStream warrants that the Customer Data provided by HealthStream as a result of certain research Service(s) ("Customer Research Data") will conform substantially to the terms specified in the Order Form. In the event of a breach of this warranty, Customer shall provide HealthStream with written notice of such breach, identifying the claimed errors or deficiencies in the Customer Research Data provided, and HealthStream shall have a reasonable period to cure

such purported errors or deficiencies. HEALTHSTREAM'S SOLE OBLIGATION UNDER THIS WARRANTY SHALL BE TO CORRECT AND/OR MODIFY THE CUSTOMER RESEARCH DATA SO THAT IT CONFORMS SUBSTANTIALLY TO THE TERMS SPECIFIED IN THE ORDER FORM. Customer shall notify HealthStream of any errors and/or deficiencies in the Customer Research Data within three (3) months of HealthStream's delivery of the Customer Research Data to Customer, or such claims shall be waived.

(c) **Non-Exclusion.** HealthStream represents and warrants that HealthStream, its officers, directors, and employees (i) are not currently excluded, debarred, or otherwise ineligible to participate in the federal healthcare programs as defined in 42 U.S.C. §1320a-7b(f) (the "federal healthcare programs"), (ii) have not been convicted of a criminal offense related to the provision of healthcare items or services and have not been excluded, debarred, or otherwise declared ineligible to participate in the federal healthcare programs, and (iii) are not, to the best of its knowledge, under investigation or otherwise aware of any circumstances which may result in HealthStream being excluded from participation in the federal healthcare programs. This shall be an ongoing representation and warranty and HealthStream shall immediately notify Customer of any change in the status of the representations and warranty set forth in this section.

7.2 Disclaimer. EXCEPT AS EXPRESSLY PROVIDED IN THIS AGREEMENT, HEALTHSTREAM MAKES NO WARRANTY OF ANY KIND, WHETHER EXPRESS, IMPLIED, STATUTORY, OR OTHERWISE. HEALTHSTREAM SPECIFICALLY DISCLAIMS ALL IMPLIED WARRANTIES, INCLUDING ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE, TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW.

8. Mutual Indemnification.

8.1 Indemnification by HealthStream. Subject to this Agreement, HealthStream shall defend, indemnify and hold Customer harmless against any loss or damage (including reasonable attorneys' fees) incurred in connection with claims, demands, suits, or proceedings ("Claims") made or brought against Customer by a third party alleging that the use of the Service(s) as contemplated under this Agreement infringes the intellectual property rights of a third party; provided, that Customer (a) promptly gives written notice of the Claim to HealthStream; (b) gives HealthStream sole control of the defense and settlement of the Claim (provided that HealthStream may not settle or defend any Claim unless it unconditionally releases Customer of all liability); and (c) provides to HealthStream, at HealthStream's cost, all reasonable assistance.

8.2 Indemnification by Customer. Subject to this Agreement, Customer shall defend, indemnify and hold HealthStream harmless against any loss or damage (including reasonable attorneys' fees) incurred in connection with Claims made or brought against HealthStream by a third party alleging that the Customer Data or Customer's use of the Service(s) (as opposed to the Service itself) infringes the intellectual property rights of, or has otherwise harmed, a third party; provided, that HealthStream (a) promptly gives written notice of the Claim to Customer; (b) gives Customer sole control of the defense and settlement of the Claim (provided that Customer may not settle or defend any Claim unless it unconditionally releases HealthStream of all liability); and (c) provides to Customer, at Customer's cost, all reasonable assistance.

9. Limitation of Liability.

9.1 Limitation of Liability. EXCEPT FOR LIABILITY ARISING UNDER SECTIONS 4 (PAYMENT OF FEES) OR 5.3 (RESTRICTIONS), IN NO EVENT SHALL EITHER PARTY'S AGGREGATE LIABILITY ARISING OUT OF OR RELATED TO THIS AGREEMENT, WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, EXCEED THE LESSER OF \$100,000 OR THE AMOUNTS ACTUALLY PAID BY AND DUE FROM CUSTOMER UNDER THIS AGREEMENT.

9.2 Exclusion of Consequential and Related Damages. IN NO EVENT SHALL EITHER PARTY HAVE ANY LIABILITY TO THE OTHER PARTY FOR ANY LOST PROFITS, LOSS OF USE, COSTS OF PROCUREMENT OF SUBSTITUTE GOODS OR SERVICES, OR

FOR ANY INDIRECT, SPECIAL, INCIDENTAL, PUNITIVE, OR CONSEQUENTIAL DAMAGES HOWEVER CAUSED AND, WHETHER IN CONTRACT, TORT OR UNDER ANY OTHER THEORY OF LIABILITY, WHETHER OR NOT THE PARTY HAS BEEN ADVISED OF THE POSSIBILITY OF THE DAMAGE.

9.3 Limitation of Action. Except for actions for non-payment or breach of either party's intellectual property rights, no action (regardless of form) arising out of this Agreement may be commenced by either party more than two (2) years after the cause of action has accrued.

9.4 WAIVER OF RIGHT TO JURY TRIAL. EACH PARTY HEREBY WAIVES ANY RIGHT TO A JURY TRIAL IN CONNECTION WITH ANY ACTION OR LITIGATION IN ANY WAY ARISING OUT OF OR RELATED TO THIS AGREEMENT, INCLUDING, WITHOUT LIMITATION, ANY ORDER FORM UNDER THIS AGREEMENT.

10. Term & Termination.

10.1 Term of Agreement. This Agreement commences on the Effective Date and, unless earlier terminated pursuant to the terms of this Agreement, continues until the later of the date when (a) all User subscriptions granted in accordance with this Agreement have expired or been terminated and (b) no Service(s) is being provided by HealthStream.

10.2 Term of User Subscriptions. User subscriptions for Online Service(s) commence on the start date specified in the relevant Order Form and continue for the subscription term specified in the Order Form. User subscriptions for Online Service(s) shall automatically renew for one (1) additional one (1) year term at 105% of the then current fee charged to Customer, unless one party provides the other notice of termination at least ninety (90) days prior to the end of the relevant subscription term.

10.3 Termination for Cause. A party may terminate this Agreement for cause: (a) upon ninety (90) days written notice of a material breach to the other party if the breach remains uncured at the expiration of the cure period; or (b) if the other party becomes the subject of a petition in bankruptcy or any other proceeding relating to insolvency, receivership, liquidation or assignment for the benefit of creditors. Upon any termination for cause by Customer, HealthStream shall refund Customer any prepaid fees for Online Service(s) for the remainder of the User subscription term after the date of termination. Termination shall not relieve Customer of the obligation to pay any fees accrued or payable to HealthStream prior to the effective date of termination.

10.4 Surviving Provisions. The following provisions shall survive any termination or expiration of this Agreement: Sections 4, 5 (excluding Section 5.2), 6, 7, 8, 9, 10 and 11.

11. General Provisions.

11.1 Relationship of the Parties; Publicity. This Agreement does not create a partnership, franchise, joint venture, agency, fiduciary or employment relationship between the parties. There are no third-party beneficiaries to this Agreement. Neither party may issue press releases relating to this Agreement without the other party's prior written consent. Either party may include the name and logo of the other party in lists of customers or vendors in accordance with the other party's standard guidelines.

11.2 Notices. All notices under this Agreement shall be in writing and shall be deemed to have been given upon: (a) personal delivery; (b) the second business day after mailing; (c) the second business day after sending by confirmed facsimile; or (d) the second business day after sending by email. Notices to HealthStream shall be addressed to the attention of its Legal Department.

11.3 Waiver and Cumulative Remedies; Severability. No failure or delay by either party in exercising any right under this Agreement shall constitute a waiver of that right. Other than as expressly stated in this Agreement, the remedies provided in the Agreement are in addition to, and not exclusive of, any other remedies of a party at law or in equity. If any provision of this Agreement is held by a court of competent jurisdiction to be contrary to law, the provision shall be modified by the court and interpreted so as best to accomplish the objectives of the

original provision to the fullest extent permitted by law, and the remaining provisions of this Agreement shall remain in effect.

11.4 Assignment. Neither party may assign any of its rights or obligations under this Agreement, whether by operation of law or otherwise, without the prior express written consent of the other party. Notwithstanding the foregoing, either party may assign this Agreement together with all rights and obligations under this Agreement, without consent of the other party, in connection with a merger, acquisition, corporate reorganization, or sale of all or substantially all of its assets. Any attempt by a party to assign its rights or obligations under this Agreement in breach of this section shall be void and of no effect. Subject to the foregoing, this Agreement shall bind and inure to the benefit of the parties, their respective successors and permitted assigns.

11.5 Governing Law and Venue. This Agreement shall be governed exclusively by the internal laws of the State of Tennessee, without regard to its conflicts of laws rules. The state and federal courts located in Davidson County, Tennessee shall have exclusive jurisdiction to adjudicate any dispute arising out of or relating to this Agreement. Each party consents to the exclusive jurisdiction of these courts.

11.6 Authority. The persons signing below have the right and authority to execute this Agreement for their respective entities and no further approvals are necessary to create a binding Agreement.

11.7 Entire Agreement. This Agreement, including all exhibits and addenda to this Agreement and all Order Forms signed under this Agreement, constitutes the entire agreement between the parties, and supersedes all prior and contemporaneous agreements, proposals or representations, written or oral, concerning its subject matter. No modification, amendment, or waiver of any provision of this Agreement shall be effective unless in writing and signed by the party against whom the modification, amendment or waiver is to be asserted. In the event of any conflict between the provisions in this Agreement and any exhibit or addendum to this Agreement, or Order Form signed under this Agreement, the terms of the exhibit, addendum or Order Form shall prevail to the extent of any inconsistency. Notwithstanding any language to the contrary therein, no terms or conditions stated in a Customer purchase order or in any other Customer order documentation (excluding Order Forms) shall be incorporated into or form any part of this Agreement, and all such terms or conditions shall be null and void. This Agreement may be executed in counterparts, which taken together shall form one legal instrument.

IN WITNESS WHEREOF, the parties' authorized signatories have duly executed this Agreement as of the Effective Date:

Salinas Valley Memorial Healthcare Systems

By: Luis Fonseca
Luis Fonseca (Aug 24, 2015)
Print Name: _____
Title _____
Date Aug 24, 2015

HealthStream Inc.

By: Karen Frazier
Karen Frazier (Aug 24, 2015)
Print Name: _____
Title _____
Date Aug 24, 2015

EXHIBIT A

Order Forms and/or PSOs

To be attached to this Exhibit and Agreement and incorporated into this Exhibit and Agreement from time to time upon signing.

EXHIBIT B

Authorized Purchasing Entities

To be attached listed by the Customer, these are entities authorized to enter into Order Forms and bind Customer under this Agreement.

Financial Performance Review

June 2026

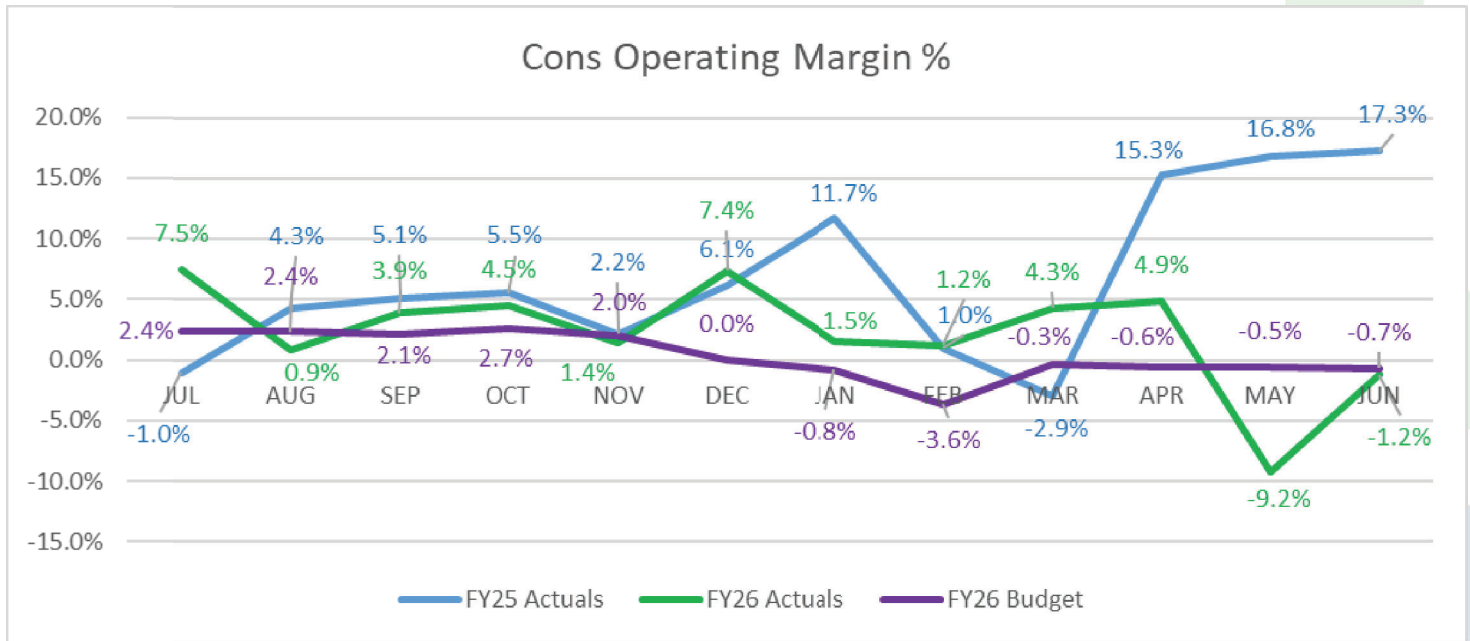
Iftikhar Hussain
 Chief Financial Officer

Consolidated Financial Results

June 2026

Month					\$ in Millions	YTD				
June			Bud Variance (unfav)			June			Bud Variance (unfav)	
Actual	Budget	Prior Year	\$	%		Actual	Budget	Prior Year	\$	%
\$ 72.3	\$ 70.2	\$ 68.9	\$ 2.1	3.0%	Operating Revenue	\$ 867.6	\$ 837.1	\$ 845.2	\$ 30.5	3.6%
73.2	70.7	57.0	(2.5)	-3.5%	Operating Expense	846.4	833.5	784.7	(12.9)	-1.5%
(0.9)	(0.5)	11.9	(0.4)	-80.0%	Income from Operations	21.2	3.6	60.5	17.6	488.9%
-1.2%	-0.7%	17.3%	-0.5%	-71.43%	Operating Margin %	2.4%	0.4%	7.2%	2.0%	500.0%
					Op. margin % full year target		3.0%			
1.6	2.5	5.6	(0.9)	-36.0%	Non Operating Income	19.3	29.8	40.2	(10.5)	-35.2%
0.7	2.0	17.5	(1.3)	-65.0%	Net Income	40.5	33.4	100.7	7.1	21.3%
1.0%	2.9%	25.4%	-1.9%	-65.52%	Net Income Margin %	4.7%	4.0%	11.9%	0.7%	17.5%

Consolidated Operating Margin



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Key Financial Indicators

Indicator Metric	YTD 6/30/2026	Budget	S&P A+ Rated	YTD Prior Year
Operating Margin*	2.4%	0.4%	4.0%	7.2%
Total Margin*	4.7%	4.0%	6.6%	11.9%
EBITDA Margin**	7.5%	5.4%	13.6%	11.7%
Days of Cash*	353	317	249	382
Days of Accounts Payable*	46	45	-	49
Days of Net Accounts Receivable***	64	60	49	72
Supply Expense as % NPR	14.7%	14.6%	-	15.3%
Labor Expense as % NPR	50.7%	55.7%	53.7%	52.3%
Operating Expense per APD*	7,414	7,205	-	6,614

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)

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Executive Summary

- June Volumes were generally positive with high admission coming mainly from the ER
- Admissions and Census
 - YTD Admissions and Observations are 2.5% higher than PY
 - YTD ADC is 4% lower than PY due to length of stay improvement
 - June Admissions of 1,111 was the highest for FY26
 - YTD ER volumes are down 2% from PY.
- Deliveries have decreased consistent with demographic trends
- Cath Lab – YTD cases are up 2% from PY
- Procedure Volumes for the year are stable.
 - Strong growth in Infusion services, up 7% from PY
 - Surgical volume higher for the month. YTD Surgeries off 1% from PY

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Executive Summary: June Financial Performance – Continued

Cost and Utilization:

- **Worked FTEs** on a per Adjusted ADC basis were **2%** unfavorable at **6.8** - compared to a target of **6.7**
- **Payor Mix** was close to budget
- **Non-Operating Income** was under budget by \$0.9 million due to unrealized loss related to higher interest rates
- **Days in AR** declined to 64 days on higher cash collections
- **Days Cash on Hand** are stable despite \$52 million in capital spending

Worked FTEs: During the month of

Key Metrics	Prior 3 Months			Current Month	
	Mar-26 Actual	Apr-26 Actual	May-26 Actual	Jun-26 Actuals	Jun-26 Budget
Total Gross Revenue	\$ 313,675	\$ 298,735	\$ 299,504	\$ 324,206	\$ 295,873
Medicare %	49%	47%	46%	47%	46%
Medicaid %	29%	28%	29%	27%	29%
Commercial %	19%	19%	21%	21%	21%
All Other %	4%	5%	4%	5%	4%

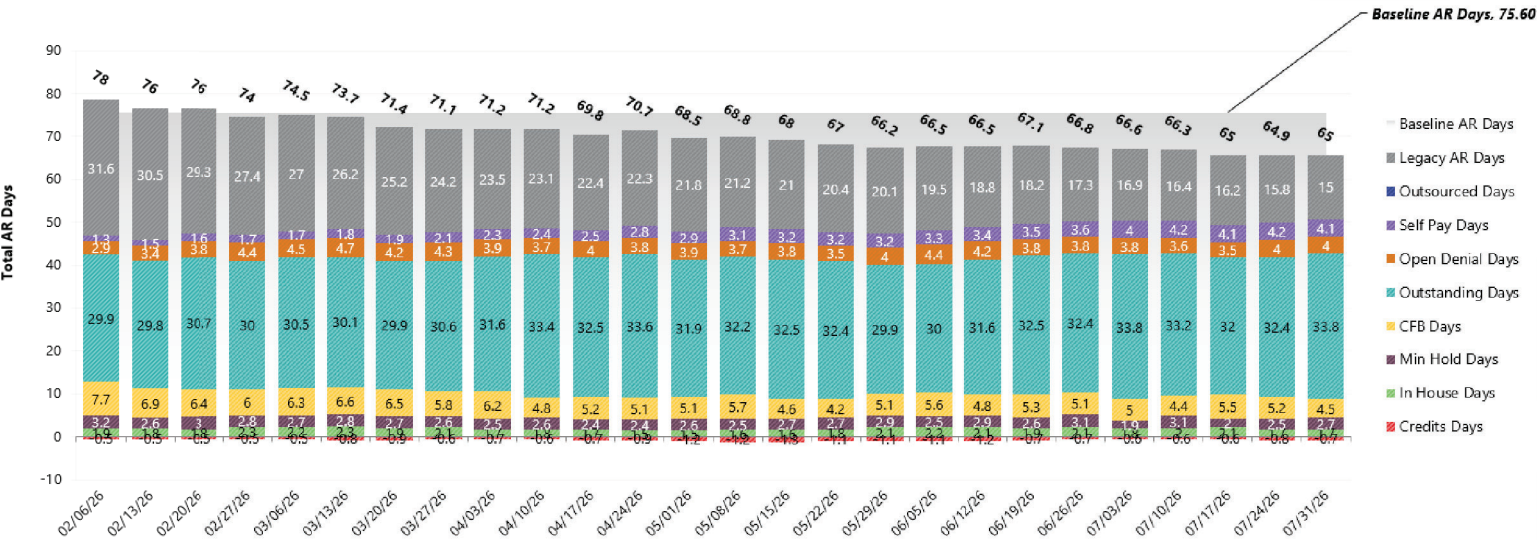
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Volume Summary – June 2026

Actual	Prior Year	Jun Bud	Bud Var	Key Statistics	YTD	YTD-PY	YTD Jun Bud	YTD Bud Var
Inpatient								
125	108	114	↑	10% ADC	110	116	114	↓ -4%
1,111	904	901	↑	23% Admissions	11,812	11,642	10,966	↑ 8%
120	107	126	↓	-5% Deliveries	1,282	1,377	1,536	↓ -17%
2.0	2.1	2.3	↓	-13% Medicare Traditional ALOS CMI Adjusted	2.1	2.2	2.3	↓ -10%
1.86	1.76	1.75	↑	6% Medicare Traditional Case Mix	1.75	1.76	1.75	↑ 0%
Emergency Room								
4,188	4,260	4,503	↓	-7% ER OP Visits	52,740	54,141	54,791	↓ -4%
872	727	695	↑	25% ER IP Admissions	9,261	9,034	8,460	↑ 9%
Procedures								
190	137	141	↑	35% IP Surgeries	1,867	1,799	1,719	↑ 9%
299	320	283	↑	6% OP Surgeries	3,590	3,718	3,447	↑ 4%
375	357	323	↑	16% Cath Lab	3,897	3,819	3,926	↓ -1%
1,201	1,127	1,121	↑	7% OP Infusion Cases	14,937	13,975	13,636	↑ 10%
391	293	392	↓	0% MRI Procedures	4,074	3,398	4,765	↓ -15%
2,327	2,017	2,098	↑	11% CT Scans	24,831	23,819	25,527	↓ -3%
Observation Cases								
146	212	148	↓	-1% Obs Cases	2,215	2,044	1,795	↑ 23%

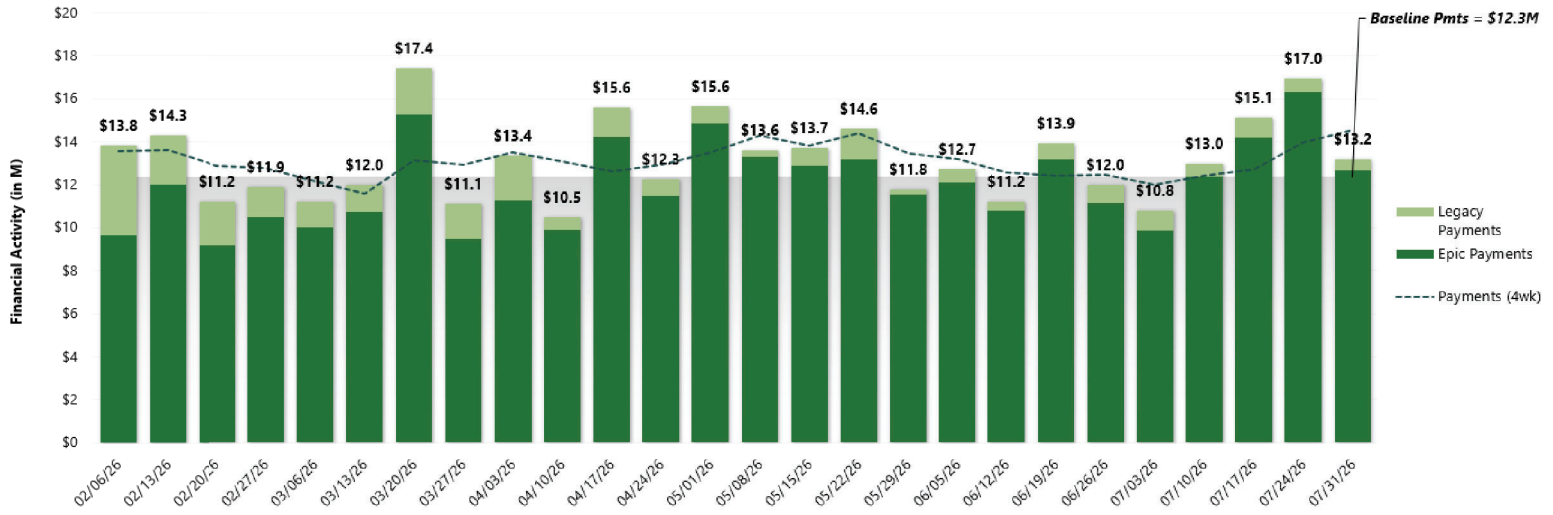
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Accounts Receivable – AR Days Trend



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Accounts Receivable –Payment Trend



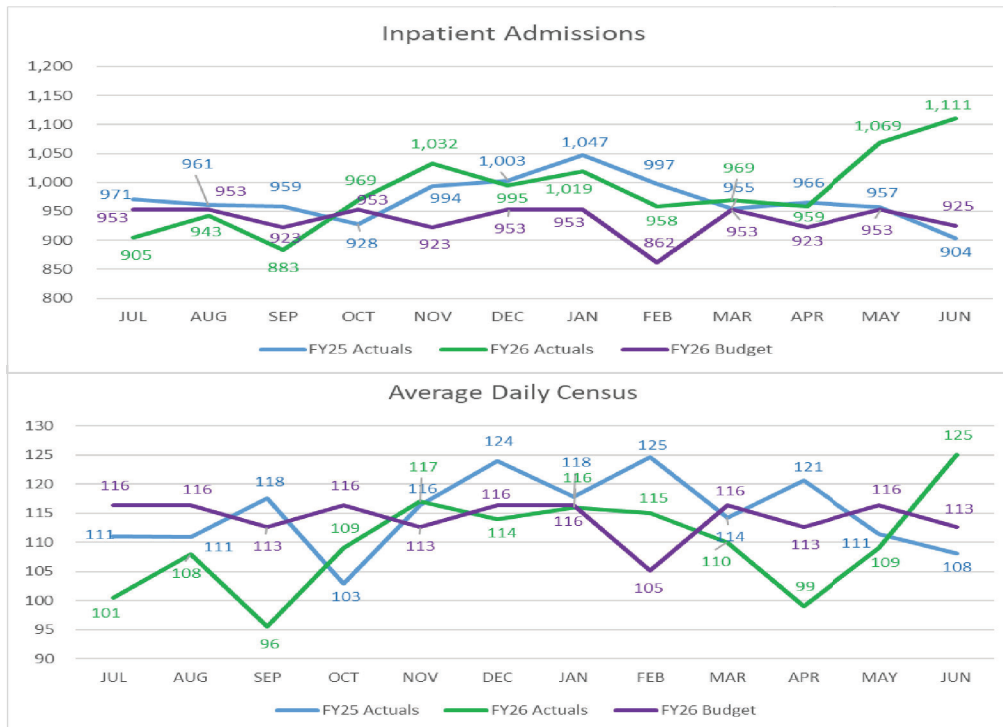
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Medi-Cal and Other Supplemental Payments

FY 2026					Regular	One Time
Date	Payor	Description	Total Amount			
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	
Jun 2026	DHCS	Medi-Cal Rate Range (net) CY 2025-26	2,218,743		2,218,743	
Oct 2026-Estimate	CAAH	Direct Payment Program (net) Phase 2- CY 2024	3,899,576		3,899,576	
Oct 2026-Estimate	CAAH	Direct Payment Program (net) Phase 1- CY 2025	18,190,740		18,190,740	
Total FY 2026			57,492,571		45,492,571	12,000,000
FY 2025					Regular	One Time
Date	Payor	Description	Amount			
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

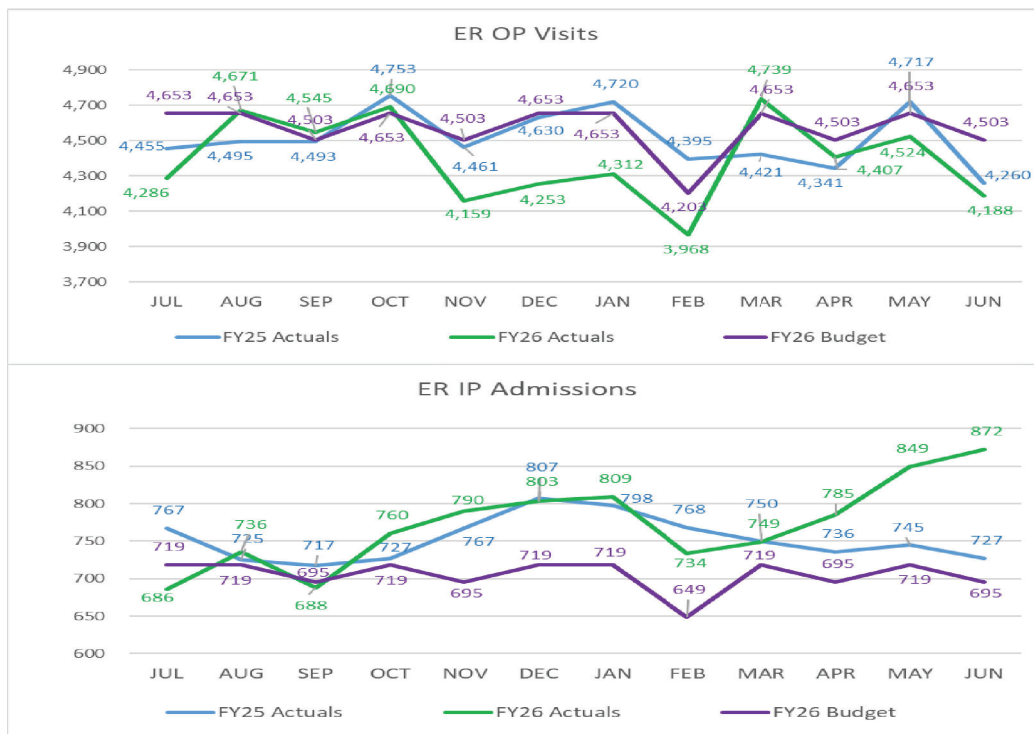
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Volume Trends – Admissions & ADC



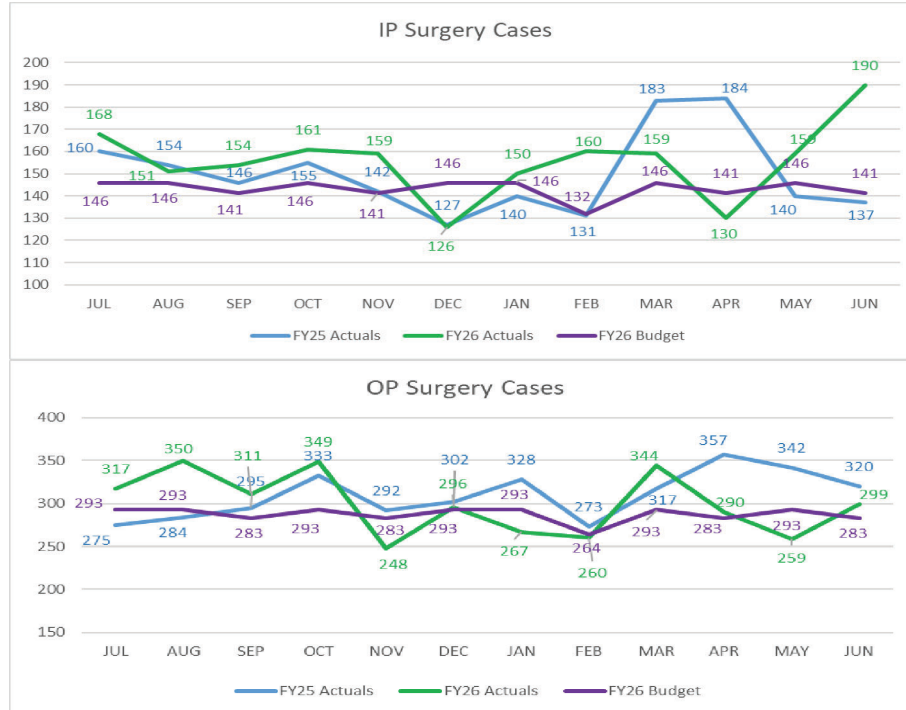
11

Volume Trends – ER



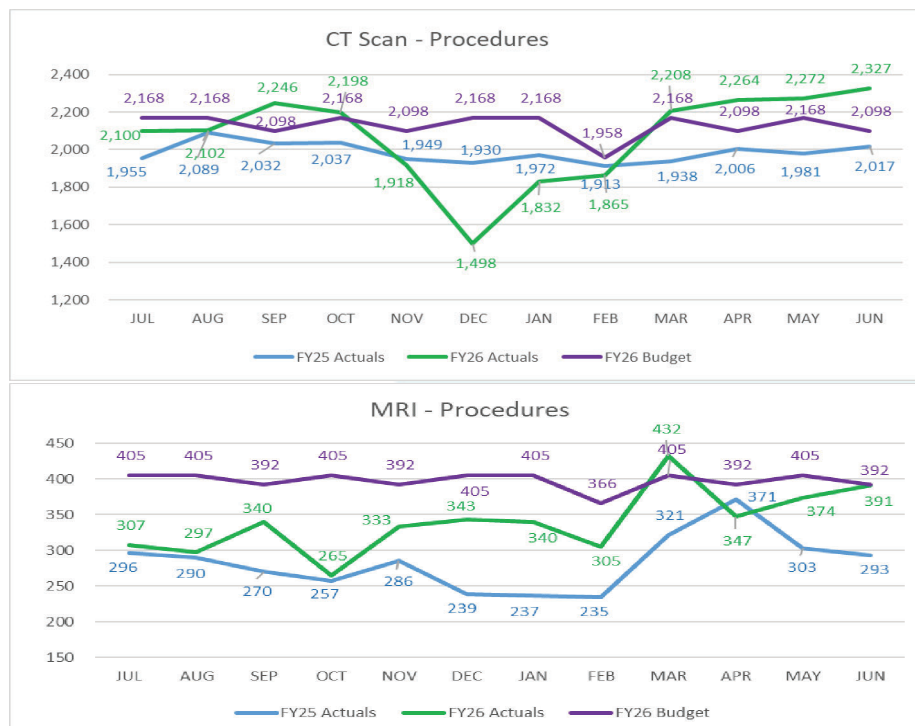
12

Volume Trends - Surgery Cases



13

Volume Trends - Imaging



14

Labor Productivity Key Indicators

Current Month					Year-to-Date			
Prior Year	Actual	Target	Variance (in FTE)		Prior Year	Actual	Target	Variance (in FTE)
1,607.1	1,788.3	1,746.1	(42.2 FTE)	Worked FTE	1,563.2	1,715.7	1,648.4	(67.3 FTE)
4.6%	4.4%	4.5%	3.0 FTE	Overtime as a % of Worked Hours	4.5%	4.4%	4.6%	3.4 FTE
3.5%	3.9%	3.0%	(16.2 FTE)	Contract Labor as a % of Worked Hours	4.0%	5.7%	3.1%	(49.6 FTE)

15

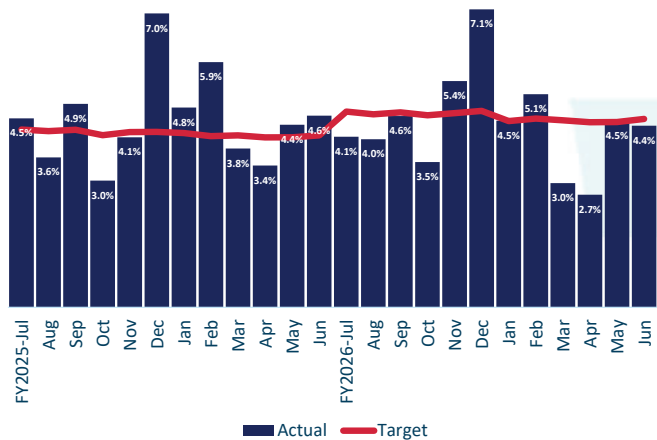
Labor Productivity As of June 2026 Year-to-Date

- **Worked FTE:** Worked FTE is unfavorable to target by 42.2 in the month (as defined by pay periods 25 & 26) and 67.3 on a year-to-date basis. The variance is primarily driven by:
 - Contract Labor: Both the current month and year-to-date contract labor utilization is higher than budget. The impact is a negative FTE variance of 16.2 in June and 49.6 on a year-to-date basis.
 - Lower Non-Productive Time: The budget assumed a 14.9% non-productive rate but the actual result was 11.8% resulting in fixed staff's worked hours being higher than plan. A major contributing factor are the Workday and Epic implementations and teams needing to be present at work in the first few months of the year.
 - Approved but Unbudgeted FTE: Approved cyber security, Workday and system analyst positions were inadvertently not added to the budget resulting in a negative variance of 10.4 FTE.
- **Contract Labor:** Contract labor usage is over budget at 3.9% of Worked FTE in the month and 5.7% 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.

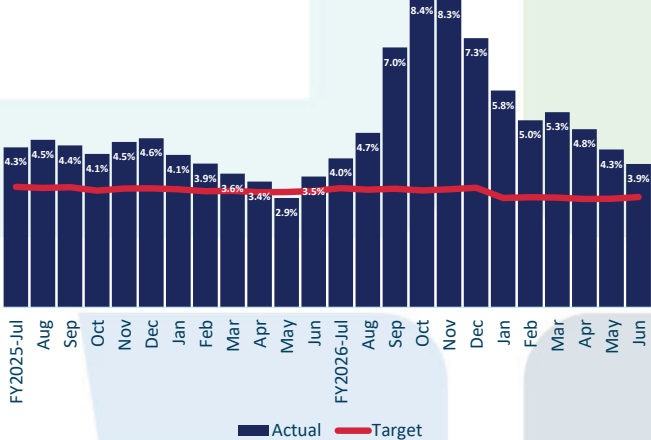
16

Overtime & Contract Labor Trends

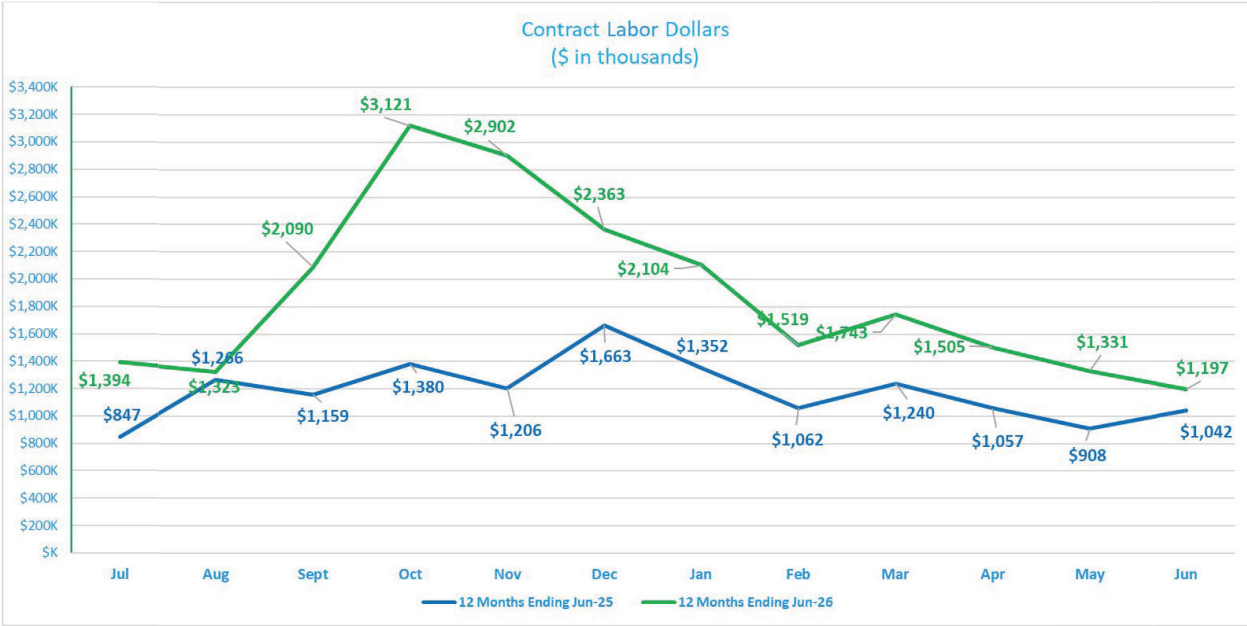
Overtime as a Percent of Worked FTE



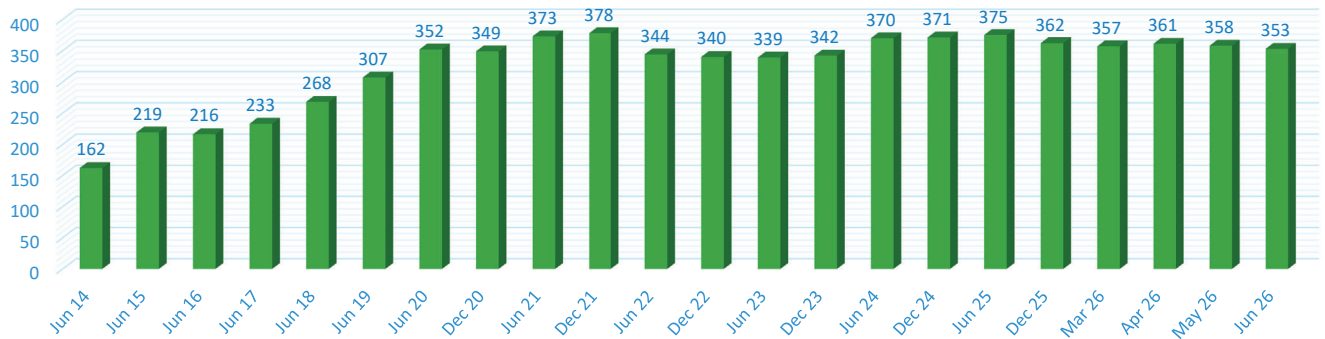
Contract Labor as a Percent of Worked FTE



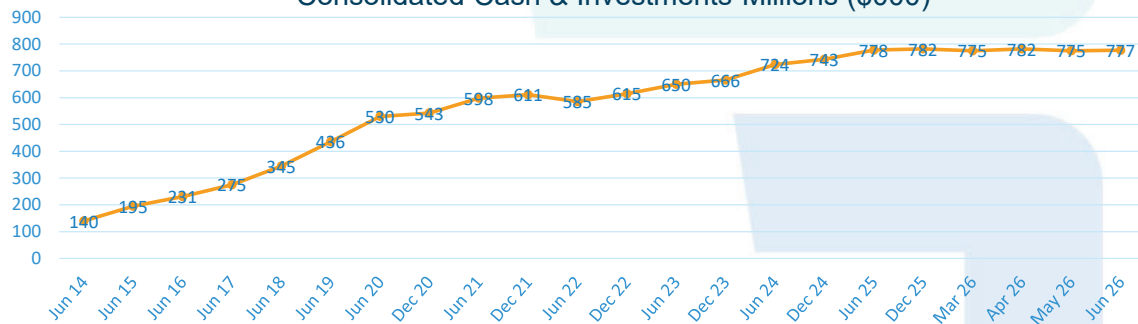
Contract Labor Trends



Days Cash on Hand = 353 Days (\$777M) - June 2026



Consolidated Cash & Investments-Millions (\$000)



19

Questions/Comments

COMMUNITY ADVOCACY COMMITTEE

*Minutes of the
Community Advocacy Committee
will be distributed at the Board Meeting*

(Rolando Cabrera, M.D.)

Medical Executive Committee Summary – August 13, 2026

Items for Board Approval

Credentials Committee

Initial Appointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Abdurashidova, Megan, DO	Neurology	Medicine	Tele-Neurology: Core
Chiang, Brenda, DO	Hematology/ Oncology	Medicine	Hematology/Oncology General Internal Medicine Taylor Farms Family Health & Wellness Center – Ambulatory Procedural Privileges: Hematology and Oncology.
Dawley, Diane, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Gharakhani, Hossein, DO	Emergency Medicine	Emergency Medicine	Emergency Medicine
Hinchey, Judith, MD	Neurology	Medicine	Tele-Neurology
Hsiung, Ingrid, MD	Cardiac Electrophysiology	Medicine	Cardiology Cardiac Electrophysiology. Salinas Valley Health Advanced Imaging – Cardiac Imaging Salinas Valley Health Cardiovascular Diagnostics. Taylor Farms Family Health & Wellness Center – Ambulatory Procedural Privileges: Cardiology
Li, Sui, MD	Neurology	Medicine	Tele-Neurology
Lilja, James, MD	Gynecologic Oncology	Ob/Gyn	Gynecologic Oncology
Malik, Lena, MD	Pediatrics	Family Medicine/ Pediatrics	Active Community – Pediatrics
Pathak, Mayank, MD	Neurology	Medicine	Tele-Neurology
Sarpel, Dost, MD	Infectious Disease	Medicine	Remote Infectious Disease
Wang, Jeff, MD	Anesthesiology	Anesthesiology	Anesthesiology

Reappointment:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Abdoo, David, DPM	Podiatry	Surgery	Podiatry Category A & B
Amarasekera, Sohani, MD	Ophthalmology	Surgery	Ophthalmology
Bagga, Pavandeep, MD	Anesthesiology	Anesthesiology	Anesthesiology
Bidar, Maziar, MD	Ophthalmology	Surgery	Ophthalmology
Blakemore, Tonya, MD	Pediatrics	Pediatrics	Pediatrics
Castellanos, Edgar, MD	Family Medicine	Family Medicine/ Peds	Family Medicine – Active Community
Collin, Carlos, MD	Psychiatry	Medicine	Tele-Psychiatry
Conner, Grant, MD	Otolaryngology	Surgery	Otolaryngology
Ganji, Shiva, MD	Internal Medicine	Medicine	Adult Hospitalist
Grandison, Amber, MD	Family Medicine	Family Medicine	Family Medicine: • Adult • Pediatrics • Well Newborn • Family Medicine OB Category I & II Obstetrics

Gregory, Maria, MD	Neurology	Medicine	Tele-Neurology
Hell, Richard, MD	Gastroenterology	Medicine	Gastroenterology
Hu, Johnny, MD	Pathology	Surgery	Pathology
Kaur, Amandeep, MD	Internal Medicine	Medicine	Adult Hospitalist
Kissell, Nicolas, MD	Endocrinology	Medicine	Endocrinology General Internal Medicine
Liu, Cici, MD	Gyn Oncology	Ob/Gyn	Gyn Oncology Gynecologic Robotic Surgery
Ramos, David, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Sepulveda, Michael, MD	Internal Medicine	Medicine	Adult Hospitalist
Simpson, Benjamin, MD	Neurology	Medicine	Tele-Neurology
Tardieu, Bert, MD	Orthopedic Surgery	Surgery	Orthopedic Surgery Robotic Surgery
Tran, Micheal, MD	Pediatric Cardiology	Pediatrics	Pediatric Cardiology Remote Pediatric Cardiology

Modification of Privileges:

NAME	SPECIALTY	PRIVILEGE
Fernandez, Robert, MD	Family Medicine	Addition of Taylor Farms Family Health & Wellness Center (TFFHWC) – Active Community
Paik, Aimee, MD	Dermatology	Addition of Taylor Farms Family Health & Wellness Center (TFFHWC) – Active Community

Staff Status Modifications:

NAME	SPECIALTY	STATUS CHANGE
Caprio, Collen, MD	Internal Medicine	Recommend advancement to Active status
Gali, Helena, MD	Ophthalmology	Remain Provisional Status
Gampala, Preethi, MD	Anesthesiology	Recommend advancement to Active status
Garcia, Erica B., MD	Family Medicine	Leave of Absence effective 7/31/2026
Kishore, Divya, MD	Radiology	Recommend advancement to Active status
Romero, Melissa, MD	Anesthesiology	Recommend advancement to Active status
Sandhu, Simranjit, DPM	Podiatric Surgery	Resignation effective 08/13/26
Glaser, Anne, MD	Tele-Radiology	Resignation effective 5/21/2026
Han, Jeniffer, MD	Tele-Neurology	Resignation effective 7/2/2026
Jensen, Jacob, MD	Emergency Medicine	Resignation effective 7/28/2026
Kumari, Anita, MD	Hematology/Oncology	Resignation effective 8/13/2026
Rivera-Morales, Roberto, MD	Tele-Radiology	Resignation effective 6/30/2026
Sra, Manntej, MD	Tele-Radiology	Resignation effective 5/21/2026
Tull, Blair, MD	Ob/Gyn	Resignation effective 9/11/2026

Other Items: (Attached)

Taylor Farms Family Health & Wellness Center – Delineation of Ambulatory Procedural Privileges	The Committee recommended approval of the revision adding Hematology, Infectious Disease, Neurosurgery, Oncology, Plastic Surgery and Urology core privileges.
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Interdisciplinary Practice Committee

Initial Appointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Sukyias, Melina, PAC	Cancer Care	Medicine	Shehzad Aziz, MD Geetha Varma, MD

Reappointment:

APPLICANT	PRIVILEGES	DEPT	COLLABORATING/SUPERVISING PHYSICIAN(S)
Cagni, Heather, PA-C	Physician Assistant	Emergency Medicine	Cristina Martinez, MD Kimberly Moulton, MD
Chu, Valerie, PA-C	Physician Assistant	Medicine	Kanae Mukai, MD Patrik Zutterlund, MD Richard Gerber, MD Steven Regwan, DO Thomas Mustoe, MD
Galindo, Sabrina, NP	Nurse Practitioner	Surgery	Vincent DeFilippi, MD Jamil Matthews, MD Andreas Sakopoulos, MD
Ganzhorn, Susan, PA-C	Physician Assistant – TFFH&W	Family Medicine	Guadalupe Arreola, MD Miguel Dorantes, MD
Kantmann, Christopher, PA-C	Physician Assistant	Emergency Medicine	Cristina Martinez, MD Kimberly Moulton, MD

Other Items: (Attached)

Revised Privilege Form: PA- TFFH&WC	Revised verbiage in qualifications, reappointment and core privilege description. <i>Medication orders for controlled substances</i> was moved from core to special privileges.
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Policies/Procedures/Plans:

- A. Laboratory Critical Call Values
- B. Physician Orders for Life Sustaining Treatment (POLST)
- C. Renal Dose Adjustment per Pharmacy Protocol
- D. Risk Management Plan

Informational Items:

I. Committee Reports:

- a. Credentials Committee
- b. Interdisciplinary Practice Committee
- c. Medical Staff Excellence Committee
- d. Lifetime Achievement Award Selection Committee

II. Other Reports:

- a. Summary of Executive Operations Committee Meetings
- b. Summary of Medical Staff Department/Committee Meetings July 2026
- c. Medical Staff Statistics Year to Date
- d. Financial Update June 2026
- e. Executive Updates
- f. HCAHPS Update August 6, 2026



**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
 - Endocrinology/Diabetes Care
 - Gastroenterology
 - General Surgery
 - Hematology
 - Infectious Disease
 - Neurosurgery
 - Oncology
 - Orthopedic Surgery
 - Obstetrics and Gynecology
 - Plastic Surgery
 - Podiatry
 - Pulmonology
 - Rheumatology
 - Sleep Medicine
 - Urology
- 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.

☐

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.

☐**Hematology Core Privileges:**

Assess, evaluate, diagnose, ~~treat~~, and provide consultation to patients who present to TFFHWC, with diseases and disorders of the blood, spleen, lymph glands, and immunologic system such as anemia, clotting disorders, sickle cell disease, hemophilia, leukemia, and lymphoma. ~~The core privileges in this specialty include the procedures on the attached procedure list and such other procedures that are extensions of the same techniques and skill, bone marrow aspirations and biopsy, administration of chemotherapy, the management and care of indwelling venous access catheters, plasmapheresis, therapeutic phlebotomy, and lymph node aspiration.~~

☐**Infectious Disease Core Privileges:**

Assess, evaluate, diagnose, treat, and provide consultation to patients who present to TFFHWC, with infectious or immunologic diseases of all types and in all organs. Privileges include, but are not limited to: management of an unusually severe infection such as tuberculosis, meningitis, disseminated tuberculosis, systemic mycosis, and unusual infections in the immunocompromised host, aspiration of superficial abscess; interpretation of Gram stain; and management of investigational anti-infective agents.

☐**Neurosurgery Core Privileges:**

Assess, evaluate, diagnose, consult and provide non-operative and pre-, intra-, and post-operative care to patients who present to TFFHWC, presenting with injuries or disorders of the central, peripheral and autonomic nervous system, including their supporting structures and vascular supply; the evaluation and treatment of pathological processes which modify function or activity of the nervous system, including the hypophysis; and the operative and nonoperative management of pain. These privileges include but are not limited to care of patients with disorders of the nervous system: the brain, meninges, skull, and their blood supply, including the extracranial carotid and vertebral arteries; disorders of the pituitary gland; disorders of the spinal cord, meninges, and vertebral column, including treatment by spinal fusion or instrumentation; and disorders of the cranial and spinal nerves throughout their distribution. These privileges also include the provision of consultation as well as the ordering of diagnostic studies and procedures related to the problem or disorder. 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.

☐**Oncology Core Privileges:**

Assess, evaluate, diagnose, treat and provide consultation to patients who present to TFFHWC, with all types of cancer and other benign and malignant tumors. ~~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; bone marrow biopsy and interpretation, administration of chemotherapeutic agents and biological response modifiers through all therapeutic routes, and management and maintenance of indwelling venous access catheters.~~

☐**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.



Plastic Surgery Core Privileges:

Assess, evaluate, diagnose, provide consultation to patients who present to TFFHWC with congenital and/or acquired defects of the body's musculoskeletal system, craniomaxillofacial structures, hand, extremities, breast and trunk and external genitalia and soft tissue including the aesthetic management. Core privileges include wound care, biopsies and or other subcutaneous procedures.



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.

**Urology Core Privileges:**

Assess, evaluate, diagnose, treat ~~(surgically or medically)~~ and provide consultation to patients who present to TFFHWC with malignant medical and surgical disorders of the genitourinary system and the adrenal gland and including endoscopic, percutaneous, and open surgery of congenital and acquired conditions of the urinary and reproductive systems and their contiguous structures.

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
 - Hematology
 - Infectious Disease
 - Neurosurgery
 - Oncology
 - Orthopedic Surgery
 - Obstetrics and Gynecology
 - Plastic Surgery
 - Podiatry
 - Pulmonology
 - Rheumatology
 - SleepSleep-Medicine
 - UrologyRheumatology
- 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 and 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



Clinical Privileges Practice Agreement
Salinas Valley Health Taylor Farms Family Health & Wellness Center
Physician Assistant-Ambulatory Care

Applicant Name: _____

To be eligible to apply for core privileges as a Physician Assistant (PA), the applicant must meet the following qualifications:

- Minimum formal training: Applicants must be able to demonstrate successful completion of a PA program accredited by the ARC-PA or its predecessors.
- In addition, the PA applicant must meet the following requirements:
 - Successful completion of the national certifying examination given by the NCCPA
 - Possession of a current unrestricted California PA license
 - ~~Possession of adequate professional liability insurance~~
 - Possession of current BLS certification as minimum
 - ~~Documentation of adequate physical and mental health to exercise the privileges requested~~
 - Employment or agreement with a physician who is a member of the SVMHS Medical Staff with privileges at Salinas Valley Health Taylor Farms Family Health & Wellness Center who is in good standing with unrestricted privileges appropriate to the supervision of a PA to
 - ~~The physician must assume responsibility for supervision or monitoring of the PA's practice as stated in the appropriate medical staff policy governing PA's~~Advanced Practice Provider Rules and Regulations, and be continuously available by telephone or other electronic communication at time of patient examination, or provide an alternate to provide consultation when requested and to intervene when necessary
 - ~~AND~~
 - Assume total responsibility for the care of any patient when requested by the PA, ~~or~~ required by this ~~policy-practice agreement,~~ or in the interest of patient care
- Required previous experience: Documentation of training and experience ~~of for~~ requested ~~practice-prerogatives clinical privileges~~ and 200 patient care activities ~~for the PA providing services for patients~~ within the past 24 months.

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

Physician Assistant Core Privileges ~~(Core privileges are defined starting on page 2)~~

Core Proctoring Requirements:

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

Reappointment Criteria for Core Privileges:

Applicants must be able to document continued NCCPA certification and inpatient services for at least ~~50-100~~ patients ~~annually over the reappointment cycle~~ within the past 24 months.

Salinas Valley Health Taylor Farms Family Health & Wellness Center

Physician Assistant Core Procedure/Condition List for Ambulatory Care: The following procedures/conditions are considered to be included in the core privileges for this specialty. When there is ambiguity as to whether a procedure is included in core, it should be clarified with the Supervising Physician, Department Chair, ~~Chief Medical Officer-Vice President of Medical Affairs~~ and/or the Chief of Staff. PAs may assess, diagnose, monitor, promote health and protection from disease, and manage patients within the age group of their supervising physician. General core privileges include the procedures on the following procedure list and such other procedures that are extensions of the same techniques and skills. Core privileges for PAs include:

1. Perform history and physical examination
2. Dictate history and physical examination results
3. Develop and implement patient management plans, record progress notes, and provide continuity of care
4. Perform/interpret laboratory, radiologic, cardiographic, and other diagnostic procedures used to identify pathophysiologic processes
5. Order therapies, using procedures reviewed and approved by the supervising physician
6. Write orders for treatments and tests consistent with the scope of practice of the PA and the supervising physician
7. Cleanse and debride wounds and suture lacerations and remove sutures and staples
8. Perform debridement and general care for superficial wounds and minor superficial surgical procedures
9. Apply, remove, and change dressings and bandages
10. Perform incision and drainage of superficial abscesses
11. Perform routine immunizations
12. Perform venipuncture
13. Perform electrocardiogram tracing
14. Counsel and instruct patients, families, and caregivers as appropriate
15. Administer local anesthetic
16. Initiate appropriate referrals
17. Write orders for medications, treatments and tests consistent with the scope of practice of the PA and the supervising physician
 - Under direction of a supervising physician, the PA may dispense to a patient a properly labeled prescription medication prepackaged by a physician, a manufacturer (as defined by pharmacy law) or pharmacist.
 - ~~All physician assistants who are authorized to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA) and maintain a valid registration.~~
 - ~~Documentation of a controlled substances education course which meets CCR Title 16 requirements.~~
18. **Treat a Patients with Worker's Comp Injury/Illness:** May provide medical treatment of a work-related injury within their scope of practice. The treating physician is to make the determination of temporary disability and sign the Doctor's First Report of Occupational Injury or Illness report. A physician assistant may authorize the patient to receive time off from work for a period not to exceed three calendar days and may co-sign the report.

SPECIAL PRIVILEGES:



Write Medication Order for Controlled Substances:

Write medication orders for controlled substances consistent with the scope of practice of the PA and the supervising physician

- All physician assistants who are authorized to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA) and maintain a valid registration.
- Documentation of a controlled substances education course which meets CCR Title 16 requirements is also required

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 Taylor Farms Family Health & Wellness Center, and I 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.

	(Physician Assistant's Signature)	Date
	Supervising Physician's Endorsement	Date

Physician Assistant

Core List of Supervising Physicians

This list of supervising physicians represents the core group of physicians with whom I will be working and is not all inclusive

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

Date

*Supervising Physician's Endorsement

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



Origination4/28/2021

ApprovedN/A

Expires2 years after approval

OwnerLori Orosco:
Director
Laboratory
Services

AreaLaboratory -
General

Laboratory Critical Call Values

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. The laboratory medical director, in consultation with medical staff, is responsible for defining critical laboratory values that may be indicative of conditions with significant risk or mortality or morbidity requiring rapid clinical intervention. Designation of critical values by clinical laboratories is required by the Clinical Laboratory Improvement Amendments and regulatory agencies.

III. DEFINITIONS

- A. Closed Loop Critical (CLC): Automated critical result delivery system implemented through the Electronic Health Record software.
- B. Critical Result: Test results requiring immediate notification of the responsible caregiver for timely intervention.
- C. Electronic Health Record (EHR): Comprehensive software used by healthcare organizations to manage patient data, clinical workflows, billing, regulatory compliance, and other patient-related functions.
- D. Electronic Communication: Secure, HIPAA-compliant software that can be utilized when delivering critical results. This includes the EHR “Secure Chat” messaging tool.
- E. ER / ED: The SVHMC Emergency Department.
- F. First positive - Encounter: For a particular patient visit or admission to SVHMC, the first critical positive test result value. Subsequent critical positive results are not required to be communicated to the responsible care provider.

- G. First positive - Patient History: The first critical high or critical low test result value spanning the entirety of the a patient's known medical history. Subsequent critical high or low values of the same classification are not required to be communicated to the responsible care provider.
- H. Initial-only: For a particular patient visit or admission to SVHMC, the first critical high or low test result value. Subsequent critical high or low values of the same classification are not required to be communicated to the responsible care provider. If the patient leaves SVHMC and returns for a different encounter, this category would start over for that different visit.

IV. GENERAL INFORMATION

- A. These Laboratory Urgent Notification / Critical Call Values have been identified and agreed upon by the medical staff. Result notification requirements, including method of delivery, responsibilities, and documentation, can be found in [LABORATORY CRITICAL RESULTS DOCUMENTATION](#).
- B. Critical results are relayed to responsible, licensed care providers with documented acknowledgment of receipt.
- C. A physician is generally the required care giver to acknowledge critical results, however some settings allow for agreed-upon physician designees to do so in their stead (see exceptions specified below).
- D. If results delivered verbally (in person or telephone), results will be read back to confirm accuracy of delivered results.

V. PROCEDURE

A. Notification exceptions are as follows:

1. Critical results for patients on pharmacy protocol are automatically sent to the pharmacy In Basket and communicated to the pharmacist on the patient care team.
2. ALL **outpatient** and **Emergency Department** critical results automatically trigger a "CLC" message to the relevant care team members for review and acknowledgement.
3. For any instance a critical value is not communicated due to policy (see "Comments" below), the reason is documented (ex. "previously critical").

B. Chemistry Values

TEST (Patient Age)	LOW VALUE	HIGH VALUE	COMMENTS
Ammonia (0-14 day)		>162 ug/dL	Initial-only
Ammonia (15 days - 6 years)		>116 ug/dL	Initial-only
Ammonia (>=7 years)		>123 ug/dL	Initial-only
Amylase		>250	Initial-only

TEST (Patient Age)	LOW VALUE	HIGH VALUE	COMMENTS
		IU/L	
Blood Gas: pH (venous)	<7.20	>7.60	Initial-only
Blood Gas: pH (capillary)	<7.20	>7.60	Initial-only
HCO ₃ (venous)	<15 mEq/L	>40 mEq/L	Initial-only
HCO ₃ (capillary)	<15 mEq/L	>40 mEq/L	Initial-only
Bilirubin, Total (<24 hours)		>9.9 mg/dL	
Bilirubin Total (2 days - 3 months)		>16.0 mg/dL	
BUN		>100 mg/dL	Initial-only; Exclude dialysis/known renal failure patients with CLS review
Calcium, Total	<6.5 mg/dL	>13.0 mg/dL	Initial-only
Calcium, Ionized	<3.2 mg/dL	>6.3 mg/dL	Initial-only
Calcium, Ionized (Post-Filter)	<0.7 mg/dL	>1.6 mg/dL	Initial-only
Carbon Monoxide		>10.0%	Initial-only
CO ₂ , Total Serum/ Plasma (0-2 days)	<13 mmol/L	>50 mmol/L	Initial-only
CO ₂ , Total Serum/ Plasma (>=3 days)	<15 mmol/L	>50 mmol/L	Initial-only
CKMB		>3.6 ng/ml	Initial-only
CK-IND		>2.0	Initial-only
Chloride	<80 mmol/L	>120 mmol/L	Initial-only
Cortisol, Post- Stimulation	<18 uG/dL		Initial-only
Creatinine (0-14 days)		>2.00 mg/dL	Initial-only
Creatinine (15 days - 15 years)		>3.00 mg/dL	Initial-only
Creatinine (>=16 years)		>4.00 mg/dL	Initial-only; Exclude dialysis/known renal failure patients with CLS review

TEST (Patient Age)	LOW VALUE	HIGH VALUE	COMMENTS
Ethanol		>400 mg/dL	
Glucose, Serum/ Plasma (0-1 day)	<20 mg/dL	>200 mg/dL	Initial-only
Glucose, Serum/ Plasma (2-6 days)	<30 mg/dL	>200 mg/dL	Initial-only
Glucose, Serum/ Plasma (>=7 days)	<50 mg/dL	>500 mg/dL	Initial-only
Glucose, CSF	<37 mg/dL	>440 mg/dL	
Lactic Acid		>2.0 mmol/L	
Lipase		>159 U/L	Initial-only
Magnesium (0-14 days)	<1.5 mg/dL	>3.9 mg/dL	Initial-only
Magnesium (15 days - 11 months)	<1.5 mg/dL	>3.1 mg/dL	Initial-only
Magnesium (1 - 18 years)	<1.5 mg/dL	>2.8 mg/dL	Initial-only
Magnesium (>=18 years)	<1.0 mg/dL	>4.9 mg/dL	Initial-only
Magnesium, OB patient on magnesium protocol		>9.0 mg/dL	
Methemoglobin		>10.0%	Initial-only
Osmolality, Serum/ Plasma	<250 mOsm/ kg	>326 mOsm/ kg	Initial-only
Phosphorus (0-14 days)	<5.6 mg/dL	>10.5 mg/dL	Initial-only
Phosphorus (15 days - 11 months)	<4.8 mg/dL	>8.4 mg/dL	Initial-only
Phosphorus (1-4 years)	<4.3 mg/dL	>6.8 mg/dL	Initial-only
Phosphorus (5-12 years)	<4.1 mg/dL	>5.9 mg/dL	Initial-only
Phosphorus (>=13)	<1.0	>8.9	Initial-only

TEST (Patient Age)	LOW VALUE	HIGH VALUE	COMMENTS
years)	mg/dL	mg/dL	
Potassium (0-11 months)	<2.8	>6.2	Initial-only
Potassium (1-13 years)	<2.8 mmol/L	>6.0 mmol/L	Initial-only
Potassium (>=14 years)	<2.5 mmol/L	>6.0 mmol/L	Initial-only
Sodium (0-11 months)	<128 mmol/L	>155 mmol/L	Initial-only
Sodium (>=1 year)	<120 mmol/L	>165 mmol/L	Initial-only
Troponin I (high-sensitivity)		>180 ng/L	Initial-only
TSH (<24 hours)	<1.00 mIU/L	>39.00 mIU/L	Initial-only
TSH (24 hours - 2 days)	<3.20 mIU/L	>34.60 mIU/L	Initial-only
TSH (3-4 days)	<0.7 mIU/L	>15.40 mIU/L	Initial-only
TSH (5 days - <1 month)	<1.70 mIU/L	>9.10 mIU/L	Initial-only
FT4 (<1 month)	<1.60 ng/dL	>4.00 ng/dL	Initial-only
Uric Acid		>13.0 mg/dL	Initial-only
THERAPEUTIC DRUGS			
Acetaminophen		>120 ug/mL	
Carbamazepine		>15.0 ug/mL	
Digoxin		>3.0 ng/mL	
Gentamicin (Random/Peak)		>12.0 ug/mL	
Gentamicin (Trough)		>2.5 ug/mL	
Lidocaine		>7.0 ug/mL	

TEST (Patient Age)	LOW VALUE	HIGH VALUE	COMMENTS
Phenobarbital		>55.0 ug/mL	
Phenytoin		>30.0 ug/mL	
Salicylate		>30 mg/dL	
Theophylline		>25.0 ug/mL	
Tobramycin (Random/Peak)		>12.0 ug/mL	
Tobramycin (Trough)		>2.5 ug/mL	
Valproic Acid		>100.0 ug/mL	
Vancomycin (Random/Trough)		>30.0 ug/mL	

C. Reference Lab

TEST	LOW VALUE	HIGH VALUE	COMMENTS
Serotonin Release Assay		Positive	
Tacrolimus (Prograf)		>20.00 ug/L	

D. Hematology

TEST	LOW VALUE	HIGH VALUE	COMMENTS
WBC	<2.0 x10 ³ /uL	>37.0x10 ³ /uL	
Bands/Immature Neutrophils		>20%	Initial-only
Hemoglobin (<24 hours)	<10.0 g/dL	>25.0 g/dL	
Hemoglobin (1 day - <1 month)	<10.0 g/dL	>22.7 g/dL	
Hemoglobin (1 - <2 months)	<8.0 g/dL	>22.0 g/dL	
Hemoglobin (>=2 months)	<7 g/dL	>18.1 g/dL	
Heparin anti-Xa		>1.0 IU/mL	Inpatients on pharmacy protocol

TEST	LOW VALUE	HIGH VALUE	COMMENTS
Platelet Count	<20 x10 ³ /uL	>900 x10 ³ /uL	
Prothrombin Time (PT)		>6.00 INR	
Partial Thromboplastin Time (PTT)		>85.0 seconds	
		>100.0 seconds	Inpatients on pharmacy protocol
FIBRINOGEN	<100 mg/dL		
D-DIMER		>1.5 mg/L	
CSF FLUID MICROSCOPY			ER or myelogram patients in Radiology – unnecessary to call. ALL OTHER LOCATIONS – call any abnormal cell morphology findings

E. Microbiology

RESULT	ACTION
Positive blood culture gram stain	First positive - Encounter; per bacterial morphotype or yeast
Positive blood culture direct molecular pathogen/resistance gene detection result	All Positives
MDRO pathogen on blood	First positive - Encounter
Inappropriate antibiotic therapy for CSF or positive blood culture	
Positive blood or stool parasite	First positive - Encounter
Eye culture growing <i>Pseudomonas. aeruginosa</i> or potential pathogen from corneal or vitreous eye fluid sources	
Identified <i>Coccidioides immitis</i>	First positive - Patient History
Identified <i>Cryptococcus neoformans</i>	First positive - Encounter
Mold resembling <i>Coccidioides immitis</i>	First positive - Encounter
Mycobacterium species identification	First positive <i>Mycobacterium tuberculosis complex</i> identified
Positive AFB smears and culture	First positive - Encounter; per specimen source
Positive <i>Bordetella pertussis</i>	First positive - Encounter
Positive Botulism result	First positive - Encounter
Positive CSF smear and/or culture	First positive - Encounter
Positive culture for <i>E.coli</i> O157	First positive - Encounter
Positive Shiga Toxin	First positive - Encounter
Positive <i>Legionella</i> or <i>Strep. pneumoniae</i> urine antigen	First positive - Encounter

RESULT	ACTION
Potential agents of bio-terrorism detected	

F. Histology

RESULT	ACTION
Unexpected malignancies	Pathologist to Report to Clinician
Unsuspected infectious disease	Pathologist to Report to Clinician
Products of Conception (POC) – no POC identified	Pathologist to Report to Clinician
Products of Conception (POC) – unexpected findings	Pathologist to Report to Clinician
Significant discrepancy between frozen section diagnosis and final diagnosis	Pathologist to Report to Clinician
All new diagnoses of Lymphoma (except SLL), Leukemia (except CLL), Small Cell Carcinoma of Lung, High Grade Neuroendocrine Carcinoma	Pathologist to call Oncologist if associated with patient, otherwise call to Clinician

G. Special Instructions By Section

H. Chemistry

- Although most critical results are only called initially, clinical judgment must be used when serially monitored test results vacillate between normal and critical.
- Check previous results for the same test on the patient.
- Visually inspect the specimen for interferents, such as hemolysis, icterus, lipemia, or odd coloration. Ensure testing was performed on appropriate specimen type (e.g. plasma/serum as required, and not on un-spun specimen).
- Check to see if specimen was drawn from a line or port for possible contamination.
- Check instrument, method, and reagent by looking at other patients' results within the run to ensure they are not also abnormal or critical. This may indicate an instrument testing issue.
- Check with phlebotomist to ensure collection was appropriate/correct (not above I.V., specimen was not placed in incorrect anticoagulant first and then transferred to correct tube, etc.).
- Document notification as a specimen comment using appropriate critical result text defined in the Laboratory Critical Results Documentation protocol.
 - Answer all prompts that are appropriate.
- If result is questionable, communicate with the patient's nurse to determine if result corresponds with:
 - The patient condition
 - Administration of a recent medication
 - A recent procedure that could have created the result.

I. Hematology/Coagulation

- Results on oncology patients may be communicated to the ordering provider's assistant or nurse.
- Check with phlebotomist to ensure collection was appropriate (i.e., not above IV).

J. Microbiology

- Critical results on patients discharged from the Emergency Department can be communicated to the Emergency Department Charge Nurse or, for culture-related critical values, to the Emergency Department Pharmacist, if present.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. College of American Pathologists, "COM.30000" All Common Checklist, December 26, 2024 edition.

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	8/13/2026
Laboratory Medical Director	Johnny Hu: PHYSICIAN	7/16/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/14/2026
Policy Owner	Lori Orosco: Director Laboratory Services	7/14/2026

Standards

No standards are associated with this document



Origination 1/13/2022
Approved N/A
Expires 3 years after approval

Owner Michelle Orta:
Director
Continuum of Care
Area Patient Care

Physician Orders for Life Sustaining Treatment (POLST)

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide a guide for hospital staff regarding correct interpretation and execution of a patient's existing, completed POLST form, as well as guidance for correct completion (or revision) and execution of new POLST form.

III. DEFINITIONS

- A. **POLST:** Physician Orders for Life-Sustaining Treatment (POLST). POLST is a physician order form that complements an advance directive by converting an individual's wishes regarding life-sustaining treatment and resuscitation into actionable physician orders.
- B. **Surrogate:** In this document, the legally recognized decision maker will be referred to as "surrogate"; deference to the surrogate usually implies that the patient does not have decision making capacity, unless decision making authority has been granted otherwise in a valid advance directive.
- C. **Health care provider:** means an attending physician. It also means a nurse practitioner or physician assistant practicing in accordance with standardized procedures or protocols developed and approved by the supervising physician and the nurse practitioner or physician assistant.
- D. **Legally recognized healthcare decision maker:** the person's agent (as designated by a power of attorney for healthcare), surrogate, conservator, closest available relative or friend, as determined by the attending physician according to CA law

IV. GENERAL INFORMATION

- A. POLST is designed to be a statewide mechanism for an individual to communicate his or her wishes about a range of life-sustaining and resuscitative measures. It is designed to be a portable, authoritative and immediately actionable physician order consistent with the individual's wishes and medical condition, which shall be honored across treatment settings.
- B. The POLST form:
 - 1. Is a standardized form meant to be printed on bright pink paper.
 - 2. Can be revised or revoked by an individual with decision-making capacity at any time;
 - 3. Is recognized and honored across treatment settings;
 - 4. Provides statutory immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction or any other sanction to a healthcare provider who tries in good faith to honor a POLST; Is an alternative to the "Pre-Hospital Do Not Resuscitate" form.
 - 5. A health care provider is not required to initiate a POLST form, but is required to make a good faith effort to follow the POLST after discussion with patient/surrogate.
 - 6. A surrogate may execute, revise or revoke the POLST form in accordance with patients known wishes, or by substitutive judgement in the patient's best interests. This excludes an escalation in care when the patient's last known wishes were for a limitation of interventions.
 - 7. While a nurse or social worker can explain the POLST form to the patient and/surrogate, the physician is responsible for discussing the nature, details, and appropriateness of the treatment options with the patient or surrogate.
 - 8. Once the POLST form is completed, it must be signed by the patient or surrogate, AND a healthcare provider (physician, NP, PA).
- C. Staff will copy the POLST form for the medical record and send a copy to registration for scanning into the EHR. A copy of the POLST form should be placed in the front of the order section of the medical record.
- D. The original POLST form will be returned to the patient / surrogate. The date, time, and recipient of the returned original POLST should be documented in the medical record.

V. PROCEDURE

- A. **Patient in Emergency Department with a Completed POLST Form**
 - 1. During the initial nursing assessment, document the existence of the POLST form and confirm with the patient or surrogate that the POLST form in hand has not been voided or superseded by a subsequent POLST form or advance directive.
 - 2. The ER nurse will communicate to the emergency department physician caring for the patient the existence of the POLST.
 - 3. If the emergency department physician, upon review of the POLST and evaluation of

the patient, determines that a change or revision of order(s) is indicated, he/she retains the right to make changes pursuant with regular standards of care. The physician should document the reasons for any deviation from the POLST in the medical record.

B. Patient Admitted with a Completed POLST Form

1. During the initial patient assessment, document the existence of the POLST form in the medical record and confirm with the patient or surrogate that the POLST form is valid and current.
2. The admitting nurse will communicate to the admitting provider caring for the patient the existence of the POLST.
3. The admitting provider reviews any POLST form as soon as possible after admission.
4. If the admitting provider, upon review of the POLST and evaluation of the patient, determines that a change or revision of order(s) is indicated, he/she retains the right to make changes pursuant to regular standards of care and document the reasons for any deviation from the POLST in the medical record.
5. Upon transfer, the nurse should make a copy of the POLST form (ensuring a copy is left in the chart) and place the original pink form and a copy in the transfer packet that will accompany the patient during any transfer. Document in the EHR that copy and original were sent to the receiving facility.

C. Completing a POLST Form with the Patient

1. If the patient or surrogate wishes to complete a POLST form, the patient's provider should be contacted. They should discuss the nature, details, and appropriateness of treatment options with the patient or surrogate as outlined in the POLST.
2. A nurse or social worker can explain the POLST form to the patient and/or the patient's legally recognized health care decision maker. The POLST will be completed, dated, and signed by both physician or nurse practitioner and patient or surrogate, and related discussions should be documented in the medical record.
3. Follow the instructions above for copying the POLST form and placing in the medical record.

D. Reviewing/Revising a POLST Form

1. At any time the provider and patient or surrogate, together, may review or revise the POLST consistent with the patient's most recently expressed wishes.
2. If the current POLST is no longer valid, HIM should be notified and the invalid POLST from should be removed from the medical record.
3. If a new POLST is completed, the above procedures are to be followed.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

- A. http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_2951-3000/ab_3000_bill_20080804_chaptered.pdf
- B. <https://capolst.org/polst-for-healthcare-providers/>
- C. California Hospital Association Consent Manual
- D. https://emsa.ca.gov/dnr_and_polst_forms/

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	8/13/2026
CNO	Carla Spencer: Chief Nursing Officer	7/10/2026
Palliative Care Medical Director	Katherine DeSalvo: Director Medical Staff Services	7/10/2026
ICU Medical Director	Katherine DeSalvo: Director Medical Staff Services	7/10/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	6/19/2026
Policy Owner	Michelle Orta: Director Continuum of Care	5/19/2026

Standards

No standards are associated with this document



Origination 5/8/2025
Approved N/A
Expires 1 year after approval

Owner Genevieve delos Santos:
Director Pharmacy
Area Pharmacy Protocols

Renal Dose Adjustment per Pharmacy Protocol

I. POLICY STATEMENT

- A. N/A

II. PURPOSE

- A. To provide standardization for adjustments of selected renally eliminated medications and to optimize medication dosing in adult patients based on estimated creatinine clearance using the Cockcroft-Gault equation.
- B. To ensure timely administration of medications and reduce risk of medication accumulation while promoting efficacious dosing as supported by current evidence-based practice.
- C. To define the responsibilities of SVH pharmacists in the monitoring, review, and adjustment of renally eliminated medications with new and active orders on all adult patients.

III. DEFINITIONS

- A. Creatinine Clearance (CrCl): The volume of blood plasma that is cleared of creatinine per unit of time to be calculated using Cockcroft-Gault equation.

IV. GENERAL INFORMATION

- A. Salinas Valley Health (SVH) pharmacists will provide dose adjustments to select renally eliminated medications. This management will be conducted in accordance with evidence-based guidelines and best practice standards alongside clinical discretion as outlined in this policy.
- B. This protocol authorizes SVH clinical pharmacists to review estimated creatinine clearance in adult patients and adjust medication dose and/or administration frequency based on guidance

approved by Pharmacy & Therapeutics/Infection Prevention Committee and in collaboration with physicians.

- C. This protocol shall establish and maintain a list of medications and their dosing regimens approved by Pharmacy & Therapeutics/Infection Prevention Committee for dose and administration frequency adjustments based on estimated creatinine clearance (as specified in Appendix B).
- D. Ordered medications which appear on the approved list, matching standard dose and frequency ranges as well as indication (when documented), shall be qualified for renal dosing per protocol. This dose conversion does not apply to medications on the approved list which are outside the standard dose and frequency ranges or alternate indications.
 - 1. If a medication which appears on the approved list (as specified in Appendix B) is ordered, but does not align with documented standard dose, administration frequency, or indication (when documented), the pharmacist will contact the prescriber to recommend dose or administration frequency adjustments.
 - 2. If a renally eliminated medication is ordered and not on the approved list (as specified in Appendix B), the pharmacist will contact the prescriber to recommend dose or administration frequency adjustments.
- E. Inclusion Criteria:
 - 1. Patients ≥ 16 years of age
 - 2. Patient has a serum creatinine laboratory value resulted within the past 24-hours; has stable serum creatinine as determined by current hospital stay; or is confirmed HD, CRRT, or PD patient.
 - 3. New or active order aligns with approved medication, route, ordered dose and frequency (See Appendix B)
- F. Exclusion Criteria:
 - 1. Patient < 16 years old
 - 2. Long-term suppression antimicrobials resumed from home medications.
 - 3. Physician indicates in order "Do Not Adjust for Renal Impairment" or other such wording in comments section of original order.

V. PROCEDURE

- A. The renal dosage adjustment protocol shall be implemented on all patients who meet inclusion criteria at time of order verification and during profile review.
- B. At time of order verification the pharmacist shall perform the following:
 - 1. Identify selected renally eliminated medications as designated for renal dose adjustment (see Appendix B).
 - 2. Assess the patient's estimated creatinine clearance using the Cockcroft-Gault equation (see guidance in Appendix A). The pharmacist may use the EHR auto-calculated CrCl using their clinical discretion.
 - a. Pharmacists will utilize clinical judgement when reviewing a patient profile.

- a. Enter the adjusted medication including labeling within the order stating “per Renal Protocol” or other such wording, upon qualification while maintaining all other properties of the original order including but not limited to:
 - a. Route, ordering label comments, days of therapy, monitoring parameters
4. Document in the EHR including but not limited to:
 - a. Originally ordered medication, dose, and frequency
 - b. Adjusted medication, dose, and frequency

the original order as indicated in B.3.a.

- a. If the medication has previously been renally dose adjusted, adjustments shall be based on originally ordered medication, dose, and frequency using the newest CrCl.
- b. To reduce frequent dose adjustments after the first 24 hours:
 - i. If patient's subsequent CrCl remains < the recommended adjustment range, dose and/or administration frequency shall be reduced/extended to meet the patient's current CrCl as calculated by Cockcroft-Gault equation (see guidance in Appendix A).
- c. The pharmacist may contact the ordering provider in instances where making renal dose adjustments per protocol is complicated by clinical presentation.

4. Document in the EHR including but not limited to:

- a. Originally ordered medication, dose, and frequency
- b. Adjusted medication, dose, and frequency
- c. Relevant patient data and recommendations

D. Monitoring

1. The pharmacist may order or recommend the following laboratory tests under this protocol:
 - a. Serum Creatinine
 - i. Frequency as clinically appropriate.
 - a. For critically ill patient's serum creatinine may be ordered or recommended every 48 hours.
 - b. For patients with whom serum creatinine is stable, serum creatinine may be ordered or recommended every 3 to 7 days, or as clinically appropriate.
 - ii. Exclusions:
 - a. Patients on CRRT, HD, or PD

E. Documentation

1. The pharmacist will document 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 the Dosing Guidelines in conjunction with clinical discretion to standardize management of renal dose and/or administration frequency adjustments per protocol.
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. Heintz BH, Matzke GR, Dager WE. Antimicrobial Dosing Concepts and Recommendations for Critically Ill Adult Patients Receiving Continuous Renal Replacement Therapy or Intermittent Hemodialysis. *Pharmacother J Hum Pharmacol Drug Ther.* 2009; 29(5):562-577
- B. Hoff BM, Maker JH, Dager WE, et al. Antibiotic Dosing for critically Ill Adult patients Receiving Intermittent Hemodialysis, Prolonged Intermittent Renal Replacement Therapy, and Continuous Renal Replacement Therapy: An Update. *Ann Pharmacother.* 2020; 54(1):43-55
- C. Patel N, Scheetz MH, Drusano GL, Lodise TP. Identification of optimal renal dosage adjustments for traditional and extended-infusion piperacillin-tazobactam dosing regimens in hospitalized patients. *Antimicrob Agents Chemother.* 2010; 54(1):460-465
- D. Crandon JL, Bulik CC, Kuti JL, et al. Clinical pharmacodynamics of cefepime in patients infected with *Pseudomonas aeruginosa*. *Antimicrob Agents Chemother.* 2010; 54(3):1111-1116
- E. Kalaria S, Williford S, Guo D, et al. Optimizing ceftaroline dosing in critically ill patients undergoing continuous renal replacement therapy. *Pharmacotherapy.* 2021; 41(2):205-2011
- F. Janssen PK, Foudraine NA, Burgers DM, et al. Population Pharmacokinetics of Cefuroxime in Critically Ill Patients Receiving Continuous Venovenous Hemofiltration With Regional Citrate Anticoagulation and a Phosphate-Containing Replacement Fluid. *Ther Drug Monit.* 2016; 38(6):699-705
- G. Berry K, Postlmayr L, Shiltz D, et al. Impact of an inpatient pharmacist-driven renal dosing policy on order verification time and patient safety. *Sage Open Med.* 2024; 12:1-8
- H. Micromedex® 2.0 (Healthcare Series), (electronic version). Truven Health Analytics, Greenwood Village, Colorado, USA. Available at: <http://www.micromedexsolutions.com/>. Accessed: January 10, 2025
- I. Medications [package insert]. Available at <https://dailymed.nlm.nih.gov/dailymed/>. Accessed Jan 10, 2025

Attachments

 [Appendix A CrCl Calculations.pdf](#)

 [Appendix B Medication Table.pdf](#)

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	8/13/2026
CNO	Carla Spencer: Chief Nursing Officer	7/6/2026
P&T or IPC	Kiri Golleher: Pharmacy Clinical Coordinator	6/16/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	5/21/2026
Policy Owner	Genevieve delos Santos: Director Pharmacy	4/16/2026

Standards

No standards are associated with this document

COPY



Origination 1/1/2022
Approved N/A
Expires 1 year after approval

Owner Donathon Rodriguez:
Manager 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
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	8/13/2026
QSC	Lisa Pietro: Department Coordinator	8/6/2026
CLO	Gary Ray: Chief Legal Officer	7/28/2026
VP Risk & Quality	Timothy Albert: Chief Clinical Officer	7/28/2026
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	7/10/2026
Policy Owner	Donathon Rodriguez: Manager Risk	7/7/2026

Standards

No standards are associated with this document

EXTENDED CLOSED SESSION
(if necessary)

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

(Meeting Chair)

*RECONVENE OPEN SESSION/
REPORT ON CLOSED SESSION*

(Meeting Chair)

*ORAL REPORT OF PROPOSED
COMPENSATION TO PUBLIC
AGENCY EMPLOYEE PRIOR TO
FINAL ACTION PURSUANT TO
GOVERNMENT CODE SECTION
54953(D)(3)(A)*

(Joel Hernandez Laguna)

*CONSIDERATION FOR APPROVAL
OF EMPLOYMENT AGREEMENT –
PRESIDENT/CHIEF EXECUTIVE
OFFICER*

(Matt Ottone)

ADJOURNMENT