November 10, 2023

TO: Legal Counsel

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

The next regular meeting of the **BOARD OF DIRECTORS OF SALINAS VALLEY HEALTH**[1] will be held **THURSDAY, NOVEMBER 16, 2023, AT 4:00 P.M., DOWNING RESOURCE CENTER, ROOMS A, B, & C, SALINAS VALLEY HEALTH MEDICAL CENTER, 450 E. ROMIE LANE, SALINAS, CALIFORNIA** or via **TELECONFERENCE** (*visit* **SalinasValleyHealth.com/virtualboardmeeting** *for Access Information*).

Pete Delgado
President/Chief Executive Officer

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

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

THURSDAY, NOVEMBER 16, 2023, 4:00 P.M.
DOWNING RESOURCE CENTER, ROOMS A, B & C
SALINAS VALLEY HEALTH MEDICAL CENTER
450 E. ROMIE LANE, SALINAS, CALIFORNIA
or via TELECONFERENCE

(Visit salinasvalleyhealth.com/virtualboardmeeting for Access Information)

AMENDED AGENDA

Presented By

1. CALL TO ORDER / ROLL CALL — *Victor Rey, Jr.*

2. CLOSED SESSION *(See Attached Closed Session Sheet Information)* — *Victor Rey, Jr.*

3. RECONVENE OPEN SESSION/CLOSED SESSION REPORT — *Victor Rey, Jr.*
(Estimated time 5:30 pm)

4. PUBLIC COMMENT — *Victor Rey, Jr.*

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.

- Check Presentation: Credit Union for Kids (Partners: Bay Federal, Central Coast, and Santa Cruz Community Credit Unions)

5. BOARD MEMBER COMMENTS — *Board Members*

6. CONSENT AGENDA - GENERAL BUSINESS — *Victor Rey, Jr.*
(Board Member may pull an item from the Consent Agenda for discussion.)

A. President's Report
B. Minutes of October 19, 2023, Special Meeting of the Board of Directors
C. Minutes of October 26, 2023, Regular Meeting of the Board of Directors
D. Minutes of November 1, 2023, Special Meeting of the Board of Directors
E. Financial Report
F. Statistical Report
G. Policies Requiring Approval
   1. Background Checks
   2. Business Plan
   3. California Paid Sick Leave
   4. CCS Paneled Pediatrician/Neonatologist
   5. Electronic Communications (Acceptable Use)
   6. Emergency Management Program Plan
   7. Falls, Management of the Patient
   8. Hazardous Materials & Waste Management Plan
   9. Nursing Record - Surgery Intraoperative
   10. Patient Safety Attendant Guidelines
   11. Policy and Procedure Management
   12. Preceptor
   13. Sale, Purchase, and Lease of District Real Property

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

14. Scope of Service: Physician and Business Development
15. Staff Nurse III Application
16. Withdrawing Life-Sustaining Treatment and Withholding Cardiopulmonary Resuscitation

H. Board Member Compensation and Expenditure Reimbursement Policy

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

7. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. **QUALITY AND EFFICIENT PRACTICES COMMITTEE** — *Catherine Carson*

Minutes of the November 13, 2023 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair.

- Fall 2023 Leapfrog Score

B. **FINANCE COMMITTEE** — *Joel Hernandez Laguna*

Minutes of the November 13, 2023 Finance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

C. **PERSONNEL, PENSION AND INVESTMENT COMMITTEE** — *Juan Cabrera*

Minutes of the November 14, 2023 Personnel, Pension and Investment 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 (i) The Findings Supporting Recruitment of Ramaiah Indudhara, MD, (ii) The Contract Terms for Dr. Indudhara's Recruitment Agreement, and (iii) The Contract Terms for Dr. Indudhara's Urology Professional Services Agreement

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

D. **COMMUNITY ADVOCACY COMMITTEE** — *Rolando Cabrera, MD*

Minutes of the November 14, 2023 Community Advocacy Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

8. REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF NOVEMBER 9, 2023, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING: — *David Ramos, MD*

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

B. Policies/Procedures/Plans:
   1. Hyperbilirubinemia-Infant Management Policy
   2. Vacuum-Induced Management of OB Hemorrhage Policy

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

9. CONSIDERATION OF LETTER AGREEMENT WITH WITTKIEFFER FOR RECRUITMENT OF PRESIDENT/CEO *Victor Rey*

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

10. CONSIDER RESOLUTION 2023-05 AUTHORIZING DESIGNATED OFFICERS TO EXECUTE FINANCIAL INSTITUTION DOCUMENTS *District Legal Counsel*

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

11. EXTENDED CLOSED SESSION *(if necessary)* *Victor Rey, Jr.*

12. ADJOURNMENT

The Annual Meeting of the Board of Directors is scheduled for **Thursday, December 14, 2023, at 4:00 p.m.**

The complete Board packet including subsequently distributed materials and presentations is available at the Board Meeting and in the Human Resources Department of the District. All items appearing on the agenda are subject to action by the Board. Staff and Committee recommendations are subject to change by the Board.

Requests for a disability related modification or accommodation, including auxiliary aids or services, in order to attend or participate in a meeting should be made to the Board Clerk during regular business hours at 831-759-3050. Notification received 48 hours before the meeting will enable the District to make reasonable accommodations.

SALINAS VALLEY HEALTH BOARD OF DIRECTORS

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

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

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. Quality and Efficient Practices Committee
   A. Report of the Medical Staff Quality and Safety Committee
      - Critical Care/Progressive Care
      - Perinatal Services
   B. Quality and Safety Board Dashboard Review
   C. Consent Agenda:
      - Organ/Tissue Procurement
      - Taylor Farms
      - Resuscitation Committee
      - Nursing Admin Transport/Interpreter Services
      - Nursing Education
      - Laboratory Services
2. Medical Executive Committee
      - Report of the Medical Staff Credentials Committee
      - Report of the Medical Staff Interdisciplinary Practice Committee

PUBLIC EMPLOYMENT

(Government Code §54957)

Title: (Specify description of position to be filled): Interim President/CEO

ADJOURN TO OPEN SESSION

CALL TO ORDER/ROLL CALL

(VICTOR REY, JR.)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

(VICTOR REY, JR.)

RECONVENE OPEN SESSION/
CLOSED SESSION REPORT
(ESTIMATED TIME: 5:00 P.M.)

(VICTOR REY, JR.)

PUBLIC COMMENT

BOARD MEMBER COMMENTS

(VERBAL)

President's Report – November 16, 2023

Pete Delgado, President/CEO

Pete's Perspective: Collaboration Opening Doors of Opportunity for Generations

As Salinas Valley Health celebrates its seventieth anniversary this year, we also celebrate a partnership with Hartnell College that dates back to our earliest days. We opened our doors to the community in 1953. Hartnell's Vocational Nurse (VN) program began in 1954. Its RN program started in 1964 and others have followed. We have welcomed Hartnell students for hands-on training throughout that time, including during the pandemic when many other hospitals and medical centers suspended student training.

Hartnell's *Center for Nursing & Health Sciences in Partnership with Salinas Valley Health* provides local students expanded opportunities for affordable nursing and health sciences education, training and employment options. It signifies that we are one community dedicated to preparing students for successful careers in the healthcare industry.

The *Center for Nursing & Health Sciences*, with its leading-edge classrooms, skills labs and simulation rooms, provides a comprehensive learning setting for Hartnell students. The hands-on training through our medical center rounds out their education with real-world experience. We are fortunate to have benefitted from this partnership in excellence for seven decades. The recent unveiling of this exceptional resource at Hartnell College stands as a tangible testament to the power of collaboration for the benefit of our community.

New Safety Reporting Platform Online

A new reporting system making it easier to submit safety events and generate improved reports and data is now live at Salinas Valley Health.

RL Datix, a risk management software for workplace occurrences and WeCares, features a number of functions empowering our team to better learn from errors and adjust workflows to reduce harm and improve patient outcomes.

The new module captures patient feedback from different sources to process complaints, compliments, suggestions and grievances. It helps eliminate data silos, ensures consistent and reliable data capture and identifies key risk areas.

Honoring our Veterans

Veterans Day is coming up - and once again, Salinas Valley Health will be honoring Veterans by participating in an annual crowd favorite, the Monterey County Veterans Day Parade held in Oldtown Salinas.

As part of our organization's Veterans Recognition Initiative, our president/CEO Pete Delgado who served in the Army will be riding in our Salinas Valley Health Mobile Clinic.

Last Walk With a Doc and Farmers' Market of the Year

Last week we saw the final Walk With a Doc and Farmers' Market of the year. This month's walk led by Shannon O'Mahoney, NP, recognized Diabetes Awareness Month and focused on treatment options for diabetes.

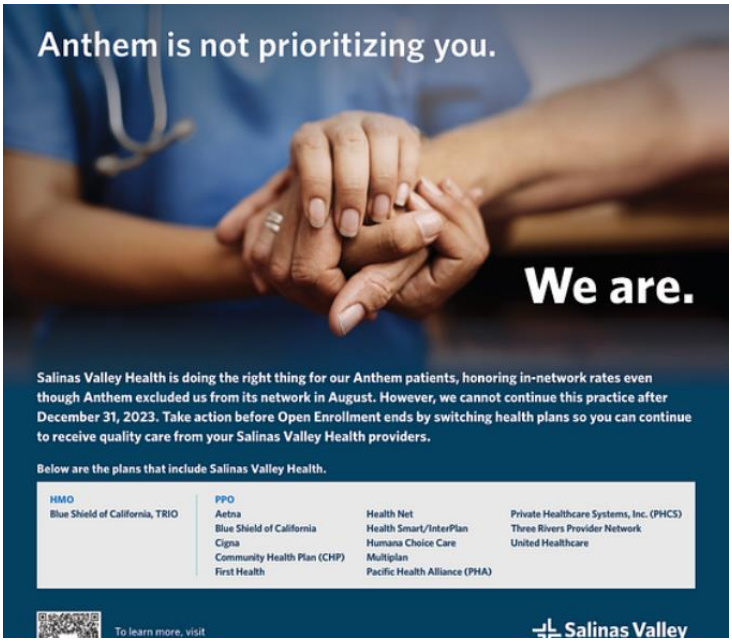
Holiday Turkeys, Tamales and Pies

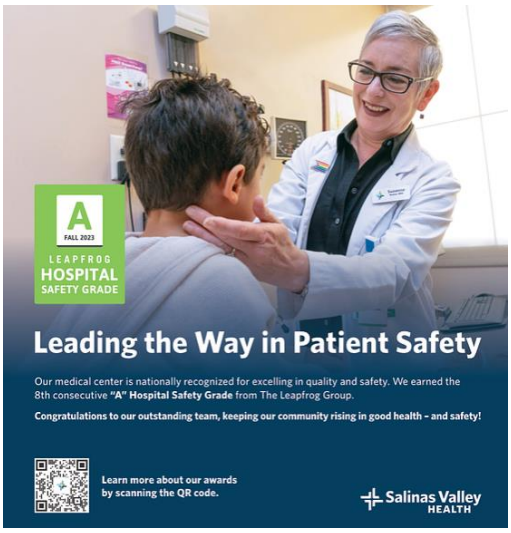
With deep appreciation for the dedication and skill of of our team, Salinas Valley Health has mailed vouchers for all staff redeemable for the gift of a turkey, tamales or pies for the upcoming holidays. The vouchers are redeemable at Star Market in Salinas between the dates of November 13, 2023, through January 6, 2024.

Salinas Valley Health Community Flu Clinic

Community Flu Clinic that will be held at Salinas Valley Health next **Saturday, November 18 from 11:00am to 2:00pm**.

Paid Media





Earned Media

BY KATHRYN McKENZIE

A LEG UP

Innovative procedure uses less invasive technique for bypass


Dr. James Joye, center, with surgical team. Photo: SVH

Earlier this year, Javier Lopez couldn't walk half a block before the pain in his right leg would stop him from taking another step. Today, the 74-year-old has gained relief from his severe peripheral arterial disease, thanks to a revolutionary procedure performed by a Monterey County interventional cardiologist.

The new FDA-approved procedure, called percurtaneous transmural arterial bypass, or PTAB for short, was performed by Dr. Jim Joye, founder of Golden State Heart & Vascular in Monterey, in July at the cath lab at Salinas Valley Health.

Dr. Joye had the idea for the medical breakthrough 20 years ago, envisioning a way to treat complex peripheral arterial disease without resorting to major surgery. PTAB is performed by using a noninvasive tech-

Hartnell College and Salinas Valley Health host a ceremony Oct. 18 to unveil the new Center for Nursing and Health Sciences building at the main campus in Salinas. (Contributed)

Featured Local News

Hartnell College, Salinas Valley Health celebrate unveiling of Center for Nursing and Health Sciences

FACILITY EXPANDS STUDENT ACCESS TO NURSING AND HEALTH SCIENCES EDUCATION, JOBS

By: **STAFF REPORT** November 1, 2023 0 61

SALINAS — Hartnell College and Salinas Valley Health celebrated the unveiling of the Hartnell College Center for Nursing and Health Sciences in Salinas last month.

This partnership between the college and the medical center is long-standing, with both organizations having collaborated for many years. The Oct. 18 unveiling celebrated the success of the partnership where students gain valuable education at Hartnell College while training at Salinas Valley Health.

Elected officials, donors and community partners gathered to commemorate the occasion with a ribbon-cutting ceremony and the unveiling of Hartnell College and Salinas Valley Health joint signage on the building.

"Today's celebration signifies that we are one community dedicated to preparing students for successful careers in the healthcare industry," said Michael Gutierrez, superintendent/president of Hartnell Community College District. "We are excited to witness the positive impact our work will continue to have on our students and our region."

Pete Delgado, Salinas Valley Health president/CEO, echoed praise for the strong partnership between Hartnell and the medical center.

"Hartnell is a vital asset to our community, and we are especially grateful for their decades of collaboration in developing the next generation of healthcare professionals," Delgado said. "When two quality organizations partner and work together as we do, the impact has a ripple effect in the community."

Made possible by Measure T funding, construction on Hartnell College's Health Sciences building at the main campus in Salinas commenced in January 2019 and was completed by Spring 2022. The addition to Hartnell College directly responded to the growing need for healthcare staff by expanding student access to nursing and health sciences education, training and employment opportunities.

Other generous support from Salinas Valley Health and community donors significantly contributed to growing operations and student programs.

The Center for Nursing & Health Sciences showcases three cutting-edge classrooms, skills labs and simulation rooms furnished with advanced technology that offer the opportunity to train in highly realistic settings while gaining essential skills through hands-on experiences.

Second-year Respiratory Care Program student Jeremy Jones describes the facility as awe-inspiring, boasting a comprehensive range of equipment crucial to his learning.

"I cannot overstate how impressive our facility is," Jones said. "Every piece of equipment found in the medical field can be found here; the simulation lab is a replica of a small Intensive Care Unit, and the mannequins in here are so lifelike."

Community members participate in a Walking Moai group in Greenfield on Nov. 7. (City of Greenfield)

Featured Local News

Blue Zones Project Monterey County hosts Diabetes Awareness series

EVENTS SET TO IMPROVE HEALTH AND WELL-BEING OF COMMUNITY

By: **RYAN CRONK** November 8, 2023 0 29

SALINAS VALLEY — November is National Diabetes Awareness Month, and Blue Zones Project Monterey County is taking the initiative to raise awareness about type 2 diabetes prevention, management and the importance of a healthy lifestyle.

With a month-long series of events and activities, many of which are taking place in South Monterey County, the organization is committed to improving the health and well-being of the community.

"Our Diabetes Awareness series is designed to empower our community members to take charge of their health and make the changes necessary for a long and fulfilling life," said Cindy Ruiz, senior marketing manager at Blue Zones Project Monterey County (BZPMC).

SUBSCRIBER ONLY

Salinas Valley Health explores JPA, possibly operating Hollis

Salinas Valley Health Board of Directors has approved a non-binding letter of intent to gather more information about what role Salinas Valley Health could play in future developments to support local healthcare delivery in San Benito County. (Salinas Valley Health)

By JAMES HERRERA | jherrera@montereyherald.com | Monterey Herald
PUBLISHED: November 6, 2023 at 2:34 p.m. | UPDATED: November 6, 2023 at 2:39 p.m.

SALINAS – Salinas Valley Health and the County of San Benito are proposing a potential collaboration with the San Benito Health Care District to form a joint powers authority to capitalize, govern, and oversee the management of Hazel Hawkins Memorial Hospital in Hollister, and for the JPA to enter into an agreement with Salinas Valley Health to operate the hospital, the health care district's rural clinics, nursing facilities and other services developed by the JPA.

"Salinas Valley Health looks forward to exploring all sustainable opportunities to support local health care delivery in San Benito County," said Pete Delgado, Salinas Valley Health president and CEO in an email. "Our Board of Directors has approved a non-binding letter of intent to gather more information about what role Salinas Valley Health could play in future developments. As of yet there is no commitment – except to explore various positive outcomes for all involved."

In a letter of intent to form a joint power authority from the San Benito County Administrative Officer Ray Espinosa, it says that JPAs are authorized under California law and provide a mechanism for one or more public agencies to jointly exercise powers common to the members. In forming a JPA, a specific purpose is established, in this case focusing on the operation and financing of health care services. JPAs can issue bonds, or enter into contracts with outside agencies, such as Salinas Valley Health, to ensure fulfillment of state goals.

The letter was intended to express San Benito County's and Salinas Valley Health's general intent only.

The San Benito Health Care District has been experiencing challenges related to cash flow, prompting the District to hire a third-party, B. Riley Advisory Services, to improve the performance of the hospital, medical clinics, and skilled nursing facilities, which has shown positive results but not enough to keep the District from declaring Chapter 9 bankruptcy, with San Benito County sharing concerns with the District Board that continued operation as a stand-alone hospital is not a viable way to meet the future health care needs of the community.

San Benito County engaged ECG Management Consultants to provide an analysis of the local health care market, the future demand for services, the financial performance of Hazel Hawkins Memorial Hospital, the clinics, skilled nursing facilities, and to provide advice on strategic challenges,

Salinas Valley Health signals it's open to exploring taking over management of San Benito County's hospital.

Pam Marino Nov 2, 2023 0

Salinas Valley Memorial Hospital is the cornerstone of the district's health care system, represented by a five-member elected board.

With their only hospital teetering on the brink of closure, the County of San Benito Board of Supervisors have been hoping for several months that one of the region's closest hospital neighbors, Salinas Valley Health in Monterey County, would jump in to save it. SVH leaders initially expressed an interest in providing advice and technical support, but not wholesale takeover or buyout of Hazel Hawkins Memorial Hospital in Hollister.

Now it appears SVH is open to exploring taking an active role in taking over management of Hazel Hawkins and all other facilities within the San Benito Health Care District.

The County of San Benito and SVH signed a non-binding letter of intent on Oct. 26, proposing a possible joint powers authority "to capitalize, govern, and oversee the management of [Hazel Hawkins] and the new JPA," with SVH operating the Hollister hospital, rural clinics and skilled nursing facilities. The letter was signed by SVH CEO Pete Delgado, and Ray Espinoza, San Benito's county administrator.

"[SVH] looks forward to exploring all sustainable opportunities to support local healthcare delivery in San Benito County," Delgado said in a written statement to the *Weekly*. "Our Board of Directors has approved a non-binding letter of intent to gather more information about what role Salinas Valley Health could play in future developments. As of yet there is no commitment—except to explore various positive outcomes for all involved."

SVH was organized in 1947 as a Local Health Care District, under California law. Its board of directors is elected by voters who live in the district, which covers Salinas and unincorporated areas of Salinas as far north as Prunedale, west to Castroville and Moss Landing, and as far south as Gonzales. Hazel Hawkins is 32 miles northeast of SVH's Salinas campus.

JPAs are a common way for "two or more public agencies to jointly exercise any power common to the contracting parties," according to California code. They may or may not be geographically connected, but they can be connected by common interests.

In a press release sent out jointly by the County of San Benito and SVH, Delgado said his agency "recognizes that we are part of the larger healthcare ecosystem of Monterey, Santa Cruz and San Benito

County, Salinas Valley Health present letter of intent to take over Hazel Hawkins

PLAN INCLUDES JPA, REVENUE FROM NEW IMPACT FEES

By: **STAFF REPORT** October 31, 2023 0 71

San Benito County and Salinas Valley Health officials last week jointly submitted a letter of intent to take over operations of Hazel Hawkins Memorial Hospital and its associated services through a joint powers authority that would raise extra long-term capital for the hospital, in part, by assessing new impact fees on commercial and residential developers, according to the county.

The county and Salinas Valley Health delivered the LOI to the San Benito Health Care District on Oct. 26. The San Benito County Board of Supervisors had voted 5-0 on Oct. 24 to submit the LOI in partnership with the Salinas-based healthcare provider. In a press release, the county said the proposed partnership is "prompted by concerns for the future of healthcare in (the) community."

The non-binding LOI signals that the county and SVH are ready for formal, detailed discussions about how their partnership could address the future operations, governance and financing of HHMH, which is currently overseen by the SBHD and its board of directors. The proposal includes HHMH as well as its skilled nursing facilities and physician clinics.

SBHD and HHMH officials have been seeking a potential partner or buyer since the board declared bankruptcy earlier this year. The Oct. 26 letter from the county and SVH is the second LOI the Hollister hospital has received from a prospective buyer; the first was from Modesto-based American Advanced Management, a for-profit healthcare provider, in August.

The hospital is still evaluating the proposal from AAM, and will discuss details of the management and capitalization terms of the county's proposal over the next 60-90 days, says a press release from HHMH.

Specifically, the LOI from the county proposes that SBHD and San Benito County form a joint powers authority "to capitalize, govern and oversee the management of HHMH;" and to enter the new JPA into a management agreement with SVH to operate the hospital, its rural clinics, skilled nursing facilities and other services that would be determined, according to the county.

The cities of Hollister and San Juan Bautista would be invited to participate in the JPA.

The JPA would be governed by a board of directors, which would include a member of each participating entity. An additional 3-5 board members would be added from among the community, and these would likely include healthcare experts, residents with needed skills and physicians, the county said.

County Administrator Ray Espinosa noted that a recent study of HHMH by ECG Management Consultants found that the community served by the local hospital will have increasing demands for healthcare services long into the future – and a partnership with the county and SVH could meet these needs by keeping HHMH under local control. The ECG assessment was commissioned by the county.

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File photo by Monserrat Solis.

Information provided the San Benito Health Care District. Lea este articulo en español aquí.

San Benito Health Care District (District) received a non-binding Letter of Intent (LOI) from San Benito County and Salinas Valley Health signaling that they are ready to begin more formal discussions collaboration with the District for the management operation of District facilities including Hazel Hawkins Memorial Hospital (HHMH).

The letter, which was sent late in the day on October 26, proposes the formation of a joint powers authority but does not yet provide detail about the participants, capitalization or management terms. These terms are proposed to be developed over the next 60-90 days.

"We are pleased the County is interested in moving forward with substantive discussions about the future of HHMH," said Mary Casillas, interim-CEO for the hospital. "We are looking forward to hearing more from the County and Salinas Valley Health on their proposal and vision for ensuring access to quality healthcare for San Benito County residents."

The County's LOI represents the second LOI the District has received.

California health system names interim CEO

Alexis Kayser (Email) - Friday, November 3rd, 2023

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Salinas (Calif.) Valley Health has tapped Allen Radner, MD, as interim CEO.

Dr. Radner joined the system's medical staff in 1994, and has served as chief medical officer for the past decade, according to a Nov. 2 news release from the system. In 2019, he was named CEO of Salinas Valley Health Medical Clinic, the systems' network of primary and specialty care clinics.

He takes the reins from Pete Delgado, who announced his resignation Oct. 9 after more than 10 years with the health system.

"The realization that there is never a 'perfect' time to step away from a role I love has weighed heavily on my decision," Mr. Delgado wrote in an email to colleagues. "Yet, I am confident that change, while challenging, is an opportunity for growth and renewal for both the organization and myself."

MONTEREY COUNTY WEEKLY NOW NEWS OPINION CALENDAR A&E PEOPLE ADS ABOUT US

Salinas Valley Health district board names its chief medical officer as interim CEO.

Pam Marino Nov 3, 2023 0

Dr. Allen Radner
Salinas Valley Health

One of the main infectious disease experts who with other medical professionals helped Monterey County navigate the Covid-19 pandemic has been tapped to lead Salinas Valley Health through its transition period as CEO Pete Delgado steps aside after 10 years in charge.

SHOW

Salinas Valley Health Board of Directors name interim CEO

By JAMES HERRERA | jherrera@montereyherald.com | Monterey Herald

Listen to this article

SALINAS – The Salinas Valley Health Board of Directors has named Dr. Allen Radner as interim CEO as it continues its search for a permanent replacement for outgoing President and CEO Pete Delgado.

Radner

Radner was named to the interim position by the board following a special board meeting on Wednesday. Radner assumes the role beginning Dec. 1.

The Board has been in the process of finding a new Salinas Valley Health chief after Delgado, who has served as president and CEO for more than a decade, announced his resignation last month.

Radner joined the medical staff of Salinas Valley Health in 1994 and for the past 10 years has served on the executive team as the health care system's chief medical officer, according to a press release from Salinas Valley Health. In October 2019, he was named CEO of Salinas Valley Health Medical Clinic, a network of primary and specialty care clinics serving Monterey County with more than 300 physicians. Radner's knowledge and expertise have resulted in various leadership positions at all three of the area hospitals. As an infectious disease expert, Radner played a role in the coordination and support of the medical community's proactive response during the COVID-19 pandemic.

The Board said its appointment of an interim CEO who is knowledgeable of Salinas Valley Health operations allows for a seamless move forward.

Delgado

Before coming to Salinas Valley Health in April 2013, Delgado had been CEO of the Los Angeles County-University of Southern California Healthcare Network for nearly a decade.

Salinas Valley Health Board of Directors name interim CEO – Monterey Herald

November 3, 2023 by Allan Embrey

SALINAS – The Salinas Valley Health Board of Directors has named Dr. Allen Radner as interim CEO as it continues its search for a permanent replacement for outgoing President and CEO Pete Delgado.

Radner

Radner was named to the interim position by the board following a special board meeting on Wednesday. Radner assumes the role beginning Dec. 1.

The Board has been in the process of finding a new Salinas Valley Health chief after Delgado, who has served as president and CEO for more than a decade, announced his resignation last month.

FROM THE CDC:

Video from the Centers for Disease Control and Prevention.

News FOLLOW 32 Followers

SVH to cover in-network costs until end of year after no agreement with Anthem Blue Cross

By Dania Romero FOLLOW

October 31, 2023 6:21 PM Published October 31, 2023 11:11 AM

SALINAS, Calif. (KION) - After more than two months of failed negotiations between Anthem Blue Cross and Salinas Valley Health 11,000 patients have been left with no choice but to look for another healthcare provider.

This is causing people like Jess Barreras to be worried, that health services for him and his family might not be covered if a deal isn't made.

SALINAS VALLEY HEALTH[1]
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
OCTOBER 19, 2023

Board Members Present:
In-person: President Victor Rey, Vice President Joel Hernandez, Director Catherine Carson, Director Juan Cabrera and Director Rolando Cabrera

Director J. Cabrera joined the meeting at 5:13 p.m.

Absent: None

Also Present:
Matt Ottone, District Legal Counsel
Kathie Haines, Executive Support

1. CALL TO ORDER/ROLL CALL

Four Board members were present, constituting a quorum and President Rey called the meeting to order at 5:03 p.m.

2. READING OF THE NOTICE OF SPECIAL MEETING

The Notice of Special Meeting was read by President, Victor Rey, Jr.

3. PUBLIC INPUT

Approximately 30 physicians attended the public input session. The following public input was received:

Alison Wilson, DO, Hospitalist Director, Vice-Chief of Staff, spoke about appointment of a new Chief Executive Officer (CEO).

Vincent DeFilippi, MD, spoke about appointment of a new CEO.

Rachel Beck, MD, spoke about appointment of a new CEO.

Erica Chan, MD, spoke about appointment of a new CEO.

Anastasia Klick, MD, spoke about appointment of a new CEO.

Misty Navarro, MD, spoke about appointment of a new CEO.

Kanae Mukai, MD, spoke about appointment of a new CEO.

Maxwell Thompson, MD, spoke about appointment of a new CEO.

Kelly Gram, MD, spoke about appointment of a new CEO.

Rakesh Singh, MD, Chief of Staff, thanked the physicians who took time out of patient care to attend the Public Input portion of the Board of Directors Meeting.

President Rey thanked everyone for coming and speaking to the Board. The Board of Directors values and appreciates the partnership with the physicians. The group was thanked for providing their perspective.

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

Public input concluded @ 5:32.

4. CLOSED SESSION

President Victor Rey, Jr., announced items to be discussed in Closed Session as listed on the posted Agenda (1) *Public Employee Appointment - Chief Executive Officer.*

The meeting recessed into Closed Session under the Closed Session Protocol at 5:34 p.m. at which time Ms. Haines was excused.

The Board completed its business of the Closed Session at 7:15 p.m.

5. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 7:16 p.m. President Victor Rey, Jr., reported that in Closed Session, the Board discussed:

(1) *Public Employee Appointment: Chief Executive Office.*

No action was taken by the Board.

6. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, October 26 at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:16 p.m.

_____

Rolando Cabrera, MD,
Secretary, Board of Directors

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM[1]
REGULAR MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
OCTOBER 26, 2023

Committee Members Present:
In-person: Vice-President Joel Hernandez Laguna, Juan Cabrera, Rolando Cabrera MD., and Catherine Carson
Via Teleconference: None
Absent: President Victor Rey, Jr.

Also Present:
Pete Delgado, President/Chief Executive Officer
Rakesh Singh, MD., Chief of Staff
Matthew Ottone, Esq., District Legal Counsel
Kathie Haines, Board Clerk

1. CALL TO ORDER/ROLL CALL

A quorum was present and Vice-President Hernandez Laguna called the meeting to order at 4:01 p.m. in the Downing Resource Center, Rooms A, B, and C.

2. CLOSED SESSION

Vice-President Hernandez Laguna announced items to be discussed in Closed Session as listed on the posted Agenda are *(1) Public Employee Appointment - Chief Executive Officer*, *(2) Reports Involving Trade Secret and (3) Hearings and Reports*. 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 5:22 p.m.

3. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 5:28 p.m. Vice President Hernandez Laguna reported that in Closed Session, the Board discussed *(1) Public Employee Appointment - Chief Executive Officer, (2) Reports Involving Trade Secret and (3) Hearings and Reports*. The Board received the reports listed on the Closed Session agenda. The Board agreed to enter into contract with WittKieffer, an executive search firm for assistance in conducting a search for a new President/CEO.

Vice-President Hernandez Laguna announced there is a need for an extended closed session. The item to be discussed in Extended Closed Session will be needed re: *Public Employee Appointment - Chief Executive Officer.*

4. REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER

Mr. Delgado announced, "*The* Mission of Salinas Valley Memorial Healthcare System is to provide quality healthcare for our patients and to improve the health and well-being of our community," and our Vision is "A community where good health grows with every action, in every place, for every person."

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

The following Mission Moment video was presented: "Navigating Breast Cancer." Featuring the experience of a patient and her family navigating Breast Cancer.

Natasha Limosnero, BSN, RN, Oncology, provided an update on the Med-Surg Cluster Practice Council's work. Projects have included Common Medication Handout and Partner in Care (team nursing), and the impact on patient experience scores.

Board Member Discussion: Further discussion with staff clarified the practice council is focusing Med-Surg nurse perception of autonomy such as critical thinking, decision making and professional independence. Ms. Limosnero and the practice council were thanked for the presentation

Mr. Delgado presented a summary of how the District is meeting each of its foundational pillars Service, Quality, Growth, Finance, People, and Community. Guest speaker Nathan Davis, District Hospital Leadership Forum (DHLF), Sr. Vice President of Finance, addressed the Board on DHLF funding initiatives to assist district hospitals; Salinas Valley Health being one of 33.

Public Comment:
No public comment

5. PUBLIC COMMENT

No public comment

6. BOARD MEMBER COMMENTS

Vice President Joel Hernandez Laguna: none

Director Rolando Cabrera, MD: none

Director Juan Cabrera: none

Director Catherine Carson: none

7. CONSENT AGENDA – GENERAL BUSINESS

A. Minutes of October 12, 2023 Special Meeting of the Board of Directors
B. Financial Report
C. Statistical Report
D. Policies Requiring Approval (27)
    1. Blood and Blood Product Administration
    2. Capital Budget Planning Purchase
    3. Cardiac Telemetry Monitoring and Management
    4. Care of the CRRT Patient-Monitoring, Troubleshooting, and Termination of PrismaFlex
    5. Care of the Mechanically Ventilated Adult Patient
    6. Chest Pain Standardized Procedure
    7. Compliance and Ethics Program
    8. Discipline Administration
    9. Family School Partnership
    10. Hyperbilirubinemia-Infant Management & Treatment
    11. Interdisciplinary Plan of Care
    12. Interpreter/Translator Communication
    13. Massive Transfusion Protocol -Nursing

14. Oral Care
15. Pacemaker: Insertion of a Temporary Pacemaker, Transvenous; Balloon-Tipped Pacing Electrode; and Epicardial
16. Patient Food Service
17. Physician Services Contract
18. Prime/QIP Data Integrity / Review
19. PTO Cash Out
20. Scope of Service: Cardiovascular Diagnostic and Treatment Units
21. Scope of Service: Case Management
22. Scope of Service: Medical Surgical Services
23. Scope of Service: Respiratory, Neurodiagnostics and Sleep Medicine
24. Scope of Service: Social Services
25. Serious Reportable Events
26. Vacuum-Induced Management of OB Hemorrhage
27. Visitors

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Carson, second by Director J. Cabrera, the Board of Directors approved the Consent Agenda, Items (A) through (D), as presented.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

A. QUALITY AND EFFICIENT PRACTICES COMMITTEE

A report was received from Director Catherine Carson regarding the Quality and Efficient Practices Committee. The committee welcomed Alison Wilson, DO, to the committee. The committee will be focusing on hospital acquired pneumonia. The committee received an update on the chest pain program; metrics are great. The team is working with IT to help improve discharge. The 3rd quarter Dashboard will be presented to the Board at the November meeting.

B. FINANCE COMMITTEE

A report was received from Director Hernandez Laguna regarding the Finance Committee. The following recommendations were made:

1. ***Consider Recommendation for Board Approval of the Optum360 Lynx Software Service Agreement Renewal***

PUBLIC COMMENT:
No public comment.

MOTION:
Upon motion by Director Rolando Cabrera, MD., and second by Director Juan Cabrera, the Board of Directors approves the Optum^{MT} Lynx software contract renewal as sole source justification and contract award in the estimated amount of $1,528,770, over the five-year term.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

2. ***Consider Recommendation for Board Approval of Project Budget for the Salinas Valley Health Clinic Refresh and Expansion at 212 San Jose Street, Suites 301 and 302 (Cardiothoracic/Vascular Surgery)***

BOARD DISCUSSION:
None

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Rolando Cabrera, MD, and second by Director Catherine Carson, the Board of Directors approves the total estimated project budget for the Salinas Valley Health Clinic Refresh and Expansion at 212 San Jose Street, Suites 301 and 302 (Cardiothoracic/Vascular Surgery) in the budgeted amount of $500,000.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

3. ***Consider Recommendation for Board Approval of Awarding Contract for Design and Engineering Services in conjunction with the Catheterization Laboratory 3 and Interventional Radiology Equipment Replacement Projects***

BOARD COMMENT:
None

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Rolando Cabrera, MD, second by Director Juan Cabrera; the Board of Directors approves

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

4. ***Consider Recommendation for Board Approval of a Management Service and Supply Agreement with Aramark for Food and Nutrition Services including Starbucks***

BOARD DISCUSSION:
None

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Catherine Carson, second by Director Rolando Cabrera, MD, the Board of Directors approves awarding the contract to Aramark Health Care, for management services for the management of the Food and Nutrition Services Department and Starbucks, includes delivery of food/nutritional supplies in the estimated amount of $4.8m the first year and up to $32.7m over 6 years, pending final contract negotiations and legal review.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

C. PERSONNEL, PENSION, AND INVESTMENT COMMITTEE

A report was received from Director Juan Cabrera regarding the Personnel, Pension, and Investment Committee. The following recommendations were made:

1. ***Consider recommendation for Board approval of:***
   - ***a. Findings Supporting Recruitment of Nicholas Klimberg, MD.;***
   - ***b. Contract Terms for Dr. Klimberg's Recruitment Agreement, and;***
   - ***c. Contract Terms for Dr. Klimberg's Pulmonology Professional Services Agreement***

BOARD MEMBER DISCUSSION: Further discussion with staff clarified Dr. Klimberg's start date is January. He is an Intensivist which is a benefit to Salinas Valley Health and supports Leapfrog survey standards.

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Catherine Carson, second by Director Rolando Cabrera, MD, the Board of Directors approved the findings supporting recruitment, the Recruitment Agreement and the Pulmonology Professional Service Agreement for Nicholas Klimberg, MD.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

2. ***Consider recommendation for Board approval of contract terms for Juan Rodriguez, MD's diagnostic and interventional radiology professional services agreement recommendation.***

BOARD COMMENT:
No public comment

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Rolando Cabrera, MD, second by Director Juan Cabrera, the Board of Directors approves terms of Juan Rodriguez, MD's diagnostic and interventional Radiology Professional Services Agreement recommendation.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

3. ***Consider recommendation for Board approval of findings supporting recruitment of physicians to Monterey Bay GI Consultants Medical Group and approval of recruitment incentives.***

BOARD COMMENT:
None

PUBLIC COMMENT:
No public comment

MOTION:

Upon motion by Director Juan Cabrera, second by Director Rolando Cabrera, MD, the Board of Directors approves findings supporting recruitment of physicians to Monterey Bay GI Consultants Medical Group and approval of recruitment incentives.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

D. TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

A report was received from Director Dr. Cabrera regarding the Transformation, Strategic Planning and Governance Committee. The following recommendation was made:

1. *Consider Recommendation for Board Approval of the Organizational Goals for FY2024.*

PUBLIC INPUT:
No public comment

BOARD DISCUSSION:
none

MOTION:

Upon motion by Director Catherine Carson, second by Director Rolando Cabrera, MD, the Board of Directors approves the Organizational Goals for FY2024.

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING ON OCTOBER 12, 2023, AND RECOMMENDATION FOR BOARD APPROVAL OF THE FOLLOWING

Rakesh Singh, Chief of Staff reviewed the reports of the Medical Executive Committee (MEC) meeting of October 12, 2023, and Rules and Regulations revision. A full report was provided in the Board packet.

Recommend Board Approval of the Following:

A. Reports
   a. Credentials Committee Report
   b. Interdisciplinary Practice Committee Report
B. Policies, Plans and Privilege Forms:
   a. Plastic & Reconstructive Surgery Clinical Privilege Delineation Revision
   b. General and Colorectal Surgery Clinical Privilege Delineation Revision
   c. Orthopedic Surgery Clinical Privilege Delineation Revision
   d. Podiatric Surgery Clinical Privilege Delineation Revision
      Regional Wound Healing Center Clinical Privilege Delineation Revision
   e. Hazardous Materials & Waste Management Plan - Update
   f. Withdrawing Life Sustaining Treatment - Update

No public comment received.

PUBLIC INPUT:
No public comment

BOARD DISCUSSION:
The policy on Withdrawing Life Sustaining Treatment was not included in the packet. This policy was tabled until the November meeting.

MOTION:

Upon motion by Director Juan Cabrera, second by Director Catherine Carson, the Board of Directors receives and approves the Medical Executive Committee Credentials Committee Report and the Interdisciplinary Practice Committee Report, and the Policies, Plans and Privilege Forms, as follows:

1. Credentials Committee Report
2. Interdisciplinary Practice Committee Report
3. Policies, Plans and Privilege Forms
    - Plastic & Reconstructive Surgery Clinical Privilege Delineation Revision
    - General and Colorectal Surgery Clinical Privilege Delineation Revision
    - Orthopedic Surgery Clinical Privilege Delineation Revision
    - Podiatric Surgery Clinical Privilege Delineation Revision
    - Regional Wound Healing Center Clinical Privilege Delineation Revision
    - Hazardous Materials & Waste Management Plan – Update

ROLL CALL VOTE:
Ayes: J. Cabrera, R Cabrera, Carson, and Hernandez Laguna,
Noes: None;
Abstentions: None;
Absent: Rey

Motion Carried

9. EXTENDED CLOSED SESSION

Vice-President Hernandez Laguna announced item to be discussed in Extended Closed Session is *Public Employee Appointment - Chief Executive Officer*. The meeting recessed into Closed Session under the Closed Session Protocol at 6:32 p.m. The Board completed its business of the Closed Session at 7:55 p.m. Vice-President Hernandez Laguna announced that no action was taken in Closed Session.

10. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, November 16 at 4:00 p.m.** There being no further business, the meeting was adjourned at 7:57 p.m.

_____
Rolando Cabrera, MD
Secretary, Board of Directors

SALINAS VALLEY HEALTH[1]
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
NOVEMBER 1, 2023

Board Members Present:
In-person: President Victor Rey, Vice President Joel Hernandez, Director Catherine Carson, Director Juan Cabrera and Director Rolando Cabrera

Absent: None

Also Present:
Matt Ottone, District Legal Counsel
Kathie Haines, Executive Support

1. CALL TO ORDER/ROLL CALL

All Board members were present, constituting a quorum and President Rey called the meeting to order at 5:33 p.m.

2. READING OF THE NOTICE OF SPECIAL MEETING

The Notice of Special Meeting was read by President, Victor Rey, Jr.

3. PUBLIC COMMENT

The following public comment was received:

Laura Welch, RN, spoke about appointment of a new CEO.

4. CLOSED SESSION

President Victor Rey, Jr., announced items to be discussed in Closed Session as listed on the posted Agenda (1) *Public Employee Appointment - Chief Executive Officer*.

The meeting recessed into Closed Session under the Closed Session Protocol at 5:39 p.m. at which time Ms. Haines was excused.

The Board completed its business of the Closed Session at 8:40 p.m.

5. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 8:42 p.m. President Victor Rey, Jr., reported that in Closed Session, the Board discussed:

(1) *Public Employee Appointment: Chief Executive Office.*

The following action was taken in Closed Session: Upon a Motion by Dr. Rolando Cabrera, MD, Seconded by Catherine Carson, the Board appoints Dr. Allen Radner, M.D. as Interim President/CEO of

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

the District, effective December 1, 2023. The Board reiterates that it is in the process of conducting a search for a permanent President/CEO and that work is progressing.

Ayes: Dr. Cabrera, Carson, Rey
Nays: Hernandez, Cabrera
Abstentions: None

6. ADJOURNMENT

The next Regular Meeting of the Board of Directors is scheduled for **Thursday, November 16 at 4:00 p.m.** There being no further business, the meeting was adjourned at 8:45 p.m.

_____

Rolando Cabrera, MD,
Secretary, Board of Directors

Financial Performance Review
October 2023

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary
For the Month of October 2023

$ in Millions	For the Month of October 2023			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 54.7	$ 60.7	$ (6.0)	-9.9%
Operating Expense	$ 59.1	$ 60.8	$ 1.7	2.8%
Income from Operations	**$ (4.4)**	**$ (0.1)**	**$ (4.3)**	**-4300.0%**
Operating Margin %	*-8.0%*	*-0.2%*	*-7.8%*	*-3900.00%*
Non Operating Income	$ 1.2	$ 1.9	$ (0.7)	-36.8%
Net Income	**$ (3.2)**	**$ 1.8**	**$ (5.0)**	**-277.8%**
Net Income Margin %	*-5.7%*	*3.0%*	*-8.7%*	*-290.0%*

Consolidated Financial Summary
YTD October 2023

$ in Millions	FY 2023 YTD October			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 225.4	$ 240.8	$ (15.4)	-6.4%
Operating Expense	$ 238.8	$ 239.8	$ 1.0	0.4%
Income from Operations	**$ (13.4)**	**$ 1.0**	**$ (14.4)**	**-1440.0%**
Operating Margin %	*-6.0%*	*0.4%*	*-6.4%*	*-1600.0%*
Non Operating Income	$ 9.9	$ 7.6	$ 2.3	30.3%
Net Income	**$ (3.5)**	**$ 8.6**	**$ (12.1)**	**-140.7%**
Net Income Margin %	*-1.6%*	*3.6%*	*-5.2%*	*-144.4%*

SVHMC Revenue Highlights October 2023

Gross Revenues were 2.2% *favorable* to budget

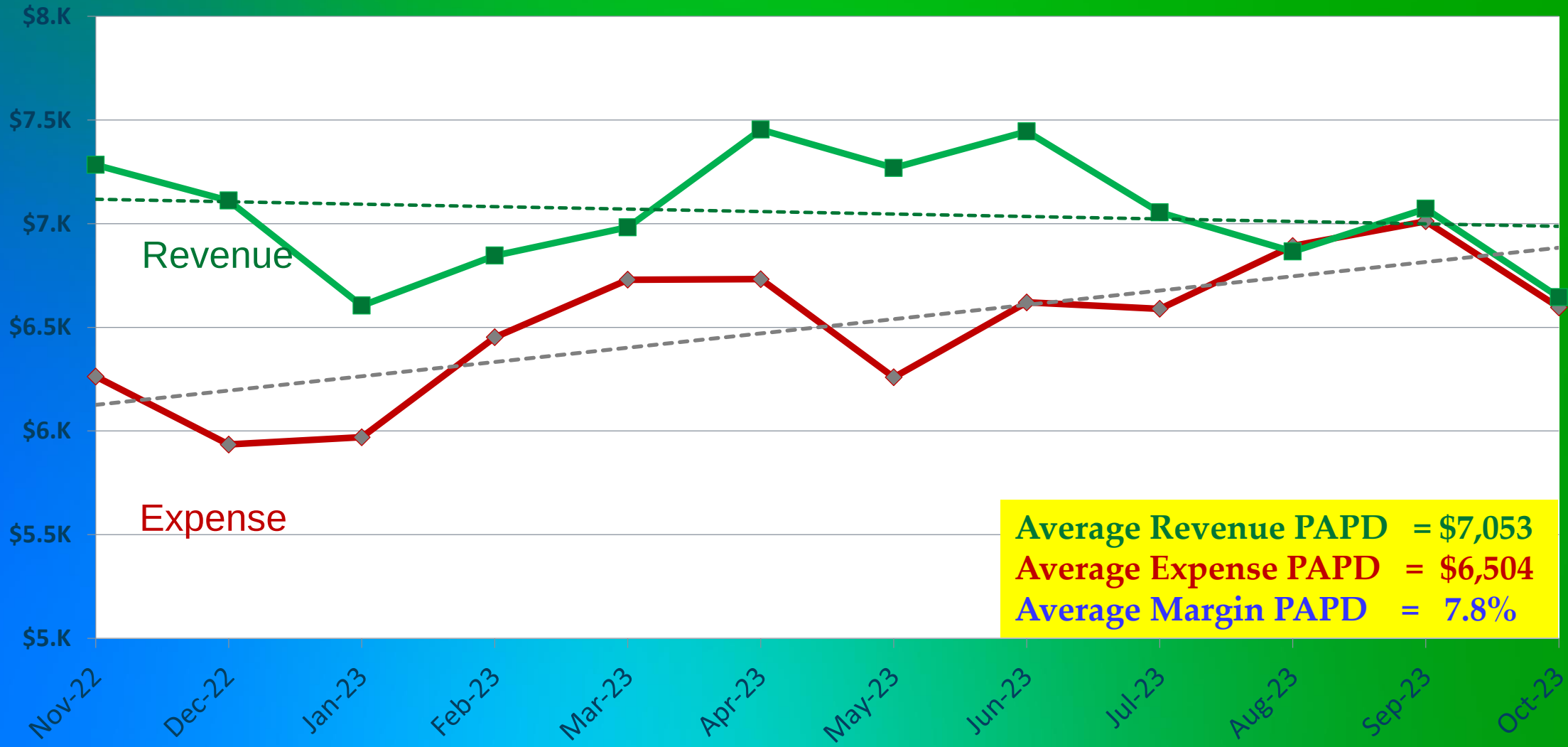
- **IP Gross Revenues** were 6% un*favorable* to budget
- **ED Gross Revenues** were 1% un*favorable* to budget
- **OP Gross Revenues** were 16% *favorable* to budget in the following areas:
  - OP Infusion
  - OP Surgery
  - Cath Lab
  - Mammography

- **Commercial:** 5% *below* budget
- **Medicaid:** 4% *above* budget
- **Medicare:** 6% *above* budget

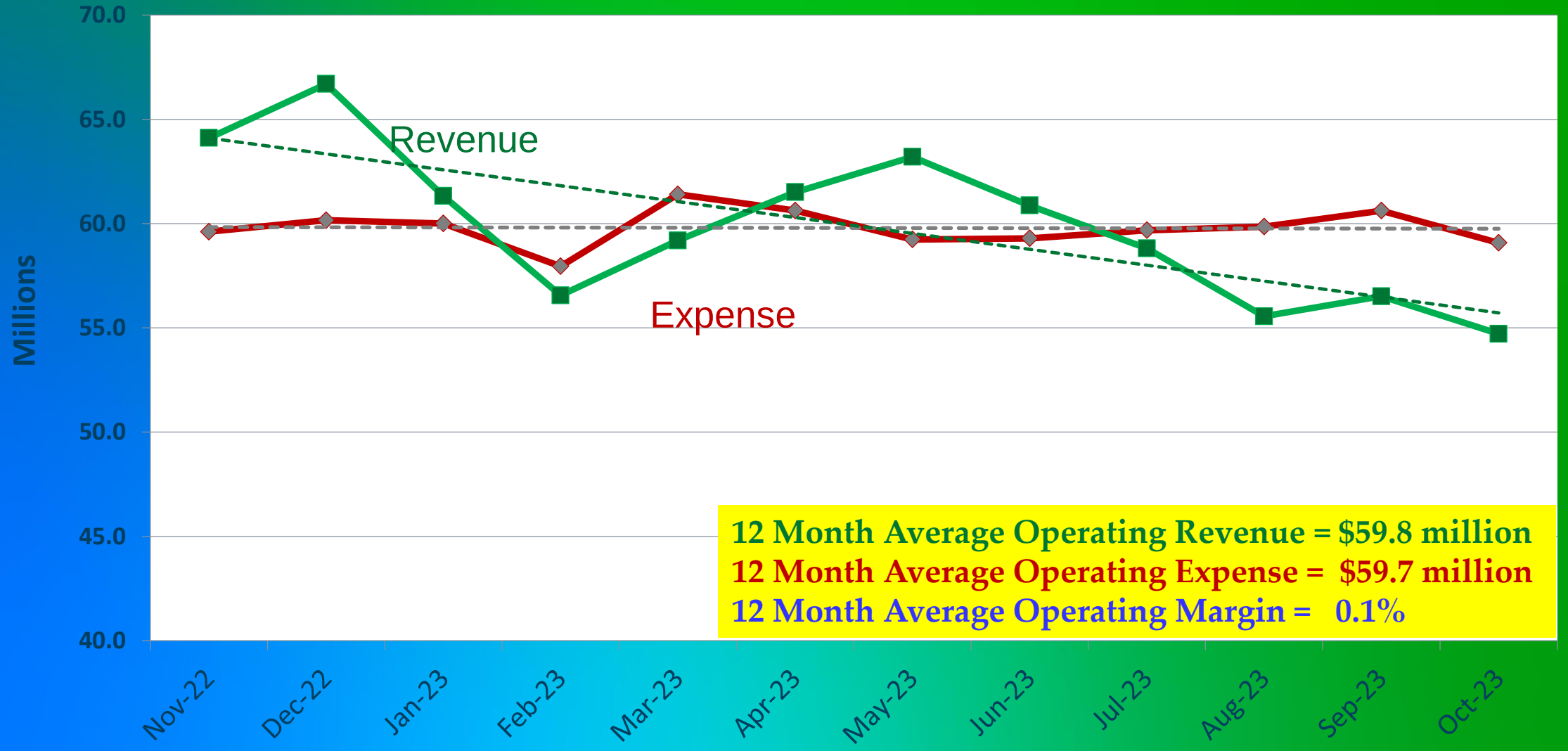
Payor Mix – Unfavorable

Total Normalized Net Patient Revenues were **$45.8M**, which was *unfavorable* to budget by **$4.6M** or 9.1%

SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Nov 22 to October 23



SVH Consolidated Revenues & Expenses
Rolling 12 Months: Nov 22 to October 23



12 Month Average Operating Revenue = $59.8 million
12 Month Average Operating Expense = $59.7 million
12 Month Average Operating Margin = 0.1%

Salinas Valley Health Key Financial Indicators

Statistic	YTD 10/31/23	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 10/31/22	+/-
Operating Margin*	-7.7%	5.0%		4.0%		4.2%	
Total Margin*	1.6%	6.0%		6.6%		4.3%	
EBITDA Margin**	-0.9%	7.4%		13.6%		8.1%	
Days of Cash*	337	305		249		340	
Days of Accounts Payable*	46	45		-		53	
Days of Net Accounts Receivable***	55	45		49		49	
Supply Expense as % NPR	14.3%	14.0%		-		13.0%	
SWB Expense as % NPR	58.7%	53.0%		53.7%		54.0%	
Operating Expense per APD*	6,782	6,739		-		6,291	

*These metrics have been adjusted for normalizing items
**Metric based on Operating Income (consistent with industry standard)
***Metric based on 90 days average net revenue (consistent with industry standard)
Days of Cash and Accounts Payable metrics have been adjusted to ***exclude*** accelerated insurance payments (COVID-19 assistance)

Questions / Comments

SALINAS VALLEY HEALTH MEDICAL CENTER
SUMMARY INCOME STATEMENT
October 31, 2023

	Month of October,		Four months ended October 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 45,775,024	$ 50,289,316	$ 187,298,780	$ 202,630,079
Other operating revenue	1,164,498	708,887	4,485,356	2,832,430
Total operating revenue	46,939,522	50,998,203	191,784,136	205,462,509
Total operating expenses	46,591,831	46,906,308	187,903,965	185,327,828
Total non-operating income	(2,820,446)	(4,949,934)	(6,919,489)	(13,005,285)
Operating and non-operating income	$ (2,472,754)	$ (858,039)	$ (3,039,318)	$ 7,129,396

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
October 31, 2023

	Current year	Prior year
ASSETS:		
Current assets	$ 333,221,641	$ 387,369,106
Assets whose use is limited or restricted by board	159,428,816	150,622,423
Capital assets	249,059,773	240,456,794
Other assets	287,119,788	189,926,803
Deferred pension outflows	116,911,125	95,857,027
	$ 1,145,741,143	$ 1,064,232,154
LIABILITIES AND EQUITY:		
Current liabilities	88,330,725	101,776,975
Long term liabilities	20,095,669	18,514,233
Lease deferred inflows	2,236,413	1,911,058
Pension liability	118,792,064	79,111,485
Net assets	916,286,272	862,918,403
	$ 1,145,741,143	$ 1,064,232,154

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
October 31, 2023

	Month of October,		Four months ended October 31,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,770	2,012	6,981	7,670
Medi-Cal	1,062	1,204	3,943	4,475
Commercial insurance	618	779	2,617	3,031
Other patient	41	112	416	407
Total patient days	3,491	4,107	13,957	15,583
Gross revenue:				
Medicare	$ 111,861,110	$ 100,067,777	$ 435,016,498	$ 397,358,669
Medi-Cal	72,269,584	69,289,259	265,522,537	260,048,351
Commercial insurance	50,764,131	51,767,295	207,746,023	208,520,709
Other patient	5,945,542	9,370,137	34,985,267	32,999,936
Gross revenue	240,840,367	230,494,468	943,270,325	898,927,665
Deductions from revenue:				
Administrative adjustment	345,030	89,863	995,072	700,155
Charity care	1,137,235	889,140	3,339,493	3,142,609
Contractual adjustments:				
Medicare outpatient	32,370,856	28,526,083	135,005,458	120,285,952
Medicare inpatient	45,454,280	47,649,599	180,714,692	173,350,023
Medi-Cal traditional outpatient	3,079,984	3,028,934	10,995,770	12,977,361
Medi-Cal traditional inpatient	5,121,884	4,814,343	18,224,509	17,997,061
Medi-Cal managed care outpatient	30,889,399	28,317,415	117,574,636	103,814,679
Medi-Cal managed care inpatient	23,804,305	25,868,830	89,909,016	97,178,833
Commercial insurance outpatient	28,092,912	17,428,652	93,807,839	70,749,488
Commercial insurance inpatient	21,742,113	18,022,711	84,674,506	76,735,571
Uncollectible accounts expense	4,256,551	3,713,662	16,977,482	15,636,031
Other payors	(1,229,206)	1,855,919	3,753,072	3,729,824
Deductions from revenue	195,065,343	180,205,151	755,971,545	696,297,587
Net patient revenue	$ 45,775,024	$ 50,289,316	$ 187,298,780	$ 202,630,079
Gross billed charges by patient type:				
Inpatient	$ 119,490,021	$ 124,454,276	$ 474,132,357	$ 473,155,211
Outpatient	91,663,337	76,791,223	349,820,626	311,875,590
Emergency room	29,687,009	29,248,969	119,317,343	113,896,865
Total	$ 240,840,367	$ 230,494,468	$ 943,270,326	$ 898,927,665

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
October 31, 2023

	Month of October,		Four months ended October 31,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 45,775,024	$ 50,289,316	$ 187,298,780	$ 202,630,079
Other operating revenue	1,164,498	708,887	4,485,356	2,832,430
Total operating revenue	46,939,522	50,998,203	191,784,136	205,462,509
Operating expenses:				
Salaries and wages	17,316,172	17,109,510	65,709,240	70,169,492
Compensated absences	3,733,512	3,240,154	12,440,217	11,199,200
Employee benefits	7,406,798	7,705,239	33,344,319	29,868,786
Supplies, food, and linen	7,420,540	6,494,538	27,987,266	26,965,431
Purchased department functions	2,141,107	4,530,945	14,500,016	16,103,028
Medical fees	2,025,614	2,033,674	9,695,478	7,453,948
Other fees	1,990,310	2,543,794	8,412,234	9,710,704
Depreciation	3,565,600	1,779,457	9,409,010	7,463,055
All other expense	992,178	1,468,997	6,406,185	6,394,184
Total operating expenses	46,591,831	46,906,308	187,903,965	185,327,828
Income from operations	347,691	4,091,895	3,880,171	20,134,681
Non-operating income:				
Donations	54,244	(500,000)	1,186,931	1,801,378
Property taxes	333,333	333,333	1,333,333	1,333,333
Investment income	1,326,514	(769,695)	7,015,808	(4,144,335)
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,534,537)	(4,013,572)	(16,455,561)	(11,995,661)
Total non-operating income	(2,820,446)	(4,949,934)	(6,919,489)	(13,005,285)
Operating and non-operating income	(2,472,754)	(858,039)	(3,039,318)	7,129,396
Net assets to begin	918,759,027	863,776,442	919,325,589	855,789,007
Net assets to end	$ 916,286,272	$ 862,918,403	$ 916,286,272	$ 862,918,403
Net income excluding non-recurring items	$ (2,472,754)	$ (858,039)	$ (3,039,318)	$ 7,129,396
Non-recurring income (expense) from cost report settlements and re-openings and other non-recurring items	0	0	0	0
Operating and non-operating income	$ (2,472,754)	$ (858,039)	$ (3,039,318)	$ 7,129,396

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
October 31, 2023

	Month of October,		Four months ended October 31,	
	current year	prior year	current year	prior year
Detail of income from subsidiaries:				
Salinas Valley Health Clinics				
Pulmonary Medicine Center	$ (190,308)	$ (300,762)	$ (756,288)	$ (796,932)
Neurological Clinic	(75,925)	(60,546)	(271,408)	(292,324)
Palliative Care Clinic	(91,337)	(64,509)	(324,335)	(247,764)
Surgery Clinic	(150,672)	(175,155)	(727,228)	(556,396)
Infectious Disease Clinic	(30,130)	(33,367)	(124,674)	(119,959)
Endocrinology Clinic	(186,720)	(142,675)	(816,873)	(612,348)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(507,023)	(562,968)	(2,099,420)	(1,667,913)
OB/GYN Clinic	(392,482)	(160,098)	(1,444,125)	(1,045,650)
PrimeCare Medical Group	(779,642)	(485,566)	(3,289,907)	(1,635,577)
Oncology Clinic	(294,875)	(436,387)	(1,217,149)	(1,190,934)
Cardiac Surgery	(348,814)	(47,016)	(1,267,006)	(834,416)
Sleep Center	(43,679)	15,357	(162,110)	(44,032)
Rheumatology	(66,637)	(50,470)	(255,402)	(236,168)
Precision Ortho MDs	(520,151)	(594,911)	(1,726,403)	(1,430,465)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(35,268)	(55,345)	(166,527)	(175,414)
Vaccine Clinic	0	571	0	(683)
Dermatology	(55,310)	(33,015)	(159,760)	(76,055)
Hospitalists	0	0	0	0
Behavioral Health	(55,202)	(45,151)	(165,387)	(117,487)
Pediatric Diabetes	(49,616)	(42,106)	(192,882)	(182,254)
Neurosurgery	(30,859)	(57,727)	(112,813)	(128,692)
Multi-Specialty-RR	5,202	26,284	20,834	47,221
Radiology	(347,064)	(221,988)	(877,791)	(635,736)
Salinas Family Practice	(150,620)	(163,626)	(535,775)	(401,037)
Urology	(182,444)	(303,218)	(671,721)	(477,344)
Total SVHC	(4,579,576)	(3,994,394)	(17,344,150)	(12,858,359)
Doctors on Duty	(113,284)	23,786	187,029	313,105
Vantage Surgery Center	0	0	0	0
LPCH NICU JV	0	0	0	0
Central Coast Health Connect	0	0	0	0
Monterey Peninsula Surgery Center	73,090	63,502	429,379	464,955
Coastal	38,901	(93,502)	147,588	(57,525)
Apex	0	0	0	0
21st Century Oncology	6,892	(55,946)	(14,709)	(27,945)
Monterey Bay Endoscopy Center	39,440	42,981	139,302	170,108
Total	$ (4,534,537)	$ (4,013,572)	$ (16,455,561)	$ (11,995,661)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
October 31, 2023

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 221,133,651	$ 276,777,968
Patient accounts receivable, net of estimated uncollectibles of $26,676,525	87,188,314	88,830,207
Supplies inventory at cost	8,001,510	7,596,948
Current portion of lease receivable	1,538,727	534,201
Other current assets	15,359,439	13,629,782
Total current assets	333,221,641	387,369,106
Assets whose use is limited or restricted by board	159,428,816	150,622,423
Capital assets:		
Land and construction in process	68,332,034	43,531,753
Other capital assets, net of depreciation	180,727,739	196,925,042
Total capital assets	249,059,773	240,456,794
Other assets:		
Right of use assets, net of amortization	5,043,074	7,137,296
Long term lease receivable	854,047	1,462,610
Subscription assets, net of amortization	9,131,508	0
Investment in Securities	247,644,024	141,829,047
Investment in SVMC	6,851,416	14,518,570
Investment in Coastal	1,829,229	1,586,175
Investment in other affiliates	20,516,116	23,321,886
Net pension asset	(4,749,626)	71,219
Total other assets	287,119,788	189,926,803
Deferred pension outflows	116,911,125	95,857,027
	$ 1,145,741,143	$ 1,064,232,154
L I A B I L I T I E S A N D N E T A S S E T S		
Current liabilities:		
Accounts payable and accrued expenses	$ 58,871,639	$ 63,194,431
Due to third party payers	5,308,933	17,755,329
Current portion of self-insurance liability	17,862,738	17,891,246
Current subscription liability	4,465,124	0
Current portion of lease liability	1,822,291	2,935,968
Total current liabilities	88,330,725	101,776,975
Long term portion of workers comp liability	13,027,333	14,058,922
Long term portion of lease liability	3,418,351	4,455,311
Long term subscription liability	3,649,985	0
Total liabilities	108,426,394	120,291,208
Lease deferred inflows	2,236,413	1,911,058
Pension liability	118,792,064	79,111,485
Net assets:		
Invested in capital assets, net of related debt	249,059,773	240,456,794
Unrestricted	667,226,499	622,461,609
Total net assets	916,286,272	862,918,403
	$ 1,145,741,143	$ 1,064,232,154

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
October 31, 2023

	Month of October,				Four months ended October 31,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 240,840,367	$ 235,748,845	5,091,522	2.16%	$ 943,270,325	$ 935,361,603	7,908,722	0.85%
Dedutions from revenue	195,065,343	185,390,067	9,675,276	5.22%	755,971,545	735,395,722	20,575,823	2.80%
Net patient revenue	45,775,024	50,358,778	(4,583,754)	-9.10%	187,298,780	199,965,881	(12,667,101)	-6.33%
Other operating revenue	1,164,498	1,332,540	(168,042)	-12.61%	4,485,356	5,330,160	(844,804)	-15.85%
Total operating revenue	**46,939,522**	**51,691,318**	**(4,751,796)**	**-9.19%**	**191,784,136**	**205,296,041**	**(13,511,905)**	**-6.58%**
Operating expenses:								
Salaries and wages	17,316,172	17,525,260	(209,088)	-1.19%	65,709,240	68,169,051	(2,459,811)	-3.61%
Compensated absences	3,733,512	2,834,756	898,756	31.70%	12,440,217	12,337,350	102,867	0.83%
Employee benefits	7,406,798	8,022,822	(616,024)	-7.68%	33,344,319	31,926,280	1,418,039	4.44%
Supplies, food, and linen	7,420,540	6,899,278	521,262	7.56%	27,987,266	27,377,505	609,761	2.23%
Purchased department functions	2,141,107	3,539,230	(1,398,123)	-39.50%	14,500,016	14,156,918	343,098	2.42%
Medical fees	2,025,614	2,359,060	(333,446)	-14.13%	9,695,478	9,436,241	259,237	2.75%
Other fees	1,990,310	2,269,528	(279,218)	-12.30%	8,412,234	9,031,399	(619,165)	-6.86%
Depreciation	3,565,600	2,107,438	1,458,162	69.19%	9,409,010	8,503,451	905,559	10.65%
All other expense	992,178	1,841,330	(849,152)	-46.12%	6,406,185	7,325,854	(919,669)	-12.55%
Total operating expenses	**46,591,831**	**47,398,702**	**(806,871)**	**-1.70%**	**187,903,965**	**188,264,050**	**(360,085)**	**-0.19%**
Income from operations	**347,691**	**4,292,616**	**(3,944,925)**	**-91.90%**	**3,880,171**	**17,031,991**	**(13,151,820)**	**-77.22%**
Non-operating income:								
Donations	54,244	166,667	(112,423)	-67.45%	1,186,931	666,667	520,264	78.04%
Property taxes	333,333	333,333	(0)	0.00%	1,333,333	1,333,333	(0)	0.00%
Investment income	1,326,514	1,185,806	140,709	11.87%	7,015,808	4,743,222	2,272,586	47.91%
Income from subsidiaries	(4,534,537)	(4,350,243)	(184,294)	4.24%	(16,455,561)	(15,864,079)	(591,482)	3.73%
Total non-operating income	**(2,820,446)**	**(2,664,438)**	**(156,008)**	**5.86%**	**(6,919,489)**	**(9,120,857)**	**2,201,368**	**-24.14%**
Operating and non-operating income	**$ (2,472,755)**	**$ 1,628,178**	**(4,100,933)**	**-251.87%**	**$ (3,039,318)**	**$ 7,911,135**	**(10,950,452)**	**-138.42%**

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

	Month of Oct		Four months to date		
	2022	2023	2022-23	2023-24	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	39	35	153	136	(17)
Other Admissions	79	79	345	329	(16)
Total Admissions	118	114	498	465	(33)
Medi-Cal Patient Days	58	59	239	221	(18)
Other Patient Days	134	141	568	556	(12)
Total Patient Days of Care	192	200	807	777	(30)
Average Daily Census	6.2	6.5	6.6	6.3	(0.2)
Medi-Cal Average Days	1.5	1.7	1.6	1.7	0.1
Other Average Days	1.1	1.8	1.6	1.7	0.1
Total Average Days Stay	1.7	1.8	1.6	1.7	0.1
ADULTS & PEDIATRICS					
Medicare Admissions	387	361	1,544	1,459	(85)
Medi-Cal Admissions	368	254	1,153	977	(176)
Other Admissions	388	292	1,258	1,153	(105)
Total Admissions	1,143	907	3,955	3,589	(366)
Medicare Patient Days	1,733	1,486	6,370	5,942	(428)
Medi-Cal Patient Days	1,243	1,058	4,644	4,053	(591)
Other Patient Days	975	734	4,047	2,996	(1,051)
Total Patient Days of Care	3,951	3,278	15,061	12,991	(2,070)
Average Daily Census	127.5	105.7	122.4	105.6	(16.8)
Medicare Average Length of Stay	4.6	4.2	4.1	4.1	(0.0)
Medi-Cal AverageLength of Stay	3.4	3.5	3.5	3.6	0.1
Other Average Length of Stay	2.6	2.1	2.6	2.1	(0.5)
Total Average Length of Stay	3.5	3.2	3.4	3.2	(0.2)
Deaths	22	31	86	100	14
Total Patient Days	4,143	3,478	15,868	13,768	(2,100)
Medi-Cal Administrative Days	5	0	32	5	(27)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	5	0	32	5	(27)
Percent Non-Acute	0.12%	0.00%	0.20%	0.04%	-0.17%

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

	Month of Oct		Four months to date		
	2022	2023	2022-23	2023-24	Variance
PATIENT DAYS BY LOCATION					
Level I	290	232	1,086	941	(145)
Heart Center	342	312	1,367	1,308	(59)
Monitored Beds	640	583	2,573	2,422	(151)
Single Room Maternity/Obstetrics	333	307	1,376	1,257	(119)
Med/Surg - Cardiovascular	922	843	3,625	3,217	(408)
Med/Surg - Oncology	307	264	982	1,082	100
Med/Surg - Rehab	529	462	2,078	1,732	(346)
Pediatrics	138	127	504	498	(6)
Nursery	192	200	807	777	(30)
Neonatal Intensive Care	163	148	533	534	1
PERCENTAGE OF OCCUPANCY					
Level I	71.96%	57.57%	67.92%	58.85%	
Heart Center	73.55%	67.10%	74.09%	70.89%	
Monitored Beds	76.46%	69.65%	77.48%	72.93%	
Single Room Maternity/Obstetrics	29.03%	26.77%	30.24%	27.62%	
Med/Surg - Cardiovascular	66.09%	60.43%	65.49%	58.12%	
Med/Surg - Oncology	76.18%	65.51%	61.41%	67.67%	
Med/Surg - Rehab	65.63%	57.32%	64.98%	54.16%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	24.73%	22.76%	22.76%	22.49%	
Nursery	37.54%	39.10%	19.88%	19.14%	
Neonatal Intensive Care	47.80%	43.40%	39.39%	39.47%	

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

	Month of Oct		Four months to date		
	2022	2023	2022-23	2023-24	Variance
DELIVERY ROOM					
Total deliveries	123	111	485	452	(33)
C-Section deliveries	41	38	143	147	4
Percent of C-section deliveries	33.33%	34.23%	29.48%	32.52%	3.04%
OPERATING ROOM					
In-Patient Operating Minutes	24,188	16,214	80,075	64,377	(15,698)
Out-Patient Operating Minutes	25,030	31,511	103,309	120,790	17,481
Total	49,218	47,725	183,384	185,167	1,783
Open Heart Surgeries	14	9	52	39	(13)
In-Patient Cases	166	127	569	478	(91)
Out-Patient Cases	263	307	1,081	1,184	103
EMERGENCY ROOM					
Immediate Life Saving	26	36	106	147	41
High Risk	560	677	2,165	2,774	609
More Than One Resource	3,074	2,842	11,965	11,384	(581)
One Resource	2,380	2,054	8,324	7,642	(682)
No Resources	93	123	371	452	81
Total	6,133	5,732	22,931	22,399	(532)

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

	Month of Oct		Four months to date		
	2022	2023	2022-23	2023-24	Variance
CENTRAL SUPPLY					
In-patient requisitions	15,071	12,414	59,035	52,341	-6,694
Out-patient requisitions	9,437	10,555	37,940	41,856	3,916
Emergency room requisitions	490	632	2,300	3,273	973
Interdepartmental requisitions	6,919	6,572	27,981	25,495	-2,486
Total requisitions	31,917	30,173	127,256	122,965	-4,291
LABORATORY					
In-patient procedures	39,630	34,762	153,219	140,091	-13,128
Out-patient procedures	10,435	21,788	43,761	55,171	11,410
Emergency room procedures	13,191	12,989	51,603	52,069	466
Total patient procedures	63,256	69,539	248,583	247,331	-1,252
BLOOD BANK					
Units processed	401	298	1,367	1,236	-131
ELECTROCARDIOLOGY					
In-patient procedures	1,096	1,037	4,306	4,130	-176
Out-patient procedures	290	398	1,401	1,564	163
Emergency room procedures	1,125	1,139	4,479	4,808	329
Total procedures	2,511	2,574	10,186	10,502	316
CATH LAB					
In-patient procedures	93	142	380	479	99
Out-patient procedures	73	123	344	413	69
Emergency room procedures	0	0	1	0	-1
Total procedures	166	265	725	892	167
ECHO-CARDIOLOGY					
In-patient studies	371	381	1,544	1,401	-143
Out-patient studies	202	296	881	1,022	141
Emergency room studies	1	6	4	6	2
Total studies	574	683	2,429	2,429	0
NEURODIAGNOSTIC					
In-patient procedures	132	135	579	511	-68
Out-patient procedures	16	23	67	78	11
Emergency room procedures	0	0	0	0	0
Total procedures	148	158	646	589	-57

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

	Month of Oct		Four months to date		
	2022	2023	2022-23	2023-24	Variance
SLEEP CENTER					
In-patient procedures	1	0	1	0	-1
Out-patient procedures	133	273	576	909	333
Emergency room procedures	1	0	1	0	-1
Total procedures	135	273	578	909	331
RADIOLOGY					
In-patient procedures	1,335	1,233	5,329	4,979	-350
Out-patient procedures	310	387	1,432	1,622	190
Emergency room procedures	1,710	1,492	6,080	5,970	-110
Total patient procedures	3,355	3,112	12,841	12,571	-270
MAGNETIC RESONANCE IMAGING					
In-patient procedures	141	130	645	571	-74
Out-patient procedures	101	108	437	499	62
Emergency room procedures	5	5	28	30	2
Total procedures	247	243	1,110	1,100	-10
MAMMOGRAPHY CENTER					
In-patient procedures	4,332	4,470	16,999	16,704	-295
Out-patient procedures	4,305	4,381	16,864	16,517	-347
Emergency room procedures	0	2	2	6	4
Total procedures	8,637	8,853	33,865	33,227	-638
NUCLEAR MEDICINE					
In-patient procedures	19	17	85	73	-12
Out-patient procedures	75	102	372	419	47
Emergency room procedures	0	0	1	0	-1
Total procedures	94	119	458	492	34
PHARMACY					
In-patient prescriptions	95,057	82,059	367,398	322,819	-44,579
Out-patient prescriptions	14,182	15,743	59,939	63,803	3,864
Emergency room prescriptions	9,348	9,423	35,080	36,752	1,672
Total prescriptions	118,587	107,225	462,417	423,374	-39,043
RESPIRATORY THERAPY					
In-patient treatments	18,074	14,275	62,679	59,355	-3,324
Out-patient treatments	1,205	471	4,155	4,385	230
Emergency room treatments	460	831	1,473	2,067	594
Total patient treatments	19,739	15,577	68,307	65,807	-2,500
PHYSICAL THERAPY					
In-patient treatments	2,588	2,606	9,841	9,951	110
Out-patient treatments	148	248	717	1,015	298
Emergency room treatments	0	0	0	0	0
Total treatments	2,736	2,854	10,558	10,966	408

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

	Month of Oct		Four months to date		
	2022	2023	2022-23	2023-24	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,660	1,520	6,561	6,031	-530
Out-patient procedures	152	239	643	926	283
Emergency room procedures	0	0	0	0	0
Total procedures	1,812	1,759	7,204	6,957	-247
SPEECH THERAPY					
In-patient treatments	417	531	1,736	1,926	190
Out-patient treatments	18	55	99	143	44
Emergency room treatments	0	0	0	0	0
Total treatments	435	586	1,835	2,069	234
CARDIAC REHABILITATION					
In-patient treatments	1	1	1	3	2
Out-patient treatments	599	499	1,948	2,007	59
Emergency room treatments	0	0	0	0	0
Total treatments	600	500	1,949	2,010	61
CRITICAL DECISION UNIT					
Observation hours	444	260	1,454	1,151	-303
ENDOSCOPY					
In-patient procedures	88	65	385	274	-111
Out-patient procedures	91	73	223	224	1
Emergency room procedures	0	0	0	0	0
Total procedures	179	138	608	498	-110
C.T. SCAN					
In-patient procedures	734	667	2,824	2,742	-82
Out-patient procedures	395	271	1,637	1,558	-79
Emergency room procedures	701	774	2,801	3,032	231
Total procedures	1,830	1,712	7,262	7,332	70
DIETARY					
Routine patient diets	21,797	13,508	105,951	77,157	-28,794
Meals to personnel	25,877	28,135	101,279	112,526	11,247
Total diets and meals	47,674	41,643	207,230	189,683	-17,547
LAUNDRY AND LINEN					
Total pounds laundered	102,898	97,871	391,314	385,464	-5,850

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: November 3, 2023

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 your approval.

	Policy Title	Summary of Changes	Responsible VP
1.	Background Checks	Template corrected, references updated, some policy statements moved to General Info	Michelle Barnhart Childs, CHRO
2.	Business Plan	Simplified the process description to reflect what we actually do, and the level of customization we provide on a project basis	Augustine Lopez, CFO
3.	California Paid Sick Leave	Typo edits made, rebranding, policy simplified, formatting changes made	Michelle Barnhart Childs, CHRO
4.	CCS Paneled Pediatrician/Neonatologist	Template corrections, Policy statement simplified, updated definitions	Lisa Paulo, CNO
5.	Electronic Communications (Acceptable Use)	Formatting changes made, rebranding, removed attachments, updated references, two policies combines in to one.	Michelle Barnhart Childs, CHRO
6.	Emergency Management Program Plan	Formatting edits, corrected hyperlinks, rebranding,	Clement Miller, COO
7.	Falls, Management of the Patient	Reworded the post fall neuro assessment, updated the references and changed from policy to procedure	Lisa Paulo, CNO
8.	Hazardous Materials & Waste Management Plan	Scope reformatted.	Clement Miller, COO
9.	Nursing Record - Surgery Intraoperative	Template changes, updated references, policy statement simplified.	Lisa Paulo, CNO

10.	Patient Safety Attendant Guidelines	PSVM - Patient Safety Video Monitoring – added to procedure	Lisa Paulo, CNO
11.	Policy and Procedure Management	Policy updated to reflect current processes with new policy management system	Clement Miller, COO
12.	Preceptor	Changed from policy to procedure. Added: Under certain circumstances, the Director and Education will discuss granting individuals who do not meet years of experience requirement but meet all other eligibility requirements preceptor differential.	Lisa Paulo, CNO
13.	Sale, Purchase, and Lease of District Real Property	Changed title Chief Administrative Officer Business Development to Chief Administrative Officer Salinas Valley Health Clinics	Augustine Lopez, CFO
14.	Scope of Service: Physician and Business Development	Rebranding and typo edits made	Gary Ray, CAO
15.	Staff Nurse III Application	Updated eligibility requirements to align with SNIII V11 packet: The nurse must have a minimum of one (1) year of specialty experience (or like specialty). Updated references.	Lisa Paulo, CNO
16.	Withdrawing Life-Sustaining Treatment and Withholding Cardiopulmonary Resuscitation	Clarified language under DNAR suspension. Template corrected.	Lisa Paulo, CNO

Status **Pending** PolicyStat ID **14310697**

Last Approved	N/A
Last Revised	09/2023
Next Review	3 years after approval
Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Area	Human Resources

Background Checks

I. POLICY STATEMENT:

A. Individuals being considered for employment, volunteer work, or student affiliation at Salinas Valley Health Medical Center ("SVHMC") will be subject to a background check. The information obtained will be from reliable, verifiable sources. Student affiliates may comply with the process through their sponsoring school.

B. Criminal record searches will be conducted for all employment, volunteer, and student candidates to include court records search of all counties that the candidate has lived or worked during the past seven years. In addition, as allowed by law, an assessment will be conducted to ensure the individual's name is not on any sanction or debarred persons lists that reflects violations, including violent sexual offender and predator registry searches.

C. Required education will be verified for candidates for employment. This requirement is not applicable to volunteers and students. Education level verified at a degree higher than the requirement may suffice as proof of completion of the lower level requirement.

D. Required license, certification, and/or degree will be verified with the primary source via a secure electronic communication or by telephone.

E. Department of Health and Human Services (HHS) and Office of Inspector General (OIG) checks will be performed for positions involved in the care of patients.

F. Credit checks will be required for individuals being considered for roles/positions that receive, handle, or involve paying out money (including non-cash funds). Volunteers who participate in Lifeline home checks will also be required to undergo credit checks. Employers in California can run credit checks on the following positions (among others not applicable here):

- A managerial position, which means an "executive" exempt as that term is defined in Wage Order 4 (8 Cal. Code Regs. 11040).
- A position for which the employer is required by law to consider credit history information.

- ~~A position that affords regular access, for any purpose other than the routine solicitation and processing of credit card applications in a retail establishment, to bank or credit card account information, Social Security numbers and dates of birth (all three are required).~~
- ~~A position where the individual is or will be a named signatory on the bank or credit card account of the employer and/or authorized to transfer money or authorized to enter into financial contracts on the employer's behalf.~~
- ~~A position that affords access to confidential or proprietary information, including a formula, pattern, compilation, program, device, method, technique, process or trade secret that (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who may obtain economic value from the disclosure or use of the information, and (ii) is the subject of an effort that is reasonable under the circumstances to maintain secrecy of the information.~~
- ~~A position that involves regular access during the workday to the employer's, a customer's or a client's cash totaling at least $10,000.~~

~~G. Department of Motor Vehicle (DMV) checks will be required for those roles/positions requiring use of a vehicle while on duty.~~

~~H. Background checks also include, but are not limited to social security number verification, employment verification to include reason for separation and eligibility for re-employment for each employer, GSA list of parties excluded from federal programs, U.S. Treasury, Office of Foreign Assets Control (OFAC) list of specially designated nationals (SDN), and applicable state exclusion list.~~

A. SVHMC conducts background checks in accordance with applicable law, including the federal Fair Credit Reporting Act (FCRA) and applicable state fair credit reporting laws.

B. Individuals being considered for employment, volunteer work, or student affiliation at Salinas Valley Health Medical Center ("SVHMC") will be subject to a background check. The information obtained will be from reliable, verifiable sources. Student affiliates may comply with the process through their sponsoring school.

C. Criminal record searches will be conducted for all employment, volunteer, and student candidates to include court records search of all counties that the candidate has lived or worked during the past seven years. In addition, as allowed by law, an assessment will be conducted to ensure the individual's name is not on any sanction or debarred persons lists that reflects violations, including violent sexual offender and predator registry searches.

II. PURPOSE:

A. Salinas Valley Health Medical Center (SVHMC) conducts background checks in an effort to help ensure a safe workplace for employees, patients and others and to help ensure individuals possess the qualifications and are otherwise suitable to perform the duties of the position/role for which they are being considered.

B. ~~Nothing in this Policy is intended to impose any obligations on the Hospital that are greater than those required by applicable law.~~

III. DEFINITIONS:

A. Candidate refers to any individual applying for employment, volunteer work, or student affiliation with SVHMC.

IV. GENERAL INFORMATION:

~~A. SVHMC is an equal opportunity employer and will comply with applicable federal and state anti-discrimination laws.~~

~~B. SVHMC also conducts background checks in accordance with applicable law, including the federal Fair Credit Reporting Act (FCRA) and applicable state fair credit reporting laws.~~

A. SVHMC is an equal opportunity employer and will comply with applicable federal and state anti-discrimination laws.

B. Required license, certification, and/or degree will be verified with the primary source via a secure electronic communication or by telephone.

C. Department of Health and Human Services (HHS) and Office of Inspector General (OIG) checks will be performed for positions involved in the care of patients.

D. Credit checks will be required for individuals being considered for roles/positions that receive, handle, or involve paying out money (including non-cash funds). Volunteers who participate in Lifeline home checks will also be required to undergo credit checks. Employers in California can run credit checks on the following positions (among others not applicable here):

1. A managerial position, which means an "executive" exempt as that term is defined in Wage Order 4 (8 Cal. Code Regs. 11040).
2. A position for which the employer is required by law to consider credit history information.
3. A position that affords regular access, for any purpose other than the routine solicitation and processing of credit card applications in a retail establishment, to bank or credit card account information, Social Security numbers and dates of birth (all three are required).
4. A position where the individual is or will be a named signatory on the bank or credit card account of the employer and/or authorized to transfer money or authorized to enter into financial contracts on the employer's behalf.
5. A position that affords access to confidential or proprietary information, including a formula, pattern, compilation, program, device, method, technique, process or trade secret that (i) derives independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who may obtain economic value from the disclosure or use of the information, and (ii) is the subject of an effort that is reasonable under the circumstances to maintain secrecy of the information.
6. A position that involves regular access during the workday to the employer's, a customer's or a client's cash totaling at least $10,000.

E. Department of Motor Vehicle (DMV) checks will be required for those roles/positions requiring

use of a vehicle while on duty.

F. Background checks also include, but are not limited to social security number verification, employment verification to include reason for separation and eligibility for re-employment for each employer, GSA list of parties excluded from federal programs, U.S. Treasury, Office of Foreign Assets Control (OFAC) list of specially designated nationals (SDN), and applicable state exclusion list.

G. Nothing in this Policy is intended to impose any obligations on the Hospital that are greater than those required by applicable law.

V. PROCEDURE:

A. Candidates for employment, volunteer work, or student affiliation must complete the appropriate application and sign the consent statement in order for the background check to be conducted and the information verified via a primary source.

B. SVHMC is not a consumer reporting agency. With regard to employment screens, the information obtained in the background check will be processed through a consumer reporting agency contracted for the purpose of obtaining job/role-related background information on final candidates for positions. SVHMC will review all information obtained and determine whether the candidate will be denied employment based upon applicable law and the criteria as set forth below. No candidate will be denied employment based solely on a criminal conviction. SVHMC will consider the nature of the offense, the date of the offense, the surrounding circumstances and the relevance of the offense to the position in question.

C. **CRITERIA FOR DENIAL OF EMPLOYMENT, VOLUNTEER WORK OR STUDENT AFFILIATION**

- Criteria for the denial of employment, volunteer work or student affiliation for **any** position includes, but is not limited to, the following:

1. Sanctions assessment that includes lists of excluded individuals (such as Medi-Cal Suspended and Ineligible database)
2. Failure to meet educational requirements and/or possess required licenses or certificates.
3. All felony convictions within the last 7 years involving crimes of violence (including but not limited to child abuse, elder abuse, murder, assault, sexual assault, or any other sex crime) or crimes of theft (including but not limited to theft, robbery and burglary). SVHMC will review any felony over 7 years old or any misdemeanor in view of its policy of ensuring a safe and secure workplace. To that end, SVHMC will consider: (1) the nature and gravity of the offense(s); (2) the time that has passed since the offense(s) and/or completion of the sentence(s); and (3) the nature of the job held or sought (including, but not limited to, access to confidential, proprietary and other personal information, and the nature and extent of management authority conferred on the position).
4. Convictions for driving on a suspended license or other convictions demonstrating disregard for authority, (i.e., evading police officers, resisting arrest, etc.) or unfitness for the position sought, where the disposition, release, or parole of the applicant has occurred within the last

seven years.

5. Confirmation at any time that any of the information placed in the job application by the applicant is false and if it becomes known that any information contained within the application is found to be intentionally inaccurate.

D. As allowed by law, candidates for certain positions will undergo a credit check in addition to the criminal background check. Criteria for denial for these positions are as follows:

- Bad check convictions.
- Poor credit history indicating mismanagement of funds.

E. In addition to the reasons listed in section V.C above, applicants for any position where the employee, volunteer or student affiliate provides direct patient care will be denied employment if they have been convicted for neglect or abuse of an elder or child (no time limits).

F. In addition to the reasons listed in section V.C above, applicants for any position for which a valid California driver's license is required by job description, will be denied employment for the following reasons:

- More than two moving violations and/or fault accident(s) within the last three years.
- Failure to possess a California Driver's License.
- Six or more traffic violations demerit points within the last three years.
- More than one conviction where the disposition, release, or parole of the applicant has occurred within the last seven years for reckless driving or driving under the influence of alcohol and/or drugs.
- Any outstanding traffic or parking tickets where gross neglect of payment is shown and results in court action.
- Existing Court imposed restrictions placed on applicant's driver's license.

G. **PRE-ADVERSE ACTION NOTIFICATION**

- Before taking "adverse action" against a candidate based, in whole or in part, on information contained in a background check (i.e., rejecting a candidate or rescinding a job offer), SVHMC will mail or arranged to mail the candidate a copy of the background report and a copy of the required disclosures (e.g., FCRA Summary of Rights).
- The purpose of the pre-adverse action notice is to allow the candidate a meaningful opportunity to alert SVHMC or the background check company that provided the report of any inaccurate or incomplete information in the background report before he or she potentially loses the job opportunity. As a result, the position may not be filled unless and until the second adverse action notice is mailed (see below).
- The appropriate managers and supervisors will be notified of SVHMC's decision to reject the candidate by stating that the candidate did not meet the requisite qualifications and, therefore, has not been offered a position.

H. **ADVERSE ACTION NOTIFICATION**

- No sooner than eight days after the date of the pre-adverse action notice, Human

Resources may, if it deems appropriate, make a final decision to disqualify the candidate based, in whole or in part, on information contained in the background report. If this occurs, SVHMC will mail the candidate a notice describing the adverse decision.

I. **DOCUMENT RETENTION AND DESTRUCTION**

- Documents related to background checks will be kept in a secure and confidential file, separate and apart from personnel files, and accessible only to those employees with a legitimate business need to know. As a general rule, all documents pertaining to a candidate's background check will not be shared with third parties, non-management employees or any other individual without the express approval of the SVHMC Sr. Administrative Director, Human Resources.
- These documents include all executed background check authorization forms, background reports, notes containing information derived from a background report, and all documents relating to any employment decision, based in whole or in part, upon a background check (i.e., pre-adverse action and final adverse action notices and information the candidate submitted regarding his or her criminal record(s)). Such documents shall be retained for a period of five years.

J. **DOCUMENTATION:**

- Investigative Consumer Report
- Employment Application Consent Form

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. California Civil Code §1786.22

B. ~~Student Affiliations Contracts/Background Check Addendum~~

C. The Joint Commission, Human Resources Chapter~~, Standard 1.02.05, EP4~~

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	09/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14564871**

Last Approved	N/A
Last Revised	10/2023
Next Review	3 years after approval
Owner	Rolf Norman: Director Financial Planning & Decision Support
Area	Administration

Business Plan

I. POLICY STATEMENT

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

II. PURPOSE

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

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

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

B. All approved projects become a component of the Strategic Financial Plan.

V. PROCEDURE

A. The project sponsor will gather the necessary strategic and financial information to provide to the Executive Leadership Group and follow the attached process in order to make a decision on the requested capital and operating investments. ~~See Sub-schedule C.~~

B. Project Categories - Projects and procedures will be broken down into the following categories:

1. Hospital owned health care services
    a. New
    b. Replacement
    c. Acquisition
    d. Divesture
2. Joint venture based health care services
    a. New
    b. Renewal
    c. Acquisition
    d. Divesture
3. Capital
    a. New Capital
    b. Replacement Capital

    Real Estate
    a. Investments
    b. Divesture
4. Non-health care based services
    a. New
    b. Renewal
    c. Acquisition
    d. Divesture

C. Assumptions Development
    1. A business plan will be developed to assess the financial impact of capital investments and ongoing operations for new services. The analysis must forecast both the Operating Statement and Cash Flow impact over the first 5 years of any program using the following guidelines:
        a. Capital Spending - Equipment: The project sponsor will work with ~~Purchasing~~Materials Management and potential vendors to gather all of the acquisition costs of potential capital. Any individual capital item in excess of $100,000 must have an assessment done by an external organization such as ECRI or MDBuyline. The estimated costs should include freight and sales tax.
        b. Facilities Costs: The project sponsor will work with facilities to determine the upfront and ongoing space costs needed for the new program. Estimates should include building modification or improvement costs.
        c. Volumes: The project sponsor should work with Business Development to gather data on volumes for the program. Sources should be documented for future reference. Any projects that impacts volumes and with capital investment in excess of $200,000 must have volume forecasts signed off by the Business Development Executive.

d. Billing codes: The project sponsor should gather and document the necessary billing codes, including MSDRG, HCPCs and ICD-9 codes to support reimbursement review signed off by CDM manager.

e. Payor Mix: The project sponsor should gather and document information to support estimation of the payor mix for the new program or service.

f. Labor: The project sponsor should gather information on the necessary direct and indirect staffing to support the new program. For new job codes, the sponsor will work with Human Resources for pay rate and benefit assumptions.

g. Supplies: The project sponsor will work with ~~Purchasing~~Materials Management and/or Pharmacy and potential suppliers to estimate the cost of the direct supplies that will be used in the new program.
Other operating costs: All other direct operating costs should be identified, including non-medical supplies, software and hardware maintenance, insurance, medical directors, consulting or any other specific program costs.

h. Reimbursement: The project sponsor will work with Finance to develop reimbursement assumptions. ~~Government payor assumption will be developed by the Revenue & Reimbursement Department and Commercial payor assumptions will be developed by the Payor Relations Department.~~

i. Inflation: Inflation factors must be developed for each of the categories above that are not contractually fixed at base levels. ~~Any inflation for reimbursement in excess of 2% must~~Inflation factors will be ~~approved by the CFO~~clearly outlined in the business case and will be part of the Executive approval process. ~~Any inflation for expenses less than 5% must be approved by the CFO.~~

j. Risk: The project sponsor must identify the most significant risk factors of the project, including current and near-term future competitors, technological obsolescence or other critical factors impacting the assumptions over time. Exit or mitigation strategies should be developed to factor into financial assumptions.

k. Clear definition of problem or opportunity with all solutions analyzed, culminating a recommendation or plan.
~~Full SWOT Analysis to support final recommendation or plan: Strengths, weaknesses, opportunities, and threats.~~

D. Financial Forecasts

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

E. Business Plan Outline

1. For all new hospital owned or joint venture based health care services, the project sponsor needs to generate a "Business Plan Outline" ~~(see attached sub-**schedule A**)~~ in a clear and understandable format.

F. Risk Evaluation

1. The Project Sponsor will work with Finance to identify the most significant risk factors in

the assumptions. The business plan will be built on the best estimate for all assumptions. In addition, the business plan must be assessed to determine variances in key assumptions, i.e. volumes above or below estimates by 20%.

G. Financial Evaluation

1. Upon completion of the project, any project with year one total expense in excess of $150,000 must be evaluated using the ~~"Financial and Strategic Portfolio and New Venture Evaluation Criteria"~~following criteria (~~see attached Sub-**schedule B**~~not all criteria may be applicable)~~, which includes the following criteria and weight:~~.

    a. Net Investment Requirement
    Payback Period
    ~~First Year~~Annual impact on Operating Margin
    Net Present Value
    Internal Rate of Return
    EBIDA
    Key Financial Variable Risk Sensitivity

H. Process

1. The Project Sponsor will request a new business plan from Finance ~~by request via the Vice President of Strategic Management & Planning~~. All of the required source data and references will be provided to finance and planning to include in the assumptions document.
2. ~~Finance will log the request and develop a list of all questions within 5 business days. A financial analyst will be assigned to the project by the Director of Finance. The project request, assigned analyst and source documents will be posted on the Office of the CFO Sharepoint site under the Business Plans section. Finance will provide the Project Sponsor with a timeline for delivery of the first draft of the business plan.~~Finance will review the request and develop a list of questions and information required for the analysis.
3. Once the business plans have been reviewed and approved between Finance~~, Strategic Planning,~~ and the Project Sponsor, the Project Sponsor will present the business case to the Executive Leadership Group (or designee) for approval. ~~(As outlined in the Sub-**Schedule C**: Project Management Process).~~
4. ~~Please see the attached Sub-schedule A: Business Plan Outline~~

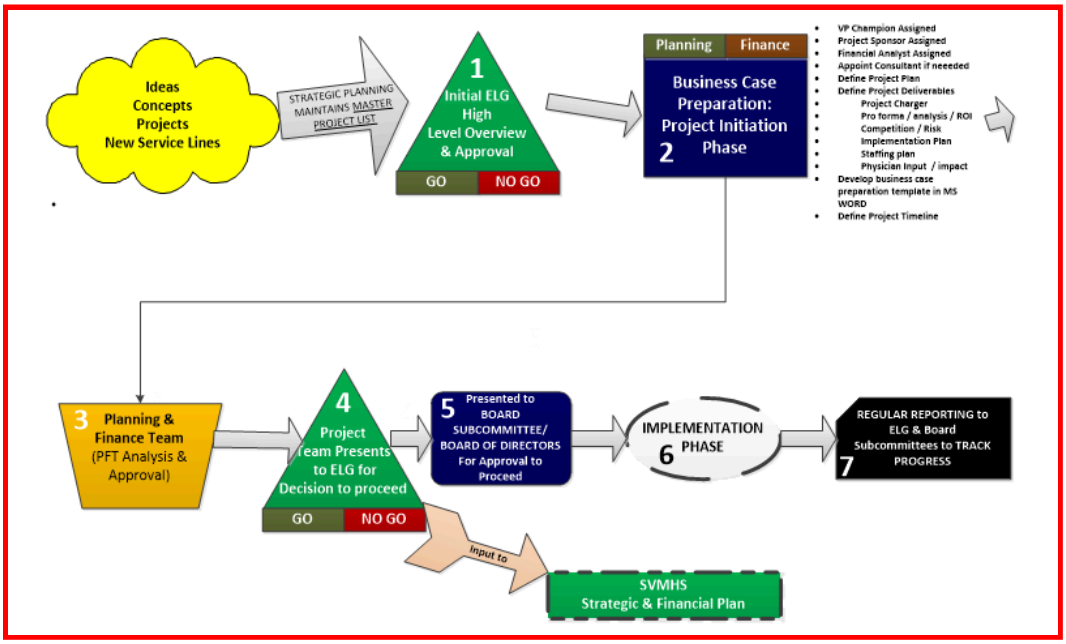
I. ~~Sub-Schedule B - Portfolio and New Venture Evaluation Criteria~~

~~1.~~

Strategic Scenario	Net Investment Requirement	Payback	First Year Operating Margin %	Net present value	Internal Rate of Return	EBIDA / Net Rev.	Key financial variable risk--sensitivity analysis+/- 5%	Finance Subtotal	Fit with Mission and Vision	Complexity/Risk to Implement	Impact on Market Position / Volumes /Image	Alignment of Physicians & Other Stakeholders	Impact on APEX and ACE Initiatives	Subjective Criteria Subtotal	Total
Weighting	*10%*	*5%*	*5%*	*10%*	*5%*	*5%*	*10%*	*50%*	*10%*	*10%*	*10%*	*10%*	*10%*	*50%*	*100%*
Measure	Dollars	Years	Percentage	Dollars	Percentage	Margin Ratio	Key Variable sensitivity		Subjective	Subjective	Subjective	Subjective	Subjective		
5	<$1 MM	<1	> 3.5%	>$1 M	> 16%	>4	Extremely low sensitivity	2.5	Strong	Easy/Low	Positive	Positive	Positive	2.5	5.0
4	$1-2.5 MM	1	2-3%	$800k-1M	12-16%	3-4	Low sensitivity	2.0						2.0	4.0
3	$2.5-5 MM	2	1-2%	$500-800K	10-12%	2-3	Moderate sensitivity	1.5	Medium	Average	Neutral	Neutral	Neutral	1.5	3.0
2	$5-10 MM	3	1%	$200-500K	7-10%	1-2	High sensitivity	1.0						1.0	2.0
1	>$10 MM	>3	<1%	<$200K	<6%	<1	Extremely high sensitivit	0.5	Weak	Hard/High	Negative	Negative	Negative	0.5	1.0

J. ~~Sub-Schedule C~~

1.



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
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Rolf Norman: Director Financial Planning & Decision Support	10/2023

Standards

No standards are associated with this document

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Last Approved	N/A	Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Last Revised	09/2023		
Next Review	3 years after approval	Area	Administration

California Paid Sick Leave

I. POLICY STATEMENT

A. Employees shall ~~be provided paid time off~~have access to Paid Time Off (PTO) from work under the California Paid Sick Leave as follows:

1. **Non-Affiliated ~~Benefitted~~Benefited Employees**: Full-time and part-time employees may use three days of their PTO bank each calendar year for PSL purposes. PTO eligible employees do not receive a separate bank of PSL, rather their PSL entitlement is through the PTO bank. The specific amount of PTO which may be used for PSL purposes each year depends on the employee's shift length as follows:
    a. Employees working 8 hour shifts may use up to 24 hours or 3 days, whichever is greater, of PTO for PSL purposes per calendar year.
    b. Employees working 10 hour shifts may use up to 30 hours or 3 .days, whichever is greater, of PTO for PSL purposes per calendar year.
    c. Employees working 12 hour shifts may use up to 36 hours or 3 days, whichever is greater, of PTO for PSL purposes per calendar year.
2. **Non-Benefitted Employees**: Any employee who is non-benefitted, whether affiliated or not, will accrue one hour of PSL for every 30 hours worked (coded as PSL PD). Non-Benefitted employees may use up to the greater of 3 days or 24 hours of PSL per calendar year. PSL accrual is capped at the greater of 6 days or 48 hours. A non-benefitted employee's unused PSL under this policy is not paid out at the time of separation from employment. However, employees who are re-employed with Salinas Valley Health ~~Medical Center (SVHMC)~~ within one year of separation will have their accrued unused allotment of PSL made available to them upon rehire.

B. ~~Newly hired employees may begin to use PSL on their 90th day of employment.~~

C. ~~PSL may be used in a minimum increment of 2 hours.~~

D. ~~SVHMC will not deny an employee the right to use accrued PSL under this policy, or discharge,~~

~~threaten to discharge, demote, suspend or in any manner discriminate against an employee for using accrued PSL days or exercising or attempting to exercise the rights provided by the Healthy Workplaces, Healthy Families Act of 2014. An employee using PSL will not be required to find a replacement worker as a condition of taking PSL.~~

E. ~~The requested amount of PSL must be in the employee's bank for the absence not to be counted as an occurrence under the Attendance Guidelines.~~

F. Leave under this policy may be used:

1. in connection with the diagnosis, care or treatment of an existing health condition, or the preventive care of, an employee or an employee's eligible family member.
2. for employees who are the victims of domestic violence, sexual assault or stalking.

II. PURPOSE

A. The purpose of this policy is to ensure that all ~~SVHMC~~Salinas Valley Health Employees understand their rights as provided by the California Paid Sick Leave Law ("PSL") (effective July 1, 2015) also known as the Healthy Workplaces, Healthy Families Act of 2014.

III. DEFINITIONS

A. "Employee" for purposes of this policy includes full time, part time, per diem, and temporary full time and part time employees.

B. "Family member" for purposes of this policy includes:

1. "Spouse" is defined as a current husband or wife.
2. "Child" (regardless of age), is defined as a biological child, adopted child, foster child, stepchild, grandchild, a legal ward, a child of a registered domestic partner, or a child or a person standing in loco parentis.
3. "Parent" is defined as biological parents as well as step-parents and parents-in-law.
4. "Grandparent" is defined as the parent of one's father or mother.
5. "Sibling" is defined as each of two or more children having one or both parents in common; a brother or sister.
6. "Registered domestic partner" as established in California and validated with the Declaration of Domestic Partnership with the Secretary of State.

IV. GENERAL INFORMATION

A. Newly hired employees may begin to use PSL on their 90th day of employment.

B. PSL may be used in a minimum increment of two hours.

C. Salinas Valley Health will not deny an employee the right to use accrued PSL under this policy, or discharge, threaten to discharge, demote, suspend or in any manner discriminate against an employee for using accrued PSL days or exercising or attempting to exercise the rights provided by the Healthy Workplaces, Healthy Families Act of 2014. An employee using PSL will not be required to find a replacement worker as a condition of taking PSL.

D. The requested amount of PSL must be in the employee's bank for the absence not to be counted as an occurrence under the Attendance Guidelines.

E. COVERAGE

1. Affiliated ~~Benefitted~~Benefited Employees: ~~Benefitted~~Benefited affiliated employees are exempt from PSL and will receive paid sick leave in accordance with the provisions of the applicable Collective Bargaining Agreement.
2. Non-Affiliated ~~Benefitted~~Benefited Employees: Non-affiliated ~~benefitted~~benefited employees are provided with CA PSL through the Paid Time Off (PTO) policy. Three (3) days of PTO annually will be designated as PSL as set forth below.
3. Non-Benefitted (Per Diem) Employees: Non-benefitted employees, whether affiliated or not, will receive PSL as set forth ~~below~~above.

V. PROCEDURE

A. Employees requesting time off under this policy should provide as much advance notice to their department director or designee as practicable. PSL eligible employees must identify their absence as covered by PSL at the time the call is made related to this policy.

B. Prior to the pay period end date, employee shall enter the appropriate pay code into the timekeeping system for the related days of absence.

1. Full-time and Part-Time Non-Affiliated Employees: PSL
2. All Per Diem and Temporary Employees: PSL PD

C. Employees who take more than three days off from work after using the maximum amount of time allowed under this Leave will be required to provide appropriate documentation to his/her Department Director/Designee in support of the additional time taken.

D. Employees will be able to view their paid sick leave used under this policy on their pay check earnings statement available in LaborWorkx and the Employee Self Service (ESS) portal.

E. PSL under this policy may run concurrently with leave taken under other applicable policies as well as under local, state, or federal law, including leave taken pursuant to the California Family Rights Act (CFRA) or the Family and Medical Leave Act (FMLA).

F. Documentation:

1. Attendance at staff meetings and orientation will be documented

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Human Resources/Attendance Guidelines

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	10/2023

Standards

No standards are associated with this document

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Last Revised	11/2023	Area	Administration
Next Review	3 years after approval		

CCS Paneled Pediatrician/Neonatologist

I. POLICY STATEMENT:

~~A. All written policies and procedures shall be developed in collaboration with a CCS approved tertiary hospital. All policies shall be approved by the governing body, as per CCR, title 22, section 70537.~~

~~B. Types of patient conditions requiring 24-hour coverage by a CCS- paneled pediatrician include but are not limited to:~~

- ~~Conditions involving the heart (congenital heart disease)~~
- ~~Neoplasms (cancer, tumors)~~
- ~~Disorders of the blood (hemophilia, sickle cell anemia)~~
- ~~Endocrine, nutritional, and metabolic diseases~~
- ~~See Attached List A~~

~~C. There also may be certain criterion that determines if a child's medical condition is eligible. For more information on medical eligibility contact the CCS office (Monterey 831-755-5500, Santa Cruz 831-763-8900).~~

A. Patient conditions requiring 24-hour coverage by a CCS- paneled pediatrician are included in attachment A.

II. PURPOSE:

A. To guide healthcare providers in meeting established provider standards for CCS-approved tertiary hospital.

III. DEFINITIONS:

~~A. N/A~~

A. CCS - California Children's Services

IV. GENERAL INFORMATION:

~~A. N/A~~

A. All written policies and procedures shall be developed in collaboration with a CCS approved tertiary hospital. All policies shall be approved by the governing body, as per CCR, title 22, section 70537.

B. There also may be certain criterion that determines if a child's medical condition is eligible. For more information on medical eligibility contact the CCS office (Monterey 831-755-5500, Santa Cruz 831-763-8900).

V. PROCEDURE:

A. Upon admission to the pediatric unit, the Charge RN will determine if the pediatric age patient requires 24-hour coverage by a CCS-paneled pediatrician or neonatologist by reviewing the list found in Attachment A.

B. If the pediatric age patient does require 24-hour coverage by a CCS-paneled pediatrician or neonatologist, the Charge RN will contact the admitting physician and request a consultation.

C. Documentation:

1. Physician's order will be written if consultation to a CCS-paneled pediatrician/ neonatologist is required.

VI. EDUCATION/TRAINING:

~~A. Education is provided during general or department specific orientation and periodically as practice or policy changes.~~

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

VII. REFERENCES:

~~A. CCR, Title 22, section 70537.~~

A. CCS regulations

Attachments

A: Types of Patients who Require 24-Hour Coverage by a CCS-Paneled Pediatrician

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Owner	Julie Vasher: Director of Women's & Children's Services	09/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13470887**

Last Approved	N/A	Owner	Michelle Barnhart Childs: Chief Human Resources Officer
Last Revised	09/2023		
Next Review	3 years after approval	Area	Administration

Electronic Communications (Acceptable Use)

I. POLICY STATEMENT

A. Employees should not have any expectation of privacy with respect to e-mail, voicemail, internet browsing and contribution, fax or other electronic communication using services, equipment, and/or media owned, operated, controlled upgraded or utilized by Salinas Valley Health Medical Center (SVHMC).

II. PURPOSE

~~This policy sets forth guidelines regarding acceptable use of electronic communication and audio/video devices, whether owned, operated, controlled or upgraded by Salinas Valley Health Medical Center (SVHMC) or personally owned. This policy includes computer technology and communication systems including but not limited to hardware, software, e-mail, fax, internet, mobile phone, text messaging, voice mail systems and digital cameras.~~

~~III. POLICY~~

~~Employees should not have any expectation of privacy with respect to e-mail, voicemail, Internet browsing and contribution, fax or other electronic communication using services, equipment, and/or media owned, operated, controlled upgraded or utilized by Salinas Valley Memorial Hospital. Although the hospital does not intend to routinely monitor such communications, it reserves the right to randomly audit as well as review or inspect, for legal compliance and legitimate business reasons, the content of any electronic communication with or without notice.~~

~~Personal Telecommunication Device Usage:~~

1. ~~The use of cellular phones or other electronic devices for personal phone calls, texting or accessing of the internet for any non-work related function, is limited to those times when an employee, volunteer or vendor is on break from their work assignment.~~

2. Personal electronic devices, including cell phones, should be set to quiet modes, such as vibrate and silence during your work hours. Such devices should not disrupt work.
3. Personal cell phones or other personal communication devices may be used in staff lounges and break rooms or the cafeteria patio. Personal cell phones are not to be used by employees for personal business while on duty.
4. Staff is reminded to use these devices with discretion to minimize disruption with the care or treatment to patients. Staff is reminded of the hospital's commitment to noise reduction in the patient care environments and HIPAA Security and Privacy rules.
5. Any use of a camera or audio/video recording device by employees, vendors, consultants, contractors and observers in and around all clinical settings is prohibited unless specifically authorized in advance for the purpose of carrying out a specific job function. This authorization must be in writing from Administration and the patient is required to sign /consent to this activity. CONSENT TO PHOTOGRAPHY #904.
    a. Any images captured on cameras shall be removed from the camera once transferred and used for intended purposes.
    b. No patient identifiable images shall be stored on local computers or other storage devices not part of the electronic medical record.
6. Hospital approved applications include, but are not limited to, EMR mobile rounding tools, staff and patient rounding application(s) and the Hospital enabled secure messaging solution which allows for text, images and recordings.
    a. SVMH prohibits the use of unsecured text messaging—that is, short message service (SMS) text messaging from a personal mobile device—for communicating protected health information.
    b. Computerized provider order entry (CPOE) is the preferred method for submitting orders as it allows providers to directly enter orders into the electronic health record (EHR).
    c. The use of secure text orders is not permitted at this time.
7. Employees driving hospital owned/operated vehicles are prohibited from utilizing a cell phone, Smartphone or audio/video playback device to the extent prohibited by law.

E-Mail Communications:

1. Passwords are intended to keep unauthorized individuals from accessing content inappropriately and may not be shared.
2. Employees are expected to use common sense and good judgment when sending messages to each other.
3. All Email communications on the SVMH domain and network are logged and archived, and should be considered discoverable and auditable at any time.
4. Refer to ACCEPTABLE USE OF COMPUTER INFORMATION SYSTEMS (IM# 953) and ELECTRONIC MAIL AND VOICE MAIL (IM #966) for more information.

Portable Audio Listening Devices:

1. Audio headsets may be worn by employees with specific job criteria which utilizes transcription/dictation or communication devices, such as Dictaphone during the performance of these specific duties.
2. The use of Portable Audio/Video Devices (with headsets) by staff during working hours is considered a detriment to an employee's performance and a safety hazard and is thereby prohibited because:
    a. It impedes the ability of the employee to communicate effectively with patients, coworker's physicians, visitors and volunteers in the workplace.
    b. It impedes the ability of the employee to hear and respond appropriately to overhead announcements of emergency conditions (Code Red, Code Blue, etc.) which could adversely impact co-workers, patients, visitors and volunteers.
    c. It impedes the ability of the employee to hear and respond appropriately to overhead pages which could directly impact the level of employee performance in their duties.
3. With Management's approval, use of portable audio/video devices, including cassette/CD/MP3 players, may be acceptable in non-patient care areas, in compliance with SVMH policies, including but not limited to Standard of Conduct, Use of English Language and Golden Rules for Customer Service.
4. This policy does not restrict the use of protective headsets/earphones when performing duties that require or encourage the use of protective equipment to reduce exposure to high noise levels. Staff members are urged to take a proactive role in safety and to utilize safety equipment.

Radio Frequency Emitting Devices (RFED)

1. Introduction of devices emitting radio frequencies such as citizen band radios, portable two-way radios, cordless phones, devices or games operated by radio remote control are not permitted within the Hospital's main campus or any off-site location owned and/or operated by SVMH unless pre-approved the Biomedical or Engineering Departments.
2. High-powered transmitting devices provided by the hospital for use by the Security, Engineering, Dietary, Transportation, Purchasing and Environmental Services Departments shall not be used around or near any medical instrumentation or digital alarm panels (i.e. ventilators, anesthesia machines, medical gas alarm panels.)
3. Any device of questionable safety must be tested and approved by the Biomedical or Engineering Department. A copy of the service report must be kept with the device as proof of approval to use.

Examples of Prohibited Behaviors

Prohibited behaviors/activities in the workplace may include but are not limited to the following:

1. Use of another's account and not one's own.
2. Intentionally transmitting and/or downloading any digital content that contain discriminatory,

derogatory, inflammatory, offensive or harassing remarks about a person's, or group's sex, race, religion, age, gender, gender identity, national origin, disability, sexual orientation, marital or veteran status.

3. Intentionally transmitting and/or downloading of sexually explicit materials, including messages, videos, images and cartoons.
4. Persistent and/or unsolicited communication with other individuals.
5. Solicitation on behalf of political, religious or other personal causes or personal business ventures. Distributing or storing chain letters.
6. Visiting or posting web sites that contain sexually explicit, racist or other material that management, in its sole judgment, considers offensive. Engaging in illegal, fraudulent or malicious activities.
7. Use of personal email accounts (i.e. Gmail, Yahoo, AOL, Hotmail, etc) for business related communications instead of using the SVMH provided email accounts (i.e. svmh.com)
8. Auto-forwarding of any SVMH provided email to an outside account.
9. Use of peer-to-peer ("P2P") software (examples include, but are not limited to BitTorrent, Gnutella, and eMule).
10. Use of personal instant-messaging or voice over internet protocol (VOIP) clients like Microsoft Messenger, Skype, Yahoo! Chat.
11. Receipt of, possession of, transmitting and/or downloading, installing, publishing, distributing or copying any copyrighted or trademarked materials, such as software, music or movies on SVMH equipment without the written consent of the copyright owner.
12. Listening or having an iPod or other audio/video device on your person during work hours except as specified above.
13. Taking a picture with a personal device at any time while at the hospital without prior authorization.
14. Playing games on a personal electronic device while on duty.
15. Recording any part of a conversation while on work time without prior authorization.

Social Networking

Due to the emerging nature of social networking (e.g., YouTube, Facebook, iTunes, LinkedIn, etc.); web feeds such as RSS, blogs and other forums, SVMH employees who violate the guidelines relating to revealing patient information or making inappropriate comments will be subject to disciplinary action, up to and including discharge under the DISCIPLINARY POLICY.

1. There can be no institutional sites or pages on You Tube, Facebook, Twitter, etc., that are presented as official pages of SVMH, including use of name and logo, unless these are developed and/or approved by the Marketing and/or Public Relations departments.

Social Computing Guidelines for SVMH Employees:

Online social media enable SVMH employees to engage in professional and personal conversations.

~~These guidelines apply to employees who identify themselves with SVMH in social media venues such as professional society blogs, Linked In, Facebook, etc. Activities which do not identify employees with SVMH, do not discuss SVMH and are purely about personal matters would normally fall outside these guidelines.~~

1. ~~Employees must follow the same Code of Ethical Conduct, Conflict of Interest Policy, HIPAA and general civil behavior guidelines cited previously in these policies.~~
2. ~~SVMH employees may list SVMH as their place of work on personal profiles such as those on LinkedIn. However, no employee should assert claims of speaking on behalf of SVMH.~~

~~Confidential Information~~

1. ~~Employees are expected to use electronic communications in a way that respects the confidential information of SVMH, its employees, and its patients. No ePHI (electronic protected health information) should be transmitted via public media such as the Internet unencrypted, it should be secured. Transmission must occur in a way that guarantees it will be seen only by a recipient who has a "need to know" the information. Please refer to the Breach of Confidentiality-Sanctions for Employees and Medical Staff Policy #HR-501 for additional information.~~
2. ~~When faxing confidential information, employees should use caution. Employees should confirm the correct fax number is used and ensure that the receiving fax machine is in a secure location and/or the intended receiver is available to receive the fax. If patient privacy was or is suspected of being compromised, please contact our HIPAA Privacy Officer, extension 1751 or (831) 755-0751.~~
3. ~~If an employee is an unintended recipient of an e-mail or fax containing confidential information, the employee should contact the originator of the message immediately.~~

~~Telephone Usage~~

1. ~~Unauthorized use of hospital telephones and inappropriate or excessive usage of personal telecommunication devices during work hours may result in disciplinary action.~~
2. ~~Employees may be required to reimburse the cost of unauthorized telephone calls.~~

A. To set forth guidelines regarding acceptable use of electronic communication and audio/video devices, whether owned, operated, controlled or upgraded by SVHMC or personally owned. This policy includes computer technology and communication systems including but not limited to hardware, software, e-mail, fax, internet, recording devices, mobile phone, text messaging, voice mail systems and cameras.

IV. ~~DEFINITIONS~~DEFINITIONS

1. ~~Camera or Audio/Video Recording Device: any device that can capture and/or record visual images or audible conversations, such as but not limited to cameras, cell phone cameras, computers, camcorders, video recorders and audio recorders.~~
2. ~~Portable Audio/Video Playback Listening Devices: refer to but are not limited to MP3 players, iPods, Cassette players, CD players, iPhone, Smartphone, tablets, and gaming consoles. These~~

~~do not include translation phones/devices.~~

~~3. Headset: includes earpieces.~~

~~4. Radio Frequency Emitting Devices (RFED): includes but not limited to cell phones, personal digital assistants (PDA), two-way radios, remote controlled devices/games, wireless handheld phones provided by the hospital for business use.~~

~~5. Personal Telecommunication Devices: cell phones, Smartphone, personal PDAs, or two-way radios not provided or owned by SVMH.~~

~~6. Wireless devices include, but are not limited to hand-held pocket computer, Portable computers, Telemetry Transmitters, Portable Wireless Patient Monitors, smart phones, tablets, notebooks.~~

A. Camera or Audio/Video Recording Device: any device that can capture and/or record visual images or audible conversations, such as but not limited to cameras, cell phone cameras, computers, camcorders, video recorders and audio recorders.

B. Electronic Devices: refer to but are not limited to mobile phones, tablets, sound / video recorders and gaming consoles. These do not include translation phones/devices.

C. Personal Telecommunication / wireless Devices: mobile phones, tablets, or two-way radios not provided or owned by SVHMC.

V. GENERAL INFORMATION

A. Although the hospital does not intend to routinely monitor such communications, it reserves the right to randomly audit as well as review or inspect, for legal compliance and legitimate business reasons, the content of any electronic communication with or without notice.

VI. PROCEDURE

~~N/A~~

A. Personal Telecommunication Device Usage

1. The use of wireless or electronic devices for personal phone calls, texting or accessing of the internet for any non-work related function, is limited to those times when an employee, volunteer or vendor is on break from their work assignment and not while on duty. At such times, devices may be used in staff lounges, break rooms or the cafeteria patio.
2. Personal electronic devices, including cell phones, should be set to quiet modes, such as vibrate and silence during your work hours. Such devices should not disrupt work.
3. Staff is reminded to use these devices with discretion to minimize disruption with the care or treatment to patients. Staff is reminded of the hospital's commitment to noise reduction in the patient care environments and HIPAA Security and Privacy rules. HIPAA SANCTIONS
4. Any use of a camera or audio/video recording device by employees, vendors, consultants, contractors and observers in and around all clinical settings is

prohibited unless specifically authorized in advance for the purpose of carrying out a specific job function. This authorization must be in writing from Administration and the patient is required to sign /consent to this activity. CONSENT TO PHOTOGRAPHY.

a. Any images captured on cameras shall be removed from the camera once transferred and used for intended purposes.

b. No patient identifiable images shall be stored on local computers, the cloud or other storage devices not part of the electronic medical record.

5. Hospital approved applications include, but are not limited to, EMR, TigerConnect, mobile rounding tools, staff and patient rounding application(s) and any other Hospital enabled secure messaging solution which allows for text, images and recordings.

a. SVHMC prohibits the use of unsecured messaging from a personal mobile device for communicating protected health information. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

b. Computerized provider order entry (CPOE) is the preferred method for submitting orders as it allows providers to directly enter orders into the electronic health record (EHR).

c. The use of secure text orders is not permitted at this time.

6. Employees driving hospital owned/operated vehicles are prohibited from utilizing a cell phone or audio/video playback device to the extent prohibited by law.

B. Electronic Communications

1. Passwords are intended to keep unauthorized individuals from accessing content inappropriately and may not be shared.

2. Employees are expected to use STAR Values, common sense and good judgment when sending messages to each other.

3. All Email communications on the SVHMC domain and network are logged and archived, and should be considered discoverable and auditable at any time.

4. Refer to ACCEPTABLE USE OF COMPUTER INFORMATION SYSTEMS and ELECTRONIC MAIL AND VOICEMAIL for more information.

C. Electronic Devices

1. Headsets and earbuds may be worn by employees with specific job criteria which utilize communication devices, during the performance of these specific duties.

2. The use of electronic devices (including headsets and earbuds) by staff during working hours is considered a detriment to an employee's performance and a safety hazard and is thereby prohibited because:

a. It impedes the ability of the employee to communicate effectively with patients, coworkers, physicians, visitors and volunteers in the workplace.

b. It impedes the ability of the employee to hear and respond appropriately to overhead announcements of emergency conditions (Code Red, Code Blue,

etc.) which could adversely impact job performance and communications with patients, coworkers, physicians, visitors and volunteers in the workplace.

3. With Management's approval, use of electronic devices, may be acceptable in non-patient care areas, in compliance with SVHMC policies, including but not limited to Standards of Professional Behavior, Use of English Language and Golden Rules for Customer Service.
4. This policy does not restrict the use of protective headsets/earbuds when performing duties that require or encourage the use of protective equipment to reduce exposure to high noise levels. Staff members are urged to take a proactive role in safety and to utilize safety equipment.

D. **Radio Frequency Emitting Devices (RFED)**

1. Introduction of devices emitting radio frequencies such as citizen band radios, portable two-way radios, phones, devices or games operated by radio remote control are not permitted within the Hospital's main campus or any off-site location owned and/or operated by SVHMC unless pre-approved the Biomedical or Engineering Departments.
2. High-powered transmitting devices provided by the hospital for use by the Security, Engineering, Dietary, Transportation, Purchasing and Environmental Services Departments shall not be used around or near any medical instrumentation or digital alarm panels (i.e. ventilators, anesthesia machines, medical gas alarm panels.)
3. Any device of questionable safety must be tested and approved by the Biomedical or Engineering Department. A copy of the service report must be kept with the device as proof of approval to use.

E. **Examples of Prohibited Behaviors**

1. Prohibited behaviors/activities in the workplace may include but are not limited to the following:
    a. Use of another's account and not one's own.
    b. Intentionally transmitting and/or downloading any digital content that contain discriminatory, derogatory, inflammatory, offensive or harassing remarks about a person's, or group's sex, race, religion, age, gender, gender identity, national origin, disability, sexual orientation, marital or veteran status.
    c. Intentionally transmitting and/or downloading of sexually explicit materials, including messages, videos, images and cartoons.
    d. Persistent and/or unsolicited communication with other individuals.
    e. Solicitation on behalf of political, religious or other personal causes or personal business ventures.
    f. Visiting or posting web sites that contain sexually explicit, racist or other material that management, in its sole judgment, considers offensive. Engaging in illegal, fraudulent or malicious activities.

g. Use of personal email accounts (i.e. Gmail, Yahoo, iCloud, etc) for business related communications instead of using the SVHMC provided email accounts (i.e. salinasvalleyhealth.com)

h. Auto-forwarding of any SVHMC provided email to an outside account.

i. Use of peer-to-peer ("P2P") software (examples include, but are not limited to BitTorrent, Gnutella, and eMule).

j. Use of personal messaging or voice over internet protocol (VOIP) clients (examples include, but are not limited to WhatsApp, Google Chat, Skype and Slack).

k. Receipt of, possession of, transmitting and/or downloading, installing, publishing, distributing or copying any copyrighted or trademarked materials, such as software, music or movies on SVHMC equipment without the written consent of the copyright owner.

l. Listening to an audio/video device during work hours except as specified above.

m. Taking a picture with a personal device at any time while at the hospital without prior authorization.

n. Playing games on a personal electronic device while on duty.

o. Recording any part of a conversation on SVHMC premises without prior authorization.

F. Social Media

1. You are prohibited from posting any content that is personal health information including patient images on any Social Media sites (e.g., YouTube, Snapchat, Instagram, Facebook, LinkedIn, etc.) Employees who violate the guidelines relating to revealing patient information or making inappropriate comments will be subject to disciplinary action, up to and including discharge under the DISCIPLINARY Policy.

a. There can be no institutional sites or pages on You Tube, Facebook, Twitter, etc., that are presented as official pages of SVHMC, including use of name and logo, unless these are developed and/or approved by the Marketing and/or Public Relations departments.

G. **Social Media Guidelines for Salinas Valley Health Employees**

1. Online social media enable SVHMC employees to engage in professional and personal conversations. These guidelines apply to employees who identify themselves with SVHMC in social media venues such as professional society blogs, LinkedIn, Facebook, Snapchat, Instagram etc. Activities which do not identify employees with SVHMC, do not discuss SVHMC and are purely about personal matters would normally fall outside these guidelines.

a. Employees must follow the same Standards of Professional Behavior, Conflict of Interest Policy, HIPAA and general civil behavior guidelines cited previously in these policies.

b. SVHMC employees may list SVHMC as their place of work on personal

profiles such as those on LinkedIn. However, no employee should assert claims of speaking on behalf of SVHMC.

H. Confidential Information

1. Employees are expected to use electronic communications in a way that respects the confidential information of SVHMC its employees, and its patients. No ePHI (electronic protected health information) should be transmitted via public media such as the Internet unencrypted, it should be secured. Transmission must occur in a way that guarantees it will be seen only by a recipient who has a "need to know" the information. Please refer to the Breach of Confidentiality-Sanctions for Employees and Medical Staff Policy for additional information. DATA CONFIDENTIALITY
2. When faxing confidential information, employees should use caution. Employees should confirm the correct fax number is used and ensure that the receiving fax machine is in a secure location and/or the intended receiver is available to receive the fax. If patient privacy was or is suspected of being compromised, please contact our HIPAA Privacy Officer, extension 1751 or (831) 755-0751.
3. If an employee is an unintended recipient of an e-mail or fax containing confidential information, the employee should contact the originator of the message immediately.

I. Telephone Usage

1. Unauthorized use of hospital telephones and inappropriate or excessive usage of personal mobile devices and social media during work hours may result in disciplinary action.
2. Employees may be required to reimburse the cost of unauthorized telephone calls.

VII. EDUCATION/TRAINING

~~A. Employees will be advised of this policy through general orientation, annual e-learning and on a periodic basis, as necessary.~~

~~VIII. DOCUMENTATION~~

~~N/A~~

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

IX. REFERENCES

~~A. RI # 904 CONSENT TO PHOTOGRAPHY~~

~~B. IM #953 ACCEPTABLE USE OF INFORMATION SYSTEMS~~

~~C. IM #966 ELECTRONIC MAIL AND VOICEMAIL~~

~~D. HR # 834 DISCIPLINARY POLICY~~

~~E. IM # 981 HIPAA SANCTIONS~~

F. ~~IM # 959 CONFIDENTIAL COMMUNICATIONS~~

G. ~~IM # 964 DATA CONFIDENTIALITY~~

H. ~~IM #1130 USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)~~

I. ~~HR #887 USE OF THE ENGLISH LANGUAGE~~

~~SVMH Golden Rule~~

~~#6396 STANDARDS OF ETHICAL BUSINESS PRACTICES~~

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14032670**

Last Approved	N/A	Owner	Earl Strotman: Director Facilities Management & Construction
Last Revised	09/2023		
Next Review	1 year after approval	Area	Plans and Program

Emergency Management Program Plan

I. SCOPE

~~The Emergency Management Program Plan ("plan") is applicable to the Salinas Valley Health entities and its licensed off-site facilities. Consideration is given for specific variations supported by site-specific policy consistent with the plan. Whenever there is a department, service, or site-specific variation, it will be supported by a department, service, or site-specific policy that is consistent with the plan. The plan identifies the leadership accountability, hazard identification, emergency operations plan, continuity of operations plan, disaster recovery plan, education and training program, testing the plans, and evaluating the plan.~~

~~II. OBJECTIVES/GOALS~~

~~The objective of the plan is to sufficiently educate employees, medical staff and other individuals providing services at the Salinas Valley Health and its licensed off-sites facilities, to provide safe, effective and timely response in the event of an internal, external, natural, technological, or man-made disaster (i.e. earthquake, loss of utilities, civil disturbance, act of terrorism, etc.) that could cause harm and/or disrupt the environment of care. The plan provides distinct policy direction, describes the roles and responsibilities of staff, and contains information and references to corresponding departmental mitigation, preparedness, response, and recovery procedures. Additionally, the plan incorporates the local, state, federal and professional codes, standards, and regulations as applicable.~~

A. The Emergency Management Program Plan ("plan") is applicable to the Salinas Valley Health Medical Center (SVHMC) entities and its licensed off-site facilities. Consideration is given for specific variations supported by site-specific policy consistent with the plan. Whenever there is a department, service, or site-specific variation, it will be supported by a department, service, or site-specific policy that is consistent with the plan. The plan identifies the leadership accountability, hazard identification, emergency operations plan, continuity of operations plan, disaster recovery plan, education and training program, testing the plans, and evaluating the plan.

I. OBJECTIVES/GOALS

A. **Objectives**

1. The objective of the plan is to sufficiently educate employees, medical staff and other individuals providing services at the SVHMC and its licensed off-sites facilities, to provide safe, effective and timely response in the event of an internal, external, natural, technological, or man-made disaster (i.e. earthquake, loss of utilities, civil disturbance, act of terrorism, etc.) that could cause harm and/or disrupt the environment of care. The plan provides distinct policy direction, describes the roles and responsibilities of staff, and contains information and references to corresponding departmental mitigation, preparedness, response, and recovery procedures. Additionally, the plan incorporates the local, state, federal and professional codes, standards, and regulations as applicable.

B. **Goals**

1. The goals for the plan are developed from program activities, such as the hazard vulnerability assessment, after-action reports and improvement plans, annual evaluation of the previous year's program activities, performance monitoring and/or planning activities with community partners. The goals for this Plan are documented in the Emergency Management Committee minutes.

III. DEFINITIONS

A. After Action Report (AAR): a detailed critical summary and analysis of an emergency or disaster incident, including both planned and unplanned events. The report summarizes what took place during the event, analyzes the actions taken by participants, and provides areas needing improvement.

B. CAHAN: California Health Alert Network

C. CDC: Centers for Disease Control

D. EMC: Emergency Management Committee

E. EMS: Emergency Medical Services

F. EOC: Environment of Care Committee

G. EOP: Emergency Operations Plan

H. FEMA: Federal Emergency Management Agency

I. HICS: Hospital Incident Command System

J. J: HVA: Hazard Vulnerability Assessment

K. ICC: Incident Command Center

L. IC: Incident Commander

M. MHOAC: Monterey Health Operational Area Coordinator

N. OES: Office of Emergency Services

IV. PLAN MANAGEMENT

A. Salinas Valley Health LEADERSHIP TEAM

The Salinas Valley Health leadership team provides the program vision, administration, support, and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Emergency Management. The Environment of Care Committee (EOC) receives reports from the Emergency Management Committee (EMC) and examines the actions taken relative to the Emergency Operations Plan (EOP). Recommendations are given to and received by the EMC. The Board of Directors has authorized the EMC to update this plan and its processes as needed without formal Board approval.

- ***Board*** – Supports the plan through approval of the plan, evaluation of the quarterly summary reports of activities and annual Environment of Care Committee report with response as necessary.
- ***Senior Leadership*** - Reviews the EOP as well as policies, training and education supporting the emergency management program. Participates on the EMC, responds to regulatory issues, often functions as Incident Commander when the plan is activated, reviews reports, activities, goals and evaluations of the program with response as necessary. Allocates resources for the emergency management program.
- ***Medical Staff*** - Supports the plan through participation in exercises and incidents. The Medical Executive Committee reviews and evaluates the Environment of Care Committee annual report with response as necessary.
- ***Department Managers*** - Support the plan through monitoring the compliance of the training and performance of staff with the plan, participates in exercises and incidents, event reporting and initiation of corrective actions.
- ***Employees*** - Support the plan by following policies and procedures, participate in exercises and incidents, report deficiencies and problems promptly and participate in training and competency for emergency management.
- ***Safety Officer and Environment of Care Committee*** – Support the plan by revieweing quarterly and annual reports, providing feedback as needed.
- ***Emergency Management Committee*** – Multidisciplinary committee responsible for planning, design, measurement, assessment and improvement processes for the emergency management plan.

B. HAZARD VULNERABILITY ANALYSIS (HVA)

1. All- Hazards Approach

Annually, Salinas Valley Health conducts a hazard vulnerability analysis (HVA) using an all-hazards approach to identify potential emergencies that could indirectly or directly affect demand for the hospital's services or its ability to provide those services. Considerations include hazards that are likely to impact the hospital's geographical region, community, facility and patient population. When available, community-based risk assessments (for example that may be developed by another organization or

agency) will also be incorporated.

Salinas Valley Health evaluates and prioritizes the findings of the HVA to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the hospital and its ability to provide services. Salinas Valley Health then uses the prioritized hazards to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and reduce disruption of essential services or functions. It is used to further develop the EOP.

See Attachment A: Hazard Vulnerability Analysis (Main Hospital Block)

See Attachment B: Hazard Vulerability Analysis (Taylor Farms Family Health & Wellness Center)

C. EMERGENCY OPERATIONS PLAN (EOP)

1. Authority to Activate the EOP

The Administrator on Duty, Nurse Administrative Supervisor, or designee may activate the EOP. In the event of a potential Mass Casualty Incident impacting the Emergency Department, the EOP may be activated by the Nurse Administrative Supervisor together with the Emergency Department's Charge Nurse and on-duty Physician (See #1102 EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS INCLUDING DECONTAMINATION)

a. When notified of a potential disaster, the person(s) having authority to activate the EOP will:

i. Evaluate the issues such as location of incident (internal, external), the distance from the campus, the scope of the incident (single individual, mass casualty, or malicious attack), and weather conditions (seasonal and current)

ii. Discuss the operations pertaining to the conversion of the organization to Hospital Incident Command System (HICS) activation.

iii. Plan care of casualty and non-casualty patients arriving in the Emergency Department during a disaster.

iv. Evaluate the information concerning this emergency and determine if initiation of the Emergency Operations Plan (EOP) is warranted. Two of the three are required to initiate the EOP, unless deemed otherwise necessary by the onsite Incident Commander.

b. Level 1 Activation:

When notified by Emergency Medical Services (EMS) and/or other sources of an incident with multiple casualties or a small incident with no casualties that occurred within the facility.

i. Situation that most likely can be managed with the staff already on duty.

ii. Staff should remain on duty and review their department specific procedures to be prepared to respond to the next level if situation requires an upgrade.

iii. The Administrative Supervisors and Charge Nurses will have a bed count and expected discharges ready to report.

iv. HICS may be set up and only selected sections activated.

c. Level 2 Activation:

Patients are received and some support from the Emergency Department will be required and/or the affected area may need some support.

i. Situation may require additional staff to be called into the hospital.
ii. All staff will remain on duty and follow their procedures.
iii. The HICS will be set up to coordinate response operations.

d. Level 3 Activation:

Large numbers of patients are received and/or a significant response to the emergency will be necessary. A level 3 activation will most likely require a full activation of HICS.

i. The HICS will be set up to coordinate disaster operations.
ii. The major event will require mobilization of most aspects of the Hospital Incident Command System in the EOP, including department callback procedure and planning for associate's relief over an extended period of time.

2. Mobilizing Incident Command

Emergency management and communications functions within an Incident Command Center utilizing HICS, through the leadership of the Incident Commander. The HICS incident command team is organized into various sections designed to optimize resources and skill.

a. Incident Command Center (ICC)

The Incident Command Center (ICC) will be set up, at the discretion of the Incident Commander, immediately upon notification of an event warranting the activation of HICS.

b. Incident Command Center Location

The primary designated ICC is located in the Main Hospital Basement Nurse Admin Supervisors office. If the event needs to expand, CP4 may be utilized. The adjacent rooms and offices may be used as staging areas for the HICS sections that have been activated. Room HB175 contains emergency response supplies to support the incident command center.

The Incident Commander (IC) may designate an alternate location for the ICC, for example if the primary ICC location is inaccessible or cannot be used as the ICC. In the event the hospital campus cannot support an ICC, the Emergency Supply trailer may be used as a mobile ICC so that the response can be coordinated from an offsite location. The primary location of the trailer is the motor pool parking area across from the parking garage entrance, but it may change as needed. A virtual command center may also be established utilizing a web-based meeting platform, if available.

c. The Role of Incident Commander

Every incident will have an Incident Commander. The leader assuming this role establishes the goals of

the response, appoints individuals to fill positions needed to meet the goals, and oversees the response. All command staff and section chiefs, below, report to the Incident Commander. Salinas Valley Health maintains a list of leaders who are authorized to assume role of Incident Commander (or appoint a designee), which includes Nurse Administrative Supervisors and Administrators-on-call. During off hours, the Administrative Supervisor will assume the role of Incident Commander until relieved by the responding Incident Commander.

Salinas Valley Health may participate in Joint Command with other authorities depending on the emergency.

d. The ICC is Staffed by the Incident Command Team:

Resource: California Hospital Association Hospital Incident Management Team Chart

i. Command Staff Positions:

- ***Liaison Officer*** - coordinates efforts with external agencies.
- ***Public Information Officer*** - communicates with the media and the public, and is set up to communicate with internal stakeholders via mass notification system. May participate in Joint Information Office with other affected hospitals/organizations to deliver consistent coordinated messaging.
- ***Medical/Technical Specialist*** - provides oversight for all medical related operations or technical response (e.g. information technology, utilities) modalities.
- ***Safety Officer*** - reviews and provides input to response plans to ensure safety of the organization, the staff, and the patients.

ii. General Staff Section Chiefs

Depending on the incident, section chiefs may need to expand their teams, and may appoint Branch Directors to lead separate initiatives. Branch directors report to their Section Chief, who in turn reports to the Incident Commander.

- ***Operations Section Chief*** develops and executes a plan (approved by IC) to resolve the incident while ensuring patient safety and the continuity of care. Depending on the incident response the Operations Section Chief may deploy one or several branches, appointing a Branch Director to each. Branch directors report to the Operations Section Chief, who then reports to Incident Commander. Following the California Hospital Association HICS model, Operations might include the following branches:

- Medical Care branch (e.g. inpatient, outpatient, casualty care, clinical support, patient registration)
- Infrastructure (e.g. power, water, HVAC, Facility assessment, medical gas)
- Security (Access control, crowd control, traffic control, law enforcement interface)
- HazMat (e.g. spill response, victim decontamination, facility decontamination)
- Business Continuity (e.g. IT systems, services continuity, records management)
- Patient Family Assistance (e.g. social services, family reunification)

- ***Logistics Section Chief*** is responsible for acquiring resources, assets and labor needed to support the incident command team and the response.
- ***Planning Section Chief*** is responsible for maintaining situation/status, coordinating periodic briefing meetings, updating the Incident Action Plan, and projecting the resources needed for possible long-term response effort. This section also performs patient tracking/information activities when needed. As the incident evolves, this section plans for demobilization and return/replenishment of resources and assets. This section collects incident documentation.
- ***Finance Section Chief*** is responsible for maintaining documentation of employee work hours and implements processes for payroll. It also completes and maintains documentation to submit to Office of Emergency Services (OES)/Federal Emergency Management Agency (FEMA) and insurance companies for disaster financial claims.

e. Collaborating with Community Partners

Salinas Valley Health's incident command structure is integrated into, and consistent with, its community's command structure. The use of the HICS model aligns with the Monterey County and State of California Emergency Operations Center, Fire Department Incident Command System (ICS), Police Department ICS, as well as neighboring hospital HICS structures.

Salinas Valley Health's IC may appoint a Liaison to communicate with community partners.

Collaboration with the Healthcare Coalition members may be accomplished using the ReddiNet platform. This platform allows Salinas Valley Health to send status alerts and send messages to community partners including healthcare coalition members, Monterey County EMS and Monterey County OES, and the Monterey County Medical/Health Operational Area Coordinator (MHOAC).

When outside resources are needed, the Monterey County Medical/Health Operational Area Coordinator (MHOAC) may be reached directly by calling Monterey County EMS Communications Center at 831-796-6444. For more information on this process see: Monterey County MHOAC Notification/ Activaction.

3. Communications Plan

a. Emergency Contacts

Salinas Valley Health maintains one or more contact list(s) of individuals and entities that may be notified in response to an emergency. The type of emergency will determine which organizations and individuals need to be contacted to assist with the incident. Contacts include:

i. Staff
ii. Providers and other licensed practitioners
iii. Volunteers
iv. Other healthcare organizations
v. Entities providing services under arrangement, including suppliers of essential services, equipment and supplies
vi. Relevant community partners (fire, police, local incident command, public health departments)

vii. Relevant authorities (federal, state, tribal, regional and local emergency preparedness staff)

viii. Other sources of assistance (e.g. health care coalitions) as appropriate

b. Establishing & Maintaining Communication with Staff, Licensed Practitioners and Volunteers

Everbridge mass notification system is in place, backed up by other communications methods including overhead paging, email, phone trees, texting app, etc.

Ongoing communication and dissemination of information to staff, licensed practitioners and volunteers is of vital importance during a disaster. It enables better utilization of assets and resources. During a disaster all information and communications will be funneled through the section Chiefs to the Incident Commander then disseminated back to the section Chiefs for communicating to the Unit Leaders and individual department directors and managers and licensed independent practitioners.

THE OPERATOR SHOULD NOT BE CALLED FOR INFORMATION.

c. Establishing & Maintaining Communication with Patients and Families

Staff will continually communicate and reassure patients during a disaster. Patient Experience Team, Social Services, Volunteers, and Administration will be made available to talk with patients as applicable. If there are patients whose family was not able to arrive at the hospital prior to an emergency in the community or the hospital, the Incident Command Team, under direction of the Incident Commander, will contact family members to inform them of the conditions of their loved ones and the emergency response activities.

If the hospital can no longer sustain operations and relocation of patients becomes necessary, the Incident Command Team will assign persons to notify family members (those present at the hospital and those unable to get to the hospital due to the nature of the emergency in the community) that their loved ones are being relocated and provide the name of the facility where the patient is being relocated, provide name and telephone number of contact individual at the facility. Augmentative and alternative communication may be used for those with difficulties communicating using speech.

d. Establishing & Maintaining Communication with Community Partners

Several local agencies may play a role in managing an emergency. Some of the key contacts include Police, Fire, EMS, OES, Department of Health, Center for Disease Control (CDC) and the Red Cross. Community partners are contacted by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

Communication with community partners will depend on the given emergency.

When all primary communication channels (telephone, cell phones and emails) are operative, they will be used. When primary communication channels are not operative, the hospital will use any available means to communicate with community partners including employment of radios, runners, satellite telephone, etc.

Monterey County Emergency Medical Services (EMS) and public health department may also be reached via 880 MHz radio, and the ReddiNet application.

Depending on the incident, community partners may maintain communications via establishment of Joint Command, or Joint Information Center. These may be in person, or utilizing a web-based meeting platform such as Webex.

Community incident updates may be obtained via California Health Alert Network (CAHAN) alerts, Monterey County OES messaging ("Alert! Monterey"), and the Monterey County OES website (https://www.co.monterey.ca.us/government/departments-a-h/administrative-office/office-of-emergency-services/incidents).

e. Establishing & Maintaining Communication with Relevant Authorities

Authorities (whether federal, state, regional or local) are contacted by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

Communication with the authority will depend on the given emergency, but as a general rule, begin with the most local authority.

When all primary communication channels (telephone, cell phones and emails) are operative, they will be used. When primary communication channels are not operative, the hospital will use any available means to communicate with the relevant authority including employment of radios, runners, satellite telephone, etc.

f. Establishing & Maintaining Communication with Media

When the EOP and HICS are activated, the hospital's communication with external agencies will depend on the given emergency. If multiple agencies and healthcare organizations are involved, all communication and coordination of activities will go through the Emergency Operations Center (EOC) at the OES.

In a major event, members of the press/media will be escorted to the Nancy Ausonio Mammography Center parking lot, or other designated area as needed, where a Public Information Center will be established. The designated Public Information Officer (PIO) will coordinate the collection and dissemination of information with the PIO at the Emergency Operations Center (EOC).

g. Communication with Vendors

Salinas Valley Health maintains vendor contacts that may provide specific services before, during, and after an emergency event.

Once emergency measures are initiated, the hospital utilizes its vendors list for essential supplies, services and equipment and notifies each vendor by telephone (or other means if the telephone system is not operational) to be on standby to respond to the hospital's needs should they arise.

h. Reporting Organizational Needs, Occupancy & Capacity to Relevant Authorities

Organizational needs, such as personal protective equipment (PPE), staffing shortages, evacuation or transfer of patients and temporary loss of part or all organization function, can be communicated to the Monterey County Healthcare Coalition. The Monterey County Medical/Health Operational Area

Coordinator (MHOAC) may be reached directly by calling Monterey County EMS Communications Center at 831-796-6444. Both admit capacity and diversion status may be reported to EMS and other community partners in the healthcare coalition via ReddiNet, or 880 MHz radio as a backup.

i. Warning and Notification Alerts

Salinas Valley Health has established a number of codes specific to emergency and disaster events, and the procedures to follow when that emergency or disaster incident occurs. See #6304 EMERGENCY CODES FOR Salinas Valley Health.

j. Sharing / Releasing Patient Information During an Emergency

During an emergency (such as a hospital evacuation, or mass casualty incident (MCI)), it may become necessary to share/release pertinent patient information with:

i. The patient's family, representative, or others involved in the care of the patient
ii. Disaster relief organizations and relevant authorities
iii. Other health care providers

Information shared may include the patient's location or medical records, for example. Sharing and releasing of patient information will be performed under the direction of the Incident Commander and will be consistent with 45 CFR 164.510 (b)(1)(ii) and (b)(4).

The method by which patient information is shared will depend on the type of incident. Patient & Family Reunification center may be established at the direction of the Incident Commander to provide location information and updates to family members. Medical records may be printed by unit nursing staff or with the support of Health Information Management department for patient transfer. During an MCI, patient information may be shared with community partners via ReddiNet to aid in community-wide patient/ family reunion efforts.

k. Primary vs. Alternate Communication Methods

The primary communication methods used by Salinas Valley Health in an emergency include overhead page, phone calls, and text notification.

When these primary methods are insufficient, then the other communication methods, mentioned throughout this section, will be employed.

l. Compatibility of Communication Methods with Community Partners

The Monterey County Heatlhcare Coalition has established common communication pathways for use across the community which includes the ReddiNet application, 880 MHz Radio, CAHAN and Alert!Monterey.

m. Testing of Alternative Communication Equipment

Salinas Valley Health's alternative communication equipment is tested for functionality on a periodic basis.

4. Staffing Plan

Salinas Valley Health maintains a plan to manage staff and volunteers to meet patient care needs during the duration of an emergency, incident, or patient surge.

a. Methods for Contacting Off-Duty Staff, Physicians, Licensed Practitioners

Contact information, including off-duty phone numbers, is maintained by Salinas Valley Health for its staff, physicians, and other licensed practitioners. If needed, an appointee (for example staffing office, HR, Medical Staff Services, or other, as appropriate) would reach out to individuals using their contact information.

b. Use of Volunteer Staffing

Staffing agencies, healthcare coalition support, and disaster medical assistance teams are all potential sources of volunteer staffing in an emergency.

c. Reporting Processes

On-duty staff report to their manager, director or immediate supervisor who will then be represented in the incident command center. Volunteers will be managed through the Labor Pool Unit under the direction of the Incident Commander.

d. Roles and Responsibilities for Essential Functions

Leaders who have been identified to assume a role in the HICS structure have received training for their roles. Ongoing education and training is also provided to staff through the exercises and activations conducted each year.

e. Integrating Outside Staff / Teams Into Assigned Roles and Responsibilities

Outside staff from staffing agencies, volunteers staffing, or deployed medical assistance teams will be oriented to their roles and responsibilities as appropriate to the nature of the emergency.

f. Managing Licensed Practitioners

During disaster situations, members of the community may report to the facility wishing to provide volunteer assistance. Some volunteers may have specific licenses, skills, or qualifications that can be valuable to patient care. These could be physicians or other medical professionals. These volunteers will be directed to a Staging Area and their names provided to the Human Resources Department or in their absence, Nursing Staff Office to verify licensure. If licensure can be verified, the volunteers will be used as necessary in conjunction with hospital staff. If licensure cannot be verified, the volunteers can be used in roles that are not directly related to patient care.

Salinas Valley Health's Medical Staff Bylaws maintains a plan to verify documents and identify of all volunteer licensed independent practitioners, perform primary source verification within 72 hours of the time the volunteer presents to the organization, and provide oversight of the care, treatment and services provided by volunteer licensed practitioners. The Bylaws also define the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners, and the process for

granting these privileges.

g. Employee Assistance and Support

In the event of a disaster or extended emergency, it is likely that staff will need additional support in order to meet the increasing demands placed on them. These needs may include, but are not limited to housing, transportation, support with family care, or mental health and wellness.

Depending on the emergency, Salinas Valley Health may provide its own resources or work with community organizations to provide the needed resource. Examples of providing Salinas Valley Health resources include providing hospital conference rooms and meals to staff seeking wildfire shelter, or repurposing campus bus parking shuttles to transport staff to and from work. Examples of working with community organizations include working with hotels to house hospital staff exposed to a pandemic illness.

To help address mental health and wellness needs, Salinas Valley Health provides the Employee Assistance Program which is available on-demand to all staff. Salinas Valley Health also maintains a Care for the Caregiver program that provides peer support.

5. Patient Care and Clinical Support Plan

a. Maintaining Continuity of Care

Salinas Valley Health cares for a number of patient populations including emergency care, adult ICU, Procedures (Cath Lab, Surgery, Diagnostic Imaging, Endoscopy) Progressive Care/Telemetry including a stroke unit, Medical/surgical including oncology and patients receiving dialysis, Mother/Child care including a Level II NICU, Labor & Delivery, post-partum, and pediatric general care.

Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care when the environments at Salinas Valley Health can no longer support care, treatment and services. The Liaison Officer will be responsible for inter facility communication between the hospital and the designated alternative care site, and a Patient Tracking team would also be deployed to document and retain records of which patients were transferred to and/or from the alternative care site(s).

The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following resources may be utilized:

- Ambulance transfer of patients between facilities
- Licensed vendors providing van/bus transportation
- Salinas Valley Health owned vehicles
- Vehicles arranged by Monterey County EMS

Additionally, Salinas Valley Health maintains supporting procedures regarding patient transfers for

certain patient populations. See:

- #399 MATERNAL TRANSPORT-TERTIARY CARE AND TRANSFER OF PATIENT.
- #2668 ACCEPTING INTERFACILITY TRANSFERS.
- #201 TRANSFER OF PEDIATRIC PATIENT TO HIGHER LEVEL OF CARE.
- #161 NICU: CONSULTATION & TRANSFER OF PATIENT TO & FROM NICU CLINICAL PROCEDURE.

b. Managing Visitors

During an emergency, the hospital may need to manage an influx of individuals that may present during a disaster that are not in need of medical care (such as visitors, or the "worried well"). Under the direction of the Incident Commander, Salinas Valley Health Security Department Officers on duty will assume responsibility for traffic and crowd control. This may involve locking certain exits and entrances and controlling entrance to the emergency department or entrances, in order to maintain a safe and effective environment to perform patient care. Hospital staff are always required to wear ID badges. In the event volunteers from outside Salinas Valley Health are assigned to duty, the Incident Command Team will employ a method to properly identify them. Only persons with proper identification will be admitted into the hospital during an emergency.

Traffic flow on the campus will be controlled by assigned security staff and law enforcement personnel only (Labor Pool may be utilized to help support efforts) allowing only authorized vehicles to enter the campus during emergencies.

At the direction of the Incident Commander, Salinas Valley Health may set up a Patient Family Reunification center to provide support and updates to visitors.

c. Managing Influx of Unidentified or Deceased Patients

i. The mortality rate during emergency conditions may increase due to casualties brought into the hospital. The hospital is only equipped for handling a minimal number of mortality casualties due to limited morgue refrigeration units. The hospital will communicate with the county morgue and provide information relative to number of casualties that the county morgues will pick up from the hospital.

ii. The hospital would also contact the local medical examiner for the appropriate clearance and procedures. A refrigerated trailer may be requested for securing bodies not able to be contained in the hospital's existing morgue. The Medical Examiner's office will be notified when the refrigerated trailer is full, or the disaster has been cleared.

6. Safety and Security Plan

a. Coordinating with Community Security Agencies

Salinas Valley Health may need to coordinate with community security agencies such as police, sheriff or National Guard. During an emergency, these entities will unite under the command of the highest-ranking law enforcement agency on site. Command of security inside the hospital's buildings will be under the hospital's Incident Commander unless the Incident Commander deems that law enforcement

intervention is required inside the buildings, and then law enforcement, in conjunction with the director of hospital security, will assume command jointly.

b. Tracking On-Duty Staff and Patients

If all or part of Salinas Valley Health is forced to shelter-in-place, relocate, or evacuate, the hospital will track the location of on-duty staff and patients. Depending on the nature of the emergency, this may be accomplished using printed schedules and patient census lists. Staff may also be polled via the Everbridge mass communication system. Tracking/head count activities may be performed periodically at intervals determined by the Incident Command Team, under the direction of the Incident Commander.

In the event of patient evacuation, Salinas Valley Health will track the specific name and location of the receiving facility or evacuation location. For more information on evacuation procedures, see HOSPITAL EVACUATION PROCEDURE.

7. Resources and Assets Plan

a. Managing Hospital Resources and Assets

Salinas Valley Health is aware of what resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency.

Inventory lists are maintained by the department who manages them, specifically:

Resource Type	Inventory Maintained by:
Medications & Related Supplies	Pharmacy
Medical/surgical supplies	Materials Management Sterile Supply
Medical gases including oxygen & supplies	RRT Engineering (bulk O2)
Potable or bottled water and nutrition	Nutrition Services
Laboratory equipment & supplies	Laboratory Blood Bank
Personal Protective Equipment	Materials Management
Fuel for operations	Engineering
Equipment and nonmedical supplies to sustain operations	Environmental Services

During an emergency or disaster incident the Logistics Section Chief, under direction of the Incident Commander, works with the responsible departments to track, monitor and locate resources as appropriate.

b. Acquiring Resources and Assets

In an emergency, Salinas Valley Health may need to obtain, allocate, mobilize, replenish and/or conserve resources and assets. Depending on the emergency, Salinas Valley Health may need to:

- Coordinate with local supply chains or vendors
- Coordinate with local, state, or federal agencies for additional resources
- Coordinate regional health care coalitions for additional resources
- Manage donations (such as food, water, equipment, materials)

High priority will be given to resources that are known to deplete quickly and are extremely competitive to receive and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications).

For those supplies with short shelf life and those that require continual replenishment, Salinas Valley Health will contact supplier immediately upon suspecting the onset of an emergency and stock up for a minimum of 96 hours if possible.

c. 96-Hour Plan

Salinas Valley Health periodically assesses its inventory to see which on-hand resources can be expected to last 96 hours, and which resources require additional sustaining measures to remain self-sustaining. See Attachment C: 96 Hour Plan.

Note: Materials management maintains Infectious Disease related Personal Protective Equipment (PPE) per CAL OSHA AB 2537 and SB 275 PPE Stockpiling Requirement. This regulation stipulates that California hospitals keep a three-month stockpile of PPE based on normal consumption patterns.

8. Utilities Plan

a. Essential Utilities

Salinas Valley Health is dependent on the uninterrupted function of its essential/critical utilities during an emergency. Essential utilities include electrical distribution, emergency power, potable water, medical gas and vacuum, ventilation, fuel, plumbing, steam boilers, and network and communication systems. If disrupted, adverse events may occur as a result. Salinas Valley Health has inventoried all its essential utilities based on calculated demand loads that may be affected under emergency conditions and is prepared to maintain effective operations of the hospital for a period of 96 hours without reliance for replenishment of supplies associated with utilities at Salinas Valley Health from external sources.

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b. Alternative Means for Providing Potable Water

See procedure #6009 FAILURE OF WATER DISTRIBUTION SYSTEM.

Salinas Valley Health also maintains a memorandum of understanding (MOU) with at least one potable water distributor.

c. Alternative Means for Providing Emergency Generators

A 2MW generator supports Salinas Valley Health's main hospital building. Salinas Valley Health also maintains a second backup generator in the event of generator failure.

Relevant supporting procedure(s): #6004 EMERGENCY GENERATOR FAILURE.

d. Alternative Means for Providing Fuel

Salinas Valley Health keeps on hand enough fuel to maintain essential functions for more than 96 hours. Refer to the 96-Hour Plan. Additionally, Salinas Valley Health maintains a memorandum of understanding (MOU) with at least one local fuel distributor.

e. Alternative Means for Providing Emergency Power Supply Systems

Salinas Valley Health has back up batteries at Taylor Farms Family Health & Wellness Center, and at the Outpatient Infusion clinic, which provide an additional 12 hours of power to medication refrigerators and freezers. If a power disruption lasts longer than 12 hours, the clinics and the main hospital pharmacy coordinate to relocate medications to the main hospital pharmacy (which is supported by generator power).

f. Alternate Source of Energy for Maintaining Safe Temperatures

Salinas Valley Health relies on maintaining temperatures that protect patient health and safety and provide sanitary storage of provisions.

Salinas Valley Health's generators support emergency lighting and fire detection, extinguishing and alarm systems. They support the HVAC system and patient medication and food refrigerators and freezers.

Salinas Valley Health is fortunate to sit in a mild coastal climate and as such, patient care areas are not subject to temperature extremes. However, if the temperature of procedure areas or sterile supply areas could not be maintained within the regulated limits, Salinas Valley Health would consider canceling non-emergent procedures or relocating supplies as appropriate to the situation.

If food refrigerators and freezers could not be powered, Salinas Valley Health would rely on its disaster menu and inventory stockpile. If only off-campus clinics are affected, their food may be relocated to the main hospital building.

If medication refrigerators and freezers could not be powered, Salinas Valley Health would look to sharing resources with the clinics within the Salinas Valley Health/SVMC system, or healthcare coalition members. If only off-campus clinics are affected, their medications may be relocated to the main hospital building.

If steam boilers could not remain functional, Salinas Valley Health may look to sharing resources with healthcare coalition members, for example to share sterilization equipment.

Relevant supporting utilities procedure(s):

- #5999 FAILURE OF NATURAL GAS SUPPLY,
- #6008 FAILURE OF STEAM DELIVERY BOILERS
- #6005 FAILURE OF HVAC SYSTEM
- #6592 EMERGENCY PLAN FOR STERILIZATION FAILURE

g. Alternate Source of Energy for Emergency Lighting

Salinas Valley Health's generators support emergency lighting in the main hospital building. If emergency

lighting could not be maintained, Salinas Valley Health may look to source emergency lighting from its own stockpiles of battery-powered lights, vendors, clinics or healthcare coalition members. As a last resort, Salinas Valley Health may consider relocation of patients in a partial or full evacuation.

h. Alternate Source of Energy for Fire Detection, Suppression & Alarm Systems

Salinas Valley Health's generators support emergency lighting in the main hospital building. If fire detection, extinguishing, and alarm systems could not be powered, Salinas Valley Health would look to implement interim life safety measures.

Relevant supporting procedure(s):

- #624 INTEREIM LIFE SAFETY MEASURES
- #5995 FAILURE OF FIRE ALARM SYSTEM

i. Alternate Source of Energy for Sewage and Waste Disposal

See procedure #6007 FAILURE OF THE SANITARY SEWER SYSTEM.

In the event of the garbage compactor loses power, Salinas Valley Health would coordinate with the hauler for more frequent pickups.

j. Additional Relevant Policies and Procedures

- #6001 FAILURE OF THE MEDICAL GAS OXYGEN SYSTEM
- #5998 FAILURE OF MEDICAL GAS SYSTEM NITROUS OXIDE
- #6002 FAILURE OF THE COMMUNICATIONS SYSTEM
- #6006 FAILURE OF NURSE CALL SYSTEM

9. Additional Procedures that Support the EOP

A. Facility Lockdown #6405
B. Fire Response Plan (Code Red) #610 (includes procedures for sheltering in place and horizontal relocation
C. Census Saturation #5886 defines the hospital surge plan

10. Hospital Role Under 1135 Waivers

In the event that the Secretary declares an 1135 waiver for a public health emergency, Salinas Valley Health will review the waiver, what is covered in the blanket waiver, and applies for additional waivers if needed. This process is managed by the Regulatory & Accreditation department.

D. CONTINUITY OF OPERATIONS PLAN (COOP)

1. Leadership Participation

Salinas Valley Health maintains a written continuity of operations plan (COOP) with the participation of

key executive leaders, business and finance leaders, and other relevant department leaders. These key leaders have identified and prioritized the services and functions that are considered essential or critical for maintaining operations.

2. Purpose

The purpose of the COOP is to provide guidance on how Salinas Valley Health will continue to perform its essential business functions to deliver essential or critical services. It identifies:

i. How and where it will continue to provide these essential business functions when the location of the service has been compromised due to an emergency or disaster incident.

ii. The order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.

3. Essential Business Functions

Salinas Valley Health's essential business functions include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.

a. Administrative / Vital Records (Health Information Management, or "HIM")

i. HIM Functions That Can be Performed Remotely:

"Remotely" indicates there is capacity to perform the work from home or another computer/device connected to the internet.

Function	Resources Needed
Correspondence	Computer, Internet, Salinas Valley Health remote access system, Access to Meditech software (web-based)
Coding / Abstracting	Computer, Internet, Salinas Valley Health remote access system, Access to Clinical Documentation Integrity (CDI) software (web-based)
Transcription	Computer, Internet, Salinas Valley Health remote access system, Access to Meditech software (web-based)

ii. HIM Succession Plan

In the event the directors of Health Information Management are unable to fulfill their function or perform their duties, the following role is authorized to assume this leadership role:

- Coding Manager

If above role(s) not available, Incident Command Team will designate another individual.

b. Information Technology (IT)

i. Information Technology has several policies and procedures articulating its continuity of operations plan:

1. Information Management Plan
2. Business Impact Analysis
3. Information Technology Standards and Best Practices
4. Data Backup Plan

ii. IT Succession Plan

1. In the event the Chief Information Officer is unable unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:
    a. IT Manager, followed by
    b. Network Engineering Manager
    c. If above role(s) not available, Incident Command Team will designate another individual

c. Financial Services

i. Financial Services Functions that can be Performed Remotely:

"Remotely" indicates there is capacity to perform the work from home or another computer/device connected to the internet.

Function	**Resources Needed**
Payroll: electronic deposits	Computer, Internet, Salinas Valley Health remote access system
Accounts Payable: electronic vendor payments	Computer, Internet, Salinas Valley Health remote access system
Billing	Computer, Internet, Salinas Valley Health remote access system

ii. **Financial Services Functions to be Performed Onsite:**

"Onsite" indicates at an accessible part of the Salinas Valley Health campus. In the event the Financial Services office is unusable during an incident, the department will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

Function	**Available Resources Needed**
Patient financial counseling	Computer with internet, phone, printer
Receiving physical mail (invoices, payments)	Computer with internet,

	phone, printer Would connect with vendors to send invoices electronically. Most payments are received via a PO box and electronically credited to the hospital via a third-party organization. The remaining payments delivered to Salinas Valley Health's onsite lockbox, if inaccessible, would be considered non-critical.

iii. Financial Services Succession Plan

In the event the Director of Patient Financial Services is unable unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

1. Assistant Director, Patient Financial Services, followed by
2. Manager, Patient Financial Services
3. If above role(s) not available, Incident Command Team will designate another individual

d. Security System

i. All Security Functions will be Performed Onsite

"Onsite" indicates at an accessible part of the Salinas Valley Health campus. In the event the Security office is unusable during an incident, Security will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

Function	Needed Resources
Security rounding	Back up radios/batteries from EM supply
Monitor CCTV, Dispatch	Computer, internet, Vigilant software Security has 3 spare laptops for this use, Alternate location: PBX office has same capabilities

ii. Security Succession Plan

In the event the Security Manager is unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

1. HSS Facility Site Supervisor
2. Shift supervisors
3. If above role(s) not available, Incident Command Team will designate another individual

e. Telecommunications

i. All Telecommunications Functions will be Performed Onsite

"Onsite" indicates at an accessible part of the Salinas Valley Health campus. In the event the Telecommunications office is unusable during an incident, Telecommunications will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

Function	**Needed Resources**
Operator	Phone reconfigured to Operator extension Computer, internet (to look up phone numbers)
Door Access Controls (override or lockdown procedures)	Computer, internet, Vigilant software Security has 3 spare laptops for this use, Alternate location: Security office has same capabilities
Managing Emergency Codes (x2222)	Dedicated phone reconfigured to ext. 2222 Computer, Internet Overhead page capability

Note: the Telephone Operator can be assigned another extension. However, both the dedicated line of 2222 and the overhead paging mechanism cannot be relocated due to current technology limitations. The alternate plan in this scenario is to communicate to all staff to call the regular Operator extension ("0") to report a code instead of 2222. To initiate codes, an alternate method of communication will be utilized. Some examples include: Everbridge notices, or via radio communication. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

ii. Telecommunications Succession Plan

In the event the Chief Information Officer is unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

1. Communications Engineering Manager
2. Network Engineering Manager
3. If above role(s) not available, Incident Command Team will designate another individual

f. CEO succession plan:

ABSENCE OF PRESIDENT/CHIEF EXECUTIVE OFFICER policy #1043

E. DISASTER RECOVERY PLAN

1. Strategies for Disaster Recovery Stages

a. Conducting Organization Wide Damage Assessments

An emergency or disaster incident can, by definition, result in damage (to people, to physical infrastructure, utilities, network or communications, etc.). Assessing the damages will be a crucial task following an acute disruption or perhaps periodically throughout a prolonged incident (e.g. earthquake

with aftershocks).

Assessing for damage will happen as soon as it is safe to do so, perhaps repeated at appropriate intervals, as determined by the Incident Management Team under the direction of the Incident Commander.

The persons conducting the assessment will be assigned by the Incident Command Team under the direction of the Incident Commander. These persons should have technical expertise in what needs assessing (for example, Salinas Valley Health Engineers assessing utilities and infrastructure, IT staff assessing network and communications, etc.).

The results of the damage assessment will be used to establish a recovery plan.

Tools for Damage Assessments

i. Recovery Checklist for Hospitals After a Disaster

Referenced on the ASPR Tracie "Recovery Planning" webpage.

b. Restoring Critical Systems and Essential Services

This phase of activities includes the repair and restoration of services to the affected area or facility, in order to render the facility functional and allow the hospital to provide services to the community. Priority would be given to restoring essential services

Tools for Restoring Critical Systems and Essential Services

i. **Information Technology**

1. See #5961 Information Management Disaster Recovery. This documents a formal contingency plan that establishes guidelines for restoring software systems and data.

ii. **Utilities**

1. A number of Salinas Valley Health procedures detail strategies for restoring critical utilities:
    a. #6004 EMERGENCY GENERATOR FAILURE
    b. #5995 FAILURE OF FIRE ALARM SYSTEM
    c. #6005 FAILURE OF HVAC SYSTEM
    d. #5998 FAILURE OF MEDICAL GAS SYSTEM NITROUS OXIDE
    e. #5999 FAILURE OF NATURAL GAS SUPPLY
    f. #6006 FAILURE OF NURSE CALL SYSTEM
    g. #6008 FAILURE OF STEAM DELIVERY BOILERS
    h. #6002 FAILURE OF THE COMMUNICATIONS SYSTEM
    i. #6001 FAILURE OF THE MEDICAL GAS OXYGEN SYSTEM
    j. #6007 FAILURE OF THE SANITARY SEWER SYSTEM

k. #6009 FAILURE OF WATER DISTRIBUTION SYSTEM

iii. Financial Recovery

1. ASPR TRACIE Federal Recovery Programs Guide for Healthcare Organizations

c. Returning to Full Operations

This goal of this phase is to return to normal operations as a whole. The strategy for returning to full operations varies widely depending on the extent of the damage. Salinas Valley Health could simply be back to full operations as soon as a damaged utility is recovered, for example. On the other hand, a full evacuation of the hospital due to an earthquake might require coordinating efforts with staff, community partners and transportation to return employees and patients to the facility. Returning to full operations might be further divided into stages for example beginning with providing critical access services.

Tools for Returning to Full Operations

- Hospital Repopulation After Evacuation Guidelines and Checklist
  - Source: California Hospital Association
- St. Louis Area Regional Hospital Re-Entry Plan
  - Source: ASPR Tracie "Recovery Planning" webpage

2. Family Reunification

In the event of an emergency or disaster incident, Salinas Valley Health may need to assist with family reunification and coordinate with community partners to help locate and assist with the identification of adults and unaccompanied children.

Depending on the incident, some strategies Salinas Valley Health is equipped to employ include:

a. Set up Family Reunification Center

A family reunification center may be set up by the Incident Management Team under the direction of the Incident Commander. The center may need to manage in-person visitors and family, or it may need to accommodate phone calls to family to notify them of patient status and location.

In-Person

- The conference room DRC A/B/C has been identified as a suitable location to manage in-person family and visitors because of its size, privacy, proximity to food, water and restrooms, and it is well equipped with power outlets for family and visitors to keep phones charged.
- Staff would be deployed to support family and visitors, and collect information about who they are looking for. Ideally, this is accomplished with social workers, chaplain(s) and RNs.
  - **Supporting Resource:** Case Management and Social Services maintain a working document of community resources for patients needing resources beyond the organizations support system. SAM's Guide to Monterey County Family Resources can also be found at www.samsresources.com. A physical copy is also kept in the MCI shed. This is a comprehensive guide to individuals who counsel families in need.

- A Patient Tracking team may also be deployed to continuously update a documented list of Salinas Valley Health patients and their descriptions (if unidentified), who will coordinate with the family reunification team to bring updates in care and, ultimately, reunify patients and families.

Phone-based

- Concierge's services may be assigned to support the patient information desk staff and assist the public in the family reunification and information center.
- Admitting may be best suited to provide updated lists of patients, assuring all patients are registered appropriately and tracking their location.
- A representative will be appointed to report updates to the Incident Command Team.
- Coordination with the PIO may be necessary to prevent inappropriate release of patient information.

b. Coordinate with the Community

Coordinating with community members may be necessary if, for example, the disaster is widespread, or if victims from an incident are taken to multiple hospitals in the area. The Incident Management Team would:

i. Confirm method of sharing information with the Healthcare Coalition. The ReddiNet Family Reunification module, phones, and even 880 MGH radio are all options.

ii. Appoint staff to be the liaison(s) to the Healthcare Coalition members. These person(s) will provide updated information from the Patient Tracking team.

F. EDUCATION AND TRAINING PROGRAM

i. Salinas Valley Health provides training based on its prioritized risks identified in the hazard vulnerability analysis, its emergency operations plan, communication plan, and applicable policies and procedures.

ii. Salinas Valley Health provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, volunteers, physicians and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training includes:

1. Activation and deactivation of the emergency operations plan
2. Communications plan
3. Emergency response policies and procedures
4. Evacuation, shelter-in place, lockdown and surge procedures
5. Where and how to obtain resources and supplies for emergencies (such as procedures or equipment)

iii. Salinas Valley Health provides ongoing education and training to all staff, volunteers, physicians and other licensed practitioners that is consistent with their roles and responsibilities in an emergency:

1. At least every two years

2. When roles or responsibilities change
3. When there are significant revisions to the emergency operations plan, policies and/or procedures
4. When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training.

iv. Salinas Valley Health trains its incident command staff to their specific duties and responsibilities in the incident command structure.

G. TESTING THE EMERGENCY OPERATIONS PLAN

i. Salinas Valley Health tests its emergency operations plan annually via planned exercises. These exercises are based on the following:
   1. Likely emergencies or disaster scenarios
   2. Emergency operations plan and policies and procedures
   3. After-action reports (AAR) and improvement plans
   4. The six critical areas (communications, resources and assets, staffing, patient care activities, utilities, safety and security)
   5. The exercise attempt to stress the limits of Salinas Valley Health emergency response procedures in order to assess how prepared the hospital may be if a real event or disaster were to occur based on past experiences.

ii. Salinas Valley Health conducts two exercises per year to test the emergency operations plan.
   1. One of the exercises consists of an operations-based exercise as follows:
      a. Full-scale, community based exercise; or
      b. Functional, facility-based exercise with a community-based exercise is not possible
      c. The other annual exercise consists of either an operations-based or discussion-based exercise as follows:
         - Full-scale, community based exercise; or
         - Functions, facility-based exercise; or
         - Mock disaster drill; or
         - Tabletop, seminar, or workshop led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

iii. Exercises are documented with an AAR.

iv. Note: if Salinas Valley Health experiences an actual emergency or disaster incident that is documented, its next operations-based exercise would be waived per regulations.

v. Each accredited freestanding outpatient care building that provides patient care, treatment and services also conducts at least one operations-based OR discussion-based exercise per year

to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises.

H. EVALUATING THE PROGRAM AND PLANS

i. The multidisciplinary Emergency Management Committee reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews AARs, identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented.

ii. Review and evaluation addresses the effectiveness of response procedures, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients, as applicable.

iii. The AARs, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to senior hospital leadership for review.

iv. Salinas Valley Health reviews and makes necessary updates based on AARs or opportunities for improvement to the following items annually:

1. Hazard vulnerability analysis
2. Emergency Management program
3. Emergency operations plan, policies and procedures
4. Communications plan
5. Continuity of operations plan
6. Education and training program
7. Testing program

V. ADDITIONAL RELEVANT POLICIES AND PROCEDURES

A. BIOTERRORISM READINESS PLAN #1789

B. EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS (MCI), INCLUDING DECONTAMINATION Policy #1102

C. Nutrition Services Disaster Plan Policy #5866

D. Laboratory Disruption of Services/Disaster Plan Policy #2628

A. **Plan Elements**

1. SVHMC LEADERSHIP TEAM
2. HAZARD VULNERABILITY ANALYSIS (HVA)
3. EMERGENCY OPERATIONS PLAN (EOP)
    a. Authority to Activate the EOP
    b. Mobilizing Incident Command

c. Communications Plan
d. Staffing Plan
e. Patient Care and Clinical Support Plan
f. Safety and Security Plan
g. Resources and Assets Plan
h. Utilities Plan
i. Additional Procedures that Support the EOP
j. Hospital Role Under 1135 Waivers

4. CONTINUITY OF OPERATIONS PLAN (COOP)
5. DISASTER RECOVERY PLAN
6. EDUCATION AND TRAINING PROGRAM
7. TESTING THE EMERGENCY OPERATIONS PLAN
8. EVALUATING THE PROGRAM AND PLANS

B. **Plan Management**

1. The plan encompasses all elements listed above and begins with section "F. SVHMC LEADERSHIP TEAM"

C. **Plan Responsibility**

1. See "F. SVHMC LEADERSHIP TEAM"

D. **Performance Measurement**

1. **See "M. EVALUATING THE PROGRAM AND PLANS"**

E. **Orientation and Education**

1. See "K. **EDUCATION AND TRAINING PROGRAM"**

F. **SVHMC LEADERSHIP TEAM**

1. The SVHMC leadership team provides the program vision, administration, support, and appropriate resources, which are embodied within and conveyed through the development and institutionalizing of business fundamentals relative to Emergency Management. The Environment of Care Committee (EOC) receives reports from the Emergency Management Committee (EMC) and examines the actions taken relative to the Emergency Operations Plan (EOP). Recommendations are given to and received by the EMC. The Board of Directors has authorized the EMC to update this plan and its processes as needed without formal Board approval.
    a. ***Board*** – Supports the plan through approval of the plan, evaluation of the quarterly summary reports of activities and annual Environment of Care Committee report with response as necessary.
    b. ***Senior Leadership***- Reviews the EOP as well as policies, training and education supporting the emergency management program. Participates on the EMC, responds to regulatory issues, often functions as Incident

Commander when the plan is activated, reviews reports, activities, goals and evaluations of the program with response as necessary. Allocates resources for the emergency management program.

c. ***Medical Staff*** - Supports the plan through participation in exercises and incidents. The Medical Executive Committee reviews and evaluates the Environment of Care Committee annual report with response as necessary.

d. ***Department Managers*** - Support the plan through monitoring the compliance of the training and performance of staff with the plan, participates in exercises and incidents, event reporting and initiation of corrective actions.

e. ***Employees*** - Support the plan by following policies and procedures, participate in exercises and incidents, report deficiencies and problems promptly and participate in training and competency for emergency management.

f. ***Safety Officer and Environment of Care Committee*** – Support the plan by reviewing quarterly and annual reports, providing feedback as needed.

g. ***Emergency Management Committee*** – Multidisciplinary committee responsible for planning, design, measurement, assessment and improvement processes for the emergency management plan.

G. HAZARD VULNERABILITY ANALYSIS (HVA)

1. All- Hazards Approach

a. Annually, Salinas Valley Health conducts a hazard vulnerability analysis (HVA) using an all-hazards approach to identify potential emergencies that could indirectly or directly affect demand for the hospital's services or its ability to provide those services. Considerations include hazards that are likely to impact the hospital's geographical region, community, facility and patient population. When available, community-based risk assessments (for example that may be developed by another organization or agency) will also be incorporated.

b. Salinas Valley Healthevaluates and prioritizes the findings of the HVA to determine what presents the highest likelihood of occurring and the impacts those hazards will have on the operating status of the hospital and its ability to provide services. SVHMC then uses the prioritized hazards to identify and implement mitigation and preparedness actions to increase the resilience of the hospital and reduce disruption of essential services or functions. It is used to further develop the EOP.

c. See Attachment A: Hazard Vulnerability Analysis (Main Hospital Block)

d. See Attachment B: Hazard Vulerability Analysis (Taylor Farms Family Health & Wellness Center)

H. EMERGENCY OPERATIONS PLAN (EOP)

1. Authority to Activate the EOP

a. The Administrator on Duty, Nurse Administrative Supervisor, or designee may activate the EOP. In the event of a potential Mass Casualty Incident impacting the Emergency Department, the EOP may be activated by the Nurse Administrative Supervisor together with the Emergency Department's Charge Nurse and on-duty Physician (See Emergency Management for Mass Casualty Incidents (MCI)

b. When notified of a potential disaster, the person(s) having authority to activate the EOP will:

    i. Evaluate the issues such as location of incident (internal, external), the distance from the campus, the scope of the incident (single individual, mass casualty, or malicious attack), and weather conditions (seasonal and current)

    ii. Discuss the operations pertaining to the conversion of the organization to Hospital Incident Command System (HICS) activation.

    iii. Plan care of casualty and non-casualty patients arriving in the Emergency Department during a disaster.

    iv. Evaluate the information concerning this emergency and determine if initiation of the Emergency Operations Plan (EOP) is warranted. Two of the three are required to initiate the EOP, unless deemed otherwise necessary by the onsite Incident Commander.

c. **Level 1 Activation**:

    i. When notified by Emergency Medical Services (EMS) and/or other sources of an incident with multiple casualties or a small incident with no casualties that occurred within the facility.

        a. Situation that most likely can be managed with the staff already on duty.

        b. Staff should remain on duty and review their department specific procedures to be prepared to respond to the next level if situation requires an upgrade.

        c. The Administrative Supervisors and Charge Nurses will have a bed count and expected discharges ready to report.

        d. HICS may be set up and only selected sections activated.

d. **Level 2 Activation**:

    i. Patients are received and some support from the Emergency Department will be required and/or the affected area may need some support.

        a. Situation may require additional staff to be called into

the hospital.

b. All staff will remain on duty and follow their procedures.

c. The HICS will be set up to coordinate response operations.

e. **Level 3 Activation**:

i. Large numbers of patients are received and/or a significant response to the emergency will be necessary. A level 3 activation will most likely require a full activation of HICS.

a. The HICS will be set up to coordinate disaster operations.

b. The major event will require mobilization of most aspects of the Hospital Incident Command System in the EOP, including department callback procedure and planning for associates' relief over an extended period of time.

2. **Mobilizing Incident Command**

a. Emergency management and communications functions within an Incident Command Center utilizing HICS, through the leadership of the Incident Commander. The HICS incident command team is organized into various sections designed to optimize resources and skill.

b. **Incident Command Center (ICC)**

i. The Incident Command Center (ICC) will be set up, at the discretion of the Incident Commander, immediately upon notification of an event warranting the activation of HICS.

c. **Incident Command Center Location**

i. The primary designated ICC is located in the Main Hospital Basement Nursing Administrative Supervisors office. If the event needs to expand, CP4 may be utilized. The adjacent rooms and offices may be used as staging areas for the HICS sections that have been activated. Room HB175 contains emergency response supplies to support the incident command center.

ii. The Incident Commander (IC) may designate an alternate location for the ICC, for example if the primary ICC location is inaccessible or cannot be used as the ICC. In the event the hospital campus cannot support an ICC, the Emergency Supply trailer may be used as a mobile ICC so that the response can be coordinated from an off-site location. The primary location of the trailer is the motor pool parking area across from the parking garage entrance, but it may change as needed. A virtual command center may also be established utilizing a web-based meeting platform, if available.

d. **The Role of Incident Commander**

i. Every incident will have an Incident Commander. The leader assuming this role establishes the goals of the response, appoints individuals to fill positions needed to meet the goals, and oversees the response. All command staff and section chiefs, below, report to the Incident Commander. SVHMC maintains a list of leaders who are authorized to assume role of Incident Commander (or appoint a designee), which includes Nurse Administrative Supervisors and Administrators-on-call. During off hours, the Administrative Supervisor will assume the role of Incident Commander until relieved by the responding Incident Commander.

ii. SVHMC may participate in Joint Command with other authorities depending on the emergency.

e. **The ICC is Staffed by the Incident Command Team:**

i. **Resource: California Hospital Association Hospital Incident Management Team Chart**

a. **Command Staff Positions:**

i. ***Liaison Officer*** - coordinates efforts with external agencies.

ii. ***Public Information Officer***- communicates with the media and the public, and is set up to communicate with internal stakeholders via mass notification system. May participate in Joint Information Office with other affected hospitals/organizations to deliver consistent coordinated messaging.

iii. ***Medical/Technical Specialist*** - provides oversight for all medical related operations or technical response (e.g. information technology, utilities) modalities.

iv. ***Safety Officer***- reviews and provides input to response plans to ensure safety of the organization, the staff, and the patients.

b. **General Staff Section Chiefs**

i. Depending on the incident, section chiefs may need to expand their teams, and may appoint Branch Directors to lead separate initiatives. Branch directors report to their Section Chief, who in turn reports to the Incident Commander.

i. ***Operations Section Chief*** develops

and executes a plan (approved by IC) to resolve the incident while ensuring patient safety and the continuity of care. Depending on the incident response the Operations Section Chief may deploy one or several branches, appointing a Branch Director to each. Branch directors report to the Operations Section Chief, who then reports to Incident Commander. Following the California Hospital Association HICS model, Operations might include the following branches:

i. Medical Care branch (e.g. inpatient, outpatient, casualty care, clinical support, patient registration)
ii. Infrastructure (e.g. power, water, HVAC, Facility assessment, medical gas)
iii. Security (Access control, crowd control, traffic control, law enforcement interface)
iv. HazMat (e.g. spill response, victim decontamination, facility decontamination)
v. Business Continuity (e.g. IT systems, services continuity, records management)
vi. Patient Family Assistance (e.g. social services, family reunification)

ii. ***Logistics Section Chief*** is responsible for acquiring resources, assets and labor needed to support the incident

command team and the response.

iii. ***Planning Section Chief*** is responsible for maintaining situation/status, coordinating periodic briefing meetings, updating the Incident Action Plan, and projecting the resources needed for possible long-term response effort. This section also performs patient tracking/ information activities when needed. As the incident evolves, this section plans for demobilization and return/ replenishment of resources and assets. This section collects incident documentation.

iv. ***Finance Section Chief*** is responsible for maintaining documentation of employee work hours and implements processes for payroll. It also completes and maintains documentation to submit to Office of Emergency Services (OES)/Federal Emergency Management Agency (FEMA) and insurance companies for disaster financial claims.

f. **Collaborating with Community Partners**

i. SVHMC's incident command structure is integrated into, and consistent with, its community's command structure. The use of the HICS model aligns with the Monterey County and State of California Emergency Operations Center, Fire Department Incident Command System (ICS), Police Department ICS, as well as neighboring hospital HICS structures.

ii. SVHMC's IC may appoint a Liaison to communicate with community partners.

iii. Collaboration with the Healthcare Coalition members may be accomplished using the ReddiNet platform. This platform allows SVHMC to send status alerts and send messages to community partners including healthcare coalition members, Monterey County EMS and Monterey County OES, and the Monterey County Medical/Health Operational Area Coordinator (MHOAC).

iv. When outside resources are needed, the Monterey County

Medical/Health Operational Area Coordinator (MHOAC) may be reached directly by calling Monterey County EMS Communications Center at 831-796-6444. For more information on this process see: Monterey County MHOAC Notification/ Activaction

3. **Communications Plan**

    a. **Emergency Contacts**

        i. SVHMC maintains one or more contact list(s) of individuals and entities that may be notified in response to an emergency. The type of emergency will determine which organizations and individuals need to be contacted to assist with the incident. Contacts include:

            a. Staff
            b. Providers and other licensed practitioners
            c. Volunteers
            d. Other healthcare organizations
            e. Entities providing services under arrangement, including suppliers of essential services, equipment and supplies
            f. Relevant community partners (fire, police, local incident command, public health departments)
            g. Relevant authorities (federal, state, tribal, regional and local emergency preparedness staff)
            h. Other sources of assistance (e.g. health care coalitions) as appropriate

    b. **Establishing & Maintaining Communication with Staff, Licensed Practitioners and Volunteers**

        i. Everbridge mass notification system is in place, backed up by other communications methods including overhead paging, email, phone trees, texting app, etc.

        ii. Ongoing communication and dissemination of information to staff, licensed practitioners and volunteers is of vital importance during a disaster. It enables better utilization of assets and resources. During a disaster all information and communications will be funneled through the section Chiefs to the Incident Commander then disseminated back to the section Chiefs for communicating to the Unit Leaders and individual department directors and managers and licensed independent practitioners.

        iii. ***THE OPERATOR SHOULD NOT BE CALLED FOR INFORMATION***

    c. **Establishing & Maintaining Communication with Patients and Families**

i. Staff will continually communicate and reassure patients during a disaster. Patient Experience Team, Social Services, Volunteers, and Administration will be made available to talk with patients as applicable. If there are patients whose family was not able to arrive at the hospital prior to an emergency in the community or the hospital, the Incident Command Team, under direction of the Incident Commander, will contact family members to inform them of the conditions of their loved ones and the emergency response activities.

ii. If the hospital can no longer sustain operations and relocation of patients becomes necessary, the Incident Command Team will assign persons to notify family members (those present at the hospital and those unable to get to the hospital due to the nature of the emergency in the community) that their loved ones are being relocated and provide the name of the facility where the patient is being relocated, provide name and telephone number of contact individual at the facility. Augmentative and alternative communication may be used for those with difficulties communicating using speech.

d. **Establishing & Maintaining Communication with Community Partners**

i. Several local agencies may play a role in managing an emergency. Some of the key contacts include Police, Fire, EMS, OES, Department of Health, Center for Disease Control (CDC) and the Red Cross. Community partners are contacted by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

ii. Communication with community partners will depend on the given emergency.

iii. When all primary communication channels (telephone, cell phones and emails) are operative, they will be used. When primary communication channels are not operative, the hospital will use any available means to communicate with community partners including employment of radios, runners, satellite telephone, etc.

iv. Monterey County Emergency Medical Services (EMS) and public health department may also be reached via 880 MHz radio, and the ReddiNet application.

v. Depending on the incident, community partners may maintain communications via establishment of Joint Command, or Joint Information Center. These may be in person, or utilizing a web-based meeting platform such as Webex.

vi. Community incident updates may be obtained via California Health Alert Network (CAHAN) alerts, Monterey County OES messaging (“Alert! Monterey”), and the Monterey County OES

website (https://www.co.monterey.ca.us/government/departments-a-h/administrative-office/office-of-emergency-services/incidents).

e. **Establishing & Maintaining Communication with Relevant Authorities**

i. Authorities (whether federal, state, regional or local) are contacted by the Incident Commander or a designee as soon as possible after an emergency response is initiated.

ii. Communication with the authority will depend on the given emergency, but as a general rule, begin with the most local authority.

iii. When all primary communication channels (telephone, cell phones and emails) are operative, they will be used. When primary communication channels are not operative, the hospital will use any available means to communicate with the relevant authority including employment of radios, runners, satellite telephone, etc.

f. **Establishing & Maintaining Communication with Media**

i. When the EOP and HICS are activated, the hospital's communication with external agencies will depend on the given emergency. If multiple agencies and healthcare organizations are involved, all communication and coordination of activities will go through the Emergency Operations Center (EOC) at the OES.

ii. In a major event, members of the press/media will be escorted to the Nancy Ausonio Mammography Center parking lot, or other designated area as needed, where a Public Information Center will be established. The designated Public Information Officer (PIO) will coordinate the collection and dissemination of information with the PIO at the Emergency Operations Center (EOC).

g. **Communication with Vendors**

i. SVHMC maintains vendor contacts that may provide specific services before, during, and after an emergency event.

ii. Once emergency measures are initiated, the hospital utilizes its vendors list for essential supplies, services and equipment and notifies each vendor by telephone (or other means if the telephone system is not operational) to be on standby to respond to the hospital's needs should they arise.

h. **Reporting Organizational Needs, Occupancy & Capacity to Relevant Authorities**

i. Organizational needs, such as personal protective equipment (PPE), staffing shortages, evacuation or transfer of patients and

temporary loss of part or all organization function, can be communicated to the Monterey County Healthcare Coalition. The Monterey County Medical/Health Operational Area Coordinator (MHOAC) may be reached directly by calling Monterey County EMS Communications Center at 831-796-6444. Both admit capacity and diversion status may be reported to EMS and other community partners in the healthcare coalition via ReddiNet, or 880 MHz radio as a backup.

i. **Warning and Notification Alerts**

i. SVHMC has established a number of codes specific to emergency and disaster events, and the procedures to follow when that emergency or disaster incident occurs. See EMERGENCY CODES.

j. **Sharing / Releasing Patient Information During an Emergency**

i. During an emergency (such as a hospital evacuation, or mass casualty incident (MCI)), it may become necessary to share/ release pertinent patient information with:

a. The patient's family, representative, or others involved in the care of the patient

b. Disaster relief organizations and relevant authorities

c. Other health care providers

ii. Information shared may include the patient's location or medical records, for example. Sharing and releasing of patient information will be performed under the direction of the Incident Commander and will be consistent with 45 CFR 164.510 (b)(1)(ii) and (b)(4).

iii. The method by which patient information is shared will depend on the type of incident. Patient & Family Reunification center may be established at the direction of the Incident Commander to provide location information and updates to family members. Medical records may be printed by unit nursing staff or with the support of Health Information Management department for patient transfer. During an MCI, patient information may be shared with community partners via ReddiNet to aid in community-wide patient/family reunion efforts.

k. **Primary vs. Alternate Communication Methods**

i. The primary communication methods used by SVHMC in an emergency include overhead page, phone calls, and text notification.

ii. When these primary methods are insufficient, then the other communication methods, mentioned throughout this section, will be employed.

l. **Compatibility of Communication Methods with Community Partners**

i. The Monterey County Heatlhcare Coalition has established common communication pathways for use across the community which includes the ReddiNet application, 880 MHz Radio, CAHAN and Alert!Monterey.

m. **Testing of Alternative Communication Equipment**

i. SVHMC's alternative communication equipment is tested for functionality on a periodic basis.

4. **Staffing Plan**

a. SVHMC maintains a plan to manage staff and volunteers to meet patient care needs during the duration of an emergency, incident, or patient surge.

b. **Methods for Contacting Off-Duty Staff, Physicians, Licensed Practitioners**

i. Contact information, including off-duty phone numbers, is maintained by SVHMC for its staff, physicians, and other licensed practitioners. If needed, an appointee (for example staffing office, HR, Medical Staff Services, or other, as appropriate) would reach out to individuals using their contact information.

c. **Use of Volunteer Staffing**

i. Staffing agencies, healthcare coalition support, and disaster medical assistance teams are all potential sources of volunteer staffing in an emergency.

d. **Reporting Processes**

i. On-duty staff report to their manager, director or immediate supervisor who will then be represented in the incident command center. Volunteers will be managed through the Labor Pool Unit under the direction of the Incident Commander.

e. **Roles and Responsibilities for Essential Functions**

i. Leaders who have been identified to assume a role in the HICS structure have received training for their roles. Ongoing education and training is also provided to staff through the exercises and activations conducted each year.

f. **Integrating Outside Staff / Teams Into Assigned Roles and Responsibilities**

i. Outside staff from staffing agencies, volunteers staffing, or deployed medical assistance teams will be oriented to their roles and responsibilities as appropriate to the nature of the emergency.

g. **Managing Licensed Practitioners**

i. During disaster situations, members of the community may report to the facility wishing to provide volunteer assistance. Some volunteers may have specific licenses, skills, or qualifications that can be valuable to patient care. These could be physicians or other medical professionals. These volunteers will be directed to a Staging Area and their names provided to the Human Resources Department or in their absence, Nursing Staff Office to verify licensure. If licensure can be verified, the volunteers will be used as necessary in conjunction with hospital staff. If licensure cannot be verified, the volunteers can be used in roles that are not directly related to patient care.

ii. SVHMC's Medical Staff Bylaws maintains a plan to verify documents and identify of all volunteer licensed independent practitioners, perform primary source verification within 72 hours of the time the volunteer presents to the organization, and provide oversight of the care, treatment and services provided by volunteer licensed practitioners. The Bylaws also define the individual(s) responsible for granting disaster privileges to volunteer physicians and other licensed practitioners, and the process for granting these privileges.

h. **Employee Assistance and Support**

i. In the event of a disaster or extended emergency, it is likely that staff will need additional support in order to meet the increasing demands placed on them. These needs may include, but are not limited to housing, transportation, support with family care, or mental health and wellness.

ii. Depending on the emergency, SVHMC may provide its own resources or work with community organizations to provide the needed resource. Examples of providing SVHMC resources include providing hospital conference rooms and meals to staff seeking wildfire shelter, or repurposing campus bus parking shuttles to transport staff to and from work. Examples of working with community organizations include working with hotels to house hospital staff exposed to a pandemic illness.

iii. To help address mental health and wellness needs, SVHMC provides the Employee Assistance Program which is available on-demand to all staff. SVHMC also maintains a Care for the Caregiver program that provides peer support.

5. **Patient Care and Clinical Support Plan**

a. **Maintaining Continuity of Care**

i. SVHMC cares for a number of patient populations including emergency care, adult ICU, Procedures (Cath Lab, Surgery, Diagnostic Imaging, Endoscopy) Progressive Care/Telemetry including a stroke unit, Medical/surgical including oncology and

patients receiving dialysis, Mother/Child care including a Level II NICU, Labor & Delivery, post-partum, and pediatric general care.

ii. Formal agreements are in place so that patients may be transferred to a facility that can provide adequate patient care when the environments at SVHMC can no longer support care, treatment and services. The Liaison Officer will be responsible for inter facility communication between the hospital and the designated alternative care site, and a Patient Tracking team would also be deployed to document and retain records of which patients were transferred to and/or from the alternative care site(s).

iii. The patient care unit transferring the patient is responsible for obtaining copies of the patient's medical records, gathering personal belongings and ensuring the patient's medications are continued throughout the transfer. If any hospital equipment is transferred with the patient, the patient care unit is responsible for documenting what equipment was transferred with the patient so that the equipment may be retrieved during the recovery phase post emergency. The following resources may be utilized:

a. Ambulance transfer of patients between facilities
b. Licensed vendors providing van/bus transportation
c. SVHMC owned vehicles
d. Vehicles arranged by Monterey County EMS

iv. Additionally, SVHMC maintains supporting procedures regarding patient transfers for certain patient populations. See:

a. MATERNAL TRANSPORT-TERTIARY CARE AND TRANSFER OF PATIENT
b. ACCEPTING INTERFACILITY TRANSFERS
c. TRANSFER OF PEDIATRIC PATIENT TO HIGHER LEVEL OF CARE
d. NICU: CONSULTATION & TRANSFER OF PATIENT

b. **Managing Visitors**

i. During an emergency, the hospital may need to manage an influx of individuals that may present during a disaster that are not in need of medical care (such as visitors, or the "worried well"). Under the direction of the Incident Commander, SVHMC Security Department Officers on duty will assume responsibility for traffic and crowd control. This may involve locking certain exits and entrances and controlling entrance to the emergency department or entrances, in order to maintain a safe and effective environment to perform patient care. Hospital staff are

always required to wear ID badges. In the event volunteers from outside SVHMC are assigned to duty, the Incident Command Team will employ a method to properly identify them. Only persons with proper identification will be admitted into the hospital during an emergency.

ii. Traffic flow on the campus will be controlled by assigned security staff and law enforcement personnel only (Labor Pool may be utilized to help support efforts) allowing only authorized vehicles to enter the campus during emergencies.

iii. At the direction of the Incident Commander, SVHMC may set up a Patient Family Reunification center to provide support and updates to visitors.

c. **Managing Influx of Unidentified or Deceased Patients**

i. The mortality rate during emergency conditions may increase due to casualties brought into the hospital. The hospital is only equipped for handling a minimal number of mortality casualties due to limited morgue refrigeration units. The hospital will communicate with the county morgue and provide information relative to number of casualties that the county morgues will pick up from the hospital.

ii. The hospital would also contact the local medical examiner for the appropriate clearance and procedures. A refrigerated trailer may be requested for securing bodies not able to be contained in the hospital's existing morgue. The Medical Examiner's office will be notified when the refrigerated trailer is full, or the disaster has been cleared.

6. **Safety and Security Plan**

a. **Coordinating with Community Security Agencies**

i. SVHMC may need to coordinate with community security agencies such as police, sheriff or National Guard. During an emergency, these entities will unite under the command of the highest-ranking law enforcement agency on site. Command of security inside the hospital's buildings will be under the hospital's Incident Commander unless the Incident Commander deems that law enforcement intervention is required inside the buildings, and then law enforcement, in conjunction with the director of hospital security, will assume command jointly.

b. **Tracking On-Duty Staff and Patients**

i. If all or part of SVHMC is forced to shelter-in-place, relocate, or evacuate, the hospital will track the location of on-duty staff and patients. Depending on the nature of the emergency, this may be accomplished using printed schedules and patient census lists. Staff may also be polled via the Everbridge mass

communication system. Tracking/head count activities may be performed periodically at intervals determined by the Incident Command Team, under the direction of the Incident Commander.

ii. In the event of patient evacuation, SVHMC will track the specific name and location of the receiving facility or evacuation location. For more information on evacuation procedures, see HOSPITAL EVACUATION.

7. **Resources and Assets Plan**

a. **Managing Hospital Resources and Assets**

i. SVHMC is aware of what resources and assets it has readily available and what resources and assets may be quickly depleted depending on the type of emergency.

ii. Inventory lists are maintained by the department who manages them, specifically:

a.

Resource Type	**Inventory Maintained by:**
Medications & Related Supplies	Pharmacy
Medical/surgical supplies	Materials Management Sterile Supply
Medical gases including oxygen & supplies	RRT Engineering (bulk O2)
Potable or bottled water and nutrition	Nutrition Services
Laboratory equipment & supplies	Laboratory Blood Bank
Personal Protective Equipment	Materials Management
Fuel for operations	Engineering
Equipment and nonmedical supplies to sustain operations	Environmental Services

iii. During an emergency or disaster incident the Logistics Section Chief, under direction of the Incident Commander, works with the responsible departments to track, monitor and locate resources as appropriate.

b. **Acquiring Resources and Assets**

i. In an emergency, SVHMC may need to obtain, allocate, mobilize, replenish and/or conserve resources and assets. Depending on the emergency, SVHMC may need to:

a. Coordinate with local supply chains or vendors

b. Coordinate with local, state, or federal agencies for additional resources

c. Coordinate regional health care coalitions for additional resources

d. Manage donations (such as food, water, equipment, materials)

ii. High priority will be given to resources that are known to deplete quickly and are extremely competitive to receive and replenish (such as fuel, oxygen, personal protective equipment, ventilators, intravenous fluids, antiviral and antibiotic medications).

iii. For those supplies with short shelf life and those that require continual replenishment, SVHMC will contact supplier immediately upon suspecting the onset of an emergency and stock up for a minimum of 96 hours if possible.

c. **96-Hour Plan**

i. SVHMC periodically assesses its inventory to see which on-hand resources can be expected to last 96 hours, and which resources require additional sustaining measures to remain self-sustaining. See Attachment C: 96 Hour Plan.

ii. Note: Materials management maintains Infectious Disease related Personal Protective Equipment (PPE) per CAL OSHA AB 2537 and SB 275 PPE Stockpiling Requirement. This regulation stipulates that California hospitals keep a three-month stockpile of PPE based on normal consumption patterns.

8. **Utilities Plan**

a. **Essential Utilities**

i. SVHMC is dependent on the uninterrupted function of its essential/critical utilities during an emergency. Essential utilities include electrical distribution, emergency power, potable water, medical gas and vacuum, ventilation, fuel, plumbing, steam boilers, and network and communication systems. If disrupted, adverse events may occur as a result. SVHMC has inventoried all its essential utilities based on calculated demand loads that may be affected under emergency conditions and is prepared to maintain effective operations of the hospital for a period of 96 hours without reliance for replenishment of supplies associated with utilities at SVHMC from external sources.

b. **Alternative Means for Providing Potable Water**

i. See procedure FAILURE OF WATER DISTRIBUTION SYSTEM.

ii. SVHMC also maintains a memorandum of understanding (MOU) with at least one potable water distributor.

c. **Alternative Means for Providing Emergency Generators**

i. A 2MW generator supports SVHMC's main hospital building. SVHMC also maintains a second backup generator in the event of generator failure.

ii. Relevant supporting procedure(s): EMERGENCY GENERATOR FAILURE.

d. **Alternative Means for Providing Fuel**

i. SVHMC keeps on hand enough fuel to maintain essential functions for more than 96 hours. Refer to the 96-Hour Plan. Additionally, SVHMC maintains a memorandum of understanding (MOU) with at least one local fuel distributor.

e. **Alternative Means for Providing Emergency Power Supply Systems**

i. SVHMC has back up batteries at Taylor Farms Family Health & Wellness Center, and at the Outpatient Infusion clinic, which provide an additional 12 hours of power to medication refrigerators and freezers. If a power disruption lasts longer than 12 hours, the clinics and the main hospital pharmacy coordinate to relocate medications to the main hospital pharmacy (which is supported by generator power).

f. **Alternate Source of Energy for Maintaining Safe Temperatures**

i. SVHMC relies on maintaining temperatures that protect patient health and safety and provide sanitary storage of provisions.

ii. SVHMC's generators support emergency lighting and fire detection, extinguishing and alarm systems. They support the HVAC system and patient medication and food refrigerators and freezers.

iii. SVHMC is fortunate to sit in a mild coastal climate and as such, patient care areas are not subject to temperature extremes. However, if the temperature of procedure areas or sterile supply areas could not be maintained within the regulated limits, SVHMC would consider canceling non-emergent procedures or relocating supplies as appropriate to the situation.

iv. If food refrigerators and freezers could not be powered, SVHMC would rely on its disaster menu and inventory stockpile. If only off-campus clinics are affected, their food may be relocated to the main hospital building.

v. If medication refrigerators and freezers could not be powered,

SVHMC would look to sharing resources with the clinics within the SVHMC/SVMC system, or healthcare coalition members. If only off-campus clinics are affected, their medications may be relocated to the main hospital building.

vi. If steam boilers could not remain functional, SVHMC may look to sharing resources with healthcare coalition members, for example to share sterilization equipment.

vii. Relevant supporting utilities procedure(s):

a. FAILURE OF NATURAL GAS SUPPLY

b. FAILURE OF STEAM DELIVERY BOILERS

c. FAILURE OF HVAC SYSTEM

d. EMERGENCY PLAN FOR STERILIZATION FAILURE

g. **Alternate Source of Energy for Emergency Lighting**

i. SVHMC's generators support emergency lighting in the main hospital building. If emergency lighting could not be maintained, SVHMC may look to source emergency lighting from its own stockpiles of battery-powered lights, vendors, clinics or healthcare coalition members. As a last resort, SVHMC may consider relocation of patients in a partial or full evacuation.

h. **Alternate Source of Energy for Fire Detection, Suppression & Alarm Systems**

i. SVHMC's generators support emergency lighting in the main hospital building. If fire detection, extinguishing, and alarm systems could not be powered, SVHMC would look to implement interim life safety measures.

ii. Relevant supporting procedure(s):

a. INTERIM LIFE SAFETY MEASURES (ILSM)

b. FAILURE OF FIRE ALARM SYSTEM

i. **Alternate Source of Energy for Sewage and Waste Disposal**

i. See procedure FAILURE OF THE SANITARY SEWER SYSTEM

ii. In the event of the garbage compactor loses power, SVHMC would coordinate with the hauler for more frequent pickups.

j. **Additional Relevant Policies and Procedures**

i. FAILURE OF THE MEDICAL GAS OXYGEN SYSTEM

ii. FAILURE OF MEDICAL GAS SYSTEM NITROUS OXIDE

iii. FAILURE OF THE COMMUNICATIONS SYSTEM

iv. FAILURE OF NURSE CALL SYSTEM

9. **Additional Procedures that Support the EOP**

a. Facility Lockdown

b. Fire Response Plan (Code Red) (includes procedures for sheltering in place and horizontal relocation

c. Census Saturation defines the hospital surge plan

10. **Hospital Role Under 1135 Waivers**

a. In the event that the Secretary declares an 1135 waiver for a public health emergency, SVHMC will review the waiver, what is covered in the blanket waiver, and applies for additional waivers if needed. This process is managed by the Regulatory & Accreditation department.

I. CONTINUITY OF OPERATIONS PLAN (COOP)

1. **Leadership Participation**

a. SVHMC maintains a written continuity of operations plan (COOP) with the participation of key executive leaders, business and finance leaders, and other relevant department leaders. These key leaders have identified and prioritized the services and functions that are considered essential or critical for maintaining operations.

2. **Purpose**

a. The purpose of the COOP is to provide guidance on how SVHMC will continue to perform its essential business functions to deliver essential or critical services. It identifies:

i. How and where it will continue to provide these essential business functions when the location of the service has been compromised due to an emergency or disaster incident.

ii. The order of succession plan that identifies who is authorized to assume a particular leadership or management role when that person(s) is unable to fulfill their function or perform their duties.

3. **Essential Business Functions**

a. SVHMC's essential business functions include administrative/vital records, information technology, financial services, security systems, communications/telecommunications, and building operations to support essential and critical services that cannot be deferred during an emergency; these activities must be performed continuously or resumed quickly following a disruption.

b. **Administrative / Vital Records (Health Information Management, or "HIM")**

i. **HIM Functions That Can be Performed Remotely:**

a. "Remotely" indicates there is capacity to perform the work from home or another computer/device connected to the internet.

b.

Function	Resources Needed
Correspondence	Computer, Internet,SVHMC remote access system, Access to Meditech software (web-based)
Coding / Abstracting	Computer, Internet,SVHMC remote access system, Access to Clinical Documentation Integrity (CDI) software (web-based)
Transcription	Computer, Internet,SVHMC remote access system, Access to Meditech software (web-based)

ii. **HIM Succession Plan**

a. In the event the directors of Health Information Management are unable to fulfill their function or perform their duties, the following role is authorized to assume this leadership role:

i. Coding Manager

iii. If above role(s) not available, Incident Command Team will designate another individual.

c. **Information Technology (IT)**

i. Information Technology has several policies and procedures articulating its continuity of operations plan:

a. Information Management Plan

b. Business Impact Analysis

c. Information Technology Standards and Best Practices

d. Data Backup Plan

ii. IT Succession Plan

a. In the event the Chief Information Officer is unable unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

i. IT Manager, followed by

ii. Network Engineering Manager

iii. If above role(s) not available, Incident Command Team will designate another

individual

d. **Financial Services**

i. **Financial Services Functions that can be Performed Remotely:**

a. "Remotely" indicates there is capacity to perform the work from home or another computer/device connected to the internet.

b.

Function	Resources Needed
Payroll: electronic deposits	Computer, Internet, SVHMC remote access system
Accounts Payable: electronic vendor payments	Computer, Internet, SVHMC remote access system
Billing	Computer, Internet, SVHMC remote access system

ii. **Financial Services Functions to be Performed Onsite:**

a. "Onsite" indicates at an accessible part of the SVHMC campus. In the event the Financial Services office is unusable during an incident, the department will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

b.

Function	Available Resources Needed
Patient financial counseling	Computer with internet, phone, printer
Receiving physical mail (invoices, payments)	Computer with internet, phone, printer Would connect with vendors to send invoices electronically. Most payments are received via a PO box and electronically

	credited to the hospital via a third-party organization. The remaining payments delivered to SVHMC on site lockbox, if inaccessible, would be considered non-critical.

iii. **Financial Services Succession Plan**

a. In the event the Director of Patient Financial Services is unable unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

i. Assistant Director, Patient Financial Services, followed by

ii. Manager, Patient Financial Services

iii. If above role(s) not available, Incident Command Team will designate another individual

e. **Security System**

i. **All Security Functions will be Performed Onsite**

a. "Onsite" indicates at an accessible part of the SVHMC campus. In the event the Security office is unusable during an incident, Security will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

b.

Function	Needed Resources
Security rounding	Back up radios/batteries from EM supply
Monitor CCTV, Dispatch	Computer, internet, Vigilant software Security has 3 spare laptops for this use. Alternate location: PBX office has same capabilities

ii. **Security Succession Plan**

a. In the event the Security Manager is unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

i. HSS Facility Site Supervisor

ii. Shift supervisors

iii. If above role(s) not available, Incident Command Team will designate another individual

f. **Telecommunications**

i.

a. "Onsite" indicates at an accessible part of the SVHMC campus. In the event the Telecommunications office is unusable during an incident, Telecommunications will relocate to an available and appropriate alternate location. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

b.

Function	**Needed Resources**
Operator	Phone reconfigured to Operator extension Computer, internet (to look up phone numbers)
Door Access Controls (override or lockdown procedures)	Computer, internet, Vigilant software Security has 3 spare laptops for this use. Alternate location: Security office has same capabilities
Managing Emergency Codes (x2222)	Dedicated phone reconfigured to ext. 2222 Computer, Internet Overhead page capability

c. Note: the Telephone Operator can be assigned another extension. However, both the dedicated line of 2222 and the overhead paging mechanism cannot be relocated due to current technology limitations. The alternate plan in this scenario is to communicate to all staff to call the regular Operator extension ("0") to report a code instead of 2222. To initiate codes, an alternate method of communication will be utilized.

Some examples include: Everbridge notices, or via radio communication. This will be accomplished with the support of the Incident Management Team under the direction of the Incident Commander.

ii. **Telecommunications Succession Plan**

a. In the event the Chief Information Officer is unable to fulfill their function or perform their duties, the following roles are authorized to assume this leadership role:

i. Communications Engineering Manager

ii. Network Engineering Manager

iii. If above role(s) not available, Incident Command Team will designate another individual

g. **CEO succession plan:**

h. ABSENCE OF PRESIDENT/CHIEF EXECUTIVE OFFICER

J. **DISASTER RECOVERY PLAN**

1. **Strategies for Disaster Recovery Stages**

a. **Conducting Organization Wide Damage Assessments**

i. An emergency or disaster incident can, by definition, result in damage (to people, to physical infrastructure, utilities, network or communications, etc.). Assessing the damages will be a crucial task following an acute disruption or perhaps periodically throughout a prolonged incident (e.g. earthquake with aftershocks).

ii. Assessing for damage will happen as soon as it is safe to do so, perhaps repeated at appropriate intervals, as determined by the Incident Management Team under the direction of the Incident Commander.

iii. The persons conducting the assessment will be assigned by the Incident Command Team under the direction of the Incident Commander. These persons should have technical expertise in what needs assessing (for example, SVHMC Engineers assessing utilities and infrastructure, IT staff assessing network and communications, etc.).

iv. The results of the damage assessment will be used to establish a recovery plan.

v. Tools for Damage Assessments

a. Recovery Checklist for Hospitals After a Disaster

b. Referenced on the ASPR Tracie “Recovery Planning”

webpage.

b. **Restoring Critical Systems and Essential Services**

i. This phase of activities includes the repair and restoration of services to the affected area or facility, in order to render the facility functional and allow the hospital to provide services to the community. Priority would be given to restoring essential services

ii. Tools for Restoring Critical Systems and Essential Services

a. **Information Technology**

i. See Information Management Disaster Recovery This documents a formal contingency plan that establishes guidelines for restoring software systems and data.

b. **Utilities**

i. A number of SVHMC procedures detail strategies for restoring critical utilities:

i. EMERGENCY GENERATOR FAILURE

ii. FAILURE OF FIRE ALARM SYSTEM

iii. FAILURE OF HVAC SYSTEM

iv. FAILURE OF MEDICAL GAS SYSTEM NITROUS OXIDE

v. FAILURE OF NATURAL GAS SUPPLY

vi. FAILURE OF NURSE CALL SYSTEM

vii. FAILURE OF STEAM DELIVERY BOILERS

viii. FAILURE OF THE COMMUNICATIONS SYSTEM

ix. FAILURE OF THE MEDICAL GAS OXYGEN SYSTEM

x. FAILURE OF THE SANITARY SEWER SYSTEM

xi. FAILURE OF WATER DISTRIBUTION SYSTEM

c. Financial Recovery

i. ASPR TRACIE Federal Recovery Programs Guide for Healthcare Organizations

c. **Returning to Full Operations**

i. This goal of this phase is to return to normal operations as a whole. The strategy for returning to full operations varies widely depending on the extent of the damage. SVHMC could simply be back to full operations as soon as a damaged utility is recovered, for example. On the other hand, a full evacuation of the hospital due to an earthquake might require coordinating efforts with staff, community partners and transportation to return employees and patients to the facility. Returning to full operations might be further divided into stages for example beginning with providing critical access services.

ii. Tools for Returning to Full Operations

a. Hospital Repopulation After Evacuation Guidelines and Checklist

i. Source: California Hospital Association

b. St. Louis Area Regional Hospital Re-Entry Plan

i. Source: ASPR Tracie "Recovery Planning" webpage

2. **Family Reunification**

a. In the event of an emergency or disaster incident, SVHMC may need to assist with family reunification and coordinate with community partners to help locate and assist with the identification of adults and unaccompanied children.

b. Depending on the incident, some strategies SVHMC is equipped to employ include:

c. Set up Family Reunification Center

i. A family reunification center may be set up by the Incident Management Team under the direction of the Incident Commander. The center may need to manage in-person visitors and family, or it may need to accommodate phone calls to family to notify them of patient status and location.

a. In-Person

i. The conference room DRC A/B/C has been identified as a suitable location to manage in-person family and visitors because of its size, privacy, proximity to food, water and restrooms, and it is well equipped with power outlets for family and visitors to keep phones charged.

ii. Staff would be deployed to support family and visitors, and collect information about who they are looking for. Ideally, this is

accomplished with social workers, chaplain(s) and RNs.

i. **Supporting Resource:** Case Management and Social Services maintain a working document of community resources for patients needing resources beyond the organizations support system. SAM's Guide to Monterey County Family Resources can also be found at www.samsresources.com. A physical copy is also kept in the MCI shed. This is a comprehensive guide to individuals who counsel families in need.

iii. A Patient Tracking team may also be deployed to continuously update a documented list of SVHMC patients and their descriptions (if unidentified), who will coordinate with the family reunification team to bring updates in care and, ultimately, reunify patients and families.

b. Phone-based

i. Concierge's services may be assigned to support the patient information desk staff and assist the public in the family reunification and information center.

ii. Admitting may be best suited to provide updated lists of patients, assuring all patients are registered appropriately and tracking their location.

iii. A representative will be appointed to report updates to the Incident Command Team.

iv. Coordination with the PIO may be necessary to prevent inappropriate release of patient information.

d. **Coordinate with the Community**

i. Coordinating with community members may be necessary if, for example, the disaster is widespread, or if victims from an incident are taken to multiple hospitals in the area. The Incident Management Team would:

a. Confirm method of sharing information with the Healthcare Coalition. The ReddiNet Family Reunification module, phones, and even 880 MGH radio are all options.

b. Appoint staff to be the liaison(s) to the Healthcare Coalition members. These person(s) will provide updated information from the Patient Tracking team.

K. EDUCATION AND TRAINING PROGRAM

1. SVHMC provides training based on its prioritized risks identified in the hazard vulnerability analysis, its emergency operations plan, communication plan, and applicable policies and procedures.
2. SVHMC provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, volunteers, physicians and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training includes:
    a. Activation and deactivation of the emergency operations plan
    b. Communications plan
    c. Emergency response policies and procedures
    d. Evacuation, shelter-in place, lockdown and surge procedures
    e. Where and how to obtain resources and supplies for emergencies (such as procedures or equipment)
3. SVHMC provides ongoing education and training to all staff, volunteers, physicians and other licensed practitioners that is consistent with their roles and responsibilities in an emergency:
    a. At least every two years
    b. When roles or responsibilities change
    c. When there are significant revisions to the emergency operations plan, policies and/or procedures
    d. When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training.
4. SVHMC trains its incident command staff to their specific duties and responsibilities in the incident command structure.

L. TESTING THE EMERGENCY OPERATIONS PLAN

1. SVHMC tests its emergency operations plan annually via planned exercises. These exercises are based on the following:
    a. Likely emergencies or disaster scenarios
    b. Emergency operations plan and policies and procedures
    c. After-action reports (AAR) and improvement plans

d. The six critical areas (communications, resources and assets, staffing, patient care activities, utilities, safety and security)

e. The exercise attempt to stress the limits of SVHMC emergency response procedures in order to assess how prepared the hospital may be if a real event or disaster were to occur based on past experiences.

2. SVHMC conducts two exercises per year to test the emergency operations plan.
    a. One of the exercises consists of an operations-based exercise as follows:
        i. Full-scale, community based exercise; or
        ii. Functional, facility-based exercise with a community-based exercise is not possible
        iii. The other annual exercise consists of either an operations-based or discussion-based exercise as follows:
            a. Full-scale, community based exercise; or
            b. Functions, facility-based exercise; or
            c. Mock disaster drill; or
            d. Tabletop, seminar, or workshop led by a facilitator and includes a group discussion using narrated, clinically relevant emergency scenarios and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
3. Exercises are documented with an AAR.
4. Note: if SVHMC experiences an actual emergency or disaster incident that is documented, its next operations-based exercise would be waived per regulations.
5. Each accredited freestanding outpatient care building that provides patient care, treatment and services also conducts at least one operations-based OR discussion-based exercise per year to test its emergency response procedures, if not conducted in conjunction with the hospital's emergency exercises.

M. **EVALUATING THE PROGRAM AND PLANS**

1. The multidisciplinary Emergency Management Committee reviews and evaluates all exercises and actual emergency or disaster incidents. The committee reviews AARs, identifies opportunities for improvement, and recommends actions to take to improve the emergency management program. The AARs and improvement plans are documented.
2. Review and evaluation addresses the effectiveness of response procedures, continuity of operations plans (if activated), training and exercise programs, evacuation procedures, surge response procedures, and activities related to communications, resources and assets, security, staff, utilities, and patients, as applicable.
3. The AARs, identified opportunities for improvement, and recommended actions to improve the emergency management program are forwarded to senior hospital

leadership for review.

4. SVHMC reviews and makes necessary updates based on AARs or opportunities for improvement to the following items annually:
    a. Hazard vulnerability analysis
    b. Emergency Management program
    c. Emergency operations plan, policies and procedures
    d. Communications plan
    e. Continuity of operations plan
    f. Education and training program
    g. Testing program

VI. REFERENCES

A. The Joint Commission, Emergency Management Chapter
B. Department of Human Health Services ASPER TRACIE: Healthcare Emergency Preparedness Information Gateway: https://asprtracie.hhs.gov/
C. ASPR Tracie "Recovery Planning" webpage.
D. Title 8 California Code of Regulations §5192(q) Hazardous Waste Operations and Emergency Response ~~https://www.caloes.ca.gov/CaliforniaSpecializedTrainingInstituteSite/Documents/C-%A75192.pdf~~HazMat Refresher Training Requirements
E. National Incident Management System (NIMS) ~~https://www.fema.gov/emergency-managers/nims~~National Incident Management System
F. CAL OSHA PPE Stockpiling Requirement (Assembly Bill No. 2537)
G. BIOTERRORISM READINESS PLAN
H. EMERGENCY MANAGEMENT FOR MASS CASUALTY INCIDENTS (MCI)
I. Nutrition Services Disaster
J. Laboratory Disruption of Services/Disaster Plan

Attachments

Attachment A: Hazard and Vulnerability Analysis (Main Hospital Block)

Attachment B: Hazard Vulnerability Assessment (Taylor Farms Family Health and Wellness Center)

Attachment C: 96 Hour Plan

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/2023
Environment of Care Committee	James Hively: Environmental Health & Safety Manager	10/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Earl Strotman: Director Facilities Management & Construction	08/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14097399

Last Approved	N/A	Owner	Elvira Mae Delfin: Clinical Manager
Last Revised	10/2023	Area	Patient Care
Next Review	3 years after approval		

Falls, Management of the Patient

I. POLICY STATEMENT

~~A. Once identified as a 'falls risk' safety precautions are instituted through development of patient specific or individualized plans of care.~~

A. N/A

II. PURPOSE

A. To guide the staff in reducing the incidence of patient falls, identifying patients at risk of falling so that appropriate interventions can be ~~deployed~~implemented, and reducing injury related to falls.

III. DEFINITIONS

A. Fall: an unplanned descent to the floor (or extension of the floor, e.g., trash can or other equipment) with or without injury to the patient.

B. ~~Accidental Fall: not identified as HRTF prior to fall – due to failure of equipment or environmental hazard~~Accidental Fall: Falls associated with extrinsic environment hazards such as spills on the floor, tubing, cords and failure of equipment or assistive devices.

C. Unanticipated Physiologic Fall: not reflected in HRTF criteria and could not have been predicted i.e. syncope; seizure; orthostatic hypotension or unanticipated drug reaction or side effect in response to treatment.

D. Anticipated Physiologic Fall: identified as HRTF

E. Pediatric-Development: non-injurious falls that are common to infant/toddlers as they are learning to walk, turn or run.

F. Baby/Child Drop: newborn, infant or child is being held or carried and is dropped by family/ caregiver

G. Injury: a disruption of structure or function of some part of the body as a result of an

unplanned event (e.g.fractures with/without treatment, sprains, cuts, bruises, aggravation of pre-existing complaints)

H. Comatose: a deep prolonged unconsciousness where the patient cannot be aroused

I. Completely immobile: a state in which the patient's motor strength is so diminished that the patient is incapable of moving the body to change position.

J. Complete paralysis: loss of motor function due to lesion of the neural or muscular mechanism, or administration of paralytic mediations, such that the patient is incapable of moving

K. HRTF: High Risk to Fall

IV. GENERAL INFORMATION

A. Once identified as a 'falls risk' safety precautions are instituted through development of patient specific or individualized plans of care.

B. Responsibility

1. Registered Nurse (RN)

   a. ~~Initial and ongoing assessment of fall risk and fall injury risk~~Perform an initial and ongoing fall risk assessment

   b. ~~Implementation of~~Implement fall prevention strategies as determined by stratified fall risk ~~and fall injury risk factors~~assessment.

   c. ~~Reporting of~~Report patient falls and treatment of fall-related injuries within the scope of practice.

2. Unlicensed Nursing Staff and Ancillary Clinical Staff (includes Certified Nursing Assistants, Clinical Assistants, Rehab Staff, Respiratory Care Practitioner and other clinical staff)

   a. Implementation of basic safety interventions

   b. Implementation of delegated interventions for patients at moderate or high risk

   c. Reporting of patient falls to RN or licensed staff

C. Patient falls are reported after appropriate assessment of the patient condition and immediate evaluation of the situation(s) that led to the fall incident.

D. This is an organization-wide policy applying to all care settings and services, with the exemption of the following populations:

1. Neonates and infants are by definition at risk of falls due to their developmental age. No assessment/ reassessment of fall risk are required for these patients in any care setting. Such patients are maintained in bassinets/cribs for their safety when not physically held or secured.

2. Pediatric patients to age 13 are evaluated using the Pediatric Falls Risk Assessment scale, which is adapted from the Humpty Dumpty scale.

E. Each care setting is assessed based on the population and setting, to determine the need for patient-specific assessment/reassessment.

1. Level One Category:

   These areas have been assessed to carry a minimal risk. No patient specific fall risk assessment for this care setting is required. Environmental risk assessments shall be performed as a component of Environmental/Hazard Surveillance Rounds. However, if a patient presents as a clear risk of fall, then appropriate interventions shall be instituted. The following areas are a level one risk:

   a. CT, MRI, Nuclear Medicine, Mammography
   b. Radiology/Ultrasound
   c. ~~Cancer Center~~
   d. ~~Wound Clinic~~
   e. ~~Pre-Operative area~~
   f. ~~Sleep Center~~
   g. ~~Taylor Farms Family Health and Wellness Center~~
   h. Pre-procedural areas (Outpatient Surgery, Heart Cente Holding Area)
   i. All non-hospital ambulatory settings and clinics (e.g. Outpatient Wound Care, Outpatient Infusion, Sleep Center, Cardiac Rehab, Taylor Farms Family Health and Wellness Center, etc.)

2. Level Two Category:

   All patients in these care settings are considered a fall risk. No specific falls risk patient assessment is required. Basic fall prevention interventions are maintained on all patients for the duration of care, treatment and service in these settings. The following areas are a level two risk:

   a. PACU
   b. ~~Cath Lab~~
   c. ~~GI Lab~~
   d. Interventional Radiology
   e. Emergency Department
   f. All hospital-based procedural areas (e.g. Surgery, Cath Lab, Interventional Radiology, Endoscopy, etc.)

3. Level Three Category: All Inpatient Units

   Patients in this care setting shall be assessed for fall risk upon admission or establishment of care, and will receive an ongoing reassessment of fall risk every shift as appropriate for inpatient settings. Fall prevention interventions shall be implemented for: at-risk patients.

V. PROCEDURE

A. Fall Management Strategies High Risk for Fall Assessment

1. Patients in inpatient settings will be assessed for potential fall risk within four (4) hours of admission ~~and~~, every shift thereafter and after a fall incident. The patient will be assessed using the Fall Risk Scale and nursing clinical judgment. See SAFE PATIENT HANDLING policy.
2. Fall Risk Assessment
    a. Assess patient for presence of fall risk factors and calculate level of fall risk on admission to unit~~,~~ and every shift ~~and prn as the patient's condition and treatment changes~~.
    b. Calculations of fall risk is not required for:
        i. Patients who are comatose, completely immobile or completely paralyzed. Implement basic safety precautions as per low risk interventions.
        ii. Patients with a history of more than one (1) fall in six (6) months prior to admission, experience a fall during this hospitalization, or are deemed to be at high fall risk per protocol, implement high fall risk interventions.
3. Reassessment is required -
    a. When there is a significant change in the patient condition
    b. Upon transfer to high or lower level of care by receiving RN
    c. After receiving moderate sedation or anesthesia
4. High Fall Risk is assessed utilizing the Fall Risk Assessment Tool per unit standard.

B. Fall Risk Prevention Strategies

1. Implement fall precaution interventions as appropriate for the patient's fall and fall injury risk assessment as noted in Attachment B Fall Prevention Strategies per Risk Stratification.
2. Interventions under low fall risk for maintaining a safe unit environment and basic safety interventions apply to all patients at all times.
3. Patient Comfort and Purposeful Hourly Rounding (Attachment C may be indicated per interventions as appropriate.
4. Patient and Family Education
    a. On admission, provide education in preventing falls while hospitalized and provide patient and family with Patient Safety and Education Guide.
    b. Advise patient/families that their active participation is encouraged as a strategy to preventing falls.
    c. Orient patient/family to the Falls Prevention Program
        i. Inpatients: education is provided using the Patient Safety and

Education Guide

ii. Outpatient: education is provided using patient handout "Guide to Preventing Falls at Home"

5. Toileting
    a. Toileting Rounds is a proven strategy for patients who meet the following criteria:
        i. Patient is Disoriented and/or Incontinent of Urine or Stool
        ii. While patient is toileting, the staff member will not leave the patient in the bathroom or on the commode. Staff will notify the other team members that they are helping a patient to the bathroom and will be unavailable during that time period.

6. ~~Discharge Planning~~
    ~~a. For patients assessed to have continued risk for falls in the community environment, incorporate fall prevention strategies into the discharge plan and provide patient with "Guide to Preventing Falls at Home"~~

C. Management of Fall Events
1. Nurse shall assess patient using the– Post Fall Assessment screen and notify physician of fall event.
2. Nurse shall conduct a huddle with appropriate staff and complete an occurrence report whenever the patient fall occurs.
3. Nurse shall follow interventions for reportable conditions

D. Reportable Conditions
1. Nurse shall notify physician/authorized prescriber of the following:
    a. Patient fall, include any change in physiologic or mental status post-fall
2. Director/Manager/designee shall notify the Risk Manager and Patient Safety Office if patient falls results in one of the following:
    a. Significant injury involving higher levels of care or medical/surgical intervention
    b. Confirmed injury by diagnostic test
    c. Death as a result of a fall event.
3. ~~Nurse shall conduct a huddle with appropriate staff and complete an occurrence report whenever a patient fall occurs.~~

E. Documentation:
1. The RN documents fall risk assessment in the Electronic Health Record (EHR), per unit standard. Document the following:
    a. Fall Risk Scores
    b. Fall injury risk factor findings

i. Implementation of fall protocol per stratified fall risk to include patient-specific fall prevention measures

ii. Fall event(s) and related assessments, re-assessments and treatment.

2. Post Fall Assessment
    a. A fall assessment must be completed.
    b. Assess patient for injury prior to moving patient. Utilize proper lift device/ equipment for transfer and mobility.
    c. If patient previously not considered a High Risk to Fall, initiate Impaired Mobility Care Plan
    d. Post fall documentation includes:
        i. Date and time of fall
        ii. Location of fall
        iii. Physical findings related to the fall
        iv. Injuries from fall
        v. Family notification, if applicable
        vi. Time of Physician notification
        vii. Orders received
    e. Document treatment if applicable, i.e. neuro checks, wound care, etc.
        i. Conduct Post Fall Huddle with the following team members: Charge Nurse, Primary Nurse, Nursing Assistant, (Rehab Staff and Administrative Supervisor if available) and document in occurrence report.
        ii. When a patient had an unwitnessed fall or hit their head during a fall, nurses must perform and document post-fall neuro assessment every 4 hours for 24 hours.

3. ~~Complete an Occurrence Report for each patient fall as appropriate to the queries in the Post Fall Huddle~~

VI. EDUCATION/TRAINING

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

VII. REFERENCES

~~A. Baechill, H., Nordman A. Bucher, H.C. & Gratzl. O. (2004). Demographics and prevalent risk factors of chronic subdural hematoma: Results of a large single-center cohort study. *Neurological Review*, 27(40, 263-266~~

~~B. Bergland, A., Wyler, T.B. (2007) Risk factors for serious fall related injury in elderly women living at home. *Injury Prevention*, 10. 308-313~~

C. ~~Fisher, L.D., Krauss, M.J., Dunagan, S.W.C., Birge, S., Hitcho, E., Johnson, S.et Al (2005). Patterns and predictors of inpatient falls and fall-related injuries in a large academic hospital. *Infection Control and Hospital Epidemiology,* 26(10, 822-827.~~

A. Agency for Healthcare Research and Quality. (2013). Tool 3N: Postfall assessment, clinical review. https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/postfall-assessment.html

B. Clinical Excellence Comission. (2023). CEC post fall guide. https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0003/258465/Post-Fall-Guide.pdf

C. Filer, W. & Harris, M. (2015). Falls and traumatic brain injury among older adults. *North Carolina Medical Journal, 76*(2), 111-114. www.ncmedicaljournal.com

D. E., Reynolds, P., Devon, R. & Exeter NHS Foundation Trust. (2015). Inpatient falls: Improving assessment, documentation, and management. BMJ Quality Improvement Reports 2015. doi: 10.1136/bmjquality.u208575.w3781

Attachments

A: Pediatric Fall Risk Assessment

B: Fall Prevention Strategies per Risk Stratification

C: Comfort and Purposeful Hourly Rounding

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	10/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Elvira Mae Delfin: Clinical Manager	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14040631**

Last Approved	N/A
Last Revised	09/2023
Next Review	1 year after approval
Owner	James Hively: Manager Environmental Health & Safety
Area	Plans and Program

Hazardous Materials & Waste Management Plan

I. SCOPE

A. Hazardous Material and Waste (HazMat) Management Plan describes the methods for handling hazardous materials and waste through risk assessment and management for the Salinas Valley Health Medical Center (SVHMC) The plan addresses the risks associated with these materials that can pose a threat to the environment, staff, patients, and visitors from the variety of hazardous substances, such as radiological, chemical, or hazardous energy sources, and to minimize the risk of harm at SVHMC. The program is designed to assure compliance with applicable codes and regulations as applied to the buildings and services at SVHMC The processes include education, procedures for safe use, storage and disposal, and management of spills or exposures.

II. OBJECTIVES/GOALS

A. **Objectives**

1. XXXXX

B. ~~The goals for the Hazmat Program are developed from information gathered during routine and special risk assessment activities, annual evaluation of the previous year's program activities, performance measures, occurrence reports and environmental tours.~~**Goals**

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

III. DEFINITIONS

A. Hazardous Material and Waste (HazMat)

B. Environment of Care Committee (EOC)

C. Safety Data Sheets (SDS)

D. Personal Protective Equipment (PPE)

E. EHS: Environmental Health & Safety

~~IV. RESPONSIBILITY~~

~~A. The EHS Manager, in collaboration with the EOC, is responsible for monitoring all aspects of the HazMat Program.~~

~~B. CT: computerized tomography~~

~~C. PET: Positive Electron Tomography~~

~~D. MRI: Magnetic Resonance Imaging~~

~~E. NM: Nuclear Medicine~~

V. PLAN MANAGEMENT

A. ~~FUNDAMENTALS~~ **Plan Elements**

1. The Scope of the hazardous materials and waste management program is determined by the materials in use and the waste generated by the hospital.
2. The hazardous materials and waste are identified in the organization's inventory and the associated hazards defined as required by law or regulation in Safety Data Sheets (SDS), guidelines, good-practice recommendations, or similar available documents.
3. Safe use of hazardous materials and handling of waste requires participation by leadership, at an organizational level and a departmental level, and other appropriate staff in the design and implementation of all parts of the plan.
4. Protection from hazards requires all staff that use or are exposed to hazardous materials and waste to be educated as to the nature of the hazards and to use equipment provided for safe use and handling when working with or around hazardous materials and waste.
5. Rapid, effective response is required in the event of a spill, release, or exposure to a hazardous materials or waste. See HAZARDOUS MATERIALS SPILL RESPONSE PROCEDURE
6. Special monitoring processes or systems may be required to manage certain hazardous gases, vapors, or radiation undetectable by humans.

B. ~~**PROCESSING FOR MANAGING THE RISK OF HAZARDOUS MATERIAL AND WASTE**~~

- ~~**Management Plan**~~

  1. ~~The organization develops and maintains the Hazardous Material and Waste Management Plan to effectively manage the risks of hazardous material and waste to the staff, visitors, and patients at Salinas Valley Memorial Hospital.~~

- ~~**Hazardous Materials and Waste Inventory**~~

1. The organization develops and maintains an inventory of hazardous materials and waste, including biological, radiological, chemotherapeutic, and chemicals. Each manager provides information on the hazardous materials and waste used, stored, or generated in that department. Inventories are received from each department and evaluated for completeness with assistance from the appropriate staff, including the Radiation Safety Officer.
2. Information identifying the hazards and emergency responses associated with these materials and wastes are available to staff, patients, and visitor at all times from such resources as Safety Data Sheets (SDS) sheets, Centers for Disease Control (CDC) Guidelines, and Nuclear Regulatory Commission (NRC) regulations. Various methods for retrieving the information are available from the internet, fax, and/or on-line severs.

- **Spills and Exposures**
    1. The EHS Manager, or designee, develops and maintains emergency procedures for the Hazardous Materials and Waste program.
    2. Salinas Valley Memorial Hospital has a procedure that evaluates spills to determine if outside assistance is necessary. A minor (incidental) spill is one that can be safely cleaned up by the staff involved, with their training and personal protective equipment. If a spill kit is used, the kit contents are replaced.
    3. A spill that exceeds the capability of the immediate staff to neutralize and clean up requires a response from outside the facility. In these cases, the area may be evacuated, ventilation controlled, and the Salinas Fire Department HAZMAT Team is called. The Salinas Fire Department takes control of the site and cleanup, or arrange for it to be cleaned up. Once determined safe, hospital staff finish the cleanup and recovery. Staff, including Environmental Services (EVS) staff, is trained to recognize the potential for a spill that is not safe to handle, and to contact their manager, and/or the Plant Operations/Engineering Department. During off-shifts, the Administrator on Duty and the Nursing Administrative Supervisor will make the determination. Staff is cautioned to err on the side of safety, and not proceed with cleanup that exceed their training knowledge, or the PPE they have available.
    4. Incidents involving spill kits, or a response from any outside agency are documented on Incident Report Forms.

- **Hazardous Chemical Risks**
    1. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous chemical materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating Safety Data Sheets for hazards before purchase of departmental supplies to assure they are appropriate, and the

least hazardous alternative practical. The department managers work with the EHS Manager and appropriate individuals to develop procedures for handling of hazardous materials. The following materials and wastes are managed:

a. Chemical materials are identified and ordered by department leadership. Appropriate storage space is maintained by each department, and reviewed as part of environmental tours in that area. Chemical materials are maintained in labeled containers, and staff is trained in understanding SDS, and in the appropriate and safe handling of the chemicals they use.

b. Chemical waste is held in the hazardous waste collection yard or generating department, until arrival of the licensed hazardous waste contractor. The contractor lab packs the chemicals, completes the manifest and removes the packaged waste. The Uniform Hazardous Waste Manifest records are maintained by Safety Office. Only authorized employees of SVHMC are permitted to sign a Uniform Hazardous Waste Manifest.

- **Radioactive Risks**

1. Salinas Valley Memorial Hospital has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous radioactive materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department managers work with the Radiation Safety Officer or Infection Prevention Manager, to develop procedures for handling of radioactive materials:

a. Radioactive material is handled subject to the Salinas Valley Memorial Hospital NRC License, and their safety is managed by the Radiation Safety Officer. Materials are handled in accordance with the requirements of the facility license.

b. Radioactive waste is held in a 'hot room' until decayed to background, then handled as the underlying hazard of the materials for disposal. The Radiation Safety Officer manages the waste and determines when it is no longer considered a radioactive hazard.

c. Radioactive deliveries are escorted to the Nuclear Med Lab by security.

- **Hazardous Energy Sources**

1. Hazardous energy sources include, but not limited to, ionizing and non-ionizing systems, and lasers will be selected and used in accordance to manufacturer's recommendation and regulatory requirements. Specific policies pertaining to operational safety and use of each hazardous energy sources are found in each department that utilizes such sources . The Department Director or a designated representative will conduct

identification and evaluation of hazardous energy sources.

2. The primary source of hazard information will be from the manufacturer and/or supplier. Engineering controls and/or work practices should be developed to reduce exposures and potential injury. All employees involved in the operation and use of hazardous energy sources will be provided with appropriate training as part of their initial orientation. Staff will follow the procedures established in the departmental policies and procedures to identify and mitigate exposure to potential risks associated with hazardous energy sources. Department leaders will maintain required documentation including applicable regulations, required permits and licenses for each hazardous energy source.

- **Hazardous Drugs**

1. Salinas Valley Memorial Hospital has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous drugs and waste from receipt or generation through use and/or final disposal

    a. Hazardous drugs and the materials used to prepare, administer, and control these materials are controlled and the waste materials collected for appropriate disposal. Staff using these materials are trained in the handling, and emergency response to spills or leaks.

    b. Chemotherapeutic residual waste is handled as part of the Regulated Medical Waste stream, with additional labeling to assure appropriate incineration as final destruction. Larger than residual volumes of chemotherapeutic waste (liquids) are handled as chemical waste.

    c. Pharmaceutical Waste is disposed of as follows:

        i. Pharmaceutical Waste placed in Blue and White Containers is sealed in the container and removed to a designated location and removed by a certified hauler.

        ii. Pharmaceuticals: R.C.R.A waste is dated and labeled and sealed in a black container, dated for removal and placed in a designated location and removed by a certified hauler.

- **Hazardous Gas & Vapor Risks**

1. The EHS Manager is responsible for managing the program for monitoring hazardous gases and vapors.

2. If a test result was above the Cal/OSHA Permissible Exposure Limit (PEL), corrective action and additional testing will be done to ensure a safe working environment.

- **Permits, Licenses, Manifests and SDS**

1. Salinas Valley Memorial Hospital has obtained and maintains permits and

licenses for handling and disposal of hazardous wastes, including chemical wastes and radioactive materials from the appropriate federal, state, and municipal agencies and safety data sheets for the chemical waste and hazardous medications waste.

2. Each shipment of hazardous waste removed from the facility is documented on a Uniform Hazardous Waste Manifest

- **Process for Labeling Hazardous Material & Waste**

1. All hazardous materials and wastes are properly labeled. Hazardous waste container labels will include the accumulation start date.

a. **Chemotherapeutic Waste:** Chemotherapeutic waste is placed into labeled containers (labeled with the OSHA and international symbol for carcinogenic wastes). These wastes are handled along with the red bag wastes. Bulk quantities of chemotherapeutic waste are handled as hazardous chemical waste.

b. **Chemical Materials and Waste:** Chemical materials are labeled throughout their use, handling, and disposal. The label is on the container prior to receipt or is placed on containers when filled or mixed within the hospital. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible. In many cases the waste is labeled by the original chemical name, in other cases, where collection containers are used, the container is labeled. These labels are required by law and the vendors of chemical disposal services to maintain the identity of the materials, and if the identity is lost, the materials are tested and analyzed to identify them for proper handling and disposal.

c. **Radioactive Materials & Waste:** Radioactive materials are labeled according to NRC, OSHA, or International agencies. Wastes are held to decay to background, when the labels are removed or covered, and wastes handled as the other hazards they may reflect. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible.

- **Reviewing CT, PET, and MRI staff dosimetry data**

1. The results of staff dosimetry monitoring for CT, PET and NM services are reviewed at least quarterly by the Radiation Safety Officer, Diagnostic Medical Physicist, or Health Physicist to assess whether staff radiation exposure levels are "As Low As Reasonably Achievable" (ALARA) and below regulatory limits

- **Managing radiation exposures**

1. The organization monitors the radiation exposures to the appropriate staff periodically. Exposure meters or radiation monitoring badges are used to monitor the radiation dose. The Radiation Safety Officer reviews the

~~results of the monitoring process and reports any concerns to the Radiation Safety Committee and the Environment of Care Committee when appropriate.~~

- ~~**Managing general waste**~~
    1. ~~SVHMCS has procedures for the proper management of general waste or "trash" generated throughout the facility. This includes the proper collection in the appropriate container, transportation of the waste to the storage or disposal site, and the prompt disposal of the waste. The Director of Environmental Services is responsibility for this process and reports and discrepancies to the Environment of Care Committee as needed.~~

- ~~**Managing regulated medical waste, including sharps**~~
    1. ~~The management of the disposal of regulated medical wastes is the responsibility of the Infection Prevention Manager with assistance from the Director of Environmental Services. The EVS staff distributes and collects appropriate containers for collection of regulated medical wastes and for medical sharps. The containers are leak proof and puncture resistant. The EVS staff collects the containers and transports them to the holding room. The appropriate staff will clean up all spills of blood or body fluids. The areas affected will be cleaned following appropriate procedures for the material involved.~~

- ~~**Evaluating the Management Plan**~~
    1. ~~On an annual basis, the EOC Committee evaluates the scope, objectives, performance, and effectiveness of the plan to manage the risks of hazardous materials and waste to the staff, visitors, and patients at Salinas Valley Memorial Hospital.~~

Plan Management

1. **PROCESSING FOR MANAGING THE RISK OF HAZARDOUS MATERIAL AND WASTE**
    a. **Management Plan**
        i. The organization develops and maintains the Hazardous Material and Waste Management Plan to effectively manage the risks of hazardous material and waste to the staff, visitors, and patients at SVHMC.

    b. **Hazardous Materials and Waste Inventory**
        i. The organization develops and maintains an inventory of hazardous materials and waste, including biological, radiological, chemotherapeutic, and chemicals. Each manager provides information on the hazardous materials and waste used, stored, or generated in that department. Inventories are received from each department and evaluated for completeness with assistance from the appropriate staff, including the Radiation Safety Officer.

ii. Information identifying the hazards and emergency responses associated with these materials and wastes are available to staff, patients, and visitor at all times from such resources as Safety Data Sheets (SDS) sheets, Centers for Disease Control (CDC) Guidelines, and Nuclear Regulatory Commission (NRC) regulations. Various methods for retrieving the information are available from the internet, fax, and/or on-line severs.

c. **Spills and Exposures**

i. The EHS Manager, or designee, develops and maintains emergency procedures for the Hazardous Materials and Waste program.

ii. SVHMC has a procedure that evaluates spills to determine if outside assistance is necessary. A minor (incidental) spill is one that can be safely cleaned up by the staff involved, with their training and personal protective equipment. If a spill kit is used, the kit contents are replaced.

iii. A spill that exceeds the capability of the immediate staff to neutralize and clean up requires a response from outside the facility. In these cases, the area may be evacuated, ventilation controlled, and the Salinas Fire Department HAZMAT Team is called. The Salinas Fire Department takes control of the site and cleanup, or arrange for it to be cleaned up. Once determined safe, hospital staff finish the cleanup and recovery. Staff, including Environmental Services (EVS) staff, is trained to recognize the potential for a spill that is not safe to handle, and to contact their manager, and/or the Plant Operations/ Engineering Department. During off-shifts, the Administrator on Duty and the Nursing Administrative Supervisor will make the determination. Staff is cautioned to err on the side of safety, and not proceed with cleanup that exceed their training knowledge, or the PPE they have available.

iv. Incidents involving spill kits, or a response from any outside agency are documented on Incident Report Forms.

d. **Hazardous Chemical Risks**

i. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous chemical materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department is responsible for evaluating Safety Data Sheets for hazards before purchase of departmental supplies to assure they are appropriate, and the least hazardous alternative practical. The department managers work with the EHS Manager and appropriate individuals to

develop procedures for handling of hazardous materials. The following materials and wastes are managed:

a. Chemical materials are identified and ordered by department leadership. Appropriate storage space is maintained by each department, and reviewed as part of environmental tours in that area. Chemical materials are maintained in labeled containers, and staff is trained in understanding SDS, and in the appropriate and safe handling of the chemicals they use.

b. Chemical waste is held in the hazardous waste collection yard or generating department, until arrival of the licensed hazardous waste contractor. The contractor lab packs the chemicals, completes the manifest and removes the packaged waste. The Uniform Hazardous Waste Manifest records are maintained by Safety Office. Only authorized employees of SVHMC are permitted to sign a Uniform Hazardous Waste Manifest.

e. **Radioactive Risks**

i. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous radioactive materials and waste from receipt or generation through use and/or final disposal. The department leadership assures their safe selection, storage, handling, use, and disposal. The department managers work with the Radiation Safety Officer or Infection Prevention Manager, to develop procedures for handling of radioactive materials:

a. Radioactive material is handled subject to the SVHMC NRC License, and their safety is managed by the Radiation Safety Officer. Materials are handled in accordance with the requirements of the facility license.

b. Radioactive waste is held in a 'hot room' until decayed to background, then handled as the underlying hazard of the materials for disposal. The Radiation Safety Officer manages the waste and determines when it is no longer considered a radioactive hazard.

c. Radioactive deliveries are escorted to the Nuclear Med Lab by security.

f. **Hazardous Energy Sources**

i. Hazardous energy sources include, but not limited to, ionizing and non-ionizing systems, and lasers will be selected and used

in accordance to manufacturer's recommendation and regulatory requirements. Specific policies pertaining to operational safety and use of each hazardous energy sources are found in each department that utilizes such sources . The Department Director or a designated representative will conduct identification and evaluation of hazardous energy sources.

ii. The primary source of hazard information will be from the manufacturer and/or supplier. Engineering controls and/or work practices should be developed to reduce exposures and potential injury. All employees involved in the operation and use of hazardous energy sources will be provided with appropriate training as part of their initial orientation. Staff will follow the procedures established in the departmental policies and procedures to identify and mitigate exposure to potential risks associated with hazardous energy sources. Department leaders will maintain required documentation including applicable regulations, required permits and licenses for each hazardous energy source.

g. **Hazardous Drugs**

i. SVHMC has established and maintains processes for identifying, selecting, handling, storing, transporting, using, and disposing of hazardous drugs and waste from receipt or generation through use and/or final disposal

a. Hazardous drugs and the materials used to prepare, administer, and control these materials are controlled and the waste materials collected for appropriate disposal. Staff using these materials are trained in the handling, and emergency response to spills or leaks.

b. Chemotherapeutic residual waste is handled as part of the Regulated Medical Waste stream, with additional labeling to assure appropriate incineration as final destruction. Larger than residual volumes of chemotherapeutic waste (liquids) are handled as chemical waste.

c. Pharmaceutical Waste is disposed of as follows:

i. Pharmaceutical Waste placed in Blue and White Containers is sealed in the container and removed to a designated location and removed by a certified hauler.

ii. Pharmaceuticals: R.C.R.A waste is dated and labeled and sealed in a black container, dated for removal and placed in a designated location and removed by a certified hauler.

h. **Hazardous Gas & Vapor Risks**

i. The EHS Manager is responsible for managing the program for monitoring hazardous gases and vapors.

ii. If a test result was above the Cal/OSHA Permissible Exposure Limit (PEL), corrective action and additional testing will be done to ensure a safe working environment.

i. **Permits, Licenses, Manifests and SDS**

i. SVHMC has obtained and maintains permits and licenses for handling and disposal of hazardous wastes, including chemical wastes and radioactive materials from the appropriate federal, state, and municipal agencies and safety data sheets for the chemical waste and hazardous medications waste.

ii. Each shipment of hazardous waste removed from the facility is documented on a Uniform Hazardous Waste Manifest

j. **Reviewing CT, PET, and MRI staff dosimetry data**

i. The results of staff dosimetry monitoring for CT, PET and NM services are reviewed at least quarterly by the Radiation Safety Officer, Diagnostic Medical Physicist, or Health Physicist to assess whether staff radiation exposure levels are "As Low As Reasonably Achievable" (ALARA) and below regulatory limits

k. **Managing radiation exposures**

i. The organization monitors the radiation exposures to the appropriate staff periodically. Exposure meters or radiation monitoring badges are used to monitor the radiation dose. The Radiation Safety Officer reviews the results of the monitoring process and reports any concerns to the Radiation Safety Committee and the Environment of Care Committee when appropriate.

l. **Managing general waste**

i. SVHMC has procedures for the proper management of general waste or "trash" generated throughout the facility. This includes the proper collection in the appropriate container, transportation of the waste to the storage or disposal site, and the prompt disposal of the waste. The Director of Environmental Services is responsibility for this process and reports and discrepancies to the Environment of Care Committee as needed.

m. **Managing regulated medical waste, including sharps**

i. The management of the disposal of regulated medical wastes is the responsibility of the Infection Prevention Manager with assistance from the Director of Environmental Services. The EVS staff distributes and collects appropriate containers for

collection of regulated medical wastes and for medical sharps. The containers are leak proof and puncture resistant. The EVS staff collects the containers and transports them to the holding room. The appropriate staff will clean up all spills of blood or body fluids. The areas affected will be cleaned following appropriate procedures for the material involved.

n. **Evaluating the Management Plan**

i. On an annual basis, the EOC Committee evaluates the scope, objectives, performance, and effectiveness of the plan to manage the risks of hazardous materials and waste to the staff, visitors, and patients at SVHMC.**Process for Labeling Hazardous Material & Waste**

2. All hazardous materials and wastes are properly labeled. Hazardous waste container labels will include the accumulation start date.

a. **Chemotherapeutic Waste:** Chemotherapeutic waste is placed into labeled containers (labeled with the OSHA and international symbol for carcinogenic wastes). These wastes are handled along with the red bag wastes. Bulk quantities of chemotherapeutic waste are handled as hazardous chemical waste.

b. **Chemical Materials and Waste:** Chemical materials are labeled throughout their use, handling, and disposal. The label is on the container prior to receipt or is placed on containers when filled or mixed within the hospital. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible. In many cases the waste is labeled by the original chemical name, in other cases, where collection containers are used, the container is labeled. These labels are required by law and the vendors of chemical disposal services to maintain the identity of the materials, and if the identity is lost, the materials are tested and analyzed to identify them for proper handling and disposal.

c. **Radioactive Materials & Waste:** Radioactive materials are labeled according to NRC, OSHA, or International agencies. Wastes are held to decay to background, when the labels are removed or covered, and wastes handled as the other hazards they may reflect. Labeling is evaluated during environmental tours, to assure the labels are maintained and legible.

C. **Plan Responsibility**

1. The EHS Manager, in collaboration with the EOC, is responsible for monitoring all aspects of the HazMat Program.

a. CT: computerized tomography

b. PET: Positive Electron Tomography

c. MRI: Magnetic Resonance Imaging

d. NM: Nuclear Medicine

D. **Performance Measurement**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Hazardous Materials Management Program. Performance measures are established to measure at least one important aspect of the Hazardous Materials Management Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.

E. **Orientation and Education**

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

~~VI. PERFORMANCE STANDARDS~~

~~A. The performance measurement process is one part of the evaluation of the effectiveness of the Hazardous Materials Management Program. Performance measures are established to measure at least one important aspect of the Hazardous Materials Management Program and are meant to focus on areas that need improvement or affect the overall safety of patient, staff, or visitors.~~

~~VII. DOCUMENTATION~~

~~A. N/A~~

~~VIII. EVIDENCE-BASED REFERENCE~~

IX. REFERENCES

A. The Joint Commission Standards, Environment of Care Chapter

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/2023
Environment of Care Committee	James Hively: Environmental Health & Safety Manager	08/2023
Policy Committees	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Policy Owner	James Hively: Environmental Health & Safety Manager	07/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13485745**

Last Approved	N/A	Owner	Carla Knight: Director Perioperative Services
Last Revised	10/2023	Area	Perioperative Services
Next Review	3 years after approval		

Nursing Record - Surgery Intraoperative

I. POLICY STATEMENT:

A. ~~The electronic Intra-operative record format is the result of collaboration by the Surgery Healthcare Management, the Information Technology Department (IT), Administration, and Salinas Valley Memorial Healthcare System's multidisciplinary Surgical Service Providers.~~

B. ~~The case record is completed by the RN's who have demonstrated skill competence to enter data through completion of training and skills checklist. Only the RN assigned to and/or relieving on a case can enter information in the Case Record. When implants are used, the Implant Record is an integral part of the Case Record. The Case Record is on file in the Electronic Medical Record System and a hard copy is retained in the patient's chart.~~

C. ~~Each circulating RN will have a password. It will not be revealed/shared. The circulating RN will be responsible for completing the Case Record. The record will reflect pertinent information, including Nursing Diagnosis, Interventions, Patient Care Goals and Evaluations of Patient Outcomes.~~

D. ~~An appointed Process Improvement (PI) review person completes case record reviews.~~

E. ~~All records will remain confidential and are only available by password to those individuals with legitimate access, reason and purpose.~~

F. ~~Hard copies of the Case Record are held for 1 month for process improvement and charge audit purposes. At the end of that time the hard copies are shredded.~~

G. ~~Process Audit:~~

1. ~~Process audits are completed.~~

a. ~~Introductory Period process audits will be initiated daily Monday through Friday. The purpose of the audit is to identify discrepancies in the case record, correct them and assist the RN with the learning process. Permanent Process Audits are done to compare the number of completed case records entered into the system with the number of cases billed. This number must be reconciled. Signed signature status is reviewed for~~

~~completion.~~

~~b. Process Improvement issues are reviewed by the PI team.~~

~~H. Purging of Records:~~

~~1. Case records for surgery patients may not be purged. Exception: Case records may be deleted from the system if the case cancels before the patient enters the OR room.~~

A. The case record is completed by the RN's who have demonstrated skill competence to enter data through completion of training and skills checklist. Only the RN assigned to and/or relieving on a case can enter information in the Case Record. When implants are used, the Implant Record is an integral part of the Case Record. The Case Record is on file in the Electronic Medical Record System and a hard copy is retained in the patient's chart.

II. PURPOSE~~:~~

A. To guide the staff in maintaining department standards for the Intra-operative Nursing Record (Case Record) data entry, record correction and process improvement activities.

III. DEFINITIONS~~:~~

A. N/A

IV. GENERAL INFORMATION~~:~~

~~A. N/A~~

A. The electronic Intra-operative record format is the result of collaboration by the Surgery Healthcare Management, the Information Technology Department (IT), Administration, and Salinas Valley Health Medical Center's (SVHMC) multidisciplinary Surgical Service Providers.

B. Each circulating RN will have a password. It will not be revealed/shared. The circulating RN will be responsible for completing the Case Record. The record will reflect pertinent information, including Nursing Diagnosis, Interventions, Patient Care Goals and Evaluations of Patient Outcomes.

C. An appointed Process Improvement (PI) review person completes case record reviews.

D. All records will remain confidential and are only available by password to those individuals with legitimate access, reason and purpose.

E. Hard copies of the Case Record are held for 1 month for process improvement and charge audit purposes. At the end of that time the hard copies are shredded.

F. Process Audit:

1. Process audits are completed.

a. Introductory Period process audits will be initiated daily Monday through Friday. The purpose of the audit is to identify discrepancies in the case record, correct them and assist the RN with the learning process. Permanent

b. Process **A**udits are done to compare the number of completed case records entered into the system with the number of cases billed. This number must be reconciled. Signed signature status is reviewed for completion.
Process Improvement issues are reviewed by the PI team.

G. Purging of Records:

1. Case records for surgery patients may not be purged. Exception: Case records may be deleted from the system if the case cancels before the patient enters the OR room.

V. PROCEDURE:

A. Accessing the computerized Case Record:

1. The circulating nurse will log into the electronic case record using their mneumonic and password, and electronically sign the Case Record using his/her password prior to logging out of the system.

B. Change of Personnel:

1. The assigned circulating RN will electronically sign the Case Record and log out of the system using the<lock case record> feature. The relief circulating RN will log in at the prompt.

C. Inclusion in record:

1. Personnel who are involved in the direct patient care and their relief replacements are included in the Case Record.

D. Implant Information:

1. The circulating RN will electronically record implants in the implant section of the case record.

E. Computer System Downtime:

1. In the event of a computer system failure and/or scheduled maintenance downtime of the electronic record system, the RN will use the handwritten case record form #7020-6029 and the Implant Record form 7020-015685 if applicable. The handwritten record will be the legal document on the patient chart. The information in the handwritten record will be transferred to the case record for statistical and billing purposes, within one (1) working day, excluding weekends and holidays, of the system coming back on line.

a. The circulating RN will input the record into the system or in his/her absence, an authorized person will perform this duty. After the handwritten case record is entered into the case record, documentation will be made in the comments section. These entries are for statistical purposes only.

F. Audit Trail:

1. An audit trail of entries in the case record is established when a designated RN opens and saves all scheduled and add-on cases.

G. Record Correction:

1. An audit trail of entries including corrections is maintained within the system. Corrected case records may replace the original record in a patient's chart no later than twenty four (24) hours following a surgical procedure. No exceptions will be made to this requirement. When twenty four (24) hours have elapsed, the corrected record will be included in the patient's chart to augment the original record. This record will be listed as an addendum to the original record already on the chart. Changes that affect charges are made within one (1) working day excluding weekends and holidays.

H. Documentation:

1. The Intra Operative Case Record and the Implant Record Reports for Quality management are gleaned from information documented within the Intra Operative Case Record for statistical and quality assurance purposes.

VI. EDUCATION/TRAINING:

~~A. Education is provided during general or department-specific orientation and periodically as practice or policy changes.~~

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

VII. REFERENCES:

A. AORN. (~~2008~~2023). Perioperative Standards and Recommended Practices. Documentation of Perioperative Nursing Care, ~~(section 3.06).~~ Association of Operating Room Nurses.

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	10/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Carla Knight: Director Perioperative Services	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **12993822**

Last Approved	N/A	Owner	Bhargavi Simhadri: Director Clinical Operations
Last Revised	10/2023		
Next Review	3 years after approval	Area	Patient Care

Patient Safety Attendant Guidelines

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To outline the process for determining the need for a Patient Safety Attendant to support safe patient care for an individual patient or patient condition. To provide an accountability process for assessment, implementation and discontinuation of the use of a Patient Safety Attendant.

III. DEFINITIONS:

A. "Psych" means related to the care of a psychiatric condition, suicidal ideations or state-required observations.

B. "Non – psych" means related to the care of non-psychiatric conditions, interference with medical care, confusion or the inability to follow instructions.

C. "Elopement" occurs when a patient is aware that he or she is not permitted to leave but proceeds to do so, this includes patients who may not actually leave the hospital grounds. The patient lacks decisional capacity as they may be confused, disoriented, combative and agitated and are unable to make informed decisions for their management and safety.

D. ADL – Activities of Daily Living

E. AS – Administrative Supervisor

F. ***PSVM - Patient Safety Video Monitoring - see procedure***

IV. GENERAL INFORMATION:

A. ~~SVMH recognizes~~Salinas Valley Health Medical Center (SVHMC) Crecognizes that Patient Safety Attendants (PSA) may be needed in order to provide safe patient care. The Hospital will use a standardized; criteria based approach for determining the appropriate use and on-going

evaluation of a PSA. The Hospital will monitor PSA usage to ensure appropriate assignment and management of resources and ensure the PSA and the patient are in a safe environment.

V. PROCEDURE:

A. ~~Assessment of PSA Usage:~~

1. ~~The nurse assesses the patient's physical condition, behaviors, and emotional status to determine if constant observation of the patient is needed to ensure the patient's safety.~~
2. ~~The nurse assesses for the following criteria/risk factors to determine the need for a PSA:~~
    a. ~~Suicide precautions and/or state-required observations.~~
    b. ~~Danger to self:~~
        i. ~~Interference with the vital medical devices.~~
3. ~~Cannot follow safety instructions, (getting out of bed without notifying staff etc.)~~
4. ~~Interference with medical care (including interference with non-vital medical devices such as NG tubes, feeding tubes, Foley catheters, IV catheters etc.)~~
    a. ~~Danger to others:~~
        i. ~~Severe behavioral or cognitive issues (impaired judgment, disorientation, confusion, agitation, impulsivity etc.).~~
        ii. ~~Wandering or at risk for elopement.~~
        iii. ~~Combative behaviors.~~
5. ~~The use of a PSA for non-suicidal observations should only be considered in the event that no other feasible alternative provides a solution. Some alternative options are:~~
    a. ~~Conduct hourly rounds consistently or more frequently if needed.~~
    b. ~~Relocate patient closer to the nursing station to provide more frequent observation of patient by nursing staff.~~
    c. ~~Provide bed/chair alarm and activate.~~
    d. ~~Re-orient frequently and employ distraction techniques.~~
    e. ~~Discuss appropriate alternative with the physician including review of medications, electrolytes, and gases as a reversible cause of confusion and disorientation.~~
    f. ~~Cohort patients with one PSA as appropriate.~~
6. ~~Nursing Director/designee should be contacted if the RN determines the patient meets criteria for a PSA prior to referral to the AS.~~

Assessment of PSA Usage:

1. ***The nurse assesses the patients risk for injury including the following:***

a. ***CNS disorders***

b. ***Sensory Impairments***

c. ***Psychiatric disorders***

d. ***Wandering or frequent attempts to get out of bed without successful redirection***

e. ***Delirium/Dementia***

f. ***ETOH or other substance withdrawal***

g. ***High risk fall (defined as failed fall precautions on current admission)***

2. ***The nurse utilizes the safety interventions listed on the PSA Checklist. These include:***

    a. ***Evaluation of physical causes***

    b. ***Evaluation of medication management including the need for addition or removal of medications***

    c. ***Locating the patient closer to the nurse's station***

    d. ***Requesting the family to stay with the patient for purposes of redirection or to alert staff to patient need***

    e. ***Ensuring staff awareness of need for frequent observation and rounding (q 30 minutes)***

    f. ***Reducing excessive sensory stimulation***

    g. ***Utilization of diversion activities***

    h. ***Assigning consistent caregivers***

    i. ***Utilization of bed or chair alarms***

3. ***If the patient safety interventions are not effective a trial of Patient Safety Video Monitoring (PSVM) will be implemented for a 2 hour period to assess effectiveness.***

4. ***If the PSVM trial is effective, it will continue to be utilized according to policy***

5. ***If the PSVM trial is not effective or a unit is not available, the need for the PSA will be communicated to the charge nurse who will ensure that the steps in the checklist have been followed.***

6. Nursing Director/designee should be contacted if the RN determines the patient meets criteria for a PSA prior to referral to the AS.

B. Requesting a Patient Safety Attendant

1. A Physician order is not required.
2. Staffing Office is not authorized to provide a PSA without Administrative Supervisor direction.
3. Director/designee will review all requests and or provide recommendations for continued safe patient care.
4. ***Staff and charge nurses will continue to assess need every 4 hours and document on***

the PSA checklist.

C. Assigning a Patient Safety Attendant

1. Consider the following:
    a. The Charge Nurse will notify the AS of the assessment and the need to assign a PSA. ***Two patients can be cohorted with one PSA as clinically appropriate.***
    b. Director/designee will attempt to staff the PSA with an existing team member from the unit.
    c. The staffing office will attempt to fill the need in the following order:
        i. Scheduled staff from other units.
        ii. Overtime staff from unit or another unit (Director approval required).
        iii. Staff from other Clinical Job Classifications (Nursing Assistant or RN will oversee clinical care).

D. ~~Oversite~~**Oversight** of the Patient Safety Attendant

1. The RN assigned to the patient remains responsible for the nursing care throughout the shift regardless of the presence of a PSA. Other caregivers will also continue to provide care as indicated by the patient's needs. ADL's and documentation of patient care will be documented by the PSA if role is assigned to a nursing assistant.
2. The RN assigned to the patient will document the assessments and observations relative to the continued need for increased observation in the medical record.
3. The Director/designee will round daily with the Charge Nurse on all patients with PSA assignments to assess and determine the continued need for the PSA.
4. Charge Nurses will report assessment and need to continued PSA assignment at AS huddles.
5. The RN will provide report to the PSA at the beginning of each shift to include reason for observations, precautions, level of awareness, communication status, mobility, dietary restrictions, toileting status, safety concerns, and status for visitors and if patient exhibits combative behaviors.
6. The PSA will document patient observations in the electronic medical record.

E. Discontinuation of PSAs

1. The nurse assesses for the following criteria/risk factors for discontinuing PSA assignment:
    a. No longer on suicide precautions and/or state-required observation.
    b. No longer a danger to self (including no interference with vital medical devices), no danger to others, or no severe behavioral or cognitive issues.
    c. Able to follow safety instructions.
    d. No longer interfering with medical care.

e. Not wandering, not at risk for elopement.

f. Alternatives to PSA use implemented and effective.

F. Monitoring/Tracking of PSAs

1. PSA will be coded in the electronic staffing schedule.
2. PSA will be assigned to cost centers to track hours and cost.
3. PSA hours will be tracked each shift to include unit & hours.
4. ~~The Nursing Administration will send biweekly reports to assess PSA use.~~

VI. EDUCATION/TRAINING~~:~~

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

VII. REFERENCES~~:~~

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Owner	Bhargavi Simhadri: Director Clinical Operations	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14568327**

Last Approved	N/A
Last Revised	10/2023
Next Review	3 years after approval
Owner	Lea Woodrow: Director Accreditation and Regulatory Compliance
Area	Administration

Policy and Procedure Management

I. POLICY STATEMENT:

A. Salinas Valley Health Medical Center (SVHMC) shall establish and adopt written administrative and patient care policies and procedures as needed to be compliant with applicable statues, regulations, and accrediting agencies. The policies shall reflect the mission, ethics, and commitment to excellence in the provision of patient care and support SVHMC's strategic plan and business operations.

B. Policies are reviewed ~~and approved~~ by the appropriate ~~senior~~leaders, executives ~~and~~, the Board and as applicable the medical staff ~~leadership, as needed, and~~ at least every three years or as otherwise determined by state, federal and other local codes and regulations. Procedures are reviewed and approved by the responsible Department Leader and the Board of Directors~~. Procedures are reviewed and approved by the responsible Executive leader and the Board of Directors~~ as required by California law.

C. Leadership, including medical staff, is responsible and accountable for the development, approval and maintenance of policies as required and appropriate for clinical practice, business and department operations in accordance with this policy. Individuals involved in developing, reviewing/revising and distributing policies shall comply with procedures in this document.

D. Policies, Procedures and Protocols will be on ~~approved~~the defined templates and titled to facilitate search capabilities.

II. PURPOSE:

A. To guide the process in which SVHMC will develop, implement, maintain, archive and track organization-wide policies and procedures.

III. DEFINITIONS:

A. **Approval** - Official acceptance through process, inclusive of leadership and medical staff involvement as appropriate, that accepts a document for implementation.

B. **Committee Facilitator** - Designated individual responsible for administering a clinical or administrative committee. Facilitates the review and endorsement of draft policies by the committee. Responsible for communicating revisions to "owners" or endorsements to the Accreditation and Regulatory Manager.

C. **DCA** – Document Control Administrator – individual(s) in the Regulatory and Accreditation Division that oversees the Policy Management System.

D. **Department-Specific Policies** - Policies that govern only one department.

E. **Effective Date** - Reflects the date the document took effect and identifies when a document will be slated for its review.

F. **Employee** - All individuals taking part in a service of SVHMC.

G. **Endorsement** - Validation, sanction or support of a policy by a workgroup committee. Endorsement indicates recommended approval for implementation.

H. **Interdepartmental Policies** - Policies that govern more than one department or discipline. These policies and procedures require the owner to identify ~~writers~~individuals for collaboration who are content experts.

I. **Owner** - Designated leader accountable for policy development related to a specific policy need. For policies that apply to the entire organization in an Administrative or Clinical capacity, this individual is considered the policy champion and is responsible for supporting the policy development process and facilitating the drafting and editing process. ~~In conjunction with the policy owner, medical staff with appropriate training in the PMSS may be designated as a writer of hospital wide policies and procedures for submission to the policy committee for review.~~

J. **Plan** - Written narrative describing a program, function, or structure that directs planning and operations of the organization. Components include scope, objectives, performance and evaluation. Plans require approval process equivalent to policy.

K. **PMSS** – Policy Management Software System

L. **Policy Committee** - the committee defined by the organization to oversee the PMSS and all processes.

M. **Policy** - ~~Organizations definitive~~Definitive method or manner of proceeding in a specified course of action. Brief written statement that defines authority, responsibility and limitations for various persons or entities that explains what activities are or are not allowed or must be completed to accomplish the goal. High level statements of concept, requirement or expectation. Generally, a policy is based on law, legal code, regulations, standards, or a leadership declared course of action. A clinical or patient care policy may be identified as a standard, technical, operational or clinical practice. It does not outline steps or the process and must meet one of the following: global statement involving culture, essential framework for function, quality or safety, labor or management, regulatory or financial.

    1. For purposes of this document, the term Policy will include: Policies, Standardized

Procedures, Scope of Care or Service and Plans and the term Procedure will include Procedures, Protocols and Guidelines. Additionally, where the term Policy is stated, it will reference both policies and/or procedures (PP).

N. **Procedure/Guideline** - ~~Detailed~~Recommended steps to accomplish ~~specific~~ tasks necessary to perform ~~specific~~ operations to implement the ~~policy~~process that achieve compliance with applicable ~~standard or policy~~standards. The portion ~~of a policy~~ that states the general, not mandated, process that will be performed to accomplish a goal or achieve compliance with a standard or policy and describes the process steps rather than the care.

O. **Protocol** - the description of a clinical process to delineate the minimum standard of care for a patient or specific population, either for general care purposes or for specific disease processes or condition, and/or a step-by-step instruction to guide a clinical procedure on a patient. These include medical orders, clinical practice processes and nursing skills such as found in ~~Lippincott or other~~ related textbooks and requires formal approval by the clinical and/or medical staff departments.

P. ~~**Proxy Author** – an individual assigned by the document owner to have authority for development and/or revision a document.~~

Q. **Review** - formal process for examination of document contents. A review indicates there are no substantial policy/procedure content changes. Examples include typographical errors, clarifying language to make intent clearer to the end user, adding or deleting cross references. Review of policies must take place at least tri-annually regardless of change to content or more often as dictated by regulations.

R. **Revision** - Formal process ~~for examination~~ that results in change to content, and/or practice that will result in the need for approvals and staff education. Examples of revisions include adding or removing policy or procedure points, definitions, responsibilities. Requires approval through the committees as defined in the template and/or Policy Committee.

S. **Standardized Procedure- As defined by Title 22**: Applies only to the function of Registered Nurses (RN) that sometimes overlap with medical staff and that the RN can perform when established requirements are met. **As defined by the Board of Registered Nursing**: Authorized performance of a medical function that is developed through collaboration of RN, physicians, and administrators in the health system in which it is to be used. A standardized procedure requires medical Staff Interdisciplinary Committee review and approval at least every three years.

T. **Scope of Care and Service** - Description of scope of practice, organizational structure, criteria for admission/discharge, staffing plan and qualifications, educational programs and department goals and performance improvement.

U. **Supersedes** - Indicates documents that have been replaced and retired.

V. **Title** - Identifies the type of policy. The title will be written in a format that facilitates document search. The first word of the title should be a noun or the primary subject, i.e. "Security, VIP" or "Latex-Safe Environment".

IV. GENERAL INFORMATION:

A. ~~For purposes of this document, the term Policy will include: Policies, Standardized Procedures, Scope of Care or Service and Plans and the term Procedure will include Procedures, Protocols~~

and Guidelines. Additionally, where the term Policy is stated, it will reference both policies and procedures (PP).

B. SVHMC will adopt Standardized Procedures in accordance with California law. Standardized procedures will be developed collaboratively by nursing, medical staff, and administration.

C. SVHMC may adopt procedures/ to outline the minimum standard of care for a patient.

D. SVHMC will adopt written Plans when appropriate to support business functions. These plans will describe a function, structure or program that directs the planning and operations of the organization.

E. SVHMC policies will be accessible to all employees via the PMSS. The software will be utilized to facilitate the development, review and approval process as well as archive old versions of policies.

F. Standard policy identification will be utilized to facilitate categorizing and access by users.

V. PROCEDURE:

A. **Development / Revision of Policies / Procedures**

1. Department heads (hereafter "Owners") with expertise and/or authority for individual policies are responsible for initiating new or revising policies. The document owner may designate a proxy author but remains the ultimate responsible person for the document from creation through approval. Generally, Department Managers are Owners for Procedures and Directors are Owners for Policy.
2. Development / Revision Criteria: PP development will be guided by the following criterialcriteria as appropriate to the nature of the PP:
    a. Legal, regulatory and accreditation requirements.
    b. Needs and expectations of patients, staff and others and employees.
    c. Results and performance improvement activities.
    d. Information about potential risks to patients when available.
    e. Evidence-based practice or scientific knowledge.
    f. Information about sentinel events.
    g. Assessment of policy application to patient safety goals.
    h. Ethical evaluation, (professional, clinical, business).
3. Development/Revision Process may include:
    a. Collaboration with appropriate disciplines/departments as appropriate to maximize standardization of best practice as well as minimize operational impact, and/or conflicting practices and understandings.
    b. Establishment of an appropriate workgroup or review by standing committee.
    c. Identification of legal and regulatory references appropriate to the nature of the policy.
    d. Maximum of 5 references within the last 5 years (or most recent).

4. Revisions to existing policies may take place during the ~~annual or triannual~~ review process or as required by changing regulations or business need. Policy Owners will be notified via the PMSS software of the review date four months prior to the expiration of the current policy.
5. ~~If a revision is necessary, the Owner will draft or edit documents in the PMSS and "submit to writers" (as applicable) and then "submit for review" to the Policy Committee. Policies that have been revised will be submitted with tracked changes.~~If a revision is necessary any leader may edit documents in the PMSS and "Start Approvals". If edits are initiated by anyone other than the document Owner, the Owner is responsible to review it and "Start Approvals" process. The PMSS automatically tracks changes in the system.

B. **Policy Review**

1. Policies and Procedures will be reviewed every three years or as required by law and regulations. Plans and Scopes of Practice/Service will be reviewed annually. The calendar will re-set after each review or revision and approval. Policy owners ~~may~~will be prompted by the PMSS of upcoming policy review dates. A report of policies overdue for revision will be made available to administration at least quarterly or as requested.
    a. Owners will review policies to determine the need for revisions or edits. If no content changes are recommended then the Owner will ~~mark the document~~change the approval work flow to "No Revision Necessary" and the document will remain as is. The updated review date will then be reset in the PMSS. These policies will be managed by the Policy Committee and not be routed through the formal approval process.
    b. If minor change(s) are necessary but do not result in a change in policy, practice or requires education of staff, the owner may contact the ~~DCA~~PMSS Administrator and these changes may be made in "~~current state~~Override". The Owner will then click on the "No Revision Necessary". The updated review date will then be reset in the PMSS. These policies will be managed by the Policy Committee and not be routed through the formal approval process.
    c. ~~If the Owner determines that a revision is required, the Owner will "Create New Version" and edit in *tracked changes* and submit through the approval process.~~If the Owner determines that a revision is required, the Owner will "Edit" and "Start Approvals". The Policy Committee may override the owner's defined template/approval flow to assure all policies are approved by all persons/divisions involved in the process.
        i. Department Specific - The Department leader is responsible to assure their polices are current at all times and reflect the department processes/pratices.
        ii. Patient Care - The Owner is responsible for obtaining review by other disciplines responsible as outlined in the policy. This can be done utilizing the "Comments" section. Changes made by all persons is automatically tracked in the system negating the

need for tracked changes. All changes are routed to the owner who has the responsibility to accept or deny changes and "Start Approvals".

iii. Administrative - The Owner is responsible to review and/or update the policy as needed to meet the organizations defined requirements.

C. **Retiring a Policy**

a. Policies that have become obsolete may be retired within the PMSS software once endorsed by the Policy Committee. Policies may be retired for reasons including but not limited to:

i. Regulatory changes

ii. Combination with another policy

iii. Structural changes within the medical center

D. **Policy Assessment & Endorsement**

1. The assessment and endorsement process will be the same for new policies and for revisions to existing policies. Assessment and endorsement of the documents prepares policies for the formal approval.

a. **Policy Owner**- Reviews assigned policies and assures completion of the required review prior to the deadline. Reviews the policy for conflicting information with other policies, duplicate policies and assures all ~~writers~~collaborators, departmental, medical staff, other departments, etc., are involved as necessary. ~~Submits policies to the Policy Committee by selecting "submit for review" in the PMSS software.~~

b. **Policy Committee**- The Accreditation and Regulatory ~~division~~Department designates members of the policy committee. The committee will review the draft document for regulatory citations, appropriate template, and readability and define the approval flow. The committee will evaluate any conflicts and if there are recommended edits; the policy may be referred back to the owner for editing or presentation to the committee by the owner for clarification. If no edits are required, the policy will move to the next step in the ~~review~~approval process.

c. **Committee Endorsement -** The Policy Committee will forward policies to clinical or administrative committees for review based on the content and requirements of the policy. Committee facilitators will take policies to designated committee for review ~~and/or comment~~ when assigned by the PMSS. ~~The~~If the committee has recommended changes the facilitator will ~~enter~~add the recommended ~~edits to~~language in the "Comments" which notifies the owner and the PMSS DCA who will update the policy ~~in the discussion board, which will then be routed back to the owner~~and continue the approval process.

d. ~~The policy owner is responsible to route their documents to the next level for review.~~

E. **Policy Approval**

1. The policy approval process includes steps as dictated by the content of the policy. The Policy Committee assumes the responsibility of assuring that policies are approved by the appropriate party.

    a. **Provisional (Implementation) Approval**

        i. The Operating Board of Directors has authorized the Chief Executive Officer (CEO), or designee, provisional approval rights to allow for implementation of policies before formal approval by the Operating Board of Directors. The CEO has delegated ~~the~~ Executive ~~Leadership Group~~Alignment (~~ELG~~EA) as the approving ~~bodies~~body for administrative policies ~~and the~~, department ~~Chief~~executive for department/patient care policies and the department director for department specific procedures.

        ii. The Medical Executive Committee has designated medical staff committees as approving bodies for policies and procedures that affect medical staff.

        iii. Policies granted provisional approval are posted in the PMSS software as approved pending formal approval by the SVHMC Operating Board of Directors.

    b. **Expedited Approval**

        i. The Expedited approval process will be utilized when circumstances require immediate changes to processes pertinent to patient care due to compliance, regulatory or accreditation requirements. Policy Owners, under the direction of the Accreditation and Regulatory ~~Manger~~Manager, may execute an expedited approval by facilitating the review of the document by the appropriate department chair and/or Medical Director as applicable. The Accreditation and Regulatory Manager will facilitate the approval process through the appropriate ~~Executive~~executive leader, CEO or designee and ~~Medical~~/or Chief of Staff as appropriate for content of the document. The Accreditation and Regulatory manager will post the approved document in the PMSS as approved and create a second version to travel through the standard review/approval process.

F. **Policy Implementation**

1. Policies become effective on the approval date or as otherwise identified by the approving body as defined above. Alternate effective dates may be established based on implementation or staff education requirements.
2. A specific policy education plan may be developed as determined by the need for training and competency validation on new or high risk practice. The policy owner or designee will facilitate the education process with leadership and medical staff as applicable to the policy document.

G. **Policy Management**

1. **Policy Administration** – The Accreditation and Regulatory Manager maintains the library of all current documents approved for implementation as well as archived documents using the PMSS. Key responsibilities of the Accreditation and Regulatory Manager include:
    a. Maintenance of policy templates to include Policies, Procedures, Standardized Procedures, Protocols, and Plans.
    b. ~~Notification of leadership when policies are approved.~~
    c. Maintenance of all users and permissions in the policy software. ~~Monitoring the annual and tri-annual review process.~~
    d. Monitoring the annual and tri-annual review process.
    e. Chair of the Policy Committee.

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. The Joint Commission (TJC)
B. Title 22
C. CMS Conditions of Participation

Attachments

A: Process

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023

Policy Owner	Lea Woodrow: Director of Accreditation and Regulatory Complianc	10/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14574823

Last Approved	N/A	Owner	Stephanie Frizzell: Manager Education
Last Revised	10/2023	Area	Education
Next Review	3 years after approval		

Preceptor

I. POLICY STATEMENT

~~A. The Department Director/Manager is responsible to select and assign a primary and secondary preceptor for every new hire or student. In the event that a department/unit does not have a preceptor available, the Clinical Manager will coordinate the orientation program.~~

A. N/A

II. PURPOSE

A. To guide the staff regarding the use of preceptors in the orientation of students from affiliated schools and/or new hires to Salinas Valley ~~Memorial Healthcare System~~Health Medical Center (SVHMC).

III. DEFINITIONS

A. Preceptor: Qualified employee who serves as a teacher or instructor for new graduate and transition of practice nurses, students or new hires

B. Orientee: New hire or student from an affiliated school who needs training for specific role and job function

C. New Graduate Nurse: A nurse that has graduated from an accredited school (associate's degree, bachelor's degree, or master's degree) with less than 12 months experience.

D. Transitions of Practice Nurse: A nurse transitioning into a specialty area without prior specialty experience.

E. Stage 1: Novice – These are beginners who have had no experience of the situations in which they are expected to perform. For example, a newly graduate professional with less than one year of work experience or is new to a clinical area or practice.

F. Stage 2: Advanced Beginner - Those who can demonstrate marginally acceptable performance, those who have coped with enough real situations to note, or to have pointed out

to them the recurring meaningful situational components. At this phase, the orientee demonstrates concrete thinking and focuses on individual aspects of role instead of the holistic situation.

G. Stage 3: Competent – Competence typified for those who have been on the job in the same or similar situations two or three years, develops when the orientee begins to see his or her actions in terms of long-range goals or plans of which he or she is consciously aware. At this phase, the orientee enters the competent stage during which an expanded knowledge base and increased ability to act independently is demonstrated.

H. Stage 4: Proficient – The proficient performer perceives situations as wholes rather than segmented parts or aspects, and enters the proficient stage of development after about five years of experience in the same area of practice. At this level, the orientee demonstrates independence with sound decision making processes and serves as a resource to other staff.

I. Stage 5: Expert – The expert performer no longer relies on an analytic principle (rule, guideline) to connect her or his understanding of the situation to an appropriate action. After seven to ten years of work experience in same area of practice, the orientee may demonstrate the expert level of professional performance by intuitively carrying out duties and role based on extensive experience.

IV. GENERAL INFORMATION

A. The Department Director/Manager is responsible to select and assign a primary and secondary preceptor for every new hire or student. In the event that a department/unit does not have a preceptor available, the Clinical Manager will coordinate the orientation program.

B. Preceptor selection

1. To be considered for an assignment as preceptor, an employee must have been employed by the hospital for a period of six (6) months, and shall have at least two (2) years of satisfactory experience and demonstrated current competency in the department to which the orientee is assigned.
2. Qualified employees who are to be designated preceptors for new hires will attend a hospital provided preceptor training program. Preceptorship is conducted in accordance with each department's established standards of practice, and reviewed by Director/Manager and Education department in collaboration with the Unit Practice Council, if present. The Director/Manager may designate a staff to be a preceptor for a student, without the pre-requisite preceptor class, based on department needs and the number of students assigned at a given time.

C. Preceptor assignments

1. Preceptor assignments will be rotated among the unit preceptors to equalize the responsibility of orientation, i.e. if the department has more than one qualified preceptor.
2. When assigned to perform preceptor duties, the preceptor and the orientee will work a shared assignment. For nursing department, only one of the nursing pair will be counted in the staffing matrix.
3. The orientee is assigned duties as determined by the preceptor and manager,

mutually agreed upon by both the orientee and preceptor and/or manager.

4. Floating assignments for preceptors who have an orientee is minimized when possible, and when unavoidable, a case-by-case determination is made by the director/manager/shift-leader whether the orientee will accompany the preceptor, or will be re-assigned to another preceptor who is remaining on the home unit.

D. Preceptor and orientee scheduling

1. The orientee is assigned to the primary preceptor's schedule as much as possible, for a seamless clinical orientation. If the primary preceptor is scheduled off, the secondary preceptor assumes responsibility to orient the new staff member.

E. Preceptor eligibility differential

1. The RN preceptor enters into a voluntary agreement with ~~Salinas Valley Memorial Healthcare System~~SVHMC to receive a pay differential when participating in the development of new graduates and/or transition of practice of RN's transferring to a new clinical department where extensive training is needed.
2. The Preceptor agreement is contingent upon the applicant having a minimum of (2) years of experience. Nurses with 2 years of experience must all be in the current specialty area to precept, nurses with 3 or more years of experience must have at least 1 year experience in the current specialty area to precept. Under certain circumstances, the Director and Education will discuss granting individuals who do not meet years of experience requirement but meet all other eligibility requirements preceptor differential.
3. The applicant's job performance must meet or exceed expectations. The applicant may not have any active disciplinary action.
4. The applicant is required to complete the Preceptor Workshop Course within the past two years.
5. Upon approval of the Preceptor Agreement, the applicant will be provided access to the Preceptor Clocking Code. It is the responsibility of the preceptor to clock in using the Preceptor Clocking Code.

F. The applicant acknowledges that no further differential will be paid by ~~Salinas Valley Memorial Healthcare System~~SVHMC if the employee fails to meet the criteria set forth and agreed upon by the Preceptor Policy and the Preceptor Agreement.

G. Preceptor Evaluation

1. The RN will be evaluated in their role as a preceptor in the practice care area on a continual basis and at a minimum annually.

V. PROCEDURE

A. Human Resources department notifies the Education Department of new hires beginning each pay period, and transitions of practice RNs upon release of previous employment. Student list for approved clinical rotation is provided by the affiliated school and communicated to the Student Liaison from the Education Department.

B. The Student Liaison/designee from the Education Department communicate with the

respective Department Director/Manager for specific preceptor selection.

C. The Department Director/Manager communicates assignment to the preceptor, the new hire, the Staffing Office and the Education Department prior to the new hire or student rotation start date.

D. The Benner's Novice to Expert Model is utilized as conceptual framework for the orientee's preceptorship program.

E. Written orientation skills checklist is available for preceptors and orientee's to use in accomplishing the department orientation. This checklist is developed by the Education Department in collaboration with the Department Director/Manager.

F. Each department may have a pre-determined time line for completion of orientation and this time line may be adjusted at the discretion of the Department Director/Manager in collaboration with the Clinical Educator, working with the preceptor and orientee.

G. The preceptor communicates orientation progress with the Department Director/Manager and Clinical Educator as assigned.

H. The orientee is responsible for completing the orientation competency checklist while the preceptor, Clinical Educator, and Department Director/Manager's job is to assist, guide, and to evaluate.

I. At the end of the clinical orientation, the orientation competency checklist is completed and signed by the employee and preceptor, and returned to the Department Director/Manager for signature.

J. The Department Director/Manager ensures that the completed orientation checklist is included in employee files.

K. Documentation:

1. Orientation is documented using the Department Specific Orientation Skills Checklist.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Benner, P. From novice to expert: Excellence and power in clinical nursing practice. Upper Saddle River, NJ: Prentice-Hall.

B. Nurse Preceptor Academy, Michigan Center for Nursing. Retrieved from Http://michigancenterfornursing.org/education/preceptor-tool-kit.

Approval Signatures

Step Description	Approver	Date

Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Stephanie Frizzell: Education Manager	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14343717**

Last Approved	N/A	Owner	Lorrie Oelkers: Director Internal Audit & Compliance
Last Revised	09/2023		
Next Review	3 years after approval	Area	Administration

Sale, Purchase, and Lease of District Real Property

I. POLICY STATEMENT

A. It is the policy of Salinas Valley Health (SVH) to ensure compliance with all Federal, State, and local laws concerning district real property ownership, leasing, and management, including Division 23 of the Health and Safety Code of the State of California ("Local Health Care District Law").

II. PURPOSE

A. The purpose of this policy is to ensure that all Real Property Transactions undertaken by SVH are in compliance with Local Health Care District Law, applicable state and federal laws, and this Policy and Procedure.

B. This Policy standardizes the process and procedures for the determination the following:

1. The evaluation and selection of District Real Property to be involved in a Real Property Transaction;
2. The selection of real estate brokerages ("Brokers") to be engaged by SVH;
3. The sale, purchase, or lease term and conditions for District Real Property; and
4. The processes to be used by SVH' executive management and administration (collectively, "Administration") in connection with a Real Property Transaction of District Real Property.

III. DEFINITIONS

A. "Real Property" means land together with all the property on it that cannot be moved, together with any attached right.

B. "Fair Market Value" means the price that an interested but not desperate buyer would be willing to pay and an interested but not desperate seller would be willing to accept on the open market assuming a reasonable period of time for an agreement to arise.

C. "Market Rental Rate" means the rental income that a landlord could most likely ask for a property in the open market, indicated by the current rents for comparable spaces.

D. "Open Market" means a market which is widely accessible to all investors or consumers.

IV. GENERAL INFORMATION

A. Local Health Care District Law grants the SVH Board of Directors ("Board" or "Board of Directors") the power to purchase, receive, have, take hold, lease, use, and enjoy property of every kind and description within and without the limits of the District) and to control, dispose of, convey, and encumber the same and create a leasehold interest in the same for the benefit of the District (collectively, "Real Property Transactions")..

B. As a Local Health Care District, SVH is subject to certain legal requirements in connection with the use and expenditures of public funds Real Property Transactions, in for leasing of real estate. Principal among these is the California Constitution's prohibition against the gifting of public funds pursuant to Article XVI, Section 6 of the California Constitution.

C. Administration shall not have the authority to enter into any agreement to list District Real Property for sale unless such listing has been reviewed and permitted in advance by the Board of Directors or a Committee of the Board.

D. It is the policy of SVH that Administration shall discuss the sale of any District Real Property completely and fully with the entire Board of Directors to permit the Board the ability to meet their fiduciary duty to the residents of the District.

E. SVH shall not sell any District Real Property unless the sales price and terms are supported as being consistent with fair market value pursuant to an independent opinion from a certified licensed real-estate professional completed no less than eighteen (18) months prior to the proposed sales date.

F. Contracts and engagements between SVH and Brokers will establish commission fees for services provided based consistent with fair market value.

G. Situations in which the District leases District Real Property to third parties for less than fair market value may constitute a gift of public funds in the amount of the difference between the lease rate and the fair market rental value of the property. In such cases, documentation should be provided to justify the below market lease rate.

H. In situations where District Real Property is leased to local health care providers, Stark Law requirements and Anti-Kickback regulations must be considered.

V. PROCEDURE

A. Sales of Real Property

1. Administration shall select duly qualified Brokers familiar with the local real property market pursuant to SVH' Policies and Procedures. Any Broker retained by Administration to list District Real Property for sale shall also be subject to the SVH's Conflict of Interest Policy.

2. Sales of District Real Property must be supported by an opinion from a certified licensed real estate professional. This opinion of Fair Market Value, shall be used as a basis for negotiations of the Real Property Transaction.

3. Upon receipt of an offer to purchase District Real Property by a third-party, the offer shall be initially delivered to Administration for review. Administration shall review the offer for completeness. However, if by the terms of the offer, the period to reply is within the period of a regular meeting of the Board of Directors, Administration shall present the material terms and conditions of the offer to the Board of Directors for consideration with a recommendation.
4. Any offer, acceptance of offer, or counter-offer pertaining to the sale or purchase of District Real Property shall include a provision requiring and shall be contingent upon the approval of the definitive terms and conditions for sales and purchase agreement by the SVH Board of Directors.

B. Purchase of Real Property
    1. Purchase of District Real Property must be supported as being consistent with fair market value by an independent opinion from a certified licensed real-estate professional. The Board has discretion in determining the purchase price of District Real Property, but such discretion should be consistent with the fair market value analysis in the opinion of value. Additional information and data that are unique to the District's specific needs and strategic objectives that are not utilized in determining the appraised value of the property may be taken into consideration for purposes of determining an appropriate purchase price. A property inspection will be performed as a condition of the purchase. This inspection will be made available to the Board of Directors for consideration.

C. Lease of Real Property where SVH is the lessee
    1. Lease of District Real Property where SVH is the lessee must be supported by a market analysis of recent transactions in the surrounding area. This analysis is exempt from public records disclosure under the California Public Records Act during the period of time of negotiations and should be used to assist in the negotiation of price and terms. A property inspection will be performed as a condition of the lease. This inspection will be made available to the Board of Directors for consideration with the lease.

D. Lease of Real Property where SVH is the lessor
    1. All inquiries to lease district real property shall be directed to Facilities and Construction Department for initial review. All inquiries shall be in written form, containing the proposed essential terms of the lease, including leasing party, location, square footage, price per square foot, length.
    2. In the event that the inquiry is made through a listing agent employed by the District to actively market and lease district real property, the listing agent's primary contact shall be the Facilities and Construction Department.
    3. Upon receipt of the written lease inquiry, the Facilities and Construction Department will incorporate the proposed terms into the attached Leasing Term Sheet, attached as Exhibit A.
    4. Initially, the Facilities and Construction Department will consult with Business Development and Physician Integration to determine if any of the parties to the lease are members of the Hospital's Medical Staff or any other existing healthcare

business relationships or affiliations ("related party"). In the event that it is determined that a leasing party may be a related party, Facilities and Construction shall meet and confer with the Chief Administrative Officer ~~Business Development and Physician Integration~~Salinas Valley Health Clinics and Legal Counsel to consider the impact of such a leasing relationship may have on the relationship between the hospital and the related party, and to determine whether any Stark Law or Anti-Kickback issues must be evaluated.

5. At the completion of the final terms being negotiated, the proposed transaction shall be presented by Facilities and Construction to the Executive Leadership Group to be reviewed and considered at its next scheduled meeting. If the final terms are acceptable to the ELG, Facilities and Construction shall request Hospital Legal Counsel to draft a lease consistent with the final terms.
6. Facilities and Construction shall then submit the proposed term sheet, along with any analysis such as market rental rates, Regulatory issues, to Administration for its review and recommendation. Administration may then accept, reject or counter-offer to the interested party. Any acceptance or counteroffer (if subsequently accepted) will be conditioned upon obtaining approval by the Board of Directors. Administration may elect to seek input from the Board in Closed Session on the terms of the transaction to assist during the negotiation of the terms.

E. Documentation:

1. All requests for leasing and space planning must be submitted to the space planning committee on the Space Request Form for review.
2. All procurement and contracting activities will be documented and maintained according to the RECORDS RETENTION policy and The Brown Act.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. California Constitution Article XVI, Section 6.
B. Local Healthcare District Law (California Health and Safety Code, Division 23)
C. 69 Federal Register 16,093 (March 26, 2004)
D. 42 U.S.C. Section 1395nn (h)(3)
E. 42 CFR Section 411.351
F. 42 CFR Section 1001.952(b)
G. The Ralph M. Brown Act (California Government Code 54950 et seq.)
H. California Government Code, Title 1, Division 1, Chapter 3.5.

Attachments

Exhibit A: Expense SVMH 100% Tenant 100 % SVMH Prorata % Tenant Prorata %

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Lorrie Oelkers: Director Internal Audit & Compliance	09/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13165135**

Last Approved	N/A	Owner	Gary Ray: Chief Administrative Officer, SVMC
Last Revised	09/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Physician and Business Development

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goal of Physician and Business Development is to:

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

III. DEPARTMENT OBJECTIVES

A. To support ~~Salinas Valley Memorial Healthcare System~~SVHMC objectives.

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

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

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

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

F. To evaluate staff performance on an ongoing basis.

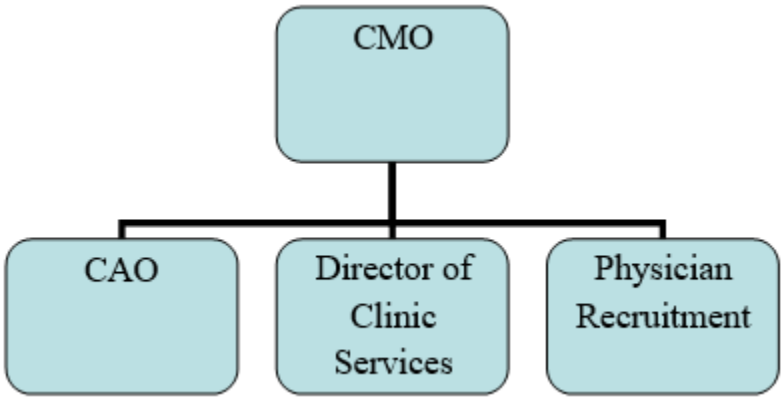
G. To provide appropriate staff orientation and development.

H. To monitor Physician and Business Development function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

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

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation
The Unit/Department provides services Monday through Friday from 8:00 a.m. to 5:00 p.m.

B. Location of department
The Department is located in the Administrative Office Building.

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

A. The Department purpose is to enhance patient services and health programs that help ~~Salinas Valley Memorial Healthcare System~~SVHMC remain a leading provider of medical care. The Department provides the following services:

1. Identifies, develops and maintains effective relationships with healthcare providers, business, government and community
2. Identifies and leads new business opportunities, market share expansion projects,

and community service need activities

3. Identifies and develops aligned physician and Hospital integration and contracting opportunities
4. Promotes the Hospital as the leader in the provision of quality healthcare services to the public and provider community
5. Represents the Hospital in community-based collaborative planning, outreach and business development activities
6. Identifies and recommends marketing and communication activities that will build market share, enhance physician relationships and strengthen the Hospital's contracting opportunities.
7. Provides leadership and support to Hospital Directors in their efforts to meet the Hospital's service and business goals in specialty care areas and centers of excellence.
8. Serves as liaison to business, government and the public.
9. Facilitates development of health system strategic plan.
10. Serves as key resource for business planning activities related to strategic investments.

B. The Chief Administrative Officer of the department assumes twenty-four (24) hour responsibility for the Department.

C. The Chief Administrative Officer of the Department is directly responsible to the Chief Medical Officer. It is the Chief Administrative Officer's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Chief Administrative Officer. In the Chief Administrative Officer's absence, the position is filled by their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF

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

A. Licensure / Certifications:

N/A

B. Competency

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

During the year in-services are conducted routinely. The in-services are part of the department's on-going efforts to educate staff and further enhance performance and improve

staff competencies. These in-services are in addition to the annual competency assessments. Department personnel who attend educational conferences are strongly encouraged to share pertinent information from the conferences with other staff members at in-services. Additional teleconferences, ~~videoconferences~~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
N/A

VIII. STAFFING PLAN

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

General Staffing Plan:

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

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

IX. EVIDENCED BASED STANDARDS

The ~~SVMHS~~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 ~~SVMHS~~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.

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

Attachments

CMO

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	11/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Gary Ray: Chief Administrative Officer, SVMC	10/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14554917

Last Approved	N/A	Owner	Stephanie Frizzell: Manager Education
Last Revised	10/2023	Area	Education
Next Review	3 years after approval		

Staff Nurse III Application

I. POLICY STATEMENT

~~A. N/A~~

A. In order for an RN to apply for a Staff Nurse III they must:

1. Be a SN II at SVHMC for at least twelve (12) months prior to application for SN III.
2. Have RN licensure for five (5) years or 5000 hours.
3. Have a minimum of one (1) year of specialty experience (or like specialty).
4. Be in a full or part-time position of not less than forty-eight hours (48) per pay period for at least twelve (12) months with same or similar area of clinical performance prior to application.
5. Have a BSN degree, existing SN IIIs as of 1/1/2020 are exempt.

II. PURPOSE

A. To guide RNs in the application and recertification process for Staff Nurse III.

B. To delineate the process for certification/recertification as a SN III.

III. DEFINITIONS

A. PPC - Professional Performance Committee

B. SN III – Staff Nurse III

C. Advisor/Mentor – a current SN III who has successfully completed two consecutive certification cycles and is endorsed by the SN III Review Board as being capable to support an aspiring SN III candidate.

IV. GENERAL INFORMATION

A. ~~Eligibility requirements:~~

1. ~~The SN III clinical ladder was created as a nursing recruitment and retention tool for the bedside clinical nurse. The clinical ladder is intended for nurses working in units that provide direct patient care twenty-four (24) hours per day and/or are on call, seven (7) days per week, and/or work in outpatient clinical departments.~~
2. ~~The nurse must be an SN II at SVHMC for at least twelve (12) months prior to his/her application for SN III. The nurse must have RN licensure for five (5) years or 5000 hours. The nurse must have a minimum of two (2) years of specialty experience (or like specialty).~~
3. ~~The nurse must be an RN in a full or part-time position of not less than forty-eight hours (48) per pay period for at least twelve (12) months with same or similar area of clinical performance prior to application.~~
4. ~~The nurse must have a BSN degree, existing SN IIIs as of 1/1/2020 are exempt.~~
5. ~~The candidate must meet or exceed standards in each aspect of current performance appraisal and be free of formal disciplinary actions/process (first or second written warning) within the previous twelve (12) months. The performance appraisal is signed by the Unit Director/designee.~~

The SN III clinical ladder was created as a nursing recruitment and retention tool for the bedside clinical nurse. The clinical ladder is intended for nurses working in units that provide direct patient care twenty-four (24) hours per day and/or are on call, seven (7) days per week, and/or work in outpatient clinical departments.

B. The candidate must meet or exceed standards in each aspect of current performance appraisal and be free of formal disciplinary actions/process (first or second written warning) within the previous twelve (12) months. The performance appraisal is signed by the Unit Director/designee.

V. PROCEDURE

A. Application: The candidate is to complete the steps in the following order and consult his/her advisor/mentor if any questions arise.

1. The candidate will be responsible for collecting and completing all eligibility requirements and all mandatory criteria using the Staff Nurse III packet. Staff Nurse Packets can be found in the Education Department and on StarNet on the Staff Nurse III Community Page.
2. The candidate will submit a written letter of intent to his/her Unit Director, Unit Manager, Education Manager, CNS/CNE, and SN III Board Chair of desire to be considered for designation as a Staff Nurse III. The candidate should follow the sample format, Letter of Intent, in the packet with advisor/mentor listed. This letter of intent should be submitted at least one year prior to the expected date of SN III application (March 1st for Spring or September 1st for Fall).
3. The Staff Nurse III subcommittee has the obligation and responsibility for pre-

screening candidates and assessing the accuracy of any aspect of the portfolio.

4. The candidate will submit their portfolio to the Staff Nurse III subcommittee for pre-screening one month prior to the April or October monthly SN III Review Board meeting (2nd Thursday of March or 2nd Thursday of September).
5. The candidate, in collaboration with the advisor/mentor, will make any revision(s) desired and resubmit to Staff Nurse III Review Board no later than April 7th for spring or October 7th for fall. Candidates and advisors/mentors who wish an opportunity to clarify recommendations may request to meet with the Staff Nurse III subcommittee to review and discuss the issues that have been identified as areas of deficiency.
6. The candidate and advisor/mentor must be present to submit the candidate's portfolio during the April or October SN III Review Board scheduled meeting.
7. Once the candidate has met all the established criteria:
    a. Candidates will be notified of the date of the SN III Review Board interview within fourteen (14) days of the semi-annual application deadline.
    b. All SN III Review Board interviews will be scheduled within forty-five (45) days of the semi-annual deadline.
    c. Candidates will be notified of the SN III Review Board decision within ten (10) working days of the interview.
    d. If accepted, the candidate will wear identification as Staff Nurse III on an official hospital name badge and may be designated as such in the hospital's newsletter.
    e. Candidates who are denied Staff Nurse III will receive the rationale for the SN III Review Board's decisions in writing, highlighting the areas of deficiency.
    f. Reapplication process is required yearly.
8. Any candidate who is denied Staff Nurse III classification may re-apply in the next application period by submitting a revised portfolio reflecting the new submission date and material, a copy of the SN III Review Board denial, and materials demonstrating corrections to areas causing previous denial.
9. If the SN III Review Board decision is made to deny the candidate's request a second time, then the candidate must wait for two (2) application periods from the date of this submission before reapplying for Staff Nurse III status.

B. Re-certification

1. Performance appraisal that meets or exceeds standards in all aspects. Copy of current performance appraisal for the last two years signed by the Unit Director/ designee.
2. Nurse maintains a full or part-time position of not less than forty-eight (48) hours per pay period with same or similar area of clinical performance at time of last certification/re-certification.
3. Refer to Staff Nurse III packet for recertification requirements

a. In the event a Staff Nurse III wishes to take an inactive role from his/her SN III responsibilities, he/she can apply for hiatus at a specified timeframe. Refer to the SN III packet for the hiatus process.

b. In the event a Staff Nurse III enters the disciplinary process and receives a first or second written warning, he/she will be returned to Staff Nurse II. The Staff Nurse II shall then be eligible to apply again for Staff Nurse III status once the disciplinary process is completed. In the event a Staff Nurse III receives a first or second written warning, he/she retains the right to utilize the grievance process.

4. If a Staff Nurse III transfers to a new area of clinical practice, he/she will maintain Staff Nurse III status through one annual performance appraisal. He/she must then meet or exceed standards in those areas identified as mandatory for Staff Nurse III in the performance appraisal and satisfy all of re-certification/clinical proficiency requirements within the current area of clinical practice at the time of next annual review.

5. Failure to meet re-certification criteria will result in the Staff Nurse III being returned to Staff Nurse II. Notification will be sent to Human Resources accordingly.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. American Nurses Association. (~~2015~~2021). Nursing scope and ~~standards~~standard of practice. ~~Silver Spring, MD~~(4th ed.) Washington D.C.: American Nurses Association.

B. Baker, S., Roberts Reyes, M. (2019). Salinas Valley Memorial Healthcare System Nursing Mentoring Program Guide & Toolkit.

C. Begley, R., Migliaccio, A., Knopp, S., & Wright, L. (2006). Our tipping point towards excellence: A professional nursing ladder. Our tipping point towards excellence: A professional nursing ladder. American Nurses Credentialing Center's (ANCC) 9th Annual Magnet Conference.

D. Benner, P. (2001). From novice to expert: Excellence and power in clinical nursing practice. New Jersey: Prentice-Hall, Inc.

E. Coleman, Y.A., Desai, R. (2019). The effects of a clinical ladder program on professional development and job satisfaction of acute care nurses. Clinical Journal of Nursing Care Practice. 3, 44-48.

F. Czerwinski, S., Blastic, L., & Rice, B. (1999). The synergy model: Building a clinical advancement program. Critical Care Nurse. 19 (4).

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	10/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Stephanie Frizzell: Manager Education	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13510477**

Last Approved	N/A	Owner	Lilia Meraz Gottfried: Director of Clinical Development
Last Revised	09/2023		
Next Review	3 years after approval	Area	Patient Care

Withdrawing Life-Sustaining Treatment and Withholding Cardiopulmonary Resuscitation

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To provide guidelines for decision making process and physician documentation as to whether or not life sustaining treatment should be withdrawn or withheld or attempts at resuscitation be undertaken. ~~SVMH~~Salinas Valley Health Medical Center (SVHMC) complies with current laws and regulations addressing advance directives and the framework for withdrawing life-sustaining treatment and withholding resuscitative services.

III. DEFINITIONS:

A. CPR (Cardiopulmonary Resuscitation) includes endotracheal intubation, chest compression or cardiac massage, defibrillation or chemical resuscitation as defined by the initiation of Advanced Cardiac Life Support (ACLS) protocols.

B. DNAR (DO NOT ATTEMPT RESUSCITATION): An order which directs that resuscitative efforts are not to be initiated in the event of cardiac and/or respiratory arrest. As such, a DNAR order authorizes the withholding of life-sustaining procedures that have been previously initiated.

C. Decisional Capacity: the patient has the ability to understand the consequences of a decision regarding death delaying treatment and express their wishes. An attending physician should determine and document decision-making capacity or its absence.

D. Legal Representative: An appointed agent or adult surrogate with capacity designated by the patient to make healthcare decisions for him/her regarding the patient's care. The authority of the legal representative becomes effective only on a determination that the patient lacks decisional capacity. A legal representative makes healthcare decisions in accordance with the

patient's individual health care instructions to the extent known to the legal representative, otherwise in accordance with the legal representative's determination of the patient's best interests. In determining the patient's best interests the legal representative shall consider the patient's personal values to the extent known to the legal representative. Please see ADVANCE DIRECTIVES policy, #448.

E. Minor: A person under 18 years of age considered legally incompetent to consent to medical treatment except as otherwise allowed by law in specific circumstances. Parents or guardians are generally the appropriate legal representatives for minors.

F. POLST: Physician Orders for Life Sustaining Treatment

IV. GENERAL INFORMATION:

A. Staff will initiate full cardiopulmonary resuscitation (CPR) or continue life sustaining treatment for any patient who suffers cardiac or respiratory arrest unless an order to the contrary has been given.

B. DNAR Order Treatment Categories:

1. **DNAR/Full Care:** in the event of cardiac/respiratory arrest, CPR is not to be initiated. If the patient still has a pulse or is breathing, all potentially effective life sustaining treatments can be initiated.
2. **DNAR/DNI:** in the event of cardiac/respiratory arrest, CPR is not to be initiated. If the patient still has a pulse or is breathing, all potentially effective life sustaining treatments, with the exception of intubation, can be initiated.
3. **DNAR/Comfort Care:** in the event of cardiac/respiratory arrest CPR is not to be initiated. If the patient still has a pulse or is breathing and their condition is declining, care should be transitioned to comfort focused care, and they should be allowed to die a natural death.

C. In certain circumstances, full CPR may not be appropriate, given the condition of the patient or wishes expressed by the patient, legal representative, or surrogate decision maker. In that case, the proper method of proceeding may involve a DNAR order, a Durable Power of Attorney for Health Care (DPAHC), a Natural Death Act (NDA) Declaration, a Living Will, a Limited Resuscitation Order, or discontinuation of life support.

D. Attention shall be given to continue palliative and symptom management or any other care necessary to provide quality patient care for a patient with DNAR order.

E. When a patient with DNAR order requires invasive or surgical procedures, it is the responsibility of the physician obtaining consent for the procedure to discuss suspension of DNAR order during the procedure with the patient, if conscious, otherwise with the patient's Authorized Person. The physician shall attempt to respect the expressed wishes of the patient and/or Authorized Person and document the decision-making process in the medical record. If the patient and or authorized person requests a suspension during the surgical procedure, the physician shall document this in the medical record. ~~The DNAR status shall not be resumed until the patient is discharged from the Post Anesthesia Care Unit (PACU). The physician must also document in the medical record that the DNAR will be resumed once the patient returns to their room post recovery and complete the appropriate orders~~

1. The DNAR status shall not be resumed until the patient is discharged from the Post Anesthesia Care Unit (PACU).
2. The physician must also document in the medical record that the DNAR will be resumed once the patient returns to their room post recovery.

F. The DNAR may be suspended during a procedure involving moderate sedation after a conference with the surgeon, interventionist, anesthesiologist, or primary physician, and the patient and/or his/her Authorized Person, and shall be documented on the patient's medical record ~~to include completed physician orders~~.

1. The DNAR status shall not be resumed until the patient is discharged from the Procedural area.
2. The physician must also document in the medical record that the DNAR will be resumed once the patient returns to their room post recovery.

G. Pre-hospital requests – forms or written instructions (*"Emergency Medical Services Pre-hospital, Do Not Resuscitate {DNAR} form"*) – for forgoing resuscitation do not apply in hospital emergency rooms or hospital inpatient units. The hospital should take immediate steps to ascertain and document the wishes of such patients regarding resuscitation and implications of a DNAR order.

1. Orders to withdraw life sustaining treatment and/or withhold cardiopulmonary resuscitation must be entered in the patient's electronic medical record and signed by the physician. If entering the orders on paper, the Limits on Patient Resuscitation and Treatment can be used. For use of the **POLST** form. PHYSICIAN ORDERS FOR LIFE SUSTAINING TREATMENT (POLST) (POLST) PROCEDURE #1990.

H. The physician should orally inform the nursing staff that such an order has been given to assure that the order is known and understood at the time it is written.

1. For emergency situations, telephone orders for DNAR can be given and must be reviewed and authenticated within eight hours of the order but no later than 10:00 am the following morning.

I. If there are differing opinions among medical personnel regarding the appropriateness of decisions to discontinue life-sustaining treatment, a hospital Bioethics Case Conference shall be called to attempt to resolve the dispute.

J. If a health care provider does not wish to comply with his or her patient's request for information on end-of-life options, the health care provider shall do both of the following:

1. Refer or transfer a patient to another health care provider that shall provide the requested information.
2. Provide the patient with information on procedures to transfer to another health care provider that shall provide the requested information.

K. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider upon the patient's request, provide the patient with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility if the patient's health care provider is not available,

may refer the patient to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options.

If the patient indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:

1. Hospice care at home or in a health care setting.
2. A prognosis with and without the continuation of disease-targeted treatment.
3. The patient's right to refusal of or withdrawal from life-sustaining treatment.
4. The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care.
5. The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.
6. The patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decision maker.

V. PROCEDURE~~:~~

~~A. DNAR Orders~~

1. ~~**DNAR Order**: is medically, ethically, and legally appropriate when the burden of life sustaining treatment outweighs the benefit to the patient. This occurs when the possibility that the patient will be successfully resuscitated and/or the quality of the patient's life following resuscitation is likely to be so low as not to merit the intrusion, discomfort, and side effects of CPR. In that case, CPR may be said to be medically ineffective with the result that it may be withheld or withdrawn if the proper procedures are followed. Patients with decision making capacity have the right to refuse life-sustaining treatment.~~
2. ~~**Assessing the Benefits and Burdens of Treatment - DNAR Order –** The patient's physician should inform the decision maker of the medical indications and contradictions for CPR as well as the benefits and burdens of treatment, The unique factors of each case must be considered:~~
    a. ~~How long the treatment is likely to extend life~~
    b. ~~Whether it can improve the patient's prognosis for recovery~~
    c. ~~The nature of the patient's additional life, specifically, the possibilities of a return to cognitive sapient life and of a remission of symptoms enabling a return towards a normal, functioning integrated existence~~
    d. ~~The degree of intrusiveness, risk, and discomfort associated with the treatment~~
3. ~~**Who Must be Consulted**~~

a. The attending physician and consulting physicians (if any) shall be responsible for determining the patient's prognoses and diagnoses and providing the patient or the patient's legal representative with the requisite information to enable him/her to evaluate a treatment's benefits and burdens.

b. A physician may choose to secure a second opinion or to consult the Bioethics Committee regarding the case whenever he/she determines that such a consultation may help clarify a patient's medical condition or substantiate a decision.

c. The patient shall be the decision maker whenever possible.

i. A patient with capacity to make health care decisions may direct the withholding or withdrawal of life-sustaining treatment after he/she has been informed of his/her diagnoses, prognoses, the nature of the treatment, its expected benefits, its associated risks and complications, and any alternative treatments and their benefits and risks.

ii. When a patient with decisional capacity has directed the withholding or withdrawal of life-sustaining procedures, it is advisable to consult the patient's immediate family. (The patient must consent to the disclosure of medical information to family and/or friends.) Life-sustaining treatment should not be withheld or withdrawn if a family member disagrees unless the patient clearly has capacity to make health care decisions and the patient has expressly given an informed refusal for the treatment.

iii. If the patient is incapable of making the decision, the health care providers and legal representatives must act in accordance with the patient's desires previously expressed. If a patient is incapable of making the decision because of his/her medical or mental condition, a legal representative should, where possible, be identified. Even where it is determined that the patient lacks decisional capacity, physicians and others should talk with the patient about the treatment and allow the patient to participate as fully as possible. Even a patient without decision making capacity may be able to understand some of what is being said and may be able to express preferences.

4. **Patient's Desires and Best Interests**

a. The physician should determine, on the basis of his/her knowledge of the patient, in consultation with the family and significant others, and any written documentation whether the patient has expressed a desire to have life-supporting measures applied under all conditions or a desire to not have his/her life artificially prolonged.

b. If the patient's desires are not known, the legal representative shall act in the patient's best interests. In general, treatment should be provided unless the benefits to be gained are outweighed by the burdens to the patient from to the treatment. This determination depends upon factors unique to each case. Factors to be considered in determining what actions are in the patient's best interests include:

i. The relief of suffering;

ii. The preservation or restoration of functioning; the degree of intrusiveness, risk and discomfort associated with the treatment;

iii. The impact of the decision on those people closest to the patient.

5. **Parent, Guardian, Agent, Surrogate, Conservator**
    a. Whenever the patient has a guardian or conservator, a copy of the certified letters of guardianship or conservatorship must be obtained and placed in the patient's medical record.
    b. Whenever an agent has been designated as the decision maker, a copy (power of attorney for health care) should be obtained and placed in the patient's medical record.

6. **Situations Involving Minors**
    a. Although minors are considered legally incompetent to make decisions in many areas of medical care by virtue of their age, nevertheless it is appropriate to discuss life-support and other medical decisions with them in a manner appropriate to their age.
    b. Many minors will be able to understand the nature and consequences of a decision to forgo life-sustaining treatment.
    c. Life-sustaining treatment should not be withheld from a mature minor unless the minor and legal representatives agree.

7. **Patient's Family and Significant Others**
    a. Whenever possible, the patient's immediate family and, in appropriate cases, significant others shall be consulted, and their wishes should be given great weight in arriving at the decision. (the patient or the patient's legal representative must consent to the disclosure of medical information to family, friends and/or significant others)

8. **Review if there is No Legal Representative Who Can Act on Behalf of a Patient Who Lacks Capacity to Make Health Care Decisions**
    a. If the patient lacks decisional capacity and no legal representative can be identified, a do not resuscitate order may be used when the patient's physician determines it is medically appropriate. In such cases it is advisable, but not required, that the physician seek a consultation before issuing the order and/or notify hospital administration.
    b. Orders to withhold or withdraw other forms of life-sustaining treatment when there are no legal representatives who can act on behalf of the patient, may not be issued unless the patient's physician has consulted appropriate parties and notified hospital administration of the proposed order and secured confirmation of the propriety of the proposed order.

9. **Hospital Administration shall be consulted before an order to withhold or withdraw treatment is issued whenever:**
    a. The patient's condition has resulted from an injury which appears to be have been inflicted by a criminal act;
    b. The patient's injury or condition was created or aggravated by a medical accident;

c. The patient is pregnant;

d. The patient (male or female) is a parent with custody or responsibility for the care and support of young children;

e. A dispute exists regarding the desires or best interests of an incompetent patient; or

f. No appropriate legal representative exists.

10. **Documentation in Support of Orders**

a. A DNAR order directing treatment is entered into the patient record by the attending physician. A physician documents in the medical record the essence of the conversation that has occurred with the patient and/or family surrounding the order.

b. The medical record shall reflect the medical reasons for the order and the circumstances regarding the DNAR consent and consultation.

11. **Process to Alert Clinical Staff in Identification of the DNAR Patient**

a. When a physician orders a code status of DNAR, a purple-colored armband with DNAR printed on it will be placed on the patient. Such band will be removed if the order is revoked or expires.

b. Such an order shall be clearly communicated to all relevant providers of care/ treatment for the patient.

c. The patient's DNAR status is entered into the electronic medical record.

d. The RN verifies the physician DNAR order prior to placement of the purple DNAR wristband and documents placement of the wristband in the patient's medical record.

e. Purple tape is applied to the medical record binder for chart recognition of patient code status.

12. **Review *of DNAR Orders***

a. ***DNAR orders shall be reviewed and*** restated in the event of a significant improvement of the patient. The attending physician has primary responsibility to review the DNAR order.

b. The nurse caring for the patient or designated RN has a responsibility for informing the physician about changes in the patient's condition that may call for reconsideration of the DNAR order.

13. **Process When DNAR Order is Revoked**

a. A decision to revoke a DNAR order shall be clearly written in the medical record.

b. When a DNAR order has been revoked, complete the following:

i. Remove DNAR armband from patient.

ii. Remove purple tape from medical record binder.

iii. If paper form used, nursing staff to write "Revoked" across Limits on Patient Resuscitation and Treatment form. Do not remove form from medical record.

14. **Documentation of DNAR Status**

    a. The order shall clearly communicate in the electronic medical record, what treatment is to be limited, withheld or withdrawn. The RN will call the physician if orders are incomplete or unclear.

    b. A DNAR Order shall be good for the duration of the hospitalization, unless the physician indicates a specific time frame.

B. Procedure for Issuing Withdrawing of Life Sustaining Treatment

1. An order to withdraw treatment can be accomplished by:

    a. An order to withdraw treatment must be written in the chart by the attending physician.

    b. The orders or decision to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the medical record of all the circumstances surrounding the decision. Such documentation must include, but is not limited to:

        i. A summary of the medical situation which specifically addresses the patient's situation. This must include reference to the patient's mental status, diagnoses, and prognosis at the time the order is written or the decision is made, and test results or an explanation if no tests were performed.

        ii. The outcome of any consultations with other physicians. Physicians who provide consultations must document their findings and recommendations.

        iii. A statement indicating the basis upon which a particular person(s) have been identified as appropriate legal representative(s) for the patient.

    c. A statement summarizing the outcome of consultations with the patient, parent, guardian, agent, surrogate, conservator, family, registered domestic partner and/or significant others. If such person not having specific legal authority to make decisions for the patient does not concur with the decision, the record should include a statement of the reason(s) why such person's opinions are believed not to be sufficient reason to preclude the withholding or withdrawal of the treatment in question.

    d. Once life sustaining treatment is withdrawn, the patient will then be defined as DNAR, and a DNAR order shall be signed as soon as possible. All procedures shall be followed as for standard DNAR protocol.

    e. All decisions to withhold life-sustaining treatment should be reevaluated periodically during the admission as medically indicated. In addition, such decisions must be reviewed whenever a change in the patient's condition warrants review. Reviews are documented in the patient's medical record.

    f. Every necessary procedure should be performed to relieve the patient's suffering and

to maintain the patient's comfort. CARE OF THE PATIENT AT END OF LIFE

g. Such an order shall be clearly communicated to all relevant providers of care and treatment for the patient.

h. Once the order has been documented, termination of life support measures can take place.

i. The administrative nursing supervisor is contacted before withdrawal of life-sustaining treatment.

ii. The attending physician is responsible for disconnecting medical devices and may direct the nursing staff to assist with this process as appropriate. Others in attendance are at the discretion of the attending physician, e.g., Respiratory Care.

iii. If the patient is a Coroner's case, the attending physician must be in attendance at the time life support is withdrawn. POST MORTEM-NOTIFICATION (CORONER, DONOR NETWORK), AUTOPSY AND RELEASE OF REMAINS, policy #297.

i. The patient will be given adequate measures to compassionately control any pain or discomfort that might arise due to the termination of life support. These measures will be left up to the discretion of the attending physician and nursing staff. Symptom Management/Palliative Care Orders may be implemented to assist with symptom management and palliative care during this time.

j. Every effort shall be made to accommodate the needs of the patient's family members with respect to visitation, including a waiving of the standard visitation restrictions. This can take place so long as there is minimal disruption to the care for other patients. This is to take place at the discretion of the physician or nursing staff.

k. Death by reason of irreversible cessation of all functions of entire brain; Reasonably brief period of accommodation; special religious or cultural practices and concerns:

i. The family or next of kin will be provided a reasonably brief period of accommodation from the time the patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with DETERMINATION OF BRAIN DEATH, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support- no other medical intervention is required.

ii. A "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside.

iii. Provide the patient's legally recognized healthcare decision-maker, family, or next of kin, if available, a written statement of the policy, upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent.

iv. If the healthcare decision-maker, family, or next of kin voices any special religious or cultural practices or concern of the patient or the patient's

~~family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.~~

2. ~~Social Services shall be contacted at the earliest possible convenience to assist the family members with issues pertaining to emotional support, counseling, and resources related to the grieving process. The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient shall be referred to the appropriate entity for that information.~~

~~C. Issues Regarding Disagreements Among Interested Parties~~

1. ~~The Bioethics Committee is available to clarify ethical issues, available options, and improve communications.~~

~~D. Objections by Employees or Physicians/~~

1. ~~Hospital employed health care professionals have the ethical and legal right to decline to participate in the limitation, withdrawal, or withholding of treatment, or the continuation of treatment they believe to be medically ineffective.~~
2. ~~Such professionals will be reassigned to other patients.~~

~~E. Documentation:~~

1. ~~Orientation records will be kept in the employee's respective department.~~

A. **DNAR Order**: is medically, ethically, and legally appropriate when the burden of life sustaining treatment outweighs the benefit to the patient. This occurs when the possibility that the patient will be successfully resuscitated and/or the quality of the patient's life following resuscitation is likely to be so low as not to merit the intrusion, discomfort, and side effects of CPR. In that case, CPR may be said to be medically ineffective with the result that it may be withheld or withdrawn if the proper procedures are followed. Patients with decision making capacity have the right to refuse life-sustaining treatment.

B. **Assessing the Benefits and Burdens of Treatment - DNAR Order** The patient's physician should inform the decision maker of the medical indications and contradictions for CPR as well as the benefits and burdens of treatment, The unique factors of each case must be considered:

   1. How long the treatment is likely to extend life
   2. Whether it can improve the patient's prognosis for recovery
   3. The nature of the patient's additional life, specifically, the possibilities of a return to cognitive sapient life and of a remission of symptoms enabling a return towards a

normal, functioning integrated existence

4. The degree of intrusiveness, risk, and discomfort associated with the treatment

C. **Who Must be Consulted**

1. The attending physician and consulting physicians (if any) shall be responsible for determining the patient's prognoses and diagnoses and providing the patient or the patient's legal representative with the requisite information to enable him/her to evaluate a treatment's benefits and burdens.
2. A physician may choose to secure a second opinion or to consult the Bioethics Committee regarding the case whenever he/she determines that such a consultation may help clarify a patient's medical condition or substantiate a decision.
3. The patient shall be the decision maker whenever possible.
    a. A patient with capacity to make health care decisions may direct the withholding or withdrawal of life-sustaining treatment after he/she has been informed of his/her diagnoses, prognoses, the nature of the treatment, its expected benefits, its associated risks and complications, and any alternative treatments and their benefits and risks.
    b. When a patient with decisional capacity has directed the withholding or withdrawal of life-sustaining procedures, it is advisable to consult the patient's immediate family. (The patient must consent to the disclosure of medical information to family and/or friends.) Life-sustaining treatment should not be withheld or withdrawn if a family member disagrees unless the patient clearly has capacity to make health care decisions and the patient has expressly given an informed refusal for the treatment.
    c. If the patient is incapable of making the decision, the health care providers and legal representatives must act in accordance with the patient's desires previously expressed. If a patient is incapable of making the decision because of his/her medical or mental condition, a legal representative should, where possible, be identified. Even where it is determined that the patient lacks decisional capacity, physicians and others should talk with the patient about the treatment and allow the patient to participate as fully as possible. Even a patient without decision making capacity may be able to understand some of what is being said and may be able to express preferences.

D. **Patient's Desires and Best Interests**

1. The physician should determine, on the basis of his/her knowledge of the patient, in consultation with the family and significant others, and any written documentation whether the patient has expressed a desire to have life-supporting measures applied under all conditions or a desire to not have his/her life artificially prolonged.
2. If the patient's desires are not known, the legal representative shall act in the patient's best interests. In general, treatment should be provided unless the benefits to be gained are outweighed by the burdens to the patient from to the treatment. This determination depends upon factors unique to each case. Factors to be considered in determining what actions are in the patient's best interests include:

a. The relief of suffering;

b. The preservation or restoration of functioning; the degree of intrusiveness, risk and discomfort associated with the treatment;

c. The impact of the decision on those people closest to the patient.

E. **Parent, Guardian, Agent, Surrogate, Conservator**

1. Whenever the patient has a guardian or conservator, a copy of the certified letters of guardianship or conservatorship must be obtained and placed in the patient's medical record.

2. Whenever an agent has been designated as the decision maker, a copy (power of attorney for health care) should be obtained and placed in the patient's medical record.

F. **Situations Involving Minors**

1. Although minors are considered legally incompetent to make decisions in many areas of medical care by virtue of their age, nevertheless it is appropriate to discuss life-support and other medical decisions with them in a manner appropriate to their age.

2. Many minors will be able to understand the nature and consequences of a decision to forgo life-sustaining treatment.

3. Life-sustaining treatment should not be withheld from a mature minor unless the minor and legal representatives agree.

G. **Patient's Family and Significant Others**

1. Whenever possible, the patient's immediate family and, in appropriate cases, significant others shall be consulted, and their wishes should be given great weight in arriving at the decision. (the patient or the patient's legal representative must consent to the disclosure of medical information to family, friends and/or significant others)

H. **Review if there is No Legal Representative Who Can Act on Behalf of a Patient Who Lacks Capacity to Make Health Care Decisions**

1. If the patient lacks decisional capacity and no legal representative can be identified, a do not resuscitate order may be used when the patient's physician determines it is medically appropriate. In such cases it is advisable, but not required, that the physician seek a consultation before issuing the order and/or notify hospital administration.

2. Orders to withhold or withdraw other forms of life-sustaining treatment when there are no legal representatives who can act on behalf of the patient, may not be issued unless the patient's physician has consulted appropriate parties and notified hospital administration of the proposed order and secured confirmation of the propriety of the proposed order.

I. **Hospital Administration shall be consulted before an order to withhold or withdraw treatment is issued whenever:**

1. The patient's condition has resulted from an injury which appears to be have been inflicted by a criminal act;
2. The patient's injury or condition was created or aggravated by a medical accident;
3. The patient is pregnant;
4. The patient (male or female) is a parent with custody or responsibility for the care and support of young children;
5. A dispute exists regarding the desires or best interests of an incompetent patient; or
6. No appropriate legal representative exists.

J. **Documentation in Support of Orders**

1. A DNAR order directing treatment is entered into the patient record by the attending physician. A physician documents in the medical record the essence of the conversation that has occurred with the patient and/or family surrounding the order.
2. The medical record shall reflect the medical reasons for the order and the circumstances regarding the DNAR consent and consultation.

K. **Process to Alert Clinical Staff in Identification of the DNAR Patient**

1. When a physician orders a code status of DNAR, a purple-colored armband with DNAR printed on it will be placed on the patient. Such band will be removed if the order is revoked or expires.
2. Such an order shall be clearly communicated to all relevant providers of care/ treatment for the patient.
3. The patient's DNAR status is entered into the electronic medical record.
4. The RN verifies the physician DNAR order prior to placement of the purple DNAR wristband and documents placement of the wristband in the patient's medical record.
5. Purple tape is applied to the medical record binder for chart recognition of patient code status.

L. **Review *of DNAR Orders***

1. ***DNAR orders shall be reviewed and*** restated in the event of a significant improvement of the patient. The attending physician has primary responsibility to review the DNAR order.
2. The nurse caring for the patient or designated RN has a responsibility for informing the physician about changes in the patient's condition that may call for reconsideration of the DNAR order.

M. **Process When DNAR Order is Revoked**

1. A decision to revoke a DNAR order shall be clearly written in the medical record.
2. When a DNAR order has been revoked, complete the following:
    a. Remove DNAR armband from patient.
    b. Remove purple tape from medical record binder.

c. If paper form used, nursing staff to write "Revoked" across Limits on Patient Resuscitation and Treatment form. Do not remove form from medical record.

N. **Documentation of DNAR Status**

1. The order shall clearly communicate in the electronic medical record, what treatment is to be limited, withheld or withdrawn. The RN will call the physician if orders are incomplete or unclear.
2. A DNAR Order shall be good for the duration of the hospitalization, unless the physician indicates a specific time frame.

O. **Procedure for Issuing Withdrawing of Life Sustaining Treatment**

1. An order to withdraw treatment can be accomplished by:
    a. An order to withdraw treatment must be written in the chart by the attending physician.
    b. The orders or decision to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the medical record of all the circumstances surrounding the decision. Such documentation must include, but is not limited to:
        i. A summary of the medical situation which specifically addresses the patient's situation. This must include reference to the patient's mental status, diagnoses, and prognosis at the time the order is written or the decision is made, and test results or an explanation if no tests were performed.
        ii. The outcome of any consultations with other physicians. Physicians who provide consultations must document their findings and recommendations.
        iii. A statement indicating the basis upon which a particular person(s) have been identified as appropriate legal representative(s) for the patient.
        iv. A statement summarizing the outcome of consultations with the patient, parent, guardian, agent, surrogate, conservator, family, registered domestic partner and/or significant others. If such person not having specific legal authority to make decisions for the patient does not concur with the decision, the record should include a statement of the reason(s) why such person's opinions are believed not to be sufficient reason to preclude the withholding or withdrawal of the treatment in question.
        v. Once life sustaining treatment is withdrawn, the patient will then be defined as DNAR, and a DNAR order shall be signed as soon as possible. All procedures shall be followed as for standard DNAR protocol.
        vi. All decisions to withhold life-sustaining treatment should be reevaluated periodically during the admission as medically

indicated. In addition, such decisions must be reviewed whenever a change in the patient's condition warrants review. Reviews are documented in the patient's medical record.

vii. Every necessary procedure should be performed to relieve the patient's suffering and to maintain the patient's comfort. CARE OF THE PATIENT AT END OF LIFE

viii. Such an order shall be clearly communicated to all relevant providers of care and treatment for the patient.

ix. Once the order has been documented, termination of life support measures can take place.

a. The administrative nursing supervisor is contacted before withdrawal of life-sustaining treatment.

b. The attending physician is responsible for disconnecting medical devices and may direct the nursing staff to assist with this process as appropriate. Others in attendance are at the discretion of the attending physician, e.g., Respiratory Care.

c. If the patient is a Coroner's case, the attending physician must be in attendance at the time life support is withdrawn. POST MORTEM-NOTIFICATION (CORONER, DONOR NETWORK), AUTOPSY AND RELEASE OF REMAINS, policy #297.

x. The patient will be given adequate measures to compassionately control any pain or discomfort that might arise due to the termination of life support. These measures will be left up to the discretion of the attending physician and nursing staff. Symptom Management/Palliative Care Orders may be implemented to assist with symptom management and palliative care during this time.

xi. Every effort shall be made to accommodate the needs of the patient's family members with respect to visitation, including a waiving of the standard visitation restrictions. This can take place so long as there is minimal disruption to the care for other patients. This is to take place at the discretion of the physician or nursing staff.

xii. Death by reason of irreversible cessation of all functions of entire brain; Reasonably brief period of accommodation; special religious or cultural practices and concerns:

a. The family or next of kin will be provided a reasonably brief period of accommodation from the time the patient is declared dead by reason of irreversible cessation of all functions of the entire brain, including the brain stem, in accordance with DETERMINATION

OF BRAIN DEATH, through discontinuation of cardiopulmonary support for the patient. During this reasonably brief period of accommodation, a hospital is required to continue only previously ordered cardiopulmonary support- no other medical intervention is required.

b. A "reasonably brief period" means an amount of time afforded to gather family or next of kin at the patient's bedside.

c. Provide the patient's legally recognized healthcare decision-maker, family, or next of kin, if available, a written statement of the policy, upon request, but no later than shortly after the treating physician has determined that the potential for brain death is imminent.

d. If the healthcare decision-maker, family, or next of kin voices any special religious or cultural practices or concern of the patient or the patient's family surrounding the issue of death by reason of irreversible cessation of all functions of the entire brain of the patient, the hospital shall make reasonable efforts to accommodate those religious and cultural practices and concerns.

2. Social Services shall be contacted at the earliest possible convenience to assist the family members with issues pertaining to emotional support, counseling, and resources related to the grieving process. The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family can easily understand. If the patient requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient shall be referred to the appropriate entity for that information.

P. **Issues Regarding Disagreements Among Interested Parties**

1. The Bioethics Committee is available to clarify ethical issues, available options, and improve communications.

Q. **Objections by Employees or Physicians**

1. Hospital employed health care professionals have the ethical and legal right to decline to participate in the limitation, withdrawal, or withholding of treatment, or the continuation of treatment they believe to be medically ineffective.

2. Such professionals will be reassigned to other patients.

R. **Documentation:**

1. Orientation records will be kept in the employee's respective department.

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. The Joint Commission – Patient Rights

B. California Hospital Association Consent Manual. HSC 442.5-442.7

Approval Signatures

Step Description	Approver	Date
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
MEC	Katherine DeSalvo: Director Medical Staff Services	10/2023
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Director	Carla Spencer: Director Critical Care Services	05/2023
Policy Owner	Lilia Meraz Gottfried: Director of Clinical Development	04/2023

Standards

No standards are associated with this document

BOARD MEMBER COMPENSATION AND EXPENDITURE REIMBURSEMENT POLICY

1. **PURPOSE**

1.1 To set forth the policy and procedure for compensating members of the Board of Directors of Salinas Valley Memorial Healthcare System and for reimbursement of authorized, district-related expenses incurred by members of the Board of Directors.

2. **POLICY**

2.1 Pursuant to the requirements of California AB1234, California Government Code, California Health and Safety Code and the Bylaws of Salinas Valley Memorial Healthcare System, compensation and expenditure reimbursement paid to members of the Board of Directors of SVMHS for district-related expenses shall be made in accordance with the following procedure.

3. **DEFINITION** - N/A

4. **PROCEDURE**

COMPENSATION

4.1 Compensation for Meetings. A member of the Board of Directors of SVMHS shall receive one hundred dollars ($100.00) per meeting, not to exceed six~~five~~ (6~~5~~) meetings per month for the time period of January 1, 2023 to December 31, 2023.

4.1.1 Findings in Support of Compensation for Meetings. Pursuant to Health & Safety Code Section 32103(a), the Board finds that the following facts support the need to compensate members of the Board of Directors of SVMHS for a total of up to six (6) meetings per month:

4.1.1.1 The Board is comprised of only five (5) members;

4.1.1.2 Each of the Board Members sit on at least two (2) separate standing committees of the Board which require monthly meetings of said committees;

4.1.1.3 Board Members are also members of various ad hoc Board Committees that have met, or will be meeting in calendar year 2023, including, ad hoc Committee of Bylaws, President/CEO Search Committee and others;

4.1.1.4 The Board maintains a close working relationship with Medical Staff that has greatly benefited the District, and such relationship is maintained by regularly attendance of Board Members as guests, at Medical Staff meetings.

BOARD MEMBER COMPENSATION AND EXPENDITURE REIMBURSEMENT POLICY

4.1.1.4 The organization is in a period of flux, which has required and will continue to require holding Special Meetings of the Board, likely on a monthly basis, to consider items including the selection of a President/CEO.

4.2 Definition of Meeting. "Meeting" shall mean regular and annual meetings held pursuant to Article V, Section 5.1, of the SVMHS Bylaws, special meetings held pursuant to Article V, Section 5.3, standing committee meetings held pursuant to Article IV, Section 4.2, ad hoc Board committee meetings, and meetings of the Medical Staff of the hospital.

EXPENDITURE REIMBURSEMENT

4.3 Authorized Expenses**.** Each member of the Board of Directors shall be allowed his or her actual necessary traveling and incidental expenses incurred in the performance of official business of SVMHS as assigned by the Board in accordance with the terms and conditions of this policy and procedure. District funds, equipment, supplies, titles, and staff time must only be used for authorized district business. Authorized expenses are, generally, expenses incurred in connection with activities including, but not limited to, the following:

4.3.1 Communicating with representatives of regional, state and national government on district adopted policy positions;

4.3.2 Attending educational seminars designed to improve Board Member's skill and information levels;

4.3.3 Participating in regional, state and national organizations whose activities affect the district's interests;

4.3.4 Participating in an event recognizing service to the district; and

4.3.5 Attending district events.

4.4 **Approval for Other Expenses.** All other expenditures require prior approval by the district board of directors. The following expenses also require prior approval by the district board of directors:

4.4.1 International healthcare/district-related travel expenses; and

4.4.2 Expenses that exceed the annual budgetary limits established for Board and Administrative purposes.

BOARD MEMBER COMPENSATION AND EXPENDITURE REIMBURSEMENT POLICY

4.5 **Personal Expenses.** Examples of personal expenses that the district will not reimburse include, but are not limited to:

4.5.1 The personal portion of any trip;

4.5.2 Political or charitable contributions or events;

4.5.3 Family expenses when accompanying board member on district-related business;

4.5.4 Entertainment expenses;

4.5.5 Personal losses incurred while on district business; and

4.5.6 Non-mileage personal automobile expenses, including repairs, traffic citations, insurance or gasoline.

4.6 **Questions**. Any question regarding the propriety of a particular type of expense should be resolved by the District Board of Directors before the expense is reimbursed.

COST CONTROL

To conserve district resources and keep expenses within community standards for public officials, expenditures should adhere to the following guidelines. In the event that expenses are incurred that exceed these guidelines, the cost borne or reimbursed by the district will be limited to the costs that fall within the guidelines.

4.7 **Transportation.** Board members shall utilize the most economical mode and class of transportation reasonably consistent with scheduling requirements and space needs, using the most direct and time-efficient route.

4.7.1 **Rental Vehicles.** Charges for rental vehicles may be reimbursed under this provision if the expense is economical and reasonable for purposes of conducting the business of the district.

4.7.2 **Airfare**. Charges for airfare may be reimbursed under this provision if the expense is economical and reasonable for purposes of conducting the business of the district.

4.7.3 **Automobile**. Automobile mileage is reimbursed at Internal Revenue Service rates in effect at the time the expense is incurred. The IRS mileage reimbursement rate does not include bridge and road tolls, which

BOARD MEMBER COMPENSATION AND EXPENDITURE REIMBURSEMENT POLICY

are also reimbursable. These rates are designed to compensate the driver for gasoline, insurance, maintenance and other expenses associated with operating the vehicle. The Internal Revenue Service rates will not be paid for rental vehicles; only receipted fuel expenses will be reimbursed for rental vehicles.

4.7.4 **Taxis/Shuttles**. Taxis or shuttle fares may be reimbursed, including a fifteen percent (15%) gratuity per fare, when the cost is economical and reasonable for purposes of conducting the business of the district.

4.8 **Lodging**. Lodging expenses will be reimbursed or paid for when travel on official district business reasonably requires an overnight stay.

4.8.1 **Conferences/Meetings.** If lodging is in connection with a conference, lodging expenses may not exceed the group rate published by the conference sponsor for the meeting in question if such rates are available at the time of booking. If the group rate is not available, see next section.

4.8.2 **Other Lodging**. Travelers must request government rates, when available. Lodging rates that are equal or less than government rates are presumed to be reasonable and hence reimbursable for purposes of this policy. In the event that government rates are not available at a given time or in a given area, reimbursement of lodging expense shall be at a reasonable rate for the specific location of lodging.

4.9 **Meals**. Reimbursable meal expenses and associated gratuities will not exceed the Internal Revenue Service rates in effect at the time the expense is incurred. When the meal function is an organized event, the board member shall be reimbursed the amount being charged by the event organizer for the meal, regardless of whether the per person cost exceeds the Internal Revenue Service rates.

4.10 **Phone/Fax/ Internet**. Board members will be reimbursed for actual telephone and fax expenses incurred on district business. Telephone bills should identify which calls were made on district business. Board members will be reimbursed for internet access connection and/or usage fees away from home, not to exceed $15.00 per day, if internet access is necessary for district-related business.

4.11 **Airport Parking**. Board members will be reimbursed for airport parking expenses. Long-term parking must be used for travel exceeding twenty-four (24) hours.

5. **DOCUMENTATION**

BOARD MEMBER COMPENSATION AND EXPENDITURE REIMBURSEMENT POLICY

EXPENSE REPORTS

5.1 **Expense Report**. All expense reimbursement requests must be submitted on an expense report form provided by the district. Expense reports must document that the expense in question met the requirements of this policy.

5.2 **Submission Deadline**. Board members must submit their expense reports within sixty (60) days of an expense being incurred, accompanied by receipts documenting each expense.

5.3 **Audits.** All expenses are subject to verification that they comply with this policy.

COMPLIANCE WITH LAWS

5.4 Board members understand that some expenditures may be subject to reporting under the Political Reform Act and other laws. All agency expenditures are public records subject to disclosure under the Public Records Act and other laws.

VIOLATION OF THIS POLICY

5.5 Under state law, use of public resources or falsifying expense reports in violation of this policy may result in any or all of the following: (1) loss of reimbursement privileges; (2) a demand for restitution to the district; (3) the agency's reporting the expenses as income to the elected official to state and federal tax authorities; and (4) other civil penalties.

6. **EDUCATION/TRAINING** – N/A

7. **REFERENCES**

7.1 California AB1234,
7.2 California Government Code
7.3 California Health and Safety Code (Local Health Care District Law)
7.4 Bylaws of Salinas Valley Memorial Healthcare System

AUTHORIZATION

BOARD MEMBER COMPENSATION AND EXPENDITURE REIMBURSEMENT POLICY

President/CEO Date

Chief Financial Officer Date

FORMULATED: ~~10/2006~~
REVISED: ~~01/2013~~
REVIEWED:
DISTRIBUTION:
Originating Dept: ~~Administration~~
Legal Review: 101/2021~~3~~

QUALITY AND EFFICIENT PRACTICES COMMITTEE

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

(CATHERINE CARSON)

FINANCE COMMITTEE

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

(JOEL HERNANDEZ LAGUNA)

PERSONNEL, PENSION AND INVESTMENT COMMITTEE

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

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

(JUAN CABRERA)

a. Committee Chair Report
b. Board Questions to Committee Chair/Staff
c. Motion/Second
d. Public Comment
e. Board Discussion/Deliberation
f. Action by Board/Roll Call Vote

Board Paper: Personnel, Pension and Investment Committee

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

Executive Sponsor: Allen Radner, MD, Chief Medical Officer, Salinas Valley Health
Gary Ray, Chief Administrative Officer, Salinas Valley Health Clinics

Date: November 14, 2023

Executive Summary

In consultation with members of the medical staff, Salinas Valley Health (SVH) executive management has identified the recruitment of a physician specializing in urology as a recruiting priority for the Medical Center's service area. Based on the Medical Staff Development Plan, completed by ECG Management Group in January 2023, the specialty of Urology is recommended as a top priority for recruitment. Furthermore, the SVH Urology clinic receives approximately 350-450 new patient referrals per month.

The recommended physician, Ramaiah Indudhara, MD, has extensive training and experience in General Urology, Urology Surgery, Robotic Surgery, and Transplant Surgery. He is currently in private practice in Brawley CA, actively serves as a Colonel in the US Army Reserves, and provides locum tenens urology services throughout California. As Dr. Indudhara transitions out of his private Urology practice over the next 6 months, he will provide Urology Services to SVH one week per month then convert to become a full-time provider.

Terms and Conditions of Agreements

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

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

   - Professional Services Agreement (PSA). Physician will be contracted under a PSA with Salinas Valley Health and a member of Salinas Valley Health Clinics that provides W-2 relationship for IRS reporting.
   - Term. PSA is for a term of 2 years. Physician's annual compensation will be reported on an IRS W-2 Form as a contracted physician.
   - Part-Time Schedule. For a period of 6 months from the start date, Physician shall provide limited part-time medical services. Such part-time services shall be defined as 32 scheduled patient care hours per week, one week per month. Physician shall also be responsible to provide patient care services to Physician's patients at the Medical Center. During Physician's scheduled weeks, Physician shall provide one shift of weekday hospital call. In addition, based on scheduling needs, Physician shall provide three weekends (Saturday and Sunday) of hospital call during this initial 6-month period.
   - Part-Time Compensation.
     - Flat Rate. Physician shall be paid a flat rate of $10,000 per scheduled week, including weekday and weekend call during the initial part-time period.
     - Productivity. To the extent Work Relative Value Units (wRVU) Productivity exceeds Physician's Flat Rate Compensation, Physician shall be paid Productivity Compensation based on the number of extra wRVUs billed by Physician for performed services multiplied by $69.00.

- Full-Time Schedule. Once Physician begins providing medical services on a full-time basis, Physician shall provide Physician Services to Clinic patients 32 scheduled patient care hours per week, in a Clinic setting. Physician shall also be responsible to provide patient care services to Physician's patients at the Medical Center. Physician shall also provide hospital call coverage in equitable rotations with other credentialed urologists.

- Full-Time Compensation. Once Physician begins providing services on a full-time basis, the following compensation shall apply:

  - Base Compensation. Physician's base compensation, which includes wRVU productivity, supervision and Hospital Call activities, shall be in the amount of $500,000 per year.

  - Work RVUs Productivity Compensation. To the extent wRVU Productivity exceeds Physician's Base Compensation, Physician shall be paid Productivity Compensation based on the number of extra Work RVUs billed by Physician for his personally performed services multiplied by $69.00.

- Benefits. Once Physician begins providing medical services on a full-time basis, Physician will be eligible for standard SVH Clinics physician benefits:
  - Access to SVH Health Plan for physician and qualified dependents. Premiums are projected based on 15% of SVH cost.
  - Access to SVH 403(b) and 457 retirement plans. Five percent base contribution to 403b plan that vests after three years. This contribution is capped at the limits set by Federal law.
  - Four weeks (20 days) of time off each calendar year.
  - Continuing Medical Education (CME) annual stipend in the amount of $2,400 paid directly to physician and reported as 1099 income.
- Professional Liability. Physician will receive professional liability policy through BETA Healthcare Group.

2. **Recruitment Agreement** that provides a recruitment incentive of $80,000 which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

The recruitment of Dr. Indudhara is aligned with our strategic priorities for the service, quality 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 opening up access to care regardless of insurance coverage or ability to pay for services.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of Dr. Indudhara to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for the SVH Urology practice.

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

Recommendation

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

1. **The Findings Supporting Recruitment of Ramaiah Indudhara, MD,**

   - That the recruitment of a urologist to Salinas Valley Health Clinics is in the best interest of the public health of the communities served by the District; and

   - That the recruitment benefits and incentives the hospital proposes for this recruitment are necessary in order to attract and relocate an appropriately qualified physician to practice in the communities served by the District;

2. **The Contract Terms of the Recruitment Agreement for Dr. Indudhara; and**

3. **The Contract Terms of the Urology Professional Services Agreement for Dr. Indudhara.**

Attachments

- Curriculum Vitae for Ramaiah Indudhara, MD

CURRICULUM VITAE
September 2021

NAME
RAMAIAH INDUDHARA, MD,MBA, FACS, CPE

CITIZENSHIP
USA

MILITARY SERVICE
U.S. Army Reserve (COLONEL)
Six Active duty deployments since 2003 to present
(including Iraq and Afghanistan)

Academic Appointments
1) Clinical Asst. Prof. in Urology, Univ. of Kansas, Wichita, KS
2) Preceptorship for PA Students (affiliated with Stanford Univ. CA) Pioneers Memorial Hospital, Brawley, CA
3) Clinical Asst. Prof, USC, Los Angeles (Inactive)

Professional Training
1) MBBS from Univ. of Mysore, INDIA.
2) General Surgery Residency in Cleveland Clinic, Cleveland, OH.
3) Urology Residency, UAB, Birmingham, AL
4) AFUD Scholar/Transplant Immunology Fellowship, Cleveland Clinic, Cleveland, OH.
5) Kidney-Pancreas Transplant Fellowship,
USC, Los Angeles, CA.
6) MBA in Health Care from U. MASS, Amherst, MA
7) CPE (certified physician executive) from AAPL (American Association of Physician Leadership).

EDUCATION
2002 - 2003 Fellow in Kidney, Kidney-Pancreas Transplant Surgery, *St. Vincent's Medical Center/USC*, Los Angeles, California

1999 - 2000 AFUD Fellow in Transplantation, *The Cleveland Clinic Foundation,* Cleveland, OH

1995 – 1999 Resident in Urology, *University of Alabama at Birmingham,* Birmingham, AL

1994 – 1995 Resident in General Surgery, *Cleveland Clinic Foundation,* Cleveland, OH

1993 – 1994 Research Fellow in Urology, *VA Medical Center,* San Francisco, CA

1992 - 1993 Fellow in Transplantation Surgery, *Karolinska Institute,* Stockholm, Sweden

1982 - 1989 Resident in Surgery/Urology, *Postgraduate Institute of Medical Education & Research,* Chandigarh, India

1977 – 1982 Medical Education, *University of Mysore/Government Medical College,* Mysore, India

LICENSURE
California - A81435 (12/31/2022)

CERTIFICATIONS (all current)
American Board of urology American Society of Transplant Surgeons American College of Surgeons American College of Physician Executives *(Certified Physician Executive)*

PROFESSIONAL MEMBERSHIPS
American Urological Association
American Transplant Society
American Society of Transplant Surgeons
Vascular Access Society of America
American Medical Association

PROFESSIONAL EXPERIENCE
March 2013 – to present
Urologist
Pioneers Memorial Healthcare District Brawley, CA 92227.

June 2011 - Feb 2015
Urologist & Transplant Surgeon
Balboa Nephrology Medical Gp.,
Pioneer Memorial Hospital, Brawley, CA 92227

February 2006 – May 2011
Staff Urologist Beaver Medical Group, L.P.
Redlands, CA 9237*3*

January 2004 - January 2006
Staff Urologist Kidney-Pancreas Transplant Surgeon
Mendez Transplant and Urology Medical Group, Inc.
and
Sharp Memorial Hospital San Diego, CA 92123

January 2003 - December 2003
Fellow in Kidney-Pancreas Transplant Surgery
St. Vincent Medical Center National Institute of Transplantation
Los Angeles, CA 90001

July 2000 - December 2002
Staff Urologist TranSouth Health Care Inc.
Jackson, TN 38301

RESEARCH EXPERIENCE

1999 - 2000 The Cleveland Clinic Foundation, Cleveland, OH, Division of Transplant Immunology (Dr. Robert Fairchild, Ph.D.): *"Role of Chemokines in Acute Allografi Rejection".*

1996 - 1997 University of Alabama at Birmingham, Birmingham, AL, Department of Hematology-Oncology (Dr. Donald Miller, MD, Ph.D.): *"Triplex Forming Oligonucleotides for Molecular Treatment of Bladder Cancer".*

1993 – 1994 University of San Francisco, CA, Department of Urology (Perinchery Narayan, MD): "*Experimental and Clinical Studies on the Effects of Nd-YAG Laser on Prostate".*

1992 – 1993 Karolinska Institute, Stockholm, Sweden, Department of Transplantation Surgery (Carl G. Groth, MD): *"Biliary Cytology in Diagnosis of Post Liver-Transplant Dysfunctions".*

1999 - 2000 American Foundation for Urologic Diseases (AFUD) Scholar

HONORS/ AWARDS

Ramaiah Indudhara, MD Curriculum Vitae

1998 – 1999 Pfizer Scholar in Urology, University of Alabama at Birmingham, AL

1992 - 1993 Awarded the Karolinska Institute Scholarship in Transplantation Surgery, Stockholm, Sweden

Secured distinction in the M.S. (surgery) degree examination of the Postgraduate Institute of Medical Education & Research, Chandigarh, 160 012,India

Distinctions awarded in the following subjects during the M.B.B.S. course: Pharmacology, Pathology, Microbiology & Parasitology, and Obstetrics *&* Gynecology. Highest in the overall aggregate.

Best outgoing student of the Government Medical College, Mysore, 570 001, India

Recipient of the Government of India National Merit Scholarship for Undergraduate Medical School.

PUBLICATIONS

1. Indudhara R. Flechner SM, Goldfarb DA, Novick AC: Association between risk of chronic renal allograft rejection with type cyclosporine formulation. *J Urology, May 2000.*

2. Indudhara R. Kenney PJ, Bueschen AJ, Burns JR: Live donor nephrectomy in patients with fibromuscular dysplasia of the renal arteries*. J Urology, 199*9: 162*:*678-681.

3. Indudhara R. Minz M, Singh SK, Yadav RVS: The psychosocial impact of donating a kidney: Long-term follow-up from a urology-based center (letter). *J Urology, 1998*: 159:2101.

4. Indudhara R. Joseph DB, Perez LM, Diethelm AG: Renal transplantation in children with posterior urethral valves revisited: A 10-year follow-up. *J Urology, 1998*: 160:1201 – 1203.

5. Indudhara R, Burns JR: In-vitro fragmentation of urinary calculi by different electrohydraulic lithtripters*. J Endourol, 1997*; 11:S47.

6. Indudhara R: Personal awareness and effective patient care (letter). *JAMA* 1991, 278 *(*20) 1657.
Ramaiah Indudhara, MD Curriculum Vitae Page 5

7. Indudhara R, Bueschen AJ, Urban DA, Burns JR, Keith Lloyd:
Nephron-sparing surgery compared with radical nephrectomy for renal tumors - current indications and results. *Southern Med J* 1997; 90:982 985.

8. Indudhara R, Burns JR, Bueschen AJ, Urban DA, Keith Lloyd L:
Donor nephrectomy in patients with fibromuscular dysplasia (FMD) of the renal arteries. *J Urolog*y 1997; 15*7:275.*

9. Indudhara R. Keith Lloyd L, Bueshen AJ, Burns JR, Urban DA:
Interstitial cystitis (IC) in Males*. J Urolo*gy 1997; 157:131.

10. Indudhara R. Vogt D, Levis HS, Church J: Isolated splenic metastases from colon cancer. *Southern Med J* 1997; 90:633-6.

11. Indudhara R. Krajewski LR: Listeria monocytigenes infection of dialysis access graft - report of a case and review of literature*. Dialysis & Transplantation* 1997.

12. Tewari A, Indudhara R, Alphonse P, Narayan P: The results of urodynamic, sonographic and cytoscopic findings following laser prostatectomy for benign prostatic hyperplasia. *Brit J Urolog*y 1997.

13. Indudhara R, Novick AC, Hodge EE et al: Cadaveric kidney transplantation under prophylactic polyclonal antibody immunosuppression with anti-lymphoblast globulin versus anti thymocyte globulin. *Urolog*y 1996; 47: 807 – 12.

PUBLICATIONS C*ONTINUED*
14. Indudhara R, Khauli RB: Kidney transplantation in highly sensitized patients: reappraisal of etiology, evaluation and management protocols. *World J Urolo*gy 1996; 14:206 – 17.

15. Indudhara R, Kenney PJ: Should renal ultrasound be performed in the patient with microscopic hematuria and a normal excretory urogram*?* (Letter)*. J Urolo*gy 1996; 156:485.

16. Tewari A, Indudhara R, Shinohara K et al: Comparison of transrectal ultrasound prostatic volume estimation with magnetic resonance imaging volume estimation and surgical specimen weight in patients with benign prostatic hyperplasia. *J Clinic Ultrasound 1*996; 24:169-74.

17. Nash PJ, Bruce JE, Indudhara R. Shinohara K: Transrectal ultrasound guided prostatic nerve blockade eases systemic needle biopsy of the prostate. *Journal of Urology* February 1996; 155:607 – 609.

18. Fournier G, Indudhara R, Gajendran V et al: Epididymo-orchitis after cryoablation of prostate for prostate cancer. *J Endourol* 1995; 9:349 ... 351.

19. Narayan P, Indudhara R: Pharmacotherapy of benign prostatic hyperplasia. *Western Journal of Medicine* 1994; 61 (5): 495 – 506.

20. Indudhara R, Khauli RB, Menon M, Stoff JS: Simultaneous quadruple induction with cyclosporine and OKT3 for high-risk renal transplant patients. *Journal of Urology* July 1994.

21. Indudhara R. Menon M, Khauli RB: Post-transplant lymphocele presenting as "Acute Abdomen". *American Journal Nephrology* April 1994.

22. Narayan P, Fournier G, Indudhara R. Leidich R, Shinohara K, Ingerman A: Transurethral evaporation of prostate (TUEP) using Nd:YAG laser in patients with benign prostatic hyperplasia. *Urology* 1994; 43: 813 - 820.

23. Chugh KS, Sakhuja V, Jain S, Minz M, Joshi K, Indudhara R: High mortality in systemic fungal infections following renal transplantation in third-world countries. *Nephrology, Dialysis and Transplantation* 1993; 8: 168. 172

24. Sharma SK, Indudhara R: Role of chemodissolution in urinary uric acid lithiasis. *Urologia Internationlis,* 1992; 48: 81 – 86.

25. Indudhara R, Minz M, Singh SK, Yadav RVS: Tubercular pyomyositis in renal transplant recipient. *Tubercle & Lung Disease*, 1992, 73: 239 241.

PUBLICATIONS CONTINUED

26. Indudhara R. Vaidyanathan S: Urethral tuberculosis *Urologia*

Internationalis 1992; 48: 436-438.: 2*7.* Das K, Indudhara R. Vaidyanathan S: Ultrasound diagnosis of urinary
tuberculosis*. American Journal of Roentgenology (AJR),* 1992; 158: 327-329.

28. Indudhara R. Singh SK, Vaidyanathan S et al: Isolated invasive candidial prostatitis*. Urologia Internationalis 1*992; 48: 362-364.

29. Das K, Vaidyanathan S, Rajwanshi A, Indudhara R: Renal tuberculosis: diagnosis with sonographically guided aspiration cytology*. American Journal of Roentgenology (AJR),* 1992; 158: 571 – *57*3.

30. Indudhara R, Goswami AK, Choudhary R, Sarode V: Coexisting renal cell carcinoma and xanthogranulomatous pyelonephritis in a chronic calculus disease*. Urologia Internationalis* 1992; 48: 450 – 452.

31. Indudhara R, Singh SK, Minz M: Opinion poll regarding knowledge, attitudes and suggestions for developing cadaver donor program in India. *Transplantation Proceedings* 1992; 24 (5): 2069.

32. Indudhara R. Das KM, Sharma M et al: Seminal vesiculitis due to

Mycobacterium gastrii leading to male infertility*. Urologia Internationlis* 1991; 46: 99-100.

33. Indudhara R. Yadav RVS, Minz M et al: Sigmoid colon conduit urinary diversion in renal transplant recipient. *Urologia Internationlis* 1991; 47: 169-171.

34. Indudhara R, Yadav RVS, Minz M et al: Rhinocerebral mucormycosis in renal transplant recipient -report of a case and review of literature. *International Journal of Clinical Practice* 1991; 7:51 – 53.

35. Goswami AK, Indudhara R. Sharma SK: Renal plication for giant hydronephrosis tuberculosis*. International Journal of Clinical Practice* 1991; 7:49. 50.

36. Rajwanshi A, Indudhara R. Goswami AK et al: Fine needle aspiration cytology of testis in the evaluation of infertile males*. Diagnostic Cytopatholo*gy 1991; 7: 3-6.

37. Indudhara R. Vaidyanathan S: Spontaneous breakage of percutaneous nephrostomy catheter*. International Journal of Clinical Practice* 1991; 7:51-53.

38. Goswami AK, Indudhara R. Sharma SK: Flock's bladder tube reconstruction of entire female urethra. *Journal of Trauma* 1991; 32: 545 – 546.

39. Indudhara R. Vaidyanathan S, Sankaranarayanan S: Oral diclofenac sodium in renal colic - a prospective randomized study comparing with Baralgan TM and Pethidine. *Clinical Trials Journal* 1990; 27: 295 – 300.

PUBLICATIONS CONTINUED

40. Indudhara R. Yadav RVS, Minz M et al: Acute colitis in renal transplant recipients. *American Journal of Gastroenterology* 1990; 85: 964 -968.

41. Mandal AK, Sharma SK, Goswami AK, Hemal AK, Indudhara R: Obstructive uropathy in pregnancy. *International Journal of Obstetrics and Gynecology* 1990; 32: 67 - 70.

42. Indudhara R. Sharma SK, Rajwanshi A: Isolated testicular metastases from renal cell carcinoma. *Urologia Internationalis* 1990; 45: 186 --- 187.

43. Raj Babu, Vaidyanathan S, Sankaranarayanan S, Indudhara R: Effect of intracesical instillation of varying doses of verapamil (25mg, 40mg, 80mg) upon urinary bladder function in chronic traumatic paraplegics with overactive detrusor function. *International Journal of Clinical Pharmacology, Therapy & Toxicology* 1990; 28: 350-354.

44. Indudhara R. Sharma GP, Malik N et al: Postpyelolithotomy bleeding due to pseudoaneurysm. *Urologia Internationalis* 1989; 44: 244 – 246.

45. Kochhar R, Indudhara R, Nagi B, Yadav RVS, Mehta SK: Colonic tuberculosis due to atypical mycobacteria in a renal transplant recipient (letter). *American Journal of Gastroenterology* 1988; 83: 1435-6.

46. Yadav RVS, Indudhara R. Kumar P et al: Cyclophosphamide in renal transplantation. *Transplantation* 1988; 45: 421 – 424.

47. Yadav RVS, Kumar P, Indudhara R et al: Evaluation of living related renal donors. *Transplantation Proceedings* 1988; 20: 799.

COMMUNITY ADVOCACY COMMITTEE

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

(Joel Hernandez Laguna)

Medical Executive Committee Summary – November 9, 2023

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Ching, Jason MD	Neurology	Medicine	Tele-Neurology
Chumakova, Anastasia, MD	Neurology	Medicine	Tele-Neurology
Edwards, Mark, MD	Neurology	Medicine	Tele-Neurology
Mann, Jaspreet, MD	Neurology	Medicine	Tele-Neurology
Moussaoui, Asma, MD	Neurology	Medicine	Tele-Neurology
Pondicherry, Arnav MD	Psychiatry	Medicine	Tele-Psychiatry
Sahgal, Alok, MD	Neurology	Medicine	Tele-Neurology
Sandhu, Simranjit, DPM	Podiatry	Surgery	Podiatry

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Arrington, Cammon, MD	Pediatric Cardiology	Pediatrics	Pediatric Cardiology
Bernardino, Carlo, MD	Ophthalmology	Surgery	Ophthalmology
Chamberlain, Brittany, MD	Family Medicine	Family Medicine	Family Medicine – Active Community:
Chen, Patrick, MD	Internal Medicine	Medicine	Medicine – Active Community
Fajardo, Eric, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Harry, Wendell, MD	Palliative Medicine	Family Medicine	Family Medicine – Active Community
Honegger, Judy, DO	Ob/Gyn	Ob/Gyn	Obstetrics and Gynecology
Kim, Kyong-Mee, MD	Pediatric Cardiology	Pediatrics	Remote Pediatric Cardiology
Navarro, Misty, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Stemerman, Amy, MD	Radiology	Diagnostic Imaging	Mammography Diagnostic Imaging Non-Cardiac Diagnostic Radiology at Ryan Ranch: Core.
Yoneda, Glenn, MD	Medicine	Internal Medicine	Medicine-Active Community

Temporary/Locum Tenens Privileges:

NAME	SPECIALTY	DATES	RECOMMENDATION
Tabrizi, Peyman, MD	Neurosurgery	10/30/2023 – 12/10/2023	Locum tenens for Theodore Kaczmar, MD and Dragan Dimitrov, MD

NAME	SPECIALTY	PRIVILEGE	RECOMMENDATION
Kadakia, Rikin, MD	Interventional Cardiology	Implantable Pressure Sensor/Monitor (CardioMEMS System)	Requesting Temporary privileges effective 11/7/2023 while awaiting Board approval.
Lew, James, MD	Family Medicine	Category I and Category II Family Medicine Obstetrics	Requesting Temporary privileges effective 11/7/2023 while awaiting Board approval.
Maynard, Walter, MD	Radiology	Mammography Center	Relinquishing mammography privileges.

Staff Status Modifications:

NAME	SPECIALTY	STATUS	RECOMMENDATION
Ganji, Shiva, MD	Internal Medicine – Hospitalist	Provisional	Recommend advancement to Active staff.
Kroopf, Lisa, MD	Pain Medicine & Rehabilitation	Active	Requesting a Leave of Absence effective 10/26/2023.
Lo, Jennifer, DDS	Dentistry	Provisional	Recommend remain provisional staff to complete FPPE requirements.
Markovtsova, Anastasia, MD	Emergency Medicine	Provisional	Recommend advancement to Active staff.

Other Items:

Dept. of Medicine – Clinical Privileges Delineation Taylor Farms Family Health & Wellness Center	The Committee recommended approval of the revision to the clinical privilege delineation for Taylor Farms Family Health & Wellness – Revision (addition of Resident Moonlighting)

Interdisciplinary Practice Committee

Modification/Addition of Privileges:

NAME	SPECIALTY	DEPARTMENT
Morong, Shane, PA-C	Cardiac Surgery	Addition of insertion of intravenous arterial, central venous and Swan-Ganz catheters as directed by the cardiac surgeon

Policies, Plans and Privilege Forms: *(Attached)*

a. Hyperbilirubinemia-Infant Management Policy
b. Vacuum –Induced Management of OB Hemorrhage Policy

Informational Items:

I. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Quality and Safety Committee Reports:
    - Organ Donation Report
    - Resuscitation Committee Report
    - Department Quality Improvement Reports:
        - Critical Care Service Line
        - Perinatal Services
        - Taylor Farms Family Health and Wellness Center
        - Laboratory Services

II. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings
c. Medical Staff Treasury Report
d. Medical Staff Statistics Year to Date
e. HCAHPS Update

Status Pending PolicyStat ID 13657944

Last Approved	N/A	Owner	Julie Johnson: Clinical Manager
Last Revised	10/2023	Area	Women's and Children's Services
Next Review	3 years after approval		

Hyperbilirubinemia-Infant Management & Treatment

I. POLICY STATEMENT

A. Total Serum Bilirubin (TSB) level(s) will be drawn on all newborns prior to discharge (preferably coordinated with newborn genetic screen) and PRN for visibly detected jaundice prior to 24 hours of age.

II. PURPOSE

A. To guide the registered nurse (RN) in identification of newborns at risk for significant hyperbilirubinemia and provide guidelines for the use of different treatment methods.

III. DEFINITIONS

A. TSB – total serum bilirubin

B. TcB – Transcutaneous bilirubin

C. G6PD – Glucose-6-phosphate dehydrogenase

IV. GENERAL INFORMATION

A. Newborns (less than 28 days of age) will be assessed for hyperbilirubinemia during hospitalization including:

1. Risk factors predisposing development of hyperbilirubinemia
2. Presence, level and intensity of jaundice

B. Newborns with elevated TSB levels will be treated by phototherapy or transferred to NICU for evaluation and treatment.

V. PROCEDURE

A. ~~Identify newborns at risk for the development of hyperbilirubinemia.~~

1. Hyperbilirubinemia Risk Factors
    a. TSB/TcB in high-risk zone
    b. Jaundice in first 24 hours
    c. ABO incompatibility with positive direct Coombs, known hemolytic disease, or elevated ETCO
    d. Gestational age 35-36 weeks
    e. Prior sibling had phototherapy
    f. Cephalohematoma or bruising
    g. Exclusive breastfeeding, esp. with poor feeding or weight loss
    h. East Asian Race
2. Neurotoxicity Risk Factors
    a. Isoimmune Hemolytic Disease
    b. G6PD deficiency
    c. Asphyxia
    d. Significant lethargy
    e. Temperature instability
    f. Sepsis
    g. Acidosis
    h. Albumin < 3.0 g/dL

Identify newborns at risk for the development of hyperbilirubinemia.

1. Risk Factors for Developing Significant Hyperbilirubinemia
    a. Lower gestational age (ie, risk increases with each additional week less than 40 wk)
    b. Jaundice in first 24 hours after birth
    c. Predischarge transcutaneous bilirubin (TcB) or total serum bilirubin (TSB) concentration close to the phototherapy threshold
    d. Hemolysis from any cause, if known or suspected based on a rapid rate of increase in the TSB or TcB of >0.3 mg/dL per hour in the first 24 hours or >0.2 mg/dL per hour thereafter
    e. Phototherapy before discharge
    f. Parent or sibling requiring phototherapy or exchange transfusion
    g. Family history or genetic ancestry suggestive of inherited red blood cell disorders, including G6PD deficiency

h. Exclusive breastfeeding with suboptimal intake
i. Scalp hematoma or significant bruising
j. Down syndrome
k. Macrosomic infant of a diabetic mother

2. Hyperbilirubinemia Neurotoxicity Risk Factors
    a. Gestational age <38 weeks and this risk increases with the degree of prematurity
    b. Albumin < 3.0 g/dL
    c. Isoimmune hemolytic disease (ie, positive direct antiglobulin test), G6PD deficiency, or other hemolytic conditions
    d. Sepsis
    e. Significant clinical instability in the previous 24 hours

B. Promote and support successful breastfeeding (see BREASTFEEDING THE NEWBORN).

C. Interpret all TSB levels according to the newborn's age in hours utilizing:
    1. The Bilitool through Data Repository in the electronic health record (at http://bilitool.org/).
    2. The Bilitool website lists Hyperbilirubinemia Risk Factors, Neurotoxicity Risk Factors and links to Nomograms (Hours-Specific, Phototherapy and Exchange Transfusion) for newborns ≥35 week gestation.
        a. When reporting results to physician, report neurotoxicity risk for determination of initiation of phototherapy.

D. ~~Examine~~Visually assess all newborns for jaundice ~~during each shift assessment and as needed~~at least every 12 hours following delivery until discharge.
    1. In newborns, jaundice can be detected by blanching the skin with digital pressure, revealing the underlying color of the skin and subcutaneous tissue. The assessment of jaundice must be performed in a well-lit room.

E. If the newborn appears jaundiced in the first 24 hours of life:
    1. Obtain TSB as per order set and notify physician of results and recommendations per Bilitool.

F. All Newborns with TSB within 2 mg/dl of exchange transfusion threshold (See Nomogram on Bilitool) or with signs of Acute Bilirubin Encephalopathy, will be admitted into the NICU for evaluation and treatment.

G. On discharge, recommended follow-up appointments should take into account age at time of discharge and Risk Zone per the Bilitool. For example: Infants in the Low Intermediate Zone with Medium Hyperbilirubinemia Risk Factors should have follow-up within 48 hours if discharge age < 72 hours.

H. Parent Education: Prior to discharge parents will receive education to include:
    1. Observing for signs and symptoms of jaundice including yellow discoloration of skin

or eyes, lethargy, or poor feeding.

2. Contacting newborn's physician if signs and symptoms of jaundice are observed.
3. Risks associated with untreated jaundice, including acute bilirubin encephalopathy and kernicterus.
4. Scheduling any follow up laboratory studies or other health agency care/ appointments

I. Outpatient newborns with elevated Total bilirubin levels > 18 should be highly considered for readmission taking into account the patient's age (in days), presence of Major-Minor Risk factors (see above), follow-up compliance, etc. and/or availability of outpatient phototherapy.

1. If a newborn is readmitted, discussions should take place with the NICU Attending regarding the most appropriate admission location (NICU or 3rd Floor Pediatrics). Low risk babies can be readmitted to the Pediatric Service to facilitate Mother –Baby Bonding. Higher risk babies should be considered for NICU admission.

J. Documentation: Assessment, results and interventions are documented in the electronic health record.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. American Academy of Pediatrics.(~~2004~~2022). Clinical Practice Guideline Revision: Management of Hyperbilirubinemia in the Newborn Infant 35 ~~weeks or more gestation~~or More Weeks of Gestation. *Pediatrics,* ~~114~~150, ~~297-316~~(3). https://doi.org/10.1542/peds.2022-058859

B. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. (2017). *Guidelines for Perinatal Care.* (8th ed.). Author.

C. Creative Commons Attribution. (~~2016~~2022). Bilitool. Retrieved from www.bilitool.org.

Approval Signatures

Step Description	Approver	Date
Pediatrics Committee	Katherine DeSalvo: Director Medical Staff Services	Pending
Director of WCS	Julie Vasher: Director of Women's & Children's Services	10/2023

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Julie Johnson: Clinical Manager	05/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13867127

Last Approved	N/A
Last Revised	N/A
Next Review	3 years after approval
Owner	Daniela Jago: Clinical Manager
Area	Women's and Children's Services

Vacuum-Induced Management of OB Hemorrhage

I. POLICY STATEMENT

~~A. For use in postpartum patients experiencing abnormal bleeding or postpartum hemorrhage requiring temporary control or reduction of postpartum uterine bleeding.~~

~~B. Relative contraindications include:~~

~~1. Ongoing intrauterine pregnancy~~
~~2. Untreated uterine rupture~~
~~3. Unresolved uterine inversion~~
~~4. Current cervical cancer~~
~~5. Known uterine anomaly~~
~~6. Current purulent infection of vagina, cervix, or uterus~~
~~7. For C-sections: cervix <3 cm dilated before use of vacuum-induced hemorrhage control device~~

A. N/A

II. PURPOSE

A. To provide clinical guidance for use of the vacuum-induced hemorrhage control device for the management of a postpartum hemorrhage with a postpartum patient who has delivered either by cesarean or vaginal delivery.

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

~~A. N/A~~

A. Relative contraindications include:

1. Ongoing intrauterine pregnancy
2. Untreated uterine rupture
3. Unresolved uterine inversion
4. Current cervical cancer
5. Known uterine anomaly
6. Current purulent infection of vagina, cervix, or uterus
7. For C-sections: cervix <3 cm dilated before use of vacuum-induced hemorrhage control device

V. PROCEDURE

A. ~~Care Provider~~Medical Staff Member:

1. Assess patient and determine method of treatment required for postpartum hemorrhage
2. Determine uterus is clear of any retained placental fragments, arterial bleeding or lacerations
3. Placement of vacuum-induced hemorrhage control device
4. Verification of correct placement of intrauterine loop within uterus and cervical seal outside the cervical os through manual exam or ultrasound
5. Continued medical management of the patient including orders for medications, hydration, blood products, monitoring, etc.
6. Documentation of plan of care, procedures performed and patient's tolerance of procedure

B. Registered Nurse (RN):

1. Assess postpartum patient for postpartum bleeding
2. Notify Care Provider if bleeding is abnormal
3. Assist in placement of vacuum-induced hemorrhage control device
4. Fill cervical seal balloon with sterile fluid (predetermined volume per care provider order)
5. Monitor patient's vital signs and vaginal bleeding
6. Assess for signs of deteriorating or non-improving conditions and notify care provider
7. Documentation of assessments, interventions and evaluation of interventions

C. Review antepartum, intrapartum, birth and recovery period for risk factors for postpartum hemorrhage

1. Potential/known infection – chorioamnionitis, GBS (Group B Strep), etc.
2. Precipitous or rapid delivery
3. Traumatic delivery – shoulder dystocia, compound presentations
4. Abnormal presentations
5. Vacuum or forceps delivery

6. Cesarean delivery

D. Vacuum-induced hemorrhage control device placement following vaginal or cesarean delivery (transvaginal placement only)
    1. Evaluate patient for lacerations, retained products of conception, other causes of bleeding, and remove any organized clots before placing the device
    2. Connect syringe to seal valve to remove air from cervical seal before use
    3. Manually compress intrauterine loop and insert transvaginally into the uterus NOTE: Avoid excessive force. Do not grasp device with an instrument to facilitate intrauterine insertion
    4. Ensure correct placement of intrauterine loop within the uterus and cervical seal within the vagina at the external cervical os
    5. Fill the cervical seal with with 60-120mL of sterile fluid to achieve full coverage of the external cervical os. NOTE: Do not advance cervical seal into the uterus while filling. Confirm cervical seal is outside cervical os
    6. Turn on vacuum source and set to 80 mmHg (+/- 10 mmHg) while occluding the end of the tubing NOTE: The maximum vacuum pressure is 90 mmHg. Do not increase pressure higher than 90 mmHg or tissue trauma may occur
    7. Connect vacuum-induced hemorrhage control device to vacuum tubing
    8. Secure tubing to patient's thigh with tape

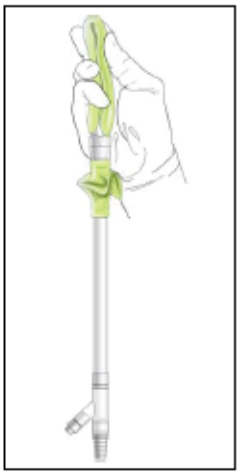


Figure 1

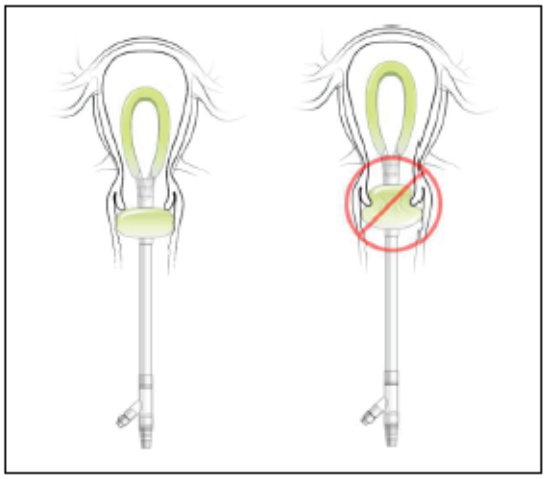


Figure 2

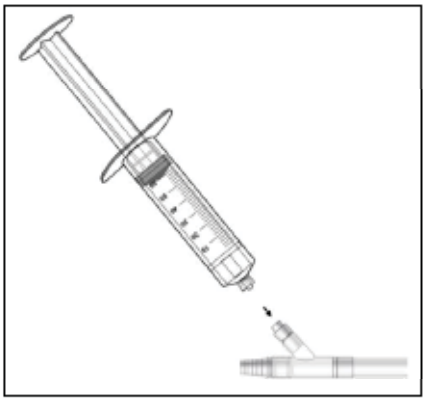


Figure 3

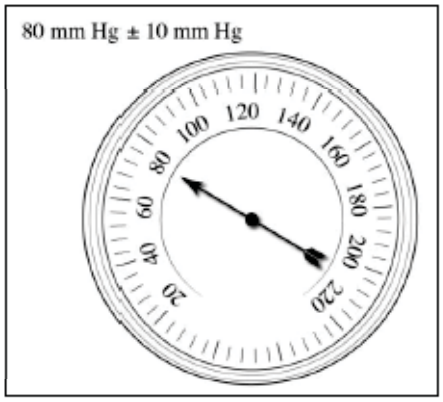
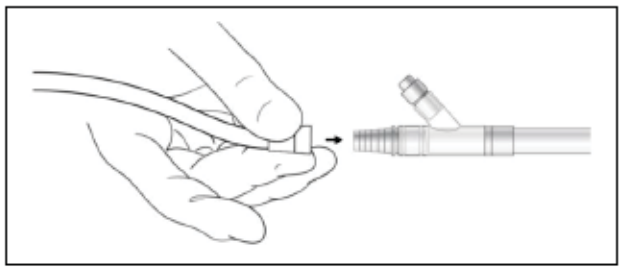


Figure 4



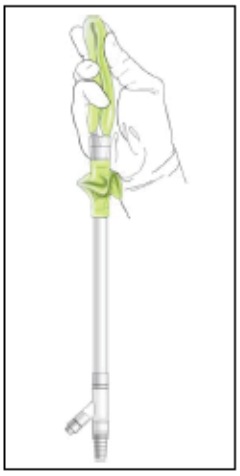


Figure 1

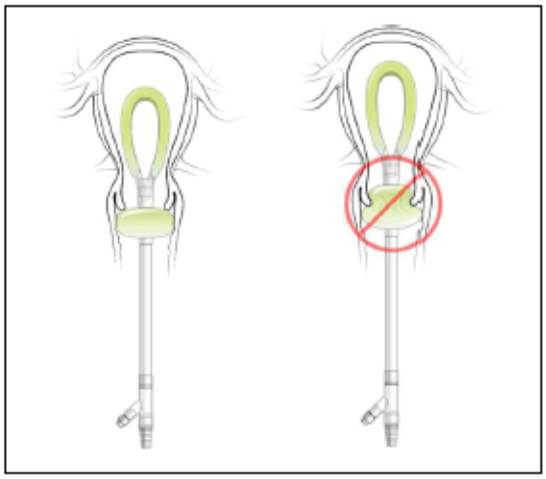


Figure 2

9.

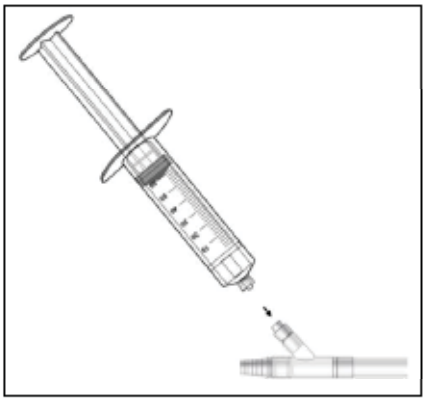


Figure 3

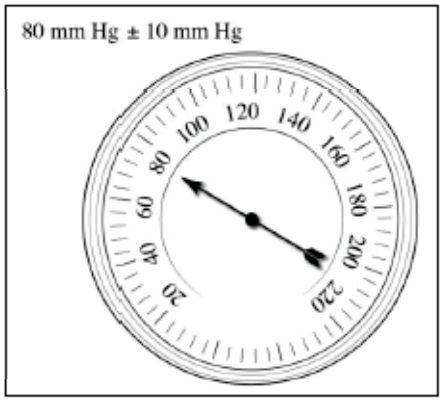
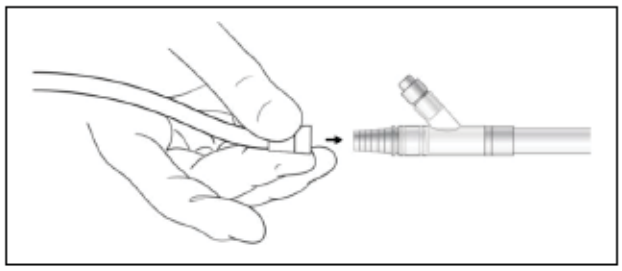


Figure 4



E. Treatment and Monitoring

1. Leave device in place with vacuum applied

2. Verify bleeding is controlled
3. Leave vacuum on far at least one hour after bleeding is controlled
4. Close monitoring for signs of increasing bleeding:
    a. Continued blood flow into the vacuum tubing and/or no improvement in uterine tone
    b. Deteriorating physiologic condition - tachycardia, decrease in BP, pallor, diaphoresis, change in level of consciousness, etc.
5. Do not leave the device in place for >24 hours
6. Monitor the patient every 15 minutes x 4, then every 30 minutes x 2, then every 1 hour until device is removed. Assessments should be increased if patient becomes unstable. **DO NOT DO VIGOROUS FUNDAL MASSAGE** Monitoring includes:
    a. Blood pressure
    b. Pulse
    c. Respirations
    d. Temperature
    e. Pain level including cramping/abdominal pain
    f. Intake and output
    g. Amount of bleeding in suction canister
    h. Amount of vaginal bleeding (if any)
7. Signs of deteriorating or non-improving conditions should indicate more aggressive treatment and management of patient uterine bleeding and requires that the provider be notified and involved with a further plan of care
8. Document all assessments, communications, interventions, and patient responses to interventions
9. Consider prophylactic antibiotics for prolonged use
10. Steps to removal of vacuum-induced hemorrhage control device
    a. Vacuum-induced hemorrhage control device can only be removed by a physician
    b. Confirm treatment is no longer needed
    c. Disconnect vacuum tubing from device while vacuum is on
    d. Remove all sterile fluid from cervical seal balloon
    e. Wait at least 30 minutes to verify bleeding is controlled
    f. If bleeding recurs, cervical seal can be re-inflated and suction restarted if appropriate
    g. If bleeding remains controlled and the uterus remains firm, the physician can slowly remove the vacuum-induced hemorrhage control device while supporting the uterine fundus
11. Following removal, monitor the patient every 30 minutes x 2, every 1 hour x 1, then resume routine assessments per postpartum standards of care. Assessments should be

increased if patient becomes unstable. Monitoring includes:

a. Blood pressure
b. Pulse
c. Respirations
d. Temperature
e. Pain level including cramping/abdominal pain
f. Intake and output
g. Amount of bleeding

12. Notify provider for signs of deteriorating or non-improving condition
13. Document all assessments, communications, interventions, and patient responses to interventions

F. Documentation:

1. Document assessment and patient response as appropriate in nursing notes

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. D'Alton, M., Rood, K., Smid, M., Simhan, H., Skupski, D., Subramaniam, A., Gibson, K., Rosen, T., Clark, S., Dudley, D., Iqbal, S., Paglia, M., Duzyj, C., Chien, E., Gibbins, K., Wine, K., Bentum, N., Kominiarek, M., Tuuli, M., & Goffman, D. (2020). Intrauterine vacuum-induced hemorrhage-control device for rapid treatment of postpartum hemorrhage. *Obstetrics & Gynecology, 136*(5), 882-891. https://doi.org/10.1097/AOG.0000000000004138

B. Organon. (2022). Jada system: Vacuum-induced hemorrhage control system, instructions for use. Retrieved online from https://www.organon.com/product/usa/pi_circulars/j/jada/jada_system_ifu_blue_seal.pdf

Approval Signatures

Step Description	Approver	Date
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Daniela Jago: Clinical Manager	08/2023

Standards

No standards are associated with this document

WittKieffer

Letter Agreement

VIA EMAIL: mchilds@salinasvalleyhealth.com

November 9, 2023

Ms. Michelle B. Childs
Chief Human Resources Officer
Salinas Valley Memorial Healthcare System
450 E. Romie Lane
Salinas, CA 93901

Dear Michelle:

Thank you for selecting Witt/Kieffer Inc. ("WittKieffer") to work in partnership with Salinas Valley Memorial Healthcare System operating as Salinas Valley Health (also "Client") for the recruitment of a new Chief Executive Officer. I and the entire WittKieffer team deeply value the confidence you've shown in us by entrusting to us this important assignment. We are pleased to begin the search process and look forward to working closely with you and the Board of Directors to its successful completion.

This Letter Agreement, including the associated exhibits and schedules, sets forth the fee and other important terms of this search assignment.

WittKieffer has agreed to a discounted professional fee, as noted below. We have also agreed to provide leadership assessments for up to three finalists in the overall fee.

- **WittKieffer Engagement Leads:** Mark Andrew and Michelle Johnson
- **Professional Fees**: WittKieffer's Professional Fee is one third of the placement's total cash compensation, inclusive of base salary, target annual incentives and any guaranteed cash compensation due during or in respect of the candidate's first full year of employment. For this particular search engagement, we agree to fix our professional fee at $325,000, regardless of the final compensation for the placed candidate.
    - **Estimated Base Salary for this Position:** $850,000
    - **Estimated Target Incentive and Cash Compensation Opportunities for this Position:** $100,000
- **Fixed Professional Fee for this Position**: $325,000
- **Technology, Research & Data Expenses**: A one-time per project fee of $10,000 will be billed for data and technology services, WittKieffer's proprietary database of more than 1.5 million leaders, specialized third party candidate database access, and other search expenses that are integral to but not easily segregable for this individual search assignment.

WittKieffer

- **Out-of-Pocket Expenses**: Out-of-pocket expenses directly related to this search assignment will be billed to Client. Such expenses may include, but not be limited to: WittKieffer consultant and candidate travel and accommodations, and other consultant-candidate interview costs, education, employment and licensure verification, media checks, advertising, overnight delivery, and professional printing.

- **Leadership Assessments with Early Onboarding Support: (Optional, Check as Applicable)**

  We believe that integrating these assessments into the search process – coordinated closely with our consultants and licensed psychologists – materially reduces the risk in your hiring decision while enhancing success in onboarding the right candidate for you. Assessments include candidate interviews by a licensed psychologist, administration of a comprehensive set of best-in-class online assessments, a findings review session with Client selection manager prior to finalist interviews, and suggested interview strategies based on assessment findings, if needed. Early onboarding support includes a 90-minute individual debrief and feedback session with the placement and the psychologist to help in their transition, a joint manager planning session (psychologist, placement, and Client hiring manager) to optimize alignment and articulate goals for the placement's success, and 100-day post hire progress review (WittKieffer, placement and psychologist) to calibrate progress and ongoing success strategies.

  As an added value for this search, WittKieffer is pleased to offer complimentary assessments for up to three finalist candidates.

☐ **Client Elects Assessments**: One Finalist Candidate: $5,000
Second Finalist Candidate: $4,000
Third and Additional Finalist Candidates: $3,000 each

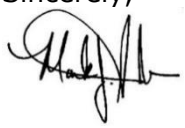
☐ **Complimentary Assessments** Up to Three Finalist Candidates $0
Additional Candidates $3,000 each

☐ **Client Declines**:

WittKieffer's standard terms and conditions are provided in the attached Exhibit A. Client's authorized signature at the bottom of this Letter Agreement confirms acceptance of the terms of this Letter Agreement including the terms and conditions provided in Exhibit A. This Letter Agreement, and the exhibits incorporated herein, contain the entire agreement between the parties with respect to the subject matter of this Letter Agreement. Any terms and conditions not contained in this Letter Agreement, shall not be valid and binding unless expressly agreed to in writing by both parties.

Thank you, again, for the opportunity to serve Salinas Valley Memorial Healthcare System operating as Salinas Valley Health. We are enthusiastic about this engagement and are fully committed to finding an outstanding leader for your organization.

Sincerely,



Witt/Kieffer Inc.
By: Mark J. Andrew
Senior Partner

WittKieffer

ACKNOWLEDGED and ACCEPTED:

_____ _____

Signature Date

_____

Title

Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

Invoices Contact: (Invoices will be sent by email.)

Email: _____

Name: _____

Title: _____

Mailing Address: _____

_____

Phone: _____

Does Client require a Purchase Order? ☐ Yes ☐ No
If yes, please send Purchase Order to ARAccounting@wittkieffer.com within five business days of execution of this Letter Agreement.

Is Client Tax Exempt? ☐ Yes ☐ No
If Yes, please forward Tax Exempt Certificate to ARAccounting@wittkieffer.com at your earliest convenience.

Letter Agreement Exhibits and Attachments

Exhibit A – Terms and Conditions of Search
Exhibit B – End User Certification
Attachment 1 – Bank Details for ACH Payments
Attachment 2 – WittKieffer W9

WittKieffer

Exhibit A
Witt/Kieffer Inc.
Terms and Conditions of Search

1. **Background Checks**.
   a. It is WittKieffer's practice to obtain background reports for each candidate, internal and external, who is advanced to Client interviews. The resulting background reports, solely used for employment purposes, include verifications of the candidate's employment, academic degrees, professional licenses and certifications, and a review of public sources for relevant information.
   b. WittKieffer uses Mintz Group LLC ("Mintz"), a leading provider of background checking and due diligence services, to conduct the background screenings. Mintz is a consumer reporting agency under the Fair Credit Reporting Act (FCRA). In addition to WittKieffer, Client is a user of the information provided in the background reports provided by Mintz for candidates being considered for employment by Client. In order to ensure compliance with the Fair Credit Reporting Act and to commence any background checks on behalf of a client, the Mintz Group requires that such client sign the End User Certification form, also attached to the Letter Agreement as Exhibit B. WittKieffer has signed the form attesting to its responsibilities in the process. WittKieffer assumes primary responsibility for the items referenced in Paragraphs 2, 3, 4 and 5 of the End User Certification, an example of which is provided in Exhibit B. Unless previously executed by Client, the End User Certification is to be executed along with this Letter Agreement.
   c. In the event that Client does not sign the End User Certification form for any reason, neither Mintz nor WittKieffer can legally provide Client with access to or copies of the background report or any information contained therein for any candidates being considered for employment by Client.
   d. In addition to the background check conducted by Mintz, Client is strongly encouraged to conduct credit and criminal background checks on any finalist(s). In addition, if Client has not signed the EUC and thus cannot access the background report or the information therein, Client also is strongly encouraged to conduct media checks on any finalist(s).

2. **Billing Arrangements**
   a. An initial invoice for one third of the Estimated Professional Fee plus the Technology, Research and Data Expenses will be submitted at the start of the search, the date of which will be mutually agreed by Client and WittKieffer.
   b. Two additional invoices, each for one third of the Estimated Professional Fee plus any Out-of-Pocket Expenses, will be submitted at 60 and 90 days.
   c. Invoices for additional Out-of-Pocket Expenses incurred will be submitted monthly thereafter.

WittKieffer

d. Payment on invoices is due within 45 days of date of invoice. Payment shall be made by electronic transfer in accordance with the instructions set forth in the invoice or such alternative instructions as may be provided by WittKieffer from time to time. A late penalty of .5% per month will be charged for past due amounts. All bills must be paid within 60 days of the candidate signed offer letter to activate the placement guarantee described in Section 6 below. Sales tax will be invoiced with fees, if it is applicable for the organization and the state.

3. Delay or Cancellation of Search

a. If the search is delayed by more than 30 days or the specifications for this search assignment are substantively changed, WittKieffer may charge an additional fee as consideration for the additional work and resources required to re-initiate the search process. If, for any reason, Client cancels the search prior to successful completion, Client is responsible only for the Estimated Professional Fees, Technology, Research and Data Expenses and Out-of-Pocket Expenses billed up to the date of cancellation, plus Out-of-Pocket expenses incurred but not yet billed.

b. A search that is suspended or placed on hold may be re-started within six months of this Letter Agreement without additional Professional Fees or Technology, Research and Data Expenses provided the search is for the same position stipulated in this Letter Agreement. Otherwise, any search that is re-started after being suspended or placed on hold will be subject to additional search fees, as provided in 3(a) above. A search placed on hold for more than six months will be considered cancelled.

c. If after nine months following the date of this Letter Agreement, WittKieffer has provided a finalist slate of candidates for selection by Client but Client seeks to restart the search process as a result of Client's material changes to its internal management of the search engagement, including but not limited to a change in the composition of the search committee or hiring manager, the search may be terminated or will be subject to additional search fees as provided in 3(a) above.

4. Hiring of Additional Candidates

a. If an additional candidate is hired by Client as a result of this search assignment, there is a professional fee equal to 20% of such candidate's first year’s total compensation inclusive of base salary, target annual incentives and any guaranteed cash compensation due during or in respect of the candidate's first full year of employment. This fee applies to any individual candidate hired within six months of the close of the search. WittKieffer's guarantee in Section 6 below is not applicable to any such additional hire.

5. Publication of Search and Use of Client Images

a. By signing this Letter Agreement, Client authorizes WittKieffer, solely with respect to the search assignment, to:

i. publish and post photographs and other images taken of Client, on our website or other social media including logos and other branded markings, photographs and other images printed, published and/or available online.

ii. use placement's name and approved image, along with Client's name, image and logo, on the WittKieffer external website and in social media, in connection with Client's press release or other announcement of new hire, if any.

6. Quality Guarantee

a. Recognizing the importance to Client of the search assignment defined in this Letter Agreement, and WittKieffer's unwavering commitment to quality, WittKieffer is pleased to extend WittKieffer's quality guarantee. If the executive we place with Client ceases to be employed by Client in any capacity within one year of the executive's commencement of employment, then WittKieffer will search for a replacement to fill the original position without additional Professional Fees or Technology, Research and Data Expenses charged to Client.

b. WittKieffer must receive notice of the need for a replacement search promptly from Client, but no later than 30 days after departure of the placement from employment with Client. Activation of the guarantee is based upon Client's notification to WittKieffer of the departure within such 30 day period. Based upon discussion between Client and WittKieffer, a mutually agreed upon start date for the replacement search should occur within a reasonable period, but no later than 90 days from the departure date of the placement.

c. This guarantee only applies to the position defined in this Letter Agreement, to the first candidate placed in the position, and for a substantially similar search and leadership profile. WittKieffer's guarantee excludes those situations where the placement departs due to organizational realignment, department restructuring, material changes in the position, death or disability. Additional out-of-pocket expenses associated with the replacement search will be charged in the same manner as the original search.

7. Data Privacy

a. In the course of the search engagement, WittKieffer may provide Client with personally identifiable information ("Personal Information") related to actual or potential candidates, participants in assessments provided as part of the engagement and/or persons who provide any view or opinion regarding the qualities or abilities of any candidate or participant, for any purpose. WittKieffer takes data privacy seriously and is committed to protecting the confidentiality of Personal Information consistent with applicable data privacy laws. Any Personal Information that WittKieffer provides to Client is provided only for use by Client in the search engagement defined in this Letter Agreement and may not be shared by Client with any other person or entity. Client agrees to use the Personal Information only for the search engagement defined in this Letter Agreement, to share such Personal Information only with Client personnel or representatives who have a need to know, to protect the confidentiality and security of Personal

Information consistent with the requirements of this Letter Agreement and applicable law relating to data protection, and to destroy all such Personal Information of candidates not employed by Client immediately following closure of this search engagement, or sooner if requested to do so by WittKieffer in writing.

8. Non-Solicitation

a. WittKieffer will not recruit any Client employees who will be directly involved, and with whom WittKieffer will work, on this search assignment during the search and for a period of one year from the completion of the search.

WittKieffer

Exhibit B
Witt/Kieffer Inc.
End User Certification

In compliance with the Fair Credit Reporting Act (FCRA) (15 U.S.C. 1681 et seq., as amended) and its state analogues, Salinas Valley Memorial Healthcare System operating as Salinas Valley Health ("End User") hereby certifies to Mintz Group LLC ("Mintz"), a consumer reporting agency, that it will comply with the following provisions:

1. End User will use the information from the report provided by Mintz for employment purposes only, and only in accordance with applicable law. End User specifically agrees that the information provided by Mintz is for End User's exclusive use only.

2. End User or its agents will make a clear and conspicuous disclosure to the applicant or employee, in writing and in a separate document, or by such other means as is permitted by applicable law, and satisfying all requirements identified in Section 606(a)(1) of the FCRA as well as any applicable state or local laws, that a consumer report may be obtained for employment purposes.

3. End User or its agents will obtain the proper written or other legally permissible authorization from the applicant or employee for any consumer report prior to requesting any consumer report.

4. End User or its agents will provide to the applicant or employee a "Summary of Your Rights Under the Fair Credit Reporting Act" (https://files.consumerfinance.gov/f/documents/bcfp_consumer-rights-summary_2018-09.pdf, as may be amended from time to time). End User or its agents also acknowledge receipt of the Notice to Users of Consumer Reports (https://www.consumerfinance.gov/rules-policy/regulations/1022/n/, as may be amended from time to time).

5. End User or its agents will maintain a copy of the applicant's or employee's signed disclosure and consent forms in its records for a period of five years (or such other period as may be required by applicable law).

6. In the event that an adverse decision regarding employment is going to be made by an End User based on information contained in a consumer report, End User will – before any adverse action is taken – provide to the applicant or employee as required by the FCRA and any other applicable law, proper notices, statements and other information, including, without limitation, a copy of the consumer report obtained, and a "Summary of Your Rights Under the Fair Credit Reporting Act;" inform the applicant or employee that he/she has the right to dispute the content of the report through Mintz; and delay taking adverse action for a reasonable time after providing this notice.

7. In the event that an End User takes an adverse action based on information contained in a consumer report, End User will – upon taking such adverse action – provide to the applicant or employee the information statutorily required by Section 615 of the FCRA as well as any applicable state or local laws, including notice of the action that is being

taken; the name, address and telephone number of Mintz; and a statement that Mintz is unable to provide to the applicant or employee the specific reasons that the adverse action was taken by the End User.

8. In addition to the disclosure requirements identified above, if the applicant or employee makes a written request within a reasonable amount of time, End User or its agents will provide: (1) information about whether an investigative consumer report has been requested; (2) if an investigative consumer report has been requested, written disclosure of the nature and scope of the investigation requested; and (3) Mintz's contact information, including complete address and toll-free telephone number. This information will be provided to the applicant or employee no later than five (5) days after the request for such disclosure was received from the applicant or employee or such report was first requested, whichever is later, unless some other period of time is required by applicable law.

9. End User will not use information from a consumer report in violation of any applicable federal or state equal employment opportunity law or regulation.

10. In the event that the applicant or employee disputes the information contained in a consumer report with respect to his or her post-secondary educational history, End User or its agent shall notify Mintz Group of the dispute and, to the extent that the applicant or employee's school or school's third-party representative prepares a report addressing the dispute, Mintz Group shall provide a copy of the report to End User or its agent, which shall then forward the report to the applicant or employee.

The undersigned is a duly authorized representative of the above-named End User who certifies that he or she has the authority to agree on behalf of the Company to the terms and conditions set forth in this End User Certification. A facsimile transmittal of this agreement may serve as a legal and binding document.

Signature _____ Date _____

Title _____

Salinas Valley Memorial Healthcare System operating as Salinas Valley Health

WittKieffer

PNC

January 6, 2022

To Whom it May Concern:

Please accept this letter as confirmation of the Witt/Kieffer, Inc. bank account at PNC Bank. We certify the account details below are correct per our records.

Account Title: Witt/Kieffer, Inc.
Account Number: 93839922
Pay Routing/Transit Number: 021052053

Should you have any questions, please contact me Sarah Vehlow, at 312.338.2293 or sarah.vehlow@pnc.com

Sincerely,

Sarah Vehlow
Senior Vice President, Relationship Manager
Corporate & Institutional Banking

PNC Financial Services Group, Inc.
1 North Franklin; Suite 2800
Chicago, Illinois 60606

WittKieffer

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
Witt/Kieffer Inc.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☑ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) 5

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
2015 Spring Road Suite 510

Requester's name and address (optional)

6 City, state, and ZIP code
Oak Brook IL 60523

7 List account number(s) here (optional)

Print or type. See Specific Instructions on page 3.

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number
			–			–				

or

Employer identification number
3	6	–	2	9	1	9	3	2	0

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here Signature of U.S. person ▶ Erin Lavelle **Date** ▶ November 7, 2022

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

Cat. No. 10231X Form **W-9** (Rev. 10-2018)

Mike Halloran
Senior Partner

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Michelle Childs
Chief Human Resources Officer
Salinas Valley Health
450 E. Romie Lane
Salinas, CA 93901

November 1, 2023

Subject: Statement of Work: Total Compensation Review for CEO

The objective of this Statement of Work ("SOW") is to outline the scope of our work and related fees for this total compensation review. This SOW is subject to the terms and conditions contained in the engagement letter between Salinas Valley Health ("SVH") and Mercer dated February 8, 2018. All capitalized terms not defined in this SOW shall have the meanings ascribed to them in our existing engagement letter.

Project Details

1. **Project name:** Market Review of CEO Total Compensation
2. **Description of Mercer responsibilities:** Review market total compensation levels for CEOs of comparable healthcare systems (to be determined with input from SVH). This review would cover all major compensation elements, including base salary, incentive opportunities, supplement retirement and any other supplemental benefits (beyond what is provided to the regular employee group), and major perquisites. (More fully described below in "Services to be provided.)
3. **Period of time over which work will be performed:** The project should take about four to six weeks to complete. Assuming we begin in mid-November, the work should be completed by end of the year. This assumes no significant delays in collecting data or in scheduling meetings/ discussions. Any follow-up work may continue through the end of the first quarter of 2024.
4. **Compensation/fees:** $20,000 to $25,000

Services to Be Provided

The following are the key steps in the project:

- **Collect and Review Relevant Data:** We would collect and review relevant data on SVH and existing compensation agreements and programs covering the CEO position (recognizing that the current CEO has announced his plans to depart)
- **Hold Telephonic Discussions:** Similar to the last review, we would plan individual phone interviews with select Board members as needed, and with you as Chief Human Resources Officer, to confirm our understanding of the existing compensation programs and agreements (to the extent they have changed since 2020), the overall objectives of the executive compensation programs, the definition of the competitive market (i.e., potential peer organizations) and any other relevant considerations

- **Identify Peer Organizations:** A group of comparable healthcare organizations will be identified for use in the market compensation analysis for the CEO position. This group will be developed based on input from SVH (Board members, possibly the current CEO and yourself) and research by Mercer. This group will include a list of specific, similar institutions along with a description of similar institutions (e.g., similar size, services, etc.) - - this description will be used to select the sample of organizations from Mercer's database to be used in the analysis. We have assumed this group will be similar to that used in the 2020 study, which included both similar organizations across the US and similar organizations in California.
- **Conduct Market Analysis:** The total compensation package for the CEO will be analyzed relative to similar positions within the peer group organizations. As discussed earlier, the analysis will cover base salary, incentives (annual target bonus and annual long-term incentives, where provided), supplemental retirement and related benefits, deferred compensation and perquisites. Statistical analyses (median, 25th and 75th percentiles) will be developed for each element of the package and for the package overall.
- **Prepare and Present Final Report:** We will summarize the results of our analyses in a final report, and meet with the Board (virtually, as requested) to present the results of the CEO compensation analysis. Specific market details will be provided across each compensation element. The report will also provide a summary of the methodology, findings and our overall conclusions.

Fee Structure

Our compensation for the services will be professional fees in the amount of $20,000 to $25,000. In addition to such compensation, we also bill for necessary travel and other expenses, including compensation survey data, related to the services requested. These charges should be minimal.

* * *

If you have any questions about these terms and conditions, please do not hesitate to call me. If not, please indicate your agreement to the terms of this Agreement by signing the enclosed copy of this Agreement and SOW, if applicable, and returning it to us.

Mercer (US) Inc.

By: Michael J. Halloran Date: November 1, 2023

Name: Michael J. Halloran

Title: Senior Partner

ACCEPTED AND AGREED
Salinas Valley Health

By: _____ Date: _____

Name: Michelle Childs

Title: Chief Human Resources Officer

RESOLUTION NO. 2023-05

RESOLUTION OF THE BOARD OF DIRECTORS OF SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

AUTHORIZING DESIGNATED OFFICERS TO EXECUTE FINANCIAL INSTITUTION DOCUMENTS

WHEREAS, Salinas Valley Memorial Healthcare System is a public health care district duly organized and operated pursuant to Division 23 of the California Health and Safety Code ("SVMHS" or "District") and operates as SALINAS VALLEY HEALTH;

WHEREAS, SVMHS maintains and utilizes one or more financial accounts for and in the name of SVMHS to meet the operational requirements of the District; and

WHEREAS, the Board of Directors have appointed Dr. Allen Radner, M.D. as Interim President/Chief Executive Officer of the District effective December 1, 2023, and have determined that Pete Delgado's term as President/CEO shall end effective November 30, 2023.

WHEREAS, the Board of Directors has determined that it is in the best interest of the District to allow the District's Board President, Interim President/Chief Executive Officer and the Chief Financial Officer to open, maintain and utilize one or more financial accounts for and in the name of SVMHS for the purpose of banking and financial transactions necessary to meet the operational requirements of SVMHS;

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

1. The SVMHS Board President, Interim President/Chief Executive Officer and the Chief Financial Officer are hereby authorized to execute any and all documents necessary to establish and maintain, on behalf of the District, such financial accounts as necessary to meet the operational needs of the District.

2. All funds in such accounts shall be invested solely in accordance and compliance with California Health Care District Law and Sections 53600 and following of the California Government Code pertaining to investments of funds as applicable to California health care districts, and with all SVMHS investment policy guidelines.

3. Any officer of the Board of Directors is hereby authorized for and on behalf of the Board of Directors to act on and execute such documents necessary to carry out the intent of this Resolution.

4. Each person designated by the Board pursuant to this resolution is authorized on behalf of the District to:

    (a) Open and maintain one or more financial accounts for and in the name of SVMHS at financial institutions meeting the requirements of SVMHS for the purpose of banking and other financial transactions;

    (b) Deposit, withdraw and transfer funds on behalf of SVMHS among such financial institutions and SVMHS as necessary to meet the operational needs of

SVMHS; and

(c) Execute all documents, and exercise and direct the exercise of all duties, rights, and powers and take all actions necessary or appropriate to perform the powers enumerated in this resolution.

5. Each of the following is authorized to perform the powers enumerated in this resolution:

(a) Victor Rey, Jr., Board President, SVMHS

_____
Signature

(b) Dr. Allen Radner, M.D., Interim President/Chief Executive Officer, SVMHS

_____
Signature

(c) Augustine Lopez, Chief Financial Officer, SVMHS

_____
Signature

6. No person or entity other than the District shall have any interest in any financial account opened in the name of the District. Effective November 30, 2023, Pete Delgado is no longer serving as President/CEO of the District.

7. The Board of Directors authorizes the Interim President/Chief Executive Officer and/or Chief Financial Officer to complete and submit any and all bank-specific Resolutions required by the District's current banking partners, including without limitation, Mechanics Bank, consistent with the terms of this Resolution.

This Resolution was adopted at a Regular Meeting of the Board of Directors of the District on November 16, 2023, by the following vote.

AYES:
NOES:
ABSTENTIONS:
ABSENT:

_____
Dr. Rolando Cabrera, Secretary
Salinas Valley Memorial Healthcare System

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT