October 20, 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, OCTOBER 26, 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, OCTOBER 26, 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**	*Joel Hernandez Laguna*
2.	**CLOSED SESSION** *(See Attached Closed Session Sheet Information)*	*Joel Hernandez Laguna*
3.	**RECONVENE OPEN SESSION/CLOSED SESSION REPORT** *(Estimated time 5:00 pm)*	*Joel Hernandez Laguna*
4.	**REPORT FROM THE PRESIDENT/CHIEF EXECUTIVE OFFICER**	*Pete Delgado*
5.	**PUBLIC INPUT** This opportunity is provided for members of the public to make a brief statement, not to exceed three (3) minutes, on issues or concerns within the jurisdiction of this District Board which are not otherwise covered under an item on this agenda.	*Joel Hernandez Laguna*
6.	**BOARD MEMBER COMMENTS**	*Board Members*
7.	**CONSENT AGENDA - GENERAL BUSINESS** *(Board Member may pull an item from the Consent Agenda for discussion.)*	*Joel Hernandez Laguna*

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

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

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

8. REPORTS ON STANDING AND SPECIAL COMMITTEES

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

Minutes of the October 23, 2023 Quality and Efficient Practices Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

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

Minutes of the October 23, 2023 Finance Committee meeting have been provided to the Board for their review. The following recommendations have been made to the Board:

1. Consider Recommendation for Board Approval of the Optum360 Lynx Software Service Agreement Renewal
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote
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)
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote
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

a. Questions to Committee Chair/Staff
b. Motion/Second
c. Public Comment
d. Board Discussion/Deliberation
e. Action by Board/Roll Call Vote

4. Consider Recommendation for Board Approval of a management service and supply agreement with Aramark for Food and Nutrition Services including Starbucks
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote

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

Minutes of the October 24, 2023 Personnel, Pension and Investment Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

1. Consider Recommendation for Board Approval of (i) The Findings Supporting Recruitment of Nicholas Klimberg, MD, (ii) The Contract Terms for Dr. Klimberg's Recruitment Agreement, and (iii) The Contract Terms for Dr. Klimberg's Pulmonology Professional Services Agreement
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote

2. Consider Recommendation for Board Approval of Contract Terms for Juan Rodriguez, MD's Diagnostic and Interventional Radiology Professional Services Agreement
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote

3. Consider Recommendation for Board Approval of Findings Supporting Recruitment of Physicians to Monterey Bay GI Consultants Medical Group and Approval of Recruitment Incentives
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote

D. **TRANSFORMATION, STRATEGIC PLANNING, AND GOVERNANCE COMMITTEE** *Rolando Cabrera, MD*

Minutes of the October 25, 2023 Transformatiuon, Strategic Planning, and Governance Committee meeting have been provided to the Board for their review. Additional Report from Committee Chair, if any.

1. Consider Recommendation for Board Approval of the Organizational Goals FY2024
    a. Questions to Committee Chair/Staff
    b. Motion/Second
    c. Public Comment
    d. Board Discussion/Deliberation
    e. Action by Board/Roll Call Vote

E. **REPORT ON BEHALF OF THE MEDICAL EXECUTIVE COMMITTEE (MEC) MEETING OF OCTOBER 12, 2023, AND RECOMMENDATIONS FOR BOARD APPROVAL OF THE FOLLOWING:** *Rakesh Singh, MD*

1. Reports
    a. Credentials Committee Report
    b. Interdisciplinary Practice Committee Report
2. Policies/Plans
    1. Plastic & Reconstructive Surgery Clinical Privilege •Delineation Revision
    2. General and Colorectal Surgery Clinical Privilege Delineation Revision
    3. Orthopedic Surgery Clinical Privilege Delineation Revision
    4. Podiatric Surgery Clinical Privilege Delineation Revision
    5. Regional Wound Healing Center Clinical Privilege Delineation Revision
    6. Hazardous Materials & Waste Management Plan - Update
    7. Withdrawing Life-Sustaining Treatment - Update

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

10. ADJOURNMENT

The Regular Meeting of the Board of Directors is scheduled for **Thursday, November 16, 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

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. Report of the Quality and Efficient Practices Committee
    - Risk Management/Patient Safety
    - Accreditation and Regulatory updates
    - Leapfrog survey and Safety Grade Reports
    - Leapfrog Hospital Survey Review

2. Quality and Efficient Practices Committee Consent Agenda:
    - Environment of Care – Workplace Safety Report
    - Risk Management / Patient Safety – Full report
    - Accreditation and Regulatory – Full report
    - Restraint Committee Full Report
    - Pharmacy & Therapeutics/Infection Prevention Full Report

3. Medical Executive Committee Report
    - Credentials Committee
    - Interdisciplinary Practice Committee
    - Medical Staff Quality and Safety Committee

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

PUBLIC EMPLOYEE APPOINTMENT
(Government Code §54957)

Title: (Specify description of position to be filled): Chief Executive Officer

ADJOURN TO OPEN SESSION

CALL TO ORDER
ROLL CALL

(Chair to call the meeting to order)

CLOSED SESSION

(Report on Items to be Discussed in Closed Session)

RECONVENE TO OPEN SESSION

(Report on Items to be Discussed in Closed Session)

REPORT FROM THE PRESIDENT/ CHIEF EXECUTIVE OFFICER

(VERBAL)

(PETE DELGADO)

PUBLIC INPUT

BOARD MEMBER COMMENTS

(VERBAL)

SALINAS VALLEY HEALTH[1]
SPECIAL MEETING OF THE BOARD OF DIRECTORS
MEETING MINUTES
OCTOBER 12, 2023

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

Absent: None

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

1. READING OF THE NOTICE OF SPECIAL MEETING

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

2. CALL TO ORDER/ROLL CALL

All Board members were present, constituting a quorum and President Rey called the meeting to order at 5:07 p.m.

3. PUBLIC INPUT

No public comment received.

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,* and (2) *Report Involving Trade Secret*.

Public Input was requested regarding the closed session items.

Present via WebEx, Rafael Garcia, former member of the Salinas Valley Health Board of Directors, commented on the outstanding performance of Mr. Delgado during his tenure and requested the current Board of Directors seek a replacement of the same caliber as Mr. Delgado.

There being no further public input, the meeting recessed into Closed Session under the Closed Session Protocol at 5:11 p.m. at which time Ms. Haines was excused.

The Board completed its business of the Closed Session at 7:55 p.m.

5. RECONVENE OPEN SESSION/REPORT ON CLOSED SESSION

The Board reconvened Open Session at 7:56 p.m. President Victor Rey, Jr. reported that in Closed Session, the Board discussed:

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

(1) *Public Employee Appointment: Chief Executive Officer* and took the following action in Closed Session:

Moved by Joel Hernandez, Seconded by Dr. Cabrera – The Board accepted the resignation of Pete Delgado and has established his departure date as June 30, 2024. The Board will commence a search for a new President/CEO immediately.

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

(2) *Report Involving Trade Secret*. No action was taken.

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 7:57 p.m.

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Rolando Cabrera, MD,
Secretary, Board of Directors

Financial Performance Review
September 2023

Augustine Lopez

Chief Financial Officer

Consolidated Financial Summary
For the Month of September 2023

$ in Millions	For the Month of September 2023			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 56.5	$ 59.0	$ (2.5)	-4.2%
Operating Expense	$ 60.6	$ 59.1	$ (1.5)	-2.5%
Income from Operations	**$ (4.1)**	**$ (0.1)**	**$ (4.0)**	**-4000.0%**
Operating Margin %	*-7.3%*	*-0.1%*	*-7.2%*	*-7200.00%*
Non Operating Income	$ 1.3	$ 1.9	$ (0.6)	-31.6%
Net Income	**$ (2.8)**	**$ 1.8**	**$ (4.6)**	**-255.6%**
Net Income Margin %	*-5.0%*	*3.1%*	*-8.1%*	*-261.3%*

Consolidated Financial Summary
YTD September 2023

$ in Millions	FY 2023 YTD September			
			Variance fav (unfav)	
	Actual	Budget	$VAR	%VAR
Operating Revenue (*)	$ 170.9	$ 180.1	$ (9.2)	-5.1%
Operating Expense	$ 179.8	$ 179.1	$ (0.7)	-0.4%
Income from Operations	**$ (8.9)**	**$ 1.0**	**$ (9.9)**	**-990.0%**
Operating Margin %	*-5.2%*	*0.6%*	*-5.8%*	*-966.7%*
Non Operating Income	$ 8.5	$ 5.7	$ 2.8	49.1%
Net Income	**$ (0.4)**	**$ 6.7**	**$ (7.1)**	**-106.0%**
Net Income Margin %	*-0.2%*	*3.8%*	*-4.0%*	*-105.3%*

SVHMC Revenue Highlights September 2023

Gross Revenues were 0.4% *favorable* to budget

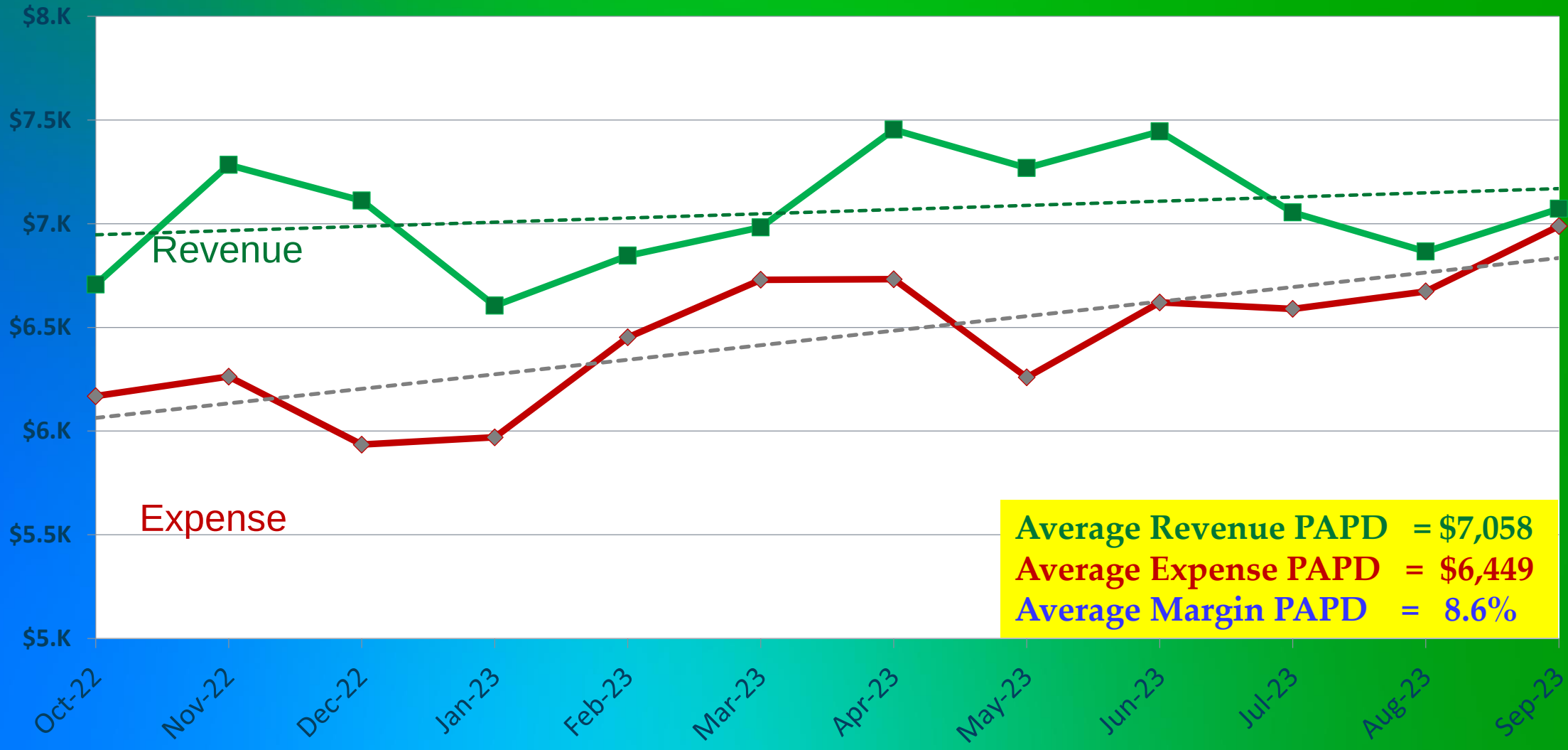
- **IP Gross Revenues** were 5% un*favorable* to budget
- **ED Gross Revenues** were 4% un*favorable* to budget
- **OP Gross Revenues** were 10% *favorable* to budget in the following areas:
  - OP Infusion
  - OP Surgery
  - Cath Lab
  - Radiology

- **Commercial:** 9% *above* budget
- **Medicaid: 3%** *below* budget
- **Medicare:** 3% *below* budget

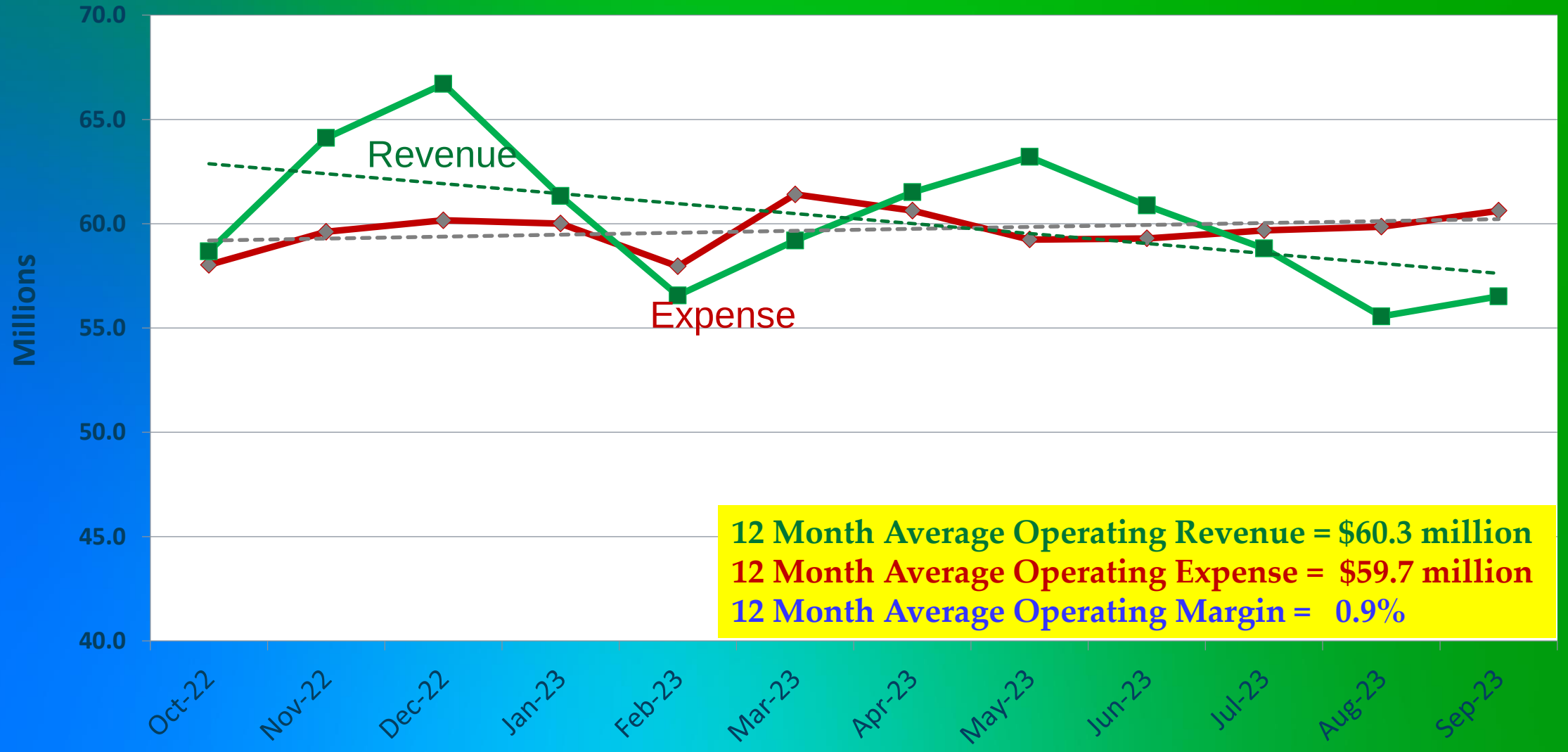
Payor Mix – Favorable

Total Normalized Net Patient Revenues were **$46M**, which was *unfavorable* to budget by **$3M** or 6.2%

SVHMC Revenues & Expenses Per Adjusted Patient Day
Rolling 12 Months: Oct 22 to September 23



SVH Consolidated Revenues & Expenses
Rolling 12 Months: Oct 22 to September 23



12 Month Average Operating Revenue = $60.3 million
12 Month Average Operating Expense = $59.7 million
12 Month Average Operating Margin = 0.9%

Salinas Valley Health Key Financial Indicators

Statistic	YTD 9/30/23	SVH Target	+/-	S&P A+ Rated Hospitals	+/-	YTD 9/30/22	+/-
Operating Margin*	-5.2%	5.0%		4.0%		4.2%	
Total Margin*	-0.2%	6.0%		6.6%		4.3%	
EBITDA Margin**	-1.0%	7.4%		13.6%		8.1%	
Days of Cash*	343	305		249		340	
Days of Accounts Payable*	50	45		-		53	
Days of Net Accounts Receivable***	53	45		49		49	
Supply Expense as % NPR	14.0%	14.0%		-		13.0%	
SWB Expense as % NPR	57.7%	53.0%		53.7%		54.0%	
Operating Expense per APD*	6,725	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
September 30, 2023

	Month of September,		Three months ended September 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 46,012,594	$ 54,134,723	$ 141,523,756	$ 152,340,762
Other operating revenue	1,092,460	550,444	3,320,858	2,123,543
Total operating revenue	47,105,054	54,685,167	144,844,614	154,464,305
Total operating expenses	46,704,544	46,961,216	141,312,135	138,421,519
Total non-operating income	(2,862,253)	(5,400,920)	(4,099,043)	(8,055,351)
Operating and non-operating income	$ (2,461,743)	$ 2,323,032	$ (566,564)	$ 7,987,436

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
September 30, 2023

	Current year	Prior year
ASSETS:		
Current assets	$ 343,091,060	$ 396,616,709
Assets whose use is limited or restricted by board	159,161,047	149,879,860
Capital assets	247,619,275	238,080,267
Other assets	277,420,772	188,380,719
Deferred pension outflows	116,911,125	95,857,027
	$ 1,144,203,279	$ 1,068,814,582
LIABILITIES AND EQUITY:		
Current liabilities	88,848,359	105,501,364
Long term liabilities	16,586,197	18,514,233
Lease deferred inflows	2,391,461	1,911,058
Pension liability	124,875,355	79,111,485
Net assets	911,501,907	863,776,442
	$ 1,144,203,279	$ 1,068,814,582

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF NET PATIENT REVENUE
September 30, 2023

	Month of September,		Three months ended September 30,	
	current year	prior year	current year	prior year
Patient days:				
By payer:				
Medicare	1,558	1,762	5,211	5,658
Medi-Cal	934	1,146	2,881	3,271
Commercial insurance	747	704	1,999	2,252
Other patient	171	76	375	295
Total patient days	3,410	3,688	10,466	11,476
Gross revenue:				
Medicare	$ 98,943,079	$ 96,219,935	$ 323,155,386	$ 297,290,893
Medi-Cal	65,009,550	67,211,441	193,252,953	190,759,092
Commercial insurance	54,980,549	52,928,243	156,981,893	156,753,414
Other patient	10,046,899	6,978,176	29,039,726	23,629,799
Gross revenue	228,980,077	223,337,794	702,429,958	668,433,197
	71.6%	73.2%	73.5%	73.0%
Deductions from revenue:				
Administrative adjustment	103,717	107,512	650,042	610,292
Charity care	275,573	535,361	2,202,258	2,253,469
Contractual adjustments:				
Medicare outpatient	30,706,988	30,181,299	102,634,602	91,759,869
Medicare inpatient	39,450,671	35,407,331	135,260,412	125,700,425
Medi-Cal traditional outpatient	2,806,770	3,220,276	7,915,786	9,948,427
Medi-Cal traditional inpatient	3,318,265	4,195,198	13,102,625	13,182,718
Medi-Cal managed care outpatient	29,060,443	27,313,755	86,685,237	75,497,264
Medi-Cal managed care inpatient	22,828,838	25,823,325	66,104,711	71,310,003
Commercial insurance outpatient	23,767,568	18,201,106	65,714,927	53,320,836
Commercial insurance inpatient	23,981,186	20,268,730	62,932,393	58,712,860
Uncollectible accounts expense	4,233,461	4,021,602	12,720,931	11,922,369
Other payors	2,434,003	(72,422)	4,982,278	1,873,905
Deductions from revenue	182,967,483	169,203,071	560,906,202	516,092,435
Net patient revenue	$ 46,012,594	$ 54,134,723	$ 141,523,756	$ 152,340,762
	20.09%	24.24%	20.15%	22.79%
Gross billed charges by patient type:				
Inpatient	$ 117,121,416	$ 112,650,472	$ 354,642,336	$ 348,700,935
Outpatient	83,818,583	81,402,029	258,157,289	235,084,367
Emergency room	28,040,078	29,285,293	89,630,334	84,647,896
Total	$ 228,980,077	$ 223,337,794	$ 702,429,959	$ 668,433,197

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES
September 30, 2023

	Month of September,		Three months ended September 30,	
	current year	prior year	current year	prior year
Operating revenue:				
Net patient revenue	$ 46,012,594	$ 54,134,723	$ 141,523,756	$ 152,340,762
Other operating revenue	1,092,460	550,444	3,320,858	2,123,543
Total operating revenue	47,105,054	54,685,167	144,844,614	154,464,305
Operating expenses:				
Salaries and wages	15,957,942	17,421,381	48,393,068	53,059,981
Compensated absences	2,761,043	2,519,565	8,706,705	7,959,046
Employee benefits	8,071,962	7,358,322	25,937,521	22,163,547
Supplies, food, and linen	6,647,977	7,497,972	20,566,727	20,470,893
Purchased department functions	4,534,538	4,356,683	12,358,909	11,572,083
Medical fees	2,624,703	2,049,972	7,669,865	5,420,274
Other fees	2,034,277	2,527,182	6,421,924	7,166,910
Depreciation	2,231,809	1,651,869	5,843,409	5,683,598
All other expense	1,840,293	1,578,270	5,414,007	4,925,187
Total operating expenses	46,704,544	46,961,216	141,312,135	138,421,519
Income from operations	400,510	7,723,951	3,532,479	16,042,786
Non-operating income:				
Donations	0	169,553	1,132,687	2,301,378
Property taxes	333,333	333,333	1,000,000	1,000,000
Investment income	1,148,556	(3,134,114)	5,689,294	(3,374,640)
Taxes and licenses	0	0	0	0
Income from subsidiaries	(4,344,142)	(2,769,692)	(11,921,024)	(7,982,089)
Total non-operating income	(2,862,253)	(5,400,920)	(4,099,043)	(8,055,351)
Operating and non-operating income	(2,461,743)	2,323,032	(566,564)	7,987,436
Net assets to begin	913,963,650	861,453,410	912,068,471	855,789,006
Net assets to end	$ 911,501,907	$ 863,776,442	$ 911,501,907	$ 863,776,442
Net income excluding non-recurring items	$ (2,461,743)	$ 2,323,032	$ (566,564)	$ 7,987,436
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	$ (2,461,743)	$ 2,323,032	$ (566,564)	$ 7,987,436

SALINAS VALLEY HEALTH MEDICAL CENTER
SCHEDULES OF INVESTMENT INCOME
September 30, 2023

	Month of September,		Three months ended September 30,	
	current year	prior year	current year	prior year
Detail of other operating income:				
Dietary revenue	$ 185,507	$ 111,488	$ 578,276	$ 373,419
Discounts and scrap sale	370,827	824	659,062	274,499
Sale of products and services	23,157	17,596	135,954	97,167
Clinical trial fees	0	0	0	0
Stimulus Funds	0	0	0	0
Rental income	151,804	173,485	532,572	523,336
Other	361,165	247,051	1,414,994	855,122
Total	$ 1,092,460	$ 550,444	$ 3,320,858	$ 2,123,543
Detail of investment income:				
Bank and payor interest	$ 1,308,603	$ 662,142	$ 4,173,054	$ 1,179,962
Income from investments	(160,047)	(3,791,540)	1,573,126	(4,549,887)
Gain or loss on property and equipment	0	(4,715)	(56,887)	(4,715)
Total	$ 1,148,556	$ (3,134,114)	$ 5,689,294	$ (3,374,640)
Detail of income from subsidiaries:				
Salinas Valley Medical Center:				
Pulmonary Medicine Center	$ (205,991)	$ (88,756)	$ (565,980)	$ (496,170)
Neurological Clinic	(60,052)	(155,202)	(195,483)	(231,778)
Palliative Care Clinic	(86,344)	(51,001)	(232,998)	(183,255)
Surgery Clinic	(176,189)	(90,825)	(576,556)	(381,241)
Infectious Disease Clinic	(33,095)	(31,748)	(94,544)	(86,592)
Endocrinology Clinic	(211,593)	(109,335)	(630,153)	(469,673)
Early Discharge Clinic	0	0	0	0
Cardiology Clinic	(595,432)	(354,671)	(1,592,397)	(1,104,945)
OB/GYN Clinic	(352,727)	(273,134)	(1,051,643)	(885,552)
PrimeCare Medical Group	(1,012,388)	(261,713)	(2,510,265)	(1,150,011)
Oncology Clinic	(303,853)	(251,289)	(922,274)	(754,547)
Cardiac Surgery	(428,015)	(349,700)	(918,192)	(787,400)
Sleep Center	(46,075)	23,695	(118,431)	(59,389)
Rheumatology	(57,820)	(69,476)	(188,765)	(185,698)
Precision Ortho MDs	(404,490)	(391,338)	(1,206,252)	(835,554)
Precision Ortho-MRI	0	0	0	0
Precision Ortho-PT	(29,389)	104,925	(131,259)	(120,069)
Vaccine Clinic	0	(1,030)	0	(1,254)
Dermatology	(54,681)	82,258	(104,450)	(43,040)
Hospitalists	0	0	0	0
Behavioral Health	(36,384)	(716,454)	(110,185)	(72,336)
Pediatric Diabetes	(51,652)	(50,614)	(143,266)	(140,148)
Neurosurgery	(21,600)	(12,719)	(81,954)	(70,965)
Multi-Specialty-RR	4,216	10,191	15,632	20,937
Radiology	(103,764)	(94,632)	(530,727)	(413,748)
Salinas Family Practice	(119,391)	(63,707)	(385,155)	(237,411)
Urology	(251,025)	47,502	(489,277)	(174,126)
Total SVMC	(4,637,734)	(3,148,773)	(12,764,574)	(8,863,965)
Doctors on Duty	113,982	64,212	300,313	289,319
LPCH NICU JV	0	0	0	0
Monterey Peninsula Surgery Center	130,531	211,934	356,288	401,453
Coastal	21,306	64,627	108,687	35,977
GenesisCare USA	(22,618)	(19,752)	(21,601)	28,000
Monterey Bay Endoscopy Center	50,390	58,061	99,862	127,127
Total	$ (4,344,142)	$ (2,769,692)	$ (11,921,024)	$ (7,982,089)

SALINAS VALLEY HEALTH MEDICAL CENTER
BALANCE SHEETS
September 30, 2023

	Current year	Prior year
A S S E T S		
Current assets:		
Cash and cash equivalents	$ 233,398,034	$ 289,479,971
Patient accounts receivable, net of estimated uncollectibles of $26,453,726	87,402,981	84,941,326
Supplies inventory at cost	7,929,121	7,599,460
Current portion of lease receivable	1,634,496	534,201
Other current assets	12,726,429	14,061,752
Total current assets	343,091,060	396,616,709
Assets whose use is limited or restricted by board	159,161,047	149,879,860
Capital assets:		
Land and construction in process	65,515,184	39,324,547
Other capital assets, net of depreciation	182,104,091	198,755,720
Total capital assets	247,619,275	238,080,267
Other assets:		
Right of use assets, net of amortization	5,202,770	7,137,296
Long term lease receivable	919,422	1,462,610
Investment in securities	246,887,410	141,849,676
Investment in SVMC	4,768,395	12,007,778
Investment in Aspire/CHI/Coastal	1,790,328	1,679,677
Investment in other affiliates	21,281,623	23,538,548
Net pension asset	(3,429,176)	705,134
Total other assets	277,420,772	188,380,719
Deferred pension outflows	116,911,125	95,857,027
Total assets	$ 1,144,203,279	$ 1,068,814,582
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	$ 63,338,193	$ 61,648,381
Due to third party payers	6,144,249	23,067,473
Current portion of notes payable	0	0
Current portion of self-insurance liability	17,525,546	17,849,542
Current portion of lease liability	1,840,371	2,935,968
Total current liabilities	88,848,359	105,501,364
Long term portion of notes payable	0	0
Long term portion of workers comp liability	13,027,333	14,058,922
Long term portion of lease liability	3,558,864	4,455,311
Total liabilities	105,434,556	124,015,597
Lease deferred inflows	2,391,461	1,911,058
Pension liability	124,875,355	79,111,485
Net assets:		
Invested in capital assets, net of related debt	247,619,275	238,080,267
Unrestricted	663,882,632	625,696,175
Total net assets	911,501,907	863,776,442
Total liabilities and net assets	$ 1,144,203,279	$ 1,068,814,582

SALINAS VALLEY HEALTH MEDICAL CENTER
STATEMENTS OF REVENUE AND EXPENSES - BUDGET VS. ACTUAL
September 30, 2023

	Month of September,				Three months ended September 30,			
	Actual	Budget	Variance	% Var	Actual	Budget	Variance	% Var
Operating revenue:								
Gross billed charges	$ 228,980,077	$ 228,115,069	865,008	0.38%	$ 702,429,958	$ 699,612,758	2,817,200	0.40%
Dedutions from revenue	182,967,483	179,068,316	3,899,167	2.18%	560,906,202	550,005,655	10,900,547	1.98%
Net patient revenue	46,012,594	49,046,753	(3,034,159)	-6.19%	141,523,756	149,607,103	(8,083,347)	-5.40%
Other operating revenue	1,092,460	1,332,540	(240,080)	-18.02%	3,320,858	3,997,620	(676,762)	-16.93%
Total operating revenue	**47,105,054**	**50,379,293**	**(3,274,239)**	**-6.50%**	**144,844,614**	**153,604,723**	**(8,760,109)**	**-5.70%**
Operating expenses:								
Salaries and wages	15,957,942	16,706,442	(748,500)	-4.48%	48,393,068	50,643,792	(2,250,724)	-4.44%
Compensated absences	2,761,043	2,984,265	(223,222)	-7.48%	8,706,705	9,502,594	(795,889)	-8.38%
Employee benefits	8,071,962	7,815,273	256,689	3.28%	25,937,521	23,903,458	2,034,063	8.51%
Supplies, food, and linen	6,647,977	6,679,670	(31,693)	-0.47%	20,566,727	20,478,227	88,500	0.43%
Purchased department functions	4,534,538	3,539,228	995,310	28.12%	12,358,909	10,617,688	1,741,221	16.40%
Medical fees	2,624,703	2,359,060	265,643	11.26%	7,669,865	7,077,181	592,684	8.37%
Other fees	2,034,277	2,222,815	(188,538)	-8.48%	6,421,924	6,761,871	(339,947)	-5.03%
Depreciation	2,231,809	2,116,532	115,277	5.45%	5,843,409	6,396,014	(552,605)	-8.64%
All other expense	1,840,293	1,801,863	38,430	2.13%	5,414,007	5,484,524	(70,517)	-1.29%
Total operating expenses	**46,704,544**	**46,225,149**	**479,395**	**1.04%**	**141,312,135**	**140,865,348**	**446,787**	**0.32%**
Income from operations	**400,510**	**4,154,144**	**(3,753,634)**	**-90.36%**	**3,532,479**	**12,739,376**	**(9,206,897)**	**-72.27%**
Non-operating income:								
Donations	0	166,667	(166,667)	-100.00%	1,132,687	500,000	632,687	126.54%
Property taxes	333,333	333,333	(0)	0.00%	1,000,000	1,000,000	0	0.00%
Investment income	1,148,556	1,185,806	(37,250)	-3.14%	5,689,294	3,557,417	2,131,878	59.93%
Income from subsidiaries	(4,344,142)	(4,099,360)	(244,782)	5.97%	(11,921,024)	(11,513,835)	(407,189)	3.54%
Total non-operating income	**(2,862,253)**	**(2,413,555)**	**(448,698)**	**18.59%**	**(4,099,043)**	**(6,456,419)**	**2,357,376**	**-36.51%**
Operating and non-operating income	**$ (2,461,743)**	**$ 1,740,590**	**(4,202,333)**	**-241.43%**	**$ (566,564)**	**$ 6,282,957**	**(6,849,521)**	**-109.02%**

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

	Month of Sep		Three months to date		
	2022	2023	2022-23	2023-24	Variance
NEWBORN STATISTICS					
Medi-Cal Admissions	40	30	114	101	(13)
Other Admissions	84	79	266	250	(16)
Total Admissions	124	109	380	351	(29)
Medi-Cal Patient Days	63	55	181	162	(19)
Other Patient Days	134	139	434	415	(19)
Total Patient Days of Care	197	194	615	577	(38)
Average Daily Census	6.6	6.5	6.7	6.3	(0.4)
Medi-Cal Average Days	1.8	1.9	1.7	1.7	0.0
Other Average Days	1.2	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	356	335	1,157	1,098	(59)
Medi-Cal Admissions	331	218	824	723	(101)
Other Admissions	395	290	949	861	(88)
Total Admissions	1,082	843	2,930	2,682	(248)
Medicare Patient Days	1,387	1,288	4,637	4,456	(181)
Medi-Cal Patient Days	1,183	977	3,401	2,995	(406)
Other Patient Days	1,005	891	3,072	2,262	(810)
Total Patient Days of Care	3,575	3,156	11,110	9,713	(1,397)
Average Daily Census	119.2	105.2	120.8	105.6	(15.2)
Medicare Average Length of Stay	3.9	3.9	4.0	4.1	0.1
Medi-Cal AverageLength of Stay	3.6	3.9	3.5	3.6	0.0
Other Average Length of Stay	2.6	2.5	2.6	2.1	(0.6)
Total Average Length of Stay	3.3	3.3	3.4	3.2	(0.2)
Deaths	22	18	64	69	5
Total Patient Days	3,772	3,350	11,725	10,290	(1,435)
Medi-Cal Administrative Days	4	0	27	5	(22)
Medicare SNF Days	0	0	0	0	0
Over-Utilization Days	0	0	0	0	0
Total Non-Acute Days	4	0	27	5	(22)
Percent Non-Acute	0.11%	0.00%	0.23%	0.05%	-0.18%

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

	Month of Sep		Three months to date		
	2022	2023	2022-23	2023-24	Variance
PATIENT DAYS BY LOCATION					
Level I	250	270	796	709	(87)
Heart Center	338	329	1,025	996	(29)
Monitored Beds	641	616	1,933	1,839	(94)
Single Room Maternity/Obstetrics	326	308	1,043	950	(93)
Med/Surg - Cardiovascular	809	718	2,703	2,374	(329)
Med/Surg - Oncology	272	261	675	818	143
Med/Surg - Rehab	463	364	1,549	1,270	(279)
Pediatrics	127	126	366	371	5
Nursery	197	194	615	577	(38)
Neonatal Intensive Care	111	164	370	386	16
PERCENTAGE OF OCCUPANCY					
Level I	64.10%	69.23%	66.56%	59.28%	
Heart Center	75.11%	73.11%	74.28%	72.17%	
Monitored Beds	79.14%	76.05%	77.82%	74.03%	
Single Room Maternity/Obstetrics	29.37%	27.75%	30.64%	27.91%	
Med/Surg - Cardiovascular	59.93%	53.19%	65.29%	57.34%	
Med/Surg - Oncology	69.74%	66.92%	56.44%	68.39%	
Med/Surg - Rehab	59.36%	46.67%	64.76%	53.09%	
Med/Surg - Observation Care Unit	0.00%	0.00%	0.00%	0.00%	
Pediatrics	23.52%	23.33%	22.10%	22.40%	
Nursery	39.80%	39.19%	20.26%	19.01%	
Neonatal Intensive Care	33.64%	49.70%	36.56%	38.14%	

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

	Month of Sep		Three months to date		
	2022	2023	2022-23	2023-24	Variance
DELIVERY ROOM					
Total deliveries	108	105	362	341	(21)
C-Section deliveries	31	32	102	109	7
Percent of C-section deliveries	28.70%	30.48%	28.18%	31.96%	3.79%
OPERATING ROOM					
In-Patient Operating Minutes	18,595	14,247	55,887	48,163	(7,724)
Out-Patient Operating Minutes	29,255	32,012	78,279	89,279	11,000
Total	47,850	46,259	134,166	137,442	3,276
Open Heart Surgeries	16	9	38	30	(8)
In-Patient Cases	126	105	403	351	(52)
Out-Patient Cases	295	305	818	877	59
EMERGENCY ROOM					
Immediate Life Saving	20	36	80	111	31
High Risk	545	654	1,605	2,097	492
More Than One Resource	3,019	2,770	8,891	8,542	(349)
One Resource	2,020	2,030	5,944	5,588	(356)
No Resources	96	104	278	329	51
Total	5,700	5,594	16,798	16,667	(131)

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

	Month of Sep		Three months to date		
	2022	2023	2022-23	2023-24	Variance
CENTRAL SUPPLY					
In-patient requisitions	15,056	12,139	43,964	39,927	-4,037
Out-patient requisitions	9,748	10,151	28,503	31,301	2,798
Emergency room requisitions	605	888	1,810	2,641	831
Interdepartmental requisitions	6,570	6,360	21,062	18,923	-2,139
Total requisitions	31,979	29,538	95,339	92,792	-2,547
LABORATORY					
In-patient procedures	36,192	33,797	113,589	105,329	-8,260
Out-patient procedures	11,321	10,924	33,326	33,383	57
Emergency room procedures	12,866	12,633	38,412	39,080	668
Total patient procedures	60,379	57,354	185,327	177,792	-7,535
BLOOD BANK					
Units processed	292	273	966	938	-28
ELECTROCARDIOLOGY					
In-patient procedures	1,060	997	3,210	3,093	-117
Out-patient procedures	355	344	1,111	1,166	55
Emergency room procedures	1,124	1,210	3,354	3,669	315
Total procedures	2,539	2,551	7,675	7,928	253
CATH LAB					
In-patient procedures	95	97	287	337	50
Out-patient procedures	88	97	271	290	19
Emergency room procedures	1	0	1	0	-1
Total procedures	184	194	559	627	68
ECHO-CARDIOLOGY					
In-patient studies	379	337	1,173	1,020	-153
Out-patient studies	217	233	679	726	47
Emergency room studies	3	0	3	0	-3
Total studies	599	570	1,855	1,746	-109
NEURODIAGNOSTIC					
In-patient procedures	134	120	447	376	-71
Out-patient procedures	11	13	51	55	4
Emergency room procedures	0	0	0	0	0
Total procedures	145	133	498	431	-67

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

	Month of Sep		Three months to date		
	2022	2023	2022-23	2023-24	Variance
SLEEP CENTER					
In-patient procedures	0	0	0	0	0
Out-patient procedures	129	202	443	636	193
Emergency room procedures	0	0	0	0	0
Total procedures	129	202	443	636	193
RADIOLOGY					
In-patient procedures	1,294	1,278	3,994	3,746	-248
Out-patient procedures	381	377	1,122	1,235	113
Emergency room procedures	1,553	1,489	4,370	4,478	108
Total patient procedures	3,228	3,144	9,486	9,459	-27
MAGNETIC RESONANCE IMAGING					
In-patient procedures	155	136	504	441	-63
Out-patient procedures	116	113	336	391	55
Emergency room procedures	7	5	23	25	2
Total procedures	278	254	863	857	-6
MAMMOGRAPHY CENTER					
In-patient procedures	3,948	4,231	12,667	12,234	-433
Out-patient procedures	3,920	4,197	12,559	12,136	-423
Emergency room procedures	0	4	2	4	2
Total procedures	7,868	8,432	25,228	24,374	-854
NUCLEAR MEDICINE					
In-patient procedures	17	17	66	56	-10
Out-patient procedures	100	95	297	317	20
Emergency room procedures	0	0	1	0	-1
Total procedures	117	112	364	373	9
PHARMACY					
In-patient prescriptions	85,619	78,767	272,341	240,760	-31,581
Out-patient prescriptions	14,998	16,001	45,757	48,060	2,303
Emergency room prescriptions	8,507	9,056	25,732	27,329	1,597
Total prescriptions	109,124	103,824	343,830	316,149	-27,681
RESPIRATORY THERAPY					
In-patient treatments	14,204	17,170	44,605	45,080	475
Out-patient treatments	1,237	1,129	2,950	3,914	964
Emergency room treatments	430	548	1,013	1,236	223
Total patient treatments	15,871	18,847	48,568	50,230	1,662
PHYSICAL THERAPY					
In-patient treatments	2,305	2,569	7,253	7,345	92
Out-patient treatments	153	270	569	767	198
Emergency room treatments	0	0	0	0	0
Total treatments	2,458	2,839	7,822	8,112	290

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

	Month of Sep		Three months to date		
	2022	2023	2022-23	2023-24	Variance
OCCUPATIONAL THERAPY					
In-patient procedures	1,720	1,554	4,901	4,511	-390
Out-patient procedures	174	212	491	687	196
Emergency room procedures	0	0	0	0	0
Total procedures	1,894	1,766	5,392	5,198	-194
SPEECH THERAPY					
In-patient treatments	379	508	1,319	1,395	76
Out-patient treatments	30	15	81	88	7
Emergency room treatments	0	0	0	0	0
Total treatments	409	523	1,400	1,483	83
CARDIAC REHABILITATION					
In-patient treatments	0	0	0	2	2
Out-patient treatments	474	424	1,349	1,508	159
Emergency room treatments	0	0	0	0	0
Total treatments	474	424	1,349	1,510	161
CRITICAL DECISION UNIT					
Observation hours	346	280	1,010	891	-119
ENDOSCOPY					
In-patient procedures	84	72	297	209	-88
Out-patient procedures	62	56	132	151	19
Emergency room procedures	0	0	0	0	0
Total procedures	146	128	429	360	-69
C.T. SCAN					
In-patient procedures	679	673	2,090	2,075	-15
Out-patient procedures	417	325	1,242	1,287	45
Emergency room procedures	705	692	2,100	2,258	158
Total procedures	1,801	1,690	5,432	5,620	188
DIETARY					
Routine patient diets	42,805	21,324	84,154	63,649	-20,505
Meals to personnel	25,145	27,758	75,402	84,391	8,989
Total diets and meals	67,950	49,082	159,556	148,040	-11,516
LAUNDRY AND LINEN					
Total pounds laundered	92,310	94,184	288,416	287,593	-823

Memorandum

To: Board of Directors

From: Clement Miller, COO

Date: October 13, 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.	Blood and Blood Product Administration	Added notification to Registration if the patient revokes the initial signed "Refusal to Permit Blood Transfusion" form. For Jehovah's Witness patients, the "notify registration" was added, and under patient teaching #3, updated the adverse reaction, from most common to alphabetical order, based on the AABB manual. Adverse reactions for fever, hypertension, and hypotension were defined.	Lisa Paulo, CNO
2.	Capital Budget Planning Purchase	Template corrections, references updated	Augustine Lopez, CFO
3.	Cardiac Telemetry Monitoring and Management	Updated to reflect current unit make up, formatting and changed Unit Clerk to Unit Assistant. References updated.	Lisa Paulo, CNO
4.	Care of the CRRT Patient-Monitoring, Troubleshooting, and Termination of PrismaFlex	Added use of citrate. Corrected timed citrate lab orders to match orderset approved by Dr. Dicus. References updated.	Lisa Paulo, CNO
5.	Care of the Mechanically Ventilated Adult Patient	Policy updated to current practice. References updated.	Lisa Paulo, CNO
6.	Chest Pain Standardized Procedure	Edited format and fixed errors.	Lisa Paulo, CNO
7.	Compliance and Ethics Program	Updates to Cypress Healthcare Partners	Augustine Lopez, CFO

8.	Discipline Administration	Added Just Culture language	Michelle Barnhart Childs, CHRO
9.	Family School Partnership	Updated to Littler recs. Template corrected.	Michelle Barnhart Childs, CHRO
10.	Hyperbilirubinemia-Infant Management & Treatment	References updated. Procedure updated to current process.	Lisa Paulo, CNO
11.	Interdisciplinary Plan of Care	Edited format, updated references	Lisa Paulo, CNO
12.	Interpreter/Translator Communication	Edited information regarding languages available in section I and accessibility for hearing impaired patients as we no longer have an agreement with local resources and only rely on language line virtual interpreter. Formatting and references updated.	Lisa Paulo, CNO
13.	Massive Transfusion Protocol - Nursing	Changes made to the unit ratios from 6/6/1 to 4/4/1. Removed ratios of products available in the MTP packs. Removed the pediatric 0.1 units/kg. Clarified the two orders in meditech. Eliminated the reference to Attachment A. Updated references. Ensured alignment with education that went out to staff.	Lisa Paulo, CNO
14.	Oral Care	Added Sodium bicarb solution for purge, updated references, removed peroxide and corrected use of CHG	Lisa Paulo, CNO
15.	Pacemaker: Insertion of a Temporary Pacemaker, Transvenous; Balloon-Tipped Pacing Electrode; and Epicardial	Changed to procedure, updated references, updated to current practice and locations.	Lisa Paulo, CNO
16.	Patient Food Service	Updated terminology and separated procedures by numbering. Formatting and references updated.	Clement Miller, COO
17.	Physician Services Contract	Template corrections, references updated	Augustine Lopez, CFO
18.	Prime/QIP Data Integrity / Review	Updated to reflect new program name	Alan Radner, CMO
19.	PTO Cash Out	Minor corrections to PTO cash out	Michelle

			Barnhart Childs, CHRO
20	Scope of Service: Cardiovascular Diagnostic and Treatment Units	Updated Org Chart	Lisa Paulo, CNO
21	Scope of Service: Case Management	Org chart updated	Lisa Paulo, CNO
22	Scope of Service: Medical Surgical Services	Changed location of CCC to 3T	Lisa Paulo, CNO
23	Scope of Service: Respiratory, Neurodiagnostics and Sleep Medicine	Removed gender references, updated job titles, corrected procedure to align with current practice	Lisa Paulo, CNO
24	Scope of Service: Social Services	Updated flow chart, formatting corrections and rebranding.	Lisa Paulo, CNO
25	Serious Reportable Events	Removed unnecessary information, added 2 additional reference, added Just Culture language	Clement Miller, COO
26	Vacuum-Induced Management of OB Hemorrhage	New Procedure.	Lisa Paulo, CNO
27	Visitors	Policy updated to reflect current visitor process. Authorized responsible parties has replaced parent/guardians.	Lisa Paulo, CNO

Status **Pending** PolicyStat ID **13789923**

Last Approved	N/A	Owner	Carla Spencer: Director Critical Care Services
Last Revised	09/2023	Area	Patient Care
Next Review	3 years after approval		

Blood and Blood Product Administration

I. POLICY STATEMENT

A.

II. PURPOSE

A. To guide clinical staff in the safe administration of blood and blood products.

III. DEFINITIONS

A. Transfusion Related Acute Lung Injury (TRALI) – acute onset hypoxemia that occurs during or within six (6) hours following transfusion with no evidence of circulatory overload. An immune-mediated condition causing permeability of the pulmonary vasculature and resulting in leaking of fluid and protein into the alveolar space.

B. TAR – Transfusion Administration Record

IV. GENERAL INFORMATION

A. Physician's informed consent is required except in a documented emergency (CONSENT TO BLOOD TRANSFUSION policy). A completed faxed copy of the informed consent is acceptable.

B. Registered Nurses may transfuse all blood and blood products.

C. Patient identification/verification is a two-person process. One individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component. The second individual is qualified to participate in the process.

D. Registered Nurses will use the scanning process where the Transfusion Administration Record (TAR) is utilized.

E. I.V. Medications are **NEVER** administered simultaneously with blood or blood products.

F. **NO** intravenous solutions other than isotonic saline (0.9%) are administered simultaneously with blood.

G. If a patient is receiving blood or a blood product and requires transfer to another unit or to a procedure (e.g., Diagnostic Imaging for an X-ray), the RN must accompany the patient and remain with the patient if another RN is not available.

H. No more than two units of blood may be transfused through one filter. (exception is Massive Transfusion Protocol). Any tubing through which blood or blood product have been infused can be used for no more than 24 hours per CDC guidelines.

I. Blood shall be hung for **no** more than four (4) hours from the time the blood unit is picked up from blood bank. Administration of blood or blood components shall be started within thirty (30) minutes from time they were released from the blood bank.

- Note: Blood/Blood Products picked up for Outpatient Infusion following proper transport process (ISSUING BLOOD PRODUCTS) will be placed in a designated refrigerator upon arrival to the Outpatient Infusion Center. Upon removal from the refrigerator, blood shall be hung for no more than (4) hours and shall be started within 30 minutes.

J. Blood products **may not** be placed in unit refrigerator. Only the Department of Surgery and Outpatient Infusion may place blood products on unit refrigerator specifically designated for this purpose.

- Note: Blood products that have been removed from the Blood Bank may not be returned after 20 minutes.

K. If a patient is using more than 10 units of packed cells in a short period of time refer to MASSIVE TRANSFUSION PROTOCOL.

V. PROCEDURE

A. Pre-transfusion

- Review physician order for type of blood product to be transfused.
- Verify Informed Consent (CONSENT TO BLOOD TRANSFUSION policy) signed by the patient or their representative.
- Order blood product electronically.
- For Jehovah's Witness patients, who consent to a blood transfusion, **notify Registration**, notify Blood Bank of the request, and fax a copy of the signed consent to the Blood Bank.
- Notify Registration if the patient revokes the initial Refusal to Permit Blood Transfusion.
- Know the indication *f*or the blood product(s) that has been ordered for the patient population.
- Review patient's transfusion history, i.e. transfusion reactions, urinary output, and vital signs and notify physician of any concerns.
- Patient teaching:
    1. Explain procedure and rationale for transfusion
    2. Instruct and explain reportable signs and symptoms of transfusion

reactions.

3. ~~Transfusion Reaction signs and symptoms:~~
    a. **Febrile reaction** occurs as a result of the patient developing antibodies to human leukocyte antigens. Symptoms include: fever rises 1° C from baseline, headache, tachycardia, and mild dyspnea.
    b. **Adverse reaction** to the transfusion can occur within first 15 minutes of transfusion. Symptoms include: transfusion site and loin pain, backache, fever, flushing, urticaria, chills, rigor, mild dyspnea and tachycardia. Be aware that Transfusion Related Acute Lung Injury (TRALI) is an acute complication that can occur up to 6 hours after transfusion; most often from plasma products.
        i. **Inpatient**: Instruct patient to immediately call the nurse if blood reaction is suspected.
        ii. **Outpatient**: Instruct patient to immediately go to the Emergency department if a suspected blood reaction occurs after discharge.

Transfusion adverse reaction can occur within first 15 minutes of transfusion. Transfusion reaction signs and symptoms are fever, chills, rigors, pruritus,urticaria, mild dyspnea, tachycardia, abdominal pain/ cramps, edema, anxiety, arrhythmia, back pain, cardiac arrest, chest discomfort (pain/tightness), coughing, cyanosis, diarrhea, erythema, flushing, headache, hoarseness/stridor, hypertension, hypotension, jugular vein distention, loss of consciousness, nausea and vomiting, pain at infusion site, tachypnea, wheezing, and widened pulse pressure.

    a. A fever is greater than equal to 1^{O}C rise in temperature from baseline. Febrile reaction occurs as a result of the patient developing antibodies to human leukocyte antigens.
    b. Hypotension is a decrease in Systolic BP of greater than or equal to 30 mmHg and Systolic BP less than or equal to 80 mmHg from baseline.
    c. Hypertension is an increase in Systolic BP of greater than or equal to 30 mmHg and a Systolic BP greater than or equal to 140 mmHg from baseline.
        i. **Inpatient**: Instruct patient to immediately call the nurse if blood reaction is suspected.
        ii. **Outpatient**: Instruct patient to immediately go to the Emergency department if a suspected blood reaction occurs after discharge.

4. If the patient is not under direct medical supervision after the transfusion, the patient and/or caregiver should be provided written instructions about

the signs and symptoms of transfusion reaction to report to the physician, and identify to whom they should report these symptoms. Provider's phone number should be given.

- Establish or confirm patency of IV access. Select a larger catheter size if blood is to be transfused rapidly. Acceptable catheter sizes for transfusion of cellular component is from 22 to 14 gauge. A larger size flows better and is more comfortable for the patient. When infusing blood for infants and toddlers, 22 or 24 gauge is acceptable but should be administered via syringe pump.
- Obtain appropriate transfusion tubing, filter, and normal saline. Appendices specific instructions on special preparation, tubing change schedule, infusion rate.
- Check for blood product availability in the electronic record.
- Take the Blood Transfusion Request Form and verify that a copy of a fully completed and signed informed consent is on the patients chart. Any unit personnel who have completed Blood Transport Competency may pick up and sign for blood from the Blood Bank.
    1. Blood Bank personnel verify the information on the Blood Transfusion request form for accuracy with person picking up the blood product. The Blood Transfusion Request Form will then be exchanged for a Blood Unit Issue Card and the blood product will be issued. This form is filed in the chart under "lab".
    2. Blood units may be split into aliquots (portions) in the blood bank, per MD order if longer hang time is required because of patient's condition or age.
- Using Standard Precautions prepare administration set according to manufacturer's instruction (see package).

B. Administration

- Use the two approved patient identifiers (see PATIENT IDENTIFICATION POLICY) to identify patient and explain procedure to patient.
    1. Match the blood or blood component to the order
    2. Match the patient to the blood or blood component
- Obtain a baseline vital sign measurement within fifteen (15) minutes prior to initiation of transfusion
- At the bedside, two (2) qualified personnel validate the right blood for the right patient by following the steps below:
    1. Scan the following items on the TAR Checklist. Each item receives a check next to the box when properly scanned.
        a. Patient wristband to accurately identify patient. If identification warning appears, STOP and do NOT proceed. Notify Blood Bank immediately.
        b. Product Unit Number. When scanning the product unit number, the Source Registration Number also auto checks.

c. Product

d. Product Blood Type

e. Product Expiration Date and Time

i. Products that have been thawed will not have a an expiration date and time barcode. Review the written expiration date and override the checkbox indicating the appropriate reason code.

f. If unable to scan product barcodes after unsuccessful troubleshooting efforts, check product against the Blood Issue Unit/Transfusion Card and verify accordingly. Select the appropriate override reason code.

2. Verify additional items on Checklist

a. Check the MAR for ordered pre-meds

b. Check patient blood type

c. Check product for signs of leakage

d. Check product for discoloration

3. During Downtime, in OR or Emergent Issue:

a. Check the patient's armband against the Blood Unit Issue/ Transfusion Card (see Patient Identification Policy for two approved patient identifiers).

b. Check the Blood Unit Issue/Transfusion Card against blood product unit or patient's name and ID number, type of blood component, blood component number, ABO and RH type, expiration date and time on unit.

c. Verify per #2 above.

- Attach primed blood tubing directly to a proximal y-site on IV line. Start the infusion slowly for the first 15 minutes. This should be timed from when the blood reaches the patient's vein. Most reactions occur in the first 15 minutes of a transfusion, so the patient's condition should be monitored closely. Obtain a set of vital signs shortly after the beginning (approximately fifteen (15) minutes) of infusion, if no adverse effects noted, increase rate to administer unit within the time ordered.
- Vital signs including temperature are monitored as follows:
    1. Shortly after the beginning of the transfusion of blood,
    2. At least once during the transfusion
    3. Post transfusion (approximately fifteen (15) minutes).
- **Upon completion of the transfused unit.** Administer blood products via a volume infusion / syringe pump.
    1. Use a pump when administering blood for:

a. Pediatric patient
b. Administration of blood via PICC.
c. Patient at high risk fluid overload.
d. Physician order.

2. Start infusion as follows:
For Adult Patients:
3. Start at 60-120 ml/hr for 15 minutes. If patient has no adverse reaction, then increase the infusion to infuse as rapidly as tolerated, recommended 240 ml/hr. If patient is at risk of fluid volume overload, recommended rate of infusion is 1 ml/kg/hr.
For Pediatric Patients:
4. Order volume of blood based on the child's weight, i.e. 10-15 ml/kg [excluding granulocytes]
5. Adjust the rate of flow to transfuse 5% of the total volume ordered in the first five minutes of whole blood, RBC's or granulocyte infusion.
6. Remain with the patient for the first 5 minutes after the start of the infusion. See Appendices B and C.

C. Post- Administration

- Upon completion of transfusion, clear line with normal saline. Discard all blood and blood products bags, tubing and blood-contaminated supplies in biohazard bin in dirty utility room.
- Follow-up on any post-transfusion labs.
- Document amount given in TAR after ending the transfusion. Verify all information is complete.

D. Suspected Transfusion Reaction

- **Immediately** stop transfusion and take down the blood and all tubing involved down to IV or CVP line hub.
- Attach new bag of saline (using all-new administration equipment) to the IV catheter and keep the IV open.
- Maintain patent airway.
- **Immediately** notify physician and blood bank.
- Obtain urine specimen **ONLY** on lab request.
- Please follow required documentation as outlined in the suspected transfusion reaction algorithm found in attachments
- Complete an Event Notification form in the electronic system.

E. Special Notes:

- Special Note: Check with manufacturers of volume infusion pump prior to administration of platelets as passing through pump equipment may destroy platelet

viability.

- Blood Transfusion refusal:
    1. Inform physician of transfusion refusal and complete a Transfusion Refusal Form 8700-90320.
    2. The following practices are restricted to specific units and are covered in unit specific policy and procedure manuals.
        a. Auto transfusions: Refer to CELL SAVER 5-SURGERY CLINICAL PROCEDURE

F. Documentation:
    1. Document infusion vital signs in the electronic medical record; Transfusion Administration Record (TAR) or electronic surgical software if administered in the perioperative area.
    2. Document in the electronic medical record
        a. Blood/blood products given
        b. Patient's response.
        c. Patient and family education completed.
    3. Include fluid volume infused in the TAR when ending the transfusion.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. American Association of Blood Banks, Standards for Blood Banks and Transfusion Services (~~28th Ed~~2022) 33rd Edition.~~)~~ AABB: Bethesda, Maryland.

B. Infusion Nurses Society, Hankins, J.; Lonsway R.A.; Hedrick, C. et al. Infusion Therapy in Clinical Practice: 2nd Edition, Author

C. Lotterman S, Sharma S.(2023) Blood Transfusion. [Updated 2022 Jun 25]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing;Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK499824/

Attachments

A: Blood and Blood Product Administration Grid

B: Packed Red Blood Cells Administration 10 ml/kg for Pediatric Patients

C: Packed Red Blood Cells Administration 15ml/kg for Pediatric Patients

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	07/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Policy Owner	Carla Spencer: Director Critical Care Services	07/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14042402**

Last Approved	N/A	Owner	Scott Cleveland: Controller
Last Revised	09/2023	Area	Administration
Next Review	3 years after approval		

Capital Budget Planning Purchase

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. ~~The purpose of this policy is to~~To outline the steps ~~that need to be followed~~to follow to submit capital items for consideration in the annual budget and for the purchase of approved capital items.

~~III. POLICY~~

~~A. Department Directors are responsible for planning for the capital needs of their department. This planning is evident in the submission of their capital budget requests on an annual basis and includes input from leaders and other key stakeholders, such as Medical Staff.~~

~~B. The President/Chief Executive Officer of Salinas Valley Health Medical Center (SVHMC) and the Board of Directors must approve all capital expenditures through the annual Budget Approval Process and plan to provide three year Capital Budget.~~

~~C. Capital items that have been approved on the budget but not purchased in the approved year or will be ordered in June but not received, must be resubmitted for consideration on a Capital Equipment Budget Request form for the next fiscal year.~~

~~D. Foundation Equipment Donations – Prior to requesting any donations from the hospital 's Foundation for equipment, your request must be submitted to the Finance Council – Vice President – Finance/IT for recommendation and approval.~~

~~E. Leaders monitor the implementation of the long-term capital expenditure plan.~~

~~F. The capital plan includes identifying in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure regardless of amount that relates to any of the following: (i) acquisition of land (ii) improvement of land, buildings, and equipment or (iii) the replacement, modernization and expansion of buildings and equipment.~~

~~G. An independent public accountant conducts an annual audit of the hospital's finances.~~

IV. DEFINITIONS

A. **Capital:** Assets that cost more than $2,000 and have a useful life of over one year. Exceptions include computer equipment and copy machines, which are considered capital if their cost is $1,000 or greater.

B. **Capital Equipment Budget Request: Must** be submitted through the Capital Budget Request template provided by Finance.

C. **Capital Purchase Order Requisition:** The form to be used when submitting capital item for purchase. This form should be used for all capital purchases, budgeted or non-budgeted. This form may be found on the ~~MEMNET~~ under FORMS, **http://MEMnet/forms.htm**.

D. **Installation and Removal costs:** Must considered as part of the capital purchase and will be depreciated over the life of the equipment.

- ~~Freight and taxes must also be included as part of the cost and capitalized.~~

1. Freight and taxes must also be included as part of the cost and capitalized.

E. **Maintenance or Warranty Costs:** May be purchased at the same time as the capital item, but will not be considered capital as they do not last the full length of the equipment's life. These items will be expensed.

F. **Free Equipment:** Supply contracts that provide free equipment are still required to go through the Capital Budget Planning Purchase process.

G. **Multiple items less than $2,000 individually but totaling more than $10,000 when purchased as a set:** For items such as surgical trays where individual instruments do not meet the capital requirement of $2,000 each, but together equal $10,000 or greater, will be capitalized. Also similar items with an individual cost of less than $2,000 but aggregate value of more than $10,000 (10 tables at $1,000 each = $10,000) will be capitalized.

H. **Non-budgeted capital item:** Non-budgeted capital items must be approved for purchase by your direct supervisor at the Vice-President Level and by the CEO. Requestor must identify an approved capital budget item for the same dollar amount for substitution. If the actual price exceeds the approved budgeted amount, the excess will be treated as a non-budgeted item.

I. **Approved budgeted amount exceeds actual purchase price:** When the approved budgeted amount exceeds the actual purchase price, the excess will be allocated to the Hospital Contingency Fund. The Executive Management Team will determine how these funds will be spent.

V. GENERAL INFORMATION

A. Department Directors are responsible for planning for the capital needs of their department. This planning is evident in the submission of their capital budget requests on an annual basis through Axiom and includes input from leaders and other key stakeholders, such as Medical Staff.

B. The President/Chief Executive Officer of Salinas Valley Health and the Board of Directors must approve all capital expenditures through the annual Budget Approval Process and plan to

provide three year Capital Budget.

C. Capital items that have been approved on the budget but not purchased in the approved year or will be ordered in June but not received, must be resubmitted for consideration on a Capital Equipment Budget Request form for the next fiscal year.

D. Foundation Equipment Donations – Prior to requesting any donations from the hospital 's Foundation for equipment, your request must be submitted to the CFO and or the Executive Alignment Committee for recommendation and approval.

E. Leaders monitor the implementation of the long-term capital expenditure plan.

F. The capital plan includes identifying in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure regardless of amount that relates to any of the following: (i) acquisition of land (ii) improvement of land, buildings, and equipment or (iii) the replacement, modernization and expansion of buildings and equipment.

G. An independent public accountant conducts an annual audit of the hospital's finances.

VI. PROCEDURE

A. **Submission of Capital Requests for consideration on the next year's capital budget:**

- ~~Each year, the Vice President/Finance will set the calendar for budget submission. For capital items to be considered for the budget they must be submitted by the submission date.~~
- ~~Capital Budget Request template will be utilized for each piece of equipment that is requested.~~
- ~~EHR devices and new equipment that will interface to MediTech must be reviewed by the EHR Device and New equipment Assessment committee (EDNA). See EDNA policy and procedures. EDNA will provide a recommendation of approval or disapproval.~~
- ~~For capital budget requests of $50,000 or greater, required signoff must include of the Directors of Engineering, Biomed and Information Technology, even if it is not apparent that these departments will be necessary for the installation or maintenance of the equipment.~~
    1. ~~Capital purchases less than $50,000 will be required to get these signatures prior to purchase, their Vice President.~~
- ~~Budget prices may be obtained in two different ways:~~
    1. ~~Request a quote for the item from the vendor of choice.~~
    2. ~~Utilize ECRI for researching the price of item. If ECRI is utilized, please use the highest price listed for the item in question. An ECRI account is available from the Director of Materials Management.~~
- ~~Vice-President must sign off on all budget requests.~~
- ~~Capital Budget requests should be submitted no later than the due date as defined in the Finance Calendar.~~
    1. ~~Capital budget is usually approved at the June Board Meeting for use in~~

~~the fiscal year starting July 1.~~

1. Each year, the Chief Financial Officer and the Director of Financial Planning and Decision Support will set the calendar for budget submission. For capital items to be considered for the budget they must be submitted by the submission date.
2. Capital Budget Request template will be utilized for each piece of equipment that is requested.
3. EHR devices and new equipment that will interface to MediTech must be reviewed by the EHR Device and New equipment Assessment committee (EDNA). See EDNA policy and procedures. EDNA will provide a recommendation of approval or disapproval.
4. For capital budget requests of $50,000 or greater, required signoff must include of the Directors of Engineering, Biomed and Information Technology, even if it is not apparent that these departments will be necessary for the installation or maintenance of the equipment.
    a. Capital purchases less than $50,000 will be required to get these signatures prior to purchase, their Vice President.
5. Budget prices may be obtained in two different ways:
    a. Request a quote for the item from the vendor of choice.
    b. Utilize ECRI for researching the price of item. If ECRI is utilized, please use the highest price listed for the item in question. An ECRI account is available from the Director of Materials Management.
6. Vice-President must sign off on all budget requests.
7. Capital Budget requests should be submitted no later than the due date as defined in the Finance Calendar.
    a. Capital budget is usually approved at the May or June Board Meeting for use in the fiscal year starting July 1.

B. **Submission of Approved Capital for Purchase:**

- ~~At the beginning of the fiscal year, an approved copy of the approved Capital Budget will be made available to the hospital leadership.~~
- ~~To proceed with purchase of an item please locate the Capital Purchase Order Requisition on the MEMNET, under FORMS.~~
- ~~Please fill in every box on the Capital Purchase Order Requisition.~~
    1. ~~Vendor Name~~
    2. ~~Vendor Phone Number~~
    3. ~~Requisition Date is the date you complete the requisition~~
    4. ~~Date needed : If this is a medical rush order, please specify date needed~~
    5. ~~Vendor Address~~
    6. ~~Department Code is the department number~~

7. ~~Department is the department name~~
8. ~~Deliver to: Please specify the person Materials should notify in your department that can take receipt of the equipment. Since policy requires that all equipment will need to be checked in through Biomed, IT or Engineering, do not specify one of these departments, as we will forward automatically as part of our intake process.~~
9. ~~Requested by: Contact Person's name~~
10. ~~Extension: Contact Person's Extension~~
11. ~~Substitution is used when you are requesting approval of a non-budgeted item. You must check the Yes Box. Once the Yes Box is checked, you will need to complete the information for the item that you want substituted in the approved capital (numbers 12 and13 below). For the new item, complete number 14 below. The new item cannot exceed the budgeted dollar amount approved in the Capital Budget, for the substituted item.~~
12. ~~Capital Budget Number or CIP Number: on the approved capital budget each item will have a distinct number ("Control Number") assigned by the Accounting Department. Please put that number in this box for tracking purposes.~~
13. ~~Approved Dollar Amount is the amount approved in EPSi~~
14. ~~Requested Dollar Amount is the actual purchase price~~
15. ~~Fill in quantity, unit, vendor catalog number, unit cost, extended cost and description.~~
16. ~~Replacement: answer yes or no to whether or not this is a replacement item or an additional piece of equipment. PLEASE ATTACH QUOTE to this form.~~
17. ~~GPO contract: Answer "Yes, No or Unsure" if this quote is from a GPO vendor or not. The sales representative will know, and the quote should reflect a GPO discount if the answer is yes.~~
18. ~~EDNA: Any Electronic Healthcare Record (EHR) device or new equipment that interfaces with MediTech must be reviewed by the EDNA Committee Review. EDNA will either recommend or not recommend approval of these items by signing on the line for EDNA Chair Review.~~
19. ~~Construction Costs: The Director of Biomed, IT or Engineering will assist you with this number if applicable.~~
20. ~~Biomedical Review, IT Review, Engineering Review, EDNA Review: For the purchase of any capital item, you must get the sign off from these three Directors prior to a purchase order being issued. EDNA Review sign off when appropriate.~~
21. ~~These three Directors will address the Construction/Alteration and OSHPD questions.~~
22. ~~Pre-purchase checklist:~~

23. ~~ECRI reports: having the quote reviewed by ECRI is highly recommended. Attach ECRI report to Capital Purchase Order Requisition.~~
24. ~~Negotiated Freight/ Tax: Attempt to have vendor pay for freight(FOB Destination should be requested) and if possible to have vendor pay sales tax. Check GPO contract to see if GPO contract obligates vendor to pick up freight. Director of Materials can assist with researching the GPO Contract. If these have been negotiated, notify Materials Management in order that the Purchase Order can reflect this. Make sure that the quote reflects the negotiated terms.~~
25. ~~Negotiated Installation Cost: Attempt to have vendor pay installation costs or reduce installation costs.~~
26. ~~Operational and Service Manuals to be delivered at no charge: Directors need to ensure that Technical operations and service manuals are available to Engineering and Biomedical departments so that they can appropriately check in equipment prior to use.~~
27. ~~Negotiated school/training: Check with Directors of Engineering/Biomed to assess if equipment will be serviced by in-house staff. If "Yes", attempt to get Engineering and/or Biomed training included in quote for free or at a discount rate.~~
28. ~~Disposition of older equipment: Discuss with the appropriate Vice President options for equipment disposition. If possible, negotiate with vendor as a trade in. If the vendor will not take equipment, please notify the Director of Materials of surplus equipment as soon as possible and prior to equipment being taken out of service.~~
29. ~~Negotiation for free software/upgrades~~
30. ~~Need to cancel existing service or contract lease: If this is the case, notify Director of Materials Management and/or Biomed/Engineering or IT.~~
31. ~~Maintenance/Service Contract should be included at time of purchase: Attempt to negotiate future service contract rates at time of original purchase, in essence getting a price guarantee on service.~~
32. ~~Notified MM: Answer "Yes or No"~~
33. ~~Payment terms for our hospital are net 45 days. If your vendor wishes to negotiate this, please contact the Controller/Treasurer for approval on altering payment terms.~~
34. ~~Completed contracts should be on file in Materials Management. Please ensure that a copy is received by and filed in that department.~~
35. ~~Materials Management Bid: as a district hospital, bid requirements are required on some items over $25,000. Please contact the Director of Materials Management for assistance and clarification.~~
36. ~~Sterile Surgical Processing Department Inservice: Please confer with the SSPD Management to evaluate if their staff will need cleaning instructions and/or an inservice on new equipment.~~

1. At the beginning of the fiscal year, an approved copy of the approved Capital Budget will be made available to the hospital leadership.
2. To proceed with purchase of an item please locate the Capital Purchase Order Requisition on the MEMNET, under FORMS.
3. Please fill in every box on the Capital Purchase Order Requisition.
    a. Vendor Name
    b. Vendor Phone Number
    c. Requisition Date is the date you complete the requisition
    d. Date needed : If this is a medical rush order, please specify date needed
    e. Vendor Address
    f. Department Code is the department number
    g. Department is the department name
    h. Deliver to: Please specify the person Materials should notify in your department that can take receipt of the equipment. Since policy requires that all equipment will need to be checked in through Biomed, IT or Engineering, do not specify one of these departments, as we will forward automatically as part of our intake process.
    i. Requested by: Contact Person's name
    j. Extension: Contact Person's Extension
    k. Substitution is used when you are requesting approval of a non-budgeted item. You must check the Yes Box. Once the Yes Box is checked, you will need to complete the information for the item that you want substituted in the approved capital (numbers 12 and13 below). For the new item, complete number 14 below. The new item cannot exceed the budgeted dollar amount approved in the Capital Budget, for the substituted item.
    l. Capital Budget Number or CIP Number: on the approved capital budget each item will have a distinct number ("Control Number") assigned by the Accounting Department. Please put that number in this box for tracking purposes.
    m. Approved Dollar Amount is the amount approved in EPSi
    n. Requested Dollar Amount is the actual purchase price
    o. Fill in quantity, unit, vendor catalog number, unit cost, extended cost and description.
    p. Replacement: answer yes or no to whether or not this is a replacement item or an additional piece of equipment. PLEASE ATTACH QUOTE to this form.
    q. GPO contract: Answer "Yes, No or Unsure" if this quote is from a GPO vendor or not. The sales representative will know, and the quote should reflect a GPO discount if the answer is yes.
    r. EDNA: Any Electronic Healthcare Record (EHR) device or new equipment

that interfaces with MediTech must be reviewed by the EDNA Committee Review. EDNA will either recommend or not recommend approval of these items by signing on the line for EDNA Chair Review.

s. Construction Costs: The Director of Biomed, IT or Engineering will assist you with this number if applicable.

t. Biomedical Review, IT Review, Engineering Review, EDNA Review: For the purchase of any capital item, you must get the sign off from these three Directors prior to a purchase order being issued. EDNA Review sign off when appropriate.

u. These three Directors will address the Construction/Alteration and OSHPD questions.

v. Pre-purchase checklist:

w. ECRI reports: having the quote reviewed by ECRI is highly recommended. Attach ECRI report to Capital Purchase Order Requisition.

x. Negotiated Freight/ Tax: Attempt to have vendor pay for freight(FOB Destination should be requested) and if possible to have vendor pay sales tax. Check GPO contract to see if GPO contract obligates vendor to pick up freight. Director of Materials can assist with researching the GPO Contract. If these have been negotiated, notify Materials Management in order that the Purchase Order can reflect this. Make sure that the quote reflects the negotiated terms.

y. Negotiated Installation Cost: Attempt to have vendor pay installation costs or reduce installation costs.

z. Operational and Service Manuals to be delivered at no charge: Directors need to ensure that Technical operations and service manuals are available to Engineering and Biomedical departments so that they can appropriately check in equipment prior to use.

aa. Negotiated school/training: Check with Directors of Engineering/Biomed to assess if equipment will be serviced by in-house staff. If "Yes", attempt to get Engineering and/or Biomed training included in quote for free or at a discount rate.

ab. Disposition of older equipment: Discuss with the appropriate Vice President options for equipment disposition. If possible, negotiate with vendor as a trade in. If the vendor will not take equipment, please notify the Director of Materials of surplus equipment as soon as possible and prior to equipment being taken out of service.

ac. Negotiation for free software/upgrades

ad. Need to cancel existing service or contract lease: If this is the case, notify Director of Materials Management and/or Biomed/Engineering or IT.

ae. Maintenance/Service Contract should be included at time of purchase: Attempt to negotiate future service contract rates at time of original purchase, in essence getting a price guarantee on service.

af. Notified MM: Answer "Yes or No"

ag. Payment terms for our hospital are net 45 days. If your vendor wishes to negotiate this, please contact the Controller/Treasurer for approval on altering payment terms.

ah. Completed contracts should be on file in Materials Management. Please ensure that a copy is received by and filed in that department.

ai. Materials Management Bid: as a district hospital, bid requirements are required on some items over $25,000. Please contact the Director of Materials Management for assistance and clarification.

aj. Sterile Surgical Processing Department Inservice: Please confer with the SSPD Management to evaluate if their staff will need cleaning instructions and/or an inservice on new equipment.

C. Documentation

1. Report: Research product information or have your quote reviewed by ECRI prior to negotiating with the vendor.
2. Quote: Once you are clear on what you need, sales representative needs to provide you with a complete quote.
3. Purchase Order: Materials Management staff will supply this once all approvals have been received for the equipment in question.
4. Approved Annual Capital Budget Documentation
    a. ECRI

VII. EDUCATION/TRAINING

~~A. Inservices will be held for all Executives and Director level employees to introduce the policy. New Directors will be trained through new manager orientation process.~~

~~B. Individual members of the Board of Directors and leaders of the organized Medical Staff are oriented to the development of the budget.~~

~~VIII. DOCUMENTATION~~

~~A. ECRI Report: Research product information or have your quote reviewed by ECRI prior to negotiating with the vendor.~~

~~B. Quote: Once you are clear on what you need, sales representative needs to provide you with a complete quote.~~

~~C. Purchase Order: Materials Management staff will supply this once all approvals have been received for the equipment in question.~~

~~D. Approved Annual Capital Budget~~

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

IX. REFERENCES

A. TJC Standards LD 01.07.01 and 04.01.03
B. CMS Standard 482.12 (d)
C. Capital Budget Request template
D. ~~Approved Capital Budget~~
E. ECRI, **http://www.ecri.org**
F. ~~SVHMC MEMNET~~

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Owner	Scott Cleveland: Controller	09/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13684436

Last Approved	N/A	Owner	Carla Spencer: Director Critical Care Services
Last Revised	10/2023	Area	Cardiology Departments
Next Review	3 years after approval		

Cardiac Telemetry Monitoring and Management

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide staff in a standardized placement of leads and process for monitoring patients with cardiac monitoring needs.

B. To define roles and responsibilities for staff (Unit ~~Clerk~~Assistant II's and Registered Nurses) who oversee the cardiac monitoring of patients on ICU, Heart Center, 1 Main, 4 Tower, 5 Tower and 5 Main/OCU.

C. To set guidelines for staff (Unit ~~Clerk~~Assistant II's and Registered Nurses) who monitor telemetry patients, and required responses to clinical telemetry alarms.

III. DEFINITIONS

A. TELEMETRY: Refers to the automatic measurement and transmission of data at a distance by radio, cellular or other means. It is an observation tool that allows for continuous monitoring of heart rate/cardiac rhythm, respiratory rate, SpO2, and blood pressure monitoring.

B. CARDIAC MONITORING: Continuous monitoring of heart activity, generally by electrocardiography with assessment of the patient's condition relative to their cardiac rhythm.

C. ECG: Electrocardiogram is a diagnostic tool that measures and records the electrical activity of the heart via electrodes placed on the skin.

D. ELECTRODE: The patch that is placed onto the patients and attaches to the lead wire.

E. LEAD WIRE: The lead that connects the electrodes to the telemetry/bedside cardiac monitoring unit.

F. ARRHYTHMIA: A rhythm in which the heart beats in an irregular or abnormal rhythm.

G. CRITICAL ALARMS: high priority alarms on medical equipment/devices designed to alert staff to the presence of a life threatening or potentially life threatening rhythms/conditions.

H. NON-CRITICAL ALARMS: medium or low priority alarms on medical equipment/devices designed to alert staff to the presence of a non-life threatening rhythms/conditions.

I. QUALIFIED STAFF: healthcare providers who have been trained in the use of medical equipment/devices. For the purpose of this policy, this includes Registered Nurse with telemetry experience and Unit ~~Clerk~~Assistant II's who have been trained and serve as cardiac monitor clerks.

J. FIXED SETTING: critical alarm settings that can only be changed with a physician's order.

IV. GENERAL INFORMATION

A. Within the Progressive Care Units (Heart Center, 1 Main, 4 Tower ~~Oncology Unit~~, 5 Tower and 5 Main/OCU) centralized monitoring is utilized to allow for all telemetry monitored cardiac rhythms to be displayed on display screens at the Unit ~~Clerk~~Assistant II's workstation, also known as the central monitoring station.

B. Two PC monitors on Heart Center, 4 Tower, 5 Tower and 1 Main display physiological waveforms, blood pressure with mean arterial pressure, SpO2 pulse oximetry and respiratory rates. On ~~4 Tower, and~~ 5 Main/OCU, the telemetry monitors only display physiological waveforms, heart rate and SpO2.

C. Two main PC Monitors in ICU display physiological waveforms, blood pressure with mean arterial pressure, SpO2 pulse oximetry and respiratory rates

D. Unit ~~Clerk~~Assistant II's are trained in rhythm recognition and staff the cardiac/telemetry monitoring roles on Heart Center, 1 Main, 4 Tower, and 5 Tower and 5 Main/OCU, 24 hour hours a day. If for some reason we are unable to staff the central monitoring station with a Unit Clerk II, a Registered Nurse with Telemetry experience and ACLS certification are assigned the role. 5 Tower has the capability to monitor 4 Tower monitors and will be used as a last resort if unable to staff 4 Tower.

    1. It is the Registered Nurses responsibility to monitor the patient alarms within the ICU unit.

E. Hardwire ECG monitors have electrodes and lead wires that are attached directly to the patient. Impulses are transmitted directly from the patient to the monitor.

F. Telemetry systems have electrodes and lead wires that are attached from the patient to a battery pack transmitting impulses to the monitor via radio wave transmission.

G. The Progressive Care Units have the ability to monitor the cardiac activity for a total of ~~84~~86 patients. Each individual unit has the ability to monitor the following numbers of patients:

    1. Heart Center: 15 monitored beds
    2. 1 Main: ~~23~~13 monitored beds
    3. 4 Tower: 13 monitored beds
    4. 5 Tower: 14 monitored beds
    5. 5 Main/OCU: ~~32~~31 monitored beds (12 of the beds can be monitored on 4Tower)

H. The ICU units has the ability to monitor the cardiac activity for 13 monitored beds.

V. PROCEDURE

A. Equipment

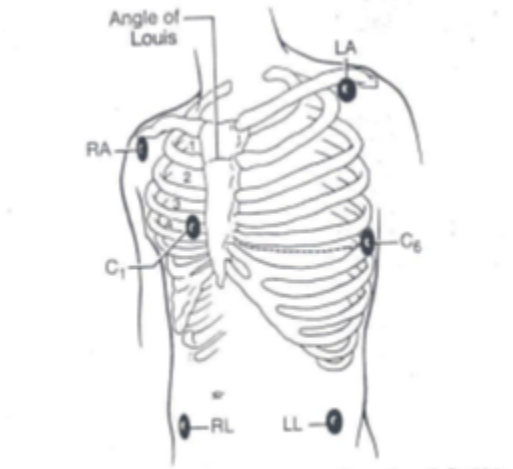
1. ECG Monitor (Central and Bedside monitor)
2. Electrodes, pre-gelled and disposable
3. 2x2 gauze pad
4. Soap and water
5. Scissors to clip hair from the chest as needed
6. Telemetry unit with battery pack
7. A five (5) lead cable

B. Prepare the skin area before applying electrodes.

C. For telemetry monitoring, insert battery into telemetry unit, matching polarity markings on transmitter.

D. OPERATION

1. Connect electrodes and lead wires on patient
   a. Apply right arm (RA) to the right shoulder close to the junction of the right arm torso.
   b. Apply the left arm (LA) to the left shoulder close to the junction of the left arm torso.
   c. Apply the right leg (RL) electrode at the level of the lowest rib, on the right abdominal region or on the hip.
   d. Apply the left leg (LL) electrode at the level of the lowest rib on the left abdominal region or on the hip.
   e. Apply chest lead electrode on the selected site: V1 fourth ICS right sternal border or V6 fifth ICS midaxillary line.



■ ● **FIGURE 51–8.** Five-lead application. (From Drew B. Bedside electrocardiographic monitoring. *AACN Clin Issues Crit Care.* 1993; 4(1):26.)

2. Set lead selector monitor to appropriate leads, preferably lead II and V lead.
3. For hardwire monitoring, fasten lead wire and patient cable to patient's gown to decrease tension which can cause interference or faulty recordings
4. For telemetry monitoring, secure transmitter in pouch or pocket of patient's gown.
5. Set alarms. Upper and lower alarm limits are set on the basis of the patient's current clinical status and heart rate or per Physician's order. Alarms should remain activated at all times.
    a. A physician order must be obtained to adjust alarms outside the upper and lower limits.
6. Tips for selection of limb leads appropriate for the clinical situation
    a. Atrial flutter: II, III, AVF
    b. Inferior myocardial infarction: II, III, and AVF select the lead with maximal elevation of ST segment on the 12 lead ECG
    c. After angioplasty: Select III or AVF – whichever has the tallest R wave
    d. If three channels are available, use V1 + I + AVF
    e. Use lead II if none of this clinical situation applies
7. Maintenance/Care
    a. Evaluate the ECG monitor pattern for the presence of P waves, QRS complex, a clear baseline, and absence of artifact or distortion.
    b. Evaluate skin integrity and change electrodes every 24 hours. Rotate sites when changing electrodes. Monitor skin for any allergic reaction to the adhesive or the gel.
8. Obtain and post an ECG strip approximately every 4 hours and interpret for:
    a. Rhythm

b. Rate
c. Presence and configuration of P waves
d. Length of PR interval
e. Length of QRS complex
f. Presence and configuration of T waves
g. Length of QT interval and QTc when indicated
h. Presence of extra waves (such as U waves)
i. Presence of dysrhythmias.

9. A monitor strip should be recorded whenever:
    a. There is a change in the patient's rhythm, vital signs or and/or hemodynamic status.
    b. The patient experiences chest pain
    c. There is a change in lead placement.
    d. When evaluating the effect of antidysrhythmic and/or cardiovascular agents

10. **Responsibilities**
    a. The responsibilities of the Unit ~~Clerk~~Assistant II's or Registered Nurse watching the telemetry monitors are:
    b. Primary responsibilities are to monitor the patient's cardiac rhythm, blood pressure, SpO2 and respiratory rate while admitted to the unit.
    c. Upon admission to the unit, the Unit ~~Clerk~~Assistant II assigns the patient to the telemetry system by pulling up the account number. This operation pulls the patient's name, DOB, age and room number into the system and sets the system up for monitoring the patient.
    d. ~~Upon admission to 4th Tower, the RN admitting the patient to telemetry will attach the Telemetry box to the patient. After the patient has been placed on the Telemetry box, the RN will call the 5 Main/OCU Unit Assistant 2 at extension 1715. The RN will provide the Unit Assistant the patients name, account number, medical record number and room assigned on 4th Tower so that the Unit Assistant will be able to add the patient to the Telemetry monitoring system.~~Upon admission to 5 Main/OCU, the RN admitting the patient to telemetry will attach the Telemetry box to the patient.
    e. Rhythm strips are printed every 4 hours for RN interpretation. Additionally, when there are changes to the rhythm or when a "Red" alarm is indicated, strips are printed for the primary nurse's review.
    f. The telemetry monitoring systems sends three types of alarms classified as "Red", "Yellow", and "Blue" alarms.
    g. The patient must be on the monitor or tele box at ALL TIMES. May not be taken off monitor and left unattended for any reason unless they have an

"off monitor" MD order.

h. Red (Highest Priority) Critical Alarms are:
    i. Extreme Bradycardia: An arrhythmia when the heart rate falls below the normal range, typically under 50 beats per minute or lower.
    ii. Extreme Tachycardia: An arrhythmia when the heart rate exceeds the normal range (dangerously high), currently set to alarm at 140 BPM or higher.
    iii. Asystole: A state of no cardiac electrical activity.
    iv. Ventricular Fibrillation (VFIB): An arrhythmia when the uncoordinated contraction of the ventricular cardiac muscle is causing the heart to quiver rather than contract properly.
    v. Ventricular Tachycardia (VTACH): An arrhythmia with a rapid heartbeat starting in the ventricles.

i. Yellow (Medium Priority) Non-Critical Alarms are:
    i. Pacer Not Capturing: When no visible pacing spikes are seen on the ECG.
    ii. Pause: When no heart beat is detected for a period longer than the pause threshold set on the monitor.
    iii. Ventricular Rhythm: When several adjacent irregular heartbeats (greater than the vent rhythm limit) and ventricular heart rate falls less than the ventricular heart rate limit (typically 20-40 beats per minute).
    iv. Desaturation: When the SpO2 level falls below the desaturation limit. Oxygen saturation of 96% to 100% is considered normal and levels falling below 90% can indicate inadequate amounts of oxygen being delivered to the body.

j. Blue (Low Priority) Non-Critical Alarms are:
    i. Battery Weak or need to replace the battery: A battery indicator is located on the telemetry monitor for each patient. The telemetry monitor tech will notify the nurse when the battery indicator gets low.
    ii. Leads Off: An indication that the caregiver needs to check that all of the required ECG lead wires are attached, and that none of the electrodes have been displaced.
    iii.

    While there are many other alarm types sounded through most physiological monitoring systems, the one's listed above have been determined to have the greatest priority to ensure timely escalation and communication to the primary nurse.

k. Escalates all "Red ~~(Highest~~" High Priority~~) Critical Alarms are~~ alarms

through the following process:

i. ~~Extreme Bradycardia: An arrhythmia when the heart rate falls below the normal range, typically under 50 beats per minute or lower.~~

ii. ~~Extreme Tachycardia: An arrhythmia when the heart rate exceeds the normal range (dangerously high), currently set to alarm at 140 BPM or higher.~~

iii. ~~Asystole: A state of no cardiac electrical activity.~~

iv. ~~Ventricular Fibrillation (VFIB): An arrhythmia when the uncoordinated contraction of the ventricular cardiac muscle is causing the heart to quiver rather than contract properly.~~

v. ~~Ventricular Tachycardia (VTACH): An arrhythmia with a rapid heartbeat starting in the ventricles.~~

vi. ~~Yellow (Medium Priority) Non-Critical Alarms are:~~

a. Pacer Not Capturing: When no visible pacing spikes are seen on the ECG.

b. Pause: When no heart beat is detected for a period longer than the pause threshold set on the monitor.

c. Ventricular Rhythm: When several adjacent irregular heartbeats (greater than the vent rhythm limit) and ventricular heart rate falls less than the ventricular heart rate limit (typically 20-40 beats per minute).

d. Desaturation: When the SpO2 level falls below the desaturation limit. Oxygen saturation of 96% to 100% is considered normal and levels falling below 90% can indicate inadequate amounts of oxygen being delivered to the body.

vii. ~~Blue (Low Priority) Non-Critical Alarms are:~~

a. Battery Weak or need to replace the battery: A battery indicator is located on the telemetry monitor for each patient. The telemetry monitor tech will notify the nurse when the battery indicator gets low.

b. Leads Off: An indication that the caregiver needs to check that all of the required ECG lead wires are attached, and that none of the electrodes have been displaced.

While there are many other alarm types sounded through most physiological monitoring systems, the one's listed above have been determined to have the greatest priority to ensure timely escalation and communication to the primary nurse.

viii. ~~Escalates all "Red" High Priority alarms through the following process:~~

a. Although leads off is a low priority alarm it will be escalated following the high priority process.

b. Alerts the RN through face-to-face communication if readily available.

c. If RN is not available for face-to-face, or when addressing a patient located on 4th Tower, the Unit Assistant will immediately escalates alarm to RN's Cisco phone.

d. If RN is not available on their Cisco phone, immediately escalates alarm to charge nurses Cisco phone. For patients located on 4th Tower, the Unit Assistant call the unit directly.

e. If Charge Nurse is not available, immediately escalates to the nearest RN for assistance.

f. If no response from primary RN, Charge RN, or in situations where no RN is immediately available at the nurse's station, and specifically when referring to "Red" alarms, a message will immediately be broadcasted through the patient call system requesting "Immediate Assistance to Room #".

g. As a last resort, in situations where the primary nurse, charge nurse or any other available nurse isn't capable of responding, a call will be placed to the hospital operator at Extension 2222 to activate a Rapid Response.

ix. Although leads off is a low priority alarm it will be escalated following the high priority process.

x. Alerts the RN through face-to-face communication if readily available.

xi. If RN is not available for face-to-face, the Unit Assistant will immediately escalates alarm to RN's Cisco phone.

xii. If RN is not available on their Cisco phone, immediately escalates alarm to charge nurses Cisco phone. For patients located on 4th Tower, the Unit Assistant call the unit directly.

xiii. If Charge Nurse is not available, immediately escalates to the nearest RN for assistance.

xiv. If no response from primary RN, Charge RN, or in situations where no RN is immediately available at the nurse's station, and specifically when referring to "Red" alarms, a message will immediately be broadcasted through the patient call system

requesting "Immediate Assistance to Room #".

xv. As a last resort, in situations where the primary nurse, charge nurse or any other available nurse isn't capable of responding, a call will be placed to the hospital operator at Extension 2222 to activate a Rapid Response.

xvi. Documents red alarms, rhythm interpretation and vital sign abnormalities on the Telemetry monitor tech report sheet used to track and pass on information to the next shifts monitor clerk.

xvii. Responds to the patient call light system.

xviii. Answer's incoming phone calls if possible.

xix. Prepares charts for admissions coming to the unit.

11. **Responding to nuisance alarms:**
    a. When responding to nuisance alarms, or a need to adjust the clinical parameters within the telemetry monitoring system (example: patient who is a marathon runner with HR consistently in the 40's, but clinical parameter set at 60's), the monitor tech must contact the primary nurse to obtain a physician order to make adjustment outside the preset parameters.

12. **Competency**
    a. Upon hire, new Registered Nurses are required to pass a rhythm strip recognition test while new graduate Registered Nurses and Unit ~~Clerks~~Assistant II's are required to attend an initial telemetry monitoring class and pass a rhythm recognition test.
    b. Annually, both registered nurses and Unit ~~Clerk~~Assistant II's are required to pass a rhythm recognition test to maintain telemetry competencies.
    c. Registered Nurses are required to maintain an active Advanced Cardiac Life Support (ACLS) certification.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. ~~The Joint Commission Perspectives on Patient Safety, December 2011, Volume 11, Issue 12. Sound the Alarm: Managing Physiologic Monitoring Systems. Joint Commission on Accreditation of Healthcare Organizations~~

B. ~~George, K.J., Walsh-Irwin, C., Queen, C., & Hawkins, C. (2014). Development of evidence-based remote telemetry policy guidelines for a multi-facility hospital system. Dimensions of Critical Care Nursing, 34(1), 10-17. DOI: 10.1097/DCC.0000000000000084~~

C. The Joint Commission National Patient Safety Goals, January 2021, Joint Commission on Accreditation of Healthcare Organizations retrieved on May 22, 2024 from

https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2021/npsg_chapter_hap_jan2021.pdf

D. Yeow RY, Strohbehn GW, Kagan CM, Petrilli CM, Krishnan JK, Edholm K, Sussman LS, Blanck JF, Popa RI, Pahwa AK. Eliminating Inappropriate Telemetry Monitoring: An Evidence-Based Implementation Guide. JAMA Intern Med. 2018 Jul 1;178(7):971-978. doi: 10.1001/jamainternmed.2018.2409. PMID: 29868894.

E. 3M Red Dot Electrodes: Application and Removal Instructions http://multimedia.3m.com/mws/media/600820O/red-dot-electrodes-application-andremoval-guide.pdf

F. McKinley,M, Electrocardiographic Leads and Cardiac Monitoring. In Wiegand, D (editor). AACN Procedure Manual for Critical Care, pp. 490-501. St. Louis, Missouri: (7th Edition 2016) Elsevier Saunders.

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	07/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Policy Owner	Carla Spencer: Director Critical Care Services	06/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13452069

Last Approved	N/A
Last Revised	09/2023
Next Review	3 years after approval
Owner	Kelly Flower: Clinical Manager
Area	Patient Care

Care of the CRRT Patient- Monitoring, Troubleshooting, and Termination of PrismaFlex

I. POLICY STATEMENT:

~~A. NA~~

A. N/A

II. PURPOSE:

~~To provide an ICU/CCU RN procedural guidelines with managing care of patient undergoing continuous renal replacement therapy~~

A. To provide an ICU/CCU RN procedural guidelines with managing care of patient undergoing continuous renal replacement therapy

III. DEFINITIONS:

A. SCUF – Slow Continuous Ultrafiltration – for fluid removal only. Poor emergent treatment of hyperkalemia and acidosis.

B. CRRT-Continuous Renal Replacement Therapy

C. CVVH – Continuous Veno-venous Hemofiltration – for convective solute clearance and patient fluid removal. Replacement solution is required.

D. CVVHD – Continuous Veno-Venous Hemodialysis – for diffusive solute clearance and patient fluid removal. Dialysate solution is required.

E. CVVHDF – Continuous Veno-Venous Hemodiafiltration – for convective and diffusive clearance and patient fluid removal. Blood pump, effluent pump, dialysate pump, and replacement pump are operational. Both replacement and dialysate solutions are required.

F. SLEDD - Sustained Low Efficiency Daily Dialysis

G. Temporary Dialysis Catheter – is a large bore, double lumen central venous catheter placed in the internal jugular vein, subclavian vein or femoral vein.

H. Dialysis – the process of diffusing blood across a semi-permeable membrane to remove toxic materials and to maintain fluid, electrolyte and acid-base balance in cases of impaired kidney function.

IV. GENERAL INFORMATION:

A. The primary responsibility of managing the CRRT is assumed by the Nephrologists in collaboration with the Critical Care physician.

B. The Dialysis RN sets up the CRRT equipment, initiates therapy according to MD order, and changes hemofilter and blood lines every 72 hours or as needed.

C. A Critical Care RN who demonstrated competency in CRRT is responsible to monitor and care for the patient throughout the course of treatment.

D. The Dialysis RN is available on-call 24 hours a day as a nursing and technical resource.

E. If the patient needs to come off CRRT for a procedure or surgery, the Critical Care RN discontinues the therapy according to procedure and collaborates with the Dialysis RN when therapy is to be reinitiated.

F. The hemofilter is changed every 72 hours or prn using the prescribed hemofilter.

G. A PRISMAFLEX cart is ordered from SSP which will be used to store all CRRT fluids and supplies while patient is on CRRT therapy.

V. PROCEDURE:

1. **Catheter Care Supplies for Heplock when not in use:**
    1. 1000 units/ml Heparin vials (use to Heplock dialysis catheter)
    2. (4) 10 mL syringes filled with 0.9% Sodium Chloride Solution
2. **PRISMAFlex Monitoring**
    1. **Status screen** displays information about the procedure during RUN mode.
    2. The first **self-test** will take place ten minutes after beginning of RUN, then every two hours thereafter. Do not make changes to circuit pressures during self-checks
    3. **Current Flow Rates** – located in upper left box. Displays the current flow rate settings.
        a. **Blood Flow Rate**– is always displayed. Stated as a physician order.
        b. **Replacement Solution Rate**- Stated as a physician order
        c. **Dialysate Rate-** Stated as a physician order
        d. **Patient set removal rate**– Net fluid removal set for the hour
        e. **Anticoagulation** Adjusted according to parameters when Heparin is use
    4. **Current Pressures-** Located in the upper right box. Gives continuous updates on pressures measured by the PRISMAFLEX system at each pressure pod location. Alarms occur if one or more pressures go out of range.
        a. ACCESS – The pressure measured as blood leaves the catheter and enters the extra-corporeal set. Since it is measured before the blood pump, it is always negative.

b. FILTER– The pressure in the extracorporeal set immediately before entering the filter. Since it is measured after the blood pump, it is always positive.

c. EFFLUENT – The pressure in the effluent line between the filter and the effluent pump. It can be positive or negative depending on the therapy chosen and filter condition.

d. RETURN – The pressure measured as the blood leaves the extracorporeal set and goes back to the patient. It is always positive.

e. TMP – Transmembrane Pressure – reflects the pressure difference between the fluid and blood compartments of the filter.

f. FILTER PRESSURE (ΔP Filter) – determine pressure conditions in the hollow fibers of the filter.

5. **Input and Output Data** - Depending on the therapy chosen, the following cumulative totals are displayed.
    a. Effluent and actual patient fluid removal
    b. Elapsed Time
    c. Treatment Time– Total treatment time for patient
        1. Filter Time – Time elapsed on current disposable set
        2. Doses and Solutions (replacement and dialysate used)
        3. The length of the I/O period is set to 60 minutes. The data on the screen accumulates for the length of time set and then reverts to zero at the end of each I/O period., A chart reminder sound (BEEP) can occurs at the end of each I/O period.

6. **Next Intervention** – An advanced warning is displayed which includes the number of minutes before the next intervention is due and what the actual intervention is. The NEXT INTERVENTION warnings are:
    a. Effluent (YELLOW) bag full- Each time the effluent bag is emptied, a NEW STERILE effluent bag must be attached. Effluent output must be emptied into the proper receptacle (i.e. hopper).
    b. Pre-blood pump scale (WHITE)
    c. Dialysate (GREEN) bag empty**.**
    d. Replacement (PURPLE) bag empty.
    e. Time to change set**.**
    f. In addition to the advanced warning, a caution alarm occurs at the time the intervention is actually due. **DO NOT change any bags until prompted to do so.**
    g. **Syringe empty** – A caution alarm but not advance warning is also given for an empty anticoagulant syringe. **Alarm provides 5 minute warning**

7. **Treatment History Screen** – Press TREATMENT HISTORY Soft key which allows viewing of treatment history information. Vital machine conditions and operating data are stored and updated minute-by-minute in software memory. The memory stores up to 96 hours of treatment data but only the last 24 hours of data are viewable in the Treatment
    a. **History Screen**- If the machine is powered down (switched off) or a total power

loss occurs during treatment, history data are retained in the Prismaflex software memory.
History data includes:

a. Patient Fluid Removal including Unintended Patient Fluid
b. Loss/Gain volume
c. Doses and Solutions – delivered doses and the amount of solutions used.
d. Pressures
e. Events

b. **Treatment History Screen** can be accessed from:
    a. The *Status* screen during a treatment (Run mode)
    b. The *Treatment Complete* screen when ending a treatment (End mode)
    c. The *Choose Patient* screen (Setup mode)
    d. With the **left and right arrows** the operator can scroll among four 24-hour intervals. Circles between the arrows are displayed unfilled if there are data available for that specific period and a filled circle indicates the selected 24-hour period. The circle to the right indicates the current day.
    e. With the **up and down arrows** the operator can scroll within the selected 24-hour interval.
c. **Patient Fluid Removal table** has three columns:
    a. Time – shows chart time intervals. The date is displayed next to the time when a new calendar day has begun.
    b. Periodic – presents the accumulated volume for the chart time interval.
    c. Total – shows the accumulated value since the start of the selected 24-hour period.
    d. The **footer displays** values for unintended patient fluid loss or gain volume and limit (selected in Setup mode)

8. **Events**
    a. Certain events that may occur during setup and delivery of a treatment are stored and displayed on the three Events screens. The control unit stores the date, hour and minute that events occur, as well as the description of the event. Up to 2500 events can be stored.
    b. Pressing the EVENTS soft key on the History screens displays the Events screen and the events are displayed in chronological order, starting with the most recent. Arrow keys to the right on the Events screen allow the operator to scroll up or down in the chronological list. When the operator presses the ALL EVENTS soft key, all events are displayed. If desired, the operator can then view only alarm-related events by pressing the ALARM EVENTS soft key or

treatment-related settings by pressing the SETTING EVENTS soft key.

9. **TMP or Transmembrane pressure**
    a. The pressure exerted on the filter membrane during operation of the Prismaflex system. It reflects the pressure difference between the blood and fluid compartments of the filter.
    b. During a patient treatment, permeability of the membrane decreases due to protein coating on the blood side of the membrane. This causes the TMP to increase.
    c. During operation, the software sets the initial TMP value at the same time as the initial pressure operating points are established (shortly after entering Run Mode). Thereafter, the initial TMP value is reset:
        1. each time the blood flow,
        2. each time the patient fluid removal is changed
        3. each time the replacement solution rates are changed and
        4. also after self-test

10. **Filter Pressure Drop**
    a. A calculated value used to determine pressure conditions in the blood compartment of the filter.
    b. During patient treatment, clotting can occur in the blood compartment of the filter. Clotting adds resistance to the blood flow through the filter and causes the filter pressure to increase. In case of severe clotting, the set needs to be exchanged.
    c. During operation, the software sets the initial value for filter pressure drop at the same as the initial operating points are established.
    d. Monitor PRISMAFLEX System pressures continuously. Chart pressure readings every hour:

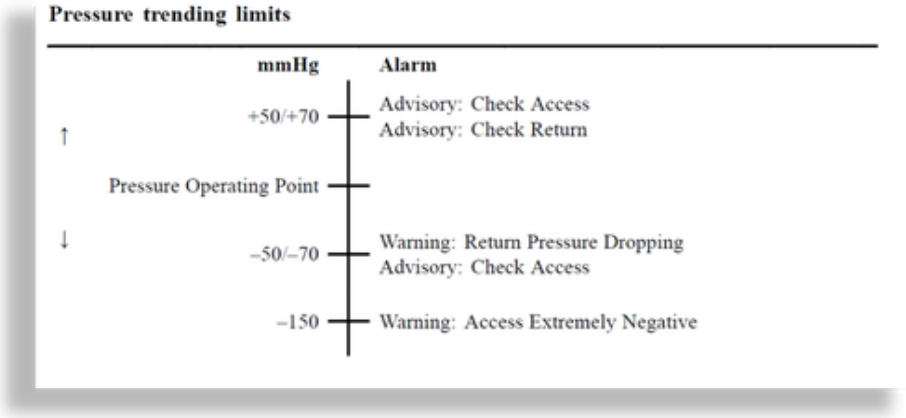
11. **Access Pressure** - The pressure measured as blood leaves the catheter and enters the extra-corporeal set
    a. Typical: -50 to –150 mmHg

12. **Return Pressure**

13. **Filter Pressure -** The pressure in the extracorporeal set immediately before entering the filter. This is always positive and higher than return pressure.

14. **Effluent Pressure**- The pressure in the effluent line between the filter and the effluent pump. This can be positive or negative depending on the therapy chosen and the ultrafiltration rate.

15. **Pressure Trending Limits**
    a. If the access or return pressure changes 50 mmHg (or 70 mmHg if blood flow >200 ml/min) negative or positive from its established pressure operating point, the control unit notifies the operator by issuing an Advisory alarm or a Warning alarm.



16. STOP soft key – stops all pumps and navigates to the Stop screen. The Prismaflex goes into STANDBY Mode when this soft key is pressed. It allows for:
    a. RESUME – to restart pumps and resume treatment
    b. CHANGE SET – allows for the operator to remove the present set, with or without returning blood t the patient and load a new set. The control unit retains the following information on set up: patient ID, current weight and current hematocrit. This the soft key that the critical care nurse presses when returning the patient's blood.
    c. To change set – Temporarily disconnect patient or end treatment,
    d. RECIRCULATE – temporarily disconnect patient and recirculate saline or blood through the blood lines.
    e. END TREATMENT – terminates the present treatment, with or without returning blood to the patient
17. Setting Flow Rates:
    a. Blood flow can be set between 200-250 mL/min. as ordered. But it can be set specific to therapy/set from 10 to 450 mL/min.
    b. PATIENT FLUID REMOVAL can be set specific to therapy or hemofilter set. The flow rate can be set at 0 or 10-1000 ml/hr in CVVH, CVVHD, and CVVHDF mode. In SCUF mode the patient fluid removal can be set from 10-2000 ml/hr. as ordered.
    c. DIALYSATE flow in CVVHD and CVVHDF mode can be set can be set specific to therapy or hemofilter set. REPLACEMENT can be set specific to therapy or hemofilter set.
    d. Pre-blood pump (PBP) Flow Rate can be set specific to therapy/set. Maximum range: 0, 10 to 4000 mL/hr. as ordered.
    e. If using Heparin 20,000 units/ 20 mL Luer Lock syringe, adjust the Heparin dose per titration as ordered or (1) 20mL Luer-Lock syringe of sterile Normal Saline (if NOT using Heparin)
        1. Note: Heparin concentration is 20,000 units per 20 mL (1000 units/ 1 ml/ 100 units/ 0.1 ml); minimum heparin rate on machine is 0.5 mL/ hour. May use heparin IV systemically via IV pump instead of through

PRISMAFlex if MD orders.

2. Date/Time/Initial Heparin/NS syringe placed in machine

3. **Critical Care RN Monitoring/care**
    1. **Heparin use**
        a. Monitor aPTT and adjust Heparin rate as ordered. Heparin 20,000 units/20ml =1000 units/1 ml= 100 units/0.1ml
        b. If protocol requires a bolus, Heparin will be obtained and administered from the Pyxis. DO NOT BOLUS through the PRISMAFlex.
            i. High-alert medication independent double check co-signature is required for new syringe and bolus doses
        c. If CRRT/SLEDD treatment is stopped (ie. clotted filter/CT/procedure):
            i. Check PTT prior to restarting.
            ii. If PTT is less than or equal to 60, IV Bolus 1000 units of Heparin x1 and resume previous heparin rate. Recheck PTT in 6 hours.
            iii. If PTT 61-80, restart Heparin at previous rate and recheck PTT in 2 hours.
            iv. If PTT is greater than 80, hold the Heparin infusion, recheck PTT in 2 hours. Restart Heparin IV at previous rate once the PTT is less than 80.
        d. When CRRT is running and heparin is set at the lower rate (500 units/hour), and the protocol recommends a decrease in the dose, HOLD heparin and recheck PTT in 2 hours.
            i. Once PTT is less than 60, resume heparin at the lower rate (500 units/hour)

~~aPTT value~~	~~Pre-Filter Heparin Bolus~~	~~Infusion Change~~	~~Repeat Lab Testing~~	
Post Filter aPTT Results	**Bolus Dose and Heparin Infusion Changes**	**When to repeat post-filter aPTT:**		
	Initial Bolus 1000 units or as directed by Physician Start Heparin at ordered rate through CRRT	2 hours		

	machine.				
~~Greater than or equal to 150~~	~~No bolus~~	aPTT > 150	No bolus; Stop ~~x~~for 1 hour, then decrease by 200 ~~u~~units/~~hr.~~hour	~~aPTT in 6 hours~~6 hours, if aPTT still > 150 seconds, notify Nephrology	
~~101-149~~	~~No bolus~~	aPTT > 100	No bolus; Stop ~~x~~for 1 hour, then decrease by 100 ~~u~~units/~~hr~~hour	~~aPTT in 6 hours~~6 hours and adjust per protocol	
aPTT 81-100	~~No bolus~~	No bolus; Decrease infusion by 200 ~~u~~units/~~hr~~hour	~~aPTT in 6 hours~~6 hours and adjust per protocol		
aPTT 61-80	No bolus; No Change	~~No change~~	~~aPTT in 6 hours~~	6 hours and adjust per protocol	
aPTT 51-60	~~No bolus~~	No bolus; Increase infusion by 100 ~~u~~units/~~hr~~hour	~~aPTT in 6 hours~~2 hours and adjust per protocol		
aPTT 41-50	~~1000 units~~	~~Increase by 200 u/hr~~	~~aPTT in 2 hours~~	1000 units IV Bolus; Increase infusion by 200 units/hour	2 hours and adjust per protocol
aPTT 30-40	~~2000 units~~	~~Increase by 200 u/hr~~	~~aPTT in 2 hours~~	2000 units IV Bolus; Increase infusion by 200 units/hour	2 hours and adjust per protocol
~~Less than 30~~	~~5000 units~~	~~Increase by 300 u/hr~~	aPTT ~~in 2 hours~~< 30	5000 units IV Bolus; Increase infusion by 300 units/hour	2 hours, if aPTT still < 30 seconds, notify Nephrology

2. **Citrate Use** - if citrate is ordered instead of heparin, the following will be implemented:
    a. Procedure
        i. Prime the CRRT circuit.
        ii. Place a 3-way stop cock to the "red access line" and the "blue return" ports of the CRRT circuit.
        iii. Attach the Citrate ACD(A) solution to a regular IV pump and then attach it to the "red" stop cock

a. The initial Citrate rate will be 250 ml/hour and will be adjusted to the POST-FILTER ionized Calcium levels.

iv. Attach the Calcium solution to a regular IV pump and then attach it to the "blue" stop cock. It may also be given via a central access line.

a. The initial Calcium rate will be 60 ml/hour and will be adjusted to the SYSTEMIC ionized Calcium levels.

v. Ionized Calcium levels:

a. Post-filter are drawn from the CRRT circuit before the IV Calcium infusion is attached to the system.

b. Systemic are drawn from the patient (venipuncture).

c. Draw pre citrate initiation; 1 hour post, Q2h x2, then Q4h thereafter as timed below

i. ** Recheck Ionized Calcium levels Q2H x2 with any titration change, then resume Q4h thereafter, if stable

vi. Time 0 (Prior to initiating CRRT and the citrate/calcium infusions)

a. Draw a baseline SYSTEMIC ionized Calcium level

b. Start the CRRT, the citrate, and calcium infusions.

vii. Time 60 (60 minutes after starting)

a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

viii. Time 180 (180 minutes after starting)

a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

ix. Time 300 (300 minutes after starting)

a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

x. Time Q4H thereafter

a. Draw a POST FILTER and a SYSTEMIC ionized Calcium level.

b. Titrate the rate of Citrate and/or Calcium infusion per chart below.

c. ** Recheck Ionized Calcium levels Q2H x2 with any

titration change, then resume Q4h thereafter if stable

xi. Use the following chart to titrate the Citrate:

Citrate-Dextrose (ACD) Solution Anticoagulation Protocol

Condition	Dose/Rate
Initial Rate	250 ml/h
Post Filter iCA2+ less than 1 mg/dl	Decrease by 20 ml/h
Post Filter iCA2+ 1 to 1.4 mg/dl	No change
Post Filter iCA2+ 1.41 to 1.56 mg/dl	Increase by 10 ml/h
Post Filter iCA2+ 1.57 to 2 mg/dl	Increase by 20 ml/h
Post Filter iCA2+ greater than 2 mg/dl	Increase by 30 ml/h
*Maximum flow of Citrate	1.5 x the Blood Flow Rate

xii. Use the following chart to titrate the Calcium Gluconate

Condition	Dose/Rate
Initial Rate	60 ml/h
Systemic iCA2+ less than 3.4 mg/dl	Increase by 40 ml/h
Systemic iCA2+ 3.4 to 3.6 mg/dl	Increase by 20 ml/h
Systemic iCA2+ 3.61 to 4.8 mg/dl	No change
Systemic iCA2+ greater than 4.8 mg/dl	Decrease by 20 ml/h

3. **Patient Monitoring**
   a. Daily weights.
   b. Vital signs – blood pressure, pulse, respirations, central venous pressure (CVP) as indicated hourly and prn. If patient becomes hypotensive, see CRRT PRISMA TROUBLESHOOTING DURING PROCEDURE.
   c. Check Blood Lines (Access Line and Return Line), Effluent Line, Replacement Line, and Dialysate Line (if applicable) for kinks. Kinking of the tubing can cause pressure alarms and interruption of the treatment.
   d. Check catheter insertion site and tubing connections for bleeding and separation of lines.
   e. Only use 21g, 22g or 25g needles in sample ports, no blunt needles
   f. Monitor electrolytes, glucose, and albumin during treatment and initiate replacement/treatment per MD order
   g. Monitor all connections are secure, no occlusion or kinks in blood lines and vascular access.
   h. Assess hourly intake and output and adjust fluid removal rate accordingly.
   i. Document the patient's intake and output, fluid removed from the machine, the level of blood/solution on the deaeration chamber, the PRISMAFLEX flow rates and pressures, hourly on the CRRT flowsheet

1. CRRT flowsheet is a part of the patient's permanent medical record.
2. Monitor flow rates continuously. Chart every hour:
3. Blood Flow Rate – Typically 200 - 250 mL/min or as ordered by MD
4. Patient Fluid Removal Rate – Calculation from CRRT flowsheet
5. Replacement Fluid Solution – Typically 2000 ml/hr as ordered by MD
6. Effluent Flow Rate – Dependent on calculated fluid removal rate, dialysate and replacement flow rates
7. Dialysate Flow Rate – Typical 500-1000 ml/hr as ordered by MD
8. Anticoagulation (Heparin) Infusion Rate – Variable dependent upon aPTT result.
9. **Intake and Output standardize I/O calculation**:

   Intake – replacement fluids, and dialysate fluids are not included with the intake.

   a. Oral/OG/NG/Peg Intake
   b. All IV infusions – e.g. IVPB, TPN,
   c. Blood products

   Output

   a. Urine
   b. Nasogastric tube drains, chest tubes, etc. Note: Do not count effluent or ultrafiltrate, on output section of the calculation. This is determined by the PrismaFlex machine as fluid removed
      a. Determine Patient Fluid Removal Rate
         1. Patient Net I + O = C= A – B
         2. A = Projected Hour Non-Prismaflex Intake (for current hour)
         3. B = Last hour's output
         4. C = Patient Net I/O
      b. Determine "RN Set Fluid removal rate" = (F = C+ or –D + or - E)
         1. F = RN set removal rate
         2. C = Patients Net I /O
         3. D = Doctors order desired fluid loss
         4. E = Previous hour deficit

j. Connect new STERILE effluent bag when directed by the machine. Check ultrafiltrate color. Should be clear light yellow.
k. For CVVHD and CVVHDF monitor dialysate rate as ordered.

l. Change dialysate, replacement fluid and post filter solution when directed by the machine.

m. Notify physician for patient care problems. **Any deviations from the protocol requires a physician order.**

n. Monitor and troubleshoot alarms on PRISMAFLEX during therapy. If pressures exceed typical settings, See CRRT CONTINUOUS RENAL REPLACEMENT THERAPY PRISMAFLEX TROUBLESHOOTING DURING PROCEDURE

o. Notify on-call Dialysis RN for clotted hemofilter or equipment troubleshooting.

p. Discontinue and return blood if allowed. by pressing CHANGE SET and following the directions on the PRISMAFLEX MACHINE

q. Do not use germicidal wipes on the Prismaflex screen. Only alcohol wipes.

4. **TROUBLESHOOTING**
Troubleshooting shall be performed by the Dialysis RN on call in collaboration with the qualified Critical Care RN assigned to the patient.

1. **ACUTE ALLERGIC REACTIONS**

a. Patients receiving angiotensin converting enzyme inhibitors can develop, within the first few minutes of treatment, symptoms similar to acute allergic reactions, including bronchospasm, edema of airways or larynx, dyspnea, angioedema, urticaria, nausea and vomiting, diarrhea, respiratory arrest, abdominal cramping, hypotension, hypovolemic shock, and death.

b. **STOP TREATMENT IMMEDIATELY.** Administration of antihistamines may not alleviate the symptoms. If symptoms of a severe reaction occur, stop treatment immediately and begin a more aggressive first-line therapy for anaphylactic reaction.

2. **ALARMS**

a. Respond to alarms and correct alarm conditions immediately according to prompts on the Status/Alarm/Help screens and/or procedures in the Operator's Manual/Policy and Procedures in order to prevent clotting in the system.

3. **OVERRIDE** Soft Key –

a. A new alarm cannot occur during the override period. Carefully observe the set and all operation during this period.

4. **POWER LOSS**

a. If power is lost to the PRISMAFLEX Control Unit, the patient can be manually disconnected from the set.

b. When performing a Manual Termination with Blood Return, visually check for air in the blood return line until the patient is disconnected.

c. The Control Unit may not detect disconnections of the set from the patient's catheter. Carefully observe the set and all operation while using the PRISMAFLEX system.

5. **AIR REMOVAL**
    a. When the AIR IN BLOOD screen appears on the PRISMAFLEX system, the user will be given step-by-step instructions on how to remove air from the PRISMAFLEX set.
6. **PRISMAFLEX Pods**
    a. When pods are out of position, put the pods back into the correct position and re-test the machine by:
        1. Pressing SYSTEM TOOLS
        2. Press SELF-TEST soft key
7. **BLOOD LEAK ALARM- NOTE:** This procedure is used when the PRISMAFLEX gives a Blood Leak Alarm.
    a. Procedure
        1. Ensure that the effluent line is properly placed in the Blood Leak Detector (BLD).
        2. You are now at Test Effluent for presence or absence of blood.
        3. Draw sample according to directions on screen and send to lab. Mark Specimen as "Effluent Fluid", not urine
        4. If false positive:
            - Press CONTINUE.
            - Press Normalize BLD soft key
            - Return to STATUS SCREEN.
        5. If true positive, perform Termination of Therapy with Expected Re-initiation.
8. **PROBLEM SOLVING**
    a. Hypotension
        1. Decrease Pt. Net Loss to 0.
        2. Administer IV fluid (fluids, albumin, plasma, etc.) Peripherally to increase plasma volume as ordered by physician. (Do not count these fluids in the calculations for Pt. Net Loss for next hour.)
        3. Follow unit specific procedures for B/P maintenance.
        4. Notify physician.
    b. Cardiac Arrest
        1. Discontinue treatment and return blood to patient by pressing STOP.
        2. Press RECIRCULATION (if will be off machine only 3-5 minutes) and follow instructions displayed on the screen or
        3. Press END TREATMENT and follow the instructions displayed on the screen.
        4. **NOTE:** A 1000ml Normal Saline bag with a Y connect and a spike

adapter must be available to connect to the patient's Access Line during the RETURN BLOOD mode. Flush both catheter lumens with 10ml NS, fill with 1000 units/ml of Heparin to fill volume as ordered. Label cath ports appropriately.

5. Notify physician.
6. Notify Dialysis nurse.

c. Bleeding

1. Bleeding From Access Catheter Site
    a. Apply direct pressure.
    b. Check anticoagulant rate, check PTT.
    c. Notify physician.
2. Separation of Blood Tubing
    i. An Access Discontinuation Warning Alarm will occur (if access pressure is more positive than –10 and more negative than –10).
    ii. Reconnect if possible. Press OVERRIDE.
    iii. If contaminated:
        1. Push STOP.
        2. Do Not Return blood.
        3. Follow instructions displayed on screen.
        4. Notify Dialysis Nurse.
3. Bleeding into Filtrate
    i. A Blood Leak Detect Warning alarm will occur.
    ii. All pumps will stop to limit blood loss.
    iii. Discontinue treatment.
    iv. To return blood to the patient, press STOP from the Alarm screen, then press CHANGE SET from the Stop screen and follow the screen instructions.
    v. Notify physician.
    vi. Notify the Dialysis nurse.

d. Air in System

1. An Air in Blood Warning alarm will occur.
2. Remove the air via instructions on the Alarm screen or refer to Operator's manual.
3. Identify and remedy cause.
4. Press CONTINUE.
5. **NOTE:** If air is prevalent in entire set, change the set via Manual Termination without Blood Return.

6. Press both clips of cartridge carrier. Tug on cartridge assembly while manually turning each pump COUNTERCLOCKWISE.
7. When pump segments are free from pump raceways, remove set and discard using Standard Precautions.

e. Air in Blood
    1. Verify all connections are secure.
    2. Visualize for break in integrity of tubing/hemofilter.

f. Without Blood Return
    1. Turn off power switch. Clamp access line (red) and return line (blue) and disconnect from patient. Flush both arterial and venous lumens of patient catheter with 10ml Normal Saline and fill with 1000 units/ml Heparin to fill volume as ordered, cap and label appropriately.

g. Access Pressure Alarm (Occurs if access pressure is more negative than the user settable "Access Pressure Extremely Negative" warning limit)
    1. Check for adequate flow from catheter.
    2. Verify secure connection to blood circuit tubing.
    3. Is patient hypovolemic?
    4. Consider vascular spasm.
    5. Change patient position.
    6. Access pressure maximum lower limit should not be less than –250.

h. Return Pressure Alarm (Occurs if return pressure is more positive than the user-settable "Return Pressure Extremely Positive" warning limit)
    1. Is patient moving?
    2. Possible kink in blood circuit line.
    3. Clotting in the blood circuit line or catheter.
    4. Check for adequate flow from catheter.
    5. Return pressure upper limit should not exceed +350.

i. Poor Ultrafiltration Rates
    1. Check functioning of filter.
    2. Is hemoconcentration occurring?
    3. Possible clotting present?
    4. What is the patient's hematocrit?

j. Poor Blood Flow Rates
    1. Does the catheter provide adequate flow?
    2. Is the hemofilter clotted or clogged?
    3. Is the patient MAP **greater than** 60mmHg?
    4. What is the patient's hematocrit? Higher hematocrit values lead to

sluggish blood flow through the hemofilter.

k. Blood Leaks
    1. Problems with the membrane possibly dropped during shipment and handling, blunt contact with other equipment in the patient's room, or manufacturing defect.
    2. Check ultrafiltrate for presence of blood. If positive, cease treatment and DO NOT return patient's blood. Discard entire blood circuit and follow facility protocol for reinitiating treatment.

l. Hypovolemia
    1. Check for secure connections to the blood circuit.
    2. Assess patient for cause of hypovolemia.
    3. Adjust ultrafiltration rate in accordance with assessment findings, and physician orders.

m. Electrolyte Imbalance
    1. Verify accurate ECG tracing.
    2. Monitor ECG tracing for changes in heart rhythm, QRS size, changes in the T waves, changes in PR interval, and changes in the ST segment.
    3. Assess laboratory values.
    4. Assess patient for changes in mentation, reflexes, seizure activity, skin turgor, muscle cramps, focal weakness, thready pulse, etc.
    5. Adjust dialysate and/or replacement solution per physician orders.

n. Calcium Imbalance
    1. Assess laboratory values.
    2. Monitor ECG tracings for changes in the QT interval.
    3. Assess patient for changes in reflexes, complaints of bone and/or chest pain.
    4. Adjust dialysate and/or replacement solutions per physician order.

o. Phosphorous Imbalance
    1. Assess laboratory values.
    2. Monitor ECG tracing for heart rate changes.
    3. Assess patient for changes in oxygenation, seizure activity, reflexes, tetany, or complaints of nausea or vomiting.
    4. Adjust dialysate and/or replacement solutions per physician orders.

p. Acid/Base Imbalance
    1. Renal failure patients tend to be acidotic related to the renal inability to excrete acid.

q. Infection Control

1. Maintain strict aseptic technique at all times.
2. Monitor patient's vital signs. Watch for trends in temperature changes.

r. Anticoagulation
   1. Deliver per facility protocol and physician orders.

5. **TERMINATION OF CRRT**
   The completion and termination of CRRT is determined by a nephrologist and performed by an ICU/CCU RN in collaboration with dialysis RN. The recommended maximum time for therapy for each hemofilter is 72 hours. Therapy will be discontinued and filter will be replaced by a dialysis RN.
   1. Equipment
      a. PRISMAFlex machine connected to patient in RUN mode. See *CRRT – Prisma Initiation of Treatment* or *CRRT – Prisma Monitoring During Therapy*.
      b. 1000ml bag Normal Saline
      c. 2 10ml syringes filled with Normal Saline
      d. Sterile piercer spike
      e. 2 - 3ml syringes
      f. 2 Sterile injection caps
      g. 3 vials Heparin 1000 units/ml
      h. 2 plastic blue clamps
   2. STOP-STANDBY mode is automatically entered when pressing the STOP key on the Status screen. By choosing one of the following options other than RESUME, END mode will automatically be entered.
      a. RESUME – To restart pumps and resume treatment.
      b. CHANGE SET – To change the set and then resume treatment.
      c. RECIRCULATION- TO temporarily disconnect the patient
      d. END TREATMENT – To terminate the treatment.
   3. RECIRCULATION- TO temporarily disconnect patient, press RECIRCULATION key
      a. **Do Not** try to return blood if clotting is present in blood lines or filter.
      b. **Follow step-by-step instructions provided on screen.**
      c. Flush patient catheter with 5-10 ml Normal Saline per limb. Instill the amount of heparin (1000units/ml) as stated on each catheter port. Clamp the catheter lumen while applying positive pressure.
      d. If significant clotting is discovered, press UNLOAD and prepare a new PRISMAFlex set.
      e. If no clotting is seen, press PRIME key and follow the same priming procedure as for a new PRISMAFLEX set.
      f. Press CANCEL to cancel temporary disconnection and return to STOP screen.

4. END TREATMENT – To end treatment, choose one of the following options:
    a. RETURN BLOOD – To return blood to patient.
    b. DISCONNECT – To disconnect patient from machine without returning blood.
    c. CANCEL – To cancel END TREATMENT choice and return to the STOP screen.
5. RETURN BLOOD
    a. Ensure that there is at least 300 mL of 0.9% Sodium Chloride left in the bag to return blood.
    b. Clamp arterial port of dialysis catheter to and the access line on the CRRT circuit. Flush the arterial port of the dialysis catheter with 10 mL flush of 0.9% Sodium Chloride. Connect the access line to either of the limbs of the Y Connect. Unclamp the access line and the clamp on the Y Connect to allow normal saline to flow.
    c. Return blood by:
        1. Pressing AUTO RETURN. The machine will return a pre-programmed amount which is equal to the volume of the extracorporeal circuit. If more blood is desired to be returned, then press and hold the MANUAL RETURN soft key.
        2. Pressing and holding the MANUAL RETURN soft key to return the desired amount of blood.
        3. Clamp patient's venous catheter port and the return line. Disconnect the return line and flush the venous catheter port with 10 mL of 0.9% Sodium Chloride. Connect return line to the Y-Connect. Press CONTINUE
6. DISCONNECT
    a. Clamp all lines in the tubing set.
    b. Disconnect access and return lines. Disconnect anticoagulant line from syringe.
    c. Flush patient catheter with 10 ml of Normal Saline per limb. Instill Heparin 1000units/ml (see recommended amount printed on the catheter port) into each catheter port per protocol and place sterile caps on ends.
7. TREATMENT COMPLETE
    a. Disconnect lines from all bags, drain any fluid remaining in bags at appropriate waste site(s) according to policy. (All bags should be emptied before discarding.)
    b. Discard all tubing and empty bags into red hazardous waste receptacle.
    c. Press the TREATMENT HISTORY key to review the treatment data from the last 24 hours.
        1. The treatment data is stored in memory until the next New Patient procedure is selected on the CHOOSE PATIENT screen.
        2. Turn off machine. Place PRISMAFlex equipment in Dirty Utility Room.
        3. Wipe down outside of PRISMAFlex machine with hospital approved

disinfectant (located on the CRRT cart).

8. MANUAL TERMINATION OF TREATMENT – Manual termination may be required due to an alarm, or conditions as stated by the PRISMAFlex machine, power failure, or other emergency.
    a. Turn the power off. Clamp and disconnect the access line from the patient. Attach the access line to sterile Normal Saline bag with at least 300 ml volume
    b. Remove the return line from the return clamp (which is always closed when the power is off) by pulling outward on clamp.
    c. Manually turn the blood pump clockwise until sufficient blood is returned to the patient. Since the power is off and the alarm system is disabled, it is important to **LOOK FOR AIR** in the return line until the patient is disconnected.
    d. Clamp the return line and disconnect from patient. Clamp all lines to bags.
    e. Press the clip of the cartridge carrier to release the filter. Starting with any pump, manually turn each pump counterclockwise. The pump segment will work itself out of the pump raceway in a few turns of the rotor. To assist, gently tug on the cartridge assembly while turning the pump.
    f. When pump segments are free, remove the set and discard as usual.
    g. For manual termination without blood return, turn off power, clamp and disconnect the access and return lines from patient. NOTE: DO not flush catheters if a clot is suspected

6. **DOCUMENTATION**
    1. Document settings, fluids, and pressures every 60 minutes after initiation of CRRT. The Dialysis nurse documents the initiation and post 60 minutes post-initiation.
    2. Document ongoing monitoring of rates, pressures, and I&O at least hourly in the critical care flowsheet.
    3. Document any complications and interventions.
    4. Document discontinuation of CRRT therapy and patient tolerance of procedures.
    5. Document insertion site and any signs or symptoms of infection.
        a. Patient's response to CRRT and daily progress towards treatment goals.

VI. EDUCATION/TRAINING:

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

B. ~~Performed by a Critical Care RN upon completion of competency and hands on orientation with preceptor.~~

VII. REFERENCES:

~~A. Gambro Lundia AB (2005-2015). Prismaflex® Operator's Manual for use with software version 7.xx. Magistratsvagen 16, SE-220 10 Lund, Sweden.~~

~~B. Astle, S., (2011), Continuous Renal Replacement Therapies. In Weigand, D. (Ed.) AACN Procedure Manual for Critical Care, (6th edition, pp. 1018-1032). St Louis, Missouri: Elsevier Saunders.~~

A. Baxter (2023). *Renal acute therapy products.* Renal Acute Education Resources. https://usrenalacute.baxter.com/renal-acute- education-resources

B. Cooper, A. (2022, August). Pharmacological interventions to prevent clotting in extracorporeal circuit during continuous renal replacement therapy. *Critical Care Nurse, 42*(4), 84-85.

C. Heering, H., & Gruenwald, J. (2023, March 24). Performing continuous renal replacement therapy in adults. In *Dynamic Health*. https://www.dynahealth.com/nursing-skills/performing-continuous-renal-replacement-therapy-in-adults

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Director	Carla Spencer: Director Critical Care Services	06/2023
Policy Owner	Kelly Flower: Clinical Manager	06/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13659554

Last Approved	N/A	Owner	Louis Villaneda Sr.: NICU/Adult Educator/ Supervisor
Last Revised	09/2023		
Next Review	3 years after approval	Area	Patient Care

Care of the Mechanically Ventilated Adult Patient

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To provide standardized guidelines for ventilator setup, management, sedation and weaning of patients requiring mechanical ventilation.

III. DEFINITIONS

A. ABG: Arterial Blood Gas

B. **SBT:** Spontaneous Breathing Trial ~~(Yang/Tobin calculation).~~

C. **NIF:** Negative Inspiratory Force.

D. Pplat: Plateau Pressure

E. RSBI: Rapid Shallow Breathing Index

F. VTE: Exhaled Vital Volume

G. **RASS:** Richmond Agitation and Sedation Scale.

H. **PBW:** Predicted Body Weight.

I. **CABG:** Coronary Artery Bypass Grafting

J. **AVP:** Adult Ventilator Protocol.

K. **RCP:** Respiratory Care Practitioner

L. **PBW:** Predicted Body Weight (Ideal Body Weight)

M. **VT:** Tidal Volume

N. **RR:** Respiratory Rate

IV. GENERAL INFORMATION

~~A. Adult Ventilator Protocol (AVP) requires a Physician's Order~~

~~B. Initial and subsequent ventilator parameter adjustments are in accordance with~~

~~C. AVP and must be documented in the Respiratory Care Department Intervention flow sheet in Meditech~~

~~D. Physician ventilator parameter orders not covered by the protocol shall be entered in the Physician order entry~~

~~E. The following protocol is physician ordered and carried out by the Respiratory Care Practitioner (RCP).~~

~~F. ***Exclusion from AVP includes the following criteria***~~

~~1. ***Patients less than 16 years old***~~

~~2. ***A written ventilator order from the primary or consulting MD that varies from the AVP and does not permit adjustment of the ventilator parameters based on AVP. In such scenario, the ICU Pulmonary MD or on-call Pulmonologist will be contacted for clarification as to whether further ventilator adjustments shall be based on AVP. The MD then has a choice to approve further use of AVP or to discontinue.***~~

A. Adult Ventilator Protocol (AVP) requires a physician's order and is carried out by the Respiratory Care Practitioner

B. All ventilator changes under the AVP must be documented in the RTC Ventilator Settings/ Assessment in Meditech

C. All ventilator orders outside of the AVP shall be entered by the physician in Meditech

D. Exclusion from AVP includes the following criteria and will require ventilator management:

1. Patient less than 16 years of age
2. A written order outside of the AVP

V. PROCEDURE

A. Use patient's predicted body weight to set patient's tidal volume:

1. Males: 50 + 2.3 [height (inches) - 60] = kg
2. ~~The following goals are targeted~~Females:
   - ~~SpO2: 88% - 95%~~
   - ~~PaO2: 60 - 80 (PaO2 takes precedence)~~
   - ~~pH: 7.30 - 7.45~~
   - ~~Plateau Pressure: less than or equal to 30 cmH2O~~

   45.5 + 2.3 [height (inches)-60] =kg

   a. The following goals are targeted:
      - SpO2: 88% - 95% Unless otherwise indicated by physician's order

- PaO2: 60 - 80 (PaO2 takes precedence)
- pH: 7.30 - 7.45
- Plateau Pressure: less than or equal to 30 cmH2O

B. **INITIAL VENTILATOR SETTINGS**:

- ~~Mode - volume targeted, pressure regulated volume control (PRVC)~~Mode - Pressure Regulated Volume Control (PRVC)
- Tidal volume (Vt) - Set initial ~~VT~~Vt to 6 ml/kg per PBW
- Plateau Pressure (Pplat) Goals: ~~less~~Less than or equal to 30 cmH20
- Rate --Set to patient's required minute volume 6-8 Lpm (*Do not exceed RR 35*)
- FIO2/PEEP -- Use combination from table below to maintain PaO2 60—80 mmHg or SpO2 88 - 95 % Unless otherwise indicated by physician's order
    - If patient's PEEP/FIO2 is not compatible with scale adjust FIO2 in increments of 0.1 Up to 1.0 and/or PEEP in increments of 2 until on scale.

FIO2	**0.3**	**0.4**	**0.4**	**0.5**	**0.5**	**0.6**	**0.7**	**0.7**	**0.7**	**0.8**	**0.9**	**0.9**	**0.9**	**1.0**
PEEP	**5**	**5**	**8**	**8**	**10**	**10**	**10**	**12**	**14**	**14**	**14**	**16**	**18**	**18**

C. **VENTILATOR MANAGEMENT**

1. ~~Every 4 hours measure and record SpO2 and plateau pressure. Use 0.5 sec pause.~~
2. Ventilator checks should be done every 4 hours and as needed
3. Plateau pressure (Pplat) should be checked every 4 hours, and after each change in PEEP, Vt, or patient condition
4. Adjust ventilator ~~according to~~settings to achieve ventilator goals: ~~plateau pressure,~~ pH, ~~and oxygenation~~pCO2, PaO2, SpO2
5. ~~Plateau Pressure: the plateau pressure should be less than or equal to 30 cmH2O.~~RCP will obtain an initial arterial blood gas (ABG) within 30 minutes of placing the patient on mechanical ventilation
6. RCP should order arterial blood gas ~~Per Policy~~(ABG) per policy 30 minutes post ventilator change or as needed If ~~Plateau pressure~~Pplat > exceeds 30 cmH20~~:~~
7. If no exceptions (*see exceptions below*)
    - ~~a. decrease VT 1 ml/kg every 2-3 hours (do not go below a minimum VT is 4 ml/kg PBW) keeping pH greater than 7.15~~
    - Adjust RR to max of 35 to keep minute volume within ~~7-9~~6-8 Lpm
    - Notify MD for pH <7.2

~~**Exceptions**~~

- ***If any of the following conditions occur, then no decreases in VT should be made:***

- ***RR = 35***
- ***pH less than 7.15 & bicarb infused or considered;***
- ***VT = 4 ml/kg.***

D. **PH GOALS are 7.30 - 7.45**

- pH greater than 7.45 - decrease RR if possible
- pH = 7.30 - 7.45 - may maintain current settings
- pH = 7.15 - 7.30 - RR to maximum of 35
- pH less than 7.15 - Increase RR to 35

E. **OXYGENATION GOALS**

1. Use standard table below for FI02 and PEEP settings with goals of PaO2: 60 – 80 mmHg (PaO2 takes precedence) or SpO2 88 – 95%. Unless otherwise indicated by physician's order

Note* If patient's PEEP/FIO2 is not compatible with table and not an exception ~~(See Exceptions in next section under Line item I)~~, adjust FIO2 in increments of 0.1 and/or PEEP in increments of 2 until on scale.

F. **Standard PEEP/Fi02 Scale**

FIO2	**0.3**	**0.4**	**0.4**	**0.5**	**0.5**	**0.6**	**0.7**	**0.7**	**0.7**	**0.8**	**0.9**	**0.9**	**0.9**	**1.0**
PEEP	**5**	**5**	**8**	**8**	**10**	**10**	**10**	**12**	**14**	**14**	**14**	**16**	**18**	**18**

Exceptions

1. ***For patients that remain on FIO2 ≥ 0.9 with PEEP = 16 at an interval > 4 hours; Contact MD for consideration of higher PEEP or alternative methods.***
2. ***Patients may only be switched to the high PEEP scale with order from MD.***

G. **High PEEP/FiO2 Scale: Requires Physician's approval**

FIO2	**0.3**	**0.3**	**0.3**	**0.3**	**0.4**	**0.4**	**0.5**	**0.5**	**0.5**	**0.6**	**0.7**	**0.8**	**0.8**	**0.9**	**1.0**	**1.0**
PEEP	**8**	**10**	**12**	**14**	**14**	**16**	**16**	**18**	**20**	**20**	**20**	**20**	**22**	**22**	**22**	**24**

SEDATION:

1. Pain and sedation should be assessed together (refer to PAIN MANAGEMENT using appropriate pain scale. Treat patient's pain as prescribed.
2. Use RASS scale to determine level of sedation. Determine if level of sedation is within the target range specified by physician (refer to MAR for target).
3. First observe patient. If patient is alert, restless, or agitated, score is 0 to +4. If patient is not alert, state patient's name and instruct to open eyes and look at the speaker
    a. Patient awakens with sustained eye opening and eye contact (score -1)

b. Patient awakens with eye opening and eye contact, but not sustained (-2)

c. Patient has any movement in response to voice but no eye contact (-3)

4. When no response to verbal stimulation, physical stimulate patient by shaking or sternal rub.
    a. Patient has any movement to physical stimulation (score-4)
    b. Patient has no response to any stimulation (score -5)
5. Titration of sedation agents is done according to orders and titration guidelines

H. **DAILY SEDATION VACATION AND SPONTANEOUS BREATHING TRIAL**

The patient is evaluated daily (0800) for Inclusion Criteria and RASS score to determine if they are eligible for Spontaneous Breathing Trial and the Sedation Vacation. ~~Inclusion criteria are:~~

- ~~MAP greater than 60, SBP greater than 90, regardless of vasopressor support~~
- ~~HR greater than 50 and less than 130~~
- ~~Temperature less than 38.3 C~~
- ~~Patient is able to tolerate decrease or termination of sedation~~
- ~~RASS upon termination of sedation is (+1) to (-1)~~
- ~~FiO2≤0.5 and PEEP≤8cmH2O~~
- ~~Obtain NIF. Patient must exceed −20cmH2O~~
- ~~RR<30; VT ≥ 5cc/Kg PBW; SpO2≥88%~~
- ~~Not on Hypothermia protocol~~

Primary Nurse Role:
Establish baseline RASS:

- If RASS less than or equal to (-1), Hold sedation for 30 min prior to beginning Spontaneous breathing trial.
- If severe agitation (>+2) results prior to 30min off of sedation, resume prior sedation rate.
- After 30 minutes off sedation, determine RASS score.
- If RASS is (+1) to (-1), notify Respiratory Therapist to perform Spontaneous Breathing Trial.

Note *If patients' screening parameters are unacceptable, patient does not meet criteria for Sedation Vacation and Spontaneous Breathing Trial.

1. **Inclusion criteria are:**
    - MAP greater than 60, SBP greater than 90, regardless of vasopressor support

- HR greater than 50 and less than 130
- Temperature less than 38.3 C
- Patient is able to tolerate decrease or termination of sedation
- RASS upon termination of sedation is (+1) to (-1)
- FiO2≤0.5 and PEEP≤8cmH2O
- Obtain NIF. Patient must exceed –20cmH2O
- RR<30; VT ≥ 6cc/Kg PBW; SpO2≥88%
- Not on Hypothermia protocol

I.

Primary Nurse Role: Establish baseline RASS:

- If RASS less than or equal to (-1), Hold sedation for 30 min prior to beginning Spontaneous breathing trial.
- If severe agitation (>+2) results prior to 30min off of sedation, resume prior sedation rate.
- After 30 minutes off sedation, determine RASS score.
- If RASS is (+1) to (-1), notify Respiratory Therapist to perform Spontaneous Breathing Trial.

Note *If patients' screening parameters are unacceptable, patient does not meet criteria for Sedation Vacation and Spontaneous Breathing Trial.

J. **Spontaneous Breathing Trials:** ***SBTs will be performed daily for patients in the ICU/CCU. Weaning Protocol and Sedation Vacation Starts at 0800***

1. Notify RN, and place patient in semi-fowlers position.
2. Place patient on ~~CPAP~~PS 0 / PEEP 5 for 30–120 minutes, on the same FIO2.
3. Calculate ~~Yang/Tobin~~RSBI – last minute of trial
4. Physician will be notified after the SBT with weaning parameters, and ~~Yang/Tobin~~RSBI
5. A decision for extubation or ~~trach~~T-Piece/Trach collar trial will be discussed with the physician

K. **Failure Criteria for SBT:** *Spontaneous breathing trial will be aborted and patient will be placed on previous ventilator settings and sedation medication if any of the following exist.*

1. A respiratory rate > 35 breaths/min for 5 min or longer
2. An SPO2 < 88% for more than 30 seconds
3. Heart rate > 140, or change of plus or minus 20% (Δ+/-20%) of baseline for > 5 min
4. A systolic blood pressure > 180 mmHg or< 90 mmHg for > 5 min Increased anxiety, or diaphoresis.
5. Onset of cardiac arrhythmias

6. Deterioration of mental status

Note* If patient fails SBT, place patient on previous ventilator settings. Patient will be reassessed for Spontaneous Breathing Trial the next morning.

L. **EXTUBATION ASSESSMENT**

1. Hemodynamically stable
2. Patient able to protect airway and control secretions (coughs, lifts head-if applicable).
3. Weaning protocol criteria maintained during SBT
4. Leak present when endotracheal tube cuff deflated, leak ≥ 25% VTE
5. If no leak is detected notify physician

Note* If the patient is assessed and physician agrees to extubate, an order must be written/ obtained from physician for extubation. Patient will be extubated to nasal cannula and subsequently room air with SpO2 ≥92%.

M. **DOCUMENTATION:**

1. Documentation is completed in the EMR on the designated intervention screens.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

1. ~~ARDSNET 2013 "Ventilator Protocol" (National Standards).~~
~~Girard, T. D., Kress, J. P., Fuchs, B. D., Thomason, J. W., Schweickert, W. D., Pun, B.T., Taichman, D. B., Dunn, J. G., Pohlman, A. S., Kinniry, P. A., Jackson, J. C., Canonico, A.E., Light, R. W., Shintani, A. K., Thompson, J. L., Gordon, S. M., Hall, J. B., Dittus, R. S., Bernard, G. R., Ely E. W. (2008). Efficacy and safety of a paired sedation and ventilator weaning protocol for mechanically ventilated patients in intensive care (awakening and breathing controlled trial): a randomized controlled trial. Lancet, 12; 371(9607):126-34.~~
2. ~~MacIntyre, N R., Cook, D. J., Eli, E. W. (2001). Evidence-based guidelines for weaning and discontinuing ventilatory support: A collective task force facilitated by the American College of Chest Physicians, the American Association for Respiratory Care, and the American College of Critical Care Medicine. Chest, 120:375S.~~
3. ~~Tobin, M. J. & Jubran, A. (2006). Weaning from mechanical ventilation: Principles and practice of mechanical ventilation. New York: McGraw Hill.~~
4. ~~Grap, M. J., Munro, C. L., Wetzel, P. A., Best, A., M., Ketchum, J., M., Hamilton, A.... Sessler, C. N. (2012, May). Sedation in adults receiving mechanical ventilation: Physiological and comfort outcomes. *American Journal of Critical Care*, 21:3.~~

1. Megan Acho, Eric Kriner, Nicole N Sartain, Souvik Chatterjee, Junfeng Sun, Burton W Lee and

Nitin Seam
Impact of a Mechanical Ventilation Curriculum on Respiratory Therapist Recognition of Patient-Ventilator Asynchrony Respiratory Care, December 2022, 67 (12) 1597-1602; DOI: https://doi.org/10.4187/respcare.09903

2. Elias N Baedorf Kassis, Andres Brenes Bastos, Maximillian S Schaefer, Krystal Capers, Benjamin Hoenig, Valerie Banner-Goodspeed and Daniel Talmor. *Adaptive Support Ventilation and Lung-Protective Ventilation in ARDS.* Respiratory Care December 2022, 67 (12) 1542-1550; DOI: https://doi.org/10.4187/respcare.10159NIH
3. Fujishima, S. Guideline-based management of acute respiratory failure and acute respiratory distress syndrome. *j intensive care* 11, 10 (2023). https://doi.org/10.1186/s40560-023-00658-
4. Papazian, L., Aubron, C., Brochard, L. *et al.* Formal guidelines: management of acute respiratory distress syndrome. *Ann. Intensive Care* 9, 69 (2019). https://doi.org/10.1186/s13613-019-0540-9
5. ARDSNET 2013 "Ventilator Protocol" (NIH National Standards)

Attachments

A: Richmond Agitation-Sedation Scale (RASS)

Image 1

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Director	Carla Spencer: Director Critical Care Services	08/2023
Policy Owner	Louis Villaneda Sr.: NICU/Adult Educator/Supervisor	08/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 14016031

Last Approved	N/A	Owner	Darlene Vaughan: Nursing Director
Last Revised	09/2023	Area	Nursing Standardized Procedures
Next Review	3 years after approval		

Chest Pain Standardized Procedure

~~POLICY~~

1. ~~N/A~~

~~DEFINITIONS~~

1. ~~Wong-Baker Scale: System to rate pain on a numeric scale, zero (0) to ten (10).~~
2. ~~EKG: Electrocardiogram~~
3. ~~IV/INT: Intravenous Therapy (saline lock) with intermittent flushes.~~
4. ~~CBC: Complete Blood Count~~
5. ~~CMP: Comprehensive Metabolic Panel~~

~~PROCEDURE~~

1. ~~Function~~
    1. ~~To expedite care for patients who present to the Emergency Department (ED) with a chief complaint of chest pain that may be cardiac in nature.~~
2. ~~Circumstances~~
    1. ~~Setting Emergency~~
        a. ~~Registered Nurses (RN) assigned to the ED may initiate orders for patients presenting with chest pain or symptoms that may be cardiac in nature prior to physician evaluation **IF:** the ED physician is not immediately available. The RN will obtain an EKG within 10 minutes, ensure blood is drawn, order approved laboratory tests, initiate cardiac monitoring, place oxygen per protocol and place an INT with routine flushes. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.~~

2. Supervision

    a. Registered Nurses who are qualified to perform this standardized procedure may independently order approved laboratory tests , order an EKG, previous EKG, Oxygen Administration, and start/place an IV saline lock with intermittent flushes of 10cc normal saline to patients who present with a chief complaint of chest pain and for whom meet the criteria above. Physician supervision is not required.

3. Patient Conditions

    a. Emergency Department patients who present with **any** of the following symptoms, the procedure will be initiated:

        i. **Chest Pain-** Discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. Patients may describe the pain as uncomfortable pressure, squeezing, fullness or pain.

        ii. **Pain in other areas of the upper body** – Symptoms can included pain in one or both arms, the back, neck, jaw or stomach. Patient may describe the pain as deep aching and throbbing in one or both arms.

        iii. **Shortness of breath** – May occur with or without chest pain/ discomfort. May be described as breathlessness and/or inability to catch breath when waking up.

        iv. **Anxiety** – Unusual nervousness, and/or feelings of impending doom.

        v. **Other signs** – These may include clammy sweating, nausea, lightheadedness or dizziness, syncope, palpations or irregular heartbeat.

    b. **NOTE**: Symptoms of heart attack in women are often different than in men. Women are more likely to experience shortness of breath, fatigue, nausea, dizziness and anxiety as presenting symptoms.

3. Data Base

    1. Subjective

        a. Prioritization and Severity of Illness

            i. Patients with a chief complaint of chest pain that may be cardiac in nature will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

            ii. History of present illness/injury/chief complaint

            iii. Characteristic of Chest Pain using the Wong-Baker Pain Scale

            iv. Consider conditions related to cardiac disease i.e.) pericarditis,

cardiomyopathy, or coronary artery disease

v. History of cardiac surgeries/illness

2. Objective

a. Chief complaint of chest pain

i. Signs of hypovolemia

ii. Chest excursion, symmetry and pain upon palpation

iii. Level of consciousness

iv. Color of skin/sclera

v. Presence or absence of peripheral edema

vi. Objective signs of pain

4. Diagnosis

1. Chest Pain suspect to be cardiac in nature

5. Plan

1. Treatment

a. The following laboratory tests may be ordered: CBC, CMP, POC I-stats as needed, Troponin I, Draw Extra, Chest XRay 1 View.

b. The order must be placed under the name of the supervising ED physician. If a different provider is later assigned to the patient, the orders will be transferred to the provider assigned.

c. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION policy). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.

d. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag

e. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

f. Cardiac monitor with rhythm interpretation (rhythm strip to be mounted in patient's medical record)

2. Patient conditions requiring consultation/reportable conditions:

a. Notify an Emergency Department physician immediately of the following:

i. Changes in airway, breathing, circulation or altered level of consciousness.

ii. Change in triage acuity.

a. Patients presenting with signs and symptoms of

possible ACS (acute coronary syndrome).

b. **Note: If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, acute myocardial infarction, pulmonary embolism or spontaneous pneumothorax.**

3. Education - Patient/Family
    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy.
4. Follow Up
    a. As needed to maintain continuity of care
5. Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    b. Enters "supervising ED physician as ordering provider.
    c. Navigates to Emergency Department Nursing Order Sets
    d. Selects "Chest Pain-Standardized Procedure" as the order source.

6. Record Keeping
    1. The facility will retain the patients' record according to the RECORD RETENTION procedure.

REQUIREMENTS FOR THE REGISTERED NURSE

1. Education
    1. A registered nurse who has completed orientation and has demonstrated clinical competency may perform the procedures listed in this protocol. Education will be given upon hire with a RN preceptor/designee
2. Training
    1. Clinical competency must be demonstrated and approved by supervising personnel or preceptor.
3. Experience
    1. Current California RN license and designated to work in ED
4. Evaluation
    1. Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.

2. Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
3. Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
4. Demonstrates knowledge of procedure through clinical performance.

DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

1. Method
    1. Review and approval every three (3) years.
    2. Policy goes through the Emergency Department Physician Group every three (3) years.
    3. Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
    4. Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.
2. Review schedule
    1. Review of policy every three (3) years
3. Signatures of authorized personnel approving the standardized procedure and dates:
    1. Approval of the standardized procedure is outlined in the electronic policy and procedure system.
    2. Nursing
        a. Director of Emergency Department every three (3) years
    3. Medicine
        a. Medical Director of Emergency Department every three (3) years
        b. Chair of Interdisciplinary Medical Practice Committee every three (3) years
    4. Administration
        a. Chief Nursing Officer (Vice President of Patient Care Services) every three (3) years

REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

1. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

~~REFERENCES~~

1. ~~Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR, Section 1379.~~
2. ~~Emergency Nurses Association: Emergency Nursing Core Curriculum (2016), 7th Edition. *Planning/interventions for myocardial infarction.*~~

I. POLICY

A. N/A

II. DEFINITIONS

A. Wong-Baker Scale: System to rate pain on a numeric scale, zero (0) to ten (10).

B. EKG: Electrocardiogram

C. IV/INT: Intravenous Therapy (saline lock) with intermittent flushes.

D. CBC: Complete Blood Count

E. CMP: Comprehensive Metabolic Panel

III. PROCEDURE

A. Function

1. To expedite care for patients who present to the Emergency Department (ED) with a chief complaint of chest pain that may be cardiac in nature.

B. Circumstances

1. Setting Emergency

a. Registered Nurses (RN) assigned to the ED may initiate orders for patients presenting with chest pain or symptoms that may be cardiac in nature prior to physician evaluation **IF:** the ED physician is not immediately available. The RN will obtain an EKG within 10 minutes, ensure blood is drawn, order approved laboratory tests, initiate cardiac monitoring, place oxygen per protocol and place an INT with routine flushes. This will apply to patients with symptoms listed in the PATIENT CONDITIONS section below.

2. Supervision

a. Registered Nurses who are qualified to perform this standardized procedure may independently order approved laboratory tests , order an EKG, previous EKG, Oxygen Administration, and start/place an IV saline

lock with intermittent flushes of 10cc normal saline to patients who present with a chief complaint of chest pain and for whom meet the criteria above. Physician supervision is not required.

3. Patient Conditions

a. Emergency Department patients who present with **any** of the following symptoms, the procedure will be initiated:

i. **Chest Pain-** Discomfort in the center of the chest that lasts more than a few minutes, or that goes away and comes back. Patients may describe the pain as uncomfortable pressure, squeezing, fullness or pain.

ii. **Pain in other areas of the upper body** – Symptoms can included pain in one or both arms, the back, neck, jaw or stomach. Patient may describe the pain as deep aching and throbbing in one or both arms.

iii. **Shortness of breath** – May occur with or without chest pain/ discomfort. May be described as breathlessness and/or inability to catch breath when waking up.

iv. **Anxiety** – Unusual nervousness, and/or feelings of impending doom.

v. **Other signs** – These may include clammy sweating, nausea, lightheadedness or dizziness, syncope, palpations or irregular heartbeat.

b. **NOTE**: Symptoms of heart attack in women are often different than in men. Women are more likely to experience shortness of breath, fatigue, nausea, dizziness and anxiety as presenting symptoms.

C. Data Base

1. Subjective

a. Prioritization and Severity of Illness

i. Patients with a chief complaint of chest pain that may be cardiac in nature will be triaged (prioritized) according to accepted triage policy based on the severity of their illness and incorporating other medical conditions and/or additional features of their illness using the Emergency Severity Index (ESI) 5 level triage (see TRIAGE ASSESSMENT)

ii. History of present illness/injury/chief complaint

iii. Characteristic of Chest Pain using the Wong-Baker Pain Scale

iv. Consider conditions related to cardiac disease i.e.) pericarditis, cardiomyopathy, or coronary artery disease

v. History of cardiac surgeries/illness

2. Objective

a. Chief complaint of chest pain

i. Signs of hypovolemia

ii. Chest excursion, symmetry and pain upon palpation

iii. Level of consciousness

iv. Color of skin/sclera

v. Presence or absence of peripheral edema

vi. Objective signs of pain

D. Diagnosis

1. Chest Pain suspect to be cardiac in nature

E. Plan

1. Treatment

a. The following laboratory tests may be ordered: CBC, CMP, POC I-stats as needed, Troponin I, Draw Extra, Chest XRay 1 View.

b. The order must be placed under the name EMERGENCY PHYSICIAN . If a different provider is later assigned to the patient, the orders will be transferred to the provider assigned.

c. The blood and urine specimens must be labeled accurately with the patient's name and account number. The accuracy of the label must be verified by using the hospital approved patient identification process (see PATIENT IDENTIFICATION policy). The labeling of specimens must occur AT THE PATIENT'S BEDSIDE.

d. Specimens collected by the ED nursing staff must be timed and initialed by the person drawing the specimen and placed in a bio-hazard specimen bag

e. Specimens collected in the ED will be handed to a phlebotomist or transported in person or by the pneumatic tube system to the lab.

f. Cardiac monitor with rhythm interpretation (rhythm strip to be mounted in patient's medical record)

2. Patient conditions requiring consultation/reportable conditions:
    a. Notify an Emergency Department physician immediately of the following:
        i. Changes in airway, breathing, circulation or altered level of consciousness.
        ii. Change in triage acuity.
            a. Patients presenting with signs and symptoms of possible ACS (acute coronary syndrome).
            b. **Note: If the patient appears unstable and/or a life threatening condition is identified: the ED RN will notify the ED physician IMMEDIATELY Conditions requiring immediate treatment include: Expanding or acute aortic abdominal aneurysm, acute myocardial infarction, pulmonary embolism or spontaneous pneumothorax.**
3. Education - Patient/Family
    a. Instruct patient or care provider on types of blood tests being ordered and necessity of intravenous therapy.
4. Follow Up
    a. As needed to maintain continuity of care
5. Documentation of Patient Treatment
    a. Document all patient procedures and care on the appropriate nursing clinical documents along with any patient responses from the interventions.
    b. Enters "EMERGENCY PHYSICIAN as ordering provider.
    c. Navigates to Emergency Department Nursing Order Sets
    d. Selects "Chest Pain-Standardized Procedure" as the order source.

F. Record Keeping
1. The facility will retain the patients' record according to the RECORD RETENTION procedure.

IV. REQUIREMENTS FOR THE REGISTERED NURSE

A. Education

1. A registered nurse who has completed orientation and has demonstrated clinical competency may perform the procedures listed in this protocol. Education will be given upon hire with a RN preceptor/designee

B. Training

1. Clinical competency must be demonstrated and approved by supervising personnel or preceptor.

C. Experience

1. Current California RN license and designated to work in ED

D. Evaluation

1. Initial: at 3 months, 6 months, and 12 months by the nurse manager through feedback from colleagues, physicians, and chart review during performance period being evaluated.
2. Routine: annually after the first year by the nurse manager through feedback from colleagues, physicians and chart review.
3. Follow up: areas requiring increased proficiency as determined by the initial or routine evaluation will be re-evaluated by the nurse manager at appropriate intervals until acceptable skill level is achieved, e.g. direct supervision.
4. Demonstrates knowledge of procedure through clinical performance.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

A. Method

1. Review and approval every three (3) years.
2. Policy goes through the Emergency Department Physician Group every three (3) years.
3. Policy goes through the interdepartmental policy committee (IDPC) upon creation of policy and when changes are made.
4. Chief Nursing Officer (Vice President of Patient Care Services) upon creation of policy and with significant changes.

B. Review schedule

1. Review of policy every three (3) years

C. Signatures of authorized personnel approving the standardized procedure and dates:

1. Approval of the standardized procedure is outlined in the electronic policy and

procedure system.

2. Nursing
    a. Director of Emergency Department every three (3) years
3. Medicine
    a. Medical Director of Emergency Department every three (3) years
    b. Chair of Interdisciplinary Medical Practice Committee every three (3) years
4. Administration
    a. Chief Nursing Officer (Vice President of Patient Care Services) every three (3) years

VI. REGISTERED NURSES AUTHORIZED TO PERFORM PROCEDURE AND DATES

A. The list of qualified individuals who may perform this standardized procedure is available in the department and available upon request.

VII. REFERENCES

A. Board of Registered Nursing, Title 16, California Code of Regulations (CCR) Section 1474; Medical Board of California, Title 16 CCR, Section 1379.

B. Emergency Nurses Association: Emergency Nursing Core Curriculum (2016), 7th Edition. *Planning/interventions for myocardial infarction.*

Approval Signatures

Step Description	Approver	Date
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	10/2023
Medical Executive Committee	Katherine DeSalvo: Director Medical Staff Services	09/2023

IDPC	Katherine DeSalvo: Director Medical Staff Services	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Darlene Vaughan: Nursing Director	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14499693**

Last Approved	N/A	Owner	Lorrie Oelkers: Director Internal Audit & Compliance
Last Revised	N/A		
Next Review	3 years after approval	Area	Administration

Compliance and Ethics Program

PURPOSE, ROLE, AND AUTHORITY

The Salinas Valley Health Medical Center (SVHMC) adopted this Compliance and Ethics Program (Program) to identify SVHMC' policies and procedures for promoting compliance with the law and preventing and detecting violations. In today's complex health care environment, SVHMC has determined that the appropriate approach to compliance is to organize, centralize and formalize compliance policies and procedures.

The Mission of SVHMC is to provide quality healthcare to our patients and to improve the health and well-being of our community. The mission of the Compliance and Ethics Program is to guide, encourage, and educate individuals and departments to conform to Federal and State Regulations and SVHMC Policies and Procedures and to make ethical decisions in the best interest of the organization.

This Program applies to members of the Board of Directors, management, hospital staff, medical staff members, volunteers, students, contractors, and other agents (collectively, "covered persons").

SVHMC desires to maintain its reputation for integrity and strict compliance with the letter and the spirit of all laws, regulations and contractual obligations. Each covered person is expected to continue to conduct SVHMC's business transactions with honesty, accuracy, fairness, and respect for others.

The Compliance Program is established by the SVHMC Board of Directors and its Corporate Compliance and Audit Committee ("Board"). The Compliance Program's responsibilities are defined by the Board as part of its oversight role.

Cypress Healthcare Partners, the Management ~~Company~~Services Organization that handles the ongoing operations of Salinas Valley Health Clinics and Taylor Farms Family Health & Wellness Clinic, has established its own hotline and compliance program. This program includes a Compliance Manual and Central Business Office Billing and Collection Policies and Procedures. The SVHMC Ethics and Compliance Officer incorporates some Salinas Valley Health Clinics and Taylor Farms Family Health & Wellness Clinic functions into its review and audit activities as necessary. A current copy of the Cypress

Healthcare Partners Central Billing Office Billing and Collection Policies and Procedures is appended to this document, and Cypress Healthcare Partners will provide SVHMC Ethics and Compliance Officer with updated or revised policies and procedures upon request. Additionally, Cypress has ~~established its own hotline and compliance program. This program includes a Compliance Manual and Central Business Office Billing and Collection Policies and Procedures. The~~confirmed and documented to the SVHMC Ethics and Compliance Officer ~~incorporates some SVHMC functions into its review and audit activities as necessary. A current copy of the Cypress Healthcare Partners Central Billing Office Billing and Collection Policies and Procedures is appended to this document, and Cypress will provide SVHMC with updated or revised policies and procedures upon request. Additionally, Cypress has confirmed and documented to the SVHMC Ethics and Compliance Officer~~ that it regularly performs exclusions/ sanctions checking for its employees and vendors. Upon request, Cypress Healthcare Partners provides the SVHMC Ethics and Compliance Officer with copies of the monthly exclusions/sanctions checking reports.

SVHMC' Program is currently structured to contain the following elements, as indicated throughout this document:

- Standardized Compliance Policies and Procedures
- Structure and Organization
- Exclusions/Sanctions Checking
- Reporting Mechanisms, Communication, and Education
- Monitoring and Auditing
- Enforcement and Discipline
- Response and Prevention
- Periodic sanctions background checks are performed as required by Federal and State regulations.
- Structured monitoring and auditing of the Program, billing policies and procedures relevant to other business risks facing SVHMC, currently and prospectively, are conducted to identify any required corrective action or training;
- Mechanisms for employees and other representatives to communicate with the Ethics and Compliance Officer provide employees and other representative with a means to report potential non-compliance issues or other areas of concern without fear of retribution;
- A process for corrective action has been established, including appropriate disciplinary measures, to address any issues of non-compliance; and
- Guidelines have been prepared by the Ethics and Compliance Officer for response and prevention of compliance offenses.

RESOLUTION AND CHARGE

SVHMC is committed to providing high quality care that conforms to and is in compliance with all applicable federal, state, and local laws and regulations, professional and ethical codes of conduct, and its policies and procedures.

Covered persons are urged to seek the guidance or report violations to the Ethics and Compliance Officer or department. Covered persons may contact Director of Internal Audit and Compliance, (Ethics and Compliance Officer) directly at (831) 759-1958 (ext. 1958).

Every covered person is expected to continue to maintain compliance with the Program. The federal government can impose monetary fines and criminal charges on both SVHMC and the covered person for violation of applicable federal, state, and local fraud and abuse laws and this Program. Each covered person must understand that the consequences of failing to comply can result in discipline up to and including discharge.

Covered persons also have a duty to report any suspected or known violation of applicable law to their supervisor, the Ethics and Compliance Officer, or through one of the processes available for confidential reporting.

STANDARDIZED COMPLIANCE POLICIES AND PROCEDURES

Policies and Procedures guide SVHMC' employees and other representatives in appropriate business practice, compliance with laws and government regulations, and reduce the likelihood of wrongdoing;

SVHMC is committed to having written policies and procedures in place throughout the system to ensure that all covered persons have access to guidance and protocols that should be followed in performing their duties. The contents of this Program will document SVHMC' policies and procedures related to the Compliance function, as well as the procedures that the Ethics and Compliance Officer will utilize to monitor various aspects of compliance. The Program will be communicated to all new and existing covered persons.

SVHMC' Program is comprised of the following components:

- This Program Document, which defines the basic framework of how the Compliance Program will operate,
- Standards of Ethical Business Practices, which provide guidelines for business decision-making and behavior, and
- Other related SVHMC compliance policies and procedures that address identified areas of risk.

All covered persons are responsible to understand and comply with the forgoing components of the Program. These components are not intended to cover every situation that may occur; covered persons are expected to comply with all applicable laws and regulations whether they are specifically addressed by the above components or not.

The Ethics and Compliance Officer is responsible to maintain, update, and promote compliance with all components of the Compliance Program.

STRUCTURE AND ORGANIZATION

The Compliance and Audit Committee of the Board of Directors of SVHMC has established the following

structure, reporting relationships and designation of responsibilities to oversee the administration of the Program and to ensure those potential non-compliance issues or violations are investigated and addressed.

- The Director of Internal Audit and Compliance serves as the Ethics and Compliance Officer and reports to the Chief Financial Officer. The Compliance function, with strict accountability for confidentiality and safeguarding records and information, is authorized to access SVHMC records, physical properties, and personnel pertinent to carrying out job responsibilities.
- The Ethics and Compliance Officer will have direct access to the Board of Directors and its Corporate Compliance and Audit Committee by means of private session, if requested by that oversight body.
- The Ethics and Compliance Officer has sufficient authority to fulfil the responsibilities of the position including design, implementation, oversight, and revision as necessary to SVHMC' efforts in establishing and maintaining the compliance program, including a review of the Program's structure in collaboration with hospital Leadership staff.
- The Ethics and Compliance Officer will meet periodically with the President/CEO, the CFO, and the Compliance and Audit Committee of the Board of Directors as necessary to review the Compliance Program.
- The Ethics and Compliance Officer is responsible for overall management of the Program as well as day-to-day administration of the Program including continued development of the areas referenced in this document and will revise the program periodically based on changes to regulations or needs of the organization.
- The Internal Ethics and Compliance Committee is chartered to oversee the implementation of ethics and compliance programs, policies, and procedures that are designed to be responsive to the various compliance and regulatory risks facing the organization; advises the Ethics and Compliance Office in the implementation of the Compliance Program, and assists the Corporate Compliance and Audit Committee of the Board in fulfilling its oversight responsibilities.
    1. The Corporate Compliance and Audit Committee of the Board of Directors is chartered by the Board of Directors to advise and assist the Board in its exercise of oversight by monitoring compliance policies, controls, and processes of the organization and to assist the Board in oversight of regulatory audits and assuring the organizational integrity of SVHMC in a manner consistent with its mission and purpose.

EXCLUSIONS CHECKING

Federal and California law enforces civil monetary penalties against organizations that employ or contract with an individual or entity that the organization knows or should know is excluded from participation in federal healthcare programs or debarred from receiving federal funds. SVHMC takes reasonable efforts to verify that information provided by employees, volunteers, and physicians are correct.

As indicated in the COMPLIANCE SANCTIONS REVIEW, SVHMC staff perform monthly screenings for employees, privileged physicians, non-staff referring providers, contracted physicians, allied health

professionals, travelers, vendors, and volunteers. The Ethics and Compliance Officer ensures that this process is followed in accordance with Federal, State, and policy and procedure requirements.

COMMUNICATION AND EDUCATION

SVHMC has a training program for all covered persons to facilitate their understanding of the Program's expectations and their responsibilities. This training program is administered and coordinated by the Ethics and Compliance Officer.

All new employees will attend an orientation training session within a reasonable period of time of commencing their employment that discusses the goals and objectives of the Program and familiarizes new employees generally with the Program. Documentation shall be maintained by Human Resources reflecting the attendance of the employee training program.

Following the initial training, all existing employees will receive update training at least once a year and as the need arises to address significant changes in the Program, in applicable laws, or any issues of interest.

The Ethics and Compliance Officer will also provide additional training and awareness sessions as determined by that Officer in coordination with leadership and department heads, and will distribute ethical awareness communications through various venues.

Additional training sessions may be conducted for specific covered persons who have responsibilities for specific compliance issues or at the direction of the Ethics and Compliance Officer.

Documentation will be maintained reflecting the attendance at all ethics and compliance training.

Members of the Board of Directors and those required by the California Fair Political Practices Act will receive compliance and ethics education within their first year and every two years after that as per California Assembly Bill 1234.

Training will be updated as required based on changes to applicable federal healthcare program requirements, applicable state requirements, and trends in compliance inquiries and hotline issues.

On an ongoing basis, covered persons are encouraged to ask questions whenever they have concerns. Initially, covered persons should request assistance from their immediate supervisor. If additional assistance is needed, covered persons are encouraged to contact the Ethics and Compliance Officer.

MONITORING AND AUDITING

SVHMC will conduct periodic auditing and monitoring activities of SVHMC in order to identify and rectify potential compliance issues.

At least annually, the Ethics and Compliance Officer will submit to the Board a risk-based audit plan for review and approval. This plan will be developed based on a prioritization of the audit universe using a risk-based methodology, including input from senior leaders and the Board. The Ethics and Compliance Officer will adjust the plan, as necessary, in response to change in SVHMC business risks, operations, programs, systems, and controls. Significant deviation from the approved plan will be communicated to

the Board through periodic activity reports.

Periodic auditing and monitoring activities will be reported at meetings of the Internal Ethics and Compliance Committee by the Ethics and Compliance Officer.

Risk-Based Audit	Self-Assessment	Monitoring
Performed by Ethics and Compliance Officer.	Questions determined by Ethics and Compliance Officer. Work performed by process owner.	Performed by Ethics and Compliance Officer or others in the organization.
Based on Board approved audit plan.	Based on Board approved audit plan or requested by a leader.	Based on Compliance Work Plan of the Internal Ethics and Compliance Committee and areas as determined necessary by the Ethics and Compliance Officer.
Objectives and scope determined by risk as well as agreed upon with process owner.	No detailed testing, so scope n/a.	Nature and scope agreed upon with process owner.
Includes questions, physical walkthrough, document review, and report analysis.	Includes questions and answers only, unless significant concerns identified.	Generally includes analysis and reporting to determine extent of compliance.
Opinion expressed about processes and controls based on audit work performed.	No opinion.	No opinion.
Recommendations made and action plans required.	Depends on results.	Depends on results.
Follow-up performed to ensure action plans are complete and mitigate the risk.	Depends on results.	Depends on results.

The Compliance Work Plan will be developed and overseen by the Internal Ethics and Compliance Committee, and updated at each meeting. Records are retained of all meetings held by that committee. Monitoring reviews and audits conducted externally will be reported to and recorded in the work plan of the Internal Ethics and Compliance Committee, along with a report of results.

For each audit, the Ethics and Compliance Officer shall determine if SVHMC has the requisite skill set to complete the review. If the Ethics and Compliance Officer determines that the skill set is not available or, for other reasons, the Ethics and Compliance Officer will recommend to the CFO, the President/CEO and the Compliance and Audit Committee of the Board the need to employ such consultants. The Ethics and Compliance Officer shall review all reports.

The Ethics and Compliance Officer or designee will have appropriate access to information and

documents to complete the audits and ensure appropriate monitoring and will maintain the confidentiality of those records. For significant issues identified, the Compliance Officer will implement a follow-up process to ensure they are addressed in a timely manner.

REPORTING MECHANISMS COMMUNICATION, AND EDUCATION

SVHMC has established a mechanism for employees and other representatives to ask questions and/or report any matter that may be an issue of non-compliance without fear of retribution.

Employees may contact the following to report a compliance concern:

- Their supervisor
- Human Resources at 831-759-1759
- Patient Safety Officer Risk Management 831-759 3075
- Ethics and Compliance Officer 831-759-1958
- Ethics Point (Hotline) (anonymously) at https://www.ethicspoint.com or call 888-274-8231.
- Occurrence Reporting ("We Care")(anonymously) at https://starnet.svmh.com/Pages/Occurrence-Reporting-System.aspx

Additionally, the established mechanism for reporting non-compliance issues is outlined in the Administrative Policy: *Non-Compliance Reporting and Response* *and* *Non-Retaliation*. All reports are prioritized according to an objective level of severity.

Retaliation against a covered person who reports a concern in good faith is prohibited, as indicated in the SVHMC *Non-Compliance Reporting and Response* *and* *Non-Retaliation*. Anyone found to have committed a retaliatory act against a covered person for a good faith report will be subject to disciplinary action, up to and including termination of employment.

ENFORCEMENT AND DISCIPLINE

There are significant legal and ethical consequences for non-compliance with the Program. The Program will be enforced consistently throughout the organization. The Ethics and Compliance Officer, in collaboration with Human Resources, will recommend to the President/CEO and/or appropriate administrators, enforcement action with respect to both violators of the Program and those who negligently or willfully fail to detect violations or who fail to respond appropriately to a violation. The Ethics and Compliance Officer will report such violations and enforcement action to the CFO and the Compliance and Audit Committee of the Board. Disciplinary action may include a range of responses depending on the circumstances, as indicated in the DISCIPLINARY POLICY.

RESPONSE AND PREVENTION

Each covered person is responsible for taking timely action in response to any suspected or known non-compliance that arises under the Program and for notifying the appropriate person when they believe a violation of law or SVHMC policy has occurred. If a covered person believes that another covered person,

regardless of their position within SVHMC, is violating the law or this policy, that employee should bring the information to the attention of their direct supervisor. If the situation is not resolved, see Reporting Mechanisms and Lines of Communications section of this document.

All reports or reasonable indications of fraud or abuse, violations of other applicable laws or regulations, or violations of SVHMC policy, will be promptly investigated.

Records of investigations will generally include documentation of the concern, copies of interview notes and key documents, lists and dates of interviews, lists of documents reviewed, results of the investigation, and corrective actions recommended (if applicable). In addition, such records may be protected by attorney-client privilege if SVHMC' legal counsel is engaged in connection with such investigation.

It is SVHMC' policy to comply with applicable law and to cooperate with any reasonable demand made in a government investigation. In so doing, however, it is essential that SVHMC' legal rights, and those of covered persons, be protected and that SVHMC' counsel be engaged at the appropriate time. If any employee receives an inquiry, subpoena, or other legal documents regarding SVHMC' business, whether at home or in the workplace, from any governmental agency, SVHMC encourages that person to notify the Hospital Operator, who will contact the Ethics and Compliance Officer immediately. In all potential legal matters the Risk Management Department will also be informed and a determination will be made by the Risk Management Department whether to notify the SVHMC liability carrier. See GOVERNMENT INVESTIGATIONS.
SVHMC will take all reasonable steps to respond to and prevent further occurrences of activities determined non-compliant.

OPERATIONAL REGULATORY MATTERS

The SVHMC Compliance Program supports and collaborates with various SVHMC operational areas to ensure that we are meeting the relevant requirements of applicable laws as well as our policies and procedures. Each of these areas will implement its own policies and procedures. The Ethics and Compliance Officer will work with respective leaders to ensure monitoring of these areas takes place, through meetings of the Internal Ethics and Compliance Committee. These areas include, but are not limited to:

Billing/Revenue Integrity –

SVHMC is committed to ensuring that its billing practices comply with all applicable laws. SVHMC also is committed to developing and maintaining policies and procedures that facilitate accurate billing and submission of claims only for services that are actually rendered and medically necessary and filing of cost reports that accurately reflect costs incurred for furnishing health care services. The Director of Patient Financial Services and the Revenue Integrity Coordinator are members of the Internal Ethics and Compliance Committee.

Accounting for Financial Transactions –

SVHMC is committed to maintaining accurate and complete financial records. These financial records serve as the basis for managing the business, for measuring and fulfilling SVHMC' obligations to

patients, employees, suppliers and others, and for compliance with tax and financial reporting requirements.

It is the policy of SVHMC to comply with the recording requirements of applicable law and generally accepted accounting principles.

Procurement –

California Local Healthcare District Law prescribes requirements related to approval of and solicitation requirements for procurement of various items as enumerated by that law. SVHMC has developed procurement policies and procedures to guide the organization in compliance with that law. A review process is in place to ensure that these requirements are followed.

Privacy –

SVHMC is committed to protecting the privacy rights of its patients. Disclosure of any patient information to anyone other than providers involved in care and treatment of the patient or the payment and health care operations of the organization specific to SVHMC, is prohibited unless otherwise permitted or required by law. Violations may be subject to immediate termination. The organization's Privacy Officer is a member of the Internal Ethics and Compliance Committee.

Information Technology –

SVHMC has developed policies and procedures related to information technology. The organization's Chief Information Officer is a member of the Internal Ethics and Compliance Committee. SVHMC is committed to meeting the increasing regulatory requirements for information technology including, but not limited to, the following:

- HIPAA Security
- HITECH

Quality of Care –

The Center for Medicare and Medicaid Services (CMS) conditions of participation (COP) require the provision of patient care consistent with established standards within the medical community. SVHMC is required to comply with applicable Medicare COP. The Director of Accreditation and Regulatory and Manager, Quality are members of the Internal Ethics and Compliance Committee.

Contracts –

There are a number of laws governing Medicare, Medi-Cal and other government health care programs. These laws prohibit remuneration in return for the referral of a government health care program patient, or to induce the purchase of goods or services to be paid for by a government health care program. Similar state laws prohibit like conduct with respect to patients not covered by a government health care program. In this section, two laws are discussed -- the Stark Law and the federal Anti-Kickback Statute ("Anti-Kickback Statute"). Physicians and hospitals that knowingly violate the Stark Law or the Anti-Kickback Statute may be subject to civil monetary penalties and exclusion from federal health care programs. Criminal penalties may also apply. The Contracts Administrator is a member of the Internal Ethics and Compliance Committee.

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Ethic Committee	Lori Orosco: Director Laboratory Services	10/2023
Policy Owner	Lorrie Oelkers: Director Internal Audit & Compliance	10/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13714018**

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

Discipline Administration

I. POLICY STATEMENT:

A. Discipline will be administered only for reasonable cause. All complaints will be investigated. Anonymous complaints may be used for purposes of investigation but may not be used as the sole basis for disciplinary action.

B. The rules and regulations of the Hospital will be made available to all employees. The Hospital agrees to exercise fair and reasonable judgment in the application of this Policy.

C. If discipline is considered by the Hospital, the Hospital will discuss such discipline with the employee. Those employees who are represented by a union may request the presence of a union representative at the meeting. The hospital reserves the right to schedule warning conferences at times consistent with maintaining efficient Hospital operations.

D. The Hospital will provide employees with written notice in progressive steps of discipline up to and including discharge. It is understood that Administration maintains the right, based on the seriousness of the incident, to move to a higher step in the disciplinary process up to and including termination.

E. The following list, while not all-inclusive, represents examples of infractions which may result in discipline:

1. Failure to demonstrate competence in clinical practices
2. Failure to perform work as required – **Examples**:
    a. Failure to adhere to established departmental and hospital standards
    b. Creating unsanitary conditions in or near the hospital
    c. Acting in any way detrimental to patient care
3. Repeat violation of Hospital policies, rules and regulations which are similar in nature, e.g., parking violations, etc. (Reference Environment of Care/PARKING AND

TRAFFIC REGULATIONS)

4. Violation of state or federal confidentiality laws including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Reference Information Management/HIPAA SANCTIONS Policy).
5. Other Causes
    a. Misconduct – **Examples**:
        i. Interfering with other employees' work.
        ii. Engaging in conduct that at any time causes discord or disharmony within the Hospital environment including disruptive behavior as defined by the Joint Commission.
        iii. Using profane language, arguing, speaking in a loud voice, or expressing anger towards patients, co-workers, or supervisors.
        iv. Using Hospital equipment or supplies for any purpose not directly related to patient care and/or Hospital operation.
        v. Failing to adhere to established departmental appearance policy (Reference – Human Resources/DRESS CODE POLICY.)
        vi. Posting of notices or bulletins of any type on Salinas Valley Health Medical Center (SVHMC) premises without written approval of the head of Human Resources/Designee.
        vii. Sleeping while on duty.
    b. Absenteeism (Reference Human Resources/ATTENDANCE GUIDELINES)
        i. Examples:
            - Unexcused absence
            - Sick leave abuse
            - Failure to notify supervisor, in advance, of absence in accordance with departmental policy
            - Tardiness
            - Leaving work assignment and/or area without permission of supervisor.
    c. **Administrative Leave** – In cases where an employee is accused of serious violation of policy, Administration may remove the employee from the schedule with or without pay while the situation is investigated.
        i. The determination of paid or unpaid administrative leave will be based on the facts available at the time and must be approved by Administration. The act of placing an employee on Administrative Leave shall not be construed to indicate, imply or suggest the employee's guilt or innocence in the matter.
        ii. While on Administrative Leave the employee must be available to the hospital, Monday – Friday during business hours of

~~8am-4:30pm. Employee must provide to the Human Resources department a working phone number where he or she can be reached during these days and times. Failure to be available/ responsive while on Administrative Leave may result in disciplinary action. If the employee cannot be reached while on Administrative Leave, the employee should be advised that the hospital will not delay formalizing its investigation results and subsequent actions.~~

~~iii. Employees who are on Administrative Leave may be on the hospital's campus solely for medical attention or the care/ visitation of a family member/ friend.~~

A. Discipline will be administered only for reasonable cause. All complaints will be investigated in alignment with Just Culture. Anonymous complaints may be used for purposes of investigation but may not be used as the sole basis for disciplinary action.

B. The rules and regulations as well as the Just Culture philosophy of the Hospital will be made available to all employees. The Hospital agrees to exercise fair and reasonable judgment in the application of this Policy.

C. If discipline is considered by the Hospital, the Hospital will discuss such discipline with the employee. Those employees who are represented by a union may request the presence of a union representative at the meeting. The hospital reserves the right to schedule warning conferences at times consistent with maintaining efficient Hospital operations.

D. The Hospital will provide employees with written notice in progressive steps of discipline up to and including discharge. It is understood that Administration maintains the right, based on the seriousness of the incident and in utilizing the Just Culture algorithm, to move to a higher step in the disciplinary process up to and including termination.

II. PURPOSE:

A. This policy sets forth the Hospital's support of the Just Culture philosophy as well as the procedures for providing guidance to correct performance deficiencies and/or improve behavior. It also sets forth the rights of the employee during the discipline process. Employee's right to file grievances and request a hearing are set forth in Human Resources/NON AFFILIATED EMPLOYEE GRIEVANCE PROCEDURE and Labor Agreements with unions representing employees.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION

A. Salinas Valley Health Medical Center (SVHMC) supports a Just Culture philosophy and approach to adverse event investigation and response. As a Hospital that places a high value on continuous improvement, our goal is to support a strong culture of safety that supports staff and carefully examines systems for improvement.

B. The following list, while not all-inclusive, represents examples of infractions which may result in discipline:

1. Failure to demonstrate competence in clinical practices
2. Failure to perform work as required – **Examples**:
    a. Failure to adhere to established departmental and hospital standards
    b. Creating unsanitary conditions in or near the hospital
    c. Acting in any way detrimental to patient care
3. Repeat violation of Hospital policies, rules and regulations which are similar in nature, e.g., parking violations, etc. (Reference Environment of Care/PARKING AND TRAFFIC REGULATIONS)
4. Violation of state or federal confidentiality laws including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Reference Information Management/HIPAA SANCTIONS).
5. Other Causes
    a. Misconduct – **Examples**:
        i. Interfering with other employees' work.
        ii. Engaging in conduct that at any time causes discord or disharmony within the Hospital environment including disruptive behavior as defined by the Joint Commission.
        iii. Using profane language, arguing, speaking in a loud voice, or expressing anger towards patients, co-workers, or supervisors.
        iv. Using Hospital equipment or supplies for any purpose not directly related to patient care and/or Hospital operation.
        v. Failing to adhere to established departmental appearance policy (Reference – Human Resources/DRESS CODE)
        vi. Posting of notices or bulletins of any type on SVHMC premises without written approval of the head of Human Resources/ Designee.
        vii. Sleeping while on duty.
    b. Absenteeism (Reference Human Resources/ATTENDANCE GUIDELINES)
        i. Examples:
            a. Unexcused absence
            b. Sick leave abuse
            c. Failure to notify supervisor, in advance, of absence in accordance with departmental policy
            d. Tardiness
            e. Leaving work assignment and/or area without permission of supervisor.

c. **Administrative Leave** – In cases where an employee is accused of serious violation of policy, Administration may remove the employee from the schedule with or without pay while the situation is investigated.

i. The determination of paid or unpaid administrative leave will be based on the facts available at the time and must be approved by Administration. The act of placing an employee on Administrative Leave shall not be construed to indicate, imply or suggest the employee's guilt or innocence in the matter.

ii. While on Administrative Leave the employee must be available to the hospital, Monday – Friday during business hours of 8am-4:30pm. Employee must provide to the Human Resources department a working phone number where he or she can be reached during these days and times. Failure to be available/ responsive while on Administrative Leave may result in disciplinary action. If the employee cannot be reached while on Administrative Leave, the employee should be advised that the hospital will not delay formalizing its investigation results and subsequent actions.

iii. Employees who are on Administrative Leave may be on the hospital's campus solely for medical attention or the care/ visitation of a family member/ friend.

C. Other applicable policies

1. Human Resources/NON AFFILIATED EMPLOYEE GRIEVANCE
2. Human Resources/ATTENDANCE GUIDELINES
3. Ethics, Rights and Responsibilities/STANDARDS OF ETHICAL BUSINESS PRACTICES
4. Information Management/HIPAA SANCTIONS
5. Standards of Professional Behavior

V. PROCEDURE:

A. **Documentation of Verbal Counseling (DOV).**

1. Employees may receive a DOV regarding disciplinary concerns prior to being given a Warning Notice.
2. The employee's supervisor must grant an employee's request for union representation, if applicable, during a verbal counseling. The head of Human Resources/Designee must approve the DOV prior to delivery. The Supervisor should advise the Human Resources department and the union and should arrange for another supervisor to be present as a witness. All those present at the meeting, including the employee and the union representative, will be asked to sign the DOV. Signature by the employee signifies that the employee received the DOV, but does not imply that the employee agrees with it. The hospital reserves the right to schedule DOV meetings at times consistent with maintaining efficient Hospital operations.

3. A copy of the DOV will be given to the employee and the original will be placed in the employee's personnel file. This DOV may not be used as the basis for a First Warning Notice for the same offense after expiration of six (6) months from the date of issuance of said DOV.

B. **Letter of Counseling (LOC) (Applicable to badging-related issues only.)**

1. Employees may receive an LOC for **badging-related issues only** prior to being given a First Warning Notice.
2. This may occur if an employee has not improved his/her attendance within a six-month period after issuance of a DOV. The employee will work with the Department Director/Designee to identify in an action plan acceptable and efficient methods for improving his/her attendance. The Department Director/Designee shall consult with the Senior Administrative Director of Human Resources/Designee prior to proceeding with any discipline. Union representation, when applicable, is required during the counseling session. The hospital reserves the right to schedule LOC meetings at times consistent with maintaining efficient Hospital operations.
3. A copy of the LOC will be given to the employee and the original will be placed in the employee's personnel file. This LOC may not be used as the basis for a First Warning Notice for the same offense after expiration of six (6) months from the date of issuance of said LOC.

C. **First Warning Notice**

1. Prior to a First Warning Notice being issued, it is the responsibility of the Department Director/Designee or Supervisor to personally discuss the merits of the Warning Notice and its wording with their respective administrator and the head of Human Resources/Designee.
2. The employee's supervisor must grant a union-represented employee's request for union representation during the issuance of a First Warning Notice. The Supervisor ~~must~~may arrange for a representative from Human Resources to be present. All those present, including the employee and the union representative, will be asked to sign the First Warning Notice. Signature by the employee signifies that the employee received the First Warning Notice, but does not imply that the employee agrees with it. The hospital reserves the right to schedule First Warning Notice meetings at times consistent with maintaining efficient Hospital operations.
3. A copy of the First Warning Notice shall remain in the personnel file of the employee; however, said First Warning Notice may not be used as the basis for a Second Written Warning Notice for the same offense after expiration of twelve (12) months from the date of the issuance of said First Warning Notice.

D. **Second Warning Notice**

1. Prior to the issuance of the Second Warning Notice, it is the responsibility of the Department Director/Designee to review any plans for suspension with their Administrator and the head of Human Resources/Designee.
2. The Second Warning Notice may be given to an employee for the same offense or violation as the first Warning Notice. This Second Warning Notice may include a

suspension from services at the Hospital for a period of time without pay, based upon the seriousness of the violation. Such suspension shall not affect seniority or other benefits.

3. The employee's supervisor must grant a union-represented employee's request for union representation during the issuance of the Second Warning Notice. The Supervisor must arrange for a representative from Human Resources to be present. All those present at the meeting, including the employee and the union representative, will be asked to sign the Second Warning Notice. Signature by the employee means the employee received the Second Warning Notice, but does not imply that the employee agrees with it. The hospital reserves the right to schedule meetings at times consistent with maintaining efficient Hospital operations.
4. A copy of the Second Warning Notice shall remain in the personnel file of the employee; however, said Second Warning Notice may not be used as the basis for a Third Written Warning Notice/Termination for the same offense after expiration of either twelve (12) or eighteen (18) months from the date of the issuance of said Second Warning Notice.
5. In connection with warning notices, if an employee believes a counter statement is necessary, a statement may be presented by the employee or their representative and become a part of their record.

E. **Third Warning Notice (Termination)**

1. Upon receipt of a third notice of violation for the same offense, the employee will be discharged.
2. The Hospital shall have the right to **discharge** any employee, without the benefit of the progressive disciplinary process, for the following:
    a. Unauthorized possession of Hospital, employee, or patient property.
    b. Punching, recording, or altering time on another employee's API report.
    c. Insubordination – **Examples**:
        - ~~Refusing to accept an order, work shift, or work location assignments by supervisor.~~
        - ~~Refusing to perform work as instructed.~~
        - ~~Refusing to cooperate as normally expected under supervision.~~
        - ~~Disrespectful attitude toward supervisors.~~
        - ~~Threats to or intimidation of supervisory personnel.~~

        i. Refusing to accept an order, work shift, or work location assignments by supervisor.
        ii. Refusing to perform work as instructed.
        iii. Refusing to cooperate as normally expected under supervision.
        iv. Disrespectful attitude toward supervisors.
        v. Threats to or intimidation of supervisory personnel.

d. Insobriety – Examples:

- ~~Reporting to work under the influence of alcohol, narcotics, or central nervous system stimulants or depressants; possession or consumption of alcohol, narcotics or central nervous system stimulants or depressants on Hospital premises; the sale of alcohol, narcotics or central nervous system stimulants or depressants.~~
- ~~Reporting to work in a condition rendering the employee incapable of working at a reasonable efficiency.~~

i. Reporting to work under the influence of alcohol, narcotics, or central nervous system stimulants or depressants; possession or consumption of alcohol, narcotics or central nervous system stimulants or depressants on Hospital premises; the sale of alcohol, narcotics or central nervous system stimulants or depressants.

ii. Reporting to work in a condition rendering the employee incapable of working at a reasonable efficiency.

e. Negligence – Examples:

- ~~Intent to inflict bodily harm on anyone at any time on Hospital property whether or not injury actually occurs.~~
- ~~Possession of explosives, firearms, or any weapon on Hospital property.~~
- ~~Violation of safety rules posted by Hospital or violation of general safe practices in performance of work or in the use of Hospital facilities for any purpose.~~
- ~~Negligence in the commission of careless and/or destructive acts.~~
- ~~Failure to comply with the Corporate Compliance Program Code of Ethical Behavior (Reference Ethics, Rights and Responsibilities/~~ STANDARDS OF ETHICAL BUSINESS PRACTICES ~~or applicable federal, state, and local laws. Disciplinary action can be taken against both violators of the Compliance Program and those who knowingly fail to report violations.~~

i. Intent to inflict bodily harm on anyone at any time on Hospital property whether or not injury actually occurs.

ii. Possession of explosives, firearms, or any weapon on Hospital property.

iii. Violation of safety rules posted by Hospital or violation of general safe practices in performance of work or in the use of Hospital facilities for any purpose.

iv. Negligence in the commission of careless and/or destructive acts.

v. Failure to comply with the Corporate Compliance Program Code of Ethical Behavior (Reference Ethics, Rights and Responsibilities/STANDARDS OF ETHICAL BUSINESS PRACTICES or applicable federal, state, and local laws. Disciplinary action can be taken against both violators of the Compliance Program and those who knowingly fail to report violations.

f. Breach of Confidentiality

- ~~Violation of confidentiality, i.e. disclosure of patient and/or Hospital business-related information.~~
- ~~Violation of Hospital Computer System and/or Confidentiality Policy as outlined in IM/DATA CONFIDENTIALITY and IM/MEDITECH SYSTEM ACCESS POLICY~~
- ~~Violation of state or federal confidentiality laws, including but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Reference IM /HIPAA SANCTIONS Policy.)~~
- ~~Violation of the Standards of Professional Behavior Policy.~~

i. Violation of confidentiality, i.e. disclosure of patient and/or Hospital business-related information.

ii. Violation of Hospital Computer System and/or Confidentiality Policy as outlined in IM/DATA CONFIDENTIALITY and IM/MEDITECH SYSTEM ACCESS POLICY

iii. Violation of state or federal confidentiality laws, including but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). (Reference IM /HIPAA SANCTIONS)

iv. Violation of the Standards of Professional Behavior Policy.

g. Dishonesty

- ~~Unauthorized possession of Hospital, employee, or patient property.~~
- ~~Falsification of records, statements, time cards, and/or employment application.~~
- ~~Badging, recording, or altering time on another employee's API report.~~
- ~~Any bargaining unit employee whose union representative believes that the employee has been unjustifiably discharged, or has been discharged or laid off to avoid advancement, or because of Union activity, may grieve the discharge or layoff~~

~~pursuant to the Grievance Procedure contained in their respective Memorandum of Agreement.~~

- ~~Any non-bargaining unit employee who believes that he or she has been unjustifiably discharged, or has been discharged or laid off to avoid advancement, may grieve the discharge or layoff pursuant to the procedure set forth in Human Resources/ Grievance Procedure.~~

i. Unauthorized possession of Hospital, employee, or patient property.

ii. Falsification of records, statements, time cards, and/or employment application.

iii. Badging, recording, or altering time on another employee's API report.

iv. Any bargaining unit employee whose union representative believes that the employee has been unjustifiably discharged, or has been discharged or laid off to avoid advancement, or because of Union activity, may grieve the discharge or layoff pursuant to the Grievance Procedure contained in their respective Memorandum of Agreement.

v. Any non-bargaining unit employee who believes that he or she has been unjustifiably discharged, or has been discharged or laid off to avoid advancement, may grieve the discharge or layoff pursuant to the procedure set forth in Human Resources/ Grievance Procedure.

F. Affiliated employees will be given notice prior to a conference concerning a warning notice. Before such discussion occurs, the employer shall inform the employee of his/her right to Union representation at the disciplinary meeting. Failure of the employer to so notify the employee will not negate the right to impose appropriate discipline. The hospital reserves the right to schedule warning conferences at times consistent with maintaining efficient Hospital operations.

G. Documentation:

1. Any supporting documentation for disciplinary action resulting from a HIPAA violation must be saved for a minimum of six (6) years. (Reference IM/HIPAA SANCTIONS Policy) This documentation retention period does not affect any of the terms of progressive disciplinary procedure described in Section IV above.

VI. EDUCATION/TRAINING:

~~A. General Orientation~~

~~B. Manager Orientation Checklist~~

A. Education and/or training is provided as needed

VII. REFERENCES:

A. ~~Employee Handbook~~
B. ~~Human Resources/~~NON AFFILIATED EMPLOYEE GRIEVANCE PROCEDURE
C. ~~Human Resources/~~ATTENDANCE GUIDELINES
D. ~~Human Resources/~~DRESS CODE POLICY
E. ~~Ethics, Rights and Responsibilities/~~STANDARDS OF ETHICAL BUSINESS PRACTICES
F. ~~Ethics, Rights and Responsibilities/~~STANDARDS OF ETHICAL BUSINESS PRACTICES ~~Information Management/~~DATA CONFIDENTIALITY
G. ~~Information Management/~~MEDITECH SYSTEM ACCESS POLICY
H. ~~Information Management/~~HIPAA SANCTIONS
I. ~~Environment of Care/~~PARKING AND TRAFFIC REGULATIONS
J. ~~Standards of Professional Behavior Policy~~

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **12873088**

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

Family School Partnership

I. POLICY STATEMENT:

A. ~~Employees~~In compliance with State regulations, Salinas Valley Health Medical Center's (SVHMC) employees, regardless of the shift they work, are allowed to take up to 40 hours per year of leave time ~~under this policy~~for child's education.

II. PURPOSE:

A. To allow employees who are parents (as defined below) time off for any of the following reasons:
    1. to participate in their children's school or licensed child care provider activities;
    2. to find a school or a licensed child care provider, to enroll or re-enroll a child;
    3. to address child care provider or school emergencies.

III. DEFINITIONS:

A. Reasonable Advance Notice is defined as notice given prior to the posting of an employee's work schedule.

B. "Documentation" means any written verification of parental participation the school or licensed child day care facility deems appropriate and reasonable.

C. "Parent" means a parent, guardian, stepparent, foster parent, or grandparent of, or a person who stands in loco parentis, to a child. If more than one parent of a child is employed by ~~Salinas Valley Health Medical Center (~~SVHMC~~)~~ at the same worksite, the parent who first gives notice is entitled to leave. Another parent of the child may not take time off at the same time to participate in school activities without ~~Salinas Valley Health Medical Center~~SVHMC's consent.

D. "Child" means those who are of the age to attend a licensed child care provider as well as

kindergarten through 12th grade.

E. Child care provider or school emergency" is defined as:

1. When a school or child care provider has requested that the child be picked up, or has an attendance policy, excluding planned holidays, that prohibits the child from attending or requires the child to be picked up from the school or child care provider.
2. Behavioral or discipline problems.
3. Closure or unexpected unavailability of the school or child care provider, excluding planned holidays.
4. A natural disaster, including, but not limited to fire, earthquake or flood.

IV. GENERAL INFORMATION:

A. Such leave may not exceed eight (8) hours in any calendar month.

B. To be eligible for the leave, the employee must provide reasonable advance notice to their Department Director/Designee.

C. Any employee who takes time off under this policyprocedure must provide documentation from the child's school or licensed child care provider facility to substantiate the fact that the employee participated in a school activity or licensed child care provider activity on a specific date and at a particular time.

D. The employee mustmay utilize existing Paid Time Off (PTO) for any absence associated with this policy. If no PTO is available, the employee may take unpaid time off.

E. Collective bargaining agreements entered into after January 1, 1995, may not diminish these leave rights.

1. Human Resources/PAID TIME OFF (PTO) POLICY FOR NUHW EMPLOYEES
2. Human Resources/PAID TIME OFF (PTO) POLICY FOR NON-AFFILIATED EMPLOYEES
3. Human Resources/PAID TIME OFF (PTO) POLICY FOR CNA EMPLOYEES

V. PROCEDURE:

A. Employee must follow department procedure for requesting Paidcomplete a Request for Time Off (PTOTO)and provide (attached), indicate "Family/School Partnership" in the Comments section, and attach documentation to substantiate participation.

B. In the event of an emergency or if the employee is unable to request time off prior to the posting of the work schedule, the Request for Paid Time Off (PTOTO) must specify the reason for the failure to request time off in a timely manner in advance.

C. Since the hospital is a 24-hour health care facility, it is essential that employees give as much notice as possible in order for their departmentdepartments to be properly staffed during their absence.

D. Human Resources/ PAID TIME OFF (PTO) POLICY FOR NUHW EMPLOYEES

E. Human Resources/PAID TIME OFF (PTO) POLICY FOR NON-AFFILIATED EMPLOYEES

F. ~~Human Resources/~~PAID TIME OFF (PTO) POLICY FOR CNA EMPLOYEES

G. ~~Human Resources/~~LEAVE OF ABSENCE

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

~~A. Legal review provided by Little Mendelson, May 2020~~

A. N/A

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	08/2023

Standards

No standards are associated with this document

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
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Pediatrics Committee	Katherine DeSalvo: Director Medical Staff Services	10/2023
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 **13174079**

Last Approved	N/A	Owner	Lisa Paulo: Chief Nursing Officer
Last Revised	09/2023	Area	Patient Care
Next Review	3 years after approval		

Interdisciplinary Plan of Care

I. POLICY STATEMENT:

A. A collaborative process that actively includes the patient or the patient's representative in development, implementation, and revision of the plan of care is utilized. Multidisciplinary staff plan the patient care, with patient participation, to meet the patient's needs for care while in the hospital as well as planning for discharge to meet post-hospital needs.

B. The written plan of care is based on the needs identified by the patient's assessment, reassessment, results of diagnostic testing, patient's goals and time frames, settings, and services required to meet the goals.

1. Goals are identified for patients based upon the diagnosis, unique needs, age, disease, condition, impairment and available resources identified through the assessment process.

C. After patient admission history and assessment is completed, the RN identifies and selects, in the computer, the plan of care related to admitting and supplemental diagnoses. This plan of care is individualized based on assessment data.

D. The following departments, when involved in the care of a patient, are required to document in the interdisciplinary plan of care: Nursing, Respiratory Care, Nutrition Services, and Rehab Services. The clinician selects and enters goals and interventions. Target dates are adjusted with the accomplishment of goals and/or interventions.

E. The plan of care is reviewed every shift by clinical staff. At appropriate intervals, updates are entered to the patient's condition and the patient's progress to treatment goals.

F. Upon discharge, the care plan remains a permanent part of the medical record.

G. Interdisciplinary patient conferences are initiated by any team member who identified a patient need. The plan of care is then updated to reflect this new information.

1. Membership at the Interdisciplinary meeting may include, but not limited to any of the following:

a. Physicians

~~b. Nursing Staff~~

~~c. Case Managers~~

~~d. Social Services~~

~~e. Registered Dietitians~~

~~f. Rehabilitation Services~~

~~g. Pharmacy~~

~~h. Respiratory Care~~

~~H. The plan of care, goals for care, treatment, and services is dynamic and is revised as the needs of the patient changes.~~

~~I. Based on the goals established in the patient's plan of care, staff evaluates the patient's progress to determine the progress towards the goal achievement and the effectiveness of the care plan. This evaluation takes place at least once every 24 hours.~~

~~J. Patients who are out-patients who make serial visits for the same condition will have plan of care updated at each out-patient visit.~~

~~K. Within twenty-four hours of admission all patients shall have a plan of care initiated by the Registered Nurse. These needs are recorded into the electronic health record.~~

A. Within twenty-four hours of admission all patients shall have a plan of care initiated by the Registered Nurse. These needs are recorded into the electronic health record.

II. PURPOSE~~:~~

A. ~~The intent of this policy is to~~To outline the elements in providing an individualized/patient-specific integrated plan of care for all patients through the use of an inter-disciplinary approach. Care plans are an important part of providing quality patient care and help guide the plan of care by providing consistency of care and allow the interdisciplinary team to customize interventions and goals for each patient.

III. DEFINITIONS~~:~~

~~A. N/A~~

A. Interdisciplinary Plan of Care - A collaborative process that actively includes the patient or the patient's representative in development, implementation, and revision of the plan of care is utilized. Multidisciplinary staff plan the patient care, with patient participation, to meet the patient's needs for care while in the hospital as well as planning for discharge to meet post-hospital needs.

IV. GENERAL INFORMATION~~:~~

~~A. N/A~~

A. The written plan of care is based on the needs identified by the patient's assessment, reassessment, results of diagnostic testing, patient's goals and time frames, settings, and

services required to meet the goals.

B. Interdisciplinary patient conferences are initiated by any team member who identified a patient need. The plan of care is then updated to reflect this new information.

C. Membership at the Interdisciplinary meeting may include, but not limited to any of the following:
Physicians
Nursing Staff
Case Managers
Social Services
Registered Dietitians
Rehabilitation Services
Pharmacy
Respiratory Care

D. The plan of care, goals for care, treatment, and services is dynamic and is revised as the needs of the patient changes.

E. Patients who are out-patients who make serial visits for the same condition will have plan of care updated at each out-patient visit.

F. Upon discharge, the care plan remains a permanent part of the medical record.

V. PROCEDURE:

~~A. Documentation:~~

~~1. Care Plans are documented by the Interdisciplinary team members in the patient's medical record.~~

~~2. Results of interdisciplinary patient care meetings/conferences are documented in the patient's medical record.~~

A. After patient admission history and assessment is completed, the RN identifies and selects, in the computer, the plan of care related to admitting and supplemental diagnoses. This plan of care is individualized based on assessment data.

B. Goals are identified for patients based upon the diagnosis, unique needs, age, disease, condition, impairment and available resources identified through the assessment process.

C. The following departments, when involved in the care of a patient, are required to document in the interdisciplinary plan of care: Nursing, Respiratory Care, Nutrition Services, and Rehab Services. The clinician selects and enters goals and interventions. Target dates are adjusted with the accomplishment of goals and/or interventions.

D. The plan of care is reviewed every shift by clinical staff. At appropriate intervals, updates are entered to the patient's condition and the patient's progress to treatment goals.

E. Based on the goals established in the patient's plan of care, staff evaluates the patient's progress to determine the progress towards the goal achievement and the effectiveness of the care plan. This evaluation takes place at least once every 24 hours.

F. Documentation:

1. Care Plans are documented by the Interdisciplinary team members in the patient's

medical record.

2. Results of interdisciplinary patient care meetings/conferences are documented in the patient's medical record.

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. ~~TJC~~The Joint Commission: Provision of Care ~~.02.01.05~~

B. ~~Comprehensive Accreditation Manual for Hospitals, PC 01.03.01~~

C. CMS Conditions of Participation ~~for Acute Care Hospitals, October 2008, 482.23(b) (4)~~

D. Nursing Practice Act, Business & Professions Code, Chapter 6 Nursing, Section 2725

E. California Code of Regulations (CCR), Title 22, Section 70215 (2)(b)

F. California Code of Regulations, Title 16, Section 1443.5

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
COO	Clement Miller: Chief Operating Officer	07/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Lisa Paulo: Chief Nursing Officer	05/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13721122

Last Approved	N/A	Owner	William Tienken: Patient Care Services Manager
Last Revised	09/2023	Area	Administration
Next Review	3 years after approval		

Interpreter/Translator Communication

I. POLICY STATEMENT

A. This policy is intended to ensure that measures are in place to support communication with everyone whose first language other than spoken English. For Spoken Language Interpreting it describes arrangements for both telephone based and face to face interpreting, and for the translation of written material.

B. Interpretative services are available 24 hours a day, 7 days a week and available in more than fifteen (15) different languages.

C. In compliance with applicable Federal Civil Rights laws, Salinas Valley Health Medical Center (SVHMC) does not discriminate on the basis of race, color, national origin, age, disability, or sex.

D. In the event of a patient complaint or grievance SVHMC will following the process outlined in the COMPLAINT AND GRIEVANCES: PATIENT. (See attachment Notice of Nondiscrimination.)

E. In compliance with state and federal regulations, the hospital posts signs that advise patients and their families of the availability of interpreters upon requests. These signs are posted in the emergency room, the admitting area, the main entrance of the hospital and in the following outpatient areas – Wound Care, Cancer Resource Center, Sleep Center, Mammography Center, Center for Advanced Diagnostic Imaging Center, Cardiac Rehab, Cardiovascular Diagnostic Outpatient Center, Taylor Farm Family Health and Wellness Center and posted on the SVHMC Website.

F. This Policy will be relevant to:

1. Patient, family and/caregivers and other service users whose first language is not spoken English. If the patient is a child or person without mental capacity, it relates to those with responsibility for the patient.
2. The hospital shall annually transmit to the California Department of Public Health a copy of this policy.

G. The aims of the policy are to:

1. ~~Ensure that all those needing interpreting support receive it~~
2. ~~Ensure that staff knows how to identify the need for interpreting support and to decide which form of interpreting support is most appropriate for the consultation or activity being performed.~~
3. ~~Describe the practices and processes for the provision of interpretation and translation services.~~

~~H. Duties (Roles and responsibilities)~~

1. ~~Directors and Managers should ensure all staff within their areas implements the policy in all appropriate circumstances.~~
2. ~~All healthcare workers are responsible to comply with this policy.~~

A. Interpretative services are available 24 hours a day, 7 days a week and available in more than fifteen (240) different languages.

B. SVHMC shall annually transmit to the California Department of Public Health a copy of this policy.

II. PURPOSE

A. ~~SVHMC is committed to ensuring that everyone whose first language is other than spoken English receives the support and information they need to communicate with health care staff and to access health services. This will allow people to make informed decisions about the care they or the person they are responsible for receive.~~

B. ~~Use of professional spoken language interpreters has been shown to improve clinical care and outcomes, use of services, patient satisfaction and to reduce communication errors.~~

C. To ensure that measures are in place to support communication with everyone whose first language other than spoken English. For Spoken Language Interpreting it describes arrangements for both telephone based and face to face interpreting, and for the translation of written material.

D. SVHMC is committed to offer easily accessible, reliable and relevant information to enable people to participate fully in their own healthcare decisions and to support them in making choices. This will include information on the quality of clinical services where there is robust and accurate information available.

E. The aims of the policy are to:

1. Ensure that all those needing interpreting support receive it
2. Ensure that staff knows how to identify the need for interpreting support and to decide which form of interpreting support is most appropriate for the consultation or activity being performed.
3. Describe the practices and processes for the provision of interpretation and translation services.

III. DEFINITIONS

A. Interpreter: "Interpreter" means a person fluent in English and in the necessary second

language, who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language. Interpreters shall have the ability to translate the names of body parts and to describe competently symptoms and injuries in both languages. Interpreters may include members of the medical or professional staff.

B. **Qualified Interpreter:** an individual who has passed a standardized test which:
    1. is designed to assess for competency in interpretation skills specific to the healthcare setting.
    2. has been administered by an interpreter service company that is contracted with SVHMC .

C. "**Language or communication barriers" means**
    1. With respect to spoken language, barriers that are experienced by individuals who are limited-English-speaking or non-English-speaking individuals who speak the same primary language and who comprise at least 5 percent of the population of the geographical area served by the hospital or of the actual patient population of the hospital. In cases of dispute, the state department shall determine, based on objective data, whether the 5 percent population standard applies to a given hospital.
    2. With respect to sign language, barriers that are experienced by individuals who are deaf and whose primary language is sign language.

D. Interpreting can be provided face to face, video conferencing or by telephone.
    1. It should be noted that interpreting is quite different to advocacy and should not be used as a form of advocacy which involves the advocate in speaking up for, or acting on behalf of the service user.

E. Translation Services
    1. The provision of translated material does not replace an interpreter, but can be used to supplement or reinforce information being given via an interpreter. It should be noted that as for all people, some people whose first language is not spoken English, may not be able to read information in their first language.
    2. SVHMC has access to a translation services as outlined in Attachment A. If an occasion arises where these are not suitable then all translation must be done through a qualified translator, for which the Trust has a contract.

F. Equality AND Diversity
    1. SVHMC is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This document has been appropriately assessed.

IV. GENERAL INFORMATION

~~A.~~ ~~N/A~~

A. Salinas Valley Health Medical Center (SVHMC) is committed to ensuring that everyone whose first language is other than spoken English receives the support and information they need to communicate with health care staff and to access health services. This will allow people to make informed decisions about the care they or the person they are responsible for receive.

B. Use of professional spoken language interpreters has been shown to improve clinical care and outcomes, use of services, patient satisfaction and to reduce communication errors.

C. In the event of a patient complaint or grievance SVHMC will following the process outlined in the COMPLAINT AND GRIEVANCES: PATIENT. (See attachment Notice of Nondiscrimination.)

D. In compliance with state and federal regulations, the SVHMC posts signs that advise patients and their families of the availability of interpreters upon requests. These signs are posted throughout the facility and posted on the SVHMC Website.

E. This policy is relevant to: patient, family and/caregivers and other service users whose first language is not spoken English. If the patient is a child or person without mental capacity, it relates to those with responsibility for the patient.

V. PROCEDURE

A. ~~Offsite~~Off site locations will follow their normal registration process of identifying patients who require interpreter services and will follow the appropriate processes outlined in this section.

B. Healthcare staff identifying the need for an Interpreter.

1. The ability to communicate with health care staff is fundamental to clinical care, and the referring practitioner should have highlighted the need for language support. This should also be highlighted throughout the patient's care. It is important to recognize that people who are able to communicate about basic issues may not have the ability to comprehend information about medical issues, especially when they feel vulnerable or stressed in hospital. Some people when they are older or have dementia, lose their ability to communicate effectively in a second language, i.e. English.
2. At the time of registration the preferred language will be documented in the medical record by the registration staff.
3. If the need for language support has not been identified at the time of referral, or if the patient is admitted as an emergency the person delivering the care is responsible for identifying the need for an interpreter. This should be recorded in the patient's records and that person is responsible for ensuring that language services are provided.

C. Documenting the Need

1. The Registered Nurse completing the Admission History will also document the preferred language. The exact language and dialect spoken should be indicated.
2. Preferred Language is available to all care providers in the Electronic Medical Record.
3. The preferred language is recorded on Electronic Health Record on the appropriate care giver Status Boards. Upon identification of the preferred language the Status

Board is automatically populated.

D. Identifying the Type of Interpreting Service Needed

1. It is essential that the type of interpreting service needed is provided for the patient or if the patient is a child or person without mental capacity, those with responsibility for the patient.

    a. Patients have a right to have a qualified interpreter when they are actively making decisions about their care or releasing their rights.
    Examples when you should use a qualified interpreter:

        i. A legal decision where a patient may waive a right such as a discussion of their advanced directive wishes and a DNR/ allowing natural death or during the consent process.

        ii. During care where a decision is made by the patient for course of care or treatment, such as whether to move forward with a surgery or opt for chemotherapy.

    b. Use of Caregivers, Family & Friends

        i. It is the health professional's responsibility to offer their patients with limited English proficiency the use of trained professional interpreters. Using the patient's friends or family members as interpreters is NOT generally regarded as good practice. Whenever possible it is always best practice to work with trained qualified interpreters instead of family members.

        ii. Staff must be aware that interpretation by people such as family and friends may be inaccurate and impartial due to, for example, lack of language skills, emotional involvement and conflicting interests. It may also break confidentiality with the patient.

        iii. For these reason relatives, caregivers, and friends should not be normally asked to interpret. Similarly, when a child cannot understand or speak English, the parents must not be asked to interpret for a child an external interpreter must be used. Children and young people should NEVER be asked to interpret for anyone, including parents or siblings

    c. Where there are concerns about safeguarding issues (adults and children) or capacity issues, under the Mental health Act and Mental health Incapacity Acts, an approved qualified interpreter should always be used even for basic communication.

    d. Summary of Interpreter Use

Type of Communication	Examples	Type of Provision Available
Basic Needs	Personal demographic details, discussions/help on toileting and feeding.	Language cards can be used. If family members

		interpret for basic issues it is important to bear issues of accuracy and confidentiality in mind. If there are any concerns about **safeguarding issues** an qualified interpreter must be used even for basic communication
Intermediate and Advanced Needs	Assessment, investigations, treatment, explaining diagnosis, referral to other services and discharge issues and for anything complicated.	Approved qualified interpreter, via telephone or face to face. The professional's clinical judgment should be used to decide whether telephone or face to face interpreting is used.
Discussions about Safeguarding Children and Adults. Safety Issue	When there are concerns about safeguarding children adults. Issues related to Mental Capacity and Domestic Violence	Approved qualified interpreter, direct face to face interpretation **even for basic communication.**
SITUATIONS REQUIRING A CERTIFIED INTERPRETER	i. When obtaining consent for an investigation or treatment, an interpreter must be used to ensure that the patient or person with parental responsibility understands the full procedure planned. Details of the interpreter or service used must be documented on the consent	Approved qualified interpreter. Direct face to face interpretation, Language Line, Video Conferencing.

	form. ii. A legal decision where a patient may waive a right such as a discussion of their advanced directive wishes and a DNR/allowing natural death or during the consent process.	

E. Approved Qualified Interpreting Services

1. All patients whose first language is other than spoken English and who need interpreting support beyond the most basic level should be offered access to an approved qualified interpreter.
2. Sign language users should be offered access to an independent approved interpreter. More information is given
    a. Spoken Language Interpreters: (Face to Face and Telephone) A list of qualified interpreters can be obtained from the Nursing Administration.
        i. SVHMC employs qualified interpreters for face to face interpretation. The professional's clinical judgment should be used to decide whether telephone/ video conferencing or face to face interpreting is used.
        ii. The qualified interpreter should have a discussion with patients about what is most useful for them may also be helpful.
        iii. Video conferencing and telephone interpreting can be set up in minutes and can be used for the duration of a clinical interaction or to support care until a face to face interpreter is available, if required.
3. Factors to consider when working with a Language Interpreter
    a. Consider the most appropriate method of translation. Will video or telephone translation provide you with what you require for the duration of the intervention or is it required until face to face interpretation is provided if required? Could you use it for some aspects of meeting patients' needs and have face to face translation at other times?
    b. Before the interpreting session starts, it is important for the clinician to spend some time with the interpreter to brief them, giving any appropriate

background information and explaining any technical terms (for example medical or legal terms) that may arise. After the interpreter session, it is advisable to discuss how the interview went and discuss any issues for example cultural difference.

c. If an interpreter does not arrive, follow the attached algorithm for interpreter options.

4. Health and safety for interpreters
    a. Interpreters are required to work in line with the health and safety requirements of their contract and with their code of conduct. You should consider whether any health and safety precautions that you take when undertaking your duties should also be applied to the interpreter. For example:
        i. If you wear a mask when you are examining a patient, you should also provide the same protection for the interpreter who is standing next to you.
        ii. Make sure the interpreter knows where the antibacterial gel is located
        iii. Interpreters should not be asked to help with any clinical tasks or to touch any bodily fluids.
    b. Transport for patients
        i. Interpreters are not responsible for providing transport to take patients to or from home. If a patient requests this service, the interpreter will convey this message to you.
5. Factors for the clinician to consider when using a Telephone or Video Language Interpreter
    a. Identify the language and dialect you need, it may take a few minutes to connect to the appropriate Interpreter.
    b. Telephone: Consider the most appropriate telephone equipment, dual handset, speaker phone, direct phone, consider confidentiality and need for participation of family/caregivers.
        i. Advise the interpreter what phone set up you have, e.g. single handset, speaker phone, two handsets.
    c. Video: Uses a Video iPad and can also provide sign language interpreters.
        i. As an additional resource, the Video can be used to translate instructions:
        ii. Video Interpreter will write out the instructions in the preferred language so the RN can copy the words onto the discharge instructions
    d. Brief the Interpreter
        i. Give any appropriate background information and explaining any

technical terms (for example medical or legal terms) that may arise.

ii. Ask them to introduce you and themselves

iii. Follow this with your lead question, e.g. how may I help you?

e. Proceed with the conversation

i. The interpreter will relay the information between you and the patient.

f. End the by saying

i. "I have all the information I need, is there anything else you would like to ask me?

F. Hearing impaired/deaf patients:

1. If it is determined that interpretation is needed for effective communications with hearing-impaired patients at the present time or at a future date, the following procedure will be followed:

~~a. To schedule an American Sign Language interpreter, Central Coast Sign Language Interpreters may be called. The phone number is (831)297-4321.~~

~~b. A booking for a deaf translator cannot exceed 1.5 hours. If the translation must occur for more than 1.5 hours, more than one translator must be found.~~

a. American Sign Language interpreter can be contacted via contracted video remote interpreter (IOW). IOWs are on all units and can be downloaded to your device.

G. Monitoring compliance:

1. The interpreter/translator program is evaluated on an annual basis or as needed to determine its effectiveness. Program revisions, process improvements are made as necessary to meet the needs of the patient population served.
2. If as a professional user you have any feedback or suggestions for improvement about the Interpreting Service these should be directed to the department director.
3. If patients wish to complain about the Interpreting Service please direct them to the department director.
4. As appropriate SVHMC reviews all forms, waivers, documents and informational materials available upon admission to determine which to translate into a language other than English

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. Affordable Care Act Section 1557
B. ~~TJC~~The Joint Commission - Patient Rights
C. California Health and Safety Code Section 1259
D. Assembly Bill 389
E. CHA Consent Manual, Chapter 1 Patients' Rights and the Basic Principles of Consent
F. 45 C.F.R. Section 84.52 (d)
G. ~~A Practical Guide to Commissioning Face to Face Language Interpreting Services (2011) Robers, A. *et al*~~

Attachments

A: Interpreting Services

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	William Tienken: Patient Care Services Manager	09/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13246620

Last Approved	N/A	Owner	Carla Spencer: Director Critical Care Services
Last Revised	10/2023	Area	Patient Care
Next Review	3 years after approval		

Massive Transfusion Protocol -Nursing

I. POLICY STATEMENT

A. N/A

II. PURPOSE

A. To guide the nursing staff in the implementation of the Massive Transfusion Protocol (MTP).

III. DEFINITIONS

A. ER: Emergency Room
B. OR: Operating Room
C. L&D: Labor and Delivery
D. ICU: Intensive Care Unit
E. MTP: Massive Transfusion Protocol, refers to rapid administration of large amounts of blood products…in fixed ratios…for the management of hemorrhagic shock (Farkas, 2021)
F. MTP Pack: Pre-defined quantities of Packed Red Blood Cells, Platelets and Fresh Frozen Plasma
G. PRBCs: Packed Red Blood Cells
H. PLTs: Platelets
I. FFP: Fresh Frozen Plasma
J. RRT: Rapid Response Team

IV. GENERAL INFORMATION

A. Indications for MTP
    1. Traumatic Hemorrhage

2. Obstetrical Hemorrhage
3. Operative Bleeding
4. Gastrointestinal Hemorrhage

B. Adult MTP ~~Pack~~
   1. Greater than 50 kg
   2. Pack consists of ~~6~~4 units ~~PRBC's~~of PRBCs, ~~6~~4 units FFP~~'s~~, & 1 unit ~~PLT's~~ PLTs

C. Pediatric MTP
   1. Less than 50 kg
   2. ~~Transfuse 0.1 unit/kg~~
   3. Pack consists of ~~4~~2 units ~~PRBC's~~of PRBCs, 2 units FFP~~'s~~, & 1 unit ~~PLT's~~PLTs

V. PROCEDURE

A. Activation of the MTP
   1. Physician orders the MTP protocol
   2. The hospital code line 2222 is called
      a. Communicate to the hospital operator the name of the code (MTP), location, and indicate if it is a pediatric patient
      b. In patient care areas other than ER, ICU, ~~ER, OR, &~~ L&D, and OR, also request an RRT (or Code Blue if applicable).
   3. ~~A call must also be placed to Blood Bank to inform them of the patient name, location, medical record number, and ordering physician~~**A call must also be placed to Blood Bank to inform them of the patient name, location, medical record number, and ordering physician**
   4. Note the activation time (must be charted on the ~~documentation form – See Attachment A~~MTP Flowsheet).
   5. Staff response:
      a. ICU RN responds to all MTPs in the hospital except in the ER.
      b. ER RN responds to all MTPs in the hospital and brings the rapid infuser and tubing (do not bring if responding to Main OR).
      c. Nursing Supervisor responds to all MTPs in the hospital.
      d. Primary RN stays in the room to assist with patient care.

B. Orders
   1. The following must be ordered in Meditech:
      ~~a. Massive Transfusion -Initial~~
         ~~i. This is the first set of blood products~~
      ~~b. Massive Transfusion -Maintenance~~

i. ~~This orders the second set of blood products, if needed~~

c. ~~Massive Transfusion Labs Maintenance~~

i. ~~Will repeat baseline labs hourly until deactivation/discontinued~~

a. Massive Transfusion -Initial

i. This requests the first set of blood products

ii. Initial Lab tests required in addition to Type and Screen
Baseline – H&H, PLTC, PT/PTT, Fibrinogen, D-Dimer, ABG, K^+ and Ionized Calcium

b. Massive Transfusion -Maintenance

i. *While MTP is activated* – H&H, PLTC, PT/PTT are repeated hourly for 4 hours

a. May be reordered for third, fourth...set of blood products

C. Vital signs must be obtained every 15 minutes, at minimum, during the MTP

D. All blood products must be checked and verified by two licensed RNs

E. Platelets are not administered via the rapid infuser.

F. Avoid hypothermia

1. Consider use of rapid infuser and warming devices.

G. If the patient is transferred to another unit, all blood products must travel with the patient.

H. Deactivation of the MTP

1. The physician will determine when to end the MTP.

2. The Blood Bank must be immediately telephoned and informed of the MTP ~~cancellation~~deactivation.

I. Documentation

1. MTP activation and deactivation times are recorded in the ~~patients~~patient's electronic health record.

2. Documentation of the blood product administration is manually completed on the ~~appropriate paperwork (see Attachment A)~~MTP Flowsheet.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

REFERENCES

A. Beiriger, J., Silver, D., Lu, L., & Brown, J. (2023). Transfusion management in trauma: what is current best practice? *Current Surgery Reports, 11*, 43-54.

B. Dynamic Health. (2022). *Performing massive blood transfusion*. Retrieved October 18, 2022, from https://www.dynahealth.~~com~~om/nursing-skills/performing-massive-blood-transfusion

C. Farkas, J. (2021). *Massive transfusion protocol (MTP).* Internet Book of Critical Care (IBCC). https://emcrit.org/ibcc/mtp

D. Jennings, L., & Watson, S. (2022, Aug. 29). Massive transfusion. In *StatPearls*. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK499929/

E. Whitaker, J. Cutler, S., & Lucena-Amaro, S. (2023). Trauma nursing 4: recognising and managing haemorrhage in trauma. *Nursing Times, 119*(2), 42-47.

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Transfusion Committee	Katherine DeSalvo: Director Medical Staff Services	10/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Carla Spencer: Director Critical Care Services	10/2023

Standards

No standards are associated with this document

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Last Approved	N/A	Owner	Kelly Flower: Clinical Manager
Last Revised	10/2023	Area	Patient Care
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Oral Care

I. POLICY STATEMENT:

~~A. The oral cavity is assessed per unit standard.~~

~~B. Unconscious, intubated or patients who cannot provide their own oral care should have oral care provided every 2 to 4 hrs and PRN.~~

~~C. Conscious patients that are capable of doing their own oral care should be encouraged to brush their teeth after each meal, or three times a day if NPO.~~

~~D. Dentures should be cleaned daily and PRN.~~

~~E. Patients in the ICU should have oral rinse with chlorhexidine gluconate (CHG) twice daily.~~

A. N/A

II. PURPOSE:

A. To provide guidance to nursing staff to provide evidence-based oral care for patients.

III. DEFINITIONS:

A. Neutropenia: An abnormal decrease in white blood cells (neutrophils) causing susceptibility to infection (WBC <1000).

B. CHG: chlorhexidine gluconate.

IV. GENERAL INFORMATION:

~~A. N/A~~

A. The oral cavity is assessed per unit standard.

B. Unconscious, intubated or patients who cannot provide their own oral care should have oral care provided every 2 to 4 hrs and PRN.

C. Conscious patients that are capable of doing their own oral care should be encouraged to brush their teeth after each meal, or three times a day if NPO.

D. Dentures should be cleaned daily and PRN.

E. Intubated patients in the ICU and ventilated tracheostomy patients in ICU and 1 Main will be provided oral care every four hours, in addition to using chlorhexidine gluconate (CHG) twice daily.

V. PROCEDURE:

For patients who are unable to perform oral care:

A. Set up suction equipment.

B. Position patient's head to the side or place in semi fowler's position.

C. Provide suction as needed, using either the yankauer for the oral cavity or the in-line suction catheter for intubated or ~~trached~~trach patients.

D. Brush teeth using a suction toothbrush and small amounts of water and non-alcohol mouthwash.

- Brush for approximately one to two minutes.
- Exert gentle pressure while moving in short horizontal or circular strokes.

E. Gently brush the surface of the tongue.

F. ~~For patients in ICU, follow brushing with CHG mouth rinse every 12 hours.~~

G. ~~Use suction oral swabs every two to four hours with 1.5% hydrogen peroxide solution to clean the mouth. Three percent (3%) hydrogen peroxide is available from the pharmacy.~~

- Dilute 3% hydrogen peroxide with equal parts hydrogen peroxide and sterile water to make 1.5%.
- Place swab perpendicular to gum line, applying gentle mechanical action for one to two minutes.

H. For intubated patients in the ICU and/or tracheostomy patients in the ICU and 1 Main:

- Perform oral care every four hours using the antiseptic oral care swabs/suction catheter kit
- Perform oral care every twelve hours using chlorhexidine gluconate (CHG) and document on the MAR

I. Apply mouth moisturizer inside ~~the mouth.~~to oral cavity as necessary

J. Apply lip balm as needed.

K. Dentures will be soaked daily (at least one hour) with an effervescent denture cleansing product, dissolved in water.

L. Documentation:

1. Assessment of oral cavity should be documented on the shift assessment.
2. Oral care should be documented in the Patient Care Record each time oral care is

given.

3. CHG rinse is documented on the MAR.

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. American Association of Critical Care Nurses (6/2017) Practice Alert: Oral Care in the Critically Ill.~~

~~B. Center for Disease Control (5/2019).CDC Guidelines for Prevention of Health Care Associated Bacterial Pneumonia.~~

~~C. Sage Products Inc. Web Site, www.sageproducts.com, Clinical Guidelines.~~

~~D. Vollman, K. & Garcia, R. (2005) Interventional Patient Hygiene: Proactive (Hygiene) Strategies to Improve patients' Outcomes., **American Association of Critical Care Nursing News**, 22(8).~~

~~E. Shay, K. (2000). Denture Hygiene: A Review and Update. **The Journal of Contemporary Dental Practice**, 1(2).~~

A. Center for Disease Control (5/2019).CDC Guidelines for Prevention of Health Care Associated Bacterial Pneumonia.

B. Sage Products Inc. Web Site, www.sageproducts.com, Clinical Guidelines.

C. Khasanah IH, Sae-Sia W, Damkliang J. (2019). The Effectiveness of Oral Care Guideline Implementation on Oral Health Status in Critically Ill Patients. SAGE Open Nursing. doi:10.1177/2377960819850975

D. Klompas, M., Branson, R., Cawcutt, K., Crist, M., Eichenwald, E., Greene, L., Berenholtz, S. (2022). Strategies to prevent ventilator-associated pneumonia, ventilator-associated events, and nonventilator hospital-acquired pneumonia in acute-care hospitals: 2022 Update. Infection Control & Hospital Epidemiology, 43(6), 687-713. doi:10.1017/ice.2022.88

E. Davis I et al (2019) Improving the provision of mouth care in an acute hospital trust. Nursing Times [online]; 115: 5, 33-36

Approval Signatures

Step Description	Approver	Date

Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Critical Care Director	Carla Spencer: Director Critical Care Services	10/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	10/2023
Policy Owner	Kelly Flower: Clinical Manager	10/2023

Standards

No standards are associated with this document

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Pacemaker: Insertion of a Temporary Pacemaker, Transvenous; Balloon-Tipped Pacing Electrode; and Epicardial

I. POLICY STATEMENT

~~A. The insertion of a temporary trans venous pacemaker is performed in emergent and elective clinical situations when the normal conduction system of the heart fails to produce an electrical impulse, resulting in hemodynamic compromise. Exposed proximal ends of the pacing wires should be insulated when not in use to prevent micro shock.~~

A. N/A

II. PURPOSE

~~A. To provide procedural guidelines in assisting physician with the insertion of a temporary trans venous pacemaker; balloon-tipped pacing electrode; and the management and care of patient with epicardial pacer wires.~~

A. To outline the care of patients receiving transvenous and epicardial pacing.

III. DEFINITIONS

A. Sensing - ability of pacemaker device to detect intrinsic myocardial electrical activity.

B. Pacing - When temporary pulse generator is activated, and the requisite level of energy travels from the pulse generator through the temporary pacing wires to the myocardium.

C. Capture - The successful stimulation of the myocardium by the pacemaker resulting in depolarization. It is evidenced on the ECG by a pacemaker spike followed by either an atrial or a ventricular complex, depending on the chamber being paced.

IV. GENERAL INFORMATION

~~A. N/A~~

A. A temporary pacemaker may be used when the normal conduction system of the heart fails to produce an electrical impulse, resulting in hemodynamic compromise.

B. Epicardial wires will remain attached to the connector cable at all times.

1. If not actively pacing, the connector cable will be removed from the socket and tied to the pulse generator.
2. The pulse generator must remain readily available at the head of the patient's bed in the event that pacing is needed.

V. PROCEDURE

A. ~~Operation~~Preparation

1. ~~**Transvenous approach/Balloon-tipped pacing electrode procedure**~~
    a. Connect patient to bedside or procedural monitoring system, and monitor ECG continuously.
    b. Assess pacemaker functioning, and insert a new battery into the pulse generator if needed.
    c. Attach the connecting cable to the pulse generator
2. Connect the patient to the bedside or procedural monitoring system.
    a. All patients must have continuous ECG monitoring.
3. **Transvenous approach/Balloon-tipped pacing electrode procedure**
    a. For central line catheter insertion and care refer to the following policies:
        i. Pulmonary Artery Catheter Insertion (Assist) Pressure Monitoring , and Removal Clinical Procedure.
        ii. Central Vascular Access Devices
    b. Assist the physician with insertion of the pacing catheter.
    c. Attach the connecting cable to the pulse generator.
        i. You will only have one connecting cable.
        ii. Verify that the "V" socket (ventricle) is used.
4. **Epicardial pacing (ICU, OR, HC~~, 1Main only~~)**
    a. Expose the epicardial pacing wires and identify the chamber of origin. ~~Wires exiting to the right of the sternum are atrial in origin. Wires exiting to the left of the sternum are ventricular in origin.~~
        i. Wires exiting to the right of the sternum are atrial in origin.
        ii. Wires exiting to the left of the sternum are ventricular in origin.

b. ~~Connect the epicardial wires to the pulse generator via the connecting cable.~~Attach the connecting cable(s) to the pulse generator.

i. Single chamber pacing (either ventricle or atrium) - one connecting cable

ii. Dual chamber pacing (both ventricle and atrium) - two connecting cables

iii. Verify that the appropriate socket is used (corresponding to the location of the epicardial wire).

5. Assess pacemaker functioning prior to attaching to the patient.

a. New batteries should be utilized for each patient.

6. Connect the pacer wires/pins to the connector cable:

a. Transvenous

i. Connect black to negative (-)

ii. Connect red to positive (+)

b. Epicardial

i. There is no negative (-) or positive (+) - either pin may go into the slots on the connector cable

7. Obtain Physician's order for pacemaker settings.

a. Mode

b. Rate

c. Atrial output (mA)

d. Ventricular output (mA)

e. Set the pacemaker mode, rate, and output as prescribed or as determined by SENSITIVITY and STIMULATION THRESHOLD testing.

f. Turn all settings to the lowest level and then turn on the pacemaker.

8. ~~Obtain Physicians order for pacemaker settings and initiate pacing~~Verify with the provider if SENSITIVITY and STIMULATION THRESHOLD testing are to be performed every shift and prn (typically not done with cardiac surgery patients).

a. ~~Determine the mode of pacing desired. Atrial or ventricular asynchronous, ventricular or atrial demand or dual chamber demand pacing.~~

b. ~~Set the pacemaker mode, rate and level of energy (output of mA) as prescribed or as determined by sensitivity and stimulation threshold testing.~~

c. ~~Turn all settings to the lowest level and then turn on the pacemaker.~~

d. If not, every shift, verify that pacemaker settings correspond with the physician's orders.

e. ~~Determine sensitivity threshold~~To determine SENSITIVITY THRESHOLD for

each chamber ~~every shift~~:

i. Gradually lower the sensitivity by turning the sensitivity dial counterclockwise (or to a higher numerical setting) and observe the pace indicator light for flashing.

ii. ~~Gradually turn~~Slowly increase the sensitivity by turning the sensitivity dial ~~counterclockwise~~clockwise (or to a ~~higher~~lower numerical setting) ~~and observe~~until sense indicator light flashes with each complex and the pace indicator light ~~for flashing~~stops. This value is the SENSING THRESHOLD.

iii. ~~Slowly turn~~Set the sensitivity dial ~~clockwise (or to a lower numerical setting) until sense indicator light flashes with each complex and the pace indicator light stops. This value is the sensing threshold. Set sensitivity dial~~ to the number that was half ~~the sensing threshold~~of the SENSING THRESHOLD to provide 2:1 safety margin. Some physicians prefer to set sensitivity settings all the way to the demand mode (most sensitive), regardless of the sensitivity threshold

f. ~~Determine stimulation threshold~~To determine STIMULATION THRESHOLD for each chamber ~~every shift~~:

i. Set pacing rate approximately 10 beats above the patient's intrinsic rate.

ii. Gradually decrease output ~~from 20 mA~~ until capture is lost.

iii. Gradually increase mA until 1:1 capture is established. This is the ~~stimulation threshold~~STIMULATION THRESHOLD.

iv. Set the mA at least ~~two~~2 times higher than the ~~stimulation threshold~~STIMULATION THRESHOLD but no less than 5 mA. This output setting is sometimes referred to as the ~~maintenance threshold~~MAINTENANCE THRESHOLD.

g. ~~Assess rhythm for appropriate pacemaker function:~~

i. Capture: Is there a QRS complex for every ventricular pacing stimulus? Is there a P wave for atrial pacing stimulus?

ii. Rate: Is the rate at or above the pacemaker rate if in the demand mode?

iii. Sensing: Does the sensitivity light indicate that every QRS complex is sensed?

B. Assessment

1. Assess pacemaker settings every shift and prn.
    a. Confirm that the settings match what is ordered by the provider.
2. Assess ECG rhythm for appropriate pacemaker function every shift and prn:
    a. Capture: Is there a QRS complex for every ventricular pacing stimulus? Is

there a P wave for atrial pacing stimulus?

b. Rate: Is the rate at or above the pacemaker rate if in the demand mode?

c. Sensing: Does the sensitivity light indicate that every QRS complex is sensed?

3. Monitor vital signs and hemodynamic response to pacing as often as patient's condition warrants.
4. Review and print ECG rhythm strips at minimum, every four (4) hours.
5. Monitor for alteration of QRS configuration initiated by pacemaker.

C. Maintenance/Care

1. ~~Monitor vital signs and hemodynamic response to pacing as often as patient's condition warrants.~~
2. ~~Evaluate ECG for presence of paced rhythm or resolution of initiating dysrhythmia.~~
3. ~~Review and print ECG rhythm strips every four (4) hours. (Not applicable to Cath Lab)~~
4. Check external pacing electrode wire position, insulation, and security of catheter terminals within pacemaker connectors every shift.
5. Restrict range of motion of extremity in which catheter is inserted.
6. ~~Monitor for alteration of QRS configuration initiated by pacemaker.~~
7. Wear gloves when handling metal portion of pacemaker electrodes to prevent microshock hazard.
8. ~~Assess pacemaker settings, function and thresholds every shift and document under "Pacemaker Function" screen on the worklist.~~
9. ~~Battery life is typically 7 days of continuous operation at nominal values~~
10. ~~**If the battery indicator light is flashing, this indicates that the pacemaker battery has <24 hours battery life**. You must change the battery immediately upon noting the light flashing. To change the battery:~~Batteries

    a. ~~Obtain two new AA Alkaline batteries from the PAR or in the black pacemaker case at bedside.~~

    b. ~~Push the black button on the bottom right side of the pacemaker to open the battery drawer.~~

    c. ~~Remove the old batteries and place the new batteries. The pacemaker has a 30 second internal battery backup~~

    d. ~~After installing new batteries, ensure the battery status indicator displays full battery power~~

    e. Battery life is typically 7 days of continuous operation at nominal values

    f. **If the battery indicator light is flashing, this indicates that the pacemaker battery has less than 24 hours of battery life**. You must change the battery immediately upon noting the light flashing.

        i. To change the battery:

a. Obtain two new AA Alkaline batteries.

b. Push the black button on the bottom right side of the pacemaker to open the battery drawer.

c. Remove the old batteries and place the new batteries.

d. The pacemaker has a 30 second internal battery backup.

e. After installing new batteries, ensure the battery status indicator displays full battery power

11. Dressing change: ~~(Not applicable to Cath Lab)~~

    a. Transparent dressing: Change every seven (7) days and PRN. Apply Biopatch at insertion site.

    b. Occlusive gauze dressing: Change every forty eight (48) hours and PRN.

12. Discontinuation

    a. Only a physician or physician's assistant may discontinue pacer wires.

D. Precautions

1. Monitor ~~mA~~Output setting~~. Insufficient mA may result in loss of capture and dangerously slow rhythm; excessive mA may result in irritability and lead to ventricular dysrhythmias.~~

    a. Insufficient mA may result in loss of capture and a dangerously slow rhythm

        i. Intervention: Increase the output

    b. Excessive mA may result in irritability and lead to ventricular dysrhythmias.

        i. Intervention: Decrease the output

2. Monitor ~~sensitivity~~Sensitivity setting~~; excessive sensitivity may cause sensing of "P" or "T" wave, resulting in failure to pace at appropriate times; insufficient sensitivity will cause fixed rate pacing with the possibility of the pacing stimulus being delivered during the vulnerable period of the cardiac cycle, leading to lethal dysrhythmias.~~

    a. Excessive sensitivity may cause sensing of "P" or "T" wave, resulting in failure to pace at appropriate times causing PAUSES

        i. Intervention: Decrease the sensitivity

    b. Insufficient sensitivity will cause fixed rate pacing with the possibility of the pacing stimulus being delivered during the vulnerable period of the cardiac cycle, leading to lethal dysrhythmias.

        i. Intervention: Increase the sensitivity

E. ~~Related Care~~

1. Check external pacing electrode wire position, insulation, and security of catheter

terminals within pacemaker connectors every shift (Not applicable to Cath Lab)

F. ~~Complications~~
    1. Pacemaker failure or malfunction
    2. Failure to sense patient's spontaneous beats; pacer spikes occur at regular intervals regardless of patient's rhythm.
    3. Failure to capture: pacer spikes visible but ventricles do not respond (no QRS).
    4. Absence of generator discharge: complete or intermittent absence of pacer spikes, and rate of patient's own rhythm is slower than pre-set rate of pulse generator.
        a. Change battery.

G. Documentation~~: Document under "Pacemaker Function" screen on the work list. (Not applicable to Cath Lab)~~
    1. Document under "Pacemaker Function" screen on the work list.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

~~A. Spotts, V., Temporary Transvenous and Epicardial Pacing, 2011, AACN Procedure Manual for Critical Care, pp. 429-442, In Weigand, D., 6th edition, St Louis Missouri, Elsevier Saunders. I~~

~~B. Hayes, D. (2019). Temporary cardiac pacing. *UpToDate*. Retreived from https://www.uptodate.com/contents/temporary-cardiac-pacing~~

~~C. Medronic.com (2019). Medtronic Academy. Retreived from https://www.medtronicacademy.com/~~

~~D. Model 5392 Temporary External Pacemaker. Medtronic user manual (2020)~~

A. Crofoot, M. Sarwar, A., Weir, A. J. (2022, Sep 12). External pacemaker. *StatPearls [Internet]*. StatPearls Publishing.

B. Larsen, A., & Gruenwald, J. (2022). Assisting with temporary transvenous pacemaker insertion and pacing initiation in adults. In M. Woten, & D. Hanson (Eds.). Dynamic Health Nursing Skill. EBSCO. Retrieved from https://www.dynahealth.com/nursing-skills/assisting-with-temporary-transvenous-pacemaker-insertion-and-pacing-initiation-in-adults/about

C. Medtronic. (2020). Model 5392 Dual Chamber Temporary External Pacemaker Manual. Retrieved from https://www.medtronic.com/content/dam/emanuals/crdm/M811268A001A_view.pdf

D. Menella, H. (2022). Assisting with temporary tranvenous pacing in pediatric patients. In M. Woten, & D. Hanson (Eds.)s. Dynamic Health Nursing Skill. EBSCO. Retrieved from https://www.dynahealth.com/nursing-skills/assisting-with-initiating-temporary-transvenous-pacing-in-pediatric-patients/about

E. Spotts, V. (2017). Temporary transvenous and epicardial pacing. In D. Wiegand , Ed. *AACN*

Procedure Manual for High Acuity, Progressive, and Critical Care (7 edition). Elsevier. 416-429.

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Critical Care Committee	Katherine DeSalvo: Director Medical Staff Services	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Director	Carla Spencer: Director Critical Care Services	08/2023
Policy Owner	Carla Spencer: Director Critical Care Services	08/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13540400

Last Approved	N/A	Owner	Jill Crowley: Manager Clinical Nutrition
Last Revised	10/2023	Area	Patient Care
Next Review	3 years after approval		

Patient Food Service

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

A. To guide the staff regarding the appropriate parameters to assure safety, accuracy, and timeliness of meal service within identified constraints.

III. DEFINITIONS:

A. N/A

IV. GENERAL INFORMATION:

A. Patients' food service will be based on the physician order in accordance with the approved ~~On Line~~ Diet Manual and Diet Manual Addendum (Links can be found in the intranet.

1. The electronic diet manual is available on all computers via ~~SVMHS Intranet~~the intranet.
2. The latest version of the Academy of Nutrition and Dietetics Nutrition Care Diet Manual is the approved manual (approved via PT/IC committee).
3. Diets orders are placed by Physicians or by telephone order. Orders are placed in the EHR and transmit to Nutrition Service via computer interface.
4. Patient information is maintained in the food service software patient card file. The patient card file may include but not limited to the following: likes, dislikes, preferences and food allergies.
5. One Day Room Service Menu is available for all diets. ~~Tray~~Meal order and tray tickets are generated after a room service order is place.

6. Nourishments and supplements are served in response to the diet therapy ~~need~~order or upon patient request. Nourishments are delivered ~~at 10:00am~~per diet therapy order, ~~2:00pm and 7:00pm or per diet order throughout the day during~~processed via room service ~~availability hours~~and can be sent with meals and/or between meals depending upon patient preference. Supplements are delivered ~~at the same time frame, but may also be included on~~with meals and/or between meals depending upon patient preference. Nourishments and supplements for isolation patients~~' meal trays. Nourishments and Supplements for isolation patients~~ are brought to the nursing station for delivery.
7. Tray-passers do not enter isolation rooms. Trays for isolation patients are left at the nursing station. A nursing representative is notified and is responsible for passing the trays to the isolation patients. Nursing will dispose of all disposable items and will return all non-disposable isolation items/trays to the tray-passing cart when patient is finished eating. ~~Trays left uneaten in the room without a patient present will be taken during tray pick up to prevent diminished quality and potential foodborne illness. A new tray can be ordered by the patient and/or nurse as needed. Tray-passers identify patients using two patient identifiers. If unable to correctly identify a patient, the tray will be left at the nursing station. Tray-passers sanitize hands before the start of tray delivery and sanitize in and out of each patient room. Meal carts are left on the patient units during active meal service times. Meal carts are cleaned prior to each meal service, again when returning to tray-line and are sanitized per cleaning schedule.~~
8. Trays left uneaten in the room without a patient present will be taken during tray pick up to prevent diminished quality and potential foodborne illness. A new tray can be ordered by the patient and/or nurse as needed.
9. Tray-passers identify patients using two patient identifiers. If unable to correctly identify a patient, the tray will be left at the nursing station and nursing staff will be notified.
10. Tray-passers sanitize hands before the start of tray delivery and sanitize in and out of each patient room.
11. Meal carts are left on the patient units during active meal service times. Meal carts are cleaned prior to each meal service, again when returning to tray-line and are sanitized per cleaning schedule.

V. PROCEDURE~~:~~

A. Physicians: Orders patient diets per established procedures in the electronic heath record.

B. Nursing: Orders diets as per MD order and delivers/pick up trays for isolation patients.

C. Nutrition Services: Patient interviews are conducted by the Diet Clerks to provide preference information and confirm food allergies. Diet Clerks also take and process meal orders for room service either on the phone and/or during floor rounding.

D. Diet Manual: The diet manual and diet manual addendeum is found ~~online~~ on the ~~SVMHS Intranet~~intranet. The latest edition of the Academy of Nutrition and Dietetics Diet Manual is the authorized hospital diet manual.

VI. EDUCATION/TRAINING:

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

VII. REFERENCES:

A. The Joint Commission.

B. Title 22.

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
FNS Director	Jason Giles: Director of Nutrition Services	07/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Policy Owner	Jill Crowley: Manager Clinical Nutrition	07/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13728652**

Last Approved	N/A	Owner	Natalie James: Contract Administrator
Last Revised	09/2023	Area	Administration
Next Review	3 years after approval		

Physician Services Contract

I. POLICY STATEMENT

A. **General**. It is the policy of SVHMC that all Physician Agreements shall comply with all applicable regulations and laws, including but not limited to the following: (i) federal Stark Law, (ii)federal and state anti-kickback statutes, (iii) Title 22 California Code of Regulations, (iv) the Centers for Medicaid/Medicare Services (CMS requirements), and (v) the Internal Revenue Code and Regulations (IRS Regulations), and (vi) the standards of The Joint Commission (TJC Standards). Each Physician Agreement will comply with the SVHMC policies and procedures set forth below and all other relevant SVHMC policies, such as the Board of Directors' Conflict of Interest Code and Fair Market Value policies.

B. **Board Direction**. The SVHMC Board of Directors reviews and approves policies and procedures of the District pursuant to which SVHMC Executive Leadership manages, executes, administers and evaluates contracts to ensure a contractor for services furnishes services in a manner that permits SVHMC to comply with all applicable federal and state laws and regulations, conditions of participation, and other standards for contracted services.

C. **Contract Management Department Collaboration**. All Physician Agreements will be prepared, reviewed, approved, and administered (where applicable) in collaboration with the SVHMC Contract Management Department. Negotiation, support, and management of individual Physician Agreements can be completed by the individual responsible department.

D. **Chief Medical Officer Oversight**. All Physician Agreements s will be under the oversight and management of the Chief Medical Officer (CMO). The CMO will collaborate with the Chief Operating Officer (COO) or designee on all equipment and real estate related agreements involving Physicians.

E. **Legal Services**. All newly created Physician Agreements will be reviewed by District legal counsel. District legal counsel will collaborate with the CMO and contracting staff to draft and review template Physician Agreements. Access to District legal for the purposes of drafting and reviewing Physician Agreements shall be at the direction of the CMO.

F. **Document Management**. The current electronic contract database (MediTract) will serve as

repository for Physician Agreements and related documents. Original Physician Agreements will be maintained on file in the Contract Management Department, under the direction of the CMO.

G. **Physician Qualifications**. SVHMC shall not enter into any Physician Agreement with a Physician who has been debarred, sanctioned or excluded from practice by any governmental agency or physician association, or who has been excluded from participation in a federal or state government program.

H. **Fair Market Value; Commercial Reasonableness**. In accordance with the SVHMC FAIR MARKET VALUE POLICY, the arrangements with Physicians under Physician Agreements will be at fair market value and will be commercially reasonable.

I. **Written Agreement**. Physician Agreements must be in writing, signed by all parties, and dated before the items or services are provided or payment is received. In addition the following requirements apply.

1. **No Retroactive Agreements**. No Physician Agreement may be executed with a retroactive effective date, unless approved by District legal counsel. No Physician Agreement may be "backdated" to misrepresent the date it was executed. A Physician Agreement may be executed by the parties within thirty (30) days of the effective date stated in the Physician Agreement if there is documentation that the physician received the Physician Agreement on or before the effective date stated in the Physician Agreement (e.g., by way of email communication).
2. **No Restrictions on Practice**. The Physician Agreement shall not restrict the Physician from establishing medical staff privileges or otherwise limit Physician's access to any other health care facility.
3. **No Required Referrals**. The Physician Agreement shall not in any way condition the agreement or any payments under the agreement on referrals to SVHMC or any affiliate.
4. **Detailed Description of Services**. The Physician Agreement will describe the scope of services to be provided. If relevant, the Physician Agreement must specify the number of hours to be worked, stating the minimum number of hours for a Physician or providing a range or a maximum number of hours for an independent contractor.
5. **Term, Termination, and Renewal**
    1. **Minimum One-Year Term**. The Physician Agreement must be for a term of at least one (1) year and may not be longer than three (3) years, unless approved by the CMS after consultation with District legal counsel.
    2. **Termination without Cause**. The normal term of the Physician Agreement is one (1) or two (2) years "Initial Term." When a physician extends beyond the Initial Term, SVHMC should retain the ability to terminate the agreement without cause and without penalty on written notice of no longer than ninety (90) days at any time after the Initial Term. SVHMC may deviate from this policy only with the approval of the CMO after consultation with legal counsel.
    3. Termination within First Year. If the Physician Agreement is terminated for any reason within the first (1st) year, SVHMC may not enter into another

~~arrangement with the same Physician for the same or similar services prior to the end of the initial one-year period on different compensation terms.~~

4. ~~Renewal. Consistent with the terms of the Physician Agreement and this Policy, renewal of a Physician Agreement may be by virtue of an automatic renewal provision, or by written and signed mutual agreement of the parties.~~

~~J. **Contract and Invoice Approval.** The CONTRACT APPROVAL MATRIX policy will be followed for final contract and invoice approval.~~

~~K. **Payment to Correct Party.** SVHMC will ensure that payments are made to the correct party, using the correct taxpayer identification number. When Physician Agreements are entered into with a corporate or partnership entity, payments must be made to that entity, and not to an individual Physician.~~

A. The general provisions of this policy and procedure apply to the various types of agreements between Salinas Valley Health Medical Center (SVHMC) and Physicians, including, but not limited to, professional, personal or consulting services, recruitment, medical directorships, leases for office space equipment or services, positions of medical staff leadership or committee members, and arrangements for conference attendance and/or training (Physician Agreements).

II. PURPOSE

A. The purpose of this Physician Services Contract Policy is to establish guidelines for the orderly processing of agreements between SVHMC and physicians, physician groups, other health care practitioners, or any persons or entities that make, receive, or influence referrals of patients or services to or from SVHMC (Physicians). This policy is intended to facilitate compliance with Stark and Anti-Kickback regulations.

B. ~~The general provisions of this policy and procedure apply to the various types of agreements between SVHMC and Physicians, including, but not limited to, professional, personal or consulting services, recruitment, medical directorships, leases for office space equipment or services, positions of medical staff leadership or committee members, and arrangements for conference attendance and/or training (Physician Agreements).~~

III. DEFINITIONS

A. N/A

IV. GENERAL INFORMATION

~~A. N/A~~

A. **General**. It is the policy of SVHMC that all Physician Agreements shall comply with all applicable regulations and laws, including but not limited to the following: (i) federal Stark Law, (ii)federal and state anti-kickback statutes, (iii) Title 22 California Code of Regulations, (iv) the Centers for Medicaid/Medicare Services (CMS requirements), and (v) the Internal Revenue

Code and Regulations (IRS Regulations), and (vi) the standards of The Joint Commission (TJC Standards). Each Physician Agreement will comply with the SVHMC policies and procedures set forth below and all other relevant SVHMC policies, such as the Board of Directors' Conflict of Interest Code and Fair Market Value policies.

B. **Board Direction**. The SVHMC Board of Directors reviews and approves policies and procedures of the District pursuant to which SVHMC Executive Leadership manages, executes, administers and evaluates contracts to ensure a contractor for services furnishes services in a manner that permits SVHMC to comply with all applicable federal and state laws and regulations, conditions of participation, and other standards for contracted services.

C. **Contract Management Department Collaboration**. All Physician Agreements will be prepared, reviewed, approved, and administered (where applicable) in collaboration with the SVHMC Contract Management Department. Negotiation, support, and management of individual Physician Agreements can be completed by the individual responsible department.

D. **Chief Medical Officer Oversight**. All Physician Agreements s will be under the oversight and management of the Chief Medical Officer (CMO). The CMO will collaborate with the Chief Operating Officer (COO) or designee on all equipment and real estate related agreements involving Physicians.

E. **Legal Services**. All newly created Physician Agreements will be reviewed by District legal counsel. District legal counsel will collaborate with the CMO and contracting staff to draft and review template Physician Agreements. Access to District legal for the purposes of drafting and reviewing Physician Agreements shall be at the direction of the CMO.

F. **Document Management**. The current electronic contract database (MediTract) will serve as repository for Physician Agreements and related documents. Original Physician Agreements will be maintained on file in the Contract Management Department, under the direction of the CMO.

G. **Physician Qualifications**. SVHMC shall not enter into any Physician Agreement with a Physician who has been debarred, sanctioned or excluded from practice by any governmental agency or physician association, or who has been excluded from participation in a federal or state government program.

H. **Fair Market Value; Commercial Reasonableness**. In accordance with the SVHMC FAIR MARKET VALUE POLICY, the arrangements with Physicians under Physician Agreements will be at fair market value and will be commercially reasonable.

I. **Written Agreement**. Physician Agreements must be in writing, signed by all parties, and dated before the items or services are provided or payment is received. In addition the following requirements apply.

    1. **No Retroactive Agreements**. No Physician Agreement may be executed with a retroactive effective date, unless approved by District legal counsel. No Physician Agreement may be "backdated" to misrepresent the date it was executed. A Physician Agreement may be executed by the parties within thirty (30) days of the effective date stated in the Physician Agreement if there is documentation that the physician received the Physician Agreement on or before the effective date stated in the Physician Agreement (e.g., by way of email communication).

    2. **No Restrictions on Practice**. The Physician Agreement shall not restrict the Physician from establishing medical staff privileges or otherwise limit Physician's

access to any other health care facility.

3. **No Required Referrals**. The Physician Agreement shall not in any way condition the agreement or any payments under the agreement on referrals to SVHMC or any affiliate.
4. **Detailed Description of Services**. The Physician Agreement will describe the scope of services to be provided. If relevant, the Physician Agreement must specify the number of hours to be worked, stating the minimum number of hours for a Physician or providing a range or a maximum number of hours for an independent contractor.
5. **Term, Termination, and Renewal**
    a. **Minimum One-Year Term**. The Physician Agreement must be for a term of at least one (1) year and may not be longer than three (3) years, unless approved by the CMS after consultation with District legal counsel.
    b. **Termination without Cause**. The normal term of the Physician Agreement is one (1) or two (2) years "Initial Term." When a physician extends beyond the Initial Term, SVHMC should retain the ability to terminate the agreement without cause and without penalty on written notice of no longer than ninety (90) days at any time after the Initial Term. SVHMC may deviate from this policy only with the approval of the CMO after consultation with legal counsel.
    c. Termination within First Year. If the Physician Agreement is terminated for any reason within the first (1st) year, SVHMC may not enter into another arrangement with the same Physician for the same or similar services prior to the end of the initial one-year period on different compensation terms.
    d. Renewal. Consistent with the terms of the Physician Agreement and this Policy, renewal of a Physician Agreement may be by virtue of an automatic renewal provision, or by written and signed mutual agreement of the parties.

J. **Contract and Invoice Approval.** The CONTRACT APPROVAL MATRIX policy will be followed for final contract and invoice approval.

K. **Payment to Correct Party.** SVHMC will ensure that payments are made to the correct party, using the correct taxpayer identification number. When Physician Agreements are entered into with a corporate or partnership entity, payments must be made to that entity, and not to an individual Physician.

V. PROCEDURE

A. The following procedures align to the Board of Director's Contract Management Policy to establish a comprehensive process to 1) provide appropriate leadership and reporting oversight of the contract process, 2) provide leadership expectations in the contract management process and 3) provide guidelines for all aspects of the Contract Management Cycle. The Contract Management Cycle includes the following key Phases.

    1. Identification Phase

2. Research Phase
3. Contract Development Phase
4. Approval & Signature Phase
5. Implementation Phase
6. Invoicing/Payment Phase
7. Oversight Phase

B. This subsection summarizes the key procedures included within the Physician Services Contract Process regarding each of the Contract Cycle Phases. Completion of these phases will be documented with the Physician Contract Review/Worksheet required as part of the approval process (Attachment A). The exceptions to the below process are annotated in paragraph C of this section. The Contract Cycle Phases and procedures are:

1. **Identification Phase**. Identification of the need for a Physician Agreement and coordination of initiation of any Physician Agreement shall be under the direction of the CMO.
   In the case of a contemplated Physician Agreement with a Physician not currently on the Medical Staff, the Contract Management Department shall conduct a sanctions/exclusion assessment composed of the following elements (See Attachment B):
   a. Evaluate and document assessment of status from the FDA Debarment List at http://www.fda.gov/ICECI/EnforcementActions/FDADebarmentList/ucm2005408.htm
   b. Evaluate and document status from U.S. Department of State Individual and Organization Terrorist List at http://www.fbi.gov/wanted/wanted_terrorists and http://www.state.gov/j/ct/rls/other/des/123085.htm
   c. Evaluate and document status (for to include both the entity and each individual physician in case of group contracts) from System of Award (SAM) List of Excluded Parties located at https://www.sam.gov.
   d. Evaluate and document status with the Department of Health and Human Services (DHHS) Office of Inspector General Federal Healthcare Program List of Excluded Individuals/Entities (located at https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/compliance-actions-and-activities/fda-debarment-list-drug-product-applications)
   e. Evaluate and document status with Medi-Cal Suspended and Ineligible database (located at http://www.medi-cal.ca.gov/references.asp).
   f. Evaluate and document assessment of status with the FBI Wanted List at: https://www.fbi.gov/wanted/wanted_terrorists.
   g. Evaluate and document assessment of conflicts check via the CMS Open Payment site at https://www.cms.gov/openpayments. Indicate year/type/total payment/ownership.
   h. Evaluate and document assessment of California and other state medical

licensees.

i. The Contract Management Department will advise the CMO or designee of any adverse findings. The Contract Management Department shall upload the completed, dated, and signed Physician Sanctions Clearance Worksheet (Attachment B) into MediTract.

2. **Research Phase**. The CMO oversees determination of the type of compensation agreement.

~~1. Physician Professional Services Agreements (PSA)~~

~~2. Medical Director Agreements~~

~~3. Committee Participation Agreements~~

~~4. Hospital Call Agreements~~

~~5. Training/Education Agreements~~

~~6. Recruitment Agreements~~

~~7. District Clinic Agreements~~

~~8. Lease Agreements~~

~~9. Medical Staff Leadership Agreements~~

~~a. If there is not a template to support the specific Physician Agreement, the CMO or designee consult with the Contract Management Department and District Counsel.~~

~~b. Ensure the contract compensation is at fair market value and is commercially reasonable. Refer to the FAIR MARKET VALUE POLICY ("FMV").~~

~~c. Examine all other existing financial arrangements between the Physician and SVHMC and evaluate the proposed arrangement to ensure services are not double counted and Physician's workload is reasonable, and overall compensation is within fair market value.~~

a. Physician Professional Services Agreements (PSA)

b. Medical Director Agreements

c. Committee Participation Agreements

d. Hospital Call Agreements

e. Training/Education Agreements

f. Recruitment Agreements

g. District Clinic Agreements

h. Lease Agreements

i. Medical Staff Leadership Agreements

i. If there is not a template to support the specific Physician Agreement, the CMO or designee consult with the Contract

Management Department and District Counsel.

ii. Ensure the contract compensation is at fair market value and is commercially reasonable. Refer to the FAIR MARKET VALUE POLICY ("FMV").

iii. Examine all other existing financial arrangements between the Physician and SVHMC and evaluate the proposed arrangement to ensure services are not double counted and Physician's workload is reasonable, and overall compensation is within fair market value.

3. **Contract Development Phase**
    a. The CMO designee will collaborate with the Contract Management Department for all Physician Agreements. The Contract Management Department initiates a Physician Contract Review Worksheet and collects applicable supporting documents to ensure all process requirements are met before the Physician Agreement is released for signature.
    b. The Contract Management Department will facilitate coordination with District counsel to support successful Physician Agreement development with stakeholders.

4. **Approval & Signature Phase**
    a. Approval authority is defined in the Contract Approval Matrix Policy.
    b. Once final, the CMO or designee will coordinate execution of the Physician Agreement by all parties, provide the Physician with a copy of the fully executed Physician Agreement, file the original in the Contract Management Department, and upload the fully executed Physician Agreement and applicable supporting documents to MediTract. The Contract Management Department will review the uploaded documents, complete the Physician Contract Review Worksheet, and upload it to MediTract.
    c. Only trained staff shall have access to load such contracts.

5. **Implementation Phase.**
   The responsible SVHMC leader will communicate and initiate any required processes to ensure successful implementation of the Physician Agreement. Such processes may include education, collaboration with other departments or oversight controls.

6. **Oversight Phase.**
    a. The Contract Management Department will provide oversight of the electronic contract database (MediTract), establish reporting methodologies, and collaborate with contract owners and executive leadership to maintain compliance.
    b. The Audit and Compliance Department will collaborate with the Corporate Compliance and Audit Committee to establish appropriate internal controls related to Physician Contracting.

c. Contract owners will provide the Contract Management Department at least sixty (60) days' written notice of the planned commencement or renewal of any Physician Agreement. Notices of upcoming contract expirations will occur via the MediTract notification function.

d. Contracts providing clinical services must be integrated into the organization's Quality Assessment and Performance Improvement (QAPI) Program by the contract owner. The contract owner is responsible for consulting with the Quality Department to address this component.

e. In accordance with the hospital leadership and medical staff responsibility to evaluate and monitor contracted services against established performance expectations as well as pre-defined, established performance metrics that reflect basic principles of risk reduction, safety, staff competence and performance improvement, the contract owner will assist as appropriate to enable such evaluation and monitoring.

f. When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care.

C. **Procedure Exceptions**: Some Physician Agreements are researched, negotiated, approved and implemented in aggregate. Examples are Hospital Call Agreements and Education/Special Committee Participation Agreements.

1. The Physician Agreement template and contract FMV are reviewed and approved by the procedure noted above. The template is used to create all Hospital Call Agreements for the term identified in the Physician Agreement.
2. For any new Physician being added to the On Hospital Call Panel after the initial implementation of Hospital Call Agreements, the effective date is modified to the date in which the Physician is being added to the particular panel. The term of the contract cannot be for less than one (1) year.
3. A single Physician Contract Review Worksheet may be completed with the master template for use as support for all Physician Agreements. As Physician Agreements are signed during the approval process, the single completed Worksheet and supporting documentation are acceptable.

D. DOCUMENTATION

1. All contract activities will be documented and maintained according to SVHMC RECORDS RETENTION POLICY and applicable local department policies.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

~~VII. DOCUMENTATION~~

~~A. All contract activities will be documented and maintained according to SVHMC RECORDS RETENTION POLICY and applicable local department policies.~~

VIII. REFERENCES

A. Federal Anti-kickback Statute 42 U.S.C. § 1320a-7a(b)
B. Federal Food, Drug, and Cosmetic Act, 21 U.S.C. 335(a), (b)(1), and (b)(2)
C. ~~Health Information Technology for Economic and Clinical Health (HITECH) Act 2009.~~
D. ~~Internal Revenue Code 26 U.S.C. §162, §4958~~
E. Physician Self-Referral Law ("Stark Law") 42 U.S.C. § 1395nn; §411.350-389
F. ~~Terrorism Sanctions Regulations 31 U.S.C., Part 595~~
G. ~~Terrorism List Governments Sanctions Regulations 31 U.S.C. Part 596~~
H. ~~The Age Discrimination in Employment Act 1975 29 U.S.C. §621; §6101~~
I. ~~The Americans with Disability Act 1990, 42 U.S.C. §12101~~
J. The Joint Commission (2014). Hospital Accreditation Standards. Oakbrook Terrace, IL: Department of Publications and Education.
K. Title 45 – Public Welfare, §160.103, §164

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Natalie James: Contract Administrator	05/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14171009**

Last Approved	N/A
Last Revised	09/2023
Next Review	3 years after approval
Owner	Marisa Ceralde: Director Enterprise Population Health Management
Area	Administration

Prime/QIP Data Integrity / Review

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) leadership, management and staff, at all levels, must make a good faith effort to manage the risks that might undermine data integrity of the PRIME/QIP Program;

B. SVHMC must facilitate data integrity through a process of self-governance. We will make every attempt to prevent, deter, identify, and rectify any data integrity issues within their respective programs;

II. PURPOSE

A. This policy outlines the requirements and procedure for creating, updating and reviewing our Quality Improvement Program (QIP) formerly known as the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) data and PRIME/QIP specific dashboard.

III. DEFINITIONS

A. EMR: Electronic Medical Record

B. GUID: Global Unique Identifier is our equivalent to a master patient index. We have six disparate EMRs using different patient identifiers. A GUID identifies a single patient across all entities.

IV. GENERAL INFORMATION

A. SVHMC will ensure that PRIME data meet the following standards:

1. Attributable--establishing who performed an action and when;
2. Legible--recorded permanently in a durable medium, readable by others, with

traceable changes;

3. Contemporaneous--with activities recorded at the time they occur (when an activity is performed or information is obtained); and
4. Accurate--reflecting the true information;

B. SVHMC will retain applicable supporting documentation for a period of five (5) years after submission of Demonstration Year reports, and make such documentation available in case of an audit conducted by external parties;

C. SVHMC will document and retain records of all incentive payment amounts earned under PRIME/QIP, as well as clinical and quality improvement data for PRIME/QIP reports;

D. SVHMC will report to California Department of Healthcare Services (DHCS) within three (3) business days of discovery, any breach of these requirements that results in discrepancies from submitted PRIME/QIP quantitative or qualitative reports.

V. PROCEDURE

A. Data from Epic, e-MDs, FigMD, Standing Stone, Meditech, and APSEN EMR software are placed it into our PRIME/QIP specific SQL database.

B. Once in the SQL database, individual SQL code, created for each measure, is turned into a stored procedure.

C. Stored procedure script will be printed with a time and date stamp after initial creation, and anytime the script is updated or modified.

D. The stored procedure is set to run daily at 2am. After execution, it is matched with our GUID to identify PRIME/QIP patients meeting and not meeting each measure.

1. See Attachment A- **PRIME Population diagram**

E. The patient names and qualifying visits populate an interactive PRIME/QIP specific dashboard where users verifying data can click on a direct link to a patient's visit within Meditech.

F. A twenty percent sample or twenty (20) patient visits, whichever is less, will be reviewed after any update to a report is made. At a minimum, data will be reviewed quarterly.

G. Those conducting the vetting process will sign and date stamp a spreadsheet, listing the patients/accounts that they verified. In addition, supporting documentation (screen shots) with the sections proving measure was satisfied or not satisfied will be captured.

H. If an error in the report is identified, it will be brought to the attention of the PRIME/QIP data team to review and resolve, and the process will begin from Step 1.

I. We will review updates to the PRIME/QIP metric specifications when/if released, to ensure our custom coding reflects any changes. We will then repeat the vetting process outlined above.

VI. EDUCATION/TRAINING

A. Education and/or training is provided as needed

VII. REFERENCES

A. N/A

Attachments

A: Prime Population Diagram

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Marisa Ceralde: Director Enterprise Population Health Management	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13951416**

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

PTO Cash Out

I. POLICY STATEMENT:

A. N/A

II. PURPOSE:

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

III. GENERAL INFORMATION:

A. Cash-outs are restricted to the following categories:

1. **Elective Cash-Out**

   a. Employees may elect to cash out a minimum of sixteen (16) hours of PTO in the next calendar year ("the Cash Out Year"). Elections must be made in the year prior to the Cash Out Year ("the Election Year"). The maximum number of hours that can be cashed out is 100 percent of the PTO hours that the employee can accrue in the Cash Out Year if the employee works his or her FTE in the Cash Out Year.

   b. If an employee elects to have a cash-out, beginning on the January 1st pay period of the Cash Out Year, all hours accrued will be banked and held until the employee accrues the PTO hours requested in his or her cash-out election. Once the PTO hours elected for cash out are fully accrued, the Hospital will process the cash out. The same process shall apply to a second cash out, if elected, and will commence when the PTO hours set for the first elected cash out have been fully accrued.

c. The amount to be cashed out cannot be more than what has been accrued in the Cash Out Year as of the date of the cash out, regardless of the employee's PTO total balance.

d. To be eligible for an elective cash-out, employees must have a minimum of eighty (80) hours of PTO in their PTO bank as of December 31 the last pay period in the Election Year.

e. The employee may elect to receive no more than two cash-outs in a Cash Out Year. Once a cash-out has been elected, it is irrevocable.

f. The employee must make a new election for each calendar year.

g. Elections for cash-outs must be made using the Elective PTO Cash Out form ~~and must~~in accordance with annual program guidelines set by the hospital each year. No exceptions will be ~~made prior to December 31 the last pay period of the Election Year. No exceptions will be~~ made.

h. It is an employee's responsibility to allow enough PTO hours in their bank to cover holidays, vacation, sick days, and emergencies. An insufficient PTO balance may result in disciplinary action.

i. The Human Resources department will send communication to employees with dates for the elective PTO cash-out process each year.

2. **Hardship Cash-Out**

a. In compliance with IRS guidance on PTO cash-outs, employees will be allowed to cash out PTO in the event of an unforeseen financial emergency. An unforeseen financial emergency is one in which:

i. an employee can demonstrate s/he has a real financial emergency caused by an event beyond his/her control;

ii. it would result in serious financial hardship if the cash payment were not made; and

iii. the amount of cash payment is limited to the amount necessary to meet the emergency.

- At least 16 hours of accrued PTO must be cashed out at one time and the employee must be left with a balance of at least 40 hours in PTO accruals.
- The request for PTO cash out must be made on a PTO Cash Out Request Form and submitted, with substantiating documentation as outlined on the form, to the Human Resources department for approval.
- PTO may not be cashed out if the request is made in the same pay period that a disciplinary action (suspension) has occurred.

3. **Elective and Hardship Cash-Out Provisions**

a. No shift differential shall be paid on PTO cash outs.

b. The rate paid to the employee will be the employee's rate at the time of the actual cash-out.

c. A separate check will be issued, on the installment date/pay date(s) specified by the employee, along with the regular paycheck. There will be no handwritten checks or "rush" checks for PTO cash out.

d. See PTO and PTO Cash Out policies on the Hospital's intranet for more details.

IV. PROCEDURE:

A. All requests must be made by completing the appropriate Cash Out Request form. Both forms are available on the Hospital's ~~intranet~~Intranet under Human Resources/Forms.

B. Forms are to be sent to the Human Resources department to be reviewed. After review, the form will be sent to the Accounting/Payroll department for processing.

C. If transferring to a per diem position or terminating employment, all PTO hours will be cashed out as of the transfer or termination date.

D. If an employee does not have enough PTO hours accrued to fulfill the elected cash-out amount, all PTO hours accrued in the Cash Out Year will be paid out at the end of the Cash Out year.

E. ~~PAID TIME OFF (PTO) POLICY FOR NON-AFFILIATED EMPLOYEES (HR#820)~~

F. ~~PAID TIME OFF (PTO) POLICY FOR CNA EMPLOYEES (HR#918)~~

G. ~~PAID TIME OFF (PTO) POLICY FOR NUHW EMPLOYEES (HR#890)~~

H. ~~PAID TIME OFF (PTO) POLICY FOR LOCAL 39 EMPLOYEES (HR#5969)~~

V. EDUCATION/TRAINING:

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

VI. REFERENCES:

A. N/A

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending

Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Michelle Barnhart Childs: Chief Human Resources Officer	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13738125**

Last Approved	N/A
Last Revised	06/2022
Next Review	1 year after approval
Owner	Christianna Kearns: Senior Admin Director Cardiovascular,Pulmonary & S
Area	Scopes Of Service

Scope of Service: Cardiovascular Diagnostic and Treatment Units

I. SCOPE OF SERVICE

The Cardiovascular Diagnostic and Treatment Units support the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and has designed services to meet the needs and expectations of patients, families and the community.

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

II. GOALS

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

The goals of the Cardiovascular Diagnostic and Treatment Units are:

A. To provide monitoring and care of patients requiring cardiac diagnostic modalities to obtain information regarding cardiac function and status.

B. To provide comprehensive angiography, structural heart and electrophysiology services to inpatients and outpatients, including emergent and scheduled cases for diagnostic and therapeutic purposes.

C. To improve physiological status and optimize risk factor status; to improve functional independence of patients; to facilitate return to gainful employment or active retirement; to reduce the deconditioning effects of inactivity/sedentary lifestyle; to reduce risk factors for disease progression and future cardiac events; to improve management of other chronic disease states.

D. To perform cardiac diagnostic modalities to include, Echocardiograms, Pharmacological Stress Echocardiograms, Exercise Stress Echocardiograms, Vascular ultrasound, and Nuclear Myocardial Perfusion Stress testing (Exercise and Pharmacologic) adult outpatients in order to obtain information regarding their cardiac function and status.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

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

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

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

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

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

H. To monitor the Cardiovascular Diagnostic and Treatment Units function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Clinical:

The Cardiology Department provides care for infant, pediatric, adolescent, adult and geriatric patients. The Department provides care to patients with primary diagnoses including, but not limited to: Chest pain, Dyspnea, murmur Acute Myocardial Infarction, Pre-Post Open Heart Surgery, Congestive Heart Failure, Acute/ Chronic Renal Failure, Acute Respiratory Failures, Anoxic Brain Injury, Septicemia, Pre-Post Abdominal Surgery, Pre-Post Thoracic Surgery and Multiple Trauma.

The Cardiac Catheterization Laboratory provides care for adult and geriatric patients only. The Department provides care to patients with primary diagnoses including, but not limited to Coronary Artery Disease, Acute Myocardial Infarction, Pre-Post Open Heart Surgery, Congestive Heart Failure, valvular disease.

The Cardiac Rehabilitation Unit provides care for patients 18 years of age through geriatric. The Department provides care to patients with primary diagnoses including, but not limited to:

1. Myocardial Infarction* (w/in the preceding 12 months for Medicare)
2. Coronary artery bypass surgery*
3. Stable angina pectoris *
4. Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting*
5. Valve replacement or repair surgery*
6. Heart or heart-lung transplant*
7. Heart Failure*

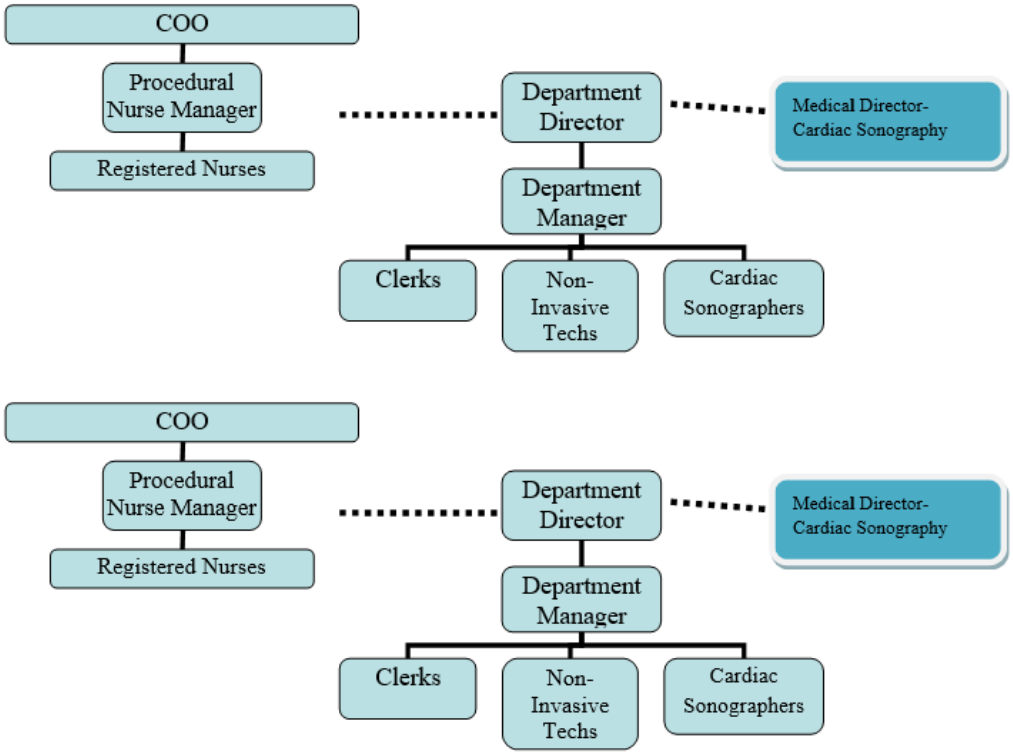
*Denotes Medicare eligible diagnosis

The Cardiovascular Diagnostic Outpatient Center provides care for adults (18 years and older) and geriatric patients.

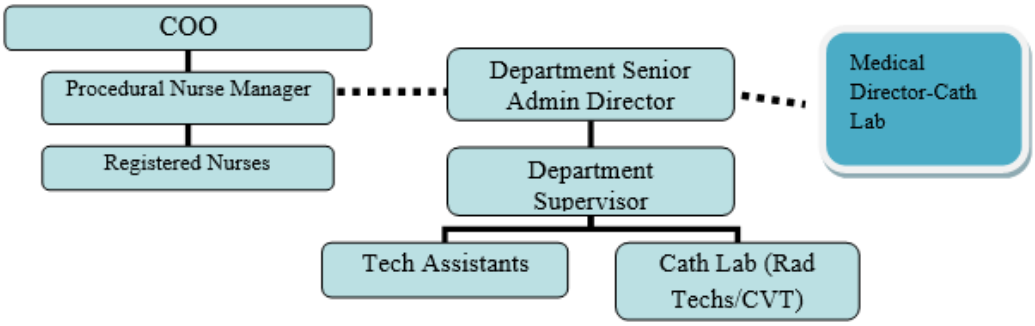
V. ORGANIZATION OF THE DEPARTMENT (include organizational chart)

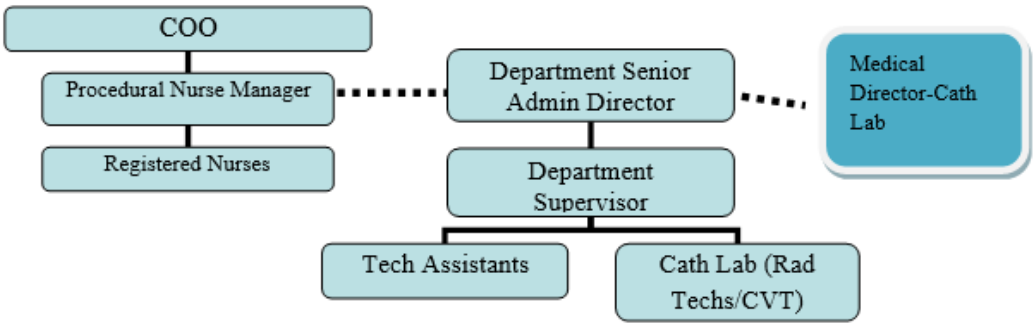
A. Hours of Operation:

- The Cardiology inpatient department provides services seven days a week, twenty-four hours a day.

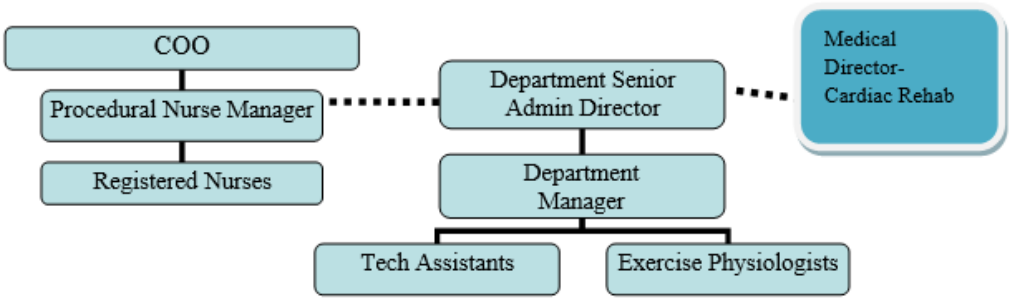


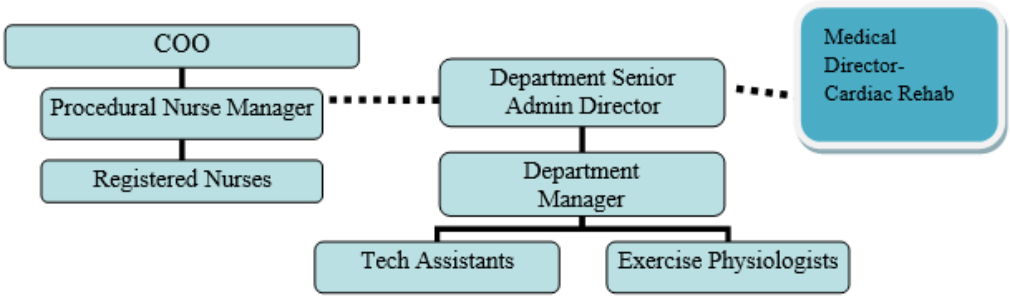
- The Cardiac Cath Lab provides services seven days a week, twenty-four hours a day.



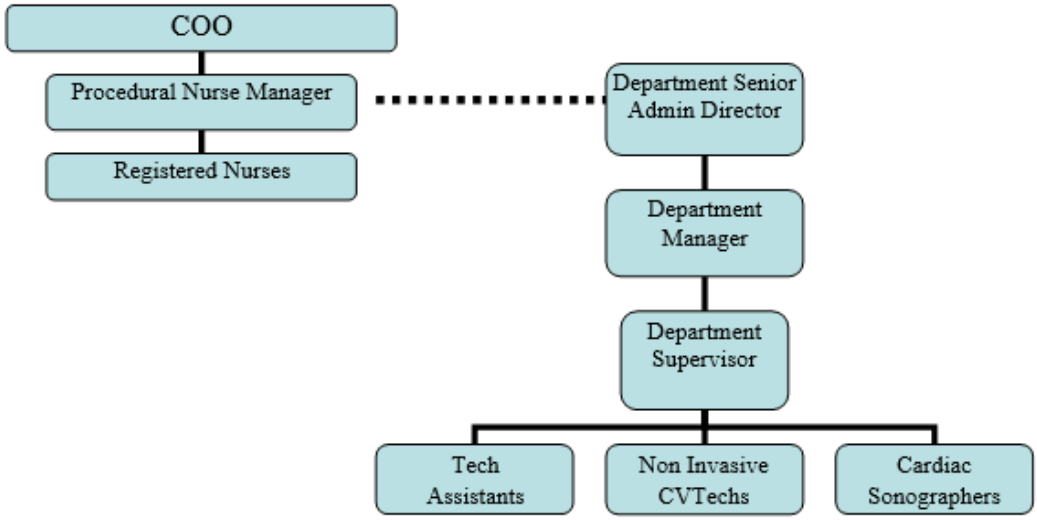


- Cardiac Rehabilitation provides services five (5) days a week 7:30 a.m. – 4:00 p.m.





- Cardiac Diagnostic Outpatient Center hours of operation are Monday through Friday 8 AM to 4:30 PM.



B. Location of departments:

- The Cardiology Inpatient Unit is located inside the hospital.
- The Cardiac Cath Lab is located on the first floor of the hospital.
- Cardiac Rehabilitation is located within the Cardiac Wellness Center in the Nathan J. Olivas Building.
- Cardiovascular Diagnostic Outpatient Center, located at 230 San Jose St, Suite B. A satellite location is also at the Ryan Ranch Center for Advanced Diagnostic Imaging (CADI), 5 Lower Ragsdale.

C. Admission, Discharge, Transfer Criteria (if applicable)

D. Major Services / Modalities of care include:

The Cardiology Department provides both portable and department-based diagnostic modalities which include ECG's, Signal-Averaged ECG's, Exercise/ Pharmacologic Stress Tests (Thallium, Routine treadmill, Dobutamine, Lexiscan and Adenosine), Holter Monitors (Application, Scanning, and Full-Disclosure Reports), Echocardiography Studies.

Cardiac Cath Lab diagnostic and interventional procedures include:

1. Right/left Coronary Angiography
2. Percutaneous Transluminal Coronary Angioplasty and Atherectomies/ Rotoblation
3. Intra-coronary Ultrasound
4. Temporary Pacemaker Insertions
5. Intra-aortic Balloon Pump Insertions
6. Myocardial Biopsies
7. Stent Insertions
8. Electrophysiology Studies
9. Implantable Cardioverter Defibrillator (ICD) Implants
10. Permanent Pacemaker Implants

11. Peripheral Angiograms, including Carotid Angiograms
12. Peripheral Interventions, including Carotid Stent Implantation
13. Ablations (Radio Frequency and Cryo)
14. Endovascular Aortic Stent Grafting, EVAR (Endovascular Aortic Repair)
15. Left Ventricular Assist device (Impella)
16. Transcatheter Aortic Valve Replacement (TAVR)
17. Left Atrial Appendage Occluder (LAAO) device placement
18. Transcatheter Edge to Edge Repair of the Mitral Valve (TEER)

Cardiac Rehabilitation procedures include: EKG, Blood glucose, Blood Pressure, pulse oximetry, monitored exercise.

The Cardiovascular Diagnostic Outpatient Center procedures performed include but not limited to: Echocardiograms, Vascular ultrasound, and Cardiac stress tests (Pharmacologic, exercise, nuclear Lexiscan and stress Echo).

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

The Cardiology Department care is delivered by a multidisciplinary team comprised of medical staff, including Medical Director of Cardiac Sonography, Cardiac Sonographers, Non-Invasive Cardiovascular techs, Registered Nurses and ancillary support according to the needs of the patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

The Senior Administrative Director, Chief Operating Officer and Manager assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

The Senior Administrative Director of the Unit is directly responsible to the Chief Operating Officer. It is the Manager duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Senior Administrative Director or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

Cardiac Cath Lab care is delivered by a multidisciplinary team comprised of medical staff, including Medical Director of Cath Lab, registered nurses, radiology technologists, cardiovascular technologists and ancillary support according to the needs of the patients. A registered nurse (RN) performs an admission assessment on patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

The Senior Administrative Director, Nursing Manager and Chief Operating Officer assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

The Senior Administrative Director of Cardiopulmonary Services is directly responsible to the Chief Operating Officer. It is the Sr. Administrative Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Sr.

Administrative Director; Nurses are under the guidance of the Chief Operating Officer. In the Sr. Administrative Director's absence, the position is filled by the Cardiology Manager and or Chief Operating Officer or their designee. It is his/her responsibility to carry out the duties of the Sr. Administrative Director in his/her absence.

Cardiac Rehabilitation care is delivered by a multidisciplinary team comprised of the Medical Director, Department Director, Nursing Staff, Exercise Physiology Staff, Registered Dietician and support staff according to the needs of the patients. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate referrals.

The Senior Administrative Director and Cardiology Manager assume twenty-four (24) hour responsibility for care provided on the Department.

The Senior Administrative Director of the Department is directly responsible to the Chief Operating Officer. It is the Cardiology Manager'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 Senior Administrative Director and Cardiology Manager. In the Manager's absence, the position is filled by the Senior Administrative Director or their designee. It is his/her responsibility to carry out the duties of the Supervisor in his/her absence.

The Cardiac Diagnostic Outpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients.

The Chief Operating Officer and Clinical Nurse Manager assume twenty-four (24) hour responsibility for nursing care provided within each department. It is the Manager's duty to attend all administrative and technical functions within the department. All Nursing personnel within the department are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Chief Operating Officer or Nursing Leader on call or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

The Senior Administrative Director and Cardiology Supervisor assume twenty-four hour responsibility for all non-nursing personnel and care within the department. The Senior Administrative Director is directly responsible to the Chief Operating Officer. It is the Cardiology Supervisor's duty to attend all administrative and technical functions within the department. All Non-nursing personnel within the department are under the guidance and direction of the Cardiology Supervisor. In the Director's absence, the position is filled by the Cardiology Supervisor or designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF (applicable to department)

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

A. Licensure / Certifications:

The basic requirements for ***Registered Nurses*** in the Cardiology Department include:

1. Current state licensure
2. Current BLS (Basic Life Support)
3. Current ACLS (Advanced Cardiac Life Support)
4. CCRN Certification preferred (Critical Care Registered Nurse)
5. TNCC preferred (Trauma Nursing Core Course)
6. Completion of an approved Critical Care Course or equivalent experience
7. Completion of competency-based orientation
8. Completion of annual competency

The basic requirements for ***Cardiac Sonographers*** in the Cardiology Department include:

1. Current registry (RDCS or RCS) (Registered Diagnostic Cardiac Sonographer or Registered Cardiac Sonographer)
2. Current BLS (Basic Life Support)

The basic requirements for ***Non-Invasive Cardiovascular*** *Tech* in the Cardiology Department include:

1. Certificate of training or EKG course
2. Current BLS (Basic Life Support)

The basic requirements for ***Registered Nurses*** in the Cardiac Cath Lab include:

1. Current state licensure
2. Current BLS (Basic Life Support)
3. Current ACLS (Advanced Cardiac Life Support)
4. Completion of competency based orientation
5. Completion of annual competencies

The basic requirements for ***Certified Radiology Technicians (CRT)*** in the Cardiac Cath Lab include:

1. Current state licensure (including fluoroscopy licensure)
2. Current BLS (Basic Life Support)
3. Completion of competency based orientation
4. Completion of annual competencies

The basic requirements for ***Cardiovascular Technicians (CVT)*** in the Cardiac Cath Lab include:

1. Program certification
2. Current BLS
3. Completion of competencies

The basic requirements for ***Registered Nurses*** in the Cardiac Rehabilitation Unit include:

1. Current state licensure
2. Current ACLS (Advanced Cardiac Life Support)
3. Current BLS (Basic Life Support)
4. CCRP preferred (Certified Cardiac Rehab Professional)
5. Completion of competency based orientation
6. Completion of annual competencies

The basic requirements for the ***Clinical Exercise Physiologist*** in the Cardiac Rehabilitation Unit include:

1. Current ACLS preferred (Advanced Cardiac Life Support)
2. RCEP preferred (Registered Clinical Exercise Physiologist)
3. CEP preferred (Clinical Exercise Physiologist)
4. Current BLS (Basic Life Support)
5. Completion of competency based orientation
6. Completion of annual competencies

The basic requirements for the ***Registered Dietitian*** in the Cardiac Rehabilitation Unit include:

1. Registered Dietitian certification
2. Completion of competency based orientation
3. Completion of annual competencies

The basic requirements for ***Registered Nurses*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current state licensure
2. Current BLS (Basic Life Support)
3. Current ACLS (Advanced Cardiac Life Support)
4. CCRN Certification preferred (Critical Care Registered Nurse)
5. Completion of an approved Critical care Course or equivalent experience
6. Completion of competency-based orientation
7. Completion of annual education

The basic requirements for ***Cardiovascular Sonographers*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current RDCS and or RVT (Registered Diagnostic Cardiac Sonographer)
2. Current BLS (Basic Life Support)
3. Completion of competency-based orientation

4. Completion of annual competency

The basic requirements for ***Tech Assistants*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current BLS (Basic Life Support)
2. Completion of competency-based orientation
3. Completion of annual competency
4. Completion of Tech assistant competency

The basic requirements for ***Non-Invasive Cardiovascular Techs*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current BLS (Basic Life Support)
2. Completion of competency-based orientation
3. Completion of annual competency

The basic requirements for ***Nuclear Medicine Technologists*** in the Cardiovascular Diagnostic Outpatient Center include:

1. Current state licensure (CTNM) (Certified Technologist Nuclear Medicine)
2. Current national licensure (ARRT (N)), and/ or (NMTCB) (American Registry of Radiologic Technologists and/or (Nuclear Medicine Technology Certification Board)
3. Completion of competency based orientation
4. Completion of annual competencies
5. Current BLS (Basic Life Support)

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, and speakers are scheduled for staff on occasion. Other internal and external continuing education opportunities are communicated to staff members.

C. Identification of Educational Needs:

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

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

D. Continuing Education:

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The units are 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. *In the event staffing requirements cannot be met, this department will meet staffing requirements by utilizing the on-call system, registry and per diem personnel.*

General Staffing Plan:

Staffing is based on patient volume and acuity.

The Cardiology Department assignments are made by the Manager based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available.

The Cardiac Cath lab assignments are made by the Sr. Administrative Director and Cath Lab Supervisor based on scheduled procedures and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. The RN to patient ratio is one RN

per patient. On call staff is composed of a team of three, including at least one (1) RN and two (2) additional staff which may be a CRT or CVT.

Cardiac Rehabilitation unit assignments are made by the Cardiology Manager based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available. A minimum of 2 trained staff members will be present in the gym during exercise therapy and one of the staff present must be an RN with ACLS certification.

Cardiovascular Diagnostic Outpatient Center assignments are made by the department Director and/or Supervisor based on acuity and needs of the patients, technology involved, competencies of the staff, the degree of supervision required, and the level of supervision available.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

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

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

activities and quality control activities.

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

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

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

Attachments

Department Senior Admin Director

Medical Director- Cardiac Rehab

Medical Director- Cardiac Sonography

Medical Director-Cath Lab

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	06/2023
Policy Owner	Christianna Kearns: Senior Admin Director Cardiovascular,Pulmonary & S	05/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14206077**

Last Approved	N/A
Last Revised	01/2022
Next Review	1 year after approval
Owner	Troy Scott: Director Case Management
Area	Scopes Of Service

Scope of Service: Case Management

I. SCOPE OF SERVICE

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

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

II. GOALS

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

The goals of Case Management are to:

A. Realize desired patient outcome by assessing, planning and delivering the case management and social work services and by brokering services across the health care continuum, in order to assure patient centered quality care, reduce fragmentation and costs.

B. The foundation for effective case management services, provided by registered nurses, social workers, and assistive personnel includes patient advocacy, care coordination, education, transition management and utilization management.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

B. To support the Department of Nursing objectives.

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

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

E. 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.

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

G. To provide high level medical and nursing management with a focus on a collaborative, multi-disciplinary approach to minimize the negative physical and psychological effects of disease processes and surgical interventions through patient/significant other education and to restore the patient to as high a level of wellness as possible.

H. To provide appropriate staff orientation and development.

I. To monitor Case Management function, staff performance, and care / service for quality management and continuous quality improvement.

J. To provide information via lectures and printed material to health care professionals and the general public.

K. If not covered by SVHMC's policies, Case Management follows guidelines as outlined by the American Case Management Association, (ACMAweb.org), the Case management Society of America (CMSA.org).

IV. POPULATION SERVED

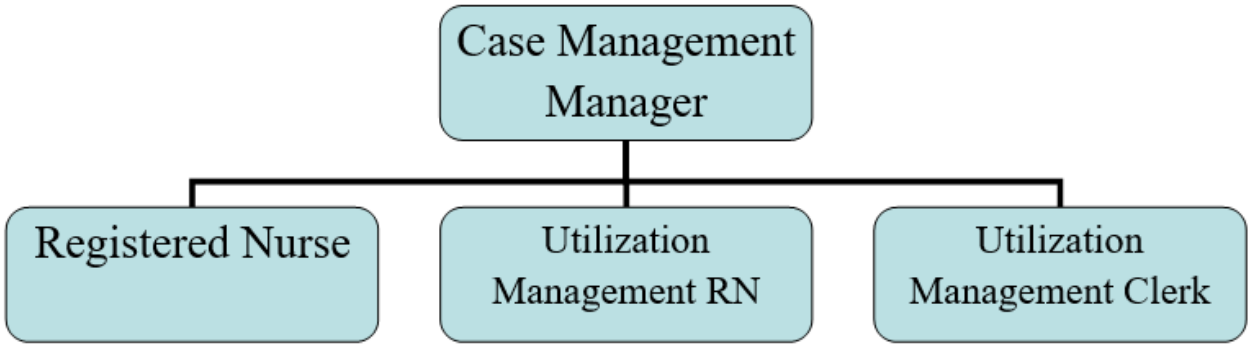
Clinical:

Case Management provides care for infant, pediatric, adolescent, adult and geriatric patients with all diagnoses.

Non-Clinical:

Case Management provides services including but not limited to:

V. ORGANIZATION OF THE DEPARTMENT



A. Hours of Operation
The Unit/Department provides services 7 days a week, 24 hours a day.

B. Location of department (s) - offices are located on every floor.

C. Admission, Discharge, Transfer Criteria (if applicable)- refer to DISCHARGE/TRANSITION PLANNING GUIDELINES

D. Major Services / Modalities of care may include:
Case Management provides care / services to patients with all diagnoses.

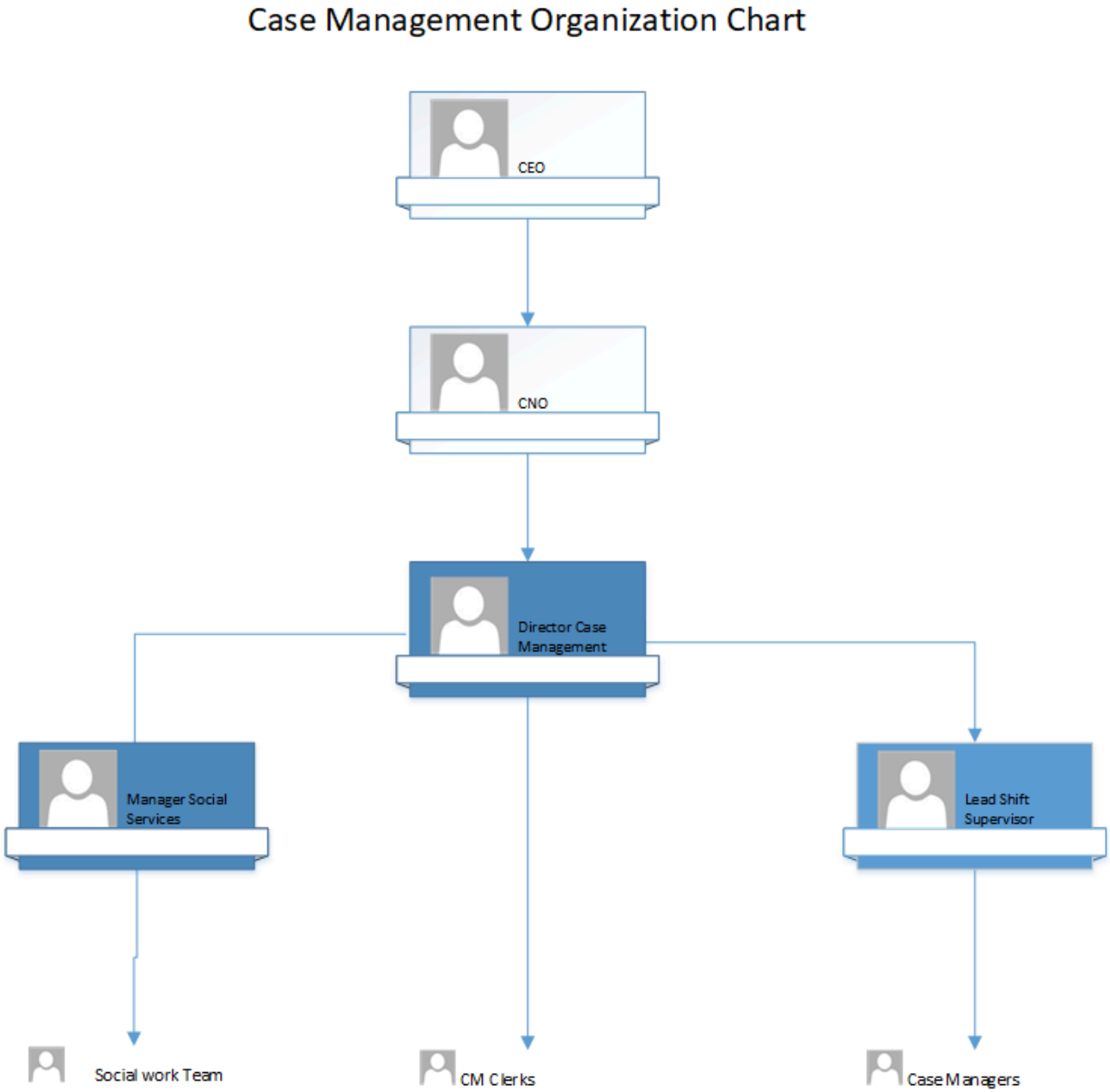
VI. DEFINITION OF PRACTICE AND ROLE IN MULTIDISCIPLINARY CARE /SERVICE

A. Case management services are provided by a multidisciplinary team comprised of registered nurses, social workers, and assistive personnel including patient advocacy, care coordination, education, transition management and utilization management. Additional services are provided through appropriate referrals.

B. The Director or designee assume twenty-four (24) hour responsibility for case management services.

C. The Director of the Unit is directly responsible to the Chief Financial Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by 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 patient care services are licensed or registered (according to applicable state law and regulation) and have the appropriate training and competence.

A. Licensure / Certifications:

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

1. Current state licensure
2. Current BLS

3. Completion of competency-based orientation
4. Completion of annual competency

The basic requirements for ***Licensed Social Workers*** include:

1. Current state licensure
2. Completion of competency-based orientation

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

General Staffing Plan:

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

In the event of a severe emergency, the minimum amount of staff required to safely operate this unit is: There is no minimum for Case management.

IX. EVIDENCED BASED STANDARDS

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

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

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

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

X. CONTRACTED SERVICES

A. N/A

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Attachments

Image 1

Organization of the Department

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Troy Scott: Director Case Management	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **14097437**

Last Approved	N/A	Owner	Agnes Lalata: Director Medical/ Surgical Services
Last Revised	09/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Medical Surgical Services

I. SCOPE OF SERVICE

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

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

II. GOALS

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

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

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

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

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

D. To support the provision of high quality service with a focus on a collaborative, multi-

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

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

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

H. To monitor the Medical Surgical Unit function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Medical Surgical Services provides care for adult and geriatric patients.

V. ORGANIZATION OF THE DEPARTMENT

(Nursing Organizational Chart for Nursing)

A. Hours of Operation:

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

B. Location of departments:

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

C. Major Services / Modalities of care may include:

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

Modalities may include:

- Wound care
- Peripheral and central line management
- Management of patients w/ CVA.

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

Modalities may include:

- Continuous oxygen monitoring

- Traction
- Cooling therapy
- Specialized pain management

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

Modalities may include:

- Chemotherapy
- Transfusions
- Pain management
- Palliative and end-of-life care
- Medical/Surgical Oncology Interventions
- Bone Marrow Aspirations
- Transfusions
- Management Of Neutropenic Patients

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

A. The inpatient care is delivered by a multidisciplinary team comprised of medical staff, registered nurses and ancillary support according to the needs of the patients. A registered nurse (RN) performs an admission assessment on patients within two (2) hour of admission. The RN selects and initiates the nursing care plans within the shift of admission and updates as indicated. Services are provided based upon patient assessments, patient and/or family preferences, plans of care and medical staff orders. Other services are provided through appropriate.

B. The Director and Clinical Manager(s) assume twenty-four (24) hour responsibility for nursing care provided on the Unit.

C. The Director of the Unit is directly responsible to the Chief Nursing Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by the Manager or Nursing Leader on call or their designee. It is his/her responsibility to carry out the duties of the Director in his/her absence.

VII. REQUIREMENTS FOR STAFF (applicable to department)

All individuals who provide patient care services are licensed or registered (according to applicable state

law and regulation) and have the appropriate training and competence. The Unit follows guidelines of national, state and local regulatory bodies. Standards of practices are consistent with BLS and other nationally recognized standards of care.

A. Licensure / Certifications:

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

1. Current state licensure
2. Current BLS
3. Completion of competency-based orientation
4. Completion of annual competency
5. Medical Surgical Nursing Certification preferred

The basic requirements for ***Registered Nurses in the Ortho Neuro Spine Unit*** include:

1. Current state licensure
2. Current BLS
3. Completion of competency-based orientation
4. Completion of orthopedic patient care competency
5. Completion of annual competency
6. Orthopedic Nursing certification preferred.

The basic requirements for ***Registered Nurses in the Comprehensive Cancer Center*** include:

1. Current state licensure
2. Current BLS
3. Chemotherapy/Biotherapy certification required
4. Completion of competency-based orientation
5. Completion of annual competencies
6. Oncology certified nurse preferred

The basic requirements for ***Certified Nursing Assistants*** include:

1. Current state licensure
2. Current BLS
3. Completion of competency-based orientation
4. Completion of annual competency

The basic requirements for ***Unit Assistants*** include:

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

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

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

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

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

D. Continuing Education

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

VIII. STAFFING PLAN

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

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

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

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

IX. EVIDENCED BASED STANDARDS

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

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

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

- In a manner that maximizes the efficient use of financial and human resources.

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

X. CONTRACTED SERVICES

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

Dialysis services are managed through the Electronic Tracking system.

XI. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

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

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

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Policy Owner	Agnes Lalata: Director Medical/Surgical Services	07/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13677586**

Last Approved	N/A
Last Revised	09/2023
Next Review	1 year after approval
Owner	Christianna Kearns: Senior Admin Director Cardiovascular,Pulmonary & S
Area	Scopes Of Service

Scope of Service: Respiratory, Neurodiagnostics and Sleep Medicine

I. SCOPE OF SERVICE

The Respiratory Care, Neurodiagnostics and Sleep Medicine Departments support the Mission, Vision, Values and Strategic Plan of Salinas Valley Health Medical Center (SVHMC) and have designed services to meet the needs and expectations of patients, families and the community.

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

II. GOALS

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

The goals of Respiratory Care, Neurodiagnostics and Sleep Medicine Departments are:

1. To provide therapeutic, diagnostic and educational modalities to inpatients and outpatients of all acuity levels and all age groups.
2. To provide comprehensive diagnostic testing for Neurodiagnostic and Sleep Medicine Department inpatients and outpatients, in a manner that is both cost effective and patient care oriented.
3. To provide comprehensive diagnostic testing for Neurology, sleep disorder patients and newborn hearing screening, for inpatients and outpatients of all ages, in a manner that is both cost effective and patient care oriented.

III. DEPARTMENT OBJECTIVES

A. To support SVHMC objectives.

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

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

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

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

F. To evaluate staff performance on an ongoing basis.

G. To provide appropriate staff orientation and development.

H. To monitor Respiratory, Neurodiagnostics and Sleep Medicine Departments function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

Respiratory Care provides services for the following departments:

1. All Acute Inpatient Services –including Emergency Department, Pulmonary Function Testing
2. All Outpatient Services provided under SVHMC
3. Community Education
4. Pulmonary Rehabilitation

Neurodiagnostics and Sleep Medicine Departments provide care for the following patient population in the inpatient and outpatient setting.

1. Sleep Medicine- ~~male and female~~ patients 6-106 years of age.
2. Neurodiagnostics (AABR) newborns
3. Neurodiagnostics (EEG) ~~male and female~~ patients of all ages.

Respiratory Care provides care for infant, pediatric, adolescent, adult and geriatric patients (edit as necessary).

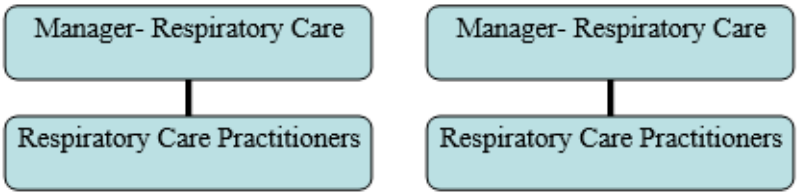
Sleep Medicine patient population consists of ~~male and female~~ patients of all age groups (neonates through geriatrics). Services are provided to outpatients and inpatients of all acuity levels.

ORGANIZATION OF THE DEPARTMENT

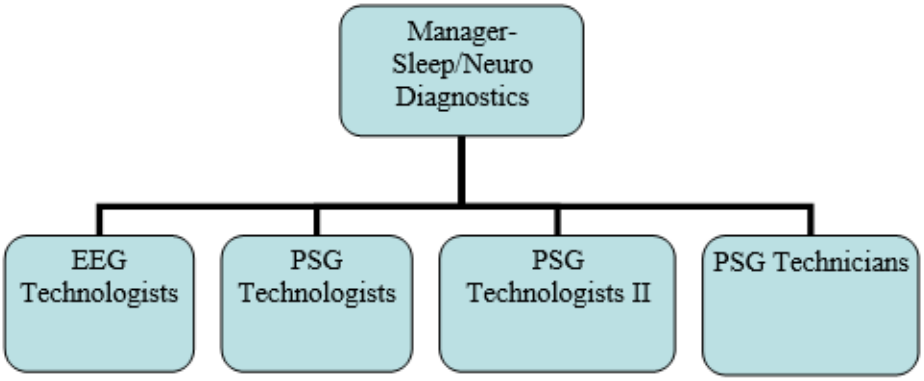
A. Hours of Operation

1. The Respiratory Care Neurodiagnostics and Sleep Medicine Department provides services Twenty-four (24) hours/day; 365 days/year. The unit consists of one (1) pulmonary function lab and (2) offices and storage rooms. Community educational services provided include COPD (Chronic Obstructive Pulmonary Disease) and Asthma

Programs. Most services are provided for inpatients at the bedside.



2. Neurodiagnostics-EEG operates nine (9) hours, five (5) days per week for both inpatients and outpatients.
3. EEG operates nine (9) hours, five (5) days per week for both inpatients and outpatients.
4. Sleep Disorder Dept. operates twelve (12) hours, seven (7) nights per week for testing and eight (8) hours, M-F for daily operations. Sleep Disorder Lab operate twelve (24) hours, seven (7) days per week for scheduled outpatient.
5. Newborn hearing screening operates 8 hours, seven (7) days per week as needed for both inpatients and outpatients
6. Neurodiagnostics- AABR (newborn hearing) operates eight (8) hours, seven (7) days per week as needed for inpatients and outpatients.



B. Location of departments:
Inpatient EEG and newborn hearing testing is performed at patient bedside.
Outpatient EEG testing is performed at offsite sleep center
At 120 Wilgart Way Salinas, CA 93901

The off-site Sleep Center is a (10) bed center located at 120 Wilgart Way.

C. Admission Discharge, Transfer Criteria (if applicable)
This is an Outpatient/Ambulatory department where patients have lifetime outpatient accounts. Patients receive treatment and are "arrived" for their appointment and "departed" after treatment. If the patient requires a higher level of care 911 is called and patient is transferred to the Emergency Department.

D. Major Services / Modalities of care include:
Respiratory Care Services are provided based upon patient assessments, plans of care and medical staff orders. Therapeutic, diagnostic, educational, palliative and lifesaving modalities provided include:

1. Medication Nebulizer Treatments
2. Medication Nebulizer/Heated Aerosol Treatments
3. Metered Dose Inhaler Administration
4. Metaneb Treatments
5. Oxygen Therapy
6. Humidity Therapy
7. Postural Drainage/Chest Percussion/IPV
8. Nasotracheal/Endotracheal Suctioning
9. Code Blue/CPR Services/ RRT (Rapid Response Team)
10. BiPAP
11. CPAP
12. Pulmonary Function Studies (PFT Lab)
13. Pulmonary Function Screens (Bedside)
14. Stat ECG (after hours when ECG tech not in house)
15. Mechanical Ventilator Support / Management
16. Bedside Bronchscopy (Assist in ICU / CCU)
17. Transport Ventilator (Adults) Internal / External
18. Bronchial Hygiene
19. Patient and Community Education
20. COPD (Chronic Obstructive Pulmonary Disease) Education Program
21. Asthma Education Programs
22. Point-of-Care Testing/Arterial Blood Gas Collection and Analysis
23. Arterial catheterization
24. Intubation
25. Metabolic studies

Patient Education (In-House)

1. Asthma
2. Acute Bronchitis
3. COPD (Chronic Obstructive Pulmonary Disease)
4. Continuous Positive Airway Pressure (CPAP)
5. Metered Dose Inhaler
6. Peak Flow Meter
7. Smoking Cessation
8. Pulmonary Rehabilitation
9. Other Respiratory education as needed by patient

Level III NICU

1. Medication Nebulizer Treatments
2. Ventilatory Support / Management
3. Surfactant Therapy
4. Intubation
5. High Risk C-Sections
6. Oxygen Therapy
7. Chest Percussion
8. NICU Transport
9. Systems, services and patient care are evaluated to determine their timeliness, appropriateness, clinical necessity, and the extent to which the level of care or services provided meets the patients' needs through any one or all of the following quality improvement practices:
10. Multidisciplinary Performance Improvement Teams

Evaluation of Services:

1. EEG/Awake
2. EEG/Asleep
3. Evoked Potentials:, VEP
4. AABR, newborn hearing screening is performed to detect hearing losses in newborns so that follow-up hearing intervention can be performed
5. Attended PSG
6. Positive Airway Pressure Titration
7. Supplemental O2

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

A. The Respiratory Care unit consists of one (1) pulmonary function lab and (2) offices and storage rooms. The client population consists of male/female patients of all age groups (neonates through geriatric). Most services are provided to the patient at bedside. Services are provided to outpatients and inpatients. Community educational services provided include COPD (Chronic Obstructive Pulmonary Disease) and Asthma Programs.

B. The Respiratory Care treatment team is comprised of either registered or certified respiratory care practitioners licensed by the State of California, nursing staff, medical staff and support services according to the needs of the patient.

C. The Senior Administrative Director and Manager assume twenty-four (24) hour responsibility for respiratory care provided at SVHMC. The leaders of this area are directly responsible to the Chief Operating Officer with oversight also provided by the Medical Director and Laboratory Director. It is the Senior Administrative Director's or their designee duty to attend all administrative and technical

functions within the department. All personnel within the department are under the guidance and direction of the Manager. In the Manager's absence, the position is filled by the Senior Administrative Director or their designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

D. The Neurodiagnostic Department provides diagnostic testing for epilepsy, head injuries, mental and maturation delay, spinal cord injuries, and neurology disorders/diseases. Portable EEG testing is performed at the bedside for suspected electrical cerebral silence diagnosis. Evoked potential studies test peripheral nerve conductivity, spinal nerve conductivity and cerebral cortex diseases and injuries.

E. The Sleep Disorders Center performs diagnostic testing for a variety of sleep disorders (obstructive sleep apnea, central sleep apnea, restless leg syndrome, hypersomnias, narcolepsy, and other diagnoses). The center also performs therapeutic studies to treat obstructive sleep apnea, central apnea, and obesity-hypoventilation syndrome with positive pressure ventilation.

F. Sleep Medicine Outpatient Care is delivered by a multidisciplinary team comprised of medical staff and ancillary support according to the needs of the patients. The Sleep Medicine Center Manager and Supervisor assumes twenty-four hour responsibility for all personnel and care within the department. The Manager is directly responsible to the Senior Administrative Director of Cardiopulmonary services. It is the Manager's duty to attend all administrative and technical functions within the department. In the Manager's absence, the position is filled by the Senior Administrative Director of Cardiopulmonary services or designee. It is his/her responsibility to carry out the duties of the Manager in his/her absence.

G. AABR/EEG: A multidisciplinary team consisting of one (1) Neurodiagnostics Manager, two (2) EEG techs, and two (2) Neurodiagnostic Assistants.

H. POLYSOMNOGRAPHY: A multidisciplinary team consisting of one (1) Sleep Center ~~Manager~~Supervisor who is a Registered Sleep Tech, and/or Respiratory Care Practitioner, six (6) Registered Polysomnography Techs, and one (1) Certified Polysomnography Tech.1:1 patients: Certain patients will be flagged by management as 1:1 patients. This means that under normal circumstances, the tech assigned to this patient will only have this one patient. The patient populations most likely to be flagged in this manner are: Patients with severe developmental delay, patients under eight years old, patients with tracheotomies, patients with neuromuscular disorders, and certain types of non-ambulatory patients.

    - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged 1:1 that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

I. High Acuity Patients: Certain patients will be flagged by management as high acuity patients. This means that under normal circumstances, it is preferable to not have the tech working alone on this particular shift. The types of patients most likely to be flagged as high acuity are from the patient populations listed above in the 1:1 section, as well as patients with severe mood disorders, patients with severe anxiety, and patients at high risk for coronary events. High acuity flagging differs from 1:1 flagging in that a tech assigned a high acuity patient will not necessarily have just one patient.

    - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged high acuity that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the ~~manager~~supervisor should you

have any questions.

VI. REQUIREMENTS FOR STAFF

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

A. Licensure / Certifications:

The basic requirements for ***Respiratory Care Practitioners*** include:

1. License by the State of California and
2. Certified or Registered through the NBRC (National Board of Respiratory Care)
3. Current BCLS
4. Current ACLS
5. Current NRP

The basic requirements for ***Supervisor*** include:

1. Current BLS
2. Registered Polysomnographic Technologist (RPSGT) and/or Registered Respiratory Therapist (RRT) Certification
3. Completion of competency based orientation
4. Completion of annual education

The basic requirements for ~~***Manager***~~***Sleep Technologists*** include:

1. Current BLS
2. ~~Registered Polysomnographic Technologist (RPSGT) and/or Registered Respiratory Therapist (RRT) Certification~~
3. Completion of competency based orientation
4. Completion of annual education

The basic requirements for ~~***Sleep Technologists***~~ ***Electroencephalography (EEG) Techs and Automated Auditory Brain Stem Response (AABR) Techs*** include:

1. Current BLS
2. Completion of competency based orientation
3. Completion of annual education

~~The basic requirements for ***Electroencephalography (EEG) Techs and Automated Auditory Brain Stem Response (AABR) Techs*** include:~~

1. Current BLS

2. Completion of competency based orientation
3. Completion of annual education

Education and training of PSG technician II, RPSG Technologist II or Sleep Center Specialist is provided through department orientation and/or annual competencies. All sleep technicians and technologists are required to have a minimum of 10 continuing education hours a year, or 50 per 5 years. Any new technicians/technologists to the center are required to reach 30 CE units in their first 3 years. CE units can be obtained from conferences sponsored by AASM, AAST, BRPT, RCB, or some other approved legislative body.

B. Competency

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

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

C. Identification of Educational Needs

Staff educational needs are identified utilizing a variety of input:

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

D. Continuing Education

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

VII. 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:

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

General Staffing Plan for Sleep Medicine Center and Neurodiagnostics

- An onsite staffing ratio of 2:1 is maintained during patient care hours.
- Flex Staffing a) a sleep technologists to patient ratio of 1:2 is the minimum for all sleep studies.
- Explanations: When units of service decrease, staff is canceled. When units of service increase, hours are rotated to cover testing. Outpatients can be rescheduled. Overtime is used only when necessary.
- AABR/EEG: A multidisciplinary team consisting of one (1) Neurodiagnostics Manager, (1) Supervisor, two (2) EEG techs, and two (2) Neurodiagnostic Assistants.
- POLYSOMNOGRAPHY: A multidisciplinary team consisting of one (1) Sleep Center ~~Manager~~Supervisor who is a Registered Sleep Tech, and/or Respiratory Care Practitioner, six (~~6~~7) Registered Polysomnography Techs, and one (1) Certified Polysomnography Tech.1:1 patients: Certain patients will be flagged by management as 1:1 patients. This means that under normal circumstances, the tech assigned to this patient will only have this one patient. The patient populations most likely to be flagged in this manner are: Patients with severe developmental delay, patients under eight years old, patients with tracheotomies, patients with neuromuscular disorders, and certain types of non-ambulatory patients.
    - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged 1:1 that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

- High Acuity Patients: Certain patients will be flagged by management as high acuity patients. This means that under normal circumstances, it is preferable to not have the tech working alone on this particular shift. The types of patients most likely to be flagged as high acuity are from the patient populations listed above in the 1:1 section, as well as patients with severe mood disorders, patients with severe anxiety, and patients at high risk for coronary events. High acuity flagging differs from 1:1 flagging in that a tech assigned a high acuity patient will not necessarily have just one patient.
    - NOTE: This policy is to be used as a guide in staffing. There may be instances when a patient will be flagged high acuity that does not have any of the above listed conditions, and there may also be instances where a patient will not be flagged that have any or all of the above listed conditions. Please consult with the manager should you have any questions

The Neurodiagnostics and Sleep Center staff consists of a Manager, Supervisor, EEG technicians, PSG technologists, PSG Technologists II (possesses a Respiratory Care license) and PSG Technicians.

- A sleep technologists to patient ratio can be 1:1, 1:2 or 1:3 depending on prescreened acuity/age of patient. 1:2 is the minimum for all sleep studies.
- An onsite staffing ratio of 2:1 is maintained during patient care hours.
- Flex Staffing Explanations: When units of service decrease, staff is canceled. When units of service increase, hours are rotated to cover testing. Outpatients can be rescheduled. Overtime is used only when necessary.

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

VIII. EVIDENCED BASED STANDARDS

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

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

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

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

IX. CONTRACTED SERVICES

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

X. PERFORMANCE IMPROVEMENT AND PATIENT SAFETY

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

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

In addition to the overall SVHMC Strategic initiatives and in concert with the Quality Improvement Plan and the Quality Oversight Structure Respiratory Care, Neurodiagnostics and Sleep Medicine Departments 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

Manager- Respiratory Care

Supervisor- Sleep/Neuro Diagnostics

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending

Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Owner	Christianna Kearns: Senior Admin Director Cardiovascular,Pulmonary & S	05/2023

Standards

No standards are associated with this document

Status Pending PolicyStat ID 13075081

Last Approved	N/A	Owner	Kimberly De Serpa: Manager Social Work
Last Revised	09/2023	Area	Scopes Of Service
Next Review	1 year after approval		

Scope of Service: Social Services

I. SCOPE OF SERVICE

Social Services 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 Social Services is to enhance patient services and health programs that help Salinas Valley Memorial Healthcare System remain a leading provider of medical care. The goal of Social Services is to ensure that all customers will receive high quality care / service in the most expedient and professional manner possible.~~

The purpose of Social Services is to enhance care by providing counseling support and services to vulnerable patients and their families. SVHMC remains a leading provider of medical care and this includes our commitment to the whole person, mind, body and spirit. The goal of Social Services is to help people by arranging services that mitigate risk, ensuring safety, fostering independence, and enhancing health and wellness.

II. GOALS

In addition to the overall ~~SVMHS~~SVHMC goals and objectives, the Social Services ~~unit~~department develops goals to direct ~~short term~~ projects and address social determinants of health. Many of these opportunities ~~evolving~~evolve out of quality management activities. These goals ~~will~~ have input from ~~other staff and leaders as appropriate~~a variety of sources and reflect SVHMC's commitment to our patients and community as well as our annual hospital goals.

~~The goals of Social Services are:~~

~~A. To attain or maintain the highest practicable psychosocial and mental well-being of our patients/families.~~

~~B. To provide crisis intervention to those who need support in coping with the trauma of medical~~

~~crisis.~~

~~C. There is sufficient service and supplies maintained to adequately perform the services that are offered to Salinas Valley Memorial Hospital System (SVMHS).~~

The main goals of Social Services are: 1. Provide mental health counseling and support to patients and their families. 2. Connect patients and families with resources to help them cope with illness, disability, and lifestyle changes. 3. Advocate for patient rights and ensure access to necessary health care services. 4. Assist in the coordination of care between multiple medical providers. 5. Provide referrals to community services and social support networks. 6. Develop and implement discharge plans to ensure continuity of care after hospitalization. 7. Educate patients and families about community resources, health promotion, and disease prevention. 8. Work with other hospital departments to coordinate services for patients. 9. Assist with end-of-life care planning. 10. Help patients and families access benefits and financial assistance. 11. Assessing safety, submitting required reports to appropriate community agencies tasked with investigating allegations of abuse, thus meeting mandated reporting requirements.

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~~. To provide the patient~~/significant other~~ and family caregivers education and support to restore the patient to the highest level of health and 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.~~To support the provision of resources designed to mitigate risk and enhance positive outcomes for patients and their family members.

F. To evaluate staff performance on an ongoing basis by providing supervision and consultation.

G. To provide appropriate staff orientation ~~and development~~, and continuing education.

H. To collaborate with community organizations fostering cooperation and care for our patient population.

I. To monitor Social Services function, staff performance, and care / service for quality management and continuous quality improvement.

IV. POPULATION SERVED

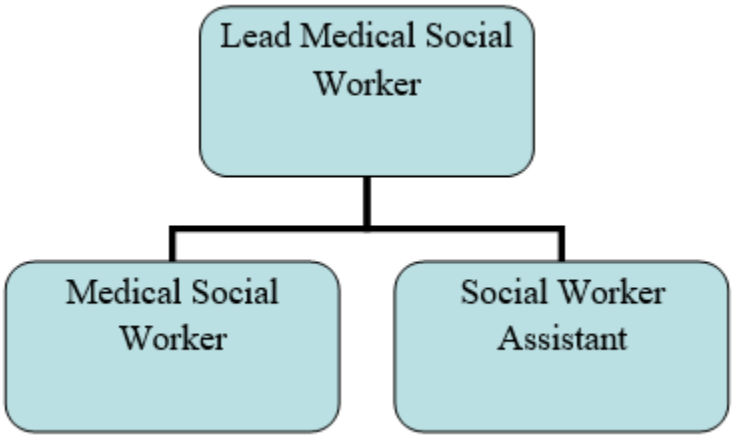
Clinical: All Departments

Social Services provides care for infant, pediatric, adolescent, adult and geriatric patients.

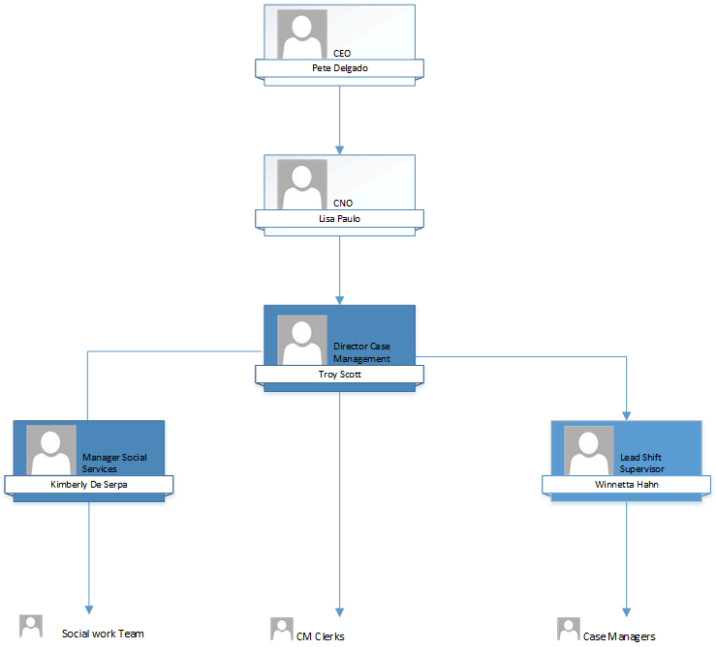
~~Non-~~Clinical:

Social Services provides services including but not limited to:

V. ORGANIZATION OF THE DEPARTMENT



Case Management Organization Chart



A. Hours of Operation
The Unit/Department provides services ~~Monday through Friday~~daily from 8:00 a.m. to ~~5~~11:00 p.m.. Weekend coverage includes Social Workers staffed in the emergency department as well as in-house. Flexible hour and weekend hours are ~~occasionally~~ required.

B. Location of department (s)
The administrative office is located ~~in the basement of the Hospital~~across the street from the hospital. Social Services Manager is located on 1 Main.

C. Admission, Discharge, Transfer Criteria - N/A

D. ~~Major~~Social Services ~~/ Modalities of~~provides care ~~may include:~~

~~Social Services provides care /~~and services to patients.

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

A. Social Workers collaborate with all hospital disciplines, community services and support services in order to meet the needs of the patient/family. Services are provided based upon reason for referral, patient assessments/reassessment, plan of care, patient preferences and medical staff orders including but not limited to:

- Screening each ~~referral~~consult using the High Risk Screening Criteria (Physician orders will be prioritized).
- ~~Providing an initial psychosocial assessment for those meeting the High Rick Screening Criteria and reassessment of changes of patient's condition occurred.~~Providing an initial psychosocial assessment and ongoing care as needed, with attention to long length of stay cases. All patients in the ICU and NICU will have an assessment within 48 hours.
- Providing crisis intervention, counseling support, grief ~~counseling including Palliative Care Services~~support, psycho education and advocacy.
- Initiating referrals ~~for complex case~~and coordinating needed services for patients and their families
- ~~Coordinating needed services~~
- ~~Assessing the appropriateness and effectiveness of services~~
- Participating in multi-disciplinary teams and patient care conferences.
- Consultation and community resources
- Mandated Abuse reporting as necessary
- Substance use disorder and mental health navigation
- Participation in Hospital Committees, i.e. Bioethics, Palliative Care, Children's Miracle Network, Community Coalitions etc.

B. The Director assumes twenty-four (24) hour responsibility for the Department.

C. The Director of the Department is directly responsible to the Chief Nursing Officer. It is the Director's duty to attend all administrative and technical functions within the department. All personnel within the department are under the guidance and direction of the Director. In the Director's absence, the position is filled by 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:

The basic requirements for ***Social ~~Workers~~Worker*** ~~include~~includes:

1. Master's Degree in Social Work
2. License eligibility
3. Licensed Clinical Social Worker preferred.
4. Completion of competency based orientation
5. Completion of annual competency and inservice

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~~

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

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

D. Employee educational needs assessment at the time of hire and annually as part of developmental planning

1. Performance improvement planning, data collections and activities
2. Staff input
3. Evaluation of patient population needs
4. New services/programs/technology implemented
5. Change in the standard of practice/care
6. Change in regulations and licensing requirements
7. Needs assessment completed by Nursing Education
8. Licensure or certification requirements

E. Continuing Education

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

VIII. STAFFING PLAN

Staffing is adequate to service the customer population. The 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 on acuity and needs of the department, competencies of the staff, the degree of supervision required, and the level of supervision available.

General Staffing Plan:

Staffing requirements will be met by authorizing overtime and/or utilizing temporary services.

In the event of a severe emergency, medical social workers are available.

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.~~

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

~~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

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

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

Attachments

Image 1

Social Services Manager

Approval Signatures

Step Description	Approver	Date
Board	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	08/2023
Policy Owner	Kimberly De Serpa: Manager Social Work	08/2023

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **13157527**

Last Approved	N/A	Owner	Lea Woodrow: Director of Accreditation and Regulatory Complianc
Last Revised	09/2023	Area	Administration
Next Review	3 years after approval		

Serious Reportable Events

I. POLICY STATEMENT:

A. Serious ~~adverse events~~Reportable Events also known as an ~~unexpected~~untoward medical occurrence~~,~~ which may or may not result in patient harm are reviewed to determine if the event meets criteria for a sentinel ~~event and adverse event which may or may not result in patient harm are reviewed to determine if the event meets the criteria for a sentinel~~ event, serious adverse event, or reportable "never event" and the harm associated with the event.

B. ~~The hospital will make all attempts to inform the patient or the party responsible for the patient of the adverse event by the time the report is made (to CDPH).~~The clinical leader, nursing manager or designee will notify the patient or next of kin that the Serious Adverse Event meets reporting to California Department of Public Health (CDPH).

II. PURPOSE:

~~A. To guide staff with investigating and responding timely to sentinel events, serious adverse events.~~

~~B. Understand the factors that contribute to an event and to improve processes to reduce the probability of the event occurring in the future.~~

~~C. To comply with federal, state and regulatory agencies.~~

A. To guide clinical staff with reporting and responding timely to serious adverse events.

B. To comply with public reporting to CDPH of serious adverse events.

III. DEFINITIONS:

A. **Action Plan (AP)** is the product of the Comprehensive Systematic Analysis that identifies the strategies the organization intends to implement to reduce the risk of a similar patient safety event occurring in the future..

B. **Adverse Event** is an injury that was caused by medical management rather than the patients' underlying condition. Not all adverse events are the result of medical error.

C. **Adverse outcome** is a result that differs from the anticipated result of a treatment or procedure and results in harm to the patient

D. **CDPH** - California Department of Public Health

E. **Comprehensive Systematic Analysis** (CSA) previously known as Root Cause Analysis -RCA is a comprehensive systematic analysis used to identify the factors that underlie a serious adverse event or sentinel event. A comprehensive systematic analysis focuses primarily on systems and processes, not on individual performance. The comprehensive systematic analysis will be completed within 45 calendar days of the serious adverse or sentinel event or of becoming aware of the event

F. **Disclosure** a process to provide open and honest communication with patients and families after adverse events or unexpected outcome by the physician or designee.

G. **BETA HEART** – ~~Beta Healthcare initiative,~~ (Healing, Empathy, Accountability, Resolution, Trust) a communication, apology and early resolution approach to adverse harm events.

H. **Just Culture-** a system of shared accountability in which organizations are accountable for the systems they have designed and for responding to the behaviors of their employees in a fair and just manner.

I. **Near Miss** is an event that did not reach a patient.

J. **Never Events** is an adverse event that is reportable under CA Health and Safety Code, §1279.1(b) (1)-(7) ,

K. **PSAT** – Patient Safety Advisory Team – A multidisciplinary administrative team that determine if the event is reportable to CDPH (Never/Sentinel event definitions), requires a full Comprehensive Review or debrief, if the event meets the HEART criteria and the disclosure process.

L. **Sentinel Event** is an unexpected occurrences involving death or major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

    1. NOTE: The term sentinel event and medical error are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

M. ~~**Risk thereof** includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.~~

N. **Unexpected Adverse Outcome** is an adverse outcome that was not expected to be the result of the patient's treatment and there was harm suffered as a result.

IV. GENERAL INFORMATION:

A. All areas licensed under the Salinas Valley ~~Memorial Hospital~~Health Medical Center (SVHMC) are subject to the policy and procedure.

B. Under the direction of the Patient Safety Officer (PSO), ~~the~~ Patient Safety and/or Risk Management ~~Divisions~~ shall collaborate with the responsible unit leaders to conduct an initial investigation of the facts of the event and identify discipline(s) to participate in the review. Specific staff participants will be recommended based on the facts known.

C. Any records, data, and knowledge collected for or by individuals assigned to investigate and review adverse events as part of the Quality Improvement Process and are confidential subject to California SB 1157 and/or the Patient Safety Work product.

D. If an event meets the criteria as a sentinel event or reportable "never event", a Comprehensive Systems Analysis (RCA) may be completed.

E. SVHMC supports a Just Culture philosophy and approach to adverse event investigation and response.

F. If the event is determined not to be a sentinel event, it will be addressed in accordance with established occurrence reporting processes.

G. ~~SVMHS~~SVHMC supports disclosure to patients/families as soon after the event as possible. DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY.

H. ~~Patient confidentiality will be maintained at all times.~~Salinas Valley Health does not report events to The Joint Commission.

V. PROCEDURE~~:~~

A. Immediate Action following a serious adverse or sentinel event.

1. Responsibilities of Staff Involved in the event

a. Stabilize the situation including but not limited to the following:

1. Assess the patient and assure their safety.
2. Notify attending physician to examine the patient.

b. If the event involves a medical device, immediately notify Biomedical Engineering to sequester the ~~devices~~device(s) that may have been involved in the event. Leave everything intact - i.e. leave pumps on but running into a receptacle, leave equipment in the room, leave all monitors/ pumps on. Save syringes/vials/ IV bags/ tubing and/or any other equipment and supplies per. ~~Under no circumstances is the equipment or evidence to be worked on, repaired, cleaned or altered from the condition it was in at the time of the event.~~ MEDICAL DEVICE INCIDENT REPORTING PROGRAM

c. ~~Immediately after the patient is stabilized and the area / secured, contact~~Notify the Administrative Supervisor and ~~unit~~the Unit leader.

d. Document patient assessment and subsequent interventions and the facts surrounding the event in the electronic health record.

e. Enter the event in the ~~electronic WeCare~~safety occurrence reporting system. ~~(Staff should not write or keep any additional notes of event).~~

2. Responsibilities of Unit Leader / Administrative Supervisor

a. ~~Assess the situation to assure staff and patient safety and identify immediate actions.~~

b. Contact the Patient Safety Officer (PSO) ~~/ designee and ascertain the known facts surrounding the event.~~and TigerConnect Page Risk

Management Team

c. Determine the need to initiate the Care for the Caregiver process. Assure staff involved in the event are capable of continuing their care assignment. ~~Staff may be removed from their assignment, if necessary, to assure continued safety of other patients. Offer support through trained counselors / EAP, or hospital Chaplain as needed or requested.~~

d. Reinforce confidentiality and security.

e. Inform staff that all media inquiries are to be referred to Media/Public Relations. Facilitate the immediate sequestering of equipment, ensure documentation in the medical record, and conduct further notifications, as needed.

f. Consult with Patient Safety Officer / Risk Management (RM) designee to identify the appropriate contact person to initiate the initial communication with the patient / family in accordance with the DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY

g. ~~Review applicable patient care policies and procedures to assess the compliance or lack thereof by staff, in relationship to the event.~~

h. Conversations with the patient/family should be witnessed and documented in the medical record.

3. Responsibilities of the PSO / Designee

a. The PSO will notify ~~the Manager,~~ Regulatory and Accreditation prior to close of business day ~~and~~who will coordinate a Patient Safety Advisory Team (PSAT) meeting ~~will~~to be scheduled within 24 hours, to include leaders of the involved areas, PSO, Chief Medical Officer / designee if applicable to medical staff , Chief Nursing Officer (if a clinical event), Risk Manager and others as necessary.

b. ~~Upon determination if event meets criteria as a sentinel / serious adverse event, the PSAT team will determine if a report to Board of Directors is indicated based on the results of the investigation.~~

c. If event meets criteria as reportable to the California Department of Public Health (CDPH), notification shall be made in accordance with the mandated reporting requirements.

d. ~~In concert with the unit leader / Risk Manager will review the situation with the attending physician to determine who, when to fully disclose event to patient/family, determine the appropriate parties to be included in the disclosure meeting and other relevant information and processes. Disclosure may be withheld if there are legal, ethical, regulatory, or psychological reasons that could cause harm to the patient. The Bioethics Committee may be consulted as a resource if decision is made to withhold disclosure. DISCLOSURE OF UNANTICIPATED OUTCOMES POLICY~~If event is determined to be reportable and potentially causing harm to a patient the PSO will notify the Chair of the Board Quality and Efficient Practices Committee. After the full investigation is completed and the action plans

are implemented, the Board of Directors will receive a detailed report on the sentinel/serious adverse event, through the regular reporting structure.

e. Notify Accounting for further handling related to accounting/billing and charges related to event. Bill will be placed on hold until reviewed in detail. RM will facilitate the ongoing process in collaboration with the Administrative Adjustment Committee.

4. Responsibilities of Risk Manager / Designee

a. Initiate investigation with the leader of the involved unit and begin evaluation of the event. ~~Initiate investigation and chronology of event with the staff involved in the event.~~

b. Collaborate with unit director(s) and staff to address immediate communication issues, sequester equipment, etc. as previously described.

c. The Biomedical Department in collaboration with the Risk Manager/ designee will be responsible for receiving and storing the impounded evidence. Medical Device Incident Reporting Program

d. Notify hospital liability carrier of event ~~and open precautionary file~~as needed.

B. Comprehensive Systematic Analysis Process

1. Each sentinel / adverse event is to be documented in the form of a Comprehensive Systematic Analysis (CSA).
2. RM facilitates the completion of the (CSA). Investigate the event and determine why it happened with staff involved.

a. Investigate the event and determine why it occurred such as:

i. Internal factors – staffing, errors of omission, overdose/under dose of medication.

ii. Process factors – process not completed per policy, investigation reveals a problem with the process.

iii. Equipment factors – failure, malfunction, electrical shock.

iv. Environmental factors – power failure, backup generator failure, hazardous spill.

b. Work with the staff and unit leaders to develop corrective actions. The use of statistical tools/analysis used, i.e., flowchart, cause and effect diagram, scatter diagram, Pareto chart may be used if needed.

c. Work with staff and unit leaders on mitigating strategies with corrective actions to help prevent reoccurrence. Assign responsibility for the action plan. Answer the questions: How will we ensure this never happens again? And who is responsible? Define when actions need to be completed by (i.e. 45 days from event).

d. In collaboration with the unit leaders the Quality Department staff facilitates the measures of successes/compliance with reporting to the

appropriate committees.

3. Responsibility of Unit Leader
    a. Attend and assure involved staff can participate in the meetings.
    b. Define and implement corrective action plans, as assigned.
    c. Monitor the implementation and effectiveness of action plans.
    d. Participate in reporting of action plans and effectiveness.
    e. Review and submit status of corrective actions & monitoring as indicated in the action plan.

/Root Cause Analysis/Investigation

1. Each sentinel/ adverse event as needed will have a Comprehensive Systematic Analysis/RCA or Investigation.
2. RM facilitates the investigation.
    a. Work with the staff and unit leaders to develop recommendations for corrective actions.
    b. In collaboration with the unit leaders the Quality Department staff facilitates the measures of successes/compliance with reporting to the appropriate committees.
3. Responsibility of Unit Leader
    a. Assure involved staff can participate in the meetings.
    b. Define and implement recommended corrective actions, as assigned.
    c. Participate in reporting of action plans and effectiveness to respective committee(s).

VI. EDUCATION/TRAINING:

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

A. Education and/or training is provided as needed

VII. REFERENCES:

~~A. The Joint Commission~~

~~B. CHA Consent Manual E. HSC 1279.1 (b)~~

A. California Department of Public Health Reportable Adverse Events Health and Safety Code, Section 1279.1 (b) (1) – (7) https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/Reportable-Adverse-Events.aspx

B. The Joint Commission-Sentinel Events

C. National Quality Forum-Serious Reportable Events

D. CHA Consent Manual E. HSC 1279.1 (b)

Attachments

A: Serious Adverse Events

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Executive Alignment	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	07/2023
Quality	Aniko Kukla: Director Quality & Patient Safety	05/2023
Risk	Brenda Bailey: Risk Manager	05/2023
Policy Owner	Lea Woodrow: Director of Accreditation and Regulatory Complianc	04/2023

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):

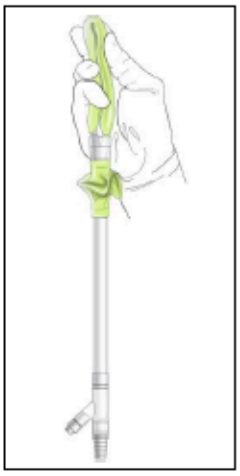
1. Assess postpartum patient for postpartum bleeding
2. Notify Care Provider if bleeding is abnormal
3. Assist in placement of vacuum-induced hemorrhage control device
4. Fill cervical seal balloon with sterile fluid (predetermined volume per care provider order)
5. Monitor patient's vital signs and 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



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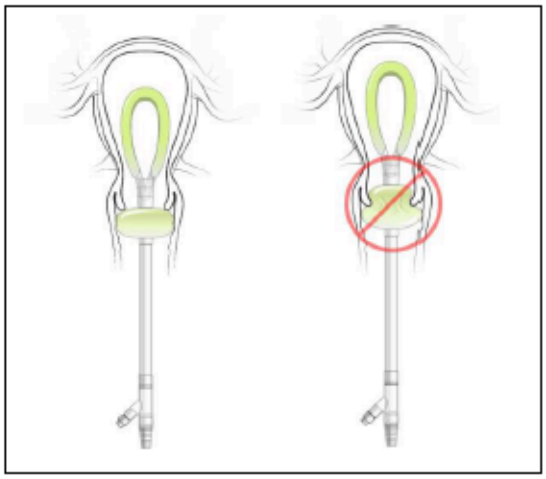

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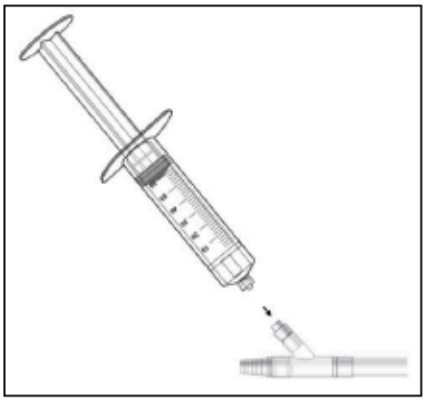

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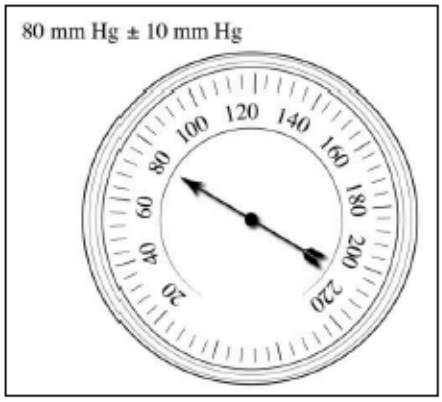

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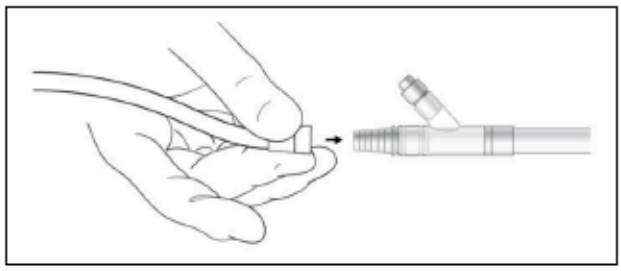

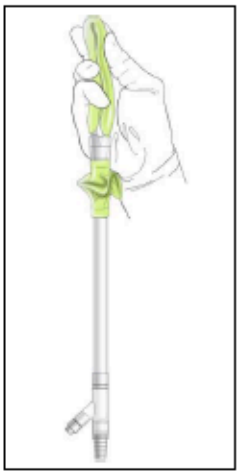

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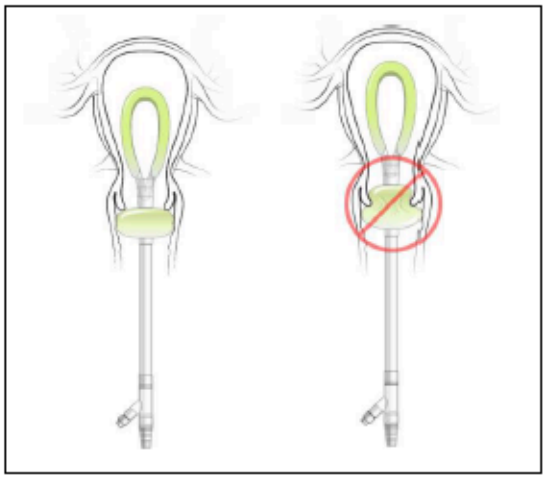
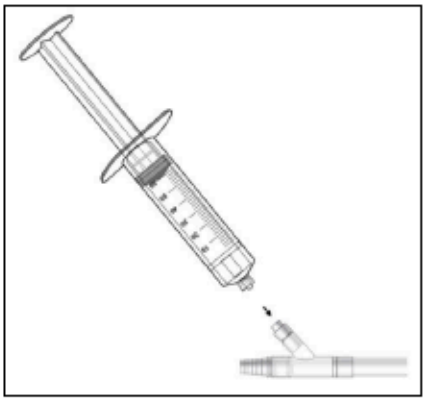


Figure 2

9.



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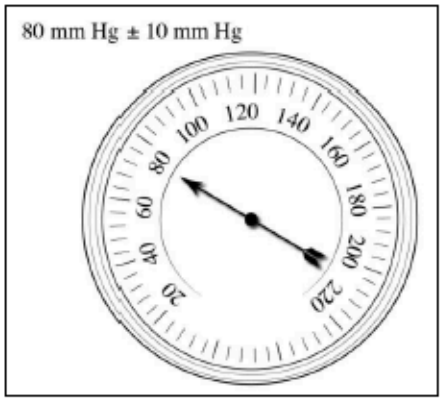

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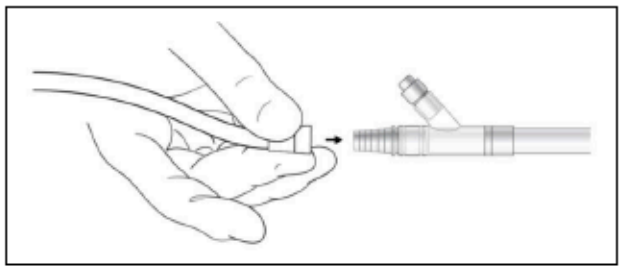


E. Treatment and Monitoring

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
Board	Julianna Juarez: Respiratory Care Practitioner Registered	Pending
Board	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
Women's & Children's Service Line	Katherine DeSalvo: Director Medical Staff Services	10/2023

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

Status Pending PolicyStat ID 14117262

Last Approved	N/A	Owner	Cynthia Vargas: Manager Patient Experience
Last Revised	09/2023	Area	Administration
Next Review	3 years after approval		

Visitors

I. POLICY STATEMENT

A. Salinas Valley Health Medical Center (SVHMC) will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity, or disability. Visitors shall enjoy full and equal visitation privileges consistent with patient preferences.

B. The patient has the right to both a support person and visitors while under the care, treatment, and service of SVHMC. Refer to Section V F.

C. The patient has the right to request anonymity (Confidential Status). If a patient requests to be designated as "Confidential" no visitors or support person is allowed. Refer to Section V E.

D. Patients are responsible to manage visitors. SVHMC does not manage "Lists" of patient requested visitors.

E. SVHMC has the right to restrict visitors for concerns such as, but not limited to, mental health crisis, infectious diseases, patient safety, etc.

II. PURPOSE

A. To define the patient's right to visitation while receiving care, treatment, and service.

B. To guide staff in the creation of a positive visiting experience for both patients and visitors at SVHMC.

C. To support a patient and family centered care environment by incorporating a support person, family and visitors into the patient's plan of care.

III. DEFINITIONS

A. Immediate family: Parents, parent's children, siblings, grandparents, ~~and~~ grandchildren and spouse/domestic partner. In the absence of immediate family, individuals whom the patient designates as "family" may visit at the attending nurse's discretion.

B. Patient: Patient or their designated surrogate decision maker

C. Significant other: spouse, domestic partner, girlfriend or boyfriend, caregiver or constant companion - not counted as a visitor.

D. Support Person: family member, friend or other individual over 18 years of age who, at the request of the patient, can provide emotional support during the patient's stay. The support person is not authorized to make medical / care decisions nor receive patient information unless authorized by the patient.

E. Authorized responsible party: Custodial parent(s), legal guardian/custodian, legal responsible party, designated surrogate decision maker.

IV. GENERAL INFORMATION

A. The right of a patient to have visitors may be limited or restricted when visitation would interfere with the care of the patient and/or the care of other patients. Circumstances reasonably related to the care of the patient and/or the care of other patients that provide a basis to impose restrictions or limitations on visitors include (but are not limited to) when:

1. There may be infection control issues.
2. Visitation may interfere with the care of other patients.
3. The hospital is aware that there is an existing court order restricting contact.
4. Visitors engage in disruptive, threatening, violent or criminal type behavior of any kind.
5. The patient or patient's roommate(s) need rest or privacy.
6. The patient is undergoing care interventions.
7. Visitation is otherwise clinically contraindicated.

B. Visiting hours at SVHMC are generally from 9AM - 8 P.M, 7 days a week. (Exceptions are managed on a case by case basis with consideration of the patient's medical condition and in collaboration with the unit charge nurse and nursing supervisor.)

1. In most areas, there are NO age restrictions for visitors unless indicated due to health considerations or special circumstances such as influenza season.
2. Specific units may have different visiting hours and/or age limitations. Detailed information will be given to patients, families and visitors in those units.

C. The organization may limit the number of visitors during a specific period of time, as well as establish minimum age requirements for child visitors when reasonably necessary to provide safe care.

D. If there are multiple family members they should be encouraged to designate a spokesperson to **minimize interruptions** of patient care.

E. SVHMC is committed to providing a quiet healing atmosphere. Some strategies include, but are not limited to:

1. Offering a "Quiet pack"
2. Lowering the volume of the TV or other electronic devices

3. Dimming the lights in the hallways or in rooms
4. Putting all cell phones and pagers on vibrate
5. Closing doors
6. Offering aromatherapy or soft music
7. Offering warm tea in accordance with the patient nutrition orders

F. The patient shall be informed of the reason for any restriction or limitation of visitors and this restriction will be recorded in the electronic health record.

G. QUIET TIME: In order to provide time for patients to rest and recover, quiet time is from 2 p.m. to 4 p.m. each day. During quiet time, visiting may prohibited.

H. END OF LIFE: Special visitation arrangements are made for patients who are receiving end of life care, including a declaration of brain death/organ donation. Flexibility for end-of-life allowed based on space constraints and maintaining privacy of other patients.

I. Patients be informed, verbally or in writing of their visitation rights, including any clinical restriction or limitation on such rights.

V. PROCEDURE

A. **VISITING GUIDELINES**

1. Visitors will check in at the Information Desk in the Main Lobby with the Concierge, Volunteer or Security officer on duty to receive a pass.
    a. After hours, security officer will request approval from the appropriate nursing unit prior to issuing a visitor pass.
2. Nursing staff should educate visitors to:
    a. The unit specific visitation processes.
    b. Limit the number to 2 (two) visitors at a time. Exceptions are made on a case by case basis.
    c. Limit their visits to a reasonable duration based on patient's condition.
    d. No consumption or under the influence of alcoholic beverages or illegal substances is allowed on hospital property.
    e. SVHMC is a smoke free facility including all tobacco products and e-cigarettes / vaping products.
    f. The hospital reserves the right to limit or disallow visitors at any time.

B. **AFTER HOURS VISITATION**

1. An announcement will be made prior to the end of visiting hours informing all visitors that regular visiting hours are over at 8:00PM. All visitors, except the patient's support person, will be asked to leave the hospital at the end of visitation hours. See **Section D** for unit specific exceptions.
2. Special after hours visits will be approved by the Administrative Supervisor or Unit Director/Designee on a case by case basis utilizing the following criteria:

a. Critical or terminally ill patient.

b. Extreme safety concern for the patient.

c. Severe language barrier not accommodated by Hospital designated interpreter service.

d. Other situations as determined by the Administrative Supervisor or Unit Director/Designee.

3. Starting at 8:00 PM, a Security Officer will make rounds of nursing units to inform visitors that visiting hours are over.

    a. If any after-hours visitors are authorized, the Security Officer will issue a new visitor's identification badge.

    b. If visitors are not authorized after hours, the visitors will be politely informed that visiting hours are over and requested to leave.

    c. Should the visitor insist on visitation or special circumstances, the Security Officer or Concierge on duty will contact the charge nurse of the unit. If visitor(s) are authorized the charge nurse will inform the Administrative Supervisor for the final authorization.

C. **LIMITING VISITATION IN SPECIFIC CARE SETTINGS**

1. The number of visitors and length of visitation may be limited in specific care settings such as intensive care units and post-operative/invasive recovery areas due to the critical nature of a patient's illness and the level of required medical care.
2. General visitor access to areas where newborn infants and pediatric patients are housed may be limited due to security concerns and the need to protect these vulnerable populations from abduction.
3. Due to care and safety concerns, visitation is not permitted during the performance of operative, invasive, or other high-risk procedures. To protect patient privacy, visitation is generally not permitted when a patient is receiving personal care such as toileting, bathing, etc.

D. **UNIT SPECIFIC VISITING POLICIES**

1. **INTENSIVE CARE / CORONARY CARE UNIT (ICU/CCU)**

    a. Visiting hours in the ICU/CCU are open and visitors are allowed at any time 24/7.

    b. Limit the number to 2 (two) visitors at a time. Exceptions are made on a case by case basis.

    c. Phones with auto dial are located at both the ICU and CCU doors and shall be used by visitors to gain access to the unit.

    d. Visitors shall generally be limited to immediate family members, significant others or by patient request.

    e. Children are welcomed as appropriate to the situation but limited due to the nature of care and the equipment used in ICU settings.

2. **PEDIATRIC**
    a. ~~Parents/guardians~~Authorized responsible parties are encouraged to visit and participate in the child's care anytime during the day and evening. Due to space restraints, only one ~~parent/guardian~~authorized responsible party is encouraged to stay overnight.
    b. ~~During the acute phase of an infectious illness, visitors are limited to immediate family only.~~
    c. Visitors under the age of 12 may visit in the pediatric unit if they are siblings of the patient.
    d. The Pediatric unit may limit sibling visitation at the discretion of the charge nurse.
3. **PERINATAL SERVICES**
    a. **Labor and Delivery Unit**
        i. When a patient is in labor, they determine who may visit throughout the labor process.
        ii. Children under the age of 12, if child of the patient, may visit. Children under the age of 12 must be supervised by an adult (not the patient) at all times and not be disruptive to nursing staff or other patients.
            1. The name(s) of the patient's child(ren) will be obtained from the patient upon admission.
        iii. Visiting hours are open for laboring patients unless there is a medical or social reason to limit visitation at the discretion of the patient or staff.
        iv. Visitors are encouraged to limit the number of visitors to 4 at a time. Exceptions are made on a case by case basis.
    b. **Mother Baby Unit**
        i. After a patient transfers to the Mother/Baby Unit, regular visiting hours will apply. Visitors should limit the time of their visits to allow the new mother and baby time to rest, bond, and allow for the necessary patient education.
        ii. ~~The father~~An authorized responsible party of the baby is welcomed to spend the day/night and participate in the plan of care as directed by the patient.
        iii. Children under the age of 12, if child of the patient, may visit. Children under the age of 12 must be supervised by an adult (not the patient) at all times and not be disruptive to nursing staff or other patients.
        iv. Visitors are encouraged to limit the number of visitors to 4~~2~~ at a time.

v. ~~The mother and father of the baby are not counted as visitors. Exceptions surrogate parents.~~An authorized responsible party of the baby is not counted as a visitor.

c. **OBED**

i. Only one visitor per patient is allowed while patients are being checked for possible admission or antepartum testing

d. **Neonatal Intensive Care Unit (NICU)**

i. The NICU fosters the Philosophy of Family Centered Care. Parents/guardians are encouraged to visit and participate in infant feeding and care in the NICU. The Nurse or Physician will assess each situation and provide support, instruction, and assistance to the parents/guardians.

ii. In general, visitation in the NICU is limited to parents/authorized responsible party and grandparents for the first twenty-four (24) hours. Thereafter, other visitors may accompany the parent/guardians. Parents/guardians may provide a list of persons who are authorized to visit the infant when parents/guardians are not present. Photo ID will be required.

iii. Visiting hours are as flexible as possible for the convenience of the visitor. In order to maintain patient confidentiality, visitors will NOT be allowed in the NICU during change of shift report: 0700-0730 hours, 1500-1530 hours, and 2300-2330 hours, or during work rounds. Parents/guardians are not considered visitors and are encouraged to be present during report times to participate in the plan of care.

iv. Siblings may visit with completion of the "visitation checklist".

v. Information pertaining to the infant's condition will be released only to the parents/guardians, unless the parent/guardians sign a written release of information authorizing otherwise.

vi. The Charge RN has authority to restrict or allow visitors based on unit activity.

4. ~~**EMERGENCY DEPARTMENT**~~

a. All visitors must check in with the Security Officer at the Emergency Department waiting room entrance.

b. Two visitors are allowed in the treatment area per patient unless otherwise authorized by the medical staff.

c. All other visitors must wait in the Emergency Department waiting area and should limit the number of visitors in the waiting area to two (2) visitors per patient as a courtesy to other families sharing this small area.

EMERGENCY DEPARTMENT

a. All visitors must check in with the security officer at the Emergency

Department entrance.

b. One visitor is allowed in the waiting room unless the Emergency Department is over capacity at which time staff will ask visitors to vacate to make room for patients.

c. One visitor is allowed with patients in patient's room unless otherwise authorized by the medical staff.

d. No visitors allowed in the Result Waiting or Fast Track areas.

e. Pediatric patients are required to have one parental figure or authorized responsible party with them at all times but will not be allowed a visitor unless authorized by the hospital staff.

5. **OUTPATIENT ~~SURGERY~~ INFUSION**

   a. Visitation will be limited to one visitor at a time due to space limitations and to optimize patient privacy. If the patient is a child, a parent/authorized responsible party must remain with the child the whole time~~; it is requested a parent remain in the hospital during the entire visit~~.

   b. Children 12 and older may visit.

6. ~~**POST-ANESTHESIA CARE UNIT (PACU)**~~

   a. Visits are allowed whenever possible, however, visitors may be restricted based on departmental activity and patient condition.

   b. Visitors may be invited approximately 30 minutes after the patient arrives in recovery, based on patient readiness.

   c. Visitation **will be limited to one visitor and limited to 5 minutes.**

      i. **The caregiver of a pediatric or special needs patient may stay with the patient longer.**

7. **OUTPATIENT SURGERY/CATH HOLDING**

   a. Visitation will be limited to one visitor at a time due to space limitations and to optimize patient privacy. If the patient is a child, a parent/authorized responsible party must remain with the child the whole time.

8. **MAIN OR POST-ANESTHESIA CARE UNIT (PACU)**

   a. The authorized responsible party for a pediatric or special needs patient may stay.

9. **MEDITATION ROOM**

   a. The Meditation Room is an area providing privacy for families of patients in crisis and during consultation with health care providers. Guidelines have been established for use of the Meditation Room.

   b. The Meditation Room may be accessed by Security and/or Concierge and the Administrative Supervisor as deemed appropriate.

E. **CONFIDENTIAL STATUS:**

1. A patient may, at any time, request to be Confidential Status, which is entered by Patient Registration staff.
2. When a patient requests Confidential Status, No visitors are allowed, except as stated in 5. This includes, immediate and other family, friends and visitors that present.
3. When a patient status is updated during their stay, after they have been registered, Nursing staff will inform Registration staff to update their status in Meditech and the Patient Status Board and will notify the Main Lobby Concierge and Security of the change in status.
4. When visitors ask for the location of a patient flagged as confidential, they will be informed that a patient by that name is not in the hospital. PBX operators will not transfer calls to the patient's room and will inform the caller that there is no patient by that name. Mail and floral deliveries will not be accepted for confidential patients.
5. Exceptions to visitors for Confidential Status patients must be approved by the Administrative Supervisor, after determining, with input from the unit charge nurse / designee and the Patient Safety Officer / Patient Experience team, that the exception is in the best interest of the patient. Safety of the organization, patients and staff will take precedence over visitors.

F. **DESIGNATING A SUPPORT PERSON:**

1. A patient has the right to designate a support person to provide emotional support during their stay. A patient's "support person" does not have to be the same person as the patient's representative who is legally responsible for making medical / care decisions on the patient's behalf.
2. The organization shall accept a patient's support person designation, orally or in writing. The name of the support person should be recorded in the electronic health record and may, at the patient's request, be changed at any time.
3. In a shared room of same-gender (or gender stated) patient where the support person is the opposite gender, the patient will be asked if they oppose the support person staying the night. If the patient is opposed, the support person will be offered to stay in the waiting area.
4. When a patient is unable to make their own medical decisions processes will be followed as defined by California laws. The Patient Safety Officer may be contacted as necessary.

G. **INFORMING THE PATIENT OF THEIR RIGHT TO VISITATION**

1. The organization shall inform patients of their visitation rights. This information shall generally be provided during the admission process.
2. The written notice shall address any clinically necessary or reasonable limitations or restrictions imposed by hospital policy on visitation rights, providing the clinical reasons for such limitations/restrictions, including how they are aimed at protecting the health and safety of all patients.
3. The information shall be sufficiently detailed to allow a patient) to determine what the visitation hours are and what restrictions, if any, apply to that patient's visitation

rights.

4. The notice must also inform the patient of the patient's right to:
    a. Receive the visitors they have designated, including but not limited to, a spouse, a domestic partner, another family member, or a friend; and
    b. Withdraw or deny his/her consent to receive specific visitors, either verbally or in writing.
5. The medical record must contain documentation that the written notice was provided to the patient.

H. **RESOLVING DISPUTES REGARDING VISITATION**

If there is a question or disagreement surrounding who may visit the patient, it shall be resolved as quickly as possible.

1. The patient shall decide who may visit as long as they have been deemed capable of decision making.
2. If the patient is unable, the patient's designated surrogate decision maker shall decide who may visit. In the event there is no designated surrogate, the support person may be consulted, but the organization will determine visitors based on the best interests of the patient and on a good faith understanding of the patient's likely wishes. The Patient Safety Officer may be consulted if necessary.

VI. EDUCATION/TRAINING

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

VII. REFERENCES

A. The Joint Commission Hospital Accreditation Standards, Patient's Rights Chapter
B. CMS Conditions of Participation 482.13

Approval Signatures

Step Description	Approver	Date
Board Approval	Julian Lorenzana: Administrative Assistant / Board Clerk	Pending
Board Approval	Rebecca Alaga: Regulatory/ Accreditation Coordinator	Pending
CNO	Lisa Paulo: Chief Nursing Officer	09/2023

Policy Committee	Rebecca Alaga: Regulatory/ Accreditation Coordinator	09/2023
Policy Owner	Cynthia Vargas: Manager Patient Experience	09/2023

Standards

No standards are associated with this document

FINANCE COMMITTEE

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

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

(JOEL HERNANDEZ LAGUNA)

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

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 of the
Finance Committee
will be distributed
at the Board Meeting

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

(JOEL HERNANDEZ LAGUNA)

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

Board Paper: Review and Approval by Board

Agenda Item:	Consider Recommendation for Board Approval of Optum™ LYNX Charge Capture Software Justification and Contract Award
Executive Sponsor:	Augustine Lopez, CFO Philip Katzenberger, Director of Health Information Management
Date:	October 17, 2023

Executive Summary

Optum™ LYNX Outpatient Charge Capture software licenses is a comprehensive charge capture solution with proprietary algorithms to capture resource utilization and patient care complexity for consistent charging across outpatient operations. Since 2014, Salinas Valley Health has used the LYNX Emergency department charging and Observation applications to help ensure compliance and achieve consistency in the emergency department.

Optum™ LYNX algorithm uses a unique combination of chief complaints plus other notable clinical resources utilized during the encounter to calculate a facility level of care is accurate. Comprehensive validation engine and configurable workflows support SVH's facility's operations and accurate claim submission and reimbursement.

For observation services, Optum™ LYNX software helps achieve compliant and consistent charging for observation services. The application calculates appropriate observation charges and reconciles exclusion or carve-out times. Helps accommodate the charging parameters that are affected by the patient's origination, acuity and payer.

Referenced FHMA Insights, Optum™ LYNX Outpatient Charge Capture ranks above average compared to their competition in capability functionality, of scalability, integration, customization, administration, and maintenance sustainable maintenance.

We do not recommend replacing the existing solution. There is risk of operational disruption during the learning curve while adapting to a new system and workflow methodology. We would expect operational disruptions and inefficiencies should we replace the current solution with another vendor's solution. We can reasonably estimate a hit to staff productivity (20% to 40% reduction) running dual systems and increases in Salinas Valley Health's mid revenue collection days valued at several millions of dollars of unclaimed/unprocessed cases.

Each application integrates with Meditech via interface customization. These customizations were created nine (9) years ago at a sunk cost of $250,000 requiring multiple disciplinary staff to aid in the custom project build, a ten (10) months duration. To recreate a similar custom build, the estimated cost is $295,000, plus consultation services. There is no proven operational advantage to switching vendors.

Unique to market, Optum[MT] has reviews in healthcare provider value-based performance management analytics. As a tool that aids in delivering insights into claims, encounters and how achieving systems can lead to seamless, cost-effective, and high-quality care.

The Lynx product functions well with periodic upgrades and new product development. We recommend the Optum[MT] five-year contract renewal as proposed.

Key Contract Terms	Optum[TM] LYNX Outpatient Charge Capture
1. Proposed contract signing date	December 28, 2023
2. Term of agreement	December 28, 2023 – December 27, 2028
3. Renewal terms	Auto one-year renewal
4. Termination provision(s)	During 5 year term a 60 day written notice with cause only to termination. Post 5 years written notice 60 day termination without cause.
5. Payment Terms	Net 45
6. Average Annual cost(s)	$305,754
7. Cost over life of agreement **	$1,528,770
8. Budgeted (yes or no)	Yes
9. Contract	1001.1459C

** Cost over Life of Agreement

Description	Baseline - Paid 12 Months Ending Sept 23	Year1 (12/28/23 - 12/27/24)	Year 2 (12/28/24 - 12/27/25)	Year 3 (12/28/25 - 12/27/26)	Year 4 (12/28/26 - 12/27/27)	Year 5 (12/28/27 - 12/27/28)
Expense Rate		0%	0%	3.50%	3.50%	3.50%
Per Visit Fee		$4.05	$4.05	$4.19	$4.34	$4.49
ED Charging Estimated Annual Total (based on 69,078 visits)		$279,766	$279,766	$289,437	$299,799	$310,160
Observation Estimated Annual Total (based on 3,307 visits)		$13,393	13,393	$13,856	$14,352	$14,848
Annual Expense Cost	$279,688	$293,159	$293,159	$303,293	$314,151	$325,008
Total Cost of 5 Year Contract:						**$1,528,770**

Recommendation

Consider recommendation for Board approval of 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.

Attachments

- Sole Source Justification Form
- Contract Renewal Amendment
- Master Software and Services Agreement

Justification for Sole Source Form

To: Proposal Evaluation Panel

From: Philip Katzenberger

Type of Purchase: (check one)

- ☐ Materials/Supplies
- ☒ Data Processing/Telecommunication Goods > $25,000
- ☐ Medical/Surgical – Supplies/Equipment > $25,000
- ☐ Purchased Services

Cost Estimate ($):	$1,528,770.00 (5year contract)
Vendor Name:	Optum™ LYNX
Item Title:	Optum360 LYNX Charge Capture Software Renewal: 2023 - 2028

Statement of Need: My department's recommendation for sole source is based upon an objective review of the product/service required and appears to be in the best interest of the SVMHS. I know of no conflict of interest on my part or personal involvement in any way with this request. No gratuities, favors or compromising action have taken place. Neither has my personal familiarity with particular brands, types of equipment, materials or firms been a deciding influence on my request to sole source this purchase when there are other known suppliers to exist.

Describe how this selection results in the best value to SVMHS. See typical examples below.

☐ Licensed or patented product or service. No other vendor provides this. Warranty or defect correction service obligations of the consultant. **Describe why it is mandatory to use this licensed or patented product or service:**

☒ Existing SVMHS equipment, inventory, custom-built information system, custom built data inventory system, or similar products or programs. **Describe. If product is off-the-shelf, list efforts to find other vendors (i.e. web site search, contacting the manufacturer to see if other dealers are available to service this region, etc.).**

Salinas Valley Health (SVH) has several services lines which each of these service lines required interface customization. These customizations were created nine (9) years ago at a sunk cost of $250,000 requiring multiple disciplinary staff to aid in the custom project build, a ten (10) months duration. To recreate a similar custom build, the estimated cost is $295,000, plus consultation services. There is no proven operational advantage to switching vendors.

KLAS Insights compares Optum™ to other vendors in the market, Optum™ LYNX Charge Capture scores higher when compared to their competition in functionality, scalability, integration, customization, administration, and sustainable maintenance.

Unique to market, LYNX Software has reviews in healthcare provider value-based performance management analytics. As a tool that aids in delivering insights into claims, encounters and how achieving systemness can lead to seamless, cost-effective, and high-quality charge capture.

We do not recommend replacing the existing solution. There is risk of operational disruption during the learning curve while adapting to a new system and workflow methodology. We would expect operational disruptions and inefficiencies should we replace the current solution with another vendor's solution. We can reasonably estimate a hit to staff productivity (20% to 40% reduction) running dual systems and increases in Salinas Valley Health's mid revenue collection days valued at several millions of dollars of unclaimed/unprocessed cases.

Justification for Sole Source Form

The Optum™ LYNX product functions well with periodic upgrades and new product development. We recommend the Optum™ LYNX Software obtain a five (5)-year contract renewal as proposed.

- ☐ Uniqueness of the service. **Describe.**
- ☐ SVMHS has established a standard for this manufacturer, supplier or provider and there is only one vendor. **Attach documentation from manufacturer to confirm that only one dealer provides the product.**
- ☐ Factory-authorized warranty service available from only this single dealer. Sole availability at the location required. **Describe.**
- ☐ Used item with bargain price (describe what a new item would cost). **Describe.**
- ☐ Other -The above reasons are the most common and established causes for an eligible sole source. If you have a different reason, **Describe:**

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

Submitter Signature: _____ Date: _____

AMENDMENT NO. 2
TO THE
LYNX APPLICATIONS PRODUCT SCHEDULE

This "Amendment No. 2", effective December 28, 2023 ("Second Amendment Effective Date") amends the LYNX Applications Product Schedule having an Effective Date of December 28, 2014 (as amended, the "Schedule"), by and between Optum360, LLC ("Optum") and Salinas Valley Memorial Healthcare System operating as Salinas Valley Health ("Customer). The Schedule is incorporated into and made a part of the Master Services and License Agreement, having an Agreement Date of December 28, 2014, between the parties.

NOW, THEREFORE, in consideration of the mutual covenants hereinafter set forth, as of the Second Amendment Effective Date, the parties agree to amend the Schedule as follows:

1. Existing Agreement. Except as set forth in this Amendment No. 2, all terms and conditions of the Schedule and Agreement remain in full force and effect. In the event of any conflict between the terms of this Amendment No. 2, the Schedule, and/or the Agreement, this Amendment No. 2 shall control.

2. Software. Section I.D of the Schedule, Software, is deleted and replaced with the following:

> "D. "Software" means the following Software applications including all updates, enhancements, and versions thereto:
>
> - Optum LYNX ED Charging Application Facility
> - Optum Lynx Observation Charging Application"

3. Term and Termination. Section VI of the Schedule, Term and Termination, is deleted and replaced as set forth below. For the avoidance of doubt, Sections VI.A and VI.B are not amended by this Amendment No.2 and remain unchanged in the Schedule.

> "VI. Term and Termination. This Schedule is effective as of the Effective Date, and continues through December 27, 2028, unless earlier terminated pursuant to the Agreement. This Schedule will automatically renew for additional, successive one (1) year periods at a rate of five percent (5%) per year of the prior year's fees, unless either party gives the other party written notice of termination at least sixty (60) days prior to the end of the initial term or any successive one (1) year term."

4. Exhibit A – Pricing. Exhibit A of the Schedule, Pricing, is deleted in and replaced with a new Exhibit A, which is attached hereto as Attachment 1 and incorporated into the Schedule by reference.

IN WITNESS WHEREOF, the parties have accepted and agreed to this Amendment No. 2.

OPTUM360, LLC	SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM OPERATING AS SALINAS VALLEY HEALTH
Signature:_____	Signature:_____
Print Name:_____	Print Name: Pete Delgado
Print Title:_____	Print Title: President/CEO
Date:_____	Date:_____

Agreement No.: 266242.2
Version: 6

Attachment 1

EXHIBIT A – PRICING

Service	Fees*
Fees for Access to the Hosted System	
Optum Lynx ED Charging Application Facility Estimated Annual Processed Visits: 82,000	$4.05 per visit, billed monthly
Lynx Observation Charging Application Estimated Annual Processed Visits: 4,000	$4.05 per visit, billed monthly

* The three and one half percent (3.5%) annual increase set forth in Section V.B.2 of this Schedule, Increases, shall not apply until December 28, 2025. Customer shall pay Optum for a minimum of 64,000 Optum Lynx ED Charging Application Facility processed visits and 3,200 Optum Lynx Observation Charging Application processed visits, annually (the "Minimum Annual Software Fees") in accordance with Section V.A.2 of this Schedule.

The following table exhibits Customer's estimated annual cost based on Customer's actual claims volume for the period of August 1, 2022, through July 31, 2023. This table is provided for planning and budgeting purposes only. Customer will pay Optum for the actual volume of visits processed subject to the annual minimum described above.

Description	Year1 (12/28/23-12/27/24)	Year 2 (12/28/24-12/27/25)	Year 3 (12/28/25-12/27/26)	Year 4 (12/28/26-12/27/27)	Year 5 (12/28/27-12/27/28)
Per Visit Fee	$4.05	$4.05	$4.19	$4.34	$4.49
ED Charging Estimated Annual Total (based on 69,078 visits)	$279,766	$279,766	$289,437	$299,799	$310,160
Observation Estimated Annual Total (based on 3,307 visits)	$13,393	13,393	$13,856	$14,352	$14,848

LYNX APPLICATIONS
Product Schedule

Optum360, LLC ("Optum") and Salinas Valley Memorial Healthcare System ("Customer"), have entered into this Product Schedule ("Schedule") with an effective date of December 28, 2014 ("Effective Date"). This Schedule is incorporated into and made part of the Master Services and License Agreement dated December 28, 2014 (the "Agreement"). The parties agree as follows.

I. Definitions. The following definitions shall apply to this Schedule:

A. "Database" shall mean the database created from Customer Data input into the Hosted System, which Optum maintains as part of the Hosted System

B. "Hosted System" shall mean the Software (as defined below), , services, Database, hardware, third party owned software, networks, program fixes, program releases, operating system software, database software, and other third-party software, as deemed necessary by Optum for proper execution of the Software at Optum's location (as set forth in the Documentation).

C. "Services" shall mean, for the purposes of this Schedule, Optum's provision to Customer of access to the Hosted System, related Support Services, and other professional Services provided to Customer pursuant to this Schedule and any additional Exhibits, as applicable.

D. "Software" shall mean the following Software applications accessible through the Hosted System, including all updates, enhancements, and versions thereto:

- LYNX E/Point Facility
- LYNX Observation Charging Application

II. Services Subscription.

A. Site(s). Customer may use the Hosted System to process cases for the following site(s) only:

- Salinas Valley Memorial Healthcare System, 450 E Romie Lane, Salinas, CA 93901

B. Optum Services. Optum shall provide to Customer access to and use of the Hosted System via the Internet through the client application component of the Software, which is downloaded onto Customer's workstations when individual users ("Users") first access the Hosted System, and the other Services solely for Customer's internal usage; and solely to enable Users to access, view, edit or print the Customer Data in the Hosted System for Customer's internal business purposes. The Hosted System includes a sublicense to use the CPT codes embedded in the Software. Customer may access and use the Hosted System only from locations within the United States.

1. Implementation. The parties acknowledge and agree that the Software referenced in Section I of this Schedule was fully implemented by Optum pursuant to the Application Service Provider Agreement dated December 27, 2011 and the related Addendum signed on June 12, 2012.

2. Authorized Use. Customer shall implement reasonable controls to ensure that the Hosted System is only accessed and used by the then-currently authorized Users. Customer shall promptly notify Optum of any unauthorized access to or use of the Hosted System that becomes known to Customer. Optum shall have the right to immediately discontinue a User's access to and use of the Hosted System if such User breaches the terms of this Exhibit or otherwise impedes or disrupts any third party's use of the Hosted System. Where reasonably possible, Optum shall deliver notice to Customer of the termination of a User's access to and use of the Hosted System.

3. Customer Managers. Within ten (10) days of the Effective Date, Optum and Customer shall each designate a supervisory representative ("Customer Manager") who shall be responsible for

the conduct and performance of its respective employees, the access to the Hosted System, the preparation and delivery of all required materials, reports, facilities or work for the addition of other Authorized Location(s) operated or owned by Customer where the Hosted System may be used under this Schedule, and other day-to-day communications. Either party may replace its Customer Manager upon reasonable prior written notice to the party.

4. Acknowledgment. Customer hereby acknowledges that there is no established government or legal mechanism by which any system for current procedural terminology ("CPT") coding can be reviewed or approved and that the software for CPT coding under this Schedule has not been so reviewed or approved. Customer further acknowledges that Optum has developed its software in good faith on the basis of its database of experience with many operators of ED facilities over a number of years and on the advice of independent experts in the field of emergency medicine. Optum does not warrant that the Hosted System and Customer Data will operate error free, or in an uninterrupted fashion, or that any defects or errors in the hosted system will be corrected. Optum disclaims any express or implied warranty that the software are error-free or will always result in CPT coding by customer that will be approved or accepted by governmental authorities.

C. Server Hosting. Optum shall host the Hosted System in accordance with the Service Level Agreement (SLA) attached to this Schedule as Exhibit B.

1. Hardware/Software: Optum will be responsible for providing the necessary hardware and software that is needed for the Hosted System. Customer is responsible for providing the necessary hardware and software that is needed on the workstations at the Authorized Locations.

2. Connection Maintenance: Optum will establish and maintain the hosted end of the VPN connection between Optum and Customer for transportation of interface data.

3. Database Backups and Archival: Optum will be responsible for the daily back-up of the Hosted System in accordance with the Optum Back-up Policy.

4. Content Maintenance: Optum will be responsible for the maintenance of the clinical, CPT and ICD-9 content within the Software.

D. Coding Exclusivity. Customer agrees that for the duration of this Schedule, Customer shall use the Hosted System to process all Emergency Department visits and that Customer will not license, purchase or otherwise procure any alternative solution from any third party.

E. Training. Optum will provide up to four (4) hours of training via WebEx to Customer staff annually, upon Customer's written request, if needed due to any system or regulatory changes. If Customer requests additional training beyond the four (4) hours of WebEx training provided annually, Optum will provide such training at Optum's then-current fees.

III. Customer Obligations.

A. Hardware, Formatting of Data, and Access.

1. System Administrator. Customer is responsible for identifying a Software System Administrator to manage user and site specific configurations.

2. Customer Project Leader: Customer must designate a project leader. This Customer project leader must be authorized by Customer to ensure that Customer hardware, software, and other system components required for operation of the Hosted System are maintained in proper working order.

3. Formatting and Delivery of Useable Data. Customer shall provide Optum with Useable Data, meeting the specifications for the Hosted System.

4. Access to Premises. For access to and operation of the Hosted System or performance of the Services, as appropriate, Customer shall provide Optum with reasonable access to and use of its premises and facilities as requested. Optum personnel shall comply with Customer's reasonable security or other comparable rules and policies while working on Customer's premises or in its facilities.

5. Hardware and Connections. Customer shall maintain the appropriate browser and other software and hardware for accessing the Hosted System, as specified in Exhibit C.

6. Customer Responsibilities. Customer acknowledges that computer systems, telecommunications systems and the Hosted System, or the components thereof, may be subject to errors or interruption. Customer shall be solely responsible for protection and backup of its computer and telecommunications systems and for the storage, retrieval or transmission of any data used, processed or compiled by the Hosted System, including the Customer Data. Client will also have the obligations outlined in the Hardware and Third Party Software Specifications.

B. Customer Requirements for Accessing the Hosted System.

1. Workstations. Customer is responsible for providing and maintaining the workstations needed for accessing the Hosted System, and for making any necessary repairs, replacements, and upgrades required to support the current version of the Hosted System. Customer is responsible for the compatibility between the Hosted System and any computer equipment, software applications, and information systems of Customer.

2. Telecommunications. Customer must install and maintain a VPN connection. Customer shall pay for all VPN installation, maintenance, and use of equipment and associated charges.

3. Work Space. Customer shall provide Optum staff working on-site performing any work related to operation of the Hosted System with the following:

- A business-like working environment including, but not limited to, office space, desks, furnishings, and telephones with access to outside lines for business calls relating to Optum's performance
- Access to Customer's network(s) and Internet
- Access to the hardware that will be remotely accessing the Hosted System

4. Information and Access. Customer shall provide Optum with sufficient support time and test time on Customer's computer system to duplicate any reported problem with the Hosted System, certify that the problem is related to the Hosted System, and certify that the problem has been corrected. At Optum's request, Customer must provide all information pertaining to Customer's computer system(s). Customer is obligated to advise Optum of any conditions that Customer is aware will affect the Hosted System or Optum's ability to provide the Services.

5. Training. Customer shall designate a training coordinator if the Optum online web based training module is utilized. This training coordinator will ensure that all Users of the Software will complete and pass the online training module before the Users access the Hosted System in a production environment.

IV. Customer Support. Optum will provide the support Services set forth below (which are included in the definition of "Services" under the Agreement). Optum may, from time to time, modify or enhance the support Services, as long as Optum does not materially degrade the support Services. Upon request and if mutually agreed, Optum will provide to Customer additional professional services, at the rates described below, pursuant to a separate, written scope of services.

A. Software Updates, Enhancements and Versions. Maintenance Services include the provisions of updates, enhancements and new versions to the Hosted System.

1. Optum will correct any errors within the Hosted System, including and without limitation, defect repair, programming corrections, and remedial programming, and provide such services and repairs required to maintain the Hosted System so that it operates properly and in accordance with the Documentation.

2. In the event of a failure of the Hosted System to perform as set forth in the Documentation, Optum will respond as set forth in the Service Level Agreement attached as Attachment B.

3. The Hosted System will provide ICD-10 coding capabilities as mandated by the Department of Health and Human Services.

4. Optum is not required to do the following as part of the provision of maintenance: (a) provide maintenance Services for other than the most current versions of the Software, (b) customize new product updates to satisfy Customer's particular requests; or (c) provide maintenance Services or correct any Errors in the Software caused by modifications made by Customer or modifications made by Optum at the request of Customer, or improper use by Customer.

B. Hosted System Technical Support. Optum will provide technical support for Users of the Hosted System twenty-four (24) hours per day, seven (7) days per week, with toll-free telephone access. Core hours are from 7 a.m. to 4 p.m. PST on all Optum business days. All other hours and days will be supported through Optum on call service. The purpose of technical support is to answer User questions, not to perform modifications or customizations, all of which may be provided by Optum on a time and materials basis.

C. Interfaces. Any modifications to the interfaces after the Hosted System goes live will result in charges for additional professional services.

D. Costs. Customer will reimburse Optum for travel and lodging costs associated with maintenance Services support issues and interface support issues that require travel to Customer's site.

V. Fees and Payment Terms.

A. Service Fees.

1. Customer will pay Optum the fees set forth on Exhibit A. The Fees will be billed monthly based on processed visits for the preceding month. Processed visits shall be defined as new patient encounters created in the Software.

2. Customer shall pay Optum for not be less than 80% of the expected annual ASP Fees, based the estimated annual number processed visits set forth in Exhibit A (the "Minimum Annual Software Fees"), subject to Section V.B.2 below. If Customer does not process enough visits for each 12 month period, calculated annually on the anniversary of the date of the first software invoice, Optum will invoice Customer for the difference between the actual invoices and the Minimum Annual Software Fees.

3. Should Customer wish to contract with Optum to provide additional Services, Optum requests an advance notice of thirty (30) days, and the parties shall mutually agree on a change order or additional Schedule.

B. Payment Terms.

1. Invoices. Optum, or its affiliate, shall submit an invoice to Customer on a monthly basis each month for the Fees due for the Hosted System or Services provided by Optum during the previous month. Customer shall pay all amounts due under this Schedule within thirty (30) days of the date of such invoice. Customer shall have twenty-one calendar days to review and return a monthly invoice if it is inaccurate, including a description of any such inaccuracies in the monthly invoice. In such event, Optum will correct the monthly invoice and re-submit it to Customer or, alternatively, contact Customer to discuss any discrepancies in a timely manner.

2. Increases. All fees stated in this Schedule are subject to annual escalation at a rate not to exceed five percent (5%) per year, effective each year on the anniversary of the Effective Date.

3. Travel Expenses. Optum will bill Customer at cost on itemized invoices for all travel and living expenses incurred by Optum in providing the Services.

C. Suspension of Services. In addition to any other remedy available at law or in equity, upon ten (10) days written notice thereof, Optum may suspend its Services or access to and use of the Hosted System by Customer if Customer is delinquent by more than two (2) monthly payments of fees and has failed to cure such delinquency within ten (10) days after written notice thereof.

VI. Term and Termination. This Schedule is effective as of the Effective Date of this Schedule, and continues for two (2) years thereafter, unless earlier terminated pursuant to this Schedule or pursuant to the Agreement. This Schedule shall automatically renew for additional, successive one (1) year periods, at the then current fees, unless either party gives the other party written notice of termination at least sixty (60) days prior to the end of the initial term or any successive one (1) year term.

A. Cooperation at Termination. Upon any termination of this Schedule, Optum shall reasonably cooperate with Customer in the transition to a new system, subject to Optum's then current standard time and material charges for such assistance. For avoidance of doubt, notwithstanding the foregoing, Optum shall not be obligated to disclose to any successor service provider any copy of the Software or other components of the Hosted System or any other Confidential Information.

B. Effect of Expiration or Termination. Customer shall immediately cease use of the Hosted System and verify in writing to Optum that it has destroyed, permanently erased or returned to Optum any portion of the Hosted System in its possession or control and all of Optum's other Confidential Information. Within fifteen (15) calendar days after the effective date of expiration or termination, Optum shall make available to Customer the Customer Data by exporting the SQL database to approved back-up media, with reasonable notice to Customer, shall erase all copies of Customer Data in the Database, and return to Customer all of Customer's other Confidential Information in Optum's possession or control. All licenses to access and use the Hosted System shall immediately terminate including, without limitation, all licenses under the User License Agreements. Optum shall remove the Customer access to the Hosted System production environment within seven (7) days. The Database shall remain on archive tapes for a period of six (6) years consistent with HIPAA regulations.

VII. Termination of ASP Agreement. Upon the Schedule Effective Date, the Agreement and this Schedule shall supersede and replace the Application Service Provider Agreement dated December 27, 2011 and the Addendum signed June 12, 2012 between LYNX Medical Systems, Inc. and Customer (together, the "Prior Agreements") and those Prior Agreements shall terminate.

IN WITNESS WHEREOF, the parties hereto have duly executed and delivered this Product Schedule as of the Effective Date set forth above.

OPTUM360, LLC	SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
BY: Allen Plunk Allen Plunk (Jan 30, 2015)	BY:
PRINT NAME: Allen Plunk	PRINT NAME:
TITLE: SVP	TITLE: CFO

Rev. 04/1/13
UPS: 1GX90899
SF:
OID:
Version 1

EXHIBIT A – Pricing

Service	Fee
Fees for access to the Hosted System	
Lynx E/Point Facility ▪ LYNX Software Application License ▪ LYNX Software Application Updates ▪ LYNX Clinical Database Updates ▪ Technical Support Estimated annual census: 51,000	$4.05 per visit, billed monthly
Lynx Observation Charging Application ▪ LYNX Software Application License ▪ LYNX Software Application Updates ▪ LYNX Clinical Database Updates ▪ Technical Support Estimated annual census: 2,203	$4.05 per visit, billed monthly

EXHIBIT B

SERVICE LEVEL AGREEMENT

Customer acknowledges that Optum uses a third party to host the Hosted System, and that from time to time the terms of this Service Level Agreement may be modified. Optum shall give Customer notice of any such changes as soon as commercially reasonable after Optum is made aware of such changes. The Hosted System is accessed by Users using the internet. Optum assumes no responsibility for a User's ability to access the internet.

System Availability	The Hosted System will be available for User access (uptime) 99% of the time 24x7x365, subject to the terms of this Service Level Agreement measured monthly. This does not include any local client system or communications failure. Uptime excludes (i) scheduled maintenance (times available upon request); (ii) emergency maintenance requested by Customer or other Optum customers that must by its nature only be conducted outside the scheduled maintenance window; provided that Optum shall notify Customer as soon as practicable of the need for such emergency maintenance before the Hosted System is taken offline; (iii) downtime caused by any unauthorized use of the Hosted System by Customer or Users; and (iv) circumstances beyond Optum's reasonable control. Optum is not responsible for issues that might occur with global internet.
Response Time	All User entries shall display in not less than 3 seconds and all transactions and screen transitions shall execute in not more than 5 seconds. (Test over 30 minutes) This includes TCP\IP Interface socket connections but excludes batch interfaces.
Latency	Average time required for round-trip packet transfers over the Optum hosted communications backbone will not exceed 500 milliseconds during a calendar month. Optum cannot be responsible for Customer LAN or WAN issues nor the internet.
Packet Loss	Average percentage of IP packet loss will be less than 1% in a given calendar month over the Optum hosted communications backbone. Optum cannot be responsible for Customer LAN or WAN issues nor the internet.
System Maintenance	Routine Server maintenance will be performed on Sundays between the hours 2 AM and 3 AM Eastern Time. Scheduled emergency maintenance will be performed between the hours of 2 AM and 6 AM Eastern Time. Minimum of two hours notification for Emergency Maintenance.
Disaster Recovery	For disaster recovery purposes, Optum shall maintain backup servers. If Optum declares a disaster situation, the Customer Data and use of the Hosted System will be restored within 72 hours at the Optum backup site. A test of this disaster recovery service will be performed once per calendar year.
Optum Support Service Levels	Phone – Optum Support Line: 1 hour initial response for Critical and High severities. 1 business day response for Medium and Low severities. Other (email, web): 1 business day response for all severities. (Critical and High severities should always be submitted via the Optum Support line.)
Critical. System is down; major functionality	Critical Response. Optum to respond within 1 hour. Optum to

is not working, material data loss or data corruption; end users unable to perform essential functions. There is no workaround for the issue(s)	communicate with Customer once every 4 hours or other mutually agreed upon time until resolved.
High. System intermittently unable to perform essential functions. Individual Users are unable to access the system for typical functions. There may be a workaround for the issue(s).	High Response. Optum to respond within 1 hour. Optum to communicate with Customer once every 8 business hours (1 business day) or other mutually agreed upon time until resolved.
Medium. Small number of Users intermittently unable to perform non-essential functions; Application functions and continues to be used (e.g. intermittently receive error message or general application/network slowness). There is a workaround for the issue(s).	Medium Response. Optum to respond within 1 day. Optum to communicate with Customer once every 24 business hours (3 business days) or other mutually agreed upon time until resolved.
Low. Does not impact the delivery of system functionality, does not impact the validity of data in the application (e.g. spelling error, misalignment of data on screen). Application clarification and enhancement requests. Any other general questions.	Low Response. Optum to respond within 1 day. Optum to communicate with Customer once every 72 business hours (9 business days) or other mutually agreed upon time until resolved.

Remedies. Customer's sole and exclusive remedy and Optum's entire liability for any breach of this Service Level Agreement shall be as follows: failure of any two of the Service Level's within a 30 day period will result in a 5% discount in ASP Fees for the next monthly billing cycle. A failure of the Service Levels related to Latency or Packet-loss must be reported to LYNX within seven (7) days of occurrence to be confirmed by a measurement of the Hosted System backbone

SLA Claims Process. Optum will provide an incident report within fourteen (14) days of a service event. Customer, at its discretion, may request a discount, if applicable, in the following month by sending a written request by email to Optum's accounting department. Discounts can only be claimed for the prior calendar month.

EXHIBIT C

HARDWARE SPECIFICATIONS

Prerequisites

The Optum™ LYNX Outpatient Charge Capture applications are fully Web-based and require a compatible operating system and browser combination. Prerequisites include:

- Internet connectivity (640 Kbps synchronous speed or greater)
- One of the following operating systems:
  - Microsoft® Windows® XP SP2 or SP3
  - Windows Vista®
  - Windows Server® 2003, 2008, or 2008 R2
  - Windows 7
- Internet Explorer® (IE) 8 or 9 with the following settings:
  - **Pop-Up Blocker** turned off
  - https://*.OptumInsightmed.com added to **Trusted Sites**
  - (Recommended) **Trusted Sites** security level set to **Low** to be able to view reports
- Microsoft Silverlight® 4
- 25 MB of disk space for the storage of temporary files
- A monitor with screen resolution set to 1280x960 or higher.

The software checks for the presence of the appropriate version of Silverlight and, if not found, provides the user with a link to download and install the application. Alternatively, prior to connecting to the 7.2 Web site, Silverlight can be downloaded and installed from the following link: http://www.microsoft.com/getsilverlight/Get-Started/Install/Default.aspx

Note: To install Silverlight, the user must have administrative rights on the workstation.

Compatibility

The following table shows Silverlight-compatible operating system and browser combinations:

Operating System	Internet Explorer 9.0	Internet Explorer 8.0
Windows 7, Windows Server 2008 R2	✓	✓
Windows Server 2003, Windows XP SP2 and SP3, Windows Vista, Windows Server 2008	✓	✓

Printing

The Reporting Module generates reports in XLS file format. To view or print XLS files, use an application capable of displaying tabular data, such as Microsoft Excel®.

Board Paper: Finance Committee

Agenda Item:	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)
Executive Sponsor:	Gary Ray, SVMC Chief Administrative Officer
Date:	October 11, 2023

Executive Summary

Salinas Valley Health is pursuing tenant improvements to two suites within an existing medical office building located at 212 San Jose Street, Salinas. The planned renovations include architectural finish replacements (flooring, paint, minor wall re-working, cabinetry/counters), low voltage cabling, office furniture, technology, and office equipment necessary to facilitate the re-configuration of the space to increase exam room census capability and provide adequate office space for expanding Medical and Administrative support staff. Facilities Management is approaching the Board to request approval of capital funding to complete renovations and procure furnishings, furniture and equipment. The total requested budget allocation for the project is $500,000.

Background/Situation/Rationale

The remodel of third floor was considered and authorized as part of our strategic capital budget for fiscal year 2024. Specific project cost approval is sought now that project parameters are defined.

Timeline/Review Process to Date:

October 2023:	Define scope and request funding
November 2023:	Contracting/Procurement & existing tenant relocation
December 2023 – March 2024:	Phased Construction Activity

Meeting our Mission, Vision, Goals

Strategic Plan Alignment:

Suite 302 is being vacated by Salinas Valley Health Pre-Surgery Assessment Team. Presently, Salinas Valley Health Clinic's Cardio/Vascular Surgery Clinic occupies suite 301. Relocating doctors and administrative staff out of suite 301, into the nearby suite 302, allows creation of exam rooms in former doctor offices and more efficient support staff areas. The 'tenant improvement build-out' is relatively minimal and will be accomplished by direct-to-owner contracts with a handful of specialty subcontractors on a 'Multi-Prime' project delivery basis, with work scheduled and overseen by facilities management, acting as the owner's representative. Technology upgrades to an existing Salinas Valley Health-managed data system are also expected to be accomplished with this project.

Pillar/Goal Alignment:

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

Fiscal Year Capital Budgeting:

Current capital budget forecast includes:
Fiscal Year 2024 - $500,000

Recommendation

Consider recommendation for Board of Directors to approve 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.

Attachments

Budget & Phasing Plan October 2023

212 San Jose - 3rd Fl - Budget & Phasing Plan - October 2023

Salinas Valley Health Clinic

Project: 212 San Jose 3rd Fl Refresh/Modify suites 301 &302

Architect:

Preliminary Blue Sky Budget - Multi-Prime Delivery

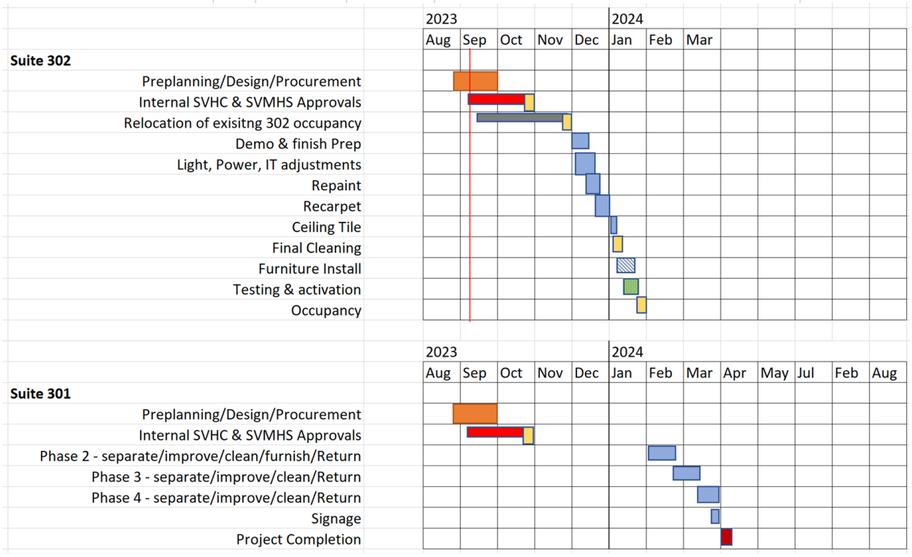
CIP: 01.1250.3790 BCI: 230811

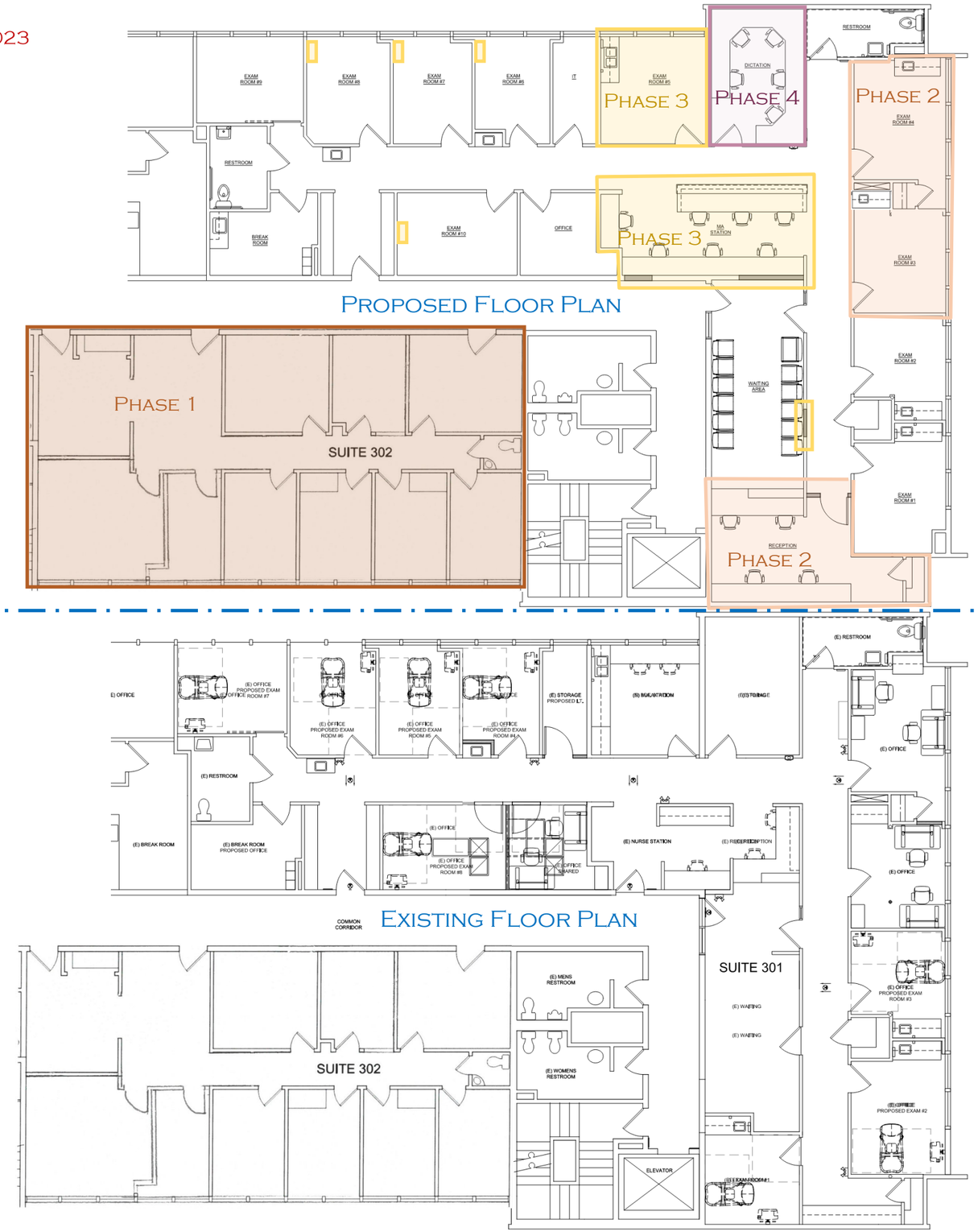
Budget Approval Date:

blue sky= internal WAG before securing bids

Issue: *10/10/2023*

	TRADE		Suite 302 Budget	Suite 301 Budget	NOTES
	HARD COSTS				
	General Conditions/Protection		$12,000	$30,000	
	Soft Demolition		$7,500	$10,000	
	Rough Carpentry Misc Work & Pick Up		$4,500	$7,500	
	Drywall		$1,500	$5,000	
	Paint		$7,500	$10,000	
	Doors / Frames / Hardware		$1,500	$3,000	allowance to mess with existing
	Acoustic Ceiling Work		$5,600	$8,500	replace tiles in 302 - keep grid, patch 301
	Deep Clean existing Carpet		$0	$0	N/A
	Floor Covering		$6,500	$0	replace 302 carpet, 301 scope a separate approved project
	Cabinetry		$0	$30,000	no work 302, Cab Shop product at 301 (no Midmark)
	Countertops		$0	$35,000	no work 302, custom Plam/Corian at 301
	Plumbing		$0	$14,000	plumb in 3 sinks at 301
	Electrical - fixtures FOB jobsite		$7,500	$7,500	LED replacements at 302, can re-work at 301
	Electrical - Labor & Misc Material		$8,000	$15,000	
	Electrical - Low voltage I.T. stuff		$34,000	$10,000	302: cabling $15,switch $13, UPS $2, WAPs $4 = $34,000
	FF+E - Furnish and Install BY OWNER		$35,000	$60,000	need to verify scope with SVHC
	Signage		$500	$4,500	need to verify scope with SVHC
			$131,600	**$250,000**	
	SOFT COSTS				
	Design Documents		$750	$12,000	builder set only, not a bid or permit set
	Const. Management/Supervision		$15,000	$40,000	
	HazMat Test & Mitigate		$0	$5,000	
	Permit Review & Fees		$0	$0	presumes no permit issued
			$147,350	**$307,000**	
	PROJECT CONTINGENCY	10%	$14,735	$30,700	
			$162,085	**$337,700**	
	PROJECT TOTAL		**$499,785**		





Board Paper: Finance Committee

Agenda Item: **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**

Executive Sponsor: Clement Miller, Chief Operating Officer
Christianna Kearns, Senior Administrative Director Cardiovascular, Pulmonary & Sleep Medicine
Gina Ramirez, Director of Imaging Services
Earl Strotman, Facilities Management
Dave Sullivan, Facilities Management

Date: October 10, 2023

Executive Summary

The fluoroscopy equipment in catheterization lab 3 (Cath lab 3) and the interventional radiology special procedures room (IR Room) have reached the end of useful life and will soon be no longer serviceable by the vendor (Siemens). Current project planning encompasses full replacement of existing equipment and building components within the procedure area, control rooms, equipment closets and adjacencies. All planned renovations require plan approval and building permits from California's Department of Health Care Access and Information (HCAi). Facilities management circulated a request for proposal from qualified architectural firms to provide comprehensive design and engineering services necessary to complete construction documents and specifications for securing agency approvals and construction services from general contractors.

Background/Situation/Rationale

Current project planning contemplates complete replacement of the entire fluoroscopy systems. Other supporting building components located within the procedure and control rooms (i.e., medical supply cabinetry, storage, surgical lights, monitor booms, etc....) are obsolete and no longer serve the needs of the physicians and staff. The control and procedure rooms require a complete overhaul to comply with current regulations and accommodate the procedures taking place in that space. Current planning contemplates both equipment replacements being permitted concurrently through HCAI. There will be two work authorizations issued to the design team, controlled by the terms and conditions of the professional services agreement. The design team fees and invoices will be tracked separately for the Cath lab and IR Room equipment replacements respectively.

The construction activities planned for Cath lab 3 will require Cath lab 3 procedures relocate to Cath lab 1 and 2 for several months. To facilitate procedures typically performed in Cath lab 3, we need to identify and potentially upgrade specific systems within Cath lab 1 and 2 to accommodate the additional volume of procedures within those labs.

For interventional radiology special procedures room, a temporary trailer will be planned to dock at an exterior location during the renovations to accommodate patients on the medical center campus. The costs for these provisions will be included during the evaluation of major equipment purchases with the Finance Committee and Board of Directors.

During the RFP process, three (3) complete proposals were received by Salinas Valley Health. Each of the proposals were scored utilizing a tiered scoring structure. A core evaluation committee comprised of Salinas Valley Health clinical leadership and facilities management conducted a scoring of the written proposals. The three primary categories utilized in the evaluation process were:

(a) Qualifications and experience of firm
(b) Approach to providing services and project management
(c) Qualifications and experience of key personnel.

After evaluating all proposals in accordance with the criteria set forth in the RFP, the evaluation committee determined that Smith-Karng Architecture was the highest-ranking proposer. As part of the response to the RFP and consistent with the Mini-Brooks Act qualification-based selection criteria, the proposers were required to submit a separately sealed cost proposal identifying the proposed fee for the requested scope of services. In accordance with the RFP procedures, Salinas Valley Health opened the cost proposal and negotiated the terms and conditions of the Professional Services Agreement. The current fee proposal is consistent with industry standards of similar projects of same size and complexity within the San Francisco Bay Area.

Timeline/Review Process to Date:

September – December 2023 – Solicit equipment vendors
November 2023 – Commence design process to secure HCAI approvals
January 2024 – Review recommendation for equipment vendor package with Board
July 2024 – Review recommendation for award of construction services with Board
August 2024 – Anticipate construction commencing for IR Room (Phase 1)
October 2024 – Complete construction for Phase 1
March 2025 – Anticipate construction commencing for Cath Lab 3 (Phase 2)
July 2025 – Complete construction for Phase 2

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications:

The fiscal years 2024, 2025 and 2026 capital budget allocated funding for planning, design and construction activities required to complete the design process. Following interviews and negotiations with fluoroscopy equipment vendors, we will return to the Board for consideration of approval for equipment contract(s). After completion of the construction bidding process, we will return to the Board for consideration of the construction contract award. The following summarizes the design and engineering fees for schematic design, design documentation, permitting process, contractor bidding support and construction administration services:

Total Planned Capital Budget	
IR Room/Special Procedures	*$3,300,000 over Fiscal Year 2024-2025
Cath Lab 3	*$3,600,000 over Fiscal Year 2024-2026

** Current budget figures indicated are preliminary project estimates at a pre-design stage of the project planning process. Following selection of equipment manufacturer and room configuration, an updated project budget will be presented to the Board in a subsequent meeting for review.*

DESIGN PHASE 1	
IR Room/Special Procedures	
Design Services Fee	$326,283
Reimbursable Allowance	$3,150
Subtotal	$329,433

DESIGN PHASE 2	
Cath Lab 3	
Design Services Fee	$349,883
Reimbursable Allowance	$3,150
Subtotal	$353,033

Total Design Services Fee	**$682,466**

Recommendation

Consider recommendation to Board of Directors to approve the overall project budgets for Cardiac Catheterization Laboratory 3 in the amount of $3.6m and the IR Room/Special Procedures room in the amount of $3.3m. In addition we recommend approving the award of the professional services agreement to Smith-Karng Architecture for Catheterization Laboratory 3 and Interventional Radiology Equipment Replacement Projects, in the amount of $682,466, as presented.

Attachments

(1) Request for Proposals for Design and Engineering Services issued August 31, 2023
(2) Smith-Karng Architecture Response prepared September 29, 2023

REQUEST FOR PROPOSALS FOR DESIGN & ENGINEERING SERVICES

FOR THE

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

CIP 01.1250.3765 & 01.1250.3760

SALINAS VALLEY HEALTH MEDICAL CENTER

450 E ROMIE LANE, SALINAS, CA 93901

August 31, 2023

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I. Request for Proposals for Design & Engineering Services

Salinas Valley Health (Owner) requests a written response to the Request for Proposals (RFP) for an engineering firm ("Prime Consultant") to provide services for the following project:

Cath Lab 3 and Angio Equipment Replacement Project

Salinas Valley Health's Cardiac Catheterization Laboratories (Cath Labs) and Interventional Radiology within the Imaging department perform thousands of diagnostic and interventional procedures each year. Salinas Valley Health offers the most sophisticated procedures available today, providing world-class care in the Monterey Bay area.

The Medical Center's Cath Lab 3 and Angio Rooms are currently located on the medical center's first level of the Cardiac Center South Building 8. The current Siemen's imaging equipment is nearing the end of its useful life and will no longer be supported by the current equipment manufacturer. The cardiovascular and radiology departments are considering three potential manufacturers through a formal RFP process. The Cath Lab 3 equipment replacement involves a floor mounted imaging equipment solution within the procedure room due to spatial constraints of the existing procedure room. The Angio Room involves replacement of an existing ceiling mounted equipment solution for the imaging equipment replacement. Notable scope of the proposed equipment replacement projects encompass the following:

(a) Removal and disposition of the existing Siemens equipment in the procedure area, equipment closet and control room to facilitate the installation of a completely new imaging system in both rooms; Cath Lab 3 will be a floor mounted solution and Angio will be a ceiling mounted solution

(b) Equipment installation including seismic anchorage of new vendor furnished components within the procedure areas, control rooms and equipment closets

(c) Electrical and low voltage infrastructure to support the new equipment upgrades; A new climate-controlled cabinet with integrated electrical and data receptacles will be required to be design and installed within the control room of Cath Lab 3 for consolidation of under-counter technology gear

(d) Alterations to mechanical, electrical and plumbing systems including HVAC balancing of the affected Cath Lab zones; Design team assuming existing cooling systems within the technology equipment closets in both angio and cath lab 3 shall be replaced; New split system cooling units shall be connected to the BMS system; This will require minor alterations to the roofing system directly above the cath lab and angio rooms

(e) Installation of a new touchless operated automatic door assembly to isolate the procedure room from the control room similar to Cath Lab 3's current configuration

(f) Removal, disposition and replacement of the existing surgical lighting system within both procedure rooms

(g) Installation of new ceiling lighting systems within the procedure and control rooms

(h) Medical gas systems will be evaluated by the design team and may need to be relocated depending on the new equipment configuration

(i) Replacement of existing casework systems within the room to optimize the space and new storage solutions

(j) Coordination and integration of Owner-procured design-build Hillrom nurse call system upgrade within the construction extents; The reporting homeruns to the Heart Center nurse station where existing raceways will be leveraged but will need to be detailed on the drawings

(k) Coordination and integration of Owner-procured design-build fire alarm system upgrade within the construction extents; Owner will leverage the existing fire alarm system as necessary to meet the current code requirements

(l) Coordination and integration of Owner-procured design-build fire suppression system upgrade within the construction extents; Owner will leverage the existing fire sprinkler system as necessary to meet the current code requirements

(m) Coordination and integration of Owner-procured physicist for lead-lining requirements upon survey of existing conditions and recommendations to comply with new equipment requirements

(n) Interior design of architectural scheme to be reviewed and approved by the Medical Center's executive team; This should include all flooring, wall and ceiling colors, door finishes, and casework finishes; All existing flooring will be replaced within the construction extents; New wall and ceiling colors will be require to be replaced

The pre-design budget for the proposed upgrades has been approved by the Board for the current fiscal year and construction is anticipated to commence in Spring 2024 for the Angio room and Fall 2024 for Cath Lab 3 in a phased approach with one general contractor. Current planning contemplates both equipment replacements being permitted concurrently through HCAI. There will be two work authorizations issued to the design team, controlled by the terms and conditions of the professional services agreement. The design team fees and invoices will be track separately for the cath lab and angio room equipment replacements respectively.

The equipment manufacturer for the major imaging equipment is currently under evaluation by both respective department leads. Notification of award for the successful equipment manufacturer is anticipated by October 2023.

In addition to the scope of work identified above, Salinas Valley Health is requesting the design team include an accessibility evaluation of the cath lab and imaging units to identify any accessibility upgrades HCAI will require to be integrated into the project scope of work per federal mandates. The work shall be incorporated into the construction documents with this project as required by the AHJ.

Based on the proposal presented in response to the RFP, and the selection process described in this RFP, the Hospital will select the most qualified firm. The selection process and criteria are set forth in part II of this RFP.

Bogard Construction must receive the completed Proposal package no later than 2:00 p.m. on September 29, 2023.

Submit the Proposal package to:

SALINAS VALLEY HEALTH – Cath Lab 3 and Angio Equipment Replacement
Bogard Construction | Attn Dave Sullivan
535 E Romie, Suite 6
Salinas, CA 93901

II. Project Information and Schedule

A. Project Description

The proposed project is located on a 9.5-acre site at 450 E. Romie Lane in the City of Salinas, California (Assessor Parcel Numbers: 002-711-002, 002-711-004, 002-711-003, and 016-131-030). The hospital was developed in its current location beginning in the early 1950s. During this time, the hospital was almost entirely surrounded by agriculture and has since been surrounded by residences and both private and hospital owned medical office facilities. The project site is bordered and accessible by driveways to the south by San Jose Street, to the north by E. Romie Lane, to the west by Wilgart Way, and to the east by Los Palos Drive.

The construction project will require extensive coordination with the Facility, Clinical Team, Owner's Representative, Design Team & Subcontractor leads for assessment of new & existing systems, and utility shutdown/interruption sequencing.

Salinas Valley Health will provide any detailed monitoring of mechanical, electrical, plumbing and fire protection systems required for this project including time-lapsed recording ammeter readings or air quantity measurements.

B. Design & Engineering Requirements

The Cath Lab 3 and Angio Equipment Replacement design must be developed in accordance with HCAI Rules and Regulations. This will require meetings with the HCAI. The design and construction of the Hospital's building projects are required to conform to all applicable Federal, State & Local regulations including the 2022 California Code of Regulations (e.g. Titles 8, 19, 24, etc, and the Americans with Disabilities Act).

The Prime Consultant for the Cath Lab 3 and Angio Equipment Replacement project must be willing to work collaboratively with Medical Center's Board, Medical Center's Administration, and the Medical Center's construction manager, as well as the facilities engineers, as part of the team under the management of the Salinas Valley Health.

C. Summary of Estimated Scope of Work

The estimated scope of work indicated in the RFP for site and meeting time is for the **Prime consultant only**. Other hours for the subconsultants will be required and need to be included in the scope and fee of the total project.

Schematic and Design Development Phase

1. Prepare design development drawings, both interim and final, full specifications, and calculations. Owner to prepare division 00 for contracting and procurement requirements.

2. Meetings and site visits with equipment vendors and other hospital stakeholders.

3. Design drawings shall include location of MEPT equipment, procedure room equipment, devices and risers, schedules for MEPT equipment, electrical single line diagrams and major duct and piping runs. Refer to Section I of this RFP for specific scope of work.

Construction Document Phase

1. Prepare construction drawings, specifications, and calculations. All design criteria in this phase will be a result of the approved Design Development Phase work as well as comments by SALINAS VALLEY HEALTH on that set of documents.

2. Meetings and site visits as necessary to document existing conditions. Design team to specify allowance of meetings provided for in their proposal.

3. Review the cost estimate prepared by Owner's consultant.

4. Integrate all Owner procured design-build contracts with the design package submitted to HCAI for review and approval.

AHJ Review/Approval

1. Revise documents as required to obtain approval from Authorities Having Jurisdiction (AHJ).

2. Meet with Authorities Having Jurisdiction as necessary to obtain project approval.

3. Communicate any changes forced by the authorities having jurisdiction or equipment vendor to the MEP set that will affect other disciplines.

4. Site meetings and visits. Design team to specify allowance of meetings provided for in their proposal.

Bidding & Negotiation Phase

1. Answer written questions of contractors during the bidding period.

2. Provide clarification of contract documents as requested.

Construction Administration Phase

1. Review and respond to requests for information for design & engineering work.

2. Review requested submittals and shop drawings for the design work. When required to review submittals for any particular sections of the design work more than twice, the general conditions of the contract will require the contractor to reimburse the design firm for the additional effort. If a substitution requires modifications to the documents or additional work to obtain approvals from the Authorities Having Jurisdiction, SALINAS VALLEY HEALTH will compensate the firm for the added work.

3. Site meetings and visits (including travel time) (including one punch list per discipline and one final walk-through per discipline) to observe the progress and quality of the work completed by the Contractor(s).

Additional requirements are set forth in the sample Professional Services Agreement.

D. Anticipated Schedule

The current anticipated schedule for the implementation of the project is as follows. All dates are subject to change at SALINAS VALLEY HEALTH discretion:

August 31, 2023	RFP issued
September 12, 2023	Requests for clarification due
September 15, 2023	Owner response to requests for clarification
September 29, 2023	Proposal Due Date
October 2-5, 2023	Evaluation Process
October 9-13, 2023	Negotiation of Fee & Reimbursable Expenses
October 2023	Administrative Review/Execute Agreement
November 2023	Design and Construction Document Preparation
February 2024	Complete Construction Documents/Bid Set
April 2024	Complete Regulatory Agencies Review
May 2024	Bid and Award for Construction Services
May 2024	Construction (90-day project) Angio Room
August 2024	Construction (90-day project) Cath Lab 3

III. Request for Proposals Submission Process and Requirements

A. Submittal of Proposals

1. Requests for Modifications or Clarifications of the Proposal Specifications

Dave Sullivan of Bogard Construction is SALINAS VALLEY HEALTH's designated representative for purposes of this RFP and is the main point of contact for all proposers. Should firms interested in submitting a Proposal have questions regarding the required services, the contents of the Proposal, the selection procedures, or any other requirements, these questions must be directed only to Dave Sullivan. Proposers should not have contact with any other SALINAS VALLEY HEALTH staff during the pendency of this RFP, until a contract is awarded.

Any requests for modifications or clarifications of the RFP requirements must be submitted in writing to Dave Sullivan at the address below. Any interpretation, change, or correction of the RFP will be made by Addenda only, duly issued by SALINAS VALLEY HEALTH. All oral modifications of these conditions or specifications are void and ineffective. SALINAS VALLEY HEALTH reserves the right to reject any Proposal that contains unauthorized conditions or exceptions.

2. Proposal Due Date

Proposers are required to submit one original and 2 hard copies of the Proposal to SALINAS VALLEY HEALTH. Proposers should also submit an electronic copy of their proposal in pdf format on a removable "thumb" drive. In case of any discrepancies, the original will be considered by SALINAS VALLEY HEALTH in evaluating the Proposal, and the electronic version is provided for SALINAS VALLEY HEALTH's convenience only. Proposals should be submitted in an envelope marked, "RFP FOR THE CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT" and plainly endorsed with Proposer's name and address. Proposals must be hand delivered or sent to the following address by FedEx or equivalent. Use of USPS is not recommended:

SALINAS VALLEY HEALTH – Cath Lab 3 and Angio Equipment Replacement
Bogard Construction
535 E Romie, Suite 6
Salinas, CA 93901
Attn: Dave Sullivan

Proposals must be received no later than September 29, 2023, by 2:00 p.m., Pacific Standard Time. Proposals received after the time and date specified may not be considered. SALINAS VALLEY HEALTH is not responsible for deliveries delayed for any reason. Submission of a Proposal constitutes a firm offer to SALINAS VALLEY HEALTH for 90 calendar days from the submission deadline for Proposals.

Each Proposal must be signed by one or more individuals with authority to bind the Proposer to the Proposal. All Proposals without the appropriate signature(s) may be deemed non-responsive and may result in the rejection of the Proposal.

SALINAS VALLEY HEALTH will review all Proposals received and several finalists may be selected.

B. Proposal Content

The following documents are included in this Request for Proposals (RFP). Attachments B and C must be completed and submitted with the Proposal.

Attachment A Selection Criteria Details
Attachment B Statement of Qualifications Form
Attachment C Information about Claims Form
Attachment D Sample Professional Services Agreement

Existing floor and site plans are available to any proposer by request. Please contact David Sullivan at dsullivan@bogardconstruction.com or 831.246.2073

To achieve a uniform review process and obtain the maximum degree of comparability, it is required that Proposals follow the following basic format. The Proposer is expected to prepare its response to fully address its ability to satisfy these components. Although SALINAS VALLEY HEALTH is not specifying a page limit, clarity and conciseness are essential and will be considered during Proposal evaluation.

Proposals should be bound in 3-ring binder or comb-bound. Include a Table of Contents. Please provide dividers with tabs to separate and identify each response item described below. The tabs shall be numbered to correspond to each section below. The Proposal should contain the following response items:

1. Cover Letter

A signed cover letter should be on company letterhead clearly stating the firm name of the Proposer, business address, telephone and facsimile numbers, and e-mail address. The following information should be included:

- Introduce the firm and summarize its qualifications.
- Name(s) of authorized principals with authority to negotiate and contractually bind the firm.
- A statement that binds the Proposer to the proposed Scope of Services and cost proposal for 90 calendar days.
- Confirm acceptance of or indicate exceptions to the Sample Agreement.
- Indicate whether there are any conflicts of interest that would limit the Proposer's ability to provide the requested services.
- Acknowledge receipt of Addenda, if any have been issued.

2. Candidate's Qualifications

In order to be considered qualified for this Project, firms must propose teams that include California licensed architects, mechanical, electrical, plumbing, and structural engineers. These requirements may be met by a single firm, or by a team approach. SALINAS VALLEY HEALTH intends on contracting with a single firm and so any team must be established on a Prime/Sub approach.

In your response to this section, please describe your team and the proposed contracting relationship. Identify by names and titles key staff members who will be assigned to the project or who will otherwise play a major role in the project. Briefly

describe each individual's proposed role and the percentage of commitment (of time) for the entire duration of the project. Provide an organizational chart indicating the relationship of the firm's staff members who are proposed to have responsibilities related to the proposed project. Indicate on the chart the names of key personnel and their titles.

In addition, as part of your response to this section complete and submit the Statement of Qualifications form, Attachment B.

Provide project data for a minimum of two (2) relevant projects similar in size, scope and complexity to the proposed project, for which construction has been completed within the last five (5) years. Also provide project data for any and all projects performed by the firm in any Santa Cruz and Monterey Bay communities within the last five (5) years.

The firm may also include other relevant information it wishes SALINAS VALLEY HEALTH to consider, such as firm's brochure or a discussion of recent and relevant work.

3. Resumes

Submit a resume for each key staff member identified in the response to Item 2 above. Include all relevant experience with similar projects, and indicate the role or duties performed on each such project. Also include employment history.

4. Response to Selection Criteria Form

Describe your firm's qualifications, experience, and approach to the work by providing a response to each bulleted item listed in Attachment A.

5. Request for Supplemental Information – Claims

Complete, sign and submit Request for Supplemental Information – Information about Claims form (Attachment C).

6. Acceptance of Terms and Conditions.

   a. The firm should carefully review the proposed sample Agreement for Services contained in Attachment D.

   b. Submittal of a proposal will be deemed acceptance of all the terms set forth in this RFP and the sample Agreement for Services unless the Proposer includes with its proposal, in writing, any exceptions or modifications requested by the Proposer to the RFP and/or sample Agreement.

7. Certificate of Insurance

Provide a completed sample Certificate of Insurance evidencing the coverage types and the minimum limits required as described in Section 12 of the Sample Professional Services Agreement.

8. Cost Proposal

Compensation under this Agreement will be on a time and materials basis, with a total not-to-exceed amount. Proposers must submit, in a separate sealed envelope, clearly marked with Proposer's name and the words "Cost Proposal," a not-to-exceed total contract price proposal, including expenses, employees' names, job-titles and burdened hourly rates inclusive of profit and overhead; and an hourly cost breakdown by task for the work outlined in this Proposal. The hourly rates or unit prices quoted shall hold firm for the duration of this Contract. Please pay special attention to the anticipated project phasing for design and construction.

C. Withdrawal of Proposal

A Proposer may withdraw its Proposal anytime before the date and time when Proposals are due, without prejudice, by submitting a written request for its withdrawal to the identified point of contact specified above. A telephone or email request is not acceptable.

D. Evaluation Process

An Evaluation Committee (Committee), which may include members of Bogard Construction or SALINAS VALLEY HEALTH staff and one or more outside experts, will review and screen the proposals submitted according to the selection criteria described in this RFP. SALINAS VALLEY HEALTH reserves the right to request additional information and clarifications during the evaluation and selection process from any or all proposers regarding their proposals.

Each member of the Committee will read, evaluate, and score all proposals by each of the criteria described in this section. The Committee will then discuss these evaluations to arrive at a composite score for each firm. The Committee's composite scores will comprise the official record for the proposal evaluation process; individual evaluation records will not be available for public inspection at any point during or after the evaluation process.

Following the initial review and screening of the written Proposals, one or more companies may at SALINAS VALLEY HEALTH's sole discretion, be invited to participate in a final stage of the evaluation process. However, a Proposer may be awarded a contract based solely on its initial Proposal. For this reason, Proposers are encouraged to submit their best proposal at the outset. The final stage of the evaluation process may, but is not required to, include any of the following:

(1) Participation in an oral interview;
(2) Submission of any additional information as requested by SALINAS VALLEY HEALTH; or
(3) References may also be checked during the final selection process.

Upon completion of the final evaluation process, SALINAS VALLEY HEALTH will rank each firm in accordance with the Selection Criteria. SALINAS VALLEY HEALTH will open the cost proposal from the top-ranked firm only, and it may accept the proposal or negotiate the terms and conditions of the Agreement. If negotiations are

unsuccessful, SALINAS VALLEY HEALTH will terminate the negotiations with that firm and may open negotiations with the next-highest ranked firm. If negotiations with this firm are also not successful, SALINAS VALLEY HEALTH may repeat the negotiations process with the next-highest ranked firm or, at its sole discretion, SALINAS VALLEY HEALTH may reject all remaining proposals. SALINAS VALLEY HEALTH, however, may award a Contract without conducting interviews or negotiations.

The Evaluation Committee shall make a recommendation to SALINAS VALLEY HEALTH's Board of Directors. All Proposers will be notified of the recommended award. No Agreement will be in force until a written authorization is issued by SALINAS VALLEY HEALTH.

The Proposer to whom award is made shall execute, and return to SALINAS VALLEY HEALTH, a written Agreement for Services within 10 calendar days after receiving the form of Agreement for execution. At the same time, the successful Proposer shall submit all other required documents.

E. Selection Criteria

SALINAS VALLEY HEALTH intends to award a Contract to the most qualified firm that submits the Proposal based on the following selection criteria. Each criteria may include sub-criteria, not listed below, that may reasonably relate to the criteria. Proposers are directed in particular to Attachment A. In determining the number of points a Proposal will receive in each category, the Evaluation Committee will consider the Proposal material submitted, oral interviews (if applicable), and any other relevant information about a given Proposer. The following criteria will be used in the evaluation of the Proposals.

a)	Qualifications and Experience of Firm	Max 80 points
b)	Approach to Providing Services and Project Management	Max 80 points
c)	Qualifications and Experience of Key Personnel	Max 50 points

F. SALINAS VALLEY HEALTH Rights

SALINAS VALLEY HEALTH reserves the right to cancel this procurement in whole or in part, at its sole discretion, at any time before the Agreement is fully executed and approved on behalf of SALINAS VALLEY HEALTH.

This RFP does not commit SALINAS VALLEY HEALTH to award an Agreement, to pay any costs incurred in the preparation of the proposal for this request, or to procure or contract for services. SALINAS VALLEY HEALTH reserves the right to modify or cancel in whole or in part this RFP, to reject any and all proposals, to accept the proposal it considers most favorable to SALINAS VALLEY HEALTH's interest in its sole discretion, and to waive irregularities or informalities in any proposal or in the proposal procedures. SALINAS VALLEY HEALTH further reserves the right to reject all proposals and seek new proposals when SALINAS VALLEY HEALTH considers such procedure to be in its best interest.

G. Confidentiality

The California Public Records Act (Cal. Govt. Code Sections 6250 et seq.) mandates public access to government records. Therefore, unless the information is exempt from disclosure by law, the content of any request for explanation, exception or substitution, response to this RFP, protest or any other written communication between SALINAS VALLEY HEALTH and the Proposer will be made available to the public.

If the Proposer believes any communication contains trade secrets or other proprietary information that the Proposer believes would cause substantial injury to the Proposer's competitive position if disclosed, the Proposer must request that SALINAS VALLEY HEALTH withhold from disclosure the proprietary information by marking each page containing such proprietary information as confidential. Proposer may not designate its entire Proposal as confidential. Additionally, Proposer may not designate Proposal Forms as confidential.

If the Proposer requests that SALINAS VALLEY HEALTH withhold from disclosure information identified as confidential, and if SALINAS VALLEY HEALTH complies with the Proposer's request, the Proposer assumes all responsibility for any challenges resulting from the non-disclosure, and by submission of a Proposal, agrees to indemnify and hold harmless SALINAS VALLEY HEALTH from and against all damages (including but not limited to attorneys' fees that may be awarded to the party requesting the Proposer information), and pay any and all cost and expenses related to the withholding of the Proposer information. The Proposer shall not make a claim, sue or maintain any legal action against SALINAS VALLEY HEALTH or its directors, officers, employees or agents in connection with the withholding from disclosure of Proposer information.

If the Proposer does not request that SALINAS VALLEY HEALTH withhold from disclosure information identified as confidential, SALINAS VALLEY HEALTH will have no obligation to withhold the information from disclosure and may release the information sought without liability to SALINAS VALLEY HEALTH.

H. Ex Parte Communication

Proposers and Proposers' representatives may not communicate orally with an officer, director, employee, or agent of SALINAS VALLEY HEALTH, with the exception of communications consistent with the procedures of this RFP, regarding this RFP until after a Notice to Proceed has been issued by SALINAS VALLEY HEALTH. Proposers and their representatives are not prohibited, however, from making oral statements or presentations in public to one or more representatives of SALINAS VALLEY HEALTH during a public meeting.

In the context of this RFP, an "ex parte communication" is any communication between a Proposer (or the Proposer's representative) and any SALINAS VALLEY HEALTH, Board Member, officer, employee or consultant, regardless of who initiates the communication, other than as part of the procurement process specified herein.

I. Waiver

By submitting a Proposal, the Proposer represents and warrants that it has sufficiently informed itself in all matters affecting the performance of the work or the furnishing of the labor, supplies, material, or equipment called for in the RFP; that Proposer has checked its Proposal for errors and omissions; that the prices stated in its Proposal are correct and as intended by it and are a complete and correct statement of its prices for performing the work or furnishing the labor, supplies, materials, or equipment required by the RFP. The Proposer waives any claim against SALINAS VALLEY HEALTH for costs incurred in preparing a Proposal and responding to this RFP.

ATTACHMENT A

RESPONSE TO SELECTION CRITERIA

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

Proposers should respond to all items listed below

1. Qualifications and Experience of Firm

   Items for Consideration:
   - *Experience in the design of Hospital Cath Lab and Interventional Radiology Services.*
   - *Demonstrated design expertise working within an operating facility.*
   - *Experience with projects of similar program, magnitude, and scope, in particular within the same geographical areas, Monterey and San Francisco Bay areas.*
   - *Experience with HCAI Level I.*
   - *Experience during construction and contract administration phases of projects.*

2. Approach to Providing Services and Project Management

   Items for Consideration:
   - *Summary of approach to work.*
   - *Understanding the opportunities and constraints of the SALINAS VALLEY HEALTH site.*
   - *Identification of particular challenges involved in this project and approach to addressing them.*
   - *Approach to working in partnership with Hospital's staff and their consultants, during both design and construction.*
   - *Demonstrated experience in conducting and participating in meetings and work sessions with diverse groups of consultants, SALINAS VALLEY HEALTH Board of Directors, and administrative staff.*
   - *Capabilities to undertake appropriate project management efforts, and anticipate and resolve problems specific to the needs of the project under consideration.*

3. Qualifications and Experience of Key Personnel

   Items for Consideration:
   - *Proposed staffing level for this project.*
   - *Qualifications and experience of proposed team in the design of similar projects.*

ATTACHMENT B

STATEMENT OF QUALIFICATIONS

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

1. Firm name: _____

2: Business Address: _____

3. Firm Established (year): _____ Telephone: _____
   Fax: _____
   Email: _____
   Website: _____

4. Type of Organization: (check one)
   Sole Proprietorship (_____)
   Partnership (_____)
   Corporation (_____)
   Joint Venture (_____)

5. Key Personnel

Name	Title	Degree or Certification	Institution	Registration

6. Average staff employed in your home office (average of past 5 years):

   Architects: _____
   Structural Engineers: _____
   Mechanical Engineers: _____
   Electrical Engineers: _____
   Civil Engineers: _____
   Drafting Technicians: _____
   Clerical: _____
   Other: _____

7. Provide at least three (3) references that SALINAS VALLEY HEALTH may contact:

8. Provide at least three (3) contractor references that SALINAS VALLEY HEALTH may contact:

Signature: _____ Date: _____

Printed Name: _____

Title: _____

ATTACHMENT B (CONT.)

PROJECT INFORMATION SHEET

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

Please complete a Project Information Sheet for each project listed in the Statement of Qualifications. If construction is not complete, give project status instead of completion date.

Project: _____ Completion Date: _____
Location: _____ Gross Sq. Feet: _____
Owner: _____ Number of Spaces: _____
Owner's Representative: _____ Construction Cost: _____

Description: _____
_____
_____

Owner/Representative Phone Number: _____
Contract Method (lump sum, negotiated, design build, multiple-prime, other):
_____

General Contractor: _____

Project Manager: _____ Superintendent: _____

Architect: _____

Principal: _____ Project Manager: _____

Structural Engineer: _____

Principal: _____ Project Manager: _____

Mechanical Engineer: _____

Principal: _____ Project Manager: _____

Electrical Engineer: _____

Principal: _____ Project Manager: _____

Other (as appropriate): _____

Principal: _____ Project Manager: _____
(provide additional sheets if necessary)

ATTACHMENT C

REQUEST FOR SUPPLEMENTAL INFORMATION - CLAIMS

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

Please submit the following information. Failure to respond may affect consideration of your firm for this project. If the firm has more than one office or division, please provide this information for the office proposed for this project. Responses may be listed on separate pages.

1. Separately list each pending unresolved claim for construction disputes and each current arbitration(s), mediation or litigation in which construction disputes or breach of contract is alleged or indemnity is being sought (because of such alleged disputes or breach of contract) using the following claimant categories:

    a. SALINAS VALLEY HEALTH against your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

    b. Any Owner, person or entity against your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

    c. SALINAS VALLEY HEALTH against any of your proposed consultant (i.e. structural, mechanical, electrical, and any other consultant). If none, indicate none.

    d. Any Owner, person or entity against any of your proposed consultants (indicate project, location and Owner). If none, indicate none.

2. Separately list each resolved (settled, arbitrated, and litigated) claim for professional negligence or breach of professional services agreement or for indemnity (because of such alleged negligence or breach of contract) during the last five (5) years using the following categories:

    a. SALINAS VALLEY HEALTH and your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

b. Any Owner, person, or entity, and your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

DECLARATION:

The undersigned declares under penalty of perjury that all of the information submitted is true and correct, and that this declaration was executed in

_____ County, California, on _____.
(County) (Date)

_____
Name and Title –Printed or Typed

_____	_____
Signature	Firm Name –if a joint venture, state name of joint venture entity
_____	_____
Address	City, State and Zip Code
_____	_____
Telephone Number	Facsimile Telephone Number

ATTACHMENT D

SAMPLE PROFESSIONAL SERVICES AGREEMENT
CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

AGREEMENT FOR PROFESSIONAL SERVICES

THIS AGREEMENT IS MADE as of the ____ day of_____, 2023, by and between the Salinas Valley Health (hereinafter referred to as "DISTRICT") and _____ (hereinafter referred to as "CONSULTANT").

WHEREAS, DISTRICT desires to obtain professional engineering design services in conjunction with the DISTRICT's Cath Lab 3 and Angio Equipment Replacement ("Project"), and has issued a Request for Proposals dated _____, 2023, attached as **Exhibit A** and incorporated herein by this reference; and

WHEREAS, CONSULTANT has represented that it is experienced and skilled in performing such services and has submitted a proposal dated _____, 2023, including a cost proposal dated ____, 2023, attached as **Exhibit B** and incorporated herein by this reference,

WHEREAS, on _____, 2023, the DISTRICT'S Board of Directors, awarded a Professional Services Agreement (AGREEMENT), to CONSULTANT, for design services related to the Project.

NOW, THEREFORE, THE PARTIES AGREE AS FOLLOWS:

1. RENDITION OF SERVICES

CONSULTANT agrees to provide professional services to DISTRICT in accordance with the terms and conditions of this AGREEMENT. In the performance of its work, CONSULTANT represents that it has and will exercise that degree of professional care, skill, efficiency and judgment ordinarily employed by engineering consultants with expertise in designing hospital Cath Labs and Interventional Radiological Procedure Rooms; and preparing design plans, technical specifications and engineer's estimates for construction contracts. CONSULTANT further represents and warrants that it holds currently in effect all licenses, registrations, and certifications in good standing that may be required under applicable law or regulations to perform these services and agrees to retain such licenses, registrations, and certifications in active status throughout the duration of this engagement.

2. SCOPE OF SERVICES

2.1 The scope of services to be provided under this AGREEMENT shall consist of specific Services as generally described in the RFP, **Exhibit A**, and CONSULTANT's Scope of Services and Cost Proposal, attached as **Exhibit B**.

2.2 CONSULTANT's final plans and specifications prepared under this AGREEMENT shall be in accordance with the following design standards:

- 2022 California Electrical Code
- 2022 California Mechanical Code
- 2022 California Plumbing Code

- 2022 California Building Code
- 2022 California Fire Code

2.3 CONSULTANT shall cooperate with representatives of the State of California, and all other DISTRICT consultants working on Project. CONSULTANT shall provide the services for Project in close liaison with DISTRICT. All personnel acting on behalf of CONSULTANT shall cooperate with DISTRICT staff during the course of this AGREEMENT. To ensure that CONSULTANT understands the requirements of this AGREEMENT, representatives of DISTRICT and CONSULTANT shall communicate as often as deemed necessary.

2.4 Throughout its performance of services under this AGREEMENT, CONSULTANT shall serve as an independent contractor to DISTRICT. Neither CONSULTANT nor any party contracting with CONSULTANT shall be deemed to be an agent or employee of DISTRICT.

2.5 CONSULTANT understands and agrees that it is solely responsible for the sufficiency, adequacy and completeness of all plans, specifications, calculations, and estimates prepared by CONSULTANT under this Agreement. CONSULTANT's final plans and specifications shall set forth the requirements for the construction of the Project in a clear, complete and accurate manner. CONSULTANT shall undertake all reasonable quality control measures to review, coordinate, and otherwise check its plans, specifications, calculations, and estimates for sufficiency, adequacy and completeness.

2.6 CONSULTANT's plans, specifications, calculations, and estimates shall be subject to DISTRICT's review. CONSULTANT acknowledges that DISTRICT will not be undertaking a detailed or comprehensive quality review of CONSULTANT's work product. DISTRICT will notify CONSULTANT of any errors or omissions that DISTRICT discovers in CONSULTANT's work product, but CONSULTANT shall not depend on DISTRICT to discover any errors or omissions in CONSULTANT's work product. Attention is directed to Section 2.5 of this Agreement.

2.7 CONSULTANT and its subconsultants shall not incorporate into the design any materials or equipment of single or sole-source origin without written approval of DISTRICT.

2.8 CONSULTANT's personnel shall keep accurate records and document the work as it progresses.

2.9 CONSULTANT's personnel shall become knowledgeable of all applicable local, state, and federal laws and regulations, and CONSULTANT's design shall comply therewith.

2.10 The Project Manager for CONSULTANT will be _____. The Project Manager for DISTRICT will be Bogard Construction Inc. CONSULTANT shall cooperate with and coordinate all of its activities with DISTRICT's Project Manager.

3. SCHEDULE AND TIME OF COMPLETION

3.1 The effective date of this AGREEMENT is_____, 2023. No work under this AGREEMENT shall begin prior to DISTRICT's issuance of a Notice to Proceed to CONSULTANT.

3.2 Time is of the essence in the performance of CONSULTANT's services under this AGREEMENT. All services to be provided pursuant to this AGREEMENT shall be performed in a timely manner so as not to delay construction of Project. In the event that CONSULTANT incurs delays in completing the services within the aforementioned timeframe for reasons beyond the reasonable control of CONSULTANT, an appropriate extension of time may be granted by DISTRICT, at its sole discretion, following the timely submission of a written request by CONSULTANT

3.3 **Exhibit A** includes a schedule for CONSULTANT's performance of activities under this Agreement. CONSULTANT shall endeavor to complete each of the tasks set forth in the schedule in accordance with this schedule. The schedule shall be subject to revision as mutually agreed upon by DISTRICT and CONSULTANT.

4. DELIVERABLES

THE DELIVERABLES TO BE PROVIDED UNDER THIS AGREEMENT SHALL CONSIST OF SPECIFIC DELIVERABLES AS GENERALLY DESCRIBED IN THE RFP UNDER THE SUMMARY OF ESTIMATED SCOPE OF WORK.

4.1 **Interim Milestone Deliverables**

During the performance of its services under this Agreement, CONSULTANT shall deliver three (3) sets of documents and electronic files for the following milestone submittals:

A. 35%-Completion Submittal

CONSULTANT shall submit for DISTRICT's review 35%-completion design plans.

B. 65%-Completion Submittal

CONSULTANT shall submit for DISTRICT's review 65%-completion design plans and Technical Special Provisions. CONSULTANT shall include in this package a list of responses to DISTRICT comments on the 35% submittal.

C. 95% Completion Submittal

CONSULTANT shall submit for DISTRICT's review electronic files of the 95%-completion design plans and Technical Special Provisions, list of bid items, construction estimate and bar chart representing estimated construction schedule for all portions of the design in the following formats:

- 95%-completion design plans – Adobe PDF files
- Technical Special Provisions - Adobe PDF and Microsoft Word files
- List of bid items - Adobe PDF and Microsoft Word files
- Engineer's construction cost estimate - Adobe PDF files and an editable file
- Bar chart representing estimated construction schedule - Adobe PDF files.

CONSULTANT shall include in this package a list of responses to DISTRICT comments on the 65% submittal.

D. Draft 100% Completion Submittal

CONSULTANT shall submit for DISTRICT's review electronic files of the 100%-completion unsigned design plans, Technical Special Provisions, list of bid items, construction estimate and bar chart representing construction schedule in the electronic file formats indicated in Section 4.1.C.

CONSULTANT shall include in this package a list of responses to the comments received from DISTRICT on the 95%-completion submittal.

Drawings shall be submitted on 11-inch by 17-inch paper size.

4.2 Final Deliverables

Prior to completion of its services under AGREEMENT, CONSULTANT shall deliver the following final deliverables to DISTRICT:

A. One (1) set of final stamped and signed design drawings in non-fading, non-smearing ink on 22-inch by 34-inch reproducible (4-mil) vellum with images in a right-reading format;

B. Electronic files of design drawings in the format specified below;

C. One (1) set of half-size (11-inch by 17-inch) final stamped and signed design drawings on vellum of reproducible quality;

D. One (1) bound set of paper copies and one (1) unbound set of paper copies of reproducible quality of Technical Special Provisions in the format specified below;

E. An electronic file of Technical Special Provisions in the format specified below;

F. Two (2) sets of paper copies of the quantity calculations and one (1) set of paper copies of independent check quantity calculations, as set forth below;

G. Two (2) sets of paper copies of all final design calculations;

H. One (1) set of paper copies of independent check design calculations;

I. Two (2) sets of paper copies of the construction cost estimate and one (1) set of all supporting data for the construction cost estimate;

J. Two (2) sets of paper copies of the estimated construction schedule and one (1) set of all supporting data; and

K. One (1) set of all other final technical documents produced during the course of this AGREEMENT not listed in Section. 4.2.

4.3 **Design Drawings Format**

The format of CONSULTANT's design drawings shall be in accordance with the following :

A. The design drawings (plans) shall be produced on AutoCAD Release 2011. Any other drafting software or third-party add-on software will not be permitted. If a newer version of AutoCAD is available that differs from the version referenced herein, CONSULTANT shall request a written authorization from DISTRICT prior to using the newer version.

B. The format of the drawings shall be Text Style Font – Simplex with minimum height of 1/8-inch and layering concept for all entities. All drawings shall have a District's Standard Title Block, which will be provided by DISTRICT. The Title block shall identify the project by name and number, subject matter of the drawing, drawing number, and the sequential sheet number with a revision block that contains the original issue date and date and number of each revision. All drawings shall have a graphic scale or scales and shall bear the signatures and seals of the Engineer of Record.

C. The final design drawings shall be complete, signed and sealed by CONSULTANT.

D. CONSULTANT shall furnish to DISTRICT uncompressed electronic files of the final signed design drawings.

4.4 **Design and Quantity Calculations**

Design calculations and independent design check calculations shall be prepared for all work indicated in CONSULTANT's design drawings and specifications. The design calculations shall be signed and stamped by the individual responsible for their preparation and who is licensed to practice their professional Engineering services in the State of California. The names of the engineers who prepared the calculations shall be identified on the calculations.

CONSULTANT's quantity calculations and independent check quantity calculations shall be signed by the engineers that prepared the calculations.

All calculations shall be organized and indexed with volumes and pages numbered.

4.5 Special Provisions Format

CONSULTANT shall furnish Technical Special Provisions, typed single-spaced on white bond paper. CONSULTANT shall also furnish the Technical Special Provisions to DISTRICT on Compact Discs (CDs). The format shall be in Microsoft Word file format with left and right margins of one and one-tenth inches (1.1"), top and bottom margins of one inch (1.0"), Text Style Font: Times Arial 12, tabs set at 0.5".

CONSULTANT shall furnish with the final Technical Specifications a signature page(s) with professional stamps and signatures of each of the professional engineers responsible for preparation of specific engineering field of the specifications, e.g., civil, traffic, mechanical, electrical, etc.

4.6 Other Documents

CONSULTANT shall obtain DISTRICT's formatting instructions for other documents to be submitted to DISTRICT.

4.7 General Requirements

A. When CONSULTANT is required under this AGREEMENT to prepare and submit its studies, reports, plans, specifications, and other documents to DISTRICT, said documents shall be submitted in a draft form as scheduled, with the opportunity for the DISTRICT to review and comment upon said documents prior to final submission.

B. The plans, designs, estimates, calculations, reports and other documents furnished under this AGREEMENT shall be of a neat appearance, well-organized, technically and grammatically correct, checked and having the preparer and checker specifically identified. Each submittal to DISTRICT shall bear the approval stamp of CONSULTANT's Project Manager, with said approval representing that he/she has verified that the submittal is complete, clear and legible, and complies with the formatting requirements of this AGREEMENT.

C. The page that identifies the preparers of engineering reports, the title sheet for specifications and each sheet of plans shall bear the professional seal, certificate number, registration classification, expiration date of the certificate, and signature of the professional Engineers responsible for preparation.

D. DISTRICT's acceptance of any and all documents submitted by CONSULTANT shall not relieve CONSULTANT of its responsibility for any deficiencies, whether latent or patent, contained in said documents.

Similarly, the stamp and signature of the District Engineer on CONSULTANT's plans and specifications shall not relieve CONSULTANT of its responsibility for its design.

5. CONSTRUCTION BIDDING PHASE

CONSULTANT's services will be required during the construction bidding stage of the Project as set forth in Exhibits A and B to provide support to DISTRICT during the bidding of the Project.

6. CONSTRUCTION PHASE

CONSULTANT's services will be required during the construction phase of the Project if a construction contract is awarded. During construction, CONSULTANT shall furnish to DISTRICT all corrected and additional drawings and special provisions required by any errors or omissions of CONSULTANT. Such drawings shall be furnished by CONSULTANT at no additional cost to DISTRICT.

CONSULTANT agrees that it will participate in any dispute resolution proceedings provided under the construction contracts covering the Project and will defend any issues asserted concerning the adequacy of CONSULTANT's design. The forum for resolution of disputes shall be as provided for in the construction contract. Upon exhaustion of those procedures, if the parties are unable to resolve the matter successfully, it shall be referred to the next step as outlined in the construction contract. If the construction contracts provide for submitting disputes to mediation under the then-current Construction Industry Mediation Rules of the American Arbitration Association, no party relinquishes or waives any of its procedural or substantive rights or remedies provided under this Agreement, the construction contracts, or applicable law, and expressly reserves such rights, remedies and contentions.

7. OWNERSHIP OF WORK

7.1 All communications, deliverables, and records originated, prepared, and in the process of being prepared, for the services to be performed by CONSULTANT under this AGREEMENT, including, but not limited to, findings, analyses, submittals, conclusions, opinions, engineering drawings, specifications, standards, process sheets, photographs, videos, manuals, technical reports and recommendations with respect to the subject matter of this AGREEMENT and raw and underlying data of such materials, regardless of format or media, including software, reports and other documentation (all of the foregoing, collectively, the "Work Product"), shall be delivered to and become the property of DISTRICT. DISTRICT shall be entitled to access and to copy the Work Product during the progress of the Work. Any Work Product remaining in the hands of CONSULTANT or in the hands of any subconsultant upon completion or termination of the work shall be immediately delivered to DISTRICT and not later than within two (2) weeks of completion or termination of the Work. If any materials are lost, damaged or destroyed before final delivery to DISTRICT, CONSULTANT shall replace them at its own expense, and CONSULTANT assumes all risk of loss, damage or destruction of or to such materials.

CONSULTANT may retain a copy of such materials for use in its general business activities, subject to the restrictions of Section 16, RELEASE OF INFORMATION.

7.2 Any and all copyright, patent rights, and other intellectual property or proprietary rights to Work Product prepared under this AGREEMENT are hereby assigned to DISTRICT. CONSULTANT agrees to execute any additional documents that may be necessary to evidence such assignment. CONSULTANT agrees not to assert any rights at common law or equity and not to establish any claim to statutory copyright in such Work Product. Except for its own internal use as reasonably necessary for its provision of services and work under this AGREEMENT, CONSULTANT shall not publish or reproduce such Work Product in whole or in part, or in any manner or form, nor authorize others to do so, without the written consent of DISTRICT pursuant to Section 16, RELEASE OF INFORMATION, of this AGREEMENT.

7.3 Notwithstanding anything herein to the contrary, DISTRICT acknowledges that as part of CONSULTANT's provision of work hereunder, CONSULTANT may utilize CONSULTANT's Information. CONSULTANT's Information is defined as proprietary works of authorship including, without limitation, software, methodologies, tools, specifications, drawings, sketches, models, samples, records and documentation, as well as copyrights, trademarks, service marks, ideas, concepts, know-how, techniques, knowledge or data, that have been originated or developed by CONSULTANT or by third parties before and apart from this AGREEMENT, or which have been purchased by, CONSULTANT for use in the provision of services or work under this AGREEMENT with the DISTRICT's express written consent; and, copyrights, trademarks, software, methodologies, tools, samples, service marks, ideas, concepts, know-how, techniques, knowledge that have been originated or developed by CONSULTANT or by third parties under AGREEMENT. DISTRICT agrees that CONSULTANT's Information, as so narrowly defined and identified, is and shall remain the sole property of CONSULTANT or such third party, except for the exclusions due to provisions of Section 15.7, PATENT RIGHTS, of this AGREEMENT. CONSULTANT agrees that DISTRICT shall be entitled to use CONSULTANT's Information in connection with this AGREEMENT, and shall grant to DISTRICT a perpetual, royalty-free, irrevocable, worldwide, non-exclusive license to use all CONSULTANT's Information and to create and use derivative works of CONSULTANT'S Information in connection with the Project.

7.4 CONSULTANT represents and warrants that it has or will have all appropriate licenses, agreements and/or ownership pertaining to all intellectual property, including but not limited to patents and copyrights, used in connection with the performance of its obligations under this AGREEMENT. CONSULTANT further represents and warrants that it will have all necessary rights to patentable and copyrightable materials, equipment, devices or processes not furnished by DISTRICT used on or incorporated in the work and assumes all risks arising from the use of such patentable and copyrightable materials, equipment, devices, or processes.

7.5 CONSULTANT shall indemnify, defend and hold harmless DISTRICT, its directors, officers, agents and employees to the maximum extent permitted by law from and against any and all claims, liabilities, losses, damages or expenses (including attorneys' fees and related costs, whether or not litigation has commenced), whether direct or indirect, arising out of, relating to, or in connection with the ownership, possession or use of any materials, equipment, devices, or processes that are protected by intellectual property rights, including patent, copyright and trade secret. In case such materials, equipment, devices or processes are held to constitute an infringement and their use enjoined, CONSULTANT, at CONSULTANT's sole cost and expense, shall: (a) secure for DISTRICT the right to continue using the materials, equipment, devices or processes by suspension of the injunction or by procuring a royalty-free license or licenses, or (b) replace such materials, equipment, devices, or processes with non-infringing materials, equipment, devices or processes that perform the same functions as the infringing item, or (c) modify them so that they become non-infringing or remove the enjoined materials, equipment, devices or processes and refund the sums paid therefore, without prejudice to any other rights of DISTRICT. If the amount of time necessary to proceed with one of these options is deemed excessive by DISTRICT, DISTRICT may direct CONSULTANT to select another option or risk default. The provisions of Section 10, RESPONSIBILITY: INDEMNIFICATION, shall also apply to the matters covered by this Section 6.5, to the maximum extent permitted by law.

8. SUBCONTRACTING

8.1 CONSULTANT shall not subcontract any services to be performed by it under this AGREEMENT without the prior written approval of DISTRICT, except for service firms engaged in drawing, reproduction, typing and printing and other firms as herein listed:

_____

_____

_____

_____

8.2 Nothing contained in this Agreement or otherwise, shall create any contractual relation between DISTRICT and any subconsultants/subcontractors, and no subcontract shall relieve CONSULTANT of its responsibilities and obligations hereunder. Neither the CONSULTANT nor any party contracting with CONSULTANT shall be deemed an agent or employee of the DISTRICT. CONSULTANT is an independent entity, and the legal relationship of any person performing services for CONSULTANT shall be one solely between that person and CONSULTANT. CONSULTANT agrees to be as fully responsible to DISTRICT for the acts and omissions of its subconsultants/subcontractors and of persons either directly or indirectly employed by any of them as it is for the acts and omissions of persons directly employed by CONSULTANT.

CONSULTANT's obligation to pay its subconsultants/subcontractors is an independent obligation from the DISTRICT'S obligation to make payments to CONSULTANT.

8.3 Any subcontract entered into as a result of this Agreement, shall contain all the provisions stipulated in this Agreement to be applicable to subconsultants/subcontractors.

8.4 CONSULTANT is referred to Section 18 of this Agreement which includes Federal and State requirements for the prompt payment to subconsultants.

8.5 Any substitution of subconsultants/subcontractors must be approved in writing by DISTRICT'S Project Manager in advance of assigning work to a substitute subconsultant/subcontractor.

8.6 CONSULTANT shall incorporate Sections 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23 into all agreements with its subconsultants that are over $25,000.

9. CONSULTANT'S PERSONNEL

9.1 All individuals identified on the organizational chart in **Exhibit B** are necessary for the successful performance of services under this AGREEMENT due to their unique expertise, depth and breadth of experience, and knowledge of Project. There shall be no change in CONSULTANT's [Project Manager}, [Engineers of Record], all other engineers and technical staff of the project team as listed in **Exhibit B** without prior written approval by DISTRICT's Project Manager. CONSULTANT recognizes that the composition of this team was instrumental in DISTRICT's decision to award this AGREEMENT to CONSULTANT and that compelling reasons for substituting these individuals must be demonstrated before DISTRICT's approval may be granted. Any substitutes shall be persons of comparable or superior experience and expertise. Failure to comply with the provisions of this section shall constitute a material breach of CONSULTANT's obligations under this AGREEMENT and shall constitute a basis for termination of this AGREEMENT for cause.

9.2 All CONSULTANT staff utilized on Project will be subject to qualification review and approval by DISTRICT. DISTRICT reserves the right to reject proposed personnel that, as determined by DISTRICT at its sole discretion, do not meet any or all of the requirements stated in this AGREEMENT. DISTRICT also reserves the right to obtain references regarding previous assignments of CONSULTANT's and subconsultants' personnel assigned to Project.

Architect of Record – List Designated Individual

Structural Engineer of Record - List Designated Individual

Electrical Engineer of Record – List Designated Individual

Civil Engineer of Record - List Designated Individual

Mechanical Engineer of Record - List Designated Individual

9.3 **CONSULTANT's Project Manager**

CONSULTANT shall provide a Project Manager to coordinate CONSULTANT's operations with DISTRICT's Project Manager. CONSULTANT's Project Manager shall be a licensed Professional Engineer in the State of California and shall demonstrate a proven successful track record in the management of design projects for major hospital projects and the production of plans, specifications and estimates of construction costs. CONSULTANT's Project Manager shall become thoroughly familiar with the Project background and design criteria for the Project.

CONSULTANT's Project Manager shall be responsible for the administration and management of CONSULTANT's performance of services under this AGREEMENT, including the assignment and supervision of CONSULTANT's personnel to assure compliance with provisions of this AGREEMENT and the most efficient deployment of resources in view of the fiscal constraints of the Project. He/she shall be responsible for the accuracy and completeness of all submittals to DISTRICT. He/she shall also be responsible for coordination of schedule and efforts between CONSULTANT and its subconsultants to assure the most efficient use of resources. CONSULTANT's Project Manager shall be accessible to DISTRICT's Project Manager at all times during DISTRICT's regular working hours.

9.4 **CONSULTANT'S Project Engineer**

CONSULTANT shall provide a Project Engineer to assist CONSULTANT's Project Manager in coordination of CONSULTANT's operations under this AGREEMENT. CONSULTANT's Project Engineer shall be a licensed Professional Engineer in the State of California and shall demonstrate a proven technical experience with design projects for hospitals, and in the production of plans, specifications and estimates of construction costs. CONSULTANT's Project Engineer shall become thoroughly familiar with the Project background and design criteria for the Project. CONSULTANT's Project Engineer shall be accessible to DISTRICT's Project Manager at all times during DISTRICT's regular working hours.

9.5 **CONSULTANT's Engineers of Record**

A. As used in this AGREEMENT, the term "Engineer of Record" shall mean the individual licensed to practice engineering in the State of California who will sign and stamp the final plans, specifications, calculations, and other technical work product prepared by CONSULTANT under this AGREEMENT. As required under Business & Professions Code Section 6735, the plans, specifications, calculations, and other technical work

product shall have been prepared by, or under the responsible charge of, CONSULTANT's Engineer of Record. Attention is directed to Section 404.1 of Title 16, Division 5 of the California Code of Regulations for the definition of "responsible charge" and the Engineer of Record's obligations regarding same.

B. Each of CONSULTANT's Engineers of Record shall have sufficient and relevant experience and qualifications to serve in such capacity for the applicable portion of CONSULTANT's work. At a minimum, an Engineer of Record shall meet the following levels of experience and qualifications:

1) The Engineer(s) of Record in charge of the electrical engineering design and whose signatures and stamps appear on the final plans shall be licensed Electrical Engineers in the State of California and shall demonstrate extensive experience and proven successful track records in the design of Hospitals as applicable to their assignments of the project, and in production of plans, specifications and estimates. They shall become thoroughly familiar with the Project background and design criteria for the Project.

2) The Engineer(s) of Record in charge of the Mechanical design, if required, and whose signatures and stamps appear on the final plans shall be licensed Mechanical Engineers in the State of California and shall demonstrate experience and proven successful track records in the design of Hospitals, as applicable to their assignments on the project, and production of plans, specifications and estimates. They shall become thoroughly familiar with the Project background and design criteria for the Project.

9.6 **CONSULTANT's Design Engineers**

The engineering staff assigned to the Project shall be experienced in acute care facility design as required by their assignments on the Project. In addition, all engineering staff utilized shall become thoroughly familiar with the project background and design criteria for the Project.

9.7 **Consultant's Drafting Staff**

CONSULTANT's drafting staff shall be thoroughly proficient with AutoCAD Release 2011, become thoroughly familiar with project-specific CAD drafting standards and requirements, have experience and a proven successful track record in contract plan production, and have a good understanding of project final submittal format requirements.

10. CHANGES

10.1 DISTRICT may, at any time, by written order, make changes within the general scope of work and services described in this AGREEMENT. If such changes cause an increase to the ceiling price of or the time required for performance of

the agreed-upon work or otherwise affect any other terms of this AGREEMENT, an equitable adjustment as mutually agreed shall be made in the limit on compensation as set forth in Section 18, COMPENSATION, or in the time of required performance as set forth in Section 3, SCHEDULE AND TIME OF COMPLETION, or both. In the event that CONSULTANT encounters any unanticipated conditions or contingencies that may affect the scope of work or services and result in an adjustment in the amount of compensation specified herein, CONSULTANT shall so advise DISTRICT immediately upon notice of such condition or contingency. The written notice shall explain the circumstances giving rise to the unforeseen condition or contingency and shall set forth the proposed adjustment in compensation. This notice shall be given to DISTRICT prior to the time that CONSULTANT performs work or services related to the proposed adjustment in compensation. If approved by DISTRICT, the pertinent changes shall be expressed in a written supplement to this AGREEMENT prior to implementation of such changes.

CONSULTANT's failure to timely supply the written notice specified herein shall constitute a waiver of CONSULTANT's entitlement to an adjustment in compensation and/or time based on the unanticipated condition or contingency.

10.2 CONSULTANT shall carefully and regularly monitor the deployment of its resources so that the budgeted levels of effort for each task set forth in the Cost Proposal in **Exhibit B** are not exceeded. CONSULTANT shall not exceed the budget for any task without first obtaining the written approval of DISTRICT. Any and all costs of CONSULTANT that exceed the task amounts set forth in **Exhibit B** will not be paid by DISTRICT unless DISTRICT has first provided written approval of the overage. Such approval, if given, may not in any case authorize exceeding the overall not-to-exceed amount set forth in Section 17, COMPENSATION.

11. RESPONSIBILITY: INDEMNIFICATION

CONSULTANT shall indemnify, defend and hold harmless DISTRICT, its directors, officers, agents, and employees to the maximum extent permitted by law from and against any and all claims, demands, actions, causes of action, damages, liability, obligation, costs and expenses of any kind whatsoever, including (without limitation) those for personal injuries (including, but not limited to death, bodily injury, emotional or mental distress and loss of consortium), property damage or pecuniary, financial or economic loss of any kind whatsoever to the extent that they are caused by any breach of CONSULTANT's obligations under this AGREEMENT, willful misconduct, or the negligent provision or omission of services contemplated by this AGREEMENT by CONSULTANT or its employees, or parties contracting with CONSULTANT or agents. CONSULTANT further agrees to defend any such claims, demands, actions, or causes of actions for any damages, injuries or losses whatsoever, and pay charges of attorneys and other costs and expenses arising therefrom or incurred in connection therewith; and if any judgment be rendered against DISTRICT or any of the other individuals enumerated above in any such action, CONSULTANT shall, at CONSULTANT's expense, satisfy and discharge the same to the extent that they are covered by the above Agreement to indemnify.

To the extent permitted by Civil Code 2782.8, CONSULTANT's duty to defend shall further apply and be enforced even if it is contended the acts, omissions or failures to act of parties other than CONSULTANT, including DISTRICT and the individuals enumerated above, caused or contributed to the losses, injuries or damages claimed.

For the purposes of this Section, the term "losses" means all amounts paid to settle or satisfy any judgments or awards plus reasonable amounts paid on account of attorneys' fees, court costs and other costs and expenses relating to the investigation, defense, satisfaction and/or settlement of such claims.

This provision is intended to be applied to the fullest extent allowed under the law and, if any portion of it is found to be void or unenforceable, the remainder is to be severable and enforceable.

12. INSURANCE PROVISIONS

12.1 **Types of Insurance** The polices and minimum amount of insurance to be carried by CONSULTANT shall be as follows:

A. Workers' Compensation and Employer's Liability Insurance

1) CONSULTANT shall procure and maintain at all times during the performance of such work Workers' Compensation Insurance in conformance with the laws of the State of California and federal laws where applicable. Employer's Liability Insurance shall not be less than One Million Dollars ($1,000,000) for each accident and One Million Dollars ($1,000,000) for each disease.

2) The policy shall contain a waiver of subrogation in favor of DISTRICT and its officers, directors, employees, volunteers and agents while acting in such capacity and their successors and assignees as they now or as they may hereafter be constituted, singly, jointly or severally.

B. Commercial General and Automobile Liability Insurance

1) *Commercial General Liability Insurance*. CONSULTANT shall, at its own cost and expense, also procure and maintain at all times during the performance of this Agreement Commercial General Liability Insurance providing bodily injury and property damage coverage with a combined single limit of at least One Million Dollars ($1,000,000) each occurrence or claim and a general aggregate limit of at least Two Million Dollars ($2,000,000). This insurance shall include but not be limited to premises and operations, contractual liability covering the indemnity provisions contained in this Agreement, personal injury, products and completed operations, and broad form property damage, and include a Cross Liability endorsement.

2) *Business Automobile Liability*. CONSULTANT shall, at its own cost and expense, procure and maintain at all times during the performance of this Agreement Business Automobile Liability

Insurance providing bodily injury and property damage with a combined single limit of at least One Million Dollars ($1,000,000) per occurrence for all owned, non-owned and hired automobiles. This insurance shall provide contractual liability covering all motor vehicles and mobile equipment to the extent coverage may be excluded from general liability insurance.

C. Professional Liability Insurance. CONSULTANT shall maintain Professional Liability Insurance covering CONSULTANT's performance of services under this Agreement with a limit of liability of at least Five Million Dollars ($5,000,000) for any one claim and Five Million Dollars ($5,000,000) annual aggregate. This insurance shall be applicable to claims arising from the work performed under this Agreement and during construction and construction warranty periods. The insurance shall not include any prior acts exclusion.

12.2 **General Insurance Requirements**

A. Evidence of Insurance. Prior to commencing work or entering onto the property, CONSULTANT shall file a Certificate of Insurance with DISTRICT evidencing the foregoing coverages with respect to the insurance, including the following endorsements:

1) That the insurance company(ies) issuing such policy(ies) shall give written notice to DISTRICT of any material alteration or reduction in aggregate limits, if such limits apply, and provide at least thirty (30) days' notice of cancellation or nonrenewal.

2) That the policy(ies) is(are) Primary Insurance and the insurance company(ies) providing such policy(ies) shall be liable thereunder for the full amount of any loss or claim that CONSULTANT is liable for under this section, up to and including the total limit of liability, without right of contribution from any other insurance effected or which may be effected by the DISTRICT.

3) That, with respect to coverages described in Section 12.1.A and B above, such insurance shall include as additional insured the DISTRICT and its respective directors, officers, employees and agents while acting in such capacity, and their successors or assignees, as they now or as they may hereafter be constituted, singly, jointly or severally.

4) That, with respect to coverages described in Section 12.1.A and B above, the policies shall also contain either a cross liability endorsement or severability of interests clause and stipulate that inclusion of the DISTRICT as additional named insured shall not in any way affect its rights either as respects any claim, demand, suit or judgment made, brought or recovered against CONSULTANT. Said policy shall protect CONSULTANT and DISTRICT in the same manner as though a separate policy had been issued to each, but nothing in said policy shall operate to increase the insurance company's liability as set forth in its policy

beyond the amount or amounts shown or to which the insurance company would have been liable if only one interest had been named as an insured.

B. Acceptable Insurance. All policies shall be issued by insurers acceptable to DISTRICT. This insurance shall be issued by an insurance company or companies authorized to do business in the State of California with minimum "Best's" rating of B+ and with minimum policyholder surplus of Twenty Five Million ($25,000,000) or a company acceptable to District in its sole discretion. All policies shall be issued in a form satisfactory to the General Manager of DISTRICT and shall be issued specifically as primary insurance.

C. Failure to Procure or Maintain Insurance. The failure to procure or maintain required insurance and/or an adequately funded self-insurance program acceptable to DISTRICT will constitute a material breach of this AGREEMENT.

D. Terms of Policies. All insurance specified above shall remain in force until all work to be performed is satisfactorily completed unless as indicated otherwise in this AGREEMENT.

E. CONSULTANT shall not violate or permit to be violated any conditions or provisions of said policies of insurance, and at all times shall satisfy requirements of the insurer for the purpose of maintaining said insurance in effect.

F. If any claim is made by any third person against CONSULTANT on account of any incident, CONSULTANT shall promptly report the fact in writing to DISTRICT, giving full details of the claim.

G. CONSULTANT shall promptly notify DISTRICT of all professional liability claims asserted against CONSULTANT that have an estimated settlement value in excess of the policy. If the amount of professional liability insurance is reduced by other claims, CONSULTANT shall procure such additional insurance to restate the limits as required under this AGREEMENT.

H. Claims-Made Insurance. If any insurance specified in Section 11.1 is provided on a claims-made basis, then in addition to the specified coverage requirements, such policy shall provide that:

1) Policy retroactive date coincides with or precedes CONSULTANT's start of work (including subsequent policies purchased as renewals or replacements).

2) CONSULTANT will make every effort to maintain similar insurance for at least three (3) years following project completion, including any applicable requirement of including all additional insureds.

3) If insurance is terminated for any reason, CONSULTANT agrees to purchase an extended reporting provision of at least three (3)

years to report claims arising from work performed in connection with this AGREEMENT.

4) Policy allows for reporting of circumstances or incidents that might give rise to future claims.

13. CONFLICT OF INTEREST

CONSULTANT shall not undertake any work under construction or construction management and inspection support contracts for the Cath Lab 3 and Angio Equipment Replacement Project.

CONSULTANT shall comply with the Code of Professional Conduct for Professional Engineers set forth at California Code of Regulations, Title 16, Division 5, Section 475, as said Code may be amended from time to time.

CONSULTANT represents and warrants that it presently has no interest and agrees that it will not acquire any interest that would present a conflict of interest under California Government Code §§ 1090 *et seq.* or §§ 87100 *et seq.* during the performance of services under this AGREEMENT. CONSULTANT shall promptly disclose any actual or potential conflict of interest to DISTRICT as soon as CONSULTANT becomes aware of such conflict. CONSULTANT further covenants that it will not knowingly employ any person having such an interest in the performance of this AGREEMENT. Violation of this provision may result in this AGREEMENT being deemed void and unenforceable.

Depending on the nature of the work performed, CONSULTANT may be required to publicly disclose financial interests under DISTRICT's Conflict of Interest Code. CONSULTANT agrees to promptly submit a Statement of Economic Interest on the form provided by DISTRICT upon receipt.

No person previously in the position of Director, Officer, employee or agent of DISTRICT may act as an agent or attorney for, or otherwise represent, CONSULTANT by making any formal or informal appearance, or any oral or written communication, before DISTRICT or any Officer or employee of DISTRICT for a period of 12 months after leaving office or employment with DISTRICT if the appearance or communication is made for the purpose of influencing any action involving the issuance, amendment, award or revocation of a permit, license, grant or contract.

14. CIVIL RIGHTS REQUIREMENTS

In addition to other nondiscrimination requirements included in this AGREEMENT, CONSULTANT agrees to comply with the following:

14.1 **Nondiscrimination**

In accordance with Title VI of the Civil Rights Act, as amended, 42 USC §2000 (d), Section 303 of the Age Discrimination Act of 1975, as amended; 42 USC §6102, Section 202 of the Americans with Disabilities Act of 1990; 42 USC §12132; and 49 USC §5332, CONSULTANT agrees that it will not discriminate against any employee or applicant for employment because of race, color, creed, national origin, sex, age, or disability. In addition, CONSULTANT agrees to

comply with applicable federal implementing regulations and other implementing requirements the Federal Highway Administration (FHWA) may issue.

During performance of this agreement, CONSULTANT and its subconsultants shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (e.g., cancer), medical history, age (over 40), genetic information, marital status, gender, gender identity, gender expression, and denial of family care leave. CONSULTANT and subconsultants shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. CONSULTANT and subconsultants shall comply with the provisions of the Fair Employment and Housing Act (Gov. Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 Title 2 of the California Code of Regulations, are incorporated into this AGREEMENT by reference and made a part hereof as set forth in full. CONSULTANT and its subconsultants shall give written notice of their obligations under this section to labor organizations with which they have a collective bargaining or other agreement. In addition, CONSULTANT agrees to comply with applicable federal implementing regulations and other implementing requirements the Federal Highway Administration (FHWA) may issue.

CONSULTANT shall include the nondiscrimination and compliance provisions of this section in all subcontracts to perform work under this AGREEMENT.

14.2 **Equal Employment Opportunity**

The following equal employment opportunity requirements apply to this AGREEMENT:

A. Race, Color, Creed, National Origin, Sex. In accordance with Title VII of the Civil Rights Act, as amended, 42 USC §2000(e), CONSULTANT agrees to comply with all applicable equal employment opportunity requirements of U.S. Department of Labor (U.S. DOL) regulations, *Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,* 41 CFR Parts 60 *et seq.* (which implement Executive Order No. 11246, *Equal Employment Opportunity,* as amended by Executive Order No. 113 75, *Amending Executive Order 11246 Relating to Equal Employment Opportunity,* 42 USC §2000 (e) note), and with any applicable federal statutes, executive orders, regulations, and federal policies that may in the future affect construction activities undertaken in the course of the Project.

During the performance of this AGREEMENT, CONSULTANT agrees as follows:

1) CONSULTANT will not discriminate against any employee or applicant for employment because of race, religion, color, sex, or national origin. CONSULTANT will take affirmative actions to ensure that applicants are employed and that employees are treated during their employment without regard to their race, religion, color, sex, or national origin. Such actions shall include, but not be limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. CONSULTANT agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided setting forth the provisions of this nondiscrimination clause.

2) CONSULTANT will, in all solicitations or advertisements for employees placed by or on behalf of CONSULTANT, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, or national origin.

3) CONSULTANT will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding a notice to be provided advising the said labor union or workers' representatives of CONSULTANT's commitments under this section, and shall post copies of the notices in conspicuous places available to employees and applicants for employment.

15. RELEASE OF INFORMATION

15.1 All financial, statistical, personal, technical, or other data and information relative to DISTRICT's operations, and specifically, the improvements contemplated by this AGREEMENT and made available to CONSULTANT in order to carry out this AGREEMENT, shall be protected by CONSULTANT from unauthorized use and disclosure, and shall not be disclosed to any third parties without DISTRICT's express written permission.

15.2 Permission by DISTRICT to disclose information on one occasion relating to this AGREEMENT shall not authorize CONSULTANT to further disclose such information or disseminate the same on any other occasion.

15.3 CONSULTANT shall not comment publicly to third parties, including the press or any other media, regarding this AGREEMENT or DISTRICT's actions on the same, except to DISTRICT's staff, CONSULTANT's own personnel involved in the performance of this AGREEMENT, at public hearings, or in response to questions from a Legislative committee.

DISTRICT's Public Information Director is the authorized spokesperson for all media inquiries concerning DISTRICT. CONSULTANT shall refer any inquiry of the news media to the Public Information Director. CONSULTANT shall not communicate regarding DISTRICT, the Project and this AGREEMENT with any representatives of the media, including, but not limited to, journalists, reporters,

technical writers, and freelance writers, without the prior written authorization of DISTRICT, as exercised in DISTRICT's sole discretion.

It is expressly understood and agreed that the above provisions equally pertain to all subconsultants to CONSULTANT with respect to their receipt of any inquiries from the media pertaining to DISTRICT, the Project or this AGREEMENT.

15.4 CONSULTANT shall not refer to DISTRICT, the Project or this AGREEMENT in any advertising or promotional materials without DISTRICT's prior written consent. CONSULTANT shall obtain DISTRICT's written consent prior to the publication of any materials prepared by CONSULTANT or any of its employees and agents pertaining to DISTRICT, the Project, or this AGREEMENT. CONSULTANT agrees that published information regarding such topics shall be factual only and in no way shall imply that DISTRICT endorses CONSULTANT's firm, service or product.

CONSULTANT and its employees and agents shall not use any images of DISTRICT, including its Work, with respect to this AGREEMENT in any current and future media format, including, but not limited to, promotional or business development photographs or videos, website postings, CD-ROMs, and any other form of publication (magazines, annual reports, etc.) without DISTRICT's prior written consent, as exercised in DISTRICT's sole discretion. If consent is granted, CONSULTANT shall comply with all requirements of DISTRICT regarding filming and still photography.

CONSULTANT and its employees and agents shall not make any speeches or presentations that mention Project or include images of Project without DISTRICT's prior written consent.

CONSULTANT and its employees and agents shall not author any technical papers or reports for publication or distribution that discuss the project without DISTRICT's prior written consent.

It is expressly understood and agreed that the above provisions pertain equally to all subconsultants and suppliers to CONSULTANT with respect to DISTRICT, the Project and this AGREEMENT.

15.5 All information related to the construction estimate is confidential and shall not be disclosed by CONSULTANT to any entity other than DISTRICT.

15.6 Any subcontract entered into as a result of this AGREEMENT shall contain all the provisions of this Section 15.

16. INSPECTION OF WORK

CONSULTANT and any subconsultant shall permit DISTRICT and its representatives to review and inspect the project activities at all reasonable times during the performance period of this AGREEMENT.

17. COMPENSATION

17.1 The payment for services under this AGREEMENT will be based on time and materials with a not-to-exceed amount. The CONSULTANT agrees to perform all of the services included in Section 2 for a total all inclusive sum not-to-exceed amount of _____ ($_____), in accordance with Exhibits A and B. The total all inclusive sum shall include all labor, materials, taxes, profit, overhead, insurance, subcontractor costs and all other costs and expenses incurred by the Consultant. The not-to-exceed amount is not guaranteed. Rather, payment will be for time actually worked. The hourly rate by personnel category shall be as set forth in Exhibit B. The DISTRICT will pay the CONSULTANT in accordance with Section 18.

17.2 CONSULTANT shall be reimbursed for actual allowable travel expenses incurred in the performance of this work upon submittal of receipts. Only coach class airfare will be reimbursed. Private cars shall be reimbursed at the current reimbursement mileage rate published by the U.S. Internal Revenue Service or, if a rental car is used, at the mid-range rental car rate while traveling away from CONSULTANT's headquarters, which are hereby designated as office locations listed in **Exhibit B**.

Lodging, meal and incidental expense costs shall not exceed the maximum reimbursable allowances published by U.S. General Services Administration (GSA) for each Federal Fiscal Year beginning October 1. The maximum reimbursable allowances published by GSA can be found at http://www.gsa.gov.

17.3 Total expenses reimbursed made under this AGREEMENT shall not exceed the sum of _____Dollars and _____Cents ($_____).

17.4 CONSULTANT's attention is directed to Section 9, CHANGES, of this AGREEMENT regarding CONSULTANT's obligations with respect to any adjustment of the not-to-exceed maximum with regard to CONSULTANT's compensation for the Project.

18. MANNER OF PAYMENT

18.1 By the tenth (10^{th}) working day of the following month, CONSULTANT shall submit invoices and receipts to DISTRICT for services performed and reimbursable expenses incurred during the previous month. DISTRICT shall render payment for all undisputed invoices within thirty (30) days following receipt of approved invoices.

Invoices shall describe in detail the services rendered by CONSULTANT and state the number of hours, and applicable hourly rate of each person. Hourly rates per personnel category shall be in accordance with the CONSULTANT's Cost Proposal in **Exhibit B.** The hourly labor rates set forth in **Exhibit B,** including those of CONSULTANT and subconsultants, shall remain in effect for the duration of this AGREEMENT.

For CONSULTANT's personnel assigned to the project, DISTRICT and CONSULTANT will jointly review, on an annual basis, proposed salary increases. CONSULTANT and its subconsultants shall submit to DISTRICT written justification supporting any proposed labor rate increases and shall obtain DISTRICT approval of such increases prior to billing them in CONSULTANT invoices under this AGREEMENT. Under this AGREEMENT, labor rate increases for CONSULTANT's personnel assigned to the Project, if any, may be made no more frequently than once a year.

18.2 DISTRICT shall retain ten percent (10%) from each monthly payment to guarantee satisfactory completion of the work. CONSULTANT may elect to submit a Letter of Credit in the amount of ten percent (10%) of the total not-to-exceed expenditure amount in a form acceptable to DISTRICT in lieu of the ten percent (10%) retention to guarantee satisfactory completion of the work. DISTRICT will release the Letter of Credit, along with all other monies due, within thirty (30) days of CONSULTANT's satisfactory completion of the work, as determined by DISTRICT, under this AGREEMENT.

Alternatively, CONSULTANT may elect to establish an escrow agreement for security deposits in lieu of the retention in a manner that substantially complies with Public Contract Code Section 22300. The form of security shall be subject to DISTRICT's reasonable approval. DISTRICT will release the security, along with all other monies due, within thirty (30) days of CONSULTANT's satisfactory completion of the work, as determined by DISTRICT, under this AGREEMENT.

18.3 In the event that DISTRICT disputes an invoice, it will pay only the undisputed amount and will notify CONSULTANT within ten days of receipt of invoice of any dispute. CONSULTANT must continue work during the pendency of any dispute over an invoice. The parties' Project Managers will meet and confer and attempt to resolve amicably any dispute over an invoice. If they are unable to resolve such a dispute, the matter will be elevated to management. DISTRICT management's determination over a disputed invoice will be final and additional dispute will be resolved pursuant to Section 25.

19. ORDER OF PRECEDENCE

In the event of an inconsistency among the components of this AGREEMENT, the following order of precedence shall apply:

1. Duly executed amendments to this AGREEMENT;
2. This AGREEMENT;
3. Exhibit A, the RFP;
4. Exhibit B, CONSULTANT's Proposal.

20. ASSIGNMENT

CONSULTANT shall not assign any rights or transfer any obligations under this AGREEMENT without the prior written consent of DISTRICT.

21. MAINTENANCE, AUDIT AND INSPECTION OF RECORDS

All CONSULTANT and subconsultant costs incurred in the performance of this AGREEMENT will be subject to audit. CONSULTANT and its subconsultants shall permit DISTRICT, the State Auditor, or their authorized representatives, to inspect, examine, make excerpts from, transcribe, and copy CONSULTANT's books, work, documents, papers, materials, payrolls records, accounts, and any and all data relevant to this AGREEMENT at any reasonable time, and to audit and verify statements, invoices or bills submitted by CONSULTANT pursuant to this AGREEMENT. CONSULTANT shall also provide such assistance as may be required in the course of such audit.

For the purpose of determining compliance with Public Contract Code 10115, et seq., and Title 21, California Code of Regulations, Chapter 21, Section 2500 et seq., when applicable and other matters connected with the performance of the contract pursuant to Government Code 8546.7; CONSULTANT, subconsultants and DISTRICT shall maintain all books, documents, papers, accounting records, and other evidence pertaining to the performance of services under this AGREEMENT, including but not limited to, the costs of administering AGREEMENT. All parties shall make such materials available at their respective offices at all reasonable times during the AGREEMENT period and for four (4) years from the date of final payment under AGREEMENT.

If, as a result of the audit, it is determined by DISTRICT that reimbursement of any costs including profit or fee under this AGREEMENT was in excess of that represented and relied upon during price negotiations or represented as a basis for payment, CONSULTANT agrees to reimburse DISTRICT for those costs within sixty (60) days of written notification by DISTRICT.

22. DISTRICT WARRANTIES

DISTRICT makes no warranties, representations, or agreements, either express or implied, beyond such as are explicitly stated herein.

23. SUSPENSION AND TERMINATION

DISTRICT shall have the right to suspend or to terminate this AGREEMENT at any time by giving written notice to CONSULTANT. In the event of suspension or termination for any reason other than the fault of CONSULTANT, CONSULTANT shall be compensated in accordance with the provisions of Section 19, MANNER OF PAYMENT, for the services performed to date of such suspension or termination, plus any reasonable costs and expenses resulting from such suspension or termination. If, in the event of suspension, the project is resumed after being suspended for more than three months, CONSULTANT's compensation shall be subject to renegotiation. If the project is resumed within the period of three months following notification of suspension, there shall be no change in CONSULTANT's compensation.

In the event of termination for reason of CONSULTANT's breach or default in the performance of any of CONSULTANT's obligations under this AGREEMENT, CONSULTANT shall be compensated in accordance with the provisions of Section 18, COMPENSATION, only for those services already performed and expenses incurred in

full accordance with the requirements of this AGREEMENT up to the effective date of termination, less an estimate reasonably made by DISTRICT of the amount of damages DISTRICT has or will suffer as a result of CONSULTANT's breach or default.

Whether terminated for convenience or breach, the DISTRICT shall not in any manner be liable for the CONSULTANT's actual or projected lost profits had the CONSULTANT completed the services required by this Agreement.

24. NOTICES

All communications relating to the day-to-day activities of the Project shall be exchanged between DISTRICT's Project Manager, David Sullivan, and CONSULTANT's Project Manager, _____.

All notices and communications regarding interpretation of the terms of this AGREEMENT and changes thereto shall be in writing and may be given by personal delivery to a representative of the parties or by mailing the same, postage prepaid, addressed as follows:

If to DISTRICT: _____

If to CONSULTANT: _____

The address to which mailings are to be made may be changed from time to time by notice mailed as described above. Any notice given by mail shall be deemed given on the day after that on which it is deposited in the United States Mail as provided above.

25. DISPUTE RESOLUTION

In the event of a dispute between DISTRICT and CONSULTANT concerning any question of fact in connection with the work performed under this AGREEMENT, the parties shall meet and confer and make good faith efforts to resolve the dispute before resorting to any legal action. CONSULTANT must file a Government Claim Form prior to initiating any legal action.

26. ATTORNEYS' FEES

If any legal proceeding should be instituted by either of the parties hereto to enforce the terms of this AGREEMENT or to determine the rights of the parties thereunder, the prevailing party in said proceeding shall recover, in addition to all court costs, reasonable attorneys' fees.

27. BINDING ON SUCCESSORS

All of the terms, provisions, and conditions of this AGREEMENT shall be binding upon and inure to the benefit of the parties hereto and their respective successors, assigns, and legal representatives.

28. APPLICABLE LAW

This AGREEMENT, its interpretation, and all work performed thereunder shall be governed by the laws of the State of California.

29. WAIVER

Any waiver of any breach or covenant of this Agreement must be in a writing executed by a duly authorized representative of the party waiving the breach. A waiver by any of the parties of a breach or covenant of this Agreement shall not be construed to be a waiver of any succeeding breach or any other covenant unless specifically and explicitly stated in such waiver.

30. SEVERABILITY

If any provision of this Agreement shall be deemed invalid or unenforceable, that provision shall be reformed and/or construed consistently with applicable law as nearly as possible to reflect the original intentions of this Agreement; and in any event, the remaining provisions of this Agreement shall remain in full force and effect.

31. NO THIRD PARTY BENEFICIARIES

This Agreement is not for the benefit of any person or entity other than the parties.

32. ENTIRE AGREEMENT; MODIFICATION

This Agreement, including any attachments, constitutes the entire Agreement between the parties with respect to the subject matter hereof, and supersedes any prior understanding or agreement, oral or written, with respect to such subject matter. It may not be amended or modified except by a written amendment executed by authorized representatives by both parties.

IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT by their duly authorized officers as of the day and year first above written.

DISTRICT:
SALINAS VALLEY HEALTH

By:_____

President, Board of Directors

:

By:_____

SALINAS VALLEY HEALTH, Chief Executive Officer

CONSULTANT:
_____

By*:_____

By*:_____

** If CONSULTANT is a corporation, this AGREEMENT must be executed by two corporate officers, consisting of: (1) the President, Vice President or Chair of the Board, and (2) the Secretary, Assistant Secretary, Chief Financial Officer or Assistant Treasurer.*

In the alternative, this AGREEMENT may be executed by a single officer or a person other than an officer provided that evidence satisfactory to District is provided demonstrating that such individual is authorized to bind the corporation (e.g., a copy of a certified resolution from the corporation's board or a copy of the corporation's bylaws).

RESPONSE TO RFQ:

ARCHITECTURAL SERVICES

SVMH Cath Lab 3 and Angio Equipment Replacement

September 29, 2023

SUBMITTED BY

SMITH-KARNG ARCHITECTURE

SKA
SMITH-KARNG
ARCHITECTURE

Client Engagement | Healthcare Expertise | Proactive Design

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SKA
SMITH-KARNG
ARCHITECTURE

360 Pine St, FLR 3
San Francisco, CA 94104
415.552.3600

September 28, 2023

Dave Sullivan
Bogard Construction
Salinas Valley Health
535 E. Romie, Suite 6
Salinas, CA 93901
Email:dsullivan@bogardconstruction.com

Re: Response to Request for Proposals for Design & Engineering Services for the Cath Lab 3 and Angio Equipment Replacement

Dear Mr. Sullivan,

We are pleased to submit the attached response to Request for Proposal for Architectural and Engineering services for the Cath Lab 3 and Angio Equipment Replacement at the Salinas Valley Health (SVH) Memorial Hospital.

Smith-Karng Architecture, Inc. (SKA) is a full-service architectural firm boasts a diverse portfolio encompassing healthcare facilities, pharmacies, laboratories, and tenant improvements. Over the past decade, we have consistently provided our expertise to Salinas Valley Health Memorial Hospital and are currently in an ongoing relationship with SVHMH. We invite you to delve deeper into the extensive spectrum of our capabilities and projects highlighted in the subsequent sections of our response.

Our collaborative ensemble, comprising Estructure, Interface Engineering, and Aurum Consulting Engineers, is known for its innovative solutions, strategic designs, and injecting an element of enthusiasm into every endeavor. The unique perspectives and rich reservoir of knowledge each team member brings to the table empowers us to continually exceed expectations in delivering optimal solutions to SVHMH. We pride ourselves on our history of successful collaboration across a multitude of facilities and our consistent delivery of successful projects. We genuinely cherish our team dynamics, infusing our shared spirit and unwavering work ethic into each assignment. This camaraderie and mutual experience help us uphold project objectives, ensuring successful completion within budget constraints.

In our response to your Request for Proposal, we have laid out a comprehensive account of our strategic approach, managerial competence, planning, design, production prowess, team accessibility, responsiveness, experience with regulatory agencies, QA/QC protocols, communication skills and methodologies and Fee Proposal. Moreover, we have furnished several examples of our team's demonstrated expertise in executing successful Cath Lab #1 and CT Scan project, alongside detailing the personnel who will be engaged in this project.

SKA, IEI, Aurum, and Estructure fully recognize the criticality of punctual delivery for a project of this magnitude, with heightened regard for the ongoing patient care operations in adjacent areas. Our recent engagements, spanning imaging suites to emergency departments, have underscored the need to assess the implications of the construction process on the broader facility.

In the years of operation, the team has completed over 600 projects ranging in complexity, size, and urgency. We believe that SKA would be well suited to assist Salinas Valley Health with the

Cath Lab 3 and Angio Equipment Replacement. We are happy to present our extensive and diverse project experience in our response following this letter.

We believe our team is the best fit for this role due to our energy, expertise, collaborative spirit and our company values which guide us with every project:

- Authenticity – we design and collaborate with honesty and confidence,
- Pride – we deliver solutions which bring the most satisfaction to us and the Client,
- Collaboration – we strive to be a cohesive team and enjoy what we do,
- Communication – we listen and engage,

Madelyn McClellan will be the primary contact for all communications pertaining to this contract.

Madelyn McClellan, RA, President
Cell phone: 415.425.7623
Email: madelyn@smithkarng.com
Address: 360 Pine Street, San Francisco, CA 94104

We are excited by the opportunity to work with Salinas Valley Health on all future projects; ones that the community can be proud of and that will serve the needs of our diverse public for years to come.

Sincerely,

Madelyn McClellan, President

ATTACHMENT A

1. Proven Experience

Our assembly of proficient architects and engineers, which includes SKA, IEI, Estructure, and Aurum Consultants have been providing their invaluable services to hospitals across the Bay Area for numerous years. These teams have been immersed in designing imaging rooms for an equally considerable amount of time.

Our team is well versed in renovation work within operational facilities with outdated construction types and aging infrastructure. SKA and IEI hold expertise in meticulously investigating and understanding the existing conditions, allowing us to comprehend the limitations of a project before we embark on the journey of designing a new one. Our method significantly reduces the chances of design modifications and minimizes disruption to neighboring operational areas during the construction phase.

A1. Radiology Experience in Occupied Facilities

As highlighted earlier, our team primarily operates in facilities that are still in use, surrounded by areas that need to remain functional.

Both examples in the following project samples have been designed for and constructed within operational facilities with patient care services occurring in adjacent spaces. The key to the successful execution of these projects with minimal interruption to the patient experience can be attributed to our team's collaborative attitude, innovative solutions, and a keen commitment to responsiveness. Our approach stems from countless learned lessons and an enduring aspiration to deliver our very best for our clients.

A2. Radiology Experience in GACH under HCAI Jurisdiction

Both of the projects featured in our examples took place within an operational Inpatient Acute Care Hospital under the jurisdiction of HCAI.

Our approach to assessing existing equipment is straightforward yet comprehensive. We devote significant resources and efforts to the initial stage of gathering information. As a team, we critically analyze as-built drawings, conduct thorough site inspections, and engage with Facility Engineers and Stakeholders to unearth any anecdotal evidence of system complications. We utilize every piece of data at our disposal, and in instances where information is unavailable, we collectively strategize to procure the needed data.

The preliminary step in establishing existing conditions, such as shielding and infrastructure, involves reviewing the existing as-built documents. In case these are inaccessible, we might suggest investigative demolition undertaken by a competent contractor. We would collaborate closely with the contractor to pinpoint the investigation locations, ensuring minimal disruption to the rooms' ongoing operations.

Regarding infrastructure examination, IEI will carry out comprehensive field surveys and might recommend involving a qualified mechanical or electrical contractor to facilitate a more in-depth investigation. Mechanical investigations may encompass air balance and pitot readings, information about fan and motor performance, and coil capacities. Electrical investigations might include panel load readings, breaker information verification, and circuit tracing. Additionally, the requirements for a PIN 70 Selective Electrical Coordination Study can pose challenges for the Facility and Design/Construction Team. The approach to this matter could vary based on whether the Owner decides to have the

Design Team or a qualified Contractor provide the service. However, we firmly believe it is immensely beneficial to discuss the potential remedial work scope that could stem from the PIN 70 efforts during the initial design stages, at the very least.

B. Experience Minimizing Facility Impacts

Our approach to handling this is simple, for every design decision we ask the question, “does this action impact the facility”. We begin with high level design decisions in regard to phasing and utility scope of work and determine if there are opportunities to avoid service interruptions, and try to provide design options to avoid them. If avoidance is unfeasible, then the team will seek options to present to the Owner which may not impact the facility. If that too is impossible, then we can help the Owner with the decision making by creating a pro/con matrix and identifying risks.

Our team has found that engaging HCAI Field Staff throughout the construction procedure often results in fewer unforeseen requirements and eleventh-hour changes to Contractor Methods of Procedure (MOPs). This design team consciously opts to stay involved in the scrutiny of Contractor MOPs and Facility Impacts, ensuring that the contractor has thoroughly considered the process and left no stone unturned. Through peer review of the Contractor’s intentions, our team can confidently present the findings to CDPH and HCAI. Experience shows that this confidence usually leads to expedited approvals for shutdowns and reduces the occurrence of unexpected testing requirements mandated by HCAI.

2. Personnel

SKA Firm Profile

Smith-Karng Architecture, Inc. (SKA) is a woman-owned, full-service architectural firm with ten employees, established in 2001, SKA has been an institution within the Bay Area Architecture community. SKA aspires to lead the industry in standards of care, in and out of the office.

We have a broad portfolio consisting of healthcare, pharmacies, laboratories, and tenant improvements. Our knowledge and expertise ranges from straightforward small projects to highly complicated infrastructure replacements. We have extensive experience working within sensitive and occupied environments and navigating many layers of Stakeholder engagement.

In the 22 years of operation, the team has completed over 500 OSHPD approved projects ranging in complexity from cosmetic refreshes to infrastructure upgrades/ replacements. Our strength lies in highly technical and involved projects which require considerable attention and fastidiousness. This strength leaves us poised to succeed at any new challenge regardless of size or complexity. We approach all projects with the same level of attention and consideration. Using LEAN strategies, push and pull planning, and clear communications, SKA is well versed as lead design professional with successful completed projects.

SKA Key Personnel

Madelyn McClellan, R.A., President / Principal in Charge

Madelyn McClellan began her career in carpentry and construction and is now a registered Architect in the State of California and Illinois. Madelyn's prior experience spans across institutional, residential, and commercial with an emphasis on creative solutions to technical problems. Her experience includes facility master plan strategies, tenant improvements, voluntary accessibility barrier removals and toilets, radiology suites, large laboratories, pharmacies, emergency departments, and primary care clinics. She excels in highly complex and heavily phased projects and infrastructure upgrades within existing facilities. Her specific experience can be found in the project samples.

Madelyn thrives in a studio environment, actively engaging with team members and encourages the distribution of knowledge which increases the teams' ability to serve the client. Similarly, her inquisitive nature makes her a critical team player when initiating projects and resolving unique project issues. Her combined construction, architectural, and teaching background gives her an advantage in being able to communicate with a wide variety of personalities and professions. She is adept at breaking through details to get to

the root of issues and clearly define project parameters. This is true for all Stakeholders, including executive members, managerial staff, and end users. She is an active listener and aids in translating Stakeholder needs into design.

Often, Madelyn provides on-call consultation to clients regarding high-level strategizing and information gathering. She has a propensity for information gathering and learning and continuously seeks opportunities to build her knowledge base. Madelyn's curious nature leads her to be code proficient and aware of design standards within various environments. She often engages in typical office design environments as well but applies healthful standards to better occupied environments. Most of her clients have facility standards which she is unquestionably able to interpret and apply throughout the entire design process. This is especially true when adapting client standards to as-built environments and legacy buildings.

Glenn Casuga, Senior Project Manager

Glenn Casuga is a licensed architect in California. Glenn's career has spanned many project types, including multi-family residential, commercial office buildings, retail centers, and healthcare. For the past 18 years, his focus has primarily been on healthcare architecture. Glenn's extensive knowledge and experience in healthcare have been instrumental in assisting hospital facilities with planning, design, and implementing best practices within the HCAI jurisdiction.

Glenn finds great satisfaction knowing a client is happy with the end product. Glenn always maintains the client's goals and desired outcomes, while maneuvering through each project task and unpredictable obstacle. His commitment to excellence is noteworthy and inspires other team members and stakeholders to also engage with the same level of dedication to the project's desired goals.

Glenn approaches project challenges with a sense of calm confidence and patience that ensures stability, knowledge, care, and fortitude which his clients, design team, consultants, and stakeholders.

Alexandra David, Project Manager

Alexandra is a licensed architect in California. Alexandra has 11 years experience in the A/E Industry and 6 Years experience as a Project Manager. Alexandra has extensive experience in wide range of imaging projects in both general acute care settings and medical office buildings, including: CT replacement, CT suite shell build out, Cath Lab equipment equipment upgrade, IR Biplace Replacement, She is experienced with Telecommunication, Healthcare and Education projects, as well as experienced with a large range of jurisdictions, Federal, State and Local such as DSA, USFS, HCAI, etc.

Alexandra is knowledgeable and proficient with all stages of the architectural process, from proposal to project closeout. She is responsible for the coordination of all project efforts, administrative and technical, to ensure the efficient and effective execution of assigned projects. Alexandra actively manages schedules, project communication, office administrative tasks, and project team assignments. She serves as the primary client liaison to bring the schedule, budgets, and scope of work to completion and to the client's satisfaction.

Alexandra brings an enthusiastic and team-oriented approach to project management. She finds communication, creative problem solving and a methodical approach to be the most valuable qualities for successful projects. She prioritizes thorough investigation at the beginning of the project, from site investigation to understanding of stakeholder needs. This results in fewer surprises during construction. Aexandra values open discussion for collective decision making, including all stakeholders and design team members in the decision-making process.

Firm Organization Chart

President/CEO
Principal in Charge
Madelyn McClellan

CFO
Project Manager
Timothy Reap

Senior Project Manager
Glenn Casuga

Office Operations Coordinator
Nicole Kron

Project Manager
Alexandra David

Project Manager
Wing Chu

Project Manager
Jai Pathade

Job Captain
Michelle Barrera

Job Captain
Jake Sealine

Architectural Designer
Mehrazin Iranbaksh

Estructure Firm Profile
Structural Engineering

Estructure is a boutique firm of highly competent and collaborative structural engineers and support staff. Over 90 percent of projects involve renovations to existing facilities. Estructure's current clients include a range of institutional and private clients for whom they provide ongoing design and consulting services. Designing for post-earthquake occupancy of buildings is at the heart of Estructure's reputation. For complicated renovation and remodel projects, success is built on detailed field investigations coupled with careful and thorough design, detailed coordination with architectural, mechanical and electrical consultants, and hands-on support during construction.

Each member of the Estructure team has a can-do spirit and a focus on clients' needs. Each is an expert in structural engineering for building renovations. Their success is based on paying careful attention to each client and each project, regardless of size or complexity, and contributing thoughtful solutions to the team. Their work is streamlined because they get directly to the heart of complex issues at the outset of a project and provide high level expertise and vast experience to guide projects throughout all stages.

Estructure was founded in 2000 by Maryann Phipps and was incorporated in 2013, at that time moved into their current offices in Oakland, California.

Please see the attached resumes for Estructure's key personnel.

Interface Engineering, Inc. Firm Profile
Mechanical, Electrical, Plumbing Engineering

Interface Engineering is a multidiscipline mechanical and electrical engineering firm known for innovative resource use, visionary sustainable design and breakthrough engineering solutions for new and existing buildings. Their work demonstrates how integrated design and creative collaboration can produce outstanding results — for their clients, community and environment.

From four employees in 1969, IEI's practice has grown into a nationally recognized consultancy with over 250 professionals in ten offices. They focus on high-performance, pragmatic design, and to date have completed several hundred LEED certified projects and Net-Zero buildings. Their diverse market sector activity has allowed them to grow and they consistently rank high in industry surveys. Today, they are at the forefront of an evolving industry, transforming the concept of what the built environment can be.

With a focus on creative design, Interface Engineering is a model for the mechanical and electrical engineering firm of the future. Their culture is collaborative with a passion for resource sensitivity. They are seasoned engineering consultants who add long-term value as design partners. To serve their clients and our community, they use integrated design to create sustainable solutions that not only perform beyond expectation, but also lead and inspire. Their mission is simple: to help build optimal environments for life.

Aurum Consulting Engineers Firm Profile
Electrical, Plumbing Engineering

Since Aurum Consulting Engineers Monterey Bay, Inc.'s inception in 1998 our focus has been on setting higher standards for electrical engineering design quality and service throughout Northern and Central California. Our comprehensive electrical engineering capabilities.

Aurum Consulting Engineers is led by a core team of ten electrical project managers with over 120 years of combined electrical engineering experience. We offer a broad spectrum of expertise in design and construction. Our design expertise includes Medical, Commercial, Educational, High Technology, Industrial, Residential, Recreational and Agricultural Facilities. We can offer support from conceptual design through post construction phases of a project, and are equally comfortable teaming with other consultants or taking the lead.

One of our core project managers is always personally involved in the engineering of every project from beginning to end. The Project Manager is responsible for coordination, design documents specifications, cost estimates and completion of design on schedule. We believe that this personal involvement is as critical as our extensive engineering expertise in meeting our client's requirements.
Our team has an unparalleled ability to coordinate its work with other design professionals, and the trades.

AURUM CONSULTING ENGINEERS

Project Team Personnel

SKA Role: Prime
Principal In Charge
Madelyn McClellan, R.A.
Senior Project Manager
GlennCasuga, R.A.
Project Manager
Alexandra David, R.A.

Structural: Estructure
Structural Engineer
Darrick Hom, S.E.

Electrical: Aurum Consulting Engineers
Project Manager/Principal
Frank Pinedo, LC
Electrical Engineer/Principal
Eldrich Bell, P.E.

Mechanical: IEI
Principal In Charge
Rick Russell, P.E.
Associate Lead Mechanical Engineer
Mary Vasquez, P.E.
Technical Associate Principal/Lead Plumbing Engineer
Thomas de Senna, P.E.

MADELYN McCLELLAN, RA, NCARB
Principal, CEO

Madelyn McClellan began her career in carpentry and construction and is now a registered Architect in the State of California and Illinois.

Madelyn's prior experience spans across institutional, residential and commercial and now focuses on Healthcare Architecture and Infrastructure, with an emphasis on creative solutions to technical problems. As the President and CEO of SKA, her role has focused on client stewardship, medical planning, and facility upgrade strategies. She also has a wealth of knowledge in Accessibility and Code compliance.

She has completed projects with County of San Mateo DPW, CPMC (Sutter Health), St. Francis Memorial Hospital, Marin Health Medical Center UCSF, and Salinas Valley Memorial Hospital many of which required HCAI approval.

EDUCATION
Masters Of Architecture,
SUNY University At Buffalo, NY

Bachelor Of Science,
University of Illinois at Urbana- Champaign

REGISTRATION
Registered Architect, C37097

CERTIFICATIONS
NCARB

EXPERTISE
Facility Infrastructure Upgrades
Master Planning & Upgrade Strategy
Medical Labs
ADA Compliance
Renovations
Hospitals, MOBs

NOTEWORTHY PROJECTS:
Salinas Valley Memorial Hospital, Salinas Valley, CA
Cath Lab 1 Replacement
Heart Center AHU Replacement
Main Tower Reroof Project
PBX Relocation
Chemistry Analyzers Replacement
Bulk Oxygen Replace & Emergency Project
Nurse Call Replacement
Elevator Modernization

California Pacific Medical Center (Sutter Health) San Francisco, CA
Davies CT Scanner Relocation
Davies North Tower HVAC Upgrades
Monteagle Radiology X-Ray Replacement
Davies Emergency Department Remodel
Davies ASU Remodel, Hand Therapy, Clinical Lab, and Central Registration Relocations

Alameda Health System
San Leandro Hospital CT Scanner & Ultrasound Replacement
Fairmont Campus Transformer Replacement Emergency Project

MarinHealth Medical Center
Nuclear Medicine Suite Relocation
Compounding Pharmacy Relocation
Elevator Modernization

GLENN CASUGA, RA
Senior Project Manager

Glenn Casuga is a licensed architect in California. Glenn's career has spanned many project types, including multi-family residential, commercial office buildings, retail centers, and healthcare. For the past 18 years, his focus has primarily been on healthcare architecture.

Glenn's extensive knowledge and experience in healthcare have been instrumental in assisting hospital facilities with planning, design, and implementing best practices within the HCAI jurisdiction.

EDUCATION
Bachelor of Architecture
California State Polytechnic University, Pomona

EXPERTISE
Hospital Renovations
MOB Renovations
Imaging Labs
Accessibility Compliance
Agency Processing & Approvals

NOTEWORTHY PROJECTS:

Kaiser Permanente, San Francisco, Santa Rosa, San Rafael, CA

Radiology/CT Scanner Replacements
Hazardous & Non-Hazardous Compounding Pharmacies
TER, TR & Wi-Fi Upgrades
Emergency Department Remodels
Dumbwaiter Replacement
Mammography Replacements
Surgical Light Replacements
Pharmacy Security Upgrades

Stanford University Hospital & Clinics

Emergency Power Upgrade
Emergency Department Remodel
Blood Centers at Mountain View
G1 Nursing Unit Remodel
801 Welch Road Medical Office Remodel

Lucile Packard Children's Hospital

Heart Center Remodel & Expansion
Hospital School Remodel
Flood Remediation
PICU Remodel
Surgery Upgrade

Stanford School of Medicine

Grant Building 1st Floor Lab Remodel
Stanford University Chiller Plant & Cooling Tower

Marin General Hospital

Cardiac Electrophysiology Laboratory
PET-CT Suite

ALEXANDRA DAVID
Project Manager

Alexandra has 11 years experience in the A/E Industry and 6 Years experience as a Project Manager. She is experienced with Telecommunication, Healthcare and Education projects, as well as experienced with a large range of jurisdictions, Federal, State and Local such as DSA, USFS, HCAI, etc.

Alexandra brings an enthusiastic and team-oriented approach to project management. She finds communication, creative problem solving and a methodical approach to be the most valuable qualities for successful projects. She prioritizes thorough investigation at the beginning of the project, from site investigation to understanding of stakeholder needs. This results in fewer surprises during construction, and later after the space is in use. She values open discussion for collective decision making, including all stakeholders and design team members in the decision-making process.

EDUCATION
Masters of Architecture
Bachelor of Architecure
Tulane University, New Orleans

EXPERTISE
OSHPD 1 Hospital Renovations
Imaging Replacements, Relocations
MOB Renovations
Emergency Departments
Infrastructure Replacements / Upgrades
Public Works

NOTEWORTHY PROJECTS:
Kaiser Permanente, Orange County, Los Angeles County CA
Cath Lab Equipment Upgrade
IR Biplane Replacement
Nuclear Med, Gamma Camera Replacement
CT Replacement
CT Suite Shell Build-out
Regional Mammography Equipment Upgrade and Remodel
X-Ray Suite Remodel
Dexascan Remodel
Stereotactic Remodel
Sterile Processing Department Remodel
Facility-wide Pyxis Replacement and Med-Prep Remodel
Inpatient Pharmacy USP 800 Upgrade
Domestic Water Heat Exchanger Replacement
Sewage Ejector Replacement
Orthopedic Clinic Expansion and Remodel

Estructure

1144 65th Street, Suite A
Oakland, CA 94608

510.235.3116
www.estruc.com

Darrick B. Hom, S.E.
Structural Engineer

dbhom@estruc.com
(510) 982-5006

Darrick Hom has over 29 years of structural engineering experience in seismic evaluation, analysis, design, bracing of nonstructural components and code development. He has worked on many healthcare renovation projects throughout the Bay Area and on numerous UC campuses. He served as technical editor of *ASCE 31-03; Seismic Evaluation of Buildings*. He currently participates on the American Society of Civil Engineers Seismic Rehabilitation Standards committee as a member of the nonstructural elements subcommittee. He has served the Structural Engineers Association of Northern California Board of Directors as President.

Education

B.S. University of California, Berkeley, 1993
M. Eng. University of California, Berkeley, 1994

Registration

Civil Engineer California, 1996 – License No. 55661
Structural Engineer California, 2000 – License No. 4460
Civil and Structural Engineer Oregon, 2005 – License No. 76750
Structural Engineering Certification Board, 2005 – Certification No. 1224-0705

Selected Professional Memberships and Affiliations

Structural Engineers Association of Northern California, President, 2014-2015
Structural Engineers Association of California, Fellow
American Society of Civil Engineers – Structural Engineering Institute
Engineers Alliance for the Arts – Director – 2010-2016

Selected Relevant Experience

- UCSF Long Heart Center Cath Lab 1 and 2
- Stanford Cath Labs 8-10 Remodel
- CPMC Pacific Campus Cath Lab 2 Remodel
- Sutter Sacramento Cath Lab 4

Salinas Valley Memorial Hospital

- Salinas Valley Memorial Hospital Cath Lab 1 Renovation
- Salinas Valley Memorial Hospital Heart Center Rooftop AHU
- Salinas Valley Memorial Hospital High Speed Elevator Modernization
- Salinas Valley Memorial Hospital Lab Analyzer Replacement
- Salinas Valley Memorial Hospital OB Cesarean Conversion
- Salinas Valley Memorial Hospital Omnicell Replacement

Rick Russell PE, LEED AP, CXA

PRINCIPAL-IN-CHARGE

Education
Master of Science, Mechanical Engineering, California State University Sacramento

Bachelor of Science, Marine Engineering Technology, California Maritime Academy

Registration
Mechanical Engineer:
California - 31923
Hawaii - 16006

LEED Accredited Professional, US Green Building Council

Certified Energy Manager (CEM)

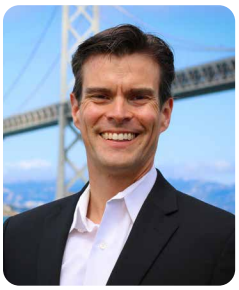
Green Building Engineer (GBE)

ACG, AABC Commissioning Group, Certified Commissioning Authority (CxA)

Professional Affiliations
American Society of Heating, Refrigerating, and Air -Conditioning Engineers

Association of Energy Engineers

International Society for Pharmaceutical Engineering



Rick is a Principal with 26 years of operation, design and construction experience. Rick's project experience includes healthcare projects such as hospitals, medical office buildings, clinics, behavioral health, laboratories and research centers for both new and renovation construction projects. He has engaged in design of sustainable engineering systems such as natural ventilation, radiant heating and cooling, vivarium system design, vav laboratories, lab heat decoupling, lab heat recovery, displacement ventilation, underfloor air distribution and chilled beams. He has also incorporated computational fluid dynamics (CFD) into his design in an effort to use the latest engineering tools to create highly sustainable buildings. Rick combines his knowledge of energy consumption, systems and costs to create designs that exceed client's expectations for performance and efficiency.

PROJECT EXPERIENCE

Salinas Valley Health Medical Center
SALINAS, CALIFORNIA

- Bulk O2 Temp System Design
- Bulk O2 Permanent Replacement System Design

Santa Clara County O'Connor Hospital
SAN JOSE, CALIFORNIA

- Cath Lab 1 Imaging Equipment Replacement
- Cath Lab 2 Imaging Equipment Replacement
- East Catheterization Laboratory
- MRI 2 Imaging Equipment Replacement
- Nuclear Med 1 Imaging Equipment Replacement
- Nuclear Medicine 2 Imaging Equipment Replacement
- Radiology Room 6 Imaging Equipment Replacement

Good Samaritan Hospital CT Equipment Replacement
SAN JOSE, CALIFORNIA

Sonoma Valley Hospital
SONOMA, CALIFORNIA

- CT EOR Supplantation
- CT Study

University of California, San Francisco
SAN FRANCISCO, CALIFORNIA

- CT Simulator Replacement and Upgrades
- Moffitt Long Emergency Department Radiology Room
- Mount Zion Angiography Equipment Replacement
- ACC 2 Spine Center / LEED Certified
- Moffitt Long Hospital M15 Acute Care Nursing Unit
- Cyber Knife

Good Samaritan Hospital Angiography Remodel
SAN JOSE, CALIFORNIA

St. Francis Memorial Hospital Imaging Unit Design for Radiology
SAN FRANCISCO, CALIFORNIA

Kaiser San Francisco 2425 Geary MRI Replacement
SAN FRANCISCO, CALIFORNIA

5858 Horton Street Stem Cell Research Laboratory
EMERYVILLE, CALIFORNIA

Mary Vasquez PE

ASSOCIATE | LEAD MECHANICAL

Education
Bachelor of Science, Mechanical Engineering, San Diego State University

Registration
Mechanical Engineer: California - M39720

Mary Vasquez has 4 years of professional experience in mechanical engineering. Mary has worked on a wide variety of project types including healthcare, bio-pharmaceutical laboratories, office buildings, mixed-use residential, educational an commercial kitchens. In addition to her engineering design experience, she has strong coordination and problem solving skills, as well as project management experience.

PROJECT EXPERIENCE

Salinas Valley Health Medical Center Bulk O2 Permanent Replacement System Design
SALINAS, CALIFORNIA

Santa Clara County O'Connor Hospital
SAN JOSE, CALIFORNIA

- Cath Lab 1 Imaging Equipment Replacement
- Nuclear Medicine 2 Imaging Equipment Replacement
-
- Cath Lab 1 Imaging Equipment Replacement
- Cath Lab 2 Imaging Equipment Replacement
- East Catheterization Laboratory
- MRI 2 Imaging Equipment Replacement
- Nuclear Med 1 Imaging Equipment Replacement
- Nuclear Medicine 2 Imaging Equipment Replacement
- Radiology Room 6 Imaging Equipment Replacement

University of California San Francisco
SAN FRANCISCO, CALIFORNIA

- CT Simulator Replacement and Upgrades
- Mount Zion Angiography Equipment Replacement

St. Francis Memorial Hospital Imaging Unit Design for Radiology
SAN FRANCISCO, CALIFORNIA

Good Samaritan Hospital CT Equipment Replacement
SAN JOSE, CALIFORNIA

Sequoia Hospital
REDWOOD CITY, CALIFORNIA

- Mammography Installation
- Philips CT Simulator Replacement Project

Kaiser South San Francisco Hospital MRI Power Conditioner
SOUTH SAN FRANCISCO, CALIFORNIA

St. Francis Memorial Hospital Bulk Liquid Oxygen Tank Study
SAN FRANCISCO, CALIFORNIA

Kaiser San Francisco Oxygen Tank Replacement
SAN FRANCISCO, CALIFORNIA

Kaiser South San Francisco ETO Sterilizer
SOUTH SAN FRANCISCO, CALIFORNIA

San Mateo Medical Center Project 1 Nursing Tower Renovation
SAN MATEO, CALIFORNIA

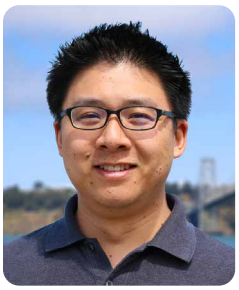
Stanford Primary Care Clinic
LOS ALTOS, CALIFORNIA

Thomas de Senna PE

TECHNICAL ASSOCIATE PRINCIPAL | LEAD PLUMBING

Education
Bachelor of Science, Mechanical Engineering, California Polytechnic State University, San Luis Obispo

Registration
Mechanical Engineer: California - M34908



Thomas is a Technical Associate and has over 15 years of experience in various project types. His project experience includes projects of all scales, from retrofits to replacement, through all phases, from schematic design to construction administration.

PROJECT EXPERIENCE

Salinas Valley Health Medical Center
SALINAS, CALIFORNIA

- Bulk O2 Temp System Design
- Bulk O2 Permanent Replacement System Design

Regional Medical Center Angio/IR Cath Lab Equipment Replacement
SAN JOSE, CALIFORNIA

Santa Clara County O'Connor Hospital MRI 2 Imaging Equipment Replacement
SAN JOSE, CALIFORNIA

St. Francis Memorial Hospital Bulk Liquid Oxygen Tank Study
SAN FRANCISCO, CALIFORNIA

University of California, San Francisco
SAN FRANCISCO, CALIFORNIA

- 675 18th Street MRI Scoping
- ACC 2 Spine Center / LEED Certified Goal
- Cardiology Clinic
- Moffitt Hospital 14th Floor Pride in Place

Kaiser Vacaville Hospital MRI Addition
VACAVILLE, CALIFORNIA

Kaiser Vacaville 64 Slice CT Replacement
VACAVILLE, CALIFORNIA

Kaiser San Francisco 2425 Geary MRI Replacement
SAN FRANCISCO, CALIFORNIA

Kaiser Santa Cruz 110 Cooper Primary Care Tenant Improvement / LEED Gold Goal
SANTA CRUZ, CALIFORNIA

Kaiser Los Gamos San Rafael MOB 70 PO Tenant Improvement
SAN RAFAEL, CALIFORNIA

Kaiser San Rafael Las Gallinas Medical Office Building Oncology/Infusion
SAN RAFAEL, CALIFORNIA

El Camino Health Integrated Medical Sobrato Pavilion / LEED Gold Goal
MOUNTAIN VIEW, CALIFORNIA

El Camino Health Behavioral Health Services Taube Pavilion / LEED Gold Goal
MOUNTAIN VIEW, CALIFORNIA

2621 Tenth (1050 Parker) / LEED Gold Goal
BERKELEY, CALIFORNIA

Kaiser South San Francisco ICU and Elevator Upgrade
SOUTH SAN FRANCISCO, CALIFORNIA

Jewish Home SF Friedman Rehab Renovation
SAN FRANCISCO, CALIFORNIA

California Pacific Medical Center Van Ness Dialysis Boxes
SAN FRANCISCO, CALIFORNIA

Sutter Palo Alto Medical Foundation ASC Remodel
PALO ALTO, CALIFORNIA

Salinas Valley Health Medical Center Experience

Bulk O2 Temp System Design

Bulk O2 Permanent Replacement System Design

Eldridge O. Bell, P.E.

ELECTRICAL ENGINEER
PRINCIPAL

EDUCATION

2003 University of the Pacific
Bachelor of Science Electrical Engineering

DESIGNATIONS

Registered Professional Engineer in California
Electrical Engineer E17789

ASSOCIATIONS

National Society of Professional Engineers (NSPE)

American Council of Engineering Companies (ACEC)

Institute of Electrical and Electronic Engineers (IEEE)

U.S. Green Building Council (USGBC)

AURUM CONSULTING ENGINEERS
MONTEREY BAY, INC.

EXPERIENCE

2004 – Present
Aurum Consulting Engineers • Monterey, California
Electrical Engineer Principal
Responsible for electrical design and coordination of construction documents.

2002
New United Motors Manufacturing Inc. • Fremont, California
Intern Facilities Engineer
Responsible for project management and in-house electrical engineering for automotive manufacturing plant.

2001
Flextronics • San Jose, California
Intern Systems Engineer
Data analysis.

HEALTHCARE EXPERIENCE

Salinas Valley Memorial Healthcare System • Salinas, California
Various OSHPD | Projects ranging from ups for Emergency Branches to suite / Department remodels.

Hazel Hawkins Memorial Hospital Various OSHPD Projects • Hollister, California
Complete renovations of Hospital includes Women's Center Building, Emergency Department Building, emergency generator, imaging, offices, exam rooms, medical records and CT Scanner.

Community Hospital of the Monterey Peninsula • Monterey, California
Various OSHPD | Projects ranging from Distribution changes to suite / Department remodels.

North Bay Regional Surgery Center • Novato, California
7,000 square foot ambulatory surgery center with three operating rooms, pre-operation and recovery rooms, 3-branch electrical system, fire alarm and lighting design. LEED Gold Certified.

611 Abbott Street Medical Office Building • Salinas, California
Electrical Engineering for a 35,000 square foot medical offices with nurse training facility, clinics, and support facilities.

Frank S. Pinedo, LC

PROJECT MANAGER
PRINCIPAL

EDUCATION

1992
High Tech Institute
Technical Associates
Electro/Mechanical

DESIGNATIONS

National Council on Qualifications for the Lighting Professions (NCQLP) Lighting Certified (LC).

ASSOCIATIONS

Institute of Electrical and Electronic Engineers (IEEE)
U.S. Green Building Council (USGBC)
BICSI

EXPERIENCE

1998 – Present
Aurum Consulting Engineers
Monterey, California
Principal/Electrical Project MGR
Electrical design/coordination of construction documents.

1995-1998
Fehr Engineering Company

AURUM CONSULTING ENGINEERS
MONTEREY BAY, INC.

HEALTHCARE EXPERIENCE

Salinas Valley Memorial Healthcare System, Various OSHPD Projects • Salinas, California
Complete renovations of Hospital including imaging, offices, exam rooms, medical records and CT Scanner. Second and Third Floor Nurse Call replacements.

Hazel Hawkins Memorial Hospital, Various OSHPD Projects • Hollister, California
Complete renovations of Hospital including Women's Center Building, Support Services Building, Emergency Department Building, emergency generator, imaging, offices, exam rooms, medical records and CT Scanner.

Community Hospital of the Monterey Peninsula, Various OSHPD Projects • Monterey, California
Complete renovations of Hospital including imaging, offices, exam rooms, medical records, CT Scanner and MRI suites. Complete Hospital Nurse Call replacement.

Natividad Medical Center, Various OSHPD Projects • Salinas, California
Complete renovations of Hospital including imaging, offices, exam rooms, medical records and phlebotomy. Complete Hospital Nurse Call replacement.

University of California San Francisco Hospital, Various OSHPD Projects • San Francisco, California
Various HVAC replacements, gift shop remodel, Fire Alarm upgrades & compliance and Sterilizer & Compactor upgrades.

Good Samaritan Hospital, Various OSHPD Projects • San Jose, California
Complete renovations of Central Supply to include washers, sonic irrigator, offices, exam rooms and LDRP suites.

Fresno VA Hospital, Various OSHPD Projects • Fresno, California
Complete renovations of hospital chiller plant as well as imaging rooms.

Garden Court Medical Offices • Monterey, California
35,000 square foot cardio-pulmonary clinic with exam rooms, patient reception, test labs and doctor's offices. Design of utilities, power, generator, lighting, data/com and fire alarm systems.

ACEMB.COM • 831.646.3330
60 GARDEN COURT, SUITE 210, MONTEREY, CALIFORNIA 93940

3. General Approach and Management Capability

Our team at SKA boasts a wide-ranging portfolio that spans across healthcare, pharmacies, laboratories, and tenant improvements. We hold expertise in tackling projects ranging from straightforward, small-scale ones to extremely complex infrastructure replacements. Our considerable experience enables us to adeptly operate within sensitive, occupied environments and engage with multiple layers of stakeholders. Our unique strength resides in our approach to technical and complex projects that demand meticulous attention to detail, from the pre-design phase through to contract administration.

We excel at working with pre-existing facilities, conditions, and materials, treating these as guiding parameters for our projects. Our design approach hinges on thorough investigative design efforts and well-informed decision-making. With extensive experience working within General Acute Care Hospitals (HCAI), our team has learned to be rigorous in our pre-design efforts. We set aside ample time with our design consultants to review as-built and known conditions, preparing detailed field survey notes and requirements.

At SKA, we insist on thoroughly investigating all existing conditions across all disciplines, employing tools like 360 cameras, video recordings, and comprehensive field notes to create a robust base for design.

When making design decisions, our team first considers the overarching project initiative or goal, then delves deeper to investigate the decision. This process enables informed decision-making that considers present and future needs, constructability, cost, and schedule. This approach typically helps bypass the need for value engineering, thereby reducing later design rework and waste in construction. Whenever feasible, we collaborate with the contractor or estimator to identify cost-saving opportunities if the budget isn't met.

With the help of LEAN strategies, push and pull planning, and clear communication, SKA has proven its proficiency as the lead design professional team, with a track record of successful projects. We deploy several strategies to promote effective communication, including scheduled meetings and regular documentation.

At SKA, we are against siloed designing. Our regular design scrum meetings set a cadence for the team, ensuring seamless communication and collaboration across all disciplines. Along with these meetings, we utilize design and decision tracker logs,

which are regularly reviewed and updated throughout the project's lifecycle. These documents are invaluable for tracking decisions, outstanding items, and identifying potential critical path items requiring additional coordination. Regularly reviewing these trackers with the design team and Owner keeps the entire team responsible and engaged which we believe reduces the number of design assumptions that eventually rear their ugly heads later in construction. If issues cannot be resolved or information is unavailable to make informed decisions, then the group can find a solution to build in design flexibility. Siloed designing can also work against providing the best product for the Stakeholders. Early input from Stakeholders is pivotal to incorporating needs, building standards, and unique requirements that may otherwise be overlooked. Understanding the importance of early stakeholder input, we ensure their needs, building standards, and unique requirements are taken into account. SKA appreciates the delicacy of decision-making and always coordinates with the Client Representative to review any queries directed to the stakeholders.

SKA also makes a point to build in flexibility into our designs and details to reduce custom details later in the construction phase. This method allows the Contractor to propose solutions which may only require a Non-Materially Altering change to the construction documents rather than designing a custom detail that needs to be submitted as an Amended Construction Document.

We closely collaborate with the Contractor, Owner, and IOR to stay abreast of progress, plan for upcoming milestones, investigate potential constraints, and devise swift solutions to construction details. An active channel of communication between these parties helps maintain tight schedules and is a vital factor in our ability to consistently achieve successful OSHPD milestones and Substantial Completion.

MEP's response on General Approach and management capabilities:

We begin incorporating existing conditions into the design during the schematic design phase of the project. Not only do we review the project area, but areas outside of the project to ensure that our project does not negatively impact the spaces around us.

A sample approach would be as follows. Please note that this could be tailored to meet a specific project type and need:

1. Obtain all available documentation for the project and surrounding areas.

2. Interview appropriate stakeholders to collect anecdotal information, such as, "the plant has plenty of capacity", "we don't know the capacity?" or "this has always been a problem." This will inform the design team about what calculations or data collection to use to promote a successful outcome to the project.

3. Conduct a field investigation of the area. In some cases, the team is paired with a contractor for preconstruction services that would allow for selective ceiling demolition to successfully uncover hidden conditions that may not be necessarily shown on the contract documents.

4. Identify areas for testing such as for electrical capacity and HVAC capacity.

5. Develop documentation to request the following readings to ensure that our project does not negatively impact outside areas:

    a. Pre-construction air balance of the project area and outside of the area.

    b. Electrical panel readings for both emergency and normal power.

6. We will review all points of connection to

verify they are where the as-builts depict them.

7. At the end of schematic design, the MEP will answer the following questions regarding the MEP systems:

    a. What do we have?

    b. What do we need?

    c. What is the delta?

    d. How do we overcome the delta?

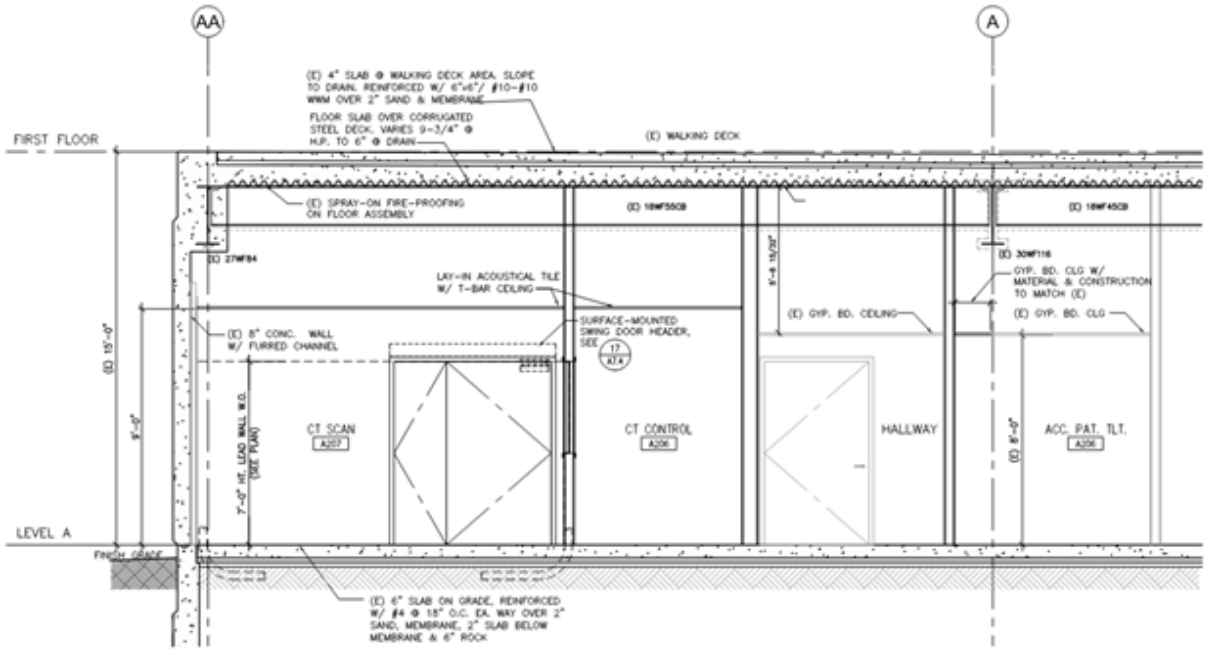
    We have found these basic questions uncover many issues early that can mitigate cost and schedule overruns.

8. We will provide various recommendations to bridge the gap with data that can assist the University in reaching a decision. Interface will also make an initial recommendation based on its understanding of the client's needs and Interface's experience.

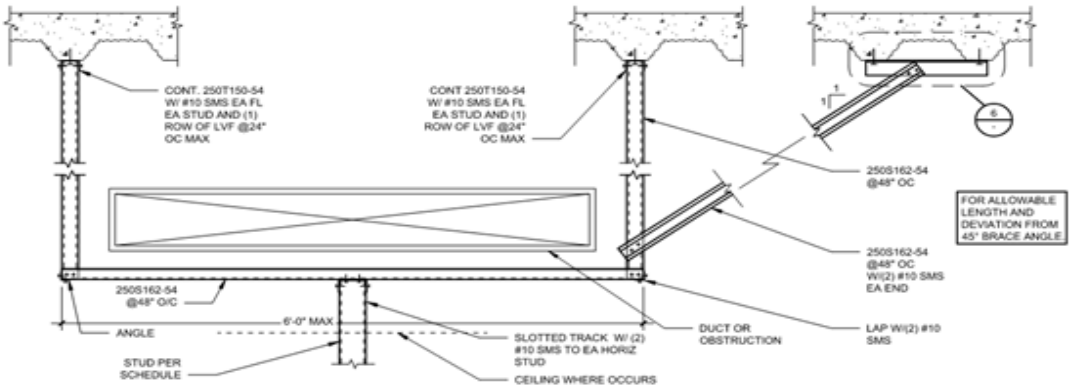
4. Planning and Design Ability

New construction within existing, operational Imaging Suites requires a keen eye and ability to move from big picture to granular detail. This A/E team regularly coordinates on projects of all sizes which require this skillset.

Smith-Karng Architecture has successfully performed projects of this type and scope within other acute care hospitals, including CPMC and San Leandro Hospital. Our experience in handling complex architectural and engineering challenges, such as Radiology installations in existing spaces, demonstrates our ability to overcome complex design hurdles and intricate phasing to deliver a successful project. Our expertise and familiarity with the specific state and HCAI requirements and regulations governing hospitals make us the ideal choice for the Cath Lab 3 & Angio Equipment replacement.



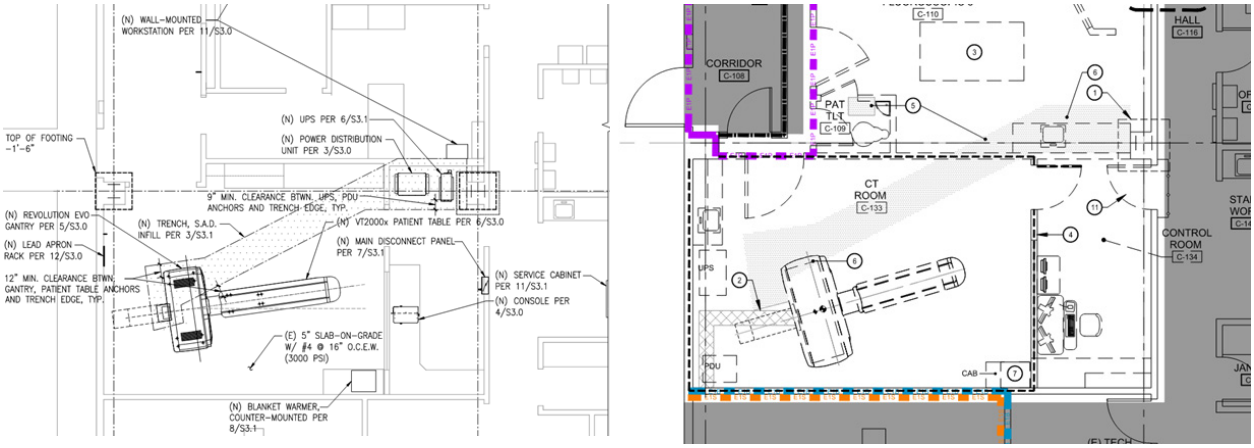
Davies CT Scanner Building Section – Provided in the construction set to show conduit routing and relationship to existing slab and adjacent spaces



7 WALL SUPPORT BELOW LARGE OBSTRUCTION
SCALE: NTS

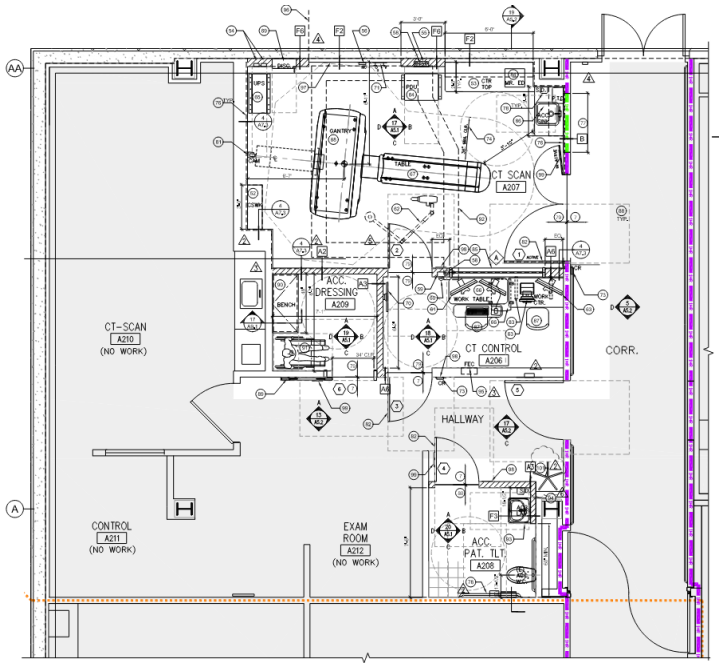
San Leandro Hospital CT Scanner Replacement Existing Condition Detail

The Design Team identified an existing duct and conduit obstruction during the initial field survey which was determined to conflict with a new wall. Due to the significant span required, SKA coordinated with Estructure to create a detail.



San Leandro Hospital CT Scanner Replacement Architectural & Structural Plan

SKA and Estructure intentionally coordinating the anticipated trenching plan. This level of coordination helps the Contractor understand the impacts of the trenching and determine phasing and scheduling.



Davies CT Scanner Relocation Floor Plan – Illustrates proximity to existing CT Scan

The floor plan utilizes layer management and linetypes to intentionally prioritize the information being communicated, for example, dark dashed lines show the anticipated trenching of the slab. When drawings and details become overwhelmed with annotations, we will split that information into separate plans.

This project had a considerably small footprint to work with and required SKA to design down to the stud and gypsum board thickness. During construction, SKA sought out time to review the plans with the Contractor to pass on the design and dimensional constraints and requested that the Contractor chalk out the wall and equipment placement to prove clearance requirements could be met.

5. Availability

The design team within 2 hours of SVMH and prepared to provide flexibility and availability at short notice for onsite visits as needed and required by the project.

6. Production Capability

SKA is a reputable and steady firm comprising nine dedicated staff members, including two registered architects, two project managers, four architectural designers, and a staffing coordinator, skilled in documentation, detailing, and construction document creation. Our office operates with agility and responsiveness, readily equipped to manage a project of this magnitude, complexity, and timeline.

Our Design Team's collective experience with Interventional Radiology projects provides us with a rich inventory of construction details and established design practices ready for implementation. Likewise, each team member brings with them valuable insights gained from working within existing facilities, encompassing aspects such as dated construction types, utility phasing, facility shutdowns, and intricate coordination. SKA's standard project management approach encourages team cohesion and leverages our collective expertise. We've instated a firm-wide project management and production standard. The following process is our way of ensuring design requirements are accurately met, checked, and delivered promptly. Our use of pull planning, the Last Planner System, resource management, regular coordination meetings (Scrum), integrated QA/QC process, and tracking documents, all contribute significantly to our team's success.

Pre-Design Stage

Our Managing Principal and Project Managers collaboratively define and uphold project objectives, timeline, cost/budget, quality, and scope. This dual managerial approach, coupled with the tools described below, enables efficient work distribution and adherence to tight deadlines.

At the project's onset, we collaborate with the design team to establish a realistic schedule based on client input and constraints. We then outline the project schedule, including major milestones such as:

- Pre-design investigation
- Vendor coordination
- Analysis
- Interdisciplinary review
- Client approvals

Often, projects are driven by a specific submission or construction date, which helps

us pull the project schedule. We employ online tools like Instagantt and Microsoft Project to adjust the project schedule and set durations. Regular review of these schedules in our design meetings ensures team awareness of impending deadlines and facilitates necessary adjustments. This methodology has seldom resulted in compressed scheduling or delays.

Regular Coordination Meetings & Project Tracking

Aligned with our LEAN agility model, SKA conducts routine design meetings and check-ins with our project team. These sessions promote collaboration and early stakeholder and team involvement, reinforcing project objectives, addressing roadblocks, and fostering continuous improvement.

Furthermore, SKA utilizes design tracking documents to ensure timely decision-making. These records also serve as a reflection of decisions made throughout the design process, shared with all team members to maintain a single information source and project design reference.

Continuous and Constant Communication & Design Coordination

Our Project Managers maintain open communication with the Client, design team members, vendors, contractors, and other stakeholders throughout the design or construction phase.

Weekly design team check-in meetings (scrum) help identify potential roadblocks and make course corrections before major issues arise. Project expectations are then documented in weekly reports distributed to the design team and Client to keep everyone informed.

For in-house and interdisciplinary design reviews, our Design Team frequently uses Bluebeam. Sessions are created to record design milestones and provide a space for each discipline to review others' comments, a process proven to significantly expedite design and detail coordination.

Depending on the project, we may use Revit to develop a model and construction documents, enabling real-time cross-discipline coordination and faster utility clash detection. However, in cases where modeling existing conditions may be cost-prohibitive, AutoCAD serves as our preferred platform for document development. Bluebeam aids in interdisciplinary coordination and review.

7. Budget and Schedule response

The design team identified in this RFQ, including both Principals and design staff, has a well-established track record of efficient collaboration, invariably resulting in projects being completed on schedule and within budget. Three main project management techniques led by SKA are regularly used by our design team to adhere to project schedules and budgets.

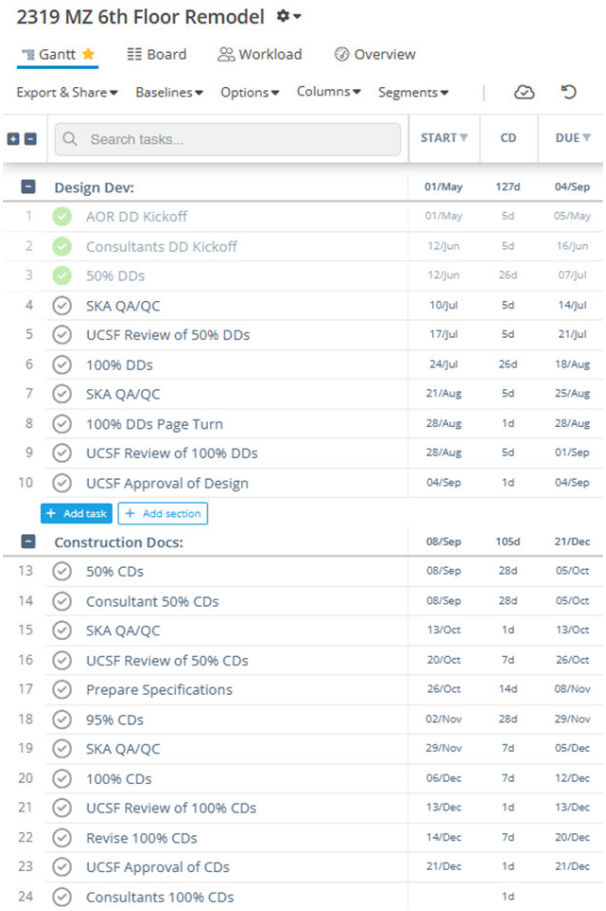
From the get-go, SKA Project Managers initiate a project charter and a project manual. Client-approved pre-design budget and schedule are firmly incorporated into the project manual. These documents serve as continuous points of reference and are regularly updated throughout the design and construction stages, a practice crucial for ensuring timely and budget-conscious project completion.

Leveraging Pull Planning, SKA collaborates with the Client to devise a design schedule tailored to Client requirements, facilitated by Instagantt, a cloud-based project scheduling tool. This schedule is shared with all design-involved parties. Regular design meetings are held with mandatory attendance for all design parties, and Clients are warmly invited to participate. Meeting outcomes are recorded through detailed documentation, meeting

minutes, sketches, Plangrid, and updated project manuals. These records are reviewed by all parties involved in the design, including Stakeholders, Client Representatives, and Contractors when applicable.

The SKA team benefits from a dedicated Staffing Coordinator whose role encompasses monitoring staff workload and project milestones. Every week, the SKA team collectively reviews the centralized, digital office calendar where all imminent milestones and submittals are examined for up to four weeks ahead. This process has repeatedly demonstrated its efficiency in overcoming project obstacles, minimizing last-minute submittal delays, and reinforcing the QA/QC process.

Our Principals and staff are unwavering in their commitment to delivering the best possible service within the available budget. Throughout all project stages, our team



will collaborate with the University to refine specific requirements and impacts, promptly addressing any collateral impacts as they emerge.

8. Regulatory Agency Experience

SKA emphasizes team agility which allows us to adjust our team based on the demand of the specific project. In the 21 years of operation, SKA has completed over 500 HCAI/OSHPD approved projects ranging in complexity from cosmetic refreshes to infrastructure upgrades/replacements.

A major strength SKA has is the well-established relationship with the HCAI Office and Field Staff. Our diligence and reliable expertise has built trust with HCAI over the last 20 years. Our strategy is to work together with the state agency as early as possible in the design process, be proactive in solving issues early in the design process, prevent costly change orders during construction, and expedite the project approvals when time is short. Our relationship and reputation allows us to effectively communicate with HCAI and act as stewards between HCAI and the Facility. In many occasions this relationship has assisted in obtaining permit extensions, scope negotiations, rapid reviews, and fast, positive field staff responses.

We believe integrated project delivery relationship among all players in construction is the way to achieve success on a project that must maintain operation throughout construction. We work closely with the Contractor, Owner and IOR to stay on top of progress, plan ahead for next milestones, investigate possible constraints, and come up with quick solutions to construction details. An active channel of communication between these parties keeps schedules tight and a key factor in our ability to have regular successful HCAI milestones and Substantial Completion. Our approach to a successful milestone driven project is deeply rooted in proactive HCAI communication. While many design

professionals find resistance and hesitation with HCAI, we do not. We have deep and positive relationship with HCAI Sacramento office officials, as well as field officers, such as Patrick Carroll (CO), Josh Trumbauer (FLSO) and Shane Gross (DSE). Without hesitation, we also regularly meet with the HCAI Field Staff for IOR project walks, milestone closeouts, and post approval document review. We are very familiar with each staff member's idiosyncrasies and regular meeting schedules which makes our review and closeout timelines shorter than average.

As these projects have many milestones and critical timelines, early coordination and planning with the Field Staff is necessary. Our sound relationship and pre-planning with the HCAI Field Staff ensures fast responses and often leniency during an ongoing project. We believe this approach will essentially eliminate the delays associated with HCAI sign-off and return the project areas to a usable state as fast as possible.

9. Quality Assurance and Quality Control

As reiterated throughout this response, the SKA team integrates various safeguards that bolster our commitment to maintaining top-notch Quality Assurance and Quality Control standards.

At the onset of a project, our SKA project managers employ Instagantt, a cloud-based project planning tool, to structure a project timeline. It is during this phase that we incorporate distinct milestones to secure dedicated review time for both the Design Team and the Managing Principal. This review time ensures that documents uphold standards of clarity and completeness. Additionally, we purposefully designate milestones for interdisciplinary QA/QC intervals and make sure to communicate these dates to our team consistently. This approach is carried over to the Plan Review stage where our team repeats these scheduling tactics.

Our Managing Principal (MP), Madelyn McClellan, plays a pivotal role in both Quality Assurance and Quality Control. The MP acts as a gatekeeper, verifying the quality of project deliverables during the in-house quality control process before any document submission. Interface Engineering employs a comparable procedure, with layers of peer review firmly established.

Lastly, we put significant effort into building a harmonious working relationship with our consultants, encouraging open dialogue across disciplines. This practice has shown to be effective as a safety net to identify and rectify minor coordination issues that may not be specific to a single discipline.

10. Client Relationship

We place significant emphasis on personalized attention for our clients, ensuring we listen intently to the Owner, Users, and Client's Representative. Our team is rooted in the belief that the key to fruitful collaboration is open dialogue and ongoing communication. Given the number of stakeholders involved in SVHMH projects, understanding and incorporating their interests into the design is essential.

Recognizing that not all stakeholders will be conversant with floor plans or the complexity of construction impacts, we routinely create visual aids to suit each scenario. These visuals can range from color-coded floor plans to 3D models, renderings, or even physical mock-ups, depending on the project. In all stakeholder meetings, we strive to maintain an atmosphere of patience and confidence, a strategy that encourages a similar confidence among our stakeholders.

SKA boasts significant experience in liaising with Facilities and Stakeholders in situations that demand areas remain

operational. Through meticulous pre-planning, comprehensive design documents, and clear written documentation, we delineate any potential impacts. Historically, we have effectively incorporated phasing and shutdown matrices into our construction documents, as evidenced by the reference image provided in the Proven Experience section of this response.We feel very confident that we have successfully provided effective communications and coordination with our Clients, including:

Client: Sutter CPMC, Davies Campus
Reference: William Conaway, Sr.Project Mngr
Project: Davies Campus CT Scan Relocation

Client: Marshall Medical Center
Reference: Derek Bogaard, Project Manager
Project: OB & ED Nurse Call Replacement

11. Sustainability

Reduce for sustainability – we strive to create minimal impact to environment when disruption is needed.

Most of our projects are required disruptions: interior renovation within a hospital. Project scopes are typically dependent on existing infrastructure and building envelope with a narrow window of opportunity to make the space more sustainable. While the opportunities are limited, we seize all opportunities including:

- Improve water efficiency by carefully selecting plumbing fixtures, cooling systems and other equipment;
- Increase energy efficiency by utilizing the latest lighting and lighting control technology and efficient HVAC equipment;
- Reduce resource use by using existing work to the maximum extent, specifying sustainably sourced materials and products, and include requirements for waste management;
- Increase indoor environment and staff comfort by implementing Lean thinking for improved workflow, allowing better lighting and temperature control, designing for better ergonomics, and installing advanced air filtration system when possible.

We recognize the utilitarian oriented purpose of this project. Limiting new work and reusing existing infrastructure as much as possible will be our focus to reduce the impact on the environment. We will take all opportunities come up during design to improve energy efficiency, material resource utilization, carbon emissions reductions with creative solutions.

Interface Engineering's response on Sustainability:

Sustainability is at the core of all of our designs. Interface Engineering is well versed with sustainable design as can be seen by the metrics below:

260 LEED, all levels

84 LEED Platinum

67 Zero (energy or water) buildings in design, under construction, ready, or built

17 Living Buildings in design, under construction or built

4 Carbon Neutral buildings in design, under construction or built

5 WELL Buildings in design, under construction or built

5 Green Globes projects in design, under construction or built

Below is an abbreviated list of our healthcare projects that were designed to meet LEED standards:

1. UCSF ACC 7 Transplant Design/ LEED Silver; San Francisco, California

    a. Interface provided MEP Engineering and Fire/Life Safety to UCSF's 7th floor transplant center. It required close coordination due to very tight fitting HVAC units with a challenging existing structure. The project was also designed as an HCAI 3 space.

2. UCSF Nancy Friend Pritzker Psychiatry Building / LEED Platinum Goal, San Francisco, California

3. El Camino Health Integrated Medical Sobrato Pavilion / LEED Gold Goal; Mountain View, California

4. El Camino Health Behavioral Health Services Taube Pavilion / LEED Gold Goal; Mountain View, California

12. Equal Employment

Our team is an equal opportunity employer. Company policy prohibits unlawful discrimination. Smith-Karng Architecture, Inc. is committed to compliance with all applicable laws providing equal employment opportunities. This commitment applies to all persons involved in Company operations. Below is a snapshot from the company Employee Handbook each employee must read, understand, and sign upon hire. Each employee maintains a copy of the Employee Handbook for their records and reference. Below is the excerpt of the document.

13. Contract

Our team is willing to accept the contract language, including the indemnification and insurance requirements, and we will execute the Professional Services Agreement and Executive Design Professional Agreement as written. We understand that once the contract is awarded, the Agreement will only be modified as it relates to the project scope.

Please see the following attachment for our Sample Certificate of Insurance.

14. Disclosure of SVHMH Work in the last 5 years

Cath Lab #1
PBX Relocation
Omnicell Replacement
SPD Wall Repair & Remodel
Tower Reroofing
Nurse Call Replacement
EndoWasher Replacement
CCTV
Centrak/Telemetry
MTCAP Program
Blanket Warmer Installation
Heart Center AHU Installation
AHU 15
AHU 2011
Virtuo Blood Bank
Lab Analyzers Replacement
Cesarean Delivery Conversion
Elevator Modernization
Bulk Oxygen Replacement & Emergency Project
Donor Walls
SOC Drawing Updates

ATTACHMENT B

ATTACHMENT B

STATEMENT OF QUALIFICATIONS

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

1. Firm name: Smith-Karng Architecture

2: Business Address: 360 Pine Street, Floor 3, San Francisco, CA 94104

3. Firm Established (year): 2001

Telephone: 415.425.7623 /415.757.0384
Fax:
Email: madelyn@smithkarng.com
Website: https://www.smithkarng.com/

4. Type of Organization: (check one)

Sole Proprietorship	( )
Partnership	( )
Corporation	(X)
Joint Venture	( )

5. Key Personnel

Name	Title	Degree or Certification	Institution	Registration
Madelyn McClellan	President/CEO	Master's Degree of Architecture	University of Buffalo, Buffalo, NY	Registered Architect, CA #C37097
Glenn Casuga	Senior Project Manager	Bachelor's Degree of Arhcitecture	California State Polytechnic University, Pomona, CA	
Alexandra David	Project Manager	Master's Degree of Architecture	Tulane University, New Orleans, LA	Registered Architect, CA #C38979

6. Average staff employed in your home office (average of past 5 years):

Architects:	4
Structural Engineers:	
Mechanical Engineers:	
Electrical Engineers:	
Civil Engineers:	
Drafting Technicians:	5
Clerical:	1
Other:	

7. Provide at least three (3) references that SALINAS VALLEY HEALTH may contact:

Client: Sutter Health, California Pacific Medical Center
Contact: William Conaway, Senior Project Manager
Reference Project: CPMC Davies ASU and CT Scanner Relocation
Email: William.Conaway@sutterhealth.org
Phone: 415.850.0135

Client: Sonoma Valley Hospital
Contact: Kimberly Drummond, Chief of Support Services
Reference Project: SVH CT Scan Suite; MRI
Email: kdrummond@sonomavalleyhospital.org
Phone: 707.935.5165

Client: MarinHealth Medical Center
Contact: Paul Donanldson, Executive Project Manager
Reference Project: Nuclear Medicine Suite, Compounding Pharmacy Relocation
Email: paul@montgomerycorp.org
Phone: 707.953.9607

Client: Alameda Health System, San Leandro Hospital
Contact: James Helena, System Director, Eng. & Fac. Services
Reference Project: SLH CT Scanner Replacement
Email: jhelena@alamedahealthsystem.org
Phone: 510.203.0757

8. Provide at least three (3) contractor references that SALINAS VALLEY HEALTH may contact:

Contractor: Herrero Builders
Contact: Brad Krill, Project Executive
Reference Project: CPMC Davies ASU; HVAC Upgrades; ED Remodel; CT Scanner Relocation
Email: bkrill@herrero.com
Phone: 415.308.3759

Contractor: GMH Builders, Inc.
Contact: Peter Schmidt, Superintendent & Project Executive
Reference Project: Sonoma Valley CT Scanner; MRI; MarinHealth Nuc Med Suite; Lab Analyzers
Email: Peter@gmhbuild.com
Phone: 707.718.6713

Contractor: Bryan Masterson Enterprises, Inc.
Contact: Joe Masterson, President
Reference Project: AHS Southshore Sewer Repair; CPMC Davies Sump Discharge Repair
Email: joe@mastersoninc.net
Phone: 415.724.7248

Contractor: Bogard Construction
Contact: Derek Bogaard, Project Manager
Reference Project: SVMH Cath Lab #1; Lab Analyzers Replacement; MMC Nurse Call Replacement
Email: derek@bogardconstruction.com
Phone: 831.246.2085

Signature: _____ Date: 9/27/2023

Printed Name: Madelyn McClellan

Title: President/CEO

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ATTACHMENT B (CONT.)

PROJECT INFORMATION SHEET

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

Please complete a Project Information Sheet for each project listed in the Statement of Qualifications. If construction is not complete, give project status instead of completion date.

Project: Catheter Lab #1 Replacement
Completion Date: June 2020
Location: 450 E. Romie Lane, Salinas, CA 93901
Gross Sq. Feet: 850 SF.
Owner: Salinas Valley Heathcare System
Number of Spaces:
Owner's Representative: Derek Bogaard
Construction Cost: $2,761,797

Description: Replacement of existing Cath Lab #1 equipment within Procedure Room, Control Room, and Equipment Room. Scope of work included rectifying non-compliant construction and ADA upgrade to Staff Toilet.

Owner/Representative Phone Number: 831.246.2085

Contract Method (lump sum, negotiated, design build, multiple-prime, other):
Lump Sum, Design-Bid-Build

General Contractor: Salinas Valley Memorial Hospital - Owner/Builder

Project Manager: Derek Bogaard
Superintendent:

Architect: Smith-Karng Architecture

Principal: Madelyn McClellan
Project Manager: George Christ

Structural Engineer: Estructure

Principal: Maryann Phipps
Project Manager: Darrick Hom

Mechanical Engineer: Axiom Engineers

Principal: Bill Estes
Project Manager: Kate Conway

Electrical Engineer: Aurum Consulting Engineers

Principal: Eldridge Bell
Project Manager: Frank Pinedo

Other (as appropriate):

Principal:
Project Manager:
(provide additional sheets if necessary)

ATTACHMENT B (CONT.)

PROJECT INFORMATION SHEET

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

Please complete a Project Information Sheet for each project listed in the Statement of Qualifications. If construction is not complete, give project status instead of completion date.

Project: CT Scanner Relocation
Completion Date: 2021
Location: 601 Duboce Ave, San Francisco, CA 94117
Gross Sq. Feet: 650
Owner: Sutter Health California Pacific Medical Center - Davies Campus
Number of Spaces:
Owner's Representative: William Conaway
Construction Cost: $1,226,555

Description: This project was tasked with relocating a GE Discovery CT750 HD CT Scanner from the CPMC CAL Campus to the Davies Campus. Scope of work included a new CT Imaging Room, Control Room, ADA Patient Dressing Room and ADA Patient Toilet within occupied space.

Owner/Representative Phone Number: 415.850.0135

Contract Method (lump sum, negotiated, design build, multiple-prime, other):
Lump sum, Design-Bid-Build with negotiated bid

General Contractor: Herrero Builders

Project Manager: Brad Krill
Superintendent: Geoff Evans

Architect: Smith-Karng Architecture

Principal: Madelyn McClellan
Project Manager: Madelyn McClellan

Structural Engineer: Estructure

Principal: Maryann Phipps
Project Manager: Darrick Hom

Mechanical Engineer: Mazzetti

Principal: Jon Inman
Project Manager: Michael Tsuchimoto

Electrical Engineer: Mazzetti

Principal: David Hicks
Project Manager: David Hicks

Other (as appropriate): Mazzetti - plumbing

Principal: Jon Inman
Project Manager: Mike Marshall
(provide additional sheets if necessary)

ATTACHMENT B (CONT.)

PROJECT INFORMATION SHEET

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT PROJECT

Please complete a Project Information Sheet for each project listed in the Statement of Qualifications. If construction is not complete, give project status instead of completion date.

Project: Bulk Oxygen Replacement
Completion Date: 2021
Location: 450 E. Romie Lane
Gross Sq. Feet: 350
Owner: Sutter Health California Pacific Medical Center - Davies Campus
Number of Spaces:
Owner's Representative: Frances Dacanay
Construction Cost: Unknown

Description: Triggered by a failing foundation, this project was initiated with a Study for replacement followed by an Emergency Authorization for a temporary oxygen system and permanent replacement project. Temp system is in place and permanent system is in review with HCAI.

Owner/Representative Phone Number: 831.246.2080

Contract Method (lump sum, negotiated, design build, multiple-prime, other):
Lump sum

General Contractor: N/A

Project Manager:
Superintendent:

Architect: Smith-Karng Architecture

Principal: Madelyn McClellan
Project Manager: Madelyn McClellan

Structural Engineer: Estructure

Principal: Darrick Hom
Project Manager: Darrick Hom

Mechanical Engineer: Interface Engineering, Inc.

Principal: Rick Russell
Project Manager: Thomas de Senna

Electrical Engineer: Interface Engineering, Inc.

Principal: Thomas Jun
Project Manager: Philip Nguyen

Other (as appropriate): Interface Engineering, Inc.

Principal: Rick Russell
Project Manager: Thomas de Senna
(provide additional sheets if necessary)

ATTACHMENT C

ATTACHMENT C

REQUEST FOR SUPPLEMENTAL INFORMATION - CLAIMS

CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

Please submit the following information. Failure to respond may affect consideration of your firm for this project. If the firm has more than one office or division, please provide this information for the office proposed for this project. Responses may be listed on separate pages.

1. Separately list each pending unresolved claim for construction disputes and each current arbitration(s), mediation or litigation in which construction disputes or breach of contract is alleged or indemnity is being sought (because of such alleged disputes or breach of contract) using the following claimant categories:

   a. SALINAS VALLEY HEALTH against your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

      None

   b. Any Owner, person or entity against your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

      None

   c. SALINAS VALLEY HEALTH against any of your proposed consultant (i.e. structural, mechanical, electrical, and any other consultant). If none, indicate none.

      None

   d. Any Owner, person or entity against any of your proposed consultants (indicate project, location and Owner). If none, indicate none.

      None

2. Separately list each resolved (settled, arbitrated, and litigated) claim for professional negligence or breach of professional services agreement or for indemnity (because of such alleged negligence or breach of contract) during the last five (5) years using the following categories:

   a. SALINAS VALLEY HEALTH and your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

      None

b. Any Owner, person, or entity, and your firm or any principal of your firm (indicate project, location and Owner). If none, indicate none.

None

DECLARATION:

The undersigned declares under penalty of perjury that all of the information submitted is true and correct, and that this declaration was executed in

San Francisco County (County) County, California, on 9/28/2023 (Date).

Madelyn McClellan

Name and Title –Printed or Typed

Signature

Smith-Karng Architecture, Inc.

Firm Name –if a joint venture, state name of joint venture entity

360 Pine Street, FLR 3

Address

San Francisco, CA 94104

City, State and Zip Code

415.757.0384

Telephone Number

Facsimile Telephone Number

5833260.3

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 12/26/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER
AssuredPartners Design Professionals Insurance Services, LLC
3697 Mt. Diablo Blvd., Suite 230
Lafayette CA 94549

License#: 6003745

CONTACT NAME: Nancy Ferrick
PHONE (A/C, No, Ext): 510-272-1400 **FAX (A/C, No):**
E-MAIL ADDRESS: nancy.ferrick@assuredpartners.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : Aspen American Insurance Company	43460
INSURER B : Sentinel Insurance Company	11000
INSURER C : Property & Casualty Insurance Company of Hartford	34690
INSURER D :	
INSURER E :	
INSURER F :	

INSURED
Smith-Karng Architecture, Inc.
800 Haight Street
San Francisco CA 94117

SMITARC-03

COVERAGES **CERTIFICATE NUMBER:** 1751450522 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
B	X **COMMERCIAL GENERAL LIABILITY**	Y	Y	57SBWRI7057	1/11/2023	1/11/2024	EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 1,000,000
	X Contractual Liab						MED EXP (Any one person)	$ 10,000
	[ ] Included						PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	[ ] POLICY [X] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	[ ] OTHER:							$
B	**AUTOMOBILE LIABILITY**	Y	Y	57SBWRI7057	1/11/2023	1/11/2024	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [ ] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
B	X **UMBRELLA LIAB** [X] OCCUR	Y	Y	57SBWRI7057	1/11/2023	1/11/2024	EACH OCCURRENCE	$ 9,000,000
	[ ] **EXCESS LIAB** [ ] CLAIMS-MADE						AGGREGATE	$ 9,000,000
	[ ] DED [X] RETENTION $ 10,000							$
C	**WORKERS COMPENSATION AND EMPLOYERS' LIABILITY** Y / N		Y	57WEGAR2M4V	1/11/2023	1/11/2024	X PER STATUTE [ ] OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [ ] **(Mandatory in NH)**	N / A					E.L. EACH ACCIDENT	$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 1,000,000
							E.L. DISEASE - POLICY LIMIT	$ 1,000,000
A	Professional Liability			AAAE30011403	1/11/2023	1/11/2024	Per Claim Aggregate Limit	$5,000,000 $5,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Insured has no company owned vehicles; therefore, Hired/Non-Owned Auto Liability is the maximum coverage that applies.
Umbrella Liability policy is follow-form underlying: General Liability/Non-Owned and Hired Auto Liability/Employer's Liability.
FOR PROPOSALS. An Actual Certificate will be issued upon the request of the Named Insured.

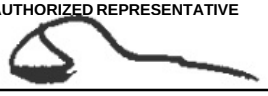
CERTIFICATE HOLDER

SAMPLE CERTIFICATE

CANCELLATION 30 Day Notice of Cancellation

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



SKA
SMITH-KARNG
ARCHITECTURE

360 Pine Street
San Francisco, CA 94104
415.757.0384

September 28, 2023

SALINAS VALLEY HEALTH – Cath Lab 3 and Angio Equipment Replacement
Bogard Construction | Attn Dave Sullivan
535 E Romie, Suite 6
Salinas, CA 93901

Re: Fee Proposal for Cath Lab 3 and Angio Equipment Replacement
SKA #23110 – Angio Room Equipment Replacement
SKA #23111 – Cath Lab 3 Equipment Replacement

Dear Mr. Sullivan:

Thank you for the opportunity of presenting this proposal for Architectural and Engineering services for the Cath Lab 3 and Angio Equipment Replacement project at Salinas Valley Health Memorial Hospital. We appreciate your consideration.

The general intent of this project is to provide full design services in a phased construction manner to replace the existing Siemens equipment on the first level of the Cardiac Center South Building 8.

This proposal has been formatted to separate the fees for the Cath Lab #3 and Angio Room scope of work. Design for these rooms will be concurrent and construction will occur consecutively.

An alternate fee has been provided for commissioning services. This scope is not considered required but is highly recommended by the design team. This service has been provided as a line item but not included in the base proposal.

The overall anticipated project schedule is as follows:

Contract Negotiation	October 9-13, 2023
Contract Execution	October 2023
PD, SD, DD, CD	November 2023 – February 2024**
Agency Review	February 2024 – April 2024
Bidding	May 2024
Angio Room Construction	May 2024 – August 2024
Cath Lab #3 Construction	August 2024 – October 2024

**We would recommend considering a longer design timeline. The design process will be taking place across (3) holidays and often see 3-4 weeks of committed holiday time-off and time lost to the project.

Scope of Work:

Our general services are outlined below.

Project Management

The following services are included in this proposal and will be provided throughout the design phases of the project. The approximate project start date is 11/01/2023. and the design time is anticipated to be approximately 3 months. Additional services may be submitted for review and approval if the design extends beyond general project expectation.

1. Establish and update Project Charter and Project Management Manual which includes project goals, assumptions, constraints, criteria, design parameters and other high-level information defining the project success.
2. Conduct bi-weekly project planning and coordination meetings with design team.
3. Conduct regular project monitor and control tasks.
4. Conduct regular Quality Control measures.
5. Apply Design Strategy methodologies, Evidence Based Design (EBD) principles and Lean principles on design solution developing, problem solving and decision making.

Pre-design Phase

1. Establish Project Charter and Project Management Manual.
2. Establish initial project program.
3. Field survey of project site to verify existing conditions shown in drawings provided to us. Document existing conditions not included in the CAD drawing provided to us.
4. Evaluate project related and vendor information provided to us.
5. Conduct preliminary code analysis.
6. Attend a Project Kick-off meeting with Stakeholder to ensure a common understanding of the project. **(1 meeting)**
7. Conduct in-person User research to collect User needs and requirements, and to understand operation workflow. **(2 hours maximum in a single trip.)**

Schematic / Design Development (DD) Phase

1. Request preliminary information and coordinate with equipment vendors.
2. Prepare Preliminary Design options for Stakeholder review. **(2 schemes)**
3. Prepare annotated design diagrams on design assumptions and EBD concepts for Stakeholder review.
4. Conduct Preliminary Design review meeting and collaborate design with Stakeholders. **(1 meeting)**
5. Revise selected design option based on Stakeholder feedback and prepare one design option for Stakeholder approval to proceed.
6. Prepare SD design and documents for Stakeholder review, comment, and approval: 100% SD. **(1 submittal)**
7. Conduct 100% SD review meeting and collaborate design with Stakeholders. **(1 meeting)**
8. Revise selected SD design based on Stakeholder feedback for Stakeholder approval to proceed.
9. Request and attend pre-application meeting with AHJ to review proposed work and seeking official interpretation on code related issues.
10. Conduct User review meetings for User approval on design. **(3 meetings at 1 hour each)**
11. Request final drawing and coordinate with equipment vendors.
12. Coordinate with special system vendors, unknown at this time, hired directly by the Owner.

13. Prepare DD drawings based on approved Schematic Design.
14. Prepare and submit design documents for Stakeholder review: 100% DD. **(1 submittals)**
15. Conduct DD review meetings with Stakeholder: 100% DD. **(1 meetings)**
16. Revise selected DD design based on Stakeholder feedback for Stakeholder approval to proceed.

Construction Document (CD) Phase

1. Prepare design documents for Stakeholder review and approval.
2. Prepare construction drawings based on approved design development documents.
3. Prepare project manual and technical specifications.
4. Select interior finishes and prepare interior finish options for Stakeholder review. **(3 schemes)**
5. Prepare and submit CD for Stakeholder review: 50%, 90% and 100% CD. **(3 submittal)**
6. Conduct 50%, 90%, and 100% CD review meeting with Stakeholders. **(3 meeting)**
7. Revise construction documents based on Stakeholder review comments.
8. Prepare plan review submittal drawings and documents.

Bidding/Negotiation Phase

1. Attend bid walk-through. **(1 meeting)**
2. Answer bidder questions (RFI) and prepare addendums as required. **(1 addendum)**

Agency Review Phase

1. Prepare submittal packages seeking agency approval.
2. Respond to plan review comments. **(2 backchecks)**
3. Prepare required post-approval paperwork (Building Permit, TIO field review, Notice of Start of Construction).

Contract Administration (CA) Phase

The approximate construction start date is 05/01/2024 and the construction time is anticipated to be approximately 3 months for each project, 6 months total. Total number of CA hours, meetings, site visits, and milestone sign-off coordination are included and listed below as allowances during the construction. When the total number of CA hours, meetings, site visits, or milestone sign-off coordination are reached, SKA will notify the Owner. Additional services may be submitted for review and approval if the listed services below extending beyond general project expectation. CA services are listed under each phases below. The breakdown below is for each project, not total.

1. Deliverables: (1) set of 11x17 approved drawings, (1) set of 30x42 approved drawings, (1) set of 8.5x11 specifications, (1) set of approved Calculations, electronic copies of all HCAI approved Contract Documents.
2. Provide CA services: review submittals, respond contractor RFI, and other services, unless excluded herein.
3. Coordinate and conduct HCAI on site construction kick-off meeting. **(1 meeting)**
4. Attend Owner-Architect-Contractor virtual construction kick-off meeting. **(1 meeting)**
5. Visit construction site as required during the construction period. **(3 visits)**
6. Attend Owner-Architect-Contractor virtual meetings once per week during the construction period. **(13 meeting)**
7. Prepare ASI and ACD for HCAI review as required. Changes due to unforeseen conditions or initiated by the Owner shall be considered additional services.
8. Conduct milestone walk-through and review; prepare compliance verify reports as required for HCAI sign-off at milestones. **(2 milestones)**
9. Prepare amendments to construction documents for local AHJ review is not included in this proposal.

10. Conduct punch-list walk-through and prepare punch-list. **(1 punch-list walk-through)**
11. Visit to job site to verify the completion of the punch-list items. **(1 visit)**

Project Close-out Phase

1. Prepare project close-out documents as required by AHJ.
2. Coordinate efforts with stakeholders and the contractor for HCAI sign-off of project.
3. Attend a project close-out walk-through with HCAI ACO.

23110 Angio Room Equipment Replacement Scope of Work:

The proposed Angio Room Equipment Replacement project program will generally include:

- Replacement of existing Siemens imaging systems equipment with unspecified ceiling mounted solution,
- Electrical and low voltage infrastructure in support of new equipment,
- New split unit cooling system and rebalancing of HVAC, including integration into existing BMS,
- Touchless operated automatic door assembly,
- Replacement of existing surgical lighting system,
- Installation of new ceiling lighting systems in procedure and control rooms,
- Ceiling layout and new ceiling structural support system,
- Assessment and potential relocation of medical gasses,
- Replacement of existing casework and storage solutions,
- Replacement of existing finishes,
- Coordination with and overstamp of Owner-procured design-build Hillrom nurse call system,
- Coordination with and overstamp of Owner-procured design-build fire alarm system,
- Coordination with and overstamp of Owner-procured design-build fire suppression system,
- Coordination with and overstamp of Owner-procured physicist for lead-lining requirements,

A site walk was conducted on 9/22/2023 at which time the following was noted as part of review of as-builts:

- Multiple stud wall conditions: red iron and 16 gauge studs,
    - Gyspum board appears to be full height in some locations but not all.
    - Multiple layers of walls along the corridor wall exist.
- Above-ceiling conditions are typical of what has been seen in this area,
- Spot check of corridor walls above ceiling show many types of non-compliant penetrations that will need to be fixed. Utilities that are partially in the wall will need to be relocated or the wall construction will need to be modified to accommodate the existing utility. A custom Engineering Judgement may be required, but is not included in this fee proposal.
- Ceiling structure appears to be compliant.
- The above-ceiling support structure appears to be compliant with 12” of fire proofing at primary structure connections. While efforts would be made to keep the existing structural system, this project would provide an analysis to determine if this system needs to be replaced.
- Above-ceiling conditions in the corridor are very congested with existing utilities right at the ceiling structure. These utilities will likely need to be resupported and confirmed to not be resting on the suspended ceiling structure. This proposal does not include trapeze supports for corridor utilities.
- The Electrical Shop is below, structural modifications if needed for the table will have little impact to patient care areas.
- Existing Equipment Room as-builts indicate shaft wall construction to maintain fire-rating with fire-rated ceiling membrane and expansion joint. It will be recommended to avoid modifying that construction as much as possible to avoid upgrading to current UL listings.
- As-builts for med gas zone valves on corridor wall appear to be compliant with 5-sided box construction. Modification to the existing zone boxes is not included in this proposal.
- As-builts indicate that a furred wall was demolished in the Control Room along the corridor wall, however, on-site observations indicate that the furred wall may have remained.
- Existing ceiling access panels are aged and will need to be replaced.

Code Assessment as it relates to the Scope of Work:

- It is assumed that Patient Holding is combined with the Cath Lab Holding area and a new space is not required.
- Room meets minimum requirements for 18 foot minimum.

- It appears that the table may not meet the minimum 4 foot clearance and may need to be relocated.
- Staff changing areas shown in the ORs will be identified as also supporting this Room. Upgrades to these rooms is not included in this proposal.
- Other supporting services, Clean and Soiled Utility, are existent and compliant. Upgrades to these rooms is not included in this proposal.
- An Alternate Means of Compliance was provided for the Cath Lab #1 Project to allow the combination of (2) Staff Toilets into (1) compliant ADA Toilet, this toilet is assumed to serve this space as well.
- It is assumed that the Path of Travel to this space is compliant, however an assessment will need to be conducted to confirm compliance. Upon initial review of Cath Lab #1 as-builts, the existing Patient Toilet at the Post Op Holding and Waiting Area Public Toilet may not comply and may need to be included as part of the Path of Travel upgrades. These Toilets were considered compliant at the time of Cath Lab #1 under 2013 CBC, however the clearance requirements have changed to current 2022 CBC. This scope will be defined in the Pre-Design and Schematic Design, the remedial scope of work for compliance is included in this proposal and assumed one toilet per project.

23110 Fees

This proposal is to provide services related to the referenced project for a maximum lump-sum fee of **$329,433 (Three Hundred Twenty-Nine Thousand Four Hundred and Thirty-Three Dollars)** including reimbursable expenses to the amount of $3,150. An alternate for HVAC Commissioning has also been provided but not included in the lump-sum fee.

Proposed Fees							
Consultant	**Discipline**	**SD/DD Phase**	**Construction Doc**	**AHU Review / approval**	**Bidding**	**CA**	**Total**
Smith Karng	Architecture	$ 50,375.00	$ 47,740.00	$ 6,370.00	$ 3,185.00	$ 46,890.00	$ 154,560.00
Interface Engineering	Mech/Plumbing Engr.	$ 32,055.00	$ 31,545.00	$ 2,500.00	$ 1,000.00	$ 15,735.00	$ 82,835.00
Aurum Engineers	Electrical Engineering	$ 12,012.00	$ 15,116.00	$ 4,260.00	$ 1,504.00	$ 12,296.00	$ 45,188.00
Estructure	Structural Engineering	$ 5,675.00	$ 21,500.00	$ 7,375.00	$ 1,795.00	$ 7,355.00	$ 43,700.00
							$ -
							$ -
Total Professional Fees		**$ 100,117.00**	**$ 115,901.00**	**$ 20,505.00**	**$ 7,484.00**	**$ 82,276.00**	**$ 326,283.00**

Reimbursables		
Description		**Total**
Travel		$ 2,750.00
Plotting		$ 400.00
Total Reimbursables		**$ 3,150.00**

Grand Total		**$ 100,117.00**	**$ 115,901.00**	**$ 20,505.00**	**$ 7,484.00**	**$ 82,276.00**	**$ 329,433.00**

ALTERNATE		
Description		**Total**
HVAC Commissioning		$ 9,000.00

23110 Assumptions and Clarifications

The following assumptions and understandings have been made with regard to this proposal:

1. The project area is limited to the existing Angiography Special Procedures Room, Control Room, and Equipment Room.
2. The construction cost is unknown at this time.
3. Building as-built drawing, including Fire and Life Safety (FLS) drawing and building accessibility information, in PDF and CAD format will be provided to us. Time to prepare FLS and accessibility drawing for agency review based on CAD provided is included. Time to survey or draw up existing FLS and accessibility conditions is not included.
4. The Authority of Jurisdiction (AHJ) on this project is HCAI. This project will be submitted as a regular project submission. Review by other agencies or community groups are not included and will be submitted as additional services as required.
5. The project delivery method is Design-Bid-Build.
6. Agency submittal drawing will be used for bidding purpose. No separate bid document is included.
7. Code required signage and design criteria is included. Signage graphics and design will match existing building standard.
8. No service interruption/shut-down is included. Preparation and seeking approval of Facility Impact Study (FIS's) will be performed under additional services.
9. The vibrational characteristics of the structural support framing are acceptable.
10. Existing structure will be reused where possible.
11. Vendor will be responsible for any required Special Seismic Certifications.
12. Seismic bracing for suspended distribution systems will be handled by OPM and the drawings will be provided by others and reviewed by this team prior to HCAI submittal. This proposal does not include custom support and bracing for suspended distribution systems.
13. Assumes the Angio Room scope of work will be submitted with the Cath Lab #3 under the same permit to HCAI.

23110 Exclusions

The following scope and services are currently excluded from this proposal, but could subsequently be added as Add Services:

1. A custom Engineering Judgement may be required, but is not included in this fee proposal.
2. This proposal does not include trapeze supports for corridor utilities.
3. Modification to the existing zone boxes is not included in this proposal.
4. Upgrades to the Staff Changing Rooms and Supporting Service rooms are not included in this proposal.
5. Upgrade scope of work for ADA Path of Travel upgrades will be defined in the Pre-Design and Schematic Design, however the remedial scope of work for compliance is not included in this proposal.
6. Vibrational Analysis of structural support framing.
7. Design of temporary power for Contractor use.
8. Life cycle cost analysis of proposed mechanical and electrical systems.
9. Acoustical analysis, design of noise attenuation requirements, and special vibration isolation requirements for mechanical systems.
10. Acoustical analysis and design of specialized noise attenuation solutions for vendor provided equipment.
11. Signage/Way Finding beyond the rooms defined in this fee proposal
12. Building accessibility upgrade work beyond the scope of work
13. Structural, mechanical, electrical, plumbing and related infrastructure upgrades

14. Cost estimating services
15. Value engineering
16. Physical, CADD (3-D) and BIM models
17. 3-D rendering for public or Stakeholder presentation purposes
18. Specialized A/V design
19. Detailed analysis of existing Structural, Mechanical, Electrical Plumbing systems not associated with the project as defined
20. Documentation of existing building systems or characteristics requiring destructive removal have not been included in this proposal
21. Detailed analysis or testing of potential hazardous materials
22. Development of as-built or record drawings after construction

-- End of Angio Room Proposal --

23111 Cath Lab #3 Equipment Replacement Scope of Work:

The proposed Cath Lab #3 Equipment Replacement project program will generally include:

- Replacement of existing Siemens imaging systems equipment with unspecified floor mounted solution,
- Electrical and low voltage infrastructure in support of new equipment,
- New split unit cooling system and rebalancing of HVAC, including integration into existing BMS,
- Touchless operated automatic door assembly,
- Climate controlled undercounter systems cabinet at Control Room (similar to Cath Lab #1),
- Replacement of existing surgical lighting system,
- Installation of new ceiling lighting systems in procedure and control rooms,
- Ceiling layout and new ceiling structural support system,
- Assessment and potential relocation of medical gasses,
- Replacement of existing casework and storage solutions, including assessment of current Staff workflow strategies and space deficiencies,
- Replacement of existing finishes,
- Coordination with and overstamp of Owner-procured design-build Hillrom nurse call system,
- Coordination with and overstamp of Owner-procured design-build fire alarm system,
- Coordination with and overstamp of Owner-procured design-build fire suppression system,
- Coordination with and overstamp of Owner-procured physicist for lead-lining requirements,

A site walk was conducted on 9/22/2023 at which time the following was noted as part of review of as-builts:

- Stud wall conditions: 16 gauge studs,
    - Gyspum board appears to be full height in observable locations.
    - The corridor wall is labeled as “1-hour” and appears to be full height. Patch and repair oft the wall has taken place and may need to be fixed as part of this project.
- Above-ceiling conditions are typical of what has been seen in this area,
- Spot check of corridor walls above ceiling show many types of questionable penetrations that will likely need to be fixed. Utilities that are partially in the wall will need to be relocated or the wall construction will need to be modified to accommodate the existing utility. A custom Engineering Judgement may be required, but is not included in this fee proposal.
- Ceiling structure appears to be compliant.
- The above-ceiling support structure could not be observed. While efforts will be made to keep the existing structural system, this project would provide an analysis to determine if this system needs to be replaced.
- Above-ceiling conditions in the corridor are very congested with existing utilities right at the ceiling structure. These utilities will likely need to be resupported and confirmed to not be resting on the suspended ceiling structure. This proposal does not include trapeze supports for corridor utilities.
- The Nutritional Services is below, structural modifications if needed for the table will have to be carefully coordinated and, if possible, avoided to reduce impacts to that area.
- Existing as-builts indicate existing corridor walls with no special construction types.
- As-builts indicate a seismic joint along the north wall of the Equipment Closet. Special consideration will be needed to maintain that construction.
- The modifications to the Control Room will require phasing and careful consideration to the continued operation of the adjacent Cath Labs #1 and #2, including maintaining access to the scrub sinks.

Code Assessment as it relates to the Scope of Work:

- It is assumed that Patient Holding is located in the Cath Lab Holding area and a new space is not required.

- Room meets minimum requirements for 400 square foot minimum.
- It appears that the table may not meet the minimum 4 foot clearance and may need to be relocated.
- Staff changing areas shown in the ORs will be identified as also supporting this Room. Upgrades to these rooms is not included in this proposal.
- Other supporting services, Clean and Soiled Utility, are existent and compliant. Upgrades to these rooms is not included in this proposal.
- An Alternate Means of Compliance was provided for the Cath Lab #1 Project to allow the combination of (2) Staff Toilets into (1) compliant ADA Toilet, this toilet is assumed to serve this space as well.
- It is assumed that the Path of Travel to this space is compliant, however an assessment will need to be conducted to confirm compliance. Upon initial review of Cath Lab #1 as-builts, the existing Patient Toilet at the Post Op Holding and Waiting Area Public Toilet may not comply and may need to be included as part of the Path of Travel upgrades. These Toilets were considered compliant at the time of Cath Lab #1 under 2013 CBC, however the clearance requirements have changed to current 2022 CBC. This scope will be defined in the Pre-Design and Schematic Design, the remedial scope of work for compliance is included in this proposal and assumed one toilet per project.
- Confirmation with HCAI will likely be needed to determine if an additional scrub sink will be required. An Alternate Means of Compliance may be required to gain acceptance of the shared use of (2) scrub sinks for the (3) Cath Labs.

23111 Fees

This proposal is to provide services related to the referenced project for a maximum lump-sum fee of **$353,033 (Three Hundred Fifty-Three Thousand and Thirty-Three Dollars)** including reimbursable expenses to the amount of $3,150. An alternate for HVAC Commissioning has also been provided but not included in the lump-sum fee.

Proposed Fees							
Consultant	**Discipline**	**SD/DD Phase**	**Construction Doc**	**AHU Review / approval**	**Bidding**	**CA**	**Total**
Smith Karng	Architecture	$ 56,995.00	$ 48,340.00	$ 6,370.00	$ 3,185.00	$ 53,450.00	$ 168,340.00
Interface Engineering	Mech/Plumbing Engr.	$ 32,055.00	$ 31,545.00	$ 2,500.00	$ 1,000.00	$ 15,735.00	$ 82,835.00
Aurum Engineers	Electrical Engineering	$ 15,012.00	$ 20,116.00	$ 4,260.00	$ 1,504.00	$ 14,116.00	$ 55,008.00
Estructure	Structural Engineering	$ 5,675.00	$ 21,500.00	$ 7,375.00	$ 1,795.00	$ 7,355.00	$ 43,700.00
							$ -
							$ -
Total Professional Fees		**$ 109,737.00**	**$ 121,501.00**	**$ 20,505.00**	**$ 7,484.00**	**$ 90,656.00**	**$ 349,883.00**

Reimbursables		
Description		**Total**
Travel		$ 2,750.00
Plotting		$ 400.00
Total Reimbursables		**$ 3,150.00**

Grand Total		**$ 109,737.00**	**$ 121,501.00**	**$ 20,505.00**	**$ 7,484.00**	**$ 90,656.00**	**$ 353,033.00**

ALTERNATE		
Description		**Total**
HVAC Commissioning		$ 9,000.00

23111 Assumptions and Clarifications

The following assumptions and understandings have been made with regard to this proposal:

1. The project area is limited to the existing Cath Lab #3 Room, Control Room, and Equipment Room.
2. The construction cost is unknown at this time.
3. Building as-built drawing, including Fire and Life Safety (FLS) drawing and building accessibility information, in PDF and CAD format will be provided to us. Time to prepare FLS and accessibility drawing for agency review based on CAD provided is included. Time to survey or draw up existing FLS and accessibility conditions is not included.
4. The Authority of Jurisdiction (AHJ) on this project is HCAI. This project will be submitted as a regular project submission. Review by other agencies or community groups are not included and will be submitted as additional services as required.
5. The project delivery method is Design-Bid-Build.
6. Agency submittal drawing will be used for bidding purpose. No separate bid document is included.
7. Code required signage and design criteria is included. Signage graphics and design will match existing building standard.
8. No service interruption/shut-down is included. Preparation and seeking approval of Facility Impact Study (FIS's) will be performed under additional services.
9. The vibrational characteristics of the structural support framing are acceptable.
10. Existing structure will be reused where possible.
11. Vendor will be responsible for any required Special Seismic Certifications.
12. Seismic bracing for suspended distribution systems will be handled by OPM and the drawings will be provided by others and reviewed by this team prior to HCAI submittal. This proposal does not include custom support and bracing for suspended distribution systems.
13. Assumes the Cath Lab #3 scope of work will be submitted with the Angio Room under the same permit to HCAI.

23111 Exclusions

The following scope and services are currently excluded from this proposal, but could subsequently be added as Add Services:

1. A custom Engineering Judgement may be required, but is not included in this fee proposal.
2. This proposal does not include trapeze supports for corridor utilities.
3. Modification to the existing zone boxes is not included in this proposal.
4. Upgrades to the Staff Changing Rooms and Supporting Service rooms are not included in this proposal.
5. Upgrade scope of work for ADA Path of Travel upgrades will be defined in the Pre-Design and Schematic Design, however the remedial scope of work for compliance is not included in this proposal.
6. Vibrational Analysis of structural support framing.
7. Design of temporary power for Contractor use.
8. Life cycle cost analysis of proposed mechanical and electrical systems.
9. Acoustical analysis, design of noise attenuation requirements, and special vibration isolation requirements for mechanical systems.
10. Acoustical analysis and design of specialized noise attenuation solutions for vendor provided equipment.
11. Signage/Way Finding beyond the rooms defined in this fee proposal
12. Building accessibility upgrade work beyond the scope of work
13. Structural, mechanical, electrical, plumbing and related infrastructure upgrades

14. Cost estimating services
15. Value engineering
16. Physical, CADD (3-D) and BIM models
17. 3-D rendering for public or Stakeholder presentation purposes
18. Specialized A/V design
19. Detailed analysis of existing Structural, Mechanical, Electrical Plumbing systems not associated with the project as defined
20. Documentation of existing building systems or characteristics requiring destructive removal have not been included in this proposal
21. Detailed analysis or testing of potential hazardous materials
22. Development of as-built or record drawings after construction

-- End of Cath Lab #3 Proposal --

Thank you for your consideration of our proposal for the Cath Lab 3 and Angio Equipment Replacement at Salinas Valley Health Memorial Hospital.

Please feel free to contact me at 415.552.3600 if you should have any questions or concerns. Thank you again, and we look forward to working with you on this project.

Sincerely,

Madelyn McClellan, President

SALINAS VALLEY HEALTH MEDICAL CENTER

SALINAS VALLEY HEALTH
Salinas, California

ADDENDUM A
TO THE
RFP FOR CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT

ISSUED: September 13, 2023

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

SEE ATTACHED ADDENDUM ITEM

Prepared By:

David Sullivan
Owner's Designated Representative

PROPOSER'S CERTIFICATION

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

Proposer's Signature

09.28.2023
Date

Smith-Karng Architecture, Inc.
Name of Company

Please return this signed page to Dave Sullivan at SVH as soon as possible to confirm receipt of this addendum. Please email as a PDF to dsullivan@bogardconstruction.com.

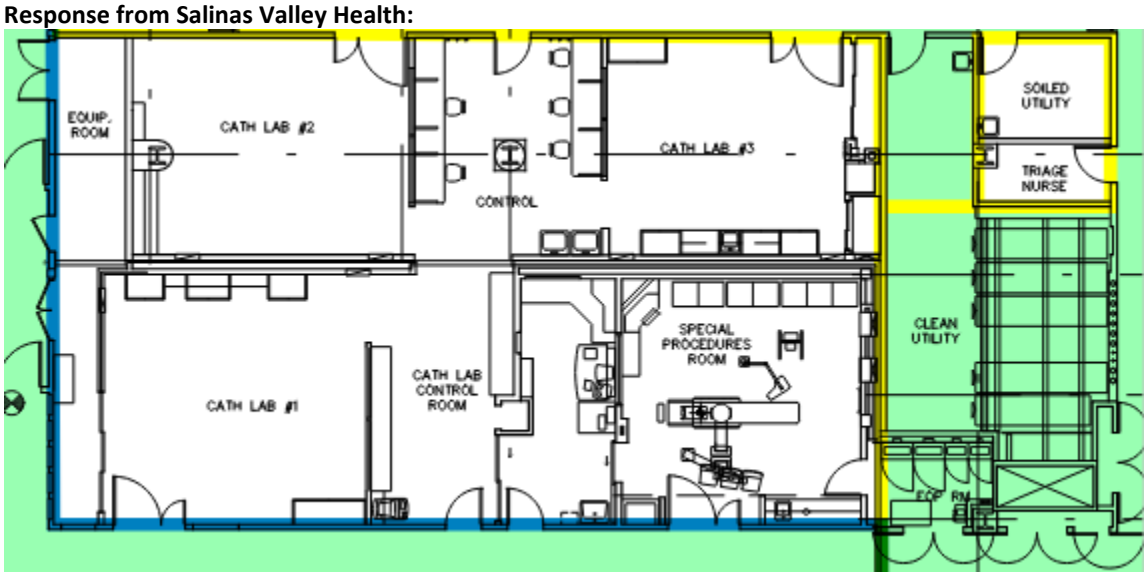
RFP FOR THE CATH LAB 3 AND ANGIO EQUIPMENT REPLACEMENT
ISSUED: September 13, 2023

CLARIFICATION REQUEST:

1) Specific Question regarding the following items:

Question from Proposer: Under "Candidates Qualifications", it states that we must "provide project data for any and all projects performed by the firm in any Santa Cruz and Monterey Bay communities within the last five (5) years." We have over a hundred projects that fit these criteria. Must we complete Attachment B for each of these projects?
Response from Salinas Valley Health: No. The intent is to showcase projects of similar size, complexity and scope completed within the last five years within the Santa Cruz and Monterey Bay communities.

Question from Proposer: Is the (E) Special Procedures Room to the right of the Cath #1 the Angio Room in the project?
Response from Salinas Valley Health:



Question from Proposer: Do we need to include the consultants' project experience information? Or, just the arch team?
Response from Salinas Valley Health: Architectural team only.

Question from Proposer: Shall we include the design of Low Voltage? Or, is it going to be design-built? Does the hospital have preferred vendor/designer on Low Voltage?
Response from Salinas Valley Health: Yes, the architect shall include design of structured cabling systems of the data network systems planned to be CFCI and incorporate equipment vendor low voltage cabling to be VFVI. Raceways shall be detailed on the construction documents with through penetrations detailed for CFCI and CFVI use. The active data network electronics, such as switches, wireless access points, etc., are expected to follow the SVH Design and Construction Standards. Cath Lab 3 is planned to have a climate-controlled cabinet to house hardware components within the control room similar to Cath Lab 1's configuration. More details will be provided by the project stakeholders during the initial design meetings.

Question from Proposer: Shall we include an equipment planner in the team?
Response from Salinas Valley Health: The architect shall determine whether an equipment planner is necessary to complete the construction documents. The construction documents shall have a complete medical equipment schedule identifying MEPT infrastructure requirements, scope of work matrix (OFOI, CFOI, CFCI, VFCI, VFOI, etc…) and anchorage requirements.

Question from Proposer: Shall we include cost estimate services?
Response from Salinas Valley Health: No.

Question from Proposer: Will the design of both rooms occur concurrently although either room will be in separate work authorizations?
Response from Salinas Valley Health: Yes. The design team will be responsible for submitting two separate invoices billing against two separate capital accounts.

Question from Proposer: Is there a plan to utilize integrated lighting and mechanical diffuser system? Or, if the conditions fit, would the hospital consider this option?
Response from Salinas Valley Health: Not at this stage. However, the medical center leadership would like to explore this configuration during schematic design discussions.

Question from Proposer: Are booms expected?
Response from Salinas Valley Health: Final equipment layouts are still being developed during the procurement process of the equipment vendor. The design team shall anticipate ceiling mounted booms and surgical lighting systems in both procedure rooms.

Question from Proposer: Does the hospital plan to conduct a site walk? If not, can we request one with you?
Response from Salinas Valley Health: Access can be coordinated through contacting Jordan Biby with Bogard Construction (jbiby@bogardconstruction.com) Phone Number 661.618.6640.

Question from Proposer: Does the electrical design team need to overstamp the Nurse Call system design drawings? Does the electrical design team need to overstamp the Fire Alarm system design drawings? Does the mechanical design team need to overstamp the Fire suppression system design drawings?
Response from Salinas Valley Health: The electrical engineer will be required to overstamp the nurse call system design drawings provided by Hilrom and integrate the drawings into the HCAI approved planset. The electrical engineer will be required to overstamp the fire alarm system design drawings by Siemens and integrate the drawings into the HCAI approved planset. The mechanical design team will be required to overstamp the fire suppression system design drawings and integrate the drawings into the HCAI approved planset.

REVISIONS TO THE RFP DOCUMENT:

1) Article I. "Request for Proposals for Design and Engineering Services," is hereby revised as follows (new text underlined, deleted text lined-out):

The Medical Center's Cath Lab 3 is located in BLD-01645 and Angio Room is located in BLD-01642. ~~are currently located on the medical center's first level of the Cardiac Center South Building 8.~~

Board Paper: Finance Committee

Agenda Item: Consider a management service and supply agreement with Aramark for Food and Nutrition Services including Starbucks.

Executive Sponsor: Clement Miller, Chief Operating Officer
Christianna Kearns, Sr. Admin Director Cardiovascular, Pulmonary & Sleep Medicine Services

Date: September 15, 2023

Executive Summary

Salinas Valley Health is seeking an agreement with Aramark Healthcare for Food and Nutrition Services management services and supply of food/related items. This partnership is aimed at enhancing the hospital's dietary offerings and improving patient and staff dining experiences, while reducing the cost associated with procuring quality produce. Aramark's expertise in food service management will provide Salinas Valley Health with innovative solutions to meet nutritional goals and elevate the overall hospital experience. In addition Aramark's robust operational excellence system will contribute to financial stewardship, quality, labor productivity and patient satisfaction.

Timeline/Review Process to Date:

5/30/23 – Research for potential partners in FNS
7/11/23- Two GPO vendors selected for RFP
8/24/23- 9/1/23 Contract sent to Contract Administrator (Natalie James), HIM (Philip Katzenberger) for BAA, MM (Judi Melton) for review of GPO pricing, Risk management (Brenda Bailey) review liabilities, Finance (Rolf Norman & Scott Cleveland).

Key Contract Terms	Vendor: Aramark
1. Proposed effective date	November 11, 2023
2. Term of agreement	6 Years *(5 years (November 10, 2028) + 1 Auto Renew Year)*
3. Renewal terms	120 days notice or auto renew for 1 year
4. Termination provision	90 days notice
5. Payment terms	Net 45
6. Budgeted	Yes, 8340 & 8345

First Year of Contract Estimate	Paid to Aramark	Hospital	Total
Current Operating Model FY24 Budget	NA	$13.8M	$13.8M
Projected expense Year 1 Using Aramark	$4.8M	$6.7M	$11.5M
Change			-$2.3M

Potential annual savings estimated at up to $2.3m dependent on actual food and supply consumption. The 6-year estimate applies 5% inflation annually to the above amounts.

Recommendation

Consider Recommendation to Board of Directors to award 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.

Attachments

GPO Contract Brief, Financial proposal

SV5082

Aramark Healthcare

Food and Nutrition Management Services

Effective dates: 04/01/2023 - 03/31/2028

Multi-source contract

OTHER CONTRACTS IN THIS CATEGORY SV5081 - ABM Food and Nutrition Management Services, SV5083 - Morrison Management Food and Nutrition Vendor Management Services, SV5084 - Sodexo Food and Nutrition Management Services, SV5086 - Metz Food and Nutrition Services - Management Only

PREVIOUS CONTRACTS IN THIS CATEGORY SV0821 - Morrison Food & Nutrition Management Services, SV0822 - Sodexo Food and Nutrition Contract Management, SV0823 - Aramark Healthcare Support Services Awarded by MedAssets

DISTRIBUTION Direct from the supplier

Agreement access

TO ACTIVATE CONTRACT TIERS - For those who have access to request tiers, click the purple "Activate Now" button on the catalog contract details page to launch the online activation process. Follow the prompts and provide all requested data until you reach the Submit stage. If requesting a different tier, click the purple "Request a New Tier" button and follow the same process.

ADDITIONAL FORM REQUIRED This contract requires an end user agreement or Supplier provided form. The form is completed as part of the online activation process described above.

Pricing and terms

PRICE PROTECTION Firm Price, Initial Term of the agreement but may be subject to reduction due to market conditions.

CONTRACT TERM Initial term is effective through 03/31/2028; Automatic Two (2) One Year Options; unless Vizient gives 90 days notice or Supplier gives 180 days notice.

CONTRACT AND PRODUCT UPDATES Product and price updates, promotions, supplier news and other changes that occur during the term of this contract are shared via Vizient Catalog. They can be viewed at the Contract News link on the contract details page.

Contract process and award rationale

COMPETITIVE CONTRACTING PROCESS Vizient awards product agreements to the suppliers that offer best overall value, as determined through a comprehensive contracting process that follows the principles of the American Bar Association's Model Procurement Code and involves participating member organizations to the greatest practical degree. The process uses member-driven criteria and a weighted award decision tool that considers financial and product specification/quality factors. This contract was awarded based solely on the results of this process.

Based solely upon the results of this process, Vizient awarded this category as described on page 1.

Request for proposal

Vizient issued a request for proposal in September 2021.

The RFP was issued to these suppliers: ABM, Aramark, AVI, Cura Hospitality, HHS, Market Square, Menulogistics, Metz, Morrison, Service Force Group, Sodexo.

Responses were received from these suppliers: ABM, Aramark, Cura Hospitality, HHS, Metz, Morrison, Sodexo.

Proposal evaluation

In addition to financial value, the proposals were evaluated based on the following product specification /quality factors, which were developed and weighted by Vizient's Purchased Services Council in July 2021:

- Quality of Service, Breadth and Depth, Value-Added Services, Member Preference, Terms and Conditions

Member input

A member preference survey was conducted in October 2021 in conjunction with the request for proposal to assess which suppliers' members find acceptable and prefer to use. Results were factored into the award recommendation.

Best-and-final offer

Based on the scoring results, ABM, Aramark, Metz, Morrison, Sodexo were invited to submit their best-and-final pricing offer in December 2021.

Award validation

Based on the proposal scorecard results and the recommendation of the council, Vizient awarded this category as described above.

Vizient wishes to thank the members of the Purchased Services Council for their valuable direction and input into this award decision.

	Total Budget	Aramark - Acute	ARMK -Starbucks	Salinas - Acute	Salinas - Starbucks	COMMENTS
		PROPOSED SPEND	PROPOSED SPEND	PROPOSED SPEND		
(ALL LABOR TO INCLUDE BOTH PRODUCTIVE AND NON PRODUCTIVE DOLLARS)						
Management Salaries On Supplier Payroll	$992,292	$649,405	$0	$342,887	$0	
Management Benefits On Supplier Payroll	$330,433	$216,252	$0	$114,181	$0	
Management Taxes On Supplier Payroll	$79,249	$51,534	$0	$27,715	$0	
TOTAL MANAGEMENT LABOR, BENEFITS, AND TAXES	**$1,401,974**	**$917,191**	**$0**	**$484,783**		
(ALL LABOR DOLLARS TO INCLUDE BOTH PRODUCTIVE AND NON PRODUCTIVE)						
Hourly Wages On Supplier Payroll	$464,716	$395,135	$69,581	$0	$0	Supervisor Wages
Hourly Benefits On Supplier Payroll	$288,586	$245,376	$43,209	$0	$0	
Hourly Taxes On Supplier Payroll	$49,879	$43,877	$6,002	$0	$0	
Hourly Wages On Hospital Payroll	$3,889,499	$0	$0	$3,306,679	$582,820	
Hourly Benefits On Hospital Payroll	$2,415,354	$0	$0	$2,053,426	$361,927	
Hourly Taxes On Hospital Payroll	$430,116	$0	$0	$361,992	$68,124	
TOTAL HOURLY LABOR, BENEFITS, AND TAXES	**$7,538,149**	**$684,389**	**$118,792**	**$5,722,097**	**$1,012,871**	
FTE COUNT (TO INCLUDE BOTH PRODUCTIVE AND NON-PRODUCTIVE)						
Management FTEs On Supplier Payroll	5.0	5.00	0.00	3.80	0.00	
Management FTEs On Hospital Payroll	0.0	0.00	0.00	0.00	0.00	
Hourly FTEs on Supplier Payroll	6.0	4.83	1.15	0.00	0.00	
Hourly FTEs On Hospital Payroll	63.0	0.00	0.00	53.36	9.66	
TOTAL FTE COUNT	**74.0**	**9.8**	**1.2**	**53.4**	**9.7**	
Patient Days as given by hospital	48,320	48,320	48,320	48,320	48,320	
Net Cleanable Sq. Ft.	0					
Supplier Average Hourly Wage Proposed	$28.80	$28.80	$28.80	$28.80	$28.80	
Benefit % (Mgmt) - including Taxes	41.3%	41.2%	n/a	41.2%	n/a	
Benefit % (Hourly) - including Taxes	73.1%	73.2%	70.7%	73.0%	73.8%	
FOOD COST						
Patient Feeding Food Cost (Patient Food includes food cost to provide maximum of three meals per day per inpatient)	$539,285	$539,285	$0	$0		
Retail Food Cost	$773,531	$352,995	$420,535		$0	
TOTAL FOOD COST	**$1,312,816**	**$892,281**	**$420,535**	**$0**	**$0**	
DIRECT EXPENSES						
Banking, Credit Card and Armored Car Service	$0	$0	$0	$0	$0	
Cleaning Supplies (Please specify in comments)	$25,475	$14,408	$11,067	$0	$0	
Communications (Cell Phones/Pagers)	$5,880	$2,940	$2,940	$0	$0	
Employee Travel	$500	$500	$0	$0	$0	
Freight, Delivery and Miscellaneous	$10,500	$10,500	$0	$0	$0	
General Liability	$66,225	$48,049	$18,176	$0	$0	
Miscellaneous/Other (Please specify in comments)	$107,625	$25,158	$82,467	$0	$0	Includes Starbucks Royalties, License Fees, and other expenses
New Hire Background and Drug Testing	$1,771	$1,534	$237	$0	$0	
Office Supplies (Please specify in comments)	$3,000	$3,000	$0	$0	$0	
Paper-Disposables (FNS-Carryout Containers/EVS-Paper/Plastic-Containers, Wrap, Bags)	$320,267	$165,333	$154,934	$0	$0	
Patient Menus	$11,295	$11,295	$0	$0	$0	
Retail Promotions Program	$2,743	$2,743	$0	$0	$0	
Small Equipment and China, Glass and Silver	$17,488	$11,954	$5,533	$0	$0	
Software and Software License Fees	$85,007	$73,025	$11,982	$0	$0	Includes IT allocations, Mashgin, computers, ONDO
Supplier's Management Overhead Charge	$112,788	$94,557	$18,231	$0	$0	G&A Fee

Training Materials	$166	$166	$0	$0	$0	
Uniforms	$18,749	$16,747	$2,002	$0	$0	
TOTAL DIRECT EXPENSES	**$789,477**	**$481,908**	**$307,569**	**$0**	**$0**	
REVENUE						
All Other Retail	$1,946,147	$0	$0	$839,475	$1,106,672	Client retains retail revenue
TOTAL REVENUE	**$1,946,147**	**$0**	**$0**	**$839,475**	**$1,106,672**	
PASS THROUGHS - VARIABLE EXPENSES (AT COST)						
Floor Stock	$120,800	$120,800	$0	$0	$0	
Catering	$145,774	$145,774	$0	$0	$0	
Nourishments	$3,866	$3,866	$0	$0	$0	
Outpatient Meals	$5,835	$5,835	$0	$0	$0	
Supplements	$10,147	$10,147	$0	$0	$0	
ER meals	$24,940	$24,940	$0	$0	$0	
TOTAL PASS THROUGHS - VARIABLE EXPENSES (AT COST)	**$311,363**	**$311,363**	**$0**	**$0**	**$0**	
PROPOSED CAPITAL INVESTMENT AMORTIZATION DETAIL						
Listing of all proposed equipment and associated costs during term of contract						
Equipment Description						
Retail	$93,182	$93,182	$0	$0	$0	
Production	$524	$524	$0	$0	$0	
Mashgin Visual Checkout	$820	$820	$0	$0	$0	
CaterTrax	$2,150	$2,150	$0	$0	$0	
Renovations	$560,000	$500,000	$60,000	$0	$0	Includes Dish Machine & Retail Renovations
Additional Capital	$250,000	$250,000		$0	$0	Available based on signing date
Total Amortization Amount For the Term of the Contract	**$906,677**	**$846,677**	**$60,000**	**$0**	**$0**	
Term of The Contract	**5**	**5**	**5**	**5**	**5**	
Annual Amortization Charge	**$181,335**	**$169,335**	**$12,000**	**$0**	**$0**	
START UP EXPENSES ; Listing of all start up costs with description						
Description		**PROPOSED SPEND**				
Smallwares	$32,239	$32,239	$0	$0	$0	
Programmatic	$4,950	$4,950	$0	$0	$0	
HR Costs	$2,746	$2,458	$288	$0	$0	
Misc. Costs	$5,800	$5,800	$0	$0	$0	
Support Costs	$84,482	$84,482	$0	$0	$0	
Total Start Up Expense	**$130,217**	**$129,929**	**$288**	**$0**	**$0**	
Labor Expenses	$8,940,123	$1,601,580	$118,792	$6,206,880	$1,012,871	
Food Expenses (Guaranteed)	$1,312,816	$892,281	$420,535	$0	$0	
Direct Expenses	$789,477	$481,908	$307,569	$0	$0	
New Investment Amortization (Proposed)	$181,335	$169,335	$12,000	$0	$0	
New Investment Amortization (Absorbed)	($181,335)	($169,335)	($12,000)	$0	$0	Aramark funds investment amortization
Management Fee	$169,181	$141,835	$27,346	$0	$0	
Start Up Expense (Proposed)	$130,217	$129,929	$288	$0	$0	
Start Up (Absorbed)	($130,217)	($129,929)	($288)	$0	$0	Aramark funds Startup Expense
TOTAL FANS EXPENSE	**$11,211,598**	**$3,117,604**	**$874,243**	**$6,206,880**	**$1,012,871**	**Billable Expenses**
REVENUE	**($1,946,147)**	**$0**	**$0**	**($839,475)**	**($1,106,672)**	**Client retains retail revenue**

NET FANS EXPENSE TO HOSPITAL	**$9,265,451**	**$3,117,604**	**$874,243**	**$5,367,405**	**($93,801)**	

Daily Rate	**$25,385**
Patient Rate	**$191.75**

PASS THROUGH COST TO HOSPITAL (AT COST)	**$311,363**	**$311,363**	**$0**	**$0**	**$0**	
NET FANS EXPENSE TO HOSPITAL	**$9,576,813**	**$3,428,967**	**$874,243**	**$5,367,405**	**($93,801)**	

Net FANS Expense ex. Sales	**$11,522,960**

MANAGEMENT SERVICES AGREEMENT

This **Management Services Agreement** (the "Agreement") is between **Salinas Valley Memorial Healthcare System**, a local health care district organized and operating pursuant to Division 23 of the California Health and Safety Code, operating as Salinas Valley Health ("Hospital"), and **Aramark Healthcare Support Services, LLC**, a Delaware limited liability company ("Aramark"). This Agreement is subject to the terms and conditions of the Supplier Services Agreements for Food and Nutritional Services, effective as of April 1, 2023, between Aramark and Vizient Supply, LLC, a Delaware limited liability company ("Vizient") (the "Vizient Agreement"). Section 10 of this Agreement, entitled "Definitions," contains a list of defined terms used in this Agreement. Notwithstanding anything to the contrary in this Agreement, or in any order acknowledgment, instrument, correspondence or other terms or conditions provided, presented or submitted, from time to time, by Aramark or its representatives to, or executed by, Hospital (any of the foregoing, "Aramark's Other Terms"), Aramark hereby expressly agrees and acknowledges that none of the rights and remedies of the Hospital, or the obligations and liabilities of Aramark, contained in the Vizient Agreement shall be reduced, eliminated, superseded or otherwise affected by any of the terms, conditions, limitation, disclaimers, restrictions or other provisions set forth in this Agreement or in any of Aramark's Other Terms.

1. **Aramark's Services**. Hospital hereby grants to Aramark the exclusive right to provide Hospital with certain Management Services at Hospital's Facilities during the Term (defined hereinafter). "**Management Services**" are defined by the scope of work described in the following Exhibits, which are attached hereto and incorporated by reference herein. The "**Facilities**" at which Management Services will be provided are defined individually for each service and are listed in the respective Exhibits. Aramark will provide the Management Services solely in accordance with the Exhibits and the terms and conditions of this Agreement.

Service	**Exhibit**
Food Services	FOOD

Aramark shall render the Management Services with the same degree of care normally exercised by other global management service providers under similar circumstances. Aramark shall at no time be acting as an architect, engineer, indoor air quality expert or advisor or other design professional and shall not be required to carry out duties requiring the services of a design professional.

2. **Term and Renewals**. The Term will begin on November 11, 2023 (the "Effective Date") and will continue until November 10, 2028 (the "Initial Term"), unless terminated in accordance with Section 8 or renewed. This Agreement will renew automatically for a term of one (1) year ("Renewal Term" and together with the Initial Term, the "Term"), unless terminated in accordance with Section 8. Either Hospital or Aramark may prevent this automatic renewal

by giving the other Party written notice at least 120 days before the date on which the Initial Term or the then-Renewal Term otherwise would end. At the end of the initial Renewal Term, this Agreement may be renewed for a second term of one (1) year by mutual agreement of the Parties in writing ("Second Renewal Term" and together with the Initial Term and Renewal Term, the "Term"), unless terminated in accordance with Section 8.

3. Personnel.

(a) Aramark Operations Team. The Aramark Operations Team will consist of at least one manager (the "Aramark Manager") and will train and manage the Service Employees and oversee the provision of the Management Services. The Aramark Manager will act as Aramark's chief representative in its day-to-day performance of the Management Services.

(b) Service Employees. Hospital will employ the Service Employees. Aramark shall manage and supervise the Service Employees, but only Hospital's rules and policies will govern the terms and conditions of the Service Employees' employment. Hospital retains ultimate authority and responsibility for the recruiting, hiring, employment, compensation, hours, benefits, insurance, promotion, discipline, discharge, and work environment of each Service Employee. Aramark shall not be a party to any of Hospital's collective bargaining agreements or an employer or a joint employer of the Service Employees. Hospital will indemnify Aramark against any claim by a third-party that Aramark is, or is deemed to be, an employer or a joint employer of the Service Employees and any claim by a Service Employee (or applicant) based upon any employment-related action or omission by Aramark (if Aramark obtained Hospital's prior approval of the action or omission at issue).

(c) Payroll Responsibility. Hospital and Aramark each will pay and provide all salaries, payroll taxes and other taxes, benefits, fees, and other charges or insurance required by law (for example, unemployment taxes, Social Security contributions, and worker's compensation premiums) attributable to each of its own employees.

(d) Laws, Rules, and Regulations. Aramark shall provide Management Services in strict accordance with all applicable state and federal laws and regulations. While at the Facilities, all Aramark employees shall be subject to Hospital's rules and regulations, copies of which Hospital will provide to Aramark reasonably in advance. Such rules and regulations may include, but are not limited to, vendor credentialing requirements.

(e) Background Evaluation. Aramark shall cause a background evaluation to be performed on any Aramark employees that are assigned to the Facilities, prior to such employees performing any services and only allow Aramark employees to be assigned to the Facilities if the employee successfully passes the background evaluation.

4. Operational Matters.

(a) Space and Utilities. Hospital will provide Aramark with appropriate office, storage, locker, warehouse, and distribution space and services at the Facilities, including all utilities and appropriate access to copiers, computers, printers, and other customary office

equipment and to Hospital's voicemail, internal e-mail, and intranet systems.

(b) Joint Review. To promote Hospital's satisfaction, the Parties' representatives will meet on a regular basis to discuss the financial and operational aspects of the Management Services. Aramark acknowledges that, in accordance with regulatory and accreditation requirements, the quality of Management Services provided will be evaluated by Hospital in accordance with established indicators/metrics, and may include data reporting requirements by Aramark, with such indicators/metrics and data reporting requirements being mutually agreed to by the Parties in writing. Such indicators/metrics shall be documented in Exhibit B, which shall be mutually agreed to and attached hereto and incorporated herein by way of later written amendment between the Parties.

(c) Purchasing. Aramark will purchase and pay for all goods and services as sales for resale to Hospital. Aramark will purchase and pay for, as a Direct Cost, all food, supplies and services in connection with the Management Services, which purchases will be made through Aramark's purchasing programs. Aramark reserves the right, in its sole discretion, to determine specific brands, product lines and other purchasing decisions, subject to compliance with the standards for the Management Services as set forth in this Agreement. Aramark may receive certain discounts, rebates, allowances and other payments from its manufacturers, suppliers and distributors (individually and collectively, the "Vendors"). Hospital acknowledges and agrees that any prompt payment or 'cash' discounts, as well as all other discounts, rebates, allowances or other payments that Aramark receives from its Vendors shall be retained by Aramark. If an affiliated company or division of Aramark furnishes product, equipment or services necessary in connection with the Management Services, the associated prices charged to Hospital will be competitive with those prices from an independent source in the open market. All purchases shall be titled in the name of Aramark (using Aramark's tax identification information) and used solely in connection with the provision of the Management Services, such purchases will then be resold to Hospital.

(d) IT System. Aramark shall develop, implement, operate and maintain the IT System, in accordance with the attached Information Technology Exhibit.

(e) Warranty. In addition to Aramark's warranties pursuant to the Vizient Agreement, Aramark represents and warrants that the Management Services will be performed (a) in a timely, competent and professional manner consistent with industry standards and (b) in compliance with applicable known legal requirements. In the event Aramark fails to perform the Management Services in such a manner, Aramark shall be required to perform the Management Services again at Aramark's sole cost and in accordance with its obligations hereunder. The warranties contained in this Section 4(e) shall survive any acceptance or payment by Hospital. This Section 4(e) and the obligations contained herein shall survive the expiration or earlier termination of this Agreement. The remedies set forth in this Section 4(e) are in addition to, and not a limitation on, any other rights or remedies that may be available against Aramark.

5. Payment.

(a) Aramark's Compensation. Hospital will compensate Aramark as provided in

Exhibit A attached hereto.

6. Other Financial Matters.

(a) Initial Payment. Before the Management Services begin, Hospital will pay Aramark an amount equal to an estimate of the Aramark Payment for one Accounting Period (the "Initial Payment"). Aramark shall not be required to segregate the Initial Payment from its general accounts, and no trust relationship shall exist between Aramark and Hospital with respect to the Initial Payment. Aramark will retain the Initial Payment and will credit that amount (without payment of interest or other amount for its use) to Hospital in Aramark's final billing upon expiration or termination of this Agreement.

(b) Invoicing. Within seven (7) days after the end of each Accounting Period, Aramark will invoice Hospital for the Aramark Payment owed for such Accounting Period. Within thirty (30) days after the end of each Accounting Period, Aramark shall submit to Hospital an operating statement for such Accounting Period. Any difference between the amount already invoiced for such Accounting Period and the amount shown on the operating statement will be reflected in the subsequent Accounting Period invoice.

(c) Financial Commitment. Aramark agrees to spend an amount not to exceed $917,375 for the purchase of equipment to be used in providing the Management Services and for undertaking renovations of the Food Service facilities at the Facilities (the "Financial Commitment"). Aramark shall purchase items with the Financial Commitment on a sale-for-resale (to Hospital) basis, and Hospital shall, upon such resale, have title to such equipment. As further outline din Section 6(g), Hospital is a tax-exempt entity and is exempt from payment of federal and state and local sales and use and other taxes. Hospital agrees to provide Aramark with all applicable tax-exempt certificates.

Upon installation of the equipment, Aramark shall amortize the Financial Commitment on a straight-line basis over a period of five (5) years, or the remaining Initial Term of the Agreement, whichever is shorter, which shall be absorbed by Aramark. Within thirty (30) days of the expiration of this Agreement or the termination of this Agreement by either Party for any reason prior to the complete amortization of the Financial Commitment, Hospital shall reimburse Aramark for the unamortized balance of the Financial Commitment plus all accrued but unbilled interest as of the date of expiration or termination. Such interest shall accrue from the date the Financial Commitment was finalized at the Interest Rate (defined below), computed each Accounting Period on the declining balance. In the event such payments owing to Aramark are not paid to Aramark within thirty (30) days of the expiration or termination of the Agreement, Hospital agrees to pay interest on such amounts at the Interest Rate (defined below) from the scheduled payment date until the date paid. The right of Aramark to charge interest for late payment shall not be construed as a waiver of Aramark's right to receive timely payment.

(d) Start-Up Services. The Management Services will begin with a start-up phase for the transition of the Management Services to Aramark, during which the Aramark Operations Team will familiarize itself with Hospital's Facilities, operations, applicable equipment, supplies, and other such matters. "Start-Up Costs" shall include costs associated with Aramark employees

who perform services in connection with the opening of the department(s), including, but not limited to, all personnel costs (including wages and salaries, vacation (including earned but unpaid vacation) and holiday pay, and other paid time off for Aramark employees working at the Facilities; travel expenses for transition personnel; payroll costs; and an allocated charge for fringe benefits and human resource services), employee training, management relocation expenses, all expenses related to survey, program design, and program implementation costs, the installation of equipment, fixtures, furnishings, decorations and other similar items, and all Aramark support service expenses.

Aramark will absorb up to $131,181 in Start-Up Costs and shall invoice any additional Start-Up Costs to Hospital. Upon complete expenditure, Aramark shall divide the amount of Start-Up Costs absorbed by the number of days remaining in the Initial Term ("the Pro Rata Start-Up Costs"). Upon expiration or termination of this Agreement by either Party for any reason whatsoever, Hospital shall reimburse Aramark for an amount equal to the Pro Rata Start-Up Costs multiplied by the number of days remaining in the Initial Term according to the payment terms in Section 6(e).

(e) Payment Terms. Hospital shall pay all amounts due under this Agreement within ten (10) days of the date of the invoice reflecting the amount. If Hospital does not pay any such amount within thirty (30) days after its invoice date, then the unpaid portion will bear interest, from the invoice date until paid, at the Prime Rate per annum (or, if prohibited by law, then the maximum rate permitted legally) (the "Interest Rate") on the unpaid balance, computed from the invoice date until the date paid.

(f) Disputes Over Amounts Due. If Hospital, in good faith, believes that it does not owe all or part of an amount reflected on an Aramark invoice, and if Hospital advises Aramark of this belief within fourteen (14) days of receiving the applicable invoice, then any obligation to pay the amount due shall be tolled for a period of fourteen (14) days. During that 14-day period, the Parties shall, in good faith, use their best efforts to resolve the dispute. Whether or not the Parties resolve the dispute, the tolling of any obligation to pay shall end at the end of the 14-day period.

(g) Taxes. If a government authority determines that any sale, purchase, payment or use of property made to or by Aramark under this Agreement, either in whole or in part, is subject to any sales, use, gross receipts, property or any similar tax, which tax was not contemplated by the Parties at the Effective Date, then Hospital shall be responsible for such tax liability and any interest, notwithstanding the fact that this Agreement may have expired or been terminated for any reason by either party hereto prior to the date of such determination.

Except as otherwise specified, Aramark will purchase goods and services as required under this Agreement as sales for resale which are exempt from sales and use tax. Aramark will provide vendors with a properly completed resale certificate at the time of purchase. Purchases will be made by and titled in the name of Aramark (using Aramark's tax identification number), and will be used solely for resale to Hospital.

Hospital is a tax-exempt entity and is exempt from payment of federal and state and local sales and use and other taxes. Hospital will provide Aramark with all applicable tax-exempt

certificates. Aramark shall invoice Hospital for all goods and services procured for resale to the Hospital in connection with the Direct Costs of operation. These items include goods and services set forth in the purchasing section of this Agreement. After an invoice is sent, title shall vest in the Hospital. Aramark will maintain records corresponding to the sale of the resold goods and services.

Hospital will be responsible for sales, use, excise, value-added, services consumption and/or gross receipts tax on the purchase and sale of any goods and services resold to Hospital and Hospital will defend, indemnify and hold harmless Aramark from and against any and all liabilities, claims, demands, losses, obligations, fines, liens, penalties, actions, judgments, damages, costs, charges, and expenses in connection with any such assessment. Hospital will be responsible for remitting sales tax on all taxable sales made at the Hospital's location.

7. Insurance.

(a) Aramark will arrange for workers' compensation insurance as required by law.

(b) Policy Requirements. Aramark shall maintain and keep in force during the Term commercial general liability insurance. Such insurance shall contain a minimum combined single limit of liability for bodily injury and property damage in the amount of not less than $2,000,000 per occurrence and $10,000,000 in the aggregate, and professional liability insurance with minimum limits of $2,000,000 per occurrence and $5,000,000 annual aggregate. Such commercial general liability policy or policies shall name Hospital as additional insureds for losses arising out of Aramark's negligent acts or omissions, or assumed under this Agreement. The liability limits may be satisfied through a combination of primary and excess policies including deductibles or self-insured retentions. Aramark shall provide a certificate of insurance to Hospital within fifteen (15) days following Hospital's request, indicating the foregoing coverage, issued by an insurer licensed to do business California within fifteen (15) days*;* provided, however, that Aramark may provide an insurance certificate issued by an insurer not licensed to do business in California, provided that such insurer has an A.M. Best rating of A-7 or greater.

(c) Amendments, Notices and Endorsements. Notice of cancellation of any insurance policies required herein shall be subject to ACORD 25 Certificate of Liability standards, and will be delivered, as applicable, in accordance with policy provisions. In the event that Aramark amends said liability insurance in accordance with this Section, Aramark shall provide Hospital with certificates evidencing the new coverage as soon as practicable after Aramark receives or gives them.

8. Termination.

(a) Termination. Hospital and Aramark each may terminate the Agreement with or without cause by giving the other Party at least ninety (90) days prior written notice. Neither Party shall issue such a notice until ninety (90) days after the Effective Date.

(b) Termination for Cause. If one Party (the "Notifying Party") believes that the other Party (the "Responding Party") has materially breached this Agreement, and if the

Notifying Party so notifies the Responding Party in writing with sufficient detail to provide the Responding Party with an opportunity to cure the alleged breach, then the Responding Party will have thirty (30) days from its receipt of such notice to cure the alleged breach (the "Cure Period"). If, after the Cure Period has ended, the Notifying Party reasonably considers that the Responding Party has not cured the alleged breach, then the Notifying Party may notify the Responding Party of its intent to terminate the Agreement, which termination shall occur after an additional 30-day transition period (the "Transition Period"). The Parties will cooperate with each other during the Transition Period, so that Hospital or another service provider may assume the Management Services in an orderly manner.

(c) Termination for Breach of Payment Obligations. If Hospital does not pay Aramark any amount due within the time provided in this Agreement and still does not do so for ten days after receiving written notice from Aramark of such failure, then Aramark may terminate this Agreement immediately.

(d) Prepaid Vendor Contracts. Upon termination or expiration of this Agreement, Hospital will reimburse Aramark for the costs of any prepaid vendor contracts that Aramark has paid, or on which Aramark has incurred an obligation to pay, for Hospital's benefit.

(e) Purchase of Inventory and Supplies. At the termination or expiration of this Agreement, Hospital shall, if requested by Aramark, purchase Aramark's usable inventory of products and supplies (purchased pursuant to Section 4(c)) that Aramark has not charged as a Direct Cost. The purchase price for such inventory will be Aramark's invoice cost, and Aramark will submit to Hospital an invoice for such inventory.

(g) Appropriation of Funds. If sufficient funds are not appropriated for Hospital's proposed budget for its next fiscal year to enable Hospital to make payments due to Aramark under this Agreement, and if Hospital has no funds available from any other source that can be used for that purpose, then Hospital will provide Aramark with an opinion letter and supporting documentation from Hospital's attorneys containing a specific description of the lack of funds and will allow Aramark to audit Hospital's books and records on the appropriations, budget, and shortfall. Hospital and Aramark then will review the Management Services in light of all funds available to Hospital for such services and Hospital's actual budget for its next fiscal year, to determine a level of Management Services that can be performed within the proportionate level of all available funds. If Aramark does not present such modifications of its Management Services program, then either Party may terminate this Agreement effective at the end of Hospital's then current fiscal year, upon 90 days prior written notice and Hospital will not contract with another service provider for services similar to the Management Services during the remainder of the then current term if this Agreement is terminated pursuant to this Section.

9. General Provisions

(a) Notice. Any notice under this Agreement must be in writing and will be effective upon receipt, including when delivered personally, when delivered by a national overnight delivery service, or three business days after being deposited in the United States mail (postage prepaid, registered or certified). All notices will be addressed to the receiving Party at the

following address (or such other address of which that Party has given proper notice):

If to Hospital:

SALINAS VALLEY HEALTH
450 East Romie Ln.
Salinas, CA 93901
ATTN: Office of the President/CEO with copy to: Christianna Kearns

If to Aramark:

ARAMARK HEALTHCARE SUPPORT SERVICES, LLC
2400 Market Street
Philadelphia, PA 19103
ATTN: President

(b) Confidential Information and Proprietary Materials.

(i) Aramark and Hospital acknowledge that each may disclose Confidential Information to the other. If that happens, then the receiving Party shall: (a) maintain the Confidential Information in strict confidence, disclosing it only to its employees, agents, and affiliates, only as necessary for the Management Services, and only after informing the recipient of the restrictions contained in this subsection; (b) use Confidential Information only to fulfill its obligations under this Agreement; (c) not photocopy or otherwise duplicate any such Confidential Information without the prior written consent of the disclosing Party; and (d) return or destroy all documents, copies, notes, or other materials containing any portion of the Confidential Information upon request of the other Party and upon termination or expiration of this Agreement. These restrictions shall not apply to the extent that disclosure is required by law nor to any portion of the Confidential Information that: (a) was known to the receiving Party before receipt, directly or indirectly, from the disclosing Party; (b) was lawfully obtained, directly or indirectly, by it from a third party that was under no obligation of confidentiality; (c) is or becomes publicly available other than as a result of an act or failure to act by the receiving Party; or (d) is developed by the receiving Party independent of the Confidential Information disclosed by the disclosing Party.

(ii) Neither Aramark nor Hospital shall disclose the terms of this Agreement to any other person or entity outside its organization other than as required by law. Notwithstanding the foregoing, nothing in this Agreement shall prohibit Hospital from disclosing any information to Vizient. Neither Hospital nor Aramark and its Affiliates shall, without the other Party's consent, use the other Party's name, logo, trademark or otherwise refer to or identify the other Party in any publicity matters relating to the Services. Notwithstanding the foregoing, both Parties and their respective Affiliates may, without prior consent of the other Party, use that Party's name or logo and the existence of this Agreement in connection with earnings calls or similar matters with their respective investors or analysts as well as communications to prospective Hospitals (if applicable) and for use in such Party's marketing materials.

(iii) All computer software programs, signs, and marketing or promotional

literature and material (collectively referred to as "Proprietary Materials") used by Aramark at the Facilities shall remain Aramark's property. Upon termination of this Agreement, Hospital shall forever cease using and accessing any trademarks, service marks and logos, software programs and files owned by Aramark or licensed to Aramark by third parties and shall immediately return all Proprietary Materials to Aramark (or, in the case of software, delete such software from Hospital's systems). Aramark will make such information available for use or inspection by Hospital's safety committee or any regulatory or compliance agency if necessary.

(iv) Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"), the Parties agree that Aramark is a "business associate" of Hospital in its provision of Management Services to Hospital, and the Parties agree to the terms and conditions of the Business Associate Addendum attached hereto as **Addendum BAA** and incorporated herein by this reference.

(c) Restrictions on Hiring Supervisory Employees. Hospital and Aramark acknowledge that the other has invested considerable amounts of time and money in training its Supervisory Employees in the systems, procedures, methods, forms, reports, formulas, computer programs, plans, techniques and other valuable information that are proprietary and unique to its manner of conducting its business and that it makes such information available to its Supervisory Employees, its subsidiaries and affiliates, on a confidential basis. Therefore, Hospital and Aramark agree that they will not employ, contract with, or utilize, directly or indirectly (such as through consulting contracts or contracts with companies that employ or otherwise retain any Supervisory Employees), any Supervisory Employee of the other Party (including its subsidiaries or affiliates) during the Term or the twelve months after the Term. Both Parties agree that this paragraph will not apply to any Supervisory Employees transitioned from Hospital to the Aramark Operations Team during the start-up phase for the transition of the Management Services to Aramark. If a Party violates the conditions of this subsection, then the other Party shall have the right to apply to a court of competent jurisdiction for an injunction without the need to post a bond, and the breaching Party shall be liable to the other Party for all reasonable attorney's fees, costs and expenses incurred in enforcing this Section. Additionally, the breaching Party will pay to the other Party, as liquidated damages and not as a penalty, an amount equal to two times the annual salary of the Supervisory Employee(s) in question. The Parties agree that the foregoing restrictions are reasonably necessary to protect their respective legitimate business interests, and that they are reasonable as to their scope and duration. Nothing in this paragraph will prevent either Party from hiring of the other party's Supervisory Employees if such Supervisory Employees independently apply for employment pursuant to a publicly available job posting.

(d) No Waiver. No waiver of any right, obligation, or remedy under this Agreement will be effective against either Party unless it is in writing and signed by the waiving Party.

(e) Severability. If a court holds that one or more provisions of this Agreement is invalid, unenforceable, or void, then that ruling will not affect any other provisions of this Agreement, and all other provisions will remain in full force and effect.

(f) Authority. Hospital and Aramark represent and warrant that they have the requisite

authority to enter into this Agreement, that the individuals who executed this Agreement on their behalf have all required authority and approvals to do so and to bind them, and that they have done and will do all things necessary so that this Agreement will be valid, binding and legally enforceable upon them.

(g) Entire Agreement and Amendments. This Agreement has been negotiated jointly and will not be construed as having been drafted by any one Party. The Vizient Agreement between Aramark and Vizient, along with this Agreement and its Exhibits contain the final and complete expression of all agreements between the Parties with respect to the subject matter of this Agreement and supersede all prior and contemporaneous agreements between the Parties, whether oral or written. Any change, modification or amendment of this Agreement must be in writing and signed by all Parties. In the event of any inconsistency between this Agreement and the Vizient Agreement, as it relates to: (i) any waiver or change to Aramark's Administrative Fee or reporting obligations or (ii) any limitation to any warranty, indemnity or liability described in the Vizient Agreement, the terms and conditions of the Vizient Agreement shall control.

(h) Counterparts. This Agreement may be executed in multiple counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. An electronic signature shall be considered valid as if an original signature.

(i) Accuracy of and Access to Records. Aramark shall maintain accurate books and records in connection with the Management Services and shall retain such records for at least four years. Hospital may audit such records at any time during regular business hours, upon reasonable advance notice. During the Term and for four years after the Term, Aramark shall make available, upon written request, to the Secretary of the United States Department of Health and Human Services, the Comptroller General of the United States, or any of their duly authorized representatives, this Agreement (including all amendments) and Aramark's supporting books, documents and records, to the extent necessary to verify Hospital's payments to Aramark. In addition, Hospital hereby authorizes all applicable third party performance measurement companies to send copies or provide directly to Aramark all Hospital scores including overall scores directly to Aramark, for all periods up to and including Aramark's last day of service under this Agreement.

(j) Regulatory Compliance. The Parties acknowledge and agree that the amounts paid to Hospital by Aramark (including the Financial Commitment) are intended to comply with Section 1128B of the Social Security Act (codified at 42 U.S.C. § 1320a-7b). Accordingly, Hospital acknowledges that it knows of the provisions governing the reporting of certain discounts and rebates pursuant to 42 C.F.R. § 1001.952(h) and agrees to report accurately to private and governmental third-party payors, health plan sponsors, patients and others, to the extent required under law, all such payments by Aramark.

(k) Assignment. Neither Party may assign this Agreement without the prior written consent of the other Party; except that Aramark may assign the Agreement to an Affiliate without the consent of Hospital. Subject to the foregoing, all rights and obligations of the Parties hereunder shall be binding upon and inure to the benefit of and be enforceable by and against any permitted successors and assigns.

(l) No Third Party Beneficiaries. This Agreement shall not confer any rights or remedies upon any party other than the Hospital and Aramark.

(m) Relationship. Aramark will perform the Management Services as an independent contractor, and, unless specifically provided in any of the Exhibits, nothing in this Agreement shall make Aramark, or its employees, a common law employee, agent, partner, or fiduciary of or co-venturer with Hospital.

(n) Licensing. Aramark is not a licensed architect or engineer and shall not act as one when providing the Management Services.

(o) Exclusivity. Hospital shall not permit a third-party to provide any part of the Management Services during the Term.

(p) Information and Conditions. In determining the resources required to perform the Management Services, Aramark relied on the information provided by Hospital about its operations and finances and on conditions existing on the Effective Date (including, but not limited to, labor and supply costs; tax rates; license and permit fees; Hospital's employees at the Facilities; the size, condition, and uses of the Facilities; average bed occupancy rates; patient volume; staffing and shifts). Hospital represents that the information it provided is current, complete, and accurate. Hospital will continue to provide similar information to Aramark from time to time and represents that such information will also be current, complete, and accurate at the time provided. If such information materially changes or is inaccurate, or if applicable conditions materially change, then the Parties shall negotiate in good faith a reasonable adjustment of the financial provisions of this Agreement (including the Budget Guarantee) and memorialize the adjustment in a written amendment.

(q) Change in Scope. During the Term, Hospital and Aramark may agree that the scope of the Management Services should change. For example, the Parties may agree that Aramark should serve in additional areas of the Facilities, in new facilities, on a more frequent basis, in a different way, or with different resources. If the agreed-upon changes are material, then the Parties shall negotiate in good faith a reasonable adjustment of the financial provisions of this Agreement and memorialize the adjustment in a written amendment.

(r) Collections. If Aramark incurs legal fees and costs in enforcing its right to payment under this Agreement, Hospital shall reimburse Aramark for those fees and costs.

(s) Indemnification.

(1) Aramark Indemnity. In addition to Aramark's indemnification obligations pursuant to the Vizient Agreement, Aramark shall indemnify, defend, and hold harmless Hospital and their respective officers, directors, agents, subsidiaries, affiliates and employees (individually an "Indemnitee", collectively, the "Indemnitees") from and against any liability to any third party for loss or damage, or any cost or expense, including, without limitation, costs and reasonable attorneys' fees, resulting from claims for: (i) bodily injury or death, or damage

to property, caused by any negligent act by or omission of Aramark, its employees, or subcontractors, or (ii) any breach or default by Aramark under this Agreement, (iii) any misrepresentation by Aramark related to Aramark's Management Services covered by this Agreement, or (iv) any patent, copyright, trademark, or trade secret infringement arising from the Management Services or Aramark's other performance under this Agreement. However, Aramark shall not be obligated under this Agreement to so defend, indemnify or hold harmless any Indemnitee from any such liability, cost or expense, to the extent such liability, cost or expense results from that Indemnitee's misconduct or negligence. Indemnitees shall cooperate with Aramark at Aramark's expense in its defense or settlement of indemnified matters.

(2) Hospital Indemnity. Except for Aramark's indemnification obligations pursuant to the Vizient Agreement, Hospital hereby agrees to indemnify, defend and hold harmless Aramark and its affiliates, subsidiaries, directors, officers, and employees (collectively, the "Aramark Indemnitees") from and against any loss, liability, damage, cost or expense, including, without limitation, costs and reasonable attorneys' fees, resulting from claims by third parties for: (i) bodily injury or death, or damage to property, caused by any negligent act by or omission of Hospital, or any of their officers or employees, or (ii) any breach or default by Hospital under this Agreement. However, Hospital shall not be obligated under this Agreement to so defend, indemnify or hold harmless any Aramark Indemnitee from any such loss, liability, damage, cost or expense, to the extent such damages result from Aramark Indemnitee's misconduct or negligence. Aramark Indemnitee shall cooperate with Hospital at Hospital's expense in its defense or settlement of indemnified matters.

(t) Personnel Actions. If Hospital or Aramark takes a personnel action at the other Party's direction that it would not have taken but for the other Party's direction, then the other Party shall indemnify it against third-party claims concerning that action.

(u) Degree of Care. Aramark shall provide the Management Services with the same degree of care normally exercised by other management service providers under similar circumstances.

(v) Limitation of Liability. Except for Aramark's indemnification obligations pursuant to the Vizient Agreement, Aramark's liability shall not under any circumstances exceed the greater of the annual Aramark Payment or the actual proceeds of insurance (described in Section 7) for the applicable claim (including the deductible portion). Except with regard to Aramark's indemnification, reporting, and confidentiality obligations under the Vizient Agreement, neither Party will be liable to the other for any loss of business, business interruption, consequential, special, indirect or punitive damages.

(w) Hazardous Substances and Pre-Existing Conditions. Aramark has no duty to investigate, to detect, or to address any Hazardous Substances and will not be responsible for any Pre-Existing Conditions. Prior to the Effective Date, Hospital will inform Aramark of the presence of any Hazardous Substances or Pre-Existing Conditions. Hospital acknowledges that Aramark employees will not be required to work in any location where they could be exposed to such Hazardous Substances unless they are provided with the proper training and protections. In addition to the Aramark's indemnification obligations pursuant to the Vizient Agreement,

Aramark will indemnify Hospital against third-party claims to the extent based on Aramark's negligent use, handling or disposal of Hazardous Substances. Hospital will indemnify Aramark against any other third-party claims concerning Hazardous Substances or Pre-Existing Conditions.

(x) Force Majeure. If either Party is rendered unable to perform its duties under this Agreement, in whole or in part, by reason of any event that is not reasonably under its control (including, but not limited to, Acts of God, fires, floods, earthquakes, accidents, strikes, riots, national emergencies, pandemics, endemics, government ordered shutdowns, and other such force majeure events), then any duty so impacted will be suspended during such event. The Party rendered unable to perform due to force majeure must promptly notify the other Party, and neither party shall be responsible to the other Party for any losses resulting from such force majeure. The Parties agree that force majeure shall not excuse either Party from payment of monies owed for services rendered. If either Party's inability to perform exceeds 120 days, then either Party may terminate this Agreement by written notice, effective upon the other Party's receipt of such written notice.

(y) Emergency Services. The parties acknowledge that Hospital is a healthcare facility and may request Aramark to provide modified or additional Management Services in an emergency or crisis situation on an immediate and temporary basis ("Emergency Services"). To the extent, Aramark is willing to provide these Emergency Services, Hospital agrees to reasonably compensate Aramark for any Emergency Services provided.

(z) Intent to be Legally Bound. Hospital and Aramark intend to be legally bound to the terms of this Agreement.

(aa) Survival. The sections and subsections of this Agreement titled "Other Financial Matters," "Insurance," "Prepaid Vendor Contracts," "Start-Up Services," "Purchase of Inventory," and "General Provisions" shall survive the termination or expiration of this Agreement.

(bb) Exclusion. Aramark warrants that, to its knowledge, neither Aramark nor its employees or agents performing services under this Agreement have been excluded from participation in federal or state healthcare programs. If an employee/agent performing services under this Agreement is excluded, Aramark will replace that employee/agent within a reasonable time. If Aramark is excluded, Hospital may terminate this Agreement, upon written notice to Aramark.

10. Definitions

10.1 A Party's "Affiliate" shall mean a company which controls, is controlled by, or is under common control with that Party.

10.2 The term "Accounting Period" shall mean the two accounting periods of four weeks each and the one accounting period of five weeks which occur in each quarter of a year; provided, however, that from time to time the Accounting Period shall consist of six (6) weeks, to allow accurate accounting, the next of which is in 2025.

10.3 The term "Aramark Operations Team" shall mean the team of Aramark employees whom Aramark will provide for the effective and efficient management of the Management Services.

10.4 The term "Confidential Information" shall mean all financial, statistical, operating and personnel materials and information, including, but not limited to, technical manuals, plans, policy and procedure manuals, computer/software programs, menus, recipes, methods, and procedures, relating to or utilized in (as applicable) either Party's business or the business of any subsidiary or Affiliate and their respective Affiliates, operations, employees, services, patients or customers.

10.5 The term "Contract Year" shall mean the 12-month period beginning on the Effective Date and ending on the 364th day after the Effective Date and every subsequent 12-month period of the Term.

10.6 The term "Facilities" shall mean the particular buildings or locations, or portions of them, where Aramark shall provide the Management Services covered by this Agreement. The Facilities are specified in each of the Service Line Exhibits.

10.7 The term "Hazardous Substances" shall mean asbestos; lead; fuel storage tanks or contents; indoor air pollutants or contaminants; hazardous, toxic, or regulated waste substances (i.e., chemo waste); mold; fungi; mildew; pollutants; or contaminants, at the Facilities or their surrounding premises.

10.8 The term "indemnify" shall mean to indemnify against and to hold harmless from; shall include such indemnification for the indemnified Party's officers, directors, and employees; and shall include damages awards, fines, and reasonable attorneys' fees and costs.

10.9 The term "IT System" shall mean the information technology system that Aramark shall develop, implement, operate and maintain to support the Management Services, as provided in Section 4(d) and explained in the attached Information Technology Exhibit.

10.10 The term "Party" refers to Hospital or Aramark.

10.11 The term "Pre-Existing Conditions" shall mean conditions that existed at the Facilities or their surrounding premises before the Effective Date, including, without limitation, environmental impairments and other conditions.

10.12 The term "Service Employees" shall mean the non-management personnel whom Aramark deems necessary for the effective and efficient provision of the Management Services and who work in the departments of Hospital's Facilities that are managed by Aramark

10.13 The term "Service Line Exhibits" shall mean the Exhibits (or Exhibit) that are attached to this Agreement, which describe Aramark's Management Services in detail and have titles that correspond to specific Hospital department in question.

10.14 The term "Supervisory Employee" means a person who performed management or professional services for the Facilities, including but not limited to technicians and clinical dieticians, directly or indirectly, at any time during the preceding twelve months. The term

"Supervisory Employee" does not include any person employed by Aramark under this Agreement who was previously employed by Hospital.

10.15 The term "Term" shall mean the period of time during which this Agreement shall be effective.

ARAMARK HEALTHCARE SUPPORT SERVICES, LLC	**SALINAS VALLEY HEALTH**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

INFORMATION TECHNOLOGY EXHIBIT

Aramark shall implement, operate and maintain an information technology system to support the Management Services (the "IT System"). The IT System may include hardware and software both owned and/or licensed by Aramark. Aramark will install the IT System on Hospital's computer network within departments managed by Aramark, consistent with Hospital's policies and procedures. Aramark shall perform all maintenance and operation of the IT System. Aramark also may utilize Hospital's other information technology systems, computer equipment, and software if necessary to provide the Management Services.

Computer equipment and software owned and provided by Aramark (including computer hardware) will remain the property of Aramark. Aramark will be responsible to repair, maintain and replace such equipment. Any costs associated with the repair and maintenance shall be billed to Hospital as a Direct Cost. All computer equipment, hardware, and/or software provided by Hospital shall remain the property of Hospital, and Hospital will be responsible to repair, maintain and replace such equipment at no additional cost to Aramark.

Aramark holds licenses to use any aspects of the IT System that are not Aramark-owned, and has the ability and authority to use same for Hospital without the further consent of any third party. Such licenses are not transferable to Hospital. Aramark warrants that its use of the IT System will not violate any intellectual property rights of any third party.

Aramark has no responsibility for the continued successful operation of any computer hardware, software, or equipment under computerized control (other than computer hardware, software and equipment provided by Aramark and Hospital's clinical equipment expressly maintained by Aramark under this Agreement), which malfunctions or ceases to operate as a result of software errors, operator errors, infection by computer virus, or tampering.

Any Aramark-owned or licensed software programs/files which have been placed on Hospital-owned computers or networks will be erased or deleted upon termination of the Agreement. Hospital agrees not to try to recover any of these removed programs or files following termination of the Agreement and that such recovery would constitute an infringement of Aramark's rights.

Exhibit A

(a) Hospital shall pay Aramark as follows. The total payment described in this subsection (a) shall be the "Aramark Payment."

1. Direct Costs. Hospital shall reimburse Aramark for all costs incurred by Aramark in providing the Management Services, including, without limitation, the costs of employing Aramark employees at the Facilities (including the compensation, severance, and related payroll costs for such personnel) and the costs of all products, supplies, equipment and services purchased and used, or expenses incurred, by Aramark.

2. Allocated Charges. Hospital shall pay a reasonable allocation of charges established by Aramark for certain services, including, without limitation: fringe benefit and human resource services, provision of insurance coverage and related services, and the development, implementation, operation and maintenance of the IT System (which may include, but not be limited to, hardware, owned and licensed software and systems support and training); if state income tax will be charged, state income tax, calculated by applying the applicable state tax rate to the Management Fee;

3. General & Administrative Expense Allowance. Hospital shall pay Aramark's general and administrative expense allowance (the "General and Administrative Expense Allowance") for each Accounting Period of an amount equivalent to $2,169 per week, for the financial reporting, legal, tax, audit services, other administrative expenses and management oversight provided to client locations by Aramark at the district, regional and corporate levels; and

4. Management Fee. Hospital shall pay a service fee (the "Management Fee") for each Accounting Period in an amount equivalent to $3,253 per week.

(b) Payment Increases. The fixed dollar amount of the General and Administrative Expense Allowance and the Management Fee each shall increase on an annual basis, on the anniversary of the Effective Date, as follows. Aramark shall notify Hospital of these increases in writing.

1. the Management Fee and the portion of the General and Administrative Expense Allowance attributable to Aramark's employment-related costs (including without limitation costs attributable to salaries and wages, payroll taxes, benefits, workers' compensation, and travel and entertainment) will increase by a percentage amount equal to the percentage increase, if any, during the prior 12-month period in the Employment Cost Index published by the United States Department of Labor, Bureau of Labor Statistics (June 1989 = 100% base period), Total Compensation for Private Industry Workers, or a comparable index if that index is not available; and

2. the remaining portion of the General and Administrative Expense Allowance will increase by a percentage amount equal to the percentage increase, if any, during the prior 12-month period in the Consumer Price Index for All Urban Consumers ("CPI-U") published by the United States Department of Labor, Bureau of Labor Statistics (1982-1984 =

100% base period), U.S. City Average, Food Away From Home, or a comparable index if that index is not available.

(c) Budget Guarantee. The Parties agree to implement a budget guarantee. The details of the budget guarantee are set forth on **Exhibit GNB**.

Exhibit GNB

Guaranteed Net Budget.

(a) Discovery Period. The Parties agree that from the commencement date of services until a period of one hundred and twenty days (120) days is necessary to establish the Fiscal Year Budget (the "Discovery Period"). Accordingly, the Parties agree that the Budget Guarantee shall not apply during the Discovery Period. The Parties agree that the Budget Guarantee shall commence July 1, 2024. The Parties shall work together during the Discovery Period and mutually establish the Fiscal Year Budget.

(b) Fiscal Year Budget. With the exception of the first Fiscal Year Budget, which shall be established through the Discovery Period, as part of the Hospital budgeting process, but in no event less than ninety (90) days prior to the beginning of each subsequent Fiscal Year, Aramark shall submit to Hospital, for its approval, a projected budget for the applicable Fiscal Year. Items in the projected budgets shall include, but not be limited to, as line items, the aggregate Aramark Payment, and such other operating expenses as may be agreed upon by Aramark and Hospital.

The projected budget shall be reviewed and approved by the following: the Chief Financial Officer or designee from Hospital and the Regional Finance Director from Aramark. Hospital agrees that the review and approval of the projected budgets shall occur in a timely manner to ensure continuity of the Management Services and agrees not to unreasonably withhold its approval of this process. Any projected budget mutually agreed to in writing by Aramark and Hospital in accordance therewith shall hereinafter be referred to as a "Fiscal Year Budget." To the extent the Parties cannot agree upon a Fiscal Year Budget prior to the start of a Fiscal Year, the Fiscal Year Budget for the prior Fiscal Year shall apply, including any Payment Increases as described in Section (b) of Exhibit A. Notwithstanding the forgoing, neither Party shall unreasonably withhold approval of a proposed Fiscal Year Budget. Fiscal Year Budgets, including any draft precursors thereto, shall be considered Confidential Information in accordance with Section 9(b) of this Agreement, and shall be treated accordingly. For purposes of clarity, the "Fiscal Year" is defined as July 1 through June 30.

(c) Penalty Payment to Hospital. Aramark shall pay a penalty payment to Hospital if the Net Operating Cost for the Hospital exceeds the Fiscal Year Budget (the "Budget Based Penalty"). Subject to the exceptions and adjustments described in this Agreement, "Net Operating Cost" for Hospital is defined as the actual Fiscal Year end costs for providing Management Services for the applicable departments, including the Aramark Payment, net of actual Retail Receipts for the Fiscal Year. The amount of the Budget Based Penalty shall be One Hundred Percent (100%) of the amount by which the Net Operating Cost exceeds the Fiscal Year Budget, but in no event shall exceed $5,000 per Fiscal Year.

(d) Incentive Payment to Aramark. Hospital shall pay an Incentive Payment to Aramark if the Net Operating Cost for the Hospital are less than the Fiscal Year Budget (the "Budget Based Incentive"). The amount of the Budget Based Incentive shall be 5% of the amount by which Net Operating Cost are less than the Fiscal Year Budget, but in no event shall exceed $5,000 per Fiscal Year.

(e) Calculation of Budget Based Penalty and Budget Based Incentive. The calculation of the actual Net Operating Cost will not include expenditures that Aramark has advised Hospital against making. Hospital (or each Facility) shall provide to Aramark applicable monthly accounts payable and general ledger reports within thirty (30) days of the end of any Fiscal Year. Aramark shall not be required to pay any Budget Based Penalty and Hospital shall not be required to pay any Budget Based Incentive until Aramark has an opportunity to examine Hospital's records and concludes that Hospital's calculation of the actual Net Operating Cost does not include amounts that are excluded from the Fiscal Year Budget or Net Operating Cost calculation pursuant to this Agreement. Any payments owed shall be paid in accordance with the Payments/Invoicing section of the Agreement.

(f) Exceptions and Adjustments to Fiscal Year Budgets. Fiscal Year Budgets shall also be subject to the following adjustments:

i. Controllable and Non-Controllable Costs. The Fiscal Year Budget includes both controllable and non-controllable department expenses. Controllable Department Expenses are defined as those expenses in which Aramark has the ability to manage through the scope of services and such amounts are included in the Fiscal Year Budgets. Non-controllable Department Expenses are defined as those expenses that Aramark does not have direct control to manage. Non-controllable Department Expenses will be billed through as a Direct Cost and any amounts over the Fiscal Year Budgets shall be excluded in the computation of the Net Operating Cost for the applicable Fiscal Year. Such Non-controllable Department Expenses are listed in the attached **Schedule GNB-2**. This **Schedule GNB-2** shall be updated as agreed upon by the Parties for each Fiscal Year.

ii. Termination Benefits. Any termination benefits that are in excess of and are not included in the Fiscal Year Budget shall be excluded in the computation of the actual Net Operating Cost for the applicable Fiscal Year. Termination Benefits are defined to mean any benefits paid to Hospital Service Employees that are paid or payable in connection with the separation, termination or other cessation of employment of such Hospital Service Employees, including, but not limited to, severance pay, and accrued but unpaid vacation pay, holiday pay, sick pay and personal time off pay.

iii. Patient Days. The number of patient days per year shall be determined by Hospital's budgeted patient days. If the actual number of patient days at Hospital is more than 5% above or below the budget patient days as provided in the Fiscal Year Budget, then the Parties agree to adjust the Fiscal Year Budget by the variable rate included in the Fiscal Year Budget for each patient day above or below 5%. The Parties acknowledge that the budgeted patient days do not include certain meals provided by Aramark as part of the Management Services (i.e. ER, Observation, or other meals). In order to appropriately capture variation in total meals served, Aramark shall provide documentation to support any variance greater than the budgeted amount.

iv. Contingency Amounts. The Parties acknowledge that the Fiscal Year Budgets contain no contingency amounts for any extraordinary item of incurred expense or for any occurrences that were due to causes beyond Aramark's control and that could not be avoided by

exercise of due care (including, for purpose of example only and not by way of limitation, Acts of God such as extreme weather; water damage; fire; earthquake; equipment failure; changes in federal, state, or local code, regulation, statute, or requirement, whether enacted before or after the Effective Date; labor contracts or activity; utility rate increases; pandemics; endemics; or other such matters). Hospital understands that any such item of extraordinary expense or occurrences shall be excluded in the computation of the actual Net Operating Cost for the applicable Fiscal Year.

v. Material Change in Scope. Notwithstanding any exceptions or adjustments stated above, if, during the Term hereof, an unforeseen material change (or material change outside of Aramark's control) occurs in the scope, manner or extent in or to which any of the Management Services is provided, the cost of which is included in the actual costs for the Fiscal Year, the Fiscal Year Budget shall be adjusted, and mutually agreed to by the Parties, so as to be comparable in scope, manner and extent of actual costs attributable to the material change. Any such adjustment shall be documented in a writing, executed by the Parties. The nature and extent of any such adjustment resulting from a material change shall be demonstrated by Aramark to Hospital. If Aramark's costs increase due to material changes, then Aramark shall give Hospital written notice of such increase, and thirty (30) business days after such notice, the Parties shall, as mentioned, meet in good faith to mutually agree upon any adjustments to the Fiscal Year Budget. Upon such mutual agreement and documentation of any adjustment, Aramark shall automatically be entitled to a pro rata increase in its financial compensation to cover increased costs resulting directly or indirectly from such increase.

For purposes of clarity, material changes may include, but are not limited to, labor, food and supply costs; federal, state and local sales, use and excise taxes; increases in employee health and welfare benefits costs; federal state and local minimum wage rates; changes in an applicable collective bargaining agreement covering Aramark's or Hospital's employees; or an increase in employer contributions to social security or payroll taxes (including retroactive changes to such contributions) and the opening and/or closing of Hospital facilities.

vi. Fill Rate. The Parties acknowledge that a vital factor in Aramark achieving Net Operating Cost less than or equal to the Fiscal Year Budget is an average fill rate of 95% or above of all vacant, approved, budgeted positions in the Food and Nutrition Services Departments. Accordingly, Hospital and Aramark agree to strive to achieve an average of 95% fill rate of all vacant, approved, budgeted positions at each Facility, commencing on the Effective Date and monitored thereafter every three (3) month quarterly period during a calendar year. For the sake of clarity, the first monitored period shall only consist of November – December 2023 with the first full period monitored consisting of January – March 2024, continuing quarterly thereafter. If this average fill rate is not achieved after a monitored quarterly period, the Parties agree to discuss in good faith any adjustments which would be necessary, which shall be mutually agreed on prior to implementation.

SCHEDULE GNB-1

Fiscal Year Budget -

Schedule GNB-2

Non-Controllable Department Expenses

- Amounts not consistent with budgeted methodology developed in the budget relating to the following components:
    - Expenses related to Hospital Service Employees, which are controlled by Hospital – i.e. average hourly wages, bonuses, fringe benefits, tuition reimbursement, etc.
    - Dietary supplements and nourishments and floor stocks (Aramark will provide departmental usage each Accounting Period)
    - Catering; the Parties agree to meet on an annual basis and discuss in good faith any specific details on catering for the given year, including but not limited to: menus, pricing, event dates, timing, and décor. Any such specific details for catering shall be mutually agreed to by the Parties and documented in writing.
    - Doctor's Dining
    - Emergency Department, Observation, Extended Recovery, or other meals (e.g. boxed lunch) excluded from the normal patient meal process
- Utilities related to the services provided, including but not limited to water, sewage, electrical, gas, internet, cable and LAN-based telecommunications

Addendum BAA

BUSINESS ASSOCIATE ADDENDUM

This Addendum (the "Addendum") to the Management Services Agreement effective November 11, 2023 (the "Agreement") between **Salinas Valley Memorial Healthcare System** ("Covered Entity") and **Aramark Healthcare Support Services, LLC** ("Business Associate") (each a "Party" and collectively the "Parties"), is made as of the Effective Date.

WHEREAS, Covered Entity and Business Associate have entered into the above-referenced Agreement under which Business Associate provides certain services or functions on behalf of Covered Entity (the "Services");

WHEREAS, the use and disclosure of certain health-related information, the electronic transmission of certain health-related information, and the security of certain health-related information is regulated by the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations promulgated thereunder, as amended and in effect (collectively referred to as "HIPAA");

WHEREAS, Covered Entity, from time to time, discloses Protected Health Information ("PHI") as defined in this Addendum to Business Associate, and Business Associate, from time to time, uses, creates and/or maintains PHI, and/or electronically transmits PHI; and

WHEREAS, both Parties are committed to complying with HIPAA and the Parties agree to enter into this mutually acceptable Addendum as necessary to so comply.

NOW, THEREFORE, for and in consideration of the agreements of the Parties set forth in the Agreement and this Addendum and intending to be legally bound hereby, Covered Entity and Business Associate agree as follows:

1. PERMITTED USES AND DISCLOSURES OF PHI

A. Use and Disclosure. Business Associate shall not use or further disclose PHI other than as permitted or required by this Addendum or as Required By Law. "Protected Health Information" or "PHI" shall have the meaning given to it under the Privacy Rule, but shall be limited to the information created, accessed, transmitted or maintained by Business Associate for or on behalf of Covered Entity. "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information (HIPAA), codified at 45 CFR parts 160 and 164, Subparts A, D and E ("Privacy Rule"), and the HIPAA Regulation codified at 45 C.F.R Parts 160 and 164, Subparts A and C ("Security Rule") as amended and in effect.

B. Compliance with Privacy Rule and Security Rule. Business Associate shall not use or disclose PHI received from Covered Entity in any manner that would constitute a violation of the Privacy Rule or Security Rule, as defined below, if used by Covered Entity except that Business Associate may use or disclose PHI for Business Associate's proper management and administration, and to carry out any of its legal responsibilities. Any permitted disclosure of PHI to a third party must be either required by law or subject to reasonable assurances from the third party to whom the information is disclosed that (1) it shall be held confidentially, and be used or further disclosed only as Required by Law or the purpose for which it was disclosed to that third party and (2) the third party will notify Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached. "Security

Rule" means the Standards for Security for the Protection of Electronic Protected Health Information, codified at 45 CFR parts 160 and 164, Subparts A and C, as amended and in effect.

C. Services. Except as otherwise limited by this Addendum, Business Associate may use or disclose the PHI necessary to perform the Services.

D. Business Activities of Business Associate. Unless otherwise limited herein, Business Associate may:

1. Provide data aggregation services related only to Covered Entity's Health Care Operations. Under no circumstances shall Business Associate disclose Covered Entity's PHI to another covered entity to whom Business Associate also provides data aggregation services without Covered Entity's express authorization.

2. De-identify any and all PHI provided that the de-identification conforms to the requirements of 45 C.F.R. §164.514. De-identified information does not constitute PHI and is not subject to the terms of this Addendum.

2. RESPONSIBILITIES OF THE PARTIES WITH RESPECT TO PHI

A. Responsibilities of Business Associate. Business Associate hereby agrees to do the following:

1. Appropriate Safeguards. Business Associate shall implement appropriate safeguards to prevent the use or disclosure of Protected Information other than as permitted by the Agreement or this Addendum, including, but not limited to, administrative, physical and technical safeguards in accordance with the Security Rule, including, but not limited to, 45 C.F.R. Sections 164.308, 164.310, and 164.312. Business Associate shall comply with the policies and procedures and documentation requirements of the Security Rule, including, but not limited to, 45 C.F.R. Section 164.316**.** "Electronic Protected Health Information" or "EPHI" shall have the same meaning as the term "electronic protected health information" in 45 CFR § 160.103, limited to the information that Business Associate creates, accesses, maintains or transmits for or on behalf of Covered Entity.

2. Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effects from the improper use and/or disclosure of PHI of which it becomes aware.

3. Agents and Subcontractors. Business Associate shall ensure that any agent and subcontractors that create, receive, maintain or transmit Protected Information on behalf of Business Associate, shall agree in writing to the same restrictions and conditions that apply to Business Associate with respect to such Protected Information and implement the safeguards required, with respect to Electronic PHI.

4. Reporting.

(i) Business Associate shall report to Covered Entity and in compliance with HIPAA, any Security Incident and any access, use or disclosure of PHI that is not permitted by this Addendum of which Business Associate becomes aware.

(ii) To the extent that any such reportable occurrence involves a Breach of Unsecured PHI, Business Associate shall provide notice to Covered Entity within ten (10) days of any

actual breach of Covered Entity's Protected Information any use or disclosure of Protected Information not permitted by the Agreement or this Addendum in accordance with the requirements of 45 C.F.R. § 164.410. Such notification shall include, to the extent possible, the following information: (1) the identity of each individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during the Breach, and (2) any particular information regarding the Breach that Covered Entity would need to include in its notification to the individual, the media and/or the Secretary of the U.S. Department of Health and Human Services ("Secretary"), as applicable, including, without limitation, a non-privileged description of the Breach, the date of the Breach and its discovery, the types of Unsecured PHI involved and a description of Business Associate's investigation, mitigation and prevention efforts.

(iii) Breach Pattern or Practice by Business Associate's Subcontractor and Agents. Pursuant to 42 U.S.C. Section 17934(b) and 45 C.F.R. Section 164.504 (e)(1)(iii); if the Business Associate knows of a pattern of activity or practice of a subcontractor or agent that constitutes a material breach or violation of the subcontractor or agent's obligations under the Agreement or this Addendum or other arrangement, the Business Associate must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the Business Associate must terminate the contract with the subcontractor or agent or other arrangement if feasible.

(iv) For purposes of the above subsection (ii), the terms "Breach," and "Unsecured PHI" shall have the same meaning given those terms under 45 C.F.R. § 164.402.

5. Access to Internal Practices. At the request of Covered Entity or the Secretary, Business Associate shall make its internal practices, books and records (including policies and procedures) relating to the use and/or disclosure of PHI available to the Secretary for purposes of the Secretary determining Covered Entity's and Business Associate's compliance with HIPAA.

6. Access to PHI. Business Associate shall make PHI it maintains in a Designated Record Set available to Covered Entity for inspection and copying in accordance with 45 C.F.R. §164.524. In the event any individual requests access to PHI directly from Business Associate, Business Associate shall forward such request to Covered Entity.

7. Amendments to PHI. Upon receipt of request from Covered Entity, within ten (10) days, Business Associate and its agents and subcontractors shall make an Individual's PHI in a Designated Record Set available for amendment and shall incorporate any amendments to PHI in accordance with 45 C.F.R. §164.526. In the event any individual submits a request for amendment directly to Business Associate, Business Associate shall forward such request to Covered Entity.

8. Accounting of Disclosures. Upon receipt of request from Covered Entity, within ten (10) days, Business Associate shall make available the information required to provide an accounting of disclosures to an Individual pursuant to 45 C.F.R. §164.528. In the event the request for accounting is delivered directly to Business Associate, Business Associate shall forward such request to Covered Entity.

9. Governmental Access to Records. Business Associate shall make its internal practices, books, and records relating to the use and disclosure of Protected Information available to Covered Entity and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining Business Associate's compliance with HIPAA 45 C.F.R. Section 164.504(e)(2)(ii)(I).

10. Restrictions/Alternatives. Upon Business Associate becoming aware of such arrangements, Business Associate shall abide by any arrangements that Covered Entity has made with an Individual regarding restricting the use or disclosure of the Individual's PHI, or providing the Individual with confidential communications of PHI by alternative means or at an alternative location pursuant to 45 C.F.R. §164.522.

11. Minimum Necessary. Business Associate and subcontractors shall use and disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, use or disclosure in accordance with 45 C.F.R. §164.502(b).

12. Covered Entity's Privacy Rule Obligations. To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under the Privacy Rule, Business Associate shall comply with the requirements of HIPAA that apply to Covered Entity in the performance of such obligation(s).

13. Data Ownership. Business Associate acknowledges that Business Associate has no ownership rights with respect to the Protected Information.

B. Responsibilities of Covered Entity.

1. Notification Requirement. With regard to the use and/or disclosure of PHI by Business Associate, Covered Entity hereby shall:

(i) Provide Business Associate with its Notice of Privacy Practices (the "Notice") that Covered Entity provides to Individuals in accordance with 45 C.F.R. §164.520, as well as any changes to or limitations in such Notice to the extent that the changes or limitations affect Business Associate's use or disclosure.

(ii) Inform Business Associate of any changes in, or revocation of, an authorization provided to Covered Entity by an Individual pursuant to 45 C.F.R. §164.508, to the extent that such changes or revocation affect Business Associate's permitted or required uses and disclosures.

(iii) Inform Business Associate of any amendments to PHI that Covered Entity has agreed to under 45 C.F.R. §164.526 that relate to PHI upon which Business Associate relies to perform the Services.

(iv) Notify Business Associate of any arrangements Covered Entity has agreed to that restrict disclosures or provide Individuals with confidential communications pursuant to 45 C.F.R. §164.522 that may impact the use and disclosure of PHI by Business Associate.

2. No Impermissible Requests. Covered Entity shall not request that Business Associate use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

3. TERM AND TERMINATION

A. Term. This Addendum shall become effective on the Effective Date and shall continue in effect until all PHI is destroyed or returned to Covered Entity. If it is infeasible to return or destroy all PHI, the protections of this Addendum are extended to such information in accordance with the termination provisions in this Section.

B. Termination for Cause by Covered Entity. Any other provision of this Addendum notwithstanding, if Covered Entity determines that Business Associate has breached a material term of this Addendum, Covered Entity shall provide Business Associate with a reasonable opportunity to cure the breach or may terminate the Agreement if cure is not feasible.

C. Termination for Cause by Business Associate. Any other provision of this Addendum notwithstanding, if Business Associate knows of a pattern of activity or practice of Covered Entity that constitutes a material breach or violation of this Addendum, Business Associate shall provide Covered Entity with a reasonable opportunity to cure the breach or may terminate the Agreement if cure is not feasible.

D. Material Breach. A breach by either Party of any provision of this Addendum shall constitute a material breach of the Agreement and shall provide grounds for termination of the Agreement, any provision in the Agreement to the contrary notwithstanding. The non-breaching Party shall provide the breaching Party with a reasonable opportunity to cure the breach or may terminate the Agreement if cure is not feasible.

E. Judicial or Administrative Proceedings. Covered Entity may terminate the Agreement, effective immediately if a finding or stipulation has been entered that Business Associate has violated any standard or requirement of HIPAA, HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate has been named.

F. Effect of Termination.

1. Upon termination of the Agreement for any reason, Business Associate shall, at the option of Covered Entity, return or destroy all Protected Information that Business Associate and its agents and subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as mutually determined by the Parties, Business Associate shall continue to extend the protections and satisfy the obligations of Paragraph 2 of this Addendum to such information, and limit further use and disclosure of such PHI to those purposes that make the return or destruction of the information infeasible. If Covered Entity elects destruction of the PHI, Business Associate shall certify in writing to Covered Entity that such PHI has been destroyed in accordance with the Secretary's guidance regarding proper destruction of PHI.

4. MISCELLANEOUS

A. Definitions. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms defined in the Privacy Rule and Security Rule, the HITECH Act, the HIPAA regulations or other applicable laws.

B. Entire Agreement. This Addendum contains the final and complete expression of all agreements between the Parties with respect to the subject matter of this Addendum and supersedes all prior and contemporaneous agreements between the Parties, whether oral or written, with respect to the subject matter of this Addendum.

C. Interpretation. Any ambiguity in this Addendum shall be resolved to permit Covered Entity to comply with HIPAA.

D. Amendments. This Addendum may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The

Parties agree and acknowledge that state and federal laws relating to data security and privacy are evolving and that amendment of this Addendum may be required to ensure compliance with such developments. Upon the request of either Party, the other Party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws.

E. Relation to Agreement. The Parties acknowledge and agree that this Addendum amends, supplements, and is made a part of the Agreement. With the exception of the terms and conditions set forth in this Addendum, all other terms and conditions of the Agreement shall remain unaltered and in full force and effect. If there is any conflict between the terms of this Addendum and the Agreement, this Addendum shall govern.

F. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

G. Counterparts; Facsimiles. This Addendum may be executed in any number of counterparts, each of which shall be deemed an original. Facsimile copies hereof shall be deemed to be originals.

H. Indemnification. (Each Party ("Indemnifying Party") shall, to the fullest extent permitted by law, indemnify and hold harmless the other Party and its directors, officers and employees from and against any and all losses, out-of-pocket costs, claims, penalties, fines, or liabilities in association with third-party claims from or related to the acts or omissions of the Indemnifying Party or its employees, directors, or agents, related to the performance or nonperformance of this Agreement and Addendum or a breach of the requirements of HIPAA. This indemnification provision shall survive termination of this Agreement and Addendum for any reason.

I. Disputes. If any controversy, dispute or claim arises between the Parties with respect to this Addendum, the Parties shall make good faith efforts to resolve such matters informally.

J. Notices. Any notices to be given hereunder to a Party shall be made via U.S. Mail or express courier to such Party's address given below.

If to Business Associate, to:

Aramark Healthcare Support Services, LLC
2400 Market Street
Philadelphia, PA 19103
ATTN: President

with a copy (which shall not constitute notice) to:

Aramark Healthcare Support Services, LLC
2400 Market Street
Philadelphia, PA 19103
ATTN: Vice President, Compliance

If to Covered Entity, to its Privacy Officer at the address set forth in the Agreement.

Each Party named above may change its address and that of its representative for notice by the giving of notice thereof in the manner herein-above provided.

ARAMARK HEALTHCARE SUPPORT SERVICES, LLC	**SALINAS VALLEY HEALTH**
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

EXHIBIT FOOD

FOOD SERVICE MANAGEMENT PROGRAM

Aramark will provide a Food Service Management Program (the "Food and Nutrition Program") to Hospital, as described in this **Exhibit Food**.

I. AREAS SERVED

All Food and Nutrition Program services will be rendered at Hospital's facilities (the "Facilities"), located at:

Salinas Valley Health Medical Center
450 E. Romie Ln.
Salinas, CA 93901

Specific Food and Nutrition Program services provided for different users and areas within the Facilities are described below in Section IV**.**

II. STAFFING: MANAGER AND SERVICES EMPLOYEES

Aramark will provide a manager for the Food and Nutrition Program (the "Food and Nutrition Director"). The Food and Nutrition Director will coordinate the management and the activities of the Service Employees within the Food Department, which personnel will be provided by, and will be employees of, Hospital. Aramark will provide other management and supervisory personnel as necessary to assist the Food and Nutrition Director in the coordination and management of the clinical, retail and other activities described in this **Exhibit Food**.

The Food and Nutrition Director's duties will be:

- To consult with, and make recommendations to, Hospital on Food and Nutrition Program functions and services;
- To provide initial recommendations and review of staffing levels, implementation of procedures, and utilization of resources within Hospital's Food Department;
- To work with Hospital to develop, implement, and maintain a Food and Nutrition Program that will comply with applicable standards as set forth in the most recent edition of the "Accreditation Manual for Hospitals" under the Hospital Accreditation Program, published by The Joint Commission ("TJC"), or such other mutually acceptable source of standards as may be applicable to Hospital;
- To produce reports related to the operation of Hospital's Food Department, as required by Hospital;
- To develop standards of performance for each position under Aramark's management;
- To track employment and training;
- To conduct Service Employee performance and progress evaluations;

- To hold team meetings for Food Department employees for training and other relevant activities; and
- To attend certification, training, and awards meetings and seminars, as may be required from time to time.

Aramark shall cause all of its employees assigned to duty at the Facilities to submit to periodic health examinations as required by law, and shall submit satisfactory evidence of compliance with all health regulations to Hospital's medical department upon request. The cost of such examinations shall be a direct cost of operations.

III. MATERIALS, SUPPLIES, AND EQUIPMENT

A. General Provisions.

1. Food and Supplies Inventory. All food and related supplies to be utilized in the Food and Nutrition Program are and will remain the property of Hospital.

2. Smallwares Inventory. Hospital will provide all equipment needed for implementation of the Food and Nutrition Program. This equipment includes, but is not limited to fixed equipment (for example, furniture, furnishings, and fixtures), movable equipment (for example, mobile and portable equipment and accessories such as unitized bases), an adequate initial inventory of Servicewares and Small Expendable Equipment (each as hereinafter defined) and all other equipment required for the Food and Nutrition Program, together with utilities, gas, electricity, hot and cold running water needed to operate that equipment and all kitchen, food preparation, and food service areas. All such Servicewares and Small Expendable Equipment are and will remain the property of Hospital, and Hospital will, at its expense, maintain such equipment in a fully operable and safe condition, and will, also at its expense, repair (including provision of replacement parts), replace, and provide additional equipment as necessary for the Food and Nutrition Program to be performed. For purposes of this Agreement, "Servicewares" shall mean items utilized in the service of food, including such things as chinaware, glassware and silverware; and "Small Expendable Equipment" shall mean items utilized in the preparation of food, including such things as pots, pans and kitchen utensils.

3. Hospital shall furnish building maintenance services for the Facilities, shall promptly make all equipment and building repairs and replacements, and shall be responsible for compliance with all federal, state, and local safety and health law and regulations with respect to the Facilities.

4. Hospital will provide all such safety equipment as may be necessary for safe performance of the Food and Nutrition Program (including, but not limited to, rescue gear, personal protective equipment, lockout equipment, monitoring equipment, etc.).

B. Government Donated Foods.

1. Government donated commodities received by Hospital will inure only to the benefit of Hospital's patient meal service operation. Aramark's normal food expenditures for Hospital's patient meal service operation will not be reduced because of the receipt of government donated commodities in compliance with the United States Department of Agriculture's regulations set forth in 7 CFR § 250.12 and 7 CFR § 250.13.

2. In order to enable Hospital to fulfill its obligations under the terms of its agreement with the state agency designated to administer the direct distribution program of the United States Department of Agriculture and the regulations set forth in 7 CFR Part 250, Aramark agrees to allow the designated state agency and the United States Department of Agriculture to (a) inspect donated commodities in storage at the Facilities, as well as storage facilities and practices followed by Aramark on behalf of Hospital; and (b) review or audit financial records of food purchases relative to Hospital's patient meal service operation in order to insure that donated commodities are used in addition to and not in substitution for food normally purchased or funds normally expended for food. Such records shall be kept by Aramark for a period of three years from the close of the federal fiscal year to which they pertain.

IV. DESCRIPTION OF SERVICES

A. Generally. Hospital and Aramark shall mutually determine hours and type of service. The Food and Nutrition Program services consist of certain services for Hospital's patients, for Hospital's retail food service, and for Hospital's credit/transfer food service, in accordance with the following:

TABLE 1

Food and Nutrition Program for Hospital's Patients

Patient Food Service	Included	Excluded	Annual Patient Food Service Volume
Patient Meal Delivery	X		48,320 inpatient days per year
Other Patient Meal Services (ER, Outpatient meals, etc.)	X		$35,775 per year (gross revenue)

TABLE 2

Food and Nutrition Program for Hospital's Retail Food Service

Retail Food Service	Included	Excluded	Volume of Annual Sales Revenue
Cafeteria(s)	X		$839,475 per year
Starbucks	X		$1,106,672 per year
Cash Catering	X		$145,774 per year
Vending Machines		X	
Meals on Wheels		X	

TABLE 3 **Food and Nutrition Program for Hospital's Credit/Transfer Food Service**			
Credit/Transfer Service	**Included**	**Excluded**	**Volume of Annual Sales Revenue**
Floor Supplies/Nourishments	X		$124,666 per year
Supplements	X		$10,147 per year
ER Meals	X		$29,940 per year
Outpatient Meals	X		$5,835 per year
Transfers		X	To be determined by the Parties at a later date
Special Functions		X	
Free Meals		X	

NOTE: The Food and Nutrition Program and the corresponding Aramark Payment are based on the foregoing data provided by Hospital. **ANY FOOD SERVICES OR OTHER DATA NOT LISTED ABOVE, AND THOSE THAT ARE INDICATED AS "EXCLUDED" IN THE ABOVE TABLES, ARE EXCLUDED FROM THE FOOD AND NUTRITION PROGRAM.**

B. Clinical Nutrition Services. As part of the Food and Nutrition Program, Aramark will manage the services provided by Hospital's Clinical Dieticians.

The Clinical Dietitian duties will be:

- To conduct the Nutrition Care Process for patients at nutritional risk (as identified by Hospital's medical team upon initial nutrition screening/consult or by Clinical Dietitian during ongoing nutrition monitoring) in an inpatient and outpatient setting. Nutrition Care Process includes:
  - Nutrition Screening
    - To review appropriate nutrition screening data for patients at nutritional risk as identified by Hospital's medical team during initial nutrition screening/consult
    - To perform ongoing nutrition monitoring of patients
  - Nutrition Assessment
    - To assess the nutrition-related health needs/status of patients identified to be at nutritional risk during Nutrition Screening process by analyzing/interpreting appropriate data based on evidence-based practice standards;
    - Appropriate data may include but is not necessarily limited to; anthropometrics, biochemical data, medical test results, nutrition focused physical assessment, nutrient intake, client/ social history, etc.
  - Nutrition Diagnosis
    - To determine nutrition diagnosis(es) after identifying the problem(s) and clarifying cause of the problem(s)
  - Nutrition Intervention
    - To develop, recommend and/or initiate an individual therapeutic nutrition care plan in accordance with the patient's medical program

goals and objectives, nutrition prescription, and self-management training
        - To develop, recommend and/or initiate frequency of therapeutic nutrition care plan/ intervention appropriate for diseases, conditions and data including therapeutic diet, enteral and parenteral nutrition if necessary;
        - To develop and initiate nutrition counseling/ education programs for inpatients and outpatients;
    - Nutrition Monitoring and Evaluation
        - To evaluate the effectiveness of medical nutrition therapy care plan/ interventions. Reassess nutrition care process and implement changes as appropriate;
- If the Parties desire utilize the Academy of Nutrition and Dietetics Scope of Practice Algorithm to obtain approval for advanced clinical practice. For the avoidance of doubt, any advanced clinical practice shall require the Parties to agree and such practice be evaluated using the Academy of Nutrition and Dietetics Scope of Practice Algorithm;
- To participate in the coordination of patient care by collaborating and communicating with the Hospital's multidisciplinary medical team through medical record documentation, meetings, rounds and medical conferences;
- To provide appropriate and timely documentation of the nutrition care plan in the patient's medical record, utilizing the Nutrition Care Process and standardized terminology (eNCPT) in accordance with professional practice guidelines;
- To identify, collect data and participate in performance improvement projects, monitor outcomes, and initiate corrective actions;
- To properly use and protect patients' protected health information in accordance with applicable laws and regulations and Hospital's policies and procedures;
- To maintain Aramark's clinical productivity standards through accurate data entry of clinical activities, including information for scheduling and billing
- To assist in achieving compliance with applicable accrediting organizations' regulatory agency standards including the Joint Commission (JC), Det Norske Veritas (DNV-GL) and/or state and federal regulations;
- To maintain dietetic registration and continuing professional education requirements;
- To maintain state licensure/certification and comply with applicable law;
- To document and implement an individualized professional development plan including participation in professional organizations/ activities, workshops, seminars/ conferences, and staff development programs;
- To attend and participate in departmental and multidisciplinary meetings;
- To work cooperatively with food and nutrition services staff to assure conformance to prescribed nutrition care orders.

C. **Host/Hostess Services**. As part of the Food and Nutrition Program, Aramark will manage the services provided by the Host/Hostess.

The Host/Hostess duties will be:

- To meet with patients prior to mealtime to receive meal selection from patient per their prescribed nutrition care orders;
- To check patient trays for accuracy and completeness;
- To deliver and collect patient trays during meal service;
- To carry an assortment of condiments and supplies to the patient floors to meet patient's requests within prescribed nutrition care orders;
- To report all meal service-related problems as observed on patient floors to the patient services manager and Nursing and Nutrition Office (as necessary); records problems on appropriate documentation;
- To attend and participate in meetings and in-services as directed;
- To follow safety rules at all times and report accidents and unsafe conditions to manager;
- To demonstrate knowledge of proper infection control and food safety standards as evidenced by good hand washing, proper use of cutting boards, FIFO, assurance of proper food temperatures, etc.;
- To adjust tray stands;
- To assist patients in opening containers and utensils on the tray;
- To maintain friendly, efficient service attitude toward patients and coworkers;
- To assemble and deliver patient nourishments;
- To inventory, assemble, and deliver unit floor stock.

D. **Retail Food Services**. As part of the Food and Nutrition Program, Aramark will coordinate operations of Hospital's Retail Food Services (as specified in **Table 2** above) with Hospital, as follows:

1. Aramark will plan and coordinate retail menus, including quantities of portions to be served, which will be established jointly by Aramark and Hospital.

2. Prices charged for food and beverages sold in retail points will be mutually agreed upon in writing by the Parties. Prices charged for food and beverages will be adjusted on an annual basis.

3. Client will collect and retain all receipts and all money from the sale of all food and beverages in retail points ("Retail Receipts") and will be responsible for the safekeeping and banking of such receipts and money.

D. **Definition of Service Areas**. The scope of the Food and Nutrition Program includes the provision of therapeutic diets and other clinical services for the patients of the Facilities. The Food and Nutrition Program and the corresponding Aramark Payment are based on the following data provided by Hospital.

Floor/Unit	Service	Beds

	TOTAL INPATIENT BEDS	**263**

E. **Hours of Operation and Service Definition**. The scope of the Food and Nutrition Program includes the production of meals for patients, employees/staff and authorized visitors of the Facilities. The Food and Nutrition Program and the corresponding Aramark Payment are based on the following data provided by Hospital.

CAFETERIA & OTHER RETAIL

	Service Definition	Open	Close
Breakfast	Grill	6:30 a.m.	10:00 a.m.
AM Break	Beverages & Cold Table	10:00 a.m.	10:30 a.m.
Lunch	Main Service	11:00 a.m.	2:00 p.m.
PM Break	Snacks/Beverages	2:00 p.m.	4:30 p.m.
Dinner	Main Service	4:30 p.m.	7:30 p.m.

F. **Cleaning Responsibilities**.

1. Aramark's Responsibilities. Aramark shall maintain high standards of sanitation and shall be responsible for routine cleaning and housekeeping in the food preparation and service areas (including food service equipment, kitchen floors, and grease filters) and for the routine cleaning of cafeteria tables and chairs. Aramark shall weekly pull down and wash vents.

2. Hospital's Responsibilities. Hospital, at its cost, shall provide regular cleaning service for cafeteria walls, windows, floors, light fixtures, draperies and blinds, and periodic waxing and buffing of floors. In addition, Hospital will be responsible for routine cleaning of grease traps, duct work, plenum chambers and roof fans. Hospital will be responsible for monthly cleaning of all hoods. The maintenance and cleaning of all pantries (including refrigerators) located on patient units shall be the responsibility of Hospital. Hospital, at its cost, shall be responsible for trash and garbage removal and extermination service.

G. **Licenses and Permits.** Aramark shall obtain all federal, state and local licenses and permits required for the Food Department. The cost of all such licenses, permits and taxes, including an estimated amount for state income taxes based on the operating unit's income, that Aramark shall obtain shall be charged as a direct cost of operation. Hospital shall obtain all licenses and permits required for the café and Starbucks locations.

H. **Taxes.** Hospital shall be responsible for all sales, use, excise, state and local income taxes and all other state and local taxes attributable to the Food Department, including all such taxes as may arise in connection with retail sales.

V. VENDOR CONTRACTS

Aramark will provide coordination and administrative oversight, but not management, of certain vendor contracts identified in **Schedule Vendor Contracts**. All such vendors will be paid directly by Hospital. Any costs that Aramark incurs in performing its services, due to a vendor's performance, will be invoiced to Hospital as a direct cost. **Schedule Vendor Contracts** shall be updated on an annual basis and mutually agreed upon by the Parties.

VI. EXTRA SERVICES

Upon request, Aramark may agree to schedule and provide various services that are not included in the Food and Nutrition Program, as Extra Services, for an additional fee on which Aramark and Hospital will agree.

VII. EXCLUSIONS

The scope of the Food and Nutrition Program is limited to the description provided above and the Schedule(s) to this Exhibit. Other duties, frequencies, and areas are excluded. Without limiting the foregoing statement, the following items are specifically excluded:

- **Utilities** – Hospital will provide, and pay for, all utilities.
- **Pest Control -** Hospital will provide, and pay for, all pest control services.
- **Trash Removal -** Hospital will provide, and pay for, all trash and garbage removal services.

Schedule Vendor Contracts

VENDOR CONTRACTS UTILIZED IN THE FOOD AND NUTRITION PROGRAM

VENDOR	SERVICE PROVIDED
Cintas	Rental Service- Terry Towels and 20" microfiber mop
Abbott Nutrition	Purchasing Agreement- Infant Formula Products

NOTE: ANY VENDOR CONTRACT NOT LISTED ABOVE IS EXCLUDED FROM THE FOOD AND NUTRITION PROGRAM.

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) the Findings Supporting Recruitment of Nicholas Klimberg, MD, (ii) the Contract Terms for Dr. Klimberg's Recruitment Agreement, and (iii) the Contract Terms for Dr. Klimberg's Pulmonology Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, Chief Medical Officer, Salinas Valley Health
Gary Ray, Chief Administrative Officer, Salinas Valley Health Clinics

Date: October 24, 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 Pulmonology/Critical Care 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 Pulmonology is recommended as a priority for recruitment. In addition, the retirement of one part-time pulmonologist and succession planning for another full-time pulmonologist emphasizes the need for an additional physician.

The recommended physician, Nicholas Klimberg, MD, received his Doctor of Medicine degree at New York Medical College in Valhalla, New York. Dr. Klimberg completed his Internal Medicine residency at University of California (UC) Davis in 2019 and continued to provide hospitalist medicine services at UC Davis after residency training. Dr. Klimberg served as Chief Pulmonology & Critical Care Fellow during his Fellowship training at University of Arizona - Banner Health in Tucson. Since completing his training in June 2023, Dr. Klimberg has been providing intensivist services on a per-diem basis at Sound Critical Care in San Jose. Dr. Klimberg has a California medical license, speaks medical Spanish and plans to join Salinas Valley Health Clinics in January 2024.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement.** The proposed professional services agreement includes the following 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.
   - Schedule. Physician will provide patient services on a full-time basis, in the clinic, hospital intensive care unit, or on hospital rounds 204 weekday shifts and 26 weekend shifts per year. These shifts are included in physician's base compensation.
   - Hospital Call. Physician will cover the pulmonary hospital call panel 65 weekday night shifts and 26 weekend night shifts year. Hospital call shifts are included in physician's base compensation.
   - Base Compensation. Physician will receive base compensation of $509,255 per year.
   - Excess Shift Compensation. Day shift and hospital call shift coverage in excess of the number of shifts included in Physician's Base Compensation will be paid at the following rates:
     - Excess Day Shift Compensation. $1,630.00 per excess shift.
     - Excess Hospital Call Weekday Night Shift: $1,325.00 per excess shift.
     - Excess Hospital Call Weekend Night Shift: $1,855.00 per excess shift.
   - Annual Incentive Plan. Compensation of up to $9,500 annually by meeting established performance metrics.

- Benefits. 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 (5%) 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 sign-on bonus of $30,000 which is structured as forgivable loan over two years of service.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

The recruitment of Dr. Klimberg is aligned with our strategic priorities for the growth and finance 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. Klimberg to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for the SVH Specialty Clinic practice.

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

Recommendation

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

1. **The Findings Supporting Recruitment of Nicholas Klimberg, MD,**
   - That the recruitment of a pulmonologist 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. Klimberg; and**
3. **The Contract Terms of the Pulmonology Professional Services Agreement for Dr. Klimberg.**

Attachments

- Curriculum Vitae for Nicholas Klimberg, MD

Nicholas Klimberg, M.D.

PROFESSIONAL EXPERIENCE

Intensivist – Sound Critical Care — July 2023 - Present
Regional Medical Center, San Jose, CA

Chief Fellow - Pulmonary / Critical Care Fellowship — July 2020 – June 2023
University of Arizona / Banner Health, Tucson, AZ

Hospitalist - Associate Physician — July 2019 – June 2020
Department of Internal Medicine
UC Davis Medical Center, Sacramento, CA

Internal Medicine Residency — July 2016 – June 2019
UC Davis Health, Sacramento, CA

M.D. — 2012 - 2016
New York Medical College, Valhalla, NY

B.S., Exercise Biology with Honors — 2007 - 2011
University of California, Davis, CA

LICENSURE/CERTIFICATIONS

Medical Board of California License (A152442)	Active
ABIM – Pulmonary Medicine	BC
ABIM – Critical Care	BE
ABIM – Internal Medicine	BC
ACLS, ENLS, NIHSS	Certified

ACTIVITIES

Professional Development

Pulmonary Grand Rounds Conference — July 2022 – June 2023
University of Arizona / Banner Health
- Organize curriculum and schedule speakers for weekly grand rounds conference

Leadership Workshop — July 2022
University of Arizona / Banner Health
- Participated in a full-day leadership workshop for chief residents/fellows

Global Health Elective — March 2019
University of Peradeniya, Sri Lanka
- Selected for a one-month elective working at a government hospital in Sri Lanka

Leadership Track — 2018 - 2019
UC Davis Health
- Engaged in journal clubs, book clubs, and seminars about leadership

Research Track — 2017 - 2019
UC Davis Health
- Participated in a structured research curriculum

Medical Education Track 2017 - 2018
UC Davis Health
- Engaged in seminars on student feedback, teaching, and evidence-based exams

Quality Improvement & Patient Safety Seminar 2013 - 2014
New York Medical College
- Participated in a 6-session small-group seminar on patient health and safety

Medical Spanish Program Summer 2013
Institute for Spanish Language Studies, Costa Rica
- Studied medical Spanish and volunteered in local clinics to practice skills

Teaching/Mentoring

Doctoring Program – Preceptor 2017 - 2018
UC Davis School of Medicine
- Tutored 2nd year medical students on clinical reasoning and exam skills

Peer Tutoring Program – Tutor 2015 - 2016
New York Medical College
- Tutored 3rd year medical students during clinical clerkships

Peer Mentoring Program – Mentor 2015 - 2016
New York Medical College
- Mentored medical students progressing through their 3rd year

AOA Tutoring Program – Tutor Fall 2013
New York Medical College
- Tutored 1st year medical students on medical anatomy

Science and Technology Entry Program (STEP) – Tutor 2012 - 2014
New York State STEP / New York Medical College
- Tutored under-represented high school students with STEM interests

Human Gross Anatomy - Teaching Assistant Winter Qtr. 2011, 2012
University of California at Davis
- Instructed 50 students on bi-weekly, three-hour anatomy lab sessions

Community / Institutional Service

Patient Quality and Safety Committee - Member Oct. 2022 - June 2023
Graduate Medical Education, University of Arizona
- Selected to serve on the GME patient quality and safety committee

ICU Committee - Resident Representative 2017 - 2018
UC Davis Medical Center
- Participated in monthly ICU Committee meetings and reported updates to the residency

La Casita de la Salud Clinic 2017 - 2018
Metropolitan Hospital, East Harlem, NY
- Cared for underserved patients at our NYMC student-run health clinic

Multiple Mini Interviewer March 2014

New York Medical College
- Interviewed medical school applicants for our multiple mini-interview process

AMSA Global Health Committee - Medication Chair Jan.-Apr. 2013
New York Medical College
- Assisted in procuring medications/supplies for a medical relief trip to Honduras

International Medicine Club – **Secretary** 2013 - 2014
New York Medical College
- Recorded meeting minutes and communicated club events to the medical school class

SCHOLARSHIP

Research Publications & Presentations

Klimberg, N, Patel B, Miller DC. Not your average ground glass opacity. Presented at: American Thoracic Society 2023 International Conference; May 19-24, 2023; Washington, D.C.

Yoshino KY, Shrestha P, Upson SM, **Klimberg N**. Use of infliximab as therapeutic option for steroid-resistant paradoxical reaction in TB. Presented at: Chest 2022 Annual Meeting; Oct 16-19, 2022; Nashville, TN. *Chest*. 2022;162(5), Suppl:A326.

Klimberg NI, Louie S, Harper RW. Sarcoidosis: protean presentations and pitfalls in diagnosis. *Consultant.* 2020;60(7):e11.

Alqalyoobi S, Boctor N, Sarkeshik AA, Hoerger J, **Klimberg N**, Bartolome BG, Stewart SL, Albertson TE. Therapeutic hypothermia and mortality in the intensive care unit: systematic review and meta-analysis. *Crit Care Resusc*. 2019;21(4):287-298.

Klimberg N, Harper RW. Factors affecting the diagnostic performance of bronchoalveolar lavage in sarcoidosis. Presented at: American Thoracic Society 2019 International Conference; May 17-22, 2019; Dallas, TX. *Am J Respir Crit Care Med.* 2019;199:A1536

Other Research Experience

Senior Thesis Research Project, Dr. William Frishman MD 2015-2016
Department of Medicine, New York Medical College
- Authored a clinical review on cardiac rehabilitation modalities for systolic heart failure

NYMC Orthopedics Lab, Dr. Paul Lucas PhD Apr. 2015
Department of Orthopedic Surgery, New York Medical College
- Prepared immunohistologic slides for a xenogenic stem cell study

PROFESSIONAL SOCIETIES

American Thoracic Society
American College of Chest Physicians
American Medical Association

INTERESTS

Professional: Critical care, airway management, obstructive lung disease, interstitial lung disease, quality improvement and patient safety, community-oriented patient service

Personal: Hiking, camping, cycling, traveling, gardening, sports

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of Contract Terms for Juan Rodriguez, MD's Diagnostic and Interventional Radiology Professional Services Agreement**

Executive Sponsor: Allen Radner, MD, Chief Medical Officer, Salinas Valley Health
Gary Ray, Chief Administrative Officer, Salinas Valley Health Clinics

Date: October 24, 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 Interventional Radiology and Diagnostic Radiology as a recruiting priority for the Medical Center's service area.

The recommended physician, Juan Rodriguez, MD, received his Doctor of Medicine degree in 1998 from University of Zaragoza School of Medicine in Spain. After completing a surgery internship in 1999 at Hospital Comarcal de Alcañiz in Spain, Dr. Rodriguez completed his radiology residency at Louisiana State University Health and Sciences Center in Shreveport, LA. Dr. Rodriguez obtained his Interventional Radiology Fellowship training at University of California San Francisco. Dr. Rodriguez has been practicing in Santa Cruz since 2006 and has worked simultaneously at other organizations on the Central Coast and in Northern California, including Natividad Medical Center in Salinas. Dr. Rodriguez holds a California medical license, is fluent in Spanish, and plans to join Salinas Valley Health Clinics in January 2024.

Terms and Conditions of Agreements

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

1. **Professional Services Agreement.** The proposed professional services agreement includes the following 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.
   - Schedule. . Radiologist Services provided during each coverage week can be either interventional radiology or diagnostic radiology services. Physician will provide during every four-week period: (i) Seven days of 24/7 coverage for Interventional Radiology (IR), plus Diagnostic Imaging (DI) coverage on weekend; (ii) Five days of ten hours of coverage for Diagnostic Radiology, plus emergency on-call coverage; (iii) IR physician will commit to 26 weeks of IR/DI coverage 13 call weekends per year.
   - Base Compensation. Physician's compensation for Radiologist Services and Hospital coverage activities pursuant to the above schedule obligations and service responsibilities shall be in the amount of $700,000.00 per year.
   - Benefits. 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 (5%) 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.

Meeting our Mission, Vision, Goals
Strategic Plan Alignment:

The recruitment of Dr. Rodriguez is aligned with our strategic priorities for the growth and finance 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. Rodriguez to SVH Clinics has been identified as a need for recruitment while also providing additional resources and coverage for the SVH Imaging practice.

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

Recommendation

Salinas Valley Health Administration requests that the Personnel, Pension and Investment Committee recommend to the Salinas Valley Health Board of Directors approval of the Contract Terms of the Diagnostic and Interventional Professional Services Agreement for Juan Rodriguez, MD.

Attachments

- Curriculum Vitae for Juan Rodriguez, MD

Curriculum Vitae
Juan R. Rodriguez, M.D.

Citizenship: American **Languages:** Spanish and English

Education

Cardenal Ram Institute: B.S. Biology, Chemistry, Physics and Mathematics (1988-1992)
University of Zaragoza, School of Medicine. (1992-1998)
M.D. issued in Zaragoza, Spain. September 15, 1998

Honors & Awards

Selected to represent Cardenal Ram Institute to receive **National Bachelor Award**, 1992

Anatomy Instructor, 1992-93. University of Zaragoza, School of Medicine

Cum Laude qualifications in: Anatomy I and II, Histology, Surgical Pathology I and II, Dermatology, Preventive Medicine, Legal Medicine, *Radiology*, Urology, and Orthopedics

2002 Chairman's Award: Highest score on the in-training exam. 99th percentile in the US. Radiology Department. LSUHSC- Shreveport

2003 Chairman's Award: Highest score on the in-training exam. 95th percentile in the US. Radiology Department. LSUHSC- Shreveport

Nominated to become **Chief Resident** for the 2004 academic year.

2004 Chairman's Award: Highest score on the in-training exam. 97th percentile in the US. Radiology Department. LSUHSC- Shreveport

2004 RSNA Roentgen Resident/ Fellow Research Award

Post-Graduate Training

Internship (Non-accredited) in Surgery (October 1998- June 1999): Hospital Comarcal de Alcaňiz; Teruel. Spain

Transitional Year Internship (July 1, 2000- June 30, 2001): LSU Health Sciences Center Shreveport, LA

Radiology Residency (July 1, 2001- June 30, 2005): LSU Health Sciences Center Shreveport, LA

Interventional Radiology Fellowship (July 1, 2005- June 30, 2006): UCSF; San Francisco, CA

Special Post Graduate Education

Clinical Skills Assessment Program (January 2001) Kaplan/Morchand. Felician College Rutherford, New Jersey

Introduction to Research Course (May 2003) 103rd Annual Meeting of the American Roentgen Ray Society. San Diego

Certifications

- E.C.F.M.G. Certificate number: 0-603-515-8, issued: March 24, 2000
- STEP 1: October 20, 1999 **246 (97%)**
- STEP 2: March 3, 1999 **234 (89%)**
- CSA: January 30, 2000 **Passed**
- STEP 3: June 26, 2001 **225 (91%)**

ABR CERTIFICATION, June 7th, 2005. Renewed 2015. MOC annually enrolled.

DR/IR CERTIFICATION, oral exam scheduled October 20th, 2023.

Medical Licenses

Louisiana State Board of Medical Examiners, License No. 026637, issued May 20, 2003

California License, issued March 3[1st,] 2005; Certificate No. A90344

Medical Society Memberships

Member: Spanish Red Cross, 1998-2000
The Radiological Society of North America, 2001-present
American Medical Association, 2001-present
American College of Radiology, 2001-present
Sociedad Iberoamericana de Intervención (SIDI), 2002-2006
Editorial Board Member of the Journal of SIDI, 2009-2010
Society of Interventional Radiology, 2003-present

American Roentgen Ray Society, 2007-present

Santa Cruz Medical Society, 2008-present

Member of the Board of Governors: 2012-13

Treasurer: 2013-14

President Elect 2014-15

CIRSE, 2009-2010

Hospital Affiliations

1. Dominican Hospital, Santa Cruz, CA. IR Medical Director. Vice Chair Radiology Department.

   Treasurer of Dominican Medical Staff, 2019-2020

   Vice Chief of Medical Staff, 2021—2022

   (Chief of Medical Staff, 2023-2024, voluntary resignation due to contract requirements at Natividad Medical Center)

2. Watsonville Community Hospital, Watsonville, CA

3. Natividad Medical Center, Salinas, CA

Employment History

1. 2006-2007; Employee, Radiology Medical Group of Santa Cruz, CA
2. 2007-present; Partner, Radiology Medical Group of Santa Cruz, CA
3. 2010-present; IR Medical Director, Dominican Hospital, Santa Cruz, CA
4. 2013-present; Vice Chair Radiology Department, Dominican Hospital, Santa Cruz, CA
5. 2012-2013; Locums at El Camino Hospital, IR section (3 weeks total, mostly weekends)
6. 2014-2018; Staff Radiologist at Hazell Hawkins in Hollister, California
7. 2016-2018: Staff Interventional Radiologist at Tri County Vascular Center, San Jose, CA

Lectures (CME 1 credit Lectures)

1. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. July 1, 2001

2. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. September 20, 2001

3. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. October 18, 2001

4. "Rad-Path Conference." LSUHSC-S Department of Radiology. January 7, 2002

5. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. January 17, 2002

6. "Traumatic Aortic Injuries." LSUHSC-S Department of Surgery, Trauma Conference. February 1, 2002

7. "Interesting Cases." LSUHSC-S Department of Radiology MIDAT Conference. March 25, 2002

8. "Radiology Spring Research Conference." LSUHSC-S Department of Radiology. April 4, 2002

9. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. April 18, 2002

10. "Rad-Path Conference." LSUHSC-S Department of Radiology. May 6, 2002

11. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. May 30, 2002

12. "Rad-Path Conference." LSUHSC-S Department of Radiology. June 3, 2002

13. "Radiology Grand Rounds Conference." LSUHSC-S Department of Radiology. June 27, 2002

14. "Radiology Grand Rounds Conference: Pneumobilia vs. Portomesenteric Venous Gas, Review of Recent Cases". LSUHSC-S Department of Radiology. August 15, 2002

15. "Traumatic Aortic Injuries: The Endovascular Therapeutic Option" LSUHSC-S Department of Radiology MIDAT Conference. August 26, 2002

16. "Anatomy of the Chest, Radiologic Correlation" Lecture given to medical students at LSUHSC-S, September 3, 2002

17. "Rad-Path Conference." LSUHSC-S Department of Radiology. October 7, 2002

18. "Rad-Path Conference." LSUHSC-S Department of Radiology. February, 2003

19. "Cases of the Month Conference" LSUHSC-S Department of Radiology. March, 2003

20. "Traumatic Aortic Injuries: Revision of Recent Cases Treated by Endovascular Technique" LSUHSC-S Department of Radiology MIDAT Conference. May, 2003

21. "Neuroradiology: Intraventricular Lesions" LSUHSC-S Department of Radiology. August 28, 2003

22. "Acute Radiology: Gun Shot Injuries" LSUHSC-S Department of Radiology. September 10, 2003

23. “Rad-Path Conference.” LSUHSC-S Department of Radiology. February, 2004

24. “Radiologic Imaging in Child Abuse” 1st Annual Radiology for the Non-Radiologist, March 20, 2004

25. “Acute Abdomen in Infancy and Childhood” 1st Annual Radiology for the Non-Radiologist, March 20, 2004

26. “Cases of the Month Conference” LSUHSC-S Department of Radiology. June, 2004

27. “Pelvic Imaging” Lecture given to first year medical students at LSUHSC, Shreveport, September 28th, 2004.

28. “Interventional Radiology for Physician Assistants” Lecture given to physician assistants at LSUHSC, Shreveport, September 30th, 2004.

29. Abdominal Imaging for Physician Assistants” Lecture given to physician assistants at LSUHSC, Shreveport, November 18th, 2004.

30. “Hepatobiliary Interventions” Dominican Hospital Grand Rounds, Santa Cruz, September 2006.

31. “Endovascular treatment of Abdominal Aortic Aneurysms” Dominican Hospital Grand Rounds, Santa Cruz, December 2006.

32. “Deep Venous Thrombosis, Endovascular treatment” Dominican Hospital Grand Rounds, Santa Cruz, October 2007.

33. “Diagnostic Imaging 2008” Dominican Hospital Grand Rounds, Santa Cruz, August 2008.

34. “IVC Filtration” Dominican Hospital Grand Rounds, Santa Cruz, August 2009.

35. “Imaging of Gunshot Wound Injuries” Dominican Hospital Grand Rounds, Santa Cruz, April 2010.

36. “Radiation Protection” Dominican Hospital, March 2012.

37. “Radiation Protection II” Dominican Hospital, March 2013

38. “Enteral Nutrition, IR Service. Why me? Dominican Hospital, March 2013

39. “Why treat sub massive pulmonary embolism aggressively” Palo Alto Medical Foundation Invited Guest Lecture, Santa Cruz, June 2014.

40. “Interventional Oncology at Dominican Hospital” Seascape Lecture, Santa Cruz, April 2017

41. “Introduction to Interventional Radiology Services to Primary Care Physicians” Dignity Medical Foundation Lecture, September 2021

Publications/Articles

1. Malik A, Odita J, **Rodríguez J**, Hardjasudarma M. Pediatric Neck Masses: A Pictorial Review for Practicing Radiologists. *Curr Probl Diagn Radiol.* 2002; July/August: 146-157.

2. **Rodríguez JR**, Malik A: Pelvis Lipomatosis, a case report. *Applied Radiology,* April 2003; 32(4).

3. De Gregorio MA, Mainar A, **Rodríguez J,** Alfonso ER, Tejero E, Herrera M, Medrano J, D'Agostino H: Colon Stenting: A Review. *Seminars in Interventional Radiology* Sept 2004; 21 (3): 205-216

4. De Gregorio MA, Gimeno MJ, Medrano J, Schönholz C, **Rodríguez J**, D'Agostino H: Ileocolic Arteriovenous Fistula with Superior Mesenteric Vein Aneurysm: Endovascular Treatment. *Cardiovasc Intervent Radiol.* 2004 Sep-Oct; 27(5): 556-9

5. De Gregorio MA, D'Agostino H, Gimeno MJ, Mainar A, Schönholz C, Alfonso ER, **Rodriguez J,** Tejero E: Transanal colonic stent implanted under fluoroscopy guidance and guided by fluoroscopy assisted by endoscopy. Comparative study. *Journal of the Iberoamerican Society of Intervention*. July 2003.

6. **Rodriguez JR**, Mailk A, Hardjasudarma M: Acute Prevertebral Calcific Tendinitis. *Applied Radiology*, September 2004; 33(9).

7. **Rodriguez, Juan MD**; Heldmann, Maureen MD; Sittig, Kevin M. MD; Modi, Kalgi MD; Reddy, Madhusudhan P. MD: Superior Vena Cava and Right Atrial Thrombus Detected on Lung Perfusion Scintigraphy. *Clinical Nuclear Medicine*. 30(9):619-620, September 2005.

8. Mendrek M, **Rodriguez JR**, Hardjasudarma M: Traumatic Rupture of the Gallbladder. *Applied Radiology*, Volume: 35 Number: 9; September 2006.

Book Chapters

1. D'Agostino HR, Sangster G, de Gregorio Ariza MA, **Rodríguez Viňuales JR**: Biopsies. Tumor ablation. Percutaneous drainage of fluid collections. Neurolysis. Cyst sclerosis. Chapter 28. In Carreira Villamor JM, Maynar Moliner M (Eds). *Diagnóstico y Terapéutica Endoluminal. Radiología Intervencionista*, 1st ed. Barcelona: Masson; 2002: 704-718.

2. **Rodríguez JR**, D'Agostino HR, Schönholz C, Malik A. Percutaneous Drainage of pulmonary collections. In de Gregorio Ariza MA (Ed). *Técnicas Intervencionistas en el Tórax.* 2nd ed. Zaragoza: Editorial Aqua; 2003: 106-117

Exhibits (including presentations and posters)

1. Zaritzky MF, Szulman C, De la Torre H, Donaldson JS, **Rodríguez J**, D'Agostino HR. *Role of Percutaneous Drainage in Multidisciplinary Management of Pancreatic Fluid Collections in Children: Indications, Technique, and Results.* 87th Scientific Assembly and Annual Meeting of the Radiological Society of North America. November 2001.

2. D'Agostino HB, Schönholz C, **Rodríguez J**, Malik A, Zamani R. *Outcome of Image-Guided Drainage of Fluid Collections Complicating Pancreatitis of uncommon Etiology.* 27th Annual Scientific Meeting of the Society of Cardiovascular and Interventional Radiology. April 2002.

3. D'Agostino HB, Schönholz C, **Rodríguez J**, Sittig K, Fotoohi M, vanSonnenberg E. *Multidisciplinary Management of Postoperative/ Blunt Trauma Pancreatic Fluid Collections: Experience in 43 patients.* 27th Annual Scientific Meeting of the Society of Cardiovascular and Interventional Radiology. April 2002.

4. D'Agostino HB, Venable D, Jimenez M, de Gregorio Ariza MA, Guerrini N, Schönholz C, **Rodríguez J**. *Percutaneous Videoendoscopy-Assisted Removal of Necrotic Debris from Pancreatic Fluid Collections.* 27th Annual Scientific Meeting of the Society of Cardiovascular and Interventional Radiology. April 2002.

5. Anil Malik MD, Chandana Lall MD, Girish Agrawal MD, **Juan Rodríguez** MD, Horacio D'Agostino. *Multiplanar Imaging of Abdominal Wall, "a Radiological Spectrum of Disease Entities beyond the Ventral Hernia"*. 102nd Annual Meeting of the American Roentgen Ray Society. Atlanta April-May, 2002.

6. Anil Malik, John C. Odita, **Juan Rodríguez,** Arun Pramanik. *Radiologic Imaging of Iatrogenic Complications in Newborn Infants.* 88th Scientific Assembly and Annual Meeting of the Radiological Society of North America; 2002

7. Claudio Schönholz, **Juan Rodríguez,** Grady Yoder, Lou Smith, and Horacio D'Agostino. *Endovascular management of life-threatening hemorrhage in a Trauma I Center Hospital.* XVI International Congress of Endovascular Interventions. Phoenix, Arizona; February 9-13, 2003.

8. **Rodríguez J.**; Braud J.; Burrel M.; Schönholz C.; Zibari G.; D'Agostino H. *Multidisciplinary Strategy for Management of Pancreatic Fluid Collections: Experience in 120 Cases.* 103rd Annual Meeting of the American Roentgen Ray Society. San Diego, May 2003.

9. **Rodríguez J.**; Stein E.B.; Nall L.; Dowden K.; Braud J.; Schönholz C, D'Agostino H. *Approach and Outcome of Patients with Nondiagnostic Fine Needle Biopsy.* 103rd Annual Meeting of the American Roentgen Ray Society. San Diego, May 2003.

10. D'Agostino H.; Braud J.; Burrel M.; **Rodríguez J**.; Schönholz C.; Sittig K. *Recurrence and Failure of Percutaneous Drainage of Pancreatic Fluid Collections in 118 patients.* 2003 Society of Interventional Radiology Annual Meeting. Salt Lake City, Utah.

11. De Gregorio MA, Schönholz C, **Rodríguez J**, Pueyo J, Cano C, De Blas M, Julia J, Montaña J, Reyes Palmero JR, Tobio R, Trueba J.: Preliminary Results of the Spanish Multicenter Herculink Plus® Renal Stent Study: the Euripides trial. Submitted to XVII International Congress of Endovascular Interventions. Phoenix, Arizona; February 2004.

12. Gonzalez-Toledo E, **Rodríguez J**: MR Physics, at www.wfns.org

13. Gonzalez-Toledo E, **Rodríguez J**: MR Spectroscopy, at www.wfns.org

14. Grady Yoder MD, **Juan Rodríguez MD**, Travis Henley MD, et al: *Magnetic Resonance Imaging as the Initial Modality for Detection and Diagnosis of Stroke.* Annual Meeting, American Society of Emergency Radiology. Las Vegas, October 2003

15. **Juan Rodríguez MD**, Claudio Schönholz MD, Miguel Ángel de Gregorio MD, Grady Yoder MD, Anil Malik MD Lou Smith MD, Horacio D'Agostino MD: *Manejo Endovascular de la Hemorragia de causa*

Yatrogénica y Traumática. VI Convención Nacional de Médicos Hispanoperuanos. Zaragoza, Spain. October 2003

16. Braud JA, **Rodríguez J**, Schönholz CJ, Zibari G, Burrel M, D'Agostino HB: *The Evolution of Image-guided Treatment of Pancreatic Fluid Collections: Broadening the Scope of Patient Care.* 89th Scientific Assembly and Annual Meeting of the Radiological Society of North America; 2003

17. Pilat M, **Rodríguez J**, Lemoine N, Black G, Schnöholz C, D'Agostino H: *A Comparison of Two Different Pathways for Core Liver Biopsy: Is Patient Admission Necessary?* Annual Meeting, Society of Interventional Radiology. Phoenix, Arizona 2004

18. D'Agostino HB, **Rodríguez J,** Schönholz C, Martinez R, Sangster GP, D'Agostino AM: *Nasojejunal and Gastrojejunostomy Enteral Feeding for Acute Pancreatitis: Experience in 40 Patients.* Annual Meeting, Society of Interventional Radiology. Phoenix, Arizona 2004

19. Schönholz C, **Rodríguez J,** D'Agostino HB, Krajcer MA, DeGregorio MA, Parodi J: *Stent Graft Technique for Carotid Artery Injuries: Report on 15 Patients.* Annual Meeting, Society of Interventional Radiology. Phoenix, Arizona 2004

20. **Rodríguez J,** Yoder, G, Hurvitz D, Schönholz C, D'Agostino HB: *Endovascular Treatment of Traumatic and Iatrogenic Arterial Injuries Using Stent-Grafts.* 105th Annual Meeting of the American Roentgen Ray Society. New Orleans, May 2005

21. Ketkar, M, **Rodríguez J**, Karim, A, Fowler M, Hardjasudarma M, Nanda A, Gonazalez-Toledo, E: *Report of a Rare Case of High-Grade Leiomyosarcoma of the Skull.* 43rd Annual Meeting of the American Society of Neuroradiology, Toronto, May 2005

22. **Rodriguez J.** DVT Intervention, Shaping Referrals Patterns, and the Role of Technologist. AVIR; 22nd Annual Scientific Meeting. San Francisco; March 27th, 2012

PRACTICE QUALITY IMPROVEMENT PROJECTS

1. Radiation Dose Registration in IR Section, 2010- present

2. IVC Filter Registry, 2011-present

3. Dose Reduction for CT Guided Interventions, 2012

4. Patient Surveys in IR Section, annual analysis since 2010

5. Lung Cancer Screening Program Director at Dominican Hospital, 2014-present

6. Member of Cancer Committee, Dominican Hospital, 2012-present

7. Physician Advisory Committee, Dominican Hospital, 2018-2022

8. Co-director of Pulmonary Embolism Response Team, Dominican Hospital. 2018-present

Board Paper: Personnel, Pension and Investment Committee

Agenda Item: **Consider Recommendation for Board Approval of Findings Supporting Recruitment of Physicians to Monterey Bay GI Consultants Medical Group and Approval of Recruitment Incentives**

Executive Sponsor: Allen Radner, MD, Chief Medical Officer, Salinas Valley Health
Gary Ray, Chief Administrative Officer, Salinas Valley Health Clinics

Date: October 24, 2023

Executive Summary

In consultation with members of Salinas Valley Health (SVH) medical staff, and in compliance with requirements of Stark Law, SVH executive management has identified the recruitment of physicians in certain medical specialties as a recruiting priority for the hospital's service area.

The Medical Staff Development Plan, completed by ECG Management Consultants in January 2023, identified the specialty of Gastroenterology as a priority for recruitment. Furthermore, the opening of the new Monterey Bay Endoscopy Center, located near the SVH Medical Center, has resulted in an increased demand for gastroenterology services in Salinas.

To support physician recruitment to the District's service area, SVH collaborates with local medical groups and practices in the recruiting process through contributions to incentives paid to physicians that relocate to our community.

Monterey Bay GI Associates Medical Group (MBGI) has requested financial support in the form of recruitment incentives to recruit two gastroenterologists into the District's service area.

Financial support for each of these recruitments consists of $25,000 in incentive payments to the recruited physicians. The incentives will be structured as forgivable loans over two years of service with SVH.

Required Documents

The proposed physician recruitments will require the execution of a Physician Recruitment Agreement among SVH, the MBGI, and the Physicians. A template of the Physician Recruitment Agreement is attached for your review.

Meeting our Mission, Vision, Goals

Strategic Plan Alignment

The recruitment of certain specialty physicians is aligned with our strategic priority for growth. We continue to support the local community physicians and private practice offices that provide care to our patients both in the hospital and the clinics. This investment provides a platform for growth that can be developed to better meet the needs of the residents of our District by increasing access to necessary care.

Pillar/Goal Alignment:

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

Financial/Quality/Safety/Regulatory Implications

The addition of gastroenterologists to the community has been identified as a need for recruitment and demonstrates the support from Salinas Valley Health to community practices. The recruitment incentive proposed for the recruitments is within fair market value and is commercially reasonable.

Recommendation

Administration requests that the Personnel, Pension and Investment Committee recommend to the SVH Board of Directors to take the following actions:

(i) The Board makes the following findings supporting the recruitment of the physicians in the specialty of gastroenterology:

- **The assistance by SVH in the recruitment of physicians in the specialty of gastroenterology by Monterey Bay GI Associates Medical Group is in the best interest of the public health of the communities served by the District; and**
- **The recruitment incentives requested by Monterey Bay GI Associates Medical Group and supported by SVH for these recruitments are necessary in order to attract and relocate appropriately qualified physicians to practice in the communities served by the District.**

(ii) Approve the recruitment support to Monterey Bay GI Associates Medical Group and the recruitment incentives for the medical specialty of gastroenterology to be set forth in Recruitment Agreements among SVH, the Monterey Bay GI Associates Medical Group, and the physicians.

Attachments:

- SVH Physician Recruitment Agreement

SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM
PHYSICIAN RECRUITMENT AGREEMENT

(*physician* and *group*)

This Physician Recruitment Agreement ("Agreement") is made effective on _____ ("Effective Date"), by and among **Salinas Valley Memorial Healthcare System**, a local health care district organized and operating pursuant to Division 23 of the California Health & Safety Code, operating as Salinas Valley Health ("SVMHS"), _____, a physician ("Physician") specializing in _____ ("Specialty"), and _____, a California professional medical corporation ("Group"). SVMHS, Physician, and Group are referred to as the "Parties" and individually as a "Party."

RECITALS

A. SVMHS owns and operates Salinas Valley Health Medical Center, a general acute care hospital located at 450 East Romie Lane, Salinas, California ("Hospital"). SVMHS provides health care services to residents of the district and surrounding communities ("Service Area"). Group is a California professional medical corporation providing medical services in the Service Area. Physician intends to practice Physician's Specialty with Group in the Service Area.

B. SVMHS has determined that there is a shortage of, and a need for, physicians specializing in Physician's Specialty in the Service Area. The shortage of such physicians jeopardizes SVMHS's ability to provide such health care services to residents of the Service Area. SVMHS also has determined that such shortage is not likely to resolve itself through market forces, but that financial support is needed if the appropriate physician is to relocate to the Service Area.

C. To facilitate its goal of providing medical services in the Service Area, SVMHS has determined that it must provide certain incentives in order to enable a physician specializing in Specialty to join a medical practice in the Service Area. SVMHS has determined that the incentives set forth in this Agreement meet a community need and promote SVMHS's mission and goal of providing health care services to all residents in the Service Area who need such care.

D. Physician is duly licensed to practice medicine in the State of California and is qualified to provide medical services in Physician's Specialty ("Professional Services"). Physician is prepared to join Group in order to practice in the Service Area and to provide Professional Services, in return for the financial assistance provided in this Agreement.

E. SVMHS has determined that the financial assistance required by Physician to relocate is justified by the benefit to patients in the Service Area. Accordingly, SVMHS is prepared to offer financial assistance to Physician under the terms and conditions set forth in this Agreement. Physician hereby acknowledges and agrees that the financial assistance provided by SVMHS under this Agreement is reasonable and not in excess of fair market value, which is not determined in a manner that takes into account the volume or value of any actual or anticipated referrals by Physician or Group to Hospital. Physician and SVMHS shall enter into an unsecured Promissory Note, attached as Exhibit A to this Agreement, for any payments made under this Agreement.

F. SVMHS, Physician, and Group wish to enter into this Agreement in order to set forth a full statement of the terms of this recruiting arrangement, which all Parties acknowledge is necessary in order to allow Physician to relocate to the Service Area and to provide Professional Services to its residents.

The Parties agree as follows:

Article 1 Duties of Physician and Group

1.1 Full-Time Practice. Physician shall conduct a full-time practice with Group in Physician's Specialty within the Service Area as determined by Hospital, with Group's practice location being the Hospital which is open twenty-four (24) hours a day, seven (7) days a week. Physician shall commence Physician's practice with

Group in accordance with this Agreement on or about _____ ("**Start Date**"). Physician shall comply with the requirements of this Agreement in order for Physician to begin practicing on the Start Date.

1.2 Services to Patients, Billing, and Collection. Physician shall provide services under this Agreement to all patients presenting at Hospital including privately insured, Medicare, Medi-Cal, and uninsured patients at a level which is at least consistent with the custom and practice in the community. Group shall be responsible for billing and collecting for Physician's Professional Services on a timely, consistent, accurate, and commercially reasonable basis.

1.3 Employment by Group. Physician has selected Group with whom Physician intends to be employed in the practice of Physician's Specialty. Physician has agreed to this employment voluntarily and without inducement or influence of SVMHS. Physician shall use reasonable, good-faith efforts to maintain this employment during the term of the Agreement. The termination of Physician's employment shall not in any way affect Physician's, Group's, or SVMHS' obligations under this Agreement.

1.4 Duties of Group. Group shall use best effort to provide Physician with a stable, productive work environment and shall take steps reasonably necessary to promote the growth of Physician's practice.

Article 2 Standards

2.1 Licensure and Board Certification. Physician shall maintain California licensure in good standing during the term of this Agreement. Physician shall be board certified or board eligible in Specialty during the term of this Agreement.

2.2 Medical Staff Standing and Hospital Regulations. Physician shall be responsible for obtaining and maintaining membership on the Hospital's Medical Staff with active Status and appropriate privileges, and shall be subject to all of the responsibilities of that membership. Subject to Section 4.4 below, in the event Physician loses active Medical Staff membership or necessary privileges, this Agreement shall terminate immediately, and any sums owed by Physician to Hospital under this Agreement shall become due and payable immediately. Physician shall at all times comply with all applicable bylaws, rules and regulations, and policies of SVMHS, Hospital, and Hospital's Medical Staff.

2.3 Corporate Compliance Program. Group and Physician shall support and comply with Hospital's Corporate Compliance Program, as applicable to this Agreement. Group and Physician shall comply with all policies and procedures adopted by Hospital in support of the Corporate Compliance Program.

Article 3 Term & Termination

3.1 Term. The term of this Agreement shall commence on the Effective Date of this Agreement and continue until the later of two (2) years from the Start Date of this Agreement, or until all sums are repaid or forgiven under the terms of this Agreement.

3.2 Immediate Termination by SVMHS. SVMHS may terminate this Agreement immediately upon the occurrence of any of the following events: (i) loss or suspension of Physician's license to practice medicine; (ii) termination of Physician's Medical Staff Membership and/or hospital/clinical privileges; (iii) Physician's failure to maintain, for any reason, Physician's Medical Staff Membership at Hospital with appropriate privileges; (iv) restriction or suspension by the Hospital Medical Staff of Physician's privileges including an administrative suspension or summary suspension of privileges; (v) Physician's conviction (final or on appeal) of a felony or any crime involving moral turpitude; or (vi) Physician's appointment of a receiver for Physician's assets, assignment for the benefit of creditors, or any relief sought by him under any bankruptcy or insolvency act. In the event SVMHS terminates this Agreement pursuant to this Section 3.2, subject to Section 4.4 below, Physician shall pay any outstanding debt to SVMHS under this Agreement and any Related Agreements.

3.3 Termination Due to Total Disability. Either Party shall have the right to terminate this Agreement in the event of total disability of Physician. Physician shall be deemed to suffer a "total disability" if Physician becomes physically or mentally incapacitated for more than three (3) months as shown by inability to perform all or substantially all of the material obligations of this Agreement, and which disability is likely, in the opinion of a physician mutually designated by Physician and SVMHS, to persist for six (6) months

following the date of determination of said physician. The cost of a disability examination, if requested by SVMHS, shall be paid by SVMHS.

3.4 Termination Not Subject to Fair Hearing. It is agreed among the Parties that should this Agreement be terminated for any reason, such decision to terminate and actual termination shall apply to rights under this Agreement only and not to Physician's Medical Staff privileges or membership on the Medical Staff of Hospital. The termination of this Agreement shall not be subject to the Fair Hearing Plan of the Medical Staff Bylaws, any hearing procedures provided by Local Health Care District Law, or any other Fair Hearing procedures regarding medical staff appointments or privileges.

3.5 Effect of Termination. Following expiration or termination of the Agreement for any reason, the Parties shall cooperate in the resulting transition in a manner that serves the best interests of the patients of SVMHS. Termination of this Agreement shall have no effect on Physician's Medical Staff membership or clinical privileges at the Hospital, which will continue unless terminated in accordance with the Hospital's Medical Staff Bylaws. Termination of this Agreement shall not affect the obligation of Physician to repay money as otherwise provided in this Agreement.

Article 4 Recruitment Incentive

4.1 Recruitment Incentive. As part of the consideration for Physician entering into and complying with the terms and conditions of this Agreement and provided that Physician commences practice in the Service Area consistent with the terms of this Agreement by the Start Date, SVMHS shall pay to Physician a recruitment incentive in the amount of _____ **Dollars ($_____.00)** on or about the Effective Date of this Agreement. Physician agrees that (i) this amount is reasonable and necessary to secure Physician's relocation and Physician's services under this Agreement, (ii) this amount is not in excess of fair market value, and (iii) this amount is not made in consideration for the referral of patients by Physician or Group to SVMHS or its affiliates.

4.2 Repayment. If either Party terminates this Agreement prior to the expiration of two (2) years from the Start Date, Physician shall be obligated to repay to SVMHS a pro-rated amount of the payment advanced by SVMHS to Physician pursuant to Section 4.1 of this Agreement, plus interest at an annual rate equal to the most recent prime rate published in the Wall Street Journal (or any successor publication) from time to time ("Prime Rate"), plus one percent (1.0%), payable monthly.

For example, if this Agreement is terminated after ten (10) months, Physician shall repay to SVMHS 14/24ths of the recruitment incentive, plus ten (10) months of accrued interest at an annual rate equal to the Prime Rate, plus one percent (1.0%), payable monthly. Such repayment shall be made within ninety (90) days of the event triggering Physician's repayment obligation. If Physician fails to make such repayment to SVMHS within this ninety (90) day period, SVMHS shall have the right to increase the interest rate on the amount owed to SVMHS to the Prime Rate plus two percent (2%), beginning on the ninety-first day.

4.3 Promissory Note. At the time of payment to Physician of any amounts under this Agreement, Physician shall execute a Promissory Note substantially in the form attached to this Agreement as Exhibit A to secure repayment of any amounts paid to Physician under this Agreement which are not forgiven by SVMHS pursuant to the terms of this Agreement.

4.4 Debt Forgiveness Over Term of Agreement. If Physician has complied and is continuing to comply with all of the terms of this Agreement, SVMHS shall reduce and eliminate the debt due to SVMHS as follows: SVMHS shall forgive fifty percent (50%) of the recruitment incentive, including accrued interest, for each full year of physician services provided by Physician after the Start Date, such that the recruitment incentive will be forgiven upon the second (2nd) anniversary of Physician's Start Date.

4.5 Debt Forgiveness at Death/Disability. SVMHS shall forgive all sums advanced by SVMHS under this Agreement and accrued interest, in the event of Physician's death or permanent disability during the Term of this Agreement.

Article 5 General Provisions

5.1 Other Agreements. This Agreement may be one of several between SVMHS, Group, and/or Physician, dealing with different aspects of their relationships. SVMHS maintains a current master list of such agreements with Group and/or Physician, together with copies of the actual agreements, that is available for review by the Department of Health and Human Services in accordance with Stark Law regulations.

5.2 Referrals. Physician shall be entitled to refer patients to any hospital or other institution Physician deems qualified to deliver health care services to a particular patient. Nothing in this Agreement shall be deemed to require Physician or Group to refer patients to Hospital, and SVMHS may not terminate this Agreement because of Physician's or Group's referral decisions. No payment or other consideration is or will be made under this Agreement for the referral of patients to SVMHS or its affiliates.

5.3 Medical Staff Privileges. Throughout the term of this Agreement, and thereafter, Physician shall be permitted to maintain medical staff privileges at other area hospitals.

5.4 Waiver. The failure of SVMHS to insist in any one or more instances upon strict performance of any of the terms of this Agreement shall not be construed as a waiver or relinquishment for the future of such terms, but the same shall continue and remain in full force and effect.

5.5 Governing Law/Venue. This Agreement shall be interpreted in accordance with the laws of the State of California, and any questions arising under it shall be construed or determined in accordance with such laws. Jurisdiction and venue shall be in Monterey County, California.

5.6 Attorneys' Fees. In the event that suit is brought regarding the enforcement of the provisions of this Agreement, the prevailing Party/Parties shall be awarded its costs of suit and reasonable attorneys' fees as part of any judgment rendered.

5.7 Partial Invalidity. Should any part of this Agreement for any reason be declared invalid, such decision shall not affect the validity of the remaining portions which shall remain in effect as if this Agreement had been executed with the invalid portion eliminated.

5.8 Government Audit. Until the expiration of five (5) years after the furnishing of any services pursuant to this Agreement, Group and Physician shall make available to the Secretary of the United States Department of Health and Human Services or to the United States Comptroller General, or to any of their duly authorized representatives, upon written request of the same, this Agreement and such books, documents, and records of Group or Physician necessary to certify the nature and the reasonable cost of services of the Hospital.

5.9 Agreements between Physician and Group. Upon request by SVMHS, Group agrees to provide SVMHS with copies of its employment agreement with Physician. Nothing in Group's agreements with Physician shall be inconsistent with Physician's obligation to perform the terms and conditions of this Agreement. Group agrees that payments by SVMHS under this Agreement shall be for the benefit of Physician. Nothing in Group's agreements with Physician shall be inconsistent with the requirements Stark Law.

5.10 Income Tax Ramifications. The Parties acknowledge that Physician may incur federal and state income tax obligations from certain of the transactions provided for in this Agreement that SVMHS is required to report items of income under relevant income tax laws and regulations, and that forgiveness of debt may constitute income to Physician. It is Physician's responsibility to consult with tax advisors with respect to the filing of income tax returns and the tax treatment of items provided for in this Agreement.

5.11 Assignment. Except as otherwise agreed in writing by the SVMHS, nothing contained in this Agreement shall be construed to permit assignment or delegation by Physician of any rights or obligations under this Agreement, and any such assignment or delegation is expressly prohibited. This Agreement shall be binding upon and inure to the benefit of the successors and assigns of SVMHS.

5.12 Applicable Legal Standards. The Parties shall exercise their rights and perform their duties under this Agreement in accordance with the legal standards set forth in the United States Code, the Code of Federal Regulations, the California Health and Safety Code, the California Business and Professions Code, and any other pertinent and applicable laws, rules, regulations, and orders of the United States and the State of California and their agencies, to the extent that such laws, rules, regulations, and orders pertain to the powers, functions, and duties of SVMHS, Group, and Physician.

5.13 Confidentiality. The Parties agree that this Agreement is personal and confidential between them, and agree, unless otherwise required by law, not to release information concerning this Agreement, or any information exchanged between the Parties pursuant to this Agreement, to any person without the consent of the other Party, which consent shall not be unreasonably denied.

5.14 Notices. All communications and notices which any Party may be required or desire to give or serve upon any other Party under this Agreement shall be made in writing and shall be delivered in person or sent by registered or certified mail, return receipt requested, to the addresses below. Any Party may change its address by giving any other Parties written notice of its new address as provided in this Agreement.

SVMHS: Salinas Valley Health
Attn: President/Chief Executive Officer
450 East Romie Lane
Salinas, CA 93901

Physician: _____
c/o _____
_____
_____

Group: _____
_____
_____
_____

5.15 Conditions and Effective Date. This Agreement is subject to approval by the Board of Directors of SVMHS, which approval has not been secured and is not guaranteed. This Agreement shall be effective as of the later of the date the Board approves the Agreement and the date it is signed by all Parties.

5.16 Entire Agreement/Modifications. This Agreement constitutes the entire Agreement between the Parties with respect to the subject matter and supersedes any and all prior negotiations, understandings, and agreements. All modifications to this Agreement must be in writing and signed by the Parties.

The Parties have executed this Agreement as of the Effective Date first set forth above.

SVMHS
Salinas Valley Memorial Healthcare System

By:_____ Date:_____
Pete Delgado, President/CEO

PHYSICIAN
_____

_____ Date:_____
_____

GROUP
_____

By:_____ Date:_____

By:_____ Date:_____

EXHIBIT A

PROMISSORY NOTE
(Recruitment Incentive)

$_____.00 _____

FOR VALUE RECEIVED, the receipt of which is hereby acknowledged, _____ ("Maker") hereby promises to pay to the order of **Salinas Valley Memorial Healthcare System** ("Holder"), at the place designated by Holder, the principal sum of _____ **Dollars ($_____.00)**, plus accrued interest on such amount calculated at an annual fixed rate equal to the prime rate published on the effective date of this Promissory Note in the Wall Street Journal ("Prime Rate"), plus one percent (1%), from the date of this Promissory Note, payable in lawful money of the United States of America. Principal and interest shall be immediately due and payable to Holder on _____. Notwithstanding the foregoing, if Maker is and remains in full compliance with the **PHYSICIAN RECRUITMENT AGREEMENT** effective _____, by and between Maker and Holder ("Recruitment Agreement"), the principal and interest due under this Promissory Note shall be forgiven pursuant to the terms and conditions of the Recruitment Agreement.

This Promissory Note is unsecured. In no event shall any payment of interest or any other sum payable hereunder exceed the maximum amount permitted by applicable law. If it is established that any payment exceeding lawful limits has been received, Holder will refund such excess or, at its option, credit the excess amount to the principal due hereunder, but such payments shall not affect the obligation to make periodic payments required herein.

Maker agrees to pay, to the extent permitted by law, all costs and expenses incurred by Holder in connection with the collection and enforcement of this Promissory Note, including, but not limited to, expenses and reasonable attorneys' fees to the extent permitted by applicable law, irrespective of whether any suit or security foreclosure or court proceeding has been commenced. Maker and all endorsers and all persons liable or to become liable on this Promissory Note, and each of them, hereby waive diligence, demands, presentation for payment, notice of nonpayment, protest and notice of protest, and specifically consent to and waive notice of any renewals or extensions of this Promissory Note, or any modification or release of security for this Promissory Note, whether made to or in favor of Maker or any other person or persons, and further agree that any such action by Holder shall not affect the liability of Maker or any person liable or to become liable on this Promissory Note.

No delay or omission by Holder in exercising any remedy, right or option under this Promissory Note shall operate as a waiver of such remedy, right or option. In any event, a waiver on any one occasion shall not be construed as a waiver or bar to any such remedy, right or option on a future occasion. The invalidity of any one or more covenants, phrases, clauses, sentences or paragraphs of this Promissory Note shall not affect the remaining portions hereof, and this Promissory Note shall be construed as if such invalid covenants, phrases, clauses, sentences or paragraphs, if any, had not been included herein.

This Promissory Note is to be construed in all respects and enforced according to the laws of the State of California. This Promissory Note may not be amended or modified except by a written agreement duly executed by Maker and Holder. This Promissory Note and the obligations created hereby shall bind Maker and, to the extent applicable, Maker's respective successors and assigns, and the benefits hereof shall inure to Holder and its successors and assigns. This Promissory Note may be assigned by Holder in its sole discretion.

Any notice to Maker under this Promissory Note shall be in writing and shall be deemed to have been given upon (i) receipt, if hand delivered, (ii) transmission, if delivered by facsimile transmission, (iii) the next business day, if delivered by express overnight delivery service or (iv) the third business day following the day of deposit of such notice in U.S. certified mail, return receipt requested to the following address:

_____
_____
_____
_____

Maker has executed and delivered this Promissory Note effective as of the date first set forth above.

MAKER:_____ Date:_____

TRANSFORMATION, STRATEGIC PLANNING AND GOVERNANCE COMMITTEE

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

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

(ROLANDO CABRERA, MD)

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

RECOMMENDATION

The Transformation, Strategic Planning and Governance Committee Recommends the Board of Directors Consider Approval of the Organizational Goals FY 2024.

Medical Executive Committee Summary – October 12, 2023

Items for Board Approval:

Credentials Committee

Initial Appointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Hussain, Asad, MD	Psychiatry	Medicine	Tele-Psychiatry
Pohl, John, MD	Radiology	Surgery	Remote Radiology Center for Advances Diagnostic Imaging (CADI) at Ryan Ranch: Remote Teleradiology/Radiology
Sandhu, Surinder, MD	Internal Medicine	Medicine	Adult Hospitalist
Hussain, Asad, MD	Psychiatry	Medicine	Tele-Psychiatry

Reappointments:

APPLICANT	SPECIALTY	DEPT	PRIVILEGES
Barghouthi, Tamara, MD	Neurology	Medicine	Tele-Neurology
Dickey, James W., MD	General Surgery	Surgery	General Surgery Regional Wound Healing Center
Dimitrov, Dragan, MD	Neurosurgery	Surgery	Neurological Surgery
Dorantes, Miguel, MD	Family Medicine	Family Medicine	Taylor Farms Family Health & Wellness Center Active Community
Ganzhorn, Frank, MD	Pulmonology/ Critical Care	Medicine	Critical Care/Pulmonary Medicine General Internal Medicine
Greenson, Nikolas, MD	Emergency Medicine	Emergency Medicine	Emergency Medicine
Harrison, Amy, MD	Neurology	Medicine	Tele-Neurology
Le, Michael, MD	Gastroenterology	Medicine	Gastroenterology General Internal Medicine Taylor Farms Family Health & Wellness Center – Gastroenterology
Luba, Daniel, MD	Gastroenterology	Medicine	Gastroenterology Taylor Farms Family Health & Wellness Center – Gastroenterology
Romero-Beltran, Pablo, MD	Family Medicine	Family Medicine	Family Medicine Well Newborn
Vu, Quang, MD	Neurology	Medicine	Tele-Neurology
Zupancic, Michael, MD	Neurology	Medicine	Neurology

Staff Status Modifications:

NAME	SPECIALTY	STATUS	RECOMMENDATION
Conner, Grant, MD	Otolaryngology	Provisional	Recommend advancement to Active status.
Howard, Mark, MD	Spine Surgery	Active	Resignation effective 10/31/2023
Jordan, Patrick, DPM	Podiatry	Active	Resignation effective 10/21/2023
Kamler, Jan, MD	Gastroenterology	Provisional	Recommend provider remain as Provisional status.
Klein, Mark, MD	Pulmonology	Active Community	Recommend Emeritus Staff effective 10/26/2023.
Liu, Cici, MD	Gynecologic Oncology	Provisional	Recommend advancement to Active status.
Manassarians, Henrick, MD	Neurology	Telemedicine	Resignation effective 9/5/2023

Rocha-Cabrero, Franklyn, MD	Neurology	Provisional	Recommend advancement to Active status.
Trieu, Chuyen, MD	Pediatrics	Active	Move to Active Community effective 10/01/2023.
Wahl, Gerald, MD	Neurology	Senior Active	Move to Emeritus Staff effective 10/26/2023.
Wilson, Hugh, MD	Pathology	Leave of Absence	Return from Leave of Absence effective 11/15/2023.

Other Items:

Clinical Privileges Delineation Plastic & Reconstructive Surgery – Revision	The Committee recommended approval of the revision to the clinical privilege delineation for Plastic & Reconstructive Surgery – Revision (addition of Regional Wound Care Center to Special Procedures/Privileges).
Clinical Privileges Delineation General And Colorectal Surgery	The Committee recommended approval of the revision to the clinical privilege delineation for General And Colorectal Surgery (addition of Regional Wound Care Center to Special Procedures/Privileges) – Revision.
Clinical Privileges Delineation Orthopedic Surgery	The Committee recommended approval of the revision to the clinical privilege delineation for Orthopedic Surgery (addition of Regional Wound Care Center to Special Procedures Procedures/Privileges) – Revision.
Clinical Privileges Delineation Podiatry	The Committee recommended approval of the revision to the clinical privilege delineation for Podiatry (addition of Regional Wound Care Center to Special Procedures Procedures/Privileges) – Revision.
Clinical Privileges Delineation Regional Wound Healing Center – Revision	The Committee recommended approval of the revision to the clinical privilege delineation for Regional Wound Healing Center – Revision.

Interdisciplinary Practice Committee

Initial Appointment:

NAME	SPECIALTY	DEPARTMENT	SUPERVISOR(S)
Keung, Michelle, PA-C	Gastroenterology	Medicine	Daniel Luba, MD; Michael Mendoza, MD; Richard Hell, MD; Anthony Razzak, MD

Reappointment:

NAME	SPECIALTY	DEPARTMENT	SUPERVISOR(S)
Romans, Helena, NP	Surgery	Surgery	Jeremy Silk, MD

Staff Status Review:

NAME	SPECIALTY	STATUS	CHANGE
Chen, Bryant, PA-C	Physician Assistant - Emergency	Advanced Practice Provider	Resignation effective 9/17/2023

Policies, Plans and Privilege Forms: *(Attached)*

1. Plastic & Reconstructive Surgery Clinical Privilege Delineation Revision
2. General and Colorectal Surgery Clinical Privilege Delineation Revision
3. Orthopedic Surgery Clinical Privilege Delineation Revision
4. Podiatric Surgery Clinical Privilege Delineation Revision
5. Regional Wound Healing Center Clinical Privilege Delineation Revision
6. Hazardous Materials & Waste Management Plan - Update
7. Withdrawing Life Sustaining Treatment - Update

Informational Items:

I. Order Sets/Treatment Plans Approved:

Treatment Plans	
Home Med Admin: Xgeva (Denosumab) 120 mg, Q12Wks	Osteoporosis or Osteopenia related to cancer treatment
Home Med Admin: Leuprolide (Leupron or Eligard) 22.5 mg, Q3Months	Prostate Cancer
Gemcitabine/OXALIplatin/PACLitaxel, Q21D (TES11)	Testicular Cancer
Dacarbazine 1,200 mg/m2, Q21D	Soft Tissue Sarcoma
Order Sets	
Opiate Withdrawal - Day 1,2	
Opiate Withdrawal - Day 1,3	
Opiate Withdrawal - Day 1,4	
Opiate Withdrawal - Day 1,5	
Opiate Withdrawal - Day 1,6	
Opiate Withdrawal - Day 1	
Opiate Withdrawal - Day 2 and beyond	

II. Proposed General Rules and Regulations Amendments – Pending General Medical Staff Vote

a. 2.3 Responsibility of the Attending Provider
b. 7.1-16 Emergency Call Panel
c. 7.A Section C Termination of Proctorship

III. Medical Staff Appointments to Board Committees 2024:

a. Personnel and Pension: Glenn Berry, MD
b. Strategic Planning: Nikolas Greenson, MD
c. Community Advocacy: Jaime Gonzalez, MD

IV. Committee Reports:

a. Credentials Committee
b. Interdisciplinary Practice Committee
c. Medical Staff Excellence Committee
d. Quality and Safety Committee Reports:
    - Chest Pain/STEMI Program
    - Risk Management – Culture of Safety – BETA HEART
    - Safety and Reliability Committee – Accreditation and Regulatory
    - Restraints Committee
    - Fall 2023 Leapfrog Update
e. Environment of Care Committee
f. Pharmacy and Therapeutics Committee

V. Other Reports:

a. Summary of Executive Operations Committee Meetings
b. Summary of Medical Staff Department/Committee Meetings – September 2023
c. Medical Staff Treasury Report – October 5, 2023
d. Medical Staff Statistics Year to Date
e. HCAHPS Update – October 4, 2023

Clinical Privileges Delineation
Plastic & Reconstructive Surgery

Applicant Name: _____

Qualifications:

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

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

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

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

Applicants more than two years out of Residency training must provide documentation of the performance of at least 100 plastic and reconstructive surgery procedures during the past 12.

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

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

Plastic and Reconstructive Surgery Core Privileges

Admit, evaluate, diagnose, provide consultation to patients presenting with congenital and/or acquired defects of the body's musculoskeletal system, craniomaxillofacial structures, hand, extremities, breast and trunk and external genitalia and soft tissue including the aesthetic management. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Plastic & Reconstructive Surgery Core Proctoring Requirements:

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

Reappointment Criteria for Plastic Surgery Core Privileges:
Continued board certification and documentation of successful performance of at least 200 plastic surgery procedures in the past 24 months.

Hand Surgery Core Privileges

To be eligible to apply for core privileges in Hand Surgery, the applicant must meet the following qualifications:
Current board certification in surgery, plastic surgery or orthopedic surgery and post graduate training in hand surgery or subspecialty certification in hand surgery (Certificate of Added Quality in Hand Surgery) by the American Board of Surgery, Plastic Surgery or Orthopedic Surgery,
Or
• Successful completion of an ACGME accredited post-graduate training program in surgery, orthopedic or plastic surgery that included training in surgery of the hand
And
Evidence of successful performance of at least 75 cases in the previous 2-years.

Hand Surgery Core Proctoring Requirements:
Core proctoring requirements include direct observation or concurrent review as per proctoring policy contained in the Medical Staff General Rules and Regulations and at least one hand surgery procedure.

Reappointment Criteria for Hand Surgery Core Privileges:
Continued Board Certification and documented successful performance of at least 24 hand procedures in the past 24 months.

Hand Surgery Core Privileges

☐ **Requested**

Admit, evaluate, diagnose, treat, provide consultation and perform surgical procedures for patients presenting with diseases, injuries, and disorders, both congenital and acquired, of the hand, wrist and related structures. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Microsurgery Core Privileges

To be eligible to apply for core privileges in Microsurgery, the applicant must meet the following qualifications:
Board certification/eligibility in General Surgery or Orthopedic Surgery with a Microsurgery Fellowship,
OR
Completion of an accredited postgraduate training program in Plastic Surgery

Applicants more than two years out of Fellowship training must provide documentation of the successful performance of at least 50 varied microsurgery cases in the previous 2 years

Policy: 1 surgeon is required for one digit. For 2+ digits, hand, arm, leg, or foot a second microsurgeon must be present. For penile microsurgery 1 microsurgeon and 1 urologist must be present.

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

Reappointment Criteria for Core Microsurgery Core Privileges:
Continued Board Certification and documented evidence of the successful performance of at least 10 microsurgery procedures in the past 24 months.

Microsurgery Core Privileges

☐ **Requested**

Admit, evaluate, diagnose, treat, provide consultation and perform microsurgical procedures such as replantation of amputated parts and free tissue transfer flaps with microvascular anastomosis.

Special Procedures/Privileges

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

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

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				Surgical correction of cleft lip and palate deformities and correction of those craniofacial deformities not requiring an intracranial approach	Documentation of formal training that included these procedures **AND** Documentation of successful performance of at least 25 of these combined procedures within the past 24 months.	1	Successful performance of at least ten (10) procedures within the past 24 months.
				Craniofacial Reconstruction	Successful completion of accredited post-graduate training program in surgery or plastic surgery **AND** Successful completion of a 1 year accredited fellowship in Craniofacial Reconstruction **AND** Evidence of successful performance of at least 50 cases within the past 24 months	1	Successful performance of at least 20 procedures during within the past 24 months.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Orthognathic Surgery	Successful completion of an accredited postgraduate training program in Plastic Surgery that included training in orthognathic surgery **AND** Evidence of successful performance of at least 10 cases within the past 24 months.	N/A	Successful performance of at least five (5) procedures during within the past 24 months.
				Resection of parotid tumors	Documented successful performance of a minimum of 10 procedures within the past 24 months	N/A	Successful performance of at least five (5) procedures during within the past 24 months.
				Major head and neck radical cancer surgery and resection of oral cancer tumors	Documented successful performance of a minimum of 25 procedures within the past 24 months	N/A	Successful performance of at least 15 procedures during within the past 24 months.
				Replantation Surgery Of 3 digits or more	Successful completion of an approved Plastic & Reconstructive Surgery Residency **OR** A General Surgery or Orthopedic Surgery Residency with a Microsurgery Fellowship **AND** Documented successful performance of at least two (2) microsurgery procedures within the past 24 months	1	Successful performance of at least one (1) microsurgery procedure within the past 24 months.
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification
				Regional Wound Healing Center (RWHC)	Applicants must meet initial appointment or reappointment criteria for Plastic and Reconstructive Surgery AND Be approved by the Medical Director of the RWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for Plastic and Reconstructive Surgery Privileges as appropriate.

Salinas Valley Health Medical Center

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

Plastic and Reconstructive Surgery:

1. Aesthetic/cosmetic surgery of the head and neck, trunk, and extremities
2. Chemical peel
3. Chemosurgery
4. Dermabrasion
5. Facial plastic surgery to include cosmetic surgery on the face, nose, external ear, eyelids, and lips
6. Hair transplantation, punch or strip
7. Liposuction or lipo-injection procedure for contour restoration, head and neck, trunk, and extremities
8. Management of infections of soft tissues and bony structures, including amputation
9. Management of patients with burns, including plastic procedures on the extremities
10. Microvascular free tissue transfer
11. Plastic procedures of external and internal male and female genitalia
12. Plastic procedures on the female and male breast, including augmentation and reduction mammoplasties, postmastectomy reconstruction
13. Plastic reconstruction of all forms of congenital and acquired soft tissue and muscle anomalies, including those requiring the use of skin grafting procedures, the use of pedicle flaps
14. Plastic reconstruction of soft tissue disfigurement or scarring, for cosmetic or functional reasons
15. Removal of benign and malignant tumors of the skin
16. Hernia Repair/Revision with/without Mesh– Non Inguinal (also excludes intraperitoneal involvement with major lysis of adhesions)
17. Nerve grafting and reconstruction of peripheral nerve injuries

Hand Surgery

1. Arthroplasty of wrist or hand, including implants
2. Bone graft pertaining to the hand
3. Carpal tunnel decompression
4. Fasciotomy and fasciectomy
5. Fracture fixation with compression plates or wires
6. Lacerations
7. Nerve graft
8. Neurorrhaphy
9. Open and closed reductions of fractures
10. Removal of soft tissue mass, ganglion palm or wrist, flexor sheath, etc.
11. Repair of rheumatoid arthritis deformity
12. Replantation of up to 2 digits
13. Skin grafts
14. Tendon reconstruction (free graft, staged)
15. Tendon release, repair, and fixation
16. Tendon transfers
17. Treatment of infections
18. Microsurgery of the hand, nerves and blood vessels

Plastic and Reconstructive Surgery Within the Head and Neck

1. Reconstruction eyelid, ptosis repair
2. Upper lid gold weight placement
3. Reconstruction aural microtia
4. Fascial sling procedures
5. Hypoglossal-facial nerve transfer
6. Accessory-facial nerve transfer
7. Injection of soft-tissue fillers
8. Management of all forms of facial or maxillofacial trauma including fractures
9. Rhinoplasty/Septoplasty
10. Temporomandibular joint surgery
11. Tracheostomy
12. Use of laser

Cosmetic Procedures:

i. Mentoplasty
ii. Rhytidectomy
iii. Blepharoplasty
iv. Liposuction or lipo-injection procedure for contour restoration, head and neck; trunk and extremities
v. Chemical peel
vi. Dermabrasion
vii. Hair transplantation, punch or strip
viii. Brow lift
ix. Endoscopic facial surgery

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

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

_____ _____

_____ _____

_____ _____

_____ _____

Applicant Signature: Date:

Clinical Privileges Delineation
General and Colorectal Surgery

Applicant Name: _____

GENERAL SURGERY:

Qualifications:

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

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in general surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

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

Applicants more than two years out of Residency training must provide documentation of the performance of at least 100 general surgical procedures during the past 12 months.

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

COLORECTAL SURGERY:

Qualifications:

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

Board Certification:
Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in colorectal surgery by the American Board of Surgery or the American Osteopathic Board of Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

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

Applicants more than two years out of Fellowship training must provide documentation of the performance of at least 50 colorectal surgical procedures during the past 24 months.

General Privilege Statement

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

SPECIAL REQUIREMENT:

Physicians involved in the evaluation and management of cancer patients must be either Board Certified, in the process of becoming board certified; or demonstrate ongoing cancer-related education by documenting 12 CME hours annually

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

☐ General Surgery Core privileges

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients with underlying surgical conditions. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

☐ Colorectal Surgery Core privileges

Admit, evaluate, diagnose, consult, and provide pre-, intra-, and post-operative care, and perform surgical procedures, to patients of all ages admission, workup, diagnosis and performance of surgical procedures on patients presenting with illnesses related to the colon, rectum & anus; to correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, abdomen and its contents, extremities, breast, skin and soft tissue, head and neck, vascular and endocrine systems. Management of trauma and complete care of critically ill patients. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Core Proctoring Requirements:

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

Reappointment Criteria for Core Privileges:

Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 5 cases per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify for reappointment.

Special Procedures/Privileges

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

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

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	1	**Current ACLS Certification AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least 2 Cases
				Insertion and management of pulmonary artery catheters	Successful completion of an accredited residency or fellowship in internal medicine, general surgery, cardiology, anesthesiology, pulmonary medicine, critical care, or family medicine; and performance of at least 10 PACs during this formal training, as primary operator **Required Previous Experience:** Active hospital practice in the chosen respective field; and performance (as the primary operator) of at least 10 PACs during the past 24 months.	1	Performance of at least 4 PACs during the past 24 months.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Sentinel Node Biopsy for Cancer	Documented proficiency in the standard diagnosis and surgical management of breast cancer and/or melanoma **AND** Successful completion of an approved course leading to the ability to evaluate the patient for and perform the sentinel node mapping procedures.	3 Retrospective Chart Reviews 1 observation	Performance of at least 4 cases during the past 24 months.
				*Intermediate Laparoscopic Surgery	Must possess unrestricted privileges for open procedures **AND** Meet criteria for credentialing in basic laparoscopic general surgery **AND** Document completion of an accredited, hands-on course in laparoscopic general surgery for any one of the procedures herein defined as intermediate, or same in residency **AND** Document successful completion of at least 4 procedures in the past 24 months	1 by proctor with at minimum Intermediate Laparoscopic Surgery Privileges	Performance of at least 4 cases during the past 24 months
				Percutaneous Endoscopic Gastrostomy (PEG).	Formal fellowship training in gastroenterology or a residency in general surgery **AND** Performance of at least 5 cases during the past 24 months	1 Observation and 3 chart reviews	Performance of at least 5 cases during the past 24 months
				Laparoscopic Sleeve Gastrectomy	Unrestricted privileges to perform advanced laparoscopic surgery (*restrictions do not include initial appointment proctoring)*	5 cases observed by a surgeon with unrestricted privileges for the procedure	Performance of at least 20 cases during the past 24 months.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				*Advanced Laparoscopic Surgery	Fulfillment of criteria initially for Basic Laparoscopic privileges **AND** Document evidence of completing an accredited, hands-on course in advanced laparoscopic general surgery in the procedure requested or in three of the other advanced laparoscopic procedures, OR document having completed training and experience for such residency **AND** Document successful completion of at least 4 procedures in the past 24 months *General Surgeons who qualify for advanced laparoscopic privileges also qualify for intermediate laparoscopic privileges.	**1** by proctor with at minimum Intermediate Laparoscopic Surgery Privileges	Performance of at least 4 cases during the past 24 moths
				Esophagogastroduodenoscopy EGD	Documentation of successful completion of 50 cases in the past 24 months	**1**	Performance of at least 25 cases during the past 24 months
				Esophageal resection and reconstruction, or esophagogastrectomy, or Transhiatal Esophagectomy	Documentation of successful completion of 4 cases in the past 24 months	**1**	Performance of at least 2 cases during the past 24 months
				Colonoscopy	Documentation of successful completion of 50 cases in the past 24 months	**1**	Performance of at least 25 cases during the past 24 months
				Hysterectomy as part of general surgical procedures	Documentation of successful completion of 8 cases in the past 24 months	**1**	Performance of at least 4 cases during the past 24 months
				Regional Wound Healing Center (RWHC)	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery Privileges AND Be approved by the Medical Director of the RWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for General and Colorectal Surgery privileges.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Percutaneous/Open Radiofrequency Ablation of Tumors	Successful completion of an ACGME/AOA accredited residency in general surgery, urology or otolaryngology **OR** fellowship training in vascular surgery or interventional radiology **AND** Documentation of successful completion of 2 procedures in the past 24 months	**1**	Performance of at least 2 cases during the past 24 months AND Documentation of CME directly related to radiofrequency ablation within the past 24 months
				Use of radiofrequency for interruption of veins	Successful completion of the equipment manufacturer's training course **AND** Current unrestricted privileges in non-radiofrequency assisted deep vein interruption procedures	**1**	Performance of at least 2 cases during the past 24 months
				Radical regional lymph node dissections, including retroperitoneal, pelvic and inguinal	Documentation of successful completion of 4 cases in the past 24 months	**1**	Performance of at least 2 cases during the past 24 months
				Salpingooopherectomy	Documentation of successful completion of 8 cases in the past 24 months	**1**	Performance of at least 4 cases during the past 24 months
				FAST Scan	Completion of an accredited Surgery Residency and documentation of a minimum of 12 hours of didactic training including physics of ultrasound, sonographic instrumentation, basic interpretation (including common pitfalls) and supervised use of instrumentation in normal patients **OR** documentation of training and experience during residency.	Seven (7) FAST Scan cases must be performed and the hard copy reviewed by a radiologist. At least three (3) scans must demonstrate free fluid or blood. Initial FAST Scans will be followed by surgery or CT Scan which will provide "Gold Standard" documentation of free fluid status.	N/A
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California Stat X-Ray S&O Fluoroscopy Certification

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

General Surgery

1. Amputations, above the knee, below knee, toe, transmetatarsal
2. Appendectomy
3. Biliary enteric anastomosis
4. Biliary tract resection/reconstruction
5. Breast: complete mastectomy with or without axillary lymph node dissection; excision of breast lesion, breast biopsy, incision and drainage of abscess. modified radical mastectomy, operation for gynecomastia, partial mastectomy with or without lymph node dissection, radical mastectomy, subcutaneous mastectomy including diagnosis and management of breast disorders
6. Colectomy, colotomy, colostomy
7. Proctectomy, including abdominoperineal approach
8. Correction of intestinal obstruction
9. Emergency thoracostomy
10. Enteric fistulae, management
11. Enterostomy (feeding or decompression)
12. Anal fistula and fissure procedures
13. Hemorrhoidectomy
14. Excision of thyroglossal duct cyst
15. Gastric operations for cancer (partial. or total gastrectomy)
16. Gastroduodenal surgery
17. Gastrostomy (feeding or decompression)
18. Hepatic lobectomy and insertion of infusion catheters, pumps
19. Incision and drainage of abscesses and cysts of the soft tissue
20. Biopsy of superficial lymph nodes, cutaneous and soft tissue lesions
21. Incision, excision, resection, and enterostomy of small intestine
22. Incision/drainage of perirectal abscess
23. Incision/excision of pilonidal cyst
24. Intraoral surgery, local excision
25. Laparotomy for diagnostic or exploratory purposes or for management of intra-abdominal sepsis
26. Liver biopsy (intra-operative)
27. Management of burns
28. Management of intra-abdominal trauma, including injury, observation, paracentesis, lavage
29. Management of multiple trauma
30. Management of soft tissue tumors, inflammations, and infections and necrosis
31. Open operations on gallbladder, biliary tract, bile ducts, hepatic ducts, excluding biliary tract reconstruction
32. Pancreatic pseudoscyst drainage
33. Debridement of infected pancreatic tissue
34. Nephrectomy with Urology present
35. Debridement of decubitus and stasis ulcers of the skin
36. Removal of ganglion (palm or wrist; flexor sheath)
37. Removal of Peritoneal Dialysis Catheter
38. Repair of perforated viscus (gastric, small intestine, large intestine)
39. Vagotomy
40. Skin grafts (partial thickness, full thickness, split thickness)
41. Splenectomy (trauma, staging, therapeutic)
42. Surgery of the abdominal wall, including management of all forms of hernias, including diaphragmatic hernias, inguinal hernias, and orchiectomy in association with hernia repair

43. Thoracentesis
44. Thyroid and parathyroid surgery
45. Tracheostomy
46. Varicose vein injection, sclerotherapy, excision & ligation, interruption of deep perforator veins of the lower extremities
47. Insertion of central venous catheters: non-tunneled, tunneled, with or without subcutaneous ports
48. Arterial line placement and monitoring
49. Basic Laparoscopy – diagnostic, appendectomy, cholecystectomy, lysis of adhesions, Peritoneal Dialysis , feeding tubes and catheter positioning and Liver Biopsy

Colorectal Surgery

1. Abdominal procedures related to diseases of the colon, rectum and anus
2. Anorectal procedures
3. Endoscopic procedures including anoscopy, rigid sigmoidoscopy, flexible sigmoidoscopy, & total colonoscopy
4. Endoscopic rectal ultrasound
5. History & Physical
6. Operative management and post-operative care of patients with pathologic conditions involving the intestinal tract, colon, rectum, anal canal and perianal area
7. Urogynecologic procedures related to diseases of the colon, rectum and anus
8. Use of Laser
9. Vascular access procedures
10. Laparoscopic Colon Surgery
11. Laparoscopic Hernia Repair

*** DEFINITIONS**

<u>Intermediate laparoscopic general surgery</u>

- Jejunostomy
- Gastrostomy
- Vagotomy
- Lymph node biopsy
- Closure perforated ulcer
- Oopherectomy and/or drainage of ovarian cyst in consultation with OB/GYN
- Hernia repair to include hiatal, umbilical, incisional and inguinal with or without graft

<u>Advanced laparoscopic general surgery</u>

- Bowel surgery to include resection, anastomosis, stoma, colectomy, hemicolectomy, and sigmoidectomy
- Common bile duct exploration
- Splenectomy
- Lymph node dissection
- Nephrectomy with Urologist present
- Adrenalectomy
- Gastrectomy

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

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

_____ _____

_____ _____

Applicant Signature: Date:

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

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

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

Applicant Signature _____ Date _____

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

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

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

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

Department Chair Signature _____ Date _____

Clinical Privileges Delineation
Orthopedic Surgery

Applicant Name: _____

Qualifications:

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

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

Board Certification:

Current Board certification or Board Eligible status (as defined by the corresponding specialty Board) in orthopedic surgery by the American Board of Orthopedic Surgery or the American Osteopathic Board of Orthopedic Surgery. For Board Eligible applicants, Board Certification as defined above must occur within 5 years of completion of residency/fellowship or within the eligibility specified by the corresponding specialty Board.

Ongoing Board Certification:

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

Applicants more than two (2) years post Residency must provide documentation of the performance of at least 100 orthopedic procedures during the last 12 months.

General Privilege Statement

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

Orthopedic Surgery Core Privileges

Admit, evaluate, diagnose, provide consultation and care to patients, to correct or treat various conditions, illnesses and injuries of the extremities, spine, and associated structures by medical, surgical, and physical means including but not limited to congenital deformities, trauma, infections, tumors, metabolic disturbances of the musculoskeletal system, deformities, injuries, and degenerative diseases of the hands, feet, knee, hip, shoulder, and elbow including primary and secondary muscular problems and the effects of central or peripheral nervous system lesions of the musculoskeletal system. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Orthopedic Spine Surgery

To be eligible to apply for core privileges in Orthopedic Surgery of the Spine, the applicant must meet the following qualifications: Same as above for Orthopedic Surgery plus successful completion of an ACGME accredited fellowship training program in orthopedic surgery of the spine.

Orthopedic Spine Surgery Core Privileges

☐ **Requested**

Admit, evaluate, diagnose, treat and provide consultation to patients of all ages, except as specifically excluded from practice, with spinal column diseases, disorders, and injuries by medical, physical and surgical methods including the provision of consultation.

Hand Surgery

To be eligible to apply for core privileges in Hand Surgery, the applicant must meet the following qualifications:
Current certification in surgery, plastic surgery or orthopedic surgery and post graduate training in hand surgery or subspecialty certification in hand surgery (Certificate of Added Quality in Hand Surgery) by the American Board of Surgery, Plastic Surgery or Orthopedic Surgery,
Or
• Successful completion of an ACGME accredited post-graduate training program in surgery, orthopedic or plastic surgery that included training in surgery of the hand
And
Evidence of successful performance of at least 75 cases in the previous 2-years.

Hand Surgery Core Privileges

☐ **Requested**

Admit, evaluate, diagnose, treat, provide consultation and perform surgical procedures for patients with diseases, injuries, and disorders, both congenital and acquired, of the hand, wrist and related structures. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

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

Core Proctoring Requirements:

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

Reappointment Criteria:

Orthopedic Surgery Core Privileges:
Applicant must provide documentation of current ability to perform requested privileges; 100 surgery procedures within the past 24 months, the majority being of a major nature as well as current Board certification or continued Board Eligible status as outlined in the initial appointment criteria.

Hand Surgery Core Privileges:
Successful performance of at least 40 hand procedures in the past 24 months reflective of the privileges requested as well as current Board certification or continued Board Eligible status as outlined in the initial appointment criteria.

Spine Surgery Core Privileges:
Successful performance of at least 25 surgical procedures in the past 24 months reflective of the privileges requested as well as current Board certification or continued Board Eligible status as outlined in the initial appointment criteria.

Special Procedures/Privileges

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

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

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

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

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				Regional Wound Healing Center (RWHC)	Applicants must meet initial appointment or reappointment criteria for Orthopedic Surgery Privileges AND Be approved by the Medical Director of the RWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for Orthopedic Surgery Privileges.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Percutaneous vertebroplasty or balloon kyphoplasty	Division of Neurosurgery with unrestricted spinal surgery privileges, or Division of Orthopedic Surgery with unrestricted spinal surgery privileges, **OR** Department of Diagnostic Imaging with unrestricted interventiona1radiology privileges **AND** 1. Documentation of successful completion of five (5) kyphoplasty procedures within the past 24 months **OR** 2. If recently completing Kyphoplasty training, applicant must provide documentation of successful completion (training course must be approved by the Salinas Valley Memorial Hospital Medical Staff) in the use of Kyphoplasty (inflatable bone tamp technology). Training must include completion of at least two successful and uncomplicated balloon kyphoplasty procedures as principal operator under the supervision of a proctor and it is recommended that a Kyphon company representative also be present.	Applicants under section 1 must have a minimum of two (2) cases observed by a qualified proctor. Applicants under section 2. above must have a minimum of two (2) cases observed by a qualified proctor and shall have the first three cases completed at SVMH retrospectively reviewed for appropriateness and outcome by a qualified proctor*	Applicants must demonstrate that they maintained competence by providing documentation of successful performance of at least five (5) Kyphoplasty or vertebroplasty procedures in the two-year reappointment cycle, of which at least two (2) must have been Kyphoplasty procedures.
				Autologous chondrocyte implantation (ACI)	The applicant must have completed a Genzyme advanced course in ACI.	**N/A**	**N/A**
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Replantation Surgery Of 3 digits or more	Successful completion of an approved Plastic & Reconstructive Surgery Residency **OR** A General Surgery or Orthopedic Surgery Residency with a Microsurgery Fellowship **AND** Documented successful performance of at least two (2) microsurgery procedures in the previous two (2) years	**1**	Successful performance of at least one (1) microsurgery procedure within the past 24 months.
				Total Cervical Disc Replacement	Documentation of successful completion of training at a hands-on training practicum in the insertion of artificial discs. This program must have consisted of at least eight (8) hours of training with experience in a laboratory setting which included personal time performing procedures on animate or cadaver models. **OR** Documentation of previous practical experience as part of an accredited fellowship or residency program in which the applicant demonstrates that they have successfully performed at least five (5) surgical procedures within the past 12 months.	**3**	Documented successful performance of at least ten (10) procedures during the reappointment cycle or five (5) procedures if reappointment occurs within a 12-month period.
				Use and/or Supervision and/or Director of C-Arm And/or O-Arm	Current CA State Fluoroscopy Certificate	N/A	Current CA State Fluoroscopy Certificate

**A qualified proctor is defined as (1) an expert outside of the SVMH Medical Staff who has been approved by the appropriate department; or (2) a Medical Staff member with unrestricted Kyphoplasty privileges*

Salinas Valley Health Medical Center

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

Orthopedic Surgery

1. Amputation surgery
2. Amputations/simple polydactyly/digital tip injuries
3. Arthrocentesis
4. Arthrodesis, osteotomy, and ligament reconstruction of the major peripheral joints
5. Arthrography
6. Arthroplasty
7. Arthroscopic surgery upper and lower extremities
8. Biopsy and excision of tumors involving bone and adjacent soft tissues
9. Bone grafts
10. Peripheral nerve decompression
11. Closed and open reduction of fractures and dislocations of the peripheral skeleton
12. Debridement of soft tissue and bone
13. Fasciotomy and fasciectomy
14. Fracture fixation with mini compression plates
15. Management of the skeleton other than spine, to include traumatic, congenital, developmental, infections, metabolic, degenerative and hematologic disorders
16. Ligament reconstruction
17. Muscle and tendon repair
18. Use of Laser

Orthopedic Surgery of the Spine (Core Spine privileges must be specifically requested on the front of the privilege form)

1. Assessment of the neurologic function of the spinal cord and nerve roots
2. Interpretation of imaging studies of the spine
3. Management of traumatic, congenital, developmental, infectious, metabolic, degenerative, and hematologic disorders of the spine
4. Treatment of extensive trauma including spine
5. Laminectomies, laminotomies, and fixation and reconstructive procedures of the spine and its contents, including instrumentation
6. Lumbar puncture
7. Spinal cord surgery for decompression of spinal cord or spinal canal, rhizotomy, cordotomy, dorsal root entry zone lesion, tethered spinal cord, or other congenital anomalies
8. Endoscopic spinal procedures
9. Scoliosis and kyphosis instrumentation

Hand Surgery

1. Arthroplasty of wrist or hand, including implants
2. Bone graft pertaining to the hand
3. Carpal tunnel decompression
4. Fasciotomy and fasciectomy
5. Fracture fixation with compression plates or wires
6. Lacerations
7. Nerve graft
8. Neurorrhaphy
9. Open and closed reductions of fractures
10. Removal of soft tissue mass, ganglion palm or wrist, flexor sheath, etc.
11. Replantation of up to 2 digits
12. Skin grafts
13. Tendon reconstruction (free graft, staged)
14. Tendon release, repair, and fixation
15. Tendon transfers
16. Treatment of infections
17. Microsurgery of the hand, nerves and blood vessels

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

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

_____ _____

_____ _____

_____ _____

_____
Signature:

_____
Date

Clinical Privileges Delineation
Podiatry

Applicant Name: _____

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

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

Category A Qualifications: Digital, Forefoot, Midfoot and Simple Rearfoot

• Board certification or qualification in foot surgery through the American Board of Foot and Ankle Surgery
AND
• Two years of CPME approved residency training (at least 12 months in surgical residency)
AND
• Documentation of at least 30 procedures performed during residency or during prior experience for Category A – Digital, forefoot, midfoot and simple rearfoot.

☐ **Category A Core Podiatric Privileges**

Evaluate and treat patients with podiatric problems/conditions of the digital, forefoot, and simple rearfoot to include all soft tissue and bony procedures involving the phalanges and metatarsal bones distal to the tarso-metatarsal joint; all soft tissue and bony procedures involving the cuneiform, navicular, and cuboid bones distal to the midtarsal joint; all soft tissue and simple exostectomy procedures involving the talar and calcaneal bones distal to the ankle joint. The core privileges in this specialty include the procedures on the attached list and such other procedures that are extensions of the same techniques and skills.

Category B Qualifications: Digital, Forefoot, Midfoot, Rearfoot and Ankle

• Board certification or qualification in reconstructive rearfoot/ankle surgery through the American Board of Foot and Ankle Surgery
AND
• Three years of CPME approved residency training (at least 24 months in surgical residency), or two years supplemented by fellowship training
AND
• Documentation of at least 20 procedures performed during residency or during prior experience for Category B – Rearfoot and ankle.

☐ **Category B Core Podiatric Privileges** ***(Check Box to Request)***

Evaluate and treat patients with podiatric problems/conditions of the rearfoot and ankle to include all procedures involving osteotomies, arthrodesis, and open repair of fractures of the talar and calcaneal bones distal to the ankle joint; all soft tissue, simple exostectomy, arthroscopy and drill hole (for ankle ligamentous reconstruction) procedures involving the distal tibial and fibular bones.

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

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

Reappointment Criteria for Core Privileges:
Applicant must provide reasonable evidence of current ability to perform requested privileges; those physicians who have fewer than 5 patient contacts per year in the hospital, and cannot provide documentation of current competence from another facility, will not qualify to reapply.

Special Procedures/Privileges

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

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

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

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

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

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Moderate Sedation	**Current ACLS Certification** **AND** Signed attestation of reading SVMH Sedation Protocol and learning module, **AND** Completion of written moderate sedation exam with minimum of 75% correct.	**1**	**Current ACLS Certification** **AND** Completion of written moderate sedation exam with minimum 75% correct **AND** Performance of at least two (2) Cases within the past 24 months
				Clubfoot Repair and/or Repair Ripped Vertical Talus	Documentation of Advanced Training in Clubfoot Repair **AND** Documentation of 30 Ripped Vertical Talus repairs or Club Foot Repairs cases within the past 24 months	3	12 within the past 24 months
				Regional Wound Healing Center (RWHC)	Applicants must meet initial appointment or reappointment criteria for Category A or B Podiatric Surgery Privileges as appropriate AND Be approved by the Medical Director of the RWHC or their designee	N/A	Applicants must meet initial appointment or reappointment criteria for Category A or B Podiatric Surgery Privileges as appropriate.

Applicant: Check box marked "R" to request privileges

R	A	C	N	Procedure	Initial Appointment	Proctoring	Reappointment
				Admitting Privileges Qualified DPM may perform history and physicals for surgery and inpatient admissions for patients who are considered *non-high risk*. *Non-high risk* patients will include: patients who are ASA III with three (3) or less <u>stable</u> medical conditions; ASA II well compensated; ASA I.	Applicant must demonstrate adequate experience in performing medical history and physical exams **AND** Must have completed an accredited podiatric surgical residency and will be required to show proof of such residency.	1 Retrospective Review	**None**
				Use of Fluoroscopy	Current California State X-Ray S&O Fluoroscopy Certification	None	Current California State X-Ray S&O Fluoroscopy Certification

Salinas Valley Health Medical Center

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

Podiatry

Category A

1. All podiatric infections or systemic illness that can manifest itself in a pedal complaint, being concurrently treated by a MD/DO physician
2. Bunionectomy, fifth toe metatarsal (w/wo osteotomy)
3. Bunionectomy, first toe metatarsal (w/wo osteotomy)
4. Bunionectomy without osteotomy or implantation
5. Bunionectomy with osteotomy
6. Capsulotomy/Tenotomy digital or forefoot
7. Capsulotomy of mid or rearfoot
8. Closed reduction of fractured metatarsals
9. Closed reduction fractures of Forefoot
10. Closed reduction of fractured phalanges
11. Debridement of wounds foot/ankle
12. Digital Amputation
13. Excision accessory foot ossicles
14. Excision, inter-metatarsal neuroma
15. Excision of condyle/forefoot exostectomies
16. Excision of soft tissue lesion, forefoot/rearfoot
17. Excision of soft tissue lesion from rearfoot (ganglion)
18. Excision retrocalcaneal spur
19. Excision plantar calcaneal exostosis
20. Excision of osseous tumors of forefoot
21. Excision of os trigonum
22. Excision of soft tissue tumors (neuromata, ganglia)
23. Excision of superficial foot lesions (nevi, inclusion cysts)
24. Excision of superficial soft tissue lesion from rearfoot (ex ganglion)
25. Excision soft tissue tumors of forefoot
26. Forefoot tenotomy
27. Foreign body removal forefoot/rearfoot
28. Fusion metatarsal – cuneiform joint
29. Fusion of IP joint of digit
30. Great toe and lesser MPJ Implants
31. Hammertoe repair or fusion
32. Hammertoe repair of digits (any method)
33. Incision and drainage of superficial abscess, foot
34. Incision and drainage procedures forefoot/midfoot
35. Metatarsal head resection – including Pan met/head resections
36. Neurolysis procedures forefoot/midfoot
37. Nerve entrapment
38. Onychoplasty (partial or complete – Nail Procedure)
39. Open reduction and internal fixation of metatarsal or phalanx
40. Open repair of fracture, forefoot
41. ORIF Forefoot and Midfoot fractures
42. Osteotomy digital (hallux ect)
43. Osteotomy of first metatarsal hallux
44. Osteotomy of lesser metatarsal
45. Osteotomy of phalanges, lesser digits
46. Osteotomy with internal fixation fore foot
47. Osteotomy, ostectomy, osteoclasis, digital and metatarsal
48. Partial ostectomy, lesser tarsus
49. Phalangeal arthroplasty

50. Phalangeal exostectomy
51. Plantar fascia release (including endoscopic)
52. Plantar fibromata excision
53. Plantar wart excision
54. Prothesis, implants, MPJ & IPJ in metatarsal area
55. Removal of foreign body from forefoot
56. Removal of foreign body from rearfoot
57. Removal of internal fixation hardware
58. Sesamoidectomy (IPJ and MPJ)
59. Sesamoidectomy forefoot/midfoot
60. Skin transfer/rotation flaps
61. Surgical Assisting Orthopedic Procedure
62. Surgical debridement, foot
63. Syndactylism of toes
64. DeSyndactylism procedure
65. Synovectomy or tenosynovectomy procedure (forefoot/midfoot)
66. Tendon transfer or redirection forefoot/midfoot
67. Tarsal tunnel release
68. Tarsal exostectomy
69. Tendon repair, forefoot/rearfoot
70. Transmetatarsal Amputation
71. Use of Laser
72. Z-Plasty procedures /rotation flaps ect./skin

Category B

1. Achilles tendon repair
2. Amputations Proximal to transmetatarsal level (ex LisFranc/Choparts/Syme)
3. Ankle Arthrodesis
4. Ankle fracture
5. Ankle joint arthroscopy
6. Ankle Osteotomy
7. Application External Fixation Ankle/Rearfoot
8. Bone Graft Harvest from calcaneous/distal tibia/fibula
9. Cartilage repair techniques Talar Dome (ex Oats/allogenic osteochondral graft)
10. Distal osteotomy of fibula/tibia
11. Endoscopic plantar fascial release
12. Excision tarsal coalition
13. Excision Tumors of rearfoot/ankle
14. Excision osseous tumor rearfoot
15. Excision Os Trigonum
16. External fixation rearfoot/ankle
17. Gastrocnemius recession/endoscopic Gastroc recession
18. I&D infections rearfoot/ankle/management Osteomyelitis
19. Mid-tarsal fusion
20. Neurolysis/Neurectomy of ankle
21. Open reduction of fractures rearfoot and ankle
22. ORIF fractures rearfoot/ankle
23. ORIF Tarsal bones
24. Osteotomies of tarsal bones
25. Remove from Form Tarsectomy
26. Repair ligamentous structures of ankle
27. Repair tendons of ankle
28. Subtalar Arthroeresis
29. Subtalar fusion
30. Tarsal tunnel release
31. Tendon transfer or redirection of midtarsus, rearfoot, ankle/leg
32. Total ankle implant

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

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

_____ _____

_____ _____

_____ _____

Applicant Signature: Date:

Salinas Valley Health Medical Center

REGIONAL WOUND HEALING CENTER (RWHC)

Medical Staff Clinical Privileges Delineation for Non-Surgical Specialties

Applicant Name: _____

Qualifications:

- MD or ~~,~~ DO ~~or DPM~~ degree with current and clear license to practice in the State of California
- Recommendation by the RWHC Medical Director
- ~~Successful completion of an accredited residency training program with ABMS, ABOMS or ABPM~~
- Current certification or active participation in the examination process leading to certification by the American Board of Medical Specialties (can state specific Board specialty) or the American Osteopathic Association Board Certification (can state specific Board specialty)
  - **Or**
- Successful completion of an accredited ACGME-or AOA-accredited post-graduate training program in SPECIALTY NAME
- S~~Documented s~~uccessfull complet~~eion~~ion ~~of~~ the SVH Wound Care educational modules within 6 months of ~~Provisional appointment~~approval of privileges. (see attachment)
-
- New applicants will be required to provide documentation of 50 ambulatory care, acute care or office cases during the past 24 months involving patients with musculoskeletal and/or skin problems. Applicants have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, and other qualifications and for resolving any doubts.

Regional Wound Healing Center Core Privileges

☐ **Requested**

Assess, evaluate, diagnose and treat patients who present to RWHC. Privileges do not include care of patients on an in-patient basis at ~~SVMH~~Salinas Valley Health Medical Center. The core privileges include consultation~~s~~, ~~debridement at five levels: partial thickness; full thickness; subcutaneous tissue; subcutaneous tissue & muscle and subcutaneous tissue, muscle & bone;~~incision & drainage, biopsies and application of artificial skin equivalents and such other procedures that are extensions of the same techniques and skills.

General Privilege Statement

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

Core Proctoring Requirements:

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

~~Proctoring requirements will include: Observing no less than one four-hour clinic with a wound care physician who has no less than one year of experience providing services at the Regional Wound Healing Center; and chart review of a minimum of 5 patient care records.~~

Reappointment Criteria for Core Privileges:

Documentation of a minimum of 10 patient contacts per year at RWHC.

Practitioners who do not meet the criteria above a~~nd who cannot provide acceptable documentation of current competence from another facility,~~ will not qualify to reapply.

Special Procedures/Privileges

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

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

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

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

R	A	C	N	Procedure	Initial Application	Proctoring	Reappointment
				~~**Use of radiofrequency for interruption of veins**~~	~~Successful completion of the equipment manufacturer's training course~~ ~~**AND**~~ ~~Current unrestricted privileges in non-radiofrequency-assisted deep vein interruption procedures~~	~~**1**~~	~~Performance of at least two (2) cases within the past 24 months~~
				Debridement exluding level ~~at~~ five ~~levels: partial thickness; full thickness; subcutaneous tissue; subcutaneous tissue & muscle and subcutaneous tissue, muscle & bone;~~	Applicants must meet criteria for Regional Wound Healing Center ~~General Surgery, Plastic & Reconstructive Surgery or Podiatric Surgery criteria for the RWHC~~	~~**Q**~~**1**	Performance of at least two (2) cases within the past 24 months. Documentation must be provided by the applicant.

Attachment

Education Requirements for Core RWHC Privileges:

- Applicants for initial appointment must complete a minimum of four (4) Modules of their choosing from The Wound Institute during the first six (6) months of their Provision appointment.
- Documentation of completion must be submitted to the Medical Staff Services Department or privileges will be automatically suspended.
- You may access the modules using the following link:

http://www.woundcme.org/courses/woundcme/online?ther%5B%5D=Wound+Care&acc%5B%5D=CME

Status **Pending** PolicyStat ID **14040631**

Last Approved	N/A	Owner	James Hively: Environmental Health & Safety Manager
Last Revised	09/2023	Area	Plans and Program
Next Review	1 year after approval		

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
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
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

History

Draft saved by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 7/17/2023, 12:05PM EDT

Edited by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 7/17/2023, 12:05PM EDT

> Corrected format

Last Approved by Hively, James: Environmental Health & Safety Manager on 7/17/2023, 1:38PM EDT

> Approved by the EOC Committee during it's January 23, 2023 meeting.

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 7/28/2023, 1:35PM EDT

> Policy Committee previously approved. Moving forward for approvals with corrected approval flow.

Comment by Zerbe, Laura: Facilities Regulatory Compliance and Improvement S on 8/1/2023, 4:47PM EDT

> @Alaga, Rebecca: Regulatory/Accreditation Coordinator @Woodrow, Lea: Director of Accreditation and Regulatory Complianc@Silva, Lucy: Manager Regulatory / Accreditation@Hively, James: Environmental Health & Safety Manager Hi, I don't think the management plan needs to go to Emergency Management Committee, just to EOC. I think the 'code orange' policy makes sense to go to EM though. Do you agree? If so can we update the approval flow for this document? Thanks, Laura

Comment by Hively, James: Environmental Health & Safety Manager on 8/1/2023, 4:53PM EDT

> Not sure why this management plan needs to go the EM Committee for approval. This has never been required in the past. It was already approved by the EOC Committee in January 2023. The approval flow should be updated.
> Thanks,
> Jim

Comment by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 8/1/2023, 5:10PM EDT

> Agreed not needed for EM

Approval flow updated in place by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 8/3/2023, 11:45AM EDT

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 8/3/2023, 11:47AM EDT

> @Hively, James: Environmental Health & Safety Manager please approve for EOC. Thank you.

Last Approved by Hively, James: Environmental Health & Safety Manager on 8/3/2023, 12:23PM EDT

> This Plan was approved by the EOC Committee on January 24, 2023.

Comment by DeSalvo, Katherine: Director Medical Staff Services on 8/3/2023, 1:58PM EDT

> The Director of Quality has requested this plan be presented to Quality and Safety Committee prior to MEC approval. Please route to Aniko Kukla. Thank you.

Comment by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 8/3/2023, 2:08PM EDT

> Why does this plan need to go to Q&S - we have not in the past presented these plans there. They go to EOCC??

Comment by DeSalvo, Katherine: Director Medical Staff Services on 8/3/2023, 2:15PM EDT

> Please check in with Aniko on this. Thanks!

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 8/4/2023, 5PM EDT

> @DeSalvo, Katherine: Director Medical Staff Services please present to next MEC per Lea.

Approval flow updated in place by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 9/22/2023, 7:06PM EDT

Comment by DeSalvo, Katherine: Director Medical Staff Services on 9/22/2023, 7:31PM EDT

> I just clarified with Aniko that she no longer needs it to go the Quality and Safety. Any reason by MEC has to review it?

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
MEC	Katherine DeSalvo: Director Medical Staff Services	Pending
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

History

Edited by Meraz Gottfried, Lilia: Director of Clinical Development on 4/18/2023, 8:29PM EDT

> Clarified language under DNAR suspension.

Last Approved by Meraz Gottfried, Lilia: Director of Clinical Development on 4/18/2023, 8:29PM EDT

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/20/2023, 5:37PM EDT

> Template corrected

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/20/2023, 5:37PM EDT

> @DeSalvo, Katherine: Director Medical Staff Services where should this go?

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/20/2023, 5:39PM EDT

> Name change

Comment by DeSalvo, Katherine: Director Medical Staff Services on 4/20/2023, 7:22PM EDT

> It can go to the Critical Care Committee, MEC and finally the Board.

Administrator override by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/21/2023, 1:02PM EDT

> Flow created per MSO recommendations

Rejected by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 4/21/2023, 1:04PM EDT

> Lilia please start approvals to send through the new workflow

Last Approved by Meraz Gottfried, Lilia: Director of Clinical Development on 4/24/2023, 4:28PM EDT

> Provided clarifying language under the DNAR suspension section.

Approval flow updated in place by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 5/16/2023, 7:19PM EDT

Administrator override by Woodrow, Lea: Director of Accreditation and Regulatory Complianc on 5/18/2023, 11:51AM EDT

> format corrected

Last Approved by Spencer, Carla: Director Critical Care Services on 5/22/2023, 2:54PM EDT

Approval flow updated in place by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 6/26/2023, 4:29PM EDT

Comment by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 6/29/2023, 5:35PM EDT

> Kate since this affects all department does this need to go to all other departments such as Op and Invasive, etc. or is MEC enough?

Last Approved by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 6/29/2023, 5:35PM EDT

> Policy Committee previously approved.

Comment by DeSalvo, Katherine: Director Medical Staff Services on 6/29/2023, 5:45PM EDT

> This policy needs to go to Critical Care Committee and then to MEC. Critical Care Committee does not meet again until September 2023. If approval is required sooner, the owner could take to the Medical Director of the ICU, Dr. Le and the Medical Director of Palliative Care, Dr. Semer for interim approval prior to MEC.

Approval flow updated in place by Alaga, Rebecca: Regulatory/Accreditation Coordinator on 9/22/2023, 6:57PM EDT

Last Approved by DeSalvo, Katherine: Director Medical Staff Services on 9/29/2023, 3:14PM EDT

> Approved by Critical Care Committee 09-29-23

EXTENDED CLOSED SESSION
(if necessary)

(VICTOR REY, JR.)

ADJOURNMENT